Great Ormond Street Hospital for Children NHS Trust

Meeting of the Trust Board
30th March 2011

Dear Members

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

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

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Attachment
1.	**Apologies for absence**	Chair	**Verbal**
2.	**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.		
3.	**Minutes of Meeting held on 26th January 2011**	Chair	**O**
4.	**Matters Arising / Action point checklist**	Chair	**P**
5.	**Chief Executive's Update** • Safe and Sustainable Review • Haringey Services • Foundation Trust Authorisation	Chief Executive	**Verbal**
6.	**Zero Harm Report**	Co-Medical Director (ME)	**Q**
	ITEMS FOR APPROVAL		
7.	**Update on Trust Objectives 2011-12**	Chief Operating Officer	**R**
8.	**Annual Financial Plan 2011-12**	Chief Finance Officer	**S**
9.	**Foundation Trust self certification documents** • Leadership and Management Board Memorandum • Quality Governance Board Memorandum • Membership Strategy Update	Chief Operating Officer	**T**
10.	**Business Rates payment for 2011/12**	Chief Finance Officer	**U**
11.	**Approval of NHSLA Premiums for 2011/12**	Chief Finance Officer/ Medical Director (ME)	**16**
12.	**Register of Seals**	Chief Executive	**V**
	ITEMS FOR DISCUSSION		
13.	**Six Day Working (Presentation)**	Chief Operating Officer	**W**
	UPDATES		
14.	**Performance Exception Report - Month 11**	Chief Operating Officer	**X**
15.	**Finance Report - Month 11**	Chief Finance Officer	**Y**

16.	**Foundation Trust Update**	Chief Operating Officer	**Z**
17.	**Update on C Difficile**	Co-Medical Director (ME)/ Director of Infection, Prevention and Control	**1**
18.	**Heads of Nursing Report**	Chief Nurse	**2**
19.	**Trust Board Members' Activities**		**Verbal**
20.	**Annual Declaration of Interests 2010/11** a) Register of Members' Declarations b) Registers of Staff Declarations	Chief Executive	**3**
21.	**Register of Gifts and Hospitality 2010-11**	Chief Executive	**4**
	ITEMS FOR RATIFICATION		
22.	**Information and Communications Technology (ICT) Strategy**	Chief Finance Officer	**5**
23.	**Risk Management Strategy**	Co-Medical Director (ME)	**6**
24.	**Health and Safety Policy**	Co-Medical Director (ME)	**7**
25.	**Consultant appointments**	Chair	**Verbal**
26.	**Code of Conduct for NHS Managers**	Chief Executive/ Company Secretary	**8**
	ITEMS FOR INFORMATION (These items will not be discussed unless a Member gives prior notification of an intention to do so.)		
27.	**Assurance Framework Summary**	Chief Operating Officer	**9**
28.	**Update on Bribery Act**	Chief Finance Officer	**10**
29.	**Trust Board Subcommittees:** • Audit Committee Minutes October 2010 • Clinical Governance Committee Minutes November 2010 • Verbal update from CGC Chair on February 2011 meeting	Audit Committee Chair – Mr Charles Tilley CGC Chair – Mr Andrew Fane CGC Chair – Mr Andrew Fane	**11** **12** **Verbal**
30.	**Management Board minutes:** • **December 2011** • **January 2011**	Chief Executive	**13** **14**
31.	**UCL Partners Management Report**	Chief Executive	**15**
32.	**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.)		
33.	**Next meeting** The next public Trust Board meeting will be held on Wednesday 27th April 2011 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

Great Ormond Street Hospital for Children NHS Trust

Draft Minutes of the meeting of Trust Board held on 26 January 2011

Present

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

In attendance

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

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

233.	**Apologies for Absence**
233.1	No apologies for absence were received.
234.	**Declarations of Interest**
234.1	No Declarations of Interest were made.
235.	**Minutes of the Meeting Held on 24 November 2011**
235.1	The minutes of the Trust Board meeting held on 24 November 2010 were received and the Chairman requested the Board Members to check them for accuracy.

235.2	Mr Fane advised Committee Members that Minute 205.1 was now inaccurate. He said that since the last meeting it had been confirmed that Dr Benjamin Jacobs would not be joining the Trust as a Consultant General Paediatrician and had been replaced by Dr Imke Meyer-Parsonson.
235.3	The minutes were **approved** as an accurate record.
236.	**Matters Arising/Action Point Checklist**
236.1	**Minute 190.2 - Communication between Home Haemo Dialysis Patients** The Chief Executive reported that the Home Haemo Dialysis team were currently investigating ways to enable communication between patients using the service.
236.2	**Minute 190.8 - Problems Viewing Presentations from the Risky Business Conference using Trust ICT Facilities** The Chief Finance Officer said that the matter had been investigated and the external NHS internet connection had been identified as the cause of the fault. She said that staff were able to access the conference videos via the Joint Academic Network (JANET) through the Institute of Child Health website.
236.3	**Minute 197.2 – Suggested Changes to Credit Ratings and Production of Longer Term Financial Forecasts** The Chief Finance Officer confirmed that the Trust was currently applying the highest short term credit ratings possible. She said that annual forecasts were being produced but she wanted to ensure that processes were embedded prior to production of longer term forecasts.
236.4	**Minute 201.3 – Recovery of debt from the Maltese Government** The Chief Finance Officer said that sufficient progress had been made in this matter and the Chief Executive would not be required to make contact with the Maltese Government.
237.	**Chief Executive Update**
237.1	**Update on Six Day Working** The Chief Executive advised Board Members that flexibility offered by 6 day working formed a key element of the 'upside' business case. She said that Mr Sven Bunn would be presenting proposals to Clinical Unit Boards and HR would be leading a discussion on the matter at the Trust Board Away Day in February.
237.2	The Chief Executive said a Project Board would be formed to steer the work and Dr Liz Jackson had agreed to chair it. She thanked Dr Jackson for agreeing to undertake the role.
237.3	**Update on UCL Partners (UCLP)** The Chief Executive said that a programme was underway to examine the opportunities for bringing together back office functions in the partner organisations. She said that in a session held prior to the meeting, Board Members had agreed to support the continuation of this work.

237.4	The Chief Executive said that Academic Health Science Centres (AHSC's) were gaining more political traction and had been mentioned in the recent Health Bill. She said that it was important to remember that the acceleration of research benefits to patients was a fundamental principal of AHSCs in general.
237.5	It was noted that a joint conference had been held by UCLP and Monitor. The Chief Executive said that Professor Michael Porter of Harvard Business School had given a presentation on value and she would send a link for viewing it to the Non Executive Directors. **Action:** Chief Executive
237.6	Professor Elliott said that the Trust needed to examine how value could be reported at a clinical unit level. He said that development of these processes would enable working practice to be monitored and challenged more effectively.
237.8	**Strategic Health Authority (SHA) Quarter 2 Governance Assessment** The Chief Executive reported that the Trust had been rated green for it Quarter 2 Governance Assessment by the SHA. She said that it had been confirmed that the assessment would now cease.
238.	**Haringey Community Children's Services**
238.1	The Chief Executive asked for the item on Haringey to be taken next. She said that the Chief Nurse and Director of Education would also provide an update on the recent Safeguarding Improvement Team (SIT) visit to GOSH main site. It was noted that the SIT was a local SHA peer review initiative.
238.2	The Chief Nurse and Director of Education advised Board Members that the team had visited the Trust at Haringey a year ago and had recently returned to assess progress. She said that they had been extremely satisfied with the improvement and maintenance of services and were pleased by the enthusiasm of the staff. It had been noted that there was a strong commitment to safeguarding throughout the Trust from the top level down.
238.3	The Chief Nurse and Director of Education said that her paper included the safeguarding dash board. She said that problems with data collection had led to the absence of the following information on case conferences.
238.4	The Chief Nurse and Director of Education said that positive feedback had resulted from an Ofsted Inspection of Haringey Community Children's Services. She said that all criteria had been graded either satisfactory or good. Formal confirmation however has not yet been received.
238.5	The Chief Executive announced that Whittington Health had successfully tendered for the future provision of Haringey Community Children's Services. She said that The Co-Medical Director (BB) and Deputy Chief Executive had been asked to oversee the staff consultation and ultimate transfer.

238.6	Mr Fane asked if resources would be released in corporate services once the transfer of the Haringey Community Children's Services to Whittington Health had been delivered. The Chief Executive said that this should be the case but had not yet been investigated.
238.7	The Chief Nurse and Director of Education reported further detail on the recent GOSH main site SIT visit. She said that normally the hospital would have been assessed alongside its local Primary Care Trust (PCT) but because of the type of organisation that the Trust was, it had been decided to undertake an independent assessment.
238.8	The Chief Nurse and Director of Education said that the visit was conducted over a whole day and assessors attended nine different departments to meet key members of staff. She said that they were impressed by the safeguarding processes and in particular the leadership demonstrated at ward level.
238.9	The Chief Nurse and Director of Education reported that a number of recommendations had been received from the visit and additional work would be required on staff training and to clarify the relationship between social care and safeguarding. She said that the assessors had recommended that the Board receive a presentation on Child Protection and receive additional training to ensure that they were in a position to challenge safeguarding arrangements as appropriate.
238.10	The Company Secretary said that the Board were due to receive update training on Child Protection at the February Away Day.
239.	**Zero Harm Report**
239.1	The zero harm report was received from the Co-Medical Director (ME). He said that the first page of the report summarised the anticipated outcomes for each of the current work streams.
239.2	The Co-Medical Director (ME) said that use of the paediatric trigger tool had established a baseline for the measurement of harm and a number of key areas had been agreed as important in harm reduction. He outlined the work taking place on each of the areas:- o Record Keeping - Work had suggested that the use of electronic records may be beneficial. o Observations and Response to Deterioration – Use of Children's Early Warning Score (CEWS) had increased from 45% to 75%. o Infections and Skin Integrity – Work had examined the reduction of pressure sores particularly in spinal patients. o Medicines Management – Rates of medication errors had fallen and it was hoped that further development of the Centralised Intravenous Additive Service (CIVAS) would create further reductions.
239.3	Professor Copp asked if the quality of patient notes could impact on the results obtained from the trigger tool. The Co-Medical Director (ME) said that the tool monitored the level of harm recorded in the notes or other

	patient records and did not monitor the quality of record keeping. However he agreed that any harm not recorded in the notes or other records could not be identified in the trigger tool.
239.4	Mr Fane asked what the upper and lower control limits on the harm graph signified. The Co-Medical Director (ME) said that gap between the limits would reduce as the assessment process became more reliable.
239.5	The Chairman asked if details on the Medicines Management work could be included with the next zero harm report. **Action:** Co-Medical Director (ME)
239.6	The report was **noted.**
240.	**Estates Strategy – Executive Summary**
240.1	The executive summary of the Estates Strategy was received from the Director of Redevelopment. He said that the full document had been discussed during a Board development session held prior to the meeting and a presentation on the benefits and risks had been provided.
240.2	The Director of Redevelopment reported that the Trust had received a risk estimate rating of 'high green' under the Care Quality Commission (CQC) Quality Risk Profile (QRP) for the outcome related to the quality of the estate. He said that the strategy was intended to be a public document and outlined the range of Key Performance Indicators that had been developed for the department.
240.3	It was noted that the strategy contained a statutory declaration of combustion emissions for the 2010 calendar year and the reported level was 216 tonnes less than in 2009.
240.4	The Estates Strategy was **approved**
241.	**Register of Seals**
241.1	The Register of Seals was received from the Company Secretary. She said that the document provided details of seals affixed and authorised between 18 November 2010 and 19 January 2011.
241.2	The Register of Seals was **approved**.
242.	**Revised terms of Reference for the Remuneration Committee**
242.1	The revised terms of reference for the Remuneration Committee were received from the Company Secretary on behalf of Mr Fane, the Committee Chair. She advised Committee members that there were not significant changes to the document and all of the changes had been highlighted.
242.2	The revised terms of reference for the Remuneration Committee were **approved**.

243.	**Performance Report – Month 9**
243.1	The Performance Report was received from the Deputy Chief Executive. It was noted that the report now contained a dashboard to indicate the movement in performance against the designated targets.
243.2	The Deputy Chief Executive said that the incidence of MSSA was now being monitored in addition to MRSA and it was thought likely that it would become a national reporting target in the near future.
243.3	Ms Brown asked why completion the rates for the WHO Surgical Safety Checklist were lower in Medicine, Diagnostic and Therapeutic Services (MDTS) than in other units. The Deputy Chief Executive said MDTS included a high volume of procedures not undertaken within the main operating theatres (e.g. radiology) and the WHO Checklist was still being rolled out to these non-operating theatre services. It was also important to note that full compliance was only recorded when check-in, time-out and check-out were all achieved. Currently the weakest area was check-out.
243.4	The Deputy Chief Executive highlighted the new graph within the KPI report which showed each clinical unit's income against planned levels. This is important as it shows which units are delivering the planned growth contained within the Integrated Business Plan. The Trust Board noted that all clinical units were overperforming on income with the exception of Neurosciences, where work was underway to help understand the reasons why.
243.5	The Deputy Chief Executive said contrary recommendations had been received from two recent external reviews regarding the reporting of management information and the new dashboard had been included in the report in an attempt to balance the recommendations. Mr Tilley said that the review by Deliotte highlighted the need for Clinical Units to have a more consistent method for the production of management information.
243.6	The Chief Finance Officer asked how the Red Amber Green (RAG) status for each of the indicators was decided. The Deputy Chief Executive said that the RAG was decided by information obtained from the Business Tracking system and reflected progress on the project milestones.
243.7	It was agreed that members would submit their comments on the types of information that were necessary for inclusion within the performance report to the Deputy Chief Executive. **Action:** All
243.8	Mr Tilley said that he felt that discussion of the report at every meeting could cause a loss of focus. Board Members discussed the frequency with which the report was currently submitted to the meeting. It was **agreed** that the full report would be received every quarter and a summary with exception reporting would be received at every meeting. Board Members requested that reports also contained information on any indicators that were rated red or that had deteriorated.

	Action: Company Secretary
244.	**Finance Report – Month 9**
244.1	It was noted that the Finance Report had been discussed during a Board development session held prior to the meeting. The Chief Finance Officer asked the Board if there were any questions or issues that they would like to raise. There were none.
244.2	The following key points were noted:- o The Trust had revised its forecast outturn to £8.8m but this was subject to a potential impairment estimated at approximately £1.5m o Pay expenditure was currently £6.4m higher than plan and non-pay was currently £5.0m lower than plan o NHS inpatient activity was 2.4% ahead of the previous year.
245.	**Foundation Trust (FT) Update**
245.1	Board Members were advised that the Trust Board had recently participated in a Board to Board meeting with the SHA and it had been confirmed that their FT Application had been approved for submission to the Department of Health (DoH).
245.2	Mr Fane requested a chronology of the next steps in the application process and asked if a list of related commitments could be included. **Action:** Mr Bunn
246.	**Update on Executive Responsibilities**
246.1	A paper updating the Board on current Executive Responsibilities was received from the Chief Executive. She said that it had been submitted to clarify a small number of recent changes.
246.2	The Co- Medical Director (BB) asked if her appointment as 'Responsible Officer' could be noted in the document. **Action:** Company Secretary
247.	**Trust Board Members' Activities**
247.1	Ms Hackman advised Board Members that the penultimate meeting of the Members Forum would be held on the 15 March and the final meeting would be held on 11 May. She said at their last meeting the Forum had received a presentation on Quality Accounts and had agreed that the way in which information was communicated was particularly important.
247.2	Mr Fane reported that Ms Yvonne Hill would be retiring from the position of Headteacher at the Hospital School after 26 years of service. It was noted that the position had been advertised and a farewell celebration would be organised.

247.3	The Chief Executive announced that the Secretary of State planned to visit the Trust on 16 March.
	ITEMS FOR INFORMATION
248.	**Management of Serious Incidents**
248.1	It was noted that the item 'Management of Serious Incidents' had been included for information. The Chairman asked if there were any questions or comments.
248.2	Board Members were advised that Serious Untoward Incidents (SUIs) would now be referred to as Serious Incidents (SIs).
248.3	The Chief Executive asked if a Senior Manager or if appropriate an executive would arrange to meet with the family of a patient soon after the incident had occurred. Professor Elliott said that this was part of the process but had unintentionally been omitted from the process diagram.
249.	**Assurance Framework Summary**
249.1	It was noted that the item 'Assurance Framework Summary' had been included for information. The Chairman asked if there were any questions or comments. There were none.
250.	**Management Board – Minutes November 2010**
250.1	It was noted that the Management Board Minutes November 2010' had been included for information. The Chairman asked if there were any questions or comments. There were none.
251.	**UCL Partners Management Report**
251.1	It was noted that the' UCL Partners Management Report' had been included for information. The Chairman asked if there were any questions or comments. There were none.
252.	**Any Other Business**
252.1	Mr Tilley provided Board Members with a summary of the Audit Committee meeting held on the 19 January. He made the following points:- o The Committee reviewed the Assurance Framework and received presentations on a number of it delegated risks. o Production of Quality Accounts would still be required and the consistency of information would be assessed through the use of 'deep dives' into specified indicators. o Assurance was received that work was underway to ensure that the Trust's Assets had been valued appropriately.

	o Certain areas of spending on back office costs had been identified as being higher than average. The finance department would be investigating whether spending in these areas is appropriate and justified.
253.	**Date of the Next Meeting**
253.1	The date of the next meeting was confirmed as 30 March 2011

ATTACHMENT P

TRUST BOARD - ACTION CHECKLIST
30 March 2011

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
24.2	28/04/10	The Co-Medical Director said that a surveillance project on Surgical Site Infections (SSIs) had commenced and a progress report would be submitted to a future meeting.	ME		Work in progress
193.7	24/11/10	The Chairman said that the Education Strategy paper was currently aspirational and would require milestones and implementation markers. She suggested that 4 or 5 priorities were selected for development and the strategy should be resubmitted to the Board in 6 months time.	LM	May 2011	Not Yet Due
195.6	24/11/10	The Chairman thanked Professor Goldblatt for his report and asked if his next report could include information on how the research conducted by UCL Partners was linking with global health initiatives.	DG	June 2011	Not Yet Due
196.2	24/11/10	The Chief Finance Officer said that she would like the opportunity to examine ICT risks further and the use of a more recent version of the organisational structure was requested on page 8 of the Risk Management Strategy.	ME	March 2011	Actioned and on agenda – Risk Management Strategy
196.4	24/11/10	It was noted that a further report on the Management Board reporting structure would be submitted to the Trust Board Away Day in February.	AF	Deferred to April 2011	Not Yet Due
196.5	24/11/10	The Deputy Chief Executive said that a new section on risk appetite had been added to the Risk Management Strategy as part of the requirements of the Foundation Trust Application process. Non Executive directors asked if examples could be provided of the Trust's risk appetite.	ME	March 2011	Actioned and on agenda – Risk Management Strategy
196.6	24/11/10	Board Members agreed that a second draft of the Risk Management Strategy should be submitted to the Board Meeting in January.	ME	Deferred to March 2011	Actioned and on agenda – Risk Management Strategy
198.3	24/11/10	Ms MacLeod suggested that further work would be required to clarify the roles and responsibilities of the	AF	Deferred to April 2011	Not Yet Due

ATTACHMENT P

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		different hospital committees outlined in the Constitution. The Chairman said that it was important that there were no misunderstandings.			
237.5	26/01/11	It was noted that a joint conference had been held by UCLP and Monitor. The Chief Executive said that Professor Michael Porter of Harvard Business School had given a presentation on value and she would send a link for viewing it to the Non Executive Directors.	JC	March 2011	Link provided by email on 23/03/11
239.5	26/01/11	The Chairman asked if details on the Medicines Management work could be included with the next zero harm report.	ME	March 2011	On agenda – Zero Harm Report
243.7	26/01/11	It was agreed that members would submit their comments on the types of information that were necessary for inclusion within the performance report to the Deputy Chief Executive.	ALL	February 2011	Verbal update
243.8	26/01/11	Performance Report - Mr Tilley said that he felt that discussion of the report at every meeting could cause a loss of focus. Board Members discussed the frequency with which the report was currently submitted to the meeting. It was **agreed** that the full report would be received every quarter and a summary with exception reporting would be received at every meeting. Board Members requested that reports also contained information on any indicators that were rated red or that had deteriorated.	AF and FD	March 2011	On agenda – Performance Report
245.2	26/01/11	Mr Fane requested a chronology of the next steps in the FT application process and asked if a list of related commitments could be included.	SB	February 2011	Actioned at Trust Board Away Day – February 2011
246.2	26/01/11	The Co- Medical Director (BB) asked if her appointment as 'Responsible Officer' could be noted in the Executive Responsibilities document.	AF	February 2011	Actioned

Attachment Q

Trust Board Meeting **30th March 2010**	
Zero Harm Report **Submitted on behalf of: Martin Elliot Co-Medical Director**	**Paper No: Attachment Q**

Summary

This paper provides an update on the following issues:

- Paediatric Trigger Tool
- Zero Harm Dashboard
- Surgical Site Infections
- Central Line Infections

Action required from the meeting

To use the data from the Trigger Tool to focus the Zero Harm programme focusing on :

- Record keeping
- Observations
- Response to Deterioration
- Infections and skin integrity
- Medicine management

To reaffirm the aim is to reduce the level of harm by 50% by end of 2012

Contribution to the delivery of NHS / Trust strategies and plans

This is one of the strategic objectives of the Trust

Financial implications

Nil

Legal issues Nil

What consultation has taken place Not Applicable

Who needs to be told about the policy? Not Applicable

Who is accountable for the monitoring of the policy? Not applicable

Author and date Peter Lachman 18th November 2010

Contributors: John Hartley and Sue Chapman

Attachment Q

Zero Harm Report for Trust Boards
November 2010

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

We have now have data for 16 months with over 300 notes reviewed by the team. The level of harm is 10-12% the majority of which is reversible and was not previously reported. An indication of the adverse events is shown is shown in figure 1 and will inform future programme development.

The Trust has to set the aim for harm reduction to be to reduce measured harm by 50% in the current year by end 2011. After excluding data from October 2009 which lies outside the upper control limit and which was felt to be due to 'double-counting of adverse events arising from the same trigger, the baseline adverse event rat was between 7.35 and 23.4%. The trend June 2010 has been a steady decline in adverse events and wit the last reported adverse event rate for January 2011 at 3.8%. Although the team of PTT reviewers has been extended over the last 2 months to include representation from each clinical unit, all reviewers have received training and the process is monitored by the PTT lead or deputy attending all reviews. Each case is discussed as a team to ensure consistency and inter-rater reliability.

Future programmes will be developed based on the information we have from the Trigger Tool. The aim of the PTT is to identify the harm that can be prevented by changes in practice in the Trust via improvement programmes. It is intended to influence the Zero Harm programme at GOSH. Case notes are chosen randomly from across the Trust and from all Units and the themes that emerge are therefore applicable to the whole Trust.

The top five themes that have emerged from the Trigger Tool so far are:

1. Clinical observations are not as reliably recorded as required. The intervention will be a programme improving the reliability of observation monitoring and use of CEWS to detect the deteriorating child
2. IV canulation has been identified as being a problem with some children being subject to unacceptable numbers of cannulation attempts. The programme to mitigate this will concentrate on early identification of difficult children with appropriate escalation to prevent repeated attempts at canulation
3. Femoral line use outside the intensive care units has been identified as an ongoing issue. The intervention programme will aim to decrease femoral IV line usage in order to reduce infection and risk to the child
4. Pressure sores /skin integrity remain a problem. The intervention programme will aim to assess early and prevent these occurring
5. Quality of medical records /documentation was highlighted in the last report to the Board. This has been confirmed by the recent audit. The aim is to improve the quality of the notes written and to have 100% compliance with the minimum standards for record keeping

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

Attachment Q

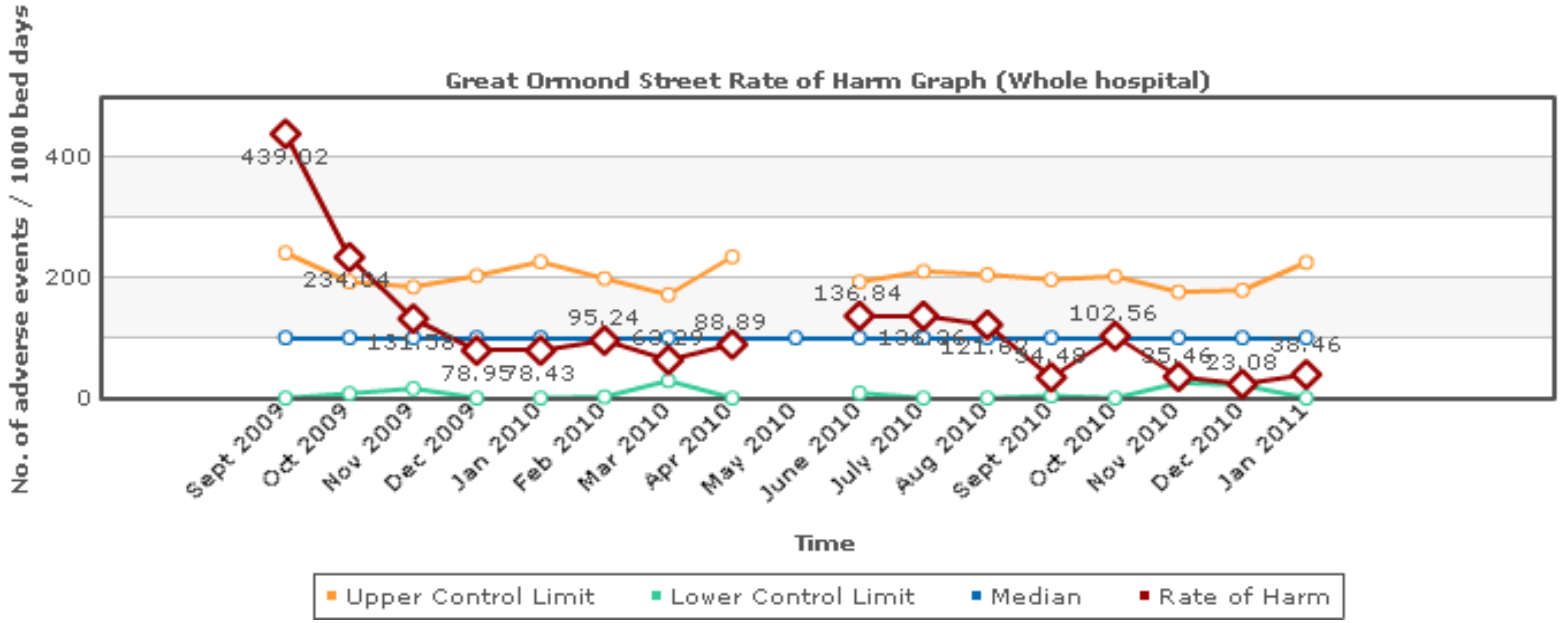
Unit Chairs have been requested to incorporate the five identified themes in Unit Improvement Plans and to develop interventions to improve care Some of the themes have will already have programmes in process and there are a number of initiatives within the Trust that are aimed at some of the themes.

The monitoring of the implementation will take place within the usual operational reporting to the COO, Chief Nurse and Co-Medical Director.

Action
The Board is requested to consider the report on the trigger tools and to note current state of harm.

The Board could consider whiter we should now move to Unit specific PTT to assess differences and where we can change further. Cardiac already do a Unit specific review.

Figure 1 Level of Harm



- This indicates approximately 3.8% harm, a reduction from 8-23% in Oct 2009 –January 2011. Notes are selected randomly, which can explain the common cause variation, but the overall trend is reducing.

Figure 2 Adverse events

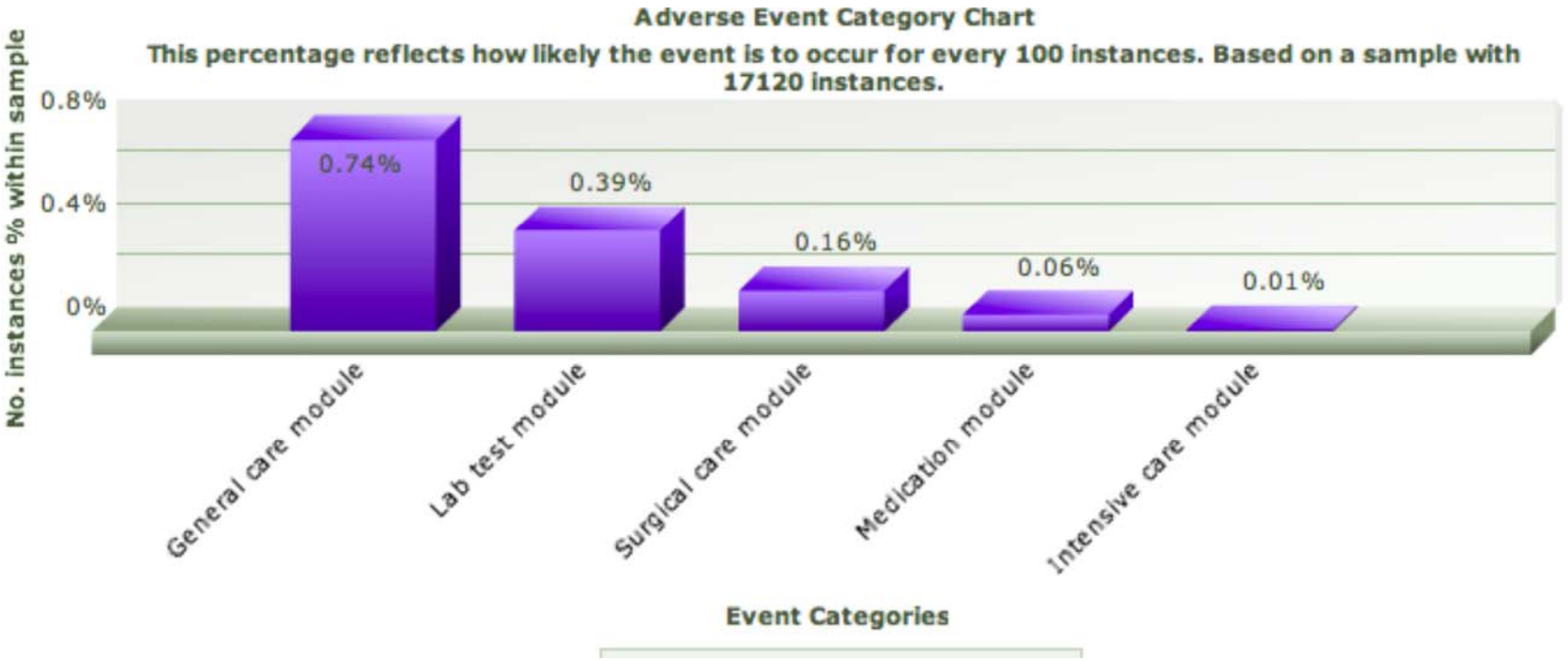
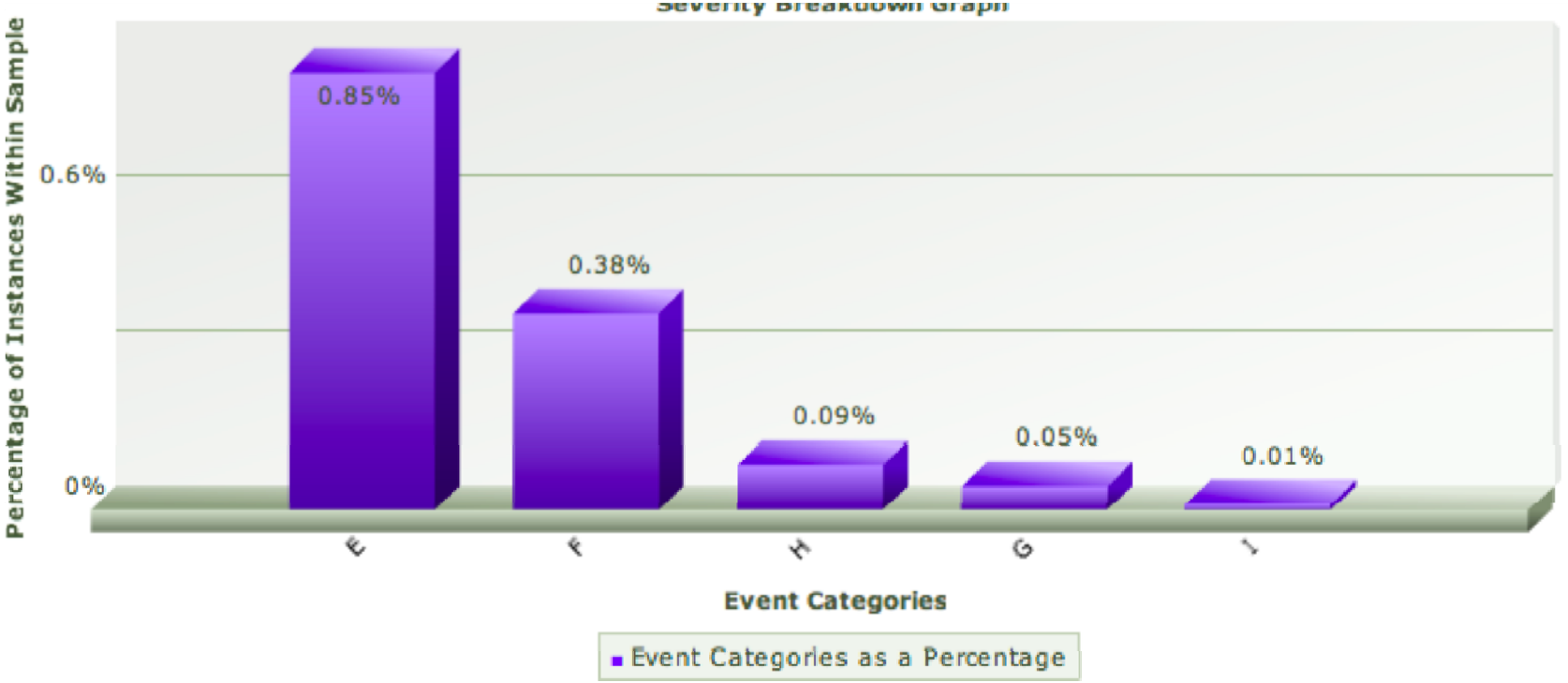


Figure 3 Severity break down



E Temporary harm to the patient and required intervention
F Temporary harm to the patient and required initial or prolonged hospitalisation
G Permanent patient harm
H Intervention required to sustain life
I Patient death

- The majority of harm is reversible and will be the focus of intervention.

B. Dashboard

The system-wide dashboard is shown in Figure 2 and demonstrates ongoing challenges. The Dashboard will now be reviewed in light of the trigger tool outcomes and will be redeveloped over the next few weeks

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

Attachment Q

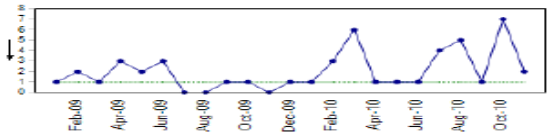
Safety System Wide Dashboard

FAQs Desired direction of change: ↑↓

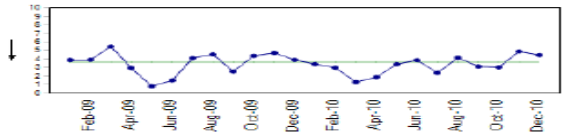
For each chart, click on a data point to display further detail.

High System Measures

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

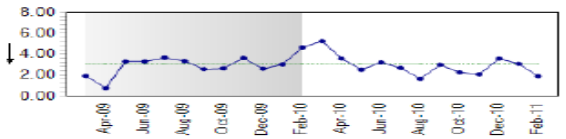


The mortality rate per 1000 discharges. Area: System Wide — Further Detail



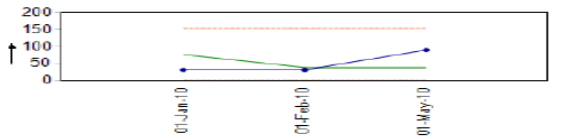
Infections

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



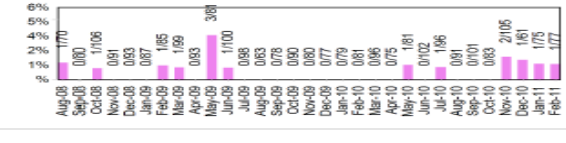
Aim: To achieve zero CVL infection by the end of Dec 2011

Time between VAPS. Area: System Wide — Further Detail



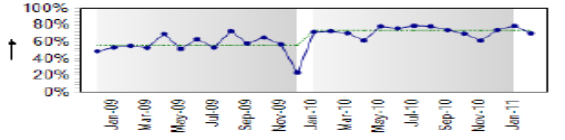
Aim: The Trust will aspire to eliminate VAPs by the end of Dec 2011

Percentage of SSIs for Urology per operation — Further Detail



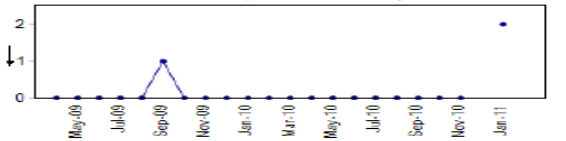
Aim: The Trust will aspire to decrease SSIs by 30% by the end of Dec 2010 once a baseline has been established.

Hand hygiene audit results. Area: System Wide — Further Detail

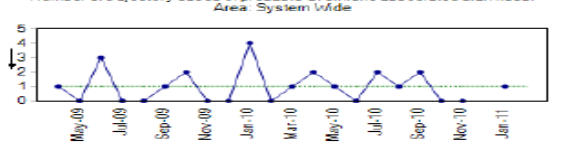


Aim: To achieve 100% in the hand hygiene audit by the end of Dec 2011

MRSA bacteraemias reported to DH. Area: System Wide — Further Detail

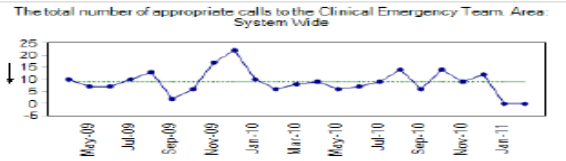


Number of trajectory cases of probable C. difficile associated diarrhoea. Area: System Wide — Further Detail



Outreach

The total number of appropriate calls to the Clinical Emergency Team. Area: System Wide — Further Detail



C. Report on Challenge noted on Medical Records

The trigger tool analysis has indicated the need to improve the quality of medical records and this was reported in the last report. Management Board has adopted the new Medical Records Policy. Units have been requested to implement improvement projects on medical records and a number of pilots have been commenced

D. Surgical site infection prevention and surveillance project Progress report 17/3/2011John Hartley DIPC

The prevention of SSI is based on the implementation of optimal care in the pre-, peri- and post-operative period, combined with systematic surveillance. In 2009 the Trust was unable to provide SSI rates for most procedures and had not implemented a standardised model of care for surgical pathways. A trial of speciality based surveillance had been unsustainable and a bid was made to the Special Trustees to fund a 3 year pilot project establishing a dedicated surgical site infection surveillance team and to aid specialities in the development and implementation of optimal care bundles.

SSI Project funding
Initial approval June 2009, to start Sept 09; funds for 4 staff (project administrator/data manager, 2 surveillance officers and a practice educator; office equipment and initial data base development).

SSI Surveillance achievements
The process for systematic inpatient and post discharge surveillance has been established and implemented in:
Orthopaedic spinal implant surgery – continuous from Jan 2010
Cardiac open and closed heart – continuous since April 2010
Cardiac data is feed back and discussed at weekly MDT
Cardiothoracic (thoracic and tracheal) – continuous from Jan 2011
Neurosurgery – continuous since Oct 2010
Craniofacial – continuous since Oct 2010
Urology – single three month period Apr – June 2010
This development has satisfied the CQUIN set for 2010/11

Development required:
Data base development has been difficult and not yet completed, restricting analysis of risk factors.Further work with specialties regarding definitions and extension to other areas required. This will be incorporated in 2011/12 proposed CQUINs.
SSI Prevention through implementation of standard model of care (care bundles)
The implementation of care bundle components is being carried out through a number of routes in the trust e.g. WHO surgical check list, in addition to the SSI Project.
Difficulties
Due to unexpected staffing issues, the Practice Educator was required to assume responsibility for Team management and surveillance process development. This restricted time allocated to implementation of care bundle.
Achievement
A standard model of care was developed
Development required: Implementation in individual surgical pathways.

Provisional Results

Spinal Surgery January-December 2010

Year 2010	January	February	March	April	May	June	July	August	September	October	November	December	Total
Number of Operations	19	14	16	12	15	23	16	10	11	16	18	10	**180**
Total of Infections	1	1	0	0	0	2	0	0	0	0	0	0	**4**
Superficial	0	0	0	0	0	2	0	0	0	0	0	0	**2**
Deep	1	1	0	0	0	0	0	0	0	0	0	0	**2**
Organ Space	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Number of SSI detected Inpatients	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Number of SSI detected Outpatients	0	1	0	0	0	2	0	0	0	0	0	0	**3**
Lost to Follow Up	6	3	2	2	3	3	2	1	2	0	4	1	**29**

2011

January	February
14	15

Cardiac Patients April-December 2010

Year 2010	April	May	June	July	August	September	October	November	December	Total
Number of Operations	48	48	58	51	47	49	53	50	43	**447**
Total of Infections	2	1	3	7	2	3	8	7	5	**38**
Superficial	1	1	3	5	2	3	8	7	4	**34**
Deep	0	0	0	1	0	0	0	0	1	**2**
Organ Space	1	0	0	1	0	0	0	0	0	**2**
Cardiac SSI detected Inpatients	1	1	1	6	2	0	3	5	3	**22**
Number of SSI detected Outpatients	1	0	2	1	0	3	5	2	2	**16**
Lost to Follow Up	11	8	5	8	6	8	7	6	4	**63**

2011

January	February
47	49

Neurosurgery

Year 2010	October	November	December	Total		2011 Jan	Feb
Number of Operations	47	47	40	**134**		61	60
Total of Infections	2	0	2	**4**			
Superficial	1	0	0	**1**			
Deep	0	0	0	**0**			
Organ Space	1	0	2	**3**			
Number of SSI detected Inpatients	1	0	2	**3**			
Number of SSI detected Outpatients	1	0	0	**1**			
Lost to Follow Up	9	8	7	**24**			

Craniofacial Surgery

Year 2010	October	November	December	Total		2011 Jan	Feb
Number of Operations	20	18	17	**55**		20	16
Total of Infections	2	3	0	**5**			
Superficial	2	3	0	**5**			
Deep	0	0	0	**0**			
Organ Space	0	0	0	**0**			
Number of SSI detected Inpatients	0	1	0	**1**			
Number of SSI detected Outpatients	2	2	0	**4**			
Lost to Follow Up	4	2	6	**12**			

E. Central Line Infections – John Hartley DIPC

Although central venous catheters are a recognised source of health care associated infection they remain an essential component of specialist paediatric care. The importance of adapting care to eliminate CVC infections has been recognised and care bundles to reduce CVC related infections are in place.

Continuous surveillance has been performed for a number of years at GOSH, demonstrating a further year on year reduction in rate of GOS acquired CVC infection but infections still occur.

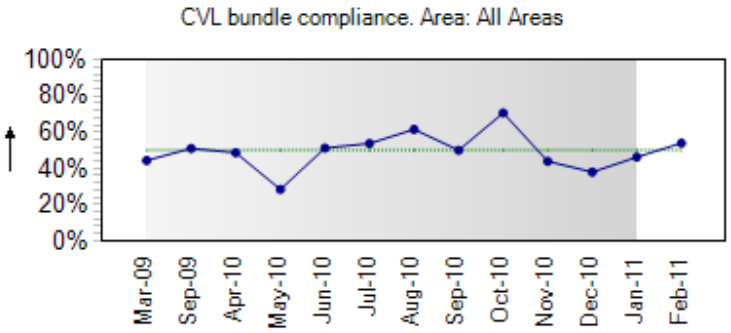
Summary of annual data shows:

For Financial year	Rate/1000 line days
06/07 (10months data)	10.1
07/08	4.4
08/09	3.7
09/10	3.3
10/11 (to end Feb 2010)	2.8

The principle actions to reduce infection are to ensure

- all lines are inserted by trained staff to a standard protocol
- all staff accessing lines have completed competency training and updates
- Line care is provided to the expected standard in the care bundle.

Surveillance of line care bundle demonstrates moderate compliance with the audits performed (e.g. in Feb 157 of 182 observations were satisfactory (86%)), but not all areas perform the expected audits and the overall audit score is lower as these areas remain in the denominator.



Further work is needed in providing Trust wide record of assurance in training and competency of staff in insertion and access.

Great Ormond Street Hospital for Children NHS Trust

Trust Board
March 2011

Title of document Review of strategic objectives and work-streams **Submitted on behalf of.** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment R**

Aims / summary

2011-12 will be 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

Review of 2010-11 work-streams

For 2010-11 we had 78 actions grouped into 22 work streams. These were identified as necessary to move us towards achievement of our strategic objectives. We have reviewed these actions at the end of the year. Of the 78 actions 61 were rated Green, 14 Amber and 3 Red. Those rated Red include actions relating to Advanced Access to outpatients which has progressed slower than planned, compliance with infection control standards (specifically C.difficile) and Business Process Management (BPM).

Proposed Work-streams for 2011-12

As in previous years, we have undertaken a review of these actions and work-streams to ensure they remain fit for purpose going forward based on the current assurance framework/high level risks, the updated SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis, the Strategic Scorecard along with the forecast activity and capacity summary.

We now propose 36 actions for 2011-12. These support the Trust's Integrated Business Plan that has been submitted with our Foundation Trust application. Once the new Workstreams are agreed, the assurance framework will then be revised to take account of the new planned actions and links between the two documents will be maintained through the year.

These work-streams will form the basis of the Trust's Annual Plan and local unit and department plans. Milestones (and metrics) for the first quarter (at a minimum) will

be agreed before the end of April to enable a comprehensive review in July. A quarterly review of work-streams will take place at the CEO Executive meeting. Clinical Unit and department plans will be monitored through the quarterly performance reviews. Clinical unit and local business plans are due to be completed by the end of March. A revised set of work-streams and actions for 2011-12 is attached along with a summary of progress against those from 2010-11.
Action required from the meeting Trust Board are asked to note the progress in 2010-11 towards our strategic objectives and to agree the revised work-streams and actions for 2011-12.
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 March 2011

GOSH Strategic Objectives - proposed work-streams and actions for 2011-12

Strategic Objective	Work-stream		Action	Accountable Executive	Responsible Manager	Continued Action (Y/N)	Amended Action (Y/N)	New Action (Y/N)	Responsible Committee	Assuring Committee
1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	**Maintain our focus on Zero Harm**	1.1	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.	Martin Elliott	Judith Cope		Y		Transformation Board	Clinical Governance Committee
		1.2	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.	Martin Elliott	John Hartley		Y		Transformation Board	Clinical Governance Committee
		1.3	Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.	Liz Morgan	Sonia Jenkins		Y		Strategic Safeguarding Committee	Clinical Governance Committee
		1.4	Develop and monitor new structure for managing and learning from Serious Untoward Incidents (SUIs)	Martin Elliott	Salina Parkyn			Y	Quality and Safety Committee	Clinical Governance Committee
		1.5	Ensure effectivce provision of nutritional care for all patients	Liz Morgan & Martin Elliott	Caroline Joyce			Y	Quality and Safety Committee	Clinical Governance Committee
		1.6	Ensure provision of safe services for the deteriorating and critically ill child.	Martin Elliott & Liz Morgan	Martin Elliott			Y	Quality and Safety Committee	Clinical Governance Committee
	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	1.7	Gather and report outcome data and information to demonstrate the clinical effectiveness of the organisation and benchmark against comparable organisations, moving towards measuring clinical effectiveness in real time.	Martin Elliott	Lisa Davies		Y		Clinical Outcomes Development Board	Clinical Governance Committee
		1.8	Ensure accountability for delivery of CQUIN targets are fully devolved operationally and monitored regularly	Claire Newton	Nick Wright		Y		Management Board	Clinical Governance Committee

GOSH Strategic Objectives - proposed work-streams and actions for 2011-12

Strategic Objective	Work-stream		Action	Accountable Executive	Responsible Manager	Continued Action (Y/N)	Amended Action (Y/N)	New Action (Y/N)	Responsible Committee	Assuring Committee
2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations	**Continue to reduce waiting times further through our 'no waits' programme**	2.1	Continue to meet national and commissioning standards and improve the utilisation and efiiciency of our resources.	Fiona Dalton	Robbie Burns		Y		Management Board	Clinical Governance Committee
	Improve the standard of customer service that we offer patients and families	2.2	Ensure the effective measurement and improvement of patient experience through agreement and implementation of a patient experience action plan	Liz Morgan	Caroline Joyce		Y		Management Board	Clinical Governance Committee
	Continue to improve our relationships with referrers in order to achieve our market share objective.	2.3	Continue to implement the actions for improvement following the results of the Referrer Survey including producing a directory, holding referrer days along with implementing a bed management solution.	Barbara Buckley	Robbie Burns		Y		Transformation Board	Clinical Governance Committee
	Continue to improve the patient environment through major upgrades, working closely with our charitable partners	2.4	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		Y		Redevelopment Board & Capital and Space Planning Committee	Clinical Governance Committee
		2.5	Prepare to move into the Morgan Stanley Clinical Building including workforce redesign.	Fiona Dalton	Natalie Robinson			Y	Management Board	Clinical Governance Committee
3. Successfully deliver our clinical growth strategy	**Deliver our planned in year growth**	3.1	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).	Fiona Dalton	Robbie Burns	Y			Management Board	Clinical Governance Committee
	Maintain IPP service growth	3.2	Improve patient access and staff recruitment and retention to ensure IPP income target is achieved	Trevor Clarke	Joanne Lofthouse		Y		Management Board	Clinical Governance Committee
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and	3.3	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.	Fiona Dalton	Sarah Dobbing & Anne Layther		Y		Management Board	Clinical Governance Committee

GOSH Strategic Objectives - proposed work-streams and actions for 2011-12

Strategic Objective	Work-stream		Action	Accountable Executive	Responsible Manager	Continued Action (Y/N)	Amended Action (Y/N)	New Action (Y/N)	Responsible Committee	Assuring Committee
	education and setting standards	3.4	Work with partners in the region to deliver paediatric tertiary care in light of NHS London proposals.	Fiona Dalton	Robbie Burns		Y		Management Board	Clinical Governance Committee
4. With partners maintain and develop our position as the UK's top children's research organisation	**Continue to develop partnership working**	4.1	Continue to work with University College London Partners (UCLP) and leverage benefits from this.	Jane Collins	Lorna Gibson	Y			Research & Innovation Committee	Clinical Governance Committee
		4.2	Extend collaboration with UCL Business to include GOSH commercial contracts and leverage benefits from this.	David Goldblatt	Lorna Gibson			Y	Research & Innovation Committee	Clinical Governance Committee
		4.3	Implement a new governance structure which spans the Division of Research and Innovation and includes all the major stakeholders	David Goldblatt	Lorna Gibson			Y	Research & Innovation Committee	Clinical Governance Committee
		4.4	Agree operational and management arrangements for Great Ormond Street Hospital / Institute of Child Health (GOSH/ICH) joint research activity administered by the Research and Development (R&D) office and clarify systems and processes for ensuring funding	David Goldblatt	Lorna Gibson		Y		Research & Innovation Committee	Clinical Governance Committee
	In year delivery (research)	4.5	Strengthen our grant-writing infrastructure to increase our success in obtaining research grants.	David Goldblatt	Lorna Gibson	Y			Research & Innovation Committee	Clinical Governance Committee
		4.6	Strengthen Communications with GOSH and ICH to ensure that press and publicity of the Division of R&I is adequately reflected internally and externally.	David Goldblatt	Lorna Gibson			Y	Research & Innovation Committee	Clinical Governance Committee
5. Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	**To work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK**	5.1	With our partner Higher Education Institutes (HEI) develop appropriate curricula to meet the professional standards required to drive excellence at GOSH.	Liz Morgan	Geoff Speed		Y		Education & Training Committee	Clinical Governance Committee
		5.2	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.	Liz Morgan	Geoff Speed			Y	Education & Training Committee	Clinical Governance Committee
6. Deliver a financially stable organisation	**Agree achievable CRES plan and ensure delivery through robust project and performance management**	6.1	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.	Fiona Dalton	Natalie Hibbs		Y		CRES steering Board	Audit Committee

GOSH Strategic Objectives - proposed work-streams and actions for 2011-12

Strategic Objective	Work-stream		Action	Accountable Executive	Responsible Manager	Continued Action (Y/N)	Amended Action (Y/N)	New Action (Y/N)	Responsible Committee	Assuring Committee
		6.2	Deliver surplus to plan.	Fiona Dalton	Fiona Dalton		Y		Management Board	Audit Committee
	Improve efficiency through our Transformation Programme	6.3	Deliver operational efficiencies through the devolved Transformation team and engine-room projects.	Fiona Dalton	Jez Phillips		Y		Transformation Board	Clinical Governance Committee
	Ensure appropriate funding for our clinical services from commissioners	6.4	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			Y	Management Board	Audit Committee
		6.5	Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.	Claire Newton	Nick Wright	Y			Management Board	Clinical Governance Committee
	Support the charity to raise targeted funds	6.6	Continue to strengthen communication between GOSH and GOSH Charity at all levels to ensure fund-raising targets are met	Jane Collins	Tim Johnson		Y		Management Board	Audit Committee
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	**Make progress towards becoming a Foundation Trust**	7.1	Complete monitor assessment, attain authorisation status and establish an effective members council.	Fiona Dalton	Sven Bunn		Y		Foundation Trust Steering Board	Audit Committee
	Ensure that the Trust is compliant with regulatory requirements	7.2	Ensure that the Trust retains registered status with CQC.	Jane Collins	Anna Ferrant	Y			Management Board	Audit Committee
		7.3	Ensure that Information Governance processes are strengthened and the self assessment score in the IG toolkit is improved.	Claire Newton	Clare Reed		Y		Management Board	Audit Committee
	Improve efficiency of business processes	7.4	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.	Claire Newton	Geoff Bassett		Y		Management Board	Audit Committee
		7.5	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.	Claire Newton	Mark Large		Y		Technical Delivery Board	Audit Committee
		7.6	Continue to develop management and leadership including Specialty Leads, Clinical Unit Teams and Trust Board.	Jane Collins	Executive Team			Y	Management Board	Clinical Governance Committee

GOSH Strategic Objectives - review of progress against 2010-11 work-streams

Strategic Objective	Work stream	Action	Accountable Exec	Report	RAG
1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	**Maintain our focus on Zero Harm**	Continue the development of systems to decrease adverse drug events by concentrating on high risk medications and high risk areas in the Trust with the aim of a 50% reduction in adverse drug events in each high risk clinical area.	Martin Elliott	Progress during year focused on PICU and CICU, with good progress on CICU. Dedicated medicines management post has been slow to move forward and progress in other high risk areas across the Trust is slow.	Amber
		Achieve 50% reduction in each specific hospital acquired infections including Central Venous Line infections (CVL), Surgical Site infections (SSI) and Ventilator Associated Pneumonia (VAP) from current baseline over the next year.	Martin Elliott	Much progress has been made against collecting baseline data for SSI. We have continued to make progress in reducing infection rates in the targeted areas but CVL rates were above the target we set ourselves.	Amber
		Continue weekly Executive walkabouts and audit actions quarterly.	Fiona Dalton	Executive walkabouts are happening every week. A new model for monthly review of new and outstanding actions has been agreed.	Green
		Review the Intensive Care Outreach team (ICON) pilot and the current 'Hospital at Night Team' and build on the successes of these two services to deliver integrated support for the sickest children on our ward.	Barbara Buckley	ICON has been agreed as a permanent service. The Standard Operating Procedure for the Hospital at Night team has been finalised and the General Paediatric Consultants have been appointed.	Green
		Maintain Child Protection structures and processes to support safe child protection practice. Child protection supervision policies to be fully implemented	Liz Morgan	Progressing as per plans. No priority actions. Haringey SIT visit very successful. Plans for GOSH SIT and Haringey Ofsted in January on track.	Green
		Achieve compliance with infection control national standards.	Martin Elliott	The Trust reported 2 cases of C. difficile in February. YTD the Trust has reported 10 cases against a year trajectory of 9. Therefore we have not achieved the CDI Target as currently set. The 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. No cases of MRSA were reported in February. The Trust remains within tolerance.	Red
		Spread the Situation, Background, Assessment, Recommendations and Decision (SBARD) communication tool and the Children's Early Warning Score (CEWS) throughout the Trust to ensure it is used by all staff.	Liz Morgan	Considerable work has been done to agree a Trust approach to CEWS. Awareness hads been raised and the tool has been disemminated across clinical areas. Further work has been identified to improve the level of observation, interpretation and action for all staff.	Amber
		Ensure Safety First is a key agenda item for all appropriate meetings.	Jane Collins	Safety is a top agenda item on the Trust Board and Management Board agendas. The Trust has agreed that at least 25% of all main committee work is related to quality issues - this is already in place for the TB, MB and the CGC.	Green
		Introduce surgical check list before 100% theatre sessions.		At the end of February 62% of surgical cases had all elements of the surgical safety checklist completed. There has been a steady upward trend over the year.	Green
		Establish the level of harm as determined by the paediatric trigger tool.	Martin Elliott	Completed. Monthly monitoring ongoing.	Green
		Implement the Priority Actions for Health Plan for phase 2 (Jan - June 2010) and phase 3 (July 2010 onwards) identified in the safeguarding plan for Haring	Liz Morgan	This task has been incorporated into Task 2016 which details the overall strategic management of safeguarding children and young people across all GOSH sites	Green
	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	Report Clinical Outcomes/Patient-Reported Outcome Measures (PROMS) through operational performance reviews and agree actions to improve.	Martin Elliott	Action plans have been developed for the clinical units to aid with the development and publication of the outcome measures in each of the units. All units March performance reviews have included a sample of outcome measures currently avaliable and at the end of March 2011 some of these outcome measures will be avaliable on the external website.	Amber
		Continue to monitor new National Institute for Clinical Excellence / National Service Framework (NICE/NSF) guidance through the Quality and Safety meetings	Martin Elliott	The NICE and NSF guidnance continue to be monitiored through the Quality and Safety Committee on a quarterly basis.	Green
		Develop benchmarking standards with international best practice across all units.	Martin Elliott	It was agreed in the outcomes meeting that the CRAB system is not an immediate viable solution for the Trust as we need to consider the current information and data systems currently deployed and the types of information which is meaningful to reflect clinical outcomes. A outcomes database is in development to incorporate publications, presentations and research on clinical outcomes which will identify areas where there is explicit benchmarking standards.	Amber
		To develop and publish a trustwide Quality Account by June 2010 in line with the Department of Health (DH) Quality Account Toolkit Advisory guidance.	Martin Elliott	2010 Quality Account was published in June 2010. Progress is being made and on track to produce the quality account 2010\11 in June 2011	Green
		To finalise our Quality and Innovation (CQUIN) measures with our lead commissioners and start reporting against these by May 2010.	Claire Newton	CQUIN measures have been in place for most of the year unless where agreed with commissioners that they needed to be redesigned.	Green
	Develop a consistent monitoring system to measure expectations, and whether we meet these.	Implement Patient and Public Involvement/Engagement Strategy	Liz Morgan	Progress is on schedule; all 2010-11 targets were met.	Green
	Continue to reduce waiting times further through our 'no waits' programme	Complete the roll out of Advanced Access OPD across all specialties	Fiona Dalton	Target was all specialties to have graduated by December. By January 19 out of 35 had acheived this. Resposibility for delivery has now been devolved to the Clinical Units and recovery plans are being confirmed and reported via Transformation Board. We now expect that this work to continue over the summer.	Red
		Ensure we have a robust action plan to continue to meet all national access targets as described in the Trust Access Policy	Fiona Dalton	18 weeks continues to be achieved. We are reporting a number of waits across some services of over 13 and 26 weeks.	Green
	Improve the standard of customer service that we offer patients and families	Continue to improve the patient and family experience and measure effectiveness, specifically focussing on areas highlighted in the Ipsos MORI survey.	Liz Morgan	Implement real time surveys through the bedside ents system Mar 2011 Benchmark results for MORI in-patient survey Mar 2011 Supppprt units and corporate depatments to achive the actions agreed in the action plans March 2011 Establish and recruit to redesigned patinet experince project worker March 2011	Green
		Ensure all staff receive an appropriate level of customer service training via inductions, update or bespoke events.	Liz Morgan	Actions on target	Green

GOSH Strategic Objectives - review of progress against 2010-11 work-streams

2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations	**Improve our understanding of our referrers, and their requirements and improve our service to meet these requirements**	Achieve contractual standards for discharge summaries	Fiona Dalton	Completion of discharge summaries remains above 70% but we have seen a slight dip in performance recently. Work continues although the support from PCTs around GP details is hindering the move to an electronic system.	Amber
		Undertake an analysis of our referral patterns, market share and competitors across all specialties to better understand our key referrers.	Fiona Dalton	Market share information presented quarterly. Meetings and action plans developed for specialties that are not achieving market share progress as planned.	Green
		Review this analysis in conjunction with our pattern of outreach clinics and consider a more formalised model of partnership with referring hospitals	Fiona Dalton	Only one response to referrers newsletter request for outreach clinics. Looking to develop more targted outreach cliinics in Cardiology. Need to formally review the potential for outreach in Neurology	Green
		Develop an action plan for improvement following the results of the Referrer Survey.	Fiona Dalton	Many actions completed, including, publication of first newsletter, updated discharge summary templates and much improved timeliness, key referrers database. Projects underway include Trust wide bed management project, trial of PiMS cc list in two specialties and revising family information form. Generally good progress	Green
	Continue to improve the patient environment through major upgrades, working closely with our charitable partners	Continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the development of the Morgan Stanley Clinical Building due to complete in December 2011 and the continued development of the Phase 2b Full Business Case for final submission in July 2011.	William McGill	The operational commissioning effort for the Morgan Stanley Clinical Building - due to be handed-over by the Contractor in December 2011 - has started and services will move to this new clinical facility between March and May 2012. The Enabling Works for Phase 2B will start on site in August 2011 and the Full Business Case for Phase 2B itself will be submitted in September 2011, following authorisation as a Foundation Trust."	Green
		Invest within our 10 year capital programme to improve the patient environment within our existing buildings. Key deliverables will include at least one ward refurbishment; enhancement of out Patient facilities; upgrading public toilets in the Variety Club Building (VCB) and the start of renewing the patient entertainment system trust wide.	William McGill	Robin, Fox, Woodland and RANU wards were all refurbished along with level 1 outpatient facilities and public toilets in the variety Club Building. Work commenced in December on a programme of engineering and building fabric works to theatres and will run till September.	Green
	Through the Foundation Trust process increase membership and develop a strategy to involve members effectively	Achieve required membership trajectory.	Fiona Dalton	Membership target (8,000) acheived in December. Recruitment will continue.	Green
		Formally agree constitution including election.	Fiona Dalton	Constitution approved by Trust Board and signed off by our solicitors.	Green
		Integrate members into our management and governance processes.	Fiona Dalton	Work continues on streamling approaches to membership. Engagement strategy now drafted and work underway to establish communication events for potential new councillors	Green
3. Successfully deliver our clinical growth strategy	**Deliver our planned in year growth**	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).	Fiona Dalton	Model 3 completed and letters received from all key commissioners. Some growth witnessed in 2010/11	Green
		Monitor compliance with new Access policy to minimise refusals.	Fiona Dalton	All refusals are being recorded and reported at Management Board. A Bed Management workstream commenced with a specific aim to minimise and eventually eradicate refusals.	Green
		Supported by the Transformation Team, deliver growth by redesigning processes to: Better utilise our assets; increase working hours e.g. Saturday; continue to reduce length of stay; improve theatre utilisation and increase day case rates.	Fiona Dalton	Transformation restructure in place. New teams working well and key project commenced in bed management. Surgical pathway project progressing well with good increase in theatre utilisation	Green
		Identify early in year and work up potential future National Commissioning Group (NCG) bids. This includes the timely submission of phase 1 and 2 proposals	Fiona Dalton	We have now had formal confimation that services for oseogenesis imperfecta and pseud-obstruction will be nationally designated for 2011-12. 8 stage 1 applications were submitted in December. The decision meeting postponed till April. after which we should hear which are to be worked up as full cases.	Green
	Revise future activity and growth plans	Revise and update our IBP growth plan, considering general population increase, clinical and market share growth.	Fiona Dalton	Model 3 completed and all key commissioners supportive of plan	Green
	Maintain IPP service growth	Review IPP workforce	Trevor Clarke	Some band 5 posts were filled following the job fare. There are still Band 5 and 6 posts vacant on Butterfly ward. An additional advert is to be placed in the new year for band 5 and 6 posts.	Green
		Increase IPP physical capacity	Trevor Clarke	Capacity remains at maximum for IPP and additional beds are open at weekend. The business case to increase surgical beds has commenced.	Green
		Review activity and improve efficiency	Trevor Clarke	Income for January exceeded previous months and the Division has generated a surplu of £539k including the delivery of CRES.	Green
		Develop a formal IPP strategy and agree an action plan to deliver the strategy	Trevor Clarke	IPP strategy was agreed at January 2011	Green
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	Work with the BLT to support the development of a paediatric trauma centre	Fiona Dalton	Working well with BLT. Still awaiting tender to be issued.	Amber
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	Work with local government partners and other statutory bodies to ensure Haringey community paediatric services are working in partnership for the benefit of children	Barbara Buckley	Work has gone to plan and we have acheived notable improvements in services in Haringey. The PCT has now re-commissioned the service with the Whittington Hospital to start in April.	Green
		Work with partners to implement the agreed North West London Paediatric Surgery network.	Fiona Dalton	Service has been established and is running under the oversight of the network board. GOSH attendance at each board meeting. Further milestones relate to establishing internal measures of success for the service and establishing a more formal SLA for 2011-12.	Green
		Pending the outcome of consultation, work with North Middlesex University Hospital NHS (NMUH) to implement the new organisational model for paediatric services.	Liz Morgan	Completed. All SLAs signed and subject to biannual review.	Green

GOSH Strategic Objectives - review of progress against 2010-11 work-streams

		Achieve accreditation as a national paediatric cardiac centre through the new national processes, and plan to accommodate any further growth that arises from this process.	Fiona Dalton	GOSH is included in all the options. Public Consultation on options is now underway.	Green
		Establish a north London tertiary paediatric network.	Fiona Dalton	Our response to the consultation is due in February	Amber
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	Achieve accreditation as a national paediatric neuro centre through the new national processes, and plan to accommodate any further growth that arises from this process.	Fiona Dalton	We received feedback from the national review on 8th October 2010. This confirmed that GOSH is the largest centre for Paediatric Neurosurgery in England, and provides the most comprehensive cover (in terms of dedicated paediatric neurosurgery staff). Stakeholder and clinician events are planned for November to further gather views on the future configeration of services. We will engage as fully as possible in these events.	Green
4. With partners maintain and develop our position as the UK's top children's research organisation	**Continue to develop partnership working**	Continue to work with University College London Partners (UCLP) and leverage benefits from this.	David Goldblatt	Positive working relations with UCLP continue, including close collaboration with other R& D units within the partnership	Green
		Agree operational and management arrangements for Great Ormond Street Hospital / Institute of Child Health (GOSH/ICH) joint research activity administered	David Goldblatt	A Service Level Agreement between ICH and the R& D office is to be signed off shortly, outlining operational and management arrangements.	Green
	Develop and agree R&D strategies at clinical service level	Agree the Trust's R& D strategy and ensure Clinical Unit R& D strategies fit with this.	David Goldblatt	Implementation of the strategy and closer working relations with clinical units is taking place.	Green
	In year delivery (research)	Strengthen our grant-writing infrastructure to increase our success in obtaining research grants	David Goldblatt	Interviews for 2 remaining research facilitator posts are taking place w/c 13 February 2011	Green
		Continue to develop our R&D activities and ensure it is adequately funded. Carry out a review of the progress made in the first year of the Clinical Research Facility (CRF) and confirm strategy for the next five years.	David Goldblatt	Review of R & D Office is complete and new strcuture will be implemented. Considerable staff change process required and underway.	Green
		Agree a financial plan for R&D which is consistent with The National Institute for Health Research (NIHR) priorities and facilitates development of successful research studies.	Claire Newton	Transition of responsibility for R& D office to GOSH has enabled the review of all financial processes, documentation of procedures and by the end of the year the general ledger will include more specific accounting structure for R& D. A financial plan for R& D will be completed once the work to identify the accountability for existing grants has been completed.	Amber
		Ensure there is an appropriate funding transition for activities currently funded by GOSH Children's Charity.	Claire Newton	Applications have been made to the GOSH CC for the targeted value	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 work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK**	Commissioning of high quality educational programmes from Higher Education Institute (HEI).	Liz Morgan	Figures for 2011-12 Indirect fundign stream advised by NHSL. GOS have queried figures - the funding that has been allocated for GOSH for indirect CPPD for next year is £352,159. This is £95,000 less than sum we were allocated last year - a significant drop of around 20% or in study terms approximately ninety 20 credit modules. Whilst acknowledging the financial climate, we have pointed out that unlike other London Trusts we have been asked to take an increase in our student nurse placement numbers of up to 28%. This requires us to have suitably educated and qualified mentors and role models in the practice setting. A reduction of £95,000 in CPPD will really put pressure on us and may mean that we are unable to maintain mentor numbers to sustain the increase in students numbers which the SHA has indicated is required. We await their response.	Green
		Ensure successful bids for Multi Professional Education and Training Levy (MPET) funding, Medical & Dental Education Levy (MADEL) and Non Medical Education and training (NMET) including additional recognition of specialist national paediatric activity.	Liz Morgan	PGME have been successful in submitting two London Deanery bids to support Simulation training.	Green
		Continue to develop the use of new technologies for innovative delivery of educational programmes	Liz Morgan	Extra £20,000 bid for and agreed with Trustees to suPport further e-learninG development. OLM rep gave GOS reps demo of the National Learning Management System (NLMS) - a possible replacement for GOS training database. E& T have sold GOLD Designs plus some development work to the Stroke Association. Some technical issues in relation to e-learning hav ebeen resolved. Creation of e-learning module to support roll out of e-Panda has been prioritised. SBARD and CEWS modules also being developed along with a number of others.	Green
		Understand and fulfil a lead role within University College London (UCL) Partners and realise potential for training in child health by ensuring developments in the treatment of the patient are fed into the education and training prospectus for medical and clinical workforce.	Liz Morgan	GOS part of sub-group being set up to look at Induction training across UCLP. In addition GOS and UCLH workig together on designing a joint assessment centre to support UCLP Sterilization project.	Green
		Develop our role as a leading education and training provider for other organisations e.g. North Middlesex University Hospital and Kuwait.	Liz Morgan	NMUH SLA has now been signed off. The Kuwait contract has commenced and the first training programmes have been delivered.	Green
		Realise potential of Health Innovation and Education Cluster (HIEC) to ensure GOSH meets obligation to play a key national and international role in the de	Liz Morgan	We will also look to use our role in the North Central London, North East London and Essex HIEC through working with our partners to ensure we share the learning and good practice. This will allow us to capitalise on opportunities for interdisciplinary educational activity whilst developing an integrated approach to education and training provision across the HIEC. It will also ensure we exploit the potential of working in partnership with educational institutions ensuring that the development, delivery and evaluation of educational opportunities support service delivery. At the moment the core projects that this HIEC are focussed on are around: - Chronic Obstructive Pulmonary Disease (COPD) patients - Prevention of cardiac disease - Normalising birth Although these current priorities are not paediatric specific, being a core member of the HIEC will allow GOS to work with our partners in the HIEC to promote innovation within paediatrics - attracting funding and support where r	Green

GOSH Strategic Objectives - review of progress against 2010-11 work-streams

6. Deliver a financially stable organisation	**Agree achievable CRES plan and ensure delivery through robust project and performance management**	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered through clear project managment	Fiona Dalton	To date £11.9m of savings have been identified, of which £10.1m has been delivered (2010/11 target it £16.6m). £1.8m worth of further savings are progressing and are likely to be realised as finance assess the end of year activity position.	Amber
		Agree a robust 5 year CRES programme, with external scrutiny, to fit with our overall Integrated Business Plan.	Fiona Dalton	The Trust has agreed a robust 5 year CRES programme which is in line with the Integrated Business Plan, this been subjected to external scrutiny through the Foundation Trust application process. The focus will now shift to maintaining and	Green
		Manage services within budget, delivering efficiency e.g. reducing agency spend.	Fiona Dalton	Projected year end surplus as planned	Green
		Invest within our capital programme to support increased revenue and decreased costs, including: Additional bed in Badger ward; additional outpatient capacity; reorganisation of Genetics and release of savings from the core lab development.	William McGill	A range of projects are in submission for ROI projects these will now be considered prior to start of the new financial year. New guidance has been issued in December 2010, This has stimulated a range of ideas which are currently Genetics have moved to York House and are currently going through a rationalisation programme(six Months) Badger Ward approved at October Management Board currently being briefed and designed. No changes from December2011	Amber
	Improve efficiency through rolling out Managing Variability Programme	Continue the roll-out of Variability and Flow (V& F) projects across the Trust, continuing to monitor the success of the cardiac project and completing	Fiona Dalton	Programme to be revised with engine room projects - surgical pathway progressinig and bed management commencing	Amber
	Ensure appropriate funding for our clinical services from commissioners	Ensure issues with Service line Reporting (SLR) system are resolved by Quarter 1 and the system is fully implemented and in use by the units by Quarter 3.	Claire Newton	SLR and PLICs are now available centrally and SLR is being used by units to identify areas requiring financial improvement	Amber
		Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.	Claire Newton	This has been monitored with commissioners throughout the year.	Green
		Complete revisions of funding baselines for the remaining National Commissioning Group (NCG) services (Transplant, Neuromuscular, Extracorporeal membrane oxygenation (ECMO) & Bridge to transplantation (BTT).	Claire Newton	This was completed and increased funding secured.	Green
	Support the charity to raise targeted funds	Work within the GOSH charity to support their work to achieve the targeted level of fund-raising.	Jane Collins	At the end of January total charity income for the year to date stood at £52.7 million vs a reforecast YTD budget of £52.1 million and £12 million ahead of the original year to date target.	Green
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	**Make progress towards becoming a Foundation Trust**	Submit Foundation Trust (FT) application by agreed timetable with SHA.	Jane Collins	Application documents sent to DH 31/1/11 Preparation for Monitor assessment commenced 1/2/11	Green
		Ensure the Trust has a robust Long Term Financial Model (LTFM) for use in the FT application process. Ensure all financial matters required to achieve FT status are delivered e.g. working capital facility; insurance programme.	Claire Newton	The various due diligence reviews of the LTFM by independent accountants have been completed successfully.	Green
	Ensure that the Trust is compliant with regulatory requirements	Ensure that the Trust retains registered status with CQC.	Jane Collins	Work is ongoing to review an IT tool to support the process. CGC and Audit Committee continue to seek assurance of compliance with the standards	Green
		Ensure that Information Governance processes are strengthened and the self assessment score in the IG toolkit is improved.	Claire Newton	Head of IG appointed dedicated to improving IG processes. Information flows charted and used to identify IG risks. Critical systems identified and Information Asset owners and risk registers should be in place by end of March.	Green
		The Public Health Action Plan is delivered in line with the Health and Adult Social Care Registration System.	Barbara Buckley	Work with Pharmacy students ongoing. Little published by NICE in recent months - all PH guidance appears to be on hold. Project to improve health of staff being initiated by Sports and Social Committee - initial discussions of measurement of impact held. Father-friendly project commenced by Tony Higgins with initial scoping and literature searching ongoing. Immunisation plan drafted - awaiting confirmation of correct approach.	Green
		Work towards achieving NHS Litigation Authority (NHSLA) level 3 Risk Assessment early in 2011.	Martin Elliott	No date comfirmed regarding the Level 3 assessment.	Green
		Ensure delivery of specific Information Governance requirements e.g. Pseudonymisation, NHS No, Data quality.	Claire Newton	Priority has been given to developing the pseudonymisation work plan and targets for all workstreams have been met but there will remain further work to do to ensure all critical systems have been addressed. A new training module on GOLD has been developed but it is likely the national targets wont be achieved during 2010/11 and so work will continue to increase no of staff completing IG training assessment in 2011/12.	Amber
		Ensure that the Trust achieves best practice in Data Quality standards for all information supporting decision making.	Claire Newton	A DataQuality group was formed and met regularly during the year and a work plan established and followed. A new information tool was purchased to enable DQ processes to be carried out more effectively and is now working successfully.	Green
		Deliver all projects included as current year projects within the Information Technology (IT) investment strategy approved by Trust Board in March 2010.	Claire Newton	Currently on track Key projects include: - Server Virtualisation (Green) - Citrix Upgrade (Green) - Order Communications (Green) - ICT Storage and SAN migration (Green) - Asset tracking wireless (Green) - Micrsoft Exchange (yellow due complexity of developing business case but progressing)	Green
		If approved by Board, ensure Business Process Management (BPM) project progresses and meets all milestones in first year of implementation and there is a recognised improvement in Referral to Treatment (RTT) processes as a result of the pilot.	Claire Newton	Trust Board did not approve the project. The fact that there was no other health provider who had implemented such a scheme limited the assurance available. As a result, a revised ICT Strategy is to be presented in March.	Red

Attachment S

Great Ormond Street Hospital for Children NHS Trust

Trust Board

30 March 2011

Financial Plan 2011/12 – Status Update and Request for Approval **Submitted by:** Claire Newton, Chief Finance Officer	**Paper No: Attachment S**

Aims

To update the Trust Board on the current status of the financial planning process for 2011/12 - since the initial briefing submitted to the January meeting - and to request approval for the financial plan.

SUMMARY

This paper summarises the key elements of the Trust's financial plan for 2011/12 which have already been discussed in more detail by the Board prior to the Board meeting.

The Trust's financial plan is based on the first year of the current version of the LTFM .
It projects a net surplus of £1.3m after an estimated charge for impairment of £5.6m arising when the new building is commissioned.

The net surplus pre impairment of £6.9m is lower than the forecast out-turn for 2010/11 due to above average losses on the changes in the PbR tariff and other commissioner price changes; and cost pressures discussed below.

For the next two financial years there will be double running costs arising in connection with the new Phase 2A building. There are also further cost pressures in 2011/12 which include the full year effect of the ICON and General paediatrician services, the increase in the VAT rate (effective Jan 2011); increase in national insurance rates, reduction in junior doctor funding and continuing increases in the CNST premium and revenue costs arising from IT investments.

A further critical assumption is the value realised from the Trust's CRES programme which is a net productivity gain of £9.9m or 4-4.5% of influenceable expenditure.

Negotiations with commissioners have not yet been concluded with all commissioners but should be concluded by the end of March.

Action required from the meeting

To approve the financial revenue and capital plan for 2011/12 and note the risk/issues which will be managed during the year

Contribution to the delivery of NHS / Trust strategies and plans

This is a key element of financial planning and therefore critical to delivery of financial sustainability

Financial implications

All matters discussed in the paper have financial implications

Legal issues

None

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) ? Managers

Who needs to be told about any decision TB

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

All managers

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

Author and date Claire Newton 17.03.11

A High Level Summary

Financial Plan 2011/12 Summary Revenue Statement						
	09/10	10/11 Annual Budget £000	10/11 Forecast Outturn	Financial plan 11/12	Incr/Decr v '1011 FC OT	% Incr/Decr
Activity Revenue Nhs	241,544	*250,279*	252,541	254,550	2,009	0.8%
Activity Revenue Non Nhs	26,003	*27,556*	29,318	31,939	2,621	8.9%
	267,547	277,834	281,859	286,489	4,630	
Other Operating Revenue	50,598	*47,607*	50,703	51,414	711	1.4%
	318,145	325,442	332,562	337,903	5,341	
Pay Costs	(184,784)	*-183,099*	(192,294)	(188,298)	3,996	-2.1%
Non Pay Costs	(105,964)	*-114,935*	(110,854)	(121,113)	(10,259)	9.3%
	(290,749)	(298,034)	(303,148)	(309,411)	(6,263)	
Depreciation	(15,348)	*-14,351*	(14,450)	(15,870)		
Other non-operating	491	12	(77)	24		
Impairment	(3,817)		(1,749)	(5,571)		
PDC	(5,172)	*-5,853*	(5,838)	(5,765)		
Total non-operating	(23,846)	*-20,192*	(22,114)	(27,182)	(5,068)	
Retained Surplus / (Deficit)	3,551	*7,215*	7,300	1,310	-5,990	
Net surplus ex impairment	**7,368**	***7,215***	**9,049**	**6,881**	**-2,168**	

B Basis of plan

The Trust's Financial Plan for 2011/12 has been based on the first year of projections within the FT LTFM (Long Term Financial Model). The members of the Trust Board have a copy of the Financial section of the IBP which provides a detailed explanation of the assumptions underlying the Trust's financial projections.

C Budget process

Budget envelopes have been discussed with all cost centre managers and the budgets for each cost centre have now been determined and will have been signed off by the managers by the date of the Trust Board meeting.

D Outline Financial Plan

D1 Activity and income

The Trust is currently targeting overall activity growth of between 2 and 4% depending on specialty and category of episode.

Tariff changes reflect the Operating Framework and the final tariff –issued in February.

Pay awards will be in accordance with nationally negotiated terms. A pay freeze for all staff above Band 2 is currently proposed although Agenda for Change increments will still be payable unless performance does not merit this.

The structure for funding of training posts for education will not change significantly this year although the Deanary has recently advised a small reduction in the numbers of posts being funded. A more radical change in structure of the funding is expected in 2012/13

We have not yet received notification of R&D funding from the NIHR and so are assuming similar levels to 2010/11.

D2 Commissioning terms

Proposals are likely to have been agreed with most Commissioners in relation to funding baselines, CQUIN targets and performance metrics by the date of the Board meeting. A brief summary will be tabled to reflect the negotiated position at the meeting with a more detailed appraisal of contract terms at the April meeting.

D3 Internal cost pressures

There have been a number of significant business cases with major cost pressures, approved by Management Board in 2010/11. These include the continuation of the ICON service, the establishment of the General paediatrician team (although this is partially funded through reduction in on call posts, and the establishment of additional Interventional radiology staff.

With effect from 1st January 2012, the Trust will have possession of the Phase 2A clinical building and will incur double running costs for the final quarter of 2011/12 and a substantial part of 2012/13.

D4 External cost pressures

The Trust is subject to national cost pressures for increases in NI rates and from the change in VAT rate to 20% has been included in the plan

Inflation on costs other than pay had been assumed to remain low

CNST premiums have increased by over £200k as a result of increases in claim numbers and values across the NHS.

The Deanary has recently notified a reduction in the number of junior doctor training posts being funded.

D5 Cost reduction programme

The CRES plan for 2011/12 is largely developed and milestones have been identified for all elements of the plan.

The Trust is expected to deliver a minimum 4% CRES based on influenceable expenditure from schemes to reduce costs, although approximately 7.5% is being targeted to allow for risk and to fund cost pressures not otherwise funded through the financial plan.

D6 Non-recurring items

It is anticipated that the Trust will transfer its community services in Haringey to Whittington Health by the second month of the financial year although a detailed transition plan has yet to be established with the successful bidder for the service.

The first “exceptional” transactions will be recorded “below the line” ie below the operating surplus in relation to the commissioning of Phase 2A. It is anticipated that a valuation of the new building will result in an impairment being recorded at the end of the financial year, currently estimated at £5.6m. This is a technical adjustment and has no cash impact.

D7 Statement of Financial Position and Working Capital / Financial Risk Ratios

The statement of financial position included in the financial plan is consistent with that included in the IBP although it has been updated in some areas to reflect the most recent out-turn balance sheet which shows a more favourable view of year end cash balances.

The financial risk ratios will meet level 3 with the adoption of a working capital facility when the Trust becomes an FT which is to protect the Trust from temporary reductions in its cash balances although it is not anticipated that this will be drawn down.

E Capital plan

The total proposed capital expenditure included in the plan is £14.4m which **in**cludes a ringfenced allocation of £2.6m for an IT / Information enterprise architecture project for which it is proposed a separate approval would be required by the board depending on the timing of the business case.

The proposed financial envelope, excluding the £2.6m, is £11.8m and has been evaluated to take into account the projected value of depreciation for the same period is approximately **£9.0m,** which is an indicator of the potential level of capital spend required to maintain the same level of assets, and the overall objective for a Foundation Trust to manage its working capital and cash within available resources.

The proposed envelope will be managed by the CASP, a sub committee of Management Board. It has been notionally allocated, and is supported by IT and Estates capital programmes as follows:

Estates & facilities	£7.7m
IT	£3.4m

This is significantly less than the total value of plans for Estates, facilities and IT put forward to CASP which amount to c£18.5m and so investment approvals will be based on an agreed prioritisation methodology and clear business cases.

In addition to the above capital expenditure allocation, the Trust will be spending an estimated £40-50m, subject to receipt of funding from GOSH charity, on completion of Phase 2A, initial design work on Phase 2B, Phase 2B enabling works and medical equipment.

It is vital that the Trust's retains flexibility to cut back planned capital spend during the year as mitigation in a downside scenario so the CASP and subsidiary investment boards will be instructed to manage the capital plan on a commitment basis and to limit commitments to 80% of the financial envelope until the final quarter of the year.

Attachment T

Great Ormond Street Hospital for Children NHS Trust

Trust Board
30 March 2011

Title of document: Foundation Trust application: Approval of board self certification statements **Submitted on behalf of:** Fiona Dalton	**Paper No: Attachment T**

Aims / summary

The following documents need to be approved by the Board and then submitted to Monitor at the beginning of their assessment process:

- Self certification statements on leadership and management
- Quality governance board statement and board memorandum
- Update on the Membership Strategy

Each document was reviewed by the Trust Board at its development session February 2011, and subsequently amended, as directed by the Board.

The Board is asked to confirm that it is satisfied that the statements have been made on the basis of a satisfactory process and appropriate evidence.

Action required from the meeting

Approval of the following documents:

- Self certification statements on leadership and management
- Quality governance board statement and board memorandum
- Update on the Membership Strategy

Confirmation that the Board is satisfied that the statements have been made on the basis of a satisfactory process and appropriate evidence.

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)

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
21 March 2011

Attachment U

Great Ormond Street Hospital for Children NHS Trust

Trust Board
30th March 2011

Approval of Business Rates payment for 2011/12	**Paper No: Attachment U**
Submitted on behalf of: Claire Newton /Bill McGill	**For APPROVAL**

Aims
To seek Board approval to pay the Trust's business rates bill as our SFIs require Trust board approval of non-pay expenditure over £1m.

Summary
The Trust's business rates bill for the hospital is individually over £1m and combined with the other three buildings amounts to £1.6m pa, analysed below. Under the current version of the Trusts SFIs, this requires Trust Board approval for payment

Camden Council Tax & Business Rates

	£ Gross value	Rate/£	£ Non dom rate	£ Supplement	£ Total
Weston House	231,000	0.433	100,023	4,620	104,643
Hospital ex Level 6&7	2,290,000	0.433	991,570	45,800	1,037,370
Basement to 4th Floor York House	855,000	0.433	370,215	17,100	387,315
GOSH at Homeopathic	105,000	0.433	45,465	2,100	47,565
					1,576,893

Action required from the meeting To approve the expenditure

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

Financial implications Routine expenditure

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

Who needs to be told about any decision? The Board

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

Who is accountable for the implementation of the action plan Estates

Author and date *Claire Newton 25.03.11*

Attachment 16

Great Ormond Street Hospital for Children NHS Trust

Trust Board
30th March 2011

Approval of NHSLA Premiums for 2011/12 **Submitted on behalf of:** Claire Newton / Martin Elliott	**Paper No: Attachment 16** **For APPROVAL**

Aims
To seek Board approval to pay the Trust's NHSLA premiums as our Standing Financial Instructions require Trust Board approval of non-pay expenditure over £1m.

Summary
The Trust's annual NHSLA premiums which include the premiums for clinical negligence are now over £2m. Under the current version of the Trusts SFIs, this requires Trust Board approval for payment. The amount will be paid in monthly instalments but this paper requests approval for the entire amount due.

Cover for clinical negligence and third party liability is unlimited but cover for property is £1m.

In general Clinical negligence premium rates have increased by c 14% this year although certain categories of staff regarded as low risk eg clinical support staff have been dealt with differently. The Trust continues to benefit from a 20% discount on the gross CN premium due to it having NHSLA Level 2.

Property and Third party liability premiums have not increased significantly

Amounts to be approved:

	£
Clinical negligence	2,436,729
Level 2 discount	- 487,346
Third party liability	178,445
Property	38,347
	2,166,175

Action required from the meeting To approve the expenditure

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

Financial implications Routine expenditure

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

Who needs to be told about any decision? Trust Board

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

Who is accountable for the implementation of the action plan Estates

Author and date Claire Newton 25.03.11

Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting **30th March 2011**	
Title of document: Register of Seals **Submitted on behalf of: Jane Collins, Chief Executive**	**Paper No: ATTACHMENT V**
Aims / summary Under Standing Order 8.3, the Chief Executive is required to keep a register of the sealing of documents. The attached table details those seals affixed and authorised between 19 January 2010 and 23 March 2011.	
Action required from the meeting To endorse the application of the common seal and executive signatures.	
Contribution to the delivery of NHS / Trust strategies and plans N/A	
Financial implications N/A	
Legal issues To ensure the Trust complies with its standing orders.	
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 Anna Ferrant Company Secretary March 2011	

Attachment V

Great Ormond Street Hospital for Children NHS Trust

Register of use of Seal from 19 January 2011 – 23 March 2011

Date	Description	Signed
01/03/11	Scheme Contract Woodland Ward Phase 3 (Balfour Beatty Group)	JC CN
01/03/11	Scheme Contract Woodland Ward Phase 4 (Balfour Beatty Group)	JC CN
01/03/11	Scheme Contract Theatre Doors VCB and associated works Phase 3 (Balfour Beatty Group)	JC CN
01/03/11	Scheme Contract Theatre Doors VCB and associated works Phase 4 (Balfour Beatty Group)	JC CN

Attachment W

Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting
30 March 2011

Title of document Six day (Saturday) working – HR issues: Presentation **Submitted on behalf of** Fiona Dalton	**Paper No: Attachment W**

Aims / summary

The attached presentation provides a brief summary of feedback from clinical unit boards and some consultants about the proposal to establish a six-day working week for elective admissions, diagnostic and out-patient services. From this feedback and the outline financial analysis (previously presented to Trust Board), it is clear that the main issue to be considered as the proposal is developed is how the human resources and associated staff contractual issues will be managed.

The presentation sets out the range of HR issues, and possible ways in which these can be addressed.

Development of six-day working in a 12-24 month time frame will require focus on specific service areas (eg. international and private patients, neurosurgery and cardiac surgery), and the willingness to address contractual changes.

Development over a longer term can be achieved through the more gradual development of staff contracts and working arrangements.

In the integrated business plan, significant six day working is not required before 2015/16, with a focus on improving utilisation and efficiency on Mondays to Fridays before then. However, higher growth than planned, if for example there is a significant increase in cardiac surgery or neurosurgery before this time is likely to require additional capacity that is currently not available without Saturday working.

Action required from the meeting

Trust Board are asked to advise on the style of approach to be used for:

- Developing staff contracts
- The pace of implementation

Contribution to the delivery of NHS / Trust strategies and plans

Contributes to achievement of Integrated Business Plan.

Financial implications

Not covered by this paper, but will be covered by specific business cases for the development of six-day working.

Legal issues: Possible staff contract changes.

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

The decision taken by the Board will be used as a basis for consultation with staff and staff-side organisations.

Who needs to be told about any decision

Staff, staff side organisations, commissioners, patients, parents and carers.

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

Sven Bunn / Ray Conley

Who is accountable for the implementation of the proposal / project

Chief Operating Officer/Deputy Chief Executive

Author and date

Ray Conley, Sven Bunn
21 March 2011

SIX DAY WORKING

Clinical unit feedback

- Presentation of business case
- Utilisation and efficiency Monday to Friday
- Decision about extended days **or** Saturdays
- Need more theatres
- HR issues - telling v. asking

Challenges to overcome

- Many consultants are not receptive to Saturday working
  - “Saturdays are too precious”
  - “possibly if voluntary and for significant premium payments”
  - “current waiting list rates are derisory”
  - “Trust needs to start talking about proper payments”
  - “it’s wrong to appoint new people on different terms it will lead to long term problems”
- Some surgeons who agree it is a good idea are expecting other teams to move to Saturday vacating time for them in the week !!

Planned Expansion – Possible Six Day Working

- Cardiac surgery
- Neurosurgery
- Spinal surgery
- Cardiac day cases
- MRI scans
- General surgery
- Orthopaedics
- Ophthalmology
- ENT
- Urology

Staff Groups Working Six Days Per Week

Core	**Support - Clinical**
Medical	Laboratory staff
Nursing	Radiographers
	Therapists
	Support – Non-clinical
	Accommodation
	Nursery
	Admin

HR Issues - Decision

- Voluntary v compulsory
- New staff v current staff
- Short-term v long term
- National terms & conditions v local contracts
- Negotiations/engagement v imposition
- Financial benefits v non-financial costs
- Onsite v on-call
- Extend working week v maximising current arrangements

Specific Issues

- Contracts
- Rostering
- Overtime/on-call
- Pay
- Recruitment
- Training
- Workforce planning
- Employee engagement

Contracts

Nationally determined -	Agenda for change Medical staff
Current restrictions -	Consultant contract: weekend working Clinical v non-clinical Pas
Possible options -	Flexibility in current AfC contract Opting-out/local contracts Bank/secondary contracts Post-retirement contracts
Key issues -	Voluntary/compulsory New/current staff Negotiation/Imposition Labour market conditions

Rostering

- Six day rotas or voluntary arrangements
- Current restrictions – EWTD
  Job planning
  Support services (eg Nursery)
- Possible options – EWTD Opt-out
  Bank working
  Flexible working
- Key issues – Contract flexibility
  Pay
  Staffing numbers
  Substantive or on-call

Overtime/On-call

Nature of service provided -	On-site attendance
	On-call
National agreements -	Agreed rates
	Harmonised on-call arrangements
	EWTD
	Job planning restrictions
	Annual leave/sickness absence payments
Possible options -	Set local overtime/on-call arrangements
Key issues -	Compulsory/amending contracts
	Local negotiations
	Staffing numbers

Pay

- Currently nationally determined
- Locally set to meet specific needs (eg 18 week compliance)
- Key issues – Funding source
  Harmonisation/equality
  Labour market conditions
  Attractive option
- Possible options - Local negotiations
  Bank working

Recruitment

- GOSH currently perceived as ‘a good place to work’
- 6 day working – beneficial or detrimental to recruitment?
- Key issues – Pay
  Flexibility
  New staff v current staff
  Local/national competitors
  Transport
- Possible options – Voluntary arrangement
  Flexible work practices
  Labour market conditions

Training

- Need to expand current pool of available skills
- Possibility of more lone/single working
- Weekend training/Induction

Workforce Planning

- Skills, professions, grades required for weekend work
- Ensuring sufficient number of skilled/qualified staff over 6 days
- Replicating current five day week arrangements

Employee Engagement

- Good/harmonious relations with staff-side organisations
- BMA
- National developments
- Reputational issues

Next Steps

- Consider key issues and decisions
- Pilot
  - IPP
  - Neurosurgery
  - Cardiac surgery
  - MRI

Attachment X

Great Ormond Street Hospital for Children NHS Trust

Trust Board **30th March 2011**	
Title of document Key Performance Indicator Dashboard Report **Submitted on behalf of.** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment X**
Aims / summary The Key Performance Indicator (KPI) report monitors progress against the Trust's seven strategic objectives, providing traffic light analysis against each of the supporting work streams with further supporting graphs representing key outcome measures. Remedial actions, where performance is not being maintained or achieved, are being addressed through Management Board. A full copy of the KPI report will be provided to Trust Board at quarter end.	
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 Plan 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 As above.	
Author and date Alex Faulkes, Head of Planning & Performance Management. March 2011	

Attachment X

KPI Exception report

1. C. difficile

In month the Trust reported 2 cases of C. difficile. Year to date the total rate is reported at 10 against trajectory of 8.25 and a year end trajectory of 9. The Department of Health (DH) have not yet agreed to a paediatric target different from adult. The DH advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) will be presenting our opinion on this again soon. On this basis we have not agreed a trajectory for 2011/12 as yet.

2. Inpatients waiting list profile by weeks waiting

Performance has decreased slightly in month with 46 patients reported as waiting over 26 weeks for inpatient treatment following data validation.

3. Outpatients waiting list profile - GP to first consultant appointment

The number of patients waiting over 13 weeks for a first consultant outpatient appointment decreased slightly from a January position of 47 to 42 following data validation.

We intend to refocus our attention on waiting lists given the recent changes to government policy in relation to both national standards and the responsibilities of regulatory bodies that monitor performance against these. We will ensure that we continue to meet new national targets in relation to referral to treatment times, resolve identified long waiting issues and make certain that reporting remains consistent across the organisation.

4. Clinic outcome form completeness

There are clear differences across Clinical Units and Specialties in the current level of outcome form completeness with some achieving 100% or near and others well below 50%. This has meant that overall level is stalled around 60%.

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

5. Staff who have a current Personal Development Review (PDR) in the last 13 months

Both clinical and non-clinical PDR rates fell marginally to 73%. The Trust has set a target of achieving 80% compliance by March 2011. Services and departments have been encouraged to continue to review staff currently identified as not receiving an appraisal.

6. Market Share Analysis

The charts show the market share trends for our priority specialties on a quarterly basis. The summary of the recent changes are;

Specialty	Target Markets	Market Share Trend	Key Competitors Changes	Comments
Cardiac Surgery	NL + Surrounding Further Regional	Stable	Southampton Oxford	Southampton have consolidated the Oxford workload
Neuro Surgery	NL and SL and Surrounding	Down	Kings	Slight signs of recovery in last quarter
General Surgery	NL + Surrounding	Up	Cambridge Barts & London	Highest level of GOSH market share achieved
Spinal Surgery	NL and SL and Surrounding	Up	Stanmore	Maintaining increased market share
Gastro	NL + Surrounding	Stable		
Haem / Onc	NL and SL and Surrounding	Stable		NL + Surrounding returned to usual level (from higher)

NL surrounding areas: Bucks, Essex, Beds and Herts
SL surrounding areas: Kent, Sussex and Surrey
Further Regional areas: Cambridge, Suffolk, Norfolk, Berks, Oxon, Hants and IOW
Green: Market Share Gain
Orange: Stable Market Share
Red: Market Share Loss

Great Ormond Street Hospital for Children NHS Trust

Trust Board

Key Performance Indicator Dashboard Report

Feb-11

Key Performance Indicator Dashboard Report

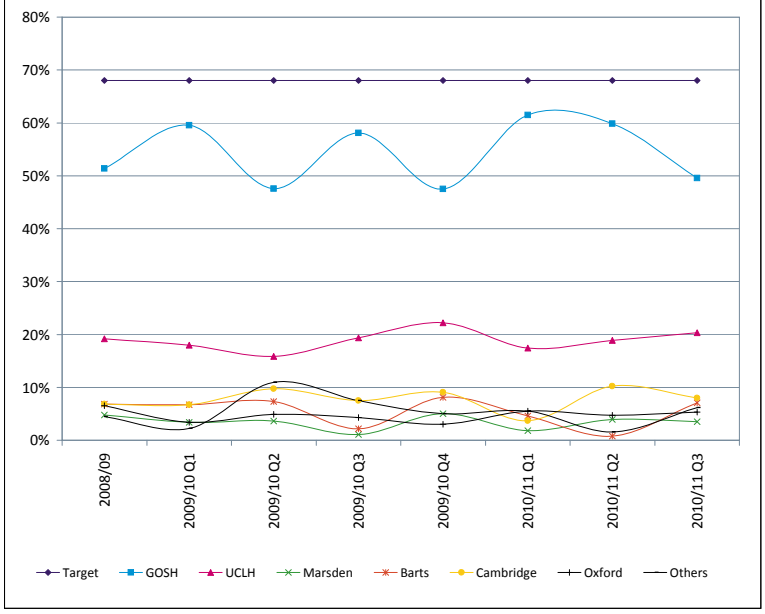
Great Ormond Street Hospital for Children NHS Trust

Objective / Indicator	YTD Target/Trajectory (10/11)	YTD Performance	In month / quarter performance	Performance against previous reporting period	Reported	YTD RAG
1. Consistently deliver clinical outcomes that place us amongst top 5 Children's Hospitals in the world						
Incidence of C.difficile	8.25	10	2	↓	Monthly	Red
Incidence of MRSA	1	1	0	↑	Monthly	Green
Incidence of MSSA	TBC	17	3	↓	Monthly	-
Mortality figures	Within tolerance	113	9	↑	Monthly	Green
No. of NICE recommendations unreviewed	<3	-	1	↑	Monthly	Green
Medication errors reported (per 1000 bed days)	Data under review	-	-	-	-	-
Serious incidents	Within tolerance	-	3	↓	Monthly	Green
Incidence of Central Venous Line related infections (per 1000 bed days)	2.4	2.71	1.9	↑	Monthly	Amber
Surgical site infections as a percentage of Urology operations	Within tolerance	0.74	1	↔	Monthly	Green
Incidence of Ventilator-Associated Pneumonia (VAP)	0	3	No Feb data		Monthly	Amber
Surgical Checklist completed - Sign in (%)	75	-	79.6	↑	Monthly	Green
Surgical Checklist completed - Time out (%)	75	-	79.9	↑	Monthly	Green
Surgical Checklist completed - Sign out (%)	75	-	69.6	↑	Monthly	Amber
2. Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations						
Inpatient waits >26wks	<5	-	46	↓	Monthly	Red
Outpatient wait >13wks	<5	-	42	↑	Monthly	Red
18 week RTT performance - Admitted (%)	90	94.32	90.65	↑	Monthly	Green
18 week RTT performance - Non-Admitted (%)	95	96.78	96.98	↑	Monthly	Green
Clinic outcome form completeness (%)	95	70.21	60.57	↓	Monthly	Red
Valid coding for ethnic category - inpatient (%)	85	88.1	85.29	↓	Monthly	Green
Discharge summary completion (%)	95	82.29	75.3	↑	Monthly	Amber
Did not attend - outpatients (%)	TBC	8.69	7.6	↑	Monthly	-
3. Successfully deliver our clinical growth strategy						
Theatre Utilisation - U4 (%)	77	-	63.1	↑	Monthly	Amber
Follow up to new ratio	4.5	-	4.21		Monthly	Green
No. of External emergency referrals to PICU/NICU refused	To reduce		No Feb data	-	-	-
Income variance - Budget against actual		-				Green
4. Currently partnered with ICH, and moving to UCL Partners with AHSC, maintain and develop our position as the UK's top children's research organisation						
External Research Grants - Commercial and non-commercial (£)	TBC	27,622,728	1,925,102	↑	Monthly	-
Clinical trials - number recruited	TBC	1532	1532	↔	Annually	-
5. To work with our academic partners to ensure that we are provider of choice for specialist paediatric education and training in the UK						
MPET SLA Value (£)	-	-	7,192,841	↔	Quarterly	-
6. Deliver a financially stable organisation						
CRES delivered (£000) - Released from budgets	16,605	10,284	-	↑	Monthly	-
Bank and Agency Total expenditure (£000)	TBC	13,477	1,222	↑	Monthly	-
Monitor Risk Rating	3	-	3	↔	Monthly	Green
Charity fundraising target	55,828,205	56,590,047	3,924,700	↑	Monthly	Green
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation						
Sickness absence rate (%)*	TBC	-	3.3	↔	Quarterly	-
No. of staff in post - Costs*	TBC	-	£47,901	-	Quarterly	-
Vacancy rate (%)	TBC	-	8.36	↑	Quarterly	-
Turnover rate (%)*	TBC	-	18.1	↔	Quarterly	-
NHS Number completeness - FCE inpatient (%)	95	98.1	98.41	↑	Monthly	Green
NHS Number completeness - outpatient (%)	95	97.8	98.49	↑	Monthly	Green
Staff PDR completeness - clinical (%)	80	-	73.8	↓	Monthly	Amber
Staff PDR completeness - non clinical (%)	80	-	73.3	↓	Monthly	Amber
Network Availability (%)	99.99	-	99.99	↔	Monthly	Green
Average Key Server Availability Monthly (%)	-	-	100	↑	Monthly	Green
Monthly Key Application Availability	-	-	98.32	↑	Monthly	Green

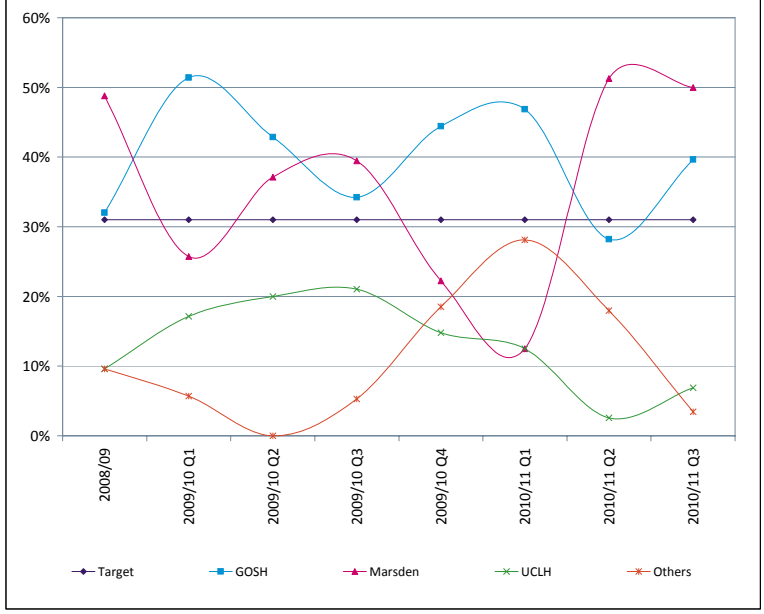
* Rolling 12 month position

Market share summaries 2010/11 Q3

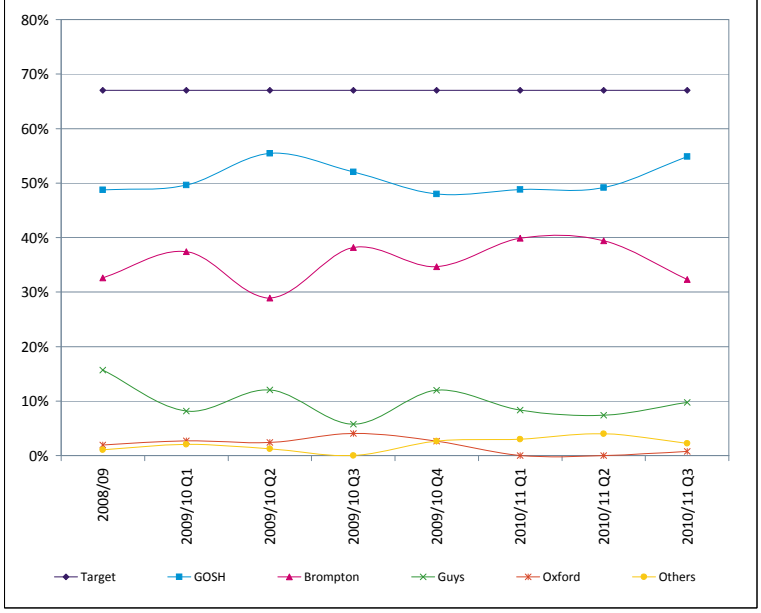
Oncology North London & Commuter Belt Market Share



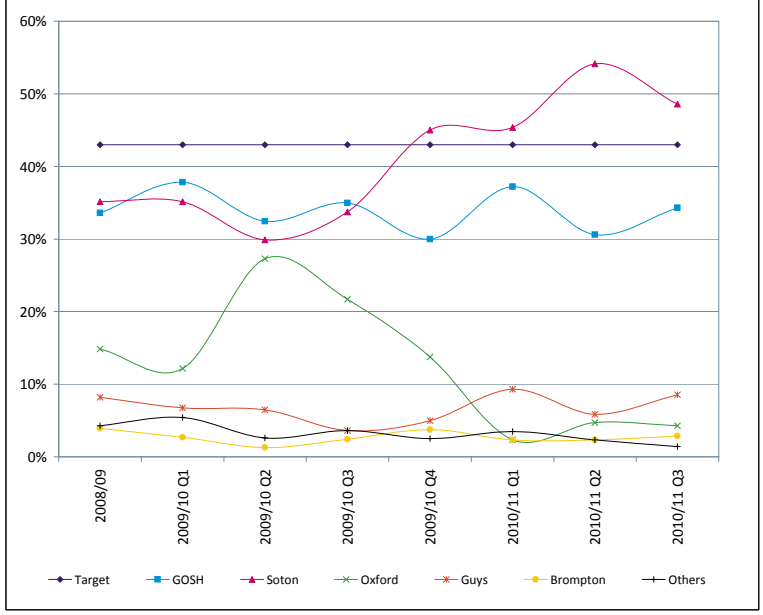
Oncology South London & Commuter Belt Market Share



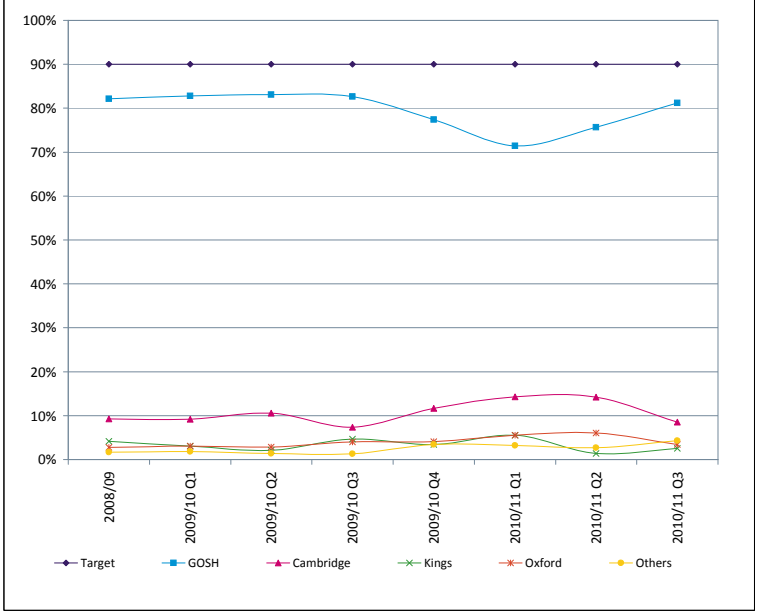
Cardiac Surgery North London & Commuter Belt Market Share



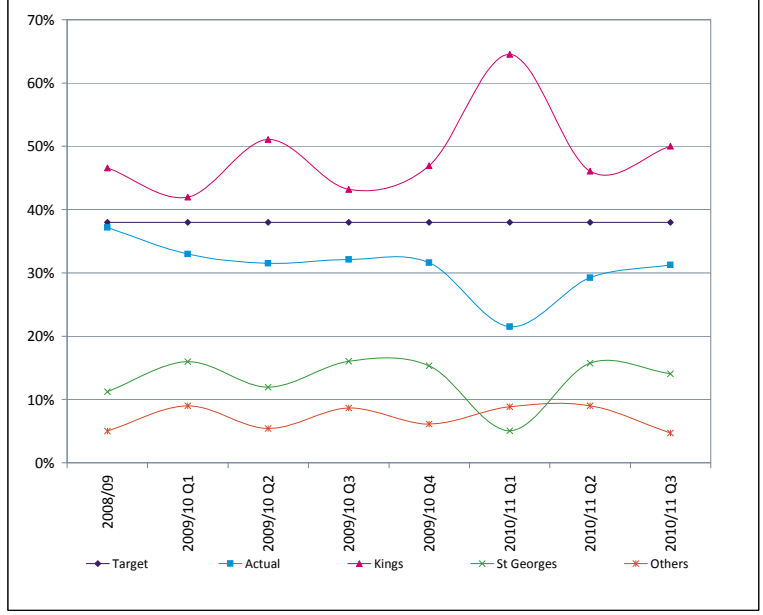
Cardiac Surgery Further Regional Market Share



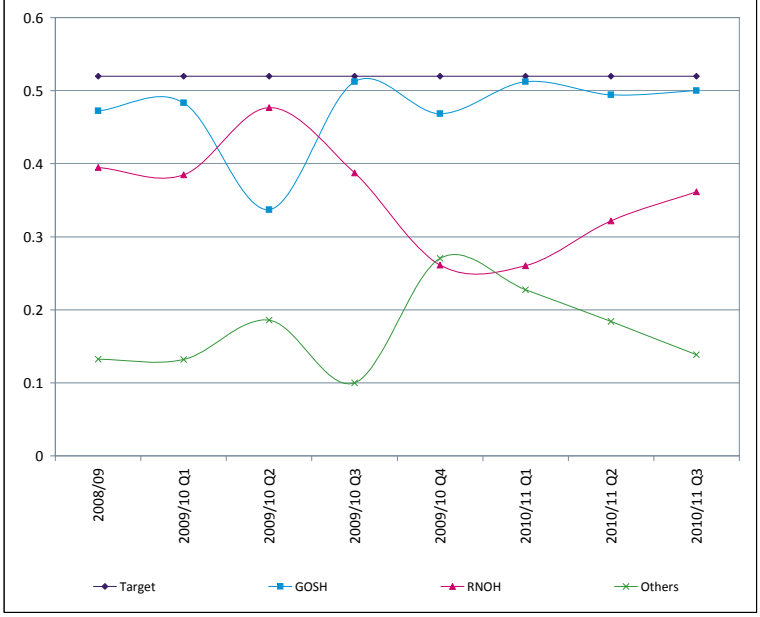
Neuro Surgery North London & Commuter Belt Market Share



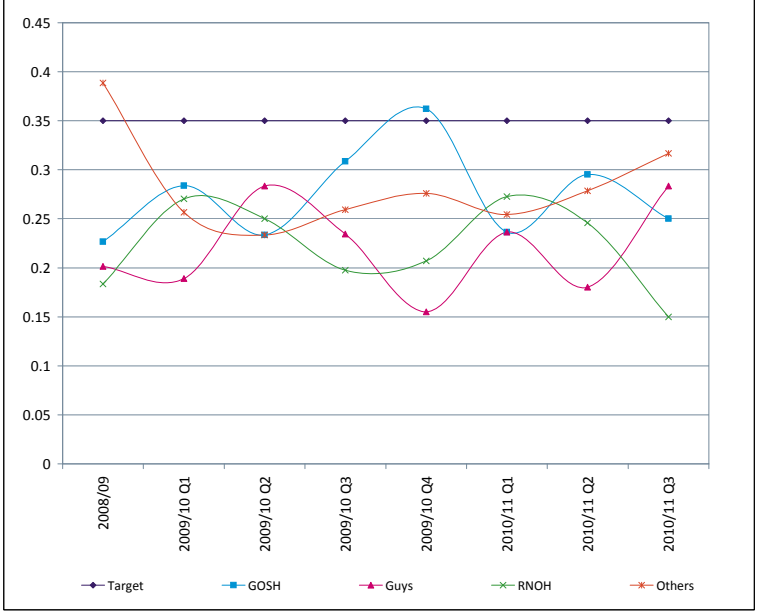
Neuro Surgery South London & Commuter Belt



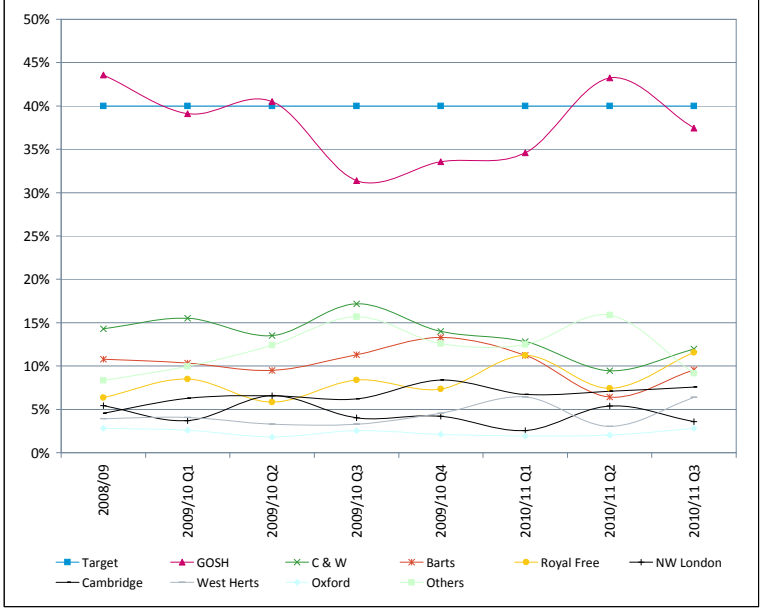
Elective Spinal Surgery North London & Commuter Belt Market Share



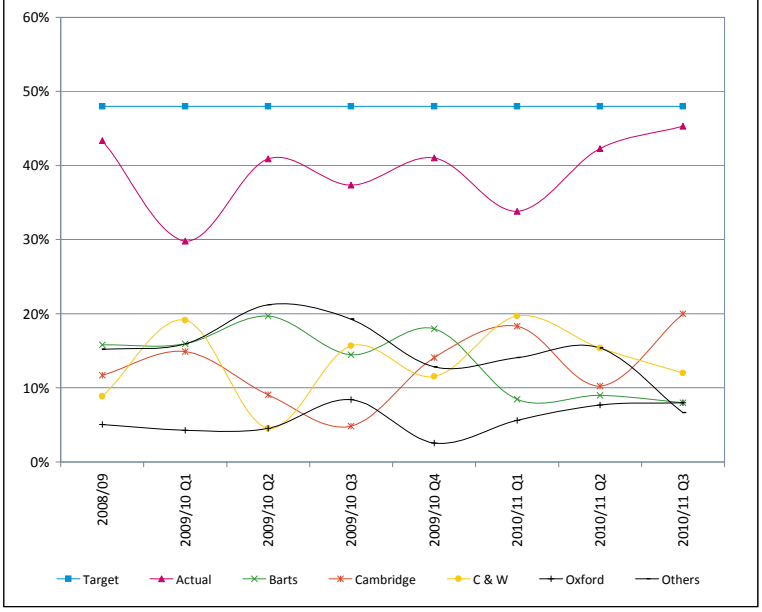
Elective Spinal Surgery South London & Commuter Belt



Gastro North London & Commuter Belt Market Share



SNAPS North London & Commuter Belt Market Share



Attachment Y

Great Ormond Street NHS Hospital for Children NHS Trust

Trust Board 30th March 2011	
Finance and Activity Report **Eleven months to 28 February 2011** **Submitted on behalf of** Claire Newton, CFO	**Paper No: Attachment Y**

AIM

To summarise the Trust's financial performance for the 11 months to **28 February 2011** and the forecast full year out-turn for 2010/11.

SUMMARY

Period 11 position

- Surplus £7.5M – £1.9M favourable to budget and £1.3M favourable to the original Provider plan
- NHS Clinical income, IPP Income and Other Operating Revenue are all higher than budget, and non pay costs are lower than budget. There are over spends on pay budgets particularly junior doctors and nursing

Forecast for full year

- The forecast is for an £8.8M surplus as adjusted for the effect of any impairment on property values. This is currently estimated at £1.5M
-

Ratios (FT)

- Overall FT score of 3 for **year to date which is at target**
  - Liquidity days score 2
  - All other ratios score 3 or above
  - EBITDA achieved score 5

BPCC performance (Non NHS – cumulative)

- 87.2% - value (87.2% last month)
- 88.2% - volume (88.5% last month)

Agency ratio to total pay

- 6.5% year to date (peaked at 8% and was 6.9% to December 2010)

Staff overpayments

- 6 overpayments totalling £8.9K

Expenditure

Pay is £8.4M higher than budget. This reflects;

- Higher than budgeted junior doctor costs to cover vacant posts in the first half of the year, although since October this has declined as many posts were filled
- Nursing budgets are overspent by £1.4M reflecting the need to cover vacancies, maternity leave and sickness.
- The effect of higher staffing levels needed to support increased levels of activity – this is particularly the case in the scientific, therapies and technical staff budgets

But agency costs have reduced yet again this month to a cumulative 6.5% (6.7% to period 10) of the pay bill

Non Pay expenditure is £2.9M lower than budget. This reflects;

- Drugs, blood and consumables continue to be lower than budgeted, including some pass through element
- FT and consultancy budgets continue to under spend
- Lower premises costs as a result of savings initiatives
- Lower education expenditure – delays in spend

Depreciation costs reflect the current shape of the capital programme and historical investment

Income

Income is £7.3M higher than budget. This reflects;

- Strong levels of PCT non tariff income
- Strong levels of IPP performance including Kuwait
- Benefits from contracts being agreed at levels higher than originally budgeted
- One of settlements in respect of land swap income and some similar items

CRES 2010/11

- The CRES targets for **2010/11** represent 8% of clinical budgets and 9% of non-clinical budgets (higher than the 7% annual target due to under-achievements in 0910).
  - CRES released (BLUE) from budgets is £10.2M
  - CRES deliverable (GREEN) is £2M

Capital

- Capital spend is forecast to be £1M lower than CRL based on current estimates by budget holders
- The capital programme is forecast to under spend by £9.6M, most of this is the Hospital redevelopment and all but £1M will be against donated funding streams

Statement of Financial Position (Balance sheet)

- Current assets fell by £3.4M largely as a result of decreased levels of NHS debtors in respect of normal billing arrangements
- Non current assets increased by £7.7M representing increased capital investment net of depreciating income
- Current liabilities have decreased by £2M
- Taxpayers equity totalled £321.1M, the increase of £7.8M reflects PDC capital drawdown, in month I& E surplus net of donated depreciation reserve movements

Working Capital Management

- Cash balances closed at £32M and were ahead of forecast
- Gross debt is £22.3M
- Debtors days are 24
- BPPC non NHS 88.2 by number and 87.2% by value (cumulative)

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 11 March 2011

PERIOD 11 - 2010/11 FINANCE REPORT

(1) Forecast position

The Trust is forecasting an £8.8M surplus before any potential impairment.

(2) Period 11 position - £7.5M surplus to period 11

Excluding international

-£3.4M	Expenditure higher than budget
+£4.9M	Income higher than budget
+£1.5M	**Favourable to plan**

International

-£2.0M	Expenditure higher than budget
+£2.4M	Income higher than budget
+£0.4M	**Favourable to plan**

Trust

-£5.4M	Expenditure higher than budget
+£7.3M	Income higher than budget
+£1.9M	**Favourable to plan**

(3) Expenditure review

(3A) Pay

Pay expenditure totals £176.3M, which is £8.4M higher than plan, although this is partly a result of the plan assuming net cost reductions as a result of productivity initiatives whereas in practice the cost of activity growth has offset the productivity reductions.

- Consultant pay budgets are under spent reflecting vacancies within the Cardiac and Surgery units, partially offset by higher than budget spend in ICI and Medicine from backdated charges including CEA costs and Renal third party charges.

- The junior doctor pay budgets are overspent by £1.7M reflecting agency covering unfilled deanary posts earlier in the year, and delays in recruiting staff in Haringey, now completed.

- Nursing pay budgets are overspent by £1.4M and spend has been increasing over the final quarter of 2010/11. Whilst some of this relates to the cost of servicing higher levels of clinical activity, a large proportion relates to the costs of temporary staff usage to cover vacancy, sick /maternity leave, particularly within Medicine & Surgery.

- Scientific, therapeutic and technical staff pay budgets are £0.4M overspent reflecting additional posts appointed to service higher activity levels and service developments. There are also costs associated with covering sick and maternity leave in the labs, and a need for additional pharmacy support for the peer review process.

Agency costs

Junior doctors	£2.4M
Nursing	£2.5M
Sci, Ther, Tech	£1.7M
Non-clinical	£4.9M
Total	£11.5M (6.5% of the pay bill to February 2011)

(3B) Non pay

Non-pay expenditure is £120.6M, which is £2.9M lower than plan.

- Drugs are underspent by £2.5M, this includes pass through drugs costs for which there is a contra adjustment in the income position. However there was High Factor 8 usage in the current month, which is in part, activity related.

- Clinical supplies & services is under spent by £0.7M, reflecting lower costs than anticipated for the growth in units activity plans net of higher costs for activity related pressures in ICU, Neurosciences theatres and cochlear.

- External consultancy is under spent by £1.2M, across a range of units/departments reflecting a general lower level of spend than anticipated at budget setting. The FT budgeted costs and legal expenses costs have been managed to lower levels.

- Education & research are under spent and this relates mainly to R+D

- The premises budgets are overspent by £0.2M YTD. The main elements areas of variance to budget are over spends in respect of the Haringey paediatricians accommodation, higher urgent maintenance related costs net of net of lower costs than budget in utilities and ICT maintenance.

- Healthcare services from non-NHS bodies are under spent by £0.2M overall YTD. There was an adverse movement in M11 resulting from high BMT harvest charges and higher Neuromuscular send away test costs.

- Transport is overspent by £0.2M YTD, partially reflecting activity levels.

- Other expenditure budgets are under spent by £0.5M YTD

- The Depreciation and Impairments budgets are overspent reflecting an unplanned impairment and slightly higher depreciation costs associated with the actual capital programme delivery being different from the original plan.

(3C) Revenue Performance

Income is £7.3M ahead of plan at £304.3M:

	Annual Budget	**YTD Budget**	**YTD Actual**	**YTD Variance**
Category	£M	£M	£M	£M
NHS Revenue Activity	250.3	228.3	230.9	2.6
Activity Revenue Non NHS	27.5	25.0	26.9	1.9
Other Operating Revenue	47.5	43.7	46.5	2.8
Grand Total	**325.3**	**297.0**	**304.3**	**7.3**

NHS Revenue

The PCT Tariff Income is £0.1M ahead of Plan

- 2009/10 estimated activity for February and March was higher than estimated
- Inpatient activity is £0.2M behind plan, mainly due to Haem/Onc consortium day cases switching categories from PBR to Non PBR
- Adjusted outpatient activity is £0.2M ahead of plan - cardiac echogram outpatient attendances are ahead of plan

PCT Non-Tariff Income is £4.1M ahead of Target

- 2009/10 estimated activity for February and March 2010 was higher than estimated mainly in respect of PICU and Haemophilia activity resulting in non-recurring income gains

- Non tariff inpatients and outpatients in total are £1.2M ahead of plan. This is mainly due to the higher than planned ICI outpatients – particularly Rheumatology
- Bed-days activity is £2.2M ahead of the plan, this is consistent with the level of over performance seen cumulatively to last month
- Packages of care are £1M behind plan – this variance is mainly in nephrology.
- Consortium activity is £1.5M ahead of plan, as a result of the higher than budgeted BMT and haem onc consortium activity and the agreement of a higher value SLA for NBS and the Genetics consortium
- PCT and Consortium Pass-through drugs usage are £0.3M behind plan. However, there is an in month positive variance of £0.2M due to higher usage of Factor 8 drugs.
- Overseas E112 income is 0.5M ahead of plan, this reflects current year performance and previously this was reported on old year activity levels as this was the mechanism for payment previously

SHA income is circa £1.7M ahead of plan

- 2009/10 estimated activity for February and March was lower than estimated
- NCG activity contracts are ahead of plan by £0.4M, this is a result of the final agreed sla value being higher than originally budget, offset by the under-performance in ECMO bridge transplant, other ECMO, gastro SCID and heart & lung transplant
- NCG pass-through drugs are £2M ahead of plan, as a result of higher than planned usage of LSD and SCIDs drugs.

Income from NHS Trust is £0.4M ahead of the plan

- Retinoblastoma service which was not included in the budget
- Variance on the North Middlesex SLA, cytogenetic consortium and small bowel transplant contracts

Income from DOH is £0.2M behind the Plan

- Representing the variance on NBS whereby income is matched to expenditure

Non NHS Revenue

- IPP is £2.4M ahead of budget
- Non England activity is £0.5M lower than budget

Other operating revenue

- Patient transport is £0.3M ahead of budget, including higher than expected foreign flight recharges
- Part year effect of the IPP Kuwait Education and Training contract contributed £1M.
- Charitable income is£0.1M behind plan
- 3rd party funded post income, renegotiated SLAs and one off income gains account for much of the balance

(4) CIP / CRES

2010/11

- The CIP target is £16.5M and represents an 8% capped target for clinical departments and 9% for corporate departments. Amounts achieved are in line with the financial plan

- **Secure CRES (Released) BLUE is £10.2M**
  This has increased by £0.6M in the month as a result of MDTS actioning £0.3M of CRES schemes that meet the BLUE criteria and the balance was delivered by Surgery, Neurosciences and Finance.

- **Secure CRES (deliverable) GREEN is £2M**

2011/12

- The Trust is targeting £16M 2011/12 representing 7% + an additional share to cover the IR cost pressure

- There is currently £0.7M unidentified
- GREEN schemes £1.18M (£0.18M increase)
- AMBER schemes £8.2M (£2M increase)
- RED £4.8M (decrease of £2.2M)

2012/13

- £12.3M of schemes have been identified and these are classified as follows;
    - GREEN schemes £0.18M
    - AMBER schemes £0.1M
    - RED £12M

(5) Capital programme and CRL

CRL

The Trust is expecting to spend below its CRL target by £1M.

Overview

The Trust's capital plan is £89.1M and the forecast expenditure is £79.5M, resulting in a total under spend of £9.6M. All but £1M of this will be against donated funds with the majority of the under spend caused by the hospital redevelopment programme where costs are being incurred in a different profile in 2010/11 than originally advised.

	Annual Plan £M	Plan YTD £M	Actual YTD £M	Variance £M
Hospital Redevelopment	71.23	68.30	57.41	10.89
Estates Maintenance Projects	8.18	7.22	7.93	(0.71)
IT Related Projects	6.84	6.12	2.04	4.08
Medical Equipment Purchases	2.88	1.63	1.70	(0.07)
Total Additions in Year	**89.13**	**83.27**	**69.08**	**14.19**
Asset Disposals	0.00	0.00	(0.06)	0.06
Donated Funded Projects	(60.83)	(55.87)	(45.24)	(10.63)
Charge Against CRL	**28.30**	**27.40**	**23.78**	**3.62**

Redevelopment

The Trust is advised that the new clinical building (phase 2A) will be delivered in line with the original plan in December 2011. However, the planned level of spend for the current year is behind plan. The under spend will be against donated funding and the Trust will have received all of the PDC capital by the 31/03/2011.

Estates, IT and Medical equipment

These three elements of the capital programme are forecast to under spend by £2.8M and £2.4M of this will be in respect of the IT programme, £0.5M relating to medical equipment and a minor over spend expected on estates schemes. These numbers are based on the latest information provided by project managers and are being monitored closely.

Disposals

The £0.06M in asset disposals line is in relation to an ultrasound scanner in Echo Cardiology Unit which is no longer on the hospital premises.

(6) Statement of financial position

Non Current Assets

Non Current Assets at the end of February 2011 totalled £313.7M a net increase of £7.7M and this increase was a combination of capital additions net of depreciation reductions. There were no new disposals or impairments.

Current Assets (excluding Cash & Cash Equivalents)

- decreased by £3.4M.

Non-NHS trade receivables (£+3.3M increase)	This reflects charity invoices raised and the IPP contract with Kuwait.
NHS Trade Receivables (£-9.5M decrease)	This is mainly the effect of a one month decrease in the debtor for NCG, education and RD.
Capital Receivables (£+2.8Mincrease)	This represents invoices raised to the charity for the hospital redevelopment

Current Liabilities

- decreased by £2M

Non-NHS Trade Payables (-£(1.6)M decrease)	This largely reflects higher level of accounts payable invoice payments as the team catch up on arrears.
Capital Payables (+£(2.0)M increase)	The largest element of this category represents capital creditors for January BAM hospital redevelopment work
Expenditure accruals (£+(0.6)M increase)	This represents higher accruals for blood, drugs and rental charges
Deferred revenue (£-(3.8)M decrease)	Representing the deferral of revenue for billing related to future months

Taxpayers' Equity

Taxpayers' Equity has increased by £7.8M this month. The principal movements were;

- Public Dividend Capital increased by £4.5M reflecting a further drawdown of PDC capital for the redevelopment
- Retained Earnings increased by £0.58M reflecting the surplus I and e position in month

(7) Working capital

Cash

- The Trust had cash holdings of £32M at the end of February **and** cash balances of between £29.2M and £45.6M during the month.
- Cumulative commercial bank balances were compliant with DH rules
- Closing cash balance was £1.0M higher than the plan as a result of lower capital spend than forecast.
- PDC of £4.5M was drawn down in the month

Payables

- BPCC (NON NHS) 88.2% by number and 87.2% by value
- NHS payables 50.9% by number and 58.8% by value

Receivables

- Gross trading debt is now £22.3M, a decrease of £5.3M in month – This reflects the receipt of quarterly advanced income from the SHA for education, etc.

- NHS debt over 90 days has increased to £3.3M from £2.7M due to the delays with PCTs failing to settle performance debt. Over 80% of debt over 90 days is attributable to 6 PCTs with individual debts ranging from £113k to £860k.

- IPP debt has increased this month to £8M from £6M. Overall, 90% of IPP debt can be attributed to 9 embassies and 1 insurer. The balance does not take into account a late

payment made in the month for £450k and further payments of £800k have been promised from one embassy in March 2011. A further £458k of overdue debt is due to 2 self-pay clients and the matter is currently with the legal department.

- Non- NHS debt over 90 days has increased to 607k from £443k. There have been delays in payment from the Welsh and NI Health Boards due to requests for more detailed patient information.

Debtor and Creditor Days

- Total debtor days are 24 based on current year planned turnover

The analysis by debt category is;

Debtor	Debtor Days
NHS	15
NON NHS	49
IPP	132

- Creditor days improved to 35.7 days from 41 days

(8) Financial risk ratios

There are five metrics used in determining the FT score used by monitor. The individual scores are in the financial pack. The scores are weighted and override restrictions come into play where there is any score of 1 and/or 2 scores of 2.

- Overall FT score is 3
- The forecast score is 3
- Liquidity score is 2
- EBITDA achieved is 5

All scores are above 3 except Liquidity at 2

(9) Salary overpayments

There were 6 salary overpayments in February totalling £8.9K.
A paper was submitted to management board suggesting options for further reduction in the incidence of such overpayments.

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Great Ormond Street Hospital for Children NHS Trust
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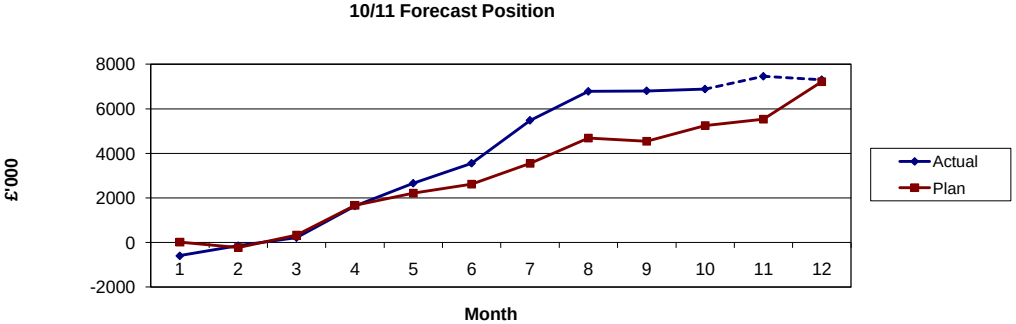
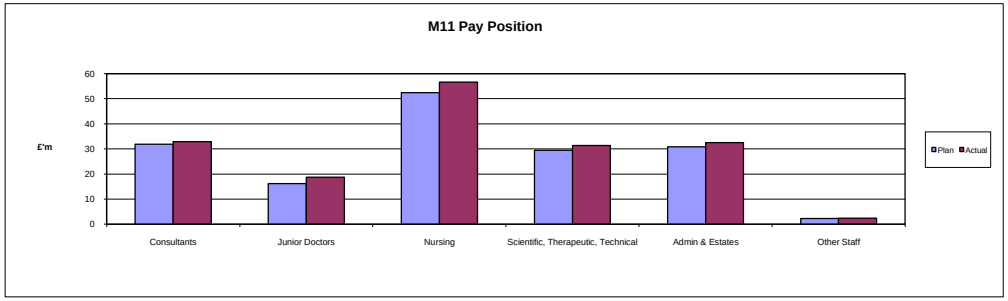
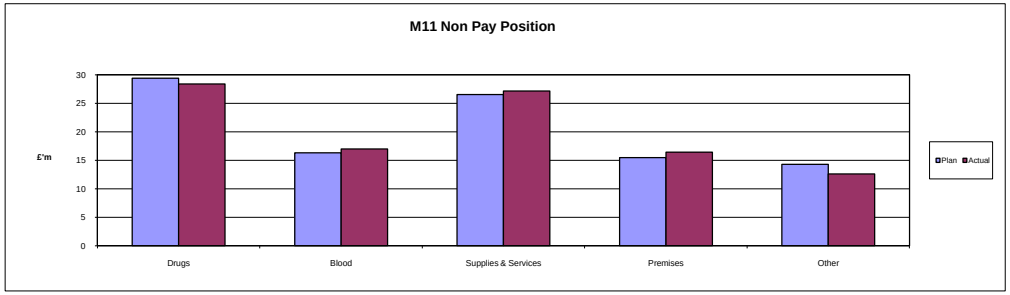
Trust Summary

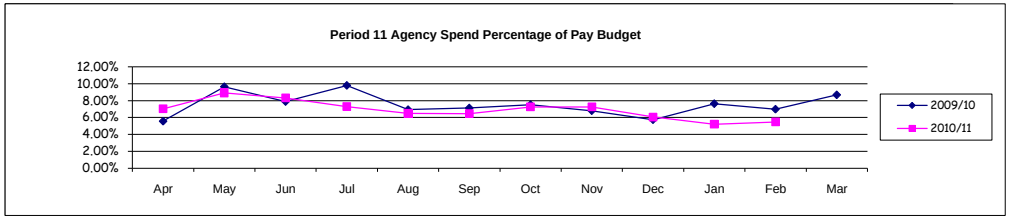
Statement of Comprehensive Income	Current Month		YTD	
	Actual	Plan Variance	Actual	Plan Variance
	£000	£000	£000	£000
Revenue				
Revenue from patient care activities	23,608	1,029	257,757	4,499
Other operating revenue	4,503	583	46,479	2,809
Operating expenses	(27,057)	(1,338)	(291,407)	(5,386)
Operating surplus	**1,054**	**274**	**12,829**	**1,922**
Investment revenue	8	5	59	26
Other gains and (losses)	0	0	(54)	(54)
Finance costs	(3)	(1)	(29)	(6)
Surplus for the financial year	**1,059**	**278**	**12,805**	**1,888**
Public dividend capital dividends payable	(487)	1	(5,352)	14
Retained surplus for the year	**572**	**279**	**7,453**	**1,902**
Other comprehensive income				
Impairments put to the reserves	0	0	(228)	(228)
Gains on Revaluation	0	0	0	0
Receipt of donated and government grant assets	3,322	(139)	45,245	(10,621)
Reclassification adjustments:				
- Transfers from donated and government grant reserves	(596)	(1)	(6,676)	(130)
Total comprehensive income for the year	**3,298**	**139**	**45,794**	**(9,077)**
Retained Surplus against FIMS	**572**	**(679)**	**7,453**	**1,253**
Total Comprehensive Income against FIMS	**3,298**	**(819)**	**45,794**	**(9,726)**







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



Staffing Staff Numbers	Budgeted Posts	WTE Paid	Maternity Paid	Temp Paid	Overtime Paid	Total Paid	WTE above plan
Admin and Other Support	869	804	27	79	6	916	(47)
Clinical Support	745	717	18	22	4	762	(17)
Medical	476	475	11	25	0	511	(35)
Nursing	1,377	1,274	72	163	5	1,514	(137)
Total	**3,467**	**3,271**	**128**	**289**	**15**	**3,703**	**(236)**

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Unit Summary and CRES Performance

	YTD						
	Income*			Expenditure			Overall Unit Position
	2009 £000	Actual £000	Variance £000	2009 £000	Actual £000	Variance £000	Variance £000
Clinical Units							
Cardiac	38,973	49,393	1,950	(25,740)	(27,330)	(505)	1,445
Surgery	51,093	58,532	254	(51,301)	(54,268)	(2,100)	(1,846)
DTS	3,212	1,462	(689)	(20,322)	(17,447)	283	(406)
ICI	43,896	51,855	133	(42,478)	(48,459)	(191)	(58)
International	19,376	23,835	2,411	(8,571)	(9,979)	(2,045)	366
Medicine	36,255	37,835	1,812	(30,264)	(35,413)	378	2,191
Neurosciences	20,058	24,998	365	(17,349)	(18,635)	(253)	111
Haringey	8,397	8,780	70	(8,490)	(9,583)	(872)	(802)
North Mid.	6,789	685	29	(6,789)	(683)	(28)	1
Total Clinical Units	**228,049**	**257,375**	**6,336**	**(211,303)**	**(221,796)**	**(5,333)**	**1,002**
Central Departments							
Operations & Facilities	1,754	1,526	(120)	(15,111)	(15,588)	(627)	(748)
Corporate Affairs	94	96	2	(1,102)	(1,129)	457	459
Estates	583	887	141	(9,390)	(10,281)	(93)	49
Finance & ICT	204	201	27	(8,959)	(9,188)	(13)	14
Human Resources	481	705	38	(2,244)	(2,563)	83	120
Medical Director	220	109	(74)	(3,323)	(3,646)	21	(53)
Nursing And Workforce Development	1,546	1,824	61	(4,750)	(4,836)	433	494
Research And Innovation	11,562	11,677	(801)	(6,330)	(5,866)	602	(199)
Redevelopment Revenue Costs	467	481	(340)	(467)	(481)	146	(194)
Total Central Departments	**16,911**	**17,507**	**(1,066)**	**(51,676)**	**(53,579)**	**1,008**	**(58)**
Corporate Budgets	**42,583**	**29,353**	2,039	**(16,602)**	**(21,407)**	**(1,081)**	**958**
Net Position	**287,543**	**304,235**	**7,308**	**(279,582)**	**(296,782)**	**(5,407)**	**1,902**

CRES 2010/11		Analysis of CRES Scheme Deliverability					
	TARGET	Released from Budgets	Deliverable Schemes	Feasible Schemes	Potential Schemes	Unidentified Schemes	Total Risk
CRES 2010/11 Target	**16,604**	**10,282**	**2,023**	**0**	**0**	**4,299**	**6,322**
Status		**Delivered**	**RISK**	**RISK**	**RISK**	**RISK**	
Recurrent 2010/11		**9,600**	**1,260**	**0**	**0**		
Non recurrent 2010/11		**682**	**763**	**0**	**0**		
Expenditure		**5,455**	**1,099**	**0**	**0**		
Income		**4,827**	**924**	**0**	**0**		
CRES 2011/12	**15,893**	**0**	**1,188**	**8,156**	**4,842**	**1,707**	**15,893**
CRES 2012/13		**0**	**176**	**107**	**12,065**		**12,348**

Analysis	Month 11			*	Month 11 New CRES	Schemes in progress	
CLINICAL	**Target**	**BLUE**	**Variance**	**released**	**New BLUE**	**(Green)**	**(Amber)**
Cardiac	1,904	**884**	-1,020	0.00	**0**	814	0
ICI	1,730	**1,618**	-112	1.00	**0**	172	0
IPP	1,114	**1,242**	128	2.00	**0**	0	0
MDTS	3,121	**1,395**	-1,726	5.40	**332**	485	0
Neurosciences	1,229	**622**	-607	3.00	**206**	75	0
Surgery	3,790	**1,956**	-1,834	4.39	**39**	0	0
Total	**12,888**	**7,717**	**-5,171**	**15.79**	**577**	**1,546**	**0**
CORPORATE							
Clinical Ops	149	**197**	48	2.00	**0**	0	0
Corporate Facilities	1,222	**892**	-330	11.57	**0**	0	0
Corporate Affairs	125	**241**	116	0.00	**0**	0	0
Estates	813	**564**	-249	0.00	**0**	217	0
Finance	837	**275**	-562	5.00	**70**	156	0
Medical Director	125	**0**	-125	0.00	**0**	50	0
Nursing and Education	236	**187**	-49	4.20	**0**	54	0
HR	172	**173**	1	1.00	**21**	0	0
Reseach and Development	38	**38**	0	0.20	**0**	0	0
Total	**3,717**	**2,567**	**-1,150**	**23.97**	**91**	**477**	**0**
Grand Total	**16,604**	**10,284**	**-6,322**	**39.76**	**668**	**2,023**	**0**

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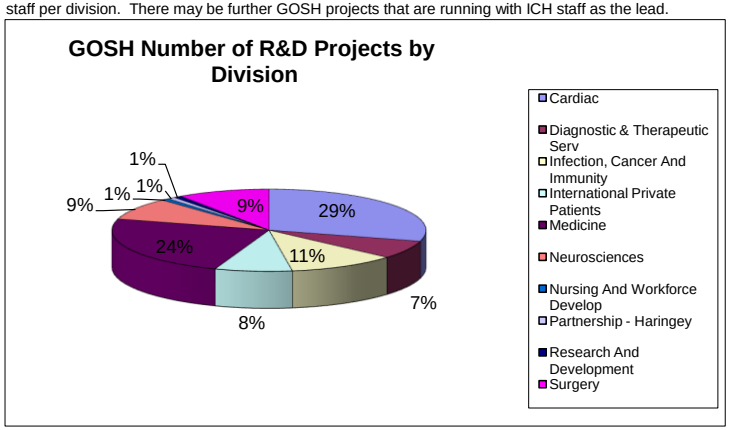
Revenue Statement

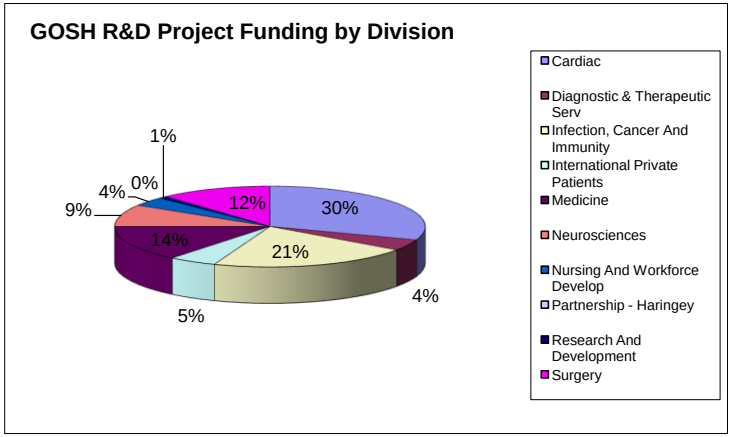
	10/11 Annual Budget £000	10/11 Mth 11 Actual £'000	10/11 Mth 11 Variance to Plan £'000	10/11 YTD Actual £'000	10/11 YTD Variance to Plan £'000	10/11 YTD Actual Variance to 09/10 YTD Actual £'000	10/11 Forecast Outturn
Primary Care Trusts Tariff	60,085	**4,888**	79	**54,722**	134	**3,887**	**59,897**
Primary Care Trusts Non Tariff	115,561	**9,884**	604	**109,584**	4,066	**13,279**	**119,816**
Primary Care Trusts Mff	23,080	**1,549**	-422	**17,390**	-3,500	**-610**	**18,971**
Strategic Health Authorities	41,025	**3,993**	575	**39,343**	1,737	**3,929**	**43,119**
Nhs Trusts	1,198	**140**	95	**1,507**	354	**-5,752**	**1,644**
Department Of Health	1,046	**79**	-8	**760**	-199	**-209**	**829**
Nhs Other	8,284	**691**	0	**7,576**	-17	**-3,038**	**8,265**
Activity Revenue Nhs	**250,279**	**21,225**	**923**	**230,882**	**2,575**	**11,486**	**252,541**
Local Authorities	1,009	**87**	3	**970**	44	**44**	**1,058**
Private Patients	22,133	**2,069**	232	**22,432**	2,411	**3,292**	**24,471**
Non Nhs Other	4,413	**227**	-129	**3,474**	-531	**-273**	**3,789**
Activity Revenue Non Nhs	**27,556**	**2,383**	**106**	**26,875**	**1,924**	**3,064**	**29,318**
Patient Transport Services	861	**44**	-26	**1,128**	345	**406**	**1,230**
Education And Training	11,727	**1,116**	139	**11,476**	726	**965**	**12,519**
Research And Development	12,363	**1,135**	104	**11,625**	292	**-572**	**12,681**
Charitable & Other Contrib	5,029	**386**	-1	**4,480**	-161	**199**	**4,888**
Depreciation Income Transfer	7,141	**596**	1	**6,676**	130	**327**	**7,283**
Non Patient Care Services	4,106	**478**	136	**3,438**	-326	**-34**	**3,750**
Revenue Generation	1,346	**154**	41	**1,718**	484	**509**	**1,874**
Other Revenue	5,034	**595**	189	**5,938**	1,319	**342**	**6,478**
Other Operating Revenue	**47,607**	**4,503**	**583**	**46,478**	**2,809**	**2,143**	**50,704**
Directors & Senior Managers	-8,785	**-697**	26	**-7,303**	758	**-714**	**-7,967**
Consultants	-36,610	**-3,058**	-15	**-32,939**	629	**-249**	**-35,933**
Junior Doctors	-18,623	**-1,598**	-51	**-16,404**	672	**362**	**-17,895**
Junior Doctors Agy	0	**-85**	-85	**-2,372**	-2,372	**-430**	**-2,588**
Administration & Estates	-25,962	**-1,899**	235	**-20,453**	3,345	**-1,225**	**-22,312**
Administration & Estates Agy	-678	**-410**	-353	**-4,762**	-4,140	**-259**	**-5,195**
Healthcare Assist & Supp	-2,311	**-181**	12	**-1,951**	167	**8**	**-2,128**
Healthcare Assist & Supp Agy	-41	**1**	5	**-219**	-182	**119**	**-239**
Nursing Staff	-60,152	**-5,174**	-190	**-54,140**	1,024	**-1,126**	**-59,062**
Nursing Staff Agy	0	**-241**	-241	**-2,458**	-2,458	**-616**	**-2,681**
Scientific Therap Tech	-33,881	**-2,797**	42	**-29,710**	1,340	**-2,445**	**-32,410**
Scientific Therap Tech Agy	0	**-98**	-98	**-1,698**	-1,698	**855**	**-1,853**
Other Staff	-269	**-22**	1	**-223**	24	**33**	**-243**
Pay Reserves	-5,191	**94**	479	**-1,639**	3,117	**-1,836**	**-1,788**
Cips And Cres Unidentified - P	9,441	**0**	-752	**0**	-8,583	**0**	**0**
Pay Costs	**-183,063**	**-16,164**	**-985**	**-176,269**	**-8,356**	**-7,523**	**-192,293**
Drugs Costs	-34,073	**-3,270**	-516	**-28,410**	2,468	**-3,732**	**-30,992**
Blood Costs	-18,742	**-1,750**	-193	**-16,972**	189	**-605**	**-18,515**
Supplies & Services - Clinical	-22,351	**-1,877**	-49	**-19,659**	705	**-1,630**	**-21,446**
Services From Nhs Organisation	-4,508	**-397**	-30	**-3,899**	203	**-501**	**-4,253**
Healthcare From Non-Nhs Bodies	-1,556	**-269**	-141	**-1,447**	-29	**23**	**-1,579**
Supplies & Services - General	-2,219	**-234**	-50	**-2,179**	-150	**-78**	**-2,377**
Consultancy Services	-2,610	**-348**	-142	**-1,239**	1,153	**-129**	**-1,351**
Clinical Negligence Costs	-1,712	**-143**	0	**-1,571**	-2	**-227**	**-1,714**
Establishment Costs	-2,562	**-206**	17	**-2,430**	-90	**-47**	**-2,651**
Transport Costs	-2,455	**-97**	99	**-2,428**	-184	**-398**	**-2,648**
Premises Costs	-17,717	**-791**	644	**-16,458**	-185	**-1,716**	**-17,954**
Auditors Costs	-353	**-33**	-3	**-341**	-17	**-32**	**-372**
Education And Research Costs	-2,856	**-142**	109	**-1,538**	1,078	**535**	**-1,678**
Expenditure - Other	-3,819	**-470**	-208	**-3,047**	478	**2,046**	**-3,324**
Non Pay Reserves	-3,127	**0**	232	**0**	2,865	**0**	**0**
Cips And Cres Unidentified - N	5,688	**0**	-453	**0**	-5,171	**0**	**0**
Non Pay Costs	**-114,971**	**-10,027**	**-685**	**-101,616**	**3,311**	**-6,494**	**-110,854**
P & L On Disp Of Fixed Assets	0	**0**	0	**-54**	-54	**-259**	**-59**
Fixed Asset Impair & Reversals	0	**0**	0	**-228**	-228	**-228**	**-249**
Depreciation & Amortisation	-14,351	**-859**	340	**-13,246**	-63	**-2,020**	**-14,450**
Interest Receivable	36	**8**	5	**59**	26	**26**	**65**
Other Revenue / Expenditure	-24	**-3**	-1	**-29**	-7	**0**	**-31**
Pdc Dividend Payable	-5,853	**-487**	1	**-5,352**	14	**-655**	**-5,838**
Corporation Tax	0	**-8**	-8	**-48**	-48	**-48**	**-52**
Other Revenue / Expenditure	**-20,192**	**-1,348**	**337**	**-18,897**	**-360**	**-3,184**	**-20,615**
Retained Surplus / (Deficit)	**7,215**	**572**	**279**	**7,453**	**1,902**	**-508**	**8,800**

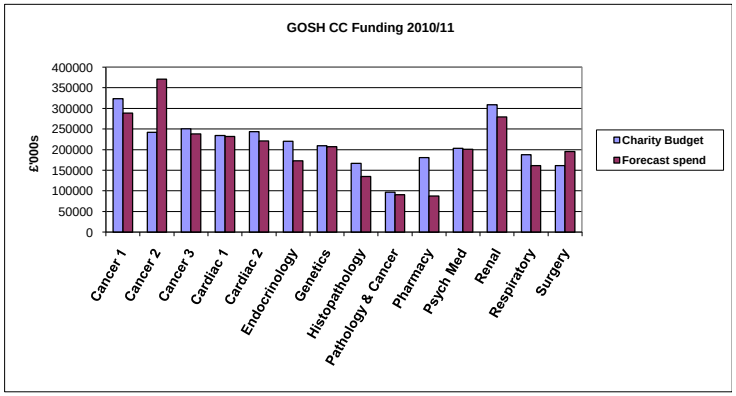
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 11 2010/11
Research and Development Activity

	Full Year Budget	Full Year Forecast	YTD Budget	YTD Actuals	YTD Variance
Biomedical Research Centre including Clinical Research Facility					
- Income	(7,718)	(7,704)	(7,075)	(6,145)	(929)
- Income deferred from 09-10	(508)	(508)	(466)	(466)	0
- Commercial Trials Income	0	(236)	0	(208)	208
- Expenditure	3,484	3,134	3,194	2,100	1,094
	(4,742)	(5,313)	(4,347)	(4,719)	372
CLRN (PCRN) Income					
- Income CLR Activity Based (Non DH R&D)	(1,604)	(1,100)	(1,471)	(1,062)	(408)
- Income PCRN (R M&G, KSS, SS)	0	(137)	0	(92)	92
- Income PCRN (R M&G, KSS, SS) 09-10 C/FWD	0	(34)	0	(25)	25
- Income Non R&D (cc CLR)	(336)	0	(308)	0	(308)
- Expenditure CLR	123	122	113	102	11
	(1,818)	(1,150)	(1,666)	(1,077)	(589)
NIHR GRANTS					
- Income	(405)	(172)	(372)	(533)	162
- Income deferred from 09-10	0	(433)	0	0	0
- Expenditure	405	605	372	534	(163)
	0	0	0	1	(1)
R&D GOSH Charity Funded Projects					
- Income	(2,396)	(2,652)	(2,196)	(2,420)	224
- Expenditure	1,748	2,102	1,602	1,967	(365)
	(648)	(550)	(594)	(453)	(141)
R&D Development Office					
- Expenditure	651	465	596	437	159
	651	465	596	437	159
TOTAL RESEARCH & DEVELOPMENT DIRECTORATE					
- R&D Income	(9,728)	(9,114)	(8,917)	(7,833)	(1,084)
- R&D Income Deferred from 09-10	(508)	(975)	(466)	(491)	25
- R&D Charitable Contribution	(2,396)	(2,652)	(2,196)	(2,420)	224
- Non DH Research Income	(336)	(236)	(308)	(208)	(101)
- Expenditure	6,411	6,428	5,877	5,140	737
	(6,557)	(6,548)	(6,010)	(5,811)	(199)
- Expenditure in Clinical Areas	6,633	6,129	6,080	5,618	462
Total R&D Division	76	(419)	70	(192)	262
			(9,493)	(8,483)	(1,010)
Centrally Held and Devolved Income					
- Flexibility & Sustainability Funding (Central) STANDARD	(2,501)	(2,501)	(2,292)	(2,292)	0
- DTS : From CLRN Additional 09-10 Support	(189)	(204)	(174)	(187)	14
- Medicine : From CLRN Additional 09-10 Support/NIHR Fellowship	0	(55)	0	(70)	70
- ICI : From MCRN 09-10 Support	(51)	(85)	(45)	(85)	40
- Surgery : From Charitable Donation	0	(21)	0	(17)	17
Total Centrally Held and Devolved Income	(2,741)	(2,866)	(2,511)	(2,651)	141
TOTAL R&D INCOME					
R&D Income	(12,977)	(12,955)	(11,893)	(10,975)	(919)
Income Generation GOS / Direct Credits	1,242	0	1,136	0	1,136
Total Income	(11,735)	(12,955)	(10,757)	(10,975)	217
Local Research Network MCRN *					
- Income	(628)	(570)	(576)	(456)	(120)
- Income DH FSF F&S (cc LRN)	0	(69)	0	(63)	63
- Income R&D Non DH (cc LRN) CLR Network	0	(143)	0	(131)	131
- Income Other Non R&D (cc LRN)	(17)	(80)	(15)	(76)	61
- Expenditure LRN	645	862	591	726	(135)
	0	0	0	(0)	0
* GOSH is Hosting this service for Central and North East London	(12,363)	(13,736)	(11,333)	(11,625)	292
TOTAL R&D INCOME (as per Board Report)					
- R&D Income	(12,363)	(13,736)	(11,333)	(11,625)	292

The piecharts 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 11 2010/11
Ratio Analysis

Provider Agency Rating	Target for FT Status	M11 Actual - FT	M10 Actual - FT	Forecast Outurn - FT	M11 FT Score
EBITDA Margin	5%	8.7%	8.8%	8.8%	3
EBITDA % Achieved	70%	109.4%	110.5%	107.3%	5
ROA	3%	4.5%	4.2%	5.1%	3
I&E Surplus margin	1%	2.5%	2.6%	2.7%	4
Liquidity Days	15.0	12	12	12	2
Weighted Average	3.0	3.2	3.2	3.4	3.2
Overall Rating	**3**	**3**	**3**	**3**	3
IPP Cap (Max 9.7%)	9.7%	8.7%	9.0%	8.7%	

Salary Overpayments		
Unit	**No.**	**Amount £'000**
ICI	1	2.7
Neuro	1	2.5
Haringey	1	1.6
Estates	1	1.0
Clinical Operations	1	0.7
Surgery	1	0.4
TOTAL	6	8.9

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 11 2010/11
Statement of Financial Position

	Actual as at 01/04/10 £000	Actual as at 31/01/11 £000	Actual as at 28/02/11 £000	Change in month £000	Forecast as at 31/03/11 £000
Non Current Assets :					
Property Plant & Equipment - Purchased	151,335	162,975	167,958	4,983	169,304
Property Plant & Equipment - Donated	97,078	132,766	135,496	2,730	141,700
Property Plant & Equipment - Gov Granted	193	368	366	(3)	500
Intangible Assets - Purchased	423	721	783	61	791
Intangible Assets - Donated	48	28	26	(2)	42
Trade & Other Receivables	9,039	9,063	9,028	(35)	9,520
Total Non Current Assets :	***258,117***	***305,922***	***313,656***	***7,734***	***321,857***
Current Assets :					
Inventories	5,173	5,394	5,289	(105)	5,263
NHS Trade Receivables	15,038	17,756	8,263	(9,493)	16,323
Non NHS Trade Receivables	9,691	8,458	11,730	3,272	7,289
Capital Receivables	5,851	2,860	5,694	2,834	5,000
Provision for Impairment of Receivables	(1,435)	(1,184)	(1,393)	(209)	(1,398)
Prepayments	2,314	2,315	2,402	86	3,774
Accrued Revenue	2,556	8,654	8,639	(16)	570
HMRC VAT	1,630	393	643	250	764
Other Receivables	909	390	360	(30)	851
Cash & Cash Equivalents	8,485	30,775	32,065	1,290	22,000
Total Current Assets :	***50,212***	***75,811***	***73,690***	***(2,120)***	***60,436***
Total Assets :	**308,329**	**381,733**	**387,346**	**5,614**	**382,293**
Current Liabilities :					
NHS Trade Payables	(586)	(4,900)	(4,831)	69	(600)
Non NHS Trade Payables	(3,716)	(4,583)	(2,937)	1,646	(8,579)
Capital Payables	(7,084)	(7,659)	(9,691)	(2,031)	(6,971)
Expenditure Accruals	(14,490)	(14,038)	(14,712)	(674)	(15,235)
Deferred Revenue	(3,326)	(16,252)	(12,446)	3,806	(4,350)
Tax & Social Security Costs	(3,816)	(4,011)	(4,017)	(6)	(4,000)
Other Payables	(48)	(1,938)	(2,425)	(487)	0
Payments on Account	(231)	(232)	(228)	4	(232)
Lease Incentives	(400)	(400)	(400)	0	(400)
Other Liabilities	(2,376)	(3,301)	(3,494)	(193)	(2,839)
Provisions for Liabilites & Charges	(1,549)	(2,515)	(2,624)	(109)	(1,625)
Total Current Liabilities :	***(37,621)***	***(59,829)***	***(57,804)***	***2,025***	***(44,831)***
Net Current Assets / (Liabilites) :	**12,591**	**15,982**	**15,886**	**(96)**	**15,605**
Total Assets Less Current Liabilities :	**270,708**	**321,904**	**329,542**	**7,638**	**337,462**
Non Current Liabilities :					
Lease Incentives	(7,728)	(7,392)	(7,361)	31	(7,323)
Provisions for Liabilites & Charges	(1,304)	(1,249)	(1,101)	147	(1,240)
Total Non Current Liabilities :	***(9,032)***	***(8,641)***	***(8,463)***	***178***	***(8,563)***
Total Assets Employed :	**261,676**	**313,264**	**321,080**	**7,816**	**328,899**
Financed by Taxpayers Equity :					
Public Dividend Capital	109,732	118,595	123,114	4,519	124,732
Retained Earnings	9,515	16,533	17,118	585	16,979
Revaluation Reserve	41,996	41,859	41,846	(13)	41,832
Donated Asset Reserve	97,126	132,794	135,522	2,728	141,742
Government Grant Reserve	193	368	366	(3)	500
Other Reserves	3,114	3,114	3,114	0	3,114
Total Funds Employed :	**261,676**	**313,264**	**321,080**	**7,816**	**328,899**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 11 2010/11
Statement of Cash Flow

Statement of Cash Flows	Actual For Month Ending 28/02/11 £000	Actual For YTD Ending 28/02/11 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating Surplus	1,054	12,828
Depreciation and Amortisation	859	13,246
Impairments and Reversals	0	228
Transfer from the Donated Asset Reserve	(594)	(6,649)
Transfer from the Government Grant Reserve	(2)	(27)
PDC Dividend Paid	0	(2,975)
Decrease/(Increase) in Inventories	105	(116)
Decrease in Trade and Other Receivables	6,174	72
(Decrease)/Increase in Trade and Other Payables	(4,845)	13,006
Increase in Other Current Liabilities	162	751
(Decrease)/Increase in Provisions	(41)	844
Net Cash Inflow from Operating Activities :	***2,872***	***31,208***
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	7	59
Payments for Property, Plant and Equipment	(6,528)	(66,017)
Payments for Intangible Assets	(68)	(454)
Net Cash Outflow from Investing Activities :	**(6,589)**	**(66,412)**
NET CASH OUTFLOW BEFORE FINANCING :	**(3,717)**	**(35,204)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	4,519	13,382
Other Capital Receipts	488	45,402
Net Cash Inflow from Financing :	**5,007**	**58,784**
NET INCREASE IN CASH AND CASH EQUIVALENTS :	**1,290**	**23,580**

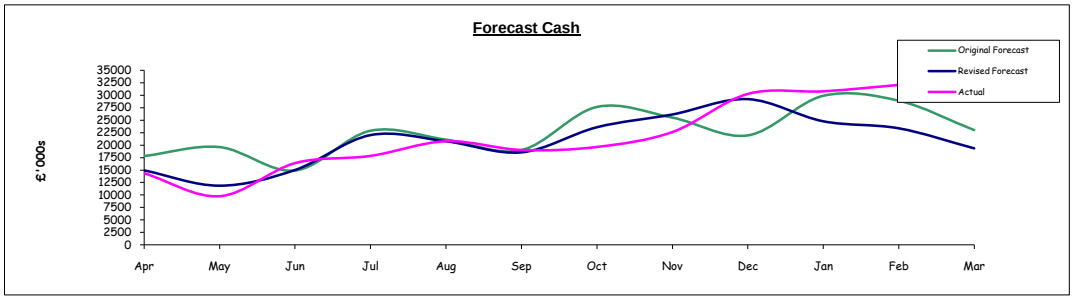
Cash and Cash Equivalents at the Beginning of the current period	**30,775**	**8,485**
Cash and Cash Equivalents at the End of the current period	**32,065**	**32,065**
Net Increase in Cash and Cash Equivalents per SOFP :	**1,290**	**23,580**

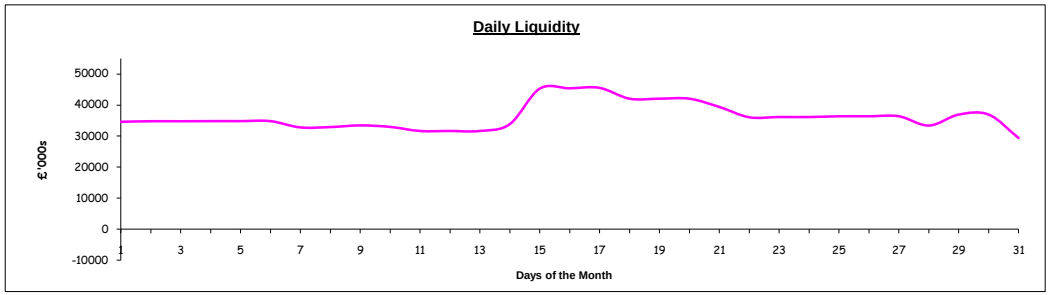
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 11 2010/2011
Activity

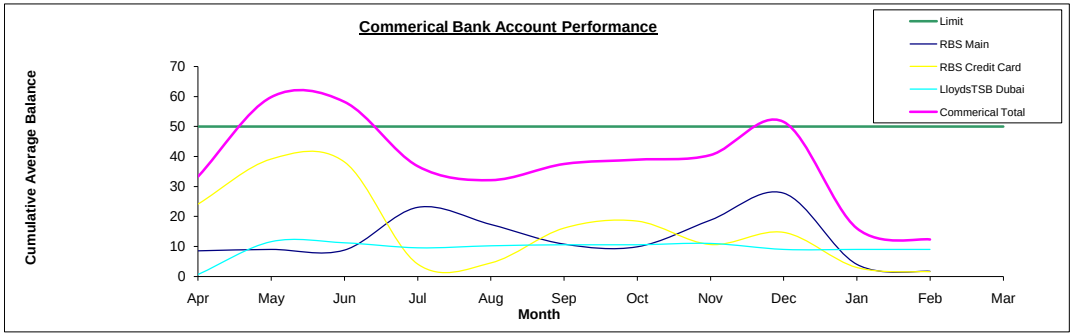
February estimated based on June to January data (excludes non-england, excess beddays etc)

	April	May	June	July	August	September	October	November	December	January	February	YTD 10/11 Actual	YTD 10/11 Plan	YTD 10/11 Variance	YTD 09/10	Variance 10/11 to 09/10
Elective PBR	1,432	1,310	1,517	1,531	1,374	1,483	1,482	1,628	1,196	1,368	1,395	15,716	16,899	-1,183	16,962	-1,246
Elective Non PBR	149	192	186	186	156	200	189	202	125	164	170	1,919	1,384	534	1,334	585
TOTAL ELECTIVE	1,581	1,502	1,703	1,717	1,530	1,683	1,671	1,830	1,321	1,532	1,565	17,635	18,283	-649	18,296	-661
Non Elective PBR	121	148	129	147	127	137	150	144	186	145	133	1,567	1,379	189	1,543	24
Non Elective Non PBR	2	0	3	4	2	5	2	2	3	3	3	29	48	-20	71	-43
TOTAL NON ELECTIVE	123	148	132	151	129	142	152	146	189	148	136	1,596	1,427	169	1,615	-19
Outpatients PBR	5,117	5,407	5,613	5,538	5,280	5,811	5,390	5,928	4,555	5,469	5,283	59,391	58,344	1,047	64,906	-5,515
Outpatients Non PBR	4,784	4,950	5,481	5,183	4,659	5,341	5,408	5,578	4,229	5,069	4,963	55,645	46,083	9,562	47,470	8,175
TOTAL OUTPATIENTS	9,901	10,357	11,094	10,721	9,939	11,152	10,798	11,506	8,784	10,538	10,246	115,036	104,427	10,609	112,376	2,661
POC (Non Consortium)	951	946	1,027	1,032	996	1,016	844	859	863	875	860	10,269	10,873	-604	11,238	-969
BEDDAYS (includes PICU Consortium)																
Panda HDU (PBR HDU)	616	507	922	1,002	896	863	681	580	647	581	603	7,898	7,875	23	8,795	-897
Transitional Care	120	123	136	181	170	150	144	77	62	101	117	1,381	1,777	-396	1,226	154
Rheumatology Rehab	191	187	175	188	187	164	231	181	125	155	161	1,945	1,904	41	1,861	83
CAMHS	210	209	201	197	220	226	247	239	254	241	209	2,453	1,418	1,035	1,600	853
Cardiac ECMO	5	12	5	0	8	4	34	11	12	0	8	99	140	-41	86	13
Neurosurgery HDU (NC)	0	0	0	3	11	14	1	6	0	0	4	39	37	2	0	39
Neurosurgery (PICU Consortium-ITU & HDU)	39	43	39	105	93	133	87	52	17	19	66	693	868	-175	632	61
Neurosurgery ITU (NC)	0	0	0	0	0	0	8	0	2	12	3	25	37	-13	0	25
Cardiac HDU (NC)	34	40	30	16	22	19	27	53	64	49	32	386	230	156	203	183
Cardiac ITU (NC)	105	108	144	93	137	134	164	140	113	76	114	1,328	690	639	616	713
Cardiac (PICU Consortium-ITU)	135	211	196	227	209	169	201	214	200	216	187	2,165	1,925	240	2,091	74
Paediatric ITU (NC)	21	62	54	41	36	25	129	74	79	40	55	616	667	-51	678	-62
Paediatric ITU (PICU Consortium)	371	387	316	378	427	389	339	380	442	415	353	4,197	3,666	530	3,625	572
TOTAL BEDDAYS	1,847	1,889	2,218	2,431	2,416	2,290	2,293	2,007	2,017	1,905	1,910	23,223	21,234	1,989	21,413	1,809
HaemOnc Consortium*																
PBR	42	43	41	41	50	59	57	48	55	58	49	543	723	-180	1,149	-606
NON PBR	117	52	129	120	111	139	170	161	133	139	133	1,404	20	1,383	0	1,404
Panda HDU (PBR HDU)	88	139	177	309	248	281	285	269	273	308	259	2,636	2,278	358	0	2,636
TOTAL HAEMONC	247	234	347	470	409	479	512	478	461	505	441	4,583	3,021	1,562	1,149	3,434

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 11 2010/11
Cash Management





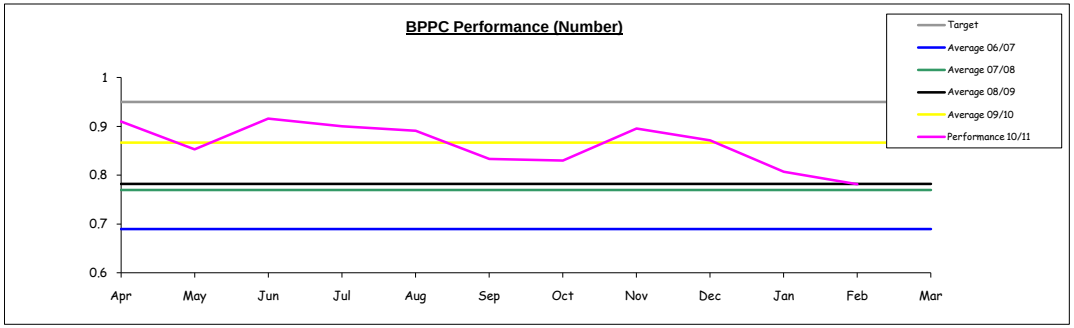


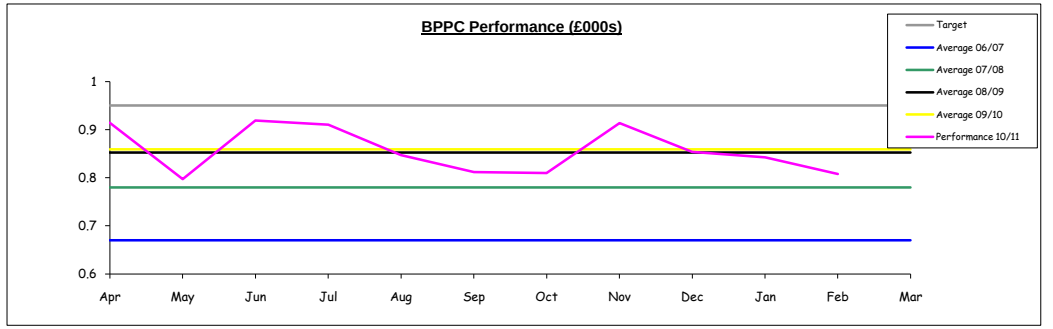
Payables Analysis

Days	Current Month	Previous Month	Movement in Month
	£000s	£000s	£000s
Not Yet Due	4,214	5,890	(1,676)
1-30	2,300	2,547	(247)
31-60	981	1,091	(110)
61-90	495	564	(69)
91-120	340	294	46
121-180	468	801	(333)
180-360	1,021	869	152
360+	1,543	1,119	424
	11,362	**13,175**	**(1,813)**

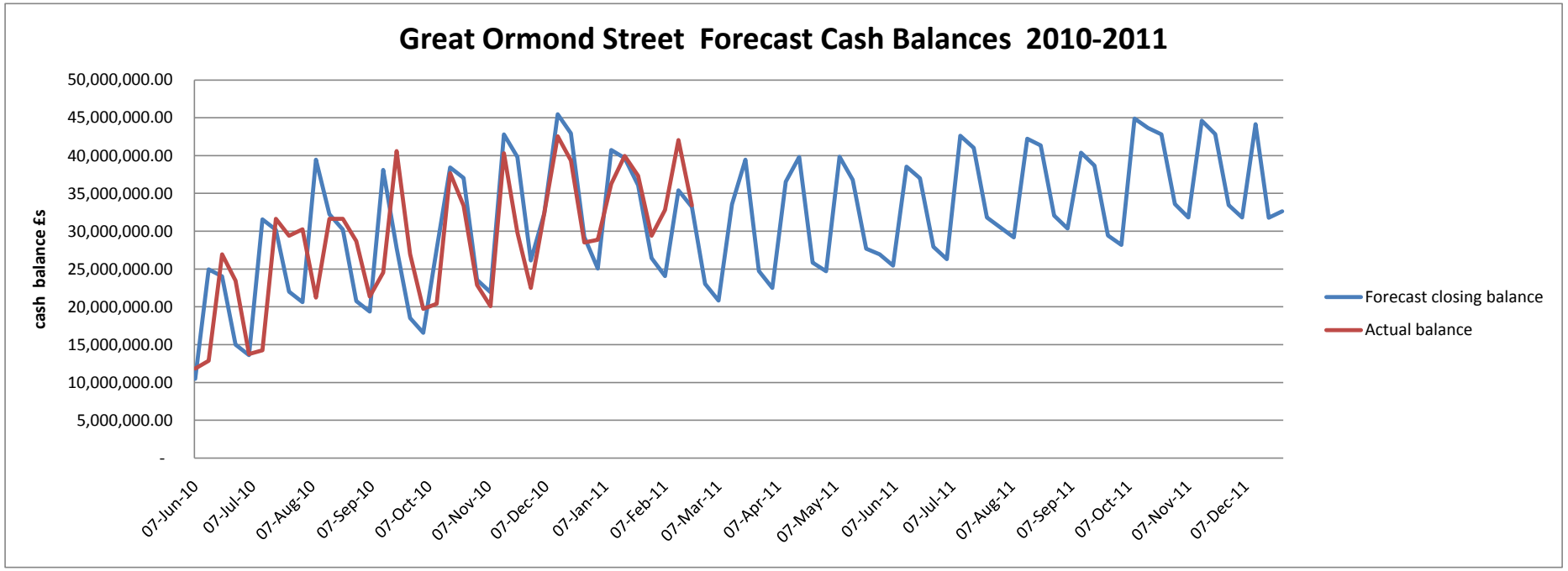
Better Payment Practice Code (BPPC)

	Number	£000s
Non-NHS Payables		
Invoices paid in the year	86824	217,118
Invoices paid within target	76545	189,378
% of Invoices paid within target	88.2%	87.2%
NHS Payables		
Invoices paid in the year	3673	19,645
Invoices paid within target	1968	12,621
% of Invoices paid within target	53.6%	64.2%





Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 11 2010/11
Cash Forecast



Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 11 2010/11
Receivables Management

Net Receivables in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	**10347**	-588	2113	1944	3114	437	953	501	1525	347
NHS Credit Note Provision	-1714	0	0	0	0	0	-150	-88	-887	-590
Specific NHS Debt Provisions	-794									
NHS Net Receivables	**7838**	**-588**	**2113**	**1944**	**3114**	**437**	**803**	**414**	**638**	**-243**
Non-NHS	**2951**	-16	1897	120	94	248	204	168	71	164
Bad Debt Provision-Non NHS	-558	0	-103	-61	-16	-26	-51	-45	-90	-167
Specific Non-NHS Debt Provisions	0									
	0	0	0	0	0	0	0	0	0	0
Non-NHS Net Receivables	**2393**	**-16**	**1793**	**59**	**79**	**223**	**152**	**123**	**-19**	**-2**
International	**8011**	-932	5457	1353	743	181	311	74	450	375
Bad Debt Provision-International	-836	0	-3	-0	-1	-0	-62	-18	-369	-382
International Net Receivables	**7175**	**-932**	**5454**	**1353**	**742**	**181**	**249**	**56**	**81**	**-8**
GOSH Charity Receivables	**1089**	-1	1052	2	3	30	0	0	4	0
Specific Activity Provisions	0	0	0	0	0	0	0	0	0	0
Net Trust Receivables	**18495**	**-1537**	**10412**	**3358**	**3937**	**871**	**1204**	**593**	**704**	**-253**

Trust Receivables in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	10347	-588	2113	1944	3114	437	953	501	1525	347
Non-NHS	2951	-16	1897	120	94	248	204	168	71	164
International	8011	-932	5457	1353	743	181	311	74	450	375
Gross Trading Receivables	**21308**	**-1536**	**9467**	**3417**	**3951**	**867**	**1468**	**744**	**2046**	**886**
GOSH Charity Receivables	1089	-1	1052	2	3	30	0	0	4	0
Total Trust Receivables	**22397**	**-1537**	**10518**	**3419**	**3953**	**896**	**1468**	**744**	**2050**	**886**

Movement in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
Gross Trading Receivables (as above)	22397	-1537	10518	3419	3953	896	1468	744	2050	886
Gross Trading Receivables (last month)	27758	-2003	9473	12856	1926	1389	753	594	2079	689
Movement in Month	**-5361**	**465**	**1045**	**-9436**	**2027**	**-493**	**714**	**149**	**-30**	**196**
Gross Trading Receivables (year end 09/10)	24,225	-922	15,403	2,627	1,990	1,802	373	691	1,392	869

Movement in Financial Year	**-2,816**	**-1,076**	**-7,585**	**994**	**2,174**	**738**	**-139**	**1,713**	**-170**	**535**

Systems Schedule

Receivables in £'000's	Gross Receivables	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
eFinancial	14386	-605	5061	2067	3211	715	1157	670	1600	511
Compucare	8011	-932	5457	1353	743	181	311	74	450	375
Trust Receivables	**22397**	**-1537**	**10518**	**3419**	**3953**	**896**	**1468**	**744**	**2050**	**886**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 11 2010/11
Capital Expenditure (£000s)

Spend by Project	Year to Date (YTD) Revised Plan (YTD)	Year to Date (YTD) **Actual (YTD)**	Year to Date (YTD) Variance (YTD)	Annual Plan Annual Plan 10/11	Annual Plan Additional Funding	Annual Plan **Revised Plan**	Forecast **Forecast**	Forecast **Variance**
Redevelopment Projects								
Trust/DH Funded	15,000	**14,091**	909	15,000		**15,000**	**15,000**	**0**
Donated Funded	53,297	**43,328**	9,969	56,230		**56,230**	**49,363**	**6,867**
Total :	**68,297**	**57,419**	**10,878**	**71,230**	**0**	**71,230**	**64,363**	**6,867**
Estates Maintenance Projects								
Trust/DH Funded	7,222	**7,442**	(220)	7,572		**7,572**	**7,622**	**(50)**
Donated Funded	0	**484**	(484)	0	606	**606**	**606**	**0**
Total :	**7,222**	**7,926**	**(704)**	**7,572**	**606**	**8,178**	**8,228**	**(50)**
IT Projects								
Trust/DH Funded	4,921	**2,040**	2,881	5,478		**5,478**	**4,432**	**1,046**
Donated Funded	1,194	**0**	1,194	1,365		**1,365**	**0**	**1,365**
Total:	**6,115**	**2,040**	**4,075**	**6,843**	**0**	**6,843**	**4,432**	**2,411**
Medical Equipment Projects								
Trust/DH Funded	252	**261**	(9)	252		**252**	**302**	**(50)**
Donated Funded	1,375	**1,432**	(57)	1,500	1,131	**2,631**	**2,131**	**500**
	1,627	**1,693**	**(66)**	**1,752**	**1,131**	**2,883**	**2,433**	**450**
Total Additions in Year	**83,261**	**69,078**	**14,183**	**87,397**	**1,737**	**89,134**	**79,456**	**9,678**
Asset Disposals	**0**	**(54)**	**54**	**0**	**0**	**0**	**(54)**	**54**
Donated Funded Projects	**(55,866)**	**(45,244)**	**(10,622)**	(59,095)	(1,737)	**(60,832)**	**(52,100)**	**(8,732)**
Charge Against CRL Target	**27,395**	**23,780**	**3,615**	**28,302**	**0**	**28,302** [1]	**27,302**	**1,000**

[1] Expected Capital Resource Limit (CRL)

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 11 2010/11
Staffing WTE

Permanent (Excludes Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Plan*	Variance
Cardiac	310	311	310	309	318	319	329	334	331	339	341	378	37
Surgery	599	610	618	622	616	627	635	638	642	643	645	697	52
DTS	498	496	500	502	514	511	512	344	343	343	344	338	-6
ICI	283	282	281	282	280	284	289	458	462	466	471	483	12
International	104	101	101	103	108	110	115	115	119	116	116	131	15
Medicine	258	227	262	260	262	261	263	272	273	275	277	249	-28
Neurosciences	240	241	245	235	233	241	246	240	244	241	248	275	27
Haringey	159	160	170	171	170	176	187	185	183	181	184	208	24
North Mid.	126	3	0	0	0	0	0	0	0	0	0	0	0
Children's Population Health	6	6	6	6	6	6	7	7	6	8	7	4	-3
Operations & Facilities	211	207	205	209	208	207	201	200	201	202	203	239	36
Corporate Affairs	14	18	13	13	14	14	15	14	12	15	15	13	-2
Estates	38	38	38	36	38	41	46	47	46	45	47	59	12
Finance & ICT	130	125	124	129	130	132	134	133	133	136	134	160	26
Human Resources	57	56	54	50	55	57	57	59	59	58	58	58	0
Medical Director	18	18	18	18	17	17	17	21	20	16	14	20	6
Nursing And Workforce Development	72	75	73	72	79	83	77	75	76	77	82	87	5
Research And Innovation	75	74	67	68	67	69	67	72	73	75	75	67	-8
Redevelopment Revenue Costs	0	0	0	0	8	9	7	8	8	8	7	0	-7
TOTAL	3197	3050	3087	3,086	3,124	3,165	3,203	3,223	3,229	3,245	3,271	3467	196

Overtime

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Plan	Variance
Cardiac	4.2	1.9	3.3	2.2	2.8	3.0	3.4	3.6	2.7	2.4	2.2	0.0	-2.2
Surgery	6.9	4.6	2.7	2.7	3.5	3.3	2.6	3.3	3.5	2.5	2.8	0.0	-2.8
DTS	2.7	0.7	1.5	1.1	0.6	1.0	0.9	0.6	1.5	1.1	0.9	0.0	-0.9
ICI	2.8	2.8	1.8	1.8	1.9	2.7	1.2	0.8	0.6	0.4	0.5	0.0	-0.5
International	1.9	1.7	1.8	1.4	3.0	1.7	2.1	1.7	1.7	1.5	2.0	0.0	-2.0
Medicine	2.9	2.5	2.2	2.7	1.7	1.5	1.3	1.3	0.6	0.4	0.3	0.0	-0.3
Neurosciences	1.5	0.3	0.4	0.9	0.6	0.7	0.7	0.4	0.6	0.3	0.5	0.0	-0.5
Haringey	0.4	0.0	0.2	0.0	0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0
North Mid.	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Children's Population Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Operations & Facilities	2.6	9.8	6.1	6.5	6.1	6.5	4.3	4.1	3.8	3.6	3.0	0.0	-3.0
Corporate Affairs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates	2.3	1.9	2.4	1.9	2.9	1.3	2.3	3.4	2.8	1.7	2.0	0.0	-2.0
Finance & ICT	1.8	1.0	0.9	0.7	1.1	0.9	1.9	1.1	1.5	1.9	1.1	0.0	-1.1
Human Resources	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0
Medical Director	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Nursing And Workforce Development	0.3	0.1	0.2	0.2	0.0	0.2	0.0	0.0	0.1	0.2	0.2	0.0	-0.2
Research And Development	1.1	0.1	0.1	0.0	0.0	0.2	0.0	0.0	0.4	0.1	0.1	0.0	-0.1
Redevelopment Revenue Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	31.7	27.4	23.7	22.0	24.2	23.0	20.9	20.3	19.9	16.1	15.5	0.0	-15.5

Agency/Locum/Bank

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Plan	Variance
Cardiac	31	42	36	37	38	39	49	42	39	35	31	0	-31
Surgery	77	79	88	89	79	69	84	77	65	50	65	0	-65
DTS	22	26	25	27	20	24	20	13	15	19	11	0	-11
ICI	32	47	40	32	34	43	40	47	42	36	41	0	-41
International	29	32	30	31	33	31	38	40	39	30	34	0	-34
Medicine	24	33	30	21	22	19	28	27	23	23	23	0	-23
Neurosciences	15	20	18	21	22	23	24	25	25	23	32	0	-32
Haringey	32	41	34	24	22	23	21	29	10	5	5	0	-5
North Mid.	18	2	0	0	1	0	0	0	0	0	0	0	0
Children's Population Health	0	1	0	0	1	0	1	1	1	1	0	0	0
Operations & Facilities	17	16	16	23	17	21	23	24	14	31	14	0	-14
Corporate Affairs	0	0	0	0	0	0	0	0	0	0	0	0	0
Estates	5	9	11	19	11	12	9	13	10	11	5	0	-5
Finance & ICT	16	15	17	16	16	14	13	14	14	16	18	0	-18
Human Resources	6	5	8	6	6	3	4	3	6	2	4	0	-4
Medical Director	3	1	1	1	1	1	1	2	1	4	1	0	-1
Nursing And Workforce Development	3	3	3	3	2	1	1	4	0	1	0	0	0
Research And Development	0	0	2	1	1	1	2	0	5	1	2	0	-2
Redevelopment Revenue Costs	0	1	1	1	1	2	2	1	3	0	1	0	-1
TOTAL	331	374	361	355	326	325	358	362	311	289	289	0	-289

TOTAL STAFFING (Excluding Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Plan	Variance
Cardiac	345	355	350	349	359	361	382	379	373	376	374	378	4
Surgery	683	694	709	714	698	700	721	719	710	696	713	697	-16
DTS	522	523	526	530	534	536	532	358	359	364	356	338	-18
ICI	317	332	322	316	316	330	331	506	504	503	513	483	-30
International	134	135	132	136	144	143	154	157	159	148	152	131	-21
Medicine	285	262	294	284	285	281	292	300	297	298	301	249	-51
Neurosciences	256	261	264	257	255	265	271	266	270	264	281	275	-6
Haringey	191	201	203	196	192	199	208	214	192	186	190	208	18
North Mid.	144	5	0	0	1	0	0	0	0	0	0	0	0
Children's Population Health	6	7	7	7	7	7	7	8	7	9	7	4	-4
Operations & Facilities	231	233	227	238	231	234	229	228	219	236	220	239	19
Corporate Affairs	15	18	14	13	14	14	15	14	12	15	15	13	-2
Estates	45	50	52	56	53	54	57	63	59	58	53	59	5
Finance & ICT	148	141	143	146	147	147	148	148	148	155	154	160	7
Human Resources	63	61	62	56	62	61	61	63	65	60	62	58	-5
Medical Director	21	19	20	20	18	18	18	23	21	20	16	20	5
Nursing And Workforce Development	75	78	76	75	82	84	78	79	76	78	82	87	5
Research And Development	77	74	69	69	68	70	69	73	78	77	77	67	-10
Redevelopment Revenue Costs	1	2	1	2	10	10	9	9	11	9	9	0	-8
TOTAL	3,559	3,452	3,471	3,462	3,475	3,513	3,582	3,605	3,560	3,550	3,575	3,467	-108

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

Attachment Z

Great Ormond Street Hospital for Children NHS Trust

Trust Board
30 March 2011

Title of document: Foundation Trust application update **Submitted on behalf of:** Fiona Dalton	**Paper No: Attachment Z**

Aims / summary

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

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

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

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

Key actions for the next month:

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

Action required from the meeting
To note the current position

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

Financial implications: None

Legal issues: None

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

Who needs to be told about any decision Not required

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

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

Author and date
Sven Bunn
21 March 2011

Foundation Trust application – March 2011 position

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

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

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

Sven Bunn
21 March 2011

Attachment 1

Great Ormond Street Hospital for Children NHS Trust

Trust Board **30th March 2011**	
Title of document Update on achievement of C. difficile target **Submitted on behalf of** Director of Infection Prevention and Control Dr John Hartley	**Paper No: Attachment 1**
Aims / summary To update Board since July 2010 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 or Trust reputation.	
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 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 17/3/2011	

Attachment 1

C difficile infection in children at GOSH 17/3/2011 John Hartley

GOSH Surveillance
Since the last report to the Board in July 2011 the situation with detection of C. difficile toxin in stools of children a GOSH is unchanged. Ongoing surveillance demonstrates a steady detection rate within the expected parameters of the last 8 years (See table below). Each case is reviewed, appropriate infection and prevention controls are implemented; detailed typing is requested.

Most cases are sporadic (although occasional cross infection may have occurred). Significance of the detection is often difficult to assign (See notes below). No serious disease has been detected.

Compliance with National Surveillance
We continue to report cases if CD infection in the children >/= 2 year olds who are in for 3 or more days when tested (when determined as possible cases by our standard protocol).

The number of cases is greater than the automatically reduced Mandatory National Target, however, this does not, in my opinion, represent a failure of the C. difficile control programme nor a significant risk to patient safety.

Appeals to DH to review national target as applied to Paediatrics
It is my opinion that, although serious disease is rare in children, paediatric surveillance is essential but targets/objectives should be based on paediatric epidemiology not adult. Since the last report, a paper was presented to the CDI Expert Advisory Committee who agreed with the principle that paediatric reporting should be different but the DH referred the issue to a further DH advisory group (ARHAI – Antimicrobial Resistance and Health Care Associated Infection). ARHAI have discussed this with DH and again there is agreement in principle that paediatric surveillance should continue but within paediatric specific criteria. I will be drawing up a proposal for this to discuss with the Paediatric Microbiology Group and submission to ARHAI.

John Hartley
Consultant Microbiologist, DIPC

Table showing first detections of C. difficile toxin by year in children tested at GOSH

	Positives	Age	>/= 2 and		
Year	All ages	>/= 2yr	in >/= 3 days		
2003/4	71	32	25		
2004/5	50	24	13	Mandatory surveillance	
2005/6	57	21	11		National
2006/7	70	29	17	Reported	Target
2007/8	75	31	17	11	
2008/9	56	22	14	11	10
2009/10	57	26	13	12	10
2010/11*	64	31	18	11	9
* to 17/3/2011					

Attachment 1

Brief review of the children with C. difficile detected in stool (Since July 2010 report)

Days in when tested (Highlighted cases were reported to HCAI mandatory site)	
0	Relapsed AML; routine surveillance stool on admission for BMT; was on co-amox. Not treating at this stage
0	Undergoing chemotherapy, episode of loose stool; has been negative when left GOSH in December and in Royal London, but was in Elephant.
0	Planned admission for BMT; has diarrhoea; only on prophylaxic co-trim
1	Previous long admission with volvulus and sepsis; survived , on to enteral feed with jejunostomy tube. Routine admission for respiratory invesigations and routine battery tests sent. Not acute diarrhoea, stool normal for him.
1	Ocology child; abdo pain and vomiting on and off, previous C dif neg: acute stomach pain and vomiting this time with diarrhoea; settled. Chemo not mucositis inducing, therefore possible CDAD
1	Epilepsy with loose stools
1	CGD, admitted with hard stool with a little blood. No disease. Has now started Cip and Clind for chest but no diarrhoea so far.
2	S. pneumoniae pneumonia and bacteraemia (post renal Tp); on Cef, diarrhoea, spontaneously settling still on CTX; could be 'sepsis' as cause but previously negative.
3	High grade glioma; developed fever and diarrhoea after chemotherapy; not mucositis; was settling when result given; on FN Abs now.
4	Neuroblastoma resected 21/12/10; prophylactic antibiotics only; loose offensive stool once couple days post op; settled and went home. Oncology with day case admissions before. Possible case but short and self limiting.
4	Post cardiac surgery loose offensive stool, continuing now while on Vanc and PTAZ IV for resp infection, (routine prophylaxis only before onset). Consider treatment.
4	Fever 3 days post Methotrexate, ceftaz and teic started 17th, loose stool next day; given metronidazole 21st. Neg in Jan. In Lion before and prior Abs.
9	Burkitts; chemotherapy giving mucositis so likely be cause; Was not on antibiotics when started diarrhoea; on regular lactulose
10	No diarrhoea; surveillance sample, negative week before; has developed diarrhoea subsequently but feb neutropenic with sepsis E coli in blood at time.
12	High risk neuroblastoma with new antibody therapy; diarrhoea is recognised side effect but earlier and was due to go home when it started, acute with fever; settled spontaneously over three days, was given PTAZ. So may be drug or CDAD. Self resolving despite PTAZ.
14	Loose stool due to constipation and overflow; after enema and more laxatives tested postive
39	Routine weekly post BMT stool; has had loose stool asa normal for post BMT; going home well. Previous negatives by VIDAS from admission, 4 times.
48	ALL; prior typhilitis, P/Ak/Mtz but finished; loose stool on lactulose; no evidence of disease now or before (negative 27/8, 21/9)

Attachment 1

71 Possible HLH/ immunodeficient; lung lesions, had Abs and now antifungals.

Highlighted notified as possible cases of CDAD

Attachment 2

Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting 30th March 2011	
Head of Nursing Report **Submitted on behalf of** **Liz Morgan**	**Paper No: Attachment 2**
Aims / summary To brief Trust Board members on some of the key achievements and challenges reported by the Heads of Nursing over the past four months.	
Action required from the meeting To note the report, the achievements and challenges reported by the Heads of Nursing.	
Contribution to the delivery of NHS / Trust strategies and plans Contributes to the strategic goal of 'zero harm'	
Financial implications None	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision N/A	
Who is responsible for implementing the proposals / project and anticipated timescales N/A	
Who is accountable for the implementation of the proposal / project N/A	
Author and date Heads of Nursing 16th March 2011	

Head of Nursing Report - March 2011

Key Successes

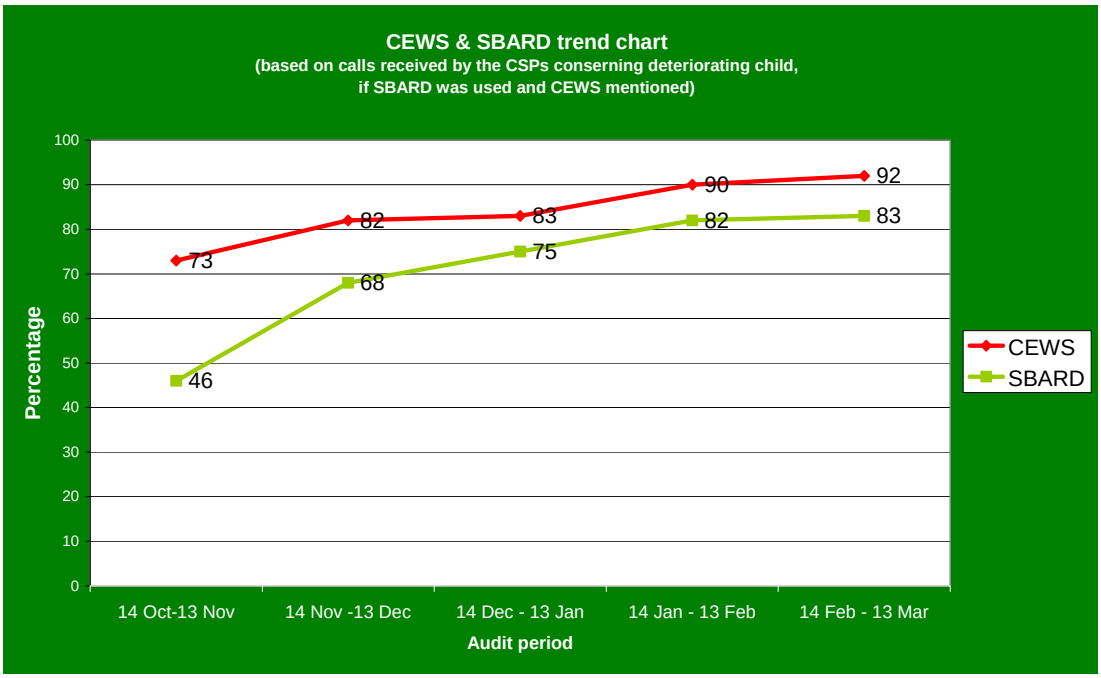
Head of Nursing role. All the clinical units now have a Head of Nursing, appointed following the review of the Matron role at the end of 2010. We attended a team away day with the Chief Nurse in February where we identified success criteria for the role. We will be undertaking 360 degree reviews to assess our progress against these criteria.

Darren Darby (Matron in PICU/NICU, awaiting the outcome of the intensive care review) has returned from 3 months in Camp Bastion, Afghanistan, where he supported the medical teams in managing the care of children injured in the fighting. He is to present his learning from the experience to the senior nursing team.

SBARD and CEWS. Significant work has been undertaken to roll out the use of CEWS and SBARD across the organisation. The Nursing performance indicators now include the use of CEWS and these indicate improvement. A clinical audit reported in February 11, also showed an overall improvement in CEWS documentation across a number of measures. However data collected through the ward KPIs did not always reflect that collected through clinical audit. In aiming to reduce the gap, wards are to get sisters from other wards to undertake the KPIs.

A policy detailing the minimum standards for patient physiological observations is in draft form due to go to Quality and Safety and Management Board for approval in April.

Monthly audit by the CSP team demonstrates a continuing increase in the number of calls from nursing staff concerning a deteriorating child where CEWS and SBARD were used.



Patient identification. The KPI for patient identification bracelets was undertaken in February 11 as a spot check and demonstrated a continued very high compliance across the trust.

Safeguarding Improvement team (SIT). The report from the SIT visit in January is now available. The team reported on the 'impressive approach to safeguarding' and noted in particular the excellent leadership demonstrated by the ward sisters.

PEAT. The formal PEAT inspection took place in February. The scores are not yet available, but the inspection was very positive with continued improvements noted by the PEAT team. Several members of the senior nursing team are always present as part of the PEAT inspection team. The Patient Environment Coordinators (PEC) recently introduced across the Trust are working closely with the Heads of Nursing and this is having a positive impact.

Medicine administration. Last year the sisters and charge nurses were taught a model that explains why systemic migrations away from guidelines and processes occur. Sue Pike lead them in applying this to the medications administration process on their wards. Discussion at ward level, and on the update programme with the Practice Educators, has increased understanding of these violations and migrations and lead to a subsequent reduction in the reported medication administration errors. To further improve safety, Sue Pike and the Heads of Nursing have undertaken work in clarifying the policy in relation to the 'double checking' of intravenous medication. To increase the effectiveness of checks and reduce the impact of making them, a position has been agreed that will enable the introduction of a system that concentrates on making checks of the critical points within the medicine administration process. This will also recognise the competence of the registered nurse. Improvement methodology will be used to test a system of "independent double checking" in clinical practice before rolling it out across the trust.

Future challenges. The opening of phase 2A in the MSCB provides the Heads of Nursing with two major challenges - the physical logistics of moving wards and departments into the new build and engaging staff to embrace the opportunities this presents. Many staff are understandably very loyal to their current ward/department and as Heads of Nursing we recognise the need to work alongside the redevelopment team to manage the process of such huge change for all of these staff. Looking further ahead the new Same Day Admit Unit (SDAU) and the Post Anaesthetic Care Unit (PACU) due to open in 2013 gives us an opportunity to redesign a cohesive workforce across all several clinical units by developing new roles and up skilling some of our current staff. We look forward to working with John Courtney (ACN Clinical Workforce) to take this forward.

Reporting Infection Prevention and Control. From July 2011 the DIPC report and the Heads of Nursing report will be scheduled as papers for the same Trust Board meetings. The DIPC and a Head of Nursing will attend Trust Board to answer questions.

Attachment 3

Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting
30 March 2011

Register of Conflicts of Interest Declarations (Members and Staff) **Submitted on behalf of** **Jane Collins, Chief Executive**	**Paper No: Attachment 3**

Aims / summary

Great Ormond Street Hospital for Children NHS Trust's Conflict of Interest Policy requires that all members of staff (including temporary and agency staff) and members of the Trust Board declare any potential or actual conflict on joining the organisation or when the potential for conflict arises. A conflict of interest occurs when the private or personal interests of a member of staff/ member of the Board could affect their role at the Trust in terms of bringing some possible advantage to them or close relatives.

Any declared interests are reconfirmed annually until such time as either the member of staff/ member of the Board leaves GOSH or the potential for a conflict of interest no longer exists.

Details and examples of potential conflicts of interests are set out in the Conflict of Interest Policy.

The Company Secretary is required to draw up a register of interests declared by members of staff and members of the Board and to report on this annually in the public part of the March Trust Board meeting. The returns are maintained in a register which is open for inspection. The registers for Trust Board members and staff are attached with this report.

Action required from the meeting
To note the content of the report.

Contribution to the delivery of NHS / Trust strategies and plans
None

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?
All staff and members are advised of the need to declare any actual or potential conflicts each year.

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
Anna Ferrant
March 2011

ATTACHMENT 3

Great Ormond Street Hospital for Children NHS Trust

Register of Staff Interests 2010/11

Name	Declaration	Declared	Renewed
Mr Stephen Cox, Chief Press Officer	Occasional freelance journalism and PR consultancy.	March 2000	February 2011
Joanne Cooke CNS Tracheostomies	Paediatric lead with Smiths Medical Health Care, assisting with the design, research into new, appropriate airway products to enhance patient care and management.	11 May 2005	February 2011
Professor Peter Hindmarsh Professor of Paediatric Endocrinology	Unpaid consultancy to Medtronic Diabetes UK	8 April 2005	February 2011
Joanne Hughes	Related to Ray Conley, Head of Hr Operations	June 2005	February 2011
Dr Catherine Cale, Consultant Immunologist	Husband is the UK Manager of Phadia Ltd (previously Pharmacia / Sweden Diagnostics) who supply GOSH with some laboratory equipment and reagents.	March 2006	February 2011
Dr Catherine Owens, Consultant Radiologist	Employed at the Portland Hospital where, along with her colleagues in Radiology, she provides an average of 3 hours per fortnight of paediatric plain film reporting, ultrasound and fluoroscopy, and occasional MRI reports. Has taken on some administrative tasks attending 4 Consultants' meetings per annum. Not perceived as a conflict to GOS Practice as declared in job plan. President of International Paediatric Radiology Meeting in May 2011. Has a reputable company organising and fundraising (John Matthews at fitwise). Has discussed this with Head of GOS fundraising and the Medical Director (RE)	March 2006	February 2011
Dr Melanie Hiorns, Consultant Radiologist, Radiology	Carries out some limited private practice at the Portland Hospital, which in no way conflicts with her work at Great Ormond Street Hospital	April 2006	February 2011
Mr Richard Bunn, Booking Co-ordinator, Central Booking Office	Related to Sven Bunn, Foundation Trust Programme Manager (cousins)	March 2007	Amended February 2011

ATTACHMENT 3

Name	Declaration	Declared	Renewed
Kimberly Gilmour, Clinical Scientist (Immunology)	RG Media (software development and hardware support) is owned by her husband. RG Media provide support for the Kodak Image Station II as required. No support was required in 2010	March 2007	Amended February 2011
Dr Victor Larcher, Consultant in General Paediatrics and Clinical Ethics	Chair of the Royal College of Paediatrics and Child Health Ethics Advisory Committee, which meets for 2 hours thrice yearly. Contributes opinions on ethical issues as required for the College. Has served on DoH sub-committees on pandemic flu and children's records. Member of the UK Clinical Ethics Network Committee which meets twice yearly. All are unpaid posts. Chairman of the examination board for the MSc in Clinical Paediatrics at the UCL Institute of Child Health, which is an unpaid post.	March 2007	February 2011
Dr Kieran McHugh Consultant Paediatric Radiologist	Occasionally reports MRDs, x-rays and ultrasounds at the Portland Hospital Occasional radiology reporting within formal trials for Hoffman La Roche (BERNIE study) for which Hoffman La Roche pay 250 Swiss Frances per hour	March 2007	Amended February 2011
Dr Oystein Olsen Consultant, Radiology	Admission rights at The Portland Hospital for Women and Children where, along with colleagues in Radiology she provides an average of 3 hours per fortnight of paediatiric film reporting, ultrasound, fluoroscopy and MRI reports. This does not conflict on either a financial or time basis with any of her work at GOSH.	March 2007	Amended September 2009 and Renewed February 2010
Renée McCulloch, Consultant, Paediatric Palliative Care	Works with Helen and Douglas House, Oxford, outside GOSH hours. Remained employed by the Oxford Radcliffe NHS Trust until 31 July 2007. Began work as a locum consultant at GOSH on 9 July 2007, prior to taking up substantive post.	June 2007	February 2010

ATTACHMENT 3

Name	Declaration	Declared	Renewed
Jacqueline Moon, Training and Practice Co-ordinator for Child Death Helpline / End of Life Care support worker.	Works as a Locum Psychotherapist and Honorary Psychotherapist at East London NHS Foundation Trust	March 2009	Amended February 2011
Professor Francesco Muntoni, Professor of Paediatric Neurology	Ad-hoc consultancies for scientific advisory work for:- Acceleron AVI Biopharma Genzyme Deblopharmd Grants from:- AVI Biopharma Summitt PTC	February 2008	Amended February 2011
Dr Marina Easty Consultant Paediatric Radiologist	Takes sessions at the Portland Hospital, performing ultrasound scans, screening, general reporting and MRI. Also GOSH in-house private patient work, as requested by the referring clinicians. There is no conflict of interest because the work is done out of NHS time.	March 2008	February 2011
Dr Alistair Duncan Calder Consultant Paediatric Radiologist	Undertakes sessions at the Portland Hospital in paediatric Radiology, averaging 3 sessions per month. These do not occur during scheduled NHS sessions, are included in my job plan and do not otherwise conflict with work at Great Ormond Street	March 2008	February 2011
Mr William Harkness Consultant Neurosurgeon	Medical Consultant to Forth Medical and Northstar.	March 2008	February 2011
Dr Alex Barnacle Consultant Paediatric Radiologist	Has practising privileges at the Portland Hospital for Women and Children but this poses no conflict of interest involving patient care. Undertakes imaging sessions at the Portland Hospital averaging 3 hours per fortnight, which is done in her own time. I have no involvement in any financial institutions that would cause a conflict of interest.	March 2008	February 2011
Dr Derek Roebuck Consultant Paediatric Radiologist	Works at Portland Hospital (and occasionally at Harley Street Clinic) in his own time.	March 2008	February 2011
Jonathan Elwood Legal Advisor	Married to a GOSH Clinical Site Practitioner	March 2009	February 2011

ATTACHMENT 3

Name	Declaration	Declared	Renewed
Caroline Brown HR Manager – Child and Care Co-ordinator	Co-ordinating review process for Trust's childcare voucher provider and currently a user of the scheme.	March 2009	Conflict no longer applicable – Declared February 2011
Vanessa Shaw Head of Dietetics	Consultancy work for Abbott Nutrition and Danone Group concerning the development of new infant and paediatric special formulas	05/02/10	TBC
Dr Thomas Jacques	I pay my private earnings into a private company known as 'Repath' of which all the consultant histopathologists, including myself are directors and shareholders. I am the Company Secretary. The Company is essentially a mechanism for handling the consultants' private fees, which are requests for opinions regarding reporting of specimens. The income is primarily derived from the International Private Patients Wing of GOSH, which is managed by the NHS. I also occasionally provide reports to HM Courts, and provide lectures for which I am paid fees. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, such as training fees for non-medical staff. The remainder of the income is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others. However, it has come to my attention that a formal declaration should be made to the Trust, and this I now do.	30/10/2009	TBC
Prof Neil Sebire	I pay my private earnings into a private company known as 'Repath' of which all the consultant histopathologists, including myself are directors and shareholders. The Company is essentially a mechanism for handling the	29/10/2009	February 2011

	consultants' private fees, which are requests for opinions regarding reporting of specimens. The income is primarily derived from the International Private Patients Wing of GOSH, which is managed by the NHS. I also perform occasional reporting work to cover for colleagues in other centres who may be off-work, for which I also get paid on a case by case basis. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, such as training fees for non-medical staff. The remainder of the income is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others. However, it has come to my attention that a formal declaration should be made to the Trust, and this I now do.		
Marion Malone	I pay my private earnings into a private company known as 'Repath' of which all the consultant histopathologists are directors. The Company is essentially a handling mechanism for the consultants' private fees, which are requests for expert opinions. The income is derived from the International Private Patients Wing, which is managed by the NHS. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, such as training fees for non-medical staff. The remainder of the income is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others. However, it has come to my attention that a formal declaration should be made to the Trust, and this I now do.	29/10/2009	March 2011

ATTACHMENT 3

Name	Declaration	Declared	Renewed
Martin Weber	I pay my private earnings into a private company known as 'Repath' of which I am a director. The income is derived entirely from the International Private Patients Wing, which is managed by the NHS. The Company is essentially a handling mechanism for the consultants' private fees. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, such as training fees for non-medical staff. The remainder of the income is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others.	29/10/2009	Amended February 2011
Michael Asworth	I pay my private earnings into a private company known as 'Repath' of which I am a director. The income is derived entirely from the International Private Patients Wing, which is managed by the NHS. The fees are for expert opinion.The Company is essentially a handling mechanism for the consultants' private fees. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, e.g. training fees for non-medical staff. The remainder is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others. However, it has come to my attention that a formal declaration should be made to the Trust, and this I now do.	29/10/2009	February 2011
Dr Lesley Rees	I am on the drug safety monitoring committee, reviewing the safety for patients of a trial of erytropoeitin (long acting) Mircera	22/03/2009	February 2011

ATTACHMENT 3

Name	Declaration	Declared	Renewed
Roxana Gunny	My work external to GOSH is conducted at the University College Hospital (NHS consultant contract), the Portland Hospital, and West Middlesex Alliance MRI. I do not believe this constitutes a conflict of interest.	15/10/2009	February 2011
Kaukab Rajput	I am attending a conference hosted by Cochlear UK. This conference will be including information about their newer devices including Hybrid device. Hybrid device may be suitable for children who develop high frequency hearing loss after ototoxic medication. I would like to declare that at all times I keep the interest of my patients as the top priority and attending this conference will have no bearing on which device I recommend to the patients.	03/10/10	
Alison Jones	I have been asked to attend and contribute to a CSL Behring Advisory Board meeting regarding a new immunoglobulin product. An honorarium will be paid from CSL Behring into the Immunology department budget.	01/11/10	
Mandy Bryon Consultant Clinical Psychologist	I offer a private clinical psychology practice in an office in Wimbledon but see patients that would not normally access clinical psychology by me as part of my post at Great Ormond Street Hospital I have been requested on occasions to give advice to television companies on recruitment policies when using children in programmes, BBC and Channel 4. I have been given payment for this service.	10/02/11	
Neil Shah Paediatric Gastroenterology	Unrestricted Educational Grant until June 2010 Nutricia Medical	13/02/11	

ATTACHMENT 3

Name	Declaration	Declared	Renewed
Carmel Maria Corbet Sister, PICU	I have been asked to make bed quilts for PICU. I make these quilts in my own time at home as an existing business and have supplied these to other private customers and to a shop in the town of Ware, Herts. The appropriate cost of making these quilts is £1700 for 10 quilts. This is paid from PICU Charity Fund and agreed by the sisters. The quilts have been tested for robustness in the washing cycle.	10/01/11	
Beatrice Teuten, DoH Project Researcher	RCPCH, Member Ethics and Advisory group RCPCH, Member Parents and Carers group Nursing and Midwifery Council, Lay Member of Council – Jan 2011 – Dec 2013 Medical Mediation – Freelance Work	10/11/10	
Sarah Barclay DoH Service Development Project Lead	It is possible that I may in future be invited to undertake mediation work at GOSH. As Vice-Chair of the Clinical Ethics Committee, I would regard this as a potential conflict of interest which would need to be discussed both with GOSH and the CEC before undertaking such work.	24/11/10	
Sue Chapman Nurse Consultant Nursing and Workforce Development	I am a panellist on the NMC's Fitness to Practise Panel	17/02/11	
Dr P. Ramnarayan Consultant, CATS	I act as a part-time Medical Advisor fro Isabel Healthcare Ltd, a diagnostic software system	11/02/11	
Lorna Gibson General Manager Research and Innovation	I am a lay member of the North West London Ethics Committee (based at the Royal Free)	08/03/11	

ATTACHMENT 3

Summary of Declared Interests
2010/11

Trust Board

Non – Executive Directors

Name	Declared Interests
Baroness Tessa Blackstone	Member, House of Lords Vice Chancellor, University of Greenwich Appointed as Director of UCL Partners in April 2009 Member, Royal Opera House Board Chair, British Library Board
Professor Andy Copp	Director Institute of Child Health, University College London Honorary Director of Research, Children's Trust, Tadworth Associate Editor, Birth Defects Research Part A, USA Board Member, Bo Hjelt Foundation, Amsterdam
Mr Andrew Fane	<u>Great Ormond Street Hospital Children's Charity</u> Chairman, Friends of the Children of GOS <u>The Children's Hospital School at Great Ormond Street and UCLH</u> Chairman of Governors <u>Institute of Child Health (GOSH/University College London Medical School)</u> Chairman, General Charitable Trust Chairman, Child Health Research Appeal Trust Chairman, Bill Marshall Memorial Fund Director, Genex Biosystems Ltd Director, ICH Productions Ltd <u>The CP Charitable Trust (supporters of ICH)</u> Trustee <u>The Coram Family</u> Trustee and Governor <u>The Foundling Museum</u> Chairman of Trustees <u>English Heritage</u> Chairman, Audit Committee <u>League of Remembrance</u> Trustee
Wife – Clare Lucy Marx CBE MB BS FRCS	Orthopaedic surgeon, Ipswich Hospital NHS Trust President, British Orthopaedic Association September 2008/9 Member of the Council of the Royal College of Surgeons of England;

ATTACHMENT 3

Summary of Declared Interests
2010/11

Mr Charles Tilley	Chief Executive, Chartered Institute of Management Accountants Non-Executive Director and Member of Audit Asset and Liability Committees – Ipswich Building Society Director of Seaview Yacht Club Limited
Mrs Mary MacLeod	<u>Chair</u> Gingerbread ESRC funded Research Advisory Group on outcomes of Domestic Violence Perpetrator programmes Safenetwork Advisory Board <u>Board Member</u> Child and Family Court Advisory and Support Service (Cafcass) Internet Watch Foundation Video Standards Council Executive Board, UK Council on Child Internet Safety Independent consultancy on family policy and child and family services
Ms Yvonne Brown	Board Member of the Solicitors Regulation Authority Consultant – Legal Management Consulting

Associate Non - Executive Directors

Ms Dorothea Hackman	Chair of GOSH Patients'/Members Forum Governor, GOSH School Volunteer, Child Death Helpline Trustee, St Pancras Lands Trust Lay Chair, South Camden Deanery Synod

Executive Directors

Name	Declared Interests
Dr Barbara Buckley	None
Mr Trevor Clarke	None
Dr Jane Collins Husband: Mr David Evans	Advisory Board Member, Judge Business School, Cambridge University Chief Executive GOSH Children's Charity Director of UCL Partners Trustee - Child Health Research Appeal Trust and the General Charitable Trust of ICH Trustee of Shooting Star Children's Hospice
Ms Fiona Dalton	None

ATTACHMENT 3

Summary of Declared Interests
2010/11

Professor Martin Elliott	Honorary President 'The Richard Hall Trust' Board Member , World Society of Pediatric and Congenital Heart Disease
Mr Robert Evans (until 31 August 2010)	Patron, Headlines (Craniofacial Support Group) Private Practice, 23 Harley Street, London W1G 9QN Chair - London Dental Forum (London Deanery) – Interest not applicable from August 2010 Member of the Patient Safety Counsel - Addenbrooke's Hospital, Cambridge – Interest not applicable from August 2010
Mrs Liz Morgan (from June 2010)	None
Mrs Claire Newton	None
Mrs Janet Williss (from 18 January 2010 till June 2010)	Fitness to Practice panellist at Nursing and Midwifery Council

Other Directors

Name	Declared Interests
Professor David Goldblatt	Member, Wellcome Trust Expert Review Group 2011 onwards Occasional Member, Expert Panels/ Advisory Boards for Pfizerm Sonofi Pasteur, Novartis and Vaccines DoH JCV1 Subcommittees - Pneumococcal DoH Scientific Pandemic Influenza Advisory Committee and Menigoccal Programme Director for Child Health, UCL Partners
Mr William McGill	None
Mr Tim Johnson	Trustee of Jeans for Genes Company Director Jeans for Genes Ltd Company Director GOSIPLtd
Mr Mark Large	Son on work experience whilst part time at University, since November 2010, on average 2 days per week at Block Solutions. Declared will not have any part in procurement involving Block Solutions.

Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting **30 March 2011**	
Title of document Register of Gifts and Hospitality **Submitted on behalf of** Jane Collins, Chief Executive	**ATTACHMENT 4**

Aims / summary

The Trust is directly responsible for ensuring that staff and board members are impartial and honest in the conduct of their official business, and that they do not abuse their official positions for personal gain or to the benefit of their family and friends.

The trust complies with the requirements that all NHS bodies are required to have an explicit procedure for board members and members of staff to declare hospitality and sponsorship offered by and accepted from contractors, suppliers and others.

The Company Secretary holds and maintains the Trust's 'Register of Gifts and Hospitality'. All staff should complete the "Gifts, Hospitality and Sponsorship Form" if they accept *or refuse* any gifts, inducement or hospitality outside of the Business Conduct Standards.

The Register of Gifts and Hospitality for 2010/11 is attached to this report.

Action required from the meeting

The Board is asked to note the entries in the Register.

Contribution to the delivery of NHS / Trust strategies and plans

No waste

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?

All staff and members are advised of the need to declare where gifts or hospitality have been accepted or declined.

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

Anna Ferrant, 21st March 2011

Attachment 4

Register of Gifts and Hospitality 2010/11

Name of recipient	*Host*	*Event (for sponsorship/ hospitality)*	*Accepted/ declined*	*Date*
Natalie Yearlett	Danone International	International Scientific Symposium - 'Functional GI Disorders and Common Deficiencies in Early Childhood'. Two night stay at 'Westin Grand' Munich. Meals and transport to the airport. Return flights between Gatwick and Munich	Accepted	06/04/2010
Vanessa Shaw	Abbott Nutrition	43rd Annual Meeting ESPGHAN. Flights to Istanbul, conference fee and accommodation	Accepted	09/04/2010
Jo Barber	ITN	Lunch	Declined	26/05/2010
Jo Barber	Amanda Stocks	Lunch	Declined	26/05/2010
Melanie Sullivan	FSD Network	£25 Marks and Spencer voucher unexpectedly received after delivery of a workshop session on business cases on 27 May 2010	Accepted	14/06/2010
Jane Collins	Berwin Leighton	1 bottle of champagne worth approximately £35. Given after a speaking event	Accepted	18/06/2010
K Moshal	Family of patient	Gift set by post as a thank you for care (now complete). Stainless steel serving set - Arthur Price	Accepted	28/06/2010
J P Elwood	Weightmans	Lunch	Accepted	06/07/2010
Rachel Skeath	SHS	£350 given towards cost of flights for SSIEM Annual Symposium. Istanbul 2010	Accepted	02/09/2010
Rachel Skeath	Vitaflo International	Two Nights Accommodation provided for SSIEM Annual Symposium Istanbul 2010	Accepted	02/09/2010
Victoria Crook	Actelion Pharmaceuticals UK Ltd	Workshop on Niemann-Pick Diseases	Accepted	08/09/2010
Stephen Cox	Sheffield Documentary Festival	Travel to Sheffield Documentary Festival by train and free admission	Accepted	15/09/2010
Marian Sewell	SHS (Scientific Hospital Supplies)	£500 for attendance at an International Sysmposium on the dietary treatment of epilepsy and other neurological disorders	Accepted	05/10/2010
C. Daly	BDA London Branch	24th March 2010 teaching session held on palliative care and nutrition issues - £50 John Lewis Voucher (July 2010)	Accepted	28/10/2010
Daniel Risson	Shire HGT	10th International Workshop on LSD's	Accepted	04/11/2010
Daniel Risson	Genzyme Therapeutics for LSD Pharmacy Network Meeting	LSD Pharmacy Network Meeting Accommodation and Travel	Accepted	21/01/2011
Anna Cornish	Canon UK	Complimentary tickets for the Six Nations' England versus France Rugby match.	Accepted	24/02/2011
Jane Collins	Health Trust Europe	Chartered Institute of Purchasing and Supply Annual Dinner	Accepted	23/03/2011
Jane Collins	Minister of Health - Oman	Visit - Napkin rings received on behalf of the Trust	Accepted	23/03/2011

Trust Board Meeting

30th March 2011

IT Strategy - Update	**Paper No: Attachment 5**
Submitted on behalf of: Mark Large, Director ICT, Claire Newton, CFO	

Aims / summary

The ICT Strategy has been in place for 2 years and considerable investment has been made in infrastructure in that period. This document identifies progress made and extends the existing strategy

Action required from the meeting

To approve the ICT Strategy and the direction proposed – in particular to support :

(i) the guiding principles and priorities

(ii) the need for the organisation to address the challenges of achieving joint commitment and ownership of the Trust's priorities and changes to pan Trust systems

(iii) the need to invest in tools to integrate the various critical clinical systems within the trust and automate processes;

(iv) the aim that at least 50% of capital investment be on clinical projects

Contribution to the delivery of NHS / Trust strategies and plans

Delivery of the vision in this strategy will see a move from paper to electronic operation.

This coupled with swift action to move forwards on the tools required to deliver service based solutions with workflow, process and portals will reduce administrative overheads, reduce transactional costs and thus improve the patient experience.

Financial implications

The strategy has implications for both revenue and capital investment but the approval for this will be sought through the financial planning process and the Trust's normal processes for considering business cases.

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?

All staff and in particular key champions/ owners of clinical and operational systems

Who needs to be told about any decision

TDB members

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

Who is accountable for the implementation of the proposal / project

Director ICT reporting to the CFO

Author and date: Mark Large, March 2011

Great Ormond Street Hospital for Children NHS Trust

Information and Communications Technology (ICT) Strategy

March 2011

Draft v2.0

Amendment History:

Version	Date	Amendment History
V0.01	4th Feb 11	Created
V0.73	18th Feb 11	First Revision. Circulated as a draft to CN, FD for review.
V1.1	23rd Feb 11	Fully reviewed by core group, ICT Management and CFO
V2.0	11th Mar 11	Revisions following TDB review

Reviewed by:

Name	Name & Title
John Campbell	Head of Projects, ICT
Geoff Bassett	Head of Information
Anthony Prince	External Review
Claire Newton	Chief Finance Officer
Geraldine Hill	Head of IT Service Management
Darren Burne	Head of Infrastructure
Dennis Murray	Enterprise Architect
Fiona Dalton	Chief Operating Officer
Martin Elliott	Co Medical Director
Sven Bunn	Programme Manager – Foundation Trust

Approved by:

Version	Date	Approval Team
V1.2	1st Mar 11	Technical Delivery Board
V2.0	17th Mar 11	Management Board
	23rd Mar 11	Trust Board

Contents

Appendices

Figures

1 Executive Summary

1.1 Purpose

This document is the ICT Strategy for the Trust. It sets the overall vision of what is to be achieved, with proposed priorities, over the next three years. It focuses on enhancing the patient experience, increasing the efficiency of the Trust's processes, and improving safety. What is achieved will be subject to prioritisation based on available funding.

The successful deployment of IT is intricately linked to user commitment at both senior and junior levels: that is, supporting the necessary cultural and process changes to help deliver the Trust objectives: no harm; no waste; no waits.

This revision forms the natural extension of the existing strategy based on conversations with staff across the Trust over the last 24 months, including senior clinicians who work both within the Trust and across other organisations.

It has been prepared at a time of increasing financial constraints, the creation of Academic Health Science Centres (UCL Partners), and a DoH consultation regarding the future of service delivery approach of Connecting for Health. Also taken into account are Department of Health white papers[1], the work of external think tanks such as 2020Health[2], and the strategies and needs of our partners in UCLP.

A key principle is that, as the fixing of the hardware and server rooms comes to an end, the focus of spend now needs to be on projects that deliver a direct change in user experience, change that supports the transformation required and the objectives of the Foundation Trust Integrated Business Plan.

Although this strategy discusses the requirements for expenditure at a high level to establish priorities, it does not of itself request approval for any expenditure.

It does however ask for confirmation from the Trust and Management Boards that the direction and priorities for ICT are consistent with the direction the Trust wishes to go:

- the guiding principles set out in section 4;
- organisational involvement and commitment to change;
- the need to invest in tools to integrate the various clinical systems and to automate processes.
- A target of at least 50% of capital investment on clinical projects

1.2 In Three Years

In three years' time we expect to have:

- Procured tools to automate & integrate key business processes;
- Achieved a significant move from paper to electronic based records;
- Improved access to high quality patient records; reduction in duplication & transcription of data; improved quality of business and medical intelligence;
- Increased online access to patient information by all of our partners; and transfer of information into Trust systems via a web page or portal;

[1] 'Liberating the NHS: An Information Revolution', 'High Quality Care For All: NHS Next Stage Review;
2 'Healthcare without walls: A framework for delivering telehealth at scale', 'Fixing NHS IT: A plan of action for a new government', 'Cutting the costs without cancelling the services'.

- Improved communications, both outside as well as inside the Trust, including major use of location awareness (knowing who is where in the building);
- Used of a variety of telemedicine applications to facilitate outreach care; and use of automated monitoring tools to reduce clinical risk;
- Much improved support for training, education, research and commercial activities (International Private Patients, Research and Development);
- Reduced transactional cost, improved efficiency, safety, outcomes, morale and thus reduced risk;
- Supported the Foundation Trust Integrated Business Plan.

Achievement of the above will mean that this strategy has played its part in transforming the organisation – both in terms of how information is used in the Trust and the cost base of the Trust. The largest component of cost in the Trust is that of staff. The removal of paper, introduction of workflow and business process management based on services will allow staff to be deployed into higher value tasks.

1.3 High Level Risks

1.3.1 Resources

The number of projects on the Trust wish list will always exceed the funding, skills available, and readiness of users. In addition it is necessary to take into account potential synergies and conflicts between the projects / programmes themselves.

All projects therefore need careful prioritisation. We need to accept that it will not be possible, nor perhaps desirable, to delivery every project on the wish list.

Delivery of the overall vision will compromised if the right tools are not procured.

1.3.2 Cultural Change

Lessons need to be learnt from recent application deployments. ICT can deliver the technical tools; but not the cultural change necessary to implement these operationally into a user department. Cultural change can only be achieved through Executive and Clinical sponsorship of projects, and ownership by the future users. Failure to manage communications, training and the discipline required to embed lasting change will be a major risk to not only the delivery of this strategy, but also benefits realisation and Trust objectives.

Project and programme delivery can be significantly improved by having a well-managed programme structure with both clinical and technical representatives involved.

1.4 Responsibility for Delivery

The Director of ICT, who reports to the Chief Finance Officer, is responsible for delivering this strategy. Delivery, as always, is subject to emerging financial constraints, full support from all other areas of the Trust, effective prioritisation and timely production and approval of good business cases. The Technical Delivery Board plays a major role in prioritising investment and monitoring progress on projects, reporting through the Capital and Space Planning committee to Management Board.

1.5 Measuring Success

Whilst this strategy contains a complex set of inter-dependent projects, at a high level, success needs to be visible and measurable:

within 1 year:

- Deployment of an Enterprise Architecture which provides common tools and standards for all projects. This will reduce costs and implementation effort;
- Integration of an operational delivery structure (programme office) involving technical delivery, cultural change and transformation;
- Delivery of the linkage between the Information Strategy with close links to the ICT architecture (both technical and enterprise);

within 2 years:

- Approval for the PiMs strategy - replacement or break up;
- Electronic medical records in place;

within 3 years:

- Clinical partners (commissioners, referrers, GPs etc.) and families able to obtain online access to information and systems.

2 Summary

The ICT Strategy must support the delivery of the Trust's strategic objectives. It reflects:

- Needs of patients and families to receive timely, high quality and safe care;
- Needs of clinicians and other staff to do their work efficiently and to have access to high quality information;
- The requirement for a robust IT infrastructure to support the business applications and processes.

The previous version was focussed mainly upon stabilising the existing environment. To this end considerable effort and investment has been put into the network, communications, power supplies, and servers. While not all stabilisation projects are complete, there is now increasing necessity for ICT to attend to the needs of the next layer up which is concerned with the systems required to support the operational needs of the Trust. These needs break into a number of distinct streams:

- Major user systems such as PiMs PAS, PACS, clinical systems;
- Features needed by clinicians and users which are common to most systems;
- Information needs – ensuring that systems and processes are in place to ensure the availability accuracy, security and relevance of data to support the Information needs of the Trust;
- End user computing - user support, helpdesk, training, local information processing, support with desktop tools and report generation;
- Infrastructure – Continued emphasis on increasing stability; laying further foundations and tools to improve efficiency, communication systems.

As always there are limited resources and some difficult decisions need to be made as to which projects should go ahead and which held back. To date such decisions have been made project-by-project. There is now a greater need to understand how resources needed for one project can impact on other areas. It is proposed that projects should be grouped within programmes of work. Clinical representatives will be fully involved in determining the priorities of projects and will take a leading role in the delivery and on-going management of the products that directly affect their day-to-day work.

The long term aim is to ensure that a minimum of 50% of the available ICT budget is spent on systems and processes that support clinical work. The remainder to be spent in roughly equally proportions on corporate systems and infrastructure.

This document is *not* the Information Strategy. Information Strategy is concerned with the creation, communication, management and availability of information within the Trust. It will be developed separately.

3 Progress to Date

3.1 Previous Strategy

The previous version of the ICT Strategy outlined what might be in place by the end of 2013 based around the premise of 3 phases:

- Phase 1 – fix the technical architecture;
- Phase 2 – fix the enterprise architecture;
- Phase 3 – transform the patient experience, and in so doing, the experience of staff at all levels.

Key elements of this include:

- Mobility enabled;
- Stable, available, scalable and high performance infrastructure;
- PACS, RIS and Order Communications;
- Electronic medical record and portals displaying the full electronic patient record becoming a reality;
- For patients, the vision is one where the wireless and portal/kiosk technology would be used to improve patient flow and experience on visits to GOSH.

The following elements of this vision that have been completed:

Stable, available, scalable and high performance infrastructure

- Wired and Wireless Network stabilised, complete re-design and replacement completed which facilitated Electronic Prescribing;
- Complete virtualisation of all of the Trust's servers and new SAN storage system implemented;
- Now moving to Voice over IP and away from analogue phones;
- Major power supply issues in server rooms resolved;
- Refurbishment of communications rooms completed;
- Security: Intrusion prevention, firewall and remote PC/access (e.g. CSA and MARS from Cisco for pan network level security, virus isolation, detection and prevention) in place;
- Various systems hardware upgraded (including PACS, CareVue, GroupWise);
- Lambs Conduit network resilience (microwave link) in place.

Mobility enabled

- Asset tracking (beds, cots, mattresses, wheel chairs, pumps etc.) to average accuracy of 2m in place. Location awareness – *"where is nearest …?"* type questions can now be answered directly;
- Robust, secure and resilient remote access portal accessible anywhere in the world in place;
- Wireless voice communications enabled;
- Network is currently being video enabled (allows collaboration both across GOSH and externally, WebEx meetings, video conferencing, instant messaging).

Whilst the following elements are in progress:

- Electronic ordering/results reporting (Order Communications);
- Electronic Prescribing IV modules;
- Image Exchange Portal link up for PACS;
- Investigate telehealth - remote clinical diagnostics/consultation capability;
- Intranet replacement project;
- Move from GroupWise to Microsoft Exchange email, upgrade to Microsoft Office;
- OneWebsite project – replacement web site;
- PACS/RIS system replacement;
- Safe Surgery system;
- ViewPoint Fœtal system;
- Data migration to new storage technology;
- Mobility project - roll out wireless devices, communications fully working and reliable;
- Video enable network, theatres AV on network;
- Twin server room completion, including remaining server refresh and application virtualisation strategy.

A complete list appears in Appendix B.

3.2 Middleware Discussion

"Middleware" provides the communications layer which lies between user devices, access to the systems, and the underlying systems themselves. This layer (originally conceived as the BPM / SOA programme or the enterprise architecture solution) is an extremely important component of the Trust ICT strategy and its presence or absence has a profound impact on our ability to deliver the Information Strategy.

Whilst considerable progress has been made on delivering the strategy, many key elements cannot be progressed until the strategic direction on middleware is so far resolved.

For example without the middleware tools the following features become very difficult to implement:

- Allowing users to view information from many sources on the same screen without having to log in to a variety of systems;
- Establishing an information bus so that information can be shared between systems;
- Providing a means so that new applications can reuse standard code (rather like applets) without having to write fresh code for each project;
- Allowing delivery of information to a variety of devices, such as mobile phones and PCs, independently of the underlying applications;
- Extending the life of legacy systems;
- Speeding the implementation and availability of new systems;
- Controlling the workflow of processes and procedures;
- Supporting document management.

UCLH is in the process of negotiating a contract with Oracle to install middleware for the purpose of integration and potential wider use, something they are keen to talk to GOSH about. GSTT are developing their systems delivery strategy using similar technologies. Amazon has deployed a similar solution with considerable success.

There are a number of implications if this project is delayed or not followed through:

- Projects will take longer to deliver as reusable code will not be available.
- Separate integration will be required for each project. This adds complexity.
- Some projects (and thus Trust objectives) will not be realistically feasible, such as those that require automated workflow.

The timing of the implementation of this technology is critical to the way in which the future infrastructure develops. Bringing the technology in at a later date continues the current silo approach and so will require a number projects to be retro-fitted. A consequence of this is that the priorities of a number of projects within the strategy could change if they are more difficult or expensive to implement.

3.3 Measurability

The previous version of the strategy placed great importance on the ability to measure progress. ICT is now reporting many key performance indicators to the Management Board and benchmarking performance against the NHS Infrastructure Maturity Model (NIMM). The updated view of our NIMM rating is shown below.

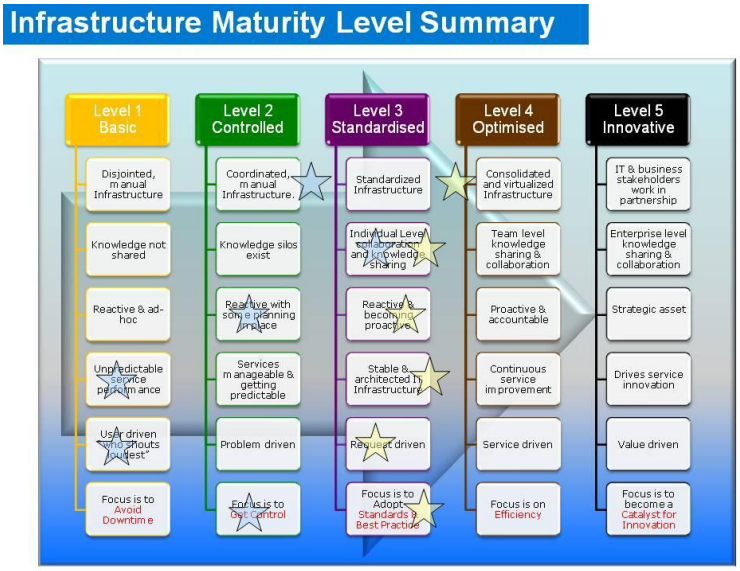


Figure 1 - Infrastructure Maturity Level Summary

Blue stars show our original rating of average 1.9, Yellow stars our current average 3.2:

A snapshot of the key performance indicators reported to management board indicates:

- Network availability > 99.999% over last 12 months;
- Key application availability 97.3% since first reported 5 months ago;
- Key server availability 99.25% since first reported 5 months ago.

Server and application availability as well as service will be key priorities for improvement moving forwards. Availability can improve further, but is only part of the story when considering service quality. New ways need to be devised to measure and transparently report service quality.

4 Vision for the Future

4.1 Guiding principles

The guiding principles for the ICT vision are:

Improving the patient experience

- To work with clinical and other staff to deliver the best solutions available to support patients and our wider community (referrers, commissioners, clinical networks and others we need to exchange information with);
- To deploy a solid foundation upon which reliable clinical, patient, and business applications can depend;
- To facilitate the timely collection of data and provision of quality information. To provide the necessary ICT so that information can be accessible, relevant, portable, and shareable wherever required.

Ensuring an effective infrastructure to support further system development

- To ensure there is flexibility and agility within the ICT strategy to ensure the Trust can exploit emerging opportunities safely and effectively;
- To use industry standard packages and interfaces; and to avoid bespoke systems wherever possible;
- To facilitate the timely collection of data and provision of quality information. To provide the necessary ICT so that information can be accessible, relevant, portable, shareable wherever required;
- To deploy a common middleware layer to transparently manage communications between user interfaces and data stores and applications (subject to the middleware layer decision);
- To focus on interoperability and integration rather than replacement (also subject to the middleware layer decision).

Increasing staff skills

- To promote and support the development of IT related skills.

Using good governance

- To use standard programme and project management methodologies (MSP and Prince2) across the Trust – for (nearly) all projects (even those which might not be ICT led);
- To review the governance of clinical projects, with ICT input, so that the clinical and patient priorities are fully considered, including process design, transformation, and staff training.

Links to other strategies

- To liaise closely with; the Information Team to ensure that the direction of the ICT strategy is closely aligned with the information needs of the organisation; the Trust Transformation Team to ensure that service improvement initiatives are carried out in a safe and sustainable manner; and to adhere to Trust strategic direction and wider policy directives.

To achieve all the above in the most cost effective and innovative way possible.

4.2 Programmes and Projects

Projects will be grouped into programmes with each programme leader ensuring proper ownership and embedding of cultural change required. While the number of programmes will vary form time to time, the initial suggestions are listed below. Many projects impact multiple programmes. For simplicity projects are listed under the programme that they primarily impact, but are marked to indicate wider impact.

The programmes are:

- GOSH Communities: projects related to collecting and providing information to staff, GPs, PCTs, families, and others who need to keep in touch;
- Information Management: projects related to the collection, provision and display of information required by the Trust (contributes to the pending Information Strategy;
- Operations: projects related to changing the way the hospital operates (be that the way that technology supports everyday tasks, eases the working day and automates tasks reducing administrative overhead;
- Governance: projects relating to ensuring the proper use of information.

The full list of projects appears in Appendix A. These are in a draft order of priorities.

4.2.1 GOSH Community Programme

Feature	Information Management	Operations	Governance
The web will become the place you want to work. You can configure your own web portal to your own look and feel, using all available resources.	-	✓	-
Multi-disciplinary team reviews are enabled through video technology. Technology to enable collaborative sharing with partners is easy and accessible for everyone.	-	✓	-
The external web site and our intranet will be transformed to have the same look, feel and potential access to information. Access to information will depend on the consumer – clinician, GP, patient, family member, member of the public etc.	-	✓	-
Working across UCL Partners will increasingly be facilitated by shared systems and or data, with remote access allowing seamless operation regardless of site.	-	✓	-
Clinical networks will be supported at all levels (both locally and through UCL Partners) to enable use of common systems and thus access to data. GOSH has invested heavily in its infrastructure and is thus now in apposition to put itself at the centre of many of these networks, helping to coordinate and provide services.	-	✓	-
Methods for handling as many administration tasks as possible (e.g. consent, referral management) online will be implemented to smooth the process of the engaging with GOSH, including the ability to transfer information such as images.	-	✓	-
Our systems will increasingly integrate with our partners, PCTs (GP Consortia as will be), GPs allowing two way access as appropriate. For example, a request fro a list of images for a patient will include those held and shared with us by our partners.	-	-	-
Patients and families or GPs will be able to use the web site to securely enter relevant information directly (no need for multiple forms on admission).	-	✓	-

The electronic Trust, coupled with advanced mobility, will make the best use possible of mobiles owned by patients, welcoming them in approach to the Trust (when they enter an adjacent cell) and informing them (map to complete their journey, how and where to register etc.).	-	✓	-
Guest access to the wireless network will be enabled and structures to allow instant messaging, audio and video calls (for example from patient hotel to bedside) to be available to our patients and their families.	-	-	-
Visits to GOSH will be transformed using tokens (that can be used to call you back to clinic just in time), and/or messaging with patient mobiles (as you approach the hospital, a text message appears welcoming you and telling you where to find information as you arrive), kiosk technology (that already exists in the market place) will be used across the campus to help patients with way finding, general information and booking activities etc. Location awareness technologies will allow the tokens carried to track where patients are and used with the kiosks to give intelligent directions.	-	-	-
Working with our partners in the clinical network, encourage the sharing of and easy access to comparative results (graphics and tables updated in as close to real time as possible at first, moving to real time eventually with data from GOSH and partners across the network).	-	✓	-
Patient participation will be encouraged via the web site or secure area, where experiences can be discussed and patients who have been through procedures can help put at rest or ease the minds of prospective patients.	✓	-	-

4.2.2 Information Management Programme

Feature	GOSH Communities	Operations	Governance
Information on outcomes will be available by secure links for patient specific data or openly available on the web site for general information and openness.	-	✓	✓
Just as in ICT, there will be configurable digital signage units across the Trust displaying key performance data, live patient status, CEWS scores etc. The dashboards will be able to be displayed on any screen in the Trust, be it dedicated or PC, mobile device.	-	✓	✓
Care pathway information will be prepared and published giving patients some indication of what to expect – where I will be treated, who the specialist treating me will be, how the procedure will be carried out and an indication of previous results.	-	-	-
Where appropriate and consented, high definition cameras will be use to record activity. Uses for this include training and legal.	-	✓	✓
Any information gathered, be it data, image, audio will be available across the Trust on demand, with an investigation into how DICOM images can be viewed locally.	-	-	-
Communication between clinical and finance systems and the creation of a patient level costing capability will make staff more aware of the cost of their choices, driving efficiency.	-	✓	-

4.2.3 Operations Programme

Feature	GOSH Communities	Information	Governance
The new reality will be the 'Hospital in your hand', where the device of your choice gives you access to what you need from anywhere. A handheld device will allow you to use instant messaging, audio or video calls across the Trust to consult with others without having to leave your desk or the patient.	-	✓	-
The wireless network is used for calls eliminating mobile phone reception problems and cutting cost. Presence technology shows where people are, and if they are available or busy, in real time simplifying administration. The device of your choice can be used.	-	✓	-
Out-dated bleep and pager systems are phased out. Your phone, video camera, bleep, email and pager converge to an integrated system.	-	-	-
Trust wide scheduling system that has the capability to schedule anything (people, rooms including theatres, equipment, consumables, appointments, beds etc.) This will need to be put in place alongside a more sophisticated Integration Engine that is able to provide data exchanges between systems and may require some procurements, developments, or replacements of systems.	-	✓	-
The journey to a near paperless environment will be completed – the key project in this respect being the electronic medical record	-	✓	✓
Bed management - the joining together of a number of processes and information capture to present a current and planned view of the bed state of the hospital. The project is likely to provide an incremental approach to developing a programme of small projects that will lead to the required levels of data capture and data presentation required to provide a full bed management solution. It will require the correct tools to be in place to allow capture, effective recording and retrieval - enterprise architecture tools.	-	✓	-
eLearning will become the norm and mobility will enable teaching to occur at the point of need, including at the bed side.	-	✓	-
Audio and video recording will be available Trust wide, with the output able to be stored for the patient record and re-used for training.	-	✓	-
Video conferencing will be available, real time, without having to call for ICT assistance.	-	✓	-
Using NerveCentre and our asset tracking capability, there will be wide spread use of our ability to use location awareness and tracking to our benefit. Answering the question *"Where is my nearest free porter?"* will be simple and immediate. Crash calls will be transformed, with the team on call easily able to respond to location based alerts – with the nearest available staff responding.	-	✓	-
The electronic medical record will be shared across the network. It will be accessed for review and data entry (e.g. anyone on cytotoxic drugs who has bloods checked remotely, but whose dose needs to be manipulated by GOS staff). Web based action could prevent an unnecessary visit to hospital for just a dose change.	-	✓	✓
Across the site, follow me printing allows you to print a document, walk to the nearest printer, key in a code and have the document printed there and then.	-	-	✓
There will be unrestricted and fast access to all medical journals and registry data.	-	✓	-
Meetings could become paper free, using collaboration technology (ability to share desktops and work together) to share documents real time, working on	-	✓	✓

a single copy, annotating or editing, but retaining control and eliminating version control issues. All users sharing the document can see the changes in real time, regardless of where they are in the world.			
GOSH will have its own conference call scheduling system and web-ex capability, allowing external parties or those off site to join in calls using what ever mode appropriate at the time. This will be simple to setup and operate by end users, with links able to be sent to all parties by email to make joining the call simple.	-	-	-
Digital dictation and voice recognition will become widely used across the Trust, eliminating the need for transcription.	-	✓	✓
Systems and information will be accessible from anywhere in the world using the new robust and resilient remote access now in place, so long as a good internet connection is possible. Secure sessions will allow those with GOSH owned and encrypted devices full access as if they were at their desk. Staff who work regularly at other sites (be that UCL Partners, ICH or further afield) will have access to the information they need using an appropriate device, from where ever they are.	-	✓	✓
Audio visual capabilities in theatres will be linked to the network, allowing clinicians to have lossless and real time video and audio connections from their desk with live theatre sessions.	-	✓	-
Just as there will be a single electronic medical record, there must be a single electronic human resource record across the Trust.	-	✓	✓

4.2.4 Governance Programme

Feature	GOSH Communities	Information	Operations
With an increasingly electronic Trust, research how our existing and new systems can be combined to create a timeline of events. This requires a holistic approach, an architectural solution that provides the structure to allow that level of rigor. The Trust deferral of a decision on architecture will delay this.	-	✓	-

4.3 Alignment to Trust objectives

The original strategy was aligned with Trust objectives. The objectives have not changed and so the vision in this revised strategy has only altered in small ways.

However it should be observed that ICT strategy is not always dependent upon Trust goals: sometimes changes in technology can help shape new goals. Perhaps the question to be asked might also be *"How does the IT strategy enable the Trust to advance on fronts not otherwise envisaged?".* Clearly the vision must be:

- Cost effective
- Deliver the service
- Offer best value
- Involve minimal effort and risk

The Trust objective specific to ICT is as follows:

> *"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 systems".*

4.4 Alignment to External Factors

The following external factors have been considered:

- Liberating the NHS: An Information revolution (DoH)
- Health Without Boundaries (2020Health)
- Fixing the NHS (2020Health)
- Commissioning influences seeking to enable more treatment at home and more collaboration between providers which need shared patient records and telemedicine
- A commoditised view of ICT.

4.5 Alignment to an Information Strategy

The Trust Information Strategy is concerned with the creation, communication, management and availability of information within the Trust, to the wider Healthcare community and to current and future patients and their carers. It needs to examine both management information and the management of information to support clinical care.

In order to support this vision an information strategy is required which promotes an information culture and ensures Trust wide acceptance of the importance of information and information provision by:

- Widening access to information and encouraging the sharing of both clinical & management information, teaching materials and good practice;
- Defining the principles of good information management and encourage staff to work towards implementing these principles.

4.5.1 Major User Systems

Key to any decisions around the strategy is the result of the on-going iSoft7 negotiation determining the future of our PiMs PAS system. That negotiation is nearing completing with the result that:

- We will remain in the iSoft7 for now.
- We will have a perpetual, irrevocable license for the use of PiMs provided that a support and maintenance contract exists and is paid for.
- The agreement gives us a minimum 5 year extension to our use of PiMs.

Along with other Trusts that have been consulted, there is a view that there should be no reason for GOSH to have to replace PiMs, if the functionality can be broken into services, and an enterprise level scheduling engine procured. A full options appraisal will be required to resolve this issue, which can take place at TDB.

In addition to PiMs, other major user systems include PACS/RIS (currently the subject of a replacement project), Order communications (currently being introduced), Pathology, Cardiology (which is currently undergoing infrastructure changes to allow cardiology images to be displayed in theatres) and Pharmacy (with on-going work to electronic prescribing).

4.5.2 Features common to most systems

A number of requests by clinicians and users are common across systems. Typically these are to:

- Remove paper wherever possible, making documents available online;
- Deliver information, electronic or otherwise, to the right place in a timely manner;

- Enable reliable and flexible communications;
- Enable mobility through the connection of many devices and anywhere;
- Improve means of communicating with patients, families, GPs, referrers, UCLP etc.

Recent developments in technology now make it much more possible to achieve these requirements.

GOSH already has a flexible and robust remote access capability that enables clinicians to access GOSH systems from anywhere in the world. What will increasingly happen is that both new and existing systems will become available via this remote access portal. The GOSH Virtual Desktop (GVD) is already available via remote access and more applications will become available remotely as they are added to the GVD. With a GOSH owned and encrypted laptop, not only do staff have access to systems, but also network drives, enabling them to operate as if in the office, from where ever they are in the world, so long as they have access to the internet.

Whereas the tables above group the vision statements by programme, Appendix A seeks to prioritise them based on (in order of priority) Patient Journey, GOSH Communities, Clinical, Information, Operations, Organisation, Training, ICT and Infrastructure. Other factors are also important, such as cost, effort, availability of the technology, etc.

One of the first tasks is to confirm that this wish list is complete and what users want; and to agree the best means for prioritising the list. ICT can then work with the user sponsors to develop a business case and take the project forward.

4.5.3 End User Computing and Infrastructure

It is recognised that end users require more control and choice over their operating environment. ICT aims to provide that flexibility. This will require on-going investment in infrastructure as well as investment in training for those technologies that are new, or end users who are less confident with information technology. Support will also be provided by the information team to help users extract information (e.g. using SQL) from the main systems so that users can merge this with their own data for further research. In addition, the following will need to be considered:

- Training – increase the level of basic computer skills as well as skills levels in individual systems;
- eLearning – to help new staff as well as small self-help modules to help existing staff at the moment of need;
- Automatic provisioning of new staff – access to systems is allowed automatically once eLearning modules for that system have been taken and tests passed – no pass, no access (we would not want to condone unsafe practice) with an alert raised for individual help from a tutor;
- A real partnership between Transformation and ICT can also yield high value results. Transformation has a track record of successful communication, and has invested a lot in brand and image, something that ICT has not been able to do. Working together on a two way flow of ideas and skills will benefit the wider organisation.

5 Enabling the Vision

5.1 Summary

For users to take full advantage of new technology there are a number of necessary conditions:

- ICT must be able to deliver the technical solutions;
- Users must transform their old processes into new processes to make optimum use of the new technology;
- The information users require must be available;
- Staff must be willing to own the new solution from the outset and learn how to embrace the tools;
- Senior managers must welcome and support the changes.

Without each of these elements in place a project has a high chance of failure and Trust resources will have been wasted.

In the past delivery of an ICT solution did not always result in a successful outcome, or take up may have taken longer than planned. The lesson learnt is simple - user ownership, not just engagement, throughout the life of any project is the key to success.

ICT can only deliver the first of these points. At present the organisational structure is not sufficiently in place to support users with the remaining four points.

The remainder of this section discusses possible ways to ensure that a high success rate is achieved for Trust projects.

5.2 Constraints to the Strategy

Current technical environment / architecture

- Enables rigid single system views whereas we need flexibility e.g. Sentillion vs. compound portal/web page type operation;
- Silos of data and function e.g. 500+ databases and spread sheets vs. single clinical data repository;
- Prevents joining up of data within a patient journey e.g. some sharing of data but no assistance in assuring service delivery;
- Connectivity to external systems / organisations limited e.g. push technologies (data sharing) rather than pull technologies will allows external access to single version of truth.

Current information environment

- Fragmented and duplicated as held in functional silos e.g. same data collected many times. No consistency of data structure / format held in local systems that prevents sharing;
- No clear single version of the truth. e.g. No master data management, how do you know which system has the right answer e.g. list of consultants;
- Management of data quality fragmented and of variable performance e.g. numbers and quality of data managers variable.

5.3 Mind the Gap

Visible change has been made and is still in progress, with the deployment of tracking, new telephony solutions, video capability and large scale projects in progress for Order Communications and Picture Archiving and Communication System and Radiology Information System. Substantial parts of the technical architecture are now in place.

The Strategy now needs to shift focus from deploying infrastructure elements of the technical architecture, and focus far more on the services side, transforming the patient and staff experience, as well as delivering the promises made to clinicians, nursing and other staff across the Trust.

The original strategy was:

- Phase 1 – to fix the technical architecture;
- Phase 2 – to fix the enterprise architecture;
- Phase 3 – to transform the patient experience, and in so doing, the experience of staff at all levels.

Phase 1 is nearing completion. Phase 3 is largely dependent on Phase 2.

To complete Phase 2 a number of enterprise architecture tools are required to link the various systems, information and process rules to the user interface. These tools have not yet been approved.

The vision is far reaching, but without the tools to fill the gap in the middle, ICT will not be able to deliver a substantial part of the technology required by users. The vision will not be realisable nor sustainable in its present form.

The following diagram explains how these all fit together:

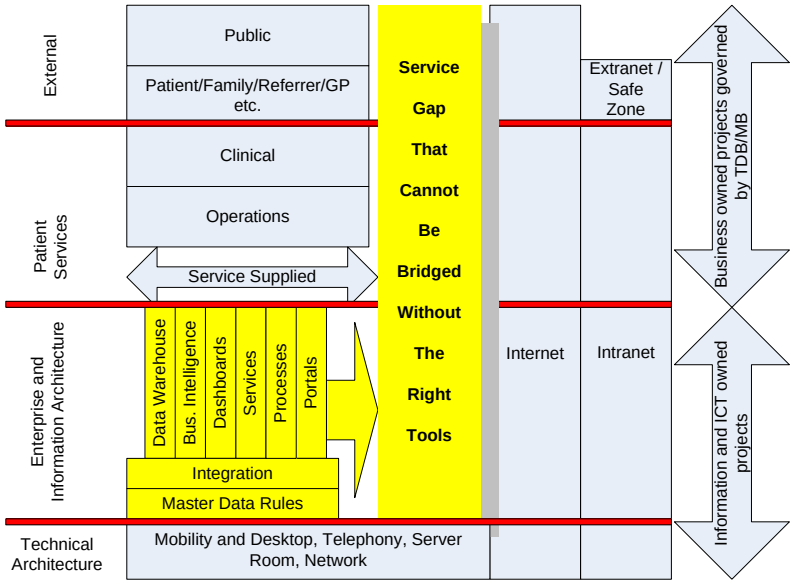


Figure 2 - The ICT Jigsaw

6 Governance and Partnerships

6.1 Governance

In the sense of managing information systems within the Trust, governance is defined to be the capability of safeguarding the Trust so that ICT activities are carried out in an orderly, safe and ethical way. It extends to all processes, systems, controls, and administration.

Good governance will clarify the various relationships and responsibilities involved in systems projects, including any contact within (clinical and administrative staff) and outside the Trust (partners and suppliers). It also defines the acceptable levels of risk and finance for each activity.

The present governance structure for ICT is defined by the following diagram:

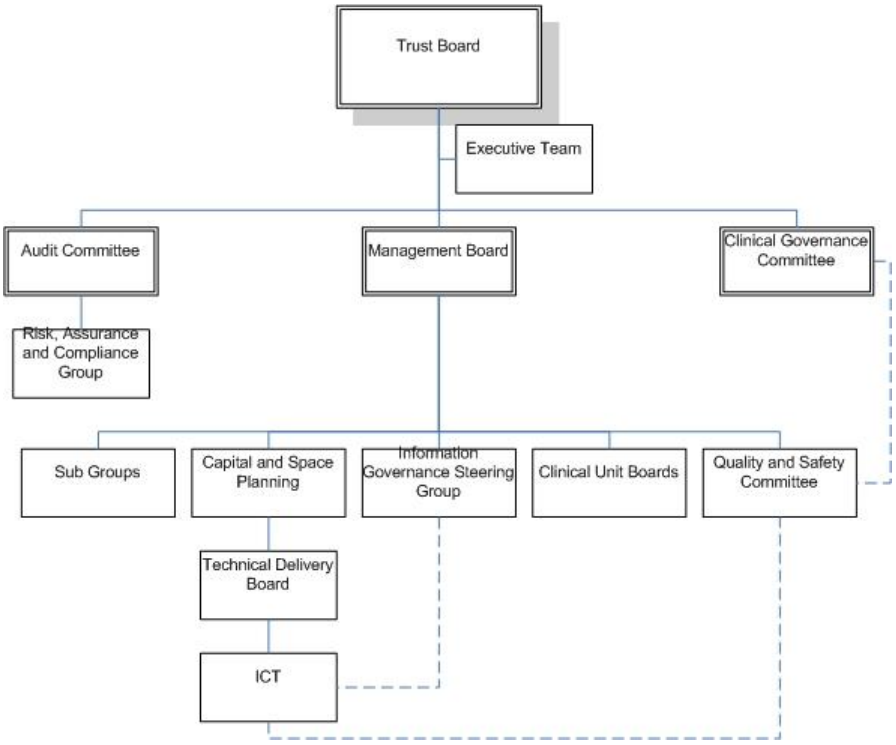


Figure 3 - Governance Structure.

Should the reader be interested in getting involved with ICT projects or finding out more about the governance and priorities of ICT, the CFO chairs TDB and should be the first point of contact.

6.2 Partnerships

ICT is a department in the Trust that deals with many technical and service issues. The ICT management team attends various clinical unit meetings and occasionally the General Clinical Medical Committee.

ICT is just one of the teams working across the Trust to support staff and bring about change that enhances the service delivered to patients, as do other teams that exist.

The governance structure ensures wide consideration and acceptance of ICT projects. It is important that ICT makes every effort to engage with groups across the hospital, both directly and using whatever structures already exist.

With multiple teams engaged in a variety of communication exercises, it is important that ICT partners appropriately to ensure a joined up approach and consistency of message. To this end, ICT will work closely with:

Information	to ensure that the right tools and supporting infrastructure is in place to support the creation, communication, management and availability of Information wherever and whenever required
Transformation	A two way partnership that both spreads a joint message as well as gathering feedback and requirements , supporting Trust wide in-depth transformation
GMSC / Clinical Units	to keep all staff fully informed of progress and time scales, allowing direct consultant input to the on-going delivery of the strategy
External	UCL Partners, Clinical Networks etc. to ensure GOSH at the centre of developments
COO / GM's	To ensure that corporate requirements are being included
Press Office	To help create and implement a communications plan

6.3 Improving Communication

As well as working closely with the above partners, ICT/Information will use all available methods to publicise the work that it does, including but not limited to:

- Participating in clinical unit meetings;
- Regular 1:2:1 meetings with all General Managers;
- Quarterly attendance and participation at the General Medical and Safety Committee;
- Monthly attendance and participation at the COOs GM meeting;
- Attendance at Transformation Board;
- Production of booklet explaining ICT Strategy in plain English;
- Monthly progress update sheet for the above forums;
- Articles in Roundabout;
- Customer satisfaction surveys sampling a percentage of calls, results openly communicated;
- Attendance at external events, presenting where possible, to spread the word about the accomplishments at GOSH.

7 Risks, Costs

7.1 Risks

Each programme and project will have its own risk register and issues log. The following are high level risks to the ICT Strategy itself:

- Lack of a clear understanding of the ICT strategy by all at a senior level; doubts, or lack of commitment to the strategy;
- Lack of involvement and commitment to change management and implementation of new systems;
- Lack of operational ownership by users, especially of cultural change and working practices issues;
- Poor process compliance – staff not following practices explained in training; staff reverting to local practices;
- Poor management of expectations – adopting a strategic solution may not necessarily deliver the exact needs of all stakeholders. It may be necessary to accept a 'fit for purpose' solution which benefits the Trust as a whole;
- Lack of firm executive or management support to users and ICT, compromising the standards intended to benefit the Trust by permitting local practices;
- Lack of the understanding of strategic implications. Failing to bear in mind the strategic implications as it affects, or is affected by, each small project;
- Forgetting that the long journey is made up of a number of interdependent steps, collectively intended to deliver results over 3 years;
- Failure to procure middleware – a key decision upon which this strategy depends. If not resolved time lines will slip and capital investment requirement may increase in the long term;
- Lack of agility - Operational imperatives from time to time may complicate the delivery of the strategy – The ICT strategy will need to sufficiently agile to encompass change required within or imposed from without the organisation;
- Lack of capital and revenue to fund the programme
- Lack of resource either directly employed or via Managed Services;
- Availability of applications and technology in the marketplace to match our time scales.

7.2 Costs

The existing 3 year capital plan proposes capital expenditure in the following proportions:

- Clinical systems: not less than 50%.
- Corporate systems: increasing to 25%.
- Infrastructure systems: decreasing to 25%.

As can be seen, the main focus is very much on clinical systems, outside of the funds required to purchase the enterprise architecture, (thought to be in the region of £2.6m plus implementation costs for the services toolkit, not involving BPM implementation till a later date). To a degree, the cost of the infrastructure is non-discretionary expenditure to keep the lights on. More detail can be found in Appendix C.

A. Three Year Vision Matrix

Note: Timescales yet to be reviewed.

The following table shows the vision statements sorted in the order of impact to various factors. The order of importance has been set to be the first 8 columns from left to right, starting with patients' communities and ending with ICT Infrastructure. The rationale is that any project that is purely about ICT Infrastructure with no benefit to patients, clinicians or corporate users would be the lowest priority).

Patient Journey	GOSH Communities	Clinical	Information	Operations	Organisation	Training	ICT and Infrastructure	3 Year Vision Matrix (still under review)	Infrastructure Ready	Organisation Ready	Delivery
√	√	√	√	√	√	√	√	The new reality will be the 'Hospital in your hand', where the device of your choice gives you access to what you need from anywhere. A handheld device will allow you to use instant messaging, audio or video calls across the Trust to consult with others without having to leave your desk or the patient.	12	18	24
√	√	√	√	√	√	√	√	The web will become the place you want to work. You can configure your own web portal to your own look and feel, using all available resources.	6	24	36
√	√	√	√	√	√	√	√	The wireless network is used for calls eliminating mobile phone reception problems and cutting cost. Presence technology shows where people are, and if they are available or busy, in real time simplifying administration. The device of your choice can be used.	3	9	18
√	√	√	√	√	√	√	√	Outdated bleep and pager systems are phased out. Your phone, video camera, bleep, email and pager converge to an integrated system.	3	9	12
√	√	√	√	√	√	√	√	Trust wide scheduling system that has the capability to schedule anything (people, rooms including theatres, equipment, consumables, appointments, beds etc.) This will need to be put in place alongside a more sophisticated Integration Engine that is able to provide data exchanges between systems and may require some procurements, developments, or replacements of systems.	3	9	18

√	√	√	√	√	√	√	√	Multi disciplinary team reviews are enabled through video technology. Technology to enable collaborative sharing with partners is easy and accessible for everyone.	3	9	12
√	√	√	√	√	√	√	√	The external web site and our intranet will be transformed to have the same look, feel and potential access to information. Access to information will depend on the consumer – clinician, GP, patient, family member, enquiring member of the public etc.	6	9	9
√	√	√	√	√	√	√	√	The journey to a near paperless environment will be completed – the key project in this respect being the electronic medical record.	12	24	48
√	√	√	√	√	√	√	√	Determine master data management needs and minimum dataset requirements of all units based on the needs for outcome monitoring. This needs sophisticated coding maps, not just ICD10 or OPCS 4, but what the specialist teams actually use, and mapped as required. The minimum dataset will, with correct coding, create a live outcomes map, especially if linked to mortality tracking through ONS and with OPD data across our network.	24	36	48
√	√	√	√	√	√	√	√	There will be central storage for data, using specialist search engines coupled with the new intranet to give open and easy access to the wealth of information that currently exists but is unavailable to a wider audience. This will include working with UCLP to have a shared resource for eLearning etc.	12	24	24
√	√	√	√	√	√	√	√	Bed management - the joining together of a number of processes and information capture to present a current and planned view of the bed state of the hospital. The project is likely to provide an incremental approach to developing a programme of small projects that will lead to the required levels of data capture and data presentation required to provide a full bed management solution. It will require the correct tools to be in place to allow capture, effective recording and retrieval - enterprise architecture tools.	12	18	24
√	√	√	√	√	√	√	√	Working across UCL Partners will increasingly be facilitated by shared systems or data, with remote access allowing seamless operation regardless of site.	12	12	18
√	√	√	√	√	√	√	√	eLearning will become the norm and mobility will enable teaching to occur at the point of need, including at the bed side	6	9	12
√	√	√	√	√	√	√	√	Video conferencing will be available, real time, without having to call for ICT assistance	6	6	12
√	√	√	√	√	√	√	√	Audio and video recording will be available Trust wide, with the output able to be stored for the patient record and re-used for training	6	12	12
√	√	√	√	√	√	√	√	Follow up data will be recorded for outcomes monitoring. Data collected will be able to be aggregated in different ways to allow full analysis.	12	24	24
√	√	√	√	√				Our systems will increasingly integrate with our partners, PCTs (GP Consortia as will be), GPs allowing two way access as appropriate. For example, a request fro a list of images for a patient will include those held and shared with us by our partners.	12	24	24

√	√	√	√	√				Using NerveCentre and our asset tracking capability, there will be wide spread use of our ability to use location awareness and tracking to our benefit. Answering the question 'Where is my nearest free porter?' will be simple and immediate. Crash calls will be transformed, with the team on call easily able to respond to location based alerts – with the nearest available staff responding.	3	12	24
√	√	√	√	√				Clinical networks will be supported at all levels (both locally and through UCL Partners) to enable use of common systems and thus access to data. GOSH has invested heavily in its infrastructure and is thus now in apposition to put itself at the centre of many of these networks, helping to coordinate and provide services.	6	36	36
√	√	√	√	√				Methods for handling as many administration tasks as possible (for example, consent, referral management) online will be implemented to smooth the process of the engaging with GOSH, including the ability to transfer information such as images etc.	9	24	24
√	√	√	√	√				Patients and families or GPs will be able to use the web site to securely enter relevant information directly (no need for multiple forms on admission)	9	24	24
√	√	√	√	√				Information on outcomes will be available by secure links for patient specific data or openly available on the web site for general information and openness.	9	24	24
√	√	√	√	√				Just as in ICT, there will be configurable digital signage units across the Trust displaying key performance data, live patient status, CEWS scores etc. The dashboards will be able to be displayed on any screen in the Trust, be it dedicated or PC, mobile device.	6	24	24
√	√	√	√	√				The electronic Trust, coupled with advanced mobility, will make the best use possible of mobiles owned by patients, welcoming them in approach to the Trust (when they enter an adjacent cell) and informing them (map to complete their journey, how and where to register etc.).	12	12	18
√	√	√	√	√				Care pathway information will be prepared and published giving patients some indication of what to expect – where I will be treated, who the specialist treating me will be, how the procedure will be carried out and an indication of previous results.	12	12	18
		√	√	√	√	√	√	The electronic medical record will be shared across the network. It will be accessed for review and data entry (e.g. anyone on cytotoxic drugs who has bloods checked remotely, but whose dose needs to be manipulated by GOS staff). Web based action could prevent an unnecessary visit to hospital for just a dose change.	12	24	36
√	√	√		√	√		√	Across the site, follow me printing allows you to print a document, walk to the nearest printer, key in a code and have the document printed there and then.	12	24	24
√	√	√		√			√	Guest access to the wireless network will be enabled and structures to allow instant messaging, audio and video calls (for example from patient hotel to bedside) to be available to our patients and their families.	3	6	9

√		√	√			√		There will be unrestricted and fast access to all medical journals and registry data.	3	3	3
		√	√	√	√	√		Meetings could become paper free, using collaboration technology (ability to share desktops and work together) to share documents real time, working on a single copy, annotating or editing, but retaining control and eliminating version control issues. All users sharing the document can see the changes in real time, regardless of where they are in the world.	3	18	24
√		√	√	√		√		Where appropriate and consented, high definition cameras will be use to record activity. Uses for this include training and legal.	6	12	12
√		√	√	√		√		With an increasingly electronic Trust, research how our existing and new systems can be combined to create a timeline of events. This requires a holistic approach, an architectural solution that provides the structure to allow that level of rigor. The Trust deferral of a decision on architecture will delay this.	12	24	36
√	√	√		√				Visits to GOSH will be transformed using tokens (that can be used to call you back to clinic just in time), and/or messaging with patient mobiles (as you approach the hospital, a text message appears welcoming you and telling you where to find information as you arrive), kiosk technology (that already exists in the market place) will be used across the campus to help patients with way finding, general information and booking activities etc. Location awareness technologies will allow the tokens carried to track where patients are and used with the kiosks to give intelligent directions.	12	18	24
		√	√	√	√	√	√	GOSH will have its own conference call scheduling system and web-ex capability, allowing external parties or those off site to join in calls using what ever mode appropriate at the time. This will be simple to setup and operate by end users, with links able to be sent to all parties by email to make joining the call simple.	3	6	6
	√	√	√	√		√		Working with our partners in the clinical network, encourage the sharing of and easy access to comparative results (graphics and tables updated in as close to real time as possible at first, moving to real time eventually with data from GOSH and partners across the network)	12	24	36
		√	√	√	√			Digital dictation and voice recognition will become widely used across the Trust, eliminating the need for transcription.	9	12	12
√	√	√						Patient participation will be encouraged via the web site or secure area, where experiences can be discussed and patients who have been through procedures can help put at rest or ease the minds of prospective patients.	12	24	24
		√	√	√	√	√	√	Any information gathered, be it data, image, audio will be available across the Trust on demand, with an investigation into how DICOM images can be viewed locally.	6	24	24

		√	√	√		√	√	Systems and information will be accessible from anywhere in the world using the new robust and resilient remote access now in place, so long as a good internet connection is possible. Secure sessions will allow those with GOSH owned and encrypted devices full access as if they were at their desk. Staff who work regularly at other sites (be that UCL Partners, ICH or further afield) will have access to the information they need using an appropriate device, from where ever they are.	3	3	3
		√	√	√		√		Audio visual capabilities in theatres will be linked to the network, allowing clinicians to have lossless and real time video and audio connections from their desk with live theatre sessions.	6	12	18
		√	√	√		√		Just as there will be a single electronic medical record, there must be a single electronic human resource record across the Trust.	12	12	24
		√	√	√				Communication between clinical and finance systems and the creation of a patient level costing capability will make staff more aware of the cost of their choices, driving efficiency.	3	18	24

B. Clinical and Infrastructure Projects

Completed:

Clinical

- Decontamination laser marking equipment
- HACCP temperature monitoring system
- NHS Number in all correspondence and across all systems
- Instrument tracking for vCJD
- Pulmonary Hypertension database (GOSH contribution)
- Patient wrist bands with barcodes and NHS number
- Asset tracking (beds, cots, mattresses, wheel chairs, pumps etc.) to great accuracy
- CareVue workstations replaced
- PACS hardware upgrades

Corporate

- Finance GL Upgrade
- Fully defined RA process with HR/ICT engaged
- Data Warehouse server upgrade

Infrastructure

- Encryption for Windows laptops and MACs, issued encrypted data pens
- Consolidate/renew support contracts (network in particular).
- Enterprise Architect review of Business Process Management and Service Oriented Architecture and technical architecture
- Extended Key Performance Indicators reported to Management Board
- ICT monitoring systems (Solar Winds, MARS, WUG etc.)
- ICT helpdesk software replaced
- Lambs Conduit network resilience (microwave link)
- Power issues in server rooms
- Refurbishment of communications rooms
- Remote PC monitoring and automated upgrade distribution
- Robust, secure and resilient remote access portal accessible anywhere in the world
- Security: Intrusion prevention, firewall and remote PC/access (e.g. CSA and MARS from Cisco for pan network level security, virus isolation, detection and prevention)
- Server virtualisation
- Standards training programme in place (Prince 2, ITIL)
- Storage solution
- Strategic partners identified and partnerships running.
- Wired/wireless network stabilisation, re-design and replacement

In Progress:

Clinical

- Allied Health Professional mobility project
- Cardiac information system consolidation
- CareVue software replacement project.
- Clinical documents database
- CDS extracts
- Electronic Document Transfer (discharges and other documents)
- Electronic ordering/results reporting (Order Communications)
- Electronic Prescribing IV modules
- Image Exchange Portal link up for PACS
- Investigate telehealth - remote clinical diagnostics/consultation capability.
- iSoft7 negotiations completed successfully
- NEON replacement project
- NEON replacement project
- PACS system replacement
- Safe Surgery system
- ViewPoint Fœtal system

Corporate

- Intranet replacement project
- OneWebsite project

Infrastructure

- GOSH Virtual Desktop project
- Move from GroupWise to Microsoft Exchange email
- Data migration to new storage technology
- Security and virus containment
- Mobility project - roll out wireless devices, communications fully working and reliable
- Move fully to Voice over IP including wireless handsets for bleep/pager replacement
- Removal of Novell - migration to 100% windows environment
- Replacement for bleep/pager
- Resolve mobile coverage issues
- Single sign on a reality (have to have removed Novell elements).
- User provisioning, context management development
- Video enable network, theatres AV on network
- Twin server room completion, including remaining server refresh and application virtualisation strategy

C. Three Year Capital Plan

Capital plans are not yet agreed and Charity funding may be requested to fund certain projects.

Clinical Systems	Funding Requested in Year ▶ 11/12 Priority ▼	5,000,000	Funding Requested in Year ▶ 12/13 Priority ▼	3,000,000	Funding Requested in Year ▶ 13/14 Priority ▼	3,000,000
CareVue	1	230,000				
Clinical Document Constructor - **from last year**	1	210,000				
Clinical Documents Database - **from last year**	1	50,000	1	50,000	1	50,000
Clinical mobility - portable wireless devices	2	300,000				
CRS Mandatory Core - **from last year** (commitments to iSoft7 funding)	1	87,000				
Databases (required if no middleware)	1	300,000	1	300,000		
Database consolidation/integration (required if no middleware)	1	60,000	1	60,000	1	60,000
Digital Dictation/Voice Recognition	2	70,000	2	70,000		
Electronic Medical Record	1	50,000	1	300,000		
Electronic Patient Record? (bring all electronic data together)	1	50,000	1	300,000	1	300,000
EP - **from last year**	1	45,000				
EP - IV modules	1	100,000				
Hand Held Clinical Device and decision support system/Clinical mobility (OJEU under way)	1	200,000				
Telemedicine	2	300,000	1	100,000	1	100,000
Implement single sign on and context management - phase 2 - **from last year**	2	50,000	2	50,000	2	50,000
NEON replacement - **from last year**	1	51,300				
Order Communications	1	150,000				
Other clinical advances	3	200,000	1	700,000	1	800,000
PACS	1	2,000,000				
PANDA - **from last year**	1	22,000				
PAS replacement?			1	50,000	1	1,400,000
Patient and clinical portal and suporting infrastructure (not yet worked up)	1	50,000	1	200,000	1	100,000
Patient/familiy mobile devices	2	100,000				
Renal			1	150,000		
Safe Suregery approved last year	1	102,000				
Scheduling system (Trust wide)	1	50,000	1	300,000		
Wireless comms/Mobile devices (wireless, laptops, pads, handhelds etc.) - **Ongoing**	2	100,000	2	100,000	2	100,000
Other clinical systems (-tive means overspend in year)	Unallocated/Contingency	72,700	Unallocated/Contingency	270,000	Unallocated/Contingency	40,000

Corporate Systems	Funding Requested in Year ▶ 11/12 Priority ▼	1,000,000	Funding Requested in Year ▶ 12/13 Priority ▼	1,600,000	Funding Requested in Year ▶ 12/13 Priority ▼	1,600,000
CDS Extracts	1	50,000	1	50,000	1	50,000
eLearning - **Ongoing**	2	50,000	2	50,000	2	50,000
Enterprise/Technical Architecture	1	200,000	1	200,000	1	100,000
ERP system (potential UCLP reuqirement)	2	50,000	2	200,000	2	100,000
Intranet project	1	50,000	1	200,000		
Project Management	1	400,000	1	400,000	1	400,000
Sentillion 'Tap and Go'						
Other corporate systems (-tive means overspend in year)	Unallocated/Contingency	200,000	Unallocated/Contingency	500,000	Unallocated/Contingency	900,000

Infrastructure	Funding Requested in Year ▶ 11/12 Priority ▼	1,200,000	Funding Requested in Year ▶ 12/13 Priority ▼	1,400,000	Funding Requested in Year ▶ 12/13 Priority ▼	1,300,000
Active Navigation (de-duplication)	2	50,000				
Aircon/power/comms room work + UPS - **Ongoing**	1	100,000	1	100,000	1	50,000
Backup/Recovery	1	60,000	1	40,000		
Enterprise Architecture including integration engine	1	0	1	0	1	0
Central storage for data - **Ongoing**		0	1	150,000	1	150,000
Computer room remediaton - **Ongoing**	1	50,000	1	25,000	1	25,000
Email Exchange/AD/Archive	1	240,000	1	120,000		
IT Security and virus containment - **Ongoing**	2	70,000	2	70,000	2	70,000
Network expansion			2	100,000	2	100,000
Phase 2a contingency	1	100,000				
Provisioning	2	100,000	2	45,000		
Server budget (virtual and physical) - **Ongoing**			1	50,000	1	50,000
Sharepoint - **Ongoing**	1	50,000	1	50,000	1	50,000
Swipe access to all comms rooms and server rooms/lock change			2	50,000	1	50,000
Thin client instead of PC replacement (workup yr 1) - **Ongoing**	2	80,000	1	80,000	1	100,000
Tracking projects and RFID devices - **Ongoing**	1	50,000	2	50,000	3	50,000
Unified fabric for virtual platform			2	150,000		
Virtualisation - **Ongoing**	1	50,000	1	50,000	1	50,000
Other infrastructure (-tive means overspend in year)	Unallocated/Contingency	200,000	Unallocated/Contingency	270,000	Unallocated/Contingency	555,000
Total capital requested per year		7,200,000		6,000,000		5,900,000

Key1:

Blue section = Clinical
Purple section = Corporate
Yellow section = Infrastructure

Priority 1 = Must do
Priority 2 = Should do
Priority 3 = Could do

Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting **30th March 2011**	
Title of document **Risk Strategy** **Submitted on behalf of** **Co-Medical Director**	**Paper No: Attachment 6**

Aims / summary

The Risk Strategy is approved annually by Trust Board and outlines the way in which the Trust will identify, manage and mitigate its principle risks to achieving its objectives regardless of source. The strategy reflects the requirements to manage risk regardless of source from unit and department level to Trust Board by means of the reporting and assurance processes in place.

The Trust Board reviewed the Risk Strategy in November 2010 (the blue text highlights the changes presented at that time). Further amendments were requested during this meeting and these are now highlighted in red text. These latter amendments include updates to the committees and responsibilities of doctors and officers and a revised risk appetite statement.

Action required from the meeting

Approval of the Risk Strategy and to ensure it meets the requirements of the Trust going forward to Foundation Status.

Contribution to the delivery of NHS / Trust strategies and plans

Provides the detailed overview of the structure in place, roles and responsibilities, monitoring and reporting processes to be implemented locally to support effective risk management for safety across the organisation.

Financial implications

N/A

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?

Who needs to be told about any decision

The strategy is available to all staff on the document library

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

Unit teams are responsible for ensuring the local management processes for risk reflect the requirements of the Risk Strategy

Who is accountable for the implementation of the proposal / project

Author and date

V Whittaker
Assistant Director, Clinical Governance & Safety
15th November 2010

Great Ormond Street Hospital for Children NHS Trust

Risk Management Strategy

March 2011

Document Control Information

Lead Author	Vivian Whittaker	**Author Position**	Assistant Director Clinical Governance & Safety
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Approved By	Trust Board	**Approver Position**	Designated committee
Read By	Executive Directors		
Ratified by	Trust Board		

Document Owner	V Whittaker	**Document Owner Position**	Assistant Director, Clinical Governance & Safety

Document Version	7.0	**Replaces Version**	6.0
Updated	August 2010		

First Introduced	July 2005	**Review Schedule**	Annual
Date approved/ ratified	November 2008 Updated April 2009 Updated June 2009 Updated August 2009 November 2009 September 2010	**Next Review**	November 2011

Policy Overview

This policy sets out the strategic direction for Great Ormond Street Hospital to systematically manage its risks and underpins the commitment by the Trust Board to ensuring a robust risk management system is in place. This extends across the organisation from the front-line service through to the Board to promote the reduction of clinical and non-clinical risks associated with healthcare and research and to ensure the business continuity of the Trust.

It identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process to provide assurance for the Trust Board review of the strategic organisational risks and the local structures to manage risk in support of this strategy.

The Risk Strategy is integrated into the management, performance monitoring and assurance systems of the Trust to ensure that safety and improvement is embedded in all elements of the Trusts work, partnerships and collaborations and existing service developments. This enables early identification of factors whether internally or externally driven, which may prevent the Trust from achieving its strategic objectives of ensuring care is provided in a cost effective way without compromising safety. It provides the framework in which risk can be managed, reduced and monitored regardless of source and the process to be followed where gaps in risk management processes are identified. It assists the Trust Board to identify the scope of the Trust risk appetite (see Appendix 5: 5.9).

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

This strategy is based on the requirements of the Department of Health (2006) Integrated Governance Handbook, guidance issued by the National Health Service Litigation Authority (NHSLA), National Patient Safety Agency (NPSA), Medicines and Healthcare Products Regulatory Agency (MHRA) among others, and identifies the consistent approach to be taken to all hazards and risks however caused, across the organisation at strategic and operational level.

Who should know about this policy?

Great Ormond Street Hospital staff regardless of location. This includes Partnership and satellite sites where appropriate.

Table of Contents

Risk Management Strategy

1.0 Introduction

Great Ormond Street Hospital for Children NHS Trust is committed to providing high quality patient services in an environment where patient safety is paramount. The Risk Management Strategy identifies how the principle risks and hazards which may prevent this occurring are assessed, prioritised, and controlled, supporting the safe development of clinical care and maintaining continuity of service delivery.

2.0 Key Aims and Objectives

The Risk Strategy identifies:

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

This strategy does not consider the detailed management of financial risk as this is subject to statutory control systems documented elsewhere[1], but does recognise that poor management of risk whether clinical, non-clinical or financial can have an impact on the Trust's ability to meet its strategic and financial objectives.

The Risk Strategy drives the risk management process but this is underpinned by other operational policies and procedures.

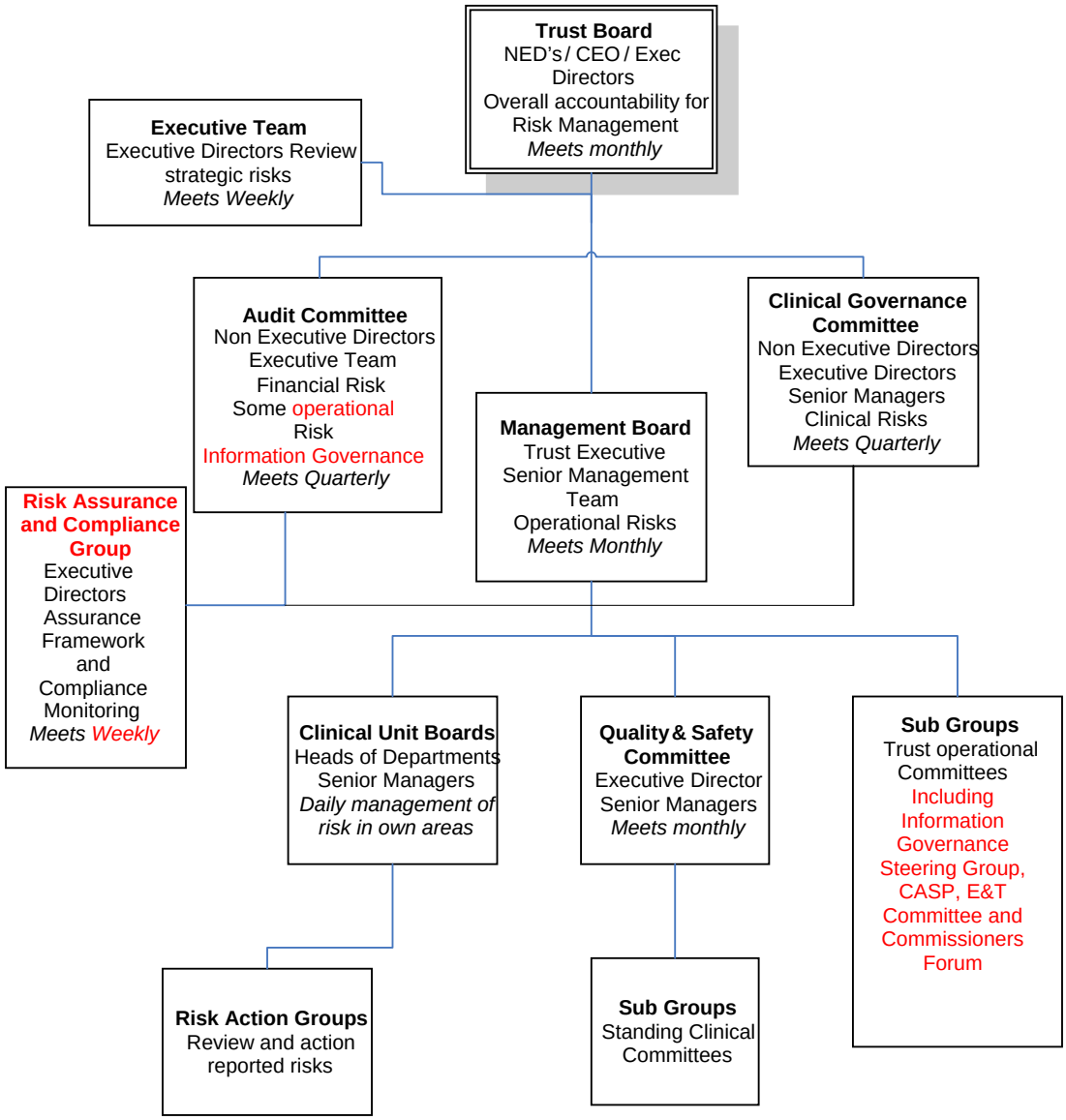
Further detail on the management of specific types of risk e.g. Clinical, Human Resources, Health & Safety, Information Governance can be found within the policies relevant to those areas, some of which are given below[2].

Incident Reporting & Management Policy
Management of external visits, inspections
Quality Strategy
Trust Vision & Objectives
Assurance Framework
Personal Responsibility Framework
Legal Policy
Complaints Policy
Health & Safety Policy
Standing Financial Instructions and policies
Fraud and Corruption Policy
All IT policies
All Personnel policies
Building and site development strategies
Information Risk and Governance Policies
Continuity and Business planning procedures

[1] Standing Financial Instructions and Scheme of Delegation
[2] This list is not exhaustive and is updated as policies are reviewed

Major Incident Policy Performance Strategy

3.0 Organisational Structure for Risk Management[3]



The organisational structure for risk management provides an integrated framework for decision making, escalation and provision of assurance. It ensures the operational framework required to deliver the trust objectives links into the wider assurance and corporate governance processes, and that all reasonable action is taken to identify, assess and manage risks to the Trust and its stakeholders in a consistent and transparent way.

To manage risk effectively, the Trust must be aware of its risk profile across the entire range of its activities whether, clinical, non-clinical or financial. These may be strategic or operational and may relate to a change or development in an existing service, or in response to an internal or external driver. As such, they require regular review and a consistent approach to assessment as their priority may change over time. The Trust committee structure, which links into this process, can be found in Appendix 1.

[3] The two assurance committees – the Audit Committee and Clinical Governance Committee – receive reports as outlined in their terms of reference. This may be from a variety of sources where assurance on any aspect of the Trust business within their remit is required or delegated from Trust Board. This may be from stand alone reports, specific committees and/or individual teams or departments.

4.0 Duties, Roles and Responsibilities

The following gives the duties, roles and responsibilities for risk management activity in the Trust at individual, department and team level. Due to the variable nature of risk, this is not exhaustive and may change depending on the type of risk identified and the action required to mitigate it. Where authority is devolved, the extent of this authority is identified with the member of staff or in the relevant job description. Assessment of risks (Appendix 3 & 4) assists in identifying how a risk will be mananaged and the level of management responsibility required.

All members of staff are responsible for their own safety and for ensuring risks to the organisation, colleagues, patients and visitors are minimised. All managers have authority to reduce risk within their areas of responsibility whether clinical, non clinical or financial and are responsible for ensuring safe systems are in place. Staff are required to report incidents when they occur, mitigate their effect, lead on investigating the causes and escalate to their unit chair, general manager or relevant director as appropriate. If in doubt advice can be sought from the Clinical Governance & Safety Team.

4.1 Chief Executive Officer:

The Chief Executive is accountable to the Board for ensuring that it receives the appropriate level of information to enable it to be assured that systems of internal control to manage risks, regardless of source, are in place.

The overall and final responsibility for all risk **and quality** management rests with the Chief Executive, who is accountable for providing the Trust with the necessary organisational structure and resources to implement policy and manage risks effectively. In line with the general philosophy of the Trust, delegation of responsibility occurs. Individuals are encouraged to assume responsibility for their own actions.

The Chief Executive or their Deputy is actively involved in the work of the sub committees with responsibility for managing risk, ensuring that there is a system to assess and review the effectiveness of the controls put in place to mitigate those risks. As the Chair of Management Board, they are aware of all key decisions made within the Trust and ensure actions to reduce risk are considered when strategic, operational or financial decisions are made, and the means by which effectiveness of action to reduce risk is monitored.

4.2 Non Executive Directors

Assurance sub committees of the Trust Board are Chaired by a Non Executive Director.They are responsible for ensuring that they are provided with the appropriate information to enable them to make a reasoned judgement as to whether the elements of risk for which they assure the Board, are being managed with proper controls in place. They have a duty and the authority to raise with the Trust Board any risk issue they believe is not being managed appropriately, that may be a threat or opportunity to the Trust, or which has caused them concern. They have a duty and authority to request additional information from any source to enable them to fulfill this function to ensure provision of safe, high quality services.

4.3 Executive Directors

The Trust Board has designated accountability for risk management and quality service provision to nominated executive directors and as such this is identified within their job descriptions. They meet regularly with the Chief Executive to ensure all aspects of risk are managed appropriately within their areas of responsibility and enable early identification of an actual or potential problem.

All Executive Directors remain accountable for reducing risk within their areas of responsibility by best practicable means and ensuring the impact of decisions taken and effect on the viability and reputation of the Trust is assessed as part of this decision making process.They delegate authority to nominated managers as appropriate to manage local risks and to specific committees or project groups to manage corporate risks[4]. They ensure a feedback mechanism is in place to monitor actions taken and compliance with internal and external regulatory or statutory compliance.

The Executive Directors are part of the Trust management structure and represent their specific areas of risk management responsibilities at Trust Board, Sub Committees and Management Board levels. They may also chair or be members of specific groups or committees to consider areas within their expertise which may be time limited or to oversee specific tasks. As part of their risk management role, they will delegate areas of accountability to nominated individuals as appropriate.

The Executive Directors with delegated responsibility for risk management are:

4.3.1 Deputy Chief Executive/ Chief Operating Officer:

Responsibility for ensuring that clinical and non clinical risk management is embedded at Clinical Unit and departmental level to ensure compliance at local level with strategic objectives. They are accountable for ensuring effective management and mitigation of risk as part of the day to day and operational practice of the Trust. This includes but is not limited to objective setting, business planning, service development and performance management of risk. Executive responsibility for Major Incident Planning and implementation and overseeing the operational review process. Executive management of facilities to reduce risk in the delivery of support services to patients, families and staff and the effective management of the human resource functions within their remit. Overall responsibility for effective management of the Assurance Framework.

4.3.2 Chief Finance Officer:

Executive responsibility and accountability for all aspects of financial risk and compliance with statutory financial requirements. This includes but is not limited to financial planning, objective setting and fraud, information governance and information risk. Acts as the Senior Information Risk Officer (SIRO) for the Trust.

4.3.3 Co-Medical Directors:

This joint role provides but is not limited to executive responsibility and accountability for clinical and non-clinical risk management. Executive responsibility for the implementation of risk management to mitigate the risks regarding clinical incidents, complaints, clinical negligence, clinical audit and effectiveness, litigation issues such as consent, confidentiality, data protection, infection control, radiation protection and health and safety. Executive responsibility for medical postgraduate training and managing associated risks as a result of changes to medical workforce, whether internally or externally driven.

4.3.4 Chief Nurse / Director of Education:

Executive responsibility and accountability for Child Protection, safeguarding, training, education and the implementation of risk management systems with regard to staffing, staff management and workforce issues within their remit.

[4] Corporate risks – these are risks which need either a Trust wide approach or which may arise as a result of external factors over which the Trust may have limited control. They are owned by the executive team who delegate their management to either a nominated individual, designated committee or designated, time limited project group. If a risk is accepted, i.e. no appropriate action to mitigate it identified, this must be agreed with by the Chief Executive or the Deputy Chief Executive and identified to Trust Board.

4.3.5 Director of Redevelopment

Executive responsibility for ensuring all risks related to the Trust estate and redevelopment of the hospital are mitigated and managed. This includes the management of contractors, safe operating procedures and safe systems of work as well as financial and service continuity risks associated with redevelopment programmes.

4.3.6 Director of Research and Development

Executive responsibility for ensuring that all risks related to research are mitigated and managed and that the research governance framework requitrements are implemented.

4.4 Company Secretary

The Company Secretary is responsible for ensuring that the Risk Management Strategy meets the requirements for and links into, the systems for Corporate and Integrated Governance.They co-ordinate the main high level sub committees and the Trust Board and ensure relevant papers are provided in line with the agreed reporting schedule. They ensure appropriate reporting occurs from the operational committees into Management Board to support the governance framework. They oversee the management of the Document and Meeting papers library and the administration of the Assurance Framework and monitor compliance with the Data Protection Act in their role as Data Protection Officer. They manage any additional risk and compliance function, such as registration and requirements of external agencies, as delegated by the Chief Executive to ensure compliance with internal, external and statutory requirements. The Health & Safety team report to the Company Secretary responsible for non clinical risk and health and safety management including statutory compliance.

4.5 Senior Managers[5]

Senior Managers are required to manage risks within their own areas of responsibility and to implement the requirements of this Risk Management Strategy. They ensure appropriate and effective risk management processes are in place to reduce risks within the work environment, implement and comply with corporate, financial, departmental and unit policies and guidelines. They ensure internal and external compliance with any regulations relevant to their own areas of work and seek advice from appropriate advisors where necessary eg. Health & Safety, Occupational Health, Infection Control, Security, Estates, Facilities, Clinical Governance & Safety, Human Resources, Finance etc. This is to ensure the reputation and continuity of services are developed and maintained. They are accountable for identifying deficits in compliance withi their department or unit, however caused, and agreeing an action plan to remedy any such deficiency with their line manager and relevant Executive Director.

4.6 Clinical Unit Chairs & General Managers

The Clinical Unit Chairs and General Managers are responsible for implementing and overseeing corporate and clinical unit policies, guidelines and procedures within their specific clinical areas in accordance with this Risk Management Strategy and ensuring the internal structure within the unit is in place to do so. The Clinical Unit Chair may delegate authority for these roles to specific competent named individuals within their unit or specialty teams who report back to the unit Chair through the existing internal structures or clinical unit board as appropriate. They ensure the clinical unit board review of risk management issues, whether clinical, non clinical or financial and that these are included where appropriate on the local risk register and discussed as part of the unit board rolling agenda. They will ensure a governance framework is in place within their units which enables information to be shared with their teams, deficits identified and actions monitored and reported back into the wider governance structure of the Trust through Management Board.

[5] This includes Clinical Unit Chairs, General Managers,Modern Matrons, Ward Sisters, Assistant Directors, Heads of Departments or equivalent level staff

4.7 Corporate and Clinical teams

Corporate and clinical teams manage risk related to their operational areas of responsibility on a daily basis. They have a duty to ensure that any factors which may create additional risk or affect the ability to manage or control risk relevant to their area of work or service risks are highlighted to the relevant senior manager or clinical unit lead.

Each corporate department must ensure compliance with its policies and procedures by a process of regular review. Staff must be informed of these policies and procedures by means of an induction process that is documented. Each head of department is responsible for ensuring that the current versions of any policy or pan Trust operational document is available on the Document Library website. The process to ensure policies are current and to alert teams when policies are due for renewal is managed by the Company Secretary.

4.8 Clinical Governance & Safety Team

The Clinical Governance & Safety Team reports directly to the Co-Medical Director. It has a specific responsibility for collation of information for external risk based assessments and reporting to ensure that the management of local clinical and non clinical risks within its remit is integrated into the Trust assurance and governance systems. It consists of the Patient Safety team responsible for the management of clinical incident reporting, root cause analysis, aggregated analysis of reported incidents and investigations. The Complaints team responsible for the management and investigation of complaints. The Clinical Audit team responsible for the management of the clinical audit process across the Trust. The Clinical Governance & Safety team will provide information to all levels of the Trust, the unit boards and RAG groups to support effective local implementation of this risk strategy on a monthly basis or as required by the clinical unit chair and general manager. It maintains the Trust wide risk register and incorporates information from this into the assurance framework.

4.9 Trust Solicitor

Responsible for the effective functioning of the Legal Team in early identification of potential risk and ongoing management of claims or legal action. They are responsible for sharing learning to reduce risk across the Trust. They report to the Co-Medical Director and provide legal advice to support decision making by the Executive team wherever necessary.

4.10 Planning, Performance Management and Information Services

The Planning and Performance Management and Information services teams liaise with clinical units and corporate departments to ensure access to appropriate and timely information on service provision and the key performance indicators to support the management and monitoring of risks (See Performance Strategy). They support management of the Assurance Framework to ensure that the Trust objectives are linked to internal and external monitoring of high level performance indicators.

4.11 All employees/Visitors

Employees, whether part of clinical or non clinical teams, are made aware of the risks within their work environment, their personal responsibilities for reporting risks and minimising risk to themselves and others. They are given the necessary information and training to enable them to work safely. All clinical and non clinical staff are expected to report incidents when they occur and be involved where appropriate in any investigation to identify the cause of specific risks or as the result of an edverse event (See Incident Reporting & Management Policy, Health & Safety Policy, Induction Policy). While visitors have a responsibility for maintaining their own health and safety while on site, employees have a responsibility to ensure that visitors are not exposed unnecessarily to risks, to report and take action to minimise any such exposure.

4.12 Contractors

Contractors carrying out work on the Trust's property are expected to comply with statute. It is the responsibility of the Executive Director contracting with them on behalf of the Trust to ensure that contractors comply with the relevant safety procedures and, where appropriate, specify detailed

health and safety and performance management requirements in any written terms of agreement before work commences.

4.13 Partnership working with other organisations

Where the Trust links in with other health care providers to deliver a specific clinical service a risk assessment is undertaken as part of the planning process and used to inform any Service Level agreement. This identifies potential risks to the individual parties, service users, the public, patients and other stakeholders and ways to reduce these. It is the responsibility of the project manager, under the guidance of the relevant Executive Director, to ensure this occurs. Wherever possible, systems to monitor and reassess risk are included as part of the business plan and incorporated into the regular performance monitoring process of the Trust.

5.0 Responsibility of Trust Committees for Risk Management

5.1 Trust Board

The Trust Board is responsible for the effective functioning of the Trust, the provision of managerial leadership and accountability. Its purpose is to ensure that the Trusts systems and working practices support good corporate governance, financial probity and the management of risk to underpin safe high quality service delivery. To do this Trust Board:

- establishes the strategic objectives for the Trust
- ensures these support delivery of the Quality Strategy
- sets out the arrangements for obtaining assurance on the effectiveness of key controls across areas of principle risk, which may threaten achievement of those objectives
- establishes a reporting system to receive relevant documents in an appropriate timeframe to enable the Board to ensure that its members are properly informed of the totality of their risks, not just financial, and to be assured that the systems to manage the principle risks are in place
- reviews the strategic risks on the trust wide risk register as part of the Assurance Framework, at least once a year as per the schedule of reporting.
- evaluates the key controls to manage the principle risks, using external and internal assessment and assurance processes.
- receives summary reports on progress against compliance with specific aspects of identified risks that may occur. Frequency of these reports is agreed with the Company Secretary if they are not part of the routine reporting schedule.
- receives performance management reports identifying key indicators monthly.
- delegates the daily strategic management of risk to the Chief Executive who is accountable for delivery of this strategy.
- approves the Risk Management Strategy and reviews it annually or more frequently in the event of significant changes whether internally or externally driven.
- demonstrates that it takes reasonable action to assure itself that the Trusts business is managed efficiently through the implementation of internal controls to manage risk and a self assessment process annually.

5.2 Sub Committees of the Trust Board

Any high level sub committee where the responsibility for overseeing the different elements of risk management has been delegated by Trust Board, clearly indicates by its terms of reference which aspects of risk management it is responsible for, and whether its role is one of assuring or being assured. It also identifies the extent of its delegated authority.

Each delegated sub committee receives regular reports as part of its schedule of reporting to enable it to take a view as to whether it can assure the Board that the controls to manage specific aspects of risk which fall within its remit are in place and working.

It is the responsbility of the Chair of the delegated sub committee to alert the Trust Board to any concerns regarding the management of risk it oversees and to request additional information as necessary. To assist this process, sub committees have cross membership and appropriate representation from the executive team, senior managers and clinical teams. Minutes or summary action points from the high level assurance sub-committees are received by Trust Board at the next available meeting.

The main high level sub committees are:

5.3 Clinical Governance Committee

The Clinical Governance Committee (CGC) meets quarterly and reports to the Trust Board. It has delegated authority to assure the Trust Board and to be assured that appropriate action is taken to minimise and control aspects of clinical risk, clinical governance and improvement work across the Trust. This includes but is not exclusive to risks from clinical incidents, complaints, claims, litigation, health and safety, and clinical audit as identified within its terms of reference. It receives relevant reports and updates on actions taken to comply with specific external assessments to fulfill this remit and within an appropriate timescale. On agreement with the Committee Chair, it also receives additional items on any other activity which creates a potential or actual risk to good clinical governance. It reviews the trust wide risk register and specific objectives from the assurance framework which fall within its remit at least once a year as per its reporting schedule.

The Chair is a Non Executive Director and cross membership of this committee assists in ensuring an integrated approach to manage clinical, non clinical and any financial risk which may affect the clinical service delivery and the Trust's ability to meet its strategic objectives. Its minutes are shared with the Audit Committee and received by Trust Board for information at the next available meeting. Additional members may be required to attend when necessary to inform the committee on any specific aspects of risk identified.

5.4 The Audit Committee

The Audit Committee reports to the Trust Board. The committee has the responsibility to assure the Trust Board and to be assured, that appropriate action is taken to minimise and control all aspects of non-clinical risk including financial within its remit. It receives relevant reports to enable it to do this and in an appropriate time scale. This includes reports from internal and external auditors in respect of the Trusts effectiveness at mitigating specific risks. As such it has delegated authority from the Board as identified in its terms of reference. It monitors the actions taken and progress against all financial requirements, certain external assessments and reviews the effectiveness of specific objectives from the assurance framework and trust risk register to identify and control risks as per the reporting schedule.

As the assurance agenda crosses clinical and non-clinical boundaries, the minutes are shared between this committee and the Clinical Governance Committee and received by Trust Board for information. The Chair is a Non Executive Director and the Chair of the CGC is a member of the Audit Committee - cross membership of this committee assists in ensuring an integrated approach to managing all risk financial, non clinical and clinical risk.The Audit Committee meets quarterly.

Additional members may be required to attend when necessary to inform the committee on any specific aspects of risk identified.

5.5 Management Board

Management Board has delegated authority from the Trust Board for the operational and performance management of the clinical services, research and development, education and training of the Trust. It is responsible for co-ordinating and prioritising all aspects of risk management issues which may affect the delivery of the clinical service as stated in its terms of reference. It is the main operational decision making committee of the Trust. It is responsible for

co-coordinating and prioritising all aspects of risk that have the potential to prevent the Trust meeting its strategic objectives.

- it ensures that all aspects of Trust activity are considered and risk assessed when decisions are made, to minimise organisational risks whether clinical, non clinical or financial.
- delegates authority to the clinical units/departments to manage risk to local service provision as appropriate.
- monitors performance against the Trust objectives, identifying variance, assessing risk management priorities and co-ordinating the Trust response.
- supports clinical unit and departmental activities to ensure appropriate use and allocation of resources to support and maintain service delivery and to minimise and control risks.
- receives updates on work and measures undertaken to mitigate risks by specific subgroups, operational committees and any other time limited group which it has established or delegated authority to, to take forward specific work.

Management Board is made up of the Executive team, clinical unit chairs, general and senior managers. Its membership reflects its role to ensure appropriate consideration and endorsement of decision-making on specific areas of risk. This includes: policy ratification, service delivery, staffing and staff management, audit, clinical and non clinical risk, estates and facilities, human resources, finance, information services, technology, improvement and organisational development work including partnership or joint working activity.

Where high risks are identified which require a Trust wide or strategic level approach and further action, they are discussed and reviewed by Management Board. The Chair is the Chief Executive and meetings are held monthly.

5.6 Standing Committees

A standing committee is a committee with delegated authority from Management Board (Appendix 2). Each standing committee is responsible for managing the cross Trust issues relevant to their area of expertise and as such has delegated authority within its terms of reference for a specific remit. This includes assessing the effectiveness of the control systems in place to reduce the risks relevant to their areas of expertise. A standing committee may be established either because it is required by statute or because it covers a key management function for the Trust to meet its objectives of efficient, effective and safe care. The clinical standing committees will provide a summary of their work as part of the schedule of reporting to the Safety & Quality Committee at least once a year. The Quality and Safety Committee reports into Management Board. The Health and Safety Committee and Infection Conmtriol Committee reports into the Quality and Safety Committee. The Information Governance Steering Group reports into Management Board. Operational standing committees report into Management Board.

5.7 Operational, time limited or task specific groups

In addition to clinical and operational standing comittees, other groups may be established to cover work which may be strategic, time limited, task driven or have a combined operational role. These may be required to over see large projects or to co-ordinate delivery of a specific objective. These groups or committees are chaired by a senior manager or executive director and the remit of the group, scope of authority, any time limits and reporting lines are included in the terms of reference. Reporting lines wherever possible link back into management board or an identified committee. This is to ensure that all work undertaken on behalf of the Trust can link into the existing reporting, monitoring and assurance systems in place.

6.0 Process for managing risk locally in support of this strategy

6.1 Clinical Unit/ Department Structures

The management of risk locally will reflect this organisational risk management strategy. Clinical units and departments will have in place:

- Internal meeting structures
- Authority within staff roles and responsibilities to manage risk at local level including financial and service risks
- Comply with the requirements of the Incident Reporting & Management Policy for reporting incidents, assessing the impact and likelihood of identified risks, scoring and grading them
- Comply with the Complaints Policy to ensure these are managed appropriately at local level and the learning used to enhance patient experience
- Ensure that clinical, financial, service risks and complaints are used as an indicator of quality and as part of the process to identify safety indicators and required actions
- Comply with Trust policies in respect of workforce management
- A risk register
- A risk action group
- Process to monitor required actions
- Process to share information and learning
- Process to escalate unresolved risks

These processes will be managed by the clinical unit board or equivalent. The internal structures will meet the need of the unit or department to deliver excellent clinical care and to identify, assess and control risk, with delegated authority to staff as appropriate. Each clinical unit and department will have a nominated person from within the Clinical Governance & Safety team who acts as a risk link for their areas.

6.2 Incident Reporting

Clinical units and departments will have a process to review their reported incidents and levels of reporting monthly. The Incident Reporting & Management Policy describes the process to report, record and investigate individual incidents in detail. Levels of reporting and aggregated analysis will be monitored by the Patient Safety team and reported through to the Quality & Safety Committee with feedback to the local teams.

6.3 Risk assessment

Each clinical unit or department will undertake risk assessments where appropriate. They will score, grade and prioritise the risks using a common approach (Appendix 3). A risk assessment will be undertaken prior to planned service changes or changes to service delivery to identify any additional risks that may be caused. They may be used to demonstrate consideration of risks as part of the business planning process, as part of a departmental review of compliance with statute e.g. a Health Technical Memorandum related to specific aspects of corporate risk such as Fire, or following an actual event.

6.4 Local Risk Registers

The clinical unit board or equivalent, or departmental meeting will have a process in place to keep their risk register updated. They will provide updates on the content of their risk register monthly to the Patient Safety team for inclusion into the Trust wide risk register. Risks will be reviewed within a stated time frame by the local team to ensure that controls in place are working, and assess whether the risk changes over time (Appendix 4). Risks may be identified through internal processes e.g. complaints, incidents, claims, service delivery changes, risk assessments or financial interests. They may be identified by external factors e.g. national reports and recommendations. Reports are run monthly for the clinical / department teams on reported incidents for consideration by the RAG groups and clinical unit boards or senior meetings. This information is used to inform the decision as to whether risks need to be added to the risk register,

regraded or removed. Changes to the risk registers are monitored centrally by the Patient Safety team.

6.5 Risk Action Groups (RAG)

Local Risk Action groups or an equivalent meeting will be established at which the principle risks to patient safety and service delivery will be discussed (Appendix 4). Their role, remit and areas of delegated authority will be identified by the Clinical Unit Board or equivalent and reflected in their terms of reference. Risk Action Groups will be multidisciplinary and may consist of a core group with additional expertise brought in pertinent to the level or type of risk identified. Each specialty is responsible for identifying its specific hazards and risks relevant to its own area of clinical expertise and practice and ensuring these are included on the risk register where appropriate. RAG's receive information monthly on their clinical and non clinical incidents reported through the central reporting system to identify key themes and where actions to control risks are required. Corporate departments establish similar systems either through a dedicated Risk Action Group or an equivalent meeting. The RAG will review reported incidents and identify to the clinical unit board or departmental meeting, issues they think should be added to the risk register, regraded or removed.

6.6 Trust risk register

The Trust risk register is the aggregation of the local clinical team and corporate department risk registers and any additional sources of risk such as external or internal reviews. It is maintained centrally by the Patient Safety team and recorded on the Datix Risk management system. As such it identifies the source, describes the risk, scores and grades it and provides a summary of the action taken to control it. It includes a review date and a residual risk rating. Risks scoring over 12 on the Trust risk register are linked to the assurance framework and reviewed by the executive team and assurance framework group. The Trust wide risk register is reviewed by Trust Board and its sub committees as per the committee reporting schedules. Changes to the risk registers are monitored centrally by the Patient Safety team. Local risks are managed and owned by the local unit teams. Corporate risks are those that need a Trust wide approach or which may arise as a result of external factors over which the Trust may have limited control. They are owned by the executive team who delegate their management to either a nominated individual, designated committee or designated, time limited project group. If a risk is accepted, i.e. no appropriate action to mitigate it is identified, this must be agreed with by the Chief Executive or the Deputy Chief Executive and identified to the Trust Board.

6.7 Assurance Framework

The Assurance Framework provides a record of the principle strategic risks to the Trust achieving its objectives. It identifies the controls in place, the methods of assurance and the control and assurance gaps. It is informed by the risks graded 12 or above on the Trust risk register as well as internal, external and strategic risks which may affect the Trusts business. It includes those identified by the Executive Team or any additional source where local controls are not sufficient to manage the risk e.g. infection control, finance or information risk. It includes key risks identified through aggregated analysis of incidents, complaints and claims which may not already appear on the Trust risk register. These are added to the Assurance Framework for executive review. It provides a vehicle for the Trust Board to be assured that the systems, polices and people in place are operating in a way that is effective and focussed on the key risks which might prevent the Trust objectives being achieved. Each risk is linked to a Trust objective and has an Executive lead, responsible for updating the controls and ensuring the actions required to mitigate the risk are completed at either local, operational or strategic level.

6.8 The Risk, Assurance and Compliance Group

The Risk, Assurance and Compliance Group meets every 6 weeks and reports to the Audit Committee and Clinical Governance Committee. The purpose of the Group is to:

- monitor risk management systems and control and assurance process;
- advise the assurance committees on the co-ordination and prioritisation of risk management issues throughout the Trust;
- ensure the Trust complies with all requirements of the Assurance Framework;

- ensure the Trust complies with all requirements of the Health and Social Care Act 2008 (Registration Requirements) and other legislative, regulatory and external authority requirements.
- monitor integration of the governance framework.

The Group is chaired by the Chief Operating Officer and has representation from executive directors, senior managers and the internal auditor. In the event of persistent uncontrolled high risk, or a significant increase in a known risk, the Chief Operating Officer informs the Executive group for consideration and decision as to whether additional action is required or whether a risk should be accepted.

6.9 Executive Group

This meeting is held weekly by the executive team and chaired by the Chief Executive or Deputy / Chief Operating Officer. Its role is to review the ongoing strategic high risks with the relevant executive director accountable for the area and to share information on gaps or controls in place to manage those risks. These risks may be as a result of internal or external factors or from clinical, non clinical or financial sources.

7.0. Risk Management Training

The following table summarises the requirement for training for all staff in respect of clinical and non clinical risk management.

Staff Member	How	Delivered by	Assurance
Executive Directors	Induction & Updates	Clinical Governance and Safety Team	Attendance monitoring and Board self assessment
Senior Managers	Induction & Updates	Clinical Governance and Safety Team	Attendance monitoring
Clinical Staff	Induction & Updates	Clinical Governance and Safety Team	Attendance monitoring
Non Clinical Staff	Induction & Updates	Clinical Governance and Safety Team	Attendance monitoring
Non Executive Directors	Induction & Updates	Clinical Governance and Safety Team	Attendance monitoring and Board self assessment
Staff with responsibility for investigating complaints	Bespoke training &/or Risk Management Training	Clinical Governance and Safety Team	Attendance monitoring
Staff with responsibility for undertaking Root Cause Analysis	Bespoke training and /or Risk Management Training	Clinical Governance and Safety Team	Attendance monitoring
New Managers	Bespoke Training	Clinical Governance and Safety Team	Attendance monitoring

Additional specific financial, business continuity, major incident and information governance training is identified for staff relevant to their roles and delivered and monitored through the Education & Training team.

8.0 Monitoring compliance with this Risk Strategy

The management of risk applies to all areas of the Trust's activity. Evaluation may occur by assessment of compliance by an external agency, compliance with statute, internal or external

reporting, as part of the independent audit function or by internal quarterly reports via the management systems in place.

Compliance with specific aspects of this policy will be monitored as follows:

Element	When	Reviewed By	Reported to
Approval of the Risk Strategy	Annually	Trust Board	
Organisational structure for risk management and inclusion in risk strategy	Annually when policy is updated	Management Board	Trust Board
Receipt of Trust wide risk register by Trust Board, Clinical Governance Committee, Audit Committee	Annually as part of compliance audit with the committee reporting schedules	CGC Audit Committee	Trust Board
Review of involvement of senior managers in risk management process	Quarterly	Quality & Safety Committee	Management Board
Role of Clinical Standing Committees	Bi- annual	Quality & Safety Committee	Clinical Governance Committee
Role of Operational Committees	Bi -annual	Management Board	Audit Committee
Assurance Framework	Quarterly	Risk, Assurance and Compliance Group	Audit Committee
Clinical Unit Risk Registers	Quarterly	Operational Review	Management Board
Risk Action Groups	Quarterly	Clinical Unit Boards	Quality & Safety Committee
Levels of incident reporting	Monthly	Clinical Unit boards	Quality & Safety Committee
Risk Management Training	Quarterly	Training Dept	Quality & Safety Committee

A report will be received by the relevant committee which will include as a minimum:

1. Rationale for the audit or review
2. What is being measured eg attendance, receipt of minutes, completeness of minutes, compliance with any reporting schedule or applicable measure identified to demonstrate compliance.
3. Results of the audit or review and whether compliance was demonstrated.
4. Compliance will be scored as follows

Score for compliance	Grade	Action required
90-100%		Report to named committee as per reporting schedule
76-89%		Report to named committee with action identified to improve compliance and time scales. Monitoring to be incorporated into the named committee meeting schedule once agreed.
<75%		As above. Discuss with responsible person depending on deficit identified eg relevant committee chair, General Manager, Unit Chair, Director, to identify deficit and means to rectify.

8.1 Strategic Performance Reviews

These meetings are held quarterly and include review of the unit or department risk register as well as operational key performance indicators, financial status and business development. They are chaired by the Chief Operating Officer or another Executive Director and are carried out with all the units.

8.2 Management of non compliance

Aspects of this strategy are audited annually prior to updating and reviewed to assess the effectiveness of the processes and tools identified within it and compliance with the stated requirements. Where deficiencies are identified, discussion with the relevant manager, executive director or at a relevant committee occurs to assess whether remedial action is required. Progress against internal and external audit recommendations is reported back through the Audit Committee.

9.0 Dissemination of this policy

The Trust Board recognises that good channels of communication are vital to the achievement of the aims of the Risk Management Strategy. An open and fair[6] culture which welcomes direct interaction between managers and staff at all levels assists in ensuring the aims of this policy are achieved.

All staff are informed of this strategy and linked policies on induction and during mandatory update training sessions.

The strategy is available on the Document Library, with links from the Clinical Governance & Safety Team webpages.

Local Risk registers, performance reports and the outcome of any external assessments regarding the Trust's ability to manage risks are made available to staff via the internal communication systems.

The Terms of Reference, schedules of meetings, minutes and papers of the key committees with delegated responsibility for the management of risk are available and accessible to staff on the Corporate Meeting Papers website, accessible from the Gosweb pages.

10.0 Specialist advice

Further advice on any aspect of risk management, reporting, assessing, monitoring, compilation of risk registers etc or to identify where additional information is available can be obtained from the Clinical Governance & Safety Team.

Additional staff available to give specialist advice on aspects of managing risk are:

- **Chief Operating Officer, Deputy Chief Executive**

Advice on all aspects of the Trusts business, inlcuding where risks may need to be accepted, the operational management and facilities of the Trust

- **Chief Finance Officer**

Advice financial risk including fraud/ the Bribery Act, information governance and information risk and non clinical audit

- **Co-Medical Directors**

[6] Appendix 6

Advice on medical staffing, clinical issues, Caldicott guardianship, partnership working and patient safety

- **Chief Nurse / Director of Education**

Advice on nursing, staffing, clinical care, child protection and safeguarding issues

- **Director of Redevelopment and estate**

Advice on risks related to construction and redevelopment work and all aspects of estates management

- **Director of ICT**

Information risk and data security and business continuity lead.

- **Assistant Director Clinical Governance & Safety**

Advice and guidance on aspects of clinical and non clinical risk management, analysis, effectiveness and audit

- **Head of Planning & Performance Management**

Aspects of performance management, indicators and reporting processes

- **Head of Clinical Governance & Patient Safety**

Advice training and guidance on aspects of clinical risk management, complaints, risk assessments, risk registers and root cause analysis

- **Complaints Manager**

Advice training and guidance on aspects of risk management, complaints, risk assessments and root cause analysis

- **Legal Advisor / Trust Solicitor**

Advice training and guidance on aspects of litigation, consent, confidentiality

- **Health and Safety Advisor**

Advice training and guidance on aspects ofnon-clinical risks, health and safety litigation and risk assessments

- **Radiation Protection Advisor**

Advice training and guidance on aspects of radiation safety

- **Counter Fraud Adviser**

Aspects of fraud or potential fraud or financial loss to the Trust

- **Company Secretary**

Care Quality Commission registration, aspects of the Trust constitution and data protection

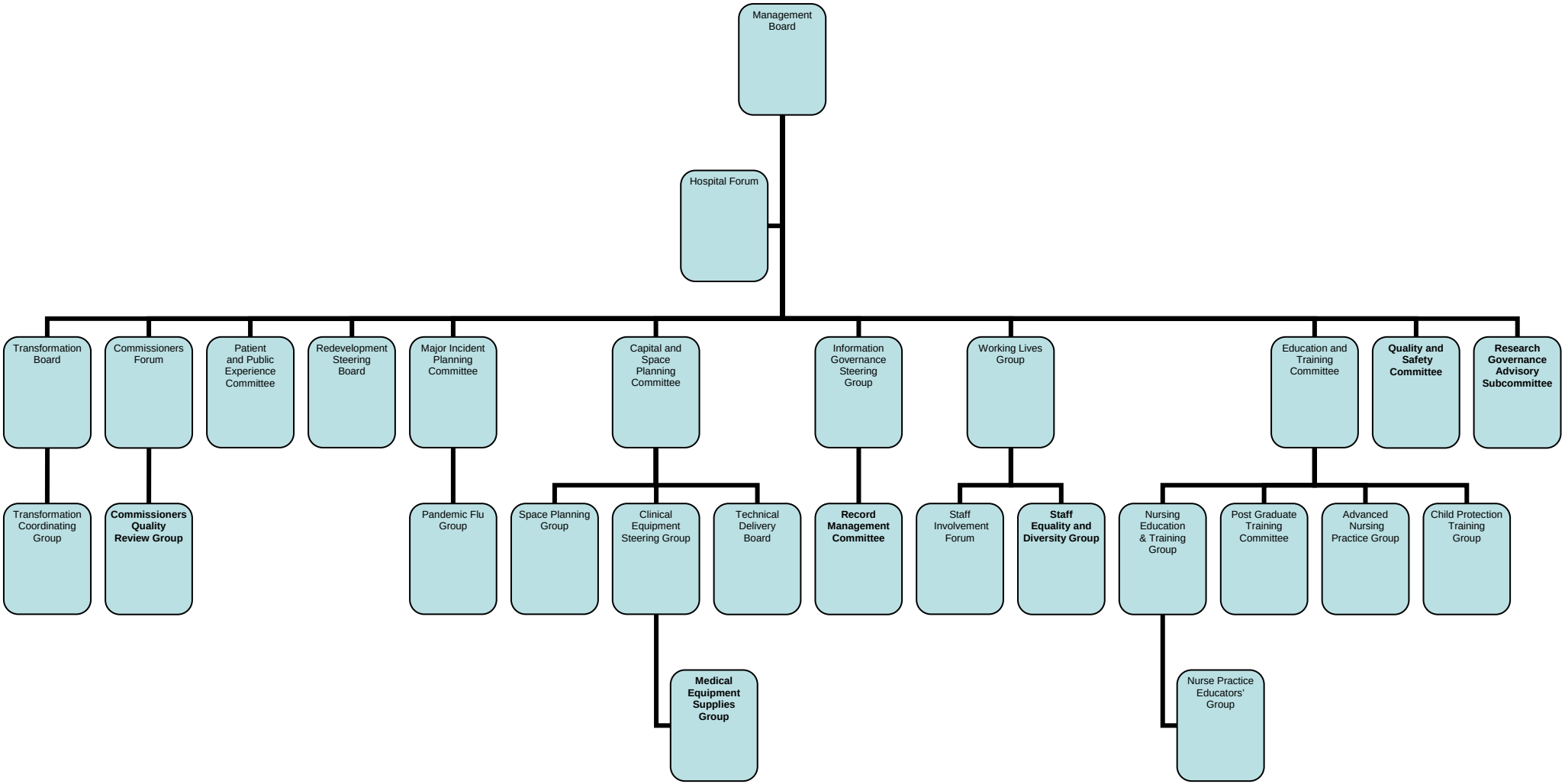
- **Head of Information Governance**

Advice on information governance requirements

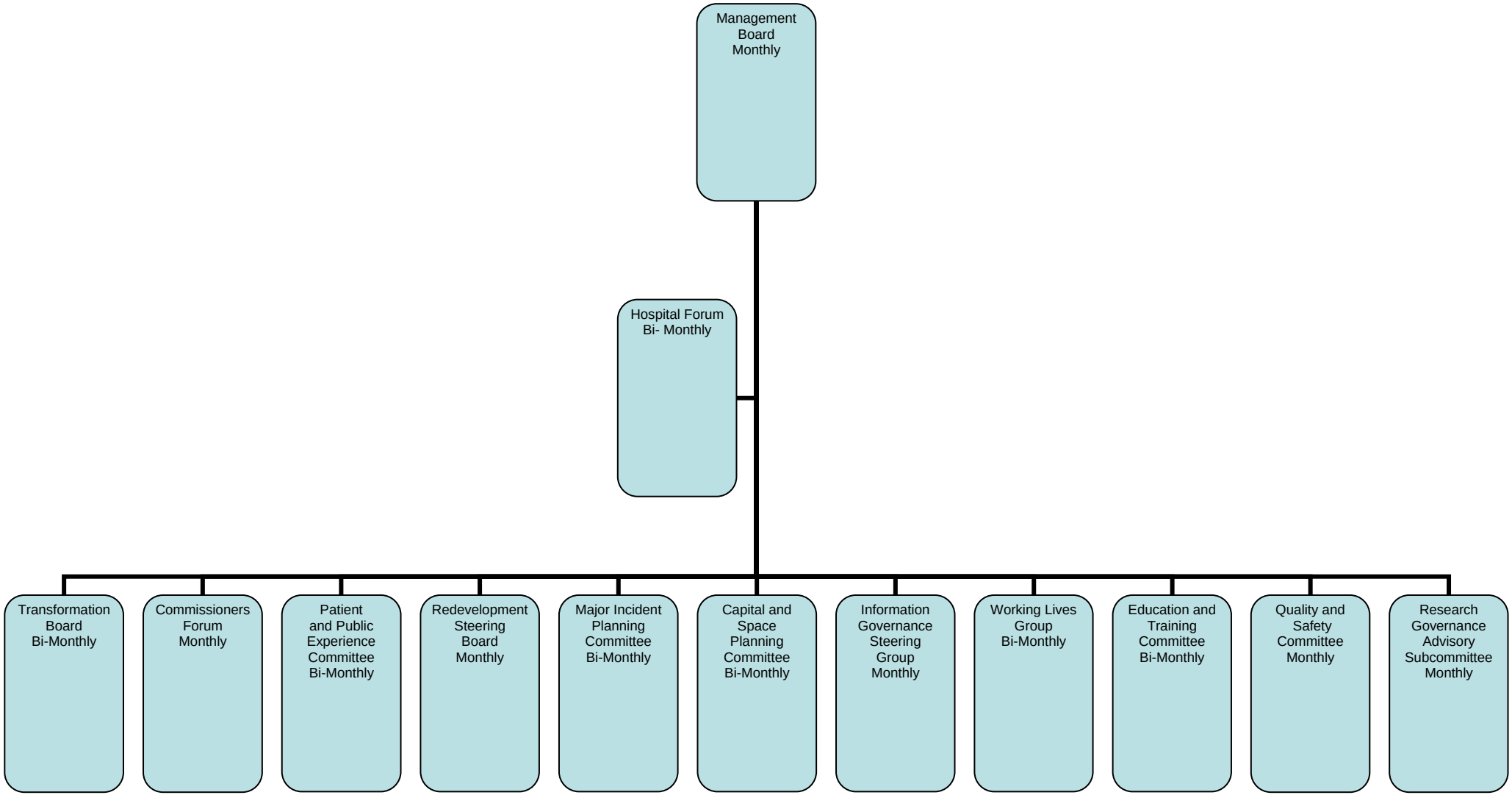
This list is not exhaustive but any of the above are able to give advice on additional sources of information whether internal or external to the Trust.

Appendix 1: Or
Structure for Ri

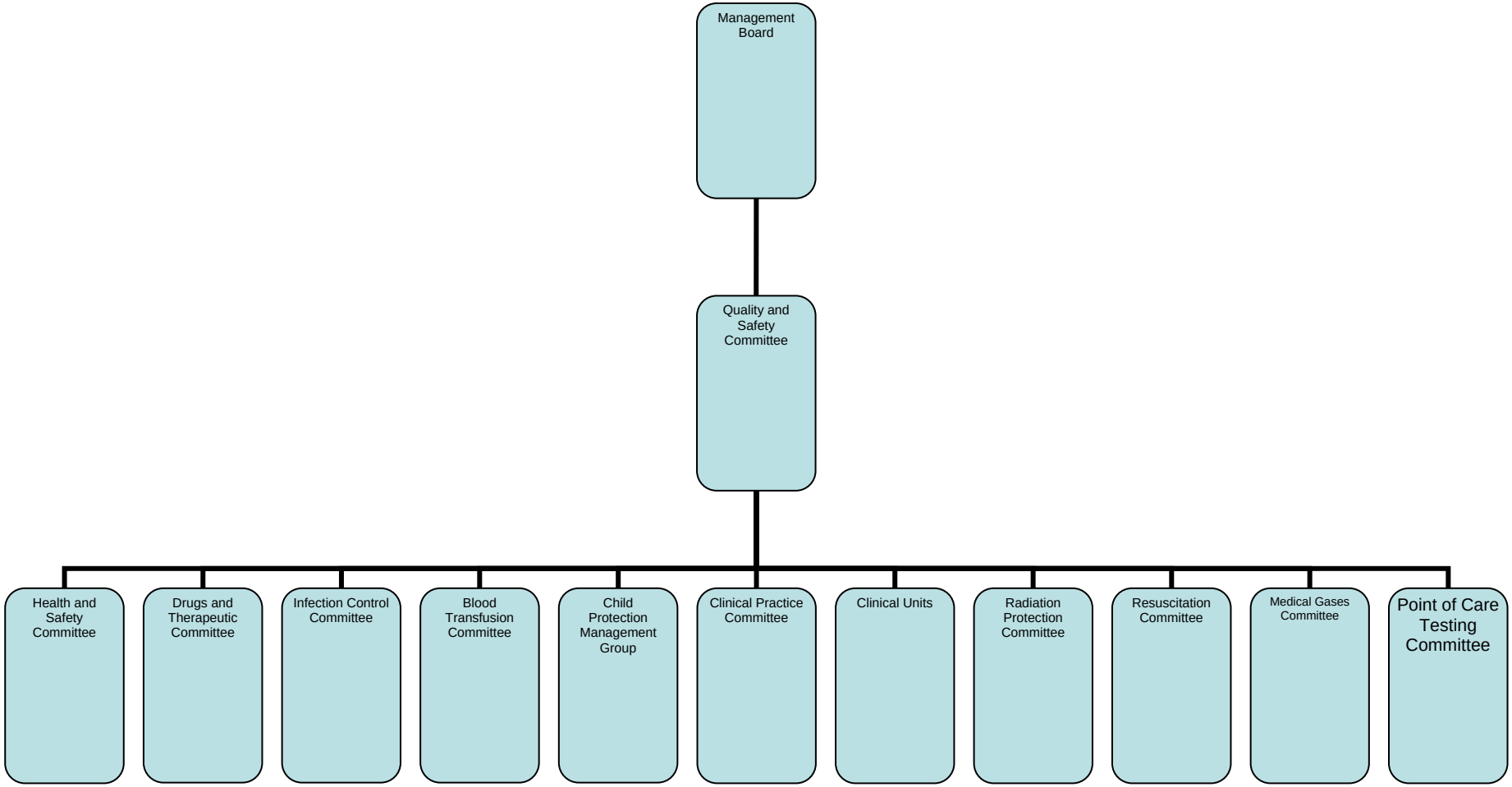
Appendix 1.1 All sub committees reporting into Management Board



1.2 Sub groups reporting direct to Management Board – Trust Operational Committees



1.3 Sub groups reporting to the Quality and Safety Committee – Standing Clinical Committees



Appendix 2: Standing Committees

The purpose of a Standing Committee is to review specific aspects of work which falls within its area of expertise and which usually has a Trust wide remit. As such these committees are key parts of the structure to manage risk from clinical and non-clinical sources and may be operational or clinical in focus. The main standing committees[7] with a remit for clinical risk are given in Appendix 1.

This role of a clinical standing committee is delegated by Management Board and is an important part of managing risk in areas known to involve high risk to patients.

Management Board establishes other operational committees or time limited working groups to manage specific areas of risk as necessary.

The following outlines the basic requirements expected by Trust Board and with which Standing Committees are required to comply.

2.1 Guideline on the drafting of Terms of Reference

This section provides guidance on the drafting of committee/ board terms of reference. It has been produced in order to ensure consistency of approach by all committees/ boards at Great Ormond Street Hospital NHS Trust.

What is the purpose of a committee/ board's 'terms of reference'?

The terms of reference outlines the role and function of a committee/ board. The document provides a summary of the role and purpose of the meeting, who should attend the meeting, and where the findings of the meeting should be reported.

Who is responsible for monitoring implementation of the terms of reference?

The Chair of the committee/ board is responsible for ensuring that the terms of reference are followed, supported by the secretary to the committee. This will be achieved by drafting the agenda in light of the purpose of the committee/ board, ensuring that the meeting is quorate and ensuring that reports are made to the relevant committees.

What areas should they cover?

The terms of reference for any committee or board at GOS should cover the following areas:

a. **Duties** – this first section should detail the role of the committee/ board and its authority. This can include responsibilities for approving or monitoring strategies and the implementation of policies; agreeing resources; recommending actions etc. The committee/ board may chose to agree an annual workplan.

b. **Reporting arrangements to the board/ high level committee** – the document should state where the committee/ board sits in the organisational structure (i.e. the committee is a sub-group of the Management Board). It should also record where the committee/ board is expected to report to and the frequency of these reports.

c. **Membership, including nominated deputy where appropriate** – The terms of reference should detail the job title of each member. Names of members should not be included. It should be clear who the Chair of the committee/ board is. Scope may be given to invite additional members on to the committee/ board for specific items of business. Each member of the Board

[7] This list is not exhaustive and is reviewed annually as a minimum.

should have a nominated deputy who will be entitled to attend and 'vote' on the committee/ board.

d. **Required frequency of attendance by members** – It is important that members are clear about the number of meetings they are expected to attend in a year. For example, for a committee/ board that meets monthly, it would be prudent to expect attendance at a minimum of 10 meetings within a 12 month period.

e. **Reporting arrangements into the committee** – The terms of reference should record those reports it expects to receive from teams or other committees and the frequency with which these should be made.

f. **Requirements for a quorum –** a quorum details the minimum number of officers and members of a committee, usually a majority, who must be present for the valid transaction of business. It should state the number of nominated deputies who may be included in the quorum to enable the committee to function (it would be expected that for a quorum of 4, a maximum of one member of the quorum would be allowed to be a deputy).

g. **Frequency of meetings** – The terms of reference should identify how often the committee / board shall meet and when papers will be expected to be received by members (usually 5 working days before the meeting).

h. **Monitoring compliance with the terms of reference** - The committee/ board will need to record in the document how it intends to monitor compliance with the terms of reference. Examples include reviewing:

- the frequency of meetings
- the attendance at meetings
- compliance with the duties of the committee/ board detailed in the terms of reference.
- Evidence based outcomes resulting from decisions taken at the committee/ Board

How often should the terms of reference be reviewed?

The committee/ board should review its terms of reference annually to ensure that its purpose and duties align with the governance arrangements in the organisation and any relevant legislation (where applicable).

All terms of reference must be uploaded to the Meeting Papers' Library.

Minutes from standing committees and meetings are made available to staff on the Meeting Papers section of the corporate website. Advice can be sought on how to action this from the Company Secretary ext 8230.

On occasion, standing committees will be required to present examples of actions taken on key areas within their remit to the Clinical Governance Committee.

The above format is recommended as good practice for any time limited or group set to complete specific tasks including reporting lines. This is to ensure decisions taken are recorded and work monitored appropriately.

The clinical standing committees will report to the Quality & Safety committee at least twice each year to provide a summary of the work undertaken. The Quality and Safety Committee will provide a report twice a year to Management Board. This process forms part of the system to monitor the effectiveness of the committee structure.

Appendix 3: Risk assessment

3.1 Assessment tools

Minimising risk requires the hazard to be identified, the risk assessed and a decision to be taken as to what control is required to mitigate that risk. The purpose of the grading assessment tool is to provide a consistent means for clinical and corporate staff to identify the key areas of risk which need to be incorporated into their risk registers, financial plans or into their business planning cycle. It assists in identifying the management responsibility and where this sits.

Risk assessments may be carried out to identify the significant risks arising out of planned changes to any of the following: Trust procedures, environmental, financial, health and safety or clinical services. They may be required following a specific event to assess the degree of risk posed to the Trust and may be internally or externally driven. They should be documented to assist in assessing the action required. This may be by using a designated risk assessment form (see examples in the Incident Reporting & Mangement Policy and Health & Safety policy), or a report format if this is more appropriate to the forum in which the assessment is to be considered. As a minimum, the risk assessment must include a description of the risk, the source of the risk, the likelihood of the risk occurring and the impact if it did. It should also include any current controls in place or additional controls that may be required. Where appropriate, consideration of resource and reputational risk should be included.

SEVERITY	**LIKELIHOOD**				
	1 **Very Unlikely** *(Freak event – no known history- 1 in 100,000 or less)*	**2** **Unlikely** *(Unlikely sequence of events1 in 100,000 to 1 in 10,000)*	**3** **Possible** *(Foreseeable under unusual circumstances 1 in 10,000 to 1 in 1000)*	**4** **Likely** *(Easily foreseeable – 1 in 100 - 1000)*	**5** **Very Likely** *(Common occurrence – 1 in 100 chance in any one year)*
1 **No harm** *(No injury, no treatment required, no financial loss.)*	Low	Low	Low	Low	Low
2 **Minor** *(Short term injury, first aid treatment required, minor financial loss)*	Low	Low	Low	Medium	Medium
3 **Moderate** *(Semi permanent injury, possible litigation, medical treatment required, moderate financial loss)*	Low	Low	Medium	High	High
4 **Major** *(Permanent injury, long term harm or sickness, potential litigation, fire, major financial loss)*	Low	Medium	High	High	High
5 **Catastrophic** *(Unexpected death, potential litigation, catastrophic financial loss)*	Low	Medium	High	High	High

3.2 Risk Scoring

Using the 5x5 matrix the likelihood of the risk occurring is multiplied by its impact to produce a risk score and grading. For a potential risk or hazard or one that nearly happened, the risk is scored for its potential impact and likelihood of occurring again.

The grading provides guidance on the action required and can be **High, Medium or Low.** The purpose of grading is to establish a baseline level of risk from the identified hazard. This enables

regrading to occur where appropriate, based on review of the effectiveness of the control identified to mitigate and manage the risk. Grading of risks is most effective when undertaken using a multidisciplinary approach wherever possible or as part of the Risk Action Group. This ensures the risk can be considered for its broadest effect on the service and referred if necessary to the clinical unit board for addition to the local risk register. The scoring assists in the prioritisation of risks of the same grade. For addition of risks to the risk registers see Appendix 4.

3.3 Management responsibility and review of risks

The following identifies the expected review schedule of risks included on the risk register for clinical unit boards and corporate departments based on the scores and grading.

Grade	Score on Risk Matrix	Frequency	By
High Risks	Score of 12 or above	Monthly review	Unit Board Executive team Assurance Framework Group
Medium	Score of 8 to 10	Two monthly review	Unit Board RAG
Low	Score of 1-6	Quarterly review	Unit Board RAG

Low Risks - included in risk register where approriate for quarterly review by clinical unit board or Risk Action Group

High and Medium Risks - require actions and controls to be identified by the clinical unit board or equivalent. High and Medium risks are reviewed by the unit board to ensure the grading and actions to be taken are appropriate to minimise the identified risks prior to inclusion on the Risk Register. The aim is to reduce, transfer or eliminate the risk wherever possible. This includes a date for further review by the unit team and a check on the grading, facilitated by the Patient & Staff Safety Link where necessary.

Corporate risks – or those requiring a Trust wide approach are managed by agreement with the relevant Executive Director and may be overseen by a nominated individual, time limited project group or Trust committee.

Local risks – are managed by the clinical team, unit board or department and escalated through their existing reporting line and meeting structure to the relevant executive Director.

3.4 High Risk Monitoring

Progress against High risks is monitored initially by the clinical unit boards monthly and included as part of the key performance indicator reports.

All high risks of 12 and above are included in the Assurance Framework and reveiwed by the Executive Team to support early identification of trends or where additional action needs to be taken.

Quarterly reports go to the Audit Committee as part of the Assurance Framework on the progress to manage assurance or control gaps for high risks.

The above is only a guide and high risks can be escalated for consideration by the assurance framework group in discussion with the relevant executive director. The Executive Group will also discuss specific high risk issues to ensure rapid action is taken where necessary and prevent delays in mitigating such risks.

Appendix 4: Risk Registers

4.1 Purpose of Risk Registers

The Risk Register provides a means to identify and prioritise the principle risks that may affect either service delivery or the environment in which services are delivered. In this way they are applicable to every clinical and non-clinical unit or department within the Trust and every layer of management within the organisation.

4.2 Management of Risk Registers

- **Local Risk Registers** are made up of the key reported events for each unit or department and any specific issues of concern affecting local service delivery or business continuity. They are maintained and updated by the clinical unit or local department, providing reports to the Patient Safety team monthly.
- **Adding risks to the Risk Register**
  A risk identified for inclusion in the register may be from any source eg internal or external factors, adverse events, complaints, claims, PALs, audits, resource issues both staffing and/or financial or by potential changes to other services within the organisation. It could be as a result of a trend following analysis of reported incidents, or something which may affect service delivery or the ability of the unit or department to meet the Trust objectives. Prior to inclusion in the register, it must be agreed with the Clinical Unit Board to ensure the risk has been assessed appropriately and controls identified to mitigate it.
- **Trust Wide Risk Register** is an assimilation of the local risk registers, and is held and updated by the Clinical Governance & Safety team.

The high risks (12 and above) from the Trust wide risk register and any additional strategic risks are themed into the Assurance Framework. The Assurance Framework identifies the Trusts principle objectives and the risks which may prevent those objectives being met (see page 16: 6.6) and is managed by the Company Secretary.

The Clinical unit board or equivalent monitors progress against the risk register and where difficulty in mitigating the risk occurs can escalate to the relevant Executive Director or their deputy. If no alternative means to control the risk is identified, unmitigated high risks are escalated to the Assurance Framework Group and Executive Team as necessary. Unit and Departmental risk registers are discussed at the quarterly Strategic Performance Review meetings.

4.3 Risk Action Groups and risk registers

The purpose of the Risk Action Group is to systematically review risks on the unit risk registers within the time scales identified in the Risk Assessment tool (Appendix 3). They also review the incidents that have been reported by the unit. Due to the specialty mix, it may be appropriate for a clinical unit to have more than one Risk Action Group or one larger group with cross specialty representation. Corporate areas may combine this function within an existing meeting schedule.

Information to inform this process for clinical, non-clinical risk, complaints, and audit is supplied by the relevant unit link from the Clinical Governance & Safety team. Information specific to other risk such as Finance, Personnel, and Information Services is supplied by the relevant link from each of these areas on request. RAG's are facilitated by the Safety Links. Compliance with the required frequency of high risk review is a performance indicator and is monitored by the Patient Safety team.

Appendix 5: Definitions

5.1 Risk Management

Risk Management is the process to identify, assess and prioritise the Trusts exposure to risk whether clinical or non clinical, which may affect its ability to meet its objectives. This may be as a result of loss or damage however caused, to patients, staff, visitors, contractors, finances, business continuity or the reputation of the Trust. Consideration of all service provision from a risk perspective and the factors which affect this, whether financial, environmental or staff related, assists the process to identify risks and mitigate their effect. It informs the decision as to whether a risk can be accepted, delegated, transferred or eliminated[8].

5.2 Clinical Risk

An adverse patient safety incident has been defined by the National Patient Safety Agency as 'any event or circumstance arising during NHS care that could have or did lead to unintended or unexpected harm, loss or damage'. Harm is defined as 'injury (physical or psychological), disease, suffering, disability, or death'. In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient's illness or underlying condition. Those incidents that did not lead to harm, but could have, are referred to as prevented incidents. Loss or damage occurring within the context of clinical risk to the patient, can equally apply to their family, staff or the organisation and may be both financial and/or to reputation. Clinical risk can also occur due to latent decisions eg change to service delivery which create different risks not just an adverse event but which may not be apparent at the time the change is made.

5.3 Non Clinical Risk

Non Clinical risks are any event or circumstance arising during NHS care that could have or did lead to impairment of the Trust's ability to deliver its objectives, whether intended or unexpected. These risks are the outcome of hazards that have the potential to cause, or actually cause, harm by affecting the organisations ability to deliver high quality services. They may relate to a number of the Trusts support mechanisms including health and safety, estates and facilities, technical, information technology, personnel, training or financial aspects of the Trusts business. They may have a direct or indirect affect on patient care, member of staff, visitor, contractor or other stakeholder and result in loss or damage. This loss may be both financial and/or to reputation.

5.4 Principle Risks

Principle risks are those that have significant potential to impair or affect the operational or financial ability of the organisation to deliver ongoing services. These can be strategic or operational and may relate to a change or development in an existing service, or in response to an internal or external driver. As such, they require a system of regular review, as their priority for the Trust in relation to meeting its objectives may change over time.

5.5 Significant Risk

A significant risk is defined as any risk identified as having a medium or high risk consequence and which requires an achievable action plan[9] to identify the controls to be put in place and monitored for effectiveness at reducing the risk. Hazards are assessed using a matrix to identify the likelihood of harm occurring and the impact of the risk. Risks are prioritised using a common format and system across the Trust (See Appendix 3).

5.6 Acceptable risk

[8] See 5.7.page 30

[9] An action plan may be in the form of a business case, written report, included on the risk register or be presented in any applicable format. It should contain what action is required, who is responsible for taking the action, when it will be completed and where it will be reported to.

The Trust makes every effort to ensure that all risks are as low as reasonably achievable. It is not possible to reduce all risks to zero, as there is no such thing as clinically neutral care and decisions must be made as to whether the benefits and best use of resources outweigh the risks. The risk assessment tool enables the Trust to assess the impact and likelihood of a risk occurring and is an aid to decision making to identify what it is reasonable to accept.

Acceptable risk is defined using the following principles:

- If following the rigorous approach to risk assessment, it is decided on balance to accept a risk, those accepted risks should still be controlled. To tolerate risk and accept a risk does not mean to disregard it. Any accepted risk must be reviewed on an annual basis and all options reviewed with an aim to reduce risks further. Patients, staff, visitors, contractors must be made aware of the risks they are being exposed to. No person should be exposed to serious risk unless they agree to accept the risk. In order to be fully informed of the risk, this must be done in a way they can understand.
- It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all the other alternatives, including doing nothing, is even greater.
- Accepted risk is a High Risk and is monitored as outlined in Appendix 3 above. Acceptable risk can only be agreed by escalation through to the Deputy Chief Executive/Chief Operating Officer or by the Chief Executive. Accepted risks are discussed at Trust Board as part of the performance monitoring and assurance systems and may be clinical or non clinical.
- The Assurance Framework is the means by which the principle risks to the Trust are identified and control and assurance gaps reported. It is the tool by which the Trust Board is able to take a view as to whether a specific risk has been reduced to an appropriate level and whether any residual risk in that instance will be accepted.

5.7 Transferring, Delegating, Eliminating risk

Transferring Risk - A service and the associated risks are transferred to another provider
Delegating Risk – a service and associated risks are delegated to another team
Eliminating Risk – a service is no longer provided and the risks are removed.

5.8 Open and Fair culture

The Trust continues to develop a culture that is open and fair where patients and their families know they can approach staff about problems without their treatment being affected; and staff feel able to report hazards, risks and mistakes without fear. Prejudging events by adopting a punitive approach to staff stops information giving, learning and improvement and the risk to patients is increased.

An open culture means that staff are aware of their professional accountability for safe practice, well trained to idenitfy risks early, and know that the outcome of any subsequent investigation is not prejudged (See Incident Reporting & Management Policy).Levels of reporting are monitored internally and externally at least quarterly and through the Risk Action Groups.

A fair culture recognises that events rarely occur as a result of a single, negligent, deliberate or reckless action, but as part of a sequence of human error, systems failures and contributory factors. Each of these factors is considered in any investigation which is undertaken.

As professionals, staff are held accountable for their actions and are expected to report incidents or hazards and to co-operate in any investigation as a result. This includes a duty to report when they feel they are a risk to patients either due to competency, conduct or health reasons as well as any concerns regarding other staff members. A consistent and unified stance for all professions throughout the Trust is maintained and any subsequent actions deemed necessary following a full and thorough investigation, is managed through the appropriate processes already established within the Trust.

5.9 Risk Appetite

The Trust defines its risk appetite as the amount of risk it is prepared to accept, tolerate, or be exposed to at any particular time. The level of risk deemed acceptable (affected by both internal and external drivers) is kept under review by the Trust Board.

The guiding principle of our risk appetite is the "the child first and always". The Trust is committed to doing everything possible to reduce clinical risk for children and to deliver high quality, efficient and effective care. For many children who come to GOSH there is no such thing as a 'no risk' option and the nature of our work is that we do innovative, ground-breaking interventions which at times are high, but controlled, risk. The Trust is committed to working with the child (when mature enough) and his or her family to ensure that they fully understand the options and controls in place to mitigate risk, and are able to give fully informed consent. Research is a key component of our activity, and is, by definition, innovative. Governance structures have been established to ensure that a detailed risk assessment (clinical and financial) of all clinical projects is performed, and the Board is able regularly to review and assess these risks via reports from the Research and Innovation Directorate.

This is also the approach used for non-clinical and business risks. The aim is not to remove all risk but to assess and identify the threats to and vulnerabilities of the business which together can produce the risk. Risk taking then occurs in an appropriate, balanced and sustainable way across the full breadth of the Trusts portfolio of risk. The Trust recognises that controlled risk taking within defined parameters (policies, procedures, objectives, risk assessment, review and control processes) and agreed by the Trust Board, encourages creativity, maximises financial rewards and improves service performance to produce benefits for the child and stakeholders.

Attachment 7

Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting **30 March 2011**	
Trust Health and Safety Policy 2011 **Aidan Holmes** **Health and Safety Advisor**	**Paper No: Attachment 7**
	Date considered by Management Board 17th March 2011

2. Aims / summary

To provide an overarching health and safety policy for the Trust which sets out a framework whereby GOS meets its statutory requirements and managers/employees are fully aware of their responsibilities within the organisation. A full risk assessment /audit program is set out for individual areas.

The appendices can be forwarded to directors on request.

3. Action required from the meeting

This paper requests that the Management Board agrees to ratify the revised policy.

4. Contribution to the delivery of NHS / Trust strategies and plans

The policy will contribute to Zero Harm, by bolstering a culture of safety and continual improvement. The policy also contributes to 'No waste' as safety impacts on revenue and time spent investigating incidents/fines. There are obvious financial benefits of not having 'accidents'.

5. Financial implications

See above.

6. Legal issues

The Trust must have an up – to- date health and safety policy.

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

The Health and Safety Committee. (16th March)
Management Board
Trust Board

8. Who needs to be told about any decision?

Health and Safety Committee. Health and Safety Representatives. Trust Board and Special Trustees

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

Health and Safety Advisor

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

Health and Safety Advisor

11.Author and date

Aidan Holmes (Health and Safety Advisor). 31st March 2011

Great Ormond Street Hospital for Children NHS Trust

Policy

Health & Safety Policy

March 2011

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Document Control Information

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Approved By	Health and Safety Committee	**Approver Position**	Designated Committee
Read By			
Ratified by	Management Board		

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Date approved /ratified	March 2011	**Next Review**	March 2012

Who should know about this policy?

All Staff

1.0 Statement of intent

Great Ormond Street Hospital for Children NHS Trust is committed to the health, safety and welfare of all persons who attend its premises whether as staff, patients, families, visitors or contractors. The Trust seeks to minimise risks to their health and safety and to manage identified risks proactively.

The Trust will provide a working environment, conditions and facilities that comply with current health and safety standards and statutory requirements, while endeavouring to continually improve upon these. It will endeavour to recruit and develop a competent and informed workforce, who receive training in health and safety principles and are provided with access to expert advice, to increase awareness and enable them to work safely.

The Trust encourages and welcomes all employees' involvement in health and safety. All employees have a part to play in maintaining high standards of health and safety and they must take reasonable care of themselves and of other persons who may be affected by their actions. Employees are required to co-operate with the Trust to enable it to meet its health and safety standards and responsibilities and should bring any health and safety risks to their line manager's attention. The Trust will provide a system and process as described in this policy by which such issues can be addressed at local level and escalated as necessary to promote good practice and learning across the Trust.

This policy applies to all areas of the Trust. The following areas are also required to have local Health & Safety policies to manage the specific identified risks in those areas:

- Estates Department
- Pathology Laboratories
- Radiology – to comply with IRMER requirements.

The Trust and the local health and safety policies will be reviewed annually or more frequently in the event of material changes within the organisation E.g. relocation of departments, addition of new services.

This policy must be read in conjunction with the following related policies:

Infection Control Assurance Framework & Operational Policy
Moving and Handling Policy
Control of Substances Hazardous to Health Policy
Security Policy and Procedures
Disinfection Policy for spillage of bodily fluids
Radiation Safety Policy
Exposure to Blood Borne Viruses (including Sharps Injuries) Clinical Guideline
Safe Disposal of Sharps Clinical Guideline
Stress Policy and Toolkit
Risk Management Strategy Policy
Incident Reporting & Management Policy
Lone Worker Policy

This list is not exhaustive.

2.0 Organisational responsibilities

This sets out the organisation of health and safety at Great Ormond Street Hospital and includes the responsibilities of all who work for the Trust. These responsibilities do not take account of job specific responsibilities of managers and staff as these should be included in individual job specifications.

2.1 Chief Executive

The chief executive has overall responsibility for health, safety and welfare at Great Ormond Street Hospital for Children and must ensure that:

- there is an effective, signed health and safety policy that has been approved by the Trust Board and that the policy is revised as appropriate;
- the Trust Board is aware of and informed about the health and safety programme at Great Ormond Street Hospital, areas identified of concern and actions taken to address these. A report on health and safety will be included in the quarterly performance review to the QSC;
- a health and safety advisor is appointed who has the necessary level of training and is provided with the resources to support implementation and facilitation of the required health and safety programme across the organisation.

2.2 Trust Board

The Trust Board must:

- ensure that the Trust has an effective health and safety policy, which is being implemented across the organisation;
- be informed of recommendations received and actions taken;
- support the health and safety programme and persons who are active in implementing it;
- provide the necessary resources to enable health and safety requirements to be met;
- be concerned about the safety of patients and persons attending the Trust's premises.

This also applies to areas under the direction of the Special Trustees where Trust staff, patients, visitors or contractors may have access or be working.

2.3 Directors

Directors must:

- determine that their areas of responsibility have an effective health and safety policy that is compatible with this policy and addresses the specific issues related to their working practice where applicable (Estates and Laboratories);
- ensure the Trust health and safety policy is implemented throughout their areas of responsibility;

- take note of and act upon information and recommendations received;
- support the health and safety programme and persons who are active in implementing it;
- provide the necessary resources to enable health and safety requirements to be met, based upon the assessment of identified risks and compliance against statutory health and safety standards;
- be concerned about the safety of persons attending the site/premises and to take action to ensure that their staff are properly trained to enable them to implement effective health and safety programmes.

2.4 Health and Safety Advisor

The health and safety advisor is responsible for the development and co-ordination of health and safety in the Trust. He or she must:

- develop and agree with the Company Secretary the annual health and safety plan, including training, which will be agreed by the Trust Board or designated committee;
- make recommendations to the Trust via the health and safety committee for the revision of the health and safety policy as necessary to ensure compliance with statutory requirements;
- ensure that the arrangements in the Trust's health and safety policy at Great Ormond Street Hospital are appropriate to manage the risks;
- ensure that all senior managers, managers, supervisors, health and safety links and staff are aware of their responsibilities for health and safety management;
- ensure that safety representatives and safety links are kept informed and consulted on any issue that may affect Great Ormond Street employees;
- be informed of health and safety regulations, approved codes of practice, other relevant guidance and current practice and to keep the chief executive, Trust Board and health and safety committee informed of these matters;
- prepare a progress report on the health and safety programme for presentation to the Health & Safety Committee.

To enable the health and safety advisor to fulfil these responsibilities he/she has a responsibility to ensure that he/she is competent and up to date with current practice as required by the Health and Safety Executive.

2.5 Senior Managers

Senior managers are responsible for the health and safety of employees in their departments and must:

- implement this health and safety policy throughout their areas of responsibility;
- ensure all managers, supervisors and employees understand and follow the policy for health and safety;
- allocate adequate resources (including funds) to meet health and safety requirements based on risk assessment of identified risks;
- nominate health and safety links for their areas of responsibility;
- ensure that risk assessments are conducted within their areas of responsibility and that safe systems of work are in place for any hazardous activities;

- ensure the managers, supervisors and employees under their line management are provided with health and safety training including induction training and mandatory eighteen monthly annual updates;
- involve and consult all their managers, supervisors and employees on aspects of health and safety issues when these are raised.

2.6 Managers and Supervisors (Heads of Dept)

Managers and Supervisors are responsible for the employees under their control and must:

- implement this health and safety policy in their areas of responsibility;
- ensure all persons working for them understand and follow this policy for health and safety;
- conduct risk assessments and audits in their areas of responsibility, or delegate that responsibility to the local health and safety link, and develop and implement safe systems of work for any hazardous activities;
- ensure that employees under their control are provided with health and safety training including local induction, Trust induction and eighteen monthly update;
- provide all new starters and any temporary workers with relevant training including local induction training, induction training and subsequent eighteen monthly updates;
- ensure employees attend any mandatory health and safety training;
- report and investigate all accidents to their manager and the Health and Safety Advisor;
- involve and consult with all employees on health and safety matters, taking appropriate action and obtaining advice from the Health and Safety Advisor as necessary.

2.7 General Responsibilities

All staff must:

- follow this health and safety policy in their work;
- take due care of their own health and safety and that of anyone who may be affected by their activities;
- bring any health and safety hazards or concerns to the attention of their line manager;
- attend any health and safety training required including induction training and mandatory annual updates;
- attend any mandatory health and safety training provided and follow Trust procedures;
- use any personal protective equipment provided and report any defects in the equipment to their line manager;
- report all accidents and incidents and assist as may be able in the investigation of these;
- assist with carrying out risk assessments as appropriate in their areas of activity and with the development and implementation of any safe systems of work

- be aware of any local health and safety requirements regarding their areas of work or environment.

3.0 Arrangements for Health and Safety

This section contains arrangements to ensure the Trust's compliance with statutory requirements for health and safety.

3.1 Risk assessments

Risk Assessment is a process which identifies hazards (*what could cause harm*) and assesses risk (*how likely an accident or ill-health is*) in order to decide whether the current methods of protection are adequate (HSE 2000).

The risk assessment will show all the risks you have identified. It is good practice to ensure that this information is disseminated so that all your colleagues are aware of the same risks. All risk assessments must be given to your department/unit risk lead. Significant risks **must** be added to your departmental/specialty risk register to ensure the risk is reviewed and new controls/actions are identified and undertaken as appropriate. As these risks are reviewed, some of them will be removed from the risk register, and new risks will be highlighted. The Health and Safety Team or the Clinical Governance and Safety Team (CGST) must be informed of changes to your risk register. If issues arise that require disseminating across the Trust, then the CGST team will facilitate this process. All high risks should have achievable action plans documented, to show whether you are going to try and, eliminate, reduce, isolate, control, or transfer the risk to someone else. (See Controls hierarchy below)

Appendix 4 sets out the procedures to be adopted when carrying out risk assessments and includes advice and guidance on completing the assessments. Local areas are responsible for assessing their own risks (Please see 2.0 Organisation Responsibilities) but should seek guidance from the Health and Safety Advisor when necessary. Each type of department (Clinical/Non-clinical/Laboratory/Facilities/Estates) has its own specific risk assessment and audit cycle.

Please see Appendix 4 for specific guidance on:

- When and What you should risk assess,
- Clinical and Non-Clinical Areas
- How to assess the risks in your workplace
- The 'FIVE STEPS' rule
- Trust wide risk assessment and audit cycle
- Monitoring your progress against the risk assessment cycle
- Risk assessment process flowchart
- HSE Control Measure Hierarchy
- Further guidance on risk assessments
    - Clinical risk assessments
    - Risk assessment and Business Cases
    - Moving and Handling
    - The GOSH generic risk assessment tool

3.2 Accident investigation and reporting

An accident is an unplanned event that can lead to injury to a person or damage to premises, property or equipment. Staff should ensure that every accident and near miss is bought to their managers' attention. Managers must investigate each accident/incident, informing the Health and

Safety Advisor via the incident reporting procedure of the outcome of the event, and must monitor their departments' risks. Accidents involving staff who are subsequently off work for more than three days require reporting under the RIDDOR requirements and these must be notified to the Health and Safety Advisor as soon as possible.

3.3 Incident Reporting

Incident reporting forms a corner stone of the Trust's attempts to systematically manage health and safety. The Trust needs to have an accurate over-view of all incidents, whether affecting patients, staff, visitors or contractors. It is the responsibility of every member of staff to report all non-clinical incidents or incidents which are likely to have a bearing on the quality, safety or efficiency of the care the Trust and its staff provide. An Incident form must be completed as soon as possible, preferably by the person involved in the incident, and passed to the relevant line manager. The completed incident form must then be sent to the health and safety team within 5 days, to satisfy statutory requirements under the Reporting of Incidents, Diseases and Dangerous Occurrence Regulations 1995 (RIDDOR) and also to ensure incidents are followed up in a timely manner. For more information please see the Trust's Incident Reporting & Management Policy.

3.4 Safety Inspections –

Managers will arrange for active monitoring of health and safety standards to be carried out when a risk is identified or by following the annual risk assessment cycle. Completed assessments/inspections must be kept in the departmental health and safety folder and reported to the health & safety Advisor. Currently ward areas receive PEAT inspections in addition to their six monthly assessments. Please refer to you areas risk assessment and audit cycle for further guidance as to when these inspections/assessments will occur. Please note that all employees are obliged to report any health and safety issues/concerns to their line manager as appropriate.

3.5 New and Expectant Mothers

Employees who become pregnant should inform their manager as soon possible. Managers must then carry out a risk assessment for the expectant mother taking into account the generic assessment for the expectant mother and her work. The assessment must then be sent to the Occupational Health Department. Advice on this assessment can be obtained from the Health and Safety Advisor. The assessment should be reviewed regularly throughout the pregnancy and when the new mother returns to work.

3.6 Young workers

Whilst rare it is important that managers are aware that must assess the risks to young persons (under 18 years old) before they start work, taking into account their lack of experience and training. Managers should also consider any specific restrictions (use of dangerous machinery, etc). The findings of the risk assessments should be sent to their school or guardians if they are below the minimum school leaving age (16years). Adequate supervision and training must be given. The line manager is responsible for securing risk assessment findings for reference/audit purposes.

3.7 Management of temporary staff

The Trust recognises that there are occasions when it is not appropriate for temporary staff to attend a full induction. However, all temporary staff should receive, as a minimum, information on the following:

- Fire precautions – including what to do if they smell smoke or see a fire, emergency exits, and fire alarm bells;
- Security/crash emergency telephone numbers;
- Who they should contact with any health and safety concerns (this should, in most circumstances, be the line manager);
- Location of the local COSHH folder;
- Infection control;
- Any local hazards;
- A copy of the induction to be retained by staff member and line manager;
- Line manager to store induction information securely for reference/audit purposes.

3.8 Manual handling

Manual handling activities with risks to health and safety should be avoided. Where unavoidable, risks must be suitably assessed in accordance with current guidance. Managers should arrange for an assessment of manual handling activities by the manual handling risk assessor and take action to eliminate, reduce or control manual handling tasks. Staff who undertake manual handling tasks must be provided with training on the safe lifting of loads. For more information see the manual handling policy.

3.9 Display screen equipment

Managers must ensure that all users of display screen equipment are identified and that they have completed a work station self assessment form. All new starters must undertake a Work Station Assessment prior to starting work. Managers must review the assessment form and take the action necessary to make the workstation safe for the user. All users should be given a copy of the guidance on the safe use of display screen equipment, which is available on the document library. The process will be audited by the Health and Safety Advisor on an annual cycle.

3.10 Slips, trips and falls

Slips, trips and falls are one of the most common causes of injury in the hospital. Risk assessments must be undertaken by local managers at ward and department level in respect of hazards which may cause slips, trips, falls involving patients, staff and others as well as falls from height. Floors and walkways should be suitable for their purpose, in a good condition and free from obstructions. Traffic routes should be organised so that people can circulate safely. A weekly health and safety walkabout monitors the state of the environment of the Trust in order to help negate the chance of incidents. The work of this group is monitored on a quarterly basis by the Health and Safety Committee. To bolster this process an annual audit is undertaken by the Health and Safety Team of the slip/trip/fall hazards in all Trust areas (See Appendix 1). Audit results and slips, trips and falls incidents are discussed on a quarterly basis at the Trust Health and Safety Committee and included in reports to wards and departments and included on the risk registers where appropriate for discussion at the local RAG groups. Where bespoke slip/trip/falls assessments involving staff/patients/visitors or environment are required please contact the Health and Safety Team for advice.

Managers are responsible for undertaking these risk assessments and should arrange regular visual inspections of the areas under their control and take appropriate remedial action to reduce risks. Staff are responsible for identifying and not causing slip or trip hazards, must clean or

arrange for appropriate cleaning of any spillage that they make and wear suitable footwear while at work. Specific risk assessment training is provided by the Health & Safety Team and monitored centrally by the Education and Training Department. Information on the management of slips trips and falls is included in induction and update in line with the requirements identified in the training needs analysis. All training is monitored centrally by the Education and Training Department. For working at height see sections 3.20 below and Appendix 3.

3.11 First aid

Managers should ensure (via risk assessment) that there is adequate first aid cover for their areas of responsibility. Managers will ensure first aiders are trained. First aiders should ensure that first aid boxes are checked each month or after use and that a record is kept of any person seeking first aid and the action taken or advice given. First aiders must complete an incident form any time they are required to administer any first aid.

3.12 Working temperatures

In line with national legislation and guidance, the Trust must provide a reasonable working temperature for staff and visitors. This is defined as between 16°C (60.8°F) and 30°C (86°F). If the work being undertaken involves severe physical effort then the lower limit is 13°C (56°F).

Managers should take reasonable steps to achieve a reasonably comfortable temperature, for example by insulating hot plant or pipes; shading windows; siting workstations away from places subject to radiant heat; where practical there should be systems of work (for example, task rotation) to ensure that the length of time for which individual workers are exposed to uncomfortable temperatures is limited; and allowing staff time to get cool or hot drinks.

Risk assessments should include an assessment of the workplace environment and managers should identify staff who are particularly at risk from extreme temperatures, such as pregnant workers or those with heart conditions. Staff doing manual work must take particular care when temperatures are high.

3.13 Chemicals and Hazardous substances (COSHH)

Managers must identify all substances used and stored within their areas of responsibility and carry out a COSHH assessment on an annual basis. The use of hazardous substances should be avoided when practicable and the more hazardous substances should be substituted for the less hazardous. Assessment findings must be conveyed to employees and evidence of the assessment kept locally in the COSHH folder (where applicable) with a copy to the Health and Safety Advisor. Employees must comply with the recommendations following the assessment and if necessary wear any provided personal protective equipment. Please refer to the Trust 'Control Of Substances Hazardous to Health' Policy for further guidance. Additional information is available from the Health and Safety Advisor or on the Clinical Governance and Safety Team website.

3.14 Fire safety

Fire Risk Assessments for the Trust are undertaken by the Hospital Fire Risk Assessment Manager. Staff must comply with all instructions given to them in regard to fire safety and any other fire procedures. *Failure to comply with such instruction may lead to disciplinary action being taken.* Staff must also report any observed shortcomings in fire precautions to their local management. Further information can be found in the Trust's fire prevention and precautions policy.

3.15 Safe use of electricity

This guidance is aimed at preventing electric shock, burns, fire or explosion. The Electricity at Work Regulations 1989 applies to all electrical equipment and installations. Managers must regularly carry out visual inspections of the electrical installations and portable equipment under their control (see risk assessment cycle Appendix 4). Staff must all carry out visual inspections of any electrical appliances before they use them. Any incidents relating to the safe use of electricity should be reported to the Works department on extension 5412.

3.16 Safe use of ladders

The main risk is of a fall from a ladder or the ladder slipping. Before using a ladder, employees should assess if a ladder is the most appropriate equipment to use for the task.
A third of all reported fall-from-height incidents in the United Kingdom involve ladders and stepladders. Many of these injuries are caused by inappropriate or incorrect use of the equipment.

The Health and Safety Advisor can give you guidance to help employees:

- know when to use a ladder;
- decide how to go about selecting the right sort of ladder for the particular job;
- understand how to use it;
- know how to look after it; and
- take sensible safety precautions;
- keep and maintain a ladder inventory.

Managers should ensure that all staff who need to use ladders are familiar with this process of risk assessment. Advice and training can be obtained from the Health and Safety Advisor.

For guidance on undertaking a working at height assessment please see Appendix 3

3.17 Confined space working

A confined space is any place, including any chamber, tank, vat, silo, pit, trench, pipe, sewer, flue, well or other similar space in which, by virtue of its enclosed nature, there arises a reasonably foreseeable specified risk. The Health and Safety Advisor can provide information and guidance to staff on the identification of confined spaces, the risk assessment requirement and how to develop a safe system of work. Please contact the Estates department for a current list of areas identified as confined spaces and measures which must be put in place prior to any work commencing.

3.18 Radon gas

See Radiation Safety Policy for full information.

3.19 Noise at work

Managers must arrange to have the noise assessed in areas where excessive noise may be occurring. This can be facilitated by contacting the Health and Safety Team on extension 7885/6. As a guide this is defined as ‘people having to shout or raise their voice to be heard by someone two metres away’.

Managers must:

- advise staff where noise levels are high and warn about the risks to hearing;

- control the noise where possible;
- provide ear protection suitable for the job, e.g. ear muffs or ear plugs;
- provide adequate information and training.

Employees must use any personal protective equipment provided and use ear protectors all the time they are exposed to loud noise. This excludes social events.

3.20 Work at height – permit to work system

All work above a 2m height requires a permit to work. Permits can only be obtained from the Works Department and will only be issued on the presentation of a suitable risk assessment and method statement. Permits must be obtained before any work at height takes place. These permits must be retained and be available for inspection as necessary. On completion of the work the permit should be returned to the issuer to be signed off. Please see Appendix 3 for assistance on undertaking a working at height risk assessment.

3.21 Traffic management, vehicular and pedestrian safety

The findings of any traffic management risk assessment should be disseminated to all relevant staff and the consequent safe system of work be complied with.

3.22 Contractor competence and control

The Trust will identify suitable contractors through competence checks and selection procedures. Managers will carry out these procedures for any contractors that they employ on site. Department managers will ensure that any health and safety hazards within the area of work are communicated to the contractor. Project managers will issue the Trust's Contractor Policy to all new contractors and arrange a health and safety induction. Project managers must ensure an Impact Risk Assessments are undertaken to mitigate risks whilst work is being undertaken on site.

3.23 Security and Security Risk Assessment Arrangements

The Security Manager (Local Security Management Specialist) must ensure that each building has a suitable and sufficient security risk assessment taking into account the physical security of the building and assets. Security risk assessments will be conducted on an annual basis or as and when there are changes in the fabric of the building or new buildings come on line. Security risk assessments will be included in the Fire and Security quarterly report monitored via the Health and Safety Committee. All staff receive security training via the induction and update program.

3.24 Health and safety audits

Monitoring your progress against the risk assessment program

Your departments' progress in undertaking risk assessments and your departmental risk register will be audited by the Trusts' Health and Safety Team. Progress against High risks is monitored initially by the Risk Action Groups/ Clinical Unit Boards on a monthly basis and included as part of the key performance indicator reports. All high risks of 12 and above are included in the Assurance Framework and reveiwed by the Executive Team to support early identification of trends or where additional action needs to be taken. The Executive Group will also discuss specific high risk issues to ensure rapid action is taken where necessary and prevent delays in mitigating such risks.

The objective of health and safety auditing is to check the adequacy of the health and safety policy, organisation and arrangements; and to measure the Trust's performance against these. Health

and safety audits will be carried out annually to the requirements of Health and Safety Executive's publication, 'Successful Health and Safety Management'.

An annual audit cycle is in place and is monitored by the Health and Safety Advisor. The audits will differ depending on the type of department but all will include a systematic examination of the health and safety management of the Trust and will include the following areas:

Trust Risk Assessment and Audit Cycle (Please click on the type of department below to see your local risk assessment and audit plan).

- Clinical Area
- Non-clinical area
- Estates Department
- Facilities
- Laboratory

3.25 Monitoring of Compliance

Compliance with this policy will be monitored as part of an ongoing audit cycle and reported quarterly to the Health & Safety Committee. The audit tools are given in Appendix 7 and the Schedule of reporting can be found on the meeting papers library.

What	Where	When	Assurance
Slips trips & Falls	Modern Matrons Sisters Health & Safety Committee	Annually	Health and Safety Committee Quality & Safety Committee
COSHH	Modern Matrons Sisters Health & Safety Committee	Annually	Health and Safety Committee Quality & Safety Committee
Sharps incidents	Modern Matrons Sisters OH user group Health & Safety Committee	Monthly	Health and Safety Committee Quality & Safety Committee
Lone worker	Health & Safety Committee	Annually	Health and Safety Committee Quality and Safety Committee
Gas regulator & bottle safety	Modern Matrons Sisters Health and Safety Committee	Annually	Health and Safety Committee Quality & Safety Committee
Walkaround results	Contractors Corporate facilities Estates Health & Safety Committee CGST	Quarterly	Health and Safety Committee Quality & Safety Committee
Trust Audit cycle results	Health & safety Committee	Annually	Health and Safety Committee

			Quality & Safety Committee
Summary report of Health & safety committee	Quality & safety Committee	Twice a year as per reporting schedule	Health and Safety Committee Quality & Safety Committee
RIDDOR	Health & Safety Committee HSE	Quarterly As occur	Health and Safety Committee Quality & Safety Committee

3.26 Health and Safety Training

A Trust wide health and safety Training Needs Analysis has been undertaken to determine the level of training required for all staff groups. This is reviewed annually at the Trust Health and Safety Committee.

Health and Safety training records are maintained centrally by the Education and Training Department with a system to identify attendance, and chase non-attenders as necessary. They will maintain central records of attendance at training sessions and feedback will be given to the relevant managers on the numbers of staff attending or not attending on a regular basis. The training given by the Health and Safety Department includes:

- Risk assessment training (Both generic and bespoke)
- Induction and Update training for all Trust staff (Including: What is Health and Safety? A guide to Health and safety/Who is responsible?/slips trips falls/stress/Sharps injuries/COSHH/Display Screen Equipment/ Skin Surveillance/Incident Reporting/RIDDOR/Lone working/ Further information).
- Manual handling training for all staff
- A local induction is undertaken for all staff and results audited by the Education and Training Department, results of which will be brought to the Trust Health and Safety Committee.
- Online DATIX incident reporting training.

4 Duties in relation to a Health and Safety Incident

The following describes the duties of individuals who may be involved in a health or safety incident or be required to ensure the health and safety of staff, patients or visitors is part of a managed process. Compliance with these roles will be monitored through the governance processes of the Trust and the Health & Safety Committee. Further detail is included within the policy.
Actions to be taken in the event of a health & safety incident

4.1 Person Involved in a Health & Safety Incident

- Ensure your own and others safety
- Undertake or access first aid as appropriate
- Report incident to your line manager
- Inform CSP out of hours
- Complete incident form
- Attend Occupational Health if advised to do so or nature of incident requires it e.g. needlestick
- Attend A&E if advised to do so
- Inform manager if injury likely to result in more than 3 days off work.

- Discuss with your manager when safe to do so the cause of the incident and how the risk of recurrence may be prevented.

4.2 Manager / Department Heads

- Ensure your own and others safety.
- For sharps incidents refer to **Exposure to blood borne viruses (Including Sharps Injuries)** clinical guideline and ensure immediate/ first aid actions are completed.
- For hazardous substances check the COSHH folder in your local area (Clinical) or the **policy found on the Document Library.**
- Take action as required to maintain safety and undertake appropriate risk assessment.
- Grade 4 & 5 incidents (permanent harm, death) - report immediately to Health and Safety Advisor ext 7885.
- Grade 0-3 (near miss, no harm, non permanent injury) - Consider first aid, deal with incident locally and in line with risk management policies.
- Check incident form completed and sent to Clinical Governance & Safety Team (CGST).
- Co-ordinate any investigation under guidance from the Health and Safety Advisor.
- Review draft reports into incidents ensuring comments from relevant staff are included.
- Review monthly incident reports and take action as required to reduce the risk.
- Carry out local risk assessments to meet health & safety requirements.
- Review Risk Register for the department/ ward area.
- Escalate any concerns to relevant General Manager / Director.

4.3 All staff

- Read the Health and Safety policy as part of the local induction.
- Read and sign COSHH policy as part of local induction.
- Understand your duty to take care, prevent and report issues which may affect your own and others health and safety.
- Use PPE if provided.
- Duty to report any accidents and incidents in line with any stated time scales within the Health and Safety Policy.

4.4 CSP / Duty manager

- Out of hours act as the manager (see above1.2).
- Inform health and safety team on next working day for grade 4-5.
- Grade 0-3 – Check incident form sent to Health and Safety.
- Initiate any investigation or external reporting required.

4.5 Health and Safety Team

- Log all health and safety incident forms.
- Grade 0-2 – Check grading and log by ward and department.
- Review monthly reports to each unit and department.
- Grade 3-5 – Check status of staff member or person involved in incident.
- Consider SUI reporting to NHS London via STEIS system – discuss with Head of Clinical Governance & Patient Safety.
- Inform Executive team, CEO, etc.
- Consider level of investigation required and agree with local manager.
- Consider whether incident needs reporting to Health & Safety executive.
- Monitor progress and support any investigation required.

4.6 Health and Safety Advisor

- Monitor Trust compliance with statutory duties and report in line with schedule of reporting to relevant operational and assurance committees as required.

- Review reports on areas relevant to health and safety compliance e.g. monthly skin checks, reported sharps injuries, slips, trips, falls.
- Oversee any investigations into health & safety incidents.
- Establish contact with relevant external agencies e.g. HSE.
- Monitor implementation of action plans regarding Health & Safety requirements.
- Monitor compliance with external alerts.
- Co-ordinate reports to external agencies.
- Co-ordinate reports internally.
- Monitor and report on compliance with Health and Safety Audit cycle, policy and follow up actions.
- Horizon scan for statutory changes or legislation regarding Trust liability.

4.7 Medical Director

- Respond to Health and Safety Advisor queries.
- Escalate to CEO as appropriate.

4.8 Chief Executive Officer

- Overall responsibility for health and safety.
- Sign off Health and Safety Policy presented to Board annually.
- Provision of adequate resource to enable Trust to meet statutory Health and Safety requirements.
- Receive assurance via governance structure of the Trust that health and safety requirements are being met.

5.0 Records of Health and Safety

This section contains evidence of the unit/departments implementation of the standards for health and safety and will be contained in the health and safety manual titled – Health and Safety Records and COSHH folder. These records will be kept on the wards/departments by the managers/sister, as applicable. They will be audited on an annual basis by the health and safety team. Results of the audit will be fed back to the health and safety committee.

Health and Safety Records and COSHH Folder

Records

5.1 Copy of Health and Safety Policy
5.2 General Risk Assessments
5.3 Manual Handling Assessments
5.4 COSHH Assessments/SOPs (If Applicable).
5.5 For Fire Safety Arrangements incl. Risk Assessment please see Fire Safety manual
5.6 Ladder Inventory and Records of Inspection (if applicable)
5.7 Health and Safety Training Records
5.8 First Aid Records including, Training and of First Aid provision
5.9 Records of Health and Safety Inspections/Audits

6.0 Useful contact details

Health and Safety Advisor	GOS ext 7885
Health and Safety Assistant	GOS ext 7886
Radiation Protection Advisor	GOS ext 5220
Staff Side Representatives	GOS ext 5284
Moving and Handling trainer	GOS ext 0149
Camelia Botnar Laboratories Representative	GOS ext 5546
Infection Control Nurse	GOS ext 5284

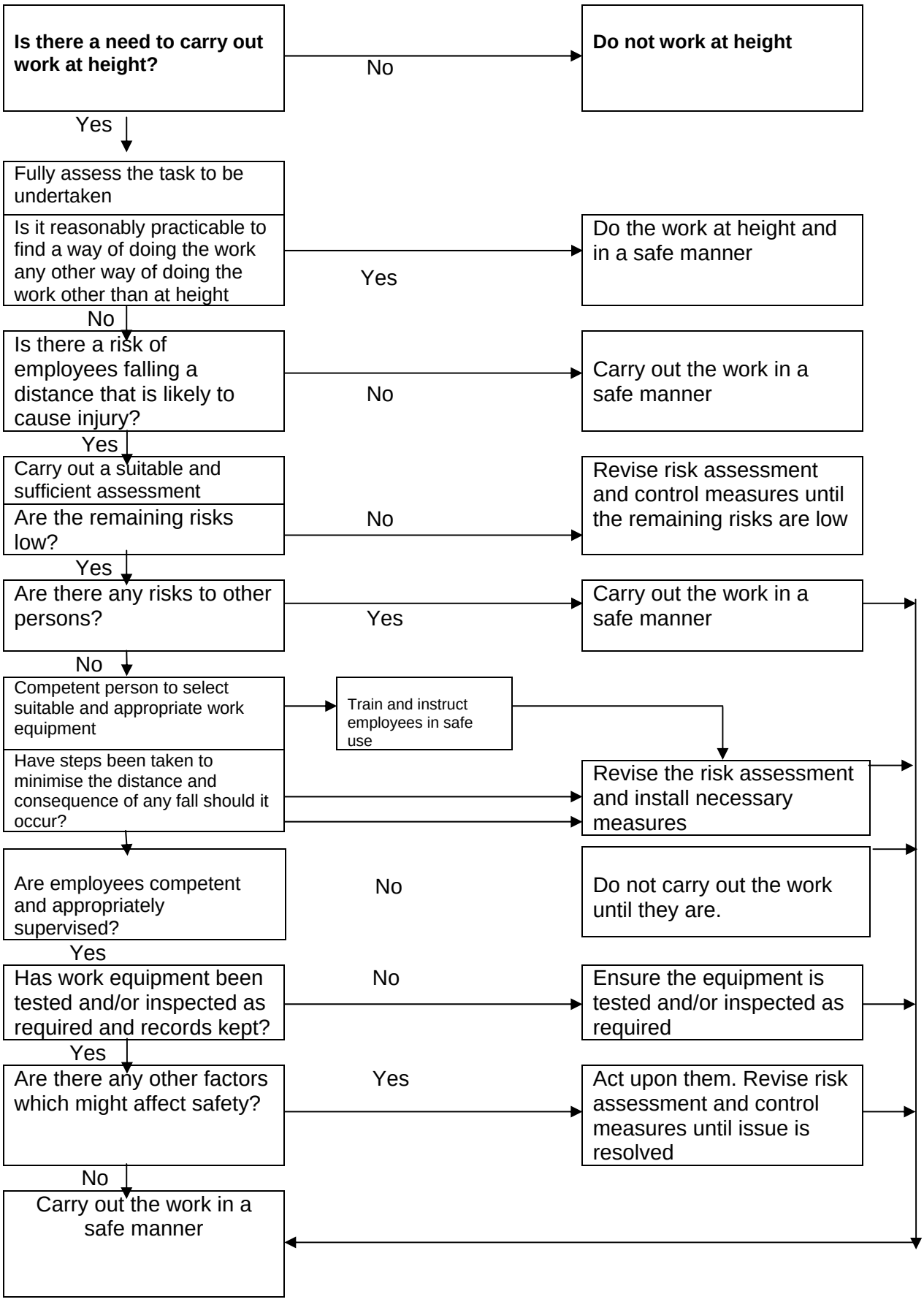
Appendix 1 - Slips/Trips/falls Ward Audit Tool

Is the floor in the ward suitable for the type of work activity that will be taking place on it?	Yes ☐ No ☐
Is the floor dry?	Yes ☐ No ☐
Is the floor clear of clutter/trip hazards?	Yes ☐ No ☐
Is the floor maintained in a good order? (No holes, uneven surface, curled up edges)	Yes ☐ No ☐
Is the floor free from trip hazards?	Yes ☐ No ☐
Check five Staff members footwear	Yes ☐ No ☐

Appendix 2 - Health and Safety Folder Audit Tool

1. Copy of Current Health and Safety Policy	Yes ☐ No ☐
2. Risk Assessments(generic/DSE/Noise)	Yes ☐ No ☐
3. Manual Handling Assessments	Yes ☐ No ☐
4. COSHH Assessments/SOPs	Yes ☐ No ☐
5. Ladder Inventory and Records of Inspection (if applicable)	Yes ☐ No ☐
6. Working at Height Risk Assessments/Training records (If applicable)	Yes ☐ No ☐
7. Health and Safety Training Records	Yes ☐ No ☐
8. First Aid Records including, Training and of First Aid provision	Yes ☐ No ☐
9. Records of Health and Safety Inspections/Audits	Yes ☐ No ☐

Appendix 3 - Working at height risk assessment flow chart



Appendix 4 - Risk Assessment

How to undertake a Risk Assessment: The 5 Steps

Risk Assessment is a process which identifies hazards (*what could cause harm*) and assesses risk (*how likely an accident or ill-health is*) in order to decide whether the current methods of protection are adequate (HSE 2000).

When and what should you risk assess?

There is a risk assessment program which clearly sets out the mandatory risk assessments you are required to undertake within your department/unit. However there are times when further assessments/reviews are necessary. These include:

- If the work changes significantly
- If there is an accident/incident
- When someone returns to work after sickness or injury, or suffers a change in their health, that could be affected by their work
- New products or process are introduced to the workplace

A risk assessment is best undertaken by a multi-disciplinary team to gain different perspectives. The process of undertaking a risk assessment is the same for clinical, non-clinical, research projects and moving and handling assessments. Please follow the steps below:

Clinical and Non-Clinical Areas

To facilitate the risk assessment process the area manager will receive a non-clinical or a clinical checklist to aid them in the undertaking of their mandatory risk assessments.

How to assess the risks in your workplace

When thinking about your risk assessment, remember:

- a **hazard** is anything that may cause harm, such as biological agents, chemicals, electricity, working from ladders, a needle etc;

- the **risk** is the chance, high or low, that somebody could be harmed by these and other hazards, together with an indication of how serious the harm could be.

Many of the hazards/risks are well known and the necessary control measures are easy to apply. You probably already know whether, for example, you have staff that move heavy loads and could therefore harm their backs, or where people are most likely to slip or trip. If so, check that you have taken reasonable precautions to avoid injury.

Follow the five steps rule when undertaking a risk assessment:

■ Identify the Hazard
■ Decide who can be harmed and how
■ Evaluate the risks and decide on precautions
■ Record your findings and implement them
■ Review your assessment and update if necessary

Step 1 Identify the hazard.

A hazard is anything that can cause harm or has the potential to cause harm. The important thing is that you identify those hazards.
There are many things in place to mitigate the risk of hazards (Safety cabinets in the laboratories, PAT testing in offices, needleless systems on the wards, manual handling training for all staff)

How can you identify hazards?

- **Walk around** your ward/workplace and look at what could reasonably be expected to cause harm (to patients/visitors/employees/contractors)
- **Ask your employees** or their representatives what they think. They may have noticed things that are not immediately obvious to you.
- **Study** previous Incidents/trends and complaints or other indicators that area available in the Trust. Your ward/department receives monthly incident reports. Use them intelligently.
- **Remember to think about long-term hazards to health** (e.g. high levels of noise or exposure to harmful substances) as well as safety hazards.

For further guidance and information please refer to the Trust Hazard Guidelines.

Step 2 Decide who can be harmed and how?

GOSH has many vulnerable groups that need to be taken into account when undertaking a risk assessment. Consider what particular risks there may be to each of the different groups of people involved (or exposed) to the hazards identified and how this will affect the level of risk.

Groups you should consider

- Patients
- Visitors
- Members of the public
- Employees
- Contractors

Do they have special needs?

- Young/old
- Pregnant
- Disabled
- Inexperienced
- Working alone

Step 3 Assess the risks and decide if measures currently in place are adequate to prevent harm or should more be done using the HSE's Controls hierarchy.

For practical examples of hazard prevention please see the hospital guide.

State the risks that are involved with the work and establish how likely it is that these will cause harm, and how severe this harm is likely to be. The matrix below will help you determine the severity of the risk. These need to be documented on the risk assessment form and this answer will determine whether or not you need to try and reduce the risk. Even after all safety measures have been implemented, some risk usually remains. What you need to decide is whether the remaining risk is high, medium or low. Your aim is to make all risks smaller by implementing adequate control measures. If the existing risk is medium or high then you should implement

additional measures to reduce the risk to 'Low' as far as possible or practicable. Then consider whether these are enough to control the risk or whether other controls or actions are required to mitigate the risk further.

SEVERITY	LIKELIHOOD				
	1 **Very Unlikely** ***(Freak event – no known history- 1 in 100,000 or less)***	**2** **Unlikely** ***(Unlikely sequence of events1 in 100,000 to 1 in 10,000)***	**3** **Possible** ***(Foreseeable under unusual circumstances 1 in 10,000 to 1 in 1000)***	**4** *Likely* ***(Easily foreseeable – 1 in 100 - 1000)***	**5** **Very Likely** ***(Common occurrence – 1 in 100 chance in any one year)***
1 **Negligible** ***(No injury, no treatment required, no financial loss.)***	Low	Low	Low	Low	Low
2 **Minor** ***(Short term injury, first aid treatment required, minor financial loss)***	Low	Low	Low	Medium	Medium
3 **Moderate** ***(Semi permanent injury, possible litigation, medical treatment required, moderate financial loss)***	Low	Low	Medium	High	High
4 **Major** ***(Permanent injury, long term harm or sickness, potential litigation, fire, major financial loss)***	Low	Medium	High	High	High
5 **Catastrophic** ***(Unexpected death, potential litigation, catastrophic financial loss)***	Low	Medium	High	High	High

■ Step 4 Record your findings and implement them

The risk assessment will show all the risks you have identified. For clinical and non-clinical risks, it is good practice to ensure that this information is disseminated so that all your colleagues are aware of the same risks. All risk assessments must be given to your department/unit risk lead. Significant risks **must** be added to your departmental/specialty risk register to ensure the risk is reviewed and new controls/actions are identified and undertaken as appropriate. As these risks are reviewed, some of them will be removed from the risk register, and new risks will be highlighted. The Clinical Governance and Safety Team (CGST) must be informed of changes to your risk register. If issues arise that require disseminating across the Trust, then the CGST team will facilitate this process. All high risks should have achievable action plans documented, to show whether you are going to try and, eliminate, reduce, isolate, control, accept or transfer the risk to someone else. (See Controls hierarchy below)

■ Step 5 Review your assessment and update if necessary

Risk reduction is an ongoing process and as such periodic reviews of risk assessments and action plans are required to evaluate its success. Sometimes, when you introduce steps to reduce risks, you may introduce further hazards. It is important that this process is reviewed on an ongoing basis so that staff and patients are not vulnerable. Few workplaces stay the same. Wards/laboratories/departments move, bring in new equipment, substances and procedures that could lead to new hazards. It makes sense, therefore, to review what you are doing on an ongoing basis.

Please see your local risk assessment timeframe to ascertain when you are scheduled to undertake your mandatory risk assessments and follow up audits. If in doubt contact the health and safety team or click on your relevant department type for guidance.

Trust Risk Assessment and Audit Cycle

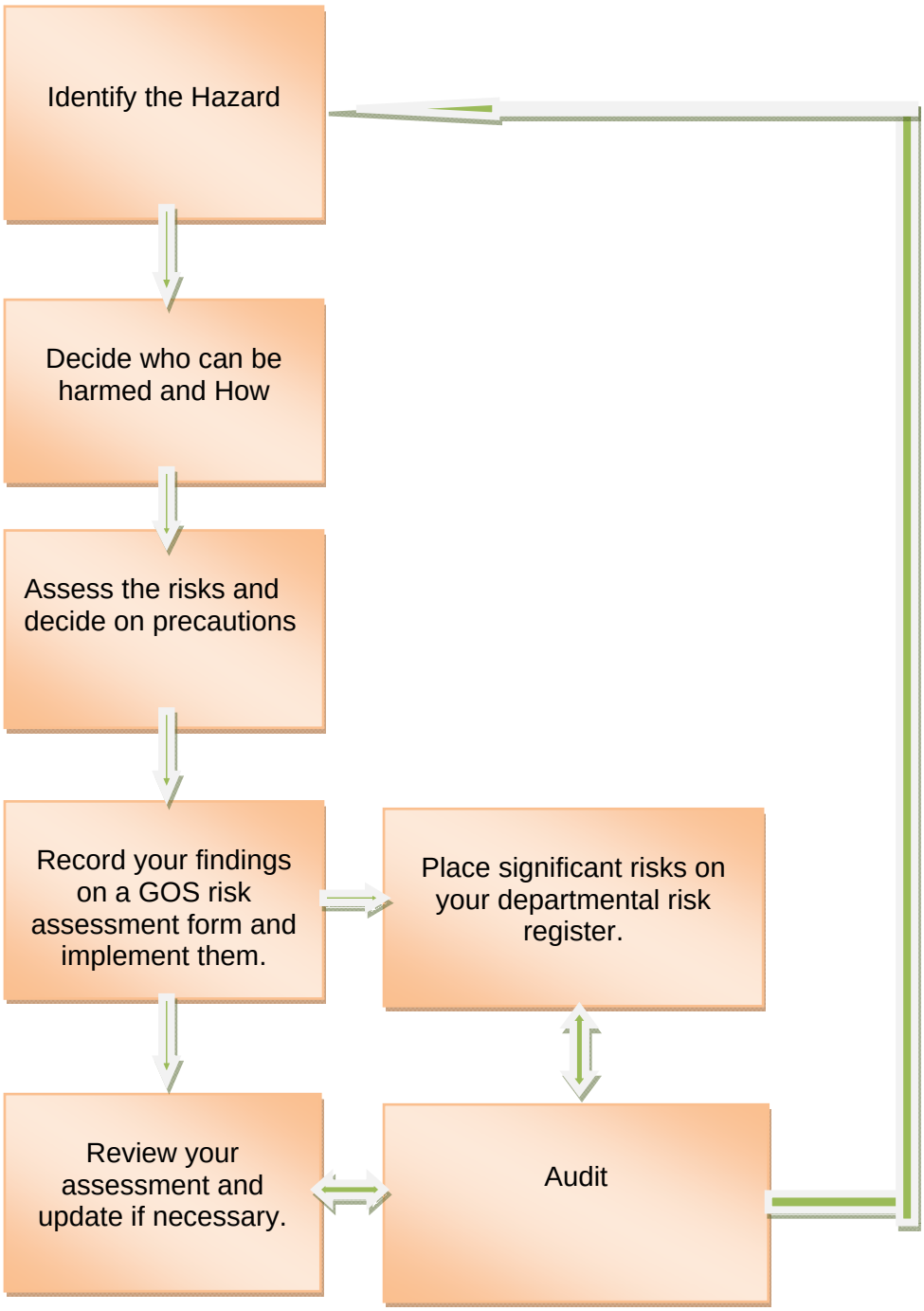
- Clinical Area
- Non-clinical area
- Estates Department
- Facilities
- Laboratory

Monitoring your progress against the risk assessment program

Your departments' progress in undertaking risk assessment and your departmental risk register will be audited by the Trusts' Health and Safety Team. Progress against high risks are monitored initially by the Risk Action Groups/ Clinical Unit Boards on a monthly basis and included as part of the key performance indicator reports. All high risks of 12 and above are included in the Assurance Framework and reveiwed by the Executive Team to support early identification of trends or where additional action needs to be taken. The Executive Group will also discuss specific high risk issues to ensure rapid action is taken where necessary and prevent delays in mitigating such risks.

The Risk Action Groups or departmental meeting must have a process in place to keep their risk register updated. They will provide updates on the content of their risk register monthly to the Clinical Governance and Safety Team for inclusion into the Trust wide risk register. Risks will be reviewed within a stated time frame by the local team to ensure that controls in place are working, and assess whether the risk changes over time. Reports are run monthly for the clinical / non-clinical department on reported incidents for consideration by the RAG groups and clinical unit boards or senior meetings. This information is used to inform the decision as to whether risks need to be added to the risk register, regraded or removed. Changes to the risk registers are monitored centrally by the Clinical Governance and Safety Team.

Risk Assessment Process Flowchart



Health and Safety executive Controls Hierarchy (Remember ERIC PD) –

Eliminate - Eliminating the hazard is the most effective method of preventing accidents and ill-health. This may be achieved in one of two ways:

- Eliminate the task e.g. making up of a chemical off site.
- Eliminate the hazard e.g. using hoists instead of lifting a patient manually.

Reduce the risk by substitution - The risk may reduced at source by substituting for a safer alternative e.g. Using less dangerous substances; replacing a substance which is 'very toxic' with one that is 'harmful'.

Isolate (the hazards and people) – The risk may be reduced by the following methods:

- Isolate the hazard –keep the hazard (e.g. cytotoxic drugs/radiation) away from people by enclosing the process
- Segregate the people – Keep the people away from the hazard (e.g. erect lead barriers to protect against x-rays/sound proofing a room, fitting guard rails on scaffolding/fence an area off where hazardous work is being undertaken)

Control –

- Engineering Controls – Use local exhaust ventilation to remove contaminants
- Change work patterns or methods – e.g. job rotation to reduce exposure to repetitive tasks/Do work out of hours to alleviate chance of disturbances in the hospital

Personal Protective Equipment (PPE) – This method is the least effective means of protecting against hazards as it protects the individual. Also workers often fail to use PPE provided. All other options should be considered first and PPE should be considered a back up. It is often appropriate in low risk work.

Discipline (Information, Supervision, Instruction and Training) -

Discipline refers to the employee following safe systems of work in place, and training.

Consider

- Information
- Training
- Instruction
- Supervision
- Safe systems of work (safe operating procedures)
- Permits-to-work
- Procedures for dealing with foreseeable emergencies

What the guidance says:

HSG(65) "...by substituting the dangerous by the inherently less dangerous …"
Moving and Handling Regulations "…are the handling operations necessary or could the desired result be achieved in some entirely different way …?"

COSHH "…prevention of exposure must be the employers' main aim …"

Further Guidance on Risk Assessments

Clinical Risk Assessments

These include anything that you think could potentially cause harm or have a negative effect on patient safety. It is also extremely useful if you think there is a potential problem but you are not sure whether you should do anything about it or not. A good example of this is 'should tracheal dilators be kept at a patient's bedside or not?' A risk assessment was undertaken looking at the risks of having tracheal dilators at the bedside and not having them. Each risk was scored for their likelihood and severity, and action plans were drawn up as the best way to deal with the issue.

Risk Assessments and Business Cases

Your risks assessments can also help underpin your business case. If you consider something is a risk within your department, but is quite costly to fix, a risk assessment should be one of the first steps you take in order to highlight the problem. It will also help you look at how you can manage the risks in the short term, until your business case is/is not accepted. This is one of the most important reasons as to why risk assessments are multi disciplinary - so that all avenues can be explored and the effect considered from a different perspective.

Moving and Handling Risk Assessments

It is the law to undertake a moving and handling risk assessment before moving a load (e.g. box, child, equipment) At Great Ormond Street we have three moving and handling assessment tools to help you undertake these assessments.

- **Loads**. Most staff move and handle items as part of their job. It is therefore essential that objects and/or systems or work, which present a risk of injury, be identified, recorded and the information disseminated amongst the relevant staff.

- **Patients/Children**. All patients must have a risk assessment completed on admission; this must be reassessed if the child's ability, mobility or condition changes.

- **Generic Patient and Non-Patient Area and Safe Systems of Work Assessments**. All areas in the trust must undertake, annually, a moving and handling risk assessment of work activities in their area to ensure that new hazards or risks are identified, recorded and disseminated amongst the relevant staff.

'High risks' or ongoing risks should be transferred onto the units' / departments' risk register, so that the General Managers can be made aware of them.

For further assistance in the undertaking of manual handling risk assessments please see the Trust Moving and Handling Policy on the document library.

Appendix 5 – Glossary of Terms

Risk Assessment: An examination of what could cause harm to people at work. It enables GOS to see whether we have the right precautions to prevent harm or should we be doing more. Please see the Trusts' risk assessment guidance e (Why, What, How, Who, When) for further information

Clinical Checklist: A checklist for ward managers to facilitate the maintenance of a safe environment and safe systems of work. This must be completed annually.

Non-Clinical Checklist: A checklist for non-clinical areas to facilitate the maintenance of a safe environment and safe systems of work. This must be completed every annually.

Control Of Substances Hazardous to Health (COSHH) Assessment: COSHH is the law that requires employers to control substances that are hazardous to health. You can prevent or reduce workers' exposure to hazardous substances by:

- finding out what the health hazards are;
- deciding how to prevent harm to health (risk assessment);
- providing control measures to reduce harm to health;
- making sure they are used ;
- keeping all control measures in good working order;
- providing information, instruction and training for employees and others;
- providing monitoring and health surveillance in appropriate cases;
- planning for emergencies.

Risk Action Group (RAG): Local RAGs or an equivalent meeting will be established at which the principle risks to patient/staff/visitor safety and service delivery will be discussed.

Risk Register: Risks will be reviewed within a stated time frame by the local RAG group to ensure that controls in place are working, and assess whether the risk changes over time. Risks may be identified through internal processes e.g. complaints, incidents, claims, service delivery changes, risk assessments. They may be identified by external factors e.g. national reports and recommendations.

Audit: The objective of health and safety auditing is to check the adequacy health and safety policy, organisation and arrangements; and to measure the Trust's performance against these.

APPENDIX 6

Directorate _____ **Number Staff** _____

Department _____

Description of work. (brief description of particular subject you are assessing if applicable) _____

			IMPACT				
			HIGH	← →			LOW
			5	4	3	2	1
LIKELIHOOD	YES	5	25	20	15	10	5
	↕	4	20	16	12	8	4
		3	15	12	9	6	3
		2	10	8	6	4	2
	NO	1	5	4	3	2	1

Date	Description of Risk	What measures are already in place to control this risk?	Assess the risk		Grade of risk	Priority of risk	Risk Mitigation / Review Date	Reassess Risk		Re-grade Risk I x L	New Risk Priority High Med Low	Reassess Date: Person responsible
			Impact 1-5	Likelihood 1-5	I x L	High Med Low	State who is responsible for monitoring risk or whether action plan is necessary **plus** date action needs to be completed.	Impact 1-5	Likelihood 1-5			

Attachment 8

Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting 31st March 2010	
Title of document: Code of Conduct for Trust Board Members **Submitted on behalf of: Chief Executive/ Company Secretary**	**Paper No: Attachment 8**

Aims / summary

Trust Board members are asked to acknowledge and adopt the Nolan principles on Standards in Public Life; the Code of Conduct / Code of Accountability in the NHS and the Code of Conduct for NHS Managers (these documents have been emailed out to Board members).

In addition to the importance of high standards of personal ethical conduct, the adoption of these principles and codes will also support compliance with the Trust's Standing Financial Instructions and Standing Orders.

Members of the Trust Board should be aware of the content of three key documents:

- The Nolan principles – Seven principles of public life (1995)
- The Code of Conduct for NHS managers (2002)
- The Code of Conduct and Accountability (2004)

The Nolan Principles:

- **Selflessness -** Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

- **Integrity-** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

- **Objectivity -** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

- **Accountability** - Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

- **Openness** - Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

- **Honesty** - Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

- **Leadership** - Holders of public office should promote and support these principles by leadership and example.

The Code of Conduct for NHS managers

The Code of Conduct for NHS Managers sets out the core standards of conduct expected of NHS managers, which underpins the principles by which NHS organisations, management and staff make decisions and can be held accountable. It aims to serve two purposes:

- to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make, and
- to reassure the public that these important decisions are being made against a background of professional standards and accountability.

The Code of Conduct / Code of Accountability:

The Code of Conduct / Code of Accountability in the NHS focuses on the three crucial public service values which must underpin the work of the health service: accountability, probity and openness.

Examples of practical demonstrations of the above principles and codes are as follows:

- GOSH Personal Responsibility Framework in place and included in staff contracts;
- Conflicts of Interest Policy – staff and members advised of this upon appointment and during employment;
- High standards of personal ethical conduct
  - Accepting corporate responsibility
  - Declaring potential & actual conflicts of interest (annually and requested at every Board meeting)
  - Declaring receipt of gifts/hospitality
- Value for Money and safeguarding of funds;
- Meaningful engagement and consideration of stakeholder views in decision making;
- Availability of timely and accurate information to Trust Board, and its committees (including reviews of this information);
- Implementation and monitoring of whistle-blowing and complaints procedures.

Management Board members will be reminded of the above codes and principles and will be asked to cascade this information to their teams.

Action required from the meeting
Trust Board members are asked to acknowledge and reaffirm the adoption of the Nolan Principles, the Code of Conduct and Accountability and the Code of Conduct for NHS Managers for the ensuing year.

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?
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
Anna Ferrant, Company Secretary, 22nd March 2010

Attachment 9

Great Ormond Street Hospital for Children NHS Trust

Trust Board 30 March 2011	
Assurance Framework Summary **Submitted on behalf of** Chief Operating Officer	**Paper No: Attachment 9**
Aims / summary The Assurance Framework provides an overview of the principal risks to achievement of the Trust's corporate objectives. There are 26 risks documented on the framework. The attached summary sheet provides an overview of each risk. The Clinical Governance Committee and Audit Committee seek assurance on behalf of the Trust Board that these risks are adequately controlled. The Assurance Framework Group continues to review and manage the Assurance Framework. Of the 26 risks, no risks are rated as red, 5 are rated as amber and 21 as green. This rating relates to the assessment of the controls in place, any outstanding actions and internal/ external assurances available.	
Action required from the meeting To note the content of the Assurance Framework summary.	
Contribution to the delivery of NHS / Trust strategies and plans Covers all Trust objectives	
Financial implications None	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision N/A	
Who is responsible for implementing the proposals / project and anticipated timescales No proposals included	
Who is accountable for the implementation of the proposal / project No proposals included	
Author and date Anna Ferrant, March 2011	

No.	Principal Risk	Accountable Executive	Responsible Assurance Committee	Initial Principal Risk Score	Revised principle risk score (after mitigations)	Assurance status	Date updated	Date reviewed by assurance committee
	STRATEGIC OBJECTIVE 1: Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world							
1A	Children may be harmed through medication errors	MD (ME)	CGC	25	**20**	AMBER	11/10/10	Nov-10
1B	Children may not be appropriately identified as being at risk of abuse and subsequent actions not taken	DN & Ed	CGC	20	**15**	GREEN	24/02/11	Jul-10
1C	Children, staff and parents may be put at risk from failure to adequately maintain the estate and non clinical equipment	DRedev	AC	25	**10**	GREEN	02/03/11	Apr 10 & Jun 10
1D	Children may be at risk from hospital acquired infection (includes decontamination & cleanliness)	MD (ME)	CGC	20	**15**	GREEN	11/10/2010	Feb-11
1E	The organisation, administration and practice of clinical services may not always optimally deliver the best outcomes	COO	CGC	20	**12**	GREEN	10/01/11	Feb-11
1F	Our clinical equipment may be inadequate for excellent clinical care and enhanced patient experience	COO	CGC	15	**10**	GREEN	22/03/11	May-10
1G	Staff in post may not be appropriately competent to deliver care	DN & Ed	CGC	15	**10**	GREEN	10/01/11	Feb-11
1H	We may not be able to recruit and retain key staff	COO	CGC	20	**15**	GREEN	07/02/11	Feb-11
1I	We may not be able to benchmark outcomes against partners and national indicators.	COO/ MD (ME)	CGC/ AC	9	**6**	GREEN	11/10/10	May-11
1J	Clinical outcomes and patients' experiences may suffer as a result of a lack of appropriate management focus	COO	CGC	9	**6**	GREEN	10/01/11	May-11
1K	Lack of appropriate clinical response to the deterioration in children	MD(ME)	CGC	20	**15**	AMBER	12/01/11	Nov-10
	STRATEGIC OBJECTIVE 2: Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations							
2A	We may not be able to measure, report and act on patients' experience	DN & Ed	CGC	9	**4**	GREEN	24/02/11	Feb-11
2B	Patients may have to wait longer than is reasonable for consultation or treatment (initial proxy being national waiting time targets)	COO	CGC	12	**9**	GREEN	10/01/11	Jul-10
2C	We may not meet referrers and other health and social care expectations around communication and accepting appropriate referrals	COO	CGC	12	**9**	GREEN	22/03/11	Nov-10
	STRATEGIC OBJECTIVE 3: Successfully deliver our clinical growth strategy							
3A	We may fail to get Commissioner 'buy in' to Trust growth plans and service developments	CFO	AC	20	**16**	GREEN	21/02/11	Apr-11
3B	We may fail to influence and capitalise on regional and national reconfiguration opportunities	COO	AC	12	**8**	GREEN	10/01/11	Oct-10
3C	We may not deliver our strategy for International Private Patients	Dir of Internat patients	AC	20	**10**	GREEN	21/02/11	Jun-10

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

Great Ormond Street Hospital for Children NHS Trust

Trust Board

30 March 2011

Brief on The Bribery Act 2010 **Submitted by:** Claire Newton	**Paper No: Attachment 10** **For Information**

Aims

To inform Trust Board on the current status and implications for GOSH of The Bribery Act 2010

Summary

The Bribery Act was enacted in 2010 under the previous government but was delayed pending a review and completion of guidance. This guidance is expected to be issued relatively soon and there will then be 12 weeks before the Act is in force. The Act addresses:

- a general offence of offering or receiving bribes;
- a corporate offence of failing to prevent bribery; and
- a specific offence of bribing a foreign public official.

Although most press commentary has concerned companies doing business overseas, there are still significant implications for business conducted in this country. The Trust's policies and procedures covering Counterfraud and Corruption; Conflicts of interest, gifts and hospitality, Procurement and Whistleblowing need to be updated to incorporate the provisions of the Act and all staff, particularly those involved in procurement and marketing of the Trust's services or individuals which may be offered hospitality by suppliers, need to be aware of its provisions.

A specific review will take place within the International Division to ensure that their procedures address the provisions of the Act relating to business transacted overseas.

Action required from the meeting
To note the implications of the Act; existing policies in force and further actions to be taken within GOSH; and the recommendation that the Action Plan be considered at the April meeting of the Audit Committee, assuming that the guidance has been issued by the Ministry of Justice.

Contribution to the delivery of NHS / Trust strategies and plans
The Act requires integrity in the conduct of business which is consistent with the Trust's values

Financial implications
Minimal

Legal issues
As described in the paper

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) ? Staff

Who needs to be told about any decision Management Board

Who is responsible for implementing the proposals / project and anticipated timescales
All managers involved in procurement or marketing of the Trust's services

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

Author and date Claire Newton 22.03.11

1 Introduction

The Bribery Act was introduced to enable courts and prosecutors to respond more effectively to bribery at home or abroad.

The Act makes it an offence not only to bribe another, but also to be bribed. The bribery may take any form and is referred to as “financial or other advantage”. The Act may also be breached via an offer, promise, request or agreement to receive a bribe. It need not be direct, but it will be considered sufficient if the bribe is provided to a third party, eg, a family member of the person who is influenced.

The wide drafting of the Act has caused much concern as it has the potential to criminalise existing business practices, eg, corporate hospitality where it might influence the behaviour of the recipient, so it is crucial to have a clear and easily accessible written policy on the offering and acceptance of gifts and hospitality and that awareness of this policy is tested and controls are in place to ensure any potential breaches would be detected. The Trust already has such a policy in place.

Where an organisation is found to be committing any of the bribery offences, a senior officer (eg a director) may find themselves liable if they consented in the commission of that offence. So even if they did not make the bribe themselves but turned a blind eye, they may be liable.

Organisations will commit an offence if a person associated with it (ie, including employees and agents) bribes another, whether in the UK or overseas, intending to obtain or retain business or a business advantage for that organisation.

Any offence under the Act committed by an individual is punishable by either imprisonment for a maximum of 10 years and/or an unlimited fine. Corporate entities that are guilty of a bribery offence or a corporate offence will be liable to an unlimited fine if convicted.

The key defence under the Bribery Act is the "**adequate procedures**" defence, which means that the company has instituted adequate compliance procedures to prevent bribery. There will be guidance as to what constitutes adequate procedures.

2 What does the new legislation say?

There are three potential offences:

- **a general offence of offering or receiving bribes;**
- **a specific offence of bribing a foreign public official; and**
- **a corporate offence of failing to prevent bribery**

Key to this is understanding the breadth of the definition of bribery. For example under a strict interpretation of the law, facilitation payments and corporate hospitality are strictly forbidden although it is anticipated that the guidance will allow some leeway where hospitality is not excessive. The Trust’s policies will need to clarify at what point gifts and hospitality, eg involving subsidized conferences etc might breach the legislation.

The offences indicated above apply wherever they take place in the world.

A key element of the new bribery offences is that the intention of the briber is that the person being bribed improperly performs his/her duties. Improper performance will arise if it is intended that, by paying the bribe, the recipient of the bribe would be expected to act otherwise than in good faith, an impartial manner or in accordance with a position of trust.

3 Corruption indicators include:

3.1 Transactions:

- Abnormal cash payments
- Pressure exerted for payments to be made urgently or ahead of schedule
- Abnormally high commission percentage being paid to a particular agency.
- Lavish gifts being received
- Payments being made through organisation different from the one supplying the service to the Trust

3.2 Behaviour by individuals:

- Individual never takes time off even if ill, or holidays, or insists on dealing with specific suppliers him / herself
- Making unexpected or illogical decisions accepting projects or contracts
- Unusually smooth process of cases where individual does not have the expected level of knowledge or expertise
- Abusing decision process or delegated powers in specific cases

3.3 Procurement practices

- Agreeing contracts not favourable to the organisation either with terms or time period
- Unexplained preference for certain contractors during tendering period
- Avoidance of independent checks on tendering or contracting processes
- Bypassing normal tendering / contractors procedure
- Missing documents or records regarding meetings or decisions

3.4 General

- procedures or guidelines not being followed

4 Six elements for bribery prevention

- **Risk Assessment** – understanding what is considered as bribery and knowing and keeping up to date with the bribery risks the Trust faces eg potentially impacting practice in procurement, acceptance of hospitality and obtaining business other than through routine NHS commissioning processes;

- **Organisational culture** – establishing a culture across the organisation in which bribery is unacceptable. Evidence of commitment to the implementation of an effective, ethical, anti-corruption policy.

- **Due diligence** – knowing who you do business with and gaining assurance that all business relationships are transparent and ethical;

- **Clear, Practical and Accessible Policies and Procedures** – applying them to everyone and covering all relevant risks such as political and charitable contributions, gifts and hospitality, promotional expenses, and responding to demands for facilitation payments or allegations of bribery;

- **Effective implementation** – ensuring that anti-bribery provisions are embedded into the organisation's internal controls, recruitment and remuneration policies, operations, communications and training on practical business issues;

- **Monitoring and review** – auditing the financial controls, regularly reviewing your policies and procedures, and considering whether external verification would help.

5 What does the Trust need to do?

5.1 Review of existing policies and procedures: to ensure that they are appropriately amended if necessary. Ideally this should be integrated with existing procedures, for example, risk management, procurement, conflicts of interest and whistleblowing.

5.2 Ensure that the policies include a clear statement of the consequences which will apply to staff for breaches. Similar considerations will need to be applied to contractors and suppliers with suitable clauses written into contracts.

5.3 Raise awareness amongst staff and suppliers of any amendments to policies and the consequences of breach

5.4 Monitoring and review. Ensuring that there are effective controls in place which might detect the "corruption indicators" and that they are consistently applied throughout the organisation.

It will also be important to demonstrate over time how the anti-bribery procedures have developed and evolved to take account of lessons learnt from incidents, near misses and audits.

Conclusion

It is recommended that a further more detailed action plan be submitted for review by the Audit Committee once the guidance has been issued.

Attachment 11

Great Ormond Street Hospital for Children NHS Trust

FINAL MINUTES OF THE AUDIT COMMITTEE
Held on 13 October 2010

Present:	Mr Charles Tilley	Non Executive Director and Committee Chairman
	Ms Yvonne Brown	Non Executive Director
	Mr Michael Dallas	Independent Member
	Mr Andrew Fane	Non Executive Director

In attendance:

Mr Roger Brealey	Director of Operations, LAC
Mr Sven Bunn*	Foundation Trust Programme Manager
Mr Robbie Burns*	Deputy Chief Operating Officer
Ms Heather Bygrave	Deloitte
Dr Jane Collins	Chief Executive
Ms Fiona Dalton	Deputy Chief Executive
Dr Anna Ferrant	Company Secretary
Mr Andrew Needham	Deputy Director of Finance
Mrs Claire Newton	Chief Finance Officer
Mrs Kam Sandhu	Counter Fraud, LAC
Mrs Elle Schlaphoff	Minutes Secretary
Mr Aaron Shah	Assistant Director of Audit, LAC
Mrs Nicki Tinniswood	Deloitte
Mrs Viv Whittaker	Assistant Director, Clinical Governance and Safety

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

67.	**Apologies for Absence**
67.1	No apologies for absence were received.
68.	**Minutes of the meeting held 9 June 2010**
68.1	The minutes of the meeting held on 9 June 2010 were received and **approved** as an accurate record.
69.	**Matters Arising and Action Point Checklist**
69.1	**Minute 11.2 – Update on the Valuation of Assets** The Deputy Director of Finance advised Committee Members that his team had started work on the valuation process for 2010/11. He said that early preparation would allow sufficient time to predict and prepare for impairments. The Chairman asked for confirmation of the earliest date on which asset valuation could take place. Ms Bygrave said that valuation could occur at any point during the financial year providing there were no significant changes in market conditions which would lead to the need for

	a further reassessment of values. **Action:** The Chairman requested the Deputy Director of Finance to provide an update asset valuation at the next meeting.
69.2	**Minute 20.3 - Standing Financial Instructions (SFIs)** The Chief Finance Officer said that she had been working with the Company Secretary to redevelop the current SFIs. She said that they hoped to submit the revised SFIs to the Trust Board in November.
69.3	It was noted that the revised SFIs would require the approval of the Audit Committee prior to submission to the Board. Committee Members **agreed** that as there was not another formal Committee meeting until January, the revised SFIs should be submitted to the Trust Board in November as planned but Mr Dallas should also be sent the document for comment prior to the meeting. **Action:** Company Secretary to ensure that Mr Dallas receives a copy of the revised SFIs on submission to the Trust Board in November.
	FOR DISCUSSION
70.	**Assurance Framework**
70.1	The Assurance Framework was received from the Deputy Chief Executive. She reminded Committee members of the current status of the risks that they were responsible for and provided an update on recent changes to the risks within the document.
70.2	The Chairman asked if the Trust had received any further updates from the Health and Safety Executive (HSE) regarding their investigation into the boiler incident that occurred at the Trust in October 2009. The Chief Executive said that the HSE were expected to report the conclusions of their investigation in the near future.
70.3	Mr Fane said the column titled 'Cross reference with other risks/related issues' was confusing and required additional clarity. It was **agreed** that the column may no longer be necessary.
70.4	The paper was **noted.**
71.	**High Level Risk Presentation : 3B We may fail to influence and capitalise on regional and national reconfiguration opportunities to increase our market share.**
71.1	A paper on risk 3B was received from Mr Robbie Burns on behalf of the Deputy Chief Executive. Mr Burns defined the risk and provided Committee Members with an explanation regarding its current risk scoring.
71.2	Mr Burns detailed the current controls that the Trust had in place against risk 3B. He said that Trust had ensured appropriate representation on national and local reconfiguration groups and was planning future

	capacity with the accommodation of additional activity in mind.
71.3	Mr Burns said that it was hoped that controls against the risk could be improved through ensuring that individual action plans for key clinical units were being adhered to. He said that it was planned for progress against the action plans to be reported to Management Board on a quarterly basis.
71.4	Mr Burns advised Committee Members that external assurance on current controls against the risk had been obtained from Ernst and Young who had conducted an assessment of the Trust's market and Integrated Business Plan (IBP) assumptions. He said that KPMG would conduct a similar assessment shortly.
71.5	The Chief Executive said that the completion of phase 2a of the redevelopment programme would provide the Trust with sufficient capacity to facilitate growth.
71.6	Mr Burns said that recent work had taken place to identify actions to improve the experience of those who refer patients to Great Ormond Street. He said that a steering group had been created and a regular newsletter to key referrers was planned.
71.7	The paper was **noted.**
72.	**High Level Risk Presentation : 6B Sustainable funding solution for each activity within the Trust strategy may not be secured (to cover IPP, R&D, Charity and Clinical activities through SLR)**
72.1	A report on risk 6B was received from the Chief Finance Officer. She said that at present there was uncertainty surrounding the specialist top up payments that the Trust would receive in the future. It was noted that a recent academic review had recommended that the current level of top up payments should be reduced from 78% to 25%. The Chief Finance Officer said that the Alliance of specialist paediatric providers was currently discussing the matter with the Department of Health but the proposed change could potentially reduce the Trust's income by up to approximately £15 million.
72.2	The Chief Finance Officer reported that there was also a risk of income reduction through adjustments to local tariffs. She advised Committee members that Primary Care Trusts (PCTs) were responsible for setting these and although Great Ormond Street had not yet been approached regarding possible reductions, she was aware that approaches had been made to other acute Trusts.
72.3	The Chief Finance Officer said that the Trust was seeking examples of costs significantly in excess of reimbursement received from the tariff. She said that patients at the Trusts had complex needs and often had a number of pre existing conditions that would make treatment more expensive.

72.4	The Chief Finance Officer said that current tariff prices had been based on reference costs and historically these had been calculated net of the subsidy from Culyer funding.
72.5	It was noted that Service Line Reporting (SLR) information was used centrally and due to be rolled out to the clinical units in the near future. The Chief Finance Officer said that she planned to give a presentation on the topic at the Board Away Day later in October.
72.6	Committee Members discussed how best to move forward with the information that had been provided. It was agreed that the Chief Finance Officer would provide a further update on the risk at the Audit Committee meeting in January 2011. **Action:** Chief Finance Officer to provide an update on risk 6B at the Audit Committee meeting in January 2011.
73.	**Risk Presentation: The Trust does not effectively utilise its assets and capacity to deliver services.**
73.1	A presentation was received from Mr Burns on behalf of the Deputy Chief Executive. He outlined the levels of asset utilisation as follows:- • Amount of total assets used in clinical activity (clinical resources). • Amount of time scheduled for use of clinical resources. • Effective use of scheduled time for use of clinical resources. He described the type of assets that could be considered as clinical resources and said that the optimum utilisation was often driven by sufficient staffing arrangements.
73.2	Mr Burns advised Committee members of the current controls and assurances in place regarding the effective use of time scheduled for clinical resources such as beds and theatres. He reported how the Trust was seeking to obtain future assurances though improvements to the current allocation of theatre sessions and plans for extended sessions and working on Saturdays.
73.3	The Chief Executive said that it was important that plans for extended sessions did not contradict the recommendations of the safer surgery report that advised routine surgery should not be conducted at night. She suggested it may be useful for Mr Burns to calculate the utilisation of other clinical resources using the 24/7, 365 days format that had been used for theatres and beds.
73.4	Mr Burns said that at present there was a lack of consistent reporting and management of the utilisation of clinical resources other than beds and theatres. He said there were numerous small specialities and different procedures were followed in different areas.
73.5	Mr Burns said that it was hoped that improved links between activity growth and redevelopment would enable better utilisation of assets and capacity in the future. It was agreed that Mr Burns would submit an

	update on his report to the April 2011 Committee meeting. **Action:** Mr Burns to provide an update on the utilisation of assets and capacity to the April 2011 Audit Committee meeting.
73.6	Mr Tilley asked if the addition of International benchmarking would be useful. The Chief Executive said that it could be but explained that data from American hospitals may not be appropriate for this purpose as they often operate below capacity to ensure that they are always able to accept new patients.
73.7	The Chief Executive said that the Special Trustees may find the information contained within Mr Burns' presentation useful. Mr Tilley asked if Mr Burns could extend his next report to include information on the use of the Computer Centre that had been recently purchased on behalf of the Trust by the Special Trustees.
73.8	The Chief Executive said that recent work to seek improvements in relation to appointment cancellations by both the Trust and the patient was underway.
73.9	The report was **noted.**
73.10	*Mr Burns left the meeting and Mr Bunn joined the meeting at this point.*
74.	**Business Process Management (BPM/SOA) business case – Costs and Savings**
74.1	A presentation on the costs and savings of the proposed business case to implement BPM/SOA IT systems architecture was received from the Chief Finance Officer. She began her presentation by outlining the key project risks as follows:- • High up-front cost • Slow benefit realisation • Timing in relation to Foundation Trust (FT) application • No known examples of the full system in a health care setting • Lack of compatibility with UCLP systems • No clarity of the level of organisational engagement required
74.2	The Chief Finance Officer said that the project had been presented as a 10 year business case and would only reach a break even point 6 years after implementation. She said benefits would increase steadily in the final 5 years. She outlined the key project benefits as follows:- • Standardised and integrated information • Automation of labour intensive processes • Reduction of administrative staff involved in duplicated tasks
74.3	The Chief Finance Officer advised Committee members that the Trust could not fund the project in 2011/12 without support from GOSH charity and an application for charitable funding would have to be considered. She said that alternatives to the project included procuring a number of

	individual business applications, making a major investment in the current patient information system at a later date and further exploration of system integration within UCL Partners.
74.4	Mr Tilley said additional consideration should be given to non financial elements of the business case and the chosen solution should provide the Trust with the correct benefits. He said that the choice of project manager was important in ensuring the success of the project.
74.5	It was noted that although a reference site had been initially identified in a Norwegian hospital, it had later been confirmed that they were using SOA (Source Orientated Architecture) to integrated systems and data but not BPM.
74.6	Committee Members discussed whether installation of the BPM system was the most cost effective solution and whether the benefits of the project would exceed the risks involved. Mr Dallas suggested that the risks of being the first implementation in a health care organisation were high and that it may not be an appropriate risk given the size of the Trust. Mr Fane asked if the cash benefits that had been predicted for the project might be too high. The Chief Finance Officer confirmed that the predictions had been appropriately tested.
74.7	The Chief Executive questioned whether the timing of the project was appropriate and said that it would be important to identify and visit an appropriate health care reference site as soon as possible. She asked if the technical information on the system could be simplified and presented to the Special Trustees. **Action:** Chief Finance Officer to develop presentation on the BPM system for the Special Trustees
74.8	It was agreed that discussions on the project would remain on the Audit Committee agenda and an update would be received at the next meeting. The Chairman requested for the update to include more information on non financial benefits and asked for all past Trust Board papers on the matter to be copied to Mr Dallas. **Action:** Chief Finance Officer to submit an update on the BPM system project including more information on non financial benefits to the January 2011 Audit Committee. **Action:** Company Secretary to copy all past Trust Board Papers on the BPM system to Mr Dallas
74.9	The paper was **noted.**
75.	**Control of Pay Costs**
75.1	A paper on the control of pay costs was received from the Chief Finance Officer. She said that she hoped it would provide clarity issues raised by Committee Members in the past.

75.2	The Chief Finance Officer said that services from Haringey PCT had transferred to Great Ormond Street in 2008/09. She said that the service was under resourced on transfer and had to grow but its activity was not included in the Trust's commonly used activity measures.
75.3	The Chief Finance Officer said that movement within pay scales created a yearly cost pressure on the pay budget. She said that the paper provided an explanation of where and why headcounts had been increased in recent years. Committee Members asked whether it was possible to include a productivity measure.
75.4	The Chief Finance Officer reported that the Trust had recently participated in a national benchmarking exercise on pay costs within corporate support departments. She said that the results had indicated higher than average costs in the back office areas of Finance, Procurement and Governance and Risk Management but lower than average cost in all other areas. Further analysis of these findings was required.
75.5	The Chief Finance Officer said that she would circulate information on the back office pay costs . **Action:** Chief Finance Officer to circulate information on the back office pay costs
75.6	The Chairman questioned whether the Committee should be focusing on pay costs in relation to agency staff. The Chief Executive advised that this was being monitored by the Management Board.
75.7	The paper was **noted.**
76.	**Update on Cash Releasing Efficiency Savings (CRES) (Assurance Framework risk 6A)**
76.1	An update paper on the CRES programme was received from the Deputy Chief Executive. She said that current work had been focused on trying to ensure that schemes for the current year were either resolved or deferred. She reported that most Clinical Units (other than surgery) were currently predicting that they would achieve their financial plan.
76.2	The Deputy Chief Executive reported that plans for the second year of the programme were due for completion by the end of October. She said that larger pan-trust schemes would be used to fill any gaps that were identified.
76.3	The Deputy Chief Executive said that plans for years 3-5 of the programme were currently top down but work was being completed to ensure ownership of the methodologies for the calculation of CRES by the Clinical Units.
76.4	The Deputy Chief Executive advised Committee Members that the CRES steering group had now been formalised and a recent assessment of the process by KPMG had suggested additional work was required to further develop the plans for year 3 of the programme.

76.5	The report was **noted.**
76.6	*The Assistant Director, Clinical Governance and Safety joined the meeting at this point.*
77.	**Overview of Safety Culture at Great Ormond Street Hospital (GOSH) (Assurance Framework Risk 1C)**
77.1	A paper containing an overview of the safety culture at GOSH was received from the Chief Executive. She said that it provided the Audit Committee with assurance against the promotion of safety within the organisation.
77.2	Committee Members asked if there had been any incidents where the actions taken had brought benefits. The Chief Executive said that a fire that occurred at the Trust in 2008 had lead to improved fire safety training. She said dedicated modules were now delivered to staff as part of their online mandatory training. It was noted that staff turnover had proved problematic to training delivery in the past.
77.3	The Assistant Director, Clinical Governance and Safety said that risk management had improved but local Risk Action Groups (RAG) were still unsure of the escalation process for their risks.
77.4	The Assistant Director, Clinical Governance and Safety said that Executive Safety Walkrounds were an effective tool for the promotion of safety issues and risk identification. She said that work was in progress to establish a suitable reporting process for the data obtained from these events.
77.5	It was noted that all risks scored 12 or above were discussed on a weekly basis by the Executive Team and on a 6 weekly basis by the Assurance Framework Group.
77.6	The Chairman requested for an update on the matter to be provided at the April 2011 Audit Committee Meeting. He asked if the update could be focused on training. **Action:** Chief Executive to provide an update on the safety culture at GOSH, focused on training for the April 2011 Audit Committee Meeting.
78.	**Overview of process for securing assurance on accuracy of Integrated Business Plan (Assurance Framework Risk 7C)**
78.1	An overview of process for securing assurance on accuracy of Integrated Business Plan (IBP) was received from Mr Sven Bunn, Foundation Trust Programme Manager, on behalf of the Deputy Chief Executive.
78.2	Mr Bunn said that the IBP contained two types of information that required validation. He said that factual information needed to be accurate and up to date whilst assumptions and projections needed to be reasonable given the information that they were based on. The Chairman advised Mr Bunn that the sources of all information used should be logged.

78.3	Mr Bunn advised Committee Members of the steps taken to review the IBP information internally and said that it would be reviewed externally by the Strategic Health Authority (SHA) and Ernst and Young. He said that the due diligence process would be completed by KPMG.
78.4	The report was **noted**.
78.5	*Mr Bunn left the meeting at this point.*
79.	**Summary of risk 7B: IT Infrastructure may not be resilient or deliver the organisation's needs which create the risk of clinical systems failing and delays investment in front line systems.**
79.1	A report on the risk 7B was received from the Chief Finance Officer. She requested for the report to be deferred to the Audit Committee meeting in January when a number of ongoing work-streams in relation to the risk would be complete. The Chairman **agreed** to her request. **Action:** Chief Finance Officer to resubmit her report on risk 7B to the January 2011 Audit Committee meeting.
79.2	Ms Brown asked for a summary of the key issues that had historically impacted on the resilience of the IT infrastructure. The Chief Finance Officer said that the current systems had contained many outdated components and the IT department had lacked staff with the skills required to maintain it. She said that the replacement of these components, investment in staff and the creation of a twin room server environment had helped to increase network stability.
79.3	The Chairman suggested that an internal survey on system could be useful to determine performance issues at a user level.
79.4	It was noted that catering facilities at the Trust were currently unable to accept payment by card. The Chief Finance said that she would investigate. **Action:** Chief Finance Officer to clarify why card payments were not accepted in Trust catering facilities.
80.	**Auditors' Local Evaluation (ALE) Summary 2009-10**
80.1	A summary on the 2009/10 ALE was received from Ms Bygrave of Deliotte. She introduced her colleague Mrs Nicki Tinnisworth who had replaced Mr Paul Hutt. Ms Bygrave advised Committee Members that they had previously received a draft version of the ALE summary and overall scores were due to be announced tomorrow.
80.2	She said that in 2009/10 the ALE assessment had been conducted using a risk based process where less work was undertaken at Trusts that were performing well. She said it anticipated that the Trust would be awarded an overall score of 3 and the individual score for financial reporting would rise from 2 to 4.

80.3	Ms Bygrave said that in the future ALE would be replaced by a new 'value for money' assessment with a focus on financial stability.
80.4	The report was noted.
81.	**Annual Audit Letter 2009/10**
81.1	The Annual Audit Letter 2009/10 was received from Ms Bygrave. She said that the letter provided an unqualified opinion and should be published on the Trust website before the end of October.
81.2	The paper was **noted.**
82.	**External Audit Planning Report 2010/11**
82.1	The External Audit Planning Report for 2010/11 was received from Ms Bygrave. She said that the audit scope and approach would be the same as the previous year and materiality had been estimated at a similar level. She said key audit risks had been identified around revenue recognition, capital accounting, private patient income and inter NHS balances.
82.2	Ms Bygrave advised Committee Members that for Foundation Trusts, Monitor would be examining the results of the audit of quality accounts. She said that the Audit Commission were still awaiting a decision on what audit work would be required for NHS Trusts in 2010/11.
82.3	Ms Bygrave said that it had been announced that the Audit Commission would be abolished. She said that additional legislation was required to enable a 'free market' approach to appointing a successor.
82.4	Ms Bygrave confirmed the independence of Deloitte as the Trust's External Auditors.
82.5	Mr Dallas asked if there was any cross working between the Trust's internal and external auditors. Ms Bygrave said that her team had met with the internal auditors and reviewed their reports but that they did not place reliance on the work of internal audit as the scope of the audit was largely substantive testing. It was suggested that the Head of Internal Audit, the External Auditors and the Chief Finance Officer should meet on a regular basis to triangulate information. **Action:** The Chairman requested the Chief Finance Officer to provide an update on meetings of the External and Internal Auditors at the next meeting.
82.6	The report was **noted.**
83.	**Internal Audit Progress Report July 2010-October 2010 including update on progress with 2010/11 Internal Audit Plan**
83.1	**The Internal Audit Progress Report was received from Mr Roger Brealey of LAC. He asked if there were any questions.**

83.2	It was noted that an audit on non pay expenditure had found that 2 out of a sample of 10 invoices had been paid with the incorrect authorisation. The Chairman asked if the sample should have been extended. Mr Brealey said that his team could have sought an extended sample but did not feel that it was necessary.
83.3	The Chairman asked if the Internal Team had been happy with the quality of the Management responses they had received. Mr Shah said that the responses had been extremely positive especially in relation to the audit on 'Lack of appropriate response to the deterioration in children' and 'Medication errors'.
83.4	The report was **noted**.
84.	**Counter Fraud Progress Report – including update on Counter Fraud activity July 2010- October 2010**
84.1	The Counter Fraud Progress Report was received from Mrs Kam Sandhu of LAC. She said that the qualitative assessment results of counter fraud activities at the Trust were due in October and benchmarking would take place against other London Trusts to ensure that resources had been appropriately allocated.
84.2	Committee Members asked for further information on a fraud case that had been detected involving a temporary staffing agency. Mrs Sandhu said that the agency had overcharged the Trust and although they had agreed to reimburse the Trust there were legalities involved in recovering the money. The Chairman asked the value of fraud detected. Mrs Sandhu said that it was approximately £100,000.
84.3	The Chief Finance Officer confirmed the Trust had ceased using one of the agencies being investigated as part of the counter fraud investigation but was still using a second (because fraud had not been proven). Mr Dallas suggested that the Trust should not be involved with a company that had been investigated in relation to fraudulent activities.
84.4	Mr Fane said that a measure of the materiality of fraud cases could be useful. The Chairman requested for one to be added to the next report. **Action:** Mrs Sandhu to add a materiality measure to the next counter fraud report.
84.5	The report was **noted.**
85.	**Audit Recommendations Update**
85.1	An Audit Recommendations update was received from the Deputy Director of Finance. He reported that satisfactory progress had been achieved since the last meeting.
85.2	The Deputy Director of Finance said that all Internal Audit recommendations for 07/08 had now been implemented. He said there were 15 recommendations outstanding for 09/10 and 14

	recommendations for 10/11. The Deputy Director of Finance confirmed that all External Audit recommendations were in progress.
85.3	The report was **noted.**
86.	**Internal Audit Terms of Reference (ToR) and Client Protocol 2010/11**
86.1	The Internal Audit ToR and Client Protocol 2010/11 was received form Mr Brealey and Mr Shah. Mr Brealey said that there had been no significant changes and all changes had been discussed with the Chief Finance Officer. Mr Shah highlighted the changes to Committee Members.
86.2	Mr Shah said that the client protocol would be issued with all new audit plans and used to inform them. He said that it was hoped that changes in the approach to the Internal Audit process would enable the earlier and identification of potential delays.
86.3	The Committee **approved** the Internal Audit ToR and Client Protocol.
87.	**Update on Compliance with Care Quality Commission (CQC) Standards and Registration**
87.1	An update on the Compliance with CQC Standards and Registration was received from the Assistant Director, Clinical Governance and Safety. She said that appendix one of her report highlighted the evidence held against each of the standards relevant to the Audit Committee and their assurance status.
87.2	The Assistant Director, Clinical Governance and Safety said that her report also contained information from the Trust's Quality Risk Profile (QRP). She said that the QRP was compiled by CQC through the triangulation of external intelligence held in relation to the Trust. It was noted that in the future the CQC hoped to issue QRP report on a monthly basis and the report utilised a four colour rating system.
87.3	It was noted that the outcome on 'suitability of management' was not applicable to the Trust so a rating had not been provided.
87.4	The Assistant Director, Clinical Governance and Safety said that the QRP report was outcome driven and as a result a rating of no confidence had been given to the consent standard as the only data available to CQC was from the NHSLA assessment. Committee members agreed that further clarification should be obtained from the CQC on this matter. The Chief Executive asked the Assistant Director, Clinical Governance and Safety to draft a letter to be sent on her behalf. **Action:** Assistant Director, Clinical Governance and Safety to draft a letter to the CQC requesting further clarification the rating of outcomes.
87.5	The Assistant Director, Clinical Governance and Safety said that at present, Trusts were unable to see each others reports but all reports would eventually be published in the public domain. Audit Committee members suggested that the Assistant Director, Clinical Governance and Safety should contact other Trusts regarding the possibility of sharing

	their reports prior to the expected publication date.
87.6	The Assistant Director, Clinical Governance and Safety said that it was planned for the QRP to be submitted to the Trust Board on a periodic basis to provide assurance against achievement of the CQC standards. It was agreed that a summary sheet would be submitted to the Trust Board meeting in November 2010. **Action:** Assistant Director, Clinical Governance and Safety to submit a summary sheet on the QRP to the Trust Board meeting in November 2010.
88.	**Information Governance (IG) Status Report**
88.1	The IG Status Report was received from the Chief Finance Officer. The report included an IG Organisational Framework for approval and also information on the current status of the Trusts compliance with IG toolkit Version 8 which had been issued in July 2010. The latest version had expanded detail on the evidence required to achieve each level (Levels range from 0-3)
88.2	At present, the Trust's position on fulfilling the requirements was mixed; as for a number of the standards there was insufficient evidence. She said that a submission was due on 31st October but the critical submission at which Level 2 scores must be obtained of a number of the standards was due on the 31 March 2011 and the high risk areas were IG training and Pseudonymisation.
88.3	The Chief Finance Officer advised Committee Members that a new Head of IG had been appointed and would address the toolkit evidence gaps. The Chief Executive asked if the completion of the toolkit would affect the Foundation Trust Application. The Chief Finance Officer said that in theory failure to achieve the appropriate level could affect the Trusts connection to the NHS Care Records Service spine but many other London Trusts were in a similar position.
88.4	The Audit Committee **approved** the IG Framework on behalf of the Trust Board and the Chairman requested an update at the next meeting. **Action:** Chief Finance Officer to provide on IG update to the Audit Committee Meeting in January 2011.
	ITEMS FOR INFORMATION
89.	**Trust Wide Risk Register**
89.1	It was noted that the 'Trust Wide Risk Register' item had been included for information. The Chairman asked The Assistant Director of Clinical Governance and Safety why there appeared to be a disproportionate number of risks in relation to Infrastructure. The Assistant Director of Clinical Governance and Safety said that work on risk categorisation was ongoing and once completed would improve identification of trends.

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90.	**NHSLA Assessment Update**
90.1	It was noted that the 'NHSLA Assessment Update' item had been included for information. The Chairman asked for further clarification on the information contained within the paragraph on current status.
90.2	The Chief Executive said that the situation in relation to the NHSLA assessment was due to be reviewed in January. She said it was hoped that work towards the Foundation Trust Application would inform the assessment process.
91.	**Provisions, Debts and Debtors and Creditors**
91.1	It was noted that the 'Provisions, Debts and Debtors and Creditors' item had been included for information. The Chairman asked for an update regarding the debt owed by Haringey PCT.
91.2	The Chief Finance Officer confirmed that the necessary paperwork to instigate payment of the debt had been completed and issued. It was noted that current debt in relation to the London Procurement Project was approximately £700k and discussions were being held with the SHA.
92.	**Overpayments to Staff Update**
92.1	It was noted that the 'Overpayments to Staff Update' had been included for information. The Chairman asked if there were any questions or comments.
92.2	The Chief Finance Office said that she wished to draw the Committee's attention to the high level of ex-staff debt. She said that it was likely that a large part of this debt would need to be written off due to difficulties in tracing staff and recovering debt but that appropriate provisions had been made.
92.3	The Deputy Chief Executive said that a small number of common circumstances for overpayments to staff had now been identified. She provided Committee Members with a brief explanation of each.
93.	**Waivers approved by Management Board**
93.1	It was noted that the 'Waivers approved by Management Board' had been included for information. The Chairman asked if there were any questions or comments. There were none.
94.	**Performance Report**
94.1	It was noted that the 'Performance Report' had been included for information. The Chairman asked if there were any questions or comments. There were none.
95.	**Minutes of the Assurance Framework Group (Draft) August 2010**

95.1	It was noted that the 'Minutes of the Assurance Framework Group (Draft) August 2010' had been included for information. The Chairman asked if there were any questions or comments. There were none.
96.	**Any Other Business**
96.1	There was no other business declared.
97.	**Date of the Next Meeting**
97.1	The date of the next meeting was confirmed as
98.	**Items for Information: Audit Committee Terms of Reference**
98.1	It was noted that the Audit Committee Terms of Reference had been included for information. The Chairman asked if there were any questions or comments. There were none.
99.	**Items for Information: Audit Committee Work Plan**
99.1	It was noted that the Audit Committee Work Plan had been included for information. The Chairman asked if there were any questions or comments. There were none.

Signed as a correct record of the Great Ormond Street Hospital for Children NHS Trust Audit Committee meeting held on 13 October 2010.

Chairman: ……

Date ……

Attachment 12

Great Ormond Street Hospital for Children NHS Trust

Final Minutes of the meeting of Clinical Governance Committee (CGC) held on 17 November 2010

Present

Andrew Fane	Non Executive Director and Chair
Jane Collins*	Chief Executive
Andrew Copp	Non Executive Director
Fiona Dalton*	Deputy Chief Executive
Martin Elliott	Co Medical Director
Liz Morgan	Chief Nurse and Director of Education
Mary MacLeod	Non Executive Director
Aaron Shah	Assistant Director Audit, LAC
Vivian Whittaker	Assistant Director, Clinical Governance and Safety

In Attendance

Jacob Bigio	Medical Student UCL
Mark Brice	NHS London
Lucy Bubb	Deloitte
Simon Crawford	NHS London
Angela Dewhurst*	Complaints Manager
Anna Ferrant	Company Secretary
Salina Parkyn	Head of Patient Safety
Andrew Pearson*	Clinical Audit Manager
Elle Schlaphoff	Trust Administrator (Minutes)

Apologies

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

52.	**Minutes of Meeting held 21 July 2010**
52.1	The Chairman welcomed Mr Brice and Mr Crawford from the SHA who would be observing the meeting as part of the Foundation Trust application process. He also welcomed Ms Bubb from Deloitte who was observing as part of an audit on Governance arrangements for Haringey Community Services and Mr Bigio from University College London who was shadowing the Co-Medical Director.
52.2	The Chairman requested Committee Members to check the minutes for accuracy.
52.3	Professor Copp requested that his title in the list of attendees be changed to 'Non Executive Director'.
52.4	Subject to the requested amendments, the minutes were **approved** as an accurate record of the meeting.

Attachment 12

53.	**Matters Arising and Action Log**
53.1	**Minute 2.6 - Modernisation of Pharmacy Services** The Chief Executive said that a number of workstreams were underway and at present the UCL Partners were exploring the possibility of creating a shared storage and manufacturing facility for intravenous drugs. She said that the work was being lead by David Sloman and central preparation of intravenous drugs could help to lower a number of risk factors.
53.2	The Chief Executive reported that the Medicines Management group had been examining how drugs were prepared and administered at ward level. She said that they were also investigating problems that had been experienced with the electronic prescribing system.
53.3	**Minute 28.5 - Communication of Patient Views to Senior Management** The Chief Nurse and Director of Education said that a new strategy had been developed to aid the measurement of patient experience and satisfaction. She said that the strategy would be discussed at the next meeting of the Patient and Public Involvement and Experience Committee (PPIEC) and submitted to the CGC in January. **Action:** Chief Nurse and Director of Education
53.4	The Chairman asked if work on the strategy would be completed in sufficient time to meet the relevant deadlines in the Foundation Trust application process. The Chief Executive said that it would.
53.5	Ms MacLeod asked if the new strategy would incorporate the suggestion that patient views should be presented to Trust Management using video. The Chief Nurse and Director of Education said that it would.
53.6	**Minute 35.6 – Effective Use of Available Capacity** It was noted that at last meeting of the CGC, the Chairman had asked the Deputy Chief Executive to provide information on the measures employed by the Trust to enable the effective monitoring of capacity. She said that the Deputy Chief Operating Officer had given a presentation on the matter to the Audit Committee and the minutes of that meeting had been included within the papers for information.
53.7	The ongoing actions on the log were noted.
54.	**Review of the Assurance Framework**
54.1	The Assurance Framework was received from the Deputy Chief Executive. She said that the document featured high level organisational risks that had been matched against corresponding organisational objectives and high level local risks. It was noted that the assurance status was independent of the risk score.
54.2	The Deputy Chief Executive said that summaries of the risks assigned to the CGC were received at every meeting and more detailed risk reports were received on a rotation basis. She confirmed that all of the high level risks

	were also reviewed regularly by the Executive Team and Assurance Framework Group.
54.3	It was noted that the risks on the Assurance Framework were not fixed and the content was reviewed on an annual basis.
55.	**Risk 1A – Children may be Harmed Through Medication Errors**
55.1	A report on risk 1A was received from the Co-Medical Director. He explained that the potential for medication errors in children was much higher than in adults because of the complicated processes involved with preparation and administration of medication. He said that the initial risk score had been set at 25.
55.2	The Co-Medical Director reported that the Transformation Team had been working in high risk areas to design processes and procedures aimed at mitigating the risk. He said that by the end of April 2011, all Clinical Units would be required to report medication errors to the Management Board on a regular basis. It was noted that the Key Performance Indicator (KPI) report now included an indicator on the issue.
55.3	The Chairman asked if child appropriate doses could be used to reduce medication errors further. The Co-Medical Director said that they could but the cost effective procurement of the necessary products would probably be unsuccessful. Professor Copp suggested that the Trust could experience more success by trying to procure the products as part of a larger group of specialist hospitals. The Chief Executive said that the proposed UCL Partner manufacturing facility could provide opportunities to remedy this in the future
55.4	The Co-Medical Director said that the Trust used dose banding as an additional risk control and was obtaining data from the Electronic Prescribing system to identify commonly used drugs. Ms MacLeod asked if any patterns of medication error had been detected. The Assistant Director, Clinical Governance and Safety said that trend analysis was completed on all incidents involving medication errors and identified trends were reported to the SHA.
55.5	The Chief Nurse and Director of Education said that she had discussed with staff at South Bank University the importance of incorporating techniques for reducing medication errors into nurse training programmes.
55.6	The Deputy Chief Executive said that the KPI on medication errors was viewed by the Trust Board at every meeting and external assurance on the risk had recently been obtained.
56.	**Risk 1K – Lack of Appropriate Clinical Response to the Deterioration in Children**
56.1	A report on risk 1K was received from the Co-Medical Director. He explained that 1K was a high scoring risk that could be reduced through the appropriate monitoring and management of children in ward locations.

56.2	The Co-Medical Director said that the use of the Children's Early Warning Score (CEWS) and the existence of the Intensive Care Outreach Network (ICON) service were steps that the Trust had taken to mitigate the risk.
56.3	The Co-Medical Director said that a clear trust-wide policy was required regarding the measurement and recording of patient observations. It was noted that for data protection reasons patient charts were sometimes stored in a central location away from the patient and this had the potential to make the observation process less effective.
56.4	The Co-Medical Director advised Committee Members that factors surrounding a recent incident at Sheffield's Children Hospital where a young child died after being moved from intensive care had provided a number of learning points for the Trust.
56.5	The Co-Medical Director reported that plans to recruit four General Paediatricians had been recently been completed. He stated that the appointments would allow earlier interventions, greater continuity of care and more support for specialist teams.
56.6	The Chief Nurse and Director of Education said that additional positive assurance against risk 1K was provided by a recent internal audit.
56.7	*Wendy Fisher joined the meeting at this point.*
57.	**Risk 4A - We may not Deliver our Research Strategy and Fail to Attract Research Funding Including Overview of Research Governance Arrangements**
57.1	A report on risk 4A was received from Wendy Fisher. Ms Fisher said that she was a Research and Development (R&D) Consultant and had recently completed a review of the R&D department at Great Ormond Street. She said that management of the department had been returned to the Trust from ICH.
57.2	Ms Fisher advised Committee Members that the risk of failing to attract funding had been mitigated by the appointment of R&D facilitators. She said that the role of the facilitators was to ensure that appropriate funding was secured for all research activities and that further development of the Research Strategy would also be required.
57.3	Ms Fisher said that systems and processes within the department had been improved and additional training had been provided where necessary. She said that posts had been created to improve the accuracy and timeliness of funding applications but were proving difficult to recruit to.
57.4	The Chairman asked about the relationship between the R&D team and the Clinical Research Facility. The Chief Executive said that work was taking place to enhance it.
57.5	Ms MacLeod asked how well participation in research activities were promoted to frontline staff. Ms Fisher said that this was an area for

	improvement and the requirements of staff who wished to undertake research would need to be examined first. She said that the R & D department was due to be re-branded as the Research and Innovation department and this would also need to be considered in the context of the type of studies that could be conducted.
57.6	*Ms Fisher left the meeting and Vic Larcher joined the meeting at this point.*
58.	**Risk 2C – We may not meet Referrers and Other Health and Social Care Expectations Around Communication and Accepting Appropriate Referrals**
58.1	A report on Risk 2C was received from the Deputy Chief Executive. She said that Referrers had been asked about their expectations in a survey conducted by IPSOS Mori. It was noted that the Trust had met their requirements regarding clinical care but areas for improvement had been identified around communication and acceptance of patients.
58.2	The Deputy Chief Executive reported that the timeliness of discharge summaries had improved but work on the process was ongoing. She said that an audit on the quality of the content had also been completed.
58.3	The Deputy Chief Executive advised Committee Members that the Trust had agreed a Commissioning for Quality and Innovation target (CQUIN) regarding outpatient letters. She said that a five day turnaround was expected but at present Consultant job plans did not incorporate sufficient time to achieve this.
58.4	The Deputy Chief Executive said that patient refusal rates were reported to Management Board on a regular basis and a recent workshop had taken place. It was noted whilst the Trust often had capacity, space was not always in an area that could provide the most effective treatment for the patient.
59.	**Overview of Risks at Great Ormond Street Hospital (GOSH) Haringey**
59.1	An overview report on the risks at GOSH in Haringey was received. It was noted that the report had been written by Jane Elias, Director of Operations, GOSH in Haringey but as she had been unable to attend the meeting, the Deputy Chief Executive was presenting it on her behalf.
59.2	The report provided a summary of the services provided by GOSH in Haringey and the risks that they presented. She explained that the high level risks could be divided broadly into the categories of capacity, processes and finance.
59.3	**Capacity** The Deputy Chief Executive said that although recruitment levels were acceptable, demand for the services was increasing. She said that recent changes to government housing policy could see more young families moving into the area than were moving out.

59.4	**Processes** The Deputy Chief Executive said that work to ensure that processes were efficient and evidence of management was provided was ongoing.
59.5	**Finance** It was noted that Haringey PCT were currently experiencing financial pressures and a paper regarding potential savings was due for submission to their board. The Deputy Chief Executive said that it was important for the funding for the services provided by GOSH in Haringey to be prioritised.
60.	**Care Quality Commission (CQC) Compliance Update Including Overview of Quality Risk Profile from the CQC and Learning from Recent CQC Inspection Reports**
60.1	An update on CQC Compliance was received from the Assistant Director, Clinical Governance and Safety. She said that at present, no registration areas were at risk of non compliance but areas where the evidence could be strengthened had been identified.
60.2	The Assistant Director, Clinical Governance and Safety advised Committee Members that evidence against the registration standards was updated on an ongoing basis and each standard had a dedicated executive and local lead.
60.3	The Assistant Director, Clinical Governance and Safety said that The Quality Risk Profile (QRP) had been due to be issued by the CQC on a monthly basis but this had not yet been achieved. She said that her report contained the most recent report that had been issued in October and an explanation of the rating system used.
60.4	It was noted that the QRP indicated 'no confidence' in relation to the registration area concerning consent. The Assistant Director, Clinical Governance and Safety said that the rating system was process driven and not outcome driven and the rating had been based on the results of the previous NHSLA assessment. The Chairman suggested that if the rating remained unchanged for the same reasons in future reports the CQC should be contacted. **Action:** The Assistant Director, Clinical Governance and Safety
60.5	The Assistant Director, Clinical Governance and Safety said that work was taking place to ensure that the Trust was also triangulating internal data on registration areas on a regular basis.
60.6	The Assistant Director, Clinical Governance and Safety reported that the CQC had recently published its findings into standards of quality and safety at Scarborough and North East Yorkshire NHS Trust. She said patient records had been examined in the absence of sufficient evidence against certain standards to ensure systems were being adhered to. It was noted that serious concerns had been noted from the assessment.
61.	**Child Protection Report**
61.1	A report on Child Protection was received from the Chief Nurse and Director

	of Education.
61.2	The Chief Nurse and Director of Education reported that the difficulties in the recruitment process for the named nurse for child protection in Haringey were continuing. She said that the named nurse for the main site had been injured and was currently on extended sick leave and this had been creating pressure on the provision of training and supervision of staff. The Chief Executive suggested that arrangements be reviewed to ensure a greater focus on continuity.
61.3	The Chief Nurse and Director of Education said that Children's services in Haringey were visited by the Safeguarding Improvement Team (SIT) in July and a follow up visit was due to take place in December 2010. She said that SIT was a London based initiative that the Haringey service had helped to develop. It was noted that the SIT would be visiting the GOSH main site for one and a half days in January 2011.
61.4	Ms MacLeod asked how many child protection referrals were made by the Trust. Dr Larcher said that approximately 100 referrals were made on an annual basis but this including children who had been admitted with current protection plans.
61.5	Ms MacLeod said that to provide the necessary assurance to the Trust Board on safeguarding processes, it would be useful for her to continue to receive the final drafts of Serious Case Reviews (SCRs).The Chief Nurse and Director of Education said that she would ensure that this continued. **Action:** The Chief Nurse and Director of Education
61.6	The Chief Nurse and Director of Education reminded Committee Members that the Trust was obliged to report involvement in SCRs to NHS London as Serious Untoward Incidents (SUIs). She said that the Trust was regularly involved with SCRs on a national basis and accordingly it had been agreed that the Trust would be required to notify all involvement in SCRs but only those involving children resident in London would be recorded as SUIs.
61.7	It was noted that two SCRs in relation to Baby Peter had been published in October.
62.	**Clinical Ethics Committee Overview**
62.1	A report regarding the GOSH Clinic Ethics Service was received from Dr Vic Larcher in the capacity of Chairman of the Clinical Ethics Committee (CEC). He said that although CECs are not mandatory in the UK, one was established at GOSH on the basis of requests made by staff.
62.2	Dr Larcher said that all members of the CEC were volunteers and approximately 40% were lay members. He said that the Committee also provided a rapid response service whereby advice could be received from one of three nominated Committee Members within 24 hours. It was noted that the rapid response team had received 11 requests in the year to date.

62.3	Dr Larcher said that in addition to the provision of advice, the CEC aided the development of policies and guidance. It was noted that although the Committee did not have administration support, minutes had been produced and anonymised versions of the minutes from the last two years would be submitted to a future meeting of the CGC for information.
62.4	The Chairman requested for a list of Committee Members and skill sets to be submitted to a future meeting of the CGC. Dr Larcher said that the Committee would also be reviewing their Terms of Reference (ToR) and this would be submitted too. **Action:** Company Secretary
63.	**Airedale Hospital NHS Foundation Trust Inquiry Report – Review of the Recommendations**
63.1	A report on the recommendations resulting from the Airedale Hospital NHS Foundation Trust Inquiry was received from the Chief Nurse and Director of Education.
63.2	The Chief Nurse and Director of Education said processes at the Trust had been reviewed in response to the findings of the inquiry and an action plan had been developed. She said the review had focused on roles that were largely autonomous or where work was often unsupervised.
63.3	It was noted that members of the GOSH Executive team made both announced and unannounced visits to departments out of regular hours and it had been suggested that patient safety walkrounds could also take place at these times. The Deputy Chief Executive said that whilst unannounced visits could be valuable, it would be important to ensure that staff did not perceive them as threatening.
63.4	The Chairman asked if the events at Airedale Hospital would have been detected sooner if a trigger tool had been used. The Chief Nurse and Director of Education felt that they would.
64.	**Investigation into Cardiac Services at Oxford Radcliffe Hospitals NHS Foundation Trust – Review of Recommendations**
64.1	A report on the recommendations resulting from the investigation into Cardiac Services at Oxford Radcliffe Hospitals NHS Foundation Trust was received from the Deputy Chief Executive. It was noted that the recommendations had been reviewed and the Trust had assessed its current position in relation to them.
64.2	The Deputy Chief Executive advised Committee Members that a key factor in the events at Oxford Radcliffe had been the lack of support available to a newly appointed Consultant. Ms MacLeod said that participation in the Consultant interview process had reassured her that sufficient support existed at GOSH.

Attachment 12

65.	**Integrated Clinical Incident, Risk, Claims and Health and Safety Report (Quarter 2 – 2010/11)**
65.1	The Integrated Clinical Incident, Risk, Claims and Health and Safety Report for quarter 2 was received from the Assistant Director, Clinical Governance and Safety. She said that the report detailed the type of incidents experienced at the Trust and attempted to provide a series of baseline levels.
65.2	The Assistant Director, Clinical Governance and Safety said that reporting rates remained high but this was an indicator of a culture of safety awareness. She said that harm was subjective and existed in varying degrees. It was not always easy to identify and could be temporary as well as permanent. Ms MacLeod asked haw many incidents at the Trust involved serious harm. The Assistant Director, Clinical Governance and Safety said that approximately 1 or 2 of the 15.3 incidents reported for every 100 admissions could be classed as serious.
65.3	Committee Members were advised that time lapses in the reporting process could affect the appearance of the graphs contained within the report. Ms Parkyn said that the process often experienced delays in August due to staff holidays.
65.4	The Assistant Director, Clinical Governance and Safety said that it was hoped the next report would contain a comparison of the Trust's safety data with that of Toronto Children's Hospital.
66.	**Complaints Report (Quarter 2 – 2010/11)**
66.1	The Complaints Report for Quarter 2 was received from Ms Angela Dewhurst, Complaints Manager. She said that the report presented a breakdown of complaint subjects by directorate.
66.2	The Chief Nurse and Director of Education suggested that it may be useful to compare the report with the information produced by the Patient Advice and Liaison Service (PALS) **Action:** Ms Dewhurst
66.3	It was noted that the Ombudsman would be reviewing the response to a recent complaint.
67.	**Internal Audit Progress Report (Quarter 2 - 2010/11)**
67.1	The Internal Audit Progress Report for Quarter 2 was received from Mr Aaron Shah, Assistant Director Audit, LAC. Mr Shah reported that the final reports for three audits had been published in the last quarter and all had offered reasonable assurance.
67.2	Mr Shah said that a number of controls noted in respect of the audit on response to deterioration in children had been at pilot stages and had not yet been fully embedded within the organisation. The Chairman asked if the audit could be performed again at a later date. Mr Shah confirmed that it could.

	Action: Mr Shah
67.3	Mr Shah reported that robust policies and guidance existed in relation to staff appraisals but in general, line managers were not sufficiently accountable for the process. He said that the audit had recorded a relatively low appraisal rate but recommendations that had been made were now in progress. The Deputy Chief Executive said that additional assurance regarding staff appraisals could be provided by the KPI report.
68.	**Clinical Audit Report (Quarter 2 – 2010/11) Including Update on Management of Confidential Enquiries and NICE Guidance.**
68.1	The Clinical Audit Report for Quarter 2 was received from Mr Andrew Pearson, Clinical Audit Manager.
68.2	Mr Pearson reported that an audit on the use of CEWS conducted in June found a usage level of 77% and a survey had been developed to evaluate the experience of nurses using the SBARD communication tool. He said that the use of CEWS had now been introduced as a nursing performance indicator and a further audit would take place in the current quarter.
68.3	Mr Pearson said that an audit had taken place regarding the quality of the content of discharge summaries. He said that the findings had been reported to the Trust Management and an action plan had been approved.
68.4	Mr Pearson advised Committee Members that there were currently 4 National Confidential Enquires into Patient Outcomes and Death (NCEPOD) studies currently open and the Trust would be participating in one study, "Deaths in Children following Surgery". The Chairman declared that his wife, Miss Clare Marx FRCS had contributed to the recent NCEPOD studies.
69.	**Foundation Trust Application Process** **Draft Quality Governance Memorandum** **Board Statement – Governance and Performance**
69.1	The Draft Quality Governance Memorandum and Board Statement on Governance and Performance were presented on behalf of the Deputy Chief Executive.
69.2	The Company Secretary explained that the red text in the memorandum provided the context of the information and advised Committee Members that both documents would be submitted to NHS London as part of the assurance process for the Foundation Trust application.
69.3	Ms MacLeod suggested that the documents should make reference to recommendations made to the Trust Board by the CGC and Audit Committee.
69.4	It was agreed that further comments would be sent to Mr Sven Bunn outside of the meeting and that subsequent to the suggested amendments the documents were **approved** for submission to the Trust Board.

Attachment 12

70.	**Staffing Information Report Quarter 2 2010/11**
70.1	It was noted that the 'Staffing Information Report Quarter 2' had been included for information. The Chairman asked if there were any questions or comments. There were none.
71.	**Freedom Of Information (FOI) Requests Quarter 2 2010/11**
71.1	It was noted that the 'FOI Requests Quarter 2' report had been included for information. The Chairman asked if there were any questions or comments. There were none.
72.	**Quality and Safety Committee Minutes July and September 2010**
72.1	It was noted that the 'Quality and Safety Committee Minutes July and September 2010' had been included for information. The Chairman asked if there were any questions or comments. There were none.
73.	**Audit Committee Minutes – October 2010 (Draft)**
73.1	It was noted that the 'Audit Committee minutes – October 2010 (Draft) had been included for information. The Chairman asked if there were any questions or comments. There were none.
74.	**Performance Report**
74.1	It was noted that the 'Performance Report' had been included for information. The Chairman asked if there were any questions or comments. There were none.
75.	**Glossary of Terms**
75.1	It was noted that the 'Glossary of Terms' had been included for information. The Chairman asked if there were any questions or comments. There were none.
76.	**Any Other Business**
76.1	No other business was declared.
77.	**Date of Next Meeting**
77.1	It was noted that the next meeting would be on Wednesday 16th February 2011 at 8:30am.

Attachment 13

Great Ormond Street Hospital for Children NHS Trust

FINAL Minutes of the meeting of Management Board held on 16th December 2010

Present:

** Denotes meeting part attended*

Jacqueline Allan (JA)	General Manager, Medicine and DTS
Sven Bunn (SB)	FT Programme Director
Robert Burns (RB)	Deputy Chief Operating Officer
Cathy Cale (CC)	ICI Unit Chair
Jane Collins (JC)	CEO (Chair)
Carlos De Sousa (CDS)	CU Chair, Neurosciences
Sarah Dobbing (SD)	GM Neurosciences
Lorna Gibson (LG)	GM Research and Innovation
Allan Goldman (AG)	CU Chair, Cardiorespiratory
Elizabeth Jackson (EJ)	CU Chair, Surgery Clinical Unit
Mark Large (ML)	Director of ICT
Anne Layther (AL)	GM, Cardiac
Joanne Lofthouse (JL)	GM, International Unit
William McGill (WM)	Director of Redevelopment
Elizabeth Morgan (EM)	Chief Nurse and Director of Education
Stephen Cox (SC)	Chief Press Officer
Claire Newton (CN)	Chief Finance Officer
Tom Smerdon (TS)	GM, Surgery
Peter Wollaston (PW)	Head of Corporate Facilities, General Facilities
Rachel Williams (RW)	GM, ICI

In Attendance

*Mark Peters (MP)	Senior Lecturer, PICU
*Sanjiv Sharma (SS)	Consultant, PICU
*Sue Chapman (SC)	Clinical Site Practitioner
*Leon Hinton (LH)	Workforce Planning Manager
*Margaret McLoughlin (MMc)	Workforce Project Manager
Marion Malone	Consultant, Histopathology
*Andy Petros (AP)	Consultant, PICU
*Cho Ng (CN)	Consultant Cardiac Intensivist
*Peter Lachman (PL)	Consultant in Service Design and Transformation
*Natalie Robinson (NL)	Deputy Director of Redevelopment
*Ellie Richardson	Clinical Planner, Redevelopment
*Glenn Anderson	Clinical Electron Microscopist
*Christine Morris	Laboratory Manager, Haematology

Attachment 13

777 **Apologies**

777.1 Apologies were received from Fiona Dalton, Chief Operating Officer & Deputy CEO; Barbara Buckley, Co-Medical Director; Martin Elliott, Co-Medical Director; and Melanie Hiorns, CU Chair Medicine and DTS.

777.2 JC welcomed Lorna Gibson, the new general manager for the Research and Innovation Unit. A monthly report would be requested from Research and Innovation by Management Board.

778 **Minutes of the Meeting held on 18th November 2010**

778.1 The minutes of the last meeting held on 18th November 2010 were approved as an accurate record.

779 **Action Log and other matters arising**

700.3 It was agreed the need to ensure completion of the DNAR policy.

716.2 It was noted this matter was on-going.

725.4 It was noted that the Clinical Ethics Committee was yet to meet to discuss this.

741.2 The trust had used 13 certificates out of the 18 so far this year– only 5 were left until the end of March 2011. The trust would need to appeal if more were required. It had been proposed that in 2011, the trust would be granted a monthly allocation of certificates rather than an annual allocation, which would create difficulties for the appointment of junior staff in February and August. It was agreed that the Chief Executive write to Professor Sir Bruce Keogh to stress the problems this proposed approach would create for the trust.

JC

779.1 **Action**: JC to write to Bruce Keogh in the New Year.

742.2 A full review of the CDD system had been undertaken by Helen Vigne, the Project Manager – it had been established that meta data was not always being completed in the system, which prevented the search facility from properly functioning. It was noted that the system did not always provide access to reports in creation date order although additional work was being commissioned with the supplier to improve the options. CC stated that staff were finding the system difficult to use. ML stressed that this was in a large part due to users not using the system correctly - further training was being provided to staff.

743.2 JW had taken this matter forward.

743.4 LM stated there is a need for a clear statement on the uniform policy at GOSH – this would be presented in January 2011.

743.7 – RB stated that FD had looked at integrating the CU risk reports and zero harm reports from January onwards.

Attachment 13

780 **Zero Harm report**

780.1 Mortality review

MP and SS delivered a presentation. SS stated that a GOSH review of mortality data had been completed over a four month period using a standardised method from the NHS Institute of Innovation and Improvement. The aim of the review was to try to identify why and how patients had died in hospital. The review looked at 50 sets of notes.

780.2 The review found limited evidence of documented communication with primary care professionals. ECMO notes were not always amalgamated into the main patient records. Patients notes were sometimes unsatisfactory the team could not always find the notes for patients. Findings showed that resuscitation was not attempted on 40 out of 50 of the children and the majority died on ICU, which had been a developing trend since the 1990s. There were examples of good care and good MDT work.

780.3 For those children who died on the ward without resuscitation, palliative care was provided. Some parents wanted their children to die in the hospital, rather than at home.

780.4 In conclusion, note keeping was unsatisfactory, observation inconsistent and there was poor documentation of DNAR orders. It was noted that clinicians often recognised the futility of resuscitation on admission. It was found that children were still being admitted to ICU when it was known that they would not survive. JC highlighted that further work was underway to understand how children were being treated in these circumstances.

780.5 PL stated that record keeping was key and another project was underway to improve the patient notes. Also, there was a need for improved documented observations of patients and establishment of a work programme to determine how the trust can improve children and families experiences towards the end of life. PL agreed to take this forward with SS. PL

780.6 **Action**: PL to report back to Management Board on the progress with this work.

780.7 Management Board was informed that a regular review of deaths would be implemented.

Management Board **noted** the report.

780.8 Update on Paediatric Trigger Tool

SC presented the report. SC explained that the Paediatric Trigger Tool was a structured case note review where 20 case notes were randomly selected and reviewed from the most recent month. The administration of certain drugs for example would determine what to look for in the notes. Other triggers included whether the patient was readmitted within 30 days. The review was not looking for errors but harm that resulted from treatment.

780.9 Harm was defined as anything that we would not wish to happen to a member of our family. Over 320 note reviews had been undertaken. Most harm at GOSH was found to be temporary harm that required some intervention. Higher categories such as permanent harm were very

low and no deaths resulting from care administered had been found.

780.10 The quality of record keeping was again not up to standard, including the filing and maintenance of files. The discharge summary was not available in some notes and so it was difficult to understand what had happened.

780.11 Observations, for example blood pressure readings in theatre, were often found not to have been documented.

780.12 Most harm was found to arise under general care. Under surgical care, infections were found to be the main reason for harm as well as vascular access issues. SC provided examples of harm, showing that a longer length of stay was associated with more harm and harm appeared to cluster around specific complex patients, particularly very young and older patients. This needed to be looked at further. SC invited member of the Board to observe a review being undertaken.

780.13 PL stated that notes were being audited across all units and he hoped to present the findings in January 2011.

The trust was planning to reduce levels of harm identified by this process by 50% by the end of 2011.

Management Board **noted** the report.

781 **Staff turnover – deep dive**

781.1 LH presented the data. Turnover was defined as the number of leavers (full time) in one year divided by the average staff in post. This excluded junior doctors and bank staff and did not include internal transfers of staff. It covered all reasons for leaving (voluntary and involuntary). Fixed term contractors also affected the numbers.

781.2 At present, the trust was running at 18.4% turnover. This had risen from 15.1% due to the NMUH TUPE transfer, which made up 4% of the turnover total. Clinical Units had been asked for reasons for any reported high turnover rates. In some cases there was no pattern evident.

781.3 A review had been undertaken to establish whether high turnover was related to high bank and agency usage. In some cases there was a very low use of temporary staff usage to cover the turnover. It was also noted that band 5 nurses seemed to not transfer within GOSH but leave and this needed to be looked at.

782 **In-house medical locum bank implementation**

782.1 MMc presented on agency and bank usage – the highest areas of usage were theatres. Theatres did not have sufficient established staff to support utilisation. A business case would be presented to Management Board to deal with this matter in due course.

782.2 CN stated that the trust had still not managed to reduce the trust's spend on agency staff. This was not just caused by CRB checks delaying the appointment of permanent staff, but the speed of the whole recruitment process. Further work would be undertaken to review this.

Management Board **noted** the report and supported the need for further work.

783 **Multidisciplinary Review of all Critical Care services at GOS**

783.1 EM presented the report. ICU was a highly regulated and expensive service and the evidence from the market assessment suggested that there would be increased demand for critical care services in the future. It had been agreed that the trust had a duty to review how services were provided and to ensure preparation for the future. This would ensure that the unit was ready to take full advantage of opportunities in the new building.

783.2 The review would look at how ICU worked with the other services across the hospital and at ward level. It would be led by an external person and commence early in 2011. The review was about the interface between ICU and other services and not how the unit was managed internally or its clinical practices.

783.3 AP welcomed the proposal to undertake a review. He stated that work was already underway to consider the running of the service on ICU and did not wish to duplicate work. It was important to ensure that this work be considered as part of the review.

783.4 A concern was raised about who would undertake the review and the necessary expertise required. Further information was also required to understand the scope of the review, for example high dependency care. Also, it was important to recognise that different wards would require different types of relationships with ICU.

783.5 Following a discussion, it was agreed that a review by an external person would be helpful, but it was important to ensure that the appropriate person was appointed. This would be a peer review to help the trust consider whether it was necessary to work differently in order to be more effective and efficient and provide higher quality care.

783.6 Management Board **supported** the review with further involvement of the ICU team in determining the scope of the review.

784 **Raising concerns in the workplace (Whistle-blowing) Policy**

784.1 RC presented the policy. A new contractual duty for staff to raise concerns was reflected in the policy as well as information on what constituted a disclosure and who to go to.

784.2 RB asked if the internal audit report recommendations had been reviewed as part of this policy update and RC confirmed that these recommendations had been incorporated into the revised policy.

Management Board **approved** the policy.

785 **Automated slide spreader tender**

785.1 Management Board was informed that the spreader would enable the trust to fully automate all the procedures for preparing slide mounted chromosome preparations used for routine diagnostic analysis. This would be achieved by purchasing four robots for harvesting, slide-

making, cover-slipping and slide staining over a two year period.

Management Board **approved** the tender.

786 **Electron microscope tender**

786.1 RW advised Management Board that the aim was to replace the current Electron Microscope (EM - now 35 years old). A replacement would enable Histopathology to achieve full CPA accreditation, (currently conditional because of a lack of EM scope). A new EM would enable revenue generation (GBP 40K per annum) and make savings (20K per annum by reducing number of renal patients started on plasma exchange while awaiting definitive biopsy results). This would also save GBP10K revenue per annum currently paid to lease time on EM scope in the NHNN.

Management Board **approved** the tender.

786.2 It was agreed the need for a more top down approach to replacement of equipment. CASP would review this.

787 **Blood tracking system tender**

787.1 RW presented the paper. The system was required to ensure the trust complied with relevant legislation. This was viewed as a quality scheme with ongoing service maintenance flagged as a cost pressure. Two potential providers had tendered and one selected that provided the most appropriate solution.

Management Board **approved** the tender subject to the contractual terms and conditions being agreed.

788 **Medical Equipment Prioritised list 2011/12**

788.1 RB presented the prioritised list. CESC members had scored the equipment against the criteria and the top 16 were selected as a result. It was asked whether the other trusts involved in funding the CATS service should also fund equipment. It was agreed to check whether it was appropriate for the charity to fund equipment for this service.

788.2 EJ stated that an anaesethic machine was not on the list to be funded but it was recognised that the criteria was applied to the information supplied at the time of the approval process. The equipment was close to exhaustion and it was therefore agreed to request that CESC review the item again. It was noted that the prioritisation process had been recently reviewed and was multi-disciplinary.

788.3 **Action**: CESC to review replacement of the anaesethic machine. WM

788.4 Management Board **approved** the list subject to reconsideration of the anaesethic machine by CESC.

789 **Phase 2B Ambulatory Care Centre**

789.1 WM presented the report, stating that the team was in the process of

designing level 2 of phase 2B. Specific services included pre admission attendance, rehabilitation and complex outpatients.

789.2 CC stated that there it had been recognised the need for more ambulatory areas and a small area had been given over in the new ICI area of phase 2 already, which raised a concern around duplication of services. NR agreed to reconsider this.

789.3 It was hoped that the proposed approach would free up other space in the hospital through relocation of complex outpatients and developing alternative settings where minor procedures could be carried out.

Management Board **approved** the direction of travel.

790 **Rehabilitation of function position paper**

790.1 SD presented the report. The work had arisen as a result of a discussion at Management Board and had looked at where the patients were referred from and the type of service GOSH should be providing. It had become a complicated discussion, but a direction of travel had been agreed by those providing the services. It was the view that streamlining of current services could be undertaken. A working group would be established to look at creating a rehabilitation multi-disciplinary team (NDT) at GOSH – it could take patients directly or operate as a hub for advice and protocol sharing. The working group would look at pathways and protocols and agree a way forward.

790.2 RB stated that a hub was not the easiest to get financed by commissioners

Management Board **supported** the direction of travel.

791 **Purchase of replacement PCs**

791.1 ML presented the report. New monitoring tools now enabled ICT to provide a complete listing of all assets connected to the GOSH network. ICT was now able to produce a list of PCs and sort by age, CPU speed, amount of memory or hard disk size/free space.

791.2 Revenue was available to spend on tactical replacement of the oldest PC stock. Macintosh computers were not included in this business case as this would require a managed support service and work was underway to consider this.

Management Board **approved** the proposal.

792 **ENT Consultant**

792.1 TS presented the business case. An increase in referrals to the ENT service had meant a growing waiting list of new patients and increasing waiting times for a first appointment. The business case proposed the appointment of a locum Consultant for 6 months to enable the service to halt any rise in the backlog of patients waiting for a new out patient appointment. The financial summary of the business case demonstrated that appointment to this post contributed significantly above 30% to

overheads, even if tariffs reduced significantly in 2011-12.

Management Board **approved** the proposal.

793 **Clinical Unit Reports (ICI, Neurosciences, Cardio-respiratory, Surgery, Medicine & DTS, International, Haringey) and zero harm reports**

793.1 Management Board took the CU risk and CU zero harm reports as read and asked for any updates additional to the reports.

793.2 IPP
The unit was working towards a business case for Butterfly Ward.

793.3 Cardio-respiratory
Adult ECMO centres were full across the country due to flu and so GOSH was being asked to take more children from other trusts.

793.4 ICI
CPA accreditation had been awarded. There had been increasing difficulties in getting central lines into patients in a timely way and this process was being reviewed.

793.5 MDTS
No additional matters were reported.

793.6 Surgery
ICU was full and this was impacting on spinal surgery waiting lists. There was a need for support from other specialities to ensure that patients were ready for surgery and for imaging on Dinosaur ward. Work was underway to reduce starving times for children prior to surgery.

Neurosciences

793.7 Video EEG equipment was of concern. WM confirmed that this was on the priority list for replacement.

Haringey

793.8 It was reported that the Haringey team were having the second day of the safeguarding improvement team visit.

Management Board **noted** the reports.

794 **Key Performance Report November 2010**

794.1 RB presented the report. There had been an increase in inpatient waiting times and a decrease in outpatient times and this was being looked at.

794.2 The number of reported CV line infections continued to reduce since September. In month, the Trust had reported 2.08 CVL infections per 1000 bed days against a target of 2.4.

794.3 Quarterly market share information was presented. There had been an increased market share in spinal surgery.

Management Board **noted** the report.

Attachment 13

795 **Finance and Activity Report November 2010**

795.1 CN presented the report. The trust was reporting a surplus of £6.8M, £2.1 in favour of the trust's internal plans. Pay was £5.7M higher than budget and Non Pay expenditure £3.8M lower than budget. Income was ahead of budget.

795.2 The Operating Framework had been published the day before and was being assessed for its impact on the trust.

Management Board **noted** the report.

796 **Foundation Trust Application Update November 2010**

796.1 SB presented the report. C Difficile was on trajectory now. There was still an emphasis on implementing CRES plans.

796.2 JC reported that the DH had been persuaded not to decrease specialist top up payments to 25% but to 60%. This would have a minor impact across the Trust but would involve changes between specialities.

Management Board **noted** the report.

797 **Assurance Framework Summary**

797.1 AF presented the framework. The Assurance Framework provided an overview of the principal risks to achievement of the Trust's corporate objectives.

797.2 There were 26 risks documented on the framework. The Clinical Governance Committee and Audit Committee sought assurance on behalf of the Trust Board that these risks were adequately controlled. Of the 26 risks, no risks were rated as red, 9 were rated as amber and 17 as green. This rating related to the assessment of the controls in place, any outstanding actions and internal/ external assurances available.

Management Board **noted** the report.

798 **National Peer Performance Benchmarks**

798.1 RB presented the report. The presentation showed that GOSH was better than peer trusts, in the majority of benchmarks measured, for example, LOS, readmission rates,, excess bed days and waiting times.

798.2 The results had been being presented to commissioners to demonstrate how services provided at GOSH were effective and value for money.

798.3 It was agreed that more specialities should be reviewed to understand were GOSH stood against other trusts.

Management Board **noted** the report.

799 **Update on proposals for national commissioning**

799.1 RB provided a verbal update. NCG proposals had to be submitted 17th December 2010. GOSH was involved in eight, for which three it was the lead:

- Heart Failure

- Transitional CHI
- Swachman Diamond Syndrome
- Beckwith Wiedermann Syndrome Macroglossia
- Langerhan's Cell Histocytosis
- Children's inpatient psychiatry
- Micro/Anopthalmia
- aHus (eculizumab)

Management Board **noted** the report.

800 **Update on Referrers Experience Improvement Programme**

800.1 RB presented the report, to update Management Board on the progress of the Referrer's Experience Improvement Programme.

800.2 Following the Referrer's Survey results earlier in the year, the trust had established a Referrer's Experience Improvement Group under the co chairmanship of Barbara Buckley and Robbie Burns.

800.3 The group had audited the timeliness of outpatient letters and quality of discharge summaries, developed templates and run a workshop to consider ways to improve the referrer's experience of inter hospital transfers with GOSH. Further work was planned and a further update would be provided in due course.

Management Board **noted** the report.

801 **CASP**

Management Board **noted** the content of the report.

801.1

802 **Transformation Board**

802.1 Management Board **noted** the content of the report.

803 **Redevelopment Programme Steering Board**

803.1 Management Board **noted** the content of the report.

804 **Technical Delivery Board**

Management Board **noted** the content of the report.

804.1

805 **Information Governance Steering Group**

805.1 Management Board **noted** the content of the report.

806 **Any other business**

There were no items of any other business.

807 **Next meeting**

The next meeting of Management Board is Thursday, 20th January 2011 in the Charles West Room

Attachment 14

Great Ormond Street Hospital for Children NHS Trust

MANAGEMENT BOARD
Thursday 20 January 2011

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
Judith Cope (JC)	Chief Pharmacist
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 Laythe r (AL)	GM, Cardiac
Joanne Lofthouse (JL)	GM, International Division
William McGill (WM)	Director of Redevelopment
Elizabeth Morgan (EM)	Chief Nurse and Director of Education
Claire Newton (CN)	Chief Finance Officer
Tom Smerdon (TS)	GM, Surgery
Peter Wollaston (PW)	Head of Corporate Facilities, General Facilities
Rachel Williams (RW)	GM, ICI

In Attendance

Robert Bingham (RB)	Consultant Anaesthetist
Ray Conley (RC)	Head of Operational HR
Sue Connor (SC)	Project Manager, Care Records
Stephanie Grunewald (SG)	Consultant in Metabolic Medicine
Madeline Ismach	
Tessa Radcliffe	Executive Assistant to Chief Executive and minute taker
*Derek Roebuck (DR)	Consultant Interventional Radiologist
Rubin Wang	Clinical Scientist, Cytogenetics

**Denotes meeting part attended*

808	**Apologies**	
808.1	Apologies had been received from Anna Ferrant, Company Secretary.	
808.2	JC welcomed Rubin Wang who was attending as part of his Organisational Observation Assignment, and the other members of staff who were attending in support of agenda items.	
808.3	JC - Whittington Healthcare (who had already successfully tendered for Haringey Adult Services) had won the contract to manage Haringey Children's Services from 01 April 2011. With Islington Children's Services this would provide the necessary critical mass to sustain the Haringey service.	
808.4	JC – Positive feedback so far from NHS London SIT team visit to GOSH.	
808.5	JC - Royal Wedding 29 April – Staff would be given as Bank Holiday although the hospital would be expected to run as normal throughout the non holiday days of the three weeks affected by the extended Bank Holiday periods of Easter and Royal Wedding/May Bank Holiday – i.e. Week commencing Monday 18 April Week commencing Monday 25 April Week commencing Monday 02 May Managers to ensure that no extended periods of leave were authorised during this period in order to avoid disruption of services on normal working days **Action:** Ray Conley to prepare letter to all staff for JC to sign.	**Ray Conley**
	(Agenda item 1) Minutes of Management Board meeting held on 17 December 2010 (Attachment A)	
809	The minutes of the last meeting held on 17 December 2010 were **approved** as an accurate record	
	(Agenda item 2) Action Log and any other matters arising (Attachment B)	
810	673.3 – Consent for email contact between hospital staff and patients and carers RE to be asked for update – pilot in nephrology scheduled to begin this month	
	700.3 – End of Life Care Decision Making Policy (including DNAR orders Sophie Pownall to be reminded legal comments had been expected in time for this meeting	
	716.2 and 740.6 – CUC Report – ICI – Removal of femoral line before discharge from PICU TS reported discussions held but no plan currently in place. LM had checked the IV training programme and spoken with Joe Brierley. Workshop to be held with both medical and nursing staff. JC asked for Workshop to be held before next Management Board meeting on 17 February.	
	743.4 – Bare Below Elbows Policy LM had sought clarification from infection control – it applied to only those involved with actual clinical care within the ward, not outside the ward. Final report to February Management Board.	
	779.1 – Interim Limit on Tier Two Applications JC advised would be on agenda for forthcoming AUKUH meeting. RC was drafting letter for JC to send to Sir Bruce Keogh.	
	788.2 – Zero Harm – Mortality Review CUs urged to pass urgent requests for replacement of equipment directly to Executive Directors for immediate consideration.	

811	**(Agenda item 3) Clinical Unit Reports** (Attachments Ci, Cii, Ciii, Civ, Cv, Cvi, Cvii, Cviii)	
811.1	ICI CC reported – Robust plan introduced to manage bed pressures. Medication errors being addressed. Repeated breakdown of lifts impacting on pathology services. Equipment failure had resulted in delayed diagnoses – work under way on recognising when equipment reaching end of useful life. (Note for all GMs – failure of vital equipment should be reported to Executive Directors for immediate decision re repair/replacement) RW – outstanding haematology patient eligibility resolved – patient ineligible for NHS treatment. **Action:** WM – to investigate recurring lift failures.	**WM**
811.2	International Division JL reported - Trust Fellow recently joined – second vacancy currently advertised. New Head of Nursing started 04 January. Recruitment remained high risk – particularly on Butterfly. Increase in prescribing errors – dedicated quiet prescribing areas on wards introduced and additional training for staff. Continuing concern over length of stay. High activity in December – all beds full during Christmas with both wards open throughout Over achievement for December income 3 refusals – no anaesthetist available.	
811.3	Neurosciences CdeS reported – Leaking roof remained an issue Mildred Creek (WM confirmed this work was now a priority. Leak caused by generator work and repair - would require generators to be moved). Prolonged Christmas close-down resulted in refusal two neurosurgery patients.	
811.4	Cardiorespiratory AG reported - Improvement Group now set up to consider continuing risk from poor patient notes. Cardio MRI server hard disk over-loaded and not adequately backed up. Bid to Technical Board for network access by other users under preparation. Negotiating with NCG for additional consultant support.	
811.5	Surgery	
811.5.1	Death of neuro-muscular patient having spinal surgery Before TS presented his report, the meeting discussed the temporary suspension of the spinal service for complex neuro-muscular patients following death of patient previous week – bringing total of four spinal patient deaths in last 12 months. Treatment was often unavailable elsewhere for these patients. ME (Co-Medical Director) - confirmed recent death was of very complex patient – initial review had shown no fault with quality of surgery which had been of the highest standard. Case selection and post operative patient management of patient to be investigated. If service restored in the short term, patients would initially transfer from theatre to ICU as a safeguard. Review of pre-assessment for spinal patients had already begun **Action:** 1. The impact of future transfer of neuro-muscular spinal patients from theatre to ICU would be an agenda item for February Management Board.	**Agenda**
811.5.2	TS reported –	

	JMS workforce remained a risk. Difficult discharges major cause of pressures in ICU. Refusals - 63 CATS and 6 cardiac patients refused during December 2010 – total of two refusals in December 2009. <u>Bid for 4 additional PICU beds</u> The meeting discussed forthcoming bid to Specialist Commissioners. Essential for the Trust to open up additional ICU capacity in 2011-2012 to accommodate patients currently refused. The ICU review would need guidance on strategy and patient volume and the ratio of internal vs external patient referrals. Important to understand precisely what the Commissioners will require. **Action:** 1. FD to meet with EJ and TS to discuss ICU refusals and additional PICU beds. 2. RB to check PbR guidance on marginal rates for 2011 – 2012. 3. CN to meet ME to discuss best next steps. 4. TS to prepare pre-bid letter to Specialist Commissioners.	**FD, EJ, TS** **RB** **CN, ME** **TS**
811.6	<u>MDTS</u> MH reported - Maternity leave and promotion among nursing staff creating vacancies remained a problem. (Business Case for expansion of IR service provision to be considered later in this meeting).	
811.7	<u>GOSH in HARINGEY</u> FD reported – OFSTED visit to GOSH this week – positive feedback so far. Financial risks outlined on page 2 of report. Commissioners considering their priorities which might include removing speech and language therapy service from secondary schools.	
811.8	<u>R and I Divisional Report</u> LG reported – Recruitment drive underway – Division should be fully recruited by 01 April. Comprehensive Local Research Network to be administered at local level. BRC re- application pending – call expected by the end of January with decision on application Summer 2011.	
812	**(Agenda item 4) ZERO HARM**	
812.1	<u>ICI Deep Dive</u> (Attachment Di) CC reported: Priorities in line with work throughout the Trust. Divisional priority was central venous lines – insertion at the right time, by the right service, no infection while in place – and timely removal. Service to be audited – with prior agreement on realistic targets. MSSA meeting held with Infection Control team - scoping work in February to establish whether MSSA was a significant issue within the Unit. Medical errors – additional pharmacy input for Haem/Onc wards. WHO Check List being rebranded for Medical specialties as the “WHO Safer Procedure Check List” - work starting in February .Needs to fit with the theatre Check List. Deteriorating Child – Use of CEWS and SBARD – timescale March – RCA on crash calls outside of ICU – timescale February. Laboratory medicine – work on dashboard completed by end of February Discussion included the current transformation work in cardiac and the increasing recognition within the Trust of the importance of quality improvement techniques.	
812.2	<u>Neurosciences</u> (Attachment Dii)	

	CdeS reviewed attachment Dii.	
812.3	Cardiorespiratory (Attachment Diii) AG reported: Poor patient notes remained a risk – Improvement Group now set up Cardio MRI server hard disk over-burdened - not adequately backed up – bid to Technical Board in preparation for network access by other users. Negotiating with NCG for additional consultant support	
812.4	Surgery (Attachment Div) TS reported: Check List completion reduced to 60% in December - (down from 93%) - reflected now counting those check lists fully completed. Work under way on accidental extubations.	
812.5	Medicine (Attachment Dv) MH reported: Gastro Suite cancellations remained a risk. New Head of Nursing to Lead on infection control.	
813	**(Agenda item 5) Key Performance Report December 2010 (**Attachments E and Ei)	
	RB presented the KPI report for December 2010 which showed a reduction in OPD waits although line infections had increased. Management Board **noted** the contents of the Key Performance Indicator Report for December 2010. Future monthly reports to include outcomes on the summary sheet.	
814	**(Agenda item 6) Finance and Activity Report December 2010** (Attachments Fi and Fii)	
	CN - Referred the meeting to the Finance and Activity Report. She also reported that the Road testing tariff had been issued just before Christmas and it was currently estimated that the Trust would suffer a reduction of c 5% on its PbR funded activity (from a combination of reduced specialist top ups and MFF reduction) and 1.5% on non PbR. GOSH would be working with other paediatric Trusts in trying to ensure the existing rate of top ups for future years The operating framework had also been released in December and introduced the obligation for Trusts to take responsibility for bearing the cost of readmissions for up to 30 days after discharge. A quick estimate indicates that GOSH could lose £600k of funding in addition to the tariff losses although the lack of appropriateness of this ruling to tertiary paediatrics is being challenged with commissioners. The FT financial projections for the next 12 months were being updated and delivery of CRES in 2012 - 2013 remains one of the highest concerns worsened by the additional costs of the new buildings starting in April 2012. The SHA have also advised the Trust that it will need a greater proportion of its CRES target achieved through cost reductions. It was highlighted that the Financial Plan did not include cost pressures to cover the five Business Cases under consideration at the meeting, particularly the expansion of the IR service, its affordability and the complex negotiations required to secure Saturday and Sunday working by IR Consultants. The issue of whether the Trust used its facilities to full capacity, particularly theatres, during day time hours was raised. Work was under way on reducing length of stay - to which earlier line insertion may not contribute.	
815	**(Agenda item 7) Foundation Trust Application Update December 2010** (Attachment G)	
	SB presented the FT Application Update setting 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 FT status. The number of c.diff cases in December pushed the Trust over target. The report showed financial pressures on the Trust increasing in 2012 – 2013. One key event	

	was forthcoming - presenting the Trust's Integrated Business Plan to the SHA. Management Board **noted** the contents of the FT Application update.	
	For Decision	
816	**(Agenda item 8) MDTS Business Case 1: Genetics Laboratories - Service Expansion – (**Attachment H)	
	Nick Lench, Director, North East Thames Regional Genetics Service Laboratories presented the report: Funding requested for new clinical service to increase market share in genetic diagnostic testing for which the demand is known to exist; to repatriate Rett gene testing and set up the first UK testing service for Kabuki syndrome. Introduction of new technology would deliver services more cost effectively and improve turnaround times - already within National guidelines. Important to position the Trust in the market place before other Trusts consider repatriating their genetic tests. Discussing how to market genetic service developments with GOSHCC Marketing and with Pathology. Other Trusts and new GP consortia would be target clients. Recruitment of one Band 7 scientist and three technical staff would release senior scientists to do more appropriate work and generate income – estimated £216k over three years. The three technical staff would initially be on 12 month contracts. Comments made during discussion included: • Tests could be grouped. • This investment would save money even if income didn't increase. • Important to understand market opportunity – can we compete e.g. with SERCO – or should we consider an industrial partnership? • Strategic planning for this service essential. **Decision:** Management Board **agreed** that MDTS Business Case One should be further reviewed by the COO outside of this meeting, with the opportunities for income generation identified and explored.	**FD**
817	**(Agenda item 9) MDTS Business Case 2: Possible expansion of GOSH Metabolic/Lysosomal storage disorders (LSD) service @ GOSH by transfer of the Cambridge Paediatric metabolic/LSD service (**Attachment I)	
	Stephanie Grunewald presented the report: Current Cambridge service to be decommissioned - run by single handed practitioner – and considered unsafe by NSCG – who proposed to transfer care of Cambridge LSD and general metabolic patients to GOSH. A complete service transfer would require nursing staff etc. to move over to GOSH in order to provide same level of care. Current NCG proposal offered £350k for service. No additional finance offered for transfer of general metabolic patients. At recent meeting with NCG MH had insisted that the Trust needed at least one 10 PA consultant - NCG suggested it may be able to realign the transfer funding. Further meeting with NCG scheduled for week commencing 24 January. The meeting expressed concerns at the current NCG under-funding of this strategically important transfer; whether the Trust has the capacity to accept this service transfer and importantly, the knock-on effect on other GOSH services. The Trust should remember the issues around the transfer of the neuro-disability service from Imperial. **Decision:** Management Board **agreed** that MDTS Business Case Two should be further reviewed by the COO outside of this meeting, with the financial implications of the proposed transfer further explored - taking into account the Trust's previous experience of external service transfer.	**FD**
818	**(Agenda item 10) MDTS Business Case 3: Increase in Provision of the Interventional Radiology (IR) Service (**Attachment J)	
	MH presented the report (third presentation to Management Board):	

	Proposal for out-of -hours 24/7 emergency cover from March 2012 – (may require planned weekend operating sessions) – with cover provided by five Consultant Interventional Radiologists (CIRs) - three currently in post. Admitting and Referral Rights to be considered for CIRs. Expansion would meet expected demand for CVCs and other procedures by increasing length and number of operating sessions, providing sustainable service models for the future and robust career paths. Provision of third IR room was critical. The meeting discussed the proposal. Comments made during discussion included: • The Trust must change its working models to use its facilities better. • How would IR capacity and demand be managed until 2012? • The benefit of IR staff working closer with theatre staff. • Additional staff requirements by 2020. • Named Consultant under whom patient would be admitted. • Cost savings would result from reduced length of stay. • WM advised the meeting that a third IR room could not be provided until Phase 2B of the Trust redevelopment (2016-2017) without sacrificing theatre space. **Decision:** Management Board **agreed** that MDTS Business Case Three, which would be an investment for an improved service to patients, should be further reviewed by the COO outside of this meeting.	**FD**
819	**(Agenda item 11) MDTS Business Case 4: Increasing the provision of Parenteral Nutrition (PN) (**Attachment K)	
	Judith Cope presented the Report. Capacity was now the issue. Trust TPN service reached capacity during 2009 – 2010 and had now increased substantially – ICI patients formed the highest % of new patients between 2005 – 2010 (result of changed/ improved practice) Options: • Continue using locum staff – considered unsustainable. • Purchase ready prepared solutions from outside organisation – cost £373k. • Provide another shift – (one additional band 6 and one additional band 5 technician)at a net cost of £82k) This was the preferred option – to provide bespoke TPN for up to 45 patients (currently 25 patients) 10 years ago the Trust made and sold TPN. Trust could sell excess in the future although any extension of in-house manufacturing of TPN e.g. to sell on to UCLP would require additional storage facility. **Decision:** Management Board **agreed** that MDTS Business Case Four, which would be an investment in an improved quality service to patients, should be further reviewed by the COO outside of this meeting.	**FD**
820	**(Agenda item 12) MDTS Business Case 5:Psychosocial & Family Services - Social Care (**Attachment L) Madeline Ismach (Head of Psychosocial Services) presented the report: Camden was withdrawing its (approx) 50% funding from July 2011 - leaving shortfall of £405k. Notice of funding withdrawal would lead to a redundancy if replacement funding not found. A decision was needed imminently. Proposed timescale following Management Board decision on funding shortfall: • In the event of decision not to fund, redundancy/redeployment process to begin. • If funding approved, January 2011 - April 2013 Stage 2 review of GOSH social care service provision and service redesign in collaboration with Clinical Units. • April 2013 - Implementation of changes to provision and service redesign.	

	If funding was approved a social care provision and service redesign review will maintain a safe Child Protection Service and ensure the impact of illness, family support and complex discharge activity is delivered flexibly and efficiently working with clinical units. Social workers' core activities as part of the overall delivery of psychosocial services could be provided via SLAs, to better meet Trust needs; Pilot in Cardiac to begin shortly - tasks and thresholds agreed with GM Anne Layther. Other opportunities for SW interventions included improving the management of patients with medically unexplained conditions - Working Group led by GM Sarah Dobbing. Potential to reduce bed days and limit readmission with a monitoring and evaluation process assisting in measuring outcomes. Child Protection training would be offered via an SLA. Alternative sources of funding may be identified from specialist charities. Trust social workers would remain Camden employees seconded to the Trust, with a management fee negotiated with Camden for specific services to the staff, in order to maximise recruitment and maintain governance requirements. **Decision:** Management Board **agreed** that MDTS Business Case Five, which would be an investment in a better quality service to patients, should be further reviewed by the COO outside of this meeting.	**FD**
821	**(Agenda item 13) ENT Business Case – Follow up brief on long-term future of ENT** – (Attachment M) TS presented the update on the Business Case for a sixth ENT Surgeon (six month fixed term post): Following the decision taken at December 2010 Management Board, a Full Business Case for sixth ENT surgeon and supporting anaesthetic and theatre staff would be presented to February Management Board.	**Agenda**
822	**(Agenda item 14) Estates Strategy 2010 – 2015 (**Attachments N and Ni) WM presented the Estates Strategy, which provide an assurance that the clinical services provided will be supported by a safe secure and appropriate environment. The plan allowed progress to be measured against objectives and a strategic context in which business cases for all capital investments can be measured. It was a statement to the public that the Trust has a positive agenda and was a clear commitment to complying with sustainable objectives. The Estates Strategy provided an assurance that risks are managed effectively, that asset management costs are appropriate. There were no immediate financial implications. The Development Control Plan had been reworked in the last 12 months, during which time the Special Trustees had bought the Computer Centre for the Trust - which would be a new build in Phase 3a. Demolition/redevelopment of the Nurses Home deferred until Phase 3b because the Trust would need to decant off-site. **Decision:** Management Board **approved** the Estates Strategy 2010 – 2015.	
823	**(Agenda item 15 – Medicine Management – extension of CIVAS service (**Attachment O) JC and Sue Conner (Project Manager, Care Records) presented the request for approval of proposed Strategic Direction: The paper came from Medicine Management Group planning last year. Robust EP data showed ICI patients required many medicines which could not be provided ready prepared. Work with Practice Educators on time spent on drug preparation revealed 21 WTE posts currently involved in this work. Drug preparation on wards was contributory factor in recruitment and retention issues. Extension of CIVAS service would reduce both error rates and agency usage, without ward skill loss, at an additional staffing cost of £307k. Proposal to produce drugs in batches where possible, for all except ICU patients. All medicines in US hospitals already made up by pharmacy teams - although use of robotics was the future with 24/7 service.	

	Decision: Management Board **approved** the strategic direction proposed by the Medicine Management Group for an extension of the CIVAS service. The proposal would be further reviewed by the COO outside of this meeting, with the opportunities for income generation explored.	**FD**
824	**(Agenda item 16 - Cover sheet, paper, apportionment (**Attachments Pi, Pii and Piii) Jane Collins referred the meeting to documents outlining the options open to the Trust for the continued usage and support of the iPM (PiMS) system. Management Board needed to decide whether to stay in the CSC contract and be part of iSOFT7, or exercise an option to go it alone. Although a new system would be required in the future, the current situation needed to be managed. The Trust had leverage with iSOFT, having been involved with the development of PiMS **Decision:** Management Board **agreed** to Option 1 – renew the contract for a five year period from March 2011 at a cost of £200k pa.	
825	**(Agenda item 17) Catering and Retail Report** (Attachment II) PW referred the meeting to the Retail Catering Review and outlined its proposals which included withdrawing the provision of hot meals in Peter Pan and amalgamation of Peter Pan with the hospital shop. Nursing representatives would in future be included in the decision taking process. The new catering facility in Phase 2a would be opening in 16 months, with catering services likely to be outsourced. **Decision:** Management Board **supported** the service changes outlined in the Report.	
826	**(Agenda item 18) UCLP CSSD Strategic Outline Case (**Attachment JJ) PW referred the meeting to the UCLP CSSD Project paper which would be now developed into a Full Business Case. The meeting was asked to note progress and to engage in the formal stakeholder process. **Decision:** Management Board **noted** the progress outlined in the UCLP CSSD Strategic Outline Case.	
827	**(Agenda item 19) UCLP Soft FM and Transport tenders (**Attachment KK) PW referred the meeting to the UCLP Estates and Facilities Workstream Update: Cleaning services were provided externally. Although a reduction in numbers of cleaning staff at GOSH would save money, it was considered a clinical risk – the recommendation was that the Trust didn't try to benchmark but maintained current levels. Security services remained outsourced but reception services had been brought back in–house. Patient representation was being redesigned – proposal currently with GOSHCC. The issue of security staff communication skills and the need for local control of cleaning in some areas was discussed. **Decision:** Management Board **approved** the proposal to proceed with market testing of Soft FM services as detailed and approval to proceed with novation to the Managed Transport service as and when practical.	
	For Discussion	
828	**(Agenda item 20) National HR Developments (**Attachment Q) Ray Conley, Head of Operational HR referred the meeting to the paper which outlined national HR initiatives and their potential impact on the Trust. A full paper would be presented to February Management Board. **2) Proposal to Freeze pay Increments** had been rejected at a national level.	

	3) Voluntary Redundancy Scheme for staff was different from last year – with bureaucracy reduced but limited to specified staff groups. The scheme would be helpful to the Trust and could be implemented until 31 March 2011 - at which time extending the deadline would be reviewed. No external scrutiny required when redundancy payments/capitalised pension costs were less than £100k. Scheme in use by Royal Free. **5) On-Call Arrangements** – RC urged those present whose areas had not so far submitted the on-call information required to do so immediately. All GMs and CUCs had been copied in on requests. **Decision:** The meeting **agreed** that the Voluntary Redundancy Scheme for Staff should be worked up for immediate introduction. Proposal to be submitted to February Management Board but should be introduced before then because of 31 March deadline.	**Ray Conley**
829	**(Agenda item 21) Honorary Contracts at GOSH (**Attachment R) Geoff Speed (Head of Education and Training) referred the meeting to the Report which gave an overview of the Honorary Contracts process at the Trust focussing on how E&T department came to manage this process, a summary of the activity and income achieved since the process has been managed within E&T and a summary of management issues. The £50k income raised from charges funds the posts which manage applications - although the number of honorary contracts (2,000 since January 2008) was putting pressure on the PGME staff who manage the process. Concern about abuse of honorary contract status by its long-term use on documents such as C.Vs long after honorary contract dates had expired. During discussion, the question of whether PGME staff had the necessary HR expertise to manage applications was raised. The current system was, however recognised as good and working well. **Decision:** Management Board **agreed** that responsibility for honorary contracts should revert to HR following a full review of the process - to be lead by Co-Medical Director Barbara Buckley.	**BB**
830	**(Agenda item 22) Financial Planning 2011 – 2012 (**Attachment S)	
	Policies for approval	
831	**(Agenda item 23) – Resuscitation Policy** (Attachments Ti, Tii, Tiii, Tiv Tv) Robert Bingham, Consultant Anaesthetist, referred the meeting to the Executive Summary of the policy and the policy appendices. The policy had been constructed to facilitate compliance with the NHSLA Risk Management Standards and was based on internationally accepted outcomes. The Executive Summary highlighted policy additions/revisions. Management Board **ratified** the Resuscitation Policy and noted that the training matrix would be agreed within the next three months, following an Extraordinary Meeting of the Committee to be convened by RB.	
832	**(Agenda item 24) Agency Staff policy and procedures (**Attachment U) This item was **deferred** until the Management Board meeting on 17 February 2011.	
833	**(Agenda item 25) Redeployment Policy and Procedure (**Attachments V and Vi) The meeting **ratified** the Redeployment Policy and Procedure.	
834	**(Agenda item 26)** **Quality of Health Records Policy (**Attachment Wi) **Quality of Health Records Audit (**Attachment Wii) These items were **deferred** until the meeting on 17 February 2011.	**Agenda**
	For Information	
835	UCL Institute for Child Health – Clinical Research and Development Report January 2011 (Attachment X)	

	Management Board **noted** the contents of the above document.	
836	UCLP Managing Directors' Report (Attachment Y) Management Board **noted** the contents of the above document.	
837	Management Board dates and times (2011) reminder (Attachment Z) Management Board **noted** the dates and times for Management Board for the remainder of 2011.	
838	E-CRB and EARCU update (Attachment AA) Management Board **noted** the contents of the above document.	
	Minutes of subcommittees/ subgroups	
839	Major Incident Planning Group (Attachments BB and BBi) Management Board **noted** the contents of the above document	
840	Capital and Space Planning Committee (Attachment CC and CCi) Management Board **noted** the contents of the above document	
841	Education and Training Committee (Attachment DD) Management Board **noted** the contents of the above document	
842	Working Lives Group (Attachment EE) Management Board **noted** the contents of the above document	
843	Transformation Board (Attachment FF) Management Board **noted** the contents of the above document	
844	Technical Delivery Board (Attachment GG) Management Board **noted** the contents of the above document	
845	Information Governance (Attachment HH) Management Board **noted** the contents of the above document	
	Waivers	
846	Waivers (Attachment MM)	
	Management Board **agreed** to waivers 253407, 253408 and £662,400.00 for a capital invoice from Mansell Construction Services Ltd for a GOSH theatre doors refurbishment estimate.	
	Any other business	
	There was no other business.	

Managing Directors report to the Extended UCLP Board March 2011

1. The company

The company has developed its financial, risk and work-force base from a "start-up" position over the last 18 months to a more robust position as below:

(a) Finance

The company is on a sound financial and commercial footing. Deloittes provided an unqualified audit of our year 1 accounts, and we have a commercial approach to create sustainability. Janet Pressland was recruited as FD – she is a senior financial resource with a successful in the NHS, education, charitable and commercial sectors and has led the development of the plans below.

In our first trading year 100% of the company income came from partner contributions. The predicted turnover for our second trading year (2010/11) is £1.9m of which £500k (26%) was contributed from the Founding Partners, £150k from new executive partners and the remainder from external grants. The turnover is expected to increase in 2011/12 to £2.7m with no increase in Partner contributions.

We have built in a contingency of 2.5% of turnover and plan to ensure, by year 3, that we always maintain a cash reserve equivalent to nine months core costs, through the same expectations on trading surpluses (5%) as our Partner FTs. The accounts to Q3 2010/11, planning principles and forward projections for the next 3 years are attached as Appendices 1 and 2 for Board discussions and approval. These provide a sound financial basis and support us to bid for NHS tenders.

(b) Insurance. To note that UCLPartners already holds Director Liability insurance and the UCL insurance brokers are currently exploring options for professional indemnity.

(c) Risk management. To discuss the updated risk register

(d) Workforce policies. To note and approve the proposed company policies. These have been developed with professional HR support (Rebecca Graham), based on our partner documentation. They comply with NHS invitation to tender guidance.

The above actions put the company on a sound financial footing with a solid trajectory for the next 3 years.

2. Achievements during 2010/11 against agreed milestones

Last year the Board agreed 10 objectives:

- Develop a sustainable self- funding model for UCLPartners over a three year period
- Support and enable all the PDs to deliver on their core objectives and establish the agreed new programmes (oral health, ENT, mental health, GIHPB)
- Agree annual milestones for the strategies for R&D, Education and Quality by July 2010 and processes for implementation
- Successfully bid for lead provider status for medical and dental education for NCL and help to establish multi-professional leadership training (Staff College)
- Successfully deliver the cancer provider network as a national pilot/exemplar for improved outcomes and reduced costs, including the pilot on brain cancer by November 2010
- Successfully implement the new patient relationship management system for juvenile diabetes and the application of this model to other long-term conditions
- Deliver a successful joint national provider bid for PBT with MAHSC and The Christie
- Enhance awareness of our activities internally and externally – bring the strategy for communications to the July Board including resolution of the UCLP website

- Ensure the HIEC has the structure, staff and support to deliver on the 3 core pathways (maternity, CVD prevention and COPD)
- Agree and implement milestones for "back-office" integration across UCLP

We have delivered against all of these objectives as described below:

(i) The company and finance

See Board item 1 above. By year 3 the company projects a cash balance equivalent to 9 months core trading costs. The contribution from the founding Partners in each of these years is capped at the present absolute level (£100k). The proportional contribution of the Founding Partners to the core costs is therefore reduced from 100% of funding in year 1, to about a quarter in future years.

The Board is asked to consider and confirm that this reflects the appropriate level of Partner contributions to core costs and a satisfactory rate of return on activities as described below.

(ii) Delivery of Programmes and projects

These are both our purpose and engine for delivery. There has been strong delivery to achieve or exceed agreed milestones across virtually all programmes and projects – see detail in Appendix 5 for each work-stream by milestone. As the detail shows overall delivery exceeds expectation in most programmes; one substantial project in a programme has been significantly delayed due to unexpected contractual issues – these should resolve in April 2011; and only one significant project within a programme has not yet got traction locally such that the PD is revisiting the approach.

Highlights from the last 12 months include:

- Stroke. Implementation across sector of stroke secondary pathways. All 7 RCP quality standards achieved (achieved by 75% of London units and only 7% nationally). Demonstration of successful impact NCL stroke: mortality reduction for stroke 6% versus 22% national average; 12% thrombolysis rate achieved –national rates circa 3-5%. London can reasonably claim to have the highest published thrombolysis rates of any major city globally. Future focus on extending the pathway to include prevention and rehabilitation - proposed methodology published JAMA Dec 2010 –and joint MRC grant submission for R&D based on large cohort studies with GMEC partners.
- Neuro-oncology. Creating the platform for neuro-oncology to deliver on the vision of reduced mortality and morbidity – consolidation of neuro-oncology surgery with collaborative ethos; strong patient and family involvement, pathway redesign, major charitable commitment to R&D, new clinical facilities, 4 new agents under test -2 to follow shortly. This has created the opportunity for a globally relevant R&D programme to address the previously intractable challenge of improving brain cancer survival through new treatments used both singularly and in combination. As the PD described recently the "opportunities are now limitless"
- Immunology and transplantation. New cross linkage across the partnership. Outline agreement to create an Immunology and Transplantation Institute hub at RFH.
- Infection. Starting to break down barriers across the 3 NCL HIV centres after many years; partnership focus on early detection and prevention of HIV; enhanced collaborative working across Partners virology; agreement with LSHTM to develop jointly a pathogen institute
- Child health. The main focus has been delivery of diabetes PRM (see below) as a cultural change initiative; extended to work on empowerment and care in the community for children with asthma

- Eyes and Vision. “Open Eyes” has been a huge development supporting UCLP goals developed and implemented by MEH; linkage to Industry and closure of translational gaps, agreement on working with RFH on immune based therapies for eye diseases (transplantation/AMD), working to achieve greater collaboration with high street optometrists to support local care, at scale, through the HIEC award . The clear focus on closure of gap 1 and gap 2 is an exemplar for all programmes
- Cardiovascular disease prevention and outcomes. Agreed transfer of the national institute for cardiovascular outcomes from the DH to UCL - £5m over 3 years - and agreed integration with the national stroke audit as part of the UCLP CVD prevention initiative
- Women’s Health – building a compelling case for a life-course approach to women’s health provision –demonstrating benefits locally, obtaining external grant support for greater scale, and engaging with key opinion leaders to create the platform for wider change
- New Programme of Liver and Digestive health – created through collaboration and consolidation the largest liver and pancreas surgical service nationally with an ethos of partnership, and justifiably the leading viral hepatitis centre in the UK. These have been substantial step changes
- New Programme of Mental Health and Wellbeing. This has brought together the largest clinical and academic mental health base in the UK (>SLaM), if not Europe – 4 major NHS Trusts and UCL reflecting > 4m population and >250 PI s. Agreement on joint research agenda and focus (dementia, cognitive therapies, value for money)
- New programme of ENT. Focus on “every child a communicator” –early detection and treatment of hearing loss, clinical trials development in ENT and the decommissioning of inappropriate interventions.
- New Programme of Population Health. Working with LSHTM, agreement for delivery on both Population Health owned projects, and with UCL agreement, creating a SL post that supports the other PDs to deliver their programmes in communities
- Value based healthcare –linking to the reform agenda – successful opening conference for >550 healthcare leaders, follow up workshop June 2011 for leading MDs and agreement for the delegates to deliver a programme of regional roll out funded by external grants
- In addition we have developed a significant programme to develop models of Integrated care as part of the 3 London AHSC work-streams - one aspect has been supporting delivery for Whittington Health through its journey to “go live” from April 1st 2011, especially around pace and cultural change; there is also a strong linkage to other integrated care projects across UCLPartners (e.g. COPD “year in the life”, creating a women’s health clinical service joined up to predictable health care needs, development of diabetes PRM and grant to extend to maternity working with Mumsnet), and our work on building relationships to support pathfinder GP consortia development to ensure we improve the primary-secondary care interface

(iii) Core support functions

(a) R&D

A core purpose of UCLP is to close the translational gaps from discovery into practice. As a paradigm shift we are developing a cadre of clinical academics –traditionally focused on the early component of the translational pathway to understand and lead/enable delivery along the whole pathway including into communities at scale.

Given the historic local (and global) weakness of the later phases the initial focus has been to recruit expertise in health sciences implementation/dissemination at scale. This included the recruitment of Dr Amanda Begley to support all of the programmes deliver innovation across populations at pace and scale. She has provided support to all the PDs and obtained successful external grant funding as a PI to develop new methodologies.

The UCLP Director of R&D, Professor Ian Jacobs, developed and had approved by the Board an underpinning strategy to enhance the R&D platform across partners. Implementation has included:

- R&D away day for staff across the partnership
- Some alignment of R&D processes –through clearly much more to do
- Joint bid for biobank resources to support UCLP
- Doubling of early phase clinical trials across UCLP during the last 12 months
- Improved public involvement in R&D

The cross boundary working has enabled additional grant funding – >£1m directly to UCLP for core costs, and significant (circa £14m) indirect contribution to joint working across/within programmes via UCL held grants (Appendix 6).

Locally driven discovery is the responsibility of individual institutions. UCLP can play a greater role as a catalyst for new R&D across traditional organisational boundaries. **Although there have been some notable research achievements through such new partnerships we plan to increase the pace and scale through closer alignment supporting the PDs, BRCs and UCLP R&D.** This will be better achieved going forwards by:

- appointment of Prof Pillay, PD infection, as the director of the UCLH CBRC, chair of the BRC group, and Director of R&D at UCLP with a specific focus on systematic gap closure
- regular R&D meetings of the 4 UCL Deans, Prof Pillay, Prof Raine, John Tooke and David Fish reporting to the UCLP executive and aligning with/supporting each programme
- ensuring collaborative, cross cutting R&D is an embedded component of the monthly PDs forum
- A new approach to building commercial links for R&D – see item 6 below

(b) Education

We have met the following agreed goals –(and see below under specific goal (iv) for more details on the staff college):

- Created an educational board. Agreed 2010/11focus on MDECs and Staff College.
- Successful bid for MDECs (lead Professor Stephen Powis).
- Successful funding and delivery of the Staff College year one (lead Professor Aidan Halligan). Local and national/international interest (see below).

In addition:

- The undergraduate programme is being redesigned to better fit with the UCLP programmes and to maximise the opportunities from integrated care settings.
- UCL is developing an ambitious CPD programme of national/international relevance including an e health educational offering

Given the recent changes in UCL Professor Sir John Tooke will hand-over chairmanship of the education sub-board shortly; recommendation to the Board that we advertise this role locally within the partnership and continue to build on our successful work-streams .

(c) Quality

UCLP's quality strategy agreed three pillars:

- Measuring Quality: emphasis to develop "Whole system" Quality measures
- Enabling partner trusts to share and learn from each other on Quality
- Developing a science of Quality Improvement: Improvement Science.

Measuring Quality: emphasis on "Whole system" Quality measures in priority areas:

Objectives set May 2010

- Develop the vital few measures best describing quality at system level for key patient pathways (This represents a novel approach to quality built around patients' needs. It connects the whole system of care within one measurement framework: prevention and public health, through primary and specialist care, to rehabilitation and secondary prevention)
- Develop more consistent measurement and reporting of Quality across partners

Progress to March 2011

- Deployment within programmes:
  - Working set of measures developed in various programmes including stroke, COPD, community gynae, cancer
  - Funded projects underway: e.g., 'year-of-care' ONEL project COPD
- Dissemination: JAMA commentary published December 2010 (stroke example); jointly developing white paper with King's Fund (publication summer 2011)
- Event: joint UCLP/Monitor conference 24 Jan 2011

Enabling partner trusts to share and learn from each other on Quality: the UCLP Quality Forum

Objectives set May 2010

- Explore opportunities for a learning forum across partner clinical leadership
- Explore opportunities for cross-trust initiatives focused on quality and quality improvement

Progress to March 2011

- UCLP Quality forum for Medical/Nursing Directors and other senior clinical leads now meets quarterly (~30-40 attendees). It is hosted in rotation by partner trusts.
- Deteriorating patient work underway across all trusts aiming to reduce avoidable cardiac arrests
- *Ad hoc* connectivity across partner trusts around the above: e.g., upcoming all trusts meeting on simulation training

Developing Improvement Science

Objective set May 2010

- Mobilise UCL and others to develop a new, multidisciplinary science of Improvement
- Introduce quality improvement perspective into undergraduate curricula

Progress to March 2011

- Increasing energy and awareness of Improvement science
  - Strong link to Division of Population Health and other UCL Schools
  - 6 UCL-based post-doc applications submitted to Health Foundation's call for Improvement Scientists (out of 70 total applications) – awaiting shortlist
  - Strong link to Health Foundation

- First multidisciplinary safety awareness week held Feb 2011 with undergraduates from medicine, nursing and AHPs

(c) IT

Not a set 2010/11 objective, but clearly pivotal and high on the risk register.

UCLP IT director funded and recruited October 2010 – highly relevant NHS cancer network and US experience (Mayo) – both to support the immediate company needs and the IT directors/strategies across the Partners and programmes

The IT programme at UCLP has been progressing in four main areas since it commenced at the end of 2010. All activities are targeted towards delivering the ultimate IT vision, as presented to the UCLP Members' Meeting in November 2010, of an interconnected patient record, with the patient's data being available wherever it is needed, and supporting patient empowerment. This effort can be broken down into four main areas:

- Delivering the IT vision: additional activities toward this to date include:
    - Leading CLMS (UCL Computational Life and Medical Sciences network) Information Governance Working Group to develop a sharing agreement between Trusts and the University for data and biological samples, and to develop appropriate standardised patient consent pro-forma
    - Evaluations of patient portal solutions such as Microsoft HealthVault, Patients Know Best
    - Evaluations of data collection systems such as Health Analytics and the Concentra Patient Care Pathway system to enable whole pathway approach to reviewing patient information
- Developing and building relationships in IT across the partnership and with key external stakeholders:
    - The Trusts – through regular IT Directors' forum
    - The University – though CLMS
    - Other AHSCs – collaboration and information exchange with KHP
    - Primary care – data collection and integration solutions
    - Industry partners – e.g. Microsoft
    - Nationally – e.g. Chartered Institute for IT response to Information Revolution proposal
- Assisting individual programmes: assistance to all programmes, chiefly:
    - Cancer – evaluation of MDT systems, representation of IT stakeholders
    - Child Health – Diabetes PRM
    - Women's Health – postpartum database; maternity PRM
    - …and most of the rest of the programmes to a lesser degree
- UCLP Central Office support
    - Management of current UCLP website and implementation of a redesign, involving clearer communication and stronger reflection of who UCL Partners are
    - Management of interim email system, provision to staff of laptops, software, connectivity support, etc., and procurement of server for document repository and email solution

(iv) MDECs bid and Staff College Leadership specific objectives

Staff College:

Objectives achieved for Staff College (multi-professional launch and external pump priming monies obtained for year 1 to obviate delegate fees during the set up phase (course co-production). There has been strongly positive delegate feedback and DoH/political interest as described in the college report below.

The UCLP NHS Staff College is now over half way through a pilot programme of four modules, the first module includes 48 selected multidisciplinary UCLP senior staff, including approximately one third general practitioners from North Central London. An early emergent lesson from the pilot programme is the importance of selection. There also appears to be an immediate impact of the programme on delegates as they return to their workplace. The programme is seeking to develop an exceptionally high quality leadership product characterised by individuals who are quick, tough, tireless and decisive. Leaders who will openly challenge others and who are comfortable being challenged themselves. The Staff College programme is developing leaders who will recognise the impact of poor behaviour, ineffective teamwork, toxic cultures and the deep rooted resistance to change and understand how to respond to those cultural alerts.

Staff College Delivery:

The design of the 2 day Introductory Briefing and 3 modules on Self Awareness, Self Management and Extreme Personal Leadership is complete. Module 4, BIG Leadership, is under design.

100 members have attended the Introductory Briefing. 48 have completed Module 1 - Self Awareness. Not all those starting the programme will progress all the way; this is based on an honest joint assessment of readiness between the member and the faculty. Alternative development programmes will be offered in these situations.

On the 4th April the sixth IB will take place with the first Module 2 – Self Management course happening on 21st March.

By the year end (31st March 2011), the following courses will have been completed:

5 x Introductory Briefings
3 x Module 1
2 x Module 2
1 x Module 3

All professions within UCLP have been represented at senior levels – medicine, nursing, AHP and management (see Appendix 1 for breakdown).

The combination of the best training from the Military, NHS and business has produced a series of events that, even those who have attended prior high profile leadership training, have described as ‘inspirational’.

The full programme has been costed in the region of £350 per day (£6300 for all 18 days). For the first full programme the cost has been kept at the UCLP/Monitor advertised rate of £275 per day. Thereafter the rate will be £350 per day for NHS members with higher cost, to be determined, for the private sector. Brighton and Sussex University Hospitals (BSUH) has notably invested in the programme and has 14 paying members signed up.

Future faculty members are being identified as they come through the programme. They will be recruited to provide a broad base of roles and experience for future programmes. The ongoing support of the network of members is a key benefit for all attendees and future events will be organised to develop this. Robust evaluation tools are being developed to provide ongoing evidence

of value from the College. Measuring outcomes is an essential requirement of any educational programme to sustain its ability to recruit and develop.

- MDECs –substantial work during the year to develop a strong bid. This also helped to build real partnership across our key local providers. Achieved designation as goal set. We will build on this to continue to bid for all available educational bundles as advertised.

(v) Cancer Provider Network

- Established principles, enacted pilots and resolved many of the issues around setting up a cancer provider network.
- £250k external grant awarded to support the work which has formed the basis for the NHS London current plans to enact formal provider networks across London.
- Transfer of brain cancer surgery to single site achieved, and successful launch with collegiate working across professionals, patients and charities.
- Extensive work with UCL Humanities and MacMillan on cultural change.
- The key issue of earlier diagnosis links in with our work on integrated care across primary and secondary care.
- Pathway Directors now appointed for brain, lung, upper GI and urology as next phase implementation.
- We are 12 months ahead of the rest of London/nationally on understanding and developing cancer provider networks, and therefore well placed for the NHS London tender process for lead cancer providers due to run during May/June 2011 (note expecting a reduction from 5 to 2-3 cancer networks for London) – see section 5 for opportunities to create greater impact.

(vi) Implement PRM for juvenile diabetes

- External grant funding achieved.
- Commercial agreement signed for future global revenue share.
- Baseline measures secured
- Pilot system developed
- Considerable challenges due to multiple commercial partners
- Top RIF bid nationally - recognised as platform for NHS expo
- Ready to go live in April 2011 after some transactional delays with commercial partners.

(vii)PBT with Manchester

- The joint PBT bid with Manchester was well received by the DH.

(viii) Enhance awareness of our activities internally and externally

External Communications –overall UCLP has achieved reputational gain as an effective AHSC with high level stakeholders through delivery (political, DoH, other AHSCs)

- Progress building media relationships and coverage
    - GP magazine and GP online: established long-term relationship following 24 January UCLP/Monitor conference involving GP taking UCLP's messages to primary care
    - Press coverage of notable programme achievements: several articles in local/national press highlighting breakthroughs at partner organisations (e.g., Evening Standard piece on laryngeal transplant)
- Hosting national/expert events
    - National conference (jointly with Monitor) on "Value in Healthcare", a priority UCLP topic (January 2011)
    - 'After the lightbulb' event on the diffusion of innovation challenge to launch a UCLP community of interest (November 2010)
    - First joint event for the three London AHSCs hosted by UCLP (November 2010, now happening six-monthly in rotation)

- Presenting at priority national events: e.g., NHS Expo, March 2011
- Direct communications from DRF nationally to all acute Trust MDs (on Value agenda)
- Strong political voice and relationships established
- Building awareness and alignment in local sector: regular sessions with NCL GPs
- Connecting with patients and patient groups: e.g., co-hosted brain cancer event with Samantha Dickson Brain Tumour Trust and NHNN
- Website: in-house improvement of website format and content; further external support from website developer currently in place (next 6 weeks); agreed responsible director and delegated structures/staff for updating each section of the content from April 2011
- Annual report web and PDF based –given the delivery at what stage should we invest in formal publications

Internal Communications

- Consistent communication: Developed set of materials on UCLP's mission and activities for internal communication to ensure consistent messaging on plan and priorities

- Key stakeholder awareness and alignment sessions
    - Trust Boards: Managing Director met every partner trust board
    - Medical and Nursing Committees: Managing Director and Directors led sessions in every partner
    - Other groups (e.g., specialty-specific; partner organisation): Managing Director and Directors led invited sessions with clinical and managerial groups (e.g., GOSH clinical directors and general managers; NCL palliative care network)

- Programme launches and other local events
    - Launches held in several programmes, incl. Women's Health and GI/hepatology
    - Support given to events held by UCL and other partners: e.g., UCL Research Day (Sep 2010); UCL Research-into-practice day (Nov 2010); "TB day" (Nov 2010); UCLH Quality Improvement Masterclasses (Q1 2011)

- Connectivity across partner communication functions: Partner organisations' communication directors now meet monthly

- Newsletters and Websites: Articles and other features in partner newsletters and websites: e.g., in UCL SLMS newsletter piece on emerging cancer provider network

The external communication of our deliverables has been more effective than the internal comms which would enhance participation for delivery of our programmes, and should be a focus for 2011/12

(ix) HIEC

- Established the structures and staff to deliver on spread of innovation across the 3 selected pathways. Three new pathways added synergistic with our goals - chronic ocular disease, migrant health and childhood asthma.
- Funding for another 12 months secured –but presume this will then cease.
- Agreed potential pathway for migration post funding of HIECs to a joint entity supported by the 3 London AHSCs. High profile clinical-academic leader identified.

(x) Back Office integration

- Developed a culture of collaboration and local ownership across some corporate and clinical support functions.
- Recruited external chief operating officer for the work-stream (Ed Lavelle)
- Project plan in place

Participating partners

Six partners have confirmed participation in the planning of the Programme, with the Whittington's board concluding that given its other commitments it is unable to participate at this stage.

Work-streams
Leads for each of the six work-streams are in place, although significant challenges remain in progressing the finance work-stream where engagement to date, beyond systems focused alignment between UCLH and Royal Free, has been disappointing. More rapid progress is now being made in the remaining work-streams.

Appointment of external advisors
Ernst & Young has been appointed as core adviser to the Programme for this stage, with KPMG providing specialist advice relating to Pharmacy out-patient dispensing and potential commercial options / structures for Pathology.

Gateway review
Participating partners have agreed that a Gateway review should be undertaken in May, with the results reported to the Executive Group and then to UCLP's Board at its May meeting. The Gateway review will assess interim progress, and consider whether the Programme as structured is likely to deliver the benefits currently anticipated and within agreed timescales.

Timing
Subject to the above Gateway review detailed plans should be available for consideration by participating trusts during May and June. At that time each trust will decide for each work-stream whether to progress to the next stage of the Programme.

Costs
The budgeted cost of the planning phase is £820,000 (incl. VAT). It has been agreed that UCLP will invoice participants 50% up-front ('the initial amount') and the balance following completion of the Gateway review. In the event that a decision is taken not to progress after the Gateway review, the balance of any amount incurred in excess of the initial amounts will be shared in proportion.

Conclusion
The Programme is now established and the planning phase has commenced. To move six work-streams with six participating trusts forward is a very significant challenge, but with great potential benefits if this can be achieved together. Where individual or smaller groups of trusts are placed to move forward at pace this will be facilitated, and the Programme Steering Group tasked to ensure this happens. To provide valuable output from this phase will require commitment, resource and active participation from each participating trust. Clear direction from Boards of participating trusts, supported by a reconstituted Programme Steering Group, will help reinforce the importance of these elements.

3. Proposed Objectives for 2011-12

For Board Discussion:

1. *Programmes*: Support delivery on core objectives across UCLP's clinical academic programmes emphasising UCLP's themes of distinctiveness
- *Patient empowerment*: including patient control of records and navigation of care pathways
- *Information*: development and dissemination of key outcome metrics at system level for priority pathways for use by both professionals and patients
- *Long Term Conditions*: simultaneous improvement of quality cost by more proactive, reliable and patient-centred 'upstream' management of disease in communities
- *Population health:* Ensure active support and integration with new UCLP population health theme and UCL population health

2. *Cancer*: Deliver the cancer provider network toward step change in unwarranted variation, outcomes, patient experience and resource use at a scale and level of international relevance.

3. Building a common n*arrative and enhanced communications:* Continue to build awareness of UCLP's purpose, activities and achievements, with particular focus on communications internally (i.e. across partner organisations), as well as externally, of a single common narrative

4. *Industry*: Support UCL and other partners in developing strong industry partnerships which benefit patients, partners and UK economy

5. *Research*: Create effective linkages and capture synergies across CBRC and both BRCs toward development of a unified research platform across partners

6. *Education*: Deliver step change in education quality in medical and dental education across NCL (as lead provider through MEDECS)

7. *Capacity building*: Deliver and support UCL in development of CPD programme and multi-professional education; focus on leadership and management skills for clinicians including the Staff College and courses such as "Value in Healthcare".

8. *Diffusion of innovation and building improvement science capability*: Establish a mechanism (to build on HIEC's progress) for effective dissemination of useful innovation across and beyond our partnership, and continue to build capacity in UCL and other partners for dissemination and improvement science

9. *Business ethos and sustainability*: Further strengthen UCLP's business ethos and capability, including external funding

10.*Enhance the impact of UCLPartners locally, regionally, nationally and globally* in line with our mission, managing the risks and ensuring continued delivery of programme and project objectives.

David Fish

Managing Director UCLPartners