Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
26th September 2012

Dear Members

There will be a public meeting of the Trust Board on Wednesday 26th September 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 25th July 2012**	Chair	**J**
3.	**Matters Arising / Action point checklist**	Chair	**K**
4.	**Chief Executive's Update**	Chief Executive (Interim)	**Y**
5.	**Clinical Presentation (Endocrinology)**	Professor Mehul Dattani, Specialty Lead	**L**
6.	**Quality, Safety & Transformation Update including update on Theatre Utilisation Improvement**	Co-Medical Director (ME)	**M**
	FOR APPROVAL		
7.	**Assurance and Escalation Framework**	Company Secretary	**O**
	UPDATES		
8.	**Performance Report (August 2012)**	Acting Chief Operating Officer	**P**
9.	**Finance and Activity Report (five months to 31st August 2012)**	Chief Finance Officer	**Q**
10.	**Management Board Effectiveness Review**	Company Secretary	**R**
11.	**NHSLA Update**	Acting Chief Operating Officer	**S**
	FOR RATIFICATION		
12.	**Consultant Appointments**	Chair	**Verbal**

	FOR INFORMATION		
13.	**Members' Council – Update from July and August 2012 meeting**	Chairman	**T**
14.	**Clinical Governance Committee update (July 2012)**	Ms Mary MacLeod, Chair of the Clinical Governance Committee/ Company Secretary	**U**
15.	**Final Management Board minutes (July and August 2012)**	Company Secretary	**W**
16.	**Key Monitor Correspondence**	Acting Chief Operating Officer	**Z**
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 28th November 2012 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT J

Attachment J

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board held on 25th July 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
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

Dr Anna Ferrant	Company Secretary
Miss Victoria Goddard	Trust Board Administrator (minutes)
Professor David Goldblatt	Director of Clinical Research and Innovation
Dr John Hartley	Consultant Microbiologist and DIPC
Ms Deirdre Malone	Deputy DIPC
Mr Stuart Player	Public Councillor

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

509 Apologies for absence

509.1 Apologies for absence were received from Ms Fiona Dalton, Chief Operating Officer.

510 Declarations of interest

510.1 No declarations of interest were received.

511 Minutes

511.1 403.6 – It was agreed that an update on this action would be brought to the next Trust Board meeting in September.

511.2 The minutes were **approved** with no amendments.

512 Matters arising and action checklist

512.1 Minute 443.4 – Professor Martin Elliott, Co-Medical Director reported that the Clinical Governance Committee was being fully updated on the Trust's

progress with NHSLA. He confirmed that the level three assessment would take place in the Autumn and work would be closely monitored by the Quality and Safety Committee and Clinical Governance Committee.

512.2 Ms Mary MacLeod reported that the Clinical Governance Committee had received an encouraging report at its last meeting.

512.3 Mrs Liz Morgan, Chief Nurse and Director of Education expressed some concern that staff being released to work on NHSLA would impact external assessments and CQUIN achievement.

512.4 Minute 482.16 – It was agreed that the Baroness Blackstone would hold an informal meeting with members of the Neurodisability team.

513 Chief Executive Update

513.1 Safe and Sustainable

513.2 Dr Jane Collins, Chief Executive reported that the decision around Paediatric Cardiac Surgery Centres had been made on 4th July 2012. She confirmed that commissioners had expressed a wish to continue to move forward with the original decision despite the reservations of a number of centres.

513.3 Professor Martin Elliott, Co-Medical Director reported that the Cardiac site in Leeds which had been decommissioned had requested that the decision be reconsidered in light of additional ECMO specialists being employed at the centre. He confirmed that Leeds would contact the Health Overview and Scrutiny Committee.

513.4 Dr Collins confirmed that a group, chaired by Dr Andrew Mitchell, Medical Director of NHS London had been established to discuss implementation. The group would be attended by Dr Collins or Ms Fiona Dalton.

513.5 Director of Redevelopment Role

513.6 Dr Collins confirmed that negotiations were on-going to appoint a Director of Redevelopment. She added that Natalie Robinson, Deputy Director of Redevelopment would be acting up into the role.

513.7 Dr Collins reported that the 2B Business Case would be submitted to Monitor for consideration at their August meeting. She confirmed that Monitor were aware that the Trust did not yet have a signed finance agreement and proposed that momentum on 2B was maintained and plans were considered at the next Finance and Investment Committee meeting.

513.8 Ms Claire Newton, Chief Finance Officer confirmed that the Trust Board would be required to sign a Governance Statement. She added that Monitor was seeking legal advice as to whether it was appropriate to review the 2B business case before the completion of procurement. She added that if it was not considered, £13m would be spent at risk prior to procurement completion.

513.9 Olympic Planning

513.10 Dr Collins confirmed that preparations were in hand for service provision during the Olympics. She reported that the cardiac wing was being used as additional storage and accommodation was being made available for families.

513.11 Dr Collins reported that departments had noted a greater number of families cancelling appointments during the Olympics, possibly due to worries about travel in London.

513.12 Baroness Blackstone suggested that the Trust was proactive in sending information to families requesting that appointments were kept.

513.13 The Trust Board **noted** the update.

514 Quality, Safety and Transformation Update

514.1 Professor Martin Elliott reported that there had been no adverse changes in the period since the last report other than a minor increase in the number of Serious Incidents.

514.2 He reported that work was on-going on the benchmarking project to confirm GOSH's position as one of the top five children's hospitals in the world.

514.3 It was confirmed that letters of agreement had been received from all competitors who had been approached to take part in the benchmarking exercise.

514.4 Baroness Blackstone asked why there had been a delay in publishing clinical outcome measure positions on the GOSH website.

514.5 Dr Collins reported that the Members' Council had provided feedback that the information was not accessible and asked that it was presented in a different way.

514.6 The Board **noted** the update.

515 Revised Trust Board Terms of Reference

515.1 Dr Anna Ferrant, Company Secretary reported that the Terms of Reference for the Board were being reviewed due to NHSLA requirements.

515.2 She confirmed that reporting and monitoring arrangements must be reference as well as the minimum number of meetings to be attended by Directors.

515.3 The following amendments were agreed:

- Directors' expected attendance to be reduced to 7 meetings per year
- Section 5 to read 'Directors are expected to attend…'
- The Company Secretary to be removed from the list of Directors who were entitled to remain during confidential business

The Terms of Reference were **ratified** subject to the above amendments.

515.4

516 Infection Control Report including Annual DIPC Report

516.1 Ms Deidre Malone, Deputy DIPC reported that each Clinical Unit now had an infection control structure in place.

516.2 It was reported that a rise in infection rates continued to impact the Trust in terms of patient flow, however from four cases of MRSA reported in 2011-12, it had been confirmed that only one case would have been preventable.

516.3 Discussion took place around the need to ensure enough staff were present to enable robust infection surveillance.

516.4 The Board was informed that modelling was being conducted to determine the costs of different methods of infection surveillance. Management Board would review these costings and agree a way forward.

516.5 The Trust Board **approved** the Infection Prevention and Control action plan.

517 Update with progress on research strategy and UCLP research

517.1 Professor David Goldblatt, Director of Clinical Research and Development reported that funding was awarded for a Biomedical Research Centre in Summer 2012 and as a result, amendments had been made to the research strategy.

517.2 It was reported that more emphasis had been placed on research into rare diseases and that the Trust was now in a strong position regarding rare disease research.

517.3 It was noted that the strategy would be submitted to the National Institute for Health Research once the new ICH Director had taken up her position on 1st October 2012.

517.4 Mr David Lomas, Non-Executive Director queried whether the five research focused KPIs concentrated on the correct areas.

517.5 Professor Goldblatt reported that the KPI metrics were in place in the absence of targets which were being developed.

517.6 It was agreed that a report would be considered at the September meeting of the Trust Board on the redevelopment of the Computer Centre (phase 3A).

517.7 **Action:** A report to be considered at the September Trust Board meeting on the redevelopment of the Computer Centre (phase 3A).

518 PDR Update

518.1 Mrs Liz Morgan, Chief Nurse and Director of Education reported that work was on-going to increase the level of PDRs completed. This wasan important

exercise in light of the NHSLA target of 95%.

518.2 She reported that information was now more accessible to units and she and the Chief Operating Officer had been working together to ensure that Clinical Units were aware of expectations around PDR completion. Mrs Morgan added that staff were becoming more engaged in the work as a result.

518.3 It was agreed that quarterly updates would be reviewed at Trust Board.

518.4 **Action:** A PDR update to be reviewed quarterly by Trust Board (Company Secretary).

518.5 Mr John Ripley, Non-Executive Director queried the number of staff on which the percentage of PDR completion was based. He stressed the importance of ensuring that the correct population of staff who were eligible for PDRs was being measured.

518.6 Dr Collins reported that figures did not include consultants and it was agreed that Mrs Morgan would update the Trust Board in September as to the population of staff being measured.

518.7 **Action:** Mrs Liz Morgan to update the Trust Board in September as to the population of staff being measured.

518.8 Professor Andy Copp suggested that the appraisal requirement for managers be re-evaluated. He reported that UCL had in place a notional maximum number of PDRs which managers were expected to carry out. He added that senior manager should be protected from carrying out a large number of PDRs.

518.9 Dr Barbara Buckley reported that doctors should be responsible for a minimum of three and a maximum of 6 reviews annually but acknowledged that individuals often carried out more.

518.10 Mr Charles Tilley, Non-Executive Director queried why this had continued to be an issue despite on-going work. He stressed that the importance of PDR completion must be emphasised.

518.11 Mrs Morgan reported that previously the value of PDRs had not been sufficiently emphasised.

The Board **noted** the update.

518.12

519 Performance Report (June 2012)

519.1 Mr Robert Burns confirmed that the Trust's Monitor Governance Risk Rating for Quarter 1 was expected to be reported as 'green'.

519.2 He brought to the Board's attention the level MSSA infections reported in year to date. He confirmed that two infections had developed outside GOSH and that the majority of GOSH acquired infections were related to peripheral or central lines. He stressed that each reported case had an associated Root Cause Analysis and action plan.

519.3 Mr Burns reported that clinic letter turnaround times were not acceptable. He reported that some patients would not require a clinic letter and confirmed that work was on-going to ensure that these areas were not being included in statistics. He added that a project had begun working across the whole organisation and feedback was being sought from referrers around the time taken to receive letters.

519.4 It was confirmed that there had been a high number of patient refusals in month which were clustered around times of staff sickness.

519.5 Mr Burns reported that a planned improvement trajectory for theatre utilisation in every specialty would be considered at the Trust Board meeting in September.

519.6 **Action**: A planned improvement trajectory for theatre utilisation in every specialty to be considered at the Trust Board meeting in September.

519.7 Dr Collins expressed some concern that refusals may rise due to an increase in international/ private patient (IPP) outliers. It was agreed that the next report would incorporate monitoring of IPP outliers and an analysis of trend data.

519.8 **Action:** Future performance reports to incorporate monitoring of IPP outliers and an analysis of trend data.

519.9 The Board **noted** the report.

520 Finance and Activity Report

520.1 Ms Claire Newton, Chief Finance Officer reported that discussions had taken place with commissioners since the Finance and Activity report had been finalised. She confirmed that commissioners were unable to increase prices for services which were currently commissioned.

520.2 Ms Newton confirmed that this had led to a funding gap of around £1m. She added that a Chief Executives' meeting would take place and it would then be decided whether or not the Trust would go to arbitration.

520.3 It was noted that Neurosciences had a £6k variance and not a £900k variance as shown in the report.

520.4 Ms Newton confirmed that the IPP cap would officially be released from 1st October 2012 and added that as a consequence it would not apply for the financial year 2012/13.

520.5 Mr Martin Elliott asked how the Trust would be seeking to recover the commissioner induced shortfall of £1m.

520.6 Ms Newton confirmed that it would be formally discussed at Finance and Investment Committee but suggested that an over performance of IPP would ensure the Trust's overall performance was unaffected.

520.7 Ms Yvonne Brown, Non-Executive Director queried the overall impact on funding when responsibility for commissioning was taken on by GP Consortia.

520.8 Ms Newton reported that the transfer of commissioners was taking place over two years. She confirmed that the commissioning for a minority of services would transfer in 2012/13 and that the 2013/14 trajectory of transfer was still being completed.

520.9 It was agreed that Ms Mary MacLeod would receive information around what would be expected from members of the IPP Strategy group.

520.10 **Action:** Ms Mary MacLeod to receive information outside the meeting around what would be expected from members of the IPP Strategy group.

520.11 Mr John Ripley, Non-Executive Director expressed some concern that a number of invoices for IPP work remained unpaid beyond the due date.

520.12 Ms Newton confirmed that deposits were received in advance, but added that final balances often remained unpaid beyond the due date.

520.13 It was agreed that Ms Newton would provide information at the next meeting around the value of deposit payments relative to the total cost of treatment.

520.14 **Action:** Ms Newton to provide information at the next meeting around the value of deposit payments relative to the total cost of treatment.

520.15 Baroness Blackstone queried the amount of debt written off in IPP and Ms Newton reported that it was a small amount which was monitored by the Audit Committee.

520.16 It was agreed that the levels of overdue debt would be discussed at the next meetings of the Audit Committee and Finance and Investment Committee.

520.17 **Action:** Levels of overdue debt to be discussed at the next meetings of the Audit Committee and Finance and Investment Committee.

520.18 It was agreed that an analysis of the contribution of IPP, GOSHCC and education would be discussed at the Trust Board away day in October.

520.19 **Action:** The Company Secretary to ensure that an analysis of the contribution of IPP, GOSHCC and education to be discussed at the Trust Board away day in October.

520.20 It was agreed that future Finance and Activity reports would focus on demonstrating relationships using bridge charts.

520.21 **Action:** It was agreed that future Finance and Activity reports would focus on demonstrating relationships using bridge charts.

521 PALS and Patient Experience Report Q1 2012-2013

521.1 Mrs Liz Morgan reported that there continued to be a high level of contact with PALS in relation to the Gastroenterology service. She confirmed that a project was in place which sought to monitor issues but it was too early to determine whether a noticeable difference had been made to outcomes for families.

521.2 Mrs Morgan reported that the limited supply and cost of items in the hospital shop was a real issue for families. She confirmed that the level of required progress had not been made.

521.3 It was reported that new issues which had arisen had a focus on communication particularly within Physiotherapy and had led to a number of projects around the way the team communicates.

521.4 Mrs Morgan reported that the Prime Minister's 'Friends and Family test' had proved difficult to implement and resource intensive in pilot centres. She added that it was likely that patients who were 16 years old would be removed from the survey in 2013.

521.5 Dr Jane Collins expressed concern about the lack of efficiency involved in a meeting with a family attended by six physiotherapists, as detailed in the PALS report.

521.6 It was agreed that in future PALS reports activity would be weighted by unit.

521.7 **Action:** Future PALS report to include activity weighted by unit.

521.8 The Board **noted** the report.

522 Update on issues identified in the Monitor Side Letter

522.1 Mr Robert Burns reported that of 17 recommendations contained in the Monitor Side Letter, 11 had been completed and 6 were in progress. He confirmed that the Trust was on target to meet the deadline.

522.2 It was agreed that the Chief Executive and the Chief Finance Officer would ask Deloitte to audit the completion of the recommendations.

522.5 **Action:** The Chief Executive and the Chief Finance Officer to ask Deloitte to audit the completion of the recommendations.

522.6 The Trust Board **noted** the update.

523 ICU Review Recommendations

523.1 Dr Barbara Buckley reported that a lot of time had been spent at Management Board reviewing feedback from the ICU review and recommendations made.

523.2 It was reported that Professor Martin Elliott was working with commissioners around lack of capacity as this had been one of the issues identified. It was confirmed that commissioners supported the proposed recommendations and the potential outcomes.

523.3 The Board noted the report.

524 CQC Registration overview

524.1 Dr Anna Ferrant reported that no risk estimates had been rated either red or amber. She confirmed that the Clinical Governance Committee continued to monitor the factors which made up the risk estimates.

524.2 The Trust Board **noted** the update.

525 Trust Board members' activities

525.1 Baroness Blackstone, Chair reported that she had attended the UCL Partners meeting. Discussions were around adult cardiovascular provision and the development of a centre of excellence.

525.2 Baroness Blackstone confirmed that the interviews for the role of Chief Executive would take place on 26th July 2012. She reported that 4 candidates had been shortlisted and had spoken to informal stakeholder panels that morning. She added that feedback would be received from Chair of each panel following the Trust Board meeting.

525.3 The Board **noted** the update.

526 Register of Seals

526.1 The Trust Board **ratified** the use of the Company Seal.

527 Clinical Governance Committee effectiveness

527.1 Dr Anna Ferrant, Company Secretary reported that the Committee worked to its Terms of Reference. She confirmed that some amendments to the Terms of Reference had been approved at the last Clinical Governance Committee meeting.

527.2 The Board **ratified** the amendments to the Terms of Reference.

528 Risk Management Update

528.1 The Company Secretary confirmed that papers provided were to inform the Board.

528.2 Mr Charles Tilley reported that the Audit Committee had taken part in an extraordinary meeting around risk on 24th July 2012.

528.3 The Board **noted** the Risk Management update.

529 Any other business

529.1 Ms Yvonne Brown, Non-Executive Director queried the corporate social responsibility (CSR) activities which members of staff took part in.

529.2 Dr Collins reported that clinicians and other individuals took part in projects but there was not a project endorsed by the Trust as a whole.

529.3 It was agreed that this would be discussed at the Trust Board Strategy Away Day in October.

529.4 **Action:** CSR activities to be discussed at the Trust Board Strategy Away Day in October.

529.5 Baroness Blackstone, Chair, noted that this would be Jane Collins' last Trust Board meeting as Chief Executive.

529.6 Baroness Blackstone thanked Dr Collins for all her work for the Trust and the Charity. The Board added their appreciation for her enormous contribution to the Trust and the way in she had worked with the Board members.

ATTACHMENT K

Attachment K

TRUST BOARD - ACTION CHECKLIST
September 2012

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
517.7	**25/07/12**	A report to be considered at the September Trust Board meeting on the redevelopment of the Computer Centre (phase 3A).	**FD**	**September 2012**	Discussions will take place outside of the meeting
518.4	**25/07/12**	A PDR update to be reviewed quarterly by Trust Board (Company Secretary).	**AF and RB**	**September 2012**	Incorporated into the Performance Report on a quarterly basis
518.7	**25/07/12**	Mrs Liz Morgan to update the Trust Board in September as to the population of staff being measured for eligibility for PDRs.	**LM**	**September 2012**	Actioned – verbal update
519.6	**25/07/12**	A planned improvement trajectory for theatre utilisation in every specialty to be considered at the Trust Board meeting in September.	**RB**	**September 2012**	On agenda under Quality, Safety and Transformation Update
519.8	**25/07/12**	Future performance reports to incorporate monitoring of IPP outliers and an analysis of trend data.	**RB**	**On-going**	Incorporated into the Performance Report
520.1	**25/07/12**	Ms Mary MacLeod to receive information outside the meeting around what would be expected from members of the IPP Strategy group.	**TC**	**July 2012**	Information provided and Strategy Group met in early September 2012
520.14	**25/07/12**	Ms Newton to provide information at the next meeting around the value of deposit payments relative to the total cost of treatment.	**CN**	**September 2012**	There is a standardised process for estimating the value of deposits requested from self-pay private patients based on the expected treatment plan. Each patient account is monitored and if there is an indication that the treatment is extended, a further deposit is requested. The aim is to ensure that

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
					treatment is paid in advance. There is also an escalation process for non-payment of deposits.
520.17	**25/07/12**	Levels of overdue debt to be discussed at the next meetings of the Audit Committee and Finance and Investment Committee.	**CN**	**October 2012**	On Audit Committee agenda for October 2012
520.19	**25/07/12**	The Company Secretary to ensure that an analysis of the contribution of IPP, GOSHCC and education to be discussed at the Trust Board away day in October.	**AF**	**October 2012**	Agenda for away day to be confirmed
520.21	**25/07/12**	It was agreed that future Finance and Activity reports would focus on demonstrating relationships using bridge charts.	**CN**	**2013**	This will be considered as part of planned changes to the financial reports later in the financial year.
521.7	**25/07/12**	Future PALS report to include activity weighted by unit.	**LM**	**Ongoing**	Incorporated into future PALS Reports
522.5	**25/07/12**	The Chief Executive and the Chief Finance Officer to ask Deloitte to audit the completion of the recommendations made in the Monitor Side Letter.	**FD&CN**	**September 2012**	Monitor Side Letter update report on agenda
529.4	**25/07/12**	The Company Secretary to ensure that Corporate Social Responsibility activities are discussed at the Trust Board Strategy Away Day in October.	**AF**	**October 2012**	On draft October Strategy Day agenda

ATTACHMENT Y

Chief Executive Update to Trust Board - September 2012

1. Operational & Compliance Issues

a. Olympics

Major logistical issues were not experienced by the hospital during the Olympics. However some families did cancel at short notice and activity levels were lower than usual, so we will need to catch up on this work in the next few months.

b. Q1 Monitor Submission

Our Trust submission for Quarter 1, 2012/13 declared ourselves as Green for Governance, with no breaches. Unfortunately we had misunderstood the requirements, believing incorrectly that performance related to the entire quarter.

Although we did meet all targets across the quarter, we failed one target (92% of incomplete pathways at 18 weeks or less) in April, only achieving 91.8%. This should have been declared to Monitor and we have apologised to them for not doing so.

This breach has changed our position to Amber-Green for Quarter 1.

We have achieved this target in all subsequent months and have robust plans to continue to do so.

c. Annual Plan Review

The Monitor team reviewed our submitted Annual Plan, and concluded that they did not need to undertake a detailed review on GOSH this year. Their letter and summary of their view of our plan are on the Board agenda for information.

d. NHSLA

Our NHSLA Level 3 assessment is in November, and the team are working extremely hard to prepare for this. A helpful mock assessment was held in September.

e. Directors

Following interview in August, Matthew Tulley has now been formally offered the role of Director of Redevelopment and he will be starting at GOSH on the 3rd December 2012.

2. Redevelopment

a. Progress on 2B and 2B Enabling Business cases

The Monitor assessment team have now concluded their initial review of the 2B Business Case, and have submitted their work to their compliance committee. We have not yet heard an outcome from this.

Productive discussions have been held with GOSH Children's Charity (GOSHCC) and the Royal Bank of Scotland about the Finance Agreement, and I can update the Trust Board verbally on this.

b. 3A Computer Centre

University College London (UCL) were successful in the first round of bidding, and subsequently submitted a final bid to the Higher Education Funding Council for England (HEFCE) for £10 million capital towards the creation of the Rare Diseases Centre. As part of this bid HEFCE requested evidence of a long term lease for the proposed site and GOSHCC

received formal advice that if they leased space direct to UCL, they could avoid VAT on the capital costs (approx. £9 million saving).

GOSHCC therefore asked for our views and following discussions with Graham Hart, UCL Dean a decision was made by the Chair and Interim CEO that we would indicate that we would be comfortable with a direct lease from GOSHCC to UCL for 25 years for up to 50% of the space, to enable them to conduct research for the direct benefit of GOSH children through clinical applications. Should the plans for the Rare Diseases Centre evolve further to entail UCL requiring more space than this within the Computer Centre, then we will discuss this with UCL and would expect a corresponding release of space by UCL to GOSH on the island site.

We believe that this is a reasonable position for all parties. It provides extra space for both UCL and GOSH to enable expansion, provides major financial benefits in VAT savings and avoids GOSH being exposed to any commercial risks in the GOSHCC/UCL agreement.

3. Other Strategic Developments

a. Neurosurgical Network

A formal expression of interest was submitted to specialist commissioners for a "Children's Neuroscience Network for the Neurosurgical Child" between GOSH Foundation Trust (FT) and Cambridge University Hospitals NHS Foundation Trust. It is planned that this network will serve North Thames and Eastern England, providing excellent care for children with neurosurgical conditions and will also work with Major Trauma Centre partners, Barts Health NHS Trust and Imperial College Healthcare NHS Trust, and with University College London Hospital NHSFT as a joint Cancer Centre.

The development of this network offers major opportunities for improving care for children, and expanding the work of GOSH's neurosurgical team.

b. Cardiac Safe and Sustainable

Professor Deidre Kelly has been appointed Chair of the National S&S Implementation Advisory Group. A Steering Group has now been established, led by the Specialist Commissioners and including CEOs of GOSH, Guys and St Thomas' and the Royal Brompton and Harefield, to implement the Joint Consultative Committee decision in London. Within GOSH, we have established an implementation group to ensure that we are ready to make the changes by April 2014, as agreed nationally.

c. R&D league tables

The National Institute for Health Research (NIHR) have developed a league table of NHS Trust research participation. They report that out of 19 acute specialist trusts, GOSH is ranked third (behind the Marsden and the Christie) for number of recruiting studies.

Fiona Dalton

Interim Chief Executive

ATTACHMENT L

Great Ormond Street Hospital for Children NHS Foundation Trust

Specialty – ENDOCRINOLOGY

General Background

Aim
We aim to provide a world class endocrine and diabetes service and seamless management from infancy to adulthood.

Service structure
The Endocrine and Diabetes Service is run jointly between UCLH and GOSH, and forms the London Centre for Endocrinology and Diabetes. All complex endocrinology and diabetes, IPPs and children <12 years are seen at GOSH. Endocrine disorders in children >12 yrs, all type 1 diabetes and gender identity problems are seen at UCLH. Inpatient activity is on Kingfisher (admissions for investigation of endocrine patients) and on Rainforest (long stay Congenital Hyperinsulinism and Endocrinology patients).

Referral pattern
Patients are referred from all over the UK for tertiary/quaternary opinions. Referrals from outside the UK include those from Europe, Middle-East, India, and the Far East.

Link to research
There are strong links with the Developmental Endocrinology Research Group in the Clinical Molecular and Genetics Unit at ICH.

Service lead
Endocrinology and Diabetes sit within the Medicine and Diagnostic and Therapeutic Services Clinical Unit. The clinical service and academic team are led by Professor Mehul Dattani. Many of the staff have joint academic and clinical posts. We are strongly supported by our CNS team.

Types of patients
Patients seen at GOSH include the following diagnostic categories:
Complex growth disorders
Septo-optic dysplasia (largest international cohort) and other forms of hypopituitarism
Thyroid disorders (largest UK cohort of patients with congenital hypothyroidism)
Adrenal disorders (largest cohort of patients with congenital adrenal hyperplasia)
Pubertal disorders
Disorders of Sex Development (a unique and highly acclaimed service)
Congenital Hyperinsulinism (a major NCG-funded centre, again highly feted)
Neuroendocrine tumours and late effects of cancer treatment
Calcium disorders (a unique resource within the UK)
Complex and rare forms of Diabetes Mellitus.

Case-mix
Many patients within our service require multi-disciplinary involvement. In addition to the large cohort of patients with primary endocrine disorders, the endocrine and diabetes service support many other specialities, including Oncology, Haematology, Neurosurgery, Neurodevelopment, Nephrology, Immunology, Gastroenterology, Metabolic Medicine and Ophthalmology. The demands on the service are therefore significant.

The NCG-funded service for patients with Congenital Hyperinsulinsim requires intensive and high dependency management of patients, particularly as an inpatient.

The Disorders of Sex Development Service exemplifies the need for a multi-disciplinary approach as it manages patients with conditions affecting their gender and sexual identity.

The Department receives patients from the Regional Newborn Screening Programme for Congenital Hypothyroidism and manages a large cohort of these patients.

The Calcium Service provides expertise for rare and complex disorders of bone and calcium metabolism.

Demands for endocrine inpatient input are high in patients with pituitary disease such as Septo-Optic Dysplasia and neurosurgical problems (e.g. brain tumours). Similarly diabetes input is critical for supporting the transplant, oncology and cystic fibrosis services. The recent appointment of a diabetes CNS has contributed significantly to an improvement in diabetes care across the trust, and enhanced the safety of patients.

Medical treatment consists of hormonal replacement therapies, which often require child and family education and support, particularly for those requiring injections or use of pumps. Regularly our patients will require interventional radiology or surgical intervention, for example removal of pancreatic tissue in patients with Congenital Hyperinsulinism and removal of endocrine tumours.

Consultants

	GOSH PAs	UCLH Pas	ICH PAs
Professor Mehul Dattani	6		6
Professor Peter Hindmarsh	1	5	6
Dr. John Achermann			10 Wellcome Trust
Dr. Rakesh Amin	5		5
Dr. Caroline Brain	6	4	
Dr. Khalid Hussain	5 (NCG)		5
Dr. Catherine Peters	10	1	
Dr. Helen Spoudeas	2	8	

CNS team (5WTE).

	Endocrine	CHI	Diabetes
Shirley Langham	√		
Carly Redington	√		
Abigail Atterbury	√		
Louise Hinchey	√	√	
Claire Gilbert		√	
Kate Morgan		√	
Samantha Drew			√

Activity (Year to date at month 5):

INPATIENTS

All FCEs	593
Daycase FCEs	261
Inpatient FCEs Emergency	3
Inpatient FCEs Elective	329

OUTPATIENTS

All Attendances	1814
New Attendances	271
Follow Up Attendances	1543
New: Fup ratio	5.69

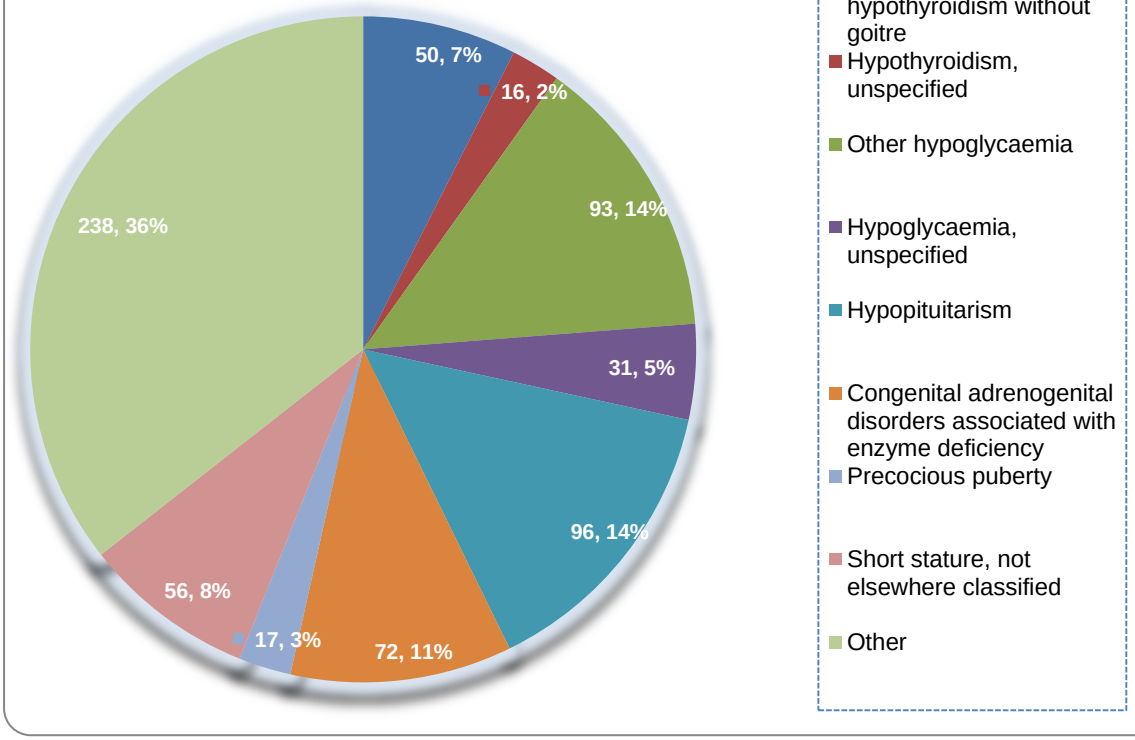
Outreach activity:

Canterbury
Dublin
Ealing
Lister
King George's Ilford
Kingston
Malta
Mayday
North Middlesex
Northwick Park
Southend
West Middlesex
Whittington

Planned: Luton, Colchester

Diagnostic mix

Patient episodes by top 10 primary diagnosis (Apr 12 - present)



Clinical Outcomes

Current
Time to normalisation of TSH in children with congenital hypothyroidism
Time to treatment of children with hypothyroidism
Congenital Hyperinsulinism inpatient stay
Participation in National Paediatric Diabetes Audit
Process outcomes within Diabetes Service relating to complications monitoring and diabetes control measures
Audit measures for hyperglycaemia in hospital and type 2 diabetes mellitus

Future
Long-term growth (height, weight) – plans to link to electronic RCPCH Red Book
Cognitive (educational attainment) outcomes for all children with chronic endocrine and diabetes conditions – applicable to all GOSH specialties
Congenital Hyperinsulinism surgical complications
Errors related to insulin management
Patient reported outcomes and experiences; for example as part of submission to the National Paediatric Diabetes Audit.

Ambitions
To be the best clinical and academic Centre of Paediatric and Adolescent Endocrinology nationally and internationally. The service would be centred around a dedicated investigation unit in order to increase activity through the provision of open tertiary diagnostic endocrine services. Additional capacity would allow the creation of a service on a single site, allowing seamless transition of patients from childhood through adolescence to adulthood.

To combine delivery of UCLH and GOSH Diabetes outpatient services onto a single shared site in order to maximize our skill set and provide an environment for holistic diabetes care and a platform for delivery of novel diabetes therapies, including islet cell transplantation and immunotherapy.

To be the chosen provider nationally for paediatric endocrinology and diabetes services

To develop a state-of-the-art IT system that will generate efficiencies of service delivery and optimal patient experience from admission to discharge. Safety of patients will also improve and this initiative would fulfill the “No waits, no waste and no harm” policy of the Trust. This would be an invaluable tool applicable to all GOSH specialties.

To develop better access systems for patients and families to training, education and services e.g. self-booking using technologies such as web based patient portal and mobile phone apps thereby fulfilling the concept of “Nothing about me without me”

To become the leading centre for research into Paediatric Endocrinology and Diabetes internationally.

To become a training centre for future clinical and academic doctors and nurses and allied professionals and to establish a sustainable and novel postgraduate endocrine and diabetes educational programme that will appeal to the wider Endocrine community.

Current research
Main areas include:
Disorders of forebrain, eye and pituitary development
Growth disorders
Thyroid disorders
Disorders of sex development
Adrenal disorders
Congenital hyperinsulinism

Research Output
1. 209 publications in last 5 years – these include Nature Genetics, JCI, Science, NEJM, BMJ, Brain, PNAS, Human Molecular Genetics, American Journal of Human Genetics, JCEM
2. Funding: in excess of £3 million from Wellcome Trust, MRC, GOSH Children's Charity

Safety & Risk

4 risks identified 2012
1. Insufficient diabetes diagnostic resources leading to prolonged inpatient stay (low)
2. Lack of qualified personnel to teach families of diabetic children use of equipment / how to perform blood glucose tests (low)
3. Lack of dedicated person to ensure staff training is up to date regarding prescription and administration of insulin as per NPSA (low)

Points 1-3 addressed by appointment of Diabetes CNS and current development of hospital-wide education programme for the safe use of insulin a step commended by the DQUINS Peer Review Report 2012

4. Delay in communication of results from inpatient stays (medium)

Point 4 currently being addressed with business case to Technical delivery board for development and introduction of IT system to improve co-ordination, efficiency and communication of endocrine inpatient admissions

Patient Experience

Involvement with patient support groups
Congenital Hyperinsulinism
Child Growth Foundation
Congenital Adrenal Hyperplasia
Diabetes UK
Juvenile Diabetes Research Foundation
Children with Diabetes

Peer review
Diabetes services across UCLH and GOSH were reviewed by a national peer review panel and found to provide a high quality standard of care with no major or minor concerns regarding service provision and delivery (DQUINS Peer Review Report 2012)

Feedback
Patient feedback from the Congenital Adrenal Hyperplasia service is attached as appendix. 94% of respondents would recommend the service to family and friends (6% responded n/a).

Complaints
There have been no formal complaints in 2012/13.

Action plans have taken forward in relation to previous complaints, these are:
Issue: Procedure for requesting funding for growth hormone treatment not effectively conveyed to patients family
Action: Trust policy relating to funding applications and has been re-distributed to medical & clinical team. Clinicians ensure that patient and parents are informed about the NICE criteria and the PCT process for approval, including timescales. Patients and parents are kept informed of PCT requests for further information, the decision taken, and the appeals process if applicable. The team use a checklist for all patients starting growth hormone treatment which has been updated to record that families have been informed about the process and by whom.

Issue: Information regarding attempts to contact patients' families not recorded in patient notes
Action: All senior and junior staff has been informed of the need to keep careful records

Waiting times

Advanced Access:
General Endocrine clinics are pooled and meeting the Advanced Access target. There are a number of specialist clinics and wait times for a first appointment are significantly longer due to the fact that a number run monthly or due to demand. Additional capacity is arranged on an adhoc basis to support achievement of Trust 12 week target for new appointments.

18 weeks (performance as at 14.09.12):

Median wait	7.0 wks
95th centile	24.7 wks
92% target	83.2%

Waiting times in clinic setting:

Time from check in to seen in clinic room 16.5-23 mins
Average consultation time 23.3 mins
Did not attend rate 4-7%

Finances (position at M5)

Expenditure budget (£):

Budget	YTD Budget	YTD Actual	YTD Variance
Non Pay	786,391	850,284	-63,894
Other Revenue	-29,892	-39,856	9,964
Pay	281,061	307,404	-26,343
Total	1,037,560	1,117,832	-80,272

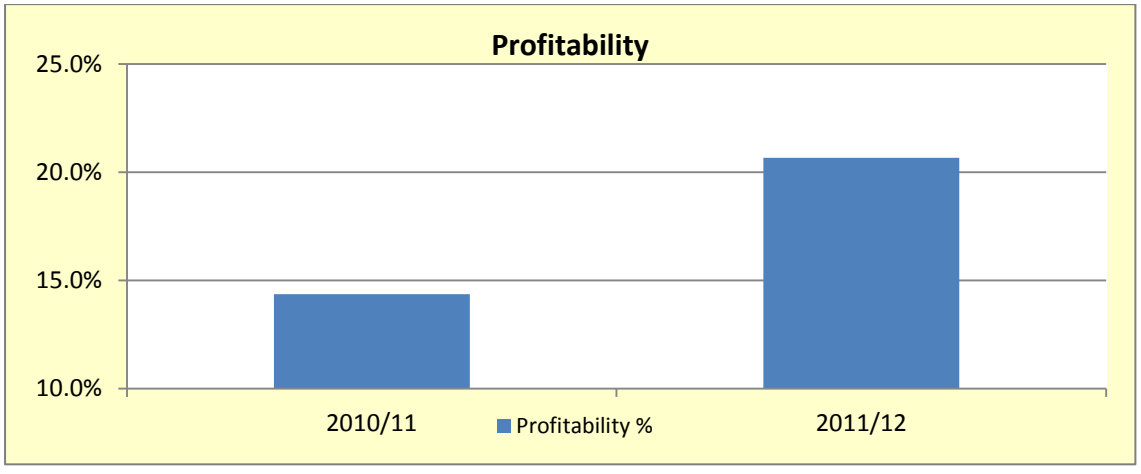
Income (£):

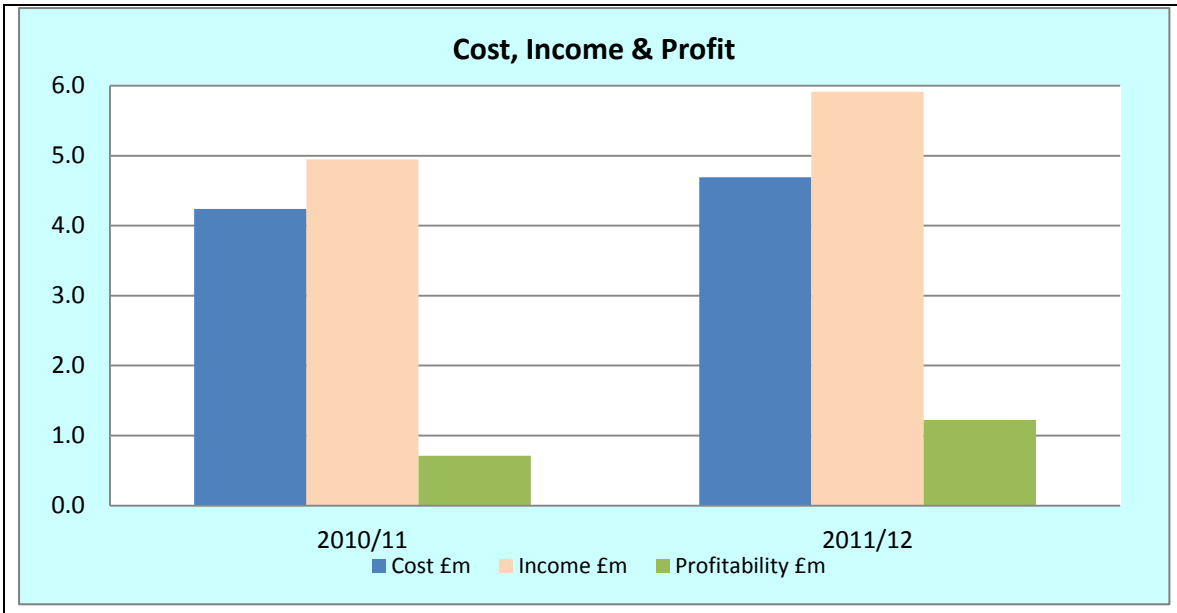
Annual Budget	5,199,183
YTD Budget	2,162,709
YTD Actual	2,412,202
YTD Variance	249,493

Annual Activity Plan	5,772
YTD Activity Plan	2,360
YTD Activity Actual	2,532
YTD Variance	171

Cumulative position to M5 is 135,425K favourable

SLR Position (including PHHI)





- The service is profitable and increased profitability is mainly due to favourable change in income tariff.
- Cost increase is mainly due to increase of length of stay; complexity of patients seems to have increased

CRES plans for 2012-13

Schemes:	£
1. Expansion of outreach clinics (Southend, N Middlesex, Colchester)	1,680
2. Increase in IPP activity to meet demand	8,820
3. Contribution claimed from growth	48,000
4. Improved coding and activity recording	13,000

Integrated Business Plan

Demographic growth forecasts have been used as the basis of the activity growth predictions for the Endocrinology unit.

Any Other Relevant Information

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board Meeting 26th September 2012	
Reporting Zero Harm - Quality, Safety & Transformation (QST) Update **Submitted on behalf of Martin Elliott**	**Paper No: Attachment M** **Date considered by Management Board September 2012**

Aims / summary

Monthly rotation of Transformation, Safety & Outcomes, with focus on Transformation.

Areas of note:

- **Appendix A** provides the high level Zero Harm report.
- The first Innovation Group was held in July, to replace Transformation Board
- Sustained central venous catheter line (CVL) infections at 1.97 per 1000 line days.
- Hand hygiene audit results show we are continuing to improve and we are looking towards a sustained improvement in the next quarter.
- Medicines Management – CICU - have had a further reduction in prescribing errors per bed day since April, which continues to be sustained, albeit with some negative outliers. PICU - following an earlier reduction in prescribing error rate during the first quarter of 2012 to 0.34, the data in the dashboard suggests that the prescribing error rate is rising again. It is difficult to ascertain why and staff are investigating, they are following the same methodology as CICU. Both teams and ICI-LM will present at the September Innovation Group.
- MRI - To improve start times, the team have rolled out the 'Golden Patient' initiative eliminating the need for the first patient on a particular weekly morning general anaesthetic list to go to a ward prior to their MRI scan.
- Bed Management – With an aim to reduce refused non-elective clinically appropriate referrals due to insufficient bed availability, all workstreams are progressing well.
- Deteriorating Child – We should be cautiously optimistic as we note small improvements for the majority of measures relating to this project. We now need to see if the improvements are sustained. There is already a sustained improvement for percentage calls to CSPs re deteriorating child using CEWS as noted in previous report.
- Theatre Utilisation – Full report went to August Management Board and a summary is included in this report.

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 September 2012

ATTACHMENT M

Quality, Safety & Transformation
Reporting to Trust Board
September 2012

The following Zero Harm report produced by the Quality, Safety & Transformation (QST), shows updates for Zero Harm (Appendix A) and a progress report for Transformation during the period end April to end August 2012.

There are currently around 100 different projects and 150 measures of information. This report highlights some particular areas of merit, challenge and will provide an overall assessment of Trust wide Transformation priorities.

It should be noted that the Transformation Board has been replaced with an Innovation Group as detailed in the April report. The first meeting in July featured projects delivered by those who had attended the Leading Improvement In Patient Safety programme. The September meeting will focus on Reducing Medication Errors.

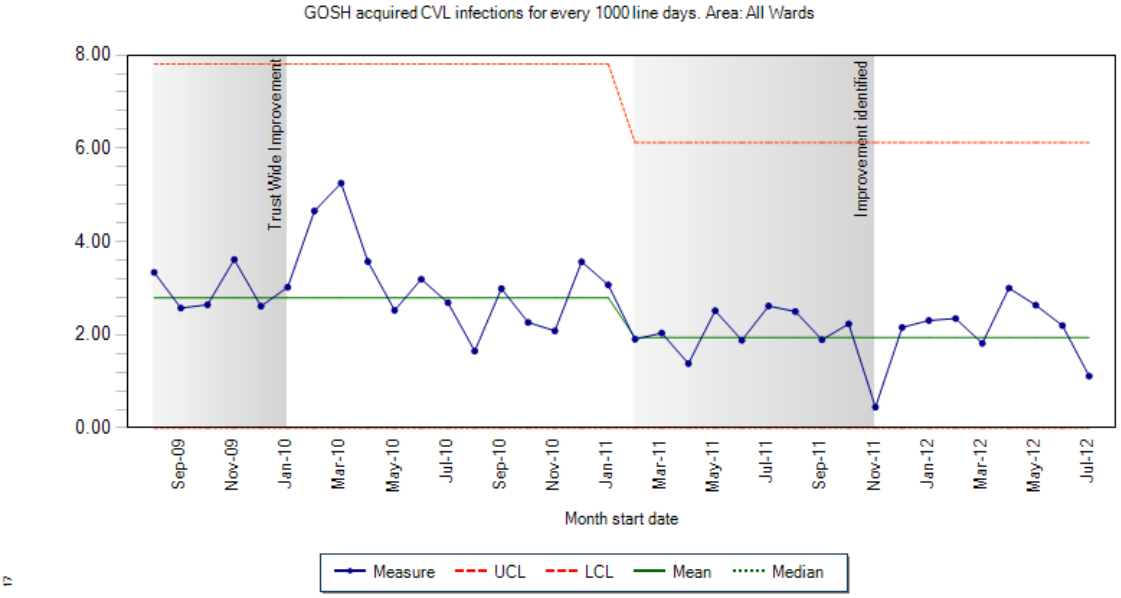
1. Infection Prevention & Control

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

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

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

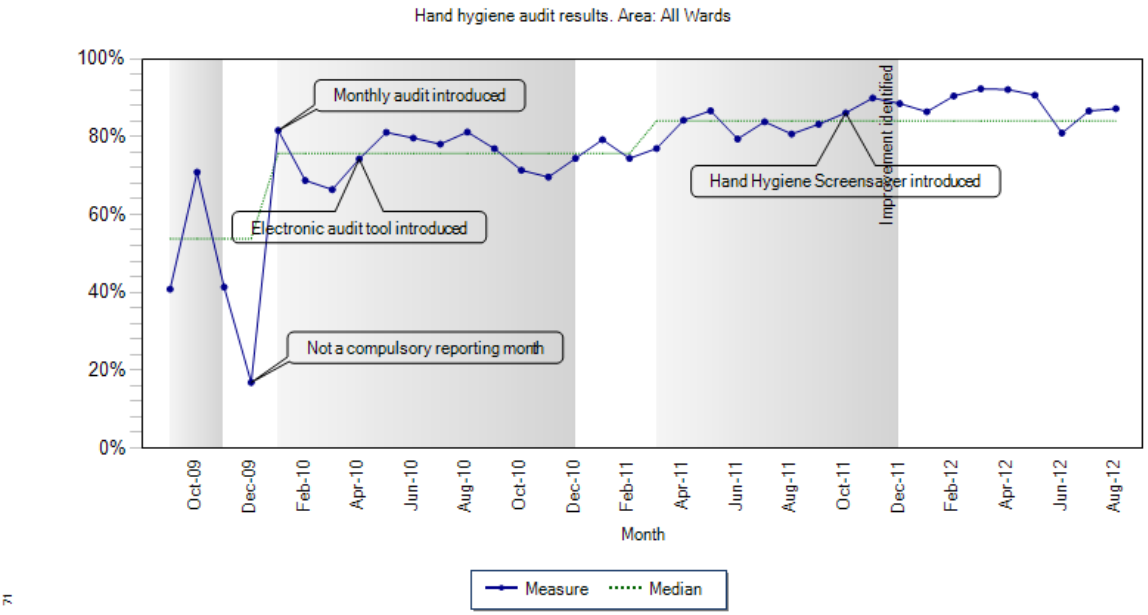
There has been no significant change in the overall figures, but this does not reflect the effort from individual areas.



As part of the GOSH/Cincinnati Children's Hospital collaborative partnership, a WebEx was set up between the Infection Prevention & Control Teams and other colleagues to discuss central venous line and surgical site infections. Discussion included sharing of definitions, ways of implementation of care bundles, costing of infections, research and clinical engagement. Teams at GOSH will take valuable lessons from this partnership to develop their own practice.

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

Hand hygiene results continue to improve. The graph below shows that the Trust is close to another statistically significant change. Each clinical unit has a plan to improve infection rates using innovative methods to engage staff, patients and families and hand washing plays a key part in this work.



Reducing Healthcare Acquired Infection in ICI-LM

ICI-LM are working to engage families and parents in promoting good practice by holding an interactive and 'fun' session during a family forum.

- Families had videos, hand hygiene games, general infection prevention and control question and answer session with the infection prevention and control team demonstrating bundle compliance on a mannequin.
- The feedback was very positive and encouraged the team to "do it more often – maybe once per month."
- All the attendees responded that they found the session "interesting" and it was "nice to see what the nurses do"

ICI-LM plan to hold these sessions more frequently and the next step is to try and educate visitors by using infection prevention and control update 'cards'

In addition to reducing CVL numbers, the consultants in ICI-LM are keen to monitor a graph of specific HCAI infection numbers, especially Gram Negative bacteria that affect their cohort of patients. This data should help to highlight to staff the importance of early detection of symptomatic patients and isolation.

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

The infection control team are working with clinical units on three aspects to prevent surgical site infections:

- A Basic Care Pathway for patients undergoing surgery where surveillance is currently conducted
- Monitoring the wound for signs of infections

- Investigating these infections

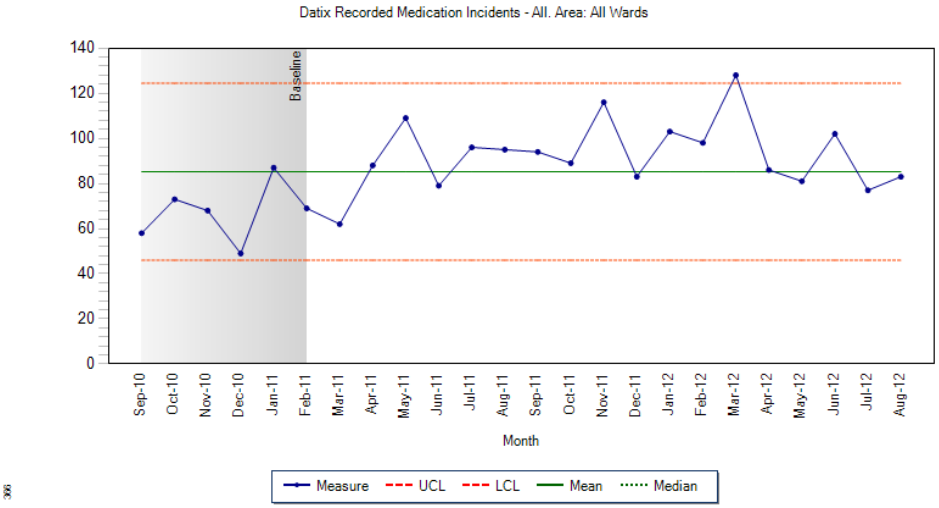
Implementing the care pathway is a priority and each specialty should look at high risk children by monitoring surveillance and giving feedback.

Cardiorespiratory
A cluster of SSI's (mainly superficial) occurred during May and June for Cardiac Surgery. A dedicated surgical registrar now attends the monthly Infection Board to address this. A wound team has now formulated and will commence next month to look at SSI bundle, compliance and issues. The team will continue to monitor antibiotic administering time and pre-op wash compliance. Clinicial practice on various SSI related issues has been included in SHO infection control orientation on Bear ward. The team are working closely with information services to include a dataset on PIMS for SSI entries.

Next steps
Funding for surveillance of SSI's will cease in May 2013 and steps need to be put in place to ensure this continues at clinical unit level. The Practice Educator for Infection Control has left the Trust and a post has been advertised for Infection Control Improvement Specialist to join the team to drive this work forward.

2. Medicines Management

Medication incidents are the most reported type of incident at Great Ormond Street Hospital. On average, 83 medication incidents are reported onto Datix per month.

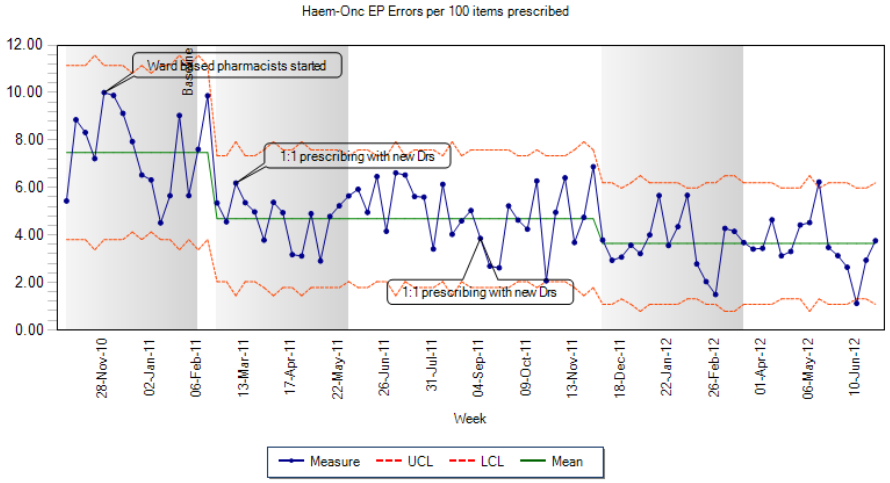


2.1. Clinical Units
A summary of medicines management initiatives being undertaken for each unit is provided below.

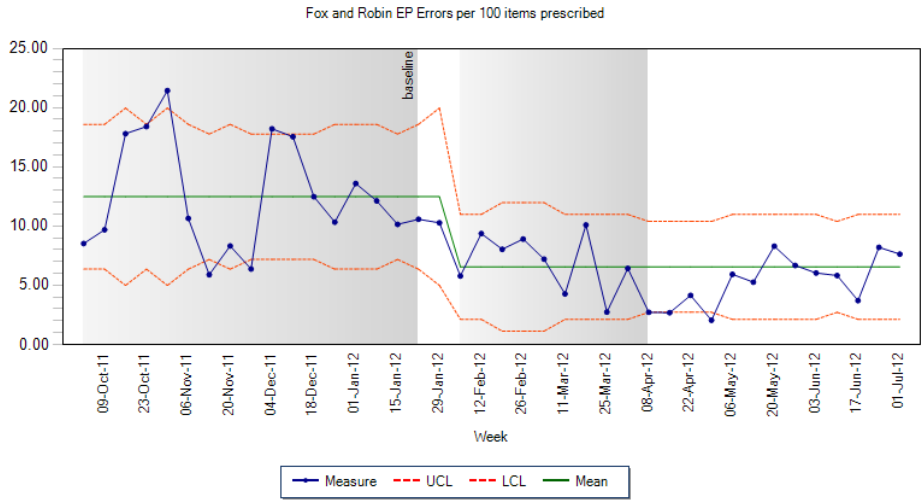
2.1.1. ICI-LM
Medicines Administration Errors
Across the unit, the ward sisters are trialling a 'mini-RCA' tool that is used alongside the existing Drug error Analysis Tool (DAT) to help nursing staff identify the factors that contributed to a medication error they were involved with. They are also developing a guide for dealing with drug errors after they happen and monitoring the effectiveness of this on Robin ward.

On Elephant and Lion (Haematology/ Oncology) wards, the ward-based pharmacists have continued their package to reduce prescribing errors (including initial close supervision of prescribing and regular feedback of errors). As part of the 12/13 CQUIN, the pharmacists are now collecting data on out of hours prescribing errors, and will be analysing high risk drug errors. This new data is being collected on

a new electronic tool developed by the pharmacists and transformation analysts, and is not yet available on the dashboards. The medicines reconciliation CQUIN has finished and the processes are now embedded so they have stopped collecting this data. As of June 2012 the prescribing error rate continues to be 3.64 per 100 drugs prescribed.



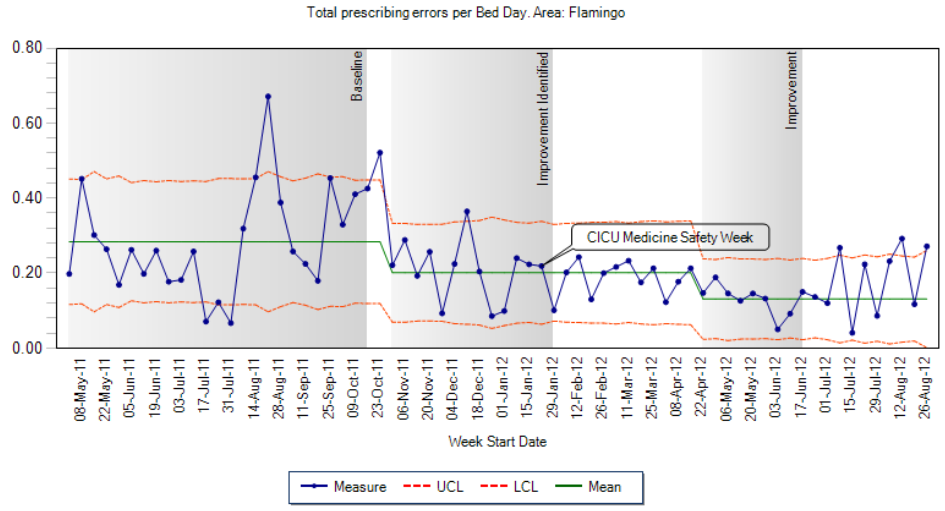
On Fox and Robin (bone marrow transplant, immunology, infectious diseases) wards, the pharmacists have implemented the same package to reduce prescribing errors. After an initial 48% reduction in errors within 3 months, as of July 2012 the prescribing error rate has remained at 6.54 per 100 drugs prescribed. The same electronic data collection tool is being used by pharmacists on these wards, and more recent data is expected to be available during September.



Fox and Robin wards are also involved in a QIDIS bid in partnership with Newcastle to transfer patients onto the 'Healthcare at Home' scheme and will be reviewing the use of Infliximab, which should result in outpatient drug cost savings.

2.1.2. Cardiorespiratory

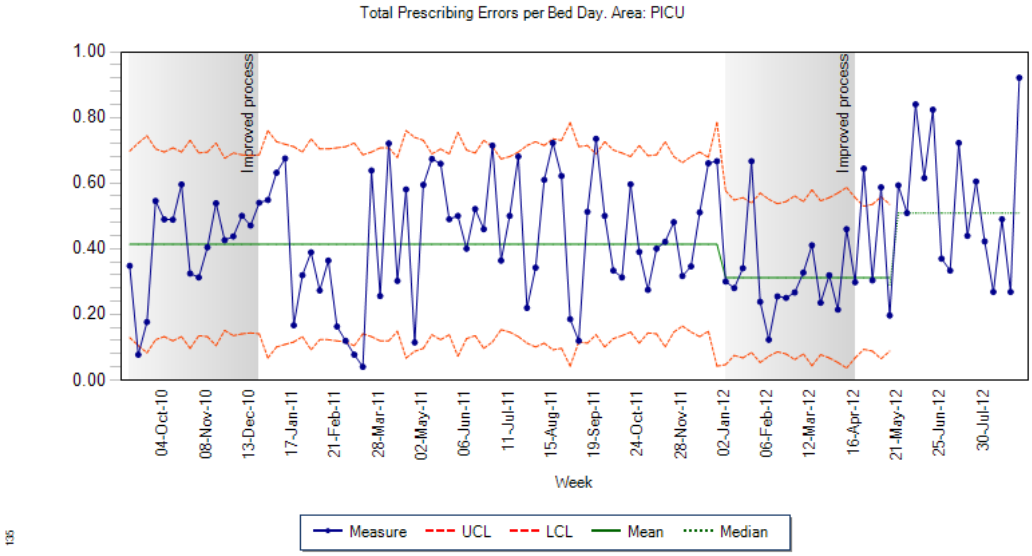
CICU have continued their package of innovations aimed at reducing prescribing errors (including prescribing test, regular feedback of errors and trends, prescribing desks, and a no interruptions policy). In addition, an electronic infusion calculator too is used, and further improvements to the tool are being tested. CICU have had a further reduction in prescribing errors per bed day since April, which continues to be sustained albeit with some recent negative outliers.



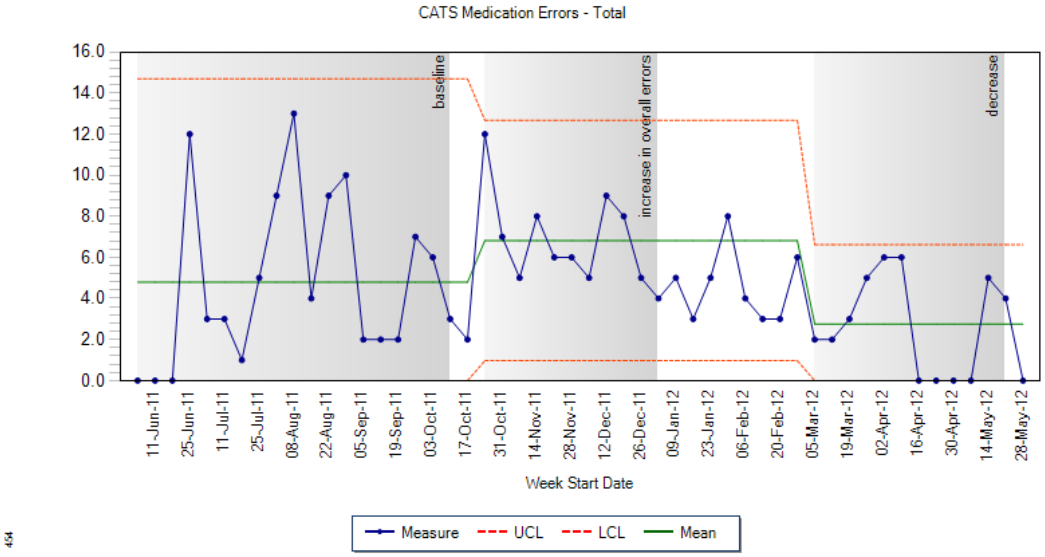
The CICU team have developed a multidisciplinary tool for reflecting on medication errors Describe/ Identify / Analyse / Reflect / Your learning (DIARY)) and are currently working to define a process for use of the DIARY tool by all health professionals involved in the error. CICU also plans to repeat the previously successful Drug Safety Week later this year, and are working towards new ways of helping nursing staff identify and follow up on prescribing errors they discover.

2.1.3. Surgery

PICU has continued with the same package to reduce prescribing errors as CICU (including prescribing tests, regular feedback of errors, prescribing desks and a no interruptions policy). The combined interventions were associated with a 54% reduction in prescribing errors. Following an earlier reduction in the prescribing error rate during the first quarter of 2012 to 0.34 errors per Bed Day, the data in the dashboards suggest that the prescribing error rate is increasing again. It has been difficult to ascertain why this may be the case; key clinical staff are investigating.



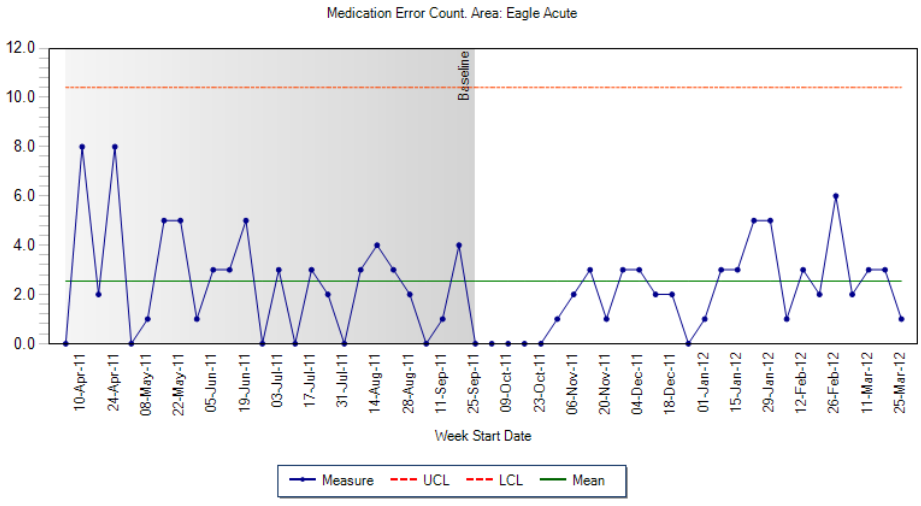
The Children's Acute Transport Service (CATS) team have begun utilising the medicines management dashboard to display medication error data they have collected. From March 2012, the service has been recording on average 2 medication errors per week.



Improvement work has begun with Theatres to address the risk of double-administering doses of medications. It is usual for anaesthetists to prescribe a STAT (one-off) dose of a pain-relieving medicine (e.g. paracetamol) and then to prescribe the PRN (when required) doses for the ward immediately afterwards. Adequate checks are needed to confirm when the last dose of the medicine was administered, before giving the next dose. Changes are to be made to the electronic prescribing system used by anaesthetists to make the timing of the last dose more visible to staff.

2.1.4. Medicine-DTS

The medical wards have launched a simple electronic tool to enable nursing staff to capture prescribing errors that they have identified and quickly rectified before error reaches the patient. The purpose of the tool is to encourage a culture of reporting all near miss medication errors, and to understand how many prescribing errors the nursing staff intervene in. The data is in addition to that which is captured on Datix, which is too lengthy for everyday recording of near-misses that do not reach a patient. As of March 2012, Eagle Acute (renal) ward was collecting 2.5 prescribing errors per week, which may suggest under-reporting of near misses currently. Data has been collected since the introduction of the electronic tool and new SPC charts are being developed. Eagle ward nursing staff have identified an issue with interruptions and self-interruptions during medication preparations and administration; improvement work is to commence over the next few weeks.

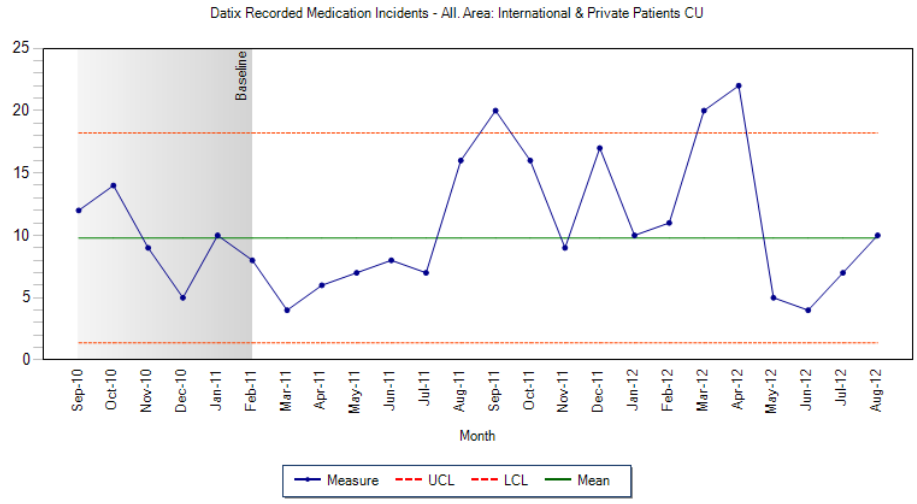


2.1.5. International and Private Patients

ATTACHMENT M

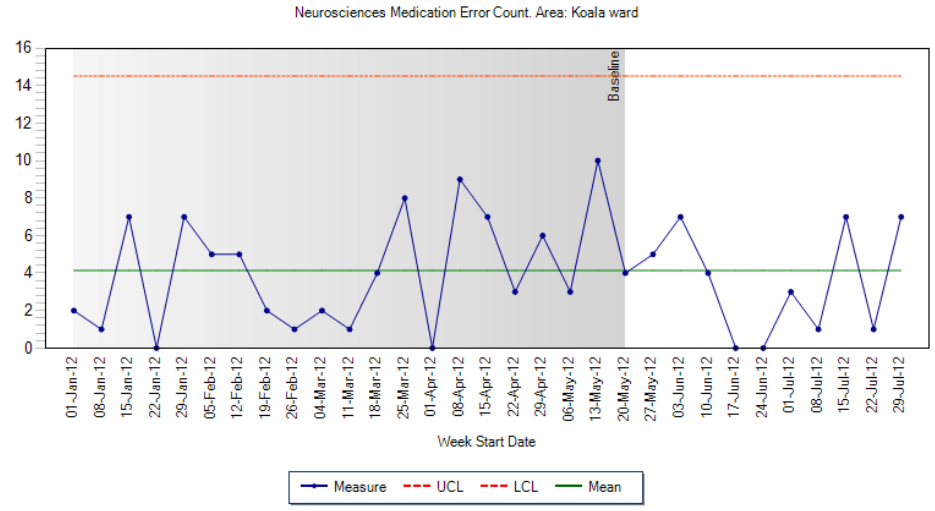
This unit is reviewing and reporting on trends in the medication incidents that staff self-report on Datix. On average, the IPP unit report 10 medication-related incidents per month. As part of the Transforming Care on Your Ward (TCOYW) project, the unit is focussing on specific elements of the medicines administration process. For example, a local 'snapshot of practice' audit is looking at adherence of staff wearing red aprons (which signifies that the wearer should not be interrupted) as they are when preparing and administering patient medication. The unit is also looking into why staff are allowing interruptions/self- interruptions. The unit has continued their review & remodelling of medication rooms to improve workflow by having separate IV and oral medication spaces and using lean methodology thinking.

IPP have also identified four primary medication issues, and assigned a working group to each one:
1. Prescribing errors on Butterfly ward
2. Administration errors on Bumblebee
3. Blood products errors
4. Chemotherapy protocols / errors



2.1.6. Neurosciences

The Koala ward pharmacist continues to record prescribing error data on log sheets to supplement the errors that are reported via Datix. Paracetamol and Morphine are the most common drugs implicated in an error. Dashboards have been set up to monitor this. Feedback of errors is immediate via the pharmacist, and the educational supervisors are informed. Medicines management is a topic on the junior doctors' induction to the unit. As of July 2012, Koala ward staff report an average of 4 medication near-misses per week. A new medicines management display board is to be set up in the prescribing room on the ward, and a new ward-based pharmacist is due to start in October. Additionally, a Patient Safety Officer (PSO) has been appointed for Neurosciences and will begin to attend the unit's medicines management group meetings.



2.2. Measurement of errors

Currently, there is no single measure or graph that shows an overall rate of medication errors as an organisation. ICI-LM has electronic prescribing implemented which enables wards to calculate their prescribing error rate per 100 drugs prescribed. The intensive care units record similar prescribing errors but categorise them differently to ICI-LM. This is partly due to the inherent differences between the specialities, but also due to intensive care use of paper-written prescription charts instead of electronic prescribing. The intensive care units are not able to ascertain a rate of errors per prescriptions written, and therefore calculate their error rates in bed days.

For areas with electronic prescribing in place, a mechanism has been developed for pulling data off the electronic prescribing software and into a server for use by transformation analyst team. It will enable the clinical units to more easily identify drug error problems. The mechanism can be run at any time by ICT and the data can be refreshed overnight. When the latest upgrade of the JAC software is completed, the mechanism will be able to be automated; ICT are working to finish the upgrade.

3. Advanced Access for Out Patients

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

All specialties that are eligible for Advanced Access have been working through a number of recommended steps to help them achieve the two week target. Fourteen specialties are currently achieving Advanced Access (there were fifteen achieving in April 2012). Another two specialties are close to achieving and all other areas are working on this with plans in place.
At the July Innovation Group, it was decided that we have reached a point where learning is now embedded in the clinical units and there is no longer a mandatory need to report this centrally through transformation. Teams still have the following resources:

- Dashboards on the intranet showing third next available appointment, capacity & demand (graphical analysis of referrals vs appointments, broken down by service and clinic) and DNA rates
- Access to tools, techniques and new innovation relating to access through local improvement manager or co-ordinator
- Support of the innovation group if required (chaired by CEO)

- Clinical Units can choose to keep advanced access as one of the projects on your clinical unit improvement plan and successes / challenges can be escalated to management / trust board if required.

Reducing waits is still a Trust priority and this will be monitored through the performance indicators, but not through transformation. This will be discussed with the Clinical Unit teams in September.

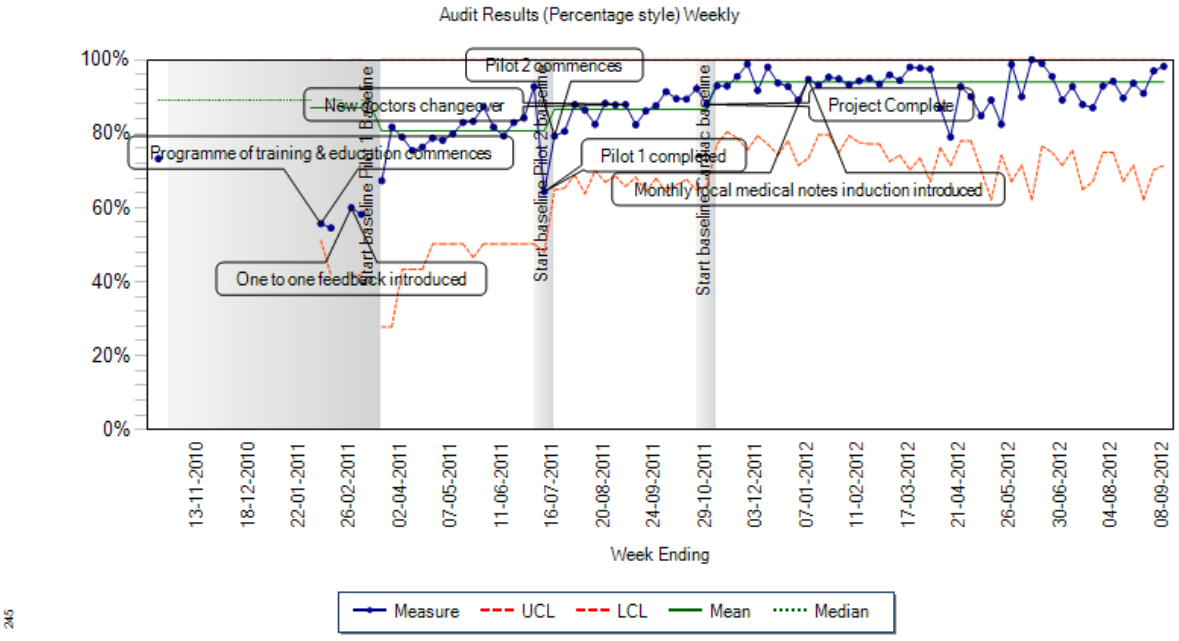
4. Medical Records

Each Clinical Unit has added a project to improve the quality of Medical Records to their project plans. This project has renewed focus as the Trust prepares for NHSLA Level 3. A review of medical notes has been added to the weekly Executive Safety Walkround for every ward.

Cardiorespiratory Clinical Unit
The unit continues and has sustained the implementation of 10 golden rules – Trust's medical notes standard over 80% compliance. Spread and sustainability incorporated in new doctors' local induction, the creation of induction passport and the monthly catch up between the Improvement Manager and ICUs doctors. One of the doctors who was involved in the start-up of this project consulted with the Improvement Manager and submitted a poster abstract to the forthcoming PICU Conference in Dublin, which was accepted and will be presented by the Clinical Unit Chair.

Another medical notes project has commenced on improving splitting and filing of notes in Cardiorespiratory. Weekly audits and feedback took place since July.

Improving Quality of Medical Notes



Improving splitting and filing of medial notes

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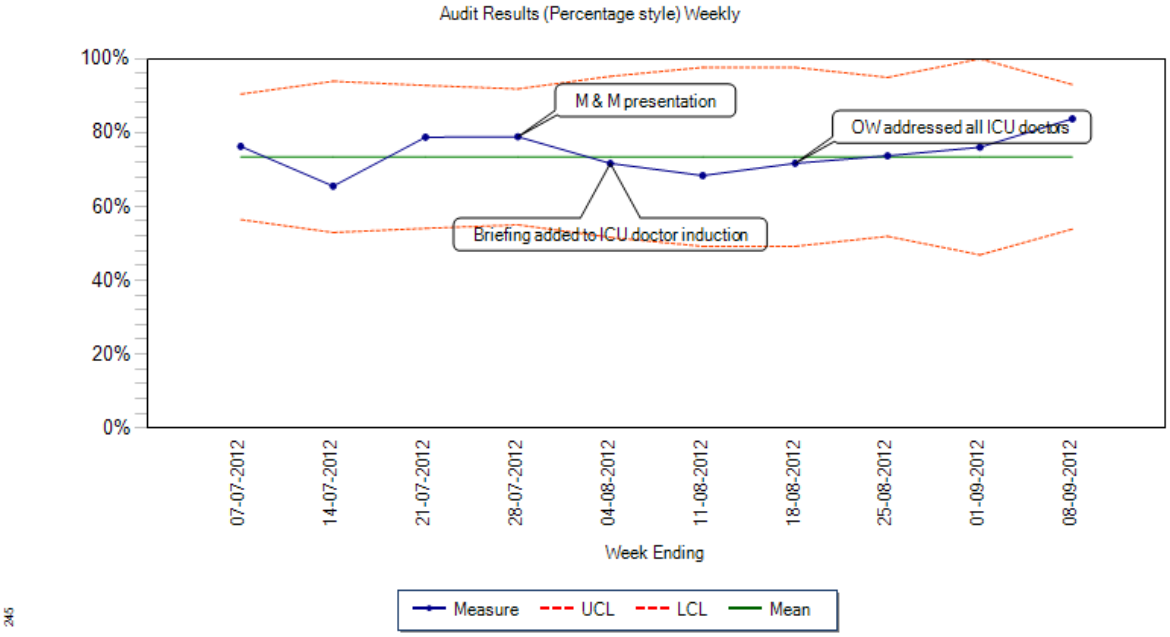


ICI-LM
Significant progress has been made on improving the splitting and filing of medical records for Haematology/Oncology patients, in conjunction with the health records team. An SLA has been written to agree standards between the health records department and the Haem/Onc teams, data will be collected every week on the level of splitting and filing that is completed and an easy 'how to guide' has been developed in conjunction with the clinical teams, which clearly outlines which documents should be kept in the current set of notes. This learning will be shared with other clinical units.

MDTS
A Medical Records audit was completed during by a Junior House Officer. The findings were largely positive in adhering to the 10 golden rules across all three wards, Kingfisher, Rainforest and Eagle. A new "Respect the Patient Record" project launched in May 2012 has a remit to address patient documentation issues one of which addresses entries made into medical records by doctors and nurses, from the coders perspective. The benefit of ensuring the notes meet the requirements of the coders ensures that the level of information is current, in-depth and captures planned investigations, results, procedures, diagnosis and co-morbidities. This level of detail will also ensure that continuity of care and patient safety is not compromised.

The first PDSA is scheduled to start in September. The Plan Do Study Act cycle will test the use of existing daily handover sheet (comprehensive, live, typed, dated, black ink, written by a medic) to be cut and pasted onto stickers and inserted into the inpatient sheet in the medical notes. There will be a two week test period on Eagle Ward with a view to increasing to further consultants and eventually across specialty.

Neurosciences
A multi-disciplinary team from Neurology are working on this project, starting with medical notes audit on Koala ward. Signed & printed names is currently the poorest performing of the 10 golden rules. Data is displayed on the medical notes trollies on the ward and in the ward's prescribing room. The Neurodisability team are trialling date and sign stamps and if this is successful, will be rolled out.

5. Procedure Pathways

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

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

WHO Safety Checklist
Total WHO Safety Checklist completion has increased to 98% median cent since April across the whole Trust.

Theatre Utilisation – *This is a summary of a more detailed report to Management Board August 2012*

Our Operating Theatres are one of our most valuable resources. A funded operating theatre standing empty can cost up to £20 per minute[1]. As such, GOSH needs to make the best use we can of every session. The stated aim of the Theatre Utilisation Project (TUP) is to sustain a mean U4 (end utilisation of planned) 77% by end 2012/3 for All Surgical Specialties.

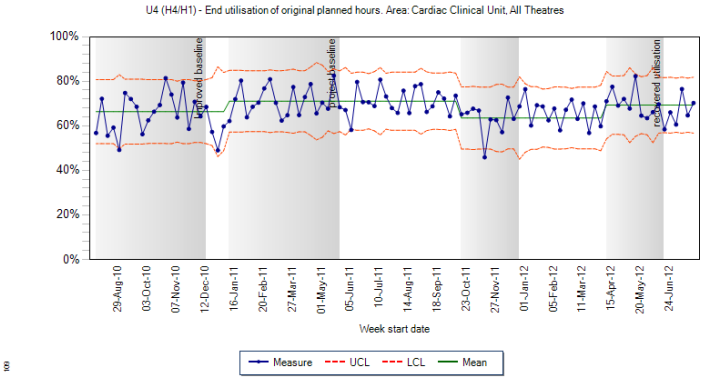
All units and specialties have been asked for action plans in place to either sustain (if already delivering over 77%) or increase utilisation to meet the Trust 2012/3 target of 77%. It is acknowledged that for various reasons, there are some instances for which this will never be feasible as an individual specialty. Units will therefore focus on specialty specific action plans to optimise list bookings, start and finish times, turnover, and minimise cancellations based on the demands and limitations of each patient cohort and service.

In addition to the work focusing on the actual running of the list, it must be recognised that there are a number of drivers to safe, well utilised operating sessions that sit outside of the remit of TUP. Provision of timely, thorough pre-operative assessment; clerking and preparation processes on the day of admission; ordering and availability of blood products; an appropriate post-operative bed; nursing staff; portering; discharge planning; all of these (and many more) contribute to the smooth, safe running of an operating list.

Please note all charts shown in this report refer to NHS sessions, with the exception of those in the IPP section.

Targets for 2012/3 – by Clinical Unit

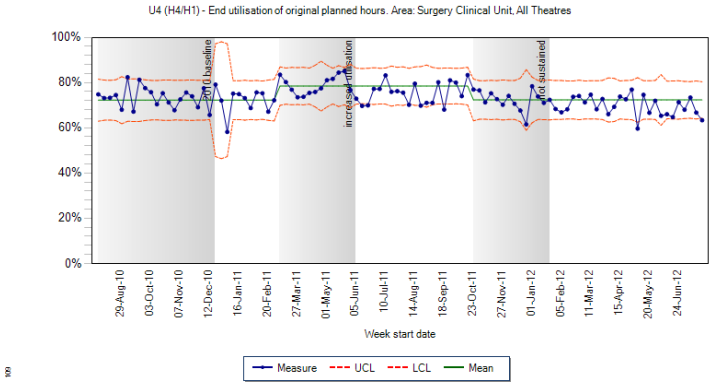
Cardiorespiratory – Baselined a unit U4 of 71% in 2011, dropping to 63% at the end of the year, and recently recovering to a mean of 69%. When combined and weighted for total hours operating, individual specialty targets could deliver up to 75.7% U4 across the unit.



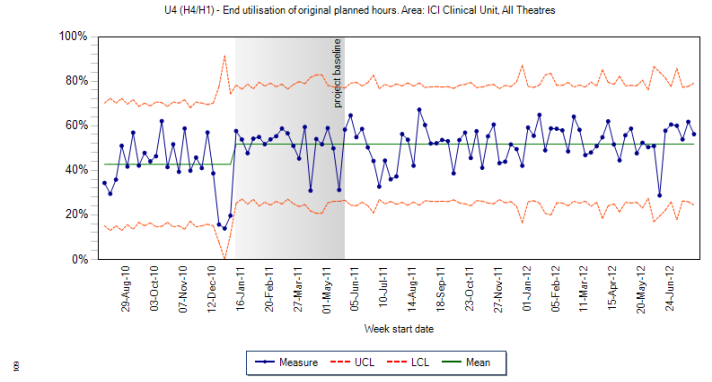
Surgery - Baselined a unit U4 of 78% in 2011, falling to a mean of 72% at the end of the year. The unit's stated target for 2012/3 is 77%. This is supported by the individual specialty targets which when combined (and weighted for total hours operating) could deliver up to 78.6% U4 utilisation. In addition to specialty

specific action plans, and in recognition of the factors affecting theatre utilisation outside of the remit of this group (as discussed above), the unit is also looking at the following;

- A cross-unit booking processes for beds and theatres (and ICU beds). This is critical in light of the number of specialties currently experiencing a drop in utilisation due to lack of available bed.
- Staffing levels on Dinosaur first thing in the morning – there are only 2/3 nurses having to prepare and escort as many as 10 'first' patients
- Finding an alternate means of support for parents coming back from theatre and being shown to post-operative wards than the escort nurse
- A surgeon-specific dashboard monitoring scheduling, booking, utilisation and bed availability
- Discharge planning from ICU
- A new decision making/escalation process for ICU to confirm availability of post-operative beds by 8am (trialling in Spines)



ICI-LM – Baselined and sustained a unit U4 of 52% in 2011. The unit's stated target for 2012/3 is 65%. This is supported by their individual specialty targets which when combined (and weighted for total hours operating) could deliver up to 66.9% U4 utilisation.



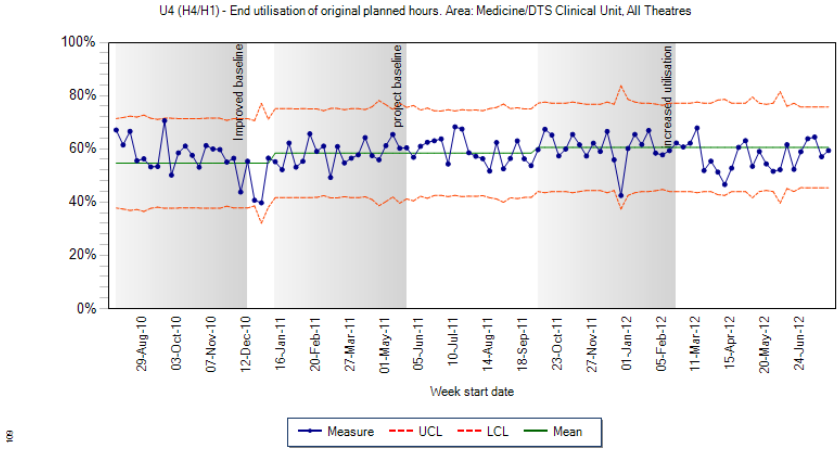
Medicine DTS - Baselined a unit U4 of 58%, increasing to 61% from the beginning of October 2011. The unit's stated target for 2012/3 is 65%, which is considered a realistic and achievable target taking into consideration the contribution of satellite theatres (Radiology & Gastroenterology) to overall U4 within MDTS. This is supported by their individual specialty targets which when combined (and weighted for total hours operating) could deliver up to 65.4% U4 utilisation.

A number of actions are being taken forward which are expected to have a positive impact on performance :

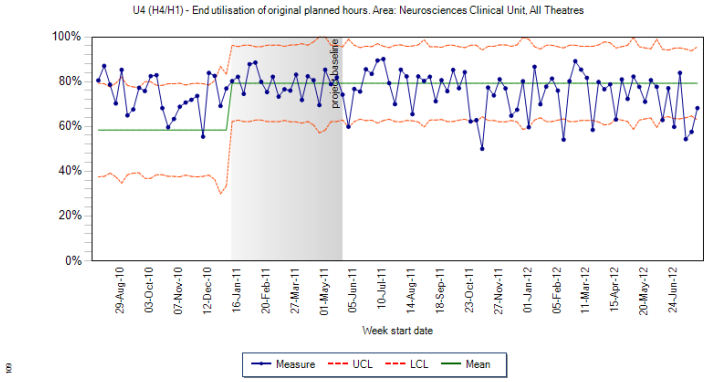
- Access to beds to ensure lists are fully utilised is also being reviewed. Availability of beds within the Unit has limited theatre utilisation. In the immediate term access to 2 additional overnight beds from September 12 is being implemented. Additionally the Gastroenterology admissions team have recently commenced attending the Surgery weekly bed meeting to facilitate access to Surgical beds for admission the following week. It is expected this will result in an improvement in utilisation but the

impact is yet to be quantified. The Unit is also commencing a comprehensive review of bed allocation across the unit.

- A second pre-admission nurse has been recruited to ensure all patients being admitted for an investigation to the GIU have had a pre-admission assessment. This will ensure our bed base is appropriately utilized and is expected to reduce the number of same day cancellations.



Neurosciences – Baselined and unit U4 of 79% in 2011, which is thus far sustained into 2012, albeit showing increased variability. The unit's stated target for 2012/3 is to maintain at least 77%. This is supported by their individual specialty targets which when combined (and weighted for total hours operating) could deliver up to 81.3% U4 utilisation.



When the Clinical Unit targets are combined and weighted, an All Specialty (i.e. whole trust, NHS) target of 73% is projected for 2012/3. All Surgical Specialties are anticipated to reach 78.9%.

International & Private Patients Division - baselined a U4 of 64% for 2011/12, with a projected aim of 70% by the end of April 2013.

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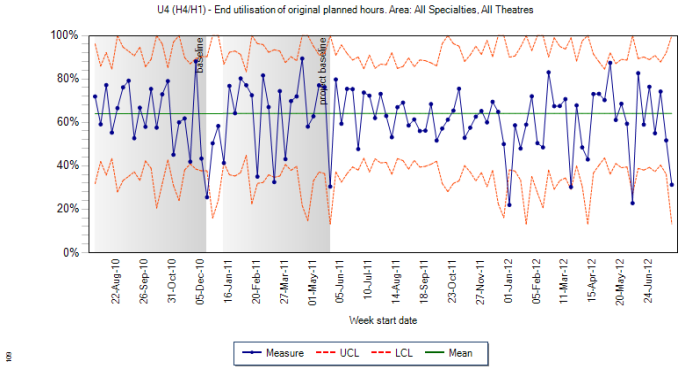

Utilisation was stable around the mean (64%) until the end of 2011, but there has been considerable variation since that date, including 3 results outside the control limits (chance alone is 1:370). This suggests that process does not have a normal distribution of results with a spread from 23%– 80% in any given week.

There are a number of reasons for this process aberration. There was a marked reduction in the number of operations between Dec 2011- Apr 2012 as we approached the end of the financial year, and whilst we did not refuse any patients, we did not have the volume of patients to backfill cancelled patients if we were notified in time. The number of operations has steadily increased over the past 3 months, with a significant percentage of these operations completed on week-end lists. These lists achieve excellent utilization. We are struggling to consistently fill our weekly Wednesday theatre lists due to late cancellations (unwell patients), with no ability to fill the list at short notice, generally the day of surgery. We are exploring options such as a general 'combined' list to allow more than one Consultant access to the list. We are also continuing to concentrate on reducing late starts in broad terms through:

- Changes made to nursing responsibilities to enable timely 'on-day' of surgery nursing admission. Changes also made to the start time of one of the IPP Doctors to ensure we have medical clerking completed in time.
- Currently reviewing pre-admission process from arrival into IPP through to theatre – trying to reduce handovers (Caterpillar – Dinosaur – Theatre – Post-op Ward)

References

1. *The Productive Operating Theatre: Building Teams for Safer Care* (2010), Institute of Innovation and Improvement, Warwick

Pre-operative Assessment

The Pre-operative Assessment project is working to develop and implement a standardised service providing equitable access for all GOSH patients being admitted for any procedures. New documentation has been approved at Clinical Practice Guidelines Committee for trial and is being used in General Surgery, Dental and Maxillofacial. Detailed data collection around current service provision has been completed on Dinosaur ward and is currently running in Outpatients, ahead of gap analysis in October. Specialist referral criteria is in draft, pathway mapping is complete and parent/patient involvement has been agreed, and the recruitment process started. It is anticipated that a business case will be put forward in early 2013.

Access to Theatres for non-elective cases

This project works to ensure non-elective patients are able to access theatres when they need to. Significant progress has been made over the summer, formal dashboards are now available and a statistically significant improvement can be seen since May 2012. Clinical protocols as to what kind of patient and procedure should fall into each category are now embedded. An electronic booking form will shortly be available, removing a step from the booking process and thus minimising potential for transcription error.

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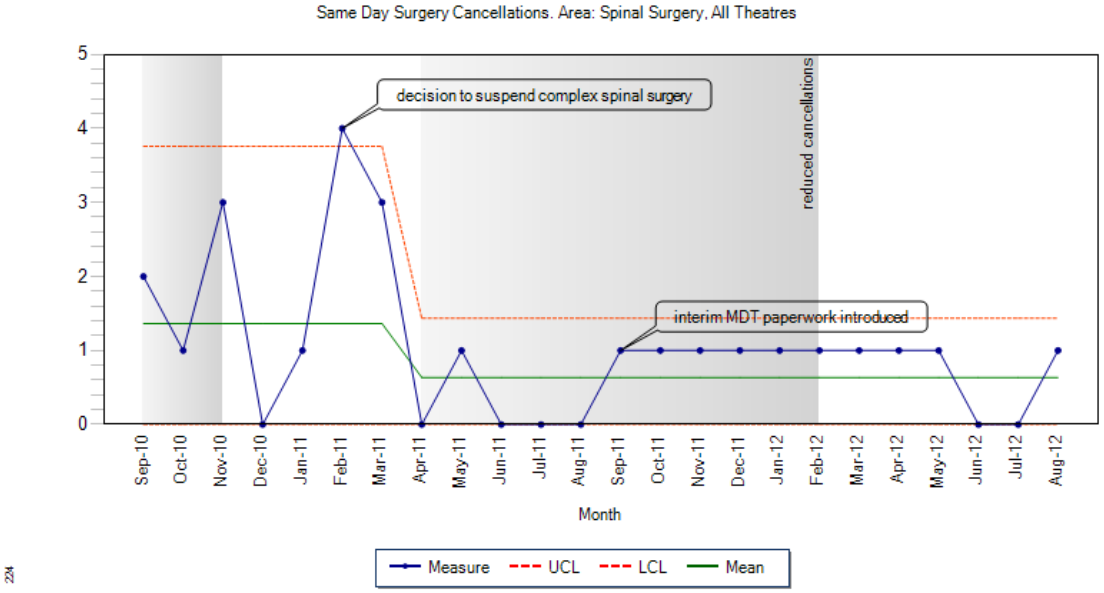
Fasting times

This project is aimed at minimising the time children are fasting for whilst remaining safe to undergo a general anaesthetic. Thus far the team have successfully reduced the means for both solid and liquid fasts by changing the way we plan and manage the lists, and most recently have updated and improved the written advice given to all families as part of their admission letter. Next steps include asking the wards to give clear fluids to patients in the latter half of lists, and as of September, rolling the project out through the surgical specialties.

Spinal Pathway

This project has redesigned the whole pathway for all patients referred for spinal surgery; implemented a set of standardised assessments and paperwork, held a monthly MDT and put forward a successful business case to implement a gold standard pathway. Since the implementation of the new MDT, the team have discussed 136 patients, 19 of which have been referred for further assessment and 13 have not offered surgery. As yet we have reported no adverse outcomes, and significantly reduced on-the-day cancellations.



Improving the MRI patient journey

The team have now created specific dashboards for each category of MRI referral enabling validation and escalation where necessary of patients requiring MRI scans. They are in the process of reviewing the administration process to facilitate the escalation of patients requiring sooner MRI scans. Work on an in-depth demand and capacity study continues for the next month so they can definitively clarify the position within the MRI, however it should be noted that there has been no increase in utilisation as yet.

To improve start times, the team have rolled out the 'Golden Patient' initiative eliminating the need for the first patient on a particular weekly morning general anaesthetic list to go to a ward prior to their MRI scan. They have eliminated the need for medical staff to clerk and consent on the day of the scan by utilising the Oncology advanced nurse practitioner for this role. .

There is continued increased compliance with the WHO Safety Checklist completion and work continues to get this to 100%.

6. Bed Management

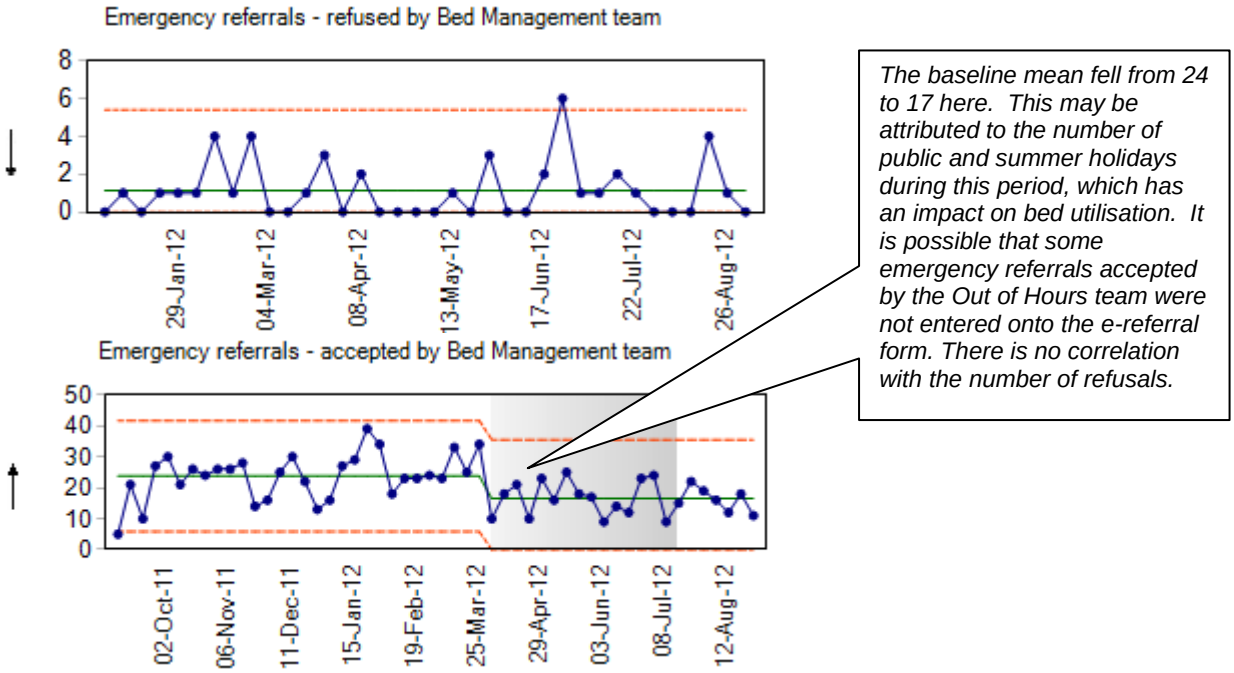
The aim of this project is to reduce the number of non-elective clinically appropriate referrals that are refused admission to GOSH due to insufficient bed availability.

GOSH receives approximately 75 emergency referrals each month to General Surgery alone. One third of these calls are for expert advice, an average of 43 are admitted for specialist neonatal or

paediatric surgery and an average of 4 are refused due to no suitable bed being available. The aim is to accept 100% of all referrals across all specialties by January 2013.

The Trust acknowledges that the number of refusals is not currently accurately recorded for all specialties. To address this data gap, a web-based *e*-referral form is being developed which captures all referrals received to the Trust and records the outcome.

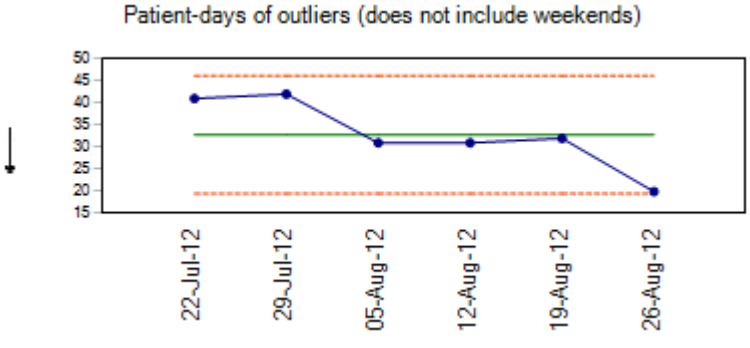
The following charts show the number of non-elective referrals entered onto the *e*-referral form that were accepted or refused admission into the Trust since January 2012. It should be noted that these are only referrals that are reported through the bed management team (so may be different to other data seen at management board). Teams should report all referrals through the bed management team.



Source: e-Referral Form database

One of the objectives of the Bed Management Improvement Project is to standardise referral procedures and explore all options before refusing a clinically appropriate referral. The Bed Management Team has a pivotal role in achieving this. Several work streams are underway to improve the transparency and quality of information that supports bed management decision making. This work has seen the following improvements:

i. A list of admission criteria has been published on the GOSH Web for staff and external referring clinicians to refer to. This is undergoing continuous audit to check it is correct.
ii. The Daily Operational Bed Meeting is now running more efficiently after small cycles of change have led to representatives bringing more useful and accurate information about current and expected bed availability for their areas.
iii. Representatives are more responsive to accepting non-elective patients and communicating this back to their teams.
iv. Patient 'outliers' are discussed at the meeting and this forum used to raise clinical concerns and/or plan for repatriation as appropriate. The definition of an outlier is: 'any patient who is placed on a ward that would not normally treat their illness'.



Source: Daily Operational Bed Meeting Spreadsheet

v. Delayed discharges are reported to the meeting, and a clear escalation procedure followed which expedites transfer, thus freeing up beds.
vi. A consensus has been reached about Trust RAG Bed Status. Green indicates that capacity is adequate to accept all elective and anticipated emergency patients. Amber status is declared in the event that no ITU beds are available or there is insufficient capacity for emergencies. The Trust escalates to Red if beds are not immediately available for patients presenting with a blocked shunt, for renal transplantation or emergency surgery.
vii. Escalation meetings are now scheduled daily at 1500hrs and follow the same format as the 1130hrs Daily Operational Bed Meeting. This has resulted in a more constructive and structured meeting and less ambiguity around roles and responsibilities when the Trust has insufficient capacity to meet projected demand.

The web-based *e*-referral form for non-elective patients has been successfully rolled out to Surgery, Urology, Respiratory and Rheumatology. Medics are seeing the benefits of entering patient information on the mobile iPad device and have asked to expand its use further to also capture all external calls for advice. Although beyond the original scope of this project, the board recognised that this development would be key to engaging clinicians and would positively influence spread and sustainability of the e-referral form.

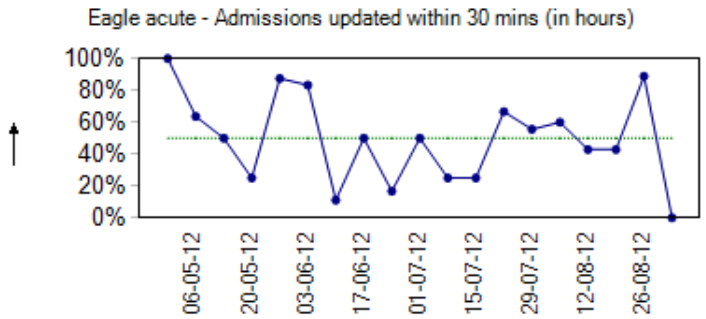
Features of the next version of the form include the ability to save advice calls logged on the system to PDF file (so these can be saved to the Clinical Document Database), and the launch of a mail-merge option which will send an automated email containing details of the advice call to the external referring clinician, copied to the GOSH Consultant on-call. The form will be demonstrated to our referrers at the Referrer's Open day in September 2012.

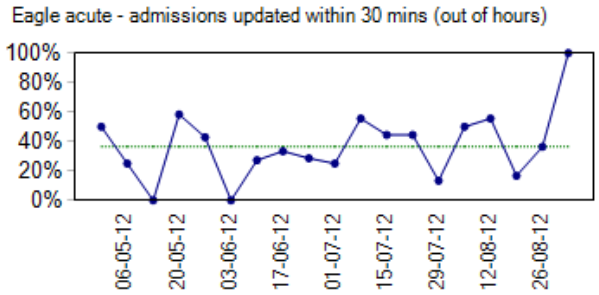
Utilisation of the *e*-referral form has enabled the trust to measure the number and type of referrals and advice calls received. These were not previously captured nor centrally reported. Junior Doctors feel reassured that advice given is documented and saved on a shared database which addresses concerns they have around information governance and reflects time spent responding to advice calls.

The implementation of a real-time bed management system will greatly improve information about capacity and patient flow. The Trust is in dialogue with four companies who have been shortlisted to provide such a system. In the next stage of the procurement process, evaluation of the scripted demonstrations and site visits will take place in October. The chosen solution will be fully implemented by the end of Summer 2013.

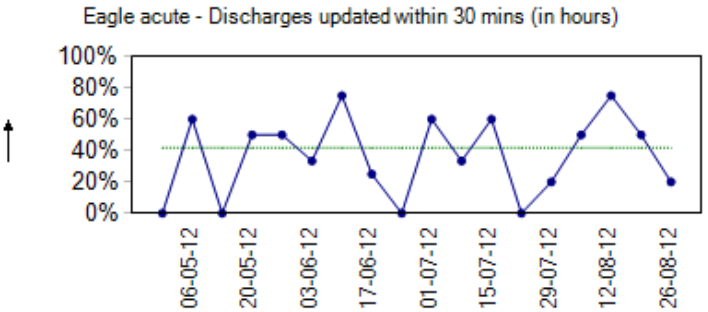
The success of any electronic bed management solution is dependent upon accurate and up-to-date PiMs information. The following charts show the percentage of admissions and discharges entered onto PiMs within 30 minutes of the actual event on Eagle Acute Ward since April 2012.

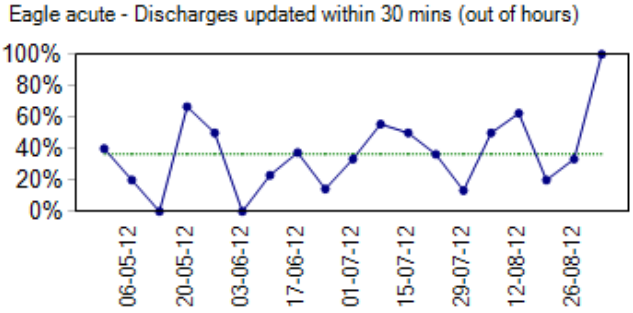
Admission updated on PiMs within 30 minutes of event on Eagle Acute Ward:





Discharges updated on PiMs within 30 minutes of actual event on Eagle Ward:





An improvement project is underway to identify why data quality is unsatisfactory both in and out-of-hours and explore possible solutions to improvement this. The aim is to have 95% of all admissions and discharges entered within 30 minutes by the end of September 2012.

7. Deteriorating Child

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 following workstreams are underway.

Standardise definition of ward arrest
Arrest data now on dashboard. Ensuring data checked for accuracy during RECALL reviews.
Rapid evaluation of Cardiac Arrest with Lessons for learning (RECALL)
Weekly reviews with clinical, resus, risk and QST staff, monitored using scorecard. Linking with Manchester team to learn from their emergency bleep review process
Improving monitoring of vital signs and monitoring plans
Initial work on Squirrel, Rainforest and Kingfisher. Releasing clinical staff to develop work is challenging. Reliable use of monitoring plan on CEWS chart is the priority. Results will be presented at next board.
Next steps to rollout learning from pilot wards across GOSH. BP equipment is being standardised across GOSH.
Escalating CEWS appropriately
New workstream in IPP - currently collecting baseline data from chart review.
Ensure CEWS identifies deterioration reliably
Initial results from focus group work highlights staff concerns over CEWS thresholds for neonates to be investigated further.
Improving situation awareness
Clear links with Bed Management and EDMS projects, ensuring that projects compliment and do not overlap. Meeting planned with Nerve Centre which incorporates electronic capture of vital signs.

ATTACHMENT M

Improving clarity of DNAR

Work being taken forward by End of Life care group.

The attached Zero Harm report provides data for number of arrests and 2222 calls.

Other Transformation Progress

1. Developments in data for improvement

Work to enhance our 'data for improvement' systems continues as a high priority. Recent initiatives are:

- A tool to allow easy creation of measures and data collection has been enhanced to include functionality to allow editing and deleting of data. This tool is particularly useful for small projects including TIMP and EQuIP projects.
- Donation of a licence for ChartFX software – this will allow better presentation of SPC charts.
- The eReferral form for the Bed Management project has continued with iterative enhancements (as detailed above).
- A web based data collection tool to quickly and easily collect prescribing errors that are intercepted before administration - that have previously never been recorded has been developed and introduced for MDTS. (These errors will be entered into Datix as a single incident once a week). This tool is an enhancement to incident reporting in Datix, not a replacement.
- Clinical Outcomes dashboards have been developed and implemented on GOSHweb. This is the first phase and uses measures that are on pre-existing Transformation dashboards. Phase 2 will look to bring clinical outcome data into the system and onto the dashboards. This will include data from locally held databases. Less structured data will follow later.

Next Steps

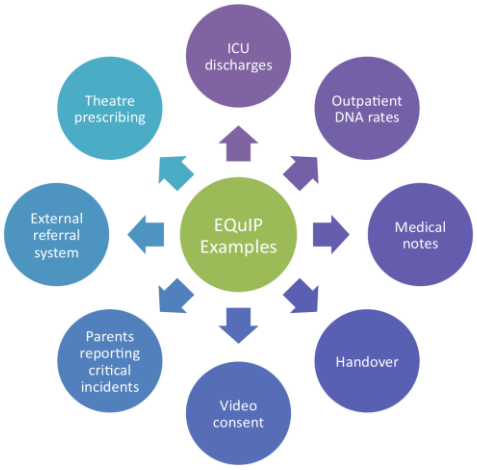
To examine development of a cross Trust early warning safety dashboard, that will combine measures to give a score to allow us to highlight areas where there may be issues. This will provide a much more proactive approach to risk management.

2. EQuIP (Enabling Doctors in Quality Improvement and Patient Safety)

The EQuIP programme delivers three levels of Quality Improvement (QI) training for doctors in postgraduate training.

EQuIP has also been supporting UCL medical students. Five students have been paired with EQuIP doctors to work on QI projects, which has been considered UCL Medical Leadership Network's most successful project this year.

On 15th August 2012, an EQuIP presentation ceremony was held at the Trust, which was well supported by the executive team and all hospital departments. 28 posters of EQuIP projects were displayed, and 6 trainees were selected for oral presentations of their work. Prizes were awarded for the best posters. All posters will be displayed on the Trust intranet to ensure spread of learning from these projects.



The success of EQuIP projects are now being recognised both within the trust and externally. Dr Jane Runnacles has had a poster presentation on EQuIP at the IHI/BMJ International Forum on quality and safety in healthcare and an oral presentation at ISQua in October. Four presented their work at the Inaugural London Deanery quality improvement conference and two were awarded The Network Prize for Innovation (www.the-network.org.uk). One has a poster presentation at ISQua and another has a poster presentation at the British association of paediatric otolaryngology annual meeting (September 2012). Three have recently had successful consultant interviews when they discussed their EQuIP project.

The EQuIP programme will be continued following the appointment of a Trust funded Darzi Fellow. The peer-level engagement of trainees in the programme is crucial. The learning from the experience of running the programme during this pilot year will ensure it is continually improved and embedded in the work of all clinical units.

3. Transformation Improvement Methodology Programme (TIMP)

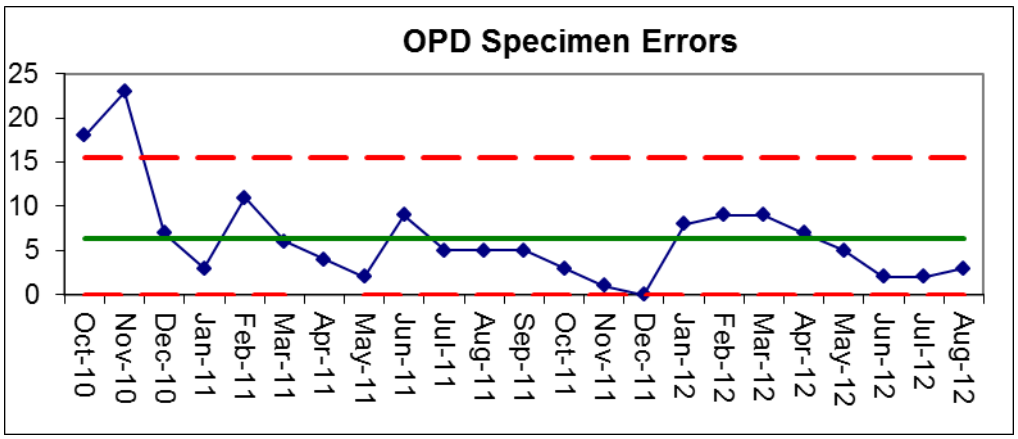
The Transformation Improvement Methodology Program has now graduated 25 delegates, across all units and disciplines, with another 20 enrolled in the current cohort. TIMP expects to graduate 17 delegates in October, including two staff from the North Middlesex Hospital, and applications are now being submitted for cohort four.

4. Corporate Facilities.

A project is currently underway to reduce the number of specimen labelling errors occur in outpatients. The principle objective is to ensure no patient needs to be re-bleed due to administration or process errors by March 31st 2013. Progress to date:

- Analysed data to understand volume of errors and reasons for them happening
- Introduced a record sheet – for completion by OPD staff when taking specimens, so that we could easily track back when errors occur
- Undertook training session with relevant outpatient staff to ensure they understood how to correctly label specimen errors
- Error rates now added as a regular agenda item in the outpatient seniors management meeting

Staff from the outpatient department have had the opportunity to visit the laboratories and meet key members who explained and help them understand what happens to the blood once it leaves the department. In order for this data to be reported every month, extensive manual validation needs to occur, to ensure accurate reporting. The next step is to look at getting this automated and to understand the reasons for errors, using small cycles of change to eliminate recurrent errors.



5. Complex Patient Pathways

As part of the work to improve the patient pathway for complex patients at GOSH the Neuromuscular and Gastro services have jointly applied for the King's Fund/The Health Foundation "Patient and Family-centred care programme". Members of the clinical teams have had their first meetings which will be followed by a residential course in late September.

6. Consent

In April 2012 a project was set up to 'ensure consenting process for treatment meets necessary standards as detailed above and exceeds patient and family expectations.. This project takes into account the Internal Audit recommendations and NHSLA standards, with an increased focus on patient / family and staff experience. The project has two broad objectives:

- Clarify what good consent is (from child / family / staff / legal perspective)
- Standardise processes where appropriate across the Trust

The project aim is to demonstrate improved quality of consent by end March 2013. A steering group and project group have been set up and and is chaired by the Co-Medical Director who acts as executive sponsor. The head of quality, safety and transformation is currently acting as project lead until a more permanent solution has been identified. The project group is made up of multiple disciplines including consultants, the PPI and patient experience officer and nurse representation. The group have discussed the scope of the project and developed a driver diagram to demonstrate the areas that need to be addressed. The key to the success of this work is that it is driven by the front line staff.

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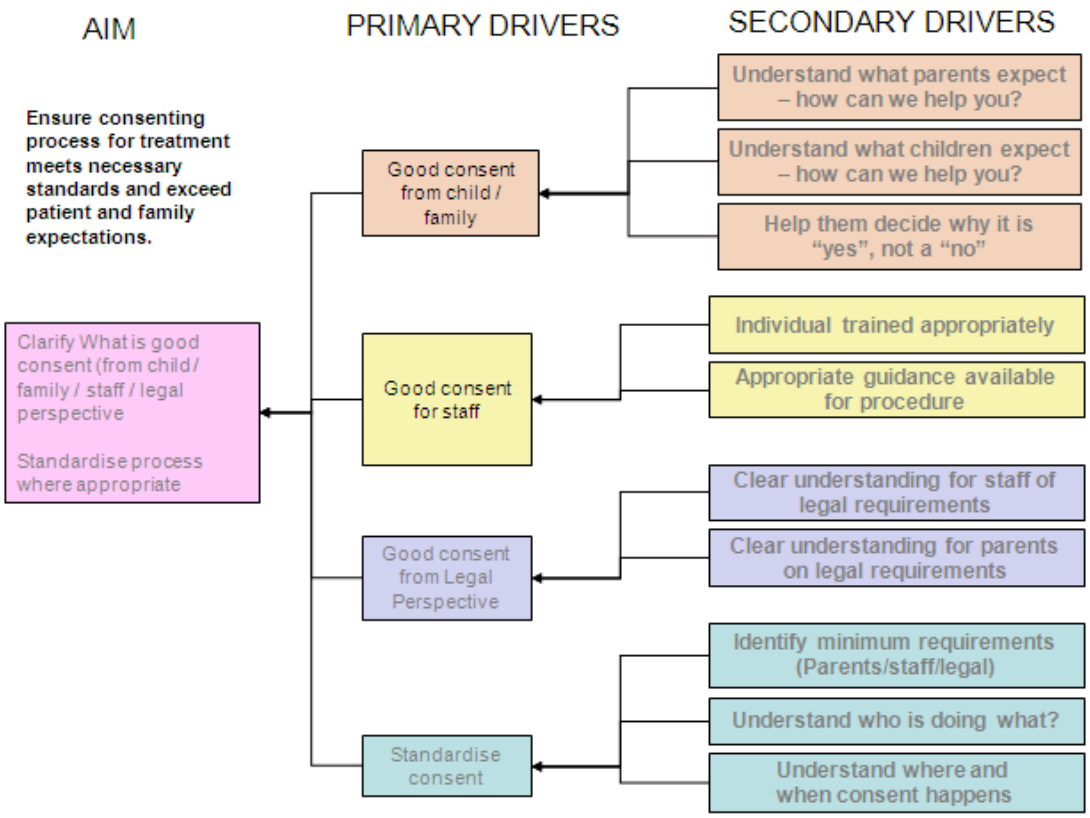


A quality improvement project has already commenced examining consent process for cardiac catheters, with a view to using videos and providing written information in advance to patients and families. This work is being monitored through the consent group and will help inform next steps.

There is also improvement work being undertaken in cardiac surgery, MDTS, spinal, haematology/oncology and neurosciences. Further work needs to be undertaken to capture the learning from all these and other areas to inform the next steps of the project.

Summary

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

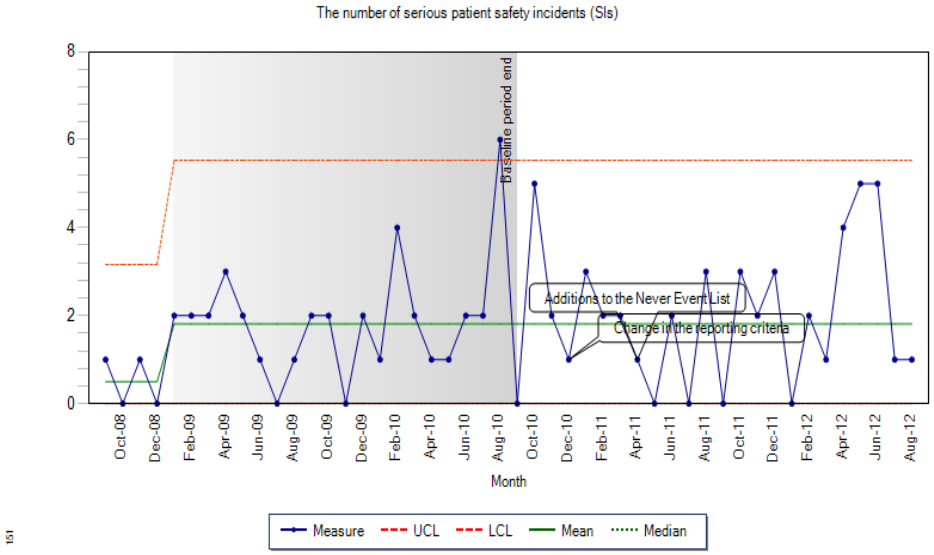
The next QST report will provide a Zero Harm highlight report and progress report on Safety to include SI, complaints and risk.

ATTACHMENT M
Appendix A

The following report produced by the Quality, Safety & Transformation (QST), provides Zero Harm data for Management and Trust Board, September 2012.

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

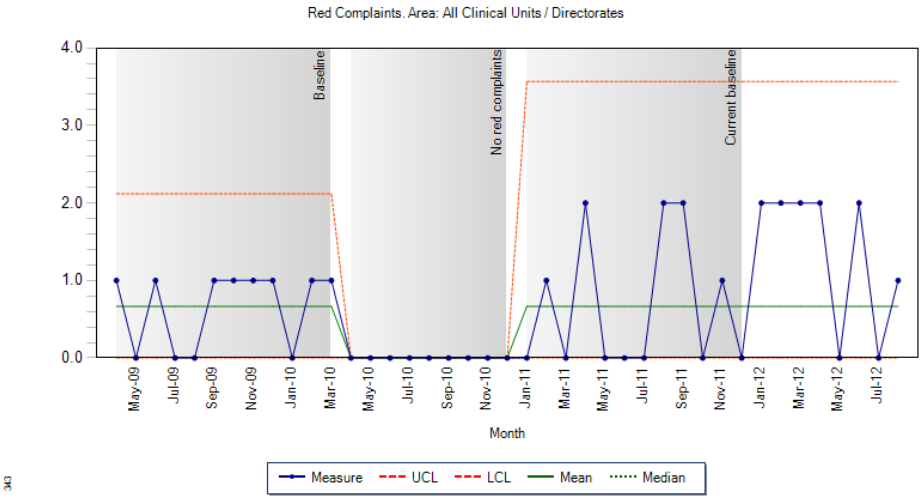


The number of serious patient safety incidents

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'

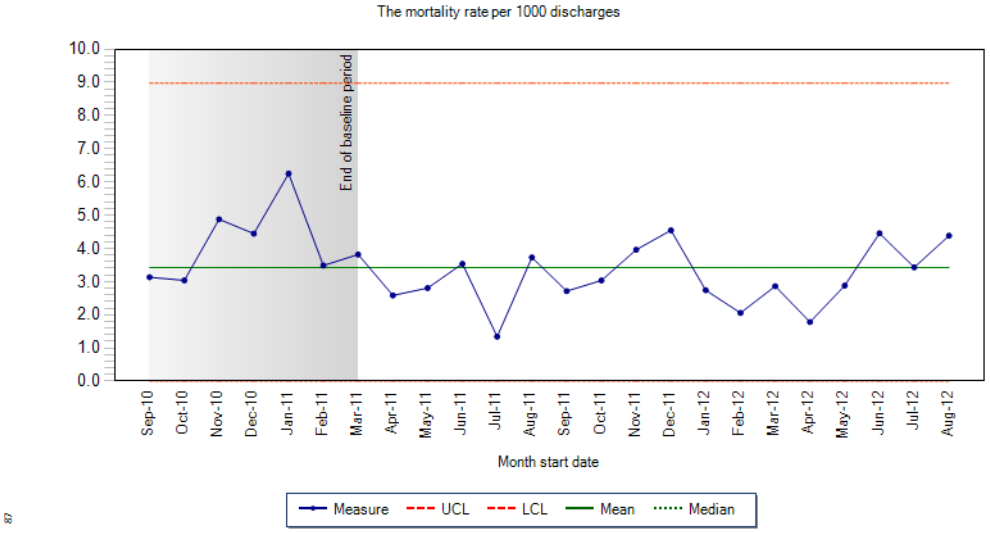
2. Red Complaints



ATTACHMENT M

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

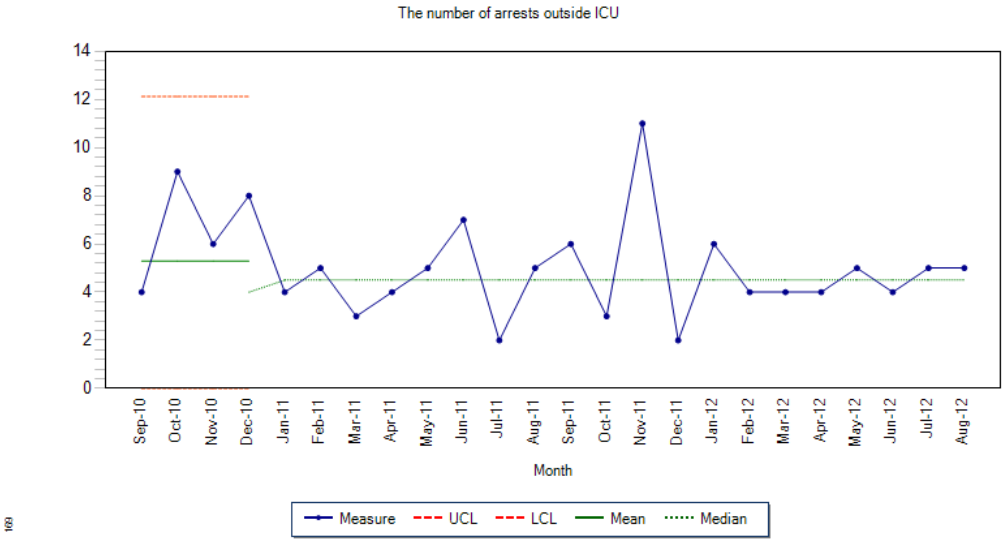
3. Mortality



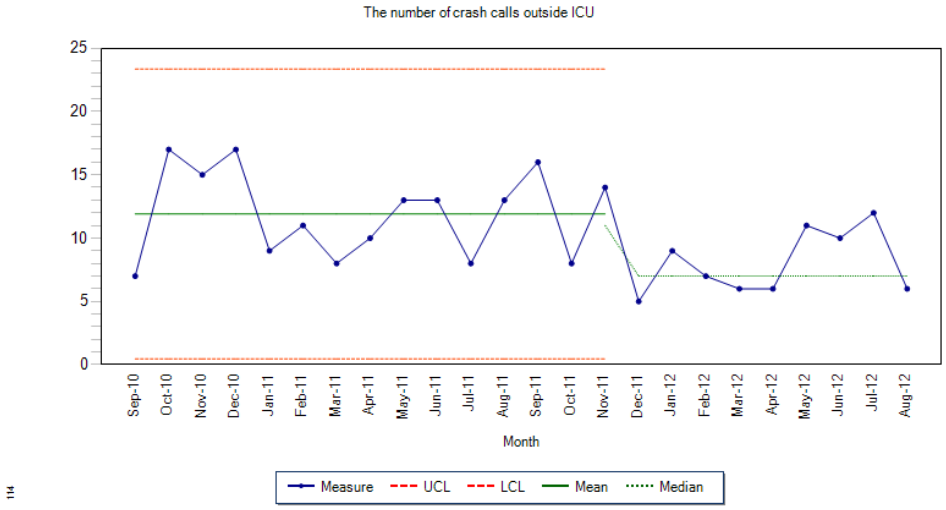
4 & 5 Arrests and crash calls outside Intensive Care Units (ICU)

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.

Please see Transformation report for update.



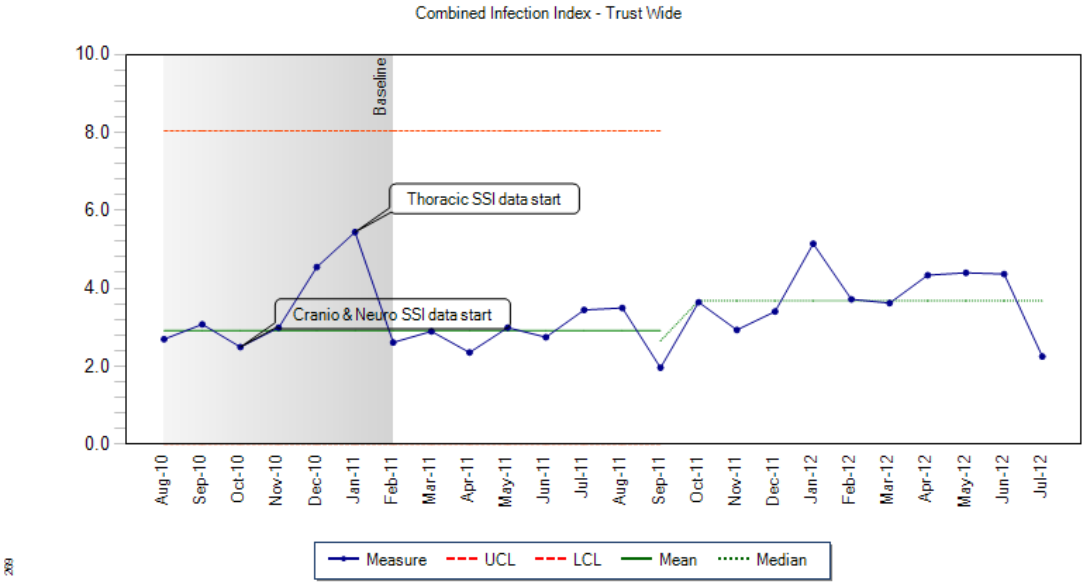
The monthly number of arrests (cardiac or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team).



The monthly number of crash calls (calls made to the 2222 Clinical Emergency Team) outside of ICU ward. All 2222 calls are now reported at the weekly QST seniors meeting, where trends are monitored and a summary sent to the COO meeting.

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.

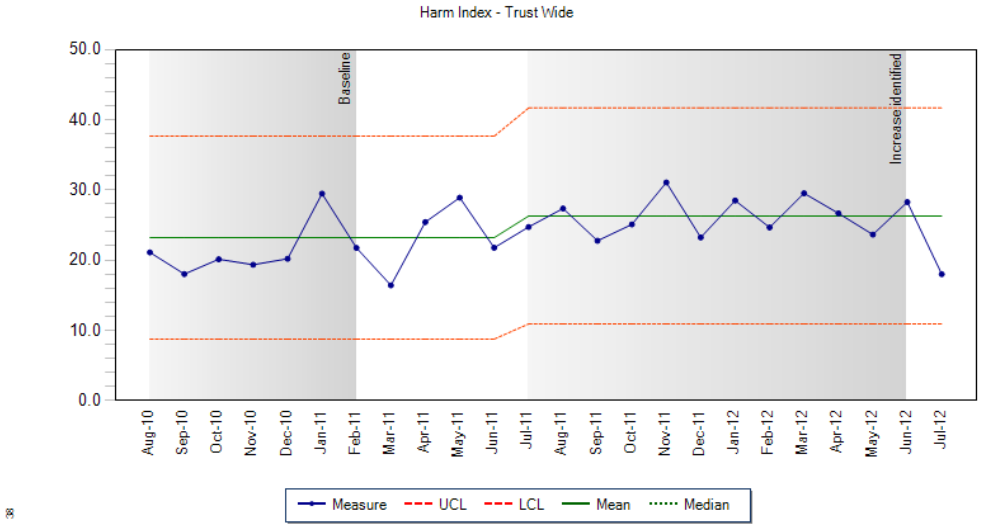


Adjusted Patient Activity = number of Finished Consultant Episodes (FCEs) + ((number of OPD appointments + (ICU bed days x 9.5)) / 12.9)

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

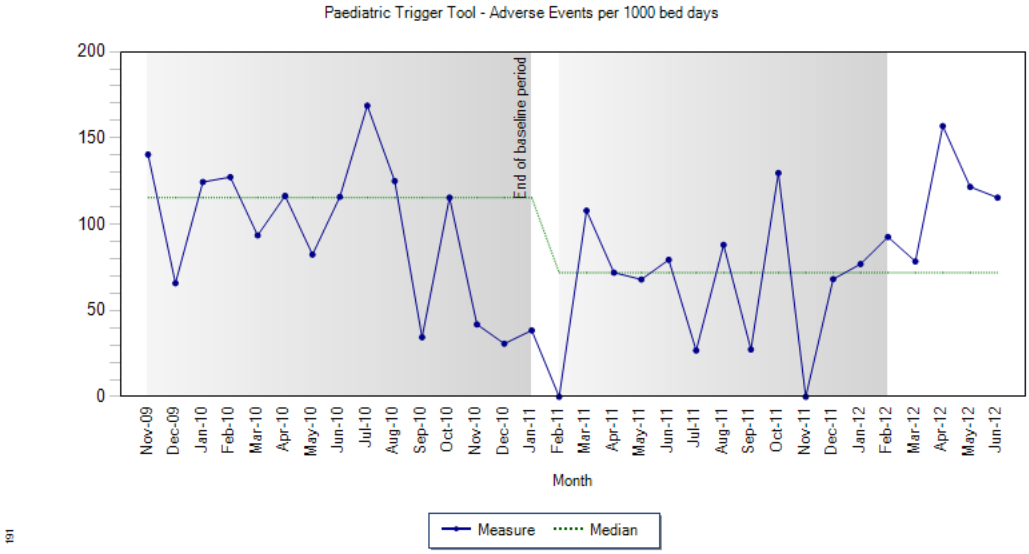
This index is the total number of harm incidents per 1000 Adjusted Patient Activities in the Trust. It includes hospital acquired infections (as above), serious incidents, non-ICU arrests, reported medication errors, patient falls, and pressure ulcers. It should be noted that the vision is to improve 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, the case notes of 20 discharged patients are randomly selected for a structured review by experienced clinical staff using the Paediatric Trigger Tool (PTT). The PTT identifies patient harm which is then graded using an international scale. Because the case note randomisation and PTT methodology are followed rigorously, the patient harm rate can be tracked over time. Recurrent harm events are feedback to QST and identified as future improvement projects.
A number of projects have been identified by the PTT including difficult vascular access(drips)/ venepuncture (blood sampling) and skin care. One of the first issues identified has been the quality and maintenance of patient healthcare records and each Clinical Unit has added a project to improve the quality of Medical Records to their project plans. This is reported through the Transformation Programme report.

ATTACHMENT M



Cases can only be selected 30 days after discharge and further time is needed to randomise and obtain all the case notes, therefore 'current' results will appear 2 months after the date of discharge.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 26th September 2012	
Assurance and Escalation Framework **Submitted on behalf of:** Fiona Dalton, Chief Executive (Interim)	**Paper No: Attachment O**
Aims / summary The Deloitte Quality Governance Assurance report (20th January 2012) included a number of medium priority recommendations to improve or reinforce quality governance arrangements at GOSH. One of these recommendations required the Trust to develop an Assurance and Escalation Framework to underpin how the Board derives assurance on controls, including reference to data quality. Monitor has requested an update on implementation of these recommendations at the end of September 2012.	
Action required from the meeting The Board is asked to review and approve the attached Framework.	
Contribution to the delivery of NHS Foundation Trust strategies and plans 7A We may fail to maintain compliance with regulatory and legislative requirements	
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? The Executive Team have been consulted on the Framework	
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 17th September 2012	

Great Ormond Street Hospital for Children NHS Foundation Trust

Board assurance and escalation framework

1. Introduction

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) has developed a range of policies, systems and processes, which, when drawn together, comprise a robust assurance and escalation framework.

This framework provides the Board with assurance about how the organisation is able to identify, monitor, escalate and manage concerns and risks in a timely fashion and at an appropriate level.

This framework summarises Trust policies, systems and processes and should be read together with the following documents:

- Terms of Reference for:
  - Trust Board
  - Audit Committee
  - Clinical Governance Committee
  - Finance and Investment Committee
  - Management Board
  - Risk, Assurance and Compliance Group
  - Standing Committees reporting to Management Board
- Quality Strategy
- Patient and Public Involvement Strategy
- Risk Management Strategy
- Performance Management Strategy
- Incident Reporting Policy

2. Purpose

This framework describes the Trust's governance structure, systems and performance indicators through which the Trust Board receives assurance. The assurance framework is a key driver in shaping the work of the Board and its committees.

The framework also describes the process for the escalation of concerns or risks which could threaten delivery of the organisation's corporate objectives, service delivery or patient safety.

3. Identification of issues and concerns

The Trust acknowledges that issues which may impact upon quality may be identified both internally and externally, examples of which are indicated in table 1 below.

Table 1

Internal sources	External sources
Staff and management	Patients, carers, public
Internal audit	External audit
Clinical audit	Regulatory bodies (CQC, Monitor)
Patient surveys and other forms of feedback	Legislative bodies
Risk register	National staff survey

Internal sources	External sources
Trends identified through complaints, litigation, incidents and PALS reporting	National clinical benchmarking data
Compliance monitoring e.g. Infection, Prevention and Control Audits	Commissioner reviews (paediatric cardiac surgery, paediatric neurosurgery, paediatric surgery, haemophilia)
Performance monitoring	Clinical peer reviews
Executive safety walkrounds	
Early Warning Trigger Tool	
External clinical reviews commissioned by the Trust	

The Management of External Visits, inspections and Accreditations Policy provides a framework for overseeing, managing and responding to assessments of the Trust by external bodies.

This assurance information (and any recommendations arising) is reviewed at relevant management committees and used to update the Trust wide risk register to provide assurance of the effectiveness of controls in place to manage risks. Results relevant to the strategic Trust objectives are reported via the assurance framework to the Trust Board's assurance committees (Audit Committee and Clinical Governance Committee).

4. Reporting mechanisms

The Trust Board, through its policies ("Being Open", "Incident Reporting and Management", "Raising Concerns in the Workplace"), encourages staff to be as open and honest as possible at all times. All communication with families and other relevant parties should be clear and honest and should occur in a timely fashion.

Staff are required to report any incident, defined as any event or circumstance that could have or did lead to unintended or unexpected, harm, loss or damage. These may be clinical or non-clinical events and can affect staff patients or visitors while on the Trust premises. There are high levels of incident reporting. GOSH has the second highest reporting rate to the NPSA for acute specialist Trusts. Following their recent unannounced visit, the CQC confirmed that they had spoken to a range of front-line staff and that all staff knew how to raise concerns, and felt confident to do so.

The Trust is committed to meaningful and effective communication with its staff and encourages a climate of openness and honesty in all of its services and business dealings. Individual members of staff are encouraged to raise with their manager(s) any matters of concern that they may have about health care issues related to the delivery of care or service to a patient or any concern relating to the possible existence of fraud, bribery or corruption in the Trust.

The Trust Whistle Blowing guidance ("Raising Concerns in the Workplace") provides the framework by which members of staff can raise concerns about safety and quality if the issues are not addressed. Harassment or victimisation of any member of staff raising a genuine concern will not be tolerated.

It is recognised that a member of staff may wish to raise a concern in confidence. If a staff member asks the Trust to protect their identity by keeping their confidence, the Trust will endeavour to do everything it can to do so. A designated Non-executive Director can be contacted directly by staff who wish to raise concerns confidentially.

The Trust's Patient and Public Involvement and Engagement (PPI) strategy was developed after extensive consultation with staff and Foundation Trust members and aims to encourage parents, patients and members of public to become engaged in Trust activity. The strategy includes a three year implementation and action plan.

A staff toolkit has been produced to give practical help and advice to staff considering engaging patients and parents in service planning. Procedures were agreed to support the recruitment of member representatives.

The Patient, Public Involvement and Experience Committee (PPIEC), chaired by the Assistant Chief Nurse (Quality, Safety and Patient Experience), and including three parents, and two councillors from the Foundation Trust Members' Council, monitors implementation of the PPI strategy, responds to proposals from the Trust's Members' Council, and provides strategic direction for the overall patient experience agenda.

The various methods by which the reporting of issues or concerns is possible in outlined in table 2.

Table 2

Internal mechanisms for reporting	External mechanisms for reporting
Serious Incidents	Serious Incidents
Datix	Complaints and Health Service Ombudsman
Performance management reporting	PALS (Patient Advice and Liaison Service)
Whistle Blowing Policy	Litigation
HR policies such as Grievance Policy	Coroner cases
Safeguarding Policy	Patient surveys
Line management processes	LINks (Local Involvement Networks)
Corporate governance policies	NHS Choices
PEAT assessment	Care Quality Commission
Visible leadership programme (nursing)	Local Authority - Health Overview and Scrutiny (HOSC)
Paediatric Trigger Tool	CQUIN (Commissioning for Quality and Innovation)
Executive Safety Walkrounds	Meetings with commissioners
Risk Action Groups	Referrer feedback
	Peer reviews

In the event that a concern cannot be raised through the above normal routes and is deemed to be so urgent that the issue requires immediate escalation, then the matter can be bought to the attention of the director responsible and if applicable recorded on the relevant
risk register.

5. Risk Management Framework

Risk Management Strategy

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

It identifies the organisational risk management structure, the duties and authority of key individuals and managers with regard to risk management activities and the roles and responsibilities of committees and groups that have some responsibility for risk. It describes the process for the management of operational and strategic risks and how high graded operational risks which require a Trust wide or strategic level approach and further action are managed by the relevant committees (see appendix 1).

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

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

Incident reporting

The Incident Reporting & Management Policy describes the process to report, record and investigate individual incidents in detail. Levels of reporting and aggregated analysis will be monitored by the Quality, Safety and Transformation Team and reported through to the Quality & Safety Committee with feedback to the local teams.

Executive Safety Walkrounds

Executive Safety Walkrounds are conducted on a weekly basis and involve executive led teams visiting areas of the hospital to discuss and pick up on key patient safety concerns, promote a safety culture and build communication and relationships with front line staff. Information from these walkrounds are required to be acted on within one month (unless requiring immediate action) and are reported on the unit risk register if not completed within this timeframe.

Risk assessment and reporting

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

The grading provides guidance on the action required and can be **High, Medium or Low.**

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

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

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

Low risks - included in risk register and are managed by the clinical team, unit board or department where appropriate for quarterly review by clinical unit board or Risk Action Group

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

Any risk identified with a score of 12+ is bought to the attention of the appropriate director.

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

Local risk registers

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

Trust risk register

The Trust risk register is the aggregation of the local clinical team and corporate department risk registers and any additional sources of risk such as external or internal reviews. It is maintained centrally by the Patient Safety team and recorded on the Datix Risk management system. As such it identifies the source, describes the risk, scores and grades it and provides a summary of the action taken to control it. It includes a review date and a residual risk rating. Risks scoring over 12 on the Trust risk register are linked to the assurance framework and reviewed by the executive team and assurance framework group.

The Trust wide risk register is reviewed by Trust Board and its sub committees as per the committee reporting schedules. Changes to the risk registers are monitored centrally by the Patient Safety team. Local risks are managed and owned by the local unit teams. Corporate risks are those that need a Trust wide approach or which may arise as a result of external factors over which the Trust may have limited control. They are owned by the executive team who delegate their management to either a nominated individual, designated committee or designated, time limited project group. If a risk is accepted, i.e. no appropriate action to mitigate it is identified; this must be agreed with by the Chief Executive or the Deputy Chief Executive and reported to the relevant Trust Board committees.

Assurance Framework

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

6. Quality Governance Framework

GOSH is committed to the care of children and young people. They and their families are at the centre of our strategy. GOSH intends to be one of the top five children's hospitals in the world. To demonstrate this, it must place Quality and Safety (Q&S) at the top of its own agenda and establish mechanisms for recording and benchmarking clinical outcomes.

GOSH utilises the three key domains identified by Darzi (Next Stage Review, DH 2008), within which continuous improvement is necessary to achieve its goals. These domains, annotated by us to reflect our priorities, are;-

- Safety (zero harm)
- Effectiveness (demonstrate clinical outcomes)
- Experience (deliver an excellent experience)

Our corporate commitments are:

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

Information on performance monitoring of quality targets and indicators is detailed in section 8 below.

7. Information Governance Framework

The Trust has arrangements in place to ensure the robust management of information in order to deliver the best possible care and service to patients. The Information governance framework sets out the organisational structure through which the integrity, availability and confidentiality of information is managed. The framework encompasses all aspects of information and data processing, storage and transfer.

The Information Governance Steering Group is responsible for overseeing day to day Information Governance issues; developing and maintaining policies, standards, procedures and guidance, coordinating Information Governance in the Trust and raising awareness of Information Governance.

Data Quality

The Trust recognises the importance of maintaining high standards of data quality to fulfil its own and its stakeholders' requirements. High quality, timely and consistent data is crucial to support patient care, contracting, performance management and decision making.

The Trust has established data management processes for its main patient-based systems with both internal and external data quality checks operating on the core data. But there are a large number of local and distributed systems set up to support needs of individual specialties or to deliver KPIs with differing data quality standards operating. An internal accreditation methodology has been established to assess the assurance available on these systems and identify whether there should be actions taken to cleanse, correct or validate the data in order to increase the assurance available. As a priority an assessment using this accreditation methodology has been carried out on all data which flows into the Trust Board KPI report in order to increase the assurance on the reliability of critical information.

8. Performance monitoring

Overview
A performance management system is in place to monitor progress against:

- Trust objectives and supporting workstreams
- Care Quality Commission (CQC), Monitor, and national priority and existing commitment performance indicators.
- Commissioning and contract agreements.
- Key internal measures

The Trust Board has identified seven key Trust-wide strategic objectives to be fully achieved over a 3 year period - supported by a number of critical workstreams and actions to deliver them. These workstreams are reviewed and updated by the Board on an annual basis to ensure they reflect both the internal and the external contexts and environments in which we operate in. To ensure our objectives and workstreams remain fit for purpose the Trust undertakes an annual PESTLE and SWOT analysis; reviews our market and competitors; reviews external strategic drivers; reviews our activity and demand and our internal capacity to deliver change.

Clinical units develop and update their local annual plans in line with changes in the Trust objectives and critical workstreams.

The Board receives a monthly Key Performance Indicator (KPI) report describing progress against: Trust objectives, locally defined targets, CQC national targets and commissioning targets.

The Trust Board periodically receive ‘deep dive’ reports reviewing key areas of poor performance and action plans in further detail.

Quarterly Strategic Performance Reviews are undertaken with Clinical Units to monitor progress against their local annual plans and key targets.

The Trust objectives additionally form the basis and structure of our Assurance and Risk Framework.

The Key Performance Indicator (KPI) report is used monitor progress against priority objectives, as outlined in our Annual Plan, and to ensure that the Trust continues to meet and remain compliant with the range of external reviews, targets and contractual standards.

Internal, external provide assurance of the effectiveness of the controls in place to manage specific risks.

Board level

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

The KPI report includes: Progress against Monitor's compliance score; the implementation of a 'dashboard' and 'RAG' scoring system with defined thresholds to clearly demonstrate movements in quality over time / immediately identify areas of poor performance; and an improved presentation of trend analysis showing a historic track record of achievement.

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

Zero harm reports have been received at Trust Board for over a year. A formal Transformation report is also presented at Trust Board as part of the monthly rotation between safety, transformation and outcomes reporting.

The Trust Board continue to receive information on all serious incidents, monthly trends on key safety and quality indicators, and information on every locally-rated high level risk across the organisation.

Specific performance issues are also escalated to Trust Board by Executive and Non-Executive members.

Clinical Unit level

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

Progress against Clinical Unit Annual Plans together with a review of unit performance against key internal and external standards and targets is monitored through Quarterly Strategic Performance Review meetings. The meetings are attended by Clinical Unit leads, Executive Team members and Heads of Department.

Quarterly Reviews of nursing performance are held, monitoring progress against nursing led KPIs and including a review of progress with education and training at Unit level; workforce and patient experience.

A series of Clinical Unit KPI dashboard reports are presented at Management Board and Trust Board. These reports are discussed at Unit Management Board meetings and also used to monitor unit performance through the Quarterly Strategic Review meetings and at fortnightly meetings between the Clinical Unit Chair and the Chief Operating Officer.

Quality

A number of key themes have been identified to ensure that quality indicators are measured consistently and that robust governance arrangements are promoted at Clinical Unit Board, Management Board and Trust Board. These include:

- Transformation improvement plans
- Risk management
- Key performance indicators
- Safety

- Finance and activity
- Cash releasing efficiency schemes (CRES)

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

Table 3

	Item	Clinical Unit Management Board	Management Board	Trust Board
1	**Transformation improvement plans**	Progress update against Transformation improvement plans	Ad hoc reports as sent by Qualit, Safety and Transformation Team for approval and information and monthly deep dives by units	Rolling alternate programme of Transformation improvement, safety and outcome project progress reports
	Information provider lead and link to data source	Head of Quality, Safety and Transformation http://gosweb/transformation/cms/news.asp?id=61	Head of Quality, Safety and Transformation	Head of Quality, Safety and Transformation
2	**Risk management**	Full Clinical Unit risk register	Monthly Trust-wide high level risk register Top 3 Clinical Unit risks identified in monthly Clinical Unit management report	Bi-annual Trust-wide high level risk register (Also presented to CGC and Audit Committee every quarter) Assurance Framework reviewed by the CGC and Audit Committee quarterly and issues escalated to Trust Board and minutes reported to Trust Board. Annual full Board Assurance Framework incorporating all Trust high level risks
	Information provider lead and link to data source	Head of Quality, Safety and Transformation Datix database	Head of Quality, Safety and Transformation	Head of Quality, Safety and Transformation
3	**KPI**	Clinical Unit level KPI report	Monthly full trust-wide KPI report	Monthly full trust-wide KPI report
	Information provider lead and link to data source	Head of Planning & Performance Management		
4	**Clinical Unit quality report**	Clinical Unit report as presented to Management Board	Report presented monthly by Clinical Unit.	Performance exceptions and significant statistical variation reported through monthly KPI report
	Information provider lead and link to data source	Head of Quality, Safety and Transformation http://gosweb/transformation/information/apps/flow/ZHStart.aspx	Head of Quality, Safety and Transformation	Head of Quality, Safety and Transformation
5	**Finance and activity report**	Monthly finance and activity report	Monthly finance and activity report	Monthly finance and activity report
	Information provider lead and link to data source	Head of Management Accounts / Head of Information Services	Head of Management Accounts / Head of Information Services	Head of Management Accounts / Head of Information Services
6	**CRES**	CRES programme update (2011/12 & 2012/13)	Monthly CRES programme update (From December 2012)	Monthly CRES programme update (From December 2012)
	Information provider lead and link to data source	CRES Project Manager O:\CRES Project	CRES Project Manager	CRES Project Manager

Monitoring compliance against Care Quality Commission (CQC) Essential Standards

The Risk Assurance and Compliance Group monitors the CQCs risk estimates of compliance with the standards and assesses the risk of non-compliance from other risk and assurance information. The Clinical Governance Committee is responsible for assuring the Trust Board that the relevant systems are in place to retain compliance with the standards.

9. Decision-making and escalation

Corporate Governance Structure

The GOSH corporate governance structure ensures quality underpins the Trust's governance arrangements and that future business strategy and performance are actively managed and assurance is provided to the Trust Board, in order to optimise the effectiveness, efficiency and economy with which the organisation delivers its services (see appendix 2).

Committee Reports to Trust Board

All committees of the Board report to the Trust Board via copies of the minutes and summaries of recent meetings. The purpose of the report is to:

- Escalate risk over the threshold delegated to the committee (in accordance with the Committee Terms of Reference or identified through other issues presented at the Committee);
- Escalate decisions outside the delegated authority of the committee;
- Communicate positive assurance and gaps in assurance;
- Integrate issues which cross the Terms of Reference of different committees;
- Forward plan;
- Commission tasks for working groups.

The committee report is considered at the next meeting of the Trust Board and is presented by the Chair of the reporting committee.

All items reported to the Trust Board, Audit Committee, Clinical Governance Committee, Finance and Investment Committee and Management Board use the Trust's standard template coversheet (see appendix 3).

Escalation of risks

Risks/issues are escalated to the levels above the normal risk owner for any of the following reasons:

- the risk requires a pan Trust risk management approach;
- the risk is so significant that it impacts the Trusts strategy, albeit that it was identified at a lower level;
- the risk is not being effectively managed at the level of the normal risk owner;
- the risk has come through secondary methods of risk/ issue identification and need to be added to a risk register.

Identified risks/ issues may, for the reasons outlined above, be escalated beyond the normal risk owner to the next level or above. The escalation route is presented in appendix 1 (text taken from the Risk Management Strategy).

10. Organisational learning

Staff are offered risk management and other training, supervision and mentoring to support them to deliver safe high quality care.

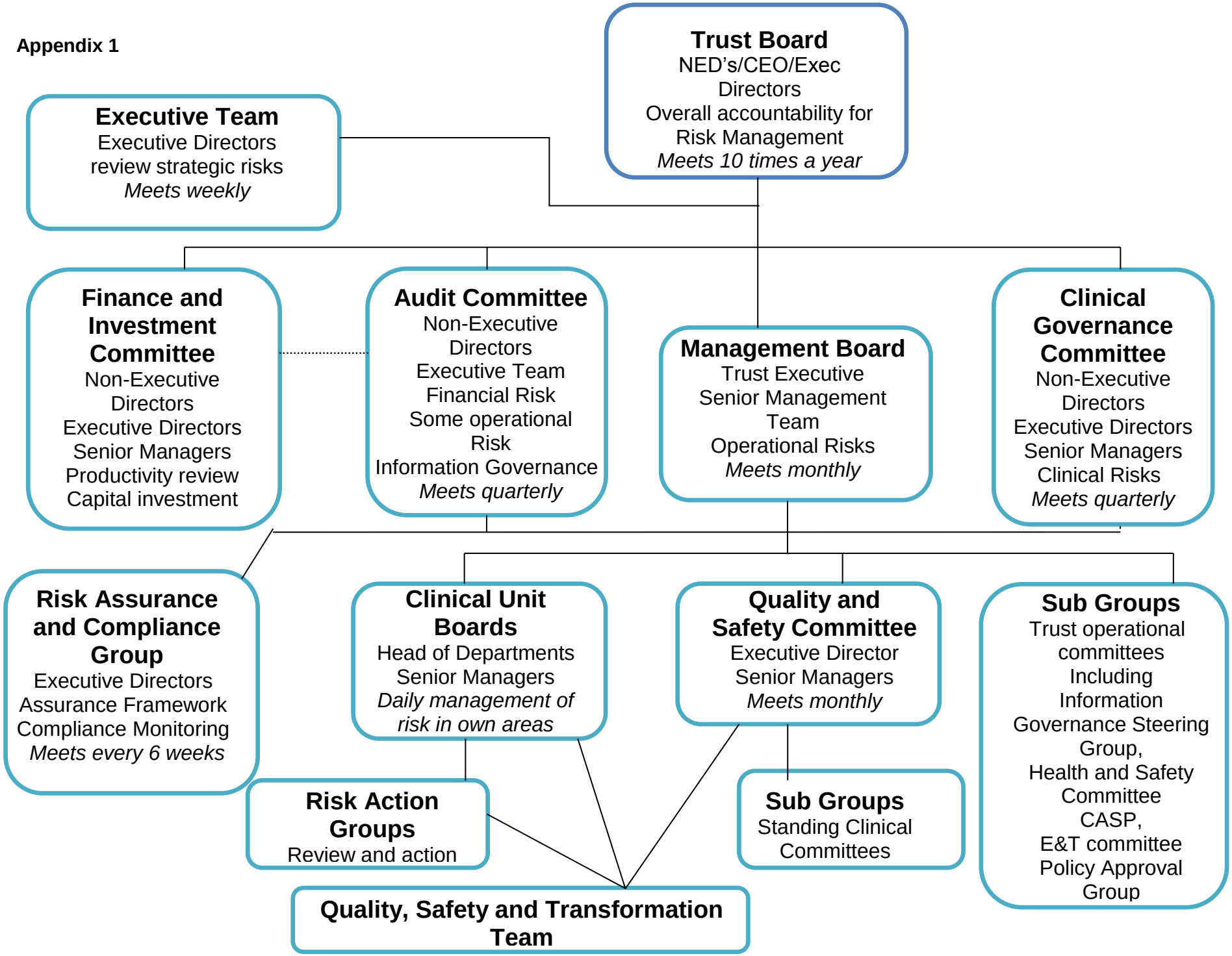
Staff are encouraged to participate in quality / continuous improvement training and development. A key part of the Transformation Programme is to spread skills and knowledge, including TIMP (Transformation Improvement Methodology Programme). The rust has a monthly programme of Transformation Master Classes with external speakers.

We have just established EQuIP (Enabling Doctors in Quality Improvement and Patient Safety Programme).

Our established partnership with Cincinnati Children's Hospital has enabled a wide variety of staff to learn from a leading institution in improvement.

The Trust is committed to learn from incidents and complaints in a culture that is open and transparent, and share this learning across the organisation. This is achieved in a number of ways, for example through publication of the Quality, Safety and Transformation Times and aggregated learning reports (incidents, risks, complaints and PALs reports) to committees.

Appendix 1


Trust Board
NED's/CEO/Exec Directors
Overall accountability for Risk Management
Meets 10 times a year
Executive Team
Executive Directors review strategic risks
Meets weekly
Finance and Investment Committee
Non-Executive Directors
Executive Directors
Senior Managers
Productivity review
Capital investment
Audit Committee
Non-Executive Directors
Executive Team
Financial Risk
Some operational Risk
Information Governance
Meets quarterly
Management Board
Trust Executive
Senior Management Team
Operational Risks
Meets monthly
Clinical Governance Committee
Non-Executive Directors
Executive Directors
Senior Managers
Clinical Risks
Meets quarterly
Risk Assurance and Compliance Group
Executive Directors
Assurance Framework
Compliance Monitoring
Meets every 6 weeks
Clinical Unit Boards
Head of Departments
Senior Managers
Daily management of risk in own areas
Quality and Safety Committee
Executive Director
Senior Managers
Meets monthly
Sub Groups
Trust operational committees
Including
Information Governance Steering Group,
Health and Safety Committee
CASP,
E&T committee
Policy Approval Group
Risk Action Groups
Review and action
Sub Groups
Standing Clinical Committees
Quality, Safety and Transformation Team

Appendix 1

Trust Board

The Trust Board is responsible for overseeing the Trust strategy, managing strategic risks, and providing managerial leadership and accountability. Its purpose is to ensure that the Trusts systems and working practices support good corporate governance, financial probity and the management of risk to underpin safe high quality service delivery. The Trust Board receives minutes from the Audit Committee, Clinical Governance Committee and Management Board. It also receives quality, performance, finance reports and updates on the Board Assurance Framework, Trust wide risk register and management of specific escalated risks.

Management Board

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

Management Board is made up of the Executive team, clinical unit chairs, general and senior managers. Its membership reflects its role to ensure appropriate consideration and endorsement of decision-making on specific areas of risk.

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

Audit Committee

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

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

Clinical Governance Committee

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

and specific objectives from the assurance framework which fall within its remit at least once a year as per its reporting schedule.

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

Finance and Investment Committee

The Finance and Investment Committee meets quarterly and reports to the Trust Board and is chaired by a non-executive Director. It has delegated authority to assure the Trust Board and to be assured that appropriate action is taken to minimise and control aspects of financial risk around financial strategy and planning, financial policy, investment and treasury matters and in reviewing and recommending for approval major financial transactions. Its minutes are shared with the Audit Committee and received by Trust Board for information at the next available meeting. Additional members may be required to attend when necessary to inform the committee on any specific aspects of risk identified. Cross membership between this committee and the Audit Committee ensures an integrated approach to the management of risk.

Executive Group

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

Management Board

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

Management Board is made up of the Executive team, clinical unit chairs, general and senior managers. Its membership reflects its role to ensure appropriate consideration and endorsement of decision-making on specific areas of risk. Where high risks are identified which require a Trust wide or strategic level approach and further action, they are discussed and reviewed by Management Board. The Chair is the Chief Executive and meetings are held monthly.

The Risk, Assurance and Compliance Group

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

- monitor risk management systems and control and assurance process;
- advise the assurance committees on the co-ordination and prioritisation of risk management issues throughout the Trust;
  ensure the Trust complies with all requirements of the Assurance Framework;
- ensure the Trust complies with all requirements of the Health and Social Care Act 2008 (Registration Requirements) and other legislative, regulatory and external authority requirements.
- monitor integration of the governance framework.

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

Clinical Unit Boards

Clinical unit board review risk management issues, whether clinical, non-clinical or financial and ensure that these are included where appropriate on the local risk register and discussed as part of the unit board rolling agenda. Risks graded 12+ are reviewed by the Risk Assurance and Compliance Group and added to the Assurance Framework as appropriate. Relevant complaints and incidents are also reviewed at the Clinical Unit Board and may prompt risks to be added to the risk register.

Risk Action Groups (RAGs)

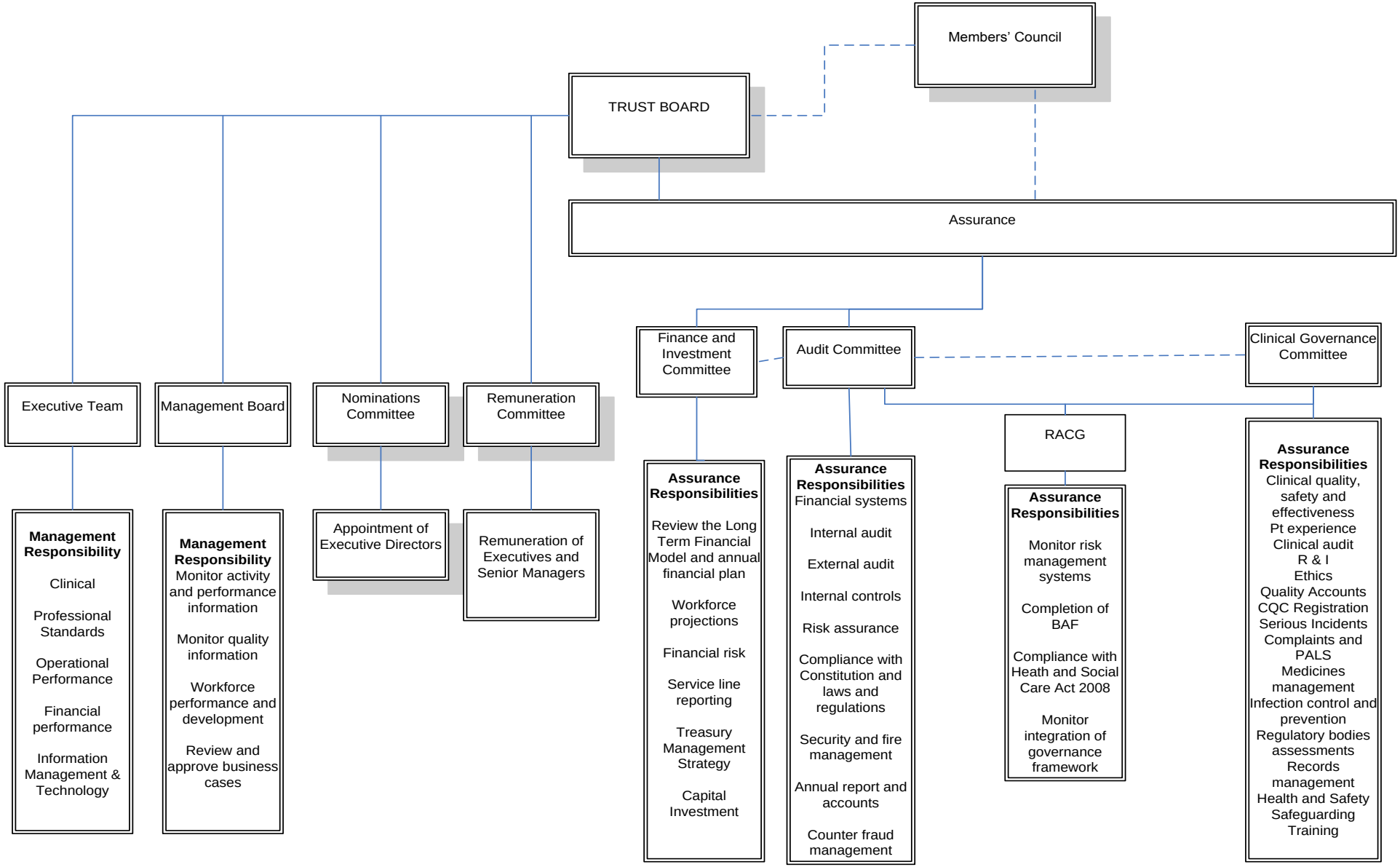
Local Risk Action groups or an equivalent meeting are established at which the principal risks to patient safety and service delivery will be discussed. Their role, remit and areas of delegated authority are identified by the Clinical Unit Board or equivalent and reflected in their terms of reference.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

Standing Committees

A standing committee is a committee with delegated authority from Management Board. Each standing committee is responsible for managing the cross Trust issues relevant to their area of expertise and as such has delegated authority within its terms of reference for a specific remit. This includes assessing the effectiveness of the control systems in place to reduce the risks relevant to their areas of expertise. A standing committee may be established either because it is required by statute or because it covers a key management function for the Trust to meet its objectives of efficient, effective and safe care. The Quality and Safety Committee reports to Management Board. The Health and Safety Committee and Infection Control Committee reports into the Quality and Safety Committee. The Information Governance Steering Group reports into Management Board.

Each standing committee will review specific relevant risks/ incidents and complaints on an escalated basis and make recommendations for action where required. These committees will also identify issues they think should be added to a risk register, re-graded or removed.

Appendix 2


Members' Council
TRUST BOARD
Assurance
Executive Team
Management Board
Nominations Committee
Remuneration Committee
Finance and Investment Committee
Audit Committee
Clinical Governance Committee
RACG
Management Responsibility
Clinical
Professional Standards
Operational Performance
Financial performance
Information Management & Technology
Management Responsibility
Monitor activity and performance information
Monitor quality information
Workforce performance and development
Review and approve business cases
Appointment of Executive Directors
Remuneration of Executives and Senior Managers
Assurance Responsibilities
Review the Long Term Financial Model and annual financial plan
Workforce projections
Financial risk
Service line reporting
Treasury Management Strategy
Capital Investment
Assurance Responsibilities
Financial systems
Internal audit
External audit
Internal controls
Risk assurance
Compliance with Constitution and laws and regulations
Security and fire management
Annual report and accounts
Counter fraud management
Assurance Responsibilities
Monitor risk management systems
Completion of BAF
Compliance with Heath and Social Care Act 2008
Monitor integration of governance framework
Assurance Responsibilities
Clinical quality, safety and effectiveness
Pt experience
Clinical audit
R & I
Ethics
Quality Accounts
CQC Registration
Serious Incidents
Complaints and PALS
Medicines management
Infection control and prevention
Regulatory bodies assessments
Records management
Health and Safety
Safeguarding
Training

ATTACHMENT P

Great Ormond Street NHS
Hospital for Children
NHS Foundation Trust

Trust Board **26th September 2012**	
Key Performance Indicator report Fiona Dalton, Interim Chief Executive Officer	**Paper no: Attachment P**
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. September 2012	

ATTACHMENT P

KPI Exception report

1. C.difficile and MRSA

In month the Trust reported 1 case of MRSA. The Trust rate has reported 2 cases year to date against a trajectory of 0 cases for the year. The Trust remains within the Monitor annual de minimis level of 6.

In month the Trust reported 2 cases of C.difficile. 5 cases have been reported year to date against a trajectory of 3.3 and a year-end trajectory of 8. The Trust remains within the Monitor annual de minimis level of 12.

2. MSSA & E-coli

No formal external targets currently exist for MSSA and E-coli. However, the Trust has set an internal standard of reducing the number of infections from the previous year. In month 1 case of MSSA was reported. 13 cases have been reported year to date against a trajectory of 5 (based on last year's rate). Infection rates continue to be monitored closely.

3. Inpatient Waiting List

As previously reported, capacity issues have been identified across a number of specialties within Surgery.

In order to address the need to meet both the national 18week RTT standards and treat the high number of long waiting non-18week pathway patients the Unit initially focussed on prioritising patients that met all of the following criteria:

- On an 18 week ticking pathway
- Past their 18 week Breach Date
- Have waited over 26 weeks based on inpatient wait rules
- And are not planned patients

Following this exercise over 100 patients have been allocated TCI dates over the next 4 months. The Unit has additionally increased the clinic outcome completeness rate and is significantly closer to achieving the 90% RTT admitted target.

However, there are approximately 180 non-18 week pathway patients that still require a TCI date. The Planning & Performance Department continue to work closely with the Unit to resolve waiting list backlog issues and will be implementing a waiting list modelling tool that has been developed by the Department of Health Intensive Support Team. The tool will help to:

- understand current capacity and how much capacity is needed to meet demand;
- understand the approximate maximum waiting list size to support the delivery of the target waiting
- see how many patients over the sustainable waiting list size the current waiting list is (backlog), and how long it might take to reduce this number;
- understand the potential effect of variation on the target waiting time

Detailed trajectories for Urology, Maxillofacial, Orthopaedics and General Surgery will be made available following this work and will be presented to October Trust Board.

4. Diagnostic waits over 6 weeks

In month the Trust reported a rate of 6.6% of all patients waiting over 6 week for a key diagnostic test against a previous month position of 7.93% and a target of less than 1%. Action plans have been put in place and trajectories set across four main pressure areas including Cystoscopy, Gastroscopy, Colonoscopy and MRI to ensure compliance by end of September.

In month, Urology reported 6 breaches against a trajectory of 5 and Colonoscopy reported 15 breaches against a trajectory of 14. Gastroscopy and MRI remain within trajectory reporting 2 breaches against a trajectory of 3 and 11 breaches against a trajectory of 20 respectively.

The Trust remains on target to achieve and remain within the tolerance by the September end census reporting period with all breaching patients allocated TCI dates in month.

5. Discharge summary completeness

Performance has deteriorated with a reported in month rate of 74.7% against a previous month rate of 76.6% and a May rate of 79.6%. The lowest rates are reported across Medicine (61.5%), Cardiac (65.2%) and ICI (71%).

Key issues within Medicine focus on a combination of staff leaving, sickness absence and pre-booked annual leave within the admissions team. A new admission structure is currently being implemented across the Unit with funding agreed for a substantive post that will be responsible for processing discharge summaries. The new structure will provide robust leadership and cover across the specialties, which is currently not possible.

The figures reported in month for Cardiac do not reflect the true position. This is primarily due to a high number of discharge summaries within Respiratory, which were given within the timeframe but not reported on PiMS as a result of unexpected staff absence. PiMS is currently being updated and the figures will be refreshed in the October report.

The total number of discharge summaries within ICI is low and progress has been made in improving the completion rate over the last three months. The Unit will be undertaking an audit of discharge summaries in order to establish activity for which no discharge summary is required and ensure these are excluded from the figures. Administration staff and will also be rostered for a Sunday to ensure sending is not a contributor to delay.

6. Patient refusals

In month performance has improved with 24 reported refusals against a previous month position of 53. 22 refusals are attributed to Surgery CATS. Year to date the Trust has reported 164 refusals against a 2011/12 year rate of 291.

7. Personal Development Review (PDR) completeness rates

The Trust PDR rate has significantly improved with a reported position of 78.6% against a previous month position of 65%. Units are reminded that continued progress against this standard is required to support the delivery of NHSLA level 3.

8. Data quality indicators

A key recommendation identified within the side letter received from Monitor in March 2012, which emerged during the scrutiny of the foundation trust application, related to the monitoring of data quality KPIs at Board level.

In response to this the report has been updated to provide a composite data quality score against the Trust Secondary User Service (SUS) return to the Department of Health. The

SUS return provides a single, comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services and includes a range of data items such as: referral data, NHS number, registered GP practice, patient postcode, PCT of residence, Commissioner, attendance status, outcome status.

Two particular areas have been highlighted as impacting on the overall composite score. These include the number of outpatients that have an 'attendance' recorded and the number of patients that have an 'outcome of attendance' recorded. The former indicator is reported at 94.8% against a target of 99.7% and the latter is reported at 81% against a target of 98.9%.

9. Market Share Analysis

Appendix 2 shows the market share trends for our priority specialties on a quarterly basis. The summary of the recent changes are;

Specialty	Target Markets	Market Share Trend	Key Competitors Changes	Comments
Cardiac Surgery	NL + Surrounding Further Regional	Up	Brompton Southampton	Signs of gains from Brompton & Southampton
Neuro Surgery	NL and SL and Surrounding	Down	Kings	Slow downward trend in South London
General Surgery	NL + Surrounding	Down	Chelsea & Westminster	Significant drop during Q1 which reflects refusals and underperformance
Spinal Surgery	NL and SL and Surrounding	Up		Recovering and moving back to previous levels
Gastro	NL + Surrounding	Down		Downward trend of market share with many other providers
Haem / Onc	NL and SL and Surrounding	Down		Clearly a change of coding practice at GOSH which needs further investigation

NL surrounding areas: Bucks, Essex, Beds and Herts
SL surrounding areas: Kent, Sussex and Surrey
Further Regional areas: Cambridge, Suffolk, Norfolk, Berks, Oxon, Hants and IOW

Green: Market Share Gain
Orange: Stable Market Share
Red: Market Share Loss

10. Escalation report

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

Where data can be analysed using methodology based upon statistical significance, we are able to determine whether each clinical unit has made a positive improvement or where a process has worsened. Similarly, for these measures we are able to make a judgement on whether an improvement is near to being realised.

ATTACHMENT P

Performance Measure	Change	Clinical Unit	Narrative
% clinic outcome forms complete (Chart 1)		Cardiorespiratory	A statistically significant reduction in performance has been identified. **Note that the most recent data point is usually subject to upward change due to late data entry.**
% Patients with discharge summary complete within 1 day of discharge (Chart 2)		Cardiorespiratory	Close to a statistically significant reduction in performance. **Note that the most recent data point is usually subject to upward change due to late data entry.**
% Patients with discharge summary complete within 1 day of discharge (Chart 3)		ICI	Close to a statistically significant reduction in performance
Hand Hygiene audit results (Chart 4)		IPP	A statistically significant improvement has been identified
% clinic outcome forms complete (Chart 5)		MDTS	A statistically significant reduction in performance has been identified. **Note that the most recent data point is usually subject to upward change due to late data entry.**
% Patients with discharge summary complete within 1 day of discharge (Chart 6)		MDTS	Close to a statistically significant reduction in performance
% clinic outcome forms complete (Chart 7)		Surgery	A statistically significant improvement has been identified. **Note that the most recent data point is usually subject to upward change due to late data entry.**

See appendix 1 below for the charts

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

Appendix 1

Chart 1
Cardio Respiratory

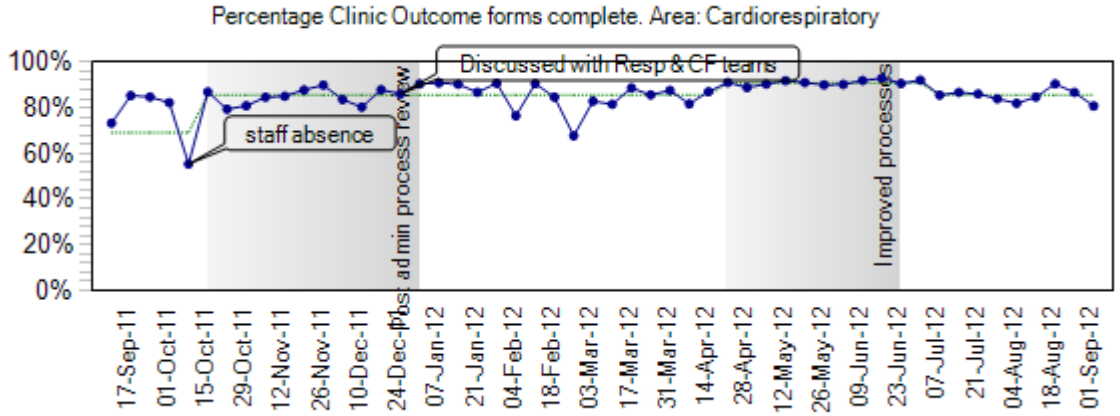


Chart 2
Cardio Respiratory

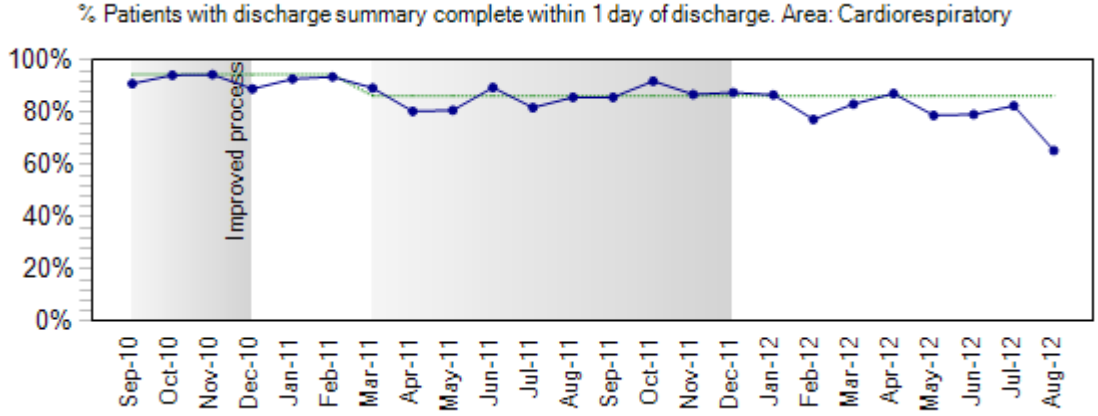
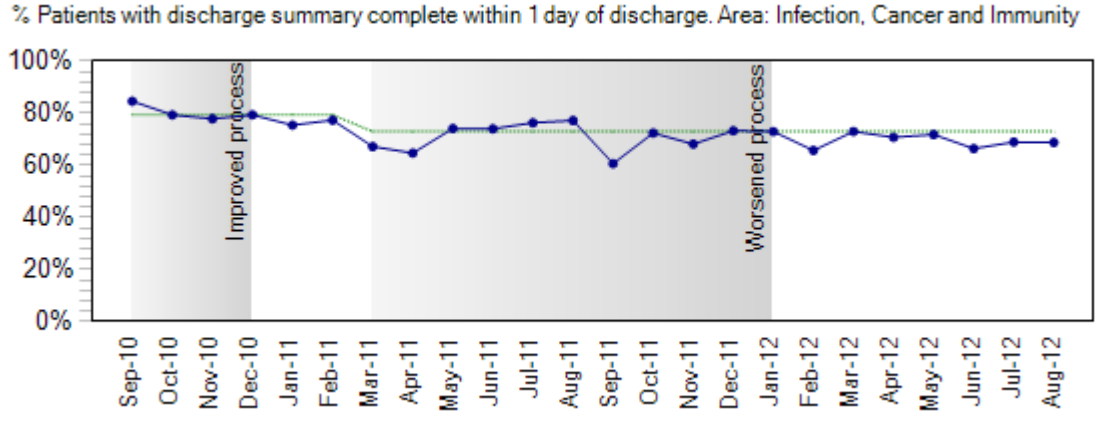


Chart 3
ICI



ATTACHMENT P

Chart 4
IPP

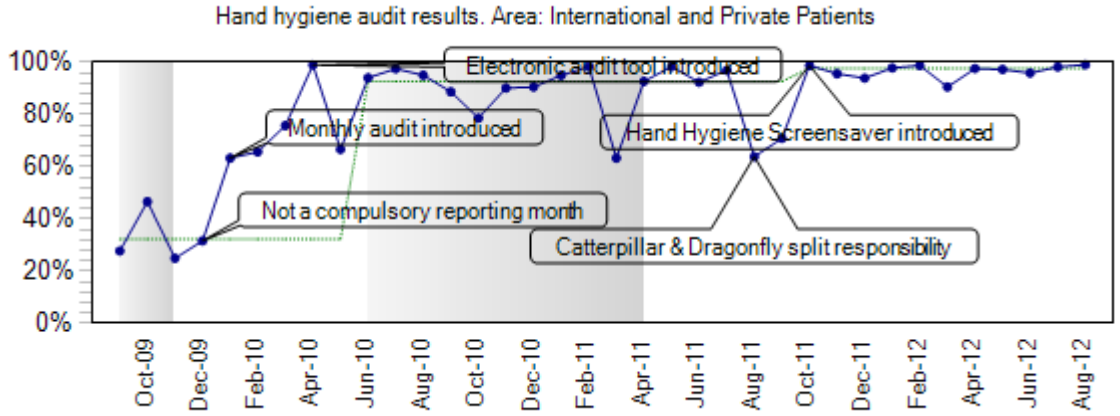


Chart 5
MDTS

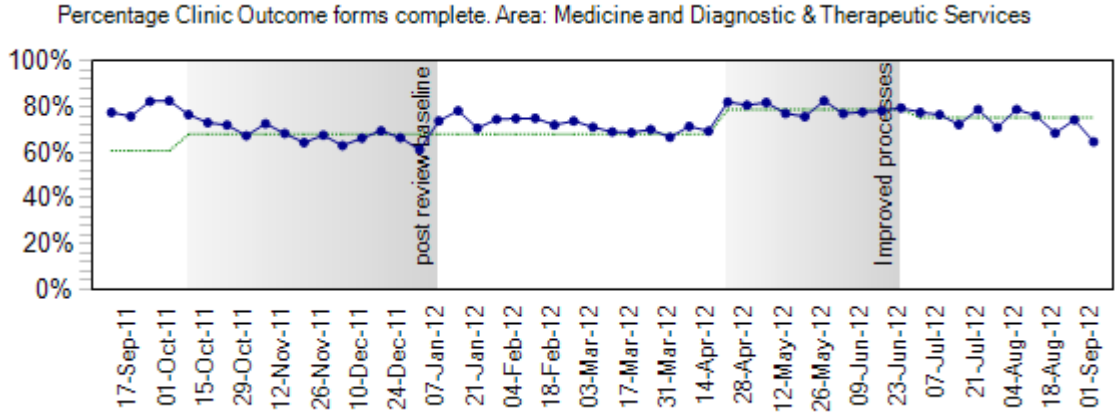
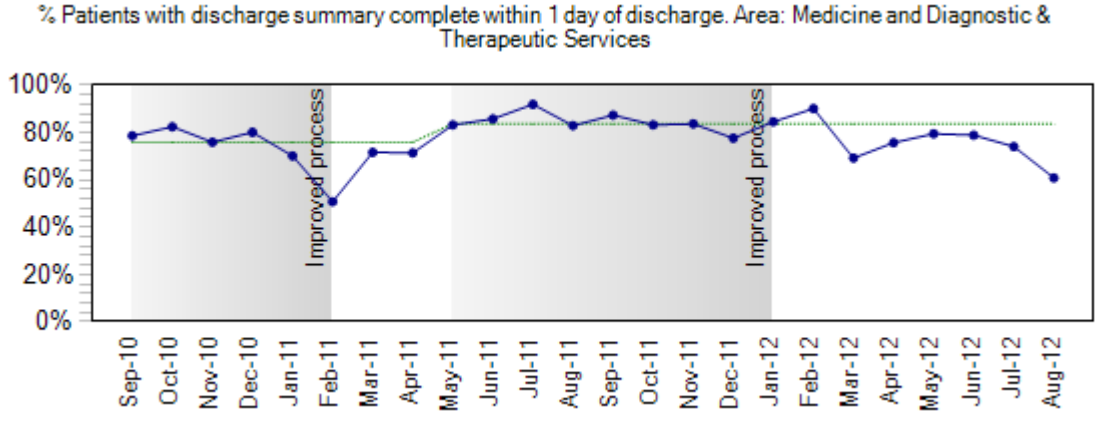
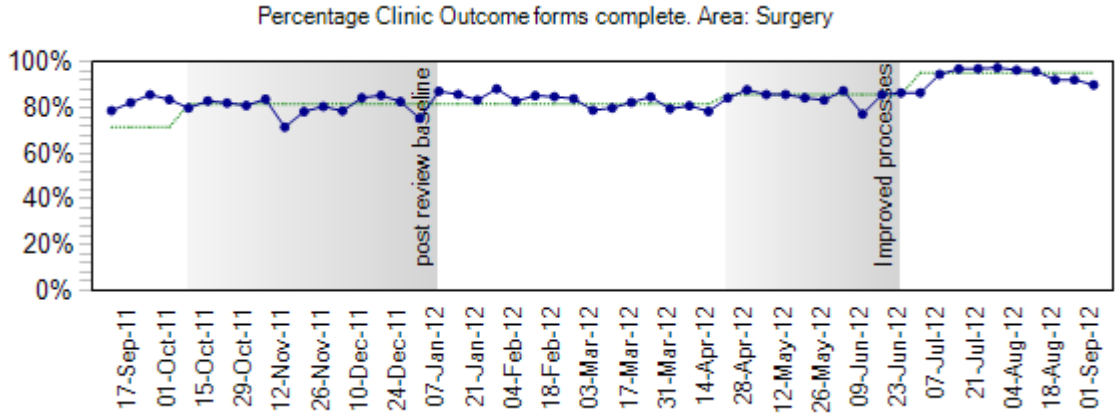


Chart 6
MDTS



ATTACHMENT P

Chart 7
Surgery



Recommendations:
Trust Board to note progress

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board

Key Performance Indicator Report

Aug-12

Objective	Graph	Page no.	Reported	YTD Target/Trajectory (12/13)	YTD Performance	Monthly Trend					Quarterly Trend				
						Apr-12	May-12	Jun-12	Jul-12	Aug-12	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4	2012/13 Q1
Objective 1	Incidence of C.difficile	4	Monthly	3.3	5	1	0	1	1	2	4	2	1	1	2
	Incidence of MRSA**	4	Monthly	0	2	0	0	0	1	1	2	0	2	0	0
	Incidence of MSSA	4	Monthly	4.6	13	2	3	4	3	1	2	2	4	3	9
	Incidence of E-Coli	4	Monthly	7.9	8	2	0	3	3	0	2	5	7	5	5
	No. of NICE recommendations unreviewed	4	Monthly	0	3	0	0	0	1	2	7	0	3	2	0
	CV Line related blood-stream infections	5	Monthly	1.5	1.94	3.02	2.65	2.21	1.11	0.89	2.00	2.33	1.58	2.15	2.63
	Mortality Figures	5	Monthly	Within tolerance	52	5	9	13	11	14	26	23	33	23	27
	Serious Patient Safety Incidents	5	Monthly	Within tolerance	17	3	7	3	2	2	6	5	6	5	13
	Surgical Check List completion rate (%)	5	Monthly	95.0	97.7	98.5	96.6	96.8	98.0	98.5	73.0	82.0	87.7	97.4	97.3
Objective 2	18 week referral to treatment time performance - Admitted (%)	6	Monthly	90	91.4	90.5	90.1	90.4	90.5	91.4	92.7	94.7	92.9	90	90.3
	18 week referral to treatment time performance - Non-Admitted (%)	6	Monthly	95	95.1	97.4	96.4	96.1	95.6	95.1	97.1	95.9	96.2	96.96	96.6
	18 week referral to treatment time performance - Incomplete Pathways (%)	6	Quarterly	92	92.0	91.8	93.4	93.2	92.0	92.0	76.2	85.5	85.4	91.97	93.2
	Inpatients waiting list profile (26+)	6	Monthly	0	270	238	244	282	270	270	64	130	185	274	282
	95th Centile - Admitted	6	Monthly	<23 weeks	36.1	26.2	24.5	22.7	36.1	Available in October	20.7	18.3	21.5	28	24.4
	95th Centile - Non-Admitted	6	Monthly	<18.3 weeks	17.8	17.6	17.7	17.7	17.8	Available in October	17.6	17.7	17.8	17.71	17.7
	Median Waits - Admitted	6	Monthly	<11.1 weeks	9.7	10.8	7.6	7.9	9.7	Available in October	10.0	10.1	10.1	9.08	8.8
	Median Waits - Non-Admitted	6	Monthly	<6.6 weeks	6.8	7.7	7.5	6.8	6.8	Available in October	7.1	6.7	7.2	6.72	7.3
	95th Centile - Incomplete Pathways	7	Monthly	<28 weeks	21.7	23.3	21.0	24.0	21.7	Available in October	37.0	30.5	30.0	21.98	22.8
	Median Waits - Incomplete Pathways	7	Monthly	<7.2 weeks	5.7	6.0	6.2	6.2	5.7	Available in October	9.1	7.6	7.1	6.43	6.1
	Discharge summary completion (%)	7	Monthly	95	79.6	79.3	79.6	78.5	76.6	74.7	76.3	78.4	81.5	79.3	79.1
	DNA rate (new & f/up) (%)	7	Monthly	10	8.8	8.7	8.1	9.6	9.0	9.0	8.0	8.0	8.0	8.30	8.7
	Cancelled Operations on day of admission (%)	8	Monthly	0.80	0.46	0.75	0.45	0.23	0.67	0.20	0.75	0.74	0.76	0.86	0.48
	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.	8	Monthly	98	100	100	100	100	100	100	100	100	100	100	100
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	9	Monthly	<=1	6.62	6.00	5.80	9.00	7.93	6.62	0.50	0.94	3.42	3.03	9.00
	Number of complaints	9	Monthly	132	51	8	13	11	7	12	41	32	28	31	32
	Number of complaints by grade High	9	Monthly	<14	4	1	0	2	0	1	2	4	2	6	3
	Theatre Utilisation (% Patient Operation Utilisation of Scheduled Duration, U4)	10	Monthly	70	66.4	68.4	68.6	66.3	66.4	65.9	72.1	69.4	62.6	68.9	67.8
	Clinic Letter Turnaround (% of letters on CDD)	10	Monthly	To be agreed	32.3	41.1	40.6	31.7	39.6	28.7	-	-	-	-	37.8
	Clinic Letter Turnaround (% of letters on CDD sent within 5 working days)	10	Monthly	To be agreed	26.6	15.4	18.9	27.3	23.6	26.5	-	-	-	-	20.5
	SUS Composite Data Quality Score (outpatients)	-	Monthly	94.9	88.9	88.6	88.4	88.2	88.4	88.9	-	-	-	-	88.4
	SUS Data Quality Score (outpatient attendance recorded)	-	Monthly	99.7	94.8	92.2	94.3	92.9	95.6	94.8	-	-	-	-	93.1
	SUS Data Quality Score (for outpatient outcome of attendance recorded)	-	Monthly	98.9	81.0	74.7	75.5	76.1	76.4	81.0	-	-	-	-	75.5
Objective 3	Patient refusals	11	Monthly	291	169	18	35	39	53	24	69	54	87	81	92
	Clinical Income variance (£, Exc. IPP)	11	Monthly	-	-2,178,427	-	-508,477	-730,662	-1,873,712	-2,178,427	278,133	-1,184,496	-1,610,703	-971,502	-730662
Objective 4	Clinical trials (CTIMPs)	12	Monthly	72	80	38	38	74	79	80	-	-	-	72	74
	GOSH research projects	12	Monthly	164	152	163	158	155	153	152	-	-	-	587	155
	Commercially-funded projects (% achieving a 70 day turnaround)	12	Monthly	95	100	100	100	100	67	100	-	-	-	83	100
	Number of UKCRN Portfolio projects	12	Monthly	134	136	124	118	129	138	136	-	-	-	134	129
	GOSH research income	12	Monthly		TBC	164,039	-	-	-	TBC	-	-	-	-	-
	Patient safety SAE's (Serious Adverse Event)	13	Monthly	7	1	3	3	1	0	1	-	-	-	14	1
	Biomedical Research Centre (BRC; Commercial Engagement) (£)	13	Monthly	1,957,857	172,535	31,683	0	-	-	172,535	-	-	-	1,294,498	-
Objective 5	MADEL SLA Value (£)	14	Quarterly	-	5,722,548	-	-	5,722,548	-	-	5,697,359	5,627,351	5,627,351	5,580,806	5,722,548
	SIFT SLA Value (£)	14	Quarterly	-	57,040	-	-	57,040	-	-	60,142	60,142	60,142	60,142	57,040
	NMET SLA Value (£)	14	Quarterly	-	725,192	-	-	725,192	-	-	1,058,375	1,007,342	1,150,924	1,165,709	725,192

Objective	Graph	Page no.	Reported	YTD Target/Trajectory (12/13)	YTD Performance	Monthly Trend					Quarterly Trend				
						Apr-12	May-12	Jun-12	Jul-12	Aug-12	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4	2012/13 Q1
Objective 6	CRES Forecast Savings 2011/12 (£)	15	Monthly	16,718,008	16,299,093	14,974,722	14,544,022	15,562,713	15,763,747	16,299,093	16,525,262	15,835,800	11,013,621	8,248,330	15,562,713
	Bank and agency total expenditure (£)	15	Monthly	To Reduce	6,113,579	1,213,240	1,231,974	1,230,979	1,119,955	1,317,432	371,669,267	4,636,000	4,215,000	4,096,000	3,677,214
	Monitor Risk Rating	15	Monthly	Not less than 3	3	4	4	3	3	3	4	3	3	Data Not Available	3
	Charity fundraising income (£)	15	Monthly	19,185,505	27,778,596	3,579,057	3,803,918	5,088,147	8,344,075	6,963,399	10,436,686	18,216,316	15,046,998	21,837,868	12,471,122
Objective 7	Sickness Rate (%)	16	Quarterly	<3.3	-	2.35	2.95	2.99	-	-	3.27	3.27	3.1	3.02	2.99
	Vacancy Rate (%)	16	Quarterly	-	-	-	-	5.46	-	-	6.43	5.53	6.77	3.8	5.54
	Trust Turnover (%)	16/17	Quarterly	-	-	22.76	16.06	15.61	-	-	20.9	21.1	20.7	21.4	15.6
	Staff PDR completeness - Clinical & Non clinical (%)	17	Monthly	95	78.6	66.0	66.5	64.5	65.8	78.6	-	-	-	-	65.7
	Information Governance Training (%)	17	Monthly	95	96.2	96.3	96.2	96.6	96.7	96.2	82.96	89.76	87.70	96.60	96.3

* 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

****Total excluding Medicine

For Key, see Glossary

Great Ormond Street Hospital for Children NHS Foundation Trust

Key Performance Indicator Report

Specialty Indicator Review

Objective	Indicator	YTD Target/Trajectory (12/13)	Trust Total Performance in month (Including IPP & Trustwide Figures)	Cardiac	ICI	Neurosciences	Medicine	Diagnostic and Theraputic Services (DTS)	Surgery
Objective 1	Incidence of C.difficile	3.3	2	0	1	0	0	0	1
	Incidence of MRSA**	0	1	0	1	0	0	0	0
	Incidence of MSSA	4.6	1	0	1	0	0		0
	Incidence of E-Coli	7.9	0	0	0	0	0		0
	No. of NICE recommendations unreviewed	0	2	0	0	2	0	0	0
	CV Line related blood-stream infections	1.5	0.89						
	Mortality Figures	Within tolerance	14						
	Serious Patient Safety Incidents	Within tolerance	2	0	0	1	0	0	0
	Surgical Check List completion rate (%)	95.0	98.5	98.0	97.7	96.4	98.5	98.9	99.3
Objective 2	18 week referral to treatment time performance - Admitted (%)	90	91.4	100	100	100	100	100	81.01
	18 week referral to treatment time performance - Non-Admitted (%)	95	95.1	99.17	95.74	93.24	94.71	-	96.27
	18 week referral to treatment time performance - Incomplete Pathways (%)	92	92.0	99.69	97.9	97.48	92.72	61.11	84.87
	Inpatients waiting list profile (26+ Non RTT Pathway)	0	270						
	95th Centile - Admitted	<23 weeks	36.1	15.28	-	16.25	16.65	17.65	43.05
	95th Centile - Non-Admitted	<18.3 weeks	17.8	14.74	17.77	18.87	18.65	-	17.49
	Median Waits - Admitted	<11.1 weeks	9.7	8.60	-	6.00	15.33	14.00	12.20
	Median Waits - Non-Admitted	<6.6 weeks	6.8	4.9	5.7	7.2	8.6	-	7.5
	95th Centile - Incomplete Pathways	<28 weeks	21.7	14.38	15.37	14.83	21.62	33.1	36.3
	Median Waits - Incomplete Pathways	<7.2 weeks	5.7	5.37	4.95	3.73	6.49	13.50	6.71
	Discharge summary completion (%)	95	74.7	65.2	71.0	84.5	61.5	100.0	86.3
	DNA rate (new & f/up) (%)	10	9.0	5.7	10.6	8.1	8.8	5.4	11.4
	Cancelled Operations on day of admission (%)	0.80	0.2						
	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
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	<=1	6.62						
	Number of complaints	-	12	0	0	1	5		2
	Number of complaints by grade High	<14	1	0	0	0	0	0	1
	Theatre Utilisation (% Patient Operation Utilisation of Scheduled Duration, U4)	70	65.9	69.5	60.0	60.4	49.8	55.8	68.1
	Clinic Letter Turnaround (% of letters on CDD)	New indicator to be confirmed	28.7	26.1	29.0	14.9	28.2	10.8	24.2
	Clinic Letter Turnaround (% of letters on CDD sent within 5 working days)	New indicator to be confirmed	26.5	28.1	38.7	21.3	46.1	51.6	26.2
	SUS Compostie Data Quality Score (outpatients)	94.9	88.9	89.50	87.40	89.20	89.10	80.00	91.00
	SUS Data Quality Score (for outpatient attendance)	99.7	94.8	98.90	93.90	93.50	93.00	77.50	98.80
	SUS Data Quality Score (for outpatient outcome)	98.9	81.0	85.20	60.10	92.90	78.80	37.30	92.60
Objective 3	Patient refusals	<218	24	0	2	0	TBC		22**
	Clinical Income variance (£)	-	-2,178,427	-507,243	-1,419,923	306,466	134,045	34,252	-726,024
			GOSH & ICH TOTAL						
Objective 4	Clinical trials (CTIMPs)	72	80	2	42	9	9	0	3
	GOSH research projects	164	152	6	13	5	5	2	7
	Commercially-funded projects (% achieving a 70 day turnaround)	95	100	0	100	0	0	0	0
	UKCRN Portfolio projects	134	136	8	54	18	28	3	16
	GOSH research income		TBC	TBC	TBC	TBC	TBC	TBC	TBC
	Patient safety SAE's (Serious Adverse Event)	7	1	0	0	0	1	0	0
	Biomedical Research Centre (BRC; Commercial Engagement) (£)	1957857	172535	0	172,535	0	0	0	0

Objective 5	MADEL SLA Value (£)	-	-	-	-	-	-	-	-	-
	SIFT SLA Value (£)	-	-	-	-	-	-	-	-	-
	NMET SLA Value (£)	-	-	-	-	-	-	-	-	-
Objective 6	CRES Forecast Savings 2011/12 (£)	16,718,008	16,299,093	2,494,868	2,287,834	1,628,451	1,626,411			2,387,964
	Bank and agency total expenditure (£)	To Reduce	1,317,432	143,609	125,047	28,753	84,133	103,977	203,516	
Objective 7	Sickness Rate (%)	<3.3	-	-	-	-	-	-	-	-
	Vacancy Rate (%)	-	-	-	-	-	-	-	-	-
	Trust Turnover (%)	-	-	-	-	-	-	-	-	-
	Staff PDR completeness - Clinical & Non-Clinical (%)	95	78.6	89.9	71.8	72.2	74.9	89.0	66.8	
	Information Governance Training (%)	95	96.2	96.5	95.4	97.3	92.4	98.2	95.1	

*Omission relating to IPP & Trustwide
**Of which 22 were CAT's (2 Cardiac)
***June 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		
	No. of NICE recommendations unreviewed	Less or equal to 1	2or 3	Greater than 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
	Surgical Check List completion rate (%)	Greater than 95%	Between 85% and 95%	Less than 85%
Objective 2	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%
	Inpatients waiting list profile (26+)	0 Breaches	Between 0 and 10	Greater than 10
	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
	Discharge summary completion (%)	Greater than or equal to 95%	Between 75% and 95%	Less than 75%
	DNA rate (new & f/up) (%)	Less than 10	-	Greater than 10
	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%
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	Less than or equal to 1		
	Number of complaints	Less than previous year		
	Number of complaints by grade High	Less than previous year		
	Theatre Utilisation (Patient Operation Utilisation of Scheduled Duration U4)	Greater than 70%	Equal to or between 65% and 70%	Less than 65%
	Clinic Letter Turnaround (% of letters on CDD)	No RAG status - Plan not confirmed		
	Clinic Letter Turnaround (% of letters on CDD sent within 5 working days)	No RAG status - Plan not confirmed		
	SUS Compostie Data Quality Score (outpatients)	94.9 or above	Between 90 & 94.8	Less than 90
	SUS Data Quality Score (for outpatient attendance)	99.7 or above	Between 95 & 99.6	Less than 95
	SUS Data Quality Score (for outpatient outcome)	98.9 or above	Between 95 & 98.8	Less than 95
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	Bank and agency total expenditure	Indicator		
	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
Objective 7	Staff PDR completeness - clinical & 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		
	Vacancy rate (%)	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	Month 4
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0	0	0	0
2	Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)	0	1	Quarterly	0	0	0	0
3	All cancers: 31-day wait for second or subsequent treatment comprising either:	TBC	1	Quarterly	0	0	0	0
	Surgery	94%			0	0	0	0
	Anti cancer drug treatments	98%			0	0	0	0
	Radiotherapy (from 1 Jan 2011)	94%			0	0	0	0
	Cancer diagnostic to Treatment	85%			0	0	0	0
4	Admitted within 18 weeks	90%	1	Quarterly	0	0	0	0**
5	Non Admitted within 18 weeks	95%	1	Quarterly	0	0	0	0
6	92% - 18 week referral to treatment time Incomplete Pathways Performance	92%		Quarterly	1	0	1	0
7	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0	0	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	0	0
Total					1	0	0	0
Overall governance risk rating					Amber-green	Green	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

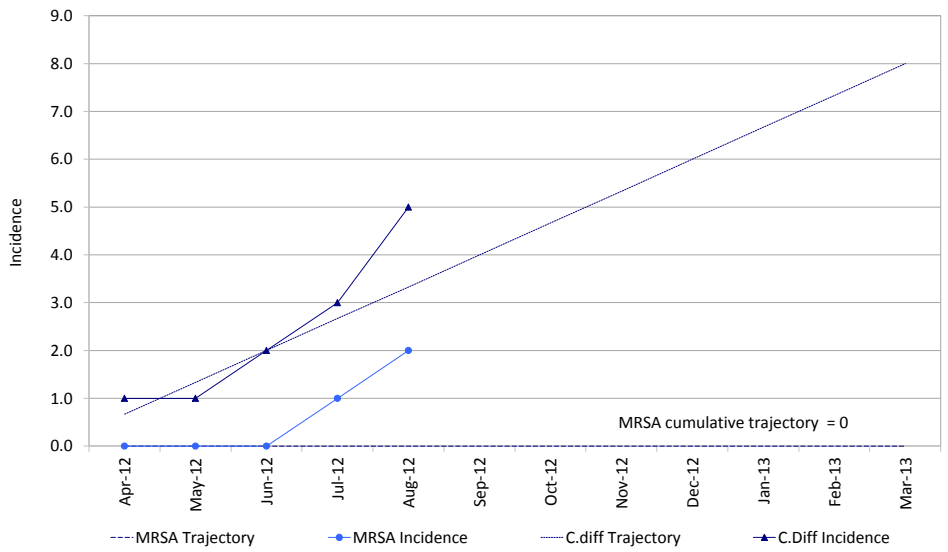
**To be confirmed but on trajectory to achieve

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.

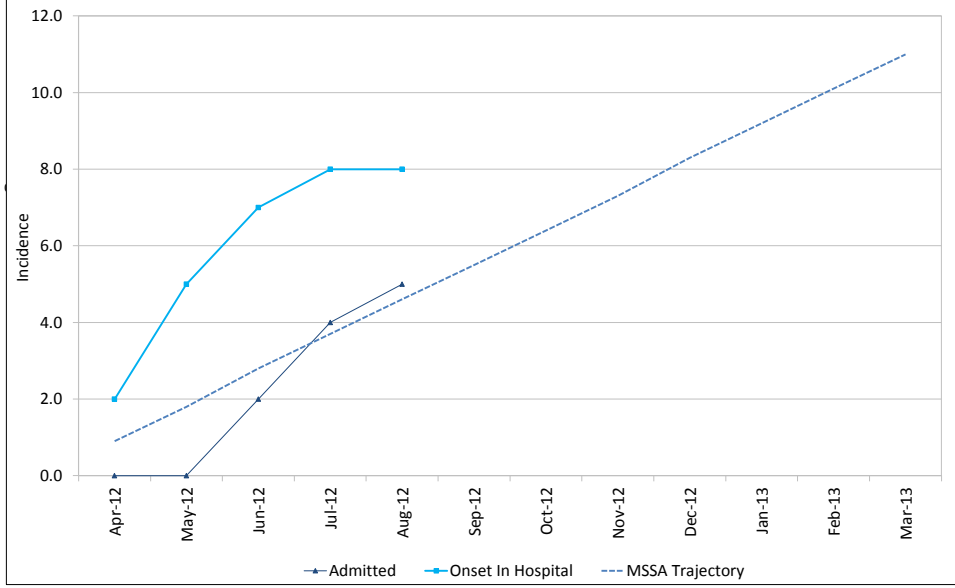
Graph 1. Incidence of MRSA and Cdifficile (cumulative totals)

National Target



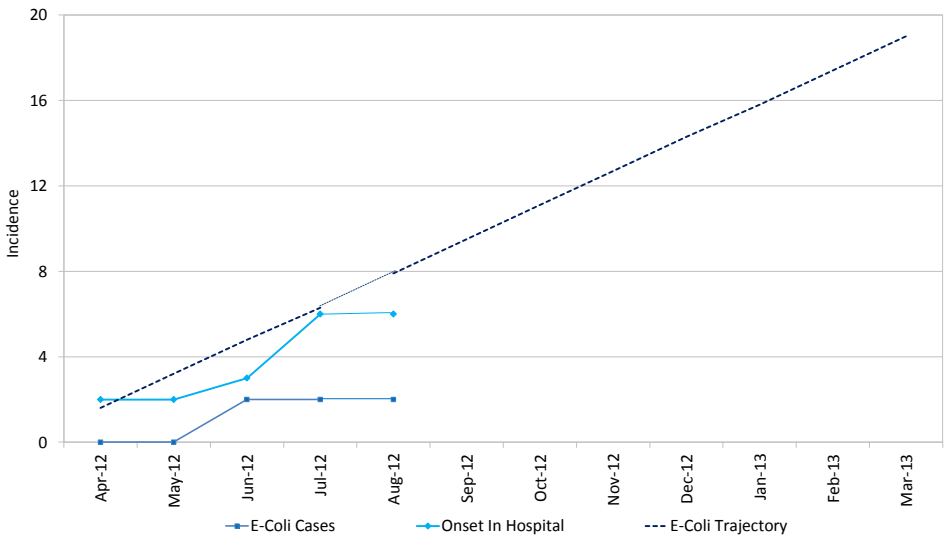
Graph 2. Incidence of MSSA

Internal Indicator



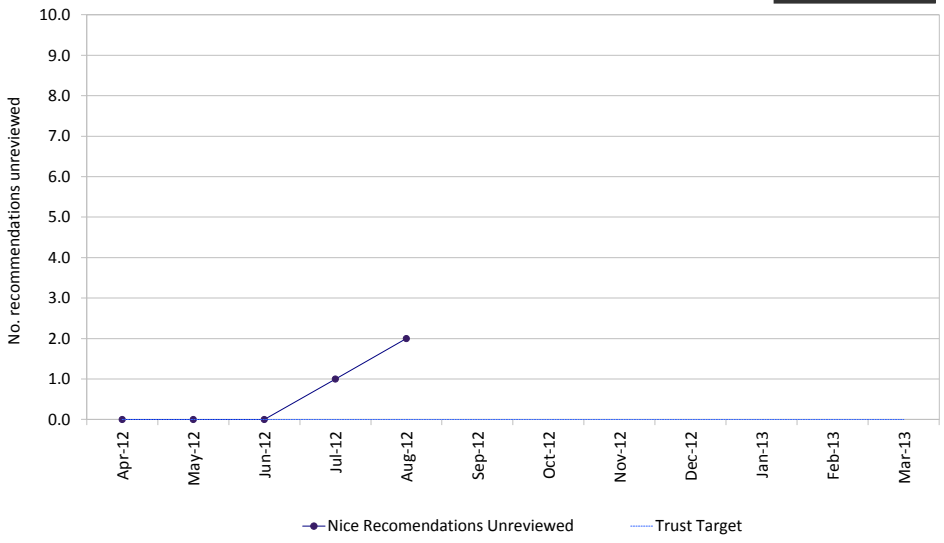
Graph 3. Incidence of E-Coli

Internal Indicator



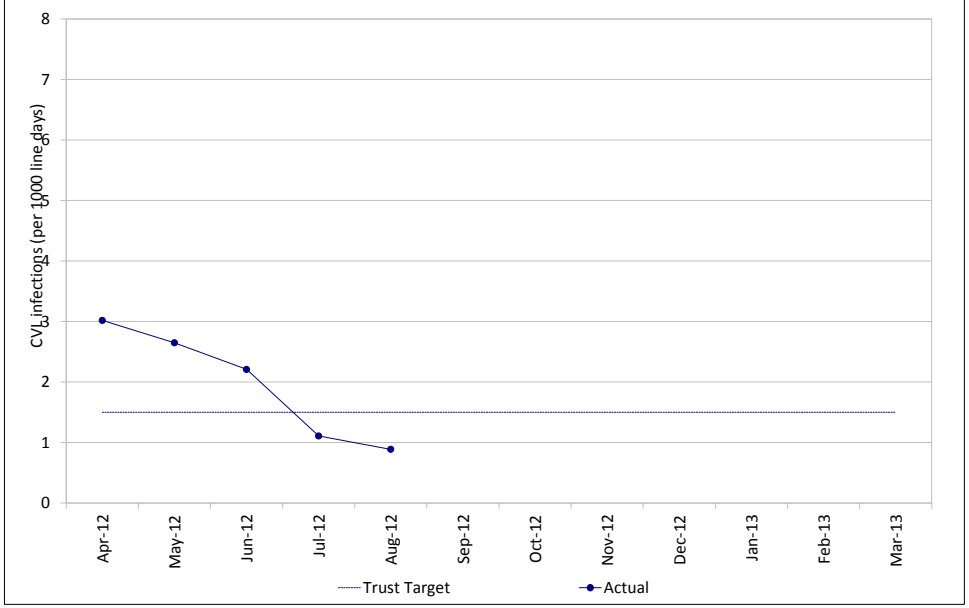
Graph 4. No. of NICE recommendations unreviewed

Internal Indicator



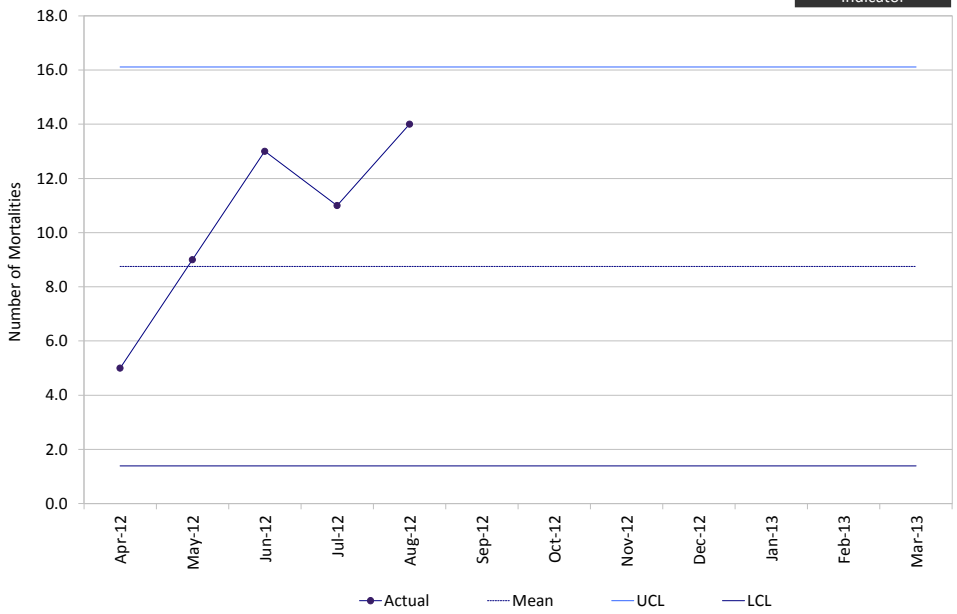
Graph 5. CV Line Infections (per 1000 bed days) - All areas

CQUIN Measure



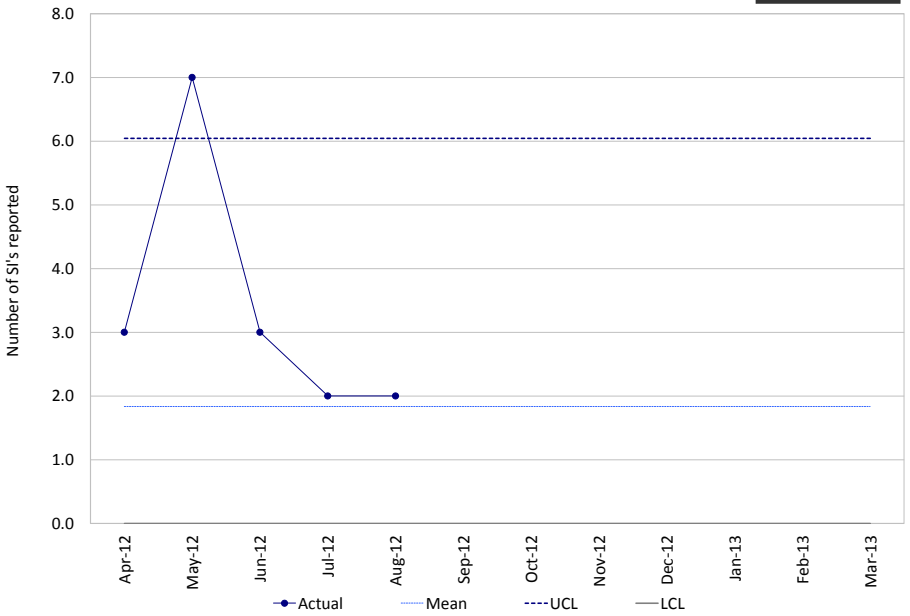
Graph 6. Mortality Figures - where discharge reason is 'Died'.

Internal Indicator



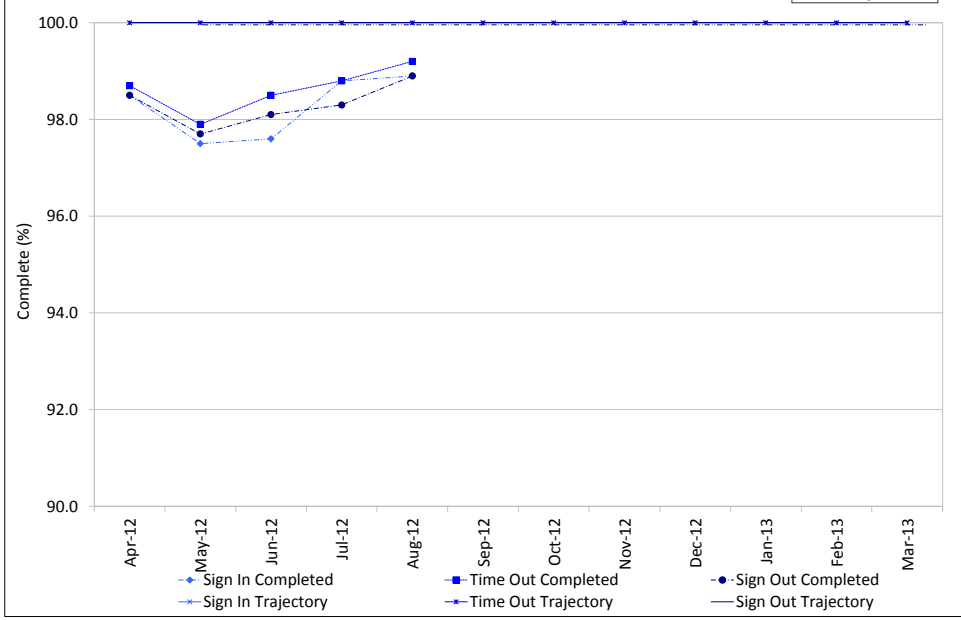
Graph 7. Serious Incidents Aug 2007 - May 2011

Internal Indicator



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

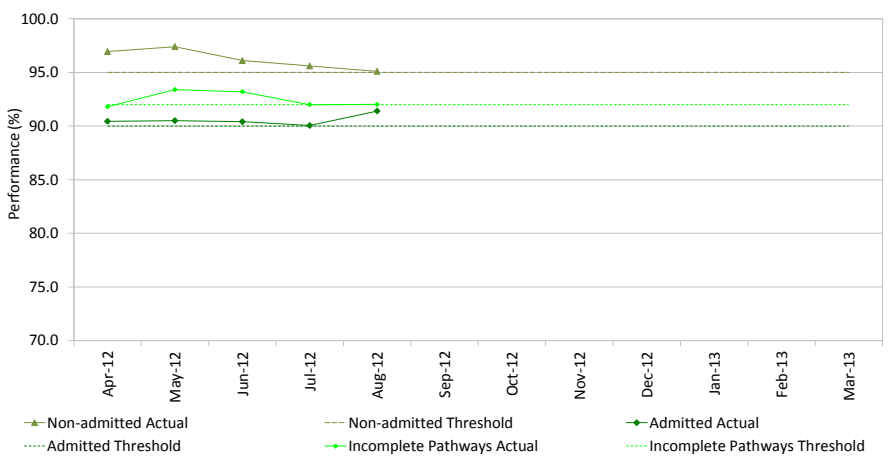
Internal Target



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

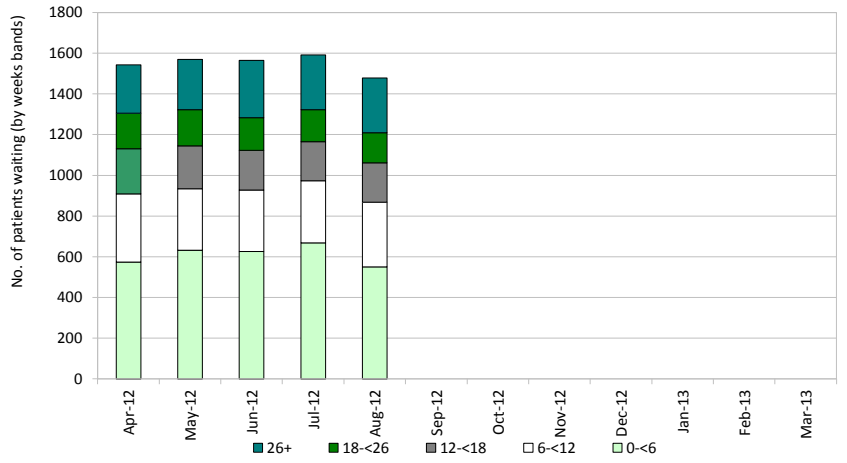
Graph 10. 18 week referral to treatment time performance

Contractual Target



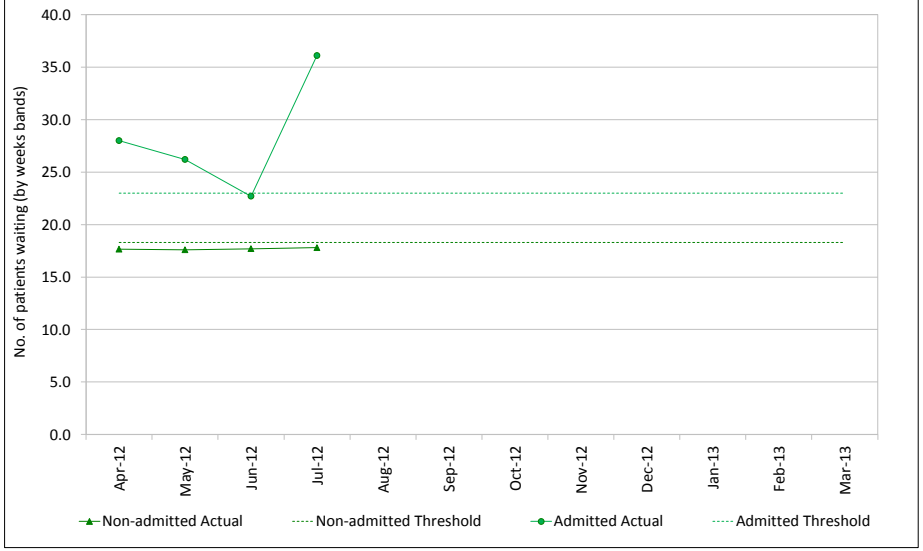
Graph 11. Inpatients waiting list profile by weeks waiting (Non 18 week pathway)

Internal Indicator



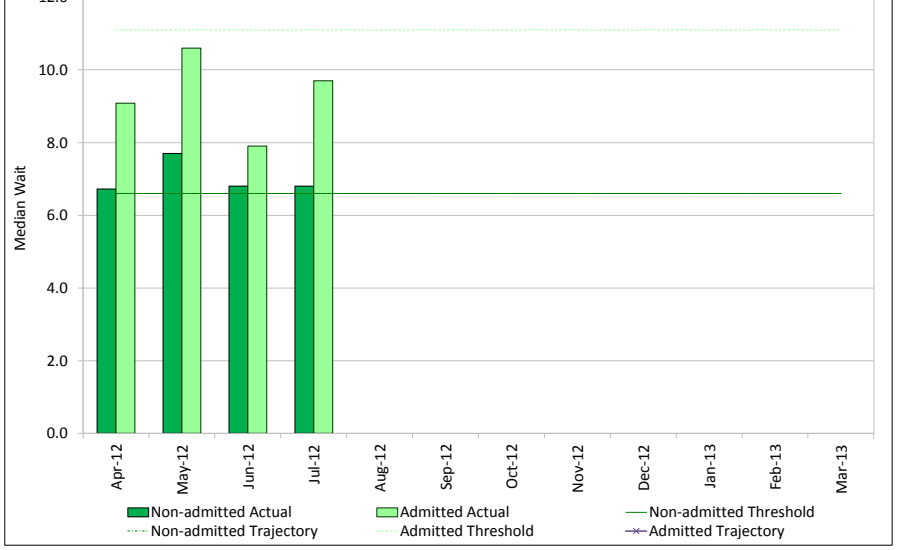
Graph 12. 95th Centile RTT performance against target (admitted and Non-admitted)

Contractual Target



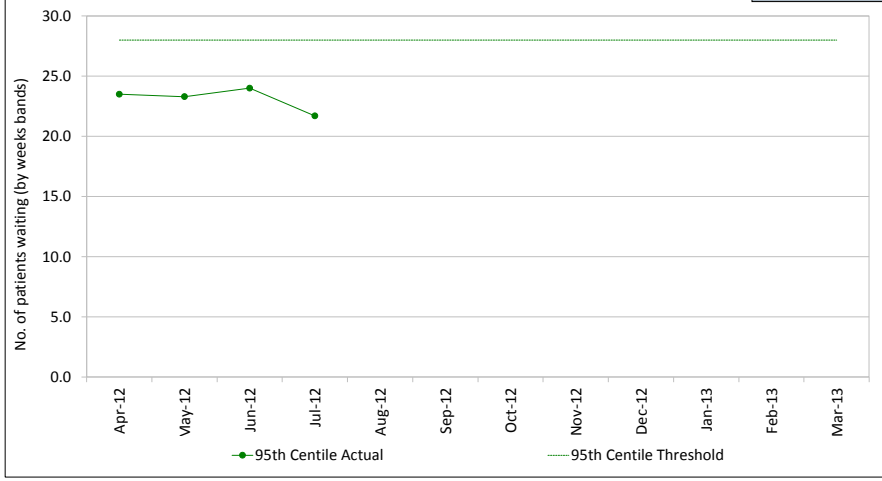
Graph 13. Median Wait RTT performance against target (Admitted and non-Admitted)

Contractual Target



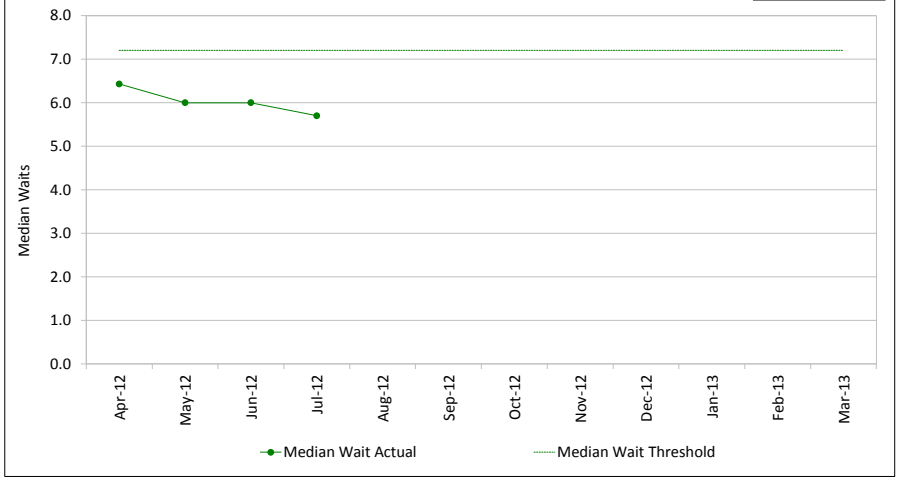
Graph 14. 95th Centile - Incomplete pathways

Contractual Target



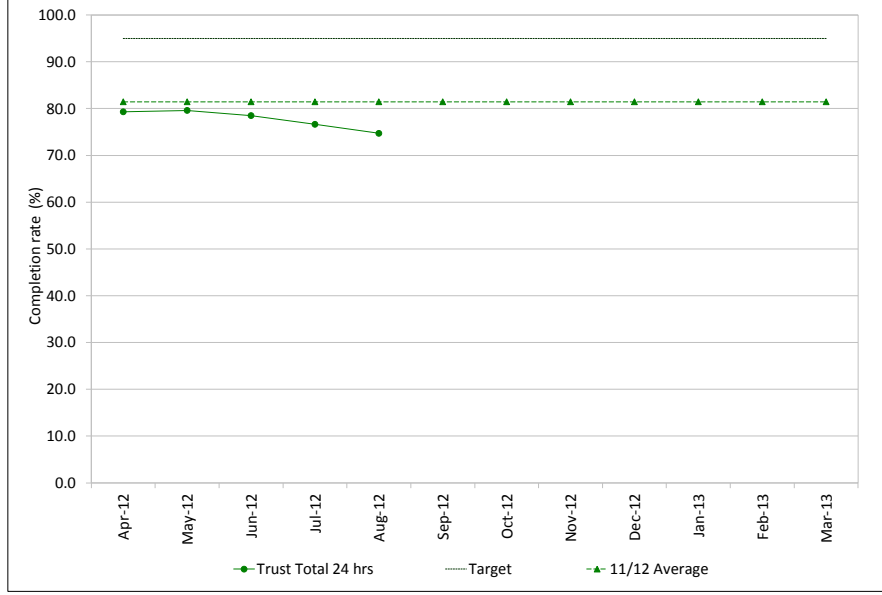
Graph 15. Median Waits - Incomplete pathways

Contractual Target



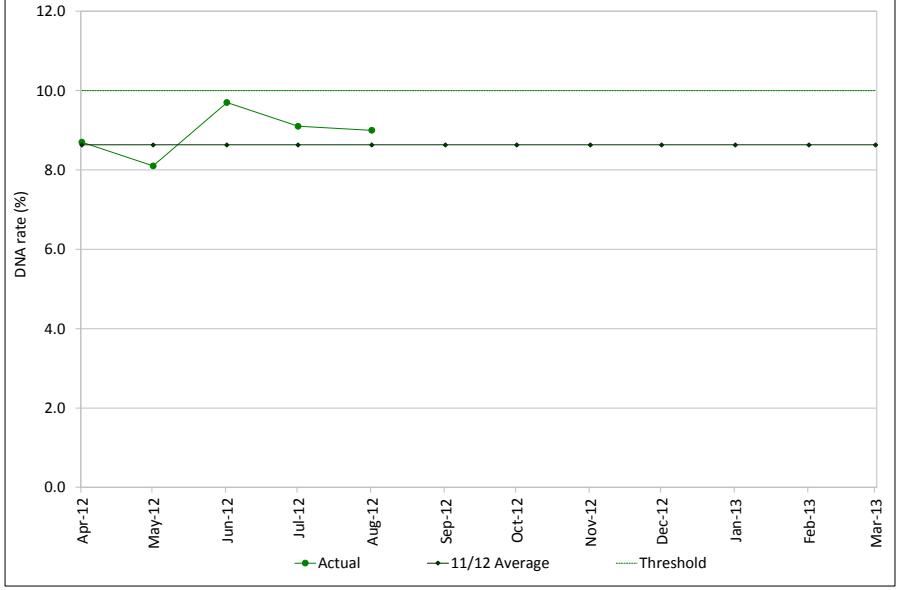
Graph 16. Trust wide discharge summary completion rates (within 24 hours)

Internal Target



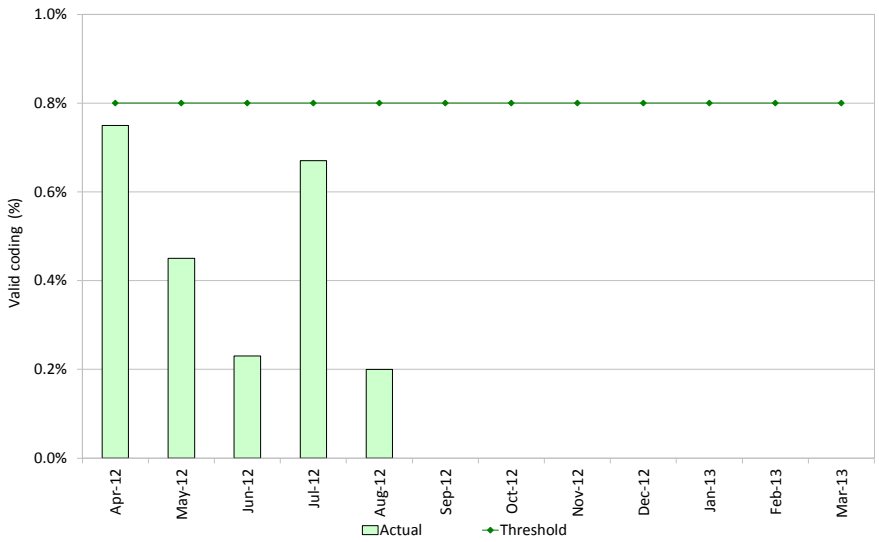
Graph 17. DNA rate (New and Follow-up patients)

Internal Target



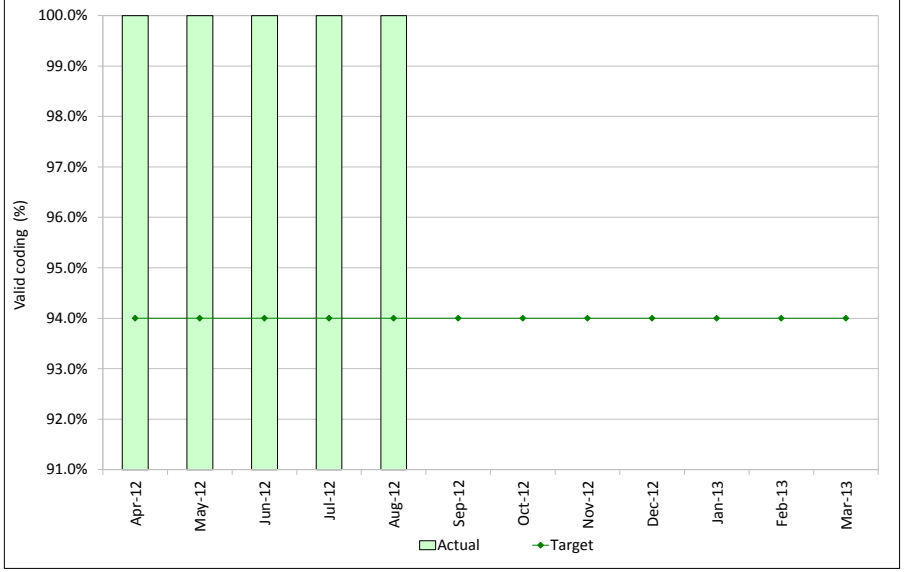
Graph 18. Percentage of all Cancelled Operations as a proportion of total elective spells

Contractual Target



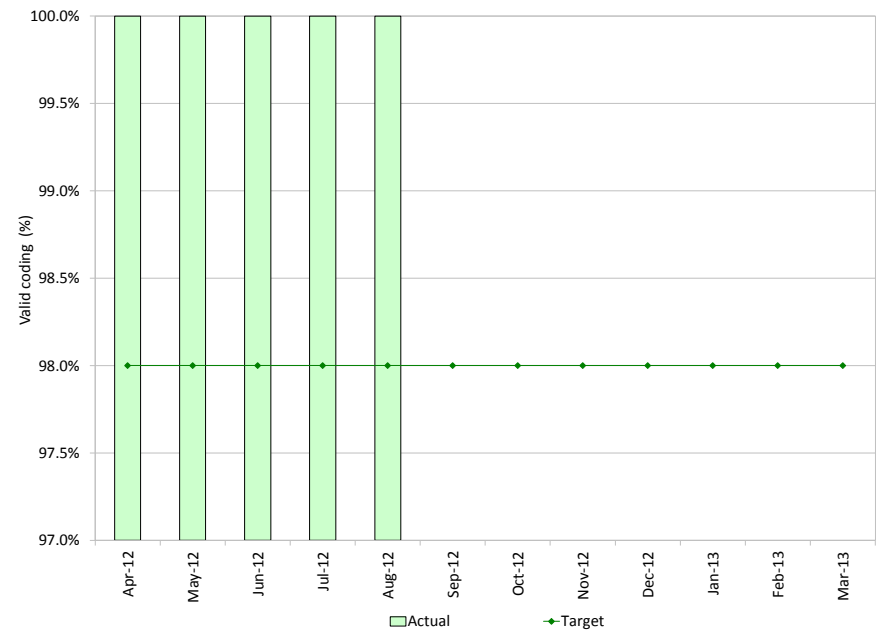
Graph 19. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - surgery

National Target



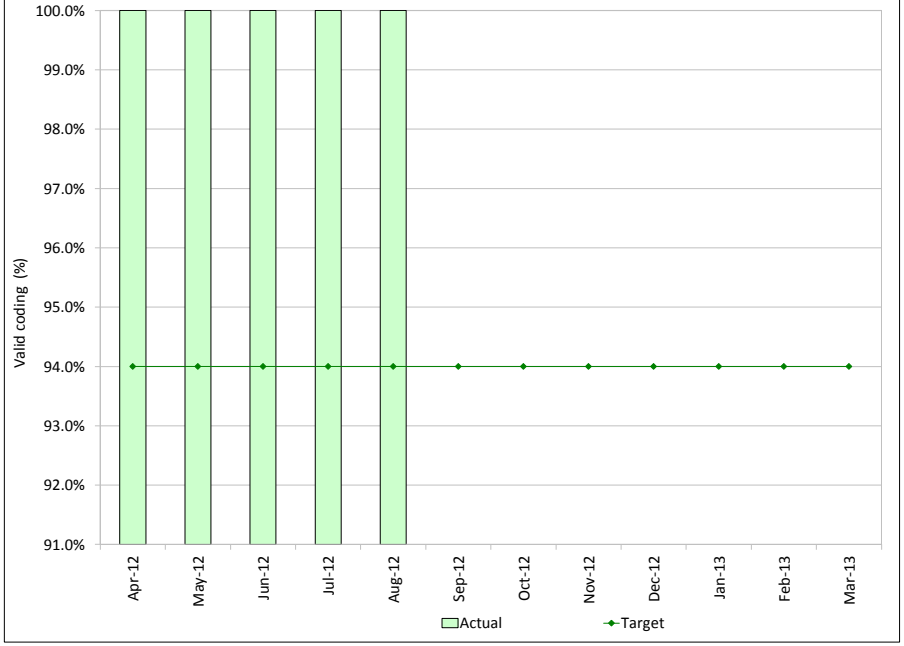
Graph 20. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - drug treatments

National Target



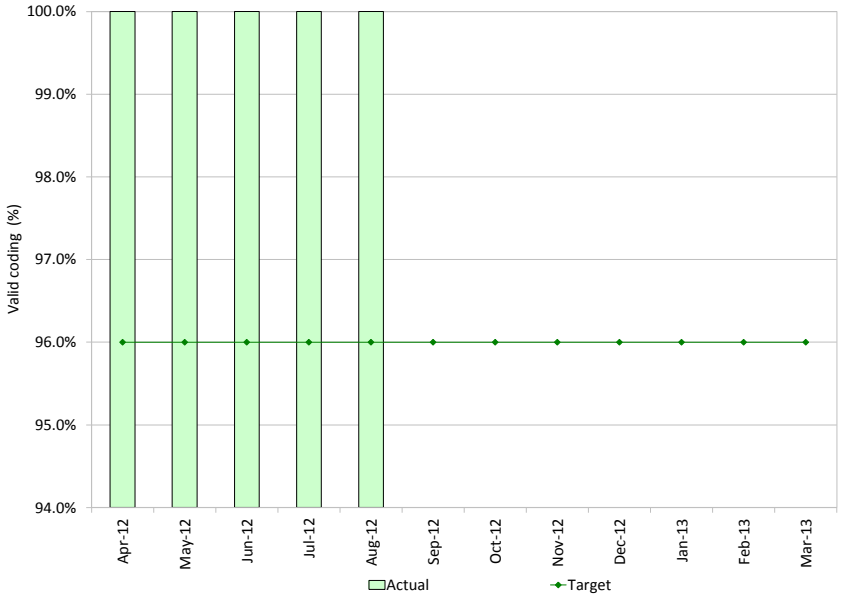
Graph 21. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - radiotherapy

National Target



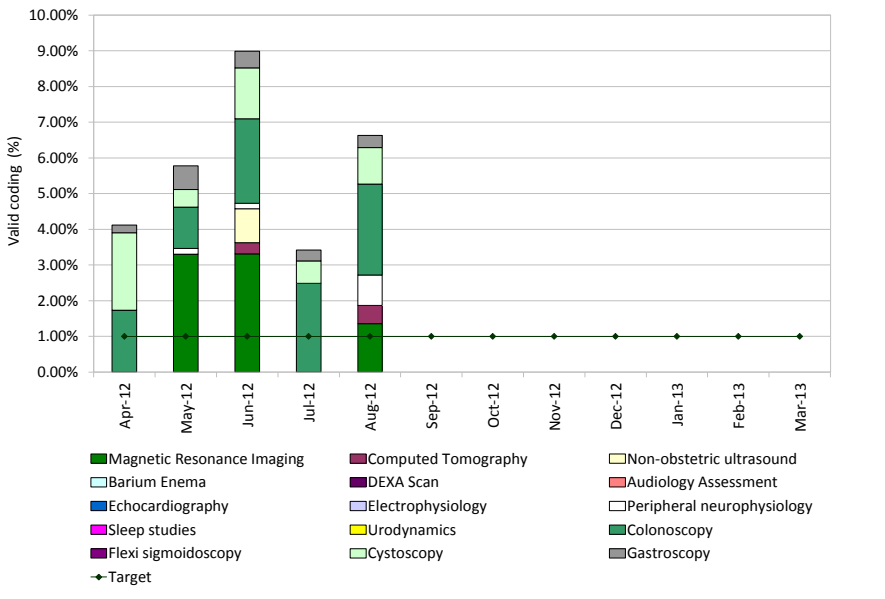
Graph 22. Proportion of Cancer patients waiting no more than 31 days from diagnosis to treatment - all cancers

National Target



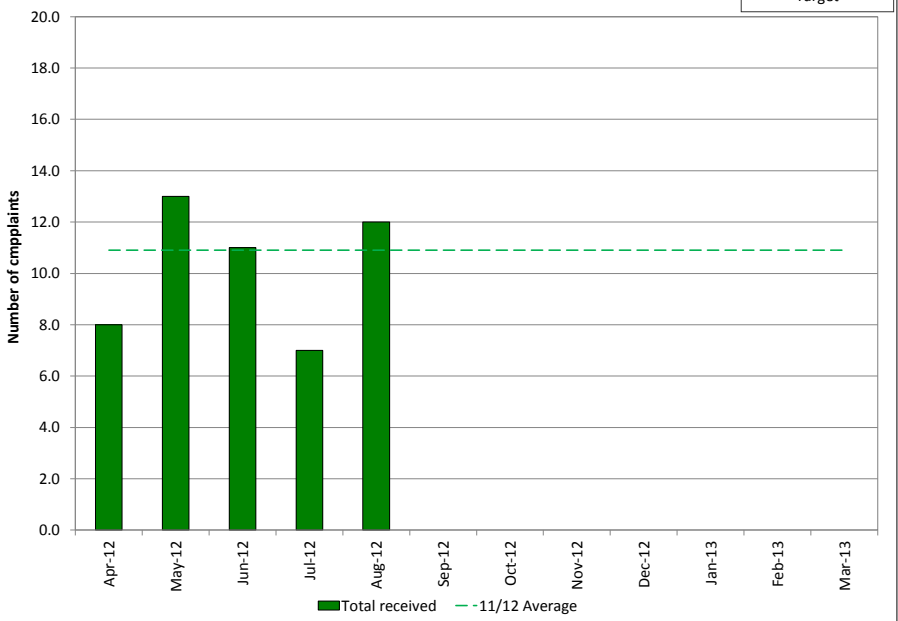
Graph 23. Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests

National Target



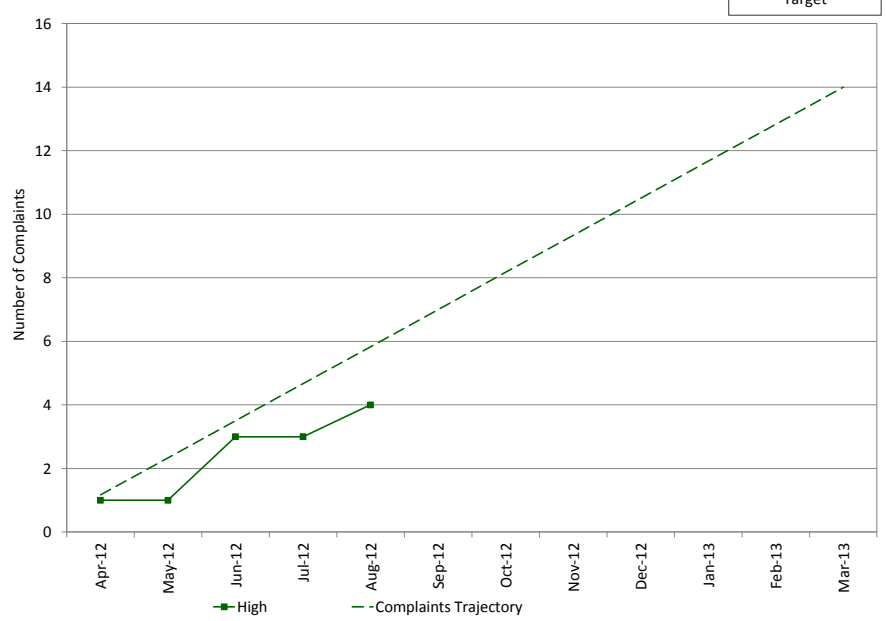
Graph 24. Complaints Received 2021/13

Internal Target

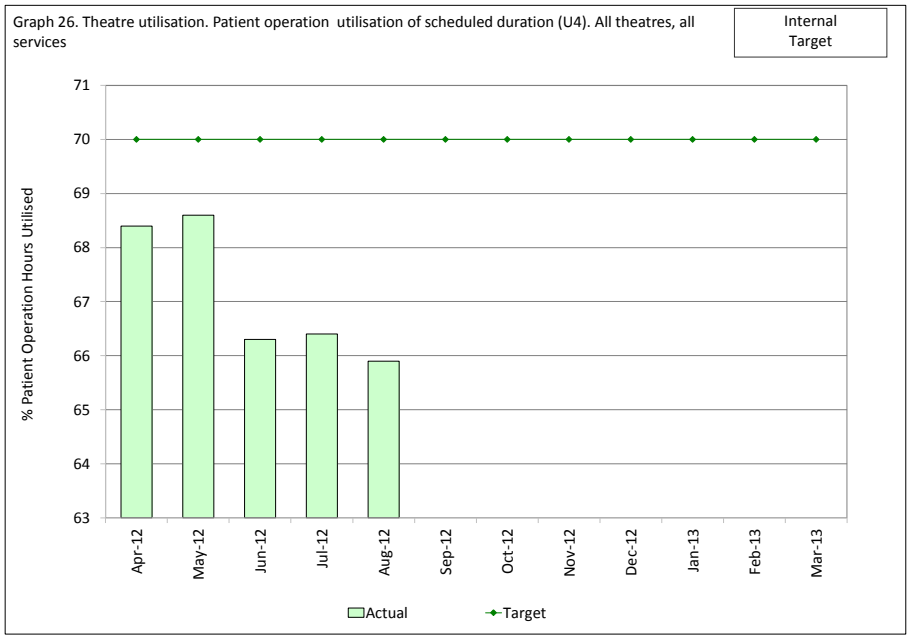


Graph 25. High complaints received by grade 2012/13 (cumulative)

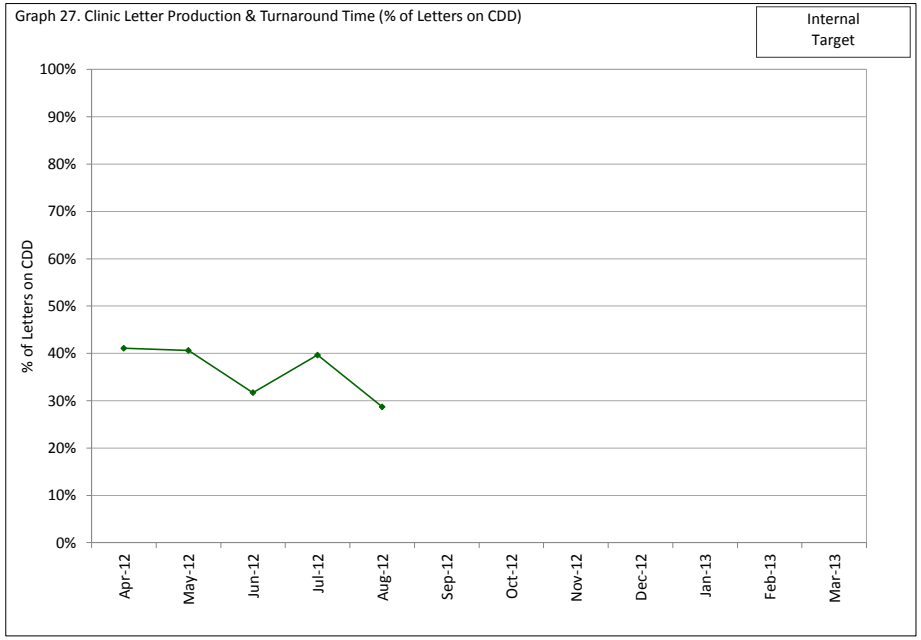
Internal Target



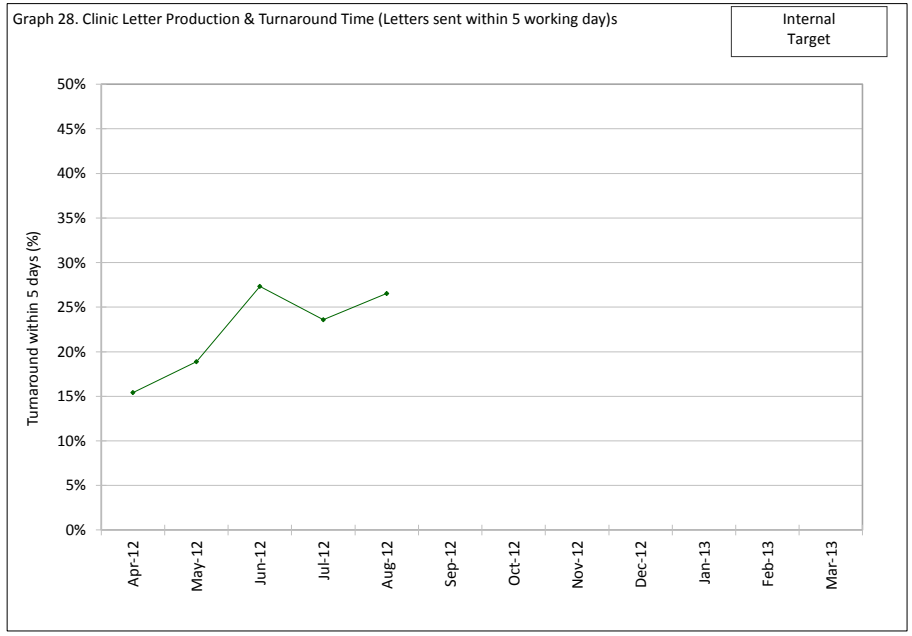
Graph 26. Theatre utilisation. Patient operation utilisation of scheduled duration (U4). All theatres, all services



Graph 27. Clinic Letter Production & Turnaround Time (% of Letters on CDD)



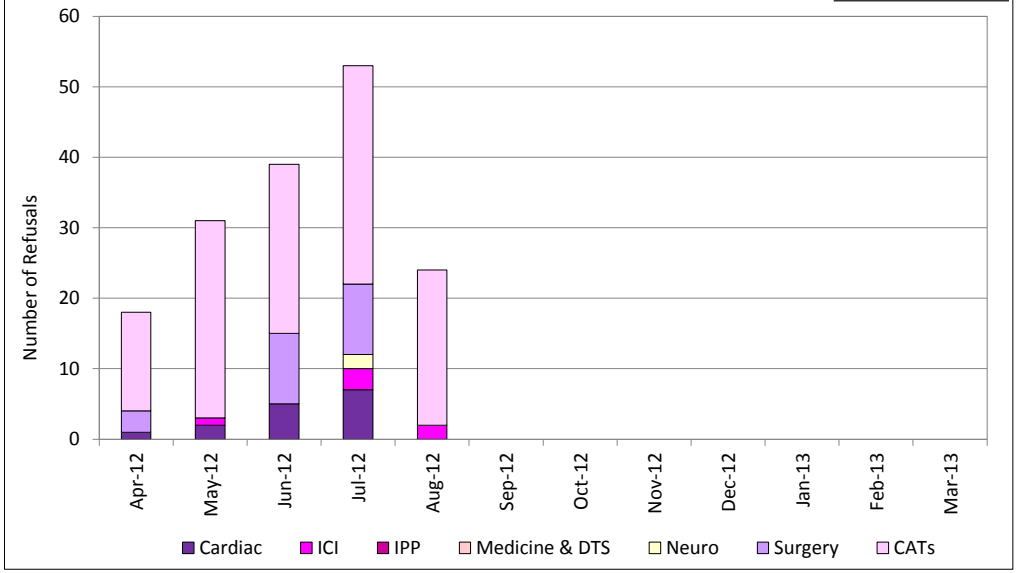
Graph 28. Clinic Letter Production & Turnaround Time (Letters sent within 5 working day)s



3. Successfully deliver our clinical growth strategy

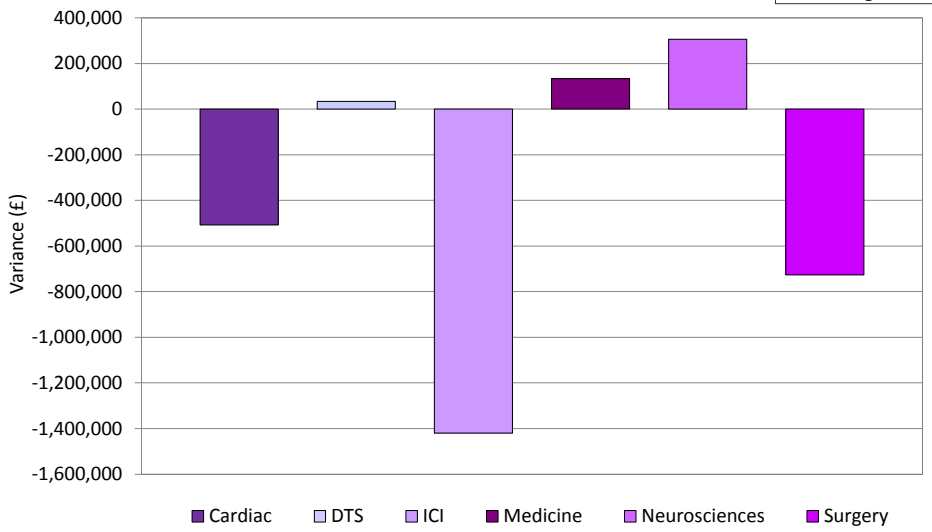
Graph 29. Patient refusals by clinical unit

Internal Indicator



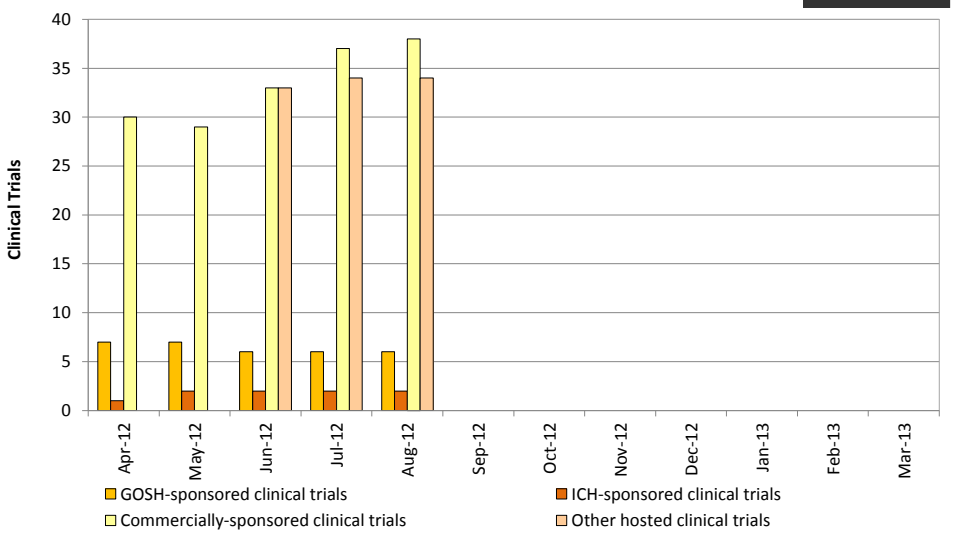
Graph 30. Clinical Income Variance M4

Internal Target

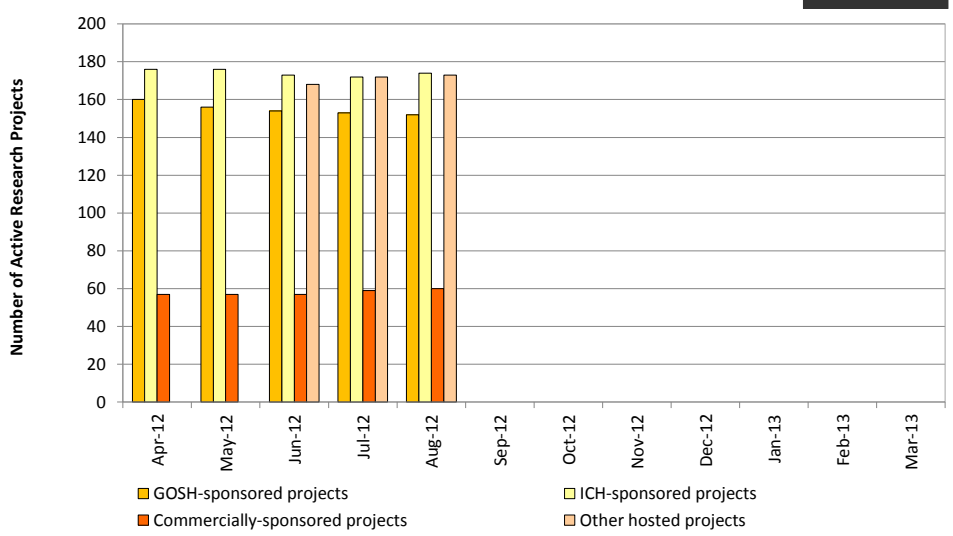


4. Currently partnered with ICH, and moving to UCL Partners with AHSC, maintain and develop our position as the UK's top children's research organisation

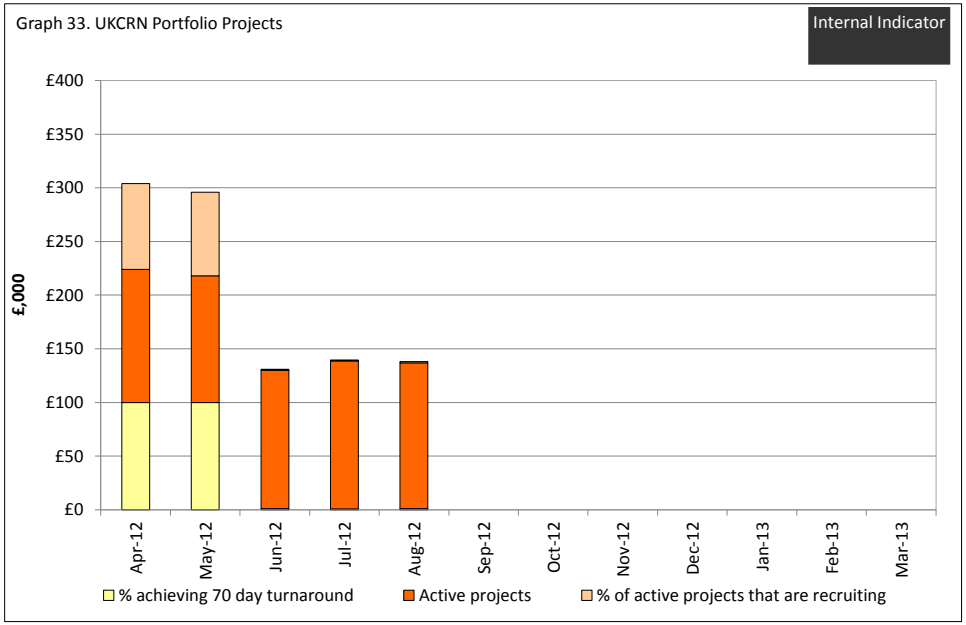
Graph 31. Clinical trials (CTIMPs) — Internal Indicator



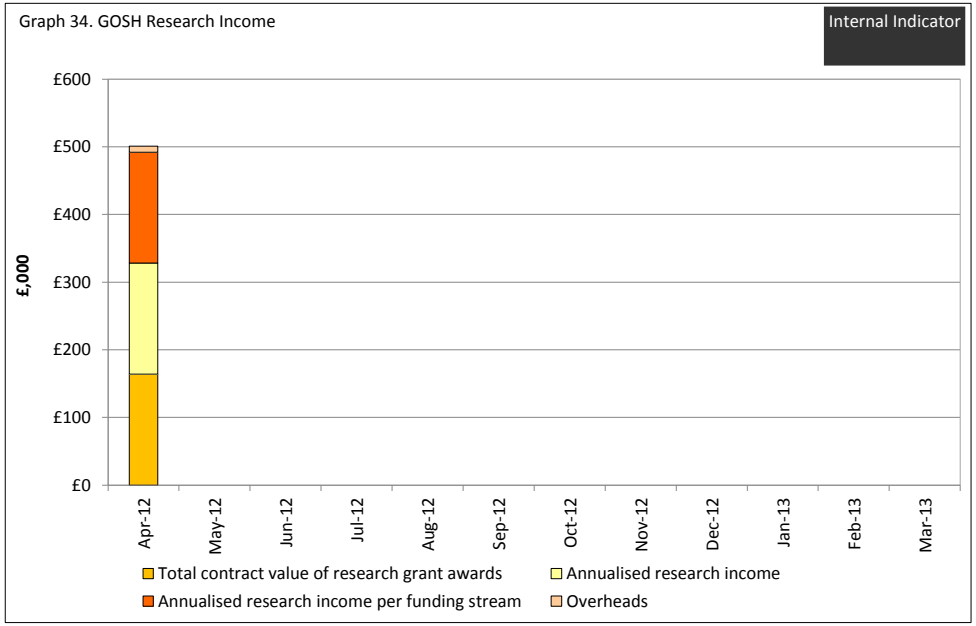
Graph 32. GOSH research projects — Internal Indicator



Graph 33. UKCRN Portfolio Projects — Internal Indicator

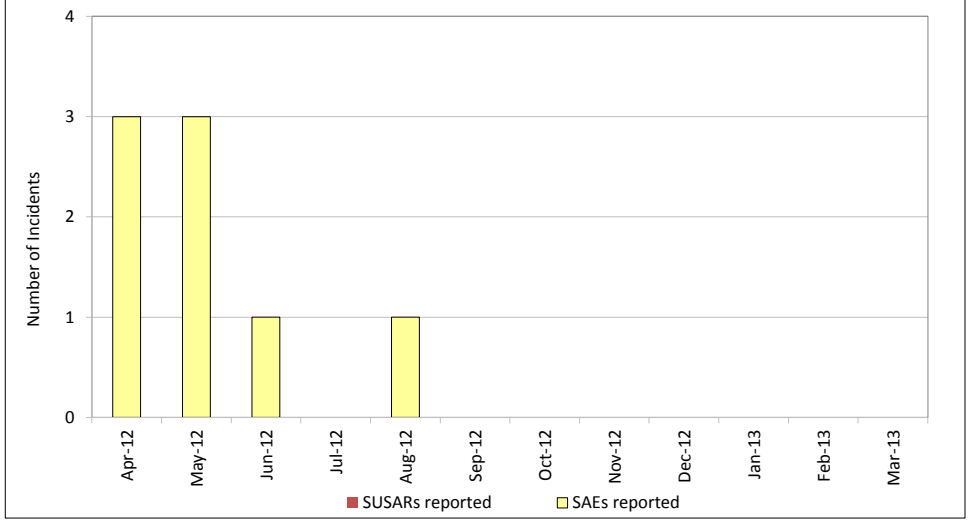


Graph 34. GOSH Research Income — Internal Indicator



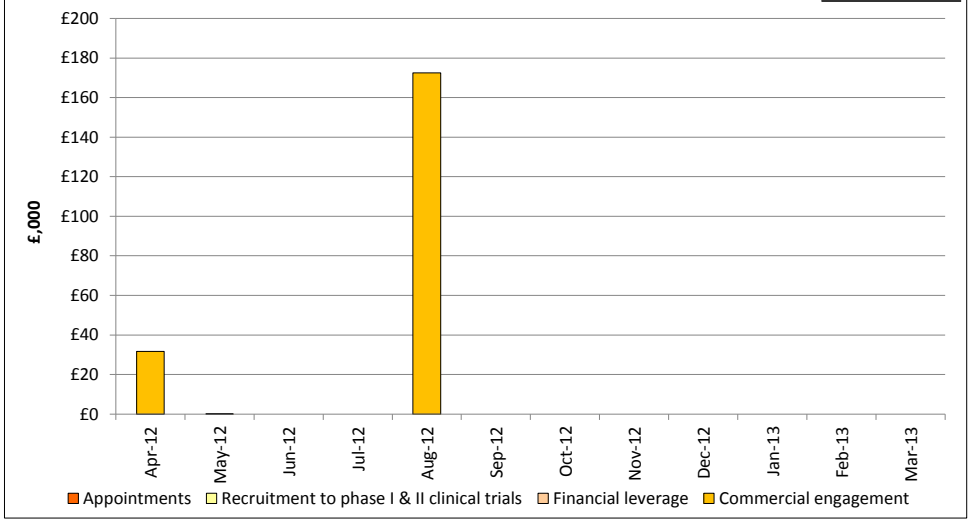
Graph 35. Patient Safety reports for GOSH sponsored clinical trials

Internal Indicator



Graph 36. Biomedical Research Council (BRC)

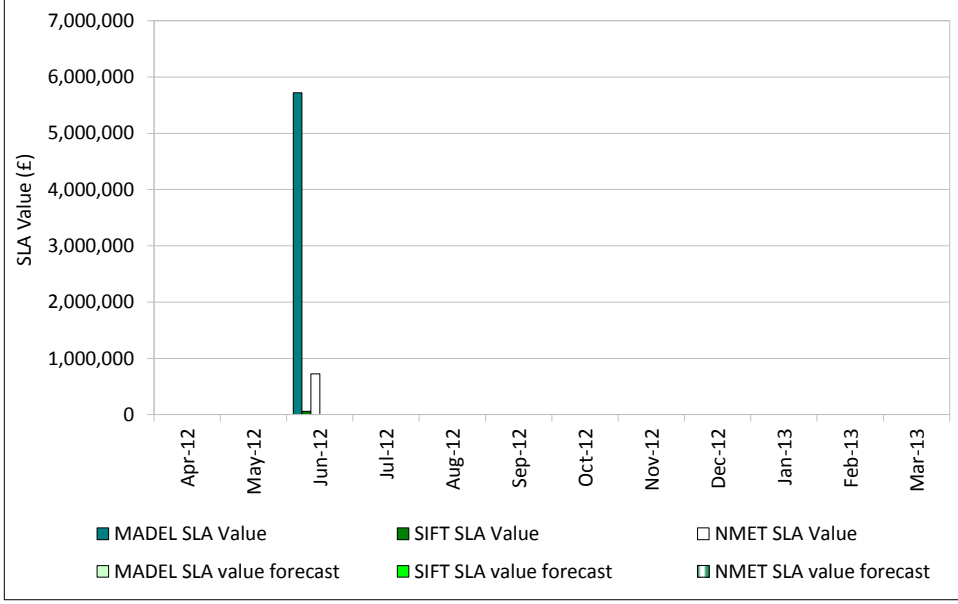
Internal Indicator



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

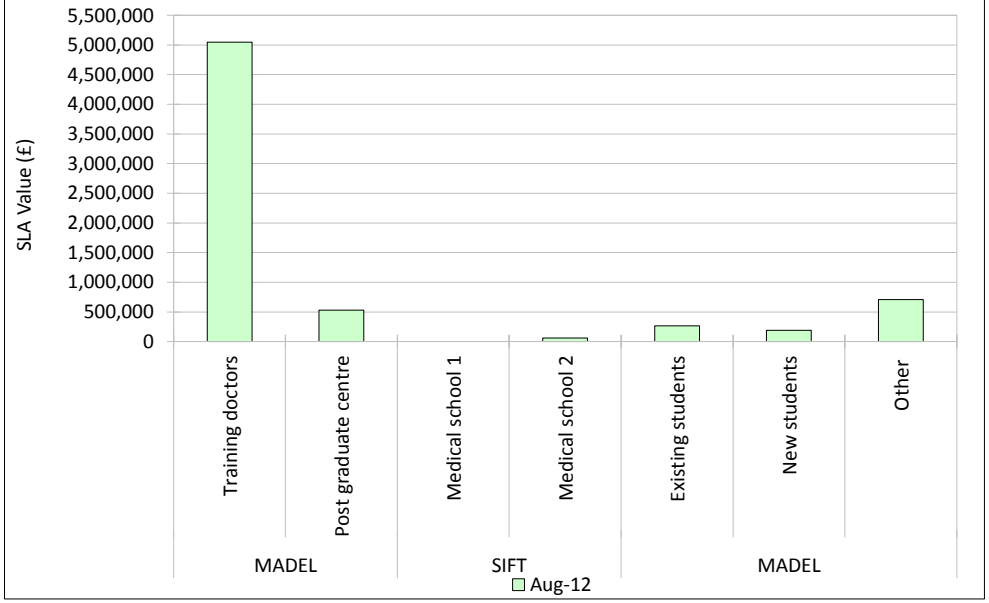
Graph 37. MPET SLA Total value summary (Q1)

Internal Indicator



Graph 38. MPET Total SLA value detail (Q1l

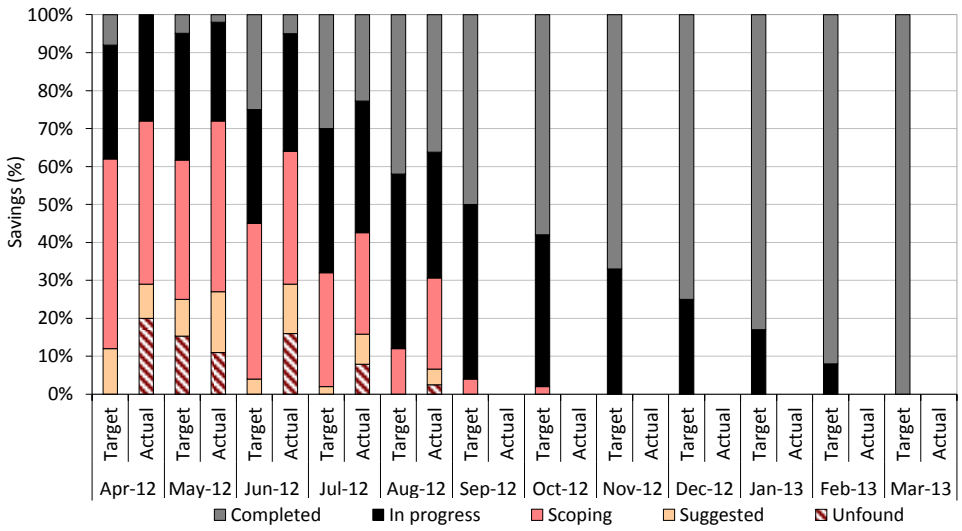
Internal



6. Deliver a financially stable organisation

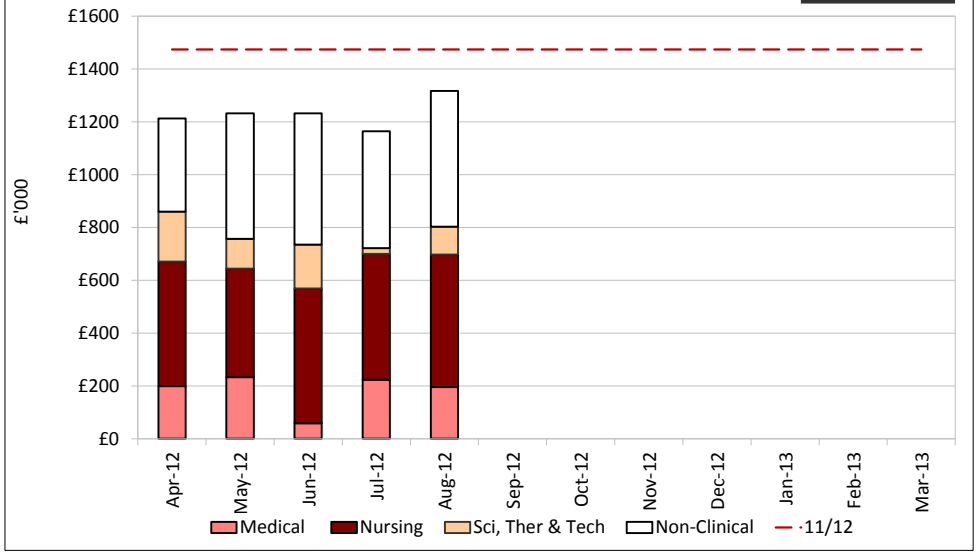
Graph 39. CRES programme, saving trajectory 2012/13

Internal Target



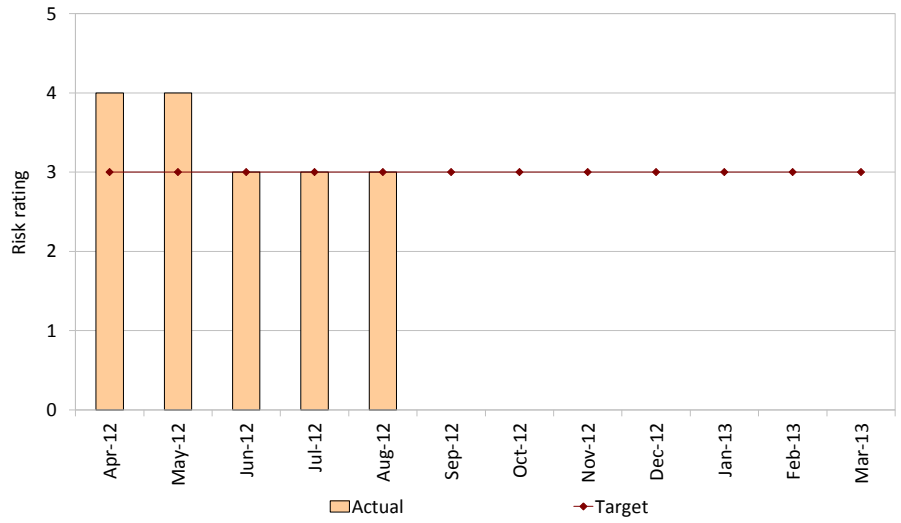
Graph 40. Bank & Agency Total Expenditure by Staff Group

Internal Indicator



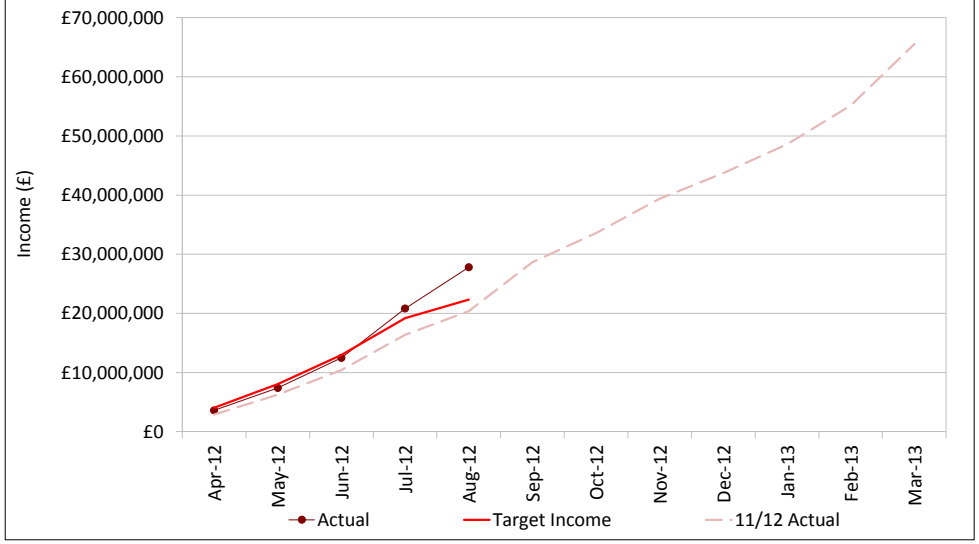
Graph 41. Monitor Risk Rating

National Target



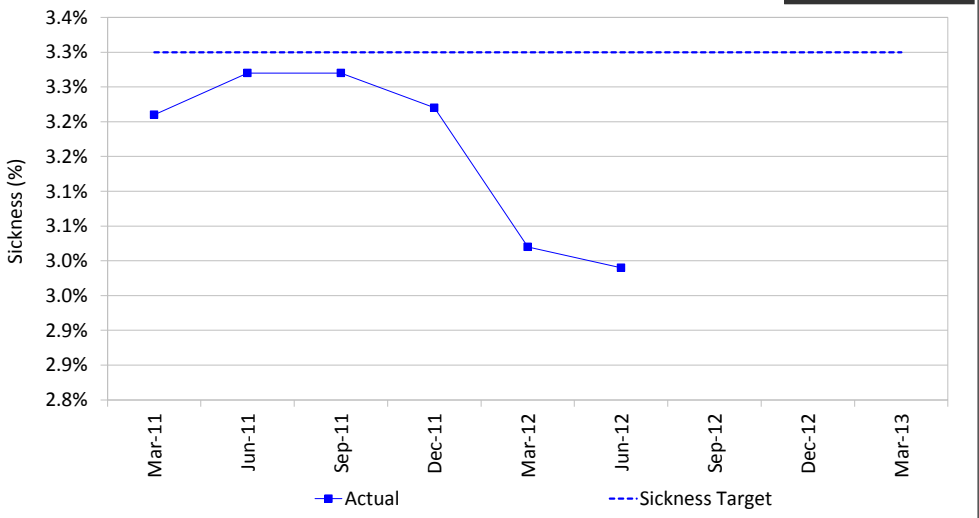
Graph 42. Charity Fundraising. YTD Income against YTD budget

Internal Target

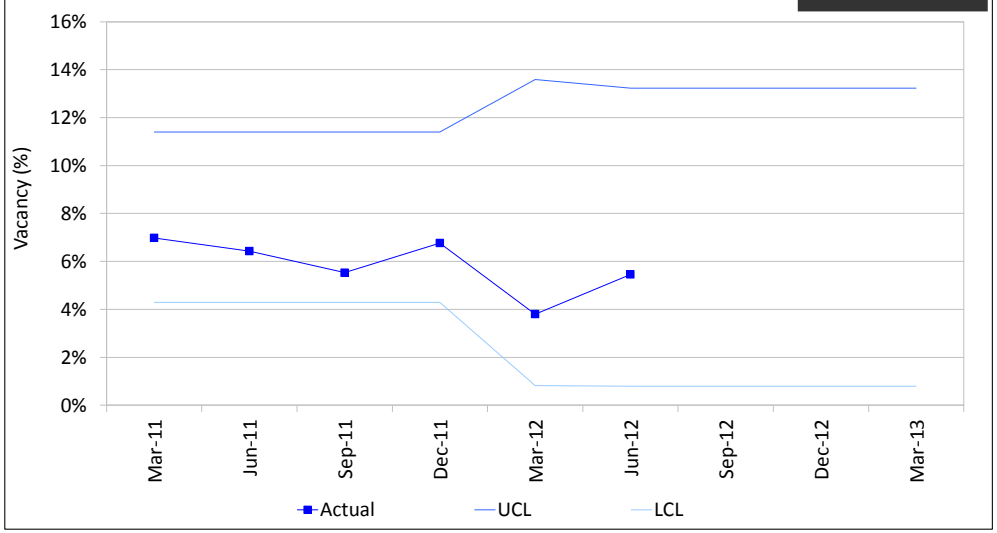


7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation

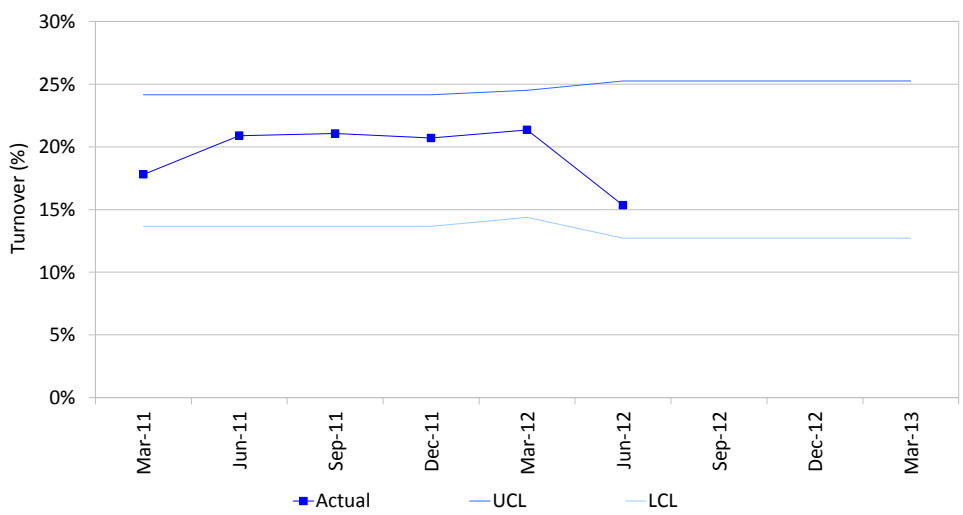
Graph 43. Sickness rate Trust-wide (%) — Internal Indicator



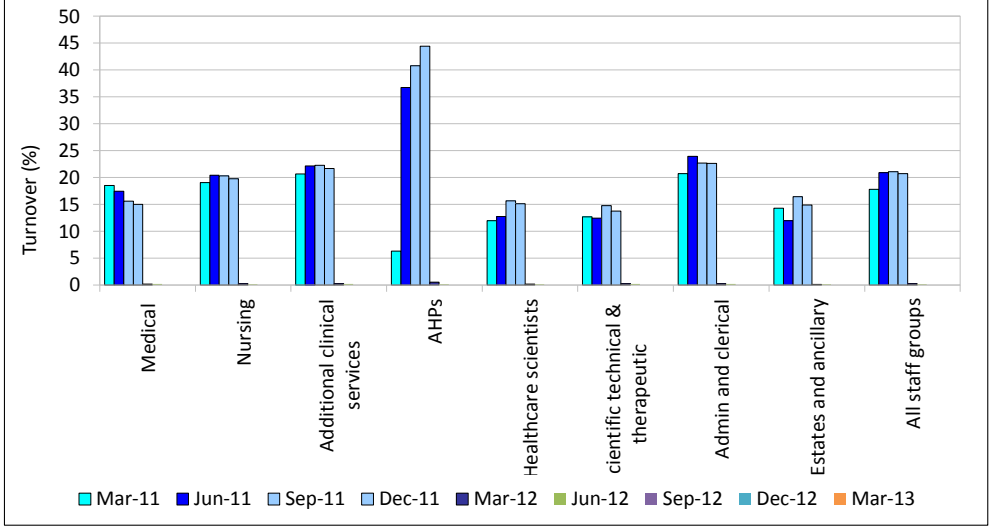
Graph 44. Vacancy rate Trust-wide (%) — Internal Indicator



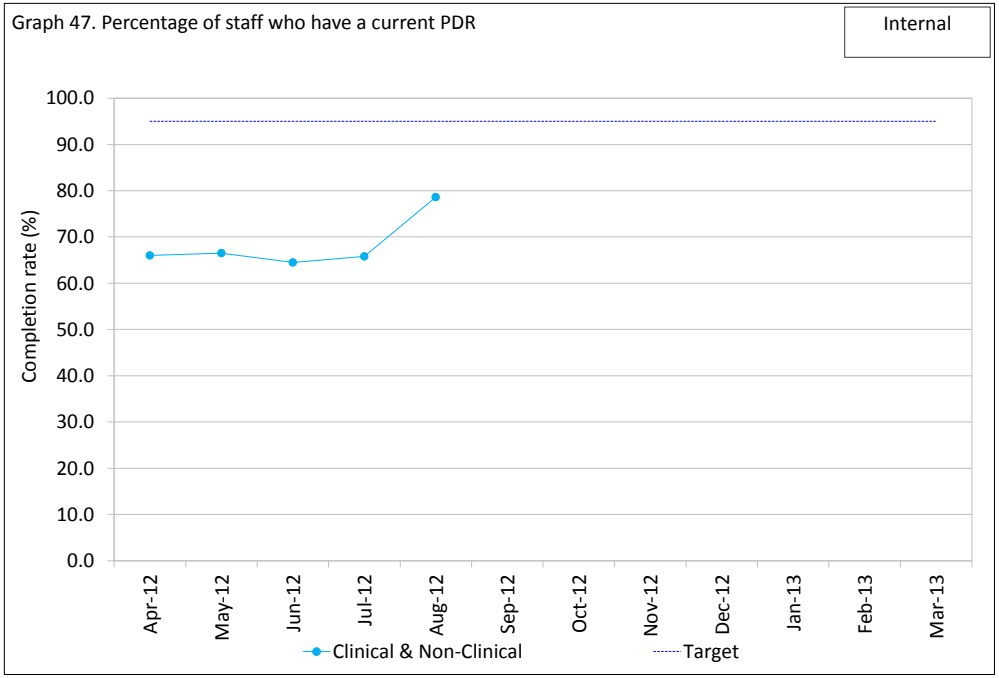
Graph 45. Turnover Trust-wide (%) — Internal Indicator



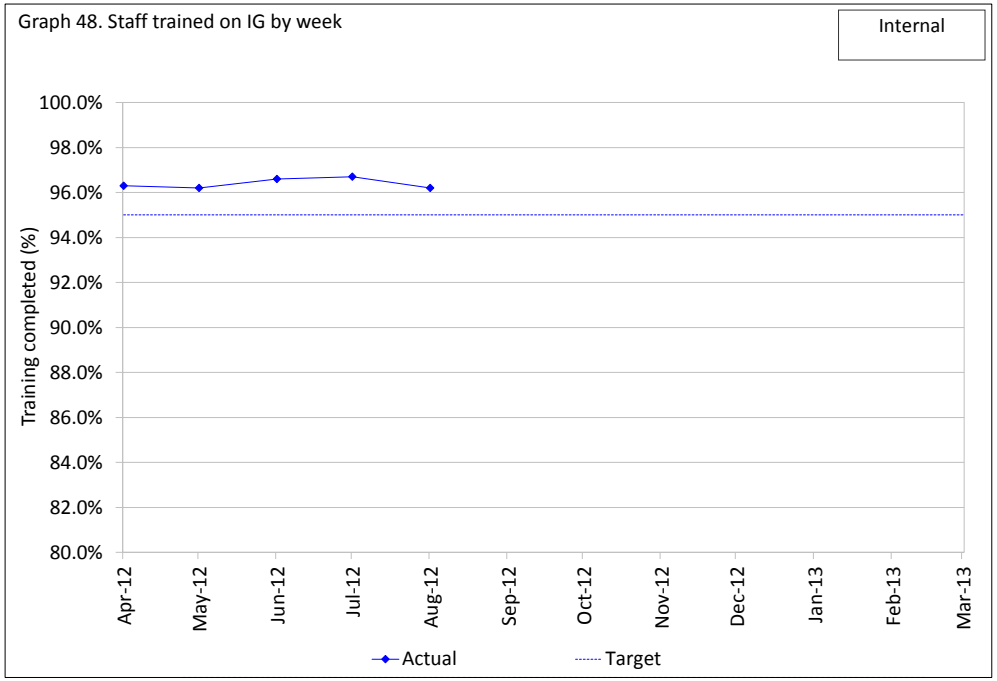
Graph 46. Turnover by staff group (%) — Internal Indicator



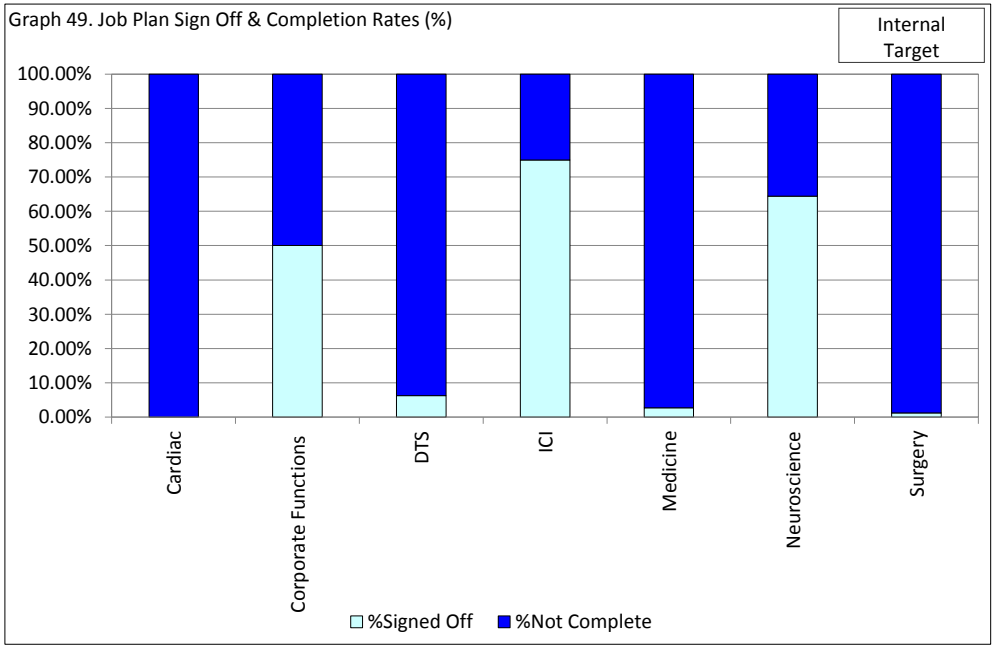
Graph 47. Percentage of staff who have a current PDR



Graph 48. Staff trained on IG by week

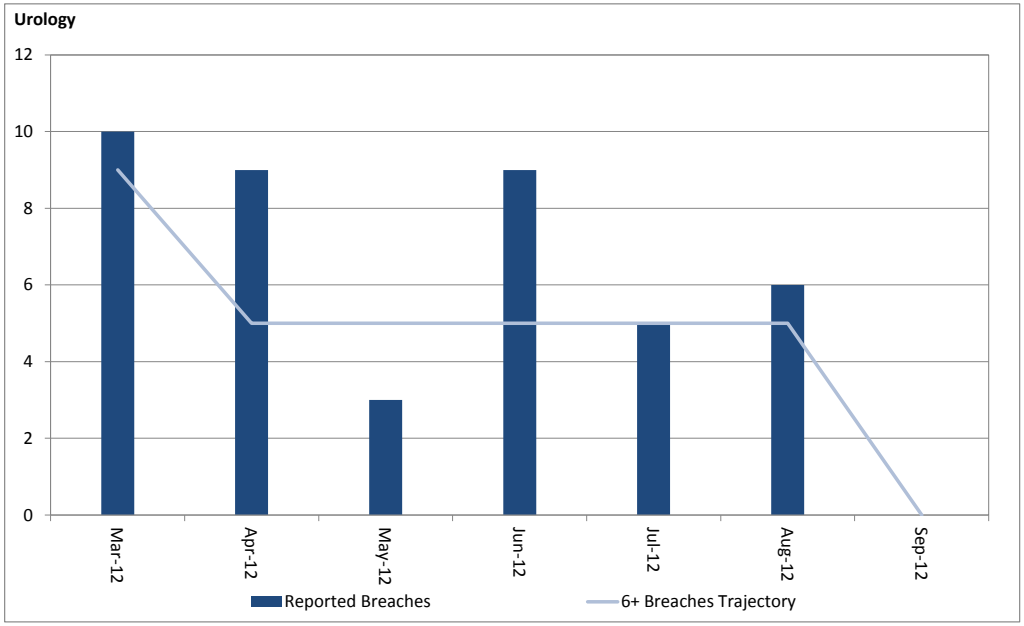


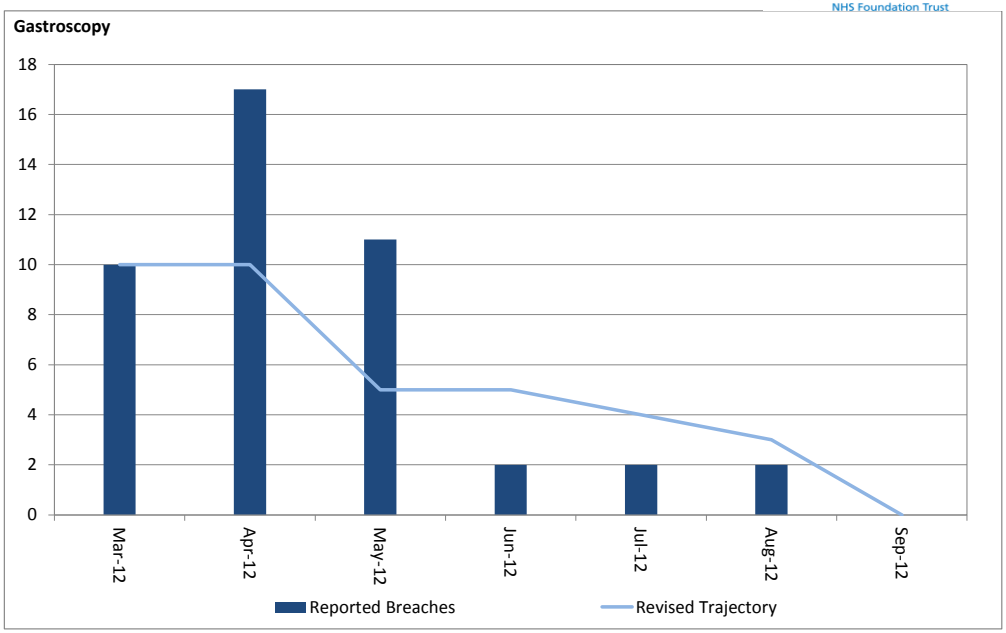
Graph 49. Job Plan Sign Off & Completion Rates (%)

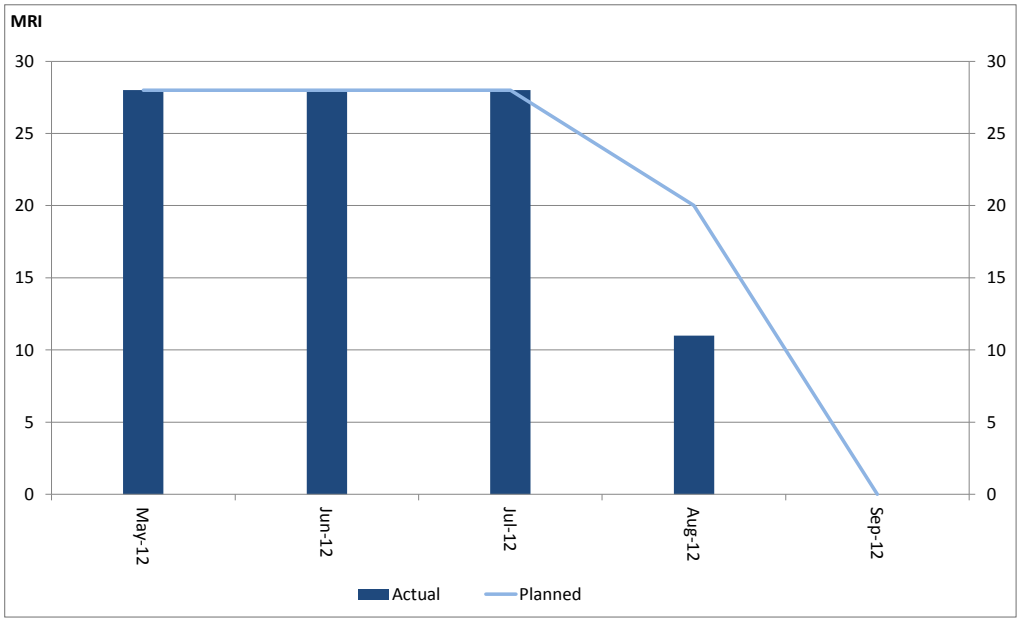


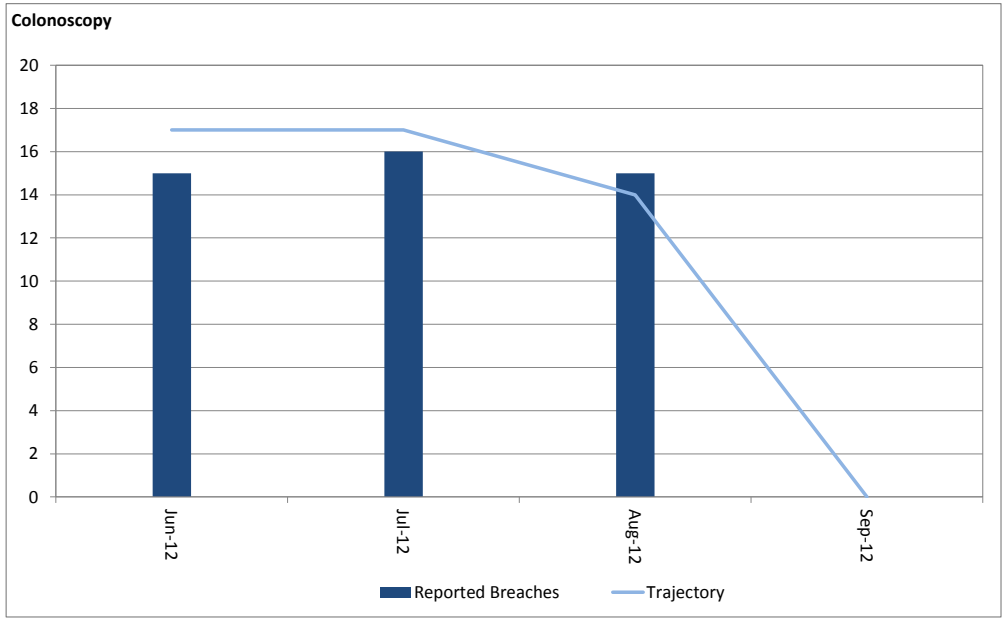
Appendix A Diagnostic 6 week+ Trajectories

Great Ormond Street Hospital for Children NHS Foundation Trust

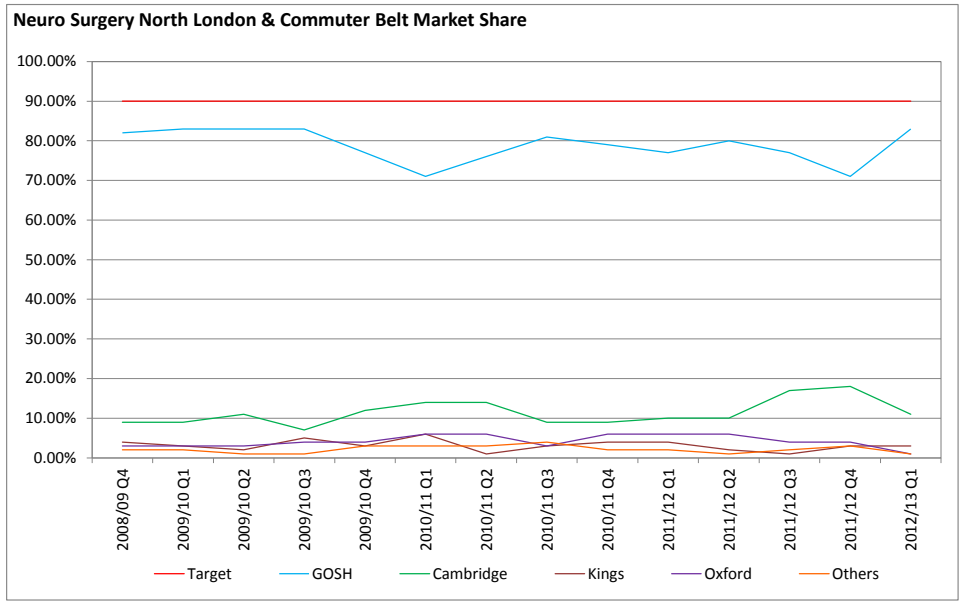


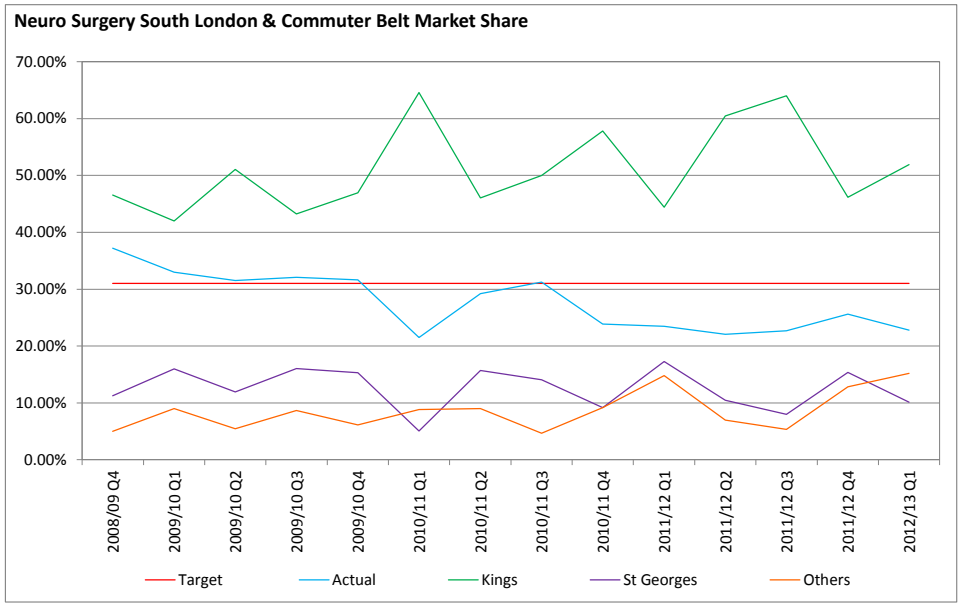


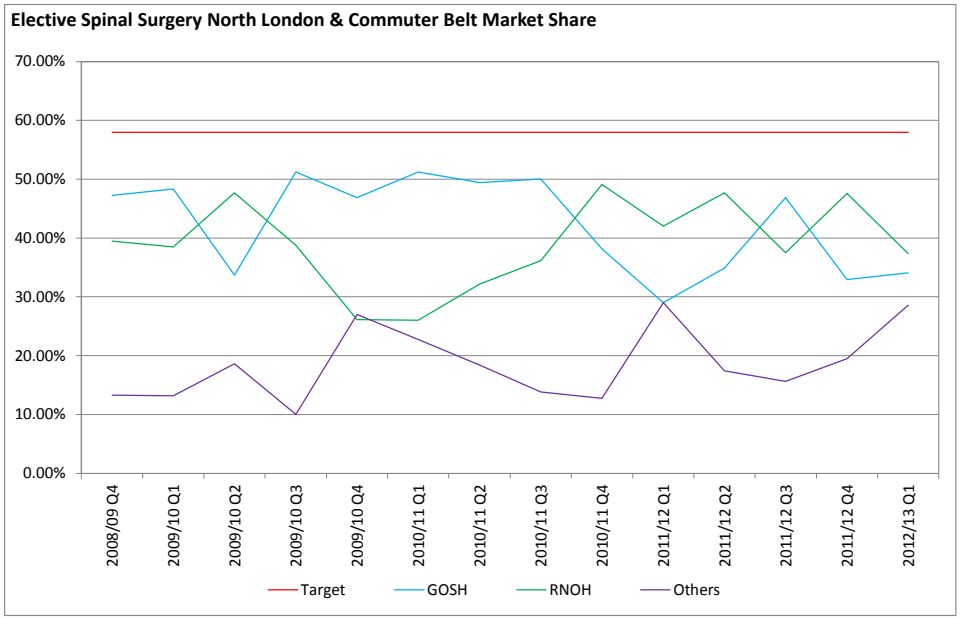


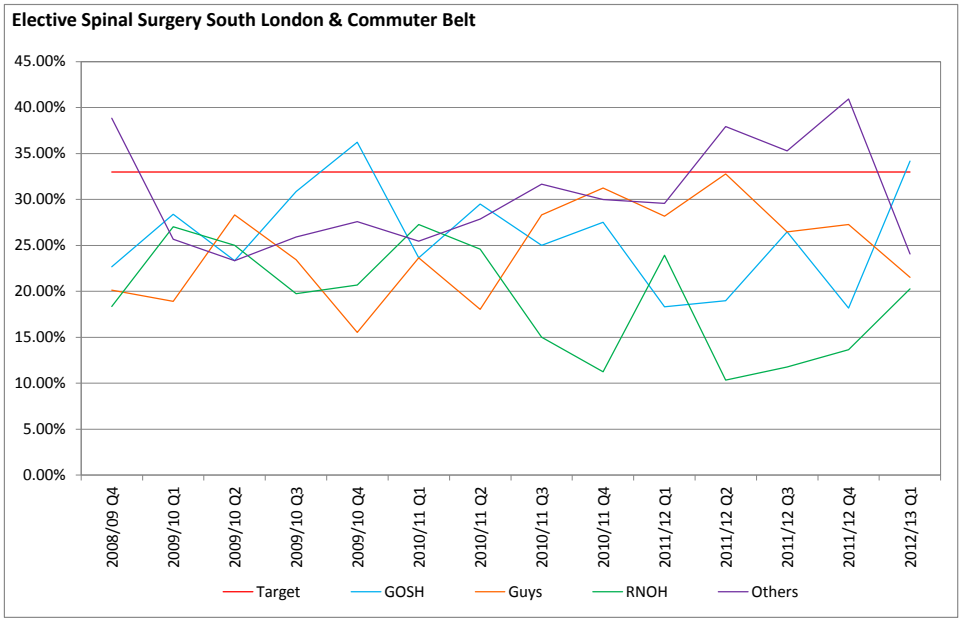


Appendix B Market Share Analysis Graphs

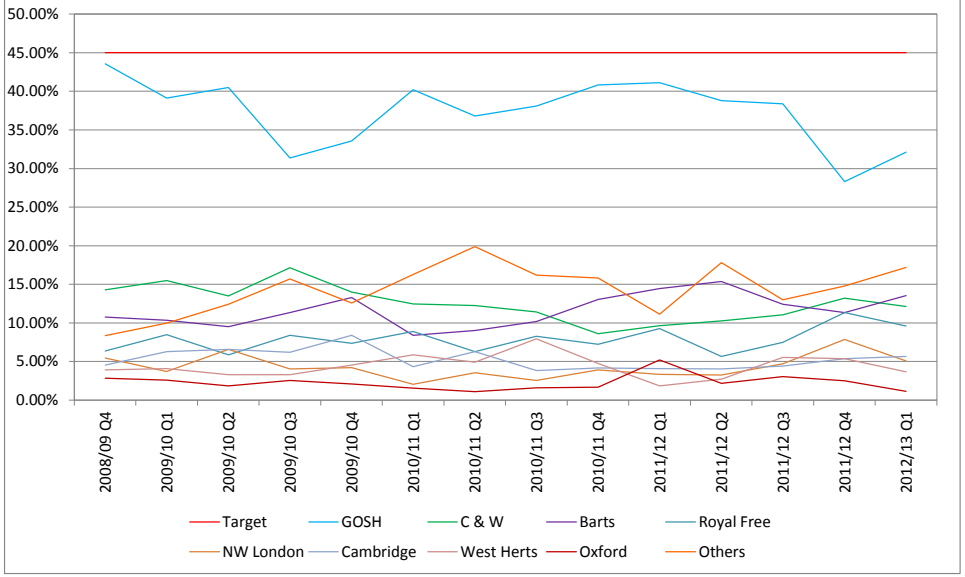




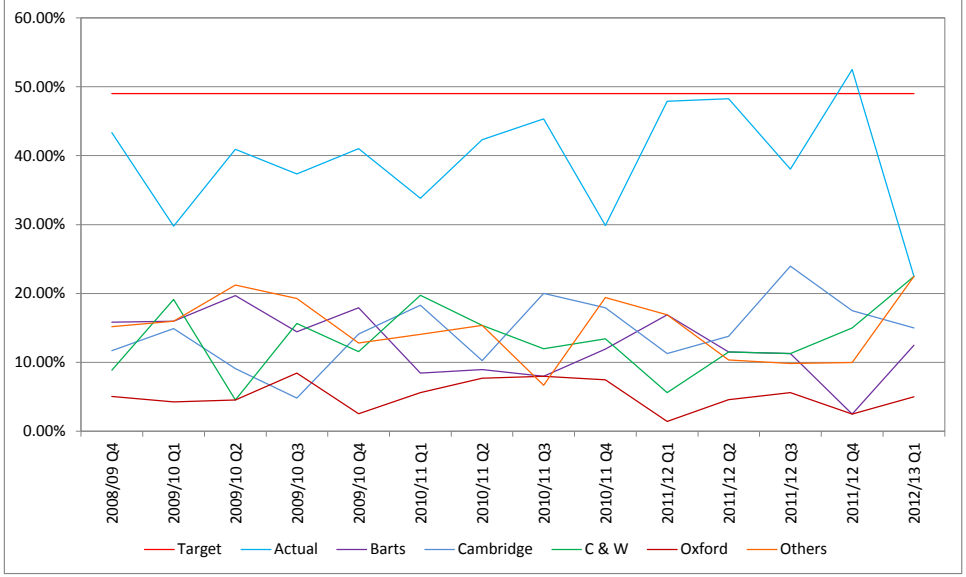




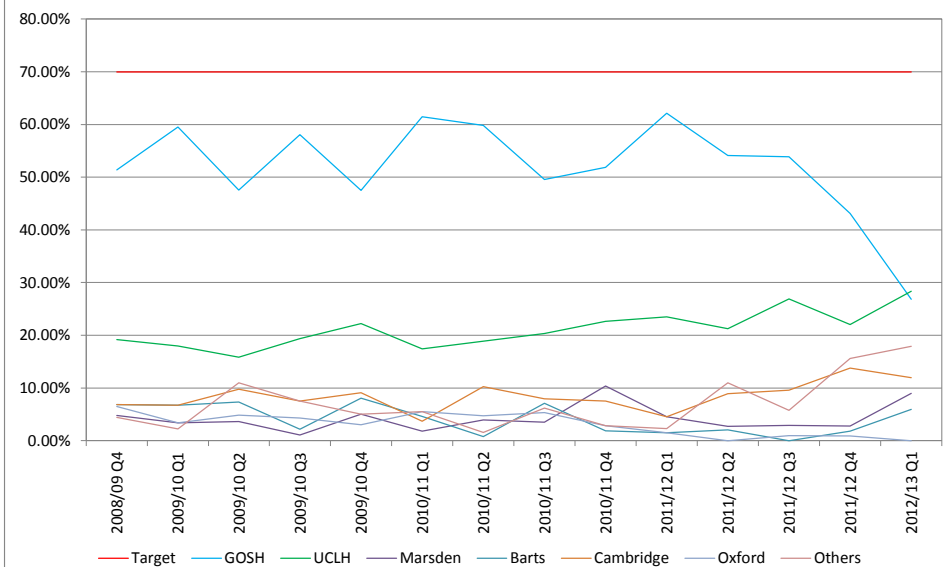
Gastro North London & Commuter Belt Market Share



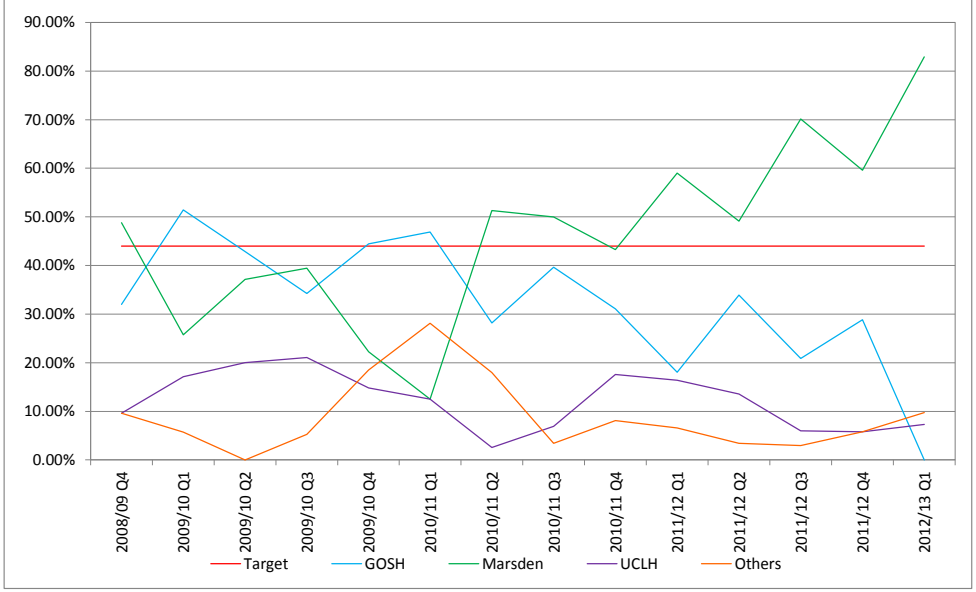
SNAPS North London & Commuter Belt Market Share



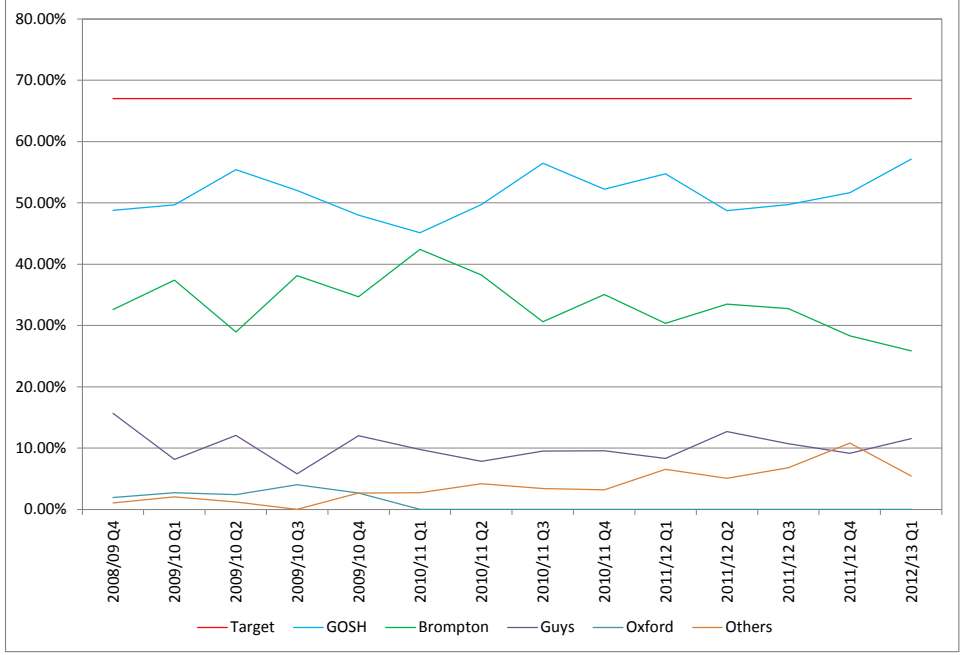
Oncology North London & Commuter Belt Market Share



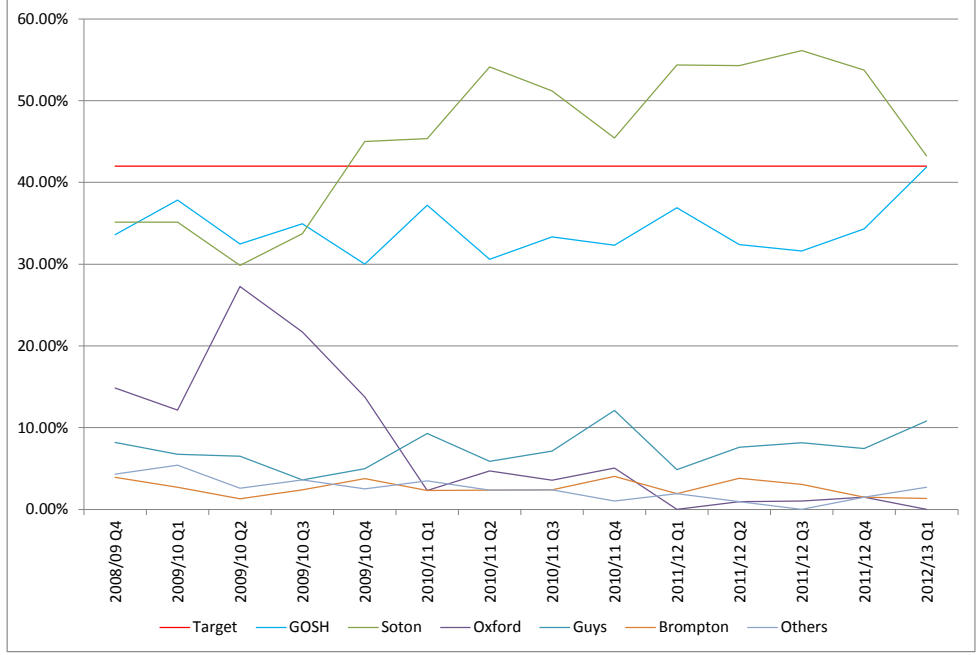
Oncology South London & Commuter Belt Market Share



Cardiac Surgery North London & Commuter Belt Market Share



Cardiac Surgery Further Regional Market Share



Attachment Q

Great Ormond Street Hospital for Children NHS Foundation Trust

TRUST BOARD 26th September 2012	
Finance and Activity Report **FIVE months to 31 August 2012** **Submitted on behalf of** Claire Newton, CFO	**Paper No: Attachment Q**
AIM To summarise the Trust's financial performance for the **FIVE** months to 31 August 2012.	

SUMMARY

Results year to date to end of August (Month 5)
The year to date surplus is **£3.1M** (excluding capital donations) this is **£3.0M** ahead of plan. Including capital donations the net surplus is £8.7M surplus; £(9.4)M worse than plan reflecting lower redevelopment capital expenditure and therefore lower donated income.

Forecast
The Trust's planned surplus for 2012/13 excluding donations and other has planned for a small surplus, once charitable donations, accelerated depreciation and impairments are excluded, and at this point in the year this forecast is unchanged.

There are a number of risks in delivering this forecast position and the most significant are:

- Delivery of the CRES plan
- Delivery of planned activity levels
- Workforce costs are maintained within planned levels
- Being able to deliver IPP income and meeting the new conditions when the cap is officially lifted
- Ensuring activity over-performance is reimbursed.

Activity/Income
Income is **£4.1M** ahead of plan excluding capital donations and £8.3M behind plan if capital donations are included.

- NHS clinical income is **£0.1M** behind plan including pass through income and **£(1.5)**m behind plan excluding pass through income, primarily due to lower than planned activity in critical care and a shortfall in the haem-onc contract price.
- Non NHS revenue is **£5.9M** ahead of plan as a result of IPP income being £6.1M higher than plan.
- Other operating revenue excl. capital donation income is £(**1.6M**) behind plan primarily relates to R&D funding and charity income
- Capital donation income is **£(12.5)M** behind plan primarily reflecting lower capital spend on 2b enabling.

Expenditure
Pay

Pay expenditure totals £81.5M, £(0.5)M higher than plan.

- The consultant budgets are underspent by £0.9M YTD
- The junior doctor budgets are overspent by £(0.5)M YTD
- The nursing budgets are overspent by £(0.5)M YTD
- The scientific and therapeutic staff budgets are £(0.2)M overspent YTD
- The management and administrative budgets are broadly on plan YTD

Agency costs representing 3.3% of the pay bill to August 2012.

Non pay – excluding depreciation and PDC

Non-pay expenditure is £53.8M, which is £0.6M below plan excluding pass through expenditure and £(0.8M) above plan including pass throug:

- The drug budgets are £0.8M underspent YTD
- The blood budgets (primarily pass through) are overspent by £1.2M YTD
- The clinical supplies & services budgets are overspent by £0.5m YTD
- Services from NHS organisations and Healthcare from non-NHS bodies are £0.4M underspent YTD
- Premises costs are £0.3m overspent YTD
- Education & research budgets are underspent by £0.8M.

Financial Risk Rating

- Overall risk rating of 4 MONITOR (unchanged from period 4)

BPPC performance (Non NHS – cumulative)

- Total payables – Value 85.8% Total payables – Number 89.1%

CRES 2012/13

- Identified schemes total £16.3M a decrease of £0.6M, when risk adjusted this totals £14.1M
- 71% of CRES is now categorised as low risk; green and blue
- The value of red schemes is **£0.7m**

CRES 2013/14

- The initial planning target is £13.7M – The risk adjusted value of identified schemes is £13.2M
- **85%** of the schemes are classified as red (84% at period 4)

CRES 2014/15

- The initial planning target is £14.4M - the risk adjusted value of identified schemes is £10.5M

Capital

- Capital spend is £7.8M; £14.4M lower than plan year to date. Donated capital spend is £12.5M lower than plan.

Statement of Financial Position

- Current Assets (excluding Cash & Cash Equivalents) increased by £1.5M largely as a result of an increase in receivables.
- Current Liabilities have increased by £4.1M, mainly due to an increase in NHS Trade payables (£3.5M)

Cash

- The Trust's cash balance was £25.9M at 31 August; there were operating balances of between £25.7M and £41.4M throughout the month.

Salary overpayments

- There were five salary overpayments totalling £9.6K.

Contribution to the delivery of strategy -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 N/A

Who needs to be told about any decision N/A

Author and date Andrew Needham - Deputy Finance Director 14 September 2012

PERIOD 5 - 2012/13 FINANCE REPORT

(1) Forecast position

The planned EBITDA is £23.4M excluding donations and £66.8M including donations. EBITDA (excluding donations) is currently ahead of plan but this is in part due to the receipt of unbudgeted 2011/12 income in the first quarter as well as high IPP income levels.

We are currently forecasting achievement of plan. A detailed forecast will be finalised once the rules regarding the removal of the private patient cap are clarified – expected before the end of September.

(2) Month 5 year to date

The year to date surplus is £3.1M excluding donations for capital additions and this is £3M favourable to plan. When donations are included the Trust is £8.7M surplus and this is £9.4M worse than plan reflecting lower donated income.

The EBITDA variance excluding donations is £2.8M favourable

Table 2.1

	Actual	**Variances**	
	M5 YTD	Excl PT	Incl PT
Clinical ex IPP	112.1	-1.7	-0.3
IPP Clinical	17.8	**6.1**	**6.1**
Other Income	17.2	-1.6	-1.6
	147.1	**2.7**	**4.2**
Capital Donations	5.6	-12.5	-12.5
Total income	**152.7**	**-9.7**	**-8.3**
Pay	-81.5	-0.5	-0.5
Non pay	-53.8	0.6	-0.8
Total op expend	**-135.2**	**0.1**	**-1.3**
Non op expend	-8.8	0.2	0.2
Net surplus incl cap donations	8.7	-9.4	-9.4
EBITDA ex capital donations	***11.9***	***2.8***	***2.8***
	8.1%		

Table 2.2 Revenue account compared with last year

£'M	Actual	Last year		
	M5 YTD	M5 YTD	Var	Incr
NHS clinical	111.3	105.4	5.9	5.6%
Other clinical	18.7	12.9	5.8	45.1%
Non clinical	22.8	19.6	3.2	16.3%
	152.7	137.9	14.9	10.8%
Haringey	0.0	1.6	-1.6	
Total income	**152.7**	**139.5**	**13.3**	**9.5%**
Pay	-81.5	-78.2	-3.2	4.1%
Non-pay	-53.8	-46.2	-7.6	16.5%
	-135.2	-124.4	-10.8	8.7%
Haringey	0.0	-1.6	1.6	-100.0%
Total operating expenditure	**-135.2**	**-126.0**	**-9.2**	**7.3%**
Non op expend	-8.8	-8.4	-0.4	5.1%
Net surplus	8.7	5.1	3.6	

(3.0) Expenditure

3.1 Pay

Pay expenditure totals £81.5M, £0.5M higher than plan.

- The consultant budgets, excluding unallocated CRES, are underspent by £0.9M YTD. Cardiac is underspent by £0.2M as a result of vacancies. Research and Innovation is £0.5M underspent. The R&D variance arises because activity is slower than planned. The remaining consultant underspend is spread across the Trust.

- The junior doctor budgets are overspent by £0.5M YTD. Key areas of pressure lie within Cardiac, Surgery and Neurosciences which are each £0.1M overspent. These pressures are mainly due to using temporary staffing to cover vacancies, maternity and sick leave.

- The nursing budgets are overspent by £0.5M YTD, mainly due to activity and case mix related pressures. Cardiac and International are underspent by £0.3M and £0.2M respectively, as a result of uncovered vacancies. Surgery is overspent by £0.3M due to temporary staff usage on PICU / NICU to cover vacancies.

- The scientific and therapeutic staff budgets are £0.2M overspent YTD. This has resulted from agency premiums on maternity and vacancy cover. There is a plan in place to reduce this expenditure across the rest of the year.

Agency costs

Junior doctors	£0.21M
Nursing	£0.66M
Sci, Ther, Tech	£0.45M
Non-clinical	£1.39M
Total	£2.71M (representing 3.3% of the pay bill to August 2012).

3.2 Non pay

Non-pay expenditure is £53.8M, which is £0.6M below plan.

- Drugs expenditure is £0.8M below budget.
- The blood budgets are overspent by £1.2M YTD, with a £0.9M adverse movement in month. £1.1m of the YTD overspend is on Factor 8 which is pass through and is directly offset by income.
- The clinical supplies & services budgets are overspent by £0.5m YTD. MDTS accounts for £0.4M of the YTD overspend, with key overspends spread across Radiology, Pharmacy and Genetics. This is due to a combination of activity related and historic pressures. Work is being undertaken within MDTS to address the radiology pressure and the genetics variance is forecast to reduce.
- Services from NHS organisations and Healthcare from non-NHS bodies are £0.4M underspent YTD. This lies within R&I and has resulted from delays in invoicing from other organisations on a number of grants. This is directly offset by income underperformance.
- Education & research budgets are underspent by £0.8M. Key underspends are within Nursing and Workforce and R&I, resulting from expenditure timing. Prior year trends demonstrate that this expenditure tends to occur later in the year. The favourable movement above trend in M5 is due to a realignment of the budgets within R&I.

(4) INCOME

Category	Annual Budget £M	YTD Budget £M	YTD Actual £M	YTD Variance £M	11/12 M4 YTD £M	% Change compare to 11/12 %
NHS Clinical Income	268.5	111.3	**111.2**	-0.1	107.0	1.61%
Non NHS Clinical Income	31.2	12.8	**18.7**	5.9	12.9	44.9%
Non Clinical Income Excl. Receipt of Asset Donation	45.1	18.8	**17.2**	-1.6	17.1	0.6%
Total before donations	344.8	142.9	**147.1**	4.2	137.0	7.37%
Receipt of Asset Donation	43.4	18.1	**5.6**	-12.5	16.7	-66%
Total including cap donations	388.2	161.0	**152.7**	-8.3	153.7	-0.65%

4.1 NHS Clinical Income

NHS clinical income is £111.2M, 0.64M lower than planned levels for August 2012. The cumulative position is £0.1M lower than plan but this includes pass through income which is £1.4M above plan and £1.1M of income related to 2011/12 income received in 2012/13.

Excluding pass through and old year income, NHS clinical activity is £2.6M lower than plan.

The largest areas of variance from plan

PCT tariff income £1.2M Adverse
The main elements are PBR elective lower than plan by £1.08M; £0.7M is in Surgery, Cardiac is lower by £0.4M, Medicine lower by £0.3M, whilst ICI is ahead of plan by £0.4M. The surgery shortfall is across the following specialties; Urology, General Surgery, ENT, Dental and Orthopaedics, whilst Audiology and plastics are ahead of plan.

Non-elective activity is ahead by £0.7M primarily within Cardiac which is ahead by £0.6M.

PCT non-tariff income is higher than plan by £1.51M
Approximately £1.1M of this relates to pass through income which has corresponding costs above plan within expenditure. Bed day activity is lower than plan by £0.7M

Non-PBR elective, outpatients and day-cases are all ahead of plan together by £1.7M with Surgery accounting for £0.7M in respect of elective activity in spinal and audiology Neurosciences is ahead by £0.5M mainly reflecting higher outpatient and elective activity and Cardiac is ahead by £0.5M in respect of outpatient activity.

NCG Income (named Strategic Heath Authority income in the Revenue statement) is in line with plan
However, the headline value masks an over-performance on pass through income which is neutral to the bottom line and with this excluded is £0.3M lower than plan and reflects an estimate of current QIDIS performance, cardiac heart and lung transplant activity, cardiac PH and lower SCIDS activity.

NHS Trust income is £0.1M lower than plan
This reflects lower recharges of scans carried out

Department of Health income is £0.3M lower than plan
This reflects lower levels of New Born screening costs

4.2 Non-NHS clinical income is £5.9M ahead of plan
This is almost entirely in respect of IPP activity, which is now £6.1M higher than plan.
Also in this category is non-England activity which is lower than plan by £0.2M with Cardiac and Neurosciences being lower by £0.4M together.

4.3 Non Clinical Income
Non clinical income is £1.6M behind plan excluding capital donations. The main elements of the £1.6M variance are lower charitable and Research income than planned for this point for the year, though there is no indication that the full year values will be lower than plan.

(5) CIP/CRES

Overview
The Trust is well advanced with its CRES programme for the 12/13 financial year and is now moving to have detailed plans for 2013/14 by early October.

CRES 2012/13

- £16.3M of schemes identified an decrease of £0.6M since month 4 as certain schemes were deemed no longer deliverable in the current timescale and some of these have been moved forward to 2013/14
- The risk adjusted value is £14.1M
- 71% of schemes are now classified as ‘secure’ in that they are green or blue and total £11.6M (68% and £11.1M at month 4)

- There remain £0.7M of red schemes down from 1.2M at period 4

CRES 2013/14

- £13.7M is the initial planning target for 2013/14, this is subject to change but likely to the minimum value required
- £15.9M has been identified a decrease of £0.3M from period 4
- £ 13.2M is the risk adjusted value of these schemes at this point
- 1 % of schemes are classified as secure in that they are coded green or blue – this is unchanged since period 4
- 85% of schemes are classified as red, at period 4 this was 84%

CRES 2014/15

- The initial planning target is £14.4M
- £11.55M of schemes have been identified for development and the risk adjusted value of the £11.55M is £10.54M

(6) CAPITAL PROGRAMME

Overview

The Trust's capital plan for the 5 months ending 31st August 2012 is £22.2M. The total spend to date amounts to £7.8m representing an under spend to date of £14.4m.

	Annual Plan £M	Plan YTD £M	Actual YTD £M	Variance £M
Hospital Redevelopment	32.9	13.7	3.1	10.6
Estates Maintenance Projects	6.2	2.6	1.7	0.9
Facilities Projects	0.4	0.2	0.1	0.1
IT Related Projects	4.5	1.9	0.9	1.0
Medical Equipment Purchases	9.2	3.8	2.0	1.8
Total Additions in Year	**53.3**	**22.2**	**7.8**	**14.4**
Asset Disposals	0.0	0.0	(0.0)	0.0
Donated Funded Projects	(43.4)	(18.1)	(5.6)	(12.5)
Trust Funded Projects	**9.9**	**4.1**	**2.2**	**1.9**

Redevelopment

Redevelopment Projects are under spent by £10.6m. This is due to delays on 2B enabling and the 2B main scheme.

Estates,Facilities, IT, and Medical equipment

Estates Management Projects are showing a total under spend of £0.9m, relating to under spend on trust funded projects.

IT Projects are £1m below plan.

Medical Equipment Projects are £1.8m under spent on Donated Projects due to phasing of equipment purchases.

(7) STATEMENT OF FINANCIAL POSITION

Non-Current Assets

Non-Current Assets at the end of August 2012 totalled £342M, a net decrease of £0.1M over the previous month. This increase was due to depreciation net of capital expenditure.

Current Assets (excluding Cash & Cash Equivalents)
Current assets increased by £1.5M

NHS Trade Receivables - Accrued (£1.0M increase)	This is primarily due to an increase in accrual for Consultant Clinical Excellence Awards (£1.3M)
Prepayment & Accrued Income (£0.8M increase)	This is primarily due to an increase in Non NHS accrued income in respect of Charity Income Accrual (£0.8M).
Capital Receivables (£0.4M decrease)	The decrease is primarily due to receipt of credit notes in respect of equipping Ocean Theatres and Phase 2A.

Current Liabilities

Current Liabilities have increased by £4.1M

NHS Trade Payables (£3.5M increase)	The increase is primarily due to one months advance payment from the East of England commissioning group
Other Payables (£0.5M increase)	This represents the increase in the PDC dividend from the previous month (£0.5M)
Expenditure Accruals (0.4M increase)	Expenditure accruals increased by £1.1M primarily due to an accrual for Premises costs (£0.5M) and an increase in the Metabolics High Cost Drugs accrual (£0.6M), net of a decrease in Invoice register accruals following an increase in the number of invoices processed (£0.7M).
Deferred Revenue (£0.6M decrease)	The decrease is due to the utilisation of deferred income in respect of invoices raised for quarter 2 income.

Taxpayers' Equity
Taxpayers' Equity has increased by £0.9M in month due to the increase in the Retained Earnings of £0.9M.

(8) WORKING CAPITAL

8.1 Cash overview

The Trust had cash holdings of £25.9M at 31 August 2012, and had operating cash balances of between £25.7M and £41.4M throughout the month. The cumulative commercial bank account balances at £0.04M was in line with the DH target maximum holding of £0.05M.

The closing cash balance is slightly lower than forecast (£0.4M below target) but the improvement in position from last month is mainly due to the advance payment of £3.7M from East of England as reduced by the delay in settlement of the Kuwait education invoice of £1.07M which was due for payment in early May 2012. Other cash variances are due to slow payment of some bills in IPP, and delays on the payment of CQUIN and performance contract invoices for 1112. Resolution of most of these delays is expected this month.

8.2 Trade Debt

Debt is £1M higher than this time last year; this is largely due to an outstanding invoice for Kuwait training of £1.4M. The overall debt aging has increased due to the material impact of the Kuwait invoice and the UAE debt £1.5M outside of terms.

	31/08/2012		31/03/2012		31/08/2011	
not yet due and COA	11,958	**56%**	15071	77%	9,126	44%
0-30	3,378	**16%**	2,469	13%	3,787	18%
30-60	1,357	**6%**	568	3%	3,711	18%
60-90	1,657	**8%**	626	3%	1,390	7%
90-120	376	**2%**	4	0%	498	2%
120-180	2,245	**10%**	153	1%	685	3%
180-360	205	**1%**	193	1%	554	3%
360+	340	**2%**	491	3%	868	4%
	21,516	**100%**	19,575	100%	20,619	
NHS	6,066		6,640		11,734	
Non- NHS	2,655		3,362		1,610	
International	12,041		7,891		6,935	
Gosh CC	753		1,296		340	
	21,516		19,189		20,619	
Revenue Debtors	**20,968**		19,103		20,619	
Capital debtors	548		86			
	21,516		**19,189**	**-**	**20,619**	

NHS debt
NHS debt is £6.07M with £2.6M outside of terms. The largest overdue debtor is NHS Hounslow (£0.5M) of which £0.47M is performance related. This includes 2011/12 invoices but commissioners have confirmed that no challenges remain. Other significant debtors include Cancer Network (£0.38M), UCLH (£0.24M), Haringey PCT (£0.2M) and Enfield PCT(£0.14M).

IPP debt is at £12.04M,
Excluding cash on account, the profile of IPP debt shows 75% as not yet due or overdue by 1-30 days which is a further decline from 83% in the previous month. There is a plan in place with the relevant embassy to settle the debt beyond terms.

Non-NHS, non clinical debt is £2.7M
The issue of non-payment of the Kuwait training invoice has been raised with the Kuwait Minister for Health and additional supporting schedules have been sent to facilitate payment. .

8.3 Trade payables

Trade payables (excluding capital) were **£11.1M** at 31 August, an increase of **£3.5M** from the previous month. This was due to the advance payment from East of England

- Creditor days increased to **26.7** from **23** days but remain within target.
- BPPC is cumulatively **89.1%** by invoice count and **85.8%** by value.

(9) FINANCIAL RISK RATING

The current ratio score is 4 and this is unchanged from period 4.

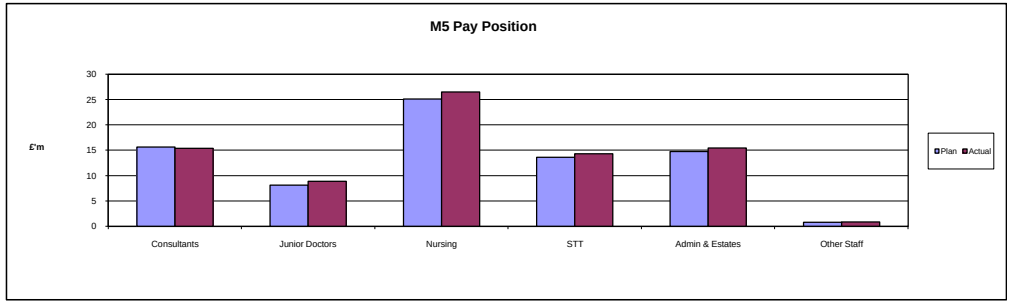
Month 5 – MONITOR basis	Rating
EBITDA Margin (ex capital donations)	3
EBITDA % Achieved	5
ROA (ex capital donations)	4
I&E Surplus margin (includes capital donations)	5
Liquidity Days	4
Weighted Average	4
Overall Score	**4**

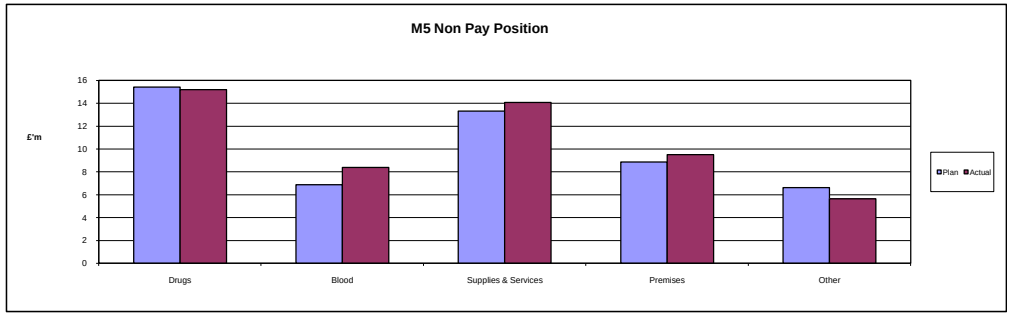
Great Ormond Street Hospital for Children NHS Trust Finance and Activity Performance Report Period 5 2012/13 Contents

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Trust Summary

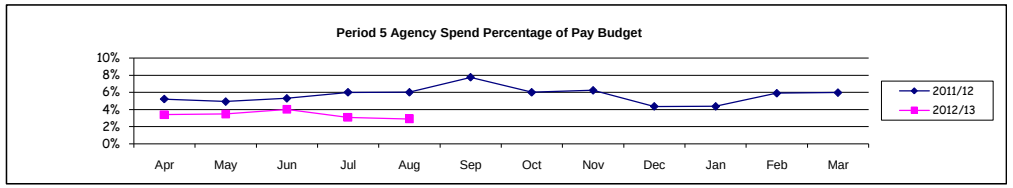
Statement of Comprehensive Income

	Current Month		YTD	
	Actual	Plan Variance	Actual	Plan Variance
	£000	£000	£000	£000
Revenue				
Revenue from patient care activities	26,323	1,740	129,929	5,771
Other operating revenue, excluding Capital Donations	3,836	(286)	17,182	(1,609)
Total Income	**30,159**	**1,454**	**147,111**	**4,162**
Operating expenses	(28,480)	(949)	(135,229)	(1,326)
EBITDA, excluding Capital Donations	**1,679**	**505**	**11,882**	**2,836**
Depreciation	(1,328)	33	(6,438)	137
Impairment	0	0	0	0
Corporation Tax	(3)	5	84	124
Operating surplus, excluding Capital Donations	**348**	**543**	**5,528**	**3,097**
Investment revenue	9	6	30	15
Other losses	9	9	7	7
Finance costs	(3)	(1)	(15)	(5)
Surplus for the financial year	**363**	**557**	**5,550**	**3,114**
Public dividend capital dividends payable	(492)	(18)	(2,458)	(92)
Retained surplus for the year, excluding Capital Donations	**(129)**	**539**	**3,092**	**3,022**
Other comprehensive income				
Impairments put to the reserves	0	0	0	0
Total comprehensive income for the year	**(129)**	**539**	**3,092**	**3,022**
Capital Donations	*1,036*	*(2,577)*	*5,617*	*(12,450)*
Surplus including Capital Donations	*907*	*(2,038)*	*8,709*	*(9,428)*
Total Income, including Capital Donations	*31,195*	*(1,123)*	*152,728*	*(8,288)*
EBITDA % of Income	*8.7%*		*11.5%*	
EBITDA % of Income, excluding Capital Donations	*5.6%*		*8.1%*	





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



Staffing Staff Numbers	11/12 M12 WTE	WTE Paid	Maternity Paid	Temp Paid	Overtime Paid	Total Paid	WTE above 11/12 M12
Admin and Other Support	927	827	12	114	5	959	(32)
Clinical Support	825	691	36	16	4	746	79
Medical	550	501	20	27	0	548	2
Nursing	1,502	1,319	67	103	2	1,492	10
Total	**3,804**	**3,338**	**135**	**260**	**11**	**3,745**	**59**

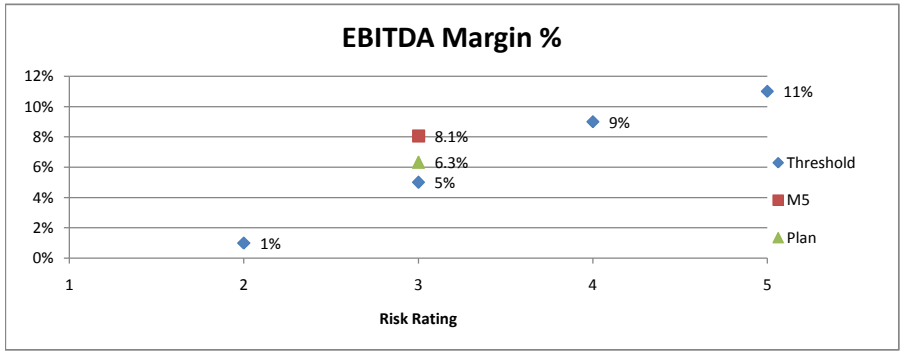
*** 12/13 wte comparator includes maternity leave at M12**

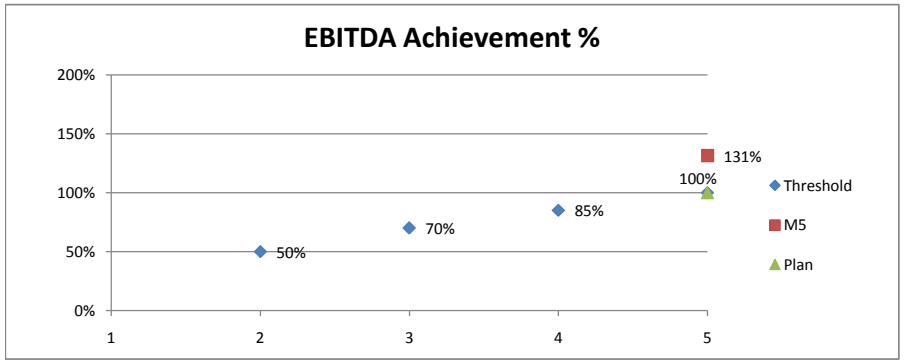
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Ratio Analysis

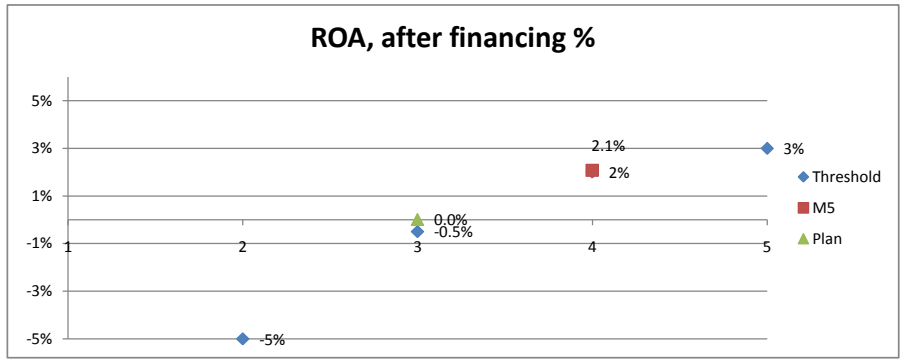
Provider Agency Rating	Target for FT Status	M5 12/13 Actual	M4 12/13 Actual	M5 Score - Monitor Basis
EBITDA Margin	5%	8.1%	8.7%	3
EBITDA % Achieved	70%	131.3%	129.6%	5
ROA, after financing	3%	2.1%	2.7%	4
I&E Surplus margin	1%	5.7%	6.4%	5
Liquidity Days	15.0	39	38	4
Weighted Average	3.0	4.1	4.1	4.1
Overall Rating	**3**	**4**	**4**	**4**
IPP Cap (Max 9.7%)	9.7%	13.7%	14.1%	

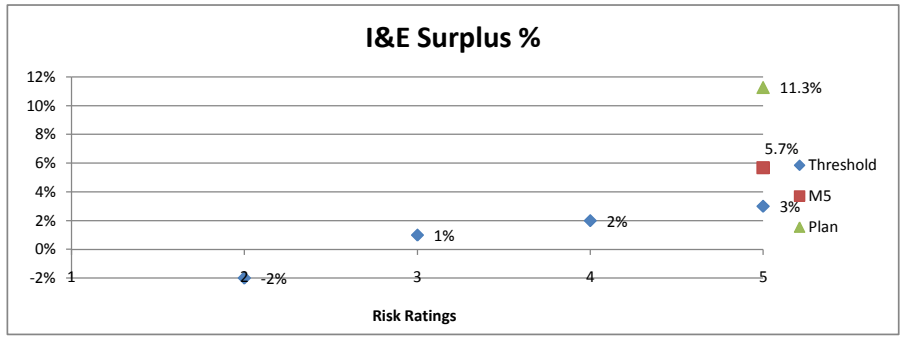
** Ratios calculated as per Monitor guidance*

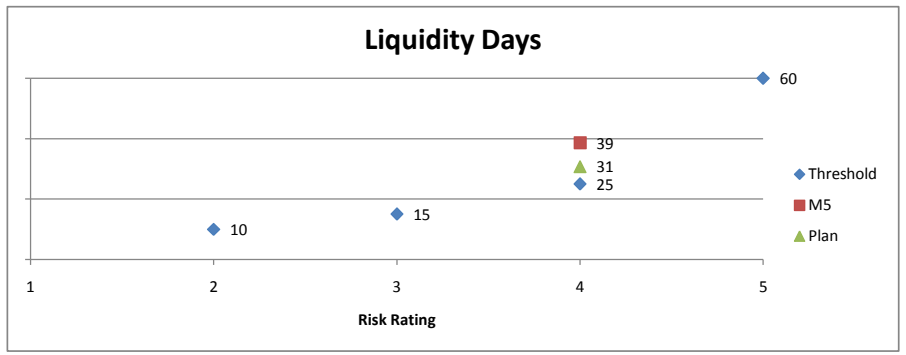
Salary Overpayments		
Unit	**No.**	**Amount £'000**
Neurosciences	2	4.0
Surgery	1	1.2
ICI	1	0.9
DTS	1	0.8
TOTAL	**5**	**6.9**











Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Unit Summary

	YTD								
	Income*				Expenditure				Overall Unit Position
	2011/12 £000	12/13 YTD Actual £000	12/13 variance to plan £000	12/13 actual variance to 11/12 actual £000	2011/12 £000	12/13 YTD Actual £000	12/13 variance to plan £000	12/13 actual variance to 11/12 actual £000	12/13 actual variance to plan £000
Clinical Units									
Cardiac	23,359	23,981	(456)	621	(13,748)	(14,589)	(271)	(840)	(727)
Surgery	26,737	27,665	(726)	928	(25,001)	(26,180)	(1,792)	(1,179)	(2,517)
DTS	787	1,552	(113)	764	(8,331)	(9,196)	(751)	(865)	(864)
ICI	23,584	24,374	(1,506)	789	(23,133)	(24,228)	(741)	(1,095)	(2,247)
International (excludes other unit recharges)	12,808	18,748	2,688	5,941	(5,187)	(6,102)	202	(915)	2,890
Medicine	17,262	18,364	(168)	1,102	(15,858)	(17,513)	43	(1,655)	(125)
Neurosciences	11,250	11,414	271	163	(9,025)	(9,420)	(416)	(394)	(145)
Pass through drugs & devices funding	4,182	4,216	115	35					115
Education & Training / Merit Award Funding	3,497	3,595	56	97					56
Other Clinical Income / CQUIN	2,938	1,613	1,263	(1,325)					1,263
Centrally held development reserves					**117**	**(926)**	3,712	(1,044)	3,712
Total Clinical Units	**126,405**	**135,521**	**1,425**	**9,116**	**(100,166)**	**(108,154)**	**(14)**	**(7,987)**	**1,411**
Central Departments									
Operations & Facilities	619	328	(38)	(290)	(6,383)	(6,676)	(614)	(292)	(652)
Corporate Affairs	23	25	(10)	2	(614)	(607)	117	8	107
Estates	265	266	(13)	1	(4,881)	(5,242)	(149)	(361)	(162)
Finance & ICT	73	136	57	64	(4,376)	(5,411)	(551)	(1,035)	(494)
Human Resources	278	262	(57)	(16)	(1,097)	(1,347)	(78)	(250)	(134)
Clinical & Medical Operations	8	389	(86)	381	(2,430)	(2,529)	(42)	(99)	(128)
Nursing And Workforce Development	787	693	(122)	(94)	(2,140)	(2,085)	304	55	182
Research And Innovation	5,402	5,409	(1,024)	7	(2,188)	(2,808)	1,191	(620)	168
Redevelopment Revenue Costs	191	262	(152)	71	(191)	(262)	68	(71)	(84)
Total Central Departments	**7,645**	**7,770**	**(1,443)**	**125**	**(24,301)**	**(26,967)**	**247**	**(2,666)**	**(1,194)**
Depreciation & Dividends	**2,540**	**0**	**0**	**(2,540)**	**(8,340)**	**(8,897)**	**44**	**(557)**	**44**
Centrally held income, incl Charitable Donations	**1,300**	**9,443**	**(9,679)**	**8,144**	**0**	**0**	**0**	**0**	**(9,681)**
Impairment		**0**	**0**	**0**	**0**			**0**	**0**
Net Position, excl Haringey & North Mid	**137,890**	**152,734**	**(9,698)**	**14,844**	**(132,807)**	**(144,017)**	**277**	**(11,211)**	**(9,420)**
Haringey	1,590	0	0	(1,590)	(1,519)	(2)	(2)	1,517	(2)
North Mid.	(3)	(5)	(5)	(3)	(29)	0	0	29	(5)
Net Position, incl Haringey & North Mid	**139,477**	**152,728**	**(9,703)**	**13,251**	**(134,355)**	**(144,019)**	**275**	**(9,664)**	**(9,428)**

* Unit income and expenditure variances have been adjusted to remove material blood, drugs and clinical supplies pass through variances

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
CRES Performance

2012 / 13

Division	Schemes completed	Schemes in progress	Schemes being scoped	Suggested schemes	Total savings identified*	Delivery target	Delivery Variance
Cardiac	727,418	909,397	828,053	30,000	2,494,868	2,574,600	-79,732
ICI	1,088,383	651,293	448,866	99,292	2,287,834	2,678,200	-390,366
International	2,051,800	141,096	234,118		2,427,014	1,022,000	1,405,014
MDTS	626,800	387,596	443,983	168,032	1,626,411	2,154,000	-527,589
Neurosciences	211,344	1,347,622	65,488	3,997	1,628,451	1,383,000	245,451
Surgery	713,838	728,523	882,582	63,021	2,387,964	3,041,326	-653,362
Corporate facilities	192,260	621,825	119,042	223,333	1,156,460	1,214,900	-58,440
Clinical Operations	98,000	104,838			202,838	193,200	9,638
Corporate affairs	91,019	14,785		6,164	111,968	152,600	-40,632
Estates	23,712	196,664	86,000	49,650	356,026	749,300	-393,274
Finance & ICT		97,742	640,993	18,000	756,735	810,082	-53,347
HR & workforce	87,623	82,989		26,000	196,612	256,200	-59,588
Medical director	37,861	52,250			90,111	88,200	1,911
Nursing & Education	104,830	206,472	47,000	0	358,302	347,200	11,102
R&I			217,500	0	217,500	53,200	164,300
Total	**6,054,886**	**5,543,093**	**4,013,624**	**687,490**	**16,299,093**	**16,718,008**	**-418,915**
% of total identified savings	*37*	*34*	*25*	*4*			
Risk adjusted totals					**14,142,991**	**16,718,008**	**-2,575,017**

* total schemes identified prior to risk adjustment methodology being applied

2013 / 14

Division	Schemes completed	Schemes in progress	Schemes being scoped	Suggested schemes	Total savings identified (1)
Cardiac	0		57,708	2,168,072	2,225,780
ICI	0		124,972	1,717,195	1,842,167
International	0		582,000		582,000
MDTS	0	58,039	171,414	2,495,996	2,725,449
Neurosciences	0	37,917		1,318,593	1,356,510
Surgery	0		974,552	3,051,565	4,026,117
Corporate facilities	0	53,596		1,055,000	1,108,596
Clinical Operations	0			149,000	149,000
Corporate affairs	0			125,305	125,305
Estates	0	673	6,466	336,329	343,468
Finance & ICT	0		254,649	209,487	464,136
HR & workforce	0			263,000	263,000
Medical director	0			278,000	278,000
Nursing & Education	0	1,600		366,726	368,326
R&I	0			85,000	85,000
Total	**0**	**151,825**	**2,171,761**	**13,619,268**	**15,942,854**
% of total identified savings	*0*	*1*	*14*	*85*	
Risk adjusted totals					**13,150,262**
Difference					**-2,792,592**
Planning total					**13,700,000**

2014 / 15

Division	Schemes completed	Schemes in progress	Schemes being scoped	Suggested schemes	Total savings identified (1)
Cardiac	0	0	0	1,400,037	1,400,037
ICI	0	0	0	1,902,953	1,902,953
International	0	0	0	665,392	665,392
MDTS	0	0	0	2,063,450	2,063,450
Neurosciences	0	0	0	926,984	926,984
Surgery	0	0	0	2,466,422	2,466,422
Corporate facilities	0	0	0	600,000	600,000
Clinical Operations	0	0	0	149,000	149,000
Corporate affairs	0	0	0	125,305	125,305
Estates	0	0	0	689,996	689,996
Finance & ICT	0	0	0	100,693	100,693
HR & workforce	0	0	0	159,000	159,000
Medical director	0	0	0	0	0
Nursing & Education	0	0	0	270,363	270,363
R&I	0	0	0	35,000	35,000
Total	**0**	**0**	**0**	**11,554,595**	**11,554,595**
% of total identified savings	*0*	*0*	*0*	*100*	
Risk adjusted totals					**10,543,374**
Difference					**-1,011,221**
Planning total					**14,400,000**

(1) The final targets for 2013/14 and 2014/15 will be a combination of the planning total, c/forward undelivered CRES and other reductions required to cover cost pressures.

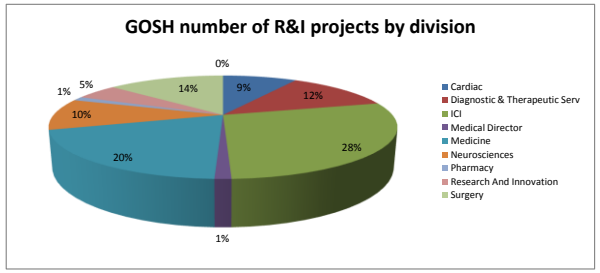
Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Period 5 2012/13
Revenue Statement

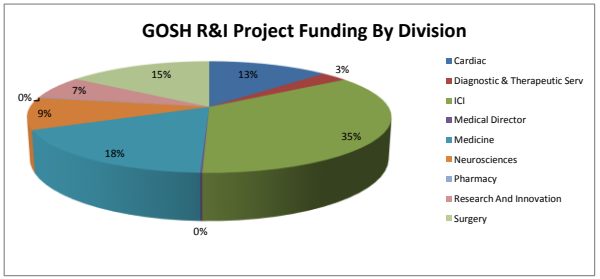
	12/13 Annual Budget £000	12/13 Mth 5 Actual £'000	12/13 Mth 5 Variance to Plan, excluding Pass Through £'000	12/13 Mth 5 Pass Through Variance £'000	12/13 Mth 5 Variance to Plan, including Pass Through £'000	12/13 YTD Actual £'000	12/13 YTD Variance to Plan, excluding Pass Through £'000	12/13 YTD Pass Through Variance £'000	12/13 YTD Variance to Plan, including Pass Through £'000	12/13 YTD Actual Variance to 11/12 YTD Actual £'000
Primary Care Trusts Tariff	88,601	**7,133**	*-335*	*0*	-335	**35,934**	-1,173	0	-1,173	8,127
Primary Care Trusts Non Tariff	126,515	**11,675**	*122*	*810*	932	**53,499**	419	1,099	1,518	4,921
Primary Care Trusts Mff	0	**0**	*0*	*0*	0	**0**	0	0	0	-8,109
Strategic Health Authorities	46,722	**3,648**	*-321*	*76*	-245	**19,465**	-318	316	-2	752
Nhs Trusts	752	**35**	*-27*	*0*	-27	**173**	-140	0	-140	-110
Department Of Health	1,215	**19**	*-83*	*0*	-83	**222**	-284	0	-284	-28
Nhs Other	4,700	**392**	*0*	*0*	0	**1,958**	0	0	0	-1,295
Activity Revenue Nhs	**268,504**	**22,902**	***-643***	***886***	**243**	**111,251**	**-1,496**	**1,415**	**-81**	**4,258**
Local Authorities	0	**0**	*0*	*0*	0	**0**	0	0	0	-151
Private Patients	28,538	**3,239**	*1,532*	*0*	1,532	**17,822**	6,084	0	6,084	6,165
Non Nhs Other	2,619	**183**	*-35*	*0*	-35	**856**	-232	0	-232	-209
Activity Revenue Non Nhs	**31,157**	**3,422**	***1,497***	***0***	**1,497**	**18,678**	**5,852**	**0**	**5,852**	**5,805**
Patient Transport Services	1,182	**90**	*-8*	*0*	-8	**536**	43	0	43	88
Education And Training	13,217	**1,102**	*13*	*0*	13	**5,350**	-157	0	-157	-341
Research And Development	13,250	**1,044**	*-341*	*0*	-341	**5,050**	-471	0	-471	-24
Charitable & Other Contrib	7,898	**918**	*58*	*0*	58	**2,596**	-695	0	-695	1,103
Depreciation Income Transfer	0	**0**	*0*	*0*	0	**0**	0	0	0	-2,540
Non Patient Care Services	3,715	**271**	*-39*	*0*	-39	**1,672**	124	0	124	121
Revenue Generation	802	**78**	*11*	*0*	11	**321**	-14	0	-14	-357
Other Revenue	4,991	**334**	*20*	*0*	20	**1,659**	-438	0	-438	-480
Other Operating Revenue	**45,056**	**3,836**	***-286***	***0***	**-286**	**17,182**	**-1,608**	**0**	**-1,608**	**-2,430**
Total Income, excluding Capital Donations Income	**344,717**	**30,159**	***569***	***886***	**1,455**	**147,111**	**2,747**	**1,415**	**4,162**	**7,634**
Directors & Senior Managers	-8,821	**-696**	*64*	*0*	64	**-3,425**	250	0	250	87
Consultants	-39,120	**-3,187**	*243*	*0*	243	**-15,425**	875	0	875	-271
Junior Doctors	-20,202	**-1,585**	*120*	*0*	120	**-8,010**	408	0	408	-696
Junior Doctors Agy	7	**-17**	*-16*	*0*	-16	**-210**	-213	0	-213	404
Junior Doctors Bank	-77	**-179**	*-172*	*0*	-172	**-701**	-669	0	-669	27
Administration & Estates	-27,585	**-1,961**	*469*	*0*	469	**-9,765**	1,729	0	1,729	-216
Administration & Estates Agy	-498	**-274**	*-222*	*0*	-222	**-1,378**	-1,170	0	-1,170	464
Administration & Estates Bank	-10	**-246**	*-242*	*0*	-242	**-894**	-889	0	-889	-894
Healthcare Assist & Supp	-1,585	**-119**	*-18*	*0*	-18	**-748**	-87	0	-87	189
Healthcare Assist & Supp Agy	0	**6**	*6*	*0*	6	**-11**	-11	0	-11	56
Nursing Staff	-62,487	**-4,790**	*372*	*0*	372	**-24,172**	1,863	0	1,863	-1,276
Nursing Staff Agy	-21	**-98**	*-96*	*0*	-96	**-666**	-657	0	-657	322
Nursing Staff Bank	-118	**-404**	*-395*	*0*	-395	**-1,706**	-1,657	0	-1,657	133
Scientific Therap Tech	-33,835	**-2,746**	*96*	*0*	96	**-13,778**	382	0	382	-437
Scientific Therap Tech Agy	0	**-94**	*-98*	*0*	-98	**-448**	-448	0	-448	304
Scientific Therap Tech Bank	0	**-11**	*-11*	*0*	-11	**-101**	-101	0	-101	-39
Other Staff	-380	**-26**	*6*	*0*	6	**-112**	47	0	47	4
Pay Reserves	-6,776	**-46**	*482*	*0*	482	**93**	2,951	0	2,951	205
Cips And Cres Unidentified - P	7,396	**0**	*-579*	*0*	-579	**0**	-3,102	0	-3,102	0
Pay Costs	**-194,112**	**-16,473**	***9***	***0***	**9**	**-81,455**	**-500**	**0**	**-500**	**-1,633**
Drugs Costs	-38,447	**-3,008**	*353*	*13*	366	**-15,200**	1,248	-414	834	-1,623
Blood Costs	-17,270	**-2,462**	*-63*	*-875*	-938	**-8,375**	-151	-1,079	-1,230	-1,379
Supplies & Services - Clinical	-23,673	**-2,273**	*-128*	*-24*	-152	**-10,358**	-588	78	-510	-681
Services From Nhs Organisation	-4,472	**-448**	*-17*	*0*	-17	**-1,760**	100	0	100	-230
Healthcare From Non-Nhs Bodies	-3,345	**-205**	*105*	*0*	105	**-1,056**	336	0	336	-259
Supplies & Services - General	-1,792	**-189**	*-36*	*0*	-36	**-895**	-148	0	-148	-91
Consultancy Services	-1,688	**-100**	*54*	*0*	54	**-543**	160	0	160	-124
Clinical Negligence Costs	-2,214	**-184**	*0*	*0*	0	**-922**	0	0	0	-110
Establishment Costs	-2,735	**-247**	*-42*	*0*	-42	**-1,058**	81	0	81	-43
Transport Costs	-2,862	**-275**	*-27*	*0*	-27	**-1,166**	26	0	26	-88
Premises Costs	-22,098	**-2,133**	*-295*	*0*	-295	**-9,520**	-312	0	-312	-1,840
Other Auditors Remuneration	-191	**-15**	*1*	*0*	1	**-112**	-32	0	-32	-39
External Auditors Fees	-229	**-20**	*-1*	*0*	-1	**-110**	-15	0	-15	-34
Education And Research Costs	-2,708	**-91**	*277*	*0*	277	**-314**	814	0	814	124
Expenditure - Other	-4,059	**-417**	*-189*	*0*	-189	**-1,394**	321	0	321	-365
Internal Recharges	242	**1**	*-91*	*0*	-91	**-26**	-127	0	-127	-19
Impairment Of Receivables	0	**63**	*63*	*0*	63	**-931**	-931	0	-931	-770
Non Pay Reserves	-4,438	**-3**	*343*	*0*	343	**-33**	1,838	0	1,838	-33
Cips And Cres Unidentified - N	4,844	**0**	*-379*	*0*	-379	**0**	-2,031	0	-2,031	0
Non Pay Costs	**-127,134**	**-12,007**	***-71***	***-886***	**-957**	**-53,774**	**589**	**-1,415**	**-826**	**-7,606**
EBITDA, excluding Capital Donations	**23,470**	**1,679**	***506***	***0***	**506**	**11,882**	**2,836**	**0**	**2,836**	**-1,606**
P & L On Disp Of Fixed Assets	0	**9**	*9*	*0*	9	**7**	7	0	7	7
Fixed Asset Impair & Reversals	-1,650	**0**	*0*	*0*	0	**0**	0	0	0	0
Depreciation & Amortisation	-20,710	**-1,328**	*33*	*0*	33	**-6,438**	137	0	137	-501
Interest Receivable	36	**9**	*6*	*0*	6	**30**	15	0	15	-1
Other Revenue / Expenditure	-24	**-3**	*-1*	*0*	-1	**-15**	-5	0	-5	2
Pdc Dividend Payable	-5,680	**-492**	*-18*	*0*	-18	**-2,458**	-92	0	-92	-56
Corporation Tax	-96	**-3**	*5*	*0*	5	**84**	124	0	124	124
Other Revenue / Expenditure	**-28,124**	**-1,808**	***33***	***0***	**33**	**-8,790**	**186**	**0**	**186**	**-425**
Retained Surplus / (Deficit), excluding Capital Donations	**-4,654**	**-129**	***539***	***0***	**539**	**3,092**	**3,022**	**0**	**3,022**	**-2,031**
Charitable Contributions-Capex	43,362	**1,036**	*-2,577*	*0*	-2,577	**5,617**	-12,450	0	-12,450	5,617
Retained Surplus / (Deficit), including Capital Donations	**38,708**	**908**	***-2,038***	***0***	**-2,038**	**8,709**	**-9,428**	**0**	**-9,428**	**3,586**

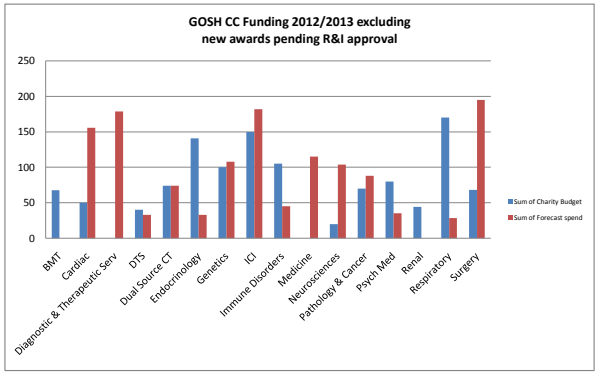
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Research and Innovation Activity

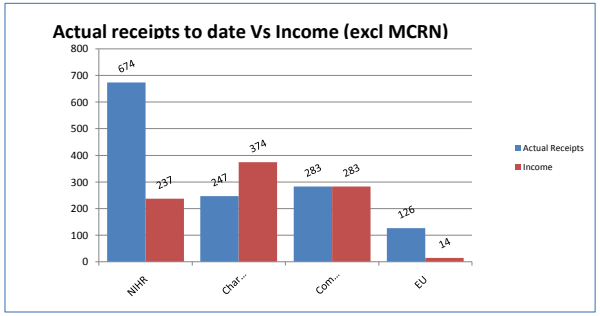
	Full Year Forecast	Full Year Budget	12/13 YTD budget	12/13 YTD Actuals	12/13 YTD Variance to Budget	11/12 YTD Actuals	12/13 YTD actual variance to 11/12 YTD actual
Summary Research & Innovation Income and Expenditure							
TOTAL RESEARCH & INNOVATION DIRECTORATE							
- R&I Income	12,712	12,666	5,278	4,095	(1,183)	4,550	(455)
- R&I Income Deferred from 11-12	0	0	0	285	285	9	276
- R&I Charitable Contribution	1,425	1,425	588	374	(214)	409	(35)
- Non Research Income	0	0	0	0	0	69	(69)
Research & Innovation Sub-Total	**14,137**	**14,091**	**5,866**	**4,754**	(1,111)	**5,037**	(283)
- Expenditure	(8,634)	(8,254)	(3,433)	(2,154)	1,279	(1,818)	(336)
Total R&I Division (excl MCRN)	**5,503**	**5,837**	**2,433**	**2,601**	**167**	**3,219**	**(618)**
- R&D Income Local Research Network MCRN	**1,347**	**1,347**	**567**	**655**	**88**	**219**	**436**
- Expenditure LRN	(1,347)	(1,347)	(567)	(655)	(88)	(219)	(436)
Total LRN MCRN	**0**	**(0)**	**0**	**0**	**0**	**0**	**0**
TOTAL R&I Division	**5,503**	**5,837**	**2,433**	**2,601**	**167**	**3,219**	**(618)**
Devolved Income							
- Cardiac	0	0	0	0	0	0	0
- DTS : From CLRN Service Support	0	0	0	0	0	41	(41)
- Medicine : Grants	0	213	89	86	(3)	75	11
- ICI : From CLRN Support / NIHR Felowships	0	565	235	177	(58)	48	129
- Surgery : From Charitable Donation	0	0	0	0	0	2	(2)
Total Centrally Held and Devolved Income	**0**	**778**	**324**	**263**	**(61)**	**166**	**97**
Revenue and Direct Expenditure by Funding Source							
Biomedical Research Centre including Clinical Research Facility							
- Income	7,132	7,132	2,972	2,157	(814)	2,981	(824)
- Income deferred from 11-12	0	0	0	285	285	9	276
- Commercial Trials Income	0	0	0	0	0	64	(64)
Income Sub-Total	**7,132**	**7,132**	2,972	**2,442**	(530)	**3,054**	**(612)**
- Expenditure	(4,291)	(4,156)	(1,732)	(1,134)	597	(905)	(229)
	2,841	2,976	1,240	1,308	68	2,149	(841)
CLRN (PCRN) Income							
- Income	1,262	1,262	526	426	(100)	244	182
Income Sub-Total	**1,262**	**1,262**	526	**426**	**(100)**	**244**	182
- Expenditure CLR	(934)	(734)	(306)	(205)	100	(100)	(105)
	328	528	220	220	(0)	144	76
NIHR GRANTS							
- Income	1,153	1,106	461	237	(224)	233	4
Income Sub-Total	**1,153**	**1,106**	461	**237**	**(224)**	**233**	4
- Expenditure	(1,045)	(998)	(415)	(192)	223	(233)	41
	108	108	46	45	(1)	0	45
R&D GOSH Charity Funded Projects							
- Income	1,425	1,425	588	374	(214)	409	(35)
Income Sub-Total	**1,425**	**1,425**	588	**374**	**(214)**	**409**	**(35)**
- Expenditure	(1,417)	(1,417)	(585)	(342)	243	(336)	(6)
	8	8	3	32	29	73	(41)
EU grants							
- Income	50	50	21	14	(7)	0	14
Income Sub-Total	**50**	**50**	**21**	**14**	**(7)**	**0**	**14**
-Expenditure	(45)	(45)	(19)	(14)	5	0	0
	5	5	2	0	(2)	0	14
R&I Development Office & Other Grants							
- Income R&I including Research Capability Funding (previously FSF)	2,364	2,375	989	979	(10)	1,092	(113)
- Other Commercial Trials Income	750	742	301	283	(18)	0	283
- Income non R&I	0	0	0	0	0	5	(5)
- Income Other R&I (ROG)	0	0	8	(1)	(9)	0	(1)
Income Sub-Total	**3,114**	**3,117**	**1,299**	**1,261**	**(38)**	**1,097**	**164**
- Expenditure	(901)	(904)	(377)	(266)	111	(244)	(22)
	2,213	2,213	922	995	73	853	142
Local Research Network MCRN *							
- Income DH to fund Network	653	653	278	366	88	219	147
- Income : Research Capability Funding (previously FSF)	143	143	60	60	0	0	60
- Commercial Trials Income	0	0	0	0	0	0	0
- Income Other Non Network	551	551	230	230	0	0	230
Income Sub-Total	**1,347**	**1,347**	**567**	**655**	**88**	**219**	436
-Expenditure	(1,347)	(1,347)	(567)	(655)	(88)	(219)	(436)
	0	(0)	0	0	0	0	0

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









For NIHR and EU, income is only recognised where expenditure has been incurred.
For charities, income is accrued to match expenditure as we invoice in arrears.

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Statement of Financial Position

	Actual as at 1 April 2012	Actual as at 31 July 2012	Actual as at 31 August 2012	Change in month
	£000	£000	£000	£000
Non Current Assets :				
Property Plant & Equipment - Purchased	170,632	170,239	169,927	(312)
Property Plant & Equipment - Donated	155,706	157,665	157,998	333
Property Plant & Equipment - Gov Granted	301	294	292	(2)
Intangible Assets - Purchased	2,034	1,840	1,790	(50)
Intangible Assets - Donated	2,897	2,881	2,877	(4)
Trade & Other Receivables	9,042	8,883	8,842	(41)
Total Non Current Assets :	***340,612***	***341,802***	***341,726***	***(76)***
Current Assets :				
Inventories	6,209	6,215	6,464	249
Revenue Debtors - Invoiced	19,103	20,763	20,968	205
NHS Trade Receivables - Accrued	3,051	6,059	7,082	1,023
Capital Receivables	6,690	4,575	4,176	(399)
Provision for Impairment of Receivables	(1,126)	(2,126)	(2,071)	56
Prepayments & Accrued Income	3,722	8,115	8,953	838
HMRC VAT	1,037	1,110	786	(324)
Other Receivables	784	676	551	(125)
Cash & Cash Equivalents	26,628	22,382	25,837	3,455
Total Current Assets :	***66,098***	***67,769***	***72,746***	***4,977***
Total Assets :	**406,710**	**409,571**	**414,472**	**4,901**
Current Liabilities :				
NHS Trade Payables	(3,922)	(5,018)	(8,531)	(3,513)
Non NHS Trade Payables	(8,675)	(2,397)	(2,637)	(240)
Capital Payables	(7,445)	(3,044)	(3,186)	(142)
Expenditure Accruals	(11,954)	(12,972)	(13,383)	(411)
Deferred Revenue	(4,290)	(6,181)	(5,605)	576
Tax & Social Security Costs	(4,136)	(4,233)	(4,185)	48
Other Payables	0	(1,967)	(2,458)	(491)
Payments on Account	(228)	(228)	(228)	0
Lease Incentives	(437)	(404)	(404)	0
Other Liabilities	(3,185)	(3,671)	(3,569)	102
Provisions for Liabilites & Charges	(3,123)	(2,453)	(2,453)	0
Total Current Liabilities :	***(47,395)***	***(42,568)***	***(46,639)***	***(4,071)***
Net Current Assets	**18,703**	**25,201**	**26,107**	**906**
Total Assets Less Current Liabilities :	**359,315**	**367,003**	**367,833**	**830**
Non Current Liabilities :				
Lease Incentives	(6,957)	(6,874)	(6,794)	80
Provisions for Liabilites & Charges	(1,234)	(1,204)	(1,206)	(2)
Total Non Current Liabilities :	***(8,191)***	***(8,078)***	***(8,000)***	***78***
Total Assets Employed :	**351,124**	**358,925**	**359,833**	**908**
Financed by Taxpayers' Equity :				
Public Dividend Capital	124,732	124,732	124,732	0
Retained Earnings	174,430	182,288	183,210	922
Revaluation Reserve	48,848	48,791	48,777	(14)
Other Reserves	3,114	3,114	3,114	0
Total Taxpayers' Equity :	**351,124**	**358,925**	**359,833**	**908**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Statement of Cash Flow

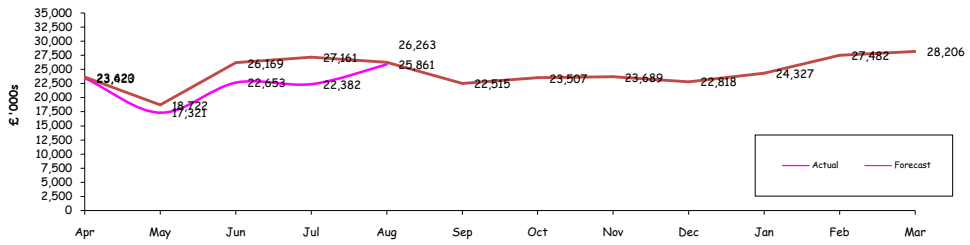
Statement of Cash Flows	Actual For Month Ending 31 August 2012 £000	Actual For YTD Ending 31 August 2012 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating Surplus	348	5,528
Charitable Contributions - Capex	1,036	5,617
Depreciation and Amortisation	1,328	6,438
Transfer from Donated Asset Reserve	0	0
Transfer from the Government Grant Reserve	0	0
Increase in Inventories	(249)	(255)
Increase in Trade and Other Receivables	(1,231)	(6,984)
Increase in Trade and Other Payables	3,540	1,364
(Decrease)/Increase in Other Current Liabilities	(182)	188
Decrease in Provisions	(1)	(713)
Net Cash Inflow from Operating Activities :	***4,589***	***11,183***
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	9	30
Payments for Property, Plant and Equipment	(1,152)	(12,013)
Payments for Intangible Assets	0	0
Proceeds from Disposal of Intangible Assets	0	0
Proceeds from Disposal of Property , Plant and Equipment	9	9
Net Cash Outflow from Investing Activities :	**(1,134)**	**(11,974)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING :	**3,455**	**(791)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	0	0
PDC Dividend Paid	0	0
Net Cash inflow from Financing :	**0**	**0**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS :	**3,455**	**(791)**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Activity

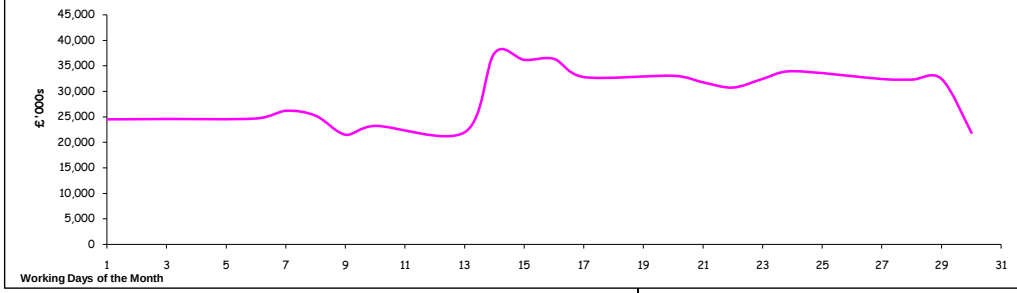
	April	May	June	July	August	YTD 12/13 Actual	YTD 12/13 Plan	YTD 12/13 Variance	YTD 12/13 Variance %	YTD 11/12	Variance 12/13 to 11/12	Variance 12/13 to 11/12 %
Elective PBR	668	770	750	811	775	3,774	4,023	-249	-6.2%	3,633	141	3.9%
Elective Non PBR	138	167	137	144	149	735	415	320	76.9%	391	344	88.0%
TOTAL ELECTIVE	806	937	887	955	924	4,509	4,439	70	1.6%	4,314	195	4.5%
Day case PBR	856	941	794	932	902	4,425	4,734	-309	-6.5%	3,979	446	11.2%
Day case Non PBR	34	0	0	37	18	89	0	89	-	301	-212	-70.4%
TOTAL SAME DAY	890	941	794	969	920	4,514	4,734	-219	0	4,280	234	-1
Non Elective PBR	138	167	137	144	149	735	728	7	0.9%	678	57	8.4%
Non Elective Non PBR	6	3	5	3	4	21	12	10	81.5%	9	12	136.9%
TOTAL NON ELECTIVE	144	170	142	147	153	756	740	16	2.2%	687	69	10.1%
Outpatients PBR	4,853	5,709	4,420	4,917	4,668	24,567	29,240	-4,673	-16.0%	29,240	-4,673	-16.0%
Outpatients Non PBR	5,605	6,780	5,552	6,339	5,808	30,084	27,214	2,869	10.5%	27,214	2,870	10.5%
TOTAL OUTPATIENTS	10,458	12,489	9,972	11,256	10,475	54,650	56,454	-1,803	-3.2%	56,454	-1,803	-3.2%
POC (Non Consortium)	867	865	852	863	862	4,309	4,229	80	1.9%	3,978	331	8.3%
BEDDAYS (includes PICU Consortium)												
Panda HDU (PBR HDU)	459	424	383	506	454	2,226	2,584	-358	-13.9%	3,803	-1,577	-41.5%
Transitional Care	183	212	207	186	200	988	809	179	22.2%	805	183	22.8%
Rheumatology Rehab	185	172	186	254	203	1,000	985	14	1.5%	953	47	4.9%
CAMHS	257	308	298	280	290	1,433	1,213	220	18.1%	1,204	229	19.1%
Cardiac ECMO	1	0	1	1	1	4	69	-66	-94.6%	52	-48	-92.8%
Neurosurgery HDU (NC)	3	14	0	0	4	21	32	-11	-33.5%	18	3	18.4%
Neurosurgery (PICU Consortium-ITU & HDU)	39	44	99	68	64	314	488	-174	-35.7%	314	0	-0.2%
Neurosurgery ITU (NC)	0	0	0	11	3	14	11	3	25.2%	13	1	6.1%
Cardiac HDU (NC)	26	28	61	43	40	198	213	-15	-7.1%	199	-1	-0.4%
Cardiac ITU (NC)	69	57	71	34	59	290	538	-248	-46.1%	480	-190	-39.6%
Cardiac (PICU Consortium-ITU & HDU)	332	322	261	258	298	1,471	1,213	258	21.3%	1,180	291	24.7%
Paediatric ITU (NC)	59	65	48	75	63	310	317	-8	-2.4%	261	49	18.7%
Paediatric ITU (PICU Consortium-ITU)	350	380	397	365	379	1,871	2,115	-244	-11.5%	1,962	-91	-4.6%
TOTAL BEDDAYS	1,963	2,026	2,012	2,081	2,057	10,139	10,588	-449	-4.2%	11,244	-1,105	-9.8%
HaemOnc Consortium*												
PBR	98	92	84	93	94	461	1,006	-546	-54.2%	260	201	77.3%
NON PBR	87	97	92	90	94	460	8	451	5367.7%	726	-266	-36.7%
Panda HDU (PBR HDU)	0	0	0	0		0	1,012	-1,012	-100.0%	939	-939	-100.0%
TOTAL HAEMONC	185	189	176	183		921	2,027	-1,106	-54.6%	1,925	-1,004	-52.2%
Bed days	1,963	2,026	2,012	2,081	2,057	10,139	11,600	-1,461	-12.6%	12,183	-2,044	-16.8%
IP	1,135	1,296	1,205	1,285	1,265	6,186	6,194	-8	-0.1%	5,987	199	3.3%
OP	10,458	12,489	9,972	11,256	10,475	54,650	56,454	-1,803	-3.2%	56,454	-1,803	-3.2%

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Cash Management

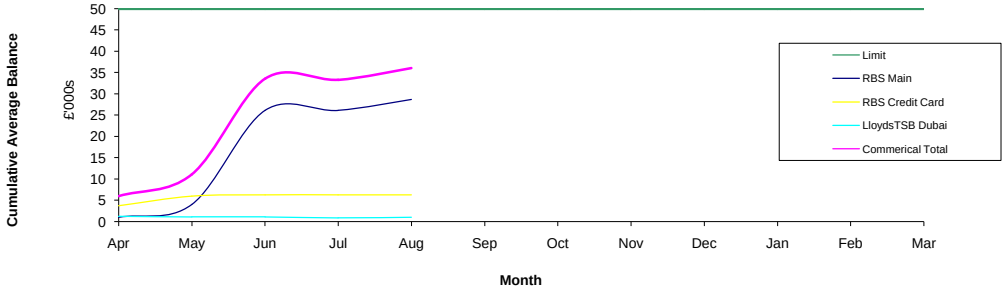
Forecast Cash



Daily Liquidity



Commerical Bank Account Performance



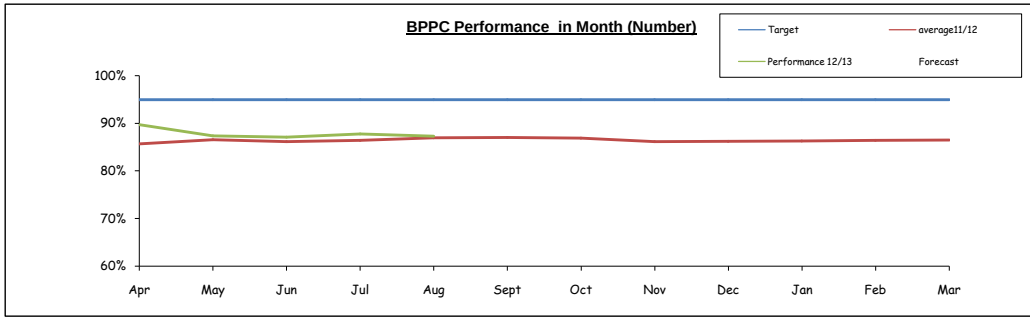
Payables and Registered Invoice Analysis

Days	Current Month	Previous Month	Movement in Month
	£000s	£000s	£000s
Not Yet Due	3,758	4,393	(635)
1-30	3,096	3,087	10
31-60	1,241	1,064	176
61-90	812	414	398
91-120	383	865	(482)
121-180	822	432	390
180-360	551	651	(100)
360+	586	528	58
	11,250	**11,434**	**(184)**

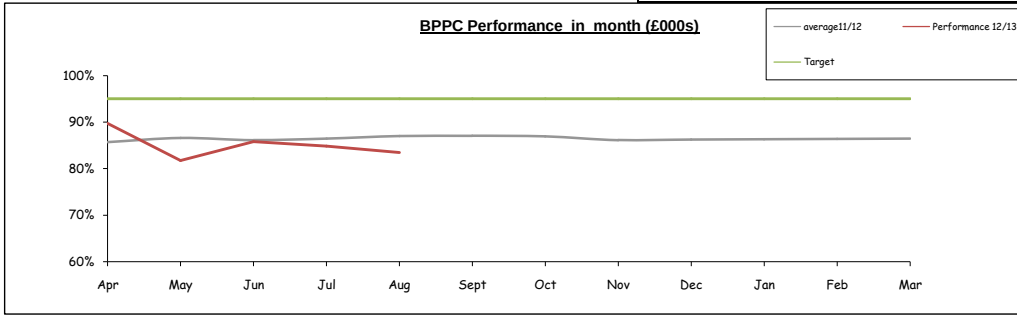
Better Payment Practice Code (BPPC)

	Number	£000s
Cumumlative Performance		
Total Payables		
% of Invoices paid within target	87.7%	83.6%
Non-NHS Payables		
Invoices paid in the year	34191	70,812
Invoices paid within target	30465	60,760
% of Invoices paid within target	89.1%	85.8%
NHS Payables		
Invoices paid in the year	1472	7,937
Invoices paid within target	822	5,094
% of Invoices paid within target	55.8%	64.2%

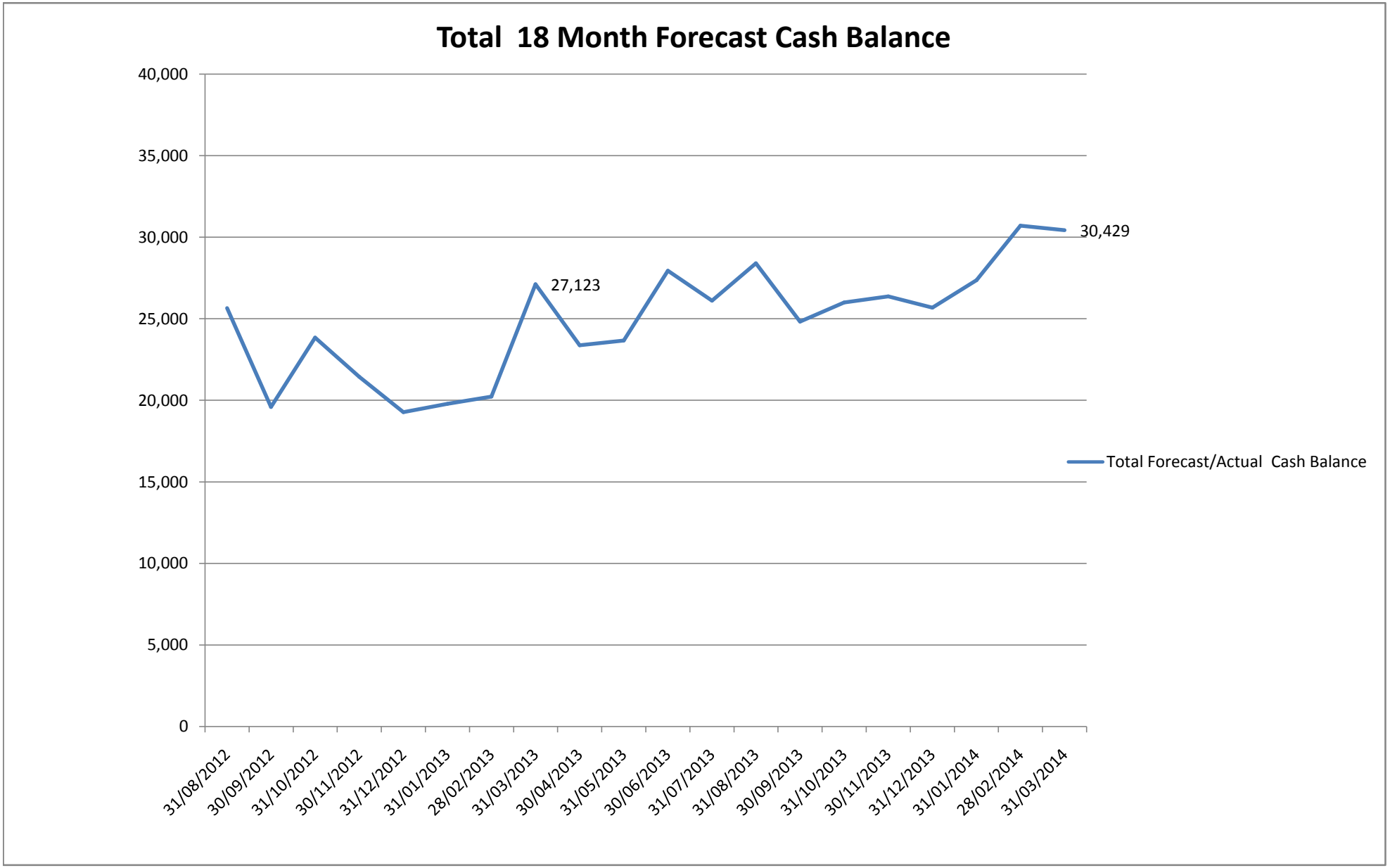
BPPC Performance in Month (Number)



BPPC Performance in month (£000s)



Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Cash Forecast



Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Receivables Management

Net Receivables in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	**1007**	-4461	2918	1478	309	811	-60	228	35	-250
Credit balances adjustment	**5059**		5059							
NHS Credit Note Provision	-222	0	0	0	0	0	-55	-46	-18	-103
Specific NHS Debt Provisions										
NHS Net Receivables	**5844**	**-4461**	**7977**	**1478**	**309**	**811**	**-115**	**181**	**17**	**-353**
Non-NHS	**2655**	-30	903	116	165	116	17	1188	132	47
Bad Debt Provision-Non NHS	-472	0	-138	-13	-29	-13	-10	-48	-135	-85
Specific Non-NHS Debt Provisions	-327		-327							
	0	0	0	0	0	0	0	0	0	0
Non-NHS Net Receivables	**1856**	**-30**	**438**	**103**	**136**	**103**	**7**	**1139**	**-2**	**-38**
International	**12041**	-1760	8630	1764	883	720	420	804	37	543
Bad Debt Provision-International	-1272	-5	-312	-7	-0	-6	-85	-161	-152	-543
International Net Receivables	**10769**	**-1766**	**8319**	**1757**	**883**	**714**	**335**	**643**	**-115**	**0**
GOSH Charity Receivables	**753**	-1	700	19	0	10	0	25	0	0
Net Trust Receivables	**19222**	**-6258**	**17433**	**3358**	**1328**	**1638**	**226**	**1989**	**-100**	**-391**

Trust Receivables in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	6066	-4461	7977	1478	309	811	-60	228	35	-250
Non-NHS	2655	-30	903	116	165	116	17	1188	132	47
International	12041	-1760	8630	1764	883	720	420	804	37	543
Gross Trading Receivables	**20763**	**-6251**	**17510**	**3359**	**1357**	**1647**	**376**	**2220**	**205**	**340**
GOSH Charity Receivables	753	-1	700	19	0	10	0	25	0	0
Total Trust Receivables	**21516**	**-6252**	**18210**	**3378**	**1357**	**1657**	**376**	**2245**	**205**	**340**

Movement in £'000's	Total	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
Gross Trading Receivables (as above)	21516	-6252	18210	3378	1357	1657	376	2245	205	340
Gross Trading Receivables (last month)	21041	-2733	13102	2132	4648	727	2337	508	-11	332
Movement in Month	**474**	**-3519**	**5107**	**1246**	**-3291**	**930**	**-1960**	**1737**	**216**	**9**
Gross Trading Receivables (year end 11/12)	19189	-2066	17138	2469	568	626	4	153	-193	491
Movement in Financial Year	**-2327**	**4186**	**-1072**	**-909**	**-790**	**-1031**	**-373**	**-2092**	**-398**	**151**

Systems Schedule

Receivables in £'000's	Gross Receivables	Cash on Account	Not Yet Due	0 - 30 Days	31 - 60 Days	61 - 90 Days	Overdue 91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
eFinancial	9474	-4492	9579	1614	474	936	-43	1441	168	-203
Compucare	12041	-1760	8630	1764	883	720	420	804	37	543
Trust Receivables	**21516**	**-6252**	**18210**	**3378**	**1357**	**1657**	**376**	**2245**	**205**	**340**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Capital

Capital Spend by Division	Annual Plan	Year to Date (YTD) Year To Date Plan	Year to Date (YTD) Actual	Year to Date (YTD) Variance (YTD)	Year to Date (YTD) Additional Commitments	Year to Date (YTD) Uncommitted Funds
Redevelopment Projects						
Donated Funded						
Phase 1	0	0	1	(1)	0	(1)
Phase 2a	4,195	1,748	2,811	(1,063)	568	815
Phase 2b Enabling	21,019	8,758	61	8,697	2,659	18,299
Phase 2b	7,605	3,169	97	3,072	99	7,409
Phase 2 - Inhouse Resources	116	48	125	(77)	35	(44)
Phase 3 - Start up costs	0	0	9	(9)	(9)	0
Total :	**32,935**	**13,723**	**3,104**	**10,619**	**3,352**	**26,478**
Estates Maintenance Projects						
Trust/DH Funded	5,000	2,083	1,192	884	625	3,183
Donated Funded	1,200	500	493	7	72	635
Total :	**6,200**	**2,583**	**1,685**	**891**	**698**	**3,817**
Facilities Projects						
Trust/DH Funded	400	167	121	46	157	123
Donated Funded	0	0	0	0	0	0
Total:	**400**	**167**	**121**	**46**	**157**	**123**
IT Projects						
Trust/DH Funded	4,500	1,875	810	1,065	1,393	2,297
Donated Funded	8	3	22	(19)	7	(21)
Total:	**4,508**	**1,878**	**832**	**1,046**	**1,400**	**2,276**
Medical Equipment Projects						
Trust/DH Funded	0	0	12	(12)	111	(123)
Donated Funded	9,227	3,845	1,998	1,853	1,475	5,754
Total:	**9,227**	**3,845**	**2,010**	**1,841**	**1,586**	**5,631**
Total Donated Funded Projects	43,369	18,071	5,617	12,460	4,906	32,853
Total Trust Funded Projects	9,900	4,125	2,135	1,983	2,287	5,472
Total Additions in Year	**53,269**	**22,196**	**7,752**	**14,444**	**7,193**	**38,325**
Asset Disposals	0	0	1	(1)	0	0

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 5 2012/13
Staffing WTE

Permanent (Excludes Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	11/12 Period 12	11-12 Ave wte	M5 variance to M12 11/12	M5 variance to ave 11-12 wte
Cardiac	399	402	401	396	397	394	368	-4	-29
Surgery	703	718	711	712	700	699	668	-1	-31
DTS	354	361	384	381	377	376	357	-1	-20
ICI	536	525	536	532	529	536	507	7	-23
International	128	124	125	129	128	125	121	-3	-7
Medicine	291	294	298	288	280	284	281	4	1
Neurosciences	287	283	287	284	288	288	273	0	-15
Children's Population Health	7	7	7	7	7	8	8	1	1
Corporate Facilities	183	176	175	173	181	176	186	-5	5
Corporate Affairs	8	9	9	10	6	14	12	8	6
Estates	49	47	49	46	47	47	45	0	-2
Finance & ICT	126	114	112	114	117	120	126	3	9
Human Resources	63	60	61	60	61	61	59	1	-2
Clinical & Medical Operations	45	45	44	45	46	45	40	-1	-6
Nursing And Workforce Development	71	72	70	74	71	69	81	-2	10
Research And Innovation	97	102	95	97	99	102	99	3	1
Redevelopment Revenue Costs	6	1	6	6	5	6	6	1	2
TOTAL	3,350	3,341	3,372	3,353	3,338	3,350	3,237	12	-101

Overtime

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	11/12 Period 12	11-12 Ave wte	M5 variance to M12 11/12	M5 variance to ave 11-12 wte
Cardiac	1.5	1.9	1.0	0.5	0.2	2.6	2.3	2.3	2.0
Surgery	3.4	2.4	2.2	2.1	2.4	2.6	2.9	0.2	0.6
DTS	0.9	0.8	0.4	0.3	0.5	0.5	0.7	0.1	0.2
ICI	0.8	0.7	0.5	0.7	0.5	0.5	0.5	0.1	0.0
International	0.5	1.1	0.8	1.0	0.7	1.8	1.2	1.0	0.5
Medicine	0.4	1.0	0.5	0.7	0.3	0.3	0.4	0.0	0.1
Neurosciences	0.5	0.0	0.1	0.4	0.1	0.8	0.6	0.6	0.5
Children's Population Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Corporate Facilities	5.4	6.5	5.2	5.2	4.4	4.2	4.5	-0.2	0.1
Corporate Affairs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates	2.4	1.9	1.9	2.5	2.2	2.3	1.7	0.1	-0.6
Finance & ICT	0.3	1.1	0.2	0.6	0.0	1.2	1.1	1.2	1.1
Human Resources	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Clinical & Medical Operations	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Nursing And Workforce Development	0.0	0.0	0.1	0.0	0.0	0.2	0.0	0.2	0.0
Research And Innovation	0.1	0.1	0.1	0.2	0.0	0.1	0.2	0.1	0.2
Redevelopment Revenue Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	16.3	17.4	12.8	14.1	11.4	17.0	16.1	5.6	4.7

Agency/Locum/Bank

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	11/12 Period 12	11-12 Ave wte	M5 variance to M12 11/12	M5 variance to ave 11-12 wte
Cardiac	30	30	29	33	28	34	34	6	7
Surgery	61	32	39	40	44	67	64	22	19
DTS	14	11	17	12	18	30	15	12	-2
ICI	26	26	27	20	23	45	35	22	12
International	27	27	33	35	38	25	33	-14	-6
Medicine	12	14	18	17	22	23	21	1	-1
Neurosciences	6	7	6	11	6	14	18	7	12
Children's Population Health	0	0	1	0	0	0	0	0	0
Corporate Facilities	3	10	10	8	14	19	12	5	-1
Corporate Affairs	0	0	0	0	4	0	0	-3	-3
Estates	6	22	2	19	11	5	11	-6	-1
Finance & ICT	33	37	36	37	35	30	23	-5	-12
Human Resources	7	0	4	2	8	3	2	-5	-5
Clinical & Medical Operations	0	1	2	3	4	5	4	1	0
Nursing And Workforce Development	0	0	1	3	1	0	2	0	1
Research And Innovation	3	4	4	2	6	3	3	-2	-3
Redevelopment Revenue Costs	0	0	2	0	0	0	0	0	0
TOTAL	229	222	233	242	260	303	277	42	16

TOTAL STAFFING (Excluding Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	11/12 Period 12	11-12 Ave wte	M5 variance to M12 11/12	M5 variance to ave 11-12 wte
Cardiac	430	434	431	429	425	430	405	5	-20
Surgery	767	752	752	754	746	768	735	22	-11
DTS	369	373	402	393	395	406	373	11	-22
ICI	562	552	564	552	553	582	542	29	-11
International	155	152	159	165	167	152	155	-15	-12
Medicine	304	309	316	306	302	307	302	6	0
Neurosciences	293	290	294	295	295	303	291	8	-3
Children's Population Health	7	7	8	7	7	8	8	1	1
Operations & Facilities	192	192	191	187	199	200	203	1	4
Corporate Affairs	8	9	9	10	9	14	12	5	3
Estates	57	71	53	67	61	54	57	-6	-3
Finance & ICT	159	152	149	152	152	151	150	-1	-3
Human Resources	70	60	65	62	68	64	61	-4	-7
Clinical & Medical Operations	45	46	47	48	50	50	44	0	-6
Nursing And Workforce Development	71	72	71	77	71	69	83	-2	12
Research And Innovation	100	106	99	99	105	105	102	1	-2
Redevelopment Revenue Costs	6	1	7	6	5	6	7	1	2
TOTAL	3,595	3,580	3,617	3,609	3,610	3,670	3,530	60	-80

Attachment R

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
26th September 2012

Review of effectiveness of Management Board (September 2011 and August 2012 inclusive) **Submitted on behalf of:** Chair of Management Board	**Paper No: Attachment R** *For discussion and approval*

Aims / summary
This report addresses how Management Board met its terms of reference during the last 12 months (September 2011 and August 2012 inclusive) and provides an overview of the matters covered during these 12 months. The paper includes recommendations as to how the Committee can function more effectively and a revised copy of the terms of reference for consideration and approval.

Action required from the meeting

To consider the recommendations outlined in this report (see action plan under section 6) and ratify the revised terms of reference.

Contribution to the delivery of NHS / Trust strategies and plans
Management Board is committed to achieving and demonstrating best governance practice. This report demonstrates that the Committee has complied with its Terms of Reference and adequately demonstrated its accountability to the Trust Board.

The report includes recommendations for changes to the terms of reference and a revised version is attached.

Financial implications
No direct financial implications.

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

Who needs to be told about any decision
Trust Board

Who is responsible for implementing the proposals / project and anticipated timescales?
All members of the Committee

Who is accountable for the implementation of the proposal / project
Management Board Chair

Author and date
Anna Ferrant September 2012

1. Introduction

Management Board is a standing committee of Trust Board. It oversees the operational management of the hospital.

The duties of Management Board are set out in the terms of reference, last reviewed by Management Board and Trust Board in October 2011.

This report comments on compliance with the terms of reference and gives an overview of the work carried out by Management Board between September 2011 and August 2012. A revised, marked up version of the terms of reference is attached at appendix one, taking account of the recommendations presented in this report.

2. Membership during the financial year

Meetings of Management Board were held in each month of the period reviewed. The members of Management Board during September 2011 and August 2012, including their attendance were as follows:

	Attended	Apologies
Chief Executive (Chair)	10	2
Chief Operating Officer/ Deputy Chief Executive	8	4 (Deputy COO attended all meetings)
Deputy Chief Operating Officer	11	1
Chief Finance Officer	9	3 (deputies attended for 2 meetings)
Chief Nurse and Director of Education	10	2 (deputies attended for 2 meetings)
Co-Medical Director (Safety)	7	5 (other Co-Medical Director attended)
Co-Medical Director (Professional Development)	10	2
Director of Redevelopment	11	1 (deputy attended)
General Manager – Research and Innovation Division	8	2 and role vacant for 2 months
Clinical Unit Chair – Cardiac and respiratory General Manager	10 11	2 1
Clinical Unit Chair/ – Medicine and DTS General Manager	10 6	2 (deputy attended for 1 meeting) 3 (and role vacant for 3 months)
Clinical Unit Chair – Surgery and ICU General Manager	11 10	1 (deputy attended) 2 (deputy attended for 1 meeting)
Clinical Unit Chair – ICI	10	2 (deputies attended for both meetings)

	Attended	Apologies
General Manager	9	3 (deputy attended for 1 meeting)
Clinical Unit Chair – Neurosciences General Manager	9 11	3 (deputy attended for 1 meeting) 1
General Manager – IPP	12	0
Director of ICT	12	0
Foundation Trust Manager	8	Role vacant for 4 months following FT authorisation
Head of Corporate Facilities	12	0

The terms of reference require at least ten members present, including at least three executive directors and a mix of clinical unit chairs/ general managers from a minimum of three of the clinical units. Members are expected to attend a minimum of nine out of twelve meetings per year. For some members who did not attend for a minimum of 9 meetings, deputies/ co-members were in attendance (Chief Operating Officer, Co-Medical Director). For the other members attending less than 9 meetings, these roles were vacant for a number of meetings, and deputies were not identified to attend in their place. It is recommended that where vacancies occur, approved deputies should be asked to attend in their place.

Recommendation 1: Where members are aware that they are unable to attend the Management Board meeting, deputies should be asked to attend in their place, and the secretariat notified of arrangements prior to the meeting (Action – all members from September 2012).

3. Overview of items considered at Management Board

The terms of reference outline the purpose and role of Management Board. A summary of matters considered during the period are documented below, including any recommendations for changes to the current terms of reference:

Item to be considered	Matters considered	Comments/ recommendations
Provide a regular meeting where issues relating to the day to day operational management and performance of the Trust are discussed and decisions taken to ensure the Trust delivers all its performance targets as efficiently and effectively as possible, maintaining quality standards;	Membership of the Board includes clinical and corporate leads from across the Trust. Management Board receives a monthly performance and finance report. Matters are discussed and decisions taken as a means to improve performance. Each Clinical Unit provides a monthly zero harm report and bi-annual detailed zero harm report on a rolling basis. Again, matters are discussed and decisions taken.	No comment
Monitor operational progress against Trust programmes of work and to take action as necessary to deliver the	The Board receives a monthly performance report and matters are discussed and decisions taken to improve performance.	No comment

Item to be considered	Matters considered	Comments/ recommendations
objectives of each work programme.	Updates on specific work programmes such as waiting times (September 2011), salary overpayments (October 2011) have been presented during the period. Salary overpayment briefing (October 2012) 2012/13 Annual Plan (May 2012) Education strategy implementation quarterly update Theatre Utilisation Report (August 2012) Monthly CRES Report	
Bi- annual review of progress against the Trust's objectives in the context of the strategy set by Trust Board, changes in external environment and operational capacity.	Trust objectives reviewed March 2012 and progress regularly reported on in the performance report	No comment
Review of risks and receive updates on work and measures undertaken to mitigate risks from Clinical Unit Boards and corporate equivalents Review of the assurance framework summary on a quarterly basis	Clinical Units top three risks were reported and reviewed on a monthly basis via the Zero Harm Report, including progress with CRES targets. Risks related to service changes and improvements as outlined in business cases were reviewed. The Assurance Framework Summary was reviewed. Safeguarding Updates received on quarterly basis Individual issues reported and discussed, for example Impact of the Safe & Sustainable decision on the estates capital plan, Foundation Trust Update, IV line access, quality of patient records. Admission Criteria & Length of Stay (November 2011) IV Access project update (December 2011) Update on Equipment Tracking and Bed and Cot Availability (December 2011) OPD Space pressures – update (December 2011) Action Plan for the Parliamentary and Health Service Ombudsman on AJ (February 2012) Intensive Care Review (March 2012) Statutory and Mandatory Update – compliance requirements (October 2011)	No comment

Item to be considered	Matters considered	Comments/ recommendations
On-going review of the content of subcommittee summary reports and annual audit of compliance with subcommittee reporting requirements to Management Board.	An audit of the summary reports received from the subcommittees by Management Board is included within this review and therefore undertaken on an annual basis.	
Review and agree business cases for developments/ major service changes within Standing Financial Instruction (SFI) limits, including consideration of related quality and risk issues.	Business cases regularly reviewed, approved or recommended to Trust Board at each meeting. In March 2012, the Business Case Review Group was established. The role of this group is to review all business cases, including quality and risk matters, funding and profitability, for approval by Management Board.	**Recommendation 2**: Reference to be made to the Business Case Review Group, reporting to Management Board on a monthly basis (see appendix 1).
Review outcomes following revenue and capital investment.	The following items were considered during the period: Impact of the Safe & Sustainable decision on the estates capital plan (July 2012) Business Case to Increase Cardiothoracic Capacity on move to Morgan Stanley (February 2012)	No comment
Review other matters relating to the delivery of the clinical service, research and development and education and training, including Special Trustee and external funding and take action as required.	Other matters reviewed over the year include: • Managed Service for Datacentre Business Case (June 2012) • Olympics Update • Impact of the Safe & Sustainable decision on the estates capital plan (July 2012) • FT application update • Replacement PACS, RIS, and Cardiology systems plus the installation of a new Vendor Neutral Archive (September 2011) • OPD Space Review (October 2011) • Electronic Document and Records Management System (EDRMS) project update (May 2012) • Action Plan for the Parliamentary and Health Service Ombudsman on AJ (February 2012) • Intensive Care Review (March 2012)	No comment
Review partnership agreements and monitor delivery of objectives.	The following items were considered during the period:	No comment

Item to be considered	Matters considered	Comments/ recommendations
	Update on Referrers Open Day (October 2011) Updates on UCLP programmes of work	
Commission reviews of trust-wide services where necessary/ appropriate.	The following reviews were commissioned/ reported on during the period: OPD Space Review (October 2011) Intensive Care Review (March 2012) A Review of Local Education Spend (August 2012)	No comment
Receive trust wide annual reports on Education and Training, Equality and Diversity, Patient and Public Involvement and Engagement	These reports were received at Management Board: Education strategy annual action plan update (March 2012) Introducing the Equality Delivery System (EDS) to improve patient/family/staff experience at GOSH (November 2011) Patient and Public Involvement and Engagement Annual Report (October 2011)	As part of streamlining reporting across committees, it is proposed to remove reporting on equality and diversity at Management Board, retaining reporting at Trust Board **Recommendation 3**: To ensure that the relevant annual reports are received by Management Board and remove reference to the Equality and Diversity Report, reporting to Management Board Reporting on patient and public involvement work has been revised for trust Board. It is proposed that reporting arrangements to Management Board are reviewed. **Recommendation 4**: To review reporting arrangements for patient and public involvement at Management Board and ensure that this is streamlined with reporting to other committees and Boards
Ratify Trust wide policies in accordance with the Policy on Policies.	Following the previous effectiveness review, a Policy Approval Group, chaired by the Deputy Director of Operations was established in December 2011, reporting to Management Board. Authors of policies are required to attend the Group to present policies. This Group meets on a bi-monthly basis (or in an emergency - virtually- if required) and has delegated authority from Management Board to approve policies and recommend revisions. The Group ensures that all regulatory and legal requirements are covered within new or revised policies. The Group works to streamline policies and ensure that key issues are identified for staff so that they are easy to refer to.	**Recommendation 5**: Reference to the Policy Approval Group (PAG) is already included in Management Board's terms of reference under section 3: Reporting. This sentence can therefore be deleted from section 1 (see appendix 1).

Item to be considered	Matters considered	Comments/ recommendations
Approve the waiving of formal tendering procedures	Waivers were considered at each meeting during the period	No comment

4 Other matters pertinent to compliance with the Terms of Reference

- **Reporting**

    - **Subcommittees reporting to Management Board**

Summary reports are required from the following subcommittees of Management Board:

- Capital and Space Planning committee (Bi-Monthly)
- Information Governance Steering Group (Monthly)
- Transformation Board (Bi-Monthly)
- Commissioners' Forum (Monthly)
- Patient and Public Involvement and Engagement Committee (Bi-Monthly)
- Redevelopment Steering Board (Monthly)
- Working Lives Group (Quarterly)
- Education and Training Committee (Bi-Monthly)
- Quality and Safety Committee (Monthly)
- CRES Working Group (Monthly)
- Policy Approval Group (Bi-Monthly)

Summary reports are required to be presented at each Management Board meeting for information. Reminders were sent out to all administrators of the above subcommittees every month. A review of summary reports received at Management Board between September 2011 and August 2012 (see appendix 2), reveals that reports were not always sent to Management Board following the subcommittee meeting.

Recommendation 6: All Chairs to be reminded of their responsibilities for ensuring that summary reports are submitted to Management Board following every meeting.

Recommendation 7: Outstanding subcommittee reports for months up to September 2012 to be submitted to the September 2012 meeting.

Following the 2011 effectiveness review, Management Board requested that a review be undertaken of subcommittees reporting to the Board to ensure that reporting is streamlined and enhanced. The following changes have been made to subcommittees reporting to Management Board:

- The Business case Review Group was re-launched and approved in March 2012, reporting directly to Management Board and responsible for reviewing and ratifying business cases in preparation for approval at Management Board. The Group meets fortnightly and reports monthly to Management Board.

- Transformation programmes are now managed within the clinical units. As a result, the Transformation Board was re-launched in June 2012 as the Innovation Group, meeting bi-monthly and chaired by the Chief Executive. The aim of this group is to provide continual innovation to the transformation programme, to move to a state of spread, sustainability within the Trust.

- The Working Lives Group now reports into the Workforce Delivery Group, which reports Quarterly to Management Board.

- In November 2011, the Education and Training Committee (meeting bi-monthly) was re-launched as the Strategic Education Committee (meeting quarterly and reporting to management Board via the Education Zero Harm Report)

- CRES Working Group – this group now meets weekly and reports monthly to Management Board.

- GOSH 2020 Board - The GOSH 2020 Board is a new subgroup of Management Board and is chaired by the Chief Executive. It is a time-limited Board which will establish a future programme and constituent projects for GOSH Redevelopment beyond Phase 2. It reports monthly.

- Commissioners Forum – this committee no longer reports to Management Board.

Taking account of the changes to certain subcommittees and adoption of the proposals, the following subcommittees will now report to Management Board (see appendix 3):

- Capital and Space Planning Committee (Monthly)
- Information Governance Steering Group (Monthly)
- Innovation Group (Bi-Monthly)
- Patient and Public Involvement and Engagement Committee (Bi-Monthly)
- Redevelopment Steering Board (Monthly)
- Workforce Delivery Group (Quarterly)
- Strategic Education Committee (Quarterly via the Education Zero Harm Report)
- Quality and Safety Committee (Monthly)
- CRES Working Group (Weekly and reports monthly to Management Board)
- Policy Approval Group (Bi-Monthly)
- Business Case Review Group (Fortnightly and reports monthly to Management Board)
- GOSH 2020 Board (Monthly)

- **Clinical Units and corporate departments reporting to Management Board**

The terms of reference state the following:

- Clinical Unit Boards will report on a monthly basis, a summary of top risks and quality reports – this information is included in the CU zero harm reports

- Corporate equivalent departments (human resources, finance, estates and facilities, information services/ ICT) will report on a monthly basis, a summary of top risks – this reporting has not taken place over the past year. It is proposed that these departments are required to report their top 3 risks on a quarterly basis. Matters arising between reports will be escalated by the relevant directors on the Board.

- **Reporting to Trust Board**

Management Board is required to report to Trust Board on a monthly basis. The approved minutes from Management Board meetings were presented at the next scheduled public Trust Board throughout the period.

- **Administration of the committee**

The secretariat for Management Board was provided by the Executive Offices. The terms of reference state that "papers will be sent out three working days before the meeting". In several cases, during the period, papers were sent out 1-2 working days before the meeting, due to the late presentation of papers by authors and resource issues in the Executive Office to allow sufficient time to collate papers electronically. The Executive Office has been working to present papers as one document, with hyperlinks to individual papers in the pack. Whilst this has been welcomed by members, it has had an impact on sending papers out within 3 working days, especially when authors are late with their submissions.

The following actions have been taken to improve adherence to this timescale;

- The deadline for papers has been moved to the Friday before the meeting is scheduled
- Emails are sent out to all Management Board members reminding them of the deadline for papers.

5 Impact Assessment

The Committee plays a key role in overseeing the operational management of the Trust.

6 Conclusion

Management Board has discharged its duties in accordance with its terms of reference for the period September 2011 - August 2012. In light of the recommendations summarised below in the action plan, a revised version of the terms of reference is attached at appendix one.

Recommendation	Action to be taken	Owner	Date for completion	Progress
1. Where members are aware that they are unable to attend the Management Board meeting, deputies should be asked to attend in their place, and the secretariat notified of arrangements prior to the meeting.	Reminder to be sent to all MB members, referencing the approved deputies for MB	CL	05/10/12	Email to be sent in preparation for October MB

Recommendation	Action to be taken	Owner	Date for completion	Progress
2. Reference to be made to the Business Case Review Group, reporting to Management Board on a monthly basis	Business Case Review Group to be added to Management Board ToR	AF	20/09/12	Draft ToR for approval at appendix 1 of this report
3. To ensure that the relevant annual reports are received by Management Board and remove reference to the Equality and Diversity Report, reporting to Management Board	Reminder emails to be sent to relevant report owners at end of financial year Management Board ToR updated	CL	31/03/12	To be actioned Draft ToR for approval at appendix 1 of this report
4: To review reporting arrangements for patient and public involvement at Management Board and ensure that this is streamlined with reporting to other committees and Boards	Meeting to be held with Chief Nurse and Director of Education to discuss reporting arrangements	AF	31/10/12	
5. Reference to the Policy Approval Group (PAG) is already included in Management Board's terms of reference under section 3: Reporting. This sentence can therefore be deleted from section 1 of the ToR.	Policy Approval Group to be added to Management Board ToR	AF	20/09/12	Draft ToR for approval at appendix 1 of this report
6. All Chairs to be reminded of their responsibilities for ensuring that summary reports are submitted to Management Board following every meeting.	Chairs and administrators to be reminded by email	CL	05/10/12	Email to be sent in preparation for October MB
7: Outstanding subcommittee reports for months up to September 2012 to be submitted to the September 2012 meeting	Outstanding reports to be chased in time for September Mb meeting	AF	12/09/12	Outstanding reports for months up to September 2012 on September MB agenda

APPENDIX ONE
DRAFT Management Board
Terms of Reference

1. Authority and Scope

1.1. Management Board is a sub-committee of the Trust Board and is chaired by the Chief Executive.

1.2. Management Board has delegated authority from Trust Board to oversee the operational management of the hospital.

2. Purpose

2.1. The purpose of Management Board is to:

- Provide a regular meeting where issues relating to the day to day operational management, performance of the Trust are discussed and decisions taken to ensure the Trust delivers all its performance targets as efficiently and effectively as possible, maintaining quality standards;
- Monitor operational progress against Trust programmes of work and to take action as necessary to deliver the objectives of each work programme.
- Bi- annual review of progress against the Trust's objectives in the context of the strategy set by Trust Board, changes in external environment and operational capacity.
- Review of risks and receive updates on work and measures undertaken to mitigate risks from Clinical Unit Boards and corporate equivalents
- Review of the assurance framework summary on a quarterly basis
- On-going review of the content of subcommittee summary reports and annual audit of compliance with subcommittee reporting requirements to Management Board.
- Receive recommendations from the Business Case Review Group to review and agree business cases for developments/ major service changes within Standing Financial Instruction (SFI) limits, including consideration of related quality and risk issues.
- Review and recommend business cases/ major service changes above SFI limits to Trust Board, including consideration of the related quality and risk issues.
- Review outcomes following revenue and capital investment.
- Review other matters relating to the delivery of the clinical service, research and development and education and training, including Special Trustee and external funding and take action as required.
- Review partnership agreements and monitor delivery of objectives.
- Commission reviews of trust-wide services where necessary/appropriate.

- Receive trust wide annual reports on Education and Training, Equality and Diversity, Patient and Public Involvement and Engagement.

- ~~Ratify Trust wide policies in accordance with the Policy on Policies.~~

- Approve the waiving of formal tendering procedures.

3. Reporting

3.1. In order to fulfil its requirements, Management Board will receive the following reports:

- Monthly reports on the Trust's activity and financial performance.

- Monthly and quarterly performance reports on progress against Trust objectives.

- Annual reports on:
    - ~~Equality and Diversity~~
    - Education and Training
    - Patient and Public Involvement and Engagement

- Summary reports from the following standing subcommittees:
    - Capital and Space Planning committee (Bi-Monthly)
    - Information Governance Steering Group (Monthly)
    - ~~Transformation Board (Bi-Monthly)~~
    - Innovation Group (Bi-Monthly)
    - Patient and Public Involvement and Engagement Committee (Bi-Monthly)
    - Redevelopment Steering Board (Monthly)
    - ~~Commissioners' Forum (Monthly)~~
    - ~~Working Lives Group (Quarterly)~~
    - Workforce Delivery Group (Monthly)
    - ~~Education and Training Committee (Bi-Monthly)~~
    - Strategic Education Committee (Quarterly via the Education Zero Harm Report)
    - Quality and Safety Committee (Monthly)
    - CRES Working Group (Monthly)
    - Policy Approval Group (Bi-Monthly)
    - Business Case Review Group (Monthly)
    - GOSH 2020 Board (Monthly)

- Clinical Unit Boards will report on a monthly basis, a summary of top risks and quality reports.

- Corporate equivalent departments (human resources, finance, education, estates and facilities, information services/ ICT) will report on a quarterly basis, a summary of top risks.

3.2. Management Board minutes will be presented to Trust Board on a monthly basis.

4. Membership

4.1. Management Board is made up of the following members – their deputies are listed in brackets:

- Chief Executive (Chair) (Deputy Chief Executive)
- Deputy Chief Executive (Deputy Chief Operating Officer)
- Deputy Chief Operating Officer (Head of Planning and Performance Management)

- Chief Finance Officer (Deputy Director of Finance)
- Director of Nursing and Education (Deputy Director of Nursing)
- Co-Medical Director (x2) (~~Assistant Director of Patient and Staff Safety~~ Co-Medical Director/ Head of Quality, Safety & Transformation)
- Director of Redevelopment (Assistant Director of Estates)
- Clinical Unit Chairs (x5) ~~(cross cover with GMs)~~
- General Managers (x6) ~~(cross cover with Clinical Unit Chairs)~~
- Director of ICT (Deputy Head of ICT)

Additional members may be invited to attend Management Board as appropriate.

4.2. For a quorum, there must be a minimum of ten members present, including at least three executive directors and a mix of clinical unit chairs/ general managers from a minimum of three of the clinical units. Only three nominated deputies will be allowed to meet the requirements of a quorum.

4.3. Members will be expected to attend a minimum of nine meetings out of twelve meetings per year.

5. Meetings

5.1. Meetings will be held on a monthly basis.

5.2. Papers will be sent out three working days before the meeting.

5.3. Secretariat support for Management Board will be provided by the Executive Assistant to the Chief Executive.

6. Monitoring

6.1. The Board shall review its terms of reference on an annual basis.

6.2. The Board shall review its effectiveness on an annual basis. This will involve monitoring and reporting on:

- Frequency of meetings;
- Compliance with the purpose of the Board as outlined in the terms of reference and associated workplan;
- Attendance at meetings;
- Evidence based outcomes resulting from decisions taken at the Board.

September 2012

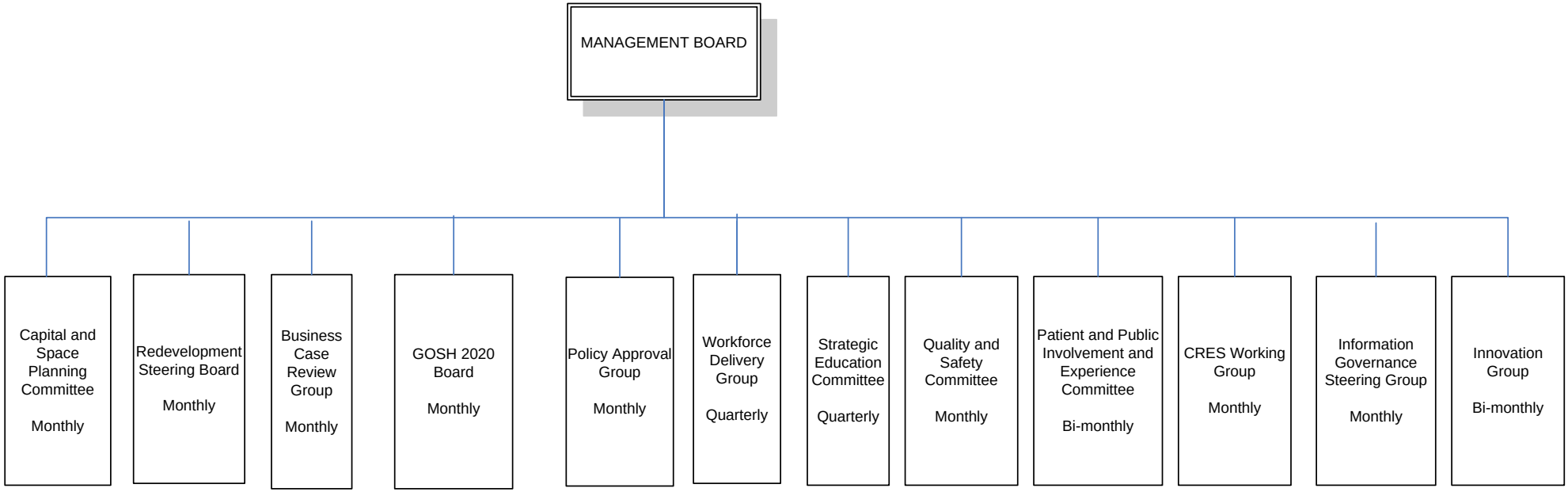
Attachment R

APPENDIX TWO

	Sep-11	Oct-11	Nov-10	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	TOTAL
Capital and Space Planning Committee (Monthly)		✓			✓			✓					3
Information Governance Steering Group (Monthly)					✓			✓					2
Transformation Board (Bi-Monthly)		✓											1
Commissioners' Forum (Monthly)		✓			✓			✓					3
Patient and Public Involvement and Experience Committee (Bi-Monthly)					✓						✓		2
Redevelopment Steering Board (Monthly)			✓		✓				✓		✓	✓	5
Workforce Delivery Group (Monthly)		✓			✓								2
Strategic Education Committee (from November 2011, reporting quarterly via the Education Zero Harm Report)		✓			✓			✓			✓		4

	Sep-11	Oct-11	Nov-10	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	TOTAL
Quality and Safety Committee (Monthly)					✓								1
Business Review Group re-launched March 2012)								✓	✓	✓	✓	✓	5
Policy Approval Group (bi-monthly but monthly during NHSLA period)			✓		✓	✓		✓	✓		✓	✓	7
CRES Working Group (weekly but reports monthly to MB)					✓	✓	✓	✓	✓	✓	✓	✓	8
													12

APPENDIX 3


MANAGEMENT BOARD
Capital and Space Planning Committee
Monthly
Redevelopment Steering Board
Monthly
Business Case Review Group
Monthly
GOSH 2020 Board
Monthly
Policy Approval Group
Monthly
Workforce Delivery Group
Quarterly
Strategic Education Committee
Quarterly
Quality and Safety Committee
Monthly
Patient and Public Involvement and Experience Committee
Bi-monthly
CRES Working Group
Monthly
Information Governance Steering Group
Monthly
Innovation Group
Bi-monthly

Attachment S

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 26th September 2012	
NHSLA update **Submitted on behalf of** Professor Martin Elliott, Co-medical Director	**Paper No: Attachment S**
Aims / summary To update the committee on the progress made in the preparations for the NHSLA assessments.	
Action required from the meeting Trust Board is asked for its continued support for the assessment.	
Contribution to the delivery of NHS / Trust strategies and plans The successful completion of the NHSLA assessment contributes to the Zero Harm and no waste aims of the Organisation.	
Financial implications The levels of assessment (levels 1,2 and 3) represent a percentage savings of the contributions of the total cost paid to the NHSLA for claims.	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? All Clinical Units and departments	
Who needs to be told about any decision N/A	
Who is responsible for implementing the proposals / project and anticipated timescales Salina Parkyn, Assistant Head of Quality, Safety and Transformation – Risk Management	
Who is accountable for the implementation of the proposal / project Professor Martin Elliott, Co-Medical Director	
Author and date Meredith Mora, Project Lead. September 2012	

Attachment S

NHSLA Update 18th September 2012

Situation
The Trust is currently working towards level 3 NHSLA assessment, booked for the 29th and 30th October 2012. A core team is focusing on the work, having divided the standards up to enable intensive checking of the detail of policies and monitoring evidence. The team is also leading on the identification and remedying of any gaps. The 12/13 NHSLA requirements are the first to employ random spot checks of the patient health record, incident reporting system and training database.

Background
GOSH's last NHSLA assessment was November 2009, when the organisation successfully attained Level 2 compliance with NHSLA Risk Management Standards. The organisation's next assessment will be at level 3, and is booked for 29th and 30th October 2012. To achieve level 3, the Trust must be compliant with each of the three levels i.e. level 1 (policies must be in place and in date), level 2 (policies have been implemented), and level 3 (effective monitoring of the policies and their use). Level 3 requires evidence of embedded cycles of monitoring-action planning-monitoring – this is to demonstrate that shortfalls are identified, improvement action is taken, and then monitored again to show whether the action plan made the expected improvements. 12 months of this evidence is required for the assessment.

There are 50 criteria – 10 in each of 5 standards, covering:

- Governance
- Learning from Experience
- Competent and Capable Workforce
- Safe Environment
- Acute, Community and Non-NHS Providers

To achieve level 3, the Trust must score between 40 and 50 marks, with at least 7 marks in each of the 5 standards. A score of 30-39 at level 3 will result in a level 2 determination. A score of 29 or less at level 3 will result in a level 0 determination.

Assessment
The project is being taken forward under timescales that are extremely challenging. However, the work has been divided between four leads who are responsible for checking the detail of evidence provided, and identifying and addressing any gaps with criterion leads. Dedicated administrative support is being put in place now to support the preparations until assessment in 6 weeks' time.

The Trust purchased a mock assessment from DNV (the company contracted by the NHSLA to undertake the risk management standards assessment), which took place on 11th September. The mock assessment identified areas of weakness and strength across 10 criteria and specific advice was provided by the assessor on how to address particular gaps prior to assessment. It should be noted that if the Trust is successful at level 3, it will be by a small margin. If the Trust is assessed as lower than level 3, it must be re-assessed in 2013/14 at the level awarded.

Recommendation
Ensure continued executive level support of the NHSLA work, including requesting immediate response to requests for action from the project team. Ensure commitment to embedding of monitoring, standardisation of committee templates and work plans going forward to ensure the Trust retains level 3 standard of NHSLA risk management.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **26th September 2012**	
Members' Council Update (July and August 2012 meeting) **Submitted on behalf of:** Baroness Blackstone, Chair	**Paper No: Attachment T**
Aims / summary To present a summary of the July and August 2012 Members' Council meetings.	
Action required from the meeting Trust board to note the content of the report.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Strategic Objective: The Code of Governance requires the Trust Board and Members' Council to work closely together.	
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? None	
Who needs to be told about any decision? None	
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 Victoria Goddard 19th September 2012	

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council Update to Trust Board

July 2012

A meeting of the Members' Council was held on 26th July 2012.

It was noted that the decision of which candidate to formally recommend to the Members' Council for appointment had been delayed and it was **agreed** that the Council would reconvene in August to consider approval of the appointment.

The Members' Council **approved** the job descriptions and terms and conditions of appointment of the Chair and Non-Executive Directors which had been amended to reflect additional duties and responsibilities resulting from becoming a Foundation Trust.

Discussion took place around the recommendations put forward by the Members' Council Nominations and Remuneration Committee for the remuneration of the Chair and Non-Executive Directors.

The Council **agreed** that in principle the responsibilities of the Chairman and Non Executive Directors had changed upon becoming a Foundation Trust and that remuneration levels should reflect this.

The Council **agreed** that the Members' Council Nominations and Remuneration Committee should meet again to further consider remuneration levels in light of the Council's views on the timing/ level of remuneration.

August 2012

An extraordinary meeting of the Members' Council was convened on 15th August 2012 to consider the approval of the appointment of the new Chief Executive.

Mr Jan Filochowski was recommended by the appointment panel to the Members' Council.

The Council was provided with background information on the shortlisting and interview process, as well as information on Mr Filochowski's experience in relation to the person specification for the role.

It was **agreed** that, if appointed, Mr Filochowski would be invited to attend the November meeting of the Members' Council to set out his vision for the Trust.

The Members' Council **approved unanimously** the appointment of Mr Jan Filochowski as Chief Executive of Great Ormond Street Hospital for Children NHS Foundation Trust.

The councillors discussed having access to GOSH email. It was agreed that this would be considered.

ATTACHMENT U

ATTACHMENT U

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Clinical Governance Committee held on 18th July 2012

Clinical Governance Committee Terms of Reference and Effectiveness Review
The committee considered and approved the effectiveness review subject to inclusion of a statement reflecting the strong focus placed on Clinical Governance during the Monitor assessments.
Assurance Framework
The committee was advised that the only risk which was not rated green was around consent. Mr Robert Burns reported that a working group was being led by Dr Barbara Buckley, Co-Medical Director to ensure that the consent process was of high quality from a patient and families' point of view as well as ensuring that training in the area was correctly documented. <u>Risk 1A – Children may be harmed through medication errors</u> The report demonstrated changes implemented following an internal audit which had provided reasonable assurance. The Trust was contacting other centres in order to learn from them. Professor Elliott reported that a further improvement would be gained through implementation of the Electronic Document Management System (EDMS). It was agreed that another internal audit would be conducted and the report would be presented at the October meeting of the committee. <u>Risk 1G – We do not make sufficient progress in developing benchmarks and demonstrating world class clinical outcomes</u> The committee was informed that progress was being made in the in the Trust's benchmarking project. <u>Risk 2A – We may not be able to measure, report and act on patients' experience</u> The level of risk had been downgraded as a result of a positive Ipsos Mori inpatient survey results. Clinical Units were engaged in ensuring that work continued in their areas. The Trust had achieved its quarter 1 CQUIN targets around patient experience however gaps had been identified around engaging with patients with a learning disability. It was confirmed that an action plan was in place.
CRES Update
The committee was informed that for schemes valued over £100k , a high value sign off process was conducted, as well as a risk assessment to assess any disadvantages which would be created by the scheme. A number of schemes which operated Trust wide and would individually be valued at

less than £100k but that together would be greater than £100k would also be considered. It was agreed that a small number of CRES schemes would be monitored rigorously against their respective measures to ensure that they were not detrimental to clinical outcomes. It was agreed that a summary of the list of clinical schemes should be provided to the committee and a deep dive should take place on one scheme per meeting.
Update on Aged Risks
There had been a reduction in the number of aged risks since the last report. The committee agreed the importance of determining whether a risk was permanent or if it was not appropriately managed.
Update on infection prevention and control in corporate areas
It was reported that the staff survey results had indicated that corporate areas had reduced the overall score for hand hygiene within the Trust. Mitie and Facilities had conducted an inspection which had found that 25% of areas had empty hand gel dispensers. Stickers would be introduced in all hand hygiene areas which would give information provided to explain the process for making arrangements for the soap and hand gel dispenser to be refilled. Audits would be undertaken.
Update on the timeliness of discharge summaries
The committee was informed that current performance had been static at a level which was below the internal target of 95%. Work was on-going, however progress was slow. It was reported that Deloitte had conducted an audit of the Trust's Quality Account which had reported on this area and had found that issues were present in the data which had been collected.
Update on NHS Litigation Authority (NHSLA) assessment
An informal NHSLA visit had taken place on Monday 16th July. The recommendation was to go ahead with NHSLA level 3 and re allocate resources to the project.
Employee Relations Activity Report
The committee was informed that activity in the last quarter had not altered the trend or analysis over the year. Ms Yvonne Brown, Non-Executive Director expressed concern about the statistic

which suggested that BME employees were around three times more likely to be called to a disciplinary. The committee was informed that BME staff were more likely to fill lower paid roles and that more disciplinary procedures were conducted amongst lower paid employees. It was stressed that more than half of the Trust's disciplinary cases were sent to external solicitors and that concerns had not been raised. The Committee agreed that it was important to ensure that BME staff had completed PDRs and were aware of training opportunities.
Medical Devices report
The Trust was accredited to ISO 9001 standard and had been audited twice in year on management of medical devices. Items to be tagged had been agreed based on a combination of value, scarcity and portability. An internal audit of the tagging system would take place in 2012.
Child Protection and Safeguarding Update
The committee was advised that the Child Protection Management Group had agreed priorities for 2012/13. Whilst there was no CQUIN for child protection, expected outcomes had been aligned to North Central London metrics. A safeguarding training refresher course would be held which would enable more staff to complete level 3 training. It was suggested that training should be tailored to different groups of staff. It was confirmed that the Child Protections team would visit units to provide bespoke training. It was agreed that the reports would be considered on a quarterly basis by the Clinical Governance Committee and annually by Trust Board.
Research Governance Update
The committee was informed that the Memorandum of Understanding between GOSH, ICH and UCL had been updated and was now valid until September 2014. She added that an internal audit had confirmed that all necessary controls were in place and reported one, low risk recommendation. It was reported that work was on-going to create a standard way of capturing and monitoring human tissue under the human tissue act.
Head of Nursing report
It was agreed that a report covering six months of activity would be brought to the October meeting of the committee and that following this, reports would be quarterly.

Attachment W

Great Ormond Street Hospital for Children NHS Foundation Trust

MANAGEMENT BOARD
19th July 2012

FINAL MINUTES

Present:

Barbara Buckley (BB)	Co-Medical Director
Robert Burns (RB)	Deputy Chief Operating Officer
Cathy Cale (CC)	CU Chair , ICI-LM
Jane Collins (JC)	Chief Executive Officer (Chair).
Dr Carlos De Sousa (CDS)	Chair of Neurosciences
Sarah Dobbing (SD)	GM Neurosciences
Professor Martin Elliott (ME)	Co Medical Director
Melanie Hiorns (MH)	CU Chair MDTS
Carla Hobart (CH)	General Manager ICI-LM
Elizabeth Jackson (EJ)	CU Chair, Surgery
Anna Jebb (AJ)	GM MDTS
Mr Mark Large (ML)	Director of ICT
Anne Laythe (AL)	GM, Cardiac
Joanne Lofthouse (JL)	General Manager, International Division
Claire Newton (CN)	Chief Finance Officer
Natalie Robinson (NR)	Deputy Director of Redevelopment
Peter Wollaston (PW)	Head of Corporate Facilities
Tom Smerdon (TS)	GM Surgery
In Attendance	
Sue Conner (SC)	Project Manager
Suzanne Cullen (SCu)	Head of Nursing, CICU
Peter Lachman (PL)*	Associate Medical Director and Consultant in Service Design & Transformation
Cho Ng (CNg)	CICU Consultant
Eithne Polke (EP)	PICU/NICU/CATS Nurse Specialist Co-ordinator
Sophie Skellett	PICU/NICU Consultant
Janet Williss (JW)	Deputy Chief Nurse

**Denotes meeting part attended*

595	**Apologies**	
595.1	Apologies were received from Fiona Dalton, Chief Operating Officer; Ms Lorna Gibson, General Manager for Research and Innovation; Allan Goldman, CU Chair, Cardio-Respiratory and Liz Morgan, Chief Nurse and Director of Education.	
595.2	Dr Jane Collins, Chair welcomed Sue Conner, Project Manager; Suzanne Cullen Head of Nursing, CICU; Cho Ng, CICU Consultant; Eithne Polke, PICU/NICU/CATS Nurse Specialist Co-ordinator and Sophie Skellett, PICU/NICU Consultant to Management Board. JC also welcomed Janet Williss, Deputy Chief Nurse who was attending in Liz Morgan's absence.	
596	**Minutes of Management Board meeting held on 17th May and 21st June, 2012**	
596.1	The minutes of meeting held on 17th May were approved as an accurate record. The minutes of meeting held on 21st June were approved as an accurate record with amendments to note Elizabeth Jackson (EJ) was present and TS presented item 573.	
597	**Action Log and other matters arising**	
597.1	323.3 Parent/Members on Interview Panels Review – it was agreed that this would be moved to the August Management Board.	
597.2	530.8 Business Case to increase Cardiothoracic Capacity on move to Morgan Stanley – it was agreed that this would be brought back to the August Management Board.	
597.3	585.8 – Requesting radiological investigations and procedures – An update was reported that a workshop was being set up by the project manager and would include as a minimum the Neuroscience and Cardiac units.	
597.4	583.5 – Spinal Business Case – it was agreed that this would be moved to the August Management Board.	
597.5	574.3 - Reporting Zero Harm - Quality, Safety & Transformation (QST) Update – RB reported that the Risks that could not be addressed but needed to be managed were discussed with Risk managers at the Clinical Governance Committee.	
598	**Review of critical care services**	
598.1	SS presented a summary of the PICU Consultants' report 'PICU Consultants' Assessment of the Review of Critical Care Services at GOSH'.	
598.2	JC thanked SS and asked that the Trust thinks about way of moving forward on from the Review.	
598.3	CNg presented a presentation on CICU perspectives on the review of critical care services. CNg reported on preserving best aspects from all the areas, single division, collaborative care, Governance and cross cover, 24 hour cover, common standards, nursing roles, CATS as independent service, Outreach and vacated area.	
598.4	JC thanked CNg for his presentation and invited feedback from the Board.	
598.5	EP presented on the nurses' perspective on the review of critical care services. EP	

	discussed concerns and issues nurses felt with the review.	
598.6	JP thanked EP for her verbal report.	
598.7	SCu gave a verbal update on the review of critical care services. SCu raised concerns over the timeline and lack of Electronic copies.	
598.8	JC reported that the Trust took the decision to not provide electronic copies of the review in order to protect the identities of the employees that might have been identifiable in the review. JC also reported it was a difficult balance for the Trust in order to get the timeline right and how long to allow feedback to be fed through.	
598.9	SC lastly gave a presentation of the feedback received on the review of critical care services received to date. SC reported that the majority of the respondents across the Trust from ICU stake holders had welcomed and supported the report although some PICU and NICU staff disagreed with the findings of the report.	
598.10	JC invited comments from the Board in particular the CU Chairs.	
598.11	All of the CU Chairs said that they welcomed the review and looked forward to taking many of the recommendations forwards. A desire to support the Consultants working on ICU through this challenging period was expressed. CNg highlighted the issue of expanded capacity for Neonate beds. CDS reported that the current implementation of the 'closed' model of care for ICU does not work in the interests of the patients. CDS stated support for a general HDU but had concerns over specialist knowledge. CDS also highlighted the importance of implementation.	
598.12	Management Board **agreed** that feedback should be completed by the end of the month, 31st July 2012.	
598.13	Management Board **agreed** that a Lead Nurse on NICU should be sought immediately.	
598.14	Management Board **agreed** that the Trust should talk to commissioners regarding funding to increase PICU capacity.	
598.15	Management Board **agreed** that an Advisory Group would be convened to look at the recommendations and feedback and that further recommendations would come back to Management Board in August. A simple communication would come out shortly on the feedback and actions agreed by Management Board.	
598.16	**Action:** Advisory Group to convene to look at the recommendations and feedback and further recommendations would come back to Management Board in August. A simple communication would come out shortly on the feedback and actions agreed by Management Board.	**LM**
	Clinical Unit and Zero Harm Reports	
599	**IPP**	
599.1	JL presented the IPP Zero Harm report.	
599.2	JL reported it was 66 days from the last SI and there were no refusal and one complaint in IPP for the month.	
599.3	JL reported the top three risks to the unit were Bone Marrow Transplant Air Flow Unit, CVL infections and recruitment.	
599.4	Management Board **noted** the content of the report.	

600	**Cardio Respiratory & Deep Dive**	
600.1	CNg presented the Cardiac Zero Harm report.	
600.2	CNg reported it was 17 days from the last SI and there were 5 refusals, no delays and 3 complaints in the unit for the month.	
600.3	CNg reported the top three risks to the unit were medication errors, ventilated patients at home - risk of ventilator breakdown out of hours and Docstore (Historic ICU Records) no longer supported.	
600.4	Management Board **noted** the content of the report.	
600.5	CNg presented the Deep Dive on the unit. CNg reported that 82% of cardiac surgery patients were discharged this week without complications and discussed the Unit's overall no complications rate. CNg reported on flow challenges; cancelled theatre cases, refused admissions, length of stays on wards, hand hygiene, CVL infections, patient safety and learning from SIs.	
600.6	Management Board **noted** the content of the report.	
601	**Infection, Cancer and Immunity**	
601.1	CC presented the ICI Zero Harm report.	
601.2	CC reported it was 237 days from the last SI and there were three complaints in the unit for the month.	
601.3	CC reported the top three risks to the unit were access to MRI scan slots, IT Systems and medication errors – administration.	
601.4	Management Board **noted** the content of the report.	
602	**MDTS**	
602.1	AJ presented the MDTS Zero Harm report.	
602.2	AJ reported it was 28 days from the last SI.	
602.3	AJ reported the top three risks to the unit were CRES, radiology - completion of PIMs forms by non-doctors and interventional access.	
602.4	CC raised concerns over IPP outliers on Zero Harm reports.	
602.5	**Action:** RB to include IPP outliers on Zero Harm reports.	
602.6	Management Board **noted** the content of the report.	
603	**Neurosciences**	
603.1	CDS presented the Neurosciences Zero Harm report.	
603.2	CDS reported it was 46 days from the last SI and there were no refusals, no delays and 2 complaints in the unit for the month.	
603.3	CDS reported the top three risks to the unit were medication errors, Neuromuscular complex pathways and shortage of outpatient space.	

603.4	Management Board **noted** the content of the report.	
604	**Surgery**	
604.1	TS presented the Surgery Zero Harm report.	
604.2	TS reported it was 21 days from the last SI and there were 34 refusals, no delays and 2 complaints in the unit for the month.	
604.3	TS reported some refusals were as a result of unplanned IPP work. JC raised concerns over the balance between IPP and NHS work. JC requested an urgent	
604.4	piece of work be completed on what the balance ought to be for each unit and the Board and Members Council need to be kept updated.	
604.5	**Action:** RB to present a paper on the acceptable balance between IPP and NHS work to the September Management Board.	
604.6	TS reported the top three risks to the unit were clerking, CRES and Recruitment of specialist workforce.	
604.7	Management Board noted the content of the report.	
605	**Reporting Zero Harm - Quality, Safety & Transformation (QST) Update**	
605.1	RB presented the report which was taken as read. RB highlighted to the Board that a special cause had been identified for the number of crash calls outside ICU, with the average reducing from 11 to 7 each month. The upper and lower control limits would be reset once the improvement was sustained. Also 85% of specialities had identified a third clinical outcome measure.	
605.2	Management Board **noted** the content of the report.	
606	**Education Zero harm Report**	
606.1	JW presented the report and informed the Board that work was underway to achieve 95% of staff undertaking statutory and mandatory training.	
606.2	Management Board **noted** the content of the report.	
607	**Key Performance Report March 2012**	
607.1	RB presented the Key Performance Indicator (KPI) report which was taken as read. 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.	
607.2	RB reported that the Trust was anticipating reporting a governance risk rating of 'Green' for Q1 although monthly performance against the % patients' waiting over 6 weeks for a diagnostic test had deteriorated, in the month 34 patients refusals were reported and the total PDR rate for clinical and non-clinical areas remained static at 65%.	
607.3	Management Board **noted** the report.	
608	**Finance and Activity Report**	
608..1	CN presented the report which was taken as read. CN reported that year to date surplus was £3.3M excluding donations for capital additions, a £3M favourable	

	variance.	
608.2	The EBITDA variance was £2.8 M favourable excluding donations. The principle reasons for the positive variances being higher international private patient activity.	
608.3	Management Board **noted** the contents of the report.	
609	**Monthly CRES Report**	
609.1	RB asked Management Board to note progress on the CRES programme.	
609.2	• The CRES position had improved by £1.6m in the last month. • There remains a £1.2m gap. • Clinical and Corporate Units needed to close remaining 12/13 gap with new schemes and to ensure progression and full delivery of current schemes.	
609.3	Management Board **noted** the contents of the report.	
610	**Cardiac S&S Outcome and implications for GOSH**	
610.1	RB presented the report. RB reported the JCPCT decision created an exceptional opportunity to considerably grow our cardiac services to become one of the largest centres in the world. The complexity of the implementation should not be underestimated and resources should be committed to ensuring successful transfer of services.	
610.2	Prior to 2B GOSH had capacity issues with accommodating all the transferred work, especially if respiratory services are also affected. The urgent needs would include; - Doubling the size of Miffy - Utilising considerable space in the vacated CICU for patients on the complex end of ward requirements - Opening all beds on CICU, Bear and Victoria (Respiratory) - Accessing an additional theatre for cardiac surgery	
610.3	Management Board **agreed** the direction of travel of the report.	
611	**Impact of the Safe & Sustainable decision on the estate capital plan**	
611.1	RB presented the report. RB reported the Safe and Sustainable decision to reduce the number of centres for paediatric cardiac surgery would result in significant increased activity at GOSH.	
611.2	We would need to ensure that we had sufficient physical capacity to treat these children and it had been shown that we would need an additional theatre. This could be achieved by transferring the Hybrid in the Morgan Stanley Clinical Building to a new room on level 3 next to the other planned angio suites. The costs of this project had been estimated at £4.5M. This proposal would need to be discussed with Morgan Stanley.	
611.3	Management Board **approved** the report.	
612	**Neuromuscular Psychosocial**	
612.1	SD presented the report on Psychosocial support for Neuromuscular Patients. The report sought to provide psychosocial support to the neuromuscular service by identifying dedicated Psychology sessions for neuromuscular patients, and creating a Family Psychotherapist post to support the service.	

612.2	Management Board **approved** the request for the part-time family therapist and SD was asked to come back to Management Board for approval for the assistant when necessary.	
613	**IPP PICU beds position paper**	
613.1	TS presented the paper. The paper provided management board with: • an update on the progress of international patent activity on ICU • outlined the business case for increased capacity for international patients on ICU • demonstrated the options available and associated risks for delivering additional capacity which will not impact NHS service delivery	
613.2	Management Board are asked to : • note international ICU activity to date • note forecast to year end • note business case progression and associated space requirements and cost implications.	
613.3	Management Board **noted** the contents of the report and **approved** direction of travel.	
614	**JD Ophthalmology consultant paper**	
614.1	CDS presented the paper which sought approval for a Consultant post in Paediatric Ophthalmology. It was highlighted that the template used for the post was incorrect.	
614.2	**Action:** RB to ask HR to update their Forms section of the internet to include the new Foundation Trust in the name on the Consultant forms.	
614.3	Management Board **approved** the post.	
615	**Rainforest refurbishment**	
615.1	RB presented the report. RB reported earlier this year, senior nursing prioritised refurbishment works for remaining Southwood wards. Miffy Ward and then Rainforest were agreed as the priorities due to the acuity of patients and length of stay. Rainforest Ward is due to move into 2B in 2016-17 after which the space may not be used for inpatient accommodation so a full refurbishment is not felt to be appropriate.	
615.2	This business case was for minor refurbishment works along with purchase of monitoring equipment and recliners for patients.	
615.3	The Capital and Space Planning committee (CASP) had reviewed the case and recommended it to Management Board for ratification. The case had been discussed with GOSHCC and Special Trustees were expecting a proposal at their next meeting in September.	
615.4	Management Board asked that a further update be given next month with workings on the financials.	
615.5	**Action:** RB to bring back a paper on Rainforest refurbishment.	
616	**DNA Extractor System**	
616.1	AJ presented report which asked the Board to award the tender to Hamilton Robotics so they can supply the Automated DNA Extractor to the Genetics	

	Laboratory.	
616.2	Management Board **approved** the report.	
617	**Report from BCRG**	
617.1	The report was taken as read.	
617.3	Management Board **noted** the content of the report.	
618	**Q1 Child Protection Update**	
618.1	The report was taken as read.	
618.2	Management Board **noted** the content of the report.	
619	**Decontamination Update**	
619.1	The report was taken as read.	
619.2	Management Board **noted** the content of the report.	
620	**OPD Space Review**	
620.1	The report was taken as read.	
620.2	Management Board **noted** the content of the report.	
621	**Review of Patient Transfer policies**	
621.1	Management Board **noted** the content of the report.	
622	**Olympic Update**	
622.1	The report was taken as read.	
622.3	Management Board **noted** the content of the report.	
624	**Policy Approval Group**	
624.1	Management Board **noted** the content of the report.	
625	**Redevelopment Programme Steering Board**	
625.1	Management Board **noted** the content of the report.	
626	**PPIEC**	
626.1	Management Board **noted** the content of the report.	
627	**2020 GOSH and Terms of Reference**	
627.1	Management Board **noted** the content of the reports.	
628	**Waivers**	
628.1	The Board noted the requested for approval for the waivers from the following suppliers:	

	Mercian Interglobal Surgical Johnson & Johnson (Biosense Webster) Terumo BCT Applied Biosystems (by Life Technologies Ltd) Management Board **approved** the waivers.	
629	**Any other business**	
629.1 629.2	JC thanked WM for all his contributions to The Trust as it was his last Management Board. BB thanked JC on behalf of the Trust of all of her major contributions to the Trust over the years. BB passed on the Board best wishes to JC and said that she would be hugely missed and would be a very hard act to follow.	

Great Ormond Street Hospital for Children NHS Foundation Trust

MANAGEMENT BOARD
16th August, 2012

FINAL MINUTES

Present:

Robert Burns (RB)	Deputy Chief Operating Officer
Cathy Cale (CC)	CU Chair , ICI-LM
Fiona Dalton (FD)	Interim Chief Executive
Dr Carlos De Sousa (CDS)	Chair of Neurosciences
Sarah Dobbing (SD)	GM Neurosciences
Professor Martin Elliott (ME)	Co Medical Director
Alex Faulkes (AFa)	Head of Planning & Performance Management
Allan Goldman (AG)	CU Chair, Cardio-Respiratory
Elizabeth Jackson (EJ)	CU Chair, Surgery
Anna Jebb (AJ)	GM MDTS
Liz Morgan (LM)	Chief Nurse and Director of Education
Mr Mark Large (ML)	Director of ICT
Joanne Lofthouse (JL)	General Manager, International Division
Natalie Robinson (NR)	Deputy Director of Redevelopment
Tom Smerdon (TS)	GM Surgery
Peter Wollaston (PW)	Head of Corporate Facilities

In Attendance

Peter Lachman (PL)*	Associate Medical Director and Consultant in Service Design & Transformation
Andrew Needham (AN)	Deputy Director of Finance
Nicky Thurlbeck	Head of Nursing
Pauline Whitmore (PWh)	Manager/Dept Head, Cardiao-respiratory Unit

**Denotes meeting part attended*

630	**Apologies**	
630.1	Apologies were received from Carla Hobart, General Manager ICI-LM; Barbara Buckley, Co-Medical Director; Claire Newton, Chief Finance Officer; Melanie Hiorns, CU Chair MDTS and Anne Layther GM, Cardiac.	
630.2	FD announced that following ratification from the Member's Council, Jan Filochowski had been appointed chief executive of the Trust. Jan was one of the UK's most experienced and respected NHS chief executives and had held CEO positions at five different NHS organisations over the last 20 years. For the last five years he had led West Hertfordshire Hospitals NHS Trust into becoming one of the most successful Trusts in the country. FD informed the Board an announcement would go out to all staff shortly.	
631	**Minutes of Management Board meeting held on 19th July, 2012**	
631.1	The minutes of meeting held on 19th July, 2012 were approved as an accurate record with the amendment that Anna Jebb had attended.	
632	**Action Log and other matters arising**	
632.1	565.3 - Maximum occupancy of Units – It was agreed that this action would be moved to the October Management Board. Following further discussions with Clinical Units, Management Board decided it should be used as a tool that can trigger escalation to alert of potential issues.	
632.2	597.2 - Business Case to increase Cardiothoracic Capacity on move to Morgan Stanley - It was decided that this action would be removed from the Action Log and a business case for the approval of any additional medical staff would come back to Board when and if required, but would only be considered following the agreement of job plans for all the Cardiologists.	
632.3	597.3 - Requesting of radiological investigations and procedures – It was decided that this action would be brought back to the October Management Board.	
632.4	548.1 - Replacement Audio-vestibular Consultant (10 Pas) – It was reported a decision was reached with Barbara not to be the lead employer given the job plan. Newham have been informed.	
632.5	602.5 Zero Harm Reports – It was reported that the action: RB to include IPP outliers on Zero Harm reports was completed.	
632.6	614.2 - Consultant Template – It was reported that the action: RB to ask HR to update their Forms section of the internet to include the new Foundation Trust in the name on the Consultant forms was completed	
632.7	615.5 - Rainforest Refurbishment – It was reported that Chairman's Action was taken on the action: RB to bring back a paper on Rainforest refurbishment and it was approved.	
	Clinical Unit and Zero Harm Reports	
633	**IPP**	

633.1	JL presented the IPP Zero Harm report.	
633.2	JL reported it was 99 days from the last SI and there were no refusal and one complaint in IPP for the month.	
633.3	JL reported the top three risks to the unit were Bone Marrow Transplant Air Flow Unit, CVL infections and recruitment.	
633.4	Management Board **noted** the content of the report.	
634	**Cardio Respiratory**	
634.1	AG presented the Cardiac Zero Harm report.	
634.2	AG reported it was 43 days from the last SI and there were 7 refusals, no delays and no complaints in the unit for the month.	
634.3	AG reported the top three risks to the unit were medication errors, Nursing Stress on CICU and Home ventilation.	
634.4	Management Board **noted** the content of the report.	
635	**Infection, Cancer and Immunity**	
635.1	CC presented the ICI Zero Harm report.	
635.2	CC reported it was 267 days from the last SI and there was one complaint, 3 refusals and 5 delays in the unit for the month.	
635.3	CC reported the top three risks to the unit were access to IT systems, High Dose Thiotepa Protocol and medication errors – administration.	
635.4	Management Board **noted** the content of the report.	
636	**MDTS & Deepdive**	
636.1	The Deepdive for the Unit was postponed to next month.	
636.2	AJ presented the MDTS Zero Harm report.	
636.3	AJ reported it was 61 days from the last SI.	
636.4	AJ reported the top three risks to the unit were requesting of radiology tests by non medical staff, diagnostic waiting times for MRI and Gastro and IR waiting times.	
636.5	Management Board **noted** the content of the report.	
637	**Neurosciences**	
637.1	CDS presented the Neurosciences Zero Harm report.	
637.2	CDS reported it was 37 days from the last SI and there were 2 refusals, no delays and 1 complaint in the unit for the month.	
637.3	CDS reported the top three risks to the unit were medication errors, Neuromuscular complex pathways and shortage of outpatient space.	

637.4	Management Board **noted** the content of the report.	
638	**Surgery**	
638.1	EJ presented the Surgery Zero Harm report.	
638.2	EJ reported it was 52 days from the last SI and there were 46 refusals, no delays and 4 complaints in the unit for the month.	
638.3	The Board had a discussion on CATS cardiac refusal and it was agreed that TS and AG would work together to try and find the reasons behind the increase in CATS cardiac refusals.	
638.4	**ACTION:** TS & AG to work together at the reasons behind the increase in CATS cardiac refusals.	**TS & AG**
638.5	EJ reported the top three risks to the unit were clerking, CRES and Recruitment of specialist workforce.	
638.6	FD asked the Board to thank the teams who put in all the prep work around the Olympics.	
638.7	**ACTION:** LM to liaise with the Olympic planning team to send around a thank you on behalf of the Board for all their work around planning.	**LM**
638.8	Management Board noted the content of the report.	
639	**Reporting Zero Harm - Quality, Safety & Transformation (QST) Update**	
639.1	RB presented the report. Areas of note in Zero Harm report were:	
639.2	• The serious harm index and the infection index were both expected to rise as the measure was defined and data collection improves. • There had been a statistically significant reduction in the number of 2222 calls over the past 7 months. The probable reasons for this were complex but what was encouraging was that the number of cardiac and/or respiratory arrests had not increased as a result.	
639.3	Management Board **noted** the content of the report.	
640	**Education Zero harm Report**	
640.1	LM presented the report. LM reported progress towards achieving NHSLA Level 3 Training levels. In order to achieve NHSLA Level 3 there was a requirement to achieve 95% compliance with mandatory training.	
640.2	Management Board **noted** the content of the report.	
641	**Key Performance Report July 2012**	
641.1	AFa 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.	

641.2	AFa reported there had been 1 case of MRSA, the first case reported year to date. Whilst above the trajectory of 0 cases for the year the Trust remains within the Monitor annual de minimis level of 6. FD enquired whether this had been reported as a SI. RB responded that he would double check that it had.	
641.3	**Action:** RB to check the case of MRSA was raised as an SI.	**RB**
641.4	AFa reported 1 case of C.difficile had been reported in the month. 3 cases had been reported year to date against a year-end trajectory of 8. The Trust remained within the Monitor annual de minimis level of 12.	
641.5	Waiting List over 26 weeks, as previously reported, capacity issues had been identified across a number of specialties within Surgery. Action plans had been put in place and waiting list issues were forecast to be resolved by early 2013.	
641.6	The number of patients waiting over 6 weeks for a diagnostic test continued to reduce.	
641.7	In month performance had deteriorated with 53 patient refusals recorded against a previous month position of 39. 41 of these related to Surgery CATS and a further 7 were attributed to Cardiac.	
641.8	FD asked AFa to ensure that the target PDR rate in the KPI report was updated to the NHSLA rate of 95% not 80%.	
641.9	**ACTION:** AFa to ensure the PDR rate in the KPI report is updated to the NHSLA rate of 95% not 80%.	**AFa**
641.10	Management Board **noted** the report.	
642	**Commissioning for Quality & Innovation (QUIN) and Quality Improvement Development & Innovation Schemes (QIDIS) Q1 2012/13**	
642.1	AFa presented the monitoring report which summarised progress against all Primary Care Trust /London Specialist Commissioning Group (LSCG) CQUIN standards and National Commissioning Group (NCG) QIDIS standards.	
642.3	Management Board noted the report.	
643	**Theatre Utilisation Project Update 2012/13**	
643.1	The report was taken as read.	
643.2	Management Board **noted** the content of the report.	
644	**Finance and Activity Report**	
644.1	AN presented the report. The trust was currently forecasting a small surplus excluding donations and impairments however much depended on the level of IPP work delivered as well as successful delivery of the CRES programme.	
644.2	The year to date surplus was £3.2M (EBITDA – excluding donations) this was £2.3M ahead of plan. At the EBITDA level including donations the position was £7.8M surplus and this was £7.4M worse than plan reflecting lower donated	

	income.	
644.3	The Board had a discussion on the possible impact of planned leave on the income on the Trust. FD requested RB report back to Management Board with the results of the audit for annual leave.	
644.4	**Action:** RB to come back to Management Board with results of the audit of leave.	**RB**
644.5	Management Board **noted** the contents of the report.	
645	**Monthly CRES Report**	
645.1	AFa asked Management Board to note progress on the CRES programme.	
645.2	The identified CRES position was improved by £200k, but the risk adjusted position has deteriorated by £555k due to high risk and lack of progress of a number of schemes.	
645.3	Management Board was asked to note the CRES position and required actions: • Clinical and Corporate Units to close remaining 12/13 gap with new schemes and to ensure progression and full delivery of current schemes • Red and Amber schemes need to progress to Green or be removed from the plan • Alternative schemes to be developed where current schemes were not delivering.	
645.4	Management Board **noted** the contents of the report.	
646	**Increase ICU Access for International Patients**	
646.1	JL presented the report. This proposal would provide improved access to ICU for children coming from overseas. Currently access was limited due to the demands on the current resource and key referrers are diverting business to other centres.	
646.2	The key objectives were to: • Provide ICU facility for international patients – currently significant level of refused admissions • Regain business lost to other private hospitals • Rebuild reputation as top class provider of tertiary services that includes ICU • Provide additional capacity funded by IPP which does not compromise NHS access	
646.3	The business case assumed that IPP utilised the current vacant bed space on PICU between October and March 2013. From April 2013, these beds would be utilised for spinal cases so the decision on the longer term option appraisal is required. There were significant risks associated with the business case: if there were no structural changes approved for NICU/CICU space, the additional private patient work would need to utilise vacant bed spaces on the existing NICU. This would affect the long term identity of NICU as an individual unit and goes against recommendations made in the CCU review. Alternatively if the Trust was unable to find a solution from April 2013, the Trust would run a high risk of damaged credibility with our key referrers and a loss of income of £1.5m.	
646.4	Management Board **approved** the Business Case for the short term plan.	
647	**Critical Care at GOSH: A Case for Change**	

647.1	LM presented the paper which made a case for change for Critical Care Services at GOSH following the extended period of staff feedback on the report 'Review of Critical Care Services'. The paper outlined the work streams and highlights where immediate action is being taken by the Executive Team (Stage 1).	
647.2	The paper also clarified the next steps as the project moves into the implementation phase with the proposal of a Critical Care Implementation Board who will oversee all work streams. LM sought approval for the membership of the Critical Care Implementation Board.	
647.3	Management Board had a discussion around the membership which would include 2 new posts: a Clinical Unit Chair and Head of Nursing. CC raised concern over ensuring that this did not set a precedent across the Trust. FD pointed out that the paper needed to be clarified regarding the nursing structure to ensure that there was no impact on individuals without consultation.	
647.4	Overall Management Board supported the progress made. **Action:** LM to amend the report as discussed	**LM**
647.5 647.6	**Action** FD to organise communication regarding the Critical Care review and have a discussion with Surgery and Cardiac on timescales.	**FD**
648	**Appointment of CATS Consultant**	
648.1	EJ presented the Business Case which requested approval for the appointment of substantive CATS Consultant 10 PA post, to replace current locum.	
648.2	Management Board **approved** the appointment to substantive CATS Consultant position.	
649	**Tender for the supply of a Heart Lung Machine**	
649.1	PWh presented the report. PWh reported the purchase of the new Heart Lung Machine was to enable the Perfusion department to have the potential to run three cardiac theatres simultaneously. This was conjunction with the expansion plan for cardiac surgery.	
649.2	Management **approved** the award of the tender to Sorin for the Heart Lung Machine.	
650	**Code of Conduct for Healthcare Support workers**	
650.1	LM presented the report. This code of conduct would help to make sure that all patients and their families get the same high-quality, safe and effective service from non-registered healthcare support workers.	
650.2	LM asked Management Board to accept the Code and support the implementation of it trustwide.	
650.3	Management **approved** the report.	
651	**Plan to establish a Young People's Forum**	
651.1	LM presented the report. As a Foundation Trust we aimed to improve our ability to gather the views of children and young people as part of the Patient Involvement & Experience strategy. A Young People's forum had been recruited to augment the	

	work of the Members Forum and ensure the views and opinions of adolescent patients are represented. Membership comprises young people aged 11 to 24 years.	
651.2	Management Board **welcomed** the report.	
652	**Report from BCRG**	
652.1	The BCRG report was taken as read. The following business cases were discussed by the BCRG in the past month:	
652.2	• IPP beds on PICU The business case to fund 2 additional PICU beds for IPP had now been completed and it was agreed that this should be presented to August Management Board.	
652.3	• Dermatology additional laser sessions business case This case to expand the laser service by an additional 2 sessions per week was discussed. Some details need refining and it was anticipated that this business case would then be ready for presentation to September Management Board..	
652.4	Management Board **noted** the content of the report.	
653	**Conflict of Interest Policy**	
653.1	FD presented the policy. The Conflict of Interest and Gifts and Hospitality Policy required that all staff members and board members with private or personal interests which might affect their role within the Trust, declare these interests on joining the organisation or when the potential for conflict arises. The policy also provided guidance to staff and board members on the procedure to be followed in the event of any gift, hospitality or sponsorship being offered and establishes a Trust gift and hospitality register whereby such gifts, hospitality and sponsorship should be recorded. The returns would be maintained in a register which would be open for inspection and accessible under the Freedom of Information Act 2000.	
653.2	This policy had been reviewed in light of the Bribery Act 2010. The policy had been circulated to Clinical Unit Chairs, General Managers, the Legal Department, Executive Directors and the Counter-fraud Officer and comments incorporated. All revisions are shown in red text. This policy was being brought to Management Board for final consultation. It is planned for this policy to be considered at the September meeting of the Policy Approval Group (PAG).	
653.3	Management Board had a discussion on the Policy and FD asked that members feed back comments to AF over the next couple of weeks and for the policy to go to GMSC chairs for their comments.	
653.4	**Action:** Management Board to read and feed back to AF comments and changes. The policy will go to GMSC for their feed back also.	**AF**
653.5	Management Board **noted** the policy.	
654	**Parent/Members on Interview Panels – Update**	
654.1	RB presented the report which was taken as read. The purpose of the paper was; • To provide Management Board with an update on parent/Member attendance on	

	GOSH interview panels during the period December 2011 – August 2012. • To keep Management Board informed of progress made to improve parent/Member attendance on panels as highlighted in a paper on member/Parent involvement submitted to the December 2011 Management Board.	
654.2	Management Board **noted** the report.	
655	**A Review of Local Education Spend**	
655.1	It was agreed the paper would come back to September Management Board.	
656	**NHSLA Update**	
656.1	The report was taken as read and the request was noted for help to achieve NHSLA. Mock in November.	
656.2	Management Board **noted** the content of the report.	
657	**Policy Approval Group**	
657.1	Management Board **noted** the content of the report.	
658	**Redevelopment Programme Steering Board**	
658.1	Management Board **noted** the content of the report.	
659	**Waivers**	
659.1	The Board noted the requested for approval for the waivers from the following suppliers: Nordic NeuroLab London Borough of Camden	
659.2	Management Board **approved** the waivers.	
660	**Any other business**	
660.1	RB reported that Lorna Gibson had left the Trust and asked to note the Board's thanks to her. RB reported that advertisement would commence in early September for the replacement post. Jude Cope would very kindly be offering support in the interim.	

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **26th September 2012**	
Key Monitor Correspondence **Submitted on behalf of** Robert Burns, Acting Chief Operating Officer	**Paper No: Attachment Z**
Aims / summary This paper provides a summary of key Monitor correspondence including: 1. Annual Plan Review 2012/13 Executive Summary 2. Monitor feedback letter for Annual Plan Review 2012/13	
Action required from the meeting Trust Board to note progress.	
Contribution to the delivery of NHS Foundation 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, councillors, 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. September 2012	

4 Matthew Parker Street
London
SW1H 9NP

T: 020 7340 2400
F: 020 7340 2401
W: www.monitor-nhsft.gov.uk

31 July 2012

Dr Jane Collins
Chief Executive
Great Ormond Street Hospital for Children NHS Foundation Trust
Great Ormond Street
London
WC1N 3JH

Dear Jane,

2012/13 Annual Plan Review

I am writing to you in relation to the 2012/13 Annual Plan Review (APR). The purpose of Monitor's review is to assess whether NHS foundation trusts are effectively planning for the future while maintaining and improving quality. This enables Monitor to make a more informed judgement about future risks to compliance with a Trust's terms of Authorisation.

Under the APR process all NHS foundation trusts are subject to a two day high-level review of the annual plans submitted to Monitor at the start of June. Following this scrutiny Monitor determines, on a trust by trust basis, the appropriate regulatory approach for the year. The regulatory approach may involve one or more of the following:

- Continued quarterly monitoring;
- Enhanced monitoring;
- Formal visit by Monitor;
- Further internal work by Monitor; and
- Suggested further work for the Trust to commission.
- In addition where concerns have been identified Monitor may, during the period from late July to early October, instigate a more detailed review that focuses on aspects of risk identified during the first stage.

For your information I enclose a summary of our analysis of your Trust's Annual Plan. This summary reflects the work done by Monitor during June and early July and as a consequence subsequent discussions which may have taken place are not reflected. It is important to note that Monitor's review process assesses but does not endorse Trusts' plans.

Risk Ratings

We have now completed the two day review on your 2012/13 Annual Plan, and your Trust has the following annual risk ratings for 2012/13 as submitted in your return to Monitor:

Financial Risk Rating	4
Governance Rating	GREEN

These ratings will be published on Monitor's website in early August. We would emphasise that these risk ratings are the Foundation Trust's own risk ratings and as such are never adjusted by Monitor. We will also publish on our website, under your entry in the Public Register of NHS foundation trusts, the components of the strategic plan that your Trust submitted that were highlighted as for publication including a summary of financial plans in a similar format to that published last year, new 2012/13 Schedule 2 (Mandatory Goods and Services), Schedule 3 (Mandatory Education and Training) and Schedule 5 (Limit on Borrowing). Please note that your Prudential Borrowing Limit is currently being calculated and approved and will be published on the Monitor website at the end of August.

Monitor will continue to assess the risks to the Trust's compliance with its terms of Authorisation through the returns provided by you as part of the normal quarterly monitoring process which commences with the review of quarter one in August 2012. We will publish an update to the risk ratings at this time.

Outcome of Annual Plan Review

Great Ormond Street Hospital for Children NHS Foundation Trust has not been selected for an in-depth review. However, it is important that the Trust Board continues to monitor the risks to compliance with its terms of Authorisation and takes appropriate mitigating action where necessary. Recognising the significant level of Cost Improvement programmes (CIPs) that need to be delivered across the Health Sector, all Trust Boards should assure themselves that where CIPs are being implemented their impact is being assessed on an on-going basis such that the quality of services is being maintained and improved and that the Trust can continue to deliver safe services sustainably.

Trusts planning to breach indicators

Please note that Monitor does not take action in respect of planned breaches. As a result Trusts planning to breach indicators or deliver sub-standard FRR and GRR ratings over the plan period should not assume that Monitor will not escalate these matters if and when they occur.

Quality of Planning

Our review of Trusts' plans has identified that in many cases while Trusts plan prudently for year 1 of their APR submission planning for years 2 and 3 appears less rigorous with Trusts simply rolling forward the same plan. This is not best practice and we believe Trusts should be considering plans equally across all three years despite more detail being required for the first year. Going forward this approach to APR submissions may be considered a governance risk.

Next steps

As in previous years, Monitor intends to publish a summary of findings from the Annual Plans that have been submitted which will include aggregated information from all NHS foundation trusts and the emerging themes from our review. We intend to publish the information contained in this document during August 2012.

Please note that due to internal restructuring and the need to balance portfolios evenly across Monitor, you have been allocated a new Compliance Manager.

Your new Compliance Manager is John Sparrowhawk and takes over responsibility from Naresh Chenani. He can be contacted on 020-7340-2575 or by email (John.Sparrowhawk@monitor-nhsft.gov.uk). Laura Mills and I will continue as your Senior Compliance Manager team.

If you have any queries in relation to any of the above, please contact me or Laura Mills by telephone on 020 7340 2473 or by email (Alexandra.Coull@monitor-nhsft.gov.uk) or (Laura.Mills@monitor-nhsft.gov.uk) at the earliest opportunity.

Yours sincerely

Alexandra Coull
Senior Compliance Manager

cc: Baroness Tessa Blackstone, Chairman
Professor Martin Elliott, Co Medical Director
Dr Barbara Buckley, Co Medical Director
Mrs Claire Newton, Chief Finance Officer

Great Ormond Street Hospital for Children NHS FT
APR 12/13 executive summary

Monitor
Independent Regulator of NHS Foundation Trusts

Risk ratings

Financial Risk Rating:

2012/13:	Q1	Q2	Q3	FY		2013/14	2014/15
	4	4	4	4		4	4

Governance Risk Rating:

Self-certified rating	GREEN	**Risk(s) identified**	• None

Prospective 12/13 Limits:

Long term borrowing limit	To be published	Working capital facility	£15.0m	Private patient income	9.7%

Financial plan summary

£m	2011/12 Actual		2012/13 Plan	2013/14 Plan	2014/15 Plan
Total revenue	**365.5**		**387.0**	**378.0**	**399.8**
Pay	-193.9		-196.4	-201.6	-203.0
PFI operating expense	0.0		0.0	0.0	0.0
Other costs	-149.0		-167.1	-151.6	-169.7
EBITDA	**22.9**		**23.5**	**24.8**	**27.1**
Surplus	**18.4**		**38.8**	**15.7**	**43.1**
EBITDA %	6.2%		6.1%	6.6%	6.8%
CIP %OpEx less PFI	1.5%		2.4%	2.2%	3.2%
CAPEX	-45.8		-53.3	-35.9	-53.8
Net cash flow	-5.7		1.2	2.6	5.2
Cash & Equiv	**26.6**		**27.9**	**30.4**	**35.6**
Liquidity days	31.4		39.6	46.8	54.9
Net current assets	18.7		26.6	33.9	41.8
Borrowing	**0.0**		**0.0**	**0.0**	**0.0**

Annual Plan Review Summary

- Delivery of the highest quality of care is the top priority for the Trust and is at the heart of its strategy. The business strategy focuses on growth through centralisation of specialist services, and private patient income increases once the cap is removed and additional capacity to deliver this planned activity is available.
- The financial plan aims to achieve a minimum FRR 3 with an FRR 4 forecasted in each year of the plan. The strategy is based on a plan to deliver clinical income growth, increased R&D income and delivery of Cash Releasing Efficiency Schemes (CRES).
- The delivery of the Phase 2B capital redevelopment is key to the Trusts medium term strategy and planned growth. The project will be funded by the Great Ormond Street Hospital Charity.

Key risks	Action taken / committed	Gaps and residual concerns
• **Delivery of Phase 2B redevelopment of cardiac wing:** Delays or cost changes following the procurement of Phase 2B will impact the medium term strategy and ability to achieve activity growth set out in the plan.	• Regular Board reporting on project status. • Use of experienced project managers to provide project management and oversight. • Track history of delivering complex redevelopment projects.	• Appointment of suitably qualified Director of Re-development following retirement of current post holder. • Delivery complexities and financial challenges associated with large scale capital re-development. • Continuity of services during complex move.
• **Board Leadership**: Appointment of a new Chief Executive following the resignation of the Chief Executive who will leave the Trust in September 2012.	• Trust has begun the process for recruiting a new Chief Executive. • Interviews are planned for 26 July 2012. • Interim Chief Executive arrangements are in place.	• Appointment of a credible Chief Executive.
• **Delivery of CRES**: The Trust fails to deliver revenue generation of £5.3m and CIP targets £7.8m required to achieve plan.	• Challenge and scrutiny from the Finance and Investment committee. • Financial monitoring of schemes and contingencies in the plan.	• Robustness of financial governance arrangements of CRES schemes. • Failure to achieve income targets will require a higher level of CIPs.

Next steps

- **Continue quarterly monitoring.**
- **Monitor Assessment team significant transaction review of Phase 2B commenced in July 2012.**