Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
30th January 2013

Dear Members

There will be a public meeting of the Trust Board on Wednesday 30th January 2013 at 2:00pm in the **Charles West Room, Paul O'Gorman Building,** Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Attachment
1.	**Apologies for absence**	Chairman	
Declarations of Interest All members 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 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 28th November 2012**	Chairman	**H**
3.	**Matters Arising / Action point checklist** • **Minute 599.12:** The Board to consider the ways in which mortality rates can be triangulated to assess whether they were at appropriate levels. • **Minute 606.4:** Dr Buckley to provide an update at the next meeting about the success of other hospitals at achieving the 5 day target.	Chairman Chief Operating Officer Co-Medical Directors (BB)	**I**
4.	**Chief Executive Report**	Chief Executive Officer	**Verbal**
	PRESENTATION		
5.	**Research Strategy and KPIs**	Director of Research and Innovation	**Presentation**
	STRATEGIC ISSUES		
6.	**Quality Strategy**	Co-Medical Director (ME)	**J**
	PERFORMANCE REPORTS		
7.	**Summary of performance for the period:** • **Targets and indicators, including workstreams** • **Cash Releasing Efficiency Savings (CRES)**	Chief Executive Chief Operating Officer Chief Operating Officer	**K**

	• **Finance and Activity** • **Quality and Safety**	Chief Finance Officer Co-Medical Director (ME)	
8.	**Q3 Monitor Return (for approval)**	Chief Finance Officer	**L**
	ASSURANCE REPORTS		
9.	**Assurance Framework Summary**	Chief Operating Officer	**M**
10.	**Redevelopment Report**	Director of Redevelopment	**N**
11.	**Patient Experience Report including IPSOS MORI Survey Results - Outpatients**	Chief Nurse and Director of Education	**O**
12.	**Update on the Care Quality Commission Quality & Risk Profile – November 2012**	Company Secretary	**Q**
	FOR RATIFICATION		
13.	**Consultant Appointments**	Chairman	**Verbal**
	SUBCOMMITTEE REPORTS		
14.	**Reports from Board assurance subcommittees (January 2013):** • **Audit Committee** • **Clinical Governance Committee** • **Finance and Investment Committee**	Audit Committee Chair Clinical Governance Committee Chair Finance and Investment Committee Chair	**S** **Verbal** **T**
15.	**Management Board minutes** • **November 2012** • **December 2012**		**U**
16.	**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.)		
17.	**Next meeting** The next Trust Board meeting will be held on Wednesday 27th March 2013 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT H

Attachment H

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board held on 28th November 2012

Present

Baroness Tessa Blackstone	Chairman
Dr Barbara Buckley	Co-Medical Director
Professor Andy Copp	Non-Executive Director
Ms Fiona Dalton	Chief Operating Officer
Professor Martin Elliott*	Co-Medical Director
Mr Jan Filochowski	Chief Executive
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

Mr Daniel Dacre	Staff Councillor
Ms Sarah Dobbing	General Manager, Neurosciences
Dr Anna Ferrant	Company Secretary
Miss Victoria Goddard	Trust Board Administrator (minutes)
Dr John Hartley	Infection Prevention and Control (DIPC)
Mr Alki Liasis	Speciality Lead for Ophthalmology
Mr Ian Lush	Public Councillor
Ms Deidre Malone	Deputy DIPC

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

593 Apologies for absence

593.1 Apologies were received from Ms Yvonne Brown, Non-Executive Director.

594 Declarations of interest

594.1 No declarations of interest were received.

595 Minutes of the meeting of 26th September 2012

595.1 The minutes of the previous meeting were approved subject to the following amendments:

595.2 Minute 549.1 – To be amended to read '… which had been decommissioned pending the outcome of judicial reviews.'

596 Matters arising and action checklist

596.1 Process for approval of job plans

596.2 Dr Barbara Buckley reported that she intended to utilise job planning to

increase productivity but emphasised that many consultants worked a greater number of hours than they were contracted to.

596.3 It was agreed that future reports would provide actual numbers of job plans rather than a percentage.

596.4 **Action:** Future reports to provide actual numbers of job plans rather than a percentage.

596.5 The Board **noted** the report.

597 Chief Executive Update

597.1 Mr Jan Filochowski provided his first Chief Executive update. He reported that he had visited much of the hospital, including staff and stakeholders.

597.2 He reported that a Director of HR would be appointed in 2013 with an interim taking up the post from January.

597.3 It was confirmed that the CQC report was expected within the next week and that all standards had been met. Mr Filochowski reported that the Trust retained an unqualified CQC registration.

598 Clinical Presentation Ophthalmology

Professor Martin Elliott joined the meeting

598.1 Dr Alki Liasis, Specialty Lead for Ophthalmology reported that the service comprised a number of multidisciplinary teams and handled referrals from across the UK.

598.2 Dr Liasis confirmed that GOSH saw approximately one third of all UK cataract patients. He added that it was possible to carry out surgery on very small babies as a result of the high specialised anaesthetics service provided at GOSH.

598.3 He reported that patients experienced longer waits in areas with smaller capacity and suggested that there was scope to do more work if capacity was increased and added that theatre utilisation had been improved since 2010.

598.4 Mr David Lomas asked for a steer on benchmarking the service with those of other hospitals. He queried whether this information would lead GOSH to believe that the service needed improvement.

598.5 Dr Liasis stressed that whilst the service would benefit from improvements, there were no serious issues present.

598.6 Ms Sarah Dobbing, General Manager for Neurosciences reported that communication was an issue within the specialty, but confirmed that this was being managed.

598.7 Ms Dobbing reported that income in 2012/13 had reduced from previous

years due in part to a number of locums being present. She added that a substantive consultant post was being advertised.

598.8 Ms Dobbing reported that Ophthalmology undertook some IPP work with ambitions to increase the level.

598.9 Mr Lomas asked what percentage of clinic letters were sent within 5 days.

598.10 Ms Dobbing confirmed that currently 70% of letters were sent within 5 days but reported that the target was 95%.

598.11 Mr Lomas queried how productivity was measured.

598.12 Ms Dobbing reported that inpatient and outpatient activity was measured. She added that consultant productivity was being looked at to ensure that work was divided in the most efficient way.

598.13 Dr Liasis reported that the service worked closely with the academic unit to carry out genetic assessments and that there were currently 3 PhD students working within the department.

598.14 Ms Dobbing reported that the Trust was working in partnership with Moorfields' Eye Hospital NHS Foundation Trust. This was a valuable relationship which would continue to move forward.

598.15 Baroness Blackstone queried the potential barriers to increasing the number of patients and subspecialties.

598.16 Dr Liasis reported that it would be necessary to appoint a greater number of sub specialty doctors. It was noted that this would present challenges in creating a team which would work together.

599 Quality, Safety and Transformation Update

599.1 Professor Elliott presented the safety report. He confirmed that there had been no red complaints from August to date and a significant reduction in amber complaints. He added that significant assurance had been provided in an internal audit of the complaints process.

599.2 The Board requested that risks that where assessed to be permanently open, high risks be reported separately from those that could be mitigated.

599.3 **Action:** For risks assessed as permanently open, high risks to be reported separately from those that could be mitigated.

599.4 Mr Ripley asked for assurance that where risks required work, there were enough resources and commitment within the organisation to carry this out.

599.5 It was agreed that information would be included in the report on how risks had been reviewed.

599.6 **Action:** Information to be included in the report on how risks had been reviewed.

599.7 Ms Mary MacLeod suggested that Root Cause Analyses on serious incidents should be conducted in a more time sensitive manner. She noted that the same recommendations were given in each serious incident resulting from a pressure sore and asked if there was further learning about treating children where pressure sores were such a high risk.

599.8 Mrs Liz Morgan reported that a greater number of pressure ulcers were now reported as a result of them being reportable as a serious incident. She added that a lot of work had been done on assessment and development of a skin care bundle with a team which considered the outcome of each case to determine learning.

599.9 The Board agreed that as part of the work on the risk culture of the organisation, the Audit Committee should look at those risks deemed to have a high impact on the organisation.

599.10 **Action:** The Audit Committee to look at those risks deemed to have a high impact on the organisation.

599.11 Ms Dalton noted that mortality rates were roughly constant but suggested the Board should consider various ways in which mortality rates could be triangulated.

599.12 **Action:** The Board to consider the ways in which mortality rates can be triangulated to assess whether they were at appropriate levels.

599.13 The Board **noted** the update.

600 New theatre and move of hybrid angiography suite Business Case

600.1 Ms Fiona Dalton reported that the Trust had a short window of opportunity to create a new theatre. She confirmed that as a result of the proposed development, theatre capacity would be available for patients moving from the Royal Brompton as a result of the Cardiac Safe and Sustainable review, or any other NHS or IPP surgery.

600.2 Ms Dalton stressed that without the additional theatre space it would not be possible to accommodate patients from the Royal Brompton or additional Cardiac or Neuro patients.

600.3 Baroness Blackstone queried the learning that had resulted from the creation of the hybrid angiography suite and stressed the importance of ensuring that future developments of this type were carefully considered.

600.4 Ms Dalton reported that it had not been possible to use the space interchangeably as either an angiography suite or a theatre, as expected. She confirmed that surgical activity was also expected to rise beyond the levels anticipated when the Morgan Stanley Clinical Building was initially designed.

600.5 Mr David Lomas, Chair of the Finance and Investment Committee confirmed that this matter had been fully discussed. He reported that the Committee had recommended that the project was approved by the Board however it was essential that income was delivered from the project.

600.6 The Trust Board **approved** the proposed projects totalling £6.8million.

601 Statement of Purpose – Care Quality Commission

601.1 Dr Anna Ferrant reported that the statement of purpose identified the services provided by the Trust and where they were provided.

601.2 She confirmed that this had previously been agreed by the Board in 2010, and that it had been revised as the Trust now wished to conduct research on a number of adults. The statement had also been updated to reflect the different types of diagnostic work carried out on adult patients. It was stressed that this did not alter the application of the CQC standards.
It was agreed that reference to 8.8% of patients being adults would be removed.

601.3 The Board **approved** the revised statement of purpose subject to the above amendment.

602 Infection prevention and control

602.1 Dr John Hartley, Director of Infection Prevention and Control informed the Board that the SHA had strongly recommended the appointment of an antimicrobial pharmacist but confirmed that this was not currently felt to be necessary within the Trust. He added that this proposal would be reviewed if necessary.

602.2 Dr Hartley confirmed that the Trust worked hard to control cross infection but reported that this had potential to impact patients' pathways.

602.3 He reported that MDTS were not engaging well with Infection Prevention and Control and the Board requested a message to go to the Clinical Unit from the Trust Board requesting further engagement.

602.4 **Action:** A message to go to MDTS from the Trust Board requesting further engagement with Infection Prevention and Control.

602.5 The Board **noted** the update.

603 KPI Performance Report

603.1 Ms Fiona Dalton reported that overall, performance was complying with Monitor's expectations and where targets were not being met, action plans had been developed.

603.2 Mr David Lomas, Non-Executive Director queried the 'median waits - non admitted' target which had not been met in 18 months.

603.3 Ms Dalton confirmed that as a tertiary hospital, patients had not been referred directly from GPs. She reported that the addition of another referral from a secondary care hospital to GOSH meant that achieving the target was unrealistic. She added that Monitor was not assessing the Trust against the target.

603.4 It was agreed that targets should be separated into those against which the Trust was monitored by an external regulator/ body and those which were not.

603.5 **Action:** Targets to be separated into those against which the Trust was monitored by an external regulator/ body and those which were not.

603.6 It was agreed that the Board would determine a realistic target for 'median waits - non admitted'.

603.7 **Action:** The Board to determine a realistic target for 'median waits – non admitted'.

603.8 Mr Lomas queried why refusals were running high.

603.9 Ms Dalton stated that there was a fundamental issue with ICU capacity. She stressed that the Trust must ensure that skill mixes were being used correctly,

603.10 Mr Ripley asked how confident the executives were that PDR levels would continue to improve.

603.11 Ms Dalton reported that all Departments had been asked to provide action plans to show how their levels of PDRs and statutory and mandatory training would be improved. She added that a date would be set, beyond which staff would be unable to work without having an up to date PDR.

603.12 The Board **noted** the report.

604 Finance and Activity Report

604.1 Mrs Claire Newton, Chief Finance Officer reported that in October there had been a change in the trend of IPP income which was lower than previous months.

604.2 Mrs Newton reported that although the level of IPP debt was unsatisfactory, two large payments had been received and a third was expected.

604.3 She confirmed that capital expenditure was below plan as a result of a delay in the phase 2B enabling works.

604.4 The Board **noted** the update.

605 Patient Experience and PALS Report

605.1 Mrs Liz Morgan, Chief Nurse and Director of Education reported that cases received by the PALS team were different to those of their normal caseload. She reported that the following themes had arisen: the importance of good communication; managing expectations; and the importance of staff following Trust policies and procedures.

605.2 Mr John Ripley noted that MDTS had the largest number of amber complaints.

605.3 Mrs Morgan reported that the greatest concern was the gastroenterology service . She informed the Board that the representatives from the service would be presenting to the Members' Council as a result of concerns expressed by Councillors.

605.4 It was agreed that the next report would provide an update on the outcomes of red rated PALS cases.

605.5 **Action:** The next report to provide an update on the outcomes of red rated PALS cases.

606 Referrers' Experience Update

606.1 Dr Barbara Buckley reported that an IPSOS MORI survey of key referrers had led to work in the area of communication and access to beds. She confirmed that two referrer open days had been valuable and a repeat of the survey was planned for early 2013.

606.2 Dr Buckley added that she and colleagues had visited main referring hospitals to hear about issues that had arisen when referring patients. She confirmed that a summary of the visits would be provided.

606.3 It was agreed that Dr Buckley would provide an update at the next meeting about the success of other hospitals at achieving the 5 day target.

606.4 **Action:** Dr Buckley to provide an update at the next meeting about the success of other hospitals at achieving the 5 day target.

606.5 Professor Andy Copp queried whether the referral route was dependant on the clinical specialty.

606.6 Dr Buckley confirmed that the registrar on call would typically receive a large number of referrals. She added that it was vital for those receiving referrals to have a real time view of bed capacity.

606.7 It was agreed that a deep dive would take place on the results of the 2013 IPSOS MORI survey and a referrer with a particular negative experience would be invited to share their experience with the Board.

606.8 **Action:** A deep dive to take place on the results of the 2013 IPSOS MORI survey and a referrer with a particular negative experience to be invited to share their experience with the Board.

607 Clinical Governance Committee (CGC) Update

607.1 Ms Mary MacLeod, Chair of the Clinical Governance Committee reported that the Committee had received an update on the deteriorating child and had requested a report on how Critical Care outreach would be managed when the Critical Care Review had been implemented.

607.2 Mrs Liz Morgan provided a correction to the report which stated that GOSH did not receive information from the national register of at risk children. She confirmed that there was no national register in place.

607.3 The Board **noted** the update.

608 Audit Committee update (October 2012)

608.1 Mr Charles Tilley, Chair of the Audit Committee reported that he had met with the Chief Executive and agreed that they would work together to take forward actions which had arisen from the risk meeting.

608.2 He confirmed that the Trust would be going out to tender for internal audit services to enable benchmarking against current provision.

608.3 The Board **noted** the update.

609 Final Management Board minutes

609.1 The Board **noted** the minutes from September and October 2012 meetings of Management Board.

610 Trust Board Members' Activities

610.1 Ms Mary MacLeod reported that four GOSH Non-Executive Directors had attended a seminar for Foundation Trust Non Executives.

610.2 Baroness Blackstone reported that she had visited Abu Dhabi as part of the Prime Ministerial Trade Visit. She confirmed that three other health providers had been present at the visit.

611 Consultant Appointments

611.1 The Board **approved** the following consultant appointments:

- Dr Aoife Waters – Renal
- Dr Juan Kaski – Cardiology
- Mrs Francisca Yankovic – Urology (locum)

612 Members' Council – update from November 2012 meeting

612.1 The Board **noted** the update.

613 Biomedical Research Centre – feedback from the National Institute for Health Research

613.1 The Board **noted** the feedback.

614 Any Other Business

614.1 There were no other items of business.

615 Next Meeting

615.1 It was noted that the next Trust Board meeting would be held on Wednesday 30th January 2013 in the Charles West Room.

ATTACHMENT I

Attachment I

TRUST BOARD - ACTION CHECKLIST
30th January 2013

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
596.4	**28/11/12**	Future reports on the approval of job plans to provide actual numbers of job plans rather than a percentage.	**BB**	**Ongoing**	To be actioned for future reports
599.3	**28/11/12**	For risks assessed as permanently open, high risks to be reported separately from those that could be mitigated.	**ME**	**January 2013**	On agenda
599.6	**28/11/12**	Quality, Safety and Transformation Update - Information to be included in the report on how risks had been reviewed.	**ME**	**January 2013**	On agenda
599.10	**28/11/12**	The Audit Committee to look at those risks deemed to have a high impact on the organisation.	**Audit Committee**	**January 2013**	To be considered as part of work on review of risk
599.12	**28/11/12**	The Board to consider the ways in which mortality rates can be triangulated to assess whether they were at appropriate levels.	**FD**	**January 2013**	On agenda under matters arising
602.4	**28/11/12**	A message to go to MDTS from the Trust Board requesting further engagement with Infection Prevention and Control.	**FD**	**January 2013**	The Clinical Unit Chair for MDTS and Director of Infection Prevention and Control are liaising to ensure that MDTS is fully engaged in the IPC agenda
603.5	**28/11/12**	Targets to be separated into those against which the Trust was monitored by an external regulator/ body and those which were not.	**FD**	**January 2013**	Actioned - on agenda

Attachment I

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
603.7	**28/11/12**	The Board to determine a realistic target for 'median waits – non-admitted'.	**FD**	**January 2013**	No longer reported in the Trust Board report, following a review of performance information (see attachment K)
605.5	**28/11/12**	The next report to provide an update on the outcomes of red rated PALS cases.	**LM**		Actioned - on agenda
606.4	**28/11/12**	Dr Buckley to provide an update at the next meeting about the success of other hospitals at achieving the 5 day target.	**BB**	**January 2013**	On agenda under matters arising
606.8	**28/11/12**	A deep dive to take place on the results of the 2013 IPSOS MORI survey and a referrer with a particularly negative experience to be invited to share their experience with the Board.	**BB**	**Following 2013 survey**	Results included as an appendix to the Patient Experience Report

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board Meeting
30th January 2013

Quality Strategy **Submitted by:** Martin Elliott, Co-Medical Director	**Paper No: Attachment J** **For approval**

Aims / summary
To present the new Quality Strategy to Trust Board.

Action required from the meeting
To note and approve the new Quality Strategy for 2013/14.

Contribution to the delivery of NHS / Trust strategies and plans
The Quality Strategy requires annual review. As a result, we have both shortened and revised the strategy, and built it around ten practical standards, as detailed below, which we would like to achieve. Our core value of putting the patient and family at the centre of our work remains.

Standard 1 developing a strong governance structure for Quality and Safety – a Systems approach to quality and safety
Standard 2 Maintain high levels of medication safety
Standard 3 Decrease and eliminate, hospital acquired infections
Standard 4 Improve clinical handover and documentation
Standard 5 Eliminate all pressure injuries
Standard 6 Recognise and respond to deterioration
Standard 7 Decrease unnecessary delay in all processes
Standard 8 GOSH will deliver clear measures of clinical outcomes to provide evidence of top 5 status
Standard 9 Work closely with our patients and their families to have high levels of experience
Standard 10 GOSH will provide equal access to all

Financial implications
The strategy supports the Trust aims of No Waste, No Waits and Zero Harm

Legal issues
N/A

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Staff will need to be aware of the new strategy to deliver their work plans.

Who needs to be told about any decision
N/A

Who is responsible for implementing the proposals / project and anticipated timescales
To be delivered during 2013/14 financial year.

Who is accountable for the implementation of the proposal / project
Martin Elliott, Co-Medical Director

Great Ormond Street Hospital for Children NHS Foundation Trust

Revised Quality Strategy

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

Draft Version: 1.02

Date: 17th January 2013

Executive Summary

Great Ormond Street Children's Hospital believes completely in its motto ***"The Child First and Always"***. Everything the Trust does is devoted to continual improvement of the health of children and to the support of their families during difficult times. GOSH has always been at the forefront of developments in children's health care, and the Trust has engaged actively in developing new ways to deliver both higher quality and greater safety. A programme called ***"Zero Harm[1]"*** commenced in 2007, and commits the Trust to the identification, progressive reduction and ultimately the elimination of harm to children when under our care. Linked with similar work under the titles of ***"No Waits"*** and ***"No Waste[2]"***, this programme is supported by an innovative process of Transformation, supported by extensive training and partnerships with external leaders in Quality Improvement (QI).[3], . This strategy builds on that experience and outlines the methods we will use to control and deliver quality, and defines our long-term aims. National goals and metrics are incorporated into our plans, but our aim is to exceed those and to *set* standards, rather than simply to respond to them.

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

We believe it is the duty of everyone who works in the Trust to make changes that will lead to better patient outcomes *(health),* better system performance *(efficiency),* better patient experience *(care)* and better professional development *(learning)*[4]. We emphasise the importance the Trust places on quality and safety, embedding it deeply in our culture.

[1] The programme incorprates the aims of Patient Safety First as well as local initiatves.
[2] These are based on the Institute of Medicine domains of quality in Crossing the Quality Chasm (2001)
[3] An example has been the link with Cincinnati Children's Hospital, Ohio, USA
[4] *Batalden P, Davidoff F."What is QI?" QSHC (2007) 16:2-3.*

Standard 1	**Develop a strong governance structure for Quality and Safety - a Systems approach to quality and safety**
Standard 2	**Maintain high levels of medication safety**
Standard 3	**Decrease and eliminate, hospital acquired infections**
Standard 4	**Improve clinical handover and documentation**
Standard 5	**Eliminate all pressure injuries**
Standard 6	**Recognise and respond to deterioration**
Standard 7	**Decrease unnecessary delay in all processes**
Standard 8	**GOSH will deliver clear measures of clinical outcomes to provide evidence of Top 5 status**
Standard 9	**Work closely with our patients and their families to have high levels of experience**
Standard 10	**GOSH will provide equal access to all**

Introduction

This Hospital is devoted to the care of children, young people and their families, and this is embedded in our culture. The Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) intends to be the Number one children's hospital in Europe and in the Top Five Children's Hospitals in the World.

To demonstrate this, GOSH 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[5] within which continuous improvement is necessary to achieve its goals. These domains, are annotated to reflect our priorities;-

The creation of a safe, effective organisation delivering excellent service demands:- corporate commitment, clear lines of accountability and an infrastructure able to deliver to decision makers the necessary data in the most appropriate way at the correct time. This embodies the concepts of high reliability – the child receives the right treatment the first time every time.

The theory we use for quality improvement is based on Deming's theory of *Profound Knowledge* in which a systems approach is taken, variation is reduced, and the interaction of people and the systems is managed to deliver high quality care[6].

[5] NHS: *Next Stage Review, DH 2008*
[6] W Edwards Deming The New Economics.

Standards of care

We will develop 10 standards against which we will continually improve.

Corporate Standards

Standard 1 Develop a strong governance structure for Quality and Safety - a Systems approach to quality and safety

Quality and Safety is delivered by clinical *micro*-systems[7]. In order to achieve this, the corporate *macro*-system needs to set the vision and goals for quality and safety, develop a measurement system for improvement, integrate teams, train for QI, and provide the supportive environment necessary for constant improvement. In turn, the clinical leaders at unit and team level need to take responsibility for improvement and change.

Corporate Commitments (Macro system)

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

Accountability for Quality and Safety (Q&S)

Executive Level

- Ultimate accountability for Q&S must rest with Trust Board, exercised via the Chief Executive of the Trust
- Day to Day Accountability will rest with;
    - *for clinical Q&S*; the Co-Medical Director responsible for Q&S who also has executive accountability for the identification, collation and benchmarking of clinical outcomes
    - *for nursing care and patient reported experience measures*; the Chief Nurse who also has executive accountability for Child Protection & Education
    - *for operational and service issues,* the Chief Operating Officer (COO)
    - *for monitoring and improvement methodologies;* joint accountability between the COO and the Co-Medical Director for Q&S, to ensure congruity between service and clinical needs.

[7] J J Mohr and P B Batalden Improving safety on the front lines: the role of clinical microsystems 2002;11;45-50 Qual. Saf. Health Care

- *For developing appropriate multi-professional education programmes to support Q&S and Patient Experience;* joint accountability Director of HR/ Chief Nurse/Director of Education and Co-Medical Director (Med Ed)

Unit Level (Meso System)

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

Speciality Level (Microsystem)

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

Infrastructure

The Quality, Safety and Transformation (Q, S&T) (Figure 1) team will facilitate the implementation of the Strategy. The team has two distinct parts working closely together. The Risk and Safety team collates evidence of risk in the Trust, working with clinical teams to investigate clinical incidents and to develop the actions required to improve.

The Quality team works to facilitate continual improvement in the organisation. The analysts in the team collate, analyse and present data from multiple data sources including major Trust systems and locally collected data to populate the dashboards presented on the QS&T website within the Intranet, which they will also administer. These dashboards are accessible throughout the Trust and are used to present relevant safety and efficiency data to Units and Boards. Other members of the Q, S&T team maintain the complaints and incident reporting mechanisms and provide regular reports to Units and Boards.

The reporting of clinical outcomes (see below) will also be collated and presented via this group, employing a dedicated outcomes manager and defined outcomes group.

The Q, S&T team will also prepare and deliver training in relevant methods including transformation, human factors, incident and complaint reporting, and the use of Datix, which is our system for recording this work.

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

Zero Harm

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

The *Zero Harm* programme aims to ensure that the patient receives the correct treatment or action the first time every time – highly reliable care.

Culture of Safety

The ethos of safety will be underpinned by the development and maintenance of **a just and learning culture** in the organisation. This includes:

- *encourage*ment of open and immediate reporting of any incidents or concerns via its electronic reporting system (Datix)
- Regular reminders (by the Co-Medical Director for Q&S) of their primary, personal responsibility for patient safety and of the obligation to report safety issues to that Director, or via their line manager.
- Alternative reporting by staff, where needed, to the Non Executive Director for raising concerns, named in the Trust's 'Raising Concerns in the Workplace' Policy.

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

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

- Monitoring and review of the Trust's safety culture
- Leadership for safety (Executive WalkRound™, Safety on the Board agenda, Safety climate and culture surveys).

- Learning from, and decreasing the incidence of, Serious Incidents.
- Training in the science and methodology of improvement
- Human factors and the impact on clinical care training.
- Improving standardisation of processes and eliminating variation where possible.
- Coaching programmes to develop and support staff
- Child Protection and Safeguarding training[8]
- Listening to, and actively involving, patients, families and referrers in the management and improvement of care and services.
- Development of systems and processes to identify and mprove health inequalities in relation to protected groups
- Learning from other hospitals and industries.

Standards for Zero Harm

The implementation of the Zero Harm component of the strategy follows the interventions recommended by the Patient Safety First Campaign. The standards GOSH has chosen are:

Standard 2 Maintain high levels of medication safety

This programme will aim at

- Decreasing risk from High-risk medications
- Elimination of prescribing errors
- Safe dispensing
- Defect-free administration of medications
- Reconciliation of medication prescription charts as a child passes through the system[9].

Standard 3 Decrease and eliminate hospital acquired infections

The aim of this programme is to focus on the following infections:

- Ventilator Associated Pneumonia
- Central line Infections
- Methicillin Resistant Staphylococcus Aureus (MRSA)
- Clostridium Difficile (C Diff)
- Surgical Site Infections. (SSIs)
- Urinary Tract Infections from indwelling catheters

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

[9] Medicine reconciliation refers to the ensuring that as a child passes from community to hospital care and back, and between clinical teams the prescriptions arw ereconciled at each point of transfer.

Standard 4 Improve clinical handover and documentation

The aim of this programme is to:

- Improve handover of all information at any point in the patient journey
- Standardise hand over information using the SBARD guidelines.[10]
- Ensure Briefings for all procedures including the surgical checklists
- Improve the quality of medical and nursing record keeping

Standard 5 Eliminate all pressure injuries

This programme aims to identify children at risk, implement interventions and eliminate all pressure injuries.

Standard 6 Recognise and respond to deterioration

The aim of this programme is to decrease unexpected deterioration of children in the hospital. This will include

- Early detection and situation awareness early warning scores - CEWS[11]
- Communication and escalation using SBAR[12],
- Intervention an outreach rapid response team from ICU.

Measurement for Zero Harm

The Zero Harm programme is built on the principles of continuous improvement. We will seek year-on-year improvement on our current results. The closer to 'Zero' we get, the harder it becomes, and thus we will continue to benchmark against our peers. A recognised leader in the field at present is Cincinnati Children's Hospital and we will continue to compare ourselves against them to identify our performance and new measures of quality.

Improvement will be measured by the decrease in harm as measured by the Paediatric Trigger Tool (PTT) and by individual measures in specific programmes. The PTT was developed by the NHS Institute for Innovation and Improvement, in collaboration with a number of NHS children's hospitals, including GOSH. The tool helps staff to measure and understand the nature of any harm that takes place in the hospital. We can use this information to develop interventions that aim to improve the safety of children being treated. The medical records of 20 randomly selected patients are reviewed on a monthly basis using the Paediatric Trigger Tool. Any themes of harm identified are considered applicable to the whole hospital.

[10] SBAR is a standardised format of transferring clinical information at each point of handover and is an acronym for *Situation Background Aseesment Recomandation and Decision.*
[11] CEWS is a clinical early warning score to detect deterioration in children
[12] SBAR is a communication tool

In conjunction with Cincinnati Children's Hospital, we are developing a 'Zero Harm Index', which will provide an even stronger tool for reporting the incidence of harm than the PTT. Validation of this method will take place over the next three years.

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

Statistical Process Control (SPC) Charts are used to facilitate reporting and permit a visual stimulus for continuous improvement and target setting. The topics under scrutiny, the data collected to monitor performance, and the subsequent SPC charts are visible on the Intranet (via the Transformation Team pages of the website) for all staff to see.

The Trust is committed to expanding the list of safety items that it monitors, identified from national and international safety reports, critical incident analysis, complaints and common sense. Annual targets will be identified in the Q, S&T annual report and the Quality Report.

No Waits, No Waste

Standard 7 Decrease unnecessary delay in all processes

The flow of children through the hospital underpins the safety and quality of the care provided. Delays are often avoidable, but cause considerable distress to patients and their families. The Trust aims to improve patient experience by minimising waits and waste in both operational and clinical systems. The Trust aims to eliminate artificial variability in the delivery of services and to minimise the effects of natural clinical and professional variability. This implies a fundamental shift in the way clinical and operational services are delivered, using the managing operations theory on variability, queuing theory and lean methodologies.[13]

This work will include improvement programmes focussing on: -

- Decrease variation in the delivery of care
- Reduce Readmission rates for the same condition to hospital
- Reduce access to outpatients to 10 working days from receipt of the referral
- Improvement of Theatre utilisation
- Increases the flow through Intensive care
- Decrease waits for investigative services such as MRI and IR
- More effective bed-management systems
- Workforce redesign to deliver quality
- Increase the use of care pathways

Measurement and methods

- Data from clinical specialties will be analysed by to the Transformation data analyst team for use by the specialties to improve care pathways.
- Assurance to the Board will be provided via the Key Performance Indicators and the regular Q, S&T report to provide insight on the data.

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

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

The aspiration of the Trust is to implement systems theory in which continual improvement might ultimately eliminate the need for target setting and inspection[14].

Measures of Achievement in No Waits, No Waste

The *No Waits, No Waste* component of the policy, is built on the principles of continuous improvement. Thus we will seek year-on-year improvement on our current results determined by analysis of the statistically achievable predictions derived from the data. Wider policy and political changes affecting the NHS may influence priority setting, but the elimination of delay and waste, will always be a priority for this Trust.

Effectiveness

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

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

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

[14] Edwards Deming. Out of the Crisis

How will we measure and monitor performance each year?

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

Measures of Achievement in delivery of effective care

Standard 8	**GOSH will deliver clear measures of clinical outcomes to provide evidence of Top 5 status**

We will develop mechanisms to publish our outcomes on the Internet in real time". We have asked each specialty defining 5 outcome measures for the 5 items of care they do best and to identify 5 centres against which they should be compared in order to provide evidence of Top 5 status. We intend to publish these on the Intranet and Internet as they are developed and verified. We will expect 75% of our specialities to achieve this within 5 years

Who is responsible for delivering the Clinical Outcomes Programme?

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

Benchmarking

What we have done to date

Each speciality has been asked to identify outcome measures that can be benchmarked against those of other leading providers, and/or to lead on the development of outcome measures that can be used by other centres. We have established relationships with the leading children's hospitals in the world and established agreements about data sharing and benchmarking.

Our Plans

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

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

- Ophthalmology – an early implementer Quality standards and indicators of the Royal College of Ophthalmologists.

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

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

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

The Trust also wishes to ensure that it records and reports effectively those outcomes reported by patients. Patients' perception of treatment and care is a major indicator of quality, and there has recently been a huge expansion in the development and application of questionnaires and rating scales that purport to measure health outcomes from the patient's perspective.

Patient-reported outcome measures (PROMs) provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life. These instruments can be completed by a patient themselves, or by others (usually the parents or guardians in our case) on their behalf.
We are keen to develop and use PROMs across the hospital to ensure that we measure and understand how patients perceive the outcomes of their care, and we see this as a vital improvement initiative. Annual targets will be presented in the Quality Account.

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

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

Standard 9 Work closely with our patients and their families to have high levels of experience

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

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

We want to create meaningful opportunities for engagement with our patients, their families and the public. We will listen *and hear* what they tell us about the care that they receive at GOSH. We want active involvement where patients and families are genuinely able to influence. Only when we fully understand how services are experienced in real time can we start to make the necessary improvements. We will develop methods of obtaining real time[15] feedback from patients, parents and families about the quality and safety of care delivered.

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

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

The Trust intends to:-

Maintain high levels of patient and parent satisfaction

The results of our independent inpatient and outpatient surveys over the past couple of years include excellent feedback scores from the patients and the parents who visit Great Ormond Street Hospital (GOSH). These annual surveys highlight areas in which we need to improve to meet the highest standards. Recent examples relate to the knowledge of how to

[15] Real time feednack is feedback obtained at the time of care delivery.

complain, or the need to improve the quality and variety of hospital food. Annual plans will be based on information from such surveys.

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

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

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

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

Measures of Achievement in PPI and Patient Experience

All clinical units and corporate departments will provide a variety of ways for patients and families to provide feedback that is monitored and acted upon e.g. WalkRounds and Patient Inspections, surveys, hand held device surveys, on-line surveys, comment cards, patient stories, feedback to PALS, parent teas/family forums, focus groups, and shadowing. We will also ensure that access is available for traditionally excluded groups such as the economically socially disadvantaged, refugees and children with learning difficulties or disabilities.

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

All clinical and non-clinical units will submit all patient survey results, satisfaction audit results, and action plans to the Patient and Public Involvement and Experience Committee to

ensure that we are responding to patient feedback and that appropriate action is being taken.

The Trust will:

- Organise a minimum of two half-day Improving Experience events annually to coincide with Members Council meetings, one targeted at children and young people, and one for parents and members.
- Organise three targeted focus groups a year in liaison with the Trust's Family Equality and Diversity Committee – e.g. bringing together patient and families of a faith, or sharing a particular disability in order to learn how these groups currently experience our services and agree priority areas for improvement with them.
- Work with the Q, S and T team and clinical unit teams to develop a central system or database to collate patient experience feedback and actions being taken that is accessible to relevant managers and staff.

The data obtained will be reported quarterly to the Patient and Public Involvement and Experience Committee on a quarterly basis with a high level summary going to Trust Board. As the system matures it will become part of the routine reporting schedule via the Q, S&T report to the Trust Board.

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

Improve communication with patients, families and referrers

Many of the patients treated at Great Ormond Street Hospital (GOSH) have complex needs and are often under the care of several specialties within the hospital, in addition to consultants at their local hospital. Therefore, it is fundamental that clinicians across GOSH communicate effectively with all of the teams that are involved in the patient's care, in addition to the patient, their family and local carers.

Information from our inpatient and outpatient surveys over the past few years showed that the majority of patients and families surveyed felt that they did have the relevant information about what would happen next or any further care that the child might need.
However, information taken from our complaints and reports from our Patient Advice and Liaison Office, and from an independent survey of referrers suggested that we are not always as good as we could be at communicating effectively with all of the relevant people involved in a child's care. The Trust is committed to improving this.

The Trust has recognised that employing a team of general paediatricians GOSH would enhance the quality of care when children interact with multiple teams, as is so often the case with the complex patients whom we treat. This has been implemented, but the way in which they work and the scope of their responsibilities will continue to evolve as we understand more of the patients' needs and responses.
We have established a referrers' experience improvement programme, which aims to address and improve the issues highlighted by the survey. Through this programme, we will:

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

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

How will we measure and monitor performance?
We will measure and monitor:

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

Who is responsible for delivering this improvement initiative?
The General Paediatrics team and the Referrers' Steering Group are responsible. The Chief Operating Officer is accountable.

Standard 10 GOSH will provide equal access to all

Equality of access to healthcare is central to its delivery[16].

The aim
The Trust will ensure that reasonable adjustments are made in the delivery of our services to ensure equal access for all patients with particular emphasis with a learning disability and those from socioeconomically disadvantaged backgrounds.

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

Progress will be monitored through the Trust Family Equality and Diversity Group.

Who is responsible for delivering this improvement initiative?
The Learning Disabilities Working Group is responsible to deliver this aim. The Co-Medical Director with responsibility for Equality and Diversity is accountable.

The Improved Access to OPD programme[17] aims to enable specialties to offer appointments to new patients within two weeks of referral acceptance. The majority of specialties have a plan in place to deliver improved access by April 2012, and we intend that all specialities will

[16] The Independent Inquiry into Access to Healthcare for People with Learning Disabilities, led by Sir Jonathan Michael, published its findings, *Healthcare for All*, on 29 July 2008

[17] Advanced Access is a method for assuring patients an appointment with the provider of choice at a date and time the patient chooses. Advanced Access requires the removal of waits and delays as there is no value in delays for appointments, phone calls, messages, referrals, etc. Changes include the following: Match supply and demand, daily, Reduce backlog, Decrease appointment types and times, Develop contingency plans, Reduce demand for unnecessary visits, Optimise the Care Team and Increase the supply of providers when needed

be engaged within the near future. We will also review our processes to reduce the number of 'did not attends' and cancellations to ensure that appointments are utilised. This will be standardised across the organisation.

Operational managers within clinical units are responsible for reviewing waiting times and ensuring that patients are seen in accordance with the above standards.

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

Who is responsible for delivering this improvement initiative?
The Head of Planning and Performance is responsible for this initiative.

Final Comments

This strategy has been developed incorporating some principles of high reliability theory,[18] to help GOSH meet its aim of "*being in the top 5 Children's hospitals in all it does".*

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

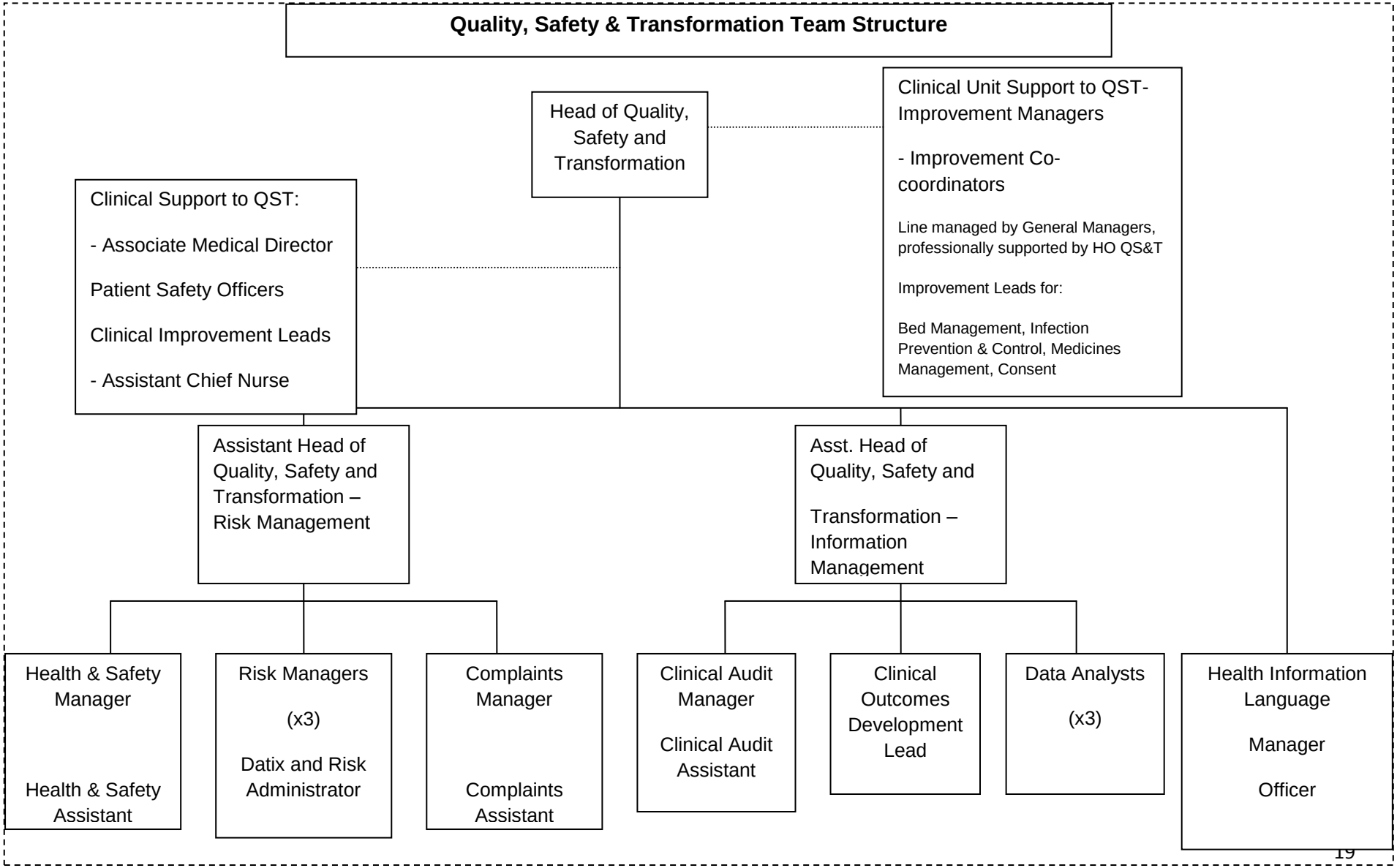
- Leadership and the development of a culture of safety.
- Understanding and measuring harm.
- Development of standardised processes wherever possible.
- Elimination of unnecessary variation.
- Training in safety, human factors and simulation.
- Prospective examination of safety and reliability for all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

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

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

Attachment J

Figure 1



Trust Board
30th January 2013

Performance summary report **Submitted by:** Jan Filochowski, Chief Executive	**Paper No: Attachment K**

Aims / summary

I promised the Board when I arrived that I would review and streamline Board reporting. I can now share the first results with you.

Work is on-going to streamline the performance reports submitted to Trust Board. This month, Board members are provided with a performance summary report outlining key issues requiring Board attention and assurance of action being taken. Those directors accountable for delivery against targets, CRES, finance and activity and quality and safety will provide further assurance of aspects of performance during the meeting. The appendices provide further detail of matters raised in the summary report below.

Work is being undertaken to streamline performance reporting including:

- A commitment to present information succinctly, escalating the appropriate issues to the Board and identifying where actions will be monitored and assurance reported, ensuring compliance with statutory and regulatory requirements.

- The best way to make more detailed information available - via the intranet or shared drive.

- The Key Performance report has been renamed the 'Targets and Indicators Report' and has been reviewed both in terms of content and format with the aim of providing a clear focus on describing exceptional change against a revised set of performance measures, whilst removing duplication with other Board reports. The number of indicators has been significantly reduced to focus on priority areas and each has been assigned an assurance level to identify the risk of achievement against plan. A series of graphs are provided against a selected number of indicators that reflect a cross-section of the report to support quick visual trend analysis. The report will continue to include progress against Monitor's foundation trust (FT) governance risk assessment. However it is proposed that the current clinical unit safety escalation report and progress against the trust CQUIN position be reported by exception only and included within the narrative cover sheet. Further detailed reports across all areas will be made available via the intranet on a monthly basis.

- A rationalisation of the financial information presented, with detailed information being reported to the Finance and Investment Committee. It is proposed that this approach will be implemented for the March 2013 meeting.

- Removal of duplication of reporting on CRES as both a separate report and in the finance and activity report (this will be subject to further review).

- A high level review of quality, safety and transformation information presented at Trust Board. This work will be undertaken consecutively with a review of the governance structure of the Quality, Safety and Transformation Team.

- A review of the Trust Board coversheet, streamlining the information presented.

This is work in progress – further changes to Board reporting will be presented at the March Board.

Action required from the meeting
The Trust Board is asked to comment on:

1. the new style Performance Report
2. performance for the period.

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
Failure to achieve contractual performance measures may result in financial penalties.

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 sub-section of the performance report on a monthly basis.

Who needs to be told about any decision
Senior Management Team

Who is responsible for implementing the proposals / project and anticipated timescales
Executive Directors and relevant senior managers.

Who is accountable for the implementation of the proposal / project
Executive Directors

Targets and Indicators - Year to Date Performance (see Appendix 1)

Despite a slow start to the year and reduced activity across the Christmas holiday period we are on track to achieve our overall activity targets. Capacity for our intensive care units remains constrained due to staffing shortages and as a consequence we are refusing a considerable number of urgent referrals and cancelling a number of operations. The opening of additional beds is a key priority for us and we are establishing a short term action group to address this issue with particular emphasis on recruitment and retention of ICU staff.

The Trust continues to meet the national 18 week referral to treatment standards for admitted and non-admitted pathways. The percentage of patients who are yet to be seen but have not waited longer than 18 weeks (i.e. incomplete pathways) also remains above the 92% standard.

The proportion of patients waiting no more than 6 weeks for a key diagnostic test remains within the tolerance of 1% for a fourth consecutive month following the implementation of remedial actions plans to address capacity issues across Cystoscopy, Colonoscopy, Gastroscopy and MRI. Progress is monitored on a daily basis and performance is expected to remain within the threshold.

Discharge summary performance has seen a slow general downward trend since May 2012 from 82% to 76%. Medicine and ICI both report rates below 75% in month. A number of service issues have been identified and remedial action plans to improve performance are being implemented. We are committed to improvement against this target but consider that achievement of the Trust target of 95% will not be achieved until during 2013/14 and a realistic March 2013 target is 85%.

The percentage of clinic letters sent within 5 working days following clinic attendance has improved significantly since April 2012. This issue has been subject to a specific improvement project involving all Clinical Units but further work is required to achieve our targets.

To date the trust has reported 3 cases of MRSA against a locally agreed year-end trajectory of 0. It should be noted that the trust remains within the Monitor annual de minimis level of 6 and as a result there is currently no detrimental impact on the FT governance risk assessment.

7 cases of C.difficile have been reported to date against year-end target of 8 but again performance is within Monitor's de minimis level of 12. Both standards remain well within the contract schedule financial penalty thresholds. Monitor has de minimis levels for both C.difficile and MRSA as performance within these levels represent maintenance of high infection prevention standards.

Monitor Governance Risk Rating

We remain Green in quarter 3 with the best possible score of 0. We anticipate this continuing in Quarter 4 with the greatest (although low) risk being exceeding the annual Monitor de minimis level of 12 C.difficile cases.

Monitor is considering the inclusion of a number of additional new metrics and standards within the governance risk matrix following the publication of the National Mandate, NHS Constitution and NHS Outcomes Framework. Indicators identified as relevant to GOSH include: Referral to diagnostic time (6weeks), 30 day emergency readmissions and medication errors causing serious harm. Monitor will be consulting formally on the metrics in 2013 following a data collection exercise across quarters 3 & 4 to identify practical issues associated with their monitoring and the impact of their introduction into their oversight framework.

Clinical Unit Performance Escalation

The following show where performance in a measure has witnessed statistically significant deterioration in a specific Clinical Unit.

Performance Measure	Clinical Unit	Reason & Remedial Action Plan
Same Day Surgery Cancellations	MDTS	The Gastroenterology booking team now call families prior to admission to ensure that the patient is well enough for the procedure and also have introduced a list of patients who can be called in at short notice if cancellations do occur. The majority of the same day cancellations, however, are in Radiology with the

		majority resulting from the patient being medically unfit or cancelling. The team are working on their consent and pre op assessment procedures to minimise cancellations and are also calling patients in advance to confirm planned attendance.
	Critical Care and CardioRespiratory	This is directly attributable to a lack of available CICU bed capacity. The issue is compounded by a significant numbers of long stay patients. December was also particularly challenging for ITU beds nationally and there were a number of days where no paediatric ITU beds were available in London with patients having to go to Southampton. We have the physical capacity to accommodate more patients but lack trained ITU nurses to open more beds. The shortage of ITU nurses is a UK wide issue. We have engaged a nursing recruitment agency and are interviewing ITU trained nurses in Dublin in the next few weeks. We are also exploring opportunities for non-ITU Cardiac staff to be ITU trained and to supplement the existing CICU nursing establishment.

Neurosciences report a statistically significant improvement in performance against WHO surgical checklist completion rates (Sign in, Time Out & Sign Out) and in the percentage of discharge summaries completed within 1 day of discharge. Surgery report statistically improved performance against the percentage of Operations identified with an Incisional Infection within 30 days of Surgery.

Progress with workstreams (see Appendix 2)

The Board is asked to note Quarter 3 progress against the Trust's Strategic Objectives and supporting work-streams. Year-end RAG forecast ratings are additionally provided. No work-streams have been rated as 'Red' at this time.

Cash Releasing Efficiency Savings (see Appendix 3)

The Board is asked to note the progress with CRES delivery in the current year and identification of schemes for 13/14:

CRES 2012/13

- £15.6M of schemes identified against a delivery target of £16.7M – this includes carry forward and the need to have a greater value of schemes to deliver the planned value
- Risk adjusted value is £15.1M
- Increase of £0.7M since period 8 – mainly in the surgery unit
- 95% of CRES is now in the secure categories; blue and green.
- CRES delivered to period 9 - £9.6M

CRES 2013/14

- £13.7M initial working target – the value will be agreed as part of the planning process in quarter 1 of 2013.
- £16.7M of schemes identified - £1.9M increase. The largest increases were recorded in Cardiac and Surgery
- Risk adjusted value is £14.4M
- 16% of CRES is in the secure categories; green and blue.

Finance and Activity (see Appendix 4)

Results year to date to end of December (Month 9)
The year to date EBITDA (excluding capital donations) is **£19.6M**, £2.6M ahead of plan. This gives a **7.5%** EBITDA margin v a planned margin of 6.6% and the equivalent period last year of 6.3%.

The net surplus excluding capital donations is **£3.6M**, £5.1M ahead of plan. In addition to the EBITDA variance of £2.6m, the positive net surplus variance results from the delay in the start of accelerated depreciation on the Cardiac Wing and an exceptional gain of £0.5m.

Forecast
The Trust is forecasting that the full year EBITDA (excluding capital donations) will be £3.7M higher than plan.

Activity / Income
Income is £3.8M ahead of plan excluding capital donations and pass through income

- NHS clinical income excluding pass through items is £2.3M or 1.2% behind plan. This is primarily due to lower than planned critical care and outpatients activity and a reduction in prices for high dependency beds
- NHS inpatient activity is broadly in line with plan, outpatients is 3.7% below plan. In activity terms, the 7.5% adverse variance in critical care bed days is offset by higher than plan excess bed days in non-critical care wards.
- Non NHS clinical income is £9.0M ahead of plan as a result of IPP income being £8.6M higher than plan and Non-England being £0.4M ahead of plan
- Other operating revenue excl. capital donations income is £2.9M behind plan, primarily relating to adverse variances on R&D, Education and Charity.
- Capital donation income is £22.5M behind plan reflecting delayed capital spend on 2B enabling.

Expenditure
Pay

- Pay expenditure totals **£148M**, £2.7M adverse to plan, the largest element being junior doctors pay but there are also adverse variances on nursing pay and agency costs in IT.
- **Agency costs** total **£4.1M** (representing 2.8% of the pay bill to December 2012) down from 5.7% in the same period last year.

Non pay – excluding depreciation and PDC
Non-pay expenditure is **£94.8M**, which is £1.4M below plan excluding pass through and £0.2M below plan including pass through.

- Under-spends in drugs of £2.4M and in R&D and education of £1.0M are offset by over spends on clinical supplies (£1.2M) and premises costs (£0.9M).

Financial Risk Rating

- Overall risk rating of 4 (unchanged from period 8)

Capital

- Capital spend is **£14.0M**; £26.0M lower than plan year to date. Donated capital spend is £22.5M lower than plan and owned capital is £3.9M lower than plan.

Cash Flow

- The Trust's cash balance was **£28.3M** at 31December, an increase of £5.2M in the

month; there were operating balances of between £25.6M and £42.8M throughout the month.

Quality, Safety and Transformation – (Appendix 5)

There is a monthly rotation of Transformation, Safety & Outcomes reported to the Trust Board, with focus on Outcomes for period 1st July to 31st December 2012.

Areas to note:

Part I – Zero Harm

- There have been no statistically significant changes during this period

Part II – Outcomes

- 87% of specialities have identified a third clinical outcome measure
- No new web publishing in last quarter due to vacancy, but catch up expected in Q4
- 15 hospitals across the world have expressed interest in the international benchmarking project. 8 have sent their responses to the scoping questionnaire, identifying their measures across six specialties

Part III - Response to minutes of previous meeting:

- Process for managing 'accepted' risks now in place. Work currently being undertaken to manage this, with Risk Managers taking a key role.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board

Targets and Indicators Report

Dec-12

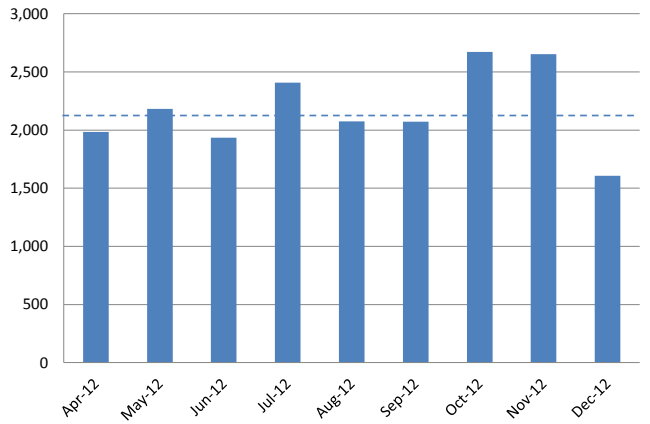
	Indicator	Graph	YTD Target	YTD Performance	Monthly Trend								
					Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Activity & Use of Resources	Number of patient spells	1	19,507	**19,589**	1,983	2,182	1,934	2,409	2,076	2,072	2,671	2,654	1,608
	Number of outpatient attendances	2	101,830	**99,493**	10,122	12,443	11,295	11,463	9,322	10,587	12,544	12,190	9,527
	DNA rate (new & f/up) (%)		<10	**8.8**	8.8	8.0	9.5	8.8	9.4	8.7	8.9	8.4	8.9
	Number of ITU bed days	3	7,329	**6,815**	772	749	684	726	637	789	836	808	814
	Number of unused theatre sessions	4	Baseline year	**206**	15	7	18	32	26	23	16	9	60
Patient Access	18 week referral to treatment time performance - Admitted (%)	5	90	**91.3**	90.5	90.1	90.4	90.5	91.4	91.7	92.8	93.8	90.6
	18 week referral to treatment time performance - Non-Admitted (%)	5	95	**95.9**	97.4	96.4	96.1	95.6	95.1	95.4	96.2	95.3	95.5
	18 week referral to treatment time performance - Incomplete Pathways (%)	5	92	**93.0**	91.8	93.4	93.2	92.0	92.0	92.8	93.3	94.5	93.9
	Cancer patients waiting no more than 31 days for second of subsequent treatment (%)		98	**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 (%)	6	<=1	**4.20**	6.00	5.80	9.00	7.93	6.62	0.84	0.17	0.63	0.77
Patient / Referrer Experience	Number of complaints		<99	**81**	8	13	11	7	12	9	10	5	6
	Number of complaints - high grade		<11	**4**	1	0	2	0	1	0	0	0	0
	Discharge summary completion (%)	7	85	**78.2**	79.8	82.6	80.4	81.1	78.3	70.8	78.4	76.7	75.9
	Clinic Letter Turnaround (% of letters on CDD sent within 5 working days)	8	50	**26.2**	14.5	17.0	19.8	22.8	20.0	34.9	34.1		
Quality & Safety	Combined Harm Index	9	Within Tolerance	**23.1**	26.8	23.7	28.4	19.6	20.9	22.1	20.9	23.8	23.1
	Paediatric Trigger Tool (adverse events per 1000 bed days)		Within Tolerance	**159**	157	122	115	91	73	28	159		
	Number of serious patient safety incidents	10	Within Tolerance	**23**	4	6	5	1	4	1	1	1	0
	Hospital mortality rate (per 1000 discharges)		Within Tolerance	**6.3**	1.8	2.9	4.5	3.4	4.4	2.9	2.3	3	5.1
	Combined infection index		Within Tolerance	**3.2**	4.3	4.2	4.1	3.2	2.4	2.7	2.3	3.1	2.2
	Incidence of C.difficile		6	**7**	1	0	1	1	2	1	1	0	0
	Incidence of MRSA		0	**3**	0	0	0	1	1	0	0	0	1
	CV Line related blood-stream infections (per 1,000 line days)	11	1.5	**1.8**	3.0	2.4	2.0	1.1	0.9	1.7	1.7	2.8	
	Number of arrests outside ICU (cardiac or respiratory)	12	Within Tolerance	5	5	6	5	6	5	4	5	5	7

Link to full report including glossary and supporting graphs

Activity and Use of Resources

1. Patient spells

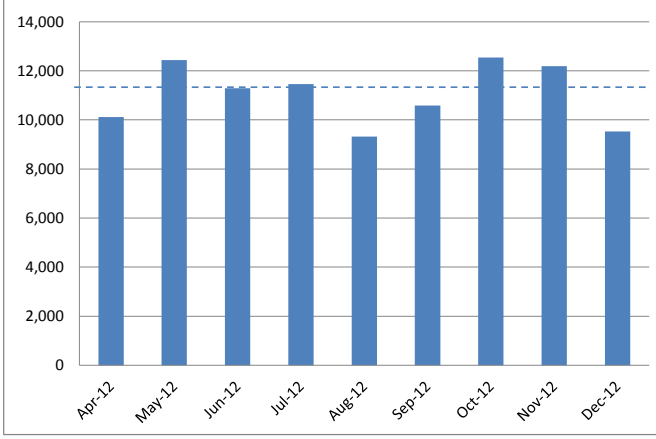
Desired direction of travel ↑



Description: **The total number of patient spells (including day case, elective and non-elective)**
Target: *Contractual target*: 2,167 spells per month
Trend: General improvement throughout year with exception of anticipated decrease in December
Comment: Slow start to year compounded by low activity during Olympics. Strong Autumn position recorded with target expected to be met by year end

2. Outpatient Attendances

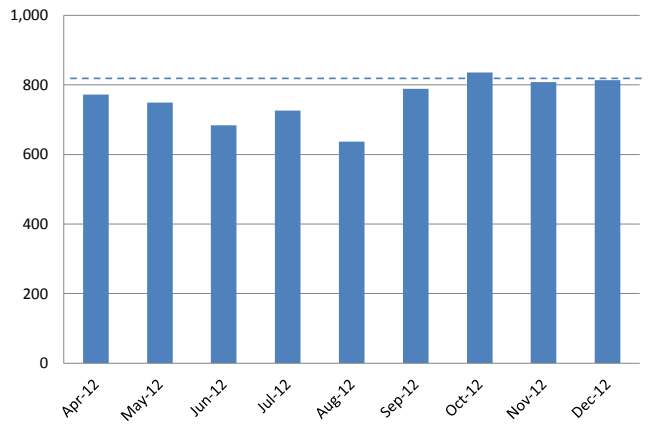
Desired direction of travel ↑



Description: **Total number of new & follow-up consultant-led chargeable appointments**
Target: *Contractual target:* 11,314 attendances per month
Trend: Trend tends to mirror inpatient activity as driven by consultant availability
Comment: Slightly under year to date target. Expect some catch-up in final 3 months

3. ITU Bed Days

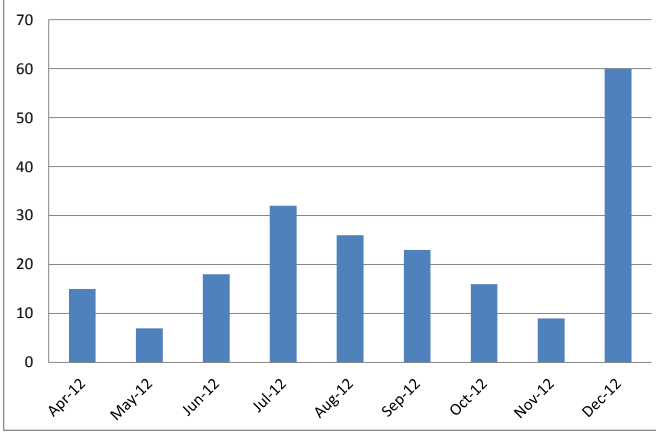
Desired direction of travel ↑



Description: **Total number of ITU bed days used per month**
Target: *Contractual target:* 814 bed days per month
Trend: Upward trend
Comment: Recent months seen increased demand as expected with winter pressures. Lower performance in year largely attributed to closure of neonatal ITU beds

4. Unused Theatre Sessions

Desired direction of travel ↓

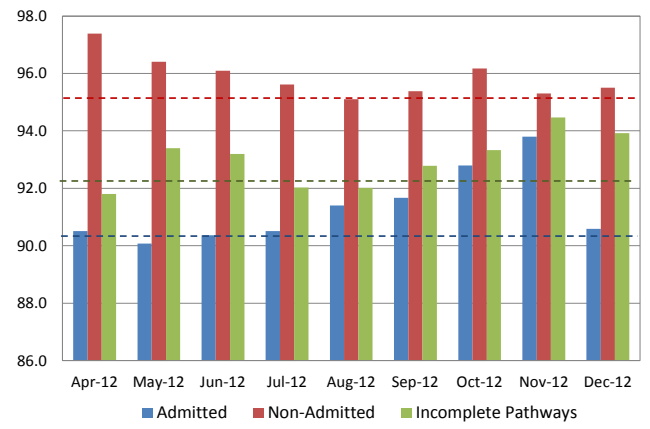


Description: **Total number of scheduled theatre sessions not used**
Target: *Internal target:* To be confirmed
Trend: Continued improvement since July 12 with exception of anticipated increase in December
Comment: December increase was as expected with Christmas holiday period and consultant/medical leave. Plans in place to reduce in future through new consultant leave policy from April 2013

Patient Access

5. Referral to Treatment Waiting Times

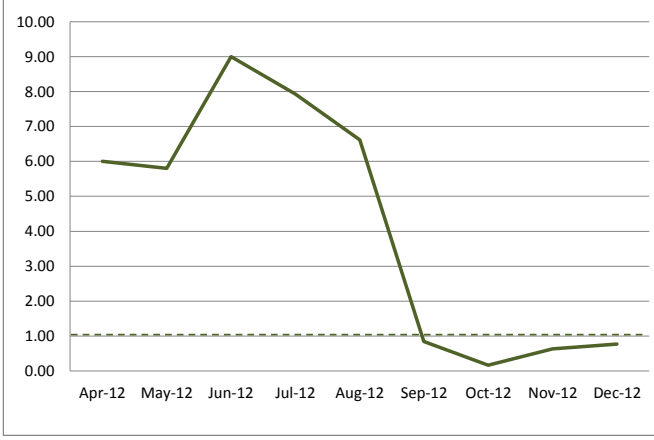
Desired direction of travel ↑↑↑



Description: **Referral to treatment waiting times for admitted and non-admitted patient pathways**
Target: *Monitor/Contractual target:* Admitted 90%, Non-admitted 95%, Incomplete pathways 92%
Trend: Adverse movement in Admitted performance reflecting low inpatient activity in December
Comment: Performance maintained above target across all three standards

6. Diagnostic Waiting Times

Desired direction of travel ↓

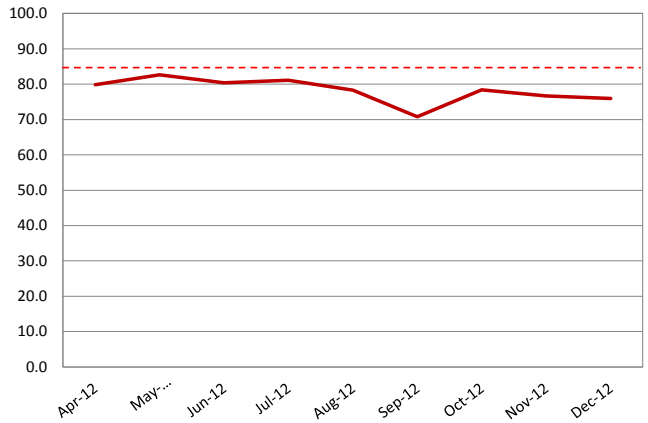


Description: **The proportion of patients waiting no more than 6 weeks for diagnostic test (across 15 national key diagnostic areas)**
Threshold: *Contractual target (likely to be Monitor target 2013/14):* <1%
Trend: Small adverse movement against previous month
Comment: Performance sustained under 1% threshold for fourth consecutive month

Patient / Referrer Experience

7. Discharge Summary Completeness

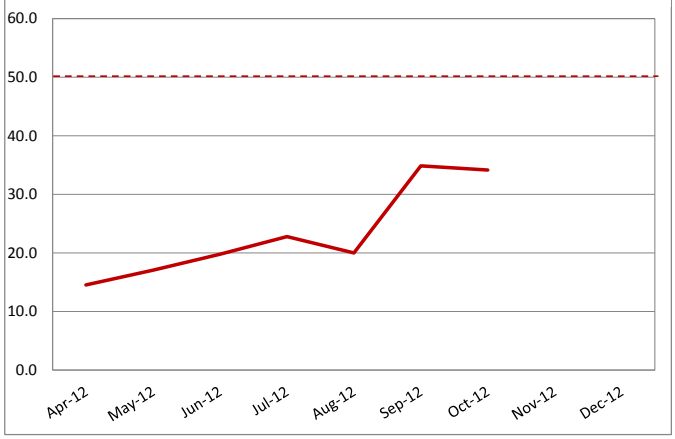
Desired direction of travel ↑



Description: **The percentage discharge summaries completed and sent within 24 hours of patient discharge**
Target: *Contractual target:* 85%
Trend: Adverse movement in performance since October 12
Comment: Plan in place to improve

8. Clinic Letter Turnaround

Desired direction of travel ↑

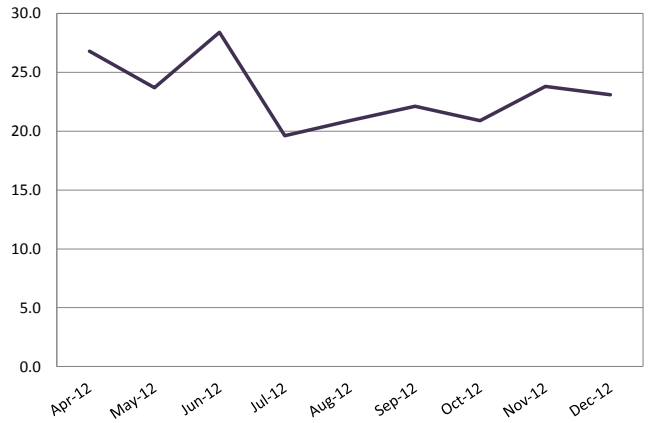


Description: **The percentage of clinic letters sent within five working days following patient clinic attendance & recorded on the Clinical Document Database (CDD)**
Target: *Contractual target:* 50%
Trend: Continued improved performance
Comment: A working group in place to progress performance. Reporting 2 months behind as recent data is skewed by letters not completed in a timely manner

Quality and Safety

9. Combined Harm Index

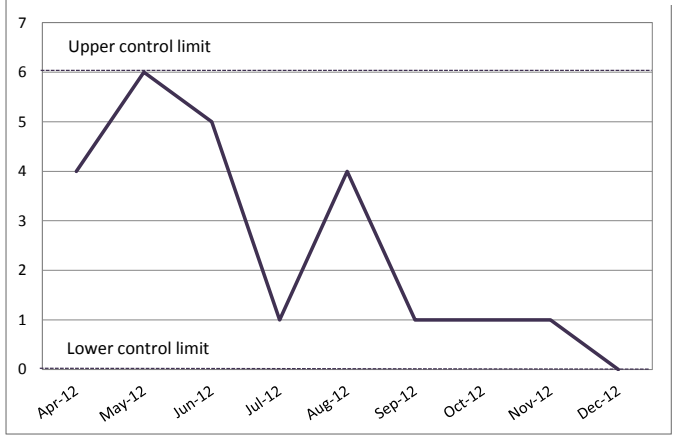
Desired direction of travel ↓



Description: **Harm index comprised of hospital acquired infections (CVL, serious incidents, non-ICU arrests, medication errors, falls, and pressure ulcers**
Target: *Internal target:* Year on year reduction
Trend: Small improvement in performance
Comment: No statistical change

10. Serious Patient Incidents

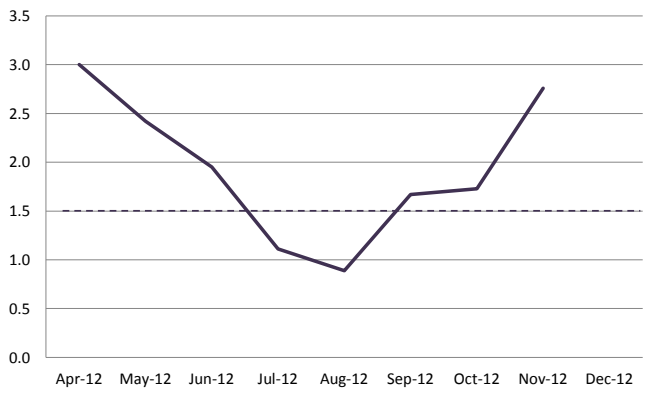
Desired direction of travel ↓



Description: **Defined as either - Unexpected/avoidable death of patient(s), staff visitors or members of public. Serious harm to patient(s), staff, visitors or members of public. Allegations of abuse. One of the core sets of 'Never Events'**
Target: *Internal target:* To remain within control limits
Trend: Improved performance with no SIs reported in December
Comment: Performance remains within statistical tolerance

11. Central Venous Line (CVL) Infections

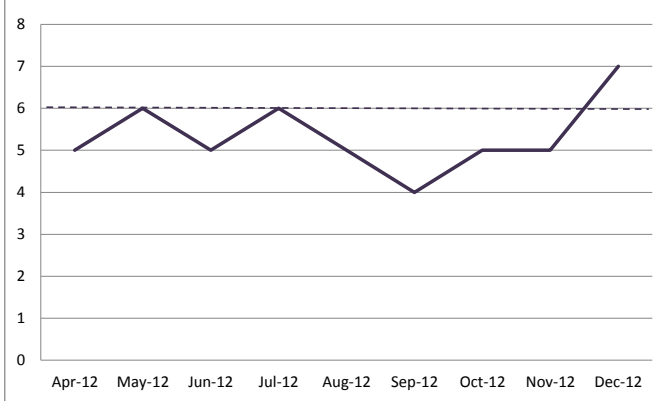
Desired direction of travel ↓



Description: **The number of CVLInfections for every 1000 Bed Days acquired at the Trust**
Target: *Internal target:* <=1.5
Trend: Adverse movement in performance since August 12
Comment: Performance remains within tolerance

12. Arrests Outside ICU

Desired direction of travel ↓



Description: **The monthly number of arrests (cardiac or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team)**
Target: *Internal target:* 50% reduction
Trend: Small adverse movement in performance
Comment: Performance remains stable

Monitor Governance Risk Rating

Targets - weighted (national requirements)		Threshold	Score Weighting	Reporting Frequency	Score Weighting				Score Weighting				Score Weighting			
					Month 1	Month 2	Month 3	Q1	Month 1	Month 2	Month 3	Q2	Month 1	Month 2	Month 3	Q3
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0	0	0	0	0	0	0	0	0	0	0	0
2	Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)**	0	1	Quarterly	0	0	0	0	0	0	0	0	0	0	0	0
3	All cancers: 31-day wait for second or subsequent treatment comprising either:		1	Quarterly	0	0	0	0	0	0	0	0	0	0	0	0
	Surgery	94%			0	0	0	0	0	0	0	0	0	0	0	0
	Anti cancer drug treatments	98%			0	0		0							0	0
	Radiotherapy (from 1 Jan 2011)	94%			0	0	0	0	0	0	0	0	0	0	0	0
5	Non Admitted within 18 weeks	95%	1	Quarterly	0	0	0	0	0	0	0	0	0	0	0	0
6	92% - 18 week referral to treatment time Incomplete Pathways Performance	92%		Quarterly	1	0	0	1	0	0	0	0	0	0	0	0
7	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0	0	0	0	0	0	0	0	0	0	0	0
8	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	0.5	Quarterly	0	0	0	0	0	0	0	0	0	0	0	0
				Total	**1**	**0**	**0**	**1**	0	0	0	0	0	0	0	0
				Overall governance risk rating	**Amber - Green**	**Green**	**Green**	**Amber-Green**	**Green**	**Green**	**Green**	**Green**	**Green**	**Green**	**Green**	**Green**

Monitor governance rating matrix	
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

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

*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

**Monitor's annual de minimis limit for cases of C. difficile is set at 12

GOSH Strategic Objectives - summary of progress at month 9

Work-stream	Action	Achievements so far this year	Still to do	**Overall Rating at end Q3 ***	**Q4 Forecast position**	**How do we measure progress?**
1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world						
Maintain our focus on Zero Harm	Continue our work to reduce drug errors.	Good progress on local transformation plans, highlighted in October Innovation Group where good practice was shared. Medicines policies have been updated.Medicines transformation post extended so regular reports and review of unit projects. Intelligent storage implemented in the Morgan Stanley wards, with evaluation underway. CIVAS continues to be expanded: syringe filler bid approved by CASP. Agreed which medicines to prepare in next phase. Charity bid submitted for ICI ward pharmacists.	Decision to be made re strategic future of CIVAS (pharmacy drug manufacture).	Amber as long term CIVAS future not agreed.	Green	Drug errors and trends reported for all high risk areas
	Continue our work on reducing infection rates.	Units all now have local infection control plan and most have an annual IPC Strategy. We have rolled out the surveillance of surgical site infections in all surgical specialties, implemented a shunt protocol and developed a combined infection dashboard.Trust wide IPC Audit programme in place. IPP have appointed an IV nurse. Antimicrobial stewardship committee formed. CUs committed to performing RCAs for all S. aureus bacteraemias	Agree future staffing arrangements (IPC Team have asked to recruit new trainee IPC nurse to support service and release senior time to work on improvement projects).	Amber as not all future plans for surgical surveillance agreed.	Green	Surgical site & central venous line infections reported across the trust. Combined infection index has been developed.
	Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.	On trajectory for commissioner safeguarding metrics on record keeping, supervision, training and attendance at Case Conferences	NHSLA requirements are higher still.	Amber as training levels not yet achieved.	Amber as may not achieve NHSLA training levels	Safeguarding metrics have been agreed with and are reported to commissioners
	Ensure effective provision of nutritional care for all patients.	We have achieved most of the milestones in the agreed action plans to achieve compliance with Care Quality Commission outcomes and national indicators. Trust is meeting the requirements of CQC outcome 5 on nutrition.	Further work to reduce fasting times. Implement the catering action plan.	Green	Green	We measure compliance with nutritional screening, height and weight audits, growth chart plotting
	Ensure provision of safe services for the deteriorating and critically ill child, including the development of a work plan in response to the critical care review.	Established baseline monitoring for 2222 and arrest calls. RECALL tool implemented for rapid review of all 2222 calls. Close to a statistically significant reduction. Critical Care Implementation Board established and new structure implemented. More ICU beds are being run than ever before but demand still exceeds supply.	Maintain momentum on use of SBARD (handover protocol) & CEWS (Children's Early Warning Scores). Continue to implement Critical Care Review.	Green	Green	We measure the use of SBARD and CEWS across the Trust, arrests outside ICU, and patients from outside GOSH refused ICU admission.
	Ensure consenting processes for treatment meet necessary standards and exceed patient and family expectations.	Approved new consent policy, addressed NHSLA L3, scoped project, identified project lead, collected baseline data, begun stakeholder engagement (including families), examined areas of good practice and General Medical Council Guidance. Project lead appointed.	Roll out plan to be developed.	Amber as progress slower than planned	Amber as progress slower than planned	Would anticipate a measurable improvement in parent satisfaction and a reduction in claims relating to consent.
Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	Continue developing outcome measures and benchmarking.	87% of specialties have identified a 3rd clinical outcome measure. Benchmarking questionnaires sent to 13 interested organisation with several responses received. Several clinical outcome measures now available in dashboard form on the GOSH intranet.	Increase outcome measures published on the website. Ensure all specialties identify a third clinical outcome measure. Establish more formal benchmarking with international children's hospitals.	Amber as we have yet to hit 3 for every specialty	Green	Progress monitored by Clinical Outcomes Board, and shown for each clinical unit at their quarterly reviews.
	Ensure accountability for delivery of CQUIN (Commissioning for Quality & Innovation) targets are fully devolved operationally and monitored regularly.	Commissioners have signed off 100% achievement of Q2 CQUINS.	The Quarter 3 position is due to be reported at end January 2013. Agreement of CQUINS for 2013-14.	Green	Green	CQUIN income for each Quarter v Total CQUIN achievable
2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations						
Continue to reduce waiting times further through our 'no waits' programme	Continue to meet national and commissioning standards for waiting times and improve the utilisation and efficiency of our resources.	Achieved diagnostic target in Q3 and maintained. Live reporting of urgent and routine MRI waits shows ongoing improvement.Continue to meet all national targets (i.e. cancer waits and 18 weeks).	Reduce the surgical cancellations due to ICU beds. Reduce MRI waiting times.	Green	Green	Waiting list KPIs (key performance indicators), theatre utilisation. MRI waits
Continually improve the standard of customer service that we offer patients and families	Implement year one of the Patient and Public Involvement and Experience (PPIE) strategic plan including the agreement of a method to measuring patient experience.	Completion of the Ipsos Mori Outpatient survey Establishment of the young members forum.	Organise a listening event for parents / adult members and subsequent action plan. A project plan is being drawn up to address the	Green	Green	CQUIN targets, reports to management board
Continue to improve our relationships with referrers in order to achieve our market share objective.	Continue to implement the actions for improvement following the results of the Referrer Survey including producing a directory, improving clinical letter turnaround times along with implementing an electronic bed management solution.	Much increased engagement with referrers. 2nd Referrer's Open Day was successful. Cardiac conference held and surgical conference planned. ICU capacity increasing.	Further work on discharge summary and outpatient clinic letter turnaround.	Green	Green	Outpatient turnaround times. Discharge summaries.

* Overall Rating (Green = on track, Amber = some delays or risks but plans should still be delivered by year end, Red = delays not retrievable by year end)

GOSH Strategic Objectives - summary of progress at month 9

Work-stream	Action	Achievements so far this year	Still to do	Overall Rating at end Q3 *	Q4 Forecast position	How do we measure progress?
Continue to improve the patient environment through major upgrades, working closely with our charitable partners	Invest within our 10 year capital programme to improve the patient environment within our existing buildings and continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the agreement of the full business case for 2B and the continuing progress of the case for 3A.	Morgan Stanley Clinical Building (MSCB) commissioned and fully opened. 2B FBC approved at Trust Board, and risk assessed by Monitor. 2B enabling Finance Agreement signed.	Approval of new programme dates for P2B in context of recommended P2B EW Programme and decisions re 3T MRI. Appointment of Design Team for Phase 3A.	Amber as progress slower than planned	Amber - as we are making progress but slower than planned.	Progress updates to Management Board
	Ensure that we maximise the advantages of our new clinical building.	All services have moved into the MSCB as planned (except craniofacial theatres). Hybrid business case agreed. Increased ICU capacity in use.	Increase in nursing establishment. Business case to open more beds on Eagle Ward. Post project evaluation of MSCB, including assessment of patient and staff views. Improve retention of ICU nurses.	Amber as not all planned theatre sessions yet running.	Green	Patient and family feedback. Activity/Income figures Post project evaluation.
3. Successfully deliver our clinical growth strategy						
Deliver our planned in year growth	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).	Activity has increased from last year. All wards in MSCB have been commissioned.	Continue to embed new theatre lists and open additional critical care capacity.	Green	Green	Activity/Income figures
Maintain International Private Patient (IPP) service growth	Improve patient access and staff recruitment and retention to ensure IPP income target growth is achieved (assuming income cap is lifted).	Staff recruitment. Relationship management with embassies. Activity increased to ensure opened beds are utilised. Review of strategy through working group with Members Council representatives.	Discussion of future strategy at TB and MC in January.	Green	Green	IPP income growth against last year and plan
Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	Achieve accreditation as a national paediatric centre for cardiac and Neuro-surgery through the new national processes, and plan to accommodate any further growth that arises from this process.	Accredited as Epilepsy centre from 1 November and agreed to work with Cambridge University Hospital as neurosurgical network. Designated as one of 2 London providers of children's cardiac surgery. Independent Review Panel visit went well.	Engagement with networks. Cardiac decision is subject to Independent Review Panel but we must work on our local implementation plan	Amber - due to uncertainties about the national decision on cardiac changes.	Amber - due to uncertainties about the national decision on cardiac changes.	Market share measures.
	Be intrinsically involved with the establishment of a North Thames paediatric network ensuring that we obtain the expected market share gains.	Excellent choice of Clinical Board appointed Opportunity to start working on specific clinical network to start	Identification by clinical board of a specific workplan.	Green	Green	Referral activity to GOSH going up
4. With partners maintain and develop our position as the UK's top children's research organisation						
Deliver the Research Strategy	Deliver the UCL GOSH Biomedical Research Centre (BRC) meeting milestones for year 1.	The BRC Scientific Board is meeting regularly to plan BRC strategy for the 5 year award term (2012-2017). The BRC Governance Board met for the first time on 20th December 2012. This will then be a quarterly meeting to oversee BRC activity. Budget arrangements are finalised and being managed by both the BRC Manager and R&I Finance Manager. Theme working groups have been established for three of the four themes, with the other to be arranged in an 2013. Pump priming funding has been launched and awarded in two themes and another	In Q4 work will be undertaken to begin to collect research output information from researchers now that they have been engaged through the theme steering groups. The Research Database will be improved to capture this imformation during Q4. Financial balance must be reached by the end of Q4,which will require management of invoicing with UCL.	Green	Green	R&I Board feedback to Management Board.
	Continue to develop academic and commercial partnerships for research.	UCLB annual report received. UCLB - BRC Proof of concept award funding projects with potential to generate IP has funded one project in 2012. The IP policy was reviewed at the Policy committee in Feb 2012 who recommended the addition of policies for management of	Funding for at least 1 IP lead project using the BRC PoC fund in Q4. Finalisation of IP policy including section for IP management across all GOSH divisions.	Green	Green	R&I Board feedback to Management Board.
	Increase research activity and income for the Trust, and measure and report impact.	The R&D Office has updated its database to begin to collect and report research data per clinical unit. KPIs have been reviewed by the R&D Office with steer from the R&I Board; revised KPIs will be reported at the next R&I meeting. Process has been established for reporting NIHR patient recruitment	We need to consider how we might capture patient recruitment data prospectively across the Trust to make NIHR reporting more streamlined. Need to successfully submit the NIHR report in January 2013.	Amber as income to GOSH has not increased.	Green	R&I KPIs
Continue to improve the mechanisms for the management of research within the Trust	Continue to improve the mechanisms for the management of research within the Trust in line with NIHR requirements.	Participating in the UCLP pilot to streamline authorisation of commercial research.	Measure and deliver the new targets for time to approval, first patient and recruiting to target.	Amber as targets not yet achieved.	Green	R&I KPIs
5. Be the provider of choice for specialist paediatric education and ensure our staff have the skills they need.						
Deliver the Education and Training Strategy	Deliver education, training and organisational development to support service transformation at GOSH.	Annual plan on track; All live mandatory training data (other than safeguarding) now on Information Services site. Supported NHSLA acheivement.	Training database replacement not completed as aresult of requirement to approach Technical Delivery Board for funding. Funding not yet secured for Clinical Skills and Simulated learning facility	Amber as funding yet to be finalised for sim suite and training database	Amber due to delay with database.	Statutory training rates in KPI reports
	To work with our partners to market our education and training programmes locally, nationally and globally.	Kuwait project on track.	Currently working on expanding international education through GOSH proposal to run specialist hospital facility.	Green	Green	Kuwait contract monitoring process Dubai bidding process

* Overall Rating (Green = on track, Amber = some delays or risks but plans should still be delivered by year end, Red = delays not retrievable by year end)

GOSH Strategic Objectives - summary of progress at month 9

Work-stream	Action	Achievements so far this year	Still to do	**Overall Rating at end Q3 ***	**Q4 Forecast position**	**How do we measure progress?**
6. Deliver a financially stable organisation						
Agree achievable CRES plan and ensure delivery through robust project and performance management	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.	CRES identified above Long Term Financial Model plan but slightly below targeted level. The majority of high value schemes have been risk assessed for quality and safety impact. Total 2013-14 CRES schemes identified £16.8M.	Finalise CRES targets for 2013-14	Green	Green	CRES delivered and identified. Financial position.
		Ahead of cumulative surplus plan	Fully deliver CRES in 12/13 and complete detailed plans for 2013/14 CRES	Green	Green	Financial position
Improve efficiency and productivity through our Transformation Programme	Deliver operational efficiencies through the devolved Transformation team and engine-room projects including Theatres, Beds and MRI usage.	The number of emergency operations carried out within target classification has increased. Utilisation of planned theatre hours has increased in many areas across all the clinical units, including MRI (although not overall as a Trust). Trust wide there has been an increase in the total number of operations. There have been increases in the completion of the WHO checklist in all areas across the Trust. We have seen an increase in the number of emergency referrals accepted by the Bed Management team.	Ensure additional capacity is utilised efficiently.	Green	Green	Theatre utilisation. Activity and income levels.
	Develop workforce to improve productivity and enhance patient experience.	Workforce numbers are below the level at the start of the financial year (although still above plan) despite higher activity levels. Agreed plan to remodel ward staffing with better support to wards. First apprentices have been recruited into the Trust. Reporting schedule agreed.	Need to tie delivery of CRES plans and workforce implications together more consistently.	Green	Green	Workforce numbers now compared to March 2012
Ensure appropriate funding for our clinical services from commissioners	Work with other specialist paediatric providers to develop rationale for changes in specialist tariffs.	Collaborative working with Department of Health and other paediatric trusts has resulted in some changes to tariff of benefit to paediatric trusts. Road testing of 2013-14 tariff carried out	Negotiating on BMT and Haemonc prices.	Green	Green	Updates from Director of Finance to Management Board.
	Ensure risks of changes to commissioning structures are managed and minimised and new commissioning support processes are established in collaboration with the specialist commissioner.	Monitoring impact of change is on-going. Work to identify " minimum take" has been completed with good working relationships between Contracts/Information Teams and Local Specialist Commissioning Group. Analysis of activity using specialist definitions completed.	Negotiating contracts for 2013/14.	Green	Green	Updates from Director of Finance to Management Board.
Support the charity to raise targeted funds	Maintain good communication between GOSH and GOSH Charity at all levels to ensure fund-raising targets are met.	Completion of fundraising for MSCB. Recruitment of fundraising Board for Rare Diseases. Structure/approach for 3A governace and project management progressed. Finance Agreement signed. Fundraising currently ahead of year to date target.	Architects appointed for phase 3A and clarity on which teams/activities will be included. More information re occupation/activity within phase 2B to enable more fundraising to take place.	Amber due to uncertainty around 2B content and timetable.	Green	Charity gross fundraising income v plan
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation						
Develop as a Foundation Trust	Develop the function of the members council and maintain the membership.	Development of committees and meetings held in quarter 4. Recommendations made to the Council on the IPP Strategy. Seminar on finance and quality arranged.	Further work required to enhance the Council workplan for the year - work has commenced and paper to January Council	Green	Green	Member numbers v previous months
Ensure that the Trust is compliant with regulatory requirements	Ensure that the Trust retains registered status as a Foundation Trust, with Care Quality Commission (CQC) along with attaining NHSLA level 3.	No concerns with FT registration. Retained CQC registration. Achievement of NHSLA level 3.	Develop actionplan for follow up NHSLA visit. Deloitte audit.	Green	Green	Monitor and CQC feedback, NHSLA result
Improve efficiency of business processes	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.	Work to improve recoirding of nationally commissioned activity almost complete. Reports now issued monthly to clinical units to identify coding discrepancies. Further unit specific reports made available using the new Qlikview tool.	Review of Information Asset Owner roles and responsibilities. Continue to progress data quality action plan and publication of further indicators on intranet.	Green	Green	
	Develop a robust Information Strategy including appropriate SMART objectives and a clear delivery plan.	Information Strategy presented to Trust Board and Trustees.	Improve clinical engagement and ensure Information Strategy is adopted and a fully resourced and funded delivery plan is devised and agreed.	Amber as delivery plan yet to be agreed.	Amber as delivery plan yet to be agreed.	
	Deliver the Trust's Information Technology plan - including successful implementation of CareVue, PACs and Order Comms.	Care Vue and PACS phase 1 complete. Electronic Document Management (EDRMS) project supplier shortlist of 2. We now have a highly resilient server and storage infrastructure that allows us to minimise the impact of issues on end users. New managed services contract for ICT Operations gone live.	Implement Order Comms. Identify preferred providers for EDRMS. Complete CareVue and PACS second phases. Agree refreshed Information and I.T. strategy.	Amber as Order Comms implemenation has slipped.	Green	I.T. updates to Management Board from the Technological Appraisal Board
	Continue to develop management and leadership across the Trust including specific plan to target Specialty Leads.	Leadership programme launched. Ongoing good feedback from management and leadership development programmes. Improved information available to managers on appraisal and training rates.	Undertake a needs analysis of specialty leads. Maintain momentum on appraisals.	Amber as more support to Specialty Leads required.	Green	Appraisal rates are included in the KPI report.

* Overall Rating (Green = on track, Amber = some delays or risks but plans should still be delivered by year end, Red = delays not retrievable by year end)

Appendix 3

CRES Position at Month 9

	2012/13					2013/14				
Division	**Delivery target**	**Total identified**	**Risk adjusted total**	**Risk adjusted variance**	**Schemes completed**	**Delivery target**	**Total identified**	**Risk adjusted total**	**Risk adjusted variance**	**Schemes completed**
Critical Care and Cardiorespiratory	3,576,600	2,534,591	2,310,961	-1,265,639	744,418	3,916,697	3,342,830	2,821,893	-1,094,804	0
ICI	2,678,200	2,096,442	2,072,415	-605,785	1,410,592	2,163,631	1,569,938	1,684,327	-479,304	0
International	1,022,000	2,269,152	2,220,956	1,198,956	2,051,960	664,439	1,230,005	1,061,257	396,818	0
MDTS	2,154,000	1,750,116	1,661,997	-492,003	957,707	2,622,255	2,410,920	2,012,611	-609,644	0
Neurosciences	1,383,000	1,667,878	1,633,147	250,147	624,297	1,418,021	1,558,385	1,690,954	272,933	0
Surgery	2,039,326	2,491,162	2,424,008	384,682	856,007	2,354,564	2,568,972	2,043,255	-311,309	0
Corporate facilities	1,214,900	978,166	936,249	-278,651	628,086	1,028,313	1,408,260	1,290,624	262,311	0
Clinical & Medical Operations	281,400	315,452	314,856	33,456	281,316	302,339	451,937	420,168	117,829	0
Corporate affairs	152,600	146,291	146,224	-6,376	139,559	120,933	115,975	99,167	-21,766	0
Estates	749,300	403,913	396,773	-352,527	146,363	783,191	869,400	744,135	-39,056	0
Finance & ICT	810,082	495,599	478,502	-331,580	157,626	764,761	661,407	575,411	-189,350	0
HR & workforce	256,200	171,441	170,618	-85,582	166,645	191,918	173,606	150,070	-41,848	0
Nursing & Education	347,200	330,685	327,645	-19,555	206,657	283,103	293,703	252,985	-30,118	0
R&I	53,200	28,000	28,000	-25,200	28,000	33,478	47,500	38,000	4,522	0
Total	**16,718,008**	**15,678,887**	**15,122,348**	**-1,595,660**	**8,399,231**	**16,647,643**	**16,702,838**	**14,884,856**	**-1,762,787**	**0**
			90%		**50%**			**89%**		**0%**

Current year delivery

At month 9, the value of identified CRES schemes for 12/13 is £15.7m, an improvement on the month 8 position of £14.4m. The risk adjusted figure has improved to £15.1m from £14.0m. The improvement in the position reflects the identification of additional savings, especially in the Surgery Unit and the progression of schemes from amber to green. However, having made good progress from July to October, movement of schemes to blue slowed in November and December. The majority of remaining schemes are green and the focus for the coming month will be on reviewing these to ensure that they are able to progress to blue by the end of the year.

The Critical Care and Cardiorespiratory Unit have the biggest variance against target and a significant proportion of this relates to the Intensive Care units, where income has been affected by bed closures. Unit management are working to address this by speeding nurse recruitment and to ensure that beds remain open and activity has increased since the reconfiguration of the units.

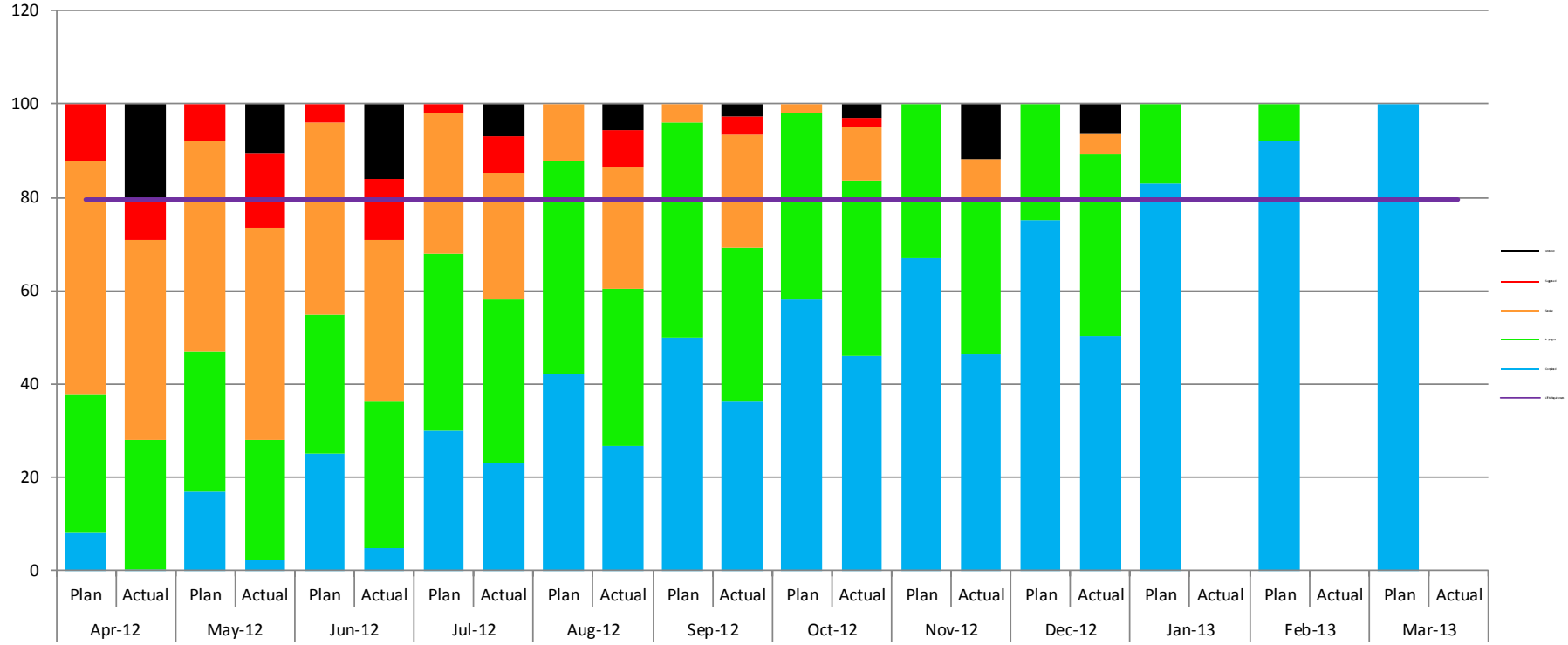
2013/14 planning

Final targets for 13/14 need to be confirmed and a piece of work to do this should be complete this month.

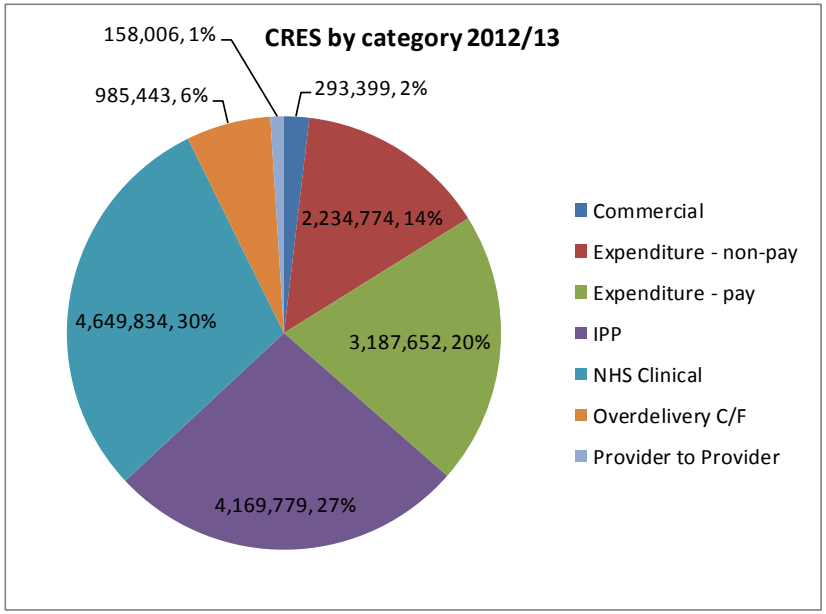
Clinical units have made good progress in identifying schemes supported by the development of seven Trust wide themes. The five NHS clinical units have presented their CRES plans to members of the executive team and a similar process will be undertaken for the larger corporate units. Units have been asked to continue to identify new savings to ensure that there is sufficient contingency in the events of planned savings slipping. Compared to the current year, private patient income currently makes a up a smaller proportion of 13/14 CRES, while pay and non-pay savings and NHS income make up a higher proportion of planned CRES.

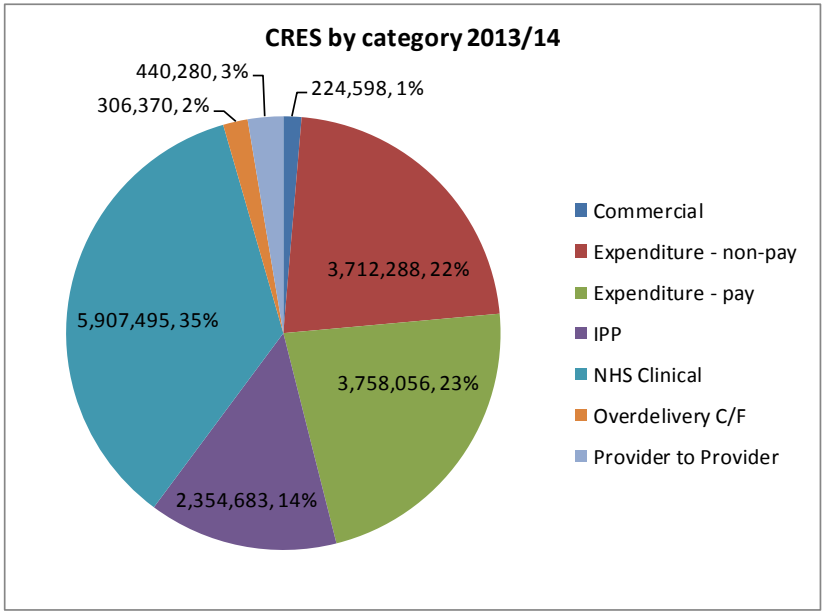
CRES programme, saving trajectory 2012 / 13

Savings are shown as a percentage of target, use the yellow cell at the bottom to view data by unit or the total



	Apr-12		May-12		Jun-12		Jul-12		Aug-12		Sep-12		Oct-12		Nov-12		Dec-12		Jan-13		Feb-13		Mar-13	
Unfound	0	20	0	11	0	16	0	7	0	6	0	3	0	3	0	12	0	6	0	0	0	0	0	0
Suggested	12	9	8	16	4	13	2	8	0	8	0	4	0	2	0	0	0	0	0	0	0	0	0	0
Scoping	50	43	45	45	41	35	30	27	12	26	4	24	2	11	0	8	0	5	0	0	0	0	0	0
In progress	30	28	30	26	30	31	38	35	46	34	46	33	40	38	33	34	25	39	17	0	8	0	0	0
Completed	8	0	17	2	25	5	30	23	42	27	50	36	58	46	67	46	75	50	83	0	92	0	100	0


CRES by category 2012/13
158,006, 1%
293,399, 2%
985,443, 6%
2,234,774, 14%
4,649,834, 30%
3,187,652, 20%
4,169,779, 27%
Commercial
Expenditure - non-pay
Expenditure - pay
IPP
NHS Clinical
Overdelivery C/F
Provider to Provider


CRES by category 2013/14
440,280, 3%
224,598, 1%
306,370, 2%
3,712,288, 22%
5,907,495, 35%
3,758,056, 23%
2,354,683, 14%
Commercial
Expenditure - non-pay
Expenditure - pay
IPP
NHS Clinical
Overdelivery C/F
Provider to Provider

Great Ormond Street Hospital for Children NHS Foundation Trust

PERIOD 9 - 2012/13 FINANCE REPORT

1 Month 9 year to date

Comparison of the high level revenue account compared to last financial year:

Table 2.2 £'M	**Actual M9 YTD**	**Last year M9 YTD**	**Var**	
NHS clinical	193.4	186.4	7.0	3.8%
Other clinical	34.4	24.0	10.4	43.3%
Non clinical	34.5	35.3	(0.9)	-2.4%
Revenue on Continuing Operations	**262.3**	**245.8**	**16.6**	**6.7%**
Haringey	0.0	1.6	(1.6)	
Total Revenue	262.3	247.4	15.0	
Pay	(148.0)	(143.3)	(4.7)	3.3%
Non-pay	(94.8)	(86.8)	(8.0)	9.2%
Expenditure on Continuing Operations	(242.8)	(230.1)	(12.7)	5.5%
Haringey	0.0	(1.6)	1.6	
Total Operating Expenditure	(242.8)	(231.7)	(11.1)	
Non op expend /gains	(16.0)	(15.2)	(0.8)	5.2%
Net surplus	**3.6**	**0.5**	**3.1**	

Note: Discontinued activities (Haringey) shown separately and donations for capital expenditure excluded.

This shows that income has grown by 6.7% and expenditure by 5.5%. Included within the non-pay expenditure growth are the running costs of the MSCB and ongoing double running costs of the Cardiac wing.

Income increased despite reductions applied to the NHS tariff and this is a result of activity growth, case mix and IPP activity which has benefited from both volume and price increases.

The exceptional gain relates to income received from a third party for use of a redundant power connection.

2 FINANCIAL RISK RATING

The current ratio score is 4 and this is unchanged from period 8.

Month 9 – MONITOR basis	**Rating**
EBITDA Margin	3
EBITDA % Achieved	5
ROA	3
I&E Surplus margin	5
Liquidity Days	4
Weighted Average	4
Overall Score	**4**

3 INCOME

3.1 NHS Clinical Income

- NHS clinical income is £193.4M YTD and £18.9M in month 9, which was lower than plan by £0.6M in the month and cumulatively lower by £1.1M. As reported previously the 2012/13 income position includes £1M that relates to 2012/13.
- Excluding pass through income the cumulative position is £2.3M lower than plan and excluding 2011/12 income is 3.3M lower than plan.

3.1.1 Inpatient combined (i.e. elective, non-elective and day cases) is £0.7M ahead of plan

- ***Medicine and DTS are*** **£0.6M favourable YTD** – unchanged from period 8
  Day case activity is ahead of plan in a number of specialties including; Endocrine, Metabolics, Nephrology and Gastro with additional beds in use. Elective activity is below mainly in Endocrinology, Gastro and metabolic, whilst Nephrology and Radiology are ahead of plan. Non-elective activity is ahead of plan mainly the result of higher Nephrology activity in respect of renal transplants.

- ***Cardiac*** **is below plan YTD by £0.4M** – an improvement of £0.3M from period 8
  Day case income is below plan in Cardiology but ahead on activity reflecting case mix and there is lower activity in Cardiac Surgery and Cardiothoracic. Elective cardiac income is below plan though this is partially offset be non-elective work – the unit is experiencing long stay patient stays in CICU impacting on elective throughput.

- ***Neuroscience is*** **£0.3M above plan YTD** – a deterioration of £0.2M since period 8.
  Day case activity is higher than plan mainly in Neurology and this is mainly case mix as well as higher throughput as a result of theatre changes. Elective income is lower than plan mainly in neurosurgery and partially reflecting reduced consultant availability and ophthalmology activity is lower than planned at this point. Non-elective activity is ahead of plan and largely offsets the shortfall on elective activity and reflects high value neurosurgery work being undertaken in the unit.
- ***Surgery is £0.1M ahead of plan*** – an improvement of £0.8M since period 8.
  Day case activity is lower than plan with Orthopaedic and Urology activity below planned levels, elective activity is on plan though lower than planned income in ENT, Orthopaedics and Urology is offset by higher than plan Spinal activity- this is partly a budget setting issue and Plastics activity.

3.1.2 Outpatient income is £0.7M behind plan– an improvement of £0.1M since period 8
The main shortfalls against plan are recorded in ICI and Surgery, whilst Cardiac and Neurosciences are ahead of plan at this point.

3.1.3 HDU & ITU bed day income combined is £2.3M behind plan– unchanged since period 8

HDU is £1M lower than plan as a result of the reduction in the Haem/onc tariffs - £0.8M of this variance relates to a change in contractual arrangements for Haem/ONC that occurred after the plan was set.

ITU bed day income is £1.3M lower than plan and this reflects reduced bed closures in Cardiac during the year associated with staffing difficulties in the main. Neurosciences is also behind its income plan and this largely reflects a shortage of consultant capacity during the year.

3.1.4 NCG Income is £0.9M behind plan – an improvement of £0.3M since period 8
The majority of the shortfall of income against plan is in Cardiac (heart and lung transplants as well as pulmonary hypertension) and ICI (lower SCIDS activity although this will reverse).

3.1.5 Other NHS clinical income is £0.9M ahead of plan - £0.1M below plan if the old year income of £1M is excluded. The largest element is lower BMT activity than planned.

3.2 Non-NHS clinical income is £9M ahead of plan

- IPP is above the target by £8.6M and achieved £0.8M ahead of the in-month plan
- Overseas Income is £0.4M ahead of plan

3.3 Non Clinical Income is £2.9M behind plan

Non clinical income is £2.9M behind plan excluding capital donations. The principal variances are Education and R&I lower than plan. To some extent both of these variances are considered timing issues and charitable revenue income is lower and this reflects spend that can be recharged as it occurs as well as specific revenue allocations.

4 Expenditure

4.1 Pay

Pay expenditure totals **£148.0M**, £2.7M higher than plan.

- **Consultant pay** at **£27.9m** is below plan by £1.5M YTD. Cardiac is below plan by £0.6M and ICI by £0.2M as a result of vacancies. Research and Innovation is £0.4M lower, primarily within charity funded projects where research activity is behind plan. This is directly offset by an adverse income variance.
- **Other *doctors pay costs at £16.2M is*** overspent by £0.9M YTD. Key areas of pressure lie within Surgery (£0.3M), Cardiac (£0.2M), Neuro (£0.1M) and International (£0.1M). These pressures are mainly due to using temporary staffing to cover vacancies, maternity, sick leave and other rota gaps. The level of overspend in month 9 is lower than trend as a result of budget realignment within Neuro.
- **Nursing pay at £47.9M** is overspent by £0.6M YTD, mainly due to activity and case mix related pressures which are partially offset by uncovered vacancies within Cardiac, IPP and Nursing & Workforce. The month 9 variance is more favourable than trend as a result of budget realignment within Research & Innovation.
- ***Scientific and therapeutic pay at £25.6M is*** £0.2M overspent YTD within Pharmacy, Radiology and Pathology. This is due to using temporary staff to cover vacancies and sick leave. Expenditure in month 9 was higher than trend due to a number of new starters and additional temporary staff costs incurred to support activity over the Christmas period.
- ***Management and administrative pay at £27.7M*** is on plan YTD.

- **Agency costs**

Junior doctors	£0.27M
Nursing	£1.02M
Sci, Ther, Tech	£0.70M
Non-clinical	£2.13M
Total	£4.12M (representing 2.8% of the pay bill to Dec 2012).

4.2 Non pay

Non-pay expenditure totals **£94.8M**, which is £0.2M below plan.

- ***Drug expenditure*** is £2.4M below budget YTD, excluding pass through.
- **Blood expenditure** is on plan YTD, excluding pass through.
- ***Clinical supplies & services*** expenditure is overspent by £1.2M YTD, excluding pass through. ICI is overspent within Pathology as a result of activity increases. MDTS is overspent within Pharmacy and Genetics due to activity increases. Some of this is a historic cost pressure to be addressed through budget reallocation. Berlin Heart expenditure is also higher than planned within Cardiac. The higher than trend

overspend has resulted from high expenditure on cochlear implants and associated devices in month 9.

- ***Services from NHS organisations and Healthcare from non-NHS bodies*** are £1.2M underspent YTD. This lies mostly within R&I and is due to project delays or delays in invoicing from other organisations on a number of grants. This is directly offset by income underperformance.
- ***Premises costs*** are £0.9M overspent YTD, mostly due to a £0.8M provision for revenue expenditure to be transferred from capital.
- ***Education & research*** costs are underspent by £1.0M. Key underspends are within Nursing & Workforce and R&I, resulting from expenditure timing.
- ***Pass through*** expenditure is overspent by £1.2M to date. Expenditure on Factor 8 is £1.4M higher than planned due to the transfer of activity from Imperial and a number of extremely high cost patients. This is directly offset by income overperformance.

5 STATEMENT OF FINANCIAL POSITION

5.1 Non-Current Assets

Non-current Assets at the end of December 2012 totalled £342.2M, a net decrease of £1.8M over the previous month. This decrease was largely due to depreciation.

5.2 Capital expenditure

The Trust's capital plan for the 9 months ending 31 December 2012 is £40M. The total spend to date amounts to £14M representing an under spend to date of £26M.

	Annual Plan £M	Plan YTD £M	Actual YTD £M	Variance £M	Forecast Outturn £M
Hospital Redevelopment	32.9	24.7	6.1	18.6	13.2
Estates Maintenance Projects	6.2	4.7	2.8	1.9	5.6
Facilities Projects	0.4	0.3	0.2	0.1	0.3
IT Related Projects	4.5	3.4	1.8	1.6	3.2
Medical Equipment Purchases	9.2	6.9	3.1	3.8	4.1
Total Additions in Year	**53.3**	**40.0**	**14.0**	**26.0**	**26.4**
Asset Disposals	0	0	0	0	0
Donated Funded Projects	-43.4	-32.5	-10.0	-22.5	-18.5
Trust Funded Projects	**9.9**	**7.5**	**4.0**	**3.5**	**7.9**

Redevelopment

£6.1M to date primarily due to the equipping and commissioning of the Morgan Stanley Clinical Building (£3.0M) and Phase 2B Enabling (£2.9M). This also includes accrual for the disputed VAT repayment, where the Trust has now been informed of its successful appeal.

Estates and Facilities

Expenditure of £2.8M to date; £2M on Trust funded schemes and £0.8M on Donated schemes.

IT projects £1.8M to date, resulting in current year slippage of £1.6M.

Medical Equipment Projects £3.1M to date;, with £1.2M relating to the Re-equipping of the Ocean Theatres, resulting in current year slippage of £3.8M.

Disposals amounted to £41K in the 9 month period.

Forecast
Following delays in starting Phase 2B enabling works, will result in expenditure on the Redevelopment Programme slipping into subsequent years by £19.7M. Forecast underspends in Trust funded projects are also due to slippage of project expenditure into next financial year.

5.3 Current Assets (excluding Cash & Cash Equivalents) -decreased in month by £3.9M

Prepayment & Accrued Income (£1.6M decrease)	The decrease is primarily due to a decrease in IPP work in progress (£0.6M), a decrease in the PCT & Consortia Exclusions accrual (£0.5M), a decrease in Rent & Rates Deferral (£0.2M) and a decrease in Prepayments (£0.2M).
Capital Receivables (£2.6M decrease)	Routine month on month changes

5.4 Current Liabilities - increased by £0.9M

Expenditure Accruals (£2.2M increase)	The increase is primarily due to an increase in accruals following the reduced level of payments processed during the holiday period.
Capital Payables (£1.4M decrease)	Similar reasons to the change in capital receivables.

6 WORKING CAPITAL

6.1 The Trust had cash holdings of **£28.3M** at 31December 2012, and had operating cash balances of between £25.6M and £42.8M throughout the month.

6.2 Trade Debt
Debt is £8.0M higher than this time last year. This is largely due to higher IPP debt (£6.3M), and higher NHS debt (£1.1M) with higher levels in both NHS and non NHS overdue categories which are being addressed:

	31-Dec-12	*Overdue > 30 days*	**31-Dec-11**	*Overdue > 30 days*
NHS	6,050	*34%*	4,917	*28%*
Non-NHS	2,983	*70%*	2,505	*16%*
International	14,905	*34%*	8,648	*32%*
GOSH CC	611	-	561	*53%*
	24,549		**16,631**	

NHS debt is £6.0M with £3.8M outside of terms. The largest overdue NHS debtor is Camden PCT , the majority relating to funds due for overseas patients which is allocated by DH and has yet to be paid to Camden (£1.26M).
Non NHS debt includes some long outstanding amounts from UCL/ICH and the issue has been escalated with some cash received in January. There are also amounts due to ICH in creditors.

6.3 Trade payables
Trade payables (excluding capital) were £8.9M. The value of registered invoices due totalled £5.9M at 31December; a reduction of £0.5M from the previous month.
BPPC is cumulatively 84.5% by invoice count and 82.2% by value.

7 SALARY OVERPAYMENTS
There was one salary overpayment in December 2012 with a value below £1K.

Great Ormond Street Hospital for Children NHS Foundation Trust Finance and Activity Performance Report Period 9 2012/13 Contents

Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Period 9 2012/13
Dashboard

Trading Position - Trust Summary £m	Month ACTUALS	Month BUDGET	Month VARIANCE	% variance	YTD ACTUALS	YTD BUDGET	YTD VARIANCE	2011/12 ACTUAL YTD	2012/13 YTD actual variance to 11/12 YTD actual
NHS CLINICAL	£18.9	£19.5	-£0.6		£193.4	£194.5	-£1.1	£188.0	£5.4
NON NHS CLINICAL	£3.6	£2.8	£0.8		£34.4	£25.4	£9.0	£24.0	£10.4
OTHER INCOME	£4.0	£4.2	-£0.2		£34.5	£37.4	-£2.9	£35.3	-£0.9
INCOME TOTAL (excl Capital Donations)	£26.5	£26.4	£0.1		£262.3	£257.3	£5.0	£247.4	£15.0
INCOME TOTAL (incl Capital Donations)	*£26.1*	*£30.1*	*-£4.0*		*£272.4*	*£289.8*	-£17.5	*£251.9*	*£20.4*
PAY	-£16.3	-£16.0	*-£0.2*		-£148.0	-£145.3	-£2.6	-£144.9	-£3.1
NON PAY	-£9.7	-£9.7	*£0.0*		-£94.8	-£95.0	£0.2	-£86.8	-£8.0
EBITDA (excl Capital Donations)	**£0.6**	**£0.7**	**-£0.2**		**£19.6**	**£17.0**	**£2.6**	**£15.7**	**£3.9**
EBITDA Margin/ % of plan (excl Capital Donations)			**79%**		**7.5%**	**6.6%**	**115%**	**6.3%**	
Depreciation	-£1.6	-£2.1	£0.5		-£12.1	-£14.2	£2.1	-£10.9	-£1.2
Impairments	£0.0	£0.0	£0.0		£0.0	£0.0	£0.0	£0.0	£0.0
PDC	-£0.5	-£0.5	£0.0		-£4.4	-£4.3	-£0.2	-£4.3	-£0.1
Profit / loss of the disposal of assets	£0.5	£0.0	£0.5		£0.5	£0.0	£0.5	£0.0	£0.5
Interest	£0.0	£0.0	£0.0		£0.0	£0.0	£0.0	£0.0	£0.0
SURPLUS (excl Capital Donations)	**-£1.0**	**-£1.8**	**£0.8**		**£3.6**	**-£1.5**	**£5.1**	**£0.5**	**£3.1**
SURPLUS % of Plan (excl Capital Donations)			**55%**				**246%**		
EBITDA MARGIN					**3**	**3**	0	3	0
EBITDA ACHIEVEMENT					**5**	**5**	0	4	1
RETURN ON ASSETS					**3**	**3**	0	3	0
I&E SURPLUS					**5**	**5**	0	4	1
LIQUIDITY					**4**	**4**	0	2	2
Overall FRR Perfomance					**4**	**4**	**0**	**3**	1

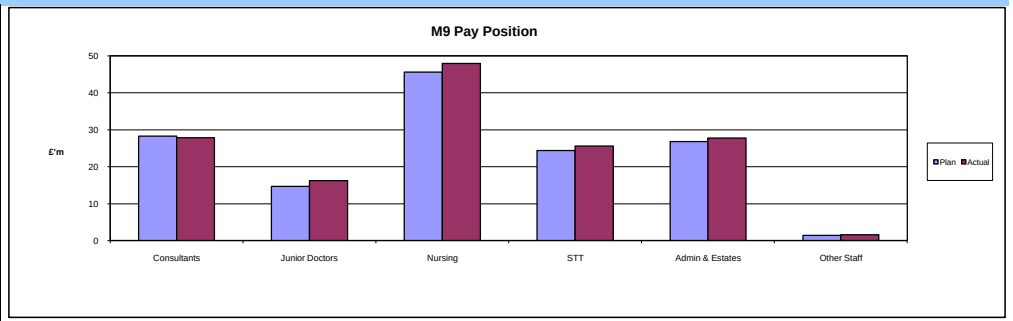
Trading Position - Unit Summary £m	Pay			% of Contribution Variance	Non Pay			Income			Contribution			Reallocation of IPP outlier costs		Contribution		
	Actual	Variance	% Variance		Actual	Variance	% Variance	Actual	Variance	% Variance	Actual	Variance	% Variance	Actual	Variance	Actual	Variance	% Variance
Cardiac	-£28.1	£0.1	0.2%		-£11.9	-£1.6	-15.1%	£55.2	-£1.9	-3.3%	£15.2	-£3.4	-18.1%	£1.3	£0.6	£16.6	-£2.8	-15.0%
Neurosciences	-£13.7	£0.0	0.0%		-£3.3	-£0.7	-27.5%	£20.6	£0.5	2.6%	£3.6	-£0.2	-4.8%	£0.2	£0.0	£3.8	-£0.1	-3.5%
ICI	-£22.8	£0.3	1.4%		-£19.9	-£2.5	-14.4%	£43.9	-£0.6	-1.4%	£1.2	-£2.8	-69.9%	£0.2	£0.1	£1.5	-£2.7	-66.8%
MDTS	-£27.9	-£0.9	-3.2%		-£18.6	£0.6	3.0%	£35.7	£0.1	0.2%	-£10.9	-£0.2	-1.9%	£1.5	£0.4	-£9.4	£0.2	2.0%
Surgery	-£23.6	-£0.9	-4.1%		-£9.8	-£1.0	-10.9%	£37.2	-£0.6	-1.6%	£3.7	-£2.5	-40.1%	£1.9	£0.2	£5.6	-£2.3	-36.3%
International	-£5.8	£0.2	3.2%		-£5.6	-£0.2	-4.5%	£31.9	£1.1	3.6%	£20.5	£1.0	5.4%	-£5.1	-£1.4	£15.4	-£0.4	-1.9%
Corporate Facilities	-£4.5	£0.0	-0.4%		-£7.2	-£0.6	-9.9%	£0.7	-£0.1	-7.1%	-£11.0	-£0.7	-6.9%			-£11.0	-£0.7	-6.9%
Research & Innovation	-£4.4	£0.4	8.9%		-£1.2	£1.3	53.0%	£10.0	-£1.7	-14.7%	£4.4	£0.0	0.6%			£4.4	£0.0	0.6%
Finance & ICT	-£6.3	-£1.0	-19.5%		-£3.0	£0.6	16.1%	£0.2	£0.1	68.6%	-£9.1	-£0.4	-4.0%			-£9.1	-£0.4	-4.0%
Estates	-£1.8	£0.0	0.5%		-£7.9	-£0.4	-4.7%	£0.5	£0.0	3.2%	-£9.2	-£0.3	-3.8%			-£9.2	-£0.3	-3.8%
Human Resources	-£1.7	£0.0	1.4%		-£0.7	-£0.1	-11.8%	£0.6	£0.0	-2.9%	-£1.8	-£0.1	-3.6%			-£1.8	-£0.1	-3.6%
Nursing & Workforce	-£2.9	£0.1	4.7%		-£0.7	£0.5	40.0%	£1.3	-£0.2	-10.6%	-£2.3	£0.5	16.3%			-£2.3	£0.5	16.3%
Clinical & Medical Operations	-£2.4	£0.0	-1.7%		-£2.1	£0.1	5.2%	£0.7	-£0.1	-14.1%	-£3.8	-£0.1	-1.4%			-£3.8	-£0.1	-1.4%
Corporate Affairs	-£0.6	£0.1	13.7%		-£0.6	£0.0	1.7%	£0.0	£0.0	-39.1%	-£1.2	£0.1	6.2%			-£1.2	£0.1	6.2%
New Born Screening	-£0.3	£0.2	37.7%		-£0.2	£0.3	58.6%	£0.5	-£0.5	-49.8%	£0.0	£0.0	-100.0%			£0.0	£0.0	-100.0%
Redevelopment	-£0.3	£0.2	32.2%		-£0.1	£0.0	-21.6%	£0.5	-£0.3	-39.4%	£0.0	-£0.2	-100.0%			£0.0	-£0.2	-100.0%
Haringey / North Middlesex	£0.0	£0.0	0.0%		£0.0	£0.0	0.0%	£0.0	£0.0	0.0%	£0.0	£0.0	0.0%			£0.0	£0.0	0.0%
Depreciation / Dividends	£0.0	£0.0	0.0%		-£16.5	£2.0	10.7%	£0.0	£0.0	0.0%	-£16.5	£2.0	10.7%			-£16.5	£2.0	10.7%
Other	-£0.6	-£1.4	-190.8%		-£1.5	£4.5	74.9%	£22.8	£9.1	66.9%	£20.6	£12.3	146.9%			£20.6	£12.3	146.9%
Trust total surplus (excl Capital Donations)	**-£148.0**	**-£2.7**	**-1.8%**		**-£110.7**	**£2.7**	**2.4%**	**£262.3**	**£5.0**	**2.0%**	**£3.6**	**£5.1**	**348.0%**	**£0.0**	**£0.0**	**£3.6**	**£5.1**	**348.0%**

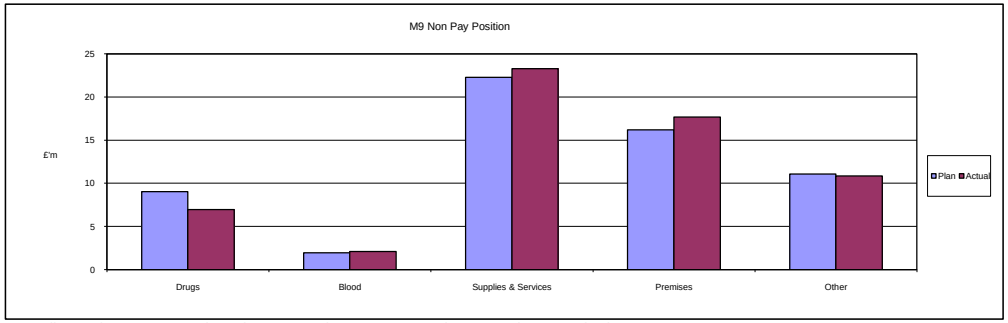
* Clinical unit actual contribution values have been adjusted to take account of outlier IPP costs.

* Contribution variances have been adjusted to reflect increases in IPP outlier costs as compared to 11-12.

Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Period 9 2012/13
Trust Summary

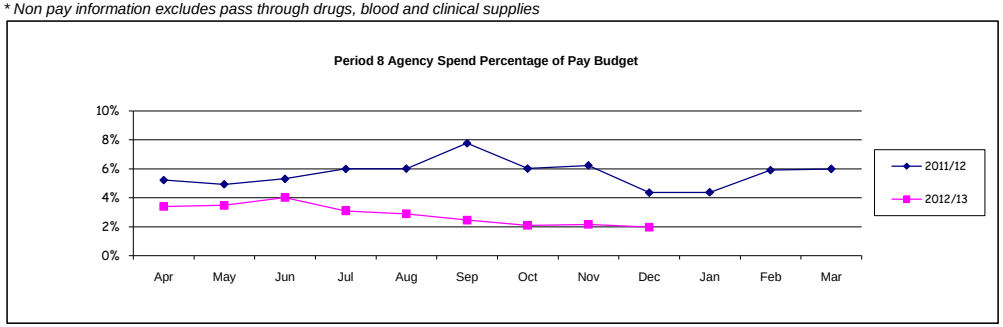
	Current Month		Current Quarter		YTD	
	Actual £000	Plan Variance £000	Actual £000	Plan Variance £000	Actual £000	Plan Variance £000
Revenue						
Revenue from patient care activities	22,520	259	74,776	1,451	227,858	7,958
Other operating revenue	3,982	(196)	11,545	(1,008)	34,472	(2,934)
Total Income	**26,502**	**63**	**86,321**	**443**	**262,330**	**5,024**
Operating expenses	(25,942)	(217)	(81,344)	(1,341)	(242,776)	(2,461)
EBITDA, excl Capital Donations	**560**	**(154)**	**4,977**	**(898)**	**19,554**	**2,563**
Depreciation	(1,611)	479	(4,261)	2,008	(12,054)	2,150
Impairment	0	0	0	0	0	0
Corporation Tax	0	0	0	0	0	0
Operating (deficit)/surplus, excl Capital Donations	**(1,051)**	**325**	**716**	**1,110**	**7,500**	**4,713**
Investment revenue	8	5	21	12	58	31
Other gains	523	523	523	523	490	490
Finance costs	(3)	(1)	(9)	(3)	(27)	(9)
(Deficit)/surplus for the financial year	**(523)**	**852**	**1,251**	**1,642**	**8,021**	**5,225**
Public dividend capital dividends payable	(492)	(19)	(1,475)	(55)	(4,425)	(165)
Retained (deficit)/surplus, excluding Capital Donations	**(1,015)**	**833**	**(224)**	**1,587**	**3,596**	**5,060**
Other comprehensive income						
Impairments put to the reserves	0	0	0	0	0	0
Total Income, including Capital Donations	26,100	(3,953)	88,088	(8,567)	272,376	(17,452)
EBITDA, including Capital Donations	157	(4,170)	6,744	(9,972)	29,600	(19,913)
EBITDA % of Income	0.6%		7.7%		10.9%	
EBITDA % of Income, excluding Capital Donations	2.1%		5.8%		7.5%	





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

** Non pay information excludes pass through drugs, blood and clinical supplies*



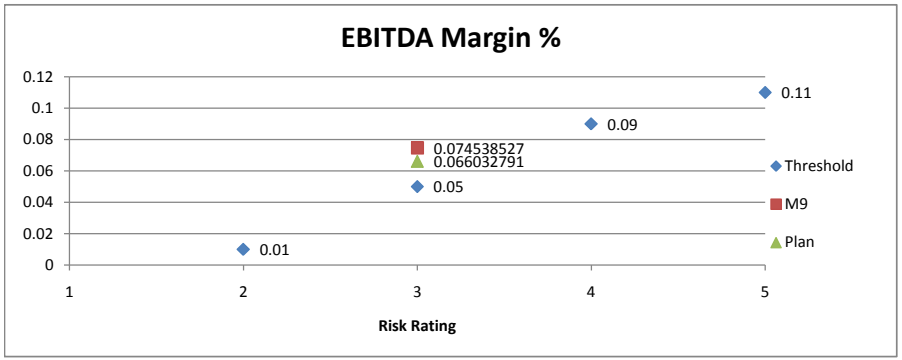
Staffing Staff Numbers	11/12 M12 WTE	WTE Paid	Maternity Paid	Temp Paid	Overtime Paid	Total Paid	WTE above 11/12 M12
Admin and Other Support	927	818	16	93	5	932	5
Clinical Support	762	697	33	13	2	744	(18)
Medical	550	512	13	17	0	543	(8)
Nursing	1,502	1,358	65	91	1	1,515	13
Total	**3,741**	**3,385**	**127**	**214**	**8**	**3,734**	**(7)**

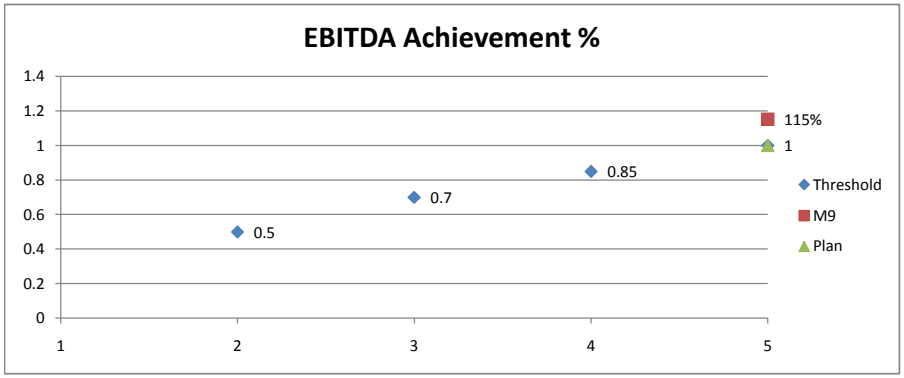
Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Period 9 2012/13
Ratio Analysis

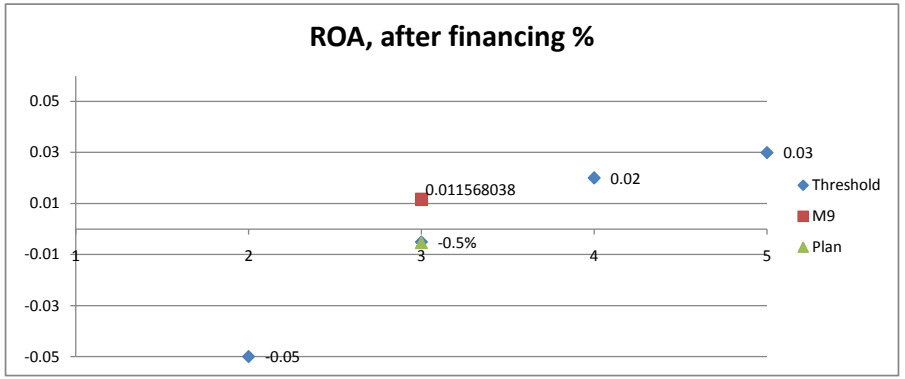
Provider Agency Rating	Target for FT Status	M9 12/13 Actual	M8 12/13 Actual	M9 Score - Monitor Basis
EBITDA Margin	5%	7.5%	8.1%	3
EBITDA % Achieved	70%	115%	117%	5
ROA, after financing	3%	1.2%	1.9%	3
I&E Surplus margin	1%	4.8%	6.1%	5
Liquidity Days	15.0	43	43	4
Weighted Average	3.0	3.9	3.9	3.9
Overall Rating	**3**	**4**	**4**	**4**
IPP Cap (Max 9.7%)	9.7%	13.3%	13.3%	

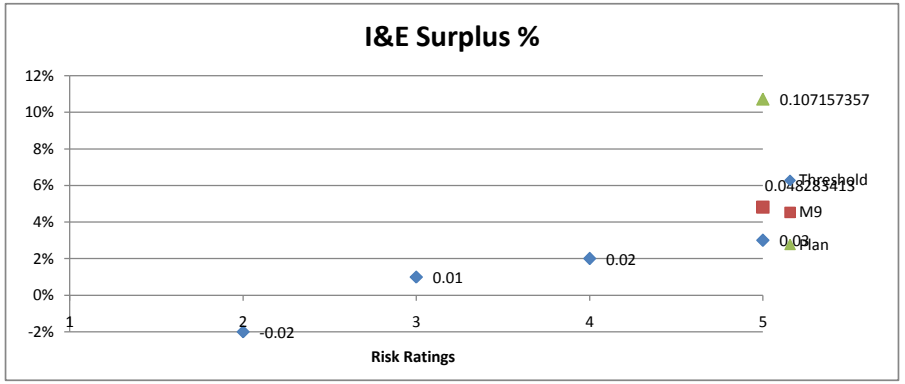
** Ratios calculated as per Monitor guidance*

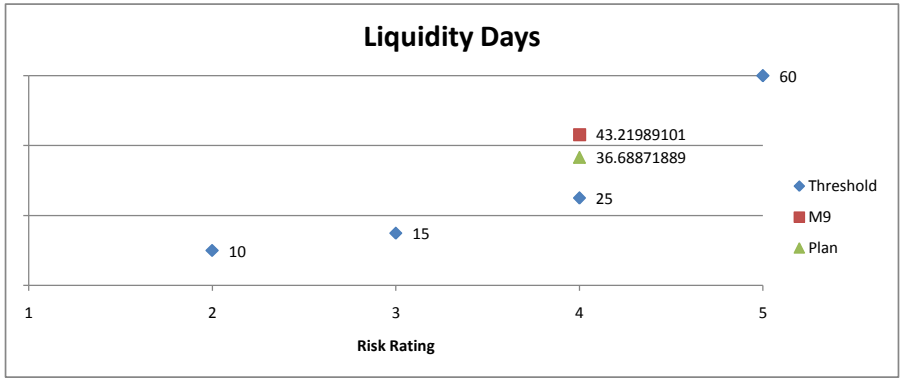
Salary Overpayments		
Unit	**No.**	**Amount £'000**
Estates	1	0.4
	1	**0.4**











Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Period 9 2012/13
Revenue Statement

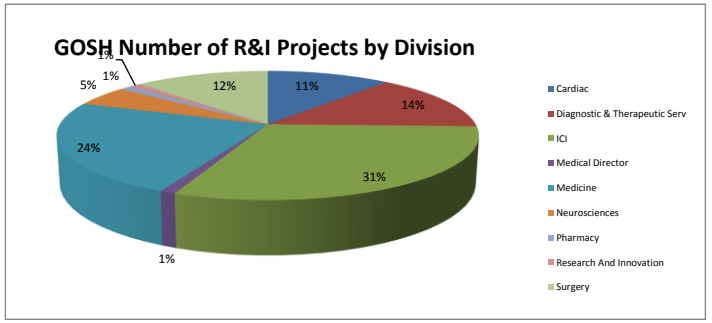
	12/13 Annual Budget £000	12/13 Mth 9 Actual £'000	12/13 Mth 9 Variance to Plan £'000	12/13 YTD Actual £'000	12/13 YTD Variance to Plan £'000	11/12 YTD Actuals	12/13 YTD Actual Variance to 11/12 YTD Actual
Day Case	18,667	**1,319**	93	**14,252**	251	**13,463**	**789**
Elective	50,782	**3,010**	-306	**36,909**	-1,022	**33,845**	**3,063**
Non-Elective	13,965	**1,271**	85	**12,020**	1,499	**9,583**	**2,438**
Outpatients	35,103	**2,320**	-122	**25,307**	-733	**24,971**	**336**
Hdu Bed Days	10,192	**780**	75	**6,681**	-944	**9,848**	**-3,167**
Itu Bed Days	24,024	**1,928**	-112	**16,752**	-1,349	**16,874**	**-123**
Ncg	30,306	**2,212**	-313	**21,838**	-892	**22,705**	**-867**
Other Nhs Clinical	34,851	**2,878**	228	**25,728**	870	**25,627**	**100**
Pass-Through	43,534	**3,225**	-183	**33,939**	1,245	**31,081**	**2,858**
Nhs Clinical Income	**261,424**	**18,943**	**-555**	**193,425**	**-1,076**	**187,997**	**5,428**
Private Patient	28,538	**3,120**	773	**30,351**	8,631	**20,433**	**9,918**
Non Nhs Clinical Income	4,906	**457**	41	**4,081**	402	**3,599**	**482**
Non-Nhs Clinical Income	**33,444**	**3,577**	**814**	**34,432**	**9,033**	**24,032**	**10,400**
Education & Training	9,880	**799**	-24	**7,193**	-217	**7,697**	**-504**
Research & Development	19,523	**1,553**	-74	**13,378**	-1,264	**13,791**	**-413**
Non-Patient Services	667	**116**	66	**669**	152	**630**	**39**
Commercial	884	**80**	-1	**603**	16	**832**	**-229**
Charitable Contributions	6,169	**453**	-62	**4,069**	-558	**2,736**	**1,333**
Other Non-Clinical	12,013	**934**	-74	**8,179**	-775	**9,304**	**-1,125**
Nhs Bank Funding	892	**47**	-27	**381**	-288	**344**	**37**
Non Clinical Income	**50,029**	**3,982**	**-196**	**34,472**	**-2,934**	**35,333**	**-862**
Total Income, excl Capital Donations	**344,896**	**26,502**	**63**	**262,329**	**5,024**	**247,363**	**14,966**
Directors & Senior Managers	-8,820	**-752**	-24	**-6,246**	364	**-6,316**	**70**
Consultants	-39,187	**-3,101**	164	**-27,865**	1,525	**-27,464**	**-401**
Junior Doctors	-20,298	**-1,663**	97	**-14,569**	654	**-13,651**	**-919**
Junior Doctors Agy	7	**-10**	-10	**-270**	-276	**-1,046**	**776**
Junior Doctors Bank	-77	**-133**	-126	**-1,382**	-1,324	**-1,263**	**-119**
Administration & Estates	-27,796	**-1,996**	315	**-17,614**	3,222	**-17,251**	**-363**
Administration & Estates Agy	-495	**-157**	-116	**-2,111**	-1,740	**-3,428**	**1,317**
Administration & Estates Bank	-10	**-224**	-223	**-1,826**	-1,818	**-81**	**-1,745**
Healthcare Assist & Supp	-1,656	**-148**	-6	**-1,359**	-160	**-1,541**	**181**
Healthcare Assist & Supp Agy	0	**-1**	-1	**-16**	-16	**-168**	**152**
Nursing Staff	-62,995	**-4,883**	442	**-43,625**	3,621	**-41,164**	**-2,461**
Nursing Staff Agy	-21	**-105**	-104	**-1,019**	-1,003	**-2,007**	**988**
Nursing Staff Bank	-169	**-348**	-334	**-3,302**	-3,176	**-3,193**	**-109**
Scientific Therap Tech	-33,800	**-2,805**	1	**-24,681**	700	**-23,633**	**-1,049**
Scientific Therap Tech Agy	0	**-44**	-44	**-696**	-696	**-1,618**	**922**
Scientific Therap Tech Bank	0	**-31**	-31	**-198**	-198	**-136**	**-62**
Other Staff	-380	**-57**	-26	**-248**	36	**-191**	**-57**
Pay Reserves	-6,375	**186**	315	**-949**	3,181	**-716**	**-234**
Cips And Cres Unidentified - P	7,373	**0**	-531	**0**	-5,546	**0**	**0**
Pay	**-194,699**	**-16,272**	**-242**	**-147,978**	**-2,649**	**-144,866**	**-3,112**
Drugs Costs	-12,346	**-913**	-112	**-6,954**	2,430	**-6,987**	**33**
Blood Costs	-2,712	**-148**	91	**-2,084**	-53	**-1,997**	**-87**
Supplies & Services - Clinical	-20,501	**-1,847**	-296	**-16,622**	-1,205	**-15,817**	**-806**
Services From Nhs Organisation	-4,647	**-187**	263	**-3,126**	368	**-3,025**	**-100**
Healthcare From Non-Nhs Bodies	-3,740	**-166**	61	**-1,945**	881	**-2,131**	**186**
Supplies & Services - General	-1,885	**-147**	10	**-1,570**	-157	**-1,491**	**-79**
Consultancy Services	-1,666	**-162**	-57	**-1,080**	154	**-1,045**	**-35**
Clinical Negligence Costs	-2,214	**-183**	1	**-1,659**	2	**-1,462**	**-196**
Establishment Costs	-2,603	**-211**	-56	**-1,950**	2	**-1,943**	**-8**
Transport Costs	-2,881	**-210**	30	**-2,062**	97	**-2,061**	**-1**
Premises Costs	-22,431	**-1,790**	96	**-17,679**	-864	**-14,644**	**-3,034**
Auditors Fees	-420	**-34**	1	**-351**	-36	**-267**	**-84**
Education And Research Costs	-2,345	**-161**	34	**-782**	977	**-1,039**	**257**
Expenditure - Other	-3,326	**-289**	-56	**-2,956**	-518	**-1,786**	**-1,170**
Pass Through	-43,534	**-3,225**	183	**-33,939**	-1,245	**-31,081**	**-2,858**
Non Pay Reserves	-2,727	**1**	57	**-39**	1,728	**-27**	**-12**
Cips And Cres Unidentified - N	3,154	**0**	-227	**0**	-2,373	**0**	**0**
Non Pay Costs	**-126,823**	**-9,670**	**25**	**-94,798**	**189**	**-86,803**	**-7,995**
EBITDA, excl Capital Donations	**23,374**	**560**	**-154**	**19,554**	**2,563**	**15,693**	**3,860**
Interest Receivable	36	**8**	5	**58**	31	**53**	**6**
P & L On Disp Of Fixed Assets	0	**523**	523	**490**	490	**-4**	**494**
Fixed Asset Impair & Reversals	-1,650	**0**	0	**0**	0	**0**	**0**
Depreciation & Amortisation	-20,710	**-1,611**	479	**-12,054**	2,150	**-10,870**	**-1,184**
Other Revenue / Expenditure	-24	**-3**	-1	**-27**	-9	**-30**	**2**
Pdc Dividend Payable	-5,680	**-492**	-18	**-4,425**	-165	**-4,324**	**-101**
Other Revenue / Expenditure	**-28,028**	**-1,575**	**987**	**-15,958**	**2,497**	**-15,175**	**-783**
Retained Surplus / (Deficit), excl Capital Donations	**-4,654**	**-1,015**	**833**	**3,596**	**5,060**	**518**	**3,077**
Receipt Of Capital Donations	43,362	**-403**	-4,016	**10,046**	-22,476	**4,569**	**5,477**
Retained Surplus / (Deficit)	**38,708**	**-1,418**	**-3,183**	**13,641**	**-17,416**	**5,087**	**8,554**

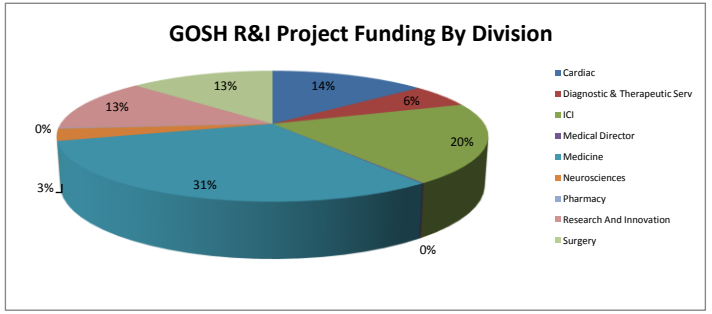
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 2012/13
Research and Innovation Activity

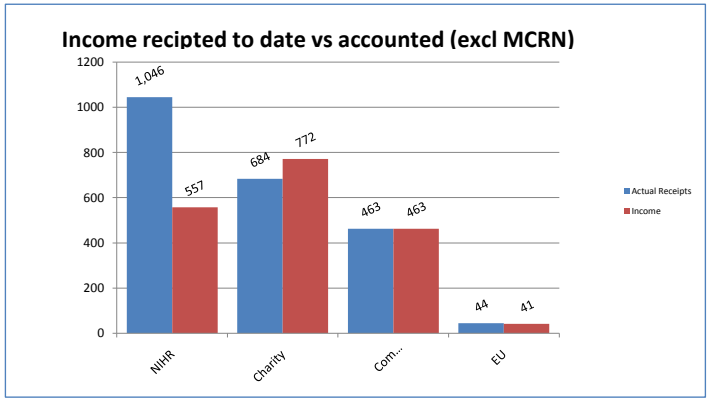
Summary Research & Innovation Income and Expenditure	Full Year Forecast	Full Year Budget	12/13 YTD Budget	12/13 YTD Actuals	12/13 YTD Variance to Budget	11/12 YTD Actuals	12/13 YTD actual variance to 11/12 YTD actual
TOTAL RESEARCH & INNOVATION DIRECTORATE							
Biomedical Research Centre	6,581	7,132	5,349	4,092	(1,257)	5,458	(1,366)
NIHR Income (Incl project specific, Research Capability funding and Central London Research NetworkCLRN)	4,281	4,516	3,387	2,871	(516)	2,928	(57)
Charity funded projects	1,463	1,639	1,218	929	(290)	667	262
Commercial	694	854	626	568	(58)	419	149
European Union	53	50	37	49	12	0	49
Other	87	115	100	45	(55)	13	32
- R&I Income Deferred from 11-12	0	0	0	285	285	0	285
Research & Innovation Sub-Total	**13,159**	**14,305**	**10,718**	**8,840**	**(1,879)**	**9,485**	**(645)**
- Expenditure	(7,485)	(8,468)	(6,342)	(4,436)	1,906	(3,679)	(757)
	5,674	**5,836**	**4,376**	**4,403**	**27**	**5,806**	**(1,403)**
Expenditure in clinical units	**(5,471)**	**(5,763)**	**(4,322)**	**(4,205)**	**118**	**(5,186)**	**981**
Total R&I Division (excl MCRN)	**203**	**73**	**54**	**199**	**145**	**620**	**(421)**
- R&D Income Local Research Network MCRN (Hosted network)	**1,558**	**1,347**	**1,021**	**1,175**	**155**	**805**	**371**
- Expenditure LRN MCRN	(1,558)	(1,347)	(1,021)	(1,176)	(155)	(805)	(371)
Total LRN MCRN	**0**	**(0)**	**(0)**	**0**	**0**	**0**	**(0)**
TOTAL R&I Division	**203**	**73**	**54**	**199**	**(145)**	**620**	**(421)**
Devolved Income							
- Cardiac	0	0	0	0	0	0	0
- DTS : From CLRN Service Support	0	0	0	0	0	63	(63)
- Medicine : Grants	0	0	0	0	0	122	(122)
- ICI : From CLRN Support / NIHR Felowships	0	557	421	394	(26)	85	309
- Surgery : From Charitable Donation	0	0	0	0	0	3	(3)
Total Centrally Held and Devolved Income	**0**	**557**	**421**	**394**	**(26)**	**275**	**120**
Revenue and Direct Expenditure by Funding Source							
Biomedical Research Centre including Clinical Research Facility							
- Income	6,581	7,132	5,349	4,092	(1,257)	5,458	(1,366)
- Income deferred from 11-12	0	0	0	285	285	0	285
- Commercial Trials Income	0	0	0	0	0	0	0
-Income Total	**6,581**	**7,132**	**5,349**	**4,377**	**(972)**	**5,458**	**(1,081)**
- Expenditure	(3,606)	(4,157)	(3,118)	(2,119)	999	(1,724)	(395)
	2,975	2,975	2,231	2,258	27	3,735	(1,477)
R&D GOSH Charity Funded Projects							
-Income Total	**1,463**	**1,639**	**1,218**	**929**	**(290)**	**667**	**262**
- Expenditure	(1,495)	(1,631)	(1,212)	(939)	273	(661)	(278)
	(32)	8	7	(10)	(17)	6	(16)
CLRN (Central london research Network) Income							
-Income Total	**1,150**	**1,150**	**863**	**597**	**(266)**	**470**	**127**
- Expenditure CLR	(914)	(622)	(467)	(345)	121	(220)	(125)
	236	528	396	252	(144)	250	2
National Institute for Health Research:Project Specific grants							
-Income Total	**871**	**1,106**	**829**	**579**	**(250)**	**614**	(35)
- Expenditure	(763)	(998)	(750)	(498)	252	(614)	116
	108	108	79	81	2	0	81
European Union grants							
-Income Total	**53**	**50**	**37**	**49**	**12**	**0**	**49**
-Expenditure	(48)	(45)	(34)	(40)	(6)	0	(40)
	5	5	4	10	6	0	10
Other							
- Research Capability Funding (NIHR)	2,260	2,260	1,695	1,695	0	1,843	(148)
- Commercial Trials Income	694	854	626	568	(58)	419	149
- Income Other R&I	87	115	100	45	(55)	13	32
-Income Total	**3,041**	**3,229**	**2,422**	**2,309**	**(113)**	**2,276**	**33**
- Expenditure	(659)	(1,016)	(762)	(495)	267	(460)	(36)
	2,382	2,213	1,659	1,813	154	1,816	(3)
Local Research Network MCRN *							
Income Sub-Total	**1,558**	**1,347**	**1,021**	**1,175**	**155**	**805**	**371**
-Expenditure	(1,558)	(1,347)	(1,021)	(1,176)	(155)	(805)	(371)
	0	(0)	(0)	(0)	(0)	0	(0)

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

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







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 9 2012/13
Statement of Financial Position

	Actual as at 1 April 2012	Actual as at 30 November 2012	Actual as at 31 December 2012	Change in month
	£000	£000	£000	£000
Non Current Assets :				
Property Plant & Equipment - Purchased	170,632	169,828	169,449	(379)
Property Plant & Equipment - Donated	155,706	160,639	159,448	(1,191)
Property Plant & Equipment - Gov Granted	301	287	285	(2)
Intangible Assets - Purchased	2,034	1,649	1,416	(233)
Intangible Assets - Donated	2,897	2,865	2,862	(3)
Trade & Other Receivables	9,042	8,759	8,761	2
Total Non Current Assets :	***340,612***	***344,027***	***342,221***	***(1,806)***
Current Assets :				
Inventories	6,209	6,576	7,122	546
Trade Receivables - Invoiced	19,103	25,097	24,549	(548)
Trade Receivables - Accrued	3,051	8,143	8,439	296
Capital Receivables	6,690	5,750	3,131	(2,619)
Provision for Impairment of Receivables	(1,126)	(1,897)	(1,936)	(39)
Prepayments & Accrued Income	3,722	7,715	6,105	(1,610)
HMRC VAT	1,037	220	317	97
Other Receivables	784	787	801	14
Cash & Cash Equivalents	26,628	23,124	28,301	5,177
Total Current Assets :	***66,098***	***75,515***	***76,829***	***1,314***
Total Assets :	**406,710**	**419,542**	**419,050**	**(492)**
Current Liabilities :				
NHS Trade Payables	(3,922)	(5,391)	(5,290)	101
Non NHS Trade Payables	(8,675)	(2,869)	(3,595)	(726)
Capital Payables	(7,445)	(4,169)	(2,724)	1,445
Expenditure Accruals	(11,954)	(13,195)	(15,407)	(2,212)
Deferred Revenue	(4,290)	(6,967)	(5,946)	1,021
Tax & Social Security Costs	(4,136)	(4,154)	(4,173)	(19)
Other Payables	0	(983)	(1,475)	(492)
Payments on Account	(228)	(229)	(229)	0
Lease Incentives	(437)	(407)	(407)	0
Other Liabilities	(3,185)	(3,691)	(3,811)	(120)
Provisions for Liabilites & Charges	(3,123)	(3,399)	(3,334)	65
Total Current Liabilities :	***(47,395)***	***(45,454)***	***(46,391)***	***(937)***
Net Current Assets	**18,703**	**30,061**	**30,438**	**377**
Total Assets Less Current Liabilities :	**359,315**	**374,088**	**372,659**	**(1,429)**
Non Current Liabilities :				
Lease Incentives	(6,957)	(6,714)	(6,679)	35
Provisions for Liabilites & Charges	(1,234)	(1,192)	(1,216)	(24)
Total Non Current Liabilities :	***(8,191)***	***(7,906)***	***(7,895)***	***11***
Total Assets Employed :	**351,124**	**366,182**	**364,764**	**(1,418)**
Financed by Taxpayers' Equity :				
Public Dividend Capital	124,732	124,731	124,731	0
Retained Earnings	174,430	189,603	188,199	(1,404)
Revaluation Reserve	48,848	48,734	48,720	(14)
Other Reserves	3,114	3,114	3,114	0
Total Taxpayers' Equity :	**351,124**	**366,182**	**364,764**	**(1,418)**

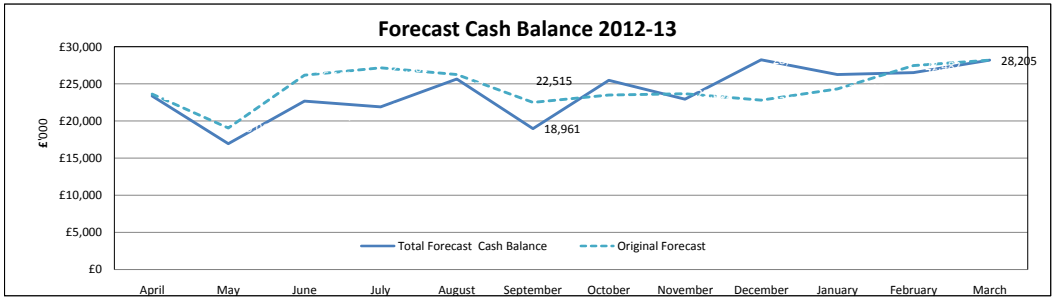
Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Period 9 2012/13
Statement of Cash Flow

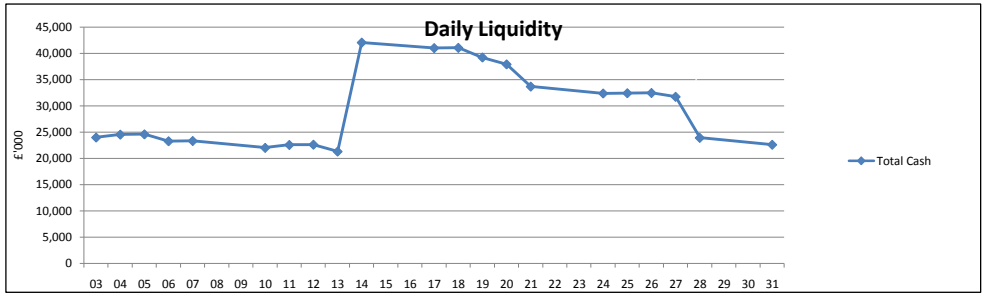
	Actual For Month Ending 31 December 2012 £000	Actual For YTD Ending 31 December 2012 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating (Deficit)/Surplus	(1,051)	7,499
Charitable Contributions - Capex	(403)	10,045
Depreciation and Amortisation	1,611	12,054
Increase in Inventories	(546)	(913)
Decrease/(Increase) in Trade and Other Receivables	4,407	(7,864)
Increase in Trade and Other Payables	1,835	1,434
Increase in Other Current Liabilities	85	318
(Decrease)/Increase in Provisions	(41)	170
Net Cash Inflow from Operating Activities :	***5,897***	***22,743***
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	8	59
Payments for Property, Plant and Equipment	(1,251)	(18,708)
Payments for Intangible Assets	0	(3)
Proceeds from Disposal of Property , Plant and Equipment	523	532
Net Cash Outflow from Investing Activities :	**(720)**	**(18,120)**
NET CASH INFLOW BEFORE FINANCING :	**5,177**	**4,623**
CASH FLOWS FROM FINANCING ACTIVITIES		
PDC Dividend Paid	0	(2,950)
Net Cash Outflow from Financing :	**0**	**(2,950)**
NET INCREASE IN CASH AND CASH EQUIVALENTS :	**5,177**	**1,673**

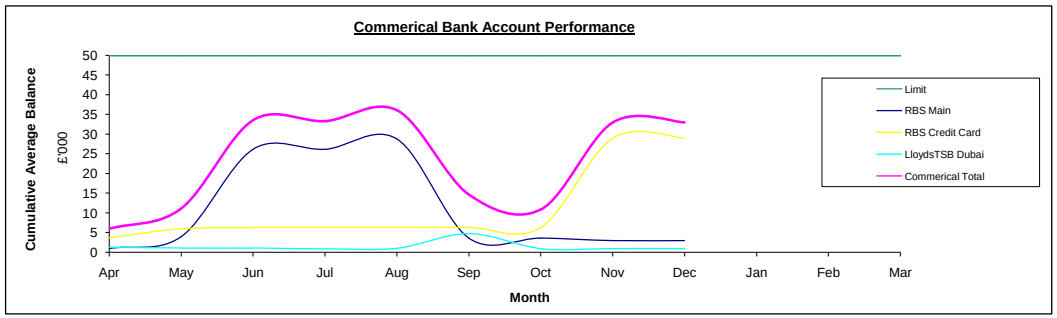
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 9 2012/13
NHS Clinical Activity & Income

	12/13 YTD						Comparison to 11/12					
	Income £000			Activity			Income £000			Activity		
	YTD 12/13 Actual	YTD 12/13 Variance	YTD 12/13 Variance %	YTD 12/13 Actual	YTD 12/13 Variance	YTD 12/13 Variance %	YTD 11/12 Actual	Variance 12/13 to 11/12	Variance 12/13 to 11/12 %	YTD 11/12	Variance 12/13 to 11/12	Variance 12/13 to 11/12 %
Day case	**14,252**	**251**	**2.7%**	**9,843**	**124**	**1.9%**	**13,463**	**789**	**5.9%**	**9,151**	**692**	**7.6%**
Elective	34,064	-1,457	-6.1%	8,388	-25	-0.4%	33,056	1,008	3.0%	7,703	685	8.9%
Elective Excess Bed days	2,845	435	30.7%	5,659	606	20.3%	789	2,056	260.5%	1,769	3,890	220.0%
TOTAL ELECTIVE	**36,909**	**-1,022**	**-4.0%**				**33,845**	**3,063**	**9.1%**			
Non Elective	10,552	1,309	21.3%	1,358	-17	-1.8%	9,110	1,442	15.8%	1,268	90	7.1%
Non Elective Excess Bed Days	1,468	190	22.4%	3,171	361	19.3%	473	996	210.6%	978	2,194	224.3%
TOTAL NON ELECTIVE	**12,020**	**1,499**	**21.4%**				**9,583**	**2,438**	**25.4%**			
Outpatient	**25,307**	**-733**	**-4.2%**	**99,494**	**-3,720**	**-5.4%**	**24,971**	**336**	**1.3%**	**105,957**	**-6,463**	**-6.1%**
Undesignated HDU Bed days	4,431	-330	-10.4%	4,208	-383	-12.5%	6,962	-2,531	-36.4%	6,573	-2,365	-36.0%
Haem/Onc Other	525	-824	-91.6%	-	-	-	1,335	-810	-60.7%	-	-	-
Non Consortium HDU Bed days	534	66	21.2%	490	49	16.7%	503	31	6.2%	465	25	5.3%
Picu Consortium HDU	1,191	145	20.8%	1,224	196	28.7%	1,049	143	13.6%	924	300	32.4%
TOTAL HDU	**6,681**	**-944**	**-18.6%**	**5,922**	**-138**	**-3.4%**	**9,848**	**-3,167**	**-32.2%**	**7,963**	**-2,041**	**-25.6%**
Non Consortium ITU Bed days	2,603	-1,352	-51.4%	1,021	-536	-51.7%	3,943	-1,340	-34.0%	1,524	-503	-33.0%
Picu Consortium ITU	14,148	3	0.0%	5,794	22	0.6%	12,931	1,217	9.4%	5,292	503	9.5%
TOTAL ITU	**16,752**	**-1,349**	**-11.2%**	**6,815**	**-514**	**-10.5%**	**16,874**	**-123**	**-0.7%**	**6,815**	**0**	**0.0%**
Ecmo Bedday	150	-493	-115.2%	34	-91	-109.3%	639	-489	-76.5%	132	-98	-74.2%
Psychological Medicine Bedday	936	43	7.3%	2,273	92	6.3%	906	30	3.3%	2,173	100	4.6%
Rheumatology Rehab Beddays	1,039	18	2.6%	1,750	-21	-1.8%	1,050	-12	-1.1%	1,787	-37	-2.1%
Transitional Care Beddays	2,097	-41	-2.9%	1,484	30	3.1%	2,006	91	4.5%	1,373	111	8.1%
Packages Of Care Elective	4,585	357	12.7%	7,803	191	3.8%	4,213	372	8.8%	7,333	470	6.4%
Other Clinical	**8,807**	**-117**	-2.0%				**8,814**	**-7**	**-0.1%**			

Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Period 9 2012/13
Cash Management





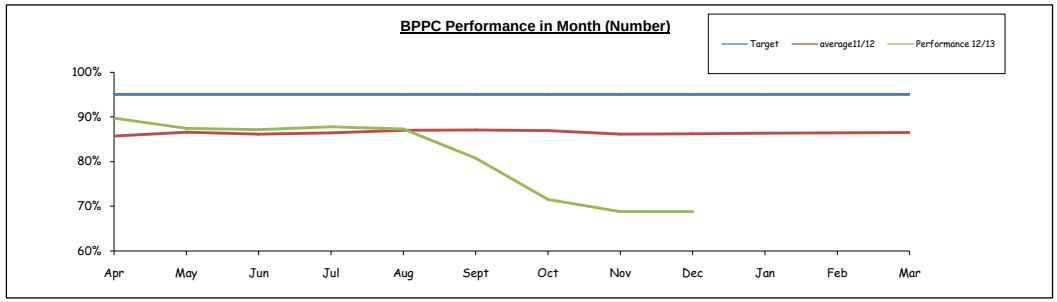


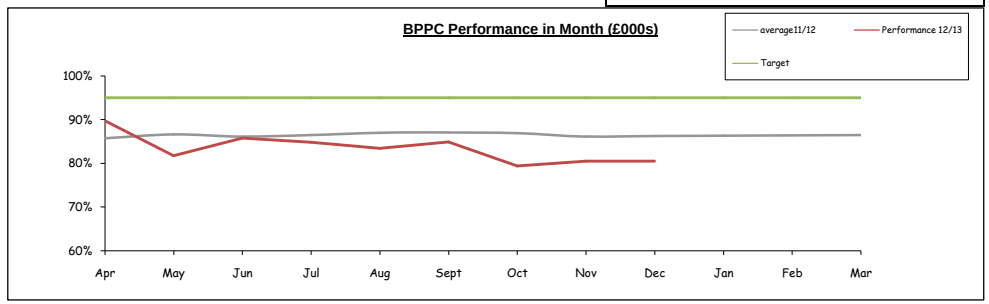
Payables and Registered Invoice Analysis

Days	Current Month	Previous Month	Movement in Month
	£000s	£000s	£000s
Not Yet Due	3,268	5,483	(2,215)
1-30	1,290	1,416	(126)
31-60	1,214	1,740	(526)
61-90	741	526	215
91-120	412	1,132	(720)
121-180	1,054	370	684
180-360	697	680	17
360+	538	513	25
	9,214	**11,860**	**(2,646)**

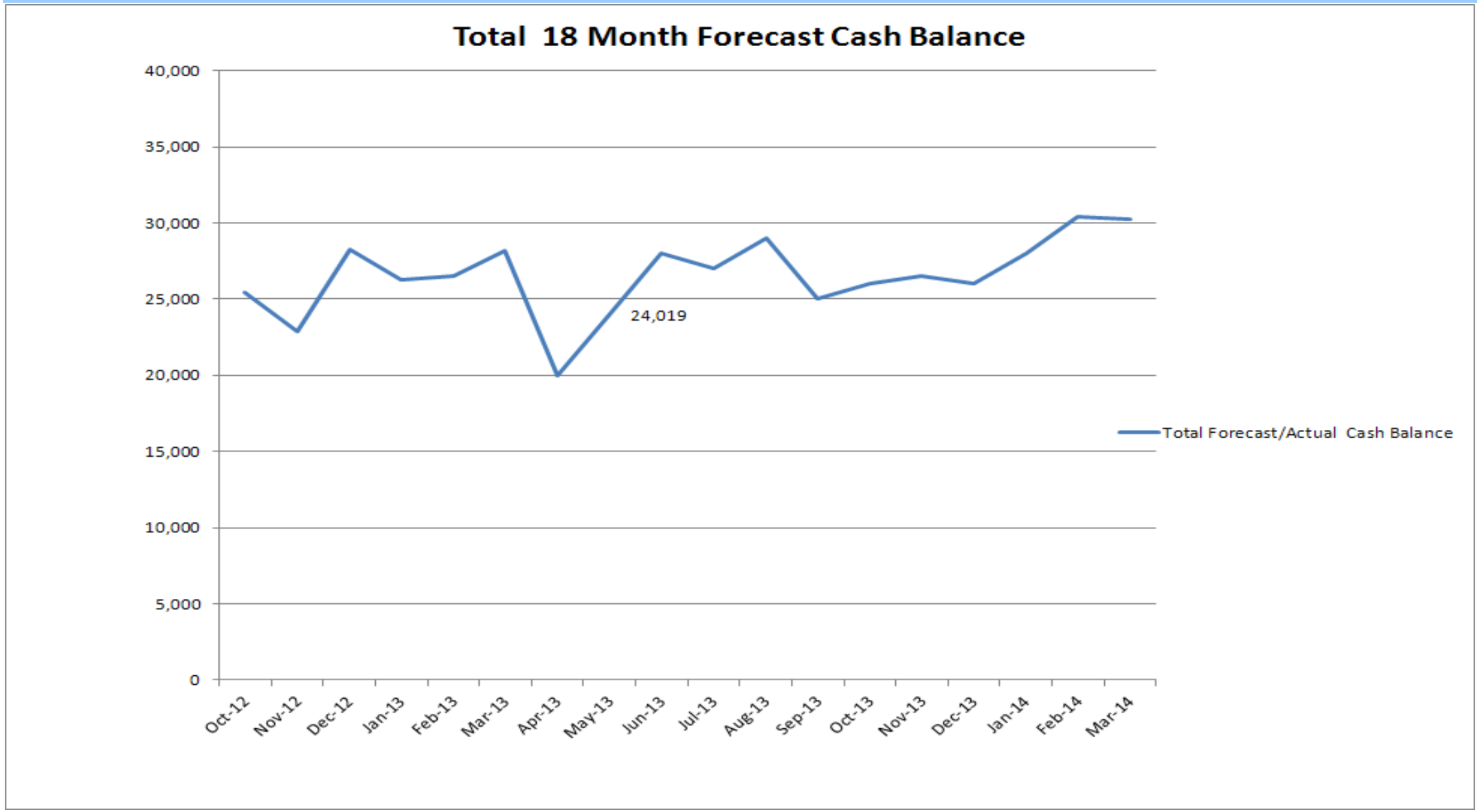
Better Payment Practice Code (BPPC)

	Number	£000s
Cumumlative Performance		
Total Payables		
% of Invoices paid within target	84.5%	82.2%
Non-NHS Payables		
Invoices paid in the year	55022	117,294
Invoices paid within target	47355	99,153
% of Invoices paid within target	86.1%	84.5%
NHS Payables		
Invoices paid in the year	2595	13,474
Invoices paid within target	1345	8,312
% of Invoices paid within target	51.8%	61.7%





Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Period 9 2012/13
Cash Forecast



Great Ormond Street Hospital for Children NHS FoundationTrust
Finance and Activity Performance Report Period 9 2012/13
Receivables Management

Net Receivables (£000)	Total	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS Receivables	**4,570**	(802)	1,542	1,792	271	265	874	656	(28)	0
Credit balances adjustment	**1,480**	0	1,480	0	0	0	0	0	0	0
NHS Credit Note Provision	(365)	0	0	0	0	0	(138)	(103)	(115)	(9)
Net NHS Receivables	**5,685**	**(802)**	**3,022**	**1,792**	**271**	**265**	**736**	**553**	**(143)**	**(9)**
Non-NHS Receivables	**2,983**	(40)	576	366	250	88	797	59	492	395
Non-NHS Bad Debt Provision	(602)	0	(58)	(49)	(28)	(9)	(23)	(17)	(302)	(116)
Net Non-NHS Receivables	**2,381**	**(40)**	**518**	**317**	**222**	**79**	**774**	**42**	**190**	**279**
International & Private Patients Receivables	**14,905**	(1,506)	8,877	2,422	1,284	1,071	1,071	863	542	281
IPP Bad Debt Provision	(1,336)	(69)	(313)	(3)	(2)	0	(218)	(175)	(275)	(281)
Net IPP Receivables	**13,569**	**(1,575)**	**8,564**	**2,419**	**1,282**	**1,071**	**853**	**688**	**267**	**0**
GOSH Charity Receivables	**611**	0	516	58	31	6	0	0	0	0
Net Trust Receivables	**22,246**	**(2,417)**	**12,620**	**4,586**	**1,806**	**1,421**	**2,363**	**1,283**	**314**	**270**

Trust Receivables (£000)	Total	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS Receivables	6,050	(802)	3,022	1,792	271	265	874	656	(28)	0
Non-NHS Receivables	2,983	(40)	576	366	250	88	797	59	492	395
International & Private patient Receivables	14,905	(1,506)	8,877	2,422	1,284	1,071	1,071	863	542	281
Gross Trading Receivables	**23,938**	**(2,348)**	**12,475**	**4,580**	**1,805**	**1,424**	**2,742**	**1,578**	**1,006**	**676**
GOSH Charity Receivables	611	0	516	58	31	6	0	0	0	0
Total Trust Receivables	**24,549**	**(2,348)**	**12,991**	**4,638**	**1,836**	**1,430**	**2,742**	**1,578**	**1,006**	**676**

Movement (£000)	Total	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
Gross Trading Receivables (as above)	24,549	(2,348)	12,991	4,638	1,836	1,430	2,742	1,578	1,006	676
Gross Trading Receivables (last month)	25,097	(2,184)	15,511	3,465	1,955	2,702	1,266	801	811	770
Movement in Month	**(548)**	**(164)**	**(2,520)**	**1,173**	**(119)**	**(1,272)**	**1,476**	**777**	**195**	**(94)**
Gross Trading Receivables (as at 31 March 2012)	19,190	(2,066)	17,138	2,469	568	626	4	153	(193)	491
Movement in Financial Year	**(5,359)**	**282**	**4,147**	**(2,169)**	**(1,268)**	**(804)**	**(2,738)**	**(1,425)**	**(1,199)**	**(185)**

Systems Schedule

Receivables (£000)	Gross Receivables	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
eFinancials	9,644	(842)	4,114	2,216	552	359	1,671	715	464	395
Compucare	14,905	(1,506)	8,877	2,422	1,284	1,071	1,071	863	542	281
Trust Receivables	**24,549**	**(2,348)**	**12,991**	**4,638**	**1,836**	**1,430**	**2,742**	**1,578**	**1,006**	**676**

Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Period 9 2012/13
Capital

		Year to Date (YTD)					
Capital Spend by Division	**Annual Plan**	**Year To Date Plan**	**Actual**	**Variance (YTD)**	**Additional Commitments**	**Uncommitted Funds**	**Forecast Outturn for the Year**
Redevelopment Projects							
Donated Funded							
Phase 1	0	0	6	(6)	0	(6)	6
Phase 2a Enabling		0	0	0		0	0
Phase 2a	4,195	3,146	2,732	414	469	994	5,117
Phase 2b Enabling	21,019	15,764	2,863	12,901	1,934	16,222	6,840
Phase 2b	7,605	5,704	312	5,392	98	7,195	1,032
Phase 2 - Inhouse Resources	116	87	230	(143)	23	(137)	230
Phase 3 - Start up costs	0	0	(10)	10	0	10	(10)
Total :	**32,935**	**24,701**	**6,133**	**18,568**	**2,524**	**24,277**	**13,215**
Estates Maintenance Projects							
Trust/DH Funded	5,000	3,750	2,038	1,712	368	2,594	4,457
Donated Funded	1,200	900	778	122	27	395	1,184
Total :	**6,200**	**4,650**	**2,816**	**1,834**	**395**	**2,989**	**5,641**
Facilities Projects							
Trust/DH Funded	400	300	163	137	79	158	300
Donated Funded	0	0	0	0	0	0	0
Total:	**400**	**300**	**163**	**137**	**79**	**158**	**300**
IT Projects							
Trust/DH Funded	4,500	3,375	1,727	1,648	1,187	1,587	3,157
Donated Funded	8	6	33	(28)	8	(34)	42
Total:	**4,508**	**3,381**	**1,760**	**1,621**	**1,195**	**1,553**	**3,198**
Medical Equipment Projects							
Trust/DH Funded	0	0	12	(12)	0	(12)	12
Donated Funded	9,227	6,920	3,101	3,819	548	5,578	4,025
Total:	**9,227**	**6,920**	**3,113**	**3,807**	**548**	**5,566**	**4,037**
Total Donated Funded Projects	43,369	32,527	10,046	22,481	3,108	30,216	18,466
Total Trust Funded Projects	9,900	7,425	3,939	3,486	1,633	4,328	7,926
Total Additions in Year	**53,269**	**39,952**	**13,985**	**25,967**	**4,741**	**34,544**	**26,392**
Asset Disposals	0	0	41	(41)	0	0	41

Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Period 9 2012/13
Staffing WTE

Permanent (Excludes Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	11/12 Period 12	11-12 Ave wte	M9 variance to M12 11/12	M9 variance to ave 11-12 wte
Cardiac	606	608	602	600	594	588	598	606	605	599	569	-6	-36
Surgery	496	512	510	508	503	493	503	514	517	494	468	-24	-49
ICI	536	525	536	532	529	533	542	533	533	536	507	4	-26
International	128	124	125	129	128	125	130	136	137	125	121	-12	-16
MDTS	646	655	683	669	656	647	645	646	656	660	638	4	-18
Neurosciences	287	283	287	284	288	280	286	287	287	288	273	1	-14
Children's Population Health	7	7	7	7	7	7	7	7	7	8	8	1	1
Corporate Facilities	183	176	175	173	181	179	179	176	176	176	186	1	10
Corporate Affairs	8	9	9	10	6	9	8	7	7	14	12	7	5
Estates	49	47	49	46	47	43	44	44	44	47	45	3	1
Finance & ICT	126	114	112	114	117	117	118	116	116	120	126	5	10
Human Resources	63	60	61	60	61	59	59	59	61	61	59	0	-2
Clinical & Medical Operations	45	45	44	45	46	44	44	45	44	45	40	2	-4
Nursing And Workforce Development	71	72	70	74	71	69	75	76	74	69	81	-5	8
Research And Innovation	97	102	95	97	99	102	89	107	116	102	99	-14	-16
Redevelopment Revenue Costs	6	1	6	6	5	7	7	7	7	6	6	-2	-1
TOTAL	3,350	3,341	3,372	3,353	3,338	3,300	3,333	3,367	3,385	3,350	3,237	-35	-148

Overtime

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	11/12 Period 12	11-12 Ave wte	M9 variance to M12 11/12	M9 variance to ave 11-12 wte
Cardiac	1.5	1.9	1.0	0.5	0.2	0.7	0.7	0.8	0.4	2.6	2.3	2.1	1.8
Surgery	3.4	2.4	2.2	2.1	2.4	2.1	2.1	1.4	1.4	2.6	2.9	1.2	1.5
ICI	0.8	0.7	0.5	0.7	0.5	0.5	0.5	0.3	0.4	0.5	0.5	0.2	0.2
International	0.5	1.1	0.8	1.0	0.7	0.8	0.8	0.9	0.5	1.8	1.2	1.3	0.7
MDTS	1.3	1.8	0.8	1.0	0.8	0.8	0.9	0.5	0.2	0.8	1.0	0.6	0.8
Neurosciences	0.5	0.0	0.1	0.4	0.1	0.2	0.2	0.2	0.1	0.8	0.6	0.7	0.5
Children's Population Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Corporate Facilities	5.4	6.5	5.2	5.2	4.4	4.2	4.2	2.4	2.6	4.2	4.5	1.5	1.8
Corporate Affairs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates	2.4	1.9	1.9	2.5	2.2	1.4	1.4	1.3	1.7	2.3	1.7	0.6	0.0
Finance & ICT	0.3	1.1	0.2	0.6	0.0	0.2	0.2	0.1	0.4	1.2	1.1	0.8	0.7
Human Resources	0.0	0.0	0.0	0.0	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	0.0	0.0	0.0	0.0
Nursing And Workforce Development	0.0	0.0	0.1	0.0	0.0	0.0	0.0	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	0.6	0.6	0.3	0.4	0.1	0.2	-0.2	-0.1
Redevelopment Revenue Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	16.3	17.4	12.8	14.1	11.4	11.5	11.6	8.4	8.0	17.0	16.1	9.0	8.0

Agency/Locum/Bank

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	11/12 Period 12	11-12 Ave wte	M9 variance to M12 11/12	M9 variance to ave 11-12 wte
Cardiac	50	40	40	47	44	41	50	50	36	53	55	17	19
Surgery	40	22	28	26	27	30	38	29	28	48	43	20	15
ICI	26	26	27	20	23	25	18	16	17	45	35	28	18
International	27	27	33	35	38	41	38	33	30	25	33	-5	3
MDTS	27	26	35	30	39	36	40	40	36	53	36	17	0
Neurosciences	6	7	6	11	6	4	9	12	7	14	18	7	11
Children's Population Health	0	0	1	0	0	0	0	0	0	0	0	0	0
Corporate Facilities	3	10	10	8	14	12	15	16	9	19	12	10	3
Corporate Affairs	0	0	0	0	4	3	2	0	0	0	0	0	0
Estates	6	22	2	19	11	12	12	15	16	5	11	-12	-6
Finance & ICT	33	37	36	37	35	32	31	31	28	30	23	2	-5
Human Resources	7	0	4	2	8	3	1	3	4	3	2	-1	-2
Clinical & Medical Operations	0	1	2	3	4	2	1	1	1	5	4	4	3
Nursing And Workforce Development	0	0	1	3	1	0	0	0	0	0	2	0	2
Research And Innovation	3	4	4	2	6	3	3	3	3	3	3	0	0
Redevelopment Revenue Costs	0	0	2	0	0	0	0	0	0	0	0	0	0
TOTAL	229	222	233	242	260	245	259	248	214	303	277	89	63

TOTAL STAFFING (Excluding Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	11/12 Period 12	11-12 Ave wte	M9 variance to M12 11/12	M9 variance to ave 11-12 wte
Cardiac	657	651	643	647	639	630	648	656	641	654	626	13	-15
Surgery	539	536	540	536	532	525	544	544	547	544	514	-3	-33
ICI	562	552	564	552	553	558	560	549	550	582	542	32	-8
International	155	152	159	165	167	167	169	171	167	152	155	-15	-12
MDTS	674	683	719	700	696	684	685	686	692	714	675	22	-17
Neurosciences	293	290	294	295	295	285	295	299	294	303	291	8	-3
Children's Population Health	7	7	8	7	7	7	7	7	7	8	8	1	1
Operations & Facilities	192	192	191	187	199	195	199	195	188	200	203	12	15
Corporate Affairs	8	9	9	10	9	12	10	7	7	14	12	7	5
Estates	57	71	53	67	61	57	58	60	62	54	57	-8	-5
Finance & ICT	159	152	149	152	152	149	149	147	143	151	150	7	6
Human Resources	70	60	65	62	68	61	60	62	65	64	61	-1	-4
Clinical & Medical Operations	45	46	47	48	50	46	46	46	45	50	44	5	-1
Nursing And Workforce Development	71	72	71	77	71	70	75	76	74	69	83	-4	9
Research And Innovation	100	106	99	99	105	105	93	110	119	105	102	-14	-17
Redevelopment Revenue Costs	6	1	7	6	5	7	7	7	7	6	7	-1	0
TOTAL	3,596	3,581	3,618	3,610	3,609	3,556	3,604	3,623	3,607	3,670	3,530	63	-77

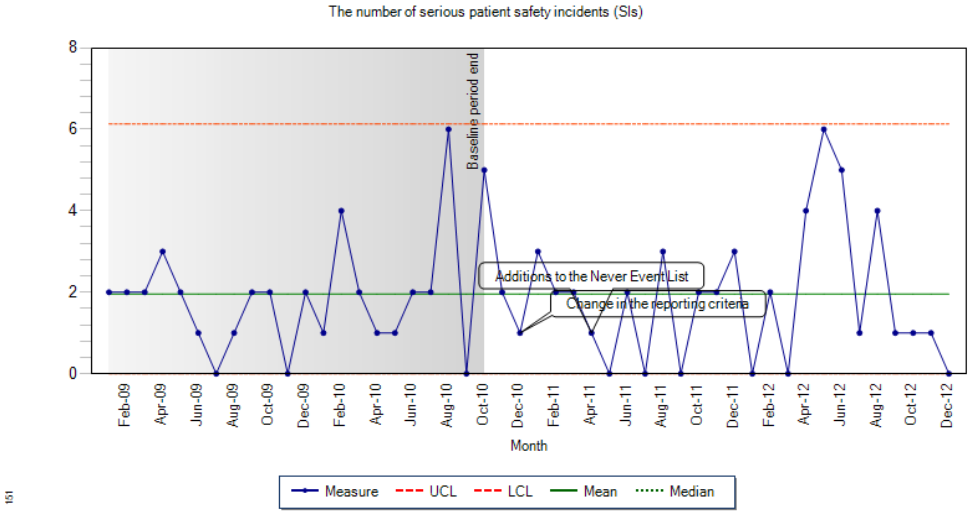
Great Ormond Street Hospital for Children NHS Foundation Trust

Appendix 5

Part I - Zero Harm Report

Where possible, the data included in this report is presented in Statistical Process Control (SPC) charts, which allows 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



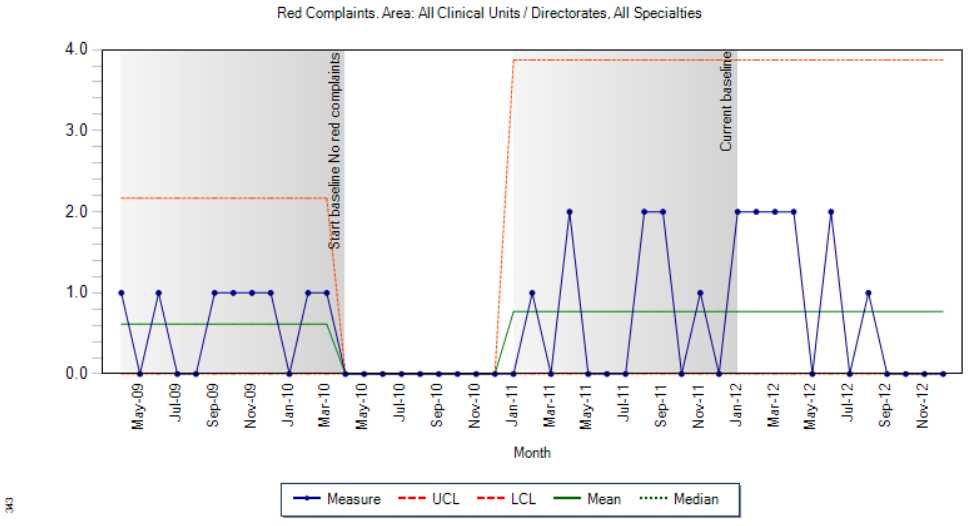
The number of serious patient safety incidents

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'*

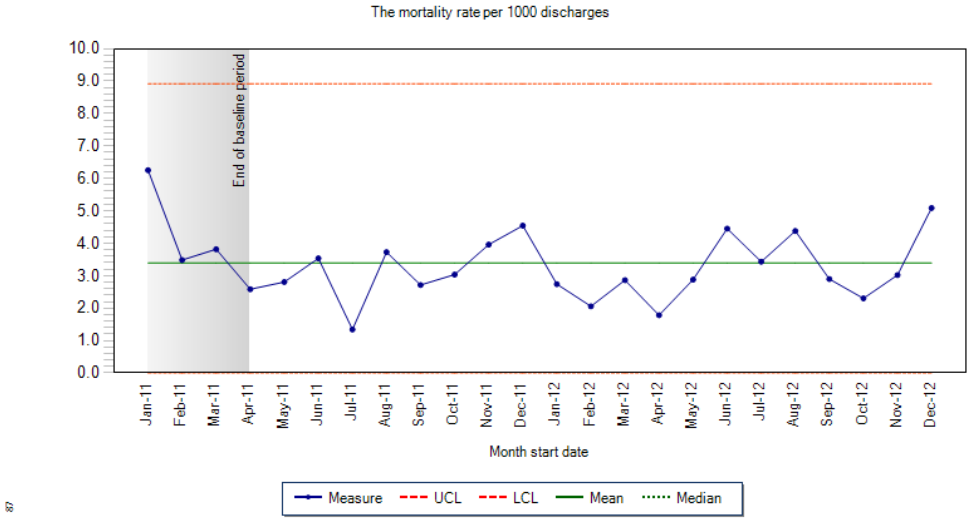
2. Red Complaints

It should be noted there have been no red complaints for 150 days (at 14th January 2013). It would be normal to expect one, on average, every 22 days.



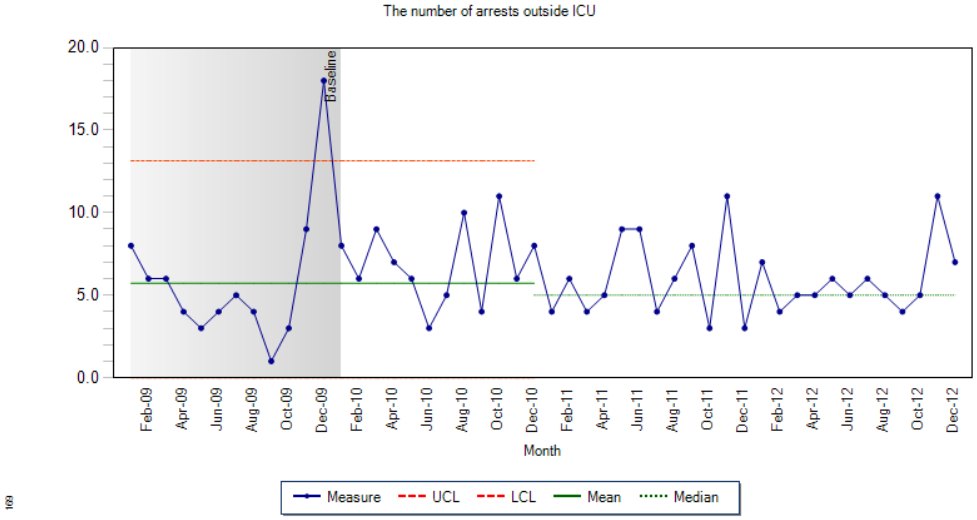
Red complaint definition: Severe harm to patient, family or reputation threat to the Trust.

3. Mortality

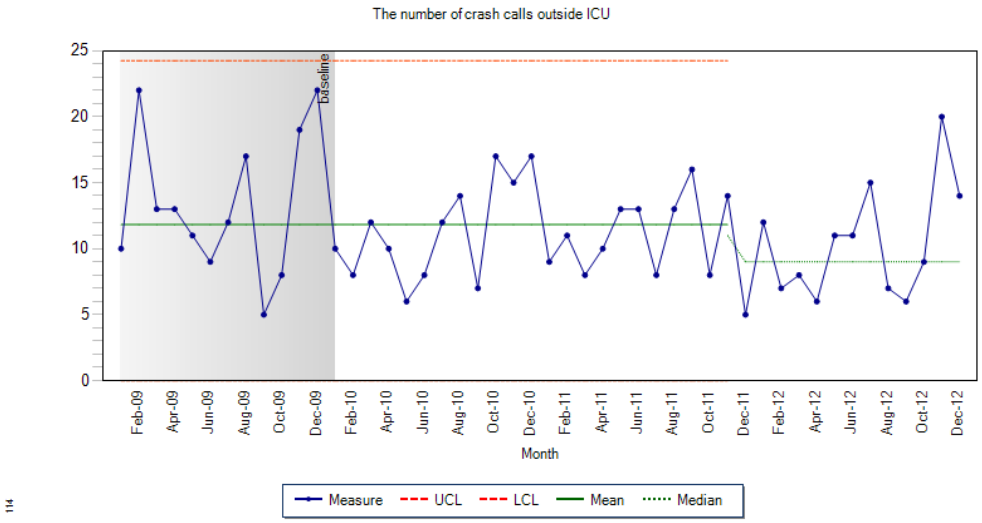


4. Arrests and crash calls outside Intensive Care Units (ICU)

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



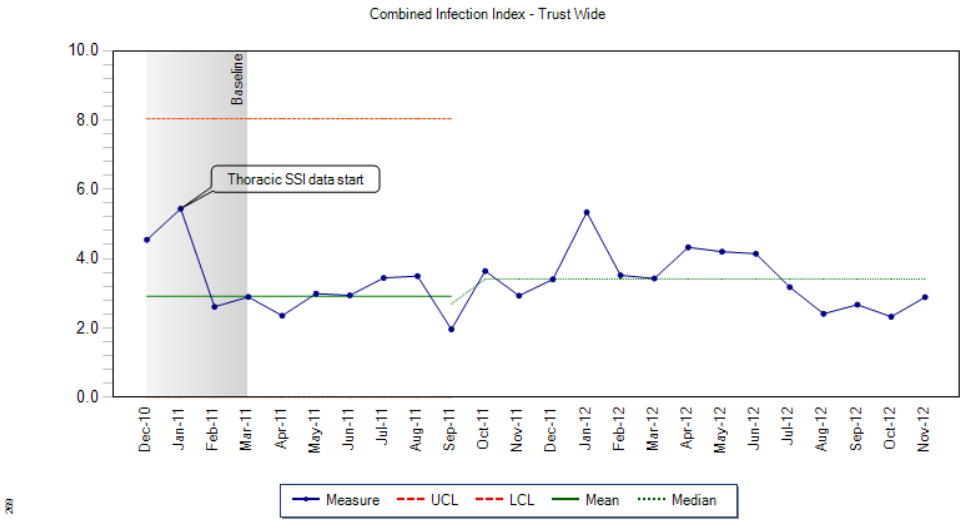
The monthly number of arrests (cardiac or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team)



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

5. 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.

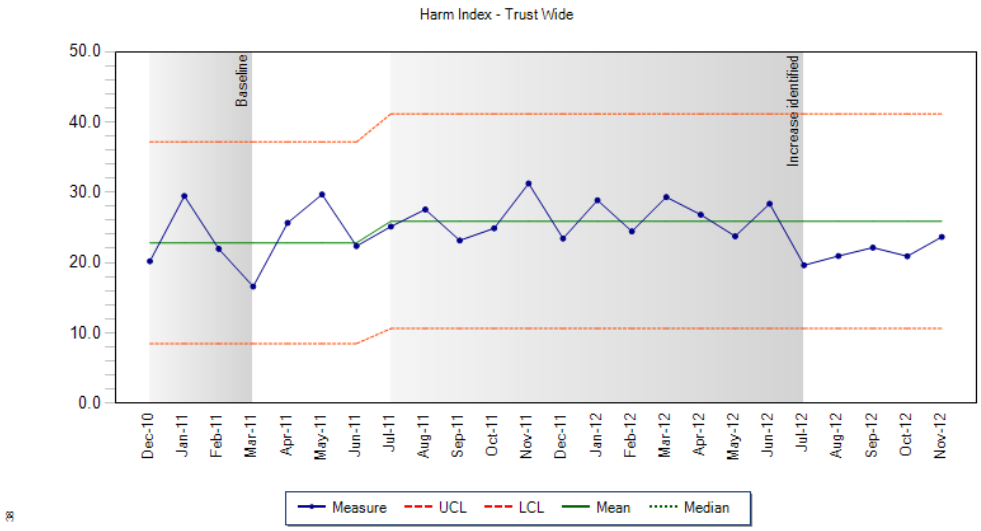


Adjusted Patient Activity = number of Finished Consultant Episodes (FCEs) + ((number of OPD appointments + (ICU bed days x 9.5)) / 12.9)

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.

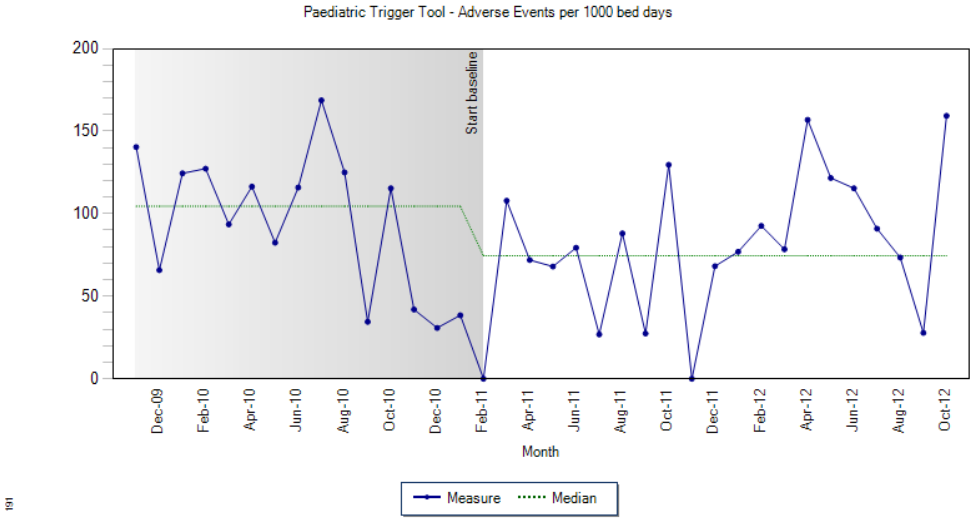
6. Combined harm index

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.



7. Paediatric Trigger Tool

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



A random sample of 20 notes are pulled each month and analysed for adverse events using a methodology developed by the IHI. It should be noted that we are working 2 months behind the date of discharge as they need to be discharged for 30 days and we need time to randomise and obtain all the case notes.

Part II – Clinical Outcomes Development

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

Milestones for 12/13, <u>per quarter</u>:

a) *Publication of at least one further speciality clinical outcome measure on the website.*
b) *25% of specialities identified a third clinical outcome measure (achieving 100% by end of Q4).*

This report provides information on for the period end July to end December 2012.

1 Clinical Outcomes

1.1 87% of specialties have identified a third outcome measure, and the programme is on track to achieve 100% by end of Q4.

1.2 No new measures have been published to the Trust website in Q3, due to the post being empty for much of this period. Units and specialties are being actively engaged with to catch up on this in Q4. The process is also being mapped to determine if it can be made simpler.

1.3 Guidelines are being prepared to support a consistent approach to outcome measure development.

2 PROMs

2.1 Agreement to build structure to PROMs development, so that all PROMs adopted or developed at GOSH will have a consistent section for universal measures of wellbeing.

2.2 Work on how to develop robust PROMS, which has already been done by other centres, will be also be shared as part of an outcomes support package.

3 International Benchmarking

3.1 Of 27 centres approached, 15 have confirmed their interest in participating in a GOSH-led benchmarking project. 7 of the 15 have provided their responses to phase 1 (common conditions and procedures; existing outcome measures and where they are reported; if there is interest in developing additional measures). Responses received have been enthusiastic and provide a foundation upon which to identify comparators and establish common language and approach.

3.2 The deadline for the scoping questionnaire responses has been extended to 31st January 2013 to capture more of the interested hospitals at phase 1.

4 Quality Account

4.1 Planning is underway. The Quality Account (or *Quality Report* under Monitor) will be shorter this year, factoring national feedback from Deloitte.

Part III – Risk & Safety

This paper reports on minutes of the previous meeting:

599.3 For risks assessed as permanently open, high risks to be reported separately from those that could be mitigated;

599.6: Information to be included in the report on how risks had been reviewed

The Trust has recently developed a process for accepting risks within the organisation. Once the process has been fully embedded the Quality Safety and Transformation team will be able to differentiate between accepted risks and aged risks.

Risks have been recorded on Datix since Datix was first introduced in 2002. 'Aged risks' is defined as risks that have been on the risk register for longer then 18 months. The Risk Managers attend the Risk Action Groups on a monthly basis to provide support, guidance and challenge on risk grading, mitigations and controls.

ICI-LM, Cardio-Respiratory, Neurosciences and International all use Datix to manage the risk registers. Medicine and DTS and Surgery will be using Datix to manage their Risk Registers from January 2013 onwards.

The Risk managers and the Clinical Unit teams have been reviewing the aged risks on their risk registers in the Risk Action Groups and update Datix accordingly.

A full report on these points has been presented at the Audit Committee

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
30th January 2013

Quarter 3 Monitor Return (Nine months to 31 December 2012) **Submitted on behalf of** Claire Newton, CFO	**Paper No: Attachment L** **For approval**

Aims / summary

This paper summarises the Trust's Quarter 3 (Q3) Return to Monitor, the regulator of NHS Foundation Trusts.

The Trust is reporting a Financial Risk Rating of **4** for the period 1 April to 31 December 2012 and a Governance Risk Rating of **green** for the period 1 October to 31 December 2012.

Key points:

Finance

- The financial information included in the template is entirely consistent with the Month 9 Board report.
- There are two financial risk indicator warnings resulting from the information included in the template:
  - **Unplanned decrease in quarterly EBITDA margin in two consecutive:**

EBITDA margin			
	Plan	**Actual**	Reduction
Q1	6.6%	9.8%	
Q2	6.5%	6.8%	-3.0%
Q3	6.8%	5.8%	-1.0%
Q1-Q3	**6.7%**	**7.5%**	

The above table shows that although the quarterly EBITDA margin has fallen in two successive quarters, the cumulative EBITDA margin of 7.5% is still higher than plan.

The reasons for the successive fall are a combination of factors. From Q1 to Q2 it was primarily due to expenditure being higher than in Q1 due to increases in the levels of estates maintenance expenditure, provision for redundancy costs and an increase in the doubtful debt provision reflecting the higher level of debt in overdue categories, particularly IPP debt. From Quarter 2 to Quarter 3 there was a reduction in both NHS and IPP clinical income due to seasonal changes in activity and a reduction in pass through income which was high in Q2. The consequential reduction in pass through expenditure from Q2 to Q3 was offset by a further increase in redundancy costs.

  - **Capital expenditure less than 75% of reforecast plan for the year to date:** Capital expenditure is below the reforecast plan due to slippage in expenditure on the 2B and 2B Enabling projects.

- The Trust is forecasting a Financial Risk Rating of 4 for the remaining quarter of the financial year and for 2013/14. The Trusts 3 year financial plan reports and FRR of at least 3 for the next financial year and there has been no significant adverse change in the current year which would mean that this cannot be achieved.

Governance

- The Trust is reporting that it has met all relevant governance targets in Q3.

The Trust has plans in place to ensure on-going compliance with all relevant governance targets and is committed to comply with all known targets going forward.

Other

- No governors' elections have taken place in the period.

There are no matters arising in the quarter requiring an exception report to Monitor.

Action required from the meeting
The Board is asked to approve the Quarter 3 'In-Year Governance Statement' prior to submission to Monitor.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Financial Stability and Health

Financial implications
N/A

Legal issues
N/A

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?
N/A

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

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

Who is accountable?
The Trust Board

In Year Governance Statement from the Board of Great Ormond Street Hospital for Children

The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see notes below)

	For finance, that:	**Board Response**
4	**The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.**	**Confirmed**
	For governance, that:	
11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix B of the Compliance Framework; and a commitment to comply with all known targets going forwards.	**Confirmed**
	Otherwise	
	The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 17 Diagram 8 and page 63) which have not already been reported.	**Confirmed**

Signed on behalf of the board of directors

Signature	_____	**Signature**	_____
Name	Baroness Tessa Blackstone	**Name**	Jan Filochowski
Capacity	Chair	**Capacity**	Chief Executive
Date	30.01.13	**Date**	30.01.13

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 30th January 2013	
Update on Assurance Framework **Submitted by** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment M**

Aims / summary

The Assurance Framework provides an overview of the principal risks to achievement of the Trust's corporate objectives. A summary of the risks presented on the Framework is attached.

As at the date of this report and of the 23 risks recorded on the Assurance Framework, no risks are rated as red, 3 as amber and 20 as green. This rating relates to an assessment of the assurances available that risks are effective. An update on the amber risks is attached for information.

The risks rated as amber are as follows:

1I Appropriately qualified and trained staff may not always obtain fully informed consent or may not obtain consent from the correct person

The project group continues to lead the work to ensure there is a standardised approach to consent. The following plan is in place and will continue to be monitored by the RACG. The Clinical Governance Committee has requested that this risk is presented at its meeting on 23rd January 2013:

- Consent Project Lead has now been appointed and commences work on 8th January 2013.
- New consent policy has been approved, published and is being promoted.
- Work is underway in Cardiorespiratory, MRI, Neurosciences. First tests of change for Cardiorespiratory are taking place first 2 weeks January 2013.
- A consent evening seminar was held in December 2012. This included expert presentations with a focus the new policy, discussion about availability of information before admission, measures and consent for research. The event was well attended and actions will be taken forward following this.
- Workstreams have been identified for Training & Education, Policy, Standardising Paperwork, Process and Parent / Patient involvement and the new project lead will facilitate these in January.
- Level 3 NHSLA achieved for Patient Information & Consent, however the Trust has not met the standard for Consent Training. This will be addressed through the Training & Education Workstream.

7B We may not meet financial and operational expectations or timescales to achieve process efficiencies and deliver electronic patient record systems through investment in IT/Information systems

The Trust Board received a presentation on the Information Strategy at the October meeting and various actions were agreed to evolve the medium term implementation plan and update the outer years of the Trust's IT investment plan. A number of projects are in development or in deployment phase to deliver increased efficiencies (EDRMS,

Ordercomms) but the full value of these efficiencies requires further clarification. A more detailed plan on how the vision will be implemented is under development.

7C The redevelopment of the site may not meet delivery timescales or financial or operational expectations

Wording for the finance agreement has been agreed and signed. A plan to deal with the delays in the building of phase 2B will be presented to the Trust Board in January 2013 as part of the redevelopment update.

The following risk has moved from amber to green assurance:

6A We may overspend on budgets by not maintaining control of costs and failing to achieve planned CRES targets

The Trust continues to closely monitor the delivery of CRES plans via regular meetings with all departments, budget management, workforce reviews and risk assessments of CRES plans. The Trust continues to forecast a positive financial year end position. This is due to planned delivery of CRES at the level required in the financial plan, plus control of costs and increased income.

A recent internal audit report sought assurance that the Trust's CRES programme has been formally established in a plan that is based on reasonable assumptions and performance against the plan is being formally monitored and reported up to the Board. The review also sought to provide assurance that shortfalls against planned saving targets are identified promptly and were possible alternative saving plans are identified and implemented to address any identified shortfalls.

On this basis, the Risk, Assurance and Compliance Group agreed that the assurance status for this risk should be changed to green.

Action required from the meeting To note the risks, controls and assurances on the Assurance Framework.
Contribution to the delivery of NHS / Trust strategies and plans Covers all Trust objectives
Financial implications None
Legal issues None
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A
Who needs to be told about any decision N/A
Who is responsible for implementing the proposals / project and anticipated timescales Risk owners
Who is accountable for the implementation of the proposal / project Risk owners

No.	Principal Risk	Accountable Executive	Assurance Committee	Initial Principal Risk Score	Revised principle risk score after mitigation	Assurance status	Date updated	Date to be reviewed by assurance committee
	STRATEGIC OBJECTIVE 1: Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world							
1A	Children may be harmed through medication errors	MD (ME)	CGC	25	**15**	GREEN	20/11/12	Jul-12
1B	Children may not be appropriately identified as being at risk of abuse and subsequent actions not taken	CN/DE	CGC	20	**15**	GREEN	16/11/12	Oct-12
1C	Children, staff and parents may be put at risk from failure to adequately maintain the estate and non clinical equipment	Dir Est	AC	25	**10**	GREEN	20/11/12	Jan-13
1D	Children may be at risk from hospital acquired infection (includes decontamination & cleanliness)	MD (ME)	CGC	20	**15**	GREEN	16/11/12	Apr-12
1E	The organisation, management, administration and delivery of clinical services (including adequacy of clinical equipment) may not always optimally deliver the best quality of service	COO	CGC	20	**15**	GREEN	18/11/12	Apr-12
1F	We may not be able to recruit and retain key staff	COO	CGC	16	**12**	GREEN	15/11/12	Jan-13
1G	We do not make sufficient progress in developing benchmarks and demonstrating world class clinical outcomes	MD (ME)	CGC	16	**8**	GREEN	19/11/12	Jul-12
1H	Lack of appropriate clinical response to the deterioration in children	MD(ME)	CGC	20	**12**	GREEN	09/11/12	Oct-12
1I	Appropriately qualified and trained staff may not always obtain fully informed consent or may not obtain consent from the correct person	MD(ME)	CGC	12	**12**	AMBER	14/11/12	Jan-13
1J	We may not work effectively across multiple teams or with parents to manage complex patients	MD	CGC	20	**15**	GREEN	14/11/12	Oct-12
	STRATEGIC OBJECTIVE 2: Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations							
2A	We may not be able to measure, report and act on patients' experience	CN/DE	CGC	9	**4**	GREEN	09/11/12	Jul-12
2B	Patients may have to wait longer than is reasonable for consultation or treatment (initial proxy being national waiting time targets)	COO	CGC	12	**9**	GREEN	15/11/12	Jan-13
2C	We may not meet referrers and other health and social care expectations around communication and accepting appropriate referrals	COO	CGC	12	**9**	GREEN	12/11/12	Jan-13
	STRATEGIC OBJECTIVE 3: Successfully deliver our clinical growth strategy							
3A	We may fail to influence and capitalise on regional and national reconfiguration opportunities	COO	AC	12	**4**	GREEN	14/11/12	Apr-12
3B	We may not deliver our strategy for International Private Patients	Dir of Internat patients	AC	20	**10**	GREEN	16/11/12	May-12

	STRATEGIC OBJECTIVE 4 : With partners maintain and develop our position as the UK's top children's research organisation							
4A	We may not deliver our research strategy and fail to deliver the required level of research income	D Research	CGC/ AC	16	**8**	GREEN	16/11/12	Apr-13
	STRATEGIC OBJECTIVE 5 : Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK							
5A	We may not deliver our education strategy and fail to maintain our position as leader of paediatric education provision and capitalise on the business opportunities resulting from the position	CN/DE	CGC	12	**8**	GREEN	16/11/12	Apr-12
5B	Staff in post may not be appropriately competent to deliver care because we are unable to deliver the education training and development they require	CN/DE	CGC	15	**10**	GREEN	16/11/12	Oct-12
	STRATEGIC OBJECTIVE 6 : Deliver a financially stable organisation							
6A	We may overspend on budgets by not maintaining control of costs and failing to achieve planned CRES targets	COO	AC	12	**8**	GREEN	18/11/12	Apr-12
6B	Sustainable funding solution for each activity within the Trust strategy may not be secured.	CFO	AC	20	**15**	GREEN	15/11/12	Oct-12
	STRATEGIC OBJECTIVE 7 : Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation							
7A	We may fail to maintain compliance with regulatory and legislative requirements	Company Secretary	AC	20	**12**	GREEN	08/01/13	Apr-12
7B	We may not meet financial and operational expectations or timescales to achieve process efficiencies and deliver electronic patient record systems through investment in IT/Information systems	CFO	AC	16	**12**	AMBER	15.11.12	Oct-12
7C	The redevelopment of the site may not meet delivery timescales or financial or operational expectations	DRedev	AC	20	**15**	AMBER	15/11/12	Jan-13

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
30th January 2013

Redevelopment Report **Submitted on behalf of:** Matthew Tulley Director of Redevelopment	**Paper No: Attachment N**

Aims / summary

To provide the Board with an update on the redevelopment programme, including phase 2B enabling works, Phase 2b main works and phase 3A (Children's Centre for Rare Diseases Research - CCRDR).

The enabling works are progressing. However delays to the schemes means the overall programme will not complete until April 2014. This has an impact on the main Phase 2B programme.

Phase 2B – procurement of the main contractor will begin in February 2013. The programme anticipates appointing a contractor in November. Due to the enabling schemes and 3T project the programme for Phase 2B has slipped, with works on-site now programmed for May 2014.

Following the procurement review, it is recommended that the procurement follows the Competitive Dialogue route.

The appointment of advisors for CCRDR continues. The functional content of the brief is being reviewed to ensure full advantage is taken of this redevelopment opportunity.

Action required from the meeting

The Board is asked to note the update and specifically;

1) The revised programme for the main 2B works
2) The proposed procurement timetable
3) The recommendation to follow the Competitive Dialogue procurement route

Contribution to the delivery of NHS Foundation Trust strategies and plans

Strategic Objective 7

Financial implications

Yes

Legal issues

Yes

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?

N/A

Who needs to be told about any decision?

N/A

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

Director of Redevelopment

Who is accountable for the implementation of the proposal / project?

Director of Redevelopment

Great Ormond Street Hospital for Children NHS Foundation Trust

Redevelopment Report

1.1 1.0 Morgan Stanley Clinical Building Update

- The 15 month Defects Liability Period –following on from Practical Completion on 22 December 2011- will be complete in March 2013.

- The Trust appealed to HMRC in respect of the VAT reclaim element which was denied – resulting in the cost shift reported in September. The Trust's VAT consultant, KPMG, has advised a successful outcome to the appeal and re-imbursement is expected from the Contractor.

1.2 Principal Outstanding Risks from previous report

- The outstanding known snagging items are largely complete, as is the final issue of the Operational and Maintenance manuals and as-installed drawings. GOSH continues to work actively with the Contractor to close this down

- The CCHP is fully operational but the arrangements for obtaining the maximum efficiency, to achieve GOSH's energy targets, are still being pursued. Remedial work to rectify the position is being specified and will be funded from the project contingency.

During October 2012, 3 of the glass curtain wall units on the north-facing façade enclosing the ward waiting areas failed. GOSH's positive position under the Contract has been confirmed [Cameron McKenna] and the Trust now understands that the Contractor will take responsibility for replacing the failed units although this has yet to be formally confirmed.

2.0 Phase 2B Enabling Works

2.1 Finance Agreement and Programme

The P2B Enabling Works Finance Agreement was agreed between the Charity and the Trust, following which the GMP [Guaranteed Maximum Price] for the Angio/PACU/Main Entrance package was approved. This allowed the revised Enabling Works programme, acknowledging the previously reported impact from introducing the 3T MRI into the P21+ framework, to be confirmed, including the milestones for future component elements, as now shown on the Enabling Works Schedule.

The 2B enabling works are now programmed to complete in April 2014. This has a consequential impact on the main 2b works programme, described in section 4.2. A review of the enabling works shows that currently the works package does not fully provide for the vacant possession of Cardiac Wing. The issue remains the identification of office space for a number of services, most significantly Portex (the previously agreed decant plan has been superceded by operational requirements) and the relocation of cardiac outpatient activity. The Redevelopment team with colleagues are working up proposed solutions. Agreement on a Cardiac Wing decant plan is required during February 2013 to avoid further delays to the main 2b programme.

3.0 3T MRI

3.1 Progress & Programme

- Work progresses on delivering the 3T project based on the selection of the GE750 MRI to be installed in L1 Cardiac Wing. The MRI can only be delivered by the Trust undertaking works to extend L1 that have previously been part of the 2B works. Planning has shown that the works can only be delivered in sequence with the Angio/Pacu works rather than progressed in parallel. This contributes to the delay in the enabling works leading to the revised programme for the 2B works.

  The 3T project is under review to consider two fundamental issues; i) the procurement choice of the GE750 is being reconsidered and ii) alternative locations for the 3T are being considered. A final decision regarding the project is required during February to avoid further delay to the main redevelopment programme.

4.0 Phase 2B New Clinical Building

4.1 Introduction

- Design work for 2B is nearing completion. A validation process will be undertaken during February to ensure relevant professional groups have been properly consulted and are content with the final design. There are three issues for the Board to be aware of: i) 2B programme, ii) procurement process and timetable and iii) operational risk.

4.2 Phase 2B Programme

- At the time of Full Business Case (FBC) approval the 2B OJEU notice was due to be issued in June 2012 with a contract award in May 2013, start on site October 2013 and project completion September 2016. The project has been delayed for a number of reasons including the delay to signing the finance agreement and changes to the enabling works schemes. A review of the programme shows that the main 2B works will now start on site May/June 2014 giving an anticipated occupation date of April 2017. There is no impact on the project budget as construction cost inflation is forecast to be flat during 2013.

- The advanced works scheme, due to start January 2014, may still be delivered to programme if the 3T works proceed as currently planned.

- The Trust Board is asked to note the revised project timetable.

4.3 Procurement Process

- A procurement strategy was agreed in March 2011. The FBC committed to review this decision prior to commencing the main procurement activities. A procurement workshop was held on 7th January 2013. Attendees included GOSH, the design team, Gardiner Theobald and the GOSHCC technical advisors EC Harris. The procurement goals were reviewed and considered to remain appropriate. Market conditions are similar to those in existence during the earlier review and the conclusions of the earlier workshop were considered to remain

valid. It is proposed that the 2B works are procured under a single stage tender process, using a design and build contract with the design team novated to the preferred contractor.

- The process did reach a different conclusion regarding the preferred tender approach. Previously, as with 2A, it has been assumed that the OJEU restricted process would be followed. However, given the complex nature of the project, specifically the site conditions, partial use of an existing structure and necessity to maintain clinical operation in L1 Cardiac Wing consideration was given to using the competitive dialogue process. On balance competitive dialogue was considered to have a number of advantages for this project. These include:

    - Allows meaningful dialogue with bidders prior to the finalisation of the tender documents.

    - A smaller number of bidders can be taken to the later stages of the competition.

    - Process has greater flexibility in the tender stages.

    - It enables contractor input in developing aspects of the project including the construction approach providing opportunities for value engineering.

    - Greater chance of achieving desired and appropriate risk transfer.

- Cabinet Office guidance states that a decision to follow the CD process cannot be confirmed until after market engagement. This is desirable anyway to discuss the tender approach with potential bidders. The use of CD requires Accounting Officer sign off.

- The proposed key procurement dates are:

    - OJEU notice issued February 2013
    - Tender documents issued May 2013
    - Contractor selected October 2013
    - Advanced works start January 2014
    - Main works commence May 2014
    - Main works completion April 2017

- The Trust Board is asked to endorse the proposed procurement route.

4.4 Operational risks associated with 2b

- The major risk associated with the main works is the continued provision of imaging services in L1 Cardiac Wing during the works programme. Deconstruction of the Cardiac Wing will take place down to two floors above L1. Major internal fit out will take place on the floor above.

- Discussions have taken place for some time with the imaging department to agree operational policies during the works period. These now need to be finalized and documented so that clear restrictions on contractor works can be included within the tender documentation.

- The structural engineers have provided assurance that the imaging department can remain operational during the 2b works. This has been based on theoretical analysis of the Cardiac Wing structure and restricted on site testing. An expanded on-site testing programme is currently in preparation to determine whether the conclusions of the earlier works remain valid.

5.0 Phase 3 Schemes

5.1 P3A

- UCL now have formal confirmation of the £10m award towards the construction of Phase 3A –The Centre for Children's Rare Disease Research (CCRDR); work is in hand to confirm compliance with HEFCE conditions

- The Project Manager [GTMS] and Cost Advisor [G&T] have been appointed; they are currently managing the OJEU selection process for the Architect, Structural Consultant and MEPH Services Consultant with input from GOSH Redevelopment Procurement and advice from GOSHCC Deputy Director of Property. Current progress is likely to see the Architect appointed at end of January 2013,approximately 4 weeks behind programme.

- The architects' presentations all demonstrated that it is feasible for the site of 20 Guildford Street to be developed beyond the current 8,900m2 brief for the CCRDR. GOSH is giving consideration as to how we might sensibly expand the brief to take advantage of this development potential in a manner that is consistent with our service ambitious and current needs.

Trust Board
30th January 2013

Patient Experience & PALS (Patient Advice & Liaison Service) Report including IPSOS MORI survey results - Outpatients **Submitted by:** Liz Morgan**,** Chief Nurse & Director of Education	**Paper No: Attachment O**

Aims / summary

This report updates the Board on progress in relation to the Trust's Patient and Public Involvement (PPI) and Patient Experience Plan for 2012/13 and includes brief extracts from the regular quarterly report of the PALS service for quarter 3.

It also provides a summary of the findings of the biannual survey of patient experience in the Outpatient Department in 2012 – see Appendix 1.

Whilst patients and their parents again report very high satisfaction with the service provided by GOSH, analysis of the results reveal that three areas in particular warrant further attention:

- Appointments: the results suggest that more appointments are being cancelled or rearranged and that parents are finding it more difficult to rearrange them where necessary. The appointments process also featured amongst the areas for improvements suggested by patients and parents themselves.
- Complaints: fewer patients and parents feel they could complain and it would be taken seriously.
- Patients with special needs: there are a number of differences in results for these patients, possibly reflecting their differing needs and expectations. While the majority of this group feels that GOSH understand their needs, one in ten does not.

An action plan to respond to the findings of the survey will be presented to and progress monitored by the Patient & Public Involvement & Experience Committee (PPIEC). The Clinical Governance Committee will seek assurance that these actions have been implemented.

Action required from the meeting

None.

Contribution to the delivery of NHS Foundation Trust strategies and plans

GOSH seeks to provide services that exceed patient and families expectations and PALS plays a key role in addressing and resolving concerns at an early stage, escalating clinical risk issues according to the agreed PALS protocol, and ensuring that managers and Trust Board are kept aware of issues and concerns raised informally.

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? A more detailed PALS Q3 report has been considered by the January 2013 Quality & Safety Committee and will also be considered by the Patient & Public Involvement & Experience (PPIEC) Committee which includes parents and representatives from the Members Council The PPIEC monitors progress in relation to the Trust's PPI & Patient Experience plan and also receives a more detailed patient experience report.
Who needs to be told about any decision? N/A
Who is responsible for implementing the proposals / project and anticipated timescales? The Outpatient Head of Nursing/Operational Manager will be responsible for delivering an action plan on areas for improvement.
Who is accountable for the implementation of the proposal / project? Liz Morgan**,** Chief Nurse & Director of Education

Patient Experience and Pals Report October 2012 – January 2013

1. Introduction

GOSH's 3 year Patient & Public Involvement & Patient Experience plan, agreed by Trust Board in January 2012, is monitored by the Patient & Public Involvement & Experience Committee (PPIEC). This report highlights recent activity to assure Trust Board of our commitment to improve the patient experience through engagement and involvement with patients and their families.

This report also includes themes identified through PALS casework from Oct 2012 to early January 2013 and brief details on case activity. PALS role is to resolve concerns informally for patients and families and to ensure that the Trust is made aware of issues where services could be improved. It is therefore a useful barometer of patient experience.

Appendix 1 provides a summary of the cases escalated to complaints/ patient safety by PALS in quarter 2 of 2012/13 (as requested by the Trust Board in November 2012).

Appendix 2 provides a summary of the findings of the IPSOS MORI Outpatient Experience Survey 2012.

2. PPI & Patient Experience activity

2.1. Young People's Forum

The third meeting of the Young Members Forum planned for February 2013 will create a work plan for 2013/14 and discuss the results of the recent 36 ward assessments against the You're Welcome Criteria standards for young people.

2.2. Front of House Project

Draft service standards are being consulted on with parents on the Patient and Public Involvement and Experience Committee. This will be rolled out in Facilities in the first instance and displayed in relevant areas once finally agreed. Consideration will then be given to whether these standards could be used more widely across the hospital.

2.3. Outpatient Survey

The bi-annual patient and family outpatient experience survey has been completed and a summary of the results is included as an appendix to this paper.

.

2.4 Inpatient Survey

Ipsos Mori has been commissioned to undertake the annual inpatient survey for 2012 with field work due to be completed in January/February 2013 and results available by the 31 March 2013.

2.5. The needs of Jewish patients and families

The report from the focus group held with Jewish patients and their families was presented to the Family Equality and Diversity Group (FED) in December 2012. A task and finish group for one year (2013/14) will prioritise issues and work on implementation. The group will report regularly to FED and will be chaired by Dr Barbara Buckley Co Medical Director.

2.6. Patient Experience of Food

Satisfaction with the quality and variety of food was identified as an area of improvement from the Ipsos Mori Inpatient survey 2010/11 and has been incorporated into the Patient Experience requirements for this financial year. A survey was conducted in October 2012 when 65 patients were surveyed in the following areas;

- Whether they received a menu - 78% did
- Did they select a meal today - 92% of the 78%
- Did they receive the food they ordered - 82% of the 92%
- Taste Standard - 75% average or above (41% Good or above)
- Presentation standard - 100% average or above (74% good or above)
- Appropriateness of food - 83% average or above (53% good or above)
- Portion size - 87% average or above (53% good or above)

An action plan is in place and a new role of Floor Manager has been introduced who is responsible for identifying any barriers to menu distribution and collection and ensuring that the Housekeepers have provided and collected menus for every patient eating on the day.

2.7 Listening Events

The Trust is proposing to hold a listening event for parents in 2013 in line with the PPIE plan. An options paper has been presented to the Membership and Engagement Committee, a sub-committee of the Members Council and a decision on the programme and timing will be made by the Members' Council.

3. PALS October 2012 – January 2013

Three 'themes' affecting patient experience were identified and escalated to management and Quality & Safety Committee as needing further consideration by the Trust.

3.1 Problems caused for families as a result of the move of the Travel Costs Reimbursement Desk to a main hospital corridor site raised by 17 families

The fares reimbursement desk has moved for a temporary period (up to a year) from Outpatients to a site in the Cardiac wing in the corridor running past the Lagoon restaurant. This is a busy, main corridor with significant patient throughput, often in beds. Parents are having conversations about their welfare benefit status and income in a busy public space. In addition the reimbursement process can take 10/15 minutes per family and so a queue of several families can wait for over an hour. This creates some obstacles in the corridor. There has also been some confusion between parents waiting for Genetics appointments and parents waiting for fare reimbursements. Lunchtimes closures also contribute to family annoyance as families need to get their fares after morning clinics before their journey home.

PALS has met with the responsible manager and recommended at minimum the purchase of a queuing management tool and a specified "waiting area", not shared with fetal medicine, and efforts are being made to address the situation by Facilities and Redevelopment.

3.2. Problems caused for families as a result of the move of the Family Accommodation Office raised by 18 families

The accommodation office has moved to the third floor of the Cardiac Building and is not signposted easily from reception. Parents have contacted us about their difficulty in finding the new space, access via old, slow, lifts for parents with prams/ suitcases/ wheelchairs, bumping into the staff fridge which is the first obstacle in the room and the poor layout. PALS and Social Work advised against this site before the move took place and have raised it again with both Facilities and Redevelopment who have agreed to relook at the site.

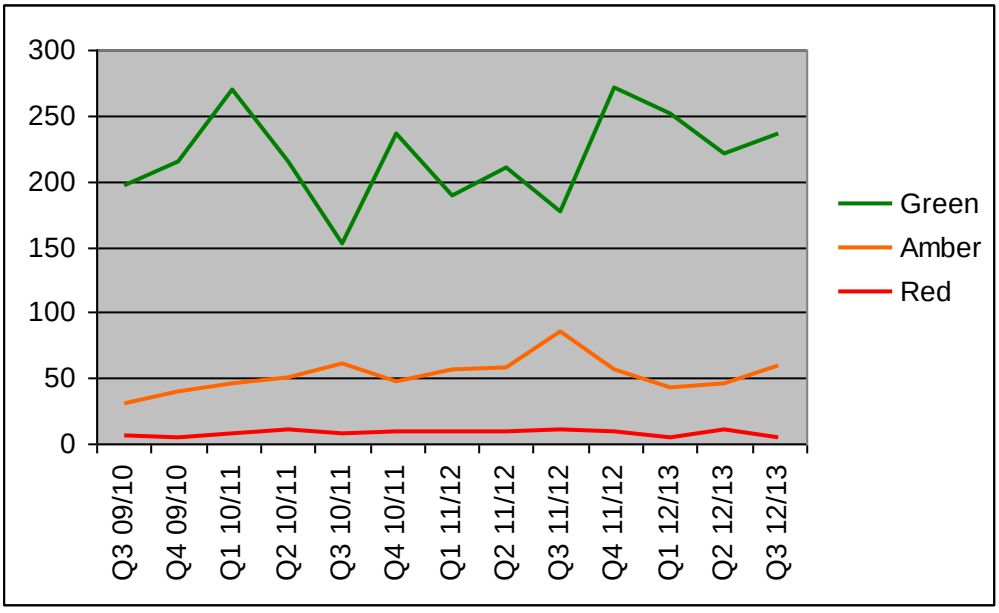
3.3. Problems with making clinic appointments and availability of clinic slots raised by 23 families

Many requests for an appointment (via clinic outcome forms or verbal requests from parents using the appointment line) cannot be met due to the high demand and low capacity for many clinics. Also, the high volume of calls to the appointment line can result in long waits whilst staff try to answer queries and then have to contact the clinical units if there is an issue with an appointment e.g. if a new patient wishes to reschedule an appointment date there may be no capacity for several weeks/months in clinics so this theoretically simple request has to be escalated to the clinical units with consequent delays and frustration for families. PALS does not know whether this is a resource issue for Appointments or a demand/capacity issue for clinics – both are given as responses from the teams.

4. PALS Casework Activity in Q3

- 334 White Cases (information)
- 240 Green Cases (resolved within 24 hours)
- 59 Amber Cases (complex, may involve meetings etc)
- Red Cases (escalated ads formal complaints or to Patient Safety)

4.1. PALS case activity for the last 3 years (not including Whites)



For the last quarter; this chart shows an increase in PALS casework for Green and Amber cases and a slight decrease in cases referred to formal complaints and patient safety.

4.2. Amber cases were resolved in liaison with staff – but a flavour is given below.

- **Communication** includes non-resident father with Parental Responsibility (PR) not getting communications as previously agreed; families unable to get through to departments or leaving messages on answerphones which are not returned; communication breakdown between Total Parenteral Nutrition (TPN) and transplant teams leading to parents having to wait several weeks before getting trained delaying discharge; a mother whose child is subject to child protection proceedings complaining of lack of information; family wanting child to be treated abroad with drugs not yet available on trial in UK and frustrated with GOSH for not urgently advocating their case; mediation meeting held with mother in dispute with clinical team after having been told that if she did not bring child in then staff would consider making a child protection referral; emotional support provided to long-term immunology patient's family as child is now on PICU and deteriorating and family are resistant to changing treatment goals

- **Clinical Care** includes 'preferring' a therapeutic intervention with a child, differing with the opinion of the parent; issues arising from a parent who has lost confidence and trust after having seen a GOSH Consultant both privately and on NHS and unclear how to obtain an overall clinical review of patient.

- **Inpatient experience** includes several cancelled surgery procedures due to lack of ITU beds and differing reactions from parents, depending on whether it was the first cancellation; a spinal patient cancelled three times for Surgery; emotional support for a family told at local hospital 'no hope for child and offered death at hospital or hospice' saying that 'after internet research they insisted on GOSH referral and now [child] is going to be fine'.

- **Admission/Discharge** includes neurosurgery coinciding with consultant leaving and another on sick leave; dispute over need for further tests between mother and Genetics

- **Staff Attitude** included disputed perception that Consultant was unsympathetic when teenage daughter did not want to undress for clinic

- **Referrals** includes frustration for two sets of parents awaiting funding decisions re cochlear implants; a lost referral and now Consultant on sick leave;

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

7. Update on 'theme' identified by PALS from Q2 July - September 2012 casework

Eligibility for NHS treatment (and the consequences of giving wrong advice) – PALS reported on several	**Update :** the Trust's Solicitor has had internal discussions with staff giving overseas patient advice to units to ensure accuracy in future and a date has

cases where inaccurate advice given by staff to families had adverse consequences for families, and in one instance to the Trust.	been set for a joint 'master-class' for key managers and other staff on 23 January 2013. Written information for clinical units is at draft stage.

7.1. Update on 'theme' identified in previous PALS reports : Gastroenterology service analysis

PALS highlighted concerns over the Gastroenterology service several times over the last few years, most recently in both Q3 and Q4 2011/12. MDTS (Medicines & Therapeutic services) also reported on efforts being made by management and staff to improve the service and PALS has met regularly with senior managers to discuss patient concerns over the last year. For this report PALS compared Gastroenterology cases by volume and by case complexity for Q3 in 2011, and Q3 in 2012.

Grading of Case	Q3: 2011	Q3: 2012
Red	3	0
Amber	24	14
Green	14	30
Total	41	44

There were a similar number of family contacts with PALS for the same quarters in 2011 and 2012. However there has been a marked change in the way that these concerns have been addressed by the service. This is evidenced by the PALS classification of enquiries which show a decrease in complex Amber and severe Red cases and an increase in routine Green cases. We think that this reflects the team's improved ability to respond to queries and concerns in a prompt and collaborative way. This reflects a cultural change from a year ago and has been welcomed by PALS and by many of the families that PALS works with.

From the above figures you can see the contrast between the high number of Amber cases in Q3 2011 and the much smaller number in Q3 2012. Such cases take a substantial amount of time from PALS and the Clinical Team to address, and their reductin is welcome. The higher number of Green cases may indicate some continuing dissatisfaction with the Gastroenterology service but these issues are now being addressed promptly and pro-actively and so are not escalated to Amber or Red. There were no formal complaints escalated from PALS regarding Gastroenterology in Q3 2012.

The Gastroenterology Team have centralised their admissions function and reviewed the management of the service and operating procedures. The data is showing a reduction in the number of concerns relating to admissions and this will continue to be closely monitored. Gastroenterology's management team are continuing to further improve all administration processes to ensure communication channels with parents are effective. All PALS concerns are being closely monitored to inform the team where further process improvements are required and a trend analysis is underway to highlight where issues persist.

It is also important to remember that the fact that a family contacts PALS about the Gastroenterology service does not always indicate that there is a service failure.

8. Concerns escalated to Complaints or Patient Safety teams (4 cases)

PALS identified 4 cases in Q3 which were referred to QS&T team for patient safety investigation or complaint. Where possible, outcomes are included, as requested by Trust Board in November 2012; however some cases are still 'open'.

IPP 8896	Child's operation was cancelled on the day after family had made strenuous attempts to get to hospital on their holy day, Eid. Complaints have contacted family who are reviewing the issues that they want addressed.
MDTS Endocrine 8887	Confusion and miscommunication as to whether patient should start growth hormone treatment. Formal complaint & response sent from Chief Executive.
SURGERY Urology 9000	Procedure cancelled, and then postponed after patient brought into hospital. Complaints & Surgery management liaising with family.
CARDIAC Surgery 8820	Parents feel that overall clinical and nursing care was poor. PALS, Risk Management and Head of Nursing liaised and apology sent to family. However, family remain dissatisfied and intend to take up offer of meeting to discuss further.

Appendix 1

UPDATE ON CASES ESCALATED TO COMPLAINTS OR PATIENT SAFETY BY PALS IN Q2

ICI Oncology 8688	Patient arrested on Lion and then transferred to PICU and father making serious allegations about clinical care and requesting toxicology reports. **Update: First copy of the complaint response was not received, second copy sent.**
ICI Rheumatology8374	Mother worried about "inappropriate and delayed" treatment leading to possible damage to her daughter's sight. Passed to Patient Safety for investigation and to organise a response/meeting with family **Update: meeting arranged with family and medical staff to discuss contested diagnosis and to provide reassurance – not dealt with by complaints**
ICI Rheum/Physiotherapy 8737	Father annoyed as they were late for last appointment of the day with Physio. due to previous clinic appointment running late. Complaint about attitude of physio. staff who they are convinced left early ignoring the family. **Update: Complaint now closed, apologies and reimbursement offered**
MDTS Gastro 8654	Failure by Gastro to organise tests agreed at MDT leading to cancelled surgical op, waste of a bed for 2 days and one night and waste of family time and emotional stress. **Update: Complaint now closed and actions being followed up (no update required)**
MDTS Gastro 8824	Parent reports that staff were unaware of the reasons for her child's admission, care and treatment during the admission was uncoordinated, nurses were not empathetic, medication was not given, treatment was delayed and food was not provided when it should have been. **Update: Complaint now closed and actions being followed up**
MDTS Gastro/Radiology 8823	Parent reports that the family have been waiting months for an angio.and abdominal MRI. They have had to call numerous times and experienced poor communication including calls not being answered or returned. The family confirmed both MRI's were taking place and attend GOSH however they were later advised in clinic that only one of the MRI's took place. The family report that the patient has internal bleeding and has had numerous blood transfusions however a treatment plan cannot be made without both MRI's. No further MRI dated had been given when making the complaint. (nearly one month on) **Update: Investigation completed, response sent and complaint closed.**
MDTS Gastro 8822	Parent raised concerns that GOSH transferred a patient to the local hospital half way through treatment; the reason given was bed management issues. The patient had to be readmitted to GOSH and the local have advised that the child should never have

	been transferred as they do not have a specialist gastro department. Parent also raised concerns regarding the amount of time it took to obtain a referral to GOSH previously and the deterioration in the patient that delay incurred. **Update: Complaint now closed and actions being followed up**
MDTS Radiology/MRI 8600	A mother was very distressed at GOSH'S poor planning as she had been awaiting an MRI for some weeks because her son cannot open his mouth; on the day it was cancelled as it was 'discovered' that two anaesthetists would be needed. **Update: Complaint now closed and actions being followed up**
MDTS Social Work Rheumatology 8825	The family has raised a series of points relating to the patients care under physio, a section 47 referral and have said that the trust is blocking and withholding social services information from full disclosure. **Update : under investigation**
MDTS Social Work 8826	Patient's father wrote in regarding social work staff member's attitude and about the social worker not completing a benefits form for the patient's father. **Update: Investigation completed, response sent and complaint closed.**
Neurosciences Koala ward 8667	Mother and baby (4 days post open-heart surgery) spent night on Koala ward in room at 11^{o} temperature. Ward staff did not reallocate patient to another room (one was available) and nor were they successful in getting Works to intervene. Situation not dealt with until post-handover on Saturday morning. **Update: Complaint now closed and actions being followed up**
Neurosciences Koala ward 8621	Following adverse outcome of a procedure SI analysis took place and support given to mother by PALS and ward staff. **Update: Incident later de-escalated; arrangements made to take mother through findings shortly – not dealt with by complaints**
Surgery Orthopaedics 8721	Patient believes there may have been "mistakes" in her clinical care and treatment and is seeking compensation. **Update: response sent to patient answering questions.**

Appendix 1

Report of IPSOS MORI Outpatient Experience Survey 2012

Aim of Survey

The 2012 outpatient survey aimed to measure and track GOSH's performance in terms of:

- Outpatients' overall perceptions of their visit to the hospital;
- Satisfaction levels with the appointments process;
- The quality and effectiveness of staff communications;
- Aspects of doctors' and nurses' care;
- The process of leaving hospital;
- Potential improvements to patients' visits.

Specific areas of service and patient care are explored within each of these overarching themes

Methodology: The 2012 survey:

- Replicated the approach used in the previous 2010 outpatient experience survey to enable comparison of results. Where there are differences these previous figures are presented in brackets.
- 751 (750) telephone interviews were conducted with either outpatients (aged 10+), or parents of outpatients (all ages) who attended the hospital during the period 1st June and 31st July 2012 (1st February – 31st March).
- Fieldwork took place between 2nd - 24th October 2012 (27th May – 20th June).
- A Computer Assisted Telephone Interviewing (CATI) approach was used.
- In total, 625 (608) parent and 126 (142) patient interviews were conducted.
- The average length of each interview was 12 (10) minutes.

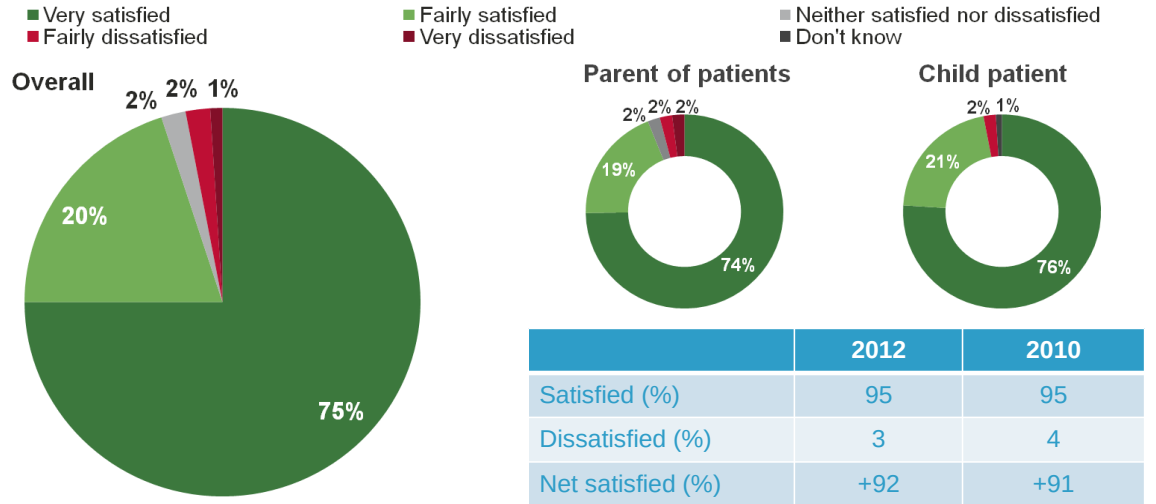
Key Messages – Overall:

- Patients and their parents again report very high satisfaction with the service provided by GOSH. Overall, 95% are satisfied, in line with the 2010 survey.
- Whilst still very high, the proportion who say they are likely to recommend the hospital to a friend or relative has fallen two percentage points since 2010, from 98% to 96%.
- The proportions of patients whose appointments have been cancelled or rearranged, either by themselves or by GOSH, have increased significantly since 2010. In addition, parents are less likely than in 2010 to say that they found to process of changing the appointment easy (76% compared to 84%).
- Patients with special needs or disabilities are more likely than those without special needs or disabilities to have cancelled or rearranged their appointment themselves (63% compared to 52%), or to have had their appointment cancelled or rearranged by GOSH (52% compared to 43%).
- Across most performance indicators there have been no significant changes, but there has been a decrease in the proportion of parents and patients who feel that they can complain and they will be taken seriously, from 82% in 2010 to 74% in 2012.
- There has also been an increase in the proportion of parents and patients who disagree that the patient was given the opportunity to talk to the doctor on their own (from 18% to 25%).

Satisfaction with visit

5

Q2 Overall, how satisfied or dissatisfied were you with your last visit to Great Ormond Street Hospital?



	2012	2010
Satisfied (%)	95	95
Dissatisfied (%)	3	4
Net satisfied (%)	+92	+91

Base: All respondents (751); 2nd-24th October 2012; 2010 base (750).

Base: All parents of patients (625); 2nd-24th October 2012. Base: All patients (126); 2nd-24th October 2012.

Source: Ipsos MORI

Ipsos MORI
Social Research Institute

Appointments – Points of Note:

Over the last 3 years Outpatients has increased activity by 24% rising from 139,159 in 2009/10 to 155,080 in 2010/11 and 172,588 in 2011/12.

With this increase there has been a decrease of 8% in ease of booking appointments with an increase of 5% of the families surveyed in 2012 finding it difficult to cancel or rearrange an appointment.

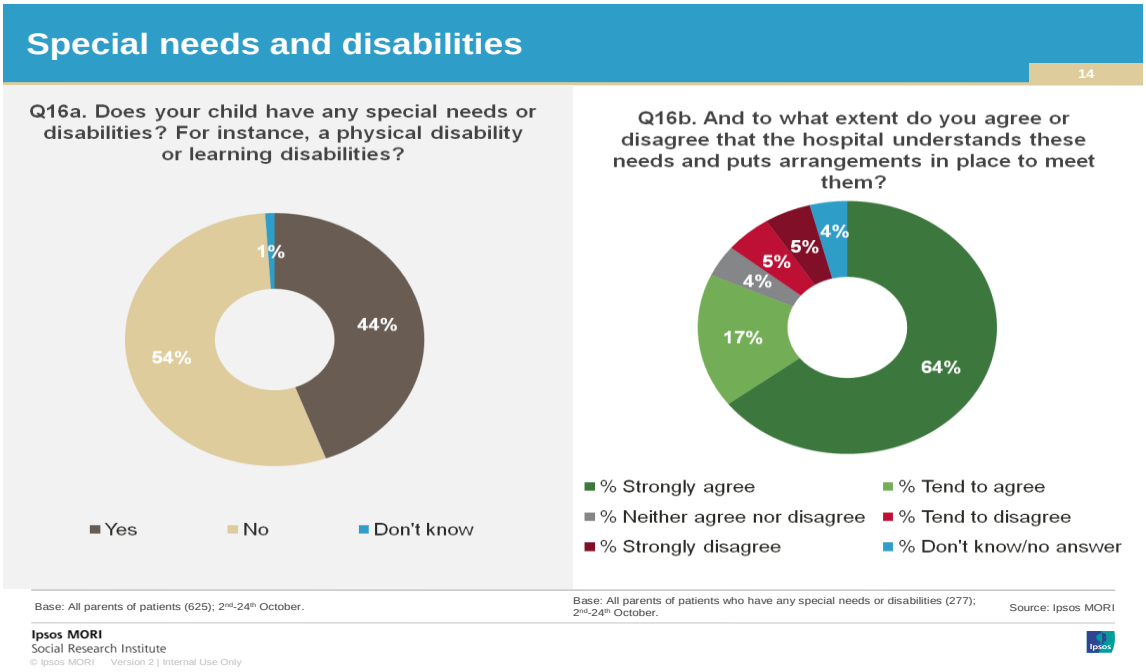
At present, it is not clear whether this is due to:

- difficulty in physically accessing services to change the appointment either through face to face contact or verbally through use of the appointment line
- actual capacity in the clinics to facilitate the change of appointment
- complexity of the patient pathway to co-ordinate appointments

The overall high satisfaction results from patients and families with communication and service leads us to believe this is more likely to be due to capacity in clinics to meet the patient demand rather than communicating with the service to change an appointment.

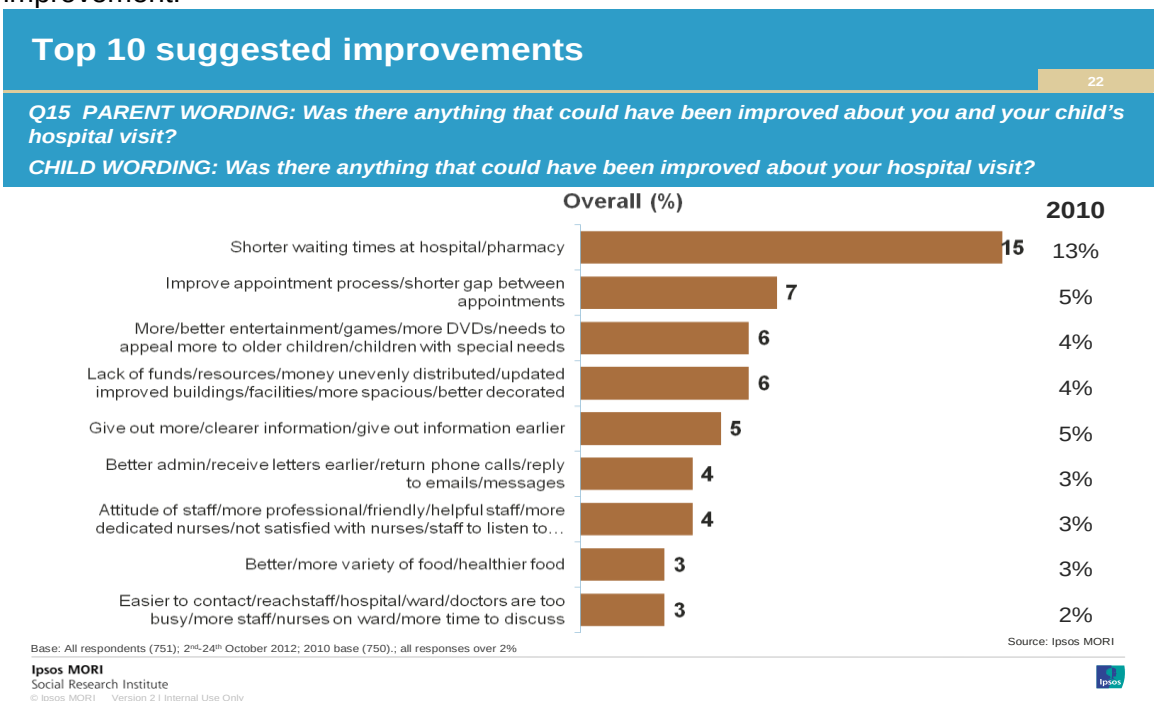
Special Needs and Disabilities:

A number of children and young people under the care of the Trust are recognised as having special needs and disabilities. It is acknowledged that visiting Outpatients can be particularly distressing for these patients and their families. To understand how well the Trust recognises and makes adjustments for these patients a specific question was asked:



Suggested Improvements and Recommendations:

While results overall are very positive, as was the case in 2010, there are a small number of areas for consideration. These arise either where results are less positive in comparison with other aspects covered in the survey or when compared to 2010, or from parents' and patients' own suggestions for improvement:



Three areas in particular warrant further attention:

- Appointments: the results suggest that more appointments are being cancelled or rearranged and that parents are finding it more difficult to rearrange them where necessary. The appointments process also featured amongst the areas for improvements suggested by patients and parents themselves.
- Complaints: fewer patients and parents feel they could complain and it would be taken seriously.
- Patients with special needs: there are a number of differences in results for these patients, possibly reflecting their differing needs and expectations. While the majority of this group feels that GOSH understand their needs, one in ten does not.

Next Steps:
The Head of Corporate Facilities and Head of Nursing/Operational Manager are developing an action plan to respond to the findings of the survey. This will be presented to and progress monitored by the Patient & Public Involvement & Experience Committee.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
30th January 2013

Update on the Care Quality Commission Quality & Risk Profile – November 2012 **Submitted by**: Anna Ferrant, Company Secretary	**Paper No: Attachment Q**

Aims / summary
To update the committee on the current status of the Care Quality Commission (CQC) Quality & Risk Profile (QRP) November 2012 data.

The CQC has issued the Trust with the November 2012 Quality and Risk Profile (QRP). This is a tool for the CQC, providers and commissioners to use in monitoring compliance with the essential standards of quality and safety.

Actions required to address any deficits identified are managed and monitored through the Risk, Assurance and Compliance Group.

Action required from the meeting
To note the current status of registration against the 16 essential outcomes.

Contribution to the delivery of NHS / Trust strategies and plans
It is a requirement under the Health & Social Care Act that the Trust is registered for the services it provides and that it actively seeks to maintain this registration.

Financial implications
Should deficits be identified, registration can be removed or maintained with conditions. This can have financial penalties for the Trust including damage to reputation.

Legal issues
Registration is a legal requirement.

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

Who needs to be told about any decision
To note.

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

Who is accountable for the implementation of the proposal / project
Chief Nurse and Director of Education

Compliance with Care Quality Commission Standards and Registration

Summary

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

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

Quality and Risk Profile

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

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

Outcome risk estimates

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

Appendix 1 provides an update on registration against the sixteen key outcomes, as reported by the CQC in November 2012 and shows changes in risk estimates over the previous 2 months.

It should be noted that all previous NHSLA level 2 data items have been removed from the November QRP. The Trust is now awaiting the addition of the October 2012 NHSLA assessment data.

CQC Inspection Report

On the 4th January 2013 the CQC published their report following an unannounced inspection of the Trust by 6 Compliance Inspectors, a Pharmacy Specialist and a Paediatric Specialist on the 25th September 2012. The report has been circulated to Board members and is available on the CQC website at: (http://www.cqc.org.uk/directory/rp401).

No actions or improvements were required following the inspections and the organisation was compliant with all outcomes inspected.

There were some negative comments made in the report about the quality and variety of food, lack of space to meet privacy and dignity needs on Peter Pan ward and medicines storage. These comments are being reviewed and where necessary, developed into an action plan.

Great Ormond Street Hospital for Children NHS Foundation Trust

CQC Quality Risk Profile – Great Ormond Street Hospital (as at November 2012)

Outcome	Standard	September 2012	October 2012	November 2012	Comment
Outcome 1	Respecting and Involving People Who Use Services	Low Green	Low Green	Low Green	No change.
Outcome 2	Consent to Care and Treatment	High Green	High Green	Low Yellow	Decrease due to the removal of an NHSLA data item.
Outcome 4	Care and Welfare of People Who Use Services	Low Green	Low Green	Low Green	No change.
Outcome 5	Meeting Nutritional Needs	High Yellow	High Yellow	Low Yellow	Improved due to the addition of a 'Scores on the Doors', Food Standards Agency Rating data item.
Outcome 6	Cooperating With Other Providers	Low Yellow	Low Yellow	High Yellow	Decrease due to the removal of an NHSLA data item and addition of a CQC, Share Your Knowledge data item
Outcome 7	Safeguarding People Who Use Services from Abuse	Low Green	Low Green	Low Yellow	due to the removal of an NHSLA data item and addition of a CQC, Share Your Knowledge data item
Outcome 8	Cleanliness and Infection Control	Low Yellow	Low Yellow	Low Yellow	No change.
Outcome 9	Management of Medicines	Low Yellow	Low Yellow	Low Yellow	No change.
Outcome 10	Safety and Suitability of Premises	Low Yellow	Low Yellow	Low Yellow	No change.
Outcome 11	Safety, Availability and Suitability of Premises	Low Green	Low Green	High Green	Decrease due to the removal of NHSLA data items and addition of Similar to Expected Counter Fraud and Security Management Service, Security Management Service Compliant Data items.
Outcome 12	Requirements Relating to Workers	Low Yellow	Low Yellow	Low Yellow	No change.
Outcome 13	Staffing	Low Yellow	Low Yellow	Low Yellow	No change.
Outcome 14	Supporting Staff	Low Yellow	Low Yellow	Low Yellow	No change.
Outcome 16	Assessing and Monitoring the Quality of Service Provision	Low Green	Low Green	Low Green	No change.
Outcome 17	Complaints	Low Green	Low Green	Low Green	No change.
Outcome 21	Records	Low Green	Low Green	Low Green	No change.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 30th January 2013	
Audit Committee Meeting Summary **15th January 2013** **Submitted by:** Claire Newton, Chief Finance Officer	**Paper No: Attachment S** **For information**

Aim

To summarise key elements of the meeting in January 2013

- ***Decisions taken***

A recommendation to the Board that time is allocated to discussion of risk at a future meeting and in particular:

- the use of the business model to assess existing and emerging risks
- the Board should consider how to clarify its risk appetite for different categories of strategic and operational risk.
- risks be split between those which are in the nature of GOSH's business and those over which there is control and can be eliminated
- incidents be more explicitly matched against the key risks which can be managed and board information be reviewed to ensure it provides relevant information about these risks.
- Management should consider if reputation, the charity relationship and Dubai activities should be included as specific risks.

IPP debtors. The increase in IPP debtors is significant and the time to pay has increased. Further action to escalate credit control processes was requested.

- ***Major agenda items:***

1 Review of strategic risks from the Assurance Framework (estate maintenance and the Redevelopment programme
2 Review of the quarterly report from the internal auditors. One Internal audit report with limited assurance (Staff rostering system) and two further reports including individual sections with limited assurance (Corporate records and Bank and Agency staff)
3 Stock loss & lone worker incidents summary reports
4 Preparation for the financial "year " end : property valuations and other matters arising from any regulatory changes

- ***Other matters for the attention of the Trust Board***

The Redevelopment programme risk presentation highlighted the complexity of the enabling programme, and the tight budget.

The R&I strategy is being presented at the January board meeting and research risk will be on the agenda of the March AC

Action required from the meeting

To note the matters discussed at the Audit Committee

Contribution to the delivery of NHS / Trust strategies and plans

Governance

Financial implications Many of the agenda items have financial implications
Legal issues N/A
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A
Who needs to be told about any decision N/A
Who is responsible for implementing the proposals / project and anticipated timescales N/A
Who is accountable for the implementation of the proposal / project Chief Finance Officer

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 30th January 2013	
Finance & Investment Committee Meeting Summary 28th November 2012	**Paper No: Attachment T**
Submitted by: Claire Newton, Chief Finance Officer	**For information**

Aim

To summarise key elements of the meeting in November 2012

- ***Decisions taken***

  Recommendation to Trust Board to approve hybrid theatre and additional angiography suite business case

- ***Major agenda items:***

  For discussion:

  a) Forecast based on M1-6 actual results. This was also submitted to Trust Board
  b) Segmental analysis of the revenue account separating the revenue accounts of the IPP activities from the NHS clinical activity, R&D and NHS Education activities. Further action was agreed to clarify the amount of the expenditure relating to the R&D and Education segments
  c) Service Line Reporting by clinical unit and how this information should be used in the future to drive the financial development of the clinical units
  d) Neurosciences – analysis of productivity measures. This information will now be produced on a regular basis and a deep dive into the productivity measures will be considered for each clinical unit in turn at subsequent meetings.
  e) CRES status report for the current financial year and the status of the plans for 2013/14

  For information:

  a) 2013/14 Financial planning process and timetable

Action required from the meeting To note the matters discussed at the F&I Committee
Contribution to the delivery of NHS / Trust strategies and plans Governance
Financial implications Many of the agenda items have financial implications
Legal issues N/A
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A
Who needs to be told about any decision N/A
Who is responsible for implementing the proposals / project and anticipated timescalesN/A
Who is accountable for the implementation of the proposal / project Chief Finance Officer

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 30th January 2013	
Management Board Minutes November and December 2012 **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment U**
Aims / summary To provide copies of minutes of Management Board in November and December 2012. Following a review of the Trust's governance structure, Management Board meetings will now be replaced by a weekly meeting of the Overall Management Group (OMG), accountable to the Chief Executive.	
Action required from the meeting To note the items discussed.	
Contribution to the delivery of NHS Foundation Trust strategies and plans STRATEGIC OBJECTIVE 7: Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation.	
Financial implications None	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? Management Board minutes are available on GOSH Web	
Who needs to be told about any decision? N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? N/A	
Who is accountable for the implementation of the proposal / project? N/A	
Author and date Anna Ferrant, Company Secretary 21st January 2013	

Attachment U

Great Ormond Street Hospital for Children NHS Foundation Trust

MANAGEMENT BOARD
15th November, 2012

FINAL MINUTES

Present:

Barbara Buckley (BB)	Co-Medical Director
Cathy Cale (CC)	CU Chair, ICI-LM
Fiona Dalton (FD)	Chief Operating Officer (Chair)
Carlos De Sousa (CDS)	Chair of Neurosciences
Sarah Dobbing (SD)	GM Neurosciences
Alex Faulkes (AFa)	Head of Planning & Performance Management
Jan Filochowski (JF)	Chief Executive
Allan Goldman (AG)	Interim Chair of Critical Care Services
Carla Hobart (CH)	General Manager ICI-LM
Melanie Hiorns (MH)	CU Chair MDTS
Elizabeth Jackson (EJ)	CU Chair, Surgery
Mark Large (ML)	Director of ICT
Anne Layther (AL)	GM, Cardiac
Joanne Lofthouse (JL)	General Manager, International Division
Liz Morgan (LM)	Chief Nurse and Director of Education.
Claire Newton (CN	Chief Finance Officer
Natalie Robinson (NR)	Deputy Director of Redevelopment
Tom Smerdon (TS)*	GM Surgery
Andrew Taylor (AT)	Interim CU Chair, Cardio-Respiratory
Peter Wollaston (PW)	Head of Corporate Facilities

In Attendance

Sue Conner (SC)	Co-Acting GM MDTS
Anna Ferrant (AF)	Company Secretary
Peter Lachman (PL)*	Associate Medical Director and Consultant in Service Design & Transformation
Catherine Lawlor (CL)	PA to Chair & Chief Executive (minutes)

**Denotes meeting part attended*

706	**Apologies**	
706.1	Apologies were received from Anna Jebb, GM MDTS; Martin Elliott, Co Medical Director and Robert Burns, Deputy Chief Operating Officer.	
706.2	FD welcomed Jan Filochowski, the new Chief Executive to the Board. JF reported he was looking forward to meeting as many people as possible and looked forward to working with everyone.	
707	**Minutes of Management Board meeting held on 18th October 2012**	
707.1	The minutes of meeting held on 18th October 2012 were approved as an accurate record with the amendments that Janet Williss, Deputy Chief Nurse had attended and Allan Goldman's title should have been noted as Interim Chair of Critical Care Services and Michael Davidson's title should have been noted as Co-Acting GM, MDTS.	
708	**Action Log and other matters arising**	
708.1	684.2 – Work Experience – LM gave a verbal update which advised that progress was underway. LM agreed to give a futher update in December.	
708.2	670.6 – Reducing Medication Errors – CC advised the Board this was in progress and a further update would be reported in January, 2013.	
708.3	670.8 – CEW Scores – All Clinical Units reported that the importance of acting appropriately – It was noted this was completed.	
708.4	675.5 – Discharge Summaries – SD to circulate the findings on an audit of discharge summaries being completed with 2 months to Management Board. It was noted this was completed.	
708.5	686.4 – Clinicians Assistants Project – LM to clarify in the paper that it is not intended that any existing roles will be changed, only that the job descriptions and line management. It was noted this was completed.	
708.6	689.4 – Child Protection Quarterly Update – JW to work with HR to ensure that there is an action plan for all out-standing CRBs that Managers are aware and that there is a date for when all will be completed. – LM gave a verbal update to the Board, LM stated a project plan was currently underway to brings levels up to 100% and a further update would be provided in February, 2013.	
	Clinical Unit and Zero Harm Reports	
709	**IPP**	
709.1	JL presented the IPP Zero Harm report.	
709.2	JL reported it was 85 days from the last SI. JL reported no refusals nor delays and one complaint in IPP for the month. JL reported that the SI was currently under investigation.	
709.3	JL reported the top three risks to the unit were medical cover for unplanned pp outliers; recognition and escalation of the deteriorating child and ward rounds / handover in IPP. JL reported all risks were being addressed.	
709.4	Management Board **noted** the content of the report.	

710	**Critical Care and Cardio Respiratory**	
710.1	AG presented the Critical Care and Cardiac Zero Harm report.	
710.2	AG reported it was 31 days from the last SI and there were 36 refusals, no delays and 3 complaints in the unit for the month which were under investigation.	
710.3	AG reported the top three risks to the unit were medication errors, Nursing Stress on CICU Flamingo and Intelligent Storage. AG reported all risks were being addressed.	
710.4	Management Board **noted** the content of the report.	
711	**Infection, Cancer and Immunity**	
711.1	CC presented the ICI Zero Harm report.	
711.2	CC reported it was 363 days from the last SI and there was one complaint, no refusals and 2 delays in the unit for the month.	
711.3	CC reported the top three risks to the unit were access to IV infusion & blood transfusion sets/lines, IT systems and access to MRI Scan slots.	
711.4	FD raised concern on the progress of the review proposed to reconfigure haem/ oncology services across London.	
711.5	**Action:** Paediatric Oncology Shared Care Units. CC to update the CEO on the progress of the review proposed to reconfigure haem/ oncology services across London.	**CC**
711.6	Management Board **noted** the content of the report.	
712	**MDTS**	
712.1	MH presented the MDTS Zero Harm report. MH reported it was 105 days from the last SI. MH reported no refusals, 1 delay and 3 complaints which were under investigation in the unit for the month.	
712.2	MH reported the top three risks to the unit were insufficient staffing to manage the current number and complexity/dependencies of patients on Rainforest and Kingfisher Wards; insufficient MRI capacity to meet demand and completion of Pims forms by non-doctors. MH reported all risks were being addressed.	
712.3	Management Board **noted** the content of the report.	
713	**Neurosciences**	
713.1	CDS presented the Neurosciences Zero Harm report.	
713.2	CDS reported it was 11 days from the last SI and there were 4 refusals, no delays and no complaints in the unit for the month.	
713.3	CDS reported the top three risks to the unit were medication errors, Neuromuscular complex pathways and shortage of outpatient space. CDS reported all risks were being addressed.	
713.4	Management Board **noted** the content of the report.	

714	**Surgery & Deepdive**	
714.1	EJ presented the Deepdive. EJ reported on 2012/13 – zero harm, infection control, Hand Hygiene, WHO safety checklist, pre-Operative Assessment, fasting times, emergency access to theatre, medicines management and the gastrostomy service project.	
714.2	EJ presented the Surgery Zero Harm report.	
714.3	EJ reported it was 37 days from the last SI and there were 6 refusals and 2 complaints which were under investigation in the unit for the month.	
714.4	EJ reported the top three risks to the unit were out of hours cover for surgical patients, not achieving adequate junior medical cover within budget and activity shortfall limiting growth income. EJ reported all risks were being addressed.	
714.5	Management Board **noted** the content of the report.	
715	**Reporting Zero Harm - Quality, Safety & Transformation (QST) Update**	
715.1	SD presented the report which was taken as read. SD reported a slight difference in crash calls which did not seem to tally with Unit crash calls report. SD reported that this would be looked into.	
715.2	**Action:** SD to look at the QST report crash calls and try to ensure they match the unit crash calls report.	
715.3	Management Board **noted** the content of the report.	
716	**Education Zero harm Report**	
716.1	LM presented the report. The report presented achievements, issues and risks in relation to the delivery of the Trust's responsibilities and objectives for education learning and development.	
716.2	LM highlighted NHSLA Level 3, gateway to Leadership and the Leadership Excellence Programme, Study Leave Policy 2012, Local Induction, KPIs for Education, PDR rates, Mandatory Training, Local induction, Resuscitation training; Information Governance; Safeguarding Children and 'No Shows'.	
716.3	JF stated that the Trust needed to take a line next month regarding mandatory training and consequences of non-compliance.	
716.4	**Action:** CU teams to work with the Education and Training Team to develop a plan of action detailing how to get all relevant staff groups to attend mandatory training and undertake their PDRs by end March 2013.	**LM & CU Teams**
716.5	Management Board **noted** the content of the report.	
717	**Key Performance Report October 2012**	
717.1	AFa presented the Key Performance Indicator (KPI) report. AFa reported on CQUIN, MRSA & C.difficile, Secondary User Service (SUS) data quality measures, Patient refusals, Theatre utilisation, PDRs and R&I.	
717.2	Management Board **noted** the report.	

718	**Finance and Activity Report**	
718.1	CN presented the report. The year to date EBITDA (excluding capital donations) was £16.4M, 8%, and this was £2.8M ahead of plan. The net surplus excluding capital donations was £3.8M, £3.5M ahead of plan, and this included a favourable variance on depreciation due to delays in the start of accelerated depreciation on the Cardiac Wing and a minor variation on PDC. Capital donations were £15M lower than plan reflecting delays in Phase2B enabling expenditure.	
718.2	Management Board **noted** the contents of the report.	
719	**Monthly CRES Report**	
719.1	AFa asked Management Board to note progress on the CRES programme. AFa reported the identified CRES position for 2012/13 had deteriorated by £400k and there was risk around remaining red and amber schemes totalling £2.0m.	
719.2	Management Board **noted** the contents of the report.	
720	**Outline Strategy for General Paediatrics at GOSH**	
720.1	CDS presented the paper which followed the paper submitted to September management board requesting permission to recruit a permanent Consultant General Paediatrician to join the General Paediatric team, a post funded through the Spinal Business case and sessions from the Cleft service.	
720.2	The paper set out the short and long-term strategy for the General Paediatric team, and provided an update to Management Board on the progress of the team since their introduction in February 2011.	
720.3	SD requested approval to proceed with the recruitment of a substantive fifth Consultant and agreement to move forward with discussions about the short and long-term plans for the general paediatric team within the hospital.	
720.4	The Board had a discussion about the job description and agreed that the possibility for future on call and other hospital functions should be built in.	
720.5	Management Board **approved** the post with the appropriate job description.	
721	**Improving the Process for Managing Serious Incidents**	
721.1	BB stated this would be brought back in January.	
721.2	**Action:** To be brought back to the January 2013 meeting with an update on progress with the revised process.	**ME**
722	**ENT Growth and Development of Head and Neck Tumour Surgery**	
722.1	TS presented the report which was taken as read.	
722.2	Management Board **approved** the strategy.	
723	**Update on OCRR system implementation**	
723.1	CC presented the paper. CC reported an order communication and results reporting system was being developed to improve the efficiency of test (for radiology and laboratory tests and some other physiological tests eg ECHO) requesting and results reporting, with attendant impact on quality of patient care	

	provided.	
723.2	The Board had a discussion and agreed that CC would bring back a proposed process for ordering radiology tests and meeting regulatory requirements.	
723.3	**Action:** To agree a process for ordering radiology tests and meeting regulatory requirements.	**CC**
724	**Palliative Care Consultant Post – Job Description/Person Specification**	
724.1	CC presented the paper which noted the job description for a new substantive 10PA consultant post, working in the Palliative Care Department in the Infection, Cancer, Immunity & Laboratory Medicine Unit.	
724.2	Management Board noted and **approved** the Job description.	
725	**Recruitment of Replacement Oncology Consultant**	
725.1	CH presented the paper as read. CH requested approval for the replacement of Dr Peppy Brock, who would retire in April 2014.	
725.2	CH reported it was important that there was a period of transfer of expertise to the new post holder so a replacement was required, ideally from approximately March 2013. The proleptic post would be funded for 12-18 months from the charity and then the post would transition into the NHS service upon Dr Brock's retirement.	
725.3	Management Board **approved** the post.	
726	**Partnership Proposals - UCLP/GSTT**	
726.1	PW presented the paper which was taken as read. Management Board approved the direction of travel but asked that the proposals be brought back next month.	
726.2	**Action:** To provide the Board with information on the reasons for the selection of GSTT as a preferred provider for a shared services model for soft FM services	**PW**
727	**Decontamination Service Delivery – Steam Sterilisation**	
727.1	PW presened the paper which requested approval to move the steam sterilisation service.	
727.2	Management Board supported the direction of travel.	
728	**Angio Hybrid Theatre**	
728.1	CN presented the paper which presented a business case for the move of the new hybrid angiography suite in the MSCB to a newly created space in VCB and adjust the existing space for use as a full operating theatre.	
728.2	Management Board **approved** for the proposal to be brought to F&I committee and Trust Board.	
729	**Tender for the provision of a managed nurse bank**	
729.1	LM presented the tender which requested Management Board's approval to award of the contract for the provision of a managed nurse bank to Bank Partners.	
729.2	Management Board **approved** the Tender.	

730	**NHSLA Update**	
730.1	BB presented the report that was taken as read.	
730.2	Management Board **noted** the content of the report.	
731	**Report from the Business Case Review Group**	
731.1	Management Board **noted** the content of the report.	
732	**Patient and Public Involvement and Experience Committee**	
732.1	Management Board **noted** the content of the report.	
733	**Any other business**	
733.1	**Cardiothoracic Surgery Locum Consultant**	
733.2	AG presented the paper which was tabled and requested Management Board's approval to recruit to the Cardiothoracic Surgery Locum Consultant post to enable the Trust to replace the current locum who was leaving at the end of January 2013.	
733.3	Management Board **approved** the post.	

Great Ormond Street Hospital for Children NHS Foundation Trust

MANAGEMENT BOARD
13th December, 2012

FINAL MINUTES

Present:

Barbara Buckley (BB)	Co-Medical Director
Robert Burns (RB)	Deputy Chief Operating Officer
Cathy Cale (CC)	CU Chair, ICI-LM
Fiona Dalton (FD)	Chief Operating Officer (Chair)
Carlos De Sousa (CDS)	Chair of Neurosciences
Sarah Dobbing (SD)	GM Neurosciences
Martin Elliott (ME)	Co Medical Director
Jan Filochowski (JF)	Chief Executive
Allan Goldman (AG)	Interim Chair of Critical Care Services
Carla Hobart (CH)	General Manager ICI-LM
Melanie Hiorns (MH)	CU Chair MDTS
Elizabeth Jackson (EJ)*	CU Chair, Surgery
Mark Large (ML)	Director of ICT
Anne Laythe r (AL)	GM, Cardiac
Joanne Lofthouse (JL)	General Manager, International Division
Liz Morgan (LM)	Chief Nurse and Director of Education.
Claire Newton (CN	Chief Finance Officer
Tom Smerdon (TS)	GM Surgery
Andrew Taylor (AT)	Interim CU Chair, Cardio-Respiratory
Matthew Tulley (MT)	Director of Redevelopment
Peter Wollaston (PW)	Head of Corporate Facilities

In Attendance

Sue Conner (SC)	Co-Acting GM MDTS
Michael Davidson (MD)	Co-Acting GM MDTS
Anna Ferrant (AF)	Company Secretary
Peter Lachman (PL)*	Associate Medical Director and Consultant in Service Design & Transformation
Catherine Lawlor (CL)	PA to Chair & Chief Executive (minutes)
Lynette Linkson (LL)	Darzi Fellow & Clinical improvement role in ICI-LM

**Denotes meeting part attended*

734	**Apologies**	
734.1	Apologies were received from Anna Jebb, GM MDTS.	
735	**Minutes of Management Board meeting held on 15th November, 2012**	
735.1	The minutes of meeting held on 15th November 2012 were approved as an accurate record.	
736	**Action Log and other matters arising**	
736.1	678.5 - Nursing Accountability – LM gave a verbal update. LM reported nursing groups and meetings had been reviewed and streamlined to clarify and simplify procedures. Management Board noted the progress.	
736.2	684.2 – Work Experience – LM gave a verbal update which advised that progress was underway. A draft proposal had gone to the GMSCs.	
736.3	711.5 - Paediatric Oncology Shared Care Unit – CC reported this had been completed.	
736.4	715.2 - Reporting Zero Harm - Quality, Safety & Transformation (QST) Update – SD reported this had been completed.	
736.5	723.3 - Ordering of radiology tests – CC reported that ME would be taking the lead on this. It was agreed an update would be provided in January, 2013.	
736.6	726.2 – Partnership Proposals – UCLP/GSTT - It was agreed this would come back in January, 2013.	
737	**Other matters**	
737.1	JF presented a presentation on first ideas on managing the Trust. JF presented on management principles, the current management structure, how the trust currently judges what committees and advisory groups were needed, new initial proposals and conclusions.	
737.2	Management Board discussed and debated the proposed prosals for change and agreed the changes and agreed to implement these in January, 2013.	
	Clinical Unit and Zero Harm Reports	
738	**IPP**	
738.1	JL presented the IPP Zero Harm report.	
738.2	JL reported it was 106 days from the last SI. JL reported no refusals, one delay and two complaints in IPP for the month which were under investigation.	
738.3	JL reported the top three risks to the unit were CVL infections, escalation of the deteriorating child and ward rounds / handover in IPP. JL reported all risks were being addressed.	
738.4	JF reported on the meeting in Dubai. JF reported the presentation had gone well and an update would be communicated once known.	
738.5	JL reported targets for PDR completions were in progress.	
738.6	Management Board **noted** the content of the report.	

739	**Critical Care and Cardio Respiratory**	
739.1	AG presented the Critical Care part of the report which was taken as read. AG reported there was an issue about intensive care beds and capacity which was a nation wide issue. AG also reported there was an issue with structure for decision making. JF suggested that a high level action group be set up to manage some of issues.	
739.2	**Action:** CL to set up the initial high level action group to manage some of issues to be chaired by AG.	**CL**
739.3	AT presented Cardio Respiratory part of the report which was taken as read. AG reported the sad news that Vanessa Garside, Cardiac Nurse Practitioners had died on 8 December. AT also reported that a SI was currently under investigation.	
739.4	AG and AT reported targets for PDR completions were in progress.	
739.5	Management Board **noted** the content of the report.	
740	**Infection, Cancer and Immunity**	
740.1	CC presented the ICI Zero Harm report.	
740.2	CC reported it was 391days from the last SI and there was one complaint, no refusals and 7 delays in the unit for the month.	
740.3	CC reported the top three risks to the unit were access to MRI Scan slots, Chemotherapy administration and Maintenance/validation of isolation cubicle air handling units.	
740.4	CC reported PDR completion plans were working well.	
740.5	Management Board **noted** the content of the report.	
741	**MDTS**	
741.1	MH presented the MDTS Zero Harm report. MH reported it was 133 days from the last SI. MH reported 2 refusals, no delays and 3 complaints which were under investigation in the unit for the month.	
741.2	MH reported the top three risks to the unit were insufficient staffing to manage the current number and complexity/dependencies of patients on Rainforest and Kingfisher Wards; insufficient MRI capacity to meet demand and completion of Pims forms by non-doctors. MH reported all risks were being addressed.	
741.3	MH reported targets for PDR completions were in progress. Management Board **noted** the content of the report.	
742	**Surgery**	
742.1	TS presented the Surgery Zero Harm report.	
742.2	TS reported it was 65 days from the last SI and there were 4 refusals, no delays and 1 complaints which were under investigation in the unit for the month.	
742.3	TS reported the top three risks to the unit were out of hours cover for surgical patients, not achieving adequate junior medical cover within budget and activity shortfall limiting growth income. TS reported all risks were being addressed.	

742.4	TS reported PDR completion plans were underway and currently at 72%.	
742.5	Management Board **noted** the content of the report.	
743	**Reporting Zero Harm - Quality, Safety & Transformation (QST) Update**	
743.1	RB presented the report which was taken as read. RB noted that there had been no red complaints for 119 days.	
743.2	Management Board **noted** the content of the report.	
744	**Genetics Strategy**	
744.1	NL provided a summary of the Genetics Laboratory Strategy as requested at Management Board (October 2012) and updated progress on the development of the business case for the next generation DNA sequencer.	
744.2	The finalised business case would come to January Management Board or the equivent for Trust approval. The case would then be presented to February GOSHCC Grants Committee for recommendation to March Special Trustees meeting for final funding approval.	
744.3	Management Board **approved** the Genetics Strategy and approved the initiation of the OJEU procurement of a next generation DNA sequencer pending approval of the associated business case. .	
745	**Neurosciences & Deepdive**	
745.1	CDS presented the Neurosciences Zero Harm report which was taken as read. CDS reported PDR completion plans were underway and queried why honorary staff were on the list. LM stated that clarity would be provided.	
745.2	**Action:** LM to provide clarity around why honorary staff were on the PDR target lists.	
745.3	CDS and SD presented the deepdive which reported an overview of risk and harm: incidents and SI, medication errors, infection control and crash calls. Also Unit zero harm projects: Consent, Shunt protocol to address infection rates, Handover for Hospital@Night, Neuromuscular complex pathways and Effectiveness of risk action group.	
745.4	Management Board **noted** the content of the report.	
746	**Education Zero harm Report**	
746.1	LM presented the report which was taken as read.	
746.2	Management Board **noted** the content of the report.	
747	**Key Performance Report November 2012**	
747.1	RB presented the Key Performance Indicator (KPI) report which was taken as read.	
747.2	Management Board **noted** the report.	
748	**Finance and Activity Report**	
748.1	CN presented the report. The year to date EBITDA (excluding capital donations)	

	was £19.0M, and this was £2.7M ahead of plan. The net surplus excluding capital donations was £4.6M, £4.2M ahead of plan, and this included a favourable variance on depreciation due to delays in the start of accelerated depreciation on the Cardiac Wing and a minor variation on PDC. Capital donations were £18.5M lower than plan reflecting delays in Phase2B enabling expenditure.	
748.2	Management Board **noted** the contents of the report.	
749	**Monthly CRES Report**	
749.1	RB gave a verbal update on CRES.	
749.2	Management Board **noted** the report.	
750	**Medical Equipment proposals for 2013-14**	
750.1	FD presented the report. Management Board discussed and agreed to agree the clinically prioritised list and that identified funding would be requested from GOSHCC via Grants Committee (or reported at PAD for MSCB).	
750.2	Management Board **approved** the report.	
751	**Epilepsy Safe and Sustainable Business Case**	
751.1	SD presented the business case which outlined the current developments of the epilepsy surgery at GOSH following the Safe and Sustainable Paediatric Neurosurgery designation as a Children's Epilepsy Surgery Service and proposed an expansion in the complex epilepsy service to facilitate the development of a new patient pathway, and create capacity for an expansion of the service.	
751.2	SD requested approval to invest in the service, with further funding once activity had been demonstrated.	
751.3	Management Board **approved** the Business Case.	
752	**Maxillofacial Business Case**	
752.1	TS presented the Business Case. TS reported a comprehensive review of the capacity and demand within the Maxillofacial Surgery service had confirmed that a second Maxillofacial Surgeon was required to ensure the Trust delived 18 week wait referral to treatment (RTT), in addition to ensuring that the service was no longer offered by a lone service provider.	
752.2	Management Board **approved** the Business case in part, the request for 100K was not approved.	
753	**Project NOVO (EDRMS)**	
753.1	PW presented the report that was taken as read. Management Board **noted** the content of the report.	
754	**Report from the Business Case Review Group**	
754.1	Management Board **noted** the content of the report.	
755	**Redevelopment Programme Steering Board**	
755.1	Management Board **noted** the content of the report.	

756 756.1	**Major Incident Planning Group** Management Board **noted** the content of the report.	
757 757.1	**Extraordinary Meeting of combined Major Incident Planning Group and Pandemic Flu Group** Management Board **noted** the content of the report.	
758 758.1	**Waivers** CN presented the report and request approval for Waivers from the following suppliers: Zip and Ardmore Healthcare Ltd. Management Board **approved** the waivers.	
759	**Any other business**	
759.1	LM reported Ofsted/CQC pilot inspection of Camden had been completed and a further update would be reported once known.	