Great Ormond Street Hospital for Children NHS Trust

Meeting of the Trust Board
29th February 2012

Dear Members

There will be a public meeting of the Trust Board on Wednesday 29th February 2012 commencing at **3:15pm** in the **Charles West Room, Paul O'Gorman Building,** Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Attachment
1.	**Apologies for absence**	Chair	
Declarations of Interest The Chair and members of this meeting are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must, as soon as practicable after the commencement of the meeting disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 25th January 2012**	Chair	**L**
3.	**Matters Arising / Action point checklist**	Chair	**M**
4.	**Chief Executive's Update** • **Foundation Trust Application** • **Safe and Sustainable** • **Tertiary Provider Network Update** • **Morgan Stanley Clinical Building** • **Haematology/ oncology peer review results** • **Ombudsman Report Update** • **IPP Cap Update**	Chief Executive	**Verbal Update**
5.	**Clinical Presentation - Department of Child and Adolescent Mental Health (CAMHS)**	Dr Margaret DeJong and Ms Sarah Dobbing	**N and presentation**
6.	**Quality, Safety & Transformation Update (Zero Harm Report - Safety)**	Co- Medical Director (ME)	**0**
	ITEMS FOR APPROVAL		
7.	**GOSH Constitution and governance matters** • **GOSH Constitution and Foundation Trust Board appointments** • **Draft Board of Directors' Nomination Committee Terms of Reference** • **Draft Members' Council Nomination and Remuneration Committee Terms of Reference** • **Code of Conduct for the Trust Board**	Company Secretary	**P** **Q** **4** **3**

8.	**Revised Finance and Investment Committee Terms of Reference**	Chief Finance Officer	**R**
9.	**Meeting the duties of the Equality Act**	Chief Operating Officer/ Co-Medical Director (BB)	**S**
10.	**Approval of New Energy Contracts**	Director of Redevelopment	**T**
11.	**Approval of Business Rates and NHSLA premium payments for 2012/13**	Chief Finance Officer	**U**
	UPDATES		
12.	**Performance Report (January 2012)**	Chief Operating Officer	**V**
13.	**Finance and Activity Report (January 2012)**	Chief Finance Officer	**W**
14.	**Foundation Trust Update**	Chief Operating Officer	**X**
15.	**HCAI peer review results**	Co-Medical Director (ME)/ Chief Nurse and Director of Education	**Y**
16.	**Summary from Audit Committee**	Audit Committee Chair	**To follow**
17.	**Management Board Minutes** • **December 2011** • **January 2012**		 **1** **2**
18.	**Trust Board Members' Activities**	Chair	**Verbal**
	FOR RATIFICATION		
19.	**Consultant Appointments**	Chair	**Verbal**
20.	**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.)		
21.	**Next meeting** The next Trust Board meeting will be held on Wednesday 25th April 2012 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT L

Great Ormond Street Hospital for Children NHS Trust

DRAFT Minutes of the meeting of Trust Board held on 25 January 2012

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 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

Mr Sven Bunn*	Programme Manager - Foundation Trust
Ms Sarah Dobbing*	General Manager - Neurosciences
Dr Carlos de Sousa*	Clinical Unit Chair - Neurosciences
Dr Anna Ferrant	Company Secretary
Dr John Hartley*	Consultant Bacteriology, Head Infection Control
Mrs Catherine Lawlor	Executive Assistant (Minutes)
Mrs Deirdre Malone*	Lead Nurse Infection Control
Mr John Ripley	Designate Non-Executive Director

323. Apologies for Absence

323.1 There were no apologies for absence.

324. Declarations of Interest

324.1 There were no declarations of interest made.

325. Minutes of the Meeting Held on 21st December 2011

325.1 The minutes of the Trust Board meeting held on 21st December 2011 were received and the Chairman requested Board Members check them for accuracy.

325.2 The minutes were **approved** with the amendment to remove item 300.9 which read: “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.”

326. Matters arising

326.1 Minute 293.6 – It was noted an email had been circulated to the Board on 18th January with the presentation on future plans for development of the Trust's strategic objectives.

326.2 Minute 293.12 – It was noted the Chief Operating Officer, Ms Fiona Dalton would make changes to the education objective (objective 4) to reflect the current drivers for improving education services at GOSH as agreed for Strategic Objectives 2012/13.

326.3 Minute 295.4 – It was noted Ms Fiona Dalton had included a one page summary for the Performance Management Strategy and Business Planning Strategy.

326.4 Minute 295.6 – It was noted Ms Fiona Dalton would ensure that multi-cycle and yearly cycles were clearly stated in the 2012/13 annual plan.

326.5 Minute 295.9 - It was noted Ms Fiona Dalton had added a section on external performance monitoring in the Performance Management Strategy.

326.6 Minute 295.10 – It was noted Ms Fiona Dalton had ensured that more overt links were included in both strategies around Patient Involvement and Experience as well as Education and Training.

326.7 Minute 296.10 – It was noted that progress was underway by the Chief Finance Officer, Mrs Claire Newton to add timescales to the data quality good practice standards action. This would be reported back to the Audit Committee in February 2012.

326.8 Minute 298.18 – It was noted that the revised terms of reference of the Finance and Investment Committee would be brought back to the February Board. It was agreed that this should include a recommendation about which committee should consider and review the Trust's pay structure.

326.9 **Action**: The Chief Finance Officer to present the revised terms of reference of the Finance and Investment Committee to the February Board, including a recommendation about which committee should consider and review and the Trust's pay structure.

327. Chief Executive's Update

327.1 Dr Jane Collins, Chief Executive provided a verbal report for the Board on the following areas:

327.2 <u>Safe and Sustainable – Cardiac Surgery</u>
Dr Jane Collins informed the Board that there were on-going appeals by both the Royal Brompton and the Safe and Sustainable team about the Safe and Sustainable consultation. There would be an update after the 19th & 20th March. It was agreed that the February Trust Board would be briefed on the impact of taking on additional services as a result of the review.

327.3 **Action**: The Chief Executive to ensure that the Trust Board is briefed at the February meeting on the impact of taking on additional services as a result of the review.

327.4 Morgan Stanley Clinical Building

Dr Jane Collins formally confirmed to the Board that the Morgan Stanley Clinical Building had been handed over to the Trust on the 22nd December, 2011.

327.5 Ombudsman Action plan Update

Dr Jane Collins gave the Board an update on the Ombudsman report that criticised the care of a patient and handling of the subsequent complaint logged by their family. Dr Jane Collins reported that both the family and the Ombudsman were happy with the action plan and things were in place to implement changes. An example was the new "red" rating for a complaint which was flagged immediately to an Executive Director. Dr Jane Collins assured the Board progress would be monitored. It was agreed that that this
327.6 process be reviewed by the Clinical Governance Committee in six months' time.

327.7 **Action**: The Company Secretary to ensure that an update on the process for managing red flagged complaints is presented to the Clinical Governance Committee in June 2012.

327.8 Executive Away Day

Dr Jane Collins reported that the Executive Team had had a successful away day on 22nd December, 2011. Dr Jane Collins reported that a formal plan for implementing a list of prioritised work would come back to the Board in March 2012.

327.9 **Action:** The Chief Executive to report back to Board on the formal plan for implementing a list of prioritised work in March 2012.

327.10 Update from Kuwait

Dr Jane Collins gave a brief update on her recent visit to Oman, Dubai and Kuwait. Dr Collins stated Oman was interested in conducting further discussions about contracting with the Trust and Kuwait had also expressed an interest in extending current services. Whilst the current legal position on the private patient cap remained, income received for clinical services (as opposed to education and training) would need to remain below the Trust's cap (<10%). Dr Jane Collins reminded the Board that the Trust had been asked its views by the FT Network about a cap of 49% of clinical income coming from private income.

327.11 Ms Mary Macleod, Non-Executive Director queried what percentage the Trust should be aiming for if the cap was amended to 49%. The Board concluded this would need to be looked at after receipt of the results of the debate in the House of Lords..

327.11 HCAI Peer Review

Dr Collins announced that there would be a HCAI Peer Review on Friday, 27th January, 2012. NHS London was currently running an HCAI Peer Review Project to address the number of HCAIs (specifically MRSA and C.Diff) across London. An update would be provided to the next Trust Board.

The Board **noted** the report.

328. Clinical Presentation – Neurosurgery

328.1 Dr Carlos de Sousa, Clinical Unit Chair of Neurosciences and Ms Sarah Dobbing, General Manager of Neurosciences gave a presentation on Safe and Sustainable Paediatric Neurosurgery. Dr Carlos de Sousa stated there were 4,200 operations per year in England and of that 1,700 of these were for hydrocephalus, 70% were emergency procedures and 30% were elective procedures. Dr Carlos de Sousa highlighted the need for change as currently survival rates for brain tumours in the UK were lower than in other developed countries.

328.2 Ms Sarah Dobbing gave the Board an overview of the Safe and Sustainable Review process and the Trust position in relation to other providers. The proposed standards and impact on the Trust's Neurosurgery was presented. The Board was informed that a tendering process was being run by the National Specialist Commissioning Group for Epilepsy Surgery, in parallel to the proposed Safe and Sustainable process which was attempting to develop networks across sites.

328.3 The Board had a discussion on the possible impact of the proposed Safe and Sustainable Review on the Trust and potential upside in demand and the concept of the network which had the potential to provide smaller centres with high volumes of less specialist work. Mr Charles Tilley, Non-Executive Director enquired when the Safe and Sustainable Review would produce a final report. Ms Dobbing answered that it was not expected that the final position would emerge this year but that the National Specialist Commissioning of the Epilepsy Surgery service (and consequent increase in workload) would commence this year.

328.4 The Board **noted** the presentation.

329. MRSA Policy – Impact on Patients and Staff

329.1 Dr John Hartley, Director of Infection, Prevention and Control (DIPC) and Deirdre Malone, Lead Nurse Infection Control presented on the Trust's MRSA policy and its impact on staff and patients. Dr John Hartley stated that MRSA is quite common in the general public with1 in 3 individuals unknowingly carrying MRSA. Government targets relate to reducing MRSA blood stream infections, which became a national issue in the late 1990s..

329.2 Dr Hartley reported that the Trust policy was an important tool in reducing the spread of MRSA. Dr John Hartley presented to the Board cases of patients who had contracted an MRSA bloodstream infection and the precautions put in place in order to control the outcome of further infection.

329.3 Dr Hartley also gave an overview of the Trust's standard precautions in place such screened patient admissions, staff screening and enforced staff leave for those colonised with MRSA.

329.4 Dr Hartley stated that attention should also be paid to MSSA which was not yet a national target but had been monitored by the Trust for the past year (on the KPI dashboard).

329.5 The Board **noted** the presentation.

330. Quality, Safety & Transformation Update (Zero Harm Report)

330.1 Professor Martin Elliott, Co-Medical Director stated that this was the first report that combined Zero Harm and Transformation updates. Professor Martin Elliott stated that the Board would be familiar already with the first part of the report on Zero Harm.

330.2 Professor Martin Elliott provided the Board with an update on zero harm indicators such as the Serious Incident (SI) report, complaints and incidents, mortality review and arrests and crash calls outside Intensive Care Units.

330.3 Professor Martin Elliott also reported on zero harm indicators currently under development such as the Combined Infection Index, Combined Harm Index and the Paediatric Trigger Tool (a tool which investigates possible themes from 20 randomly selected case notes, allowing identification of areas for improvement through transformation).

330.4 Professor Elliott presented the second part of the report, the Transformation Update, and stated that this was the first month of rotation of Transformation, Safety & Outcomes progress and with the focus on Transformation.

330.5 Mr Charles Tilley queried whether lessons could be learnt from the recent unfortunate incident where pseudomonas bacteria found in a hospital in Ulster had led to the deaths of four babies. Dr Hartley stated that the pseudomonas bacteria was not new and was currently being screened for in the Trust. No current risk had been identified.

330.6 Ms Yvonne Brown, Non-Executive Director queried why the Combined infection index was benchmarked with Cincinnati Children's Hospital Medical Centre. Professor Martin Elliott stated that it was appropriate to benchmark with Cincinnati as this hospital was one of the founding pioneers of infection control in North America.

330.7 Professor Martin Elliott presented to the Board the Trust-wide Transformation priorities such as infection prevention and control (which aimed to reduce acquired central venous catheter line (CVL) infections, the number of surgical site infections (SSI) in Spinal, Cardiothoracic, Neurosurgery, Craniofacial and Urology specialties, the number of ventilator-associated acquired pneumonia (VAPS) and improve hand hygiene audit results and CVL bundle compliance hand hygiene audit results), improve medical records and the use of procedure pathways (such as WHO Safety Checklist, theatre utilisation, pre-operative assessment, access to theatres for non-elective cases, improving the MRI patient journey), efficient bed management and management of the deteriorating child.

330.8 Mr David Lomas, Non-Executive Director enquired if a target of 77 per cent by end of 2012 to deliver an average theatre utilisation of planned hours was achievable. Ms Fiona Dalton stated that there had been a consistent year on year improvement since 2009 so it was reasonable to believe this target could be achieved. It was agreed that this target would be reviewed again in March 2012.

330.9 **Action**: The Chief Operating Officer to provide an update on progress with achievement of the theatre utilisation target in March 2012.

330.10 Professor Elliott summarised that good progress continued in most areas of the Transformation programme, with projects that were being reported to and supported by the Transformation Board. In 2012, the QST would continue to provide the Trust Board with a monthly highlight report for the Zero Harm Indicators. Transformation would report progress and highlight areas of achievement and challenge in their next quarterly report to the Trust Board. The next QST report would provide a Zero Harm highlight report and progress report on Safety to include SI, complaints and risk.

330.11 The Board **noted** the report.

331 Quality Strategy

331.1 Professor Martin Elliott, Co-Medical Director reported that the Quality Strategy had 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 were also described. The Trust Board was asked to consider and approve the Quality Strategy.

331.2 Baroness Blackstone, Chair congratulated the team on a much improved report. Ms Mary MacLeod, Non-Executive Director highlighted that she was pleased to see that the Board suggestions had been included. Mr John Ripley agreed the revised version was an improvement because of its better linkage with other documents. It was noted that the Strategy would be presented at the next meeting of the Members' Council.

331.3 The Board **approved** the Quality Strategy.

332 GOSH PPI (Patient and Public Involvement) and Patient Experience Plan 2012-2015

332.1 Mrs Liz Morgan, Chief Nurse/Director of Education informed the Board that the current PPI and patient experience strategy was due for review in March 2012. Mrs Morgan presented a new 3 year plan and appendices, which noted achievements over the last 3 years in both PPI and patient experience. The plan had been written so that it could be shared with the wider membership. It was anticipated and welcomed that once internal approval had been given, the new Members' Council would contribute their views on priorities in March 2012 and assist in agreeing a timetable and action plan for implementation.

332.2 Dr Barbara Buckley asked that clear reference be given to patients with learning disabilities. Baroness Blackstone, Chair asked if the frequency of meeting times (i.e. 10 times a year) for the Patient and Public Involvement and Experience Committee (PPIEC) be perhaps reduced to less meetings. Mrs Morgan agreed to look into this. Dr Buckley requested that consideration be given to merging the Family Equality and Diversity Group with the PPIEC. The Board agreed that this should be considered.

332.3 **Action**: The Chief Nurse and Director of Education to review the frequency of the meetings of the PPIEC and to consider merging the Family Equality and Diversity Group with the PPIEC.

332.4 The Board **approved** the Plan with the above considerations.

333. Performance Report (December 2011)

333.1 The Chief Operating Officer, Ms Fiona Dalton presented the report, which monitored progress against the Trust's seven strategic objectives and progress against Monitor's Governance Risk Framework and Quality Governance Framework. It provided 'RAG' performance analysis against defined thresholds and tolerances as well as monthly and quarterly performance trends.

333.2 Ms Dalton reported that to date the Trust had reported 7 cases of C. difficile against a year-to-date trajectory of 6.8. The Trust trajectory for the year was 9 cases.

333.3 In response to a requirement set out in the Department of Health 2012/13 Operating Framework, the Trust had 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. New processes were now in place to ensure that waiting lists were appropriately managed for the future.

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

333.5 **Action**: The Chief Operating Officer would bring back to the Trust Board a trajectory for delivering the incomplete pathway target.

333.6 In month, the non-admitted median wait was reported at 6.74 weeks against a target of 6.6 weeks. Inpatient Waiting List in month performance had deteriorated with 199 patients waiting over 26 weeks. Particular capacity issues had been identified across a number of specialties, including: Urology, Orthopaedics, Dental & Maxillofacial, Plastic Surgery and Craniofacial. The Board asked Ms Dalton to present a plan for achieving the 26 week waiting list target at the February Trust Board meeting.

333.7 **Action**: The Chief Operating Officer to present a plan for achieving the 26 week waiting list target at the February Trust Board meeting.

333.8 Theatre Utilisation had seen a statistically significant drop in the last few months of 2011. Initial analysis indicated that this was mostly due to lack of bed availability (particularly CICU) which had led to increased cancellation of cases. Detailed investigations and action plans were on-going on a specialty by specialty basis and this process was being managed by the Procedural Pathway Group of the Transformation Programme.

333.9 The Trust was projected to achieve the 2011/12 CRES savings required in the LTFM. Appraisal completion rates had remained fairly consistent level during 2011 but were now beginning to decline. Performance remained steady at 87% against a target of 95%. Lastly, a summary was presented of changes in performance of the measures at Clinical Unit level that had been reported to Management Board and escalated to Trust Board.

333.10 Professor Andy Copp, Non-Executive Director questioned why Object 4 relating to the number of Active Research Projects, UKCRN Portfolio Studies, Clinical trials recruitment portfolio, GOSH Research and Research Grant Awards did not have KPI targets. Baroness Blackstone, Chair concurred this would not be difficult to measure and ought to be included.

333.11 **Action:** The Chief Operational Officer to ask the R&I Division to propose specific KPI targets for Objective 4 which relates to the number of Active Research Projects, UKCRN Portfolio Studies, Clinical trials recruitment portfolio, GOSH Research and Research Grant Awards.

333.12 It was noted that the PDR target should read '80% of staff' rather than '95 % of staff'. The Board requested that an action plan be presented on achievement of the PDR rate by end of the financial year.

333.13 **Action**: The Chief Nurse and Director of Education to present an action on achievement of the PDR rate by end of the financial year.

333.14 The Board **noted** the report.

334. Finance and Activity Report (December 2011)

334.1 The Chief Finance Officer, Mrs Claire Newton presented the report that summarised the Trust's financial performance for the nine months to 31 December 2011. Results year to date were reported as a Net surplus of £5.1M, which is £0.3M ahead of the rephased plan and normalised EBITDA of 6.4% (Budget 6.9%; Full year budget 7.0%).

334.2 The forecast surplus for the financial year was a £2.3M surplus after a property impairment estimated at £5.6M (value yet to be determined by the District Valuer). The most significant risks in delivering the normalised forecast were 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 was appropriately reimbursed and ensuring Phase 2A double running and project costs are in line or better than plan.

334.3 Activity based income remained ahead of plan boosted by critical care and other bed day activity which was 5% above plan although core inpatient activity is fractionally (0.8%) below plan, but remains 3.5% ahead of last year. Pay was over spent by £3.9M excluding pass through. The majority of the over spend related to nursing and junior medical staffing where there were higher than planned levels of agency staff. Part of this variance related to the costs incurred in delivering activity higher than plan, particularly in critical care areas. There were actions in place to reduce other agency usage by the year end.

334.4 Capital spend was £29.4M; £6.8M lower than plan year to date. There were five salary overpayments totalling £14.7K (three late notified leavers) during the period.

334.5 The DH released the provisional tariff for 201213 in December and Mrs Newton reported that the Trust had completed an analysis of the impact on its services. It was estimated that in overall terms the impact would be

broadly neutral but there were potential upsides if the Trust achieved CQUIN quality targets (Metrics and targets as yet to be agreed with commissioners) as the CQUIN rates had been increased to 2.5% from 1.5%.

334.6 Mr Charles Tilley, Non-Executive Director highlighted the analysis of the revenue account on continuing activities compared with the previous financial year which showed in overall terms the income growth at 4.3% was currently exceeded by cost growth at 5.8%. Mr Charles Tilley noted that this variance was not sustainable, and a productive discussion ensued regarding how robust CRES delivery and the management of productivity would be targeted to deliver future plans.

334.7 The Board **noted** the report.

335 PALS Patient Experience Report

335.1 Mrs Liz Morgan, Chief Nurse/Director of Education presented the report on patient experience issues raised with the PALS service between October 2011 and December 2011. It identified issues arising from casework that required Trust action and provided an update on actions taken in relation to issues identified in the previous quarter.

335.2 Professor Andy Copp, Non-Executive Director stated that page 6 of the report regarding “Inpatient experience” which praised nursing staff stated the mother would like to take story to the Board. Professor Andy Copp highlighted that the Board was interested in hearing a wide range of views and would also like to hear from families who were less complimentary of their experiences so that the Board had a broad range of views reported. The Board agreed.

335.3 Baroness Blackstone, Chair expressed concern for dialysis patients on Victoria Ward who reported having patient transport delays. Baroness Blackstone asked that it be made known to the Board if support was needed. Dr Barbara Buckley, Co-Medical Director advised the Board that and that this problem was being actively addressed by the new Transport Manager. Dr Buckley was asked to provide an update on this matter in April 2012.

335.4 **Action**: The Co-Medical Director, Dr Barbara Buckley to provide an update on transport delays for dialysis patients on Victoria Ward in April 2012.

335.5 Baroness Blackstone requested that initials and acronyms be spelled out in the report.

335.6 **Action:** The Chief Nurse and Director of Education to ensure initials and acronyms in the PALS Patient Experience Report are spelled out.

335.7 The Board **noted** the report.

336. Foundation Trust Update

336.1 Mr Sven Bunn, Foundation Trust Programme Manager presented the report which set out the current position for the Trust against the assessment criteria used by the SHA and the Secretary of State for Health to determine readiness for Foundation Trust status.

336.2 Mr Bunn reported that Monitor had restarted the assessment process, and had a timetable of meetings in December and January 2012. A board to board meeting with Monitor had been scheduled for 8 February 2012.

336.3 Mr Bunn reported that Deloitte had been commissioned to review the basis and assurance for the board statement on quality governance and had found no outstanding issues or concerns which would present a barrier to FT Authorisation. They had however come back with recommendations to further improve processes. Mr Sven Bunn agreed to report back to the Board on the implication of those recommendations and to send the report to Monitor.

336.4 **Action:** Mr Sven Bunn to send Deloitte's report on recommendations to improve basis and assurance for the board statement on quality governance to Monitor.

336.5 **Action:** Mr Sven Bunn to report back to the Board in 6 months time on the implication of Deloitte's recommendations to improve the basis and assurance for the board statement on quality governance.

336.6 The Board **noted** the report.

337. Care Quality Commission Registration Update

337.1 The Company Secretary, Dr Anna Ferrant updated the Board on the current status of the Care Quality Commission (CQC) registration standards.

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

337.3 The Board **noted** the report.

338. Trust Board Members' Activities

338.1 There were no activities to report.

339. Consultant Appointments

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

339.2 Dr Jasveer Mangat, Cardiology;
Dr Michelle Carr, Cardiology;
Dr Brijesh Patel, Maxillofacial/Dental (joint appointment with Broomfields);
Dr Daljit Gill, Maxillofacial/Dental;
Mr Nagarajan Muthialu, Cardiothoracic Surgery;
Dr Rakesh, Amin, Endocrinology;
Dr Liina Kiho, Histopathology;
Dr Keith Sibson, Haematology
Miss Naima Smeulders, Urology.

339.3 The Board **ratified** the appointments.

340. UCL Partners Board Minutes December 2011

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

340.2 The Board **noted** the report.

341. Any Other Business

341.1 Ms Yvonne Brown, Non-Executive Director queried why the minutes from the December Management Board had not been included in the pack. Dr Anna Ferrant stated that December Management Board minutes had been approved after the Board papers had been disseminated.

342. Date of the Next Meeting

342.1 The date of the next meeting of the Trust Board was confirmed as 29th February 2012.

ATTACHMENT M

Attachment M

TRUST BOARD - ACTION CHECKLIST
29th February 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 – Risk Team reminded of request
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

Attachment M

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
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	On agenda
326.9	25/01/12	The Chief Finance Officer to present the revised terms of reference of the Finance and Investment Committee to the February Board, including a recommendation about which committee should consider and review and the Trust's pay structure.	CN	February 2012	On agenda
327.3	25/01/12	Dr Jane Collins informed the Board that there had been further appeals by the Royal Brompton about the results of the Safe and Sustainable consultation. There would be an update after the 19th & 20th March.. It was agreed that a paper be submitted to the February Trust Board on the impact of taking on additional services as a result of the review The Chief Executive to ensure that the Trust Board is briefed at the February meeting on the impact of taking on additional services as a result of the review.	JC	February 2012	On agenda
327.7	25/01/12	The Chief Executive to report back to Board on the formal plan for implementing a list of prioritised work in March 2012.	JC	March 2012	Not yet due
330.9	25/01/12	The Chief Operating Officer to provide an update on progress with achievement of the theatre utilisation target in March 2012.	FD	March 2012	Not yet due
332.3	25/01/12	The Chief Nurse and Director of Education to review the frequency of the meetings of the PPIEC and to consider merging the Family Equality and Diversity Group with the	LM	April 2012	Not yet due

Attachment M

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		PPIEC.			
333.6	25/01/12	The Chief Operating Officer to present a plan for achieving the 26 week waiting list target at the February Trust Board meeting.	FD	February 2012	On agenda
333.10	25/01/12	The Chief Operational Officer to include measurement of KPI targets for Objective 4 which relates to the number of Active Research Projects, UKCRN Portfolio Studies, Clinical trials recruitment portfolio, GOSH Research and Research Grant Awards.	FD	February 2012	On agenda
333.12	25/01/12	The Chief Nurse and Director of Education to present an action on achievement of the PDR rate by end of the financial year.	LM	April 2012	Not yet due
335.4	25/01/12	The Co-Medical Director, Dr Barbara Buckley to provide an update on transport delays for dialysis patients on Victoria Ward in April 2012.	BB	April 2012	Not yet due
335.6	25/01/12	The Chief Nurse and Director of Education to ensure initials and acronyms in the PALS Patient Experience Report are spelled out.	LM	February 2012	To be actioned for next quarterly report
336.4	25/01/12	Mr Sven Bunn to send Deloitte's report on recommendations to improve basis and assurance for the board statement on quality governance to Monitor.	SB	February 2012	Actioned
336.5	25/01/12	Mr Sven Bunn to report back to the Board in 6 months time on the implication of Deloitte's recommendations to improve the basis and assurance for the board statement on quality governance.	SB	July 2012	Not yet due

ATTACHMENT N

Great Ormond Street Hospital for Children NHS Trust

Specialty –The Department of Child and Adolescent Mental Health - CAMHS

General Background

CAMHS is a Tier 4, specialist mental health service. Patients are referred from local CAMHS teams for specialist care, or from Paediatricians. Referrals are received from across the country, but the majority of referrals come from the South East.

The speciality is led by Una McCrann and managed within the Neurosciences Clinical Unit. There are 4 Consultant Psychiatrist, 4 trainee Psychiatrists, and one SHO. There are 11 Clinical Psychologist posts, 25 Nurses (including Therapeutic Care Workers and Night Support Workers), 7 Psychotherapist and Systemic Psychotherapists.

CAMHS includes an inpatient Ward – the Mildred Creek Unit, and three distinct Outpatient teams: The Social Communication Disorder team, The Feeding and Eating Disorder Team and the Parenting and Child Team.

Clinical Outcomes

A number of outcome measures are recorded for each patient, inline with national best practice for CAMHS services. The information was historically collected to monitor individual patient progress. Since April 2011 the CAMHS department has been developing a database for collating these outcomes measures to allow us to monitor outcomes across teams.

Strengths and Difficulties Questionnaire – two parent versions and one patient version. The information is collated at initial assessment, at six months and twelve months.

Goal Based Outcomes – patient identified goals and assessment of achievement. Again, the information is collated at initial assessment, at six months and twelve months.

Safety & Risk

Record keeping – this was identified as a risk in 2009. The department have been undertaking regular audits to monitor compliance with the ten golden rules, and results are fed back to individuals and teams.

Environment – limited space in Frontage and state of some outpatient areas have been identified as a risk

Medication errors – there has been a recent increase in medication errors on MCU. All staff are undertaking retraining.

Patient Experience

Recent complaints regarding the CAMHS service have related to administrative processes and information governance concerns when a list of patients was sent to a small group of parents.

Poor rarent feedback often concerns the environment in the Frontage building, which can be hot and at times very busy. The heat will hopefully be improved by recent renovations.

Positive feedback relates to friendly staff, and high quality support offered to families.

Finances

CAMHS Income target - £3.8m for 2011-12, current under performance by -£324k
CAMHS Expenditure budget - £2.7m, current under spend of £97k

CRES Plans for 2012-13:
- workforce review to improve efficiency of individual teams - £25k
- development of new service to replace CIPP team - £337k

Integrated Business Plan

The CAMHS department aims to develop and strengthen it's referral base, and the IBP includes growth of 2.5% in new referrals in 2012-13.

Any Other Relevant Information

In February 2012 the Centre for Interventional Pyschopharmacology (CIPP) transferred from GOSH to South London and the Maudsley NHS Trust (SLAM). The CIPP team had provided a highly specialist service for children with complex needs, and received referrals from medical teams at GOSH, particularly the endocrine and metabolic teams.

The transfer of the service provides the CAMHS department with the opportunity to develop a new service to meet the needs of patients at GOSH, and a business case has been proposed to support the creation of a new part-time neuro-psychiatry post and a complex psychological intervention service. This service will link with teams across the Trust to provide time-limited care for children with complex mental health needs and co-morbid physical conditions.

Attachment O

Great Ormond Street Hospital for Children NHS Trust

Trust Board 29th February 2012	
Reporting Zero Harm - Quality, Safety & Transformation (QST) Update **Submitted on behalf of** **Martin Elliott**	**Paper No: Attachment O**

Aims / summary

Part I – Status update on the high level measures.
Areas of note:
There are no statistically significant changes in the Zero Harm.

Part II – Second monthly rotation of Transformation, Safety & Outcomes, with focus on Safety for November 2011-January 2012.
Areas of note:

- Number of days since last SI (close of business on 31st January): 24
- Number of SI's reported: 5
- Number of SI's closed: 11
- 3 SI's that have followed the new SI process have all been closed within the correct timescales
- Number new formal complaints: 28
- Number of red complaints: 3
- Percent of complaint responses sent out on time: 89% (above national average)
- Number of concerns regarding communication: 16
- Number of open risks currently recorded on Datix Risk Management System: 374
- Number of risks closed (November-January): 107
- New risks opened (November-January): 53
- Number of audits registered: 32 and completed 6
- The new QST team are working together to identify where data for improvement and transformation methodology will support learning from SI's, complaints, risk and will complement the audit work.

Action required from the meeting
To note, approve and support.

Contribution to the delivery of NHS / Trust strategies and plans
Delivering No Waits, No Waste, Zero Harm.

Financial implications
N/A

Legal issues
None

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

Who needs to be told about any decision N/A

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

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

Author and date
Katharine Goldthorpe, 16th February 2012

Quality, Safety & Transformation
Reporting to Trust Board
February 2012

The following report produced by the Quality, Safety & Transformation (QST), provides for Zero Harm data (Appendix A) and a progress report for Safety covering the period start November 2011 to end January 2012.

Part I

Zero Harm Update

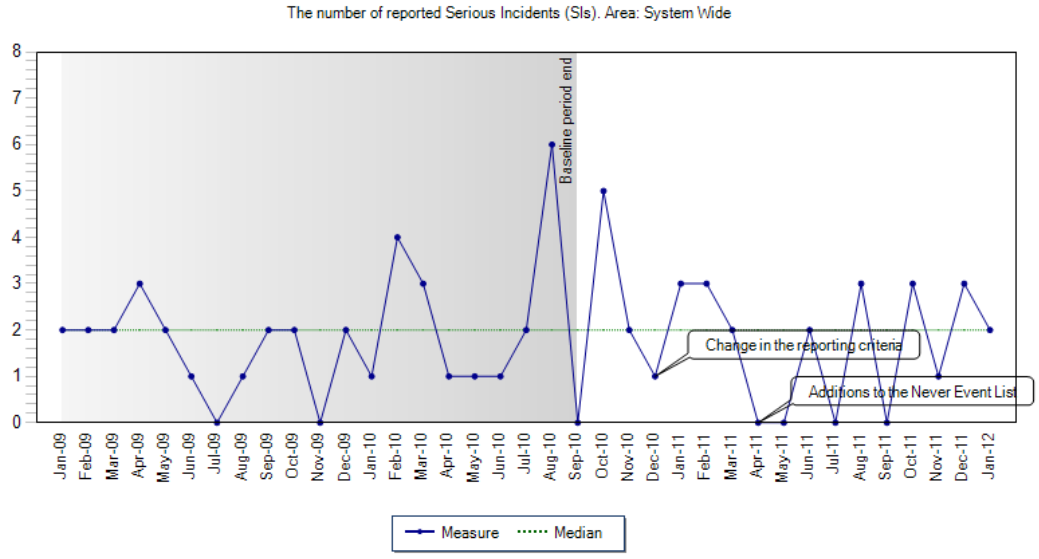
There are no statistically significant changes in the Zero Harm Indicators (Appendix A). The work in each of these areas continues to be reported in detail as part of the Transformation, Safety and Outcomes monthly updates.

Part II

This is the second month of rotation of Transformation, Safety & Outcomes, with the focus on Safety. The following Safety Report provides key information for the last three months activity. In future this report will be developed as a reflective document, which will provide data in SPC charts where appropriate. This report will provide information on the following:

1. Serious incident
2. Complaints
3. Responding to external alerts
4. Risk
5. Clinical Audit
6. Health and Safety

1. Serious Incidents (SI) Analysis



The number of serious 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

1.2 Rate of SI's reported

Number of days since last SI (close of business on 31st January): 24

Between November and January new 5 SI's were reported. Of these, 2 have been investigated and are now closed. The categories are as follows:

	Cardiorespiratory	MDTS	Estates
Failure of Procedure or Treatment	2	2	
Theft			1

1.2 Number of SI's closed

Number of SI's closed (November-January): 11

Of 11 SI's closed, 6 of these were closed within the timescale set by NHS London and 5 were outside the timescale. One of these were due to an external Health and Safety Executive investigation.

	Surgery	Estates	Security	Medical Director	Cardio-respiratory	MDTS
Within timescale	2		1	1	1	1
Late	3	1			1	

1.3 SIs and Clinical Audit

The table below reflects the planned audits to be carried out by the Clinical Audit Team following SIs closed within the last three months:

Summary	Audit to be undertaken
Never event - Wrong site surgery – tooth extracted	• Hard copy x-rays to be present at sign in • Surgery Clinical Governance Manager to arrange initial audit meeting
Never event – retained throat pack	• Inclusion of throat pack in surgical count
Wrong gastrostomy insertion	• Audit the number of incomplete or inaccurate PIMS request forms

1.4 Key interventions for management of SI's

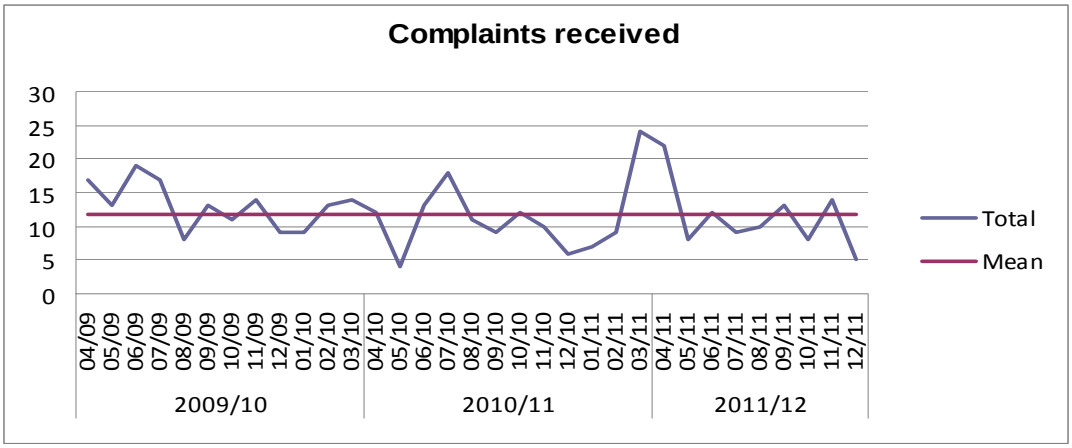
- New guidelines for managing SI's have been implemented – the 3 SI's that have followed the new process have all been closed within the correct timescales.
- The Head and Assistant Head of QST meeting with Clinical Units to discuss how they can be supported.
- Quality, Safety and Transformation senior team members meeting weekly to ensure all SI's are being dealt with appropriately that executives have been notified.
- New Risk Managers (3) have been recruited, due to start April/May.
- The new QST team are working together to identify where data for improvement and transformation methodology will support learning from SI's and complement the audit work.

2. Complaints Analysis

2.1 Number of new complaints received

Number new formal complaints received (November-January): 28
Number of red complaints received (November-January): 3

The run chart below shows the number of formal complaints which received. In order to show that there has been no statistically significant increase in complaints this data could in future be shown and analysed using SPC.



2.2 Number of complaint responses sent

Percent of complaint responses sent out on time: 89%

Between November and January 28 complaint responses were due, 3 of these were sent out late, therefore 89% of complaint responses were sent out on time, which is above the national average. Of these, 1 complaint response was sent out late due to staff annual leave and 2 required further time to collate additional information.

2.3 Complaint themes

Communication

Number of concerns regarding communication: 16

Communication covers many areas, including communication relating to cancellation of procedures, the way we correspond with families, issues around confidentiality and the way information is shared.

2.4 Key interventions for management of complaints

- Actions have been implemented by individual teams involved in complaints to ensure the issues raised have been addressed. These cases are added to the complaint team's action log and are followed up to ensure the agreed actions have been put in place.

- Complaints Manager working with Improvement Managers and Coordinators to improve the process for managing complaints.
- A work stream is being developed to address communication. This will be managed through Transformation and will report to the Transformation Board.
- Quality, Safety and Transformation senior team members meeting weekly to ensure all red complaints are being dealt with appropriately and that executives are notified.

3. Responding to external alerts, guidance and audit

The Central Alert System disseminates alerts to Trusts from several sources.

- MHRA alerts (notices about faulty/defective equipment)
- NPSA (Alerts regarding actions to improve patient safety)
- DH/NHS Estates & Facilities

3.1 MHRA alerts

There were 24 MHRA and Estates and Facilities alerts closed between November and January. Of these, 17 were closed within the deadline and 7 were overdue due to a delay in responding to the Risk Management team. There are currently no overdue MHRA or Estates and Facilities Alerts.

3.2 Rapid Response Reports

Number of open alerts: 3

From the 27th January 2011 the Trust's CAS responses to NPSA alerts have been published monthly on the NPSA website this data contributes to the Quality Risk Profile that the Care Quality Commission (CQC) issue to the Trust. There are currently 3 open alerts. These relate to:

- Minimising risks of mismatching spinal, epidural and regional devises with incompatible connectors
- Safer spinal (intrathecal), epidural and regional devices Part A: update
- Safer spinal (intrathecal), epidural and regional devices - Part B

Appropriate leads have been identified for each alert. The Trust is currently awaiting results of a trial in Wales prior to sourcing replacing equipment in relation to these alerts. The deadline is April 2012.

3.3 NICE Guidance

Number of NICE guideline requiring review: 1

NICE guidelines are received and reviewed by the Clinical Audit Manager, who assigns them to an appropriate specialty lead. The specialty lead should review and ensure actions are put into place where necessary to implement the intended benefit of relevant guidance.

The current NICE guideline requiring review has been escalated to the Clinical Unit Chair and General Manager for Neurosciences.

The guideline is: Drainage, irrigation and fibrinolytic therapy for post haemorrhagic hydrocephalus (Neuosurgery)

3.4 Participation in National Audits

There were 51 National Audits released by the Department of Health. Participation is deemed to be mandatory (where appropriate) and is reported in the Quality Account. Of the 51 audits, 17 are applicable and are currently underway. There are 33 which have been viewed as not appropriate to GOSH. There is 1 remaining audit which is awaiting further confirmation of relevance from the National Pain Database and the Anaesthetic department. This relates to the "National Pain Database Audit: Chronic Pain Services"

3.5 Participation in National Confidential Enquiries

Three NCEPOD studies are currently collecting data but do not require GOSH participation as they exclude paediatrics:

- Cardiac Arrest Procedures
- Bariatric Surgery
- Alcohol related liver disease

NCEPOD published a report and recommendations on the 27th October 2011 following the Deaths in Surgery Study in which the Trust participated (2010/11). This has been reviewed and an organisational gap analysis and was reported to the Quality and Safety Committee in January 2012. The key actions to take place following the recommendations made by NCEPOD:

- Review whether there are local policies regarding who can operate on and anaesthetize children for elective and emergency surgery
- Establish if the Trust currently has mortality and morbidity meetings in all specialities if attendance is appropriate, and if these meetings are documented.
- A group established to ensure that all deaths are reviewed across the Trust.
- There is some review of capacity of the hospital at night programme and medical support for surgical patients.

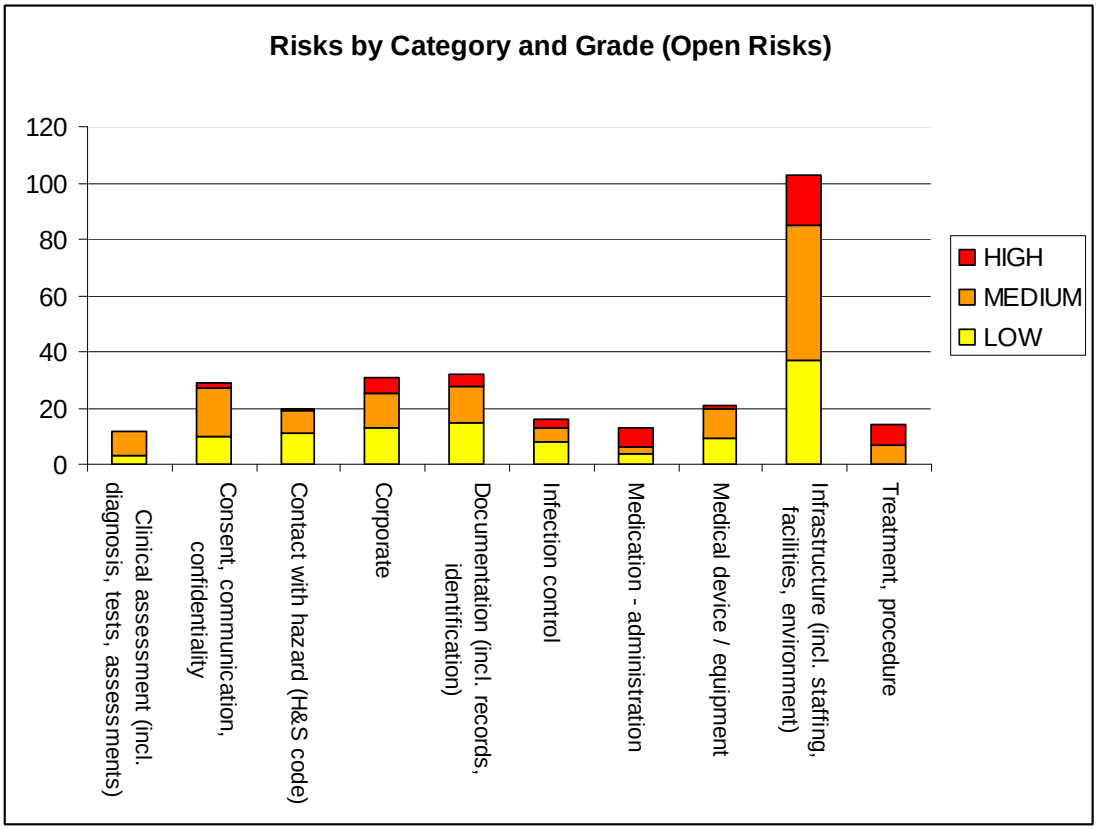
The actions are being monitored by the Quality and Safety Committee.

4. Risk Analysis

Number of open risks currently recorded on Datix Risk Management System: 374
Number of risks closed (November-January): 107
New risks opened (November-January): 53

4.1 Risk Types

Each risk is categorised upon entry to the Datix system to allow for analysis. Within each category the number of risks at each risk grade (High, Medium, Low) can be seen in the chart below. Only categories with more than 10 risks are shown.



High Risks

- There are 57 open high risks on the Datix system
- 12 new high risks have been added during the reporting period
- Between November to January, 11 high risks were closed on the basis of controls introduced and action taken.

Medium Risks

- There are 169 medium risks on the Datix system
- 19 new medium risks have been added during the reporting period
- Between November to January, 38 medium risks were closed on the basis of controls introduced and action taken.

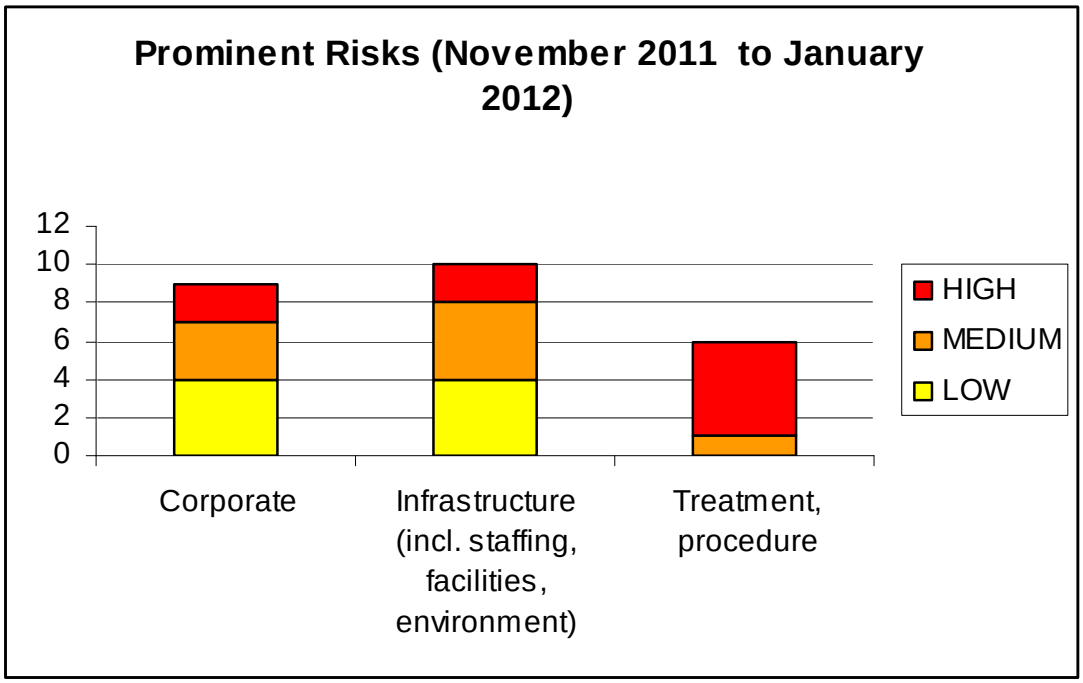
Low Risks

- There are 148 low risks on the Datix system
- 22 new low risks have been added during the reporting period
- Between November to January, 58 low risks were closed on the basis of controls introduced and action taken.

4.2 Analysis of Risks

The majority of open risks in the Trust fall under the '**Infrastructure'** category. This includes staffing, facilities and environment. This pattern is reflected in the proportion of new risks reported from November 2011 to January 2012, although the number of infrastructure high level risks is relatively low accounting for a fifth.

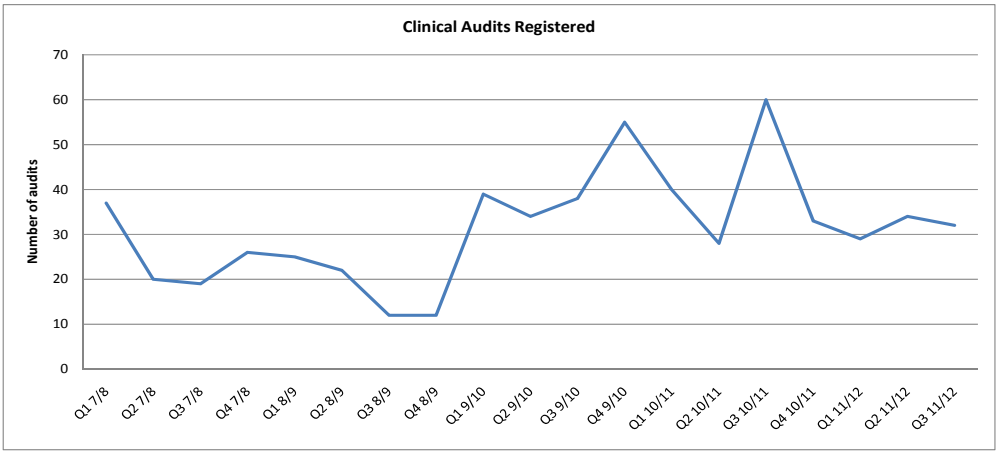
Risks categorised as **'Corporate'** form the second largest category of new risks for the period similarly with a low proportion of high risks. **'Treatment and Procedure'** type risks represent the largest increase in high level risks for the period.



4.3 Key interventions for management of Risk

- Lead Analyst to scope use of SPC for analysing data relating to risk
- QST to work with clinical units and corporate services to address backlog of outstanding risks, particularly those classed as high risk.
- QST to work with clinical units to review those themes that are cross cutting and should be addressed through Transformation work programme.

5. Registration of Clinical Audits in Specialties



Clinical Unit	Audits registered Q3	Completed Clinical Audit Projects in Specialties Q3
Surgery	11	2
Cardiac	7	1
Neurosciences	8	
ICI	3	
MDTS	3	3
Total	**32**	**6**

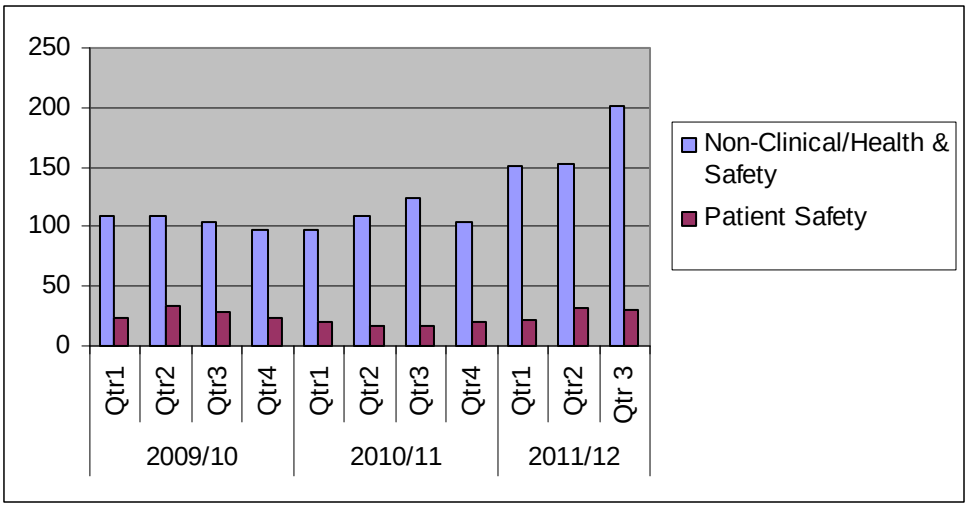
6. Health and Safety

Number and severity of incidents reported (Pan Trust) November – January

Incident Severity (excluding patient safety incidents):

- 1 RIDDOR incident (Moving and Handling incident involving dry ice)
- 1 Serious Incident reported involving the theft of electrical cables.
- 1 Root Cause Analysis initiated relating to a fire on site.

The graph below explains the rate in which Health and Safety incidents are reported that involve patients compared to staff.



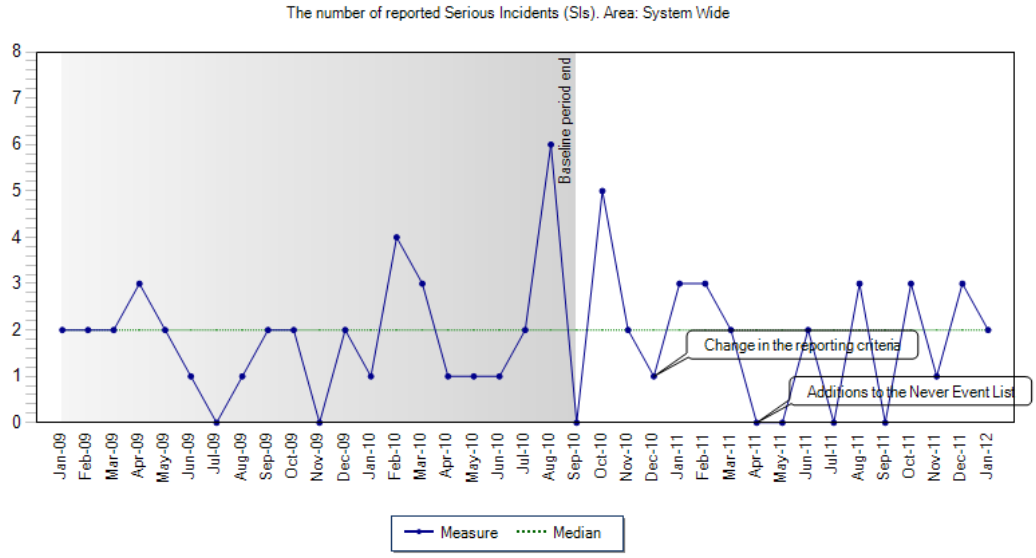
Key interventions for management of Health and Safety

- Lead Analyst to scope use of SPC for analysing data relating to Health and Safety

Appendix A

Where possible, 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.

1. Serious Incidents



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

2. Complaints and Incidents

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

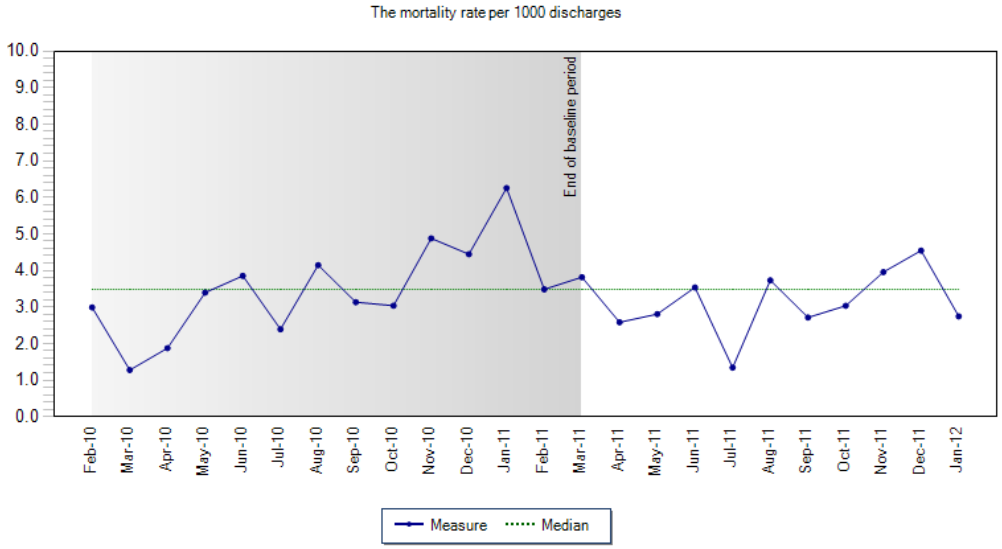
In 2012, the QST team will be undertaking work with the clinical units to address the actions and recommendations from incidents and complaints. This will be presented to Trust Board as part of the Safety report.

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

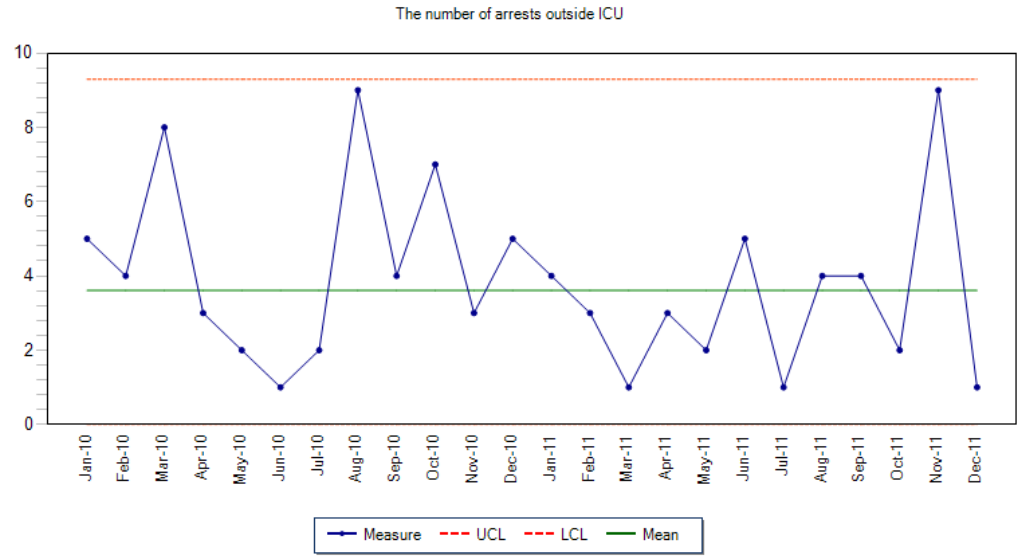


4&5 Arrests and crash calls outside Intensive Care Units (ICU)

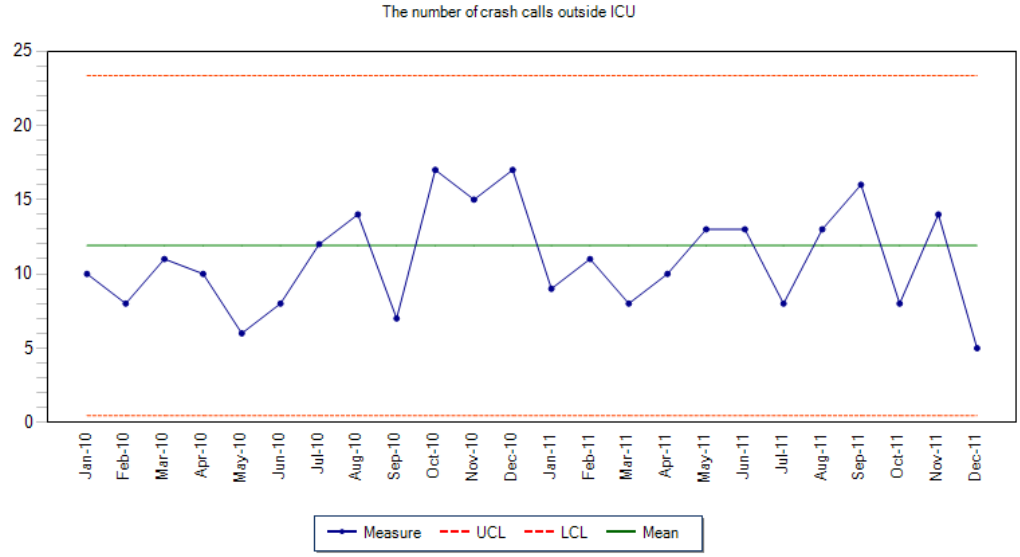
The SPC charts below show the number of arrests and crash calls outside the ICU areas.
Key to tackling this is the work undertaken through the Deteriorating Child project. The aim of this project is to reduce harm from deterioration, more specifically to reduce the number of cardiac arrests by 50 per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

4. Combined infection index (under development)

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

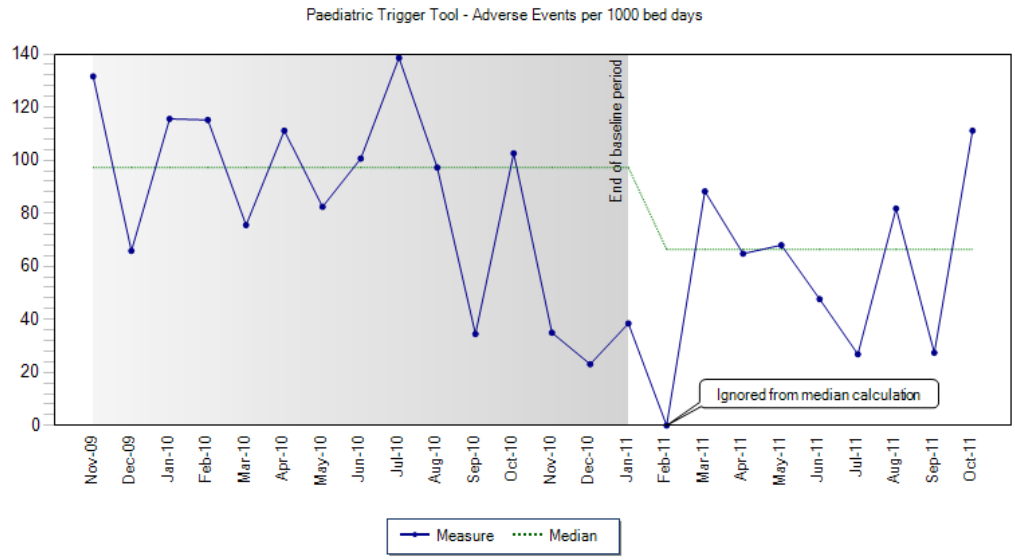
Clinical Unit teams will be supported by the appointment of an Infection Control Practice Educator from end-November 2011 and priority will be given to training and education in infection control.

5. Combined harm index (Under development)

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

6. Paediatric Trigger Tool

Each month, 20 case notes are randomly selected to be reviewed by a group of clinical staff using the Paediatric Trigger Tool. Common themes have risen from these projects which will be worked on as improvement projects.
One of the first issues to be tackled has been the maintenance of patient notes. Issues such as overfull records which were difficult to handle and at risk of coming loose, and inconsistent filling, leading to difficulties in finding key parts of the record, such as discharge summaries and missing records. Secondly, issues were highlighted around entries made by clinical staff, including the failure to follow basic standards of record keeping and failure to document key events in the patient journey. Each Clinical Unit has added a project to improve the quality of Medical Records to their project plans. This will be reported through the Transformation Programme report.



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

Great Ormond Street Hospital for Children NHS Trust

Trust Board
29th February 2012

GOSH Constitution and Foundation Trust appointments **Submitted on behalf of:** Dr Jane Collins, Chief Executive	**Paper No: Attachment P**

Aims / summary

Updated Constitution (to note)

The Trust's Constitution has recently been reviewed and updated and approved by Monitor. The changes are as follows:

- Constitution and Annex 9 – amended to include an additional NED on the Board of Directors (from 5 to 6 NEDs);

- Annex 4 –make-up of the Members' Council. The partnership organisations, 'Contact a Family' and 'Voluntary Action Camden Race and Health Group' have been unable to recruit to an appointed councillor position on the Members' Council. The Constitution has been amended to show that the Council is now made up of 28 councillors rather than 30 councillors (10 councillors from the patient and carer constituency; 7 councillors from the public constituency; 5 councillors from the staff constituency and 6 appointed councillors). The Trust proposes to consult with the Members' Council to appoint two alternative partnership organisations to the Council;

- Paragraph 1, Annex 7 has been amended to reflect the proposal to appoint an additional NED, subject to the approval of the Members Council post FT authorisation. This paragraph also includes clarification about the name of the Members' Council nominations and remuneration committee; the ability of the committee to recommend the re-appointment of a NED to the Members' Council and rewording of the section dealing with when the chairman or deputy chairman are being appointed;

- Paragraph 4.4 of Annex 8 has been revised to reflect the role of the Lead Councillor in presiding over meetings where the Chairman or Deputy Chairman are absent or unable to participate for reasons of declared conflicts of interest.

A copy of the full constitution and annexes will be sent to Board members under separate cover.

Appointment of the Deputy Chairman (for decision)

Paragraph 24 of the Constitution states that the Members' Council shall appoint one of the Non-Executive Directors as the Deputy Chairman. The Standing Orders for the Board of Directors (annex 9 of the Constitution) state that the Deputy Chairman shall be the acting Chairman of the NHS Foundation Trust should the Chairman be unable to discharge their office as Chairman. The Deputy Chairman will also chair the Members' Council meeting and members' meetings should the Chairman be absent or disqualified from participating due to a conflict of interest (annexes 8 and 10 of the Constitution).

It is proposed that Charles Tilley is nominated as Deputy Chairman of the Trust, for consideration by the Members' Council.

Appointment of the Senior Independent Director (for decision)

The NHS Code of Governance published by Monitor states that the Board of Directors of a Foundation Trust should appoint one of the Non-Executive Directors to be a Senior Independent Director (SID) in consultation with the Councillors.

The role of the SID is to lead the Non-Executive Directors in the performance evaluation of the Chairman, and to help resolve any concerns Councillors or Members may have about the Trust where contact through the Chairman, Chief Executive or Chief Finance Officer is either inappropriate or has been unsuccessful.

The Standing Orders for the Board of Directors (annex 9 of the Constitution) state that the Board of Directors shall appoint one of the independent Non-Executive Directors to be the SID in consultation with the Members' Council.

It is proposed that Mary MacLeod is appointed as the Senior Independent Director. The Council will be consulted on this appointment.

The role descriptions for Deputy Chairman and Senior Independent Director are attached as at appendix 1. These are consistent with the requirements of the Code of Governance and good practice in other Foundation Trusts.

Action required from the meeting
To note the Constitution and annexes.
To approve the nomination for the role of Deputy Chairman and appointment to the role of SID.

Contribution to the delivery of NHS / Trust strategies and plans
STRATEGIC OBJECTIVE 7: Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation.

Financial implications
None

Legal issues
Legal advice has been sought on specific issues within the Constitution and annexes.

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? The Legal Constitution Group has been involved in the drafting of the Constitution and annexes.
Who needs to be told about any decision The Board of Directors and Members' Council when appointed (the Deputy Chairman will be subject to approval by the Members' Council).
Who is responsible for implementing the proposals / project and anticipated timescales N/A
Who is accountable for the implementation of the proposal / project N/A
Author and date Anna Ferrant, Company Secretary 22nd February 2012

Appendix 1

ROLE OF THE DEPUTY CHAIRMAN

The Members' Council will appoint one of the Non-Executive Directors as the Deputy Chairman. The role of the Deputy Chairman is to preside at any meeting of the Trust Board (and Members' Council and members' meetings) should the Chairman be absent from the meeting (including as a result of any conflict of interest).

ROLE OF THE SENIOR INDEPENDENT DIRECTOR (SID)

The Board of Directors will appoint one of the Non-Executive Directors as the Senior Independent Director (SID). In addition to their existing responsibilities as a Non-Executive Director, the SID will:

1. Be available to Board members if they have concerns about the performance of the Board or the welfare of the Trust, which contact through the normal channels of Chairman, Chief Executive or Chief Finance Officer has failed to resolve or for which such contact is inappropriate;
2. Facilitate the appraisal of the Chairman, including at least annually hold a meeting with the other independent Non-Executive Directors to evaluate the performance of the Chairman;
3. Be available to Councillors and Members if they have concerns about the performance of the Board of Directors, the Trust's compliance with its Terms of Authorisation or the welfare of the Trust, which contact through the normal channels of Chairman, Chief Executive or Chief Finance Officer has failed to resolve or for which such contact is inappropriate;
4. Help resolve any disagreements that may arise between the Members' Council and Board of Directors, in accordance with any procedures agreed by the Trust;
5. Maintain a sufficient dialogue with Councillors (including attending meetings as appropriate) in order to develop a balanced understanding of the issues and concerns of Councillors.

The Board of Directors will consult the Members' Council when appointing the Senior Independent Director.

The Board should state its reasons for determining a director is 'independent', if the director:

- Has been an employee of the NHS Foundation Trust within the last five years;

- Has, or has had within the last three years, a material business relationship with the NHS Foundation Trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS Foundation Trust;

- Has received or receives additional remuneration from the NHS Foundation Trust apart from a director's fee, participates in the NHS Foundation Trust's performance-related pay scheme, or is a member of the NHS Foundation Trust's pension scheme;

- Has close family ties with any of the NHS Foundation Trust's advisers, directors or senior employees;

- Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies; or

- Has served on the Board for more than six years from the date of their first election.

- is an appointed representative of the NHS foundation trust's university medical or dental school.

Great Ormond Street Hospital for Children NHS Trust

Trust Board
29th February 2012

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

Aims / summary

Under Foundation Trust Standing Orders of the Board of Directors', the Board of Directors will appoint a Nominations Committee. Draft terms of reference (ToR) are attached. Monitor's Code of Governance and best practice guidance from the Foundation Trust Network have been used to update the ToR.

The Board of Director's Nominations Committee will be responsible for appointing board executive directors.

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

Contribution to the delivery of NHS / Trust strategies and plans
STRATEGIC OBJECTIVE 7: Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation.

Financial implications
None.

Legal issues
None.

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

Who needs to be told about any decision
N/A

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

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

Author and date
Anna Ferrant,
Company Secretary
22nd February 2012

DRAFT Board of Directors' Nominations Committee

Terms of Reference

1. Authority

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

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

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

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

2. Role

2.1 Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the board and make recommendations to the board with regard to any changes.

2.2 Give full consideration to and make plans for succession planning for the chief executive and other executive board directors taking into account the challenges and opportunities facing the foundation trust and the skills and expertise needed on the board in the future.

2.3 Be responsible for identifying and nominating for appointment, candidates to fill posts within its remit as and when they arise.

2.4 Be responsible for identifying and nominating a candidate, for approval by the members' council, to fill the position of chief executive.

2.5 Before an appointment is made, evaluate the balance of skills, knowledge and experience on the board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates, the committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates for a wide range of backgrounds; consider candidates on merit against objective criteria.

2.6 Consider any matter relating to the continuation in office of any executive board director at any time including the suspension or termination of service of an individual as an employee of the foundation trust.

2.7 To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.

3. Membership and attendance

3.1 The foundation trust chairman will chair the committee.

3.2 All other non–executive directors shall be members of the committee.

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

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

4. Quorum

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

5. Secretary

5.1 The trust board administrator shall be secretary to the committee.

6. Frequency of meetings

6.1 The committee shall meet at least once a year, normally in March.

7. Minutes and reporting

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

7.2 The nominations committee will report to the full board of directors after each meeting.

7.3 The nominations committee shall ensure that information about the appointment or removal of members of the board of directors' are accurately reported in the required format in the foundation trust's annual report.

8. Performance evaluation

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

9. Review

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

January 2012

Great Ormond Street Hospital for Children NHS Trust

Trust Board
29th February 2012

Members' Council Nominations and Remuneration Committee Terms of Reference **Submitted on behalf of: Dr Jane Collins, Chief Executive**	**Paper No: Attachment 4**

Aims / summary

It is the responsibility of the Members' Council to appoint (and remove) the Chairman and Non-Executive Directors (NEDs). These decisions must be taken by the full Members' Council. However in line with the Code of Governance, it is common practice for Foundation Trusts to establish a Nominations Committee to recommend suitable candidates to the Members' Council.

In order to develop an effective framework for appointing the Chairman and non-executive directors and setting their remuneration, it has been agreed that it would be most effective to establish a Members' Council 'Nominations and Remuneration Committee'.

Annex 7 of the Trust's Constitution makes provision for the establishment of such a Committee. Proposed terms of reference for the Committee have been developed (see attached). These are consistent with the requirements of the Constitution, the Code of Governance, and Monitor's guide for Governors on exercising their statutory duties.

The Committee will make recommendations to the Members' Council on the appointment and terms and conditions of the Chairman and NEDs and review the results of the performance evaluation process for the chairman and non-executive directors.

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

Contribution to the delivery of NHS / Trust strategies and plans
STRATEGIC OBJECTIVE 7: Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation.

Financial implications
None.

Legal issues
None.

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

Who needs to be told about any decision
N/A

Attachment 4

Who is responsible for implementing the proposals / project and anticipated timescales Company Secretary
Who is accountable for the implementation of the proposal / project Chair of the Nominations and Remuneration Committee
Author and date Anna Ferrant, Company Secretary 29th February 2012

Great Ormond Street Hospital for Children NHS Trust

DRAFT Members' Council Nominations and Remuneration Committee

Terms of Reference

The members' council nominations and remuneration committee is authorised by the members' council to act within its terms of reference. All members of staff are requested to co-operate with any request made by the members' council nominations and remuneration committee.

Nominations role

The members' council nominations & remuneration committee will:

- Periodically review the balance of skills, knowledge, experience and diversity of the non-executive directors on the board and make recommendations to the board of directors with regard to the outcome of the review.

- Give consideration to succession planning for non-executive directors in the course of its work, taking into account the challenges and opportunities facing the NHS foundation trust and the skills and expertise needed on the board of directors in the future.

- Keep the leadership needs of the foundation trust under review at non-executive level to ensure the continued ability of the NHS foundation trust to operate compete effectively in the health economy.

- Keep up to date and fully informed about strategic issues and commercial changes affecting the NHS foundation trust and the environment in which it operates, having regard to any relevant legislation and requirements of the independent regulator.

- Agree with the members' council a clear process for the nomination of a chair, non-executive.

- Take into account the views of the board of directors on the qualifications, skills and experience required for each position.

- Prepare a description of the role and capabilities required for an appointment of non-executive directors, including the chair.

- Interview and nominate candidates as non-executive directors for approval by the members' council respectively, ensuring that candidates are eligible for appointment under the Constitution.

- Ensure that a proposed chair's or non-executive director's other significant commitments are disclosed to the members' council before appointment and that any changes to their commitments are reported to the members' council as they arise.

- Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

- Ensure that on appointment non-executive directors including the chair receive a formal letter of appointment setting out clearly what is expected of them in terms of time commitment, committee service and involvement outside board of directors meetings.

- Review the results of the performance evaluation process for the chairman and non-executive directors.

- Review annually the time requirement for non-executive directors.

- Make recommendations to the members' council concerning plans for succession particularly for the key roles of chair.

- Make recommendations to the members' council on the membership of committees as appropriate, in consultation with the chairs of those committees.

- Advise the members' council in respect of re-appointment of any non-executive directors in relation to a term beyond six years (in accordance with paragraph 7, annex 9 of the Constitution).

- Advise the members' council in regard to any matters relating to the removal of office of a non-executive director including the chair.

Remuneration role

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

- Salary, including any performance-related pay or bonus;

- Provisions for other benefits, including pensions and cars; and

- Allowances.

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

To advise upon and oversee contractual arrangements for non-executive directors, including but not limited to termination payments.

Request for advice

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

The committee is authorised, subject to funding approval by the company secretary, to request professional advisors and the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise its functions.

Membership

The members' council nominations and remuneration committee will comprise the chairman of the trust, the deputy chairman, two councillors from the public constituency and/or the patient and carer constituency), one staff councillor and one appointed councillor. Each member of the committee shall have one vote.

The committee will normally be chaired by the NHS foundation trust chairman. Where the chairman has a conflict of interest, for example when the committee is considering the chairman's re-appointment or salary, the committee will be chaired by the deputy chairman.

When the chairman is being appointed or reappointed, the deputy chairman shall take his or her place, unless he or she is standing for appointment, in which case another non-executive director shall be identified and agreed prior to the meeting to take his or her place.

Where the number of councillors prepared to serve on the committee is greater that the number of places available, then committee members will be selected by election by their councillor peers.

A quorum shall be four members, including the chairman or deputy chairman and at least one councillor from the public constituency/the patient and carer constituency and one councillor from the staff constituency/an appointed councillor.

Attendance

Meetings of the committee may be attended by the chief executive; head of human resources (operations); the company secretary; and any other person who has been invited to attend a meeting by the committee so as to assist in deliberations.

Frequency of meetings

Meetings shall be held as required, but not less than once a year.

Minutes and reporting

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

The nominations and remuneration committee will report to the members' council after each meeting. The Chair of the committee will be required to brief the board of directors.

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

Members of the committee will be required to attend the annual general meeting to answer questions from the Foundation Trust members and the wider public.

Review

The terms of reference of the committee shall be reviewed by the members' council and the board of directors at least annually.

Great Ormond Street Hospital for Children NHS Trust

Trust Board 29th February 2012	
Code of Conduct for Trust Board Members **Submitted on behalf of: Company Secretary**	**Paper No: Attachment 3**

Aims / summary

Board members of NHS Trusts are asked to acknowledge and adopt the Nolan principles on Standards in Public Life; the Code of Conduct / Code of Accountability in the NHS and the Code of Conduct for NHS Managers (these documents have been emailed out to Board members).

In addition to the importance of high standards of personal ethical conduct, the adoption of these principles and codes will also support compliance with the Trust's Standing Financial Instructions and Standing Orders.

Members of the Trust Board should be aware of the content of three key documents:

- The Nolan principles – Seven principles of public life (1995)
- The Code of Conduct for NHS managers (2002)
- The Code of Conduct and Accountability (2004)

Annex 1 provides an overview of these documents. Management Board members will be reminded of the above codes and principles and will be asked to cascade this information to their teams.

Monitor's Code of Governance requires a Foundation Trust Board of Directors to: "*operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility*."

The Trust Board is asked to consider and approve the attached code of conduct for the Board of Directors (Annex 2), drafted in line with best practice guidance from Beachcrofts - '*The Foundations of Good Governance'*. Councillors have recently signed a similar document.

Once approved by the Board and upon Foundation Trust authorisation, Trust Board members will be asked to sign the attached code of conduct.

Action required from the meeting

Trust Board members are asked to acknowledge and reaffirm the adoption of the Nolan Principles, the Code of Conduct and Accountability and the Code of Conduct for NHS Managers.

Trust Board members are asked to approve the Code of Conduct for the Board of Directors.

Contribution to the delivery of NHS / Trust strategies and plans

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

Financial implications

None

Legal issues None
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A
Who needs to be told about any decision N/A
Who is responsible for implementing the proposals / project and anticipated timescales N/A
Who is accountable for the implementation of the proposal / project N/A
Author and date Anna Ferrant, Company Secretary 8th February 2012

Annex 1

The Nolan Principles:

- **Selflessness -** Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

- **Integrity-** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

- **Objectivity -** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

- **Accountability** - Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

- **Openness** - Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

- **Honesty** - Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

- **Leadership** - Holders of public office should promote and support these principles by leadership and example.

The Code of Conduct for NHS managers

The Code of Conduct for NHS Managers sets out the core standards of conduct expected of NHS managers, which underpins the principles by which NHS organisations, management and staff make decisions and can be held accountable. It aims to serve two purposes:

- to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make, and
- to reassure the public that these important decisions are being made against a background of professional standards and accountability.

The Code of Conduct / Code of Accountability:

The Code of Conduct / Code of Accountability in the NHS focuses on the three crucial public service values which must underpin the work of the health service: accountability, probity and openness.

Examples of practical demonstrations of the above principles and codes are as follows:

- GOSH Personal Responsibility Framework in place and included in staff contracts;
- Conflicts of Interest Policy – staff and members advised of this upon appointment and during employment;

- High standards of personal ethical conduct
  - Accepting corporate responsibility
  - Declaring potential & actual conflicts of interest (annually and requested at every Board meeting)
  - Declaring receipt of gifts/hospitality
- Value for Money and safeguarding of funds;
- Meaningful engagement and consideration of stakeholder views in decision making;
- Availability of timely and accurate information to Trust Board, and its committees (including reviews of this information);
- Implementation and monitoring of whistle-blowing and complaints procedures.

Great Ormond Street Hospital for Children NHS Trust

Draft
Board of directors - Code of Conduct

1. Introduction

High standards of corporate and personal conduct based are an essential component of public services. As an NHS foundation trust, Great Ormond Street Hospital NHS Foundation Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice. The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all directors and employees.

This code, with the code of conduct for councillors and the NHS constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the foundation trust. The code is intended to operate in conjunction with the code of governance, the constitution and with standing orders. The code applies at all times when directors and employees are carrying out the business of the foundation trust or representing the foundation trust.

2. Principles of public life

All directors and employees are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

Selflessness

Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

3. General principles

Foundation trust boards of directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public. The board of directors therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. The board of directors will lead in ensuring that the provisions of the constitution, the standing orders, financial standing orders and accompanying scheme of delegation conform to best practice and serve to enhance standards of conduct. The board of directors expects that this code will inform and govern the decisions and conduct of all directors.

4. Confidentiality & access to information

Directors and employees must comply with the foundation trust's confidentiality policies and procedures. Directors and employees must not disclose any confidential information, except in specified lawful circumstances.

Information on decisions made by the board of directors and information supporting those decisions should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the freedom of information act 2000[1] and other applicable legislation and directors and employees must not seek to prevent a person from gaining access to information to which they are legally entitled.

[1] Requests for information under the Freedom of Information Act must be communicated to the FOI Coordinator (FOITeam@gosh.nhs.uk)

The foundation trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the data protection act, the freedom of information act and other relevant legislation which will be followed at all times by board of directors and all staff.

5. Register of interests

Directors are required to register all relevant interests on the foundation trust's register of interests in accordance with the provisions of the constitution. It is the responsibility of each director to update register entry if their interests change, using the relevant pro-forma. Failure to register a relevant interest in a timely manner may constitute a breach of this code.

6. Conflicts of interest

Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the foundation trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a director or for doing (or not doing) anything in that capacity.

If a director has in any way a direct or indirect interest in a proposed transaction or arrangement with the corporation, the director must declare the nature and extent of that interest to the other directors. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the trust enters into the transaction or arrangement.

The chair will advise directors in respect of any conflicts of interest that arise during board of directors meetings, including whether the interest is such that the director should withdraw from the meeting for the period of the discussion. In the event of disagreement it is for the board of directors to decide whether a director must withdraw from the meeting. The company secretary will provide advice on any conflicts that arise between meetings.

7. Gifts & hospitality

The board of directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of foundation trust for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The board of directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the foundation trust in the eyes of the community.

The board of directors has adopted a policy on conflicts of interest, including acceptance of gifts and hospitality which will be followed at all times by directors and all employees. Directors and employees must not accept gifts or hospitality other than in compliance with this policy.

8. Whistle-blowing

The board of directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The board of directors has adopted a whistle-blowing policy on raising matters of concern which will be followed at all times by directors and all staff.

9. Personal conduct

Directors are expected to conduct themselves in a manner that reflects positively on the foundation trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the foundation trust into disrepute. Specifically directors must:

- Act in the best interests of the foundation trust and adhere to its values and this code of conduct.
- Respect others and treat them with dignity and fairness.
- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion.
- Be honest and act with integrity and probity.
- Contribute to the workings of the board of directors as a board of directors' member in order for it to fulfil its role and functions.
- Recognise that the board of directors is collectively responsible for the exercise of its powers and the performance of the foundation trust
- Raise concerns and provide appropriate challenge regarding the running of the trust or a proposed action where appropriate.
- Recognise the differing roles of the chair, senior independent director, chief executive, executive directors and non-executive directors.
- Make every effort to attend meetings where practicable.
- Adhere to good practice in respect of the conduct of meetings and respect the views of others.
- Take and consider advice on issues where appropriate.
- Acknowledge the responsibility of the members' council to represent the interests of the foundation trust's members and partner organisations in the governance and performance of the foundation trust, and to have regard to the views of the members' council.
- Not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person.
- Accept responsibility for their performance, learning and development.

10. Compliance

The members of the board of directors will satisfy themselves that the actions of the

board of directors and directors in conducting board of directors business fully reflect the values, general principles and provisions in this code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon.

Failure to comply with the code may result in sanctions in accordance with agreed procedure.

11. Interpretation & concerns

Questions and concerns about the application of the code should be raised with the foundation trust company secretary. At meetings the chair will be the final arbiter of interpretation of the code.

12. Review and revision of the code

The company secretary will periodically lead a review of the code.

13. Acceptance of the Code of Conduct

Each director, on appointment, must sign the following declaration of acceptance of this code of conduct.

Declaration:

I …… (full name) as an executive/ non-executive director (delete as appropriate), have read, understood, and agree to abide by the code of conduct for the board of directors of Great Ormond Street Hospital NHS Foundation Trust

Signature: ……

Date: ……

Attachment R

Great Ormond Street Hospital for Children NHS Trust

Trust Board
29th February 2012

Revised Terms of Reference for a new Board Committee – the "Finance and Investment Committee" **Submitted by:** **Claire Newton, Chief Finance Officer**	**Paper No: Attachment R**

Aims
To propose revised terms of reference for the new Board Committee.

Summary
At the December meeting a first draft of Terms of Reference was considered to encompass a new board committee to consider the following:

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

The attached draft Terms of Reference have been revised according to the board discussion at the December meeting.

Action required from the meeting
To discuss and confirm revised draft terms of reference

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

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

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

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

Who needs to be told about any decision
The Board

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

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

Author and date
Claire Newton 22.02.12

Great Ormond Street Hospital for Children NHS Trust

FINANCE AND INVESTMENT COMMITTEE

DRAFT TERMS OF REFERENCE

1 Authority

The Committee will operate as a sub-committee of the Trust Board under the broad aims of assisting the Board in overseeing financial strategy and planning, financial policy, investment and treasury matters and in reviewing and recommending for approval major financial transactions. The Committee will also maintain an oversight of the Trust's financial position, and relevant activity data and workforce metrics.

2 Membership

Chair
The Board will nominate a Non-Executive Director to act as Chair of the Committee. In their absence, another Non-Executive Director shall act as Chair.

Regular members
Non-Executive Directors x 3 [one of whom shall be the Chair]
Chief Executive
Deputy Chief Executive /Chief Operating Officer
Chief Finance Officer
Director of Redevelopment

In Attendance
Deputy Director of Finance
Deputy Chief Operating Officer

In addition the Committee may ask any relevant member of senior management or external advisers to attend and address meetings of the Committee either regularly or by invitation, but the invitees have no right of attendance.

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

Quorum Chair or nominated deputy, one other NED and two Directors which must include the Chief Finance Officer or if absent, the Deputy Finance Director must be in attendance.

3 Conduct

The Committee will develop a work plan with specific objectives which will be reviewed regularly and effectiveness on an annual basis and ensure relevant financial topics are considered according to a regular cycle.

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

Frequency/ Duration of Meetings: Meetings shall normally take place on a quarterly basis and the Committee will meet not less than 4 times a year.

4 Responsibilities

Financial

- Review the Long Term Financial Model and annual financial plan for revenue and capital, and make recommendations to the Board.
- Review progress against key financial and external targets, including monthly finance and activity reports and financial performance ratings (e.g. Monitor metrics).
- Ensure appropriate contracting arrangements are in place and review overall performance on contracts.
- Examine specific areas of financial risk and highlight these to the Board as appropriate.
- Review capacity utilization, productivity and efficiency measures.
- Oversee the Trust's treasury management strategy and borrowings arrangements
- Review workforce projections and monitor trends in actual workforce numbers and costs including temporary staffing costs, in order to ensure resource levels remain within the levels prescribed by the financial plan
- Review progress on Service Line Reporting;
- Review the Trust's procurement policies and functions and ensure they are fully aligned with the savings plan.
- Advise the Board on best practice and policy in relation to financial management, including latest Monitor guidance.
- Ensure there are processes to determine that value for money is obtained by the Trust
- Identify related areas of strategic and business risk and report these to the Board

Capital and revenue investments /service developments

- Oversee the development and implementation of the estates and IT strategy and to review estates and IT performance ensuring actions are agreed as appropriate.
- Advise the Board and maintain an oversight on all major investments and business developments including the Redevelopment programme
- Advise the Board on all proposals/business cases for major capital expenditure over £1,000,000 and to approve financial governance for approving proposals under £1,000,000
- Seek assurance that the strategies are delivered in accordance with agreed milestones
- Identify key risks associated with the delivery of strategies and ensure these are reported to the Board.

5 Information requirements

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

The Committee will also receive the minutes of the Redevelopment Steering Group, CASP, Technical Delivery Board, CESC

6 Reporting

The Committee shall make recommendations and report to the Board on financial matters on a regular basis and in any event, when such reports or recommendations are requested by the Board.

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

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

7 Other Matters

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

DATE: February 2012

REVIEW DATE: November 2012

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Great Ormond Street Hospital for Children NHS Trust

Trust Board Meeting
29th February 2012

Meeting the duties of the Equality Act 2010 **Submitted on behalf of:** Ms Fiona Dalton, Chief Operating Officer and Dr Barbara Buckley, Co-Medical Director	**Paper No: Attachment S**

Aims / summary
To provide Trust Board with assurance that the Trust is meeting its statutory obligation under the Equality Act 2010. To inform the Board about how the NHS Equality Delivery System has been implemented and the equality objectives which have been developed.

Action required from the meeting
To note the content of the paper and approve the equality objectives for the coming three year period.

Contribution to the delivery of NHS / Trust strategies and plans
Meeting statutory duty to report publically on this activity. Work promotes fairness and equity in service delivery and employment.

Financial implications
None.

Legal issues
Statutory duty to report on this activity.

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?
Families are represented on the Family Equality and Diversity Group and staff on both FED and the Staff Equality and Diversity Group – both families and staff were involved in workshops to develop grading and objectives.

Who needs to be told about any decision
N/A.

Who is responsible for implementing the proposals / project and anticipated timescales
Family and Staff Equality and Diversity Groups.

Who is accountable for the implementation of the proposal / project
Fiona Dalton for staff and Barbara Buckley for families.

Author and date
Sue Lyon
Beki Moult
17th February 2012

Attachment S

Meeting the duties of the Equality Act 2010

Introduction

The Equality Act came into force on 1st October 2010, simplifying existing equalities law into one single source of Statute. The Act also changed and refined certain concepts and definitions, as well as introducing some new provisions. In addition to the Act, a new statutory duty (the Equality Duty) came into force in April 2011 which is applicable to all public sector bodies.

As a Trust we must demonstrate that we comply with the Equality Act and are meeting the Equality Duty through the work we do, the involvement we have of the Trust Board in this work and through publishing a range of equalities data on an annual basis. This paper sets out how we are meeting the general and specific duties of the Equality Act 2010.

To comply with the first specific duty of the Act, the Trust was legally required to publish equality data relating to both service users and staff at the end of January 2012. The Trust has compiled a comprehensive report containing equality information, a copy of which is available on the GOSH website at www.gosh.nhs.uk/about-us/equality-and-diversity/ .This will be updated on an annual basis.

The second part of the specific duty requires the Trust to 'prepare and publish equality objectives, which should be specific and measurable, setting out how progress towards these objectives should be measured. Details of the engagement in developing these objectives should also be published.' To help develop relevant equality objectives involving key stakeholders, the Family Equality and Diversity (FED) and Staff Equality and Diversity (SED) groups have utilised the NHS Equality Delivery System (EDS) to grade the Trust against several equality related outcomes.

This paper sets out the four objectives required by the Equality Act for the next three year period, how they were identified and how they will be monitored. The appendix covers how we assessed our organisation against the four goals and 18 outcomes of the Equality Delivery System (EDS). In addition other ongoing activities are identified which will be carried out during the coming three year period.

Equality objectives for period 2012 to 2015

Using the information gained as a result of collating equality and diversity data, the evidence collected during the EDS process and on the basis of the EDS grades awarded, both FED and SED have developed equality objectives. FED identified two objectives relating to goals 1 and 2 and SED a further two objectives for goals 3 and 4.

In selecting objectives, consideration has also been given to objectives which will foster the aims of the general Equality Duty concerning issues which affect people with protected characteristics and which will have the most impact on the disadvantages they face.

As well as the objectives outlined below and required by law, other work will be ongoing throughout the year to progress specific equality issues:

- SED will continue to support the work of the Black and Minority Ethnic Network (BAMEN) group, review a system for monitoring flexible working requests and explore cultural competence training for managers.
- FED will continue to improve services for children and families with learning disabilities, identify methods of understanding the patient experience of specific groups, such as non-

English speakers or faith groups, and work to analyse clinical outcomes by demographic groups.

The objectives identified will help us achieve the requirements of the Equality Duty, but they will also support our attainment of existing organisational goals.

Objective 1:

While carrying out the analysis for the FED report about our patient population, referred to earlier in this document, it became apparent that there was potential overlap between the response options in PiMS. For ethnic group, the options in the drop-down menus are 'not asked or known', 'not specified' and 'refused to give' while for religion, there is only the option of 'not specified'. In both cases, the default option is 'not specified'.

In order to make this data more coherent, it is proposed to remove the 'not specified' options for ethnic group and religion, making the default value 'not asked'. This is planned to happen from 1st April 2012.

The 'refused to give' option will remain under ethnic group field and be created for the religion field. It is not obligatory for families to provide this information so the 'refused to give' option must be included.

We aim to reduce the number of patients for whom ethnic group and religion is 'not asked' by ten per cent year on year. Until the amendments noted above are carried out, we are unable to provide a baseline against which we can measure our progress.

This objective forms part of a wider plan to revisit data collection and usage at GOSH, which will enable more meaningful analysis and action in future.

Objective 2:

Each year, GOSH commissions Ipsos MORI to carry out a survey of patient experience at GOSH. Around 750 inpatients or outpatients and their parents are asked a series of questions so that we may better understand their experience and levels of satisfaction with our services. In 2011, two additional questions about disability were added:

- Does you child have any special needs or disabilities? For instance, a physical disability or learning disabilities.
- To what extent do you agree or disagree that the hospital understands these needs and puts arrangements in place to meet them?

We aim to increase the percentage of respondents stating that they agreed that the hospital understood these needs and put arrangements in place to meet them year on year. Until the first survey containing these questions has been completed, we are unable to provide a baseline or specify by how much we will aim to increase 'agree' responses.

This objective forms part of a wider plan to improve our services for children with disabilities, which is required by Monitor and other organisations.

Objective 3:

Staff appraisal data shows that 61 per cent of staff have an appraisal. Of those who do not have a current appraisal 40 per cent are from a BME background, or their ethnicity is not known. The proportion of BME staff without an appraisal is therefore higher than the proportion employed in the

Trust, which is 29 per cent. In 2010-11 work was undertaken to identify the blocks to appraisals and remedial action taken. This resulted in an increase in appraisal rates although the disproportion of BME staff receiving an appraisal remained. However, we have recently seen another dip in rates and an action plan and a Trust wide objective is in place to address this.

Following on from the Trust objective to increase appraisal rates for all staff to 80 per cent, we aim to achieve a year on year improvement of the percentage of staff from protected groups having appraisals. By 2013 the appraisal rates for all protected groups will match the appraisal rates of all other staff.

In order to help achieve this departments and units having low appraisal rates will be targeted and priority targeting of those areas of low appraisal rates and a high proportion of BME staff will be put into place.

Objective 4:

There is evidence from our recruitment data and through sources such as our staff survey that suggests staff from BME backgrounds (and in some instances with other protected characteristics) are not as successful in being recruited into the Trust as other groups. There may be many complex factors affecting this, but increasing the objectivity of the selection process will help mitigate unfair or unwitting discrimination.

In addition, selection testing for 'people skills' will help the Trust to appoint staff who are able to undertake supervisory and management roles. A common theme from the EDS grading exercise was that the experiences and perceptions of our staff are very much dependent on the quality of the line management they receive. It was consistently asserted that high quality staff management is important to help ensure fairness and inclusivity.

Currently, relatively very few pre-selection tests are used. The increased usage of an electronic recruitment system and the development of a dedicated recruitment team will enable more pre-selection tests to be used in order to inform employment decisions.

There will be a year on year increase in the percentage of tests used in recruitment selection processes. Benchmarking of current usage of selection testing is currently underway. Once this has been identified a percentage increase will be set and this objective will be updated accordingly.

The increase in the number of recruitment episodes that include tests will be reviewed in conjunction with demographic recruitment data to monitor the impact of the objective below on the numbers of staff who have protected characteristics who are appointed.

Monitoring progress against objectives

Objectives 1 and 2 will be formally monitored by FED and objectives 3 and 4 by SED. Progress against each objective will be reviewed every six months. Progress against all objectives will be formally reported to Trust Board annually.

Action required

Trust Board are asked to note the contents of this report and approve the equality objectives identified for the coming three years.

Appendix 1

The Equality Delivery System (EDS) grading system

At the heart of the EDS is a set of 18 outcomes grouped into four goals. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these goals and outcomes that performance is analysed, graded and action determined.

Goal 1 – Better health for all
Goal 2 – Improved patient access and experience
Goal 3 – Empowered, engaged and included staff
Goal 4 – Inclusive leadership at all levels

Each outcome can be assigned one of four grades based on a RAG+ rating system as below:

Grade	Description
Purple = Excelling	Outcome is met for all nine protected groups*
Green = Achieving	Outcome is met for six to eight of the nine protected groups
Amber = Developing	Outcome is met for three to five protected groups
Red = Undeveloped	Outcome is met for one or two groups only or no groups at all OR No evidence can be found to prove outcome has been met

* "Protected groups" means characteristics which must not be used as a reason to treat some people worse than others. These are: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The grading assigned to each objective is then aggregated to determine the overall grading for each goal.

How we carried out our grading

Goals 1 and 2 were assigned to the Family Equality and Diversity (FED) Group and Goals 3 and 4 to the Staff Equality and Diversity (SED) Group. Similar approaches were taken by both groups although on separate occasions as the audience for the grading were quite different.

Goals 1 and 2

Evidence to enable the grading exercise was collected and collated, although it was quite difficult to collect evidence against some of the outcomes, purely because the data did not exist or was not accessible. Also, as a children's hospital, GOSH is in a rather different position to most other hospitals in that it could be argued that several protected groups are not relevant to children aged less than 16 years. An additional challenge is that in order to fully understand our service provision and its suitability for our users, we need to consider the protected characteristics of our patients' parents.

A small-scale workshop was held in early January with a mixture of public/parent members and representatives of most service delivery departments within GOSH. Public/parent members were recruited in a direct email to our FT Membership, resulting in six expressions of interest. Standing members of the FED Group were also invited, along with other members of staff showing interest in the topic.

In a two hour session, attendees were asked to work in pairs to 'vote' using sticky dots for the protected groups for whom we confidently felt we were meeting the outcome. Nine sheets (one for each outcome) were developed to make 'voting' as clear and simple as possible. Evidence for each

outcome was identified and displayed on the voting sheet above a grid showing each protected group covered by the Act.

After discussion in pairs, each attendee applied a sticky dot to the protected group(s) for whom they felt we were meeting the outcome. Attendees were advised to be mainly guided by the evidence provided, although if additional evidence was known, this could be added to the sheet for consideration by remaining pairs. Once each pair had 'voted', the sheet was passed on to the next pair and the process repeated until every pair had voted on each of the nine outcomes.

Goals 3 and 4

A short anonymous survey was sent out to all staff electronically in order to elicit their views regarding the nine outcomes which fall under goals three and four. A total of 270 staff responded. The responses, along with information gained from a legal review of GOSH staffing-related practices and policies and information from other sources such as the staff survey, were used as evidence to inform the grading process.

A workshop was held in January which was attended by members of SED, senior managers, staff-side, Foundation Trust shadow staff councillors and other key stakeholders. This enabled us to ensure that there were people present who could reflect the views and experiences of many of the protected groups including black and minority ethnic (BME) staff, lesbian, gay, bisexual and transgender (LGBT) staff and disabled staff. Attendees were split into small groups and each group considered the evidence presented and allocated a provisional grade for every outcome. At the end of the session final grades were discussed and agreed by consensus of the whole group.

Grading Results

Prior to the Equality Act 2010, statute concentrated on collecting data and reporting against race, sex and disability. Under the EDS, data has to be available on **more than five** protected groups to grade any outcome above developing (amber). Consequently most outcomes for the Trust have been rated as underdeveloped or developing on the basis that data about all protected groups is not available. Developing more complete data is an area that both FED and SED will be improving, and an area that the national systems used by the Trust will also need to address.

The following grading was reached following voting at the workshop for Goal 1 and 2:

Outcome	Grade assessed	Notes/Comments
1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well being and reduce health inequalities	Undeveloped	Policy in place but evidence only available for a couple of groups
1.2 Individual patients' health needs are assessed, and resulting services, provided, in appropriate and effective ways	Developing	Good evidence for three groups but little for others
1.3 Changes across services for individual patients are discussed with them and transitions are made smoothly	Developing	Good evidence for three groups but little for others
1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all	Undeveloped	Policy in place but little evidence of results available

1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups	Developing	Evidence available for few groups only
2.1 Patients, carers and communities can readily access services and should not be denied access on unreasonable grounds	Undeveloped	Little hard evidence available
2.2 Patients are informed and supported to be as involved as they wish to be in their diagnosis and decisions about their care and to exercise choice about treatments and places of treatments	Developing	Good evidence for three groups but little for others
2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised	Undeveloped	Strong evidence for some groups, little for others
2.4 Patients' and carers' complaints about services and subsequent claims for redress should be handled respectfully and efficiently	Undeveloped	Policy in place but little evidence of outcomes

The following grading was allocated at the workshop for Goal 3 and 4:

Outcome	Grade assessed	Notes/comments
3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades	Developing	Good recruitment processes but variable implementation by line managers possible.
3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing the same work in the same job being remunerated equally	Developing	Good staff-side engagement in banding decisions.
3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately	Developing	Variability of line manager influences access to training across the board and not in respect to any specific protected group.
3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all	Developing	New staff support service offering improved mediation.

3.5 Flexible working options are made available to all staff, consistent with the needs of patients and the way that people lead their lives	Developing	No central recording system of requests exists. Lots of people access.
3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population.	Achieving	Lots of initiatives in place and evidence that they are readily accessible to all protected groups. Planned further work to support managers dealing with mental ill health.
4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond.	Developing	Group felt that equality and diversity is upheld but no overt evidence for all protected groups. Many survey respondents couldn't comment.
4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination,	Developing	Managers have varying levels of skills.
4.3 The organisation uses the NHS Equality and Diversity competency framework to recruit, develop and support strategic leaders to advance equality outcomes	Not applicable	GOSH do not use this framework but have several other leadership and competency frameworks in place and work to support the development of equality and diversity across the organisation.

Great Ormond Street Hospital for Children NHS Trust

Trust Board 29th February 2012	
Approval of New Energy Contracts **Submitted on behalf of:** **Mr William McGill, Director of Redevelopment**	**Paper No: Attachment T**

The Contract starts on the 1st April 2012 and replaces the current PASA Framework which ends on the 31st March 2012. It has been set up by Buying Solutions (Government Procurement Services) and has been offered to NHS and MoD sites to give massive buying power. Buying Solutions have been purchasing electricity and gas for us since June 2011 on the whole market.

Buying Solutions have appointed EDF, British Gas and Corona as the suppliers of Half Hourly electricity, non-Half Hourly electricity and gas respectively. This means that we have entered into an agreement with Buying Solutions to purchase electricity and gas on our behalf on the whole market, and we now need to enter an agreement with these three suppliers to actually supply the energy and to invoice us. The contracts with the suppliers have been written by Buying Solutions on our behalf and are standardised.

The agreement with Buying Solutions lasts for three years and we need to give 6 month notice of leaving the agreement to take account of the fact that they are buying energy on the futures market.

As the agreement starts on the 1st April the new suppliers are requesting the transfer of meters from our current suppliers as soon as we have returned the contract to them. To note - if the transfer has not been successful by the 1st April then we will be in a situation where we are not in an agreement with any suppliers and will then enter a default 'Deemed Contract' with the current supplier and they will bill GOSH with rates of 25.5p/kWh until we successfully enter a new contract (we currently pay ~ 6.6p/kWh).

Action required from the meeting
To approve the contracts

Contribution to the delivery of NHS / Trust strategies and plans

Financial implications

	2012/13 Forecast	
	Electricity	Gas
2011/12 Budget	£ 2,017,423	£ 797,341
MSCB increase	£ 296,700	£ 50,212
Rate change 2012/13	-5%	11%
Total expected budget	£ 2,198,417	£ 940,784

Legal issues None
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place N/A
Who needs to be told about any decision Trust Board. Estates Managers
Who is responsible for implementing the proposals / project and anticipated timescales The Director of Redevelopment
Who is accountable for the implementation of the proposal / project Director of Redevelopment
Author and date William McGill Director of Redevelopment 29th February 2012

Great Ormond Street Hospital for Children NHS Trust

Trust Board
29th February 2012

Approval of Business Rates and NHSLA premium payments for 2012/13 **Submitted on behalf of:** Claire Newton /Bill McGill	**Paper No: Attachment U** **For APPROVAL**

Aims
To seek Board approval for two items of annual expenditure in excess of £1m
This is to comply with the Trust's SFIs

Summary
The Trust's annual business rates bill and the Trust's NHSLA insurance premium are both over £1M

Both amounts are payable in instalments during the year
Under the current version of the Trusts SFIs, this requires Trust Board approval for payment

RATES: We have not yet received the assessment for 201213 but we estimate that the annual rate expenditure including amounts payable for the MSCB will be £2.3M-£2.4M
The Trust Board are requested to authorise any two executive directors the authority to approve this expenditure up to £2.4M payable to LB Camden once the assessment has been received and validated by the Estates staff. It is likely that the MSCB element may be assessed later than for the existing buildings.
An analysis of the estimated value of this expenditure is included on page 2 of the paper

NHSLA PREMIUM:
The renewal premium has been notified at £2,455,000 payable to NHSLA
The Trust Board are requested to authorise this payment.
An analysis of the premium and an explanation of the basis on which it is calculated is included on page 3 of the paper

Action required from the meeting To approve the expenditure

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

Financial implications Routine expenditure

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

Who needs to be told about any decision? The Board

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

Who is accountable for the implementation of the action plan Estates

Author and date *Claire Newton 21.02.12*

Estimated annual expenditure with London Borough of Camden for Business rates 2012-13

Property	Description	Business Rates 2011-12 (£)	Business rates estimate for 2012-13	Estimated Cost pressure for 2012-13	
Main Hospital assessment excl.levels 6 & 7 of Cardiac block incls Octav Botnar	Hospital & Premises	1,037,370	1,095,463	58,093	5.6%
Weston House	Hospital & Premises	104,643	110,503	5,860	5.6%
Leasehold:					
York House - Bst-4th floor	Office & premises	387,315	409,005	21,690	5.6%
Grnd floor, 34 Great Ormond street	Hospital & Premises	3,377	3,567	189	5.6%
55/57 Great Ormond Street (Ground & second floor)	Offices & premises	1,197	1,264	67	5.6%
3rd floor rear, Ormond Hse, 26-27 Boswell St	Offices & premises	17,537	18,519	982	5.6%
Royal London Homoeopathic Hospital	Hospital & Premises	47,565	50,229	2,664	5.6%
3rd floor, 21-27 Lamb's Conduit St	Offices & Premises	37,029	39,103	2,074	5.6%
	TOTAL	**1,636,033**	**1,727,651**	**91,618**	5.6%
Morgan Stanley Clinical Building	Hospital & Premises		589,248	589,248	
Estimated annual rates expenditure payable to LB Camden				**2,316,899**	**680,866**

Notes on basis for estimate:

- The 5.6% estimated increase reflects the RPI increase in October 2011.
- the estimated liability for the Morgan Stanley Clinical Building has been provided by our rating advisers at Drivers Jonas Deloitte based on 1011 values and inflated by 5.6%. The rateable value for this building is due to be set by the Valuation Office following discussion with our rating advisers. Rates will become payable on the MSCB following beneficial occupation by the trust (this is likely to be in March.)

The NHSLA premium comprises amounts for unlimited cover on clinical negligence and £1M cover per incident for property and third party liability cover (Employers and Public Liability).

The amount of the premium compared with the previous year is as follows:

	2012/13	**2011/12**	
Clinical negligence	2,766,782	2,436,729	13.5%
Level 2 discount	(553,356)	(487,346)	13.5%
Third party liability	202,908	178,445	13.7%
Property	38,794	38,347	1.2%
	2,455,128	2,166,175	

The Trust receives a discount of 20% on its premium as it has been assessed at level 2. If it can meet Level 3 requirements it could achieve a further 10% discount on its premium but this would only commence in the financial year following the assessment

The clinical negligence premium is calculated based on rates for clinical staff depending on their professional qualifications and specialty in which they work. Approximately 94% of the premium relates to medical staff. The premium has increased by 13.5% as a result of an increase in medical staff and an average increase in rates of 10% for medical staff. The highest rate increases are for neurosurgery and orthopaedic trauma. In the main, the increases in rates for medical staff were 8.2%.

Trust Board 29th February 2012	
Key Performance Indicator report **Submitted on behalf of.** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment V**

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.

In response to a recent letter from David Flory, which outlined the need for organisations to remain focussed on key waiting time standards, the report has been updated to include:

- Proportion of patients that have been waiting longer than 6 weeks for one of 15 key diagnostic tests.
- Proportion of patients on a ticking Referral to Treatment (RTT) pathway that have been waiting longer than 18 weeks for treatment.

NHS London has approved a bid for quarter 4 Winter Access Funding. The bid supports the opening of 6 additional theatre sessions per week and four short stay surgical beds.

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

Action required from the meeting
Trust Board to note progress.

Contribution to the delivery of NHS / Trust strategies and plans
To assist in monitoring performance against internal and external defined objectives and NHS targets.

Financial implications
None

Legal issues
None

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Our lead Commissioner receives a copy of the executive summary on a quarterly basis.

Who needs to be told about any decision
Senior Management Team

Who is responsible for implementing the proposals / project and anticipated timescales
Each Trust objective task has an identified person responsible for implementation and an Executive Director nominated as the accountable officer.

Who is accountable for the implementation of the proposal / project
As above

Author and date
Janine Gladwell – Access & Capacity Manager. February 2012

KPI Exception report

1. Referral to Treatment – Incomplete Pathways

The Trust remained below the 92% incomplete pathway standard and breached the 95th centile target of 28 weeks in December, reporting a formal position of 86.3% and 31.5 weeks respectively. Steady progress continues to be made in reducing the overall Trust backlog. A trajectory has been set to achieve both the 92% and 95th centile targets by the end of March.

2. Inpatient Waiting List

All specialties within Surgery have undertaken a complete review of the planned waiting list and corrected all entries that should have been placed on the elective waiting list. This has had a significant adverse effect on the number of 26 week breaches.

In month performance has deteriorated with 268 patients waiting reported as over 26 weeks. Particular capacity issues have been identified across a number of specialties, including: Urology, Orthopaedics Dental & Maxillofacial, Plastic Surgery and Craniofacial.

Urology have reviewed their booking process and are currently 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. This is, in part, supported by the Winter Access Initiative funding from London SHA, which will enable the Trust to run a number of additional lists until the end of the year. Additional theatre capacity will be available in May 2012 following the opening of the Morgan Stanley building.

Due to consultant capacity issues Orthopaedics currently report 39 patients waiting over 26 weeks for surgery. Referrals are currently being reviewed, and where appropriate admitted under another consultant.

Following agreement at Management Board, a locum job description is being written in order to ease the capacity issues within 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.

3. Diagnostic Waits

In month performance has deteriorated with 30 patients waiting over 6 weeks for a key diagnostic test. Particular capacity issues have been identified within Urology and Gastroenterology.

Urology report 18 Cystoscopy patients breaching the standard. The service is currently managing the number of long waiting inpatients, which is putting pressure on the availability of theatre capacity to undertake diagnostic tests.

The unit is currently reviewing the number of slots available for clinically urgent patients to try and redress the balance of numbers of diagnostic breaches being reported. This is supported by the availability of NHS London Winter Access Funding to open six additional theatre slots and four short stay beds per week. In the longer term, further theatre time will made available to Urology following the opening of the Morgan Stanley building.

Gastroenterology report 8 Colonoscopy and 4 Gastroscopy breaches. Overnight bed and cubicle capacity issues have been identified on Rainforest Ward following a concentration of more complex patients for whom it is difficult to undertake home bowel preparation. The unit are currently reviewing the demand and capacity of this service and are developing an action

plan to resolve the position. As a primary step they are reviewing the availability of resource to enable earlier access to pre-op, so that the needs of the patient bed space can be understood at an earlier stage.

A 'deep dive' analysis report into Urology and Gastroenterology waiting times will be presented at March Management Board.

4. Cancelled Operations

In month, the percentage of cancelled operations (on the day of admission for non-clinical reasons) exceeded the national standard of 0.8% at 1.06%. This was largely due to a high number of cancelled operations within Cardiac - where intensive care beds were not available. The position will be monitored closely to ensure the Trust does not breach the quarter reporting standard.

5. Personal Development Review (PDR) completeness rates

Appraisal completion rates have remained fairly consistent during 2011 but are now beginning to decline. In month, the Trust rate is reported at 70% and 57% against a target of 80% for clinical and non-clinical areas respectively. A number of recommendations to improve performance are being implemented following a recent internal audit of the Trust staff appraisal process. These include:

- To investigate any department that consistently fails to meet the required target and develop an action plan to reduce level of non-compliance.
- To introduce a formal regular monitoring process within the Clinical Unit Board meetings with PDR being a standing item on the agenda of each meeting.
- To implement Clinical Unit level KPI reports which include PDR performance information.

A formal action plan will be submitted to March 2012 Management Board outlining how the Trust will achieve the 80% target.

6. Information Governance training

Performance remains consistent at 88.2% against a target of 95% for all staff trained on information governance. The lowest compliance rates are identified across Medical and Dental. Regular reports continue to be circulated to all departments. The need to complete training is reinforced at Management Board on a monthly basis and Clinical Unit performance is additionally reviewed through the Quarterly Strategic Review meetings. To ensure that rates are maintained, a simplified training process has been implemented for staff that require an annual update.

Escalation to the February 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.

Performance Measure	Change	Clinical Unit	Narrative
Total WHO checklist completion (Chart 1)		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 2)		MDTS	An improvement has been observed on Rainforest ward 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 – per bed day in CICU (Chart 3)		Cardio Respiratory	The Unit held a Multidisciplinary Medicine Safety Week with a different theme each day. Day 1: Focused on Top 10 Drug Errors Day 2: Human Factors Expert came in to discuss communication between teams and how to communicate up and down the hierarchy Day 3: Live stories of drug errors. Doctor came in who gave a wrong drug and patient died. Unit had 0 drug errors for the following 2 days. Day 4: Focused on re education on smart pumps, guardrails and electronic calculator Day 5: Drug quiz
Prescribing errors – non-clinical – per bed day in CICU (Chart 4)		Cardio Respiratory	As Above

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

Appendix 1

Chart 1
MDTS

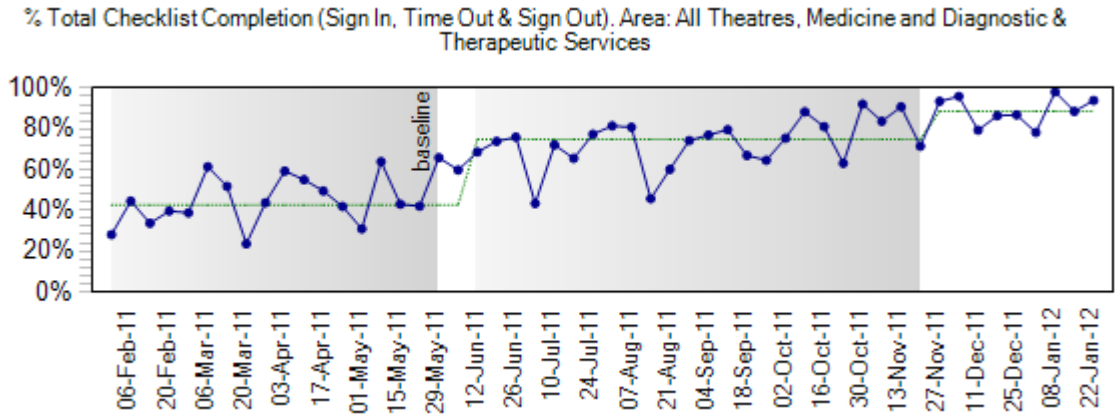


Chart 2
MDTS

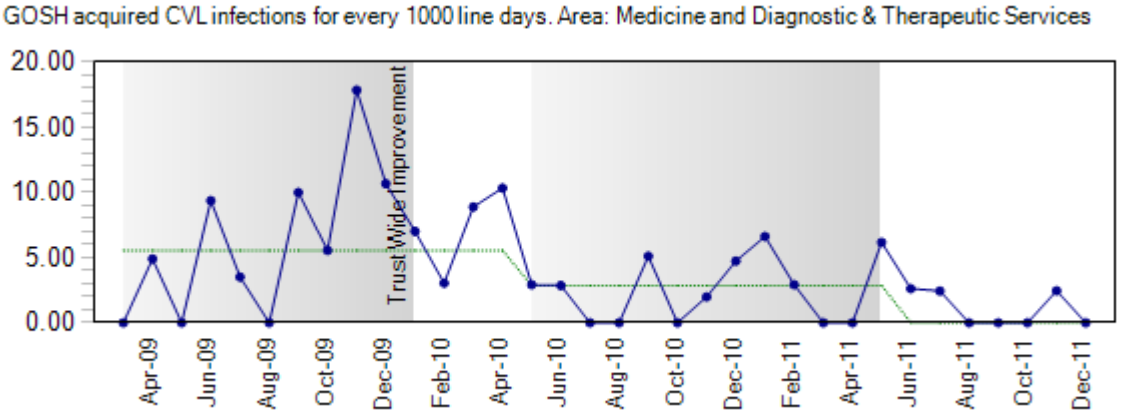


Chart 3
Cardio Respiratory

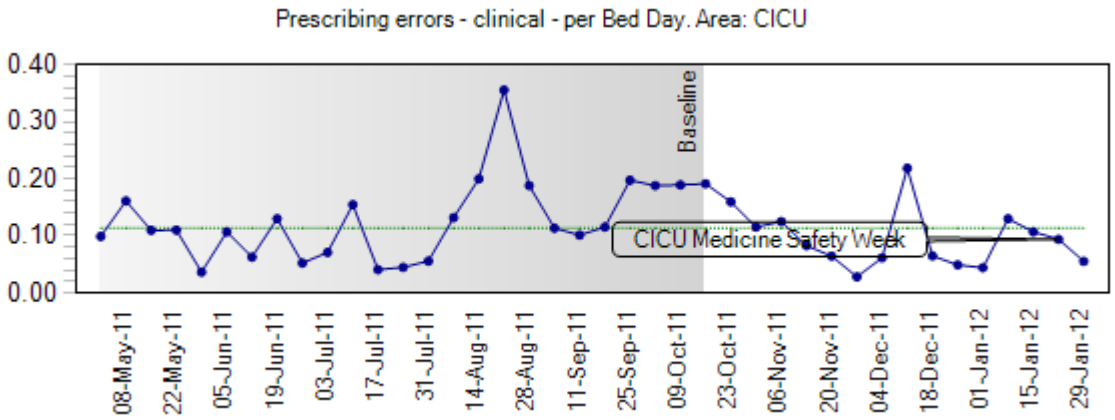
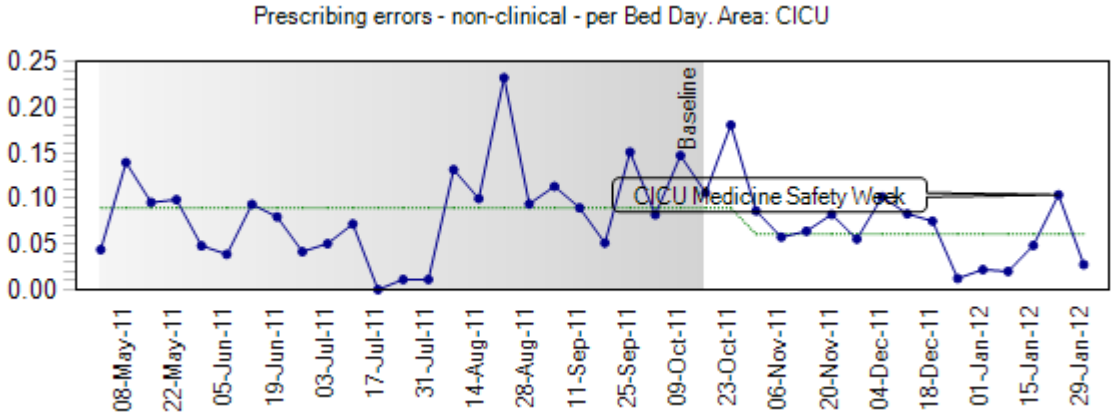


Chart 4
Cardio Respiratory



Recommendations:
Trust Board to note progress

Great Ormond Street Hospital for Children NHS Trust

Trust Board

Key Performance Indicator Report

Jan-12

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	Jan-12	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4
Objective 1	Incidence of C.difficile	5	Monthly	7.5	7	0	2	1	1	0	1	1	0	1	0	0	4	2	1	
	Incidence of MRSA**	5	Monthly	0	4	0	1	0	1	0	0	0	0	1	1	0	2	0	2	
	Incidence of MSSA	5	Monthly	11/12 setting the baseline	19	3	1	1	0	2	0	3	3	3	3	3	2	5	9	
	Incidence of E-Coli	5	Monthly	11/12 setting the baseline	16	3	0	0	1	1	3	1	3	1	3	3	1	5	7	
	No. of NICE recommendations unreviewed	5	Monthly	0	-	1	3	6	7	8	11	0	2	1	3	1	7	0	3	
	CV Line related blood-stream infections	6	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	2.2	2.00	2.33	1.58	
	Mortality Figures	6	Monthly	Within tolerance	90	8	7	8	11	4	11	8	9	12	12	8	26	23	33	
	Serious Patient Safety Incidents	6	Monthly	Within tolerance	20	3	2	0	4	1	4	0	2	1	3	3	6	5	6	
	Surgical Check List completion rate (%)	7	Monthly	95.0	82.3	89.3	72.1	71.5	77.4	83.6	80	83.7	84.6	86.1	89.7	89.3	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	
Objective 2	18 week referral to treatment time performance - Admitted (%)	8	Monthly	90	93.6	94.1	91.2	91.3	94.8	92.4	96.1	95.7	95.4	90.5	94.1	Data available in March	92.7	94.7	92.9	
	18 week referral to treatment time performance - Non-Admitted (%)	8	Monthly	95	69.4	96.5	97.7	97.6	97.0	96.8	95.1	96.0	95.9	96.3	96.5	Data available in March	97.1	95.9	96.2	
	18 week referral to treatment time performance - Incomplete Pathways (%)	8	Quarterly	92	80.8	86.3	77.5	72.5	76.2	77.6	88.3	85.5	86.7	83.8	86.3	Data available in March	76.2	85.5	85.4	
	Inpatients waiting list profile (26+)	8	Monthly	0	-	268	66	73	64	71	163	118	148	132	199	268	64	118	199	-
	95th Centile - Admitted	8	Monthly	<23 weeks	20.5	22.3	21.8	21.3	19.2	21.5	17.8	17.9	18.0	22.7	22.3	Data available in March	20.7	18.3	21.5	
	95th Centile - Non-Admitted	8	Monthly	<18.3 weeks	17.7	17.8	17.6	17.7	17.5	17.5	18.0	17.8	17.9	17.8	17.8	Data available in March	17.6	17.7	17.8	
	Median Waits - Admitted	8	Monthly	<11.1 weeks	10.3	8.6	9.5	8.9	11.4	11.3	9.4	9.6	10.3	10.0	8.6	Data available in March	10.0	10.1	10.1	
	Median Waits - Non-Admitted	8	Monthly	<6.6 weeks	7.0	6.5	7.0	8.2	7.1	6.7	6.5	6.9	7.7	6.7	6.5	Data available in March	56.0%	6.7	7.2	
	95th Centile - Incomplete Pathways	9	Monthly	<28 weeks	33.7	31.5	33.8	36.6	37.4	36.5	25.7	27.9	27.9	32.7	31.5	Data available in March	37.0	30.5	30.0	
	Median Waits - Incomplete Pathways	9	Monthly	<7.2 weeks	8.0	6.9	8.7	9.8	9.0	8.1	7.0	7.6	7.3	6.9	6.9	Data available in March	9.1	7.6	7.1	
	Discharge summary completion (%)	9	Monthly	95	79.1	78.2	74.3	77.2	77.2	80.8	80.4	74.9	81.9	81.2	81.4	78.2	76.3	78.4	81.5	
	DNA rate (new & f/up) (%)	9	Monthly	10	8	9	8.8	8.8	8.4	7.9	9.1	8.7	8.2	8.9	7.7	9	8.0	8.0	8.0	
	Cancelled Operations on day of admission (%)	10	Monthly	0.80	0.78	1.06	0.65	0.86	0.74	0.73	0.71	0.78	0.77	0.78	0.74	1.06	0.75	0.74	0.76	
	Percentage of Cancer patients waiting no more than 31 days for second of subsequent treatment - Surgery	10	Monthly	94	100	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	10	Monthly	98	100	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	10	Monthly	94	100	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.	11	Monthly	85	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	11	Monthly	<=1	1.75	4.38	1.04	0.21	0.18	1.35	1.06	0.42	1.78	4.00	4.38	Data available in March	0.50	0.94	3.42	
	Number of complaints	11	Monthly	New indicator to be confirmed	109	8	21	8	12	9	10	13	7	16	5	8	41	32	28	
	Number of complaints by grade Low	11	Monthly	New indicator to be confirmed	51	2	6	1	3	3	6	8	7	11	4	2	10	17	22	
	Number of complaints by grade Medium	11	Monthly	New indicator to be confirmed	48	4	13	7	9	6	2	3	0	4	0	4	29	11	4	
	Number of complaints by grade High	11	Monthly	New indicator to be confirmed	10	2	2	0	0	0	2	2	0	1	1	2	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	Jan-12	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4
	Theatre Utilisation (% Patient Operation Utilisation of Scheduled Duration, U4)	12	Monthly	70	-	70.3	72	74.3	70	71.4	67.4	69.3	70.9	67.3	50.1	70.3	72.1	69.4	62.6	
Objective 3	New to follow up ratio	13	Monthly	4.18	4.4	-	4.4	4.3	4.6	4.2	4.4	4.4	4.3	4.1	4.5	Data available in March	4.4	4.3	4.3	
	Patient refusals	13	Monthly	To reduce	250	40	28	22	19	27	9	18	20	31	36	40	69	54	87	
	Clinical Income variance (£)	13	Monthly	-	-	-1,211,135	0	1,053,912	278,133	48,168	-511,511	-1,184,496	-1,436,184	-1,336,486	-1,610,703	-1,211,135	278,133	-1,184,496	-1,610,703	
Objective 4	Number of Active Research Projects	14	Monthly	-	-	566	648	639	625	622	618	604	607	599	573	566	1912	1844	1779	
	UKCRN Portfolio Studies	14	Monthly	-	-	106	95	97	98	99	98	98	101	103	105	106	290	295	309	
	Clinical trials recruitment portfolio	14			-	26	117	124	162	118	151	88	90	131	77	26	403	357	298	
	GOSH Research Grants (£)	14	Monthly	-	-	130,508	53,502	42,244	60,558	495,853	27,500	218,142	247,175	189,896	75,000	130,508	156,304	741,495	512,071	
	Research Grant Awards (£)	14	Monthly	-	-	165,535	465,797	1,447,693	1,052,451	2,220,191	806,276	1,381,638	3,622,018	500,098	361,712	165,535	2,965,942	4,408,105	4,483,828	
	Patient safety reports for GOSH-sponsored clinical trials	15	Monthly	-	7	1	1	0	3	0	0	1	0	1	0	1	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	10,705,790	-	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	10,705,790	16,525,262	15,835,800	11,013,621	
	Bank and agency total expenditure (£)	17	Monthly	To Reduce	-	1,168	1,253	1,152	1,312	1,577	1,338	1,721	1,618	1,454	1,143	1,168	3,717	4,636	4,215	
	Monitor Risk Rating	17	Monthly	3	-	3	2	2	3	3	3	3	3	3	3	3	3	3	3	
	Charity fundraising income (£)	18	Monthly	43,682,622	48,577,280	4,877,280	2,899,725	3,324,829	4,212,132	5,929,690	4,032,098	8,254,528	4,919,193	5,799,095	4,328,710	4,877,280	10,436,686	18,216,316	15,046,998	
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	-	-	3,383			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	80	-	70.3	73.3	75.7	75.9	77.6	75.9	72.1	68.6	66.2	69	70.3	75.9	72.1	69	
	Staff PDR completeness - non clinical (%)	20	Monthly	80	-	57	73	74.9	73	72.3	71.1	65.8	61.9	57.2	54.5	57	73	65.8	54.5	
	Information Governance Training (%)	20	Monthly	95	-	88.2	34.15	51.86	82.96	85.53	88.36	89.76	86.90	87.70	87.7	88.2	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

Great Ormond Street Hospital for Children NHS Trust

Appendix 1. Glossary

	Graph	Tolerance		
		On Target	Of Concern	Action Required
		Green	Amber	Red
Objective 1	Incidence of C.difficile	Less than YTD Target	Within 10% of YTD Target	Worse than 90% of YTD Target
	Incidence of MRSA	0 Cases	Trajectory less than 6 Cases**	Trajectory greater than 6 Cases
	Incidence of MSSA	First Year of Recording		
	Incidence of E-Coli	First Year of Recording		
	Surgical Check List completion rate %	Greater than 95%	Between 85% and 95%	Less than 85%
	No. of NICE recommendations unreviewed	Less or equal to 1	2or 3	Greater than 3
	48 Hour readmission to ITU	Less than 3%	Less than 3.3%	Greater than or equal to 3.3%
	Mortality Figures	Indicator		
	Serious Patient Safety Incidents	Indicator		
	CV Line related blood-stream infections	Less than 1.5	Between 1.5 and 2.5	Greater than 2.5
Objective 2	Discharge summary completion (%)	Greater than or equal to 95%	Between 75% and 95%	Less than 75%
	DNA rate (new & f/up) (%)	Less than 9	Either 9 or 10	Greater than 10
	Theatre Utilisation (Patient Operation Utilisation of Scheduled Duration U4)	Greater than 70%	Equal to or between 65% and 70%	Less than 65%
	18 week referral to treatment time performance - Admitted	Greater than 91%	-	Less than 90%
	18 week referral to treatment time performance - Non-Admitted	Greater than 96%	-	Less than 95%
	18 week referral to treatment time performance - Incomplete Pathways	Greater than 92%	-	Less than 92%
	95th Centile - Admitted	Less than 23 weeks	-	Greater than 23 weeks
	95th Centile - Non-Admitted	Less than 18.3 weeks	-	Greater than 18.3 weeks
	95th Centile - Incomplete Pathways	Less than 28 weeks	-	Greater than 28 weeks
	Median Waits - Admitted	Less than 11.1 weeks	-	Greater than 11.1 weeks
	Median Waits - Non-Admitted	Less than 6.6 weeks	-	Greater than 6.6 weeks
	Median Waits - Incomplete Pathways	Less than 7.2 weeks	-	Greater than 7.2 weeks
	Number of complaints	No RAG status - Plan not confirmed		
	Number of complaints by grade Low	No RAG status - Plan not confirmed		
	Number of complaints by grade Medium	No RAG status - Plan not confirmed		
	Number of complaints by grade High	No RAG status - Plan not confirmed		
	Percentage of Cancelled Operations	Equal to or less than 0.8%	-	Greater than 0.8%
	Percentage of patients waiting no more than 31 days for second of subsequent treatment - Surgery	Equal to 100%	Greater than or equal to 95%	Less than 94%
	Percentage of patients waiting no more than 31 days for second of subsequent treatment - Drug	Equal to 100%	Greater than or equal to 99%	Less than 98%
	Percentage of patients waiting no more than 31 days for second of subsequent treatment -	Equal to 100%	Greater than or equal to 95%	Less than 94%
	Maximum waiting time of one month from diagnosis to treatment for all cancers.	Equal to 100%	Greater than or equal to 95%	Less than 85%
	Inpatients waiting list profile (26+)	0 Breaches	Between 0 and 10	Greater than 10
Objective 3	New to follow up ratio	Less than 4.18	-	Greater than 4.18
	Patient refusals	Indicator		
	Clinical Income variance	Indicator		

Objective 4	Patient safety reports for GOSH-sponsored clinical trials	No RAG status - Plan not confirmed		
	Clinical trials recruitment portfolio	No RAG status - Plan not confirmed		
	Number of Active Research Projects	No RAG status - Plan not confirmed		
	GOSH Research Grants (£)	No RAG status - Plan not confirmed		
	Research Grant Awards (£)	No RAG status - Plan not confirmed		
	UKCRN Portfolio Studies	No RAG status - Plan not confirmed		
Objective 5	MADEL SLA Value (£)	No RAG status - Plan not confirmed		
	SIFT SLA Value (£)	No RAG status - Plan not confirmed		
	NMET SLA Value (£)	No RAG status - Plan not confirmed		
Objective 6	Monitor Risk Rating	Equal to 3	-	Less than 3
	Charity fundraising income	Within - 5% Variance from Plan	More than - 5% Variance from Plan	More than - 15% Variance from Plan
	Bank and agency total expenditure	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	Q2	Month 10
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0	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	0
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	0
	Surgery	94%			0	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	0
	radiotherapy (from 1 Jan 2011)	94%			0	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	0
5	Non-Admitted 95thCentile Performance	<18.3 weeks	1	Quarterly	0	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	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	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

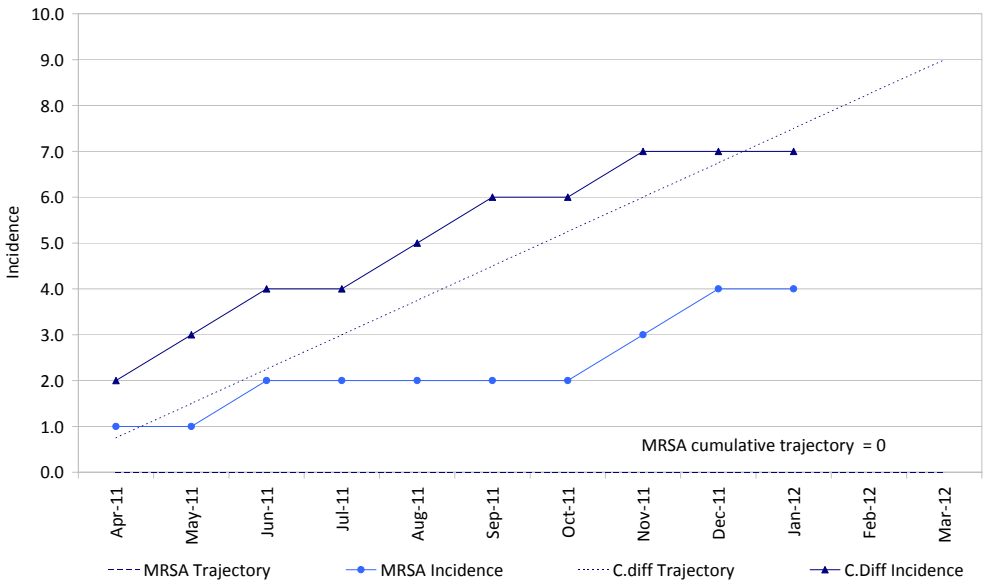
Monitor Quality Governance framework assessment (Feb 2012)

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 • Updated quality strategy	Green
1B: Is the Board sufficiently aware of potential risks to quality?	Amber / Green (0.5)	**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	Green		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 / Green (0.5)	**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	Amber / Green (0.5)
4C: Is quality information used effectively?	Green		Green
Overall score	**4**		**1**

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

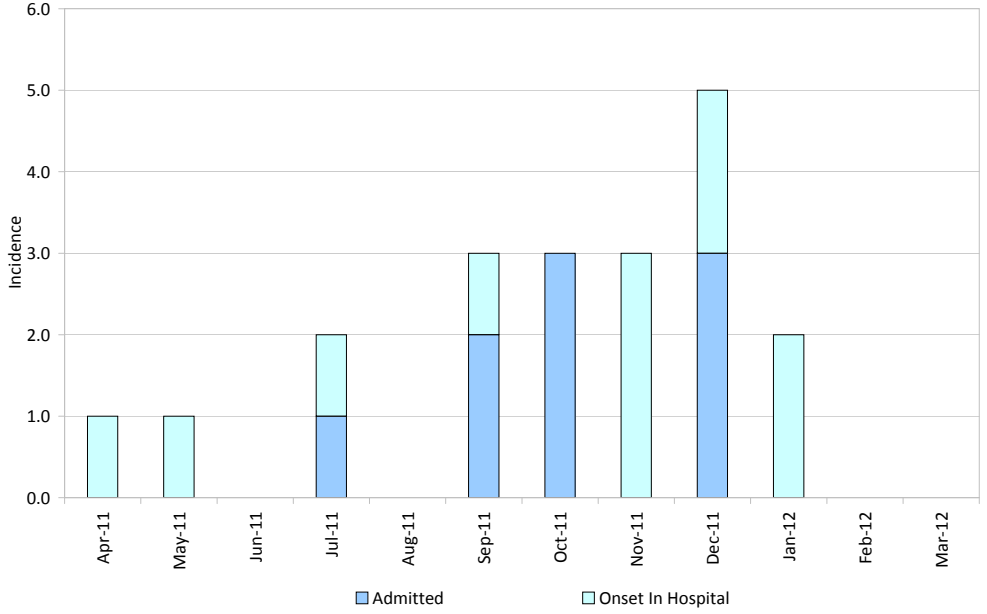
Graph 1. Incidence of MRSA and Cdifficile (cumulative totals)

National Target



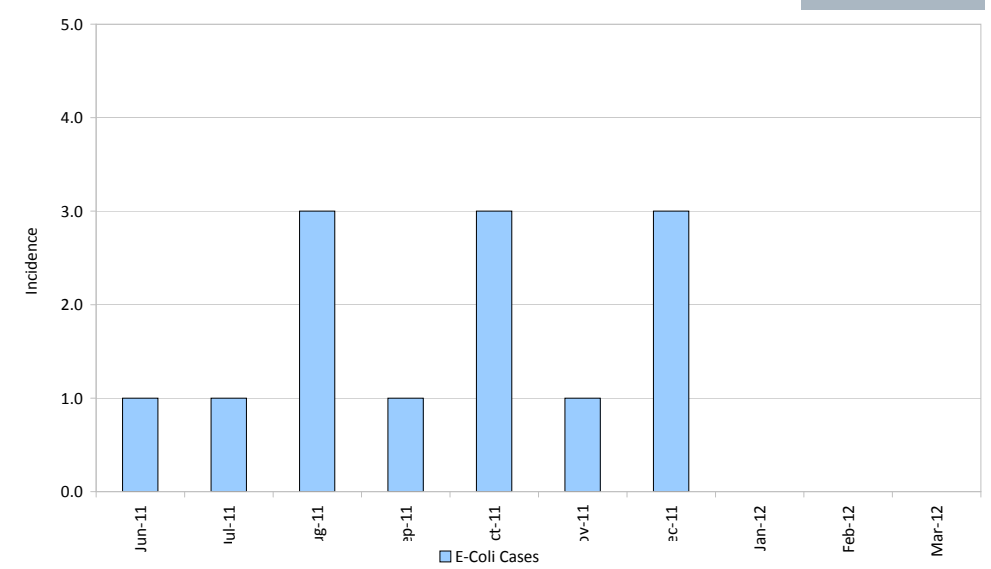
Graph 2. Incidence of MSSA

National Target



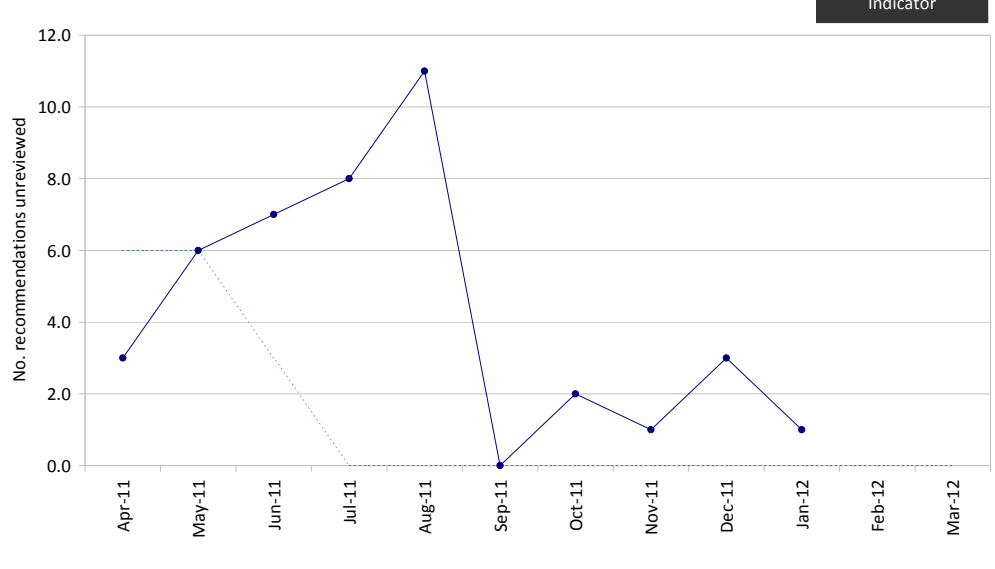
Graph 3. Incidence of E-Coli

National Target



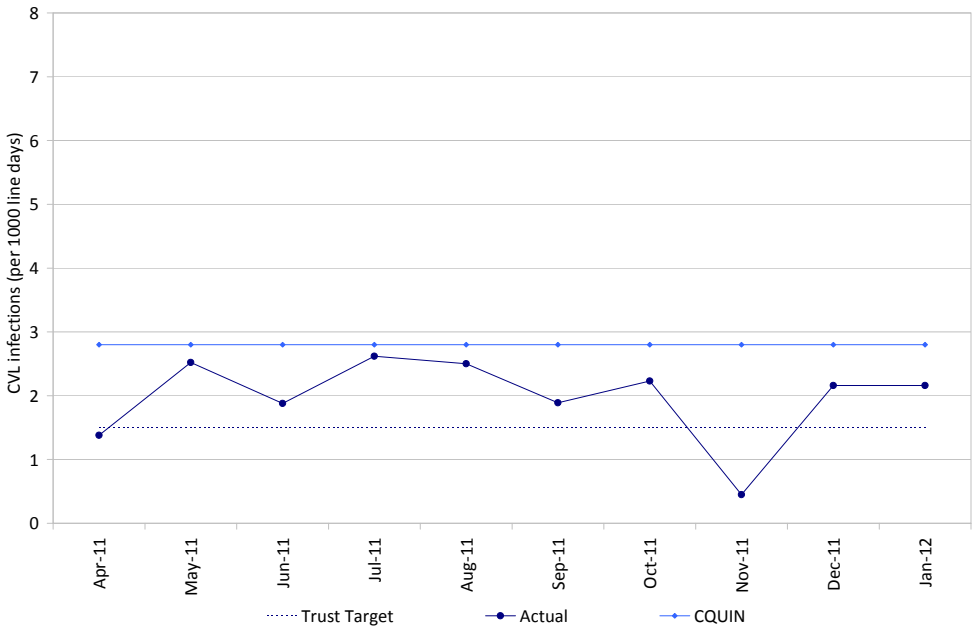
Graph 4. No. of NICE recommendations unreviewed

Internal Indicator



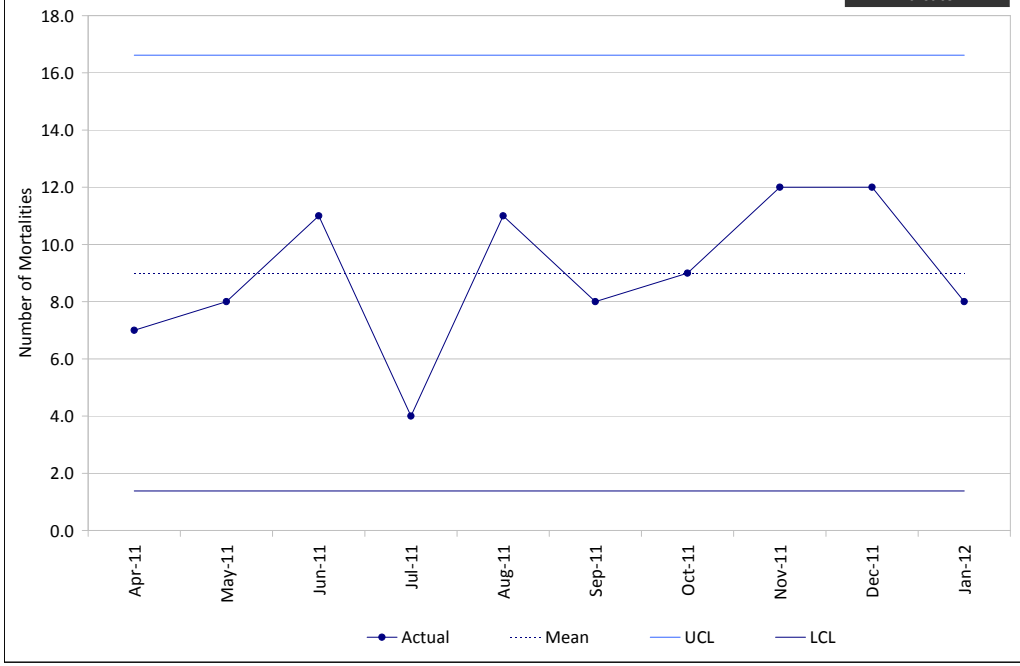
Graph 5. CV Line Infections (per 1000 bed days) - All areas

CQUIN Measure



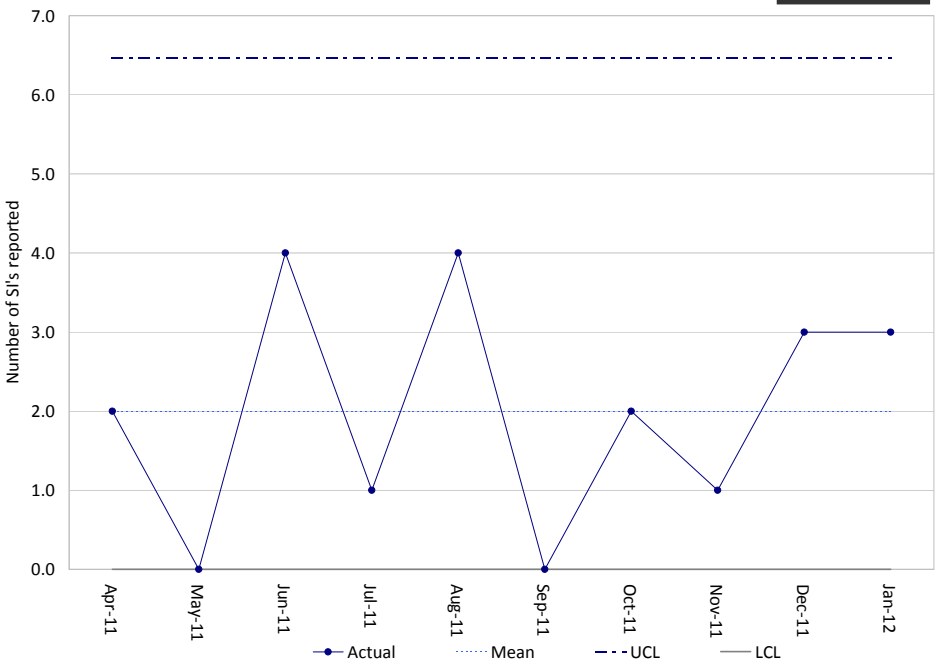
Graph 6. Mortality Figures - where discharge reason is 'Died'.

Internal Indicator



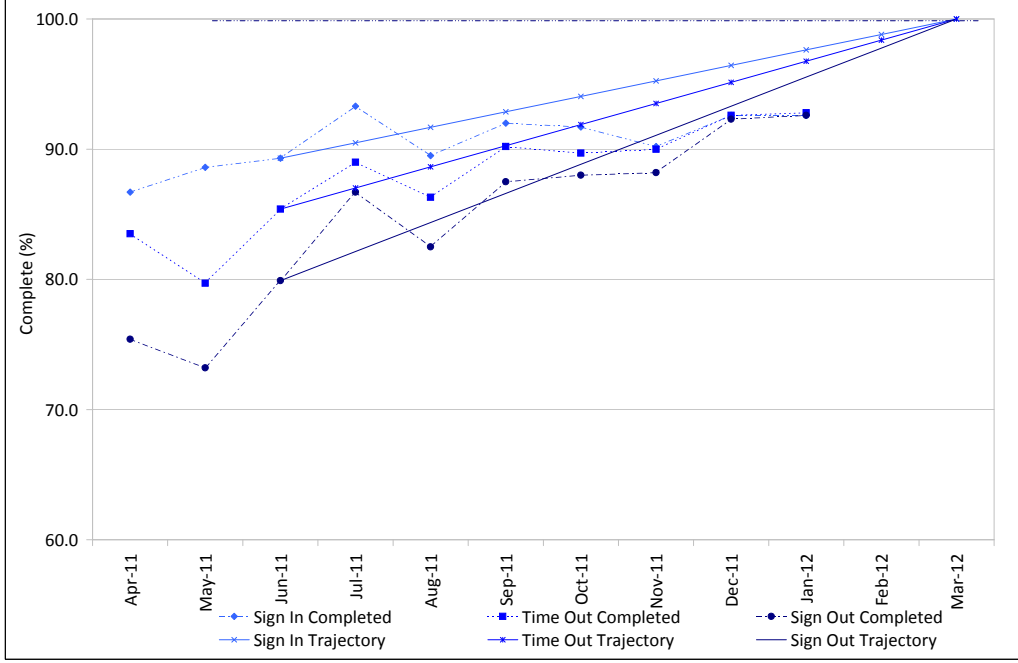
Graph 7. Serious Incidents Aug 2007 - May 2011

Internal Indicator

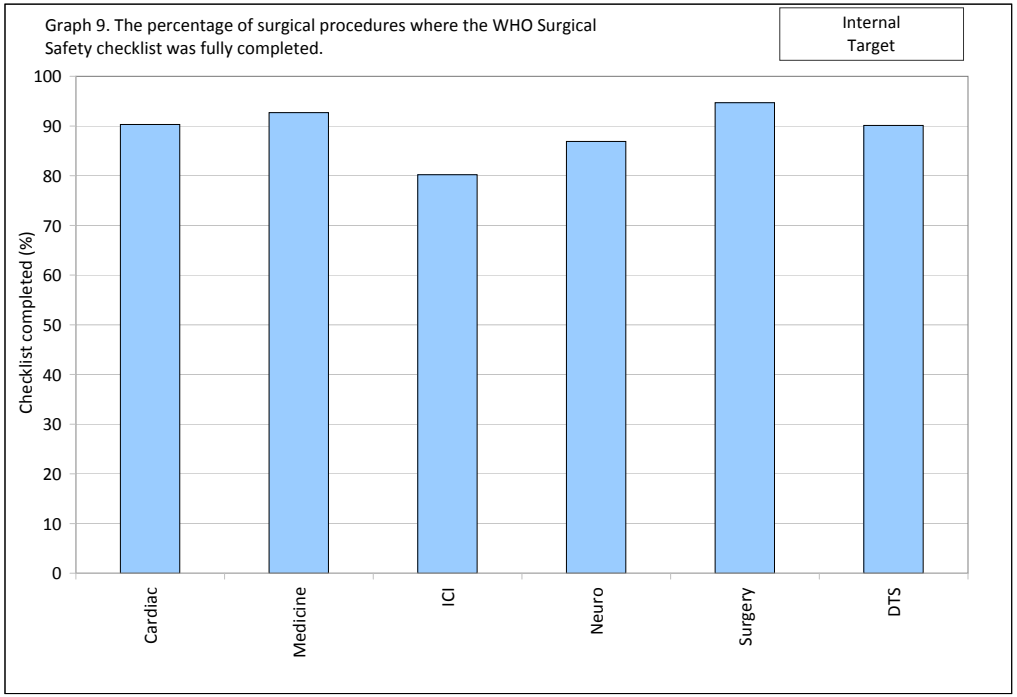


Graph 8. Theatre Patient Safety Checklist Completion rates against total operations

Internal Target



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

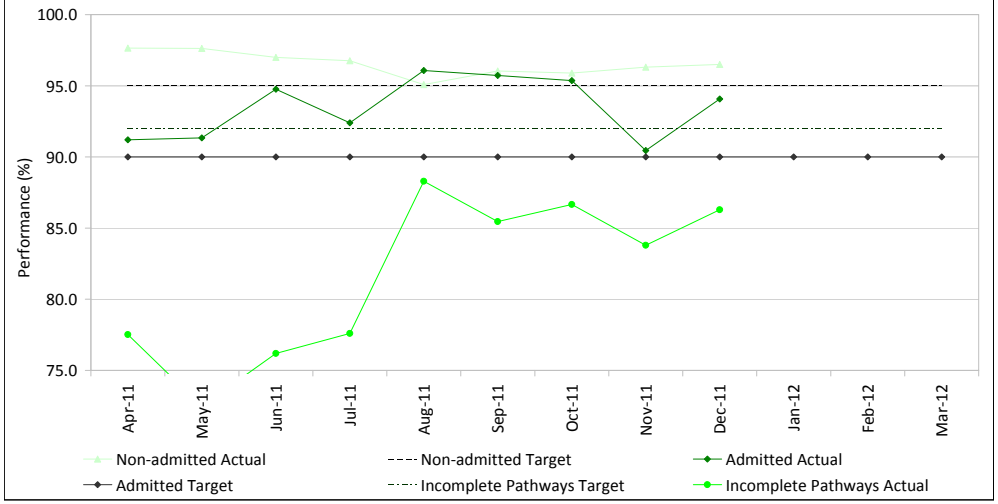


Great Ormond Street Hospital for Children NHS Trust

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

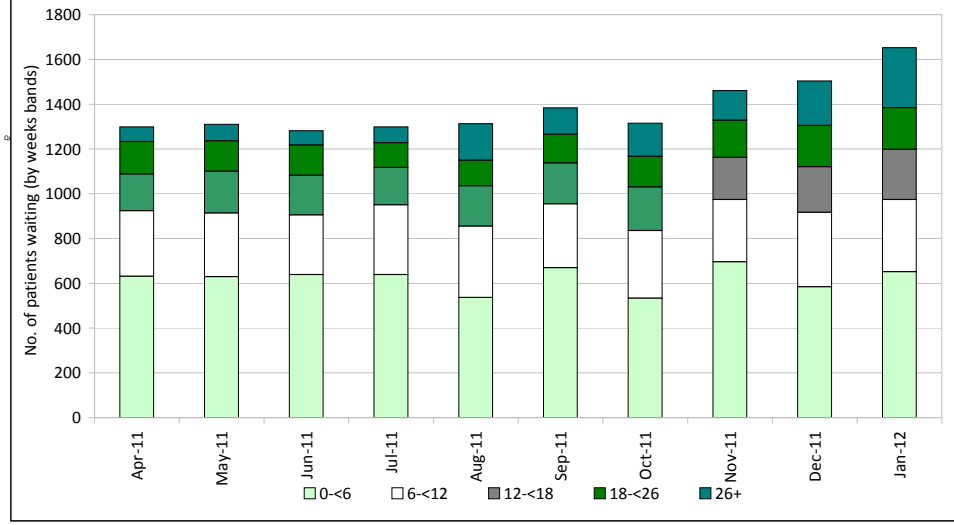
Graph 10. 18 week referral to treatment time performance

Contractual Target



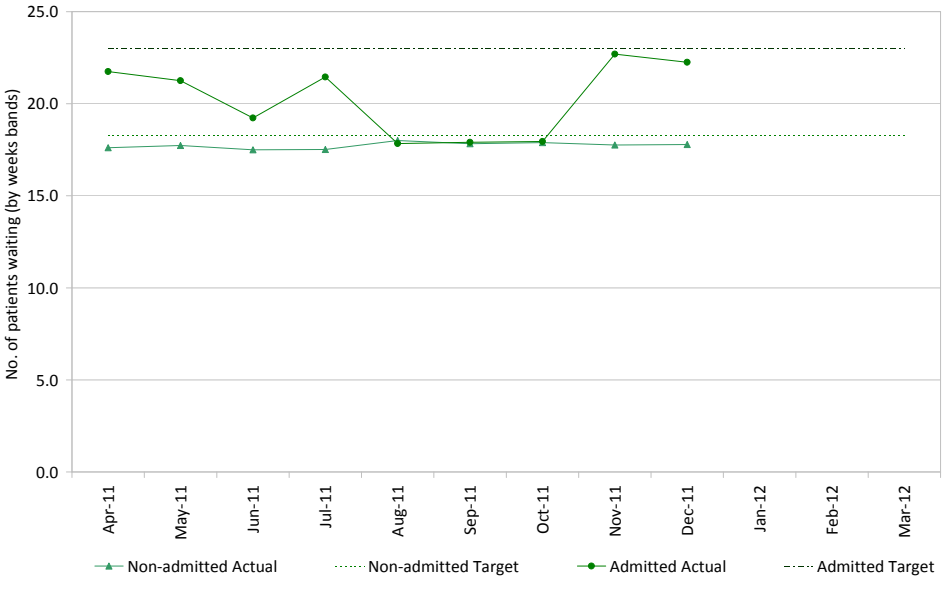
Graph 11. Inpatients waiting list profile by weeks waiting

Internal Indicator



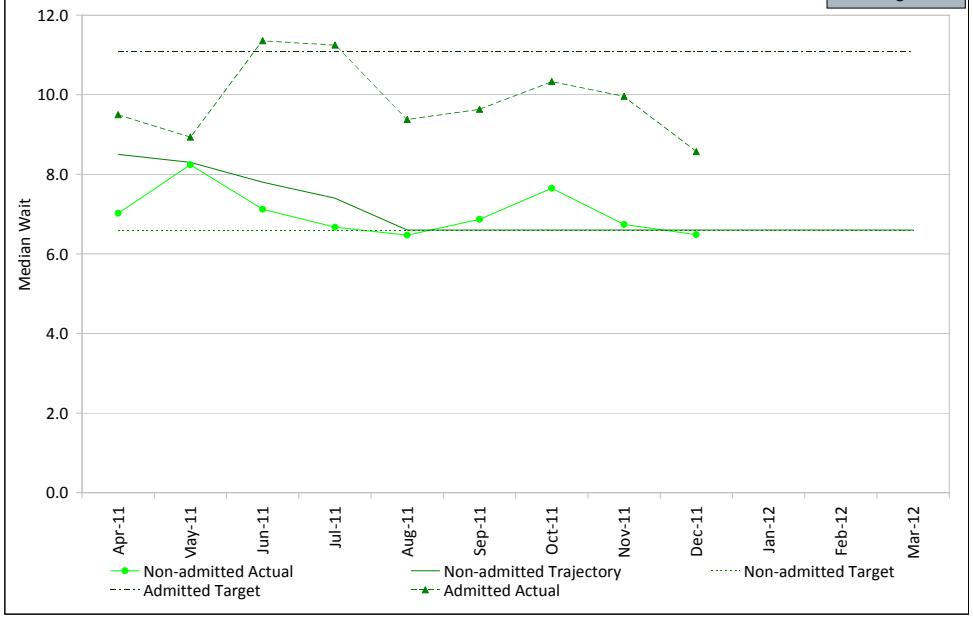
Graph 12. 95th Centile RTT performance against target (admitted and Non-admitted)

Contractual Target



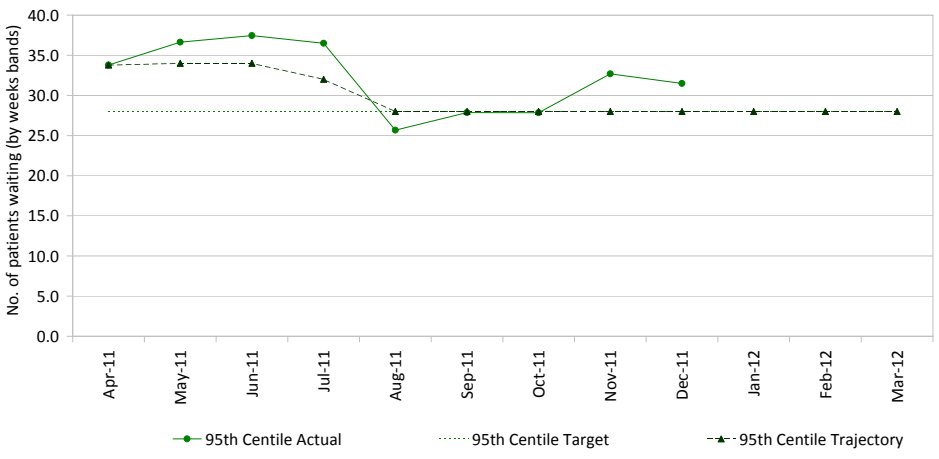
Graph 13. Median Wait RTT performance against target (Admitted and non-Admitted)

Contractual Target



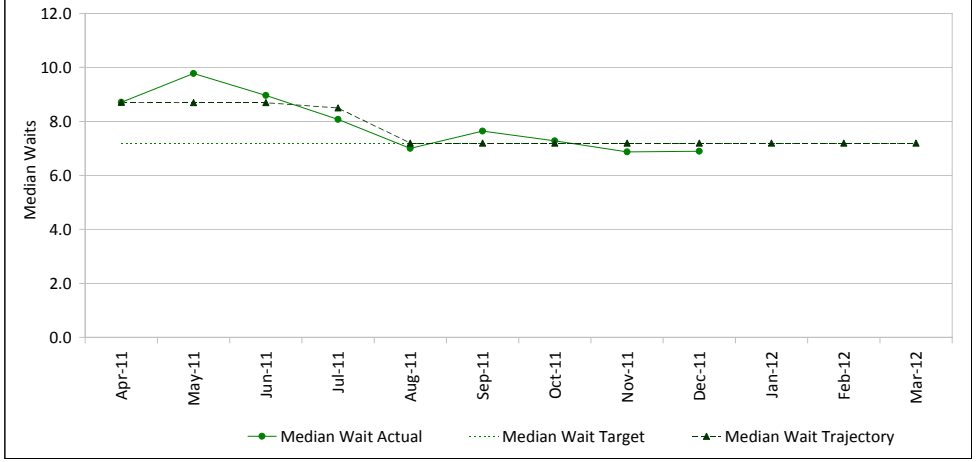
Graph 14. 95th Centile - Incomplete pathways

Contractual Target



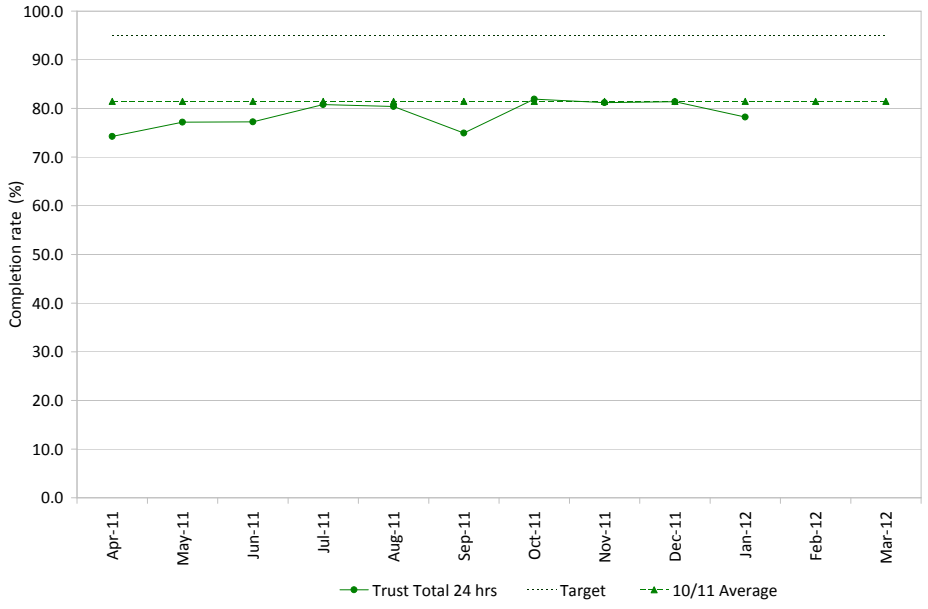
Graph 15. Median Waits - Incomplete pathways

Contractual Target



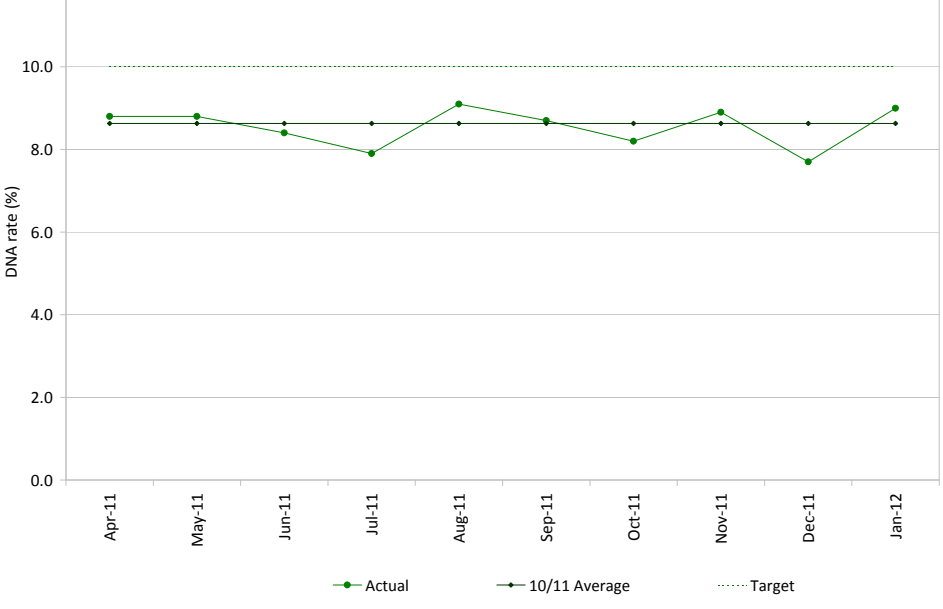
Graph 16. Trust wide discharge summary completion rates (within 24 hours)

Internal Target



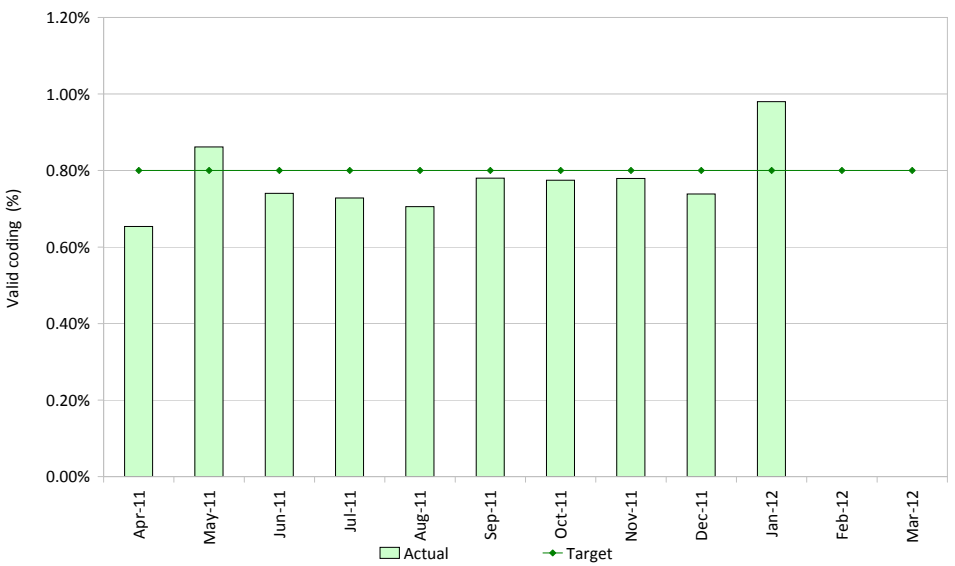
Graph 17. DNA rate (New and Follow-up patients)

Internal Target



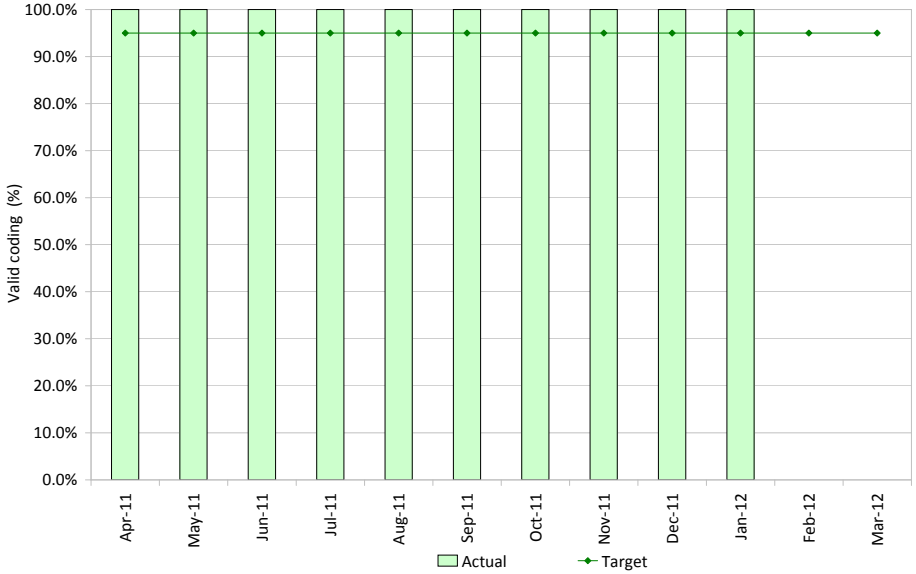
Graph 18. Percentage of all Cancelled Operations as a proportion of total elective spells

Contractual Target



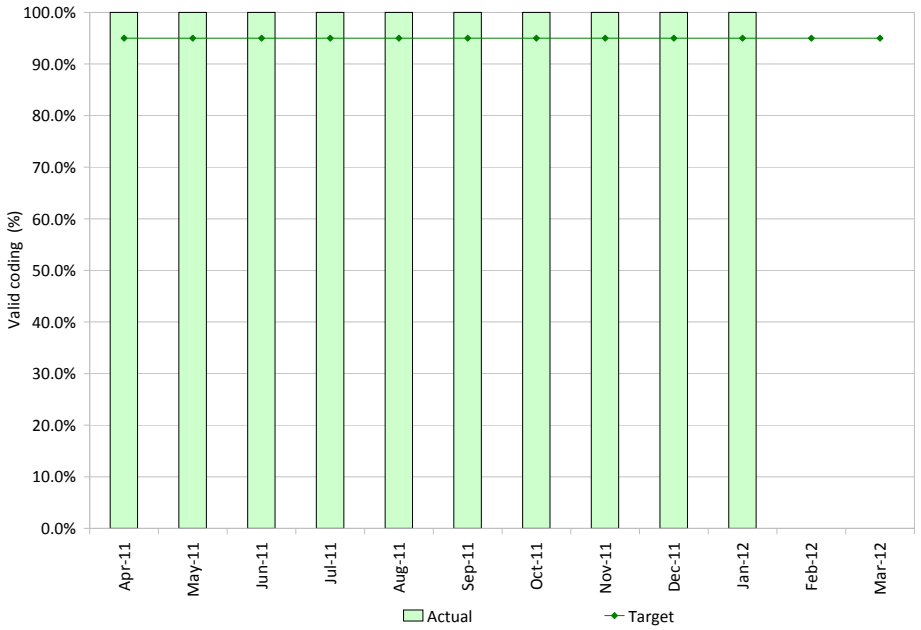
Graph 19. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - surgery

National Target



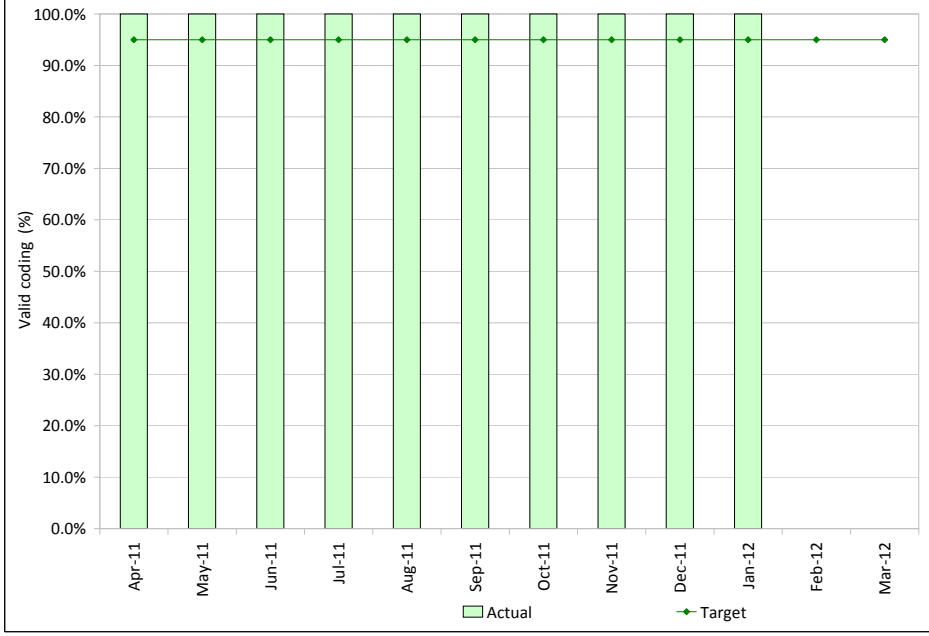
Graph 20. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - drug treatments

National Target



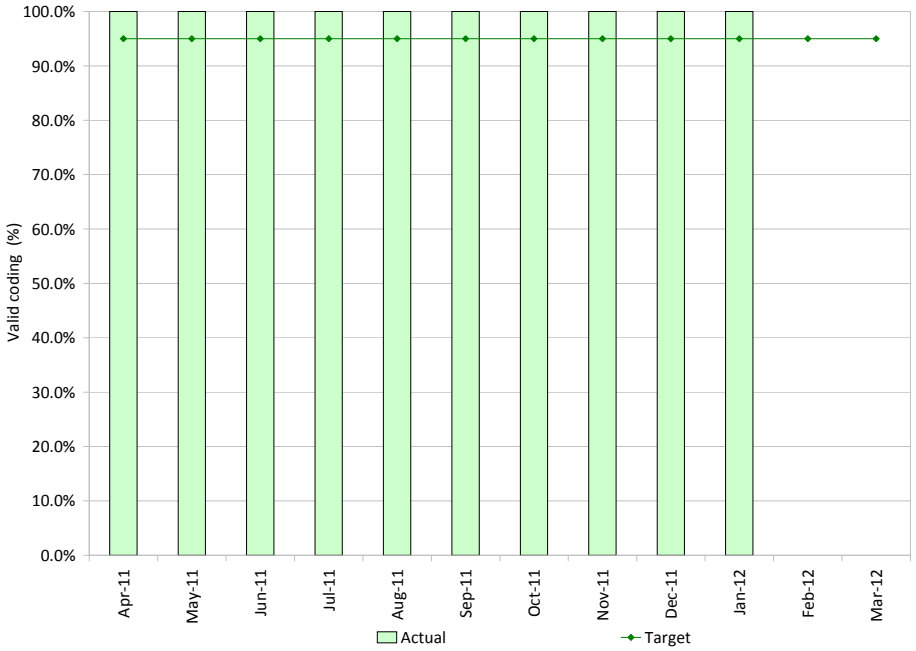
Graph 21. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - radiotherapy

National Target



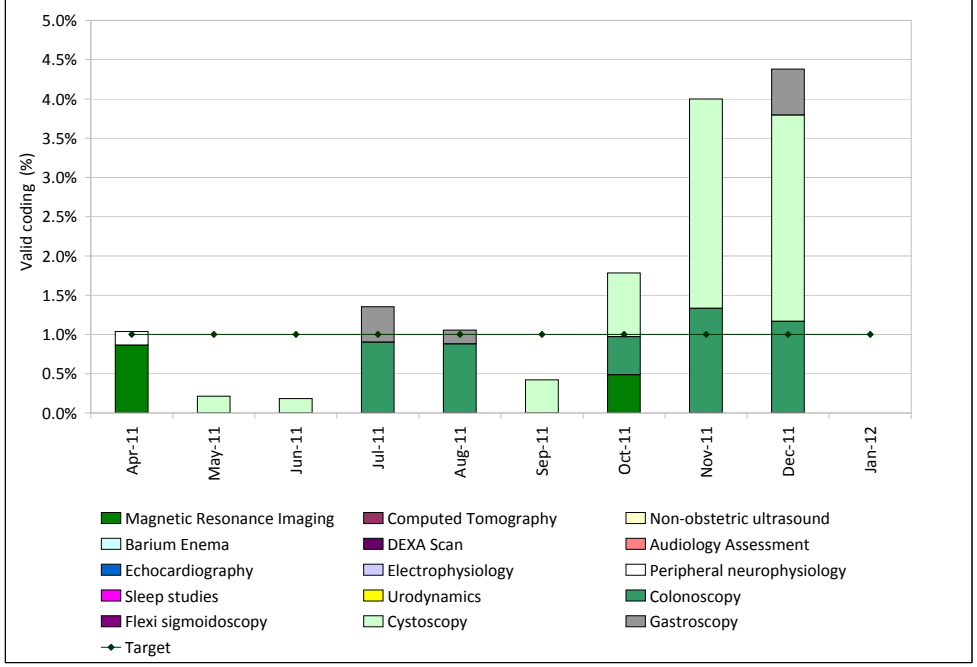
Graph 22. Proportion of Cancer patients waiting no more than 31 days from diagnosis to treatment - all cancers

National Target

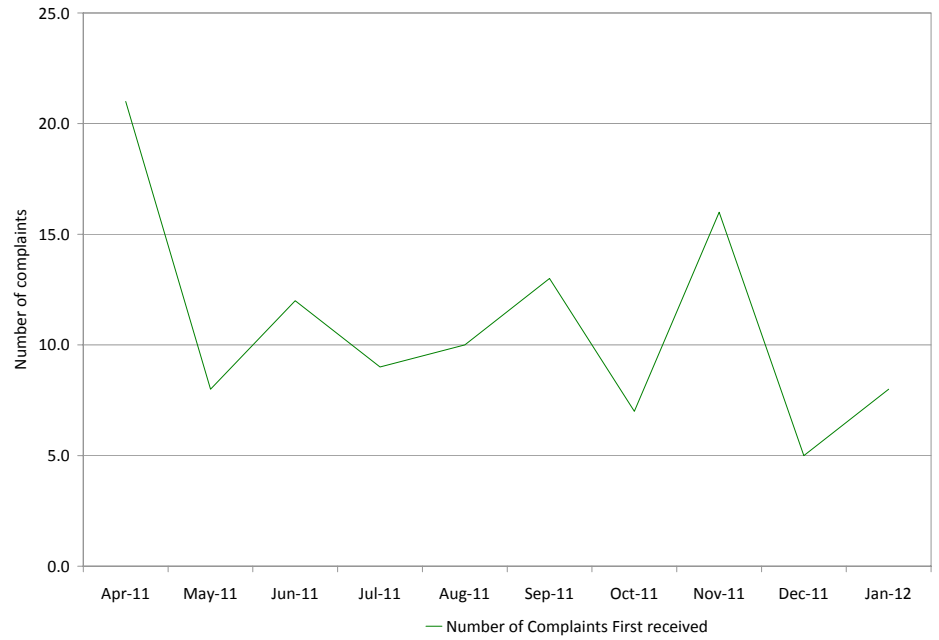


Graph 23. Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests

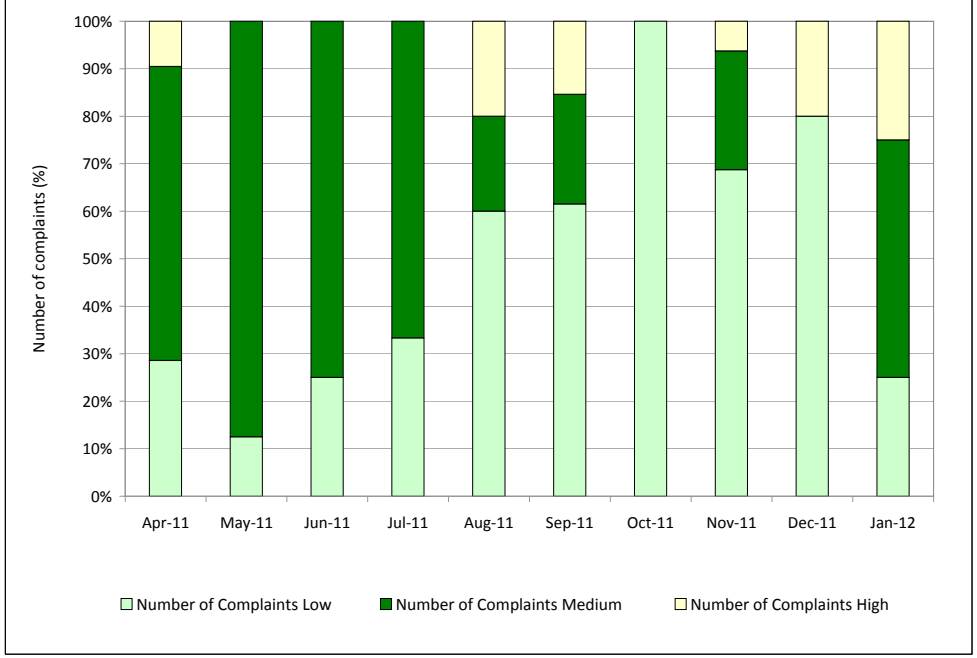
National Target



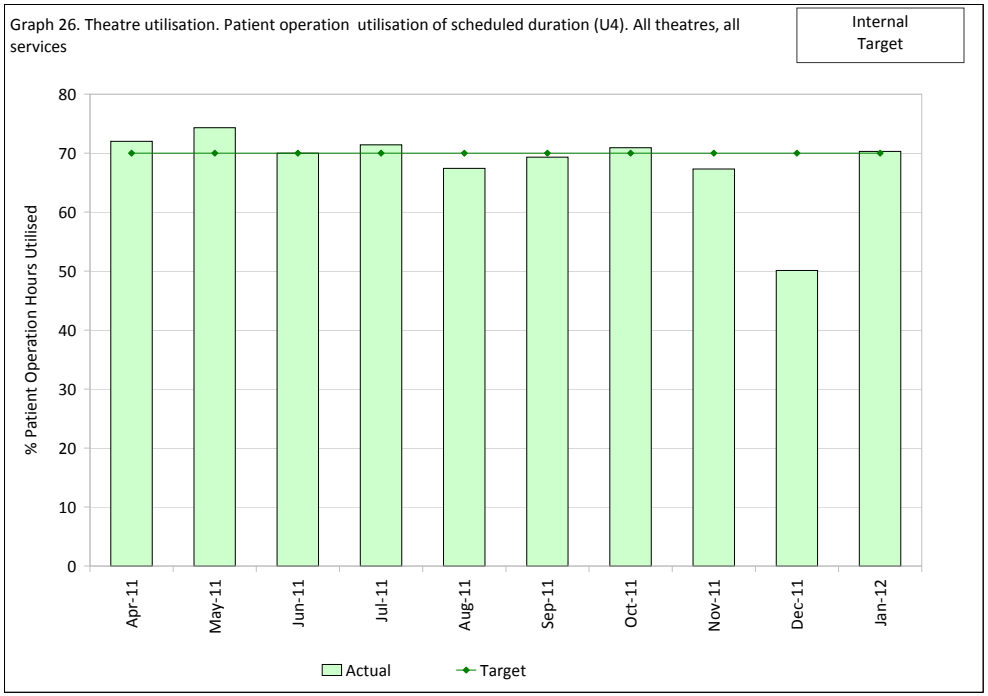
Graph 24. Complaints received 2011/12



Graph 25. Complaints received by grade 2011/12



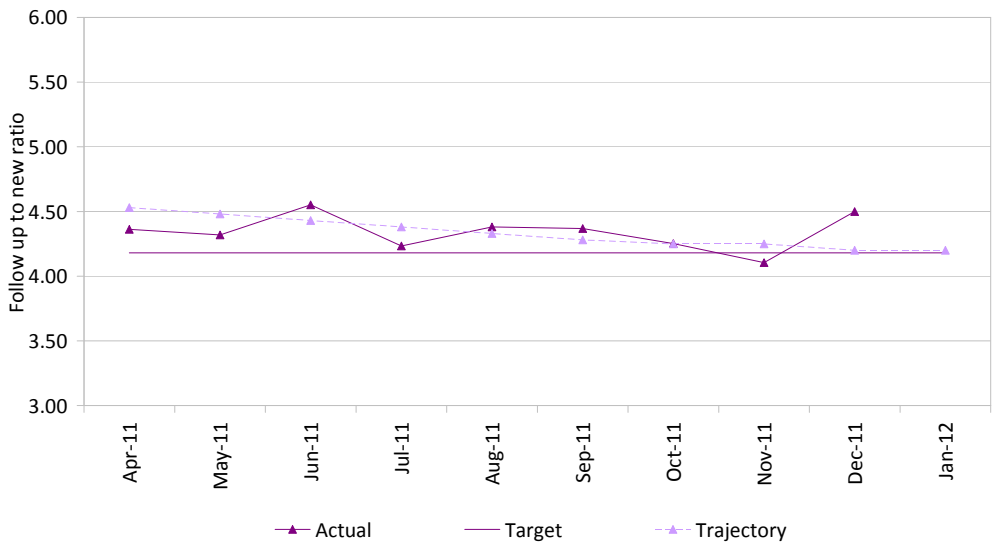
Graph 26. Theatre utilisation. Patient operation utilisation of scheduled duration (U4). All theatres, all services



3. Successfully deliver our clinical growth strategy

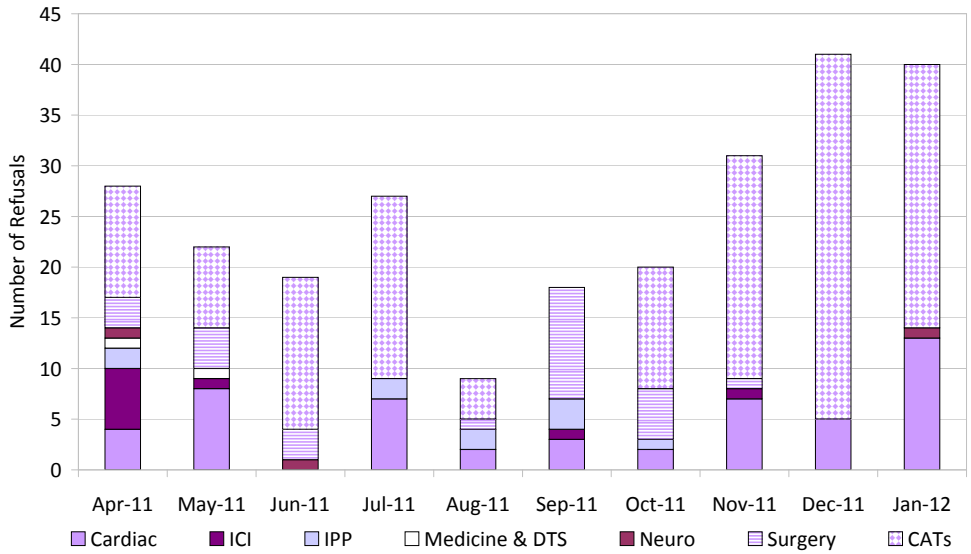
Graph 27. Follow up to new ratio

Contractual Target



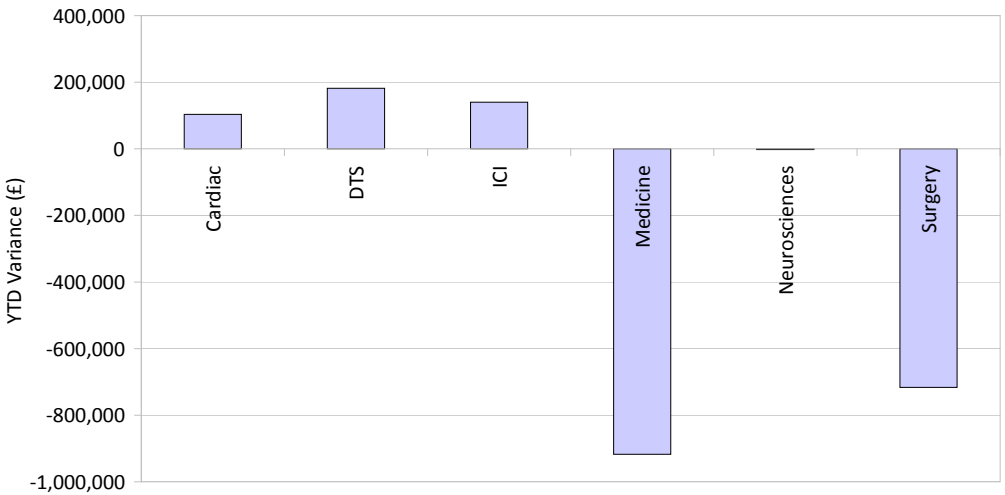
Graph 28. Patient refusals by clinical unit

Internal Indicator



Graph 29.Clinical income variance (Month 9 budget vs Month 9 actuals)

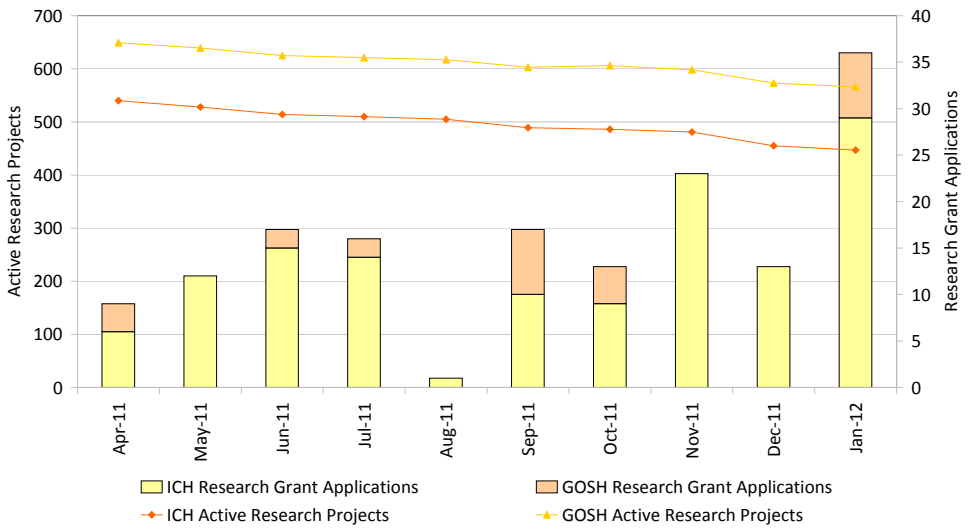
Internal Target



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

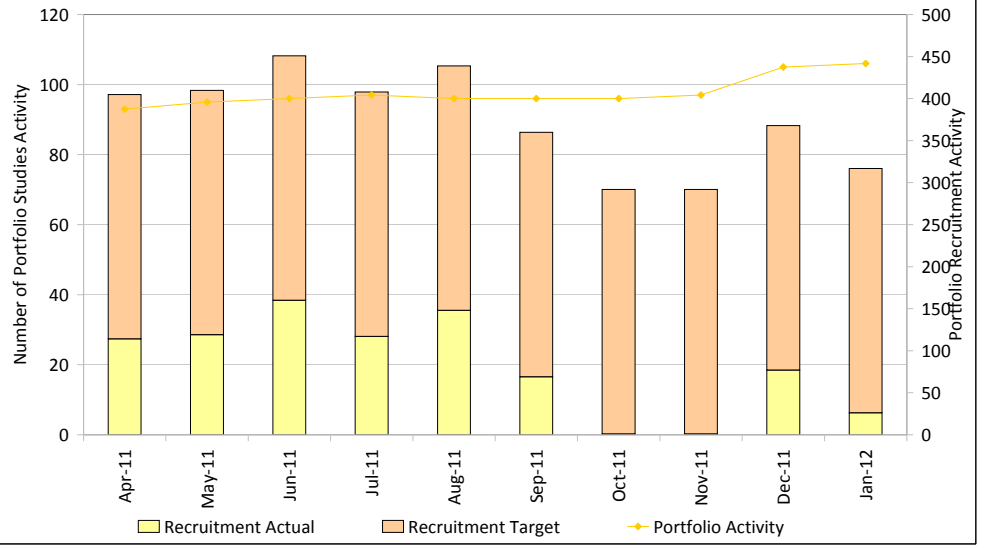
Graph 30. Research Activity

Internal Indicator



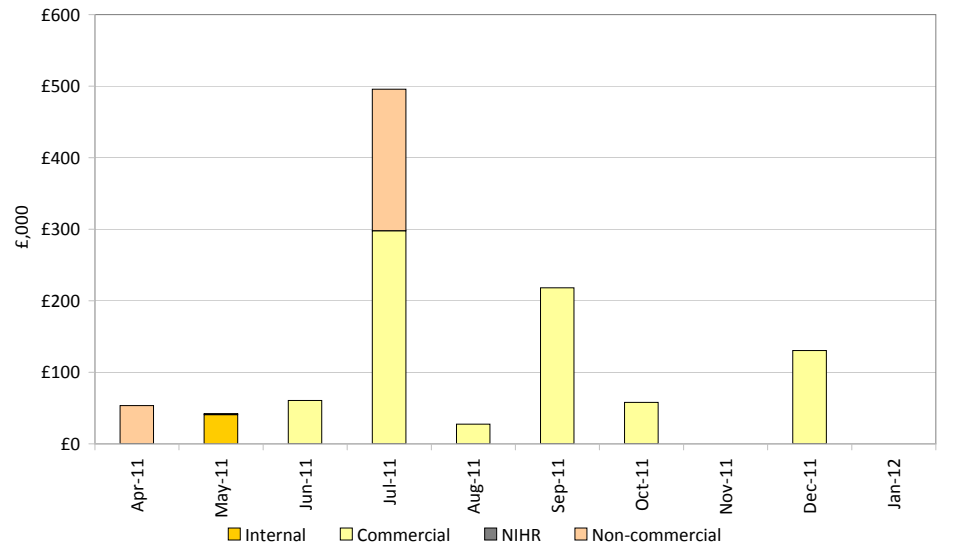
Graph 31. UKCRN Portfolio Activity

Internal Indicator



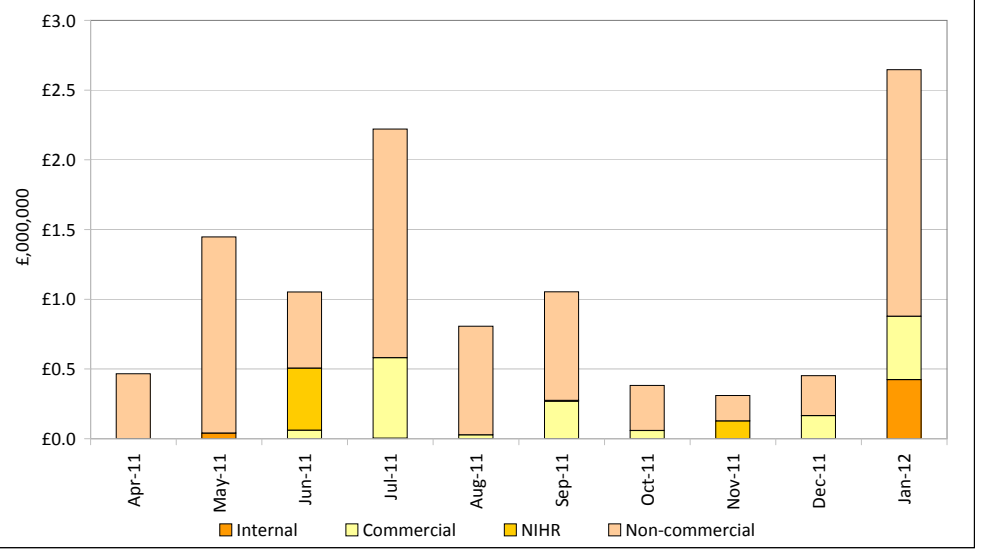
Graph 32. GOSH Research Grants

Internal Indicator



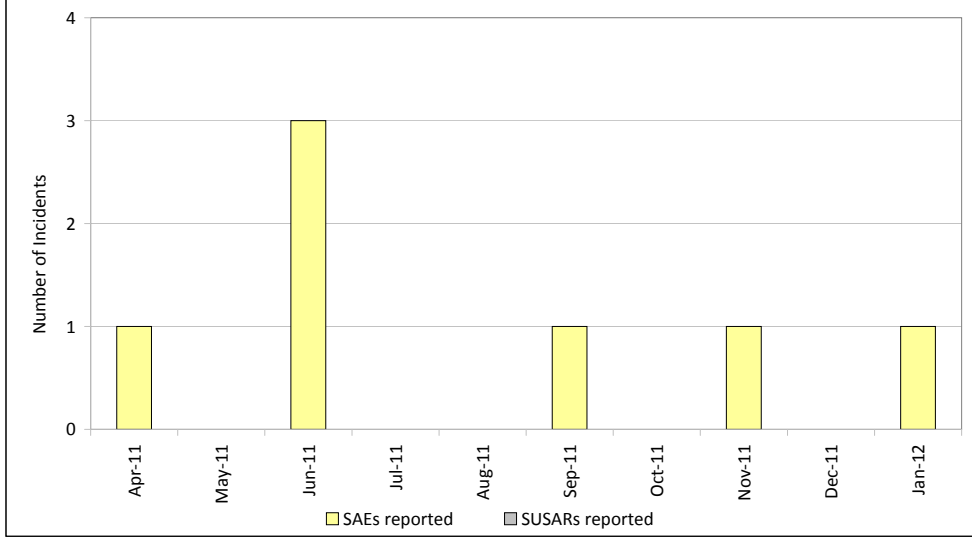
Graph 33. Research Grant Awards

Internal Indicator



Graph 34. Patient Safety reports for GOSH sponsored clinical trials

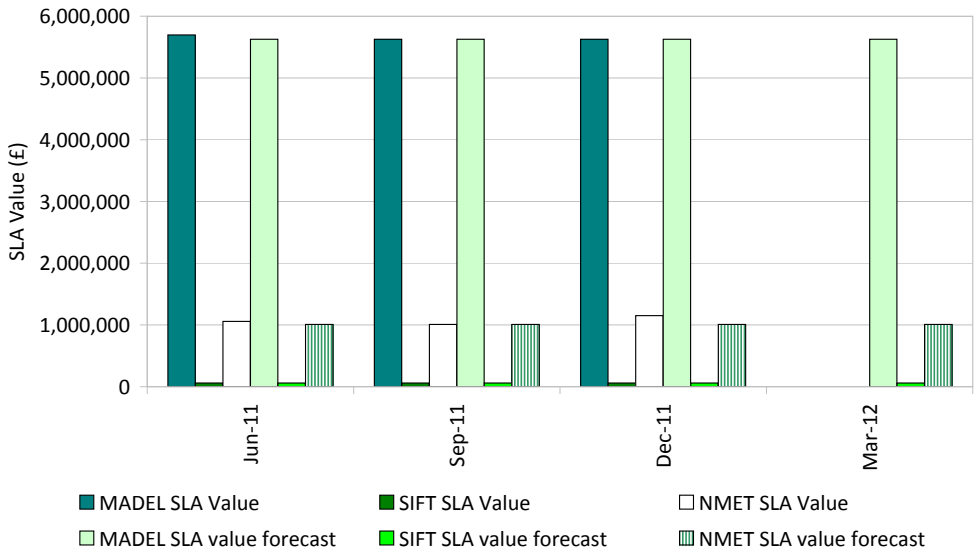
Internal Indicator



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

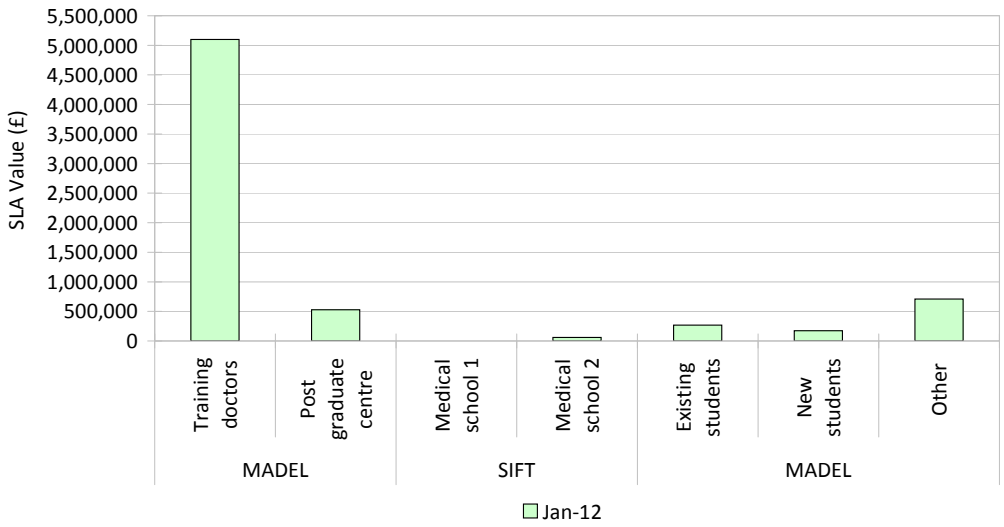
Graph 35. MPET SLA Total value summary

Internal Indicator



Graph 36. MPET Total SLA value detail

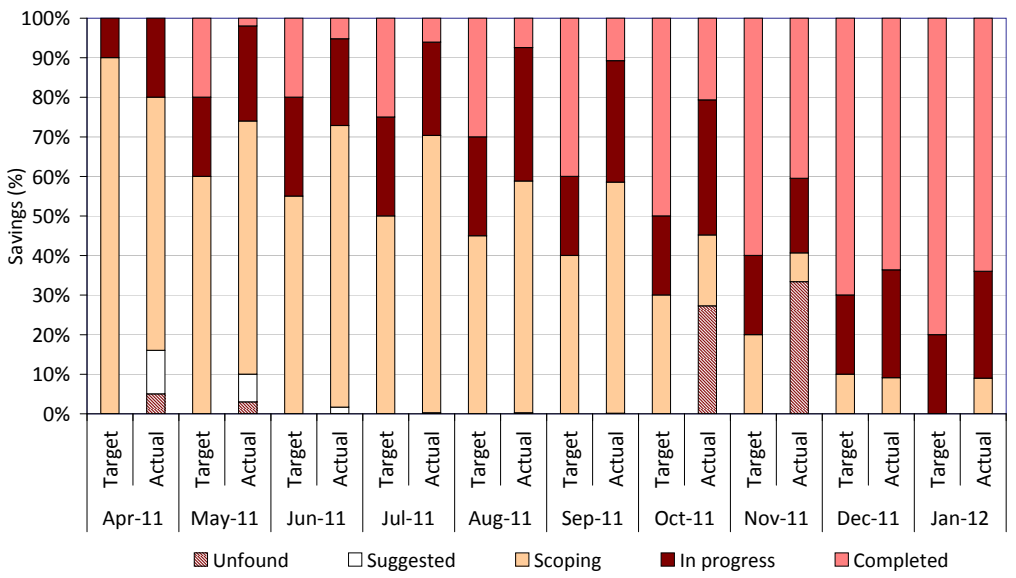
Internal Indicator



6. Deliver a financially stable organisation

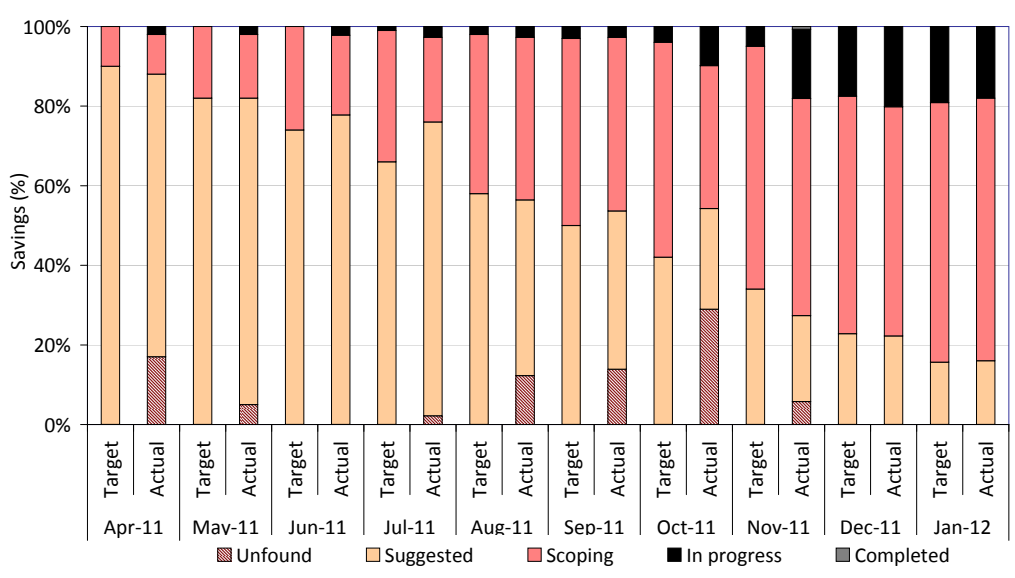
Graph 37. CRES programme, saving trajectory 2011/12

Internal Target



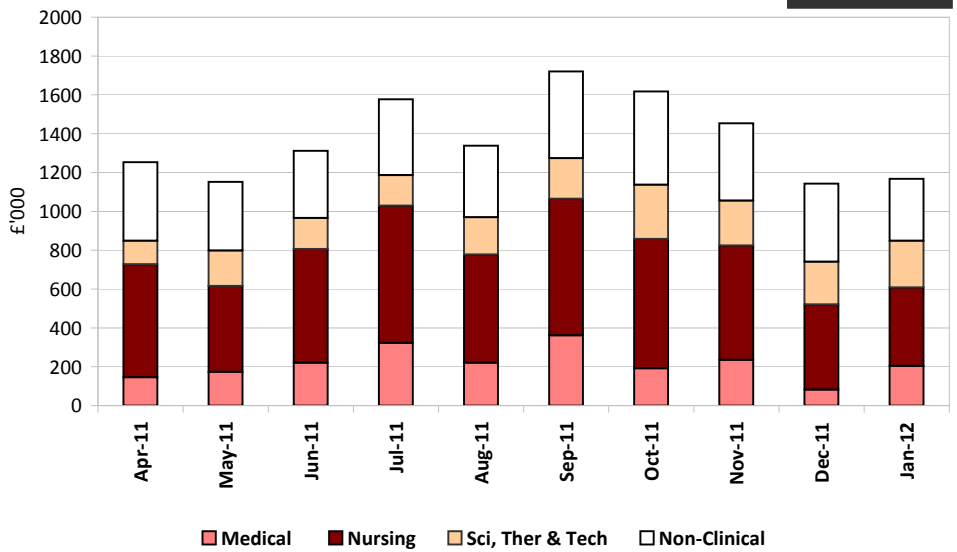
Graph 38. CRES programme, saving trajectory 2012/13

Internal Target



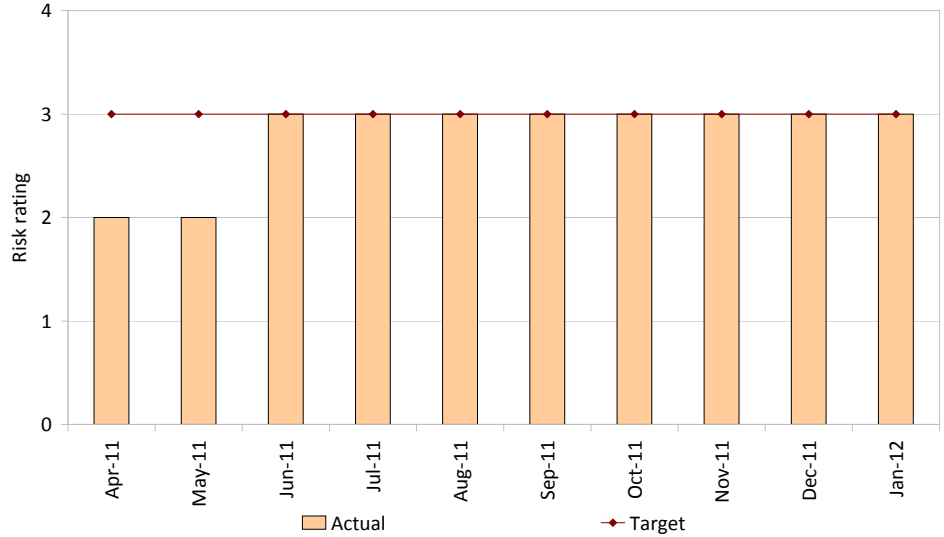
Graph 39. Bank & Agency Total Expenditure by Staff Group

Internal Indicator

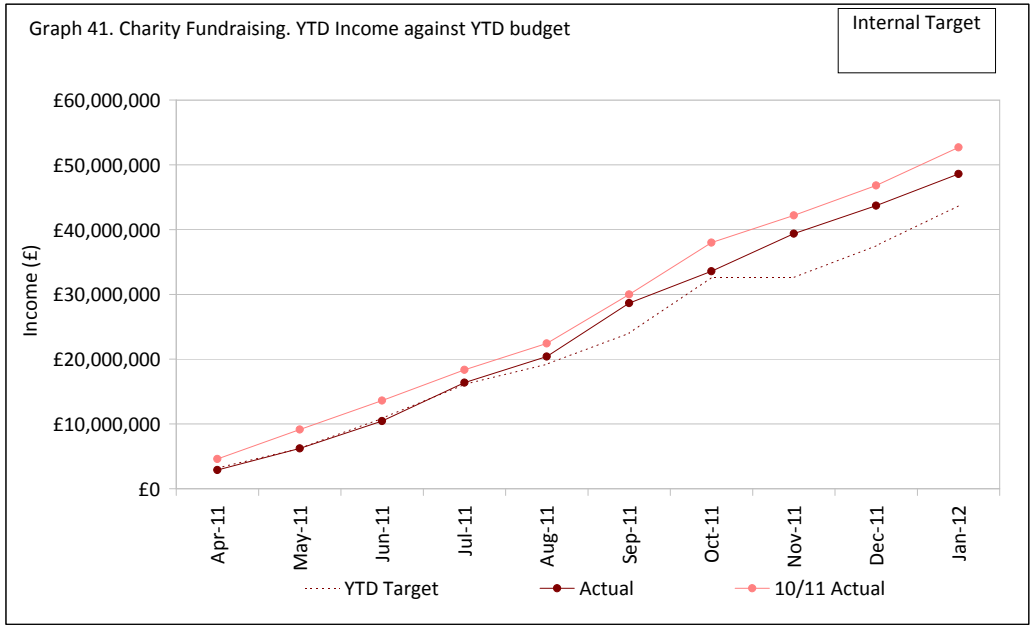


Graph 40. Monitor Risk Rating

National Target



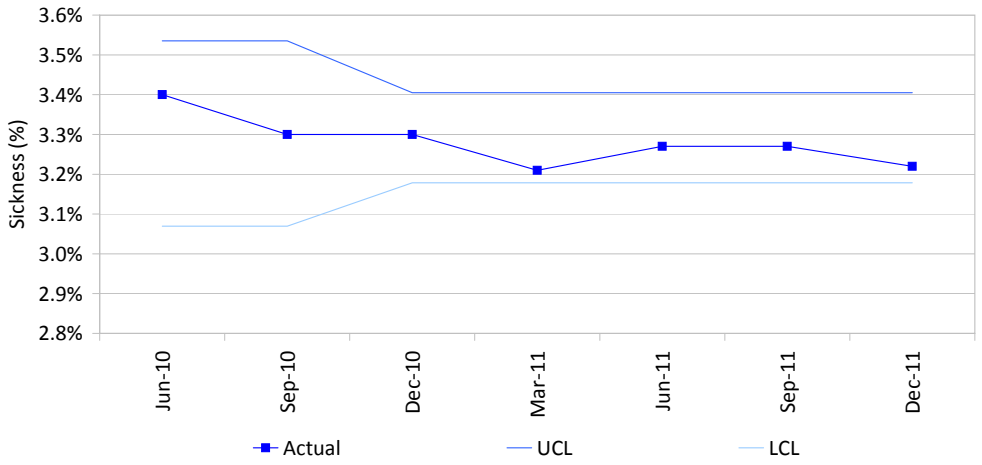
Graph 41. Charity Fundraising. YTD Income against YTD budget



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

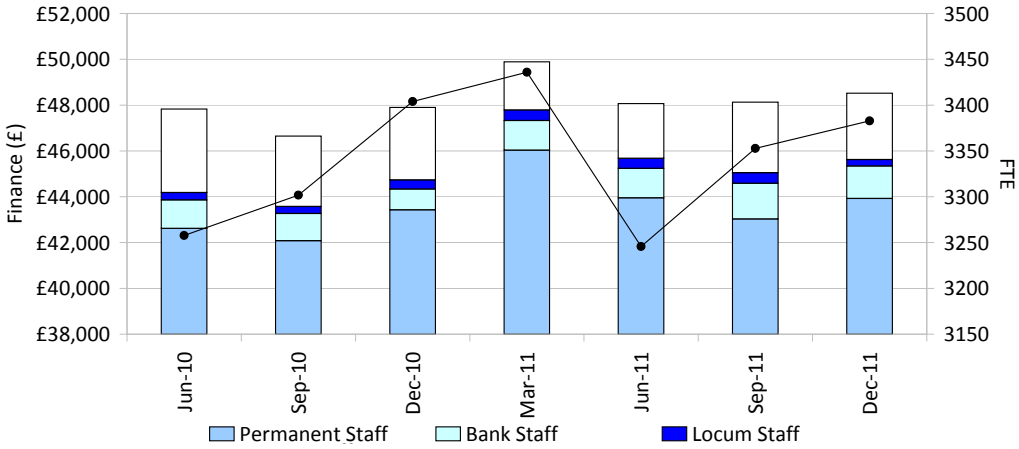
Graph 42. Sickness rate Trust-wide (%)

Internal Indicator



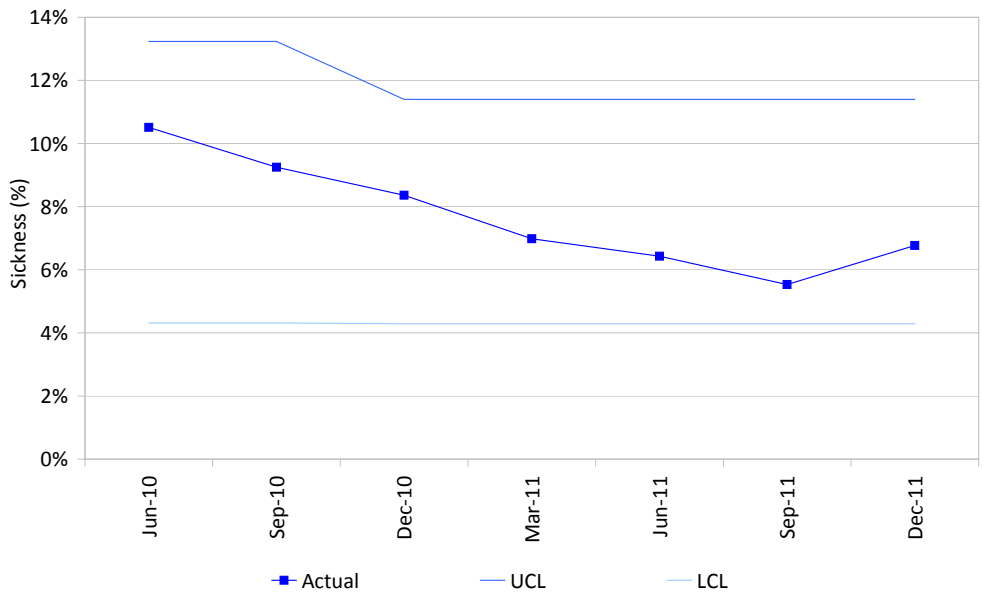
Graph 43. FTE and equivalent costs

Internal Indicator



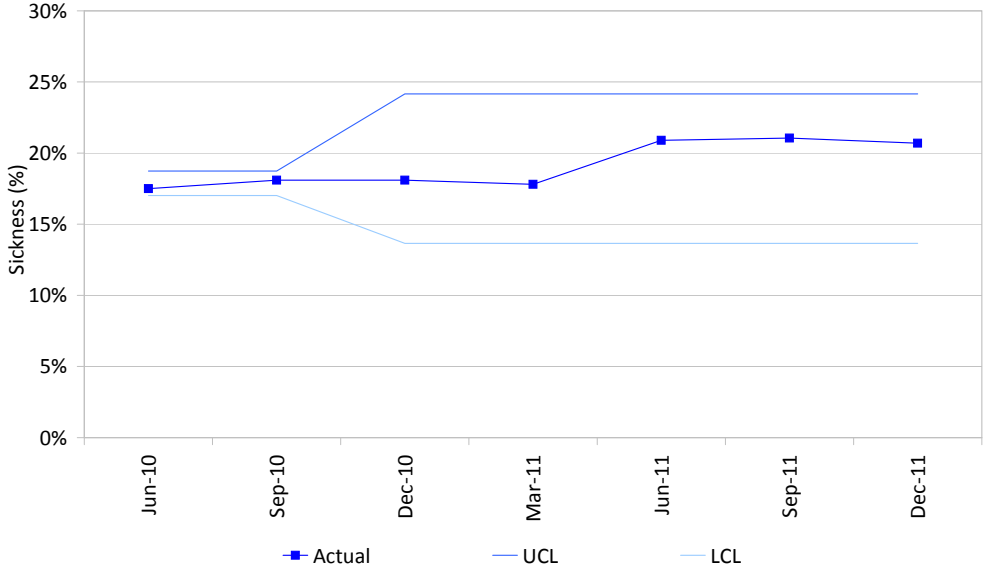
Graph 44. Vacancy rate Trust-wide (%)

Internal Indicator



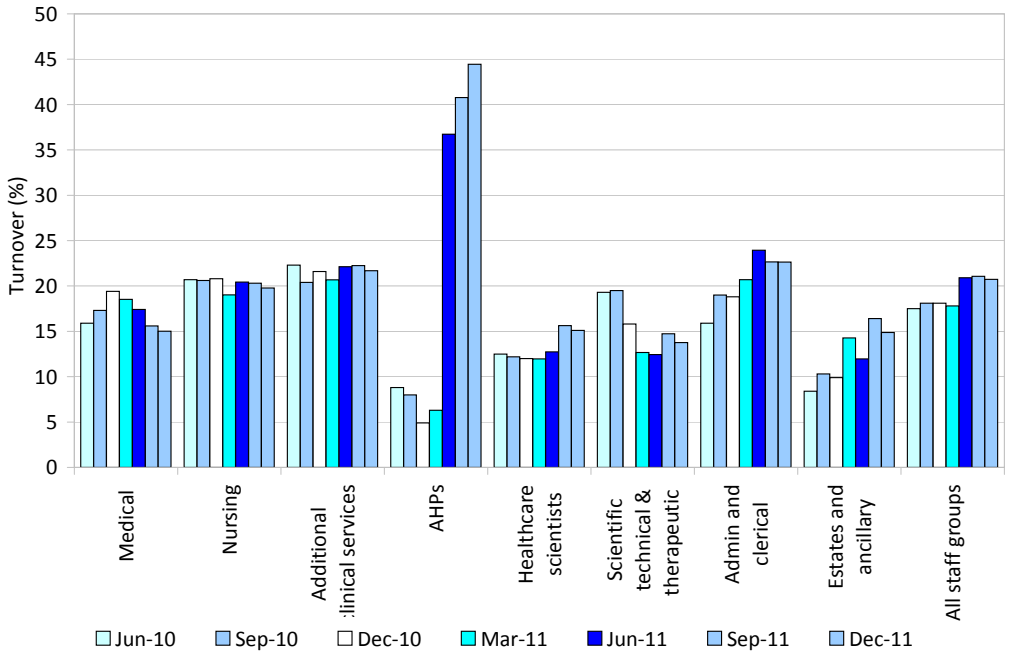
Graph 45. Turnover Trust-wide (%)

Internal Indicator



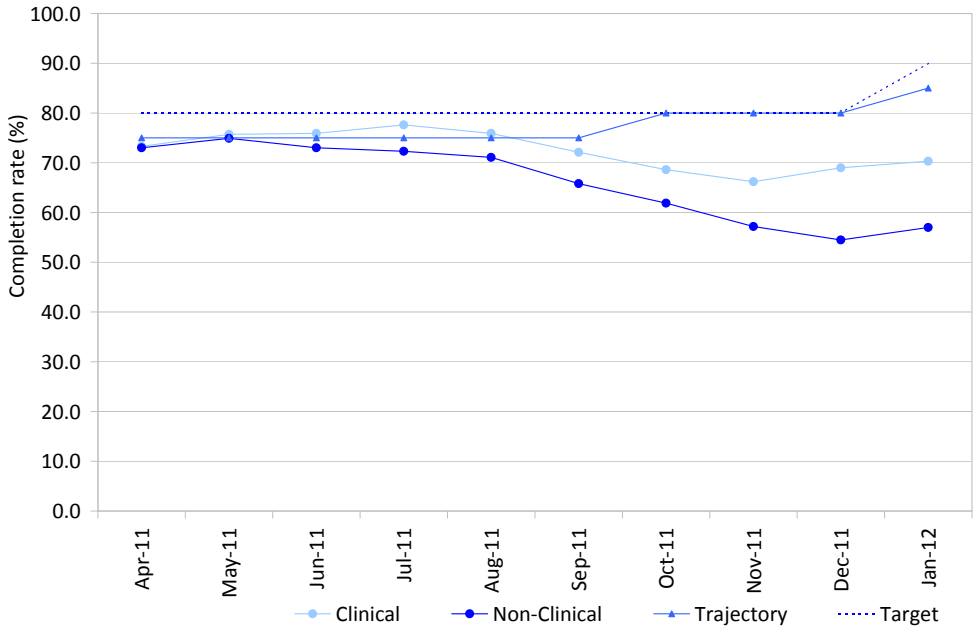
Graph 46. Turnover by staff group (%)

Internal Indicator



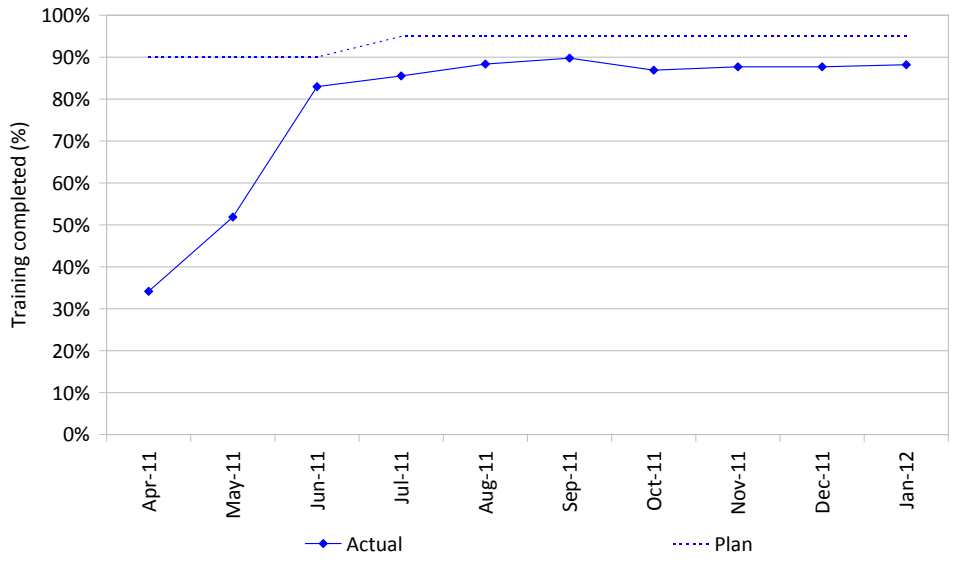
Graph 47. Percentage of staff who have a current PDR in the last 13 months and predicted next 2 months (Excluding doctors and consultants)

Internal Target



Graph 48. Staff trained on IG by week

Internal Target



Attachment W

TRUST BOARD 29th February 2012	
Finance and Activity Report **TEN months to 31 January 2012** **Submitted on behalf of** Claire Newton, CFO	**Paper No: Attachment W**

AIM
To summarise the Trust's financial performance for the **TEN** months to31January 2012.

SUMMARY

Results year to date to end of period 10

- Net surplus **£6.0M**, which is £0.7M ahead of the re-phased plan

Forecast
The Trust is still forecasting a net surplus of £2.3M after the estimated impact of impairments for the full year. However, the level of impairment has not yet been finalised

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

- Delivery of the remainder of the CRES plan
- Units delivering the financial forecast that they agreed at period 7 – this has been modelled and is crucial to the delivery of the planned surplus. This includes 5% higher activity in the final quarter than the average for the previous three quarters due to a higher number of working days and some further increase in activity in services where activity was below plan in the early part of the year.
- Ensuring that projected income billed is recoverable
- Controlling Phase2A costs to planned levels

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

Total income, if pass through funding is excluded is above plan by £2.3M.

- NHS revenue is ahead of plan by £4.6M reducing to £4.2M if non-England activity is included
- IPP revenue is behind plan by £0.3M.
- Other Operating Revenue is £1.6M behind plan if the timing differences in respect of the charity pass through are removed; the largest variances being on R&D income and catering (where the activity was outsourced and thus income received net). This income category also reflects the removal of the cost of living income that was previously assumed.

Expenditure

- Pay is over spent by £4.5M excluding pass through. The largest elements of this are related to junior medical staffing and nursing but there are also overspends on scientific and administrative budgets. Some of the overspend is related to higher activity levels as well as covering vacancies, sickness and rota issues.

- Non Pay is under-spent by £1.6M 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 86.7%
- Total payables – Number 86.5%

CRES 2011/12

- Financial Plan requires £10.4M and £10.1M identified

CRES 2012/13

- Financial Plan requires £13.6M and £13.5M identified (risk adjusted)

CRES 2013/14

- Financial Plan requires £13.4M and 13.6M identified (risk adjusted)

Capital

- Capital spend is £31.2M; £11.2M lower than plan YTD. Donated capital spend is £10.1M lower than plan
- Forecast capital spend is likely to be approximately £9.2M lower than original plan and this will be donated capital and largely related to the Redevelopment programme (£6.6M) 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)

- Current Assets **(excluding Cash & Cash Equivalents)** rose by £7.8M largely as a result of an increase in NHS Trade Receivables (£8.1M) and a decrease in Inventories of £0.4M.
- Non Current Assets increased by £0.6M to £348M representing increased capital investment net of depreciation.
- Current liabilities have increased by £8.5M, mainly due to an increase in deferred revenue (£7.9M) and an increase in Non NHS Trade Payables (£1.3M).
- Taxpayers' equity totalled £357.9M, the increase of £1M is reflected in the increase in Retained Earnings (£0.9M).

Salary overpayments

- There were eight salary overpayments totalling £9.3K (two late notified leavers)

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 February 2012

PERIOD 10 - 2011/12 FINANCE REPORT

(1) Forecast position

The Trust is forecasting a £2.3M surplus including an expected property impairment currently estimated at £5.7M and pre-impairment of £8.1M. The improvement in surplus from original plan reflects reduced accelerated depreciation in-year costs.

Achieving the forecast will be challenging as it is assumed that activity levels will be 5% higher than the average month year to date. However, this is consistent with the seasonal pattern experienced in the two previous years.

The monthly running rates in the following table show the extent of the higher income forecast in the final two months. Costs are fractionally higher as well but this includes some double running costs in operating the new Phase 2A building.

£m	2011/12 to month 10				Latest Forecast		Monthly Running rates:	
	YTD M1-10	YTD M1-10	Variance	% Variance	M11-12	Forecast	M1-10	M11-12
	Actual	Budget	to Budget		2 months	outturn		
Total Income	**280.8**	**281.3**	**1.9**	**0.7%**	**59.7**	**340.5**	**28.1**	**29.9**
Total Costs	**(257.9)**	**(257.6)**	**(2.8)**	**1.1%**	**(53.4)**	**(311.4)**	**(25.8)**	**(26.7)**
EBITDA	**22.8**	**23.8**	**(0.9)**	**-3.9%**	**6.3**	**29.1**	**2.3**	**3.1**
EBITDA margin %	*8.1%*	*8.4%*			*10.5%*	*8.6%*	*0.8%*	*5.3%*
Normalised EBITDA	***17.8***	***18.3***			***4.9***	***22.7***	**1.8**	**2.5**
Surplus/(deficit)	**6.0**	**5.3**	**0.7**	**12.5%**	**(3.2)**	**2.8**	**0.6**	**(1.6)**
Surplus/(deficit) margin %	*2.1%*	*1.9%*			*-5.4%*	*0.8%*		
Normalised surplus	***6.0***	***5.3***			***2.2***	***8.2***	**0.6**	**1.1**

(2) Month10 year to date net surplus

The year to date surplus is £6.0M. This represents a favourable variance of £0.7M relative to the re-phased plan. An analysis of the variances on each major revenue category between pass through (PT) and non pass through (ex PT) items shows that when the variances on pass- through are excluded income is ahead of plan by £1.9M but operating expenditure is over plan by £2.9M.

2.1 Revenue account excluding Pass Through

	Actual	Variances	
	M10 YTD	**Excl PT**	**Incl PT**
NHS Clinical	215.5	4.6	3.3
Non NHS Clinical	25.0	-0.7	-0.1
Other Income	35.1	-1.6	-2.4
	275.7	2.3	0.8
Don asset tfr	5.1	-0.4	-0.4
	280.8	1.9	0.4
Pay	-160.9	-4.5	-3.9
Non pay	-97.0	1.6	3.5
Total op expend	-257.8	-2.9	-0.4
Non op expend	-16.9	1.7	1.7
Net surplus	**6.0**	**0.7**	**0.7**
Normalised EBITDA	**17.9**	**-0.6**	**-0.6**
	6.5%		

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 4.1% is currently exceeded by cost growth at 5.4%.

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

- The effect of tariff decline which is not matched by cost reductions in non pay.
- Higher marginal costs of delivering some of the activity growth
- IPP growth has been limited by the private patient cap

£'M	Actual M10 YTD	Last year M10 Ytd	Var incl PT		Plan M10 YTD	Var incl PT	
NHS clinical	**214.1**	202.8	11.4	5.6%	210.8	3.3	1.6%
Other clinical	**25.1**	24.5	0.6	2.6%	26.1	-1.0	-3.9%
Non clinical	**39.9**	41.0	-1.0	-2.5%	42.8	-2.8	-6.6%
	279.2	268.2	11.0	4.1%	279.7	-0.6	-0.2%
Haringey	**1.6**	7.9	-6.3		1.6	0	0.0%
	280.8	276.1	4.7	1.7%	281.3	-0.6	-0.2%
Pay	**-159.3**	-152.0	-7.2	4.8%	-155.3	-3.9	2.5%
Non-pay	**-97.0**	-91.0	-6.0	6.6%	-100.4	3.5	-3.5%
	-256.2	-243.0	-13.2	5.4%	-255.7	-0.5	0.2%
Haringey	**-1.6**	-8.7	7.1	-81.6%	-1.6	0.0	0.0%
	-257.8	-251.7	-6.1	2.4%	-257.3	-0.5	0.2%
Non op expend	**-16.9**	-17.5	0.6	-3.5%	-18.6	1.7	-9.1%
Net surplus	**6.0**	6.9	-0.9		5.3	0.7	12.5%

3 Expenditure

3.1 Pay

Pay expenditure totals £160.9M, £3.9M higher than plan.

- Consultant pay is under Plan by £0.9M YTD. Cardiac and ICI are under spent by £0.3M and £0.1M respectively as a result of vacancies. The Research and Innovation Division is £0.6M 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 doctors pay is overplan by £2.0M 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. IPP is also £0.2M overspent due to using temporary staff to cover weekend rotas.

- Nursing pay is over plan by £2.3M YTD. £0.8M of this is activity related and offset by income. Surgery is overspent by £1.0M as a result of using agency staff within theatres, ICUs and the other wards to cover vacancies, maternity leave and sickness.

Cardiac is £0.1M overspent mainly due to using temporary staff to meet activity and patient dependency levels. The higher than trend adverse M10 movement has resulted from moving miscoded ODA staff from the healthcare assistant line to nursing staff within surgery. With surgery healthcare assistant and support staff are now £0.3M under spent YTD, this offsets some of the nursing overspend.

- Scientific and therapeutic staff pay is £0.5M overplan. ICI is £0.3M 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. Surgery is £0.1M overspent due to cover required for long term sick and maternity leave.

- 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 expenditure reductions happening as planned. Finance / ICT are overspent by £0.4M due to the use of temporary staff to cover vacancies pending restructures, and to support specific projects.

Agency costs

Junior doctors	£1.16M
Nursing	£2.10M
Sci, Ther, Tech	£1.83M
Non-clinical	£3.86M
Total	£8.95M (representing 5.6% of the pay bill to January 2011)

3.2 Non pay

Non-pay expenditure is £97.0M, which is £3.5M below plan.

- Drugs are £0.3M overspent year to date, with a £0.2M adverse movement in month. The year to date and month 10 overspends are activity / case mix related and relate to pass through items. These are directly offset by income. On other drug expenditure the Trust is on plan both in month and year to date.
- Blood is under spent by £1.4M YTD: - 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.
- Clinical supplies & services are broadly on plan YTD. Spinal implants are underspent by £0.6M, directly offset by income.
- Services from NHS organisations and Healthcare from NHS bodies are £0.1M overspent YTD. ICI is £0.3M overspent on BMT harvest and Anthony Nolan charges. This expenditure is directly related to activity and case mix within the BMT service. This overspend is partially offset by a £0.2M underspend within New Born Screening (pass through)
- Premises budgets are overspent by £0.6M YTD with a £0.5M adverse movement in month 10. There are on-going maintenance pressures within the IT budgets.
- Education & research budgets are under spent by £0.8M as a result of timing issues on training expenditure and on elements of Research & Innovation expenditure.
- Other expenditure budgets are under spent by £1.8M YTD. £0.3M of this is due to delays on charity funded expenditure on PMG projects, this is directly offset by income. £1.2M is due to HMRC credits and also to credits that have arisen as a result of work undertaken in Finance to review creditor liabilities.

4 Income

Income is £2.3M ahead of Plan (when pass through income variances are excluded)

£'M	YTD Actual	YTD variance incl PT	*YTD var excl PT*
NHS revenue including pass through	215.5	3.3	*4.6*
Non NHS revenue	25.1	(1.0)	*(0.7)*
Other Operating Revenue ex donated asset tfr	35.1	(2.4)	*(1.5)*
Normalised income	**275.7**	**(0.1)**	***2.3***
Donated asset transfer	5.1	(0.4)	*(0.4)*
Total income	**280.8**	**(0.5)**	***1.8***

4.1 NHS Revenue

Overall activity trends:

		v Last year	v Plan
- Inpatient activity:			
	o spells	+4.4%	-0.7%
	o bed days	+6.9%	+5.8%
- Outpatient activity		+11.3%	+2.7%

Although activity is showing a strong growth relative to last year (weighted average 6% as per the table below), underlying income growth is lower at 2.5% due to the impact of tariff deflation and MFF reductions and other tariff and case mix changes.

However income growth increases to 5.6% when pass through, prior year and sundry income is included.

	Estimated variance analysis of increase in NHS activity income (excludes pass through and sundry clinical income)					
£'M	**Tariff & MFF decline**	**Other price/mix variance**	**Activity growth**	***Growth ex price/mix variances***	**NET INCREASE**	**Total income growth**
Cardiac	(£1.0)	(£1.5)	*£5.2*	*11.4%*	**2.7**	5.9%
ICI	(£0.6)	£0.5	*£0.0*	*0.1%*	**(0.1)**	-0.4%
MDTS	(£0.4)	£0.7	*£0.9*	*4.7%*	**1.2**	5.9%
Neurosciences	(£0.6)	(£1.9)	*£2.0*	*9.5%*	**(0.5)**	-1.9%
Surgery	(£1.2)	£0.1	*£1.8*	*3.7%*	**0.7**	1.6%
TOTAL TRUST	**(£3.8)**	**(£2.1)**	***£10.0***	***6.0%***	***4.1***	**2.5%**

Analysis by activity currency:

BED DAYS	(£0.6)	(£2.0)	£2.0
INPATIENTS	(£2.3)	£0.5	£2.2
OUTPATIENTS	(£0.5)	£0.7	£3.5
NCG	(£0.4)	£0.0	£1.9
Other	(£0.1)	(£1.3)	£0.4
TOTAL	(£3.8)	(£2.1)	£10.0

NOTES:
a) Tariff decline comprises -1.5% tariff price and an additional -2.0% on PbR relating to the reduction on MFF from 31.8% to 29.1% averaging -2.3%
b) The other price/mix variance for bed days is a combination of average price reductions due to marginal rates and capping of bed day prices in some areas and a further mix variance due to higher growth in lower price bed dayd

Income by clinical unit and by currency is shown in bar charts on page 12

PCT Income
A number of specialties are at higher than planned levels these include Dermatology, Cardiac Surgery, Orthopaedic, Rheumatology, and Cochlear unilateral implants.

Spinal activity is £0.7M lower than plan reflecting lower in-year activity. Outpatient activity is ahead of plan by £0.6M (£0.5M at period 9) and bed-day income is £1.5M ahead (£1.3M at period 9) partly reflecting higher CICU, ECMO and Transitional care unit activity.

The income plan included an estimate for penalties in respect of the emergency threshold, readmissions and outpatient follow ups – these are lower than estimated earlier in the year.

Overseas E112 income is now £0.6M behind plan (£0.5M at period 9)

SHA (NCG) income is £1.3M ahead of plan (£1.1M ahead excluding pass-through)
This, in part, reflects Neuroblastoma drug licences costs with income being release into the position, but which was not included in the budget at the time due to timing matters. Also, Ecmo and SCIDS have seen significant improvements in activity levels in January. All other activity is close to plan excluding pass through.

4.2 Non NHS Revenue is £1M behind plan (£0.8M ahead excluding pass-through income)

Non England activity is lower than plan by £0.7M
Private patient income is £0.3M behind plan and this fluctuates dependent on case mix, but forecast activity levels are at the planned level.

4.3 Other operating revenue is £2.4 M behind plan (£1.6M including pass through)

The principal variations from plan relate to:
- Catering income has reduced due to the outsourcing of the café and this is offset in expenditure
- 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 £1.5M behind plan due to lower hospice income, third party funded posts and central DH funding.
- Research income is below plan
- Charity funding is lower than plan due to lower than planned spend on charity funded projects.

(5) CIP/CRES

The Trust has materially identified schemes to cover the £10.4M 2011/12 target and has risk adjusted these to ensure the target can be delivered. There are some further schemes that need to be added to the CRES database which are expected to complete the 2011/12 programme.

The Trust has set higher targets to units/departments to ensure that the 5% planning level can be achieved.

CRES 2011/12
The Target for 2011/12 is £10.4M of which in excess of £10.1M is recognised as being delivered and the balance will come from some schemes that we believe are delivering though not included in the database at this point.
94% of schemes are now classified as Green or Blue.

CRES 2012/13
The financial plan requires £13.6M of CRES to be delivered and the risk adjusted database of schemes values this currently at 13.59M
There are £15.72M of schemes meaning 15% more than the required level, though inevitably some of these will not come to fruition and these will be deleted or most likely rolled forward into future year schemes.

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 £13.6M.
There are £15.7M of schemes which is also 15% higher than the planning target value and at this stage 13% are Amber with the balance being classified as Red at this point –m this is not unreasonable as the focus is on bringing to fruition the schemes for the more immediate years at this point.

(6) CAPITAL PROGRAMME AND CRL

CRL
The Trust is expecting to undershoot its CRL target of £13.8Mby £1.5M.

Overview
The Trust's capital plan is £55.9M with planned expenditure for the ten months ending 31 January amounting to £42.4M. The total spend to date amounts to £31.2M representing an under spend to date of £11.2M.

	Annual Plan £M	Plan YTD £M	Actual YTD £M	Variance £M
Hospital Redevelopment	36.3	27.4	19.5	7.9
Estates Maintenance Projects	9.0	6.8	6.7	0.1
IT Related Projects	7.0	5.4	2.7	2.7
Medical Equipment Purchases	3.6	2.8	2.3	0.5
Total Additions in Year	**55.9**	**42.4**	**31.2**	**11.2**
Asset Disposals	0.0	0.0	0.0	0.0
Donated Funded Projects	(42.1)	(31.8)	(21.7)	(10.1)
Charge Against CRL	**13.8**	**10.6**	**9.5**	**1.1**

Redevelopment
Redevelopment Projects are currently under spent by £7.9M. The current forecast outturn is expected to be £6.6M under plan. The Trust is forecasting a slippage to 2012/13 on Phase 2B enabling of £5.3M with the balance representing an under spend on Phase 2A of £1.3M. Forecast under spends will be offset by a reduction in donated income.

Estates IT and Medical equipment

Estate Management Projects are now currently behind plan by £0.1M, a further 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 £2.7M. This is due to in year slippage with certain Projects such as PACS not incurring major spend until February/March. The Trust is forecasting £1.5M slippage into 2012/13.

Medical Equipment Projects are currently behind plan by £0.5M 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 January 2012 totalled £348M, a net increase of £0.6M 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 risen by £7.8M

NHS Trade Receivables (£8.1M increase)	This represents an increase in NHS Debtors following the raising of quarter four invoices for SHAs (£6.3M) and an increase in PCT accrued income (£1.4M).
Inventories (£0.4M decrease)	Representing a decrease in Pharmacy stock (£0.3M) and Cochlear stock (£0.1M)
Capital Receivables (£0.2M decrease)	This represents a decrease in the capital debtor following receipt of payment from the Special Trustees.
Non NHS Trade Receivables (£0.3M decrease)	This is primarily due to a decrease in the private patient debtors following an in month exercise to reduce the outstanding debt.

Current Liabilities

Current Liabilities have increased by £8.5M

NHS Trade Payables (£0.9M decrease)	The decrease is mainly due to invoices accrued in the previous month now paid.
Non NHS Trade Payables (£1.3M increase)	The increase is due to an increase in invoices received but not yet paid for three suppliers totalling £0.7M and other suppliers with lower value but higher volume invoices.
Deferred revenue (£7.9M increase)	Represented mainly by the raising of invoices in the fourth quarter.
Other Payables (£0.5M increase)	This represents accrual of one month of PDC dividend relating to January 2012.
Capital Payables (£0.8M decrease)	This decrease is as a result of the payment of construction invoices.

Taxpayers' Equity

Taxpayers' Equity has increased by £1M in month. The principal movement was an increase in the Retained Earnings of £0.9M.

(8) WORKING CAPITAL

8.1 Cash overview

The Trust had a cash balance of £18.6M at 31January and had operating cash balances of between £17.8M and £34.9M throughout the month. Commercial bank account balances at 31 January were £0.01M, in line with the DH maximum holding of £0.05M.

The closing cash balance was £2.7M lower than the forecast. This is due to lower than expected cash collections (see receivables review) and the continued work to improve the payables service to suppliers..

8.2 Trade Debt

Gross trading debt increased to £24.05m, an increase from £16.4M, in the previous month. This was due mostly partial payment of invoices raised quarterly in advance to the NCG and SHA. Improvements in debt collection have led to a significant reduction in aged debt. Overall debt over 90 days has been reduced by £2.3M compared to this time last year and NHS debt overall is £3.7M lower than January 2011.

	31/01/2012		31/03/2011		31/01/2011	
not yet due and COA	9,280	**39%**	9571	62%	7,471	27%
0-30	9,794	**41%**	1,550	10%	12,856	46%
30-60	2,516	**10%**	779	5%	1,926	7%
60-90	573	**2%**	524	3%	1,389	5%
90-120	494	**2%**	423	3%	753	3%
120-180	241	**1%**	515	3%	594	2%
180-360	365	**2%**	1,385	9%	2,079	7%
360+	762	**3%**	734	5%	689	2%
	24,025	**100%**	15,481	100%	27,758	
NHS	11,230		4,543		19,705	
Non- NHS	2,634		2,830		1,327	
International	7,858		7,053		5,991	
Gosh CC	2,303		1,055		735	
	24,025		15,481		27,758	

NHS debt

The overall level is now £11.2M, an increase from last month and reflects quarterly billing for a number of income streams. Income collections have been variable and there continues to be continued dispute of performance debt for which we believe there is no valid dispute and this continues to be actively pursued with some of this escalated to CFO level**.**

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. This debt was settled on 6 Feb 2012 after the month end.
The increase in debt at 180+ days is due to a disputed salary recharge invoice with a children's hospice.

IPP debt has reduced by £0.61M this month to £7.9M due to increased collections in month.

- The UAE military account remains overdue at £0.9M over terms. Options are being considered in respect of a large self pay debt of £0.25M that is 360 days overdue.

- There appears to be evidence of Middle East debt taking longer to pay and this is being closely monitored
- There has been a reduction in Greek debt over terms to £188K following the settlement of a high value patient episode.
- Kuwait settled a further £672K after the month end

8.3 Trade payables

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

- Trade payables excluding capital payables at £6.0m are £3.4m lower than at the end of the same period last year.
- Accrued invoices are £6.1M compared with £9.1M 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 fallento £0.08M whereas a year ago it was £1.1M

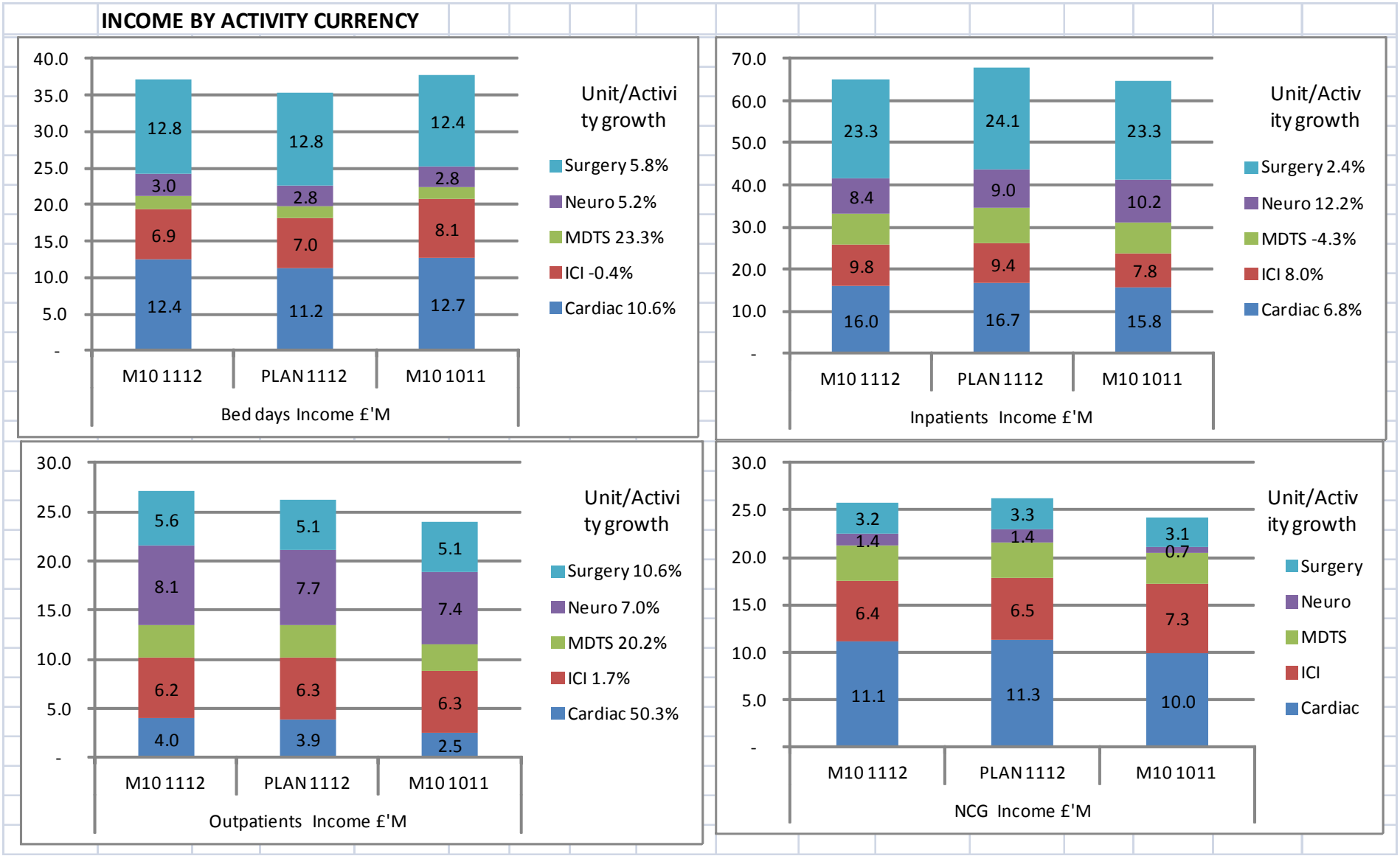
There remains £0.6M of NHS trade payables which are more than 90 days overdue for payment but these relate to a small number of organisations where there are long standing issues which require further information from the supplier but these are being addressed.

(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 10 and the forecast score for each metric and shown the threshold scores for achieving the higher metric values.

Month 10	**Score**
EBITDA Margin	3
EBITDA % Achieved	4
ROA	3
I&E Surplus margin	4
Liquidity Days	2
Weighted Average	3.1
Overall Score	**3**

Attachment W

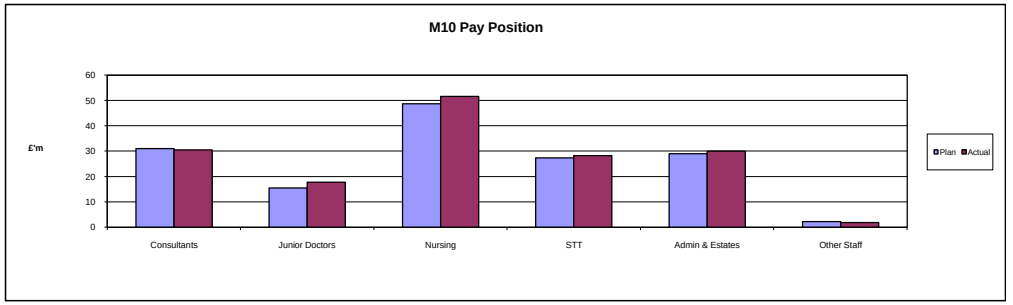


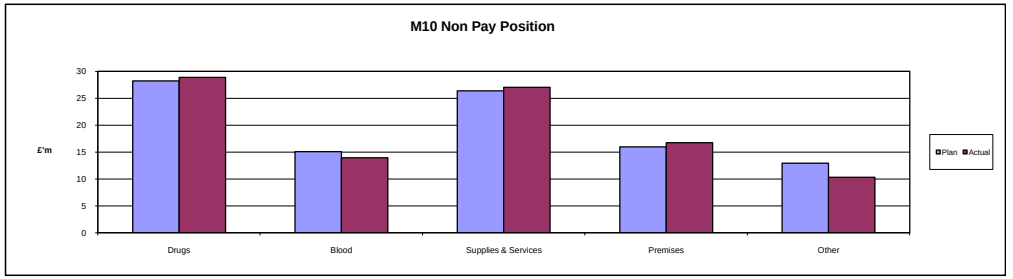
Great Ormond Street Hospital for Children NHS Trust Finance and Activity Performance Report Period 10 2011/12 Contents

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 2011/12
Trust Summary

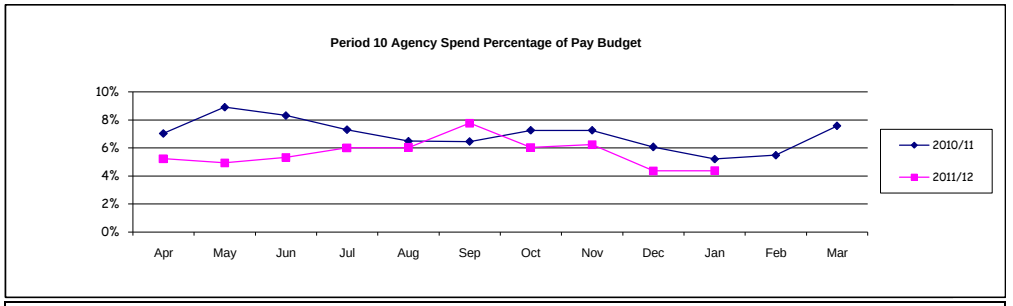
Statement of Comprehensive Income

	Current Month		YTD	
	Actual	Plan Variance	Actual	Plan Variance
	£000	£000	£000	£000
Revenue				
Revenue from patient care activities	25,838	1,485	240,638	2,275
Other operating revenue	3,006	(1,270)	40,138	(2,829)
Total Income	**28,844**	**215**	**280,776**	**(554)**
Operating expenses	(26,221)	(404)	(257,819)	(472)
EBITDA	**2,623**	**(189)**	**22,957**	**(1,026)**
Depreciation	(1,239)	520	(12,109)	1,536
Corporation Tax	(8)	12	(80)	115
Operating surplus	**1,376**	**343**	**10,768**	**625**
Investment revenue	4	2	57	27
Other losses	32	32	28	28
Finance costs	(3)	(1)	(33)	(12)
Surplus for the financial year	**1,409**	**376**	**10,820**	**668**
Public dividend capital dividends payable	(481)	(1)	(4,805)	(1)
Retained surplus for the year	**928**	**375**	**6,015**	**667**
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	580	(4,004)	21,735	(10,095)
Reclassification adjustments:				
- Transfers from donated and government grant reserves	(499)	(145)	(5,068)	(395)
Total comprehensive income for the year	**1,009**	**(3,774)**	**22,682**	**(9,823)**
Total Income, excluding Donated Asset Transfer	*28,345*	*70*	*275,708*	*(949)*
EBITDA, excluding Donated Asset Transfer	*2,124*	*(334)*	*17,889*	*(1,420)*
EBITDA % of Income	*9.09%*		*8.18%*	
EBITDA % of Income, excluding Donated Asset Transfer	*7.49%*		*6.49%*	





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



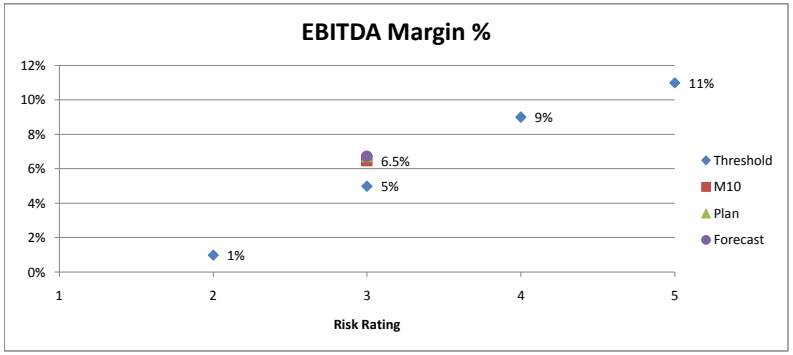
Staffing Staff Numbers	10/11 M12 WTE	WTE Paid	Maternity Paid	Temp Paid	Overtime Paid	Total Paid	WTE above 10/11 M12
Admin and Other Support	898	808	15	59	6	888	11
Clinical Support	731	668	39	41	5	752	(21)
Medical	516	483	18	34	0	535	(19)
Nursing	1,426	1,294	66	116	4	1,480	(55)
Total	**3,571**	**3,254**	**138**	**249**	**14**	**3,655**	**(84)**

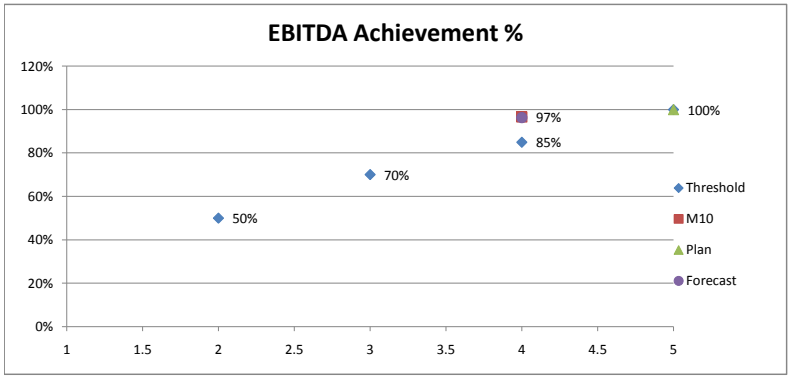
* 10/11 wte comparator includes maternity leave at M12, but excludes Haringey.

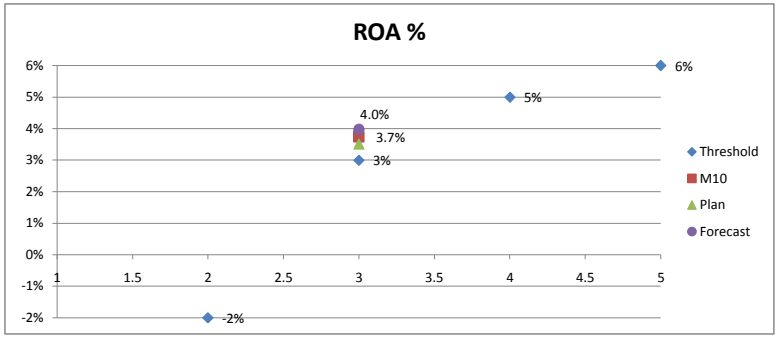
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 2011/12
Ratio Analysis

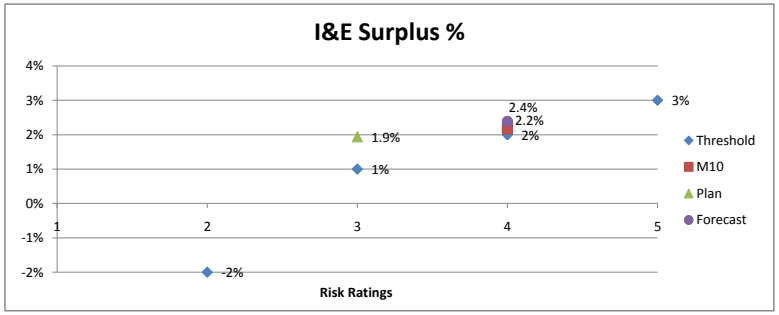
Provider Agency Rating	Target for FT Status	M10 11/12 Actual - FT	M09 11/12 Actual - FT	Forecast Outurn - FT	M10 FT Score
EBITDA Margin	5%	6.5%	6.4%	6.7%	3
EBITDA % Achieved	70%	96.6%	96.4%	96.4%	4
ROA	3%	3.7%	3.6%	4.0%	3
I&E Surplus margin	1%	2.2%	2.1%	2.4%	4
Liquidity Days	15.0	13	13	15	2
Weighted 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%	9.4%	9.5%	9.5%	

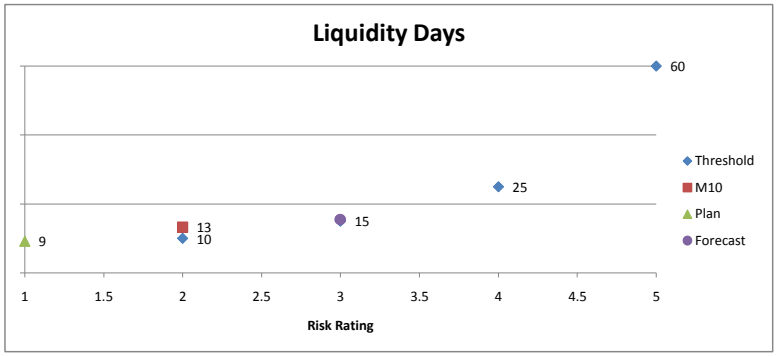
Salary Overpayments		
Unit	No.	Amount £'000
MDTS	2	3.7
Neuro	1	2.5
ICI	3	2.1
Operations & Facilties	1	0.9
Cardiac	1	0.1
TOTAL	8	9.3











Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 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	46,978	208	2,122	(27,915)	(1,532)	(3,337)	(1,324)
Surgery	54,278	(214)	436	(51,508)	(3,272)	(2,248)	(3,486)
DTS	1,872	(186)	723	(16,868)	(209)	(1,098)	(395)
ICI	47,818	(144)	770	(46,621)	(1,450)	(2,727)	(1,594)
International	24,918	(187)	3,356	(10,217)	(2)	(1,297)	(189)
Medicine	36,270	(379)	2,231	(33,786)	(608)	(2,318)	(987)
Neurosciences	22,286	85	(312)	(18,426)	(180)	(1,656)	(95)
Pass through drugs & devices funding	7,912	570	493				570
Education & Training / Merit Award Funding	6,970	(565)	86				(565)
Other Clinical Income / CQUIN	6,536	4,149	4,102				4,149
Centrally held development reserves				**(1,823)**	5,177	1,307	5,177
Total Clinical Units	**255,838**	**3,336**	**14,007**	**(207,164)**	**(2,076)**	**(13,374)**	**1,261**
Central Departments							
Operations & Facilities	975	(45)	(414)	(12,472)	(297)	1,734	(342)
Corporate Affairs	48	(23)	(17)	(1,422)	129	(403)	107
Estates	668	(0)	(154)	(9,953)	(346)	(582)	(346)
Finance & ICT	185	24	2	(9,921)	(1,103)	(1,636)	(1,079)
Human Resources	650	22	91	(2,426)	290	(122)	313
Medical Director	9	(56)	(109)	(2,904)	(165)	272	(221)
Nursing And Workforce Development	1,586	72	(37)	(4,597)	292	(257)	364
Research And Innovation	11,598	(631)	976	(5,011)	374	352	(256)
Redevelopment Revenue Costs	379	(364)	(62)	(379)	191	62	(173)
Total Central Departments	**16,097**	**(1,001)**	**276**	**(49,084)**	**(634)**	**(580)**	**(1,634)**
Depreciation & Dividends	**5,068**	**(395)**	**(1,012)**	**(16,918)**	**1,531**	**616**	**1,136**
Centrally held income	**2,193**	**(80)**	**(1,586)**	**0**	**0**	**0**	**(80)**
Net Position, excl Haringey & North Mid	**279,196**	**1,861**	**11,685**	**(273,166)**	**(1,178)**	**(13,338)**	**683**
Haringey	1,590	7	(6,346)	(1,597)	(13)	7,142	(6)
North Mid.	(11)	(11)	(687)	2	2	678	(9)
Net Position, incl Haringey & North Mid	**280,776**	**1,857**	**4,652**	**(274,761)**	**(1,190)**	**(5,518)**	**668**

* 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 10 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	371,092	291,667		871,219	**836,257**	
ICI	2,163,631	1,716,244	33,586			1,749,830	**1,732,331**	
International	664,439	1,036,824				1,036,824	**1,026,456**	
MDTS	2,622,255	1,354,027	440,957			1,794,984	**1,745,741**	
Neurosciences	1,418,021	460,555	370,834	152,060		983,449	**959,929**	
Surgery	3,356,564	236,091	764,540			1,000,630	**990,624**	
Corporate facilities	1,025,794	614,103	18,720	48,336		681,158	**668,997**	
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	663,569	69,654	92,885		826,108	**810,270**	
Finance & ICT	731,684	231,140	61,796	141,465		434,401	**417,325**	
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	262,190	65,130		8,210	335,530	**330,615**	
R&I	33,478		35,000			35,000	**34,650**	
Total	**15,773,128**	**7,233,603**	**2,238,308**	**842,862**	**8,210**	**10,322,982**	**10,110,824**	**8,119,269**
						Updated target	**10,400,000**	
							(289,176)	

NHS Clinical Income	1,161,583	1,010,786	288,778	8,210	2,469,357	**2,417,899**
Other Income	2,124,700	84,254	15,654		2,224,608	**2,201,736**

2012/13

Unit	Target	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
Cardiac			22,363	1,145,809	404,988	1,573,160	**1,307,899**
ICI			963,033	1,303,930	110,126	2,377,090	**2,152,055**
International			94,965	1,164,441		1,259,406	**1,142,012**
MDTS			446,030	1,719,773	207,077	2,372,880	**1,999,974**
Neurosciences			88,745	1,140,354	19,872	1,248,971	**1,067,212**
Surgery			756,000	1,837,319	258,761	2,852,081	**2,445,062**
Corporate facilities			105,895	736,345	321,186	1,163,426	**984,612**
Clinical Operations				153,867		153,867	**130,787**
Corporate affairs			125,305	60,227	-	185,532	**182,926**
Estates			417,000	662,623	45,217	1,124,840	**1,012,233**
Finance & ICT			7,355	542,762	184,092	734,209	**608,758**
HR & workforce			27,252	60,338	58,172	145,762	**124,846**
Medical director					32,250	32,250	**25,800**
Nursing & Education			142,000	60,000	77,036	279,036	**243,357**
R&I					217,500	217,500	**163,125**
Total	**15,773,128**	**-**	**3,195,943**	**10,587,789**	**1,936,277**	**15,720,009**	**13,590,659**
						Provisional target	**13,615,000**
							(24,341)

NHS Clinical Income	-	669,990	3,395,040	446,815	4,511,845	**3,974,146**
Other Income	-	494,443	846,353	265,500	1,606,296	**1,474,508**

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	**1,610,218**
ICI				50,000	1,717,195	1,767,195	**1,486,142**
International				963,819		963,819	**867,437**
MDTS				60,000	2,470,996	2,530,996	**2,133,097**
Neurosciences					1,318,593	1,318,593	**1,120,804**
Surgery				878,073	2,919,762	3,797,835	**3,278,330**
Corporate facilities					1,055,000	1,055,000	**939,500**
Clinical Operations					149,000	149,000	**134,100**
Corporate affairs					125,305	125,305	**112,775**
Estates					528,992	528,992	**460,143**
Finance & ICT					736,103	736,103	**659,733**
HR & workforce					215,000	215,000	**190,700**
Medical director					278,000	278,000	**252,350**
Nursing & Education					366,726	366,726	**334,143**
R&I					35,000	35,000	**29,750**
Total	**15,773,128**	**-**	**-**	**1,995,892**	**13,763,370**	**15,759,261**	**13,609,220**
						Provisional target	**13,473,000**
							136,220

NHS Clinical Income	-	-	788,906	2,595,043	3,383,949	**3,102,458**
Other Income	-	-	963,819	1,501,111	2,464,930	**2,252,355**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 2011/12
Revenue Statement

	11/12 Annual Budget £000	11/12 Mth 10 Actual £'000	*11/12 Mth 10 Variance to Plan, excluding Pass Through £'000*	*11/12 Mth 10 Pass Through Variance £'000*	11/12 Mth 10 Variance to Plan, including Pass Through £'000	11/12 YTD Actual £'000	*11/12 YTD Variance to Plan, excluding Pass Through £'000*	*11/12 YTD Pass Through Variance £'000*	11/12 YTD Variance to Plan, including Pass Through £'000	11/12 YTD Actual Variance to 10/11 YTD Actual £'000
Primary Care Trusts Tariff	64,349	**5,636**	*179*	*0*	179	**53,997**	*718*	*0*	718	**4,163**
Primary Care Trusts Non Tariff	120,130	**11,022**	*562*	*188*	750	**100,202**	*2,676*	*-1,573*	1,103	**503**
Primary Care Trusts Mff	18,754	**1,643**	*52*	*0*	52	**15,802**	*274*	*0*	274	**-39**
Strategic Health Authorities	45,155	**4,189**	*367*	*60*	427	**38,920**	*1,073*	*218*	1,291	**3,571**
Nhs Trusts	874	**116**	*43*	*0*	43	**673**	*-56*	*0*	-56	**-694**
Department Of Health	850	**172**	*102*	*0*	102	**599**	*-109*	*0*	-109	**-81**
Nhs Other	5,993	**592**	*221*	*0*	221	**5,323**	*71*	*0*	71	**-1,563**
Activity Revenue Nhs	**256,105**	**23,370**	***1,526***	***248***	**1,774**	**215,516**	***4,647***	***-1,355***	**3,292**	**5,859**
Local Authorities	168	**0**	*0*	*0*	0	**151**	*-17*	*0*	-17	**-732**
Private Patients	27,669	**2,205**	*-246*	*0*	-246	**22,681**	*-313*	*0*	-313	**2,318**
Non Nhs Other	3,602	**262**	*-28*	*-15*	-43	**2,290**	*-423*	*-264*	-687	**-956**
Activity Revenue Non Nhs	**31,439**	**2,468**	***-274***	***-15***	**-289**	**25,122**	***-753***	***-264***	**-1,017**	**629**
Patient Transport Services	1,216	**82**	*-19*	*0*	-19	**957**	*-56*	*0*	-56	**-127**
Education And Training	13,386	**1,208**	*111*	*0*	111	**11,258**	*66*	*0*	66	**898**
Research And Development	13,364	**1,318**	*-50*	*254*	204	**11,112**	*-396*	*371*	-25	**416**
Charitable & Other Contrib	5,278	**187**	*-31*	*-215*	-246	**3,581**	*327*	*-1,162*	-835	**-513**
Non Patient Care Services	3,631	**312**	*10*	*0*	10	**3,395**	*369*	*0*	369	**435**
Revenue Generation	1,802	**28**	*-123*	*0*	-123	**1,067**	*-435*	*0*	-435	**-497**
Other Revenue	6,088	**-629**	*-1,061*	*0*	-1,061	**3,699**	*-1,518*	*0*	-1,518	**-1,438**
Other Operating Revenue, excl Donated Asset Income	**44,765**	**2,506**	***-1,163***	***39***	**-1,123**	**35,069**	***-1,643***	***-791***	**-2,434**	**-826**
Directors & Senior Managers	-8,606	**-697**	*-4*	*0*	-4	**-7,013**	*171*	*0*	171	**-407**
Consultants	-37,750	**-3,107**	*-83*	*125*	42	**-30,571**	*260*	*624*	884	**-690**
Junior Doctors	-18,900	**-1,692**	*-112*	*-5*	-117	**-16,606**	*-807*	*-49*	-856	**-1,801**
Junior Doctors Agy	11	**-111**	*-112*	*0*	-112	**-1,158**	*-1,167*	*0*	-1,167	**1,129**
Administration & Estates	-26,081	**-1,949**	*191*	*10*	201	**-19,280**	*2,414*	*75*	2,490	**-727**
Administration & Estates Agy	-528	**-251**	*-206*	*0*	-206	**-3,679**	*-3,239*	*0*	-3,239	**673**
Healthcare Assist & Supp	-2,429	**15**	*246*	*0*	246	**-1,526**	*498*	*0*	498	**244**
Healthcare Assist & Supp Agy	0	**-14**	*-14*	*0*	-14	**-182**	*-182*	*0*	-182	**39**
Nursing Staff	-59,072	**-5,181**	*-273*	*-45*	-318	**-49,538**	*-84*	*-110*	-194	**-572**
Nursing Staff Agy	-21	**-90**	*-88*	*0*	-88	**-2,097**	*-2,080*	*0*	-2,080	**120**
Scientific Therap Tech	-33,162	**-2,650**	*50*	*6*	56	**-26,413**	*1,268*	*44*	1,311	**499**
Scientific Therap Tech Agy	-53	**-210**	*-206*	*0*	-206	**-1,833**	*-1,789*	*0*	-1,789	**-233**
Other Staff	-295	**-19**	*6*	*0*	6	**-210**	*35*	*0*	35	**-10**
Pay Reserves	-3,640	**-28**	*-232*	*0*	-232	**-743**	*2,120*	*0*	2,120	**991**
Cips And Cres Unidentified - P	2,323	**0**	*228*	*0*	228	**0**	*-1,949*	*0*	-1,949	**0**
Pay Costs	**-188,202**	**-15,984**	***-609***	***90***	**-518**	**-160,850**	***-4,530***	***584***	**-3,946**	**-746**
Drugs Costs	-34,592	**-3,140**	*-34*	*-187*	-221	**-28,870**	*124*	*-411*	-287	**-3,731**
Blood Costs	-18,494	**-1,346**	*373*	*-153*	220	**-13,930**	*144*	*1,213*	1,357	**1,291**
Supplies & Services - Clinical	-23,864	**-2,061**	*108*	*84*	192	**-19,757**	*-478*	*565*	87	**-1,533**
Services From Nhs Organisation	-4,227	**-232**	*177*	*-41*	136	**-3,128**	*395*	*-36*	359	**374**
Healthcare From Non-Nhs Bodies	-2,389	**-367**	*-169*	*0*	-169	**-2,498**	*-507*	*0*	-507	**-1,172**
Supplies & Services - General	-1,721	**-167**	*-22*	*0*	-22	**-1,658**	*-227*	*0*	-227	**567**
Consultancy Services	-1,277	**-91**	*2*	*0*	2	**-1,136**	*-44*	*0*	-44	**-368**
Clinical Negligence Costs	-1,950	**-162**	*0*	*0*	0	**-1,624**	*0*	*0*	0	**-196**
Establishment Costs	-2,886	**-210**	*89*	*1*	90	**-2,153**	*255*	*10*	265	**72**
Transport Costs	-2,671	**-274**	*-53*	*0*	-53	**-2,335**	*-29*	*-78*	-107	**-5**
Premises Costs	-19,060	**-2,104**	*-551*	*3*	-548	**-16,748**	*-628*	*26*	-602	**-1,082**
Auditors Costs	-420	**-19**	*16*	*0*	16	**-286**	*63*	*0*	63	**22**
Education And Research Costs	-2,293	**-78**	*27*	*85*	112	**-1,117**	*380*	*415*	795	**279**
Expenditure - Other	-4,158	**28**	*512*	*-156*	356	**-1,686**	*1,653*	*122*	1,775	**143**
Non Pay Reserves	-2,337	**-13**	*-145*	*0*	-145	**-40**	*1,799*	*0*	1,799	**-40**
Cips And Cres Unidentified - N	1,492	**0**	*146*	*0*	146	**0**	*-1,252*	*0*	-1,252	**0**
Non Pay Costs	**-120,847**	**-10,236**	***476***	***-363***	**113**	**-96,967**	***1,648***	***1,826***	**3,474**	**-5,379**
EBITDA	**23,259**	**2,123**	***-43***	***0***	**-43**	**17,889**	***-631***	***0***	**-631**	**-462**
P & L On Disp Of Fixed Assets	0	**32**	*32*	*0*	32	**28**	*28*	*0*	28	**82**
Fixed Asset Impair & Reversals	-5,571	**0**	*0*	*0*	0	**0**	*0*	*0*	0	**228**
Depreciation & Amortisation	-17,164	**-1,239**	*520*	*0*	520	**-12,109**	*1,536*	*0*	1,536	**278**
Interest Receivable	36	**5**	*2*	*0*	2	**57**	*27*	*0*	27	**6**
Other Revenue / Expenditure	-24	**-3**	*-1*	*0*	-1	**-33**	*-13*	*0*	-13	**-7**
Pdc Dividend Payable	-5,765	**-480**	*0*	*0*	0	**-4,805**	*-1*	*0*	-1	**60**
Corporation Tax	-234	**-8**	*12*	*0*	12	**-80**	*115*	*0*	115	**-40**
Other Revenue / Expenditure	**-28,723**	**-1,695**	***564***	***0***	**564**	**-16,942**	***1,692***	***0***	**1,692**	**607**
Retained Surplus / (Deficit), excl Donated Asset Income	**-5,464**	**428**	***521***	***0***	**521**	**947**	***1,062***	***0***	**1,062**	**145**
Depreciation Income Transfer	6,773	**500**	*-146*	*0*	-146	**5,068**	*-395*	*0*	-395	**-1,012**
Retained Surplus / (Deficit), incl Donated Asset Income	**1,309**	**928**	***375***	***0***	**375**	**6,015**	***667***	***0***	**667**	**-866**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 2011/12
Research and Development Activity

Summary Research & Innovation Income and Expenditure

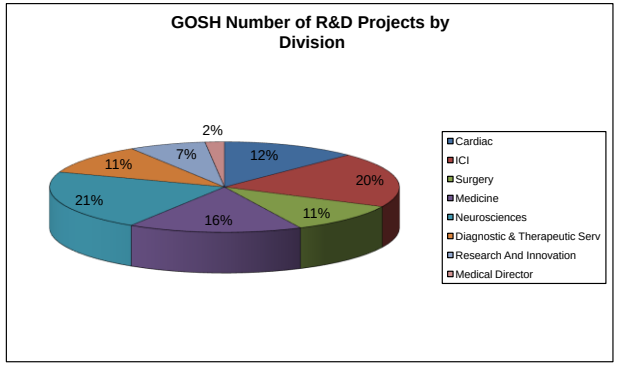
	Full Year Forecast	Full Year Budget	11/12 YTD Actuals	11/12 YTD Variance to Plan	10/11 YTD Actuals	11/12 YTD actual variance to 10/11 YTD actual
TOTAL RESEARCH & DEVELOPMENT DIRECTORATE						
- R&D Income	12,648	12,656	9,949	(606)	9,186	763
- R&D Income Deferred from 10-11	0	0	0	0	448	(448)
- R&D Income Local Research Network MCRN	935	788	923	267	648	275
- R&D Charitable Contribution	1,519	1,694	646	(788)	2,223	(1,577)
- Non Research Income	30	0	79	79	200	(121)
Income Sub-Total	**15,132**	**15,138**	**11,598**	**(1,048)**	**12,705**	**(1,108)**
- Expenditure	(7,017)	(6,948)	(5,011)	791	(4,714)	(296)
	8,115	8,190	6,587	(256)	7,991	(1,404)
- Expenditure in Clinical Areas	(7,779)	(8,587)	(6,483)	673	(5,108)	(1,375)
Total R&D Division	336	(397)	104	417	2,883	(2,779)
Devolved Income						
- Cardiac	0	0	2	2	0	2
- Flexibility & Sustainability Funding (Central) STANDARD & Central Finance	0	(415)	0	357	0	0
- DTS : From CLRN Service Support	76	218	76	(106)	159	(83)
- Medicine : Grants	169	82	125	53	31	94
- ICI : From CLRN Support / NIHR Felowships	81	67	94	39	71	23
- Surgery : From Charitable Donation	3	0	(3)	(3)	17	(20)
Total Centrally Held and Devolved Income	329	(48)	295	343	278	17

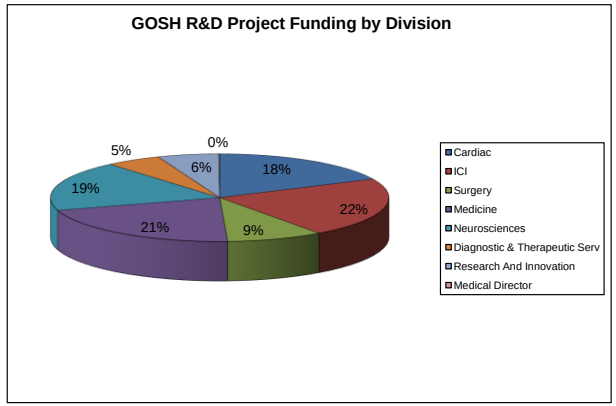
Revenue and Direct Expenditure by Funding Source

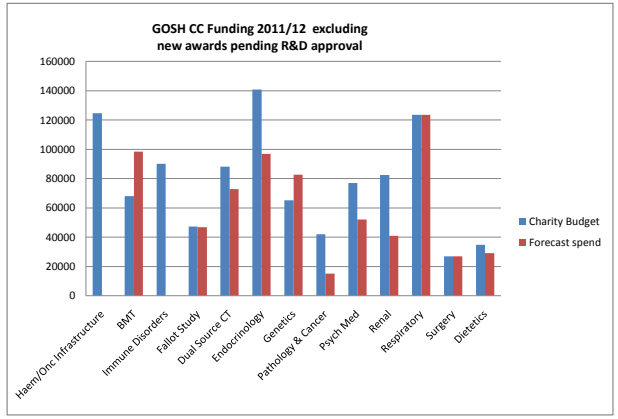
Biomedical Research Centre including Clinical Research Facility						
- Income	7,813	7,882	6,038	(530)	5,597	441
- Commercial Trials Income	295	0	598	598	423	175
- Non R&D Income	30	0	79	79	200	(121)
Income Sub-Total	**8,139**	**7,882**	**6,715**	**147**	**6,220**	**495**
- Expenditure	(2,812)	(2,811)	(1,895)	448	(1,917)	22
	5,327	5,070	4,820	594	4,303	517
CLRN (PCRN) Income						
- Income CLR Activity Based (Non DH R&D)	293	1,186	250	(738)	940	(690)
- Income PCRN (R M&G, KSS, SS)	86	0	71	71	92	(20)
- Income PCRN (R M&G,)	272	0	244	244	25	219
- Income Non R&D (cc **CLR**)	0	112	0	(94)	0	0
Income Sub-Total	**650**	**1,298**	**565**	**(517)**	**1,057**	**(492)**
- Expenditure CLR	(249)	(198)	(267)	(102)	(88)	(179)
	401	1,100	298	(619)	969	(671)
NIHR GRANTS						
- Income	935	983	644	(183)	473	171
Income Sub-Total	**935**	**983**	**644**	**(183)**	**473**	**171**
- Expenditure	(935)	(987)	(680)	151	(473)	(207)
	0	(4)	(36)	(32)	0	(36)
R&D GOSH Charity Funded Projects						
- Income	1,519	1,694	646	(788)	2,223	(1,577)
Income Sub-Total	**1,519**	**1,694**	**646**	**(788)**	**2,223**	**(1,577)**
- Expenditure	(1,483)	(1,552)	(726)	571	(1,817)	1,092
	36	142	(79)	(217)	406	(485)
R&D Development Office & Other Grants						
- Income R&D including Flexibility and Sustainability	2,955	2,479	2,104	38	2,084	20
- Income non R&D	0	0	0	0	0	0
- Income EU Grants	0	15	0	(12)	0	0
						0
Income Sub-Total	**2,955**	**2,494**	**2,104**	**26**	**2,084**	**20**
- Expenditure	(603)	(612)	(520)	9	(419)	(101)
	2,351	1,881	1,585	(17)	1,665	(80)
Local Research Network MCRN *						
- Income DH to fund Network	628	628	784	261	401	383
- Income : Network Flexibility and Sustainability	143	143	79	(40)	58	21
- Income R&D :CLRN Network	164	0	60	60	119	(59)
- Income Other Non R&D	0	17	0	(14)	71	(71)
Income Sub-Total	**935**	**788**	**923**	**267**	**648**	**275**
- Expenditure LRN	(935)	(788)	(923)	(267)	(648)	(275)
	0	0 0	0	0	(0)	0

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

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







Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 2011/12
Statement of Financial Position

	Actual as at 1 April 2011	Actual as at 31 December 2011	Actual as at 31 January 2012	Change in month	Forecast as at 31 March 2012
	£000	£000	£000	£000	£000
Non Current Assets :					
Property Plant & Equipment - Purchased	177,238	179,100	179,269	169	175,392
Property Plant & Equipment - Donated	141,526	158,162	158,250	88	159,230
Property Plant & Equipment - Gov Granted	363	316	311	(5)	301
Intangible Assets - Purchased	972	1,054	1,415	361	741
Intangible Assets - Donated	25	10	8	(2)	5
Trade & Other Receivables	9,505	9,160	9,120	(40)	9,041
Total Non Current Assets :	***329,629***	***347,802***	***348,373***	***571***	***344,710***
Current Assets :					
Inventories	5,156	6,330	5,888	(442)	6,100
NHS Trade Receivables	7,455	12,972	21,029	8,057	7,758
Non NHS Trade Receivables	10,360	11,361	11,033	(328)	8,948
Capital Receivables	6,571	3,849	3,604	(245)	6,880
Provision for Impairment of Receivables	(1,498)	(1,248)	(1,208)	40	(1,250)
Prepayments & Accrued Income	4,919	6,398	6,817	419	5,827
HMRC VAT	1,895	519	717	198	750
Other Receivables	807	943	1,078	135	840
Cash & Cash Equivalents	32,371	17,535	18,560	1,025	26,050
Total Current Assets :	***68,036***	***58,659***	***67,518***	***8,859***	***61,903***
Total Assets :	**397,665**	**406,461**	**415,891**	**9,430**	**406,613**
Current Liabilities :					
NHS Trade Payables	(7,722)	(4,623)	(3,708)	915	(2,387)
Non NHS Trade Payables	(2,519)	(1,008)	(2,339)	(1,331)	(1,017)
Capital Payables	(12,179)	(4,022)	(3,251)	771	(10,591)
Expenditure Accruals	(14,866)	(13,308)	(13,568)	(260)	(13,200)
Deferred Revenue	(6,280)	(5,825)	(13,734)	(7,909)	(5,400)
Tax & Social Security Costs	(4,022)	(4,044)	(4,103)	(59)	(4,050)
Other Payables	0	(1,441)	(1,922)	(481)	0
Payments on Account	(228)	(228)	(228)	0	(228)
Lease Incentives	(400)	(444)	(467)	(23)	(400)
Other Liabilities	(2,754)	(3,683)	(3,790)	(107)	(3,700)
Provisions for Liabilites & Charges	(2,867)	(2,704)	(2,672)	32	(2,426)
Total Current Liabilities :	***(53,837)***	***(41,330)***	***(49,782)***	***(8,452)***	***(43,399)***
Net Current Assets	**14,199**	**17,329**	**17,736**	**407**	**18,504**
Total Assets Less Current Liabilities :	**343,828**	**365,131**	**366,109**	**978**	**363,214**
Non Current Liabilities :					
Lease Incentives	(7,327)	(7,026)	(6,992)	34	(6,926)
Provisions for Liabilites & Charges	(1,250)	(1,194)	(1,197)	(3)	(1,178)
Total Non Current Liabilities :	***(8,577)***	***(8,220)***	***(8,189)***	***31***	***(8,104)***
Total Assets Employed :	**335,251**	**356,911**	**357,920**	**1,009**	**355,110**
Financed by Taxpayers' Equity :					
Public Dividend Capital	124,732	124,732	124,732	0	124,732
Retained Earnings	16,868	22,087	23,030	943	19,282
Revaluation Reserve	48,623	48,490	48,475	(15)	48,446
Donated Asset Reserve	141,551	158,172	158,258	86	159,235
Government Grant Reserve	363	316	311	(5)	301
Other Reserves	3,114	3,114	3,114	0	3,114
Total Taxpayers' Equity :	**335,251**	**356,911**	**357,920**	**1,009**	**355,110**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 2011/12
Statement of Cash Flow

Statement of Cash Flows	Actual For Month Ended 31 January 2012 £000	Actual For YTD Ended 31 January 2012 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating Surplus	1,376	10,768
Depreciation and Amortisation	1,239	12,109
Transfer from Donated Asset Reserve	(495)	(5,017)
Transfer from the Government Grant Reserve	(5)	(52)
PDC Dividend Paid	0	(2,818)
Decrease/(Increase) in Inventories	442	(732)
Increase in Trade and Other Receivables	(8,477)	(15,208)
Increase in Trade and Other Payables	8,644	2,043
Increase in Other Current Liabilities	96	768
Decrease in Provisions	(32)	(281)
Net Cash Outflow from Operating Activities :	***2,788***	***1,581***
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	4	57
Payments for Property, Plant and Equipment	(2,232)	(39,544)
Payments for Intangible Assets	(380)	(635)
Proceeds from Disposal of Intangible Assets	20	28
Net Cash Outflow from Investing Activities :	**(2,588)**	**(40,094)**
NET CASH OUTFLOW BEFORE FINANCING :	**200**	**(38,513)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	0	0
Other Capital Receipts	825	24,702
Net Cash Inflow from Financing :	**825**	**24,702**
NET DECREASE IN CASH AND CASH EQUIVALENTS :	**1,025**	**(13,811)**

Cash and Cash Equivalents at the beginning of the financial year	**17,535**	**32,371**
Cash and Cash Equivalents at the end of the current period	**18,560**	**18,560**
Net Decrease in Cash and Cash Equivalents per SoFP :	**1,025**	**(13,811)**

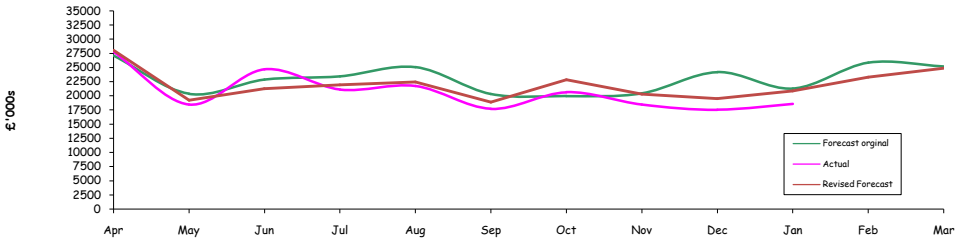
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 2011/2012
Activity

January activities are based on April to December

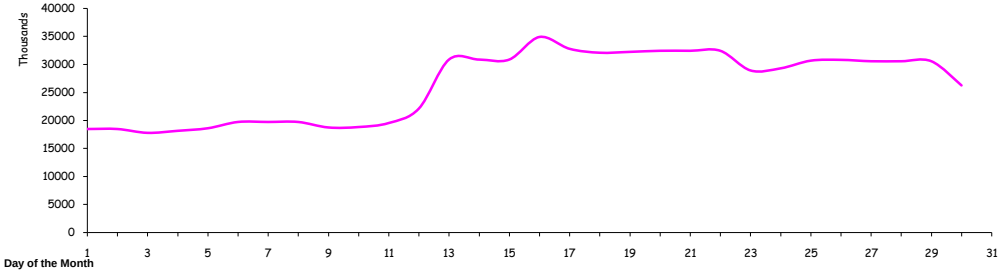
	April	May	June	July	August	September	October	November	December	January	February	March	YTD 11/12 Actual	YTD 11/12 Plan	YTD 11/12 Variance	YTD 11/12 Variance %	YTD 10/11	Variance 11/12 to 10/11	Variance 11/12 to 10/11 %
Elective PBR	1,416	1,499	1,652	1,515	1,531	1,541	1,584	1,656	1,388	1,574			15,356	14,911	445	3.0%	14,316	1,040	7.3%
Elective Non PBR	106	151	159	129	146	130	167	147	152	145			1,432	1,897	-465	-24.5%	1,741	-309	-17.7%
Same Day PBR																			
Same Day Non PBR																			
TOTAL ELECTIVE	1,522	1,650	1,811	1,644	1,677	1,671	1,751	1,803	1,540	1,719	0	0	16,788	16,808	-20	-0.1%	16,057	731	4.6%
Non Elective PBR	143	155	134	115	131	117	136	146	130	136			1,343	1,500	-157	-10.5%	1,455	-112	-7.7%
Non Elective Non PBR	3	1	1	3	1	3	1	4	1	2			20	44	-24	-54.0%	28	-8	-28.6%
TOTAL NON ELECTIVE	146	156	135	118	132	120	137	150	131	138	0	0	1,363	1,543	-180	-11.7%	1,483	-120	-8.1%
																0.0%			
Outpatients PBR	5,604	6,732	7,578	6,662	6,605	7,709	7,220	7,878	6,050	7,274			69,312	67,385	1,927	2.9%	55,969	13,343	23.8%
Outpatients Non PBR	4,282	4,842	5,077	4,869	4,849	5,388	5,221	5,374	4,363	5,108			49,373	48,179	1,194	2.5%	50,677	-1,304	-2.6%
TOTAL OUTPATIENTS	9,886	11,574	12,655	11,531	11,454	13,097	12,441	13,252	10,413	12,382	0	0	118,685	115,564	3,121	2.7%	106,646	12,039	11.3%
POC (Non Consortium)	801	788	803	792	810	819	832	829	835	812			8,121	8,783	-662	-7.5%	9,328	-1,207	-12.9%
BEDDAYS (includes PICU Consortium)																			
Panda HDU (PBR HDU)	744	622	757	890	790	646	871	604	788	766			7,478	7,181	297	4.1%	7,295	183	2.5%
Transitional Care	140	176	139	164	186	160	124	120	116	149			1,474	1,250	224	17.9%	1,264	210	16.6%
Rheumatology Rehab	145	194	216	218	180	199	224	224	141	196			1,937	1,844	93	5.1%	1,784	153	8.6%
CAMHS	214	239	252	251	248	229	244	251	279	249			2,456	2,460	-4	-0.1%	2,244	212	9.4%
Cardiac ECMO	17	6	19	0	10	30	1	32	7	14			136	77	59	76.6%	91	45	49.5%
Neurosurgery HDU (NC)	0	11	0	7	0	7	7	13	3	5			53	33	20	61.3%	35	18	51.4%
Neurosurgery (PICU Consortium-ITU & I	2	51	100	90	71	145	53	84	72	75			743	645	98	15.2%	610	133	21.8%
Neurosurgery ITU (NC)	1	0	0	12	0	0	0	0	3	2			18	19	-1	-2.8%	22	-4	-18.2%
Cardiac HDU (NC)	33	28	42	54	42	42	65	62	34	45			447	341	106	31.0%	354	93	26.3%
Cardiac ITU (NC)	61	101	146	102	70	113	108	130	107	106			1,044	963	81	8.4%	1,214	-170	-14.0%
Cardiac (PICU Consortium-ITU & HDU)	251	165	179	308	277	209	210	177	222	225			2,223	2,093	130	6.2%	1,978	245	12.4%
Paediatric ITU (NC)	48	68	71	44	30	85	80	83	39	62			610	695	-85	-12.2%	561	49	8.7%
Paediatric ITU (PICU Consortium-ITU)	399	367	374	435	387	398	370	393	422	400			3,945	3,917	28	0.7%	3,830	115	3.0%
TOTAL BEDDAYS	2,055	2,028	2,295	2,575	2,291	2,263	2,357	2,173	2,233	2,294	0	0	22,564	21,516	1,048	4.9%	21,282	1,282	6.0%
HaemOnc Consortium*																			
PBR	50	55	53	54	48	54	52	44	52	53			515	530	-15	-2.9%	494	21	4.3%
NON PBR	134	142	145	144	163	143	168	154	140	152			1,485	1,405	80	5.7%	1,266	219	17.3%
Panda HDU (PBR HDU)	202	256	154	329	311	210	315	263	334	271			2,645	2,302	343	14.9%	2,307	338	14.7%
TOTAL HAEMONC	386	453	352	527	522	407	535	461	526	476	0	0	4,645	4,237	408	9.6%	4,067	578	14.2%

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 2011/12
Cash Management

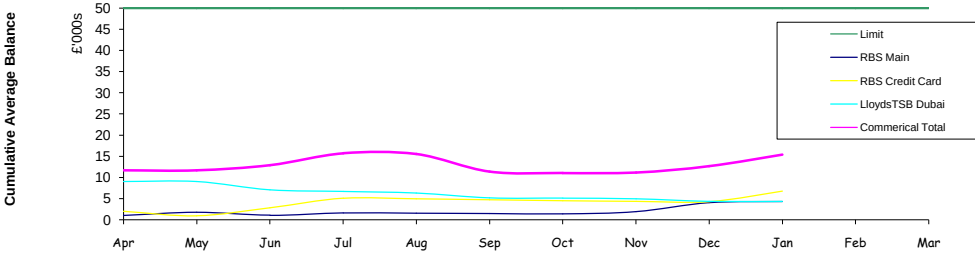
Forecast Cash



Daily Liquidity



Commerical Bank Account Performance



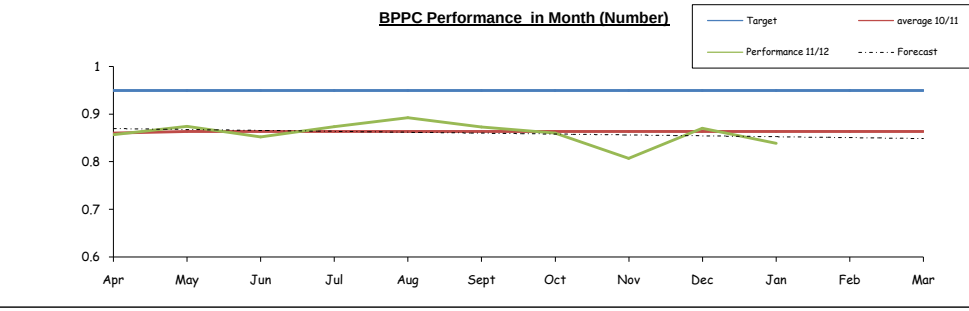
Payables Analysis

Days	Forecast March 12	Current Month	Previous Month	Movement in Month
		£000s	£000s	£000s
Not Yet Due	5,000	5,911	2,506	3,405
1-30	2,500	1,232	1,800	(569)
31-60	1,250	339	804	(465)
61-90	675	100	371	(271)
91-120	200	166	193	(28)
121-180	125	188	253	(66)
180-360	125	338	450	(112)
360+	125	485	591	(105)
	10,000	**8,759**	**6,968**	**1,790**

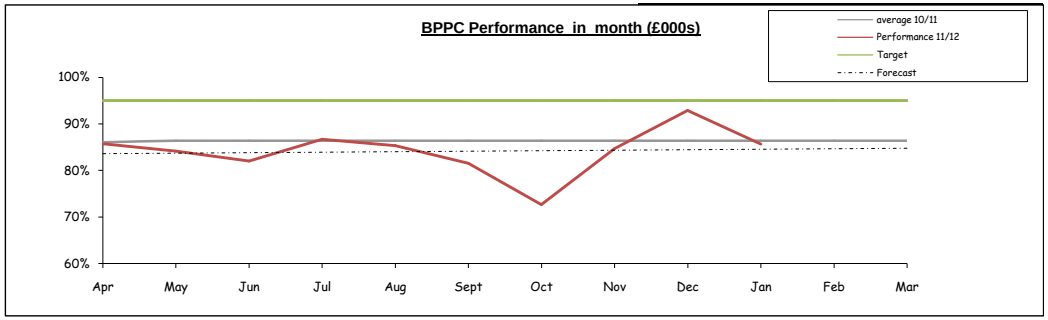
Better Payment Practice Code (BPPC)

	Number	£000s
Cumumlative Performance		
Total Payables		
% of Invoices paid within target	85.2%	83.7%
Non-NHS Payables		
Invoices paid in the year	67430	155,559
Invoices paid within target	58343	134,847
% of Invoices paid within target	86.5%	86.7%
NHS Payables		
Invoices paid in the year	2864	16,633
Invoices paid within target	1534	9,304
% of Invoices paid within target	53.6%	55.9%

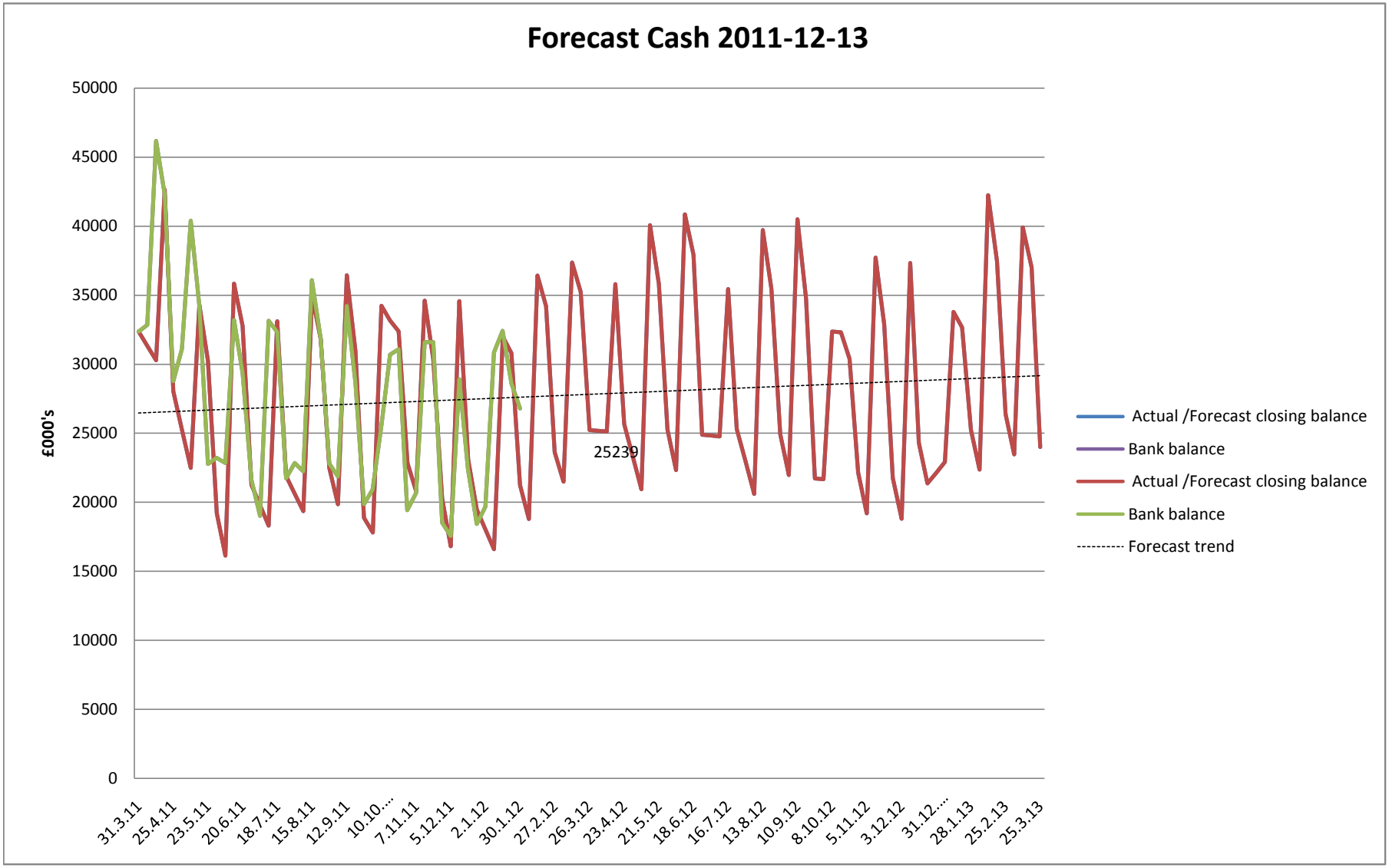
BPPC Performance in Month (Number)



BPPC Performance in month (£000s)



Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 2011/12
Cash Forecast



Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 2011/12
Receivables Management

Net Receivables in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	**11230**	-546	3270	7687	517	11	81	76	31	104
NHS Credit Note Provision	-713	0	-0	0	0	0	-32	-41	-296	-344
Specific NHS Debt Provisions										
NHS Net Receivables	**10518**	**-546**	**3270**	**7687**	**517**	**11**	**49**	**35**	**-265**	**-240**
Non-NHS	**2634**	-16	630	273	1433	84	49	-16	95	103
Bad Debt Provision-Non NHS	-400	0	-53	-32	-45	-13	-12	-21	-99	-124
Specific Non-NHS Debt Provisions	0	0	0	0	0	0	0	0	0	0
Non-NHS Net Receivables	**2234**	**-16**	**577**	**241**	**1387**	**71**	**37**	**-37**	**-4**	**-22**
International	**7858**	-1071	5128	1690	502	306	341	168	238	555
Bad Debt Provision-International	-808	-3	-1	-0	-1	-0	-70	-34	-135	-563
International Net Receivables	**7050**	**-1073**	**5127**	**1690**	**502**	**305**	**271**	**133**	**103**	**-7**
GOSH Charity Receivables	**2303**	-3	1888	145	65	172	23	13	1	-0
Net Trust Receivables	**22105**	**-1639**	**10861**	**9762**	**2470**	**559**	**380**	**145**	**-165**	**-269**

Trust Receivables in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	11230	-546	3270	7687	517	11	81	76	31	104
Non-NHS	2634	-16	630	273	1433	84	49	-16	95	103
International	7858	-1071	5128	1690	502	306	341	168	238	555
Gross Trading Receivables	**21722**	**-1632**	**9027**	**9650**	**2452**	**401**	**471**	**227**	**364**	**762**
GOSH Charity Receivables	2303	-3	1888	145	65	172	23	13	1	-0
Total Trust Receivables	**24025**	**-1636**	**10916**	**9794**	**2516**	**573**	**494**	**241**	**365**	**762**

Movement in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
Gross Trading Receivables (as above)	24025	-1636	10916	9794	2516	573	494	241	365	762
Gross Trading Receivables (last month)	22702	4672	7876	3058	4147	332	728	693	634	562
Movement in Month	**1323**	**-6308**	**3039**	**6736**	**-1631**	**241**	**-234**	**-452**	**-269**	**200**
Gross Trading Receivables (year end 10/11)	15481	-1747	11317	1550	779	524	423	515	1385	734
Movement in Financial Year	**-8544**	**-111**	**402**	**-8244**	**-1737**	**-49**	**-71**	**275**	**1020**	**-28**

Systems Schedule

Receivables in £'000's	Gross Receivables	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
eFinancial	16167	-565	5787	8105	2014	267	152	73	127	207
Compucare	7858	-1071	5128	1690	502	306	341	168	238	555
Trust Receivables	**24025**	**-1636**	**10916**	**9794**	**2516**	**573**	**494**	**241**	**365**	**762**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 2011/12
Capital Expenditure (£000s)

Capital Spend by Division	Year to Date (YTD)					
	Annual Plan	Year To Date Plan	Actual (YTD)	Variance (YTD)	Forecast Outturn	Forecast Variance to Plan
Redevelopment Projects						
Trust/DH Funded						
Phase 2a Enabling	0	0	0	0	0	0
Donated Funded						0
Phase 1	26	20	(7)	27	12	14
Phase 2a Enabling	0	0	0	0	0	0
Phase 2a	27,778	20,946	17,594	3,351	26,474	1,304
Phase 2b Enabling	6,271	4,729	105	4,623	1,000	5,271
Phase 2b	1,953	1,473	1,573	(100)	1,998	(45)
Pre-phase 2	0	0	18	(18)	18	(18)
Phase 2 - Inhouse Resources	344	260	234	25	292	52
Other Redevelopment Projects	0	0	0	0	0	0
Total :	**36,372**	**27,426**	**19,518**	**7,908**	**29,794**	**6,578**
Estates Maintenance Projects						
Trust/DH Funded	7,702	5,906	6,683	(777)	7,581	121
Donated Funded	1,250	962	20	942	520	730
Total :	**8,952**	**6,868**	**6,703**	**165**	**8,101**	**851**
IT Projects						
Trust/DH Funded	6,000	4,600	2,656	1,944	4,500	1,500
Donated Funded	1,000	760	15	745	1,000	0
Total:	**7,000**	**5,360**	**2,671**	**2,689**	**5,500**	**1,500**
Medical Equipment Projects						
Trust/DH Funded	90	74	176	(102)	216	(126)
Donated Funded	3,500	2,682	2,182	500	3,145	355
Total:	**3,590**	**2,756**	**2,357**	**399**	**3,361**	**229**
Total Additions in Year	**55,914**	**42,410**	**31,249**	**11,161**	**46,755**	**9,159**
Asset Disposals	0	0	(4)	4	(4)	4
Donated Funded Projects	(42,122)	(31,830)	(21,735)	(10,095)	(34,459)	(7,663)
Charge Against CRL Target	**13,792**	**10,580**	**9,511**	**1,069**	**12,292**	**1,500**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 10 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	Period 10	10/11 Period 12	M9 variance to M12 10/11
Cardiac	350	354	348	358	354	363	373	379	375	372	342	-30
Surgery	650	644	640	649	652	647	669	676	680	681	646	-35
DTS	354	356	354	351	355	346	354	362	355	353	349	-3
ICI	479	481	472	482	486	487	501	519	512	515	460	-55
International	114	116	117	118	117	113	120	127	122	129	115	-14
Medicine	280	284	275	274	280	281	271	276	279	284	282	-2
Neurosciences	261	264	254	258	258	273	278	279	282	283	255	-28
Haringey	183	175	0	1	0	0	0	0	0	0	0	0
North Mid.	2	2	2	2	2	0	0	0	0	0	0	0
Children's Population Health	7	8	8	9	7	7	8	7	8	7	7	0
Operations & Facilities	202	203	208	207	207	192	204	206	215	213	208	-5
Corporate Affairs	15	13	12	14	10	10	14	10	7	8	13	5
Estates	46	45	45	45	44	43	45	45	45	45	48	3
Finance & ICT	138	138	140	135	138	135	127	120	121	121	134	13
Human Resources	57	55	54	57	58	60	56	59	62	61	57	-4
Medical Director	14	14	13	14	14	14	8	8	7	8	15	7
Nursing And Workforce Development	80	78	75	76	76	75	80	77	83	87	80	-7
Research And Innovation	57	63	66	75	71	78	79	77	76	81	77	-5
Redevelopment Revenue Costs	7	7	7	8	8	8	6	6	6	6	7	2
TOTAL	3297	3300	3089	3,134	3,137	3,131	3,194	3,233	3,236	3,254	3096	-158

Overtime

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	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	1.6	2.6	1.0
Surgery	3.3	2.4	1.8	1.4	1.8	3.1	2.7	3.4	2.6	2.4	2.6	0.1
DTS	0.4	0.8	1.1	1.0	0.7	0.4	0.4	0.4	0.6	0.6	0.5	0.0
ICI	0.4	0.3	0.1	0.5	0.8	0.4	0.5	0.5	0.4	0.4	0.5	0.1
International	0.2	1.5	0.8	1.0	0.9	1.8	0.9	1.0	0.7	1.3	1.8	0.5
Medicine	0.3	0.8	0.4	0.2	0.1	0.1	0.4	0.4	0.1	0.5	0.3	-0.3
Neurosciences	0.9	0.6	0.7	0.4	0.5	0.7	0.5	0.3	0.2	0.3	0.8	0.5
Haringey	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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	0.0
Children's Population Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Operations & Facilities	3.6	4.0	4.3	4.3	4.9	3.1	2.8	3.8	4.1	5.5	4.2	-1.3
Corporate Affairs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates	2.0	1.2	1.4	2.0	2.0	1.0	1.6	1.4	1.3	1.1	2.3	1.2
Finance & ICT	3.1	1.2	1.7	0.9	1.5	0.5	0.8	0.6	0.6	0.5	1.2	0.7
Human Resources	0.1	0.0	0.0	0.0	0.1	0.0	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	0.0
Nursing And Workforce Development	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	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	0.2	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	0.0
TOTAL	20.6	15.7	13.8	13.9	15.0	13.1	12.3	14.7	12.6	14.3	17.0	2.7

Agency/Locum/Bank

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	10/11 Period 12	M9 variance to M12 10/11
Cardiac	34	29	36	40	36	48	31	41	37	42	41	-1
Surgery	56	62	63	66	63	76	83	80	64	62	67	6
DTS	9	10	18	17	14	15	17	17	14	16	13	-3
ICI	40	34	37	44	46	37	43	34	24	36	49	13
International	41	44	37	37	36	43	33	29	21	22	31	9
Medicine	27	22	21	23	15	23	24	22	20	20	28	7
Neurosciences	25	18	21	23	17	26	21	18	21	11	31	19
Haringey	4	5	0	0	0	0	0	0	0	0	0	0
North Mid.	0	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	0
Operations & Facilities	9	18	16	14	17	28	24	12	16	11	27	16
Corporate Affairs	0	1	0	0	2	1	0	0	0	0	0	0
Estates	5	15	7	15	4	12	41	8	5	0	7	7
Finance & ICT	15	11	14	12	17	15	19	24	22	20	14	-5
Human Resources	4	0	4	5	2	4	2	2	1	1	9	8
Medical Director	2	2	1	2	1	2	0	0	0	0	2	2
Nursing And Workforce Development	3	2	3	3	1	4	1	1	1	2	3	1
Research And Innovation	1	2	3	1	1	2	2	2	2	6	4	-2
Redevelopment Revenue Costs	0	0	3	0	3	1	1	2	2	1	6	4
TOTAL	277	273	284	304	276	338	342	291	250	249	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	Period 10	10/11 Period 12	M9 variance to M12 10/11
Cardiac	390	385	386	401	392	413	406	423	414	415	385	-29
Surgery	709	709	704	716	717	726	755	759	746	745	716	-29
DTS	364	366	373	369	370	361	371	379	369	370	363	-7
ICI	519	515	510	527	532	525	544	554	536	551	510	-41
International	154	162	155	156	154	158	153	157	143	152	148	-4
Medicine	308	306	296	298	295	305	296	299	299	305	310	5
Neurosciences	287	283	276	282	275	300	300	297	303	294	286	-8
Haringey	187	180	0	1	0	0	0	0	0	0	0	0
North Mid.	2	2	2	2	2	0	0	0	0	0	0	0
Children's Population Health	9	8	8	9	7	7	8	7	8	7	7	0
Operations & Facilities	214	225	228	226	229	223	231	222	236	229	239	10
Corporate Affairs	15	14	12	14	13	11	14	10	7	8	13	5
Estates	53	61	54	62	50	56	87	54	52	46	57	11
Finance & ICT	155	150	155	148	157	151	147	145	144	141	149	9
Human Resources	62	55	57	62	60	64	59	61	63	62	66	4
Medical Director	17	16	14	16	15	16	8	8	7	8	17	9
Nursing And Workforce Development	83	80	77	80	77	79	81	78	84	89	84	-5
Research And Innovation	58	65	69	76	72	81	82	80	79	87	81	-7
Redevelopment Revenue Costs	7	7	11	8	10	9	7	7	8	7	13	6
TOTAL	3,594	3,588	3,388	3,451	3,428	3,483	3,548	3,539	3,498	3,518	3,444	-73

Great Ormond Street Hospital for Children NHS Trust

Trust Board
29 February 2012

Foundation Trust application update **Submitted on behalf of:** Sven Bunn	**Paper No: Attachment X**

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 completed their assessment meetings in January and the board to board meeting with Monitor was held on 8 February 2012. The remaining areas of work following the board to board meeting include:

- Financial viability:
  - Demonstration of productivity improvements
  - Further evidence on the forecast out-turn for 2011/12.
  - Review of scope and deliverability of downside mitigations, to ensure that Monitor accept schemes to sufficiently mitigate downside scenarios.
- 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. Ensure that changes to the arrangements for managing quality governance have been implemented and embedded.

Key actions for the next two months:

- Complete the Monitor assessment process.
- Complete actions arising from the board to board meeting.

Action required from the meeting

To note the current position for the foundation trust application.

Contribution to the delivery of NHS / Trust strategies and plans

Achievement of Trust objective to secure Foundation Trust status

Financial implications: None

Legal issues: None

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

Who needs to be told about any decision Not required

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

Sven Bunn, FT Programme Manager

Who is accountable for the implementation of the proposal / project

Jane Collins, Chief Executive

Author and date

Sven Bunn
20 February 2012

Foundation Trust application – February 2012 position

Assessment of current performance for Great Ormond Street Hospital against the seven domains of the Secretary of State assurance process (changes since January 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 ~**8,500** 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 downside FRR of 2 in 13/14 onwards. • 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	• 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. • Current CQC assessment: assessed as compliant with all key standards (reviewed July 2011)	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	• **No outstanding issues**	Green
Evidence that delivery is meeting or exceeding plans	• Good performance management system	Green
7. Local health economy issues / external relations		**Green**
If local health economy financial recovery plans in place, does the application adequately reflect this?	• Participation in London specialised children's services review. • Participation in national reviews	Green
Any commissioner disinvestment or contestability	• None	Green
Effective and appropriate contractual relations in place	• Commissioner Forum • Risk to commissioner agreement with growth plans	Green
Other key stakeholders such as local authorities, SHAs, other trusts, etc.	• Good working relationships	Green

Sven Bunn
20 February 2012

Great Ormond Street Hospital for Children NHS Trust

Trust Board **29th February 2012**	
HCAI Peer Review Report **Submitted on behalf of** **Deirdre Malone, Lead Nurse Infection Prevention & Control / Deputy DIPC**	**Paper No: Attachment Y**
Aims / summary To feedback the recommendations of the HCAI Peer Review to the Board Members	
Action required from the meeting No action required as there will be a formal action plan developed as a result of the report.	
Contribution to the delivery of NHS / Trust strategies and plans **Contributes to our overall aim of reducing HCAI's**	
Financial implications None identified	
Legal issues No	
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 Executive team, all clinical staff, Clinical unit Chairs, General Mangers	
Who is responsible for implementing the proposals / project and anticipated timescales Executive team, all clinical staff, Clinical unit Chairs, General Mangers, Infection Prevention & Control team	
Who is accountable for the implementation of the proposal / project Deirdre Malone	
Author and date Deirdre Malone – 16/02/2012	

Healthcare Associated Infection (HCAI) Peer Review findings and recommendations

Introduction

MRSA bloodstream infections are a significant cause of morbidity and can be difficult to treat because of their multiple antibiotic resistance. Infections may increase hospital length of stay, possible resulting in increased morbidity and in some cases resulting in death.

The Department of Health (DoH) set an ambitious target to achieve a 60% reduction in MRSA rates 2007/2008. The intention is that action on MRSA will also reduce the incidence of other infections.

As a result of the efforts made by organisations to reduce their MRSA rates, the DoH set a target to reduce *Clostridium difficile* rates by 30% in 2010/11, based on the 2007/08 baseline.

The majority of NHS Trust throughout England achieved and surpassed both targets and national trends in both MRSA and *Clostridium difficile* suggested continued reductions.

However, in the second half of 2011 there were increases in both MRSA and *Clostridium difficile* rates across England, with the highest increase in London.

NHS SHA London, commissioned a project director and project manager to review 11 Trusts across London, which were failing to meet their MRSA and *Clostridium difficile*.

The process

The project director and project manager recruited a number of Infection Prevention & Control Lead Nurses, microbiologists, antimicrobial pharmacists to conduct peer review visits across these 11 Trusts in London. The peer review process started on December 22$^{nd\ 2011}$ and ended on February 16th 2012.

Those professionals mentioned above attended a training afternoon last November to help them understand the process.

GOSH Peer Review – January 27th 2012

The peer review team requested a number of documents in preparation for their visit. The team visited the following areas;

Squirrel

Badger

CICU

Elephant & Lion

These wards were chosen as Squirrel, Badger & CICU have had cases of MRSA bacteraemia, although one case was shared care across Badger & CICU. Elephant & Lion wards have had the highest detection of *Clostridium difficile* during 2011.

The team also interviewed the Medical Director, Chief Nurse, General Managers, Heads of Nursing, Lead Nurses, Ward Sisters, Antimicrobial Pharmacist and the Facilities Manager.

Recommendations

It was very clear just how seriously the Board were taking this issue and how much of a priority you viewed it. They were impressed with just how professional, motivated and helpful they found the senior nursing staff. The Infection Prevention and Control team clearly had a high profile and were visible, passionate, well regarded and respected by Trust staff. The organisation has developed an impressive data system and our use information in a visual and robust way.

The peer reviewers overall observations are that the actions we are focusing on are primarily the correct ones. However, there are a number of areas where these actions can be strengthened and would, therefore, make the following comments.

Central and Peripheral Line Insertion and Care

Root Cause Analysis (RCA) has shown that lines were potential causes of your MRSA BSI and you recorded a total of 89 BSI (all microorganisms) line related infections last year. Given the complexity of cases and the lack of ability to easily benchmark your infection rates, it is not possible for you at this time to determine the rate that may have been unavoidable. That said, your current systems and processes cannot provide adequate assurance that all good practice is being applied consistently, nor that the risks to acquiring line related BSIs are effectively minimised or mitigated.

Although you assess ANTT competence of nurses, you assume doctors coming to your organisation have completed the required training and assessment through current medical education processes. Given your current number of line related infections, we would suggest you need to assure this is the case.

Your audit compliance to Saving Lives HII related bundles should offer effective assurance of compliance, but you do not currently have a process in place to test the effectiveness of these controls.

We recognise that you have done a large amount of work to reduce the risk of line related infections but we would suggest that your organisation might benefit from a refreshed “campaign approach” to this risk. This needs to include:

- A refreshed set of compelling messages and information for all staff that raises the focus and sets expectations
- A plan that clearly articulates the risks to acquiring a line related infection and the actions required to minimise or mitigate these
- A process that provides effective assurance to the Board on progress and implementation
- A method of assuring competence of all clinical staff undertaking line insertion (Central Manchester have undertaken such a process - the Chief Nurse is Gill Heaton)

- On-going training and assessment of competence with records kept of all staff assessed (as you do with nursing staff)
- A simple method of measuring progress (in addition to your excellent measurement systems) such as number of days between line related infections

Antimicrobial Stewardship

The Trust has in place a comprehensive set of policies and guidelines that would support prudent antibiotic prescribing and reflect the complex needs of very vulnerable and sick babies and children. However, your audits suggest variation in compliance to those policies.

Annual audits showed:

- 67% compliance with prescribing guidance (you could not be assured whether there were clinically appropriate reasons for this due to incomplete documentation with 52% compliance to recording reason for prescribing antibiotic
- Only 25% compliance recording duration of antibiotic

You have a part time Antimicrobial Pharmacist, an academic based at the University, who is responsible for updating policies and undertaking your annual audits. We do not believe this post holder's experience and role responsibility will support the changes you require.

You are in the process of rolling out e-prescribing which most organisations see as the way they will drive more prudent prescribing. However, your system currently lacks the functionality to do this. The system does not enable clinicians to easily record reason for prescribing and it will take until 2013 to resolve. It will not be possible to use the system to drive improvements in compliance to policies, duration or IV to oral switch. Anecdotally, some staff stated it made it harder to promote good prescribing practices.

To strengthen your work undertaken to date on prudent prescribing, building on the awareness raising you have done, and effective use of your intranet we would recommend:

- Review the resource, role, responsibility and competence required for your Antimicrobial Pharmacist. Deirdre Malone has met a number of highly visible, well regarded pharmacists during the review process and may be able to utilise their job descriptions/person specifications etc.
- Review the specification and requirements for your e-prescribing system to ensure it ultimately supports prudent prescribing and offers a means of assuring compliance.
- Place clear responsibility and expectation for prudent prescribing with the senior leadership team of your Clinical Units. This should then be underpinned with an effective governance and assurance process that articulates the risks to delivery and the actions necessary to minimise or mitigate those risks.

Agree a set of KPIs for the Units that can be used to drive further improvement such as:

- IV use and IV to oral switch
- Duration of antibiotics
- Recording reason for use of antibiotic on drug chart
- Compliance to policy

The Antimicrobial Pharmacist undertakes what is essentially a prevalence audit and this should be the process that tests the effectiveness of the controls you put in locally rather than being the primary source of audit data. To this end we would suggest you do audits more frequently until you can be assured you good practice is embedded. Use formal and informal methods such as junior doctors undertaking audits, and senior medical staff checking compliance during ward

rounds. Consultant and senior medical staff need to regularly check and review antibiotic prescribing during their ward rounds and tackle any deviations from expected practice.

Review the training and education of your doctors. You need to be assured that doctors of all grades have a comprehensive understanding of the rationale behind prudent prescribing and are clear about their roles and the Trust's expectation of compliance. E-learning packages exist that both provide the theory and test knowledge and could be a useful start to this process.

Cleaning and Environment

Discussion with the facilities team indicated there were good systems and processes in place to ensure a clean and tidy environment. The environment was clean and cleaning staff were well informed and knowledgeable. Audits undertaken by the facilities team are of a good standard and further assured by multi-disciplinary unannounced visits. New staff members are trained and a buddy system operates. There was some disconnect between what we heard during the one to ones and during the walkabout where some staff expressed that "we have to keep a close eye on the cleaning" – "things get sorted for a while." This disconnect requires further exploration.

On the walkabout it was observed that CICU was extremely cluttered. We recognised that the nature of the children being care for required swift access to equipment, and we acknowledge that this unit will be moving to a new location in the relatively near future. However, we would suggest staff consider whether all of the equipment needed to be there, and if there was scope for an improved environment that would be somewhat easier to clean and therefore help reduce the risk of environmental contamination and potential spread of infection.

Root Cause Analysis (RCA)

You currently undertake a very detailed and comprehensive root cause analysis on cases of MRSA BSI. Review of your IC Committee minutes and discussion with staff suggests this process takes a long time. In addition, it is not easy to see how results are used to drive further improvement. Although there are times when an in-depth RCA may be necessary, the purpose of original national guidance encouraging its use was to quickly review and understand what may have been the causes of the bacteraemia or *Clostridium difficile* infection and to use this to inform improvement action. We would suggest that you review and simplify your process to achieve its core purpose.

Screening and Decolonisation for MRSA

You currently have a standard to screen within 48 hours which we would recommend is reduced to 24 hours. Although most staff stated that they generally screen children on admission, you cannot be assured of this. We would suggest you build in a simple assurance process of tracking compliance and compliance to following the decolonisation process.

Infection Control Committee

Reviewing the minutes showed a heavily nurse dominated presence, with apologies from most doctors. This has been a common finding during the London Peer Review process. In part the ICC has been a very long standing committee in most organisations with a quite traditional format. To ensure it is an effective component of your governance and assurance processes and to promote greater local ownership we would suggest that you review the role, purpose, membership, and deliverables of this committee.

Actions Plans

Plans, including those following RCA, require significant strengthening. For example, they state actions like “ensure all staff aware” which will not offer you any assurance.

The plans also do not make the distinction between what you need to do at a corporate level and what actions you need the Clinical Units to deliver. We would recommend that you review all plans in order to:

- Clearly identify and separate the corporate actions from the Business Unit ones.
- Ensure Unit activities are owned and delivered by them with input from the infection prevention team where it is clear their specialist knowledge is essential.
- Identify the outcomes you are seeking (e.g. high compliance to antimicrobial prescribing) and align the actions to delivering those.

- Clearly identify the person(s) accountable for the action(s) and the timescales for delivery.
- Put in place an effective process of tracking progress and identifying any slippage to timescales so that issues are escalated and addressed.
- Provide to the Board a high level monthly report that focuses on expected deliverables, risks, and mitigating actions.
- Ensure plans are implemented with pace, focus, and grip.

- To enhance your intention to create further local ownership you could underpin this with ensuring objectives for HCAI in all Clinical Directors and consultants' job plans objectives and appraisals.

Conclusion

In conclusion, you have most of the actions required to reduce HCAI in place. Your desire to achieve local accountability, assurance and governance is an important component of sustainable reductions in HCAI and you are making good progress on the journey to achieving this.

ATTACHMENT 1

Attachment 1

Great Ormond Street Hospital for Children NHS Trust

MANAGEMENT 15th December 2011

FINAL MINUTES

Present:

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

In Attendance

Anna Ferrant (AF)	Company Secretary
Peter Lachman (PL)	Associate Medical Director for Patient Safety, Consultant for Service Redesign and Transformation and Consultant Paediatrician
Catherine Lawlor (CL)	PA to Chair & Chief Executive (minutes)

**Denotes meeting part attended*

Attachment 1

303	**Apologies**	
303.1	Apologies were received from Jacqueline Allan, General Manager, Medicine and DTS; Martin Elliott, Co-Medical Director and Claire Newton, Chief Finance Officer.	
304	**Minutes of Management Board meeting held on 17th November 2011**	
304.1	The minutes were approved as an accurate record with the following amendments: the Business case for ENT should be brought back to the Board when the tariff is finalised and the full Business case for Urology should be brought back to the Board in February (not January).	
305	**Action Log and other matters arising**	
305.1	The following updates were received on the documented actions:	
305.2	265.4 – Updates on Missing records and splitting of notes policy – was taken to the Policy Approval Group.	
305.3	265.10 – Quality and Safety Strategy – ME reported that the Quality Accounts would be going to Trust Board. A summary of the actions would come to Management Board in January.	
305.4	**Action:** ME to present a Summary of actions from Quality Accounts in January 2012.	**ME**
305.5	265.13 – Parental Leave Policy – taken to the Policy Approval Group.	
305.6	265.16 - Protection of Earnings Policy – to be taken to the Policy Approval Group in May 2012.	
305.7	267.1 - Clinical Unit and Zero Harm Reports to be corrected to include MSSA infections - RB reported reports had been corrected.	
305.8	269.2 - Clinical Unit and Zero Harm Reports reported Sis - RB amended Clinical Unit and Zero Harm Reports to include both days since last SI (not related to RCA) with recognition of de-escalation and learning from the last SI with RCA.	
305.9	281.5 - Business Planning Strategy 2011/12 version 2 - RB included AHPs in point 5.6 “Involvement with stakeholders - Who has been consulted about the project? Is there anyone else who will need consulting if the project goes ahead?” of the Business Planning Strategy 2011/12.	
306	**Other Matters Arising**	
306.1	JC gave the Board a brief overview of the outcome of the Rare Diseases Initiative Workshop on the future development of the Computer Centre site which would be taken to Trust Board on the 21st December.	
306.2	JC suggested that a steering group “GOSH 2020” would be set up to develop the overarching ideas for the Computer Centre as well as the rest of the site and each unit should nominate someone to be on that steering group.	

306.3 306.4	**Action:** Each Clinical Unit to come back to JC with other ideas and name of nominated representative for the GOSH 2020 Steering Group. The Board **noted** the verbal report.	**Clinical Unit Chairs**
	Clinical Unit and Zero Harm Reports	
307 307.1 307.2 307.3 307.4	**IPP** JL presented the IPP Zero Harm report. JL reported there had been no delayed admissions or complaints. There had been one refused patient in the month and it had been 247 days since the last Serious Incident (SI) within IPP. JL reported that the three top risks were recruitment and retention, medication errors and income target exceeding the CAP. JL reported that all risks were being addressed. JL reported income was below target in November and cumulatively the CAP position was 9.51%. This was being monitored against NHS income monthly and measures had been put in place to ensure IPP income remained below the CAP. Management Board **noted** the content of the report.	
308 308.1 308.2 308.3 308.4 308.5 308.6 308.7	**Cardio Respiratory** AG presented the Unit's zero harm report. AG reported the Unit had been under some strain because of the volume of work and had had another SI recently. This was a never event, involving the incorrect placement of a nasogastric tube despite the patient having a respiratory tube. AG reported the patient was currently doing well and the never event was under investigation. JC stated the hospital needed to look at how busy we can allow a unit to become without jeopardising patient safety. **Action:** All clinical Units to do a review of allowable maximum occupancy with minimum impact on patient safety to be reported to the February Management Board meeting. AG reported that there had been 9 refusals and 4 complaints. AG reported the Unit's top risks were medication errors and the instability of the Carevue electronic clinical information charting system. AG reported on medication errors and stated that the majority of errors were arising from omissions on drug charts. The zero tolerance prescribing policy was not yet proving effective. Some individual members of staff had received feedback and additional training. Prescribing of IV Paracetamol was under review. There was an on-going issue of high junior medical staff turnover. AG reported the CareVue system remained unstable. Configuration of replacement system was on track and was due to go live on 28th March 2012. Management Board **noted** the content of the report.	**All Clinical Units**

Attachment 1

309	**Infection, Cancer and Immunity**	
309.1	CC reported that there had been a significant increase in the number of 2222 calls. All calls had been investigated and a number of different issues identified. CC reported it had been 316 days since their last SI. CC reported one refusal, 4 delays and two complaints during the month. The two complaints were contact-ability of Rheumatology CNS and a complaint regarding co-ordination of Rheumatology care within clinical team. CC reported that both complaints were under investigation.	
309.2	CH reported the three main risks for the Unit were access to MRI scan slots, lack of patient beds/cots and cleanliness of clinical areas. CC reported that all risks were being addressed. JC reported that John Hartley had been concerned over the number of gram negative micro-organisms in sinks. There was currently a drive within the Infection control team to try to reduce this risk.	
309.3	Management Board **noted** the content of the report.	
310	**MDTS**	
310.1	JA presented the paper. JA reported there had been 24 days since their last SI. JA reported that there had been 4 complaints, nursing care on renal ward, miscommunication regarding planned tests (Gastro), cancellation of procedure on the day (IR), allegedly due to delay in prep on ward and communication regarding cancellation of gastrostomy under IR. Complaints were currently under investigation.	
310.2	JA reported that the top three risks for the Unit were meeting CRES, interventional radiology consultants and Pathology systems manual entry. Although 7% CRES had been identified by the unit there were some high risk schemes which the unit continued to work on.	
310.3	Interventional Radiology – 2 new consultants were not yet in post but plans were in place. There was some concern regarding the ease of access to Pathology results. All risks were under investigation. Management Board **noted** the content of the report.	
311	**Neurosciences and Deep dive**	
311.1	CDS and SD presented the deep-dive on Neurosciences' Zero Harm. This covered ways of improving the Neurosciences Safety Dashboard, reducing infections, implementation of the WHO checklist, Neurosurgery surgical outcomes, and work underway to reduce medication errors. CDS reported the Unit also aimed to improve the attendance at hospital at night handover. AG reported that the Cardiac Unit had just completed a project (circa 20 months) on identifying ways of improving the handover at night and would share the findings with Management Board.	
311.2	**Action:** AG to present findings from handover at night attendance project for January Management Board.	**AG**
311.3	CDS and SC also presented new pathway for looking after complex spinal patients, complex MDT involvement, a new approach to Child Protection and improving the Quality of Medical Records.	
311.4	Management Board **noted** the content of the deep dive.	

311.5	CDS reported that it was 121 days since their last SI occurred and the learning from it. CDS reported 1 refusal and 2 complaints. Both complaints had been registered under two clinical units - there had been some involvement within Neurosciences. Both complaints were currently under investigation. CDS reported the risks the Unit faced were medication errors, inadequate IV access and insufficient outpatient space for Ophthalmology and Neurodisability. CDS reported that these risks were currently being dealt with.	
311.6	Management Board **noted** the content of the report.	
312	**Surgery**	
312.1	EJ reported that it had been 61 days since the last SI and on the learning from the last SI. JC asked the Board if they had given any more thought to Rule 43 which provides coroners with the power to make recommendations to a person or organisation where the coroner believes that action should be taken to prevent future deaths. The Board felt more work needed be done around ensuring that GPs and other healthcare providers in the community had sufficient information available to them about a child's health and agreed to have further discussion outside the board. All Clinical Unit Chairs were asked to report back to the board as and when they needed.	
312.2	**Action:** All Clinical Unit Chairs to take discussion on Rule 43 outside the Board and report back as and when needed.	**All Clinical Unit Chairs**
312.3	EJ also reported 23 refusals and 3 complaints relating to the booking processes, clinical care time from referral to assessment and infection control. EJ reported complaints were under review and on the lessons learnt from previous complaints.	
312.4	EJ identified the Unit's top three risks as medication errors, recruitment and agency staff and medical records. EJ reported all risks were under review.	
312.5	Management Board **noted** the content of the report.	
313	**R & I Divisional Report**	
313.1	LG presented the report on R&I current divisional activity which included: ▪ Arrangements for the GOSH/ICH Biomedical Research Centre for 2012 were being taken forward. The independent financial review of the spend from 2007-2012 award was now in process. ▪ A Joint BRC Public-Patient Involvement workshop was held on the 1st December with UCH and Moorfields which would form the basis of future PPI activities and research. ▪ A Divisional Road Show was held for three half-days, which introduced the new team and outlined current arrangements for research. ▪ The GOSH Exemplar working group continued to identify areas of delay in turnaround times for study set up, and arrangements were being taken forward to improve with support departments to clarify processes, signatories, and timeframes. This was key as from 2013 Department of Health funding would be dependent on meeting a 70 day turnaround time. ▪ In November, 1 application for Contingency Funds from the CLRN was awarded for £21,549.	

313.2	Management Board **noted** the content of the report.	
314	**Key Performance Report November 2011**	
314.1	RB presented the Key Performance Indicator (KPI) report. The report had been revised following a number of recent recommendations from Monitor. In particular, the dashboard had been expanded to include 'RAG' performance against defined thresholds and tolerances as well monthly and quarterly performance trends. Progress against Monitor's governance risk framework was now reported monthly.	
314.2	The Operating Framework for the NHS in England 2012/13 was published on the 24th November 2011. Key Trust performance messages included: ▪ The operational standards of 90 per cent for admitted and 95 per cent for non-admitted completed waits as set out in the NHS Constitution remained. ▪ Trusts would need to ensure that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks. ▪ It was expected that less than 1 per cent of patients were to wait longer than six weeks for a diagnostic test. ▪ Patients should be added to planned waiting, pending or review lists only if there are clinical or personal reasons why they cannot have a procedure or treatment until a specified time. Trusts must have systems in place to review such lists regularly to ensure that safety and standards of care are not compromised to the detriment of outcomes for these patients. ▪ All organisations must have reviewed planned waiting lists for all specialties and diagnostic services by no later than the end of December 2011.	
314.3	Management Board **agreed** revised report format and **noted** the report.	
315	**Finance and Activity Report**	
315.1	The Board noted the summary of the Finance and Activity for the Trust which summarised the Trust's financial performance for the EIGHT months to 30 November 2011. Net surplus was £6.0M, which was £0.7M below the re-phased plan and normalised EBITDA was 7.0% (Budget 7.5%; Full year budget 7.0%)	
315.2	The forecast position was a £2.3M surplus after a property impairment estimated at £5.6M. The most significant risks in delivering the forecast were: • Delivery of the remainder of the CRES plan • Reducing agency costs • Delivering income growth and ensuring the Trust is appropriately reimbursed • Ensuring Phase 2A double running and project costs are in line with plan. There was also a technical risk in that the value of the impairment assumed on Phase 2A has not yet been determined by the District Valuer and so the forecast (non normalised) surplus was likely to change as a result	
315.3	Total income, if pass through funding was excluded was above plan by £1.8M. • NHS revenue was ahead of plan by £2.8M reducing to £2.5M if non-England activity was included • IPP revenue was in line with plan. • Other Operating Revenue was £0.6M behind plan if the timing differences in respect of the charity pass through are removed; the largest variances being on R&D income and catering (where the activity was outsourced and thus income received net).	
315.4	Pay was over spent by £3.3M excluding pass through. The majority of the over spend	

	related to nursing and junior medical staffing where there were higher than planned levels of agency staff. Part of this variance related to the costs incurred in delivering activity higher than plan, particularly in critical care areas. There were actions in place to reduce other agency usage by the year end. Non Pay was under-spent by £0.3M when pass through of blood, drugs and clinical devices were taken into account.	
315.5	There was an overall FT score of 3 year to date with a forecast score of 3.	
315.6	Management Board **noted** the contents of the report.	
316	**Foundation Trust Application Update November 2011**	
316.1	SB presented the paper which set out the current position for the Trust against the assessment criteria used by the SHA and the Secretary of State for Health to determine readiness for Foundation Trust status.	
316.2	Monitor had restarted the assessment process, and had a timetable of meetings in December and January. A board to board meeting with Monitor had been scheduled for 8 February 2012. This stage of the assessment would 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 had 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 related to board reporting (noted above), reporting of CRES scheme safety risks, and management of data quality. Deloitte had been commissioned to review the basis and assurance for the board statement on quality governance.	
316.3	Key actions for the next two months: • Complete additional work required on the three issues identified by Monitor. • Complete the Monitor assessment process.	
316.4	Management Board **noted** the report.	
317	**Replacement Consultant Post in Dermatology**	
317.1	CH presented the paper. The Dermatology service wished to replace a post. The replacement post would be 10PAs, a reduction of 1PA from the current incumbent but with a plan to deliver an additional clinical session within the job plan (either laser or outpatients depending on the skills and interests of the appointee).	
317.2	Dermatology activity had been increasing year on year and it was reported that it was crucial to have sufficient consultant time to be able to support laser procedures, outpatient and inpatient activity, and that there would be continued full time, consistent senior support to help to continue the development of the service.	
317.3	Planning for this retirement and new incumbent had included a review of the whole service and a number of changes to service delivery to optimise capacity and efficiency had been planned or was underway.	

317.4	Complex patient care was to be realigned so that at least 2 consultants had a good knowledge of each patient group so that high quality care was maintained for 52 weeks a year. For patient groups where there were multiple specialties involved, extent of contribution of Dermatology to ongoing care would be reviewed, in particular which should be the lead specialty would be discussed and definitively agreed with other specialties. Ambulatory care and nurse lead care was to be reviewed and expanded to make best use of capacity, both physical and staff (nurse led clinics have commenced and are being developed). On call arrangements required review and consideration would be given to sharing the rota with paediatric dermatology consultants in other hospitals. Additional laser capacity was to be developed. The department planned to develop a clear clinical research strategy, which would incorporate developing an academic role within the department The department were considering the introduction of a consultant of the week rota for the ward	
317.5	Management Board **approved** the replacement post.	
318	**Proposal for Sustaining Clinical Outcome and Patient and Family Experience Research Activity by Nursing and Allied Health Professionals**	
318.1	LM presented the paper which requested support to seek charitable funding to support the infrastructure and activity of the Centre for Nursing and Allied Health Research. This was in order to ensure the success of the third theme of the GOSH Research Strategy. In this way the Trust would have greater awareness of the impact that the design and model of GOSH services had on outcomes, children's and families' experiences and whether their needs were being met.	
318.2	This embryonic Centre was in receipt of financial support from ICH to fund 15 hours of staff time only until June 2013. Without financial support, the Centre's future activity could not be sustained and the contribution it could make to the GOSH Clinical Research Strategy would be greatly reduced.	
318.3	The Board had discussion around the proposed request for charitable and the knock on effect approval would have on other proposals the Trust would put forward to the Charity.	
318.4	Management Board **approved in principal the proposal** pending further discussions around other funding requests with the Charity. LM was asked to bring an update to the next appropriate Management Board.	
318.5	**Action**: LM to update the Management Board on funding of the proposal.	
319	**IV Access project**	
319.1	LM presented the paper which updated the Board on progress that had been made with regard to the IV Access project following concerns being raised about the adequacy of Intravenous access in situations after children were discharged from PICU.	
319.2	Following a task and finish group the following recommendations had been considered at Management Board. PICU would be asked to discharge children to wards with femoral line access where necessary following discussion with the	

	receiving clinical team and clear transfer of accountability from them to the new ward. A number of mitigations had been put in place to reduce associated risk and a meeting between the Specialty Lead for PICU, Medical Director – Quality and Safety and the Chief Nurse had taken place.	
319.3	In light of the mitigations this had been agreed with the proviso that where Intensivists were unhappy with the clinical team's ability to manage the line, this would be escalated to a Medical Director.	
319.4	It was agreed there would be a letter from the Medical Director to the Speciality Leads acknowledging the Intensivists concerns. This letter was currently being written in collaboration with the Trust solicitor. The CSP team would be informed of agreement with PICU by Assistant Chief Nurse – Clinical Workforce. LM reported all actions set out in the action plan were in hand or had been completed within agreed timescales. The Board agreed the timing for completion of the project would be 1st February, 2012.	
319.5	**Action:** IV Access project to be completed by 1st February, 2012.	**LM**
319.6	Management Board **noted** the report.	
320	**Update on Equipment Tracking and Bed and Cot availability**	
320.1	PW presented the paper which updated the Board on equipment tracking and bed and cot availability. PW reported a working group had been set up to ensure additional beds/cots were procured as required for both MSCB and the enabling works. Orders were to be placed by end Jan 2012.	
320.2	The working group had also reviewed the current status of the percentage of beds to cots and reflected this against patient mix (work would be completed by the end January 2012). The group was also in the process of testing options to include bed occupation status as part of the tracking system (to be completed by end December 2011), to ensure that a full rollout of training for clinical staff on the tracking system was completed (completion date, end December 2011 with a training period of 3 months) and to review and update the policy on clinical equipment to include clear guidance on beds and cot (completion date by end January, 2012).	
320.3	PW reported that the working group were also investigating the need for bed storage if the outcomes of the review on bed and cot numbers recommended a change in the ratio. This would be included in planning for Phase 2b Enabling. They are also developing a process to fully integrate bed movement into existing helpdesk processes (CFM to agree plan with EBME by End Feb 2012).	
320.4	Management Board **noted** the report.	
321	**OPD Space pressures – update**	
321.1	PW updated the Board on the situation currently around OPD capacity and possible actions to mitigate risks identified at Management Board by various Clinical Units. The paper outlined the short term measures to alleviate problems for the next 6-12 months. Outcomes of review would be discussed with Clinical Units (at the Space Group and Operational Delivery Group) and would also be taken as a paper to CASP to approve funding required to deliver.	
321.2	Management Board **approved** the report.	

Attachment 1

322	**Replacement Radiology Consultant**	
322.1	MH presented the paper which sought approval for a 10 PA appointment of replacement general Radiology Consultant. The Unit anticipated that there would be a better choice of candidates towards the middle of next year, around April to June 2012. Therefore it was planned to initially advertise for a locum position to start from March 1st and to appoint the substantive position in the second half of 2012. During this period, cover for Musculo-skeletal service (MSK) services would be provided mostly through internal cover.	
322.2	Management Board **approved** the business case.	
323	**Parents/Members on Interview Panels – Update**	
323.1	FD presented the paper. The purpose of which was threefold: • To provide Management Board an update on parent/Member attendance on GOSH interview panels during the period January – November 2011. • To present the findings of a survey conducted in October/November in which parents/Members were asked about their attendance on panels and barriers to further attendance. • To secure Management Board approval of an action plan designed to increase parent/Member participation in future.	
323.2	Management Board **approved** the action plan designed to increase parent/Member participation in future and agreed to have a 6 monthly review.	
323.3	**Action:** FD to present a 6 monthly review on Parents/Members on Interview Panels to the July 2012 Management Board.	
324	**Performance Management Strategy and Business Planning Strategy**	
324.1	RB presented the Performance Management strategy which had been considered within the wider context of the Trust's strategic planning framework and Foundation Trust requirements. Foundation Trust Boards must be able to satisfy themselves that all aspects of the organisations' performance and operations were of an appropriate quality, and ensure that the organisation understands and meets the requirements of regulatory bodies and inspectorates as outlined in their Authorisation. As such, the work described in the strategy set out the framework that would enable the Board to satisfy itself that it is discharging its responsibility effectively. The strategy had been updated to reflect changes in Trust governance structures and external performance requirements including, commissioning and contractual standards and Monitor's governance compliance framework.	
324.2	RB also presented the Trust-wide strategy for business planning. The strategy had also been considered within the context of the Monitor's Annual Planning requirements for Foundation Trusts. It defined the systems and monitoring process required to be in place to enable the Trust Board and all stakeholders to be assured that its commitment to effective business planning was met. The strategy had also been updated to reflect changes in Trust governance structures and business planning processes.	
324.3	Management Board **approved** the strategies with the following additions to the Performance Management Strategy: Nursing reviews to be included and on page 9 of the report further clarity around the information that is reported to the Clinical Unit Management Board.	

324.4	**Action:** RB to update the Performance Management Strategy in readiness for submission to the Trust Board in December 2011.	**RB**
325 325.1 325.2 325.3	**Update from Policy Approval Group** RB gave a verbal update on the new Policy Approval Group. RB reported the minutes would come to the January 2012 Management Board meeting. RB reported that 12 policies were presented at the Policy Approval Group. RB stated that Alison Vizulis, the new Compliance and Governance Manager would write a guide on how to improve policies which would aim to make policies more concise with a summary of key points at the front. Policies approved were Special Feeds Unit Policy, Dietetics Policy, Parental Leave Policy, Policy for Practicing Privileges for Allied Health Professionals Providing Services to international & Private Patients, Missing Records and splitting notes Accessing Health Records Policy, Decontamination of Clinical Equipment and Patient Identification Policy. Management Board **noted** the verbal report.	
326 326.1 326.2	**2012-13 NHS Operating Framework briefing** SB presented the briefing paper which highlighted key issues for the Trust arising out of the 2012-13 NHS Operating Framework. Management Board **noted** the report.	
327 327.1	**Major Incident Planning Group** Management Board **noted** the contents of the above document.	
327 327.1 327.2	**Waivers** The Board noted the requested for approval for the waiver from the supplier, Qiagen Management Board **approved** the waiver.	
328	**Any other business**	
328.1 328.2	WM reported that the new building (end Phase 2b) was scheduled to be handed over on the 22nd December, 2011. Management Board **noted** the verbal report.	

ATTACHMENT 2

Attachment 2

Great Ormond Street Hospital for Children NHS Trust

MANAGEMENT BOARD
19th January 2012

FINAL MINUTES

Present:

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

In Attendance

Anne-Marie Conneally (AC)	Operational Manager
Anna Ferrant (AF)	Company Secretary
Catherine Lawlor (CL)	PA to Chair & Chief Executive (minutes)
Una McCrann (UM)	Lead Nurse, C.A.M.H.S/ DPM
Joe Curry (JCu)*	Consultant, Surgery

**Denotes meeting part attended*

Attachment 2

329	**Apologies**	
329.1	Apologies were received from Carlos De Sousa, CU Chair, Neurosciences and Tom Smerdon GM, Surgery and Elizabeth Jackson (EJ) CU Chair, Surgery Clinical Unit. Una McCrann, Lead Nurse, Anne-Marie Conneally, Operational Manager and Joe Curry, Consultant attended on behalf of Carlos De Sousa, Tom Smerdon and Elizabeth Jackson. JC welcomed the Monitor team to the Board.	
330	**Minutes of Management Board meeting held on 15th December, 2011**	
330.1	The minutes of meeting held on 15th December, 2011 were approved as an accurate record.	
331	**Action Log and other matters arising**	
331.1	The following updates were received on the documented actions:	
331.2	318.5 – Proposal for Sustaining Clinical Outcome and Patient and Family Experience Research Activity by Nursing and Allied Health Professionals – LM gave the board a verbal updated. LM reported that the proposal was still being considered and a decision should be made by the Charity in March.	
331.3	**Action:** LM to report back to the March Management Board on further progress.	**LM**
	Clinical Unit and Zero Harm Reports	
332	**IPP**	
332.1	JL presented the IPP Zero Harm report. JL reported there had been no delayed or refused admissions. There had been one complaint received which was part of a complaint received by the surgical division in the month and it had been 279 days since the last Serious Incident (SI) within IPP.	
332.2	JL reported that the three top risks were recruitment and retention, medication errors and income target exceeding the CAP. JL reported that all risks were being addressed.	
332.3	JL reported patient income for month 9 was £1k behind plan, cumulatively patient income was £73k behind plan and delivery against PPI CAP was 9.53%. Outliers had financially under-performed by £227k in the month, which meant a cumulative under-performance position (-£208k), this was mainly due to PICU refusals; there was seasonal pressure for PICU beds.	
332.4	Management Board **noted** the content of the report.	
333	**Cardio Respiratory**	
333.1	AG presented the Unit's zero harm report. AG reported the Unit gave an update on the never event, involving the incorrect placement of a nasogastric tube despite the patient having a respiratory tube. AG reported that the Unit had brought in an independent consultant to help to try to unravel the cause. AG would report back to	

	Board once the evaluation had been completed.	
333.2	**Action:** AG to report back to Management Board on findings once evaluation of Never Event involving the incorrect placement of a nasogastric tube was complete.	**AG**
333.3	AG reported that there had been 5 refusals and no complaints. AG reported the Unit's top risks were medication errors, although overall error rate had gone down and the instability of the CareVue electronic clinical information charting system.	
333.4	AG reported the CareVue system remained unstable. Configuration of replacement system was on track and was due to go live on 28th March 2012. AG reported that the recent CICU bed capacity issue had a direct impact on CRES targets.	
333.5	Management Board **noted** the content of the report.	
334	**Infection, Cancer and Immunity and Deep dive**	
334.1	CC reported it had been 341 days since their last SI. CC reported one refusal, 4 delays and two complaints during the month. The two complaints were an issue regarding copying of letters to separated parent, with Trust wide implications, and disclosure of BMT donor information to an incorrect parent and the second complaint related to the discharge prior to transplant of a SCID baby, who subsequently died post transplant. CC reported that both complaints were under investigation.	
334.2	CH reported the three main risks for the Unit were access to MRI scan slots, lack of patient beds/cots and power supply to laboratories. CC reported that all risks were being addressed. CC reported there had been an incident over weekend where power was lost to labs for extended period resulting in major incident standby. This had been declared as an SI and estates were leading investigation. CBL was now on mains power from Octav Botnar. CC reported there was a need to continue to focus on a permanent robust solution, to clarify the contingency plans for the hospital in the event of the labs not being functional and also communication to relevant staff in the event of any further issues.	
334.3	CC presented a zero harm deep dive presentation on ICI. CC reported the unit was making good process on reducing prescribing errors, for example Haem/Onc baseline of 7.47 errors had reduced by 37% to 4.68 errors. CC reported on Infection Prevention & Control, the unit had ran a Hand Hygiene awareness week – October 2011 and drop-in training sessions for ward staff – particularly medical staff and training sessions for families. CC reported that CVL bundle compliance was improving. CC reported on improving implementation of the WHO Checklist, Medical Records standards and Laboratory Medicine standards. CC reported that there would be a cancer peer review on the 3 Feb, 2012 and gave an overview of focus and delivery for 2012-13.	
334.4	Management Board **noted** the content of the presentation and report.	
335	**MDTS**	
335.1	MH presented the paper. MH reported there had been another SI since the 42 days listed in the report. This involved a placement of a central line in a neonate patient. There was a question as to whether this ought to be considered an SI And it may be de-escalated. MH reported that there had been no refusals nor delays and 2 complaints, one in	

335.2	Endocrinology regarding the parents' request to be referred to Manchester for consideration for a trial and delay in updating the family regarding this and one in Gastroenterology, regarding doctor cover for the outreach clinic. On investigation there was no complaint for us to answer. MH reported on learning from previous complaints.	
335.3	MH reported that the top three risks for the Unit were completion of PIMs imaging and procedure request forms by clinicians' assistants and other non-doctor staff, the Interventional Radiology service provision and prolonged waiting times for both urgent and routine patients and multiple cancellations and delays.	
335.3	MH announced that Jackie Allen, General Manager, Medicine and DTS would be retiring soon and asked that a huge and personal thanks was recorded by MH and the whole of Management Board.	
335.4	Management Board **noted** the content of the report.	
336	**Neurosciences**	
336.1	SD reported that it was 156 days since their last SI occurred and the learning from it. CDS reported no refusals and 1 complaint involving a family who were invited for consultant appointment but upon arrival they were informed that the consultant had left the Trust. Apologies were offered regarding the poor communication and details of the new consultant were provided.	
336.2	SD reported the risks the Unit faced were medication errors, feedback from Drug Error Analysis Tools where it had been suggested that interruptions in prescribing were a contributory factor. This should improve with the designated prescribing room on Koala Ward. Secondly, in Neurophysiology, a lack of isotope for dynamic studies. An epilepsy co-ordinator was keeping families informed about likely waiting times. Lastly, insufficient outpatient space was resulting in increased waiting times and inability to deliver effective care.	
336.3	Management Board **noted** the content of the report.	
337	**Surgery**	
337.1	AC, standing in for EJ and TS, reported that it had been 92 days since the last SI and on the learning from the last SI. AC also reported 36 refusals (which were lower than last year) and 2 complaints relating to booking processes, clinical care, infection control and cancellation of scheduled procedures and information governance. AC reported the unit's complaints procedures and the lessons learnt from previous complaints were under review. ME reported that the Trust should receive the International Intensive Care Review report shortly and it would come to Management Board in either February or March.	
337.2	**Action:** ME to bring the Intensive Care Review report to the Management Board in February or March (depending upon release date).	**ME**
337.3	AC identified the Unit's top three risks as medication errors, recruitment and agency staff and medical records. AC reported all risks were under review.	
337.4	Management Board **noted** the content of the report.	

Attachment 2

338 338.1	**Reporting Zero Harm - Quality, Safety & Transformation (QST) Update** RB presented the report on behalf of ME which gave an update on the status on the high level measures. RB asked the Board to note: • QST had 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 were addressed at clinical unit level. Secondly, RB asked the Board to note the second part of the report which included the first monthly rotation of Transformation, Safety & Outcomes, with focus on Transformation. Areas of note were: • 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 had improved from 51 to 60 percent. • SSI surveillance process was 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 would support this project for 2012. • Advanced Access – 32 specialties working on this project. 8 specialties were currently achieving, with the majority planning to achieve by end March 2012. 6 specialties do not think they would be ready by March 2012. • Each Clinical Unit was 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 had reached target until a period at the end of the year where there had been a drop from 78 to 72 per cent (still above target). This was being investigated, but was likely due to bed shortages. The Board was invited to comment to RB on the new report's format. Management Board **noted** the content of the report.	
339 339.1	**R & I Divisional Report** LG presented the report on R&I current divisional activity which included: • The NIHR had issued details of changes to Flexibility and Sustainability Funding (FSF) which would come in to effect as of 1st April 2012. LG outlined the changes. The total to be allocated to GOSH was still to be confirmed. • The GOSH Exemplar working group continued to identify areas of delay in turnaround times for study set up, and arrangements were being put in place with our support departments to clarify processes, signatories, and timeframes. • Funding arrangements for Activity-Based Funding allocation were being discussed with the CLRN. • The R&D Office had been invited to be a host-site for the new UCL's Clinical Trials Unit. • An analysis of current and proposals for research using MRI facilities had been submitted to the 3T working group. • Arrangements for the GOSH/ICH Biomedical Research Centre for 2012 were being progressed, with BRC strategy group meetings taking place. • GOSH/ICH would host a BRC Schools' Day on the 9th February. • The MCRN CLRN Contingency Fund was £164,000, of which the total awarded to GOSH was £86,017. CC asked for clarification on how allocation would be made in regards to changes to	

	the Flexibility and Sustainability Funding. The clinical units requested clarification on the ICH/GOSH ownership of research.	
339.2	**Action:** LG to come back to the Board with clarification on the impact that changes to FSF would have on the Trust in terms of financial allocation. Discussion was also held with regards to how gosh studies were allocated which LG was to take forward as a working group to ensure accurate reporting. A query was also raised as to how staff within the Institute of Cardiovascular Science were allocated which LG was to check.	**LG**
339.3	Management Board **noted** the content of the report.	
340	**Education Zero harm Report**	
340.1	LM presented the report which highlighted the activity within Education at GOSH and key performance data related to local department managers' responsibilities in relation to education, training and development of staff. LM reported the Trust current activity headlines, implementing the Education Strategy, Developing Leadership Potential Programme (DLPP) and training programmes in preparation for moving into MSCB.	
340.2	LM gave an overview on the KPIs for Education on PDR rates, Mandatory Training, Resuscitation training, Information governance and Safeguarding Children. JC suggested that perhaps training rates could be improved it they were linked to employee's financial benefits (it was understood that some other Trust's had implemented this). LM concurred that this was a good point and one she would take away.	
340.3	Management Board **noted** the content of the report.	
341	**Key Performance Report December 2011**	
341.1	RB presented the Key Performance Indicator (KPI) report. The report had been revised following a number of recent recommendations from Monitor. In particular, the dashboard had been expanded to include 'RAG' performance against defined thresholds and tolerances as well as monthly and quarterly performance trends. Progress against Monitor's governance risk framework was now reported monthly.	
341.2	The Operating Framework for the NHS in England 2012/13 was published on the 24th November 2011. Key Trust performance messages included: ▪ Trusts would not have contractual fines levied in 2012/13 against the performance target of '92 per cent of patients on an incomplete pathway waiting no more than 18 weeks'. This would be monitored for improvement – and contractual fines implemented within contracts in 2013/14. ▪ The Trust had put forward a bid to NHS London for winter access funding, to aid the Trust improve admitted 18 week performance in quarter 4 of 2011/12. This bid proposed funding to support the opening of 6 additional theatre sessions per week, and four short stay surgical beds. An official confirmation of funding had not been received yet, however the scheme had been rated 'green' by North Central London – and it was expected that a response would arrive shortly. Additional reporting had been requested by NCL in order to measure weekly performance against the 18 weeks and diagnostic metrics.	

341.3	RB reported that NHS London was currently running an HCAI Peer Review Project to address the number of HCAIs (specifically MRSA and C.Diff) across the region. London had led the way in making significant reductions in both MRSA & C.Diff. However, in a number of organisations' performance had deteriorated or they have not achieved the levels of improvement anticipated. London was now an outlier, in particular for MRSA reduction, and needed to get back on track. The SHA had set up a time limited piece of work to offer organisations a peer review to see if there were things that could be done differently. RB reported that the Trust's Peer Review would take place on 27th January, 2012.	
341.4	Management Board **noted** the report.	
342	**Finance and Activity Report**	
342.1	CN presented the report that summarised the Trust's financial performance for the nine months to 31 December 2011. Results year to date were reported as a Net surplus of £5.1M, which was £0.3M ahead of the re-phased plan and normalised EBITDA of 6.4% (Budget 6.9%; Full year budget 7.0%).	
342.2	The forecast surplus for the financial year was a £2.3M surplus after a property impairment estimated at £5.6M (value yet to be determined by the District Valuer). The most significant risks in delivering the normalised forecast were 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 was appropriately reimbursed and ensuring Phase 2A double running and project costs are in line or better than plan.	
342.3	Activity based income remained ahead of plan boosted by critical care and other bed day activity which was 5% above plan although core inpatient activity is fractionally (0.8%) below plan, but remains 3.5% ahead of last year. Pay was over spent by £3.9M excluding pass through. The majority of the over spend related to nursing and junior medical staffing where there were higher than planned levels of agency staff. Part of this variance related to the costs incurred in delivering activity higher than plan, particularly in critical care areas. There were actions in place to reduce other agency usage by the year end.	
342.4	The Trust was now reporting risk adjusted values for CRES, having completed an exercise to remove or reduce schemes where there was uncertainty over scheme delivery. Capital spend was £29.4M; £6.8M lower than plan year to date. There were five salary overpayments totalling £14.7K (three late notified leavers) during the period.	
342.5	CN reported that contract values were still being negotiated with all commissioners. CN agreed to bring back to the Board a detailed briefing on the implications of the transfer of commissioning responsibility for specialised services from PCT clusters to the London Commissioning Group. ME highlighted concerns in regards to commissioning Intensive care. JC emphasised the priority of ensuring an appropriate ICU price was and offered any support required given the importance of ICU to the Trust's strategy	
342.6	**Action:** CN agreed to bring back to the Board a detailed briefing on the implications of the transfer of commissioning responsibility for specialised services from PCT clusters to the London Commissioning Group.	**CN**
342.7	Management Board **noted** the contents of the report.	

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343	**Monthly CRES Report**	
343.1	RB updated the Board regarding progress on the CRES programme. RB noted the operational CRES report was based on the CRES dashboard as achieved on the first working day of the month. Values could therefore differ slightly from those reported by Finance.	
343.2	RB asked the Board to note the progress on the CRES programme, in particular: • The current CRES position. • Changes to the content of the CRES report that had been made in response to Monitor and Trust Board requirements. • The new addition of a section in this report on 'Enabling Schemes', allowing Management Board to link the progress of Transformation, I.T, etc schemes with any impact on CRES delivery. • Clinical and Corporate Units to progress 11/12 Amber schemes ensuring full delivery. • Clinical and Corporate Units to close remaining 12/13 gaps and progress schemes out of Red.	
343.3	Management Board **noted** the contents of the report.	
343	**Foundation Trust Application Update December 2011**	
343.1	SB presented the paper which set out the current position for the Trust against the assessment criteria used by the SHA and the Secretary of State for Health to determine readiness for Foundation Trust status.	
343.2	SB reported that Monitor had restarted the assessment process, and had a timetable of meetings in December and January. A board to board meeting with Monitor had 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 had been updated to ensure that performance against Trust objectives, CRES delivery, trend analysis and highlighted key issues were presented more clearly. Arrangements for performance management at clinical unit level were also being updated. • Governance arrangements. The main issues related to board reporting (noted above), reporting of CRES scheme safety risks, and management of data quality. Deloitte had 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.	
343.3	The Key actions for the next two months were: • Complete the Monitor assessment process. • Complete the board to board meeting and any further actions.	
343.4	Management Board **noted** the report.	
344	**Quality and Safety Strategy**	
344.1	ME presented the Quality and Safety Strategy which had 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 were also described in the strategy	
344.2	Management Board **ratified** the strategy for final approval by Trust Board.	
345	**Quality Accounts Update**	
345.1	ME reported that the Trust had published two Quality Accounts for 2009/2010 and 2010/2011. Within the 2009/2010 Quality Account priorities were identified to improve the quality of the care in line with focus on quality domains as follows: • Safety priority – Reducing all harm to zero • Clinical Effectiveness priority – Consistently deliver clinical outcomes that place us among the top five children's hospitals in the world • Experience priority – Consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations	
345.2	Management Board **noted** the report.	
346	**PPI and Patient Experience : What we Plan to do 2012-2015 & PPIEC Revised Terms of Reference**	
346.1	LM reported the current PPI and patient experience strategy would come to an end in March 2012. This was a new 3 year plan and included achievements over the last 3 years in both PPI and patient experience. The plan had been written so that it could be shared with the wider membership. It was anticipated and welcomed that once internal approval had been achieved, the new Members Council would contribute their views on priorities in March 2012 and assist in agreeing a timetable and action plan for implementation.	
346.2	LG asked whether the BRC strategy on public patient involvement and engagement activities could be integrated into the Plan. BB asked that clear reference be given to patients with learning disabilities and consideration be given to merging the Family Equality and Diversity Group with the PPIEC. FD asked that LM made reporting of actions more explicit.	
346.3	**Action:** LM to integrate the BRC strategy on public patient involvement and engagement activities, give clear reference to patients with learning disabilities and consideration to merging the Family Equality and Diversity Group with the PPIEC and greater clarity to how to report progress in the PPI and Patient Experience: What we Plan to do 2012-2015.	**LM**
346.4	Management Board **agreed** the plan with the suggested amendments and **agreed** the Revised terms of reference.	
347	**Equipment for additional Surgical Activity & Medical Equipment bids for 2012-13**	
347.1	FD presented the bids for Equipment for additional Surgical Activity and Medical Equipment. The Trust's Integrated Business Plan (IBP) included the growth assumptions for individual specialties over the next few years. Growing surgical specialties increases the demand for theatre capacity. With the commissioning of the Morgan Stanley Clinical Building (MSCB) in May 2012 there would be a net increase	

	from 10 to 11 theatres.	
347.2	At the July 2011 Management Board, the Trust's increased theatre capacity was discussed and the surgical specialties were identified. It was noted at this time that it was necessary to equip the theatre and ask for the GOSH Children's Charity (GOSHCC) to fund the required equipment. The business cases for the individual surgical specialties increased activity identified equipment required to support this growth. Also the revised theatre schedule has been agreed and required some specialties (Ophthalmology and Orthopaedics) to work across 2 theatres which also added to our equipment requirements.	
347.3	The final equipment list had been agreed and totals an estimated £2,142,098. Donated medical equipment was not subject to VAT.	
347.4	The Board had a discussion around the prioritisation of medical Equipment on the list. It was agreed that this ought to be linked to the risk register.	
347.5	Management Board asked that Equipment for additional Surgical Activity & Medical Equipment bids for 2012-13 come back to Management Board next month.	
347.6	**Action:** Equipment for additional Surgical Activity & Medical Equipment bids for 2012-13 come back to Management Board next month with revised links showing correlation to risk register.	**FD**
348	**Bed Solution for additional Surgical Activity**	
348.1	RB presented the Business case. RB reported the Trust's Integrated Business Plan (IBP) included the growth assumptions for individual specialties over the next few years. Growing surgical specialties increased the demand for theatre capacity. With the commissioning of the Morgan Stanley Clinical Building (MSCB) in May 2012 there would be a net increase from 10 to 11 theatres.	
348.2	Business cases for additional surgical activity in Neurosurgery, ENT, Urology and SNAPS were discussed at November Management Board and highlighted the need for additional bed capacity and some options were described. At the time it was agreed that a solution to the bed requirements would be presented to January Management Board after further discussion with the clinical teams.	
348.3	Management Board **agreed** the Business case and **agreed** the direction of travel for a Business Case to come for Miffy ward).	
349	**Recruitment of Replacement Rheumatology Consultant**	
349.1	CC presented the proposal for the Rheumatology service to replace Dr Kiran Nistala who was due to leave in 3 months to take up a fully funded academic post.	
349.2	CC reported that Rheumatology contributed significantly to the total Trust outpatient activity and was a service that made a positive financial contribution to the Trust as a whole. There was currently a small senior medical team in Rheumatology, consisting of 6 postholders but only 1 permanent full time consultant. 3 Consultants were locums, 2 work one day per week and one was academic support.	
349.3	The department previously had 2 full time NHS consultants (along with 3 part time academics). Following the departure of one of the postholders, the retirement of one of the academics and a successful previous business case to management board the	

	full time number of NHS posts was increased to 3. Due to a lack of suitable candidates the department has been sustained with locums for the last 2 years. 2 posts were advertised and recruited in 2010, but subsequently one of the postholders had been successful in obtaining an academic post and had resigned. This left a vacant post, previously agreed by MB, to be recruited to. Management Board **approved** the recruitment of a replacement Rheumatology consultant.	
349.4		
350	**Transfer of CIPP team and development of CAMHS**	
350.1	SD presented the proposal which explained the rationale for the Transfer of the Centre for Interventional Psychopharmacology (CIPP) to another Trust, identified gaps in the CAMHS department provision following the departure of the CIPP service, outlined a direction of travel for developing CAMHS at GOSH. The report requested support from Management Board to proceed with the transfer of the CIPP team in February 2012 and to develop a business case for the development of CAMHS, and agreement that the Consultant recruitment process could begin in the interim.	
350.2	Management Board **agreed** the transfer of the CIPP team in February 2012 and **supported** the proposal for a business case for the development of CAMHS. The Board ask that a business case with full Job Description come back to the Board for approval. It refused to agree that recruitment could start.	
350.3	**Action:** SD to bring back Business case for the development of CAMHS and Business case for recruitment of Consultant to Management Board for approval.	**SD**
351	**Immunoassay System Reagent Rental Contract**	
351.1	CH presented the report. The Chemical Pathology Department required an Immunoassay system for the provision of a full Chemical Pathology service, supporting all aspects of the Trust's work, including but not exclusively, acute and intensive care activities, metabolic medicine, general paediatric care, renal, oncology, and surgery.	
351.2	The department currently used an Immulite 2500 immunoassay system. However, the current reagent supplier was discontinuing the production of this model and associated reagent kits by1/4/2012. Therefore a replacement immunoassay system was required to ensure service continuation without disruption.	
351.3	Siemens Healthcare Diagnostics Ltd was selected for the award of a public contract via Negotiated Procedure with no prior OJEU notice, as they were the sole organisation with the technical capacity and intellectual property to fulfil the Trust requirements (in accordance with The Public Contracts Regulations 2006, Regulation 14, Paragraph 1(a)(iii).	
351.4	CH requested the Boards approval to award a 3 year reagent rental contract to Siemens Healthcare Diagnostics Ltd for supply of an Immulite Xpi Immunoassay System, all associated consumables and maintenance support.	
351.5	Management Board **approved** the Contract.	
352	**Staff Residential Accommodation**	

352.1	JC asked members of the Board to declare if they had a conflict of interest. FD and LG declared a conflict of interest and departed from the room in order for the item to be discussed.	
352.2	WM presented the report which proposed steps to use staff accommodation to more effectively support recruitment, in particular by enforcing a one-year lease policy in order to release stock to offer accommodation to new recruits. WM also sought the Boards approval for the launch of new internet site to offer greater support in finding accommodation.	
352.3	The Board discussed whether the accommodation should be used primarily as an incentive to support recruitment or retention of staff. Due to differing opinions the Board voted on this issue with the vast majority voting for an incentive to support recruitment.	
352.4	Management Board requested that Staff Residential Accommodation come back to Management Board including further operational details which took into consideration the Board's opinion on the matter.	
352.5	**Action:** WM to come back to Management Board with Staff Residential Accommodation (including further operational details on how the scheme would operate.)	**WM**
353	**Assurance framework**	
353.1	FD provided an overview of the principal risks to achievement of the Trust's corporate objectives. FD reported that of the 26 risks recorded on the Assurance Framework, no risks were rated as red, 5 were rated as amber and 21 were rated as green. This rating related to the assessment of the controls in place, any outstanding actions and internal/external assurances available. Ms Fiona Dalton, Chief Operating Officer stated that all amber risks were reviewed by the Risk, Assurance and Compliance Group (RACG).	
353.2	FD stated the risk involving clinical equipment adequacy for excellent clinical care and enhanced patient experience was being address and the risk was likely to be downgraded to "green" soon.	
353.3	FD reported an internal audit into the controls in place to manage the deteriorating child was expected in the next few weeks.	
353.4	FD stated that the consent policy for the Trust was under review. Draft internal audit results revealed that there was a lack of documentary evidence available to confirm that staff had received training in consent at a local level. A programme of work would commence to address these gaps.	
353.5	FD reported a PPI Strategy was in place and a revised strategy was on the Management Board agenda. A new patient experience officer had commenced work. A lot of work had been undertaken to collate parents' views and a project had commenced to report patient stories directly to the Trust Board.	
353.6	FD reported the Trust may not deliver the IT and Information strategies resulting in failure to achieve process efficiencies and to deliver effective electronic patient information and record systems in support of the Trust's clinical strategy. The risk had been revised to amber due to the need to develop robust plans for implementation of the electronic patient record. A clear action plan would be in place	

	by 31st March 2012. The Trust continued to employ robust security mechanisms to prevent unauthorised access to systems and data.	
353.7	Management Board **noted** the report.	
354	**CQC update**	
354.1	AF updated the Board on the current status of the Care Quality Commission (CQC) registration standards.	
354.2	The CQC had issued the Trust with the November 2011 Quality and Risk Profile (QRP). This was a tool for the CQC, providers and commissioners to use in monitoring compliance with the essential standards of quality and safety.	
354.3	AF reported that actions required to address any deficits identified were managed and monitored via the Risk, Assurance and Compliance Group.	
354.4	Management Board **noted** the report.	
355	**Budget Process for 2012/13**	
355.1	CN presented the paper which set out the plans for developing and agreeing budgets with all budget holders prior to the start of the financial year and ensuring the budgets were consistent with the Trusts overall targeted financial plan	
355.2	Management Board **noted** the report.	
356	**Education strategy implementation quarterly update**	
356.1	It was noted that due to an administrative error the correct paper was not included in the pack so therefore would come back to the next Management Board in February.	
356.2	**Action:** LM to bring the Education strategy implementation quarterly update to the February Management Board.	**LM**
357	**IG Training Requirements Brief**	
357.1	CN briefed the Board on the plans to achieve the target for 95% of staff to have received IG training by the end of March and ensure Management Board members were involved in ensuring their staff received the training	
357.2	CN reported there remained a number of staff who did not take the e-learning training and pass the assessment. The Training Department sends regular notifications to department managers including the names of staff who had not taken the training and it was essential that these were followed up with the relevant staff.	
357.3	CN reported Information governance assessment was now part of the staff induction and mandatory update which must be completed by all staff every 2 years.	
357.4	CC highlighted that a reminder to departmental managers of when training was due would also be helpful. LM stated that this ought to be possible through IT and would pick up and action.	
357.5	**Action:** LM to action through IT a reminder system for departmental managers of when IG training needed to be renewed.	**LM**

357.6	Management Board **noted** the report.	
358	**Update on 3a Development**	
358.1	JC presented the report which advised Management Board of the outcome of the Rare Diseases Initiative Workshop which was held on the 5th November, 2011 and the suggested process to take forward the future development of the Computer Centre site as well as how best to consider the whole site, given the possibility of additional clinical growth and the need for other developments to deliver the Clinical Research Strategy.	
358.2	Management Board was requested to note the progress of this initiative and each clinical unit asked to identify an appropriate representative to sit on the Phase 3A Development Group to develop the initial design brief. Management board were also asked to consider and decide on the proposal to form a time limited group looking more broadly at site development and called the GOSH2020 Steering Committee reporting to Management Board.	
358.3	**Action:** Each clinical unit should identify an appropriate representative to sit on the Phase 3A Development Group to develop the initial design brief.	**CU Chairs**
358.4	Management Board **noted** the report and **approved** the direction of travel.	
359	**GOSH Child Protection & Quarterly update October 2011 – December 2011**	
359.1	LM provided an update regarding operational progression of the Trust Child Protection Action Plan 2011-2012 as well as relevant information impacting on Child Protection operational and strategic compliance of the Trust.	
359.2	LM asked the Board to note the evidence of continued implementation of the Trust strategy to protect children.	
359.3	Management Board **noted** the report.	
360	**Olympic Planning Update**	
360.1	FD presented the update. FD reported that the GOSH planning for 2012 London Olympics continued.	
360.2	FD asked the Board to note the accompanying documents on the General Olympic Planning update, GOSH A-Z of the Olympics - which answered many FAQs for both Staff and Managers and additional HR Guidance for GOSH Managers.	
360.3	FD reported that NHS London had issued the final 2012 Games Planning Pack which we would be worked through over the next month to ensure we are 'Games-ready' by April 2012.	
360.4	Management Board **noted** the report.	
361	**PAG**	
361.2	Management Board **noted** the contents of the above document.	

Attachment 2

362 362.1	**Working Lives Group** Management Board **noted** the contents of the above document.	
363 363.1	**CASP** Management Board **noted** the contents of the above document.	
364 364.1	**Quality and Safety Committee** Management Board **noted** the contents of the above document.	
365 365.1	**Patient and Public Involvement & Experience Committee** Management Board **noted** the contents of the above document.	
366 366.1	**Redevelopment Programme Steering Board** Management Board **noted** the contents of the above document.	
367 367.1	**Education Strategic Committee** Management Board **noted** the contents of the above document.	
368 368.1	**Information Governance Steering Group** Management Board **noted** the contents of the above document.	
369 369.1	**Commissioners Forum and Commissioners Contract Review Group** Management Board **noted** the contents of the above document.	
370 370.1 370.2	**Waivers** The Board noted the requested for approval for the waivers from the following suppliers, EMS Physio Ltd, ParAid Medical and LifePort Inc. Management Board **approved** the waivers.	
371	**Any other business**	
371.1 371.2 371.3 371.4	FD reported that there had been a MRSA reported recently but this was a patient who already had MRSA that had been readmitted in to the hospital so this was a case of double counting. BB congratulated the Cardiac team on a successful CF Network Peer Review - Core Panel visit to GOSH which took place on the 18th January, 2012. JC also asked that thanks be recorded to WM and his team for the successful and below budget handover of the Morgan Stanley Clinical Building. Management Board **noted** the verbal reports.	