Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
27th June 2012

Dear Members

There will be a public meeting of the Trust Board on Wednesday 27th June 2012 commencing at **2:30pm** 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	Authors
1.	**Apologies for absence**	Chair	
Declarations of Interest The Chair and members of this meeting are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must, as soon as practicable after the commencement of the meeting disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 30th May 2012**	Chair	**K**
3.	**Matters Arising / Action point checklist**	Chair	**L**
4.	**Chief Executive's Update** • **Timetable for departure of Chief Executive** • **ICU Review** • **Update on Safe and Sustainable Reviews** • **Results of Monitor's Quarter 4 monitoring** • **Morgan Stanley Opening**	Chief Executive	**Verbal**
5.	**Clinical speciality presentation – Neurodisability**	Dr Alison Salt, Consultant in Neurodisability and Sarah Dobbing, General Manager, Neurosciences	**M**
6.	**Quality, Safety & Transformation Update**	Co-Medical Director (ME)	**N**
	UPDATES		
7.	**Performance Report (May 2012)**	Chief Operating Officer	**O**
8.	**Finance and Activity Report (May 2012)**	Chief Finance Officer	**P**
9.	**Annual PPI and PALS report 2011/12**	Chief Nurse and Director of Education	**Q**
10.	**Update on progress with research strategy and UCLP research**	Director of Research and Innovation	**R**
11.	**Update on revalidation of doctors**	Co-Medical Director (BB)	**S**
12.	**Management Board minutes from April 2012**	Chief Executive	**T**

13.	**Trust Board Members' Activities**	Chair	
	FOR RATIFICATION		
14.	**Consultant Appointments**	Chair	
	FOR INFORMATION		
15.	**Annual Health and Safety Report**	Chief Executive	**U**
16.	**UCL Partners' Update – May 2012**	Chief Executive	**V**
17.	**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.)		
18.	**Next meeting** The next Trust Board meeting will be held on Wednesday 25th July 2012 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT K

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board held on 30th May 2012

Present

Baroness Tessa Blackstone	Chairman
Ms Yvonne Brown	Non-Executive Director
Dr Barbara Buckley	Co-Medical 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 John Ripley	Non-Executive Director
Mr Charles Tilley	Non-Executive Director

In attendance

Ms Chris Caldwell	Assistant Director of Education and Organisational Development
Dr Anna Ferrant	Company Secretary
Miss Victoria Goddard	Trust Board Administrator (minutes)
Mr William McGill	Director of Redevelopment

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

430 Apologies for absence

430.1 There were no apologies for absence received.

431 Declarations of interest

431.1 No declarations of interest were received.

432 Minutes

432.1 The minutes from the meeting of 25th April 2012 were **approved** with no amendments.

433 Matters arising and action checklist

433.1 Minute 327.7 – Dr Jane Collins, Chief Executive confirmed that priorities were discussed at the Executive Away Day. It had been agreed that achievement of CRES was the primary concern. Other priorities were implementation of phase 2B, the improvement of Research and Innovation Income and the implementation of recommendations arising from the ICU

Review.

434 Chief Executive Update

434.1 Dr Jane Collins reported that a presentation of the Intensive Care Review would be received in the confidential session. She confirmed that the report had been circulated to the Board.

434.2 Dr Collins reported that the staff within ICU and around the hospital would be presented with the findings in the week commencing 11th June. Recommendations would be discussed and this would be led by Mrs Liz Morgan, Chief Nurse and Director of Education and Professor Martin Elliott, Co-Medical Director.

434.3 Dr Collins confirmed that a Members' Council Development Session had taken place earlier in May. She stressed the importance of the Board and Members' Council working together and suggested that Councillors were invited to public Board meetings. The Board agreed.

434.4 **Action:** Dr Anna Ferrant, Company Secretary to ensure that Councillors are invited to future public sessions of the Trust Board.

434.5 Ms Mary MacLeod, Non Executive Director explained that she had spoken to Ian Lush, Lead Councillor and it had become clear that there was some confusion around the nature of Councillors' responsibilities. He had confirmed that the training received by Councillors had been helpful. Ms MacLeod added that discussions were on-going with Dr Collins to create a programme of joint workshops with the Trust Board.

434.6 It was agreed that Baroness Blackstone, Chair would have lunch with Ian Lush to provide an informal environment for a discussion of the Councils' role.

434.7 **Action:** Baroness Blackstone to meet informally with the lead councillor to discuss the role of the Council and how it will work with the Board in the future.

434.8 Dr Collins reported that a meeting of the Joint Committee of Primary Care Trusts looking at Cardiac Surgery was scheduled to take place on 4th July with preliminary meetings taking place prior to that date. She noted that it was likely that a decision would be recommended at that meeting.

434.9 Dr Collins reported that she and the Chief Operating Officer had met with the Cardiac Team who would be actively engaged and part of the Communications plan.

434.10 It was confirmed that Safe and Sustainable had designated four Neurolsurgery centres for epilepsy surgery and that GOSH had been described as the 'lead centre'. Dr Collins added that Professor Helen Cross and Mr William Harkness would take on a national role in supporting other centres to develop.

434.11 It was noted that it would not be possible for the Trust to carry out all Epilepsy assessments for London and the South East and that these would

be taking place in partnership with Kings College Hospital where good relationships were already in existence.

435 NHS and Foundation Trust Final Accounts and Annual Reports

435.1 Mr Charles Tilley, Non Executive Director and Chair of the Audit Committee confirmed that the Audit Committee had considered both NHS and Foundation Trust accounts. He reported that a positive report had been received from external auditors, Deloitte, in respect of the financial accounts.

435.2 He confirmed that issues discussed in Deloitte's report were around changes in the treatment of donated assets and very small, non-material errors around the cut off between months for NHS and Foundation Trust reporting.

435.3 It was confirmed that Mr Tilley had taken part in a confidential meeting with the auditors and all issues were dealt with satisfactorily.

435.4 The Board thanked the finance team for producing two excellent sets of Annual Accounts.

435.5 It was reported that Deloitte had agreed that the annual accounts be formally signed off.

435.6 Mr Tilley confirmed that the Audit Committee was able to recommend both the accounts and representation letter to be approved by the Board.

435.7 It was agreed that a number of minor amendments in relation to the Annual Reports would be discussed outside the meeting.

435.8 It was agreed that the statement on directors' independence be revised to accurately reflect that all directors were viewed as independent.

435.9 It was agreed that the statement around staff witnessing errors and near misses be reworded to accurately reflect the findings from the staff survey

435.10 **Action:** Dr Anna Ferrant to make the above amendments to the Foundation Trust Annual Report.

435.11 Mr David Lomas asked why the number of incidents was not reducing.

435.12 Professor Elliott confirmed that the Trust had encouraged the reporting of incidents and for this reason, reporting numbers remained high.

435.13 Mr John Ripley, Non Executive director stressed that this should be captured in the report.

435.14 **Action:** Dr Anna Ferrant to ensure that explanation is given within the Annual Report as to why the number of incidents is increasing.

435.15 The Board **approved** the NHS and Foundation Trust Annual Accounts and Annual Reports.

435.16 The Board **authorised** Dr Jane Collins to sign the letter of representation.

435.17 The Board thanked the Company Secretary for her excellent work to produce two annual reports within such a tight time frame.

436 Quality Account

436.1 Professor Martin Elliott, Co-Medical Director reported that the Quality Strategy had been revised to ensure it fitted well with the Quality Account. He confirmed that of 15 priorities for improvement, 13 had been completed in the previous Quality Account. He confirmed that there were still improvements to be made in the areas of food and communication.

436.2 Professor Elliott confirmed that Deloitte had reviewed the data and were comfortable with what had been provided with the exception of the data on discharge summaries, where dates were not always recorded when each discharge summary was sent.

436.3 Mr Charles Tilley reported that the Auditors confirmed they were happy to sign the report.

436.4 Ms Mary MacLeod, Chair of the Clinical Governance Committee confirmed that the Committee had received a previous draft of the Quality Account and had provided comments.

436.5 The Board thanked Mr Robert Burns, Deputy Chief Operating Officer and Ms Lisa Davies for their work to develop the report.

436.6 Ms Yvonne Brown, Non Executive Director asked for a steer on the timeline for recruiting a member of staff to address issues of tissue viability.

436.7 Mrs Liz Morgan reported that the post had been difficult to appoint to. She added that an action plan was in place to address tissue viability issues.

436.8 It was agreed that '*numbers increased as the dedicated staff post became vacant*' would be removed to ensure that a link was not created to the number of pressure sores as Mrs Liz Morgan confirmed there was no evidence of such a link.

436.9 **Action:** Dr Anna Ferrant to remove the wording '*numbers increased as the dedicated staff post became vacant*' to ensure that a link was not created around the number of pressure sores

436.10 The Quality Account was **approved** subject to the above amendment.

437 **Audit Committee Annual Report**

437.1 Mr Charles Tilley, Chair of the Audit Committee confirmed that the committee was comfortable with the comprehensive content of the report. He added that amendments should be made around highlighting the minutes of the meeting and making reference to the fact that work was undertaken in conjunction with the Clinical Governance Committee.

437.2 It was added that there is a clear differentiation between the risks related to

the Clinical Governance Committee and the Audit Committee.

437.3 Mr John Ripley confirmed that the Audit Committee was satisfied that no gaps existed in the split of risks between the two committees.

437.4 The Board **approved** the report.

438 **Draft Schedule of Reservation and Delegation of Powers**

438.1 Dr Anna Ferrant , Company Secretary reported that the paper provided an overview of the decisions reserved to the Board and other committees and individuals. She added that it had been reviewed against Terms of Reference, Standing Orders and Standing Financial Instructions.

438.2 It was noted that amendments had been received from the Audit Committee in terms of removing items from the document where no decision would be taken.

438.3 The Board **approved** the schedule subject to the above amendments.

439 **Quality, Safety and Transformation Update**

439.1 Professor Martin Elliott confirmed that the Transformation Report had been produced by Katharine Goldthorpe, Peter Lachman and Jez Phillips. He reported that it outlined the scope of transformational work and the ways in which it was being embedded within the Trust.

439.2 Professor Elliott reported that overall there had been a consistent improvement in processes.

439.3 Mr David Lomas, Non Executive Director queried what would drive the combined harm index to increase in year.

439.4 Professor Elliott confirmed that this would happen as a result of improved reporting around Medication Errors. He added that the giving of medication had the potential to cause harm more than any other incident.

439.5 Ms Fiona Dalton reported that although the areas of harm shown were decreasing, better medication error reporting was leading to the overall increase because of the large number of drug doses given.

439.6 Mr John Ripley queried the achievement of 100% of all out patients achieving advanced access. He stressed the importance of creating a challenging but achievable target which could be achieved in 2012/13.

439.7 Ms Dalton reported that this metric had been discussed in detail at Transformation Board. She confirmed that it was taking longer than anticipated to implement.

439.8 **Action:** Professor Martin Elliott to consider an achievable target for advanced access for outpatients for 2012/13.

440 **Performance Report**

440.1 Ms Fiona Dalton reported that a further indicator had been introduced relating to written communication with referrers and outpatients. She confirmed that this would be considered in conjunction with discharge summaries which were only relevant to inpatients.

440.2 It was reported that currently the average number of days between an out patient appointment and a letter being sent was 25.4 days which was below expectation. Ms Dalton added that in a number of clinics no letters were being sent.

440.3 Ms Dalton then reported the following concerns:

- CVL infections had spiked due to incidents from a particular ward. This was being discussed with the lead nurse in ICI and IPP.
- Waiting time targets were being focused on by clinical units and Ms Dalton reported that she was confident that they would be achieved.
- PDR rates were still below expectation. Mrs Liz Morgan reported that the education team were supporting clinical units and managers to complete PDRs and that paper work had been refined. General Managers would receive monthly reports on PDR levels.

440.4 Professor Andy Copp asked that quarterly trend columns be completed even in instances where the last quarter was in the previous financial year.

440.5 **Action:** Ms Fiona Dalton to ensure that the quarterly trend column is completed in all reports.

440.6 The Board **noted** the report.

441 **Finance and Activity Report**

441.1 Mrs Claire Newton presented the finance and activity report which incorporated the 12 month figures to the end of March.

441.2 She reported that the Trust did not achieve its CRES targets but the EBITDA finished close to plan as a result of sundry income.

441.3 Mrs Newton confirmed that in April planned activity levels and income were achieved and expenditure was within the month's budget.

441.4 She added that currently £1.8m was in dispute with commissioners and that business cases had been delivered demonstrating the Trusts underfunding in two services. It was confirmed that the commissioners were appealing to the JCPCT for increased funding.

441.5 Mr David Lomas, Non Executive Director asked for a high level steer around how the current financial year would be different from 2011/12.

441.6 The Chief Operating Officer reported that central vacancy controls were on-going and had been rolled out to non rostered clinical staff. She added that

Clinical Units who had not identified CRES targets would be asked to identify posts for removal.

441.7 It was agreed that this would be discussed in detail at the next Finance and Investment Committee.

441.8 It was agreed that a written briefing on Agenda for Change would be provided at the next Trust Board meeting.

441.9 **Action:** The Chief Operating Officer to provide a written briefing on Agenda for Change at the next Trust Board meeting in June.

441.10 Baroness Blackstone expressed some concern around the achievement of CRES targets and the confidence around the results of the current financial year.

441.11 Ms Yvonne Brown asked what the Trust's position was on altering the terms and conditions offered to staff under Agenda for Change.

441.12 Ms Dalton confirmed that currently the Trust had no plans to move away from Agenda for Change terms and conditions. However discussions were underway about other policies (e.g. pay protection) which would enable future restructuring to be carried out more cost effectively.

441.13 Baroness Blackstone asked that a plan be received at the June meeting around controlling the number of staff with increases offset with savings in other areas.

441.14 **Action:** A plan to be received at the June meeting around controlling the number of staff with increases offset with savings in other areas. In depth discussions to take place.

441.15 The Board **noted** the report.

442 **Update on Progress with Education and Training Strategy**

442.1 Mrs Liz Morgan, Chief Nurse and Director of Education reported that good progress was being made against the action plan with the majority of staff having accessed training over and above statutory and mandatory training requirements.

442.2 She confirmed that significant work had been undertaken to reduce the length of time staff were required to take part in face to face education.

442.3 It was noted that the education team had been restructured to create one cohesive team which had reduced the number of staff. Links with Clinical Units were being strengthened to ensure staff were being training in the most appropriate way.

442.4 Mr David Lomas asked to what extent education was being provided to parents. He reported that providers in the USA were placing a focus on providing additional web based training to parents.

442.5 Mrs Liz Morgan reported that this education was provided through nurses and it was a considerable amount of their workload particularly in some areas. She added that the Trust had a duty to ensure that parents were competent to support their child when away from the hospital.

442.6 The Board **noted** the update.

443 **Audit Committee**

443.1 Mr Charles Tilley reported that a further Audit Committee meeting had taken place on 30th May 2012. He confirmed that three risks had moved from green to amber:

- Achievement of CRES targets
- IT systems and data issues
- The private patient cap

443.2 It was noted that the Audit Committee would be convening an additional meeting at the end of July to focus on risk to which the Chair of the Clinical Governance Meeting would be invited.

443.3 Mr Tilley confirmed that an interim NHSLA assessment would take place in July and the outcome of this would be brought to the Trust Board in the same month.

443.4 **Action:** The outcome of the July NHSLA assessment to be considered at the July meeting of the Trust Board.

443.5 The Board **noted** the update.

444 **Clinical Governance Committee**

444.1 The Board **noted** both the summary report and the minutes of previous meetings.

445 **Management Board**

445.1 The Board **noted** the minutes from the March meeting.

446 **Consultant Appointments**

446.1 The Board **ratified** the following consultant appointments:

- Dr Despina Eleftheriou, Rheumatology.

447 **Any other business**

447.1 There were no items of other business

448 **Next meeting**

448.1 It was noted that the next meeting would take place on 27th June 2012.

ATTACHMENT L

TRUST BOARD - ACTION CHECKLIST
June 2012

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
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	To be conducted as part of review of effectiveness of Management Board in September 2012	Not yet due
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
403.6	25/04/12	The Director of Redevelopment to provide an update at the next Trust Board meeting as to the reason for low workforce scores in baseline assessment results of the good corporate citizenship model of the Sustainability Management Plan.	WM	June 2012	To be discussed at the Sustainable Development Committee on Monday 28th May 2012. An update to be provided at the June Board meeting.
407.7	25/04/12	A paper on the revalidation of Doctors to be brought to the May meeting of the Trust Board	BB	June 2012	On agenda
415.3	25/04/12	The Chief Finance Officer to investigate the administration of payment of amounts due to consultants for their private patient practice through a private company to ensure the Trust's reputation would not be disadvantaged by these actions.	CN	June 2012	Verbal update

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
434.4	30/05/12	Dr Anna Ferrant, Company Secretary to ensure that Councillors are invited to future public sessions of the Trust Board.	AF	June 2012	Actioned – councillors invited by email to public sessions of the Trust Board
434.7	30/05/12	Baroness Blackstone to meet informally with the lead councillor to provide an informal environment for a discussion of the Councils' role.	TB	June 2012	Baroness Blackstone met with Mr Ian Lush on Friday 15th June – verbal update
435.10	30/05/12	Dr Anna Ferrant to make the relevant amendments to the Foundation Trust Annual Report.	AF	June 2012	Actioned and report submitted to Monitor
435.14	30/05/12	Dr Anna Ferrant to ensure that explanation is given within the Annual Report as to why the number of incidents is increasing.	AF	June 2012	Actioned and report submitted to Monitor
436.9	30/05/12	Dr Anna Ferrant to remove the wording 'numbers increased as the dedicated staff post became vacant' to ensure that a link was not created around the number of pressure sores	AF	June 2012	Actioned and report submitted to Monitor
439.6 439.8	30/05/12	Mr John Ripley queried the achievement of 100% of all out patients achieving advanced access. He stressed the importance of creating a challenging but achievable view of what could be achieved in 2012/13. Professor Martin Elliott to consider an achievable target from advanced access for outpatients for 2012/13.	ME	June 2012	Verbal update
440.4 440.5	30/05/12	Professor Andy Copp asked that quarterly trend columns be completed even in instances where the last quarter was in the previous financial year. Ms Fiona Dalton to ensure that the quarterly trend column is completed in all reports.	FD	June 2012	Report on agenda

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
441.9	30/05/12	A written briefing on agenda for change to be provided at the next Trust Board meeting.	FD	June 2012	Considered at the Finance and Investment Committee on 18th June – verbal update from meeting
441.14	30/05/12	A plan to be received at the June meeting around containing the number of staff with increases offset with savings in other areas. In depth discussions to take place.	FD	June 2012	Considered at the Finance and Investment Committee on 18th June – verbal update from meeting
443.4	30/05/12	The outcome of the July NHSLA assessment to be considered at the July meeting of the Trust Board.	ME	July 2012	Not yet due

ATTACHMENT M

Great Ormond Street Hospital for Children NHS Foundation Trust

Specialty – Neurodisability

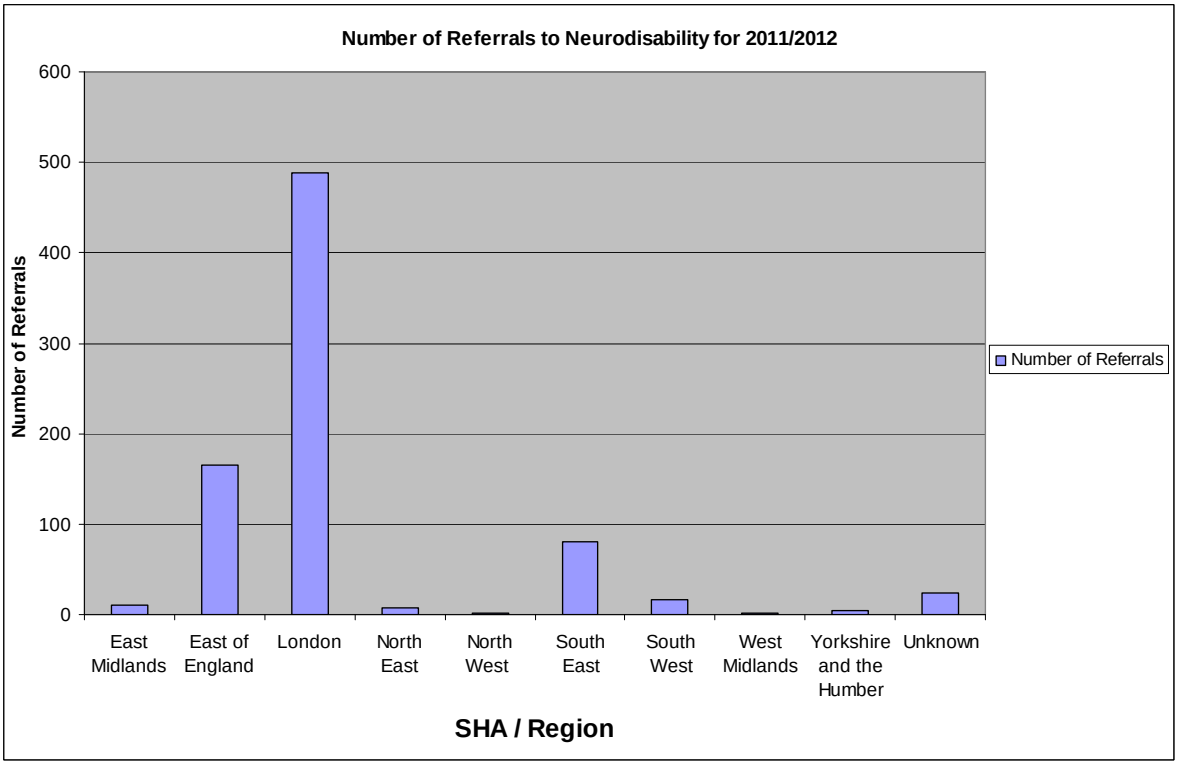
General Background

The Wolfson Neurodisability service provides services to children with neurodevelopmental and physical disability and is comprised of a number of specialist clinics for children with different conditions, including:

- Autism and social communication disorders
- Learning disability including specific difficulties – e.g. dyslexia, dyspraxia
- Epilepsy (especially syndromes that affect development)
- Cerebral palsy and other physical disabilities who have:
  - Feeding and Swallowing difficulty
  - Movement disorders (MDS)
  - Communication difficulty
- Visual impairment
- Metabolic disorders
- Osteogenesis imperfecta (Brittle bones)

The clinics respond to questions raised by referrers and parents about diagnosis and management advice which cannot be answered by local secondary level child development centres or paediatricians. The clinics provide a holistic assessment and understanding of the child's difficulties and practical recommendations for on-going care. Intervention with botulinum toxin for spasticity and treatment to strengthen bones in children with brittle bones are also provided on a day case basis.

The graph below shows where our patients came from last year, the majority being from London, East of England and the South East.



The service is predominantly based in outpatients with in-patients being day cases for the 175 patients seen within the Osteogenesis Imperfecta service and Movement Disorder Clinic sees 16 patients as day cases per year.

Over the past 5 years the service has seen continual growth in the number of outpatient appointments as can be seen from the table below.

	2008/2009	2009/2010	2010/2011	2011/2012
Number of Referrals	633	749	793	807
Total Number of Patients seen	1411	1604	1875	1925
Number of New Patients seen	523	541	672	722
Number of F/U Patients seen	888	1063	1203	1203

The speciality is led by Alison Salt and managed within the Neurosciences Clinical Unit.

Staff (Whole Time Equivalents): The service is staffed by a highly-skilled multidisciplinary team including:

- Specialist Neurodisability and Neurology Paediatricians (4.8),
- Clinical psychologists (4.8),
- Speech therapists (4.8),
- Occupational therapists (4.8),
- Physiotherapy (3.9),
- Nurse specialist (1.0),
- Assistive technologist (1.0),
- Administrators including NCG (5.5).

Staff turnover is low, and we have traditionally found it easy to recruit to vacancies.

Clinical Outcomes

Parent Satisfaction and understanding of their child's disability are the main clinical outcomes that the service uses to measure the quality and performance. Outcomes provide evidence that the service attains a high level of parent satisfaction (see below).

Increasing parent understanding of their child's disability is an important goal of the service. We have developed a new measure - PUN-Q (Parent Understanding of Neurodisability – questionnaire). Our research has shown that increased parent understanding is significantly associated with reduced mental health risks and increased parent competence. A further study is being planned to evaluate the tool as a measure of change.

In the augmentative communication service and botulinum toxin service: outcomes are regularly measured against goals agreed with local professionals and parents for each individual child.
Botulinum toxin: yearly safety audit is undertaken to monitor any adverse events in association with injections.

Benchmarking

Currently developing benchmarking for Botulinum toxin services with The Evelina Children's hospital
Osteogenesis Imperfecta (OI) service - benchmark against other NCG OI services
Other services are unique but the service continues to be involved in setting national standards for neurodisability services.

What are the speciality's ambitions?

We continue to increase activity in line with our business plans and to develop services in known areas of unmet need. However, expansion is reliant on the availability of appropriate

outpatient space in the Djanogly outpatient building level 1 which we have been assured will be available following relocation of the social work department.

The Speciality aims to become the London hub for provision of augmentative communication services in collaboration with adult services, when commissioning for these services is transferred from Education to Health (2013). The service is currently receiving funding to the complete a feasibility study for DoH and DfE.

Services for children with cerebral palsy are not meeting the current demand for surgical treatment, or more state of the art spasticity management and gait analysis. We are looking to be able to support the development of these services in this area of unmet need. This would include exploring closer working with Institute of Neurology, orthopaedics and neurosurgery.

The Speciality aims to develop improved assessment and support services for children following traumatic brain injury including building closer working relationships with The Children's Trust, Tadworth.

We continue to develop collaborative research activity across the Trust in a number of services.

Safety & Risk

The top risk for the service is the lack of outpatient space provided in Level 1 Frontage building. This has prevented us from opening as many new clinic slots as planned, and this has affected our ability to reduce waiting times.

The other risk is the type of space provided which is not suitable for the types of patients we see, in particular the movement disorder service does not have an appropriate space to review patients walking (pre- and post- treatment) and so this often has to take place in a corridor.

There have been no serious incidents in Neurodisability.

Patient Experience

Parent satisfaction survey 2011 – high level of satisfaction with all aspects of service received. MDS service nominated for award by families. Opportunity for immediate feedback to the team by parents and child available in clinic, with positive feedback and suggestions from children received.

The Speciality has received four complaints in the last 18 months, two complaints related to parents being unhappy with the diagnosis that had been reached, one was about results not being communicated to parents in a timely manner and the last one concerned a medication error.

The team are undertaking a Transformation project to reduce the length of time taken for comprehensive detailed reports to be completed and sent out. The initial results show that improvements are being made.
All parents are also given a summary report on the day of clinic and urgent information is communicated to referrers within 5 days.

Over the last year, improvements have been made with clinic capacity and usage and the average waiting time for an appointment within the Speciality has steadily declined.

Whilst the number of days that patients have to wait continues to be a top priority, much of the waiting is by patient choice.

	2010/2011	2011/2012	2012/2013
Average Waiting time in days	68	57	43

When introducing 'Advanced Access' the clinical team noted that families were rarely able to attend appointments at short notice. They conducted a patient survey asking parents how long they would be prepared to wait for a complex assessment, and have used this information to set internal targets for appointment waiting times.

Finances

The neurodisability service has a local tariff agreement for their outpatient clinics. The tariffs per appointment are:

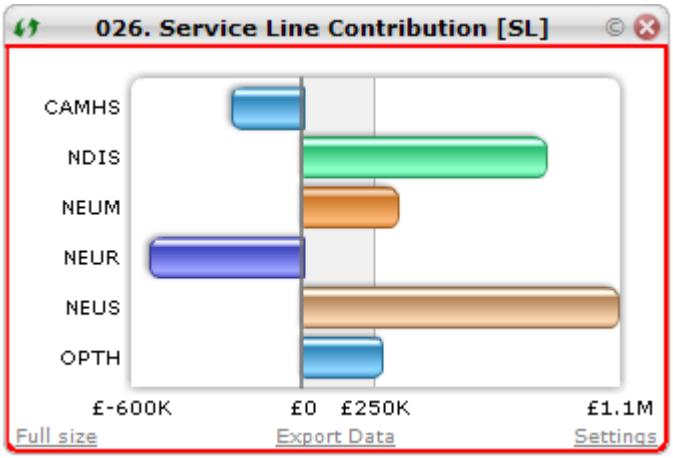
Band 1 (family liaison appointment) = £159
Band 2 (single professional assessment) = £396
Band 3 (multi-professional appointment) = £1,663

75% of appointments within the service are classed as Band 3.

In the financial year 2011-12 the Neurodisability Service made a considerable contribution to the Trust:

	2011-12 Budget	2011-12 Actual	Variance
Pay	1,156,048	1,093,260	62,788
Non-pay	134,888	172,818	(37,930)
Income	(3,018,577)	(3,066,550)	47,973
Overall	(1,727,640)	(1,800,472)	72,832

The Neurodisability service performs strongly on Service Line Report:



CRES plans:
In 2012-13 the neurodisability CRES plan relates to increasing activity in line with the agreed business case and the IBP.

Integrated Business Plan

The neurodisability service is not one of the identified key priority areas, however it is important to note that the service does support the Neurosurgery service – working with the epilepsy surgery service, with brain injury patients and in cerebral palsy spasticity management.

The service aims to continue growing to meet increasing demand for our services. The IBP for the service predicts 6.5% growth in 2012-13.

Any Other Relevant Information

Equipment issues: Limited funding for the loan library for augmentative communication equipment (such has eye-gaze technology) has raised concerns from families and limits the service that can be provided. Proposal to CESC was unsuccessful and GOSH Trust charity are not able to support this need. Not being able to provide this service in the short term may jeopardise the Trusts bid to become the main centre for London for the provision of communication aids.

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27th June 2011	
Reporting Zero Harm - Quality, Safety & Transformation (QST) Update **Submitted on behalf of Professor Martin Elliott, Co-Medical Director**	**Paper No: Attachment N**

Aims / summary

Monthly rotation of Transformation, Safety & Outcomes, with focus on Safety for period 1st February 2012 – 31st May 2012.
Areas of note:

- Number of days since last SI (close of business on 31st May): 2
- Number of SI's reported: 9
- Number of SI's closed: 3
- Of the 3 SI's closed 1 was closed within the correct timescales
- Number new formal complaints 45
- Number of red complaints 6
- Percent of complaint responses sent out on time 73.5%
- New risks high opened: 13
- 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, 13th June 2012

Attachment N

Quality, Safety & Transformation
Reporting to Trust Board
June 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 1st February 2012 to 31st May 2012.

Part I

Zero Harm Update

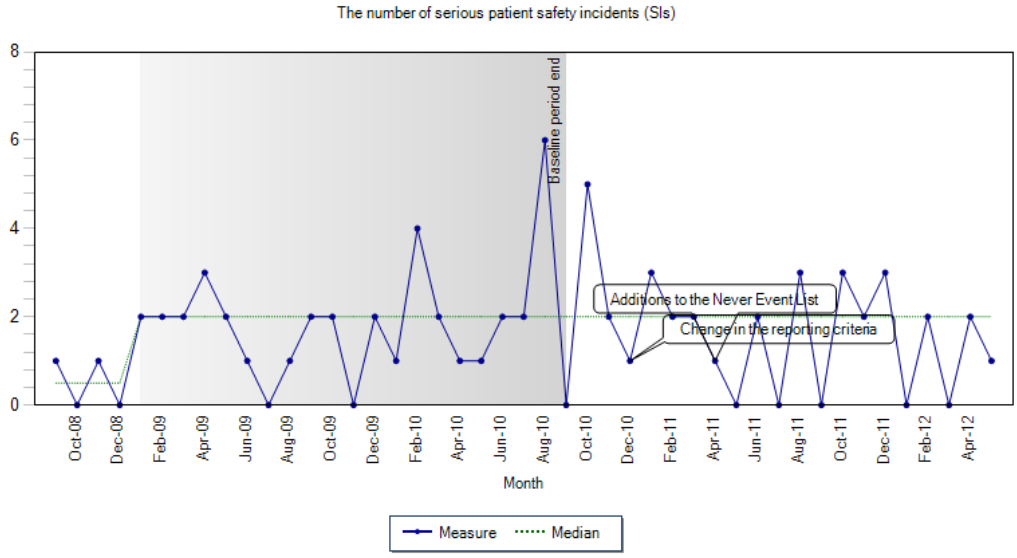
There are no statistically significant changes in the Zero Harm Indicators (Appendix A). The work in each of these areas continues to be reported in detail as part of the Transformation, Safety and Outcomes monthly updates.

Part II

This is the second Safety report produced by Quality, Safety & Transformation. This provides key information to show the last three months activity. This report is under continuous development, so we can provide a clear picture of where concerns are in the Trust, what improvements are being undertaken and how the team can monitor how the units are mitigating their risks. This report will provide information on the following:

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

1. Serious Incidents (SI) Analysis



A serious patient safety incident is defined as an incident that occurred in relation to care resulting in one of the following:
- Unexpected or avoidable death of one or more patients, staff visitors or members of the public.
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
- Allegations of abuse
- One of the core sets of 'Never Events'

1.2 Rate of SI's reported

Number of days since last SI (close of business 31st May 2012): 2

Between 1st February 2012 and 31st May 2012 there were new 9 SI's were reported. The departments in which they were reported are as follows:

Department	Number of SIs
Finance	1
MDTS	3
Cardiorespiratory	3
Surgery	1
ICI-LM	1

1.2 Number of SI's closed

Number of SI's closed (1st February 2012 and 31st May 2012): 3

Of 3 SI's closed, 1 of these was closed within the timescale set by NHS London and 2 were outside the timescale.

	Finance	ICI-LM	MDTS
Within timescale		1	
Late	1		1

1.4 Key learning and improvement from SIs

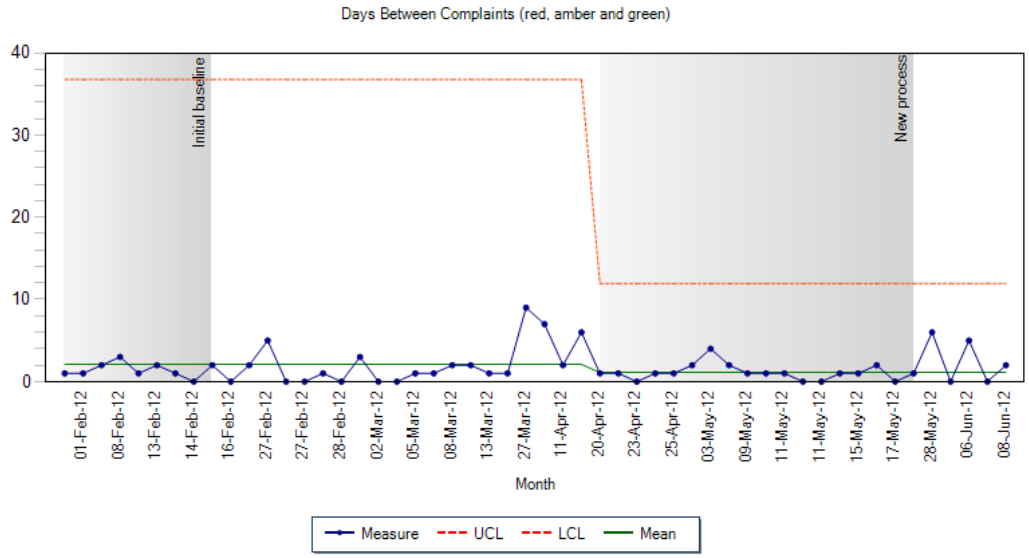
- New Risk Managers (3) have been recruited and started in post April/May.
- The new QST team are working together to identify where data for improvement and transformation methodology will support learning from SIs and complement the audit work.
- The SIs in ICI-LM and MDTS both indicated that there is a risk within the Trust when patients are transferred to our care with a diagnosis already made. Both of the SIs related to wrong diagnosis and therefore treatment being given to patients (one for 14 years and one for a number of weeks) Although the learning points were different, both investigations highlighted the need for Trust staff to request written confirmation of the results that have led to the diagnosis being made. At the Quality and Safety Committee is was agreed that the learning points for both of these SIs will be amalgamated and presented in a variety of ways (lessons learned seminars, roundabout article, risk action groups).
- The use of faxing to communicate sensitive data is being reviewed due to the Information Governance Breach SI and due to the recent fines imposed by the Information Commissioners Office on NHS Trusts who have failed to keep data in a safe and secure manner.

2. Complaints Analysis (1st February – 31st May 2012)

2.1 Number of new complaints received

Number new formal complaints 45
Number of red complaints 6 (see Zero Harm report for SPC chart)
Percent of complaint responses sent out on time 73.5%

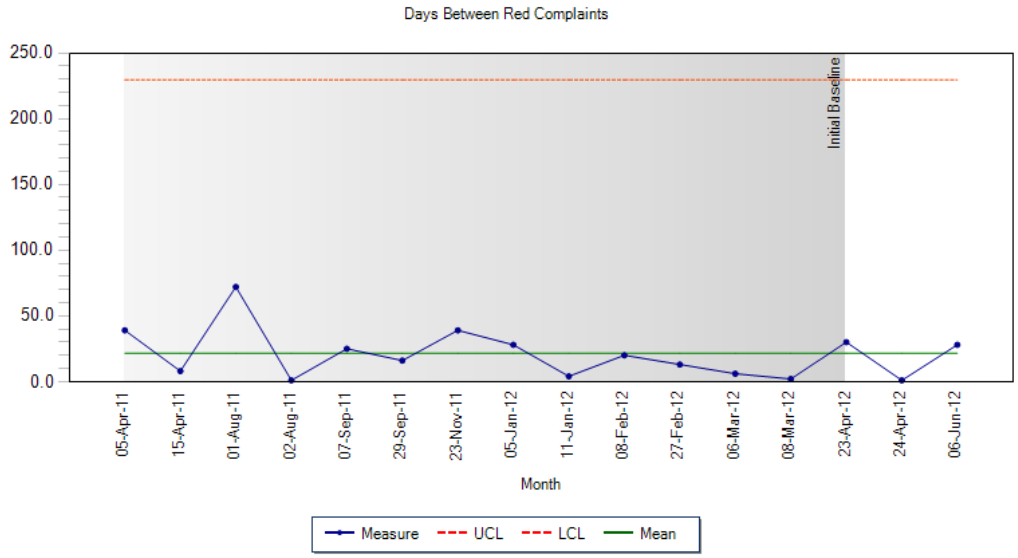
Days between complaints (red, amber and green)



It should be noted that during the between 9th May and 18th May the Trust received 9 complaints relating to Gastroenterology and Surgery (jointly). Of these, 3 were regarding Gastroenterology alone and 3 were regarding Surgery alone.

The complaints department have seen an increase in the number of complaints raising concerns regarding communication for Gastroenterology and Surgery. This issue was discussed at the weekly aggregated analysis meeting and it was established that the number of cases has increased in the PALS department, incidents being reported and Serious Incidents. See below for interventions.

Days between red complaints



Red complaints - severe harm to patient or family or reputation threat to the Trust.
Amber complaints - lesser than severed but still poor service, communication or quality evident.
Green complaints - minor issues or difference of opinion rather than deficient service.

2.2 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. This information will be shared with the allocated Risk Manager for the units involved to ensure that the actions are discussed and monitored through the Risk Action Groups (RAG) and added to the Risk Register if required.
- Complaints Manager working with Improvement Managers and Coordinators to improve the process for implementing and monitoring the learning identified through the complaints process..
- A work stream is being developed to address communication, particularly where patients are seen by more than one service. This will be managed through Quality, Safety and Transformation and will report to the Quality & Safety Committee.
- 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 or Medical Devices Alerts (MDA) (notices about faulty/defective equipment)
- NPSA (Alerts regarding actions to improve patient safety)
- DH/NHS Estates & Facilities

3.1 MHRA alerts

The Trust has received 31 new alerts between 1st February and 31st May 2012:

28 MHRA/MDA alerts
1 NPSA alert
2 Estates and Facilities Alerts.

20 of the alerts were not relevant, the remaining 11 were relevant and completed.

None of the above alerts are currently outstanding and all were responded to on time with the exception of 1 MHRA/MDA alert which was delayed as a result of staffing issues within the Risk Management Team.

3.2 Rapid Response Reports

There are currently no open Rapid Response Alerts.

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. .

3.3 NICE Guidance

Number of relevant NICE guidelines: 1

Details: Percutaneous balloon cryoablation for pulmonary vein isolation in atrial fibrillation
Action: To ensure that the relevant data is submitted to the UK Central Cardiac Audit Database (CCAD).

3.4 Participation in National Audits

During 2011/12 GOSH participated in 15 of the 17 non-mandatory national audits as follows:

EMACH: Perinatal Mortality
PICANet: Paediatric Intensive Care
Congenital Heart Disease: Paediatric Cardiac Surgery
British Thoracic Society: Paediatric Asthma
British Thoracic Society: Paediatric Pneumonia
NHS Blood and Transplant: Potential Donor Audit
NCAA: Cardiac Arrest Audit
National Inflammatory Bowel Disease: Ulcerative Colitis and Crohn's Disease
British Thoracic Society: Bronchiectasis
National Pain Audit: Chronic Pain
NHS Blood and Transplant: UK Transplant Registry: Intrathoracic
Cardiac arrhythmia (Cardiac Rhythm Management Audit)
Renal Registry: Renal Replacement Therapy
NHSBT UK Transplant Registry: Renal Transplantation
National Comparative Audit of Blood Transfusion: Bedside Transfusion

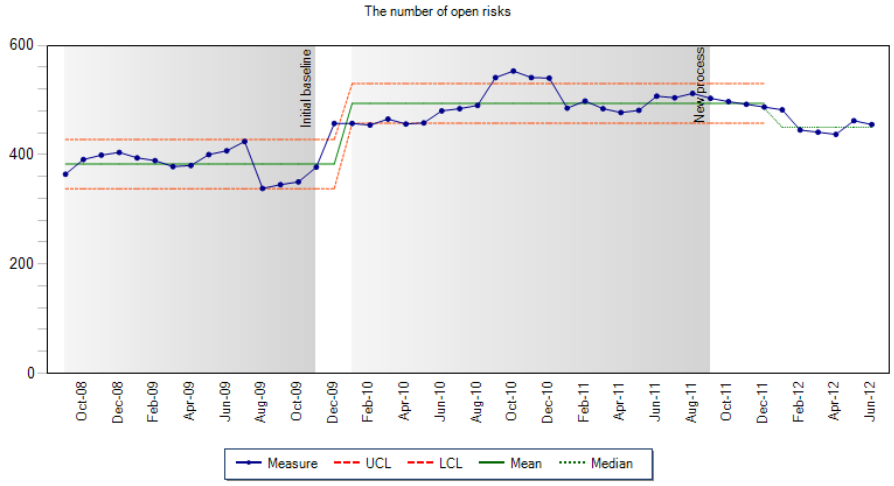
3.5 Participation in National Confidential Enquiries

There is currently no requirement for GOSH to participate in any NCEPOD studies

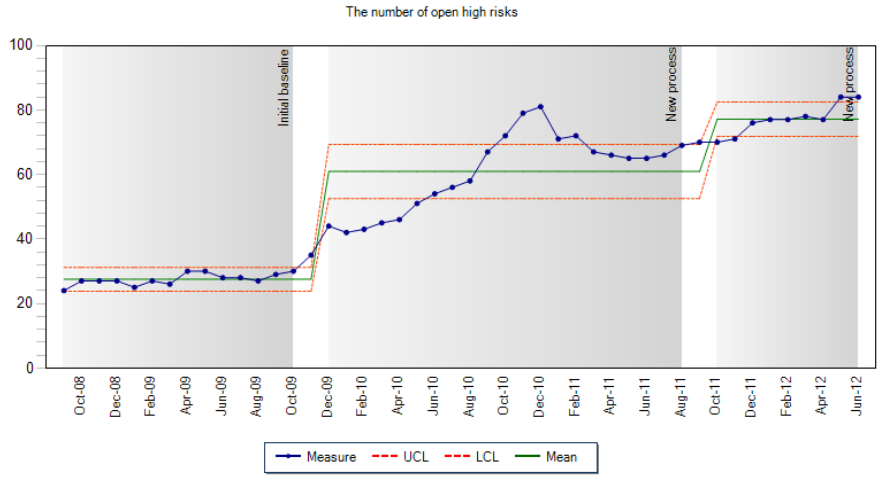
4. Risk Analysis

This is the first use of SPC methodology for measuring risk and will need further validation. It should be noted that the introduction of Datix has had an impact on the figures in 2011/12.

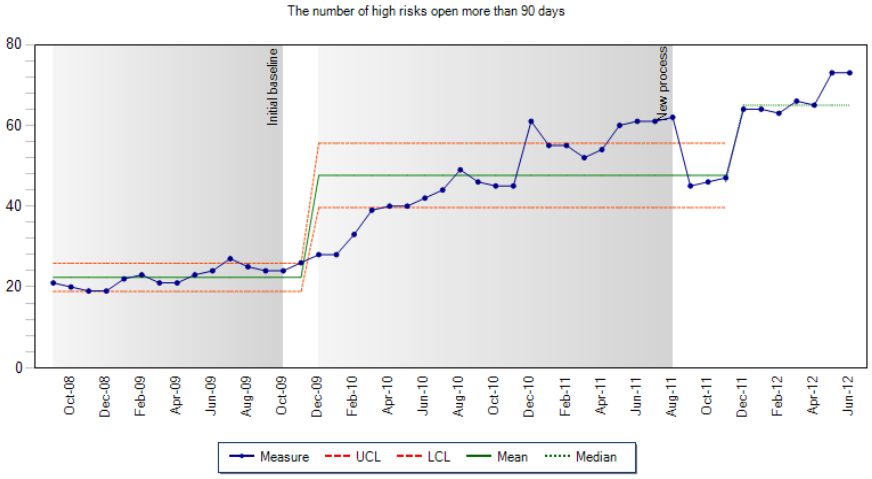
Number of open risks



Number of open high risks

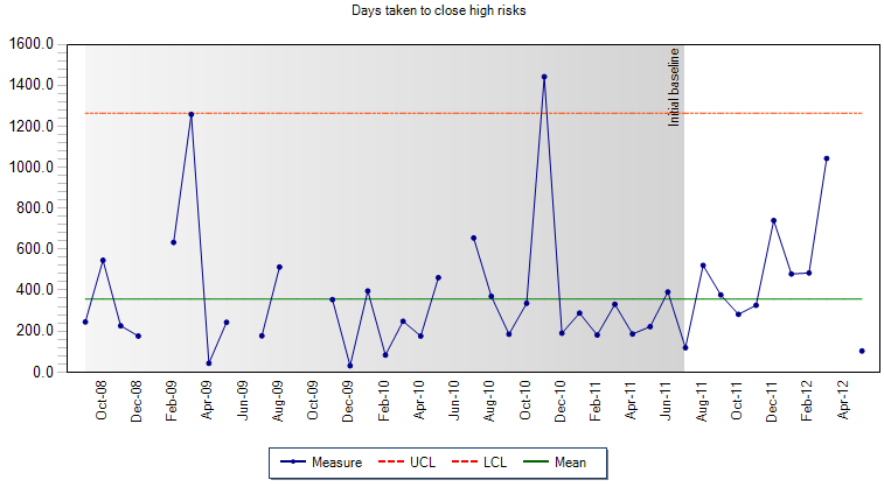


Number of high risks open more than 90 days



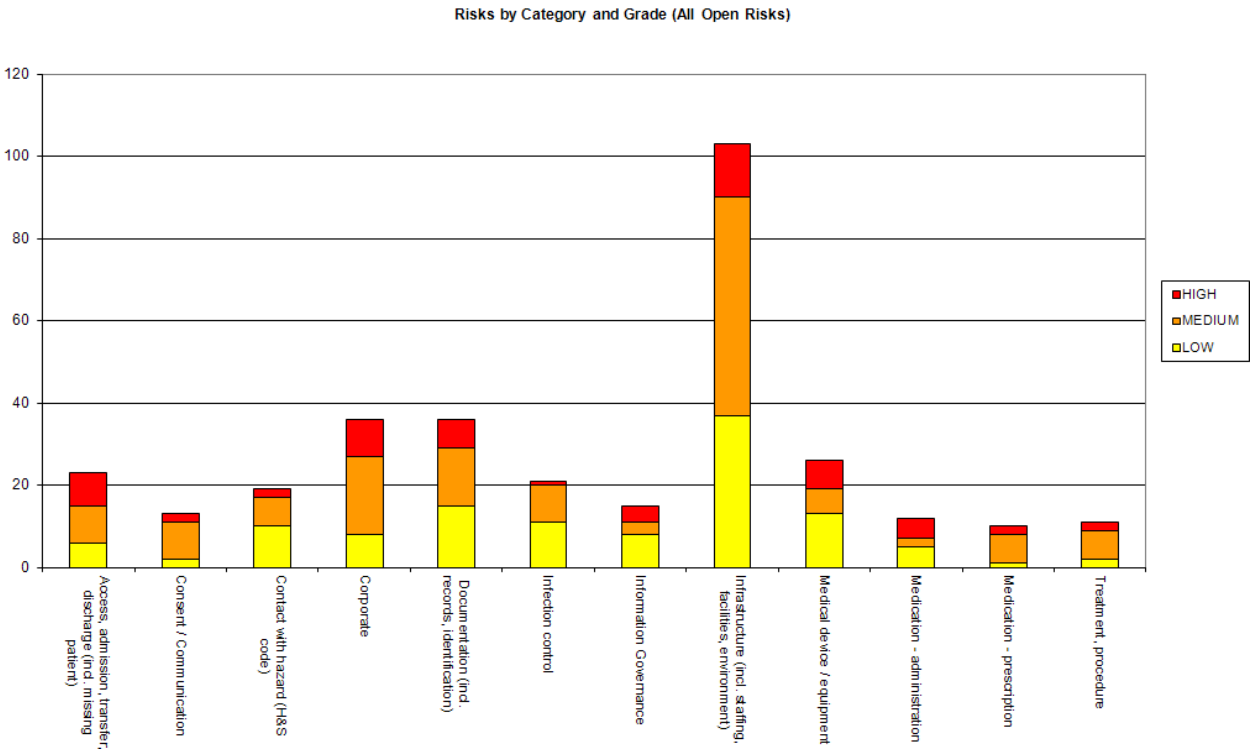
Time taken to close high risks

Note: it is not currently possible to include when risks are de-escalated



You will see that there has been a decline in the number open incidents, but an increase in the number of open high risks, the number of high risks open over 90 days and the number of time taken to close high risks. It is not yet clear whether this is a reporting issue or whether there has been an actual increase in high risk. The new risk managers are working closely with the clinical units to identify correct grading of new risks and de-escalation or closure of existing risks where appropriate.

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



4.2 Key learning and improvement from risk

The Assistant Head of Quality, Safety and Transformation – Risk Management is working with all of the users of Datix (Risk Management, Complaints, Pals and the Legal team) to review and update the categories that are used on Datix to ensure that a more detailed and uniform analysis can be undertaken for all elements of Clinical Governance.

4.3 High Risks

There were 13 new high risks added to the Risk register in the timeframe (1st February – 31st May 2012). 4 of these risks have been listed under the category of 'Infrastructure' this includes risks identified with availability of non-medical equipment (x2), space and new risks identified with the introduction of a new IT system. All of these risks have controls in place and will be reviewed at their next Risk Action Groups.

The risk of not successfully achieving the NHSLA L3 assessment is on the risk register as a high risk. The NHSLA project team meet on a fortnightly basis and has the support of an Executive Director and a designated Project lead.

The availability of manual handling advice and cover when the advisor is on leave or unavailable has also been identified. Currently the health and safety advisor is contacted but is neither qualified or an expert in the field.

Two 'Estates' risks have been added in this time frame, the first is the lack of on-load generator testing and the other is the plant rooms have not been fire risk assessed since 2009. This has been escalated to the Director of Redevelopment and will be reviewed in the June RAG.

All of the risks are reviewed monthly and will be monitored via the Risk Action Groups, Clinical Unit Board and for high risks, the Risk Assurance and Compliance Group.

5. Clinical Audit

Topics covered between 1st February 2012 to 31st May 2012:

Topic	Reason for work
Process for clinicians assistants requesting radiological investigations	Serious incident
Prevention of retained throat packs in the operating theatre,	Serious incident
Maladministration of methotrexate	Check controls to prevent a Never Event
Storage of medicines and controlled drugs	Requested by the Department of Health and reported to the Care Quality Commission following a serious incident at another hospital which had national media attention
Blood Pressure Monitoring	Part of ongoing work to improve quality and standardised blood pressure recording.
Compliance with provision of same sex accommodation	Department of Health requirement

Some work scheduled for Q2 has commenced

Topic	Reason
Management of Femoral Lines	Check that improvements have been made to safety following introduction of Femoral Line Policy.
Maladministration of insulin	Check of controls to prevent a Never Event.

The Clinical Audit team are providing significant support or facilitating the following improvement work:

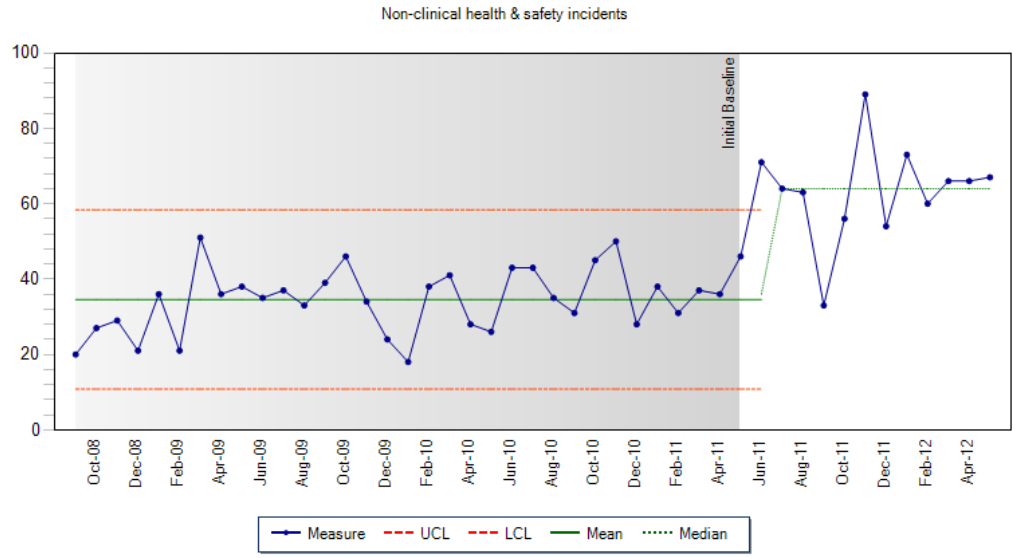
Topic	Reason
Ensuring that emergency trolleys are fit to be used to support the deteriorating patient	Audit in 2011/12 identified risk of unsafe trolleys
Reducing hospital acquired pressure ulcers	CQUIN target. Audit in 2011/12 has suggested an increase in occurrence of ulcers.
Reducing blood sampling errors	This project achieved the best project award for the 2011/12 TIMP graduates. This work continues to try and reduce the number of times patients need to be bled.

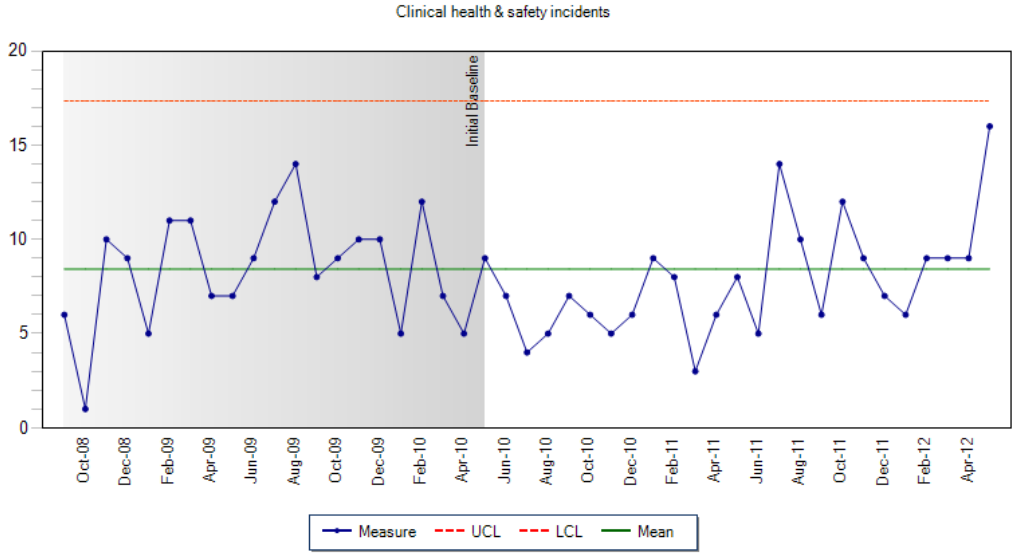
6. Health and Safety

There were 259 reported non-clinical incidents reported between 1st February 2012 to 31st May 2012.

The reporting increase in August 2011 onwards is attributable to the introduction of the new online reporting System (Datix) which has seen a rise in all forms of health and safety incident reporting.

Attachment N





Key interventions for management of Health and Safety

A new Major Project Licence Agreement has been introduced by the Estates' Directorate. Certain work undertaken by the Estates team has the capacity to impact on the large swathes of the hospital. The licence requires the sign off from senior clinical and operational staff prior to any work being undertaken. In order for this to occur risk assessments/method statements/risk impact assessments and communication plans must be submitted and the nature of the proposed work explained to relevant parties.

Each area is getting its own health and safety intranet page which will include all 'Control Of Substances Hazardous to Health' (COSHH) assessments and Standard Operating Procedures (SOPs). These are being reviewed, updated where necessary and placed on the GOS intranet site. This will aid all staff to manage the safe use and disposal of any hazardous substances. Local risk assessments/policies/protocols will also be available online.

An updated Lone worker policy has been agreed and introduced. Managers and staff must be aware of the possible heightened risks associated with working alone and the guidance and practical help the Trust can

provide in mitigating these risks. A suitable risk assessment must be in place with appropriate measures to mitigate the risk.

An issue with straps on the patient beds was highlighted by the incident reporting system and the Biomedical Engineering Department. The Health and Safety Assistant initiated an improvement project which led to the removal of finger guards on the beds as he established they were not fit for purpose causing more of a risk than they prevented.

An ongoing project is under way to reduce sharps injuries across the Trust, protecting staff and patients alike. This is being done in conjunction with the Head Nurse for Clinical Equipment, Infection Control and the Occupational Health Department as well as external auditing help and the help of the clinical teams. The project is taking a holistic look at practise/safe sharps systems/sharps boxes/incident reporting and follow up.

Summary

Work is being undertaken to better understand the aggregate analysis of incidents, complaints and risks at GOSH, taking into account other contributing factors. Good progress has been made in the last 5 months to develop the way QST present and analyse the data and this will continue.

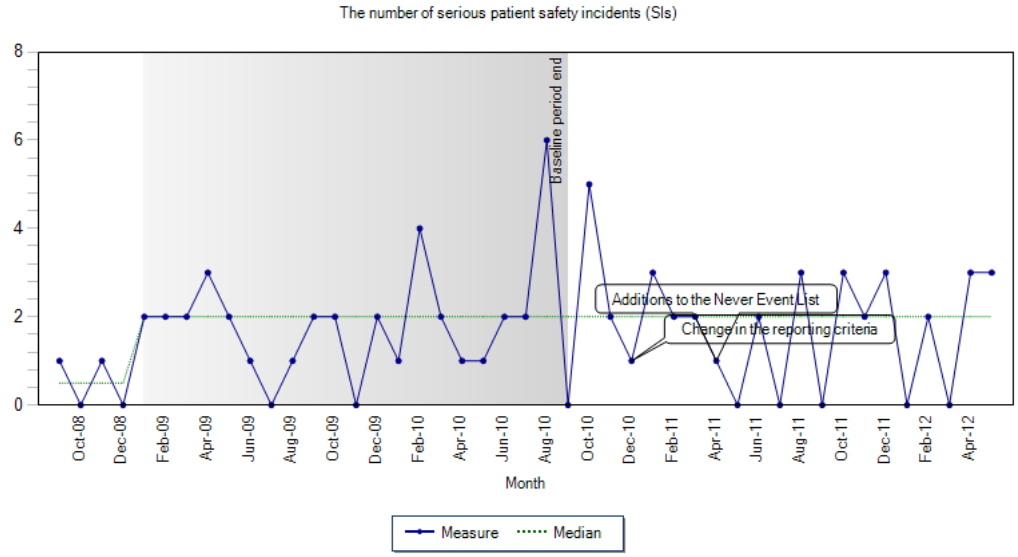
Appendix A

The following report produced by the Quality, Safety & Transformation (QST), provides Zero Harm data.

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. When using SPC charts, we are looking for special causes, which result from a significant change in the underlying process. If a special cause occurs, we will highlight this accordingly. SPC is the tool that we use to determine where a change in practice has led to an improvement.

1. Serious Incidents

See Safety Report for summary on Serious Incidents.



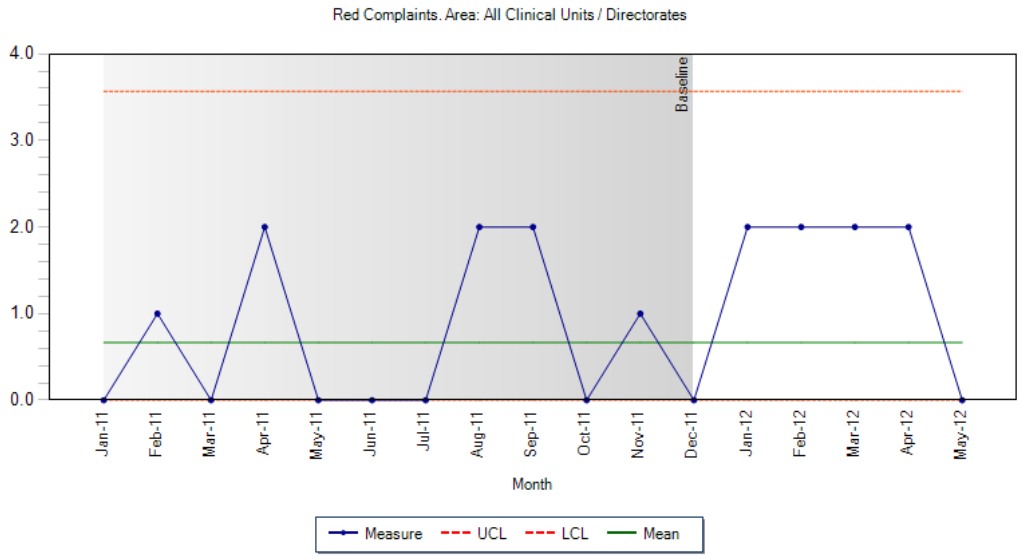
The number of serious patient safety incidents

A serious patient safety incident is defined as an incident that occurred in relation to care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff visitors or members of the public.
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
- Allegations of abuse
- One of the core sets of 'Never Events'

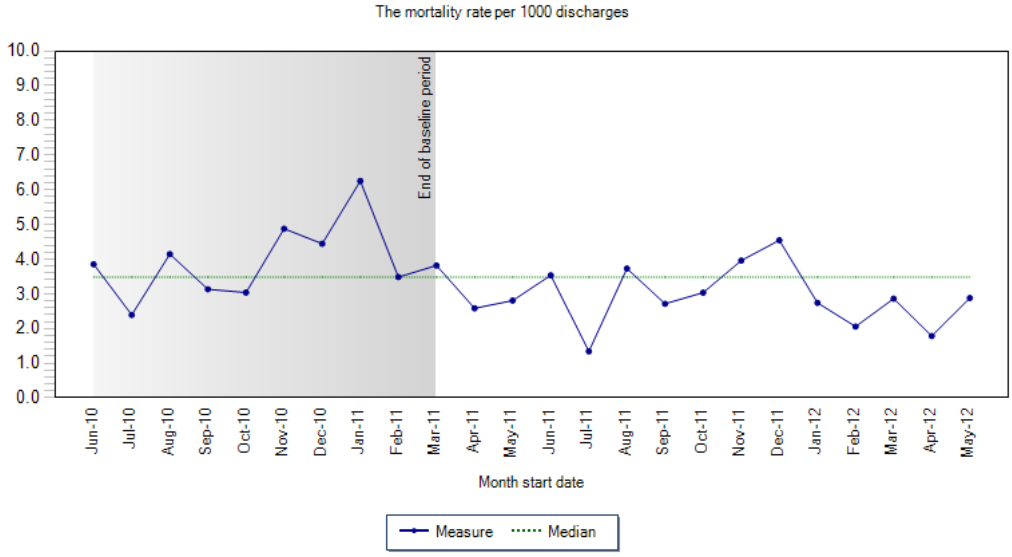
2. Red Complaints

See Safety Report for summary on Red Complaints.



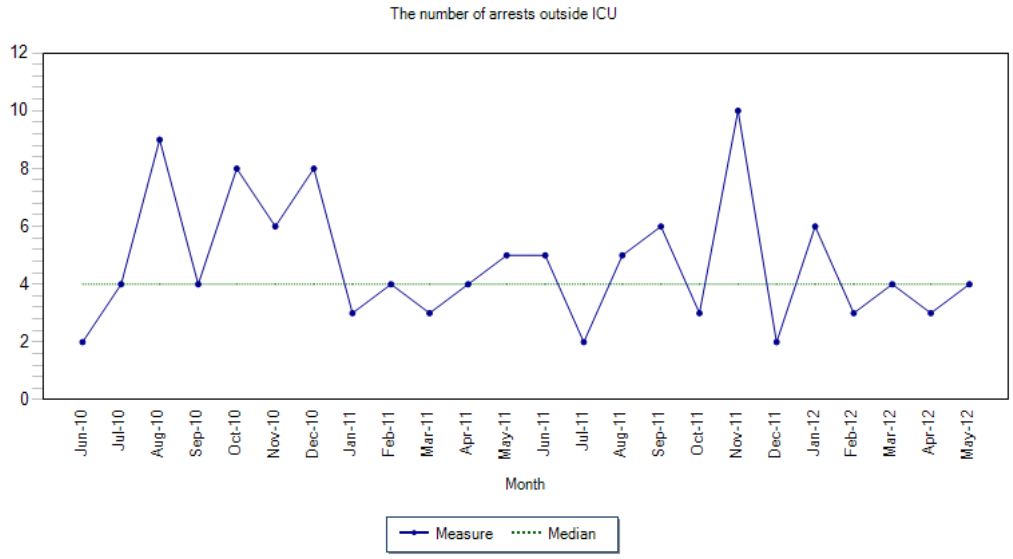
Red complaint definition: Severe harm to patient, family or reputation threat to the Trust.

3. Mortality

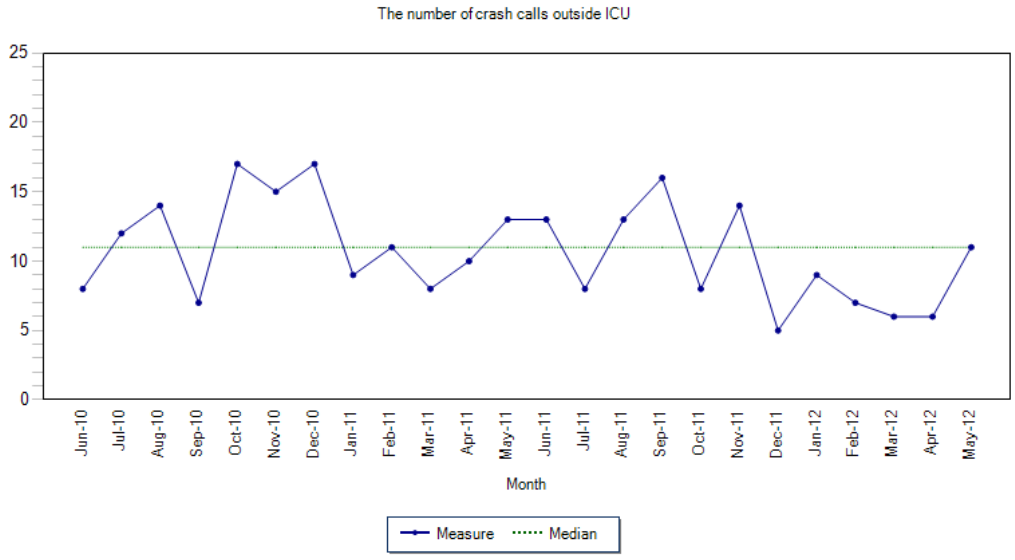


4&5 Arrests and crash calls outside Intensive Care Units (ICU)

The SPC charts below show the number of arrests and crash calls outside the ICU areas.
The overall aim of the Deteriorating Child project is to eliminate harm from preventable deterioration of children on wards outside intensive care, theatres and other related areas such as angiography. Deterioration which is unrecognised or poorly managed can lead to significant harm, including respiratory/cardiac arrest or death. To tackle the most serious cases, the project has set a target of reducing the number of cardiac and respiratory arrests on wards outside of theatres and intensive care by 50 per cent by end March 2013.



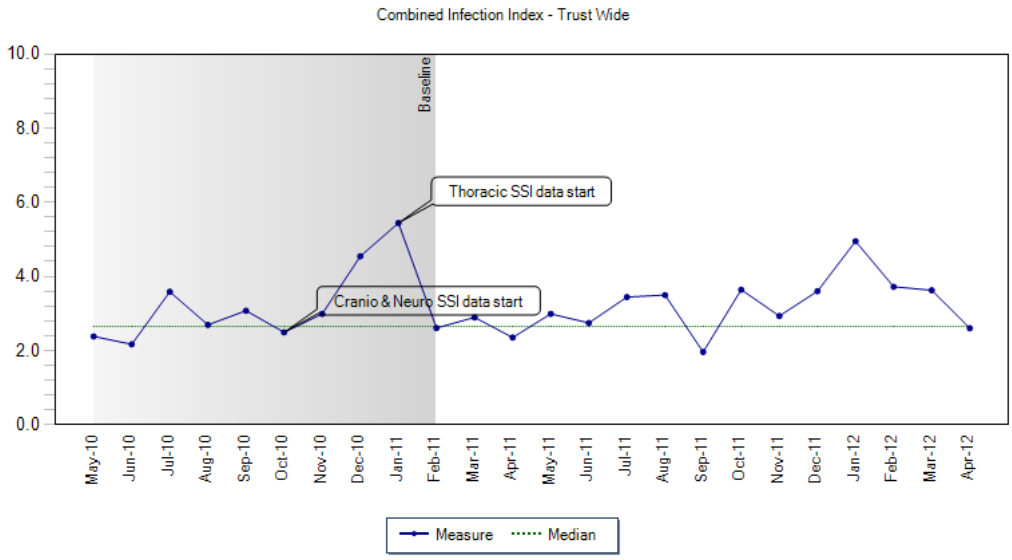
The monthly number of arrests (cardiac or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team)



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

4. Combined infection index

This index is the combined number of specified hospital acquired infections (HAI), per 1000 adjusted patient activities. It includes the total number of reported Central Venous Line (CVL) infections, Surgical Site Infections (SSI), Ventilator Associated Pneumonia (VAP), MRSA, MSSA and Clostridium difficile. It should be noted that the vision is to improve reporting of errors, so it is likely that the numbers will increase before they decrease ultimately. For example, the number of SSI's has increased and will continue to increase as surveillance improves.

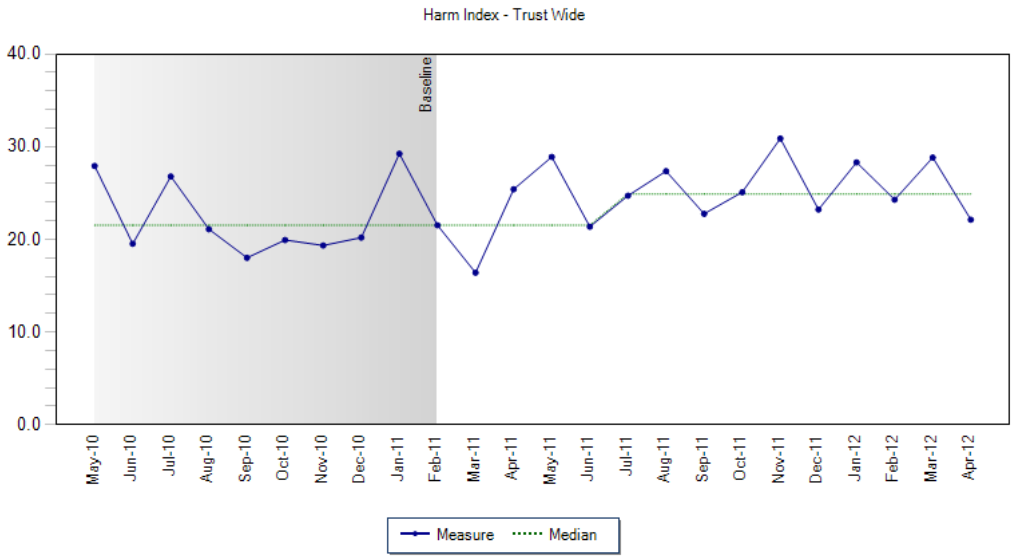


Adjusted Patient Activity = number of Finished Consultant Episodes (FCEs) + ((number of OPD appointments + (ICU bed days x 9.5)) / 12.9)

Adjusted Patient Activity (APA) is a measure of activity which weights outpatients, inpatients and critical care bed days into a combined figure representative of overall healthcare resource activity. For example on average an inpatient requires more input than and an outpatient and thus several outpatients will be the equivalent of one inpatient. This combined APA enables different specialties to be compared with each other and over time and will account for the relative differences in patient complexity. It can be used as a denominator for comparable measures across the Trust such as harm and workforce productivity.

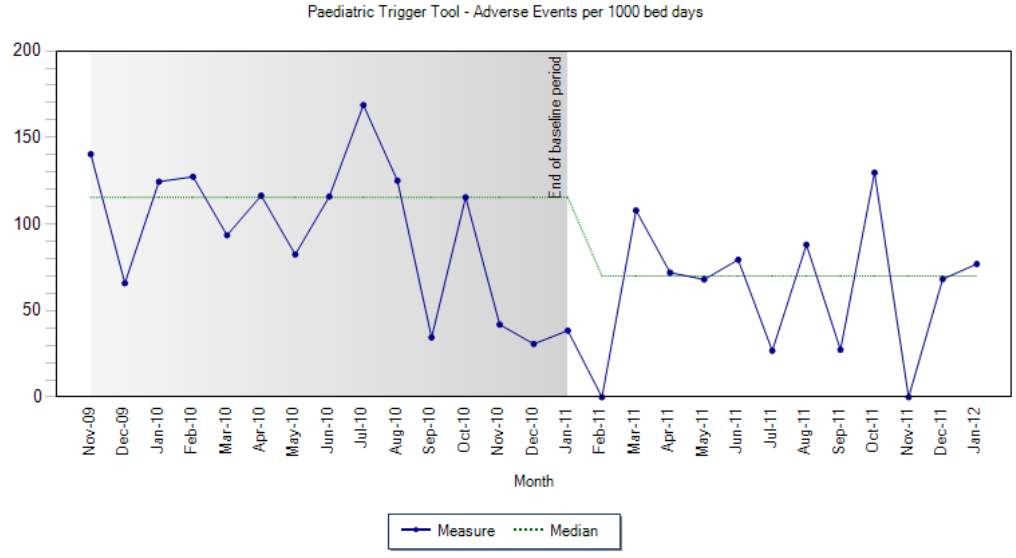
5. Combined harm index

This index is the total number of harm incidents per 1000 Adjusted Patient Activities in the Trust. It includes hospital acquired infections (as above), serious incidents, non-ICU arrests, reported medication errors, patient falls, and pressure ulcers. It should be noted that the vision is to improve reporting of errors, so it is likely that the numbers will increase before they decrease ultimately. For example, the number of reported medication errors will increase as we encourage the reporting of incidents.



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 notes are pulled each month and analysed for adverse events using a methodology developed by the IHI. It should be noted that we are working 2 months behind the date of discharge as they need to be discharged for 30 days and we need time to randomise and obtain all the case notes.

Great Ormond Street NHS
Hospital for Children
NHS Foundation Trust

Trust Board 27th June 2012	
Key Performance Indicator report **Fiona Dalton, Chief Operating Officer**	**Paper No: Attachment O**

Aims / summary

The KPI report monitors progress against the Trust's seven strategic objectives and Monitor's Governance Risk Framework. The report provides 'RAG' rated performance analysis against defined thresholds and tolerances as well as monthly and quarterly performance trends.

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

Alex Faulkes, Head of Planning & Performance Management. June 2012

KPI Exception report

1. Monitor Governance Risk Rating

In month, the Trust is anticipating reporting a rating of 'Green'. No cases of MRSA and C. difficile were reported. The Trust achieved the Referral to Treatment (RTT) Incomplete Pathway standard reporting a rate of 93.4% against a target of 92%. The RTT Admitted and Non-Admitted standards will be reported in July but it is anticipated that these standards will continue to be achieved. All relevant cancer waiting times were additionally met.

2. Infection Control

MSSA and E-coli

No formal external targets currently exist for E-coli and MSSA. However, the Trust has set an internal standard of reducing the number of infections from the previous year.

In month, no cases of E-coli were reported. 2 cases have been reported year to date, remaining within the year end trajectory of 20.

In month, 3 cases of MSSA were reported. Performance remains above the year end trajectory of 19 with 5 cases reported to date. Infection rates continue to be monitored closely.

Central Venous Line infections

In month, the Trust line infection rate decreased with a reported rate of 2.6 against a previous month position of 3.0 (per 1,000 line days). The rate remains within the statistical control limits. Line infection rates continue to be monitored closely.

3. Inpatient Waiting List over 26 weeks

As previously reported, particular capacity issues have been identified within Surgery. Specialty plans and trajectories have been put in place with waiting list issues forecast to be resolved by early 2013. Head and Neck and Maxillofacial remain within trajectory however Urology and Orthopaedics report a number of patients above trajectory.

The Unit continues to work through a prioritised waiting list allocating TCI dates across July, August and September during which time we will expect to see the overall number of long waiting patients reduce. The Unit have also ensured that RTT incomplete pathways continue to be validated, supporting the Trust to meet the 92% standard and that admitted and non-admitted patient pathways remain within the national standards.

4. Diagnostic waits over 6 weeks

A high number of diagnostic waiting times above 6 weeks were previously identified within Medicine and Surgery. Trajectories to reduce the number of breaches within Urology and Gastroenterology were put in place in March 2012 with the aim of achieving the national standard by September and December respectively. These trajectories have subsequently been brought forward by several months following correspondence with North Central London. The Trust is currently meeting the new trajectory for Urology and whilst the number of patients remains outside of trajectory within Gastroenterology the overall number has continued to reduce.

It should be noted that the Radiology department has recently introduced a new reporting system (RIS). MRI diagnostic waits have not been reported over the last few months due to system reporting difficulties, which have now been resolved. In month

20 patients have been identified currently waiting over 6 weeks for MRI. A system review and action plan is currently being developed to ensure that all patients currently breaching the standard are seen as soon as possible and that all future patients are seen within 6 weeks.

5. Patient refusals

In month the Trust reported 32 patient refusals of which 28 were attributed to the CATS team, which is an extremely high number for a non-winter period.

6. Personal Development Review (PDR) completeness rates

PDR rates remain static at 66% and 59% for clinical and non-clinical areas respectively against a target of 80%. Continued progress against this standard is required to support the delivery of NHSLA level 3.

Education & Training leads have started to attend Unit Board meetings to identify specific issues that are preventing managers from achieving not only the PDR target but also all mandatory training requirements. Reports for appraisals, statutory/mandatory training and local induction will be available via GOSH web next month, which will allow managers to continuously review progress. An article focussing on staff appraisals will additionally be published in July's Roundabout magazine.

Recommendations:

Trust Board to note progress

Great Ormond Street Hospital for Children NHS Trust

Trust Board

Key Performance Indicator Report

May-12

Objective	Graph	Page no.	Reported	YTD Target/Trajectory (12/13)	Q4 2011/12 Performance	YTD Performance	Monthly Trend		Quarterly Trend			
							Apr-12	May-12	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4
Objective 1	Incidence of C.difficile	4	Monthly	8	1	1	1	0				
	Incidence of MRSA**	4	Monthly	0	0	0	0	0				
	Incidence of MSSA	4	Monthly	19	3	5	2	3				
	Incidence of E-Coli	4	Monthly	20	5	2	2	0				
	No. of NICE recommendations unreviewed	4	Monthly	0	2	0	0	0				
	CV Line related blood-stream infections	5	Monthly	1.5	2.15	2.8	3.0	2.6				
	Mortality Figures	5	Monthly	Within tolerance	23	14	5	9				
	Serious Patient Safety Incidents	5	Monthly	Within tolerance	5	6	3	3				
	Surgical Check List completion rate (%)	6	Monthly	95.0	97.4	97.6	98.5	96.6				
Objective 2	18 week referral to treatment time performance - Admitted (%)	7	Monthly	90	90	90.5	90.5	Available in July				
	18 week referral to treatment time performance - Non-Admitted (%)	7	Monthly	95	96.96	97.4	97.4	Available in July				
	18 week referral to treatment time performance - Incomplete Pathways (%)	7	Quarterly	92	91.97	93.4	91.9	93.4				
	Inpatients waiting list profile (26+)	7	Monthly	0	274	244****	238	244****				
	95th Centile - Admitted	7	Monthly	<23 weeks	28	26.2	26.2	Available in July				
	95th Centile - Non-Admitted	7	Monthly	<18.3 weeks	17.71	17.6	17.6	Available in July				
	Median Waits - Admitted	7	Monthly	<11.1 weeks	9.08	10.8	10.8	Available in July				
	Median Waits - Non-Admitted	7	Monthly	<6.6 weeks	6.72	7.7	7.7	Available in July				
	95th Centile - Incomplete Pathways	8	Monthly	<28 weeks	21.98	23.3	23.3	Available in July				
	Median Waits - Incomplete Pathways	8	Monthly	<7.2 weeks	6.43	6.0	6.0	Available in July				
	Discharge summary completion (%)	8	Monthly	95	79.25	79.5	79.3	79.6				
	DNA rate (new & f/up) (%)	8	Monthly	10	8.3	8.3	8.8	8.0				
	Cancelled Operations on day of admission (%)	9	Monthly	0.80	0.86	0.45	0.75	0.45				
	Percentage of Cancer patients waiting no more than 31 days for second of subsequent treatment (Surgery, Drug Treatements, Radiotherapy) & Maximum waiting time of one month from diagnosis to treatment for all cancers.	9	Monthly	98	100	100	100	100				
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	10	Monthly	<=1	3	5.80	6.00	5.80				
	Number of complaints	10	Monthly	-	31	21	8	13				
	Number of complaints by grade High	10	Monthly	<14	6	1	1	0				
	Theatre Utilisation (% Patient Operation Utilisation of Scheduled Duration, U4)	11	Monthly	70	68.9	-	68.4	68.6				
	Clinic Letter Turnaround (% within 5 days)	11	Monthly	New indicator to be confirmed	39.61	-	25.4	23.8				
Objective 3	Patient refusals	12	Monthly	218	81	53	18	35				
	Clinical Income variance (£)	12	Monthly		-971,502	-508,477	-	-508,477				
Objective 4	Clinical trials (CTIMPs)	13	Monthly	No decrease	-	38	38	38				
	GOSH research projects	13	Monthly	No decrease	-	156	161	156				
	Commercially-funded projects (% achieving a 70 day turnaround)	13	Monthly	No decrease	-	100	100	100				
	Number of UKCRN Portfolio projects	13	Monthly	-	317	118	124	118				
	GOSH research income	13	Monthly	-	-	TBC	164,039	TBC				
	Patient safety SAE's (Serious Adverse Event)	14	Monthly	0	0	6	3	3				
	Biomedical Research Centre (BRC) (£)	14	Monthly	-	-	-	31,683	0				
Objective 5	MADEL SLA Value (£)	15	Quarterly	-	5,580,806	-	-	-				
	SIFT SLA Value (£)	15	Quarterly	-	60,142	-	-	-				
	NMET SLA Value (£)	15	Quarterly	-	1,165,709	-	-	-				

Objective	Graph	Page no.	Reported	YTD Target/Trajectory (12/13)	Q4 2011/12 Performance	**YTD Performance**	Monthly Trend		Quarterly Trend			
							Apr-12	May-12	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4
Objective 6	CRES Forecast Savings 2011/12 (£)	16	Monthly	TBC	8,248,330	14,544,022	14,974,722	14,544,022				
	Bank and agency total expenditure (£)	16	Monthly	To Reduce	4,096,000	2,445,214	1,213,240	1,231,974				
	Monitor Risk Rating	16	Monthly	TBC	3	-	4	Available in July				
	Charity fundraising income (£)	16	Monthly	8,019,604	21,837,868	7,382,975	3,579,057	3,803,918				
Objective 7	Sickness Rate (%)	17	Quarterly	<3.3	3.02	-	2.35	Available in July				
	Staff in Post (WTE excluding maternity leave)	17	Quarterly	-	3,453	-	3,313	3,341				
	Vacancy Rate (%)	17	Quarterly	-	3.8	-	-	-				
	Trust Turnover (%)	17/18	Quarterly	-	21.36	-	22.70	Available in July				
	Staff PDR completeness - clinical (%)	18	Monthly	80	65.6	-	66.0	66.5				
	Staff PDR completeness - non clinical (%)	18	Monthly	80	54	-	59.7	58.9				
	Information Governance Training (%)	18	Monthly	95	96.6	-	96.3	96.2				

* Rolling 12 month position

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

*** Excludes readmissions to CICU from HDU

****Further Validation currently being undertaken

For Key, see Glossary

Key Performance Indicator Report

Great Ormond Street Hospital for Children NHS Foundation Trust

Specialty Indicator Review

Objective	Indicator	YTD Target/Trajectory (12/13)	YTD Trust Total Performance (Including IPP & Trustwide Figures)	Cardiac	ICI	Neurosciences	Medicine	Diagnostic and Theraputic Services (DTS)	Surgery
Objective 1	Incidence of C.difficile	9	1	0	0	0	0	0	0
	Incidence of MRSA**	0	0	0	0	0	0	0	0
	Incidence of MSSA	19	5	0	1	0	1		1
	Incidence of E-Coli	20	2	0	0	0	0	0	0
	No. of NICE recommendations unreviewed	0	0	0	0	0	0	0	0
	CV Line related blood-stream infections	1.5	2.8	-	-	-	-	-	-
	Mortality Figures	Within tolerance	14						
	Serious Patient Safety Incidents	Within tolerance	6	2	0	0	0	0	1
	Surgical Check List completion rate (%)	95.0	97.6	97.9	96.1	98.1	98.1	97.2	98.1
Objective 2	18 week referral to treatment time performance - Admitted (%)	90	90.5	100	100	100	87.5	-	84.21
	18 week referral to treatment time performance - Non-Admitted (%)	95	97.4	100	96.91	97.35	95.2	100	99.42
	18 week referral to treatment time performance - Incomplete Pathways (%)	92	91.90	97.2	98.11	98.00	95.29	94.12	85.17
	Inpatients waiting list profile (26+)	0	244	2	0	2	1	1	238
	95th Centile - Admitted	<23 weeks	26.2	15.62	12.85	10.70	34.60	-	28.60
	95th Centile - Non-Admitted	<18.3 weeks	17.6	14.03	17.87	16.86	17.97	9.9	17.25
	Median Waits - Admitted	<11.1 weeks	10.8	8.50	12.00	1.50	6.75	-	13.38
	Median Waits - Non-Admitted	<6.6 weeks	7.7	4.9	7.0	8.6	9.4	9.5	7.2
	95th Centile - Incomplete Pathways	<28 weeks	23.3	14.99	14.05	14.63	16.94	20.15	33.95
	Median Waits - Incomplete Pathways	<7.2 weeks	6.0	4.96	4.47	4.94	6.78	10.50	7.75
	Discharge summary completion (%)	95	79.50	72.66	69.90	87.34	78.10	-	86.66
	DNA rate (new & f/up) (%)	10	8.3						
	Cancelled Operations on day of admission (%)	0.80	0.45						
	Percentage of Cancer patients waiting no more than 31 days for second of subsequent treatment (Surgery, Drug treatments, Radiotherapy) & Maximum waiting time of one month from diagnosis to treatment for all cancers.	98	100	100	100	100	100	100	100
	Number of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests	<=1	35	0	0	1	30	0	4
	Number of complaints	-	21*	0	0	2	5		5
	Number of complaints by grade High	<14	1	0	0	0	0	0	0
	Theatre Utilisation (% Patient Operation Utilisation of Scheduled Duration, U4)	70	68.6	69.6	52.3	77.1	46.5	64.2	70.0
	Clinic Letter Turnaround (% within 5 days)	New indicator to be confirmed	23.8	-	-	-	-	-	-
Objective 3	Patient refusals	<218	32	2	1	0	1		28**
	Clinical Income variance (£)	-	-508,477	128,480	193,574	317,367	-311,681	-12,172	-824,045
			Gosh & ICH Total						
Objective 4	Clinical trials (CTIMPs)	-	38	0	17	6	7	0	2
	GOSH research projects	-	156	4	11	5	6	2	7
	Commercially-funded projects (% achieving a 70 day turnaround)	-	100	-	100	-	-	-	-
	UKCRN Portfolio projects	-	118	5	51	14	29	5	14
	GOSH research income	-	TBC	-	-	-	-	-	-
	Patient safety SAE's (Serious Adverse Event)	-	6	0	0	1	2	0	0
	Biomedical Research Centre (BRC) (£)	-	-	0	0	0	0	0	0
Objective 5	MADEL SLA Value (£)	-	Data Not Available	-	-	-	-	-	-
	SIFT SLA Value (£)	-	Data Not Available	-	-	-	-	-	-
	NMET SLA Value (£)	-	Data Not Available	-	-	-	-	-	-
Objective 6	CRES Forecast Savings 2011/12 (£)	TBC	14,544,022	1,796,919	1,998,985	1,509,841	2,121,371		2,884,607
	Bank and agency total expenditure (£)	To Reduce	2,445,214	156,054	137,337	29,977	50,104	57,037	151,227

Objective 7	Sickness Rate (%)	<3.3	-	-	-	-	-	-	-	-
	Staff in Post (WTE excluding maternity leave)	-	3,341	-	-	-	-	-	-	-
	Vacancy Rate (%)	-	-							
	Trust Turnover (%)	-	-	-	-	-	-	-	-	-
	Staff PDR completeness - Clinical & Non-Clinical (%)	80	66.5	49.9	60.3	53.8	66.5	69.0	62.5	
	Information Governance Training (%)	95	96.2	95.3	95.1	97.8	94.3	97.7	94.0	

*Omission of complaints relating to IPP & Trustwide
**Of which 28 were CAT's
***April Figures

Key Performance Indicator Report

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 High	No RAG status - Plan not confirmed		
	Percentage of Cancelled Operations	Equal to or less than 0.8%	-	Greater than 0.8%
	Percentage of Cancer patients waiting no more than 31 days for second of subsequent treatment (Surgery, Drug Treatements, Radiotherapy) & Maximum waiting time of one month from diagnosis to treatment for all cancers.	Equal to 100%	Greater than or equal to 95%	Less than 94%
	Inpatients waiting list profile (26+)	0 Breaches	Between 0 and 10	Greater than 10
	Clinic Letter Turnaround (%)	No RAG status - Plan not confirmed		
Objective 3	Patient refusals	Indicator		
	Clinical Income variance	Indicator		

Objective 4	Clinical trials (CTIMPs)	No RAG status - Plan not confirmed		
	GOSH research projects	No RAG status - Plan not confirmed		
	Commercially-funded projects (%)	No RAG status - Plan not confirmed		
	UKCRN Portfolio projects	No RAG status - Plan not confirmed		
	GOSH research income	No RAG status - Plan not confirmed		
	Patient safety SUIs	No RAG status - Plan not confirmed		
	BRC	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 95%	-	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	Month 1	Month 2	Q1
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0	0	
2	Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)	0	1	Quarterly	0	0	
3	All cancers: 31-day wait for second or subsequent treatment comprising either:	TBC	1	Quarterly	0	0	
	Surgery	94%			0	0	
	Anti cancer drug treatments	98%			0	0	
	Radiotherapy (from 1 Jan 2011)	94%			0	0	
	Cancer diagnostic to Treatment	85%			0	0	
4	Admitted within 18 weeks	90%	1	Quarterly	0	0**	
5	Non Admitted within 18 weeks	95%	1	Quarterly	0	0**	
6	92% - 18 week referral to treatment time Incomplete Pathways Performance	92%		Quarterly	1	0	
7	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0	0	
8	Certification against compliance with requirements regarding access to healthcare for peopl e with a learning disability	N/A	0.5	Quarterly	0	0	
Total					1	0	
Overall governance risk rating					Amber-green	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

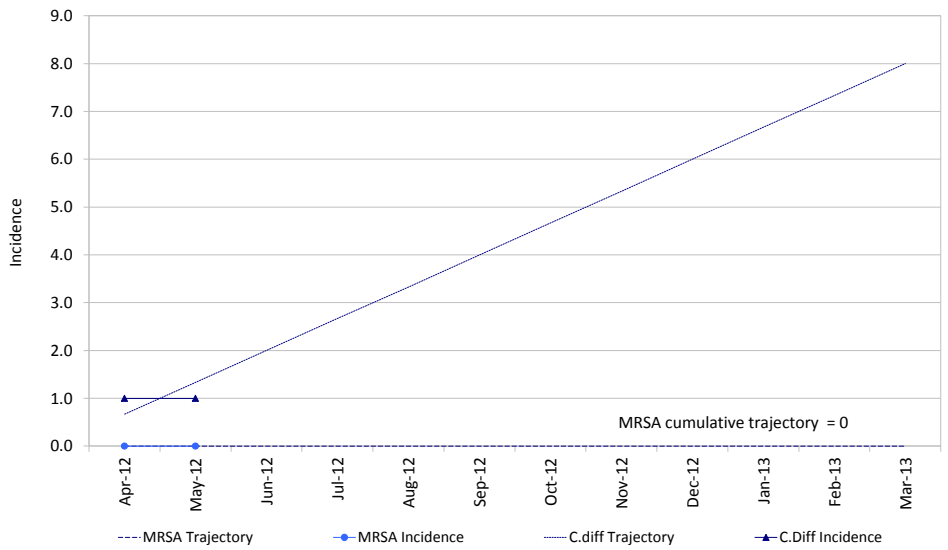
**To be confirmed but on trajectory to achieve

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

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

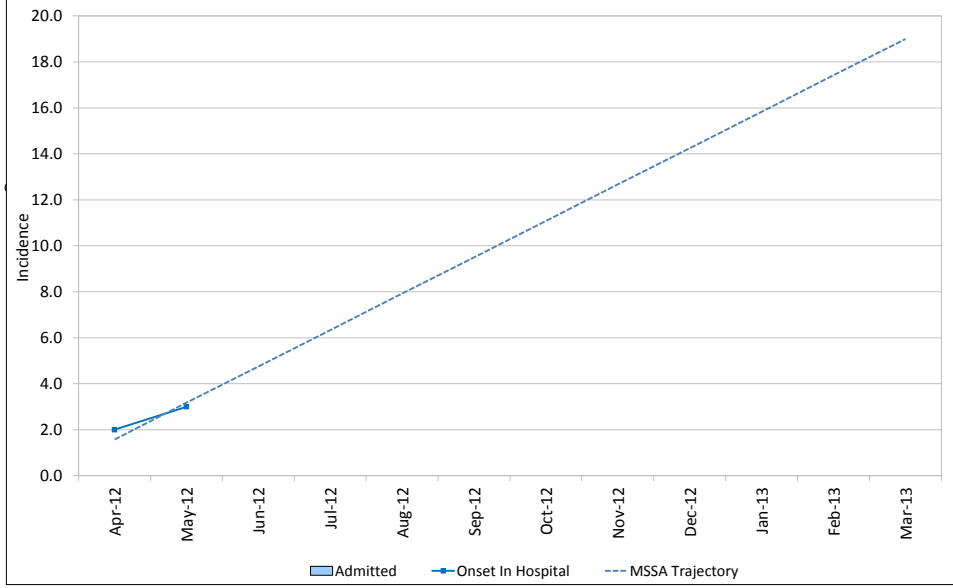
Graph 1. Incidence of MRSA and Cdifficile (cumulative totals)

National Target



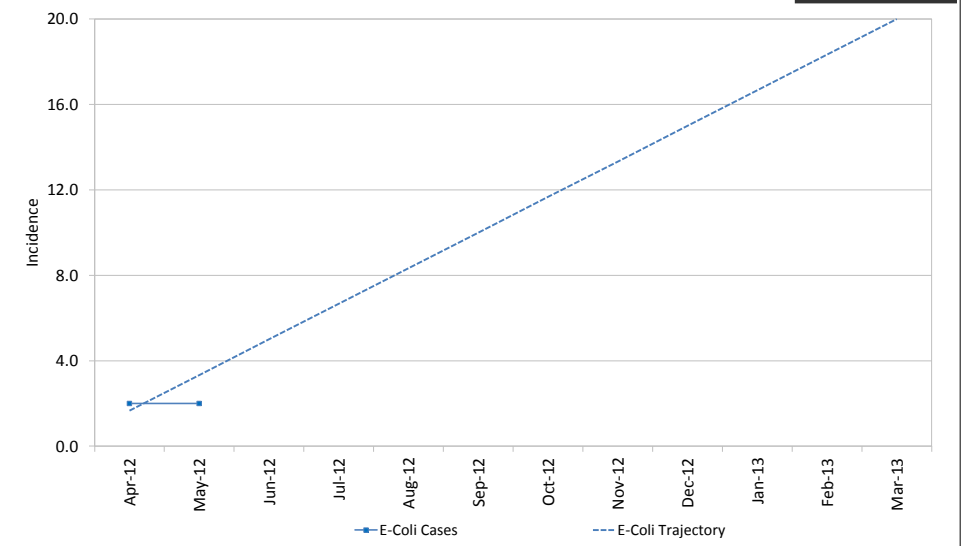
Graph 2. Incidence of MSSA

Internal Indicator



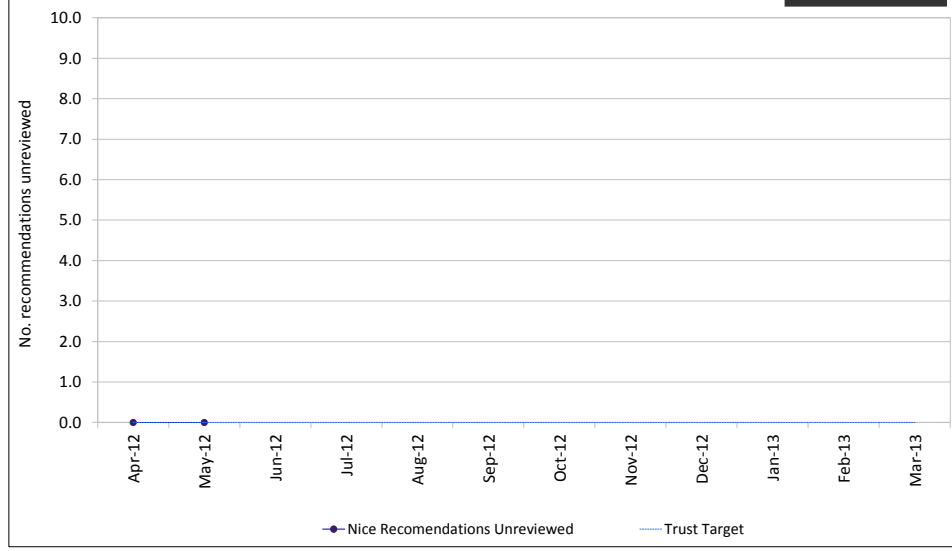
Graph 3. Incidence of E-Coli

Internal Indicator



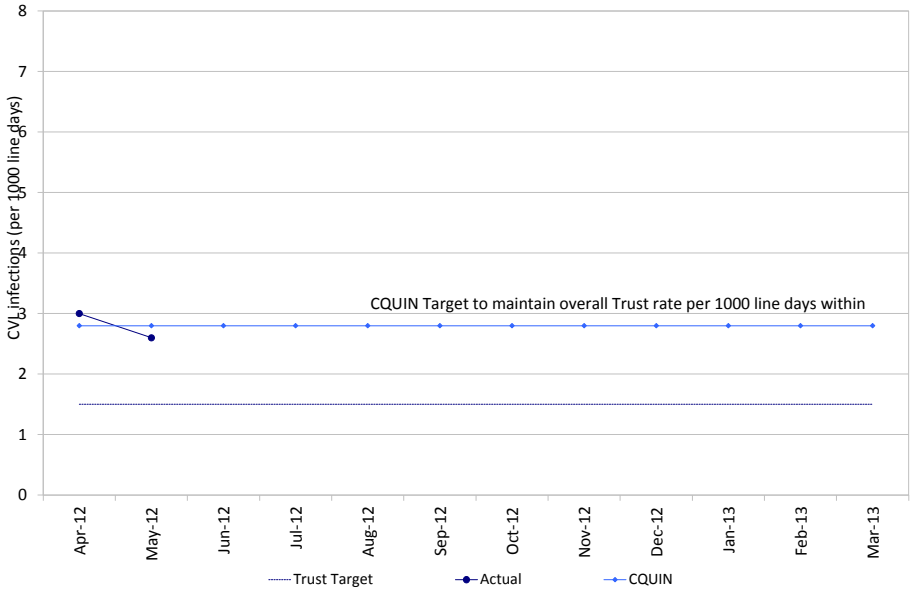
Graph 4. No. of NICE recommendations unreviewed

Internal Indicator



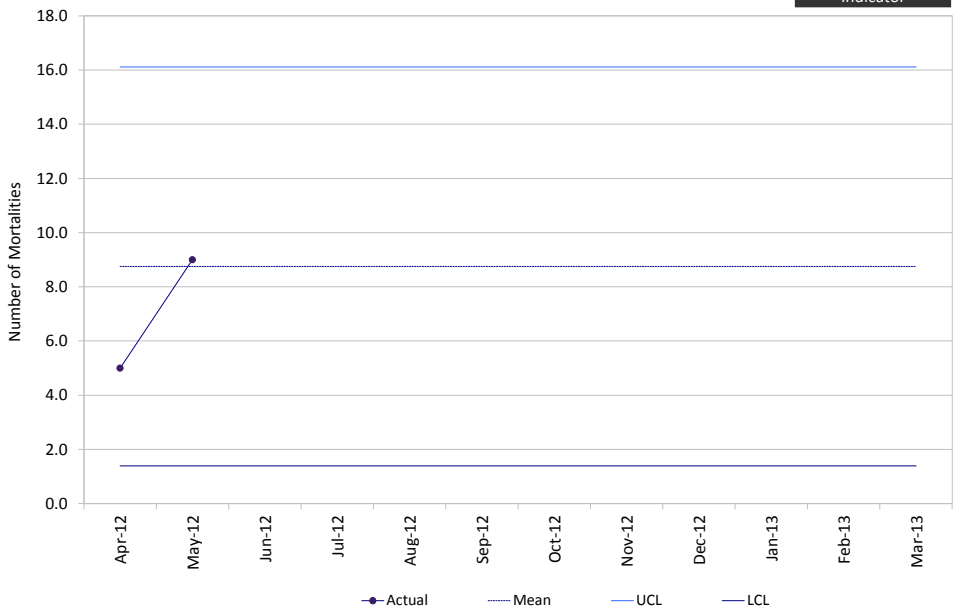
Graph 5. CV Line Infections (per 1000 bed days) - All areas

CQUIN Measure



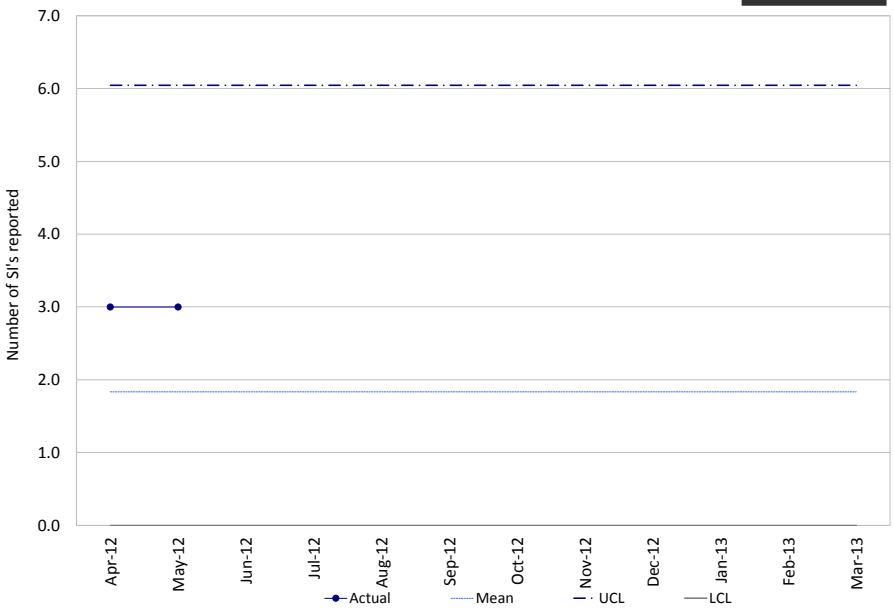
Graph 6. Mortality Figures - where discharge reason is 'Died'.

Internal Indicator



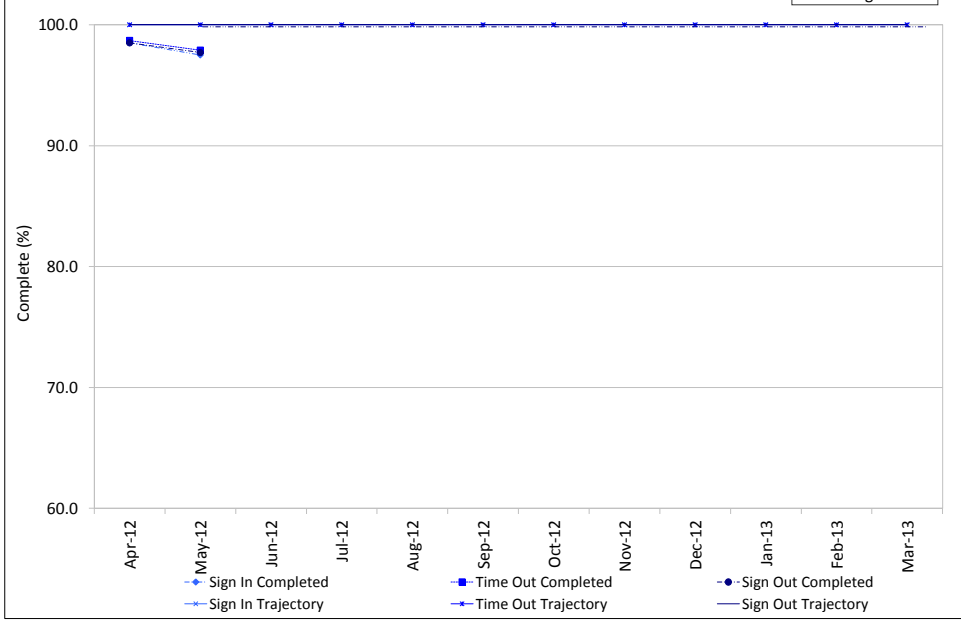
Graph 7. Serious Incidents Aug 2007 - May 2011

Internal Indicator

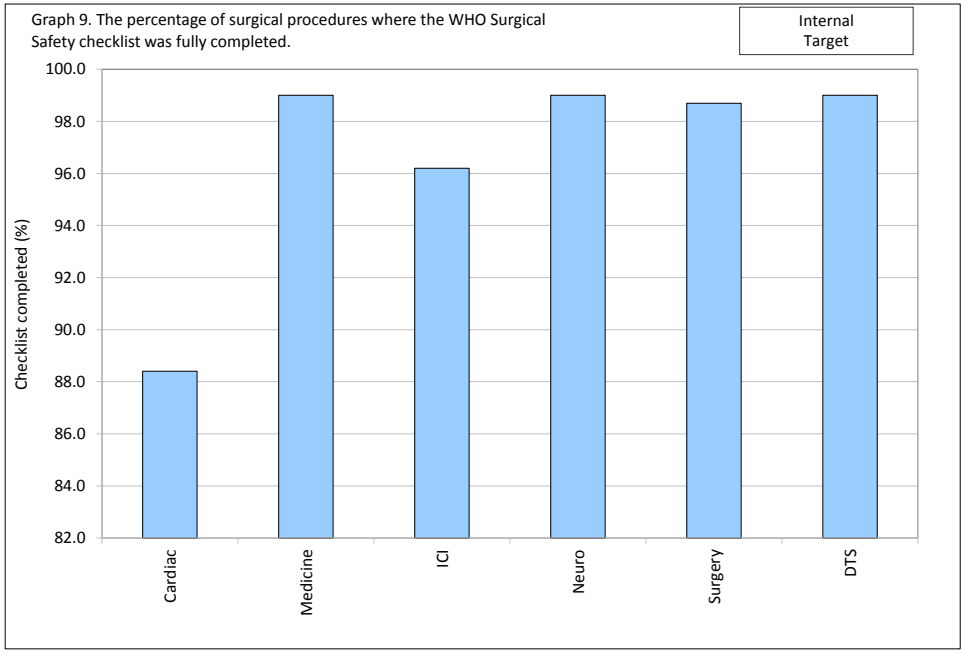


Graph 8. Theatre Patient Safety Checklist Completion rates against total operations

Internal Target



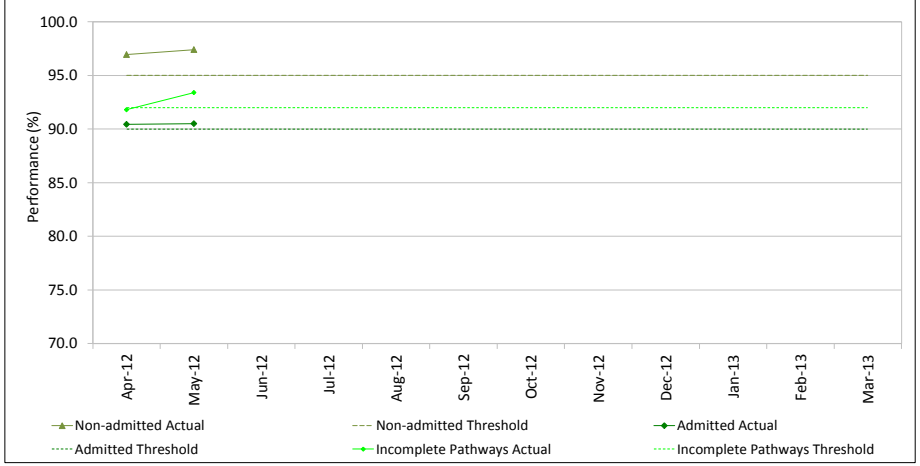
Graph 9. The percentage of surgical procedures where the WHO Surgical Safety checklist was fully completed.



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

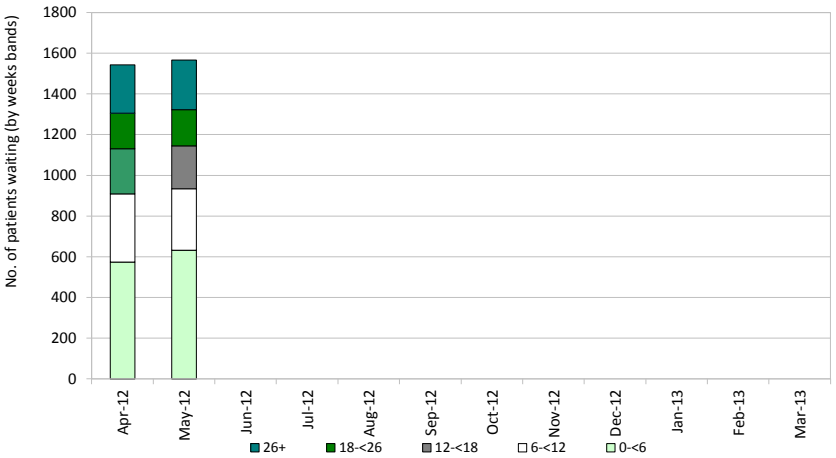
Graph 10. 18 week referral to treatment time performance

Contractual Target



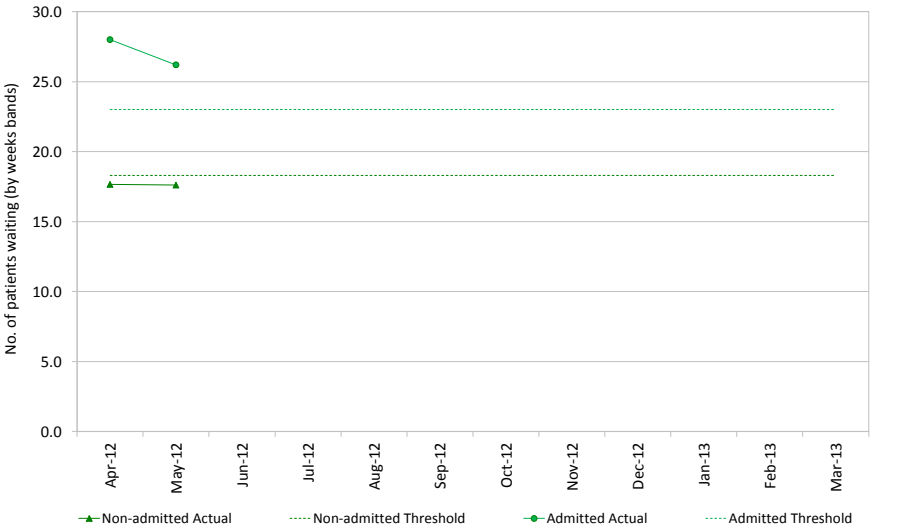
Graph 11. Inpatients waiting list profile by weeks waiting

Internal Indicator



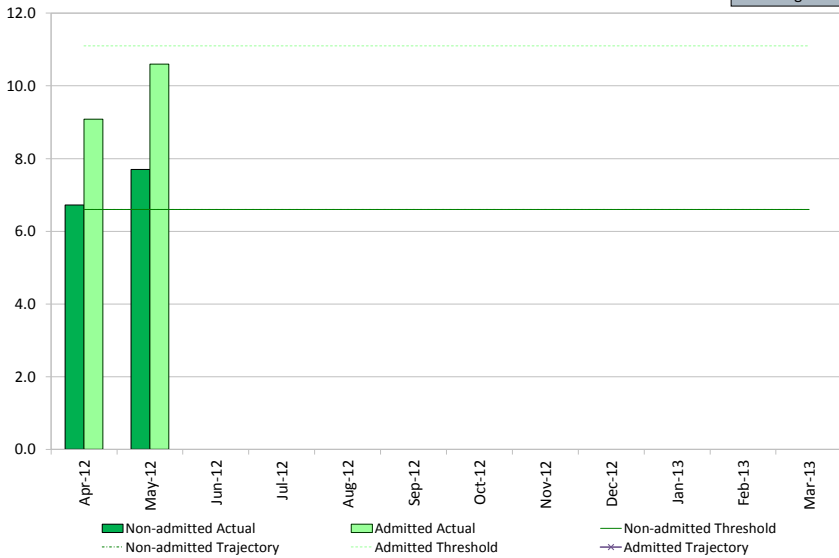
Graph 12. 95th Centile RTT performance against target (admitted and Non-admitted)

Contractual Target

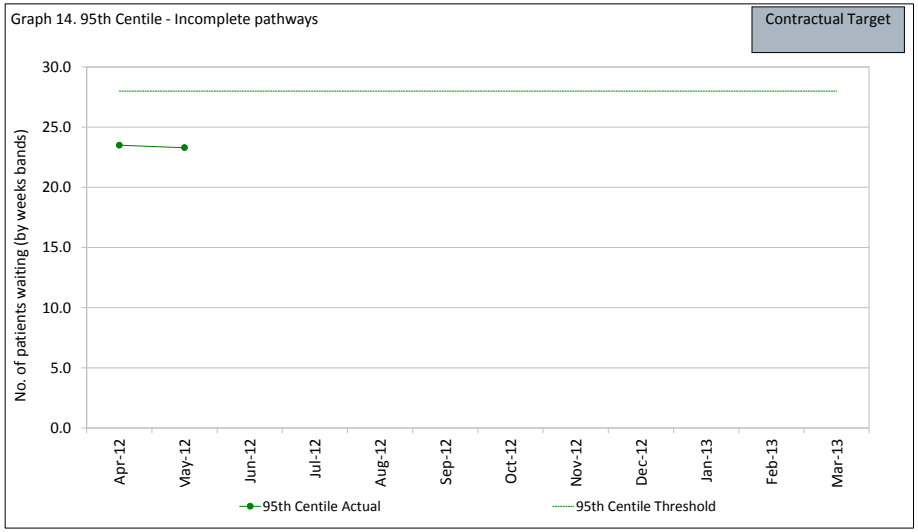


Graph 13. Median Wait RTT performance against target (Admitted and non-Admitted)

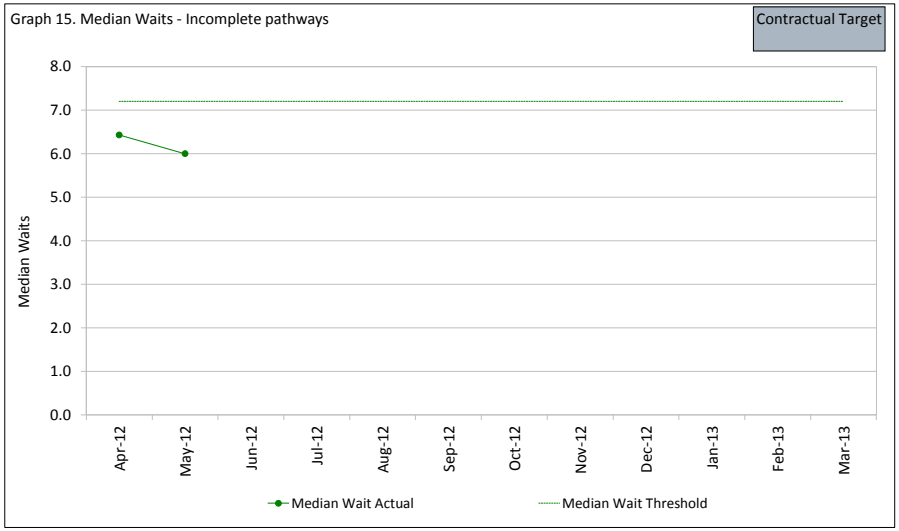
Contractual Target



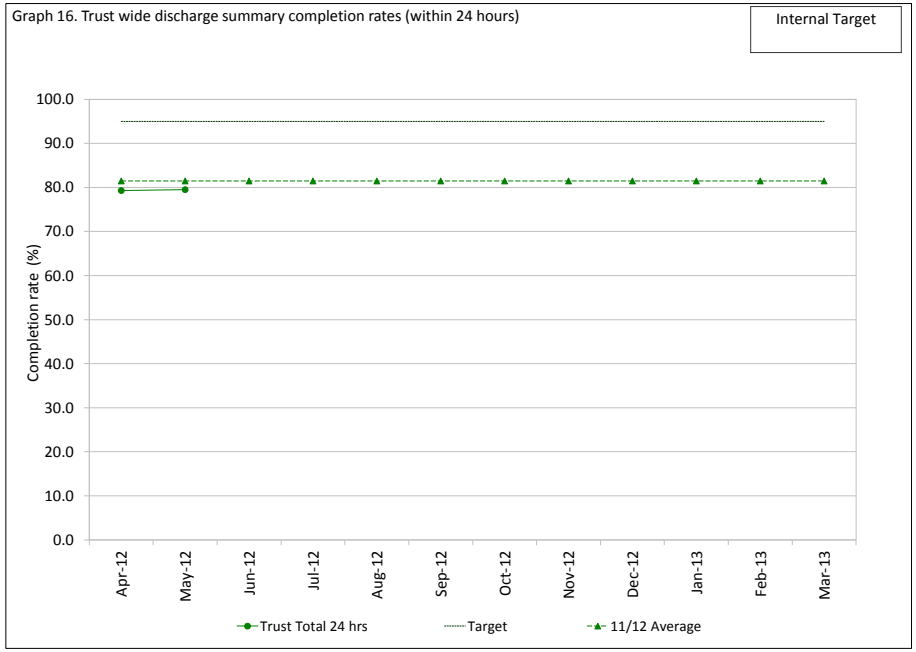
Graph 14. 95th Centile - Incomplete pathways



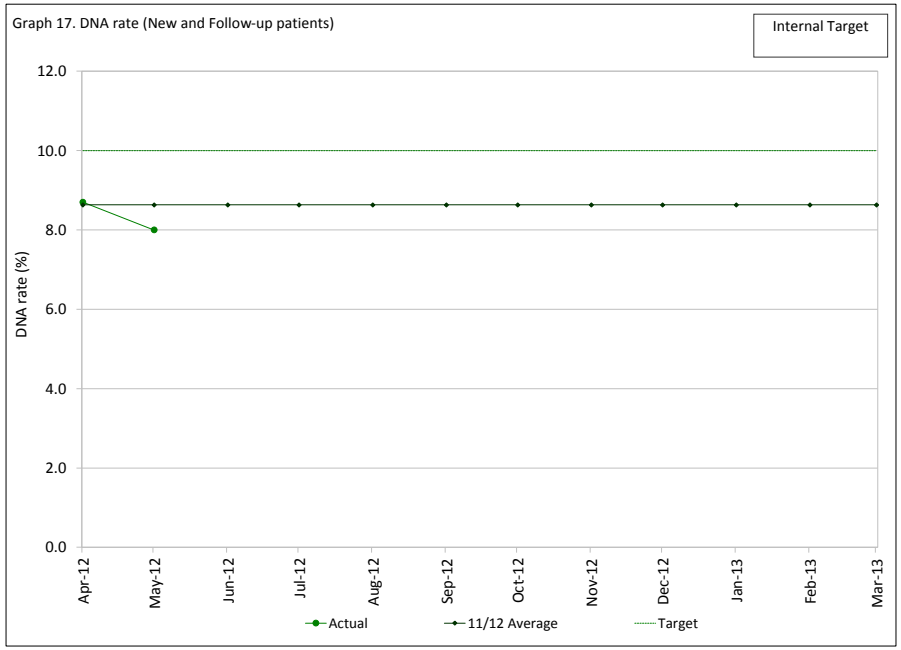
Graph 15. Median Waits - Incomplete pathways



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

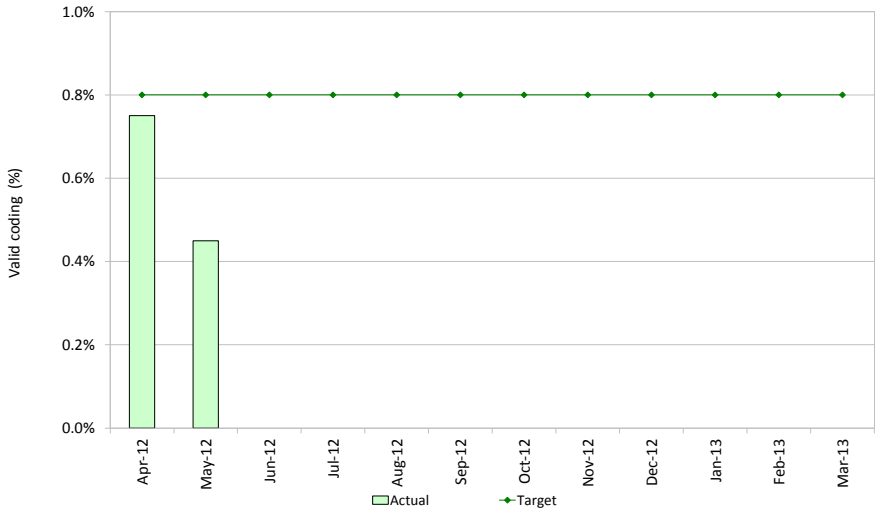


Graph 17. DNA rate (New and Follow-up patients)



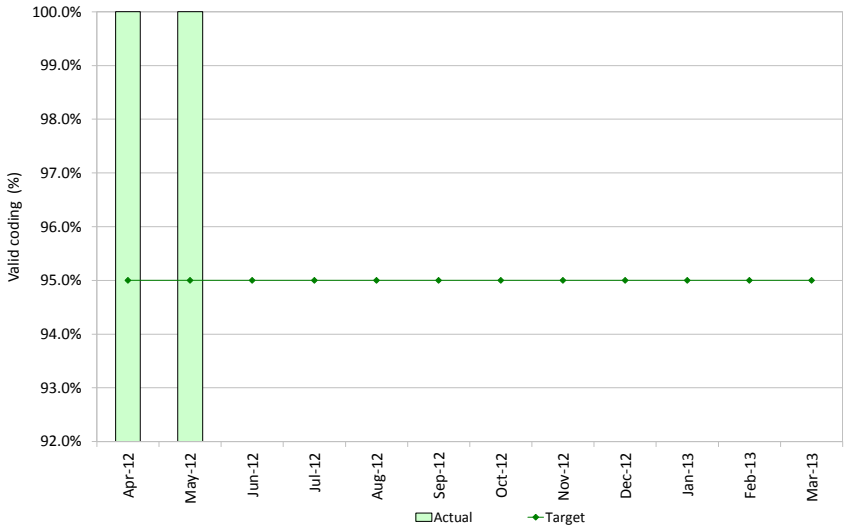
Graph 18. Percentage of all Cancelled Operations as a proportion of total elective spells

Contractual Target



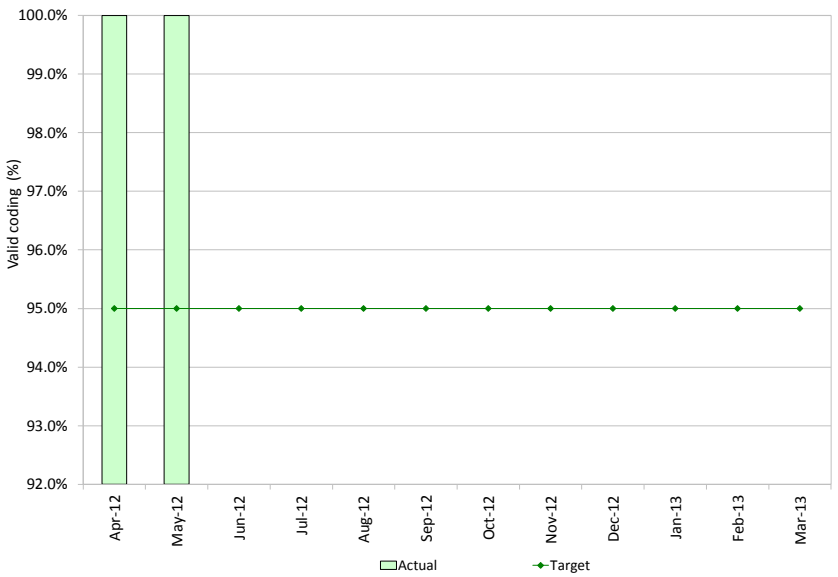
Graph 19. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - surgery

National Target



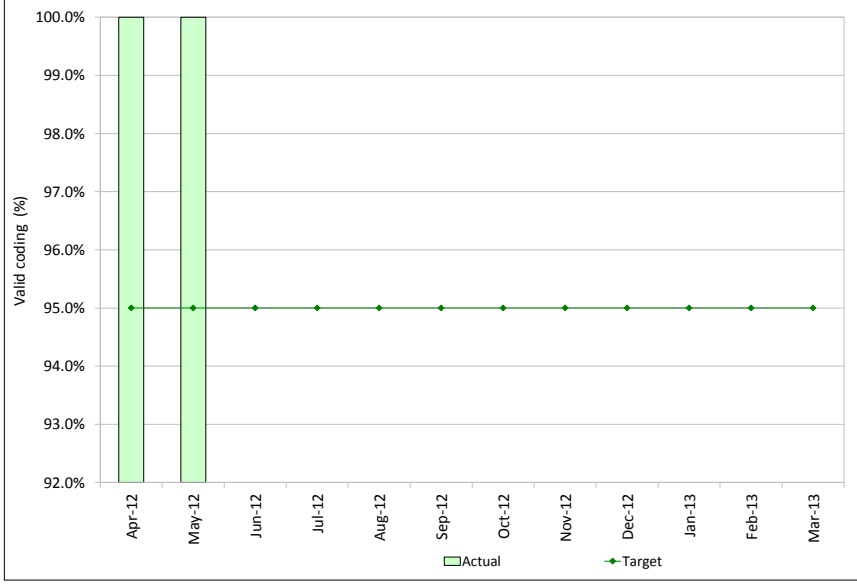
Graph 20. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - drug treatments

National Target



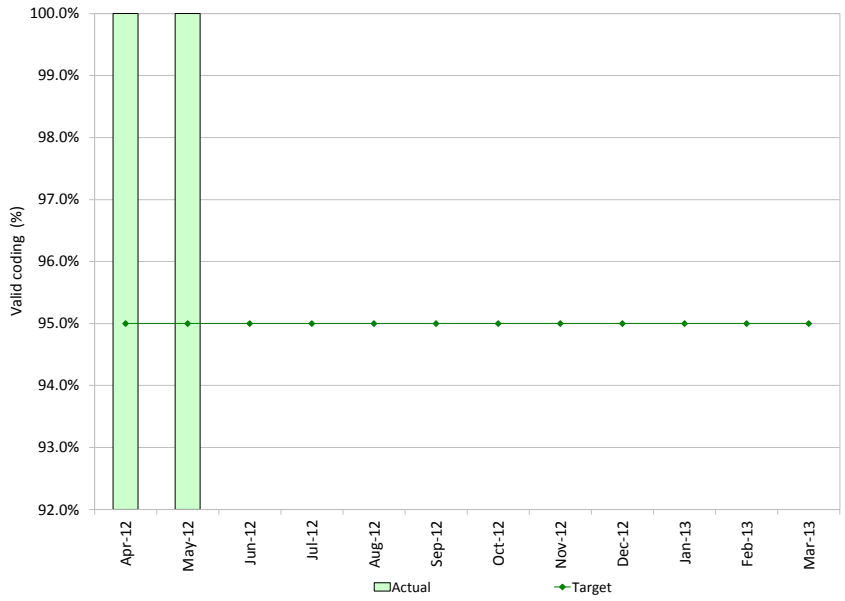
Graph 21. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - radiotherapy

National Target



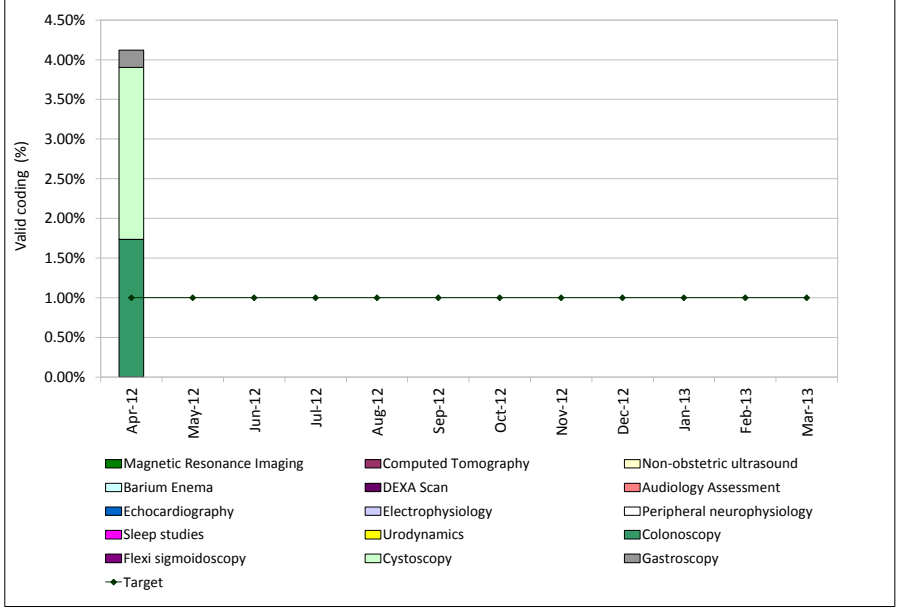
Graph 22. Proportion of Cancer patients waiting no more than 31 days from diagnosis to treatment - all cancers

National Target

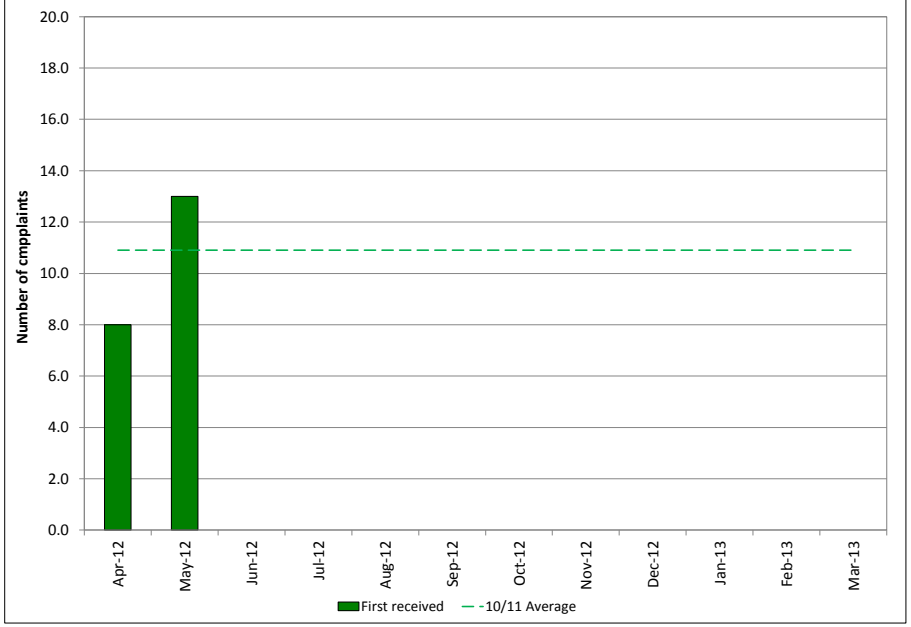


Graph 23. Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests

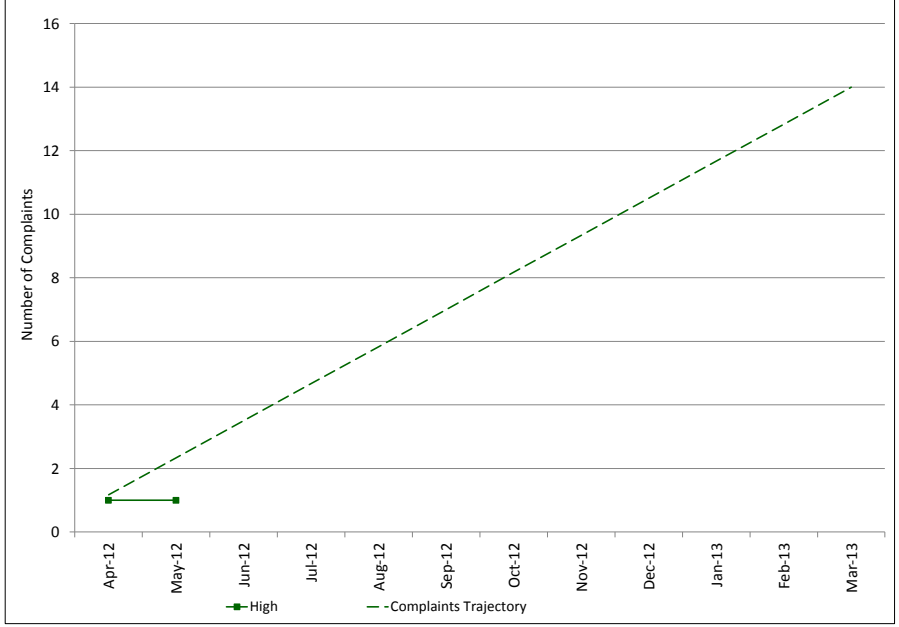
National Target



Graph 24. Complaints Received 2011/12

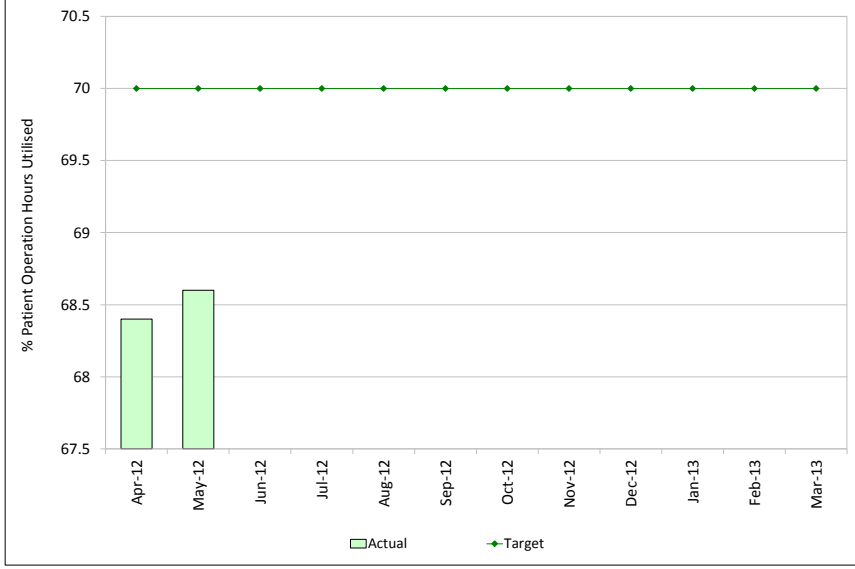


Graph 25. Complaints received by grade 2011/12



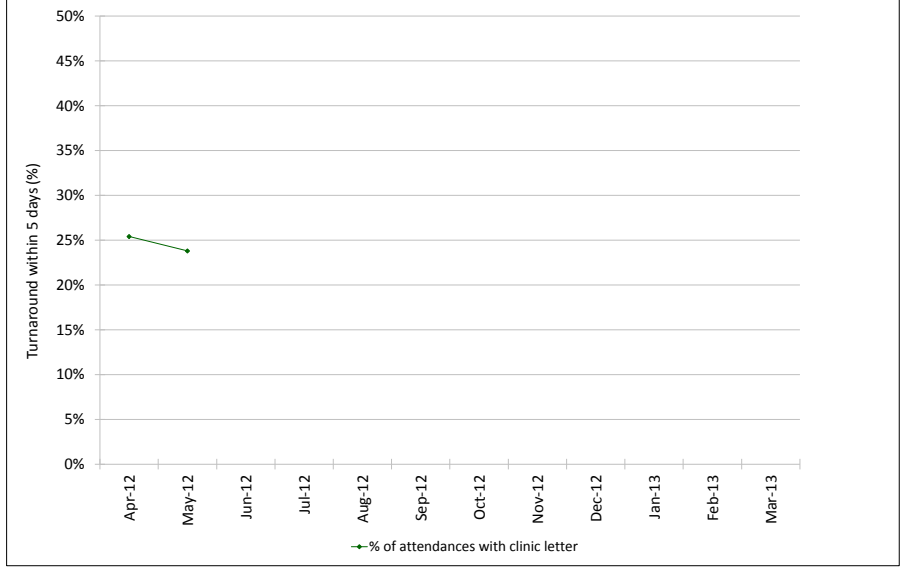
Graph 26. Theatre utilisation. Patient operation utilisation of scheduled duration (U4). All theatres, all services

Internal Target



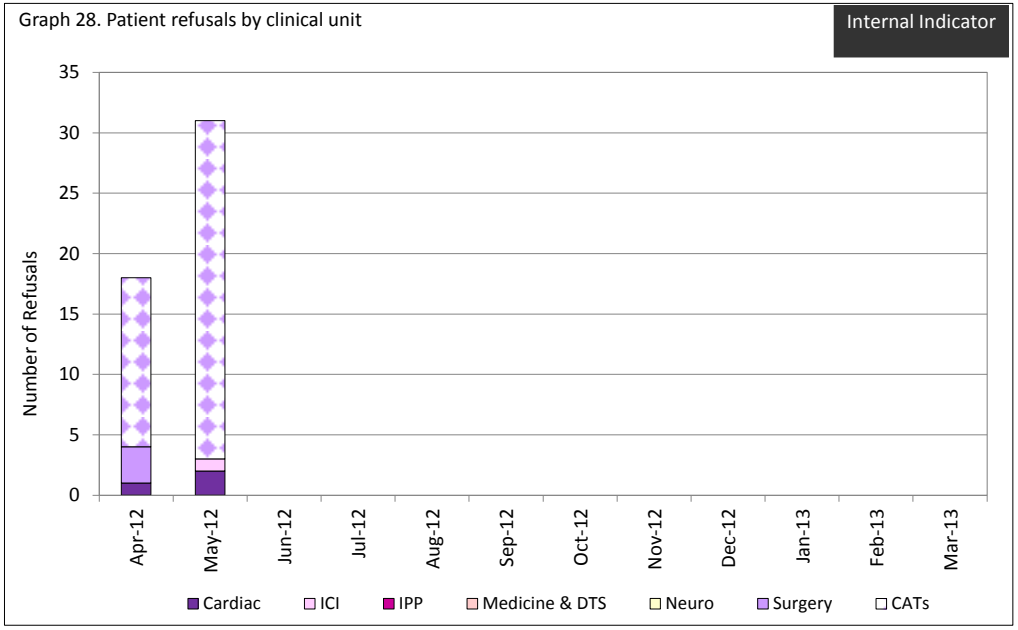
Graph 27. Clinic Letter Production & Turnaround Time

Internal Target

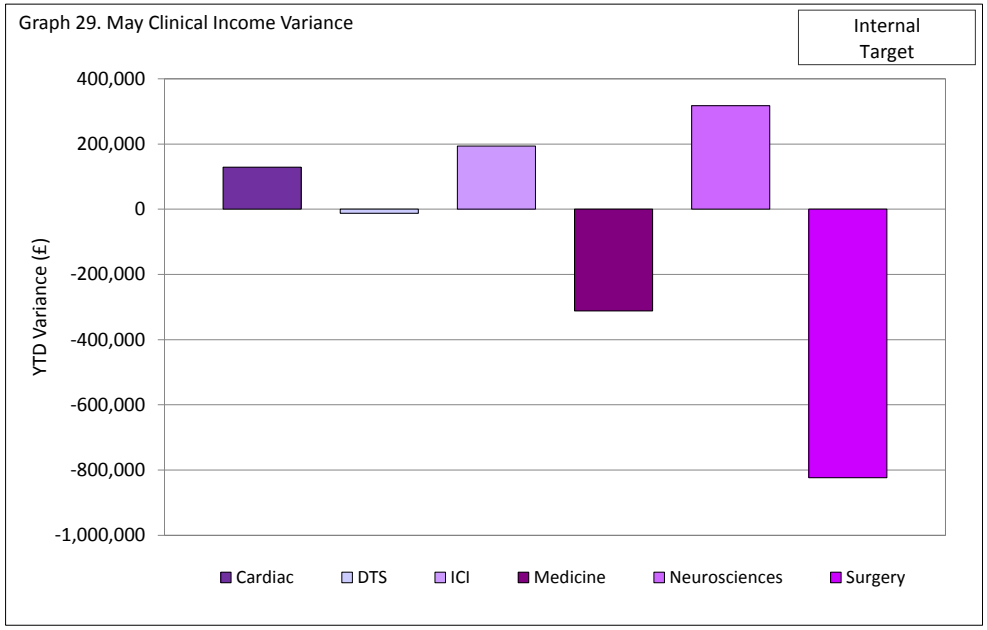


3. Successfully deliver our clinical growth strategy

Graph 28. Patient refusals by clinical unit

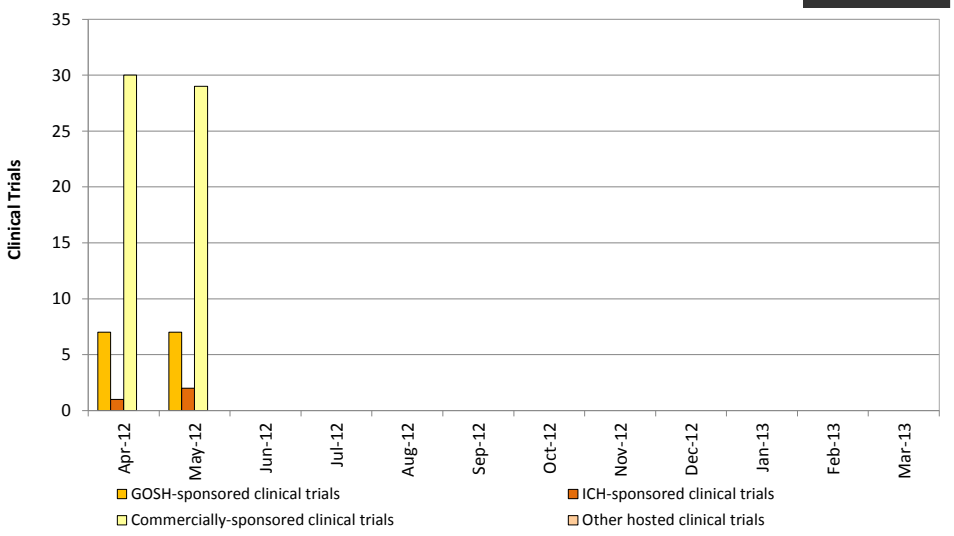


Graph 29. May Clinical Income Variance

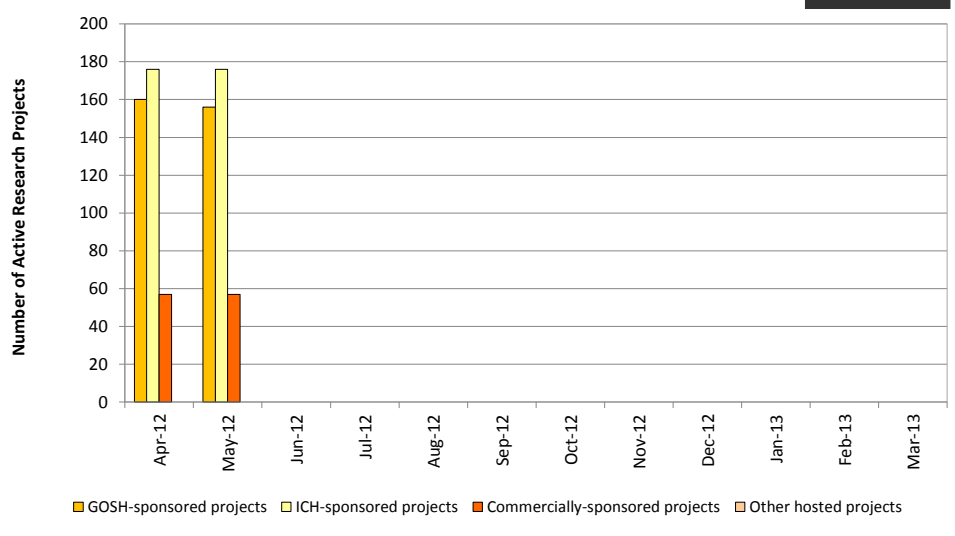


4. Currently partnered with ICH, and moving to UCL Partners with AHSC, maintain and develop our position as the UK's top children's research organisation

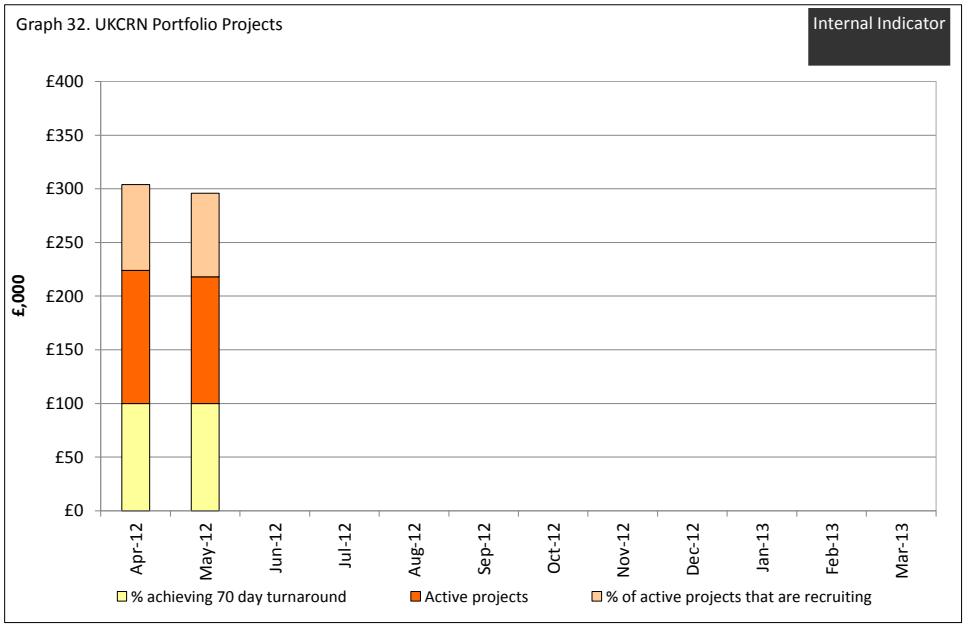
Graph 30. Clinical trials (CTIMPs) — Internal Indicator



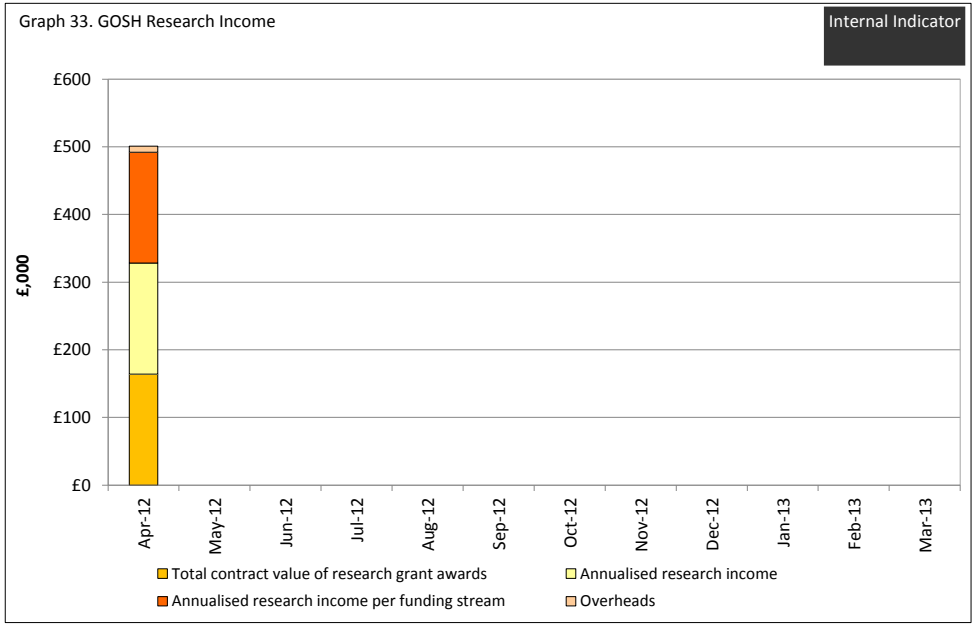
Graph 31. GOSH research projects — Internal Indicator



Graph 32. UKCRN Portfolio Projects — Internal Indicator

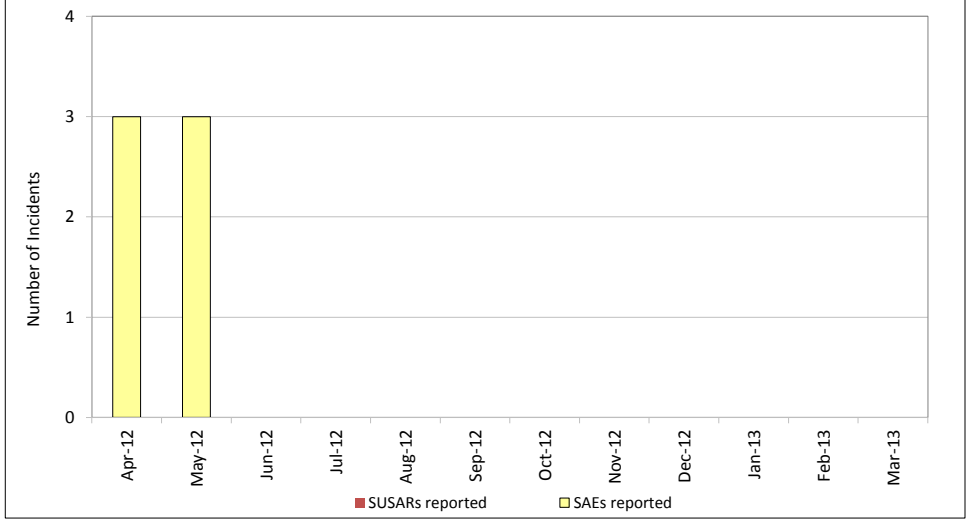


Graph 33. GOSH Research Income — Internal Indicator



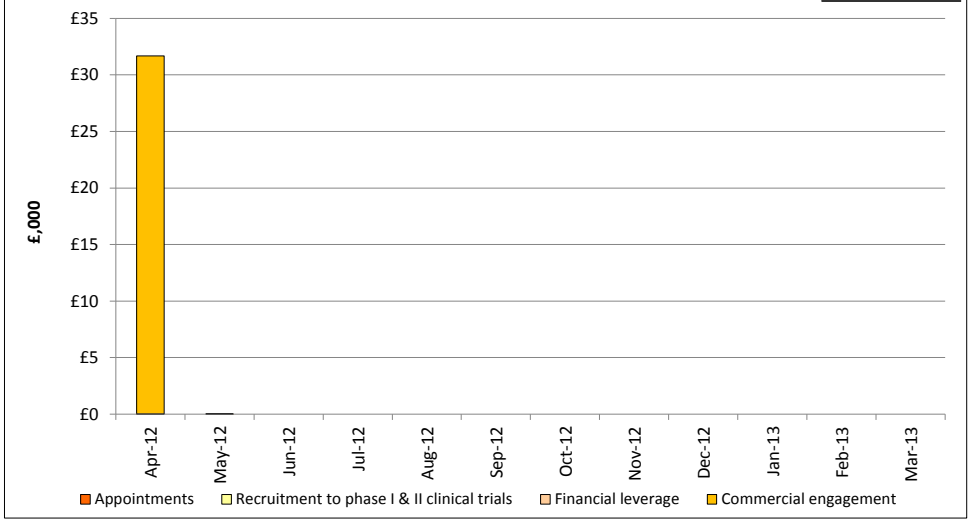
Graph 34. Patient Safety reports for GOSH sponsored clinical trials

Internal Indicator



Graph 35. Biomedical Research Council (BRC)

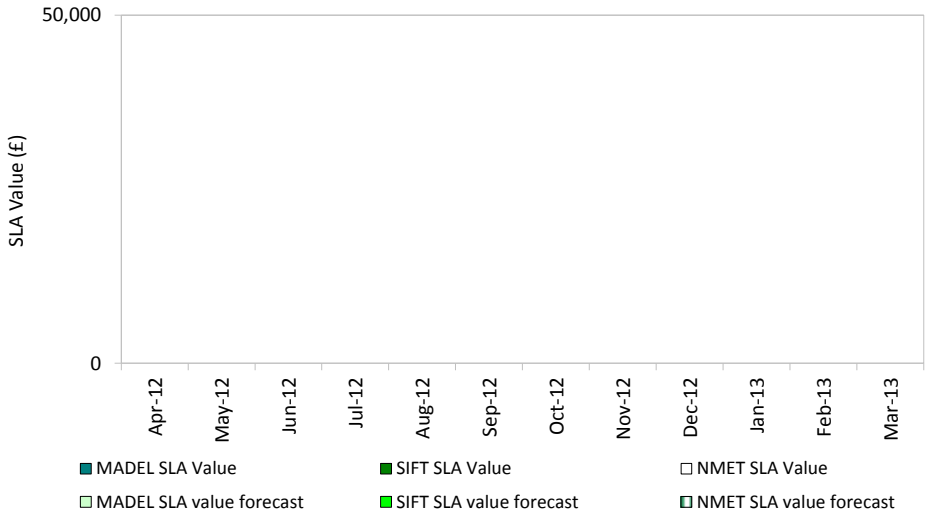
Internal Indicator



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

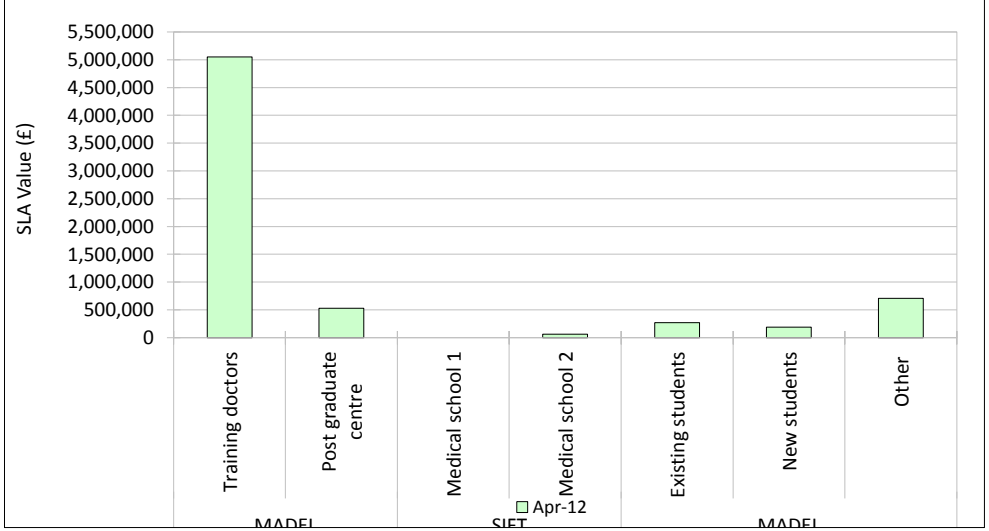
Graph 36. MPET SLA Total value summary

Internal Indicator



Graph 37. MPET Total SLA value detail

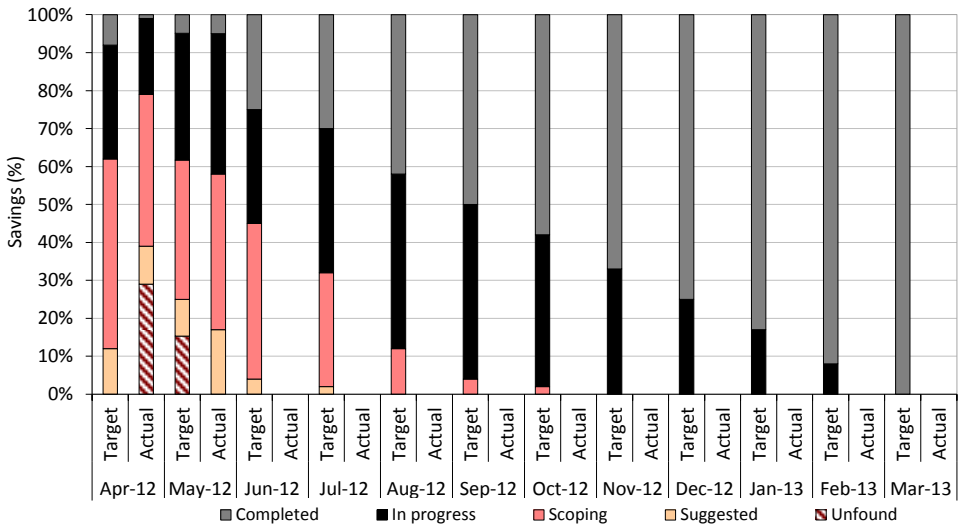
Internal Indicator



6. Deliver a financially stable organisation

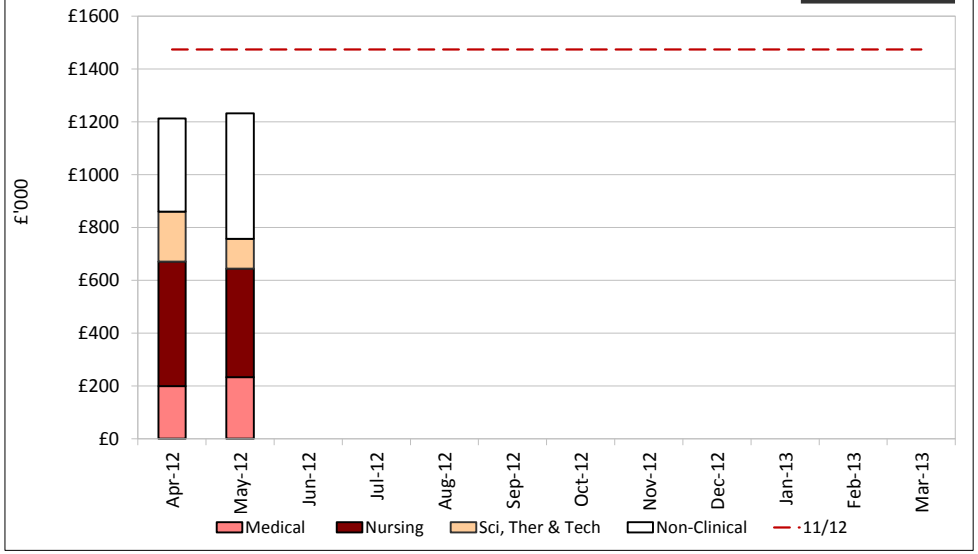
Graph 38. CRES programme, saving trajectory 2012/13

Internal Target



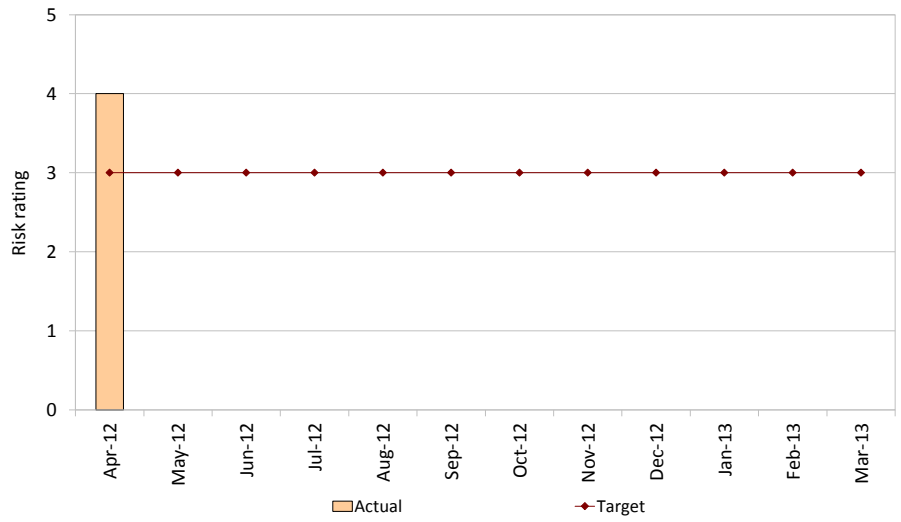
Graph 39. Bank & Agency Total Expenditure by Staff Group

Internal Indicator



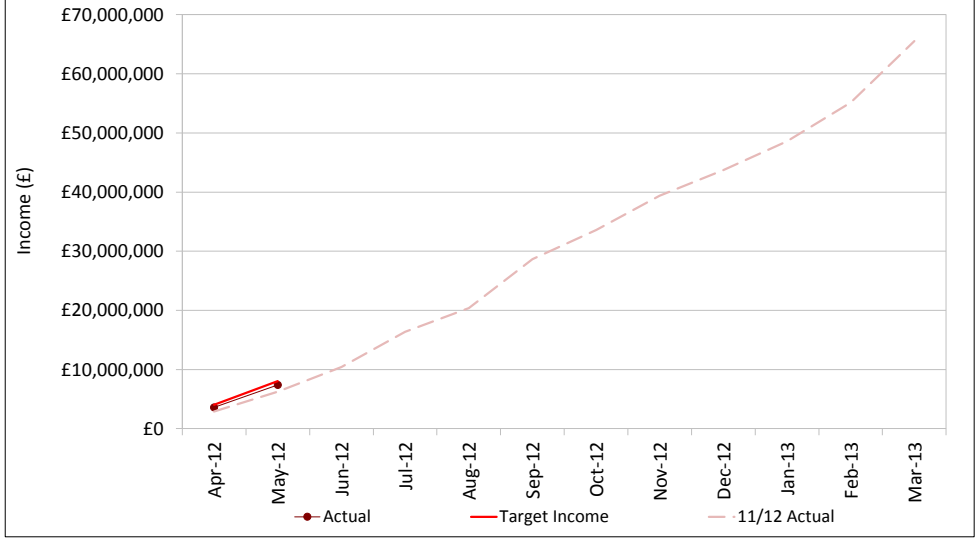
Graph 40. Monitor Risk Rating

National Target



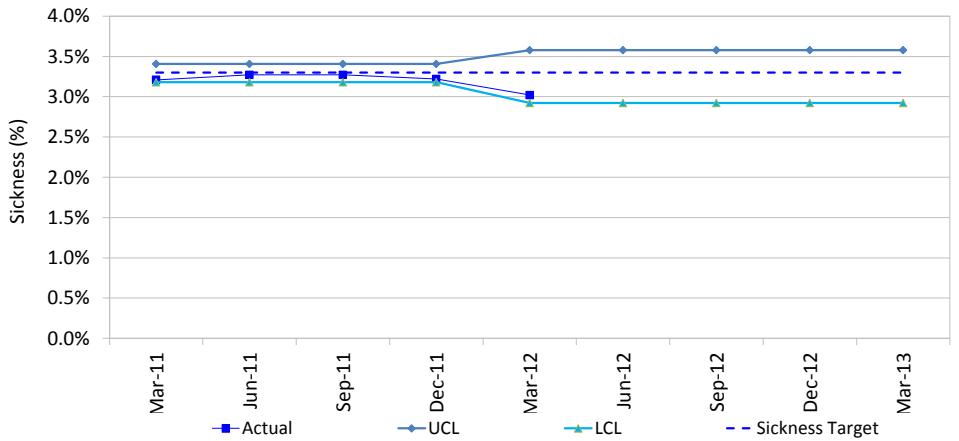
Graph 41. Charity Fundraising. YTD Income against YTD budget

Internal Target

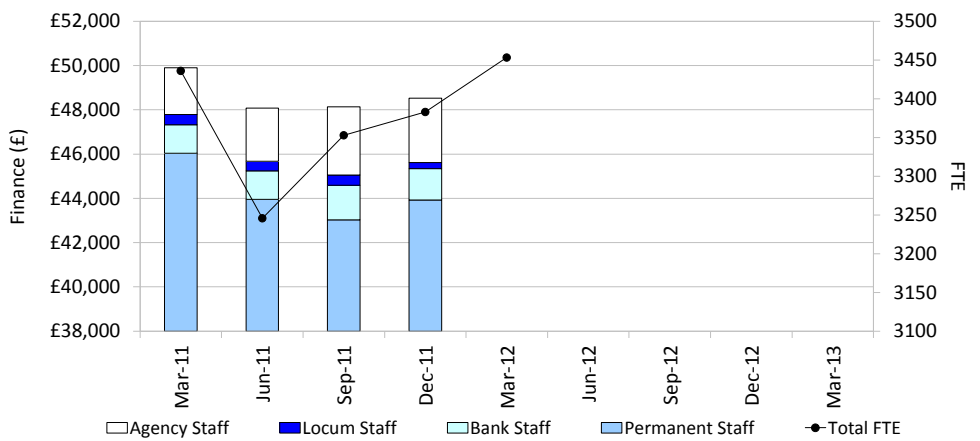


7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation

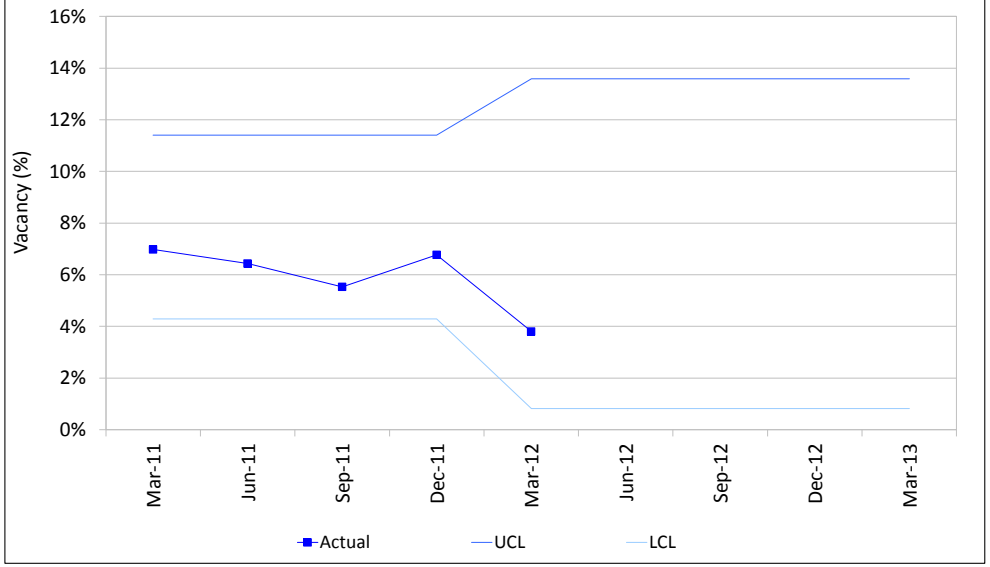
Graph 42. Sickness rate Trust-wide (%) — Internal Indicator



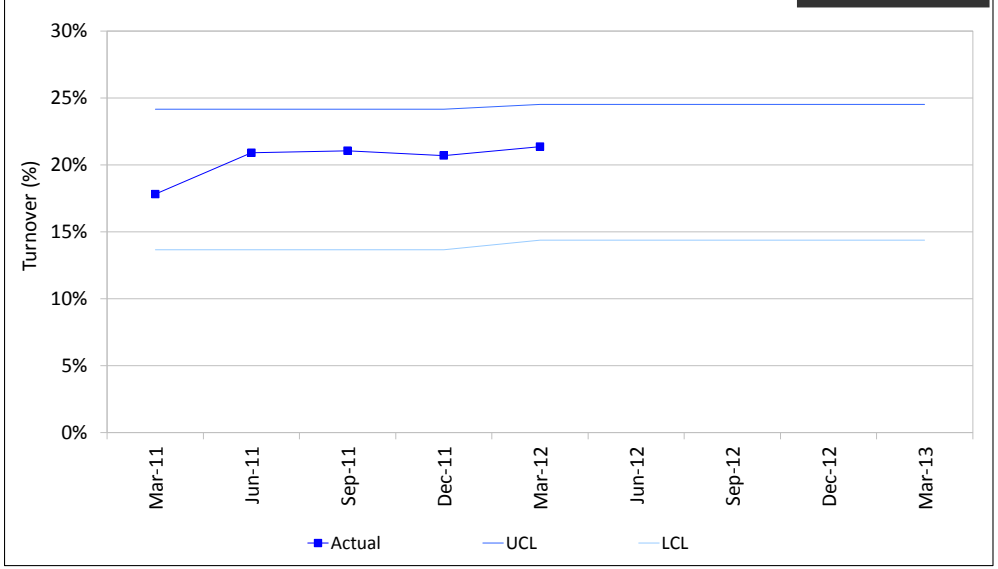
Graph 43. FTE and equivalent costs — Internal Indicator



Graph 44. Vacancy rate Trust-wide (%) — Internal Indicator

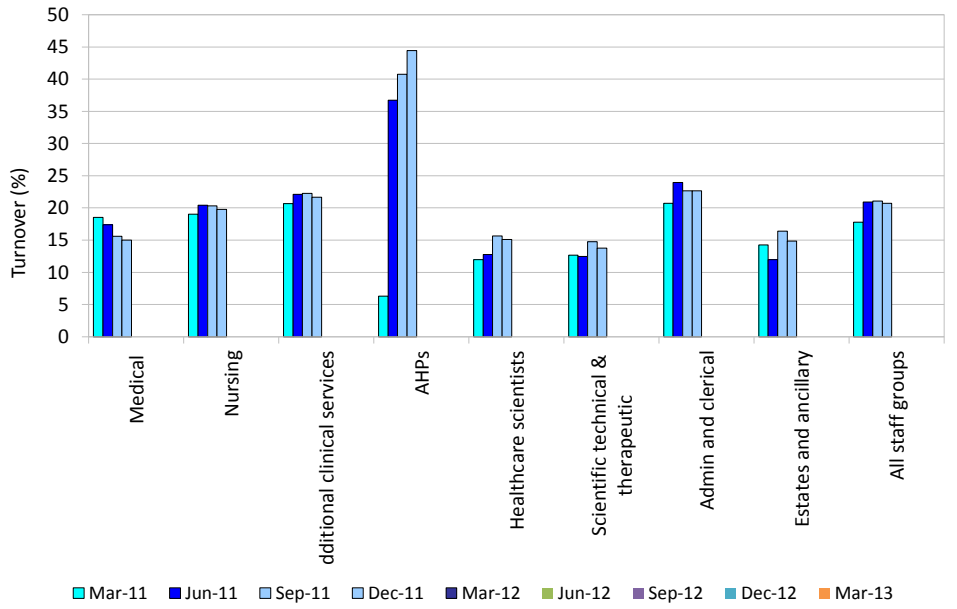


Graph 45. Turnover Trust-wide (%) — Internal Indicator



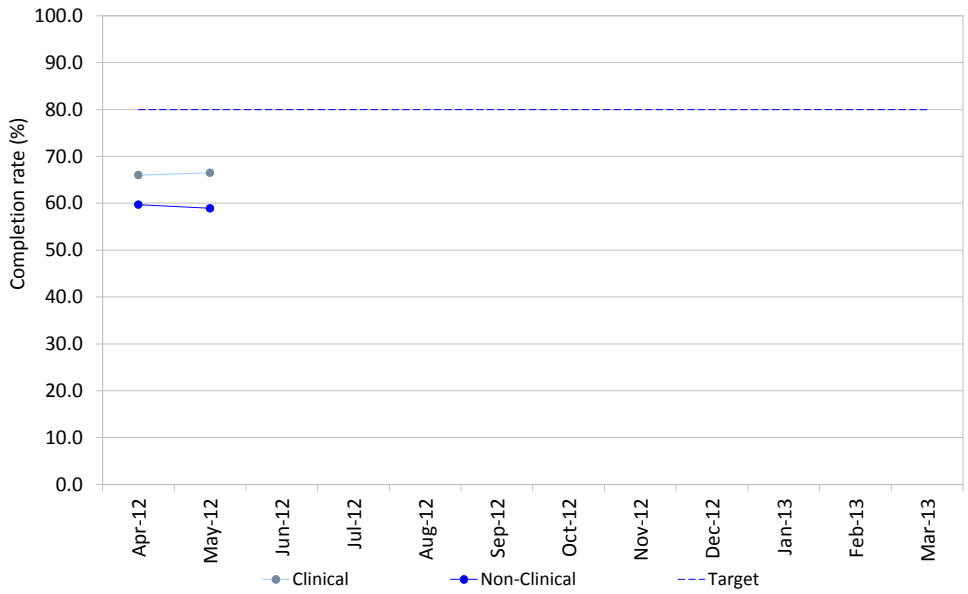
Graph 46. Turnover by staff group (%)

Internal Indicator



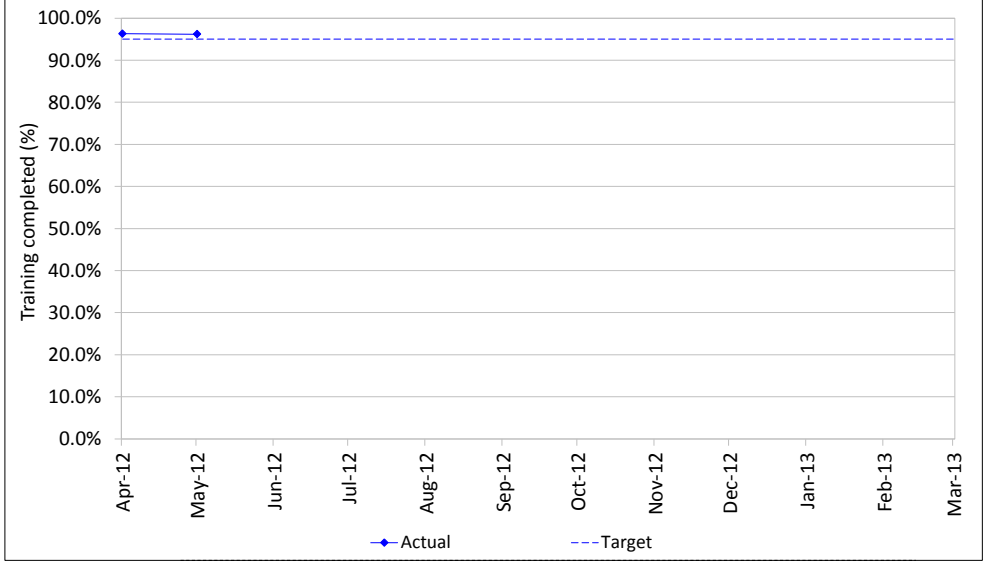
Graph 47. Percentage of staff who have a current PDR in the last 13 months and predicted next 2 months

Internal Target

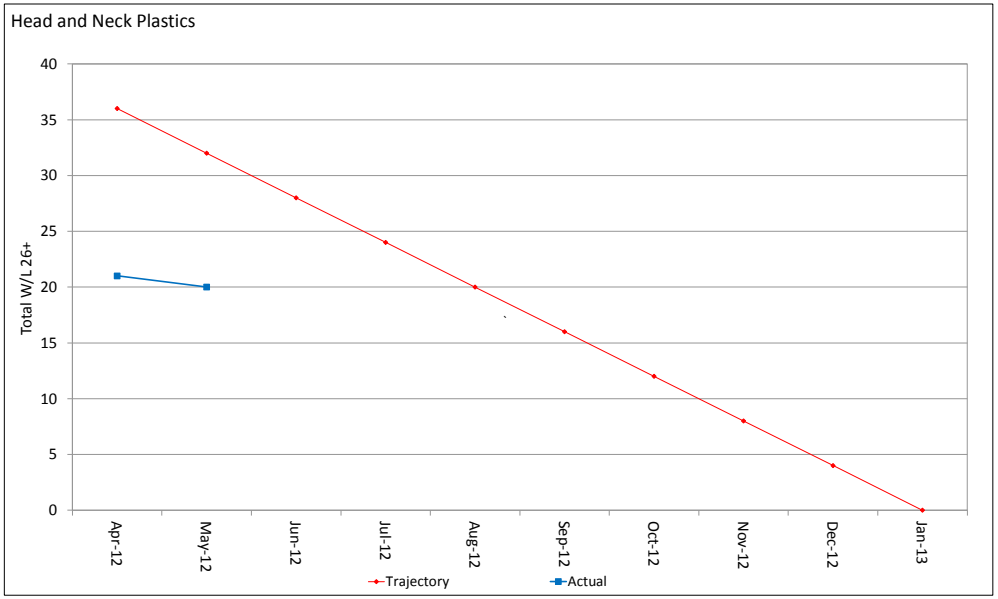


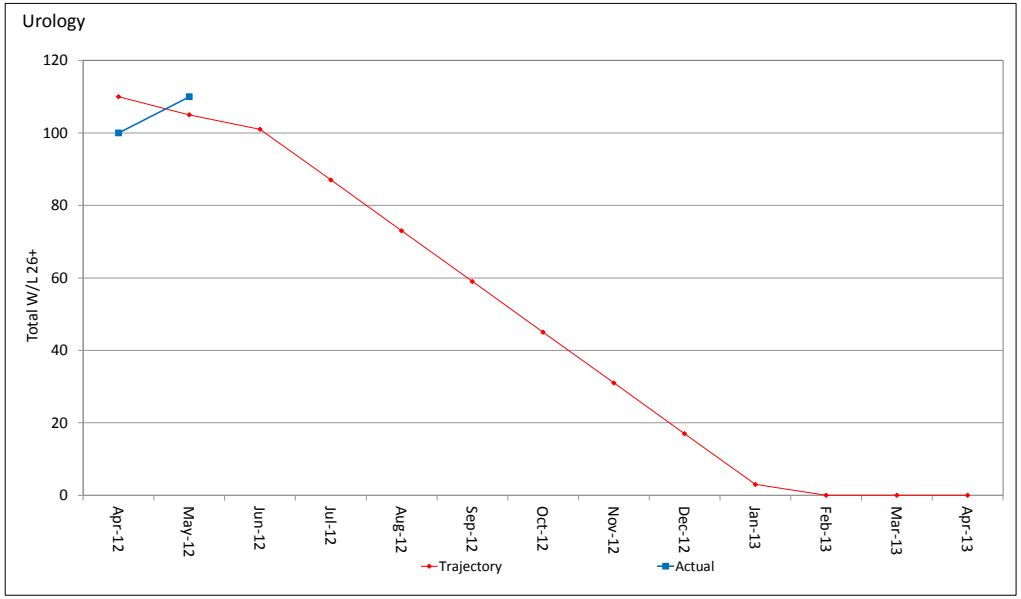
Graph 48. Staff trained on IG by week

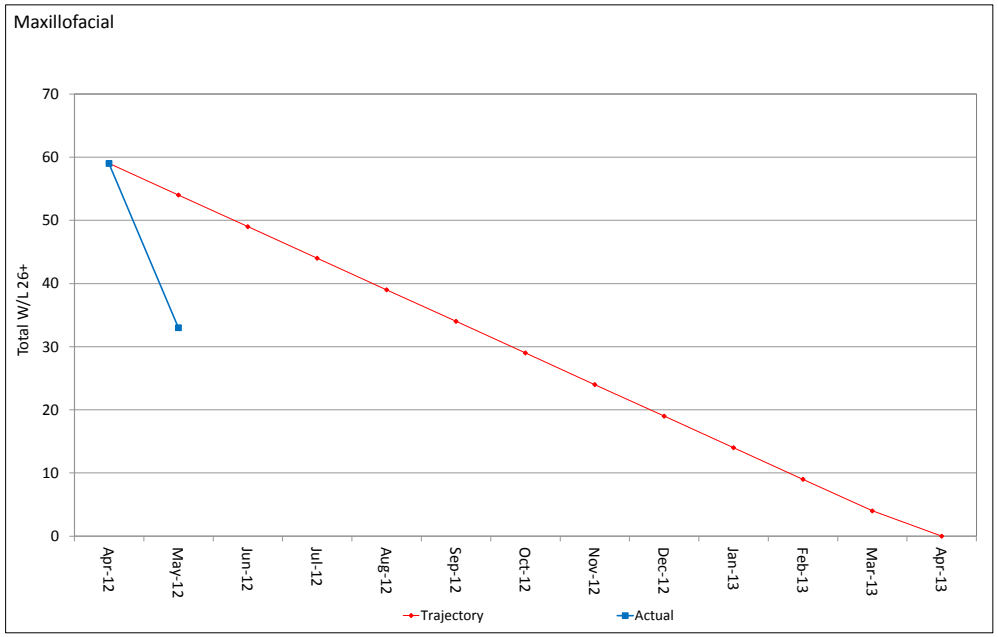
Internal Target

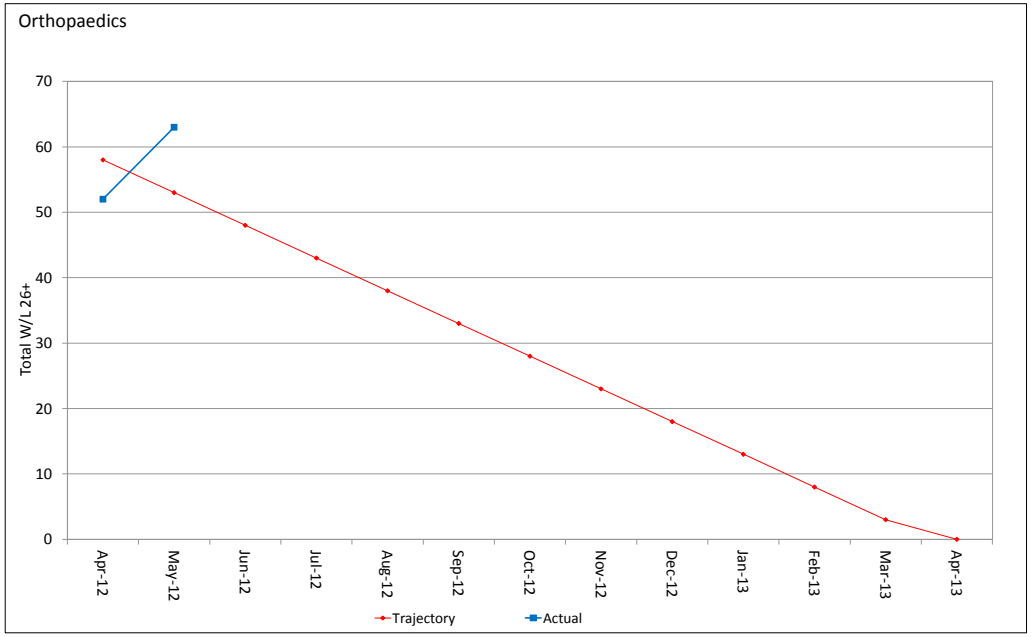


Appendix A Surgery 26+ week wait Trajectories

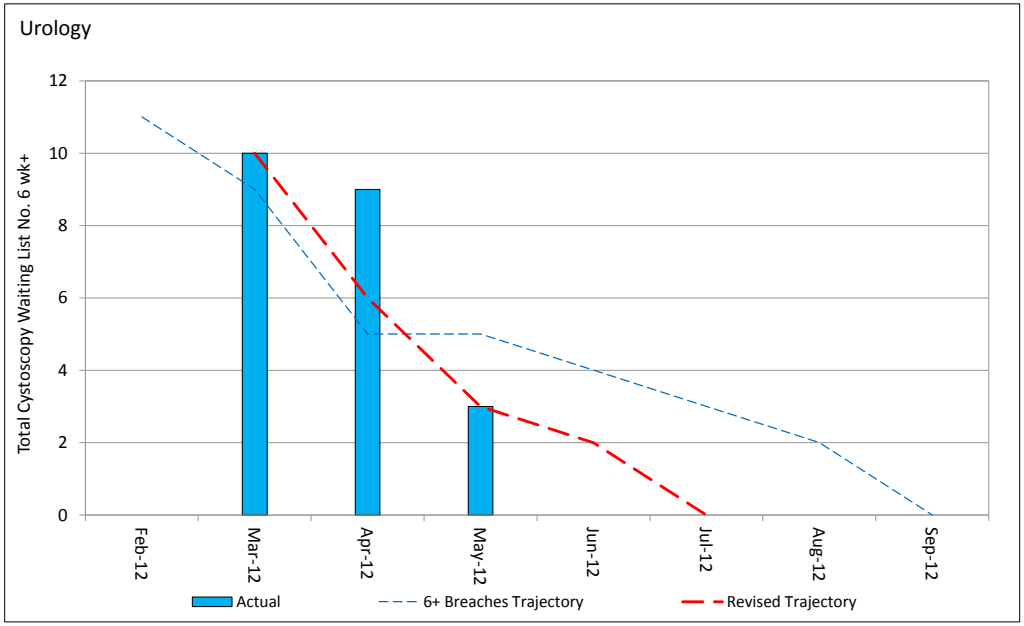


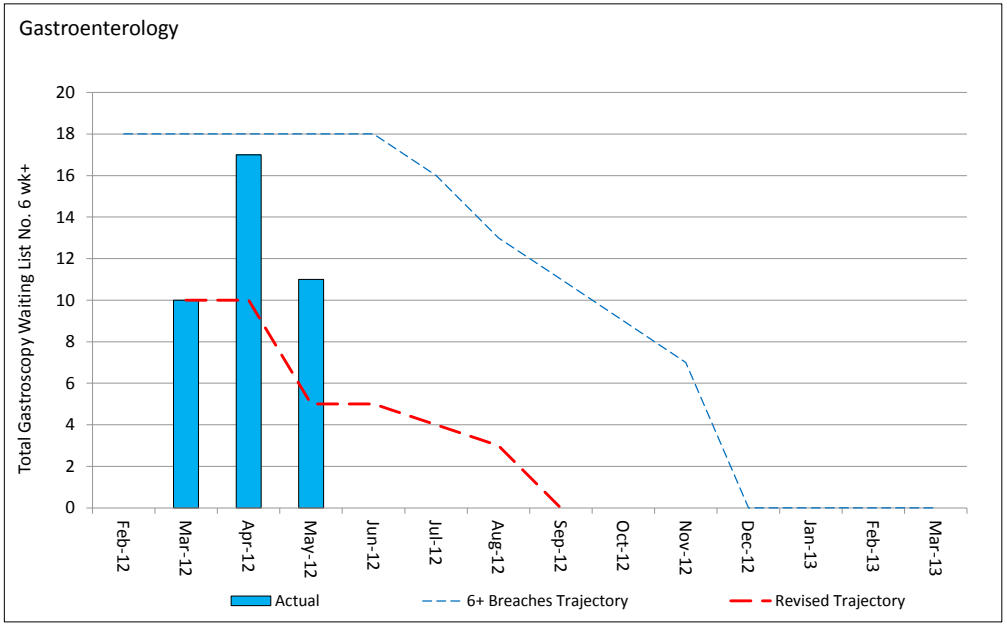






Appendix B **Diagnostic 6 week+ Trajectories**





MRI Under Construction

Attachment: P

Great Ormond Street Hospital for Children NHS Foundation Trust

TRUST BOARD 27 June 2012	
Finance and Activity Report **TWO months to 31 May 2012** **Submitted on behalf of** Claire Newton, CFO	**Paper No: Attachment P**

AIM
To summarise the Trust's financial performance for the **TWO** months to 31May 2012.

SUMMARY

Results year to date to end of May (Month2)

- Net surplus **£3.2M**, which is £2.9M above plan; excluding donations for capital expenditure. This positive variance primarily reflects higher than planned levels of IPP activity which is a timing benefit only whilst the private patient cap remains in place and some non recurring NHS activity.

Forecast
The Trust is forecasting delivery of a pre-impairment surplus of approximately £1M before income for donated capital additions.

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

- Delivery of the CRES plan including costs reduction and the contribution from growth
- Delivery of planned activity levels
- Controlling workforce levels in line with the workforce plan

Activity/Income
Total income excluding capital donations is £1.7M ahead of plan.

- NHS clinical income is £0.8M ahead of plan excluding pass through, primarily due to a benefit from 2011/12 income being higher than estimated at month 12
- Non NHS clinical activity is ahead of plan by £2.8M this is due to higher levels of private patient work.
- Other Operating income/Non clinical income (excluding capital donations) is £1.8M behind plan, primarily shortfalls on R&D, Education and charitable funding, which are partially offset by lower expenditure.
- Donations for capital expenditure are £4.7M behind plan reflecting the delay in the start of phase 2b enabling.

Expenditure

- Pay is under plan by £0.4M at £32.2M excluding pass through. Junior medical staffing and nursing budgets are overspent, this is offset by underspends on Consultants and the pay contingency
- The level of agency pay costs compared with last year has reduced from 4.8% to 3.4% due to the increase in the use of the new in house bank for medical and administrative staff
- Non Pay is under-spent by £0.5M excluding pass through. The main causes of this are R&D and Education being below plan in both expenditure and income

Financial Risk Rating

- Overall risk rating of 4 year to date in part due to the strong performance of IPP which is a timing benefit only
- Forecast risk rating is **4**

These ratios are calculated on the new basis used by Monitor for calculating the Financial Risk Rating which changed from the beginning of 2012/13 to take account of the reporting of donations for capital expenditure as income.

BPPC performance (Non NHS – cumulative)

- Total payables – Value 87.6%
- Total payables – Number 89.7%

CRES 2012/13

- The Trust is targeting £16.7M which includes £13.3M, 5% efficiency requirement in the current year and a contingency. To date £14M of schemes have been identified which have a risk adjusted value of £11M.

CRES 2013/14

- The Trust has identified £16.2M of schemes, at this point £0.1M is classified as deliverable and the balance are schemes which will be developed in deliverable schemes going forward.

CRES 2014/15

- There are £13.8M of schemes and 98% of these will need to be developed into deliverable schemes going forward.

Capital

- Capital spend is £3.9M; £4.9M lower than plan year to date. Donated capital spend is £4.7M lower than plan.

Statement of Financial Position (Balance sheet)

- Current assets (excluding cash &cash equivalents) rose by £7.0M.
- Non-current assets increased by £0.2M to £342M representing increased capital investment net of depreciation.
- Current liabilities have decreased by £2.7M, mainly due to a decrease in Non-NHS trade payables.
- Taxpayers' equity totalled £357M, an increase of £3.8M reflecting the increase in retained earnings (£3.8M).

Cash

- The Trust's cash balance was £17.3M at 31 May; there were operating balances of between £16.9M and £37.7M throughout the month.

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 15 June 2012

PERIOD 2 - 2012/13 FINANCE REPORT

(1) Forecast position

The Trust is forecasting a pre-impairment EBITDA of £66.8M and a pre-impairment surplus of £44.3M, these figures include £43.4M of income in respect of donated capital additions. The overall surplus including all of these items is £38.8M.

(2) Month 2 year to date net surplus

The year to date surplus is £5.7M (£3.2M before donations for capital additions). This represents an adverse variance of £1.8M against 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 (excluding income in respect of donated capital additions) is ahead of plan by £2.0M and operating expenditure is under plan by £0.9M.

2.1 Revenue account excluding Pass Through

	Actual	Variances	
	M2 YTD	Excl PT	PT
Clinical ex IPP	44.9	0.7	0.7
IPP Clinical	7.2	2.9	2.9
Other Income	6.2	-1.6	-1.9
	58.3	2.0	1.7
Capital Donations	2.5	-4.7	-4.7
	60.8	-2.7	-3.0
Pay	-32.2	0.4	0.5
Non pay	-19.4	0.5	0.8
Total op expend	-51.6	0.9	1.3
Non op expend	-3.5	0.0	0.0
Net surplus	5.7	-1.8	-1.8
Normalised EBITDA	6.7	3.0	3.0
	11.4%		

2.2 Revenue account compared with the previous financial year

An analysis of the revenue account on continuing activities (excluding Haringey) reveals a 7.8% increase in overall income. There is a 6% increase in NHS clinical income, which includes the effect of current year prices as well as activity levels, private patient income is 45.4% higher.

£'M	Actual M2 YTD	Last year M2 YTD	Var		Plan M2 YTD	Var	
NHS clinical	44.5	42.0	2.5	6.0%	43.7	0.7	1.7%
Other clinical	7.5	5.2	2.4	45.4%	4.7	2.8	60.7%
Non clinical	6.3	6.9	(0.6)	10.8%	8.1	-1.8	-
Income	58.3	54.1	4.2	7.8%	56.6	1.7	3.0
Donations capital	2.5	1.0	1.5		7.2	(4.7)	
	60.8	55.1	5.7		63.8	(3.0)	
Haringey	0.0	1.6	-1.6		0.0	0	
	60.8	56.7	4.1	7.3%	63.8	-3.0	-4.7%
Pay	-32.2	-31.0	-1.3	4.1%	-32.7	0.5	-1.5%
Non-pay	-19.4	-19.4	0.1	-0.3%	-20.1	0.8	-3.8%
	-51.6	-50.4	-1.2	2.4%	-52.9	1.3	-2.4%
Haringey	0.0	-1.6	1.6	-100.0%	0.0	0.0	
	-51.6	-52.0	0.4	-0.7%	-52.9	1.3	-2.4%
Non op expend	-3.5	-3.3	-0.2	5.5%	-3.5	0.0	1.4%
Net surplus	5.7	1.4	4.3		7.5	-1.8	-23.8%

3 Expenditure

3.1 Pay

Pay expenditure totals £32.2M, £0.5M lower than plan.

- The consultant budgets are under spent by £0.3M YTD. Cardiac is under spent by £0.1M as a result of vacancies. Research and Innovation is £0.15M under spent. This lies mainly within the consultant budgets attached to charity projects which have not yet started and is offset by an adverse income variance.

- The junior doctor budgets are overspent by £0.2M YTD. This cost pressure is spread across the Trust and is mainly due to agency premiums on vacancy cover and cover required for maternity leave.

- The nursing budgets are overspent by £0.3M YTD. Surgery is £0.2M overspent. £0.1M of this is within theatres, which have become over-established due to additional lists. The surgical wards are £0.1M overspent as a result of covering sickness on NICU and new posts from the opening of Island Day Unit – these will be funded from growth monies.

- The scientific and therapeutic staff budgets are £0.1M overspent YTD. This overspend lies within MDTS in the Dietetics, Radiology and Pharmacy budgets. Some of this overspend is due to additional posts from business cases which will be funded from growth monies. The balance has resulted from agency premiums from covering maternity leave and vacancies.

- The management and administrative budgets are on plan YTD.

Agency costs

Junior doctors	£0.10M
Nursing	£0.26M
Sci, Ther, Tech	£0.21M
Non-clinical	£0.55M
Total	£1.11M

This represents 3.5% of the pay bill to May 2012 and compares with 4.8% for the same period last year , the reduction being a result of the increase in use of in house bank staff.

3.2 Non pay

Non-pay expenditure is £19.4M, which is £0.8M below plan.

- The drug budgets are £0.3M underspent YTD,
- The blood budgets are over spent by £0.2M YTD, with a £0.1M movement in month. This is due to high expenditure on Factor 8, directly offset by income.
- The clinical supplies & services budgets are £0.2M underspent YTD. Surgery is underspent on Ilizarov frames and spinal metal. This is directly offset by income underperformance. ICI is £0.1M underspent, mainly within pathology. This is connected to activity and is in line with last year's expenditure trend.
- Services from NHS organisations and Healthcare from non-NHS bodies are £0.3M underspent YTD. £0.2M of this lies within R&I and has resulted from delays in invoicing from other organisations. This is directly offset by income underperformance.
- Premises budgets moved adversely by £0.1M in month 2. This is due to additional energy costs which have occurred as a result of the CHP system in MSCB not yet functioning effectively.
- Education & research budgets are under spent by £0.3M, this is timing only.

4 INCOME

Income is £3.0M behind Plan, and without pass-through items, income is £2.6M behind plan.

- NHS Clinical Income is £0.7M ahead of plan
- Non NHS revenue is £2.9M ahead of plan
- Other operating revenue is £1.9M behind plan

Category	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Variance Excl. Pass-through
	£M	£M	£M	£M	£M
NHS Clinical Income	263.8	43.8	44.5	0.7	0.8
Non NHS Clinical Income	31.1	4.6	7.5	2.9	2.9
Non Clinical Income Excl. Receipt of Asset Donation	48.7	8.2	6.3	-1.9	-1.6
Receipt of Asset Donation	43.4	7.2	2.5	-4.7	-4.7
Grand Total	**387.0**	**63.8**	**60.8**	**-3.0**	**-2.6**

4.1 NHS Clinical Income is £0.7M ahead of plan

NHS clinical income is £0.7M ahead of plan for the YTD, however this includes approximately £1.1m relating to the previous financial year where actually activity billed was higher than estimated.

The main clinical activity variances for 2012/13 YTD include Surgery and Medicine with lower than planned elective activity and bed day income.

Non NHS Clinical Income is £2.9M ahead of plan

IPP activity is significantly higher than plan at this point of the year. Whilst the Trust hopes to grow IPP income once the private patient cap procedural changes have occurred, expected at some point in this current year, the Trust has for now has moved ahead of YTD plan to recognise that there are likely to be seasonal down turns in Q2 and Q3.

Non Clinical Income is £6.6M behind plan

The main elements of the variances are:
Charitable donations for capital are £4.7M lower than plan – this largely reflects income that would follow capital expenditure and this is partly a phasing issue and partly reflects the Phase 2B enabling programme which has not occurred at this point.

- Charitable revenue income is £0.7M lower than plan – this is largely timing issue and neutral to the overall bottom line for the trust with correspondingly lower expenditure being incurred
- Education £93K lower – largely a timing issue
- Research and development is £0.8M and this is neutral to the bottom line and a timing/phasing issue

(5) CIP/CRES

CRES 2012/13
The Trust is targeting the delivery of £16.7M in 2012/13, this is higher than the efficiency requirement which is at 5%. At present £14M has been identified though when this is risk adjusted using the Trust's risk methodology the value is closer to £11M.

The CRES programme is currently showing 57% of schemes as feasible/potential schemes – this means they are not formally implemented with the exception of certain income schemes that cannot be classified as delivering income contribution from clinical activity growth, though the intention is to recognise this once period 2 income has been analysed and therefore a clearer understanding will be available shortly. There is 43% of the CRES programme showing as schemes delivering benefit.

CRES 2013/14
The Trust is currently targeting £18.1M of CRES in 2013/14. Currently £16.1M is classified as feasible or possible schemes and 1% is classified as deliverable representing the full-year effect of a 2012/13 scheme.

CRES 2014/15

The Trust continues to plan for the outer year's CRES delivery and has currently identified £13.8M of schemes, at this stage the robustness of these schemes is less as the focus is on the near-year schemes, but the Trust will continue to develop the 2014/15 programme and forward.

(6) CAPITAL PROGRAMME

Overview
The Trust's capital plan for the two months ending 31 May is £8.9M. The total spend to date amounts to £4.0M representing an under spend to date of £4.9M.

	Annual Plan £M	Plan YTD £M	Actual YTD £M	Variance £M
Hospital Redevelopment	32.9	5.5	1.8	3.7
Estates Maintenance Projects	6.2	1.0	0.8	0.2
Facilities Projects	0.4	0.1	0.1	0.0
IT Related Projects	4.5	0.7	0.5	0.2
Medical Equipment Purchases	9.2	1.5	0.7	0.8
Total Additions in Year	**53.2**	**8.8**	**3.9**	**4.9**
Asset Disposals	0.0	0.0	(0.0)	0.0
Donated Funded Projects	(43.3)	(7.2)	(2.5)	(4.7)
Charge Against CRL	**9.9**	**1.6**	**1.4**	**0.2**

Redevelopment
Redevelopment Projects are under spent by £3.7M. This is mainly due to delays on 2B Enabling amounting to £3.5M.

Estates,Facilities, IT, and Medical equipment
Estates Management Projects are showing a total under spend of £0.2M, relating to underspend on Donated Funded projects.

IT Projects are £0.2M below plan.

Medical Equipment Projects are £0.8M under spent on Donated Projects due to phasing of equipment purchases.

Disposals
There were no disposals during the period.

(7) STATEMENT OF FINANCIAL POSITION

Non-Current Assets
Non-current assets at 31 May totalled £342M, a net increase of £0.2M over the previous month. This increase was due to capital additions net of depreciation.

Current Assets (excluding Cash & Cash Equivalents)

- Current assets rose by £9.9M

NHS Trade Receivables (£4.9M increase)	The movement is primarily due to increases in English PCT debtors (£2.9M) and English SHAs (£1.4M)
Other Receivables (£0.8M increase)	The increase is due to additional Charitable income not yet reclaimed from the Charity (£0.7M)

Non-NHS Trade Receivables (£1.3M increase)	This is primarily due to an increase in invoices raised to the Charity (£0.5M) and an increase in invoices raised to private patients (£0.7M)

Current Liabilities

Current Liabilities have decreased by £2.7M

NHS Trade Payables (£1.7M increase)	The increase is mainly due to credit notes raised in respect of PCT under performance (£2.4M) net of payments made to NHS Supplies (£0.3M) and NHS Blood & Transplant (£0.3M)
Non NHS Trade Payables (£2.6M decrease)	The major movements are due invoices paid in month for Mansell Construction (£0.7M), Medco Health Solutions (£0.5M), UCL (£0.4M) and BUPA Home Healthcare (£0.3M)
Deferred revenue (£1.2M decrease)	The decrease is due to the utilisation of the income from invoices raised in the first quarter.
Other Payables (£0.5M increase)	This represents the increase in the PDC dividend relating to May 2012.
Capital Payables (£1.0M decrease)	Representing payment of invoices during the period

Taxpayers' Equity

Taxpayers' Equity has increased by £3.8M in month. The movement was an increase in the Retained Earnings of £3.8M.

(8) WORKING CAPITAL

8.1 Cash overview

The Trust had cash holdings of £17.3M at 31 May, and had operating cash balances of between £16.9M and £37.7M throughout the month. Cumulative commercial bank account balances at £0.01M was in line with the DH target maximum holding of £0.05M.

The closing cash balance was £1.4M lower than the forecast. This is mostly due to the late receipt of payment of a training invoice of £1.07m which was due for payment in early May 2012. The release of these funds is awaiting final authorisation and a payment date yet to be confirmed.

The forecast is subject to on-going review to reflect the current and forecast trading position at this point and in respect of the forecast revenue and capital position.

The forecast cash position is also dependent on delivery of the CIP programme as well as the recovery of number of debts in a timely fashion, particularly performance debt, IPP debt, R&D MFF and training debt.

8.2 Trade Debt

Debt is higher than this time last year but all aging is lower than this time last year and the majority of debt is not yet due. IPP debt is higher than last year due to increased trading and IPP debt not due is 77% of total debt compared to 33% this time last year.

Charity Debt is higher than normally seen due to capital invoicing and a number of invoices raised before the grant had been confirmed by the charity committee meeting. These are expected to clear in June 2012.

Debt over 90 days before bad debt provision or credit note adjustment is under 5%

	31/05/2012		31/03/2012		31/05/2011	
not yet due and COA	13,255	**62%**	15,071	79%	3,533	19%
0-30	3,151	**15%**	2,469	13%	4,546	24%
30-60	3,036	**14%**	568	3%	6,389	34%
60-90	942	**4%**	626	3%	855	5%
90-120	328	**2%**	4	0%	544	3%
120-180	223	**1%**	153	1%	488	3%
180-360	- 252	**-1%**	- 193	-1%	1,404	7%
360+	598	**3%**	491	3%	1,046	6%
	21,281	100%	**19,189**	100%	18,805	100%
NHS	4,362		6,640		10,347	
Non- NHS	2,891		3,362		2,951	
International	9,784		7,891		8,011	
Gosh CC	4,243		1,296		1,089	
	21,281		19,189		22,397	

NHS debt
NHS debt is £4.3M with £2.1M outside of terms. This includes year-end over-performance invoices. Of the debt outside terms, £0.67M has been approved and £0.33M relates to estimated year-end CQUIN invoices which are to be credited and reissued with actual values.

Non-NHS debt is £2.89M
This debt includes a training invoice for £1.07m. Non-NHS debt also includes retentions of £0.32M at 31 May; these will continue to form part of the overall debt values until they are settled later in 2012 and 2013.

Non-NHS Debt over 180 days has fallen over the last year to £0.16M in part due to the write-off of salary recharges.

IPP debt is at £9.7M due to increased billing in the period of £4.4M. Cash collections were also correspondingly high with £3.9M in month compared to typically £2.5M-£2.8M. Excluding cash on account, the profile of IPP debt is now 78% not due or 1-30 days.
Several IPP debtors have been clearing significant amounts of debt over 90 days.

8.3 Trade payables

Trade payables (excluding capital) were £8.2M, a decrease of £4.37M from 31 March. Following the agreement of NHS balances exercise in March 2012, meetings are to be arranged with the Trust's main NHS counterparties to resolve disputed invoices both on the payables and receivables ledgers.
Creditor days are 25, a decrease from the year-end of 32 which was higher than seen in previous periods due to the timing of the year-end payment runs.

(9) SALARY OVERPAYMENTS

There were eleven salary overpayments in May 2012 totalling £25.2K; six of which were caused by late notification. Of the total, two related to Neurosciences (£12.4K), six related to ICI (£9.0K), two related to Surgery (3.8K) and one to Clinical Operations (0.1K).

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th June 2012

Patient & Public Involvement, Patient Experience and Pals (Patient Advice & Liaison service) Annual Report 2011/12 **Submitted on behalf of** Liz Morgan Chief Nurse & Director of Education	**Paper No: Attachment Q**

Aims / summary
This report combines information on patient and public involvement activity at GOSH at a Trust-wide level and Unit level, with information on improving patient experience, including the Trust's response to themes identified through Pals casework in 2011/12.
A separate, more detailed Pals Annual Report 2011/12 is available.

Action required from the meeting
None

Contribution to the delivery of NHS Foundation Trust strategies and plans
GOSH seeks to provide services that exceed patient and families expectations and does this best by involving and engaging with them to learn how to provide the best possible experience for patients, families and visitors.

Financial implications
None

Legal issues
None

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?
This report, as well as the more detailed Pals report has been considered by the Patient & Public Involvement & Experience (PPIEC) Committee which includes parents and representatives from the Members Council. The Pals Annual report has been considered by the Quality & Safety Committee.

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
Grainne Morby, Head of Pals & PPI June 2011

Patient Experience, Patient & Public Involvement and Pals Annual Report 2011/2012

1. Summary

This report aims to bring together highlights of some of the work done in the Trust in 2011/12, particularly at a Clinical Unit level, on improving patient experience, engaging patients, parents and membership and in listening to, and responding to the concerns voiced by users of GOSH services.

'What happened to me and how I feel about it', GOSH's definition of patient experience, is broad and deliberately subjective as every single staff member in every service area can make a difference to the way in which a family experiences their visit, as do the expectations and past experiences brought with every visitor.

This report also draws on the Pals Annual Report 2011/12 by including the key themes identified by Pals from its casework, and the Trust's response.

2. Trust-wide highlights

2.1. Agreeing a corporate definition of 'patient experience', recruiting the Trust's first dedicated PPI & Patient experience Officer; a new 3 year strategic plan for 2012-15 and embedding patient experience into the Trust's Quality Strategy, approved by Management Board and Trust Board in January 2012.

2.2. Facilitating a seamless transition from the Members Forum to the newly elected Members Council, and identifying further involvement opportunities for elected councillors

2.3. Updating guidance for staff on engaging patients, parents and public and publishing new 'Patient Stories' guidance for staff on gathering and using patient stories to improve services. Patient stories are being used by the Transformation team as an improvement technique; they are being used to share 'veteran' patient and family experience with new patients on the website and on the Charity's Facebook site and on new clinical unit portals; and Aiden's story went to Trust Board as an example of using a patient's story to focus decision-makers on the patient perspective from the outset of a meeting.

2.4. The Ipsos Mori 2011Survey of in-patients was again overwhelmingly positive. We achieved patient experience CQUIN requirements related to a composite score of five national priority questions – achieved 92% against a target of 90%; although we did not achieve CQUIN target of 5% improvement on knowing how to feedback or complain and satisfaction with quality and variety of food. It is intended to address these issues in 2012/13 and survey out-patients.

2.5. Using focus groups and one-to-one interviews work began to gain an insight into the experiences at GOSH of parents of children with an autism spectrum disorder with a view to identifying service improvements. This group was identified as having special

and unmet needs which are not visible. It is intended to use some of the insights gained from talking to families and young people with an autism spectrum disorder in the Trust's continuing efforts to make improvements for patients and families with a learning disability. Key messages include the need for quiet space and the need to keep waits and physical change of rooms to a minimum.

2.6. A similar in-depth approach has been taken to gain an insight into the experiences of Jewish children and families, including members of the Orthodox communities but implementing the results of this work will take place in 2012/13.

2.7. The young people's survey of adolescent patients continued to take place quarterly and plans laid to move this into a digital format. Work started in 2011/12 on a self assessment of services from a young person's perspective and this is expected to flourish next year with a 'listening event' targeted at young people and the development of a Young People's Forum.

2.8. Several parents were recruited to the Trust's Clinical Outcomes Development group to help make clinical outcomes information as helpful and accessible as possible by using the GOSH website. Patient Reported Outcome measures, though often separately considered in clinical conversations, are just as important and are now being considered for all services.

2.9. Redevelopment continued to throw up countless opportunities to look at space, building and layout from a patient and family perspective. A survey of in-patients and visitors to 'wards about to move' took place in 2011 and this will be repeated in 2012 following the opening of the Morgan Stanley building to measure improvements and to identify anything unforeseen.
'The patient's input into the redesign of Eagle ward was totally invaluable' (Clinical Unit Improvement Facilitator)

2.10. A pilot to collect 'real-time' parent/patient views took place on four wards using IPads and volunteers. However, this identified the need for a strategic rethink in 2012 as the pilot revealed difficulties in sustaining reach and consistency using volunteers, IT back-up problems using IPads, low returns on wards where patients stay for longer periods and issues of data ownership and feedback to participants.

2.11. Parent/member involvement in the staff recruitment interview process continues. A survey conducted towards the end of 2011 highlighted that the main barriers to parents and lay members attending interviews was fitting them around work/carer commitments and needing to receive more notice from the recruitment team. A decision was therefore made at Management Board that recruiting managers should only advertise with interview dates. There are plans to review the current cohort of parents with a look to expanding this group.

3. Local highlights

3.1 Neurosciences

The merger of Parrot and Tiger wards into the newly opened Koala ward provided an opportunity to engage families in thinking through the changes; two parent

representatives contributed to the planning and were key to making a successful transition.
Parent representatives continue to sit on the Neurology Modernisation Committee which meets weekly, and feedback from patients and families was obtained from local surveys in Ophthalmology, Clinical Nurse Specialist telephone consultations in Craniofacial and monthly ‘coffee mornings’ held for families of Neuromuscular service patients.

3.2. Surgery

A parent was recruited to the Spinal Surgery Pathway project group set up to review and improve the process.

Sky ward has introduced a welcome/information folder which is to be rolled out across all wards, a bi-annual local patient survey which will be rolled out across all surgical wards and patient feedback boxes have been ordered for all surgical wards with plans for regular feedback using ‘You said/We did’ boards.

A pilot focus group was held for parents with experience of general surgery who supported more comprehensive pre-admission assessments and improved facilities for Dinosaur ward.

3.3. Infection, Cancer and Immunity

ICI uses a range of methods to improve patient experience. Patient satisfaction surveys take place quarterly on all their wards – Elephant, Fox, Robin, Penguin and Safari and Dermatology surveyed users of its Epidermis Bullosa service. In addition there are now weekly Family Forums held on Fox/Robin and Lion/Elephant wards which give families the opportunity to give feedback.

Involving families in the monitoring of infection control is crucial and an infection control ‘ward walk’ was piloted on Fox ward which revealed parents perception of barriers to effective control, including the need for changes to ward layout and increased monitoring of the sluice room.

3.4. Cardiorespiratory

A patient experience group reports monthly, and is an integral part of the Unit’s Outcomes, Quality & Improvement Group It has been responsible for ensuring action plans are created and responded to following the 2011/2 patient satisfaction surveys on Ladybird & HDU, Intensive care and Octopus, the sleep unit, ECMO, Pulmonary hypertension, and Cystic fibrosis.

3.5. International Private Patients

Following a survey of patient and family satisfaction amongst Arabic families, senior nursing staff and an advocate now do a joint walkaround on both wards twice a week to elicit experiences and deal with any family issues. Hand hygiene has been taught and regular parent teas have been organised.

3.6. Somers Clinical Research Facility

Regularly survey their children and families and have a ‘listening to you’ board in the waiting area; they are also part of the Medicines for Children research network which has an active young people’s forum.

3.7. Outpatients

A pilot for a reminder text messaging service for outpatients appointments took place, and the new service ‘went live’ in May 2012 giving patients whose clinic has opted into the service 7 days reminder of their forthcoming outpatient appointment. The service will monitor impact on reducing cancellations.

3.8. Nursing

As part of the introduction of its visible leadership strategy, senior nursing staff are making monthly visits/inspections of wards to engage with front-line staff, patients and families to find out about their day to day experiences, as well as offering an opportunity for peer review of practices in each others areas. Highlights include staff ‘Being the patient’ for 30 minutes to an hour observing experience from the point of view of the patient and sharing lessons learnt. Noise levels have been an unexpected result – noisy bins, televisions blaring with no one watching, telephones’ ringing, pumps alarming for prolonged periods of time.

3.9. Corporate Facilities

Front of house survey using volunteers – nearly 1,000 families participated in a questionnaire about their experiences of the outpatients reception, the main reception and the travel & reimbursement desks – results have provided the basis for customer care training and a set of measurable standards to monitor against.

4. Pals Activity 2011/12

Pals helped over 2,550 families and patients during the course of the year and its casework provides the Trust with a useful barometer of patient experience for those families who were not ‘very satisfied’ at the point of contacting Pals. Pals recorded 1139 cases and overwhelmingly these were parents who had problems, concerns or complaints that needed to be resolved.
A separate and more detailed Pals Annual report for 2011/12 is available. However the following ‘themes/issues’ were identified in year and reported to both the Trust’s Quality & Safety Committee and the Patient and Public Involvement Committee.

5. Key Issues for Improvement identified by Pals in 2011/12

5.1. Interventional Radiology - patients experiencing delays

Update: the issue of IR availability was investigated through the IV Access group and a business case for increased service agreed. The concerns around the amount of time families wait for Interventional Radiology procedures was addressed with a plan to appoint another consultant interventional radiologist and the provision of three further operation lists per week. There are further plans to implement an on-call service to

further accommodate emergency cases. This will increase the number of patients that can be seen and also help to decrease the number of cancellations in response to emergency procedures.

5.2. Managing expectations for family accommodation and use of Weston House – issues of capacity, allocation and consistency and the need for flexibility due to increasing range of social care needs.

Update: The findings of the 2010 review of parent accommodation at GOSH were gradually implemented; however the demand for accommodation often exceeds capacity. A review took place involving changed criteria for Weston House to cope with the demand. There is now a more consistent approach to family accommodation, better communications with families and staff and a more sensitive approach to the use of discretion for families where there are social/unexpected family issues.

5.3. Difficulties contacting the Appointments Centre

Update: Due to installation and configuration errors in December 2011 telephone calls to the Appointments Centre were being directed to extension numbers that were not correct and some calls were unanswered and some messages were not responded to. In addition the ‘caller sequence’ escalated rather than descended for some callers. This made it impossible to judge where a caller was in the queue and how long a caller would be waiting. However following these concerns being raised with the Appointments Centre and working with ICT/Telecoms to identify and resolve the above problems, Pals have now stopped receiving calls regarding this issue.

5.4. Poor environmental state and management of Peter Pan café

Update: Catering Manager sorted out the cleaning problems due to change of contractor. Café area now much smaller and cleaning no longer an issue.

5.5. Failings in the Gastroenterology service continued despite these being highlighted in 2010/11

Update: The gastroenterology team, supported by a project manager, have started work to address the problems with the delivery of their service. A project steering group has started work on implementing the project plan, including revised admission criteria to provide a clear basis for communication about the purpose and course of admission with patients, parents, and referrers. A weekly admissions meeting now takes place to ensure that admission requests are prioritised on the basis of clinical need. Additional manometry lists will be made available from June 2012 which will progressively reduce waiting times for these tests.

A review of administration was undertaken and additional support provided to deal with a backlog. Improvements being implemented include better processes for managing telephone and email queries, and reducing the turnaround times for making bookings, sending out clinic letters and discharge reports.

Rainforest ward will be admitting patients with pseudo-obstruction on a regular basis from May 2012 which will also reduce the long waiting times for this group of patients.

5.6. Patient transport delays for dialysis patients on Victoria ward identified after several parents approached Pals in October 2011. Ward staff on Hippo were also spending a disproportionate amount of staff time trying to sort out late transport.

Update: Project team set up with Transport Manager, Patient, Public & Involvement (PPI) and Patient Experience Officer, families and ward staff to investigate and improve service. Parents kept diaries for a month, and issues identified (including other quality issues) were discussed face-to-face with contractors who were keen to make changes and improve service. Delays have reduced to an acceptable level, and families and staff report that they 'felt heard and taken seriously'. (targeted focus groups are part of the PPI & Patient Experience Plan for 2012/13)

5.7. Access to information for non-resident fathers with parental responsibility

Update: It is now the case that the address of any non-resident parent with parental responsibility who asks, can be put on PIMS in a way that does not compromise the confidentiality of either parent's address allowing us to send out appointment letters which are 'computer generated'. However there is no pan-Trust system for sending out post-clinic letters or discharge letters that can 'guarantee' a 'second' parent receives them all; the system depends on individual clinician's assistants checking PIMS, noting both addresses and posting.

5.8. Hospital Shop pricing policy under new management

Update: Following many complaints about high prices in the outsourced hospital shop and coffee bar backed up by research undertaken by Pals on price comparisons with local supermarkets, the Catering Manager negotiated a drop in price on some key staple items. It would be fair to say that there continues to be adverse comment about prices and the limited stock range in the Shop.

6. Concluding Remarks

The Trust has made headway this year in the engagement of Members, patients, parents and public, particularly at Unit level. It is anticipated that as the Members Council begins to settle in, extend its knowledge base and councillor involvement, it will act as a 'critical friend' and ensure that we focus on what matters most to our users and how we can listen better to improve more.

Attachment R

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **27th June 2012**	
Update on progress with the GOSH research strategy and UCLP research **Submitted on behalf of** Professor David Goldblatt, Director of Research and Innovation	**Paper No: Attachment R**
Aims / summary To provide an update on progress with the GOSH research strategy and UCLP research.	
Action required from the meeting For information and discussion.	
Contribution to the delivery of NHS / Trust strategies and plans With partners maintain and develop our position as the UK's top children's research organisation.	
Financial implications N/A	
Legal issues N/A	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision N/A	
Who is responsible for implementing the proposals / project and anticipated timescales Prof David Goldblatt and Lorna Gibson	
Who is accountable for the implementation of the proposal / project Prof David Goldblatt and Lorna Gibson	
Author and date Prof David Goldblatt	

Trust Board Report Research and Innovation Division

Progress with research strategy including update on UCLP research activities

Research Strategy:

Further refinement of the GOSH research strategy has taken place largely as a result of the efforts surrounding our successful reapplication for funding for a Biomedical Research Centre.

Following GOSH/UCL's successful bid to the NIHR in 2011 for funding of a BRC, feedback from the International assessment panel included a request for a Strategy refresh to reflect an increase focus on Rare Diseases and a demonstration of the integration of GOSH's BRC with the academic strengths of UCL. While this refresh was only required at the end of the first year of funding (March 2013) we decided to undertake an immediate refresh to take advantage of the planning we have been undertaking to develop a new **Centre for Rare Diseases in Childhood** at Great Ormond Street Hospital. The key elements of the new scientific focus and strategic links for our new BRC are as follows:

- An explicit emphasis on research on rare diseases which make up a significant part of the wide variety of patients presenting to and cared for by GOSH NHS Foundation Trust; and embedding that focus within each of our four interlinked themes that follow the research process from bench to bedside.
- Establishing industrial liaison theme leads to work with UCL's Director of Translational Research and Industrial Partnerships (Prof David Miller) to explicitly promote enterprise activity and nominate at Scientific Board level a theme leader with responsibility for the enterprise portfolio.
- Leveraging the basic science strengths existing within UCL, integrating our strategy with the Francis Crick Institute and the established UCL Domains that align with our thematic focus.
- Sharing Experimental Medicine facilities including platform technologies and technical expertise across UCL to leverage the most appropriate support for our research.
- Maximising the opportunities of our unique group of partner specialist hospitals including Moorfields Eye Hospital, the Royal National Throat, Nose & Ear Hospital, and the National Hospital for Neurology & Neurosurgery via discussion between BRC Boards and at UCL Partners.
- Training Strategy: We will actively search for talented individuals across a range of disciplines including clinical academics, nurses and allied health professionals and train them in Experimental Medicine. We will provide career development tailored to each group, making use of appropriate NIHR training initiatives, as well as mentoring using local mentorship networks. Our training strategy will be directed by the BRC Scientific Board and a designated Training Lead. Membership of the NIHR Infrastructure training forum will help to further develop the training strategy within the GOSH BRC.

The strategy refresh will be formally submitted to NIHR in the autumn of 2012.

The Centre for Rare Diseases in Childhood at Great Ormond Street Hospital

Professor David Goldblatt and Professor Bobby Gaspar are co-ordinating efforts to plan the functional content of the new Centre which will be built on 20 Guilford Street. Following widespread discussions within the Trust, the focus of the new centre will align with the hospitals major research themes which include understanding the genetic and molecular basis of disease to aid diagnosis and the development and implementation of new therapies to help treat diseases. It is envisaged that the new centre will focus on establishing the genetic basis of rare diseases with the aim of correcting such defects via stem and genetic cell therapies. To this end the new centre will include clinical laboratories accredited for manipulating cells for the purpose of delivering them back to patients as well as the requisite informatic support for the sophisticated genetic investigations and analyses envisaged. It will also focus on building on cellular therapies and regenerative medicine techniques.

UCLPartners

It has been agreed by UCLP that there is a need to convene a Research Sub Board that will report to the UCLP Executive and Board. With the emergence of Academic Health Science Networks and a clearer role for the "C" in AHSC, it is important that UCLP is fulfilling its research potential. The Board will oversee the strategic alignment of research activity involving the partner organisations in pursuit of population health gain and wealth creation. The Board will also facilitate development of the portfolio of BRC and BRU activities conducted by the partnership by encouraging sharing of expertise, platforms and performance data to drive up achievement. GOSH will be represented on the Board by the BRC Director (David Goldblatt).
A number of Program Directorships are being re-advertised after the initial terms have come to an end and Professor Goldblatt has stepped down as Program Director for Child Health. A proposal is currently being considered by UCLP to rename the program the "Children and Young People Programme" and to advertise for a new Director with a specific focus on technology and social media enabling more healthcare to be taken out of the acute hospital setting. This follows the success of the Diabetes and Asthma UCLP research programs that are utilising an internet portal and smartphones respectively to aid in the management of these chronic conditions.

David Goldblatt
June 17th 2012.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27th June 2012	
Update on Revalidation Readiness **Submitted on behalf of** **Dr Barbara Buckley, Co-Medical Director**	**Paper No: Attachment S**
Aims / summary To provide reassurance to Trust Board that robust processes are being developed to ensure that we are able to fulfil our responsibilities relating to the revalidation of medical staff that will commence in 2013.	
Action required from the meeting To note the progress to date which meets standards required by the revalidation support team organisational readiness self-assessment tool. To note the risks to successful implementation, in particular sufficient administrative resource.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Strengthened appraisal for the purpose of revalidation will help strengthen medical engagement in quality improvement activities and development of measurable clinical outcomes, helping us to deliver measurably high quality clinical, research and educational outcomes.	
Financial implications N/A	
Legal issues Provision of adequate resource by Trusts is mandated in the Medical Profession (responsible officer) regulations 2010/2841	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? Medical Staff at GOSH by regular email updates, GMSC.	
Who needs to be told about any decision?	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Cale	
Who is accountable for the implementation of the proposal / project? Dr Buckley	
Author and date Dr Catherine Cale, Deputy Medical Director 13th June 2012	

Trust Board June 2012

Medical Revalidation Update

Background

1. The General Medical Council (GMC) have confirmed that revalidation for medical staff will commence from early 2013. The majority of doctors who are registered with a licence to practice from the GMC are likely to require revalidation over the 3 year period of April 2013-16, with subsequent revalidation once every 5 years.

2. Revalidation will occur after a recommendation from the designated body's Responsible Officer to the GMC regarding the individuals fitness to practice, based on a review of all appraisals since the previous revalidation.

3. In accordance with regulation 2010/2841 (the Medical Profession (Responsible Officer)) Chapter 19 each designated body must provide the responsible officer with sufficient funds and other resources necessary to enable the Responsible Officer to discharge their responsibilities for that body.

4. GOSH will be responsible for revalidation of all Consultants, Trust doctors, jointly-contracted doctors where the majority of their work is at GOSH, locums, and Clinical Academics who undertake the majority of their clinical work at GOSH (responsibility for revalidating doctors in recognised training programmes lies with the relevant Deanery). For GOSH this numbers about 400 individuals.

5. In order satisfy the requirements of appraisal, each doctor must develop and maintain a portfolio of supporting information and evidence covering all aspects of the doctors work (eg Clinical, management, teaching, research, private practice). Contents is mandated by the GMC and includes CPD, quality improvement activity, significant events, complaints and complements and statements regarding probity and health. An additional requirement is for patient and colleague feedback, both informal but also in the form of formal 360 degree appraisal at least once in every 5 year cycle. Evidence of mandatory training will also be incorporated. The quality and content of appraisal as undertaken currently will need to be enhanced to meet the requirements of revalidation. This will have the benefit of improving the data available to support quality and safety work and initiatives in the Trust, and will help drive engagement of Medical Staff in defined quality outcomes.

6. Secondary employers will seek assurance from us that individuals have undergone satisfactory appraisal at GOSH, and we will need to also do this for individuals who do some work at GOSH but for whom we are not their main employer.

7. Implementation of revalidation is supported by the Revalidation Support Team (RST) (www.revalidationsupport.nhs.uk).

Progress to Date

1. The Revalidation and Appraisal team is led by Dr Barbara Buckley (Co-medical Director and Responsible Officer), with support from Dr Catherine Cale (Deputy Medical Director) and Mrs Christine Lowe (Medical HR Manager).

2. BB and CC have undertaken relevant training and attend regular regional meetings to ensure that we are implementing robust plans.

3. All doctors for whom we believe we will be responsible have been notified. This is complicated by the large number of medical staff at GOSH who either have an Academic institution as their main employer (principally ICH) or who work in a number of other NHS organisations aswell as at GOSH.

4. Approximately 70 appraisers will be required to appraise all staff. Appraisers have been identified for the majority of specialties within the Trust, and more than 50 have been booked onto training courses over June and July 2012 (RST recommends a minimum 50% of appraisers should be re-trained in 2012). This is part e-learning to minimise time taken out of the normal working week.

5. Appraisee training is being offered, again e-learning so that it can be undertaken flexibly.

6. Appraisal paperwork has been modified in line with the new requirements and we are moving from a paper-based to an electronic system of information recording.

7. How we provide activity, complaints, serious and other incident information to Doctors (as required by the GMC in their guidance on supporting information for appraisal and revalidation) is being reviewed and streamlined with Information Systems and the QST teams.

8. A quality assurance system is being developed so that we can improve both the administrative elements of the process and also provide constructive feedback to appraisers to improve their skills.

9. Given the complexity of enhanced medical appraisal for a large number of individuals where 5 years of information will need to be reviewed by the RO, agreement to fund the purchase of licenses for a commercial internet based solution has been agreed by Hospital Management Board. This will be combined with a review of our Consultant Job Planning e solution as using a single provider is likely to have significant practical and financial advantages. Evaluation of a number of providers will be undertaken later this year with a view to implementation for the 2013 appraisal round.

10. The Organisational Readiness Self Assessment submitted to the SHA in May confirms that we are compliant with or have clear plans to be compliant with all the standards required.

Risks to Provision of Successful Medical Appraisal and Revalidation at GOSH

Risk	Mitigation	Level
Lack of medical staff engagement	Provision of regular communication Clear incentive to participate (no license, no work)	Low
Adequate recruitment and training of appraisers	Active recruitment Flexible training (blended training package)	Medium
Poor consistency and quality of appraisals	Quality Assurance system with feedback	Low
Inadequate administrative support for R and A team	0.5 WTE allocated from HR	High
Inadequate provision of required information to Drs by Trust	Work with IS/QST Feedback from appraisees to improve content and provision	Medium
Inadequate IT facilities/support (eg scanners) for preparation of appraisal portfolio	Work with specialties to ensure support available	Low
Disputes re recommendations by RO to GMC unable to be resolved	Robust appraisal process 2nd experienced RO from another Trust identified	Low

Dr Catherine Cale
13th June 2012

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **27th June 2012**	
Summary of items discussed at Management Board in April 2012 **Submitted on behalf of:** Dr Jane Collins, Chief Executive	**Paper No: Attachment T**
Aims / summary To provide a summary of the items discussed at Management Board in April 2012.	
Action required from the meeting To note the summary and the items discussed.	
Contribution to the delivery of NHS Foundation 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, councillors, commissioners, children and families) and what consultation is planned/has taken place? Management Board minutes are available on GOSH Web	
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 20th June 2012	

Summary of Management Board – 19th April, 2012

Minutes of Board held on 15th March were agreed with one amendment.

Items Noted:

- Updates from clinical units including IPP, R&I, QST and Education - safety & zero harm, key clinical and operational risks, other updates
- Facilities Zero Harm Deep Dive
- Key Performance Report
- Finance and Activity Overview
- Monthly CRES
- Quality Account
- PDR Action Plan
- Greek and Cypriot (southern) patients which were referred via E112 / S2 (back with clarity)
- Industrial action update
- Annual Safeguarding Report
- Update on the implementation of the Interventional Radiology (IR) business cases
- Decontamination Strategy
- Staff survey results
- Choice of 3-T MRI
- Report from the Business Case Review Group including Terms of Reference

Items which were Approved:

- Proposal for extension and renewal of Kuwait Paediatric Haematology/Oncology contract. (Approved direction of travel)
- Recruitment of Replacement Immunology Consultant & Flexible re-appointment of retiring consultant
- Medical Appraisal and Revalidation (Approved in part)
- Replacement Nephrology Consultant (6 PAs) (Approved with amendments)
- Replacement Neurosurgery Consultant (Approved with amendments)
- Update for Psych/Derm Business Case (Chairs action to be taken)
- Tender for the supply of a Tandem Mass Spectrometer
- OPD Space pressures – update (Approved direction of travel)
- Mitie Contract Extension
- Waivers

Items to come back next month:

- Staff Residential Accommodation

Items for Information:

- Update from Policy approval Group
- Code of Conduct
- EDRMS project
- Minutes of subcommittees/subgroups

Attachment T

Great Ormond Street Hospital for Children NHS Foundation Trust

MANAGEMENT BOARD
19th April, 2012

FINAL MINUTES

Present:

Barbara Buckley (BB)	Co-Medical Director
Sven Bunn (SB)	General Manager, Medicine and DTS
Robert Burns (RB)	Deputy Chief Operating Officer
Cathy Cale (CC)	CU Chair , ICI-LM
Jane Collins (JC)	Chief Executive Officer (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
Elizabeth Jackson (EJ)	CU Chair, Surgery
Mark Large (ML)	Director of ICT
Anne Laythe r (AL)	GM, Cardiac
Joanne Lofthouse (JL)	General Manager, International Division
Claire Newton (CN)	Chief Finance Officer
Peter Wollaston (PW)	Head of Corporate Facilities

In Attendance

Helen Cooke (HC)*	Head of Workforce Planning
Jude Cope (JCop)*	Chief Pharmacist, Pharmacy
Lucinda Carr (LC)	Consultant, Neurodisability
Peter Lachman (PL)*	Associate Medical Director and Consultant in Service Design & Transformation
Catherine Lawlor (CL)	PA to Chair & Chief Executive (minutes)
Natalie Robinson (NR)	Deputy Director of Redevelopment
Janet Williss (JW)	Deputy Chief Nurse

**Denotes meeting part attended*

483	**Apologies**	
483.1	Apologies were received from Liz Morgan, Chief Nurse and Director of Education; Martin Elliott, Co-Medical Director; William McGill, Director of Redevelopment; Carlos De Sousa, CU Chair, Neurosciences and Tom Smerdon, GM, Surgery.	
484	**Minutes of Management Board meeting held on 15th March, 2012**	
484.1	The minutes of meeting held on 15th March, 2012 were approved as an accurate record with an amendment to change item 409.4 to be reworded.	
485	**Action Log and other matters arising**	
485.1	JC asked the Board for suggestions for actions following the BBC programme which was critical of the Trust. The Board had a discussion and supported the plan to complain to the BBC about the accuracy and balance of the report and to release a press release on the Trust internet site so that patient and parents were reassured that the Trust is a safe, open and high performing Trust which promotes a culture of quality and safety.	
458.2	The following updates were received on the documented actions:	
485.3	169.8 – Patient Transfer Policy and Patient Discharge Policy – RB reported that review had been put back to April pending the outcome of the External Critical Care review.	
485.4	284.12 & 374.7 – ENT and Urology – it was reported that these actions were still ongoing and TS would provide a report at the next Board.	
485.5	405.4 - Maximum occupancy of Units – it was reported that TS was working on a new report with Geoff Basset's team and this would be shared to the Board in due course and would be presented to the Board in July.	
485.6	**Action:** TS to report on Maximum occupancy of Units to the July Board.	
485.7	405.6 – Handover at night findings – AG reported that findings would be reported to the Board in July.	
485.8	**Action:** AG to present findings to the April Management Board.	
485.9	405.8 **-** Proposal for Sustaining Clinical Outcome and Patient and Family Experience Research Activity by Nursing and Allied Health Professionals – was postponed to May Board	
485.10	**Action:** LM to update the Management Board on funding of the proposal post decision by Charity.	
485.11	374.13 - Flexibility and Sustainability Funding – LG gave an update.	
485.12	457.2 – Staff Residential Accommodation – Postponed to May.	
485.13	**Action:** WM to report back to the May Board on Residential Accommodation.	
485.14	405.14 - Phase 3A Development Group – JC gave the Board an update and thanked the units for finding a representative from each of the Units.	

485.15	462.4 – PPI – JL gave the Board on update on the paper which was submitted on referrals via E112/S2. JL reported Patients who normally resident outside of the United Kingdom were not routinely entitled to free NHS care. If an elective referral was received from a clinician overseas and/or where the patient's address was given as overseas then the following guidance should be followed: 1. Patients from the European Union. 2. Patient's from Outside of the European Union. 3. Emergency and Planned Transfers from other hospitals. The Board were advised to contact JL if in need of further expert advice on referrals via E112/S2.	
485.16	451.4 – Business case to increase Cardiothoracic Capacity on move to Morgan Stanley – Approval for Medical Staff posts to come back to May Management Board.	
485.17	407.3 – Consultant to Consultant transfer of care – AG will pick up with ME when he returns.	
485.18	**Action:** AG to pick up with ME when he returns.	
485.19	408.4 – Intranet site – postponed to May Management Board.	
485.20	413.4, 416.5 & 416.7 – BRC, 26 week wait and 6 week diagnostics within Surgery and R&I targets were reported as completed.	
485.21	418.3 – Band 1 – 6 (non-bank) agency administrative staff – FD reported progress had been good. JL highlighted concern over the skills of some Bank administrative staff. FD to feed back concerns to Bank management.	
485.22	**Action:** FD to back concerns over level of skills to Bank management	
485.23	475.2 – Sustainable Development Management Plan – postponed to May Management Board.	
	Clinical Unit and Zero Harm Reports	
486	**IPP**	
486.1	JL presented the IPP Zero Harm report. JL reported it had been 364 days since the last SI and 2 refusals for the month of March.	
486.2	JL reported that the top 3 risks were Blood products, Recruitment on Butterfly and Increase in CVL infections. JL reported there had been a near miss and an over transfusion in the Division. There were now regular meetings with the Trust's transfusion team and training was to be attended by all qualified staff. There was concern regarding the number of CVL infections especially on Bumblebee Ward, the Trust's Infection Control and Prevention team were helping the Division to investigate the reasons for the infections and reviewing practice.	
486.3	JL reported the Division had achieved the target year end position. In March the highest income ever was achieved.	
486.4	Management Board **noted** the content of the report.	
487	**Cardio Respiratory**	
487.1	AG reported that an SI had occurred 2 nights ago involving a pump. AG reported that investigations were underway to try to work out what happened.	

487.2	AG reported there had been 1 refusals and 1 complaint. AG reported the Unit's top risks were Medication Errors, Home Ventilation breakdown and CareVue. AG reported all risks were being addressed.	
487.3	Management Board **noted** the content of the report.	
488	**Infection, Cancer and Immunity**	
488.1	CC reported that it had been 146 day since the last SI. CC reported the learning from the last SI involving a misdiagnosis at another hospital of Factor X clotting deficiency and treatment given that was not required. CC reported 1 refusal, 2 complaints and 2 delays during the month, all under investigation.	
488.2	CC reported the three main risks for the Unit were access to MRI slots, lack of timely availability of cots and IT systems. CC reported that all risks were being addressed.	
488.3	CC highlighted concerns over blogs concerning staff by patient's parents. JC advised that Lesley Miles and Rob Evans ought to be able to help with this issue and LM would action.	
488.4	**Action:** LM to seek advice from Lesley Miles and Rob Evans over the concern of blogs pertaining to members of staff.	
488.5	Management Board **noted** the content of the report.	
489	**MDTS**	
489.1	MH presented the paper. MH reported there had been an SI involving an IR line placement on Friday, which was currently under investigation. MH highlighted the difficulty with deciding whether to report an unavoidable complication an SI which should be investigated. CC concurred with this view. JC asked that Katharine Goldthorpe review the SI guidance and report back to the May Management Board.	
489.2	**Action:** Katharine Goldthorpe review the classification of SI guidance and report back to the May Management Board.	
489.3	MH reported that there had been 3 refusals and 2 complaints MH reported the complaints were currently under investigation.	
489.4	MH reported that the top three risks for the Unit were Completion of PIMs forms by non-doctors, Interventional Radiology Service provision and lack of results for discharge summaries from inpatients stays. MH reported that all risks where being addressed.	
489.5	Management Board **noted** the content of the report.	
490	**Neurosciences**	
490.1	SD reported that it was 243 days since their last SI and the learning from it. SD reported 3 refusals and 1 complaint. One complaint involving an implant which the family thought was in place. SD reported the complaint was being addressed. SD reported that there were three neurosurgical refusals, due to lack of beds, particularly around the time of the move to Koala.	
490.2	SD reported the risks the Unit faced remained the same as last month: medication errors, risk of delays to patient care in complex pathways and inadequate outpatient space to deliver service. SD reported all risks were being addressed.	
490.3	Management Board **noted** the content of the report.	

491	**Surgery**	
491.1	EJ reported that it had been 14 days since the last SI. EJ also reported 19 refusal and 2 complaints. All reported complaints were under investigation.	
491.2	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.	
491.3	RB highlighted that there was a new KPI report which shows the number of appointments and whether a follow up letter has been generated and the time lapse.	
491.4	Management Board **noted** the content of the report.	
492	**Reporting Zero Harm - Quality, Safety & Transformation (QST) Update**	
492.1	RB presented the report. There were no statistically significant changes in the Zero Harm report. Clinical outcomes update gave an overview of the work that had been done on clinical outcomes over the last year or so. Highlights of progress to date included: • All clinical units had made good progress in identifying clinical outcome measures and collecting data for measurement, information on clinical outcomes was now available on the website for 20 specialities • At least 10 specialities across the hospital were using patient or parent reported outcome measures • At least 12 specialities across the hospital were using clinical outcome measures that could be benchmarked.	
492.2	Plans for 2012-13 included: • Identifying a third clinical outcome for each speciality and further publication of outcomes on the GOSH website. • Focus on collecting follow up responses to PROMs and develop a collaborative workshop for clinicians using PROMs, informed by some patient and parent focus groups. • Benchmarking scoping project was currently being explored and letters had been sent to leading Children's Hospitals across the world to seek interest in initially sharing clinical outcome measures and determining if services were comparable • Review of how specialities, clinical units and the trust was using clinical outcomes measures to inform performance • Review of the information systems used for recording clinical outcome measures	
492.3	Management Board **noted** the content of the report.	
493	**R & I Divisional Report**	
493.1	LG presented the report on R&I. LG reported the current divisional activity, governance, industry and clinical trials, clinical research facilitators, data, finance, BRC, clinical research facility, Medicines for Children Research Network, Comprehensive Local Research Network (Central and East London), UCL and forthcoming work plan.	
493.2	Management Board **noted** the content of the report.	
494	**Education Zero harm Report**	
494.1	JW presented the report. JW presented highlights of activity within Education and key performance data related to local department managers' responsibilities in relation education training and development of staff.	
494.2	JW reported on line managers' compliance with completing Personal Development Reviews (PDR), NHSLA inspection, progress with the Education dashboard and	

	increased data available through the data warehouse, changes to education and workforce commissioning, KPIs for Education, PDR rates, mandatory training, resuscitation training, information governance, safeguarding children and staff booked on training who did not attend on the day without giving appropriate prior notice.	
494.3	Management Board **noted** the content of the report.	
495	**Facilities Zero Harm Deep Dive**	
495.1 495.2	PW presented the Facilities Zero Harm Deep Dive. PW reported it had been 394 days since the last SI and the learning from it. PW presented on outpatient hand hygiene, PEAT, decontamination services, fire & security, portering services, governance arrangements and priorities for 2012-13.	
495.3	AG complimented the team on the organisation of the fire drills around the move to the Morgan Stanley Building. AG felt this was done well. AG raised concerns over the quality and price of food at the new restaurant in the Lagoon. PW stated it was work in progress. The food was partly catered by an external company and would be reviewed in a couple of months once things had settled down. SB stated that a member of Council had given feedback on the Lagoon. JC asked that SB pass it on to Anna Ferrant so that gets fed back to PW.	
495.4	**Action:** SB to ensure Anna Ferrant has feedback by a member of council regarding the Lagoon.	SB
496	**Key Performance Report March 2012**	
496.1	RB presented the Key Performance Indicator (KPI) report. The KPI report monitored progress against the Trust's seven strategic objectives and Monitor's Governance Risk Framework. The report provided 'RAG' performance analysis against defined thresholds and tolerances as well as monthly and quarterly performance trends.	
496.2	RB reported on Key performance messages: Monitor Compliance Framework 2012/13, Monitor Quality Governance Assessment Framework and 26+ week inpatient and diagnostic waits.	
496.3	Management Board **noted** the report.	
497	**Finance and Activity Report**	
497.1	CN gave a verbal update which summarised the Trust's financial performance for the year end for 2012.	
497.2	CN highlighted concerns for CRES for next year. RB gave a presentation and reported 2012/13 would be a much more challenging year financially; 2011/12 CRES was not fully delivered and 2012/13 CRES was not fully identified. NEDs had requested that we urgently develop some contingencies.	
497.3	RB presented the key messages that the Trust must deliver our CRES targets (including carry forward); Growth plans must be achieved and the Trust can not afford cost pressures.	
497.4	JC advised that there was an email to Clinical Units advising of restrictions on non-essential non pay purchases and a communication to all staff would go out by next week to all staff.	
497.5	Management Board **noted** the contents of the report.	

498	**Monthly CRES Report**	
498.1	RB asked Management Board to note progress on the CRES programme, in particular noting the current CRES position, Clinical and Corporate Units to close remaining 12/13 gap and Clinical and Corporate Units to progress current schemes to ensure earliest possible release of savings.	
498.2	Management Board **noted** the contents of the report.	
499	**Quality Account 2011-2012**	
499.1	FD asked the Board to review the Quality Account 2011-2012 First Draft. Quality Accounts were an annual report intended for the public from providers of NHS healthcare about the quality of the services they deliver. The primary purpose of	
499.2	quality accounts was to encourage boards and leaders of healthcare organisations to report on quality across all the healthcare services they offer. The Health Act 2009 required all providers of NHS healthcare services (excluding primary care and community services) to provide a quality account from April 2010.	
499.3	The layout of the Quality Account was determined by the Health Act 2009.The Trust's priorities for improvement were zero harm, demonstrate clinical outcomes and deliver excellent experience.	
499.4	FD asked that the Board come back to Lisa Davies, Robbie Burns and Martin Elliott with final feedback.	
500	**Proposal for extension and renewal of Kuwait Paediatric Haematology/Oncology contract**	
500.1	JL presented the paper. By extending the current contract with Kuwait MOH and providing additional support in other service areas in Kuwait, GOSH would deliver trust wide objectives in: • Income generation • Strengthening its position as preferred provider in paediatric haematology and oncology services for children from Kuwait • Developing its position as provider of education and training	
500.2	Management Board were asked to note the proposal for contract extension and agree to the continuation of formal contract negotiation. The Board was also asked to note the review of areas for future involvement and the work up of these proposals for Board approval.	
500.3	JC asked that thanks be given to the haematologists, particularly Drs Nick Goulden and Phil Ancliffe, who have been very effective ambassadors for GOSH.	
500.4	Management Board noted the contents of the report and **approved** the direction of travel.	
501	**Recruitment of Replacement Immunology Consultant & Flexible re-appointment of retiring consultant**	
501.1	CC presented the report. The Immunology service wished to replace Dr Graham Davies who would take flexible retirement on 31st August 2012.	
501.2	CC asked the Board to agree to recruit to this replacement Consultant post and to reappoint Dr Graham Davies to a part time post.	
501.3	It was proposed that a full time Consultant Paediatric Immunologist was appointed to	

	replace Dr Davies with an emphasis on being the lead for the inpatient clinical service.	
501.4	Dr Davies would hold a part time position with either 3 or 5 PAs (NSCG invited us to apply for 12 months of proleptic funding; the outcome of this application was awaited).	
501.5	Management Board **approved** the report.	
502	**Medical Appraisal and Revalidation**	
502.1	CC presented the report which provided an update on medical appraisal in preparation for revalidation implementation at GOSH and to seek approval for purchase of an IT support system.	
502.2	CC asked the Board to authorise funding for the purchase of a revalidation IT system (including 360 degree appraisal).	
502.3	Management Board **approved** the funding but not Admin support. This would need to be found within current resources.	
503	**Replacement Nephrology Consultant (6 PAs)**	
503.1	MH presented the paper. MH sought the Boards approval of the business case for appointment of a replacement Nephrology Consultant GOSH 5 PAs + Chelsea and Westminster Hospital NHS Foundation Trust 1PA .	
503.2	The Board discussed the Business Case and advised that reference to Chelsea's financial commitment, travel time, IPP and productivity be made clearer.	
503.3	Management Board **approved** the Business Case with those changes.	
504	**Replacement Neurosurgery Consultant**	
504.1	SD presented the case. SD reported one of the substantive 10 PA Consultant Neurosurgeons had resigned. The department would like to replace the post with another substantive Consultant post, and the job plan for this post had been reviewed and amended in light of changes to the requirements of the service. SD sought the Board's approval to proceed with recruitment of this post.	
504.2	EJ highlighted that the SPA and job plan read as 2.5. SD noted and agreed to change.	
504.3	Management Board **approved** the Business Case with those changes.	
505	**Staff Residential Accommodation**	
505.1	It was decided the Staff Residential Accommodation update would be brought back to May Management Board as WM had sent his apologies.	
505.2	**Action:** WM to bring back the Staff Residential Accommodation update to the May Management Board.	**WM**
506	**Choice of 3-T MRI**	
506.1	FD presented the paper. The recent assessment of the different options for the replacement of MR1 with a diagnostic 3-T MRI had highlighted the differing	

	requirements on the GOSH site. It was clear that a strategic decision needed to be made before the Trust could go ahead with any procurement.	
506.2	The decision was whether the 3-T replacement of MR1 was to prioritise advanced neuro imaging and research or to contribute to the flexibility/capacity of the overall Trust MR resource. Alternatively the trust might need to consider other options.	
506.3	Following any decision the Trust would still have to finalise whether the clinically preferred magnets were able to fit in the space vacated by MR1 and what the final cost would be.	
506.4	Management Board discussed the report and noted its contents.	
506.5	Management Board **noted** the contents of the report.	
507	**Report from the Business Case Review Group including Terms of Reference**	
507.1	RB presented the report. Following on from discussion at Management Board the Business Case Review Group (BCRG) was established. The group's remit was to help facilitate the process by which business cases get to Management Board. The BCRG would scrutinise proposals looking at quality, operational issues and financial risk and highlight resulting key issues to Management Board. To assist with this a scored checklist would accompany each business case.	
507.2	The checklist was in two parts. The first was to highlight whether the case contributed to the Trust strategy and financial position and whether it improved quality. The second part scored levels of demonstration in the business case (poor, limited, satisfactory, good excellent) against various criteria.	
507.3	Management Board **agreed** the Terms of Reference and noted the report of The Group's activity.	
508	**Update for Psych/Derm Business Case**	
508.1	CH presented the Business Case. Management Board considered the Psych/Derm business case in February. Questions were raised about the existing psychology resources in the Trust and how that resource was utilised. Approval of the business case was delayed pending further information about our existing psychology resource.	
508.2	It was agreed that information would be provided to March Management Board to show how the different banded psychologists were utilised, what proportion of their time was spent directly on patient care and whether the job plan included in the business case was typical. Psychology provision fell into two categories in the Trust. • Paediatric Liaison Psychology (under MDTS) • Neuro-psychology and CAMHS (under Neurosciences)	
508.3	Management Board discussed the Psych/Derm Business Case and agreed that SB would talk to Madaline Ismach around delivering the service with within the means of the current system. It was agreed that Chair's action could then be taken.	
508.4	Management Board agreed Chair's action could be taken following discussions to incorporate service in to current systems.	

509	**Tender for the supply of a Tandem Mass Spectrometer**	
509.1	CH presented the Tender. GOSH Newborn Screening Laboratory delivered a newborn bloodspot screening service for North Thames, Hertfordshire, Essex and parts of Bedfordshire, generating external income for the trust. To ensure continuity of this service and compliance with the national newborn screening standards a replacement for the laboratories' 12 year old tandem mass spectrometer was urgently required.	
509.2	Funding was agreed through CESC (ME3413) to purchase a new Tandem Mass Spectrometer. An OJEU advert was placed and six suppliers expressed an interest to tender. Tender documents were sent out and four suppliers responded. The project group then evaluated the four tender responses and decided to award the Tender to supply the new Tandem Mass Spectrometer to Applied Biosystems.	
509.3	Management Board **approved** award of the tender to Applied Biosystems to supply the new Tandem Mass Spectrometer to the Newborn Screening Laboratory.	
510	**OPD Space pressures – update**	
510.1	PW updated Management Board on the situation regarding OPD capacity, and proposed further actions to mitigate risks identified at Management Board by various Clinical Units	
510.2	PW outlined the status of the short term measures proposed in December 2011 and proposed a further bid to utilise space in the vacated cardiac wing for 12 months.	
510.3	PW requested that identified teams completed the outstanding actions from the December 2011 plan, approval for use of Cardiac Wing space for the agreed period and to note that a plan would be developed for early evening outpatient sessions	
510.4	Management Board **approved the direction of travel** of the report	
511	**Mitie Contract Extension**	
511.1	PW presented the Contract Extension. The Trusts contract for Domestic Services was originally awarded in Nov 2006 with a period of five years with the potential for 2 further 2 year extensions.	
511.2	The Trust had been working within UCLP on different options around Soft Facilities and had yet to conclude a formal option for Domestics as part of that work and MB agreed last January to extend the contract until Apr 2012 whilst that work continued.	
511.3	In order to ensure delivery of CRES targets for 2012/13 and also to deliver additional benefits it was recommended that a two year extension with Mitie.	
511.4	Management Board **agreed** the Contract Extension.	
512.	**PDR Action Plan**	
512.1	LM updated Management Board on the Trust's strategy to increase PDR rates across the Trust.	
512.2	Management Board **noted** the report.	
513	**Industrial action update**	
513.1	FD presented the paper which provided the Board with an update on planned and anticipated industrial action affecting the NHS/GOSH.	

513.2	The Government had presented to trade-unions (which represent public sector employees) final proposals on planned changes to public sector pension schemes, including the NHS pension scheme.	
513.3	Management Board **noted** the report.	
514	**Annual Safeguarding Report**	
514.1	LM provided a summary report of Trust progress, activity and achievements April 2011-March 2012 and identified areas of development for 2012-2013. Management Board were asked to ratify report, raise any issues or areas of concern report raises.	
514.2	This was the first annual report since GOSH services had reverted back to one site. It outlined the Trust work against the Safeguarding/Child Protection initiatives identified as part of the Trust objectives for Child Protection. Any additional learning from operational practice as well as local and national guidance was also included in the report. The GOSH Child Protection Action Plan (CP) 2011-2012 reflected the identified work for the year and this report highlighted progress on those identified objectives.	
514.3	Management Board **noted** the report.	
515	**Update on the implementation of the Interventional Radiology (IR) business cases**	
515.1	JCop presented the report on the two business cases for IR which was approved by Management Board in 2011. The first expanded the service and provided appropriate MDT/Clinic support. The second enabled an IR on call service to be established (including the appointment of a fifth consultant). The report was an update on progress.	
515.2	Management Board **noted** the report.	
516	**Decontamination Strategy**	
516.1	PW presented the paper. PW reported on outcomes from review of Trust Decontamination Strategy, proposals on direction of travel to continue existing arrangements around current provision of steam sterilisation as well as future options on SSD service and gave an update on UCLP Decontamination Project	
516.2	Management Board noted the outcomes from the review of the Trust Decontamination Strategy, confirmed agreement on direction of travel for the provision of SSD services offsite, noting that a formal business case will be presented in June and supported the option for Steam Sterilisation to stay at UCLH until September and to transfer to the provider approved when business case was presented in June (noting progress on UCLP Project)	
517	**Staff Survey result**	
517.1	HC gave the Board an update on Staff Survey results.	
517.2	Management Board **noted** the report.	
518	**Code of Conduct**	
518.1	AF asked the Board to acknowledge and reaffirm the adoption of the Nolan Principles, the Code of Conduct and Accountability and the Code of Conduct for NHS Managers and to cascade these to their teams.	

518.2	Management Board **noted** the report.	
519	**Electronic Document and Records Management System (EDRMS) project**	
519.1	PW updated Management Board on the progress of the project	
519.2	Management Board **noted** the report.	
520	**Education Strategic Committee**	
520.1	Management Board **noted** the contents of the above document.	
521	**Commissioners Forum and Commissioners Contract Review Group**	
521.1	Management Board **noted** the contents of the above document.	
522	**Information Governance Steering Group Meeting**	
522.1	Management Board **noted** the contents of the above document.	
523	**Policy Approval Group**	
523.1	Management Board **noted** the contents of the above document and the policies approved.	
524	**Capital and Space Planning**	
524.1	Management Board **noted** the contents of the above document.	
525	**Equality & Diversity Group**	
525.1	Management Board **noted** the contents of the above document.	
526	**Waivers**	
526.1	The Board noted the requested for approval for the waivers from the following suppliers, Medtronic, Synthes Penlon, Johnson & Johnson, Fresenius Kabi, Colibri/Synthes, Medtronic and Guymark.	
526.2	Management Board **approved** the waivers.	
527	**Any other business**	
527.1	Management Board noted the Chair's action would be taken on a Locum for IPP.	
527.2	Management Board **noted** the report.	

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th June 2012

Health and Safety Annual Report 2011 - 2012 **Submitted on behalf of** **Dr Jane Collins, Chief Executive**	**Paper No: Attachment U**

Aims / summary
The health and safety annual report provides information about health and safety incidents across the Trust, an update on involvement with external agencies and information about key work done by the health and safety team during 2011-12.

Action required from the meeting
None

Contribution to the delivery of NHS Foundation Trust strategies and plans
In line with the Trust objective of children being safe in hospital and for Zero Harm, the report identifies areas that the Health & Safety team will continue to monitor in the coming year, working with colleagues to reduce the level of incidents occurring and the associated severity.

Financial implications
Failure to comply with health and safety legislation may lead to prosecution and subsequent fines.
Increased incidents may lead to increased costs associated with investigation time/time off sick etc.

Legal issues
Failure to comply with health and safety legislation may lead to prosecution.

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?
The report has considered by the Health and Safety Committee which includes representatives from both staff side and Management representatives. It has also considered by the Quality and Safety Committee.

Who needs to be told about any decision?
All relevant staff.

Who is responsible for implementing the proposals / project and anticipated timescales?
Aidan Holmes (Health and Safety Advisor)

Who is accountable for the implementation of the proposal / project?
Aidan Holmes (Health and Safety Advisor)

Author and date
Aidan Holmes 13/06/12

Attachment U

Health and Safety Annual Report 2011 -2012

Executive Summary

The annual health and safety report provides information about health and safety incidents across the Trust for the Health and Safety Committee (HSC), an update on involvement with external agencies and information about key work undertaken by the health and safety during the previous financial year.

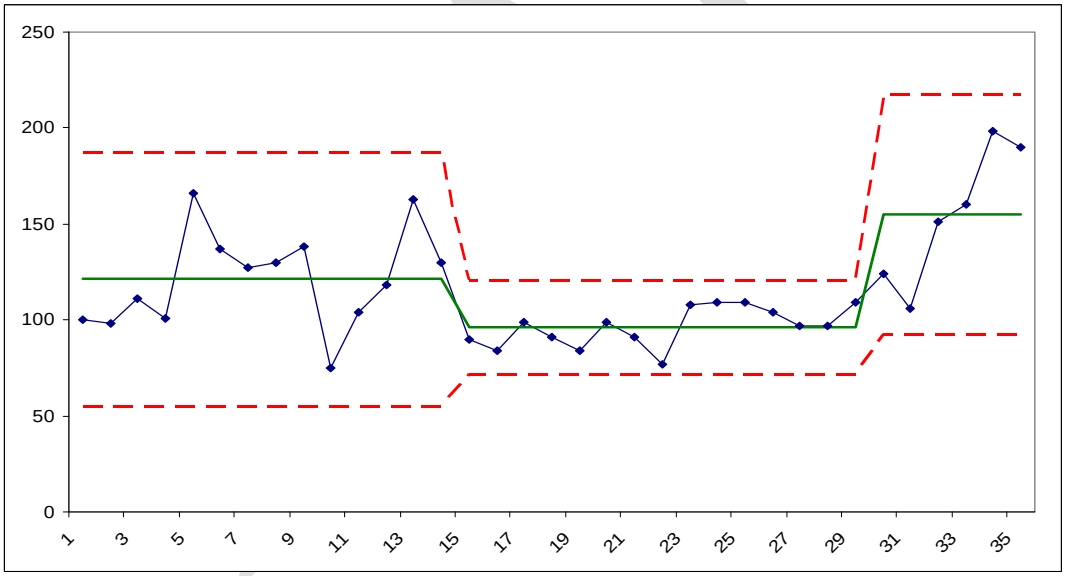
Number and severity of incidents reported (Pan Trust)

GOSH employees reported 811 health and safety incidents from the 1st of April 2011 to the 31st of March 2012 including 99 patient safety incidents.

During the period, there were:

- 7 RIDDOR reportable incidents (1 reported as severe)
- 46 incidents reported as moderate severity.
- 327 incidents reported as low harm, and
- 437 incidents reported as no harm.

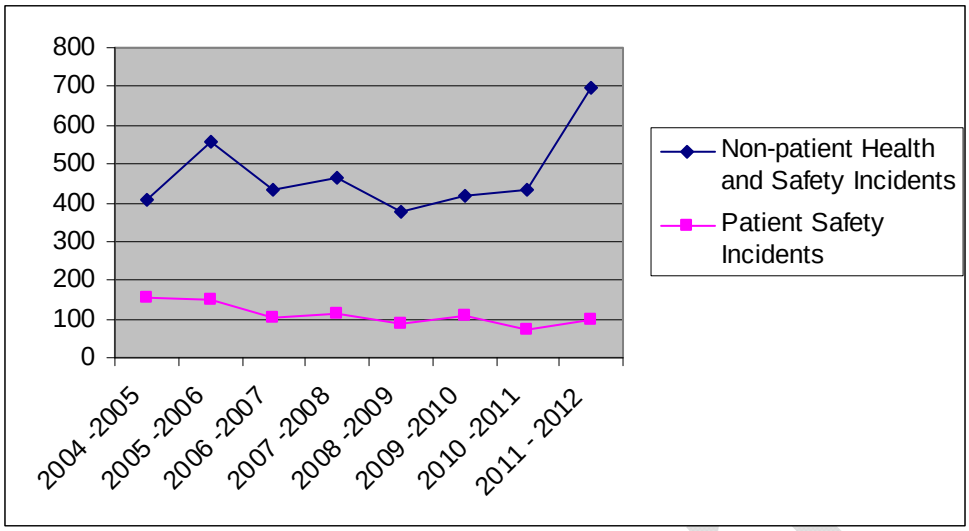
Number of Reported Incidents per quarter affecting staff/contractors and visitors(Q1 2004- Q4 2011) (Table 1)



The number of reported non-clinical incidents affecting staff, contractors and visitors has increased considerably over the past 12 months following the introduction of the new online reporting system. However, the number of patient safety incidents has remained relatively stable over the same period (see Table 2).

Attachment U

(Table 2) Reported non-clinical incidents (2004 – 2012)



Strategic Performance Review 2012

Key functions for successful health and safety management can be classified into three broad areas:

- Formulating and developing policy. This includes identifying key objectives and reviewing of progress against them.
- Planning, measuring, reviewing and auditing health and safety activities to meet legal requirements and minimise risks.
- Ensuring effective implementation of plans and reporting on performance.

The Trust must manage health and safety with the same degree of expertise and to the same standards as other core activities, if the Trust is to effectively control risks and prevent harm to people. In order to achieve this aim the key functions listed above have been built on by the Trust in the past year. These include:

- The Trust Health and Safety Policy and Lone Worker Policy have been revised.
- Each ward/area has a bespoke website which contains their local risk assessments/Control Of Substances Hazardous to Health (COSHH) assessments/safety data sheets/policies/guidance and procedures.
- New Terms of Reference have been created for all safety committees ensuring the effective monitoring of the audit and checklist cycle.
- Health and safety audit tool and cycle have been revised to ensure the Trust meets its statutory duties.
- Additional audits have been devised which include new contractors based permanently on site.
- Quarterly workshop audits have been introduced with Unison.

The Health and Safety Department continues to work closely with Estates Directorate towards improving safety culture within both the Projects and Works departments. Both departments continue to have monthly Health and Safety Committee meetings which oversee safety management/statutory compliance and quality initiatives across the Estates Directorate.

The team have worked on both the audit schedule and room checklist, improving their layout and functionality. The changes to the audit tool have been made in part to review the Trust documents and in part to monitor whether the Trust is meeting its statutory obligations.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

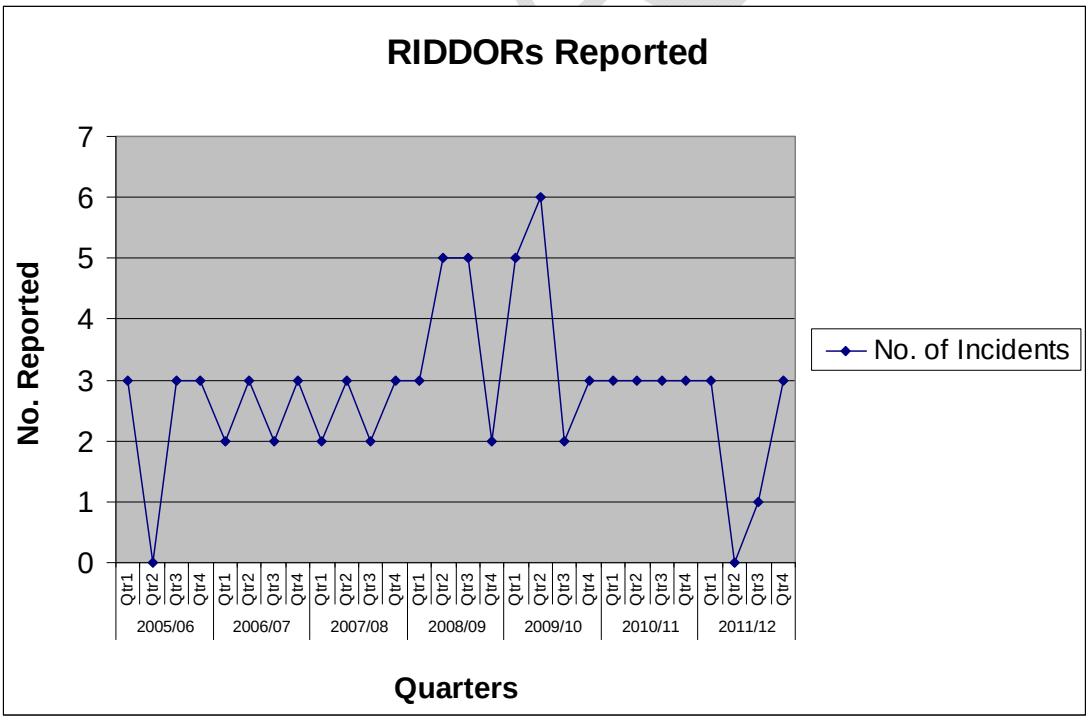
The Trust is required to report RIDDOR incidents promptly to the Health and Safety Executive (HSE). If we do not we may be subject to considerable fines. To report effectively, the Health & Safety Team (H&ST) are dependent on colleagues across the Trust to let them know immediately about any incident that is RIDDOR reportable.

The following incidents were reported as a RIDDOR.

- Violence against Works staff member > 3 days
- Pathology staff member banged head > 3 days
- ICT staff member fell causing minor fracture of wrist - Major injury
- Pharmacy staff member strained back moving boxes > 3 days
- Health Care assistant strained arm moving boxes > 3 days
- Staff member strained shoulder moving dry ice > 3days
- Play staff member fractured shoulder after slipping on wet floor. Wet floor signs in situ. – Major injury. This incident was classed as severe.

There have been 7 RIDDORS in this financial year.

Table 3: RIDDORs



Proposed changes to the Reporting of Injuries Disease and Dangerous Occurrence Regulations 1995 (RIDDOR) 6 April 2012

On the 6th of April 2012, subject to Parliamentary approval, RIDDOR's over three day injury reporting requirement will change. From then the trigger point will increase from over three days' to over seven days' incapacitation (not counting the day on which the accident happened).

Incapacitation means that the worker is absent or is unable to do work that they would reasonably be expected to do as part of their normal work.

GOSH must still keep a record of all over three day injuries.

Training and Update of safety culture at Great Ormond Street Hospital

As part of the annual report an overview of health and safety training is given below.

DATIX electronic incident reporting April 2011 - March 2012

484 staff have been trained as incident investigators to date. The training provides local teams ownership of their incidents and risks helping to bolster their safety culture.

First Aid:

- First aid at work Qualification 15
- First Aid requalifier 0 and First Aid Update 0

TOTAL = 15

Induction training

- 418 Non-Clinical
- 415 Clinical
- 28 Consultants

TOTAL = 861

Attendance of updates

- Clinical Staff (Practical) 70
- Clinical (Non Pain Pump User) 106
- Clinical Pain Pump 287
- Consultants and Junior Doctors 48
- Non Clinical and Allied Health Professionals 354
- Pulse 57

TOTAL = 922

Prevention, Treatment, Cure = 24

The Health and Safety team continue to make available bespoke health and safety training for all GOS departments.

Estates' Training

Greater emphasis has been placed on enhancing the safety culture within the whole of the Estates Directorate. Staff are openly encouraged to undertake relevant courses incorporating safety aspects. These include:

- Conflict resolution training
- Institute of Occupational Safety and Health training
- Ladder training
- Site specific generator training
- Release of trapped person training
- Asbestos Training
- High Voltage Authorised Person training
- Customer services training
- Power electronics generator training session
- Authorised Person LV (Healthcare) training
- Eclipse training (Building System Management)

Contractors cannot work on site unless they have provided all their relevant safety documentation, which is subsequently audited. They must also provide proof that that they are part of the "Safe Contractor Scheme". This is an external accreditation scheme which reviews and audits the health and safety policies, procedures and documentation of contractors requiring evidence that the contractors actually do what their procedures state. If the contractor fails to meet the criteria they are given the opportunity to resubmit, but if they fail then GOS will not use their services.

Records inspected include:

- Health and safety policy statement and management structures
- Co-operation/Co-ordination/Communication
- Emergency Procedures
- Welfare Provision
- COSHH
- Maintenance of equipment
- Health and safety training
- Risk assessment
- First aid provision
- Accident reporting and investigation
- Manual handling procedures
- Health and Safety Legal/Enforcement Action
- Selection, assessment and use of sub-contractors
- Reviews/Audits/Monitoring
- Health and Safety Advice

Annual audit cycle and specialised checklists

The audit tool has two primary functions; firstly to review the health and safety documentation to ascertain whether the Trust has the appropriate policies and procedures to ensure statutory compliance, contribute to embedding risk management into the organisation's culture and provide assurance to GOS. The progression of GOS through the tool is logical and follows the development, implementation, monitoring and review of policies and procedures.

Where deficiencies have been identified, action plans must have been drawn up and changes made to reduce the risks. These action plans and subsequent changes are monitored by local Risk Action Groups (RAGS) and assurance given by the Trust Health and Safety Committee.

Safety checklists are used to support local managers in meeting their statutory responsibilities. The Health and Safety Team use them to ensure that patients and staff are in a safe environment and also as a reminder to senior staff of their duties under the Trust's Health and Safety Policies.

There are 5 different audits undertaken:

- Estates
- Facilities
- Clinical
- Non-clinical
- Laboratory

The safety team undertake the documentation audit and assisted in all aspects of the audit tool to make the process easier and less burdensome to staff.

Results

Overall the results of the audit were positive. The team which had most attention placed on them were the Estates' team whose documentation at the time of the audit was all in place. The areas covered by the audit include:

- General safety
- Management regulations
- Provision and Use of Work Equipment Regulations 1998 (PUWER)
- Control Of Substances Hazardous to Health
- Electricity at Work and Portable appliance Testing and Fixed Installation Testing
- Pressure Systems Safety Regulations 2000
- Gas Safety and Medical Gasses
- Personal Protective Equipment
- Lifting Operations and Lifting Equipment regulations 1998 (LOLER)
- Asbestos
- Legionella
- Display Screen Equipment (DSE)
- Working at Height

The overall results were very positive for both Projects and Works, improving on the previous years results. There were some minor discrepancies between the Estates'

policies and procedures (Asbestos/Legionella/Electricity at Work) and their practical application in the workplace. Work has been undertaken to rectify any gaps which will be reflected in the 2013 results. The Works department and the Projects team have a monthly health and safety meeting incorporating legal compliance/audit/risk assessment/incidents/Root Cause Analysis which helps the department meet their audit requirements.

Internal Audit of GOSH Health and Safety System

Audit confirmed that a number of key controls and processes are in place including:

- Trust Health and Safety Policies are compliant with national statutory requirements and generally followed consistently;
- There is an incident monitoring and reporting system with issues escalated where appropriate.
- Committee lines of reporting to the Trust Board are clear and appropriate.
- Health and Safety risks are appropriately filtered from a local level to the relevant committees.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) is undertaken in an effective manner and escalated where appropriate;
- Training is provided which meets the statutory & mandatory training requirements for the Trust; and
- There is a system in place to centrally monitor and follow-up non attendance at mandatory Health and Safety training.

However, there was one issue which required management attention:

- Newly improved measures to prevent incidents during IT infrastructure projects are not yet embedded in the Trust

The Health and Safety Team now attend monthly Risk Action Groups with the IT services. Additionally, IT also attends the Projects' Monthly Health and Safety Committee.

Risk Action Groups

The health and safety team currently facilitate **17** monthly risk action groups across the corporate areas of the Trust.

Serious Incidents (SIs)

There were 2 incidents investigated an SI. This is the same amount as the previous financial year. These were as follows:

These include:

- Staff altercation (SI)
- Theft of Cable from back-up generator (SI)
- Fire in MRI (RCA)

Key Incident Groups

Breakdown of Health and Safety Incidents:

Table 4: Category of incident 2010 – 2012 (Non – patient incidents)

	2010-11	2011-12
Person collapses	10	9
Clinical care required by family member / visitor	2	5
Construction	7	23
Contact with hazard	42	49
Environmental factors	58	71
Exposure to harmful agent	30	37
Incidents relating to fires or fire alarms	5	10
Hit by/against object	51	54
Housekeeping issues	25	61
Lifting/handling injury	15	18
Lone Worker	1	3
Medical devices & equipment	10	40
Contact with needle or other sharps	51	45
Other	42	186
Slips, trips and falls	19	47
Trapped	1	6
Violence / Abuse / Harassment	49	48
Totals:	418	712

Table 5: Breakdown of Patient incident figures by sub category

	2010-11	2011-12
Collision / contact with an object	24	15
Inappropriate patient handling / positioning	2	1
Other	6	27
Contact with sharps (includes needle stick)	5	4
Slips, trips, falls	29	47
Exposure to hazardous substance	1	0
Exposure to heat	0	5
Totals:	67	99

Patient Safety Incidents

There were 99 patient safety incidents. These included:

- 1 incident graded as moderate. This involved a patient walking into a bin and banging their head.
- 47 slips, trips or falls
- 15 incidents of colliding with an object.

Key Incident Groups

Environment incidents
There were 71 issues under the environment category.

Common themes included:

- Cold/hot environment
- Lack of soap in dispensers
- Pest Issues

Slips, Trips and Falls

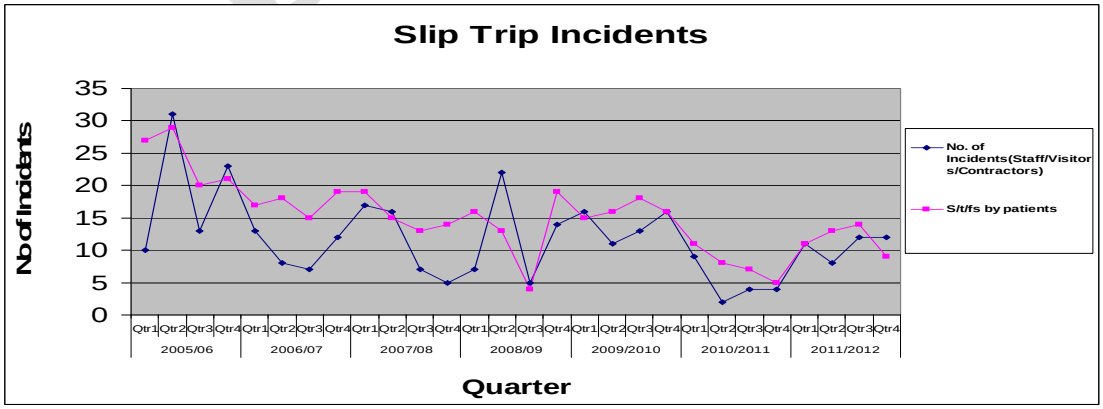
To support the systematic management of risk the Health and Safety Team have established a data base which monitors slips/trips and falls across the Trust, tracking their number and location. The number of reported slips/trips and falls had decreased significantly (See below) during the past five years. This owes much to the work undertaken by the Estates team and the use of less water by the MITIE cleaners. However there has been an increase in the past 12 months which may be attributable to the ease with which staff can report incidents following the introduction of the online incident reporting system.

As part of a Transformation Improvement Methodology Project (TIMP) the Health and Safety Assistant looked at how to reduce the number of patient falls within the Trust. After liaising with nursing staff and biomedical engineering it became obvious that there was a problem with a particular part of the beds. A defective finger guard was losing it's elasticity after washing causing it to get trapped in the locking mechanism when the bed sides were put up. This gave the impression that the sides were up and locked into place but in fact they were not. This meant that when a child leaned against the sides they would fall down and the child would fall with them. According to the Health and Safety Executive's hierarchy of control removing the hazard at source is the best way to solve the problem.

This led GOS to contact the MHRA and the manufacturer to ask if the Trust could remove the ineffective finger guards from the bed. A risk assessment was written in conjunction with the Infection Control team, Bio-Medical Engineering, the Trust's Legal team and the Health and Safety Team. The assessment was presented at the Trust's Health and Safety Committee where it was agreed to put the plan into place and monitor the number of finger entrapments. Thus far there have been none.

Slip/Trip/Falls assessments have been undertaken across the Trust and areas of concern have been investigated and tested against national guidelines.

Table 6:Slips/Trips/Falls



Sharps Injuries

The average percutaneous injury rate for non-teaching hospitals is 18 injuries for every 100 occupied beds. At GOSH it is 19.51 compared to 25.6 last year.

The formula below is the standard method used to calculate the rate of sharps injuries per 100 occupied beds over a given year. At GOSH there were a total of 45 reported sharps injuries (reported on Datix incident), a decrease on 15 on the previous year. The average bed occupancy during this period was 230.62.

Number of sharps injuries 45 x 100 = 19.51
Average bed occupancy 230.62

The largest number of incidents occurred in Theatres where there were 12 sharps injuries. 2 of these injuries were not clinical and involved someone stepping on a piece of glass and another were a staff member cut their hand on a sharp piece of metal. A TIMP project has been initiated to try to reduce the numbers of sharps injuries across the Trust.

Table 7: Needlestick Injuries per 100 occupied beds

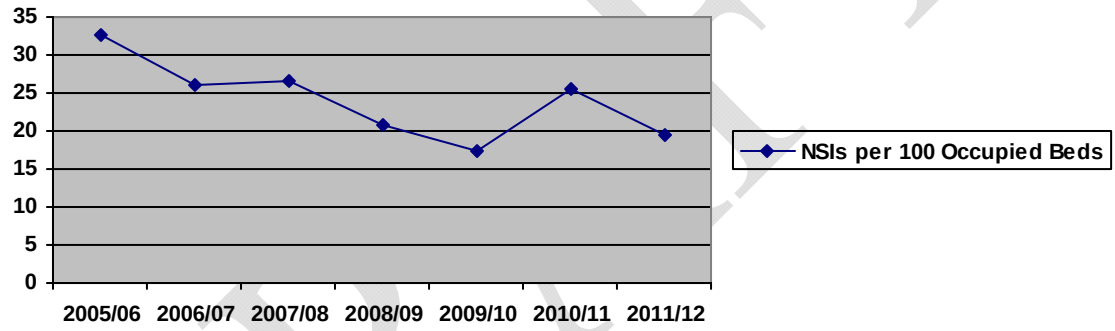
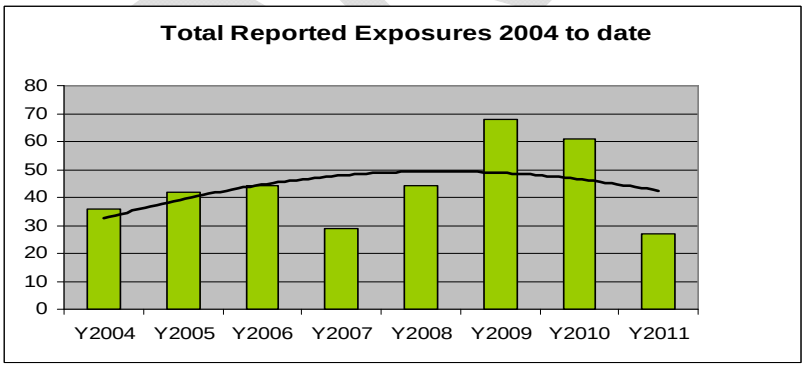


Table 8: **Total reported dirty sharps**



Violence/Abuse/Aggression

There were 48 incidents of violence/abuse or harassment reported as opposed to 49 in the previous year. 4 of these incidents were graded as moderate and these were

- Violence from one staff member to another (Reported as SI)
- Threats being made to individual staff member on the phone
- An adolescent patient attacking a doctor
- A patient attacking a student nurse on 3 separate occasions

The figures also included 11 reported assaults by patients on members of staff or visitors. 4 of these incidents were on the Mildred Creek Unit. Of these, 4 were whilst the patient was being restrained. All MCU staff receive specialist PRICE restraint training. New starters attend a 2 day course, and all staff receive annual updates.

There were 24 incidents reported concerning verbal abuse or aggressiveness. The only incident rated above low severity is highlighted above re: phone call.

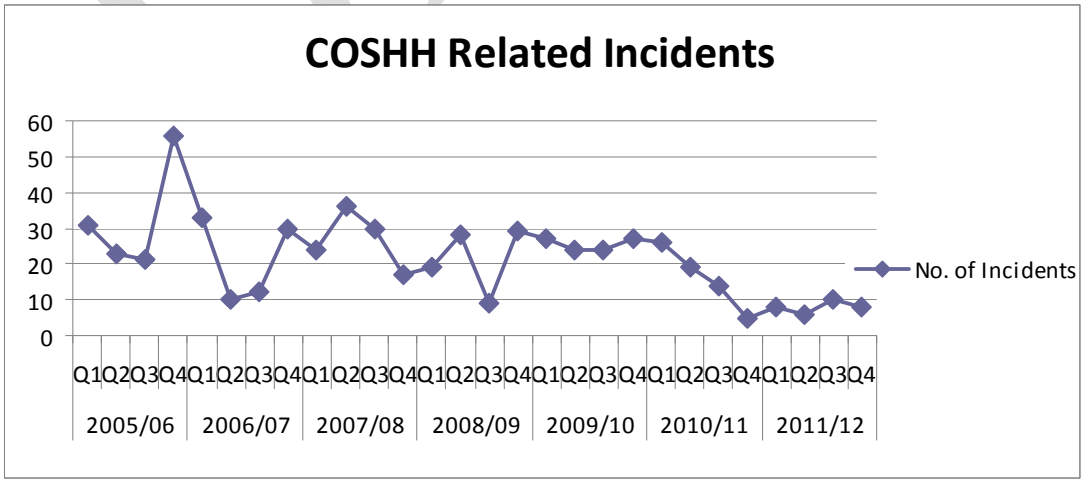
There were 0 reported incidents of sexual harassment.

There was 1 incident reported categorised as 'Other' involving threatening letters being sent to the MITIE management team.

Control Of Substances Hazardous to Health (COSHH)

Despite the overall increase in the number of incidents being reported by GOS staff, COSHH related incidents have seen a steady reduction over the past 2 years. The Health and Safety Team have taken a fresh look at the way COSHH is managed within the Trust. All COSHH assessments / Managements Safety Data Sheets / SOPs and local risk assessments have been placed on the intranet. Individual ward/area safety intranet sites have been created (excluding the Camelia Botnar Laboratories) giving local areas greater accessibility and ownership. Each area will be audited against their website content.

Table 9:



Attachment U

Appendix 1: Health and Safety Committee Annual Plan 2012/13

Agenda Item/Issue	April	June	August	October	December	Feb
Trust Audit						
Estates Department Results			✓			
Pathology Laboratory Results			✓			
Clinical Area				✓		
Non-Clinical Departments				✓		
Corporate Facilities				✓		
Checklist feedback						
Non – Clinical Checklist Feedback Report.		✓	✓			
Clinical Checklist Feedback		✓	✓			
External Agency Reports/Alerts						
CAS alerts. (NPSA/MHRA/DH)	✓	✓	✓	✓	✓	✓
HSE / Environmental Health						
Reports						
Health and Safety Annual /Quarterly Report	✓	✓Annual	✓		✓	
Fire and Security Annual/Quarterly Report	✓	✓Annual	✓		✓	
H&S walkabout results.	✓	✓	✓	✓	✓	✓
Peat Feedback (Health and Safety relevant parts)		✓				
Stress Survey Report		✓				✓
Moving and Handling Quarterly Report	✓	✓	✓ Annual			✓
Food Hygiene Report						
Works Health and Safety Committee Update	✓	✓	✓	✓	✓	✓
Projects Health and Safety Committee Update	✓	✓	✓	✓	✓	✓
CBL Health and Safety Committee Update	✓		✓		✓	
Infection Control Annual Report			✓			
Policy Ratification						
Health and Safety	✓					

Attachment U

Policy						
Control Of Substances Hazardous to Health (COSHH)		✓				
Governance Matters						
Audit recommendations update		✓		✓		✓
Annual review of Audit						✓
Review terms of reference						✓
Review of annual work-plan						✓
Review of other reports and policies as appropriate e.g. Food hygiene etc.			✓			

Attachment V

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27th June 2012	
UCL Partners Update **Submitted on behalf of** Dr Jane Collins, Chief Executive	**Paper No: Attachment V**
Aims / summary To provide Trust Board with an update on the work of UCL Partners.	
Action required from the meeting To note the UCL Partners May 2012 update.	
Contribution to the delivery of NHS / Trust strategies and plans All strategic objectives.	
Financial implications N/A	
Legal issues N/A	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision N/A	
Who is responsible for implementing the proposals / project and anticipated timescales N/A	
Who is accountable for the implementation of the proposal / project N/A	
Author and date Anna Ferrant Company Secretary June 2012	

UPDATE: May 2012

Our Integrated Cancer System continues to make strong progress with the evident commitment from patients and staff across the whole patient pathway to work together to improve outcomes – for research. This will help support the launch of our programme (June 11th) to understand why 1:4 cancer patients still present to A&E and to drive the continuous reduction of that figure so as to relentlessly improve clinical outcomes.

Our AHSP is helping to define how we can better benchmark AHSCs against national and international comparators across research, education, site specific and population based clinical outcomes – with patients feeling empowered to help drive continuous improvement. The Partnership is working with each of the existing programme areas to look how we can best develop the appropriate metrics and support delivery of these ambitions. We will continue to update as each programme is reviewed and developed (interim report available here).

As I reported in April, UCLP was delighted to welcome BHRUT to the partnership. To highlight a few initiatives already underway: early involvement of BHRUT people in planning new curricula and LETB arrangements and BHRUT's participation in the UCLP nurse leader programme. We were particularly pleased that Tom Lee from Harvard Partners (who many of you know from his work on value and New England Journal editorship), managed to combine a short trip to London as RCP's Lilly Lecturer with a seminar with clinical and other leaders at Queen's on our shared journey to improve value. UCLP is learning how we can help support alignment across the wider geography through a model that enables more direct/on site engagement with the Partners.

It is encouraging for the future that the cohesive functioning of our transitional LETB, with leadership from all the CNOs, has worked successfully with NHSLondon to improve how we support undergraduate nursing development within the partnership. Similarly the UCLP led accelerated development scheme for newly qualified nurses is now open for recruitment. These are key steps forwards for the workforce development, and will link well with the advances in medical and dental education. UCLP is looking to learn from these developments to drive forward education and training for other professions on a similar basis –in line with the Future Forum recommendations.

The UCLP Members meeting on May 21st was very well attended with broad professional, patient and geographic participation reflecting the diverse populations we serve. As previously there was considerable depth to the input in formulating our strategic plans that facilitate both strong local delivery - for example the integrated cancer system and other integrated care pathfinder programmes, and enabling these to make a greater national/international contribution to healthcare and wealth creation for our geography and beyond.

I expect that during June there will be the launch of the AHSN national programme –focused even more on delivery of innovation into practice. UCLP is well placed to bid for this work using our existing strengths and structure and will welcome local new members who share our values and challenges, as works best for patients and population benefit.

David Fish