Great Ormond Street Hospital for Children NHS Trust

Meeting of the Trust Board
21st December 2011

Dear Members

There will be a public meeting of the Trust Board on Wednesday 21st December 2011 commencing at **2:45pm** in the **Charles West Room, Paul O'Gorman Building,** Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Attachment
1.	**Apologies for absence**	Chair	
Declarations of Interest The Chair and members of this meeting are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must, as soon as practicable after the commencement of the meeting disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 30th November 2011**	Chair	**J**
3.	**Matters Arising / Action point checklist**	Chair	**K**
4.	**Chief Executive's Update** • **Safe and Sustainable** • **Ombudsman Report action plan** • **Spinal surgery review**	Chief Executive	**Verbal Update**
5.	**Reporting Zero Harm - Quality, Safety & Transformation Update**	Co- Medical Director (ME)	**L**
6.	**Overview of strategic objectives for 2012-15**	Chief Operating Officer	**Presentation**
	ITEMS FOR APPROVAL		
7.	**Academic Health Science Centre – Monitor compliance requirements**	Chief Executive	**M**
8.	**Performance Management Strategy and Business Planning Strategy**	Chief Operating Officer	**N**
9.	**Update on Data Quality Action Plan**	Chief Finance Officer	**O**
10.	**Revised Remuneration Committee Terms of Reference (Board of Directors)**	Company Secretary	**P**
11.	**Draft Terms of Reference for Finance, Resources and Investment Committee**	Chief Finance Officer	**Q**

	UPDATES		
12.	**Performance Report (November 2011)**	Chief Operating Officer	**R**
13.	**Finance and Activity Report (November 2011) including analysis of trend in staff and agency costs**	Chief Finance Officer	**S**
14.	**Foundation Trust Update**	Chief Operating Officer	**T**
15.	**Patient and Public Involvement and Patient Experience (PPIE) update report**	Chief Nurse and Director of Education	**U**
16.	**GOSH Child Protection Update Report December 2011**	Chief Nurse and Director of Education	**V**
17.	**Management Board - November 2011 Minutes**	Chief Executive	**W**
18.	**Trust Board Members' Activities**	Chair	**Verbal**
	FOR RATIFICATION		
19.	**Consultant Appointments**	Chair	**Verbal**
	ITEMS FOR INFORMATION (These items will not be discussed unless a Member gives prior notification of an intention to do so.)		
20.	**UCL Partners Board Update – November 2011**	Chief Executive	**X**
21.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)		
22.	**Next meeting** The next Trust Board meeting will be held on Wednesday 25th January 2012 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT J

Great Ormond Street Hospital for Children NHS Trust

DRAFT Minutes of the meeting of Trust Board held on 30 November 2011

Present

Baroness Tessa Blackstone	Chairman
Dr Barbara Buckley	Co-Medical Director
Ms Yvonne Brown	Non-Executive Director
Professor Andy Copp	Non-Executive Director
Dr Jane Collins	Chief Executive
Ms Fiona Dalton	Chief Operating Officer
Professor Martin Elliott	Co-Medical Director
Mr Andrew Fane	Non-Executive Director
Mr David Lomas	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

Dr Anna Ferrant	Company Secretary (and minutes)
Professor Davis Goldblatt*	Director if Research and Innovation
Mr William McGill	Director of Redevelopment
Mr John Ripley	Designate Non-Executive Director

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

244. Apologies for Absence

244.1 There were no apologies for absence.

245. Declarations of Interest

245.1 There were no declarations of interest made.

246. Minutes of the Meeting Held on 30th September 2011

246.1 The minutes of the Trust Board meeting held on 30th September 2011 were received and the Chairman requested Board Members check them for accuracy.

246.2 The minutes were **approved**, subject to the following amendments:

246.3 Minute 193.2 – the final sentence in the paragraph to be reworded to read: "*This increase was due to the fact that it was no longer appropriate to undertake this surgery*."

246.4 Minute 202.7 – Minute to be changed to read: *The Chief Nurse to bring an update on to the December 2011 Board meeting.*

247 Matters arising

247.1 Minute 198.6 – Ms Fiona Dalton, the Chief Operating Officer stated that the Technical Delivery Board was considering the appropriate technological solution to the production of discharge summaries

247.2 Minute 198.9 – Ms Dalton reported that she had been asked to update the Trust Board on whether the outstanding reviewed how NICE recommendations were relevant to children's services or not. This information was difficult to provide as the decision over relevance was part of the review which was done by each clinical service. However she could inform the Board that the one outstanding piece of guidance this month was about the management of autism in children. This was of course very

247.3 relevant to GOSH and was currently being considered by the appropriate clinical services.

247.4 Minute 202.6 – Mrs Liz Morgan, Chief Nurse and Director of Education reported that she had clarified the RAG rating system. The use of amber reflected the fact that work was still required to be completed.

247.5 Dr Jane Collins. Chief Executive stated that the use of RAG ratings posed a problem for the Board in that it was not always clear if they are being used consistently .. Dr Collins agreed to discuss this matter with the executives to develop consistent criteria.

Action: The Chief Executive to discuss and agree consistent criteria for RAG ratings in Board and other key reports.

248 **Patient Story – Parent's report about care at Trust**

248.1 The Chair, Baroness Tessa Blackstone welcomed Mrs Debbie Davey, a parent of a child receiving care on Elephant Ward at the hospital. Mrs Davey presented an overview of the care her son had received at the hospital, and praised the staff and the approach taken to caring for all of the family.

248.2 Baroness Blackstone and the Board thanked Mrs Davey for her presentation and time taken to present her story.

The Trust Board reflected on how valuable it had been to hear Mrs Davey's story, and in particular how reassuring it had been to hear about how well staff had adapted their working practices to manage the learning difficulties of Mrs Davey's son.

249. Clinical Unit Presentation – Cardio-respiratory Unit

249.1 Dr Allan Goldman, Mrs Anne Layther and Mrs Suzanne Cullen attended the meeting to deliver a presentation on the work of the cardiac unit at the Trust.

249.2 The presentation included an analysis of reasons for theatre cancellations. High levels of demand and increased acuity of patients had led to A number of operations being cancelled due to capacity issues on the wards and this had resulted in increases in surgical waiting lists.

249.3 Dr Goldman also presented a review of morbidity, surgical infections, serious incidents and prescribing errors.

249.4 The unit had received 7 complaints in the last year, mainly about communication issues with children and parents.

249.5 Dr Goldman presented data on prescribing errors and explained that the unit was responsible for prescribing a large number of drugs on the wards. The ward pharmacist provided feedback on errors on a daily basis. Dr Goldman explained that most drug errors did not result in any harm –for example it was a drug error when a registrar had not signed the drug chart.

249.6 Dr Goldman presented data on 'observed over expected deaths' between different trusts, which showed that GOSH was performing well.

249.7 Mr David Lomas, non-executive director, asked about the high staff turnover rate and what this was attributed to. Dr Goldman explained that the unit had a high number of middle grade medical staff, and as a result, suffered from high turnover rates due to the rotation system.

249.8 In light of the turnover data, Baroness Blackstone asked whether the Trust needed to review the care model in place and look at a more sustainable model, where care was provided by different grades and professions. Dr Barbara Buckley, Co-Medical Director stated that the London Deanery was looking at reviewing the trainee rotation system.

249.9 Mrs Liz Morgan, Chief Nurse and Director of Education suggested that the Trust consider the role of nurses in providing elements of care on the ward. Dr Goldman agreed and stated that this review was essential in light of the changing national requirements for the increased number of nurses per bed.

249.10 Baroness Blackstone asked what was being done about managing the length of time of patients in ICU on Berlin hearts. Dr Goldman agreed that questions were being asked about whether ICU was the best place of these patients and advances in technology might now enable them to be moved to a more appropriate environment.. .

249.11 The Board agreed the need for the sharing of risk across partner Trusts, once the outcome of the Safe and Sustainable Review had been determined. This would help ensure that GOSH services were not disadvantaged by increased pressure of highly specialist patients. It was noted that discussions could take place within the London Paediatric Network

249.12 The Board thanked Dr Goldman for his presentation.

250. **Chief Executive's Update**

250.1 Dr Jane Collins, Chief Executive reported that the first meeting of the Members' Council had taken place on 17th November. The meeting had been positive and a good opportunity to meet the Councillors.

250.2 The Safe and Sustainable review into Neurosurgery Services was underway. It was being managed slightly differently to the cardiac review and Trusts were invited to tender for epilepsy services as the first phase of the review. GOSH had done so. Dr Collins reported that the commissioners were also

interested in the Trust's ability to support the development of services elsewhere.

250.3 Following receipt of the Ombudsman Report into the complaint raised by Arvind Jain's family, an action plan was being developed. A positive meeting had been held with the Muscular Dystrophy Campaign to discuss the recommendations and the Chief Executive and Co Medical Director (ME) had met the family, who had asked whether Arvind's name could be applied to the principles developed from the recommendations. The Board fully supported this suggestion.

250.4 Dr Collins informed the Board that the public sector strike was taking place that day and that 77 member of staff had gone on strike. The Trust had continued to work normally with minimal disruption to clinics and theatre lists. This was due to the willingness of the staff side to work co-operatively with the Trust.

250.5 Following reports on the number of patients dying in British hospitals over weekends, the Chief Executive informed the Board that she had personally asked for work to be conducted to review any deaths that had happened at Great Ormond Street over weekends and at specific hours of the day.

250.6 The Board **noted** the report.

251. Zero Harm Report

251.1 Professor Martin Elliott, Co-Medical Director presented the report which included the zero harm dashboard and examples of improvement in the implementation of safety systems.

251.2 Mr John Ripley, designate non-executive director commended the richness of the data presented but requested more contextual information so that learning could be extracted and applied elsewhere. Professor Elliott stated that the work was underway to revise the format of the report and provide tis contextual information.

251.3 The Board **noted** the report.

252. Foundation Trust Application Update

252.1 Ms Fiona Dalton, Chief Finance Officer presented the report, which included a summary of documents reviewed by the Board and a revised timetable for the final stage of assessment by Monitor.

The Board confirmed that it was satisfied that:

- The capital plan is sufficient to meet estate maintenance requirements, the delivery of CRES schemes, medical equipment and IM&T requirements.
- Performance information seen by the Management and Trust Boards (e.g. Zero Harm & KPI reports) has been reviewed and updated, and is consistent with reports that are reviewed by Clinical Unit Boards.
- The development plan to improve the management of data quality.

The Board was asked to approve the Foundation Trust application

assessment timetable, and the work plan for the presentation of evidence across the following areas: financial viability of the Trust; information reported to the Board (Key Performance Indicator report and CRES delivery); and quality governance arrangements, all of which had been discussed by the Board in the morning.

252.2 The Board **approved** the revised timetable and work plan.

253. Risk Management Policy

253.1 Professor Martin Elliott, Co-Medical Director presented the revised Risk Management Policy. Minor alterations had been made to the layout of the policy, inclusion of the use of consistent terminology and reference to the whistle blowing procedure.

253.2 The Chair asked that careful consideration be given to the use of the term 'whistle-blowing'. It was important that staff were aware of the various ways to raise concerns in the hospital and that the whistle-blowing procedure was a final stage of this process when all other such avenues for reporting concerns had failed.

253.4 The Board requested that the terminology around the use of 'he' and 'she' be agreed and consistently applied.

253.5 The Board **approved** the revised policy, subject to the above amendments.

254. Review of effectiveness of Management Board revised terms of reference and subcommittee reporting

254.1 The Company Secretary, Dr Anna Ferrant presented the paper and reported that following a review, it had been found that Management Board had discharged its duties in accordance with its terms of reference. A number of recommendations had been agreed, aimed at improving the Board's governance arrangements, including a reduction of the number of subcommittees reporting to it.

254.2 The Chair noted the number of subcommittees reporting to Management Board and suggested that a further review of its governance arrangements was conducted post Foundation Trust authorisation. Dr Jane Collins explained that some of the committees were established under statute, but that there was scope for further consolidation of subcommittees.

254.3 **Action**: The Company Secretary to conduct a further review of the subcommittees reporting to Management Board post Foundation Trust authorisation.

254.4 The Board considered and **approved** the revised terms of reference for Management Board

255. Revised Audit Committee Terms of Reference

255.1 The Company Secretary, Dr Anna Ferrant presented the revised terms of reference for the Audit Committee.

255.2 A number of changes to the terms of reference were agreed by the

Committee at its October 2011 meeting. The key changes were:

- The Committee endorsed the revised reporting arrangements proposed, with Ms Yvonne Brown attending both the Audit Committee and Clinical Governance Committee and the Company Secretary presenting a short summary of matters discussed and agreed at the Clinical Governance Committee at every meeting of the Audit Committee.
- It was agreed that the Clinical Governance Committee should continue to take the lead on clinical risk matters and that the key was to ensure that reporting was aligned.
- The Committee agreed that it would be helpful to hold a meeting with the Clinical Governance Committee to consider the risk management framework and ensure that it was aligned between the committees. This meeting would take place before on 12th December 2012.

255.3 The Trust Board noted and **approved** the revised terms of reference for the Audit Committee.

255.4 Baroness Blackstone reported that she had asked Ms Mary Macleod to chair the Clinical Governance Committee and requested the Board's approval. The Board **approved** Ms MacLeod as the new chair of the CGC.

256. Equality Delivery System

256.1 Dr Barbara Buckley, Co-Medical Director presented the report which provided an overview of the Equality Delivery system. This system would enable the Trust to meet its legal requirements arising from the Equality Act 2010.

256.2 The Board **approved** implementation of the system.

257. Performance Report (October 2011)

257.1 Ms Fiona Dalton, Chief Operating Officer presented the report and informed the Board that the format of the report had been revised to include new indicators and performance trends over time. Monitor's finance and governance ratios were also included in the report. The final page of the report included a summary of the tolerance levels for each target.

257.2 Ms Dalton reported that the Trust was currently scoring 1.5 for the Monitor governance ratio due to the confirmed incidents of C Difficile (6 cases against a trajectory of 5.25 for the year to date) and the results of the learning disability internal audit.

257.3 It was agreed that the Trust should horizon scan for other performance issues and report these to the Board as and when they arose.

257.4 The Board requested that the information included in the escalation report was brought back in the form of an action plan to demonstrate the work underway to improve performance and the timescales for implementation. Particular reference was made to the need to understand the work underway to improve inpatient waiting times.

257.5 **Action**: The Chief Operating Officer to report on escalated matters in the performance report in the form of action plans and timescales for improvement.

257.6 Ms MacLeod, non-executive director asked whether the staff turnover rates included junior doctor rotations. Dr Buckley stated that this data was not included as it was known that these staff would move on and be replaced. Ms Dalton informed the Board that although the figure for staff turnover appeared to be high, the Trust performed better than other similar Trusts in Central London.

257.7 Mr Charles Tilley, non-executive director, asked why there was a disparity between clinical units in the use of the WHO checklists. Ms Dalton explained that the checklists had originally been designed for surgical areas. At GOSH work was underway to develop checklists for non-surgical areas such as MRI. Discussions were also underway with members of teams of surgical areas where checklists had not been used – in some cases this was because the checklist had been used but not signed off.

257.8 Mr Tilley requested all indicators to have a target to reach. Ms Dalton agreed to review those indicators with no targets.

257.9 **Action**: The Chief Operating Officer to review and update all indicators with targets.

257.10 The Board **noted** the report.

258. Finance and Activity Report (October 2011)

258.1 Mrs Claire Newton, Chief Finance Officer presented the report and informed the Board that a ratio analysis had been added to the report, including where the thresholds were.

258.2 At the end of month 7, the Trust was achieving a net surplus of £5.2 million, which was £0.8million lower than the revised plan. The forecast position for the end of the financial year was £2.3million surplus after property impairment estimated at £5.7million and accelerated depreciation.

258.3 Mrs Newton stated that a detailed review into the use of bank and agency staff was underway and a detailed update would be brought to the next meeting.

258.4 **Action**: The Chief Finance Officer to provide a detailed update on the use of bank and agency staff at the next Board meeting.

258.5 The Board requested that further detail be provided around the table showing growth relative to 2010/11, with particular reference to Neurosciences. Mrs Newton agreed to provide this detail in the next report to the Board.

258.6 **Action**: The Chief Finance Officer to provide detail of the relative growth in income and activity to 2010/11, with particular reference to Neurosciences.

258.7 The Board **noted** the report.

259. UCLP Research Activities Update

259.1 Professor David Goldblatt, Director of Research and Innovation presented the report.

259.2 He informed the Board that UCL Partners had recently held the 2nd child health symposium into childhood diseases and care in community.

259.3 Meetings were taking place with staff to discuss how the Computer Centre site would be used. The focus was around rare diseases and the development of diagnostics, particularly molecular diagnostics and the development of novel gene, stem and cellular therapies, to reflect the GOSH/ICH research strategy. A workshop was planned for 5th December 2011 and recommendations would be brought to the Trust Board.

259.4 The success in attracting further funding for the Biomedical Research Centre had provided the Trust with an opportunity to refresh the GOSH/ICH research strategy and make enhanced reference to work around rare diseases and how this work is of relevance to children across the country.

259.5 Mr David Lomas, non-executive director asked if the Research and Innovation department had a robust plan in place to deliver the research strategy and the appropriate resources available to capture the necessary data and support staff in developing research initiatives.

259.6 Professor Goldblatt stated that systems and staffing levels had recently been reviewed and the department restructured in readiness to implement the strategy. Road shows were being held to provide an opportunity for staff to meet the research teams.

259.7 Work was underway to encourage A level students to consider careers in clinical science and collaboration with 7 schools had been established. Seminars were planned to be held showing the students how research can be translated to the bedside.

259.8 Professor Goldblatt informed the Board that he would be stepping down from his position with UCL Partners in 2012.

259.9 The Board **noted** the report.

260. Head of Nursing Report

260.1 Mrs Liz Morgan, Chief Nurse and Director of Education introduced Mrs Julie Bayliss, Head of Nursing ICI to present the report. The Board was informed that the report had been recently revised to provide assurance about nursing leadership and quality.

260.2 Mrs Bayliss stated that the quarterly nursing performance reviews had been successful and enabled shared learning opportunities.

260.3 Completion of height audits had improved and posters were due to be placed around the Trust to remind staff and visitors about the importance of hand hygiene. A competition was being held at the GOSH School to design a child friendly poster.

260.4 Following the CQC planned review, improvements had been made to the tagging of clinical equipment and provision of the house keeping service.

260.5 It was agreed that data on the number of breaches to the same sex accommodation requirements be included in the next report.

260.6 The Board **noted** the report.

261. Audit Committee Update from October 2011 meeting

261.1 Mr Charles Tilly, non-executive director and Chair of the Audit Committee presented the report. He stated that the Committee had continued its focus on data quality and viability of proposed CRES schemes.

261.2 The Board **noted** the report.

263. Management Board (September and October 2011) Minutes

263.1 Dr Jane Collins, Chief Executive and Chair of Management Board presented the reports.

263.2 The Board **noted** the content of the reports and requested that the full minutes from Management Board be presented at forthcoming Trust Board meetings.

264. Infection, Prevention and Control Update

264.1 Professor Martin Elliott, Co-Medical Director presented the report and informed the Board that there had been 2 MRSA cases during the year. C Difficile numbers continued to be above target given the particular issues around children.

264.2 Dr Collins congratulated the infection control and occupational health team in their work to promote and administer the flu vaccine across the Trust.

264.3 Dr Barbara Buckley, Co-Medical Director raised the issue of a complaint received from a parent about the implementation of the MRSA Policy and its impact on their child. The parent had received an explanation about why it was essential that the policy was strictly adhered to, although it was recognised that sometimes this could have a negative effect on families.

264.4 The Board **noted** the report.

265. Update on Compliance with Care Quality Commission Standards and Registration

265.1 The Company Secretary, Dr Anna Ferrant presented the report, which provided an update on the current status of the Care Quality Commission (CQC) registration standards. Dr Ferrant noted the amber status reported for outcome 8 (cleanliness and infection control) and highlighted the work undertaken by the Trust to improve performance around infection control and cleaning.

265.2 The Board **noted** the report.

266. Overview of Trust Wide Risk Register

266.1 Professor Martin Elliott, Co-Medical Director presented the report and highlighted the key themes arising from the analysis of the risk register. .

266.2 Mr Charles Tilley requested that additional detail be provided in future reports about the different types of 'infrastructure' risks. Professor Elliott agreed to take this forward.

266.3 **Action**: Professor Elliott to provide additional detail on the different types of 'infrastructure' risks reported in the Trust Wide Risk Register Report.

266.4 The Board **noted** the report.

267. Redevelopment Update

267.1 Mr William McGill presented the report and highlighted that the contract completion date for phase 2A was still on track for 22nd December 2011.

267.2 A one month delay would still allow the Trust to continue to fit out the building. The timetable was tight and there was still a need to run all systems together to ensure that they were fully integrated.

267.3 Mr Charles Tilley asked whether there was any learning from this project –in the past the Trust was confident of the phase 2A being delivered before Christmas and now plans were in place in case of delays. Mr McGill reported that the company was working all hours to complete and handover the development before Christmas. The company had recognised how technical the building programme was.

267.4 Baroness Blackstone reported that unfortunately the Queen was not available to open the building in 2012 due to a large number of public engagements.

267.5 The Board **noted** the report.

268. Trust Board Members' Activities

268.1 Baroness Blackstone reported that she had attended and chaired the first meeting of the Members' Council on 17th November 2011. She had also attended an event hosted by the Association of UK University Hospitals.

269. Consultant Appointments

269.1 Baroness Blackstone informed the Board of the names of the consultants appointed since the last meeting in September:

269.2

•	Mr	Ramesh Nadarajah	Spinal Surgery (Locum)
•	Dr	Samer Hamada	Neurosciences (Locum)
•	Dr	Kiran Nistala R	heumatology
•	Dr	Shahin Moledina	Cardiac
•	Dr	Jasveer Mangat	Cardiac
•	Dr	Michelle Carr	Cardiac
•	Mr	Nagarajan Muthialu	Cardiac
•	Mr	Gary Pollock	Surgery

- Dr Brijesh Patel Surgery
- Dr Daljit Gill Surgery

269.3 The Board **noted** the appointments.

270. Register of Seals

270.1 Dr Anna Ferrant, Company Secretary presented details of seals affixed and authorised between 12th October 2011 and 23rd November 2011.

270.2 The Board **approved** the application of the common seal and executive signatures to the listed documents.

271. External Auditor's Management Letter 2010-11

271.1 Mrs Claire Newton, Chief Finance Officer presented the report from the external auditors, which provided a summary of the key issues from the audit of the year ended 31st March 2011.

271.2 The Board **noted** the report.

272. UCL Partners Board Minutes September 2011

272.1 Dr Jane Collins, Chief Executive presented the report which provided the Board with an update on the work of UCL Partners.

272.2 The Board **noted** the report.

273. Any Other Business

273.1 There were no items of any other business.

274. Date of the Next Meeting

274.1 The date of the next meeting of the Trust Board was confirmed as 21st December 2011.

ATTACHMENT K

Attachment K

TRUST BOARD - ACTION CHECKLIST
21st December 2011

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
17.4	27/04/11	Ms MacLeod said that a presentation received prior to the meeting about working with governors had highlighted the need for further work to clarify how patient, carers and the public members of the Trust engaged with the Board and its subcommittees. It was agreed that the work would be revisited in the autumn once the Member's Council had been formed.	AFe	Deferred to March 2012	Not Yet Due
202.6	28/09/11	The Chairman commented that the report highlighted a lot of areas rated as amber. The Chief Nurse stated that this assessment required a review. Although the requirements around CP training were tough, it was also important to reflect accurately where progress had been made. Mr Tilley suggested that information about actions being taken to resolve areas where further progress is required would be helpful. The Board agreed. The Chief Nurse to bring an update on this to the December 2011 Board meeting.	LM	December 2011	On agenda
247.5	21/12/11	Dr Jane Collins. Chief Executive stated that the use of RAG ratings posed a common problem for the Board in that it was not always clear why a particular rating had been applied. Dr Collins agreed to discuss this matter with the executives to develop a common set of criteria. The Chief Executive to discuss and agree common criteria for the use of RAG ratings in Board and other key reports.	JC	December 2011	Verbal Update
254.3	21/12/11	The Chair noted the number of subcommittees reporting to Management Board and suggested that a further review of its governance arrangements was conducted post	AF	Post FT Authorisation	Not yet due

Attachment K

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		Foundation Trust authorisation. Dr Jane Collins explained that some of the committees were established under statute, but that there was scope for further consolidation of subcommittees. The Company Secretary to conduct a further review of the subcommittees reporting to Management Board post Foundation Trust authorisation.			
257.5	21/12/11	The Board requested that the information included in the escalation report was brought back in the form of an action plan to demonstrate the work underway to improve performance and the timescales for implementation. Particular reference was made to the need to understand the work underway to improve inpatient waiting times. The Chief Operating Officer to report on escalated matters in the performance report in the form of action plans and timescales for improvement.	FD	December 2011	On agenda
257.9	21/12/11	Mr Tilley requested all indicators to have a target to reach. Ms Dalton agreed to review those indicators with no targets. The Chief Operating Officer to review and update all indicators with targets.	FD	December 2011	On agenda
258.4	21/12/11	Mrs Newton stated that an investigation into the use of bank and agency staff was underway and a detailed update would be brought to the next meeting. The Chief Finance Officer to provide a detailed update on the use of bank and agency staff at the next Board meeting.	CN	December 2011	On agenda

Attachment K

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
258.6	21/12/11	The Board requested that further detail be provided around the table showing growth relative to 2010/11, with particular reference to Neurosciences. Mrs Newton agreed to provide this detail in the next report to the Board. The Chief Finance Officer to provide detail of the relative growth in income and activity to 2010/11, with particular reference to Neurosciences.	CN	December 2011	On agenda
266.3	21/12/11	Mr Charles Tilley requested that additional detail be provided in future reports about the different types of 'infrastructure' risks. Professor Elliott agreed to take this forward. Professor Elliott to provide additional detail on the different types of 'infrastructure' risks reported in the Trust Wide Risk Register Report.	ME	December 2011	For next report to Board in 2012

Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting
21st December 2011

Reporting Zero Harm - Quality, Safety & Transformation Update **Submitted on behalf of** **Fiona Dalton** **Martin Elliott**	**Paper No: Attachment L**

Aims / summary

The attached report proposes standardised reporting of Zero Harm by Quality, Safety & Transformation team, to commence fully in January 2012. This replaces the previous Zero Harm report and provides structured high level Zero Harm summary and, from January 2012, a more detailed presentation into Safety, Transformation or Outcomes on a monthly rotation. For December the board are provided the first Zero Harm report which shows the proposed high level Zero Harm Indicators. Some of these are still being developed.

In January, Transformation will provide a full Annual Report, which will show progress, challenges and supporting data for all the No Waits, No Waste, Zero Harm projects:

- Infection Prevention & Control
- Medicines Management
- Advanced Access
- Bed Management
- Procedure Pathway
- Deteriorating Child
- Medical Records

For information, also included are the minutes of the November Transformation Board which show presentations and progress for Neurosciences and International Private Patients.

Action required from the meeting To consider and approve the proposed Zero Harm report

Contribution to the delivery of NHS / Trust strategies and plans
Delivering No Waits, No Waste, 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? The new reporting has been discussed at Director level and has been presented to Monitor. All Transformation work has been delivered to Transformation Board with 2 parent representatives as members.

Who needs to be told about any decision N/A

Who is responsible for implementing the proposals / project and anticipated timescales Head of Quality, Safety & Transformation

Who is accountable for the implementation of the proposal / project
Co-Medical Director and Chief Operating Officer

Author and date Katharine Goldthorpe, 13th December 2011

Attachment Li

Quality, Safety & Transformation
Reporting to Trust Board

This paper outlines the process for reporting on Quality, Safety & Transformation (QST) to Trust Board at GOSH.

On a monthly basis, Trust Board receive an update from Quality & Safety Committee on Serious Incidents and the Trust wide Risk Register. This report should continue.

The new QST structure will deliver a standard monthly report, firstly to Management Board and then to Trust Board. This report will incorporate the core QST achievements, risks and challenges. It provides congruency and not duplication with other reports such as KPI report. Also, as appropriate, a patient safety story will be presented. The QST report will include:

1. Zero Harm Indicators

- SI report
- Complaints / Incidents
- Mortality
- Arrests outside ICU
- Non ICU crash calls
- Combined infection index
- Combined harm index (Under development)
- PTT

2. A monthly rotation of Transformation, Safety & Outcomes progress

Transformation

- Infection Prevention & Control
- Medicines Management
- Advanced Access
- Bed Management
- Procedure Pathway
- Deteriorating Child
- Medical Records
- Other Clinical Unit or Corporate improvements of note

Safety

- Serious Incidents
- National Alerts (relevance, gap analysis, compliance, monitoring)
- NICE Guidance (relevance, gap analysis, compliance, monitoring)
- NCEPOD studies
- Complaints
- Risks Registers: report of themes appearing and actions being taken around recommendations and monitoring, whether direct operational changes or improvement projects

Outcomes

- Outcome measures
- Benchmarking
- PROMS

Quality, Safety & Transformation
Reporting to Trust Board
December 2011

This is the first Zero Harm report produced by the Quality, Safety & Transformation (QST), presented to Trust Board at GOSH. This report provides the information previously presented by Peter Lachman, Associate Medical Director in a standard format.

The data included in this report is presented in Statistical Process Control (SPC) charts, which allow you to see the difference between common variation and special cause variation. The red lines are the upper and lower control limits and data which falls within these limits are within variation. When using SPC charts, we are looking for special causes, which result from a significant change in the underlying process.

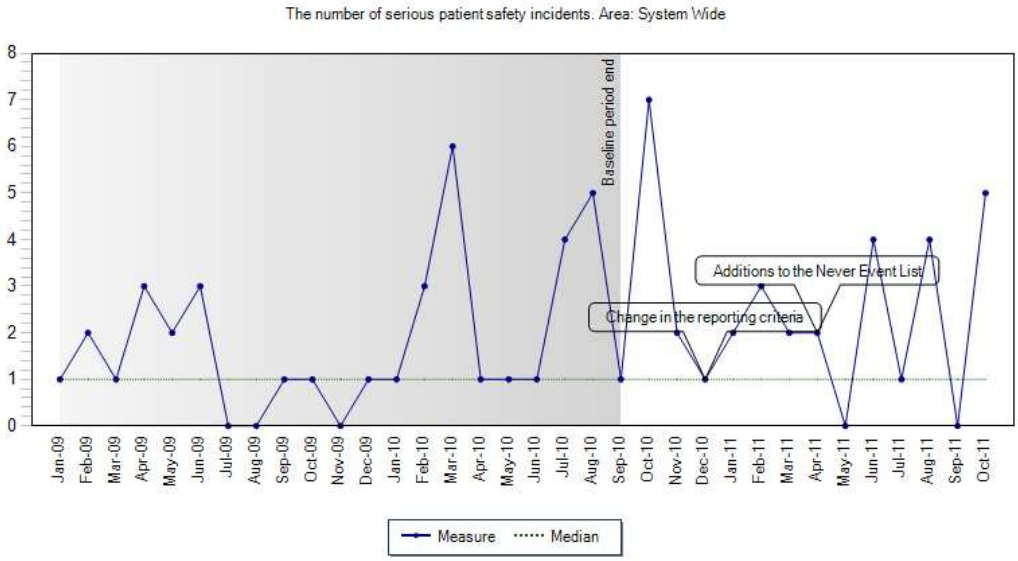
Part I
Zero Harm Indicators

The first part of the report will provide Trust board with a status update on the following measures.

1. SI report

On a monthly basis, Trust Board receives a detailed update from Quality & Safety Committee on Serious Incidents and the Trust wide Risk Register. This report should continue.

The following SPC chart shows the journey and is a tool we can use to show where a change in practice has led to an improvement. The current status shows that there has been no significant change to the process to date. In 2012, the QST team will be examining all recommendations for all serious incidents and considering how we can embed them Trust wide using improvement methodology. This will be presented to Trust Board as part of the Safety report.



The number of serious patient safety incidents (levels 4 and 5).
4 (Major) – Permanent injury, long term harm or sickness, involving one or more persons, potential litigation, extensive injuries, loss of production capability, some toxic release, fire, major financial loss
5 (Catastrophic) – Unexpected death of one or more persons, national adverse publicity, potential litigation, toxic gases, fire, bomb, catastrophic financial loss

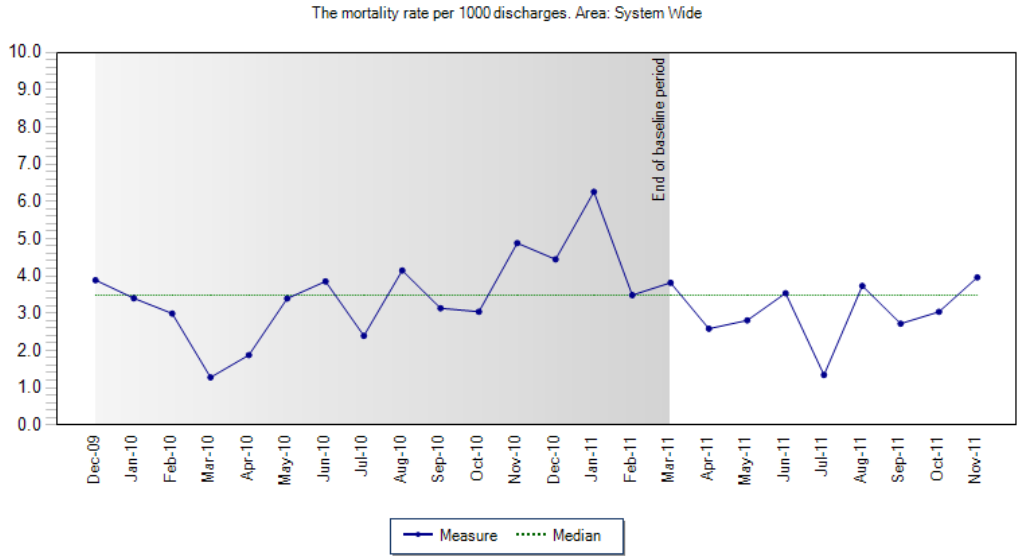
2. Complaints and Incidents

All information regarding numbers of complaints and incidents is currently stored in Datix, which is an industry standard solution for recording safety related data. Work is currently being undertaken to address how this data can be presented using SPC. It is important to get the definition right for these measures, with different levels of incidents and complexity of complaints.

In 2012, the QST team will be undertaking work with the clinical units to address the actions and recommendations from incidents and complaints. This will be presented to Trust Board as part of the Safety report.

3. Mortality

Work is currently being undertaken to consider lessons learned through mortality review. The Mortality Review Group should provide a quarterly report to Trust Board with incidence, trends and points of interest. They will highlight to the QST Team any work which may need further investigation or which needs to be developed as an improvement project.



4&5 Arrests and crash calls outside Intensive Care Units (ICU)

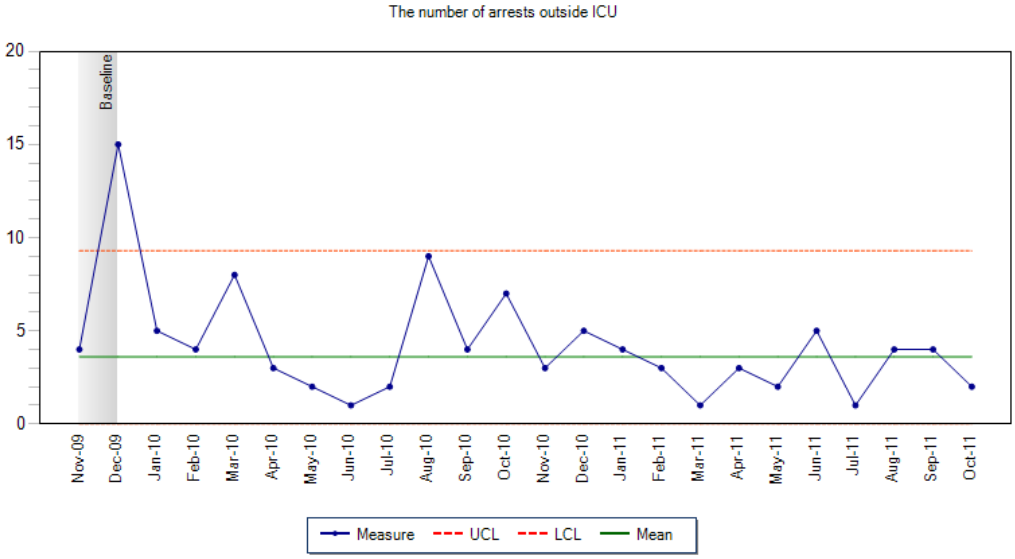
The SPC charts below show the number of arrests and crash calls outside the ICU areas.

Key to tackling this is the work undertaken through the Deteriorating Child project. The aim of this project is to reduce harm from deterioration, more specifically to reduce the number of cardiac arrests by 50 per cent within one year. To achieve this, a work programme has been developed to focus on the following:

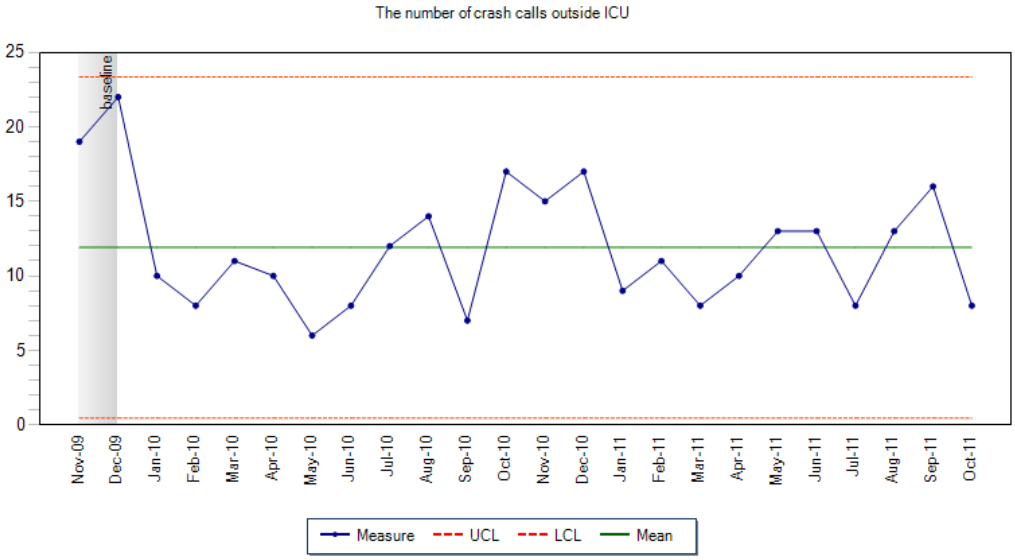
- Reduce Risk
- Identify Deterioration
- Respond to Deterioration

GOSH has introduced many initiatives to improve the recognition and response to the deteriorating ward patient including the Clinical Site Practitioners, Intensive Care Outreach Network (ICON), general paediatricians and simulation training. Much of the work so far has focused on implementing the Children's Early Warning Score (CEWS) - a system to detect deterioration through vital sign monitoring and the

communication tool SBARD (Situation-Background-Assessment-Recommendation-Decision).



The monthly number of arrests (cardiac or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team)

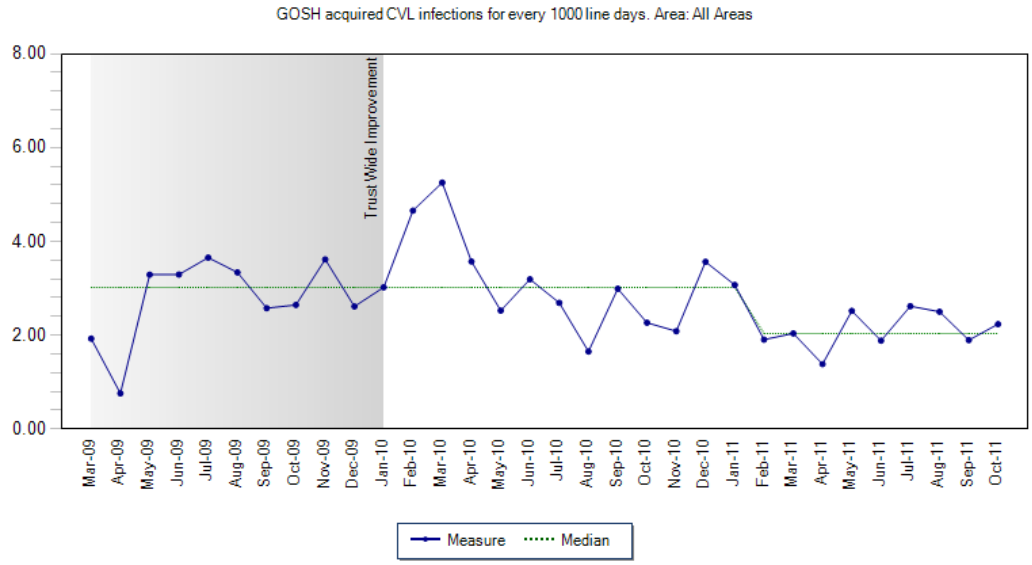


The monthly number of crash calls (calls made to the 2222 Clinical Emergency Team) outside of ICU ward

4. Combined infection index (under development)

A measure to show how we are reducing infection rates overall is being developed in conjunction with Cincinnati Children's Hospital Medical Centre (CCHMC). This will include Central Venous Line (CVL) infections, Surgical Site Infections (SSI), Ventilator Associated Pneumonia (VAP), MRSA, MSSA and *Clostridium difficile*. This would give us a larger sample size than we currently have for the individual infections, which will only become smaller as we improve (see CVL SPC below). This will give us a better overview as an organisation as to how we are tackling infection at a high level.

Clinical Unit teams will be supported by the appointment of an Infection Control Practice Educator from end-November 2011 and priority will be given to training and education in infection control.



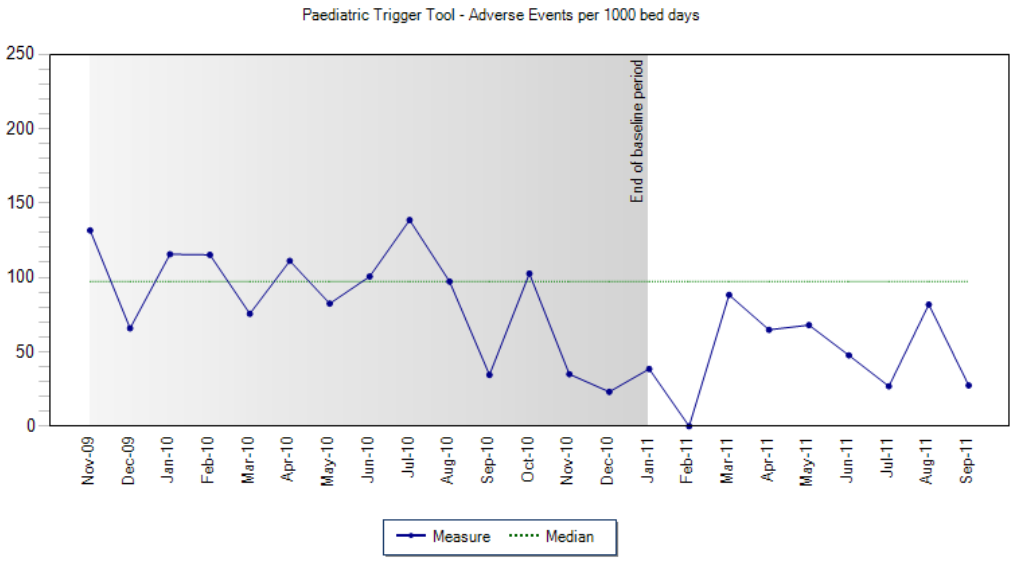
5. Combined harm index (Under development)

The combined harm index works on the same principles as the combined infection index and is also being used at CCHMC. This will provide opportunities for benchmarking. The combined harm index includes all hospital acquired infections, serious incidents, non-ICU arrests and serious patient falls. This is a complex measure and the Transformation analysts are currently examining how to adapt the CCHMC model to suit GOSH without losing the ability to benchmark.

6. Paediatric Trigger Tool

Each month, 20 case notes are randomly selected to be reviewed by a group of clinical staff using the Paediatric Trigger Tool. Common themes have risen from these projects which will be worked on as improvement projects.

One of the first issues to be tackled has been the maintenance of patient notes. Issues such as overfull records which were difficult to handle and at risk of coming loose, and inconsistent filling, leading to difficulties in finding key parts of the record, such as discharge summaries and missing records. Secondly, issues were highlighted around entries made by clinical staff, including the failure to follow basic standards of record keeping and failure to document key events in the patient journey. Each Clinical Unit has added a project to improve the quality of Medical Records to their project plans. This will be reported through the Transformation Programme report.



A random sample of 20-40 notes are pulled each week and analysed for adverse events using a methodology developed by the IHI

Part II
A monthly rotation of Transformation, Safety & Outcomes progress

The first month of rotation of Transformation, Safety & Outcomes progress will start in January 2012 with a full progress report from Transformation.

Transformation

- Infection Prevention & Control
- Medicines Management
- Advanced Access
- Bed Management
- Procedure Pathway
- Deteriorating Child
- Medical Records
- Other Clinical Unit or Corporate improvements of note

Safety

- Serious Incidents
- National Alerts (relevance, gap analysis, compliance, monitoring)
- NICE Guidance (relevance, gap analysis, compliance, monitoring)
- NCEPOD studies
- Complaints
- Risks Registers: report of themes appearing and actions being taken around recommendations and monitoring, whether direct operational changes or improvement projects

Outcomes

- Outcome measures
- Benchmarking
- PROMS

Summary
It is proposed that the QST Zero Harm report will provide the Trust Board with the high level information required each month, with detail on the progress of individual projects on a rotating basis.

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Great Ormond Street Hospital for Children NHS Trust

Transformation Board
Minutes
Monday 21 November, 11:00 – 13:00
Charles West Boardroom, Great Ormond Street Hospital

Present:
Jane Collins (JC) – Chief Executive (Chair)
Fiona Dalton (FD) – Chief Operating Officer
Anthony Higgins (AH) – Communication and Engagement Officers
Geoff Bassett (GB) – Head of Information
Greg Holdsworth (GH) – Parent representative
Jez Phillips (JP) – Assistant Head of Quality, Safety & Transformation - Information
Katharine Goldthorpe (KG) – Transformation Programme Manager
Liz Morgan (LM) – Chief Nurse
Claire Newton (CN) – Chief Operating Officer
Peter Lachman (PL) – Consultant in Re-design
Robbie Burns (RB) – Deputy Chief Operating Officer
Mark Large (ML) – Director of ICT
Phillippa Murray (PM) – Parent representative
Martin Elliott (ME) – Co - Medical Director
Caroline Joyce (CJ) – Assistant Chief Nurse
Salina Parkin (SP) – Assistant Head of Quality, Safety & Transformation - Risk
Geoff Bassett (GB) – Head of Information

Attendees:
Caroline Wells (CW) – Improvement Coordinator - Neurosciences
Kevin Jones (KJ) - Senior Analyst - Transformation
Eva Wilkinson (EW) – Notes - Transformation
Toral Pandya (TP) – Improvement Coordinator – ICI-LM
Sarah Dobbing (SD) – General Manager Neurosciences
Joanne Lofthouse (JL) – General Manager International and Private Patients
Owase Jeelani (OJ) – Consultant Neurosurgeon
Jane Runnacles (JR) – Darzi Fellow
Mandy Smith (MS) – Medical Student
Bob Wachter (BW) - Visitor

	Item	Action / Responsibility
1.0	**Apologies and Welcome**	
	1.1 Apologies from Tom Smerdon (TS) – General Manager – Surgery and Grainne Morby (GM) 1.2 Caroline Joyce (CJ), Salina Parkin (SP) and Mandy Smith (MS) were welcomed to the Board 1.3 JC welcomed Bob Wachter to the meeting and reminded Board that he would be giving a Master Class in the afternoon.	
2.0	**Minutes of last meeting and matters arising from the last Board meeting on 17 October 2011**	
	2.1 The minutes were approved subject to the following amendments: 2.2 Allan Goldman and Olivia Waller were in attendance at the last meeting.	
3.0	**Action log and Matters Arising**	
	3.1 All actions closed on the log apart from the following:	

	3.2 **Action 3.3 –** ZS to send GH a copy of the admission criteria document. **21 Nov Update:** Document is awaiting approval by Management Board and then will be sent to GH. 3.4 **21 Nov update on Action 5.22 –** KG to investigate whether there is a Trust CVL bundle training video and if not investigate the logistics of creating one**:** 3.5 PL met with teams and reported that cardiac have a new CVL and line insertion bundle video. 3.6 PICU has a training checklist and training video for bundle. .7 LM added that the video needed to cover insertion and needed to take into account the different staff groups involved with CVL. This was agreed by the Board and will be taken forward by TH. 3.10 **21 Nov update on Action 6.3 –** RB to investigate any delays greater than double the time they are meant to wait. According to the appropriate access to theatres, for non elective cases classification system: 3.11 RB stated that the main concerns were as follows: • Quality of recording • Access to the emergency list • Whether or not to use O negative blood in an emergency 3.12 **21 Nov update on Action 4.2 -** TS to confirm the date of Squirrel HDU opening and then to add this to the exception: 3.13 Squirrel HDU to open February 2012	***Action – to 'Deep Dive' Delay Audit Project at December Transformation Board - RB***
4.0	**Analyst Update – Kevin Jones & Jez Phillips**	
	4.1 JP shared with the board the new redesigned Trust Zero Harm Dashboard. 4.2 PL clarified that when looking at erious Incidentss it's the last one called and not the last one investigated that is being referred to. 4.3 JC stated that 'CRASH' means different things to different staffing groups. CRASH should refer to a Cardio-respiratory arrest only and does not just refer to any occasion when 2222 is dialled for emergency back-up. 4.4 PL reminded the Board that the data on the Zero Harm Dashboard records the number of a preventable infections. 4.5 There was some discussion about why it was a number reported and not a rate worked out. This was due to difficulty in calculating arate. . 4.6 JP talked about how the Zero Harm Index designed by Cincinnati differs to the one designed by GOS. JP explained that Cincinnati based their denominator around the cost of care for a patient and this was difficult to translate for an NHS Hospital. 4.7 JP explained that they have created an Inpatient Harm Index and will have an Index for Outpatients soon; once more data has been collected. 4.8 CJ asked how would we compare inpatients with outpatients 4.9 RB thought that it looking at money was not a bad way to compare, if we look at the amount of money spent and how many patients were treated with a certain amount of money for both inpatients and outpatients. 4.10 JC suggested that perhaps further conversations could happen outside	

	of the meeting and that money as a way of comparing should not be dismissed. 4.11 JP stated that there was still more work to do, that SI surveillance was not complete and that more data was needed. 4.12 GH asked why we should wait for units to provide measures. 4.13 JC suggested naming and shaming units that had not stepped up and provided measures. 4.14 PL pointed out that while drug errors are recorded as incidents they are often recorded as Zero Harm. So when there is a decrease in drug errors this doesn't affect Zero Harm. 4.13 KG stated that drug errors were measured differently from ward to ward 4.14 SP informed the board that the electronic incident recording system 'Datex' records near misses and no harm incidents. 4.16 PL explained SSI's are recorded up to 30 days after the procedure. And that getting the families from overseas was problematic. 4.17 The board discussed how the data should be shared and how actively it widely it would be shared. JC concluded that it should be available publicly. 4.18 KG mentioned a Safety Barometer to measure a patient going through the hospital with no harm. 4.19 PL Said that this was being trialled in Cardiaorespirator & Medicine over the next 3 months, however there is no One measure which can tell us that the hospital is safe and we must use a variety of different measures. 4.20 KJ then went on to present a number of special causes to the board 4.21 CATS have reduced time until mobilisation by 10 mins as a result of 2 people from the team being on TIMP. 4.22 The presentation showed that there was an improvement in correct expected discharge dates. 4.23 FD asked whether this was due to the fact that people had started to record day cases where previously they hadn't, as day cases tend to be discharged same day as anticipated. However, it was noted this field had always been mandatory. 4.24 There was a discussion around patients cancelling within 2 days of follow up. 4.25 PL said that there were 50 % more cancellations by families. 4.26 JC decided this needs looking into further. 4.27 KG suggested that it would be useful to look at the New to Follow Up ratio for appointments and see whether in areas where this is high, are more follow ups are being cancelled. 4.28 KJ Suggested that there be an 'Editors pick of the month' of exceptions to present to the Management Board and the Trust.	

	4.29 BW congratulated the Board on the level of commitment they showed towards capturing data, variances, and the role of data and for highlighting both successes and failures. He expressed that it is important not just to measure what we can but also ask if there are any immeasurable concerns, as these are equally important. He also made the point that when recording incidents, it is difficult to know whether there is an improvement in recording incidents or there are truly more incidents. BW shared a story about the Google search engine which changes its search engine several times a day based on user activity and advised that we should pay close attention to user behaviour.	***Action: It was suggested at the next analyst update, the teams themselves should present special causes - KJ***
5.0	**Exception Report**	
	5.1 TP reported that she is having difficulty with Data for BMT CQUIN due to JAC data being hard to access. GB working with JAC to get data. 5.2 TP is struggling to find funding for Haem Onc CQUIN collection data by the bedside. 5.3 FD doesn't want to develop a system for ICI that can't be used elsewhere. 5.4 GB made the point that information has to be drawn by his team using the proper process.	*Action: GB to examine how data for improvement can be accessed from JAC*
6	**Aims No Waits No Waste – Katharine Goldthorpe**	
	Note: the following is a summary of discussion only, actual presentation attached. 6.1 KG presented a table showing which of the specialties will have achieved Advanced Access by December 2011, March 2012 and an action plan for those who will deliver later in the year. The Advanced Access aim should remain on the plans as the project will then go into sustain phase. 6.2 A tool has been developed to monitor the number of refused referrals to collect the data more accurately. This is currently being tested by the bed managers. 6.3 KG said that it is difficult to measure the target for estimated discharge date. 6.4 GH asked if credit was given for when a patient goes home earlier than expected and asked about how the estimated time is given. Is the estimated time the time that it would take, only if there are no clinical complications? 6.5 One of the difficulties in measuring is that clinicians are not accepting that some procedures can be more predictable than others and care pathways should be put in place for those that are more predictable. 6.6 The discussion moved on to Outliers in GOS. 6.7 CJ said GOSH patients which are outliers on other wards don't get seen by their host team as often as they might if they were staying on the ward of the host team. 6.8 PM said that her son had a chest infection and the local sent him to Lion as he was a cancer patient which was appropriate for his cancer and tracheotomy needs but that it was then difficult to access Badger who were caring for his respiratory needs, which was why he was in hospital. 6.9 JC asked for definition of 'Outliers' 6.10 Theatre Utilisation: KG reported that there was not enough Fasting audit data to take away.	

	6.11 MRI have got aims but no measures have come back. 6.12 Labs will be able to produce data for improvement form the Omni lab system. 6.13 Financial Savings: Working with accountants and looking at which CRES programmes have a transformation projects linked to them to work out how much more is being saved as a result of the projects. 6.14 PL stated that the MRI wait target seemed to be losing sight of patient need he felt that we shouldn't be focusing on meeting targets but rather making sure patients got MRI as soon as they needed them.	
7	**Clinical Unit Presentation International & Private Patients - Joanne Lofthouse**	
	Note: the following is a summary of discussion only, actual presentation attached. 7.1 JL gave her presentation. 7.2 PM asked if CVL infections were on track including butterfly. 7.3 JL answered that they were. 7.4 PM asked if there were baselines for SSI's 7.5 JL answered that this was included in the the dashboard for each speciality. 7.6 JC asked JP if we could pull this data out. 7.7 PL suggested that it might be a problem collecting accurate date from IPP as patients leave the country and therefore do not report SSI's within 30 days. 7.8 JL stated that many of them stay to be followed up at GOSH	
8	**Clinical Unit Presentation Neurosciences – Sarah Dobbing & Caroline Wells**	
	Note: the following is a summary of discussion only, actual presentation attached. 8.1 SD and CW gave their presentation 8.2 PL asked if we are experiencing less harm in Theatre. 8.3 CW audited SSI's earlier in the year 8.4 Different protocols regarding giving antibiotics in theatre and on the ward 8.4 OJ said with regard to the WHO checklist, when processing data, how accurate is the data collected and how robust is the process for recording data? 8.6 OJ mentioned an incident where an incision was made on a patient on the wrong side but the outcome was No Harm as the patient was not then operated on the wrong side. 8.7 PM suggested that the parents would not see a patient being cut unnecessarily as 'No Harm' but rather that no further harm took place after the incision was made in error. 8.8 GH asked if a WHO checklist had been completed in this instance.	

	8.9 The answer to this was no. 8.10 JC commented that a parent would not want this to happen to their child. 8.11 PM added that the outcome of this incident could have been much worse. 8.12 It was agreed by the board that this was an instance of harm, but that it was managed appropriately in terms of the learning. 8.13 CW reported that they experiencing a lot more pull and interest. 8.14 GH asked if the team were working as expected. 8.15 SD answered that initially they hadn't understood the extent to how many patients fall under different teams and they are now reviewing the success of the project. 8.16 LM asked if this was the same as the work being done by AG and that it was important to make sure that there are no duplications or overlaps in work. 8.17 SD said that they had found the Nurse Led Triage challenging as the nurse had asked for a lot more than expected in terms of Training. 8.18 JC asked if the Human Factor was to change and do we need to support this?	
9	**Next Meeting**	
	The next meeting will be held on Monday 19th December 2011 11:00 – 13:00 The Charles West Board Room	

IPP Deep Dive

Joanne Lofthouse
General Manager

IPP Services

Inpatient Beds

Bumblebee	Surgical unit (16 beds)
Butterfly	Medical unit (13 /15 beds)
Dragonfly	Day Care (4 beds)

Outpatients

Caterpillar	Outpatients (260 Appts /wk)

Overseas Services

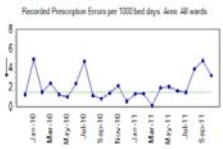
Kuwait	Education contract
	'Spoke' Office – overseas patients

7 Projects (2011)

1. Reducing Medication Errors (by 25%)
2. Reduce Infections (CVL by 50%)
3. Transforming Care on your Ward
4. Surgical Patient Pathway
5. Risk Reporting Process
6. Documentation
7. Administration Pathway

Reducing Medication Errors

Aim
Reduce Drug Errors by 25% by 31st Dec 2011

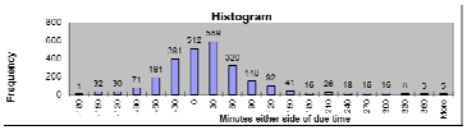


Key Changes
- Analysis of JAC data – all changes of medications (trends)
- Circulated weekly 'prescribed in error' data from JAC
- Re-introduction of 'no interruption' sign & 'quiet' room for prescribing Doctor

Measures
- Historically - 8 errors per 100 items prescribed
- JAC - self reported 'prescribed in error' – substantially lower
- Datix - errors reported, not compared to total meds prescribed

Reducing Medication Errors

Next Steps
- Appointment of new pharmacist (Nov 2011)
  - Actively reporting errors on datix (expect increase in incidents)
  - Highlight 'error' theme for previous week at weekly ward round
- Introduce Medication Errors into RAG
- Process Mapping – Oncology Chemotherapy Protocol
- Re-establish 'no interruption' culture & dedicated 'write up' area
- Daily (10.30) fluid/ product prescription round
- Review of delay in administering medication (first data)



Reducing Infections

Aim To achieve a 50% reduction in CVL Infections (Dec 2011)

Key changes
- Increase awareness through creation of IPP dashboard
- Review & support the utilisation of care bundles
- Improve ownership of audits (1 person to team)
- Introduced monthly Infection Control meeting with IC Dept
- Introduced monthly 'morning teas' for parents
- Updating all non qualified ward staff on Hand hygiene

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Reducing Infections

Measurement
- Line recording improvement
- CVL Infections – normal variation (review all)
- Hand hygiene – has increased in numbers and compliance

Next Steps
- Improve number of bundle compliance – widen scope
- Continue to develop educational information in Arabic/ Greek
- Increase medical link input

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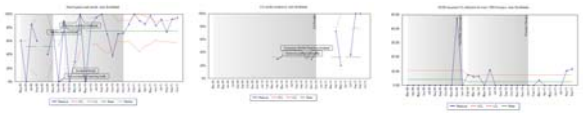
Bumblebee



Key Changes
- Increased number of IC Link nurses & role clarity
- Audits – now in teams (named person)
- Weekly board – reminder of progress
- Care Bundle compliance improvement early days

Next Steps
- Ensure bundle audit compliance sustainability
- Develop new strategies for increasing hand hygiene compliance with parents/ families.

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Transforming Care on Your Ward

Aim Reduce LOS in IPP by 10% by 31 Dec 2011

Key Changes
- Review & redesign pre-admission process
- Pre-Admission Team meeting every Friday (all clinical / admin info)
- Introduction of PSAGB (17.11.2011)
- Improve and reduce information on nursing/ doctor handovers

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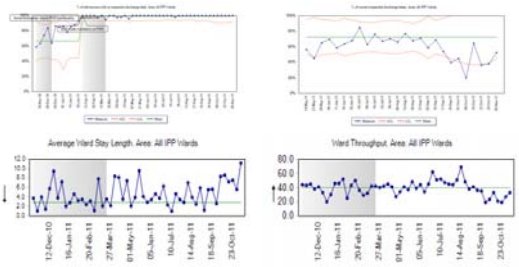
Transforming Care on your Ward

Measure
- EDD Completion
- EDD Accuracy



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Transforming Care on your Ward

Next Steps

- Accurately measuring our delayed discharges daily
- Pilot EDD accuracy – new model
- Discharge medications prepared minimum 24 hrs prior
- Review patient information (pre-admission)

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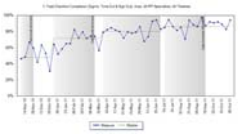
Surgical Patient Pathway

Aim
Achieve a completed Treatment Plan for at least 90% of all surgical admissions by 30th Nov 2011.

Key Changes
- Completed process mapping surgical pathway
- 4 work groups re-designing different parts of the process
- Introduction of 2 new ICPs
- Completion of Fasting Audit (Nov 2011)
- Activity Follow – Doctors surgical work stream
- Pre Admission Team meeting - WIP

Surgical Patient Pathway

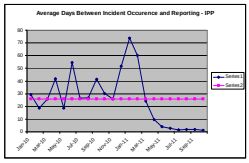
Measures
- WHO checklist
- Fasting Audit baseline
- Treatment Plan completion



Next Steps
- New ICP in development
- Revising booking form – reduce delays
- Pre-admission confirmation call (evening before) – audit
- Review of theatre delays
- Analyse fasting data
- Establishing a baseline discharge documentation (Sep- Dec 2011)

Risk Reporting Process

Aim
All Clinical Incidents to be reported within 4 hrs of occurrence, and escalated as per as per protocol, by Dec 2011. All clinical incident reports to be reviewed within 48 hours, and appropriate protocol followed.



Key Changes
- Datix training to all staff & baseline measures completed

Measures
- Risk Reporting Times
  - SUI Completion Times 100% (within 24 hours)
  - Incident Reporting Time improving (within 48 hours)

Next steps
- Pilot feedback systems (Usergroup / Diary/ Staff Room/ Montly Educ'n)

Clinical Documentation

Aim
Achieve 80% compliance of the medical notes gold standard by the end Of 31st January 2012. Adhere to national standards for nursing documentation.

Key Changes
- Medical case note review (Aim 5 /wk)

Measurement
- Evidence of local compliance (low numbers) – Doctors
- SPC – not helpful as data not transferred from Speciality to Ward
- Bumblebee establishing a baseline (nursing)

Next Steps
- Increase scope in Dec to include other medical teams' entries
- Increase number of nursing notes audits & widen range of auditors.

Administration Pathway

Aim
Develop a clear administration process – all patient documentation is ready 24 hours prior to their admission/ appointment by Dec 2011.

Key Changes
- Reduced all incoming authorisations to one fax & one email address
- Dedicated one email address as a job plan – several staff
- Early morning 'board' meeting – plan for the day

Measurements
- Reduction in number of 'No Logs'
- Increase in number of patients attending with LOG's
- Consultant feedback positive

Next Steps
- OPD Medication authorisation

Summary

7 Key Projects
- Mostly on track – re-prioritised

Successes
- Surgical Pathway - staff engaged and committed to change
- Reducing Infections – engaged staff leading the way

Challenges
- Utilising data in a timely way – medication errors
- Staying focused & delivering on time

Next Stage
- Working on plans for 2011/12

Neurosciences Improvement Plan

November 2011

Sarah Dobbing
Owase Jeelani
Caroline Wells

Context

- Previous update at Transformation Board in June 2011
- Successes - reducing patient harm projects
- Challenges - improving patient flow projects
- Plans for the next year – changing context

Neurophysiology Neurology

Ophthalmology Neuromuscular

NEUROSCIENCES

Neurosurgery Neurodisability

Neuropsychology CAMHS General Paediatrician Team

Summary of Improvement Plan

	Project Description	2010 / 2011 N	D	J	F	M	2011 / 2012 A	M	J	J	A	S	O	N	D	J	F	M
Zero Harm	Improving the safety dashboard																	
	Reducing hospital acquired infections																	
	General Paediatrician team																	
	Reducing medication errors																	
No Waits	Neurodisability clinical administrative process redesign																	
	Advanced access																	
	Variability and flow management																	
	Theatre utilisation – Neurosurgery, Ophthalmology and Neurology																	
No Waste	Neuromuscular service redesign																	
	Koala 2012																	
	CAMHS capacity and demand																	

Zero Harm

Improving the Neurosciences Dashboard

Aims:

- Provide accurate real time information on key harm indicators
- Use data for improvement
- Improve use of dashboards by clinicians

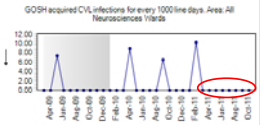
Key changes:

- Safety and Key Measures Dashboards
- Added 10 more indicators
- Including SSIs, WHO checklist, patient readmissions, cancellations on the day of surgery, pre-operative length of stay
- Reviewed monthly and disseminated to specialty leads
- Special causes investigated

Zero Harm

CVLs

- Participated in PICU femoral / central line work
  - Improved process for considering patients' IV access post-ICU needs
  - Improved pre-admission planning
  - ANTT training for medical staff
- Improved education and training



- Developing team of infection control link practitioners to provide infection control resource on the wards and to improve compliance with hand hygiene, IV line days and bundle audits

Transformation
working together towards zero harm•no waste•no waits

Great Ormond Street Hospital for Children NHS

Zero Harm

SSIs

- Recommendations from RCA implemented
- Pre-op bath / hair wash
- Improved patient information
- MRSA and septic screen
- Staff training
- Standardised antibiotic protocol and wound prep
- SSI surveillance resumed

Shunt infections

- Developing robust process for completing RCAs for all shunt infections
- Supported by Clinical Improvement Lead

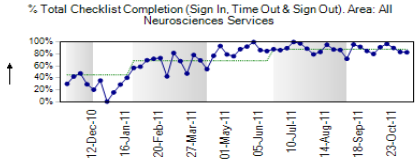
Transformation
working together towards zero harm•no waste•no waits

Great Ormond Street Hospital for Children NHS

Zero Harm

WHO Checklist

- Improved recording on PiMS
- Ongoing education and training
- Use of video to review practice
- Monitoring monthly at Clinical Unit Board



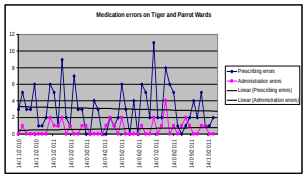
Transformation
working together towards zero harm•no waste•no waits

Great Ormond Street Hospital for Children NHS

Zero Harm

Medication errors

- Neurosciences Medicines Management Group meeting every 2 months to review and address trends
- Process in place for feeding back to prescribers
- Use of Drug Error Analysis Tool (DAT)
- Improved training for staff
- Quiet area for prescribing
- JAC data required



Transformation
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Great Ormond Street Hospital for Children NHS

Zero Harm

General Paediatrician Team

Improving the quality of the handover process

- Improved engagement of clinical teams
- CSP involvement at morning handover
- Procedure reviewed, revised and relaunched
  - Improved time-keeping
  - Improved clarity over roles and responsibilities
- Criteria for flagging patients revised to include safeguarding issue
- Improved documentation of handover

Transformation
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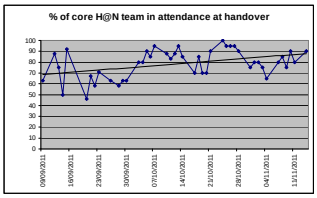
Great Ormond Street Hospital for Children NHS

Zero Harm

General Paediatrician Team

Outcome measures

- % of core hospital at night team in attendance
- Number of appropriate patients flagged at handover
- Number of clinical incidents involving patients not flagged



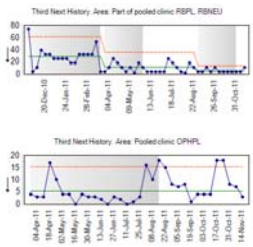
Transformation
working together towards zero harm•no waste•no waits

Great Ormond Street Hospital for Children NHS

Advanced Access

Specialties achieving

- **Clinical neurophysiology** – achieving
- **Ophthalmology** – progress with reducing DNAs and cancellations, written referral criteria, pooling and reduced average follow up to new ratio



Advanced Access

Specialties expected to achieve by end of December 2011 / March 2012

- **Neurology** – reduction in backlog following new consultant, more robust acceptance / rejection criteria, and reduction in cancellation rate

- **Neurosurgery** – two out of five clinics achieving, capacity constraints identified in particular clinic

Advanced Access

Challenges

- **Neurodisability** – clinic by clinic approach, business case approved to eradicate backlog in certain clinics, redesigning clinic templates
- **Neuromuscular** – work has been done to reduce DNAs, exploring options for increasing capacity in clinics by changing the working model, however team organisation, culture, and roles and responsibilities need to be addressed alongside this
- **CAMHS** – AA data not available but waiting lists are reducing

Theatre Utilisation

- **Neurosurgery – improved to 81% (baseline 77%)**
  - Raised awareness about starting on time
  - Ensuring that patients are ready on the ward when called for
- **Ophthalmology – improved to 72% (baseline 66%)**
  - Telephone consultation to flag problems prior to admission
  - Improved communication on the day
  - EUAs to utilise spare capacity
  - Additional patients booked on list to reduce early finishes
  - Consultant pairs to provide cover
- **Neurology - 48%**
  - Pre-assessment
  - Improved planning and communication
  - Standardised process for taking samples
  - Theatre environment
  - 68% utilisation in October

Variability and Flow Management

Aims:

- To improve MRI co-ordination and utilisation
- To improve patient experience

Progress:

- Reviewed and updated Neurosciences Admission Planner
- Revised and relaunched bedside communications tool – several PDSAs
- Botox patients on RANU
- Launched new process for managing patients admitted for MRI scans under GA – several PDSAs
  - Nurse-led triage is challenging
  - Linking in with MRI project
- Plan to reassess patient experience

Koala Ward

Aims:

- To bring Koala Ward into operational use
- To redesign and streamline ward processes and environments to improve and transform care on the ward and bring together the different clinical teams
- CRES – potential financial implications

Key developments:

- **Effective ward rounds and MDT meetings**
  - Reviewed existing ward rounds including feedback from parent representatives
  - Proposed changes to be tested prior to move
  - Proforma developed for psychosocial meetings
- **Patient pathways** within Neurology, Neurosurgery and Craniofacial have been reviewed and actions put in place to address issues
- **Policies and procedures** updated

Koala Ward

Key developments (continued)

- **Handover**
  - Nurses improving handover process using SBARD
- **Workforce**
  - Themes identified from analysis of workforce, including culture and organisation, systems, processes and IT, administrative duties, and roles and responsibilities
  - Difficulties with data from workforce project
  - New ways of working e.g. nurses cross-covering, admissions team providing more support for bed management process
- **Parent involvement**
  - Information for parents prior to move
  - Updating welcome leaflets
- **Next steps – Moving in March 2012**

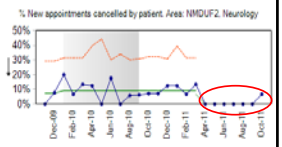
Neuromuscular Service Redesign

Aim:

- To increase throughput and reduce patient waiting times within the service
- CRES – potential financial implications

Progress to date:

- Understanding referrals
- Streamlining referral admin processes
- Reduction in DNA and cancellation rates – telephone reminders
- Identification of delays in patient pathway - changes to physiotherapy template to reduce delays
- Understanding and reducing late starts in clinic – improved letter templates



Neuromuscular Service Redesign

Project extension

- Phase 1
  - Engagement with clinical and administrative teams
  - Identification of root causes and barriers to change
- Phase 2
  - Implementation of physical changes

Neurodisability Clinical Administrative Process Redesign

- Initial focus on reducing report times:
  - Electronic sign off of report
  - Reminders for clinicians
  - Changes to report tracker
  - Standardised preliminary report
- Expansion of project to include:
  - Reducing the time from receipt of referral to offer of appointment to achieve 5 day target
- New project lead is revising the project plan (part of TIMP)

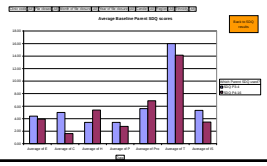
CAMHS

Aims:

- To redesign services to maximise utilisation and efficiency

Progress:

- Capacity and demand data collected for each service within CAMHS
- Micro-efficiency – value added clinical time
  - E.g. clinicians working singularly rather than in pairs
- Telephone reminders to reduce DNA and cancellation rates in PACS service
  - Initial reduction in DNA and cancellation rates in PACS service
- Clinical outcomes
  - drawing information from each team for all patients
  - Measuring patients at referral, 6 months, 12 months and discharge



Summary

Reflections

- Data driven change has worked well
- Pockets of engagement but some challenging areas
- Change without data or where there are 'human factors' is challenging

Priorities for the next quarter

- Neuromuscular Service Redesign
- Koala Ward - Implementation
- Surgical Site Infections
- General Paediatricians – Setting objectives for next year

Great Ormond Street Hospital for Children NHS Trust

Trust Board 21 December 2011	
Academic Health Science Centre Board self-certification statement **Submitted on behalf of:** Jane Collins	**Paper No: Attachment M**

Aims / summary
The Monitor Compliance Framework requires the Trust Board to make a self-certification statement in relation to the Trust's membership of the UCL Partners Academic Health Science Centre.

The statement confirms that the membership of UCL Partners will not compromise the ability of the Trust to remain compliant with foundation trust terms of authorisation, and that any risks associated with membership have been assessed and managed appropriately.

Action required from the meeting
Approval of the self-certification statement.

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

Financial implications: None

Legal issues: None

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Not applicable.

Who needs to be told about any decision Monitor

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
14 December 2011

Attachment M

Great Ormond Street Hospital for Children NHS Trust

Board statement on the UCL Partners Academic Health Science Centre

Great Ormond Street Hospital for Children NHS Trust is a member of the UCL Partners academic health science centre (AHSC). UCL Partners brings together world-class medical researchers and clinicians from a range of academic and health care organisations in north and east London.

UCL Partners works to advance medical research, quality patient care and education. The aim is to improve the health of Londoners, share scientific knowledge, and train an internationally renowned, caring workforce focused on academic, clinical and educational excellence.

The Trust's membership of the AHSC is subject to a legal agreement. This arrangement meets the triggers set out in Monitor's *Compliance Framew*ork (Appendices C4 and F), and the Board is therefore required to confirm that it is satisfied with the following statements and the evidence and assurance that support them.

In relation to this agreement the Board is satisfied that it has and continues to:

- ensure that the partnership will not inhibit the trust from remaining at all times compliant with its Authorisation;
- have appropriate governance structures in place to maintain the decision making autonomy of the Trust;
- conduct an appropriate level of due diligence relating to the partners when required;
- consider implications of the partnership on the Trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities;
- consider implications of the partnership on the Trust's governance risk rating having taken full account of the impact on the seven elements of governance identified in the Compliance Framework;
- conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk;
- comply with any consultation requirements;
- have in place the organisational and management capacity to deliver the benefits of the partnership;
- involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services;
- address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework);
- ensure appropriate commercial risks are reviewed;
- ensure that the principles and rules of the Co-operation and Competition Panel (CCP) are considered and where appropriate the CCP is consulted;
- maintain the register of interests and no residual material conflicts identified; and
- engage the governors of the Trust in the development of plans and give them an opportunity to express a view on these plans.

Trust Board assurance

The Chair, Chief Executive and executive directors of Great Ormond Street Hospital were closely involved in developing the overall objectives, governance arrangements and the bid for AHSC status for UCL Partners.

The Trust Board considered the development of the partnership, the possible scope of work and governance arrangements at several meetings in 2007 and 2008.

In May 2008 the Board considered the following issues:

- Governance: a decision was taken to not integrate the management of partner organisations, and to instead explore a partnership structure with appropriate levels of responsibility within the partnership
- The need to ensure that the benefits of the partnership were fully explored.
- The likely financial benefits of combining certain services and research teams were queried.
- The need to maintain a specific focus on child health issues within the partnership as a primary theme, rather than as a secondary issue within other themes.
- Ensuring that all partners were committed to the partnership.
- The need to focus mainly on translational research and adherence to evidence-based practice rather than operational issues.
- The potential impact on GOSH Children's Charity.

The Trust Board to the decision to join UCL Partners on 30 July 2008. To reach their decision the board considered two supporting papers; 'Academic Health Science Centres' and 'UCL Partners Governance Arrangements'.

At this meeting the Board discussed the potential reputation risk that both joining and not joining the partnership could bring. It was agreed that risks would be managed more effectively by joining the partnership at its start and taking an active role in its development.

UCL Partners applied for formal Academic Health Science Centre (AHSC) status in 2009. The application was approved and met the government's criteria for designation:

- Excellence in biomedical clinical and applied health research that is of international standing across a range of interests and of critical mass;
- Excellence in undergraduate and postgraduate medical education and (as appropriate) other areas of healthcare and health science education;
- Excellence in patient care;
- The vision, ambition and partnership arrangements for delivering benefits in patient care, with an emphasis on benefits for the local community,; and
- Sound financial performance.

The Trust Board reviewed governance arrangements for the partnership in April 2009, including:

- Legal advice on the governance arrangements.
- Ensuring that the operation of the partnership does not have an adverse impact on the day to day running of the hospital.
- The partnership would help to increase the hospital's International reputation.
- The impact of the partnership on the organisation's ability to secure research funding compared with what could be achieved as a separate organisation.
- Ensuring that the restrictions on the partnership to borrow funds were clarified.

A UCL Partners management report has been considered at each subsequent Trust Board meeting.
The Trust remains free to act independently when required. The UCL Partners Agreement states:

> "6.3 The Company and all the Partners acknowledge that each Partner has its own distinctive sense of purpose and identity. Nothing in this Agreement shall oblige a Partner to do anything or refrain from doing anything which would:
>
> 6.3.1 limit the discretion of any Partner to act in its own interests and to conduct its respective operations and activities as it sees fit; or
>
> 6.3.2 limit the discretion of any Partner to pursue its own fundamental mission or impose on any Partner a change in such mission (without such Partner's express approval)."

The partnership is not engaged in any activities which have, or will have, any material impact on the Trust's financial risk rating. The Trust pays a fixed subscription of £150,000 each year towards the running costs of UCL Partners. The financial relationship between the Trust and UCL Partners is set out in a funding agreement. The Trust is not required to guarantee or provide any security or accept any other liability with respect to any borrowings by, or loan facilities made available to, UCL Partners.

The partnership is not engaged in any activities which have, or will have, any material impact on the Trust's governance risk ratings. The partnership provides advice and facilitation, but cannot direct or bind the Trust to specific actions. Any shared service provided by one partner on behalf of other partners will be governed by a service level agreement between the partners directly, and not with UCL partners. The terms of any service level agreement would include provisions to ensure that the Trust continues to meet regulatory governance requirements.

None of the current or proposed activities of the partnership are subject to formal or statutory consultation processes. This is monitored by the Trust's executive group and board of directors.

The Trust's division of Research and Innovation manages the delivery of partnership programmes across the partnership. The Trust's Chief Executive chairs the partnership shared services workstream.

There are no commercial risks or liabilities arising from the activities of the partnership. The partnership does not provide any commercial services. Its consultancy services are funded from partners' subscriptions.

None of the current or proposed activities of the partnership conflict Co-operation and Competition Panel's ten principles and rules.

Both the Trust and UCL Partners maintain registers of interest. Any conflict of interest will be managed in the normal way, through the Standing Orders of the Trust. As noted above, in the event of any conflict of interest, the Trust's interests will take precedence over those of the partnership.

The Members' Council has not yet had its first meeting. Councillors will be given the opportunity to express a view on future plans of the partnership when the Trust has been authorised.

Attachment M

For and on behalf of the Board: _____

Date: _____

Great Ormond Street Hospital for Children NHS Trust

Trust Board 21st December 2011	
Performance Management Strategy and Business Planning Strategy **Submitted on behalf of.** Robert Burns, Deputy Chief Operating Officer	**Paper No: Attachment N** Reviewed by Management Board on 15th December 2011

Aims / summary

Performance management strategy

The Performance Management strategy has been considered within the wider context of the Trust's strategic planning framework and Foundation Trust requirements. Foundation Trust Boards must be able to satisfy themselves that all aspects of the organisations' performance and operations are of an appropriate quality, and ensure that the organisation understands and meets the requirements of regulatory bodies and inspectorates as outlined in their Authorisation. As such, the work described in the strategy sets out the framework that will enable the Board to satisfy itself that it is discharging its responsibility effectively.

The strategy has been updated to reflect changes in Trust governance structures and external performance requirements including, commissioning and contractual standards and Monitor's governance compliance framework.

Business planning strategy

The document sets out the Trust-wide strategy for business planning. The strategy has been considered within the context of the Monitor's Annual Planning requirements for Foundation Trusts. It defines the systems and monitoring process required to be in place to enable the Trust Board and all stakeholders to be assured that its commitment to effective business planning is met.

The strategy has been updated to reflect changes in Trust governance structures and business planning processes.

Action required from the meeting

Management Board to agree strategies

Contribution to the delivery of NHS / Trust strategies and plans

A framework to support the monitoring and delivery of the Trust's strategic plans.

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

As above

Who is accountable for the implementation of the proposal / project

As above

Author and date

Alex Faulkes, Head of Planning and Performance Management

Great Ormond Street Hospital for Children NHS Trust

Performance Management Strategy

December 2011

Contents

Document Control Information

Lead Author	Alex Faulkes	**Author Position**	Head of Planning & Performance Management
Additional Contributor (s)			

Approved By	Robert Burns	**Approver Position**	Deputy Chief Operating Officer
Read By	Management Board		
Ratified by	Management Board / Trust Board		

Document Owner	Alex Faulkes	**Document Owner Position**	Head of Planning & Performance Management

Document Version	2.0	**Replaces Version**	1.0
Updated		**Replaces Version**	

First Introduced	August 2010	**Review Schedule**	Annually
Date approved/ ratified	December 2011	**Next Review**	December 2012

Policy Overview

This policy sets out the Trust-wide strategy for performance management at Great Ormond Street Hospital. The strategy has been considered within the context of the Trusts strategic plan and Foundation Trust application requirements. It defines the systems and monitoring process required to be in place to enable the Trust Board and all stakeholders to be assured that its commitment to effective performance management is met.

Who should know about this policy?

All Great Ormond Street Hospital staff regardless of location.

Performance Management Strategy

1.0 Introduction and background

1.1. Introduction
This document sets out the Performance Management Strategy for Great Ormond Street Hospital NHS Trust (GOSH). The strategy has been considered within the wider context of the Trust's strategic plan and Foundation Trust application requirements.

1.2 Background
The Trust Board is collectively responsible for the full range of operations of their organisation and for all aspects of its performance, including:

- Clinical standards, safety and quality;
- The discharge of service performance obligations, including contractual obligations as defined in the organisation's Authorisation. This includes the requirement to meet nationally defined standards and to deliver nationally specified targets;
- A sound financial position;
- An acceptable physical environment for patient treatment;
- Effective management of all other elements of the overall organisation, including employing sufficient skilled, competent and qualified staff to deliver the full range of obligations;
- Any activities carried out by third parties on behalf of the NHS foundation trust.

Foundation Trust Boards must be able to satisfy themselves that all aspects of the organisations' performance and operations are of an appropriate quality, and ensure that the organisation understands and meets the requirements of regulatory bodies and inspectorates as outlined in their Authorisation. As such, the work described in this strategy sets out the framework that will enable the Board to satisfy itself that it is discharging its responsibility effectively by better understanding:

- Indicators of the current levels of clinical quality and safety, how they compare to those of other providers and what is required to improve performance;
- The leading indicators that suggest there is a risk that a national standard or target may be beached or that clinical quality is not acceptable;
- To recognise quickly when a standard has been breached or that clinical quality is not acceptable;
- What actions to take when indicators are negative or a breach has occurred i.e. develop internal capabilities to address issues quickly and to utilise outside advice and support where required.

2.0 Developing the performance framework

The performance management agenda is driven by the Trust strategic objectives, incorporating national standards and contractual targets set by the Care Quality Commission (CQC), Department of Health (DH), Primary Care Trusts (PCT) Strategic Health Authority (SHA) and Monitor.

This strategy is complementary to the Quality Strategy, Patient and Public Involvement Strategy, Research

Strategy, Clinical Audit policy, Workforce Strategy, and further work on information management and data quality.

Key policies which should be read in conjunction with the Performance Management Strategy include:

- Risk Management Operational Policy
- Risk Management Policy
- Trust Annual Plan
- Assurance Framework
- Education & Training Strategy
- Information Management Strategy

3.0 Key Aims and Objectives

The Performance Management Strategy will:

- Provide a framework to enable close monitoring and delivery of the Trust's objectives.
- Ensure the trust remains compliant with all external and internal national performance standards, targets, regulatory and legislative requirements.
- Improve the performance of all services and directorates;
- Meet the needs of commissioners, patients and users of the service;
- Provide a clear and logical process to improve performance;
- Maximise staff contribution to achieving the best possible performance;
- Improve understanding of performance management across the Trust; and
- Strengthen clinical ownership and responsibility for performance.

The Trust Board is fully committed to this approach and it is a requirement of the strategy that each unit and corporate department within the Trust has a system in place to deliver these aims and objectives. Documentary evidence will be required to assure the Trust Board that the systems described are in place to control and mitigate risks and to learn from the process to improve services for children.

4.0 Performance Management Framework

The performance management process is summarised in daigram 1. As part of the Annual Planning process the Trust undertakes detailed analysis of the internal and external environment and considers its purpose and values within the contexts in which it will be operating during the coming year. This includes: A review of key strategic drivers for change; an analysis of our strengths, weaknesses, opportunities and threats (SWOT); an analysis of the political, economic, social, technical environments (PEST); and a review of our own organisational capacity and capability to manage these effectively in order to identify priority objectives and work streams for the year ahead.

A comprehensive Key Performance Indicator (KPI) report has been developed to monitor progress against priority objectives and to ensure that the Trust continues to meet and remains compliant with the range of external reviews, targets and contractual standards. These include:

- CQC Registration
- Special Reviews and studies
- Annual assessments
- New and existing targets
- Clinical Negligence Scheme for Trusts (CNST)
- Information Governance Toolkit
- Independently Commissioned Patient Surveys
- Commissioning of Quality and Innovation (CQUIN),Quality Improvement, Development and Initiative Schemes (QIDIS) contractual standards
- Quality Account
- Monitor compliance framework and quality governance assessment

A copy of the KPI report is received by Management Board on a monthly basis and at each Trust Board meeting. The report details progress against each indicator with performance assessed against clear thresholds and targets. Benchmarking data is provided where possible. Remedial actions plans, including timescales, to address underperformance are provided against each indicator identified as 'Red' against the thresholds set and described in an accompanying exception report.

'Deep dive' reports will be presented to Management Board on an ad hoc basis where particular performance concerns are identified and require further analysis. These reports are produced by relevant department / service leads.

A Data Quality Committee will proactively consider information issues and concerns and will facilitate the monitoring and auditing of the quality of clinical and operational data capture. The committee reports to the Information Governance Steering Group, which in turn reports to Management Board.

Clinical units will additionally provide unit specific reports to Management Board every month. These reports include progress against a number of zero harm measures including: Infection control, medicines management, finance, risk, and patient access. Statistically relevant change in performance against these measures is additionally reported to Trust Board as part of the KPI exception report.

A separate monitoring group has been established to review the progress of CQUIN. The group is chaired by the Co-Medical Director and attended CQUIN indicator leads. The group meets on a monthly basis to review progress and identify remedial actions where performance is not being achieved before formal reporting to lead commissioners. The group reports to Management Board.

The Trust Board already receives a detailed Finance report at every Board, and this will continue and our lead commissioners will receive separate performance reports on agreed contractual and CQUIN /QIDIS measures.

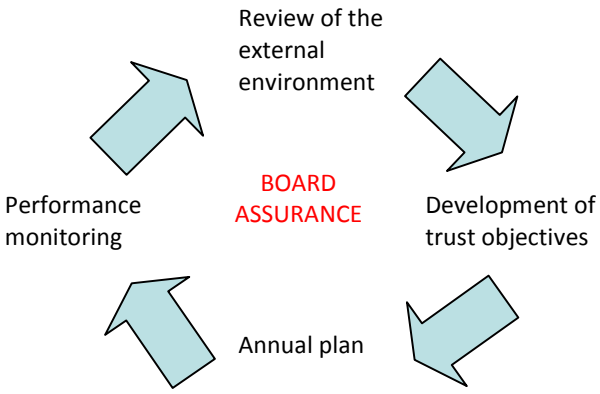


Diagram 1 Summary of performance management process

Clinical Units will develop local Annual Plans, detailing how they will meet the Trust objectives. Progress against plans together with a review of unit performance against key internal and external standards and targets are monitored through Quarterly Strategic Performance Review meetings. The meetings are attended by Clinical Unit leads, Executive Team members and Heads of Department.

A number of key themes have additionally been identified to ensure that performance management is aligned and robust governance arrangements are promoted across Clinical Unit and Trust Board meetings. These include:
- Transformation improvement plans
- Risk management
- Key performance indicators
- Safety
- Finance and activity
- Cash releasing efficiency schemes

The table below outlines how each theme is aligned and monitored across Board meetings and identifies information provider leads and where applicable links to information sources.

	Item	Clinical Unit Management Board	Management Board	Trust Board
1	**Transformation improvement plans**	Progress update against Transformation improvement plans	Ad hoc reports as sent by Transformation Board for approval and information	Rolling alternate programme of Transformation improvement, safety and outcome project progress reports
	Information provider lead and link to data source	Head of Quality, Safety and Transformation http://gosweb/transformation/cms/news.asp?id=61	Head of Quality, Safety and Transformation	Head of Quality, Safety and Transformation
2	**Risk management**	Full Clinical Unit risk register	Monthly Trust-wide high level risk register Top 3 Clinical Unit risks identified in monthly Clinical Unit management report	Bi-annual Trust-wide high level risk register (Also presented to CGC and Audit Committee every quarter) Quarterly full Board Assurance Framework

				incorporating all Trust high level risks
	Information provider lead and link to data source	Head of Quality, Safety and Transformation Datix database	Head of Quality, Safety and Transformation	Head of Quality, Safety and Transformation
3	**KPI**	Clinical Unit level KPI report	Monthly full trust-wide KPI report	Monthly full trust-wide KPI report
	Information provider lead and link to data source	Head of Planning & Performance Management		
4	**Clinical Unit safety report**	Clinical Unit report as presented to Management Board	Report presented monthly by Clinical Unit.	Performance exceptions and significant statistical variation reported through monthly KPI report
	Information provider lead and link to data source	Head of Quality, Safety and Transformation http://gosweb/transformation/information/apps/flow/ZHStart.aspx	Head of Quality, Safety and Transformation	Head of Quality, Safety and Transformation
5	**Finance and activity report**	Monthly finance and activity report	Monthly finance and activity report	Monthly finance and activity report
	Information provider lead and link to data source	Head of Management Accounts / Head of Information Services	Head of Management Accounts / Head of Information Services	Head of Management Accounts / Head of Information Services
6	**CRES**	CRES programme update (2011/12 & 2012/13)	Monthly CRES programme update (From December 2012)	Monthly CRES programme update (From December 2012)
	Information provider lead and link to data source	CRES Project Manager O:\CRES Project	CRES Project Manager	CRES Project Manager

Appendices 1 to 5 details Trust reporting requirements against national standards, internal indicators, agreed CQUIN measures, commissioning contractual standards, Monitor's governance compliance framework and quality governance assessment and CQC Registration.

The performance framework will continue to develop to reflect changes to external policy and priorities throughout the year.

5.0 Success Criteria

- Performance is measured, reported and targeted at all levels in the organisation.
- The Board will have access to the most recent sources of performance data, allowing them to make informed business decisions.
- Staff have access to the most recent sources of performance data, allowing them to make informed business decisions.
- Strategic organisational targets are being achieved and regulatory and legislative requirements are being met.

6.0 Accountability framework

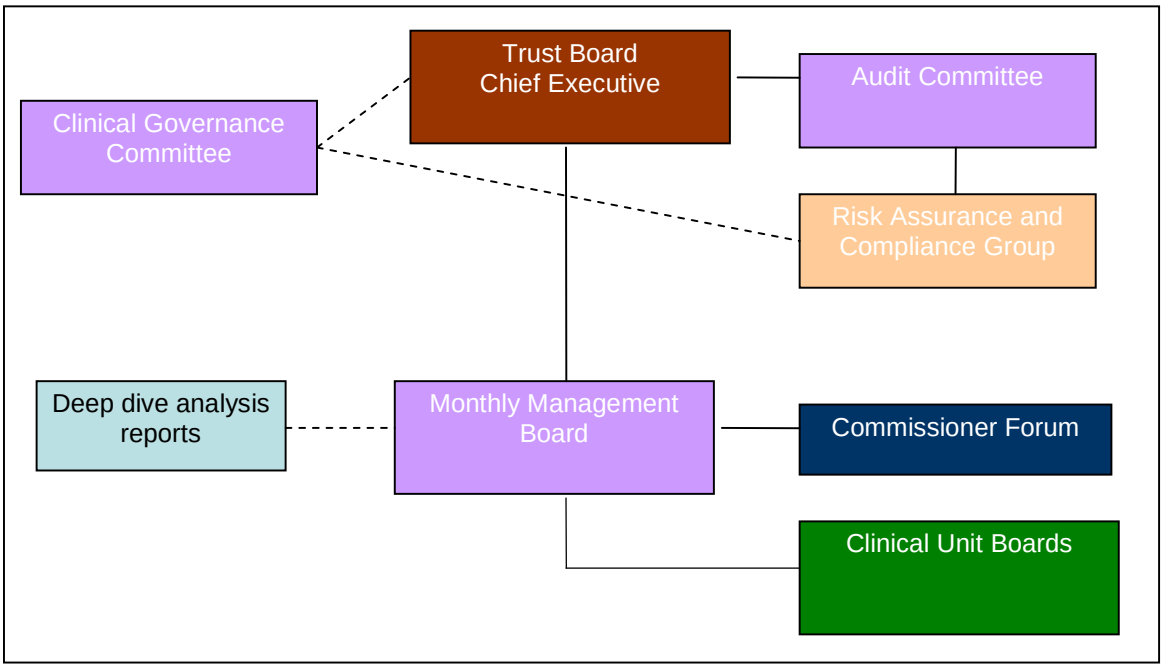


Diagram 3 Performance management accountability framework

- Trust Board

The Trust Board has corporate responsibility for the Trust's performance.

- Management Board

The Trust has an established Management Board. The Chief Executive, all the Executive Directors, General Managers, Clinical Unit Chairs and named Heads of Department/Service attend this Committee. The Management Board holds an operational overview of a wide range of internal and external performance indicators. The Management Board will approve the monthly KPI report and identify remedial actions to address areas of poor performance

- Audit Committee and Clinical Governance Committee

These committees provide assurance to the Trust Board that systems and processes are working effectively and that corporate and clinical risks are being mitigated or removed.

- Risk Assurance and Compliance Group

The purpose of the Group is to ensure that the Trust complies with all requirements of the Assurance Framework and all requirements of the Health and Social Care Act 2008 (Registration Requirements). The group will additionally monitor risks to meeting Trust objectives. The group reports to the Audit Committee.

- Chief Executive Office

The Chief Executive Officer has overall responsibility for leadership and management of the Trust.

- Chief Operating Officer

The Chief Operating Officer has Board-level responsibility for operational performance management. The post holder is instrumental in ensuring clinical and managerial engagement and leadership in driving

change.

Medical Directors
The Medical Directors are responsible for patient and staff safety and clinical quality through accurately measuring the hospital's performance, and continually striving to improve standards and public health within the Trust.

- Chief Nurse and Director of Education

The Chief Nurse is responsible for supporting frontline teams ensuring staff reach their full potential in order to best meet the needs of the children and their families. This will include monitoring and reporting of identified key standards.

- Head of Planning and Performance Management

The Head of Planning & Performance Management provides leadership on and is responsible for the definition of performance criteria, and monitoring performance and its improvement.

- General Managers and Clinical unit Chairs

General Managers and Clinical Unit Chairs are responsible for enabling their Business Teams to have the capacity to participate fully and meaningfully with the Trust-wide agenda.

- Finance Department

The Finance Department is responsible for the production of financial data, which allows the Trust to assess financial position and progress against objectives.

- Workforce Planning & Development Department

The Workforce Planning & Development Department is responsible for the production of workforce related data, which allows the Trust to reach reliable conclusions about the staff it employs.

- Education & Training Department.

The department provides staff with education and training resources and will support staff through the appraisal process.

- Individuals

All members of staff are responsible for the quality of the data they enter into Trust-wide information systems and will contribute effectively to the objectives of their department.

- Monitoring of Performance Management

Reporting will be included in existing reporting schedules of Trust governance assurance and governance committees.

The Trust will use the established management structure and forums to ensure that implementation of the strategy is given a high priority within the organisation and that responsibility and accountability for taking action is clearly identified.

This strategy will be reviewed each year to ensure it remains in line with national guidance.

7.0 Appendices **Page**

Appendix 1 CQUIN measures 2011/12

The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation. The framework aims to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion. Each provider on a national standard contract is entitled to earn 1.5% of contract value subject to achieving goals in a CQUIN scheme. The agreed CQUIN measures for 2011/12 are detailed below.

CQUIN measure		Indicator Splits	Financial Value	Contract %
Overall			2,020,790	1.500
Patient Experience: Undertake further inpatient and outpatient surveys and achieve improvement in key areas most notably communication with parents and patients during admission to hospital on issues such as medication side effects, patients fears and concerns and decision making	1	100%	202,080	0.150
Composite Score on Ipsos MORI Survey (Local Q's):	1a	10%	20,208	0.015
Implementation Plan and Monitoring:	1b	30%	60,624	0.045
Composite Score on Ipsos MORI Survey (National Q'S)	1c	50%	101,040	0.075
Qualitative Benchmarking	1d	10%	20,208	0.015
Surgical Site Infections: Reduction of current rate of surgical site infection in 4 specialties and the establishment of surveillance in 5 new specialties	2	100%	363,742	0.270
Reduction or maintenance of infection rate in 4 specialties	2a	50%	181,871	0.135
Establish Implementation of 5 new specialties	2b	50%	181,871	0.135
CVC Infections: Further reduction in the rate of central venous catheter (CVC) infections from latest reported rate of 2.8/1000 line days	3	100%	363,742	0.270
Maintain CVC rate at 2010-11 Levels	3a	50%	181,871	0.135
Improve CVC Infection Rate	3b	50%	181,871	1.135
Nutrition Screening: To implement and evaluate GOSH nutrition flowchart; monitor patient outcomes using Z weight scores; full audit of height measurement	4	100%	363,742	0.270
Implement GOSH Flowchart	4a	40%	145,497	0.108
Monitor patient outcomes using Z weight scores	4b	20%	72,749	0.054
Full audit of height measurement	4c	40%	145,497	0.108
Child protection: Strengthen the quality of the annual audit of child protection cases; achieve improvement in levels of group supervision for staff; increase the % of staff achieving level 3 training	5	100%	363,742	0.270

Record Keeping	5a	20%	72,749	0.054
Supervision	5b	60%	218,244	0.160
Level 3 Training	5c	20%	72,749	0.054
Paediatric Trigger Tool: Continue to review 20 sets of case notes per month and undertake a peer review of the implementation of the tool	6	100%	363,742	0.270
Review process and continue to undertake tool	6a	100%	363,742	0.270
TOTALS			2,020,790	1.500

London Specialised Commissioning Group

Paediatric Haemophilia	7			
Optimal dosage of prophylactic clotting factor for children with haemophilia A and B	7a		199, 662	
Paediatric and Cardiac Intensive Care	8			
Reducing the % of unplanned readmissions into Intensive Care within 48 hours of the initial admission and reducing the number of accidental exubations	8a		199, 662	
Paediatric BMT and Paediatric Haematological Oncology	9			
Reduce prescribing errors in haematology and oncology through improved training, improved patient information and drug pre-preparation. Also to map the usage of antifungal drugs and costs from Allogeneic BMT patients	9a		199, 662	

Appendix 2 Contract Management Performance Indicators

In addition to the CQUIN measures we have agreed a number of contract performance quality indicators with our commissioners to support the delivery of our national contract. These metrics are based on a number of national and locally defined standards and indicators that cover the key areas of Quality, Nationally Specified Events and Never Events. The agreed metrics are detailed below.

Schedule 3 Part 4A: Quality Requirements

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
HQU01	Methicillin resistant Staphylococcus Aureus (MRSA) bacteraemia	Calculation of threshold as per VSA01	Review of monthly report under clause 29.1	Contract Management Clause 32
	Methicillin sensitive Staphylococcus Aureus (MSSA)	>0	Review of monthly report under clause 29.1	All MSSA must be reported
	E. coli bloodstream infections	>0	Review of monthly report under clause 29.1	All E.Coli must be reported
HQU05,06,07	RTT waits (95th percentile measures) - admitted 95th percentile - non-admitted 95th percentile - incomplete 95th percentile	 23 weeks 18.3 weeks 28 weeks	RTT consultant-led waiting times data collection	Contract Management Clause 32
SQU24,25,26	RTT (Median wait measures) Median time waited for admitted and non-admitted Patients completing an RTT pathway, and for incomplete pathways	 Admitted 11.1 Non-Admitted 6.6 Incomplete 7.2	Unify Returns and RTT consultant led waiting times data collection	Contract Management Clause 32
	Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission	0.80%	Number of patients where HRG4 is cancelled due to hospital/unkown reasons SUS	Non payment for any costs incurred by the Provider
	Provider failure to ensure that "sufficient appointment slots" are made available on the Choose and Book system	0.04%	NHS Direct Weekly Report	Contract Management Clause 32
	Breach of clause 31.5 (re cancelled operations)	>0	Quarterly Monitoring Cancelled Operations Data set	Provider must pay for the relevant Patient's treatment by another provider of the Patient's choice

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	Delayed transfers of care to be maintained at a minimal level	3% of acute beds	SITREPs	Contract Management Clause 32
	Percentage of SUS data altered in period between (a) 5 Operational Days after month-end, and (b) the Inclusion Point for the month in question	2%	Monthly Performance Report	Contract Management Clause 32
SQU06	Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	80%		Contract Management Clause 32

Schedule 3 Part 4B: Nationally Specified Events

Technical Guidance Reference	Nationally Specified Event	Threshold	Method of Measurement	Consequence per breach
	Percentage of Patients seen within 18 weeks across all speciality groups for admitted and non-admitted pathways - Supporting measures: Number of diagnostic waits > 6 weeks - Percentage of Patients seen within 18 weeks for direct access audiology treatment	As set out in Schedule 3 Part 1, paragraph 8	Review of monthly report under clause 29.1	As set out in Schedule 3 Part 1, paragraph 8
HQU02	Rates of Clostridium difficile	As set out in Schedule 3 Part 1, paragraph 9	Review of monthly report under clause 29.1	As set out in Schedule 3 Part 1, paragraph 9 and where there have been fewer than 50 cases (so that the financial adjustment does not apply) the Commissioners' remedy shall be to follow the Contract Management process set out in clause 32
SQU05_03, 04,05	Proportion of Patients receiving first definitive treatment for cancer within 62 days of - an urgent GP referral for suspected cancer - referral from an NHS Cancer Screening Service - following a consultant's decision to upgrade the Patient priority	Operating standard of 85% Operating standard of 90% As outlined in cancer specific metrics	Review of monthly Service Quality Performance Report	2% of the Actual Outturn Value of the service line revenue
SQU05_06	Percentage of Patients receiving first definitive treatment within one month of a cancer diagnosis	Operating standard of 96%	Review of monthly Service Quality Performance Report	2% of the Actual Outturn Value of the service line revenue
SQU05_07	Proportion of Patients waiting no more than 31	Operating standard of 94%	Review of monthly Service Quality Performance Report	2% of the Actual Outturn Value of

Technical Guidance Reference	Nationally Specified Event	Threshold	Method of Measurement	Consequence per breach
	days for second or subsequent cancer treatment - surgery			the service line revenue
SQU05_08	Proportion of Patients waiting no more than 31 days for second or subsequent cancer treatment - drug treatments	Operating standard of 98%	Review of monthly Service Quality Performance Report	2% of the Actual Outturn Value of the service line revenue
SQU05_09	Proportion of Patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	Operating standard of 94%	Review of monthly Service Quality Performance Report	2% of the Actual Outturn Value of the service line revenue
HQU08	Sleeping Accommodation Breach	> 0	Verification of the monthly data provided pursuant to Schedule 5 Part 1 , in accordance with Professional Letter	Retention of £250 per day per Patient affected as may be varied pursuant to Guidance
	Failure to publish a Declaration of Compliance or Declaration of Non-Compliance pursuant to clause 4.24	0	Publication (with easy access for the public) of the Declaration of Compliance/Declaration of Non-Compliance on Provider's website	Retention of up to 1% of all monthly sums payable under clause 7 (*Prices and Payment*) for each month or part month until either a Declaration of Compliance or Declaration of Non-Compliance is published
	Publishing a Declaration of Non-Compliance pursuant to clause 4.24	0	Publishing a Declaration of Non-Compliance	Retention of up to 1% of all monthly sums payable under clause 7 (*Prices and Payment*) in the month following publication

Schedule 3 Part 4C: Never Events

Never Events	Threshold	Method of Measurement	Never Event Consequence (per occurrence)
Wrong site surgery	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Wrong implant/prosthesis	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Retained foreign object post-operation	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Wrongly prepared high-risk injectable medication	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Maladministration of potassium-containing solutions	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Wrong route administration of chemotherapy	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Wrong route administration of oral/enteral treatment	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Intravenous administration of epidural medication	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Maladministration of Insulin	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or

Never Events	Threshold	Method of Measurement	Never Event Consequence (per occurrence)
		Report	care
Overdose of midazolam during conscious sedation	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Opioid overdose of an opioid-naïve Patient	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Inappropriate administration of daily oral methotrexate	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Suicide using non-collapsible rails	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Falls from unrestricted windows	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Entrapment in bedrails	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Transfusion of ABO-incompatible blood components	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Transplantation of ABO or HLA-incompatible organs	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Misplaced naso- or oro-gastric tubes	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care

Never Events	Threshold	Method of Measurement	Never Event Consequence (per occurrence)
Wrong gas administered	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Failure to monitor and respond to oxygen saturation	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Air embolism	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Misidentification of Patients	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Severe scalding of Patients	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care

Appendix 3 Monitor compliance framework

For governance risk, Monitor uses a graduated system: green (lowest risk); amber-green; amber-red; and red (highest risk), derived from a number of factors including: performance against national targets and indicators; Care Quality Commission registration and ongoing performance against registration requirements (see appendix 4); and provision of mandatory goods and services.

The table below sets out the national targets and indicators and associated weighting scores that support the governance risk score.

Targets - weighted 1.0 (national requirements)		Thresholds	Weighting	Monitoring period	Area
1.	Clostridium difficile – meeting the Clostridium difficile objective	9	1	Quarterly	Safety
2.	MRSA - meeting the MRSA objective	0	1	Quarterly	Safety
3.	All cancers: 31-day wait for second or subsequent treatment comprising **either:**		1	Quarterly	Quality
	Surgery	94%			
	anti cancer drug treatments	98%			
	radiotherapy (from 1 Jan 2011)	94%			
4.	All cancers: 62-day wait for first treatment comprising **either:**		1	Quarterly	Quality
	From urgent GP referral to treatment	85%			
	From consultant screening service referral	98%			
5.	All cancers: 31 day wait from diagnosis to first treatment	96%	0.5	Quarterly	Quality
6.	Referral to treatment waiting times – admitted (95th percentile)	23 weeks	1.0	Quarterly	Patient Experience
7.	Referral to treatment waiting times – non admitted (95th percentile)	18.3 weeks	1.0	Quarterly	Patient Experience
8.	Stroke indicator	TBC	0.5	Quarterly	Quality
9.	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	0.5	Quarterly	Patient Experience

Monitor rating matrix

Green	a score of less than 1.0
Amber-green	a score from 1.0 to 1.9
Amber-red	a score from 2.0 to 3.9
Red	a score of 4.0 or more

Appendix 4 Monitor Quality Governance Assessment

Strategy	Capabilities and Culture	Processes and Structures	Measurement
1A: Does Quality drive the Trusts' strategy? **Proposed RAG rating:**	2A: Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? **Proposed RAG rating:**	3A: Are there clear roles and accountabilities in relation to quality governance? **Proposed RAG rating:**	4A: Is appropriate quality information being analysed and challenged? **Proposed RAG rating:**
1B: Is the Board sufficiently aware of the potential risks to quality? **Proposed RAG rating:**	2B: Does the Board promote a quality focused culture throughout the Trust? **Proposed RAG rating:**	3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? **Proposed RAG rating:**	4B: Is the Board assured of the robustness of the quality information **Proposed RAG rating:**
		3C: Does the Board actively engage patients, staff and stakeholders on quality? **Proposed RAG rating:**	4C: Is quality information used effectively? **Proposed RAG rating:**

Appendix 5 CQC Registration compliance framework

As the regulator of health and adult social care in England, the CQC make sure that the care people receive meets essential standards of quality and safety. The registration system for health and adult social care makes sure that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights. The system is focused on outcomes rather than systems and processes, and places the views and experiences of people who use services at its centre.

The CQC will continuously monitor compliance with essential standards as part of a new, more dynamic, responsive and robust system of regulation. The CQC's assessors and inspectors will frequently review all available information and intelligence they hold about a provider. They will seek information from patients and public representative groups, and from organisations such as other regulators and the National Patient Safety Agency. The CQC essential standards are outlined below.

Section
Section 1: Involvement and information
OUTCOME 1 - Respecting and involving people who use services (Regulation 17RA)
1A - Ensure personalised care through involvement
1B - Respect, listening and involvement
1C - Manage risk through effective procedures about involvement
1D - Consider relevant guidance
1E - Promote rights and choices through information provision
1F - Promote independence
1G - Human rights and diversity are respected
1H - Provided with information about the aims, purpose of the service and facilities available
1I - Supported to discuss needs or concerns re equality, diversity and human rights
1J- Involved in decision making re service delivery and development
1K -Outcome of diagnostics and assessments are discussed with them
OUTCOME 2 : Consent to Care and Treatment (Regulation 18RA)
2A Procedures to obtain consent
2B Consent process
2C Competence and capability to give consent
2D Consent guidance
2E Information on options
2H Consent decisions and directions
OUTCOME 3: Fees (Regulation 19)
3A Payment for individuals by those acting on their behalf(Embassies, Insurers)
3C Payment by individuals (self pay)
3D Consideration of relevant guidance
Section 2: Personalised care, treatment and support
OUTCOME 4 - Care and welfare of people who use services (Regulation 9 RA)
4A Individual needs established
4B Learn from experience, external guidance and reviews
4C Discharge planning and contacts
4D Identifying deterioration
4E Provision of information to support decision making
4G Length of stay and any restrictions
4H Appropriate use and analysis of diagnostic tests
4I Specific needs of children
4K End of life care
4L Risk of harm to self or others
4M Response to safety alerts and recommendations

Section
4W Pre admission visits/pre assessment
OUTCOME 5 - Meeting nutritional needs (Regulation 14RA)
5A Nutrition assessment, choice and access
5B Nutrition assessment and monitoring
5C Choice and availability
5D Management of fasting
5E Access to breastfeeding support
OUTCOME 6 - Cooperating with other providers (Regulation 24RA)
6A Co-ordination of care
6B Transfer of information
6C Multi agency working
6D Major Incident and contingency planning
6E Information governance
6F Management of concerns
6G Transparency of information used to deliver care
6H Information sharing
6I Access to additional sources of support
6M Transfer to adult services
Section 3: Safeguarding and safety
OUTCOME 7 - Safeguarding vulnerable people who use services (Regulation 11RA)
7A Safeguarding
7B Collaborative working
7D Maximise choice, recognise accountability
7E Know how to take action
7F Trained in the use of restraint
7G Behaviour management
7H Monitoring of restraint use
7I Management of alleged or actual abuse
7J Child Protection training
7K Management of safeguarding information
7P Rapid tranquilisation
OUTCOME 8 - Cleanliness and Infection Control (Hygiene Code) (Regulation 12RA)
HC 1 Systems to manage and monitor prevention and control
HC 2 Maintain a clean environment
HC 3 Provide accurate information to service users and their visitors
HC4 Provision of information to those providing further support
HC 5 Identification and treatment
HC 6 Staff involvement in prevention and control of infection
HC 7 Provision of isolation facilities
HC 8 Laboratory access
HC 9 Infection control policies in place and monitored
HC 10 Staff monitoring, protection from exposure and training
OUTCOME 9 - Management of medicines (Regulation 13RA)
9A Medication is prescribed and administered appropriately
9B Policies and procedures are followed
9C Takes account of relevant guidance
9D Access to information for users and staff
9G Medication policy, availability and monitoring
9H Resuscitation medication
9J Management of alerts from NPSA
OUTCOME 10 - Safety and suitability of premises (Regulation 15RA)
10A Design and layout

Section
10B Medical gases, Waste licences, COSHH, change of use of premises
10C Site Security
10D Maintenance , risk assessment, management of waste, design process, management of regulated activities, relevant guidance
10E Emergency planning
10 F DDA compliance, patient facilities toilets, breastfeeding, call systems, private areas
10G Compliance with statutory requirements, manufacturers instructions, fire evacuation procedures
10H Business continuity for utility failures, site decoration programme, Legionella control
10 I Play and recreational space, facilities for carers to stay
10J Management of radionuclides
10 K Staff facilities when on call
OUTCOME 11 Safety, availability, suitability of Equipment (Regulation 16RA)
11A Installed, maintained and stored correctly
11B Assessed for suitability of use
11C Staff and users are trained to use it
11D Equipment policy is in place
11E Management reflects current guidance
11F Used and maintained appropriately
11H Availability of resuscitation equipment
Section 4: Suitability of staffing
OUTCOME 12 -Requirements relating to workers (Regulation 21)
12A Recruitment
12B Qualifications, experience and personal development
12C Employment checks and staff support
OUTCOME 13 - Staffing (Regulation 22RA)
13 A Workforce planning
OUTCOME 14 Supporting workers (Regulation 23RA)
14 A Induction and training
14 B Paediatric specific education
14C Appraisal and supervision of staff
14D Policies and procedures in place to reduce risks to staff
14G Maintain professional competence
14H Qualified paediatric registered staff
14J Maintenance and monitoring of registration
Section 5: Quality and management
OUTCOME 15 - Statement of purpose (Regulation 12)
15A Regulated activities
OUTCOME 16 - Assessing and monitoring the quality of service provision (Regulation 10)
16A Process to monitor quality of service provision
16B Risk management process in place
16C Learning from experience
16D Decision making process
16E Continuous quality improvement system
OUTCOME 17 - Complaints (Regulation 19RA)
17 A Complaints policy in place and followed
17B-D Complaints co-ordination
17E Complaints process
OUTCOME 18 - Notification of a death of a person that uses services (Regulation 16)
18A-F Death of a service user
OUTCOME 19 - Death or absence under the Mental Health Act (Regulation 17)
19A-J Death or absence under the Mental Health Act

Section
OUTCOME 20 - Notification of other incidents (Regulation 18)
20 A-E Notification of incidents to the NPSA
20 F Incidents affecting any person, involving the police or compromising service delivery
20 G Information required
20 H Injuries to service users
20 I Incidents of harm, permanent damage
20M Where service delivery is affected by staffing, utility or other operational failure
20N-Q Other incidents e.g. abuse, allegation
OUTCOME 21 - Records (Regulation 20RA)
21 A Maintenance, storage, retention of clinical and corporate records
21B Disposal and archiving
Section 6: Suitability of management
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Great Ormond Street Hospital for Children NHS Trust

Business Planning Strategy

December 2011

Contents

1. Document Control Information

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2. Policy Overview

This policy sets out the Trust-wide strategy for Business Planning at Great Ormond Street Hospital (GOSH). The strategy has been considered within the context of the Monitor's[1] Annual Planning requirements for Foundation Trusts. It defines the systems and monitoring process required to be in place to enable the Trust Board and all stakeholders to be assured that its commitment to effective business planning is met.

3. Who should know about this policy?

All Great Ormond Street Hospital staff regardless of location.

[1] *Monitor:* Independent regulator of Foundation Trusts.

4. Business Planning Strategy

4.1 Introduction and background

1.1. Introduction
This document provides the Business Planning Strategy for GOSH. The strategy has been considered within the context of Monitor's Annual Planning requirements for Foundation Trusts.

1.2 Background
For the Annual Plan Review[2], Monitor requires each NHS Foundation Trust to submit a forward looking plan ("annual plan") including its main strategic priorities, forecast financial performance and details of any major risks to compliance with its Authorisation and how these will be addressed.

The annual planning framework set out by Monitor aims to:

- Encourage high quality planning by NHS Foundation Trusts, including engagement across the Trust and with key stakeholders
- Identify potential risks to the Authorisation – financial, clinical and governance, and proposed actions by Boards to protect the quality of healthcare provision
- Identify risks of poor planning
- Provide a reliable basis by which to assess and compare NHS Foundation Trust performance in-year with plans
- Publish forward plans for all NHS Foundation Trusts, which is a statutory requirement
- Provide relevant benchmark information for the FT sector.

The table below sets out the main elements of Monitor's Annual Planning requirements as described in the Compliance Framework. NHS Foundation Trusts are required to make these submissions as part of their annual plans. Annual plans are required to be submitted to Monitor by 31 May.

Element		**Description**
Commentary	Past	▪ Strategic overview of past year's performance ▪ Review of past year's financial performance in relation to plan (including income and expenditure and cash flow statements and the reasoning behind any exceptional income and expenditure items ▪ Review of other major issues (financial or non financial) that arose in the year
	Future	Strategic overview of: ▪ Changes to forecasts and plans for service development (including revenue plans and mandatory services) ▪ Changes to operating resources required (including pay and non-pay costs; and any other changes to cost improvement programmes ▪ Changes to investment and disposal strategy, including any investments that may affect the NHS Foundation Trust financial risk rating ▪ Changes to financing and working capital forecasts or plans ▪ Any unforeseen cyclicality in income/cost/capex in the in-year

[2] Annual plan review process. Monitor Compliance Framework 2010/11, Risk and reporting statutory requirements, page 20.

		forecasts
	Risk analysis	Commentary on expected risk ratings, and identification, analysis and mitigation of significant (e.g. top three to five) risks in each of the following categories: ▪ Finance ▪ Governance ▪ Mandatory services (Schedules 2 & 3 of the Authorisation) ▪ Any other aspect that could lead to non compliance with the authorisation
	Membership report	▪ Explanation the constituencies and commentary on changes in membership numbers, with reference to the table of analysis of membership size and movements ▪ Details of the election turnout rates by each constituency ▪ Plans to develop a representative membership, by reference to the table of analysis of current membership ▪ Explanation of the membership plan for the future
Board statements		The Board is required to confirm a number of self-certification statements against: ▪ Clinical quality ▪ Service performance ▪ Risk management ▪ Compliance with Authorisation ▪ Board roles, structures and capacity
Financial projections		Submit financial projections including: ▪ Income statement ▪ Balance sheet ▪ Cash flow statement

5. Developing the business planning framework.

This strategy is complementary to the Performance Strategy, Quality Strategy, Patient and Public Involvement Strategy, Research Strategy, Clinical Audit policy and Workforce Strategy.

Key policies which should be read in conjunction with the Business Planning Strategy include:

- Performance Strategy
- Risk Management Strategy
- Risk Management Operational Policy
- Trust Annual Plan
- Assurance Framework
- Education & Training Strategy

6. Aims and objectives

This strategy sets out Monitor's Foundation Trust annual planning requirements and focuses on the framework for developing Trust-wide strategic priorities, service growth and service development proposals.

The Business Planning Strategy will:

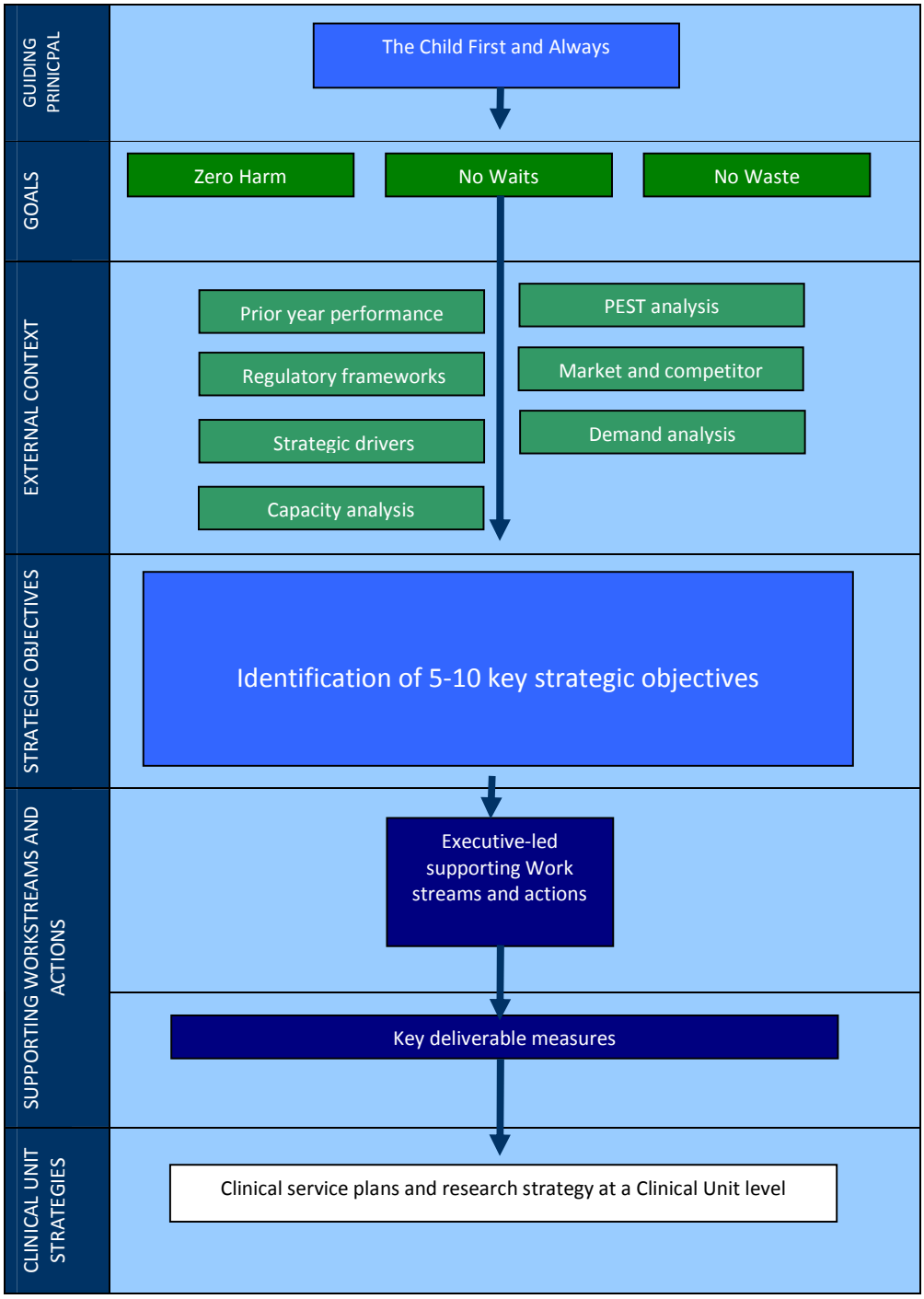
- Provide a framework to enable the development, close monitoring and delivery of the Trust's strategic objectives.
- Improve the business planning function of all services and directorates;

- Provide a clear and logical process to improve business planning;
- Maximise staff contribution to achieving the best possible and comprehensive business plans;
- Improve understanding of business planning across the Trust; and
- Strengthen clinical ownership and responsibility for business planning.

The Trust Board is fully committed to this approach and it is a requirement of the strategy that each unit and corporate department within the Trust has a system in place to deliver these aims and objectives. Documentary evidence will be required to assure the Trust Board that the systems described are in place to control and mitigate risks and to learn from the process to improve services for children.

The following section describes the process by which the organisation will consider the development of its strategic objectives and priorities.

7. Developing strategic objectives



The diagram summaries the process the organisation has adopted to identify its 3 year strategic objectives and the supporting priority workstreams and actions to deliver them. Each year the Trust will consider its purpose and values and the internal and external contexts in which it will be operating during the coming year. The organisation will identify drivers, opportunities and threats and review the organisational

capacity and capability to manage these effectively.

The Trust will review the strategic objectives to ensure that they remain fit for purpose going forward into the new financial year and will identify a series of key deliverable outcome measures in order to ensure that the strategic elements of the plans are achieved.

The planning and Performance Department, in conjunction with Clinical Units and corporate departments, will undertake a series of reviews and analysis in relation to each of the above areas. This includes:

- Analysing the external environment
  - Political, Economical, Strategic, Technological, Legal & Environment (PESTLE) Analysis
  - Analysis of regulatory requirements and policy
  - Drivers for change
- Market and competitor analysis
- Strategic drivers
- Review and forecast of activity and demand
- Review of our internal capacity

7.1 Analysing the External Environment

7.1.1 PESTLE Analysis
To help make decisions and to plan for future events, the organisation will need to understand the wider 'meso-economic' and 'macro-economic' environments in which they operate. (The meso-economic environment is the one in which we operate and have limited influence or impact, the macro-environment includes all factors that influence the organisation but are out of its direct control). By understanding these environments, it is possible to take the advantage to maximise the opportunities and minimise the threats to the organisation. Conducting a strategic analysis entails scanning these economic environments to detect and understand the broad, long term trends.

7.1.2 Regulatory Frameworks
In developing our objectives the Trust will additionally assess key regulatory frameworks and legislation to ensure that it is in a position to respond to and continue to meet national requirements. Key regulation that the Trust will need to continue to monitor includes:

- Care Quality Commission

All health and adult social care providers who provide regulated activities were required by law to be registered with the Care quality Commission. To remain registered providers must show that they are meeting new essential standards of quality and safety across all of the regulated activities they provide. The new system will make sure that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights. The system is focused on outcomes, rather than systems and processes, and places the views and experience of people who use services at the centre.

- Monitor Compliance Framework

Monitor first published the Compliance Framework on 31 March 2005. The framework has since been updated to incorporate additions or amendments which came out of consultation exercises on areas such as clinical quality, service-line reporting, amendments to the financial risk ratings and to accommodate mental health Trusts becoming NHS Foundation Trusts.

- NHS Operating Framework

The Operating Framework for the NHS sets out the priorities for the year ahead to enable organisations to begin their planning. The framework includes national performance indicators and standards.

- The Commissioning for Quality and Innovation CQUIN / Contract monitoring

The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation. The framework aims to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion. Each provider on a national standard contract is entitled to earn 1.5% of contract value subject to achieving goals in a CQUIN scheme

- Liberating the NHS: White paper

The White Paper sets out the Government's ambitious agenda for the NHS for the next five years and seeks views on the policies included within it.

7.2 Market and Competitor Analysis

Competitors

The organisation will work with Clinical Unit leads to identify key areas of growth and review our competitors within these markets. For example, this may include a review of all designated providers as eligible hospitals for specialist children's top up tariffs located within the North London and commuter belt market.

Porter's Five Forces

The organisation will additionally use Porter's Five Forces analysis to measure the competitive intensity of the market. This analysis examines the potential influence that external factors could have upon the services we provide. Used along side our Strengths, Weaknesses, Opportunities & Threats (SWOT) analysis it reveals the areas and competitors that we must consider when devising our service strategy.

Strategic drivers

The organisation will review key strategic drivers that will directly impact on the service or that will provide an opportunity to strengthen and grow our existing services. Examples include national service development programmes such as The Safe and Sustainable Children's Cardiac Surgery Services Programme and the Safe and Sustainable Children's Neurosurgical Services Review.

7.3 Review of capacity

7.3.1 SWOT Analysis

The organisation will undertake SWOT analysis of the internal and external environment - providing information that is helpful in matching the organisation's resources and capabilities to the competitive environment in which it operates. As such, it is instrumental in strategy formulation and selection. As part of the business planning process the Trust will undertake a SWOT analysis of several key areas including:

- Brand
- Clinical services
- Staff
- Referrers
- Research
- Education
- Resources

7.3.2 CIMA strategic scorecard ™

Following the development of the Trust strategic direction and key strategic objectives, and in order to help the Trust Board to fulfill their responsibility to contribute and challenge the strategy effectively, the organisation will adopt the CIMA strategic scorecard™. The scorecard will provide the Board with a monthly assessment of strategic issues by regularly summarising the key aspects of the environment in which the organisation is operating to ensure that the Board is aware of the ongoing changing competitor,

economic and other factors; and identifying the (key) strategic options that could have material impact on the strategic direction of the organisation.

The objectives of the scorecard are to:

- Assist the Board, in particular the non-executive directors, in the oversight of an organisation's strategic process. In effect, it gives the Board the big picture.
- Provide an integrated and dynamic framework for dealing with strategy at Board level that focuses on the major strategic issues facing the organisation and ensures that the strategy is discussed at Board level on a regular basis.
- Provide strategic information in a consistent and summarised format to help directors to obtain sufficient grasp of the material so that they can offer constructive, informed input.
- Assist the Board in dealing with strategic choice and transformational change and the attendant risks.
- Provide assurance to the Board in relation to the organisation's strategic position and progress.
- Assist the Board in identifying key points at which it needs to take decisions.

Although the scorecard is primarily aimed at Board level for use as an agenda item at Board meetings, it offers considerable benefits to the organisation's management:

- The discipline of having to prepare and update the scorecard helps management to keep its focus on the key strategic issues.
- It facilitates discussion within the management team and helps the team to refine its proposals prior to exposure to the Board.
- It can help to identify gaps in knowledge and analysis and can improve the quality of information presented to the Board.
- Because the scorecard improves the quality of the Board's contribution, this will lead to more constructive engagement with management. The strategic process and content are thus enriched. This makes for better governance and performance

The scorecard uses four dimensions to assess the strategic position and identify strategic options and risks. These are summarised in the diagram below.

CIMA Strategic Scorecard

Strategic position This focuses on information that is required to assess the organisation's current and likely future position. It covers externally focused information such as economic and market developments and market share as well as internal issues such as competences and resources.	**Strategic options** Having set the scene with relevant background and information, the focus of the scorecard shifts towards decision making. Strategic options can be defined as those options that have the greatest potential for creating or destroying stakeholder value.
Strategic implementation At this point, the emphasis of the scorecard is to identify key milestones for the Board and to monitor implementation of the agreed strategy. Decisions on appropriate action may be required if things are not proceeding as planned.	**Strategic risks** This dimension underpins the others by focusing specifically on the major strategic risks that pose the greatest threat to the achievement of the organisation's strategy as well as key issues such as the organisation's risk appetite.

The scorecard will bring all the high-level strategic information together in a summarised, but coherent form for the Board's use within a robust framework. This will be supported by a strong Foundation of high

quality management information which the Board can access if it is felt necessary to explore a particular issue in greater depth.

Timescales

The Planning and Performance department will begin to undertake this analysis from September. The Executive team will use the analysis to inform the development of the Trust's strategic objectives and workstreams. The workstreams will be agreed by Management Board in January and will consider input from the senior management team. The strategic objectives will also be put forward for agreement by Trust Board in January.

7.4 Activity and capacity planning

The Market assessments and wider analysis will additionally inform a more detailed Trust-wide activity and capacity model. The model will be used to generate future activity plans, identify areas of growth and determine the capacity and workforce implications to deliver this. The activity model will be costed by the Finance department and will be integrated into the financial commissioner baseline plan for negotiation. This process is detailed in appendix 1. The Finance department have a key responsibility to ensure that all strategic plans fit together, are financially robust and support the strategic direction of the organisation.

The activity and capacity model can additionally be used to support new business case proposals by identifying activity growth, resource implications and potential income and expenditure implications. This information can then be fed back in to the trust-wide model, once the case has been through the necessary process and authorised by Management Board (see section 8).

7.5 Clinical Unit Annual Plans

Clinical Units will also develop local annual plans, detailing how they will meet the Trust objectives within their individual specialties. The Planning and Performance department will work with Clinical Unit leads to develop and provide annual planning templates and guidance to enable local plans to be developed consistently across the organisation. Clinical Unit annual plans will be developed by March.

Clinical Unit plans should additionally identify, as far as possible, services development proposals for the coming year.

8. Process for service development proposals

The Planning and Performance department has developed guidance to support Clinical Units and departments in the construction of service development business cases (Appendix 2). The team will continue to work with Clinical Units and departments to develop high quality and consistent proposals, ensuring that service developments are aligned to the Trusts' strategic objectives, includes robust market analysis, identifies and analyses demand, capacity and resources required, identifies the impact on other services, considers space implications and details costs, income and savings.

To ensure that appropriate consideration has been given to all potential services affected by the proposal and that the financial modelling is robust, a formal sign off process has been developed prior to presentation at Management Board for agreement. This process is detailed in appendix 2 and includes the following steps:

- Business cases must include the completed and signed off 'check-list' in order to be included on the Management Board agenda.

- The business case and supporting documentation will have been submitted via the Trust's Business Tracking System (BTS).

- The Planning & Performance department will review the business case and will facilitate the necessary sign off from affected departments.

- The local Finance Manager will complete the finance pro forma which will require sign off by the Chief Finance Officer or Deputy Chief Finance Officer. The Finance Manager will upload the completed pro forma to the BTS. Any financials in the business case must be consistent with those in the pro forma. Finance will clarify the information required for the appraisal of a financial business case September Management Board.

- Following stakeholder consultation and completion of initial financial analysis, business cases that involve clinical activity must be presented to the Business Case Review Group (BCRG) at the end of the month preceding Management Board to enable sufficient time to review gain final agreement. The BCRG will allow scrutiny of proposals particularly from the perspectives of quality, operational issues and financial risk. These views will be represented by the Assistant Chief Nurse for Quality and Safety, The Deputy Chief Operating Officer and the Deputy Finance Director. Actions raised at the BCRG will need to have been completed and agreed as a final sign off before proposals are presented to Management Board.

- Business cases must be formally received by the Executive Office from the Planning and Performance department.

9. Capital Planning

This section identifies the governance and reporting framework for capital planning.

The Capital and Space Planning Committee (CASP) is responsible for the Trust's non-redevelopment capital schemes. CASP will report to Management Board.

The Trust's capital allocation will be split between Estates, IT and Medical Equipment budgets.

Estates capital projects can be broadly categorised into two groups:
- Backlog maintenance (Condition B) schemes
- Other estates schemes.

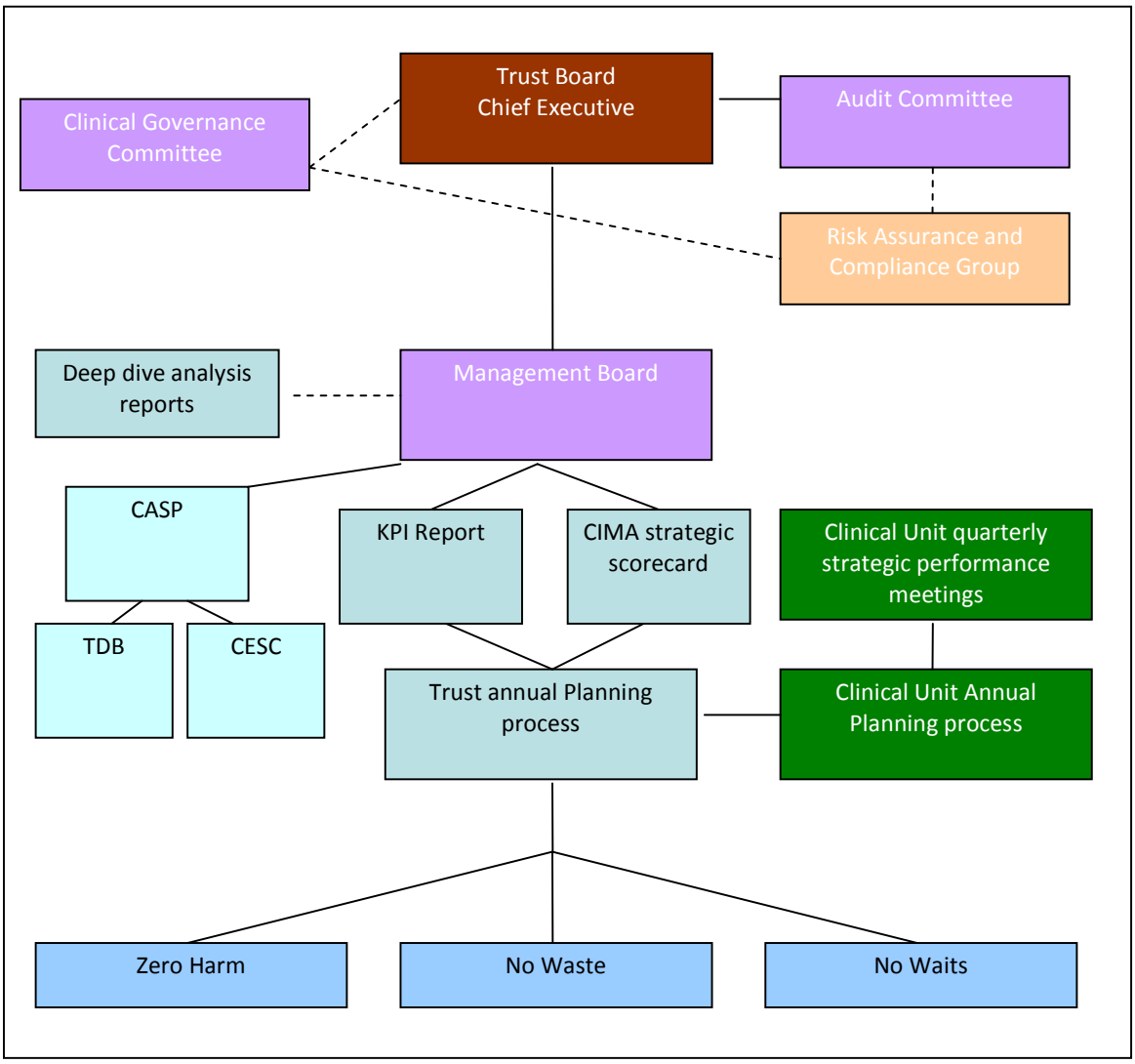
Estates are responsible for producing a survey that identifies the Condition B priorities. Other estates schemes will need to be prioritised by clinical/operational teams. Business cases for all estates schemes will be scrutinised and agreed at CASP.

Responsibility for IT capital projects is delegated to the Technical Delivery Board (TDB) that is a sub-committee of CASP. The Trusts IT strategy will have been agreed by Management Board. Individual IT business cases will be scrutinised and prioritised at TDB.

The Clinical Equipment and Supplies Committee (CESC) is a sub-committee of CASP that is responsible for assessing and prioritising medical equipment capital investment proposals. There is an annual bidding round for investment proposals. Clinicians representing the departments across the trust prioritise the proposals in terms of clinical need according to an agreed scoring methodology (Appendix 3). In general medical equipment projects are funded using charity monies.

10. Business planning corporate framework

The following diagram outlines the corporate governance and monitoring framework for business planning



10.1 Monitoring

The Trust has developed a comprehensive Key Performance Indicator (KPI) report to monitor progress against the priority objectives and the supporting work streams to deliver these.

The Trust has an established Management Board. The Chief Executive, all the Executive Directors, General Managers, Clinical Unit Chairs and named Heads of Department/Service attend this Committee. The Management Board holds an operational overview of a wide range of internal and external performance indicators. The Management Board will approve the monthly KPI report and identify remedial actions to address areas of poor performance. The Management Board will also receive 'deep dive' analysis reports and presentations on areas of specific concern on an ad hoc basis. These reports are produced by relevant department / service leads.

The Risk Assurance and Compliance Group monitors risks to meeting Trust objectives and also considers compliance against CQC registration standards. The Risk Assurance and Compliance Group reports to the Audit Committee.

Progress against Clinical Unit plans and performance against key internal and external standards and targets are monitored through Quarterly Strategic Performance Review meetings. These meetings are attended by Clinical Unit leads, Executive Team members and Heads of Department.

The Trust Board receives a copy of the monthly KPI and exception report and will additionally receive a monthly strategic scorecard report.

11. Success Criteria

- Business planning is developed, reported and monitored consistently at all levels in the organisation.
- The Board has access to up-to-date information relating to the operational context in which the Trust operates, allowing them to make informed business decisions.
- Staff have access to up-to-date information relating to the operational context in which the Trust operates, allowing them to make informed business decisions.
- Strategic organisational standards are being achieved and regulatory and legislative requirements are being met.

12. Accountability

- Trust Board

The Trust Board has corporate responsibility for the Trust's strategic and business planning. Each strategic objective key supporting workstream is overseen by a responsible Executive Team member.

- Management Board

The Management Board monitors progress against our business plans and key strategic objectives.

- Audit Committee and Clinical Governance Committee

These committees provide assurance to the Trust Board that systems and processes are working effectively and that corporate and clinical risks are being mitigated or removed.

- Risk Assurance and Compliance Group

The purpose of the Group is to ensure that the Trust complies with all requirements of the Assurance Framework and all requirements of the Health and Social Care Act 2008 (Registration Requirements). The group reports to the Audit Committee.

- Chief Operating Officer

The Chief Operating Officer has Board-level responsibility for business planning. The post holder is instrumental in ensuring clinical and managerial engagement and leadership in driving change.

- Head of Planning and Performance Management

The Head of Planning & Performance Management provides leadership on and is responsible for developing the business planning cycle and annual plan.

- General Managers and Clinical Unit Chairs

General Managers and Clinical Unit Chairs are responsible for enabling their Business Teams to have the capacity to participate fully and meaningfully with the Trust-wide agenda.

- Individuals

All members of staff are responsible for the quality of the data they enter into Trust-wide information systems and will contribute effectively to the objectives of their department.

- Monitoring of key business planning objectives

Reporting will be included in existing reporting schedules of Trust governance assurance and governance committees.

The Trust will use the established management structure and forums to ensure that implementation of the strategy is given a high priority within the organisation and that responsibility and accountability for taking action is clearly identified.

This strategy will be reviewed each year to ensure it remains in line with national guidance.

13. Appendices

1. Capacity and activity planning cycle

2. Service development:
- Proposal guidance
- Submission process and timetable
- Check-list proforma

3. Medical equipment investments:
- Proposal guidance
- Scoring methodology

Appendix 1 Activity & Capacity Planning Process

The activity and capacity model is created through the following process:

- Developing an activity plan baseline
- Verifying the baseline predicted capacity levels
- Generating Clinical Unit growth assumptions

The activity plan baseline is formulated through using a set period of coded activity, for instance month 1-6, and annualising this to give a full years set of data. The activity plan baseline is prepared and made ready for use by the Finance Department, who send a complete full years forecast out turn to the Planning and Performance Department. This happens 1 month after the period end, therefore month 1-6 information is generally available by the 1st November.

The activity baseline is then run through the activity and capacity modelling database. This database contains a table which averages length of stay information and theatre usage by procedure type (using the Healthcare Resource Group code). This table is created by looking at information within a certain time period. This table is then linked to the baseline activity model and used to generate how many ward, high dependency unit, critical care, and day case beds as well as theatre sessions are required by each individual specialty. The baseline level of resource required can then be validated by the Clinical Units prior to being used to predict future resource requirements.

Once the baseline data has been produced and run through the capacity model, work can be undertaken with the Clinical Units to develop growth assumptions. These are split into three categories:

Growth Type	**Description**
Demographic Growth	Population growth derived from the Office of National Statistics. Different rates of growth are applied depending on the geographical area of the patient.
Market Share Growth	Clinical Unit described growth. Demonstrates an increase in activity due to a shift of work from another Trust to Great Ormond Street Hospital.
Clinical Development Growth	Clinical Unit described growth. Growth as a result in a change in the management of a patient clinical pathway.

The growth described by the Clinical Unit can only fall into two categories, Market Share, or Clinical Development. Demographic growth is automatically applied to all activity unless there is a specific restriction in capacity affecting this.

Meetings are held with the Clinical Units to discuss specialty by specialty and by activity type how they see individual services developing over the next 10 years, using their agreed Market Assessments and business cases as a guide to discussions. Analysis and work to develop the growth assumptions for the model and validate the baseline data as a result of these meetings is undertaken jointly between the Planning & Performance department and the Clinical Units.

Once growth assumptions have been agreed these are run through a modelling database to produce a forecast activity and capacity plan showing the level of activity, and amount of resource in terms of bed and theatres numbers required year by year for the next 10 years.

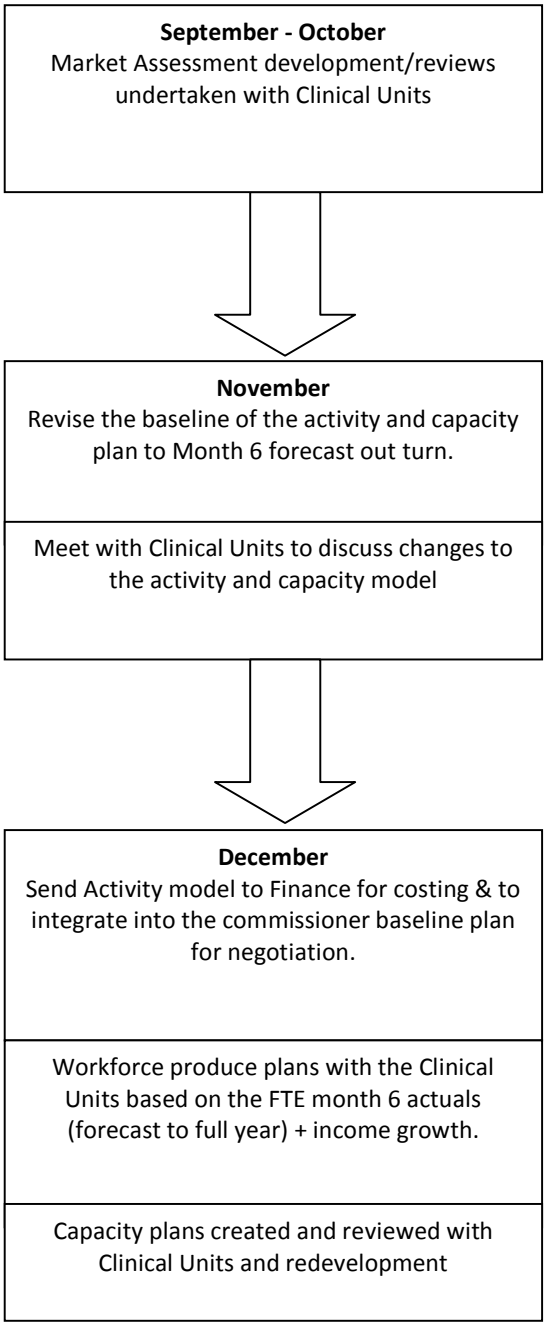
The activity plan once completed, verified by the Clinical Unit, and checked, is sent to Finance so that

income values can be attached to the data. This information is then factored into the Foundation Trust Long Term Financial Model (LTFM).

The activity modelling is also used by the Finance Department to produce baselines for the Trust's Commissioner Plans. These plans determine the level of income the trust will receive as part of our contractual arrangements with other NHS bodies. These are negotiated and discussed and the baseline activity is changed throughout December until the usually altered plans can be agreed by both the Trust and the Commissioner in early January.

Another use for the activity plan is to help inform the Workforce Plan. Finance take the income growth percentage per Clinical Unit and remove a set amount of this growth for CRES (this varies from unit to unit) and then apply the revised percentage growth figures to the month 1-6 annualised workforce expenditure figures to get a 'resource envelope' for Clinical Units to base their workforce plans on.

The capacity plan generated from the activity plan is then integrated into a Trust wide view of demand and capacity by number of beds and theatres ward by ward. This is then fed into discussions with redevelopment with regard to how the requirements of each specialty are mapped into the new building occupation plans.



Appendix 2 Service Development proposal guidance

1. Aims and objectives

Brief statement establishing what you are proposing and what it will achieve

2. Background

Provide brief background that will place the rest of the bid into a context for people less familiar with the area. Content will of course vary with the type of bid, but may include:

- Brief description of the current service
- Population / patients served
- Conditions treated/treatments provided
- Clinical developments
- Relationships to services in other providers
- Unmet patient need in this service area
- Current risks that are being carried, which would be addressed by the proposed investment
- Current waiting times issues

3. Strategic Context

How will the bid support the Trust's strategic objectives and the local objectives of the unit/department. It is expected that most anticipated service growth would have already been identified and included in the Integrated Business Plan (IBP).

4. Market Analysis

Supporting market analysis information should be included to shows there is a clear understanding of our market share, the opportunities that exist and who our competitors are. It is also important to understand geographically where are any additional activity is coming from as it can impact on income assumptions.

5. Activity volumes and capacity

Where relevant, provide outline demand and capacity analysis that shows

a) how the investment will increase activity volumes
b) the capacity required to deliver those new activity volumes, including how any capacity shortfalls will be made up
c) current utilisation of resources (beds, theatres etc)
d) impact on waiting times

Much of this information will already be in the IBP. If not the differences in assumptions must be explicit. Both Planning and Information Services are able to assist with these kinds of analysis.

Demand for the service must be robustly demonstrated.

6. Resources required

The onus is on the business case to prove for each additional resource requested that it is not possible to meet demand within existing resources.

The business case must show how the existing resource is utilised and that it can be demonstrated how much capacity is currently taken up. The business case should address what would happen if the requirement had to be met within existing resources or if only part of the requested additional resource was available. This might be reflected in an options appraisal.

Any changes of service model have been considered (or implemented) should be mentioned along with any other efficiencies that have been gained?

7. Impact on other services and departments

Impact on other departments should be taken into account. Departments will sign off on the Business Case checklist that they have been considered and are happy to support the proposal.

8. Costs, income and savings

Once all resource requirements have been agreed (and signed off by associated departments) then the costs can be calculated. Likewise the income can be calculated based on the detailed description of the activity linked to the business case.

The departmental finance manager is responsible for organising the completion of the finance pro forma. This will ensure that costs are consistently applied and that the intricacies of our income streams are correctly considered.

The finance pro forma will be signed off by The Director (or Deputy Director) of Finance.

9. Space considerations

The business case must clearly identify space requirements.

10. Options Appraisal

Consider whether you need to do an options appraisal for your project: are there different ways of delivering your stated outcomes.

Where you decide an options appraisal is useful, you need to do the following:

List options: (including “Do nothing”)
For minor proposals two options may suffice, with comparison made against “do nothing”

Set criteria: these should flow directly from the key points that you have identified in the strategic context section above. That is they are the issues that will help you understand the most appropriate option. You will normally use 4-5 criteria.

Score against the criteria: Score each option against criteria as above (criteria can be weighted to reflect relative importance)

Outcomes: Outline the outcomes expected should the proposal be supported, both in terms of quality enhancements and projected additional activity. This is extremely important for the Trust and our Commissioners as judgments about the relative priority of proposals can only be made in the context of what they seek to achieve. These will also be used to measure the success in delivering the changes required.

11. Timeframes

Set out the key milestones for the project. Is this a staged project? Are further developments planned? How long are the lead-ins for recruitment? These timescales should match predicted activity levels and capacity/resource requirements.

12. Risks

An outline of risks that might impact on successful implementation of the investment

- Risks associated with projections on Demand, and therefore income
- Risks of not achieving stakeholder support for the development

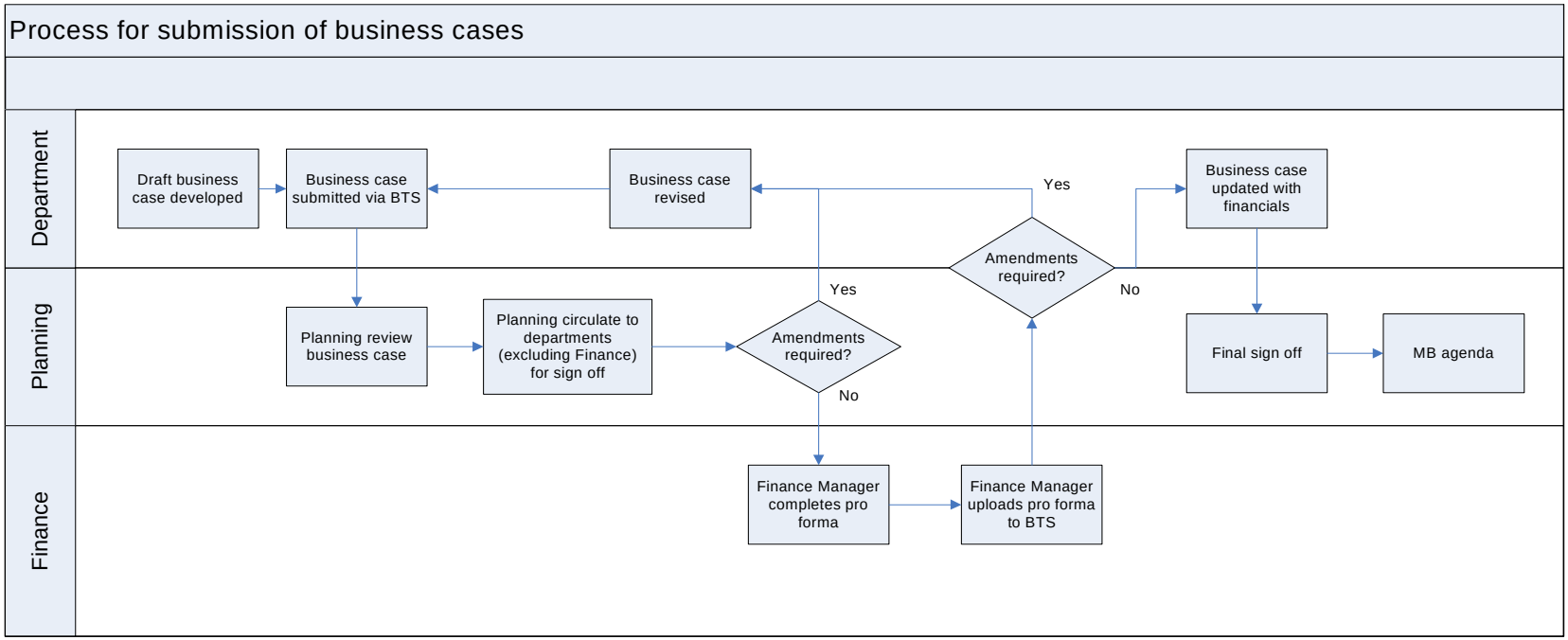
Risks relating to other providers developing the service - opportunity for risk sharing.

13. Outcomes and performance management

More detailed description of how it will be possible to demonstrate that the investment has generated the benefits that were intended, for example details of performance indicators, satisfaction measurement, evidence of clinical effectiveness.

If it isn't possible to demonstrate clearly the benefits from an investment then this should be explained

Service development submission process



Service development 'check-list'

1. Business Case submitted via the Business Tracking System ☐

2. Business Case has considered:

Alignment with Trust Objectives	
Nursing	
Estates	
Space	
Workforce & HR	
ICT	
Diagnostic & Therapeutic Services	
Cardio-respiratory	
ICI	
Medicine	
Neurosciences	
Surgery (inc Theatres)	
IPP	

3. Finance pro forma uploaded by Finance Manager ☐

Business case signed off by:

Chief Finance Officer …… Date …….

Chief Operating Officer …… ……..Date …….

Appendix 3 Medical Equipment investment proposal guidance and scoring methodology

1. Introduction

This document outlines the process for submitting proposals for the annual medical equipment bidding round.

2. Process

New and replacement medical equipment should have been already identified in the Clinical Unit's business plan (and may also be on their risk register). The Clinical Unit needs to be clear about which items are priorities and whether any alternative funding sources can be identified.

Each year Clinical Units submit investment bids for medical equipment. The Clinical Equipment and Supplies Committee (CESC) is responsible for prioritising medical equipment bids. All bids are scored by the clinical representatives who cover all departments across the Trust.

Charity money is generally used to fund medical equipment capital budgets as it is then possible to gain VAT exemption on these purchases. The Trust decides what allocation of Charity money can be spent each year on medical equipment. This budget is expected to be in the region of £1.5M.

Replacement items of small value (less than £10K) may be funded from the Bio-Medical Engineering replacement budget held by Jude Cope.

A business case is required to support each proposal.

3. Timetable

April – July	Units to discuss their priorities
August – September	Business cases submitted via BTS
October	Bids scored by CESC representatives
November	CESC reviews scores
December	Prioritised list seen by Capital and Space Planning Committee (CASP) and Management Board
January – March	Charity Special Trustees authorise funding

4. Submission of bids

As with last year, all bids will be submitted via the Trust's Business Tracking System (BTS). This can be found at http://gosweb/Corporate/BTS/home.aspx.

If previously unsuccessful proposals are to be re-submitted, then they must be updated as necessary, and the grouping added (see 5.10 below). In these cases it is worth reviewing existing business cases and evaluating why they did not gain sufficient prioritisation previously before re-submitting.

5. Content of business cases

It should be noted that the clinical representatives will be reviewing a large number (65 last year) of proposals. **Therefore it is important to be brief and to the point.** All sections of the business case should be completed on the BTS. Business cases should include the following:

5.1. Aims and objectives

This should be a summary of the project. It should include what the equipment is, why it is required (and whether it is a replacement) and what it is to be used for.

5.2. Project background

Some general background will be required. This should set the proposal in context, give the current situation and provide enough information to convey the importance and value of the equipment.

While the clinical representatives who will score the proposals are all clinicians they will not necessarily have expertise in every specialty, so layman's terms should be used wherever possible. Detailed technical information is not required.

5.3. Scope and linkage

What is the scope of the project? Does it link with other projects in the Trust?

5.4. Outcomes and Benefits

What are the expected outcomes for the project? How will it benefit patients, the department, the Trust?

5.5. Risks to Project Implementation

Any risks to the success of the project should be identified.

5.6. Involvement with stakeholders

Who has been consulted about the project? Is there anyone else who will need consulting if the project goes ahead?

5.7. Business case headings

Business cases should be **clear and concise**. These are the criteria against which the proposal will be scored. The table below specifies the scoring criteria with notes where applicable:

Criteria	Score	Notes
1. Service continuity	20	How does the proposal impact on the continuity of the service?
2. Reducing the risk of harm	20	Will the equipment help reduce clinical risk? If appropriate include information about whether this appears on the Clinical Unit's risk register and

		give the risk rating. Risk of not meeting NICE guidelines should be included.
3. How the bid supports R&D innovation	10	How the proposal contributes supports delivery of the research strategy
4. Number of patients treated	10	There are two components to the score: ▪ Number of patients ▪ Proportion of service Make sure both are clear.
5. Clinical quality improvements	10	What improvement in clinical quality will be brought about by the proposal?
6. Increased savings or income	10	Be clear about whether this has been quantified
7. Layman's description		This is required for the Charity and is used to describe the equipment to potential donors to the hospital. It should include which clinical conditions or disease states it is used for.
8. Impact on patients		This is required by the Charity. As such proposals must address this and state how the impact will be measured once the project is complete if they are to be considered.

5.8. Finances

In the first instance capital and revenue (additional) requirements should be estimated along with savings generated and any additional anticipated income. The local Finance Manager should be asked to sense check this information.

Further financial analysis will be required and organised by the local Finance Manager before any funding would be agreed.

5.9. Objectives

Make it clear which of the Trust's objectives this proposal would support.

5.10. Groupings

On the BTS the following task grouping should be added as well as the appropriate department and Clinical Unit:

113: Medical Equipment bid for 2011-12

5.11. Other documentation

Other documentation can be uploaded but will not generally be used in the scoring process.

6. Support

The Planning and Performance department (extension 8464) are available to advise on business cases and also for training or support with the BTS.

Scoring of Medical Equipment Proposals

The Clinical Representatives of CESC are each responsible for scoring all medical equipment proposals in the annual bidding round. The scoring is to establish a medical priority. Financial information will not be provided at this point.

There are two components to the scoring of these proposals.

1. **Objective scoring.**

There are five criteria that must be scored out of 10 or 20 by each clinical representative for each proposal (Patient numbers no longer need to be scored by clinical representatives as this is based on a formula). These criteria, along with some of the issues that might be considered for each are as follows:

A. Generates additional income or savings (10)
   i. Savings in staff or materials
   ii. Capturing a market
   iii. Expansion of existing service with revenue potential
B. Clinical quality improvements (10)
   iv. More accuracy in diagnosis
   v. More patients to be seen
   vi. Innovative techniques or treatment
C. Research and innovation (10)
   vii. Contribution to the research strategy
D. Service continuity (20)
   viii. is the service going to be undeliverable in the next 12 months
   ix. have the companies involved withdrawn technical and replacement parts
   x. end of warranty
E. Reducing risk of harm (20)
   xi. Has any regulatory body withdrawn its licence on the equipment
   xii. Any clinical incidents that have occurred as a result of the state of the equipment

2. **Subjective scoring**

This should be done after the objective scoring has been completed and should not require further reading of the proposals. The subjective score is out of 10. All proposals should be given a score. Note that this is a change from 2010/11. A prioritised list will be drawn up from the aggregated scores and discussed at the CESC meeting. Proposals that did not score well overall (and therefore unlikely to be funded) but received a high score for reducing the risk of harm or received a high subjective score will be scrutinized further.

Great Ormond Street Hospital for Children NHS Trust

Trust Board
21.12.2011

Update on Data Quality Action Plan Submitted by: Claire Newton	**Paper No: Attachment O** **For Information**

Aims
To brief the Trust Board on the current status of the Data Quality workstreams aimed at continuous improvement of Data Quality

Summary
This paper addresses the Quality Governance Question 4B: ***Is the Board assured of the robustness of the quality information?***

The last update on data quality improvement workstreams was discussed at the Audit Committee in October 2011.
Data quality is a key priority for the NHS and this Trust and encompasses:

- Clinical data, clinical records and clinical outcomes including data collected for research
- Patient activity data including coding of episodes with diagnostic and procedure coding
- Financial data
- HR data
- Other data included in information presented to the Board or third party organisations relating to strategic or operational performance

It is critical that the Board is aware of the extent to which data and information presented to them meets appropriate data quality standards in terms of being from a reliable source, processed accurately, presented fairly and subject to periodic validation.

Reference to Data Quality processes in the Monitor assessment of our Quality Governance
"There is no strategy or overall development plan yet in place for Information/Data Management and therefore it is unclear whether these controls are comprehensive and timely. The Trust has not provided a responsibility map for data. Trust is unclear what the current coding accuracy is."

This paper summarises work streams aimed at improving the quality of data .
In addition, an internal audit of Data Quality is currently being carried out and will be reported at the January meeting of the Audit Committee.

Action required from the meeting To note the update and endorse the importance of data quality and ensuring that data quality processes are embedded within the organisation

Contribution to the delivery of NHS / Trust strategies and plans
Data quality is critical for operations and Board effectiveness

Financial implications
There will be additional project costs to accelerate the workstreams required to embed data quality principles throughout the Trust

Legal issues

Who needs to be / has been consulted about the proposals in the paper and what consultation is planned/has taken place? N/A

Who needs to be told about any decision The Board

Who is responsible for implementing the proposals / project and anticipated timescales
Medical Director as Chief Clinical Information Officer and CFO for activity and financial data

Who is accountable for the implementation of the proposal / project
CEO as Accountable Officer

Author and date Claire Newton 14/12/11

1 Background

The Trust has an over arching Data Quality policy and this has was updated and approved by Management Board in 2011.

2 The Information and Data Quality Development Plan

2.1 Overview

The Trust has a Data Quality policy which has recently been updated which sets out core principles, roles and responsibilities for data quality. This policy establishes that the roles and responsibilities for ensuring data quality rest with the 'information asset owner' (IAO) ie the most senior manager of the department operating and using the information system.

For Trust wide corporate systems, which include finance, patient activity and HR, these responsibilities are held centrally by the functional leads, however for 'local' systems where the majority of the data recording is completed by staff within units the responsibility lies with respective IAO.

Work in progress:
We are currently in the process of ensuring that the IAO is clearly identified for all locally managed information systems which are critical to the Trust in terms of delivering information eg specialty specific clinical systems used for patient information and clinical outcomes.

Where critical information is not structured within an IT system at present eg medical records, the responsibilities are split ie the systems are administered centrally but the qualitative information is completed locally. In this case the Medical Director through the Transformation leads is championing a quality improvement initiative and there are further initiatives within the Records Management department for improving the quality of the administration.

2.2 Data Responsibility Map

This is attached as Appendix B.

There is a further spreadsheet not attached to this paper which is a register of all clinical databases used by specialties. We plan to complete an assessment of all significant databases in January . This assessment will include a collection of basic information which will be used to make an assessment of the criticality to the Trust and the quality of the information. Eg the following questions will be asked:

- Responsible manager
- Use – internally and externally
- Who has access and what access controls are there to prevent unauthorised access
- Are there adequate controls to ensure data cannot be lost
- Does it include confidential patient information
- Size / number of records
- Links to other Trust systems
- Processes for ensuring data is quality assured

Quality assessments for all critical information systems
For all critical data used and relied upon by staff or managers within the Trust, an assessment will be carried out and scored using the following criteria:

- the data is derived from a reliable source ie
    - defined procedures for data recording and reporting
    - a well defined information structure
    - training for users,
- there is standardisation of data definitions – in general the Trust uses NHS data definitions but the Information Services team has been carrying out a comprehensive review of all reports published on the intranet to ensure consistent definitions are in use
- analysed appropriately by individuals with the skills and experience to do so;
- DQ exception reporting is used where appropriate
- quality assured before issuance;
- subject to periodic DQ assurance checks/audits.

3 Board Information

We are currently assessing the sources of all Board KPI information at a detailed level. A large part of this information comes from the central information warehouse and HR systems but there are some elements which are collected locally from functional heads or clinical leads. The results of this assessment will be reported back to the Board in January.

4 Accuracy of coding data

The Trust employs a coding auditor within the coding department to carry out reviews of the accuracy of coding. Findings are reviewed by the Head of Information Services and used by the Coding department manager to ensure coders are aware of errors and new coders are adequately trained.

The Audit Commission last carried out an audit of IP coding in 2009/10. No audit was carried out in 2010/11 as the results of the previous audit were considered of a sufficient standard that a further audit would not be required for two years.

*The audit found that **4.5%** of HRGs were derived incorrectly which was lower than the national average of 9.1% when compared to all other audited trusts in 2009/10.*
*The gross value of the HRG changes in this audit when expressed as **3.1%** of the total audit sample price was lower than the national average of4.3%.*

The next IP coding audit is scheduled for January 2012

3 Other independent reviews of data quality

The Audit Commission carried out an audit of our OP data in 2011/12 and our reference costs. The results of the audit of OP data were graded, the main shortfall identified was the Trust does not yet code OP procedures. This is being addressed.
However the auditor also found instances where OP attendances had been recorded incorrectly eg a first attendance coded as a follow up

The following table shows the results and identifies the main specialty with data recording issues as haematology – although some of the errors were a result of medical records not being found

Area Audited	Attendance errors (%)	First / F-up errors (%)	Treatment function errors (%)	Total errors (%)	Errors affecting payment (%)	Net monetary change (%)
Cardiology	0%	6%	0%	2%	6%	3.9%
Urology	2%	0%	0%	0.7%	2%	-2%
Haemotology	14%	2%	0%	5.3%	16%	-20.4%

The results of the reference cost audit were satisfactory.

4 How does the Board assure itself of the standards of data quality in the organisation

An Audit Commission checklist (***See Appendix A***) sets out good practice standards in Data Quality which should be complied with and a draft response in terms of compliance is included in the Appendix. This identifies some actions which will be addressed over the next 6 months.

It is proposed that further reports on data quality the progression of this checklist are reported back to the Audit Committee.

Appendix A – AUDIT COMMISSION Data Quality Standards Checklist

Standards for better data quality

1 Governance and leadership

The body has put in place a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation.

Key components:	Response:
1.1 There is clear corporate leadership of data quality by those charged with governance.	Data quality policy approved by Management Board Data quality action plan reported to Audit Committee
1.2 A senior individual at top management level (for example a member of the senior management team) has overall strategic responsibility for data quality, and this responsibility is not delegated.	Currently non clinical data lead by CFO and clinical data by Medical Director (CCIO)
1.3 The corporate objectives for data quality are clearly defined (although this may not necessitate a discrete document for data quality), and have been agreed at top management level.	Through policy
1.4 The data quality objectives are linked to business objectives, cover all the body's activities, and have an associated delivery plan.	Through policy
1.5 The commitment to data quality is communicated clearly, reinforcing the message that all staff have a responsibility for data quality.	*Further action required – this will be linked to the work being carried out in January to register and assess all critical data sources in the Trust*
1.6 Accountability for data quality is clearly defined and is considered where relevant as part of the performance appraisal system.	There is clear accountability for the main information warehouse and responsibilities for medical records are clearly set out in the guidelines publicised on the Transformation intranet. *This needs to be reviewed for local systems*
1.7 There is a framework in place to monitor and review data quality, with robust scrutiny by those charged with governance. The programme is proportionate to risk.	IGSG currently takes responsibility. IGSG reports to Management board
1.8 Data quality is embedded in risk management arrangements, with regular assessment of the risks associated with unreliable or inaccurate data.	*Not done explicitly but will be introduced at the Information Strategy steering group in January*
1.9 Where applicable, the body has taken action to address the results of previous internal and external reviews of data quality.	Responses have been made to all recommendations
1.10 Where there is joint working, there is an agreement covering data quality with partners (for example, in the form of a data sharing protocol, statement, or service level agreement).	Information sharing agreement with GOSH CC *As yet – no sharing agreement with ICH but addressed through use of joint employment contracts*

2 Policies

The body has put in place appropriate policies or procedures to secure the quality of the data it records and uses for reporting.

Key components:	
2.1 There is comprehensive guidance for staff on data quality, translating the corporate commitment into practice. This may take the form of a policy, set of policies, or operational procedures, covering data collection, recording, analysis and reporting. The guidance has been implemented in all business areas.	Policy exists and has been regularly updated
2.2 Policies and procedures meet the requirements of any relevant national standards, rules, definitions or guidance, for example the Data Protection Act, as well as defining local practices and monitoring arrangements.	Yes
2.3 Policies and procedures are reviewed periodically and updated when needed. The body is proactive in informing staff of any policy or procedure updates on a timely basis.	Yes
2.4 All relevant staff have access to policies, guidance and support on data quality, and on the collection, recording, analysis, and reporting of data. Where possible this is supported by information systems.	Through intranet
2.5 Policies, procedures and guidelines are applied consistently. Mechanisms are in place to check compliance in practice, and the results are reported to top management. Corrective action is taken where necessary.	*Not yet consistent in terms of coverage of all categories of data*

3 Systems and processes

The body has put in place systems and processes which secure the quality of data as part of the normal business activity of the body.

Key components:

3.1 There are systems and processes in place for the collection, recording, analysis and reporting of data which are focused on securing data which are accurate, valid, reliable, timely, relevant and complete.	There are systems for all categories of centrally managed data
3.2 Systems and processes work according to the principle of right first time, rather than employing extensive data correction, cleansing or manipulation processes to produce the information required.	Confirmed
3.3 Arrangements for collecting, recording, compiling and reporting data are integrated into the business planning and management processes of the body, supporting the day-to-day work of staff.	This is correct for the centrally managed systems
3.4 Information systems have built-in controls to minimise the scope for human error or manipulation and prevent erroneous data entry, missing data, or unauthorised data changes. Controls are reviewed at least annually to ensure they are working effectively.	Modern systems do have built in controls. The Trust currently has a number of legacy systems which are due for replacement where controls are not extensive

	and there needs to be manual controls and checks
3.5 Corporate security and recovery arrangements are in place. The body regularly tests its business critical systems to ensure that processes are secure, and results are reported to top management.	Significantly strengthened recently

4 People and skills

The body has put in place arrangements to ensure that staff have the knowledge, competencies and capacity for their roles in relation to data quality.
Key components:

4.1 Roles and responsibilities in relation to data quality are clearly defined and documented, and incorporated where appropriate into job descriptions.	This will be included in role of "Information Asset owner"
4.2 Data quality standards are set, and staff are assessed against these.	Within policy
4.3 The body has put in place and trained the necessary staff, ensuring they have the capacity and skills for the effective collection, recording, analysis and reporting of data.	Central teams (Information Services and Transformation) are managed appropriately *There may be data staff within units which need awareness training*
4.4 There is a programme of training for data quality, tailored to needs. This includes regular updates for staff to ensure that changes in data quality procedures are disseminated and acted on.	Training on PiMs *Training for Other systems is carried out locally by System administrators etc* *Scope of PiMs training to be reviewed*
4.5 There are corporate arrangements in place to ensure that training provision is periodically evaluated and adapted to respond to changing needs.	Yes

5 Data use and reporting

The body has put in place arrangements that are focused on ensuring that data supporting reported information are actively used in the decision making process and are subject to a system of internal control and validation.

Key components:

5.1 Internal and external reporting requirements have been critically assessed. Data provision is reviewed regularly to ensure it is aligned to these needs.	Reporting requirements are in general assessed and submissions to external organisations are reviewed
5.2 Data used for reporting to those charged with governance are also used for day-to-day management of the body's business. As a minimum, reported data, and the way they are used, are fed back to those who create them to reinforce understanding of their wider role and importance.	Comply
5.3 Data are used appropriately to support the levels of reporting and decision making needed (for example, forecasting achievement, monitoring service delivery and outcomes, and identifying corrective actions). There is	Performance reports draw data from a variety of sources.

evidence that management action is taken to address service delivery issues identified by reporting.	
5.4 Data used for external reporting are subject to rigorous verification, and to senior management approval.	Finance data Activity data Clinical data > national specialty databases eg nephrology > ICU data to Picanet
5.5 All data returns are prepared and submitted on a timely basis, and are supported by a clear and complete audit trail.	Finance data: SHA and DH Activity data: SUS

DATA FLOW MAP FOR BOARD INFORMATION – APPENDIX B

CATEGORY	DATA SYSTEMS	REPOSITORY	QA	PUBLISHING MECHANISM	REPORT/ FORMAT	ADD	
STRUCTURED INFORMATION	PiMs	DATA WAREHOUSE (DQ coding audits)	DQ & ANALYSIS TOOLS	Transformation portal	KPI REPORTS (National targets, commissioners targets and internal performance indicators)	TARGETS & BENCHMARKS	BOARD INFORMATION
	HR (ESR)			Information services portal			
	Training DB Absence DB						
	Other Trust wide or Clinical Unit clinical systems: Safety data (? Collected through Transformation) Diagnostic results (PACSRIS, OC, Tomcat) Monitoring (CareVue) (EPanda) Risk (Datix) Resource utilisation(Roster pro)	NOT THROUGH DATA WAREHOUSE		Web portals / intranet	QUALITY ACCOUNTS / OUTCOME REPORTS Zero Harm report Outcomes		
	Specialty databases			Eg Cardiac portal OTHERS NONE?			
	FINANCE SYSTEMS	FINANCE LEDGER & SPREADSHEETS (FORECAST INFORMATION) (Audited)		Documents	FINANCE REPORTS		
		SLR SLAM		SLR Dashboard Spreadsheet reports			

DATA FLOW MAP FOR BOARD INFORMATION – APPENDIX B

CATEGORY	DATA SYSTEMS	REPOSITORY	QA	PUBLISHING MECHANISM	REPORT/ FORMAT		
SEMI-STRUCTURED INFORMATION				Intranet			
	Board Assurance Framework	Shared drive	CoSec	Datix portal Shared drive	Minutes of Assurance committees & MB		
	SIs / Complaints	Reports	PSS	Website	Risk management reports eg incidents, complaints		
				(Outsourced)	Patient surveys		
UNSTRUCTURED INFORMATION	Annual Reports: • Nursing • Patient experience • PALs • Safeguarding • H&S etc	Board papers in document library	Chief Nurse	Paper	Paper reports		

OTHER CRITICAL TRUST INFORMATION SYSTEMS

STRUCTURED	R&D database	? Central server	Head of R&I	Information maintained within R&I office	N/A
UNSTRUCTURED	Medical records	Medical records library	Records Manager	N/A	N.A
UNSTRUCTURED	Clinical document database	Central servers	All units	Accessed by clinical unit staff	N/A

NOTE:

- The term structured data is used to describe data organised in a database with clear predefined code structures and rules for access
- The term semi structured data is used to describe data and text set out in accordance with a predefined consistent format with some elements of judgement applied as to content eg the addition of free text. An example would be a GOSH policy or a Board paper using the standard templates.
- Unstructured data is any data and text which does not have a homogeneous format, albeit that it may be stored in a structured way eg patient notes, qualitative board reports

DATA FLOW MAP FOR BOARD INFORMATION – APPENDIX B

DATA SYSTEMS - INFORMATION ASSET OWNERS (MANAGER RESPONSIBLE), QUALITY CHECKS AND ACTION PLAN

Information system	**DQ ASSESSMENT**	**DATA OWNER**	**QA CHECKS**	**AUDIT**	**Further actions**
Finance	HIGH STRENGTHS: Well defined processes for inputting data All data input through finance team Central team reconciles key balances and variances WEAKNESSES: Miscoding can occur	CFO/DFD	Journal reviews Management account variance reporting Balance reconciliations	Internal and external audit	Plans to introduce better access tool which would speed up month end variance analysis
HR	MEDIUM / HIGH STRENGTHS: Pay dependent on good input Input tends to be by managers through SRS WEAKNESSES: Some information not kept regularly up to date but used for reporting eg vacancies	Head of HR / Head of Workforce	Not known	None	*To be followed up*
Information Warehouse	MEDIUM/HIGH STRENGTHS: Well defined process for inputting data Central team manages content Well structured Reports designed by skilled staff WEAKNESSES Very large user base in underlying systems, some examples of variances in local practice PiMSUser training and documentation needs improvement	HIS	DQ exception reports Review of information reported by clinical units	Audit Commission has audited parts	Detailed work plan in progress: - All data quality reports scheduled and usage to be reviewed - "one version" workstream to ensure one common source used for all reports requiring same data - Analysis tool in use and to be rolled out - PIMS training programme to be reviewd
Tomcat Cardiac database	*?To be assessed*	*Cardiac data team*		*Not known*	

DATA FLOW MAP FOR BOARD INFORMATION – APPENDIX B

Datix	MEDIUM /HIGH STRENGTHS: • Central team monitors content • Users review reports on a regular basis WEAKNESSES: • Large number of users providing input	Patient & Staff Safety		None	A number of workstreams to improve documentation on recommendations and follow up
Other data bases	?To be assessed	Numerous		Not known	Not yet commenced
Other specialty records Eg Infection records					

Great Ormond Street Hospital for Children NHS Trust

Trust Board
21st December 2011

Board of Directors' Remuneration Committee Terms Of Reference **Submitted on behalf of: Dr Jane Collins, Chief Executive**	**Paper No: Attachment P**

Aims / summary
The Board of Directors' Remuneration Committee Terms of Reference (ToR) have been revised and are attached with this paper. Monitor's Code of Governance and best practice guidance from the Foundation Trust Network have been used to update the ToR.

The Board of Director's Remuneration Committee will be responsible for monitoring and agreeing remuneration matters for board executive directors and designated senior managers.

Additions to the ToR are highlighted in yellow shading.

Members of the Remuneration Committee were consulted on a draft of the ToR at the last meeting in November 2011.

Action required from the meeting
Trust Board is asked to approve the terms of reference.

Contribution to the delivery of NHS / Trust strategies and plans
STRATEGIC OBJECTIVE 7: 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?
The Remuneration Committee has been consulted.

Who needs to be told about any decision
N/A

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

Who is accountable for the implementation of the proposal / project
Chair of Remuneration Committee

Author and date
Anna Ferrant,
Company Secretary
13th December 2011

Great Ormond Street Hospital for Children NHS Trust

DRAFT Board [of Directors'] Remuneration Committee

Terms of Reference

1. Authority

1.1 The remuneration committee is constituted as a standing committee of the [foundation] trust's board [of directors]. Its constitution and terms of reference shall be as set out below, subject to amendment at future board [of directors'] meetings.

1.2 The remuneration committee is authorised by the trust's board [of directors] to act within its terms of reference. All members of staff are directed to co-operate with any request made by the remuneration committee.

1.3 The remuneration committee is authorised by the trust's board [of directors] to instruct professional advisors and request the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise its functions.

1.4 The remuneration committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. Role

2.1 Determine and agree with the board the framework of remuneration for the board executive directors and designated senior managers;

2.2 To decide and review the terms and conditions of office of the [foundation] trust's board executive directors in accordance with all relevant [foundation] trust policies, including:

- Salary, including any performance-related pay or bonus
- Provisions for other benefits, including pensions;
- Termination payments
- Allowances.

2.3 To monitor and evaluate the performance of individual board executive directors.

2.4 Where appropriate to authorise contractual and non-contractual payments (other than payments made in settlement of Employment Tribunal claims) to chief executive, board executive directors, other members of staff and ex-members of staff.

2.5 To monitor redundancy/ capitalised pension costs for all staff groups.

2.6 In line with Monitor's requirements, to approve any redundancy/ capitalised pension cost in excess of £100,000.

2.7 To adhere to all relevant laws, regulations and policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate executive directors whilst remaining cost effective.

2.8 To assess and influence the remuneration incentives offered within the [foundation] trust.

2.9 To receive a report of the names of recipients of the annual clinical excellence awards.

2.10 The chair and another non-executive director are authorised to approve the following outside the meeting:

2.10.1 any redundancy/ capitalised pension cost in excess of £100,000;
2.10.2 Salaries and terms and conditions of office for newly advertised board executive director posts.

2.11 Where such actions are taken, these will be reported to the next meeting of the committee.

3. Membership and attendance

3.1 A non-executive director will chair the committee.

3.2 All other non–executive directors, including the chair of the board [of directors] shall be members of the committee.

3.3 The chief executive and head of operational human resources shall normally be invited to attend meetings in an advisory capacity.

3.4 The chief executive shall not be present during discussions concerning his/her performance and salary.

3.5 Other members of staff and external advisers may attend all or part of a meeting by invitation of the committee chair where required.

4. Quorum

4.1 The quorum necessary for the transaction of business shall be 3 members including the chair or senior non-executive director of the Trust.

5. Secretary

5.1 The company secretary shall be secretary to the committee.

6. Frequency of meetings

6.1 The committee shall meet at least twice a year, normally in March and November.

7. Minutes and reporting

7.1 The minutes of all meetings of the remuneration committee shall be formally recorded.

7.2 The remuneration committee will report to the full board [of directors] after each meeting.

7.3 The remuneration committee shall ensure that [board of] directors' emoluments are accurately reported in the required format in the foundation trust's annual report.

8. Performance evaluation and training

8.1 The remuneration committee shall review its collective performance and that of its individual members on a regular basis.

8.2 Members of the remuneration committee should seek continually to develop and refresh their knowledge of current remuneration practices.

9. Review

9.1 The terms of reference of the committee shall be reviewed by the [board of] directors at least annually.

December 2011

Attachment Q

Great Ormond Street Hospital for Children NHS Trust

Trust Board
21st December 2011

Proposed Terms of Reference for a new Board Committee – the "Finance, Resources and Investment Committee" Submitted by: Claire Newton	**Paper No: Attachment Q**

Aims
To propose terms of reference for the new Board Committee

Summary
At the November Board meeting it was agreed that the Board would set up a new committee which would meet before the main Board meetings to consider in detail performance information relating to:

- finance,
- resources,
- Productivity improvement plans linked to the Trust's CRES programme
- revenue and capital investment plans and programmes and
- any major business cases requiring Trust Board approval

Action required from the meeting To discuss and confirm draft terms of reference which will be considered at the first meeting of this Committee in January 2012 and then subsequently resubmitted to the Trust Board for ratification

Contribution to the delivery of NHS / Trust strategies and plans
The workings of this Committee will assist in providing assurance to the Board in relation to the financial and resource elements of the Trust's Strategy

Financial implications No direct financial implications although the purpose of the group is to consider financial matters

Legal issues
The Board needs to be included in the Trust's governance documents where appropriate

Who needs to be / has been consulted about the proposals in the paper and what consultation is planned/has taken place? Board members

Who needs to be told about any decision The Board

Who is responsible for implementing the proposals / project and anticipated timescales
Chair of the Trust Board and the Chair of the Committee

Who is accountable for the implementation of the proposal / project
CEO as Accountable Officer

Author and date Claire Newton 14/12/11

FINANCE, RESOURCES AND INVESTMENT COMMITTEE
DRAFT TERMS OF REFERENCE

The Board will resolve in December to establish a Committee of the Board of Directors to be known as the Finance, Resources and Investment Committee (the Committee).

Membership
Non-Executive Directors x 3 [one of whom shall be the Chair]
Chief Executive
Deputy Chief Executive /Chief Operating Officer
Chief Finance Officer
Deputy Director of Finance
Deputy Chief Operating Officer
Director of Redevelopment
Head of Estates
Director of ICT
Head of Human Resources

Attendance
The following would attend as required by the agenda:
All other Executive Directors
Company Secretary
Head of Contracting
Head of Facilities
Head of Information Services
Head of Planning
Clinical Unit Chairs
General Managers
Head of Procurement
Other individuals by invitation

Secretarial support shall be provided to the Committee to take minutes of the meeting and give appropriate support to the Chair and Committee members, initially from the Finance Department.

Quorum Chair or nominated deputy, one other NED and two Directors which must include either the Chief Finance Officer or her deputy

Frequency/ Duration Meetings shall normally take place on a monthly basis and the Committee will meet not less than 8 times a year.

Authority The Committee with operate under the broad aims of reviewing financial and resources strategies and risks. This will include the financial consequences of HR strategies, capital and revenue investments and productivity and savings plans ("CRES"). The Committee has responsibility on behalf of the Board to:

The Committee has responsibility on behalf of the Board to:

- Review monthly financial performance information including CRES performance and capacity and workforce productivity measures
- Review and recommend financial plans to the Board and business cases requiring board approval

- Identify areas of strategic and business risk which impact on financial sustainability and report these to the Board
- Oversee the development of the Trust's long term financial strategy and its Capital plans and Investment strategy
- Ensure value for money is obtained by the Trust

Duties

Financial

- To receive and consider the annual financial plan for revenue and capital, and make recommendation to the Board.
- To review progress against key financial and external targets, including financial performance, CRES plans, workforce costs and financial risk ratings (e.g. Monitor metrics).
- To ensure appropriate contracting arrangements are in place and review overall performance against contract.
- To review the Trust's management processes for the development and implementation of the estates and IT strategy and to review estates and IT performance ensuring actions are agreed as appropriate.
- To advise the Board on best practice and policy in relation to financial management, including latest Monitor guidance.
- To examine specific areas of financial risk and highlight these to the Board as appropriate.
- To review capacity utilization, productivity and efficiency measures.
- To review the Trust's procurement policies and functions and ensure they are fully aligned with the savings plan.
- To review the Trust's treasury policies and plans.

Human Resources

- To ratify annual workforce plans to ensure achievement of the Trust's Annual Financial Plan, CRES plans and Long Term Financial projections. The work of the Committee does not include consideration of workforce matters and plans relating to the effective delivery of clinical services and clinical outcomes which, if they arise, will be referred to Management Board for consideration.
- To review key workforce/HR performance indicators including sickness absence, appraisal and mandatory training, temporary staffing costs, equality & diversity and recruitment & retention/turnover, ensuring appropriate actions are agreed and progressed as required utilizing benchmarking data where appropriate.
- To review, advise upon and approve opportunities for maximizing workforce productivity.
- To monitor progress against the Trust's Equality Scheme on behalf of the Board of Directors

Capital and revenue investments /service developments

- To advise the Board and maintain an oversight on all major investments and business developments including the Redevelopment programme
- To advise the Board on all proposals for major Capital expenditure over £1,000,000 and to approve financial governance for approving proposals under £1,000,000

I&T & Estates

- To review and make recommendations to the Board on the Trusts IT, Information and Estates Strategies

- To seek assurance that the strategies are delivered in accordance with agreed milestones
- To identify key risks associated with the delivery of strategies and ensure these are reported to the Board.

Reporting

The Committee will ensure that the minutes of its meetings are formally recorded and submitted to the Board along with a verbal Chair's report identifying key areas discussed at the most recent Meeting. Any items of specific concern or which require Board of Directors approval will be the subject of a separate report.

The Committee will prepare and submit an annual report on its activities and its effectiveness to the Board of Directors.

The Committee will receive regular reports on financial performance, workforce and staff costs, relevant metrics which will include information at clinical unit and departmental level and capital investment.

Sub Committees/ Working groups reporting to the Committee:

None but the Committee will receive the minutes of the Redevelopment Steering Group, CASP, Technical Delivery Board, CESC

Conduct

- The Committee will develop a work plan with specific objectives which will be reviewed regularly by the Trust Board and the Committee will review its effectiveness on an annual basis.

- Agendas, papers and minutes to be distributed not less than 4 working days prior to meetings. Papers to be tabled in exceptional circumstances. Any other business to be notified to the Chair of the meeting in advance.

Other Matters

These Terms of Reference will be reviewed following 6 months of operation and thereafter on an annual basis.

DATE: December 2011
REVIEW DATE: September 2012

ATTACHMENT R

Great Ormond Street Hospital for Children NHS Trust

Trust Board

Key Performance Indicator Report

Nov-11

Objective	Graph	Page no.	Reported	YTD Target/Trajectory (11/12)	**YTD Performance**	**In month / quarter performance**	Monthly Trend								Quarterly Trend			
							Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4
Objective 1	Incidence of C.difficile	6	Monthly	5.25	7	1	2	1	1	0	1	1	0	1	4	2		
	Incidence of MRSA	6	Monthly	0	3	1	1	0	1	0	0	0	0	1	2	0		
	Incidence of MSSA	6	Monthly	11/12 setting the baseline	13	3	1	1	0	2	0	3	3	3	2	5		
	Incidence of E-Coli	6	Monthly	11/12 setting the baseline	10	1	0	0	1	1	3	1	3	1	1	5		
	No. of NICE recommendations unreviewed	6	Monthly	0	-	1	3	6	7	8	11	0	2	1	7	0		
	CV Line related blood-stream infections	7	Monthly	1.5	2.19	2.23	1.38	2.52	1.88	2.62	2.50	1.89	2.23	-	2.00	2.33		
	Mortality Figures	7	Monthly	Within tolerance	70	12	7	8	11	4	11	8	9	12	26	23		
	Serious Patient Safety Incidents	7	Monthly	Within tolerance	14	1	2	0	4	1	4	0	2	1	6	5		
	Surgical Check List completion rate %	7/8	Monthly	95%	-	86.1	72.1	71.5	77.4	83.6	80	83.7	84.6	86.1	73.0	82.0		
	48 Hour readmission to ITU	8	Quarterly	3%	-	1.18			1.14			1.18			1.14	1.18		
	18 week referral to treatment time performance - Admitted	9	Monthly	90	93.8	95.7	91.2	91.3	94.8	92.4	96.1	95.7	95.4	-	92.7	94.7		
	18 week referral to treatment time performance - Non-Admitted	9	Monthly	95	96.4	96	97.7	97.6	97.0	96.8	95.1	96.0	95.9	-	97.1	95.9		
	Inpatients waiting list profile (26+)	9	Monthly	0	-	148	66	73	64	71	163	118	148		64.0	118.0		
	95th Centile - Admitted	9	Monthly	<23 weeks	19.6	18	21.8	21.3	19.2	21.5	17.8	17.9	18	-	20.7	18.3		
	95th Centile - Non-Admitted	9	Monthly	<18.3 weeks	17.7	17.9	17.6	17.7	17.5	17.5	18.0	17.8	17.9	-	17.6	17.8		
	Median Waits - Admitted	9	Monthly	<11.1 weeks	10.10	10.3	9.5	8.9	11.4	11.3	9.4	9.6	10.3	-	10.0	10.1		
	Median Waits - Non-Admitted	9	Monthly	<6.6 weeks	7.1	7.7	7.0	8.2	7.1	6.7	6.5	6.9	7.7	-	7.3	6.7		
	95th Centile - Incomplete Pathways	10	Monthly	<28 weeks	33.7	27.9	33.8	36.6	37.4	36.5	25.7	27.9	27.9	-	37.0	30.5		
	Median Waits - Incomplete Pathways	10	Monthly	<7.2 weeks	8.1	7.3	8.7	9.8	9.0	8.1	7.0	7.6	7.3	-	9.1	7.6		
	Discharge summary completion (%)	10	Monthly	95	78.7	80.2	74.3	77.2	77.2	80.8	80.4	74.9	77.7	80.2	76.29	78.37		
	DNA rate (new & f/up) (%)	10	Monthly	10	7.1	8.4	8.6	8.9	6.9	8.2	8	7.1	7.4	8.5	8.03	8		
	Percentage of Cancelled Operations	11	Monthly	0.80%	0.76%	0.81%	0.70%	0.86%	0.74%	0.69%	0.71%	0.72%	0.77%	0.81%	0.78%	0.72%		
	Percentage of Camcer patients waiting no more than 31 days for second of subsequent treatment - Surgery	11	Monthly	94	100	100	100	100	100	100	100	100	100	100	100	100		
	Percentage of Cancer patients waiting no more than 31 days for second of subsequent treatment - Drug treatments	11	Monthly	98	100	100	100	100	100	100	100	100	100	100	100	100		
	Percentage of Cancer patients waiting no more than 31 days for second of subsequent treatment - Radiotherapy	11	Monthly	94	100	100	100	100	100	100	100	100	100	100	100	100		
	Maximum waiting time of one month from diagnosis to treatment for all cancers.	12	Monthly	85	100	100	100	100	100	100	100	100	100	100	100	100		
	Number of complaints	12	Monthly	New indicator to be confirmed	85	5	21	8	12	9	10	13	7	16	41	32		
	Number of complaints by grade Low	12	Monthly	New indicator to be confirmed	37	3	6	1	3	3	6	8	7	11	10	17		
	Number of complaints by grade Medium	12	Monthly	New indicator to be confirmed	42	2	13	7	9	6	2	3	0	4	29	11		
	Number of complaints by grade High	12	Monthly	New indicator to be confirmed	6	0	2	0	0	0	2	2	0	1	2	4		

Objective	Graph	Page no.	Reported	YTD Target/Trajectory (11/12)	**YTD Performance**	**In month / quarter performance**	Monthly Trend								Quarterly Trend			
							Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4
Objective 3	Theatre Utilisation (Patient Operation Utilisation of Scheduled Duration U4)	13	Monthly	70	-	66.9	72	74.3	70	71.4	67.4	69.5	70.8	66.9	72.1	69.4		
	New to follow up ratio	13	Monthly	4.18	4.37	4.25	4.4	4.3	4.6	4.2	4.4	4.4	4.25	-	4.4	4.33		
	Patient refusals	13	Monthly	To reduce	174	31	28	22	19	27	9	18	20	31	69	54		
	Clinical Income variance	13	Monthly	-	-£1,336,486	-	0	£1,053,912	£278,133	£48,168	-£511,511	-£1,184,496	-£1,436,184	-£1,336,486	£278,133	-£1,184,496		
Objective 4	Number of Active Research Projects	14	Monthly	-	-	486	649	639	625	621	617	603	606	598	625	603		
	UKCRN Portfolio Studies	14	Monthly	-	-	96	93	95	96	97	96	96	96	97	96	96		
	Clinical trials recruitment portfolio	14			-	1	112	118	157	117	148	69	1	1	387	334		
	GOSH Research Grants (£)	14	Monthly	-	-	58,000	53,502	42,244	60,558	495,853	27,500	218,142	58,000	0	156,304	741,495		
	Research Grant Awards (£)	14	Monthly	-	-	382,713	465,797	1,447,693	1,052,451	2,220,191	806,276	1,053,908	382,713	310,202	2,965,942	4,080,375		
	Patient safety reports for GOSH-sponsored clinical trials	15	Monthly	-	6	1	1	0	3	0	0	1	0	1	4	1		
Objective 5	MADEL SLA Value (£)	16	Quarterly	5,627,351	5,627,351	-			5,697,359			5,627,351			5,697,359	5,627,351		
	SIFT SLA Value (£)	16	Quarterly	60,142	60,142	-			60,142			60,142			60,142	60,142		
	NMET SLA Value (£)	16	Quarterly	1,007,342	1,007,342	-			1,058,375			1,007,342			1,058,375	1,007,342		
Objective 6	CRES Forecast Savings 2011/12	17	Monthly	15,773,126	10,506,544	-	15,063,656	15,240,001	16,525,262	16,525,262	16,525,262	11,759,564	11,759,564	10,506,544	16,525,262	11,759,564		
	Bank and agency total expenditure	17	Monthly	To Reduce	-	1,454	1,253	1,152	1,312	1,577	1,338	1,721	1,618	1,454	3,717	4,636		
	Monitor Risk Rating	17	Monthly	3	-	3	2	2	3	3	3	3	3	3	3	3		
	Charity fundraising income	18	Monthly	32,605,203	33,572,195	4,919,193	2,899,725	3,324,829	4,212,132	5,929,690	4,032,098	8,254,528	4,919,193	-	10,436,686	18,216,316		
Objective 7	Sickness Rate	19	Quarterly	3.3	-	3.27			3.27			3.27			3.27	3.27		
	Staff in Post (£)	19	Quarterly	-	-	3352.7			3245.66			3352.7			3245.66	3352.7		
	Vacancy Rate	19	Quarterly	-	-	6.60%			6.66%			6.60%			6.66%	6.60%		
	Trust Turnover	19/20	Quarterly	-	-	21.1%			20.9%			21.1%			20.9%	21.1%		
	Staff PDR completeness - clinical (%)	20	Monthly	80	-	66.2	73.3	75.7	75.9	77.6	75.9	72.1	68.6	66.2	75.9	72.1		
	Staff PDR completeness - non clinical (%)	20	Monthly	80	-	57.2	73	74.9	73	72.3	71.1	65.8	61.9	57.2	73	65.8		
	Information Governance Training	20	Monthly	-	-	87	34.2	51.5	83.0	85.5	88.4	89.8	87.0	87.7	83	89.8		

* Rolling 12 month position

**Were an NHS foundation trust has an annual MRSA objective of six cases or fewer (the de minimus limit) and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purpose of Monitor's Compliance Framework.

For Key, see Glossary

Appendix 3. Monitor Governance Risk Rating

Targets - weighted 1.0 (national requirements)		Thresholds	Weighting	Monitoring period	Performance Score									
					Month 1	Month 2	Month 3	Q1	Month 4	Month 5	Month 6	Q2	Month 7	Month 8
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0	0	0	0	0	0	0	0	0	0
2	Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)	0	1	Quarterly	1	1	1	1	1	1	1	1	1	1
3	All cancers: 31-day wait for second or subsequent treatment comprising either:	TBC	1	Quarterly	0	0	0	0	0	0	0	0	0	0
	Surgery	94%			0	0	0	0	0	0	0	0	0	0
	anti cancer drug treatments	98%			0	0	0	0	0	0	0	0	0	0
	radiotherapy (from 1 Jan 2011)	94%			0	0	0	0	0	0	0	0	0	0
4	Admitted 95thCentile Performance	<23 weeks	1	Quarterly	0	0	0	0	0	0	0	0	0	0
5	Non-Admitted 95thCentile Performance	<18.3 weeks	1	Quarterly	0	0	0	0	0	0	0	0	0	0
6	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0	0	0	0	0	0	0	0	0	0
7	Stroke Indicator	TBC	0.5	Quarterly	-	-	-	-	-	-	-	-	-	-
8	Certification against compliance with requirements regarding access to healthcare for peopl e with a learning disability	N/A	0.5	Quarterly	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Total								1.5				1.5		
Overall governance risk rating								Amber-green				Amber-green		

Monitor governance rating	
Green	from 0 to 0.9
Amber-green	from 1.0 to 1.9
Amber-red	from 2.0 to 3.9
Red	4.0 or more

*Where an NHS foundation trust has an annual MRSA objective of six cases or fewer (the de minimis limit) and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of Monitor's Compliance Framework

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

Quality Governance – Self assessment October 2011 – overall summary

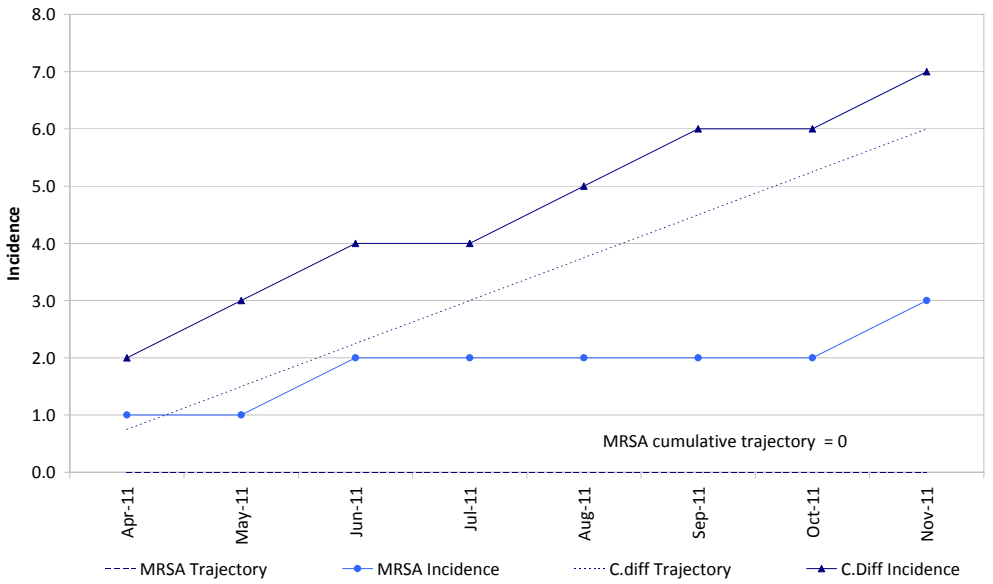
Strategy	Capabilities and Culture	Processes and Structures	Measurement
1A: Does Quality drive the Trusts' strategy? **Proposed RAG rating: Green**	2A: Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? **Proposed RAG rating: Green**	3A: Are there clear roles and accountabilities in relation to quality governance? **Proposed RAG rating: Green**	4A: Is appropriate quality information being analysed and challenged? **Proposed RAG rating: Amber / Green** Issues: Evidence of board challenge? To be discussed at TB Selection of KPIs
1B: Is the Board sufficiently aware of the potential risks to quality? **Proposed RAG rating: Green** Issues: Believe we have addressed Monitor concerns about CRES risk assessments from Sept 11. Remaining concerns about assessment of external risks (eg. funding)?	2B: Does the Board promote a quality focused culture throughout the Trust? **Proposed RAG rating: Green**	3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? **Proposed RAG rating: Green** Issues: Deloitte review recommendation about links between risk, quality and governance processes on whistle blowing has now been addressed.	4B: Is the Board assured of the robustness of the quality information **Proposed RAG rating: Amber / Green** Issues: Data quality assurance.
		3C: Does the Board actively engage patients, staff and stakeholders on quality? **Proposed RAG rating: Green**	4C: Is quality information used effectively? **Proposed RAG rating: Green**

Risk rating	Scoring	Definition	Evidence
Green	0	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber/Green	0.5	Partially meets expectations but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, has no major omissions and robust action plans to address perceived shortfalls with proven track record of delivery
Amber/Red	1	Partially meets expectations but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in early stage of development with limited evidence of track record of delivery
Red	4	Does not meet expectations	Major omission in Quality Governance identified. Significant volume of action plans required and concerns on management capacity to deliver.

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

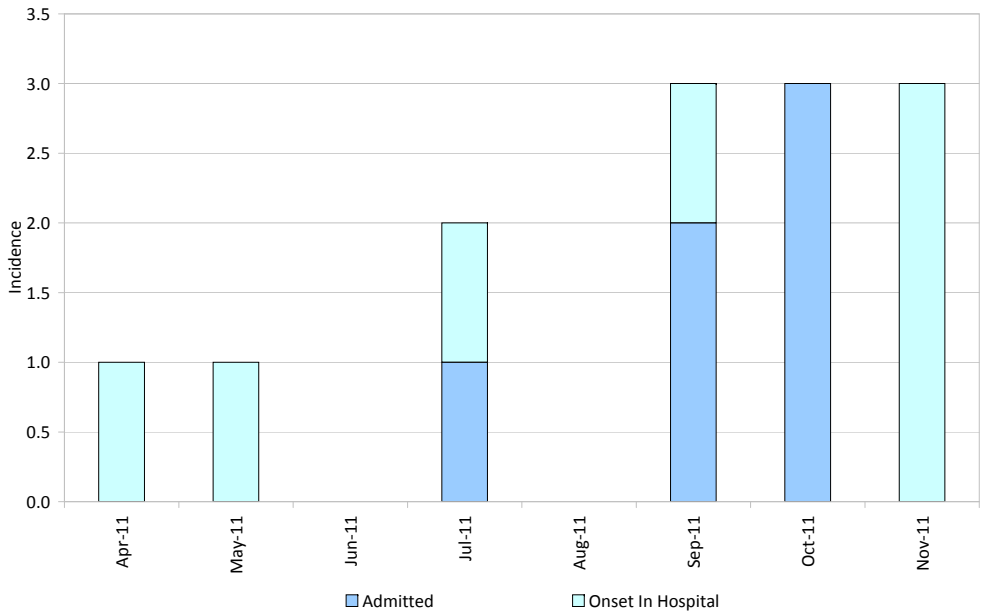
Graph 1. Incidence of MRSA and Cdifficile (cumulative totals)

National Target



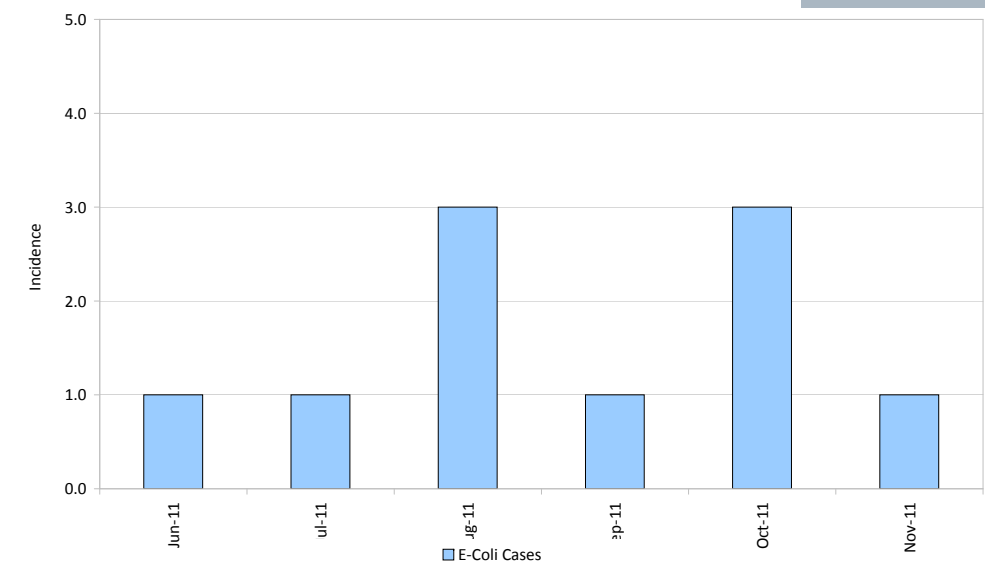
Graph 2. Incidence of MSSA

National Target



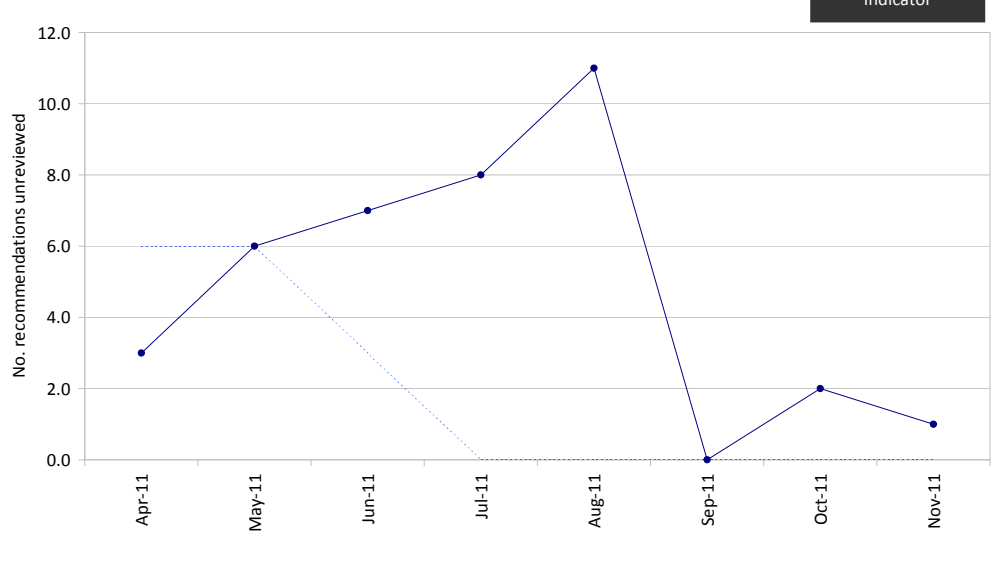
Graph 3. Incidence of E-Coli

National Target



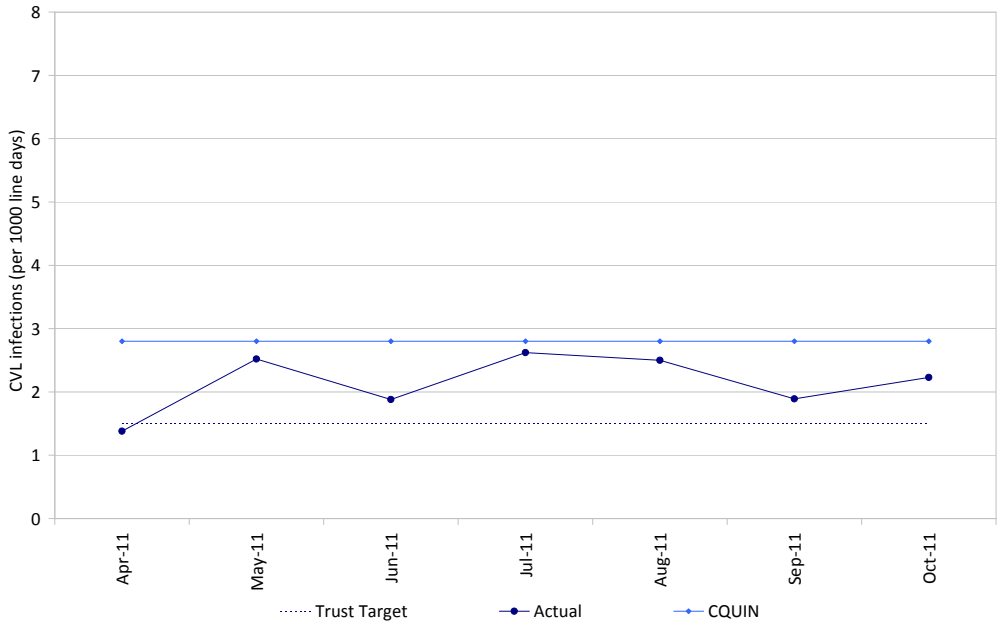
Graph 4. No. of NICE recommendations unreviewed

Internal Indicator



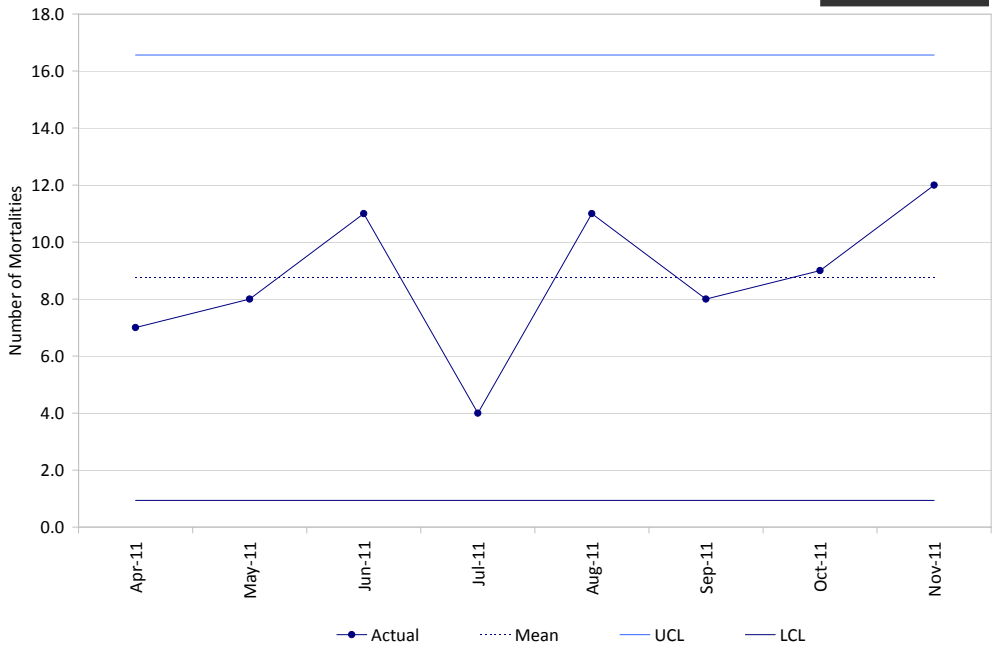
Graph 5. CV Line Infections (per 1000 bed days) - All areas

CQUIN Measure



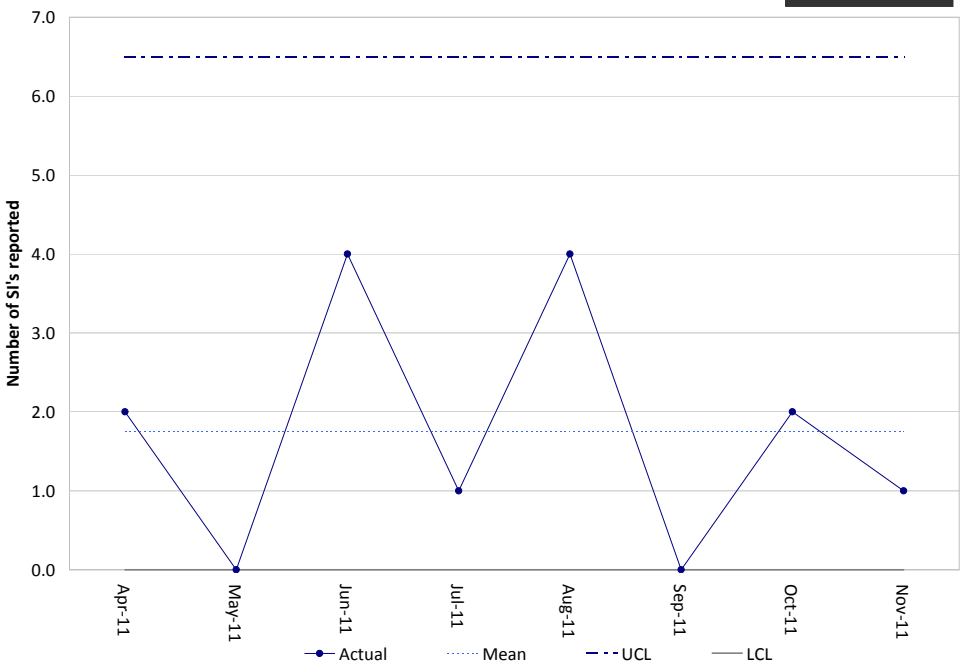
Graph 6. Mortality Figures - where discharge reason is 'Died'.

Internal Indicator



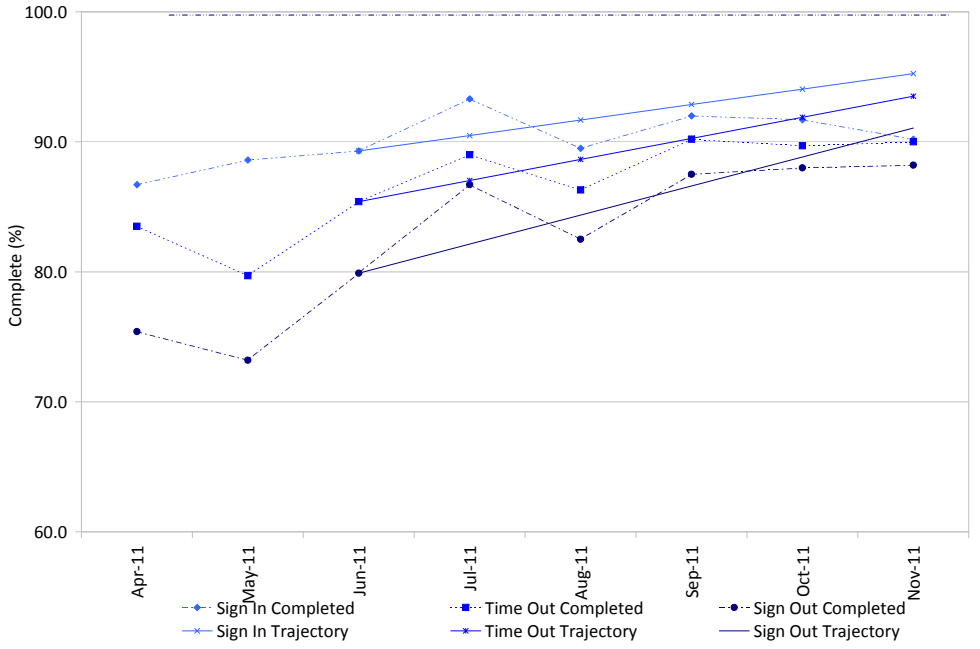
Graph 7. Serious Incidents Aug 2007 - May 2011

Internal Indicator

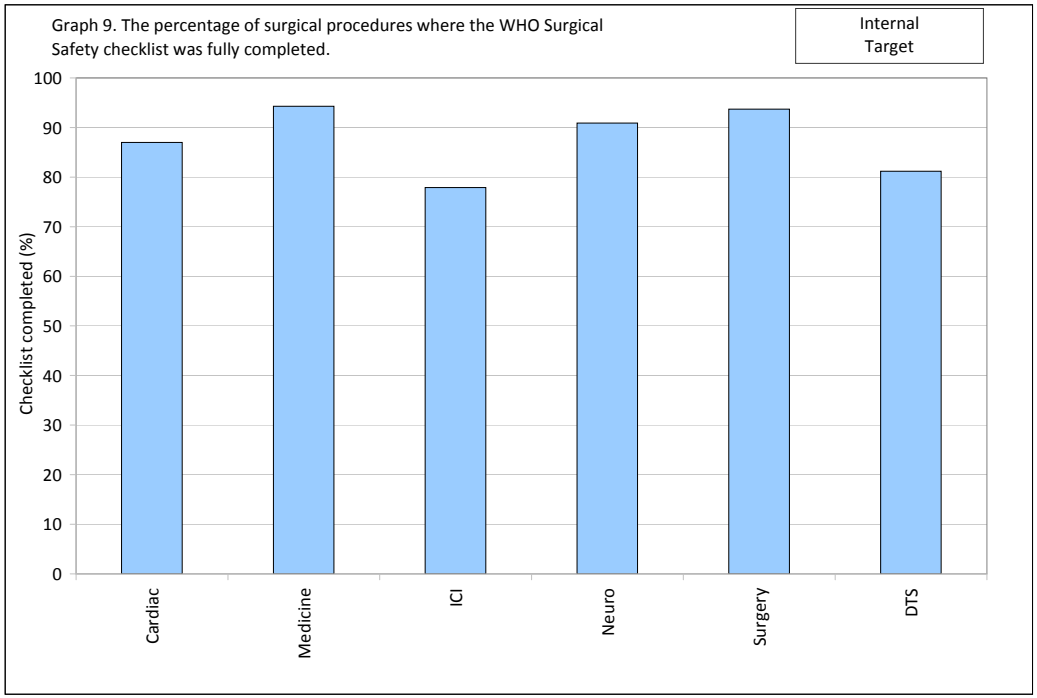


Graph 8. Theatre Patient Safety Checklist Completion rates against total operations

Internal Target



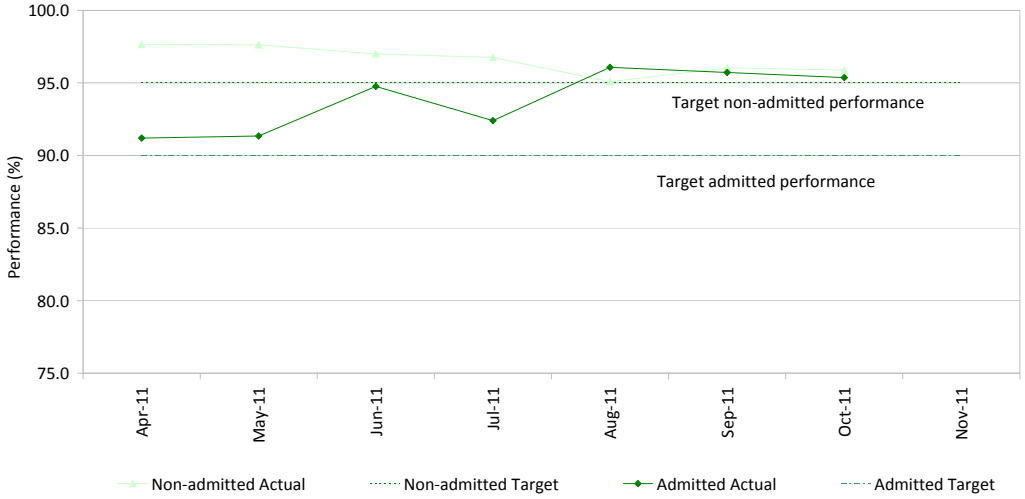
Graph 9. The percentage of surgical procedures where the WHO Surgical Safety checklist was fully completed.



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

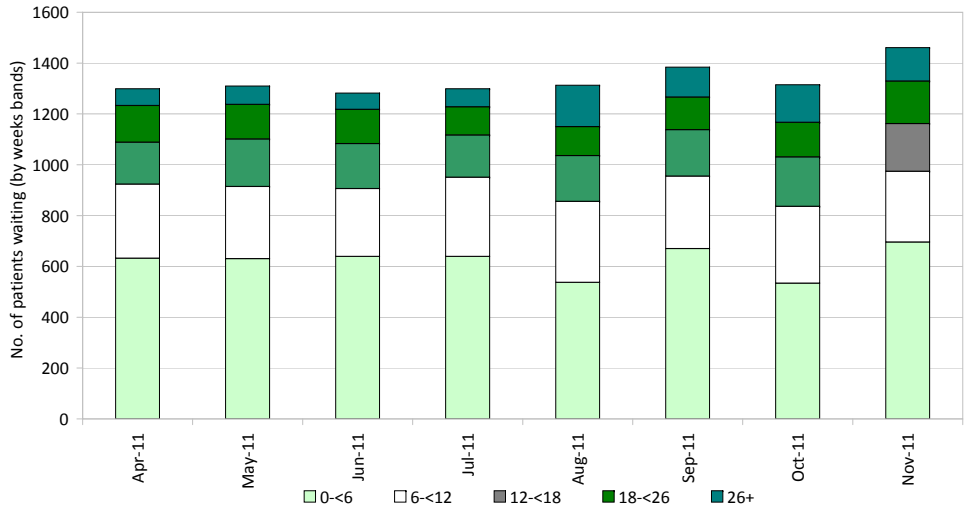
Graph 10. 18 week referral to treatment time performance

Contractual Target



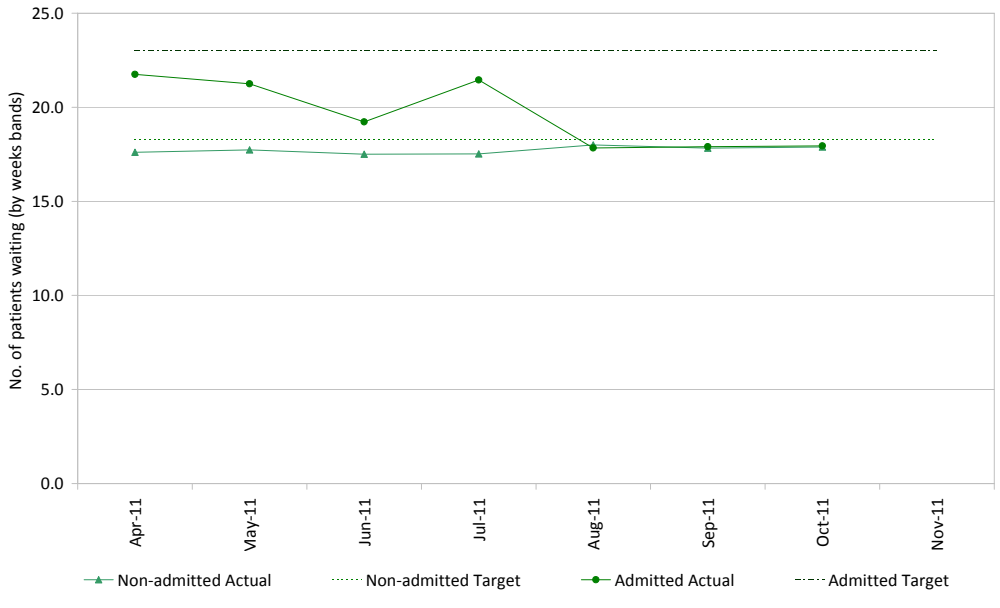
Graph 11. Inpatients waiting list profile by weeks waiting

Internal Indicator



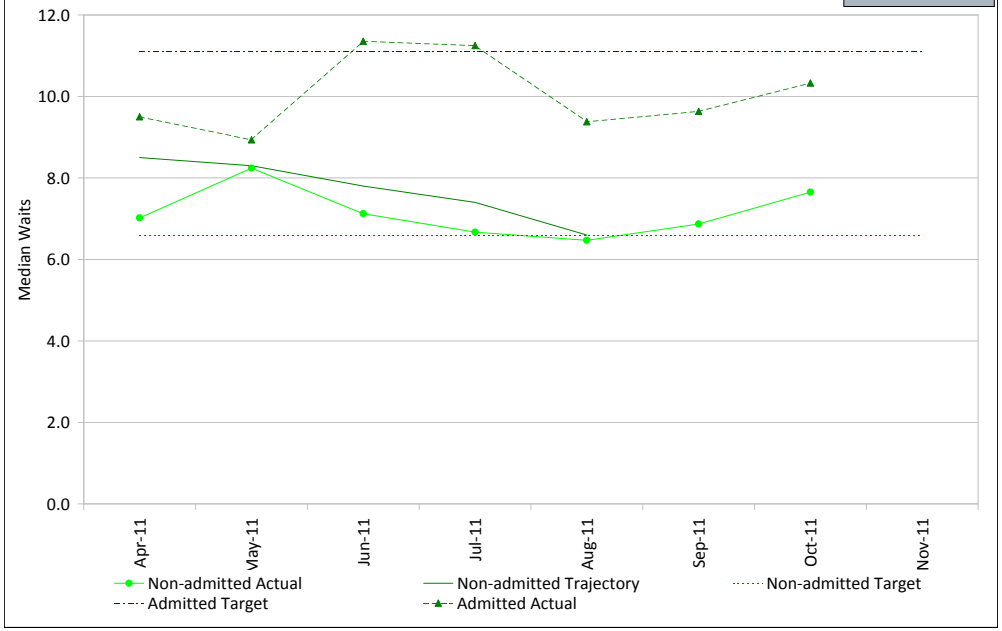
Graph 12. 95th Centile RTT performance against target (admitted and Non-admitted)

Contractual Target



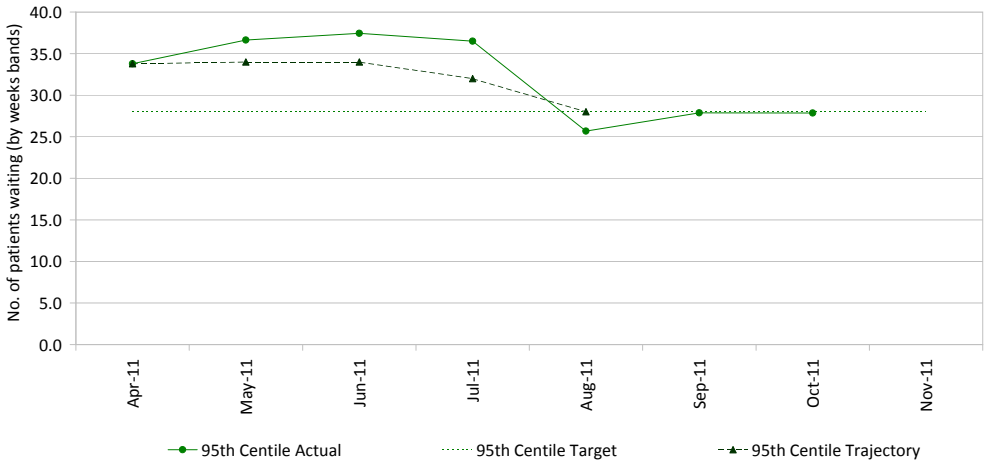
Graph 13. Median Wait RTT performance against target (Admitted and non-Admitted)

Contractual Target



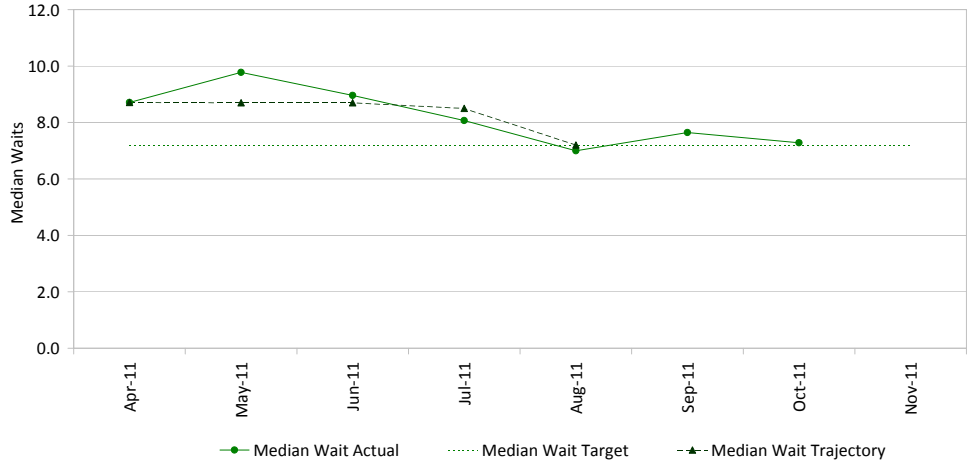
Graph 14. 95th Centile - Incomplete pathways

Contractual Target



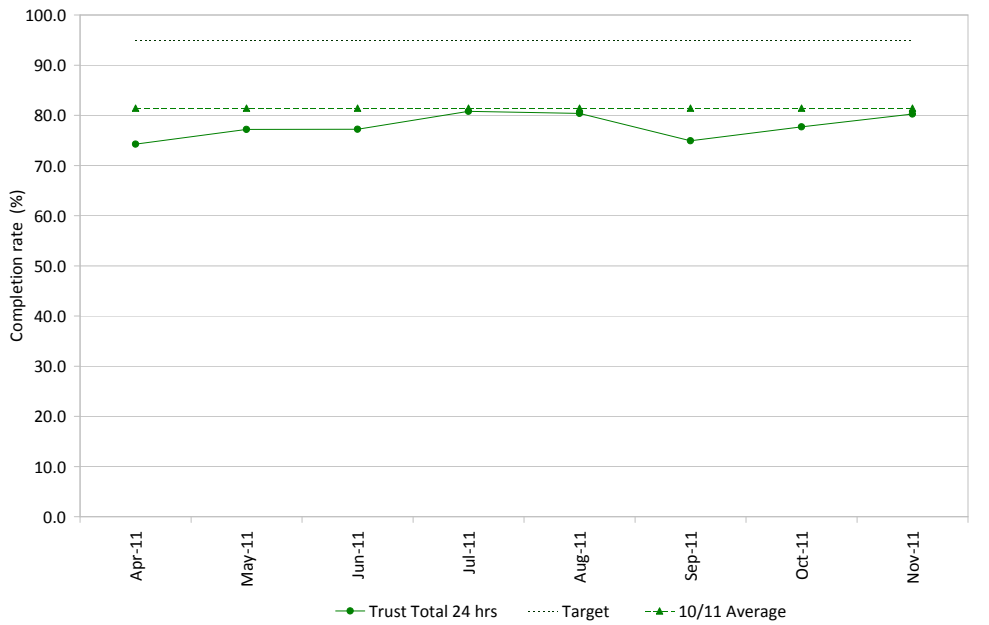
Graph 15. Median Waits - Incomplete pathways

Contractual Target



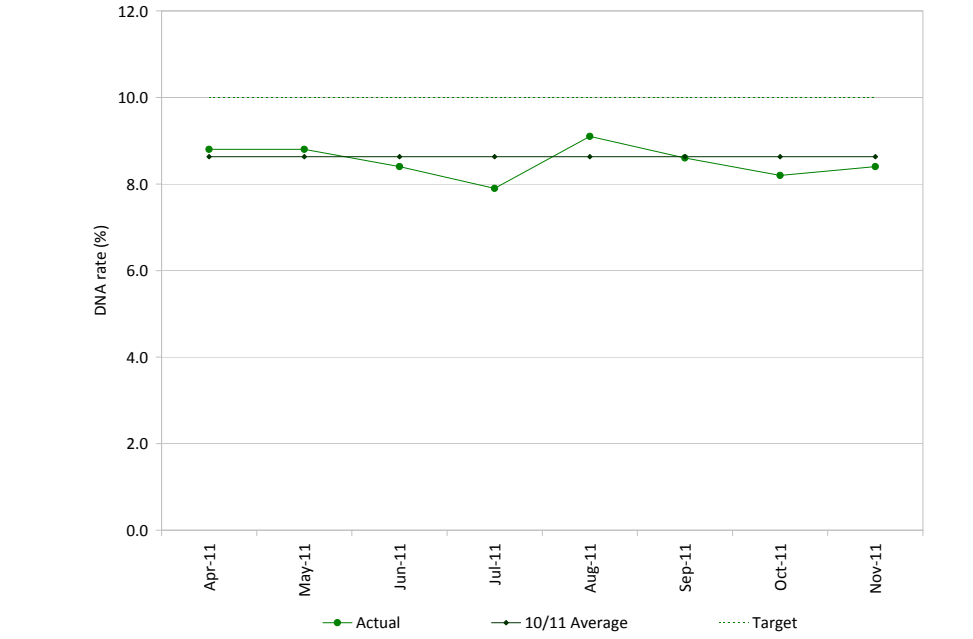
Graph 16. Trust wide discharge summary completion rates (within 24 hours)

Internal Target



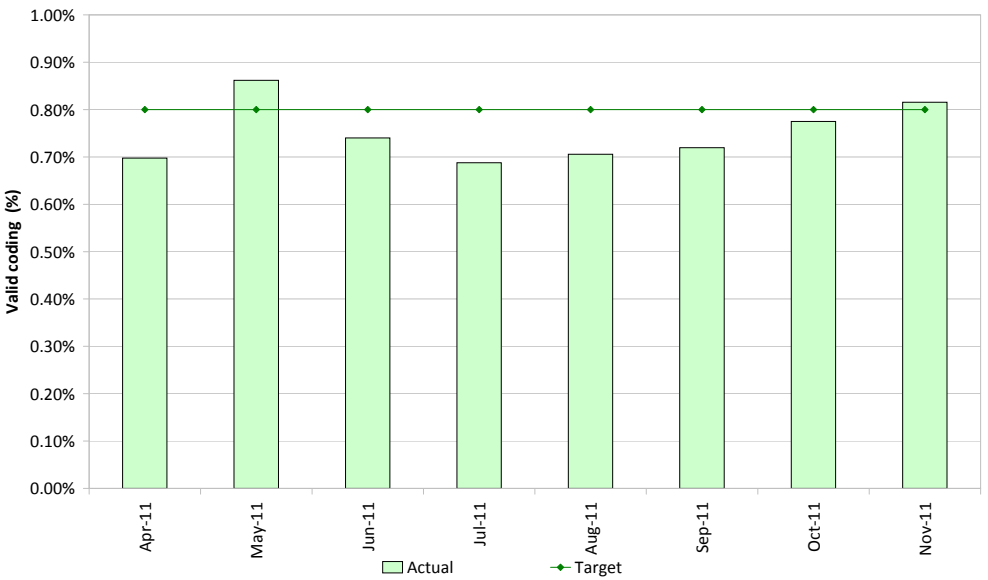
Graph 17. DNA rate (New and Follow-up patients)

Internal Target



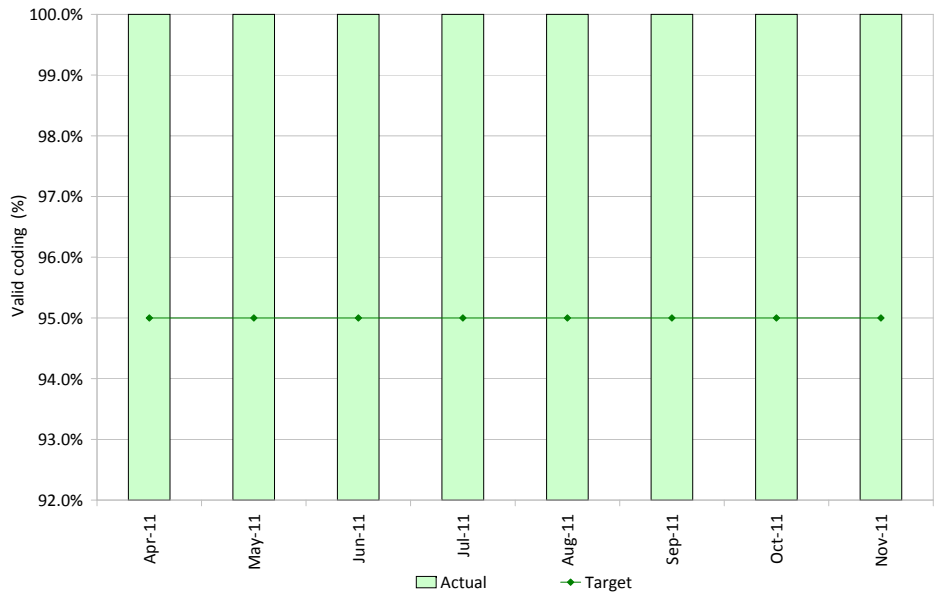
Graph 18. Percentage of all Cancelled Operations as a proportion of total elective spells

Contractual Target



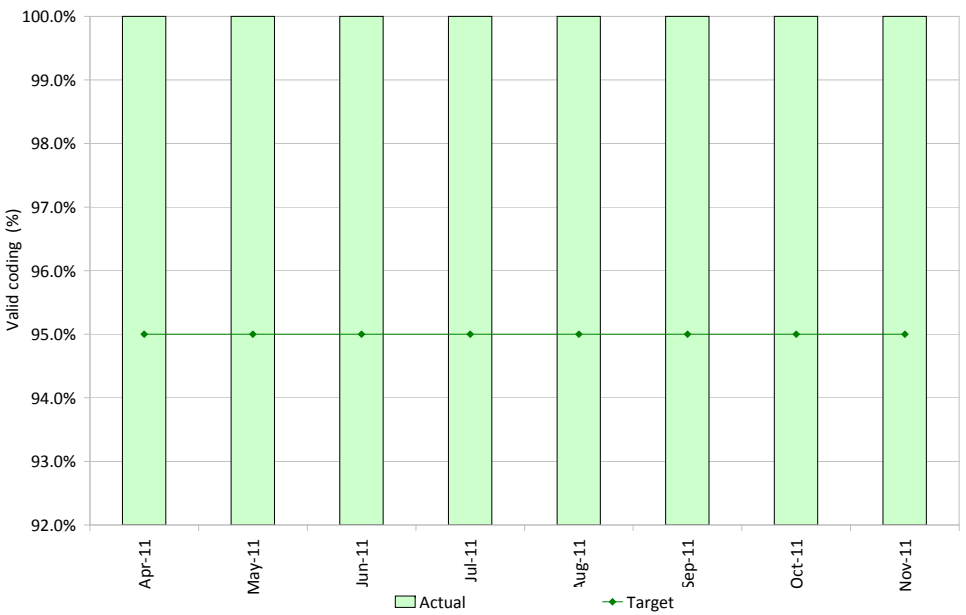
Graph 19. Proportion of patients waiting no more than 31 days for second or subsequent treatment - surgery

National Target



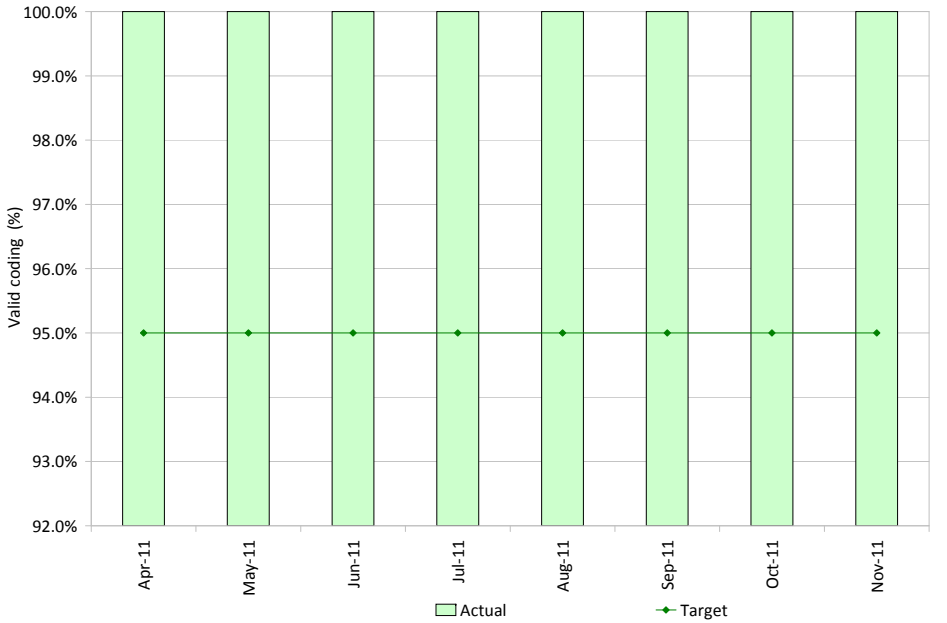
Graph 20. Proportion of patients waiting no more than 31 days for second or subsequent treatment - drug treatments

National Target

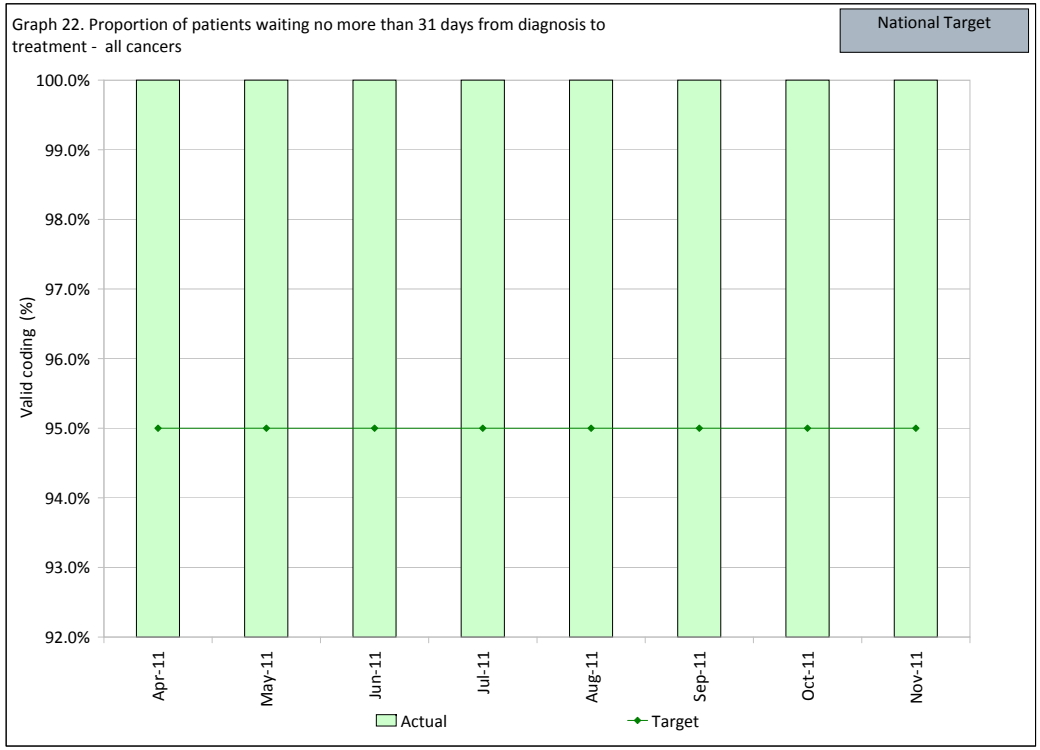


Graph 21. Proportion of patients waiting no more than 31 days for second or subsequent treatment - radiotherapy

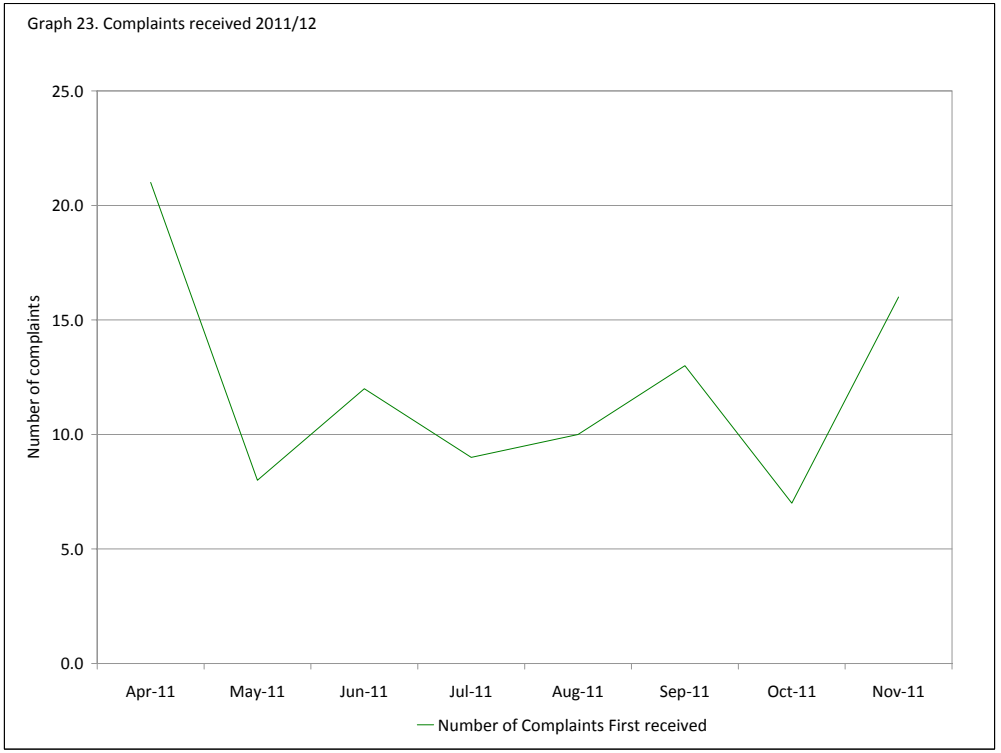
National Target



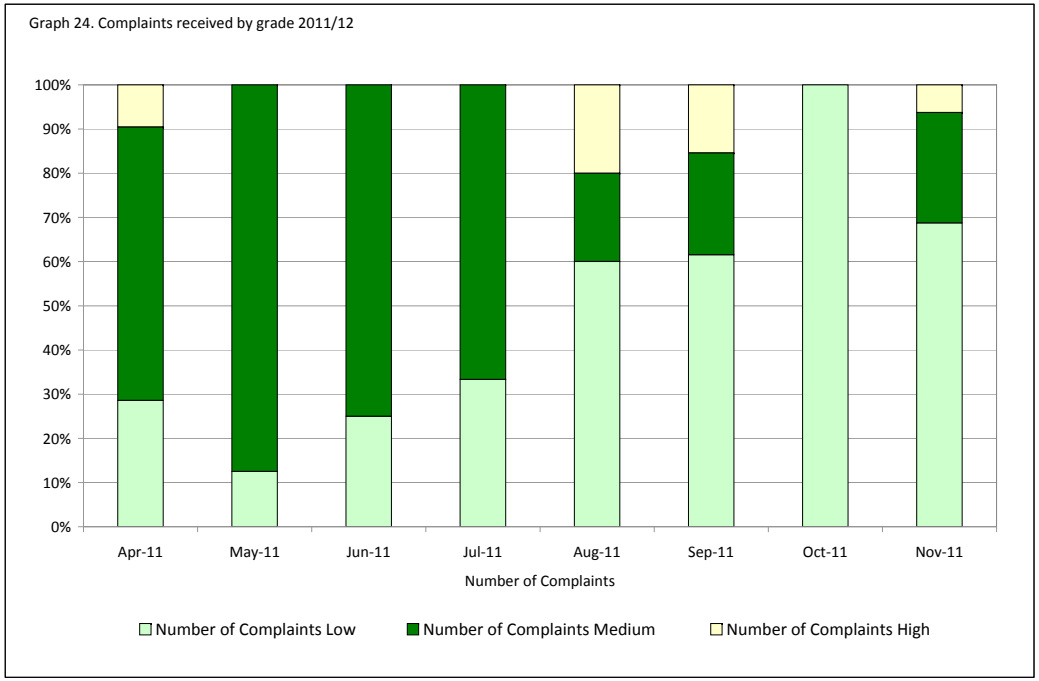
Graph 22. Proportion of patients waiting no more than 31 days from diagnosis to treatment - all cancers



Graph 23. Complaints received 2011/12



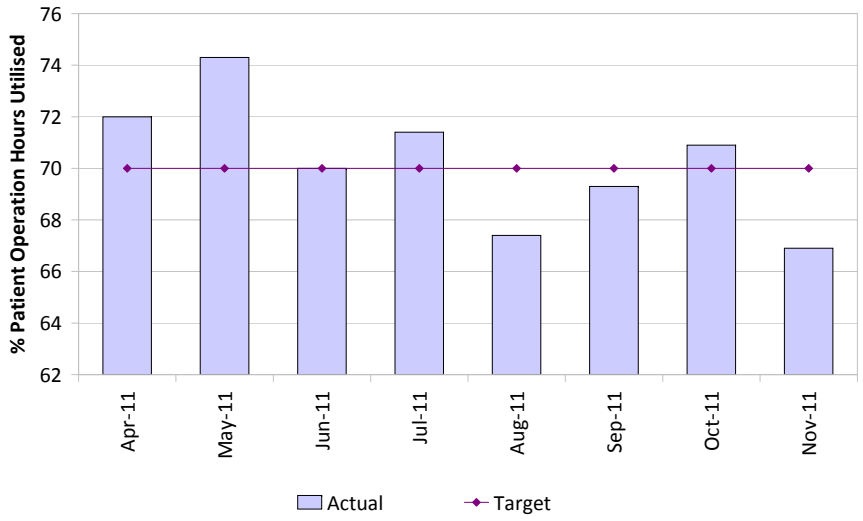
Graph 24. Complaints received by grade 2011/12



3. Successfully deliver our clinical growth strategy

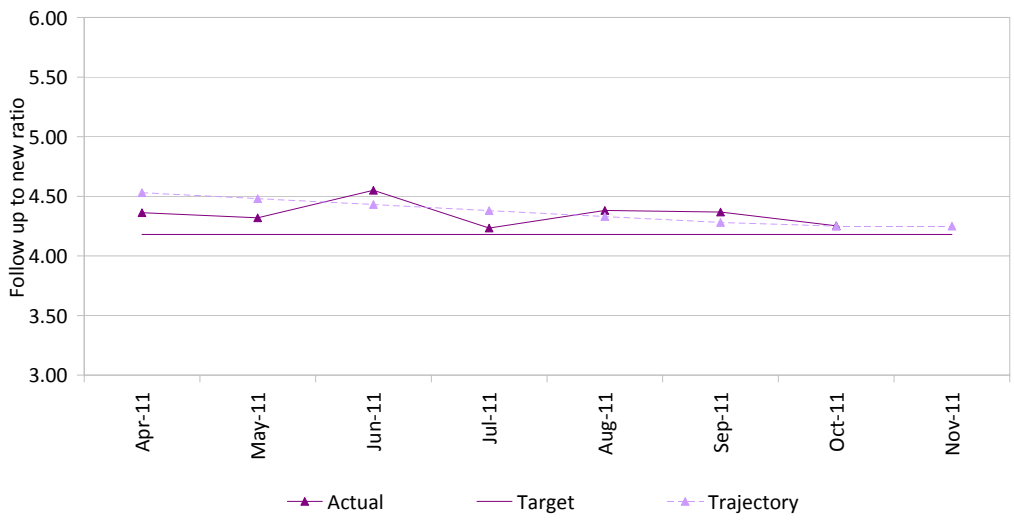
Graph 25. Theatre utilisation. Patient operation utilisation of scheduled duration (U4). All theatres, all services

Internal Target



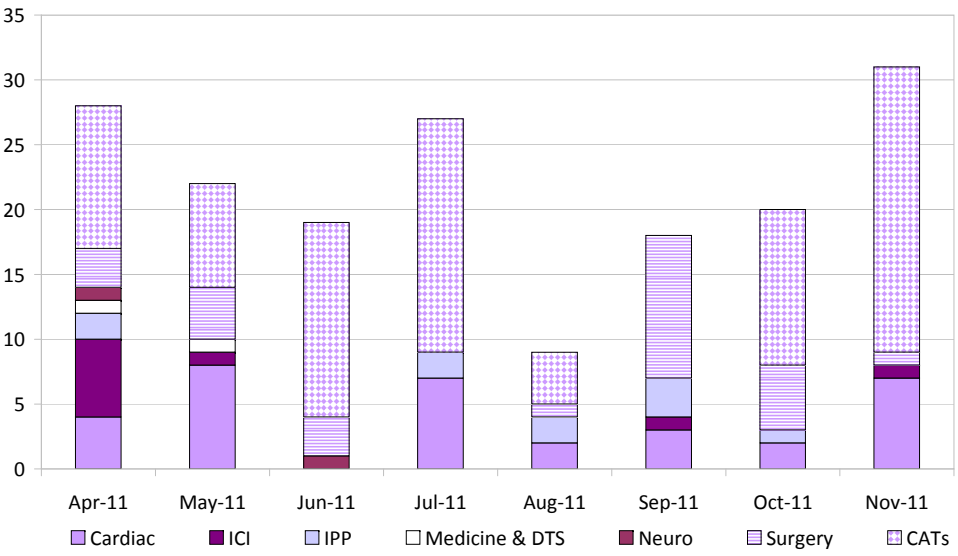
Graph 26. Follow up to new ratio

Contractual Target



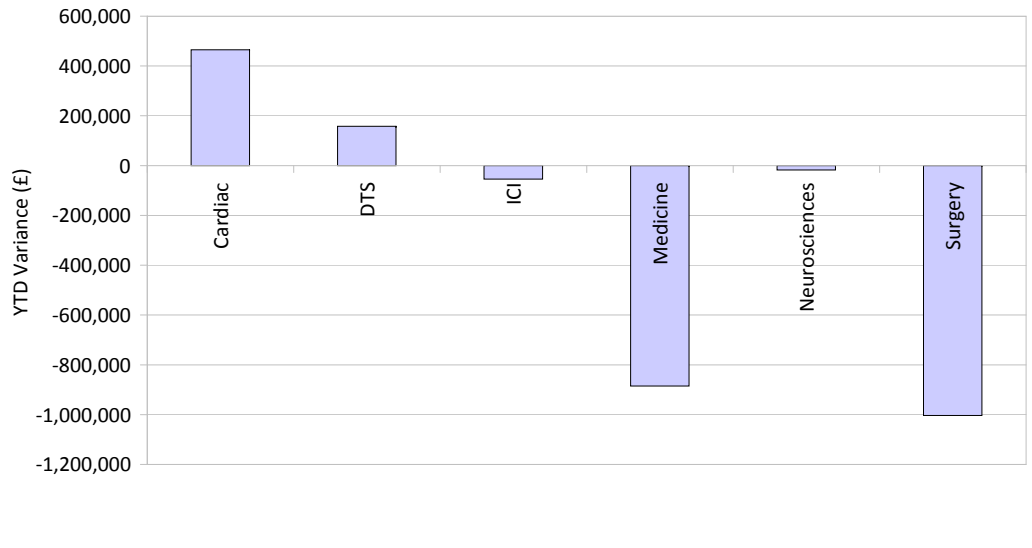
Graph 27. Patient refusals by clinical unit

Internal Indicator



Graph 28.Clinical income variance (Month 7 budget vs Month 7 actuals)

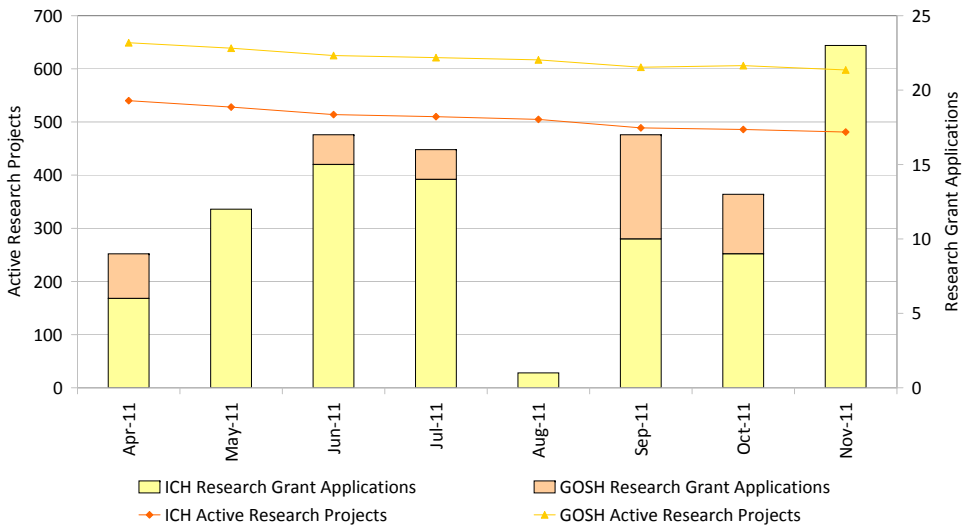
Internal Target



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

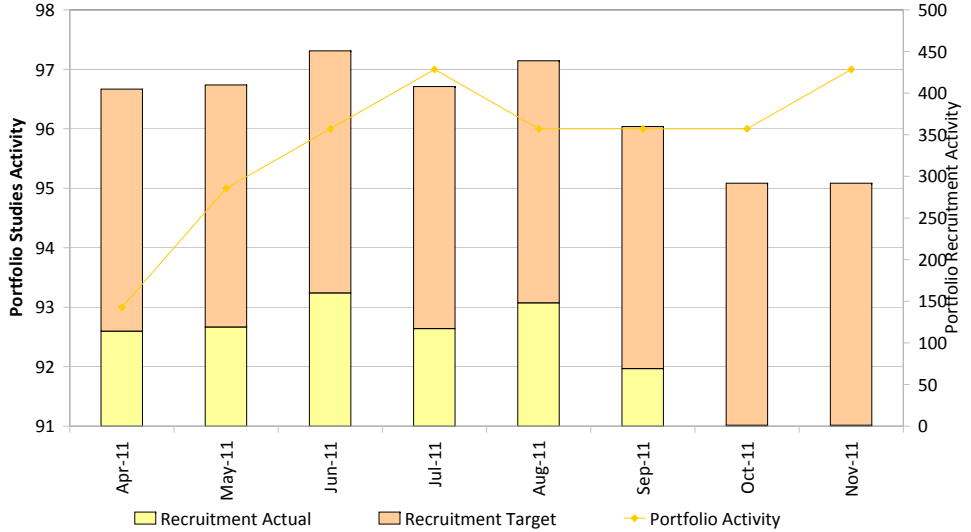
Graph 29. Research Activity

Internal Indicator



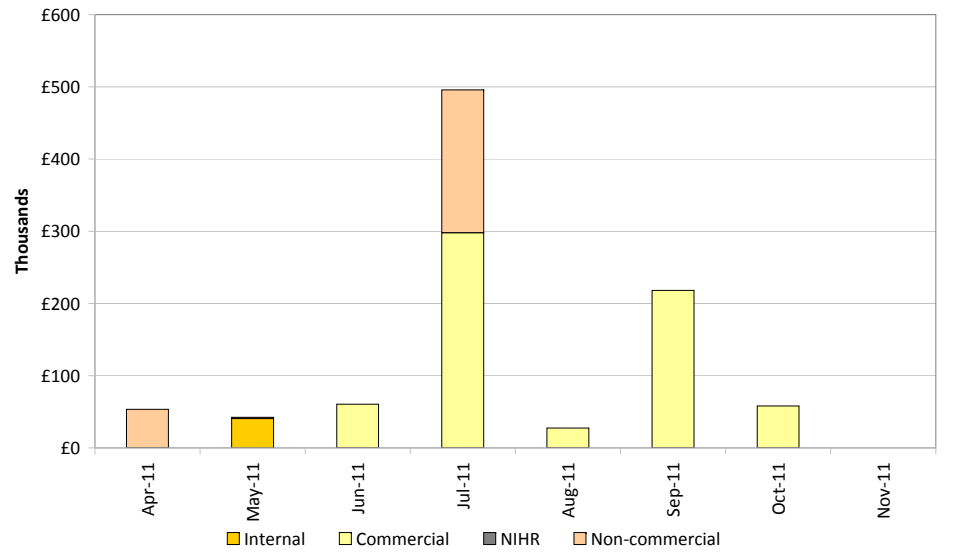
Graph 30. UKCRN Portfolio Activity

Internal Indicator



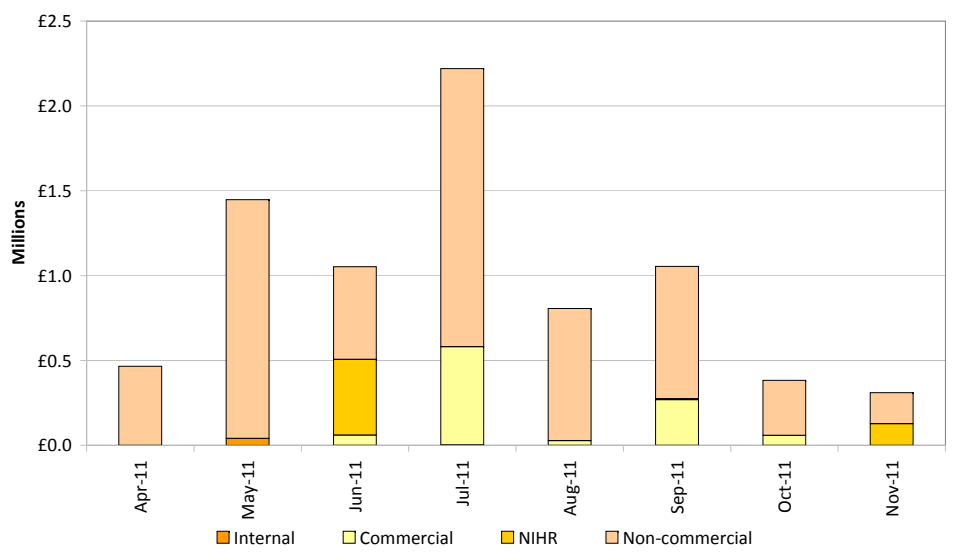
Graph 31. GOSH Research Grants

Internal Indicator



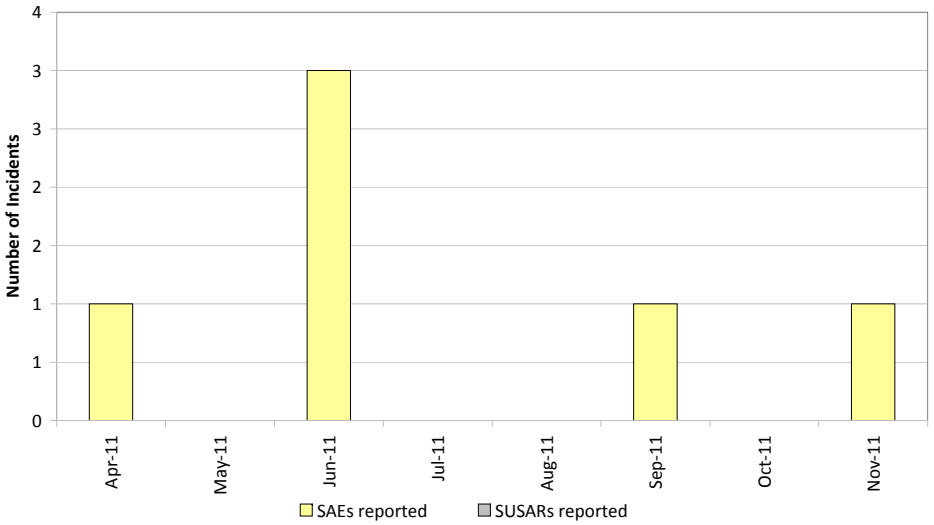
Graph 32. Research Grant Awards

Internal Indicator



Graph 33. Patient Safety reports for GOSH sponsored clinical trials

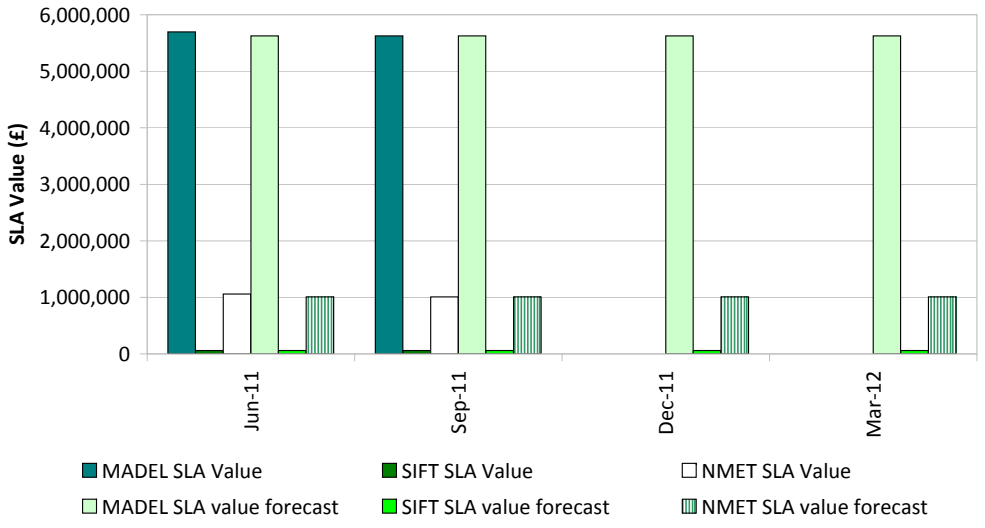
Internal Indicator



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

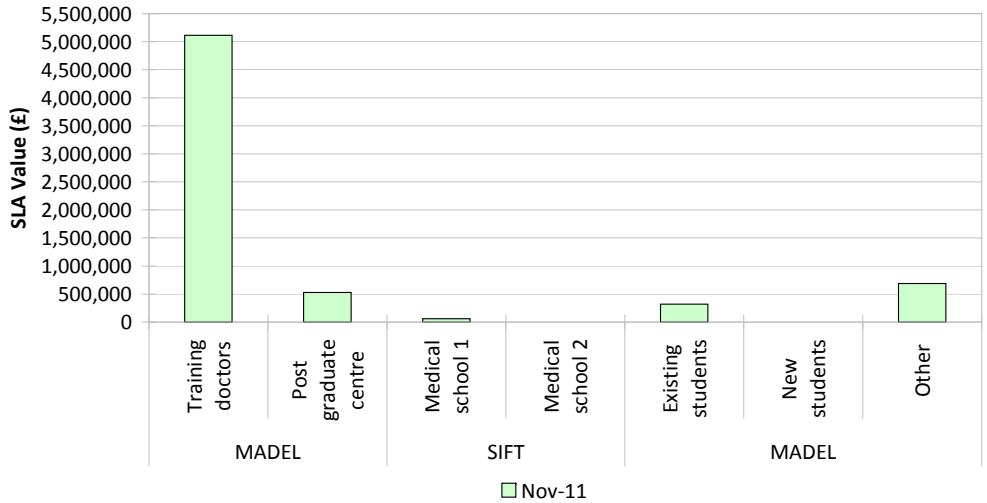
Graph 34. MPET SLA Total value summary

Internal Indicator



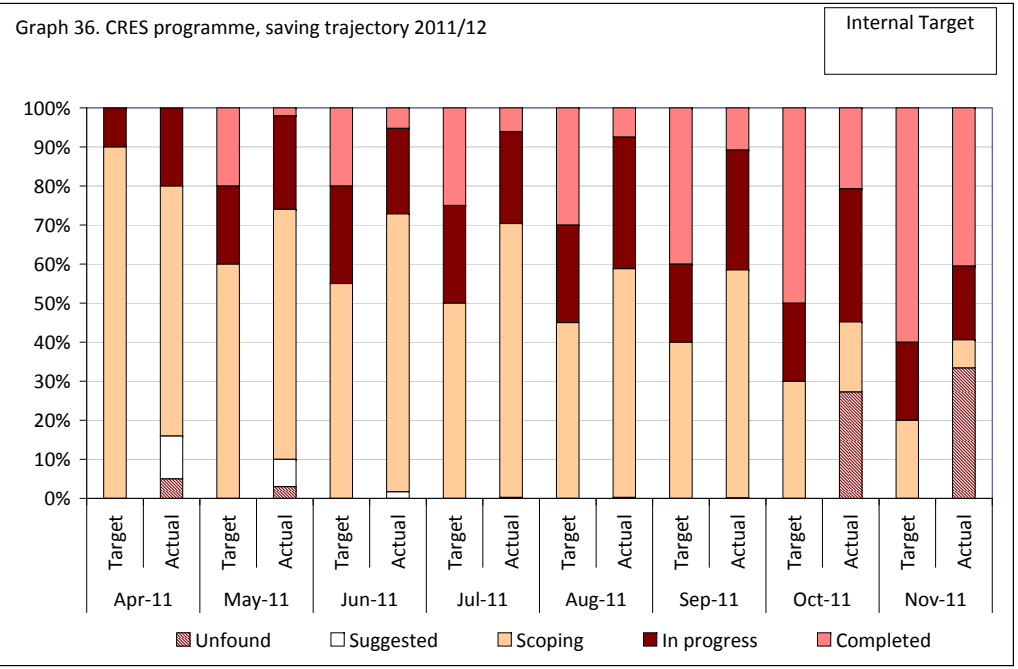
Graph 35. MPET Total SLA value detail

Internal Indicator

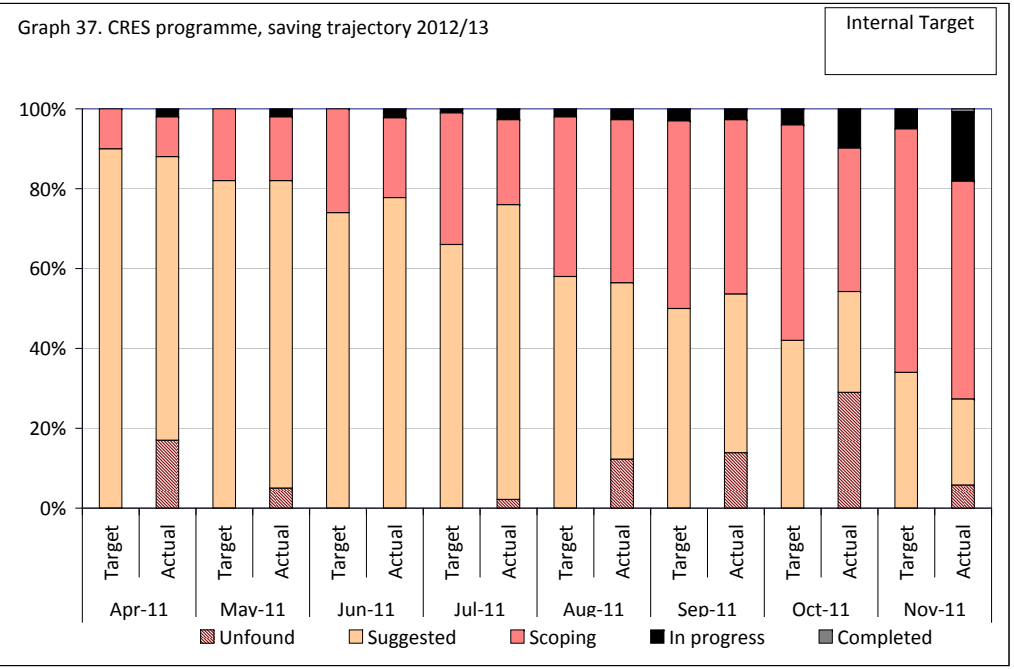


6. Deliver a financially stable organisation

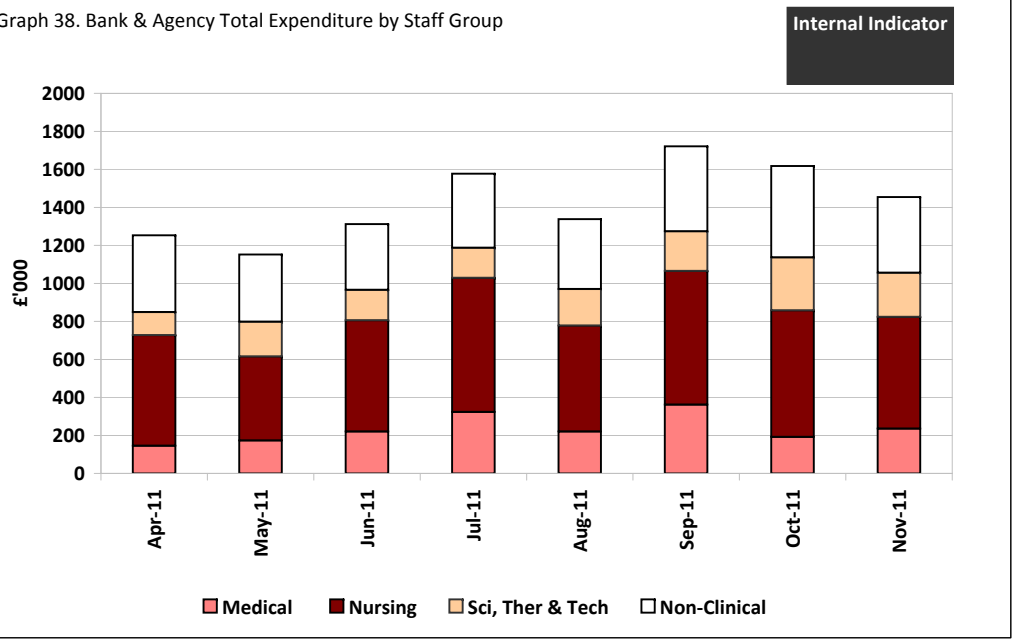
Graph 36. CRES programme, saving trajectory 2011/12



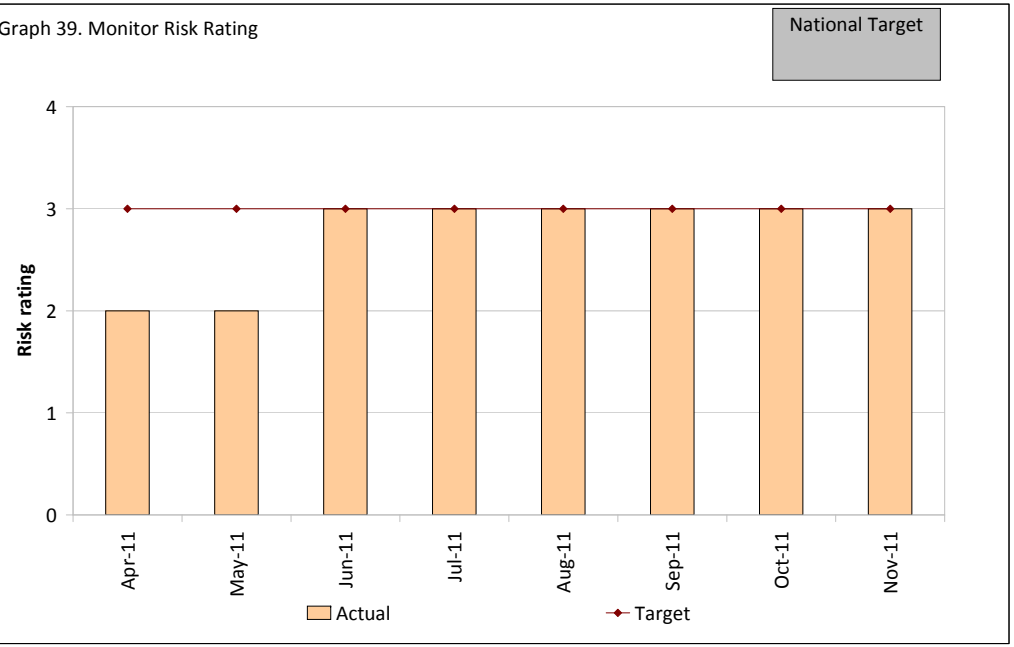
Graph 37. CRES programme, saving trajectory 2012/13



Graph 38. Bank & Agency Total Expenditure by Staff Group

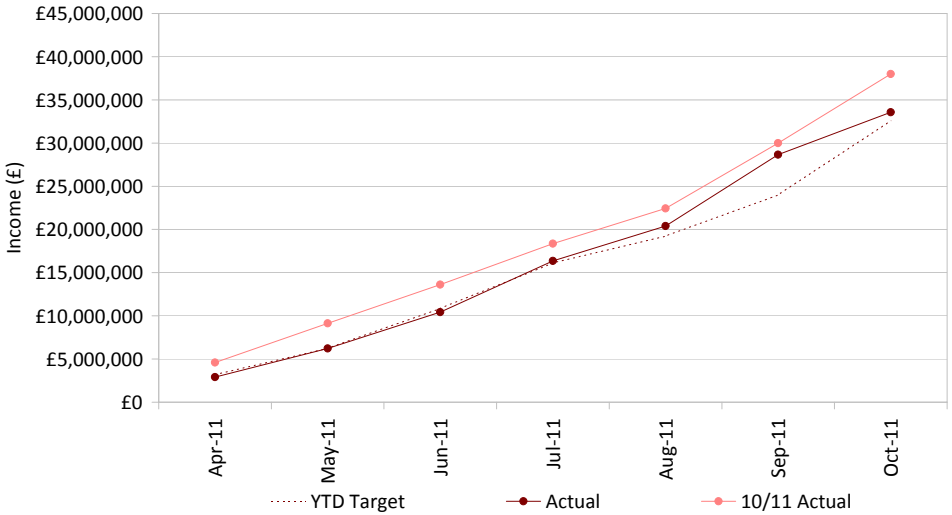


Graph 39. Monitor Risk Rating



Graph 40. Charity Fundraising. YTD Income against YTD budget

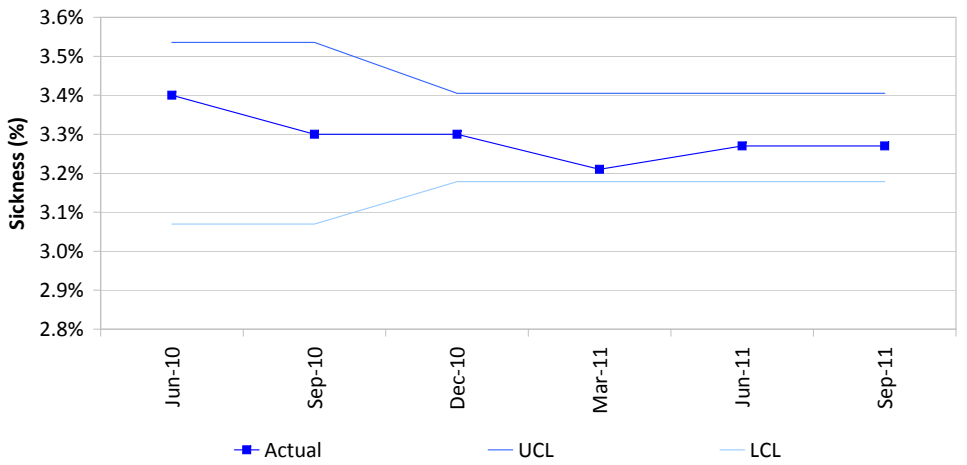
Internal Target



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

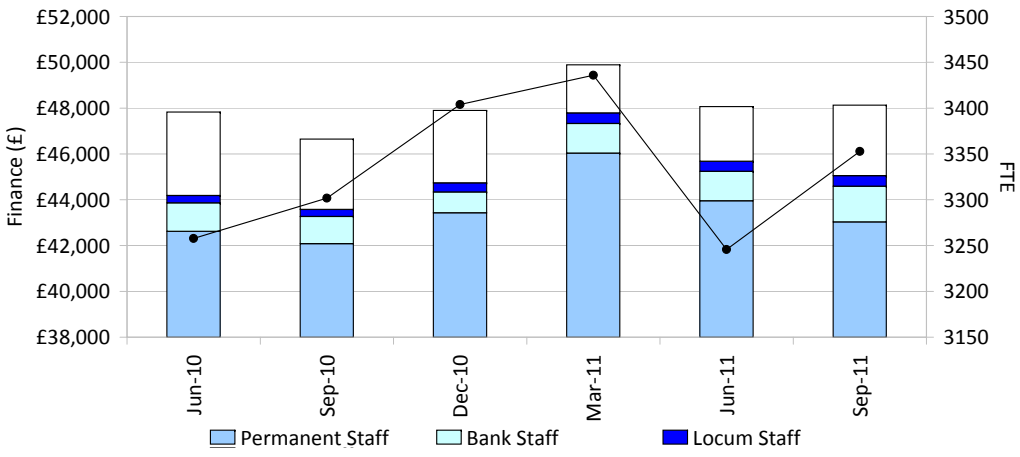
Graph 41. Sickness rate Trust-wide (%)

Internal Indicator



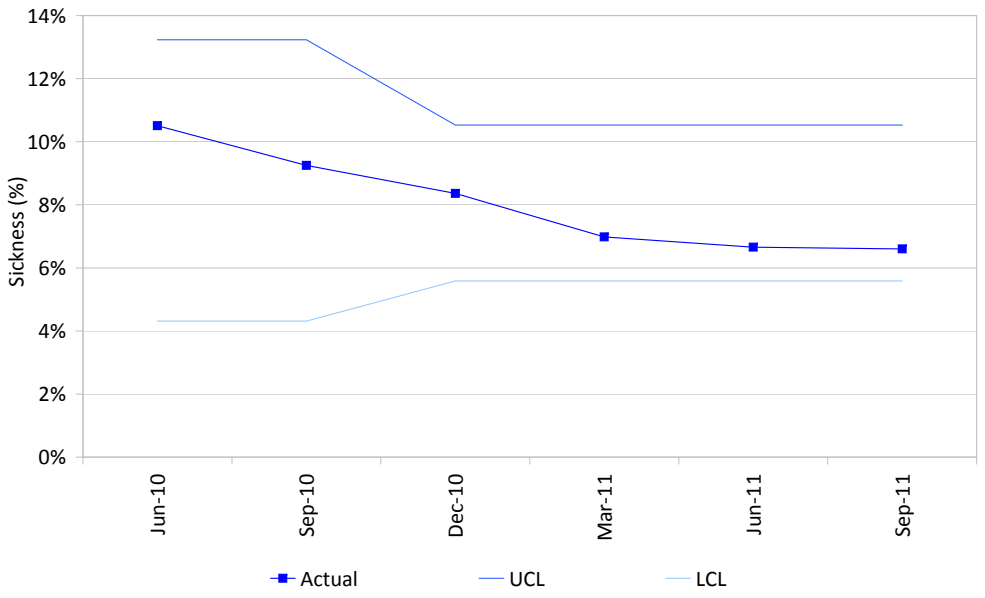
Graph 42. FTE and equivalent costs

Internal Indicator



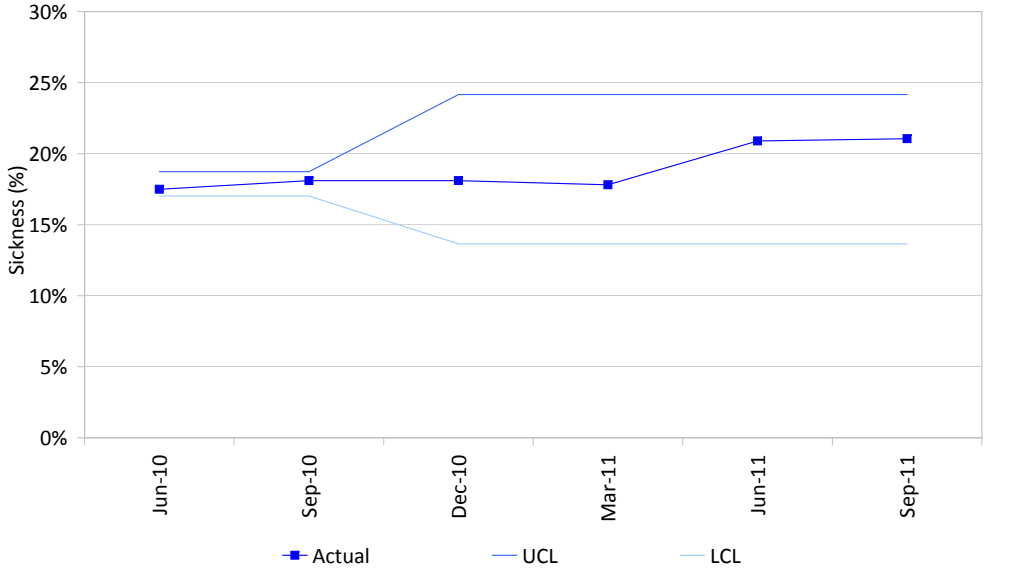
Graph 43. Vacancy rate Trust-wide (%)

Internal Indicator



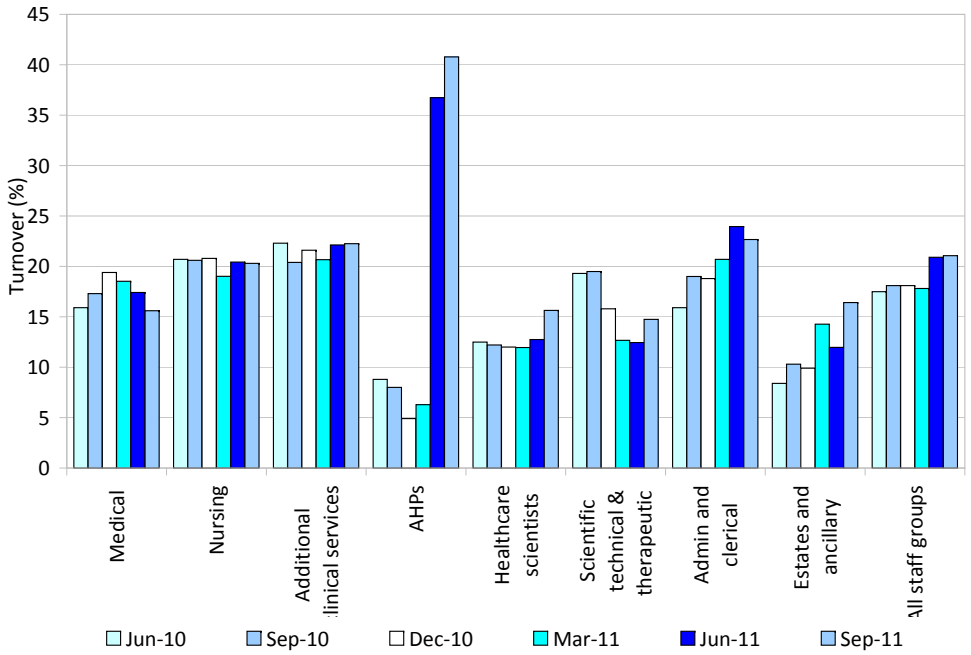
Graph 44. Turnover Trust-wide (%)

Internal Indicator



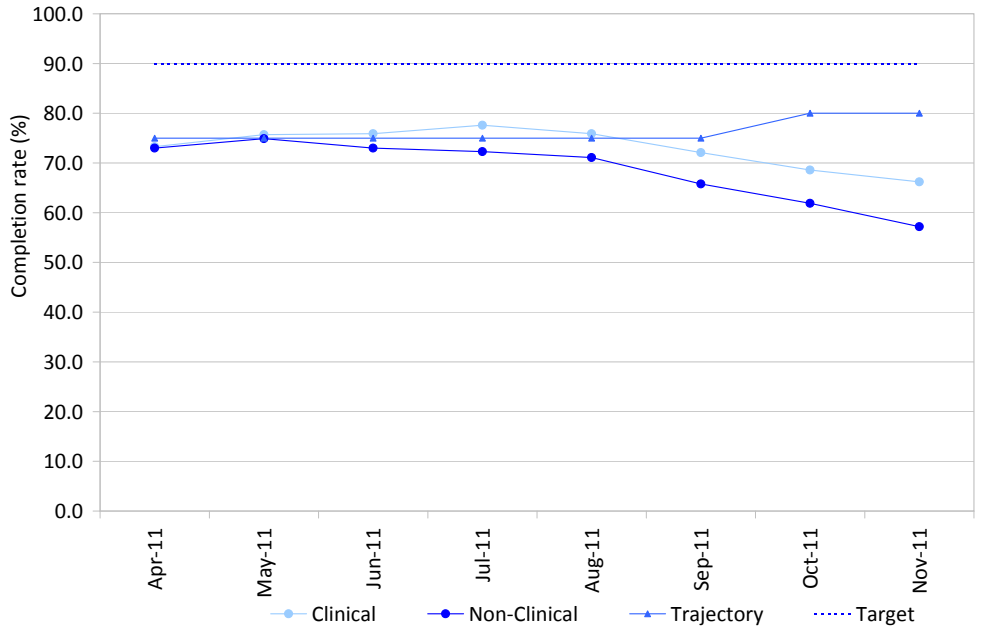
Graph 45. Turnover by staff group (%)

Internal Indicator



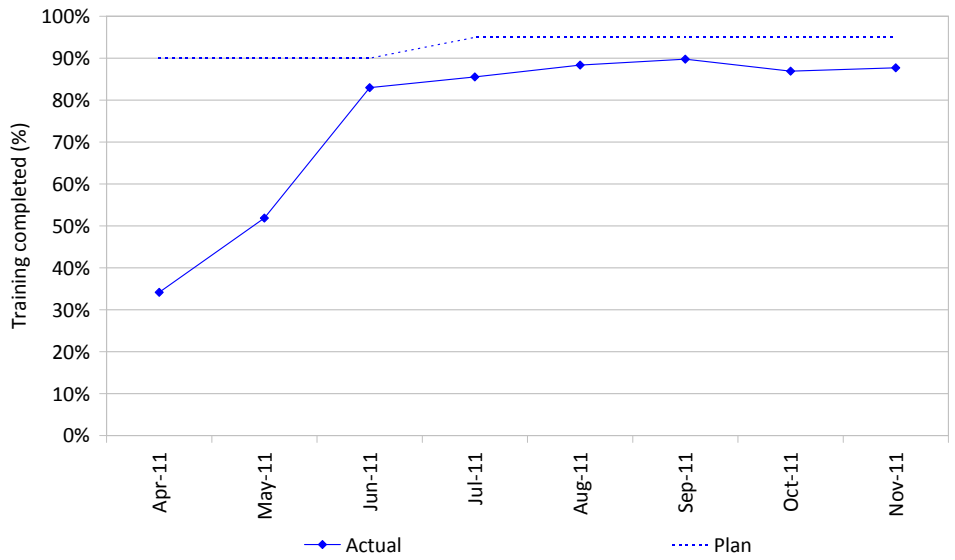
Graph 46. Percentage of staff who have a current PDR in the last 13 months and predicted next 2 months (Excluding doctors and consultants)

Internal Target



Graph 47. Staff trained on IG by week

Internal Target



Appendix 1. Glossary

	Graph	Tolerance		
		On Target	Of Concern	Action Required
		Green	Amber	Red
Objective 1	Incidence of C.difficile	Less than YTD Target	Within 10% of YTD Target	Worse than 90% of YTD Target
	Incidence of MRSA	0 Cases	Trajectory less than 6 Cases**	Trajectory greater than 6 Cases
	Incidence of MSSA	First Year of Recording		
	Incidence of E-Coli	First Year of Recording		
	Surgical Check List completion rate %	Greater than 95%	Between 85% and 95%	Less than 85%
	No. of NICE recommendations unreviewed	Less or equal to 1	2or 3	Greater than 3
	48 Hour readmission to ITU	Greater than 3%	Greater than 2.7%	Less than or equal to 2.7%
	Mortality Figures	Indicator		
	Serious Patient Safety Incidents	Indicator		
	CV Line related blood-stream infections	Less than 1.5	Between 1.5 and 2.5	Greater than 2.5
Objective 2	Discharge summary completion (%)	Greater than or equal to 95%	Between 85% and 95%	Less than 85%
	DNA rate (new & f/up) (%)	Less than 9	Either 9 or 10	Greater than 10
	18 week referral to treatment time performance - Admitted	Greater than 91%	Between 90% and 91%	Less than 90%
	18 week referral to treatment time performance - Non-Admitted	Greater than 96%	Between 95% and 96%	Less than 95%
	95th Centile - Admitted	Less than 21 weeks	Between 21 and 23 weeks	Greater than 23 weeks
	95th Centile - Non-Admitted	Less than 17 weeks	Between 17 and 18.3 weeks	Greater than 18.3 weeks
	95th Centile - Incomplete Pathways	Less than 26 weeks	Between 26 and 28 weeks	Greater than 28 weeks
	Median Waits - Admitted	Less than 10 weeks	Between 10 and 11.1 weeks	Greater than 11.1 weeks
	Median Waits - Non-Admitted	Less than 6.6 weeks	Between 6.6 and7 weeks	Greater than 7 weeks
	Median Waits - Incomplete Pathways	Less than 6.5 weeks	Between 6.5 and 7.2 weeks	Greater than 7.2 weeks
	Number of complaints	No RAG status - Plan not confirmed		
	Number of complaints by grade Low	No RAG status - Plan not confirmed		
	Number of complaints by grade Medium	No RAG status - Plan not confirmed		
	Number of complaints by grade High	No RAG status - Plan not confirmed		
	Percentage of Cancelled Operations	Equal to or less than 0.8%	-	Greater than 0.8%
	Percentage of patients waiting no more than 31 days for second of subsequent treatment - Surgery	Equal to 100%	Greater than or equal to 95%	Less than 94%
	Percentage of patients waiting no more than 31 days for second of subsequent treatment - Drug	Equal to 100%	Greater than or equal to 99%	Less than 98%
	Percentage of patients waiting no more than 31 days for second of subsequent treatment -	Equal to 100%	Greater than or equal to 95%	Less than 94%
	Maximum waiting time of one month from diagnosis to treatment for all cancers.	Equal to 100%	Greater than or equal to 95%	Less than 85%
	Inpatients waiting list profile (26+)	0 Breaches	Between 0 and 10	Greater than 10
Objective 3	Theatre Utilisation (Patient Operation Utilisation of Scheduled Duration U4)	Greater than 70%	Equal to or between 65% and 70%	Less than 65%
	New to follow up ratio	Less than 4.18	Between 4 and 4.18	Greater than 4.18
	Patient refusals	Indicator		
	Clinical Income variance	Indicator		

Objective 4	Patient safety reports for GOSH-sponsored clinical trials	No RAG status - Plan not confirmed		
	Clinical trials recruitment portfolio	No RAG status - Plan not confirmed		
	Number of Active Research Projects	No RAG status - Plan not confirmed		
	GOSH Research Grants (£)	No RAG status - Plan not confirmed		
	Research Grant Awards (£)	No RAG status - Plan not confirmed		
	UKCRN Portfolio Studies	No RAG status - Plan not confirmed		
Objective 5	MADEL SLA Value (£)	No RAG status - Plan not confirmed		
	SIFT SLA Value (£)	No RAG status - Plan not confirmed		
	NMET SLA Value (£)	No RAG status - Plan not confirmed		
Objective 6	Monitor Risk Rating	Equal to 3	-	Less than 3
	Charity fundraising income	Within - 5% Variance from Plan	More than - 5% Variance from Plan	More than - 15% Variance from Plan
	Bank and agency total expenditure	Greater than or equal to 82%	Greater than or equal to 80%	Less than to 80%
Objective 7	Staff PDR completeness - clinical (%)	Greater than or equal to 97%	Less than or equal to 97%	Less than to 95%
	Staff PDR completeness - non clinical (%)	Greater than or equal to 97%	Less than or equal to 97%	Less than to 95%
	Information Governance Training	Greater than or equal to 97%	Less than or equal to 97%	Less than to 95%
	Sickness Rate	Indicator		
	Staff in Post (£)	Indicator		
	Vacancy rate by staff group	Indicator		
	Trust Turnover	Indicator		

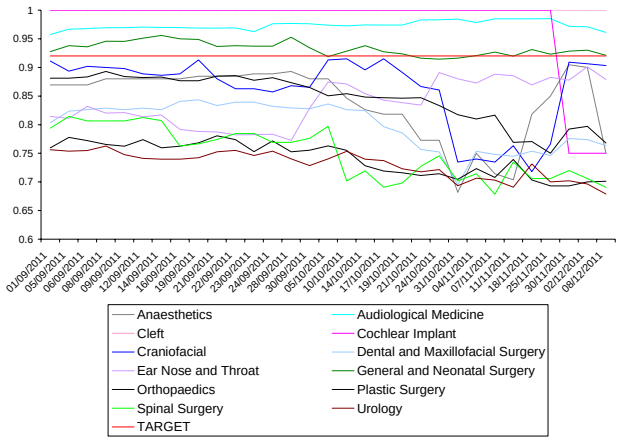
Key	
Target / Indicator	Internal
CQUIN	Contractual
National	DH Standard / Monitor

Key Performance Indicator Report

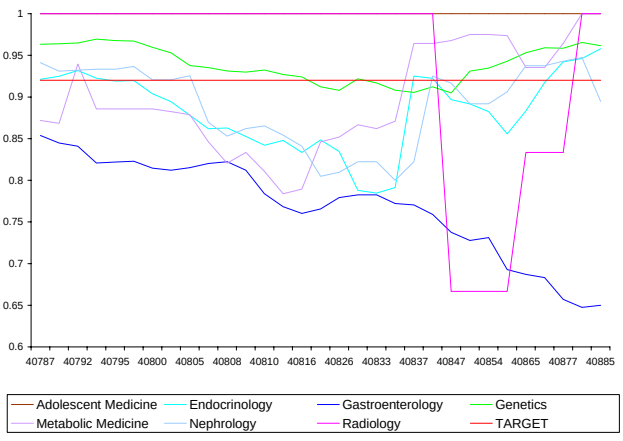
Great Ormond Street Hospital for Children NHS Trust

Appendix 2. Percentage of Incomplete Pathways within 18 weeks by Specialty

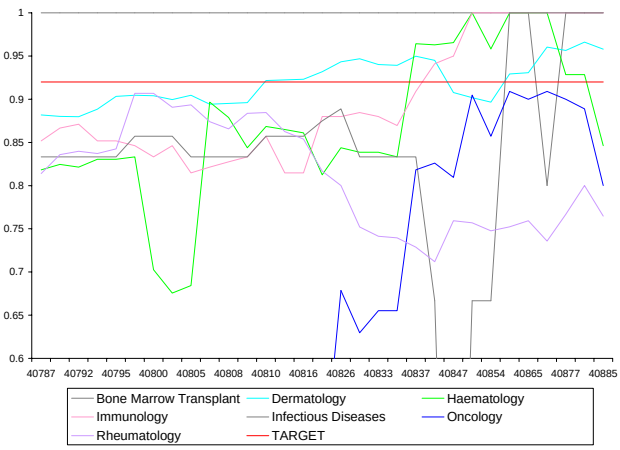
Surgery % of Incomplete Pathways within 18 weeks



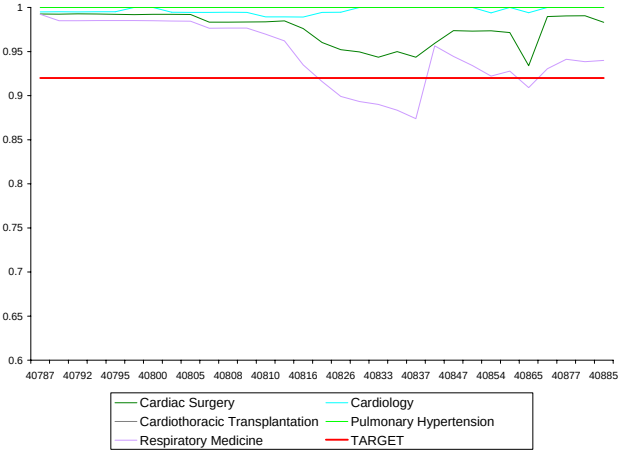
Medicine % of Incomplete Pathways within 18 weeks



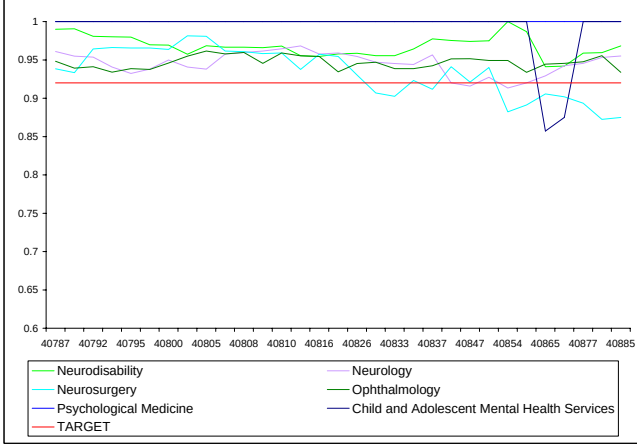
ICI % of Incomplete Pathways within 18 weeks



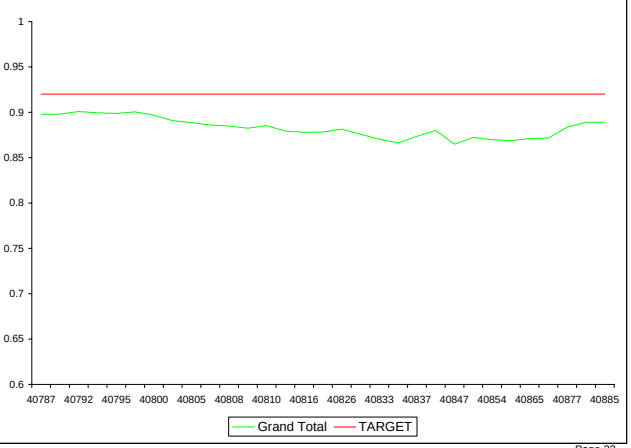
Cardiac % of Incomplete Pathways within 18 weeks



Neuro % of Incomplete Pathways within 18 weeks



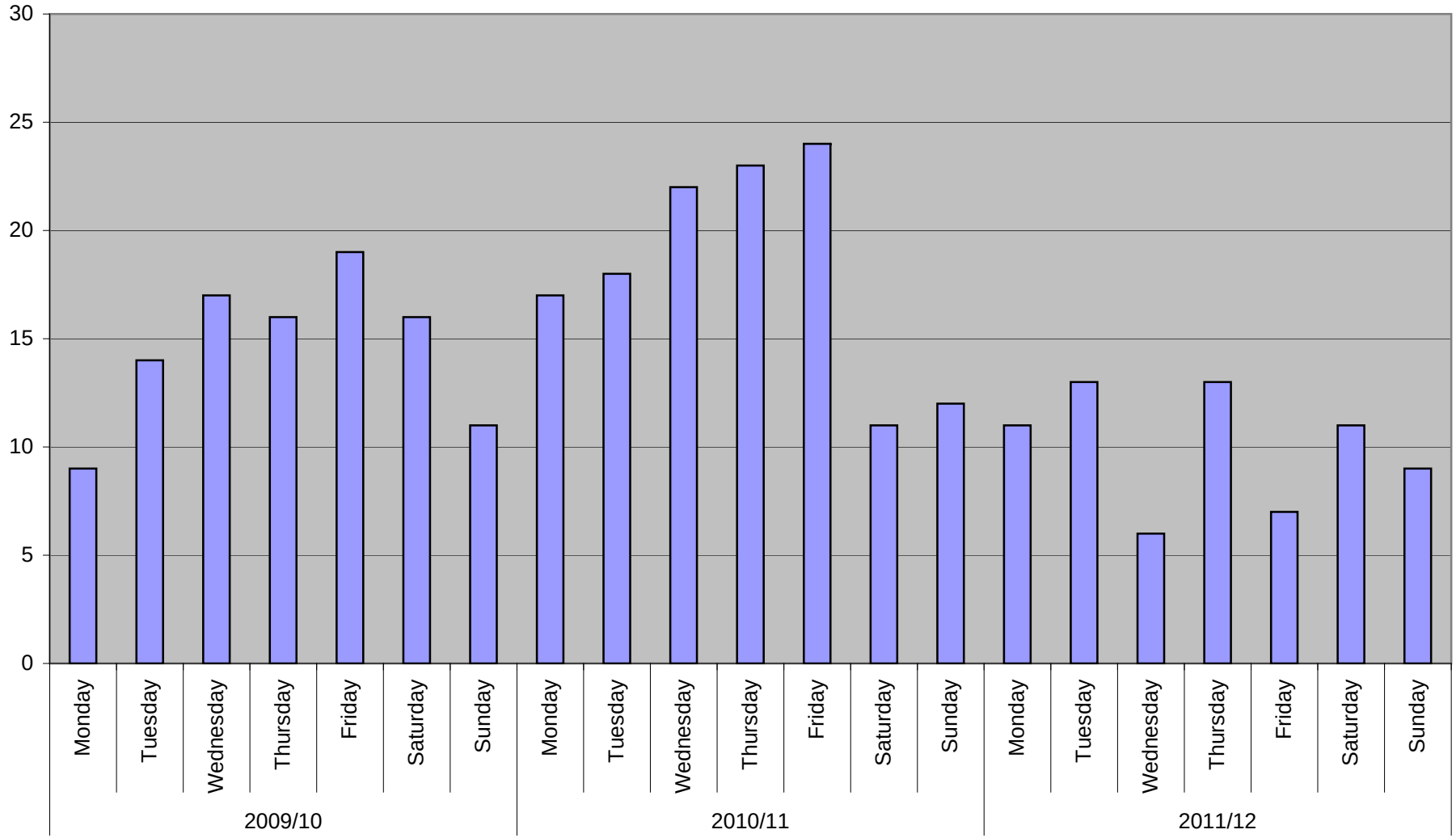
Trust wide % of Incomplete Pathways within 18 weeks



Key Performance Indicator Report

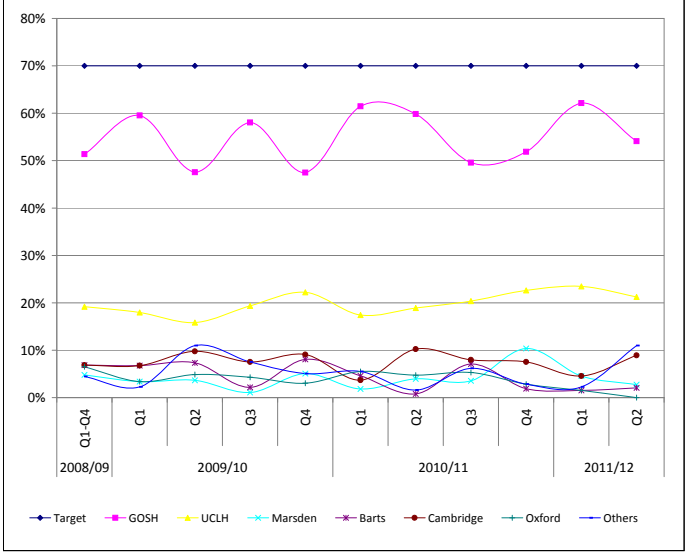
Great Ormond Street Hospital for Children NHS Trust

Appendix 3. Mortality Rates by Day of the Week

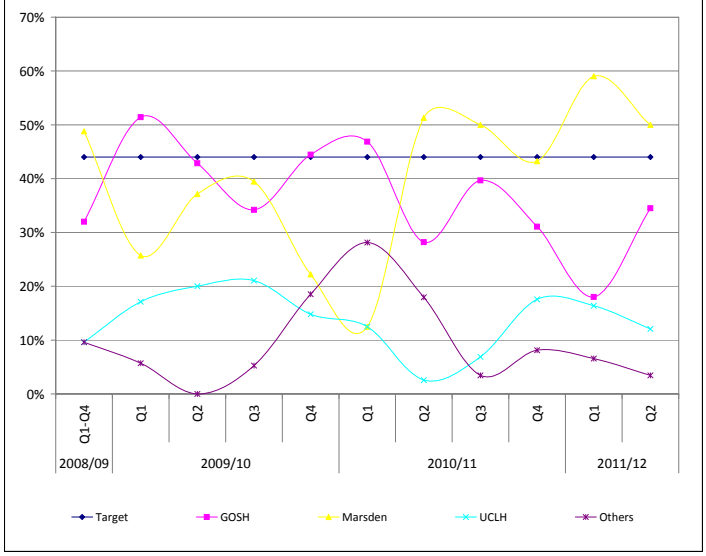


Appendix 4. Market share summaries 2011/12 Q2

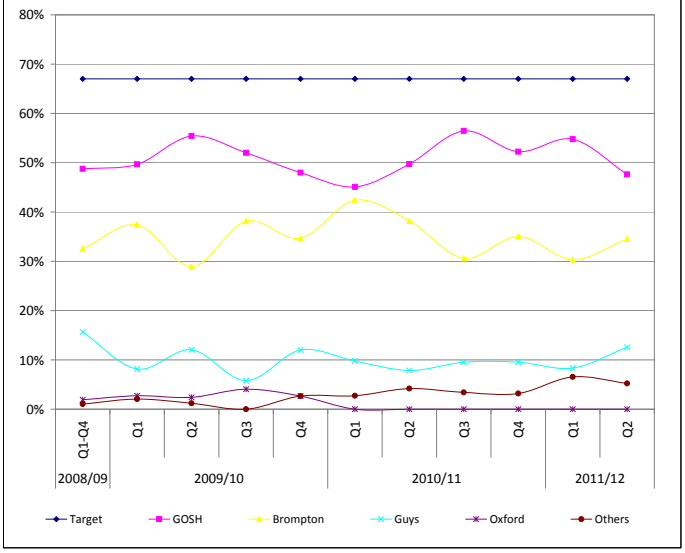
Oncology North London & Commuter Belt Market Share



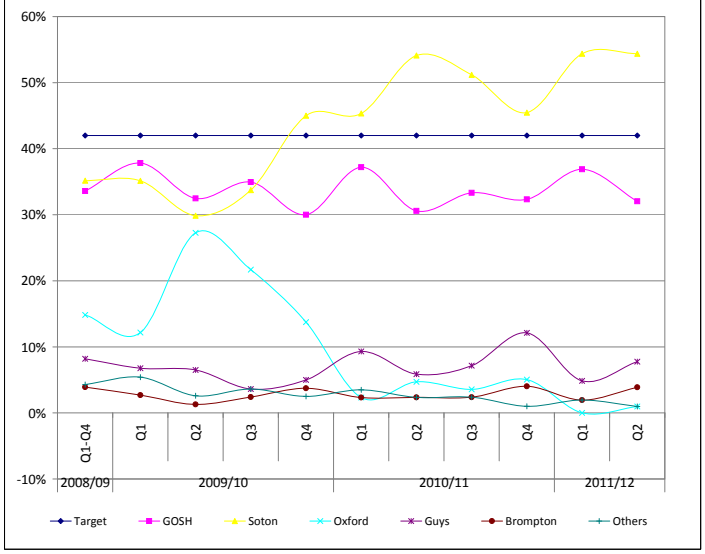
Oncology South London & Commuter Belt Market Share



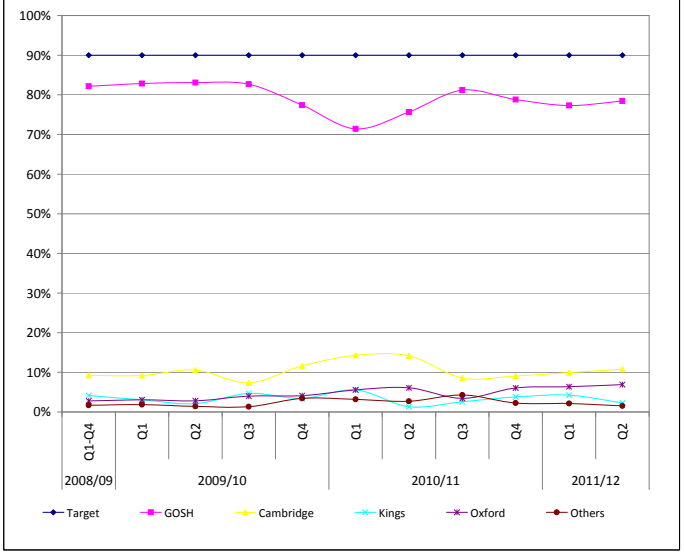
Cardiac Surgery North London & Commuter Belt Market Share



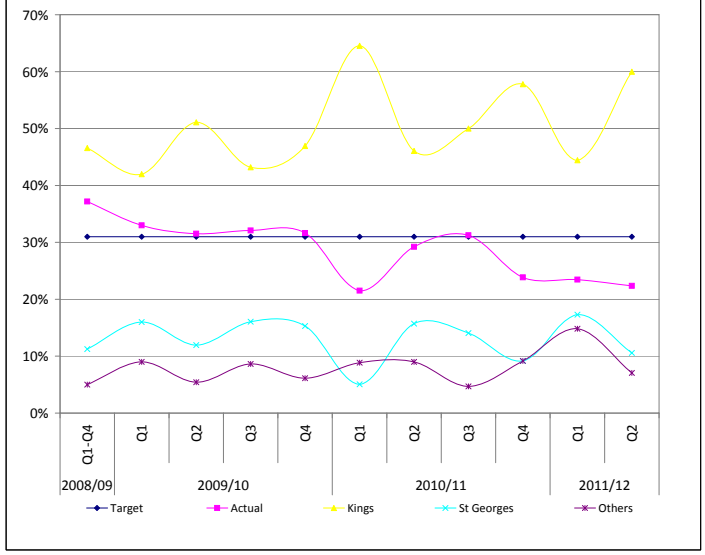
Cardiac Surgery Further Regional Market Share



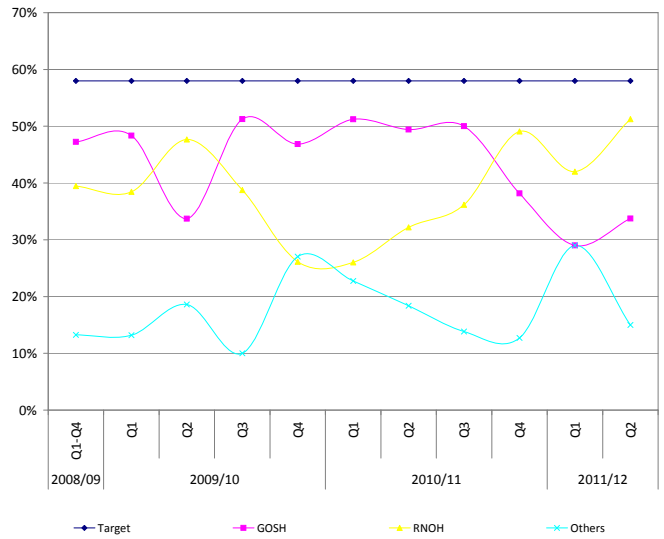
Neuro Surgery North London & Commuter Belt Market Share



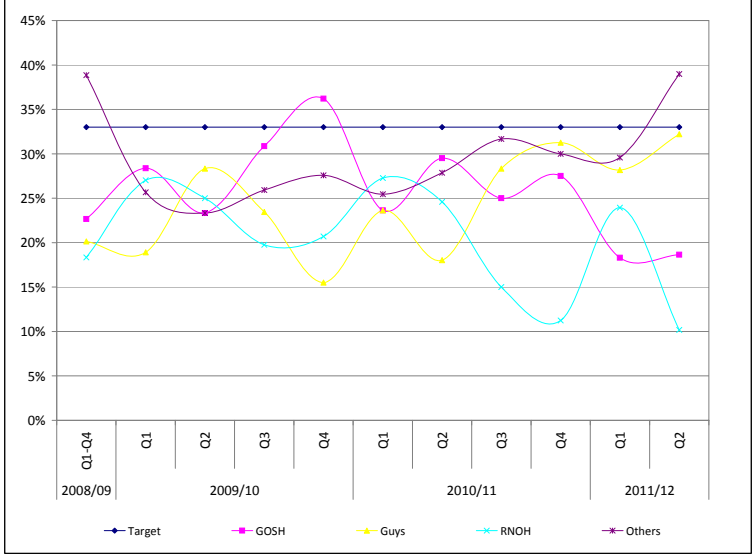
Neuro Surgery South London & Commuter Belt



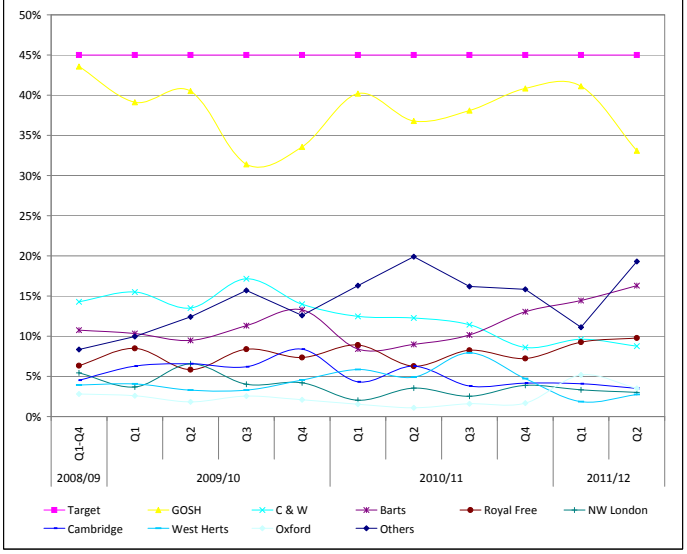
Elective Spinal Surgery North London & Commuter Belt Market Share



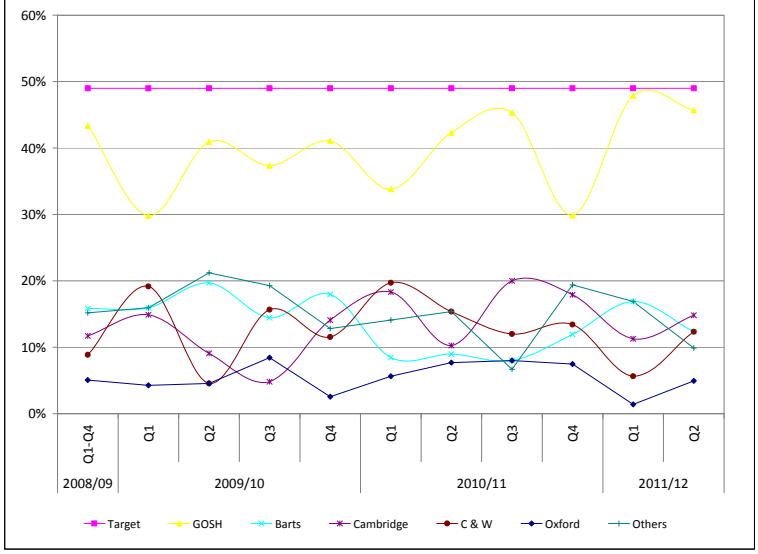
Elective Spinal Surgery South London & Commuter Belt



Gastro North London & Commuter Belt Market Share



SNAPS North London & Commuter Belt Market Share



Attachment:

Great Ormond Street NHS Hospital for Children NHS Trust

Trust Board 21 December 2011	
Finance and Activity Report **EIGHT months to 30 November 2011** **Submitted on behalf of** Claire Newton, CFO	**Agenda item/Paper No** **Attachment S**

AIM
To summarise the Trust's financial performance for the **EIGHT** months to 30 November 2011.

SUMMARY

Results year to date to end of period 8

- Net surplus **£6.0M**, which is £0.7M below the rephased plan
- Normalised EBITDA 7.0% (*Budget 7.5%; Full year budget 7.0%)*

Forecast
The forecast position is a £2.3M surplus after a property impairment estimated at £5.6M

Risks / Issues
The most significant risks in delivering the forecast are:

- Delivery of the remainder of the CRES plan
- Reducing agency costs
- Delivering income growth and ensuring the Trust is appropriately reimbursed
- Ensuring Phase 2A double running and project costs are in line with plan

There is also a technical risk in that the value of the impairment assumed on Phase 2A has not yet been determined by the District Valuer and so the forecast (non normalised) surplus is likely to change as a result

Activity/Income
Activity based income remains ahead of plan boosted by very high critical care and other bed day activity although core inpatient activity is slightly below plan, but remains ahead of last year.

Total income, if pass through funding is excluded is above plan by £1.8M.

- NHS revenue is ahead of plan by £2.8M reducing to £2.5M if non-England activity is included
- IPP revenue is in line with plan.
- Other Operating Revenue is £0.6M behind plan if the timing differences in respect of the charity pass through are removed; the largest variances being on R&D income and catering (where the activity was outsourced and thus income received net).

Expenditure

- Pay is over spent by £3.3M excluding pass through. The majority of the over spend relates to nursing and junior medical staffing where there are higher than planned levels of agency staff. Part of this variance relates to the costs incurred in delivering activity higher than plan, particularly in critical care areas. There are actions in place to reduce other agency usage by the year end. ***An additional report on agency costs, as requested at the last Board meeting, is appended to this report.***
- Non Pay is under-spent by £0.3M when pass through of blood, drugs and clinical devices are taken into account.

Ratios (FT)

- Overall FT score of 3 year to date
- Forecast score is **3**

BPCC performance (Non NHS – cumulative)

- Total payables – Value 86.0% (to period 7–85.9%)
- Total payables – Number 86.3% (to period7- 87%)

CRES

The Trust is now reporting risk adjusted values for CRES having completed an exercise to remove or reduce schemes where there is uncertainty over scheme delivery.

CRES 2011/12

- Financial Plan requires £11.2M and £11.0M identified

CRES 2012/13

- Financial Plan requires £11.9M and £11.9M identified

CRES 2013/14

- Financial Plan requires £13.2M and 13.9M identified

Capital

- Capital spend is £27.8M; £2.8M lower than plan YTD. Donated capital spend is £2.5M lower than plan
- Forecast capital spend is likely to be approximately £5.9M lower than original plan and this will be donated capital and largely related to the Redevelopment programme (£4.4M) as well as slippage on IT projects into 2012/13 (£1.5M).
- The Trust is forecasting to undershoot its CRL by £1.5M.

Statement of Financial Position (Balance sheet)

- Non Current Assets increased by £0.2M representing increased purchases net of transfers to the revenue position.
- Current assets (excluding cash) decreased by £1.9M - a reduction in accruals relating to quarterly NHS billing.
- Cash decreased to £18.4M in the month
- Current liabilities decreased by £4.4M.

Salary overpayments

- There were five salary overpayments totalling £35.8K

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 9 December 2011

PERIOD 8 - 2011/12 FINANCE REPORT

(1) Forecast position

The Trust is forecasting a £2.3M surplus including an expected property impairment currently estimated at £5.6M

(2) Month 8 year to date net surplus

The year to date surplus is £6.0M surplus as the impairment will only be recorded once Phase 2A is handed over and valued. This represents a variance of £(0.7M) relative to the re-phased plan. An analysis of the variances on each major revenue category between pass through (PT) and non pass through (ex PT) items shows that when the variances on pass-through are excluded income is ahead of plan by £1.7M but operating expenditure is over plan by £3.0M.

2.1 Revenue account excluding Pass Through

	Actual	Variances	
	M8 ytd	Ex PT	PT
Clinical ex IPP	174.3	2.5	(2.0)
IPP Clinical	18.3	(0.0)	-
Other income	28.5	(0.6)	(1.2)
	221.1	1.8	(3.1)
Don asset tfr	4.1	(0.1)	-
	225.1	1.7	(3.1)
Pay	(128.9)	(3.3)	0.4
Non pay	(76.7)	0.3	2.7
Total op expend	(205.6)	(3.0)	3.1
Non op expend.	(13.5)	0.6	-
Net surplus	6.0	- 0.7	0.0
Normalised EBITDA	15.5	- 1.2	0.0
	7.0%		

2.2 Revenue account compared with the previous financial year

An analysis of the revenue account on continuing activities (Haringey shown separately) compared with the previous financial year and the Plan is shown over page.
This shows that in overall terms the income growth at 4% is currently exceeded by cost growth at 5.5%.

There are a number of changes contributing to this which include:

- Tariff declining whilst costs growing due to non pay cost inflation and salary increments
- R&D funding being lower than last year – some of this temporary due to the transition period on charitable R&D funding
- Some of the activity growth has been achieved at a high marginal cost due to the usage of agency staff prior to completion of recruitment
- IPP growth has been limited by the private patient cap

£'M	Actual	Last year			Plan		
	M8 ytd	M8 ytd	Var		M8 ytd	Var	
NHS Clinical	170.8	162.2	8.6	5.3%	169.6	1.3	0.7%
Other clinical	20.1	18.5	1.6	8.7%	20.7	- 0.6	-3.0%
Non clinical	32.5	34.0	- 1.5	-4.5%	34.6	- 2.1	-6.0%
	223.5	214.8	8.7	4.0%	224.9	- 1.4	-0.6%
Haringey	1.6	7.0	- 5.4		1.6	-	0.0%
	225.1	221.8	3.3	1.5%	226.5	- 1.4	-0.6%
Pay	- 127.3	- 120.4	- 6.9	5.7%	- 124.5	- 2.7	2.2%
Non-pay	- 76.6	- 72.9	- 3.8	5.2%	- 79.5	2.8	-3.6%
	- 203.9	- 193.3	- 10.7	5.5%	- 204.0	0.1	0.0%
Haringey	- 1.6	- 8.0	6.4	-79.4%	- 1.7	0.1	-3.1%
	- 205.6	- 201.3	- 4.3	2.1%	- 205.7	0.1	-0.1%
Non-operatin	- 13.4	- 13.7	0.3	-2.1%	- 14.0	0.5	-3.7%
Net surplus	6.0	6.8	- 0.7		6.8	- 0.8	-11.4%

3 Expenditure

3.1 Pay

Pay expenditure totals £128.9M, £2.9M higher than plan.

- Consultant pay is under spent by £0.8M YTD. Cardiac and ICI are underspent by £0.2M and £0.1M respectively as a result of vacancies.

- Junior doctor pay is overspent by £1.7M YTD. The most significant areas of overspend are within ICI (£0.4M) and Surgery (£0.5M). This is due to reliance on temporary staffing to cover rotas. The units are putting measures in place to address this and there is evidence of an expenditure reduction in month 8 within ICI. IPP is also £0.2M overspent due to using temporary staff to cover weekend rotas. The rota system within IPP is currently under review.

- Nursing pay is overspent by £1.7M YTD. £0.7M of this is activity related and offset by income. Other key overspends are within the following areas: Surgery £0.7M, MDTS £0.1M and International £0.1M. There is high reliance within these areas on temporary staff to cover vacancies, maternity & sick leave, to support supernumerary new starters and to care for particularly complex patients. The adverse movement in month 8 against trend lies within Surgery.

- STT pay is £0.2M overspent YTD. This variance is mostly within the labs and has resulted from the use of temporary staff to cover maternity leave and vacancies. There are also activity related cost pressures which are offset by income.

- Management and admin pay is £0.5M overspent YTD. Medicine is overspent by £0.1M due to reliance on agency members of staff. There is a planned trajectory to reduce this, with evidence of a reduction in month 8. Finance / ICT are overspent by £0.2M due to the use of temporary staff to cover vacancies pending restructures, and to support specific projects. IPP is also £0.1M overspent as a result of using temporary staff members to cover vacancies.

Agency costs (PLEASE SEE APPENDIX FOR ADDITIONAL REPORT ON AGENCY)

Junior doctors	£1.07M
Nursing	£1.84M
Sci, Ther, Tech	£1.42M
Non-clinical	£3.23M
Total	£7.56M (representing 5.9% of the pay bill to November 2011)

3.2 Non pay

Non-pay expenditure is £76.7M (excluding depreciation and PDC), which is £3.0M below plan.

- Drugs is underspent by £0.2M in month 8. Drug expenditure varies depending on activity levels and case mix within the month. The month 8 underspend is mostly on high cost drugs, offset by an adverse income movement.

- Blood is underspent by £1.0M YTD. Factor 8 products within ICI are under spent by £1.4M, this is as a resultof the movement of children onto research trials where a commercial company funds these costs. This is a pass through item and directly offset by an adverse income variance. This under spend is partially offset by a £0.2M activity / case mix related overspend within Cardiac.

- Clinical supplies & services are underspent by £0.3M YTD. £0.4M of this is on expensive pass through items offset by income, mostly spinal metal. This is partly offset by activity / case mix related overspends in other clinical units, namely MDTS, ICI and Neuro.

- Services from NHS organisations and healthcare from non-NHS bodies are on plan. There is a £0.2M under spend on Newborn Screening as a result of delays in charging from other organisations. This is directly offset by income. ICI is overspent by £0.3M on BMT related expenditure, such as Anthony Nolan, harvest and tissue typing charges. This is patient specific, activity related expenditure.

- Premises are on plan YTD, but there was a £0.3M adverse movement in month 8. £0.2M has resulted from the reclassification of costs within Estates. There was also an increase in electricity and building contract charges this month.

- Education & research are under spent by £0.7M as a result of timing issues on training expenditure within NWD and on elements of Research & Innovation expenditure.

- Other expenditure budgets are under plan by £1.4M YTD. £0.6M of this reflects lower spend on charity funded items, but this is neutral to the financial position as it is offset by lower income. There has also been a reduction as a result of a creditor review which has led to lower accrual levels. The profile of bad debts in terms of both value and ageing has also resulted in lower provisions this month.

- Non-pay budgets also contain £1.2M as yet undelivered CRES targets & £0.5M reserves to be allocated to units.

4 INCOME

Income is £1.8M ahead of plan when pass through income variances are excluded:

- NHS revenue is £2.7M ahead plan
- Non NHS revenue is £0.3M behind plan
- Other operating revenue is £0.6M behind plan

Category	YTD Actual £M	YTD var incl pass through £M	YTD var Excl pass through
NHS Revenue	172.2	1.0	2.7
Activity Revenue Non NHS	20.3	-0.6	-0.3
Other Operating Revenue ex donated asset transfer	28.4	-0.8	-0.6
Donated asset transfer	4.1	-1.1	
Grand Total	225.1	-1.5	1.8

4.1 NHS Revenue

Overall activity trends:

		v Last year	v Plan
-	Inpatient activity:		
	o spells	+3.2%	-1.2%
	o bed days	+9.9%	+6.1%
-	Outpatient activity	+8.2%	+1.2%

PCT Tariff Income is £1M ahead of Plan (including MFF)

Cardiac Surgery, Dermatology, Rheumatology, Orthopaedics and Cochlear (in respect of unilateral cochlear implant) are higher than plan. (NB Bilateral Cochlear activity, which is non-tariff - is lower than plan). Medicine is behind plan by £1.1M mainly related to Nephrology, where there are issues with billing for activity due to the contract currencies, and Metabolic Medicine. Plastic Surgery is also behind plan by 0.2M mainly relating to case mix changes – with procedures required for patients this year generally being less complex than last year. There is also an adverse variance £0.2M in Cardiac outpatient (echo) procedures relating to an early year coding problem that has been corrected.

PCT Non-Tariff Income is £0.1M behind Plan (£1.6M ahead of plan excluding pass-through income)

Non-Tariff inpatient income is lower than plan due to:

- Bilateral Cochlear being lower than plan by £0.8M as a result of higher unilateral implant
- Spinal activity is £0.7M lower than plan reflecting lower in-year activity.

Outpatient activity in ahead of plan by £0.5M and bed-day income is £1M ahead reflecting high activity level in CICU.

The impact of the penalties for emergency threshold, readmissions and outpatient ratio levels are lower than originally estimated and therefore benefitting the position in this income category.

Overseas E112 income is £0.5M behind plan, mainly in Surgery and Cardiac.

SHA (NCG) income is £0.6M ahead of plan (£0.5M ahead excluding pass-through)
Variance due to 2010/11 deferred Neuroblastoma drug licences being released equally through the year.
NCG activity is on target, but underperforming against the contract value, mainly on Ecmo, PH, and Gastro SCID activity. All other activity is close to plan excluding pass through. Pass through income is £0.1M higher than plan.

NHS Other Clinical income is £0.4M behind plan (£0.2M behind excluding pass-through income)
This mainly relates to pass through income which is £0.2M behind plan but there is also lower than planned activity on the contract with Kings to carry out Small Bowl Assessments.

4.2 Non NHS Revenue is £0.6M behind plan (£0.4M including pass-through)

This relates to lower than planed Non England activity, and this offsets some of the over performance under NHS income. Private patient income is on plan.

4.3 Other operating revenue is £2M behind plan (£0.7M including pass through)

The principal variations from plan relate to:

- Non patient Care Services is £0.2M ahead of plan, this mainly relates to course income and income for sale of drugs
- Other revenue is £0.5M behind plan with lower hospice income and third party funded post.
- Research income £0.4M primarily a timing issue and also an over conservative decision resulted in c £0.2m of commercial income being deferred which could have been released to revenue
- Charity spend is lower than plan at this point and considered to be a timing issue

There is a £1.3M shortfall on pass through budgets in respect of charitable donations

(5) CIP/CRES

CRES 2011/12
This month some schemes have been either removed or deferred as it has been accepted that they would not be realised in the current financial year. In addition there have been new schemes identified and others that have progressed in terms of their BRAG status including many that have been actioned in the ledger.

As a result the tables reveal that the amber CRES schemes now total just £1.1M a reduction of nearly 0.9M. The remaining schemes are considered still able to deliver CIP but cannot be actioned or progressed further due to their go-live dates.

The overall effect has been a reduction to the 2010/11 total to just below the target value of £11.2M.

CRES 2012/13
The financial plan requires £11.8M of CRES to be delivered and the risk adjusted values total £11.9M, so above plan by £0.1M.
In addition to the value increasing, there has also been progress with the status of schemes with Green - approved schemes increasing by £1.3M, Amber – feasible schemes increasing to £8.6M and Amber schemes decreasing by £0.6M reflecting the development of schemes in terms of being implementable.

CRES 2013/14
The financial plan requires £13.2M of CRES to be delivered and the risk adjusted value indicates £13.9M is available.
It is important to note that most of these schemes are classified as Red and will require more work over the coming months to fully assess their potential to deliver and to work these into more formal schemes with specific actions and dates.

(6) CAPITAL PROGRAMME AND CRL

Overview
CRL: The Trust is expecting to undershoot its CRL target by £1.5M for the year as IT projects are slipped into 2012/13

The Trust's annual capital plan is £55.9M with planned expenditure for the eight months ending 30 November amounting to £30.5M. The total spend to date amounts to £27.7M representing an under spend to date of £2.8M.

	Annual Plan £M	Plan YTD £M	Actual YTD £M	Variance £M
Hospital Redevelopment	36.3	20.1	18.6	1.5
Estates Maintenance Projects	9.0	4.8	5.3	(0.5)
IT Related Projects	7.0	3.7	1.6	2.1
Medical Equipment Purchases	3.6	1.9	2.2	(0.3)
Total Additions in Year	**55.9**	**30.5**	**27.7**	**2.8**
Asset Disposals	0.0	0.0	0.0	0.0
Donated Funded Projects	(42.1)	(23.2)	(20.7)	(2.5)
Charge Against CRL	**13.8**	**7.3**	**7.0**	**0.3**

Redevelopment
Redevelopment Projects are currently underspent by £1.5m. The current forecast outturn is expected to be £4m under plan. This should be increased by a pending VAT reduction on Phase 2A currently estimated at £0.8m. The Trust is forecasting a combined slippage to 2012/2013 on 2B & 2B enabling of £3m with the balance representing slippage on 2A of £1m. Forecast underspends will be offset by a reduction in donated income.

Estates IT and Medical equipment

- Estate Management Projects are currentlyahead of plan by £0.5m, but the Trust is still forecasting an annual outturn equivalent to plan.
- IT Projects are currently under spent by £2.1M. This is due to in year slippage with certain Projects such as PACS not incurring major spend. The Trust is forecasting that £1.5M will slip into 2012/13.
- Medical Equipment Projects are currently ahead of plan by £0.3m predominantly relating to Donated Funded schemes.

Disposals
There have been no asset disposals during the period.

(7) STATEMENT OF FINANCIAL POSITION

Non Current Assets
Non Current Assets at the end of November 2011 totalled £347.5M, a net increase of £0.2M over the previous month. This increase was due to capital additions net of depreciation reductions. There were no asset disposals in the period.

Current Assets (excluding Cash & Cash Equivalents)

Current assets have fallen by £1.9M

NHS Trade Receivables (£1.8M decrease)	Reduction in the NCG accruals for drugs, gastro and osteopathy, the quarterly bills for which were raised in M06 (£2.2M) net of an increase in PCT Income accruals (£0.4M).
Inventories (£0.2M	Reduction in Haemophilia stock (£0.1M) and a reduction in

decrease)	Pharmacy stock (£0.1M).
Provision for Impairment of Receivables (£0.4M reduction)	Bad debt provision was reduced following a review and a clearance of aged non-NHS debt (£0.2M).
Capital Receivables (£0.1M decrease)	Decrease in Redevelopment and medical equipment expenditure to be recharged to the Trustees.
Prepayments & Accrued Income (£1.6M decrease)	This is largely due to a reduction in IPP work in progress (£0.5M), a reduction in Non-England overperformance (£0.3M) and a reduction in prepayments (£0.5M).
Non NHS Trade Receivables (£1.0M increase)	This is primarily due to increases in IPP debtors (£0.4M) and Non-NHS debtors (£0.4M).

Current Liabilities

Current Liabilities have decreased by £4.4M

NHS Trade Payables (£0.6M increase)	This is largely due to early receipt West Kent PCT's December SLA value (£0.9M) net of invoices accrued in October and paid in November (£0.3M).
Deferred revenue (£3.1M decrease)	One month's deferral of income for invoices raised in the third quarter (£3.0M).
Other Payables (£0.5M increase)	Accrual for M07 and M08 PDC dividends following the payment of the half yearly dividend in September.
Capital Payables (£1.1M decrease)	Reduction in the monthly redevelopment expenditure.
Expenditure Accrual (£0.7M decrease)	Decrease in invoice register accruals (£1.0M) net of a reduction in Non-NHS accruals (£0.3M).

Taxpayers' Equity

Taxpayers' Equity has increased by £0.2M in month. The principal movements were a reduction in the Donated Asset Reserve of £0.3M (due to depreciation on donated assets being higher than donated additions) and an increase in the Retained Earnings of £0.5M.

(8) WORKING CAPITAL

8.1 Cash overview

The Trust had cash holdings of £18.4M at the close November 11, and had operating cash balances of between £31.8M and £18.4M throughout the month. Cumulative commercial bank account balances at £0.01M was in line with the DH target maximum holding of £0.05M.

The closing cash balance was £2M lower than the forecast. This is due to lower than expected cash collections (see receivables review) and the continued work to improve the payables service to suppliers. The forecast is subject to ongoing review to reflect the current and forecast trading position at this point and in respect of the forecast revenue and capital position.

The forecast cash position is also dependent on delivery of the CIP programme as well as the recovery of debt in a timely fashion.

8.2 Trade Debt

Overall compared to this time last year there has been a small reduction in NHS debt not due and there is 10% of debt in the over 90 day category compared with 25% last year.

Although IPP debt is higher, the majority of the increase is in the "not yet due" category but there has been an increase of £0.3M in the over 90 day category due to the inclusion of one large self pay debt.

Non- NHS debt is £2.8M.

- This debt includes a recent invoice to Kuwait for £1.28M that has recently been raised but isn't yet due for payment.
- Debt includes retentions that will continue to form part of the overall debt values of £0.21M and these won't be paid until 2012 and 2013 (two elements)

IPP debt has increased by £0.5M this month to £8.8M however progress has been made on the clearance of ageing debt.

- £0.3M of the debt over 90 days reported in M07 has been cleared in the month
- The increase in overdue debt this month is due mostly to a debt from one large customer which has moved into 1-30 days but no issues are anticipated with collection
- There was approximately £0.6M of Greek debt at 30 November but the Trust has received confirmation that £0.4M is to be settled the week commencing 12th Dec 2011.

8.3 Trade payables

The delays in processing trade payables experienced at the end of last financial year have largely been addressed:

- Trade payables excluding capital payables at £7.2m are £2m lower than at the end of the same period last year.
- Accrued invoices are £5.1M compared with £8.9M at the end of the same period last year
- The value of Non NHS trade payables which is due for payment but not paid has fallen to £0.3M whereas a year ago it was £2M

There remain £1.5M of NHS trade payables which are more than 90 days overdue for payment but these relate to a small number of organisations where there are long standing issues to remedy but these are being addressed

(9) FINANCIAL RISK RATIOS

The **current overall score is 3** and **forecast score is 3**. This is the minimum level required by Monitor.In the financial pack we have incorporated the current period 8 and the forecast score for each metric and shown the threshold scores for achieving the higher metric values.

Month 8	**Score**
EBITDA % Achieved	4
ROA	3
EBITDA Margin	3
I&E Surplus margin	4

Liquidity Days	2
Weighted Average	3.1
Overall Score	**3**

(10) SALARY OVERPAYMENTS

There were five salary overpayments in November 2011 totalling £35.8K. Four of which were caused by late notification of leavers. Of these, three related to Surgery (£20.4K), one to ICI (£9K) and one related to Operations & Facilities (£6.4K).

Appendix to Finance and Activity Report

Analysis of trend in staff and agency costs (excludes Haringey services from both years)

A Summary

A1 Analysis by staff category

The following analysis of pay costs compared with the same period in last financial year shows that the overall use of agency has fallen slightly from 6.3% to 5.8% and for medical staff has been replaced by bank at a lower cost.

The use of agency in the STT staff categories has increased, primarily as a result of the use of interim pharmacy staff to support ward teams and save senior nursing time.

The cost of nursing agency has also increased but a part of that will be an increase in the average cost due to cost pressures following a renewal of the procurement arrangements (a national framework agreement) in 2010.

£'M	M8 Ytd 1112	M8 Ytd 10 11	(Incr)/Decr		Budget	Var v Bud	
Admin & estates							
Permanent	20.7	18.9	*(1.8)*		23.0		
Agency	3.1	3.5	*0.4*		0.4		
	23.8	**22.4**	***(1.4)***	**-6.1%**	**23.3**	***(0.5)***	**-2.0%**
Consultants	**24.2**	**23.3**	***(0.9)***	**-4.0%**	**25.0**	***0.8***	**3.0%**
Other doctors:							
- permanent	12.0	11.3	*(0.8)*		12.5		
- bank	1.2	0.3	*(0.8)*		0.1		
- agency	1.0	1.7	*0.7*		- 0.0		
	14.2	**13.3**	***(0.9)***	**-6.9%**	**12.6**	***(1.6)***	**-12.8%**
Nurses							
- permanent	35.9	33.3	*(2.6)*		38.9		
- bank	2.9	2.9	*0.1*		0.1		
- agency	1.8	1.5	*(0.4)*		0.0		
	40.6	**37.7**	***(2.9)***	**-7.7%**	**39.0**	***(1.6)***	**-4.1%**
Scientists / Therapists							
- permanent	20.8	20.0	*(0.7)*		21.9		
- agency	1.4	1.0	*(0.5)*		0.0		
	22.2	**21.0**	***(1.2)***	**-5.9%**	**21.9**	***(0.3)***	**-1.4%**
Other	2.4	3.2	*0.9*		1.8	*(0.5)*	-29.2%
Total Pay	**127.4**	**120.9**	***(6.5)***	**-5.3%**	**123.6**	***(3.7)***	**-3.0%**
Agency %	5.8%	6.3%					
Bank %	3.2%	2.7%					
Agency % by staff category:							
Admin	12.9%	15.5%					
Doctors	7.2%	12.7%					
Nurses	4.5%	3.9%					
STT	6.5%	4.6%					

A2 Analysis by unit

The analysis of agency usage by clinical unit/department shows that the highest users of agency are IPP and Corporate department but the use of agency has increased in the Cardiac unit this year, primarily to fill vacancies ahead of recruitment of full time staff to deliver the units growth plan.

	Agency M8 ytd 1112		Agency M8 ytd 1011	
	£'M	%	£'M	%
Cardiac	0.8	5.4%	0.4	3.2%
Medicine DTS	1.3	5.5%	1.3	5.6%
ICI	0.9	4.6%	0.9	5.0%
Neurosciences	0.4	3.5%	0.4	3.6%
Surgery	1.2	4.1%	1.9	6.7%
IPP	0.6	13.2%	0.5	11.7%
Corporate	2.1	11.7%	2.4	13.4%
TOTAL	**7.5**	**5.9%**	**7.8**	**6.5%**

C3 Analysis of admin and estates agency costs

The following table shows management and admin agency costs and the cost as a percentage of total agency and admin pay.

There are a range of reasons for the continuing high level of admin agency cost. These include :

- Routine reasons such as maternity and vacancy cover

- Delays in recruitment to permanent posts due to the significant lag inherent in recruitment processes and also difficulties in finding staff with the appropriate skills at the banded levels
- A number of internal reorganisations which have resulted in agency staff temporarily filling posts pending recruitment
- Within IT, agency levels have remained high pending the resolution of an outsourcing consultantion
- Within finance, agency levels were reduced but have increased again to resolve skills shortages in staff in the purchase ledger

Trajectories have been requested from all department heads but some of them are quite long term due to the underlying issues causing the agency usage. In the meantime, all agency staff likely to remain in the organisation beyond 4-6 weeks are being approached to join the agency bank.

In addition it is important to note that a high proportion of the junior levels of admin staff are supplied through one agency which previous analysis has indicated is cost effective.

B Progress with action to reduce the cost of agency staff

B1 Establishment of In-house Locum Bank

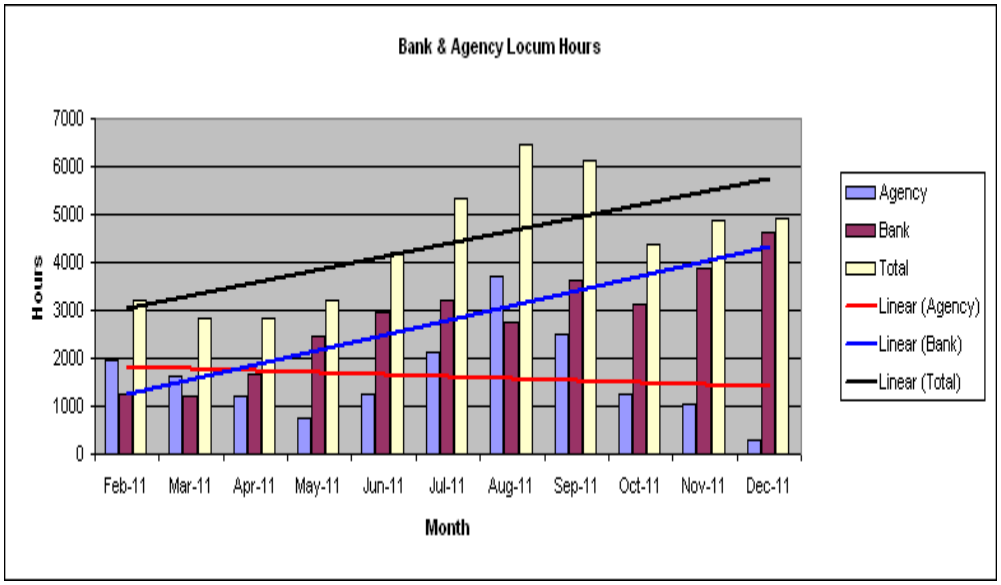
The Trust has achieved savings estimated at £436k since the implementation of the in house locum bank in January 2011. The saving has been calculated by comparing the difference in cost between shifts filled via the in house bank as opposed to costs had these shifts been filled by agency and the commensurate reduction in the costs associated with using agency staff, in this case c.£21 per hour, that is, the cost of commission and VAT. Junior doctors, consultants and managers have very actively supported the in house bank.

Date	Anticipated Bank : Agency	Actual Bank:Agency	Anticipated Savings Per Month	Actual Savings Per Month	Anticipated Savings in the first 12 months	Actual Savings at 11 months post 'go-live'
End of Dec 10	10:90	**No Bank**	£8,981	**No Bank**		
End of Jan 11	15:85	32:68	£13,806	£17,474		
End of Feb 11	20:80	39:61	£18,408	£26,094		
End of Mar 11	25:75	43:57	£23,009	£25,607		
End of Apr 11	30:70	59:41	£27,611	£34,883		
End of May 11	35:65	77:23	£32,213	£51,975		
End of Jun 11	40:60	71:29	£36,815	£51,975		
End of Jul 11	45:55	60:40	£41,417	£67,606		
End of Aug 11	50:50	62:38	£46,091	£ 58245		
End of Sep 11	55:45	53:47	£50,621	£50,621		
End of Oct 11	60:40	70:30	£55,223	£51,429		
End of Nov 11	60:40	82:18	£55,223	To date Nov. £38,105.	**£409,418**	**£435,909**

The above table sets out the savings that were anticipated from the in house medical locum bank, and those that were actually achieved. Savings were generated at a faster rate than expected largely as a result of junior medical staff joining the bank very rapidly after it commenced and support for the bank from consultants and managers across the Trust, as well as an infrastructure that facilitated a rapid shift from agency to internal bank arrangements (eg workforce information and payroll and fast track recruitment processes)

Work on controlling demand-side costs is gathering pace, with units implementing escalation processes for permission to go to agencies. However, the requirements around junior doctor rotas result in the Trust having more limited discretion in deciding whether to fill vacant shifts. M6 generally sees an increase in demand as a new intake of junior staff cannot undertake bank work

until they are fully familiar with the working environment. In addition, there was a cluster of unforeseeable episodes of pregnancy-related absence in M6 and M7, an increase in vacant posts and Surgery unit agreeing to backfill junior doctor weekly training commitments. The proportion of bank usage has increased again significantly between M6 and M10 . From M7 demand is on a downward trend as outlined in the trend graph below.



	Jan-11	*Feb-11*	*Mar-11*	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**
Agency	*1784*	*1957*	*1618*	1189	768.5	1254	2131	3694	2506	1240	1027	290
Bank	*825*	*1232*	*1209*	1647	2454	2958	3192	2750	3612	3130	3857	4635
Total	*2609*	*3189*	*2827*	2836	3222.5	4212	**5323**	**6444**	**6118**	4370	4884	4925

B2 Development of an Admin staff bank

An electronic bank management syste is currently being implemented. This will form the platform for bank expansion. To date c. 90 non-nursing/non-medical staff has joined or are in the process of joining the In-house bank.

In terms of demand, as there is currently no centralised management for A&C and other non-clinical requests manager can only be challenged retrospectively. Demand will be controlled more stringently once booking are centralised within the In-house bank. Reasons for requests will also be monitored and cross referenced against recruitment pathways, sickness reporting etc.

B3 Nursing staff

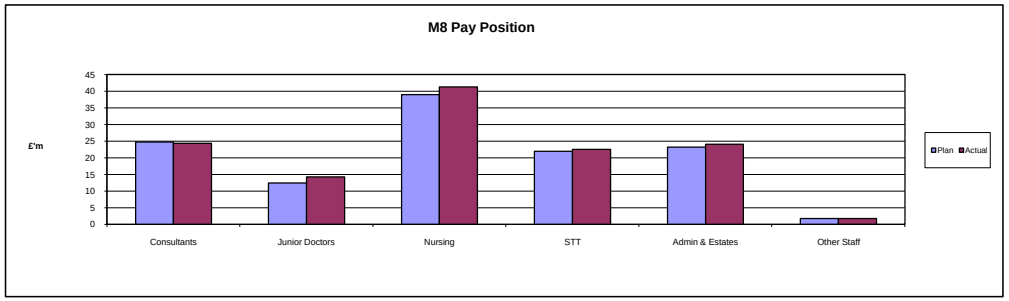
The ratio of bank to agency staff filling shifts stands at approximately 69:31. This ratio has been constant for the last 24 months. Demand has also remained constant but due an increase in agency charge rates and an increase in ENI charges overall spend has increased. Workforce development and the Assistant Chief Nurse for Nursing & Workforce are developing an establishment summary tool to monitor overall substantive, bank and agency usage against budgeted establishment and accuity.

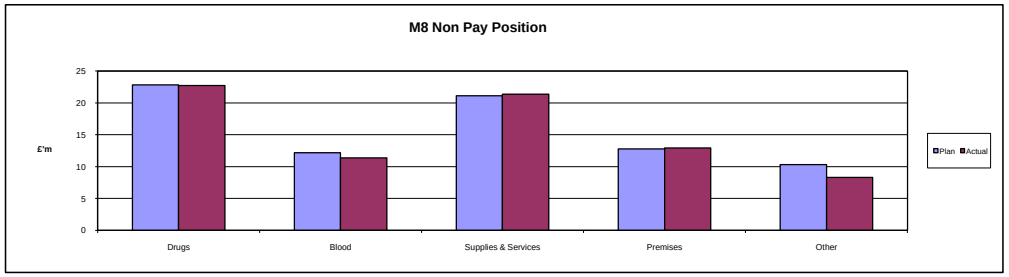
Great Ormond Street Hospital for Children NHS Trust Finance and Activity Performance Report Period 8 2011/12 Contents

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 2011/12
Trust Summary

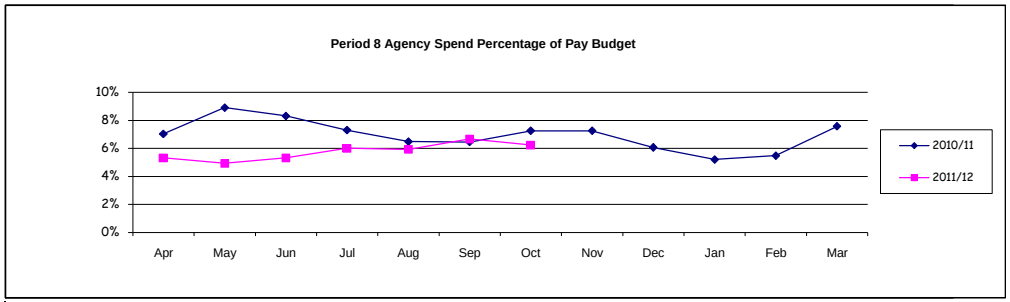
Statement of Comprehensive Income

	Current Month		YTD	
	Actual	Plan Variance	Actual	Plan Variance
	£000	£000	£000	£000
Revenue				
Revenue from patient care activities	24,107	(710)	192,592	489
Other operating revenue	3,883	(398)	32,528	(1,883)
Total Income	**27,990**	**(1,108)**	**225,120**	**(1,394)**
Operating expenses	(25,407)	744	(205,579)	129
EBITDA	**2,583**	**(364)**	**19,541**	**(1,265)**
Depreciation	(1,244)	522	(9,616)	503
Corporation Tax	(8)	12	(64)	92
Operating surplus	**1,331**	**170**	**9,861**	**(670)**
Investment revenue	5	2	48	24
Other losses	0	0	(5)	(5)
Finance costs	(3)	(1)	(27)	(11)
Surplus for the financial year	**1,333**	**171**	**9,877**	**(662)**
Public dividend capital dividends payable	(480)	0	(3,844)	0
Retained surplus for the year	**853**	**171**	**6,033**	**(662)**
Other comprehensive income				
Impairments put to the reserves	0	0	0	0
Gains on Revaluation	0	0	0	0
Receipt of donated and government grant assets	240	(1,076)	20,687	(2,494)
Reclassification adjustments:				
- Transfers from donated and government grant reserves	(503)	149	(4,062)	104
Total comprehensive income for the year	**590**	**(756)**	**22,658**	**(3,052)**
Total Income, excluding Donated Asset Transfer	*27,486*	*(959)*	*221,057*	*(1,290)*
EBITDA, excluding Donated Asset Transfer	*2,080*	*(216)*	*15,478*	*(1,161)*
EBITDA % of Income	*9.23%*		*8.68%*	
EBITDA % of Income, excluding Donated Asset Transfer	*7.57%*		*7.00%*	





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

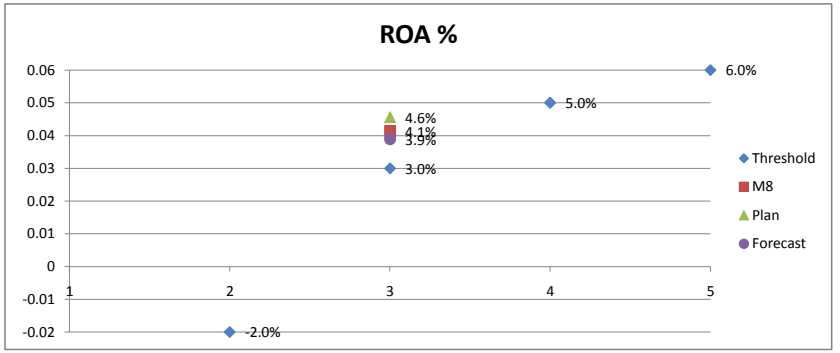


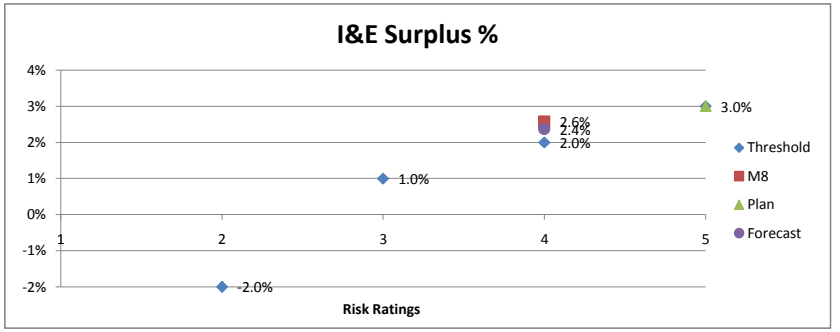
Staffing	10/11	WTE	Maternity	Temp	Overtime	Total	WTE above
Staff Numbers	**M12 WTE**	**Paid**	**Paid**	**Paid**	**Paid**	**Paid**	**10/11 M12**
Admin and Other Support	898	807	16	76	7	905	(7)
Clinical Support	731	671	32	31	2	736	(5)
Medical	516	483	17	42	0	542	(25)
Nursing	1,426	1,273	77	142	5	1,498	(72)
Total	**3,571**	**3,233**	**142**	**291**	**15**	**3,681**	**(110)**

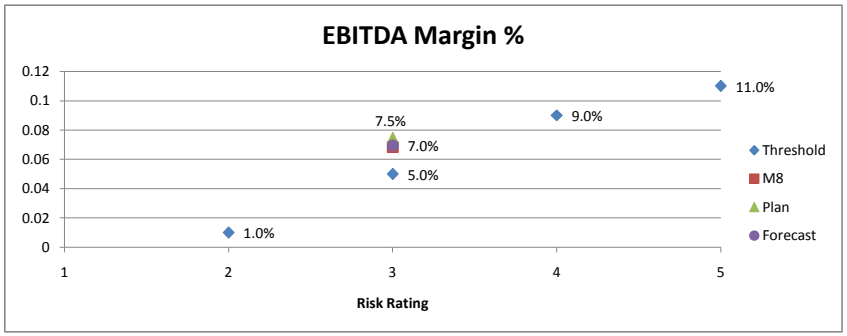
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 2011/12
Ratio Analysis

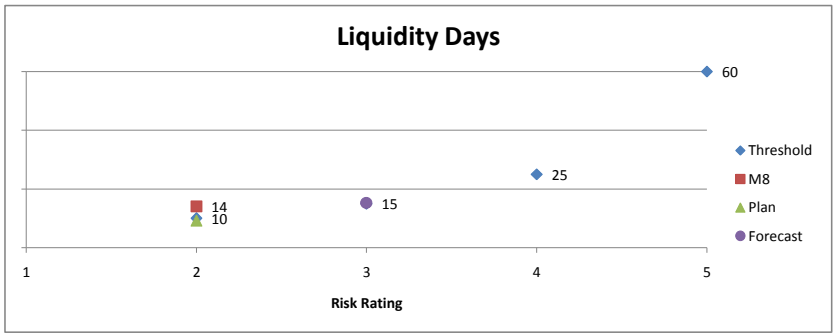
Provider Agency Rating	Target for FT Status	M8 11/12 Actual - FT	M07 11/12 Actual - FT	Forecast Outurn - FT	M8 FT Score
EBITDA Margin	5%	6.8%	6.9%	7.0%	3
EBITDA % Achieved	70%	90.8%	93.4%	100.3%	4
ROA	3%	4.1%	4.2%	3.9%	3
I&E Surplus margin	1%	2.6%	2.7%	2.4%	4
Liquidity Days	15.0	14.1	15	15	2
Weighted Average	3.0	3.1	3.3	3.4	3.1
Overall Rating	**3**	**3**	**3**	**3**	**3**
IPP Cap (Max 9.7%)	9.7%	9.5%	9.5%	9.3%	

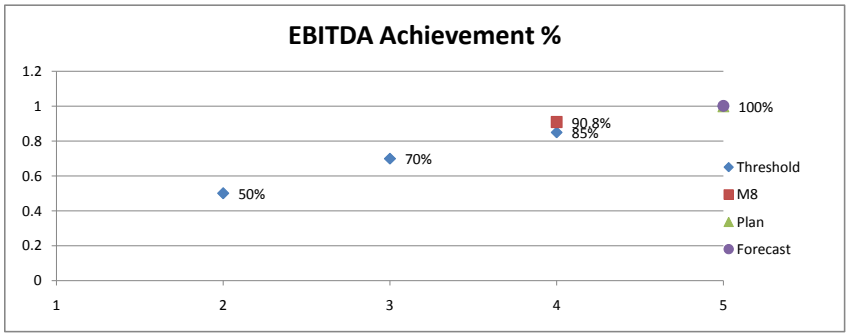
Salary Overpayments		
Unit	**No.**	**Amount £'000**
Surgery	3	20.4
ICI	1	9.0
Operations & Facilities	1	6.4
TOTAL	5	35.8











Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 2011/12
Unit Summary

	YTD						
	Income*			Expenditure			Overall Unit Position
	11/12 YTD Actual £000	11/12 variance to plan £000	11/12 actual variance to 10/11 actual £000	11/12 YTD Actual £000	11/12 variance to plan £000	11/12 actual variance to 10/11 actual £000	11/12 actual variance to plan £000
Clinical Units							
Cardiac	38,118	642	2,366	(22,213)	(1,163)	(2,538)	(520)
Surgery	43,193	(649)	(265)	(41,064)	(2,536)	(1,359)	(3,186)
DTS	1,590	(62)	696	(13,343)	29	(728)	(34)
ICI	38,148	56	1,009	(36,979)	(1,363)	(2,614)	(1,307)
International	20,094	69	3,627	(8,188)	(0)	(1,439)	68
Medicine	28,899	(893)	1,424	(26,962)	(231)	(1,661)	(1,124)
Neurosciences	17,975	65	108	(14,802)	(373)	(1,416)	(307)
Pass through drugs & devices funding	6,359	414	400				414
Education & Training / Merit Award Funding	5,641	(397)	445				(397)
Other Clinical Income / CQUIN	4,726	3,803	1,091				3,803
Centrally held development reserves				**(1,523)**	3,123	1,417	3,123
Total Clinical Units	**204,742**	**3,047**	**10,902**	**(165,075)**	**(2,514)**	**(10,337)**	**533**
Central Departments							
Operations & Facilities	818	(243)	(507)	(10,017)	(99)	1,278	(342)
Corporate Affairs	38	(20)	(17)	(1,088)	131	(226)	111
Estates	557	22	(163)	(8,056)	(356)	(596)	(333)
Finance & ICT	135	6	21	(7,629)	(564)	(911)	(558)
Human Resources	491	(11)	34	(1,927)	245	(63)	235
Medical Director	8	(53)	(99)	(2,269)	(69)	381	(122)
Nursing And Workforce Development	1,281	70	(32)	(3,695)	202	(192)	272
Research And Innovation	8,943	(490)	430	(4,013)	(66)	252	(556)
Redevelopment Revenue Costs	306	(289)	(44)	(306)	150	44	(139)
Total Central Departments	**12,578**	**(1,008)**	**(377)**	**(39,000)**	**(425)**	**(34)**	**(1,432)**
Depreciation & Dividends	**4,062**	**(104)**	**(827)**	**(13,464)**	**498**	**283**	**394**
Centrally held income	**2,155**	**(192)**	**(933)**	**0**	**0**	**0**	**(192)**
Net Position, excl Haringey & North Mid	**223,537**	**1,744**	**8,764**	**(217,539)**	**(2,441)**	**(10,088)**	**(697)**
Haringey	1,590	7	(4,759)	(1,550)	34	5,345	41
North Mid.	(8)	(8)	(698)	2	2	692	(6)
Net Position, incl Haringey & North Mid	**225,120**	**1,743**	**3,307**	**(219,087)**	**(2,405)**	**(4,051)**	**(662)**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 2011/12
CRES Performance

2011/12

Unit	Target	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total savings	Risk adjusted savings	Total Year To Date Delivery
Cardiac	2,073,257	208,461	213,342	225,417	-	647,219	**620,460**	
ICI	2,163,631	2,117,016	33,586	-	-	2,150,602	**2,129,096**	
International	664,439	1,036,824	-	144,750	-	1,181,574	**1,156,731**	
MDTS	2,622,255	1,134,464	688,699	-	-	1,823,163	**1,773,638**	
Neurosciences	1,418,021	364,972	437,690	184,220	-	986,882	**960,433**	
Surgery	3,356,564	92,757	1,222,215	158,510	-	1,473,482	**1,444,201**	
Corporate facilities	1,025,794	502,145	44,794	143,399	-	690,337	**670,528**	
Clinical Operations	154,079	180,344	-	10,397	-	190,741	**187,898**	
Corporate affairs	120,933	122,318	-	9,630	-	131,948	**129,762**	
Estates	783,191	582,737	168,332	130,885	-	881,954	**862,138**	
Finance & ICT	731,684	234,915	52,893	13,713	-	301,522	**297,272**	
HR & workforce	191,918	143,201	-	19,457	-	162,658	**159,281**	
Medical director	150,781	4,535	7,000	76,965	-	88,500	**80,688**	
Nursing & Education	283,103	239,723	70,130	56,189	-	366,042	**356,075**	
R&I	33,478	-	35,000	-	-	35,000	**34,650**	
Total	**15,773,128**	**6,964,413**	**2,973,681**	**1,173,531**	**-**	**11,111,625**	**10,862,849**	**7,240,470**
							11,203,453	
							(340,604)	

NHS Clinical Income	1,831,502	1,340,431	451,862	-	3,623,795	**3,514,405**
Other Income	2,140,536	89,254	160,404	-	2,390,194	**2,352,460**

2012/13

Unit	Target	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
Cardiac		-	15,112	350,479	791,089	1,156,680	**1,043,296**
ICI		-	1,337,135	1,303,930	110,126	2,751,192	**1,902,548**
International		-	94,965	1,259,120	-	1,354,085	**1,224,425**
MDTS		-	368,436	1,794,145	407,077	2,569,658	**1,522,566**
Neurosciences		-	9,820	1,102,558	138,545	1,250,923	**1,068,426**
Surgery		-	376,378	743,500	733,216	1,853,095	**1,665,004**
Corporate facilities		-	36,771	747,026	314,716	1,098,513	**979,500**
Clinical Operations		-	-	153,867	-	153,867	**138,480**
Corporate affairs		-	125,305	60,227	5,837	191,369	**181,509**
Estates		-	491,500	718,469	45,217	1,255,186	**1,154,242**
Finance & ICT		-	-	288,299	360,731	649,030	**577,795**
HR & workforce		-	-	48,838	85,172	134,010	**121,051**
Medical director		-	-	-	32,250	32,250	**29,025**
Nursing & Education		-	-	35,000	162,036	197,036	**169,231**
R&I		-	-	-	217,500	217,500	**184,875**
Total	**11,871,000**	**-**	**2,855,423**	**8,605,458**	**3,403,512**	**14,864,393**	**11,961,973**
							11,871,000
							90,973

NHS Clinical Income	-	475,097	1,908,496	1,586,530	3,970,123	**3,225,179**
Other Income	-	494,443	710,103	387,717	1,592,263	**1,382,467**

2013/14

Unit	Target	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
Cardiac		-	-	-	1,847,698	1,847,698	**1,662,928**
ICI		-	-	50,000	1,717,195	1,767,195	**1,545,476**
International		-	-	963,819	-	963,819	**867,437**
MDTS		-	-	60,000	2,445,996	2,505,996	**2,255,396**
Neurosciences		-	-	-	1,318,593	1,318,593	**1,186,734**
Surgery		-	-	-	3,424,227	3,424,227	**3,081,804**
Corporate facilities		-	-	-	1,055,000	1,055,000	**949,500**
Clinical Operations		-	-	-	149,000	149,000	**134,100**
Corporate affairs		-	-	-	125,305	125,305	**112,775**
Estates		-	71,000	-	528,992	599,992	**543,543**
Finance & ICT		-	-	100,983	488,895	589,878	**530,890**
HR & workforce		-	-	-	215,000	215,000	**193,500**
Medical director		-	-	-	278,000	278,000	**250,200**
Nursing & Education		-	-	-	366,726	366,726	**330,053**
R&I		-	-	-	35,000	35,000	**31,500**
Total	**13,224,000**	**-**	**71,000**	**1,174,802**	**13,995,627**	**15,241,429**	**13,675,836**
							13,224,000
							451,836

NHS Clinical Income	-	-	-	2,774,678	2,774,678	**2,497,210**
Other Income	-	-	963,819	2,201,111	3,164,930	**2,848,437**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 08 2011/12
Revenue Statement

	11/12 Annual Budget £000	11/12 Mth 08 Actual £'000	11/12 Mth 08 Variance to Plan, excluding Pass Through £'000	11/12 Mth 08 Pass Through Variance £'000	11/12 Mth 08 Variance to Plan, including Pass Through £'000	11/12 YTD Actual £'000	11/12 YTD Variance to Plan, excluding Pass Through £'000	11/12 YTD Pass Through Variance £'000	11/12 YTD Variance to Plan, including Pass Through £'000	11/12 YTD Actual Variance to 10/11 YTD Actual £'000
Primary Care Trusts Tariff	64,349	5,379	-264	0	-264	43,762	703	0	703	3,384
Primary Care Trusts Non Tariff	120,130	10,483	405	-474	-69	79,710	1,592	-1,698	-106	-520
Primary Care Trusts Mff	18,754	1,624	-20	0	-20	12,819	270	0	270	-16
Strategic Health Authorities	45,155	3,598	-93	-72	-165	30,723	483	137	620	3,115
Nhs Trusts	874	82	9	0	9	488	-95	0	-95	-814
Department Of Health	850	-13	0	-84	-84	384	0	-183	-183	-167
Nhs Other	5,993	369	-1	0	-1	4,362	-149	0	-149	-1,143
Activity Revenue Nhs	**256,105**	**21,522**	**36**	**-630**	**-594**	**172,247**	**2,804**	**-1,744**	**1,060**	**3,839**
Local Authorities	168	0	0	0	0	151	-17	0	-17	-559
Private Patients	27,669	2,304	-76	0	-76	18,318	-18	0	-18	2,623
Non Nhs Other	3,602	280	3	-42	-39	1,875	-311	-225	-536	-943
Activity Revenue Non Nhs	**31,439**	**2,584**	**-73**	**-42**	**-115**	**20,344**	**-346**	**-225**	**-571**	**1,122**
Patient Transport Services	1,216	107	5	0	5	755	-55	0	-55	-91
Education And Training	13,386	1,078	-19	0	-19	9,049	50	0	50	590
Research And Development	13,364	1,011	-64	-39	-103	8,527	-292	-90	-382	17
Charitable & Other Contrib	5,278	179	10	-272	-261	2,719	254	-1,078	-824	-997
Non Patient Care Services	3,631	263	-39	0	-39	2,645	224	0	224	41
Revenue Generation	1,802	77	-73	0	-73	915	-287	0	-287	-221
Other Revenue	6,088	665	241	0	241	3,855	-506	0	-506	-167
Other Operating Revenue, excluding Donated Asset Income	**44,765**	**3,380**	**62**	**-311**	**-249**	**28,466**	**-611**	**-1,168**	**-1,779**	**-827**
Total Operating Income, excluding Donated Asset Income	**332,309**	**27,486**	**25**	**-984**	**-959**	**221,057**	**1,846**	**-3,137**	**-1,290**	**4,133**
Directors & Senior Managers	-8,606	-697	-62	0	-62	-5,621	140	0	140	-353
Consultants	-37,750	-3,017	145	83	228	-24,368	356	433	789	-468
Junior Doctors	-18,900	-1,635	-60	0	-60	-13,183	-554	-29	-583	-1,410
Junior Doctors Agy	11	-110	-111	0	-111	-1,066	-1,073	0	-1,073	1,003
Administration & Estates	-26,107	-1,963	296	-5	291	-15,344	2,076	61	2,138	-776
Administration & Estates Agy	-526	-376	-398	0	-398	-3,080	-2,730	0	-2,730	524
Healthcare Assist & Supp	-2,390	-149	131	0	131	-1,390	203	0	203	18
Healthcare Assist & Supp Agy	0	1	1	0	1	-150	-150	0	-150	112
Nursing Staff	-59,051	-4,964	-21	8	-13	-39,427	281	-97	184	-327
Nursing Staff Agy	-21	-289	-287	0	-287	-1,844	-1,844	14	-1,830	-69
Scientific Therap Tech	-33,164	-2,615	-23	28	4	-21,150	1,089	56	1,145	244
Scientific Therap Tech Agy	-53	-209	-205	0	-205	-1,422	-1,360	-27	-1,387	-182
Other Staff	-295	-19	6	0	6	-173	24	0	24	-19
Pay Reserves	-4,252	2	321	35	356	-641	2,158	35	2,193	771
Cips And Cres Unidentified - P	2,915	0	-159	0	-159	0	-1,944	0	-1,944	0
Pay Costs	**-188,189**	**-16,041**	**-426**	**149**	**-277**	**-128,860**	**-3,328**	**447**	**-2,881**	**-933**
Drugs Costs	-34,610	-2,872	64	162	227	-22,734	703	-268	435	-2,427
Blood Costs	-18,494	-1,457	-79	266	186	-11,364	-369	1,384	1,015	595
Supplies & Services - Clinical	-23,629	-1,898	51	111	162	-15,597	-137	439	302	-1,114
Services From Nhs Organisation	-4,200	-314	-24	81	57	-2,509	194	108	302	308
Healthcare From Non-Nhs Bodies	-2,378	-227	0	-27	-27	-1,921	-336	11	-325	-1,109
Supplies & Services - General	-1,721	-167	-20	0	-20	-1,339	-190	0	-190	440
Consultancy Services	-1,277	-128	-38	0	-38	-927	-21	0	-21	-266
Clinical Negligence Costs	-1,950	-162	0	0	0	-1,300	0	0	0	-157
Establishment Costs	-2,819	-204	16	5	21	-1,733	136	15	151	20
Transport Costs	-2,671	-335	-114	0	-114	-1,837	11	-63	-52	2
Premises Costs	-19,162	-1,943	-326	16	-310	-12,953	-132	138	6	-1,361
Auditors Costs	-420	-16	19	0	19	-223	56	0	56	12
Education And Research Costs	-2,293	-147	-34	79	45	-879	290	363	652	243
Expenditure - Other	-4,179	509	648	141	789	-1,391	834	563	1,397	1,472
Non Pay Reserves	-2,926	-3	124	0	124	-11	528	0	528	-11
Cips And Cres Unidentified - N	1,869	0	-102	0	-102	0	-1,246	0	-1,246	0
Non Pay Costs	**-120,861**	**-9,365**	**185**	**834**	**1,020**	**-76,718**	**320**	**2,689**	**3,010**	**-3,354**
EBITDA	**23,259**	**2,080**	**-216**	**0**	**-216**	**15,478**	**-1,161**	**0**	**-1,161**	**-153**
P & L On Disp Of Fixed Assets	0	1	1	0	1	-4	-4	0	-4	50
Fixed Asset Impair & Reversals	-5,571	0	0	0	0	0	0	0	0	228
Depreciation & Amortisation	-17,164	-1,244	522	0	522	-9,616	503	0	503	-43
Interest Receivable	36	5	2	0	2	48	24	0	24	9
Other Revenue / Expenditure	-24	-3	-1	0	-1	-27	-11	0	-11	-6
Pdc Dividend Payable	-5,765	-480	0	0	0	-3,844	-1	0	-1	48
Corporation Tax	-234	-8	12	0	12	-64	92	0	92	-50
Other Revenue / Expenditure	**-28,723**	**-1,730**	**536**	**0**	**536**	**-13,507**	**604**	**0**	**604**	**236**
Retained Surplus / (Deficit), excl Donated Asset Income	**-5,464**	**350**	**319**	**0**	**319**	**1,971**	**-558**	**0**	**-558**	**83**
Depreciation Income Transfer	6,773	503	-149	0	-149	4,062	-104	0	-104	-827
Retained Surplus / (Deficit), incl Donated Asset Income	**1,309**	**853**	**171**	**0**	**171**	**6,033**	**-662**	**0**	**-662**	**-744**

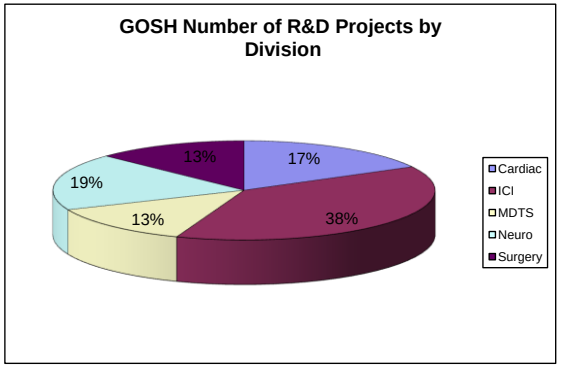
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 08 2011/12
Research and Development Activity

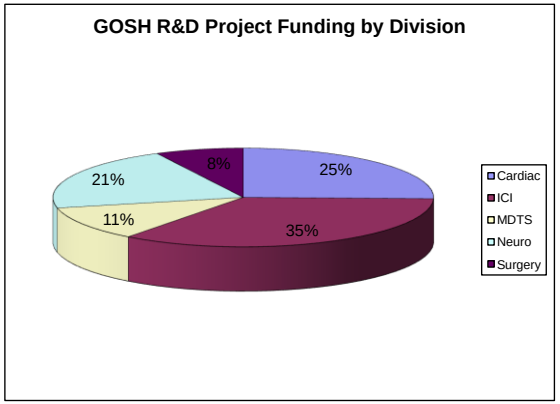
	Full Year Forecast	Full Year Budget	YTD Actuals	YTD Variance
Summary Research & Innovation Income and Expenditure				
TOTAL RESEARCH & DEVELOPMENT DIRECTORATE				
- R&D Income	(12,690)	(12,656)	(7,627)	(827)
- R&D Income Deferred from 10-11	0	0	0	0
- R&D Income Local Research Network MCRN	(935)	(788)	(706)	181
- R&D Charitable Contribution	(1,519)	(1,694)	(545)	(617)
- Non Research Income	(30)	0	(66)	66
- Expenditure	7,017	6,948	4,013	641
	(8,157)	(8,190)	(4,931)	(556)
- Expenditure in Clinical Areas	7,779	8,587	5,186	539
Total R&D Division	(378)	397	255	(17)
Devolved Income				
- DTS : From CLRN Service Support	(76)	(218)	(58)	(88)
- Medicine : Grants	(169)	(82)	(109)	47
- ICI : From CLRN Support / NIHR Felowships	(81)	(67)	(83)	39
- Surgery : From Charitable Donation	(3)	0	(3)	3
- Other	0	415	0	300
Total Centrally Held and Devolved Income	(329)	48	(245)	293
Revenue and Direct Expenditure by Funding Source				
Biomedical Research Centre including Clinical Research Facility				
- Income	(7,855)	(7,882)	(4,857)	(397)
- Commercial Trials Income	(295)	0	(70)	70
- Non R&D Income	(30)	0	(66)	66
- Expenditure	2,812	2,811	1,544	330
	(5,369)	(5,070)	(3,450)	70
CLRN (PCRN) Income				
- Income CLR Activity Based (Non DH R&D)	(293)	(1,186)	(167)	(624)
- Income PCRN (R M&G, KSS, SS)	(86)	0	(57)	57
- Income PCRN (R M&G,)	(272)	0	(195)	195
- Income Non R&D (cc **CLR**)	0	(112)	0	(75)
- Expenditure CLR	249	198	204	(72)
	(401)	(1,100)	(215)	(518)
NIHR GRANTS				
- Income	(935)	(983)	(596)	(75)
- Expenditure	935	987	596	79
	0	4	(0)	4
R&D GOSH Charity Funded Projects				
- Income	(1,519)	(1,694)	(545)	(617)
- Expenditure	1,483	1,552	509	488
	(36)	(142)	(36)	(128)
R&D Development Office & Other Grants				
- Income R&D including Flexibility and Sustainability	(2,955)	(2,479)	(1,683)	30
- Income non R&D	0	0	0	0
- Income EU Grants	0	(15)	0	(10)
- Expenditure	603	612	454	(4)
	(2,351)	(1,881)	(1,229)	17
Local Research Network MCRN *				
- Income DH to fund Network	(628)	(628)	(612)	193
- Income : Network Flexibility and Sustainability	(143)	(143)	(33)	(62)
- Income R&D :CLRN Network	(164)	0	(60)	60
- Income Other Non R&D	0	(17)	0	(11)
- Expenditure LRN	935	788	706	(181)
	0	0	0	(0)

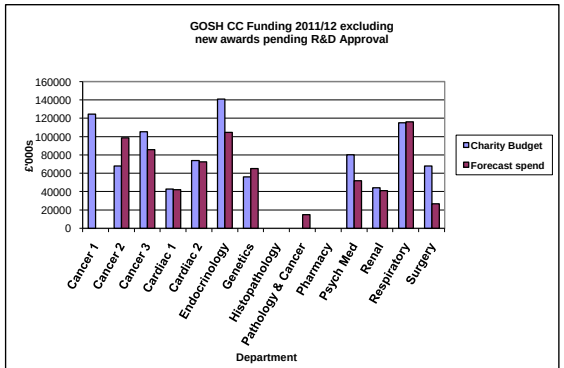
* GOSH is Hosting this service for Central and North East London

Analysis of Total Research & Innovation Funding				
TOTAL R&D INCOME				
-R&D Income Excluding Hosted network	(13,019)	(12,608)	(7,880)	(526)
-R&D Income Local Research Network MCRN	(935)	(788)	(706)	181
-Income Generation GOS / Direct Credits	0	0	0	0
Total Income	(13,954)	(13,396)	(8,586)	(345)

The pie charts below show the % split of number and funding of research projects undertaken by GOSH staff per division at end of November 2011







Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 2011/12
Statement of Financial Position

	Actual as at 1 April 2011 £000	Actual as at 31 October 2011 £000	Actual as at 30 November 2011	Change in month £000
Non Current Assets :				
Property Plant & Equipment - Purchased	177,238	178,224	178,686	462
Property Plant & Equipment - Donated	141,526	158,473	158,199	(274)
Property Plant & Equipment - Gov Granted	363	327	322	(5)
Intangible Assets - Purchased	972	942	1,043	101
Intangible Assets - Donated	25	22	12	(10)
Trade & Other Receivables	9,505	9,240	9,201	(39)
Total Non Current Assets :	***329,629***	***347,228***	***347,463***	***235***
Current Assets :				
Inventories	5,156	6,262	6,084	(178)
NHS Trade Receivables	7,455	20,979	19,219	(1,760)
Non NHS Trade Receivables	10,360	11,060	12,068	1,008
Capital Receivables	6,571	5,415	5,282	(133)
Provision for Impairment of Receivables	(1,498)	(1,720)	(1,321)	399
Prepayments & Accrued Income	4,919	7,265	5,695	(1,570)
HMRC VAT	1,895	555	674	119
Other Receivables	807	564	743	179
Cash & Cash Equivalents	32,371	20,633	18,436	(2,197)
Total Current Assets :	***68,036***	***71,013***	***66,880***	***(4,133)***
Total Assets :	**397,665**	**418,241**	**414,343**	**(3,898)**
Current Liabilities :				
NHS Trade Payables	(7,722)	(4,498)	(5,104)	(606)
Non NHS Trade Payables	(2,519)	(2,572)	(2,134)	438
Capital Payables	(12,179)	(5,364)	(4,307)	1,057
Expenditure Accruals	(14,866)	(14,723)	(13,982)	741
Deferred Revenue	(6,280)	(13,700)	(10,596)	3,104
Tax & Social Security Costs	(4,022)	(3,965)	(4,031)	(66)
Other Payables	0	(480)	(961)	(481)
Payments on Account	(228)	(228)	(228)	0
Lease Incentives	(400)	(400)	(444)	(44)
Other Liabilities	(2,754)	(3,989)	(3,753)	236
Provisions for Liabilites & Charges	(2,867)	(2,674)	(2,622)	52
Total Current Liabilities :	***(53,837)***	***(52,593)***	***(48,162)***	***4,431***
Net Current Assets	**14,199**	**18,420**	**18,718**	**298**
Total Assets Less Current Liabilities :	**343,828**	**365,648**	**366,181**	**533**
Non Current Liabilities :				
Lease Incentives	(7,327)	(7,093)	(7,060)	33
Provisions for Liabilites & Charges	(1,250)	(1,216)	(1,218)	(2)
Total Non Current Liabilities :	***(8,577)***	***(8,309)***	***(8,278)***	***31***
Total Assets Employed :	**335,251**	**357,339**	**357,903**	**564**
Financed by Taxpayers' Equity :				
Public Dividend Capital	124,732	124,732	124,732	0
Retained Earnings	16,868	22,152	23,019	867
Revaluation Reserve	48,623	48,519	48,505	(14)
Donated Asset Reserve	141,551	158,495	158,211	(284)
Government Grant Reserve	363	327	322	(5)
Other Reserves	3,114	3,114	3,114	0
Total Taxpayers' Equity :	**335,251**	**357,339**	**357,903**	**564**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 2011/12
Statement of Cash Flows

Statement of Cash Flows	Actual For Month Ended 30 November 2011 £000	Actual For YTD Ended 30 November 2011 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating Surplus	1,330	9,861
Depreciation and Amortisation	1,244	9,616
Transfer from Donated Asset Reserve	(504)	(4,021)
Transfer from the Government Grant Reserve	1	(41)
PDC Dividend Paid	0	(2,818)
Decrease/(Increase) in Inventories	178	(928)
Decrease/(Increase) in Trade and Other Receivables	1,664	(12,901)
(Decrease)/Increase in Trade and Other Payables	(3,610)	439
(Decrease)/Increase in Other Current Liabilities	(226)	775
Decrease in Provisions	(53)	(303)
Net Cash Inflow/(Outflow) from Operating Activities :	***24***	***(321)***
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	5	48
Payments for Property, Plant and Equipment	(2,599)	(35,533)
Payments for Intangible Assets	0	(113)
Proceeds from Disposal of Intangible Assets	0	8
Net Cash Outflow from Investing Activities :	**(2,594)**	**(35,590)**
NET CASH OUTFLOW BEFORE FINANCING :	**(2,570)**	**(35,911)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Other Capital Receipts	373	21,976
Net Cash Inflow from Financing :	**373**	**21,976**
NET DECREASE IN CASH AND CASH EQUIVALENTS :	**(2,197)**	**(13,935)**

Cash and Cash Equivalents at the Beginning of the current period	**20,633**	**32,371**
Cash and Cash Equivalents at the End of the current period	**18,436**	**18,436**
Net Decrease in Cash and Cash Equivalents per SoFP :	**(2,197)**	**(13,935)**

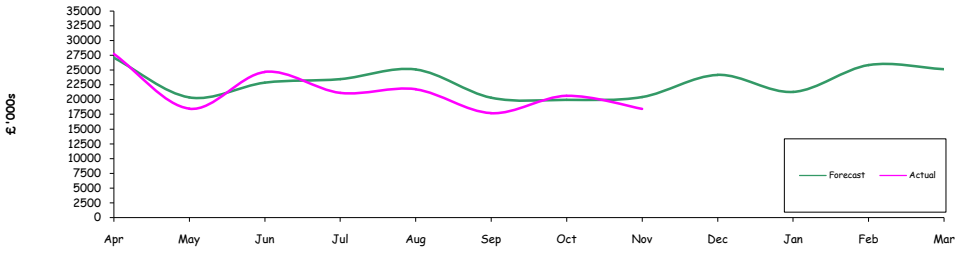
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 2011/2012
Activity

November activities are based on April to October

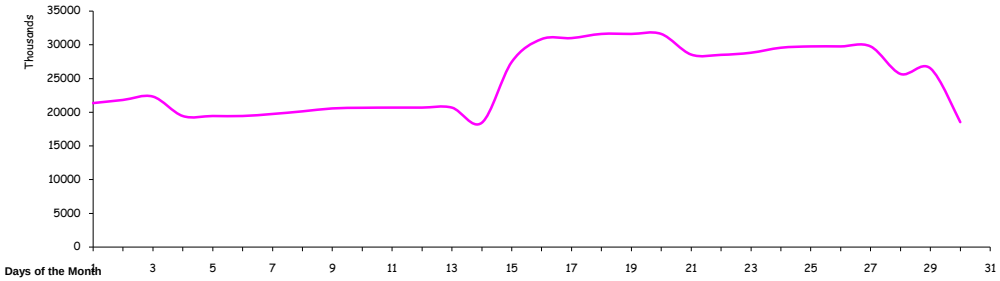
	April	May	June	July	August	September	October	November	December	January	February	March	YTD 11/12 Actual	YTD 11/12 Plan	YTD 11/12 Variance	YTD 11/12 Variance %	YTD 10/11	Variance 11/12 to 10/11	Variance 11/12 to 10/11 %
Elective PBR	1,416	1,499	1,652	1,515	1,531	1,542	1,581	1,641					12,377	12,074	303	2.5%	11,724	653	5.6%
Elective Non PBR	106	151	159	129	146	130	171	157					1,149	1,536	-387	-25.2%	1,151	-3	-0.2%
TOTAL ELECTIVE	1,522	1,650	1,811	1,644	1,677	1,672	1,752	1,798	0	0	0	0	13,526	13,610	-84	-0.6%	12,876	650	5.0%
Non Elective PBR	143	155	134	115	131	117	130	130					1,055	1,196	-141	-11.8%	1,404	-349	-24.9%
Non Elective Non PBR	3	1	1	3	1	3	1	2					15	35	-20	-57.3%	22	-7	-32.6%
TOTAL NON ELECTIVE	146	156	135	118	132	120	131	131	0	0	0	0	1,069	1,231	-161	-13.1%	1,426	-357	-25.0%
Outpatients PBR	5,604	6,732	7,578	6,662	6,605	7,709	7,262	7,559					55,711	54,771	941	1.7%	45,785	9,926	21.7%
Outpatients Non PBR	4,282	4,842	5,077	4,869	4,849	5,391	5,272	5,320					39,902	39,161	742	1.9%	41,282	-1,380	-3.3%
TOTAL OUTPATIENTS	9,886	11,574	12,655	11,531	11,454	13,100	12,534	12,880	0	0	0	0	95,614	93,931	1,682	1.8%	87,067	8,547	9.8%
POC (Non Consortium)	812	799	816	803	821	830	845	818					6,544	7,026	-482	-6.9%	7,338	-794	-10.8%
BEDDAYS (includes PICU Consortium)																			
Panda HDU (PBR HDU)	744	622	757	890	790	646	871	813					6,133	5,815	318	5.5%	5,662	471	8.3%
Transitional Care	140	176	139	164	186	160	124	153					1,242	997	245	24.6%	997	245	24.6%
Rheumatology Rehab	145	194	216	218	180	199	224	193					1,569	1,470	99	6.7%	1,441	128	8.9%
CAMHS	214	239	252	251	248	229	244	235					1,912	1,961	-49	-2.5%	1,819	93	5.1%
Cardiac ECMO	17	6	19	0	10	30	1	12					95	61	33	54.1%	64	31	47.9%
Neurosurgery HDU (NC)	0	11	0	7	0	7	7	4					36	26	10	39.2%	26	10	40.3%
Neurosurgery (PICU Consortium-ITU & HDU)	2	51	100	90	71	145	53	72					584	514	69	13.5%	509	75	14.8%
Neurosurgery ITU (NC)	1	0	0	12	0	0	0	2					15	15	0	0.3%	15	0	1.1%
Cardiac HDU (NC)	33	28	42	54	42	42	65	43					349	272	77	28.2%	263	86	32.5%
Cardiac ITU (NC)	61	101	146	102	70	113	108	98					799	768	32	4.1%	903	-104	-11.5%
Cardiac (PICU Consortium-ITU & HDU)	251	165	179	308	277	209	241	229					1,859	1,669	189	11.3%	1,594	265	16.6%
Paediatric ITU (NC)	48	68	71	44	30	85	80	60					486	554	-68	-12.3%	439	46	10.6%
Paediatric ITU (PICU Consortium-ITU)	399	367	374	435	387	398	370	383					3,113	3,123	-10	-0.3%	3,037	76	2.5%
TOTAL BEDDAYS	2,055	2,028	2,295	2,575	2,291	2,263	2,388	2,295	0	0	0	0	18,190	17,246	945	5.5%	16,769	1,422	8.5%
HaemOnc Consortium*																			
PBR	50	55	53	54	48	54	52	56					422	429	-8	-1.8%	356	65	18.4%
NON PBR	134	142	145	144	163	143	171	159					1,201	1,137	64	5.6%	1,053	148	14.1%
Panda HDU (PBR HDU)	202	256	154	329	339	210	317	276					2,083	1,864	219	11.7%	1,681	402	23.9%
TOTAL HAEMONC	386	453	352	527	550	407	540	491	0	0	0	0	3,706	3,431	275	8.0%	3,090	616	19.9%

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 November 2011/12
Cash Management

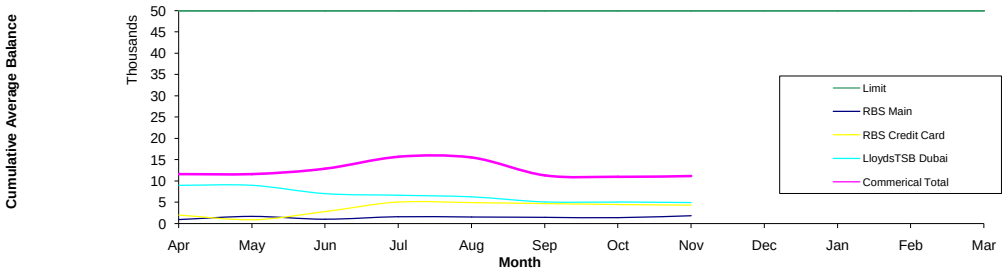
Forecast Cash



Daily Liquidity



Commerical Bank Account Performance



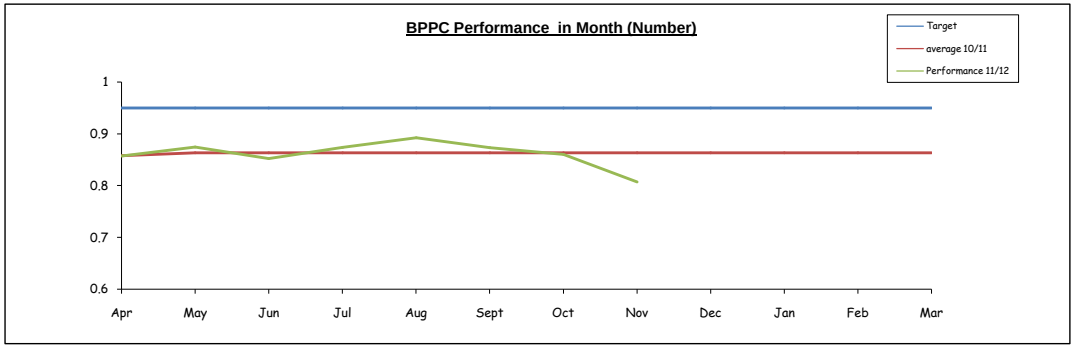
Payables Analysis

Days	Current Month	Previous Month	Movement in Month
	£000s	£000s	£000s
Not Yet Due	4,988	3,787	1,201
1-30	1,315	3,117	(1,802)
31-60	227	1,185	(958)
61-90	(54)	411	(465)
91-120	131	329	(198)
121-180	(85)	381	(466)
180-360	505	657	(152)
360+	650	486	164
	7,678	**8,367**	**(689)**

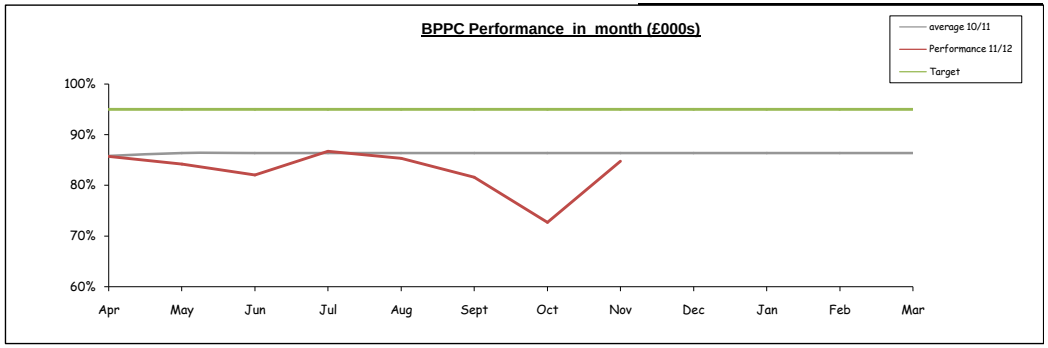
Better Payment Practice Code (BPPC)

	Number	£000s
Cumumlative Performance		
Total Payables		
% of Invoices paid within target	85.0%	82.5%
Non-NHS Payables		
Invoices paid in the year	55185	128,054
Invoices paid within target	47650	110,130
% of Invoices paid within target	86.3%	86.0%
NHS Payables		
Invoices paid in the year	2215	13,612
Invoices paid within target	1162	6,677
% of Invoices paid within target	52.5%	49.1%

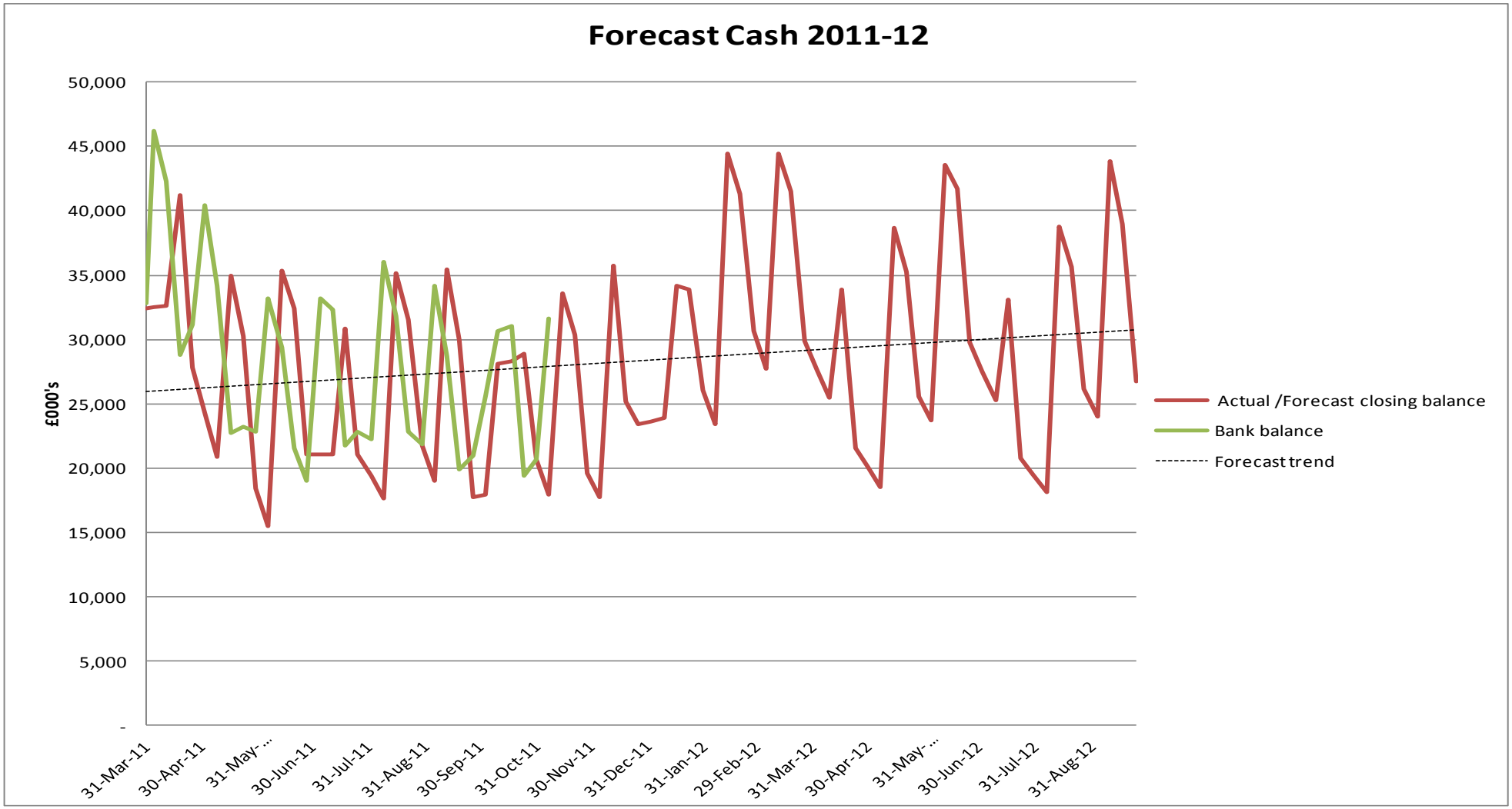
BPPC Performance in Month (Number)



BPPC Performance in month (£000s)



Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 2011/12
Cash Forecast



Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 2011/12
Receivables Management

Net Receivables in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	**9668**	-1696	6159	778	3318	38	548	272	266	-15
NHS Credit Note Provision	-904	0	0	0	0	0	-102	-112	-342	-348
Specific NHS Debt Provisions										
NHS Net Receivables	**8764**	**-1696**	**6159**	**778**	**3318**	**38**	**446**	**160**	**-76**	**-363**
Non-NHS	**2826**	-16	2371	210	65	-23	13	54	52	99
Bad Debt Provision-Non NHS	-526	0	-286	-29	-7	-5	-12	-15	-54	-118
Specific Non-NHS Debt Provisions										
	0	0	0	0	0	0	0	0	0	0
Non-NHS Net Receivables	**2300**	**-16**	**2085**	**181**	**58**	**-28**	**1**	**39**	**-1**	**-19**
International	**8767**	6386	-1213	1300	691	310	161	342	313	478
Bad Debt Provision-International	-795	-28	-1	-1	-3	-1	-33	-69	-173	-486
International Net Receivables	**7972**	**6358**	**-1215**	**1299**	**688**	**310**	**128**	**273**	**139**	**-8**
GOSH Charity Receivables	**1442**	-1	560	770	73	6	7	24	3	0
Specific Activity Provisions (IPP)		0	0	0	0	0	0	0	0	0
Net Trust Receivables	**20478**	**4645**	**7589**	**3029**	**4137**	**326**	**581**	**496**	**65**	**-390**

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	9668	-1696	6159	778	3318	38	548	272	266	-15
Non-NHS	2826	-16	2371	210	65	-23	13	54	52	99
International	8767	6386	-1213	1300	691	310	161	342	313	478
Gross Trading Receivables	**21261**	**4674**	**7317**	**2288**	**4074**	**325**	**721**	**668**	**631**	**562**
GOSH Charity Receivables	1442	-1	560	770	73	6	7	24	3	0
Total Trust Receivables	**22702**	**4672**	**7876**	**3058**	**4147**	**332**	**728**	**693**	**634**	**562**

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)	22702	4672	7876	3058	4147	332	728	693	634	562
Gross Trading Receivables (last month)	21511	-1929	8576	9446	1018	1281	441	1294	818	567
Movement in Month	**1191**	**6601**	**-699**	**-6388**	**3129**	**-949**	**287**	**-601**	**-184**	**-4**
Gross Trading Receivables (year end 10/11)	15481	-1747	11317	1550	779	524	423	515	1385	734
Movement in Financial Year	**-7221**	**-6419**	**3441**	**-1508**	**-3367**	**192**	**-305**	**-177**	**751**	**172**

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	13935	-1713	9090	1758	3456	21	567	351	321	84
Compucare	8767	6386	-1213	1300	691	310	161	342	313	478
Trust Receivables	**22702**	**4672**	**7876**	**3058**	**4147**	**332**	**728**	**693**	**634**	**562**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 2011/12
Capital Expenditure (£000s)

Capital Spend by Division	Year to Date (YTD) Annual Plan	Year To Date Plan	Actual (YTD)	Variance (YTD)	Forecast Outturn	Forecast Variance to Plan
Redevelopment Projects						
Trust/DH Funded						
Phase 2a Enabling	0	0	0	0	0	0
Donated Funded						0
Phase 1	26	14	(7)	22	12	14
Phase 2a Enabling	0	0	0	0	0	0
Phase 2a	27,778	15,362	17,090	(1,728)	29,285	(1,507)
Phase 2b Enabling	6,271	3,468	83	3,386	1,133	5,138
Phase 2b	1,953	1,080	1,245	(165)	1,953	0
Pre-phase 2	0	0	18	(18)	18	(18)
Phase 2 - Inhouse Resources	344	190	181	9	288	56
Other Redevelopment Projects	0	0	0	0	0	0
Total :	**36,372**	**20,115**	**18,608**	**1,507**	**32,688**	**3,684**
Estates Maintenance Projects						
Trust/DH Funded	7,702	4,108	5,299	(1,191)	7,559	143
Donated Funded	1,250	670	34	636	520	730
Total :	**8,952**	**4,778**	**5,333**	**(555)**	**8,079**	**873**
IT Projects						
Trust/DH Funded	6,000	3,200	1,613	1,587	4,500	1,500
Donated Funded	1,000	530	16	514	1,000	0
Total:	**7,000**	**3,730**	**1,629**	**2,101**	**5,500**	**1,500**
Medical Equipment Projects						
Trust/DH Funded	90	52	166	(114)	237	(147)
Donated Funded	3,500	1,866	2,029	(163)	3,498	2
Total:	**3,590**	**1,918**	**2,195**	**(277)**	**3,736**	**(146)**
Total Additions in Year	**55,914**	**30,541**	**27,765**	**2,776**	**50,003**	**5,911**
Asset Disposals	0	0	(4)	4	(4)	4
Donated Funded Projects	(42,122)	(23,181)	(20,687)	(2,494)	(37,707)	(4,416)
Charge Against CRL Target	**13,792**	**7,360**	**7,074**	**286**	**12,292**	**1,500**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 8 2011/12
Staffing WTE

Permanent (Excludes Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	10/11 Period 12	M8 variance to M12 10/11
Cardiac	350	354	348	358	354	363	373	379	342	-38
Surgery	650	644	640	649	652	647	669	676	646	-29
DTS	354	356	354	351	355	346	354	362	349	-12
ICI	479	481	472	482	486	487	501	519	460	-59
International	114	116	117	118	117	113	120	127	115	-12
Medicine	280	284	275	274	280	281	271	276	282	6
Neurosciences	261	264	254	258	258	273	278	279	255	-25
Haringey	183	175	0	1	0	0	0	0	0	0
North Mid.	2	2	2	2	2	0	0	0	0	0
Children's Population Health	7	8	8	9	7	7	8	7	7	0
Operations & Facilities	202	203	208	207	207	192	204	206	208	2
Corporate Affairs	15	13	12	14	10	10	14	10	13	3
Estates	46	45	45	45	44	43	45	45	48	3
Finance & ICT	138	138	140	135	138	135	127	120	134	14
Human Resources	57	55	54	57	58	60	56	59	57	-2
Medical Director	14	14	13	14	14	14	8	8	15	7
Nursing And Workforce Development	80	78	75	76	76	75	80	77	80	3
Research And Innovation	57	63	66	75	71	78	79	77	77	0
Redevelopment Revenue Costs	7	7	7	8	8	8	6	6	7	2
TOTAL	3297	3300	3089	3,134	3,137	3,131	3,194	3,233	3096	-138

Overtime

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	10/11 Period 12	M8 variance to M12 10/11
Cardiac	6.3	2.4	1.0	2.0	1.6	1.6	1.6	2.4	2.6	0.2
Surgery	3.3	2.4	1.8	1.4	1.8	3.1	2.7	3.4	2.6	-0.8
DTS	0.4	0.8	1.1	1.0	0.7	0.4	0.4	0.4	0.5	0.1
ICI	0.4	0.3	0.1	0.5	0.8	0.4	0.5	0.5	0.5	0.0
International	0.2	1.5	0.8	1.0	0.9	1.8	0.9	1.0	1.8	0.8
Medicine	0.3	0.8	0.4	0.2	0.1	0.1	0.4	0.4	0.3	-0.2
Neurosciences	0.9	0.6	0.7	0.4	0.5	0.7	0.5	0.3	0.8	0.5
Haringey	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
North Mid.	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
Operations & Facilities	3.6	4.0	4.3	4.3	4.9	3.1	2.8	3.8	4.2	0.4
Corporate Affairs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates	2.0	1.2	1.4	2.0	2.0	1.0	1.6	1.4	2.3	0.9
Finance & ICT	3.1	1.2	1.7	0.9	1.5	0.5	0.8	0.6	1.2	0.5
Human Resources	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Medical Director	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Nursing And Workforce Development	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.2	0.2
Research And Innovation	0.1	0.3	0.6	0.0	0.0	0.4	0.2	0.4	0.1	-0.3
Redevelopment Revenue Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	20.6	15.7	13.8	13.9	15.0	13.1	12.3	14.7	17.0	2.3

Agency/Locum/Bank

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	10/11 Period 12	M8 variance to M12 10/11
Cardiac	34	29	36	40	36	48	31	41	41	0
Surgery	56	62	63	66	63	76	83	80	67	-13
DTS	9	10	18	17	14	15	17	17	13	-3
ICI	40	34	37	44	46	37	43	34	49	16
International	41	44	37	37	36	43	33	29	31	2
Medicine	27	22	21	23	15	23	24	22	28	5
Neurosciences	25	18	21	23	17	26	21	18	31	13
Haringey	4	5	0	0	0	0	0	0	0	0
North Mid.	0	0	0	0	0	0	0	0	0	0
Children's Population Health	2	0	0	0	0	0	0	0	0	0
Operations & Facilities	9	18	16	14	17	28	24	12	27	14
Corporate Affairs	0	1	0	0	2	1	0	0	0	0
Estates	5	15	7	15	4	12	41	8	7	-1
Finance & ICT	15	11	14	12	17	15	19	24	14	-10
Human Resources	4	0	4	5	2	4	2	2	9	7
Medical Director	2	2	1	2	1	2	0	0	2	2
Nursing And Workforce Development	3	2	3	3	1	4	1	1	3	3
Research And Innovation	1	2	3	1	1	2	2	2	4	1
Redevelopment Revenue Costs	0	0	3	0	3	1	1	2	6	4
TOTAL	277	273	284	304	276	338	342	291	332	41

TOTAL STAFFING (Excluding Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	10/11 Period 12	M8 variance to M12 10/11
Cardiac	390	385	386	401	392	413	406	423	385	-37
Surgery	709	709	704	716	717	726	755	759	716	-43
DTS	364	366	373	369	370	361	371	379	363	-15
ICI	519	515	510	527	532	525	544	554	510	-44
International	154	162	155	156	154	158	153	157	148	-9
Medicine	308	306	296	298	295	305	296	299	310	11
Neurosciences	287	283	276	282	275	300	300	297	286	-11
Haringey	187	180	0	1	0	0	0	0	0	0
North Mid.	2	2	2	2	2	0	0	0	0	0
Children's Population Health	9	8	8	9	7	7	8	7	7	0
Operations & Facilities	214	225	228	226	229	223	231	222	239	17
Corporate Affairs	15	14	12	14	13	11	14	10	13	3
Estates	53	61	54	62	50	56	87	54	57	3
Finance & ICT	155	150	155	148	157	151	147	145	149	5
Human Resources	62	55	57	62	60	64	59	61	66	5
Medical Director	17	16	14	16	15	16	8	8	17	9
Nursing And Workforce Development	83	80	77	80	77	79	81	78	84	6
Research And Innovation	58	65	69	76	72	81	82	80	81	1
Redevelopment Revenue Costs	7	7	11	8	10	9	7	7	13	5
TOTAL	3,594	3,588	3,388	3,451	3,428	3,483	3,548	3,539	3,444	-95

Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting
21 December 2011

Foundation Trust application update **Submitted on behalf of:** Sven Bunn	**Paper No: Attachment T**

Aims / summary

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

Monitor have restarted the assessment process, and have a timetable of meetings in December and January. A board to board meeting with Monitor has been scheduled for 8 February 2012. This stage of the assessment will focus on:

- Financial viability:
  - Demonstration of efficiency in the base case.
  - Application of Monitor economic assumptions from 2012/13 onwards.
  - Review of scope and deliverability of downside mitigations.
- Management of performance information. The trust wide KPI report has been updated to ensure that performance against Trust objectives, CRES delivery, trend analysis and highlighted key issues are presented more clearly. Arrangements for performance management at clinical unit level are also being updated.
- Governance arrangements. The main issues relate to board reporting (noted above), reporting of CRES scheme safety risks, and management of data quality. Deloitte have been commissioned to review the basis and assurance for the board statement on quality governance.

Key actions for the next two months:

- Complete additional work required on the three issues identified by Monitor.
- Complete the Monitor assessment process.

Action required from the meeting

To note the current position for the foundation trust application.

Contribution to the delivery of NHS / Trust strategies and plans

Achievement of Trust objective to secure Foundation Trust status

Financial implications: None

Legal issues: None

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? Not required

Who needs to be told about any decision Not required

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

Sven Bunn, FT Programme Manager

Who is accountable for the implementation of the proposal / project

Jane Collins, Chief Executive

Author and date

Sven Bunn
12 December 2011

Attachment T

Foundation Trust application – December 2011 position

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

1. Legally constituted and representative		**Green**
The trust's proposed NHS foundation trust application is compliant with current legislation	• Draft constitution completed and approved by Trust Board (July 2010). Confirmation of compliance with NHS Act 2006 received from Capsticks (Jan 2011). • Monitor have reviewed the constitution and have confirmed that it is satisfactory (Oct 2011).	Green
The trust has carried out due consultation process	• Consultation commenced on 9 Feb 10 and was completed on 18 June 2010. • Consultation feedback was provided on 13 August 2010.	Green
Membership is representative and sufficient to enable credible governor elections	• Currently ~8,200 members. • **Two recruitment mailings per year, plus face to face recruitment in out-patients to maintain membership levels.**	Green
2. Good business strategy		**Green**
Strategic fit with SHA direction of travel	• Participation in London specialised children's services review. Support development of specialist paediatric networks. • Paediatric cardiac review • Paediatric neurosurgery review	Green
Commissioner support to strategy	• Meetings held with NCG, NHS London and local commissioners supported principles of growth • Reconfirmation of support received in April 2011 from NHS North Central London, London SCG, East of England SCG and National Commissioning Group (84% of NHS contract income). • Commissioners re-confirmed support in meetings with Monitor	Green
Takes account of local/national issues	• Thorough and detailed market assessment completed • Involved in national service reviews • Anticipate tougher economic conditions from 11/12 onwards.	Green
Good market, PEST and SWOT analyses	• Specialty based market assessments which encompass portfolio, strategic and competitor analysis. • SWOT and PEST analyses updated as part of IBP development. • External assurance of market assessment completed.	Green
3. Financially viable		**Green**
FRR of at least 3 under a downside scenario	• Currently 3 in all years • Monitor assessor case has more stringent assumptions, which lead to FRR of 2 in 14/15 (downside FRR 1) • Risks from CRES delivery	Amber
Surplus by year three under a downside scenario and reasonable level of cash	• As above.	Green
Above underpinned by a set of reasonable assumptions	• Assumptions generated and downside modelling completed. • External assurance completed.	Green
Commissioner support for activity and service development assumptions	• Support letters received from NHS North Central London, London SCG, East of England SCG and National Commissioning Group (84% of NHS contract income)	Green

4. Well governed		**Amber**
Evidence of meeting statutory targets	• Current CQC assessment: Meeting all core standards (July 2011) • **HAI Performance (c. diff – 7 cases; MRSA – 3 cases).** • 95th centile of admitted pathway waiting time achieved since Feb 11.	Amber
Declaring full compliance or robust action plans in place	• Achieved full CQC registration. • Robust action plan has been developed as a result of boiler failure. HSE improvement notice now lifted.	Green
Comprehensive and effective performance management systems in place	• Well developed corporate and clinical unit level performance management and risk management systems. • Monitor concerns about: - Monitoring of CRES schemes for impact on safety - Board KPI report and range of KPI indicators at unit and specialty level. - Management of data quality	Amber
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. • External support for board development has been provided.	Green
Evidence of independent analysis of board capability/capacity	• Board effectiveness assessment completed. • External assurance programme completed. • On-going board development programme.	Green
Evidence of learning appetite via NHS foundation trust processes	• Board development programme. • External board assessment	Green
Evidence of effective, evidence based decision making processes	• Governance structure • Existing TB and MB minutes	Green
6. Good service performance		**Green**
Evidence of meeting all statutory and national/local targets	• Good performance management system • **HAI Performance (c. diff – 7 cases; MRSA – 3 cases)**	Amber
Evidence of no issues, concerns, or reports from third parties, e.g. HCC and in future CQC	• HSE improvement notice relating to boiler incident has been lifted (July 2010). • Awaiting final HSE report.	Green
Evidence that delivery is meeting or exceeding plans	• Good performance management system	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
12 December 2011

Great Ormond Street Hospital for Children NHS Trust

Trust Board 21st December 2011	
Patient and Public Involvement and Patient Experience (PPIE) update report **Submitted on behalf of** Mrs Liz Morgan Chief Nurse and Director of Education	**Paper No: Attachment U**
Aims / summary The purpose of the report is to update the committee on Patient and Public Involvement and Experience in the Trust.	
Action required from the meeting Acknowledgement of receipt of the information	
Contribution to the delivery of NHS / Trust strategies and plans Achievement of the Trusts business plan objective relating to improving patient experience and delivering the patient experience CQUIN.	
Financial implications Nil	
Legal issues Nil.	
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? NA	
Who needs to be told about any decision NA	
Who is responsible for implementing the proposals / project and anticipated timescales NA	
Who is accountable for the implementation of the proposal / project NA	
Author and date Caroline Joyce Assistant Chief Nurse Quality, Safety and Patient Experience 6.12.2011.	

Attachment U

Great Ormond Street Hospital for Children NHS Trust

Trust Board

Patient and Public Involvement and Experience (PPIE) Update Report

This is a summary report to update Trust board on current PPIE initiatives and work that have been taking place in the Trust.

1. Development of new PPIE strategy from 2012 – 2015.

The Head of PPI and Pals has been leading work on the development of a new 3 year strategy for PPIE which sets out our plans for further embedding the PPI and Patient experience work of the Trust. Key priorities will include improving member involvement and support, obtaining feedback from hard to reach groups, obtaining and collating more real time experience information, acting on the themes from patient experience feedback and developing systems to enable this information to be easily accessible and presented to a wide audience, including staff, managers and executive staff.

The strategy has been consulted on widely including member representatives and will now be going through the Trust committee's approval processes with the aim of it being approved by Management Board in January 2012. The strategy will also be reviewed in the light of the new Operating and Outcomes frameworks for 2012-13 released in the last week by Health Secretary Andrew Lansley.

2. PPI and Patient Experience Liaison Officer

In September a new position of PPI and Patient Experience Liaison Officer commenced and we are pleased to welcome Rehana Ahmed who will be our dedicated resource for supporting and developing our active members and for the support and development of patient experience initiatives.

Key priorities for Rehana in the first 6 months include:-

- Review of members involvement
- Piloting a real time patient experience system
- Facilitating 2 focus groups – one related to disability the other related to those speaking a different language or from a different spiritual background.
- Organising the annual listening event

3. Members Involvement

We continue to have active members involved in a wide range of committee's and improvement work across the Trust including the Transformation Board, redevelopment, PPIEC and PPIEG, transplant committee and surgery unit board,

Following concerns raised about the lack of consistency in recruitment practices and support for active members involved in the Trusts improvement and committee work, Rehana is undertaking a review of existing member's experiences and developing an

action plan to identify how their needs can best be met in line with the requirements for volunteers.

Rehana will work closely with the Trusts FT membership team in the charity to ensure effective communication with members about opportunities for involvement as well as promoting the benefits of involving parents and young members to managers in the Trust.

4. Patient Stories

The PPIE team were pleased to have the opportunity to bring a patient story to the Trust board in November 2011 and intend to enable this to happen on a quarterly basis initially. Working with Debbie to bring Aidan's story to the board was a privilege but identified a number of practical issues that may often occur that will need to be considered each time a story is brought to the board. Rehana is currently developing guidelines for staff on how to collect and use patient stories thoughtfully and safely. Others ways of incorporating patient stories or feedback from families are also being explored with the development of the new quality strategy and plans for developing the zero harm reports into a more holistic quality report. This will enable better triangulation of information related to quality, safety and patient experience.

5. Real time patient experience survey
The Trust has established a project to pilot a locally developed real time patient experience survey developed with the data analysts in the transformation team. The survey will be facilitated via Ipads and administered by volunteers. The first day of the trial was completed on the 30th November with further days planned for December the team will then evaluate the results obtained, the experience of using Ipads and volunteers in administering the survey.

6. Improving Patient Experience
All units are required to have a business plan objective related to the improvement of patient experience and are responsible for their local initiatives. Many unit improvement plans involve initiatives to improve patient experience e.g. improving access, booking procedures for admission and theatre time which are not always seen as being under the PPIE umbrella but ultimately improve patient and families experience.

In addition there are a number of corporate projects which include:-

- The improvement of patients knowing how to feedback and complain through the development of podcast from Pals on the new internet site and a triangular table top menu device identifying how patients can feedback, find Pals or make a complaint.
- Improving the quality and variety of food through the nutrition project where work has included more detailed surveying of patients and families, a focus group and a pilot of mealtime feedback cards. A ward food project group has been established which is looking at improving access to menu's, housekeeper training, reviewing meal trolley delivery times to the ward, protecting patients meal times, and the quality of food served.
- Transport project – following a number of concerns raised to Pals about transport issues on the dialysis unit Rehana has been working with the

Accommodation and transport manager and the families to look at how the service can be improved, this work has included patients and families keeping diaries of their experiences of the transport issues they have faced to enable staff to better understand the impact these experiences have on their lives to aid improvement.

- Rehana and the facilities team are also working on improving the hospital reception service in relation to customer care with bespoke training being provided to relevant staff.

Work is currently underway to map themes from the annual surveys, local surveys, Pals and complaints to better understand areas for improvement. These will then be mapped against existing work streams so that any gaps can be identified and consideration given to how these can be addressed.

7. Key milestones by April 2012

- Approval of the new PPIE strategy and year 1 action plan, to be presented to Trust Board and the Members Council.
- To have completed and evaluated pilot of real time survey and determined the way forward.
- To have undertaken 2 focus groups related to special needs and a diversity need.
- To have undertaken the annual listening event
- Completion of the 2011/12 Ipsos Mori inpatient survey.

Great Ormond Street Hospital for Children NHS Trust

Trust Board
21st December 2011

GOSH Child Protection Update Report December 2011 **Submitted on behalf of:** Liz Morgan, Chief Nurse and Director of Education	**Paper No: Attachment V**

Aims / summary
This is a summary report to update Trust Board on current Safeguarding/Child Protection initiatives identified as part of the Trust objectives for Child Protection. The GOSH Child Protection Action Plan 2011-2012 has consolidated the work for the year and this report summarises progress on those identified objectives since the last report to Trust Board on 28th September 2011.

Action required from the meeting
To note the evidence of continued implementation of the Trust strategy to protect children.

Contribution to the delivery of NHS / Trust strategies and plans
Keeping children safe is a primary objective of the Trust.

Financial implications
All initiatives currently funded.

Legal issues
N/A

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

Who needs to be told about any decision
Chief Nurse/Director of Education, Child Protection Co-Ordinating Manager, Named Professionals

Who is responsible for implementing the proposals / project and anticipated timescales
Child Protection Co-Ordinating Manager and named professionals.

Who is accountable for the implementation of the proposal / project
Chief Nurse/Director of Education

Author and date
Sonia Jenkins, December 2011

Great Ormond Street Hospital for Children NHS Trust

Trust Board – 21st December 2011

Child Protection Update Report

This is a summary report to update Trust Board on current Safeguarding/Child Protection initiatives identified as part of the Trust objectives for Child Protection as well as any additional learning from local and national guidance. The GOSH Child Protection Action Plan[1] 2011-2012 has consolidated the work for the year and this report summarises progress on those identified objectives since the last report to Trust Board on 28th September 2011.

Key

Achieved target

Meeting and/or on track to achieve by end of year

Not on track to achieve target

1. Child Protection Supervision - Developing and embedding targeted child protection supervision (See item 1 on CP Action Plan)

The Named Nurse and Named Doctor have continued to lead on the second phase of implementation of targeted child protection supervision. This has been supported by the GOSH social work managers and the Trust now have a systematic way of identifying staff eligible for supervision based on child protection referrals as well as now offering supervision to identified groups such as CSP's, CATS, CNS's and AHP's. The strategy has had marked impact on the increase in child protection supervision from 20% in 2010 to currently 48.1% (QT2 figures).

2. Case Conference compliance (See item 5 on CP Action Plan)

The Trust implemented a pathway for managing case conference attendance in 2009. Due to the tertiary nature of referrals to our hospital it was a particular challenge to ensure that we collated all invitations to attend and or send a report to Local Authorities. We worked with Camden LSCB to incorporate a standard template which has been used by Trust staff. A comprehensive policy has recently been agreed by Child Protection Management Group which will now encompass the pathway as well as Trust reporting responsibilities and staff support. Case conference attendance is also one of the Safeguarding indicators on our GOSH Safeguarding scorecard.

[1] The action plan has been adapted for clarity as a result of feedback from the last update to Trust Board.

3. Implement the audit calendar for child protection

We continue to work closely with the audit team along with our social work colleagues to ensure that relevant audits are planned and that annual audits are undertaken in respect of record keeping. In the recent Link audit which measures the level of knowledge of staff regarding basic child protection practices a marked improvement has been reported. Since the last audit in 2010 e.g. 82% of staff knew how to check CP concerns have been raised for a child (compared to 75% in 2010); 93% of staff knew what to do when they had concerns (compared to 85% in 2010); 93% of staff knew where to access the CP policy (2% improvement on 2010).

4. Update the SCR systems and processes in relation to the Munro recommendations 2011 (See item 6 on CP Action Plan)

GOSH currently have a pathway for managing invitations to SCRs and this is contained within the GOSH Child Protection Policy and Procedures. However, following the Munro Review of Child Protection it was recommended that the methodology used in Serious Case Reviews be changed. The Government have accepted the recommendation but have asked for further pilot studies. Chapter 8 of Working Together to Safeguard Children 2010 (Serious Case Reviews) will be amended in the new year and the new model will be phased in.

5. Implement the new GOSH child protection structure (following handover of Haringey Community Services to Whittington Health)

The Child Protection Management Structure at GOSH has now been revised to reflect current Child Protection management roles as well as support professionals. The structure now includes Heads of Nursing, General Paediatricians and Unit Chairs, General Mangers (Unit CPMG) and Link support Professionals.

6. Complete the review of the roles, responsibilities and competencies of CP Link Group members (See item 8 on CP Action Plan)

The review of the child protection link professionals is underway following the recommendations from NHS London Safeguarding Improvement Team (SIT) earlier this year. The groups have been split into clinical and allied health professionals to ensure that the needs of both groups are met. The Named Nurse will continue to lead on the clinical group and the Child Protection Co-ordinating Manager will now lead on the AHP group. A paper has been drafted by the Named Nurse regarding the competencies, roles and responsibilities of the Link professionals. This has been circulated to the Heads of Nursing and will also be circulated to Senior Allied Health Professionals for comment before the final document is agreed by the Child Protection Management Group.

7. Devise action plan to address required safeguarding information from referrers

Both GOSH social work and the Named Doctor for child protection attended the referrers day where safeguarding information was raised and this will be repeated in the next referrers day in the spring of next year.

In addition there are a number of corporate safeguarding projects which include:-

- **E safety** (See item 11 on action plan)
  The Child Protection office has worked with the IT department to pull all relevant internet related policies under an umbrella policy. Staff safeguarding and child protection responsibilities are now clearer throughout the policy and it will be linked to the Child Protection Policy and Procedures. The policy also encompasses a section for children and young people. It highlights staff responsibilities to them if safeguarding concerns arise during usage. The final version of this policy will be ratified by Camden E-Safety sub group once it has been ratified by Management Board next year.

- **NAI Network**
  The CP office is currently co-ordinating a pilot scheme which is proposing the establishment of a London wide national network of paediatric Radiologists to peer review all cases where Non-Accidental Injury (NAI) is suspected or a concern.

- **Improvement of written referrals to social work /introducing E social work referrals** (See item 3 under completed tasks on CP action plan)
  Following a decline in written referrals to GOSH social work service to raise Child Protection concerns, the Safeguarding team and Social Work colleagues have developed an electronic referral system in addition to the existing paper referral system to improve adherence with the Trust requirement that telephone/verbal referrals are followed up in writing. This has been disseminated to all wards and departments.

- **Child Maltreatment audit** (See item 10 on CP action plan)
  GOSH is currently taking part in a child maltreatment audit in association with Ruth Gilbert (ICH). The aim of the audit is to discuss how GOSH could improve data capture on safeguarding concerns or suspected maltreatment as well as referrals to children social care. The first analysis of findings will take place in spring 2012.

8. Key milestones by April 2012

- Continue to effectively manage Child Protection Service Level Agreement with North Middlesex University Hospital NHS.

- Expand level 3 training towards compliance with national guidelines and achieve CQUIN 2011/2012.

GOSH Child Protection Work Plan / Action Plan April 2011 – April 2012
Update for Trust Board

This live document:-

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

The plan will be:

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

= Completed task

Achieved target

Meeting and/or on track to achieve by end of year

Not on track to achieve target

Please see progress box for actions being undertaken to achieve the task

Task	Source	Lead	Plan Current update in bold	Timeframe	Progress Current update in bold	Rating
1. CP supervision	**JAR AP** **IMR**	Jan Baker	CP Supervision for identified groups also: - *Named Nurse / Doctor* Paediatricians Doctors involved in CP case (on request and when required because involved in a case). All GOSH nursing staff (on request). Target: one supervision session per quarter per identified group <u>Q2</u> • JB, NL & SJ targeting referrals to social work to ensure focussed supervision. • Agreement with GOSH social work re access to notification of social work referrals. **<u>Q3 Midway</u>** **CP Supervision now implemented across agreed groups and individuals now targeted from CP referrals to social work.**	April 2011 – April 2012	The following groups of staff have been identified for group supervision sessions with Named Nurse: CSP's (Clinical Site Practitioners), CNS's (Clinical Nurse Specialists), CATs team (Children's Acute Transport Service), AHPs (Allied Health Professionals), Band 6's. Audit will take place in Quarter 3 GOSH is currently compliant with CP supervision for named professionals. Other staff groups have a minimum of one supervision session per quarter which have all been achieved 80% except for CNS's to begin in Q2. JB expanding this and to review how it is done. Will be made wider so not just focussing on named groups. To get more flyers on wards advertising the supervision drop in clinics. CP admin distributing laminated copies of flyers to CP links on 25/08/11 for advertising in their wards/areas. Flyers also disseminated at UCPMG and CP Link Meetings. **Q2 supervision needs further clarification and programme of CP supervision from CP referrals implemented.**	

Task	Source	Lead	Plan Current update in bold	Timeframe	Progress Current update in bold	Rating
2.1 Representative from General Paediatrics team to sit on Unit CPMG	**CPMG**	Nick Lessof	NL to share with General Paediatricians and agree allocation of Units. **<u>Q2</u>** • **NL to raise at next GP team meeting and feedback to next CPMG.**	January 2012	NL to speak to General Paediatricians to agree allocation to clinical units and role in Unit CPMG's. SJ has agreed to attend with NL. Jane Valente (JV) to discuss further with GP team at their September team meeting. **NL trying to attend all UCPMG meetings but with member of GP team attending if he is not available. To revisit with GP team.** **SJ/JB/NL/MC to also meet to agree some alternatives as to how UCPMG meetings should be run and what is manageable regarding attendance.**	

Task	Source	Lead	Plan Current update in bold	Timeframe	Progress Current update in bold	Rating
3. CP webpage to be set up on GOSH internet to replace pre-existing page. To also consider an internal CP webpage on the GOSH intranet.	**CPMG**	Sonia Jenkins	To set up a webpage so staff can access information around CP. Dependent on CP Admin resource/priority. <u>Q2</u> • Lack of capacity in CP Admin to progress at present. **<u>Q3 Midway</u>** **What should go on external webpage?**	February 2012	Trust is changing software for web development of intranet and will make new development tool available in July 2011 for launch in September 2011. **<u>Internal webpage.</u>** Meeting to be arranged to discuss content of page once new development tool available and pending availability of CP admin to work on webpage creation. **JB met with CO (Education and Training) re CP info to go on GOLD site.** **SJ to organise small working group to review and progress what needed on internal site.** **<u>External webpage</u>** **Current information to be sent out to CPMG members to review content and update accordingly.**	

Task	Source	Lead	Plan Current update in bold	Timeframe	Progress Current update in bold	Rating
4. Domestic Violence Awareness	**CPMG**	Jan Baker	To plan a week of activities including an information stand, awareness training etc. <u>Q2</u> DV Policy • Feedback received from HR to be incorporated by JB • To come back to CPMG for sign off then ratification by Quality & Safety and Management Board. DV Training • DV level 3 training progressing well. **<u>Q3 Midway</u>** **JB attended DV conference in Camden in November. JB working with E&T to plan DV conference in 2012.**	March 2012	DV module completed for Level 3 training. Policy for staff experiencing DV drafted and discussed at February CPMG. Amended policy to be circulated. Aim is to launch the policy around the DV week in November in conjunction with the study day. Study day cancelled due to delay in marketing of event. JB to add in comments received from HR/Occ health to draft policy for it to be reviewed and ratified.	
5. Due to Trust requirement around case conference attendance, policy to be drafted.	**CPMG**	Jan Baker	Draft policy following current agreed flowchart. <u>Q2</u> • Policy delayed 'unborn' babies to be incorporated into policy following GOSH involvement in pre-birth case. **<u>Q3 Midway</u>** **Policy 'signed off' at November CPMG meeting. Minor amendments needed and can then go to Q&S.**	January 2012	JB circulated amended draft at July CPMG which was agreed by group. Will now need to go to Quality and Safety for approval and Management Board for ratification. There are some issues re 'unborns' and if they are covered in the policy. JB to discuss further at October CPMG due to absence at September meeting. **To be tabled at Q&S committee in January.**	

Task	Source	Lead	Plan Current update in bold	Timeframe	Progress Current update in bold	Rating
6. SCR Policy to be drafted	**CPMG**	Sonia Jenkins	Due to the complexity of the SCR pathway, an SCR policy now needs to be drafted. Awaiting further direction – expected end of 2011. <u>Q2</u> • On hold awaiting further government guidance. **<u>Q3 Midway</u>** **On hold awaiting outcome of further pilot schemes and government transition agreed to start July 2012.**	March 2012	Draft to CPMG October 2010. Following government response to Munro Review SCR position needs clarity before proceeding. The Government agrees that systems review methodology should be used by LSCBs when SCRs are undertaken and that there should be a group of accredited reviewers to support the local application of this methodology. The Government will give further consideration to this recommendation including: • which organisation (s) would be able to take responsibility for recruiting the reviewers, accrediting their practice and deploying them to local areas; • to whom the reviewers would be accountable; and • the resourcing requirements. During the second half of 2011 the Government will, working with the sector, consider the evidence and opportunities for using systems review methodologies for Serious Case Reviews and the options for developing the national resources Prof Munro recommends. Further consideration will be given over the summer to ending the evaluation of SCRs in their current format. **Pilot still being tested in London Boroughs. Outcome report of pilot due in new year.**	

Task	Source	Lead	Plan **Current update in bold**	Timeframe	Progress **Current update in bold**	Rating
7. Produce criteria for the lead doctor role in safeguarding	**SIT Recommendation January 2011**	Nick Lessof	Identify an appropriate medical structure for safeguarding beyond named doctor role. <u>Q2</u> • NL to meet with identified staff members and feedback to December CPMG. **<u>Q3 Midway</u>** **NL and PD meeting AG from cardiac unit.**	31 December 2011	NL to meet with staff currently in 'CP lead consultant' roles + relevant unit general manager. Support and supervision for these consultants by named doctor considered and plan to absorb into CP Link group and also provide social work managerial support for these four members of staff who have taken up roles within specific areas.	

Task	Source	Lead	Plan Current update in bold	Timeframe	Progress Current update in bold	Rating
8. Allied Health Professionals – SIT found a sense of them not feeling as well integrated across trust with safeguarding as might be expected	**SIT Recommendation January 2011**	Madeline Ismach Sonia Jenkins Jan Baker	a) MI to meet with Head of Physiotherapy to discuss further. b) To look at possibility of having a separate link group meeting for AHPs. c) JB to look at the programme of CP link meetings to see whether there are any that would be suitable for AHPs to join. An assessment of what their needs are will need to be done. <u>Q2</u> • Clinical review in draft awaiting feedback. • If no feedback by end of November, policy to come to CPMG for circulation. • AHP policy to be drafted by SJ. • Circulation of AHP draft by SJ January 2012. • Both signed off by CPMG February 2012. **<u>Q3 Midway</u>** **d) SJ to adapt final plan for AHPs so they can be launched together.**	31 August 2011 October 2011 February 2012	MI met with Head of Physiotherapy. Letter sent to CP Links about splitting links into two groups – nursing and clinical support professionals. New structure in place for CP links meeting held on 19 July 2011. Appropriate support for nursing/AHP staff needs to be agreed as well as understanding professional responsibilities and threshold. SJ/JB to go through programme of CP link meetings. JB doing a review of CP links. To meet with Andrew Pearson regarding doing a survey of nursing and AHPs. **J**B took a proposal to Heads of Nursing meeting in August re role of CP links. Awaiting comments back from them. Feedback received from one Head of Nursing and SJ. Reminder sent to Heads of Nursing /Leads for comments. **October CPMG agreed report should be circulated to CPMG for comments. Further two weeks given to Heads of Nursing to comment.**	 

Task	Source	Lead	Plan Current update in bold	Timeframe	Progress Current update in bold	Rating
9. CP Policy and Procedures – on Parrot ward there was an out of date folder of CP material	**SIT Recommendation January 2011**	Jan Baker	a) Email to be sent to CP Links and ward sisters asking them to check that any copies of the policy held on their wards/units is the current version as per the document library. b) CP Links to undertake a regular spot-check within their wards/units. <u>Q2</u> • Ensure compliance from feedback of CP link audit. • Feedback to CPMG November 2011. **<u>Q3 Midway</u>** **JB presented draft report to CPMG.**	30 September 2011 31 December 2012	Following Neuro CPMG meeting on 1 March 2011, Patrick Dodds removed out of date folder from Parrot Ward. a) The issue was discussed within the wider feedback on SIT report to the CP Links. b) The checks are to be completed at the time of the CP Link Audit. Audit now in progress – deadline for completion extended to 12 October. A review of CP link competencies taken to Heads of Nursing meeting in August. Feedback received from one Head of Nursing and SJ. Reminder sent to Heads of Nursing /Leads for comments. **Audit report shared. Marked improvement on last audit in 2010 e.g. 82% of staff knew how to check CP concerns have been raised for a child (compared to 75% in 2010); 93% of staff knew what to do when they had concerns (compared to 85% in 2010); 93% of staff knew where to access the CP policy (2% improvement on 2010).**	 

Task	Source	Lead	Plan Current update in bold	Timeframe	Progress Current update in bold	Rating
10. Audit coding of child maltreatment associated admissions.	**CPMG**	Nick Lessof	To agree outcomes and who should be involved. To meet with Ruth Gilbert and Clinical Coding manager to discuss further. **<u>Q2 Plan</u>** • **Second meeting planned for March/April 2012.**	September 2012	Meeting held on 5 July. **Audit launched 11/09/11. First analysis Spring 2012.**	
11. IT issues	**CPMG**	SJ	Webcams Policy / E-Safety **<u>Q2 Plan</u>** • **Safeguarding component** • **Complete policy to come back to CPMG for sign off** • **Policy to Camden E-Safety sub group** • **Quality & Safety for ratification** • **To GOSH Management Board.**	January 2012	**SJ has amended policy to reflect link to CP procedures. To be linked in with CP Policy. Working group if now decided to devise overarching policy for children and staff. All IT/E type policies now contained in one E-Safety Policy for staff and patients (in two parts). All leads amending sections and final drafts to come to CPMG for 'sign off' of safeguarding aspects as soon as completed.**	

Task	Source	Lead	Plan Current update in bold	Timeframe	Progress Current update in bold	Rating

Completed tasks

2. Implement the new Child Protection Structure	**CPMG**	Madeline Ismach Sonia Jenkins	Local accountability and expectations of Unit CPMG's to be devised and circulated to each Unit lead. **Q2** • **ToRs signed off at Strategic CPMG meeting.** • **Issue re capacity of Named Nurse/Named Doctor and social work** • **Meeting to be held (Named Staff and social work) to clarify before new ToRs sent to Unit Leads/ GMs.**	November 2011	MI to rework/update accountability and expectations of clinical chairs/general managers by updating ToRs for Unit CPMG. **SJ revised ToRs and roles / responsibilities and circulated to CPMG for comment.**	
3. Devise plan to improve written referrals to Social Work	**CPMG**	Sonia Jenkins Marion Cullen	To consider implementation of electronic referral system. Q2 • Initial pilot difficult due to IT problems/ access/migration • Electronic referrals 'opened out' Trust wide • Advise all staff via Unit CPMG, training and circular from Chief Nurse • Will use both written and electronic referral system. **Q3 Midway** **Circular sent to all staff from Liz Morgan via GOSH Newsletter on 2nd December regarding electronic / paper referrals and compliance.**	November 2011	Three month pilot of the electronic referral system commenced in June on PICU, NICU, Tiger and IPP wards. It was reported that no forms have been received electronically yet. Some staff have been printing off the forms, filling in by hand and then taking to social work! Only one referral received so far. IPP are not completing or making any referrals. JV attending a meeting in IPP so agreed to discuss further with them then. SJ to ask LM to send out email circular to unit leads of pilot areas to say that they need to be using electronic referral system. If paper referral made it needs to be followed up with an electronic referral. Discussed at Surgery	

Task	Source	Lead	Plan Current update in bold	Timeframe	Progress Current update in bold	Rating
					and Neuro UCPMG. Pilot has been extended for another month due to delay with start date. Feedback on pilot to be given at October CPMG.	
4. Devise action plan to address inclusion of referrer information needed regarding Local Authority involvement and CP status of children to better address risk to inpatient/outpatient referrals.	**Post IMR training with outpatients units**	Sonia Jenkins	SJ to discuss with LM and MI Q2 Plan • Achieved – no further work to be done.	December 2011	SJ met with RB 14 June 2011 Clear plan to include in new referral packs to be launched end of September 2011. SJ and JR working on wording JV said there is a 'Referrers day' to be held soon for all referrers to GOSH. GP team have a slot at the day and JV said MI is attending as well. SJ to talk to MI to ask if she bring this up then. Covered by GP team at Referrers Day. Another day is planned in the Spring when Social Work will attend and cover CP.	

Trust Board 21st December 2011	
Management Board Minutes **Submitted on behalf of** Chief Executive	**Paper No: ATTACHMENT W**
Aims / summary Management Board meets once a month and comprises representatives from all operational areas of the hospital. The minutes from the November 2011 meetings are attached.	
Action required from the meeting To review and note those matters considered by Management Board in November 2011.	
Contribution to the delivery of NHS / Trust strategies and plans Covers all Trust objectives	
Financial implications None	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision N/A	
Who is responsible for implementing the proposals / project and anticipated timescales	
Who is accountable for the implementation of the proposal / project	
Author and date Anna Ferrant, Company Secretary 13th December 2011	

MANAGEMENT 17th November 2011

FINAL MINUTES

Present:

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

In Attendance

Mehul Dattani (MD)	Consultant, Endocrinology
Anna Ferrant (AF)	Company Secretary
Peter Lachman (PL)	Associate Medical Director for Patient Safety, Consultant for Service Redesign and Transformation and Consultant Paediatrician
Catherine Lawlor (CL)	PA to Chair & Chief Executive (minutes)

**Denotes meeting part attended*

263	**Apologies**	
263.1	Apologies were received from Fiona Dalton, Chief Operating Officer and Melanie Hiorns, CU Chair MDTS (represented by Mehul Dattani).	
264	**Minutes of Management Board meeting held on 15th September 2011**	
264.1	The minutes were approved as an accurate record with the following amendments: Catherine Cale was not present at the meeting and item 251 should have read AN had spoken to the paper rather than RB.	
265	**Action Log and other matters arising**	
265.1	The following updates were received on the documented actions:	
265.2	891.4 – Family viewing in the mortuary – AL reported that progress was slower than initially anticipated; the recruitment process was currently underway. JC asked how this new service would be communicated to the Units. AL reported plans were in place to communicate to relevant staff through the bereavement service and in the Trust's relevant policy.	
265.3	218.3 – Salary Overpayments options – CN reported work was underway.	
265.4	160.4 – Updates on Missing records and splitting of notes policy – it was reported that this would come back in December.	
265.5	**Action**: Missing records and splitting of notes policy to come back to December meeting	**PL**
265.6	183.8 – IV Access Action Plans – LM reported that the meeting with Intensive Care Unit Leads has unfortunately not taken place but was scheduled to take place post the Board so therefore would come back to the December Board.	
265.7	186.3 – Asset Tracking of Equipment – JC asked PW to forward the timetable for staff access to tracking equipment to CL so that it could be circulated to the Board.	
265.8	**Action:** PW to forward timetable for tracking equipment to CL so that it may be circulated to the Board.	**PW**
265.9	221.3 – Omni 10 – ML gave an update regarding the issues surrounding Omni 10. A further update would be provided at the December Board.	
265.10	**Action**: Further update on Omni 10 to be provided at the December Board.	**ML**
265.11	227.4 – Quality and Safety Strategy – SB reported that ME would review the whole plan and present it at the December Management Board.	
265.12	**Action:** ME to review the Quality and Safety Strategy and present at December Management Board.	**ME**
265.13	228.6 - Key Performance Report September 2011 – RB reported that the report had been updated accordingly.	
265.14	**Action**: Action on Formal Disciplinary Policy and Procedure to be brought back to the December Board.	**RB**

265.15	244.4 – Parental Leave Policy – It was decided the Parental Leave Policy would come back to the December Board.	
265.16	**Action**: Parental Leave Policy to be brought back to the December Policy Approval Group	**RC**
265.17	248.3 – Protection of Earnings Policy – RC reported that the Trust was currently in the process of rewriting the pay protection policy and would shortly commence discussions with staff-side regarding the contents. RC asked the Board approve renewal of the currently policy for 6 months while the new policy was being written. The Board **approved** the Protection of Earnings Policy for 6 months with a request to include how the policy relates to dentists and doctors within the over-arching policy.	
265.18	**Action:** RC to come back to the May 2012 Board with a new Protection of Earnings Policy.	**RC**
266	**Other Matters Arising**	
266.1	RC gave the Board an update on the industrial action scheduled to take place on the 30th November and the likely impact this may have on the Trust. RC presented the Trust's contingency plan and actions that should be taken by Managers.	
266.2	JC reminded the Board of the deadlines for the submission of papers. JC stated that the deadlines would be in future strictly adhered to.	
266.3	The Board **noted** the report.	
	Clinical Unit and Zero Harm Reports	
267	JC highlighted that under MRSA / MSSA Infections in the Clinical Unit reports the number of MRSA bacteraemias was listed twice in error. RB agreed to getthe reports amended.	
267.1	**Action:** RB to correct Clinical Unit and Zero Harm Reports to include MSSA infections.	**RB**
267.2	**IPP**	
267.3	JL presented the IPP Zero Harm report. JL reported there had been one delayed admission and one refused patient in the month and it had been 220 days since the last Serious Incident (SI) within IPP. JL reported there had been no complaints.	
267.4	JL reported that the three top risks were Recruitment and Retention, Medication errors and income target exceeding the CAP. JL reported that all risks were being addressed.	
267.5	JL reported in October there was an increase in the number of incidents reported from 34 to 43. This was mainly due to an increase in blood products and infection control incidents and were being investigated.	
267.6	Lastly, JL asked the Board to remind Bed Managers that there were currently two beds available in IPP if needed for NHS patients.	
267.7	Management Board **noted** the content of the report.	
268	**MDTS**	
268.1	JA presented the paper. JA reported there had been 487 days since their last SI. JA reported that there had been 2 complaints, a gastro complaint from commissioner	

	regarding request to provide carers for 2 patients requiring tracheostomy care and a gastro complaint regarding communication of histopathology results and prognosis. JA reported that the top three risks for the Unit remained the same CRES,	
268.2	interventional radiology consultants and lack of diabetes clinical nurse specialist.	
268.3	Management Board **noted** the content of the report.	
269	**Cardio Respiratory**	
269.1	AG presented the Unit's zero harm report. It had been 266 days since their last SI (5 under investigation). The Board agreed that actual SI should be declared and the report should include both SIs (related and non related to RCA).	
269.2	PL suggested that Clinical Units should also present the time since the last SI was declared rather than the time since it was confirmed as truly being an SI after a proper RCA.	
269.3	**Action:** RB to amend Clinical Unit and Zero Harm Reports to include both days since last SI (not related to RCA) with recognition of de-escalation matters and learning from last SI with RCA.	
269.4	AG reported that there had been 2 delays and 2 refusals. AG reported the Unit's top risks were medication errors and the Carevue electronic clinical information charting system.	
269.5	AG reported on Medication Errors and stated that there was an ongoing reinforcement of 'Zero Tolerance' in relation to drug prescribing by improving communication between medical and nursing staff. Drug error analysis had revealed prescriber 'outliers' who have been identified for urgent retraining. An electronic infusion prescriber had been launched but there were currently some technical issues to resolve. A Revised Drug Error Analysis toolkit was awaited from PSST.	
269.6	The CareVue System was no longer supported by the manufacturer but stabilisation had been achieved until replacement.	
269.7	Management Board **noted** the content of the report.	
270	**Infection, Cancer and Immunity**	
270.1	CC presented the report and announced that CH had been appointed to the post of General Manager ICI-LM. JC welcomed CH formally to the Board. CC reported it had been 283 days since their last SI. CC reported no refusal, delays or complaints during the month.	
270.2	CH reported the three main risks for the Unit were access to MRI scans slots, lack of patient beds/cots and Omni 10. There was a Trust wide piece of work being initiated to look at MRI capacity. Whilst equipment issues had been largely addressed there remained issues with there being insufficient physical beds/cots. Omni 10 continued to present operational issues post implementation. New release of new upgrade expected on 15/11/11. ML reported that the team were working hard to resolve the issues surrounding the upgrade of Omni 10. JC stated that the Board would be supportive if additional support would be needed.	
270.3	Management Board **noted** the content of the report.	
271	**Neurosciences**	
271.1	CDS presented the report. CDS reported that it was 93 days since their last SI occurred and the learning from it. CDS reported 4 refusals and 2 complaints. The	

	complaints were behaviour of professionals (Neurodisability / social work) and a patient's reaction to glue used for an EEG. CDS reported on lessons learnt from previous complaints.	
271.2	CDS reported the risks the Unit faced were Medication errors, inadequate IV access and insufficient outpatient space for Ophthalmology and Neurodisability. CDS reported that they were currently being dealt with.	
271.3	SD reported Safe & Sustainable neurosurgery work was ongoing and seemed to be going well.	
271.4	Management Board **noted** the content of the report.	
272	**Surgery and Deep Dive**	
272.1	EJ presented the deep-dive on Surgery's Zero Harm and Infection control. EJ reported on CVL infections and infection control such as hand hygiene, the use of Chloraprep into theatre practice.	
272.2	EJ highlighted that the WHO Safety checklist was better than other trusts. JC asked that thanks be given to Jilly Hale and the team in theatres.	
272.3	EJ reported on the progress made on the pilot for an anaesthetic pre-assessment clinic and the continued work around medicine management. EJ presented further measures such as the introduction of prescribing tests for new clinical staff and infusion calculators.	
272.5	EJ lastly presented ona Rule 43 case which provides coroners with the power to make recommendations to a person or organisation where the coroner believes that action should be taken to prevent future deaths. EJ reported that in June 2011 the Trust was issued with Rule 43 notice following the death of a patient with a renal tract abnormality from a urinary tract infection. She described the steps the Unit took to look at systematic weaknesses. The Unit will ensure correspondence issued to family and GP includes indications for urinary tests to be carried out within the community, ensure printed information sheets on urological conditions are available and distributed to families and develop a card for parents to show GPs which summarises indications for urinary tests. She emphasised there was a need for pan trust learning from this case.	
272.6	Management Board **noted** the content of the Deep Dive.	
272.7	TS reported 17 refusals and 2 complaints relating to accommodation, booking processes and clinical care. TS reported complaints were under review and on the lessons learnt from previous complaints, ensuring documentation regarding clinics was sent out in a timely fashion, perceived attitude and behaviour of staff and how this can affect patient and family experience and ensuring we communicate with families in a clear and consistent way that helps them understand issues and their child's care pathway more easily. TS identified the Unit's top three risks as Medication errors, Recruitment and Agency staffing and medical records. TS reported all risks were under review.	
272.8	Management Board **noted** the content of the report.	
273	**R & I Divisional Report**	
273.1	LG presented the report on R&I current divisional activity which included: • Arrangements for the GOSH/ICH Biomedical Research Centre for 2012 being taken	

	forward. • A road show was being organised by the Division of R&I consisting of 3 sessions when the Joint R&D Office, BRC, CRF, and MRCN teams would be available to outline current arrangements for research, and provide an opportunity for GOSH/ICH colleagues to meet the new team. • Arrangements were also in place for Divisional workshops for GOSH colleagues to take place in January to outline research processes and provide assistance with topics such as applying for research funding, setting up clinical trials, liaising with industry, the research governance processes, how to use to Clinical Research Facility, etc. • The roll-out of a new research database (Edge) to replace ReDA was now in its final stages which included arrangements for staff training. • Discussions were continuing with the UCL's Clinical Trials Unit with regards to facilitating collaboration with the Division of R&I. • The Research Review for 2010 was now available from the Joint R&D Office and distributed at the meeting. • In October, 3 applications for Contingency Funds were submitted to the CLRN, totalling £142,376	
273.2	Management Board **noted** the content of the report.	
274	**Education Zero Harm Report**	
274.1	LM presented the report to Management Board presenting achievements, issues and risks in relation to the delivery of the Trust's responsibilities and objectives for education and training.	
274.2	Current activity headlines included: • Review of Trust induction and update programmes had been completed with 2 yearly update cycles to commence in January 2011. Simplified matrices were being finalised and would be published across the Trust and on GOLD; ▪ training requirements for corporate mandatory training for each staff group ▪ safeguarding training requirements for each staff group. • Developing Senior Managers Programme 2011 delegates 'graduated' this month - A number of execs and senior managers attended the final presentations and evaluation. • A review of progress with learning programmes for improvement and transformation was currently underway. Paper proposing next steps would be presented at Transformation Board. • A review of systems and process for delivering nurse education and training at GOSH had commenced and would report in January 2011	
274.3	Management Board **noted** the content of the report.	
275	**Key Performance Report September 2011**	
275.1	RB presented the Key Performance Indicator (KPI) report. The report had been revised following a number of recent recommendations from Monitor. In particular, the dashboard had been expanded to include 'RAG' performance against defined thresholds and tolerances as well monthly and quarterly performance trends. Progress against Monitor's governance risk framework was now reported monthly. Management Board were asked to agree revised report format and note progress.	

275.2	RB reported the following areas as RED: 1. C. difficile and MRSA. To date the Trust had reported 6 against a year-to-date trajectory of 5.25. The Trust trajectory for the year is 9 cases. No cases were reported in October. 2. Discharge summary completion rates. In-month performance increased to 77.7% against a previous month figure of 74.3%. An electronic solution was required and was currently being discussed through the Technical Delivery Board. 3. The Trust continued to meet the 95th percentile waiting time standards. A number of issues remained in sustaining performance against the incomplete pathway and non-admitted median wait standards. 4. Inpatient Waiting List. In month performance had deteriorated with 148 patients waiting over 26 weeks. Particular capacity issues have been identified across a number of specialties, including: ▪ Urology ▪ Dental & Maxillofacial ▪ Orthopaedics ▪ Plastic Surgery ▪ Spinal Detailed action plans were developed and submitted to August Management Board and a number of business cases to increase capacity were now being developed for approval. 5. The new to follow up ratio had reduced in October to 4.25 from a previous month performance of 4.38. The Trust had a contractual target to reduce this to 4.18 and retain this by December 2011. Following discussion at the recent Clinical Unit Review meetings, units had been asked to consider specialty specific reductions and trajectories against those areas with high ratios. 6.. Appraisal completion rates had remained fairly consistent during 2011 but were now beginning to decline. The Trust reported an in-month rate of 68.6% for clinical areas and 61.2% in non-clinical against an October interim target of 80%. Managers were reminded to continue to work proactively to ensure that all staff had a current PDR. 7. Staff Trained on Information Governance. Performance was reported at 87% against a target of 95%. The lowest compliance rates were identified across Medical and Dental. All new staff was now required to undertake the training as part of their induction.	
275.3	AG asked how key indicators were selected and how background ‘noise’ was eliminated so that data being reviewed was statistically significant. RB informed the Board that the Transformation Team were currently working on ways of refining the key indicators. ME congratulated the team for all the hard work that went in to the new report which will hopefully make trends easier to identify.	
275.4	Management Board **agreed** revised report format and **noted** the report.	
276	**Finance and Activity Report**	
276.1	CN provided a summary of the Finance and Activity for the Trust. Results year to date to end of period 7. • Net surplus £5.2M, which is £0.8M lower than the revised plan • Normalised EBITDA 6.9% (Budget 7.4%; Full year budget 7%)	

276.2	The forecast position was £2.3M surplus after a property impairment estimated at £5.7M	
276.3	The most significant risks in delivering the forecast were: • Control of Agency spend • Delivery of the remainder of the CRES plan; • Delivering income growth and ensuring the Trust is appropriately reimbursed • Ensuring Phase 2A double running and project costs are in line with plan	
276.4	Total income, if pass through funding was excluded, was above plan by £2.7M. • NHS activity was ahead of plan £2.6M • IPP was in line with plan. • Other Operating Revenue was £0.2M behind plan if the timing differences in respect of the charity pass through are removed.	
276.5	Pay was over spent by £3.4M excluding pass through. The majority of the over spend related to nursing and junior medical staffing where there were higher than planned levels of agency staff. Non Pay was under-spent by £0.3M when pass through of blood, drugs and clinical devices are taken into account.	
276.6	• Overall FT score of 3 year to date • Forecast score was 3	
276.7	The Trust was now reporting risk adjusted values for CRES having completed an exercise to remove or reduce schemes where there was uncertainty over scheme delivery.	
276.8	• Capital spend was £26.2M; £1.4M lower than plan YTD. Donated capital spend was £1.4M lower than plan • There were eight salary overpayments totalling £25.2K.	
276.9	Management Board **noted** the contents of the report.	
277	**Foundation Trust Application Update October 2011**	
277.1	SB presented the paper which set out the current position for the Trust against the assessment criteria used by the SHA and the Secretary of State for Health to determine readiness for Foundation Trust status.	
277.2	He reported that Monitor had completed the first phase of their assessment work at the end of October. Their initial feedback had been mainly positive, but there were some areas where they require more evidence or changes in systems and processes. These were in three broad areas: • Financial viability: - They had applied higher levels of efficiency to the base case. This results in an FRR of 2 by 14/15. Their assumptions relating to this requirement would be tested. - Accepted downside mitigations. Further work would be required to demonstrate that proposed mitigations were feasible and can be delivered. • Information reported to the Board: the KPI report should have a wider range of indicators relating to Trust objectives and CRES delivery, and should present trend analysis and highlight key issues more clearly. • Governance arrangements. Monitor had suggested that the Trust had a quality governance score of 5.5 (maximum 4 required for authorisation). The main issues related to board reporting, reporting of CRES scheme safety risks, and management of data quality.	
277.3	Further work was being undertaken to develop the KPI reports, CRES safety risk reports, and the management of data quality. Following completion of this work,	

	Monitor would resume and complete their assessment. The board to board meeting and authorisation was now expected to be in early 2012.	
277.4	The elections to the Members' Council had been completed, and the first meeting of the Council took place on 17 November 2011.	
277.5	Key actions for the next month: • Complete additional work required on the three issues identified by Monitor. • Complete the Monitor assessment process.	
277.6	Management Board **noted** the report.	
278	**Child Protection Q2 report**	
278.1	LM presented the report which provided evidence of continued implementation of the Trust strategy to protect children. Full details of Trust wide activity were outlined in the Trust Child Protection Action Plan which demonstrated the level of on-going development, and improved oversight of all services for which the Trust had safeguarding responsibility.	
278.2	Overall, since June 2011 the Trust continued to make good progress against planned activity and goals and was working hard to embed strategic processes across the Trust to ensure good outcomes for children and young people.	
278.3	Highlights included: GOSH Safeguarding Scorecard, Staffing, Inspections and Audit, Serious Case Reviews, Social Care Referrals, Training, Case Conference attendance and Safeguarding Supervision.	
278.4	Management Board **noted** the report.	
279	**Commissioning for Quality & Innovation (QUIN) and Quality Improvement Development & Innovation Schemes (QIDIS) Monitoring Report, Quarter 2**	
279.1	RB presented the report which had been developed to monitor progress against all Primary Care Trust and London Specialist Commissioning Group CQUIN standards and National Commissioning Group (NCG) QIDIS for 2011/12.	
279.2	A monitoring group had been established that was chaired by the Co-Medical Director and attended indicator leads. The group meets on a monthly basis to review progress and identify remedial actions where performance was not being achieved before formal reporting to lead commissioners.	
279.3	CQUIN. 17 indicators were reported as 'achieved' against the milestones set in quarter 2. 1 indicator (safeguarding record keeping) was reported as 'not achieved'.	
279.4	Safeguarding record keeping - The indicator sought to strengthen the quality of the annual audit of child protection cases and to take the learning (both good and improved) into account both operationally and strategically.	
279.5	The audit compliance of child protection case notes was reported at 66%. This was largely due to the absence of the referral form. A robust action plan has been developed and implemented to ensure future ongoing compliance. The indicator carries a financial weighting of £18,120.	
279.6	QIDIS. The QIDIS schemes identified as fulfilling the six strategic aims of NSCG services were in project form per service on a National basis. First wave approval was given in September meaning that projects that were initially reliant on additional staffing resource would naturally suffer a shortfall on Quarter 2 deliverables. Overall 46% of targets had been achieved.	

279.7	Management Board **noted** the report.	
280	**Revised Complaints and SI Processes**	
280.1	RB presented the report which outlined the investigation and completion of SIs. There was a need to improve the quality of the reports produced and the systems for escalating issues. The new processes outlined the key expectations of individuals, time scales and raise the seniority of involvement. It was proposed that the revised processes were reviewed in 6 months to ascertain effectiveness. Approval of the new processes for the management of SIs and Complaints was requested.	
280.2	The overarching aims of the proposed revised process for dealing with Serious Incidents were as follows: • Raise the profile of SIs – they should be the most important task for a manager when one had occurred • Devolve the role of investigation lead to the Clinical Units with named specialist support provided centrally (Risk Managers) • Each SI to have a named Exec lead and for clinical SIs named Medical & Nursing Director Leads as appropriate • Ensure a robust and defined link between an SI and subsequent recommendations with clear responsibilities around actions.	
280.3	The overarching aims of the proposed process for dealing with complaints were as follows: • Stratify seriousness immediately with different process for red complaints • Greater opportunity to liaise with family, with this being essential for red complaints • Each red complaint to have a named Exec lead • All red complaints to have 2 letters provided – one following the investigation and one outlining the actions to be undertaken. • Ensure a robust and defined link between a complaint and subsequent recommendations with responsibilities around actions • A Trust wide guide about responding to complaints would be produced in the near future with the aim to raise the standard of responses to a consistently high level across the organisation.	
280.4	Management Board **approved** the report with review of effectiveness in 6 months.	
280.5	**Action:** RB to present a review of the effectiveness of the Revised Complaints and SI Processes to the May 2012 Board.	**RB**
281	**Business Planning Strategy 2011/12 version 2**	
281.1	RB presented the strategy which set out the Trust-wide strategy for business planning. The strategy had been considered within the context of the Monitor's Annual Planning requirements for Foundation Trusts. It defined the systems and monitoring process required to be in place to enable the Trust Board and all stakeholders to be assured that its commitment to effective business planning was met.	
281.2	The strategy had been updated to reflect changes in Trust governance structures and business planning processes.	
281.3	TS highlighted that preliminary discussions with the Units and Finance for potential Business cases should include core financial information. CN agreed.	
281.4	LM highlighted that point 5.6 *"Involvement with stakeholders - Who has been consulted about the project? Is there anyone else who will need consulting if the project goes ahead?"* should include AHPs.	
281.5	**Action:** RB to include AHPs should be included in point 5.6 *"Involvement with*	**RB**

	stakeholders - Who has been consulted about the project? Is there anyone else who will need consulting if the project goes ahead?" of the Business Planning Strategy 2011/12.	
281.6	It was agreed that the Business Planning Strategy 2011/12 should be brought back to the December Management Board.	
281.7	**Action:** The Business Planning Strategy 2011/12 to be brought back to the December Management Board	**RB**
282	**Performance Management Strategy 2011/12 version 2**	
282.1	RB presented the Performance Management Strategy which had been considered within the wider context of the Trust's strategic planning framework and Foundation Trust requirements.	
282.2	Foundation Trust Boards must be able to satisfy themselves that all aspects of the organisations' performance and operations were of an appropriate quality, and ensure that the organisation understands and meets the requirements of regulatory bodies and inspectorates as outlined in their Authorisation. As such, the work described in the strategy sets out the framework that would enable the Board to satisfy itself that it was discharging its responsibility effectively.	
282.3	The strategy had been updated to reflect changes in Trust governance structures and external performance requirements including, commissioning and contractual standards and Monitor's governance compliance framework.	
282.4	The Board discussed the strategy and agreed more work needed to be done. It was agreed that the Business Planning Strategy 2011/12 should be brought back to the December Management Board.	
282.5	**Action:** RB to present a revised version of the Performance Management Strategy 2011/12 at the December 20111 Board.	**RB**
283	**Admission Criteria and Length of Stay for GOSH Patients**	
283.1	RB outlined the aim of the Bed Management Improvement Project which was to ensure GOSH never declines a clinically appropriate referral due to insufficient bed availability. In order to determine clinical appropriateness, each clinical unit had been asked to produce a list of admission criteria and length of stay information for each specialty. This would be used by clinicians and the Bed Management Team to aide decision making when a referral was received, as per the Admission & Bed Management Policy, September 2011.	
283.2	The admission criteria and length of stay would also be published on the GOSH internet site in the Health Professionals; Refer a Patient section. This follows feedback from our referrers who had expressed that they would like to have access to this information. Action required: 1. Agree content of the document 2. Agree to this being published on the GOSH internet where it will be in the public domain.	
283.3	CDS highlighted that there were some typos in the Neurosciences section that needed changing (such as days not weeks). There were concerns raised over putting this information on the external web before ironing out any initial teething problems.	
283.4	The Board **agreed** the direction of travel of the report and agreed to publish the information on the web (with amendments) post a 3 month internal trial period.	

283.5	**Action:** RB to report back to Board on progress made with Admission Criteria and Length of Stay for GOSH Patients data readiness for external publication (by February 2012).	**RB**
284	**Business cases for growth in cardiac surgery, neurosurgery, ENT, urology and SNAPS**	
284.1	The Business Case Review Group (BCRG) had been established to help facilitate the process by which business cases get to Management Board. The BCRG would scrutinise proposals looking at quality, operational issues and financial risk and highlight resulting key issues to management board.	
284.2	This month business cases that were reviewed by the first BMRG included the 5 relating to the additional theatre capacity delivered from May 2012. These are for growth in cardiac surgery, neurosurgery, ENT, urology and SNAPS.	
284.3	Key issues raised: 1. How have our plans changed from what was in the Long Term Financial Model? The activity and capacity model was currently undergoing the annual review process where assumptions about growth and resource usage would be updated prior to the next commissioning round. 2. Did we have sufficient bed capacity? Beds were physically available but not necessarily in the correct specialties. Options were being explored and a solution would be proposed in January. 3. Did we have sufficient MRI capacity? A project had been established and was confident of providing a solution.	
284.4	Management Board was asked to note the report and agree the plan to resolve the key issues.	
284.5	<u>Neurosurgery</u> SD presented the paper which outlined the plans to increase neurosurgery theatre capacity by adding a Tuesday all-day theatre list. The aims of the proposal were: • To increase theatre capacity for neurosurgery • To ensure that Neurosurgery has sufficient capacity to support the activity projected in the Integrated Business Plan • To ensure that Neurosurgery has sufficient capacity to respond appropriately to the Safe and Sustainable review of Paediatric Neurosurgery • To improve the effectiveness of the neurosurgical service by ensuring patients receive surgery in a timely way. • Improve data collection and audit within neurosurgery. Action required from the meeting • Agree to support the funding for this expansion of services	
284.6	Management Board **<u>approved</u>** the Neurosurgery Business case.	
284.7	<u>SNAPS</u> TS presented the paper which aimed to make the case to invest 10 Consultant PAs and associated costs in the SNAPS service. This would enable SNAPS to take an additional all day theatre session once Phase 2A opens.	
284.8	Two options included in the paper were: • Option 1 – do nothing • Option 2 – invest in service expansion	
284.9	Management Board **<u>approved</u>** the SNAPS Business case with the amendments to include clarity on mitigation and address smart measures.	
284.10	<u>ENT</u> TS presented the paper which aimed to make the case to invest 9.5 Consultant PAs	

	and associated costs in the ENT service. This would enable recruitment of a second Consultant to carry out complex head and neck cancer work. It would also provide the capacity to take an additional all day theatre session once Phase 2A opens.	
284.11	Four options are included in the paper: • Option 1 – do nothing • Option 2 – restrict referrals • Option 3 – temporarily increase capacity • Option 4 – permanently increase capacity through appointment of full time surgeon Management Board **approved** the locum. It was agreed that the full Business case would come back to the December Management Board.	
284.12	**Action:** TS to bring back to Management Board full Business case for ENT subject to 2012-13 tariff being confirmed.	**TS**
284.13	Urology TS presented the paper which aimed to make the case to invest 8.5 Consultant PAs and associated costs in the Urology service. This would enable Urology to tackle a significant waiting list backlog, as well as providing capacity for expected levels of referral in the future.	
284.14	Two options are included in the paper: • Option 1 – do nothing • Option 2 – invest in service expansion	
284.15	Management Board **approved** the funded theatre time and Locum. It was agreed that the full Business case would come back to the February Management Board.	
284.16	**Action:** TS to bring back to January Management Board full Business case for Urology.	**TS**
285	**Introducing the Equality Delivery System (EDS) to improve patient/family/staff experience at GOSH**	
285.1	BB presented the paper which introduced the Equality Delivery System, following which will allow the Trust to meet its legal requirements arising from the Equality Act 2010.	
285.2	Over the past 10 years, much progress had been made regarding improving the experience of patients, families and staff at GOSH. We had a better understanding about our patient and staff population and had improved a variety of services to better meet their needs such as: ▪ A wider variety of food was served in our eating facilities, including vegetarian, Kosher and Halal options every day. ▪ Faith facilities had been improved, with the introduction of Friday prayers for Muslim families and staff and the Shabbat Room for Jewish families. The multi-faith room had also been refurbished recently to make it more suitable for daily use. ▪ Various courses at all levels were offered to staff, including classes in English as a Second or Other Language. ▪ The Trust supports staff through the BAMEN (Black, Asian and Minority Ethnic Network) group.	
285.3	Management Board **approved** the report.	
286	**CRB checking of ICH staff**	
286.1	RB presented the paper on ICH staff who work clinically at GOSH and had contact with children, who have an enhanced CRB through their honorary contract with GOSH. It was unclear whether ICH provided a CRB to those staff. However other	

	ICH staff e.g. admin, estates or laboratory staff do not have a CRB.	
286.2	This was because the GOSH policy on enhanced CRB was at odds with the expected standard in other services. It was generally expected that only staff who had substantial direct contact with children or vulnerable adults needed a CRB. Organisations who apply for staff that do not fit this criterion may be liable to a penalty. However GOSH had agreed a policy that all staff would be subject to an enhanced CRB check because of the nature of the work and the reputational risk. JC reported that Professor Andy Copp had suggested that Honorary contract holders wear a different colour ID badge to GOSH staff so that they were easily recognisable. PW stated that the Trust was currently rewriting the hierarchy of access rights and would take this in to consideration.	
286.3	Management Board **approved** the paper and the suggestion the Honorary contract holders wear different colour ID Badges.	
287	**Consultant Neurosurgeon appointment (proleptic)**	
287.1	CDS presented the paper. The Neurosciences Clinical Unit sought Management Board approval to request funding from GOSHCC to appoint a Consultant Neurosurgeon. This was a proleptic appointment for 2 years, prior to the retirement of the current postholder. This appointment was intended to maintain continuity of service for epilepsy surgery - a highly specialist area of neurosurgical practice.	
287.2	The Post was: • 10 PA Consultant in Neurosurgery Funding for this post was being sought from the GOSH Charity.	
287.3	Management Board were asked to approve: • Recruitment to this post.	
287.4	Management Board **approved** the appointment.	
288	**Approval of Radiographer Consultant post**	
288.1	JA presented the paper which aimed to gain agreement from the Trust to proceed with obtaining approval from the Strategic Health Authority for a radiographer consultant post and subsequently appoint to the post	
288.2	Management Board **approved** the paper.	
289	**Draft Terms of Reference for the Policy Approval Group**	
289.1	AF presented the paper. At the October 2011 Management Board meeting, it was agreed to establish a Policy Approval Group. This Group would be chaired by the Deputy Director of Operations and would report to Management Board and consider and approve all policies. It would also review the format of policies, check that policies reflect current legislative and regulatory requirements and monitor the timeliness of updates to policies.	
289.2	It was agreed that AL, SD, JA and CC would be part of the Approval Group.	
289.3	Management Board **approved** the attached terms of reference.	
290	**Parental Leave Policy**	
290.1	RB presented the policy which outlined the steps to be followed when a member of staff wished to request a period of parental leave. This policy had been updated in the following ways: • Ensuring compliance with the Equality Act 2010 by referencing all Protected	

	Characteristics. • Reference made to the Trust's personal responsibility framework. • Nominated carer has been included and clarification given that disabled children are those children in receipt of Disability Living Allowance. • Advised staff to contact the Payroll Department to discuss pension contributions during any parental leave period. Added in response to rule changes to the NHS Pension Scheme in relation to unpaid leave and contributions. • Clarification added that any disagreement on the application of this policy may be addressed under the Trust's Grievance Procedure.	
290.2	The need for requests for parental leave to be agreed in line with service requirements is highlighted, it was not possible to completely refuse leave but it can be postponed.	
290.3	Parental leave was unpaid and should be managed like other leave within a department	
290.4	EJ suggested that the line under "*How do I apply for Parental Leave*" should be altered. JC asked for the policy to be compared with others Trusts.	
290.5	It was agreed that the policy would come back to the Policy Approval Group in December.	
290.6	**Action**: Parental Leave Policy to be taken to the Policy Approval Group in December.	
291	**Retirement Policy**	
291.1	RB presented the policy which aimed: • To update the policy in line with statutory changes removing the retirement age • Inclusion of different retirement options • Inclusion of the effect of each option on pension benefits under both the 1995 and 2008 sections of the NHS Pension Scheme • Clarification regarding returning to work following retirement • Clarification regarding CEAs following retirement • Clarification of responsibilities during the retirement process • Also can confirmed that employer pension contributions would not be paid to individuals who had retired and returned to work.	
291.2	Management Board **approved** the policy.	
292	**Pneumatic Air Tube Transport System Policy**	
292.1	PW highlighted that the Policy came to Management Board in error and would be brought to the next Policy Approval Group.	
293	**Postal Service Operational Policy 2011 V5**	
293.1	PW highlighted that the Policy came to Management Board in error and would be brought to the next Policy Approval Group.	
294	**Information Sharing Protocol**	
294.1	CN highlighted that the Policy came to Management Board in error and would be brought to the next Policy Approval Group.	
295	**Domestic Services Operational Policy 2011 (v5)**	

295.1	PW presented the Policy. This was the 2nd amended version in 2011 due to the changes that were required following the CQC Visit in July 2011. The main changes were as follows:	
295.2	• All Clinical equipment and relevant non clinical equipment to be 'tagged' post cleaning to show compliance • A secondary tagging type to use on equipment that cannot hold the current Yellow Tag • More extensive Audit arrangements to check Tagging compliance (Executive Walk-Rounds, Patient Environmental Audits and Nursing clinical checks) • Appendix 2 was a new insert that describes the process of cleaning clinical equipment and the governance arrangements described above • The Cleaning Responsibility matrix had also been amended to show the type of tagging designated to each piece of equipment.	
295.3	Management Board **approved** the policy.	
296	**Intravenous access escalation policy**	
296.1	LM presented the policy. Effective and appropriate intravenous access was an integral part of delivering safe care for children at GOSH. Inserting IV access can also be a distressing procedure for children and their families, and this distress was increased if the procedure failed and had to be re-attempted.	
296.2	The policy set out responsibilities for managing children with difficult IV access to enable us to do the 'right thing first time, every time'.	
296.3	Management Board **approved** the policy.	
297	**Update on establishment of the Members Council**	
297.1	JC gave a verbal update the establishment of the Members Council.	
297.2	Management Board **noted** the verbal report.	
298	**Update of Olympics**	
298.1	RB gave a verbal update on the Olympics.	
298.2	Management Board **noted** the verbal report.	
299	**Redevelopment Programme Steering Board**	
299.1	Management Board **noted** the contents of the above document.	
300	**Technical Delivery Board**	
300.1	Management Board **noted** the contents of the above document.	
301	**Waivers**	
301.1	CN requested approval for waivers from the following suppliers: ELITech UK Ltd Philips Healthcare and Clarke Energy Ltd	
301.2	Management Board **approved** the waivers.	
302	**Any other business**	

302.1 302.2	LM highlighted to the Board that a working group had been set up by Madeline Ismach to try to improve things for discharged children with long term conditions. The group planned to request funding from the Trustees. Management Board **noted** the verbal report.	

Great Ormond Street Hospital for Children NHS Trust

Trust Board 21st December 2011	
UCL Partners Update **Submitted on behalf of** Dr Jane Collins, Chief Executive	**Paper No: Attachment X**
Aims / summary To provide Trust Board with an update on the work of UCL Partners.	
Action required from the meeting To note the UCL Partners November Update.	
Contribution to the delivery of NHS / Trust strategies and plans All strategic objectives.	
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? 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 December 2011	

UCLPartners
Academic Health Science Partnership **UPDATE: NOVEMBER 2011**

The November UCLPartners seminar was the first joint workshop of the expanded AHSS. It focused on our core objective to address the cultural and system barriers that delay proven new innovations getting into practice, and applied this to work on earlier diagnosis in cardiovascular, stroke, cancer, mental health and COPD, all areas of real progress across the AHSS.

Previous studies show it takes on average 17yrs to deliver a proven intervention into widespread usage (with only 3% rate of spread p.a.). This results in a major loss of life, significant morbidity and poor value – dwarfing the impact of virtually all new discoveries – and rightly creating a shift in focus for research funders, scientists and healthcare staff at time of financial constraint.

Dr Begley, UCLPartners Director of Innovation and Implementation, reported her research work with Prof Albury to identify the characteristics of a healthcare system that would enable faster diffusion of new proven interventions. Findings include the need to:

- *Provide granular, accessible comparative performance information*
- *Engage and empower patient and carer networks and organisations*
- *Build alliances across interfaces, between internal and external networks*
- *Strengthen and exploit provider autonomy*
- *Incentivise and reward scaling and spreading from the outset*
- *Actively decommission and disinvest*
- *Encourage competition*
- *Focus investment and risk capital*
- *Acknowledge necessary instability and fluidity.*

There was a shared commitment to systematically apply this learning to each project across the partnership, recognising that we need to better inform and encourage patients to act as empowered "pull through agents" for themselves and others, and to use the academic power across UCL, QM and City and other collaborations to examine how to leverage the most from these factors.

Despite many proven treatments for early phase tumours, we know that more than 25% of our cancer patients first present via A&E. We are working with National Cancer Director, Professor Sir Mike Richards, to develop a study that will investigate the specific reasons for individual delay and use the process and findings concurrently to drive improvements across our communities. A senior resource has been identified to support this work from within the partnership.

Continuing the focus on outcomes that matter to patients per £ spent, UCLPartners is supporting a further workshop on Value based healthcare, jointly with the GLA (venue City Hall, date Feb 29th 2012), which will be led by Profs Michael Porter and Tom Lee.

Prof Chris Fowler has been appointed to chair the UCLPartners education board, taking over from Sir John Tooke. The focus of the board's work over the next year will include establishing a local education and training board and its relationship to UCLPartners as a lead provider, ensuring we deliver a high quality programme for MDECs, and that we develop better multi-professional training, and enhanced career pathways for nurses, midwives and AHPs.

Finally a reminder that UCLPartners staff have moved to 170 Tottenham Court Road London W1T 7HA, which will provide better meeting room facilities to support the expanded partnership, and closer working with local and national groups focused on prevention and outcomes research.