Meeting of the Trust Board
25th January 2012

Dear Members

There will be a public meeting of the Trust Board on Wednesday 25th January 2012 commencing at **3:30pm** in the **Charles West Room, Paul O'Gorman Building,** Great Ormond Street, London, WC1N 3JH.

Company Secretary

Direct Line: 020 7813 8230

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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 21st December 2011**	Chair	**H**
3.	**Matters Arising / Action point checklist**	Chair	**I**
4.	**Chief Executive's Update** • **Safe and Sustainable** • **Morgan Stanley Clinical Building** • **Ombudsman's Action Plan** • **Executive Away Day** • **Update from Kuwait**	Chief Executive	**Verbal Update**
5.	**Clinical Presentation - Neurosurgery**	TBC	**Presentation**
6.	**MRSA Policy – Impact on Patients and Staff**	Dr John Hartley	**Presentation**
7.	**Quality, Safety & Transformation Update (Zero Harm Report)**	Co- Medical Director (ME)	**J**
	ITEMS FOR APPROVAL		
8.	**Quality Strategy**	Co-Medical Director (ME)	**K**
9.	**GOSH PPI (Patient and Public Involvement) and Patient Experience Plan 2012-2015**	Chief Nurse and Director of Education	**L**
	UPDATES		
10.	**Performance Report (December 2011)**	Chief Operating Officer	**M**

11.	**Finance and Activity Report (December 2011)**	Chief Finance Officer	**N**
12.	**PALS Patient Experience Report**	Chief Nurse and Director of Education	**O**
13.	**Foundation Trust Update**	Chief Operating Officer	**P**
14.	**Care Quality Commission Registration Update**	Company Secretary	**Q**
15.	**Trust Board Members' Activities**	Chair	**Verbal**
	FOR RATIFICATION		
16.	**Consultant Appointments**	Chair	**Verbal**
	ITEMS FOR INFORMATION (These items will not be discussed unless a Member gives prior notification of an intention to do so.)		
17.	**UCL Partners Board Update – December 2011**	Chief Executive	**R**
18.	**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.)		
19.	**Next meeting** The next Trust Board meeting will be held on Wednesday 28th March 2012 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT H

DRAFT Minutes of the meeting of Trust Board held on 21 December 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
Mr John Ripley	Designate Non-Executive Director

287. Apologies for Absence

287.1 There were no apologies for absence.

288. Declarations of Interest

288.1 There were no declarations of interest made.

289. Minutes of the Meeting Held on 30th November 2011

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

289.2 The minutes were **approved**.

290. Matters arising

290.1 Minute 247.5 – Dr Jane Collins, Chief Executive, provided a verbal update for the Board following discussions with the executives to agree common criteria for the use of RAG ratings in Board and other key reports. Dr Collins noted that clarity between red amber and green issues had been agreed and the subject would be further discussed in the tabled report, item 16 on the

agenda.

291. Chief Executive's Update

291.1 Dr Collins provided a verbal report for the Board on the following areas:

291.2 Safe and Sustainable – Cardiac Surgery
Dr Collins informed the Board that the results of the judicial review were being assessed but that progress continued to be made. The Chair, Baroness Blackstone, queried when the Cardiac Surgery decision would be taken. Dr Collins stated that a date could not be set until the legal process was completed.

291.3 Dr Collins reported that a different approach had been adopted for the Neurosurgery Safe and Sustainable Review, including a requirement for interested providers to tender for the right to provide specific services such as epilepsy services.

291.4 Ombudsman report action plan
Dr Collins provided some background information for the Board into the Ombudsman report that criticised the care of a patient and handling of the subsequent complaint lodged by their family. Dr Collins reported that a very constructive meeting had taken place with the family a few weeks previously and that she had also been in contact with and met representatives from the Muscular Dystrophy Campaign. Dr Collins offered her assurance to the Board of just how much importance had been placed on this case and that the experience of other patients would be improved as a result of the learning.

291.5 Co-Medical Director, Professor Martin Elliott, added that during the work on the action plan, the extent of difficulties of building a pathway across the Trust had emerged. Professor Elliot noted that some time had been spent discussing cross-Trust activity, and that in the New Year this would be examined further, as currently, planning the patient's journey was very difficult.

291.6 Dr Collins noted that this would be on the agenda for discussion at the next Executive away day scheduled for 22nd December 2011.

291.7 Spinal surgery review
Dr Collins informed the Board that the review had been completed and invited Co-Medical Director, Dr Barbara Buckley, to provide further detail.

291.8 Dr Buckley informed the Board that the inquest of a child whose case had formed part of the review had been held and that the Coroner found the cause of death was surgical complications due to the underlying medical conditions. Dr Buckley noted that the Coroner had also described 'good care' in the pre-operative stage.

291.9 Dr Buckley reported that the spinal surgery service was now taking new complex patients.

291.10 Dr Buckley noted that during the spinal review, two key lessons had been identified regarding the process of service review itself. In the first instance, parents should be involved at an earlier stage and informed of the Trust's

intention to conduct a review. Secondly, robust terms of reference should be agreed at the beginning of the review and progress regularly monitored.

291.11 Dr Collins informed the Board that the final action plan would be taken for review to the Clinical Governance Committee, early in 2012.

291.12 Private Patient Cap
Dr Collins informed the Board that the private patient cap remained an issue and was currently under debate in the House of Lords. As part of the consultation, the Trust had been asked its views by the FT Network about a cap of 49% of clinical income coming from private income. Dr Collins confirmed that the current private patient cap for the Trust was less than 10%.

291.13 Ms MacLeod asked whether there could be a discussion of what the percentage the Trust should be aiming for if the cap goes. Dr Collins confirmed that a discussion would take place, once it was clear what the proposals were from the Bill.

291.14 The Board **noted** the report.

292. Reporting Zero Harm – Quality, Safety & Transformation update

292.1 Professor Martin Elliott, Co-Medical Director presented the report which outlined the revised format of the future Zero Harm Report to the Trust Board, incorporating information from the recently combined Quality and Safety and Transformation teams.

292.2 Professor Elliott invited questions from the Board.

292.3 Non-Executive Director, Mr Charles Tilley, queried in each of the performance charts, how it was known that the benchmark set was reasonable.

292.4 Professor Elliott clarified that the green line in the relevant graphs represented measurement of the mean and that continuous improvement against this mean should be the aim.

292.5 Professor Elliott noted that due to the specialist nature of many services provided by the Trust, comparisons could not always be made with other centres.

292.6 Mr Ripley challenged whether the UK was the correct benchmark for the Trust to be aiming for.

292.7 Professor Elliott confirmed that it should be worldwide and this was clearly stated in the trust strategic objectives. International benchmarks were used where possible.

292.8 Mr Ripley queried whether improvement could come at too high a price and questioned whether the cost of improvement at the higher end of the scale would outweigh the benefit of its achievement.

292.9 Professor Elliott stated that the patients using the services would argue that the benefit would be felt.

292.10 Chief Operating Officer, Ms Fiona Dalton, noted that the Global Trigger Tool was a useful check for ensuring the Trust concentrates on key causes of harm.

292.11 Professor Elliott stated that the current benchmarks, for example mortality, were not always the best measurement as the rate is fortunately low and that work needed to be conducted to find more sensitive indicators.

292.12 Non-Executive Director, Professor Andy Copp, drew the attention of the Board to the Paediatric Trigger Tool graph on page 5, querying whether the dramatic improvement should have been enough to lower the mean.

292.13 Professor Elliott stated that it had not been statistically sufficient an improvement.

292.14 Professor Elliott reported that in conjunction with Cincinnati Hospital, a Serious Harm Index was also being developed.

292.15 Dr Collins clarified for the benefit of newer members of the Board that the Trust had established a link with Cincinnati Hospital and links with other centres around the world were being developed.

292.16 Non-Executive Director, Ms Yvonne Brown, raised a query regarding persistent failings with the upkeep of patient notes. Ms Brown noted that each unit appeared to have its own plan for improvement of patient notes and queried whether this was a 'world class' approach? She asked at what stage the Trust was at in its plans to implement an electronic medical record.

292.17 Professor Elliott stated that a number of potential electronic document management systems (EDMS) were being examined by the Trust and that further work was underway to review these for the future. Prioritisation of the work would be discussed at the Executive Away Day.

292.18 Professor Elliott added that the IT structure would support the next stage of development of the EDMS.

292.19 Professor Elliott noted that to answer a lot of Mr Ripley's queries regarding benchmarks and to assure the Board that spending in areas like electronic patient records was suitably beneficial, the emerging themes from the Frances Enquiry into incidents at Mid Staffordshire Hospital would be helpful; that the question should not be 'can we afford to do this' instead 'can we afford not to.'

292.20 Professor Elliott stated that each specialty had been approached and asked who they would be best suited to benchmark against, resulting in both the UK as well as international centres being selected as benchmarks. Professor Elliott noted that a pragmatic approach was necessary as some services provided in the Trust were so specialist there were no other UK providers.

292.21 The Board **noted** the report.

293. Overview of strategic objectives for 2012-15

293.1 Ms Fiona Dalton, Chief Operating Officer, reminded the Board that seven

strategic objectives had been agreed three years ago to form the basis around which annual plans, risk assurances and frameworks were based. In turn, the clinical units had based their objectives around these objectives.

293.2 The Board was asked to consider whether they would like to retain the same set of objectives for the next three years or prefer a different approach to be taken.

293.3 Ms Dalton addressed each of the seven strategic objectives in turn, providing suggestions for potential changes, looking ahead to the next three years.

293.4 Ms Dalton noted that the timetable for review was driven by the need to have an annual plan agreed. Ms Dalton welcomed thoughts of how to reach agreement on a new set of objectives by January 2012.

293.5 Mr Tilley requested that the presentation be circulated to Board members so that suggestions could be made.

293.6 **Action**: The Chief Operating Officer to circulate the presentation on future plans for development of the Trust's strategic objectives to the Trust Board.

293.7 Mr Lomas queried whether the time frame for implementation of some of the achievements needed to be made explicit so as to inform a measure of productivity within the Trust. Ms Dalton agreed that this would be helpful.

293.8 Professor Copp queried whether other objectives should be included, for example, the proposal to establish six day working at the Trust.

293.9 Professor Elliott noted that it was important to separate strategic objectives with other, longer-term projects, such as six day working.

293.10 Ms Dalton noted that the objectives had been highlighted for the Board as the three year period was now at an end. There was a need to develop an annual plan for 2012/2013.

293.11 It was agreed that minor changes be made to the education objective (objective 4) to reflect the current drivers for improving education services at GOSH.

293.12 **Action**: The Chief Operating Officer to make changes to the education objective (objective 4) to reflect the current drivers for improving education services at GOSH.

293.13 The Board agreed that in light of the impending Foundation Trust assessment, the current objectives should be retained for a further year (subject to the minor changes to objective 4) and a plan be developed for implementation of new objectives from April 2013.

293.14 Ms Dalton requested that meanwhile any minor changes to the wording of the objectives should be forwarded to her for inclusion.

293.15 The Board **noted** the presentation.

294. Academic Health Science Centre – Monitor compliance requirements

294.1 Dr Collins presented the paper that had been produced in response to Monitor's request for the Trust Board to make a self-certification statement around the Trust's membership of UCL Partners Academic Health Science Centre

294.2 Dr Collins drew the attention of the Board to page two of the report which outlined the ability of the Trust to act independently of UCL Partners. This had reduced any risk that Monitor had identified.

294.3 The Board **approved** the statement.

295. Performance Management Strategy and Business Planning Strategy

295.1 The Chief Operating Officer, Ms Fiona Dalton presented the revised paper drawing the Board's attention to the addition of a table on pages eight and nine that set out what and how the Trust monitors performance and oversees business planning.

295.2 Non-Executive Director, Mr David Lomas, queried whether it would be possible for lengthy documents to include a one page summary at the start.

295.3 Dr Collins agreed that this could be included.

295.4 **Action:** The Chief Operating Officer to include a one page summary for the Performance Management Strategy and Business Planning Strategy.

295.5 Mr Ripley noted that in the annual plan, multi-cycle and yearly cycles could be made clearer. The Board agreed.

295.6 **Action**: The Chief Operating Officer to ensure that multi-cycle and yearly cycles are clearly stated in the annual plan.

295.7 The Chief Finance Officer, Mrs Claire Newton, queried whether the Performance Management Strategy included enough information about those organisations that monitored performance, citing the need for inclusion of commissioners. Mrs Newton noted that there was a mention in the appendix, but that it should be made explicit in the main document as well.

295.8 Ms Dalton agreed to add a section about external performance monitoring.

295.9 **Action**: The Chief Operating Officer to add a section on external performance monitoring in the Performance Management Strategy.

295.10 The Chief Nurse and Director of Education, Mrs Liz Morgan, requested that more overt links be included in both strategies around Patient Involvement and Experience as well as Education and Training. Mrs Morgan reported that this linking up had been mentioned at Management Board the previous week, but that time constraints had not allowed for the discussions to lead to additions to the paper.

295.11 **Action**: The Chief Operating Officer to ensure that more overt links be included in both strategies around Patient Involvement and Experience as well as Education and Training.

295.12 The Board **approved** the report subject to the above changes noted by Mrs Morgan and Mrs Newton.

296. Update on Data Quality Action Plan

296.1 The Chief Finance Officer, Mrs Claire Newton updated the Board with the current status of the Data Quality work stream, aimed at continuous improvement of Data Quality.

296.2 Mrs Newton reported that the Trust had been challenged following the results of an Audit Commission audit of Outpatient data in 2011/12 and the Trust's reference costs. The results of the audit revealed shortfalls in coding, which were in the process of being addressed.

296.3 Baroness Blackstone queried how often the Trust would report back to the Audit Committee on progress against the Data Quality Action Plan. Mrs Newton clarified that this would be reported bi-annually to the Audit Committee.

296.4 Non-Executive Director, Mr Charles Tilley, drew the attention of the Board to the table on page 4. Mr Tilley noted the large percentages and queried whether it was a large financial issue.

296.5 Mrs Newton noted that there had been an issue of the correct categories not being selected for coding purposes and the prices assigned were therefore not always accurate. Mrs Newton added that this was data from a few years ago that did not reflect the improvement work that has subsequently been undertaken.

296.6 Mrs Newton presented an Audit Commission checklist, providing good practice standards in Data Quality. This had been applied to the Trust and actions identified for addressing over the next 6 months.

296.7 Mr Tilley noted that there were no timescales in the action plan.

296.8 Mrs Newton agreed to add timescales.

296.9 **Action**: The Chief Finance Officer to add timescales to the action plan

296.10 The Board **noted** the report.

297. Revised Remuneration Committee Terms of Reference (Board of Directors)

297.1 Dr Anna Ferrant, Company Secretary, presented the revised terms of reference for the Remuneration Committee.

297.2 Baroness Blackstone advised the Trust Board that Ms Yvonne Brown, non-executive director had agreed to chair the Remuneration Committee following the retirement of Andrew Fane. Baroness Blackstone requested the Board's endorsement of her appointment. The Board approved the appointment of Ms Yvonne Brown as chair of the Remuneration Committee.

297.3 Dr Ferrant highlighted the key changes and informed the Board that the proposal for consideration of the cost of the Trust's pay structure had been included in the terms of reference of the proposed Finance and Investment Committee, to be discussed under the next agenda item.

297.4 The Trust Board noted and **approved** the revised terms of reference for the Remuneration Committee.

298. Draft Terms of Reference for Finance, Resources and Investment Committee

298.1 The Chief Finance Officer presented the draft terms of reference for a proposed Finance, Resources and Investment Committee.

298.2 Baroness Blackstone noted her concern at the addition of another committee for Board members to attend, stating that the committee membership should be smaller and the number of meetings per year set at a maximum of 4 to 6 in order to reduce the amount of time members spent in meetings.

298.3 Baroness Blackstone suggested that the meeting should not include HR, appraisal specific matters as examples, and that these should be dealt with by the Management Board.

298.4 Mrs Newton stated that she would be happy to reduce the number of Non-Executive members on the committee but that the Executive membership was required in order to enable the Committee to fulfil its terms of reference.

298.5 Mrs Newton noted that the number of meetings per year could be discussed and that there had been the idea that this committee would meet an hour before the Trust Board to avoid recalling many of the same members on another day.

298.6 Baroness Blackstone queried the depth to which the committee needed to cover areas, for example, CRES and productivity.

298.7 In response, Mrs Newton noted that it would be difficult to ask a finance committee not to discuss these driving issues.

298.8 Mrs Newton queried whether the Board should consider the wider question of whether the Trust Board should retain responsibility for finance and investment or a separate committee be established to oversee these matters, reporting in to Trust Board.

298.9 Ms Dalton stated that she felt it was important that detailed discussion was needed and that the Board should consider how it ensured that this had taken place.

298.10 Mr Ripley agreed that it was very difficult to find a finance committee that didn't do the work that overlapped with that of the Board.

298.11 Mr Ripley also noted his concern with the relationship of the committee to the Audit Committee and potential duplication of work there too.

298.12 Mr Ripley suggested that one aspect of finance and investment could be discussed in depth every quarter with a detailed report of each area for

information at each Trust Board meeting.

298.13 Mr Tilley noted that he was of the understanding that a focus of the committee should be on productivity. Baroness Blackstone commented that this was at odds with her own understanding.

298.14 Mr Lomas agreed that a detailed discussion did need to take place and that productivity was a Trust Board issue.

298.15 Ms MacLeod noted that care should be taken to ensure that there was no overlap between the audit and finance committees, requesting that a clear overview be provided of where this committee would sit in the context of the other committees mentioned.

298.16 Ms MacLeod noted that the Board should not completely delegate responsibility for finance.

298.17 Mrs Newton agreed with the suggestion made by Mr Ripley for quarterly in depth discussions of different areas. The Trust Board agreed.

298.18 The Board agreed that the cost of the Trust's remuneration structure should be considered at the proposed Finance and Investment Committee.

298.19 **Action:** Chief Finance Officer to review the Terms of Reference in an effort to reduce membership, streamline its scope and provide clarity as to the relationship of this committee with the Audit Committee.

299. Performance Report (November 2011)

299.1 The Chief Operating Officer, Ms Fiona Dalton presented the report, apologising that the full copy of the narrative to the report had not been included ahead of the meeting. This was tabled

299.2 Ms Dalton reported that the Department of Health had a renewed focus on waiting times targets, although these targets had not changed. In particular, there was a current focus on planned waiting lists.

299.3 Ms Dalton noted that following a review of data nationally, there had been found to be a correlation between mortality rates and the day of the week on which patients died. This found that mortality rates were higher at the weekends. The Trust had analysed its mortality by day of the week and found that the mortality rate was in fact higher during weekdays due to the increased mortality risk surrounding the perioperative time. The 6 monthly mortality review group would analyse in more detail any trends around the time of deterioration and the time in the day or week.

299.4 Mr Lomas drew the attention of the Board to graph 25 on page 13 of the report and queried why the number of surgery hours utilised in November 2011 was so low.

299.5 Ms Dalton responded that there had been a planned cardiac theatre closure for refurbishment. Clarification as to whether this had been accounted for in the figures was currently being checked.

299.6 Ms Dalton noted that she would report again at the next Trust Board to

ensure this issue was resolved.

299.7 Ms Dalton offered to provide a specialty wide report to offer further clarity.

299.8 **Action**: The Chief Operating Officer to review whether the planned cardiac theatre closure had been accounted for in the figures presented to the Board and to provide a specialty wide report on the subject.

299.9 Mr Lomas challenged whether it was correct that graphs 19 to 21 on page 11 should show 100% against the National target.

299.10 Ms Dalton confirmed that this information was correct, and explained that this information had previously not been provided for the Board as the Trust always met the targets. However Monitor had requested that the Executive demonstrate this information to the Board, so it would be included from now on.

299.11 Ms MacLeod noted that it was good to have these figures as it was important to demonstrate success.

299.12 In response to Mr Lomas' query as to why the CATs patient refusal number in November was so high, Ms Dalton informed the Board that it was due to winter pressures on the service.

299.13 Professor Elliott challenged as to whether this would be a performance indicator for the Trust or region wide.

299.14 Ms Dalton clarified that these refusals took place on the day that the Trust is identified as the centre for retrievals for the region and when there are not sufficient beds available. Refusals were also counted when the Trust was specifically requested by the referring hospital but was unable to take the patient.

299.15 Dr Collins noted that the figures were a good indicator for unmet need and demand.

299.16 Mr Lomas challenged that it was not only the winter months that showed levels for concern.

299.17 Ms Dalton responded that these figures would inform the case, for example, of a new bed or money to enable additional staffing hours. The figures would also inform the upcoming ICU Review.

299.18 Dr Collins noted that graph 27 showed that more patients would like to be treated at Great Ormond Street, which supported the Trust's growth model.

299.19 Mrs Newton queried whether all of the referrals were clinically appropriate and Ms Dalton confirmed that they were.

299.20 Ms MacLeod noted that the targets for central venous line related blood-stream infections were high and queried whether unrealistic targets were being set.

299.21 Professor Elliott agreed that this was a fair challenge and that targets should be reviewed annually, but that the Trust needed to have a high level of

ambition.

299.22 Mr Ripley noted his concern at the number of red actions.

299.23 Baroness Blackstone agreed with Mr Ripley and challenged why issues remain consistently red, for example the discharge summary completion.

299.24 Ms Dalton acknowledged the concern of the Board and noted that the solution had been discussed previously. The introduction of the electronic patient records would be the way forward.

299.25 Ms Dalton noted that a lot of improvement had been made, for example the completion of discharge summaries for 80% of patients within 24 hours compared to less than 30% in 48 hours last year.

299.26 Mr Ripley requested that additional trajectories be included in the report to indicate whether the Trust was on track to meet the target.

299.27 Baroness Blackstone agreed that this would be helpful and asked that Ms Dalton review all red graded targets. Mrs Newton noted that the addition of consequences of not meeting the targets would also be useful and the Board agreed.

299.28 Baroness Blackstone also queried whether there were too many key indicators.

299.29 Professor Copp challenged that there was no change to the research indicators which was disappointing as this information informed the process of grant applications and award. Professor Copp requested that more information be included, for example annual targets, the amounts of money awarded to grants and the number of publications produced each year.

299.30 **Action:** Chief Operating Officer to review the overall number of key indicators; the appropriateness of target levels; the inclusion of additional trajectories to map progress with those graded as red; and inclusion of the consequences of not meeting the targets.

299.31 The Board **noted** the report.

300. Finance and Activity Report (November 2011) including analysis of trend in staff and agency costs

300.1 The Chief Finance Officer, Mrs Claire Newton presented the report that summarised the Trust's financial performance for the eight months to 30 November 2011.

300.2 Mrs Newton reported that further analysis of the impact of clinical activity was required to fully understand the complete risk of the implications of this activity. Mrs Newton stated that she would like to provide a detailed report of this analysis at the Trust Board in January and the Board agreed.

300.3 **Action**: The Chief Finance Officer to provide analysis of the impact of clinical activity to the Trust Board in January 2012.

300.4 Mrs Newton reported that the level of pay remained a concern along with the

use of agency staff, noting that an appendix regarding the use of agency staff was attached.

300.5 Mr Lomas drew the attention of the Board to the figures of revenue (up 4%) and the cost of labour (up by almost 6%) noting his concern that this situation was not sustainable for the future.

300.6 Baroness Blackstone queried whether the pay overspend was due to the use of agency staff?

300.7 Mrs Newton clarified that some of the overspend was due to agency use, however it was also a question of need. Agency staff could be used to enable quick expansion in a service to meet internal targets such as 'No Refusals'. However, in investing in the use of these staff, the expectation should be that the return from the use of these staff should be greater than their cost.
Mr Lomas stated that it was important to look at what was being done differently this year compared to last, to cause a 5.7% increase in pay.

300.8 In response to Baroness Blackstone's query as to the process in place to agree additional clinical appointments, Dr Collins confirmed that a business case was made in each instance.

300.9 Mr Lomas noted that the issue of temporary versus permanent staff was not important and that emphasis should be placed on the fact that there was too many staff in total.

300.10 Mrs Newton reminded the Board that there were two dates agreed for January 2012 for the Board to meet and discuss these matters in detail.

300.11 The Board **noted** the report.

301. Foundation Trust Update

301.1 The Board **noted** the report.

302. Patient and Public Involvement and Patient Experience (PPIE) update report

302.1 Mrs Liz Morgan, Chief Nurse and Director of Education introduced the report as a summary of the patient and public involvement work that had been undertaken to date.

302.2 Mrs Morgan reported that a new strategy was under development that would simplify the Trust's intention with regards development of patient and public involvement work and would be brought before the Board in due course.

302.3 Mrs Morgan informed the Board that following a restructure of the team, a Patient Experience Liaison Officer post had been created and had proven extremely successful in supporting the Clinical Units in their patient and public involvement work. Mrs Morgan reported that the person in post had already made a significant impact, encouraging much more active involvement and enabling piloting of schemes for example, a real time patient experience system.

302.4 The Board **noted** the report.

303. GOSH Child Protection Update Report December 2011

303.1 Mrs Liz Morgan, Chief Nurse and Director of Education presented the summary report to update Trust Board on current Safeguarding/Child Protection initiatives.

303.2 Mrs Morgan reported that the action plan had been adapted following feedback from the last update to the Trust Board. Actions had now been classified as green if the target has been achieved, the use of amber indicating that the target was on track to achieve by end of year. Finally, red signified that the Trust was not on track to achieve the target.

303.3 Mrs Morgan was pleased to report that there were no targets categorised as red.

303.4 Mr Ripley thanked Mrs Morgan for the clarification of red, amber and green.

303.5 Mr Ripley queried whether any of the amber targets would be achievable in the next three to four months.

303.6 Mrs Morgan noted that point 4 of the report (item 6 on CP Action Plan) may be achievable, but that this would be informed by the Munro recommendations when they were published.

303.7 In response to Baroness Blackstone's query as to whether the Munro review would have a significant impact, Mrs Morgan reported that only minor changes are expected.

303.8 The Board **noted** the report.

304. Management Board – November 2011 Minutes

304.1 Dr Collins presented the minutes of the meeting of Management Board from November 2011.

304.2 Mr Lomas requested an update of the ICU Review. Professor Elliott stated that the report was being finalised and would be sent to the Trust early in 2012.

304.3 The Board **noted** the report.

305. Trust Board Members' Activities

305.1 There were no activities to report.

306. Consultant Appointments

306.1 Baroness Blackstone informed the Board of the names of the consultants appointed since the last meeting in November:

306.2
- Dr Rakesh Amin Endocrinology
- Dr Liina Kiho Histopathology
- Dr Keith Sibson Haematology

306.3 The Board **ratified** the appointments.

307. UCL Partners Board Minutes November 2011

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

307.2 The Board **noted** the report.

308. Any Other Business

308.1 There were no items of any other business.

309. Date of the Next Meeting

309.1 The date of the next meeting of the Trust Board was confirmed as 25th January 2011.

ATTACHMENT I

Attachment I

TRUST BOARD - ACTION CHECKLIST
25TH January 2012

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
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 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.	AF	Post FT Authorisation	Not yet due
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	April 2012	Not yet due
293.6	21/12/11	The Chief Operating Officer to circulate the presentation on future plans for development of the Trust's strategic objectives to the Trust Board.	FD	January 2012	Completed – emailed on 18th January 10 Trust Board

Attachment I

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
293.12	21/12/11	The Chief Operating Officer to make changes to the education objective (objective 4) to reflect the current drivers for improving education services at GOSH.	FD	January 2012	Will be changed as agreed for Strategic Objectives 2012/13
295.4	21/12/11	The Chief Operating Officer to include a one page summary for the Performance Management Strategy and Business Planning Strategy.	FD	January 2012	Completed – in final version of strategy
295.6	21/12/11	The Chief Operating Officer to ensure that multi-cycle and yearly cycles are clearly stated in the annual plan.	FD	January 2012	Will be included in 2012/13 Annual Plan
295.9	21/12/11	The Chief Operating Officer to add a section on external performance monitoring in the Performance Management Strategy.	FD	January 2012	Completed – in final version of strategy
295.10	21/12/11	The Chief Operating Officer to ensure that more overt links be included in both strategies around Patient Involvement and Experience as well as Education and Training.	FD	January 2012	Completed – in final version of strategy
296.10	21/12/11	The Chief Finance Officer to add timescales to the data quality good practice standards action plan	CN	January 2012	In progress – to report back to the Audit Committee in February 2012
298.18	21/12/11	The Chief Finance Officer to review the Terms of Reference of the proposed Finance and Investment Committee in an effort to reduce membership, streamline its scope and provide clarity as to the relationship of this committee with the Audit Committee.	CN	February 2012	Not yet due
299.9	21/12/11	The Chief Operating Officer to review whether the planned cardiac theatre closure had been accounted for in the figures presented to the Board and to provide a specialty wide report on the subject.	FD	January 2012	On agenda under Performance Report

Attachment I

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
299.30	21/12/11	The Chief Operating Officer to review the overall number of key indicators; the appropriateness of target levels; the inclusion of additional trajectories to map progress with those graded as red; and inclusion of the consequences of not meeting the targets.	FD	January 2012	On agenda under Performance Report
300.3	21/12/11	The Chief Finance Officer to provide analysis of the impact of clinical activity to the Trust Board in January 2012.	CN	January 2012	On agenda

Attachment J

<table>
<tr><td colspan="2">Trust Board Meeting
25th January 2011</td></tr>
<tr><td rowspan="2">Reporting Zero Harm - Quality, Safety & Transformation (QST) Update

Submitted on behalf of
Fiona Dalton
Martin Elliott</td><td>Paper No: Attachment J</td></tr>
<tr><td>Date considered by Management Board: 19th January 2012</td></tr>
<tr><td colspan="2">Aims / summary
Part I – Status update on the high level measures.
Areas of note:
QST have recruited 2 new risk managers to support the new structure
Review of all risk action plans to give a cross cutting view being undertaken by QST team to ensure common themes addressed at clinical unit level.
Part II – First monthly rotation of Transformation, Safety & Outcomes, with focus on Transformation.
Areas of note:
A sustained improvement in central venous catheter line (CVL) infections from 3.02 to 1.97 per 1000 line days.
A sustained improvement in hand hygiene audit results from 75 to 83 per cent compliance. CVL bundle compliance rate has improved from 51 to 60 percent.
SSI surveillance process is now in place and the data is now at a point where statistical process control (SPC) charts can be produced
Medicines Management has been a challenge in 2011 and the recruitment of a Medicines Management Improvement Specialist will support this project for 2012.
Advanced Access – 32 specialties working on this project. 8 specialties are currently achieving, with the majority planning to achieve by end March 2012. 6 specialties do not think they will be ready by March 2012.
Each Clinical Unit is currently undertaking a project to improve the quality of Medical Records.
WHO Safety Checklist has increased from 56 per cent to 87 percent with particular improvement showing in surgical specialties.
Theatre utilisation has reached target until a period at the end of the year where there has been a drop from 78 to 72 per cent (still above target). This is being investigated, but is likely due to bed shortages.</td></tr>
<tr><td colspan="2">Action required from the meeting To note, approve and support.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
Delivering No Waits, No Waste, Zero Harm.</td></tr>
<tr><td colspan="2">Financial implications Theatre utilisation could have impact on CRES plans. This is to be investigated further.</td></tr>
<tr><td colspan="2">Legal issues None</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? All Transformation work has been delivered to Transformation Board with 2 parent representatives as members.</td></tr>
<tr><td colspan="2">Who needs to be told about any decision N/A</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales Head of Quality, Safety & Transformation</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
Co-Medical Director and Chief Operating Officer</td></tr>
<tr><td colspan="2">Author and date Katharine Goldthorpe, 13th January 2012</td></tr>
</table>

Attachment J

Great Ormond Street Hospital for Children NHS Trust

Quality, Safety & Transformation
Reporting to Trust Board
January 2012

The following Zero Harm report produced by the Quality, Safety & Transformation (QST), shows updates for Zero Harm (Part 1) and a progress report for Transformation (Part II)

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

Part I

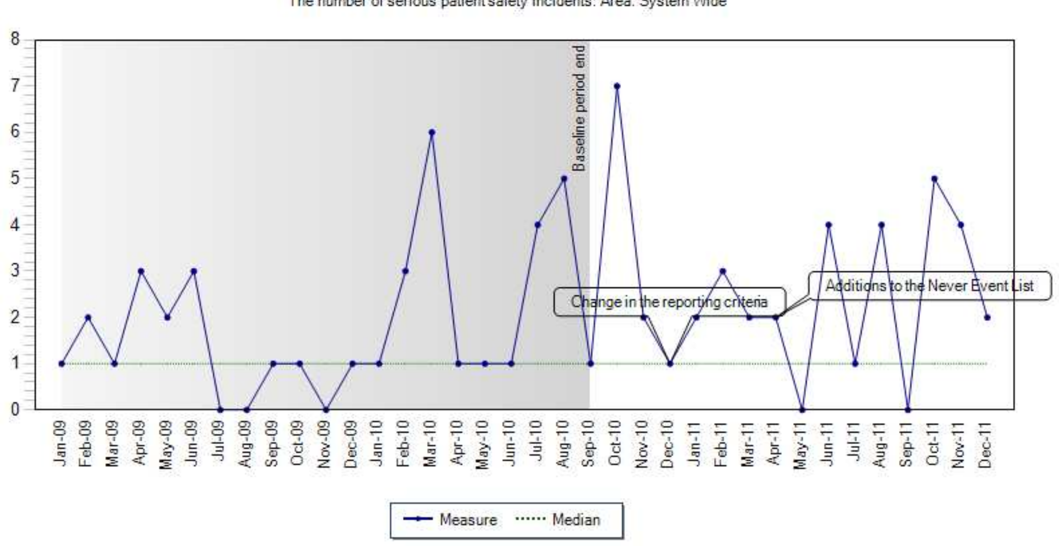
Zero Harm Indicators

The first part of the report provides Trust board with a status update on the agreed high level measures. In future, this will become an appendix and the board will be provided with a highlight report which shows areas of improvement or challenge.

1. SI report

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

Update

- QST have recruited 2 new risk managers who will be based in the central QST team and will work directly with the Clinical Units to identify areas of concern. Interviews for a 3rd risk manager will take place in January.
- Review of all actions plans to give a cross-cutting view will be undertaken by the QST team to ensure common themes are addressed using an improvement approach where appropriate. The risk managers, improvement managers/co-ordinators and patient safety officers will work at clinical unit level to ensure actions are implemented.
- Meetings scheduled with General Managers and Head of QST and Assistant Head of QST for Risk to discuss their requirements to support them with managing their safety agenda.

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.

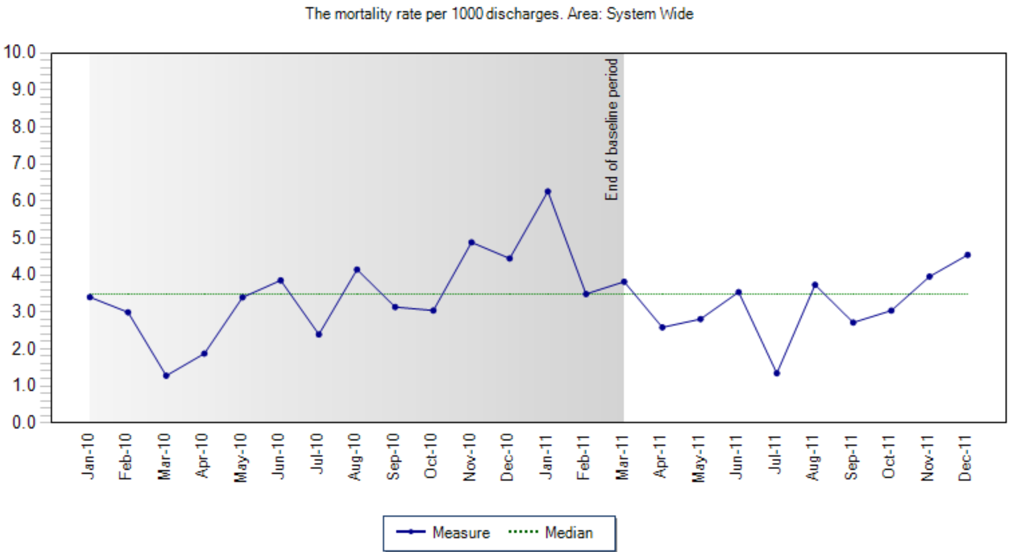
In 2012, the QST team will be undertaking work with the clinical units to address the actions and recommendations from incidents and complaints. This will be presented to Trust Board as part of the Safety report.

Note: The actual number of complaints and incidents per month is included in the key performance indicator 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.

Note: The actual number of deaths per month is included in the key performance indicator report

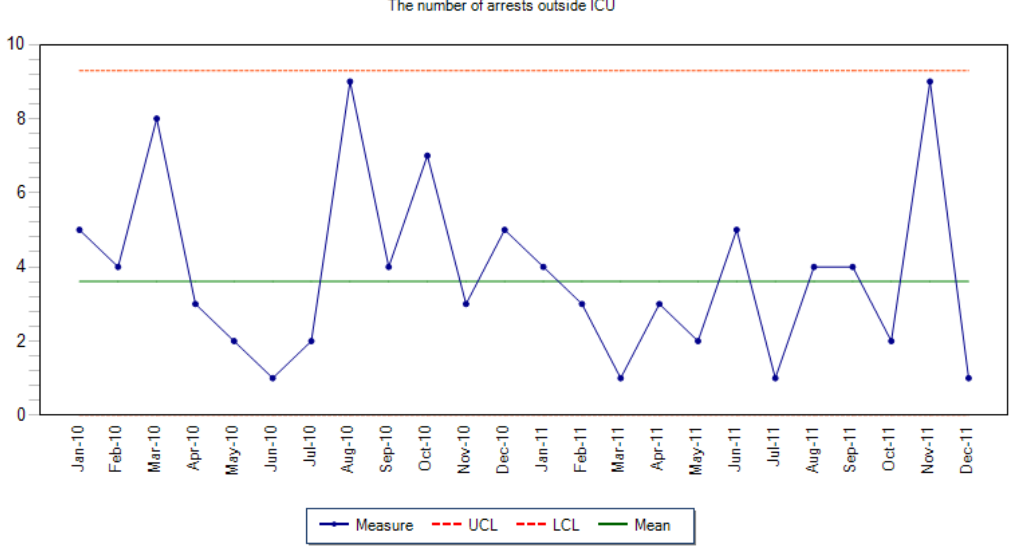


4&5 Arrests and crash calls outside Intensive Care Units (ICU)

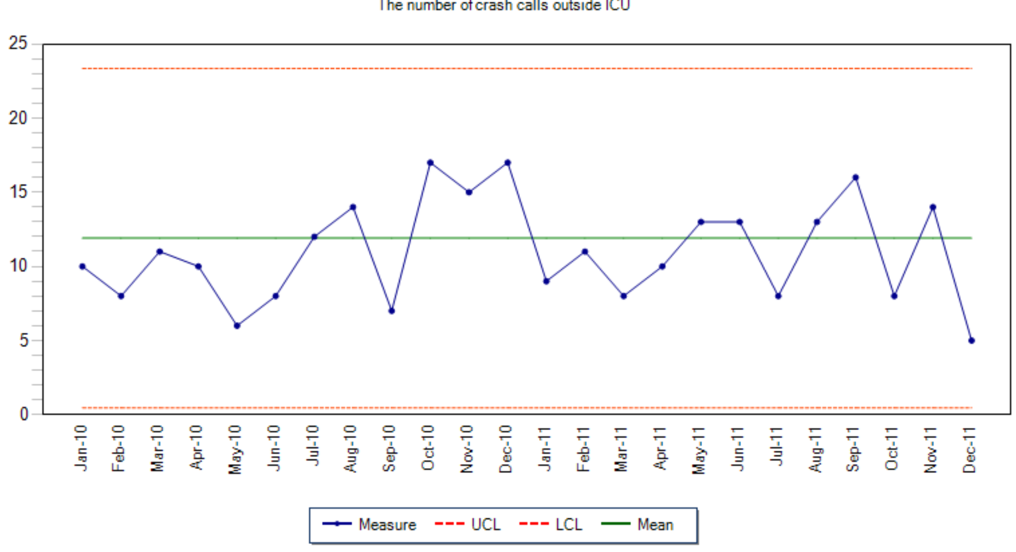
The SPC charts below show the number of arrests and crash calls outside the ICU areas.
Key to tackling this is the work undertaken through the Deteriorating Child project. The aim of this project is to reduce harm from deterioration, more specifically to reduce the number of cardiac arrests by 50 per 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

Update – see Part II Transformation for update on Deteriorating Child Project

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.

Update – see Part II Transformation for update on Infection Control

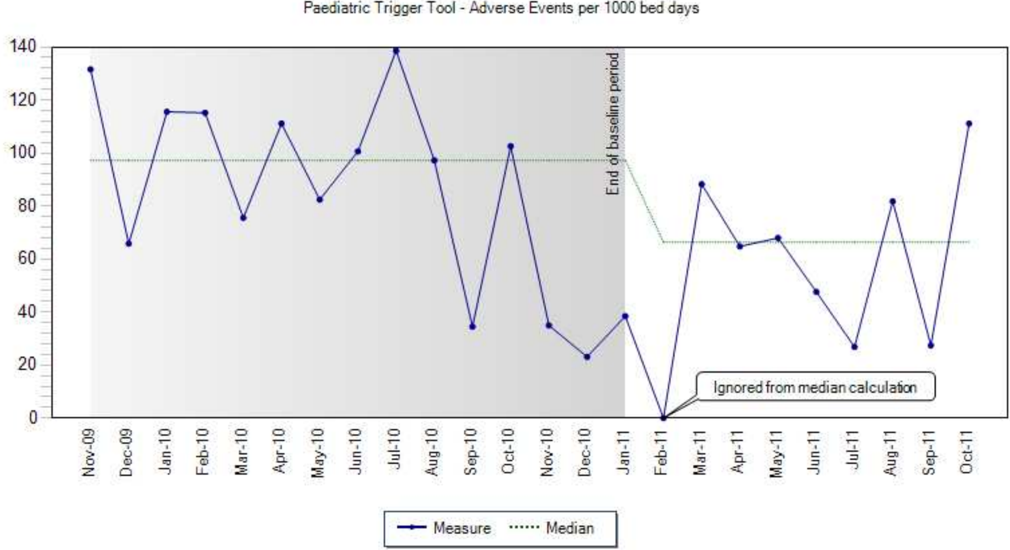
5. Combined harm index (Under development)

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.

- Meeting with CCHMC leads to be planned for January 2012. The purpose of the meeting is to further understand the use of the measure at CCHMC and the benefits for GOSH.

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

Update – see Part II Transformation for update on improving Medical Records

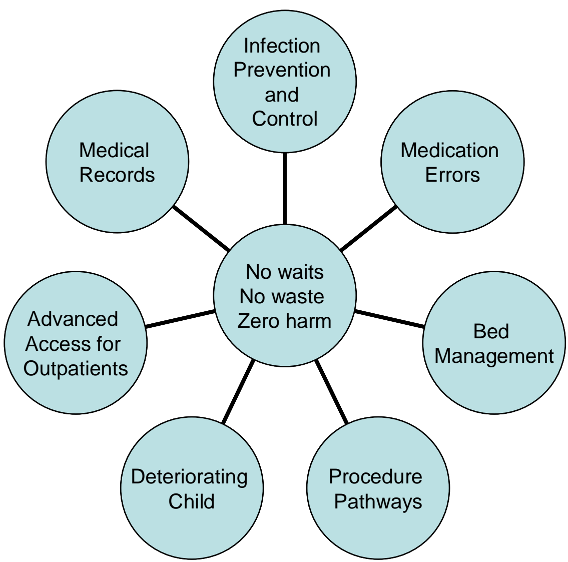
Part II

Monthly rotation of Transformation, Safety & Outcomes progress

This is the first month of rotation of Transformation, Safety & Outcomes progress and with the focus on Transformation.

Reporting the breadth of work being undertaken through Transformation presents a challenge. With around 100 different projects and 150 measures of information, it is not easy to capture in a single document all the changes that are happening. This report highlights some particular areas of merit, challenge and will provide an overall assessment of Trust wide Transformation priorities.

Trust Wide Transformation Priorities



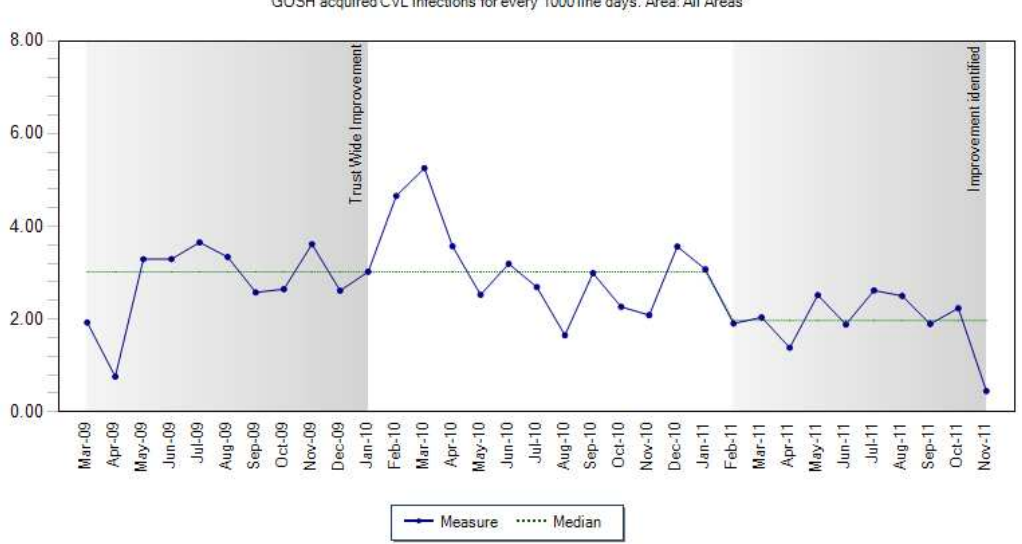
1. Infection Prevention & Control

With a high level aim that infection would decrease by 50 per cent year on year, in 2011 the Clinical Units agreed that they would:

- *1.1 Reduce the number of GOSH-acquired central venous line (CVL) infections*
- *1.2 Improve hand hygiene audit results and CVL bundle compliance*
- *1.3 Reduce the number of Surgical Site Infections (SSI) in Spinal, Cardiothoracic, Neurosurgery, Craniofacial and Urology specialties.*
- *1.4 Reduce the number of ventilator-associated pneumonia (VAP)*

1.1 Reducing GOSH-acquired central venous catheter line (CVL) infections

In 2011 there has been a significant improvement in the number of CVL infections per 1000 line days from 3.02 to 1.97 per 1000 line days. Although the aim of 1.5 CVL infections per 1000 line days has not been achieved, there has been a significant, sustained change.

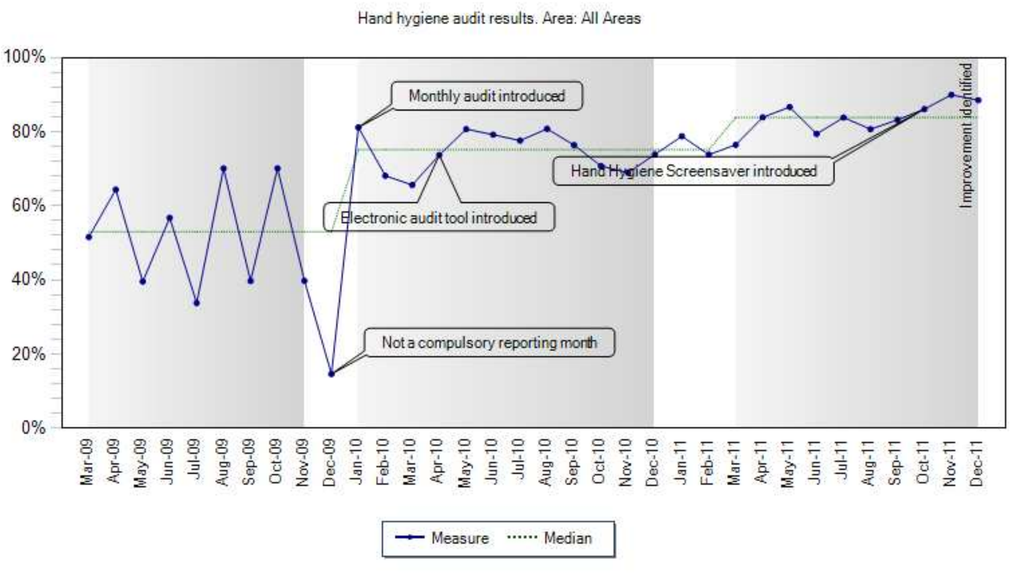


How do we plan to improve in 2012

Clinical Unit teams will be supported by the appointment of an Infection Control Practice Educator from who joined the Trust in November 2011 and priority will be given to training and education. Root cause analysis (RCA) are undertaken for all *Staphylococcus aureus* bacteraemia.

1.2 Improve hand hygiene audit results and CVL bundle compliance hand hygiene audit results

There has been a significant improvement in compliance with hand hygiene audits from 75 per cent to 83 per cent compliance. CVL bundle compliance rate Trust wide has improved from 51 per cent to 60 per cent. However, for bundle compliance data is not always consistently collected at ward level so we should not draw any firm conclusions with this measure but continue to encourage better data collection.



How we plan to improve in 2012
Work has already started to take hand washing to the next level in 2012. The Infection Control Practice Educator will be working with front line teams to really get underneath the problems and learning from the areas that have progressed well already. Mapping the steps a member of staff might take is one initiative, to ensure that at every "touch point" the facilities are available to wash their hands – making the right thing to do easy to do.

1.3 Reduce the number of surgical site infections (SSI) in Spinal, Cardiothoracic, Neurosurgery, Craniofacial and Urology specialties

The Trust plan to reduce SSIs is based on the introduction of systematic SSI surveillance with regular team feedback, review of serious infections or episodes of increased incidence and the introduction of a standard care bundle. Collecting data on SSI may be performed from within the Clinical Unit team's current multidisciplinary audit process (for Urology or ventriculoperitoneal shunt infection in neurosurgery) or by the newly established SSI surveillance team (for Spinal, Cardiac, Neurosurgery, Craniofacial and Thoracic).

An inpatient and post-discharge surveillance process and bespoke database have been developed to allow the collection, analysis and display of the SSI data. This data is almost at a point where SPC charts can be produced.

How we plan to improve in 2012
In 2012 we plan to establish baseline surveillance data in all surgical specialties and continue development of the care bundles. Although we know there is work being undertaken on the front line, we have identified more needs to be done in some areas. The new Practice Educator for Infection Control has already met with Improvement Managers and Co-ordinators to address this.

1.4 Reduce the number of ventilator-associated acquired pneumonia (VAPS)

At GOSH in 2011 regular systematic VAP surveillance was not planned on all Intensive Care Units, although limited surveillance did not detect cases on Neonatal or Paediatric Intensive Care using established criteria. All ICU areas have implemented the paediatric VAP care bundle, however no formal audits have been undertaken. A project for 2012 is to add the VAP care bundle to the existing electronic audit tool to facilitate regular auditing (if resources are available).

2. Medication errors

In 2011, the Clinical Units agreed the high level aims for reducing medication errors:

2.1 Medication Errors (except high risk drugs) – 25 per cent reduction year on year
2.2 Medication Errors (high risk drugs) – 100 per cent reduction

2.1 Medication Errors (except high risk drugs) – 25 per cent reduction year on year

JAC e-prescribing is the system that has been rolled out across the Trust (excluding the ICUs) over the last few years. This system holds a wealth of data that is valuable for operational reporting, research and financial reporting as well as for use in improvement work. One of the challenges faced is how the data are extracted. Work is currently being undertaken by Information Services at GOSH to support this. Currently, there is no single graph that shows the overall reduction as an organisation, as each area is measuring different things.

Each unit is keen to collect more detailed data for prescribing errors, down to patient and drug level data. PICU, NICU, Fox, Robin, Lion, Elephant and IPP are all attempting to use the same classification for prescribing errors. ICI-LM are piloting a data collection tool in January, which will enable accurate, timely and efficient collection of prescribing errors. This is with a view to use the same tool for all wards.

A Medicines Management Improvement Specialist has joined the Trust in January 2012 to support the Medication Errors project.

2.2 Medication Errors (high risk drugs) – 100 per cent reduction
Much work has been undertaken to address improving medication errors for high risk drugs, such as clinical practice guidelines have been written for prescribing insulin and individual areas are tackling their own issues.

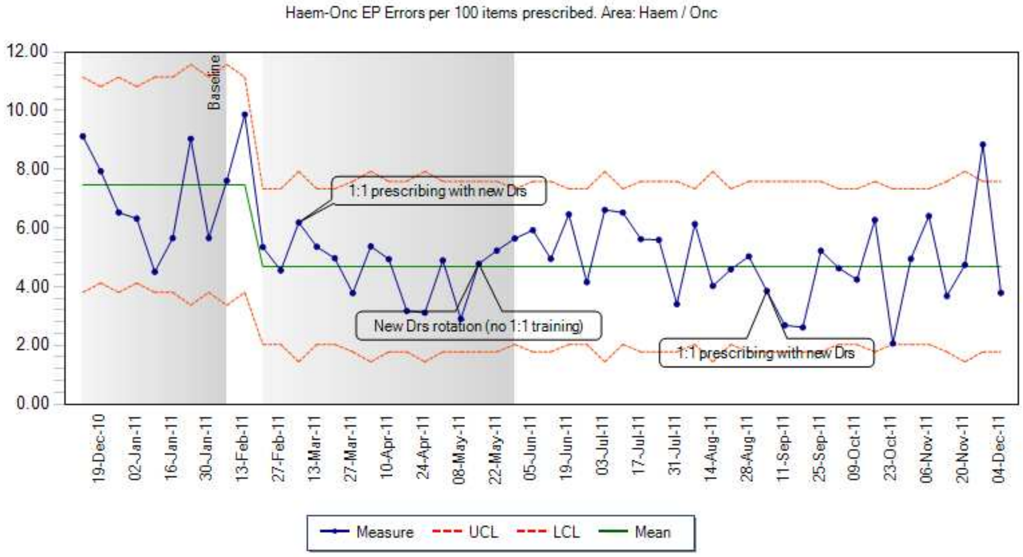
As an example, Haematology and Oncology wards prescribe a large number of high risk medications and the consequences of prescribing errors are significant for patients. By employing the principles of high reliability prescribing, they are working towards a reduction in prescribing errors.

Key interventions have been:

- Daily capture of prescribing errors for each patient every day
- Medication history checked by pharmacists within 24 hours of admission
- Immediate one to one feedback and correction of errors
- Pharmacists to act as 'watchers' – feeding back themes to ensure local action and making interventions before errors occur.
- Discharge counselling for parents regarding medications

Next steps

- Focus on out of hours interventions
- Examine specific recurring themes with particular drugs, including high risk drugs (Amikacin and Vancomycin) and ensure the 'desired outcomes are the default'.
- Share learning with other areas who prescribe high risk drugs.



3. Advanced Access for Out Patients

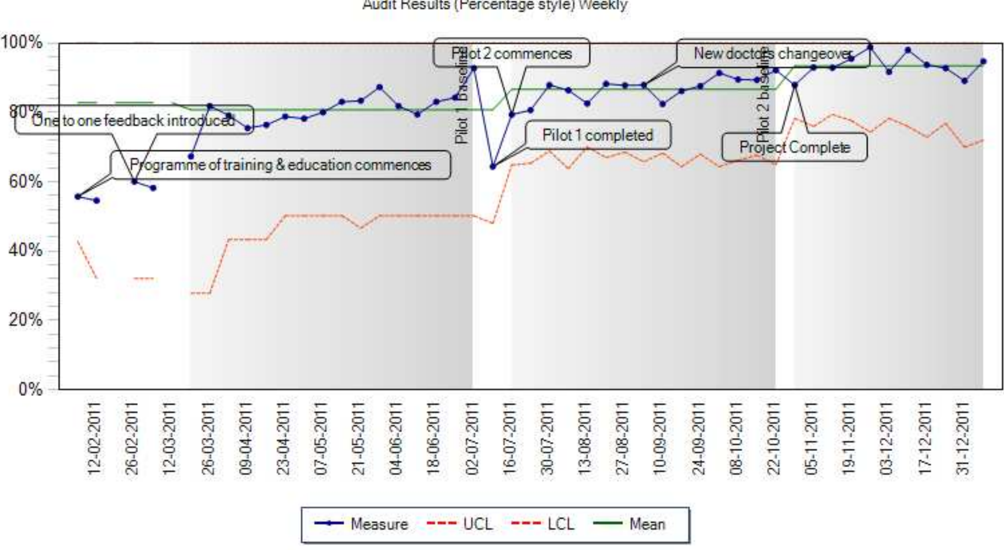
Advanced Access for Outpatients means that by end March 2012, all patients should have a first appointment within two weeks of referral, where clinically appropriate.

All 32 specialties that are eligible for Advanced Access have been working through a number of recommended steps to help them achieve the two week target. 8 specialties are currently achieving Advanced Access, with the majority of clinics planning to achieve by the end of March 2012. There are 6 specialties that do not think they will be ready by March 2012, 3 of which have dates to deliver and three are still working on their plans. The Executive Sponsor is working closely with them to support delivery.

4. Medical Records

Each Clinical Unit has added a project to improve the quality of Medical Records to their project plans. As an example of where it has worked well, Cardiorespiratory Clinical Unit undertook a project to achieve 80 per cent audit compliance with the Trust's medical notes standard.

Baseline date was obtained during November and December 2010, showing an overall compliance rate of 66.98 per cent and the project rolled out across the whole clinical unit. By the conclusion of the project, overall audit compliance rate of all 5 cardiorespiratory wards was 87 per cent, which has subsequently been improved upon with the current compliance rate being 93 per cent



The success of the project was attributed weekly audits, one to one feedback, education and peer support. To get to 100 per cent, there needs to be a zero tolerance policy, with specialty leads ensuring staff are aware of the Trust's standard and staff training to be provided at induction and on an ad-hoc basis when requested. This learning will now be spread to other Clinical Units through the improvement managers and clinical improvement leads.

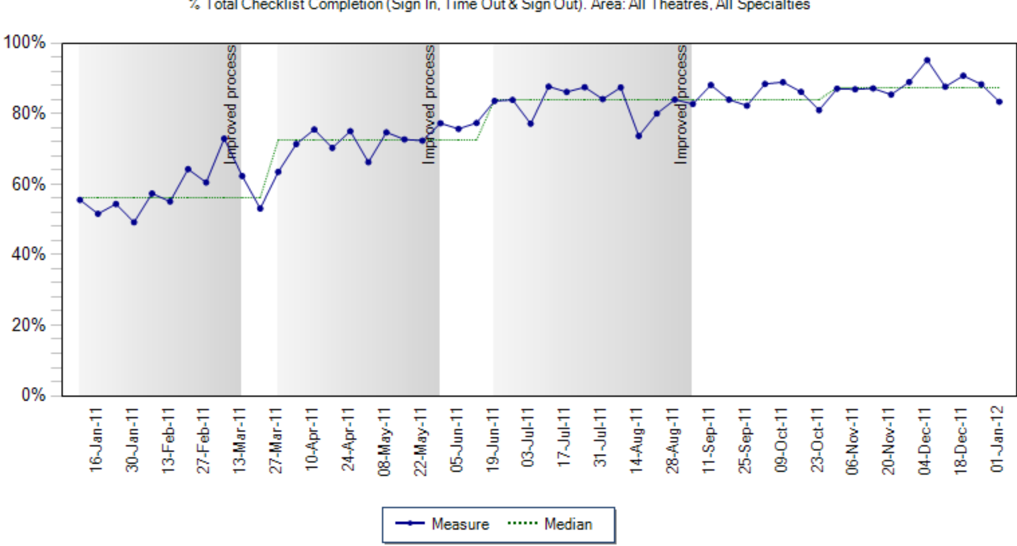
5. Procedure Pathways

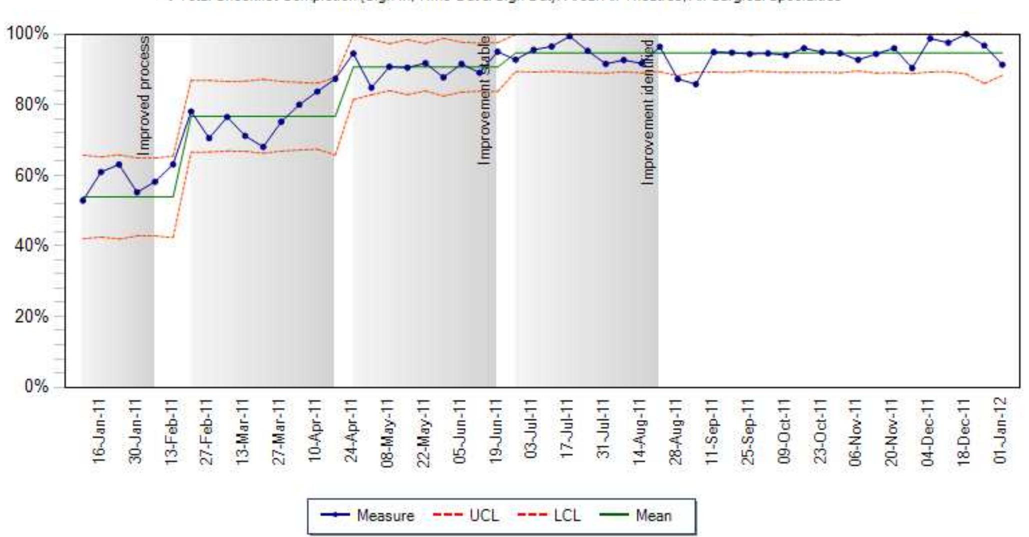
In March 2011, the Transformation Board outlined 5 objectives for 2011/12:

- *WHO Safety Checklist 100 per cent completion*
- *Increase theatre utilization*
- *Implement pre-assessment*
- *Improve access to theatres for non elective cases*
- *Improving the MRI patient journey*

WHO Safety Checklist

Total WHO Safety Checklist completion has increased from a median of 56 per cent to 87 per cent since the beginning of 2011 across the whole Trust. The project is now focusing on particular areas where this has proved harder to implement. Actions to continue improvement include a focus on those areas that have proved harder to implement, Safety Checklist training video and escalation of non-compliance to the Medical.



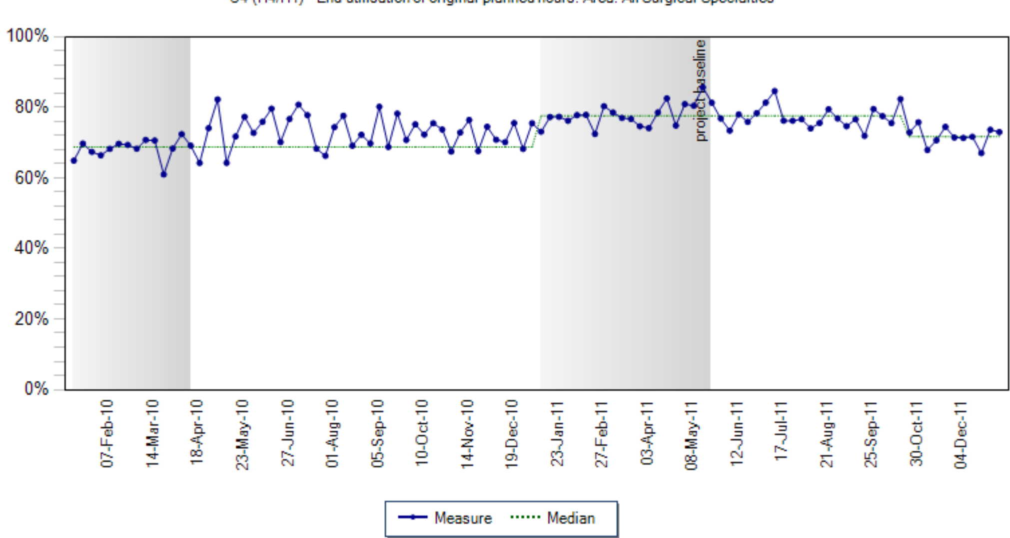


Theatre Utilisation

The original stated aim of the theatre utilization project was to deliver an average utilisation of planned hours of 70 per cent during 2011 for All Surgical Specialties, and 77 per cent by end 2012.

As a whole, this group of specialties baselined and then sustained an average of 78 per cent, until a brief period toward the end of the year, where we have seen a drop to 72 per cent from 23rd October. This new mean will continue to adjust as we add further data to make up a new process average heading into 2012. It is likely that this drop is due to bed capacity and this is currently being investigated by the procedure pathway project group. The data is being analysed at specialty level and specific action plans are being developed. It should be noted that this is potentially a project which delivers efficiency savings and this drop could potentially have an impact.

All units and specialties have action plans in place to either sustain (if already delivering over 77 per cent) or increase utilisation to meet the Trust 2012 target of 77 per cent. Units will focus on specialty specific action plans to optimise list bookings, start and finish times, turnover, and minimise cancellations based on the demands and limitations of each patient cohort and service.



Pre-operative Assessment

The Pre-operative Assessment project is tasked with developing and implementing a standardised service providing equitable access for all GOSH patients being admitted for any procedures. In November 2011, a Lead Nurse for Pre-Assessment was appointed and started a pilot service, with an anaesthetist in place every afternoon to see patients who require additional support and assessment prior to admission. Over the course of 2012, this service will be expanded to cover all specialties and units.

Access to Theatres for non-elective cases

This project works to ensure non-elective patients are able to access theatres when they need to. Clinical protocols as to what kind of patient and procedure should fall into each category has been drawn up and agreed. The project group has been measuring what time patients are booked and what time they get to theatre. They have now baselined two months' data and are investigating the outcomes for those cases that did not meet the target.

Improving the MRI patient journey
Currently, we know that not all patients receive an MRI as quickly as they should do. This project aims to improve the per cent of patients (emergency, urgent, planned and routine) who receive their MRI within an agreed, acceptable timescale. This project entails the Cardio-Respiratory and MDTS Clinical Units working together to understand how to improve utilisation, reduce waiting times and improve the service offered to all patient groups. The MRI Superintendent Radiographer has been seconded for three days a week as the Project Manager for the MRI Project.

6. Bed Management

The aim of this project is to develop a real-time bed management solution which will optimise access to specialist inpatient services, ensuring an appropriate referral is never declined due to insufficient bed availability.

Work has been undertaken to standardise referral procedures and acceptance criteria.
To do this, a web-based Electronic Patient Referral form is being piloted by the Bed Management Team.

The Bed Management policy has been reviewed and relaunched. Key personnel have received training in relation to bed management and escalation procedures when there is limited bed availability across the Trust.

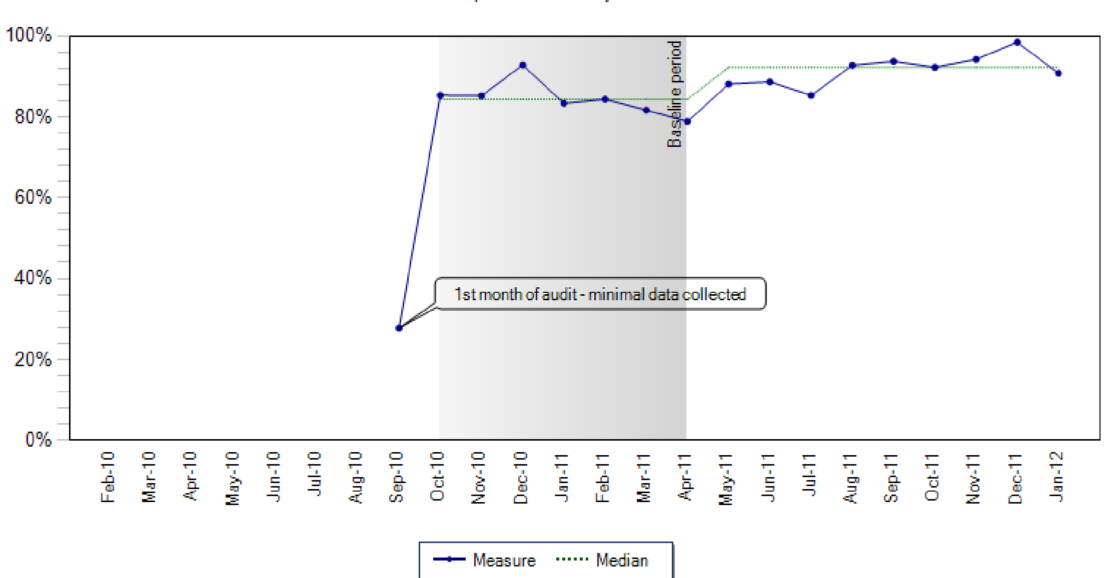
Further work has being undertaken to develop the specification for a real time information system to identify whether a bed is occupied / funded / resourced / clean etc, the level of dependency of each patient as determined by their CEWS score and the patient's estimated discharge date. A group are now examining this specification to identify the most appropriate bed management tool and delivery dates for this will be discussed at the January Project Group.

7. Deteriorating Child

The overarching aim of the Deteriorating Child 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 use of CEWS, audited with a random sample of over 100 patients each month

GOSH is also part of the UCL Partners deteriorating patient quality improvement programme whose aim is to reduce the number of cardiac arrests by 50 per cent within one year. GOSH are leading the paediatric work stream and supporting the overall programme through training and data processing.

Summary

Good progress continues in most areas of the Transformation programme, with projects that are in exception being reported to and supported by Transformation Board.

In 2012, the QST will continue to provide the Trust Board with a monthly highlight report for the Zero Harm Indicators.

Transformation will report progress and highlight areas of achievement and challenge in their next quarterly report to Trust Board.

The next QST report will provide a Zero Harm highlight report and progress report on Safety to include SI, complaints and risk.

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

25th January 2012</td></tr>
<tr><td rowspan="2">Quality Strategy

Submitted on behalf of:

Professor Martin Elliott, Co-Medical Director</td><td>Paper No: Attachment K</td></tr>
<tr><td>Date reviewed by Management Board:

19th January 2012</td></tr>
<tr><td colspan="2">Summary
The Quality Strategy has been revised to better reflect the core values of the Trust, to align the style more effectively with the annual Quality Account, to clarify governance and accountability arrangements after the integration of the quality, safety and transformation teams and to describe 3 and in some cases 5 year goals. Revised monitoring and reporting arrangements are also described.</td></tr>
<tr><td colspan="2">Action required from the meeting
The Trust Board is asked to consider and approve the Quality Strategy.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
The Quality Strategy describes and underpins all the Trusts core values, emphasising the importance of quality, safety, effectiveness and efficiency.</td></tr>
<tr><td colspan="2">Financial implications
None</td></tr>
<tr><td colspan="2">Legal issues
None</td></tr>
<tr><td colspan="2">What consultation has taken place?
Q,S&T Team, Executive Directors</td></tr>
<tr><td colspan="2">Who needs to be told about the policy?
All Staff via Intranet</td></tr>
<tr><td colspan="2">Who is accountable for the monitoring of the policy?
The Quality and Safety Committee will monitor progress with implementation of the strategy</td></tr>
<tr><td colspan="2">Author and date
Professor Martin Elliott
16th January 2012</td></tr>
</table>

Attachment K

Revised Quality Strategy

Author; Martin Elliott (martin.elliott@gosh.nhs.uk)

Draft Version: 1.02

Date: 17th January 2012

Executive Summary

Great Ormond Street Children's Hospital believes completely in its motto ***"The Child First and Always".*** Everything the Trust does is devoted to improving the health of children and to the support of their families during what we know are difficult times. GOSH has always been at the forefront of developments in children's health care, and the Trust has engaged actively in developing new ways to deliver both higher quality and greater safety. It has become well known that hospitals are dangerous places, and that there is much work to be done to make them safe. In 2007, the Chief Executive, Dr Jane Collins, initiated a programme called ***"Zero Harm"***, committing the Trust to the identification of, progressive reduction of and ultimately the elimination of harm to children when under our care. Linked with similar work under the titles of ***"No Waits"*** and ***"No Waste"***, this programme was supported by an innovative process of Transformation, supported by extensive training and partnerships with, for example, Cincinnati Children's Hospital, Ohio, USA. This strategy builds on that experience and outlines the methods we will use to deliver quality control, and defines our long-term aims. National goals and metrics are, of course, incorporated into our plans, but our aim is to exceed those and to set standards, rather than simply respond to them.

The Trust also aspires to be one of the Top Five Children's' Hospitals in the World. To do so it must identify, validate and publish its clinical outcomes, and be able to benchmark those outcomes against its peers. The mechanisms by which the Trust intends to do this are incorporated into this Strategy.

We believe it is the duty of everyone who works in the Trust to make changes which will lead to better patient outcomes *(health),* better system performance *(care) better patient experience* and better professional development *(learning)*. We emphasise the importance the Trust places on quality and safety, embedding it deeply in our culture. It is our commitment to be one of the Top Five Children's hospitals in the world and to develop methods which allow us both to prove it and to exceed the expectations of our patients and their families.

Introduction

This Hospital is devoted to the care of children, young people and they and their families, are at the centre of our culture. The Great Ormond Street Hospital for Children NHS Trust (GOSH) intends to be one of the Top Five Children's Hospitals in the World. To demonstrate that it must place Quality and Safety (Q&S) at the top of its own agenda, and establish mechanisms for recording and benchmarking clinical outcomes. GOSH utilises the three key domains identified by Darzi (*Next Stage Review, DH 2008*), within which continuous improvement is necessary to achieve its goals. These domains, annotated by us to reflect our priorities, are;-

The creation of a safe, effective organisation delivering excellent service demands:- corporate commitment, clear lines of accountability and an infrastructure able to deliver to decision makers the necessary data in the most appropriate way at the correct time.

Corporate Commitments

- **The Trust Board will always place the Quality and Safety (Q&S) of clinical services as its top priority.**
- The Trust Board and Management Board will devote a minimum of **25% of their activity to Q&S.**
- The Trust is committed to **continuous improvement** in service, outcomes, processes and the monitoring thereof.
- The Trust will be preoccupied by **the prevention of failure**, and if it does occur, **learning** from it.
- The Trust will **celebrate success** in the delivery of improvements in Q&S.
- The Trust is committed to the **development of benchmarking** its performance against other internationally renowned Children's Hospitals.
- The Trust will, through its management structure and clinical leaders, ensure that **Q&S dominate thinking** at all levels of the organisation.

Accountability for Quality and Safety (Q&S)

Executive Level

- Ultimate accountability for Q&S must rest with Trust Board, exercised via the Chief Executive of the Trust
- Day to Day Accountability will rest with;
  - *for clinical Q&S*, the Co-Medical Director responsible for Q&S who also has executive accountability for the identification, collation and benchmarking of clinical outcomes
  - *for nursing care and patient reported experience measures*, the Chief Nurse (currently Ms Liz Morgan) who also has executive accountability for Child Protection & Education
  - *for operational and service issues,* the Chief Operating Officer (currently Ms Fiona Dalton)
  - *for monitoring and improvement methodologies,* joint accountability between the COO and the Co-Medical Director for Q&S, to ensure congruity between service and clinical needs.
  - *For developing appropriate multi-professional education programmes to support Q&S and Patient* Experience joint accountability Chief Nurse/Director of Education and Co-Medical Director (Med Ed)

Unit Level

- Accountability for Q&S at Unit level will rest with the Clinical Unit Chair, working with the Unit Patient Safety Officer, the General Manager and Head of Nursing

Speciality Level

- Accountability for Q&S will rest with the Speciality Lead

Infrastructure

Since our CEO introduced the Zero Harm agenda in 2007, a Transformation Team was established to improve systems of measurement, monitoring and change. There have since been many service and quality improvements. However, we have realised that the previous arrangement, of having a Patient and Staff Safety Team *separate* from the data management, analytic and change skills of the Transformation Team, was inefficient, and that the sum of the two could be greater than the individual parts. Thus, the two departments have been merged, and many, previously central, transformational tasks have been devolved to the clinical units. The new arrangements, which provide the core infrastructure to support the continued improvement of quality and safety, are shown in Figure 1.

The Quality, Safety and Transformation (QS&T) team will facilitate the Strategy. The analysts in the team will collate, analyse and present data from multiple data sources including major Trust systems (usually via the Data Warehouse) and locally collected data to populate the dashboards presented on the QS&T website, which they will also administer. These dashboards will be freely visible throughout the Trust and be used to present relevant safety and efficiency data to Units and Boards. Other members of the QS&T team will maintain the complaints and incident reporting mechanisms and provide regular reports to Units and Boards. The reporting of clinical outcomes (see below) will also be collated and presented via this group, employing a dedicated outcomes manager and defined outcomes group. The Q,S&T team will also prepare and deliver training in relevant methods including transformation, human factors, incident and complaint reporting and the use of Datix, our system for recording this work.

Q,S&T will provide a monthly report to Trust Board, but will rotate the primary topic so that each area will effectively report quarterly to Trust Board. More detail regarding reporting is included in the text.

Zero Harm

Zero Harm is the part of the strategy aimed at minimising harm to patients; safety improvement. We aim to achieve zero harm, but recognise that this will be a long process. However, we are committed to reducing harm year on year, and to doing so as rapidly as possible.

Overall Aim of the Zero Harm programme

The *Zero Harm* programme aims to ensure that the patient receives the correct treatment or action the first time every time. This will be measured by the decrease in harm as measured by the Paediatric Trigger Tool (PTT) and by individual measures in specific programmes. This tool was developed by the NHS Institute for Innovation and Improvement, in collaboration with a number of NHS children's hospitals, including GOSH. The tool helps staff to measure and understand the nature of any harm that takes place in the hospital. We can use this information to develop interventions which aim to improve the safety of children being treated.
The medical records of 20 randomly selected patients are reviewed on a monthly basis using the Paediatric Trigger Tool. Any themes of harm identified are therefore applicable to the whole hospital. In conjunction with Cincinnati Children's Hospital we are developing a Zero Harm Index which we hope will provide an even stronger tool for reporting the incidence of harm than the PTT. Validation of this method will take place over the next three years.

In addition to using the PTT to identify safety areas for improvement, we review National targets and campaigns, and feedback from staff, parents and our commissioners.

The implementation of the Zero Harm component of the strategy follows the interventions recommended by the Patient Safety First Campaign. The elements of the campaign are:

- Leadership for safety (Executive WalkRound™, Safety on the Board agenda, Safety climate and culture surveys).
- High-risk medications (Prescribing, dispensing, administration and reconciliation).
- Peri-operative care (Briefing, WHO checklist, surgical site infections).
- Critical care (Ventilator Associated Pneumonia, Central line Infections).
- Deteriorating patient (ICON[1] outreach, SBAR[2], CEWS[3]).
- Decreasing Serious Untoward Incidents.
- Human factors training.
- Child Protection training
- Improving standardisation of processes and eliminating variation where possible.

Over recent years, these target areas have been the subject of intense scrutiny, the development of detailed methods of monitoring and the subsequent creation of Statistical Process Control (SPC) Charts that facilitate reporting and permit a visual stimulus for continuous improvement and target setting. The topics under scrutiny, the data collected to monitor performance and the subsequent SPC charts are visible on the Intranet (via the Transformation Team pages of the website) for all staff to see. These data are aggregated for Unit and Board reporting and summarised as part of the regular Q,S& T reports to the Board. Each Unit uses these sites to report performance to the Management Board, and to highlight safety issues.

The Trust is committed to expanding the list of safety items which it monitors, identified from national and international safety reports, critical incident analysis complaints and common sense. Annual targets will be identified in the Q,S&T annual report and the Quality Account. The Trust looks to achieve year on year improvement, and to work with its peers to

[1] ICON is an outreach rapid response team from ICU
[2] SBAR is a communication tool
[3] CEWS is a clinical early warning score to detect deterioration in children

benchmark safety outcomes where possible. Our relationship with Cincinnati Children's Hospital, a leader in this field, is very useful in establishing these programs of work.

The whole ethos of safety will be underpinned by the development and maintenance of a just and learning culture in the organisation. The Trust will encourage open and immediate reporting of any incidents or concerns via its electronic reporting system (Datix), and all staff will be reminded at regular intervals (by the Co-Medical Director for Q&S) of their primary, personal responsibility for patient safety and of the obligation to report safety issues to that Director, or via their line manager. Staff who have concerns which they feel unable to raise with such staff are encouraged to report to the Non-Executive Director for Whistle blowing named in the Trust's Whistle blowing policy. We wish here to restate our absolute commitment to patient safety and to the excellence of the care we provide.

The Trust will ensure that care and services are patient-centred and that access is equitable to all. This involves the development of a *safety* culture, (within which all staff feel able to challenge each other in order to maintain the very highest standards of quality, safety and patient experience) and a culture of *continuous improvement*.

The elements of this work, led by example from the Board, and facilitated by the Q,S & T teams and the education departments, include:

- Monitoring and review of the Trusts' safety culture
- Development of a just and learning culture in all parts of the Trust
- Coaching programmes to develop and support staff
- Human factors training
- [4]Child Protection and Safeguarding training
- Listening to, and actively involving patients, families and referrers in the management and improvement of care and services.
- Development of systems and processes to identify and improve health inequalities in relation to protected groups
- Learning from other hospitals and industries

Measures of Achievement in 'Zero Harm'

The Zero Harm program, like all the projects incorporated into the Quality Strategy, is built on the principles of continuous improvement. Thus we will seek year on year improvement on our current results, and to do so at the current rate (50% improvement in relevant variable year on year). We know that the closer to 'Zero' we get, the harder it becomes, and thus we will continue to benchmark against our peers. The recognised leader in the field at present is Cincinnati Children's Hospital and we will continue to compare ourselves against them to identify our performance and new measures of quality.

No Waits, No Waste

The Trust aims to improve patient experience by minimising waits and waste in both operational and clinical systems. The Trust aims to eliminate artificial variability in the delivery of services and minimise the effects of natural clinical and professional variability. This implies a fundamental shift in the way clinical and operational services are delivered,

[4] Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate document (2010) the Royal College of Paediatrics and Child Health London.

using the managing operations theory on variability, queuing theory and lean methodologies.[5]

This work will include improvement programmes focussing on: -

- Reducing Readmission rates
- Advanced access for outpatients
- Improving Theatre utilisation
- Making bed-management more effective
- Workforce redesign
- Increasing the use of care pathways

Measurement and methods

- Data will again be fed from specialities to the Transformation analyst team in the way described above
- Assurance to the Board will be provided via the Key Performance Indicators and the regular Q,S&T report

The data content of the KPIs and Dashboards will be reviewed annually and configured as appropriate for either the Trust Board or other audience as is appropriate.

The aspiration of the Trust is to implement systems theory in which continual improvement might ultimately eliminate the need for target setting and inspection[6].

Measures of Achievement in No Waits, No Waste

The No Waits, No waste component of the policy, is built on the principles of continuous improvement. Thus we will seek year on year improvement on our current results, and to do so at the current rate (50% improvement in relevant variable year on year). The current changes in the NHS may influence priority setting, but the elimination of waiting and wasting is necessary to maximise efficiency, and will always be a priority for this Trust.

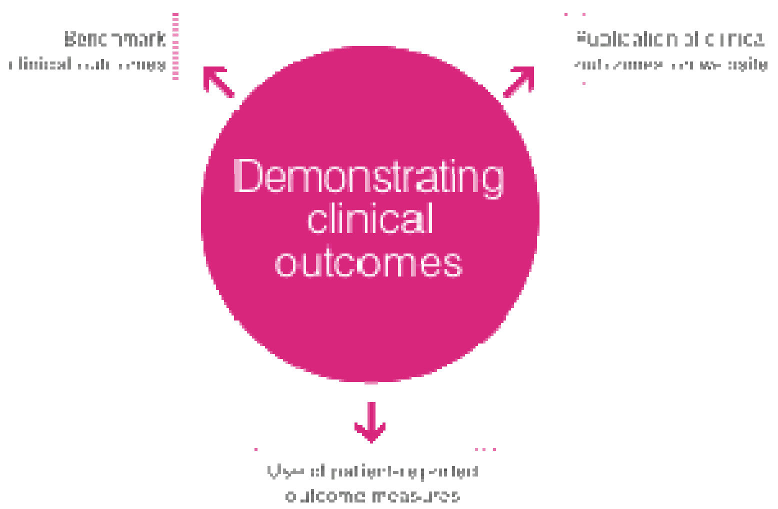
[5] Litvak E. Managing Patient Flow in Hospitals: Strategies and Solutions, Second Edition. Joint Commission International 2009. http://www.jointcommissioninternational.org/Books-and-E-books/Managing-Patient-Flow-in-Hospitals-Strategies-and-Solutions-Second-Edition/1497/

[6] Edwards Deming. Out of the Crisis

Effectiveness

It is the aim of the Trust consistently to deliver clinical outcomes which place us amongst the Top Five Children's Hospitals in the World. The Trust is aware that several of its teams already achieve this level of quality, and that it will take time for all its specialities to achieve this goal. Whilst clearly an ambitious target, the Trust takes the view that setting this high standard will encourage teams to identify areas for improvement and engage them in that process.

The principles we intend to deploy are shown in the following diagram:-



We have already developed a program for identifying key outcomes for each of our specialities, and at least two such outcomes per Unit are now available for Internet publication via our website. Several specialities have many more measurable outcomes than others, and the good practice they have developed will be spread throughout the Trust. The Clinical Outcomes Board and Manager will work with specialities to identify, validate and report the clinical outcomes which best reflect that specialities practice and particularly those which are benchmarkable. The number of defined outcomes will continue to increase until all our clinical activity is effectively and transparently recorded

How will we measure and monitor performance each year?

We will measure the number of specialties and associated clinical outcomes that are available on the website.
Progress in the development, measurement and publication of these clinical outcomes is reviewed and monitored on a monthly basis by the Clinical Outcomes Board.
Each clinical unit is required to present information on its progress and provide examples of clinical outcomes to the Executive team at quarterly performance reviews, and these reports will be aggregated into a quarterly report to Trust Board presented via the Q, S&T team report.

Measures of Achievement in No Waits, No Waste

We have set ourselves a 5 year target of each speciality defining 5 outcome measures for the 5 items of care they do best and to identify 5 centres against which they should be compared to provide evidence of Top 5 status. We intend to publish these on the Intranet and Internet at the end of that 5 year period. We will expect 75% of our specialities to achieve this within 5 years

Who is responsible for delivering the Clinical Outcomes Program?

The Clinical Outcomes Development Lead is operationally responsible and The Co-Medical Director, for Q&S, is accountable.

Benchmarking

What we have done to date

We have asked specialities to identify outcome measures that can be benchmarked against those of other leading providers, and/or to lead on the development of outcome measures that can be used by other centres. We have also begun discussions with some of the leading children' hospitals in the world to begin to develop agreements about data sharing and benchmarking.

Our Plans

In the short term we will continue to develop reporting of outcomes against established national and international registries, where they exist, for example:

- Cardiology and cardiothoracic surgery – through the Central Cardiac Audit Database
- Cardiac and paediatric intensive care – through the Paediatric Intensive Care Audit Network
- Cystic fibrosis – through the Cystic Fibrosis Registry
- Renal – through the National Health Service Blood and Transplant Organisation
- Adolescent medicine – through the National Outcomes Database
- Gastroenterology inflammatory bowel disease – through the ImproveCareNow Registry
- Haemophilia – through a specialist commissioning forum
- Infectious diseases – through the Collaborative HIV Paediatric Study
- Ophthalmology – an early implementer Quality standards and indicators of the Royal College of Ophthalmologists.

We will work with the specialist commissioning forums to identify and/or develop measures that can be used across centres to compare clinical outcomes.

The Clinical Outcomes Development Lead will continue to support specialties in the development, measurement and publication of benchmarked outcomes.

During the coming years we will develop and share with other centres the full portfolio of clinical outcomes we report, and attempt to get both agreement to share such data and to create common baseline datasets with Centres we identify as in the Top 5. This is complex, and cannot be achieved rapidly, because each speciality will have different comparator centres and even within specialities, certain management protocols or procedures may require alternate groupings for comparison.

The Trust also wishes to ensure that it records and reports effectively those outcomes reported by patients. Patients' perception of treatment and care is a major indicator of quality, and there has recently been a huge expansion in the development and application of questionnaires and rating scales that purport to measure health outcomes from the patient's perspective.
Patient-reported outcome measures (PROMs) provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life. These instruments can be completed by a patient about themselves, or by others (usually the parents or guardians in our case) on their behalf.

We are keen to develop and use PROMs across the hospital to ensure that we measure and understand how patients perceive the outcomes of their care, and we see this as a vital improvement initiative. Annual targets will be presented in the Quality Account.

How will we measure and monitor both the process of development of clinical outcome monitoring and the outcomes themselves?

Progress in the development, measurement and publication of clinical outcomes will be reviewed and monitored monthly by the Clinical Outcomes Board.
Each clinical unit is required to present its specialities' clinical outcomes to the Executive team at quarterly performance reviews. Summary outcome data will be presented quarterly to Trust Board in the Q,S & T report, along with details of the progress of the whole program.

Experience

We aim consistently to deliver and excellent experience that exceeds our patients', families' and referrers' expectations. This is described diagrammatically below:

We recognise that the memories and perceptions that patients and families have of Great Ormond Street Hospital are heavily influenced by the quality of their experience. Therefore, we must measure patient experience across the hospital and ensure that we use that information continuously to improve the services we offer.

We want to create meaningful opportunities for engagement with our patients, their families and the public. We will listen *and hear* what they tell us about the care that they receive at GOSH. We want active involvement where patients and families are genuinely able to influence. Only when we fully understand how services are experienced can we start to make the necessary improvements.

GOSH therefore needs to know the 'good and the bad' about current experiences as well as more about the expectations people bring with them when they come to GOSH. This plan is about getting this information from patients, families and visitors and using it to help us improve.

The detail of how we intend to deliver our involvement, engagement and patient experience objectives can be found in the PPI (Patient and Public Involvement) and Patient Experience Strategic Plan. Annual reports and targets will be provided in the Quality Account.

The Trust intends to:-

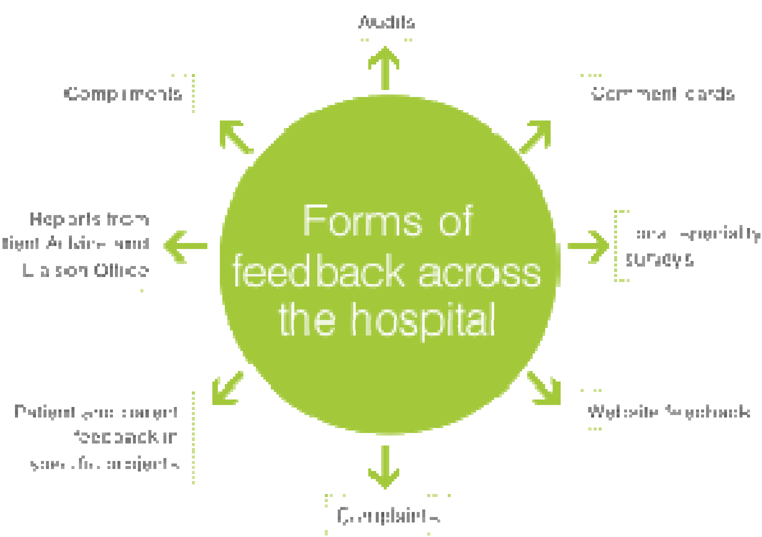
1) Maintain high levels of patient and parent satisfaction

The results of our independent inpatient and outpatient surveys over the past couple of years include excellent feedback scores from the patients and the parents who visit Great Ormond Street Hospital (GOSH).

These annual surveys highlight areas in which we need to improve to meet the highest standards. Recent examples relate to the knowledge of how to complain, or the need to improve the quality and variety of hospital food. Annual plans will be based on information from such surveys.

2) Establish a frequent feedback system for ongoing measurement of patient satisfaction and experience

The results of our independent inpatient and outpatient surveys have given us benchmarks that we did not have before, and an indication of some areas in which we need to improve. However, these surveys provide only a snapshot of patients and families who visit Great Ormond Street Hospital within a short period of time. We also collect feedback from patients and families in a number of different ways, as shown below:



Ongoing feedback gives a more regular indication of how we are doing, and local feedback to teams regarding the quality of the service they offer can help to identify areas that need improvement.

This improvement initiative was identified by reviewing national campaigns which inform our experience agenda, and following feedback from staff, our commissioners, and patients and parents.

Measures of Achievement in PPI and Patient Experience

All clinical units and corporate departments will provide a variety of ways for patients and families to provide feedback which is monitored and acted upon e.g. Walkabouts and Patient Inspections, surveys, hand held device surveys, on-line surveys, comment cards, patient stories, feedback to Pals, parent teas/family forums, focus groups, shadowing, and ensure that access is available for traditionally excluded groups

All clinical and non-clinical units will say how they intend to engage with patients, parents and members within their improvement and business plans, and recruit members' representatives to Unit Management Boards and all substantial service redesign projects.

All clinical and non-clinical units will submit all patient surveys/satisfaction audits, results and action plans to the Patient and Public Involvement and Experience Committee to ensure that we are responding to patient feedback and that action is being taken.

Organise a minimum of two half-day Improving Experience events annually to coincide with Members Council meetings, one targeted at children and young people, and one for parents and members

Organise three targeted focus groups a year in liaison with the Trust's Family Equality and Diversity Committee – e.g. bringing together patient and families of a faith, or sharing a particular disability in order to learn how these groups currently experience our services and agree priority areas for improvement with them.

Work with the Quality, Safety and Transformation team and clinical unit teams to develop a central system or database to collate patient experience feedback and actions being taken that is accessible to relevant managers and staff.
The data obtained will be reported quarterly to the Patient and Public Involvement and Experience Committee on a quarterly basis with a high level summary going to Trust Board. As the system matures it will become part of the routine reporting schedule via the Q, S&T report to the Trust Board.

The Assistant Chief Nurse – Quality Safety and Patient Experience is responsible for overseeing this work and The Chief Nurse and Director of Education is accountable.

3) Improve communication with patients, families and referrers

Many of the patients treated at Great Ormond Street Hospital (GOSH) have complex needs and are often under the care of several specialties within the hospital, in addition to consultants at their local hospital. Therefore, it is fundamental that clinicians across GOSH communicate effectively with all of the teams that are involved in the patient's care, in addition to the patient, their family and local carers.
Information from our inpatient and outpatient surveys over the past few years showed that the majority of patients and families surveyed felt that they did have the relevant information about what would happen next or any further care that the child might need.
However, information taken from our complaints and reports from our Patient Advice and Liaison Office, and from an independent survey of referrers suggested that we are not always as good as we could be at communicating effectively with all of the relevant people involved in a child's care. The Trust is committed to improving this.

The Trust has recognised that employing a team of general paediatricians GOSH would enhance the quality of care when children interact with multiple teams, as is so often the case with the complex patients whom we treat. This has been implemented, but the way in which they work and the scope of their responsibilities will continue to evolve as we understand more of the patients' needs and responses.

We have established a referrers' experience improvement programme, which aims to address and improve the issues highlighted by the survey. Through this programme, we will:

- continue to review our processes in order to improve the timeliness and quality of written and verbal information provided to the relevant teams, our patients and their parents
- ensure that circulation lists for information are up-to-date and cross-referenced with the patient's medical records
- review our bed-management systems to enable us to accept more emergency patients
- host regular referrers' open days.

Referrer involvement and focus across all of the clinical units will be encouraged.

How will we measure and monitor performance?

We will measure and monitor:
• the timeliness and quality of our outpatient letters and discharge summaries • the number of complaints and frequency of common themes
• the input of the General Paediatric team via specific measured goals
• feedback from the referrers' open day.

Who is responsible for delivering this improvement initiative?

The General Paediatrics team and the Referrers' Steering Group are responsible . Chief Operating Officer is accountable.

4 Ensure equal access to all

Equality of access to healthcare is central to its delivery. The Independent Inquiry into Access to Healthcare for People with Learning Disabilities, led by Sir Jonathan Michael, published its findings, Healthcare for All, on 29 July 2008. The inquiry was ordered following Mencap's 'Death by Indifference' report, which told the stories of six people with a learning disability who died while receiving NHS care. The inquiry sought to identify the action needed to ensure that adults and children with learning disabilities receive appropriate treatment in acute and primary healthcare in England.
We know that how well and how quickly children recover depends not only on their clinical treatment, but also on whether they and their families feel comfortable, safe, understood, respected and listened to during their time with us. This is why we believe that promoting equality and diversity at Great Ormond Street Hospital (GOSH) is not only right, but also makes clinical and business sense.

What the Trust will do

The Trust will ensure that reasonable adjustments are made in the delivery of our services to ensure equal access for patients with a learning disability.

We have developed a learning disabilities group, involving staff from across the hospital. This group has developed an action plan to make improvements to the services we offer. We will initially develop our systems to enable us to identify patients who have a learning disability. We will then ensure that the views and interests of people with learning disabilities and their carers are included in the planning and development of our services.
This forms part of our ongoing work to ensure that GOSH meets the requirements of the Equality Act 2010.
Progress will be monitored through the Trust Family Equality and Diversity Group.

Who is responsible for delivering this improvement initiative?

The Learning Disabilities Working Group is responsible. The Co-Medical Director with responsibility for Equality and Diversity is accountable.

5) Offer patients timely access to services at Great Ormond Street Hospital (GOSH)

Timely access to services is an important factor in the way patients rate the quality of the service they receive. Whilst the Trust has met consistently the statutory targets it has been set for waiting and access times for patients, we always wish to do better.

Thus we introduced the Advanced Access programme, which aimed to enable specialties to offer appointments to new patients within two weeks of referral acceptance. The majority of specialities have a plan in place to deliver Advanced Access by April 2012, and we intend that all specialities will be engaged within the near future. We will also review our processes to reduce the number of 'did not attends' and cancellations to ensure that appointments are utilised.
Operational managers within clinical units are responsible for reviewing waiting times and ensuring that patients are seen in accordance with the above standards.

How will we measure and monitor performance?

Advanced Access performance is measured and monitored via online dashboards and reports, to which all staff in the hospital has access and performance in each specialty is updated on a monthly basis. The delivery of this programme is monitored and reviewed by the Transformation Board, and reported to the Trust Board via the KPI report. Performance will also be monitored at monthly operational board meetings and quarterly clinical unit strategic performance review meetings.

Who is responsible for delivering this improvement initiative?

The Head of Planning and Performance is responsible. The Chief Operating Officer is accountable.

Final Comments

This strategy has been developed incorporating some principles of high reliability theory,[7] to help GOSH meet its aim of "*being in the top 5 Children's hospitals in all it does".*

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

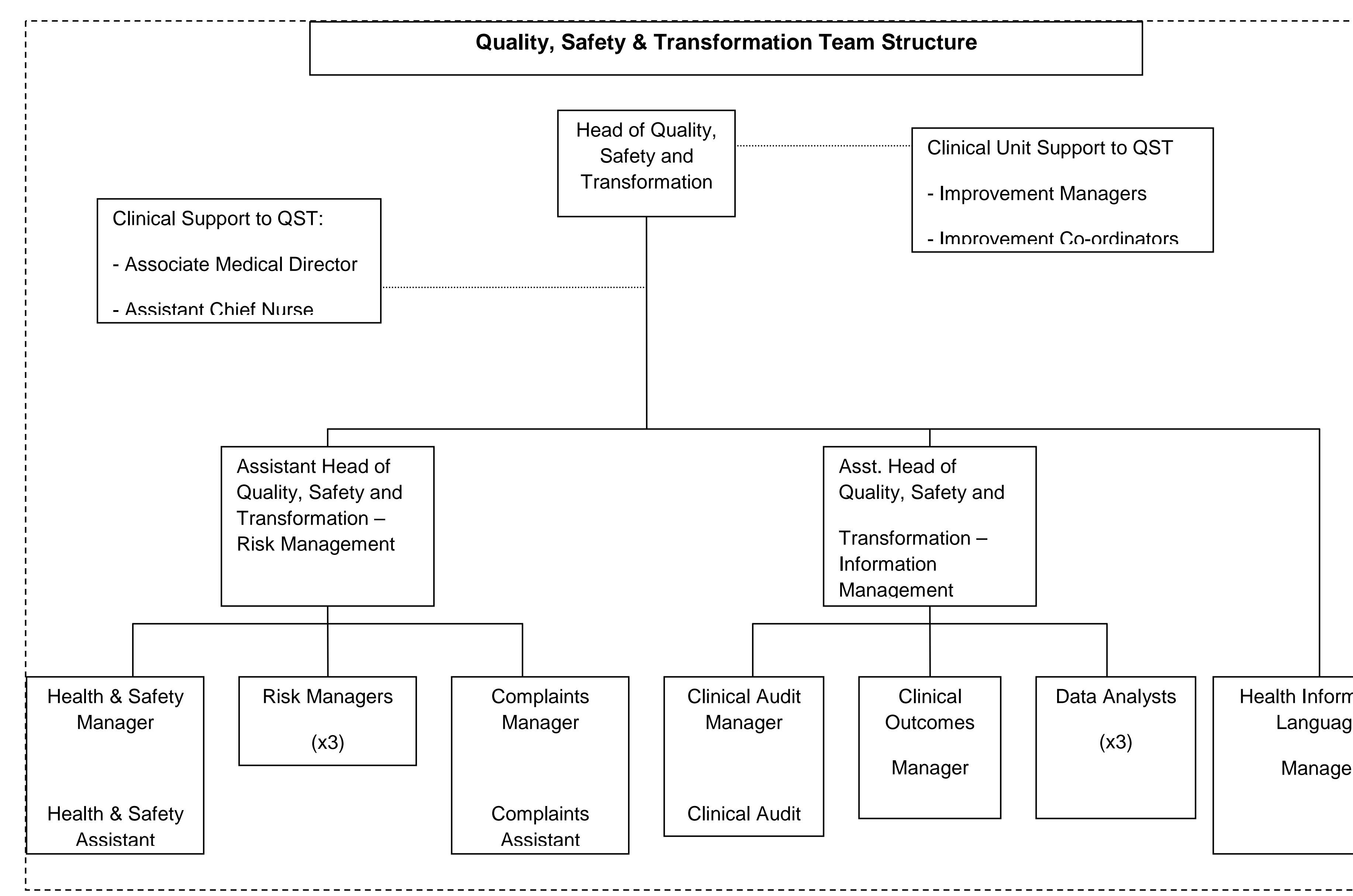
- Leadership and the development of a culture of safety.
- Understanding and measuring harm.
- Development of standardised processes wherever possible.
- Elimination of unnecessary variation.
- Training in safety, human factors and simulation.
- Prospective examination of safety and reliability for all the Trust's activities.
- Organisational learning by retrospective analysis of accidents or incidents and implementation of change as needed.
- The innovative blending of improvement methodology into existing learning pathways
- Listening to the patient experience through stories, feedback systems and learning from PALS and complaints.
- Learning from Serious Case Reviews, Safeguarding Inspections and listening to staff involved in carrying out their safeguarding roles and responsibilities.
- Triangulation of information in relation to performance activity, PROM's, levels of harm and patient experience.

These goals are constant and form the basis of the continuous improvement to which this Trust is committed.

[7] Wieck K and Sutcliffe: Managing the Unexpected: Assuring High Performance in an Age of Complexity San Francisco, California, U.S.A.: Jossey-Bass Inc Pub, 2001

Attachment K

Figure 1



Attachment K

Attachment L

<table>
<tr><td colspan="2">Trust Board
25th January 2012</td></tr>
<tr><td>GOSH PPI (Patient and Public Involvement) and Patient Experience Plan 2012-2015

Submitted on behalf of
Liz Morgan, Chief Nurse/Director of Education</td><td>Paper No: Attachment L

Date considered by Management Board: 19th January 2012</td></tr>
<tr><td colspan="2">Aims / summary
The current PPI and patient experience strategy comes to an end in March 2012. This is a new 3 year plan and appendices include achievements over the last 3 years in both PPI and patient experience. The plan has been written so that it can be shared with the wider membership. It is anticipated and welcomed that once internal approval has been achieved, the new Members' Council will contribute their views on priorities in March 2012 and assist in agreeing a timetable and action plan for implementation.</td></tr>
<tr><td colspan="2">Action required from the meeting
For consideration and approval by Trust Board</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
Exceeding patient and family expectations of services is a key corporate aim.</td></tr>
<tr><td colspan="2">Financial implications
None</td></tr>
<tr><td colspan="2">Legal issues
None</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, members, children and families) and what consultation is planned/has taken place?
Detailed consultation has taken place with individual 'active' Members, with parent representatives and staff. Members Council will be consulted before year end.</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
All Staff</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Caroline Joyce, Assistant Chief Nurse Patient Quality, Safety and Experience</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
Liz Morgan, Chief Nurse/ Director of Education</td></tr>
<tr><td colspan="2">Author and date
Caroline Joyce, Assistant Chief Nurse, Patient Quality, Safety and Experience
Grainne Morby, Head of Pals and PPI, January 2012.</td></tr>
</table>

PPI (Patient and Public Involvement) and Patient Experience

What we plan to do

2012 – 2015

1. Summary

GOSH seeks to provide the best possible services to patients and their families who come from diverse backgrounds and from all parts of the UK and abroad. We therefore need many ways to find out about, and improve patient and family experience, and we do this best by involving and engaging our patients, their families and members in shaping health care at GOSH that is appropriate to their needs and by making best use of the knowledge and skills of our staff.

The Trust will listen to, learn from and act upon patient experience ensuring that time is taken to understand patient and families experience of care and services, and how this can be improved upon. This plan will be developed and monitored in partnership with the Members Council. The plan will take account of other related plans in the Trust on issues such as quality and membership.

2. Where we are now

We need this new three year involvement and engagement plan as our current one ends in March 2012.

We have done much in the last three years to engage with our patients and their families, and our membership. Details are available in the Trust's PPI and Patient Experience Annual Report 2010/11.

This plan includes three appendices –
Appendix 1 Background to Patient and Public Involvement (PPI) at GOSH
Appendix 2 Background to Patient Experience at GOSH
Appendix 3 Laws and Regulations about PPI.

3. Role of the Members Council

The elected Members Council provides us with a great opportunity to work in closer partnership with patient, parent, public and staff representatives, and members as well as local community agencies and representatives of patient groups

Once the Council is fully established, it will be encouraged to contribute more fully, and even take the lead on developing and monitoring the plan in future years. A Year One Action Plan for 2012/13 will be drawn up once this plan is

agreed. Subsequent annual action plans will be drawn up in liaison with the Members Council.

4. Vision 2012-15

GOSH has a vision that it will consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations.

We want to create meaningful opportunities for engagement with our patients, their families and the public. We will listen *and hear* what they tell us about the care that they receive at GOSH. We want active involvement where patients and families are genuinely able to influence. Only when we fully understand how services are experienced can we start to make the necessary improvements.

GOSH therefore needs to know the 'good and the bad' about current experiences as well as more about the expectations people bring with them when they come to GOSH. This plan is about getting this information from patients, families and visitors and using it to help us improve.

We know that sometimes patients and their families may not always agree with decisions made but we will be open and transparent in our consultations and in our decision-making. Our principles for involving patients and families and other Members are that we will be

- Open about what can and cannot be influenced
- Genuine about our commitment to making improvements
- Transparent about how decisions are made
- Timely in our consultation, engagement and feedback

We would like to get a rolling action programme reporting to Trust Board and Members Council which responds to poor patient experience in areas that matter most to patients and their families. We want to see changes for the better, and be able to prove that things have got better as a result.

We also want to celebrate and learn from things that we do well.

5. What we want to do in the next three years

5.1. Reach out to patients and families who have traditionally faced barriers to participation owing, for example, to their age, disability, gender, ethnicity, religion and belief or language by organizing special events to listen to their views.

5.2. Consult with older children and young people separately from their parents/carers as their priorities may differ.

5.3. Introduce different ways in which patients and members can be involved, interact or offer feedback including the use of new social media.

5.4. Make best use of the skills, expertise and willingness to contribute of the whole membership by finding out their interests and keeping in touch with them. Opportunities for Members to contribute will be advertised on the FT Members section of the GOSH website and Members will be kept regularly informed through their newsletter.

5.5. Ensure that we get regular feedback from patients (children and young people) and families at ward and at specialty level, on what they appreciate/value about their experience and what they feel could be improved.

5.6. Show that the Trust considers and makes changes in response to negative feedback and suggestions for improvement and that the Trust tells patients and families what it has done in response to feedback.

5.7. Find ways to reassure families that negative feedback will not affect the care provided to their child.

5.8. Find ways to promote a culture where parents/ carers are listened to and enabled to share their expertise and knowledge of their own child in order to work in partnership with staff. Find ways to prevent 'labelling' of patients and families as 'difficult', 'demanding, or 'over anxious'.

5.9. Identify patient experience issues at Members Council consultations, or through Pals, Complaints, ward surveys, walkabouts etc. that need action plans for improvement.

5.10. Make improvements in some key areas such as communicating with GOSH, pre-admission information or patient transport by setting up time limited 'task and finish' projects to tackle patient experience issues that we already know matter to families.

5.11. Use patient experiences alongside other types of performance and quality data – this may be done through the use of patient stories for example. This is called 'triangulation' and is a way of making sure that we use all available information to get as full a view as possible of the quality of services.

5.12. Give staff the skills and abilities to involve and engage with patients and families, and confidence and expertise in communicating with all children, young people and families.

5.13. Meet national standards to make sure services are appropriate to the needs of patients, for example, 'You're Welcome' which is a set of standards that improve services for adolescent patients.

6. What we will do next year from April 2012- March 2013

The tasks below will form an Action Plan for 2012/13 which will say who is responsible, to do what, by when, and how we will know that it has been done.

Involving and engaging

6.1. Involve young people/patients in obtaining feedback, possibly through a young peoples sub-group of the Members Council and/or through the use of young volunteers for peer interviews, surveys, walkabouts and so on.

6.2. All clinical and non-clinical units will say how they intend to engage with patients, parents and members within their improvement and business plans, and recruit members' representatives to Unit Management Boards and all substantial service redesign projects.

6.3. We will investigate whether Member's involvement in public-facing job interviews has declined, with a view to removing any obstacles.

6.4. Review and update existing recruitment, induction and support of Members representatives to bring them in line with Trust-wide volunteering support mechanisms.

Improving patient experience

6.5. All clinical and non-clinical units will submit all patient surveys/satisfaction audits, results and action plans to the Patient and Public Involvement and Experience Committee to ensure that we are responding to patient feedback and that action is being taken.

6.6. Agree some guiding principles for staff to describe a positive patient experience in consultation with Members and the Members Council. It may also be helpful to agree a more detailed set of standards with measures from a patient's perspective.

6.7. Create a measurable set of service standards with our patients, families, members and staff that will bring about sustainable improvements in

- Dignity and respect for patients and their families
- Privacy and confidentiality for patients
- Reception, meeting and greeting services
- Cleanliness and tidiness
- Access and waiting times
- Communication with patients and their families

Obtaining feedback

6.8. Organise a minimum of two half-day Improving Experience events annually to coincide with Members Council meetings, one targeted at children and young people, and one for parents and members

6.9. Organise three targeted focus groups a year in liaison with the Trust's Family Equality and Diversity Committee – e.g. bringing together patient and families of a faith, or sharing a particular disability in order to learn how these groups currently experience our services and agree priority areas for improvement with them.

6.10. Encourage staff to attend consultations; and consider an event targeted at staff to input their views on improving patient's experience.

6.11. All clinical units and corporate departments will provide a variety of ways for patients and families to provide feedback which is monitored and acted upon e.g. Walkabouts and Patient Inspections, surveys, hand held device surveys, on-line surveys, comment cards, patient stories, feedback to Pals, parent teas/family forums, focus groups, shadowing, and ensure that access is available for traditionally excluded groups.

6.12. Agree a policy together with staff guidance for collecting patient stories to encourage the appropriate use of these patient stories at relevant unit, Trust boards and other meetings and agree programme for Trust Board.

6.13. Pilot social media mechanisms for obtaining and responding to patient experience feedback

Collating feedback

6.13 Work with the Quality, Safety and Transformation team and clinical unit teams to develop a central system or database to collate patient experience feedback and actions being taken that is accessible to relevant managers and staff.

6.14. Work with the Transformation team to establish efficient and effective ways of collating the results of patient experience feedback and the best ways of linking the information with clinical outcomes and safety data. This may need to include the design of a patient experience report, or input to an existing reporting system.

6.15. Consider use of Executive Walkabouts to focus on patient experience and talking to patients and families (particularly in areas or about issues identified as in need of improvement through ward surveys) to report back to the PPIEC.

Acting on feedback

6.16. Merge the Patient and Pubic Involvement and Engagement Committee (PPIEC) and the PPI Approval/Experience Group and review membership to focus on action plans in response to Members consultations, surveys, Pals and Complaints reports enabling it to take action on patient experience issues. It will consider the outcomes of surveys and patient satisfaction audits as well as approving and commissioning patient experience surveys and feedback initiatives. The new committee will also monitor progress on the PPI and Patient Experience Plan and compliance with Care Quality Commission Outcome 1 and the Trust's patient experience CQUINs. (see Appendix 3)

6.17. This new committee will meet ten times a year and ensure that patient experience reports are made to the appropriate committees in a format that is relevant. This will include quarterly reports to Management Board and annually to the Members Council and Trust Board.

6.18. All clinical unit/corporate facilities management boards will include patient experience as a standing item on their agendas.

7. Resources

There is a limited funding resource for conducting the annual inpatient survey with additional funding obtained from GOSH Charity in 2011/12 for new initiatives which we will ask be continued, although this cannot be guaranteed.

8. Key Responsibilities

A new PPI and Patient Experience officer post has been created in the Directorate of Nursing. The postholder is responsible through the Head of Pals and PPI to the Assistant Chief Nurse, Quality and Patient Safety for collaborating with staff across the Trust to implement this plan.

The Assistant Chief Nurse, Quality and Patient Safety will co-chair the PPIEC with a representative from Members Council and be accountable for the implementation of the policy.

Executive responsibility is with the Chief Nurse/Director of Education.

9. Appendices

1. Background to PPI at GOSH
2. Background to Patient Experience at GOSH
3. Laws and Regulations

Appendix 1 BACKGROUND TO PPI AT GOSH

GOSH has had a plan for the development of PPI since 2009/10. Core principles to guide this work are

- Start early and continue throughout the process
- focus on improvement
- be inclusive, informed, fit for purpose, transparent, influential, make a difference
- be reciprocal – include feedback, be proportionate to the issue and be sustainable and proactive.

Three levels of involvement and engagement are defined as follows

Level 1: relates to the quality of the relationships and communications between patients, their parents/carers and staff. (example: the use of the DVD made by patients outlining their expectations of doctors and nurses, *GOSH What A Hospital !* in staff induction and junior doctor training)

Level 2**:** relates to improvements or changes in services at speciality or Unit level. (example: recruiting parents on to unit management boards; involving patients in ward redesign or service improvement projects)

Level 3**:** relates to engagement in Trust-wide strategic issues (example : consultations with Members Forum on FT status, redevelopment, corporate objectives etc)

These core principles for PPI and the levels of engagement will continue to underpin the 2012-15 plan.

Key achievements over the last 3 years have been

- Annual listening events for children and young people
- Development of initiatives such as 'You are the difference' to address feedback from listening events.
- Recruitment of parents to a variety of Trust committee's, improvement projects, unit boards and HR recruitment panels.
- Members forum acting as a critical friend and a key influence on development of PPI activities
- Members Forum legacy document which will be shared with the new Members Council

This plan aims to build on the levels of good practice that have been achieved and improve the consistency and reliability of involvement and engagement at GOSH. Areas for improvement will include:-

- Bringing support and recognition for active members inline with that provided to volunteers

- Increasing the emphasis on engaging children and young people in PPI activity and in finding out more about their experience as patients, and engaging them in improvement activities.
- Increasing the accountability and responsibility of clinical unit teams for PPI and Patient experience

Appendix 2 BACKGROUND TO PATIENT EXPERIENCE AT GOSH

1. Defining patient experience

Patient experience has been defined as ‘feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it’
(Dr. Foster’s Intelligent Board report 2010- Patient Experience).

GOSH defines Patient Experience as

‘**This is what happened to me and this is how I feel about it’**

2. Setting standards

2.1. To provide a truly excellent quality service requires us to pay attention not only to clinical effectiveness and safety, but also to the patient’s experience.

2.2. NICE is currently consulting on generic patient experience standards in adult services. They will be published in December 2011 and is expected to recommend standard setting around the themes identified as most mattering to adult patients:

- Fast access to reliable health advice
- Effective treatment delivered by trusted professionals
- Involvement in decisions and respect for preferences
- Clear, comprehensible information and support for self-care
- Attention to physical and environmental needs
- Emotional support, empathy and respect
- Involvement of, and support for, family and carers
- Continuity of care and smooth transition

2.3. We also know from our own listening events that

Children and young people at GOSH want

- To be listened to and taken seriously
- To be given information by doctors in a way which makes it understandable
- To be involved in decisions regarding treatment
- To be given somewhere private when treated or examined
- To have access to enough toys, games and things to do on the ward

Teenagers have strong views on what ‘to be listened to, and taken seriously’ means to them – they want to be talked to as individual patients and not via their parents; they want to feel they are a person and not a disease and they want ‘to be believed’. Two additional satisfaction features are of particular note – the ability to maintain contact with school, and a plea to staff ‘to smile and be positive’.

2.4. Parents/Carers at GOSH say that first and foremost they want their children to receive high quality, safe care, and in addition they would like

- To be treated as an individual – for staff to introduce themselves and the team caring for their child with an explanation about roles; to ask how parents want to be addressed rather than assuming that 'Mum' and 'Dad' is acceptable', for staff to recognise the difficulties for parents juggling with sick children, siblings, home and work and for staff to say 'hello' when passing.

- To be respected as a care partner- to be involved and consulted in decision-making about treatment and care and to have their views listened to, and taken seriously.

- To receive the information that they need – how and whom to contact at GOSH; to explain and check understanding; to be told the truth even when news is difficult or when something has gone wrong; to receive written care information whenever possible

- To receive clear plans for follow-up care including clarity over care plans and lead responsibilities at discharge; and confidence that local health care teams are briefed on follow-up care.

2.5. In addition consistent feedback from patients and their families through Pals, Complaints, surveys and listening events strongly suggest that communication is key to whether or not an experience is positive. Factors identified as having a negative impact include:-

- poor communication -verbal, written, style, attitude
- lack of information
- inadequate explanation
- poor comprehension
- Poor communication between staff, teams and departments internally and externally
- Lack of co-ordination of care for children of families under multiple specialties

3. **Key Achievements**

Key achievements in patient experience over the last 3 years include

- Development of the Ipsos Mori Inpatient and Outpatient surveys which have enabled tracking of results over time.
- Development of a Patient Experience action plan and infrastructure which included a new PPI and Patient Experience Liaison officer post from Sept 2011
- Increasing local measurement of patient experience through surveys and feedback cards

Appendix 3 LAWS AND REGULATIONS

1. The Health and Social Care act regulations 2010 (set out in the Care Quality Commission standards) requires the Trust to provide assurance evidence for Outcome 1 Respecting and involving people who use the services. We need to demonstrate that at GOSH :-

- Patients and families can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- That their views and experiences are taken into account in the way that the service is provided and delivered, and
- That we encourage and enable people who use services to be involved in how the service is run.

2. The NHS Constitution, 2010 gives patients certain legal rights which include the right to expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide, and the right of patients to be treated with dignity and respect, in accordance with their human rights.

3. The NHS Operating Framework 2012/13 emphasises the quality of a patient's experience and highlights the importance of listening to patients and carers and providing information to enable patients to be fully involved in decision making and choices about health care.

4. The NHS Outcomes Framework, for 2012/13 has 'ensuring that people have a positive experience of care' as one its 5 five key domains. For the first time, children and young people's experience of health care services has been identified as an improvement area. This means that the Department of Health will publish some improvement indicators in 2012 which will be relevant to GOSH. They are awaiting the results of research being done by the Kings Fund and Kings College London, as well as work by NICE on patient experience quality standards, before publishing indicators that we will be measured against.

5. In the wake of the Francis report 2009 (the independent enquiry into failings at Mid-Staffordshire Hospitals NHS Foundation Trust) there is a requirement for Trust Boards to ensure that they regularly receive patient experience feedback and that this is visibly linked and put into context with other information received e.g. finance, safety, clinical outcomes. Details of these requirements are set out for Trust Boards in the Dr. Foster Intelligent Board Report, 2010 and expected to be strengthened when the Final Report is published in early 2012.

6. Commissioners are now commissioning for better patient experience, through the use of CQUINs's with targets set for improvement based on local and national patient concerns. Commissioners are using their influence to bring greater consistency to the way that we measure and report on patient

experience, to enable greater transparency and to make it easier to compare us to other Trusts.

7. Other interested parties include the Trust's Membership, Camden Council's Health and Scrutiny Committee and Local Health Watch.

<table>
<tr><td colspan="2">Trust Board
25th January 2012</td></tr>
<tr><td rowspan="2">Key Performance Indicator Report (KPI)

Submitted on behalf of.
Fiona Dalton, Chief operating Officer</td><td>Paper No: Attachment M</td></tr>
<tr><td></td></tr>
<tr><td colspan="2">Aims / summary
The Key Performance Indicator (KPI) report monitors progress against the Trust's seven strategic objectives and progress against Monitor's Governance Risk Framework and Quality Governance Framework. It provides 'RAG' performance analysis against defined thresholds and tolerances as well as monthly and quarterly performance trends.

Clinical Units provide unit specific reports to Management Board every month. These reports contain tailored information on a variety of indicators including: Infection control, medicines management, finance, risk, and patient access. Any statistically significant changes (either better or worse) in the individual performance metrics are highlighted to the as part of the KPI exception report

Remedial actions to address performance and operational issues will be undertaken by Management Board.</td></tr>
<tr><td colspan="2">Action required from the meeting
Trust Board to note progress.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
To assist in monitoring performance against internal and external defined objectives and NHS targets.</td></tr>
<tr><td colspan="2">Financial implications
None</td></tr>
<tr><td colspan="2">Legal issues
None</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Our lead Commissioner receives a copy of the executive summary on a quarterly basis.</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
Senior Management Team</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Each Trust objective task has an identified person responsible for implementation and an Executive Director nominated as the accountable officer.</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
As above</td></tr>
<tr><td colspan="2">Author and date
Janine Gladwell – Access & Capacity Manager. January 2012</td></tr>
</table>

KPI Exception report

1. C. difficile and MRSA

To date the Trust has reported 7 cases of C. difficile against a year-to-date trajectory of 6.8. The Trust trajectory for the year is 9 cases.
The Department of Health (DH) have not yet agreed to a paediatric target different from adult. The DH advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) will be presenting our opinion on this again soon.

In month 1 case of MRSA was reported. The Trust has reported a total to 4 cases to date against a year trajectory of 0. Where 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.

2. Planned Waiting Lists

In response to a requirement set out in the Department of Health 2012/13 Operating Framework, the Trust recently completed a sample audit of planned waiting lists across each specialty. 13.3% of all records audited were found to be incorrectly placed on the planned waiting list. The largest proportion of incorrect entries occurred within Surgery, and specifically under the specialty of Urology.

Urology have since undertaken a complete review of the planned waiting list and corrected all inaccurate entries. All other specialties within Surgery have been asked to undertake the same validation of the total planned waiting list and this work is expected to be completed by the 23 January. Progress will be monitored through Management Board.

3. Referral to Treatment – Incomplete Pathways

The Trust remained outside the 92% incomplete pathway standard in November at 83.8% and has breached the 95th Centile target of 28 weeks - reporting a position of 32.89.

Clinical Units continue to validate patients on an incomplete pathway and to ensure that all patients that are over the 18 week breach date have a TCI date. Significant improvements are observed within Rheumatology and Gastroenterology who have reduced the number of 18 week breaches by more than 50%. Key areas that require further work include Dental & Maxillofacial and Plastic Surgery. Management Board continue to monitor progress.

4. Non-Admitted – Median Waits

In month, the non-admitted median wait is reported at 6.74 weeks against a target of 6.6weeks. Continued improvement in performance is expected following work to progress clinic outcome form completeness.

5. Inpatient Waiting List

In month performance has deteriorated with 199 patients waiting over 26 weeks. Particular capacity issues have been identified across a number of specialties, including: Urology, Orthopaedics, Dental & Maxillofacial, Plastic Surgery and Craniofacial.

Planned waiting list validation undertaken in Urology has led to an increase in the number of elective patients breaching the 26 week standard. The specialty is working through the waiting list and booking patients by clinical need and waiting time. It is anticipated that the position will improve over the next few months. Additional capacity will also be available when the Morgan Stanley Building Theatres open.

Consultant capacity issues within Orthopaedics have contributed to a number of patients waiting over 26 weeks for surgery. Referrals are currently being reviewed, and where appropriate admitted under another consultant.

A locum job description is being written in order to ease the capacity issues seen in the Maxillofacial service. It is anticipated that a locum will be in post by April 2012. All patients are currently being booked according to total waiting time and clinical urgency to ensure that the patients waiting the longest period of time are treated as soon as reasonably possible.

The Trust has additionally put forward a Winter Access Fund bid to NHS London to support further improvements in the admitted 18 week performance for the last quarter of the financial year. The funding will support the opening of 6 additional theatre sessions per week, and four short stay surgical beds. An official confirmation of funding has not been received yet, however the scheme has been rated ‘green’ by North Central London (NCL) – and it is expected that a response will be delivered shortly.

6. Theatre Utilisation Rates

Theatre Utilisation has seen a significant drop in the last few months of 2011. Initial analysis indicates that this is mostly due to lack of bed availability (particularly CICU) which has led to increased cancellation of cases. Detailed investigations are ongoing on a specialty by specialty basis and this process is being managed by the Procedural Pathway Group of the Transformation Programme.

7. Forecast CRES Savings 2011/2012

The Trust is projected to achieve the 2011/12 CRES savings required in the LTFM. Clinical Units continue to work to highlight CRES schemes to develop potential savings for the current and future years.

8. Personal Development Review (PDR) completeness rates

Appraisal completion rates have remained fairly consistent level during 2011 but are now beginning to decline. The Trust reported an improved in-month rate for clinical areas at 69% and a reduced position in non-clinical areas at 54.5% against a December target of 80%.
The Education & Training department continue to circulate regular service and department performance reports and managers have been reminded to continue to work proactively to ensure that all staff have a current PDR.

9. Staff Trained on Information Governance

Performance remains steady at 87% against a target of 95%. The lowest compliance rates are identified across Medical and Dental. All new staff are required to undertake the training as part of their induction.

Escalation to the January 2012 Trust Board

This report is a summary of changes in performance of the measures at Clinical Unit level that have been reported to Management Board.

Where data can be analysed using methodology based upon statistical significance, we are able to determine whether each clinical unit has made a positive improvement or where a process has worsened. Similarly, for these measures we are able to make a judgement on whether an improvement is near to being realised. The escalated statistically significant graphs are additionally provided to give assurance that quality and safety isn’t going off track in a particular unit as a result of CRES schemes.

Attachment M

Performance Measure	Change	Clinical Unit	Narrative
Total WHO checklist completion (Chart 1)		ICI	Have been issues regarding data entry of the checklist completion on PIMs in both the laser room for Dermatology and for high turnover Rheumatology lists on Safari. We have now gained agreement from ODPs that they will undertake this - as they do in other theatre environments. Also a reflective video is being used in Dermatology for the team to see how they are undertaking the checklist and where they could make improvements
Total WHO checklist completion (Chart 2)		IPP	IPP have completed an improvement project on the surgical pathway and this has focused on documentation at all stages. Additionally all IPP lists are consultant delivered.
Total WHO checklist completion (Chart 3)		MDTS	WHO checklist improvement is a consequence of raising the profile and awareness of the importance of the process in ensuring safe delivery of care. There has been a particular improvement in the "signing out" part of the process which is where we had previously identified weaknesses.
CVL infections per 1000 line days (Chart 4)		MDTS	This has taken place on Rainforest ward and is as a result of identifying a particular member of staff to link with infection control and actively work to raise the profile and discuss the issues regularly with staff
Prescribing errors – clinical PICU (Chart 5)		Surgery	The Unit has had an extremely busy period (as is usual in the winter months) and some of this time has been without the routine pharmacy cover. We are looking at ways to ensure that clinical prescribing errors do not increase during these predictable times (seasonal PICU peak and pharmacist annual leave)

See appendix 1 below for the charts

A statistically significant improvement has been identified
Close to a statistically significant improvement
Close to a statistically significant reduction in performance
A statistically significant reduction in performance has been identified

Attachment M

Appendix 1

Chart 1
ICI

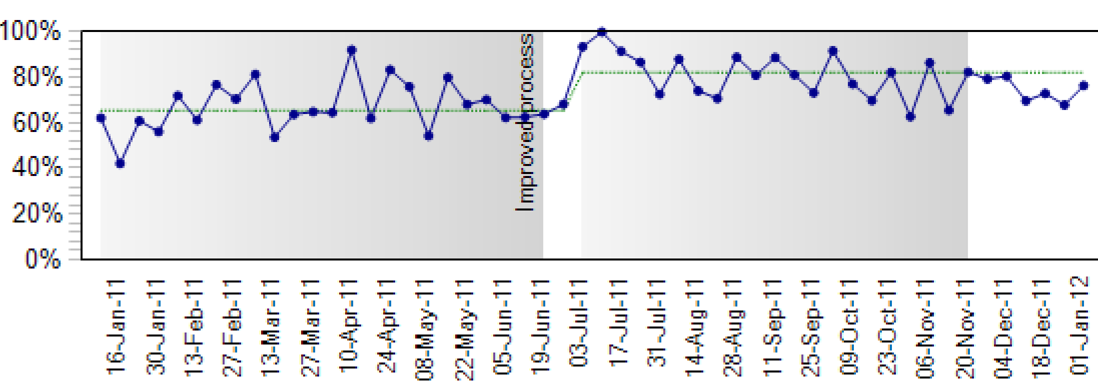


Chart 2
IPP

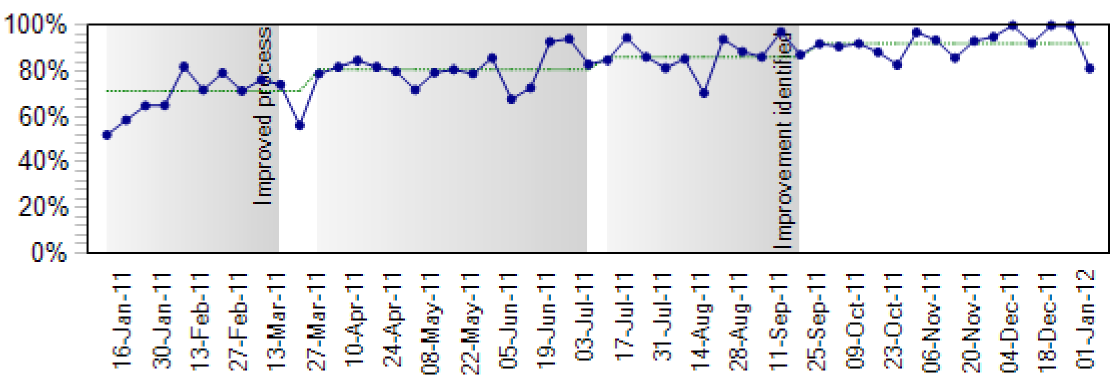
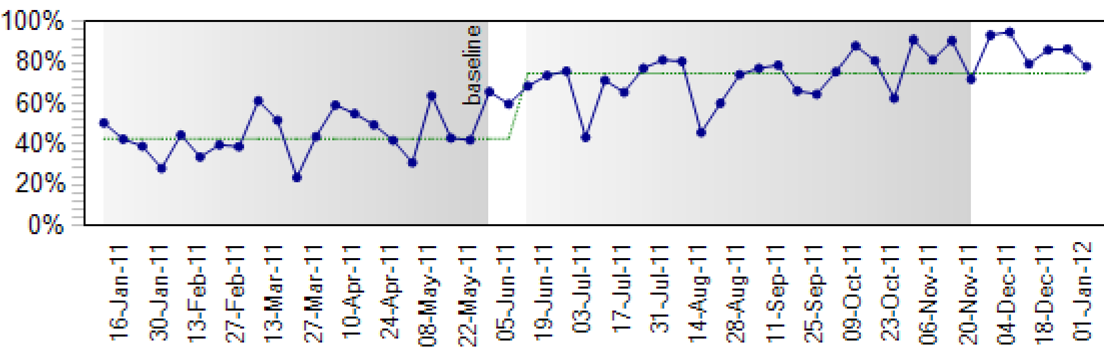


Chart 3
MDTS



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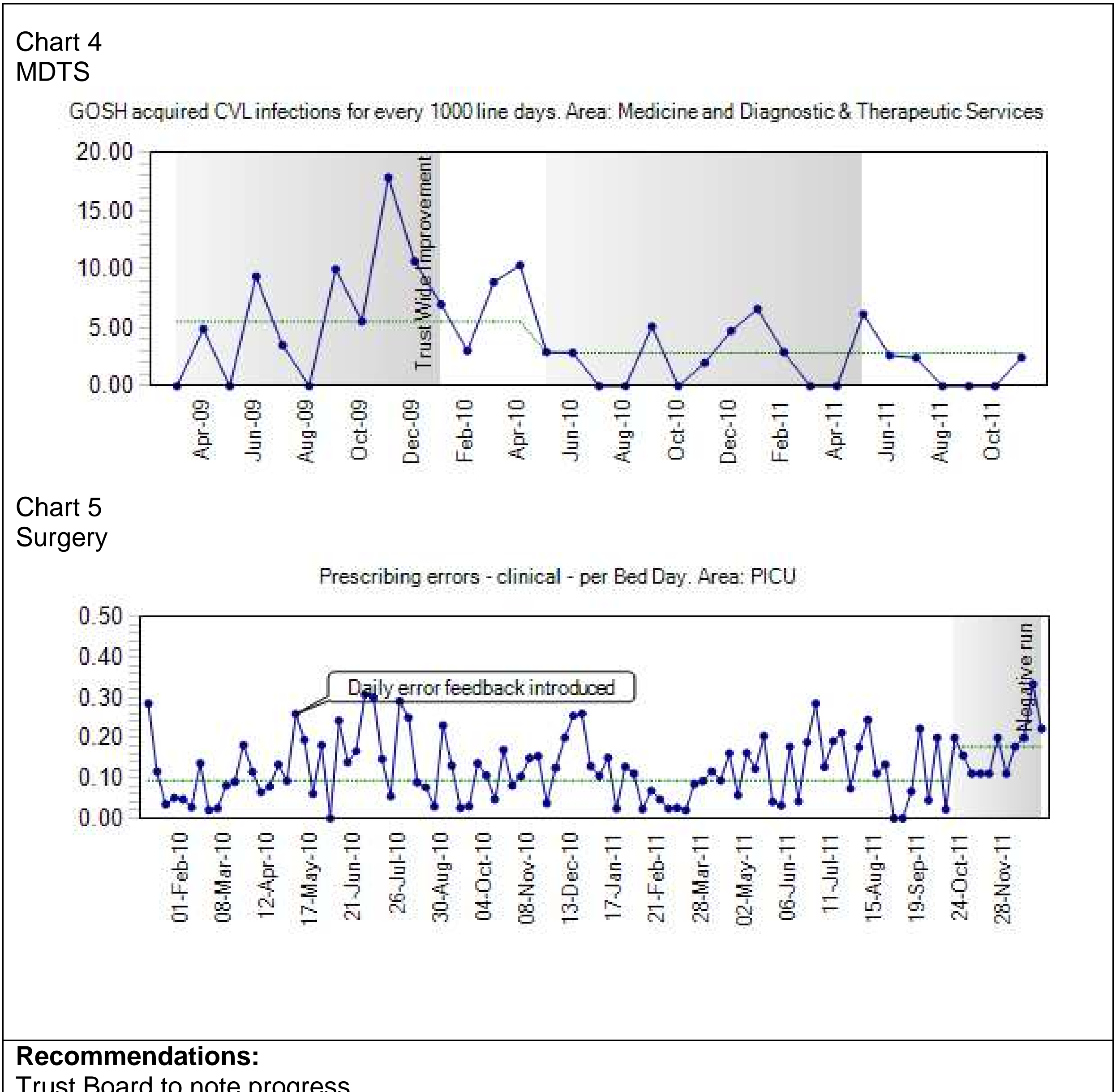


Recommendations:
Trust Board to note progress

Trust Board

Key Performance Indicator Report

Dec-11

Objective	Graph	Page no.	Reported	YTD Target/Trajectory (11/12)	YTD Performance	In month / quarter performance	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4
							Monthly Trend									Quarterly Trend			
Objective 1	Incidence of C.difficile	6	Monthly	6.8	7	0	2	1	1	0	1	1	0	1	0	4	2	1	
	Incidence of MRSA**	6	Monthly	0	4	1	1	0	1	0	0	0	0	1	1	2	0	2	
	Incidence of MSSA	6	Monthly	11/12 setting the baseline	16	3	1	1	0	2	0	3	3	3	3	2	5	9	
	Incidence of E-Coli	6	Monthly	11/12 setting the baseline	13	3	0	0	1	1	3	1	3	1	3	1	5	7	
	No. of NICE recommendations unreviewed	6	Monthly	0	-	3	3	6	7	8	11	0	2	1	3	7	0	6	
	CV Line related blood-stream infections	7	Monthly	1.5	2.0	2.2	1.4	2.5	1.9	2.6	2.5	1.9	2.2	0.5	2.2	2.00	2.33	1.58	
	Mortality Figures	7	Monthly	Within tolerance	82	12	7	8	11	4	11	8	9	12	12	26	23	33	
	Serious Patient Safety Incidents	7	Monthly	Within tolerance	17	3	2	0	4	1	4	0	2	1	3	6	5	6	
	Surgical Check List completion rate (%)	7/8	Monthly	95.0	82.3	89.7	72.1	71.5	77.4	83.6	80	83.7	84.6	86.1	89.7	73.0	82.0	87.7	
	48 Hour readmission to ITU (%)***	-	Quarterly	3.0	0.98	0.45			1.14			1.36			0.45	1.14	1.36	0.45	
	18 week referral to treatment time performance - Admitted (%)	9	Monthly	90	93.6	90.5	91.2	91.3	94.8	92.4	96.1	95.7	95.4	90.5	-	92.7	94.7	-	
	18 week referral to treatment time performance - Non-Admitted (%)	9	Monthly	95	69.4	96.3	97.7	97.6	97.0	96.8	95.1	96.0	95.9	96.3	-	97.1	95.9	-	
	18 week referral to treatment time performance - Incomplete Pathways (%)	9	Monthly	92	80.8	83.8	77.5	72.5	76.2	77.6	88.3	85.5	86.7	83.8	-	76.2	85.5	-	
	Inpatients waiting list profile (26+)	9	Monthly	0	-	132.0	66.0	73.0	64.0	71.0	163.0	118.0	148.0	199.0	-	64	118	-	-
	95th Centile - Admitted	9	Monthly	<23 weeks	20.5	22.7	21.8	21.3	19.2	21.5	17.8	17.9	18.0	22.7	-	20.7	18.3	-	
	95th Centile - Non-Admitted	9	Monthly	<18.3 weeks	17.7	17.7	17.6	17.7	17.5	17.5	18.0	17.8	17.9	17.7	-	17.6	17.8	-	
	Median Waits - Admitted	9	Monthly	<11.1 weeks	10.3	10.0	9.5	8.9	11.4	11.3	9.4	9.6	10.3	10.0	-	10.0	10.1	-	
	Median Waits - Non-Admitted	9	Monthly	<6.6 weeks	7.0	6.7	7.0	8.2	7.1	6.7	6.5	6.9	7.7	6.7	-	7.3	6.7	-	
	95th Centile - Incomplete Pathways	10	Monthly	<28 weeks	33.7	32.9	33.8	36.6	37.4	36.5	25.7	27.9	27.9	32.9	-	37.0	30.5	-	
	Median Waits - Incomplete Pathways	10	Monthly	<7.2 weeks	8.0	6.9	8.7	9.8	9.0	8.1	7.0	7.6	7.3	6.9	-	9.1	7.6	-	
	Discharge summary completion (%)	10	Monthly	95	79.1	78.0	74.3	77.2	77.2	80.8	80.4	74.9	81.9	81.2	81.4	76.29	78.37	81.50	
	DNA rate (new & f/up) (%)	10	Monthly	10	8	7	8.8	8.8	8.4	7.9	9.1	8.7	8.2	8.7	7	8.03	8.00	8.00	
	Cancelled Operations on day of admission (%)	11	Monthly	0.80	0.76	0.78	0.65	0.86	0.74	0.73	0.71	0.78	0.77	0.78	0.74	0.78	0.72	0.76	
	Percentage of Cancer 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	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	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	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	100	100	
	Number of complaints	12	Monthly	New indicator to be confirmed	101	5	21	8	12	9	10	13	7	16	5	41	32	28	
	Number of complaints by grade Low	12	Monthly	New indicator to be confirmed	49	4	6	1	3	3	6	8	7	11	4	10	17	22	
	Number of complaints by grade Medium	12	Monthly	New indicator to be confirmed	44	0	13	7	9	6	2	3	0	4	0	29	11	4	
	Number of complaints by grade High	12	Monthly	New indicator to be confirmed	8	1	2	0	0	0	2	2	0	1	1	2	4	2	

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	Dec-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	-	50.1	72	74.3	70	71.4	67.4	69.3	70.9	66.9	50.1	72.1	69.4	62.6	
	New to follow up ratio	13	Monthly	4.18	4.4	4.5	4.4	4.3	4.6	4.2	4.4	4.4	4.3	4.1	4.5	4.4	4.3	4.3	
	Patient refusals	13	Monthly	To reduce	179	5	28	22	19	27	9	18	20	31	5	69	54	56	
	Clinical Income variance (£)	13	Monthly	-	-1,610,703	-	0	1,053,912	278,133	48,168	-511,511	-1,184,496	-1,436,184	-1,336,486	-1,610,703	278,133	-1,184,496	-1,610,703	
Objective 4	Number of Active Research Projects	14	Monthly	-	-	571	648	639	625	622	618	604	607	599	571	1912	1844	1777	
	UKCRN Portfolio Studies	14	Monthly	-	-	102	95	97	98	99	98	98	101	103	102	290	295	306	
	Clinical trials recruitment portfolio	14			-	1	117	124	162	118	151	88	90	131	1	403	357	222	
	GOSH Research Grants (£)	14	Monthly	-	-	75,000	53,502	42,244	60,558	495,853	27,500	218,142	247,175	189,896	75,000	156,304	741,495	512,071	
	Research Grant Awards (£)	14	Monthly	-	-	361,712	465,797	1,447,693	1,052,451	2,220,191	806,276	1,381,638	3,622,018	500,098	361,712	2,965,942	4,408,105	4,483,828	
	Patient safety reports for GOSH-sponsored clinical trials	15	Monthly	-	6	0	1	0	3	0	0	1	0	1	0	4	1	1	
Objective 5	MADEL SLA Value (£)	16	Quarterly	-	5,627,351	-			5,697,359			5,627,351			5,627,351	5,697,359	5,627,351	5,627,351	
	SIFT SLA Value (£)	16	Quarterly	-	60,142	-			60,142			60,142			60,142	60,142	60,142	60,142	
	NMET SLA Value (£)	16	Quarterly	-	1,150,924	-			1,058,375			1,007,342			1,150,924	1,058,375	1,007,342	1,150,924	
Objective 6	CRES Forecast Savings 2011/12 (£)	17	Monthly	15,773,126	11,013,621	-	15,063,656	15,240,001	16,525,262	16,525,262	16,525,262	15,835,800	15,835,800	11,473,144	11,013,621	16,525,262	15,835,800	11,013,621	
	Bank and agency total expenditure (£)	17	Monthly	To Reduce	-	1,143	1,253	1,152	1,312	1,577	1,338	1,721	1,618	1,454	1,143	3,717	4,636	4215	
	Monitor Risk Rating	17	Monthly	3	-	3	2	2	3	3	3	3	3	3	3	3	3	3	
	Charity fundraising income (£)	18	Monthly	32,605,203	43,789,290	4,418,000	2,899,725	3,324,829	4,212,132	5,929,690	4,032,098	8,254,528	4,919,193	5,799,095	4,418,000	10,436,686	18,216,316	15,136,288	
Objective 7	Sickness Rate (%)	19	Quarterly	3.3	-	3.22			3.27			3.27			3.22	3.27	3.27	3.22	
	Staff in Post	19	Quarterly	-	-	3382.73			3,246			3,353			3,383	3,246	3,353	3,383	
	Vacancy Rate (%)	19	Quarterly	-	-	6.8			6.4			5.5			6.8	6.43	5.53	6.77	
	Trust Turnover (%)	19/20	Quarterly	-	-	20.7			20.9			21.1			20.7	20.9	21.1	20.7	
	Staff PDR completeness - clinical (%)	20	Monthly	95	-	69	73.3	75.7	75.9	77.6	75.9	72.1	68.6	66.2	69	75.9	72.1	69	
	Staff PDR completeness - non clinical (%)	20	Monthly	95	-	54.5	73	74.9	73	72.3	71.1	65.8	61.9	57.2	54.5	73	65.8	54.5	
	Information Governance Training (%)	20	Monthly	95	-	87.7	34.15	51.86	82.96	85.53	88.36	89.76	86.90	87.70	87.7	83	89.76	87.7	

* 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.

*** Excludes readmissions to CICU from HDU

For Key, see Glossary

Key Performance Indicator Report

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
Objective 1	Incidence of MRSA	0 Cases	Trajectory less than 6 Cases**	Trajectory greater than 6 Cases
Objective 1	Incidence of MSSA	First Year of Recording		
Objective 1	Incidence of E-Coli	First Year of Recording		
Objective 1	Surgical Check List completion rate %	Greater than 95%	Between 85% and 95%	Less than 85%
Objective 1	No. of NICE recommendations unreviewed	Less or equal to 1	2or 3	Greater than 3
Objective 1	48 Hour readmission to ITU	Less than 3%	Less than 3.3%	Greater than or equal to 3.3%
Objective 1	Mortality Figures	Indicator		
Objective 1	Serious Patient Safety Incidents	Indicator		
Objective 1	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 75% and 95%	Less than 75%
Objective 2	DNA rate (new & f/up) (%)	Less than 9	Either 9 or 10	Greater than 10
Objective 2	18 week referral to treatment time performance - Admitted	Greater than 91%	-	Less than 90%
Objective 2	18 week referral to treatment time performance - Non-Admitted	Greater than 96%	-	Less than 95%
Objective 2	18 week referral to treatment time performance - Incomplete Pathways	Greater than 92%	-	Less than 92%
Objective 2	95th Centile - Admitted	Less than 23 weeks	-	Greater than 23 weeks
Objective 2	95th Centile - Non-Admitted	Less than 18.3 weeks	-	Greater than 18.3 weeks
Objective 2	95th Centile - Incomplete Pathways	Less than 28 weeks	-	Greater than 28 weeks
Objective 2	Median Waits - Admitted	Less than 11.1 weeks	-	Greater than 11.1 weeks
Objective 2	Median Waits - Non-Admitted	Less than 6.6 weeks	-	Greater than 6.6 weeks
Objective 2	Median Waits - Incomplete Pathways	Less than 7.2 weeks	-	Greater than 7.2 weeks
Objective 2	Number of complaints	No RAG status - Plan not confirmed		
Objective 2	Number of complaints by grade Low	No RAG status - Plan not confirmed		
Objective 2	Number of complaints by grade Medium	No RAG status - Plan not confirmed		
Objective 2	Number of complaints by grade High	No RAG status - Plan not confirmed		
Objective 2	Percentage of Cancelled Operations	Equal to or less than 0.8%	-	Greater than 0.8%
Objective 2	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%
Objective 2	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%
Objective 2	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%
Objective 2	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%
Objective 2	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%
Objective 3	New to follow up ratio	Less than 4.18	-	Greater than 4.18
Objective 3	Patient refusals	Indicator		
Objective 3	Clinical Income variance	Indicator		

Objective	Measure	Green	Amber	Red
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	Indicator		
Objective 7	Staff PDR completeness - clinical (%)	Greater than or equal to 97%	Less than 97%	Less than to 95%
	Staff PDR completeness - non clinical (%)	Greater than or equal to 97%	Less than 97%	Less than to 95%
	Information Governance Training	Greater than or equal to 97%	Less than 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

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	Month 9	Q3
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0	0	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	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	0	0
	Surgery	94%			0	0	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	0	0
	radiotherapy (from 1 Jan 2011)	94%			0	0	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	0	0
5	Non-Admitted 95thCentile Performance	<18.3 weeks	1	Quarterly	0	0	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	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	0.5	0.5
Total								1.5				1.5				1.5
Overall governance risk rating								Amber-green				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

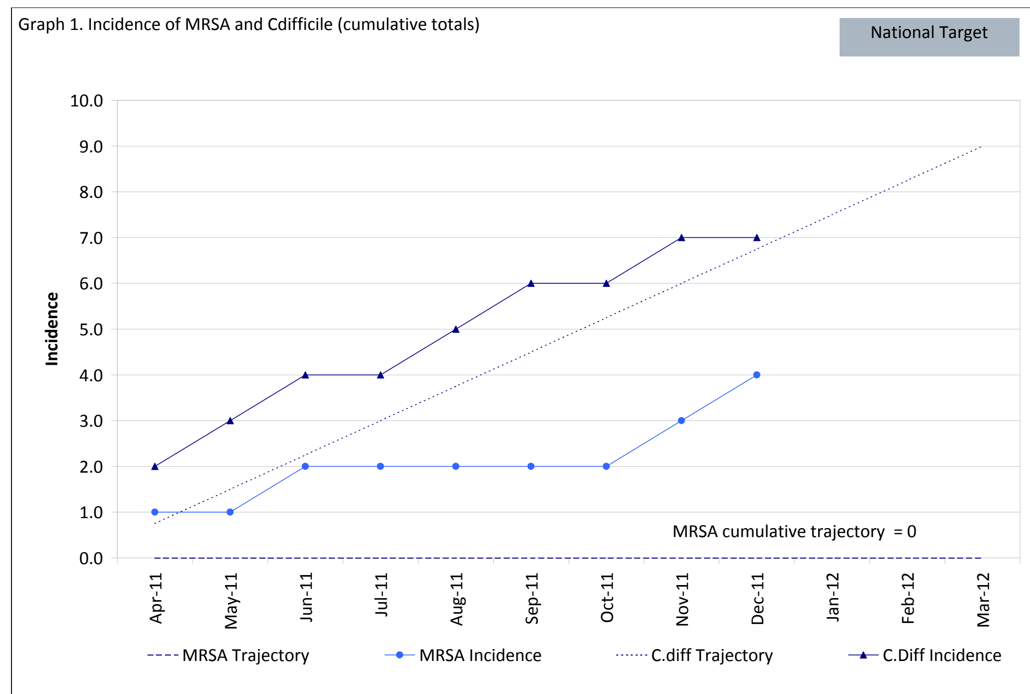
Risk rating	Description (risk of significant breach of authorisation)
Green	No material concerns
Amber-green	Emerging concerns
Amber-red	Potential future significant breach if not rectified
Red	Likely or actual significant breach

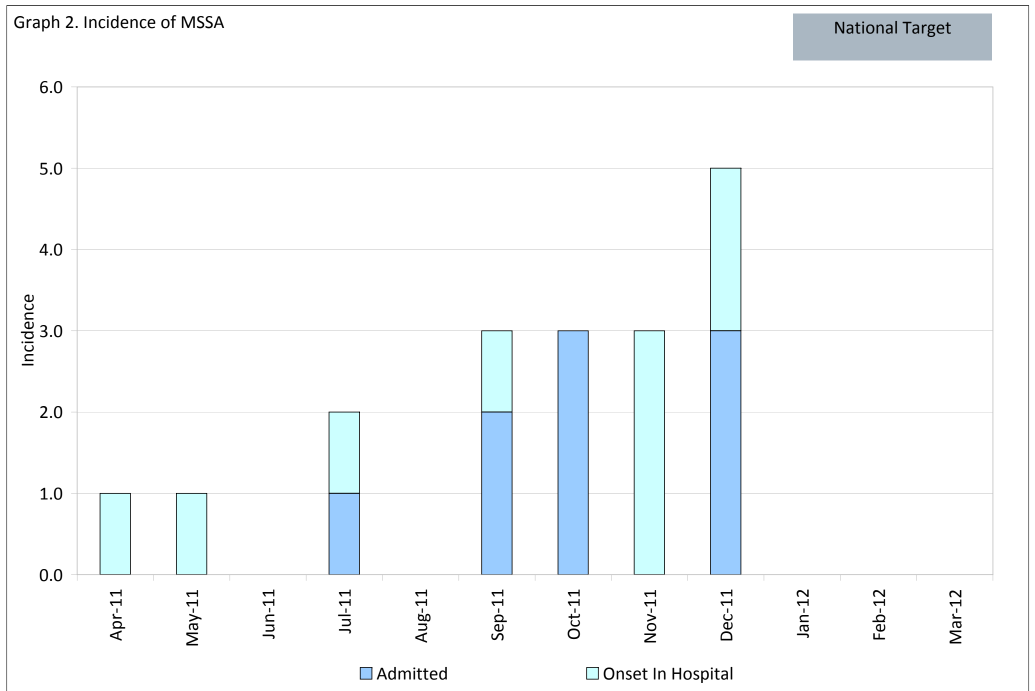
Monitor Quality Governance framework assessment (Jan 2012)

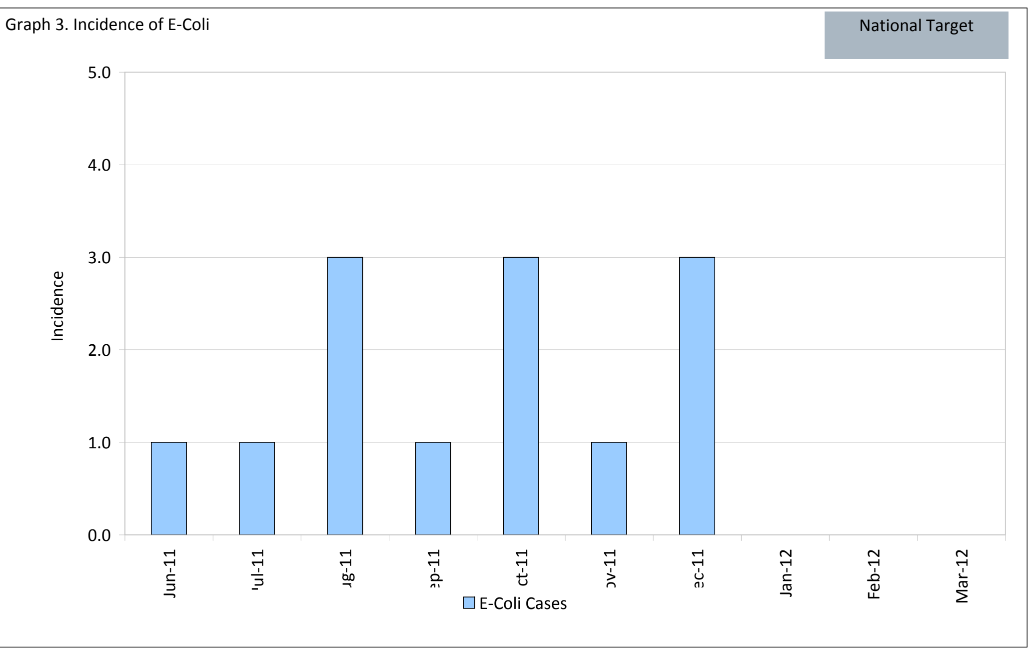
Domain	Monitor rating	Action plan	Trust rating after action plan
1A: Does quality drive the Trust's strategy?	Amber / Green (0.5)	**Completed:** KPI report updated Accountability map **To be completed:** Updated quality strategy	Amber / Green (0.5)
1B: Is the Board sufficiently aware of potential risks to quality?	Amber / Red (1)	**Completed:** KPI report CRES links to KPIs **To be completed:** Unit risk registers show hospital-wide Balanced scorecard for services	Amber / Green (0.5)
2A: Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	Amber / Green (0.5)	**Completed:** KPI report updated	Green
2B: Does the Board promote a quality-focused culture throughout the Trust?	Green	**Completed:** Evidence of board leadership shown	Green
3A: Are there clear roles and accountabilities in relation to quality governance?	Amber / Green (0.5)	**Completed:** Evidence of TB leadership on quality · Accountability map	Green
3B: Clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	Amber / Green (0.5)	**Completed:** Updated performance management strategy Evidence for Q&S ctte review of learning.	Green

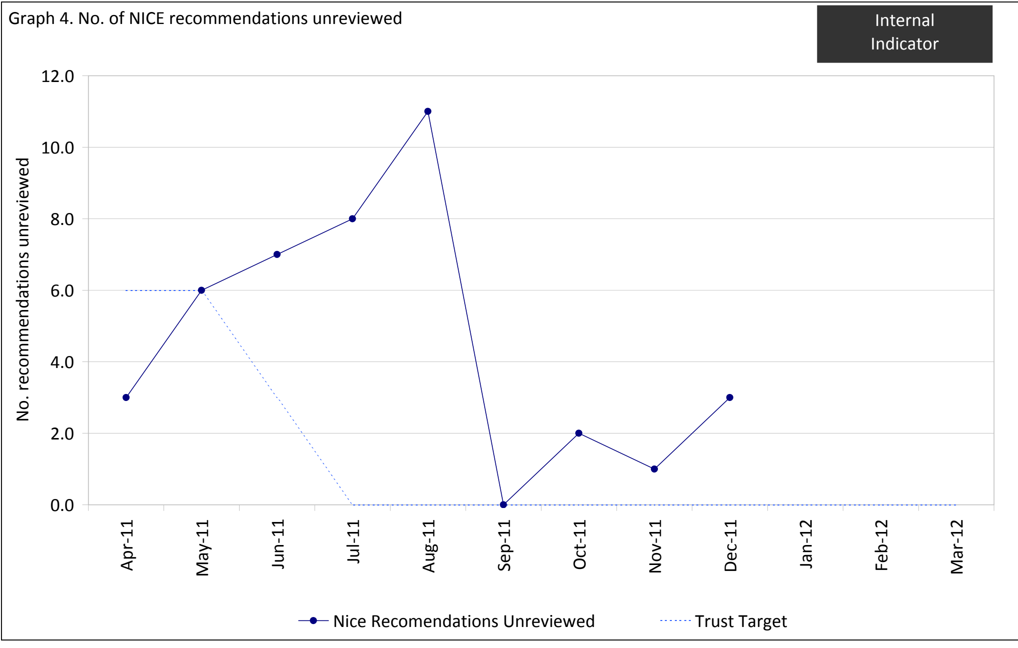
3C: Does the Board actively engage patients, staff and other key stakeholders on quality?	Green		Green
4A: Is appropriate quality information being analysed and challenged?	Amber / Red (1)	**Completed:** KPI report updated Consistency across specialty / unit / board KPI reports Summary of clinical unit reports to TB	Green
4B: Is the Board assured of the robustness of the quality information?	Amber / Red (1)	**Completed:** Audit plan **To be completed:** Clinical audit programme Review IT training processes Identify all IAOs DQ guidance in place Clinical outcomes development	Amber / Green (0.5)
4C: Is quality information used effectively? (Amber Green)	Amber / Green (0.5)	**Completed:** Mortality Review Board to report to TB and CGC on six monthly basis	Green
Overall score	**4.5**		**1.5**

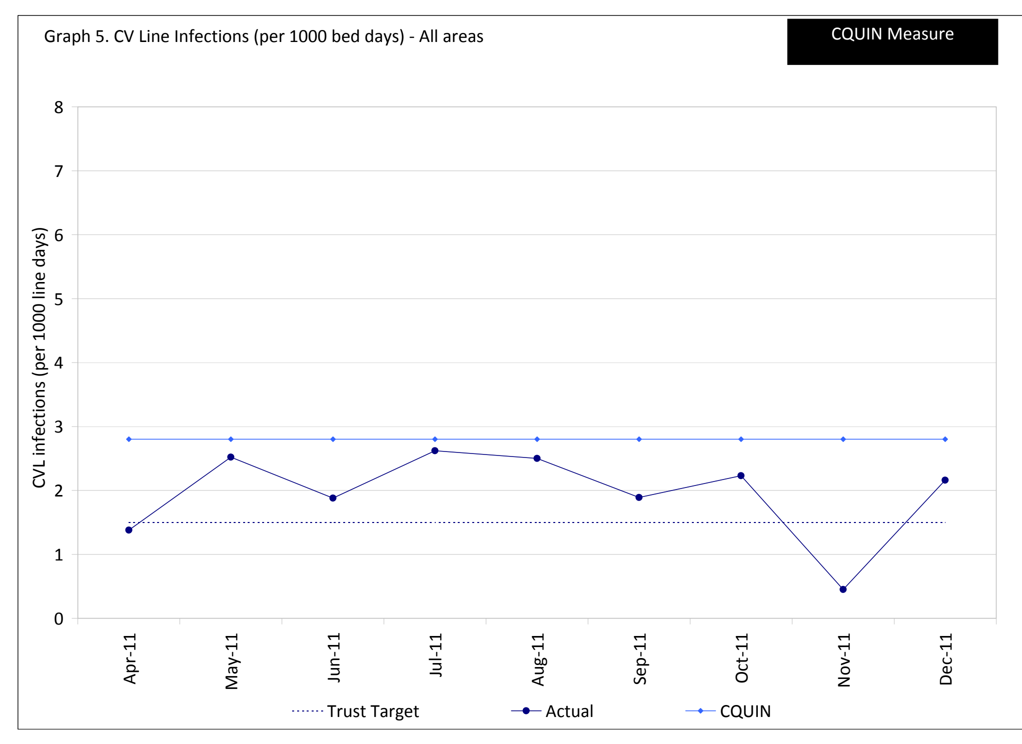
1. Consistently deliver clinical outcomes that place us amongst top 5 Children's Hospitals in the world.

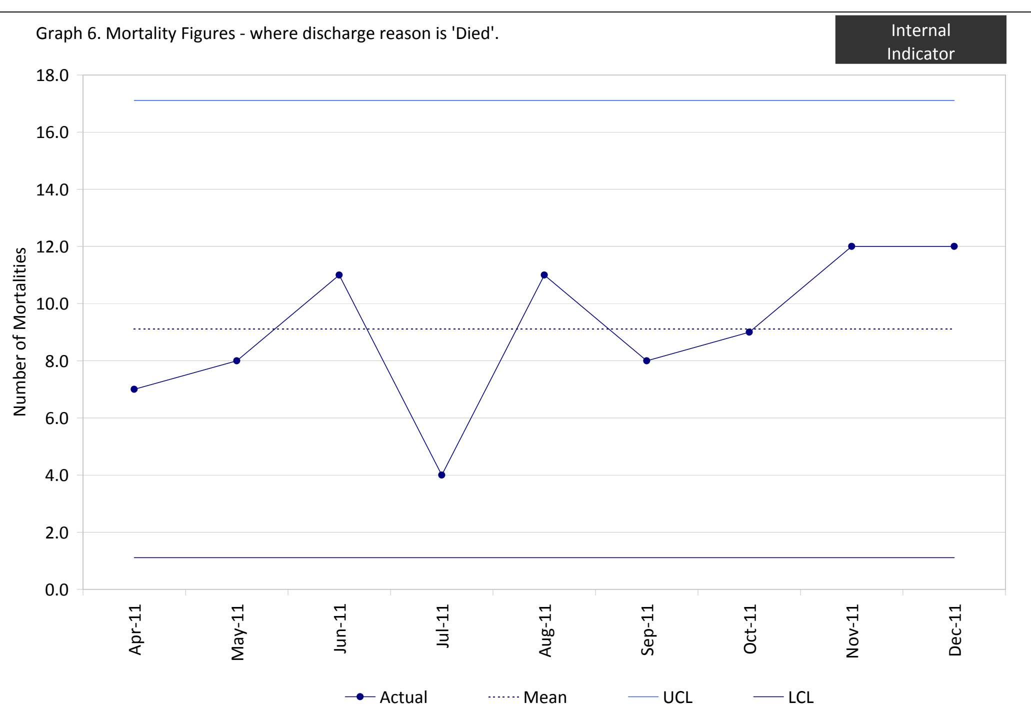


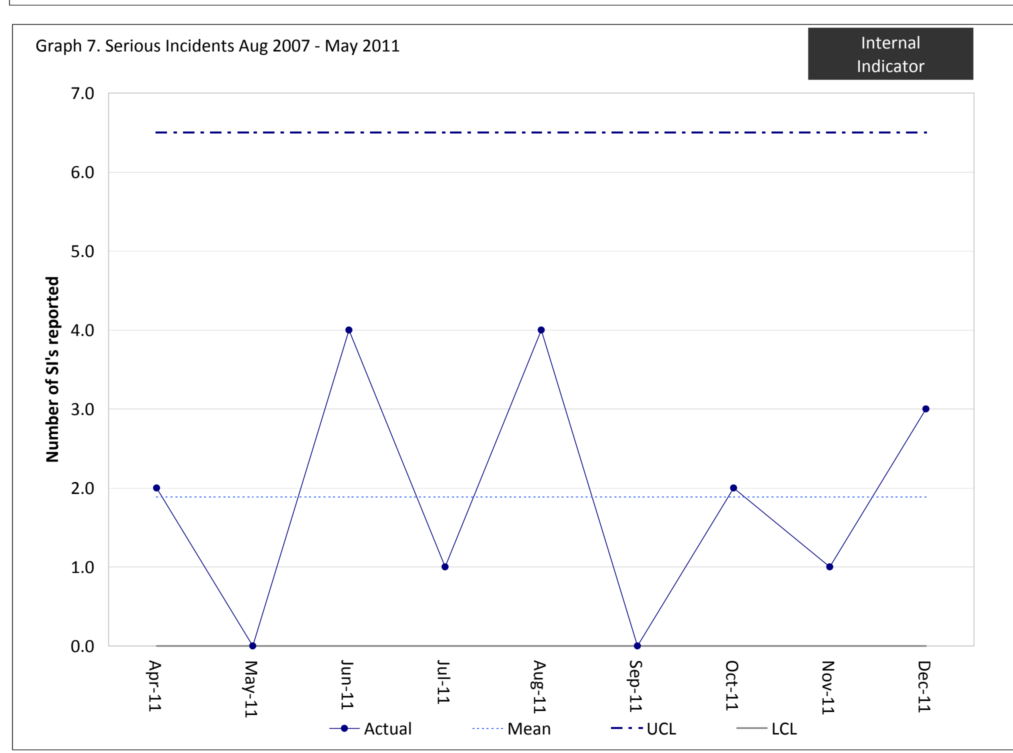


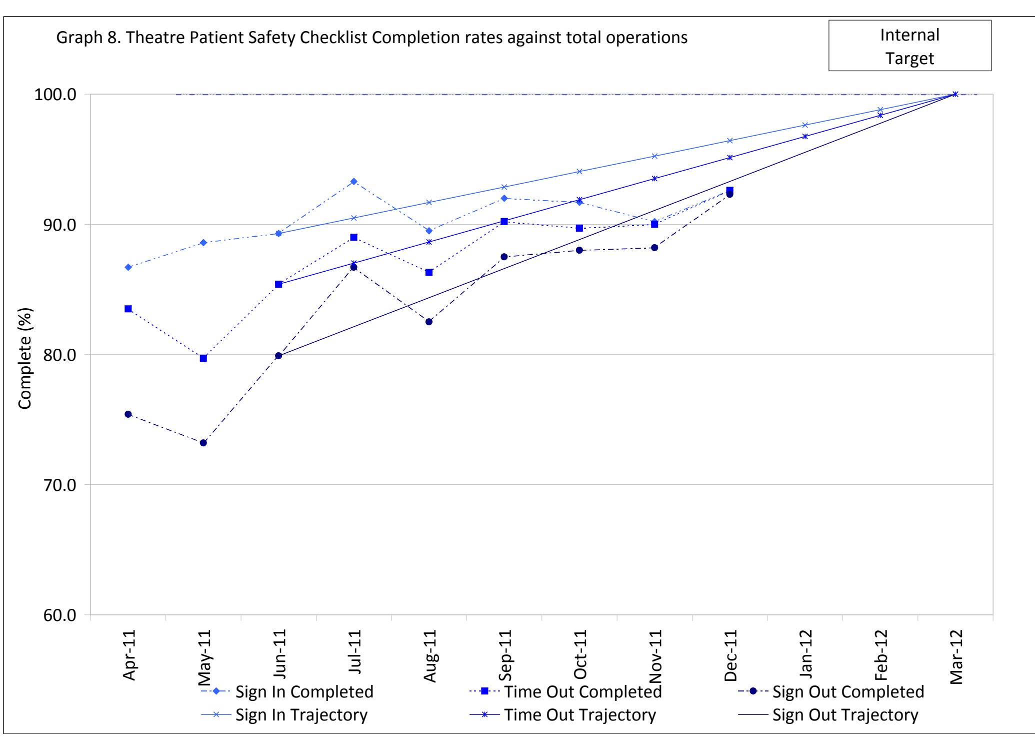


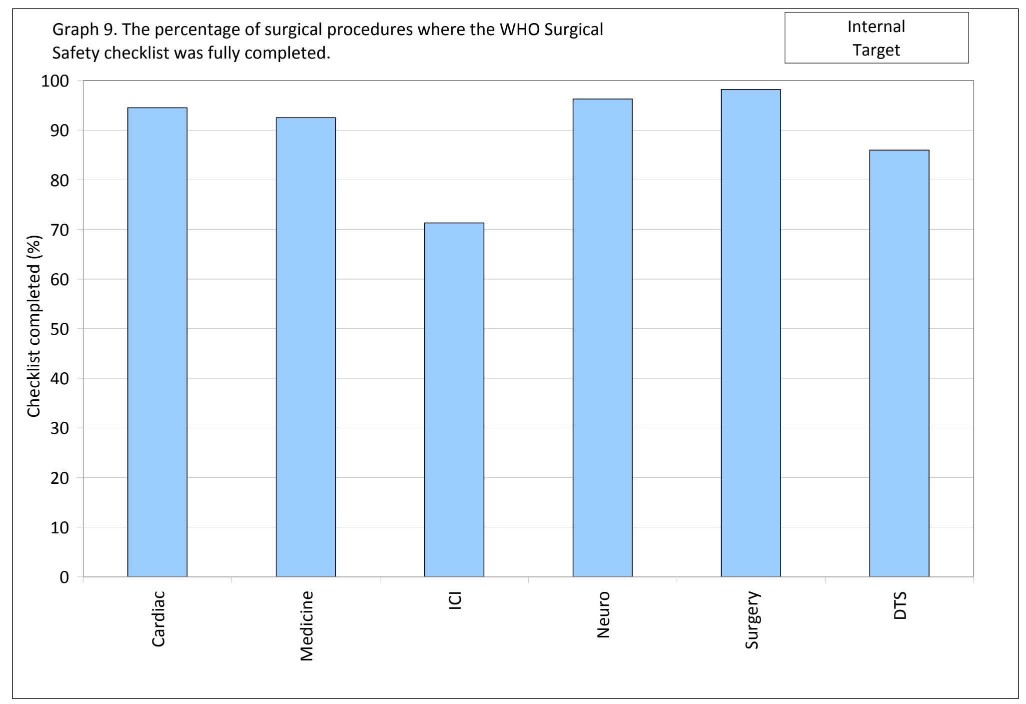



Graph 5. CV Line Infections (per 1000 bed days) - All areas
CQUIN Measure
CVL infections (per 1000 line days)
8
7
6
5
4
3
2
1
0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Trust Target
Actual
CQUIN


Graph 6. Mortality Figures - where discharge reason is 'Died'.
Internal Indicator
Number of Mortalities
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Actual
Mean
UCL
LCL

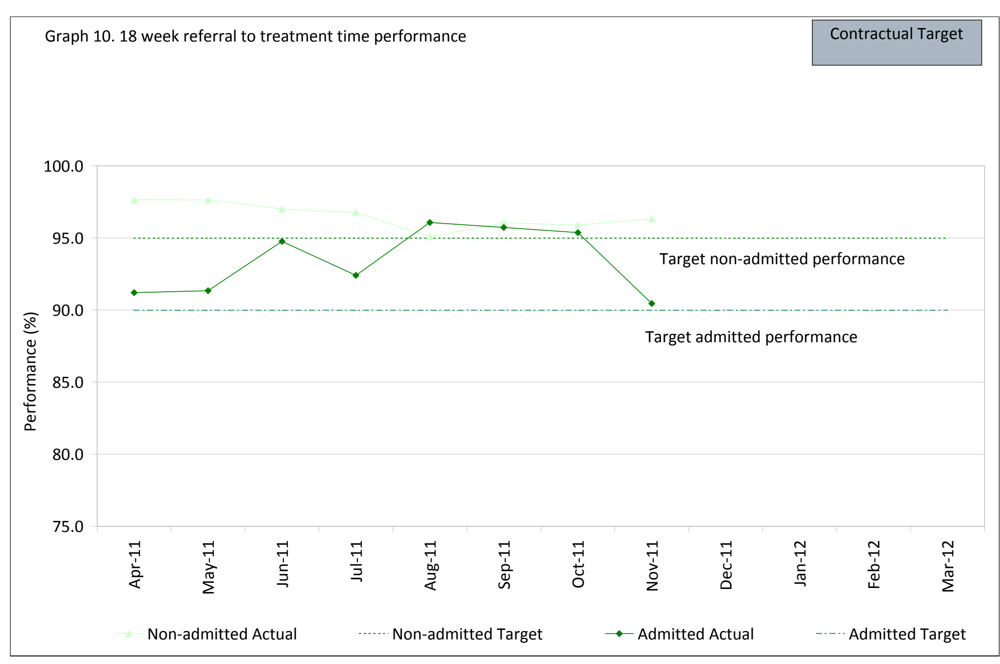

Graph 7. Serious Incidents Aug 2007 - May 2011
Internal Indicator
Number of SI's reported
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Actual
Mean
UCL
LCL

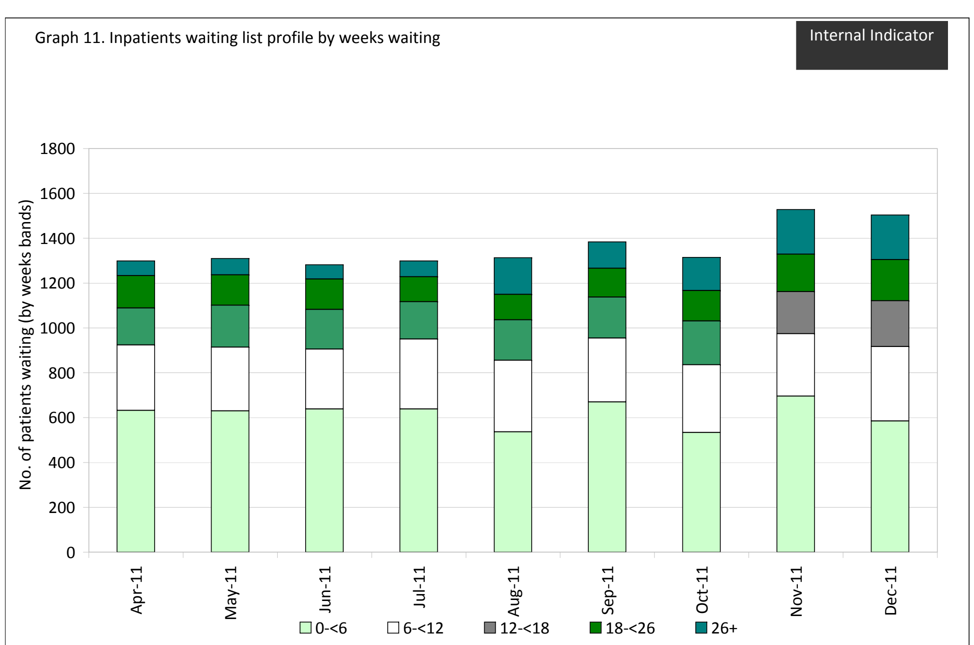

Graph 8. Theatre Patient Safety Checklist Completion rates against total operations
Internal Target
Complete (%)
100.0
90.0
80.0
70.0
60.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Sign In Completed
Time Out Completed
Sign Out Completed
Sign In Trajectory
Time Out Trajectory
Sign Out Trajectory

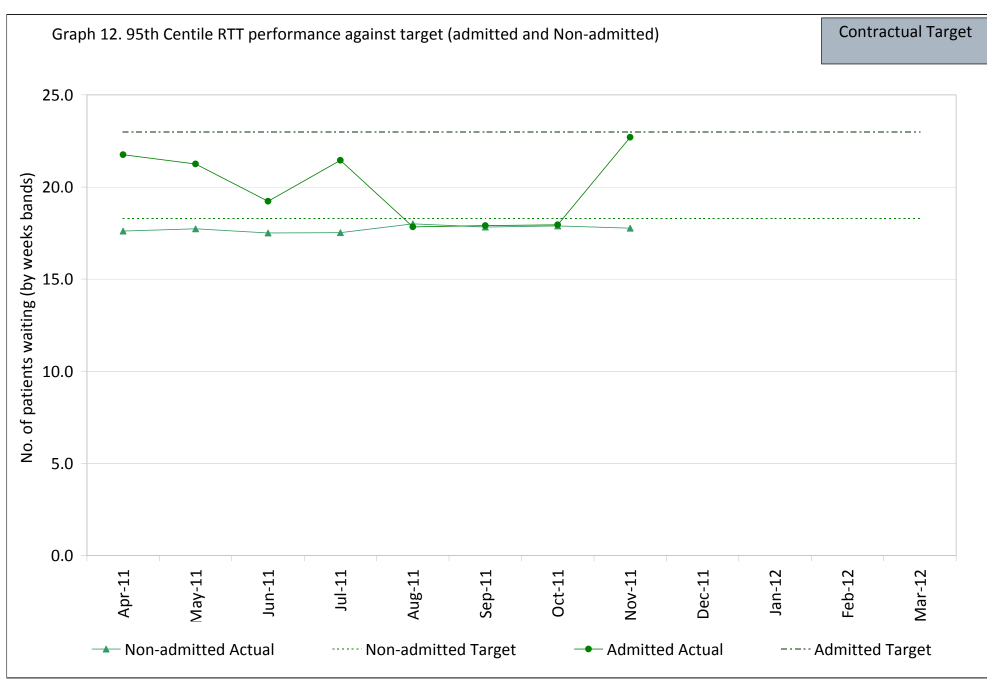

Graph 9. The percentage of surgical procedures where the WHO Surgical Safety checklist was fully completed.
Internal Target
Checklist completed (%)
100
90
80
70
60
50
40
30
20
10
0
Cardiac
Medicine
ICI
Neuro
Surgery
DTS

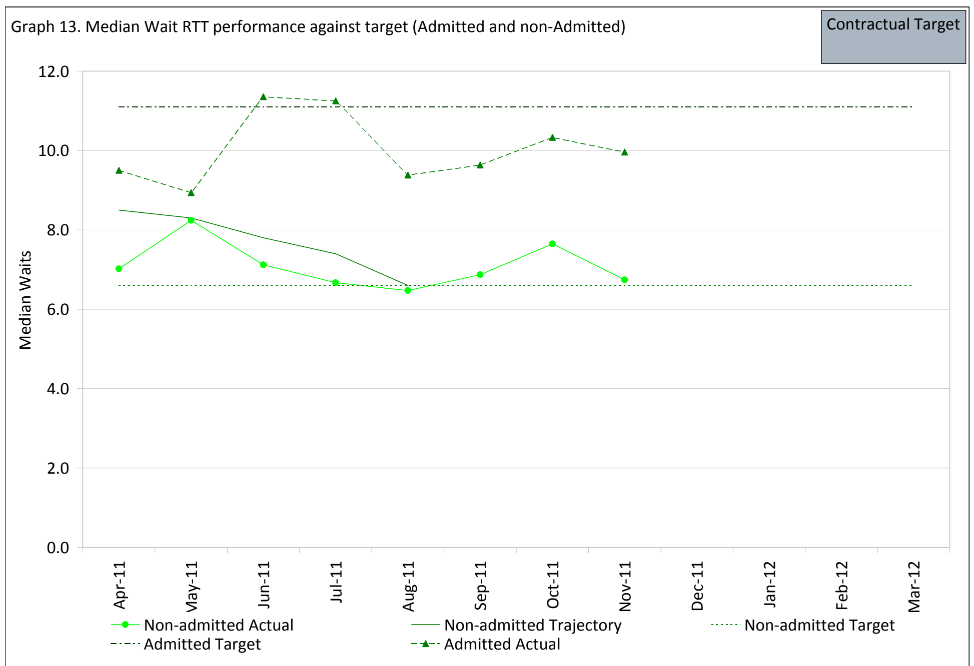
Great Ormond Street Hospital for Children NHS Trust

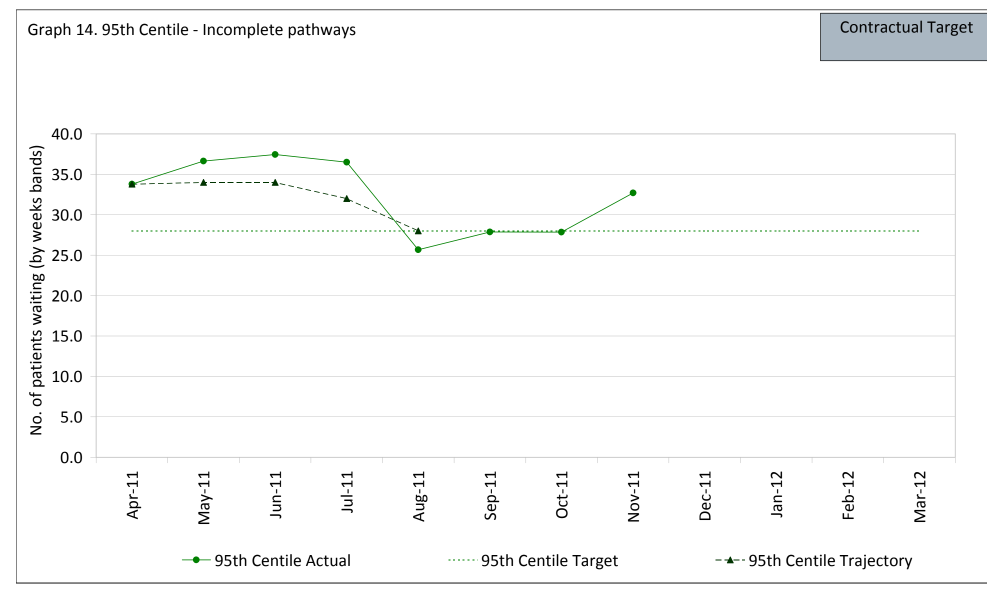
2. Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations

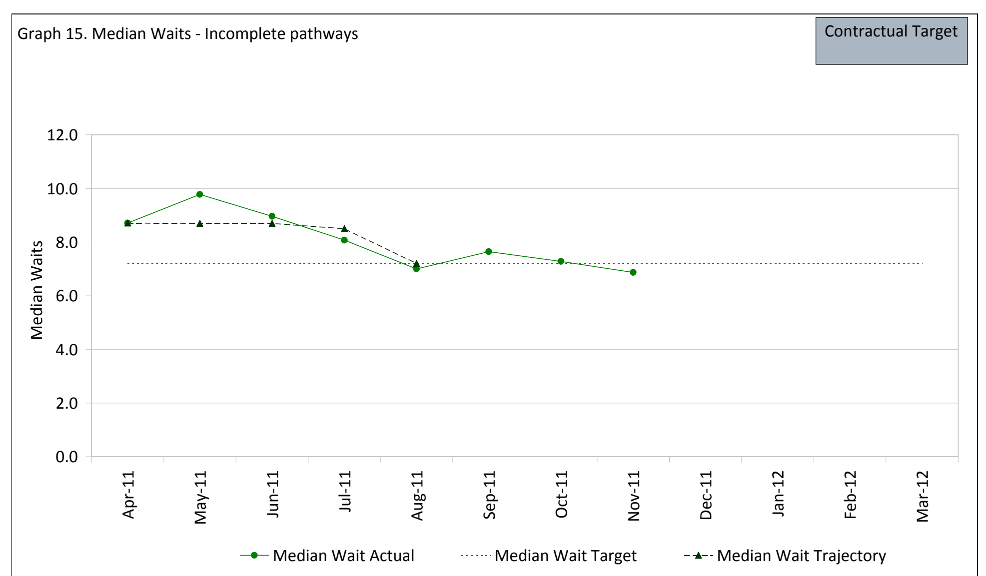


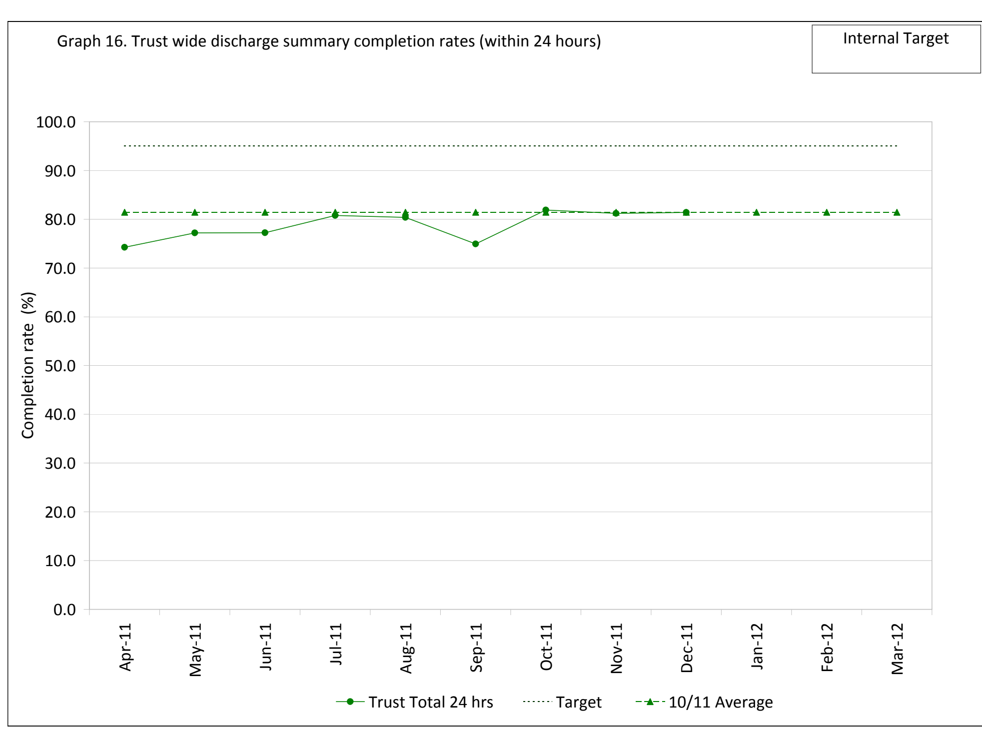


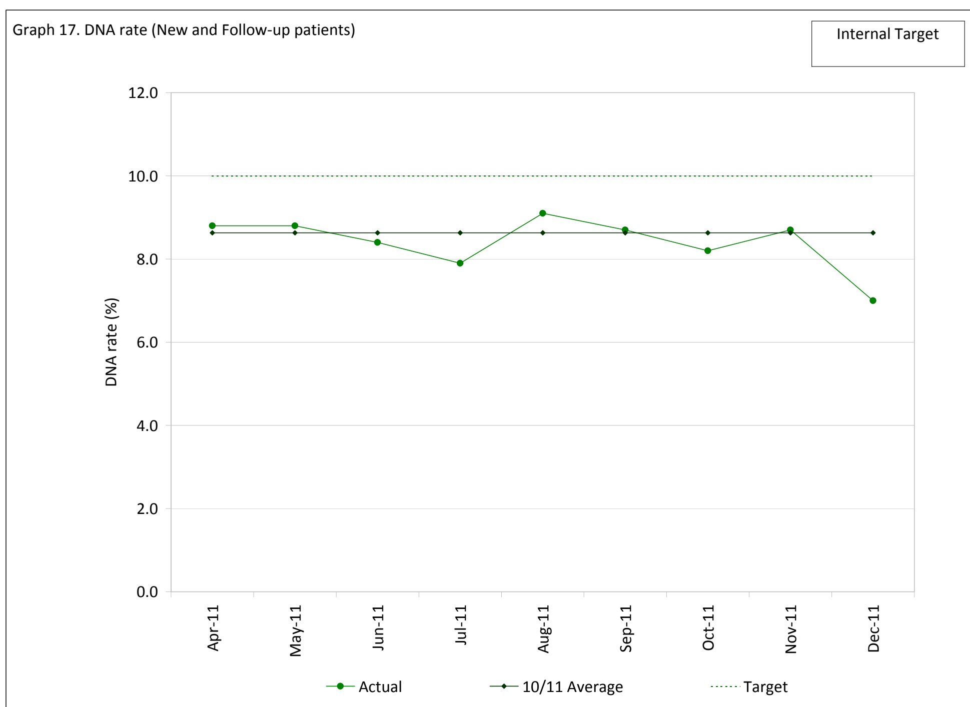


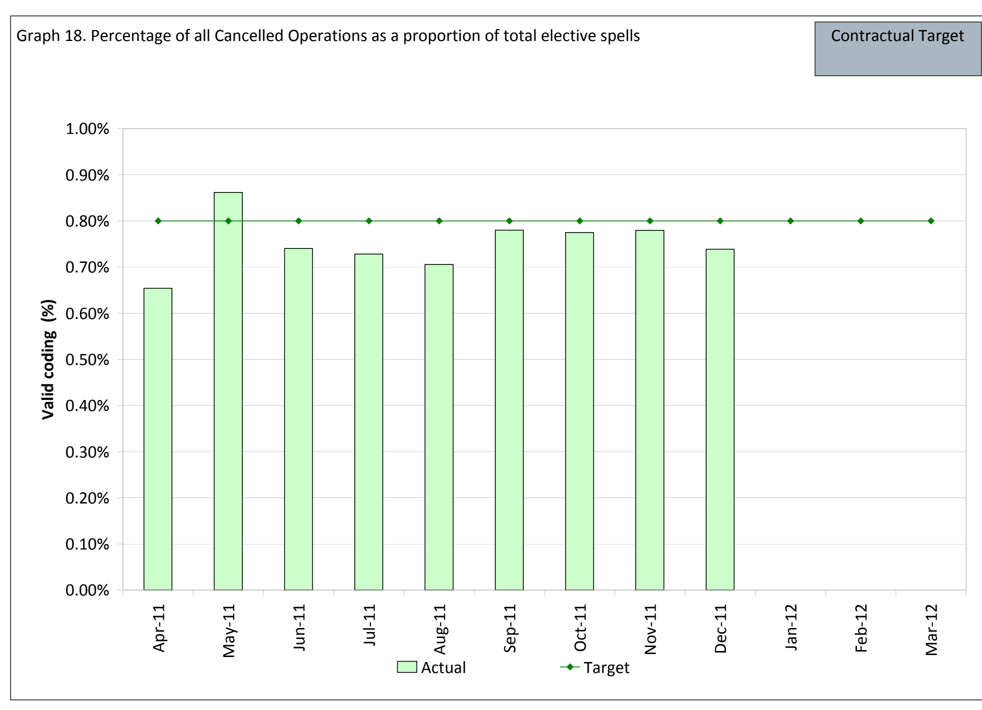


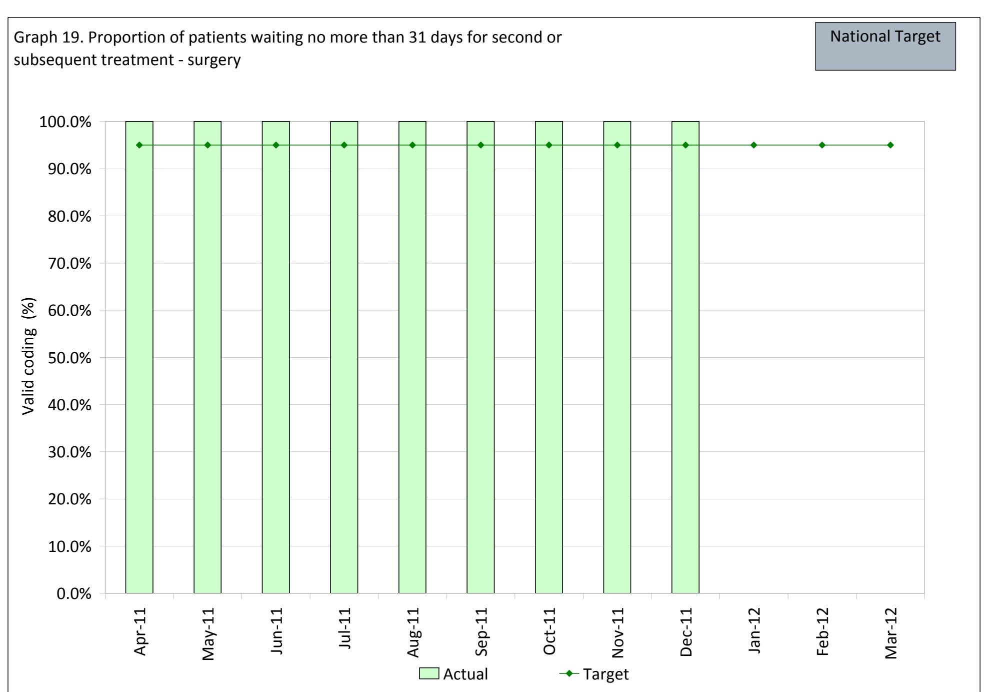

Graph 14. 95th Centile - Incomplete pathways
Contractual Target
No. of patients waiting (by weeks bands)
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
95th Centile Actual
95th Centile Target
95th Centile Trajectory

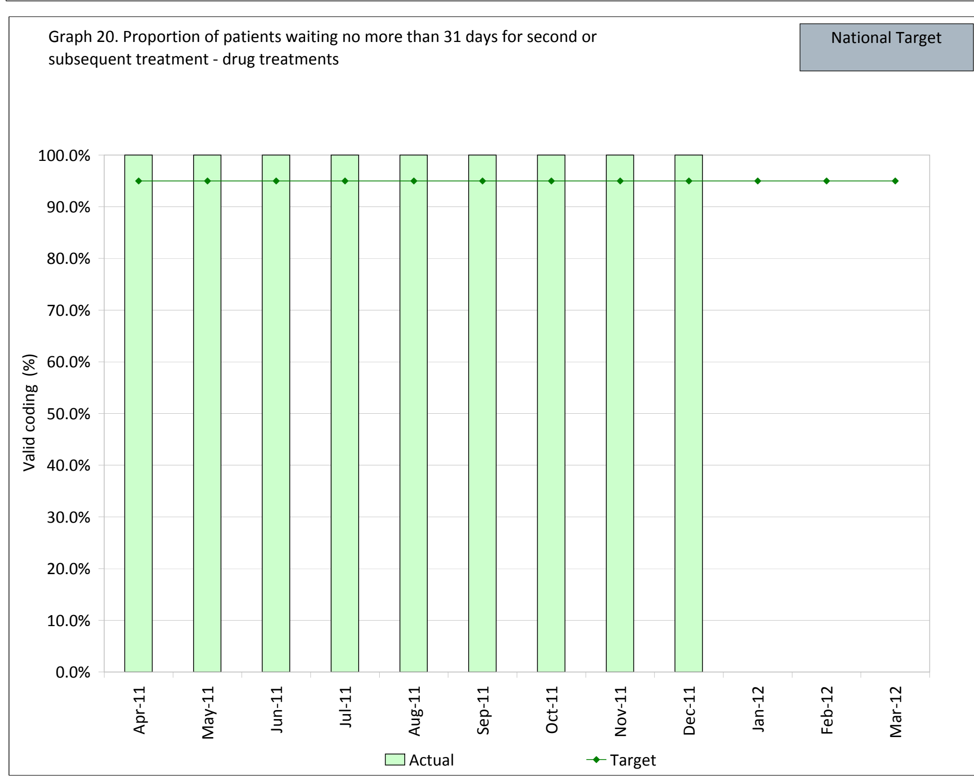

Graph 15. Median Waits - Incomplete pathways
Contractual Target
Median Waits
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Median Wait Actual
Median Wait Target
Median Wait Trajectory

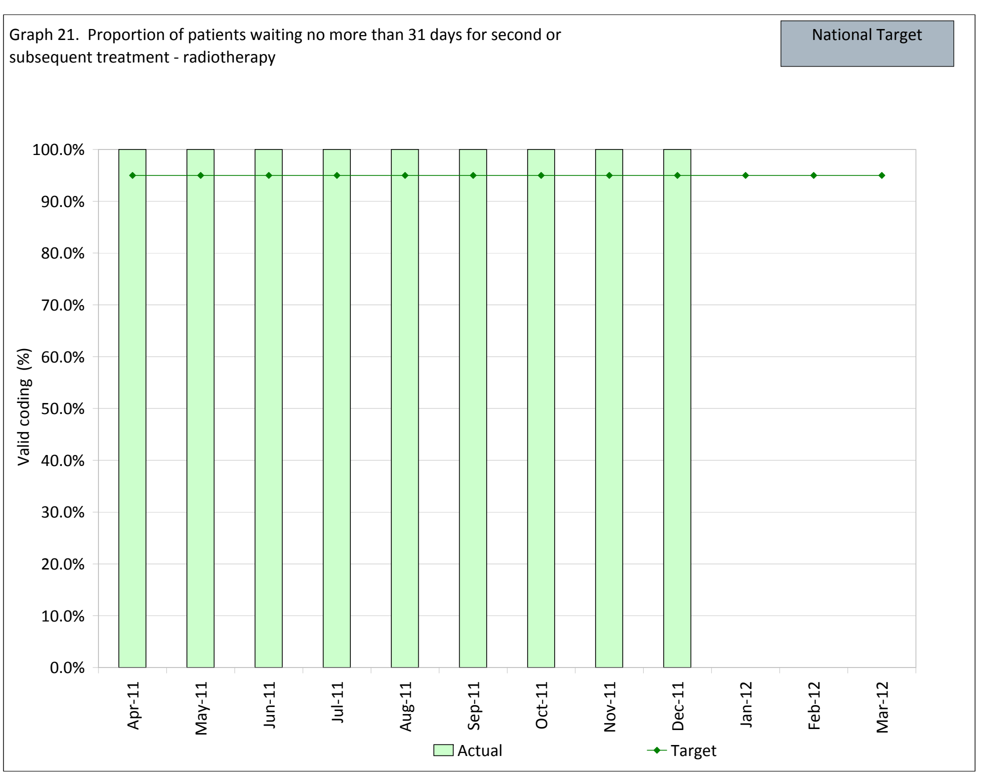

Graph 16. Trust wide discharge summary completion rates (within 24 hours)
Internal Target
Completion rate (%)
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Trust Total 24 hrs
Target
10/11 Average

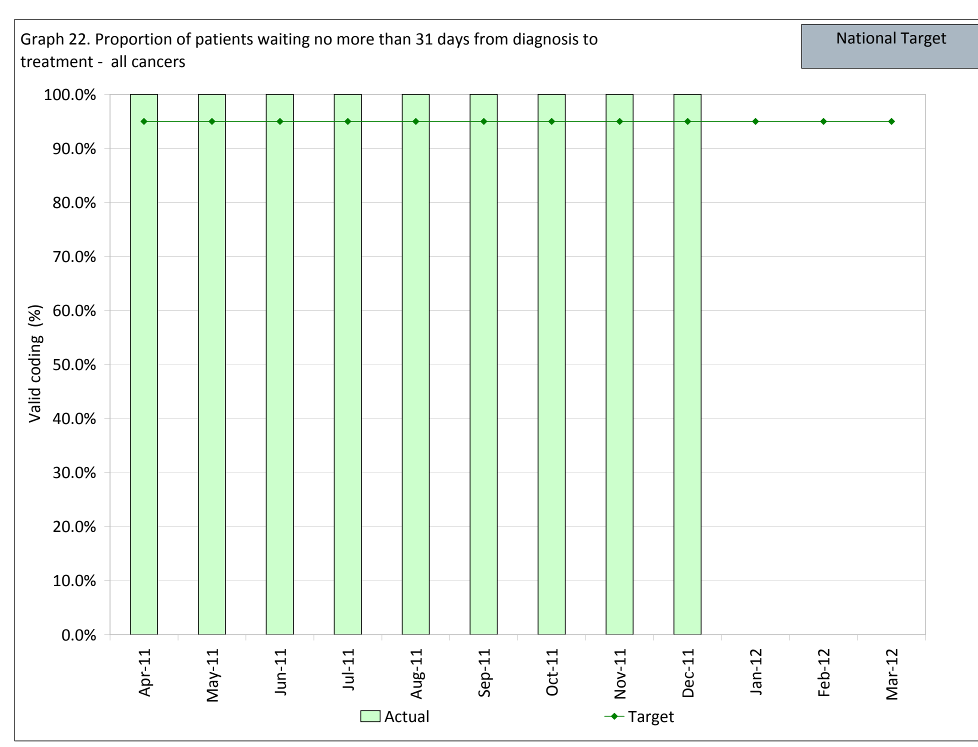

Graph 17. DNA rate (New and Follow-up patients)
Internal Target
DNA rate (%)
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Actual
10/11 Average
Target


Graph 18. Percentage of all Cancelled Operations as a proportion of total elective spells
Contractual Target
Valid coding (%)
1.00%
0.90%
0.80%
0.70%
0.60%
0.50%
0.40%
0.30%
0.20%
0.10%
0.00%
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Actual
Target

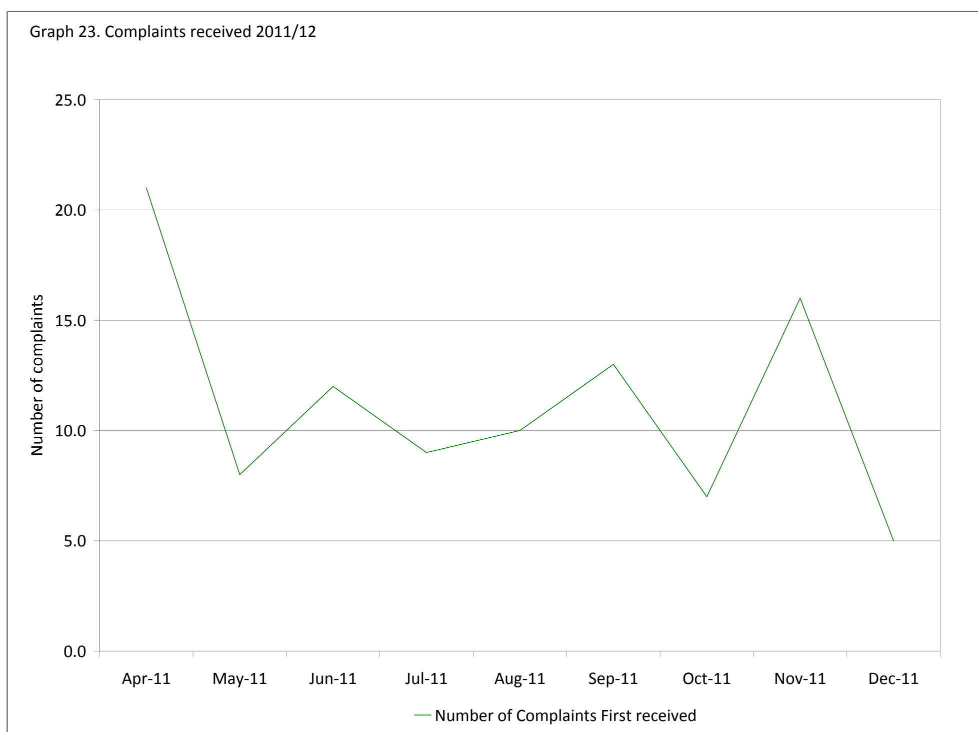

Graph 19. Proportion of patients waiting no more than 31 days for second or subsequent treatment - surgery
National Target
Valid coding (%)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Actual
Target


Graph 20. Proportion of patients waiting no more than 31 days for second or subsequent treatment - drug treatments
National Target
Valid coding (%)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Actual
Target

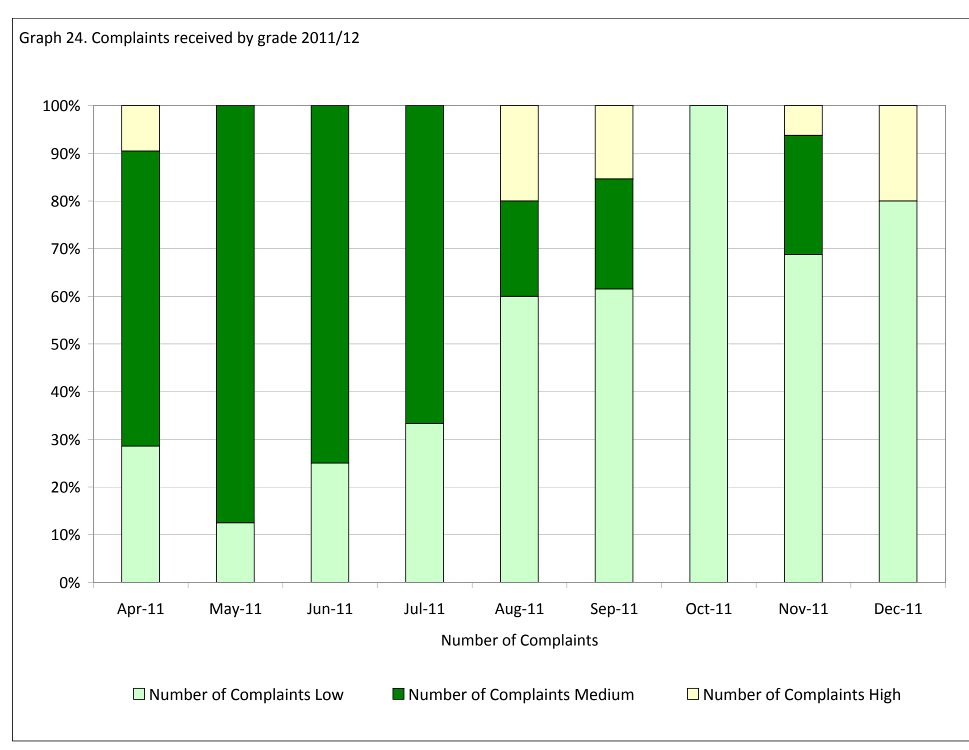

Graph 21. Proportion of patients waiting no more than 31 days for second or subsequent treatment - radiotherapy
National Target
Valid coding (%)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Actual
Target



Graph 22. Proportion of patients waiting no more than 31 days from diagnosis to treatment - all cancers
National Target
Valid coding (%)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Actual
Target



Graph 23. Complaints received 2011/12
Number of complaints
25.0
20.0
15.0
10.0
5.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Number of Complaints First received

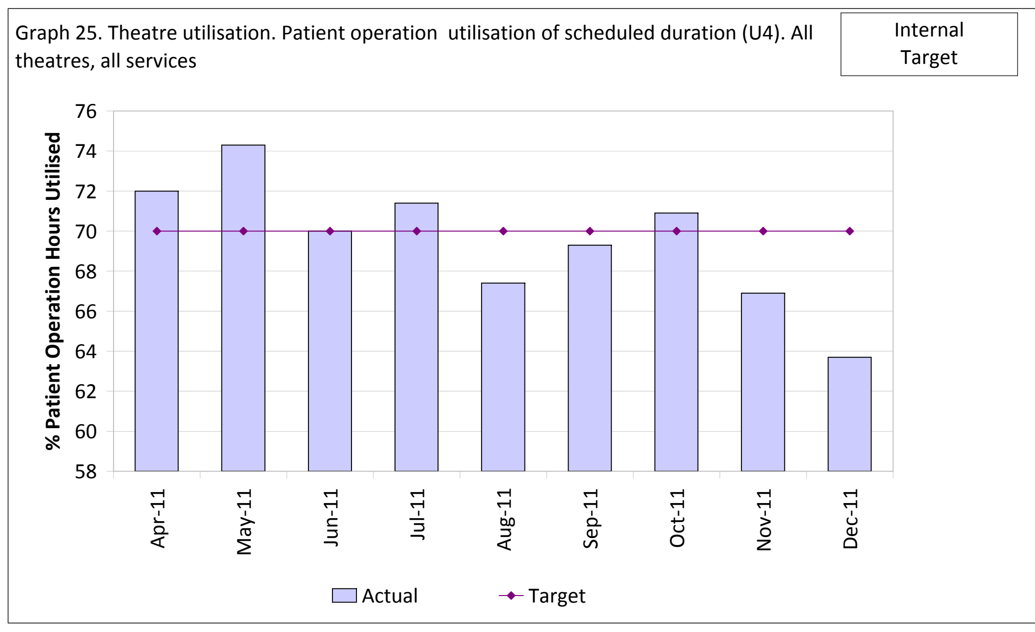


Graph 24. Complaints received by grade 2011/12
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Number of Complaints
Number of Complaints Low
Number of Complaints Medium
Number of Complaints High

3. Successfully deliver our clinical growth strategy

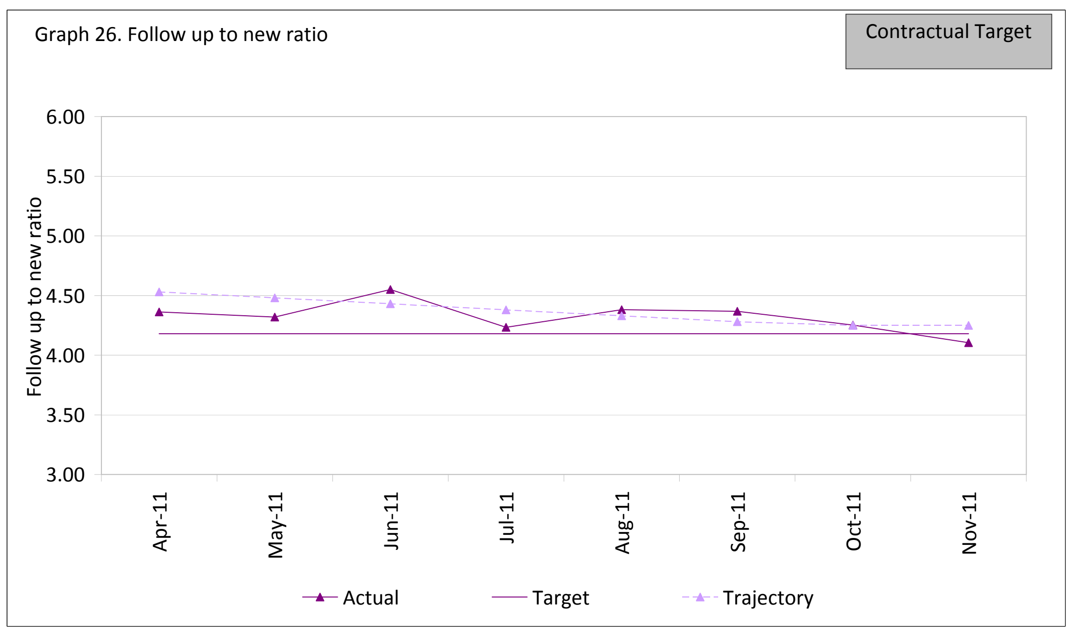
Graph 25. Theatre utilisation. Patient operation utilisation of scheduled duration (U4). All theatres, all services

Internal Target



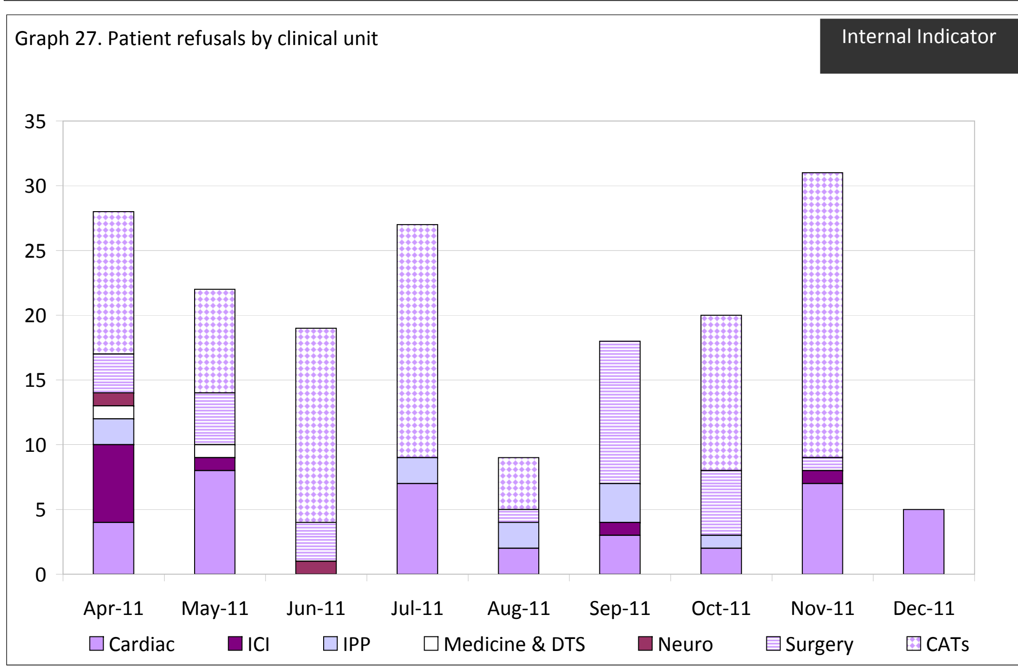
Graph 26. Follow up to new ratio

Contractual Target



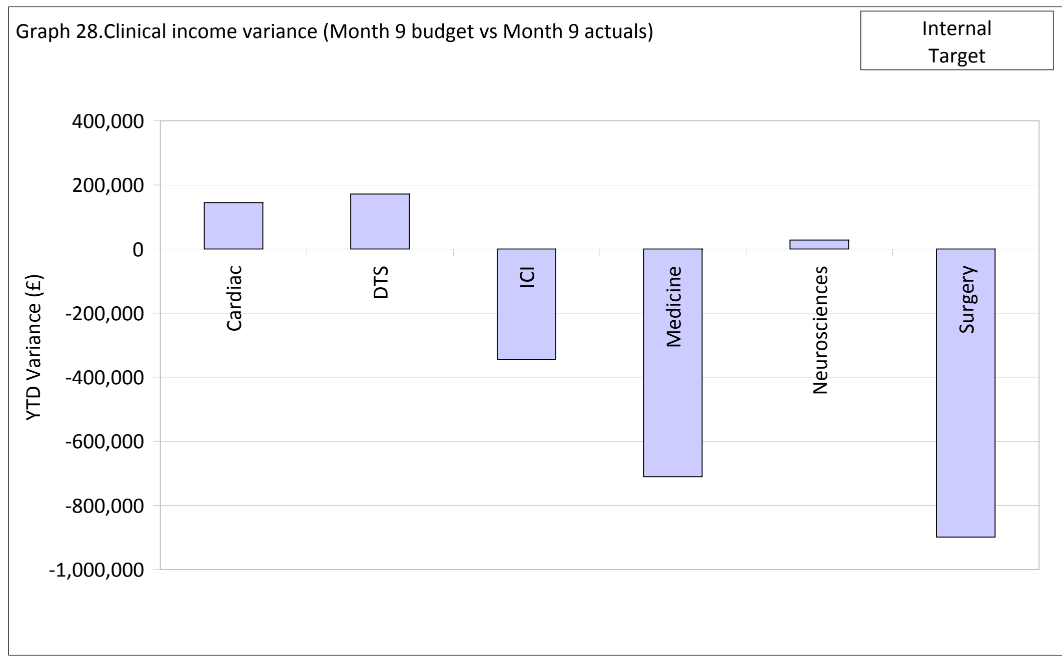
Graph 27. Patient refusals by clinical unit

Internal Indicator

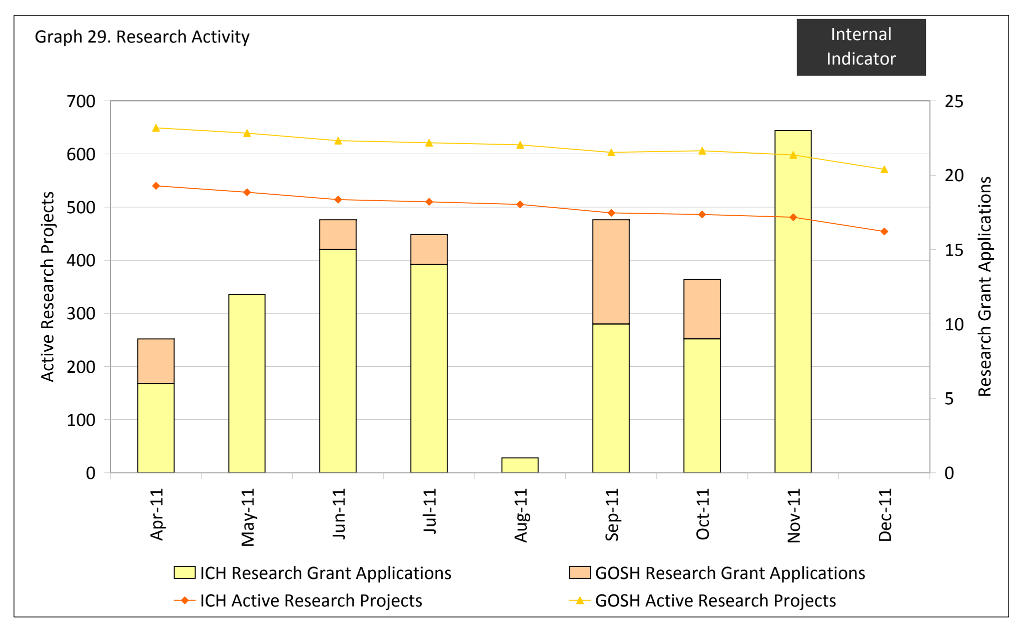


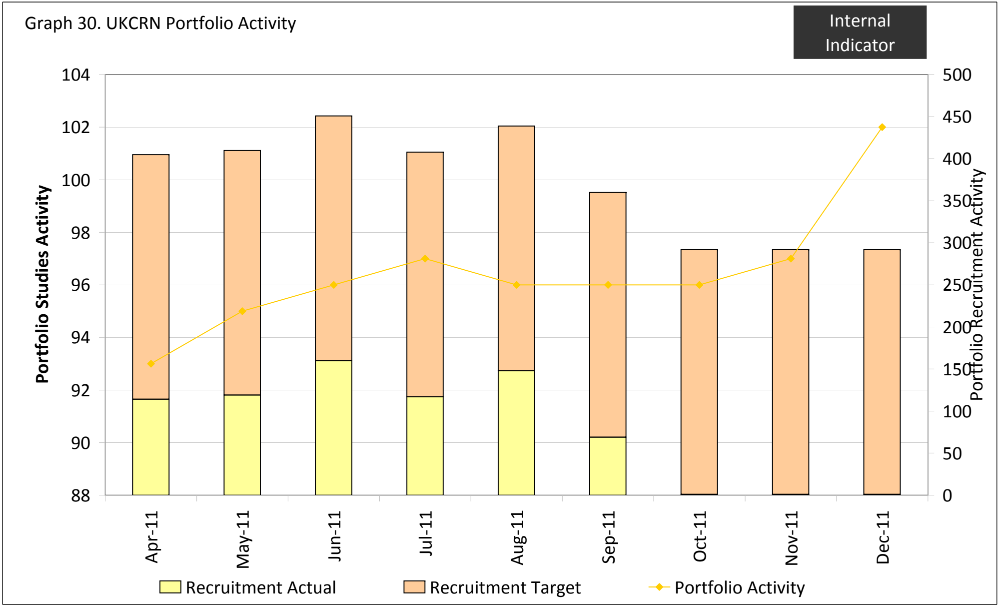
Graph 28.Clinical income variance (Month 9 budget vs Month 9 actuals)

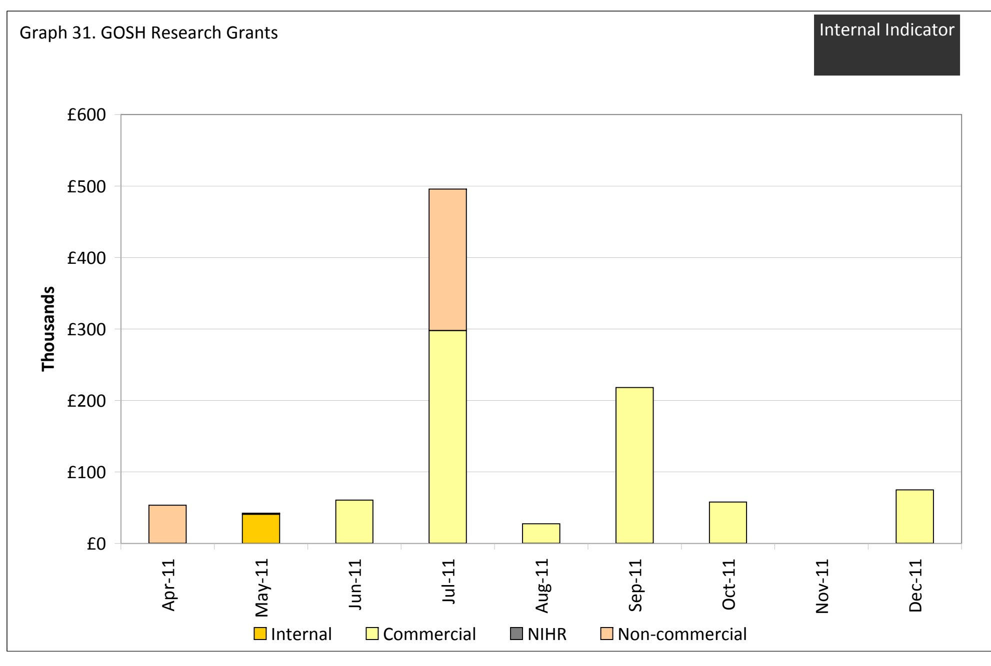
Internal Target

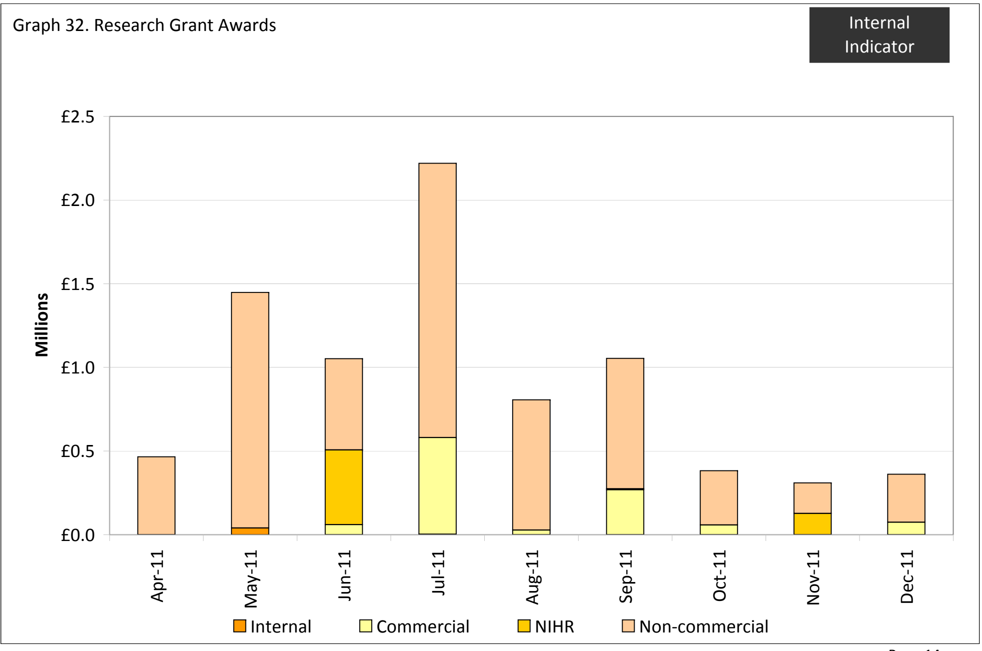


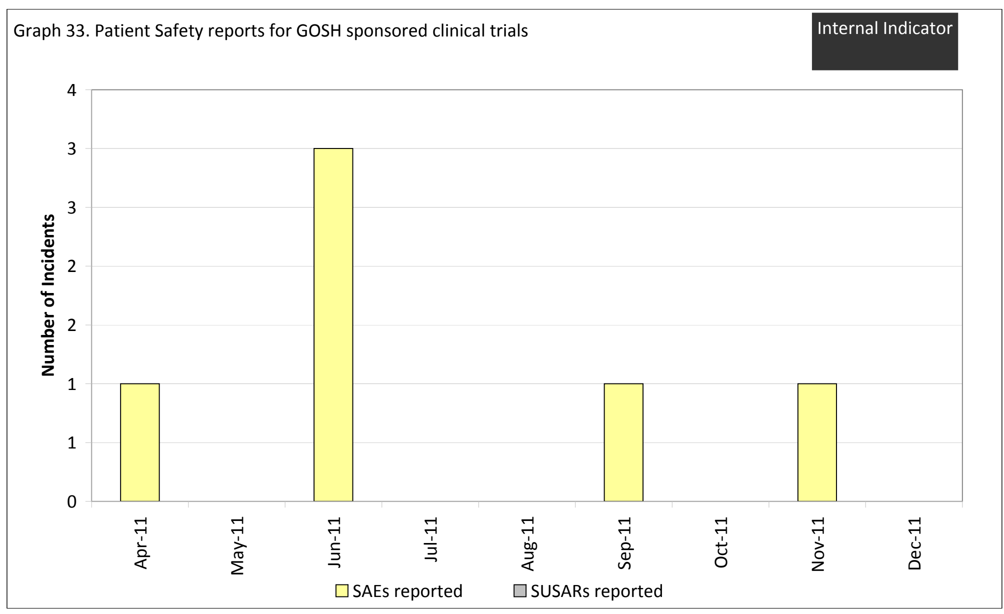
4. Currently partnered with ICH, and moving to UCL Partners with AHSC, maintain and develop our position as the UK's top children's research organisation



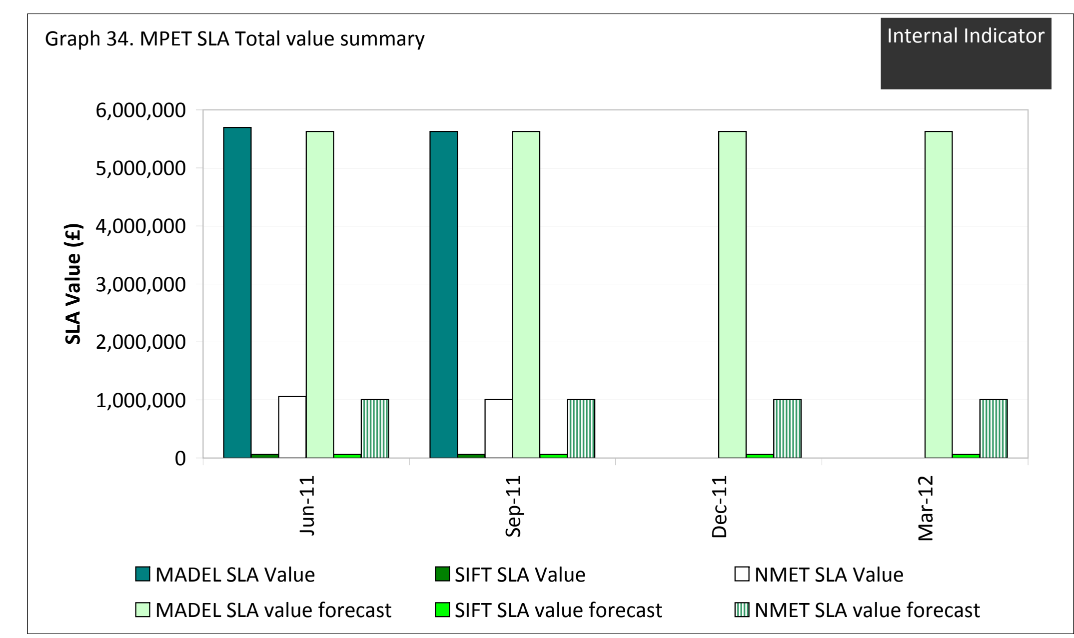


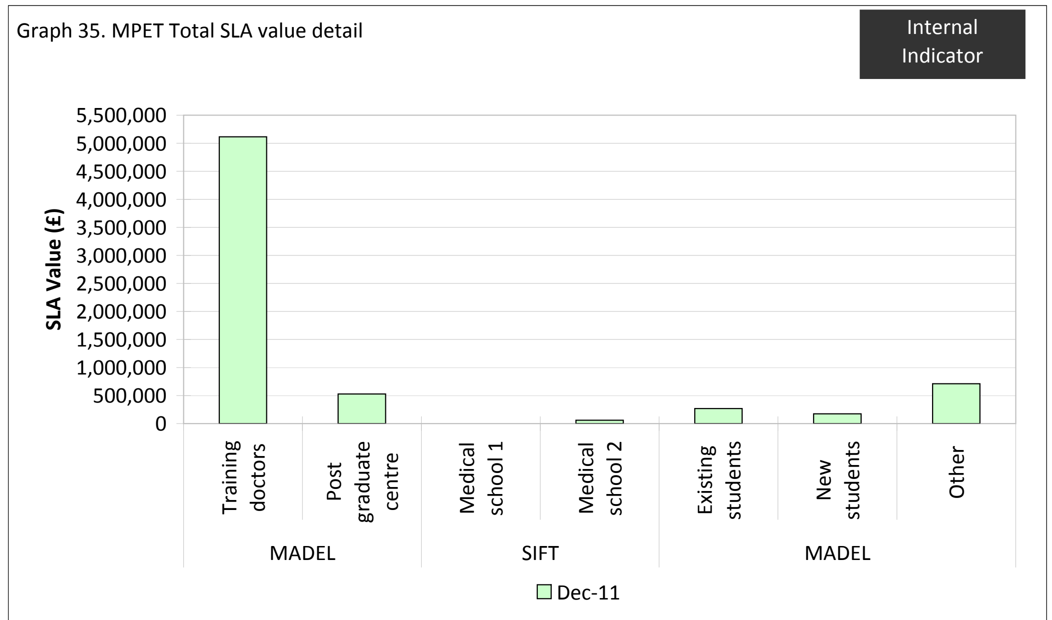




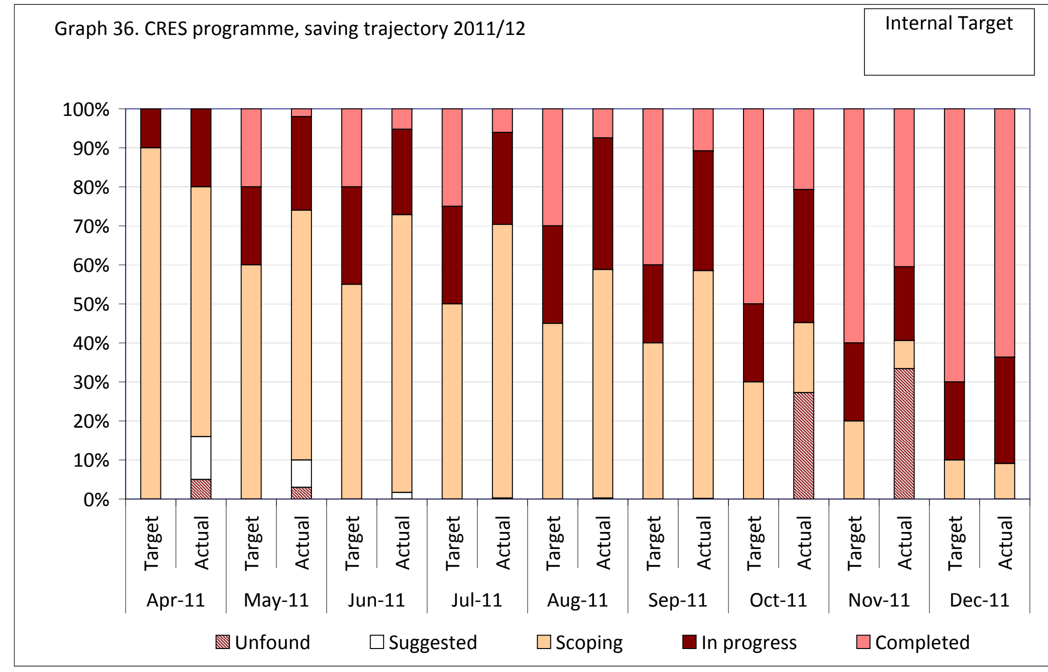

Graph 33. Patient Safety reports for GOSH sponsored clinical trials
Internal Indicator
Number of Incidents
4
3
3
2
2
1
1
0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
SAEs reported
SUSARs reported

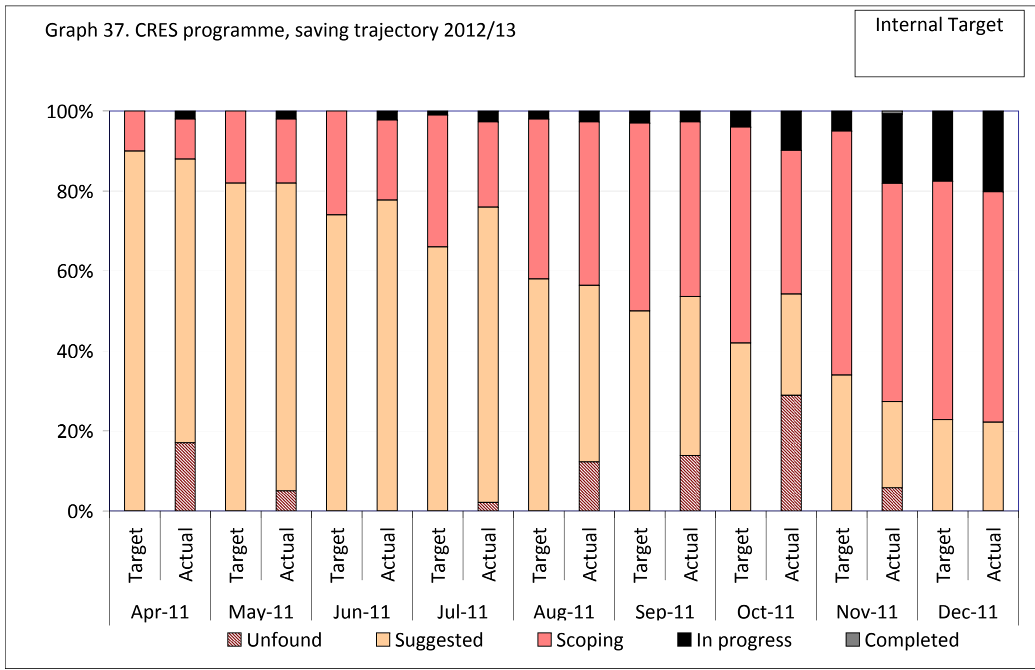
5. To work with our academic partners to ensure that we are provider of choice for specialist paediatric education and training in the UK

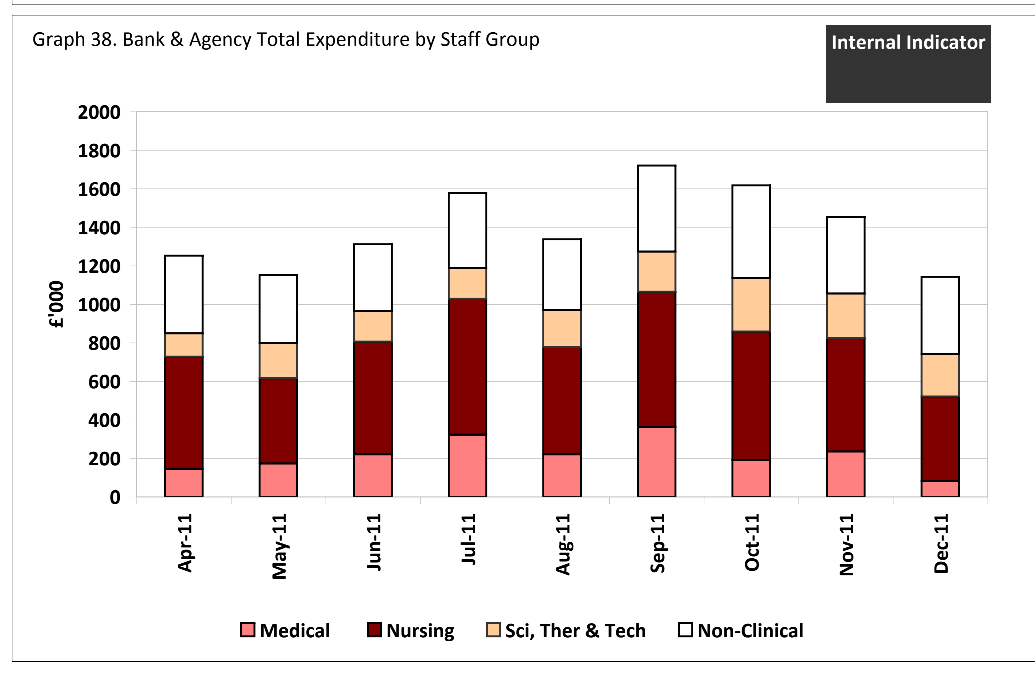


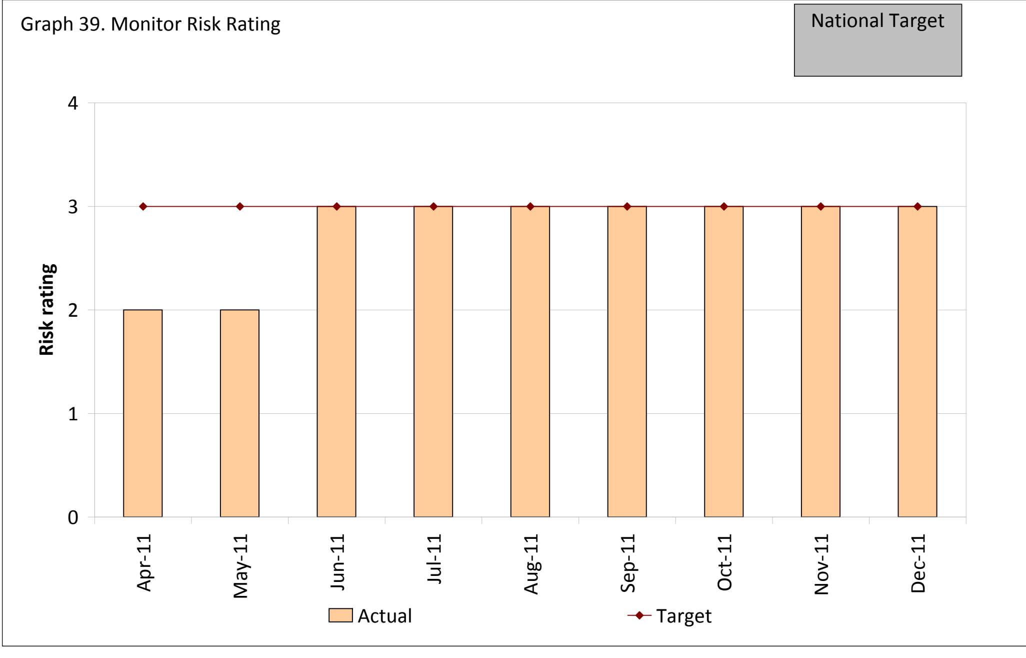


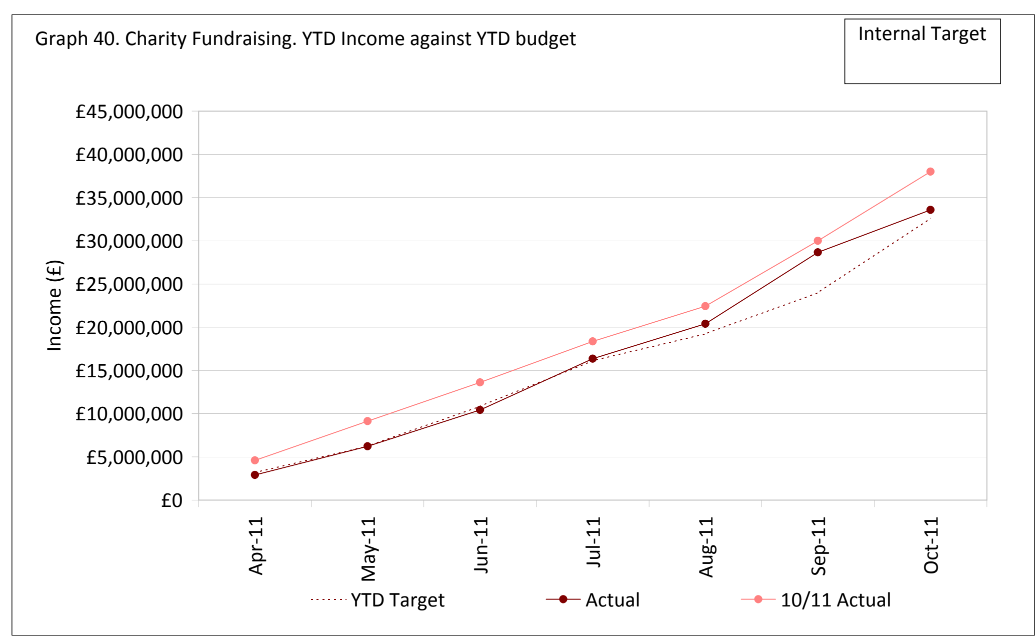
6. Deliver a financially stable organisation



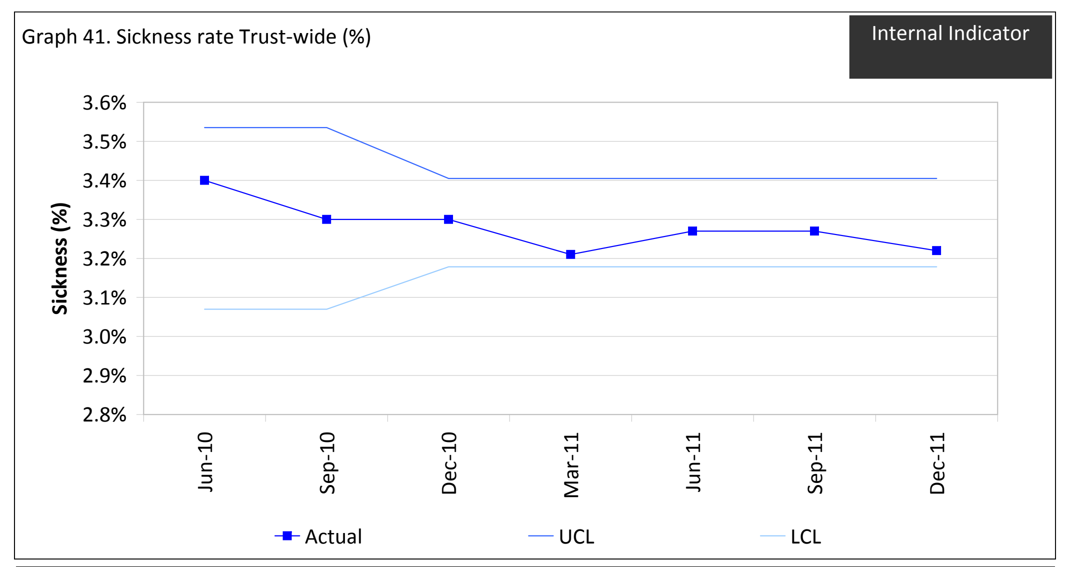


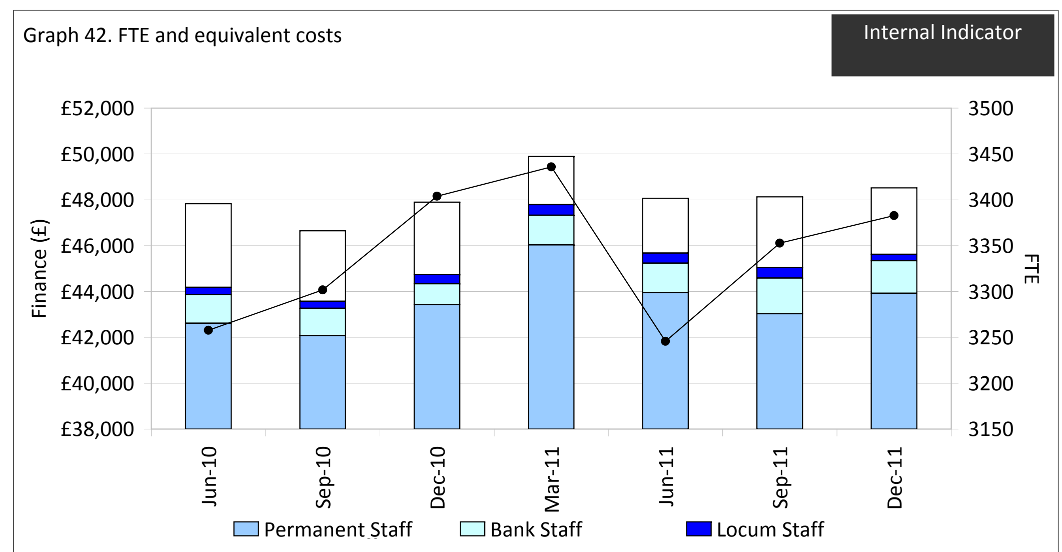


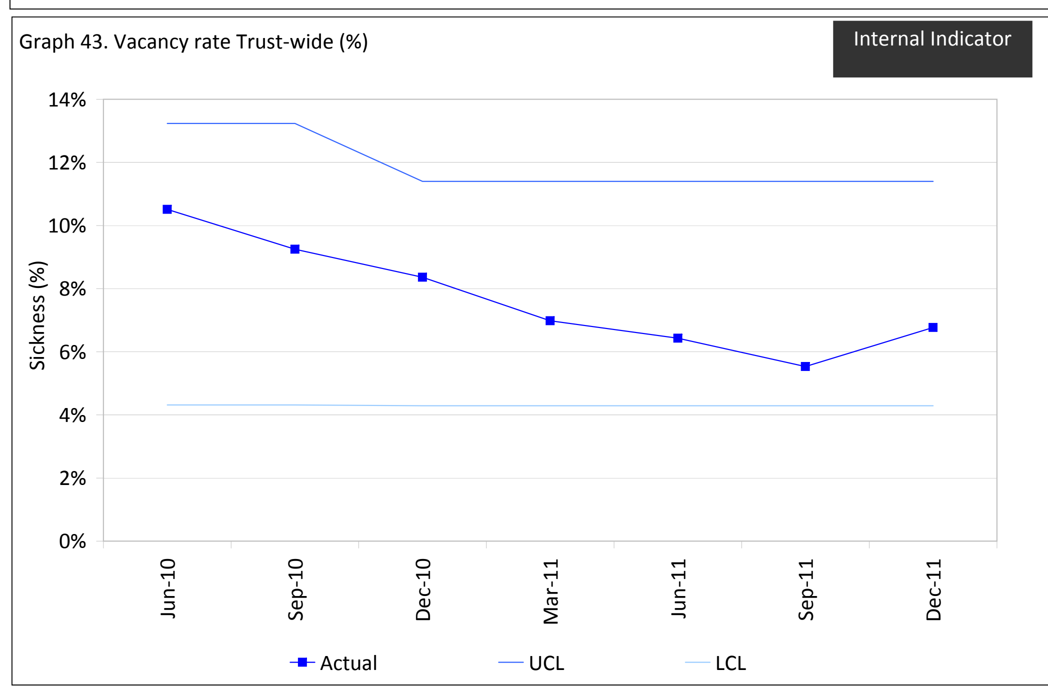


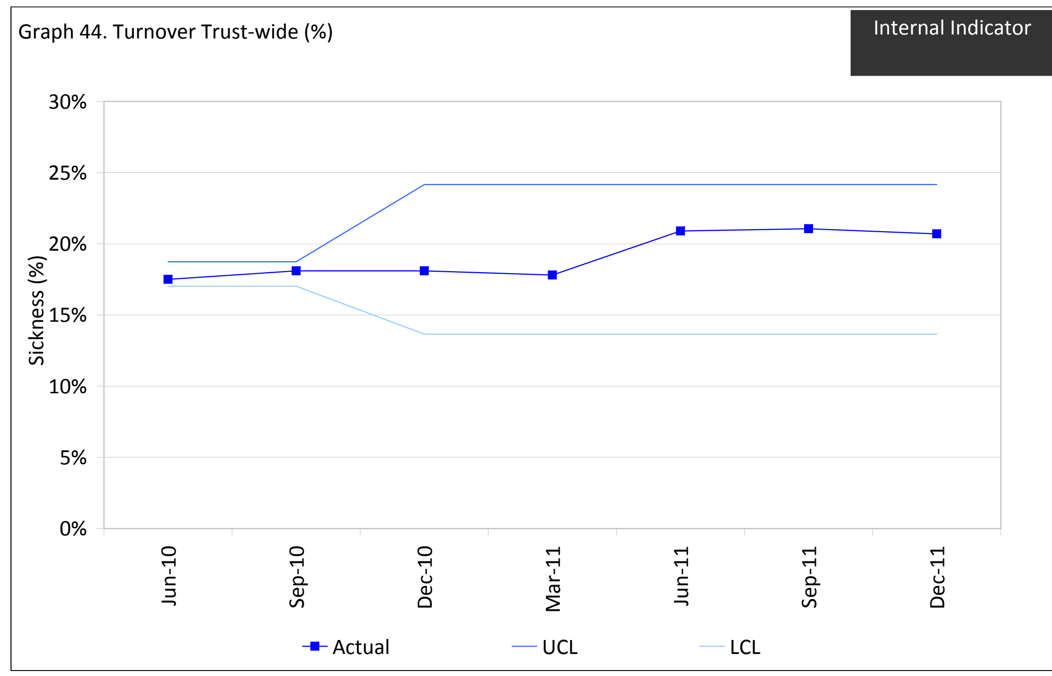

Graph 40. Charity Fundraising. YTD Income against YTD budget
Internal Target
£45,000,000
£40,000,000
£35,000,000
£30,000,000
£25,000,000
£20,000,000
£15,000,000
£10,000,000
£5,000,000
£0
Income (£)
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
YTD Target
Actual
10/11 Actual

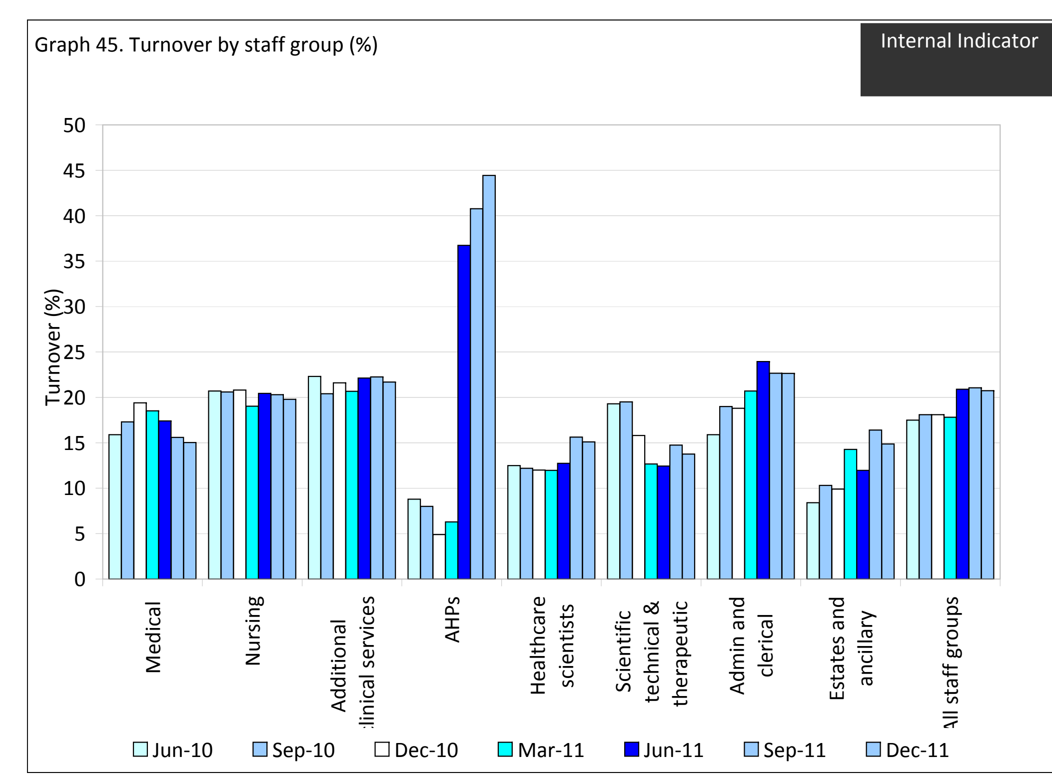
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation

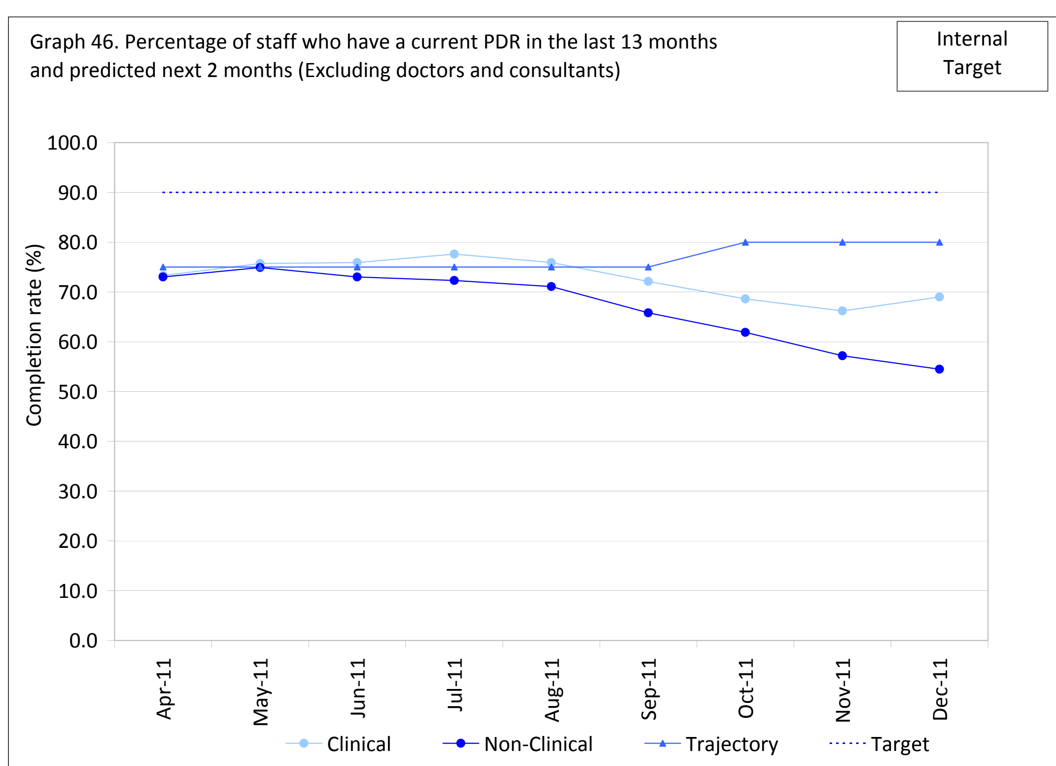


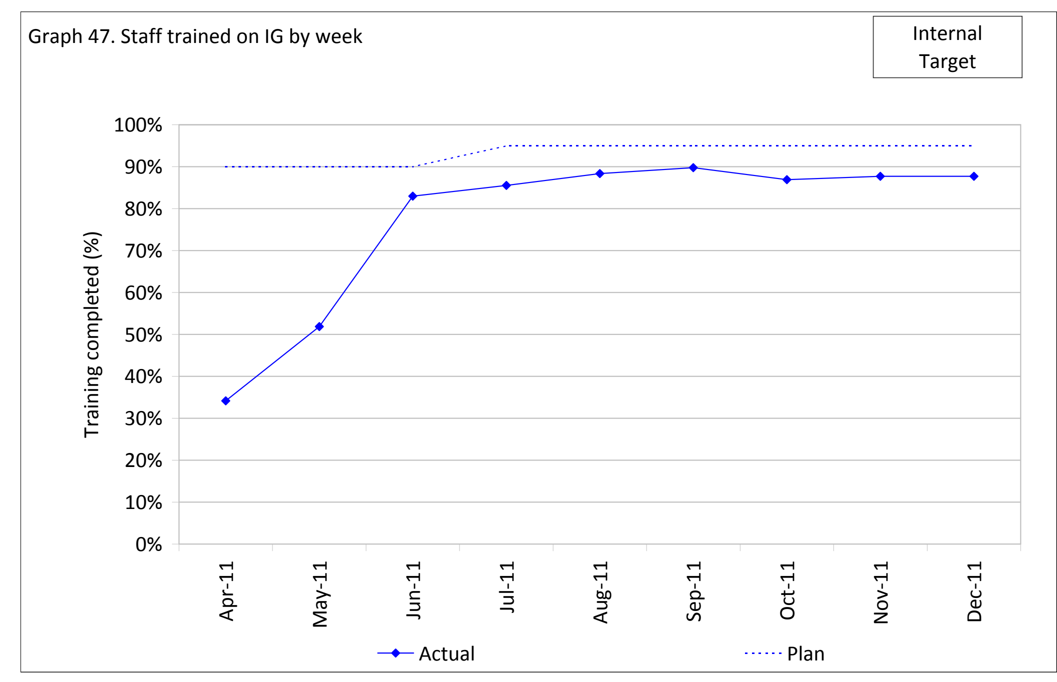







Graph 45. Turnover by staff group (%)
Internal Indicator
Turnover (%)
Medical
Nursing
Additional clinical services
AHPs
Healthcare scientists
Scientific technical & therapeutic
Admin and clerical
Estates and ancillary
All staff groups
Jun-10
Sep-10
Dec-10
Mar-11
Jun-11
Sep-11
Dec-11


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
Completion rate (%)
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Clinical
Non-Clinical
Trajectory
Target


Graph 47. Staff trained on IG by week
Internal Target
Training completed (%)
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Actual
Plan

Attachment: N

Great Ormond Street NHS Hospital for Children NHS Trust

<table>
<tr><td colspan="2">TRUST BOARD

25 January 2012</td></tr>
<tr><td>Finance and Activity Report
NINE months to 31 December 2011

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

SUMMARY

Results year to date to end of period 9

- Net surplus **£5.1M**, which is £0.3M ahead of the rephased plan
- Normalised EBITDA 6.4% (*Budget 6.9%; Full year budget 7.0%)*

Forecast

The forecast surplus for the financial year is a £2.3M surplus after a property impairment estimated at £5.6M (value yet to be determined by the District Valuer). The normalised surplus excluding the impairment remains unchanged from previous forecasts and assumes all units achieve the forecast positions recently agreed with them.

Risks / Issues

The most significant risks in delivering the normalised forecast are:

- Delivery of the remainder of the CRES plan
- Continuing the reduction in agency costs in line with unit trajectories
- Delivering planned income growth for the remainder of the year and ensuring the Trust is appropriately reimbursed
- Ensuring Phase 2A double running and project costs are in line or better than plan

Activity/Income

Activity based income remains ahead of plan boosted by critical care and other bed day activity which is 5% above plan although core inpatient activity is fractionally (0.8%) below plan, but remains 3.5% ahead of last year.

Total income, if pass through funding is excluded is above plan by £2.9M.

- NHS revenue is ahead of plan by £4.1M reducing to £3.5M if non-England activity is included
- IPP revenue is in line with plan.
- Other Operating Revenue is £0.5M 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 £3.9M 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
- Non Pay is under-spent by £0.4M excluding pass through and £3.4M 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 86.8% (to period 8 – 86.0%)
- Total payables – Number 86.6% (to period 8 – 86.3%)

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 £10.4M and £10.5M identified

CRES 2012/13

- Financial Plan requires £13.6M and £12.2M identified

CRES 2013/14

- Financial Plan requires £13.4M and 13.7M identified

Capital

- Capital spend is £29.4M; £6.8M lower than plan YTD. Donated capital spend is £6.1M lower than plan
- Forecast capital spend is likely to be approximately £9.0M lower than original plan and this will be donated capital and largely related to the Redevelopment programme (£6.5M) 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)

- Movements in the month:
- Cash fell by **£0.9m** to **£17.5m** due primarily to a net reduction in working capital
  - Current Assets (excluding Cash & Cash Equivalents) fell by **+£5.9M** largely as a result of a decrease in NHS Trade and capital Receivables
  - Current liabilities have fallen by **-£6.8M**, mainly due to a reduction in deferred revenue (£4.8M) and a reduction in Non NHS Trade Payables (£1.1M).
  - Non Current Assets increased by £**-0.3M** to £347.8M representing increased capital investment net of depreciation.

Salary overpayments

- There were five salary overpayments totalling £14.7K (three late notified leavers)

Tariff for next year

The DH released the provisional tariff for 201213 in December and we have completed an analysis of the impact on the Trust's services. We estimate that in overall terms the impact will be broadly neutral but there are potential upsides if the Trust achieves CQUIN quality targets (Metrics and targets as yet to be agreed with commissioners) as the CQUIN rates has been increased to 2.5% from 1.5%.

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 13 January 2012

PERIOD 9 - 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 9 year to date net surplus

The year to date surplus is £5.1M. This represents a favourable variance of £0.3M 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 £2.7M but operating expenditure is over plan by £3.5M.

2.1 Revenue account excluding Pass Through

	Actual	Variances	
	M9 YTD	Excl PT	PT
Clinical ex IPP	194.3	3.4	-2.6
IPP Clinical	20.5	-0.1	0.0
Other Income	32.6	-0.5	-0.8
	247.4	2.9	-3.4
Don asset tfr	4.6	-0.2	0.0
	251.9	2.7	-3.4
Pay	-144.9	-3.9	0.4
Non pay	-86.7	0.4	3.0
Total op expend	-231.6	-3.5	3.4
Non op expend	-15.2	1.1	0.0
Net surplus	5.1	0.3	0.0
Normalised EBITDA	15.8	-0.6	0.0
	6.4%		

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 4.3% is currently exceeded by cost growth at 5.8%.

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		
Ex Haringey:	M9 YTD	M9 Ytd	Var		M9 YTD	Var	
NHS clinical	190.5	180.5	10.0	5.6%	189.0	1.5	0.8%
Other clinical	22.7	21.8	0.9	4.0%	23.4	-0.7	-3.1%
Non clinical	37.1	37.7	-0.6	-1.5%	38.7	-1.6	-4.0%
	250.3	240.0	10.3	4.3%	251.1	-0.8	-0.3%
Haringey	1.6	7.1	-5.5		1.6		
	251.9	247.1	4.8	2.0%	252.7	-0.8	-0.3%
Ex Haringey:							
Pay	-143.3	-136.2	-7.0	5.2%	-139.8	-3.4	2.5%
Non-pay	-86.7	-81.2	-5.5	6.8%	-90.1	3.4	-3.7%
	-230.0	-217.5	-12.5	5.8%	-229.9	-0.1	0.0%
Haringey	-1.6	-7.7	6.1	-79.2%	-1.6	0.0	0.0%
	-231.6	-225.2	-6.4	2.9%	-231.5	-0.1	0.0%
Non op expend	-15.2	-15.1	-0.1	0.9%	-16.4	1.1	-6.9%
Net surplus	5.1	6.8	-1.7		4.8	0.3	6.1%

3 Expenditure

3.1 Pay

- Consultant pay is under spent by £0.8M YTD. Cardiac and ICI are under spent by £0.2M and £0.1M respectively as a result of vacancies. The Research and Innovation Division is £0.5M under spent. This lies mainly within the consultant budgets attached to the new charity projects which have not yet started and is offset by an adverse income variance.

- Junior doctor pay overspent by £1.8M YTD. £0.5M of this relates to activity increases and is offset by income. Within the balance, 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. ICI has put measures in place to address this and there is evidence of recent expenditure reductions within ICI. IPP is also £0.2M overspent due to using temporary staff to cover weekend rotas.

- Nursing pay is overspent by £1.9M YTD. £0.7M of this is activity related and offset by income. Surgery is overspent by £0.8M as a result of using agency staff within theatres, ICUs and the other wards to cover vacancies, maternity leave and sickness. MDTS and Cardiac are both £0.1M overspent mainly due to using temporary staff to meet patient dependency levels.

- Scientific and therapeutic pay is £0.3M overspent YTD. ICI is £0.2M overspent, mostly within the Paediatric Malignancy Unit. This is offset by over performance on test income. Cardiac is also £0.1M overspent due to payments for perfusion overtime and on-call, and also to using agency staff to cover vacancies. The higher movement than trend in month 9 is due to the movement of miscoded costs from a junior doctor line in Neuro.

- The management and administrative budgets are £0.6M 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 recent expenditure reductions. Finance / ICT are overspent by £0.3M 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

Junior doctors	£1.05M
Nursing	£2.01M
Sci, Ther, Tech	£1.62M
Non-clinical	£3.60M
Total	£8.28M (representing 5.7% of pay to December 2011)

(3B) Non pay

Non-pay expenditure is £86.7M, which is £3.4M below plan.

- The drug budgets are on plan YTD, but £0.5M overspent in month 9. Expenditure on SCIDS drugs was particularly high in month 9 (£0.2M overspent). This is a pass through item and directly offset by income. The balance of the overspend is mainly due to the assumption within the plan of a reduction in drugs expenditure in December month, but expenditure in fact remained at a consistently high level. This is for the most part offset by income over performance.

- The blood budgets are under spent by £1.1M YTD. £1.6m of this under spend is on Factor 8 products within ICI, which has resulted from 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 activity / case mix related overspends within other areas of ICI and Cardiac.

- The clinical supplies & services budgets are broadly on plan YTD, but there was a £0.4M adverse movement in month 9. £0.2m of this resulted from high cochlear activity within Surgery in December. Cardiac overspent by £0.1M due to high ECMO activity and a continuing cost pressure on genetics tests caused MDTS to overspend by £0.1M..

- Education & research budgets 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 spent by £1.4M YTD. £0.3M of this is due to delays on charity funded expenditure on PMG projects, this is directly offset by income. £0.8M is due to HMRC credits and also credits that have arisen as a result of work undertaken in Finance to review creditor liabilities.

- Non-pay budgets also contain £1.4M undelivered CRES targets and £1.9M reserves not allocated to units.

4 INCOME

Income is on £0.5M behind Target (when pass through income variances are excluded, income is £2.9 ahead of plan)

- NHS revenue is £1.5M ahead plan
- Non NHS revenue is £0.7M behind plan

- Other operating revenue is £1.3M behind plan

Category	YTD Actual	YTD var incl pass through	YTD var Excl pass through
	£M	£M	
NHS Revenue	192.1	1.5	4.0
Activity Revenue Non NHS	22.7	(0.7)	(0.7)
Other Operating Revenue ex donated asset transfer Donated asset transfer	32.6 4.6	(1.3) (0.2)	(0.5)
Grand Total	252.0	(0.7)	2.9

4.1 NHS Revenue

Overall activity trends:

	v Last year	v Plan
- Inpatient activity:		
o spells	+3.5%	-0.8%
o bed days	+9.0%	+5.3%
- Outpatient activity	+10.4%	+2.4%

PCT Tariff Income is £0.8M ahead of Plan (including MFF)

PCT tariff income variance reflects the impact of estimated 2010/11 activity outturn being higher than forecast.

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 £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 £0.4M ahead of Plan (£2.3M ahead of plan excluding pass-through income)

Non Tariff income includes the effect of 2010/11 estimated activity being lower and resulting in a small adverse impact to 2011/12.

- Bilateral Cochlear being lower than plan by £0.1M 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 £1.3M 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 benefiting the position in this income category.

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

SHA (NCG) income is £0.9M ahead of plan (£0.7M ahead excluding pass-through)
Variance due to 2010/11 deferred Neuroblastoma drug licences being release 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 £0.2M higher than plan.

NHS Other Clinical income is £0.5M behind plan (£0.3M ahead excluding pass-through income)
This mainly relates the overspend that occurred on the Haringey service earlier in the financial year, that is not recoverable and lower than planned Kings Small Bowel Assessment activity.

4.2 Non NHS Revenue is £0.7M behind plan

This relates to lower than planned Non England activity (plan set based on last year which was exceptionally high), and this offsets some of the over performance under NHS income. Private patient income is on plan.

4.3 Other operating revenue is £1.3M behind plan (£0.5M including pass through)

The principal variations from plan relate to:
- Catering income has reduced due to the outsourcing of the café.
- Non patient Care Services is £0.4M 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 posts.
- Research income £0.2M (£0.3M excluding pass through)
- Charity funding is lower than plan due to lower than plan spend on funded projects by £0.6M

There is a £0.9M shortfall on pass through budgets in respect of Charity

(5) CIP/CRES

The Trust has undertaken a half year review of all CRES schemes and as a result has actioned a large number of growth and income as these schemes are now past the six months period and can be counted as CRES. The Trust will continue with its policy of targeting more CIP schemes than is required to ensure the planned value is delivered.

CRES 2011/12
The Target for 2011/12 is £10.4M of which:
- BLUE has reduced overall by £0.7M reflecting a revision to an ICI income scheme.
- GREEN CRES has remained static in the month.
- AMBER has only reduced by £0.1M through a number of small value schemes.

CRES 2012/13
The financial plan requires £13.6M of CRES to be delivered and so far, the risk adjusted exercise has a value of £12.2M. There has been no significant change in month 9.
- GREEN has increased by £0.4M demonstrating progress in the plan.
- AMBER rated schemes have decreased by £0.4M as they have progressed.
- RED has remained unchanged

CRES 2013/14
The financial plan requires £13.4M of CRES to be delivered and the risk adjusted exercise is estimating this will be exceeded at £13.7M.

(6) CAPITAL PROGRAMME AND CRL

CRL
The Trust is expecting to undershoot its CRL target of £13.8m by £1.5m.

Overview
The Trust's capital plan is £55.9m with planned expenditure for the nine months ending 31 December amounting to £36.2m. The total spend to date amounts to £29.4m representing an under spend to date of £6.8m.

	Annual Plan £M	Plan YTD £M	Actual YTD £M	Variance £M
Hospital Redevelopment	36.3	23.5	19.0	4.5
Estates Maintenance Projects	9.0	5.8	6.2	-0.4
IT Related Projects	7.0	4.5	1.9	2.6
Medical Equipment Purchases	3.6	2.3	2.2	0.1
Total Additions in Year	**55.9**	**36.2**	**29.4**	**6.8**
Asset Disposals	0.0	0.0	0.0	0.0
Donated Funded Projects	(42.1)	(27.2)	(21.1)	(6.1)
Charge Against CRL	**13.8**	**9.0**	**8.3**	**0.7**

Redevelopment
Redevelopment Projects are currently under spent by £4.5m. The current forecast outturn is expected to be £6.5m under plan. The outturn has been reduced by an additional £0.93m VAT reduction on Phase 2A resulting from a claim relating to additional Medical Equipment contained within the main BAM contract. The Trust is forecasting a slippage to 2012/2013 on 2B enabling of £5.3m with the balance representing an under spend on 2A of £1.2m. Forecast under spends will be offset by a reduction in donated income.

Estates IT and Medical equipment

- Estate Management Projects are currently ahead of plan by £0.36m, a slight reduction on the previous month. The Trust is forecasting an annual outturn equivalent to plan less £0.13m representing additional Trust Purchased Medical Equipment.

- IT Projects are currently under spent by £2.6m. This is due to in year slippage with certain Projects such as PACS, a large single project, not yet invoiced. The Trust is forecasting £1.5m slippage into 2012/13.

- Medical Equipment Projects are currently behind plan by £0.16m on donated projects and overspent by £0.1m on Trust Funded purchases.

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 December 2011 totalled £347.8M, a net increase of £0.3M 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 £7.3M

NHS Trade Receivables (£6.2M decrease)	This represents a reduction in NHS Debtors following the receipt of payment for outstanding invoices raised to the National Commissioning Group (£5.6M) and English PCT debtors (£0.6M)
Inventories (£0.2M increase)	Representing an increase in Pharmacy stock (£0.2M).
Capital Receivables (£1.4M decrease)	This represents a decrease in the retention amount held for the main contractor in respect of the completion of the Phase 2A project.
Prepayments & Accrued Income (£0.7M increase)	This is largely due to a reduction in accrued income for Private Patients WIP (£0.1M), Month 9 salary recharges not raised in month (£0.2M) and Transformation charity invoice not raised in month (£0.2)
Non NHS Trade Receivables (£0.7M decrease)	This is primarily due to an increase in invoices raised to the Trustees (£0.9).

Current Liabilities

Current Liabilities have decreased by £6.8M

NHS Trade Payables (£0.5M decrease)	This is due to a decrease relating mainly to the clearance of the payment in advance received from West Kent PCT in month 8 (£0.9M), net of an increase in unpaid stores invoices (£0.3M) and an increase in invoice register accruals for English Foundation Trusts (£0.3M)
Non NHS Trade Payables (£1.1M decrease)	The reduction is due to the payment of invoices recorded as creditors in the previous month, primarily: BUPA (£0.5M), Southern Electric (£0.2M) and PULSE (£0.1M).
Deferred revenue (£4.8M decrease)	release of deferred income for invoices raised in the third quarter (£4.5M).
Other Payables (£0.5M increase)	This represents an accrual for Quarter 3 PDC dividends following the payment of the half yearly dividend in September.
Expenditure Accrual (£0.7M decrease)	This mainly represents a reduction in Non-NHS accruals (£1.5M) primarily due to payment of month 8 accruals for domestic contract (£0.7M) and Pharmacy drugs (£0.7M) net of an increase in invoice register accruals (£0.7M).

Taxpayers' Equity

Taxpayers' Equity has decreased by £1.0M in month.
The principal movement was decrease in the Retained Earnings of £0.9M.

(8) WORKING CAPITAL

8.1 Cash overview

The Trust had cash holdings of £17.5M at the close December 2011, and had operating cash balances of between £37.1M and £17.5M 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 £6M lower than the forecast. This is due to delays in receipt of central DH allocated funding which are being actively chased and some delays in collection of overperformance debt and IPP debt.

8.2 Trade Debt

Gross trading debt reduced to £16.5M, a decrease from £6.4M, in the previous month. This was due mostly to the settlement of NHS debt. Improvements in debt collection have led to a

significant reduction in aged debt. Overall debt over 90 days has been reduced by £1.8M compared to this time last year and NHS debt overall is £3.9M lower than December 2010.

Non- NHS debt is £2.5M.

- This debt includes a recent invoice to Kuwait for £1.28m that has recently been raised and is overdue. This has increased the debt at 1-90 days as seen below. We have been advised that payment was remitted 9th Jan 2012
- The next largest debt grouping is for performance debt to health bodies in the UK but outside of England (£198K specialist Welsh commissioning).

IPP debt has reduced by £0.3M this month to £8.4M due mainly to a reduction in billing in the month.

- One self- pay debt of £0.25M exists and is over 360 days overdue. Use of an international debt collection agency is now being pursued.
- There has been a small reduction in Greek debt from £600k to £569k and £100k was received in Dec 11
- 2.

8.3 Trade payables

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

- Trade payables excluding capital payables at £5.6m are £5.1m lower than 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 £0.2M whereas a year ago it was £3.4M

There remains £0.6M 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 which require further information from the supplier 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 9 and the forecast score for each metric and shown the threshold scores for achieving the higher metric values.

Month 9	**Score**
EBITDA Margin	3
EBITDA % Achieved	4
ROA	3
I&E Surplus margin	4
Liquidity Days	2
Weighted Average	3.1
Overall Score	**3**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 2011/12
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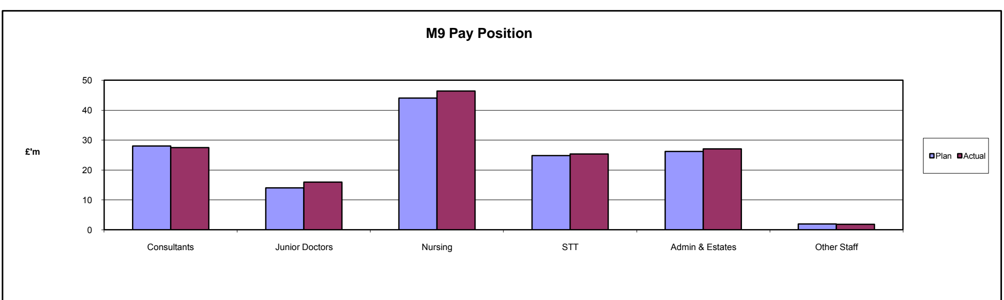
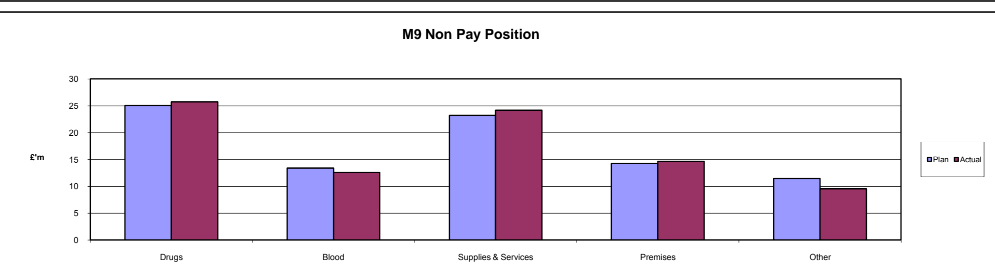
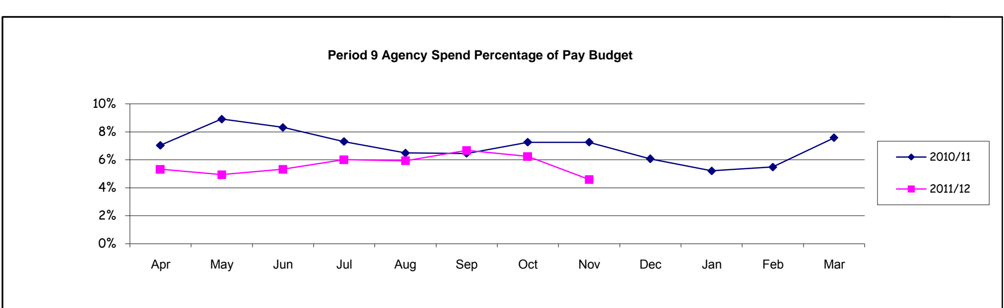
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 2011/12
Trust Summary

Statement of Comprehensive Income	Current Month		YTD	
	Actual	Plan Variance	Actual	Plan Variance
	£000	£000	£000	£000
Revenue				
Revenue from patient care activities	22,210	302	214,800	790
Other operating revenue	4,604	324	37,132	(1,560)
Total Income	**26,814**	**626**	**251,932**	**(770)**
Operating expenses	(26,021)	(198)	(231,598)	(68)
EBITDA	**793**	**428**	**20,334**	**(838)**
Depreciation	(1,253)	513	(10,870)	1,016
Corporation Tax	(8)	12	(72)	104
Operating surplus	**(468)**	**953**	**9,392**	**282**
Investment revenue	5	3	53	26
Other losses	0	0	(4)	(4)
Finance costs	(3)	(1)	(30)	(11)
Surplus for the financial year	**(466)**	**955**	**9,411**	**293**
Public dividend capital dividends payable	(480)	(1)	(4,324)	(1)
Retained surplus for the year	**(946)**	**954**	**5,087**	**292**
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	466	(3,598)	21,155	(6,092)
Reclassification adjustments:				
- Transfers from donated and government grant reserves	(507)	145	(4,569)	249
Total comprehensive income for the year	**(987)**	**(2,499)**	**21,673**	**(5,551)**
Total Income, excluding Donated Asset Transfer	*26,307*	*771*	*247,363*	*(521)*
EBITDA, excluding Donated Asset Transfer	*288*	*573*	*15,766*	*(588)*
EBITDA % of Income	*2.96%*		*8.07%*	
EBITDA % of Income, excluding Donated Asset Transfer	*1.09%*		*6.37%*	





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



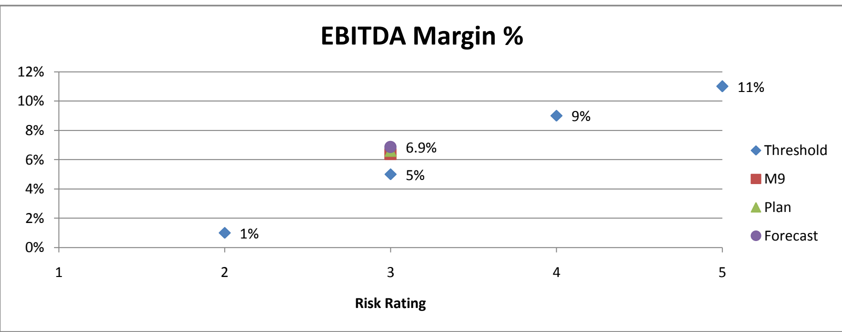
Staffing Staff Numbers	10/11 M12 WTE	WTE Paid	Maternity Paid	Temp Paid	Overtime Paid	Total Paid	WTE above 10/11 M12
Admin and Other Support	898	810	17	70	6	903	(4)
Clinical Support	731	666	31	36	3	736	(5)
Medical	516	481	15	26	0	522	(6)
Nursing	1,426	1,280	72	117	3	1,472	(47)
Total	**3,571**	**3,236**	**135**	**250**	**13**	**3,633**	**(62)**

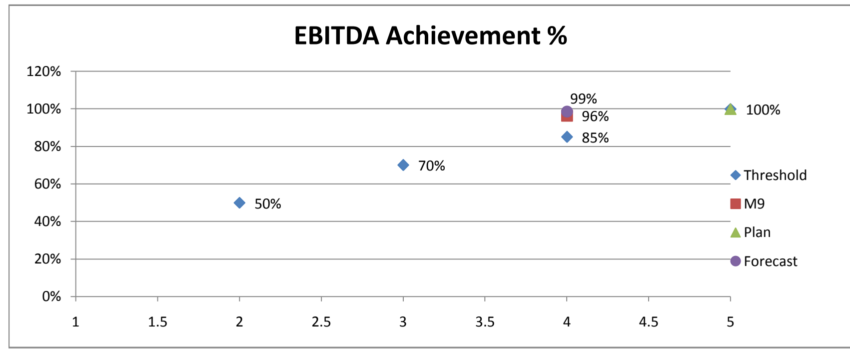
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 2011/12
Ratio Analysis

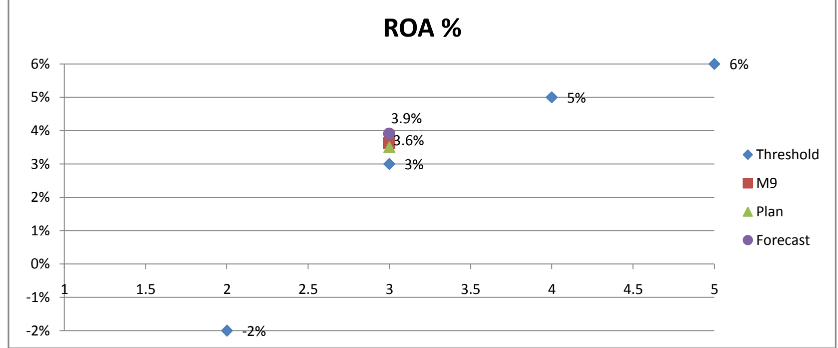
Provider Agency Rating	Target for FT Status	M9 11/12 Actual - FT	M08 11/12 Actual - FT	Forecast Outurn - FT	M9 FT Score
EBITDA Margin	5%	6.4%	6.8%	6.9%	3
EBITDA % Achieved	70%	96.4%	90.8%	98.5%	4
ROA	3%	3.6%	4.1%	3.9%	3
I&E Surplus margin	1%	2.1%	2.6%	2.4%	4
Liquidity Days	15.0	13	14	15	2
Weighted Average	3.0	3.1	3.1	3.3	3.1
Overall Rating	**3**	**3**	**3**	**3**	**3**
IPP Cap (Max 9.7%)	9.7%	9.5%	9.5%	9.5%	

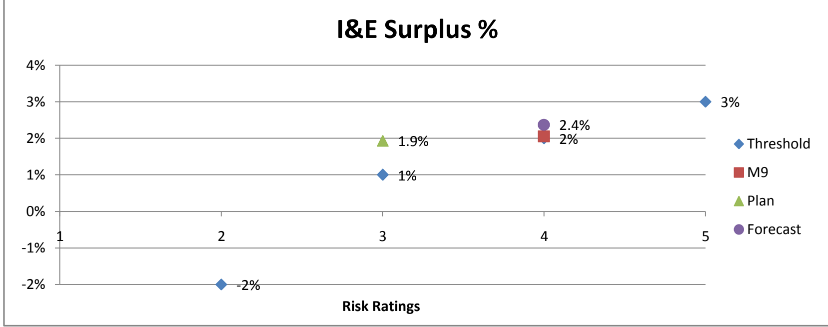
Salary Overpayments

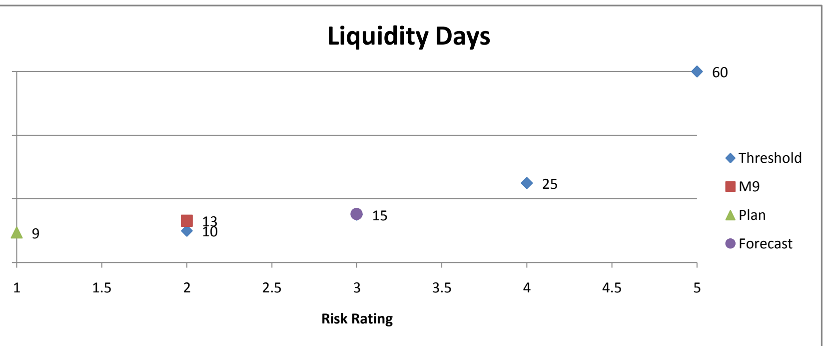
Unit	No.	Amount £'000
ICI	2	8.7
Surgery	1	2.6
R&I	1	2.0
ICT	1	1.4
TOTAL	5	14.7











Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 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	42,253	339	2,329	(24,988)	(1,433)	(2,802)	(1,094)
Surgery	48,568	(423)	(235)	(46,262)	(3,002)	(1,656)	(3,425)
DTS	1,797	(51)	805	(15,062)	14	(784)	(37)
ICI	42,310	(262)	849	(41,399)	(1,380)	(2,732)	(1,642)
International	22,466	23	3,458	(9,156)	32	(1,389)	55
Medicine	32,632	(479)	2,080	(30,534)	(745)	(2,397)	(1,223)
Neurosciences	20,037	110	(141)	(16,663)	(428)	(1,559)	(318)
Pass through drugs & devices funding	6,990	399	435				399
Education & Training / Merit Award Funding	6,300	(486)	(84)				(486)
Other Clinical Income / CQUIN	5,366	3,902	2,444				3,902
Centrally held development reserves				**(1,986)**	7,588	290	7,588
Total Clinical Units	**228,719**	**3,072**	**11,940**	**(186,050)**	**647**	**(13,029)**	**3,719**
Central Departments							
Operations & Facilities	889	(58)	(380)	(11,246)	(338)	1,436	(395)
Corporate Affairs	43	(21)	(17)	(1,282)	103	(319)	82
Estates	639	37	(148)	(9,118)	(454)	(722)	(417)
Finance & ICT	166	21	38	(8,678)	(740)	(1,176)	(718)
Human Resources	583	18	79	(2,140)	303	(45)	322
Medical Director	8	(60)	(102)	(2,539)	(64)	473	(124)
Nursing And Workforce Development	1,411	49	(48)	(4,187)	200	(232)	248
Research And Innovation	10,309	(561)	804	(4,503)	202	264	(359)
Redevelopment Revenue Costs	344	(325)	(53)	(344)	169	58	(156)
Total Central Departments	**14,393**	**(900)**	**173**	**(44,036)**	**(619)**	**(263)**	**(1,518)**
Depreciation & Dividends	**4,568**	**(248)**	**(918)**	**(15,198)**	**1,011**	**(88)**	**763**
Centrally held income	**2,671**	**(2,691)**	**(91)**	**0**	**0**	**0**	**(2,691)**
Net Position, excl Haringey & North Mid	**250,351**	**(766)**	**11,104**	**(245,284)**	**1,038**	**(13,381)**	**272**
Haringey	1,590	7	(5,553)	(1,569)	15	6,114	22
North Mid.	(9)	(9)	(705)	8	8	704	(2)
Net Position, incl Haringey & North Mid	**251,932**	**(769)**	**4,846**	**(246,845)**	**1,061**	**(6,562)**	**292**

* Unit income and expenditure variances have been adjusted to remove material pass through variances

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 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	299,092	363,667	-	871,219	**829,777**	
ICI	2,163,631	1,716,244	33,586		-	1,749,830	**1,732,331**	
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	378,566	452,823	152,060	-	983,449	**959,929**	
Surgery	3,356,564	92,757	1,170,510	9,510	-	1,272,777	**1,258,913**	
Corporate facilities	1,025,794	502,145	108,794	48,336	-	659,274	**647,331**	
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**	**6,577,235**	**3,086,859**	**1,035,558**	**-**	**10,699,652**	**10,466,414**	**7,435,573**
						Updated target	**10,400,000**	
						Variance to target	**66,414**	

		Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total savings	Risk adjusted savings
NHS Clinical Income		2,535,989	1,220,468	336,932	-	4,093,388	**4,022,916**
Other Income		833,745	85,130	160,404	-	1,079,279	**1,054,832**

2012/13

Unit	Target	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
Cardiac		-	15,112	1,095,809	404,988	1,515,909	**1,366,952**
ICI		-	682,818	1,303,930	110,126	2,096,875	**1,902,548**
International		-	94,965	1,019,691	-	1,114,656	**1,008,939**
MDTS		-	100,447	1,397,362	317,077	1,814,886	**1,522,566**
Neurosciences		-	9,820	1,219,279	19,872	1,248,971	**1,071,103**
Surgery		-	376,378	979,246	549,929	1,905,553	**1,726,254**
Corporate facilities		-	36,771	715,963	314,716	1,067,450	**951,543**
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		-	7,307	288,299	360,731	656,337	**584,736**
HR & workforce		-	27,252	60,338	58,172	145,762	**132,590**
Medical director		-	-	-	32,250	32,250	**29,025**
Nursing & Education		-	142,000	35,000	77,036	254,036	**231,881**
R&I		-	-	-	217,500	217,500	**184,875**
Total	**15,773,128**	**-**	**2,109,675**	**9,047,480**	**2,513,451**	**13,670,607**	**12,187,244**
						Provisional target	**13,615,000**
						Variance to target	**(1,427,756)**

		Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
NHS Clinical Income		-	779,823	3,272,131	742,320	4,794,274	**4,048,975**
Other Income		-	189,718	466,965	275,500	932,183	**680,872**

2013/14

Unit	Target	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
Cardiac		-	-	44,000	1,847,698	1,891,698	**1,702,528**
ICI		-	-	50,000	1,717,195	1,767,195	**1,545,476**
International		-	-	963,819	-	963,819	**867,437**
MDTS		-	-	60,000	2,470,996	2,530,996	**2,255,396**
Neurosciences		-	-	-	1,318,593	1,318,593	**1,186,734**
Surgery		-	-	-	3,443,437	3,443,437	**3,099,093**
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	**15,773,128**	**-**	**71,000**	**1,218,802**	**14,039,837**	**15,329,639**	**13,732,725**
						Provisional target	**13,473,000**
						Variance to target	**259,725**

		Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
NHS Clinical Income		-	-	129,819	3,829,928	3,959,747	**3,790,572**
Other Income		-	-	834,000	1,283,861	2,117,861	**1,679,275**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 09 2011/12
Revenue Statement

	11/12 Annual Budget £000	11/12 Mth 09 Actual £'000	*11/12 Mth 09 Variance to Plan, excluding Pass Through £'000*	*11/12 Mth 09 Pass Through Variance £'000*	11/12 Mth 09 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	**4,599**	*-164*	*0*	-164	**48,361**	*539*	*0*	539	**3,397**
Primary Care Trusts Non Tariff	120,130	**9,470**	*664*	*-206*	458	**89,180**	*2,353*	*-2,001*	352	**294**
Primary Care Trusts Mff	18,754	**1,340**	*-48*	*0*	-48	**14,160**	*222*	*0*	222	**-106**
Strategic Health Authorities	45,155	**4,008**	*224*	*21*	245	**34,731**	*707*	*158*	865	**3,375**
Nhs Trusts	874	**69**	*-4*	*0*	-4	**557**	*-98*	*0*	-98	**-804**
Department Of Health	850	**43**	*30*	*-59*	-28	**427**	*273*	*-484*	-211	**-169**
Nhs Other	5,993	**369**	*23*	*-24*	-1	**4,731**	*98*	*-248*	-150	**-1,464**
Activity Revenue Nhs	**256,105**	**19,899**	***726***	***-268***	**459**	**192,146**	***4,094***	***-2,575***	**1,519**	**4,524**
Local Authorities	168	**0**	*0*	*0*	0	**151**	*-17*	*0*	-17	**-645**
Private Patients	27,669	**2,158**	*-48*	*0*	-48	**20,475**	*-66*	*0*	-66	**2,475**
Non Nhs Other	3,602	**153**	*-108*	*0*	-108	**2,028**	*-644*	*0*	-644	**-954**
Activity Revenue Non Nhs	**31,439**	**2,311**	***-156***	***0***	**-156**	**22,654**	***-728***	***0***	**-728**	**876**
Patient Transport Services	1,216	**120**	*18*	*0*	18	**875**	*-37*	*0*	-37	**-147**
Education And Training	13,386	**1,001**	*-96*	*0*	-96	**10,050**	*-45*	*0*	-45	**625**
Research And Development	13,364	**1,267**	*-53*	*206*	153	**9,794**	*-346*	*117*	-229	**225**
Charitable & Other Contrib	5,278	**676**	*59*	*176*	235	**3,395**	*374*	*-963*	-589	**-280**
Non Patient Care Services	3,631	**438**	*135*	*0*	135	**3,083**	*359*	*0*	359	**400**
Revenue Generation	1,802	**124**	*-26*	*0*	-26	**1,039**	*-313*	*0*	-313	**-395**
Other Revenue	6,088	**472**	*49*	*0*	49	**4,327**	*-457*	*0*	-457	**-66**
Other Operating Revenue, excluding Donated Asset Income	**44,765**	**4,097**	***86***	***383***	**469**	**32,563**	***-464***	***-846***	**-1,310**	**363**
Total Operating Income, excluding Donated Asset Income	**332,309**	**26,307**	***656***	***115***	**771**	**247,363**	***2,902***	***-3,422***	**-520**	**5,763**
Directors & Senior Managers	-8,630	**-694**	*28*	*6*	34	**-6,316**	*148*	*27*	175	**-367**
Consultants	-37,750	**-3,096**	*71*	*-17*	53	**-27,464**	*343*	*499*	842	**-538**
Junior Doctors	-18,900	**-1,731**	*-141*	*-15*	-156	**-14,914**	*-695*	*-44*	-739	**-1,675**
Junior Doctors Agy	11	**20**	*19*	*0*	19	**-1,046**	*-1,054*	*0*	-1,054	**1,148**
Administration & Estates	-26,084	**-1,988**	*207*	*-56*	151	**-17,331**	*2,275*	*14*	2,289	**-632**
Administration & Estates Agy	-526	**-348**	*-303*	*0*	-304	**-3,428**	*-3,052*	*19*	-3,034	**537**
Healthcare Assist & Supp	-2,390	**-151**	*49*	*0*	49	**-1,541**	*252*	*0*	252	**47**
Healthcare Assist & Supp Agy	0	**-18**	*-18*	*0*	-18	**-168**	*-168*	*0*	-168	**110**
Nursing Staff	-59,051	**-4,930**	*-39*	*-31*	-70	**-44,357**	*238*	*-124*	114	**-579**
Nursing Staff Agy	-21	**-163**	*-163*	*2*	-161	**-2,007**	*-2,007*	*16*	-1,991	**66**
Scientific Therap Tech	-33,164	**-2,613**	*141*	*-30*	110	**-23,764**	*1,185*	*70*	1,256	**378**
Scientific Therap Tech Agy	-53	**-201**	*-195*	*-1*	-197	**-1,623**	*-1,556*	*-28*	-1,584	**-251**
Other Staff	-295	**-19**	*6*	*0*	6	**-191**	*30*	*0*	30	**-14**
Pay Reserves	-4,386	**-75**	*984*	*0*	984	**-716**	*2,371*	*0*	2,371	**846**
Cips And Cres Unidentified - P	2,881	**0**	*-243*	*0*	-243	**0**	*-2,187*	*0*	-2,187	**0**
Pay Costs	**-188,358**	**-16,006**	***402***	***-144***	**258**	**-144,866**	***-3,879***	***450***	**-3,429**	**-925**
Drugs Costs	-34,610	**-2,997**	*-545*	*44*	-501	**-25,731**	*159*	*-225*	-66	**-3,351**
Blood Costs	-18,494	**-1,221**	*-3*	*125*	122	**-12,584**	*-469*	*1,606*	1,137	**715**
Supplies & Services - Clinical	-23,527	**-2,133**	*-492*	*57*	-435	**-17,696**	*-602*	*497*	-105	**-1,202**
Services From Nhs Organisation	-4,200	**-387**	*-113*	*33*	-80	**-2,896**	*42*	*180*	222	**260**
Healthcare From Non-Nhs Bodies	-2,389	**-175**	*15*	*0*	15	**-2,131**	*-290*	*-48*	-338	**-971**
Supplies & Services - General	-1,721	**-152**	*-15*	*0*	-15	**-1,491**	*-205*	*0*	-205	**509**
Consultancy Services	-1,277	**-118**	*-16*	*-10*	-25	**-1,045**	*-46*	*0*	-46	**-288**
Clinical Negligence Costs	-1,950	**-163**	*0*	*0*	0	**-1,462**	*0*	*0*	0	**-177**
Establishment Costs	-2,819	**-209**	*25*	*0*	24	**-1,943**	*145*	*30*	175	**107**
Transport Costs	-2,671	**-224**	*5*	*-8*	-2	**-2,061**	*17*	*-71*	-54	**19**
Premises Costs	-19,162	**-1,691**	*-44*	*-16*	-60	**-14,644**	*-175*	*121*	-54	**-1,671**
Auditors Costs	-420	**-44**	*-9*	*0*	-9	**-267**	*48*	*0*	48	**-26**
Education And Research Costs	-2,293	**-160**	*142*	*-111*	30	**-1,039**	*331*	*352*	683	**255**
Expenditure - Other	-4,179	**-324**	*107*	*-86*	21	**-1,714**	*890*	*529*	1,419	**349**
Non Pay Reserves	-2,829	**-15**	*601*	*0*	601	**-27**	*1,934*	*0*	1,934	**-27**
Cips And Cres Unidentified - N	1,849	**0**	*-142*	*0*	-142	**0**	*-1,388*	*0*	-1,388	**0**
Non Pay Costs	**-120,692**	**-10,014**	***-485***	***29***	**-456**	**-86,731**	***389***	***2,972***	**3,361**	**-5,498**
EBITDA	**23,260**	**288**	***574***	***0***	**573**	**15,766**	***-588***	***0***	**-587**	**-660**
P & L On Disp Of Fixed Assets	0	**0**	*0*	*0*	0	**-4**	*-4*	*0*	-4	**50**
Fixed Asset Impair & Reversals	-5,571	**0**	*0*	*0*	0	**0**	*0*	*0*	0	**228**
Depreciation & Amortisation	-17,164	**-1,253**	*513*	*0*	513	**-10,870**	*1,016*	*0*	1,016	**-420**
Interest Receivable	36	**5**	*2*	*0*	2	**53**	*26*	*0*	26	**9**
Other Revenue / Expenditure	-24	**-3**	*-1*	*0*	-1	**-30**	*-12*	*0*	-12	**-6**
Pdc Dividend Payable	-5,765	**-480**	*0*	*0*	0	**-4,324**	*-1*	*0*	-1	**54**
Corporation Tax	-234	**-8**	*12*	*0*	12	**-72**	*104*	*0*	104	**-54**
Other Revenue / Expenditure	**-28,723**	**-1,740**	***525***	***0***	**525**	**-15,247**	***1,129***	***0***	**1,129**	**-140**
Retained Surplus / (Deficit), excl Donated Asset Income	**-5,463**	**-1,453**	***1,099***	***0***	**1,099**	**519**	***541***	***0***	**541**	**-799**
Depreciation Income Transfer	6,773	**507**	*-145*	*0*	-145	**4,569**	*-249*	*0*	-249	**-917**
Retained Surplus / (Deficit), incl Donated Asset Income	**1,309**	**-946**	***954***	***0***	**954**	**5,087**	***292***	***0***	**292**	**-1,717**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 09 2011/12
Research and Development Activity

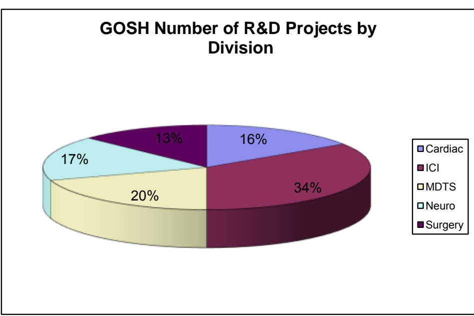
	Full Year Forecast	Full Year Budget	YTD Actuals	YTD Variance
Summary Research & Innovation Income and Expenditure				
TOTAL RESEARCH & DEVELOPMENT DIRECTORATE				
- R&D Income	(12,690)	(12,656)	(8,746)	(759)
- R&D Income Deferred from 10-11	0	0	0	0
- R&D Income Local Research Network MCRN	(935)	(788)	(805)	214
- R&D Charitable Contribution	(1,519)	(1,694)	(667)	(635)
- Non Research Income	(30)	0	(72)	72
- Expenditure	7,017	6,948	4,483	749
	(8,157)	(8,190)	(5,806)	(359)
- Expenditure in Clinical Areas	7,779	8,587	5,186	539
Total R&D Division	(378)	397	(620)	180
Devolved Income				
- DTS : From CLRN Service Support	(76)	415	0	329
- Medicine : Grants	(169)	(218)	(63)	(100)
- ICI : From CLRN Support / NIHR Felowships	(81)	(82)	(122)	55
- Surgery : From Charitable Donation	(3)	(67)	(85)	35
- Other	0	0	(3)	3
Total Centrally Held and Devolved Income	(329)	48	(275)	322
Revenue and Direct Expenditure by Funding Source				
Biomedical Research Centre including Clinical Research Facility				
- Income	(7,855)	(7,882)	(5,458)	(453)
- Commercial Trials Income	(295)	0	(419)	419
- Non R&D Income	(30)	0	(72)	72
- Expenditure	2,812	2,811	1,724	385
	(5,369)	(5,070)	(4,226)	424
CLRN (PCRN) Income				
- Income CLR Activity Based (Non DH R&D)	(293)	(1,186)	(186)	(703)
- Income PCRN (R M&G, KSS, SS)	(86)	0	(64)	64
- Income PCRN (R M&G,)	(272)	0	(219)	219
- Income Non R&D (cc **CLR**)	0	(112)	0	(84)
- Expenditure CLR	249	198	220	(72)
	(401)	(1,100)	(250)	(576)
NIHR GRANTS				
- Income	(935)	(983)	(614)	(135)
- Expenditure	935	987	614	139
	0	4	0	4
R&D GOSH Charity Funded Projects				
- Income	(1,519)	(1,694)	(667)	(635)
- Expenditure	1,483	1,552	661	511
	(36)	(142)	(6)	(124)
R&D Development Office & Other Grants				
- Income R&D including Flexibility and Sustainability	(2,955)	(2,479)	(1,784)	(75)
- Income non R&D	0	0	0	0
- Income EU Grants	0	(15)	0	(11)
- Expenditure	603	612	460	(0)
	(2,351)	(1,881)	(1,324)	(87)
Local Research Network MCRN *				
- Income DH to fund Network	(628)	(628)	(637)	166
- Income : Network Flexibility and Sustainability	(143)	(143)	(107)	0
- Income R&D :CLRN Network	(164)	0	(60)	60
- Income Other Non R&D	0	(17)	0	(13)
- Expenditure LRN	935	788	805	(214)
	0	0	0	0

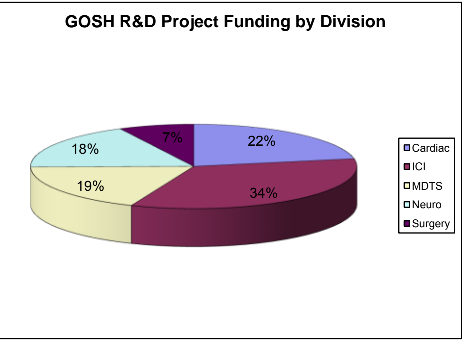
* GOSH is Hosting this service for Central and North East London

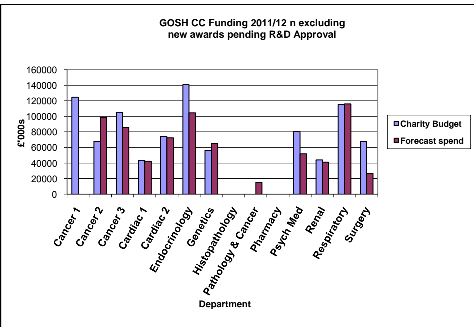
Analysis of Total Research & Innovation Funding

	Full Year Forecast	Full Year Budget	YTD Actuals	YTD Variance
TOTAL R&D INCOME				
-R&D Income Excluding Hosted network	(13,019)	(12,608)	(9,020)	(436)
-R&D Income Local Research Network MCRN	(935)	(788)	(805)	214
-Income Generation GOS / Direct Credits	0	0	0	0
Total Income	(13,954)	(13,396)	(9,825)	(222)

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







Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 2011/12
Statement of Financial Position

	Actual as at 1 April 2011 £000	Actual as at 30 November 2011	Actual as at 31 December 2011	Change in month £000	Forecast as at 31/03/12 £000
Non Current Assets :					
Property Plant & Equipment - Purchased	177,238	178,686	179,100	414	175,392
Property Plant & Equipment - Donated	141,526	158,199	158,162	(37)	159,230
Property Plant & Equipment - Gov Granted	363	322	316	(6)	301
Intangible Assets - Purchased	972	1,043	1,054	11	741
Intangible Assets - Donated	25	12	10	(2)	5
Trade & Other Receivables	9,505	9,201	9,160	(41)	9,041
Total Non Current Assets :	***329,629***	***347,463***	***347,802***	***339***	***344,710***
Current Assets :					
Inventories	5,156	6,084	6,330	246	6,100
NHS Trade Receivables	7,455	19,219	12,972	(6,247)	7,758
Non NHS Trade Receivables	10,360	12,068	11,361	(707)	8,948
Capital Receivables	6,571	5,282	3,849	(1,433)	6,880
Provision for Impairment of Receivables	(1,498)	(1,321)	(1,248)	73	(1,250)
Prepayments & Accrued Income	4,919	5,695	6,398	703	5,827
HMRC VAT	1,895	674	519	(155)	750
Other Receivables	807	743	943	200	840
Cash & Cash Equivalents	32,371	18,436	17,535	(901)	26,050
Total Current Assets :	***68,036***	***66,880***	***58,659***	***(8,221)***	***61,903***
Total Assets :	**397,665**	**414,343**	**406,461**	**(7,882)**	**406,613**
Current Liabilities :					
NHS Trade Payables	(7,722)	(5,104)	(4,623)	481	(2,387)
Non NHS Trade Payables	(2,519)	(2,134)	(1,008)	1,126	(1,017)
Capital Payables	(12,179)	(4,307)	(4,022)	285	(10,591)
Expenditure Accruals	(14,866)	(13,982)	(13,308)	674	(13,200)
Deferred Revenue	(6,280)	(10,596)	(5,825)	4,771	(5,400)
Tax & Social Security Costs	(4,022)	(4,031)	(4,044)	(13)	(4,050)
Other Payables	0	(961)	(1,441)	(480)	0
Payments on Account	(228)	(228)	(228)	0	(228)
Lease Incentives	(400)	(444)	(444)	0	(400)
Other Liabilities	(2,754)	(3,753)	(3,683)	70	(3,700)
Provisions for Liabilites & Charges	(2,867)	(2,622)	(2,704)	(82)	(2,426)
Total Current Liabilities :	***(53,837)***	***(48,162)***	***(41,330)***	***6,832***	***(43,399)***
Net Current Assets	**14,199**	**18,718**	**17,329**	**(1,389)**	**18,504**
Total Assets Less Current Liabilities :	**343,828**	**366,181**	**365,131**	**(1,050)**	**363,214**
Non Current Liabilities :					
Lease Incentives	(7,327)	(7,060)	(7,026)	34	(6,926)
Provisions for Liabilites & Charges	(1,250)	(1,218)	(1,194)	24	(1,178)
Total Non Current Liabilities :	***(8,577)***	***(8,278)***	***(8,220)***	***58***	***(8,104)***
Total Assets Employed :	**335,251**	**357,903**	**356,911**	**(992)**	**355,110**
Financed by Taxpayers' Equity :					
Public Dividend Capital	124,732	124,732	124,732	0	124,732
Retained Earnings	16,868	23,019	22,087	(932)	19,282
Revaluation Reserve	48,623	48,505	48,490	(15)	48,446
Donated Asset Reserve	141,551	158,211	158,172	(39)	159,235
Government Grant Reserve	363	322	316	(6)	301
Other Reserves	3,114	3,114	3,114	0	3,114
Total Taxpayers' Equity :	**335,251**	**357,903**	**356,911**	**(992)**	**355,110**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 2011/12
Statement of Cash Flow

Statement of Cash Flows	Actual For Month Ended 31 December 2011 £000	Actual For YTD Ended 31 December 2011 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating Surplus	(468)	9,392
Depreciation and Amortisation	1,254	10,870
Transfer from Donated Asset Reserve	(501)	(4,522)
Transfer from the Government Grant Reserve	(6)	(47)
PDC Dividend Paid	0	(2,818)
Decrease/(Increase) in Inventories	(246)	(1,174)
Decrease/(Increase) in Trade and Other Receivables	6,169	(6,731)
Decrease in Trade and Other Payables	(7,040)	(6,601)
Decrease/(Increase) in Other Current Liabilities	(103)	672
Increase/(Decrease) in Provisions	54	(249)
Net Cash Outflow from Operating Activities :	***(887)***	***(1,208)***
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	5	53
Payments for Property, Plant and Equipment	(1,777)	(37,310)
Payments for Intangible Assets	(142)	(255)
Proceeds from Disposal of Intangible Assets	0	8
Net Cash Outflow from Investing Activities :	**(1,914)**	**(37,504)**
NET CASH OUTFLOW BEFORE FINANCING :	**(2,801)**	**(38,712)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Other Capital Receipts	1,900	23,876
Net Cash Inflow from Financing :	**1,900**	**23,876**
NET DECREASE IN CASH AND CASH EQUIVALENTS :	**(901)**	**(14,836)**

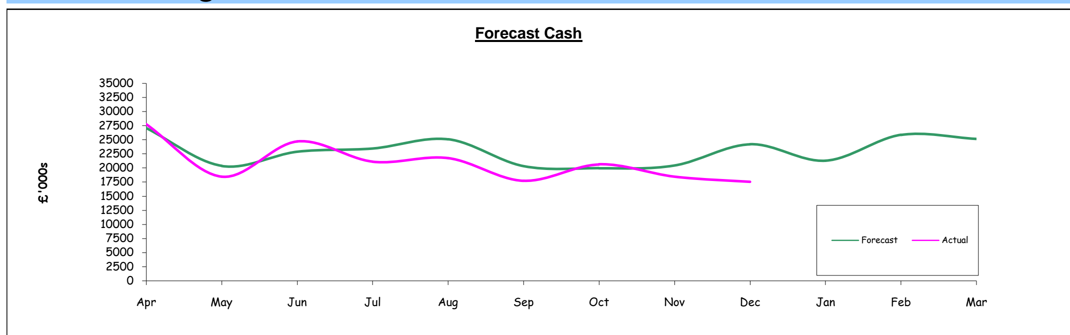
Cash and Cash Equivalents at the Beginning of the current period	**18,436**	**32,371**
Cash and Cash Equivalents at the End of the current period	**17,535**	**17,535**
Net Decrease in Cash and Cash Equivalents per SoFP :	**(901)**	**(14,836)**
	0	0

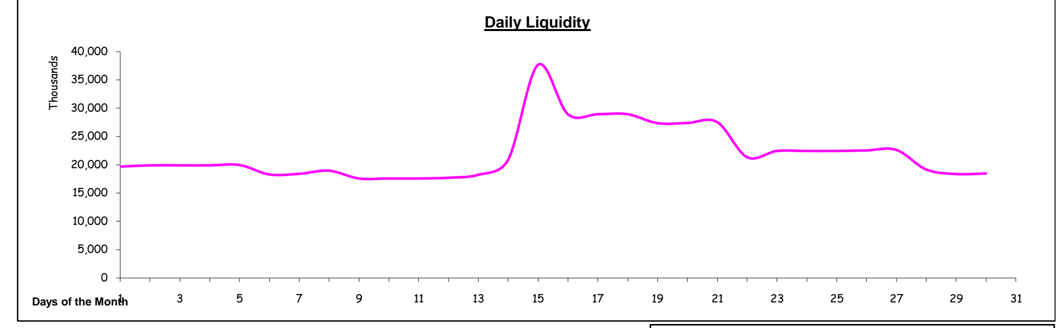
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 2011/2012
Activity

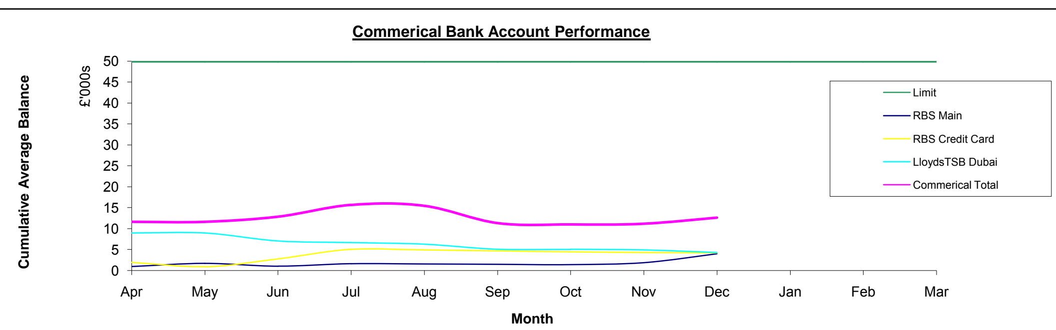
December activities are based on April to November

	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
Elective PBR	1,415	1,499	1,652	1,515	1,531	1,541	1,589	1,681	1,351				13,774	13,383	390	2.9%	12,996	778
Elective Non PBR	107	151	159	129	146	130	167	158	124				1,271	1,703	-432	-25.4%	1,276	-5
Same Day PBR													0	0	0	0.0%	0	0
Same Day Non PBR													0	0	0	0.0%	0	0
TOTAL ELECTIVE	1,522	1,650	1,811	1,644	1,677	1,671	1,756	1,839	1,475	0	0	0	15,045	15,086	-41	-0.3%	14,272	773
Non Elective PBR	143	155	134	115	131	117	136	145	137				1,213	1,348	-135	-10.0%	1,582	-370
Non Elective Non PBR	3	1	1	3	1	3	1	5	2				20	39	-19	-48.1%	25	-5
TOTAL NON ELECTIVE	146	156	135	118	132	120	137	150	139	0	0	0	1,233	1,387	-154	-11.1%	1,607	-374
Outpatients PBR	5,604	6,732	7,578	6,662	6,605	7,709	7,220	7,889	6,039				62,038	60,414	1,624	2.7%	50,502	11,536
Outpatients Non PBR	4,282	4,842	5,077	4,869	4,849	5,388	5,221	5,382	4,112				44,022	43,195	827	1.9%	45,536	-1,514
TOTAL OUTPATIENTS	9,886	11,574	12,655	11,531	11,454	13,097	12,441	13,271	10,151	0	0	0	106,060	103,609	2,451	2.4%	96,038	10,022
POC (Non Consortium)	812	799	816	803	821	830	844	841	821				7,387	7,905	-518	-6.6%	8,255	-869
BEDDAYS (includes PICU Consortium)																		
Panda HDU (PBR HDU)	744	622	757	890	790	646	871	610	643				6,573	6,445	128	2.0%	6,276	297
Transitional Care	140	176	139	164	186	160	124	120	154				1,363	1,123	239	21.3%	1,123	239
Rheumatology Rehab	145	194	216	218	180	199	224	211	202				1,789	1,657	132	8.0%	1,624	165
CAMHS	214	239	252	251	248	229	244	251	245				2,173	2,210	-37	-1.7%	2,050	122
Cardiac ECMO	17	6	19	0	10	30	1	32	15				130	69	60	87.3%	72	57
Neurosurgery HDU (NC)	0	11	0	7	0	7	7	13	6				51	30	21	71.7%	29	21
Neurosurgery (PICU Consortium-ITU &	2	51	100	90	71	145	53	84	76				672	580	92	15.9%	573	98
Neurosurgery ITU (NC)	1	0	0	12	0	0	0	0	2				15	17	-2	-12.0%	17	-2
Cardiac HDU (NC)	33	28	42	54	42	42	65	62	47				415	307	108	35.2%	297	118
Cardiac ITU (NC)	61	101	146	102	70	113	108	129	105				935	865	70	8.1%	1,018	-83
Cardiac (PICU Consortium-ITU & HDU)	251	165	179	308	277	209	210	178	226				2,003	1,881	121	6.5%	1,797	206
Paediatric ITU (NC)	48	68	71	44	30	85	80	83	65				574	624	-51	-8.1%	495	79
Paediatric ITU (PICU Consortium-ITU)	399	367	374	435	387	398	370	412	399				3,541	3,520	21	0.6%	3,422	119
TOTAL BEDDAYS	2,055	2,028	2,295	2,575	2,291	2,263	2,357	2,185	2,183	0	0	0	20,232	19,329	903	4.7%	18,794	1,438
HaemOnc Consortium*																		
PBR	50	55	53	54	48	54	52	44	45				455	476	-21	-4.4%	395	60
NON PBR	134	142	145	144	163	143	168	156	130				1,325	1,261	64	5.1%	1,167	158
Panda HDU (PBR HDU)	202	256	154	329	311	210	317	288	224				2,291	2,066	225	10.9%	1,863	428
TOTAL HAEMONC	386	453	352	527	522	407	537	488	399	0	0	0	4,071	3,803	268	7.0%	3,425	646
Spell based activity	1,852	2,003	2,144	1,960	2,020	1,988	2,113	2,189	1,788				18,057	18,210	-152	-0.8%	17,441	616

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 December 11/12
Cash Management







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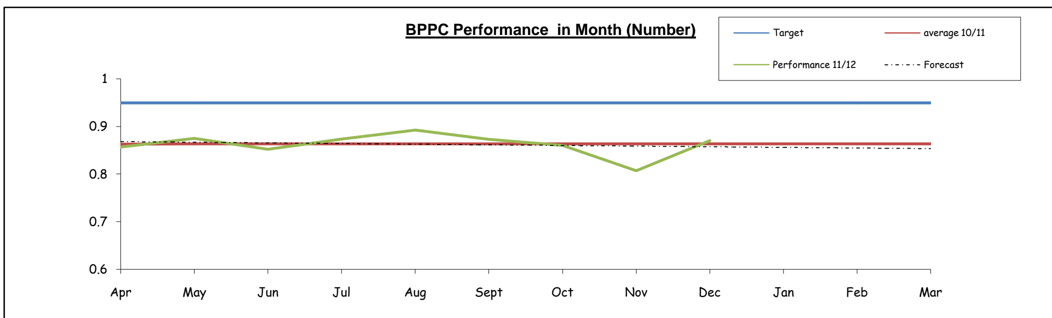
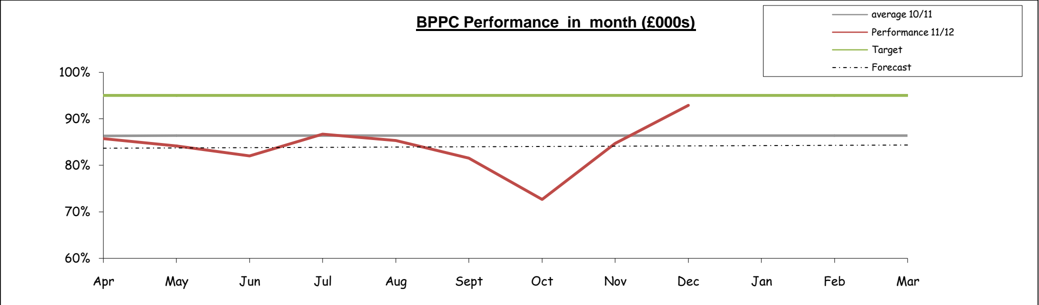
Payables Analysis

Days	Forecast March 12	Current Month £000s	Previous Month £000s	Movement in Month £000s
Not Yet Due	5,000	2,506	4,988	(2,482)
1-30	2,500	1,800	1,315	485
31-60	1,250	804	227	577
61-90	675	371	(54)	425
91-120	200	193	131	62
121-180	125	253	(85)	338
180-360	125	450	505	(55)
360+	125	591	650	(60)
	10,000	**6,968**	**7,678**	**(709)**

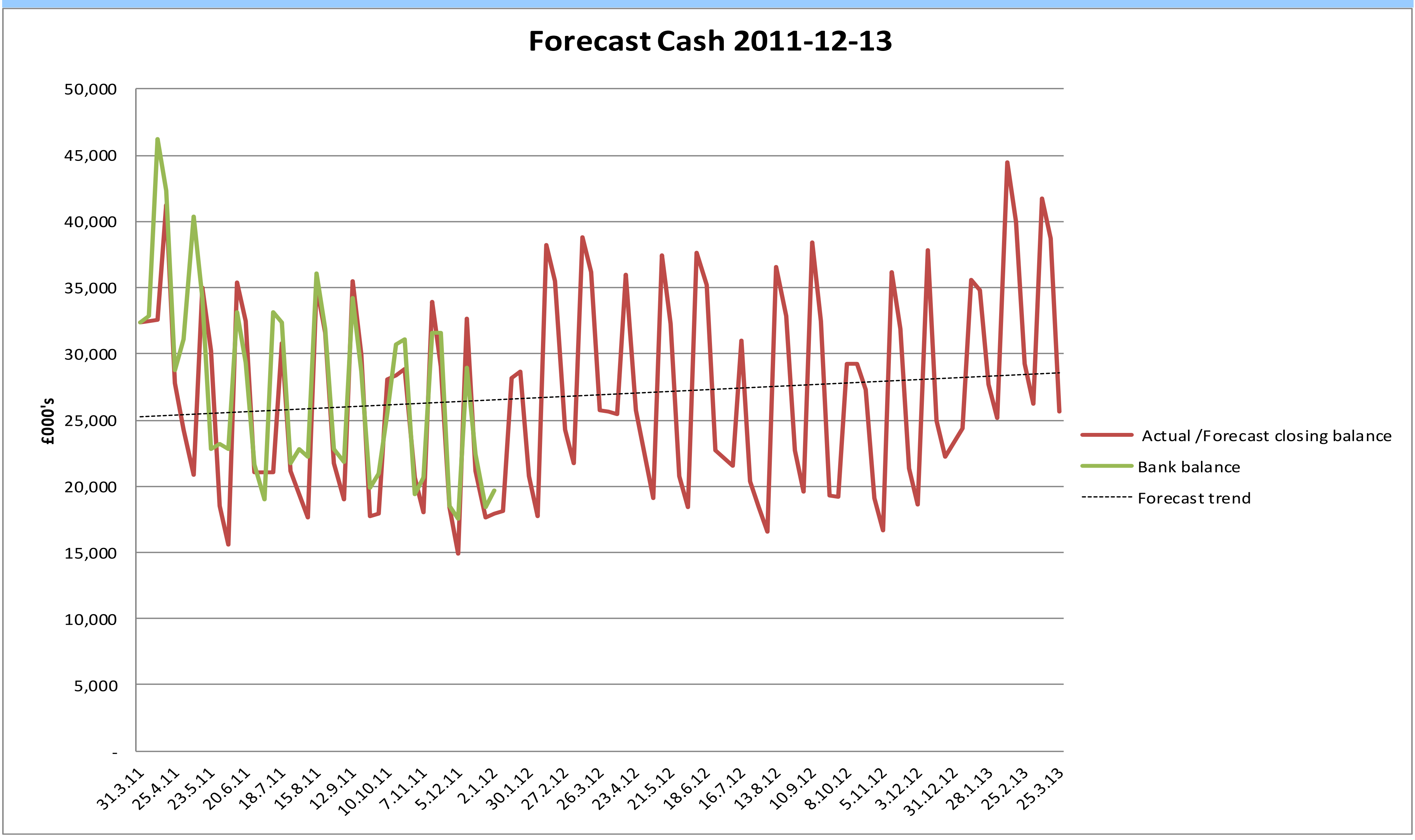
Better Payment Practice Code (BPPC)

	Number	£000s
Cumumlative Performance		
Total Payables		
% of Invoices paid within target	85.3%	83.5%
Non-NHS Payables		
Invoices paid in the year	62109	143,427
Invoices paid within target	53782	124,527
% of Invoices paid within target	86.6%	86.8%
NHS Payables		
Invoices paid in the year	2533	14,497
Invoices paid within target	1330	7,384
% of Invoices paid within target	52.5%	50.9%





Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 2011/12
Cash Forecast



Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 2011/12
Receivables Management

Net Receivables in £'000's	Total	Cash on Account	Not Yet Due	Overdue						
				0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	**4917**	-493	2693	1326	103	375	122	671	32	87
NHS Credit Note Provision	-840	0	0	0	0	0	-42	-216	-237	-345
Specific NHS Debt Provisions										
NHS Net Receivables	**4076**	**-493**	**2693**	**1326**	**103**	**375**	**80**	**455**	**-205**	**-258**
Non-NHS	**2505**	-16	610	1507	156	64	-27	31	75	106
Bad Debt Provision-Non NHS	-480	0	-53	-167	-21	-9	-9	-19	-76	-126
Specific Non-NHS Debt Provisions	0	0	0	0	0	0	0	0	0	0
Non-NHS Net Receivables	**2025**	**-16**	**557**	**1340**	**135**	**55**	**-37**	**13**	**-1**	**-21**
International	**8468**	5538	-1142	1374	806	588	209	297	304	494
Bad Debt Provision-International	-768	-5	-2	-1	-1	-3	-40	-52	-164	-501
International Net Receivables	**7700**	**5534**	**-1144**	**1373**	**805**	**586**	**168**	**245**	**140**	**-7**
GOSH Charity Receivables	**561**	-1	58	204	194	73	6	26	0	-0
Net Trust Receivables	**14363**	**5023**	**2165**	**4243**	**1237**	**1089**	**218**	**739**	**-65**	**-286**

Trust Receivables in £'000's	Total	Cash on Account	Not Yet Due	Overdue						
				0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	4917	-493	2693	1326	103	375	122	671	32	87
Non-NHS	2505	-16	610	1507	156	64	-27	31	75	106
International	8468	5538	-1142	1374	806	588	209	297	304	494
Gross Trading Receivables	**15891**	**5029**	**2161**	**4207**	**1065**	**1028**	**304**	**1000**	**412**	**686**
GOSH Charity Receivables	561	-1	58	204	194	73	6	26	0	-0
Total Trust Receivables	**16451**	**5027**	**2219**	**4411**	**1258**	**1101**	**310**	**1026**	**412**	**686**

Movement in £'000's	Total	Cash on Account	Not Yet Due	Overdue						
				0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
Gross Trading Receivables (as above)	16451	5027	2219	4411	1258	1101	310	1026	412	686
Gross Trading Receivables (last month)	22702	4672	7876	3058	4147	332	728	693	634	562
Movement in Month	**-6251**	**355**	**-5657**	**1353**	**-2889**	**769**	**-418**	**333**	**-222**	**124**
Gross Trading Receivables (Forecast year end 11/12	15206	-1500	9058	3283	1182	899	487	292	939	567
Gross Trading Receivables (year end 10/11)	15481	-1747	11317	1550	779	524	423	515	1385	734
Movement in Financial Year	**-970**	**-6774**	**9098**	**-2861**	**-479**	**-577**	**113**	**-511**	**973**	**48**

Systems Schedule

Receivables in £'000's	Gross Receivables	Cash on Account	Not Yet Due	Overdue						
				0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
eFinancial	7983	-511	3361	3037	452	513	102	728	108	193
Compucare	8468	5538	-1142	1374	806	588	209	297	304	494
Trust Receivables	**16451**	**5027**	**2219**	**4411**	**1258**	**1101**	**310**	**1026**	**412**	**686**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 2011/12
Capital Expenditure (£000s)

Capital Spend by Division	Annual Plan	Year To Date Plan	Actual (YTD)	Variance (YTD)		Forecast Outturn	Forecast Variance to Plan
	Year to Date (YTD)						
Redevelopment Projects							
Trust/DH Funded							
Phase 2a Enabling	0	0	0	0		0	0
Donated Funded							0
Phase 1	26	17	(7)	24		12	14
Phase 2a Enabling	0	0	0	0		0	0
Phase 2a	27,778	17,956	17,268	688		26,599	1,179
Phase 2b Enabling	6,271	4,054	99	3,955		1,000	5,271
Phase 2b	1,953	1,262	1,419	(157)		1,998	(45)
Pre-phase 2	0	0	18	(18)		18	(18)
Phase 2 - Inhouse Resources	344	222	208	15		292	52
Other Redevelopment Projects	0	0	0	0		0	0
Total :	**36,372**	**23,511**	**19,004**	**4,507**		**29,919**	**6,453**
Estates Maintenance Projects							
Trust/DH Funded	7,702	5,007	6,161	(1,154)		7,580	122
Donated Funded	1,250	816	20	796		520	730
Total :	**8,952**	**5,823**	**6,181**	**(358)**		**8,100**	**852**
IT Projects							
Trust/DH Funded	6,000	3,900	1,918	1,982		4,500	1,500
Donated Funded	1,000	645	15	630		1,000	0
Total:	**7,000**	**4,545**	**1,933**	**2,612**		**5,500**	**1,500**
Medical Equipment Projects							
Trust/DH Funded	90	63	166	(103)		216	(126)
Donated Funded	3,500	2,274	2,115	159		3,145	355
Total:	**3,590**	**2,337**	**2,280**	**57**		**3,361**	**229**
Total Additions in Year	**55,914**	**36,216**	**29,399**	**6,817**		**46,880**	**9,034**
Asset Disposals	0	0	(4)	4		(4)	4
Donated Funded Projects	(42,122)	(27,246)	(21,154)	(6,092)		(34,585)	(7,537)
Charge Against CRL Target	**13,792**	**8,970**	**8,241**	**729**		**12,292**	**1,500**
	42,122	**27,246**	**21,154**	**6,092**	**42,122**	**34,585**	**13,431**
	13,792	8,970	8,245	725	13,792	12,296	**4,051**
						46,880.3	

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 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	Period 9	10/11 Period 12	M9 variance to M12 10/11
Cardiac	350	354	348	358	354	363	373	379	375	342	-34
Surgery	650	644	640	649	652	647	669	676	680	646	-34
DTS	354	356	354	351	355	346	354	362	355	349	-6
ICI	479	481	472	482	486	487	501	519	512	460	-52
International	114	116	117	118	117	113	120	127	122	115	-7
Medicine	280	284	275	274	280	281	271	276	279	282	3
Neurosciences	261	264	254	258	258	273	278	279	282	255	-27
Haringey	183	175	0	1	0	0	0	0	0	0	0
North Mid.	2	2	2	2	2	0	0	0	0	0	0
Children's Population Health	7	8	8	9	7	7	8	7	8	7	-1
Operations & Facilities	202	203	208	207	207	192	204	206	215	208	-7
Corporate Affairs	15	13	12	14	10	10	14	10	7	13	6
Estates	46	45	45	45	44	43	45	45	45	48	3
Finance & ICT	138	138	140	135	138	135	127	120	121	134	13
Human Resources	57	55	54	57	58	60	56	59	62	57	-5
Medical Director	14	14	13	14	14	14	8	8	7	15	7
Nursing And Workforce Development	80	78	75	76	76	75	80	77	83	80	-3
Research And Innovation	57	63	66	75	71	78	79	77	76	77	0
Redevelopment Revenue Costs	7	7	7	8	8	8	6	6	6	7	2
TOTAL	3297	3300	3089	3,134	3,137	3,131	3,194	3,233	3,236	3096	-140

Overtime

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	10/11 Period 12	M9 variance to M12 10/11
Cardiac	6.3	2.4	1.0	2.0	1.6	1.6	1.6	2.4	1.6	2.6	0.9
Surgery	3.3	2.4	1.8	1.4	1.8	3.1	2.7	3.4	2.6	2.6	0.0
DTS	0.4	0.8	1.1	1.0	0.7	0.4	0.4	0.4	0.6	0.5	-0.1
ICI	0.4	0.3	0.1	0.5	0.8	0.4	0.5	0.5	0.4	0.5	0.2
International	0.2	1.5	0.8	1.0	0.9	1.8	0.9	1.0	0.7	1.8	1.1
Medicine	0.3	0.8	0.4	0.2	0.1	0.1	0.4	0.4	0.1	0.3	0.2
Neurosciences	0.9	0.6	0.7	0.4	0.5	0.7	0.5	0.3	0.2	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	0.0
North Mid.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Children's Population Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Operations & Facilities	3.6	4.0	4.3	4.3	4.9	3.1	2.8	3.8	4.1	4.2	0.0
Corporate Affairs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates	2.0	1.2	1.4	2.0	2.0	1.0	1.6	1.4	1.3	2.3	0.9
Finance & ICT	3.1	1.2	1.7	0.9	1.5	0.5	0.8	0.6	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	0.0
Medical Director	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Nursing And Workforce Development	0.0	0.1	0.0	0.1	0.0	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	0.2	0.1	0.0
Redevelopment Revenue Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	20.6	15.7	13.8	13.9	15.0	13.1	12.3	14.7	12.6	17.0	4.4

Agency/Locum/Bank

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	10/11 Period 12	M9 variance to M12 10/11
Cardiac	34	29	36	40	36	48	31	41	37	41	4
Surgery	56	62	63	66	63	76	83	80	64	67	3
DTS	9	10	18	17	14	15	17	17	14	13	-1
ICI	40	34	37	44	46	37	43	34	24	49	26
International	41	44	37	37	36	43	33	29	21	31	10
Medicine	27	22	21	23	15	23	24	22	20	28	8
Neurosciences	25	18	21	23	17	26	21	18	21	31	10
Haringey	4	5	0	0	0	0	0	0	0	0	0
North Mid.	0	0	0	0	0	0	0	0	0	0	0
Children's Population Health	2	0	0	0	0	0	0	0	0	0	0
Operations & Facilities	9	18	16	14	17	28	24	12	16	27	10
Corporate Affairs	0	1	0	0	2	1	0	0	0	0	0
Estates	5	15	7	15	4	12	41	8	5	7	1
Finance & ICT	15	11	14	12	17	15	19	24	22	14	-8
Human Resources	4	0	4	5	2	4	2	2	1	9	8
Medical Director	2	2	1	2	1	2	0	0	0	2	2
Nursing And Workforce Development	3	2	3	3	1	4	1	1	1	3	3
Research And Innovation	1	2	3	1	1	2	2	2	2	4	1
Redevelopment Revenue Costs	0	0	3	0	3	1	1	2	2	6	3
TOTAL	277	273	284	304	276	338	342	291	250	332	82

TOTAL STAFFING (Excluding Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	10/11 Period 12	M9 variance to M12 10/11
Cardiac	390	385	386	401	392	413	406	423	414	385	-29
Surgery	709	709	704	716	717	726	755	759	746	716	-30
DTS	364	366	373	369	370	361	371	379	369	363	-6
ICI	519	515	510	527	532	525	544	554	536	510	-26
International	154	162	155	156	154	158	153	157	143	148	5
Medicine	308	306	296	298	295	305	296	299	299	310	11
Neurosciences	287	283	276	282	275	300	300	297	303	286	-16
Haringey	187	180	0	1	0	0	0	0	0	0	0
North Mid.	2	2	2	2	2	0	0	0	0	0	0
Children's Population Health	9	8	8	9	7	7	8	7	8	7	-1
Operations & Facilities	214	225	228	226	229	223	231	222	236	239	3
Corporate Affairs	15	14	12	14	13	11	14	10	7	13	6
Estates	53	61	54	62	50	56	87	54	52	57	5
Finance & ICT	155	150	155	148	157	151	147	145	144	149	6
Human Resources	62	55	57	62	60	64	59	61	63	66	3
Medical Director	17	16	14	16	15	16	8	8	7	17	10
Nursing And Workforce Development	83	80	77	80	77	79	81	78	84	84	0
Research And Innovation	58	65	69	76	72	81	82	80	79	81	2
Redevelopment Revenue Costs	7	7	11	8	10	9	7	7	8	13	5
TOTAL	3,594	3,588	3,388	3,451	3,428	3,483	3,548	3,539	3,498	3,444	-54

<table>
<tr><td colspan="2">Trust Board
25th January 2012</td></tr>
<tr><td>Pals (Patient Advice and Liaison service) Patient Experience Report Q3 October 2011-December 2011

Submitted on behalf of
Liz Morgan Chief Nurse/Director of Education</td><td>Paper No: Attachment O</td></tr>
<tr><td colspan="2">Aims / summary
This report covers patient experience issues raised with the PALS service between October 2011 and December 2011. It identifies issues arising from casework that require Trust action and provides an update on actions taken in relation to issues identified in the previous quarter.</td></tr>
<tr><td colspan="2">Action required from the meeting
To consider and note the content of the report.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
STRATEGIC OBJECTIVE 2: Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations

GOSH seeks to provide services that exceed patient and families expectations.</td></tr>
<tr><td colspan="2">Financial implications
None</td></tr>
<tr><td colspan="2">Legal issues
None</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Not applicable</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
Not applicable</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Grainne Morby, Head of Pals and PPI</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
Liz Morgan, Chief Nurse and Director of Education</td></tr>
<tr><td colspan="2">Author and date
Grainne Morby, Head of Pals and PPI January 2012</td></tr>
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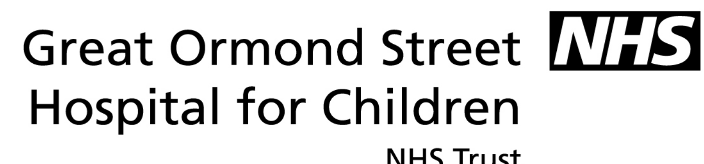


Pals Patient Experience Report – Q3 October 2011 – December 2012

1. Key themes of this report

- Updates on key issues from Q2
- Case Work Activity in Q3
- Learning from Patient Experience in Q3
- Complaints

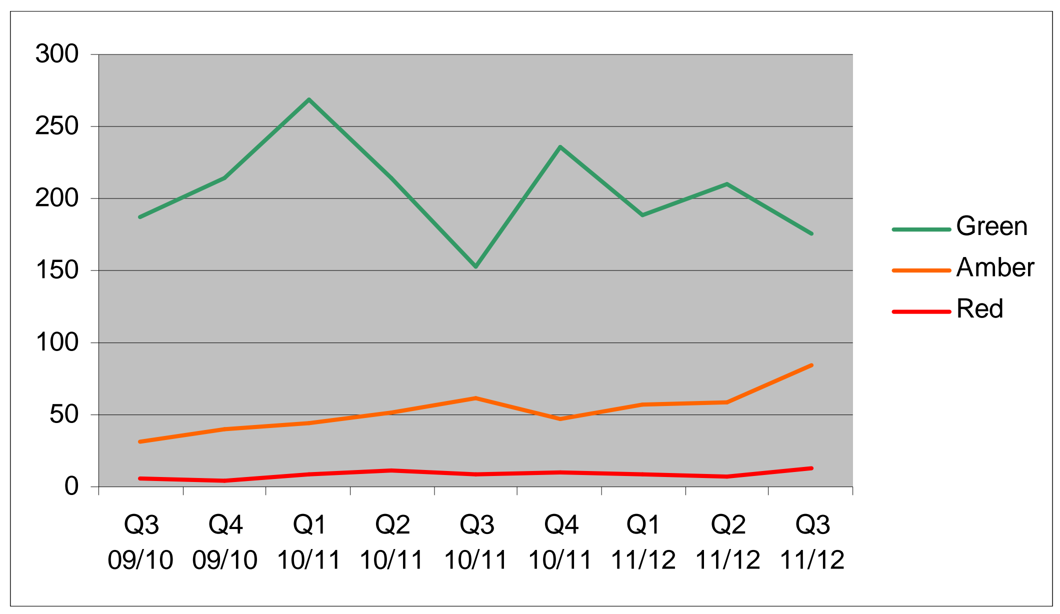
2. Updates for key issues from Q2

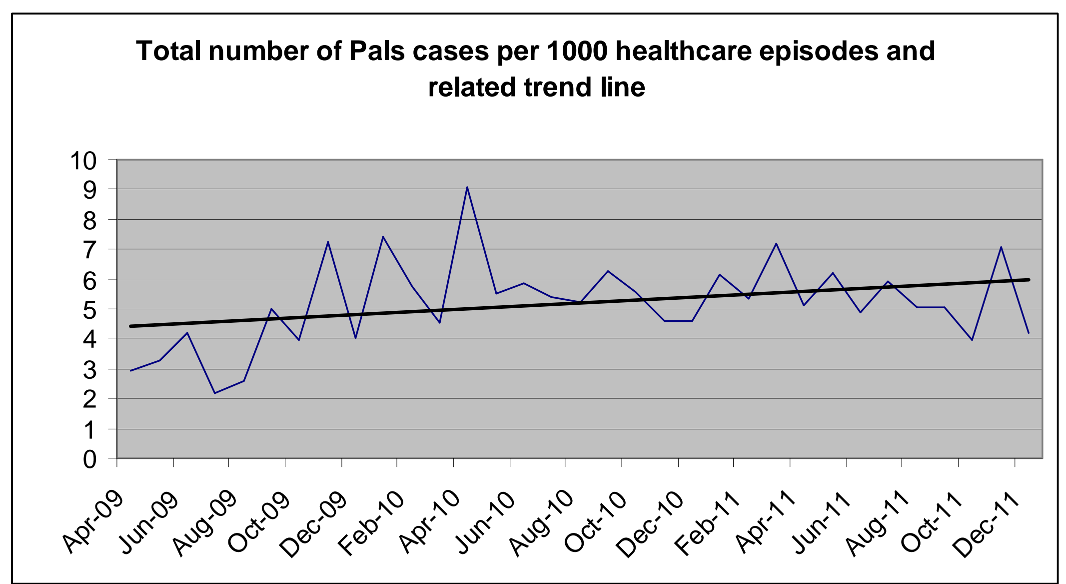
Issue: Poor state and management of Peter Pan café	**Update :** Catering Manager sorted out the cleaning problems due to change of contractor. Café area now much smaller and cleaning no longer an issue.
Issue: Gastroenterology service cases continue to be disproportionately represented in Pals casework.	**Update** : Gastro. cases are still disproportionately represented in Pals casework. However, Gastro. staff and managers are extremely efficient in responding to Pals enquiries.

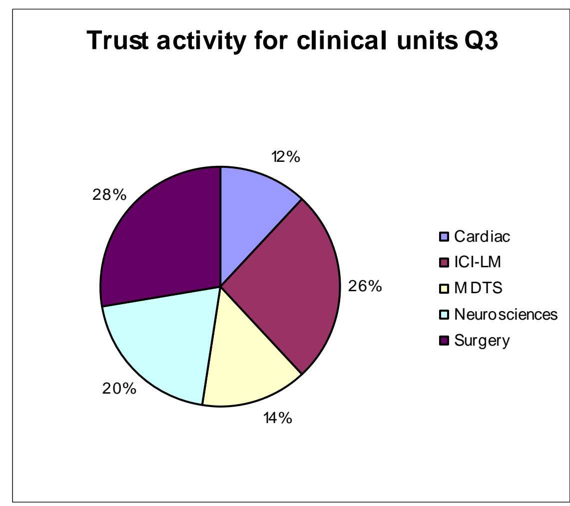
3. Pals Casework Activity in Q3

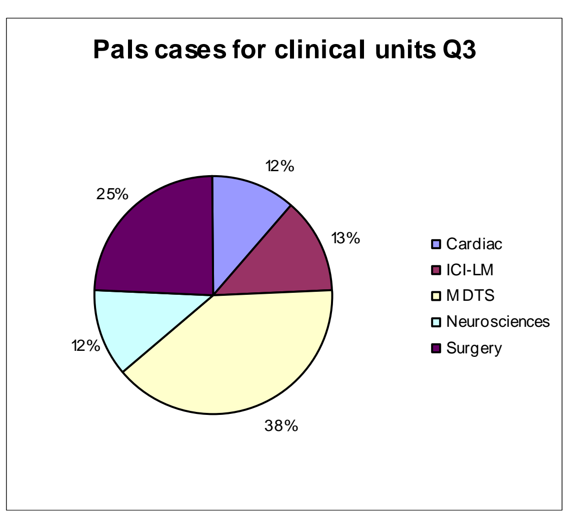
- 370 White Cases
- 176 Green Cases
- 85 Amber Cases
- 11 Red Cases

4. Pals cases over the last 2 years



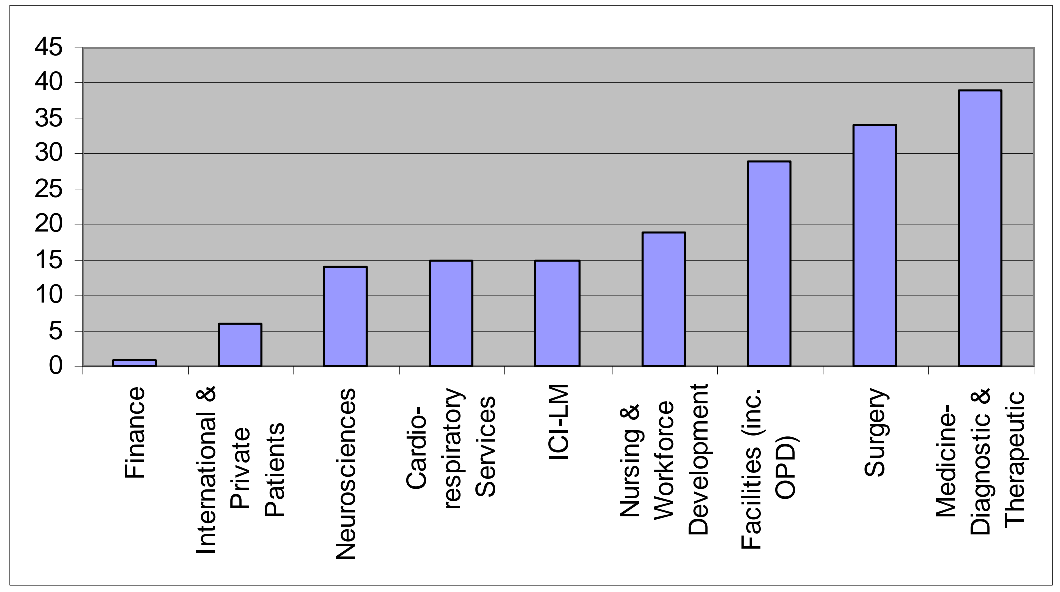




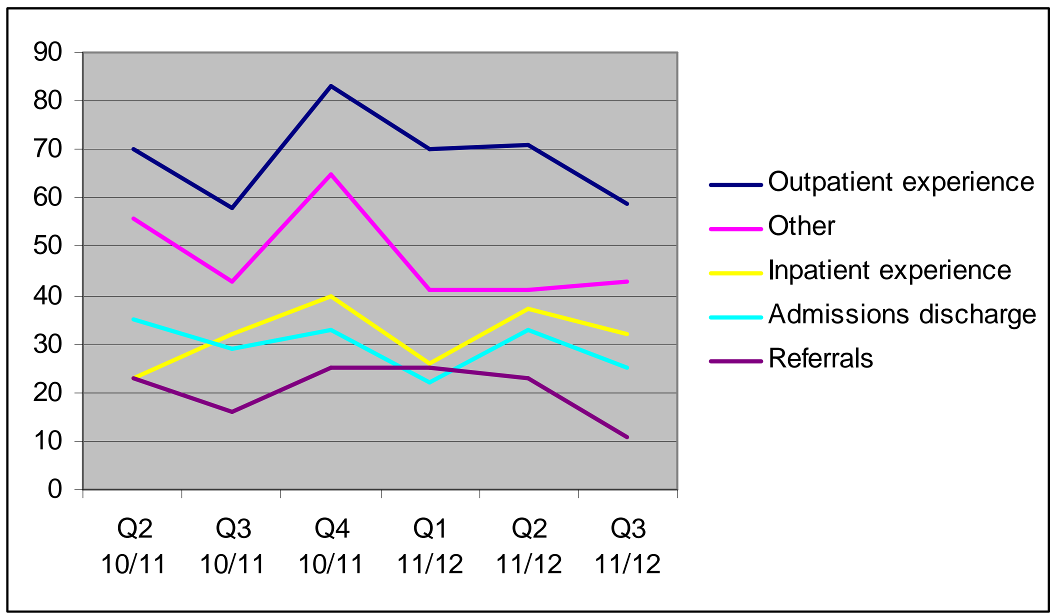


5. Pals Green Cases

5.1 Pals Green cases by Directorate for Q3 (176 cases)



5.2 Pals Green Cases from Q2 10/11 to Q3 11/12



Admission /Discharge includes general pre-admission queries including 'chasing confirmations' to wards and accommodation concerns whilst at GOSH. Families of 7 op. cancellations (5 Cardiac day surgery, 1 Craniofacial, 1 General Surgery) wanting explanations, apologies, rescheduled dates and fare reimbursements; MRI cancelled due to endocrine booking error; getting access to baby feed not available in the UK; advice to families who do not want to be discharged back to particular hospitals.

In-Patient Experience includes concerns with special milk not being available 'for some hours'; TV not working on wards/Italian building; advice on consent; hoovering /cleaning at dead of night in Weston House; family feeling need to return home to Liverpool to collect special chair for mother as unable to use GOSH chairs; families wanting to have patients moved to cubicles from bays; families seeking support following theft from lockers, and lost luncheon vouchers.

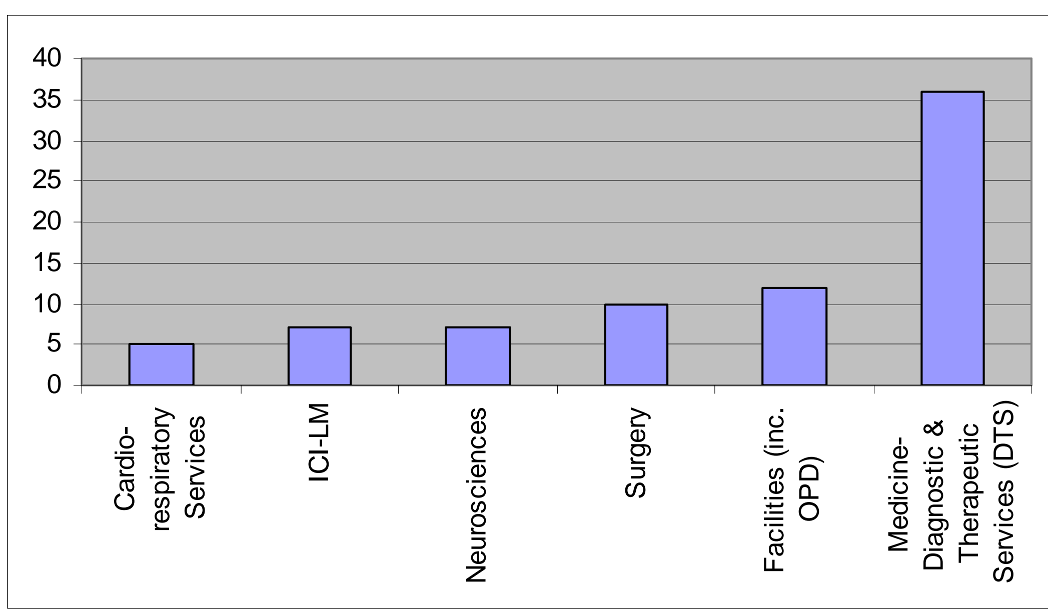
Other includes positive feedback about GOSH switchboard staff; advice sought by grandparents suspecting abuse; teenager wishing to donate kidney, several issues relating to financial hardship/fear of losing employment; ex-patients involved in clinical studies wanting updates and advice on orthopaedics surgery closure at Royal London and possible transfer to GOSH.

Out-Patient Experience includes advice on how to get specialist equipment locally; 2 Consultants alerting Pals post-difficult consultations; requests for letters of support for housing; family receiving duplicate copies of clinic letters; 7 clinic appointments. cancelled 'without prior notice' and families seeking fare reimbursement; two late patient transport complaints with knock-on effects for clinic; father wanting to counter ex-wife's version of events; complaints re waits for clinics – one hour, 'too long',

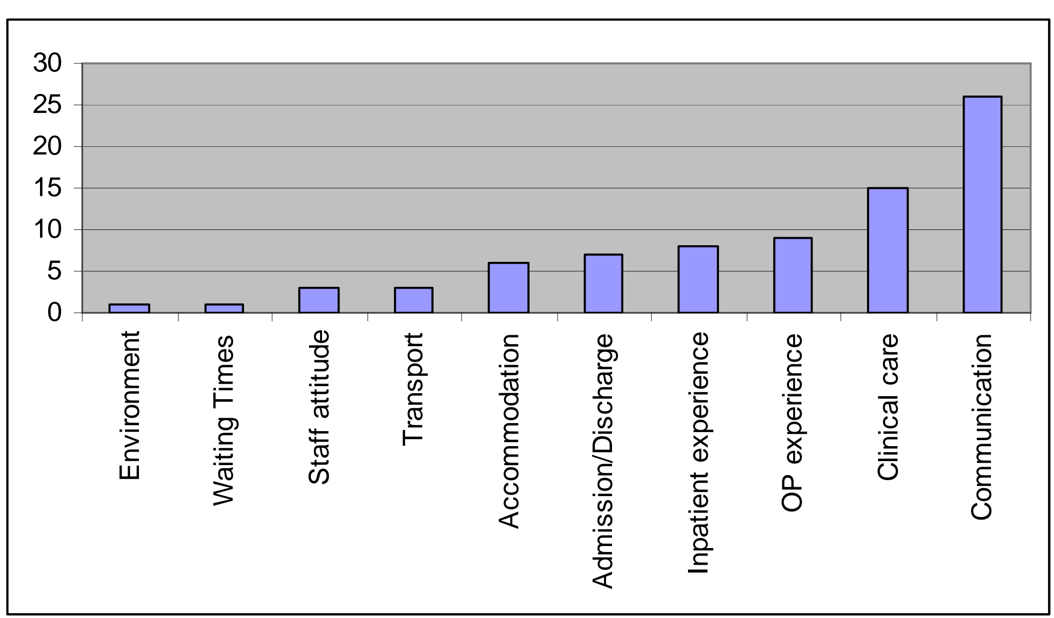
Referrals include advice on transition to adult services, IPP referrals, GP surgeries requesting referral information and parents wanting advice on challenging behaviour of children.

6. PALS AMBER CASES

6.1 by Directorate for Q3 (85 cases)



6.2 Pals Amber Cases by Theme for Q3 (85 cases)



These cases were resolved – but a flavour is given below.

- **Environment includes** altercation in the laundry over disputes about removal of washing and stolen clothes; concerns re cleanliness of laundry; concerns about reconfiguration of Penguin ward playroom making it smaller and 'inappropriately' next to injection room; autistic older patient distressed as needs access to WII console in Weston House; Peter Pan café being dirty first thing in morning.

- **Staff Attitude** includes poor attitude by Main Reception when asked to accept Xmas toys for the charity', OP reception who 'ignored and humiliated' family who had just received distressing news; concerns re attitude of a Clinical Nurse specialist escalated to DN&WD; communication issues with an Ophthalmology doctor who had not looked at child's notes and who made jocular comments about child's eyes which were not welcomed by parent. (In addition there were two instances of family feedback re 'rude staff' in the Accommodation office in Pals Green cases).

- **Accommodation** includes assisting with obtaining accommodation for a mother of child at GOSH for two weeks physio. rehab who has another child with special needs who also needs to be with mother; liaising with High Commission, family and accommodation team to resolve payment for accommodation for family from Gibraltar who had previously been given free accommodation; liaising with Accommodation to ensure that new rules are flexible for families on benefit from e.g. Devon for OP appointments can stay in WH night before.

- **Admission/Discharge** includes negotiating issue of appropriate care level on ward for patient who has 20 hours a week home care for 7 days; negotiating an earlier appt. for orthopedic patient hallucinating, on morphine and in DGH awaiting consultant's return from leave; patient transport driver falling asleep at wheel; child admitted twice with excoriated bottom from surgery OP needing bed – but 'whose bed'.

- **Inpatient experience includes** emotional support to mother of child on Berlin heart, mother of child 'locked in', and intense support to family on Rainforest whose daughter has a pattern of improvement/deterioration and who find it difficult to explain their concerns to staff constructively; parents of long-term BMT patient wanting flu jab from GOSH; praise for nursing care on Elephant ward (mother agreed to take patient story to Trust board).

- **Outpatient experience** includes one instance of notes being 'wrong' /test results not accessible and lengthy wait; Endocrine clinic 'overwhelming' for patient as four additional SPRs/visiting doctors/students in room in addition to patient, nurse, consultant and mother and no-one was introduced and no-one asked the family in advance; mother annoyed with clinic assistant although clinic late due to Surgery Consultant being late.

- **Clinical Care** includes dispute between family and dieticians as to degree of active engagement appropriate for patient; support to parent about whether to consent to GOSH recommended gene therapy; family not understanding that a 'picture of growth' needs to be built up before prescribing growth hormones; procedure cancelled due to disagreement between surgeon and anesthetist over estimated time of procedure; Gastro. outlier not reviewed by Gastro. for a week despite requests; four attempts at cannulation prior to MRI – 3rd attempt involved needle stick injury to a member of staff and mother 'felt pressed into consenting for further bloods for staff benefit'; parents with further questions following brain damage arising from brain surgery.

- **Communication** includes parents 'misinformed' that consultant unable to administer adrenaline if necessary during an endoscopy; several stressed parents finding constructive engagement on wards difficult; Rheumatology appt. not on PIMS and family from Sussex not able to see doctor as they were 'overcommitted'; manometry appointments cancelled over phone by staff saying 'the equipment isn't working and I have no other information to give you'; difficulties getting through to Gastro.; parent confused as patient has been seen in Gastro. privately and under the NHS and they do not understand why they now have to choose one or the other; mother feels day surgery in Kingfisher was 'traumatic' mostly because child not given a bed until 4pm – staff view is that beds are allocated on clinical need; advice sought by Consultant in response to family who had given negative feedback after a clinic consultation; parents unhappy with

wording in CAMHS assessments; family not understanding a clinical comment 'going past the stomach' made communication and consent difficult.

- **Same Sex Accommodation**: there have been no cases this quarter.

7. Learning and Patient Experience from Pals Cases in Q3

7.1 Issue: Patient transport delays for dialysis patients on Victoria ward

Case	Experience	Outcome
7820	Mother of patient feels that child having to wait increasingly lengthy periods after each dialysis appt. – feels that delays are increasing.	Project team set up with Transport Manager, PPI and Patient Experience Officer, ward and families to investigate and improve service. Results expected in Q4
7480 7795	Mother came to Pals on two occasions to raise concerns about increasingly long delays in patient being picked up after dialysis. Child feeling particularly low and tired and really wants to get home.	
7522	Mother wants to complain on behalf of other parents on Victoria ward - says they are all fed up about transport delays	

7. 2 Issue: Non-resident fathers with parental responsibility not being able to receive information about forthcoming clinic appointments

Case	Experience	Outcome
7796	Father has order for contact via a contact centre and has parental responsibility and mother is content that medical information be shared with father by GOSH (though she does not herself share). Father receives clinic letters (though he usually has to make persistent requests) but he never receives details of forthcoming appointments which he argues he is legally entitled to receive.	unresolved
7825	Father with PR reportedly does not receive OPA letters and on a number of occasions has not received clinic letters or other correspondence such as letters of referral to other Trusts.	unresolved
7685	Father with PR not routinely getting clinic appointment letters and other hospital information about his son making him very aggrieved.	unresolved

Attachment O

Pals Red Cases (11 cases)

Pals identified 10 Red cases in Q3 which were referred to CGST for patient safety investigation or complaint. There is an additional complaint being supported by Pals against a local hospital.

CARDIAC, CICU 7695	Complaint re poor communication between local hospital and tracheal team leading to delay in treatment and deterioration in child's health. Update: Formal complaint open
FINANCE/ICT/PIMS 7685	Father with PR not routinely getting clinic appointment letters and other hospital information about his son making him very aggrieved. Update: Formal complaint open
MDTS Gastro 7793	Child due a gastrostomy cancelled as last on list due to MDR TB. Child has autism and epilepsy and is refusing oral feeds and mother says she will not co-operate in pin-downs any longer. Patient Safety team alerted as child remains an infection risk. Child operated on the following day. Update: Formal complaint response sent to family explaining reasons for for cancellation and apologies for communication problems.
MDTS Gastro 7595	Patient on Squirrel ward following major gastro surgery for five weeks unable to see lead gastro consultant who had recommended the operation. Family discharged without any discussion on outcome or future care. Update: Formal complaint open; family offered meeting to discuss.
NEUROSCIENCES Gastro, Surgery & General Paeds. 7824	Family reference confidentiality breaches from GOSH to local school, unhappy that child's operation cancelled and unhappy with social work/psychological input. Update: Formal complaint open
SURGERY Urodynamics/OPD 7772	Transport and accommodation not arranged for clinic appointment. Update: Formal complaint response sent to family giving explanation of policy and availability of Trust accommodation
MDTS Mildred Creak Unit 7748	Support given to patient on MCU wishing to make a formal complaint about an admission to another hospital. Update: draft complaint being agreed with patient, and with parents.

The following cases were resolved satisfactorily after escalation to Complaints.

MDTS Endocrine 7792	Father complained of very poor service from Endocrine. Bloods given in August got lost and father had to 'chase' for new appointment. Offered dates which GOSH cancelled; and messages went unanswered. Feeling loss of confidence that son will ever be treated for hormone problem by GOSH.
SURGERY 7667 Ortho	Patient had lots of orthopaedic work and had casts on his legs. When the casts came off the consultant found burns and blisters and a referral was made to social services at GOSH: the family have now met with social services and this is not being taken further.
SURGERY Audiology 7778	Father wanted son to have a second cochlear implant and did not wish to engage in any form of mediation.
SURGERY Ortho 7588	GOSH delayed referral to Stanmore for child's knee operation with subsequent delay to operation

Appendix 1

Grading of Pals cases

White

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

Green

A case is categorised as Green when it involves

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

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

Amber

A case is categorised as Amber when it involves

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

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

Red

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

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

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

<table>
<tr><td colspan="2">Trust Board Meeting
25th January 2012</td></tr>
<tr><td>Foundation Trust application update

Submitted on behalf of:
Sven Bunn</td><td>Paper No: Attachment P</td></tr>
<tr><td colspan="2">Aims / summary
The attached paper sets out the current position for the Trust against the assessment criteria used by the SHA and the Secretary of State for Health to determine readiness for Foundation Trust status.
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.
Further work to address these issues was largely completed by 6 January, and documents were submitted to Monitor to provide evidence of completion.
Key actions for the next two months:
• Complete the Monitor assessment process.
• Complete the board to board meeting and any further actions.</td></tr>
<tr><td colspan="2">Action required from the meeting
To note the current position for the foundation trust application.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
Achievement of Trust objective to secure Foundation Trust status</td></tr>
<tr><td colspan="2">Financial implications: None</td></tr>
<tr><td colspan="2">Legal issues: None</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Not required</td></tr>
<tr><td colspan="2">Who needs to be told about any decision Not required</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Sven Bunn, FT Programme Manager</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
Jane Collins, Chief Executive</td></tr>
<tr><td colspan="2">Author and date
Sven Bunn, 12 January 2012</td></tr>
</table>

Attachment P

Foundation Trust application – January 2012 position

Assessment of current performance for Great Ormond Street Hospital against the seven domains of the Secretary of State assurance process (changes since December 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: assessed as compliant with all key standards (reviewed July 2011) • **HAI Performance** (c. diff – 7 cases; **MRSA – 4 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 – 4 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

Attachment Q

Trust Board **25th January 2012**	
Update on Compliance with Care Quality Commission Standards and Registration **Submitted on behalf of:** **Anna Ferrant, Company Secretary**	**Paper No: Attachment Q**
Aims / summary To update Trust Board on the current status of the Care Quality Commission (CQC) registration standards. The CQC has issued the Trust with the November 2011 Quality and Risk Profile (QRP). This is a tool for the CQC, providers and commissioners to use in monitoring compliance with the essential standards of quality and safety. Actions required to address any deficits identified are managed and monitored via the Risk, Assurance and Compliance Group.	
Action required from the meeting To consider and note the current status of registration against the 16 essential outcomes.	
Contribution to the delivery of NHS / Trust strategies and plans It is a requirement under the Health & Social Care Act that the Trust is registered for the services it provides and that it actively seeks to maintain this registration.	
Financial implications Should deficits be identified, registration can be removed or maintained with conditions. This can have financial penalties for the Trust including damage to reputation.	
Legal issues Registration is a legal requirement.	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? Not applicable	
Who needs to be told about any decision Not applicable	
Who is responsible for implementing the proposals / project and anticipated timescales Executive Team and Company Secretary	
Who is accountable for the implementation of the proposal / project Chief Executive	
Author and date Alison Vizulis, 10th January 2012	

Attachment Q

Compliance with Care Quality Commission Standards and Registration

Summary

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

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

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

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

The types of services provided are declared as:

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

Quality and Risk Profile

The Quality Risk Profile (QRP) is produced by the CQC on a 4-6 weekly basis and brings together a wide range of information about a provider. It is used by the CQC to prioritise any areas identified as being at risk, and may trigger a responsive review of compliance with registration. For each type of data, the analysis method is designed to measure the difference between the observed result and an expected level of performance on a common scale.

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

Outcome risk estimates

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

Appendix 1 provides an update on registration against the sixteen key outcomes, as reported by the CQC in November 2011. The updated QRP shows that between October and November 2011:

- **Outcome 1 (Respecting and involving people who use services)** moved from 'high green' to a rating of 'low neutral'

  The estimate of risk for this outcome is produced following analysis of 10 quantitative and 2 qualitative data items. Analysis has shown that there are no changes to data underlying this risk estimate and it is therefore assumed

that the move in rating is due to the CQC adjusting its statistical model and analytical methods used for calculating this risk estimate.

It should be noted that Outcome 1 was 'low neutral' in September 2011. A move to 'high green' occurred in October, with a subsequent change to 'low neutral' in November 2011.

- **Outcome 5 (Meeting nutritional needs)** moved from 'low neutral' to 'insufficient data'.

  The estimate of risk for this outcome is produced following analysis of 5 quantitative and 2 qualitative data items. One data item (12747 - food hygiene rating) was removed from the risk estimate for November 2011. The CQC has subsequently reviewed the data available for this standard and determined that there is insufficient data to provide a risk estimate.

- **Outcome 9 (Management of Medicines)** moved from 'not enough data' to a rating of 'low neutral'.

  Analysis has shown that there are no changes to data underlying this risk estimate and it is therefore assumed that the move in rating is due to the CQC adjusting its statistical model and analytical methods.

- Risk estimates for the remaining 13 outcomes remained the same for this period.

- **Update on Outcome 8 (cleanliness and infection control)** remains 'low amber'.

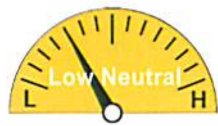
  The estimate of risk for this outcome is produced following analysis of 30 quantitative data items and 2 qualitative data items. As reported at the November 2011 Trust Board, the shift in risk estimate to 'low amber' is as a result of the CQC comparing data items against other similar Trusts relating to the national level of MRSA and C Difficile; results from the NHS Staff survey results on the availability of hand-washing materials (investigated and understood to relate to non-clinical areas); the PEAT score for cleanliness; and the minor concern reported in the CQC report (June 2011) around the labelling of clinical equipment for the purposes of cleaning.

  A summary of all actions taken to improve performance around infection control and cleaning was documented and sent to the CQC. The CQC is satisfied with the work undertaken, but, as with all outcomes, the Commission will maintain constant monitoring.

Ongoing Self Assessment

The QRP is reported to the Clinical Governance Committee and reviewed by the Risk, Assurance and Compliance Group. The Clinical Governance Committee receives individual reports on compliance against each outcome on a rolling basis throughout the year, and, on an escalated basis when required.

A key to the dials in the QRP



Reducing risk of non-compliance

Increasing risk of non-compliance

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

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

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Guidance

For help on how to use and interpret this QRP please view QRP guidance or email CQC

enquiries@cqc.org.uk

Key to risk estimates

Provider Code	Provider Name	Version	Version Date
RP4	Great Ormond Street Hospital for Children NHS Trust	3.7	30/11/11

Latest risk estimates

The Care Quality Commission's quality and risk profiles (QRPs) bring together information about a care provider and provide an estimate of risk of non-compliance against each of the 16 essential standards of quality and safety.

They are primarily intended as a tool to support the day to day work of CQC's inspectors. The table below lists the two most recent risk estimates for each of the 16 standards.

Section 1 - Involvement and information

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 1 (R17) Respecting and involving people who use services	High Green	Low Neutral	Total number of data items: 11 Number of qualitative data items: 1 Number of quantitative data items: 10
Outcome 2 (R18) Consent to care and treatment	High Green	High Green	Total number of data items: 2 Number of qualitative data items: 1 Number of quantitative data items: 1

Section 2 - Personalised care

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 4 (R9) Care and welfare of people who use services	Low Green	Low Green	Total number of data items: 21 Number of qualitative data items: 5 Number of quantitative data items: 16
Outcome 5 (R14) Meeting nutritional needs	Low Neutral	Insufficient Data	Total number of data items: 6 Number of qualitative data items: 1 Number of quantitative data items: 5
Outcome 6 (R24) Cooperating with other providers	Low Neutral	Low Neutral	Total number of data items: 3 Number of qualitative data items: 2 Number of quantitative data items: 1

Section 3 - Safeguarding and safety

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 7 (R11) Safeguarding people who use services from abuse	Insufficient Data	Insufficient Data	Total number of data items: 1 Number of qualitative data items: 1 Number of quantitative data items: 0
Outcome 8 (R12) Cleanliness and infection control	Low Amber	Low Amber	Total number of data items: 32 Number of qualitative data items: 2 Number of quantitative data items: 30
Outcome 9 (R13) Management of medicines	Insufficient Data	Low Neutral	Total number of data items: 11 Number of qualitative data items: 4 Number of quantitative data items: 7
Outcome 10 (R15) Safety and suitability of premises	High Green	High Green	Total number of data items: 27 Number of qualitative data items: 1 Number of quantitative data items: 26
Outcome 11 (R16) Safety, availability and suitability of equipment	High Green	High Green	Total number of data items: 11 Number of qualitative data items: 1 Number of quantitative data items: 10

Section 4 - Suitability of staffing

	Previous Risk		

Outcome	Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 12 (R21) Requirements relating to workers	Low Neutral	Low Neutral	Total number of data items: 4 Number of qualitative data items: 1 Number of quantitative data items: 3
Outcome 13 (R22) Staffing	Low Green	Low Green	Total number of data items: 22 Number of qualitative data items: 1 Number of quantitative data items: 21
Outcome 14 (R23) Supporting staff	Low Neutral	Low Neutral	Total number of data items: 46 Number of qualitative data items: 1 Number of quantitative data items: 45

Section 5 - Quality and management

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 16 (R10) Assessing and monitoring the quality of service provision	Low Green	Low Green	Total number of data items: 36 Number of qualitative data items: 6 Number of quantitative data items: 30
Outcome 17 (R19) Complaints	Low Neutral	Low Neutral	Total number of data items: 10 Number of qualitative data items: 4 Number of quantitative data items: 6
Outcome 21 (R20) Records	Low Neutral	Low Neutral	Total number of data items: 62 Number of qualitative data items: 1 Number of quantitative data items: 61

Great Ormond Street Hospital for Children
NHS Trust

<table>
<tr><td colspan="2">Trust Board
25th January 2012</td></tr>
<tr><td>UCL Partners Board Update (December 2011)

Submitted on behalf of

Dr Jane Collins, Chief Executive</td><td>Paper No: Attachment R

For information</td></tr>
<tr><td colspan="2">Aims / summary

To provide Trust Board with an update on the work of UCL Partners.</td></tr>
<tr><td colspan="2">Action required from the meeting

To note the UCL Partners’ December Update.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
All strategic objectives.</td></tr>
<tr><td colspan="2">Financial implications
N/A</td></tr>
<tr><td colspan="2">Legal issues
N/A</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
N/A</td></tr>
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N/A</td></tr>
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N/A</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
N/A</td></tr>
<tr><td colspan="2">Author and date
Anna Ferrant, Company Secretary
January 2012</td></tr>
</table>

UPDATE: DECEMBER 2011

There are two core challenges for the academic health science partnership. How do we facilitate the provision of better value health (outcomes that matter to patients per pound spent) and how do we support economic regeneration for the population through science into practice, at a local, national and global level?

Looking back at 2011 we have made real inroads into the first challenge through the 56 on-going UCLP projects and co-creating a platform for delivery of international scale and relevance with the expanded partnership across NEL and NCL. This work, which is on-going in most cases, spans prevention, organisation of care around individual patients, reconfiguration of services to enable proven interventions, education and new diagnostics, and bringing devices and treatments into practice.

Significant achievements in facilitating better value health have included:

1. Prevention

- *Reducing cardiovascular mortality*
    - Creation of the national centre for cardiovascular prevention and research.
    - Aligning national databases on cardiovascular outcomes.
    - Building teams to enable better local delivery on hypertension and thrombo-prophylaxis of atrial fibrillation in the community.
- *Earlier diagnosis of cancer to improve outcomes*
    - Creation of a single cancer integrated system inclusive of all major providers across NCL, NEL and SW Essex. Primary care engagement events have seen active involvement from over 120 GPs.
    - Agreement by partner Trusts to treat all first presentations of cancer to A&E departments as a serious untoward incidents to establish and address the root causes for any system failures (>3,000/14,000 new cancer cases p.a. across partnership population).
    - Changes to referral processes for GI cancer in response to GP feedback, now offering direct communication to hospital specialists upon referral, for advice and guidance.
    - Established academic programmes to identify NHS determinants of delayed diagnosis and to evaluate cancer integrated care system
- *Reducing in-patient mortality*
    - Earlier intervention to identify and treat deteriorating patients on hospital wards.

- Creation of a collaborative network already of six major Trusts who have each committed to halve avoidable cardiac arrests by the end 2012. Agreement to expand interventions across the wider partnership in 2012.
- Continuous learning through systematic quality measurement and improvement. Demonstrable improvements are already evident.

2. Organising clinical care around individual patients to improve outcomes, patient experience and reduce cost

•*New models of integrated care for populations*

- Support for the development of Whittington Health as it moves towards a population based model of care, focusing on patients with multiple co-morbidities and with community services organised and delivered in partnership with primary care, around the needs and preferences of individuals.
- Establishment of an academic programme to evaluate required changes to the national tariff (reflecting a potential shift from PbR to "year in the life care*")*.

•*Chronic obstructive pulmonary disease*

- A focus on priority interventions to keep patients well and out of hospital across 200 GP practices and 30,000 patients.
- Enhancement of diagnostic accuracy (currently 1:3 patients with COPD are undiagnosed in the community, only 50% of practices have the spirometry equipment to diagnose so properly, and 20% of patients with a diagnosis of COPD do not have that condition).
- Co-creation with practices & patients of educational interventions and data-feeds to enable consistent excellent care.

- *Empowering patients through new e health tools*
  - Delivery of new IT portal and management system for children and teenagers with diabetes to achieve better control.
  - Delivery with the HIEC of new iPhone applications for children and teenagers with asthma to better understand and manage their own conditions.
  - Working with the London Health Improvement Board to provide more information to patients to enable informed choices, and integrating primary, secondary health and social care data to enhance value.

3. Reconfiguring services to better implement proven interventions

- Collaborative consolidation of specialist services across institutions to create the volumes required to deliver better outcomes for patients (trauma, liver and pancreas surgery, vascular surgery, neurosurgery and ENT in NCL).

- Delivery and formal evaluation of a new stroke system, resulting in:
    - An increase in thrombolysis rates to the highest levels in any city globally (from 3.5% to 17%);
    - A reduction in whole system costs by 90 days through reduced morbidity and length of impatient stays;
    - A reduction in mortality across UCLP to below half the national average.
    - provided formal population evidence evaluation to underpin major Trust reconfigurations

4. New educational programmes for system change

- The establishment of a Staff College for leadership development with more than 200 delegates from primary and secondary care, including allied health professionals and managers, and with more than 95% strongly recommending the course to others.
- The delivery of combined Medical and Dental Education across NCL and NEL with modular Masters Provision, across all partner Universities for future entrants, including leadership, management and cross boundary working.
- Agreement from all partners to create a structured career pathway for nurses, midwifes and AHPs from graduation to senior clinical, managerial and specialist roles, with shared master's modules linked to the MDECs programme and based on delivery of whole pathways of care across traditional boundaries.
- Securing agreement to develop a new national training programme in women's heath built around predictable life-course events.
- Delivery in 2011 jointly with Monitor and Harvard Business School of two oversubscribed, highly successful national workshops on better value in healthcare, with excellent delegate feedback from both events. A third seminar is planned for 29 February 2012.
- Agreement to help create a single pathfinder local education and training board for NCL and NEL together with an associated skills provider network.

5. Developing new treatments into practice

There are many opportunities and examples across the partnership, including for example:

- Significant increase in partnerships with British industry e.g. new sharing partnership deal between GSK and Institute of Ophthalmology (£5M) with three candidates moving through to clinical trials
- A new MRI based programme for better prostate cancer diagnosis and treatment which will be open to recruitment for patients across UCLPartners from Jan 2012;
- A doubling of new treatments under evaluation for brain cancer, with 10 new studies now open to recruitment for patients across UCLP;

- Major NIHR award to establish a UK trials infrastructure for ENT which will support the development of a new cadre of research leaders – to transform the pipeline from ENT discovery to practices which benefit patients and populations

- New national proposals for proton beam therapy developed jointly with The Christie and MAHSC, including a national training and R&D programme. Funding has been announced, with confirmation of the number of sites awaited from the DH.

- Design & experimental evaluation of interventions to increase uptake of (& reduce inequalities in uptake of) the National Bowel Cancer Screening Programme

Delivery of new treatments in to widespread practice requires the development of new funding and business models. TSB grant awarded to Janssen UK (lead partner), UCL and UCLP to develop business tools to bring disease management diagnostics to market, with chronic Hepatitis C as an exemplar.

Supporting economic regeneration: the contribution from academic health science partnerships

The Prime Minister set out the imperative and some of the opportunities for biomedicine to make a greater contribution to our nation's GDP in his speech of 5 December 2011. The capacity to generate wealth will be a significant determinant contributor to future population well-being and health.

The three London AHSCs have committed to work together, and with GLA and NHS London, to maximise the economic value, inward investment and health gain of biomedical research and education for Londoners and nationally.

This builds on the existing work of the NHS providers, NIHR and Universities to maximise the potential gains for our patients and population. There is already a cadre of major developments underway for the individual programmes and these will be taken further through synergies with Barts and The London and Queen Mary.

In Immunology, for example, this is one of the fastest growing therapeutic fields:

- There has been a doubling of translational research activity in the last year (RFH Institute; QMUL).

- Together our partners have created one of the top five centres worldwide in delivering first in man vaccination, cell and gene therapy trials.

Specifically for immunology in 2011:

- In vaccination: we have demonstrated efficacy of CMV vaccine in solid organ transplant patients;

- In cell therapy, our partners have:

    - Demonstrated efficacy of T cell therapy in lymphoma, with the subsequent adoption of this protocol for the clinical management of patients;

    - Jointly with a commercial partner, performed the world's first phase III randomised T cell therapy
    - Started Europe's first embryonic stem cell trial for inherited retinal dystrophy
- In gene therapy, our partners have:
    - Shown the long-term clinical benefit of gene therapy in children with primary immunodeficiency;
    - Demonstrated clinical benefit of gene therapy in patients with haemophilia;
    - Discovered novel genes causing primary immunodeficiency and inflammatory bowel disease and implemented new diagnostic tests.
    - Continued world's first gene therapy for eye disease with further treatments of patients with retinal dystrophies and developing programmes for other gene defects

UCLPartners contribution to the future growth agenda will also include:

- Enhancing and integrating informatics across London, developing a common understanding of information governance and sharing clinical information securely to support patient care, choice, facilitate change and improve value.
- Better defining the care and outcomes for large cohorts of patients (e.g. stroke) to understand disease processes and make available to such patients across the whole partnership new therapies under evaluation if they wish to enter clinical studies.
- Linking resources and professional strengths across our sites, and across London, to maximise London's global academic competitiveness.
- Linking together with Industry more effectively to co-develop and evaluate new diagnostics, devices and treatments.
- Identifying and implementing those specific areas where a pan London focus will be more effective for our global competitiveness.
- Ensuring delivery of new treatments into practice at pace and scale.

UCLP will track our contribution separately and also collectively with the other London AHSSs to this agenda for the wider benefit of London and nationally.

David Fish

Jo Martin