Meeting of the Trust Board
30 November 2011

Dear Members

There will be a public meeting of the Trust Board on Wednesday 30 November 2011 commencing at **3:45pm** in the **York House Conference Room, Level 2,** Great Ormond Street, London, WC1N 3JH.

Company Secretary

Direct Line: 020 7813 8230

Fax: 020 7813 8218

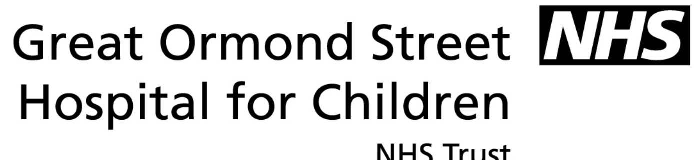
AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Attachment
1.	**Apologies for absence**	Chair	
Declarations of Interest The Chair and members of this meeting are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must, as soon as practicable after the commencement of the meeting disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 28th September 2011**	Chair	**K**
3.	**Matters Arising / Action point checklist**	Chair	**L**
4.	**Chief Executive's Update** • **Members' Council** • **Safe and Sustainable (cardiac and neurosurgery)** • **Ombudsman Report- update** • **Public Sector Strike Update**	Chief Executive	**Verbal Update**
5.	**Patient Story – Parent's report about care at Trust**	Chair	**Presentation**
6.	**Clinical Unit Presentation – Cardio-respiratory Unit**		**Presentation**
7.	**Zero Harm Report**	Co- Medical Director (ME)	**N**
	ITEMS FOR APPROVAL		
8.	**Foundation Trust Application Update**	Chief Operating Officer	**O**
9.	**Risk Management Policy**	Co- Medical Director (ME)	**P**
10.	**Review of effectiveness of Management Board revised terms of reference and subcommittee reporting**	Company Secretary	**Q**
11.	**Revised Audit Committee Terms of Reference**	Company Secretary	**R**
12.	**Equality Delivery System**	Co-Medical Director (BB)	**S**

	UPDATES		
13.	**Performance Report (October 2011)**	Chief Operating Officer	**T**
14.	**Finance and Activity Report (October 2011)**	Chief Finance Officer	**U**
15.	**Audit Committee Update from October 2011 meeting**	Mr Charles Tilley	**V**
16.	**Management Board** • **September 2011 minutes** • **October 2011 Minutes**	Chief Executive	**W**
17.	**Update on Compliance with Care Quality Commission Standards and Registration**	Company Secretary	**Y**
18.	**Head of Nursing Report**	Chief Nurse and Director of Education/ Head of Nursing	**Z**
19.	**Infection, Prevention and Control Update**	Co-Medical Director (ME)/ John Hartley	**1**
20.	**Overview of Trust Wide Risk Register**	Co-Medical Director (ME)	**2**
21.	**UCLP Research Activities Update**	Director of Research and Innovation	**3**
22.	**Redevelopment Update**	Director of Redevelopment	**4**
23.	**Trust Board Members' Activities**	Chair	
	FOR RATIFICATION		
24.	**Consultant Appointments**	Chair	**Verbal**
25.	**Register of Seals**	Chief Executive	**5**
	ITEMS FOR INFORMATION (These items will not be discussed unless a Member gives prior notification of an intention to do so.)		
26.	**External Auditor's Management Letter 2010-11**	Chief Finance Officer	**6**
27.	**UCL Partners Board Minutes September 2011**	Chief Executive	**7**
28.	**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.)		
29.	**Next meeting** The next Trust Board meeting will be held on Wednesday 25th January 2012 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT K

Attachment K



DRAFT Minutes of the meeting of Trust Board held on 28 September 2011

Present

Baroness Tessa Blackstone	Chairman
Dr Barbara Buckley	Co-Medical Director
Ms Yvonne Brown	Non-Executive Director
Prof Andy Copp	Non-Executive Director
Dr Jane Collins	Chief Executive
Ms Fiona Dalton	Chief Operating Officer
Professor Martin Elliott	Co-Medical Director
Mr Andrew Fane	Non-Executive Director
Ms Mary MacLeod	Non-Executive Director
Mrs Liz Morgan	Chief Nurse and Director of Education
Mrs Claire Newton	Chief Finance Officer
Mr Charles Tilley	Non-Executive Director

In attendance

Mr Trevor Clarke	Director of International and Private Patients
Dr Anna Ferrant	Company Secretary (and minutes)
Mr William McGill	Director of Redevelopment
Mr David Lomas	Designate Non-Executive Director

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

189. Apologies for Absence

189.1 There were no apologies for absence.

190. Declarations of Interest

190.1 There were no declarations of interest received.

191. Minutes of the Meeting Held on 27 July 2011

191.1 The minutes of the Trust Board meeting held on 27th July 2011 were received and the Chairman requested Board Members to check them for accuracy.

191.2 The minutes were **approved** as an accurate record, subject to the following changes:

191.3 161.11 – The word ‘currently’ to be removed from the sentence about ICH.

192. Matters arising

192.1 160.2: Professor Martin Elliott, Co-Medical Director reported that work was underway to improve systems around identifying the deteriorating child, with a work programme led by a nurse consultant.

192.2 163.12: This matter was covered in the performance report on the agenda.

193. Clinical Unit Presentation (SNAPS) Specialist Neonatal and Paediatric Surgery

193.1 Mr Joe Curry delivered the presentation, highlighting that the speciality's referral base covered London, the rest of Great Britain and also received international patients. SNAPS was based on Squirrel ward and included 22 beds with 2 bays for HDU.

193.2 He reported that the speciality had experienced a 12% increase in referrals in 2010-11. This included an increase in appendix and hernia referrals in children under one year of age. This increase was partly due to the fact that surgeons in DGHs were increasingly refusing to carry out this surgery.

193.3 Mr Curry reported that the speciality had been involved in a transformation programme and this had enabled a significant improvement in bed management, in particular with the non-elective pathway so that there was reduced variation in how children were managed.

193.4 Integrated pathways had been developed and work was underway to implement these and hold multi-disciplinary discharge meetings and improve communications with referrers. Work was also underway to review performance metrics by consultant.

193.5 Work was being conducted to reduce the length of stay of patients. By streamlining care, it had been found that the speciality could shave days off admission. Work was also under way to plan for discharge in a more consistent way.

193.6 Some of the challenges faced included bed capacity, theatre capacity, referral routes and skill mix of staff. Another challenge had been with developing outcomes that were comparable with other Trusts.

193.7 The Chairman asked if there was a national shortage of staff in the speciality – Mr Curry stated that cover in other trusts was provided by junior paediatric staff and that GOSH did not have this option available to it. Consideration was being given to the appointment of middle grade physicians who would have no on call responsibilities but provide 9-5 cover.

193.8 Mr Curry highlighted the areas that the speciality wished to improve, including establishment of stronger links with local referrers, development of a 'no refusal' policy, management of theatres and support services for

staff.

193.9 Mr Andrew Fane, Non-Executive Director asked whether the Unit had the resources to sustain the current growth. Mr Curry stated that the Trust would need to keep up withcompetitors, as they were starting to impose on market share by appointing specialists to work in peripheral areas of their Trusts.

193.10 Mrs Liz Morgan, Chief Nurse and Director of Education asked whether the speciality had encountered difficulties in getting children back to local hospitals for treatment. Mr Curry stated that this was a problem as local hospitals found it difficult dealing with complex ill children.

193.11 Ms Yvonne Brown, Non-Executive Director asked if the appointment of the general paediatricians had improved quality and safety on the wards. Mr Curry stated that their appointment had had a positive impact on the number of serious incidents occurring on the wards and had also enhanced the management of central venous lines.

193.12 The Chairman thanked the SNAPS team for the presentation.

194. Chief Executive's Update

194.1 Dr Jane Collins, Chief Executive provided the Board with a verbal update.

194.2

- Safe and Sustainable Cardiac Review

The Judicial Review was underway, following a challenge from the Royal Brompton NHS Foundation Trust about the results of the consultation and an outcome awaited.

Work had commenced on the neurosurgery safe and sustainable review with discussions taking place between ourselves and Kings College London and Addenbrookes.

194.3

- Ombudsman Report

A complaint had been upheld against the Trust by the Parliamentary Ombudsman for Health. The complaint related to the delivery of the service to a child and the handling of the subsequent complaint. Work was underway to finalise an action plan to respond to the report. It was noted that the Ombudsman had sought expert advice on the care provided to the child and that the consensus was that the failure in the standard of care had not caused the child's death. Nevertheless, the Chief Executive stated that the Trust had failed this child and let the family down. It was noted that the Clinical Governance Committee had taken responsibility for seeking assurance that the action plan was developed and that the actions would be implemented.

194.4

- Learning Disability Audit

The Chief Executive informed the Board that a recent internal audit report had found limited assurance of the systems in place for considering patients with a learning disability. An action plan had been developed and

Clinical Governance Committee would seek assurance that actions had been implemented.

194.5 • Spinal Surgery Review

The Spinal Surgery Review had been completed and the teams were working to develop an action plan. It was noted that the cluster of deaths were identified by spinal surgeons as a result of an audit of patient outcomes.

194.6 • Biomedical Research Centre

The Chief Executive was pleased to announce that the Trust had been successful in being re-awarded BRC status. The Board congratulated the teams involved in the application process.

194.7 The Board **noted** the report.

195. Zero Harm Report , including update on work programmes for medicines management and deteriorating children

195.1 Professor Martin Elliott, Co-Medical Director presented the report.

195.2 He informed the Board that patient safety officers had been appointed to support the units in their zero harm work. Results from the Patient Trigger Tool demonstrated a trend in the reduction in rate of harm to patients.

195.3 Work was under way to speed up the time it took to complete investigations into incidents. There was a plan to bring patient stories to the Board in the new year.

195.4 The Trust had had success in managing central venous line infections and continued to work to improve performance in hand washing.

195.5 Issues still remained around monitoring the deteriorating child and a programme of work was being implemented.

195.6 Mr Charles Tilley, Non-Executive Director asked how the Trust was working to ensure that the Board was appraised of quality matters. The Co-Medical Director stated that data was available to the Board at every meeting and all Board members also attended safety walk-arounds in the Trust.

195.7 Professor Andy Copp, Non-Executive Director queried the data showing the number of crash calls and number of arrests outside of ICU. Professor Elliott confirmed that this was the same data but that analysis showed that the number of arrests arising from a crash call was reducing.

195.8 Ms Mary MacLeod, Non-Executive Director stated that the Board was presented with a number of different reports and recommendations for improvements related to quality and safety and asked if these requirements were centrally pulled together and monitored. Professor Elliott stated that the Quality and Safety Committee was responsible for monitoring implementation of recommendations. The Chief Executive

stated that the Transformation Team and Transformation Board also had an overview of implementation .

196. **Trust Board Terms of Reference**

196.1 The Company Secretary presented the revised terms of reference (ToR). The terms of reference had been reviewed in light of the Monitor's Code of Governance, the Trust's governance structure, amendments to the Standing Orders (as currently drafted) and draft Reservation and Delegation of Powers. The ToR were last approved in April 2010.

196.2 The revised ToR included reference to increasing the number of Non-Executive Directors (NEDs) from five to six. This had previously been approved by the Board and the Company Secretary reminded the Board that the sixth NED position would be subject to consideration for full appointment following authorisation by Monitor as a Foundation Trust.

196.3 The Board **approved** the revised terms of reference, noting that the items in brackets would be adopted once the trust was authorised as a Foundation Trust.

197. **Dubai Office and Registration**

197.1 The Director of International and Private Patients presented the proposal to downsize the Dubai office, with the aim of achieving reduced rent and providing the same services within a smaller floor space. The Board was advised that this move would not affect the service provision or staff numbers, but would reduce costs. There were no financing requirements as the one-off costs would be absorbed within the savings generated in year one, and there would be a CRES in all years.

197.2 The Board **approved** the proposal to downsize and relocate the Dubai Office in the Dubai Health Care City.

198. **Performance Report Month 5 (2011-12)**

198.1 The Chief Operating Officer presented the report and included the update on C Difficile.

198.2 She reported that the Department of Health was considering changing the operating framework for next year for paediatric hospitals in relation to the assessment of C Difficile. The update on C Difficile showed that the Trust undertook a greater number of tests on children than other trusts and that this approach did not impact on the numbers of cases identified and was appropriate practice.

198.3 The Chief Operating Officer reported that the reason for the high number of incomplete pathways was due to a data quality issue and validation of the data had been conducted. Following this work, the Trust was now achieving the median and 95th Centile standards for incomplete pathways for August.

198.4 The Board was informed that despite the fact that external targets no

longer existed around waiting times for patients, the Trust still viewed this as important and continued to monitor performance. The median wait for non-admitted patients should be 6.6 weeks from point of referral (from the GP) and as a result of prioritisation, the Trust was achieving 6.67 weeks.

198.5 Mr Tilley asked about progress with the discharge summary target. The Chief Operating Officer stated that the electronic solution would help with improving performance in this area. It was agreed that an update on this would be provided at the Trust Board in November 2011.

198.6 **Action**: The Chief Operating Officer to provide an update on the implementation of the IT system for producing discharge letters.

198.7 Professor Copp asked that the number of relevant paediatric NICE recommendations be presented in summary form. The Chief Operating Officer agreed to look at this.

198.9 **Action**: The Chief Operating Officer to consider how the number of relevant paediatric NICE recommendations can be presented in summary form in the performance report.

198.10 Mr David Lomas, Designate Non-Executive Director asked what criteria had been used to determine the use of red, amber and green in the performance report. The Chief Operating Officer stated that criteria was being developed and advised that amber should be viewed as 'work in progress. Mr Lomas stated that it would be helpful to understand how long some of the targets had been assessed as 'red'. The Chief Operating Officer stated that the quarterly report showed this.

198.11 The Board **noted** the report.

199. Finance Report

199.1 The Chief Finance Officer presented the report, which was taken as read. Year to date, the Trust had £5.1 m surplus which £1.1m lower than plan. The forecast out-turn remained in line with 'Plan' at £7.1m pre-impairment.

199.2 The most significant risks in delivering the forecast were:

- achievement of the Trust's CRES plan;
- managing Phase 2A double running costs in line with Plan;
- managing commissioning contracts to ensure activity delivered was appropriately reimbursed;
- containing the higher than planned levels of agency staff although this was currently primarily to deliver planned activity;
- ensuring Research and Innovation income shortfall was made up from the new sources being pursued.

199.3 In addition, the Trust's international income was currently close to the private patient cap due to over-performance. The Board was informed that action was being taken to manage it going forward below the cap, pending any changes in the forthcoming legislation.

199.4 Agency staff spend continued to be a challenge. The Chief Finance Officer reported that the Trust was trying to shift as many agency staff as possible to bank contracts, in order to reduce costs.

199.5 The Board **noted** the content of the report.

200. Foundation Trust update

200.1 The Chief Operating Officer presented the report.

200.2 The Board was reminded that Monitor started their formal assessment on 3 August 2011. Since then, they had visited the hospital for 6 days in total for meetings with individual staff and groups. The assessment covered finance, clinical quality, education & training, audit, CRES, the constitution, charity, research & innovation, IT, data quality, performance management, two tours of the hospital, and visits to wards.

200.3 The main themes emerging from these meetings were:

- A focus on risk, in terms of service quality, clinical and financial risks. In particular, the assessment of risks associated with the CRES programme and service developments;
- Contingency planning for the redevelopment programme;
- Board decision making and assurance.

200.4 The Chief Operating Officer stated that the Trust had now reported 5 cases of C Difficile.

200.5 The Board **noted** the report.

201. In-year review of Strategic Objectives and work-streams

201.1 The Chief Operating Officer presented the report and stated that the work-streams were on track for achievement by the end of the year.

201.2 The Board **noted** the report.

202. Child Protection Update (March 2011– Present)

202.1 The Chief Nurse and Director of Education presented the report and informed the Board that progress was being made against the annual plan.

202.2 A scorecard was under development to improve child protection (CP) performance and was being used to undertake an annual audit against the Laming standards around record keeping. A drop in reporting had instigated more regular reporting on this indicator (now on a quarterly basis).

202.3 Work was underway to increase CP supervision across all relevant staff groups.

202.4 There had been no Serious Case Reviews in the last year for the Trust which was consistent with the reduction in number of reviews at other Trusts.

202.5 The Chairman commented that the report highlighted a lot of areas rated as amber. The Chief Nurse stated that this assessment required a review. Although the requirements around CP training were tough, it was also important to reflect accurately where progress had been made. Mr Tilley suggested that information about actions being taken to resolve areas where further progress is required would be helpful. The Board agreed.

202.6 **Action**: The Chief Nurse to include information on actions being taken to resolve areas where further progress is required in the next CP report to the Board.

202.7 Ms Brown raised the issue of the lack of reporting in the International Private Patient Department. The Chief Nurse confirmed that the low levels of reporting were related to the department not using the electronic reporting system which would be addressed.

202.8 The Board **noted** the report.

203. Redevelopment Update

203.1 Mr William McGill, Director of Redevelopment presented the report which included an update on Phase 2A, Phase 2B, Phase 3 progress and the Cardiac Wing Levels 6 and 7.

203.2 He informed the Board that the work on the Phase 2A clinical building was within budget, with a revised completion date of 20th December 2011, although it was expected that the project would completed a few days earlier. The installation of Disney equipment in the Canteen was causing some minor problems but plans had been put in place to mitigate any delays. Noise from the generator in the building was also being investigated.

203.3 The Chairman congratulated Mr McGill and his team on progress to date.

204. PALS (Patient Advice and Liaison Service) Annual Report 2010-11

204.1 It was noted that the 'PALS Annual Report 2010-11' had been included for information. The Chairman asked if there were any questions or comments. There were none.

205. Annual Aggregated risk, complaints and incident report 2010-11

205.1 It was noted that the 'Annual Aggregated risk, complaints and incident report 2010-11'had been included for information. The Chairman asked if there were any questions or comments. There were none.

206. Trust Board Members' Activities

206.1 The Chair reported that she had attended a Charity event at Downing Street.

207. Six Day Working Update

207.1 It was noted that the 'Six Day Working Update' had been included for

information. The Chairman asked if there were any questions or comments. There were none.

208. **Clinical Governance Committee (CGC) Minutes (June 2011)**

208.1 It was noted that the June 2011 Clinical Governance Committee Minutes had been included for information. The Chairman asked if there were any questions or comments. There were none.

209. **Update from Clinical Governance Committee (September 2011)**

209.1 Mr Andrew Fane informed the Board that a meeting of the Clinical Governance Committee had been held in September. The Committee had considered the actions taken to respond to the findings of the internal audit into the tracking and maintenance of clinical equipment, as previously raised at the Trust Board.

209.2 The Board **noted** the report.

210. **Management Board minutes**

201.1 It was noted that the Management Board minutes from the June and July 2011 meetings had been included for information. The Chairman asked if there were any questions or comments. There were none.

211. **UCL Partners Management Report**

211.1 It was noted that the 'UCL Partners Management Report' 'had been included for information. The Chairman asked if there were any questions or comments. There were none.

212. **Great Ormond Street Hospital NHS Trust Annual Report 2010/11**

212.1 It was noted that the 'Trust Annual Report 2010-11' had been included for information. The Chairman asked if there were any questions or comments. There were none.

212.2 The Chairman reminded the Board that the Annual General meeting would take place directly following the meeting.

213. **Any Other Business**

213.1 There were no items of any other business.

214. **Date of the Next Meeting**

214.1 The date of the next meeting in public of the Trust Board was confirmed as 30th November 2011.

ATTACHMENT L

Attachment L

TRUST BOARD - ACTION CHECKLIST
30 November 2011

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
196.4	24/11/10	It was noted that a further report on the Management Board reporting structure would be submitted to the Trust Board Away Day.	AFe	Deferred to November 2011	Update on effectiveness of Management Board and revised subcommittee structure on agenda
17.4	27/04/11	Ms MacLeod said that a presentation received prior to the meeting about working with governors had highlighted the need for further work to clarify how patient, carers and the public members of the Trust engaged with the Board and its subcommittees. It was agreed that the work would be revisited in the autumn once the Member's Council had been formed.	AFe	Deferred to March 2012	Not Yet Due
198.6	28/09/11	Mr Tilley asked about progress with the discharge summary target. The Chief Operating Officer stated that the electronic solution would help with improving performance in this area. It was agreed that an update on this would be provided at the Trust Board in November 2011. The Chief Operating Officer to provide an update on the implementation of the IT system for producing discharge letters.	FD	November 2011	Verbal Update
198.9	28/09/11	Professor Copp asked that the number of relevant paediatric NICE recommendations be presented in summary form. The Chief Operating Officer agreed to look at this. The Chief Operating Officer to consider how the number of relevant paediatric NICE recommendations can be presented in summary form in the performance report.	FD	November 2011	Verbal update

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
202.6	28/09/11	The Chairman commented that the report highlighted a lot of areas rated as amber. The Chief Nurse stated that this assessment required a review. Although the requirements around CP training were tough, it was also important to reflect accurately where progress had been made. Mr Tilley suggested that information about actions being taken to resolve areas where further progress is required would be helpful. The Board agreed. The Chief Nurse to include information on actions being taken to resolve areas where further progress is required in the next CP report to the Board.	LM	November 2011	RAG rating clarified with further explanation on front sheet Further clarity inserted about plan to achieve task as requested

Trust Board 30th November 2011	
Zero Harm Report **Prepared for Professor Martin Elliott Co-Medical Director by Dr Peter Lachman**	**Paper No: Attachment N**
Summary This paper provides an update on the following issues: 1. Updated Quality and Safety Strategy and responsibilities of the Trust Board 2. Patient Story progress 3. Examples of improvements: IPP and Cardio Respiratory 4. Unit Deep Dive - Surgery	
Action required from the meeting To note the progress made	
Contribution to the delivery of NHS / Trust strategies and plans This is one of the strategic objectives of the Trust	
Financial implications Nil	
Legal issues Nil	
What consultation has taken place Not Applicable	
Who needs to be told about the policy? Not Applicable	
Who is accountable for the monitoring of the policy? Not applicable	
Author and date Peter Lachman 21st November 2011	

Zero Harm Report for the Trust Board

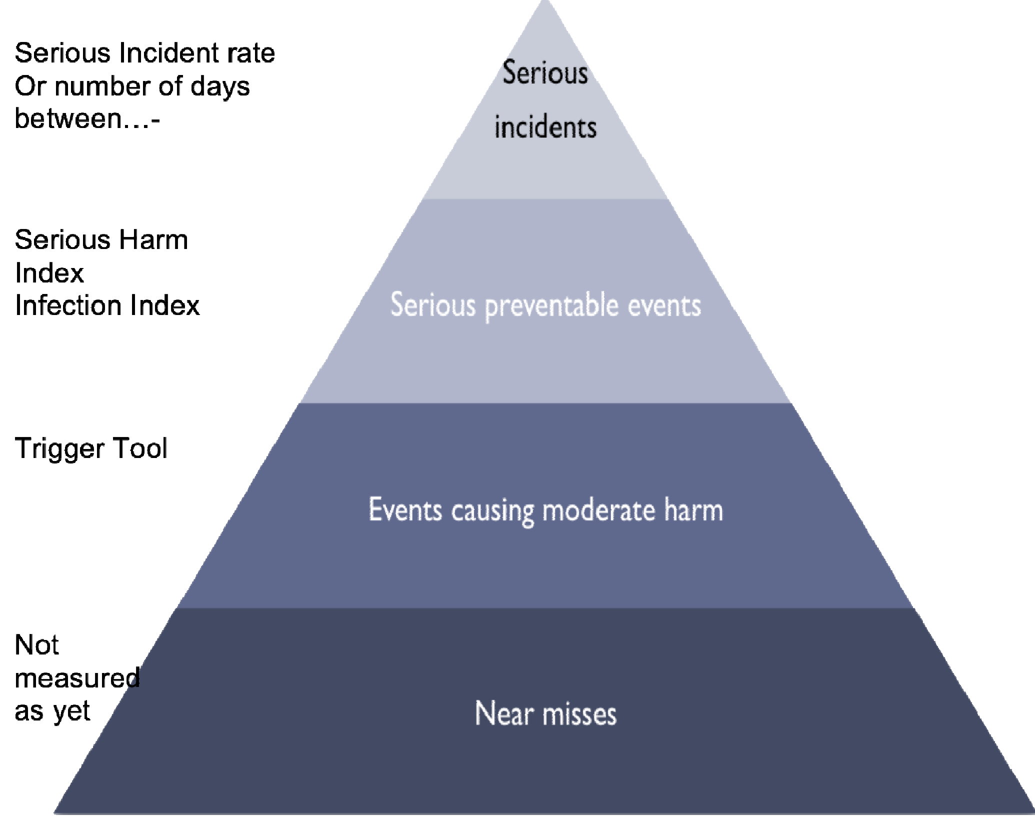
The Zero Harm report aims to compliment the other safety reports the Board receives, in particular those presented to the Governance committee. The aim is to reflect the Zero Harm improvement programme. Developments over the last 5 months include:-

1. The design of a system wide dashboard providing a trust-wide over view of safety. Each measure reflects a different aspect of safety.
2. the use of patient stories presented to the Board to give examples of the patient/parent perspective
3. Highlights of a unit deep dive report to identify codd practice and challenges to the Board
4. Examplews of improvements from two Units

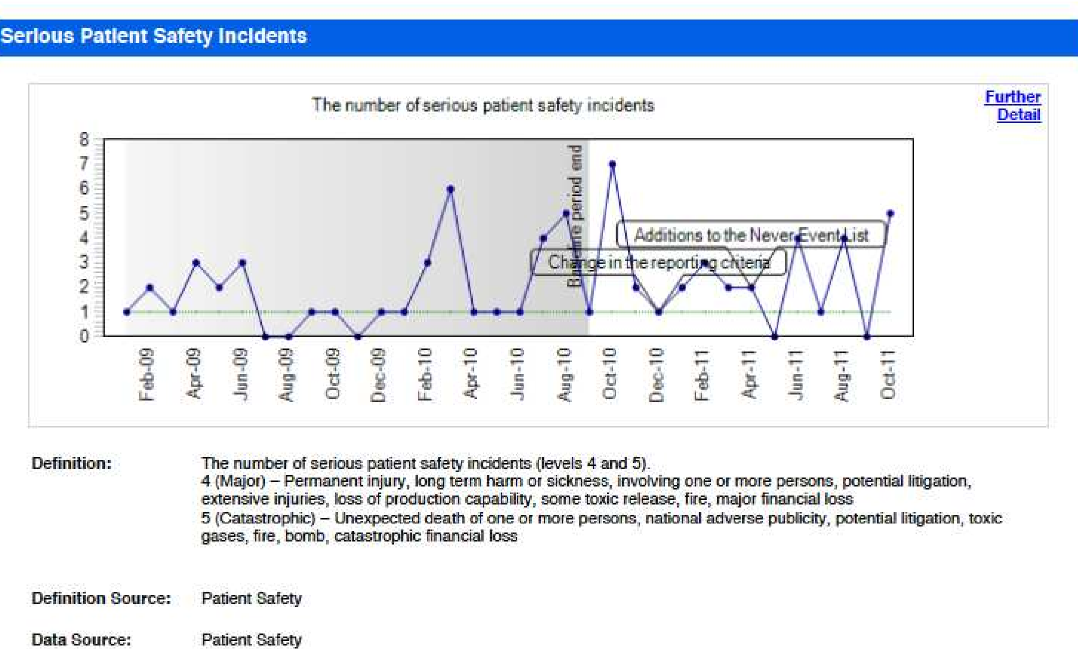
The report is evolutionary and will change, though follow a standardized format.

1. Zero Harm Dashboard

The dashboard has been under development and good progress has been made
The paradigm used is as follows:



Serious Patient Safety Incidents



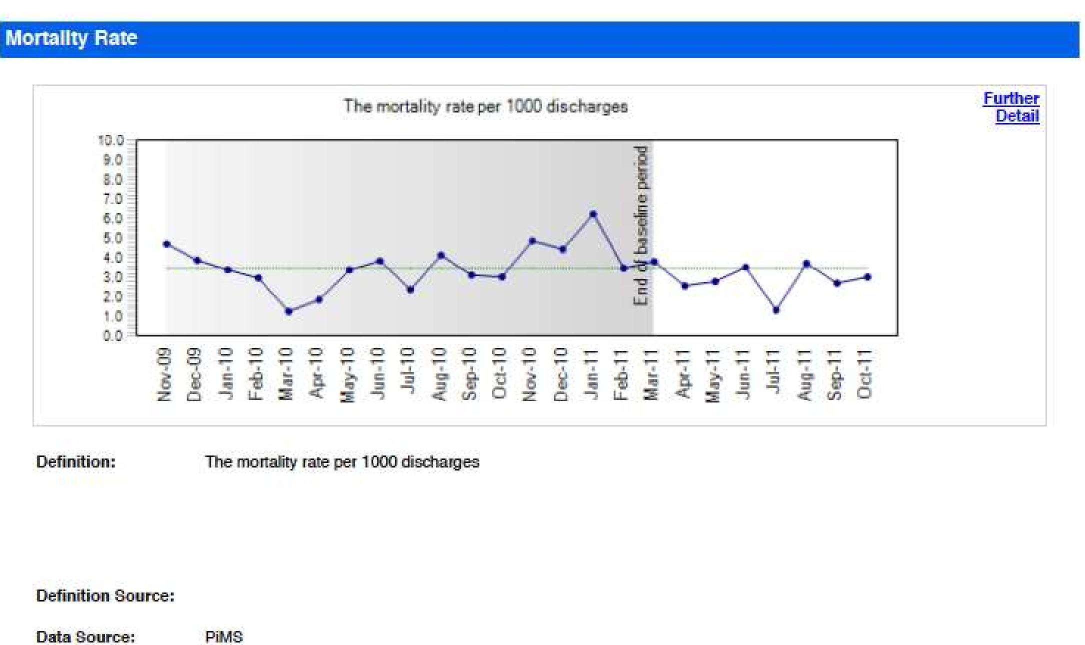
Definition: The number of serious patient safety incidents (levels 4 and 5).
4 (Major) – Permanent injury, long term harm or sickness, involving one or more persons, potential litigation, extensive injuries, loss of production capability, some toxic release, fire, major financial loss
5 (Catastrophic)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

Definition Source: Patient Safety

Data Source: Patient Safety

The serious incident report is still under development as we define the criteria. We hope to report this in 3 ways – the actual number, as a rate per patients and as days since last SI.

Mortality Rate



Definition: The mortality rate per 1000 discharges

Definition Source:

Data Source: PiMS

The Mortality rate remains constant subject to normal variation. However, a mortality review group has been established to review each death and identify the appropriate lessons to be learned.

Zero Harm Trust Dashboard

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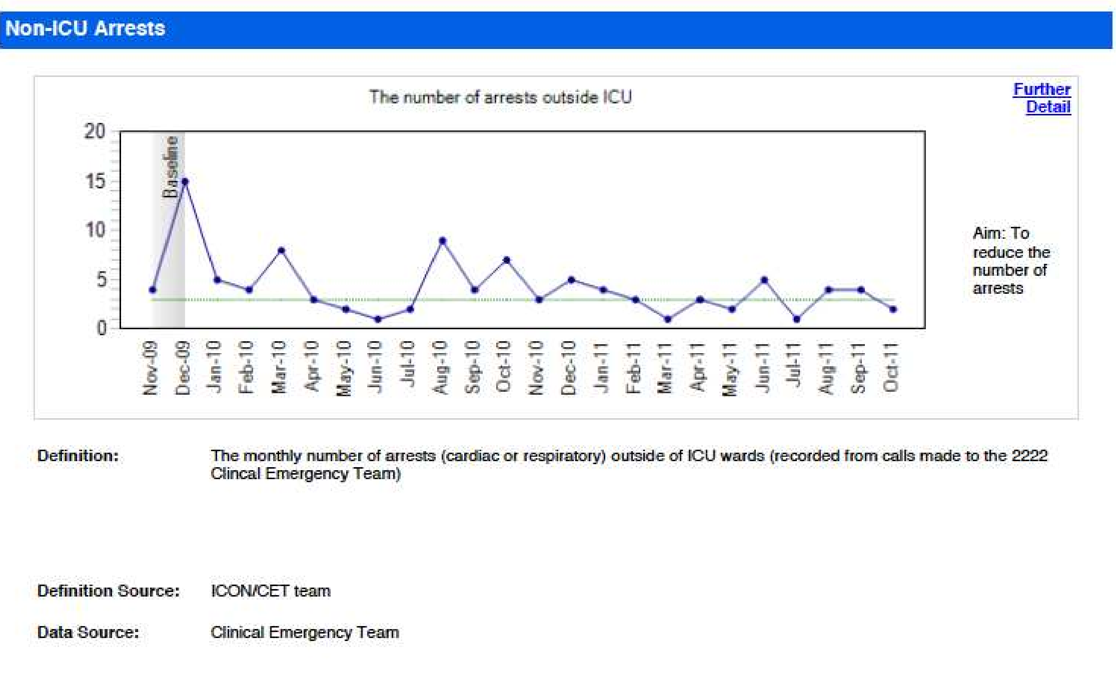
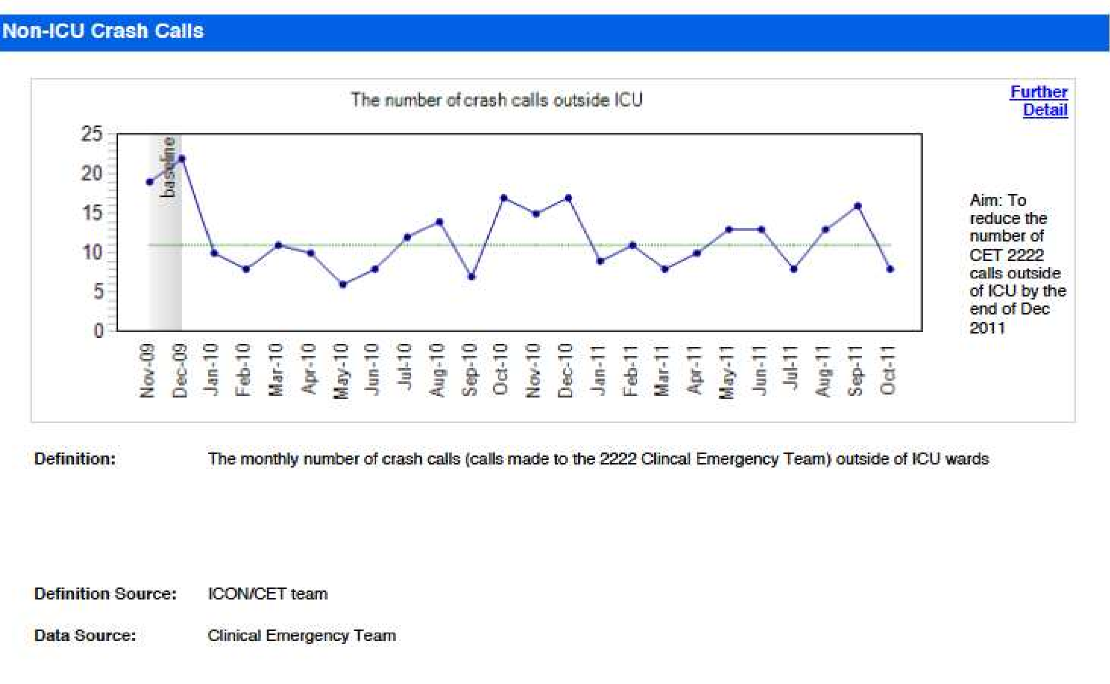


Definition: The monthly number of arrests (cardiac or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clincal Emergency Team)

Definition Source: ICON/CET team

Data Source: Clinical Emergency Team

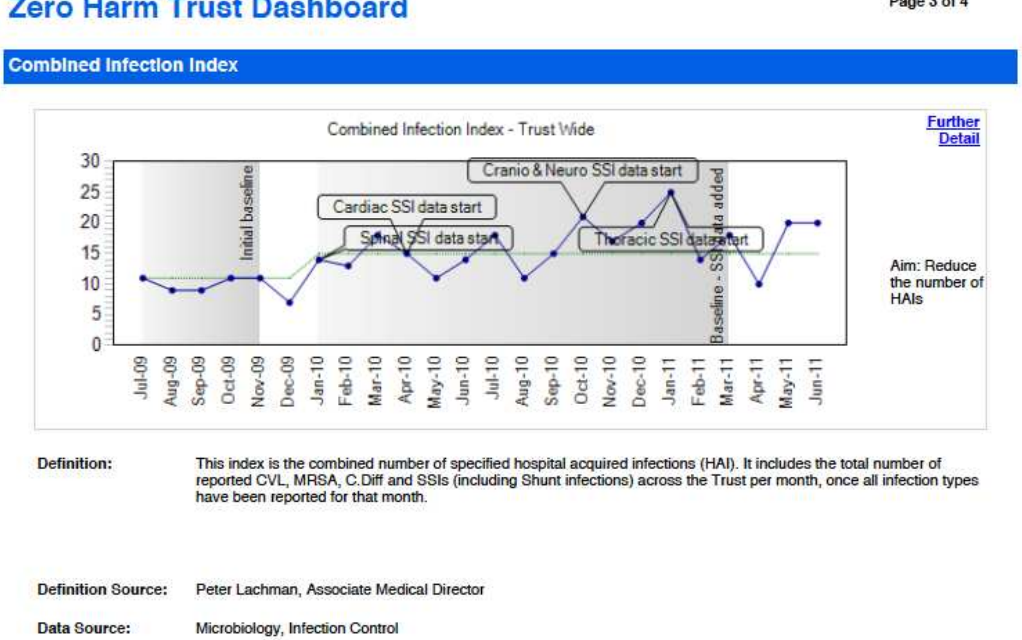


Definition: The monthly number of crash calls (calls made to the 2222 Clincal Emergency Team) outside of ICU wards

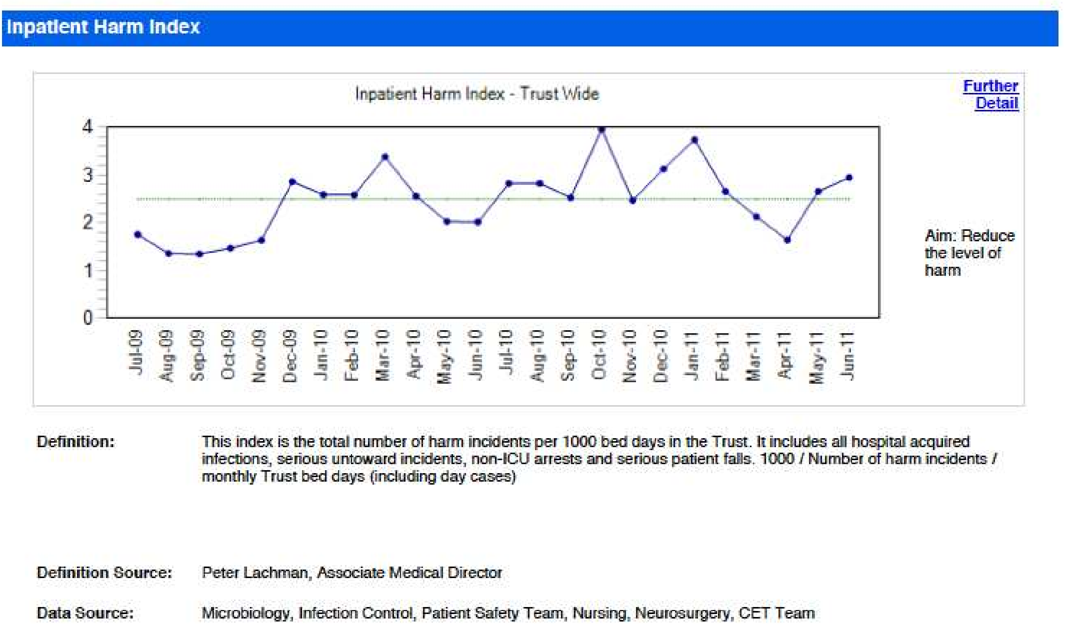
Definition Source: ICON/CET team

Data Source: Clinical Emergency Team

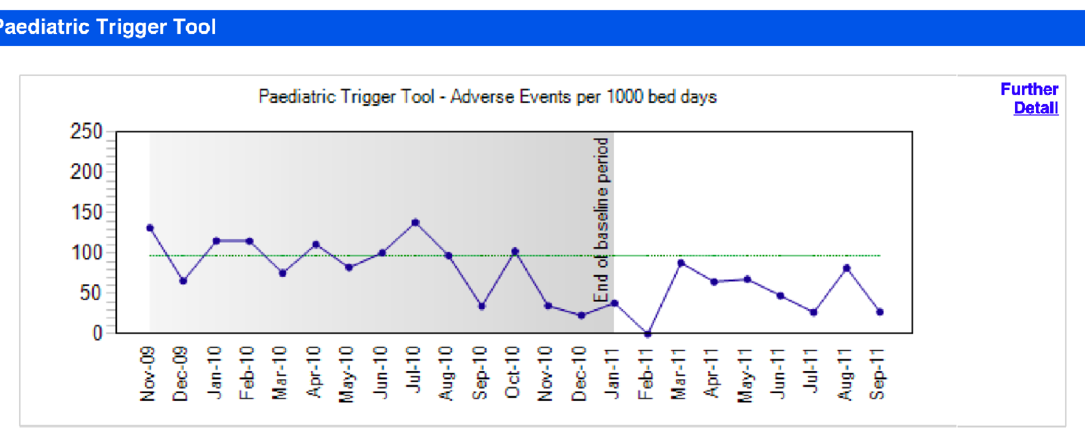
The deteriorating child programme will be reviewing regularly the above measures.



This is a composite rate and each month we will highlight one component. We will also highlight areas of good practice and areas presenting challenges.



The Serious Harm Index has been enhanced and will be further developed as we develop better ways of assessing serious incidents. It is expected this rate will rise initially as we add events and then improvements develop



The trigger tool continues to show improvement though this is not yet statistically significant. However, the Trigger Tool has shown us where we can concentrate some of our efforts. Four identified areas are currently being addressed:

- Quality of records
- Quality of observations
- Pressure sores
- Cannulation

2. Patient Stories

- A policy/process is being developed to enable staff thoughtfully to collect patient stories to be used in different forums across the Trust.
- The transformation team has been testing bringing stories to the their meetings
- It is planned to bring the first story to the Trust Board in November, dependant on availability of the parent.
- This will be tested in different formats for the Board over the next few months.

3. Good examples of Improvement

3.1. IPP

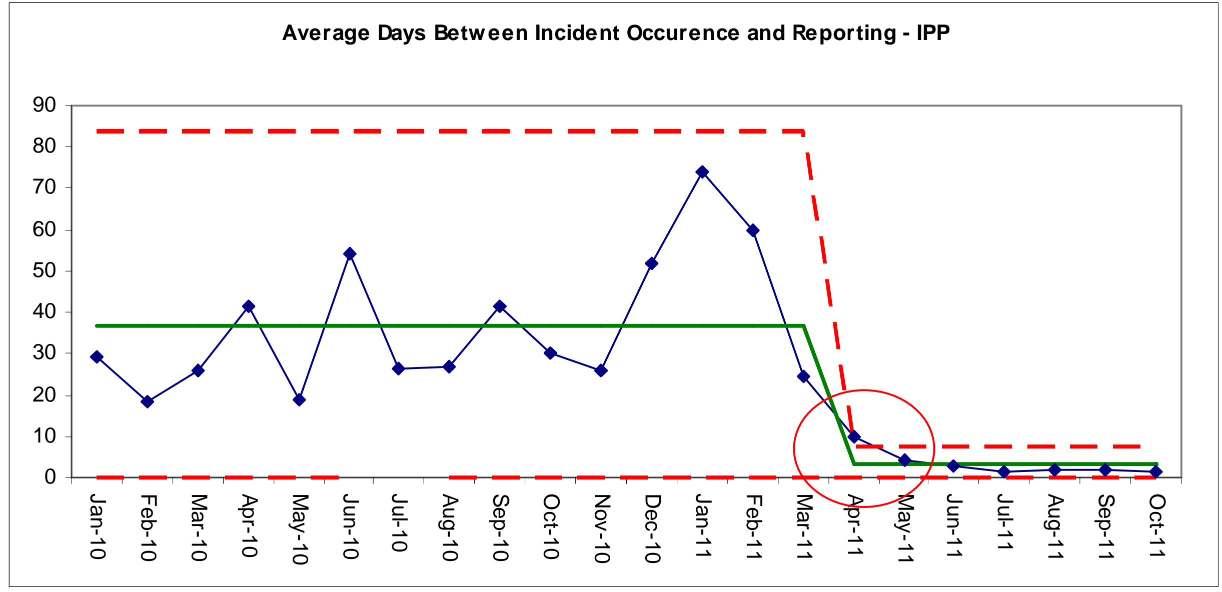
The reporting of clinical incidents in a timely manner is vital for improvement. IPP has demonstrated how one can improve the reporting of incidents.

Average days between Incident Occurrence and Reporting (IPP)

Aim: All Clinical Incidents to be reported within 48 hours of occurrence.
NB:

Total number of incidents equates to approx 20 per month.

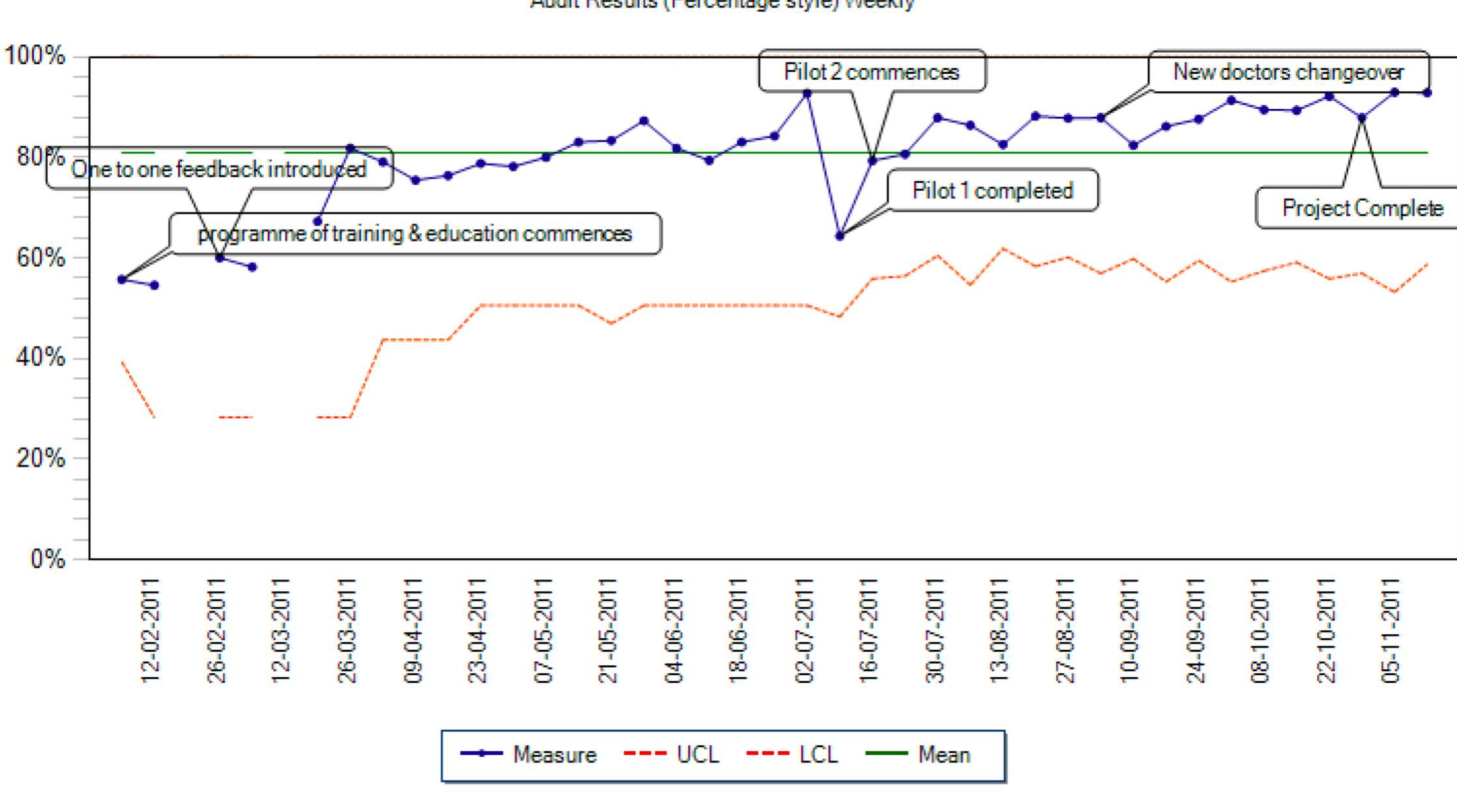
583 Total incidents, 210 (Approx) between March 2011 – October 2011



These data have been accessed via a report from the Datix system. In future, data from the Datix database will be transferred automatically to the data warehouse and reports will be live on the dashboard.
In March/ April 2011, IPP introduced the Datix reporting system into all the clinical areas. The training was performed over a 6-weekperiod. Next stage – review the closure of SI's and learning from action plans

3.2. Cardio Respiratory

The paediatric trigger tool demonstrated that the quality of the medical records needed to be improved
. The SPC chart show improvement from less than 60% compliant with the 10 medical record standards to almost 100%. This is a good demonstration of how the Trigger Tool can detect an area to improve and how clinical teams can respond.



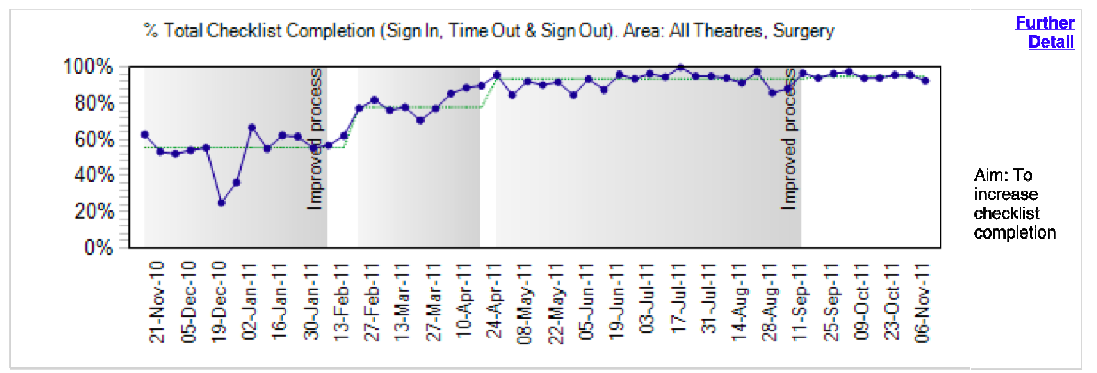
4. Unit Reports

A different Unit will be highlighted each month

Surgery presented their 6th monthly review of its Unit Zero Harm report at the November meeting of the Management Board. The presentation is attached. A key demonstration of improvement is the almost 100% compliance on the WHO checklist in theatre, for which the team has won the AFPP Peri-operative Team of the Year. As well as winning the Siobhan Rankin award, they have won an educational grant of £2000 and one years free membership to AFPP.

WHO Surgical Safety Checklist / Debriefing

The checklist applies wherever an anaesthetic is given or a procedure is undertaken:



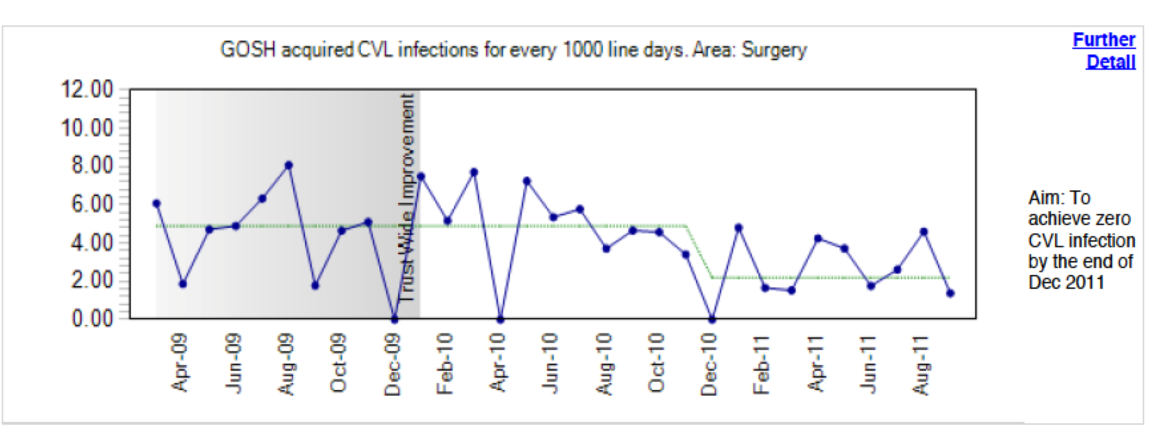
Serious Incidents (SI) grade 4 and 5

The number of days since last SI: (with completed RCA)	31 (accurate on the day of compiling this report - 14 Nov 2011)
Description and learning from last SI:	The coroner concluded and inquest at Southwark Coroner's Court into the death of a patient. The medical cause of death was septicaemia. The patient presented at their GP on a number of occasions and a urinary test was not carried out. It appeared the Gp was unaware that these tests should be carried out. Evidence was heard from a GOSH consultant that her death could have been prevented if the UTI was diagnosed earlier. Lessons learned: 1. Ensuring that information regarding the indication of urinary tests to be carried out where appropriate for urology patients is documented. 2. the importance of providing accessible and user friendly information sheets for families on the potential risks and management or urological conditions.

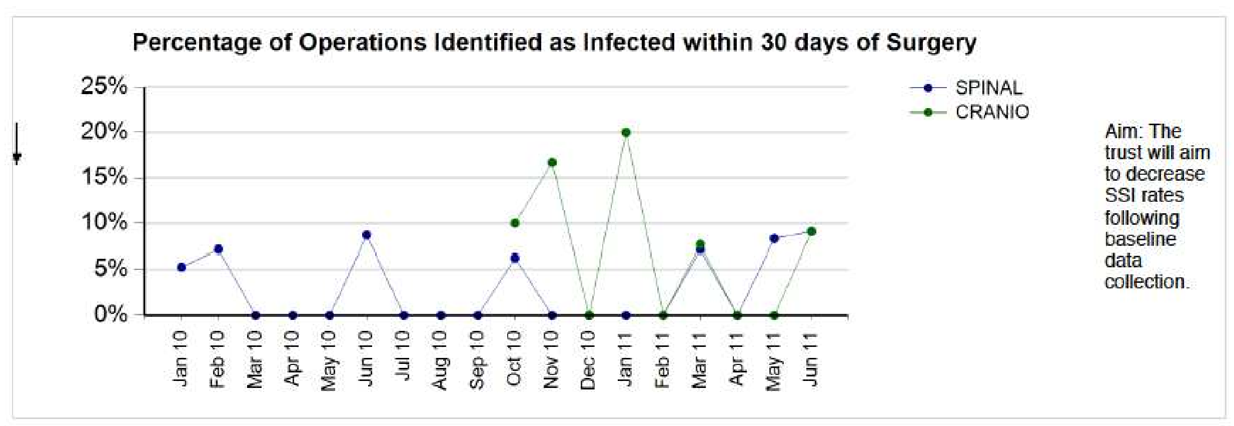
2222 Calls Outside ICU / Theatres

2222 calls outside ICU / Theatres and details:	0

Infections



The most recent CVL data is for: Sep 2011

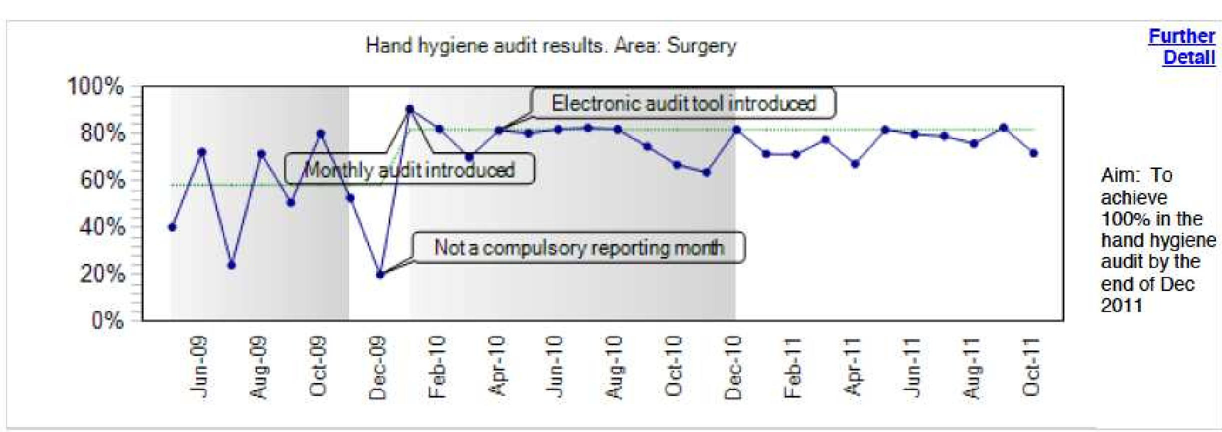


Please note: Surgical Site Infections require 30 days before positive identification - therefore the latest data will not be for the reporting month, but for the month before that.

MRSA / MSSA Infections

Number of MRSA bacteraemias: 0

Number of MRSA bacteraemias: 0



Overall there has been good progress in this Unit.

Peter Lachman
21st November 2011

Trust Board
30 November 2011

Foundation Trust application update **Submitted on behalf of:** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment O**

Aims / summary

The attached paper sets out the current position for the Trust against the assessment criteria used by the SHA and the Secretary of State for Health to determine readiness for Foundation Trust status.

Monitor completed the first phase of their assessment work at the end of October. Their initial feedback has been mainly positive, but there are some areas where they require more evidence, or changes in systems and processes. These are in three broad areas:

- Financial viability:
  - They have applied higher levels of efficiency to the base case. This results in an FRR of 2 by 14/15. Their assumptions relating to this requirement will be tested.
  - Accepted downside mitigations. Further work will be required to demonstrate that proposed mitigations are feasible and can be delivered.
- Information reported to the Board: the KPI report should have a wider range of indicators relating to Trust objectives and CRES delivery, and should present trend analysis and highlight key issues more clearly.
- Governance arrangements. Monitor have suggested that the Trust has a quality governance score of 5.5 (maximum 4 required for authorisation). The main issues relate to board reporting (noted above), reporting of CRES scheme safety risks, and management of data quality.

We propose that further work is undertaken to develop the KPI reports, CRES safety risk reports, and the management of data quality. Following completion of this work, Monitor will be asked to resume and complete their assessment. We will also request that a board to board meeting with Monitor is arranged for February 2012. Subject to Monitor's decision, authorisation will be completed on 1 March 2012.

The elections to the Members' Council have been completed, and the first (shadow) meeting of the Council took place on 17 November.

Key actions for the next month:

- Complete additional work required on the three issues identified by Monitor.
- Complete the Monitor assessment process.

Action required from the meeting
To approve the proposed timetable for further preparation and assessment.

Contribution to the delivery of NHS / Trust strategies and plans
Achievement of Trust objective to secure Foundation Trust status

Financial implications: None

Legal issues: None

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Formal consultation has been completed (18 June 2010)
A set of commissioner meetings have been held with lead commissioners.

Who needs to be told about any decision Not required

Who is responsible for implementing the proposals / project and anticipated timescales
Sven Bunn, FT Programme Manager

Who is accountable for the implementation of the proposal / project
Jane Collins, Chief Executive

Author and date
Sven Bunn
18 November 2011

Foundation Trust application – November 2011 position

Assessment of current performance for Great Ormond Street Hospital against the seven domains of the Secretary of State assurance process (changes since September in **bold**):

1. Legally constituted and representative		**Green**
The trust's proposed NHS foundation trust application is compliant with current legislation	• Draft constitution completed and approved by Trust Board (July 2010). Confirmation of compliance with NHS Act 2006 received from Capsticks (Jan 2011). • **Monitor have reviewed the constitution and have confirmed that it is satisfactory.**	Green
The trust has carried out due consultation process	• Consultation commenced on 9 Feb 10 and was completed on 18 June 2010. • Consultation feedback was provided on 13 August 2010.	Green
Membership is representative and sufficient to enable credible governor elections	• Currently ~**8,200** members. • Opt-out system for staff membership; appointment of FT ambassadors to promote involvement • Face to face and direct mail recruitment activities have been restarted to replace members who have moved.	Green
2. Good business strategy		**Green**
Strategic fit with SHA direction of travel	• Participation in London specialised children's services review. Support development of specialist paediatric networks. • Paediatric cardiac review • Paediatric neurosurgery review	Green
Commissioner support to strategy	• Meetings held with NCG, NHS London and local commissioners supported principles of growth • Reconfirmation of support received in April 2011 from NHS North Central London, London SCG, East of England SCG and National Commissioning Group (84% of NHS contract income). • **Commissioners re-confirmed support in meetings with Monitor**	Green
Takes account of local/national issues	• Thorough and detailed market assessment completed • Involved in national service reviews • Anticipate tougher economic conditions from 11/12 onwards.	Green
Good market, PEST and SWOT analyses	• Specialty based market assessments which encompass portfolio, strategic and competitor analysis. • SWOT and PEST analyses updated as part of IBP development. • External assurance of market assessment completed.	Green
3. Financially viable		**Green**
FRR of at least 3 under a downside scenario	• Currently 3 in all years • **Monitor assessor case has more stringent assumptions, which lead to FRR of 2 in 14/15 (downside FRR 1)** • Risks from CRES delivery	**Amber**
Surplus by year three under a downside scenario and reasonable level of cash	• As above.	Green
Above underpinned by a set of reasonable assumptions	• Assumptions generated and downside modelling completed. • External assurance completed.	Green
Commissioner support for activity and service development assumptions	• Support letters received from NHS North Central London, London SCG, East of England SCG and National Commissioning Group (84% of NHS contract income)	Green

4. Well governed		**Green**
Evidence of meeting statutory targets	• Current CQC assessment: Meeting all core standards (July 2011) • HAI Performance (c. diff – 6 cases; MRSA – 2 cases). • 95th centile of admitted pathway waiting time achieved since Feb 11.	Amber
Declaring full compliance or robust action plans in place	• Achieved full CQC registration. • Robust action plan has been developed as a result of boiler failure. HSE improvement notice now lifted.	Green

Comprehensive and effective performance management systems in place	• Well developed corporate and clinical unit level performance management and risk management systems.
	• **Monitor concerns about:**
	  – **Monitoring of CRES schemes for impact on safety**
	  – **Board KPI report and range of KPI indicators at unit and specialty level.**
	  – **Management of data quality**
		Amber

5. Capable board to deliver		**Green**
Evidence of reconciliation of skills and experience to requirements of the strategy	• Board effectiveness assessment and board development process completed. Board skills analysis will be completed by December 2010. • External support for board development has been provided.	Green
Evidence of independent analysis of board capability/capacity	• Board effectiveness assessment completed. • External assurance programme completed. • On-going board development programme.	Green
Evidence of learning appetite via NHS foundation trust processes	• Board development programme. • External board assessment	Green
Evidence of effective, evidence based decision making processes	• Governance structure • Existing TB and MB minutes	Green
6. Good service performance		**Green**
Evidence of meeting all statutory and national/local targets	• Good performance management system • HAI Performance (c. diff – 6 cases; MRSA – 2 cases	Amber
Evidence of no issues, concerns, or reports from third parties, e.g. HCC and in future CQC	• HSE improvement notice relating to boiler incident has been lifted (July 2010). • Awaiting final HSE report.	Green
Evidence that delivery is meeting or exceeding plans	• Good performance management system	Green
7. Local health economy issues / external relations		**Green**
If local health economy financial recovery plans in place, does the application adequately reflect this?	• Participation in London specialised children's services review. • Participation in national reviews	Green
Any commissioner disinvestment or contestability	• None	Green
Effective and appropriate contractual relations in place	• Commissioner Forum • Risk to commissioner agreement with growth plans	Green
Other key stakeholders such as local authorities, SHAs, other trusts, etc.	• Good working relationships	Green

Sven Bunn
18 November 2011

Trust Board
30 November 2011

Risk Management Policy **Submitted on behalf of:** Professor Martin Elliott, Co-Medical Director	**Paper No: Attachment P**

Aims / summary
In support of its foundation trust application, the Trust Board is required to prepare and approve a quality governance board memorandum. This states that the trust has, and will keep in place, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients. The board memorandum and overall quality governance arrangements have been reviewed recently by Deloitte. Their review made the following recommendations:

- Ensure that robust whistle blowing processes are embedded into the risk management framework, the Quality Strategy and that the Memorandum and that supporting evidence demonstrate its effectiveness to date.
- Ensure that all Board members have a clear understanding of how the data quality programme links to the performance reporting framework to ensure that they can make balanced decisions on the data they are reviewing.
- Ensure that the evidence presented and the Memorandum makes reference to the performance against clinical coding accuracy.

As a result of the first recommendation, the following changes to the Risk Management Policy have been made:

- Page 33: reference to the Trust whistle blowing policy (“Raising Concerns in the Workplace”) has been added.
- Correction of typos and formatting throughout the document.
- Consistent reference to the document as the “Risk Management Policy” (rather than “Risk Management Strategy”).

Action required from the meeting
To approve the revised Risk Management Policy.

Contribution to the delivery of NHS / Trust strategies and plans
Achievement of Trust objective to secure Foundation Trust status

Financial implications: None

Legal issues: None

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

Who needs to be told about any decision
Revised policy will be distributed to senior staff and posted on the Trust document library.

Who is responsible for implementing the proposals / project and anticipated timescales
Salina Parkin, Head of Patient and Staff Safety

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

Author and date
Sven Bunn
18 November 2011

Attachment P

Risk Management Policy

November 2011

Document Control Information

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Read By	Executive Directors		
Ratified by	Trust Board		
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Date approved/ ratified	November 2008 Updated April 2009 Updated June 2009 Updated August 2009 November 2009 September 2010 March 2011 November 2011	**Next Review**	November 2012

Policy Overview

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

It identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process to provide assurance for the Trust Board review of the strategic organisational risks and the local structures to manage risk in support of this policy.

The Risk Policy is integrated into the management, performance monitoring and assurance systems of the Trust to ensure that safety and improvement is embedded in all elements of the Trusts work, partnerships and collaborations and existing service developments. This enables early identification of factors whether internally or externally driven, which may prevent the Trust from achieving its strategic objectives of ensuring care is provided in a cost effective way without compromising safety. It provides the framework in which risk can be managed, reduced and monitored regardless of source and the process to be followed where gaps in risk management processes are identified. It assists the Trust Board to identify the scope of the Trust risk appetite (see Appendix 5: 5.9).

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

This policy is based on the requirements of the Department of Health (2006) Integrated Governance Handbook, guidance issued by the National Health Service Litigation Authority (NHSLA), National Patient Safety Agency (NPSA), Medicines and Healthcare Products Regulatory Agency (MHRA) among others, and identifies the consistent approach to be taken to all hazards and risks however caused, across the organisation at strategic and operational level.

Who should know about this policy?

Great Ormond Street hospital staff regardless of location. This includes Partnership and satellite sites where appropriate.

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1 Introduction

Great Ormond Street Hospital for Children NHS Trust is committed to providing high quality patient services in an environment where patient safety is paramount. The Risk Management Policy identifies how the principal risks and hazards which may prevent this occurring are assessed, prioritised, and controlled, supporting the safe development of clinical care and maintaining continuity of service delivery.

2 Key aims and objectives

The Risk Policy identifies:

- the organisational structure and reporting systems for the management of risk
- the duties, scope, responsibility, accountability and authority of individuals, teams, departments, committees and subgroups
- requirements for local management of risk to reflect this policy and the link into existing committee structures, performance monitoring and assurance processes
- the management tools which enable the Trust to assess its risks systematically at strategic and operational levels, document the outcome of risk assessment and improve transparency of decision making
- the process to ensure consideration of risks and options of managing them is integrated into the wider management and operational processes of the Trust
- the process to ensure regular review, monitoring of required actions to mitigate risks and obtaining assurance on mitigation
- the process for monitoring compliance with this policy at strategic and local level and to remedy any deficiencies identified
- the process to disseminate the policy and share lessons learned

This policy does not consider the detailed management of financial risk as this is subject to statutory control systems documented elsewhere[1], but does recognise that poor management of risk whether clinical, non-clinical or financial can have an impact on the Trust's ability to meet its strategic and financial objectives.

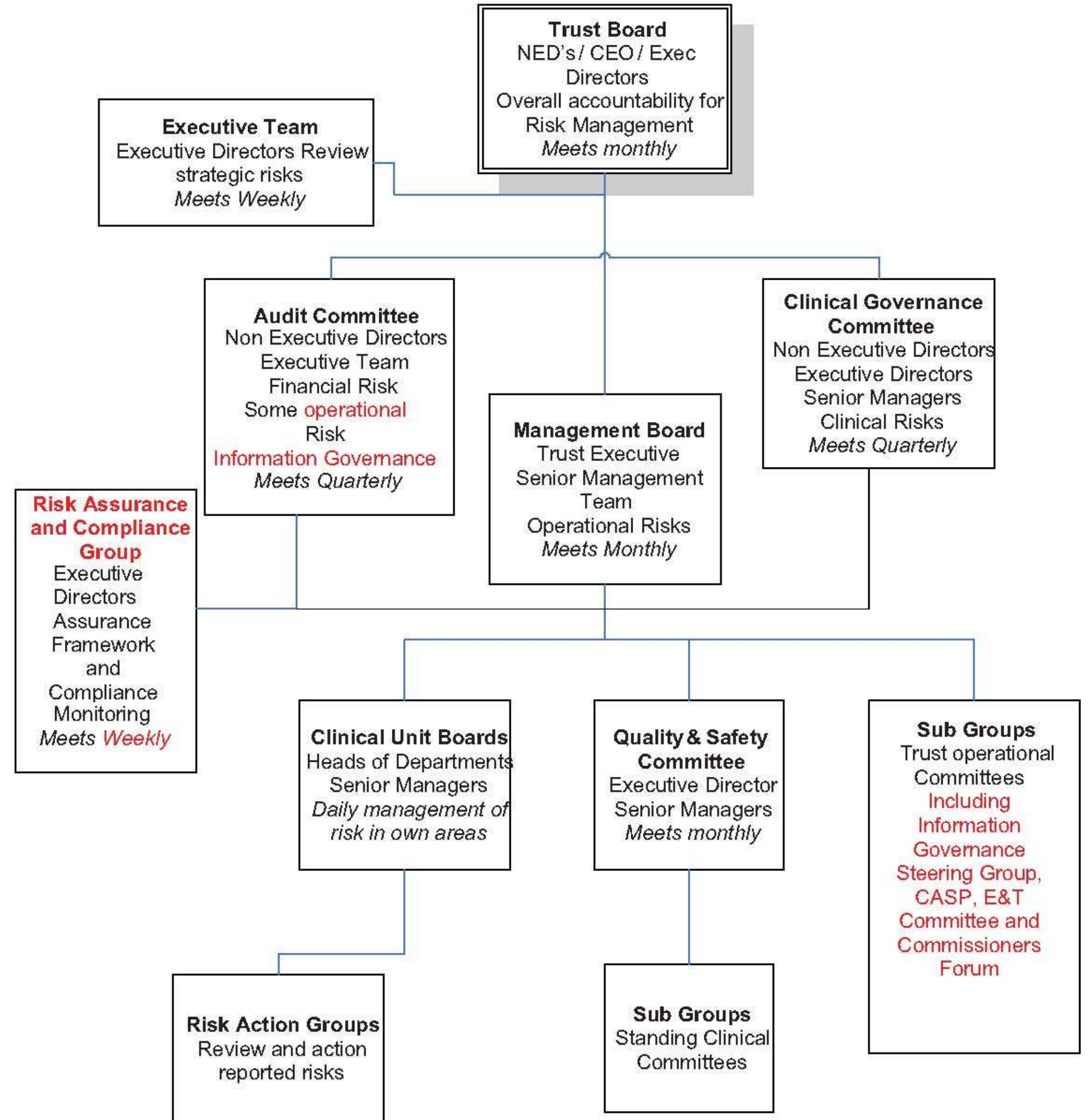
The Risk Policy drives the risk management process but this is underpinned by other operational policies and procedures.

Further detail on the management of specific types of risk e.g. Clinical, Human Resources, Health & Safety, Information Governance can be found within the policies relevant to those areas, some of which are given below[2]:

All IT policies
All Personnel policies
Assurance Framework
Building and site development strategies
Complaints Policy
Continuity and Business planning procedures
Fraud and Corruption Policy
Health & Safety Policy
Incident Reporting & Management Policy
Information Risk and Governance Policies
Legal Policy
Major Incident Policy
Management of external visits and inspections
Performance Strategy
Personal Responsibility Framework
Quality Strategy
Standing Financial Instructions and policies
Trust Vision & Objectives

[1] Standing Financial Instructions and Scheme of Delegation
[2] This list is not exhaustive and is updated as policies are reviewed

3 Organisational structure for risk management[3]



The organisational structure for risk management provides an integrated framework for decision making, escalation and provision of assurance. It ensures the operational framework required to deliver the trust objectives links into the wider assurance and corporate governance processes, and that all reasonable action is taken to identify, assess and manage risks to the Trust and its stakeholders in a consistent and transparent way.

To manage risk effectively, the Trust must be aware of its risk profile across the entire range of its activities whether, clinical, non-clinical or financial. These may be strategic or operational and may relate to a change or development in an existing service, or in response to an internal or external driver. As such, they require regular review and a consistent approach to assessment as their priority may change over time. The Trust committee structure, which links into this process, can be found in Appendix 1.

[3] The two assurance committees (the Audit Committee and Clinical Governance Committee) receive reports as outlined in their terms of reference. This may be from a variety of sources where assurance on any aspect of the Trust business within their remit is required or delegated from Trust Board. This may be from stand alone reports, specific committees and/or individual teams or departments.

4 Duties, roles and responsibilities

The following gives the duties, roles and responsibilities for risk management activity in the Trust at individual, department and team level. Due to the variable nature of risk, this is not exhaustive and may change depending on the type of risk identified and the action required to mitigate it. Where authority is devolved, the extent of this authority is identified with the member of staff or in the relevant job description. Assessment of risks (Appendix 3 & 4) assists in identifying how a risk will be managed and the level of management responsibility required.

All members of staff are responsible for their own safety and for ensuring risks to the organisation, colleagues, patients and visitors are minimised. All managers have authority to reduce risk within their areas of responsibility whether clinical, non clinical or financial and are responsible for ensuring safe systems are in place. Staff are required to report incidents when they occur, mitigate their effect, lead on investigating the causes and escalate to their unit chair, general manager or relevant director as appropriate. If in doubt advice can be sought from the Clinical Governance & Safety Team.

4.1 Chief Executive Officer

The Chief Executive is accountable to the Board for ensuring that it receives the appropriate level of information to enable it to be assured that systems of internal control to manage risks, regardless of source, are in place.

The overall and final responsibility for all risk and quality management rests with the Chief Executive, who is accountable for providing the Trust with the necessary organisational structure and resources to implement policy and manage risks effectively. In line with the general philosophy of the Trust, delegation of responsibility occurs. Individuals are encouraged to assume responsibility for their own actions.

The Chief Executive or their Deputy is actively involved in the work of the sub committees with responsibility for managing risk, ensuring that there is a system to assess and review the effectiveness of the controls put in place to mitigate those risks. As the Chair of Management Board, they are aware of all key decisions made within the Trust and ensure actions to reduce risk are considered when strategic, operational or financial decisions are made, and the means by which effectiveness of action to reduce risk is monitored.

4.2 Non Executive Directors

Assurance sub committees of the Trust Board are Chaired by a Non Executive Director. They are responsible for ensuring that they are provided with the appropriate information to enable them to make a reasoned judgement as to whether the elements of risk for which they assure the Board, are being managed with proper controls in place. They have a duty and the authority to raise with the Trust Board any risk issue they believe is not being managed appropriately, that may be a threat or opportunity to the Trust, or which has caused them concern. They have a duty and authority to request additional information from any source to enable them to fulfil this function to ensure provision of safe, high quality services.

4.3 Executive Directors

The Trust Board has designated accountability for risk management and quality service provision to nominated executive directors and as such this is identified within their job descriptions. They meet regularly with the Chief Executive to ensure all aspects of risk are

managed appropriately within their areas of responsibility and enable early identification of an actual or potential problem.

All Executive Directors remain accountable for reducing risk within their areas of responsibility by best practicable means and ensuring the impact of decisions taken and effect on the viability and reputation of the Trust is assessed as part of this decision making process. They delegate authority to nominated managers as appropriate to manage local risks and to specific committees or project groups to manage corporate risks[4]. They ensure a feedback mechanism is in place to monitor actions taken and compliance with internal and external regulatory or statutory compliance.

The Executive Directors are part of the Trust management structure and represent their specific areas of risk management responsibilities at Trust Board, Sub Committees and Management Board levels. They may also chair or be members of specific groups or committees to consider areas within their expertise which may be time limited or to oversee specific tasks. As part of their risk management role, they will delegate areas of accountability to nominated individuals as appropriate.

The Executive Directors with delegated responsibility for risk management are:

4.3.1 Deputy Chief Executive / Chief Operating Officer:

Responsibility for ensuring that clinical and non clinical risk management is embedded at Clinical Unit and departmental level to ensure compliance at local level with strategic objectives. They are accountable for ensuring effective management and mitigation of risk as part of the day to day and operational practice of the Trust. This includes but is not limited to objective setting, business planning, service development and performance management of risk. Executive responsibility for Major Incident Planning and implementation and overseeing the operational review process. Executive management of facilities to reduce risk in the delivery of support services to patients, families and staff and the effective management of the human resource functions within their remit.

Overall responsibility for effective management of the Assurance Framework.

4.3.2 Chief Finance Officer:

Executive responsibility and accountability for all aspects of financial risk and compliance with statutory financial requirements. This includes but is not limited to financial planning, objective setting and fraud, information governance and information risk. Acts as the Senior Information Risk Officer (SIRO) for the Trust.

4.3.3 Co-Medical Directors:

This joint role provides but is not limited to executive responsibility and accountability for clinical and non-clinical risk management. Executive responsibility for the implementation of risk management to mitigate the risks regarding clinical incidents, complaints, clinical negligence, clinical audit and effectiveness, litigation issues such as consent, confidentiality, data protection, infection control, radiation protection and health and safety. Executive responsibility for medical postgraduate training and managing associated risks as a result of changes to medical workforce, whether internally or externally driven.

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[4] Corporate risks – these are risks which need either a Trust wide approach or which may arise as a result of external factors over which the Trust may have limited control. They are owned by the executive team who delegate their management to either a nominated individual, designated committee or designated, time limited project group. If a risk is accepted, i.e. no appropriate action to mitigate it identified, this must be agreed with by the Chief Executive or the Deputy Chief Executive and identified to Trust Board.

Printed copies of this document may not be up to date. Always obtain the most recent version from GOSWEB.

4.3.4 Chief Nurse / Director of Education:

Executive responsibility and accountability for Child Protection, safeguarding, training, education and the implementation of risk management systems with regard to staffing, staff management and workforce issues within their remit.

4.3.5 Director of Redevelopment

Executive responsibility for ensuring all risks related to the Trust estate and redevelopment of the hospital are mitigated and managed. This includes the management of contractors, safe operating procedures and safe systems of work as well as financial and service continuity risks associated with redevelopment programmes.

4.3.6 Director of Research and Development

Executive responsibility for ensuring that all risks related to research are mitigated and managed and that the research governance framework requirements are implemented.

4.4 Company Secretary

The Company Secretary is responsible for ensuring that the Risk Management Policy meets the requirements for and links into, the systems for Corporate and Integrated Governance. They coordinate the main high level sub committees and the Trust Board and ensure relevant papers are provided in line with the agreed reporting schedule. They ensure appropriate reporting occurs from the operational committees into Management Board to support the governance framework. They oversee the management of the Document and Meeting papers library and the administration of the Assurance Framework and monitor compliance with the Data Protection Act in their role as Data Protection Officer. They manage any additional risk and compliance function, such as registration and requirements of external agencies, as delegated by the Chief Executive to ensure compliance with internal, external and statutory requirements. The Health & Safety team report to the Company Secretary responsible for non clinical risk and health and safety management including statutory compliance.

4.5 Senior Managers[5]

Senior Managers are required to manage risks within their own areas of responsibility and to implement the requirements of this Risk Management Policy. They ensure appropriate and effective risk management processes are in place to reduce risks within the work environment, implement and comply with corporate, financial, departmental and unit policies and guidelines. They ensure internal and external compliance with any regulations relevant to their own areas of work and seek advice from appropriate advisors where necessary eg. Health & Safety, Occupational Health, Infection Control, Security, Estates, Facilities, Clinical Governance & Safety, Human Resources, Finance etc. This is to ensure the reputation and continuity of services are developed and maintained. They are accountable for identifying deficits in compliance within their department or unit, however caused, and agreeing an action plan to remedy any such deficiency with their line manager and relevant Executive Director.

4.6 Clinical Unit Chairs & General Managers

The Clinical Unit Chairs and General Managers are responsible for implementing and overseeing corporate and clinical unit policies, guidelines and procedures within their specific clinical areas in accordance with this Risk Management Policy and ensuring the internal structure within the unit is in place to do so. The Clinical Unit Chair may delegate authority for these roles to specific competent named individuals within their unit or specialty

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[5] This includes Clinical Unit Chairs, General Managers, Modern Matrons, Ward Sisters, Assistant Directors, Heads of Departments or equivalent level staff

teams who report back to the unit Chair through the existing internal structures or clinical unit board as appropriate. They ensure the clinical unit board review of risk management issues, whether clinical, non clinical or financial and that these are included where appropriate on the local risk register and discussed as part of the unit board rolling agenda. They will ensure a governance framework is in place within their units which enables information to be shared with their teams, deficits identified and actions monitored and reported back into the wider governance structure of the Trust through Management Board.

4.7 Corporate and Clinical teams

Corporate and clinical teams manage risk related to their operational areas of responsibility on a daily basis. They have a duty to ensure that any factors which may create additional risk or affect the ability to manage or control risk relevant to their area of work or service risks are highlighted to the relevant senior manager or clinical unit lead.

Each corporate department must ensure compliance with its policies and procedures by a process of regular review. Staff must be informed of these policies and procedures by means of an induction process that is documented. Each head of department is responsible for ensuring that the current versions of any policy or pan Trust operational document is available on the Document Library website. The process to ensure policies are current and to alert teams when policies are due for renewal is managed by the Company Secretary.

4.8 Clinical Governance & Safety Team

The Clinical Governance & Safety Team reports directly to the Co-Medical Director. It has a specific responsibility for collation of information for external risk based assessments and reporting to ensure that the management of local clinical and non clinical risks within its remit is integrated into the Trust assurance and governance systems. It consists of the Patient Safety team responsible for the management of clinical incident reporting, root cause analysis, aggregated analysis of reported incidents and investigations. The Complaints team responsible for the management and investigation of complaints. The Clinical Audit team responsible for the management of the clinical audit process across the Trust. The Clinical Governance & Safety team will provide information to all levels of the Trust, the unit boards and RAG groups to support effective local implementation of this risk policy on a monthly basis or as required by the clinical unit chair and general manager. It maintains the Trust wide risk register and incorporates information from this into the assurance framework.

4.9 Trust Solicitor

Responsible for the effective functioning of the Legal Team in early identification of potential risk and ongoing management of claims or legal action. They are responsible for sharing learning to reduce risk across the Trust. They report to the Co-Medical Director and provide legal advice to support decision making by the Executive team wherever necessary.

4.10 Planning, Performance Management and Information Services

The Planning and Performance Management and Information services teams liaise with clinical units and corporate departments to ensure access to appropriate and timely information on service provision and the key performance indicators to support the management and monitoring of risks (See Performance Strategy). They support management of the Assurance Framework to ensure that the Trust objectives are linked to internal and external monitoring of high level performance indicators.

4.11 All employees and visitors

Employees, whether part of clinical or non clinical teams, are made aware of the risks within their work environment, their personal responsibilities for reporting risks and minimising risk

to themselves and others. They are given the necessary information and training to enable them to work safely. All clinical and non clinical staff are expected to report incidents when they occur and be involved where appropriate in any investigation to identify the cause of specific risks or as the result of an adverse event (See Incident Reporting & Management Policy, Health & Safety Policy, Induction Policy). While visitors have a responsibility for maintaining their own health and safety while on site, employees have a responsibility to ensure that visitors are not exposed unnecessarily to risks, to report and take action to minimise any such exposure.

4.12 Contractors

Contractors carrying out work on the Trust's property are expected to comply with statute. It is the responsibility of the Executive Director contracting with them on behalf of the Trust to ensure that contractors comply with the relevant safety procedures and, where appropriate, specify detailed health and safety and performance management requirements in any written terms of agreement before work commences.

4.13 Partnership working with other organisations

Where the Trust links in with other health care providers to deliver a specific clinical service a risk assessment is undertaken as part of the planning process and used to inform any Service Level agreement. This identifies potential risks to the individual parties, service users, the public, patients and other stakeholders and ways to reduce these. It is the responsibility of the project manager, under the guidance of the relevant Executive Director, to ensure this occurs. Wherever possible, systems to monitor and reassess risk are included as part of the business plan and incorporated into the regular performance monitoring process of the Trust.

5 Responsibility of Trust committees for risk management

5.1 Trust Board

The Trust Board is responsible for the effective functioning of the Trust, the provision of managerial leadership and accountability. Its purpose is to ensure that the Trusts systems and working practices support good corporate governance, financial probity and the management of risk to underpin safe high quality service delivery. To do this Trust Board:

- establishes the strategic objectives for the Trust
- ensures these support delivery of the Quality Strategy
- sets out the arrangements for obtaining assurance on the effectiveness of key controls across areas of principal risk, which may threaten achievement of those objectives
- establishes a reporting system to receive relevant documents in an appropriate timeframe to enable the Board to ensure that its members are properly informed of the totality of their risks, not just financial, and to be assured that the systems to manage the principal risks are in place
- reviews the strategic risks on the trust wide risk register as part of the Assurance Framework, at least once a year as per the schedule of reporting.
- evaluates the key controls to manage the principal risks, using external and internal assessment and assurance processes.
- receives summary reports on progress against compliance with specific aspects of identified risks that may occur. Frequency of these reports is agreed with the Company Secretary if they are not part of the routine reporting schedule.
- receives performance management reports identifying key indicators monthly.

- delegates the daily strategic management of risk to the Chief Executive who is accountable for delivery of this policy.
- approves the Risk Management Policy and reviews it annually or more frequently in the event of significant changes whether internally or externally driven.
- demonstrates that it takes reasonable action to assure itself that the Trusts business is managed efficiently through the implementation of internal controls to manage risk and a self assessment process annually.

5.2 Sub-committees of the Trust Board

Any high level sub committee where the responsibility for overseeing the different elements of risk management has been delegated by Trust Board, clearly indicates by its terms of reference which aspects of risk management it is responsible for, and whether its role is one of assuring or being assured. It also identifies the extent of its delegated authority.

Each delegated sub committee receives regular reports as part of its schedule of reporting to enable it to take a view as to whether it can assure the Board that the controls to manage specific aspects of risk which fall within its remit are in place and working.

It is the responsibility of the Chair of the delegated sub committee to alert the Trust Board to any concerns regarding the management of risk it oversees and to request additional information as necessary. To assist this process, sub committees have cross membership and appropriate representation from the executive team, senior managers and clinical teams. Minutes or summary action points from the high level assurance sub-committees are received by Trust Board at the next available meeting.

The main high level sub committees are:

5.3 Clinical Governance Committee

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

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

5.4 The Audit Committee

The Audit Committee reports to the Trust Board. The committee has the responsibility to assure the Trust Board and to be assured, that appropriate action is taken to minimise and control all aspects of non-clinical risk including financial within its remit. It receives relevant reports to enable it to do this and in an appropriate time scale. This includes reports from internal and external auditors in respect of the Trusts effectiveness at mitigating specific

risks. As such it has delegated authority from the Board as identified in its terms of reference. It monitors the actions taken and progress against all financial requirements, certain external assessments and reviews the effectiveness of specific objectives from the assurance framework and trust risk register to identify and control risks as per the reporting schedule.

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

Additional members may be required to attend when necessary to inform the committee on any specific aspects of risk identified.

5.5 Management Board

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

- it ensures that all aspects of Trust activity are considered and risk assessed when decisions are made, to minimise organisational risks whether clinical, non clinical or financial.
- delegates authority to the clinical units/departments to manage risk to local service provision as appropriate.
- monitors performance against the Trust objectives, identifying variance, assessing risk management priorities and co-ordinating the Trust response.
- supports clinical unit and departmental activities to ensure appropriate use and allocation of resources to support and maintain service delivery and to minimise and control risks.
- receives updates on work and measures undertaken to mitigate risks by specific subgroups, operational committees and any other time limited group which it has established or delegated authority to, to take forward specific work.

Management Board is made up of the Executive team, clinical unit chairs, general and senior managers. Its membership reflects its role to ensure appropriate consideration and endorsement of decision-making on specific areas of risk. This includes: policy ratification, service delivery, staffing and staff management, audit, clinical and non clinical risk, estates and facilities, human resources, finance, information services, technology, improvement and organisational development work including partnership or joint working activity.

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

5.6 Standing Committees

A standing committee is a committee with delegated authority from Management Board (Appendix 2). Each standing committee is responsible for managing the cross Trust issues

relevant to their area of expertise and as such has delegated authority within its terms of reference for a specific remit. This includes assessing the effectiveness of the control systems in place to reduce the risks relevant to their areas of expertise. A standing committee may be established either because it is required by statute or because it covers a key management function for the Trust to meet its objectives of efficient, effective and safe care. The clinical standing committees will provide a summary of their work as part of the schedule of reporting to the Safety & Quality Committee at least once a year. The Quality and Safety Committee reports into Management Board. The Health and Safety Committee and Infection Control Committee reports into the Quality and Safety Committee. The Information Governance Steering Group reports into Management Board.

Operational standing committees report into Management Board.

5.7 Operational, time limited or task specific groups

In addition to clinical and operational standing committees, other groups may be established to cover work which may be strategic, time limited, task driven or have a combined operational role. These may be required to over see large projects or to co-ordinate delivery of a specific objective. These groups or committees are chaired by a senior manager or executive director and the remit of the group, scope of authority, any time limits and reporting lines are included in the terms of reference. Reporting lines wherever possible link back into management board or an identified committee. This is to ensure that all work undertaken on behalf of the Trust can link into the existing reporting, monitoring and assurance systems in place.

6 Process for managing risk locally in support of this policy

6.1 Clinical Unit and Department Structures

The management of risk locally will reflect this organisational risk management policy. Clinical units and departments will have in place:

- Internal meeting structures
- Authority within staff roles and responsibilities to manage risk at local level including financial and service risks
- Comply with the requirements of the Incident Reporting & Management Policy for reporting incidents, assessing the impact and likelihood of identified risks, scoring and grading them
- Comply with the Complaints Policy to ensure these are managed appropriately at local level and the learning used to enhance patient experience
- Ensure that clinical, financial, service risks and complaints are used as an indicator of quality and as part of the process to identify safety indicators and required actions
- Comply with Trust policies in respect of workforce management
- A risk register
- A risk action group
- Process to monitor required actions
- Process to share information and learning
- Process to escalate unresolved risks

These processes will be managed by the clinical unit board or equivalent. The internal structures will meet the need of the unit or department to deliver excellent clinical care and to identify, assess and control risk, with delegated authority to staff as appropriate. Each

clinical unit and department will have a nominated person from within the Clinical Governance & Safety team who acts as a risk link for their areas.

6.2 Incident reporting

Clinical units and departments will have a process to review their reported incidents and levels of reporting monthly. The Incident Reporting & Management Policy describes the process to report, record and investigate individual incidents in detail. Levels of reporting and aggregated analysis will be monitored by the Patient Safety team and reported through to the Quality & Safety Committee with feedback to the local teams.

6.3 Risk assessment

Each clinical unit or department will undertake risk assessments where appropriate. They will score, grade and prioritise the risks using a common approach (Appendix 3). A risk assessment will be undertaken prior to planned service changes or changes to service delivery to identify any additional risks that may be caused. They may be used to demonstrate consideration of risks as part of the business planning process, as part of a departmental review of compliance with statute; e.g. a Health Technical Memorandum related to specific aspects of corporate risk such as Fire, or following an actual event.

6.4 Local risk registers

The clinical unit board or equivalent, or departmental meeting will have a process in place to keep their risk register updated. They will provide updates on the content of their risk register monthly to the Patient Safety team for inclusion into the Trust wide risk register. Risks will be reviewed within a stated time frame by the local team to ensure that controls in place are working, and assess whether the risk changes over time (Appendix 4). Risks may be identified through internal processes e.g. complaints, incidents, claims, service delivery changes, risk assessments or financial interests. They may be identified by external factors e.g. national reports and recommendations. Reports are run monthly for the clinical / department teams on reported incidents for consideration by the RAG groups and clinical unit boards or senior meetings. This information is used to inform the decision as to whether risks need to be added to the risk register, regraded or removed. Changes to the risk registers are monitored centrally by the Patient Safety team.

6.5 Risk Action Groups (RAG)

Local Risk Action groups or an equivalent meeting will be established at which the principal risks to patient safety and service delivery will be discussed (Appendix 4). Their role, remit and areas of delegated authority will be identified by the Clinical Unit Board or equivalent and reflected in their terms of reference. Risk Action Groups will be multidisciplinary and may consist of a core group with additional expertise brought in pertinent to the level or type of risk identified. Each specialty is responsible for identifying its specific hazards and risks relevant to its own area of clinical expertise and practice and ensuring these are included on the risk register where appropriate. RAG's receive information monthly on their clinical and non clinical incidents reported through the central reporting system to identify key themes and where actions to control risks are required. Corporate departments establish similar systems either through a dedicated Risk Action Group or an equivalent meeting. The RAG will review reported incidents and identify to the clinical unit board or departmental meeting, issues they think should be added to the risk register, regraded or removed.

6.6 Trust risk register

The Trust risk register is the aggregation of the local clinical team and corporate department risk registers and any additional sources of risk such as external or internal reviews. It is maintained centrally by the Patient Safety team and recorded on the Datix Risk

management system. As such it identifies the source, describes the risk, scores and grades it and provides a summary of the action taken to control it. It includes a review date and a residual risk rating. Risks scoring over 12 on the Trust risk register are linked to the assurance framework and reviewed by the executive team and assurance framework group. The Trust wide risk register is reviewed by Trust Board and its sub committees as per the committee reporting schedules. Changes to the risk registers are monitored centrally by the Patient Safety team. Local risks are managed and owned by the local unit teams. Corporate risks are those that need a Trust wide approach or which may arise as a result of external factors over which the Trust may have limited control. They are owned by the executive team who delegate their management to either a nominated individual, designated committee or designated, time limited project group. If a risk is accepted, i.e. no appropriate action to mitigate it is identified, this must be agreed with by the Chief Executive or the Deputy Chief Executive and identified to the Trust Board.

6.7 Assurance Framework

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

6.8 The Risk, Assurance and Compliance Group

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

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

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

6.9 Executive Group

This meeting is held weekly by the executive team and chaired by the Chief Executive or Deputy / Chief Operating Officer. Its role is to review the ongoing strategic high risks with the relevant executive director accountable for the area and to share information on gaps or

controls in place to manage those risks. These risks may be as a result of internal or external factors or from clinical, non clinical or financial sources.

7 Risk management training

The following table summarises the requirement for training for all staff in respect of clinical and non clinical risk management.

Staff Member	How	Delivered by	Assurance
Executive Directors	Induction & Updates	Clinical Governance and Safety Team	Attendance monitoring and Board self assessment
Senior Managers	Induction & Updates	Clinical Governance and Safety Team	Attendance monitoring
Clinical Staff	Induction & Updates	Clinical Governance and Safety Team	Attendance monitoring
Non Clinical Staff	Induction & Updates	Clinical Governance and Safety Team	Attendance monitoring
Non Executive Directors	Induction & Updates	Clinical Governance and Safety Team	Attendance monitoring and Board self assessment
Staff with responsibility for investigating complaints	Bespoke training &/or Risk Management Training	Clinical Governance and Safety Team	Attendance monitoring
Staff with responsibility for undertaking Root Cause Analysis	Bespoke training and /or Risk Management Training	Clinical Governance and Safety Team	Attendance monitoring
New Managers	Bespoke Training	Clinical Governance and Safety Team	Attendance monitoring

Additional specific financial, business continuity, major incident and information governance training is identified for staff relevant to their roles and delivered and monitored through the Education & Training team.

8 Monitoring compliance with this Risk Policy

The management of risk applies to all areas of the Trust's activity. Evaluation may occur by assessment of compliance by an external agency, compliance with statute, internal or external reporting, as part of the independent audit function or by internal quarterly reports via the management systems in place.

Compliance with specific aspects of this policy will be monitored as follows:

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Element	When	Reviewed By	Reported to
Approval of the Risk Policy	Annually	Trust Board	
Organisational structure for risk management and inclusion in risk policy	Annually when policy is updated	Management Board	Trust Board
Receipt of Trust wide risk register by Trust Board, Clinical Governance Committee, Audit Committee	Annually as part of compliance audit with the committee reporting schedules	CGC Audit Committee	Trust Board
Review of involvement of senior managers in risk management process	Quarterly	Quality & Safety Committee	Management Board
Role of Clinical Standing Committees	Bi- annual	Quality & Safety Committee	Clinical Governance Committee
Role of Operational Committees	Bi -annual	Management Board	Audit Committee
Assurance Framework	Quarterly	Risk, Assurance and Compliance Group	Audit Committee
Clinical Unit Risk Registers	Quarterly	Operational Review	Management Board
Risk Action Groups	Quarterly	Clinical Unit Boards	Quality & Safety Committee
Levels of incident reporting	Monthly	Clinical Unit boards	Quality & Safety Committee
Risk Management Training	Quarterly	Training Dept	Quality & Safety Committee

A report will be received by the relevant committee which will include as a minimum:

- Rationale for the audit or review
- What is being measured eg attendance, receipt of minutes, completeness of minutes, compliance with any reporting schedule or applicable measure identified to demonstrate compliance.
- Results of the audit or review and whether compliance was demonstrated.
- Compliance will be scored as follows

Score for compliance	Grade	Action required
90-100%		Report to named committee as per reporting schedule
76-89%		Report to named committee with action identified to improve compliance and time scales. Monitoring to be incorporated into the named committee meeting schedule once agreed.
<75%		As above. Discuss with responsible person depending on deficit identified eg relevant committee chair, General Manager, Unit Chair, Director, to identify deficit and means to rectify.

8.1 Strategic Performance Reviews

These meetings are held quarterly and include review of the unit or department risk register as well as operational key performance indicators, financial status and business development. They are chaired by the Chief Operating Officer or another Executive Director and are carried out with all the units.

8.2 Management of non compliance

Aspects of this policy are audited annually prior to updating and reviewed to assess the effectiveness of the processes and tools identified within it and compliance with the stated requirements. Where deficiencies are identified, discussion with the relevant manager, executive director or at a relevant committee occurs to assess whether remedial action is required. Progress against internal and external audit recommendations is reported back through the Audit Committee.

9 Dissemination of this policy

The Trust Board recognises that good channels of communication are vital to the achievement of the aims of the Risk Management Policy. An open and fair culture which welcomes direct interaction between managers and staff at all levels assists in ensuring the aims of this policy are achieved.

All staff are informed of this policy and linked policies on induction and during mandatory update training sessions.

The policy is available on the Document Library, with links from the Clinical Governance & Safety Team webpages.

Local Risk registers, performance reports and the outcome of any external assessments regarding the Trust’s ability to manage risks are made available to staff via the internal communication systems.

The Terms of Reference, schedules of meetings, minutes and papers of the key committees with delegated responsibility for the management of risk are available and accessible to staff on the Corporate Meeting Papers website, accessible from the Gosweb pages.

10 Specialist advice

Further advice on any aspect of risk management, reporting, assessing, monitoring, compilation of risk registers etc or to identify where additional information is available can be obtained from the Clinical Governance & Safety Team.

Additional staff available to give specialist advice on aspects of managing risk are:

Chief Operating Officer, Deputy Chief Executive
Advice on all aspects of the Trusts business, including where risks may need to be accepted, the operational management and facilities of the Trust

Chief Finance Officer
Advice financial risk including fraud/ the Bribery Act, information governance and information risk and non clinical audit

Co-Medical Directors
Advice on medical staffing, clinical issues, Caldicott guardianship, partnership working and patient safety

Chief Nurse / Director of Education
Advice on nursing, staffing, clinical care, child protection and safeguarding issues

Director of Redevelopment and Estates
Advice on risks related to construction and redevelopment work and all aspects of estates management

Director of ICT
Information risk and data security and business continuity lead.

Assistant Director Clinical Governance & Safety
Advice and guidance on aspects of clinical and non clinical risk management, analysis, effectiveness and audit

Head of Planning & Performance Management
Aspects of performance management, indicators and reporting processes

Head of Clinical Governance & Patient Safety
Advice training and guidance on aspects of clinical risk management, complaints, risk assessments, risk registers and root cause analysis

Complaints Manager
Advice training and guidance on aspects of risk management, complaints, risk assessments and root cause analysis

Legal Advisor / Trust Solicitor
Advice training and guidance on aspects of litigation, consent, confidentiality

Health and Safety Advisor
Advice training and guidance on aspects ofnon-clinical risks, health and safety litigation and risk assessments

Radiation Protection Advisor
Advice training and guidance on aspects of radiation safety

Counter Fraud Adviser
Aspects of fraud or potential fraud or financial loss to the Trust

Company Secretary
Care Quality Commission registration, aspects of the Trust constitution and data protection

Head of Information Governance
Advice on information governance requirements

This list is not exhaustive but any of the above are able to give advice on additional sources of information whether internal or external to the Trust.

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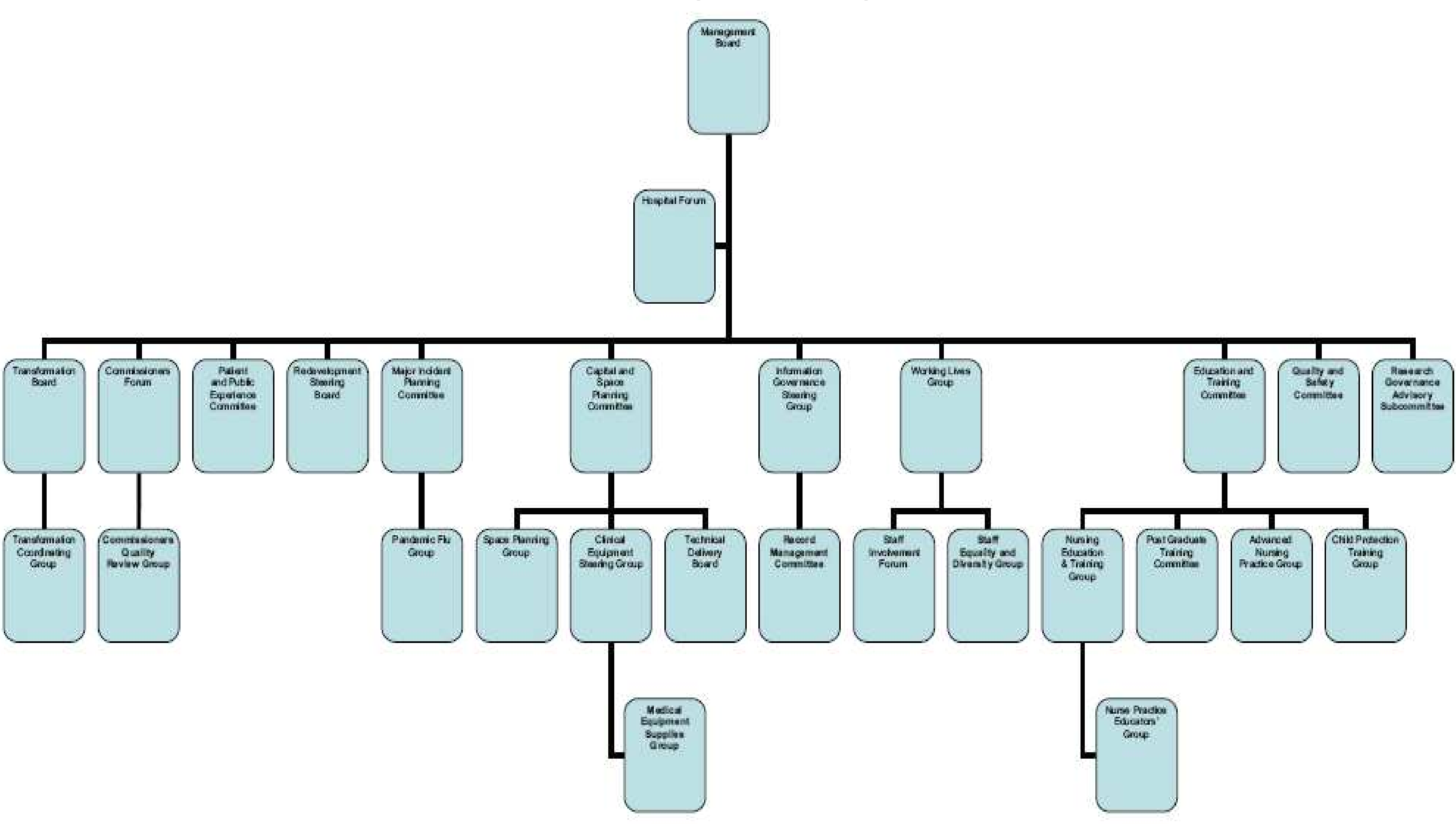
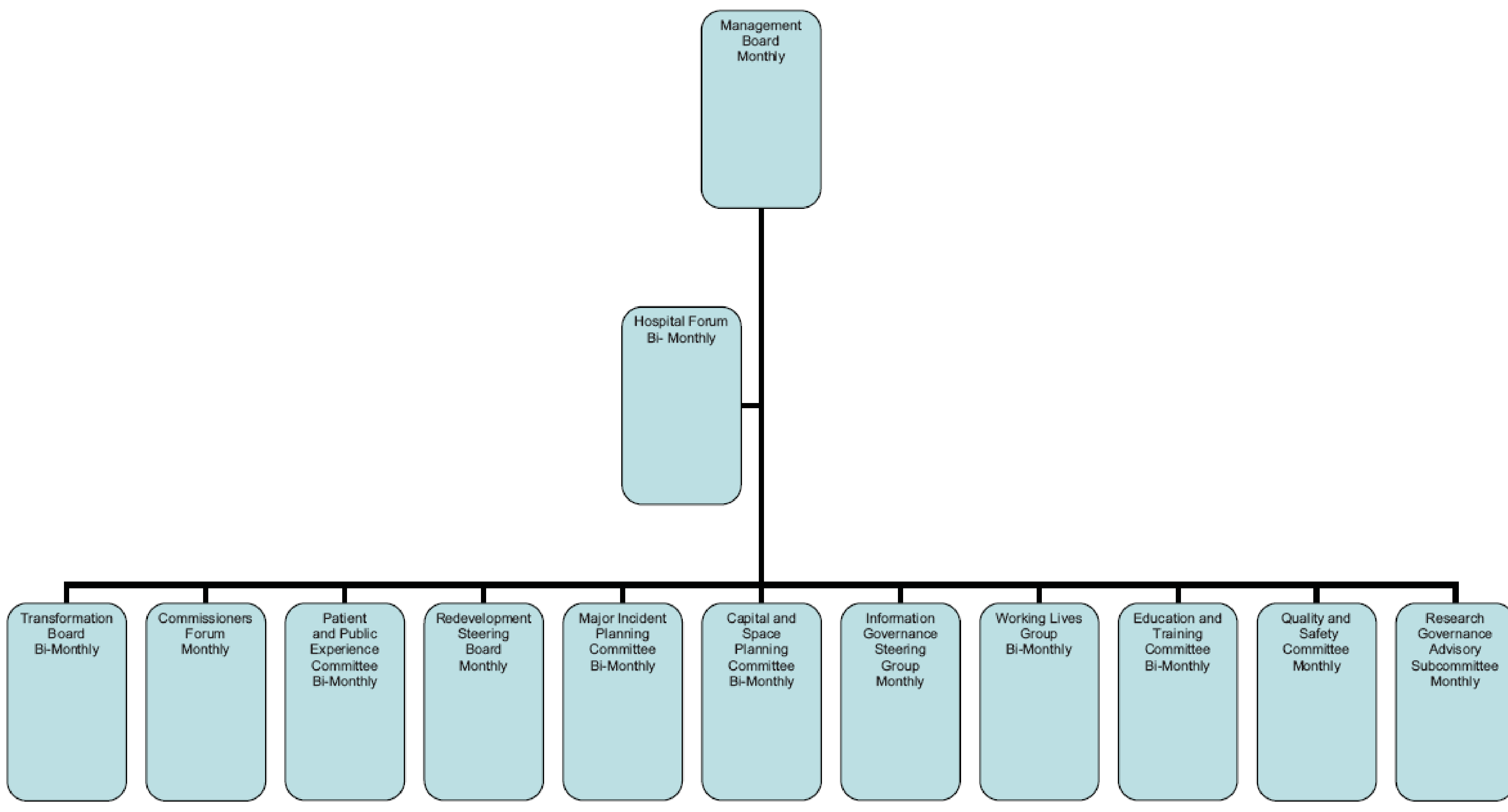
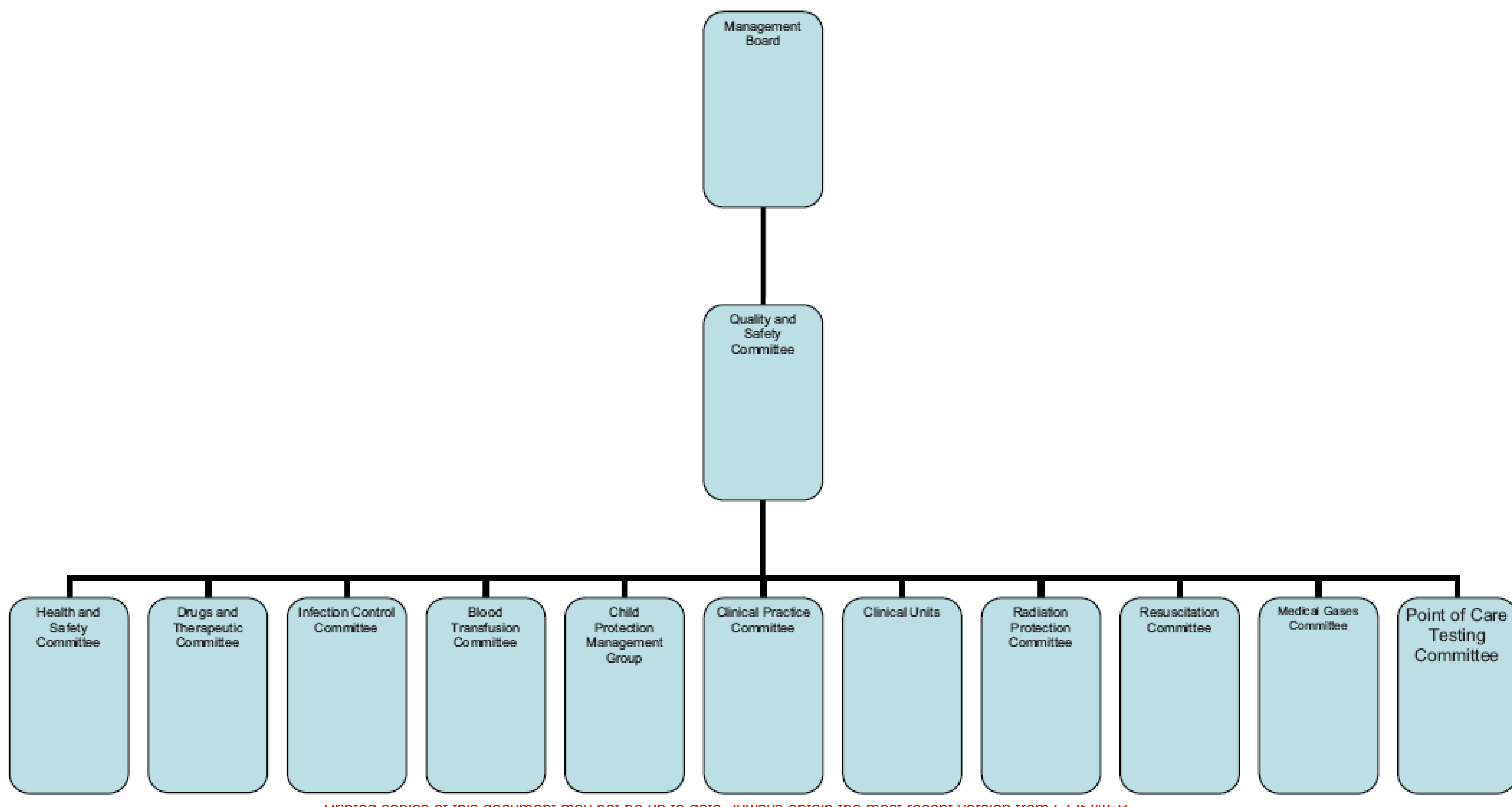
11 Appendix 1: All sub committees reporting into Management Board



11.1 Sub groups reporting direct to Management Board – Trust Operational Committees



11.2 Sub groups reporting to the Quality and Safety Committee – Standing Clinical Committees



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12 Appendix 2: Standing Committees

The purpose of a Standing Committee is to review specific aspects of work which falls within its area of expertise and which usually has a Trust wide remit. As such these committees are key parts of the structure to manage risk from clinical and non-clinical sources and may be operational or clinical in focus. The main standing committees[6] with a remit for clinical risk are given in Appendix 1.

This role of a clinical standing committee is delegated by Management Board and is an important part of managing risk in areas known to involve high risk to patients.

Management Board establishes other operational committees or time limited working groups to manage specific areas of risk as necessary.

The following outlines the basic requirements expected by Trust Board and with which Standing Committees are required to comply.

12.1 Guideline on the drafting of Terms of Reference

This section provides guidance on the drafting of committee/ board terms of reference. It has been produced in order to ensure consistency of approach by all committees/ boards at Great Ormond Street Hospital NHS Trust.

What is the purpose of a committee/ board's 'terms of reference'?
The terms of reference outlines the role and function of a committee/ board. The document provides a summary of the role and purpose of the meeting, who should attend the meeting, and where the findings of the meeting should be reported.

Who is responsible for monitoring implementation of the terms of reference?
The Chair of the committee/ board is responsible for ensuring that the terms of reference are followed, supported by the secretary to the committee. This will be achieved by drafting the agenda in light of the purpose of the committee/ board, ensuring that the meeting is quorate and ensuring that reports are made to the relevant committees.

What areas should they cover?
The terms of reference for any committee or board at GOS should cover the following areas:

a. **Duties** – this first section should detail the role of the committee/ board and its authority. This can include responsibilities for approving or monitoring strategies and the implementation of policies; agreeing resources; recommending actions etc. The committee/ board may chose to agree an annual workplan.

b. **Reporting arrangements to the board/ high level committee** – the document should state where the committee/ board sits in the organisational structure (i.e. the committee is a subgroup of the Management Board). It should also record where the committee/ board is expected to report to and the frequency of these reports.

c. **Membership, including nominated deputy where appropriate** – The terms of reference should detail the job title of each member. Names of members should not be included. It should be clear who the Chair of the committee/ board is. Scope may be given to invite additional members on to the committee/ board for specific items of business. Each

[6] This list is not exhaustive and is reviewed annually as a minimum.

member of the Board should have a nominated deputy who will be entitled to attend and 'vote' on the committee/ board.

d. **Required frequency of attendance by members** – It is important that members are clear about the number of meetings they are expected to attend in a year. For example, for a committee/ board that meets monthly, it would be prudent to expect attendance at a minimum of 10 meetings within a 12 month period.

e. **Reporting arrangements into the committee** – The terms of reference should record those reports it expects to receive from teams or other committees and the frequency with which these should be made.

f. **Requirements for a quorum –** a quorum details the minimum number of officers and members of a committee, usually a majority, who must be present for the valid transaction of business. It should state the number of nominated deputies who may be included in the quorum to enable the committee to function (it would be expected that for a quorum of 4, a maximum of one member of the quorum would be allowed to be a deputy).

g. **Frequency of meetings** – The terms of reference should identify how often the committee / board shall meet and when papers will be expected to be received by members (usually 5 working days before the meeting).

h. **Monitoring compliance with the terms of reference** - The committee/ board will need to record in the document how it intends to monitor compliance with the terms of reference. Examples include reviewing:

- the frequency of meetings
- the attendance at meetings
- compliance with the duties of the committee/ board detailed in the terms of reference.
- Evidence based outcomes resulting from decisions taken at the committee/ Board

How often should the terms of reference be reviewed?
The committee/ board should review its terms of reference annually to ensure that its purpose and duties align with the governance arrangements in the organisation and any relevant legislation (where applicable).

All terms of reference must be uploaded to the Meeting Papers' Library.

Minutes from standing committees and meetings are made available to staff on the Meeting Papers section of the corporate website. Advice can be sought on how to action this from the Company Secretary ext 8230.

On occasion, standing committees will be required to present examples of actions taken on key areas within their remit to the Clinical Governance Committee.

The above format is recommended as good practice for any time limited or group set to complete specific tasks including reporting lines. This is to ensure decisions taken are recorded and work monitored appropriately.

The clinical standing committees will report to the Quality & Safety committee at least twice each year to provide a summary of the work undertaken. The Quality and Safety Committee will provide a report twice a year to Management Board. This process forms part of the system to monitor the effectiveness of the committee structure.

13 Appendix 3: Risk assessment

13.1 Assessment tools

Minimising risk requires the hazard to be identified, the risk assessed and a decision to be taken as to what control is required to mitigate that risk. The purpose of the grading assessment tool is to provide a consistent means for clinical and corporate staff to identify the key areas of risk which need to be incorporated into their risk registers, financial plans or into their business planning cycle. It assists in identifying the management responsibility and where this sits.

Risk assessments may be carried out to identify the significant risks arising out of planned changes to any of the following: Trust procedures, environmental, financial, health and safety or clinical services. They may be required following a specific event to assess the degree of risk posed to the Trust and may be internally or externally driven. They should be documented to assist in assessing the action required. This may be by using a designated risk assessment form (see examples in the Incident Reporting & Management Policy and Health & Safety policy), or a report format if this is more appropriate to the forum in which the assessment is to be considered. As a minimum, the risk assessment must include a description of the risk, the source of the risk, the likelihood of the risk occurring and the impact if it did. It should also include any current controls in place or additional controls that may be required. Where appropriate, consideration of resource and reputational risk should be included.

SEVERITY	**LIKELIHOOD**				
	1 Very Unlikely *(Freak event – no known history- 1 in 100,000 or less)*	**2 Unlikely***(Unlikely sequence of events1 in 100,000 to 1 in 10,000)*	**3 Possible** *(Foreseeable under unusual circumstances 1 in 10,000 to 1 in 1000)*	**4 Likely***(Easily foreseeable – 1 in 100 - 1000)*	**5 Very Likely***(Common occurrence – 1 in 100 chance in any one year)*
1 No harm *(No injury, no treatment required, no financial loss.)*	Low	Low	Low	Low	Low
2 Minor *(Short term injury, first aid treatment required, minor financial loss)*	Low	Low	Low	Medium	Medium
3 Moderate *(Semi permanent injury, possible litigation, medical treatment required, moderate financial loss)*	Low	Low	Medium	High	High
4 Major*(Permanent injury, long term harm or sickness, potential litigation, fire, major financial loss)*	Low	Medium	High	High	High
5 Catastrophic *(Unexpected death, potential litigation, catastrophic financial loss)*	Low	Medium	High	High	High

13.2 Risk scoring

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

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

The purpose of grading is to establish a baseline level of risk from the identified hazard. This enables regrading to occur where appropriate, based on review of the effectiveness of the control identified to mitigate and manage the risk. Grading of risks is most effective when undertaken using a multidisciplinary approach wherever possible or as part of the Risk Action Group. This ensures the risk can be considered for its broadest effect on the service and referred if necessary to the clinical unit board for addition to the local risk register. The scoring assists in the prioritisation of risks of the same grade. For addition of risks to the risk registers see Appendix 4.

13.3 Management responsibility and review of risks

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

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

Low risks - included in risk register where appropriate for quarterly review by clinical unit board or Risk Action Group

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

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

Local risks – are managed by the clinical team, unit board or department and escalated through their existing reporting line and meeting structure to the relevant executive Director.

13.4 High risk monitoring

Progress against High risks is monitored initially by the clinical unit boards monthly and included as part of the key performance indicator reports.

All high risks of 12 and above are included in the Assurance Framework and reveiwed by the Executive Team to support early identification of trends or where additional action needs to be taken.

Quarterly reports go to the Audit Committee as part of the Assurance Framework on the progress to manage assurance or control gaps for high risks.

The above is only a guide and high risks can be escalated for consideration by the assurance framework group in discussion with the relevant executive director. The Executive Group will also discuss specific high risk issues to ensure rapid action is taken where necessary and prevent delays in mitigating such risks.

14 Appendix 4: Risk registers

14.1 Purpose of risk registers

The Risk Register provides a means to identify and prioritise the principal risks that may affect either service delivery or the environment in which services are delivered. In this way they are applicable to every clinical and non-clinical unit or department within the Trust and every layer of management within the organisation.

14.2 Management of risk registers

Local Risk Registers are made up of the key reported events for each unit or department and any specific issues of concern affecting local service delivery or business continuity. They are maintained and updated by the clinical unit or local department, providing reports to the Patient Safety team monthly.

Adding risks to the Risk Register
A risk identified for inclusion in the register may be from any source eg internal or external factors, adverse events, complaints, claims, PALs, audits, resource issues both staffing and/or financial or by potential changes to other services within the organisation. It could be as a result of a trend following analysis of reported incidents, or something which may affect service delivery or the ability of the unit or department to meet the Trust objectives. Prior to inclusion in the register, it must be agreed with the Clinical Unit Board to ensure the risk has been assessed appropriately and controls identified to mitigate it.

Trust Wide Risk Register is an assimilation of the local risk registers, and is held and updated by the Clinical Governance & Safety team.

The high risks (12 and above) from the Trust wide risk register and any additional strategic risks are themed into the Assurance Framework. The Assurance Framework identifies the Trusts principal objectives and the risks which may prevent those objectives being met (see section 6.6 above) and is managed by the Company Secretary.

The Clinical unit board or equivalent monitors progress against the risk register and where difficulty in mitigating the risk occurs can escalate to the relevant Executive Director or their deputy. If no alternative means to control the risk is identified, unmitigated high risks are escalated to the Assurance Framework Group and Executive Team as necessary. Unit and Departmental risk registers are discussed at the quarterly Strategic Performance Review meetings.

14.3 Risk Action Groups and risk registers

The purpose of the Risk Action Group is to systematically review risks on the unit risk registers within the time scales identified in the Risk Assessment tool (Appendix 3). They also review the incidents that have been reported by the unit. Due to the specialty mix, it may be appropriate for a clinical unit to have more than one Risk Action Group or one larger group with cross specialty representation. Corporate areas may combine this function within an existing meeting schedule.

Information to inform this process for clinical, non-clinical risk, complaints, and audit is supplied by the relevant unit link from the Clinical Governance & Safety team. Information specific to other risk such as Finance, Personnel, and Information Services is supplied by the relevant link from each of these areas on request. RAGs are facilitated by the Safety Links. Compliance with the required frequency of high risk review is a performance indicator and is monitored by the Patient Safety team.

15 Appendix 5: Definitions

15.1 Risk management

Risk Management is the process to identify, assess and prioritise the Trusts exposure to risk whether clinical or non clinical, which may affect its ability to meet its objectives. This may be as a result of loss or damage however caused, to patients, staff, visitors, contractors, finances, business continuity or the reputation of the Trust. Consideration of all service provision from a risk perspective and the factors which affect this, whether financial, environmental or staff related, assists the process to identify risks and mitigate their effect. It informs the decision as to whether a risk can be accepted, delegated, transferred or eliminated[7].

15.2 Clinical risk

An adverse patient safety incident has been defined by the National Patient Safety Agency as ‘any event or circumstance arising during NHS care that could have or did lead to unintended or unexpected harm, loss or damage’. Harm is defined as ‘injury (physical or psychological), disease, suffering, disability, or death’. In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient’s illness or underlying condition. Those incidents that did not lead to harm, but could have, are referred to as prevented incidents. Loss or damage occurring within the context of clinical risk to the patient, can equally apply to their family, staff or the organisation and may be both financial and/or to reputation. Clinical risk can also occur due to latent decisions eg change to service delivery which create different risks not just an adverse event but which may not be apparent at the time the change is made.

15.3 Non-clinical risk

Non Clinical risks are any event or circumstance arising during NHS care that could have or did lead to impairment of the Trust's ability to deliver its objectives, whether intended or unexpected. These risks are the outcome of hazards that have the potential to cause, or actually cause, harm by affecting the organisations ability to deliver high quality services. They may relate to a number of the Trusts support mechanisms including health and safety, estates and facilities, technical, information technology, personnel, training or financial aspects of the Trusts business. They may have a direct or indirect affect on patient care,

[7] See 15.7.page 33

member of staff, visitor, contractor or other stakeholder and result in loss or damage. This loss may be both financial and/or to reputation.

15.4 Principal risks

Principal risks are those that have significant potential to impair or affect the operational or financial ability of the organisation to deliver ongoing services. These can be strategic or operational and may relate to a change or development in an existing service, or in response to an internal or external driver. As such, they require a system of regular review, as their priority for the Trust in relation to meeting its objectives may change over time.

15.5 Significant risk

A significant risk is defined as any risk identified as having a medium or high risk consequence and which requires an achievable action plan[8] to identify the controls to be put in place and monitored for effectiveness at reducing the risk. Hazards are assessed using a matrix to identify the likelihood of harm occurring and the impact of the risk. Risks are prioritised using a common format and system across the Trust (See Appendix 3).

15.6 Acceptable risk

The Trust makes every effort to ensure that all risks are as low as reasonably achievable. It is not possible to reduce all risks to zero, as there is no such thing as clinically neutral care and decisions must be made as to whether the benefits and best use of resources outweigh the risks. The risk assessment tool enables the Trust to assess the impact and likelihood of a risk occurring and is an aid to decision making to identify what it is reasonable to accept. Acceptable risk is defined using the following principles:

- If following the rigorous approach to risk assessment, it is decided on balance to accept a risk, those accepted risks should still be controlled. To tolerate risk and accept a risk does not mean to disregard it. Any accepted risk must be reviewed on an annual basis and all options reviewed with an aim to reduce risks further. Patients, staff, visitors, contractors must be made aware of the risks they are being exposed to. No person should be exposed to serious risk unless they agree to accept the risk. In order to be fully informed of the risk, this must be done in a way they can understand.
- It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all the other alternatives, including doing nothing, is even greater.
- Accepted risk is a High Risk and is monitored as outlined in Appendix 3 above. Acceptable risk can only be agreed by escalation through to the Deputy Chief Executive/Chief Operating Officer or by the Chief Executive. Accepted risks are discussed at Trust Board as part of the performance monitoring and assurance systems and may be clinical or non clinical.

The Assurance Framework is the means by which the principal risks to the Trust are identified and control and assurance gaps reported. It is the tool by which the Trust Board is able to take a view as to whether a specific risk has been reduced to an appropriate level and whether any residual risk in that instance will be accepted.

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[8] An action plan may be in the form of a business case, written report, included on the risk register or be presented in any applicable format. It should contain what action is required, who is responsible for taking the action, when it will be completed and where it will be reported to.

15.7 Transferring, delegating, eliminating risk

Transferring Risk - A service and the associated risks are transferred to another provider Delegating Risk – a service and associated risks are delegated to another team Eliminating Risk – a service is no longer provided and the risks are removed.

15.8 Open and fair culture

The Trust continues to develop a culture that is open and fair where patients and their families know they can approach staff about problems without their treatment being affected; and staff feel able to report hazards, risks and mistakes without fear. Prejudging events by adopting a punitive approach to staff stops information giving, learning and improvement and the risk to patients is increased.

An open culture means that staff are aware of their professional accountability for safe practice, well trained to identify risks early, and know that the outcome of any subsequent investigation is not prejudged (See Incident Reporting & Management Policy). Levels of reporting are monitored internally and externally at least quarterly and through the Risk Action Groups.

The Trust Whistle Blowing policy (“Raising Concerns in the Workplace”) provides the framework by which members of staff can raise concerns about risks, safety and quality.

A fair culture recognises that events rarely occur as a result of a single, negligent, deliberate or reckless action, but as part of a sequence of human error, systems failures and contributory factors. Each of these factors is considered in any investigation which is undertaken.

As professionals, staff are held accountable for their actions and are expected to report incidents or hazards and to co-operate in any investigation as a result. This includes a duty to report when they feel they are a risk to patients either due to competency, conduct or health reasons as well as any concerns regarding other staff members. A consistent and unified stance for all professions throughout the Trust is maintained and any subsequent actions deemed necessary following a full and thorough investigation, is managed through the appropriate processes already established within the Trust.

15.9 Risk appetite

The Trust defines its risk appetite as the amount of risk it is prepared to accept, tolerate, or be exposed to at any particular time. The level of risk deemed acceptable (affected by both internal and external drivers) is kept under review by the Trust Board.

The guiding principle of our risk appetite is the "the child first and always". The Trust is committed to doing everything possible to reduce clinical risk for children and to deliver high quality, efficient and effective care. For many children who come to GOSH there is no such thing as a 'no risk' option and the nature of our work is that we do innovative, ground-breaking interventions which at times are high, but controlled, risk. The Trust is committed to working with the child (when mature enough) and his or her family to ensure that they fully understand the options and controls in place to mitigate risk, and are able to give fully informed consent. Research is a key component of our activity, and is, by definition, innovative. Governance structures have been established to ensure that a detailed risk assessment (clinical and financial) of all clinical projects is performed, and the Board is able regularly to review and assess these risks via reports from the Research and Innovation Directorate.

This is also the approach used for non-clinical and business risks. The aim is not to remove all risk but to assess and identify the threats to and vulnerabilities of the business which together can produce the risk. Risk taking then occurs in an appropriate, balanced and sustainable way across the full breadth of the Trusts portfolio of risk. The Trust recognises that controlled risk taking within defined parameters (policies, procedures, objectives, risk assessment, review and control processes) and agreed by the Trust Board, encourages creativity, maximises financial rewards and improves service performance to produce benefits for the child and stakeholders.

Printed copies of this document may not be up to date. Always obtain the most recent version from GOSWEB.

Great Ormond Street Hospital for Children NHS Trust

Trust Board
30th November 2011

Review of effectiveness of Management Board revised terms of reference and subcommittee reporting **Submitted on behalf of:** Chief Executive	**Paper No: Attachment Q**

Aims / summary

Following an effectiveness review, Management Board has been found to have discharged its duties in accordance with its terms of reference for the period October 2010-September 2011. The review covered attendance at meetings, compliance with the Board's terms of reference and compliance with reporting requirements. A full copy of the review is available from the Company Secretary.

At its October meeting, Management Board approved a number of recommendations arising from the review and aimed at improving the Board's governance arrangements (see below). A revised copy of the terms of reference was approved at the October Management Board meeting and is attached for ratification by the Trust Board (see appendix 1). The revised subcommittee structure is also attached for information (see appendix 2).

Action required from the meeting

To approve the revised terms of reference and note the revised subcommittee structure.

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

Management Board approved the following recommendations for changes to the terms of reference (see appendix 1), as follows:

1. An audit of compliance with subcommittee reporting requirements to Management Board to be carried out on an annual basis as part of the effectiveness review.

2. Establishment of a Policy Approval Group, chaired by the Deputy Director of Operations. Authors of policies will be required to attend to present policies to the Group. This Group will meet on a bi-monthly basis and will have delegated authority from Management Board to approve policies and recommend revisions. The Group will ensure that all regulatory and legal requirements are covered within new or revised policies. The Group will also work to streamline policies and ensure that key issues are identified for staff so that they are easy to refer to. A list of approved policies will be submitted to Management Board following each meeting identifying any issues raised.

3. The Major Incident Planning Group to report to the Quality and Safety Committee, escalating management related issues to Management Board as required. Business continuity matters will be considered by the Q and S Committee in the first instance from a quality and safety perspective and escalated where Management Board decision is

required. 4. The Theatre Management Group to report to the Quality and Safety Committee with issues considered from a quality and safety perspective. Relevant operational matters to be escalated to Management Board as required. 5. The reporting arrangements for the Commissioners'' Forum to be reviewed. 6. All Chairs to be reminded of their responsibilities for ensuring that summary reports are submitted to Management Board following every meeting. 7. Corporate departments (human resources, finance, estates and facilities, information services/ ICT) to report their top 3 risks to Management Board on a quarterly basis. Matters arising between reports will be escalated by the relevant directors on Management Board. A revised subcommittee structure is attached at appendix 2.
Financial implications No direct financial implications.
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A
Who needs to be told about any decision Trust Board; operational managers (for governance arrangements around approving policies) and chairs of subcommittees reporting to Management Board
Who is responsible for implementing the proposals / project and anticipated timescales? All members of the Committee and the Company Secretary
Who is accountable for the implementation of the proposal / project Management Board Chair – Chief Executive
Author and date Anna Ferrant, Company Secretary 21st November 2011

APPENDIX ONE
Management Board
Terms of Reference

1. Authority and Scope

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

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

2. Purpose

2.1. The purpose of Management Board is to:

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

- Receive trust wide annual reports on Education and Training, Equality and Diversity, Patient and Public Involvement and Engagement.
- Ratify Trust wide policies in accordance with the Policy on Policies.
- Approve the waiving of formal tendering procedures.

3. Reporting

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

- Monthly reports on the Trust's activity and financial performance.
- Monthly and quarterly performance reports on progress against Trust objectives.
- Annual reports on:
  - Equality and Diversity
  - Education and Training
  - Patient and Public Involvement and Engagement
- Summary reports from the following standing subcommittees:
  - Capital and Space Planning Committee (Bi-Monthly)
  - Information Governance Steering Group (Monthly)
  - Transformation Board (Bi-Monthly)
  - Commissioners' Forum (Monthly)
  - Patient and Public Involvement and Experience Committee (Bi-Monthly)
  - Redevelopment Steering Board (Monthly)
  - ~~Major Incident Planning Committee (Bi-Monthly)~~
  - Working Lives Group (Bi-Monthly)
  - Education and Training Committee (Bi-Monthly)
  - Quality and Safety Committee (Monthly)
  - ~~Research Governance Advisory Sub-committee (Monthly)~~
  - ~~Theatre Management Group (Monthly)~~
  - Policy Approval Group (Bi-Monthly)
  - Technical Delivery Board (for information)
- Clinical Unit Boards will report on a monthly basis, a summary of top risks and quality reports.
- Corporate equivalent departments (human resources, finance, estates and facilities, information services/ ICT) will report ~~on a monthly basis~~ on a quarterly basis, a summary of top risks.

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

4. Membership

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

- Chief Executive (Chair) (Deputy Chief Executive)
- Deputy Chief Executive (Deputy Chief Operating Officer)
- Chief Finance Officer (Deputy Director of Finance)
- Director of Nursing and Education (Deputy Director of Nursing)
- Co-Medical Director (x2) (Assistant Director of Patient and Staff Safety)
- Director of Redevelopment (Assistant Director of Estates)

- Deputy Chief Operating Officer (Head of Planning and Performance Management)
- Clinical Unit Chairs (x5) (cross cover with GMs)
- General Managers (x6) (cross cover with Clinical Unit Chairs)
- Director of ICT (Deputy Head of ICT)
- ~~Interim General Partnership Development Manager, Acute Paediatrics, NMUH & GOSH~~

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

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

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

5. <u>Meetings</u>

5.1. Meetings will be held on a monthly basis.

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

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

6. <u>Monitoring</u>

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

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

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

November 2011

Trust Board 30th November 2011	
Revised Audit Committee Terms of Reference 2011-12 **Submitted by: Anna Ferrant, Company Secretary**	**Attachment R** **FOR APPROVAL**

Aims / summary

The Audit Committee has revised its terms of reference. The Audit Committee's terms of reference (ToR) were last updated in full in March 2010.

In order to ensure that the ToR are fit for purpose once the Trust is authorised as a Foundation Trust, the document has been updated in the light of requirements and guidelines detailed in the following documents:

- The NHS Audit Committee Handbook – new version published in May 2011
- The NHS Confederation's Audit Committee terms of reference template
- Monitor's Code of Governance and any changes since the last review
- The Trust's Constitution, Standing Orders and Standing Financial Instructions
- The recent publication by the Financial Reporting Council on Guidance on Board Effectiveness (March 2011) and Effective Company Stewardship – Enhancing Corporate Reporting and Audit (March 2011).

A number of changes to the ToR were agreed by the Committee at its October 2011 meeting. These are:

- The Committee endorsed the revised reporting arrangements proposed, with Ms Yvonne Brown attending both the Audit Committee and Clinical Governance Committee and the Company Secretary presenting a short summary of matters discussed and agreed at the Clinical Governance Committee at every meeting of the Audit Committee.
- It was agreed that the Clinical Governance Committee should continue to take the lead on clinical risk matters and that the key was to ensure that reporting was aligned.
- The Committee agreed that it only wished to receive a report on compliance with the Care Quality Commission outcomes where specific risks were raised that were relevant to the Audit Committee.
- It was agreed that the Committee would continue to meet four times a year, with the flexibility to hold an additional meeting if required.
- The Committee agreed that it would be helpful to hold a meeting with the Clinical Governance Committee to consider the risk management framework and ensure that it was aligned between the committees. It was suggested that this meeting should take place before the end of 2011.
- It was agreed that paragraph 4.5 of the terms of reference be deleted (attendance of the Chair of the CGC at the Audit Committee), in the light of attendance of Yvonne Brown at the CGC.

A revised copy of the ToR is attached over-page. Sections highlighted in yellow in the ToR detail the revised/ additional text. Those sections in brackets will be applied once the Trust is authorised as a Foundation Trust.

Action required from the meeting To approve the attached terms of reference.
Contribution to the delivery of NHS / Trust strategies and plans STRATEGIC OBJECTIVE 7: Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation.
Financial implications None
Legal issues None
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? The Trust Board and Clinical Governance Committee
Who needs to be told about any decision The Trust Board and Clinical Governance Committee
Who is responsible for implementing the proposals / project and anticipated timescales Company Secretary
Who is accountable for the implementation of the proposal / project Company Secretary
Author and date Anna Ferrant, Company Secretary, November 2011

Great Ormond Street Hospital for Children NHS Trust NHS

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Authority

1.1. The Audit Committee is a non-executive committee of the Board of Great Ormond Street Hospital for Children NHS Trust (the Board), established in accordance with [paragraph 36 of the Trust's Constitution and] section 27 of the Board's Standing Orders.

2. Remit

2.1.The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial internal controls that supports the achievement of the organisation's objectives.

3. Authority

3.1. The Committee is authorised by the Board to:

a) investigate any activity arising within its terms of reference;

b) to seek any information it requires from any member of staff and all members of staff must co-operate with any request made by the Committee;

c) to request specific reports from individual functions within the Trust.

d) to obtain independent legal or professional advice; and

e) to request the attendance of individuals and authorities outside the Trust with relevant experience and expertise if it considers this necessary.

4. Membership

4.1. The Audit Committee shall be composed of three non-executive directors. The Chairman of the Trust shall not be a member of the Committee.

4.2. At least one of the committee members shall have recent and relevant financial experience. Two members shall constitute a quorum.

4.3. The Board may appoint an independent member of the committee in addition to the non executive director members to bring in additional experience and expertise.

4.4. One of the non executive members will be appointed as Chair of the Committee by the Board.

~~4.5. One of the non-executive members shall be the Chair of the Clinical Governance Committee.~~

5. Attendance at meetings

5.1. The Chief Executive, Chief Finance Officer, Chief Operating Officer, Assistant Director of the Clinical Governance Support Team; representative of the external auditors; and the Head of Internal Audit shall normally be invited to attend meetings.

5.2. The external auditors and internal auditors shall meet with the Committee without executive directors present.

5.3. The Company Secretary shall be the Secretary to the Committee.

5.4. The Committee may invite any member of GOSH staff or directors to attend a meeting of the Committee, should it be considered necessary.

6. Frequency of meetings

6.1. Meetings shall be held four times a year at dates agreed to coincide with key stages in the accounting and audit cycle. The external auditors or Head of Internal Audit may request a meeting if they consider one is necessary.

7. Duties

7.1. To discharge the Trust's duties for Audit, the Committee shall ensure that the business of the Trust is conducted fully in accordance with the principles of accountability and probity by undertaking the following duties:

8. Governance, risk management and internal control

8.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

8.2. In particular, the Committee shall review the adequacy and effectiveness of:

8.2.1. All risk and control related disclosure statements (in particular the Statement on Internal Control), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to the endorsements by the Board.

8.2.2. The underlying processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of the principal risks and the appropriateness of the above disclosure statements.

8.2.3.The policies and strategies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

8.2.4.The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the Counter Fraud Service.

8.3. The Assurance Framework will be used to guide the Committee's work and that of the audit and assurance functions that report to it.

8.4. The Committee shall review and make recommendations to the Board on the management of risk, and the resources required including the annual business plan.

9. **Internal Audit**

9.1.The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards [Internal Audit Standards in a Foundation Trust] and provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board. This will be achieved by:

9.1.1.consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal;

9.1.2.review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that it is consistent with the audit needs of the organisation as identified in the Assurance Framework;

9.1.3.consideration of the major findings of internal audit work (and management's response) and ensuring coordination between the internal and external auditors to optimise audit resources;

9.1.4.ensuring that internal audit function is adequately resourced and has appropriate standing within the organisation.

9.1.5.receipt of interim and annual reports from the head of internal audit on internal audit activities and the results of its work, including progress against performance measures;

9.1.6.monitoring of the implementation of audit recommendations by management;

9.1.7.initiation of special projects or investigations on any matter arising from within its terms of reference;

9.1.8.an annual review of the effectiveness of internal audit.

10. External Audit

10.1. The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

10.1.1.[Consideration of the appointment and performance of the external auditors as outlined below:

10.1.1.1. The Committee will assess the external auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Members' Council with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards. To the extent that that recommendation is not adopted by the Members' Council, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

10.1.1.2. The Committee will oversee the conduct of a market testing exercise for the appointment of an auditor at least once every [five – to be agreed] years and, based on the outcome, make a recommendation to the Members' Council with respect to the appointment of the auditor.

10.1.1.3. The Committee will develop and implement a policy on the engagement of the external auditor to supply non-audit services.

10.1.1.4. The Committee will consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal.]

10.1.2.Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate , with other external auditors in the local health economy

10.1.3.Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust [and associated impact on the audit fee];

10.1.4. Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses and progress on implementation of the recommendations.

11. Other assurance functions

11.1. The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications for the governance of the Trust.

11.2. The Committee will review the work of other committees in the Trust whose work can provide relevant assurance to the Audit Committee's scope of work. In particular, this will include the Clinical Governance Committee but may also include specific Risk Assessment Groups (RAGs).

11.3. The Committee will receive a report from the Clinical Governance Committee on the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission (CQC), as reported to the Clinical Governance Committee and the robustness of the processes behind the Quality Accounts.

12. Counter Fraud

12.1.The Committee shall satisfy itself that the Trust has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

13. Whistle blowing

13.1.The Audit Committee should review arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.

13.2.The Audit Committee will monitor the arrangements in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

14. Financial reporting

14.1. The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's performance.

14.2. The Committee shall ensure that the systems for reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

14.3. The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

14.3.1.the wording in the Statement on Internal Control and other disclosures relevant to the terms of reference of the Committee;

14.3.2.changes in, and compliance with, accounting policies, practices and estimation techniques;

14.3.3.unadjusted mis-statements in the financial statements;

14.3.4.significant adjustments in preparation of the financial statements;

14.3.5.significant adjustments resulting from the audit.

14.3.6. letter of representation

14.3.7.qualitative aspects of financial reporting.

15. Standing Orders, Standing Financial Instructions and Standards of Business Conduct

15.1.On behalf of the board of directors, the Committee shall:

15.1.1. review the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

15.1.2.examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

15.1.3.review the scheme of delegation.

15.1.4.reports to the Trust Board on its findings and recommends amendments for approval.

16. Administration of the Committee

16.1. The Committee shall undertake an annual review of its effectiveness.

16.2. The Committee shall be supported administratively by the Company Secretary, whose duties shall include:

16.2.1.Agreement of the agendas with the Chair and collation of the papers;

16.2.2.Taking the minutes;

16.2.3.Keeping a record of matters arising and issues to be carried forward;

16.2.4.Advising the Committee on pertinent issues/ areas;

16.2.5.Enabling the development and training of Committee members.

16.3. The Committee shall review its terms of reference and work-plan on an annual basis.

16.4. The Committee shall receive the minutes of the Risk, Assurance and Compliance Group and Clinical Governance Committee.

17. Reporting

17.1. The minutes of the Audit Committee shall be submitted to a meeting of the Board.

17.2. The Chair of the Committee shall draw to the attention of the Board [and the Members' Council] any issue that requires disclosure to the full Board or requires action, making recommendations as to the steps to be taken.

17.3. The Committee will report to the Board at least annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework; the completeness and extent to which risk management in the Trust is embedded; the integration of governance arrangements and the assurances sought of the robustness of the evidence demonstrating fitness to register with the Care Quality Commission; and the robustness of processes behind production of the Quality Accounts.

17.4. The Committee will report to the Members' Council with respect to the re-appointment or removal of the auditor, as outlined under paragraph 10.1.1.1 above.

October 2011

Trust Board 30 November 2011	
Introducing the Equality Delivery System (EDS) to improve patient/family/staff experience at GOSH **Submitted on behalf of:** Dr Barbara Buckley, Co-Medical Director	**Paper No: Attachment S** **Ratified by:** Approved by Family Equality and Diversity Group and representatives of the Staff Equality and Diversity Group and Management Board (November 2011)
Summary This paper introduces the Equality Delivery System, following which will allow us to meet our legal requirements arising from the Equality Act 2010.	
Action required from the meeting For approval.	
Contribution to the delivery of NHS / Trust strategies and plans Meets legislative requirements concerning equality and diversity as a public sector body.	
Financial implications N/A	
Legal issues Meets current and forthcoming equality legislation.	
What consultation has taken place? The policy has undergone consultation with both the Family and Staff Equality groups and with senior members of the HR management team.	
Who needs to be told about the policy? All members of staff	
Who is accountable for the monitoring of the policy? Family Equality and Diversity Group, Staff Equality Group	
Author and date Sue Lyon (for Staff Equality Group) and Beki Moult (for Family Equality and Diversity Group)	

Introducing the Equality Delivery System (EDS) to improve patient/family/staff experience at GOSH

1. Introduction

1.1. Over the past 10 years, much progress has been made regarding improving the experience of patients, families and staff at GOSH. We understand much more about our patient and staff population and have improved a variety of services to better meet their needs.

1.1.1. A wider variety of food is served in our eating facilities, including vegetarian, Kosher and Halal options every day.

1.1.2. Faith facilities have been improved, with the introduction of Friday prayers for Muslim families and staff and the Shabbat Room for Jewish families. The multifaith room has also been refurbished recently to make it more suitable for daily use.

1.1.3. Various courses at all levels are offered to staff, including classes in English as a Second or Other Language.

1.1.4. The Trust supports staff through the BAMEN (Black, Asian and Minority Ethnic Network) group.

1.2. Equality and diversity matters are overseen by two groups at GOSH: the Staff Equality and Diversity Group and the Family Equality and Diversity Group. These groups work closely together on Trust-wide initiatives, such as the Healthy Diversity Fact File, Single Equality Scheme and annual reports to the Trust Board.

1.3. In order to continue progress to improve the patient/family/staff experience at GOSH, particularly in light of the introduction of the Equality Act 2010, both groups are recommending implementation of the Equality Delivery Scheme.

2. The Equality Act 2010

2.1. The Equality Act 2010 came into effect on 6th April 2011 with the aims of:

2.1.1. Eliminating discrimination, harassment and victimisation and other conduct prohibited by the Act

2.1.2. Advancing equality of opportunity between people who share a protected characteristic and those who do not

2.1.3. Foster good relations between people who share a protected characteristic and those who do not

2.2. In addition to the general duty stated above, public bodies are required to:

2.2.1. Prepare and publish equality objectives, which should be specific and measurable, setting out how progress towards these objectives should be measured. Details of the engagement in developing these objectives should also be published.

2.2.2. Publish information, including information on the effect that policies and practices have had on employees, service users and others from the protected group. This should also include details of how these policies and practices will further the three aims of the general duty.

2.3. The nine protected groups covered by the Equality Act 2010 are:

2.3.1. Age

2.3.2. Disability

2.3.3. Gender reassignment

2.3.4. Marriage or civil partnership

2.3.5. Pregnancy and maternity

2.3.6. Race

2.3.7. Religion or belief

2.3.8. Sex

2.3.9. Sexual orientation

2.4. There may be additional protected groups that are as or more pertinent to GOSH, which will be considered when developing objectives and publishing data.

3. The Equality Delivery Scheme (EDS)

3.1. The EDS was developed by the NHS Equality and Diversity Council, chaired by Sir David Nicholson, with representatives from the NHS, Department of Health and other interests.

3.2. The EDS provides a framework to:

3.2.1. improve the equality performance of the organisation, making it mainstream business for the Board and all staff and

3.2.2. help the organisation meet the evidential requirements of the Equality Act 2010, especially the public sector equality duty, as well as the statutory duty under the NHS Act 2006 to consult and involve patients, communities and other local interests

3.3. The EDS comprises 18 outcomes grouped under four objectives: better health outcomes for all, improved patient access and experience, empowered, engaged and inclusive staff and inclusive leadership. Please see Appendix 1 for a list of the 18 outcomes. Outcomes have been mapped to existing regulatory frameworks such as the Care Quality Commission and the NHS Constitution.

3.4. Each Trust (including Foundation Trusts) will assess themselves against these outcomes, as will representatives of special interest groups, initially our Members' Council and Membership.

3.5. We shall have to be assessed by our special interest groups for each of the nine protected groups against each outcome.

3.6. These assessments will inform development of a maximum of five equality objectives for the following three-year period, which will be integrated into the Trust's business planning processes.

3.7. There will no longer be the requirement to publish a Single Equality Scheme or annual reports. However, policies, procedures and strategies will require an equality analysis rather than the formal equality impact assessment as currently. Equality analyses along with equality data and progress against objectives will also require annual publication.

4. Proposed actions

4.1. The following proposed actions have been devised in order to meet the national requirements (in bold):

4.1.1. October 2011 – Present paper to FED group for discussion and agreement

4.1.2. October 2011 – Request workstream at Trust Board away day

4.1.3. November 2011 – Submit paper to Management Board for information

4.1.4. November 2011 – Submit paper to Trust Board for ratification and inclusion in Trust objective workstreams

4.1.5. January 2012 – Hold consultation event (with Membership for outcomes 1 and 2 and staff for outcomes 3 and 4)

4.1.6. **31st January 2012** – NHS organisations are required by law to publish information to demonstrate compliance with the public sector equality duty.

4.1.7. February 2012 – Identify four equality objectives – two for outcomes 1 and 2 and two for outcomes 3 and 4

4.1.8. March 2012 – Ensure equality objectives included in unit and local business plans

4.1.9. **6th April 2012** – NHS organisations are required by law to publish one or more equality objectives for the following three-year period, developed after assessment against the EDS outcomes and consultation with interested parties.

4.2. Task 3.1.5 has to be repeated on an annual basis but 3.1.8 every three years.

4.3. In addition, the process for carrying out equality analyses will be revisited and refreshed in light of lessons learned from the introduction of equality impact assessments.

5. Recommendation

5.1. The Board is invited to approve the implementation of the EDS at GOSH and receive future reports as required.

6. Appendix 1 – EDS outcomes

Objective	Narrative	Outcome
1. Better health outcomes for all	The NHS should achieve improvements in public health and patient safety for all, based on comprehensive evidence of needs and results	Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities
		Patients' health needs are assessed, and resulting services provided, in appropriate and effective ways
		Changes across services are discussed with patients, and transitions are made smoothly
		The safety of patients is prioritised and assured
		Public health, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds
		Patients are informed and supported so that they can understand their diagnoses, consent to their treatments, and choose their places of treatment
		Patients and carers report positive experiences of the NHS, where they are listened to and respected and their privacy and dignity is prioritised
		Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently
3. Empowered, engaged and well-supported staff	The NHS should increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs	Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades
		Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing the same work in the same job being remunerated equally
		Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately
		Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all
		Flexible working options are made available to all staff, consistent with the needs of patients, and the way that people lead their lives
		The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect

		individual staff and the wider population
4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond
		Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination
		The organisation uses the NHS Equality & Diversity Competency Framework to recruit, develop and support strategic leaders to advance equality outcomes

Trust Board November 2011	
Title of document Key Performance Indicator (KPI) report **Submitted on behalf of.** Fiona Dalton, Chief Operating Officer	**Agenda item/Paper No**
Aims / summary The report has been revised following a number of recent recommendations from Monitor. In particular the dashboard has been expanded to include 'RAG' performance against defined thresholds and tolerances as well monthly and quarterly performance trends. Progress against Monitor's governance risk framework is now reported monthly. Remedial actions to address performance and operational issues will be undertaken by Management Board.	
Action required from the meeting Trust Board to note progress.	
Contribution to the delivery of NHS / Trust strategies and plans To assist in monitoring performance against internal and external defined objectives and NHS targets.	
Financial implications None	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? Our lead Commissioner receives a copy of the executive summary on a quarterly basis.	
Who needs to be told about any decision Senior Management Team.	
Who is responsible for implementing the proposals / project and anticipated timescales Each Trust objective task has an identified person responsible for implementation and an Executive Director nominated as the accountable officer.	
Who is accountable for the implementation of the proposal / project Remedial actions to address performance and operational issues are undertaken by Management Board.	
Author and date Janine Gladwell – Access & Capacity Manager. November 2011	

KPI Exception report

1. C. difficile and MRSA (Report page 2 Graph 1)
To date the Trust has reported 6 against a year-to-date trajectory of 5.25. The Trust trajectory for the year is 9 cases. No cases were reported in October.

The Department of Health (DH) have not yet agreed to a paediatric target different from adult. The DH advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) will be presenting our opinion on this again soon.

2. Discharge summary completion rates. (Report page 6)
In-month performance increased to 77.7% against a previous month figure of 74.3%. An electronic solution is required and is currently being discussed through the Technical Delivery Board.

3. Referral to Treatment – Median Waits
The Trust continues to meet the 95th percentile waiting time standards. A number of issues remain in sustaining performance against the incomplete pathway and non-admitted median wait standards.

The Trust remains just outside the median incomplete pathway standard at 7.6 weeks. Whilst much progress has been made in reducing the overall Trust backlog Clinical Units are asked to remain particularly vigilant with respect to the number of patients on an incomplete pathway and to ensure that all patients that are over the 18 week breach date have a TCI date.

In month, the non-admitted median wait is reported at 6.9 weeks against a target of 6.6weeks. It is anticipated that the work on improving clinic outcome form completeness will increase the Trust performance against this standard.

4. Inpatient Waiting List
In month performance has deteriorated with 148 patients waiting over 26 weeks. Particular capacity issues have been identified across a number of specialties, including:

- Urology
- Dental & Maxillofacial
- Orthopaedics
- Plastic Surgery
- Spinal

Detailed action plans were developed and submitted to August Management Board and a number of business cases to increase capacity are now being developed for approval.

5. New to Follow Up Ratio (Report page 8)
The new to follow up ratio has reduced in October to 4.25 from a previous month performance of 4.38. The Trust has a contractual target to reduce this to 4.18 and retain this by December 2011. Following discussion at the recent Clinical Unit Review meetings, units have been asked to consider specialty specific reductions and trajectories against those areas with high ratios.

6. Personal Development Review (PDR) completeness rates (Report page 14)
Appraisal completion rates have remained fairly consistent level during 2011 but are now beginning to decline. The Trust reported an in-month rate with 68.6% for clinical areas and 61.2% in non-clinical against an October interim target of 80%. Managers are reminded to continue to work proactively to ensure that all staff have a current PDR.

7. Staff Trained on Information Governance (Report page 14)
Performance is reported at 87% against a target of 95%. The lowest compliance rates are identified across Medical and Dental. All new staff are now required to undertake the training as part of their induction.

Appendix 1 - The report now includes performance issues from the Clinical Unit Management Board reports that have shown statistical change. The areas of decreased performance have included a narrative from the Clinical Unit which highlight the reasons for the declined performance and actions being taken to tackle the issue.

Clinical Unit Escalations to Trust Board – November 2011 – Appendix 1

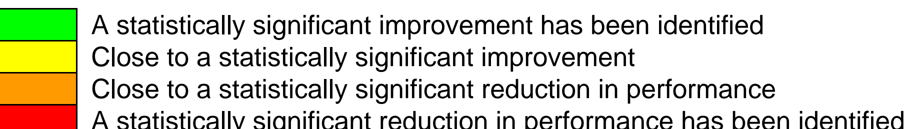
This report is a summary of changes in performance of the measures at Clinical Unit level that have been reported to Management Board.

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

Performance Measure	Change	Clinical Unit	Narrative
CVL infections per 1000 line days (Chart 1)		Neurosciences	Zero CVL infections for 7 months
Hand hygiene (Chart 2)		MDTS	A significant improvement
WHO checklist completion (Chart 3)		Surgery	A significant improvement
Prescribing errors (Chart 4)		Cardio-respiratory	The unit has been extremely busy during the period of declined performance. Two more interventions have been implemented to try and reduce errors; direct feedback to all doctors with those with highest level of errors contacted by the Clinical Unit Chair and the introduction of an electronic infusion calculator
Discharge summary completion (Chart 5)		ICI-LM	Discharge summary performance analysed at specialty level to identify key areas Rheumatology rehabilitation programme - a simple data issue resolved (need to mark 'not required' for each day of the 10 day programme until it is completed) Locum doctors and sickness an issue in Dermatology - will look to improve the instructions they are given when they arrive Additional weekend member of admin staff on Sundays to improve rates for weekend discharges in terms of faxing them in a timely way and have admin until 7pm in key areas Ongoing monitoring - direct feedback to doctors in worst areas
Discharge summary completion (Chart 6)		Surgery	Our approach to improving performance in 2010 was to individually chase the junior medical teams to complete

	Red		discharge summaries. However this proved unsustainable with the resource available, causing our rate to drop. We are now working with ICT to develop a solution to provide a pre-populated template at the point of discharge, making the process simpler and quicker. This will be implemented initially in General Surgery and Urology, where our greatest discharge numbers are, and we expect to see an improvement by April 2012. Timelines are subject to change depending on supplier selection in January.
Discharge summary completion (Chart 7)	Yellow	MDTS	Near to a significant improvement
Clinic outcome form completeness (Chart 8)	Red	Cardio-respiratory	The reduced performance has coincided with a change of process – this process will revert back to the original process
Clinic outcome form completeness (Chart 9)	Green	MDTS	A significant improvement

See appendix 1 below for the charts



Appendix 1

Chart 1
Neurosciences

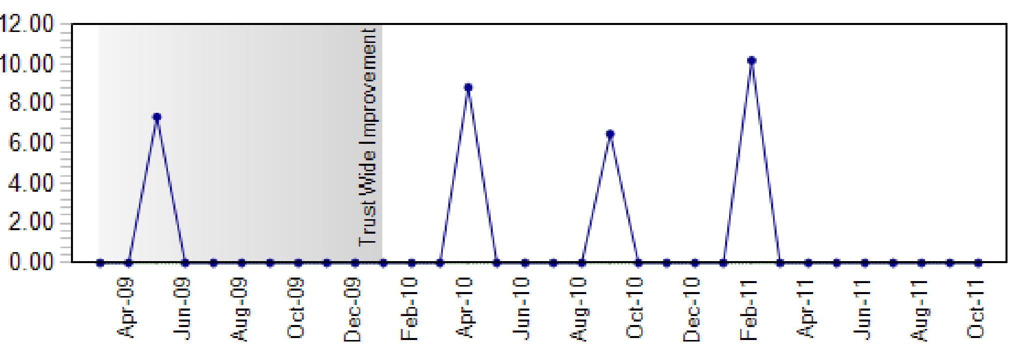


Chart 2
MDTS

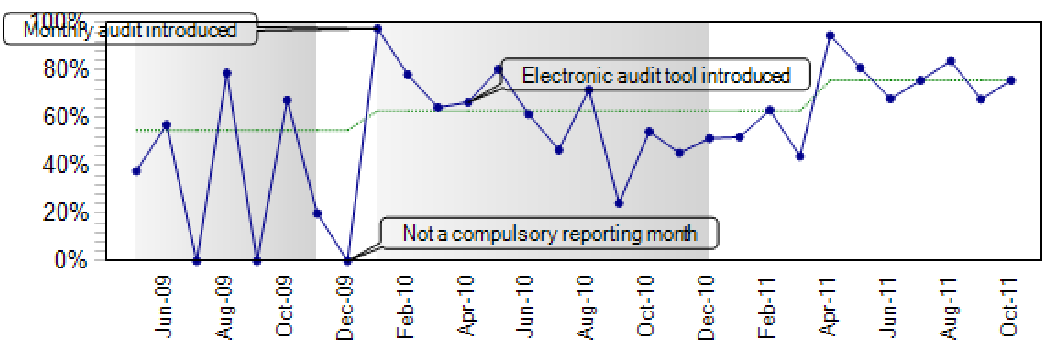


Chart 3
Surgery

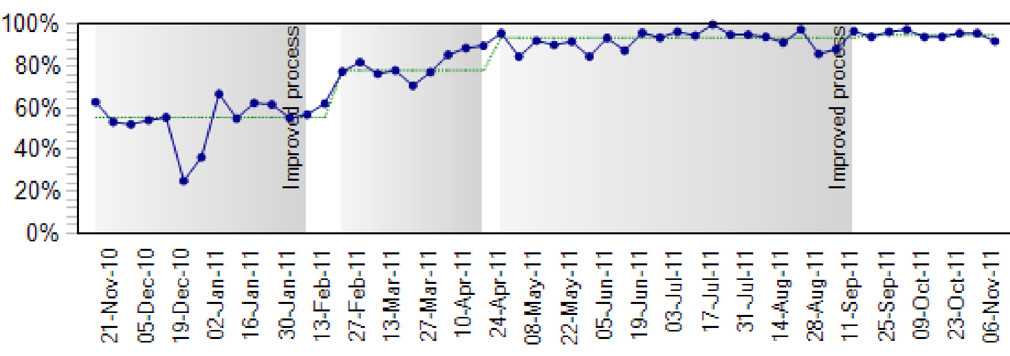


Chart 4
Cardio-respiratory

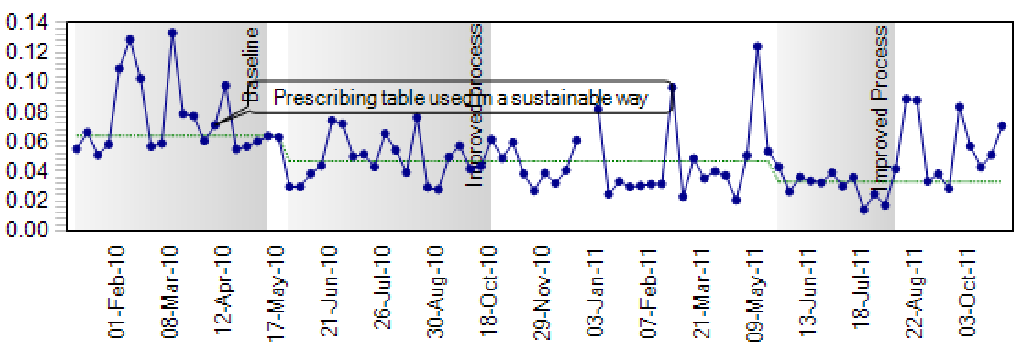


Chart 5
ICI-LM

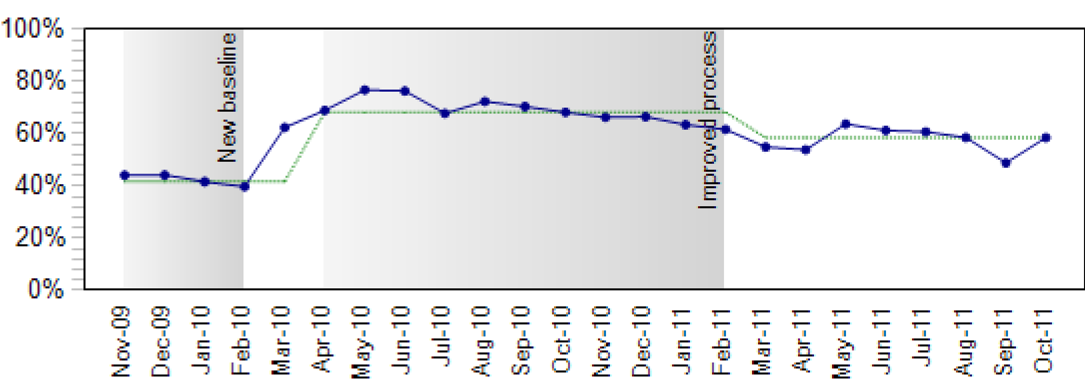


Chart 6
Surgery

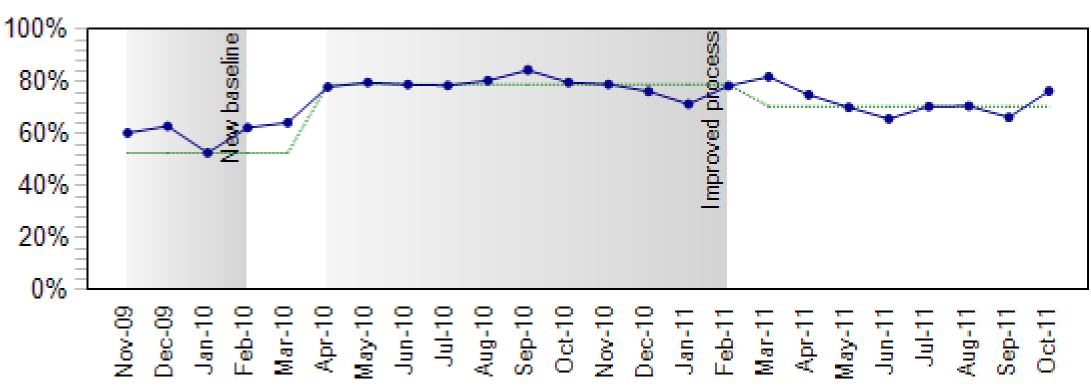


Chart 7
MDTS

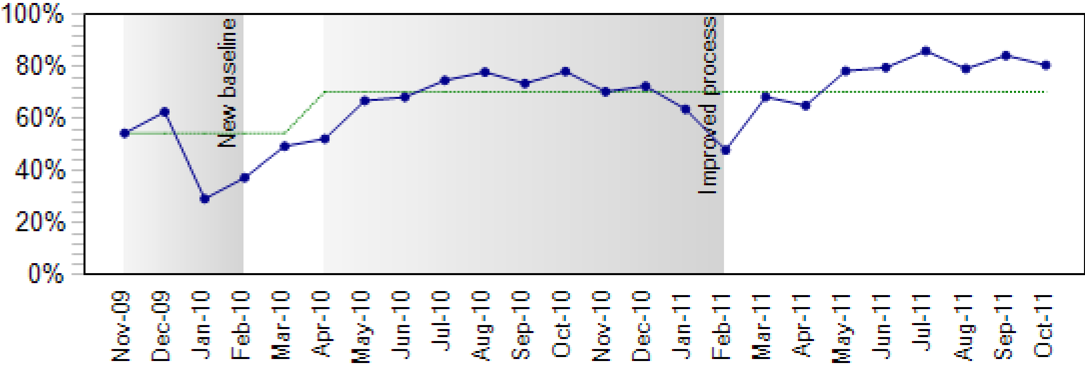


Chart 8
Cardio-respiratory

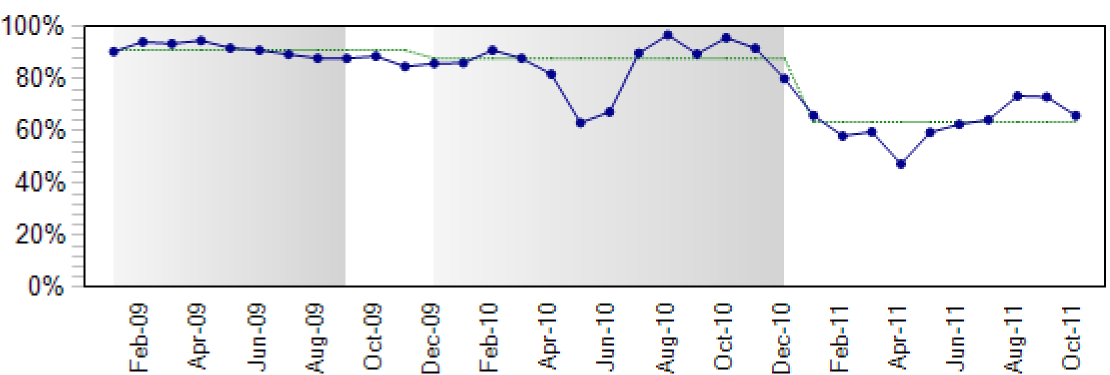
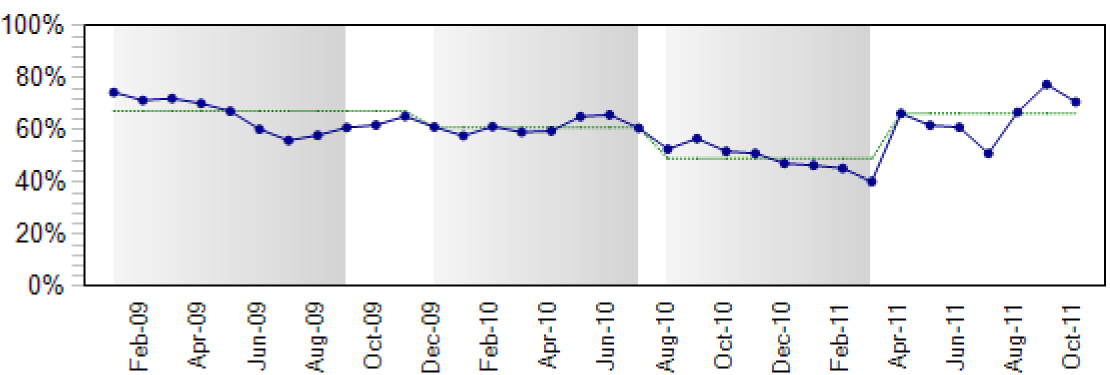


Chart 9
MDTS



Attachment:

Great Ormond Street Hospital for Children NHS Trust

TRUST BOARD

30 November 2011

Finance and Activity Report **SEVEN months to 31 October 2011** **Submitted on behalf of** Claire Newton, CFO	**Agenda item/Paper No** **Attachment U**

AIM
To summarise the Trust's financial performance for the **SEVEN** months to **31 OCTOBER 2011.**

SUMMARY

Results year to date to end of period 7

- Net surplus **£5.2M**, which is £0.8M lower than the revised plan
- Normalised EBITDA 6.9% (*Budget 7.4%; Full year budget 7%)*
- FRR of 3 with adequate headroom

Forecast
The forecast position is £2.3M surplus after a property impairment estimated at £5.7M and accelerated depreciation. Although the result at M7 is below plan, the forecast includes an assumption, following discussion with units, that certain areas which underperformed in the year to date have now been addressed and that the current level of agency staff can be reduced.

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

- Control of Agency costs
- Delivery of the remainder of the CRES plan;
- Delivering income growth and ensuring the Trust is appropriately reimbursed
- Ensuring Phase 2A double running and project costs are in line with plan

Activity/Income
Total income, if pass through funding is excluded is above plan by £2.7M.

- NHS income is ahead of plan by £2.6M, with underlying activity broadly in line with plan
- IPP income is in line with plan
- Other operating revenue is £0.2M behind plan if the timing differences in respect of the charitable donations pass-through are removed.

Expenditure
Pay is over spent by £3.4M excluding pass through. The majority of the over spend relates to nursing and junior medical staffing where there are higher than planned levels of agency staff. Non Pay is under-spent by £0.3M when pass through of blood, drugs and clinical devices are taken into account.

Cash
Currently lower than plan at £20.6M and forecast to end at £28M. A review has shown that the Plan did not adequately address the seasonality of debtors or a number of variables present at the beginning of the year which boosted the opening cash balance on a non recurring basis.

Debtors
Although lower than the same month last year, there have been some increases in debt levels which are actively being pursued. The ageing analysis shows most of the increase is in current debt.

BPCC performance (Non NHS – cumulative)

- Total payables – Value 85.9% (to period 6 – 82%)
- Total payables – Number 87% (to period 6 - 87%)
- Scores improving due to continued clearance of old creditor invoices

CRES
The Trust is now reporting risk adjusted values for CRES having completed an exercise to remove or reduce schemes where there is uncertainty over scheme delivery.

CRES 2011/12

- Financial Plan requires £11.2M and 11.0M identified

CRES 2012/13

- Financial Plan requires £11.81M and 10.4M identified

CRES 2013/14

- Financial Plan requires £13.2M and 13.8M identified

Capital

- Capital spend is £26.2M; £1.4M lower than plan YTD. Donated capital spend is £1.4M lower than plan
- Forecast capital spend is likely to be approximately £4.6M lower than original plan and this will be donated capital and largely related to the Redevelopment programme.
- The Trust is forecasting to remain within CRL target for the year

Salary overpayments

- There were eight salary overpayments totalling £25.2K

Contribution to the delivery of NHS / Trust strategies and plans
Financial sustainability and health

Financial implications As explained in the paper

Legal issues N/A

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

Who needs to be told about any decision N/A

Author and date Andrew Needham - Deputy Finance Director 14 November 2011

PERIOD 7 - 2011/12 FINANCE REPORT

(1) Forecast position

The Trust is forecasting a £2.3M surplus after charging an expected property impairment currently estimated at £5.6M on the new 2A clinical building.

(2) Period 7 position

The following table summarises the revenue account compared with budget and the last financial year, with discontinued items and normalising items shown separately. It also shows variances to budget excluding pass through items.

	2011/12				2010/11	
	M7 YTD Budget	**M7 YTD Act**	*Var ex pass through*	*Pass through var*	M7 YTD	Var 11/12 v 10/11
NHS Income	*147.5*	**149.1**	*2.7*	*(1.0)*	138.7	8.7
International income	*16.0*	**16.0**	*0.1*	*-*	13.8	2.2
Other activity income	*2.3*	**1.7**	*(0.3)*	*(0.2)*	2.8	(0.6)
Other income ex DAT	*26.6*	**25.1**	*(0.2)*	*(1.3)*	25.4	1.2
Total normalised income	***192.3***	**192.0**	***2.2***	***(2.5)***	**180.8**	**11.5**
Haringey etc	*1.6*	**1.6**			6.6	(5.0)
DAT	*3.5*	***3.6***	*0.0*	*-*	4.3	(0.8)
Total income	*195.8*	***195.5***	*2.2*	*(2.5)*	191.7	4.1
						-
Pay	*(108.5)*	**(111.3)**	*(3.5)*	*0.6*	(105.1)	(3.3)
Non-pay	*(69.5)*	**(67.3)**	*0.3*	*1.9*	(62.7)	(6.8)
Total normalised operating expenditure	***(178.0)***	**(178.6)**	***(3.1)***	***2.5***	**(167.9)**	**(10.1)**
Haringey etc	*(1.6)*	**(1.6)**			(6.6)	5.0
	(179.6)	***(180.2)***	*(3.1)*	*2.5*	*(174.5)*	*(5.1)*
EBITDA (ex DAT)	***14.3***	***13.4***	***(0.9)***	***0.0***	***12.9***	***1.4***
Non-operating expenditure	*(11.8)*	**(11.8)**	*0.1*	*-*	(11.8)	(0.0)
DAT	*3.5*	**3.6**	*0.0*	*-*	4.3	(0.8)
Net surplus	***6.0***	**5.2**	***(0.8)***	***0.0***	**5.4**	**0.6**

- Income and expenditure are approximately 6% ahead of the prior financial year with a small improvement in EBITDA.
- Relative to Plan, excluding pass through, income is ahead of plan by £2.2M but expenditure is currently above plan by £3M, primarily due to higher then expected pay costs as use of agency for junior medical staff and nursing has risen again.

(3) Variance summary

An analysis of variances by unit and department is included as PAGE 4 of the appended report

A high level assessment of the growth in income and expenditure by clinical unit relative to last financial year is shown in the following table. However some of the comparisons have been adjusted to exclude items which distort the comparison between years:

- Neurosciences expenditure now includes the costs of the Gen Paediatric team for which there is no direct funding (team started March 2011). This expenditure in 1112 has been excluded resulting in a reduction in the unit's expenditure growth from 10% to 7%.

- DTS income growth is a result of a transfer of income for psychologists which was reported through Neurosciences in 2010/11. This income has been adjusted from DTS to Neurosciences for comparison purposes only

		Growth relative to 1011					
		Income		Activity	Expenditure		WTE
			ex tariff deflation			*ex ave cost inflation*	
Cardiac		**6.1%**	*7.2%*	11.9%	**13.1%**	*10.7%*	12.0%
ICI		**2.1%**	*3.2%*	4.6%	**8.4%**	*6.0%*	9.6%
Medicine		**4.5%**	*5.6%*	-0.5%	**6.9%**	*4.5%*	7.0%
Neurosciences	**	**-0.2%**	*0.9%*	6.8%	**7.0%**	*4.6%*	8.2%
Surgery		**7.6%**	*8.7%*	3.0%	**3.7%**	*1.3%*	3.6%
DTS	**				**6.2%**	*3.8%*	0.0%
Total NHS		**3.1%**	***4.2%***	**6.5%**	**9.1%**	***6.7%***	
International		**22.3%**		21.7%	**28.0%**		14.3%

** adjusted for items not comparable between years

The above table shows that in overall terms, activity has grown by 6.5%, slightly above plan, and expenditure at a similar level. Some of the major drivers of activity growth are in Cardiac where referrals are growing and Cardiac has worked hard to minimise refused referrals and in ICI where bed numbers were increased in the middle of last financial year in response to Commissioners demands to reduce refused admissions.

The neurosciences average activity growth rate is skewed by high growth in Outpatients which has lower average values. Neurosciences also lost out on tariff changes.

In addition cost efficiencies are masked by a number of cost pressures, most notably quality investments such as the additional General Paediatric team and the full year effect of funding the ICON team. Income has reduced due to tariff deflation and some reductions in tariff.

WTE has increased at a higher rate than activity in both Neurosciences and Cardiac as both units have increased resources for specific business developments but this is subject to review.

International expenditure shows a higher growth than income growth as its expenditure budget includes costs relating to the education contract in Kuwait and there has also been an increase in bed days within the International wards offset by some reductions in the use of beds in NHS wards where the expenditure would be within the clinical unit.

Expenditure in corporate departments is only slightly above plan.

(3A) Pay

Pay expenditure totals £112.8M, £2.8M higher than plan including pass through and £3.4M higher excluding pass through.

Junior doctor pay is overspent by £1.5M YTD. Key areas of overspend are within ICI (£0.4M) and Surgery (£0.4M). This is due to reliance on temporary staffing to cover rotas. The units are putting measures in place to address this and there is evidence of an expenditure reduction in month 7 within ICI. IPP is also £0.2M overspent due to using temporary staff to cover weekend rotas. This is also being reduced. Cardiac has also seen an increase in expenditure resulting from the ward expansion.

Nursing pay is overspent by £1.4M YTD with £0.6M of this being activity related and offset by income. Other key overspends are within the following areas: Surgery £0.4M, MDTS £0.1M, International £0.1M & Neuro £0.1M. There is high reliance within these areas on temporary staff to cover vacancies, maternity & sick leave, to support supernumerary new starters.

Agency costs

Junior doctors	£0.95M
Nursing	£1.55M
Sci, Ther, Tech	£1.21M
Non-clinical/HCA	£2.85M
Total	£6.56M (representing 5.8% of the pay bill to October 2011)

(3B) Non pay

Non-pay expenditure is £79.2M, which is £2.2M lower than plan excluding pass through (£0.3M lower than plan excluding pass through).

There is a £1.9M favourable variance on pass through items reflecting lower blood and devices spend, this is neutral to the overall variance position with income correspondingly lower.

- Drugs are underspent by £0.6M in month 7, as a result of activity and case mix related expenditure increases. Including pass through items the variance was £0.2M underspent.

- Blood was overspent by £0.3M YTD, excluding pass through, with Cardiac £0.2M overspent and ICI £0.1M overspent as a result of activity increases and case mix / individual patient requirements.

The clinical supplies & services budgets are overspent by £0.2M YTD excluding pass through. This is spread across the Trust but the main area of overspend is within radiology (£0.3M).

The services from NHS organisations and healthcare from non-NHS bodies budgets are under-spent by £0.3M. This is mainly in ICI and relates to tissue typing and BMT harvest charges, linked to activity and case mix.

The premises budgets are under spent by £0.3M YTD. £0.5M of this is due to a timing issue on the budgeted costs for Phase 2A. It is expected that expenditure will be incurred more heavily from December 2011 onwards.

Education & research budgets are under spent by £0.5M as a result of timing issues on training expenditure within NWD and on some elements of R & I expenditure.

(4) INCOME

Income is £0.3M behind plan (excluding pass through budgets £2.2M ahead of plan)

Category £'M	Annual Budget	YTD Actual	YTD Var*
NHS Revenue Activity	256.1	150.7	1.6
Activity Revenue Non Nhs	31.4	17.8	-0.4
Other Operating Revenue	51.5	28.6	-1.5
Total income	**339.1**	**197.1**	**-0.3**

* Including pass through

4.1 NHS Revenue

4.1.1 PCT Tariff Income is £1.3M ahead of Plan (including MFF)

The variance includes the effect of 2010/11 February and March activity being higher than estimated and higher than planned current year activity in Cardiac Surgery, Dermatology, Rheumatology, Orthopaedics and Cochlear (especially in respect of unilateral cochlear implant, this offsets the adverse variance for bilateral activity under PCT non tariff income).

Medicine is behind plan by £0.9M as a result of adverse income variances in a number of specialties (excluding Endocrinology). In Metabolic medicine, activity is below plan and last year but in the other specialties although income is below plan, it is higher than last year. Plastic is also behind plan by 0.3M mainly relating to case mix changes. There is also an adverse variance in Cardiac outpatient (echo) procedures however the coding has since been corrected from month 4.

4.1.2 PCT Non-Tariff Income is £0.1M behind Plan including pass through (1.6M ahead of plan including pass through)

The variance includes the effect of 2010/11 February and March activities being lower than estimated offsets CQUIN payments being agreed at a slightly higher than initially anticipated.

Non Tariff **inpatient** is lower than plan due to:

1) Bilateral cochlear implant activity is lower than plan by £0.7M as a result of higher unilateral implant
2) Spinal activity is £0.6M lower than plan reflecting lower in-year activity whilst a service review was taking place.

4.1.3 Outpatient activity and bed day income is ahead of plan by £1.5M

4.1.4 Other:

- Reimbursements to commissioners for non-elective readmissions and outpatient follow up are currently lower than the maximum estimated for the Plan.
- Overseas E112 income is also in this category and is £0.4M behind plan, mainly in Surgery and Cardiac
- Pass through budgets are £1.7M lower than plan

4.1.5 SHA (NCG) income is £0.2M ahead of plan (£0.8M including pass through)

NCG activity is £0.2M ahead, but underperforming against the contract value, mainly on ECMO, PH, and Gastro SCID activity. All other activity is close to plan excluding pass through.

4.1.6 NHS Other Clinical income is £0.2M behind plan

This mainly relates the overspend that occurred on the Haringey service earlier in the financial year, that is not recoverable and lower than planned Kings Small Bowl Assessment activity.

4.2 Non NHS Revenue is £0.2M lower than plan (£0.4M including pass through)

This relates to lower than planned Non England activity, and this offsets some of the over performance under NHS income.

4.3 Private patient income is on plan.

4.4 Other operating revenue is £0.2M lower than plan (£1.5M including pass through)
The principle variations from plan relate to:
1) Non patient Care Services is £0.2M ahead of plan, this mainly relates to course income and income for sale of drugs
2) Other revenue is £0.7M behind plan with lower hospice income and third party funded post.
3) Research income £0.3M and this is a timing issue
4) Charity spend is lower than plan at this point and considered to be a timing issue. There is a £1.3M shortfall on pass through budgets in respect of Charity

(5) CIP/CRES

CRES delivered to date is approximately £6m, assuming productivity improvements are sustained for the rest of the financial year.
The appended report shows the value of the three years of CRES programmes by clinical unit and the risk adjusted value of these schemes

CIP 2011/12
The Trust has identified 11.0M of CIP, once risk adjusted, and this includes the CIP required to fund the IR development. This is marginally below the £11.2M target, but the final assessment of CIP is now being completed and indications are that there will be some increased values that will close the remaining gap.
There remains £2.0M of Amber CIP, some of which is income and subject to rules restricting its reclassification to Green/blue until later in the financial year.

CRES 2012/13
The financial plan requires £11.8M of CRES to be delivered in 2012/13 and the risk adjusted value of schemes currently indicates £10.4M could be delivered, this is unchanged from month 6. Units are expecting to have closed the CIP gap at the risk adjusted level by mid November 2011.

CRES 2013/14
The financial plan requires £13.2M of CRES to be delivered and the risk adjusted value of outline schemes is estimated at £13.87M.

(6) CAPITAL PROGRAMME AND CRL

Overview
The Trust's capital plan is £55.9M with planned expenditure for the seven months ending 31 October amounting to £27.6M. The total spend to date amounts to £26.2M representing an under spend to date of £1.4M.
The forecast spend is £51.9M to £52.9M, which is £4M lower than plan and this will be in respect of charitable capital.

	Annual Plan £M	Plan YTD £M	Actual YTD £M	Variance £M
Hospital Redevelopment	36.3	19.5	18.5	1.0
Estates Maintenance Projects	9.0	3.7	4.2	(0.5)
IT Related Projects	7.0	2.9	1.5	1.4
Medical Equipment Purchases	3.6	1.5	2.0	(0.5)
Total Additions in Year	**55.9**	**27.6**	**26.2**	**1.4**
Asset Disposals	0.0	0.0	0.0	0.0
Donated Funded Projects	(42.1)	(21.9)	(20.4)	(1.4)
Charge Against CRL	**13.8**	**5.8**	**5.8**	**0.0**

CRL
The Trust is expecting to meet its CRL target of £13.8M for the full year.

Redevelopment
Redevelopment Projects are currently under-spent by £1M. The current forecast outturn is expected to be £4.6M under plan. This may be increased by a pending VAT reduction on Phase 2A currently estimated at £1M. The Trust is forecasting a combined slippage to 2012/2013 on 2B & 2B enabling of £3M with the balance representing slippage on 2A of £1M. Forecast under-spends will be offset by a reduction in donated income.

Estates IT and Medical equipment

- **Estate Management Projects** are currently ahead of plan by £0.5M, but the Trust is planning to manage spend to the current capital availability in the plan.
- **IT Projects** are currently under spent by £1.4M. This is due to in year slippage with certain Projects such as PACS not incurring major spend until later in the year (February 2012).
- **Medical Equipment Projects** are currently ahead of plan by £0.5M predominantly relating to Donated Funded schemes.

Disposals
There have been no asset disposals during the period.

(7) STATEMENT OF FINANCIAL POSITION

7.1 Non Current Assets

Non Current Assets at the end of October 2011 totalled £347.2M, a net increase of £2.5M. This increase was due to capital additions net of depreciation reductions. There were no asset disposals in the period.

7.2 Current Assets (excluding Cash & Cash Equivalents)

- Current assets have increased by £7.5M

NHS Trade Receivables (£8.4M increase)	The increase is largely a result of quarterly invoices relating to NCG being raised in the period (£5.0M). Other factors include NCG drugs income accruals (£1.4M, an invoice has now been raised in month 8) and an increase in PCT income accruals (£1.6M)
Inventories (£0.5M increase)	Inventories increased by £0.5M mainly due to recent deliveries and returned products for Haemophilia (£0.2M), Pharmacy Dispensary stock increase (£0.1M) and unused stock in Surgery (£0.1M)
Capital Receivables (£2.2M decrease)	A decrease in Redevelopment and medical equipment expenditure to be recharged to the Trustees.
Prepayments & Accrued Income (£1.0M)	Primarily due to increases in IPP Work in Progress (£0.4M), Non English over-performance income (£0.2M), Trustees accrual (£0.1M) and Social Work Charity accrual (£0.1M)
HMRC VAT (£0.8M decrease)	September VAT refund received in the current period.
Non NHS Trade Receivables (£0.6M increase)	Primarily an increase in Non NHS Debtors for the Kuwait SLA (£0.7M)

7.3 Current Liabilities

Current Liabilities have increased by £11.6M

NHS Trade Payables (£0.9M decrease)	Primarily invoices from UCLH NHS Foundation Trust (£0.7M) shown as creditors in September 2011, subsequently paid during the current month.
Deferred revenue	Represents two months deferral of income for invoices raised in the

(£8.9M increase)	third quarter (£6.0M), an increase in the BRC income accrual (£1.7M) and an accrual in respect of the Kuwait SLA (£0.7M)
Non NHS Trade Payables (£0.7M increase)	Mainly invoices from Southern Electric (£0.2M), London Borough of Camden (£0.2M) and Medical Services (£0.1M) received during the month and unpaid as at 31 October 2011.
Other Payables (£0.5M increase)	First monthly accrual of PDC following the payment of the half yearly dividend in September 2011
Expenditure Accrual (£2.0M increase)	Mainly an increase in invoice accruals and is a payment timing change only. There has been significant progress in clearing old creditors.

7.4 Taxpayers' Equity

Taxpayers' Equity has increased by £1.3M this month.

The principal movements were the Donated Asset Reserve increased by £1.2M representing mainly Donated Hospital Development spends and the Retained Earnings increased by £0.1M

(8) WORKING CAPITAL

8.1 Cash

The Trust had cash of £20.6M at the close October 11, and had operating cash balances of between £17.9M and £36.9M throughout the month. Cumulative commercial bank account balances at £0.01M was in line with the DH target maximum holding of £0.05M. The closing cash balance was £0.6M slightly higher than the forecast although c £8m below the original plan which did not adequately factor in the non recurring elements of the opening cash balances and routine delays in collecting cash on overperformance.

The forecast cash position is dependent on delivery of the CIP programme as well as the recovery of debt in a timely fashion and PCT actions in terms of settling for end of year activity which in past years has varied.

8.2.1 NHS Debt

Overall compared to this time last year there has been a reduction in NHS debt even allowing for the £2m reduced invoicing.

	31/10/2011		31/03/2011		31/10/2010	
not yet due and COA	6,647	31%	9571	62%	8,441	32%
0-30	9,446	44%	1,550	10%	8,435	32%
30-60	1,018	5%	779	5%	1,845	7%
60-90	1,281	6%	524	3%	1,273	5%
90-120	441	2%	423	3%	957	4%
120-180	1,294	6%	515	3%	1,319	5%
180-360	818	4%	1,385	9%	3,271	12%
360+	567	3%	734	5%	1,083	4%
	21,511	100%	15,481.49	100%	26,623	
NHS	10,497		4543		17,745	
Non- NHS	2,417		2830		1,751	
International	8,327		7053		5,842	
Gosh CC	270		1055		1,286	
	21,511		15481		26,623	

8.2.2 Non- NHS debt is £2.4M.

- An increase in this debt occurred partly as a result of a recent invoice to Kuwait that has recently been raised and that isn't due at this point
- A significant settlement was received from the Northern Irish Health Boards of overdue debt in the month
- Debt includes retentions that will continue to form part of the overall debt values of £0.21M and these won't be paid until 2012 and 2013 (two elements)

- There was a decrease in debt over 360 days this month partly due to the write-off of aged debt deemed irrecoverable.

8.2.3 **IPP debt** has increased by £0.2M this month to £8.3M.

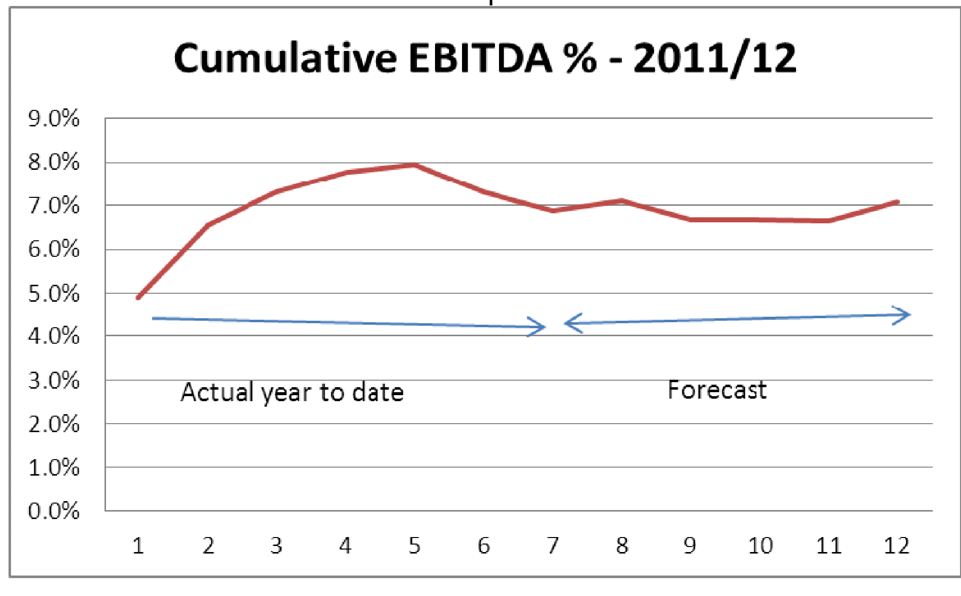
- One self pay debt of £0.25M exists and is over 360 days overdue
- Overall, 90% of IPP debt can be attributed to 9 embassies and 1 insurer. Middle east debt currently taking longer to collect
- £600K is Greek debt

(9) FINANCIAL RISK RATIOS

The **current overall score is 3** and **forecast score is 3**. This is the minimum level required by MONITOR. The following table shows the M7 ratios relative to the threshold scores for each of FRR 3 and FRR4. The FRR at M7 has adequate headroom at FRR of 3.

	Threshold for FRR of 3	***Threshold for FRR of 4***	**M7 11/12 Actual**	**M06 11/12 Actual**	**Forecast Outurn**	**M7 FT Score**
EBITDA Margin	*5%*	*9%*	**6.9%**	7.3%	7.0%	**3**
EBITDA % Achieved	*70%*	*85%*	**93.4%**	101.0%	100.3%	**4**
ROA	*3%*	*5%*	**4.2%**	4.6%	3.9%	**3**
I&E Surplus margin	*1%*	*2%*	**2.7%**	3.1%	2.4%	**4**
Liquidity Days	*15*	*25*	**15**	17	15	**3**
Weighted Average	***3.0***	***4.0***	**3.3**	**3.6**	**3.4**	**3.3**
Overall Rating	***3***	***4***	**3**	**3**	**3**	**3**
IPP Cap (Max 9.7%)	*9.7%*	*9.7%*	**9.5%**	9.4%	9.3%	

The following chart shows the cumulative EBITDA percentage by month and includes forecast information for M8-12. EBITDA for an individual month will tend to vary with activity levels (eg there are seasonal lows in activity and income at holiday periods), as a large proportion of costs occur relatively evenly during the year other than certain non pay costs in connection with the redevelopment.



(10) SALARY OVERPAYMENTS

There were eight salary overpayments in October 2011 totalling £25.2K.

Two of the overpayments were a result of processing errors whilst the balance was a result of late notification, by clinical units, of leave dates or reduction in employees working hours.

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
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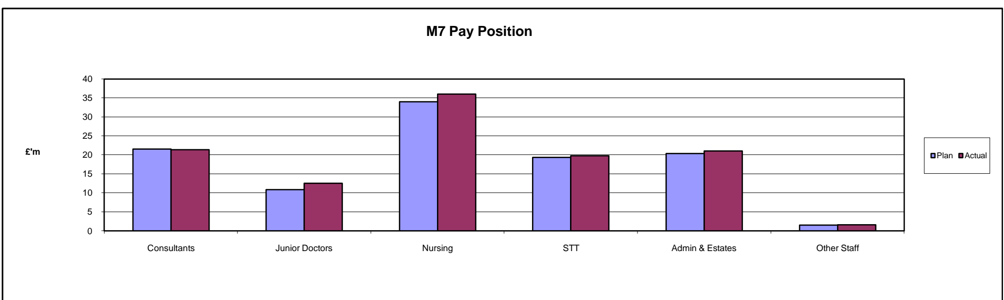
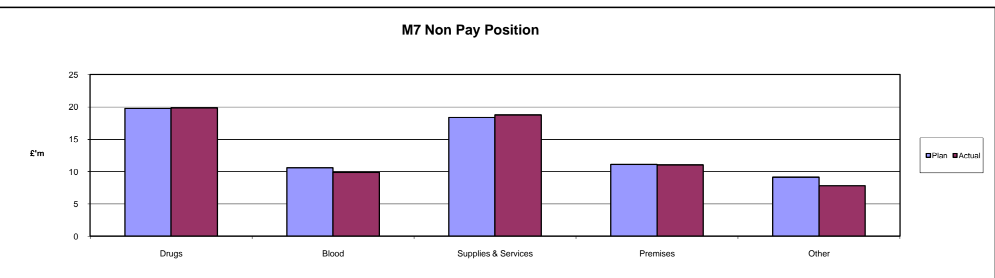
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
Trust Summary

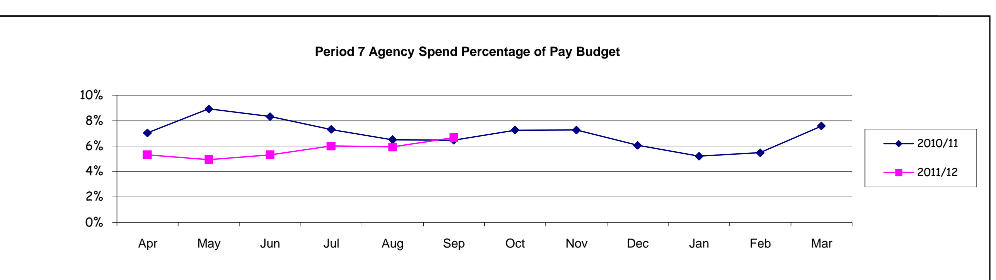
Statement of Comprehensive Income

	Current Month Actual £000	Current Month Plan Variance £000	YTD Actual £000	YTD Plan Variance £000
Revenue				
Revenue from patient care activities	24,900	417	168,486	1,198
Other operating revenue	4,250	(82)	28,645	(1,485)
Total Income	**29,150**	**335**	**197,131**	**(287)**
Operating expenses	(27,329)	(1,395)	(180,173)	(612)
EBITDA	**1,821**	**(1,060)**	**16,958**	**(899)**
Depreciation	(1,265)	24	(8,372)	(19)
Corporation tax	(8)	12	(56)	81
Operating surplus	**548**	**(1,024)**	**8,530**	**(838)**
Investment revenue	5	2	43	22
Other gains and (losses)	0	0	(5)	(5)
Finance costs	(3)	(1)	(23)	(9)
Surplus for the financial year	**550**	**(1,023)**	**8,545**	**(830)**
Public dividend capital dividends payable	(480)	(1)	(3,364)	(1)
Retained surplus for the year	**70**	**(1,024)**	**5,181**	**(831)**
Other comprehensive income				
Impairments put to the reserves	0	0	0	0
Gains on Revaluation	0	0	0	0
Receipt of donated and government grant assets	1,801	306	20,447	(1,418)
Reclassification adjustments:				
- Transfers from donated and government grant reserves	(543)	10	(3,559)	45
Total comprehensive income for the year	**1,328**	**(708)**	**22,069**	**(2,204)**
Total Income, excluding Donated Asset Transfer	*28,607*	*325*	*193,571*	*(331)*
EBITDA, excluding Donated Asset Transfer	*1,280*	*(1,070)*	*13,399*	*(943)*
EBITDA % of Income	*6.25%*		*8.60%*	
EBITDA % of Income, excluding Donated Asset Transfer	*4.47%*		*6.92%*	





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

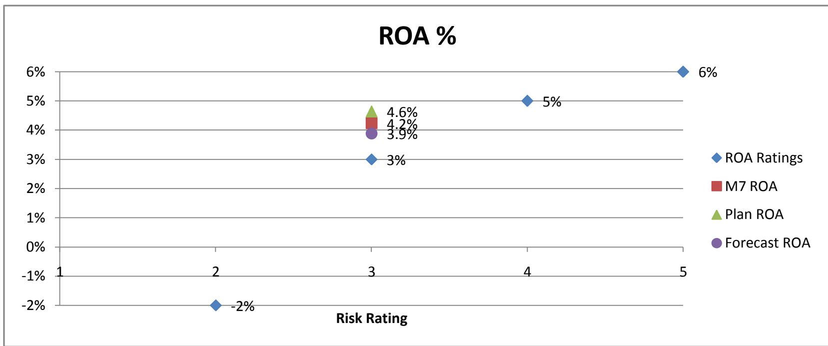


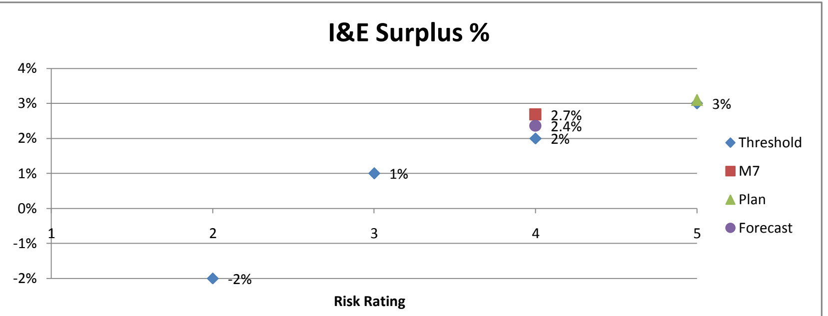
Staffing Staff Numbers	10/11 M12 WTE	WTE Paid	Maternity Paid	Temp Paid	Overtime Paid	Total Paid	WTE above 10/11 M12
Admin and Other Support	898	806	15	116	6	943	(44)
Clinical Support	731	656	30	46	2	734	(3)
Medical	516	476	18	34	0	528	(12)
Nursing	1,426	1,256	78	146	4	1,484	(59)
Total	**3,571**	**3,194**	**141**	**342**	**12**	**3,689**	**(118)**

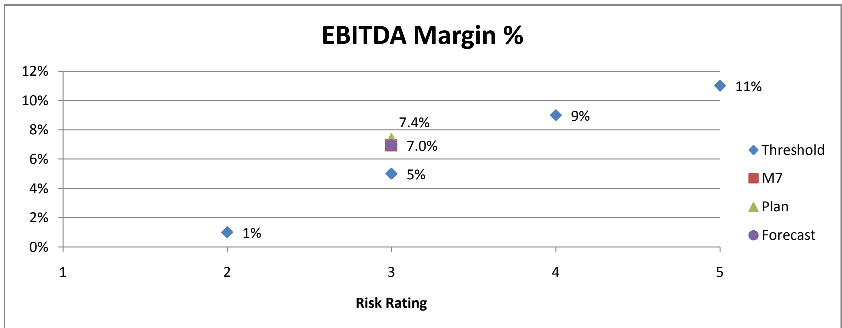
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
Ratio Analysis

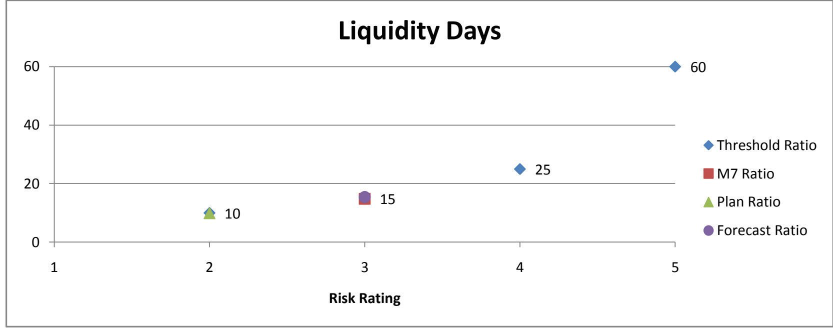
Provider Agency Rating	Target for FT Status	M7 11/12 Actual - FT	M06 11/12 Actual - FT	Forecast Outurn - FT	M7 FT Score
EBITDA Margin	5%	6.9%	7.3%	7.0%	3
EBITDA % Achieved	70%	93.4%	101.0%	100.3%	4
ROA	3%	4.2%	4.6%	3.9%	3
I&E Surplus margin	1%	2.7%	3.1%	2.4%	4
Liquidity Days	15.0	15	17	15	3
Weighted Average	3.0	3.3	3.6	3.4	3.3
Overall Rating	**3**	**3**	**3**	**3**	**3**
IPP Cap (Max 9.7%)	9.7%	9.5%	9.4%	9.3%	

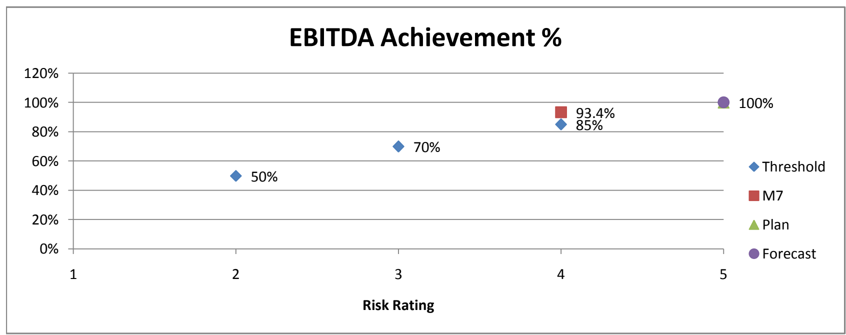
Salary Overpayments		
Unit	**No.**	**Amount £'000**
MDTS	3	13.6
ICI	1	5.3
Cardiac	1	3.1
Neuro	2	2.1
Surgery	1	1.0
TOTAL	8	25.1











Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
Unit Summary

	YTD						
	Income*			Expenditure			Overall Unit Position
	11/12 YTD Actual £000	11/12 variance to plan £000	11/12 actual variance to 10/11 actual £000	11/12 YTD Actual £000	11/12 variance to plan £000	11/12 actual variance to 10/11 actual £000	11/12 actual variance to plan £000
Clinical Units							
Cardiac	33,208	250	2,038	(19,417)	(911)	(2,246)	(660)
Surgery	37,242	(1,165)	(347)	(35,864)	(2,013)	(1,272)	(3,178)
DTS	1,392	(47)	652	(11,748)	(56)	(684)	(103)
ICI	33,521	487	1,372	(32,399)	(1,375)	(2,521)	(888)
International	17,558	123	3,196	(7,379)	(285)	(1,615)	(162)
Medicine	25,050	(965)	1,152	(23,492)	(118)	(1,520)	(1,083)
Neurosciences	15,616	37	(27)	(12,899)	(274)	(1,178)	(237)
Pass through drugs & devices funding	5,565	407	1,013	-	-	-	407
Education & Training / Merit Award Funding	4,957	(311)	19	-	-	-	(311)
Other Clinical Income / CQUIN	4,934	2,858	1,756	-	-	-	2,858
Centrally held development reserves				(4,538)	4,524	(2,560)	4,524
Total Clinical Units	**179,043**	**1,676**	**10,825**	**(147,735)**	**(508)**	**(13,596)**	**1,168**
Central Departments							
Operations & Facilities	754	(175)	(392)	(8,709)	(33)	1,085	(208)
Corporate Affairs	33	(19)	(11)	(921)	106	(150)	87
Estates	442	99	(220)	(6,958)	(346)	(546)	(247)
Finance & ICT	119	6	23	(6,664)	(472)	(1,030)	(466)
Human Resources	407	(17)	47	(1,700)	185	(91)	167
Medical Director	8	(45)	(54)	(763)	(129)	1,597	(174)
Nursing And Workforce Development	1,124	65	(36)	(3,181)	226	(147)	290
Research And Innovation	7,918	(521)	551	(3,519)	99	213	(422)
Redevelopment Revenue Costs	268	(252)	(39)	(268)	131	39	(121)
Total Central Departments	**11,073**	**(860)**	**(131)**	**(32,682)**	**(234)**	**970**	**(1,094)**
Depreciation & Dividends	3,017	45	(1,287)	(9,995)	(57)	1,809	(12)
Centrally held income	**2,403**	**(950)**	**1,032**	**0**	**0**	**0**	**(950)**
Net Position, excl Haringey & North Mid	**195,536**	**(89)**	**10,439**	**(190,413)**	**(799)**	**(10,817)**	**(888)**
Haringey	1,590	7	(4,364)	(1,543)	41	4,478	48
North Mid.	4	4	(683)	5	5	692	9
Net Position, incl Haringey & North Mid	**197,131**	**(78)**	**5,392**	**(191,951)**	**(754)**	**(5,647)**	**(831)**

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

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
CRES Performance

2011/12

Unit	Target	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings	Total Year To Date Delivery
Cardiac	2,073,257	75,561	324,242	247,417	-	647,220	**618,480**	
ICI	2,163,631	1,009,753	755,965	480,774	-	2,246,492	**2,177,757**	
International	664,439	1,036,824	-	144,750	-	1,181,574	**1,156,731**	
MDTS	2,622,255	374,547	1,335,616	-	-	1,710,163	**1,661,768**	
Neurosciences	1,418,021	313,564	550,121	184,220	-	1,047,905	**1,020,846**	
Surgery	3,356,564	92,757	1,272,242	281,260	-	1,646,259	**1,601,952**	
Corporate facilities	1,025,794	465,906	108,794	108,386	-	683,086	**665,499**	
Clinical Operations	154,079	63,844	116,500	10,397	-	190,741	**187,898**	
Corporate affairs	120,933	120,933	-	10,397	-	131,330	**129,081**	
Estates	783,191	357,000	227,865	248,828	-	833,693	**803,744**	
Finance & ICT	731,684	106,778	142,557	163,977	-	413,312	**394,421**	
HR & workforce	191,918	114,786	14,000	20,794	-	149,580	**146,213**	
Medical director	150,781	4,535	7,000	76,965	-	88,500	**80,688**	
Nursing & Education	283,103	239,723	70,130	56,189	-	366,042	**356,075**	
R&I	33,478	-	35,000	-	-	35,000	**34,650**	
Total	**15,773,128**	**4,376,511**	**4,960,032**	**2,034,354**	**-**	**11,370,897**	**11,035,803**	**6,166,325**
							11,203,453	
							(167,650)	

	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
NHS Clinical Income	1,209,665	1,401,375	861,665	-	3,472,705	**3,326,162**
Other Income	2,026,415	276,030	160,404	-	2,462,849	**2,424,567**

2012/13

Unit	Target	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
Cardiac		-	15,112	350,479	628,653	994,244	**905,225**
ICI		-	566,402	659,408	699,448	1,925,258	**1,755,053**
International		-	94,965	571,603	-	666,568	**605,659**
MDTS		-	43,683	1,090,745	285,436	1,419,864	**1,186,490**
Neurosciences		-	9,820	947,855	138,545	1,096,220	**929,194**
Surgery		-	168,045	743,500	733,216	1,644,761	**1,467,087**
Corporate facilities		-	36,771	664,028	214,716	915,515	**819,802**
Clinical Operations		-	-	153,867	-	153,867	**138,480**
Corporate affairs		-	125,305	-	5,837	131,142	**124,293**
Estates		-	491,500	312,967	45,217	849,684	**789,291**
Finance & ICT		-	-	-	740,273	740,273	**736,002**
HR & workforce		-	-	-	85,172	85,172	**74,655**
Medical director		-	-	-	32,250	32,250	**29,025**
Nursing & Education		-	-	35,000	162,036	197,036	**169,231**
R&I		-	-	-	217,500	217,500	**184,875**
Total	**11,871,000**	**-**	**1,551,603**	**5,529,452**	**3,988,299**	**11,069,354**	**10,389,293**
							11,871,000
							(1,481,707)

	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
NHS Clinical Income	-	256,764	1,072,391	2,108,211	3,437,366	**3,046,268**
Other Income	-	378,027	625,103	387,500	1,390,630	**1,228,927**

2013/14

Unit	Target	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
Cardiac		-	-	-	2,172,570	2,172,570	**1,955,313**
ICI		-	-	50,000	1,717,195	1,767,195	**1,545,476**
International		-	-	963,819	-	963,819	**867,437**
MDTS		-	-	60,000	2,445,996	2,505,996	**2,255,396**
Neurosciences		-	-	-	1,318,593	1,318,593	**1,186,734**
Surgery		-	-	-	3,424,227	3,424,227	**3,081,804**
Corporate facilities		-	-	-	1,055,000	1,055,000	**949,500**
Clinical Operations		-	-	-	149,000	149,000	**134,100**
Corporate affairs		-	-	-	125,305	125,305	**112,775**
Estates		-	71,000	-	528,992	599,992	**543,543**
Finance & ICT		-	-	-	488,895	488,895	**440,006**
HR & workforce		-	-	-	215,000	215,000	**193,500**
Medical director		-	-	-	278,000	278,000	**250,200**
Nursing & Education		-	-	-	366,726	366,726	**330,053**
R&I		-	-	-	35,000	35,000	**31,500**
Total	**13,224,000**	**-**	**71,000**	**1,073,819**	**14,320,499**	**15,465,318**	**13,877,337**
							13,224,000
							653,337

	Savings realised Total	Approved Total	Scoping Total	Proposed Total	Total	Risk adjusted savings
NHS Clinical Income	0	0	0	2,774,678	2,774,678	**2,497,210**
Other Income	0	0	963,819	2,201,111	3,164,930	**2,848,437**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 07 2011/12
Revenue Statement

	11/12 Annual Budget £000	11/12 Mth 07 Actual £'000	*11/12 Mth 07 Variance to Plan, excluding Pass Through £'000*	*11/12 Mth 07 Pass Through Variance £'000*	11/12 Mth 07 Variance to Plan, including Pass Through £'000	11/12 YTD Actual £'000	*11/12 YTD Variance to Plan, excluding Pass Through £'000*	*11/12 YTD Pass Through Variance £'000*	11/12 YTD Variance to Plan, including Pass Through £'000	11/12 YTD Actual Variance to 10/11 YTD Actual £'000
Primary Care Trusts Tariff	64,349	**5,625**	*168*	*0*	**168**	**38,383**	*967*	*0*	**967**	**3,373**
Primary Care Trusts Non Tariff	120,130	**10,173**	*-66*	*-502*	**-568**	**69,227**	*1,586*	*-1,623*	**-37**	**1,017**
Primary Care Trusts Mff	18,754	**1,639**	*49*	*0*	**49**	**11,195**	*290*	*0*	**290**	**76**
Strategic Health Authorities	45,155	**4,168**	*372*	*33*	**405**	**27,125**	*177*	*608*	**785**	**2,933**
Nhs Trusts	874	**63**	*-10*	*0*	**-10**	**406**	*-104*	*0*	**-104**	**-699**
Department Of Health	850	**70**	*0*	*0*	**0**	**397**	*-99*	*0*	**-99**	**-100**
Nhs Other	5,993	**369**	*-1*	*0*	**-1**	**3,992**	*-148*	*0*	**-148**	**-1,256**
Activity Revenue Nhs	**256,105**	**22,108**	***512***	***-470***	**42**	**150,726**	***2,669***	***-1,015***	**1,654**	**5,344**
Local Authorities	168	**0**	*0*	*0*	**0**	**151**	*-17*	*0*	**-17**	**-436**
Private Patients	27,669	**2,482**	*370*	*0*	**370**	**16,015**	*58*	*0*	**58**	**2,234**
Non Nhs Other	3,602	**310**	*35*	*-30*	**5**	**1,595**	*-284*	*-213*	**-497**	**-649**
Activity Revenue Non Nhs	**31,439**	**2,792**	***405***	***-30***	**375**	**17,760**	***-243***	***-213***	**-456**	**1,149**
Patient Transport Services	1,216	**101**	*-1*	*0*	**-1**	**649**	*-60*	*0*	**-60**	**-115**
Education And Training	13,386	**1,071**	*-47*	*0*	**-47**	**7,971**	*69*	*0*	**69**	**715**
Research And Development	13,364	**798**	*-412*	*97*	**-315**	**7,516**	*-311*	*32*	**-280**	**184**
Charitable & Other Contrib	5,278	**650**	*343*	*-134*	**209**	**2,539**	*760*	*-1,322*	**-562**	**-731**
Non Patient Care Services	3,631	**390**	*87*	*0*	**87**	**2,382**	*263*	*0*	**263**	**88**
Revenue Generation	1,802	**85**	*-66*	*0*	**-66**	**838**	*-214*	*0*	**-214**	**94**
Other Revenue	6,088	**612**	*41*	*0*	**41**	**3,190**	*-746*	*0*	**-746**	**-592**
Other Operating Revenue, excluding Donated Asset Income	**44,765**	**3,707**	***-55***	***-37***	**-92**	**25,085**	***-240***	***-1,290***	**-1,530**	**-357**
Total Operating Income, excluding Donated Asset Income	**332,309**	**28,607**	***862***	***-537***	**325**	**193,571**	***2,187***	***-2,518***	**-331**	**6,136**
Directors & Senior Managers	-8,736	**-713**	*9*	*0*	**9**	**-4,924**	*202*	*0*	**202**	**-326**
Consultants	-37,586	**-3,195**	*214*	*24*	**239**	**-21,351**	*68*	*493*	**561**	**-467**
Junior Doctors	-18,900	**-1,730**	*-31*	*-9*	**-40**	**-11,547**	*-500*	*-22*	**-522**	**-1,266**
Junior Doctors Agy	11	**-63**	*-64*	*0*	**-64**	**-956**	*-962*	*0*	**-962**	**973**
Administration & Estates	-25,957	**-1,909**	*249*	*10*	**259**	**-13,380**	*1,807*	*40*	**1,846**	**-670**
Administration & Estates Agy	-639	**-477**	*-420*	*0*	**-420**	**-2,704**	*-2,332*	*0*	**-2,332**	**379**
Healthcare Assist & Supp	-2,252	**-150**	*38*	*0*	**38**	**-1,241**	*72*	*0*	**72**	**-9**
Healthcare Assist & Supp Agy	0	**-21**	*-21*	*0*	**-21**	**-150**	*-150*	*0*	**-150**	**94**
Nursing Staff	-58,948	**-4,910**	*384*	*12*	**396**	**-34,463**	*165*	*32*	**197**	**-294**
Nursing Staff Agy	-21	**-279**	*-278*	*0*	**-278**	**-1,556**	*-1,543*	*0*	**-1,543**	**-92**
Scientific Therap Tech	-33,342	**-2,581**	*360*	*14*	**373**	**-18,535**	*1,046*	*95*	**1,141**	**153**
Scientific Therap Tech Agy	-53	**-264**	*-260*	*0*	**-260**	**-1,213**	*-1,161*	*-21*	**-1,182**	**-93**
Other Staff	-295	**-18**	*6*	*0*	**6**	**-154**	*18*	*0*	**18**	**-17**
Pay Reserves	-4,252	**-320**	*129*	*0*	**129**	**-643**	*1,837*	*0*	**1,837**	**95**
Cips And Cres Unidentified - P	3,469	**0**	*1,331*	*0*	**1,331**	**0**	*-2,024*	*0*	**-2,024**	**0**
Pay Costs	**-187,500**	**-16,631**	***1,647***	***51***	**1,698**	**-112,819**	***-3,459***	***616***	**-2,842**	**-1,539**
Drugs Costs	-34,593	**-2,893**	*-307*	*275*	**-32**	**-19,862**	*607*	*-399*	**208**	**-2,293**
Blood Costs	-18,494	**-1,520**	*-86*	*133*	**48**	**-9,907**	*-289*	*1,118*	**829**	**453**
Supplies & Services - Clinical	-23,631	**-2,142**	*-44*	*-50*	**-94**	**-13,699**	*-182*	*323*	**140**	**-951**
Services From Nhs Organisation	-4,200	**-442**	*-87*	*0*	**-87**	**-2,195**	*245*	*0*	**245**	**277**
Healthcare From Non-Nhs Bodies	-2,378	**-547**	*-192*	*48*	**-144**	**-1,694**	*-339*	*41*	**-299**	**-1,015**
Supplies & Services - General	-1,721	**-175**	*-28*	*0*	**-28**	**-1,172**	*-170*	*0*	**-170**	**363**
Consultancy Services	-1,382	**-179**	*-41*	*0*	**-41**	**-799**	*17*	*0*	**17**	**-262**
Clinical Negligence Costs	-1,950	**-162**	*0*	*0*	**0**	**-1,137**	*0*	*0*	**0**	**-137**
Establishment Costs	-2,841	**-263**	*-15*	*3*	**-12**	**-1,529**	*111*	*19*	**130**	**-34**
Transport Costs	-2,671	**-192**	*-20*	*-56*	**-75**	**-1,502**	*62*	*0*	**62**	**-12**
Premises Costs	-19,024	**-1,523**	*84*	*2*	**86**	**-11,009**	*301*	*15*	**316**	**-886**
Auditors Costs	-420	**-30**	*5*	*0*	**5**	**-207**	*37*	*0*	**37**	**-30**
Education And Research Costs	-2,290	**-149**	*2*	*39*	**41**	**-732**	*466*	*141*	**607**	**253**
Expenditure - Other	-4,291	**-472**	*-317*	*92*	**-224**	**-1,900**	*-36*	*644*	**608**	**156**
Non Pay Reserves	-3,539	**-8**	*-4,816*	*0*	**-4,816**	**-8**	*594*	*0*	**594**	**-8**
Cips And Cres Unidentified - N	1,876	**0**	*2,282*	*0*	**2,282**	**0**	*-1,095*	*0*	**-1,095**	**0**
Non Pay Costs	**-121,549**	**-10,696**	***-3,580***	***486***	**-3,093**	**-67,353**	***328***	***1,902***	**2,230**	**-4,127**
EBITDA	**23,260**	**1,280**	***-1,071***	***0***	**-1,070**	**13,399**	***-944***	***0***	**-943**	**469**
P & L On Disp Of Fixed Assets	0	**0**	*0*	*0*	**0**	**-5**	*-5*	*0*	**-5**	**49**
Fixed Asset Impair & Reversals	-5,571	**0**	*0*	*0*	**0**	**0**	*0*	*0*	**0**	**228**
Depreciation & Amortisation	-17,164	**-1,265**	*24*	*0*	**24**	**-8,372**	*-19*	*0*	**-19**	**-255**
Interest Receivable	36	**5**	*2*	*0*	**2**	**43**	*22*	*0*	**22**	**9**
Other Revenue / Expenditure	-24	**-3**	*-1*	*0*	**-1**	**-23**	*-9*	*0*	**-9**	**-5**
Pdc Dividend Payable	-5,765	**-480**	*0*	*0*	**0**	**-3,363**	*-1*	*0*	**-1**	**41**
Corporation Tax	-234	**-8**	*12*	*0*	**12**	**-56**	*81*	*0*	**81**	**-47**
Other Revenue / Expenditure	**-28,723**	**-1,752**	***37***	***0***	**37**	**-11,777**	***68***	***0***	**68**	**20**
Retained Surplus / (Deficit), excl donated asset income	**-5,463**	**-472**	***-1,034***	***0***	**-1,034**	**1,621**	***-876***	***0***	**-876**	**489**
Depreciation Income Transfer	6,773	**543**	*10*	*0*	**10**	**3,559**	*45*	*0*	**45**	**-744**
Retained Surplus / (Deficit), incl donated asset income	**1,309**	**70**	***-1,024***	***0***	**-1,024**	**5,181**	***-831***	***0***	**-831**	**-255**

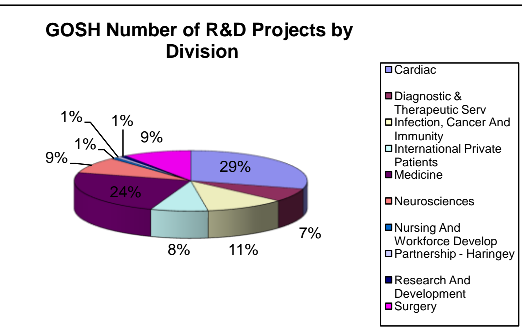
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 07 2011/12
Research and Development Activity

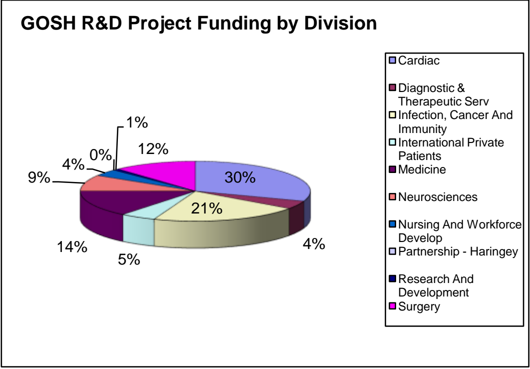
	Full Year Forecast	Full Year Budget	YTD Actuals	YTD Variance
Summary Research & Innovation Income and Expenditure				
TOTAL RESEARCH & DEVELOPMENT DIRECTORATE				
- R&D Income	(12,690)	(12,656)	(6,617)	(704)
- R&D Income Deferred from 10-11	0	0	0	0
- R&D Income Local Research Network MCRN	(935)	(788)	(627)	167
- R&D Charitable Contribution	(1,519)	(1,818)	(981)	(549)
- Non Research Income	(30)	0	(40)	40
- Expenditure	7,017	7,049	3,866	624
	(8,157)	(8,213)	(4,399)	(422)
- Expenditure in Clinical Areas	7,779	8,587	4,538	471
Total R&D Division	(378)	374	139	49
Devolved Income				
- DTS : From CLRN Service Support	(76)	(218)	(52)	(75)
- Medicine : Grants	(169)	(82)	(99)	42
- ICI : From CLRN Support / NIHR Felowships	(81)	(67)	(90)	51
- Surgery : From Charitable Donation	(3)	0	(3)	3
- Other	0	415	0	271
Total Centrally Held and Devolved Income	(329)	48	(245)	293
Revenue and Direct Expenditure by Funding Source				
Biomedical Research Centre including Clinical Research Facility				
- Income	(7,855)	(7,882)	(4,217)	(380)
- Commercial Trials Income	(295)	0	(70)	70
- Non R&D Income	(30)	0	(40)	40
- Expenditure	2,812	2,811	1,340	300
	(5,369)	(5,070)	(2,988)	30
CLRN (PCRN) Income				
- Income CLR Activity Based (Non DH R&D)	(293)	(1,100)	(210)	(432)
- Income PCRN (R M&G, KSS, SS)	(86)	(86)	(50)	0
- Income PCRN (R M&G,)	(272)	0	(149)	149
- Income Non R&D (cc **CLR**)	0	(112)	0	(65)
- Expenditure CLR	249	198	182	(67)
	(401)	(1,100)	(226)	(416)
NIHR GRANTS				
- Income	(935)	(983)	(562)	(31)
- Expenditure	935	987	552	45
	0	4	(10)	14
R&D GOSH Charity Funded Projects				
- Income	(1,519)	(1,818)	(981)	(549)
- Expenditure	1,483	1,654	857	463
	(36)	(165)	(124)	(86)
R&D Development Office & Other Grants				
- Income R&D including Flexibility and Sustainability	(2,955)	(2,479)	(1,358)	(6)
- Income non R&D	0	0	0	0
- Income EU Grants	0	(15)	(1)	(8)
- Expenditure	603	612	320	37
	(2,351)	(1,881)	(1,039)	23
Local Research Network MCRN *				
- Income DH to fund Network	(628)	(628)	(533)	166
- Income : Network Flexibility and Sustainability	(143)	(143)	(33)	(50)
- Income R&D :CLRN Network	(164)	0	(60)	60
- Income Other Non R&D	0	(17)	0	(10)
- Expenditure LRN	935	788	614	(154)
	0	0	(13)	13

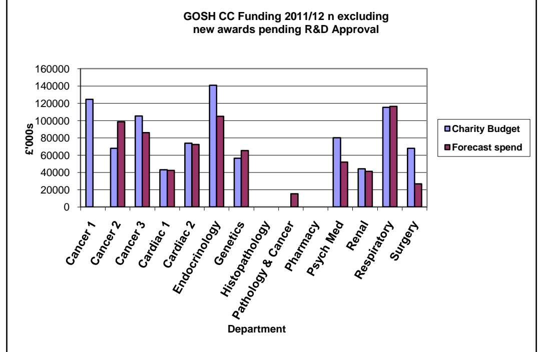
* GOSH is Hosting this service for Central and North East London

	Full Year Forecast	Full Year Budget	YTD Actuals	YTD Variance
Analysis of Total Research & Innovation Funding				
TOTAL R&D INCOME				
-R&D Income Excluding Hosted network	(13,019)	(12,608)	(6,862)	(412)
-R&D Income Local Research Network MCRN	(935)	(788)	(627)	167
-Income Generation GOS / Direct Credits	0	0	0	0
Total Income	(13,954)	(13,396)	(7,488)	(245)

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







Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
Statement of Financial Position

	Actual as at 1 April 2011 £000	Actual as at 30 September 2011	Actual as at 31 October 2011 £000	Change in month £000
Non Current Assets :				
Property Plant & Equipment - Purchased	177,238	176,920	178,224	1,304
Property Plant & Equipment - Donated	141,526	157,228	158,473	1,245
Property Plant & Equipment - Gov Granted	363	332	327	(5)
Intangible Assets - Purchased	972	939	942	3
Intangible Assets - Donated	25	15	22	7
Trade & Other Receivables	9,505	9,280	9,240	(40)
Total Non Current Assets :	***329,629***	***344,714***	***347,228***	***2,514***
Current Assets :				
Inventories	5,156	5,746	6,262	516
NHS Trade Receivables	7,455	12,538	20,979	8,441
Non NHS Trade Receivables	10,360	10,482	11,060	578
Capital Receivables	6,571	7,586	5,415	(2,171)
Provision for Impairment of Receivables	(1,498)	(1,744)	(1,720)	24
Prepayments & Accrued Income	4,919	6,301	7,265	964
HMRC VAT	1,895	1,374	555	(819)
Other Receivables	807	602	564	(38)
Cash & Cash Equivalents	32,371	17,709	20,633	2,924
Total Current Assets :	***68,036***	***60,594***	***71,013***	***10,419***
Total Assets :	**397,665**	**405,308**	**418,241**	**12,933**
Current Liabilities :				
NHS Trade Payables	(7,722)	(5,378)	(4,498)	880
Non NHS Trade Payables	(2,519)	(1,920)	(2,572)	(652)
Capital Payables	(12,179)	(5,219)	(5,364)	(145)
Expenditure Accruals	(14,866)	(12,765)	(14,723)	(1,958)
Deferred Revenue	(6,280)	(4,787)	(13,700)	(8,913)
Tax & Social Security Costs	(4,022)	(4,109)	(3,965)	144
Other Payables	0	0	(480)	(480)
Payments on Account	(228)	(228)	(228)	0
Lease Incentives	(400)	(400)	(400)	0
Other Liabilities	(2,754)	(3,724)	(3,989)	(265)
Provisions for Liabilites & Charges	(2,867)	(2,417)	(2,674)	(257)
Total Current Liabilities :	***(53,837)***	***(40,947)***	***(52,593)***	***(11,646)***
Net Current Assets	**14,199**	**19,647**	**18,420**	**(1,227)**
Total Assets Less Current Liabilities :	**343,828**	**364,361**	**365,648**	**1,287**
Non Current Liabilities :				
Lease Incentives	(7,327)	(7,127)	(7,093)	34
Provisions for Liabilites & Charges	(1,250)	(1,213)	(1,216)	(3)
Total Non Current Liabilities :	***(8,577)***	***(8,340)***	***(8,309)***	***31***
Total Assets Employed :	**335,251**	**356,021**	**357,339**	**1,318**
Financed by Taxpayers' Equity :				
Public Dividend Capital	124,732	124,732	124,732	0
Retained Earnings	16,868	22,066	22,152	86
Revaluation Reserve	48,623	48,534	48,519	(15)
Donated Asset Reserve	141,551	157,243	158,495	1,252
Government Grant Reserve	363	332	327	(5)
Other Reserves	3,114	3,114	3,114	0
Total Taxpayers' Equity :	**335,251**	**356,021**	**357,339**	**1,318**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
Statement of Cash Flow

Statement of Cash Flows	Actual For Month Ending 31 October 2011 £000	Actual For YTD Ending 31 October 2011 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating Surplus	548	8,530
Depreciation and Amortisation	1,265	8,372
Transfer from Donated Asset Reserve	(538)	(3,517)
Transfer from the Government Grant Reserve	(5)	(43)
PDC Dividend Paid	0	(2,818)
Increase in Inventories	(516)	(1,106)
Increase in Trade and Other Receivables	(9,110)	(14,565)
Increase in Trade and Other Payables	10,500	4,049
Increase in Other Current Liabilities	231	1,001
Increase/(Decrease) in Provisions	257	(250)
Net Inflow/(Cash Outflow) from Operating Activities :	***2,632***	***(347)***
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	5	43
Payments for Property, Plant and Equipment	(3,685)	(32,932)
Payments for Intangible Assets	0	(113)
Proceeds from Disposal of Intangible Assets	0	8
Net Cash Outflow from Investing Activities :	**(3,680)**	**(32,994)**
NET CASH OUTFLOW BEFORE FINANCING :	**(1,048)**	**(33,341)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Other Capital Receipts	3,972	21,603
Net Cash Inflow from Financing :	**3,972**	**21,603**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS :	**2,924**	**(11,738)**

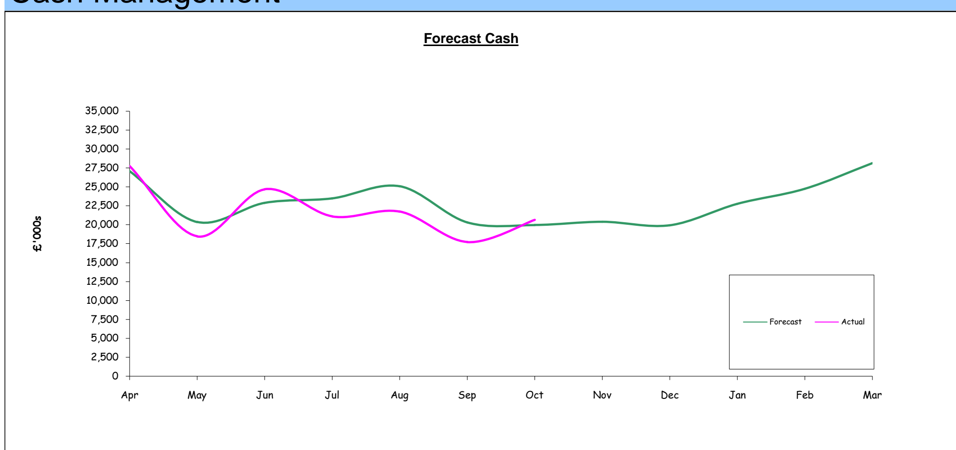
Cash and Cash Equivalents at the Beginning of the current period	**17,709**	**32,371**
Cash and Cash Equivalents at the End of the current period	**20,633**	**20,633**
Net Increase/(Decrease) in Cash and Cash Equivalents per SoFP :	**2,924**	**(11,738)**

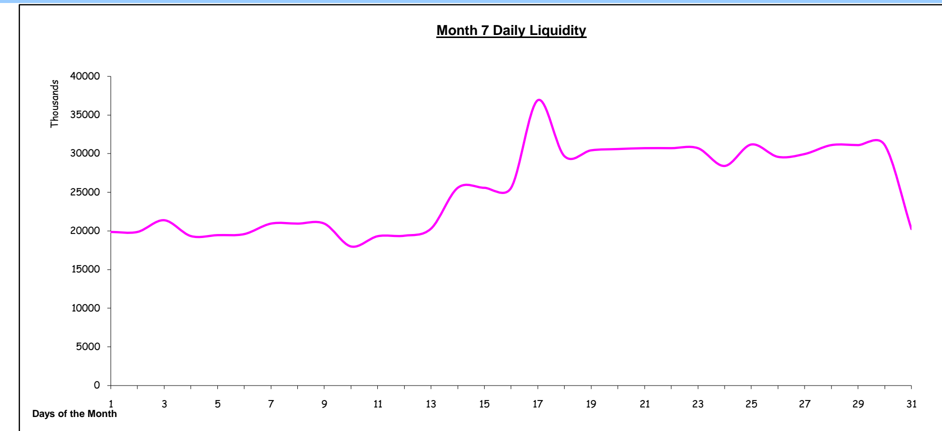
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/2012
Activity

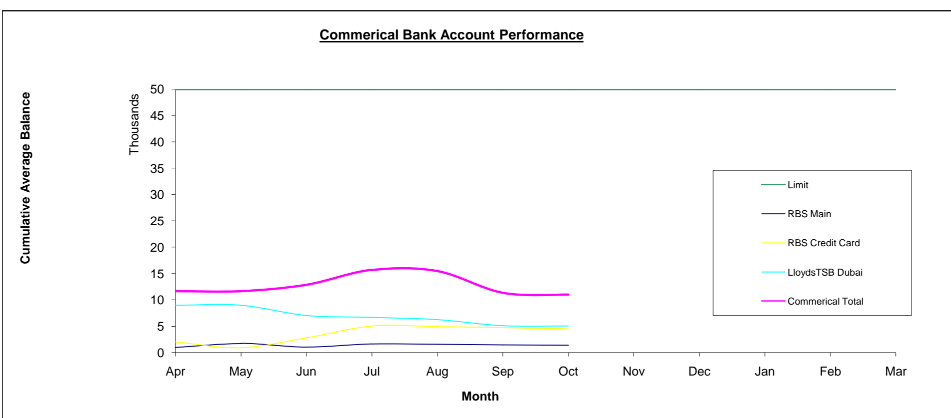
September activities are based on April to September

	April	May	June	July	August	September	October	November	December	January	February	March	YTD 11/12 Actual	YTD 11/12 Plan	YTD 11/12 Variance	YTD 11/12 Variance %	YTD 10/11	Variance 11/12 to 10/11	Variance 11/12 to 10/11 %
Elective PBR	1,424	1,506	1,664	1,525	1,537	1,552	1,575						10,783	10,474	309	2.9%	10,171	612	6.0%
Elective Non PBR	106	151	159	129	147	136	142						970	1,332	-362	-27.2%	999	-29	-2.9%
TOTAL ELECTIVE	1,530	1,657	1,823	1,654	1,684	1,688	1,717	0	0	0	0	0	11,753	11,806	-53	-0.5%	11,169	584	5.2%
Non Elective PBR	143	155	134	115	131	117	135						930	1,049	-119	-11.3%	1,231	-301	-24.5%
Non Elective Non PBR	3	1	1	3	1	3	2						14	30	-16	-54.0%	19	-5	-27.4%
TOTAL NON ELECTIVE	146	156	135	118	132	120	137	0	0	0	0	0	944	1,079	-135	-12.5%	1,251	-307	-24.5%
Outpatients PBR	5,604	6,732	7,578	6,662	6,603	7,764	7,204						48,147	47,468	679	1.4%	39,680	8,467	21.3%
Outpatients Non PBR	4,282	4,842	5,077	4,869	4,851	5,412	5,049						34,382	33,939	443	1.3%	35,778	-1,396	-3.9%
TOTAL OUTPATIENTS	9,886	11,574	12,655	11,531	11,454	13,176	12,253	0	0	0	0	0	82,529	81,407	1,122	1.4%	75,458	7,071	9.4%
POC (Non Consortium)	812	799	816	803	821	830	814						5,695	6,148	-453	-7.4%	6,421	-726	-11.3%
BEDDAYS (includes PICU Consortium)																			
Panda HDU (PBR HDU)	744	622	757	890	790	643	759						5,205	5,044	161	3.2%	4,912	293	6.0%
Transitional Care	140	176	139	164	186	160	163						1,128	874	254	29.0%	874	254	29.0%
Rheumatology Rehab	145	194	216	218	180	199	195						1,347	1,289	58	4.5%	1,264	83	6.6%
CAMHS	214	239	252	251	248	229	243						1,676	1,720	-44	-2.6%	1,596	80	5.0%
Cardiac ECMO	17	6	19	0	10	30	14						96	54	42	78.3%	56	40	71.0%
Neurosurgery HDU (NC)	0	11	0	7	0	7	4						29	23	6	26.2%	23	6	27.2%
Neurosurgery (PICU Consortium-ITU & HDU)	2	51	100	90	71	145	78						537	451	86	19.0%	446	91	20.4%
Neurosurgery ITU (NC)	1	0	0	12	0	0	2						15	13	2	15.8%	13	2	16.6%
Cardiac HDU (NC)	33	28	42	54	42	42	41						282	239	43	18.2%	231	51	22.1%
Cardiac ITU (NC)	61	101	146	102	70	113	100						693	673	20	2.9%	792	-99	-12.5%
Cardiac (PICU Consortium-ITU & HDU)	251	165	179	308	277	239	240						1,659	1,464	195	13.3%	1,398	261	18.7%
Paediatric ITU (NC)	48	68	71	44	30	85	59						405	486	-81	-16.6%	385	20	5.1%
Paediatric ITU (PICU Consortium-ITU)	399	367	374	435	387	398	400						2,760	2,739	21	0.8%	2,663	97	3.6%
TOTAL BEDDAYS	2,055	2,028	2,295	2,575	2,291	2,290	2,298	0	0	0	0	0	15,832	15,070	762	5.1%	14,653	1,179	8.0%
HaemOnc Consortium*																			
PBR	50	55	53	54	48	56	54						370	372	-2	-0.7%	309	61	19.8%
NON PBR	134	142	145	144	163	144	149						1,021	987	34	3.5%	913	108	11.8%
Panda HDU (PBR HDU)	202	256	169	329	339	213	257						1,765	1,617	148	9.1%	1,458	307	21.1%
TOTAL HAEMONC	386	453	367	527	550	413	460	0	0	0	0	0	3,156	2,976	180	6.0%	2,680	476	17.7%

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
Cash Management





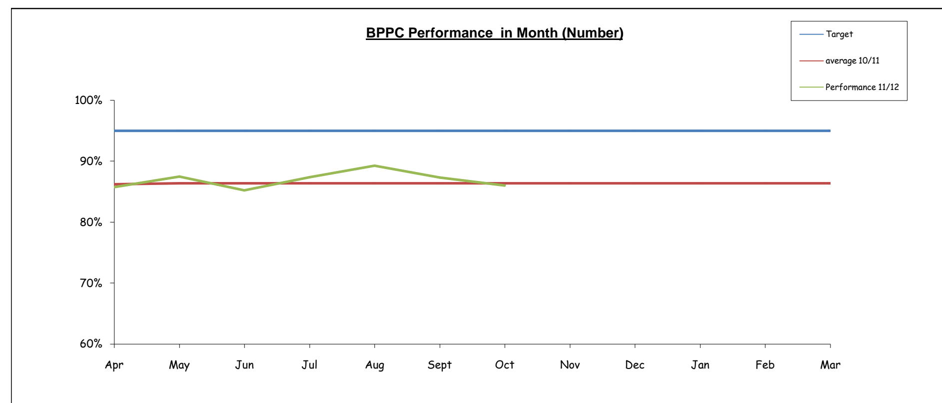


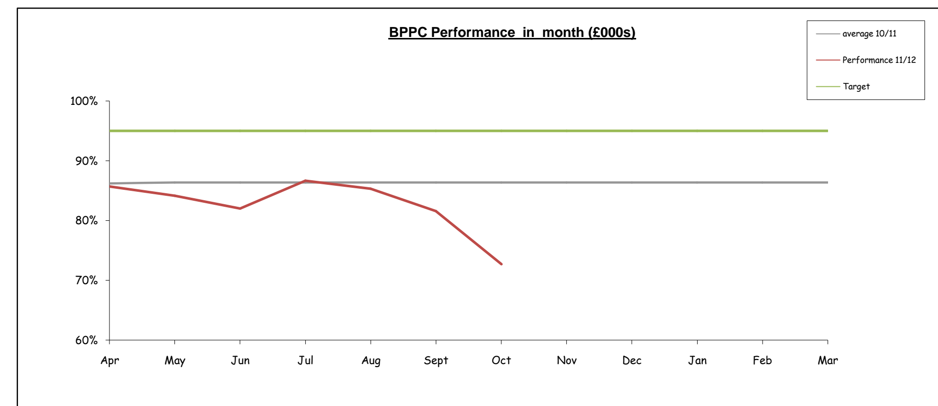
Payables Analysis

Days	Current Month	Previous Month	Movement in Month
	£000s	£000s	£000s
Not Yet Due	3,787	3,327	459
1-30	3,117	1,894	1,223
31-60	1,185	510	675
61-90	411	316	95
91-120	329	239	91
121-180	381	326	55
180-360	657	724	(67)
360+	486	1,031	(545)
	10,353	**8,367**	**1,986**

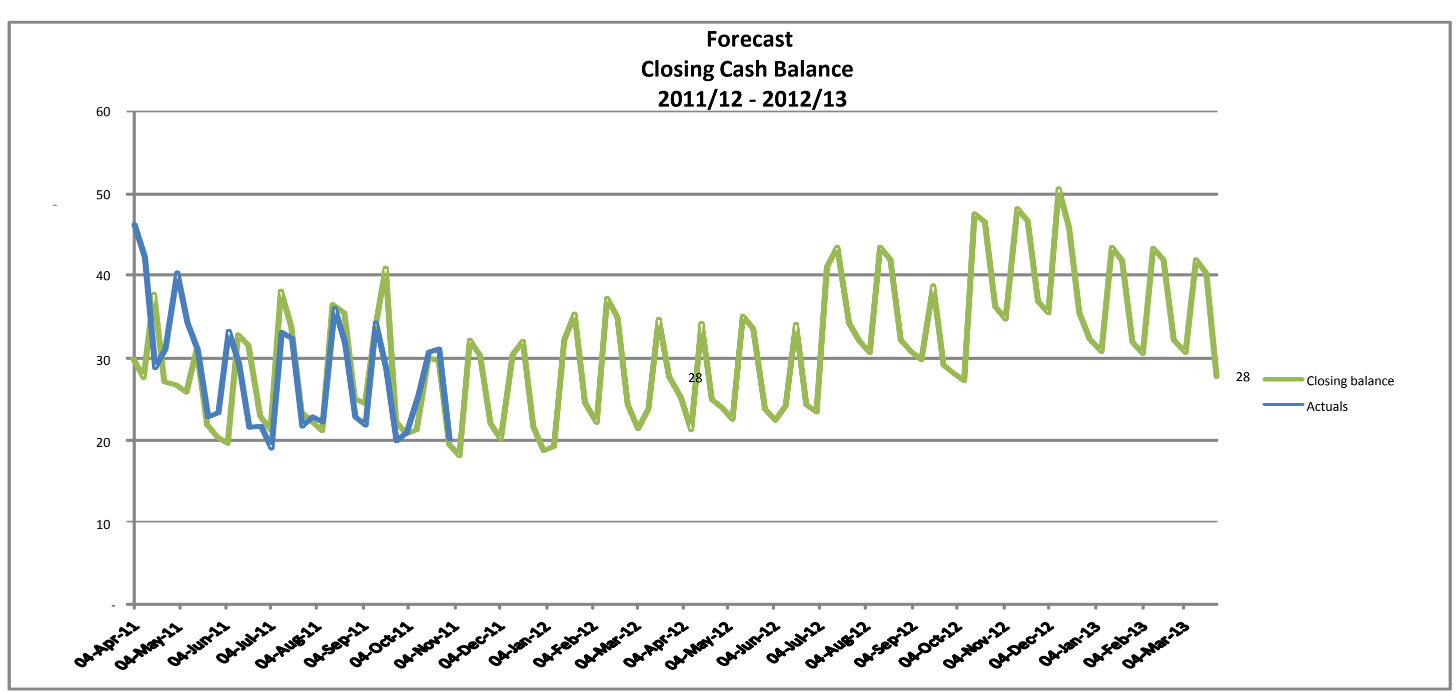
Better Payment Practice Code (BPPC)

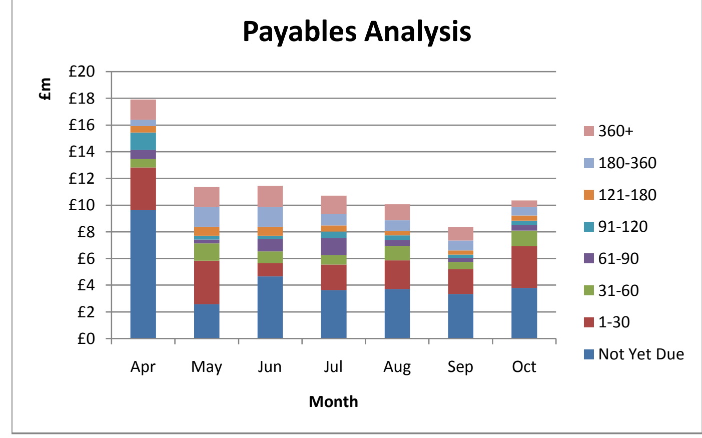
	Number	£000s
Cumumlative Performance		
Total Payables		
% of Invoices paid within target	85.9%	82.1%
Non-NHS Payables		
Invoices paid in the year	46342	111,915
Invoices paid within target	40485	96,122
% of Invoices paid within target	87.4%	85.9%
NHS Payables		
Invoices paid in the year	1999	11,881
Invoices paid within target	1017	5,539
% of Invoices paid within target	50.9%	46.6%

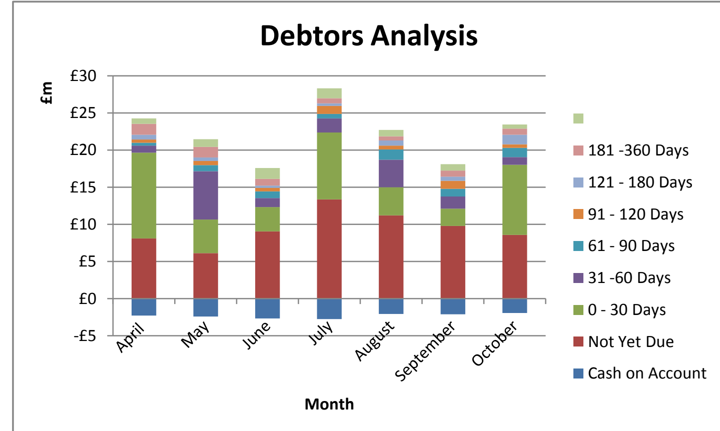




Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
Cash Forecast, Debtors and Payables Analysis







Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
Receivables Management

Net Receivables in £'000's	Total	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	**10497**	-872	1406	7790	327	953	71	1027	-192	-13
NHS Credit Note Provision	-1221	0	0	0	0	0	-83	-568	-226	-344
Specific NHS Debt Provisions										
NHS Net Receivables	**9276**	**-872**	**1406**	**7790**	**327**	**953**	**-11**	**459**	**-418**	**-358**
Non-NHS	**2417**	-15	1490	150	212	14	40	79	351	96
Bad Debt Provision-Non NHS	-747	0	-188	-16	-29	-9	-12	-21	-356	-115
Specific Non-NHS Debt Provisions	0	0	0	0	0	0	0	0	0	0
Non-NHS Net Receivables	**1670**	**-15**	**1302**	**134**	**183**	**5**	**28**	**58**	**-6**	**-19**
International	**8327**	-1040	5660	1327	458	295	310	176	656	484
Bad Debt Provision-International	-974	-42	-3	-5	-1	-1	-62	-37	-329	-493
International Net Receivables	**7354**	**-1082**	**5657**	**1323**	**457**	**294**	**248**	**140**	**327**	**-9**
GOSH Charity Receivables	**270**	-1	19	179	20	20	19	11	3	0
Specific Activity Provisions (IPP)		0	0	0	0	0	0	0	0	0
Net Trust Receivables	**18570**	**-1971**	**8385**	**9426**	**988**	**1271**	**284**	**667**	**-94**	**-386**

Trust Receivables in £'000's	Total	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	10497	-872	1406	7790	327	953	71	1027	-192	-13
Non-NHS	2417	-15	1490	150	212	14	40	79	351	96
International	8327	-1040	5660	1327	458	295	310	176	656	484
Gross Trading Receivables	**21241**	**-1927**	**8556**	**9267**	**998**	**1261**	**422**	**1283**	**815**	**567**
GOSH Charity Receivables	270	-1	19	179	20	20	19	11	3	0
Total Trust Receivables	**21511**	**-1929**	**8576**	**9446**	**1018**	**1281**	**441**	**1294**	**818**	**567**

Movement in £'000's	Total	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
Gross Trading Receivables (as above)	21511	-1929	8576	9446	1018	1281	441	1294	818	567
Gross Trading Receivables (last month)	15996	-2110	9782	2351	1619	1033	1094	532	823	872
Movement in Month	**5515**	**181**	**-1206**	**7095**	**-601**	**248**	**-653**	**761**	**-6**	**-305**
Gross Trading Receivables (year end 10/11)	15481	-1747	11317	1550	779	524	423	515	1385	734
Movement in Financial Year	**-6030**	**182**	**2742**	**-7896**	**-239**	**-757**	**-18**	**-779**	**567**	**167**

Systems Schedule

Receivables in £'000's	Gross Receivables	Cash on Account	Not Yet Due	Overdue 0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
eFinancial	13184	-889	2916	8119	560	986	131	1117	161	83
Compucare	8327	-1040	5660	1327	458	295	310	176	656	484
Trust Receivables	**21511**	**-1929**	**8576**	**9446**	**1018**	**1281**	**441**	**1294**	**818**	**567**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
Capital Expenditure (£000s)

Capital Spend by Division	Annual Plan	Year To Date Plan	Actual (YTD)	Variance (YTD)	Forecast Outturn	Forecast Variance to Plan
	Year to Date (YTD)					
Redevelopment Projects						
Trust/DH Funded						
Phase 2a Enabling	0	0	0	0	0	0
Donated Funded						0
Phase 1	26	14	(7)	21	12	14
Phase 2a Enabling	0	0	0	0	0	0
Phase 2a	27,778	14,868	17,226	(2,358)	29,285	(1,507)
Phase 2b Enabling	6,271	3,357	8	3,349	1,133	5,138
Phase 2b	1,953	1,045	1,096	(51)	1,953	0
Pre-phase 2	0	0	18	(18)	18	(18)
Phase 2 - Inhouse Resources	344	184	155	29	288	56
Other Redevelopment Projects	0	0	0	0	0	0
Total :	**36,372**	**19,468**	**18,495**	**973**	**32,688**	**3,684**
Estates Maintenance Projects						
Trust/DH Funded	7,702	3,209	4,234	(1,025)	7,597	105
Donated Funded	1,250	524	34	490	520	730
Total :	**8,952**	**3,733**	**4,269**	**(536)**	**8,117**	**835**
IT Projects						
Trust/DH Funded	6,000	2,500	1,445	1,055	6,000	0
Donated Funded	1,000	415	16	399	1,000	0
Total:	**7,000**	**2,915**	**1,461**	**1,454**	**7,000**	**0**
Medical Equipment Projects						
Trust/DH Funded	90	41	118	(77)	199	(109)
Donated Funded	3,500	1,458	1,902	(444)	3,253	247
Total:	**3,590**	**1,499**	**2,020**	**(521)**	**3,452**	**138**
Total Additions in Year	**55,914**	**27,615**	**26,245**	**1,370**	**51,258**	**4,657**
Asset Disposals	0	0	(4)	(4)	(4)	4
Donated Funded Projects	(42,122)	(21,865)	(20,447)	(1,418)	(37,462)	(4,661)
Charge Against CRL Target	**13,792**	**5,750**	**5,794**	**(52)**	**13,792**	**0**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 7 2011/12
Staffing WTE

Permanent (Excludes Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	10/11 Period 12	M7 variance to M12 10/11
Cardiac	350	354	348	358	354	363	373	342	-31
Surgery	650	644	640	649	652	647	669	646	-23
DTS	354	356	354	351	355	346	354	349	-4
ICI	479	481	472	482	486	487	501	460	-41
International	114	116	117	118	117	113	120	115	-5
Medicine	280	284	275	274	280	281	271	282	11
Neurosciences	261	264	254	258	258	273	278	255	-23
Haringey	183	175	0	1	0	0	0	0	0
North Mid.	2	2	2	2	2	0	0	0	0
Children's Population Health	7	8	8	9	7	7	8	7	-1
Operations & Facilities	202	203	208	207	207	192	204	208	4
Corporate Affairs	15	13	12	14	10	10	14	13	-2
Estates	46	45	45	45	44	43	45	48	3
Finance & ICT	138	138	140	135	138	135	127	134	7
Human Resources	57	55	54	57	58	60	56	57	1
Medical Director	14	14	13	14	14	14	8	15	7
Nursing And Workforce Development	80	78	75	76	76	75	80	80	0
Research And Innovation	57	63	66	75	71	78	79	77	-2
Redevelopment Revenue Costs	7	7	7	8	8	8	6	7	1
TOTAL	3297	3300	3089	3,134	3,137	3,131	3,194	3096	-98

Overtime

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	10/11 Period 12	M7 variance to M12 10/11
Cardiac	6.3	2.4	1.0	2.0	1.6	1.6	1.6	2.6	0.9
Surgery	3.3	2.4	1.8	1.4	1.8	3.1	2.7	2.6	-0.1
DTS	0.4	0.8	1.1	1.0	0.7	0.4	0.4	0.5	0.2
ICI	0.4	0.3	0.1	0.5	0.8	0.4	0.5	0.5	0.0
International	0.2	1.5	0.8	1.0	0.9	1.8	0.9	1.8	0.9
Medicine	0.3	0.8	0.4	0.2	0.1	0.1	0.4	0.3	-0.1
Neurosciences	0.9	0.6	0.7	0.4	0.5	0.7	0.5	0.8	0.3
Haringey	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
North Mid.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Children's Population Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Operations & Facilities	3.6	4.0	4.3	4.3	4.9	3.1	2.8	4.2	1.4
Corporate Affairs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates	2.0	1.2	1.4	2.0	2.0	1.0	1.6	2.3	0.7
Finance & ICT	3.1	1.2	1.7	0.9	1.5	0.5	0.8	1.2	0.4
Human Resources	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
Medical Director	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Nursing And Workforce Development	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.2	0.2
Research And Innovation	0.1	0.3	0.6	0.0	0.0	0.4	0.2	0.1	-0.1
Redevelopment Revenue Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	20.6	15.7	13.8	13.9	15.0	13.1	12.3	17.0	4.7

Agency/Locum/Bank

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	10/11 Period 12	M7 variance to M12 10/11
Cardiac	34	29	36	40	36	48	31	41	10
Surgery	56	62	63	66	63	76	83	67	-16
DTS	9	10	18	17	14	15	17	13	-4
ICI	40	34	37	44	46	37	43	49	6
International	41	44	37	37	36	43	33	31	-1
Medicine	27	22	21	23	15	23	24	28	4
Neurosciences	25	18	21	23	17	26	21	31	10
Haringey	4	5	0	0	0	0	0	0	0
North Mid.	0	0	0	0	0	0	0	0	0
Children's Population Health	2	0	0	0	0	0	0	0	0
Operations & Facilities	9	18	16	14	17	28	24	27	2
Corporate Affairs	0	1	0	0	2	1	0	0	0
Estates	5	15	7	15	4	12	41	7	-35
Finance & ICT	15	11	14	12	17	15	19	14	-5
Human Resources	4	0	4	5	2	4	2	9	7
Medical Director	2	2	1	2	1	2	0	2	2
Nursing And Workforce Development	3	2	3	3	1	4	1	3	3
Research And Innovation	1	2	3	1	1	2	2	4	2
Redevelopment Revenue Costs	0	0	3	0	3	1	1	6	4
TOTAL	277	273	284	304	276	338	342	332	-10

TOTAL STAFFING (Excluding Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	10/11 Period 12	M7 variance to M12 10/11
Cardiac	390	385	386	401	392	413	406	385	-20
Surgery	709	709	704	716	717	726	755	716	-39
DTS	364	366	373	369	370	361	371	363	-8
ICI	519	515	510	527	532	525	544	510	-34
International	154	162	155	156	154	158	153	148	-5
Medicine	308	306	296	298	295	305	296	310	14
Neurosciences	287	283	276	282	275	300	300	286	-13
Haringey	187	180	0	1	0	0	0	0	0
North Mid.	2	2	2	2	2	0	0	0	0
Children's Population Health	9	8	8	9	7	7	8	7	-1
Operations & Facilities	214	225	228	226	229	223	231	239	8
Corporate Affairs	15	14	12	14	13	11	14	13	-2
Estates	53	61	54	62	50	56	87	57	-31
Finance & ICT	155	150	155	148	157	151	147	149	2
Human Resources	62	55	57	62	60	64	59	66	7
Medical Director	17	16	14	16	15	16	8	17	9
Nursing And Workforce Development	83	80	77	80	77	79	81	84	3
Research And Innovation	58	65	69	76	72	81	82	81	-1
Redevelopment Revenue Costs	7	7	11	8	10	9	7	13	6
TOTAL	3,594	3,588	3,388	3,451	3,428	3,483	3,548	3,444	-104

Trust Board **30th November 2011**	
Audit Committee Update Report from October 2011 meeting **Submitted on behalf of** Chief Executive	**Paper No: Attachment V**
Aims / summary The Audit Committee met on 11th October 2011. The attached report provides a summary of the matters discussed. A final approved full set of minutes will be available to the Trust Board in January 2012.	
Action required from the meeting To review and note those matters considered by the Audit Committee in October 2011.	
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	
Who is accountable for the implementation of the proposal / project	
Author and date Anna Ferrant, Company Secretary 20th November 2011	

SUMMARY REPORT FROM THE AUDIT COMMITTEE

Held on 11 October 2011

The Committee was reminded that this was Mr Andrew Fane's (Non-Executive Director), last meeting with the Audit Committee as he would be retiring on 31st October 2011. Ms Yvonne Brown, Non-Executive Director would now attend both the Audit Committee and the Clinical Governance Committee so as to provide a link between the two assurance committees.
Assurance Framework
The Chief Operating Officer, Ms Fiona Dalton presented the report and highlighted how, at the request of the Audit Committee in April 2011, risk 1E (The organisation, management, administration and delivery of clinical services may not always optimally deliver the best quality of service) had been reviewed and two further risks identified as separate risks in the Framework. The risks were: • Appropriately qualified and trained staff may not always obtain fully informed consent or may not obtain consent from the correct person • Children's nutritional status is not appropriately assessed The Risk Assurance and Compliance Group had reviewed these risks and following further assurances from the risk owners, both risks had been rated as green assurance.
The Chief Operating Officer highlighted risk 1C (Children, staff and parents may be put at risk from failure to adequately maintain the estate and non-clinical equipment) and the related local risks documented for this risk about theatre doors. The Chief Operating Officer had personally sought to clarify that this risk had now been actioned with fire doors being replaced and escape routes cleared. Improved storage facilities would become available with the opening of phase 2A. The Chief Operating Officer stated that fire training had been undertaken in theatres. The Committee received reports on the following risks on the Assurance Framework: **Risk 3B We may fail to influence and capitalise on regional and national reconfiguration opportunities –** the Committee accepted the assurances provided around the work underway to capitalise on the national safe and sustainable programmes in cardiac and neurosurgery. **Risk 3C We may not deliver our strategy for International Private Patients -** The Chairman asked whether the assurance status was correct at green, in light of proximity of the IPP income levels to the Cap. It was confirmed that this assurance status was appropriate and that all controls were in place and being closely monitored. **Risk 7B We may not deliver the IT and Information strategies resulting in failure to achieve process efficiencies and to deliver effective electronic patient**

information and record systems in support of our clinical strategy – the Committee was assured by the update on the work to improve information systems across the Trust.

Update on boiler investigation by Health and Safety Executive (HSE)- at the time of the Committee meeting, there had been no updates from the HSE.

Update on Arson Incident – the Committee was informed that investigations were on-going in respect of the recent arson incident. The Committee was advised that a defence locking design plan for plant rooms was being incorporated into new builds and retrospective fitting of all plant room was underway.

Update on Soft Facilities Management & Outsourcing Contracts

It was confirmed that all work programs (covering three areas of soft facilities management – catering, retail and security) were on track in relation to meeting CRES targets but that implementation was delayed due to time taken for other trusts to reach decisions on implementation of the programs.

Salary Overpayment Briefing

The Committee was advised that the outstanding balance of salary overpayments for the year to date was £328k. There had been 26 overpayments in the current financial year and if annualised, this revealed a fall in total numbers when measured against last year. The main reason for overpayments was staff circumstances not being accurately recorded,

Where departments continued to fail to accurately report staffing information, resulting in salary overpayments, a new system was being trialled, whereby each payment was individually signed off by the relevant managers. It was noted that as a result of this system, neurosciences had improved in their performance and reduced the number of overpayments. The Chairman asked for another briefing on salary overpayments at the April 2012 meeting.

The Trust had appointed an agent to try to trace staff for past overpayments, but had not been successful. The Committee **agreed** to write off the £80,000 debt related to untraced salary overpayments.

Data Quality Action Plan

The Action Plan summarised how the Trust will take forward the information strategy.

Progress had been made in the cleansing of data. Work was underway to ensure that managers understood what data they were responsible for and a plan to ensure that the information was accurate. A checklist would be used to formalise and standardise the Trust's approach to documenting and monitoring data quality across the Trust. It was confirmed that internal audit would review data quality during the financial year.

Update on CRES

The Committee was advised that the Trust Board had asked the Audit Committee to look in more detail into one CRES scheme to seek assurance of the controls in place and expected and achieved outcomes.

The Combined Heat and Power (CHP) scheme would enable the Trust to generate its own electricity, by exploiting heat from the engine to heat hot water for the Trust. Savings of £161k could be made.

Other savings included isolating the hot water feed to the Homeopathic Hospital. This hospital required much hotter water and would be providing this for themselves in future. This reduced the costs for the Trust through the lower levels of gas required.

The Committee was presented with the highest value schemes for 2011-12 and 2012-13 and agreed to look at these schemes in more detail during future meetings. It was suggested that the tender for single contract for soft services was a CRES scheme and should be considered at the January 2012 meeting. The Committee was informed that Internal Audit were due to re-audit the CRES programme in November/ December 2011.

Report to the Audit Committee on the audit for the year ending 31 March 2012

The Committee was advised that the Trust would be required to produce two sets of accounts if it was authorised as a Foundation Trust in December 2011. This was because one organisation was ceasing to exist and a new organisation was formed.

Monitor were looking at aligning the format of the financial reporting requirement with the Department of Health (DoH). It was thought that the deadline for receipt of the accounts would be before the parliamentary summer recess. As an FT, additional disclosures would need to be made around the accounts, including private patient work and the Cap. An external audit on content of quality accounts would need to be conducted as well as a report on mandated indicators (such as MRSA and C Diff) and local indicators. These reports would be published.

The Chairman asked what happened about the working practices between the Trust and Deloitte once the Trust became an FT and it was confirmed that a contract was in place between the two organisations and that guidance was available on this.

Quality Governance Audit

The Committee received the results of an audit by KPMG on the quality governance memorandum and evidence that supported it. Issues had been raised around the need for reference to data quality and clinical coding in the memorandum. It was also recommended that the strategy included quality aspirations over time, rather than providing an overview of the Trust's quality governance framework. It was also important to detail in the memorandum how goals and aspirations were cascaded to staff, commissioners and contractors. It was felt that the Trust's approach to quality governance was relatively robust. The Trust had a strong aspiration to achieve zero harm.

Internal Audit Progress Report: July 2011- October 2011

The Committee was informed that Internal Audit had issued eight reports to the Trust since the previous meeting. The Chairman asked if Internal Audit was happy with the management responses received and it was confirmed that the responses had been provided and that in particular, there had been a thorough response to the learning

disability audit.
The Committee noted inclusion of an overview of the results of internal audits conducted in other trusts. A few of the Trusts had a larger number of audit reports rated as ‘significant assurance’. It was agreed that a number of criteria could affect these results such as the risk profile of the other trusts and how the trusts directed their auditors to look at specific areas of risk. It was agreed that the Trust should continue to work with Internal Audit to focus on gaps in assurance.
Internal and External Audit Recommendations – Update on Progress with Actions
An update on progress against the actions arising from Internal and External Audit recommendations was received and it was noted that there were only a few recommendations that were outstanding. It was agreed that information on timescales for recommendations to be cleared and who was responsible for implementing the relevant actions would be included in future reports.
Revision of the Audit Committee Terms of Reference (ToR)
The Committee noted that a number of variations had been proposed to the current version of the ToR, including the recommendation from the revised NHS Audit Committee Handbook (2011) that the work of the Clinical Governance Committee, and in particular issues around clinical risk, are reviewed by the Audit Committee as a means to satisfy itself that risks across the Trust are adequately controlled.
The Committee considered the proposals and agreed the following: • The Committee endorsed the revised reporting arrangements proposed, with Ms Yvonne Brown attending both the Audit Committee and Clinical Governance Committee and the Company Secretary presenting a short summary of matters discussed and agreed at the Clinical Governance Committee at every meeting of the Audit Committee. • It was agreed that the Clinical Governance Committee should continue to take the lead on clinical risk matters and that the key was to ensure that reporting was aligned. • The Committee agreed that it only wished to receive a report on compliance with the Care Quality Commission outcomes where specific risks were raised that were relevant to the Audit Committee. • It was agreed that the Committee would continue to meet four times a year, with the flexibility to hold an additional meeting if required. • The Committee agreed that it would be helpful to hold a meeting with the Clinical Governance Committee to consider the risk management framework and ensure that it was aligned between the committees. It was suggested that this meeting should take place before the end of 2011.
Revision of Standing Financial Instructions and Scheme of Delegation
The Committee was informed that the revised Standing Financial Instructions (SFIs) and Scheme of Delegation had been reviewed against Foundation Trust requirements and assessment of other Trusts’ SFIs. Changes had been made around treasury and borrowing, risk management and insurance and inclusion of Councillor responsibilities.

One material change had been made to the detail in the SFIs, with a section being added around research and development. Some of the low level financial limits in the Scheme of Delegation had been increased and the managerial level for sign-off extended. A formal process had been included for the delegation of authority for signing off invoices that were large but were in the normal course of business i.e. invoices for blood. The Committee suggested that budgets are regularly reforecast and that the Scheme is updated to reflect that this process will take place.

The Committee **ratified** the SFIs and Scheme of delegation for approval by Trust Board.

Trust wide risk register Analysis Report

It noted that there were 77 high risks on the risk register and that 25 of these had been reported in the last period. The Committee was advised that it was important to focus on the movement in the severity of the risks reported towards lower graded risks.

The Committee asked for information to be included on the report about how long risks had been on the register. It was agreed the need for inclusion of aging profile of the risks.

The Committee noted that some risks were repeated on different unit risk registers and requested a review of the high level risks to ensure that there was no duplication.

Debt write off recommendation

The Committee was reminded that there was a process to ensure that the debt was fully investigated.

The Committee approved the write off of the following debt:

1.	IPP	£218,426.00
2.	Salary Overpayments	£79,475.89
3.	Lab Reports	£5,336.73
4.	Miscellaneous	£1,424.70
	Total	£304,663.32

Other reports received by the Audit Committee:

- Counter Fraud Update Report
- NHS Litigation Authority Plan
- Purchase Ledger Processes and Better Payment Practice Code
- Working Capital, Losses and compensations
- Waivers approved by Management Board
- Information Governance Update
- Local Security Manager Report and Fire Report
- KPI Performance Report – Month 5
- Clinical Governance Committee Minutes, June 2011
- Risk Assurance and Compliance Group Minutes

Trust Board 30th November 2011	
Management Board Minutes **Submitted on behalf of** Chief Executive	**Paper No: ATTACHMENT W**
Aims / summary Management Board meets once a month and comprises representatives from all operational areas of the hospital. Abridged versions of the minutes from the September and October 2011 meetings are attached. Full sets of minutes are available from the Company Secretary.	
Action required from the meeting To review and note those matters considered by Management Board in September and October 2011.	
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	
Who is accountable for the implementation of the proposal / project	
Author and date Anna Ferrant, Company Secretary 20th November 2011	

Great Ormond Street Hospital for Children NHS Trust

MANAGEMENT BOARD

15th September 2011

ABRIDGED VERSION OF FINAL MINUTES

	Clinical Unit and Zero Harm Reports
184	**IPP & Deepdive**
184.1	Joanne Lofthouse (JL) presented the IPP Zero Harm report. JL reported there had been one delayed admissions and two refused patients in the month and it had been 153 days since the last Serious Incident (SI) within IPP. JL reported one complaint; a Staff nurse had taken a decision to reduce 1:1 nursing from patient without contacting the patient's consultant. Learning from the complaint is that nurses must liaise with patient's consultants prior to making the decision to reduce 1:1 nursing ratio.
184.2	JL reported one of the top three risks was recruitment and retention. Recruitment for Bumblebee and Butterfly continued. Both wards had approx 10 WTE vacancies - the bank and agency fill rate was high, with staff familiar with IPP. The second risk was Patient identification (paper tabled). Name bands and stickers for clinical notes needed to be printed with both PX and hospital numbers. The registration form had been redesigned to include both numbers. GMs were discussing format of stickers with PiMS team - instructions to print name bands with both numbers were issued.
184.3	Lastly, JL reported income may exceed the CAP. IPP income was closely monitored against the income target set. The Divisional Head of Finance was liaising with Finance to monitor NHS income monthly to ascertain % against CAP. Measures to slow income without affecting long term business aims had been developed.
184.4	JL gave a presentation on the Units next steps. JL presented on the Unit's Serious Incidents Arrests outside PICU, CVL infections, Hand Hygiene, risks, walkrounds, refusals and complaints. Peter Wollasron (PW) stated he would pick up the issue of cleaning standards dropping if normal cleaner are on holidays.
184.5	**Action:** PW to pick up the issue of cleaning standards dropping if normal cleaner is on holidays.
184.6	Management Board **noted** the content of the report.
185	**Cardio Respiratory**
185.1	Cho Ng (CNg) presented the report. It had been 205 days since their last SI. CNg reported that there had been no delays and 2 refusals. There was also one complaint, relating to the rudeness of a receptionist and appointments booked on GOSH's systems for ECHO.
185.2	CNg reported the Unit's top three risks were medication errors, Carevue electronic clinical information charting system and outpatient waiting times.

185.3	CNg reported that there was an overall reduction in medication error rates/patient with multiple interventions in place; however a recent increase in errors had been linked to the new junior staff intake. CNg reported that induction of new trainees with prescribing tasks was in place and individual feedback on prescribing errors had been set up.
185.4	CNg reported Electronic Infusion prescribing guidelines would be implemented this month. CareVue - Electronic clinical data collection system was no longer supported by supplier. The system was increasingly unstable with 26 downtime episodes in the last 3 weeks. Procurement was underway for replacement. Jane Collins (JC) questioned whether the Trust should have foreseen these issues and looked at replacing the equipment earlier? The Board agreed that lessons should be learnt. It was also reported that Theatre 7 and 8 would need further work on ventilation (approx. 3-4 weeks). JC agreed to consult with William McGill and Graham Mills.
185.5	**Action:** JC to discuss the knock on effect of ventilation issues in Theatre 7 and 8 with William McGill and Graham Mills and ensure any work done as quickly as possible.
185.6	Outpatient Waiting Times – Island Day Care outpatients would be made available from mid-September 2011 to deal with the increased number of new cardiology outpatient appointments. One new clinic had started. Arrangements were in place to add new general cardiology clinics over the coming month.
185.7	Management Board **noted** the content of the report.
186	**Infection, Cancer and Immunity**
186.1	Catherine Cale (CC) presented the report. CC reported it had been 94 days since their last SI. CC reported no refusals, 5 delays and 3 complaints during the month. Complaints related to the Trust not identifying the secondary cause of HLH, unhappiness with care by physiotherapist and delay in obtaining TTA medication for an outlier. CC reported on learning from previous complaints.
186.2	CC reported the three main risks for the Unit were access to MRI scans, the blood fridge alarm system and limited availability of beds & cots. There was a Trust wide piece of work initiated, looking at MRI capacity. The blood fridges were subject to a manual check whilst IT sourced a suitable and more reliable alarm system. There remained issues with there being sufficient physical beds/cots. PW was asked to look into these issues and to bring back a paper for Management Board.
186.3	**Action:** PW to bring back a paper on asset tracking of equipment such as bed and cots.
186.4	Management Board **noted** the content of the report.
187	**MDTS**
187.1	Melanie Hiorns (MH) presented the paper. MH reported there had been 427 days since their last SI and there had been no refusal or delays for the month. MH reported that there had been 3 complaints for the month two in Radiology and one in Clinical Genetics and reported on lessons learnt.
187.2	MH reported the top risks to the unit were around CRES, Lack of Diabetes Clinical Nurse Specialist and Interventional Radiology. All risks were currently being addressed.
187.3	Management Board **noted** the content of the report.

188	**Neurosciences**
188.1	Carlos De Sousa (CDS) presented the report. CDS reported that it was 30 days since their last SI occurred.
188.2	CDS reported the three risks the Unit faced were Medication errors, Inadequate IV access and Insufficient outpatient space for Ophthalmology and Neurodisability. CDS reported that all risks were being dealt with.
188.3	Management Board **noted** the content of the report.
189	**Surgery**
189.1	Tom Smerdon (TS) presented the report. TS reported that their last SI had occurred 162 days ago. TS also reported 4 refusals and 2 complaints.
189.2	TS identified the Unit's top three risks as Non Invasive Ventilation capacity for surgical patients; patients not being clerked appropriately and Hospital Acquired Infections. TS reported all risks were being dealt with. TS reported that there had been some issues with availability of certain types of cochlear implants. JC asked that it be expedited with procurement if necessary. Claire Newton (CN) asked to be alerted if additional help was needed.
189.3	Management Board **noted** the content of the report.
190	**R & I Divisional Report**
190.1	Robert Burns (RB) presented the report on R&I current divisional activity which included:- • Funding for the GOSH/ICH Biomedical Research Centre was successful, thus securing full funding for 2012-7. • Arrangements for a "Code of Conduct for Research" was appended for Management Board approval. • A briefing document on research-funded staff appointments (HR and Finance arrangements) was also appended for approval. • Arrangements for procurement of a new research database (Edge) to replace ReDA are being taken forward. • The MCRN would be reviewing CLRN applications from this month onwards. There were two applications this month (September), one from GOSH and the other from Whipps Cross Hospital, which would be reviewed at this Management Board.
190.2	Management Board **noted** the content of the report.
191	**Initial Development Proposal for a "Centre for Innovation and New Therapies in Childhood Disease" [Redevelopment P3A –Computer Centre site]**
191.1	JC presented the background to the paper which set out the vision for a new Centre which would provide a focus for realising the aims of the Trust's Research Strategy. The paper had been prepared by Professor Goldblatt (DG)and Professor Gaspar (BG) and showed how the Computer Centre site might be developed with the likely capital cost and timing. The paper set out the steps necessary to develop the proposal further and recommended establishing a Steering Group for 3 months to oversee this first phase. This would include taking external advice and hearing from individual groups within the hospital to define the content of the Centre. The aim was to have a broad consensus by Christmas 2011 for consideration by the Trust Board. JC reported that GOSHCC Special Trustees were keen to invest in the Computer Centre site.
191.2	BG reminded Management Board of the Trust's research strategy, which focused on, although

	was not only about, the genetic and molecular basis of disease. He demonstrated one vision about what could be delivered using the Computer Centre.
191.3	Management Board were asked to consider this vision, the development of the Computer Centre site and the establishment of the Steering Group.
191.4	JC invited the Board's views on the vision and asked the Board to consider practical issues. Martin Elliott (ME) stated he was committed to this as an idea and highlighted that it may also have the benefit of attracting more talent to the Trust and could potentially be profitable.
191.5	CDS concurred that this was an exciting vision; however, he was concerned that it appeared to leave little space for other ideas. CDS highlighted that Genetics had long promised to deliver more than it had as yet done. CDS commented we might be in danger of forgetting the interplay of other aspects of disease such as environmental factors. BG accepted CDS's point.
191.6	CC stated she was supportive but raised concerns over funding of research that was different from research that was focussed on genetic or rare disorders. JC reminded Management Board that the research strategy as a whole was delivered across the whole campus and that this would continue as there was not room for all research activity, as well as associated groups, to go into the Computer Centre.
191.7	Janet Willis stated she was also supportive. Management Board was reminded that the Trust would need to knock down the nurses' home and so all those currently located there needed to be rehoused. JC proposed that the new building be built in a flexible way and reported that William McGill (WM) had looked at the Francis Crick Institute which had been built in a similar way.
191.8	CDS reiterated concerns that the research was too prescriptive and focused on one important area. JC stated discussion and consultation would take place to agree the vision.
191.9	Management Board **noted** the content of the report and **agreed** the direction of travel pending a successful outcome of talks with Speciality Leads.
195	**Commissioning for Quality & Innovation (QUIN) Monitoring Report, Quarter 1**
195.1	RB stated that the report had been developed to monitor progress against all PCT and London Specialist Commissioning Group CQUIN standards for 2011/12. The quarter 2 report would be updated to include progress against the National Commissioning Group (NCG) Quality Improvement Development and Innovation schemes (QIDIS).
195.2	The report described indicator definitions and constructs in addition to the allocated weighting of payment for milestones throughout the year and sets out the rules for achievement. A monitoring group had been established chaired by the Co-Medical Director and attended by QUIN indicator leads. The group would meet on a monthly basis to review progress and identify remedial actions where performance was not being achieved before formal reporting to lead commissioners.
195.3	In quarter 1 15 indicators were reported as being 'achieved' and 2 indicators were reported as being 'partially achieved'.
195.4	Management Board **noted** the report.
196	**Quality, Safety and Transformation Team**
196.1	RB presented the report which undated the Board on the establishment of a Quality, Safety and

	Transformation Team and proposed new processes for serious incidents and Complaints. RB requested that the Board note the new team structure and comment on the proposed processes which would be developed for approval at October Management Board.
196.2	JC reported that a new post will be created to support the Company Secretary with assurance.
196.3	Management Board **noted** the report.
197	**Corporate Facilities UCLP Projects Update**
197.1	PW presented the report which updated the Board on a range of projects related to UCLP Workstreams. Management Board were asked to note the progress on projects and support by agreeing to the actions identified in the Project Updates including the following :
197.2	• Support pilot of Housekeeping management in Cardiac and neurosciences • Support Pilots identified to improve recruitment , retention and quality of staff • To approve establishment of Project Board for retail pharmacy, retail catering and dispensing opticians.
197.3	Management Board **noted** the report.
198	**Statutory & Mandatory Training**
198.1	Janet Williss (JW) presented the paper which was in response to a request following the July Management Board to provide an overview of the Trust's Statutory & Mandatory training commitments.
198.2	The paper sets out the current training needs analysis for GOS in relation to statutory and mandatory training and offered a comparison across the UCLP Trusts. It also provided an overview of the plan to improve and streamline the provision of this training.
198.3	JW reported that the Trust was at 62% year to date for mandatory training, the Trust target would be 80% in the first instance, then 90%. JW reported that induction refresher courses would be reduced from 18 months to 2 years.
198.4	The Board had a discussion different training strategies. AF requested that the paper also included a page demonstrating compliance and Health & Safety. The Board agreed. It also agreed to take Haringey out of paper and review how it is working in 6 months time.
198.5	**Action:** JW to provide an update to demonstrate that the changes recommended are compliant with regulatory requirements and report to the October meeting for information.
198.6	**Action**: To remove Haringey and to come back to provide an update on Statutory and Mandatory Training in 6 month time (March 2012).
198.7	Management Board **noted** the report.
199	**Safeguarding Training Strategy – Response Paper**
199.1	JW presented this paper in response to issues raised following the July submission of the Trust's Safeguarding Training Strategy. The Board agreed that Safeguarding was important but was concerned over the bureaucracy. JW agreed review how it was going.
199.2	Management Board **noted** the report.
200	**Options for replacing MR1 with a 3-Tesla MRI**

200.1	RB presented the options for replacing MR1 with a 3-Tesla MRI. The different options included:
200.2	1. Deliver standalone 3-T replacement for MR1 2. Deliver intra-operative 3-T (iMRI) replacement for MR1. Co-located theatre delivered 2016 as part of Phase 2B. 3. Deliver intra-operative 3-T in the basement of the Octav Botnar Wing Provisional analysis of these options suggested a solution that offered a way forward that would not delay the provision of a 3-T MRI but would also not preclude an iMRI solution. A full options appraisal concerning iMRI would require additional feasibility studies.
200.3	CDS stated he was supportive of acquiring 3-Tesla without delay. CDS highlighted concern over the summary of options on page 4 of the report – "could preclude" and not preclude.
200.4	Management Board **supported** the planned direction of travel.
201	**Proposal for Future Operational Model for Paediatric and Adult Highly specialised Pathology Services at GOSH/NHNN**
201.1	CC presented the proposal. NHS London had undertaken reviews of Pathology services over the last year (Adult and Paediatric). The paper was the response to the reviews by the SHA and built on the existing relationships with NHNN. The proposal fulfilled the key outcomes of the reviews: to co-locate specialist laboratory and clinical services and to have a North London hub for paediatric pathology services. The proposal was to develop a close partnership for all the laboratory services on the island site to improve co-operation and efficiencies, whilst maintaining the co-location of clinical, research and laboratory expertise.
201.2	CDS and Barbara Buckley (BB) stated they supported the proposal.
201.3	Management Board **supported** the direction of travel of the report.
202	**Proposal to redirect funding in business case (approved January 2011) to provide an Interventional Radiology (IR) on call service**
202.1	MH presented the proposal to provide an interventional radiology on call service for emergency procedures. As a by product, this would also provide extra week day sessions in IR.
202.2	The range of costs of the on-call service was £289k - £339k, this total includes associated costs for the 3 additional day time non-GA operating sessions which would become available should the decision to appoint a 5th Consultant be pursued. i.e. resource made available from the non on-call 5th Consultant PAs. The range of costs was attributed to the un-quantified non-pay cost element which would be incurred by running the additional non-GA sessions.
202.3	The proposal stated that approximately £180k of these costs were offset by funding accounted for in previous business cases and the reconfiguration of existing IR services. The re-distribution of these monies assumed that activity changes associated with these expansions (Haem/Onc & BMT, Butterfly business case) could be met by the IR service through the introduction of the on-call service and 3 additional non-GA sessions.
202.4	After considering the offset of these costs there was a 'net' cost to the organisation of £110-160k. The realisation of this cost pressure varies in line with the start dates of new Consultant appointments. i.e activity costs associated with new clinical workloads.
202.5	The underlying assumption behind the recruitment of a 5th IR Consultant post was that the demand in the Trust IBP would fulfil the clinical workload for the new post that was not

	attributed to the on-call service. i.e. there was adequate growth in clinical services to satisfy a 9 PA work plan.
202.6	Liz Jackson (LJ) highlighted that the impact on anaesthetics capacity
202.7	Management Board **supported** the direction of travel of the report pending steps being taking to look at finances for anaesthetics' and will bring back to the Board.
203	**Replacement PACS, RIS, and Cardiology systems plus the installation of a new Vendor Neutral Archive**
203.1	MH presented the paper on the replacement of PACS, RIS and Cardiology systems plus the installation of a new Vendor Neutral Archive. PACS (picture archiving and communications system) was the electronic system for storing and distributing patients radiological images (Xray, CT, ultrasound, MRI etc) around the Trust and RIS (Radiology Information System) was the electronic system for handling this patient data, bookings, and reports relating to these radiological investigations and was integrated to the PACS system. The existing PACS system was installed in 2002 and both the current PACS and RIS system were now at their end of life and must be replaced. The current annual expenditure on support costs would rise to £578,000 (+VAT) per annum in February 2012, from the current cost of £389,000. The Trust commenced an OJEU procurement process using the Competitive Dialogue Procedure in February 2011.
203.2	The document had been reviewed by a Board member responsible for clinical system change. The risks had been reviewed and it was agreed in principle that the project could proceed and that these would be managed as part of the implementation process.
203.3	MH requested the Board supported the recommendation to award a contract to GE for replacement PACS, RIS, and Cardiology systems plus the installation of a new Vendor Neutral Archive to allow storage of the radiological images, and potentially other imaging records in due course. MH stated it was hopeful that this would go to Trust Board in February 2014.
203.4	JL highlighted that each system would need to include the use of the PX number for billing purposes.
203.5	Management Board **recommended** the proposal be taken forward to Trust Board.
204	**Briefing document on GOSH research-funded staff**
204.1	Lorna Gibson (LG) outlined the paper entitled the "Briefing document for GOSH research-funded staff" which clarified HR and financial arrangements.
204.2	The paper outlined the procedure for recruiting to research funded staff on GOSH contracts –it referred to staff recruited for a particular research project on a fixed term basis as opposed to existing staff who were funded permanently by research funds.
204.3	The Board was advised that all managers should ensure that if they were recruiting a member of staff to work on a time limited or funding limited projects (such as a research project which had a funding end date) they should make this clear at the time of advertisement and recruitment. To assist with this, a section had been added to the VNF for research funded staff and a section to input the funding end date (end of the project).
204.4	Management Board **approved** the report.
205	**Time Off for Staff Councillors Policy**

205.1	Fiona Dalton (FD) presented the Time Off for Staff Councillors Policy which outlined how staff who were elected to the FT Members Council would be supported to undertake their duties.
205.2	BB highlighted that it was important to be consistent for all and it should be made clear that staff would be supported in working hours.
205.3	Management Board **approved** the Policy subject to those changes.

Other reports reviewed by September 2011 Management Board:

- Key Performance Report
- Finance and Activity Report
- Foundation Trust Application
- Education Zero Harm Report
- Space Management Review
- Waivers

Policies reviewed and approved at September 2011 Management Board:

- Time Off for Staff Councillors Policy
- Admission and Bed Management Policy
- Data Quality Policy
- Managing nasogastric and orogastic tubes

Great Ormond Street Hospital for Children NHS Trust

MANAGEMENT BOARD

20th October 2011

ABRIDGED VERSION OF FINAL MINUTES

	Clinical Unit and Zero Harm Reports
219	**IPP**
219.1	Joanne Lofthouse (JL) presented the IPP Zero Harm report. JL reported there had been no delayed admissions and three refused patients in the month and it had been 182 days since the last Serious Incident (SI) within IPP. JL reported one complaint from a parent regarding respect for and privacy of their 12 year old daughter by nursing staff during a Caterpillar Outpatients' appointment.
219.2	JL reported one of the top three risks was recruitment and retention. Recruitment for Bumblebee and Butterfly was underway. Both wards had approximately 10 WTE vacancies - the bank and agency fill rate was high, with staff familiar with IPP. The second risk was patient identification for which a paper was tabled. Name bands and stickers for clinical notes needed to be printed with both PX and hospital numbers. The registration form had been redesigned to include both numbers. GMs were discussing the format of stickers with the PiMS team - instructions to print name bands with both numbers were issued.
219.3	Lastly, JL reported income may exceed the CAP. JL highlighted IPP income was closely monitored against the income target set. The IPP Head of Finance was liaising with Finance to monitor NHS income monthly to ascertain the percentage against the CAP. Measures to slow income without affecting long term business aims had been developed. Management Board **noted** the content of the report.
220	**Cardio Respiratory**
220.1	Allan Goldman (AG) presented the deep-dive presentation for the Cardio Respiratory clinical unit. The presentation included an overview of the Unit’s flow failures, cancellations, refused admissions and complications. The review found an improvement on cancelled theatre cases and looked at reasons for cancellations refused admissions and length of stay predictions. AG stated that results from these predictions would be included in the next deep-dive on the Unit. AG reported on trends found in the data on SSIs, complications and surgical site infections. AG reported that wound infection was now down to 3.9%. AG also highlighted the Units intranet site which showed videos of how GOSH carry out procedures such as CVIs.
220.2	AG presented a program called “Frequent flyer” set up to tackle Cystic fibrosis. AG reported the results of the program (N=16) were encouraging. It was found that hospital stay was down by a third, days in hospital were reduced by 151 days and total IV day were reduced by 295 days. AG reported the Unit was hoping to roll out the programme with the help of the Charity.
220.3	Fiona Dalton highlighted that the Trust was currently using 6 different methods for CVIs. The

	Trust needs to standardise the method for such procedures for cardiac patients and the Unit's intranet site ought to reflect that. The Board agreed.
220.4	AG lastly presented the Unit's zero harm report. It had been 235 days since their last SI. AG reported that there had been no delays and 3 refusals. There was also one complaint from a family's Member of Parliament regarding problems with transport, access to the patient hotel and waits on a ward during a recent admission. AG reported the complaint was currently under investigation.
220.5	AG reported the Unit's top three risks were medication errors, the Carevue electronic clinical information charting system and outpatient waiting times.
220.6	AG reported on Medication Errors and stated that the Electronic Infusion calculator was ready, awaiting a decision on the platform for users (iPAD V Laptop) at the prescribing desk
220.7	The CareVue System was no longer supported: - the contract was now awarded for a replacement system. Legacy system seemed more stable since a recent hardware upgrade but remained at risk of failing. Cardiology outpatient waiting times had improved; patients waiting for consultation were down from 140 to 77 in last two weeks.
220.8	Management Board **noted** the content of the report.
221	**Infection, Cancer and Immunity**
221.1	Carla Hobart (CH) presented the report. CH reported it had been 214 days since their last SI. CH reported 1 refusal, 12 delays and no complaints during the month.
221.2	CH reported the three main risks for the Unit were access to MRI scans, the blood fridge alarm system and Omni 10 (currently Medium risk). There was ongoing work on MRI Trust wide. A new system for blood fridge alarms was to be purchased. Omni 10 continued to present operational issues post implementation. There was a concern that not all issues would be resolved with the new release. Jane Collins (JC) asked Mark Large (ML) to keep an eye on issues surrounding the new communication system.
221.3	**Action:** ML to report back to Management Board on the issues surrounding Omni 10.
221.4	Management Board **noted** the content of the report.
222	**MDTS**
222.1	Melanie Hiorns (MH) presented the paper. MH reported there had been 457 days since their last SI and there had been no refusal or delays for the month. MH reported that there had been 3 complaints for the month, first was joint with Central Bookings relating to nursing care of a patient, second was refusal of a referral as patient out of area and third was relating to poor communication with Clinical Psychology, Social Work, Gastroenterology. MH also reported on lessons learnt.
222.2	MH reported that losing one of the MRI scanners would be a big risk for the Trust. MH reported the top risks currently to the unit were around CRES, a lack of a Diabetes Clinical Nurse Specialist and Interventional Radiology. All risks were currently being addressed.
222.3	MH reported income was below budget in relation to achieving 2011/12 CRES targets. Plans were in place to secure posts for two new consultants in Interventional Radiology. There were currently plans in place for a Clinical Nurse Specialist to ensure staff and families had access to appropriate training on complex diabetes in an appropriate time frame.

222.4	Management Board **noted** the content of the report.
223	**Neurosciences**
223.1	Carlos De Sousa (CDS) presented the report. CDS reported that it was 65 days since their last SI occurred and the learning from it. CDS reported no refusals and 3 complaints. The complaints were a delay in tests and subsequent treatment, poor communication around test results (joint complaint with NHS West Essex) and delays in outpatients and whilst in hospital, poor communication. CDS reported the Unit had learnt from previous complaints and was currently working to improve communication with referring organisations.
223.2	CDS reported the risks the Unit faced were Medication errors and Inadequate IV access. CDS reported that they were currently being dealt with.
223.3	CDS also reported insufficient outpatient space for ophthalmology and neuro-disability. The Board had a discussion around the issue of lack of meeting space. Peter Wollaston (PW) highlighted that the new room booking system would shortly be on line and should help alleviate some of the issues. JC took Chairman's action and approved Neurosciences use of the room near Cardiac pending training of Neurosciences' staff to use the technical equipment in the room.
223.4	Management Board **noted** the content of the report.
224	**Surgery**
224.1	Tom Smerdon (TS) presented the report. TS reported that their last SI had occurred 162 days ago on facial surgery. TS also reported 11 refusals and 5 complaints relating to accommodation, booking, feeding, clinical care and prescribing. TS reported complaints were under review and on the lessons learnt from previous complaints.
224.2	TS identified the Unit's top three risks as Medication errors, Recruitment and Agency and medical records. TS reported all risks were being dealt with.
224.3	TS reported that the Unit had won the Bouremount Award for the WHO checklist. The award monies would go towards human factor training.
224.5	Management Board **noted** the content of the report.
225	**R & I Divisional Report**
225.1	Robert Burns (RB) presented the report on R&I current divisional activity which included:- • Arrangements for a "Code of Conduct for Research" were appended for management Board approval later on the agenda. • Arrangements for the GOSH/ICH Biomedical Research Centre for 2012 were being taken forward. • The roll-out of a new research database (Edge) to replace ReDA was now in its final stages. • A roadshow was being organised by the Division of R&I for early December, consisting of 3 afternoons when the Joint R&D Office, BRC, CRF, and MRCN teams would be available to outline current arrangements for research, and provided an opportunity for GOSH/ICH colleagues to meet the new team. • Training session for researchers were being arranged for January, covering topics such as how to set up a clinical trial, working with industry, documents required for R&D approval, and the CRF facility.

	• Discussions had been held for collaboration with the UCL's Clinical Trials Unit. • The Research Review for 2010 was now available from the Joint R&D Office. • Mechanisms of financial reporting research income via the Division of R&I were still being finalised with GOSH Management Accounts. • Arrangements for a new archiving policy for research within GOSH was being finalised in time for the November Management Board. • An update on the ICH intranet (for the R&D pages) was to be finalised this month (which would be mirrored on the new GOSH intranet). • Within the R&D Office, new appointments had been made for a PA, and Clinical Research Facilitator. Posts currently at advertisement were for a BRC Manager (band 7), and Clinical Trials Co-ordinator (band 6). Until the new Clinical Research Facilitator was in post, interim arrangements had been put in place to ensure that GOSH/ICH was fully covered. • Within the CRF, interviews for a band 7 Clinical Trials Pharmacist, band 6 Research Nurse, and Band 4 HCA were scheduled.
225.3	Management Board **noted** the content of the report.
227	**Quality and Safety Strategy**
227.1	Sven Bunn (SB) presented the paper on the Trust's updated Quality and Safety Strategy.
227.2	SB asked the Board to consider the strategy and its implications for the Board, make any recommendations, approve the strategy so that the implementation could be made at Unit level, make arrangements for the dissemination of the strategy internally and externally and to ensure all other policies and strategies were in keeping with the Quality and Safety Strategy.
227.3	SB highlighted that there were two main updates in the report around communication of the strategy and quality assurance.
227.4	Anna Ferrant (AF) queried whether it might be useful to have an overarching plan. TS agreed it would be helpful. SB and RB agreed to take this idea away for further discussion.
227.5	**Action:** SB and RB agreed to take away the idea of an overarching plan around Quality and Safety for further discussion. Management Board **noted** the strategy.
231	**London 2012 Olympics**
231.1	FD updated the Board on the Trust's planning for the London 2012 Olympic Games. The GOSH Olympic Planning Group met for the third time in October 2011. There were a range of logistical, management and communication challenges that the Trust would need to address to ensure services continued to be delivered unhindered during the Olympic period. These were noted in the Olympic Planning Report and Action Plan. The paper outlined for the Board the most recent discussions from the meeting held on the 12th October and gave the direction of travel. The Action Plan addressed :
231.2	1. Reducing the need to travel for staff 2. Influencing the time of travel 3. Influencing the method of travel used to reach GOSH 4. Deliveries 5. Promotion Strategy 6. Accommodation 7. NHS Command and Control / reporting requirements 8. Major Incident / Contingency Planning requirements

	9. Financial considerations 10. Business continuity Plans 11. Essential Supplies
231.3	ML highlighted that the survey that was sent round to all staff did not include Liverpool Street Station. JL highlighted IPP would have to try to plan around the Olympics because flights to and from London could be fully booked. Liz Morgan (LM) stated that training would have to be reduced during that time. JC asked that the Planning Group look at what was planned for the Flu pandemic and use the work already done as a structure to help around planning to deal with the challenges that may arise as a result of the Olympics.
231.4	The Board **agreed** the plan and agreed that the Planning Group ought to include a representative from each of the Clinical Units with monthly updates to the Board.
232	**Outpatients Space pressures**
232.1	RW presented the report which provided an update on the situation currently around OPD capacity and possible actions to mitigate risks identified at Management Board by various Clinical Units.
232.2	The paper produced by the Outpatients Management Team highlighted the issues and identified possible solutions in short and medium term which would require further detailed review.
232.3	Key recommendations were : ▪ Discussion and plans to be commenced with the Estates and Facilities team for the potential of utilising space identified in the Feasibility study carried out in 2009 by Hermantes Basha. ▪ Review of office space in the main GOSH site located near the Outpatient consulting rooms with the view to relocate the office space and utilise these areas for clinical consultations. ▪ In support of the work taking place with the Redevelopment and Estates and Facilities Departments, clinical units to assess their new to follow up ratio and look at their discharge policy. ▪ Clinical units to review their underutilisation availability from clinics which did not commence until 10.00am. ▪ With the introduction of the new room booking system and the collaborative working with the Transformation Team, from Jan 2012 monthly updates to be provided to the clinical units of the utilisation of the clinic rooms versus planned appointments on Pims for their specialities clinics.
232.4	The Board had a discussion around the issue of space and **approved** the recommendations with a view of booking the rooms in terms of slots (with 45 minutes for new patients being adhered to), rather than sessions.
233	**Replacement of critical Care Clinical Information System (CIS) – CareVue**
233.1	ML presented the report. At the September Management Board meeting it was agreed that the Chair of Management Board would take Chair's action between meetings to consider the recommendations of the CareVue replacement project team and approve the procurement

	decision and authorisation of the business case. This was due to the urgency for replacing this critical system.
233.2	At the TDB meeting on 4th October 2011, the business case and the procurement recommendation were discussed and confirmed and a recommendation made to the Chief Executive. The Board was asked to ratify the Chair's decision to approve the project requiring a capital investment of £654k excluding VAT and to approve the award of a contract to Philips for replacement Information System to support the Intensive care units in GOSH and which is expandable to include potential future service expansions and developments.
233.3	ML stated the department was aiming at being completed by 31st March 2012 to allow smooth transition to new building and for the roll out of training.
233.4	JC queried why IT had not taken action sooner when problems first stared to occur. ML conceded with hindsight that is what should have been done. JC asked ML to inform the Board if there were any delays.
233.5	Management Board **approved** the report.
234	**Tender for the provision of a staff support service**
234.1	FD presented the tender for the provision of a staff support service. The Board was asked for their approval to award the contract to Care first.
234.2	FD highlighted that the tender supports delivery of reduced absence rates and actions related to staff survey results on stress. Mediation services form part of the Trust's approach to dealing with inappropriate behaviour amongst staff. The staff support contract would enable all staff to access timely, high quality psychological support and counselling on a 24/7 basis, with ongoing access where required over the telephone or face-to-face at a site close to GOSH or to their home address. Access to other forms of intervention including debrief will also form part of the contract as will access to advice and information (including welfare, debt and legal advice).
234.3	Management Board **approved** the tender.
235	**Interpreting Services – Award of new contract under LLP Framework**
235.1	PW presented paper. The Trust's Interpreting Services contract expired in April 2011 and a temporary extension of the agreement was put in place pending the award of the new LPP Framework for interpreting services, which the Trust had agreed to participate in.
235.2	The LPP Framework agreement for interpreting services was awarded on 1st September 2011 and was valid until 31st August 2014 with an option for a further 12 month extension. A review of the prices available under this new framework had been undertaken and it was estimated that annual savings in the region of £26,000 could be achieved through switching to the new contract if the Trust continued with the current service levels.
235.3	The Trusts current contract was with Language Line Services and the new LPP Contract would be provided through the Big Word. A review of the quality of the services that could be provided though the Big Word had been undertaken and satisfactory references had been obtained from other NHS organisations. Discussions had also been undertaken with regards to how the Big Word would ensure a smooth transition to the new contract.
235.4	In order to transfer to the new contract, a 3 month notice would be required to be given to the current supplier, so the intended start date for the new contract would be 1st February 2012.

235.5	PW asked the Board to approve the transfer of the Interpreting Services Contract to the Big Word under the new LPP Interpreting Services Framework for a 1 year term commencing 1st February 2012 with the option to extend for further 12 month periods in line with the length of the LPP Framework.
235.6	Management Board **approved** the tender.
236	**Tender for the supply of a Gas Chromatography Mass Spectrometer**
236.1	CH presented the paper seeking the Board's approval to replace ageing, out dated equipment that suffered from frequent breakdowns and failures, with reliable state of the art analysers that had computer controlled result interpretation. This would improve the quality of reporting, reduce the turn around time for key income generating assays and help to maintain and grow income.
236.2	The Metabolic laboratory in Chemical Pathology provided a renowned national and international service for Urine Organic Acids, the assay used Gas Chromatography Mass Spectrometry (GCMS). The Trust's current GCMS instruments were many years old and the interpretation of results was labour intensive and required highly trained staff.
236.3	Because of this continuing growth of external and internal work, the Board was advised that the Trust was at risk of losing income because it could no longer meet the turn around time expected by its users, nor match the turnaround time of our competitors. This had clinical implications and had been highlighted as a formal non-conformance in a recent CPA (UK) Ltd visit.
236.4	Funding was agreed through CESC for £109,000 (ME3413) to purchase two new Gas Chromatography Mass Spectrometers. An OJEU advert was placed and 7 suppliers expressed an interest to tender. Tender documents were sent out and five suppliers responded by sending back their tender responses. The project group evaluated the five tender responses and decided to award Agilent Technologies to supply the two GCMS that are required.
236.5	CH asked the Board to approve the award of the tender to Agilent so they could supply the two Gas Chromatography Mass Spectrometers to the Metabolic Laboratory.
236.6	Management Board **approved** the tender.
237	**Recruitment of Replacement CATS Consultant**
237.1	TS presented the paper which sought agreement from the Board to recruit a replacement CATS Consultant post.
237.2	The CATS service wished to replace a consultant, who left in June 2010, and whose position had been occupied by a locum since that time. The post was already in the budgeted establishment.
237.3	Management Board **approved** the report.
238	**Neurosurgery Theatre Expansion**
238.1	Sarah Dobbings (SD) presented the paper that outlined the plans to increase neurosurgery theatre capacity by adding a Tuesday all-day theatre list. The aims of the proposal were: • To ensure that Neurosurgery had sufficient capacity to support the activity projected in the

	Integrated Business Plan • To ensure that Neurosurgery had sufficient capacity to respond appropriately to the Safe and Sustainable review of Paediatric Neurosurgery • To improve the effectiveness of the neurosurgical service by ensuring patients receive surgery in a timely way. • Improve data collection and audit within neurosurgery.
238.2	MH highlighted the concern over the burden that an additional theatre list would have on demand for equipment such as the MRI scanner. CDS queried why the hospital's 4 magnets could not cope with increased demand. MH advised that 2 of the scanners were currently being used for Research and would have to be upgraded. MH also highlighted the need for additional trained paediatric MRI radiographers.
238.3	Andrew Needham (AN) highlighted the that there would be an increase in demand on beds. TS raised concerns over capacity, beds MRI, PICU and outpatients across the 5 business cases that were upcoming for approval to the Board. AN highlighted that there was no certainty around cost versus income.
238.4	FD reminded the Board that these 5 Business cases had been intended to come since July and were included in the IBP. The challenges would have to be overcome.
238.5	The Board took a vote as to whether or not to continue with approval for this and upcoming business cases and an overall majority agreed (2 members opposed) to continue with the approval of the 5 Business cases.
238.6	Management Board **approved** the business case in principal, taking in to account MRI capacity and the need to place advertisements for additional trained paediatric MRI radiographers. The other business cases should come to the November meeting.
239	**SNAPS Business case**
239.1	TS presented the paper which made the case for investment in 10 Consultant PAs and associated costs in the SNAPS service. This would enable SNAPS to take an additional all day theatre session once Phase 2A opens.
239.2	TS asked the Board to reach a decision on whether to proceed with the business case. TS reiterated concern over business cases and the knock on effect across the trust. FD reminded the Board that each of the Unit's CRES targets were reliant upon approval and implication of these Business cases.
239.3	Management Board **approved** the Business case in principal.
242	**Business case to replace MR1 with a 3-Tesla MRI**
242.1	FD presented the Business case to replace the Trust's oldest MRI (MR1). There was considerable pressure on MRI waiting times at present and was required when considering the Trust's predicted growth documented in the Integrated Business Plan.
242.2	The magnetic strength in a '3-Tesla' MRI scanner was twice that of a standard '1.5 Tesla' scanner. The purpose of an MRI scan was to provide detailed images of abnormalities. The clinical representatives on the Clinical Equipment and Supplies Committee (CESC) had agreed last year that this was an urgent clinical priority for the Trust.
242.3	3-Tesla MRI was a technology that would advance the Trust's diagnostic ability particularly for neurosciences and research and was evidenced as the technique of choice for epilepsy

	(GOSH is currently the biggest centre nationally).
242.4	This paper considered 3 options: 1. Do nothing 2. Replace with 1.5T 3. Replace with 3-T The recommendation was option 3 replace with 3-T
242.5	FD requested the Board: 1. Agreed to support the business case which would need to be presented to Trust Board for approval 2. Agreed that pending Trust Board approval of the case, it would be presented to GOSHCC as a formal request for funding
242.6	Management Board **approved** the report.
250	**Code of Conduct for Research**
250.1	RB presented the paper which outlined a new document entitled the "Code of Conduct for Research within GOSH" which was based broadly on that from UCL, with reference to GOSH HR policies. The GOSH code of conduct in research covers six main areas: 1. professional and personal integrity of researchers. 2. process of research design. 3. publication process. 4. leadership responsibilities. 5. institutional responsibilities. 6. personal responsibilities.
250.2	The final section of the code listed GOSH policies and procedures and provided links to the detailed versions of these policies and procedures.
250.3	Management Board **approved** the paper.
251	**Salary Overpayment briefing**
251.1	AN presented the paper which provided an update on salary overpayments. The results showed how late notification of leavers/hours changes had increased. AN explained the new procedures put in place to try and combat the problem.
251.2	• There was currently £328.1K of debt outstanding – a recommendation was being made in a separate paper for write off of £79.5K "old" overpayments to former staff for which all debt recovery processes had been pursued without success • 19 overpayments in this financial year were caused by late notification on SRS • Positive Reporting was being trialled in Neurosciences, Surgery and Medicine.
251.3	Management Board **noted** the contents of the report

Other reports reviewed by October 2011 Management Board:

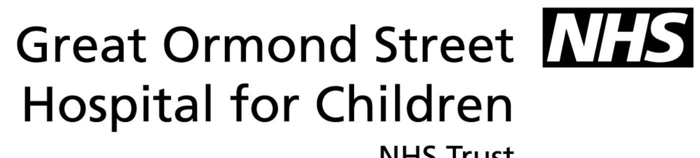
- Key Performance Report September 2011
- Finance and Activity Report
- Foundation Trust Application Update September 2011
- Education Zero Harm Report
- Waivers

Attachment W

Policies reviewed and approved at October 2011 Management Board:

- Formal Disciplinary Policy and Procedure
- Freedom of Information Policy
- Managing Attendance Policy
- Sickness Notification Procedure
- Confidentiality Policy

Attachment Y



Trust Board **30th November 2011**	
Update on Compliance with Care Quality Commission Standards and Registration **Submitted on behalf of** **Jane Collins, Chief Executive**	**Paper No: Attachment Y**
Aims / summary To update the Trust Board on the current status of the Care Quality Commission (CQC) registration standards. The CQC has issued the Trust with the October 2011 Quality 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. The QRP is monitored by the Risk, Assurance and Compliance Group (RACG).	
Action required from the meeting To review the summary of 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.	
Legal issues Registration is a legal requirement.	
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.	
Author and date Anna Ferrant, Company Secretary 20th November 2011	

Attachment Y

Compliance with Care Quality Commission Standards and Registration

Summary

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

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

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

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

The types of services provided are declared as:

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

Planned review for CQC

In June 2011, the CQC conducted a planned review of all 16 outcomes. A minor concern was raised about processes for tagging clinical equipment for the purposes of cleaning. An action plan was developed to deal with the matters raised and the content of the plan approved by CQC. This action plan will be be implemented by beginning December 2011.

Queries raised by the CQC

The Trust has recently been contacted by the CQC to confirm actions taken to deal with a number of issues relating to patient care and estates management. The Trust responded to the queries raised and the CQC has confirmed that no further action will be taken.

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

Attachment Y

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 September and October 2011. The updated QRP shows that:

- No risk estimates worsened between September and October 2011;
- Risk estimates for 5 outcomes remained the same between September and October 2011 – this includes a move to amber for outcome 8, cleanliness and infection control between July and September 2011 (see below)
- Risk estimates for 5 outcomes improved between September and October 2011
- Two risk estimates moved from 'not enough data' to a RAG status estimate (outcomes 2 – consent moved to 'high green' and 6 – cooperating with other providers moved to 'low neutral')
- Outcome 7 (safeguarding) moved from a risk estimate of 'no information' to 'not enough data'.

Analysis of the QRP data

Analysis of the data across all outcomes reveals that the results from the CQC's planned review in June 2011 have been entered into the QRP. Inclusion of this data has had a positive effect on many of the risk estimate results.

In September 2011, the QRP risk estimate for outcome 8 (cleanliness and infection control) moved from a risk estimate of 'high green' to 'low amber'. The estimate of risk for this outcome is produced following analysis of 29 quantitative data items and 2 qualitative data items. The shift in risk estimate to 'low amber' was as a result of the CQC comparing the following data items against other similar Trusts and GOSH scoring worse than those Trusts:

- Data item 'MRSA relative to current national level' scored as 'worse than expected';
- Data item 'MRSA relative to short-term national trend' scored as 'much worse than expected';
- Data item 'MRSA relative to long-term national trend' scored as 'much worse than expected';
- NHS Staff survey results on the availability of hand-washing materials scored at 'tending towards worse than expected'
- Data item 'Clostridium difficile relative to current national level (for ages 2+) scored at ' tending towards worse than expected';
- Data item 'Percentage score for site against National Specifications for Cleanliness of NHS scored at 'tending towards worse than expected'.

The assessment also includes qualitative data items, both of which are assessed as 'negative' in the QRP:

- One negative comment from a CQC complaints review (18/07/11)
- A minor concern raised during the CQC planned review about the tagging of clinical equipment for the purposes of cleaning.

All of the other data items were scored as 'similar to expected'.

As soon as the Trust was informed of the 'low amber' score for outcome 8, a summary of all actions taken to improve performance around infection control and cleaning in relation to the above measures was documented and sent to the CQC (**see Appendix 2**). The CQC are satisfied with the work undertaken, but, as with all outcomes, the Commission will maintain constant monitoring.

Ongoing Self Assessment

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

Provider Code	Provider Name	Version	Version Date
RP4	Great Ormond Street Hospital for Children NHS Trust	3.6	25/10/11

Latest risk estimates

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

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

Section 1 - Involvement and information

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 1 (R17) Respecting and involving people who use services	Low Neutral	High Green	Total number of data items: 11 Number of qualitative data items: 1 Number of quantitative data items: 10
Outcome 2 (R18) Consent to care and treatment	Not Enough Data	High Green	Total number of data items: 2 Number of qualitative data items: 1 Number of quantitative data items: 1

Section 2 - Personalised care

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 4 (R9) Care and welfare of people who use services	Low Green	Low Green	Total number of data items: 20 Number of qualitative data items: 4 Number of quantitative data items: 16
Outcome 5 (R14) Meeting nutritional needs	Low Neutral	Low Neutral	Total number of data items: 7 Number of qualitative data items: 1 Number of quantitative data items: 6
Outcome 6 (R24) Cooperating with other providers	Not Enough Data	Low Neutral	Total number of data items: 3 Number of qualitative data items: 2 Number of quantitative data items: 1

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Provider Code	Provider Name	Version	Version Date
RP4	Great Ormond Street Hospital for Children NHS Trust	3.6	25/10/11

Latest risk estimates (continued)

Section 3 - Safeguarding and safety

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 7 (R11) Safeguarding people who use services from abuse	NO INFORMATION	Not Enough Data	Total number of data items: 1 Number of qualitative data items: 1 Number of quantitative data items: 0
Outcome 8 (R12) Cleanliness and infection control	Low Amber	Low Amber	Total number of data items: 31 Number of qualitative data items: 2 Number of quantitative data items: 29
Outcome 9 (R13) Management of medicines	Not Enough Data	Not Enough Data	Total number of data items: 11 Number of qualitative data items: 4 Number of quantitative data items: 7
Outcome 10 (R15) Safety and suitability of premises	Low Neutral	High Green	Total number of data items: 26 Number of qualitative data items: 1 Number of quantitative data items: 25
Outcome 11 (R16) Safety, availability and suitability of equipment	Low Neutral	High Green	Total number of data items: 11 Number of qualitative data items: 1 Number of quantitative data items: 10

Section 4 - Suitability of staffing

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 12 (R21) Requirements relating to workers	Low Neutral	Low Neutral	Total number of data items: 4 Number of qualitative data items: 1 Number of quantitative data items: 3
Outcome 13 (R22) Staffing	High Green	Low Green	Total number of data items: 21 Number of qualitative data items: 1 Number of quantitative data items: 20
Outcome 14 (R23) Supporting staff	Low Neutral	Low Neutral	Total number of data items: 46 Number of qualitative data items: 1 Number of quantitative data items: 45

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Provider Code	Provider Name	Version	Version Date
RP4	Great Ormond Street Hospital for Children NHS Trust	3.6	25/10/11

Latest risk estimates (continued)

Section 5 - Quality and management

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 16 (R10) Assessing and monitoring the quality of service provision	L Low Neutral H	L Low Green H	Total number of data items: 36 Number of qualitative data items: 6 Number of quantitative data items: 30
Outcome 17 (R19) Complaints	L Low Neutral H	L Low Neutral H	Total number of data items: 9 Number of qualitative data items: 3 Number of quantitative data items: 6
Outcome 21 (R20) Records	L Low Neutral H	L Low Neutral H	Total number of data items: 61 Number of qualitative data items: 1 Number of quantitative data items: 60

Attachment Y

Overview of GOSH work programmes related to specific data items under outcome 8 (October 2011)

Item ID and description	Rationale and data source	Comparator with expected
8452: MRSA relative to current national level	**This information measures the extent to which current infection rates differ from the nationally rate for the type of Trust. (01/01/11 – 31/03/11) (Health Protection Agency (HPA), MRSA Bacteraemia Surveillance Scheme)**	**Worse than expected**
8454: MRSA relative to short-term national trend.	**This information measures the extent to which infection rates have changed over the past 4 quarters compared to the changes observed nationally for the type of trust. (01/04/10 – 31/03/11)(Health Protection Agency (HPA), MRSA Bacteraemia Surveillance Scheme)**	**Much worse that expected**
11205: MRSA relative to long-term national trend	**This information measures the extent to which infection rates have changed in the past 8 quarters compared to the changes observed nationally for the type of Trust. (01/04/09 – 31/03/11) (Health Protection Agency (HPA), MRSA Bacteraemia Surveillance Scheme)**	**Much worse that expected**

Comment

The Trust reported 1 MRSA bacteraemia from 01/04/09 – 31/03/2010 and 1 from 01/04/10 – 31/03/2011. Comparison to the other Children's hospitals, for which there is data on the HCAI site, is shown in the table below:

	GOSH	Liverpool, Alder Hey	Birmingham Children's	Sheffield Children's
2009/10	1	4	3	0
2010/11	1	2	1	0

The actual number of MRSA bacteraemias in the Trust in the last 8 months referred to is low, within the National Target set, and not worse than expected when compared to other Children's Hospitals.

Our very acute, highly dependent case-mix means that it is not surprising that our MRSA rate per 1000 bed days is higher than would be expected. We are striving for 0 MRSA cases and have undertaken a full root cause analysis on both of the two patients who have contracted a MRSA blood stream infection this year.

The Trust implements an extensive and active MRSA Control programme (including screening of appropriate admissions, isolation, decolonisation where appropriate and investigation of any apparent MRSA acquisition with staff and environmental screening if needed) and programmes to reduce all S. aureus infection related to vascular access and surgical procedures.

Note: 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.

Item ID and description	Rationale and data source	Comparator with expected
10037/ 12660: PEAT - Percentage score for site against national specification for cleanliness of NHS	**Healthcare services should be provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises. (04/01/10-26/03/10) – this date may change with the new QRP data (National Patient Safety Agency (NPSA), Patient Environment Action Team (PEAT))**	**Tending towards worse than expected**

Comment

Great Ormond Street NHS Trust audited against the PEAT standards in February 2011 and returned a score of Good (94%) for the Environmental element. This follows a year-on-year improvement in the Environmental Score (2009 - 76.9%, 2010 - 85.5%). In respect to the Cleanliness elements (Specific Cleanliness and Toilet and Bathroom Cleanliness) the Trust has scored 97% of the possible scores as 4 and above.

The Trust believes the scores to be robust due to the approach that it takes in respect to the PEAT audit. Since 2007 the Trust PEAT method has used a three team approach and individually scored each department (rather than giving a single score for the Trust as a whole). The scores have been aggregated to produce a single PEAT Score for the formal PEAT return. In addition to the required annual PEAT inspection, the Trust works to a quarterly schedule to ensure that there is continuous improvement rather than a one-off focus each year.

Although the multiple team approach introduces a greater degree of subjectivity into the audit, the Trust believes that it achieves an increased percentage of audit coverage, a more focused approach for each individual audit, and a more detailed action plan for post audit work.

The Trust believes that the quarterly audit schedule and the in-depth action plans have effectively engaged the individual departments to deliver a real improvement in environmental standards within the Trust, mainly around the environmental elements (cleanliness, clutter etc) as reflected by the scores. With the approach of multiple scoring there is always a risk that the aggregated score might be impacted due to the local method of aggregation but even given this, the Trust is confident that the PEAT return shows that the Trust has achieved a high level of compliance particularly as it is backed up by the technical auditing of cleanliness for the same period (Very high risk =98% , High risk =97%).

Item ID and description	Rationale and data source	Comparator with expected
12370: Clostridium difficile relative to current national level (for ages 2+)	**This information measures the extent to which current infection rates differ from the national rate for the type of trust. (01/01/11 – 31/03/11) (Health Protection Agency (HPA), Clostridium Difficile Surveillance Scheme)**	**Tending towards worse than expected**

Comment

The rate of C. difficile reported to the HPA has remained stable since reporting started. This is as would be expected in a paediatric population; the slightly higher numbers compared to other children hospitals reflecting the patient group and surveillance strategy. While the National Objective remains in place it is likely that the ‘trending towards worse than expected’ will continue.

Clostridium difficile is a poorly understood infection in children, usually causing asymptomatic or mild infection. Diarrhoea is common in hospitalised children undergoing intensive therapy and detection of C. difficile in stool is frequently co-incidental. At GOSH we believe knowledge of the presence of C. difficile is useful because:

1. very occasionally severe disease may be seen (at any age) and treatment will be indicated;
2. isolates may be grown and typed to allow surveillance and monitoring of the effectiveness of infection control precautions and changing epidemiology (e.g. introduction of ribotype 027 into the paediatric population).

Extensive surveillance of C. difficile infection has been undertaken in children at GOSH for many years (prior to introduction of National Surveillance and comparative rates). This surveillance has shown a steady state of C. difficile detection with very little cross infection and almost complete absence (currently) of ribotype 027. Treatment is occasionally given when, on the balance of clinical evidence, the infection is considered to be causing disease (C. difficile associated disease CDAD).

The comparison of C. difficile rates in paediatrics with the adult Target/Objective is not appropriate. The Antimicrobial Resistance and Health Care Associated Infection (ARHAI) group recognises adults and children are different and will review the paediatric Objective when further data is available (please refer to Professor Mike Sharland, Chair, for confirmation).

A control programme for C. difficile is in place. Standard infection control precautions are used to control diarrhoea. Surveillance demonstrates that most cases are not cross infection. The Trust does have a high use of antibiotics, principally due the high number of immune compromised children and extensive surgery, and additional focus is being placed on reducing antibiotic use.

Item ID and description	Rationale and data source	Comparator with expected
11271: Care Quality Commission, Survey of NHS Staff 2010 - Availability of hand washing materials	**Staff should work in an environment that promotes high standards of hygiene and cleanliness. (01/10/10 – 31/12/10) (Care Quality Commission, Survey of NHS Staff)**	**Tending towards worse than expected**

Comment

Great Ormond Street Hospital believes implicitly in the importance of hand hygiene. Extensive facilities are made available to all clinical staff. We were very concerned by the national staff survey and therefore we carried out an in house survey on staff using Survey Monkey in April, to ascertain which areas were experiencing problems with hand hygiene facilities within the organisation.

This survey demonstrated that the principal staff concerns related to problems in non –clinical areas within the Trust with the provision of water and consumables.

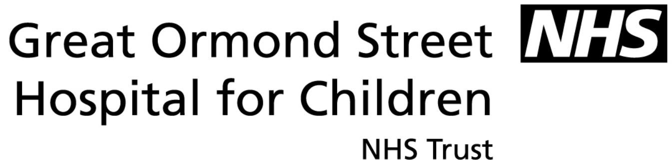
This opinion was confirmed during our CQC inspection, on June 9th 2011, where the inspector felt that the Trust had more than adequate facilities within the clinical areas inspected (the CQC advised that it only inspects clinical areas).

The non clinical areas were surveyed by the Estates & Facilities department and improvements are being made where possible.

We undertake monthly audits of handwashing on each ward in the hospital - this information is displayed as run-charts on the hospital intranet, and on notice board in wards, and used in our drive for consistent improvement.

Trust Board 30th November 2011	
Head of Nursing Report **Submitted on behalf of** Mrs Liz Morgan, Chief Nurse and Director of Education	**Paper No: Attachment Z**
Aims / summary The aim of this report is to update the trust board on the nursing successes, key performance indicators for nursing and some aspects of Infection Control (IC) not covered in the IC report to Trust Board. The Board will receive a quarterly report from the Heads of Nursing.	
Action required from the meeting For information and discussion.	
Contribution to the delivery of NHS / Trust strategies and plans With partners maintain and develop our position as the UK's top children's research organisation.	
Financial implications N/A	
Legal issues N/A	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision N/A	
Who is responsible for implementing the proposals / project and anticipated timescales Liz Morgan, Chief Nurse and Director of Education and the Heads of Nursing	
Who is accountable for the implementation of the proposal / project Liz Morgan, Chief Nurse and Director of Education and the Heads of Nursing	
Author and date Julie Bayliss Head of Nursing November 2011	

Attachment Z



Head of Nursing Trust Board Report

November 2011

Situation
To provide the trust board with assurance, on aspects of clinical nursing leadership and quality within the head of nursing report.

Background

The aim of this report is to update the trust board on the nursing successes, key performance indicators for nursing and some aspects of Infection Control (IC) not covered in the IC report to trust board.

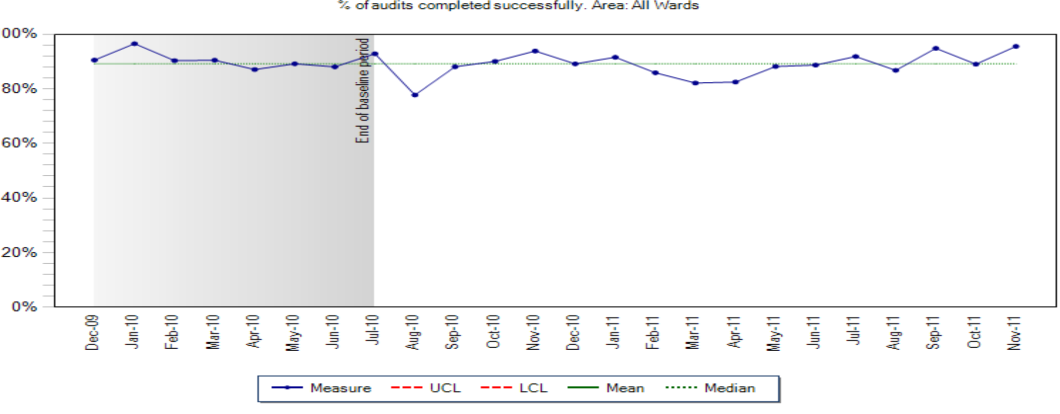
Assessment

There are a number of successes to report on, trust wide nursing quality initiatives, outcome on key nursing performance indicators (KPI) and some outstanding individual and team achievements for nursing.

Quarterly Performance Reviews:

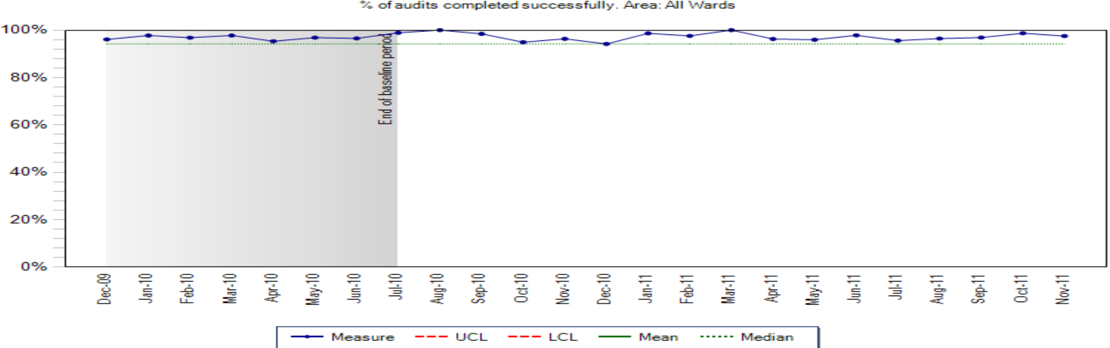
There has been a second round of quarterly performance reviews during this quarter, which has provided a level of assurance and shared learning. There area range of nursing key performance indicators, nine for some units; this report will focus on those not covered in previous reports or within other transformation, infection control reports.

Pressure Ulcers Assessment completed
There is a general sustained improvement in this area with 89%pressure ulcer risk assessment completed (see table below). Two to eight pressure ulcers are reported per month within the trust. There is a plan to review of the pressure ulcer assessment tool and focus attention towards preventing pressure ulcers. However, we have struggled to recruit to the tissue viability nurse post thus these responsibilities have now been incorporated into a new Nursing Quality Practice Educator post which will commence in December 2011.



Attachment Z

Patient Weighed within the last 7 days and recorded on prescription
There is a steady sustained improvement for this KPI within all wards in the trust which is demonstrated in the table below.



Update on Nutritional Care- Results of the documentation of patient height audit
The levels of improvement on documentation of height and weight are significant, and really reflect the hard work and the enthusiasm of the ward teams with the support of the Nutrition CNS on this project. To ensure that we are providing the best quality of nutritional care for patients during their time as an inpatient, an audit was undertaken to demonstrate the documentation of patient's height. This reiterates standards outlined in Outcome 5 of the CQC Essential Standards: Meeting Nutritional Needs. The key highlights from the audit are:

There has been a 19% improvement on height measurement documented inpatient notes and electronic prescribing from the baseline audit carried out in March - our target for the end of the year was 20%

Height documented visibly in the patient notes	April%	July %	September %	Difference between April and September
Yes	55%	51%	74%	+19%

Based on if the height was recorded on the following; Electronic Prescribing, Patient Assessment Form, UK 90 growth Chart or UK WHO 0-4 Chart.

Height recorded on Electronic Prescribing?	April%	July %	September %	Difference between April and September
Yes	38%	43%	64%	+26%

*Samples from Intensive Care were excluded from this question.
*Patients whose information could not be found on Electronic Prescribing were excluded from this question.

The audit has shown an improvement in compliance with growth chart completion - UK 90 charts up by 32% and WHO UK 0 - 4 charts up by 48% - a real success.

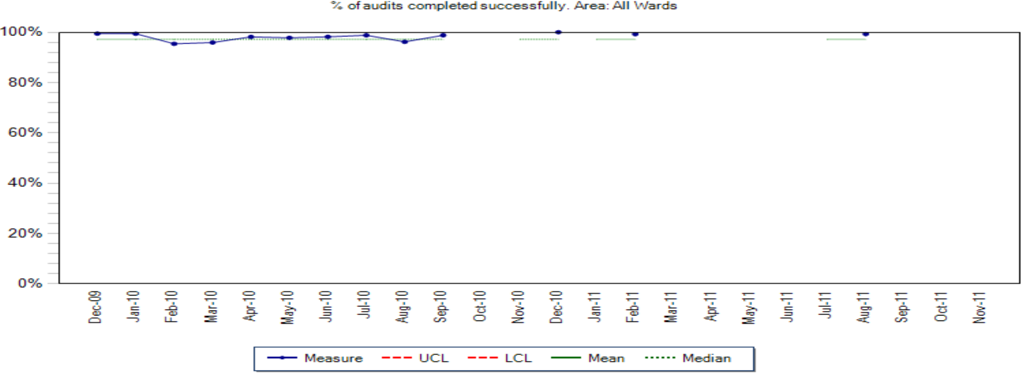
Is there a UK WHO 0-4 Chart present:	April%	July %	September %	Difference between April and September
Yes	32%	55%	69%	+37%
Of the UK WHO 0-4 Charts present, how many were complete:	**April%**	**July %**	**September %**	
Yes	25%	44%	73%	+48%

Attachment Z

The nutritional audit has also shown that there is 65% compliance with use of the nutrition screening tool in those wards where it has been implemented.

Patient Identification

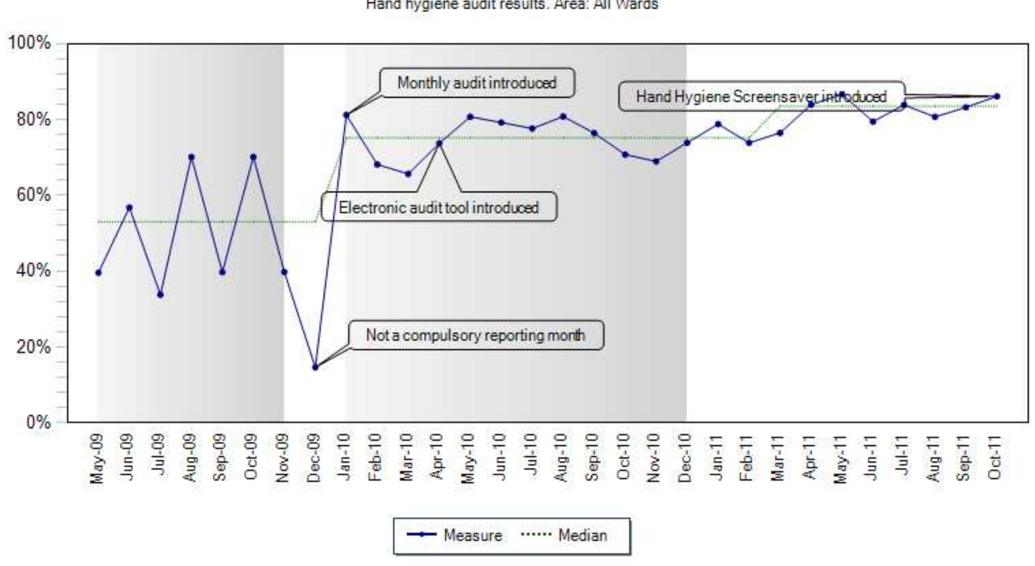
The KPI for patient identification bracelets was undertaken in August as a spot check, the results demonstrated a continued very high compliance across the trust as demonstrated in the table below. The plan is to continue with spot checks to provide a measure of quality assurance.



Hand Hygiene

All wards and departments continue to carry out monthly audits, the results of these are published as other KPI's on the transformation dashboard. We are now able to audit had hygiene compliance for individual staff groups. All wards and departments have any annual programme in place to train and update staff on the correct hand washing technique.

The trust hand care group has agreed that once the MSCB opens we will have a company who will design hand hygiene awareness posters for the public. The trust is currently running a competition in the school for children to design a child friendly hand hygiene awareness poster.



Attachment Z

Cleaning

Cleaning standards continue to be acceptable supported by the CQC inspection earlier in the year and the individual audit results. The Level 2 and 3 intervention processes for areas of concern is embedded and resulting in sustained improvement. Levels of infection clean requests continues to be high and consequently a concern and further work from clinical teams is required to ensure all cleans are requested at the required level. The audit process has been improved to ensure each room in each area is now audited against the NHS cleaning specifications replacing the sample approach. The audit results are now reported on a monthly basis in line with the requirements.

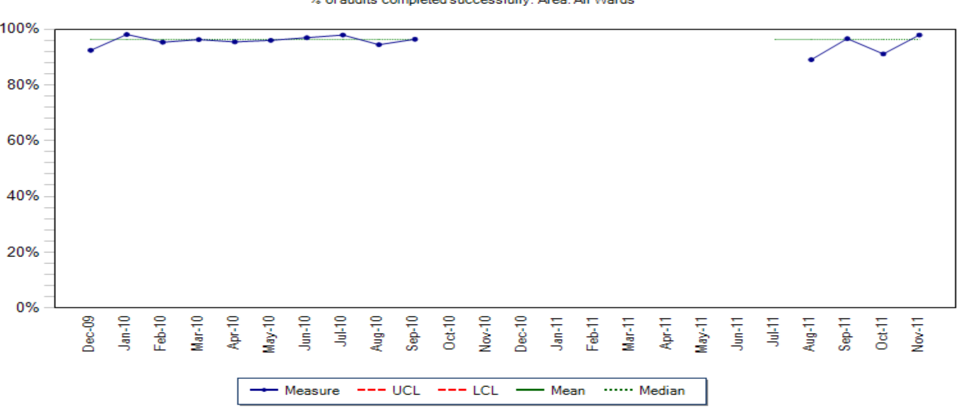
CQC Action Plan

The Action plan following the inspection in June 2011 centered on the required improvement on the recording of the equipment cleans using a tagging mechanism. It has been coordinated between the Facilities and Nursing departments and has specifically focused on mobilising the change in tagging procedure and the associated monitoring. All actions are now complete with the exception ensuring that each designated piece of clinical equipment holds the required tag - this is a pan Trust action and will be completed on 27th November 2011.

Housekeeping Project

Facilities have begun a Housekeeping Project designed to illustrate how the Housekeeping Service could be delivered with reduced impact on Clinical Time. A trial is currently running on CICU, Tiger, Parrot, Rainforest, and Sky with the focus on the management of the service delivered by Facilities with clinical engagement and coordination remaining with the department leads. The trial outcomes and recommendations will be formally presented early next year.

The following cleaning equipment KPI demonstrates steady improvement with equipment cleaning throughout the trust, the HofN and ward teams continue to look at new ways to sustain this area of practice.



Another key success this quarter have been the arrival of 70 new IVAC stands, these were ordered and then distributed into the clinical areas last month which has made a real difference to care delivery and reduction in time wasted looking for a stand.

Visible Nursing and Leadership

The Heads of Nursing and Corporate Nursing Team are piloting this new initiative which occurs one Friday each month so far October and November. All HofN's were in uniform and the Chief Nurse, Deputy and ACN's will eventually be in the same uniform. For the first three months of the pilot the team will focus on three core elements – personlised care and patient experience, care co-ordination and staffing.

The sessions will include a variety of formats which may include
1. Inspection and policing.
2. Observations of the way aspects of care are delivered
3. Engagement with patients, families and staff.
4. Audits
5. Working along side staff in providing patient care.

The days so far have involved observation of an aspect of care on the wards for a morning, followed by a debrief session, shared learning and agreed action. The focus for the first session was observing the five key moments of hand hygiene and the second explored aspects related to privacy and dignity. The mornings have involved observing practice, talking to staff, patients and families on that aspect of care. The assurance so far has been very positive, families expressed confidence in hand hygiene delivered by staff, and parents felt very strongly that their needs around privacy and dignity were very well addressed by ward teams. The feedback so far has been positive but a formal evaluation of the programme will take place after the third day in December and an agreed way forward.

Delivering same sex accommodation
The results of the **October** 2011 quarterly inpatient survey of privacy and dignity for young people demonstrated 7 out 15 felt there preference was met, 5 respondents who wrote a comment rather than a score had been nursed in a cubicle. Again a vast majority would prefer to share with people their own age, rather than single sex accommodation with young children with babies, this was echoed during the visible nursing leadership day looking at areas of privacy and dignity.

Unit Progress Reports
ICI-LM update on CIVAS (Centralized Intravenous Venous Additive Service)
Following the agreed business case wards in ICI-LM have started to receive some of the Phase 1 medicines. This service is having a positive impact on reducing risk and transferring time back to nursing teams for direct patient care by reducing the time spent on the preparation of Intravenous Medication at ward level.

Medicine DTS update on Centralisation of PH Studies
After discussions between Surgery and Medicine it has been agreed that the pH and Impedance studies will be centralised and performed in the Gastrointestinal unit. This will ensure assurance in the reporting of these investigations. The nursing staff will perform the investigations and be reported on by the gastro consultants, the plan is for the nursing staff to be trained by the gastro consultants to down load the results and "clean up" the traces of artefacts so that the consultants can produce the report in a shorter time frame. The patients will be referred to the gastro unit through our booking system, the plan is to go live with the centralisation of the service in February 2012.

Nursing Awards and Achievements
The Practice Education Nursing Team in theatres have been awarded AFPP peri-operative team of the year award for their excellent work on the DOH WHO surgical site safety checklist and its impact on patient safety.

Julie Bayliss Head of Nursing ICI-LM, was awarded WellChild Best Nurse Award for 2011, presented by Prince Harry at a star studded ceremony. Julie was recognized for making tremendous improvements to nursing care for children and their families. Also within ICI-LM, Oncology Advanced Nurse Practitioner Renate Tulloh has been invited to chair two nursing seminars by the Professor of Nursing in Colorado, at the International Society Paediatric Neuro-Oncology Conference in Toronto June 2012 which is a great achievement for nursing.

Recommendation:
To strengthen the Trust Board's nursing quality assurance, we recommend this report quarterly. Each quarter we will seek to highlight specific nursing KPI's and quality initiatives.

<table>
<tr><td colspan="2">Trust Board
30th November 2011</td></tr>
<tr><td>Infection Prevention and Control Update

Submitted on behalf of
Director of Infection Prevention and Control (Dr John Hartley)</td><td>Paper No: Attachment 1</td></tr>
<tr><td colspan="2">Aims / summary
To inform Board of progress with the annual Infection Prevention and Control and Plan and important issues which have arisen in IPC</td></tr>
<tr><td colspan="2">Action required from the meeting
To note areas requiring ongoing action and facilitate progress</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
Essential to achieve zero harm; minimising risk of infection is a central transformation goal</td></tr>
<tr><td colspan="2">Financial implications
Failure to prevent or control infections leads to harm and cost.
Failure to meet CQUIN targets will result in financial penalties.</td></tr>
<tr><td colspan="2">Legal issues
Compliance with the Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance (from 1 April 2010) is a Statutory requirement for registration with the Care Quality Commission</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
On going programme</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
Infection prevention and control is responsibility of all staff.</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Clinical and Corporate Units and all staff
Infection Prevention and Control Team.</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
Director of Infection Prevention and Control</td></tr>
<tr><td colspan="2">Author and date
Dr John Hartley 18/11/2011</td></tr>
</table>

Attachment 1

Regular report from DIPC (Dr John Hartley) to Trust Board November 2011

(Please see Heads of Nursing Report for Unit information)

Infection Prevention and Control (IPC) management arrangements

1. Deidre Malone started as Lead Nurse in IPC started in Feb 2011 and a new Practice Educator post (funded through Transformation) will start in November 2011.
2. Clinical Units and Speciality lines of accountability for IPC and local plans – progress has been made but medical accountability and local plans are still not available for all units. Units will be regularly reporting to Board through nursing structure.

Health care associated infection (HCAI) statistics and prevention programmes

1. **Current HCAI mandatory reporting for financial year 2011/12**

a. **MRSA bacteraemia** (target = zero) – Current number trust apportioned cases this year = 2

b. ***C. difficile* infection** (Target < 10) – current trust apportioned cases = 6.
DH Antimicrobial Resistance and Health Care Associate Infection (ARHAI) committee acknowledge children are different but have not changed target for paediatrics this year.

c. **Methicillin sensitive *S. aureus* (MSSA) bacteraemia** (no national 'target')
Focus has been on reducing MSSA bacteraemia; RCA returns have improved. Data shows reduction year on year
MSSA bacteraemias (divided by time in hospital before onset):

	Q1 2010	Q2 2010	Q3 2010	Q4 2010	Q1 2011	Q2 2011	Q3 2011	Q4 2011 (to Nov 18th)
In for < 48 hours	3	1	4	4	6	0	3	3
In for > 48 hours	4	9	5	6	1	2	2	0

d. **E. coli bacteraemia** (no national 'target')
Reporting began in June 2011. There have been 9 episodes to date.

2. **Surgical site infection prevention and surveillance**

The SSI surveillance team performed baseline surveillance in spinal (From Jan 10), cardiac (from April 10), neuro and craniofacial surgery (from Nov 2010). Data is displayed on the dashboard. The preventative components of the model of care are being integrated into care pathways. Urology continue specialty based surveillance. Reductions of rates have been shown in cardiac surgery:

SSIS Team record of all infections detected (inpatient and post-discharge telephone surveillance)	Cardiac (open and closed heart)
	2010/11 Financial year – 7.8% (46/592)
	2011/12 To 15/11/2011 – 4.4% (15/341)

Additional specialties will be recruited this financial year; with intention to have available data on all specialties by end of next.

3. GOSH acquired Central venous line related blood stream infection.

Ongoing surveillance shows a further reduction in CVL infections, with

Financial year	6/7	7/8	8/9	9/10	10/11	11/12(to Oct 2011)
Rate per 1000 line days	9.9	4.3	3.7	3.3	2.6	2.2

However, this still equates to a projected 90 episodes in 2011/12 (from 249 in 6/7) and continued effort is required in ensuring 100% compliance with the care bundle.

4. Ventilator associated pneumonia

Rates on ITU were shown to be low and systematic surveillance was not undertaken this year.

5. Antibiotic resistant organisms and communicable viral infections in 2011 to date

a. **MRSA** – 10 children possibly/probably acquired in hospital, although all were sporadic episodes. 131 were shown to be colonised when first seen at GOSH. One child acquired carriage and infection.

b. **Multiresistant gram negative (MDR-GN) organisms** (as defined in GOSH admission screening policy) – 165 new children have a first detection of MDR-GN, for 15 this is likely to have been by cross-transmission from other children in the trust in two clusters. This is significantly increased from previous years (124 detections in total, no clusters), reflecting the national situation.

c. Respiratory viruses – 159 children have had a respiratory virus detected, one quarter with onset of illness in hospital. The number is greater than previous years, partly due to improved testing.

d. Enteric viruses – 32 children had confirmed gastrointestinal viral infections with onset in hospital, 30 were admitted with confirmed infection; there are small clusters but mostly case are sporadic reflecting high level in community, intermittent excretion in immunocompromised children. There was a single norovirus outbreak leading to restriction on ward entry.

The ongoing admission of colonised and infected children, and sporadic acquisition while in hospital, reinforces the need for application of standard infection prevention and control precautions by all staff, patients and visitors at all times.

Infection prevention and control regular audits
Regular planned audit cycle continues with the results displayed on dashboard. Results are not consistently 100% in all areas, but show improvement. Local review and action is essential.

Corporate facilities
a. Level 2 and 3 cleaning. A new electronic booking system (CARPS) has been successfully implemented and cleaning requirements are better prioritised.
b. Patient environment coordinators (PECS) have been appointed to improve service provision and respond to environmental issues.
c. A successful mattress replacement programme was undertaken
d. An additional waste stream (offensive waste) is being introduced to reduce disposal costs
e. Need for clear definition of cleaning responsibility and compliance reinforced

Estates
a. Legionella control in tap water. Regular surveillance in all areas has demonstrated ongoing control of legionella risk; additionally detailed surveillance will be needed with the new MSCB.
b. Critical ventilation systems. Further urgent work has been required in clinical areas with specialised ventilation, requiring theatre closure. An external contractor has been appointed to assist in the planned preventative maintenance of critical plant in the future.
c. Extensive building work is taking place through re-development and regular maintenance and upgrade requiring input and monitoring from IPC team.

Occupational Health
Flu vaccine uptake has been excellent this year, with a second order of stock required.

Health and safety
The Trust needs to work on compliance with the Toolkit for implementation of European Directive on prevention from sharps injuries (Council Directive 2010/32/EU) in Member States, by March 31st 2013.

J C Hartley Consultant Microbiologist and DIPC
D Malone Lead Nurse IPC and Deputy DIPC 18/11/2011

Trust Board **30th November 2011**	
Overview of Trust wide Risk Register **Submitted on behalf of** Professor Martin Elliott	**Paper No: Attachment 2**
Aims / summary To provide the Trust Board with an overview of key trends and themes arising from the Trust Risk Register. This includes movement of risk within the risk register and any appropriate links to incidents which have been reported in April 2010 – October 2011.	
Action required from the meeting To review the document and identify whether any further action is required. Act on recommendations as appropriate.	
Contribution to the delivery of NHS / Trust strategies and plans Zero harm strategy	
Financial implications N/A	
Legal issues N/A	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision Assistant Head of QS&T – Risk Management	
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 Leigh Gibson Risk Management Assistant 22/11/11	

Attachment 2

Overview of Trust wide Risk Register
Public Trust Board - November 2011

Summary

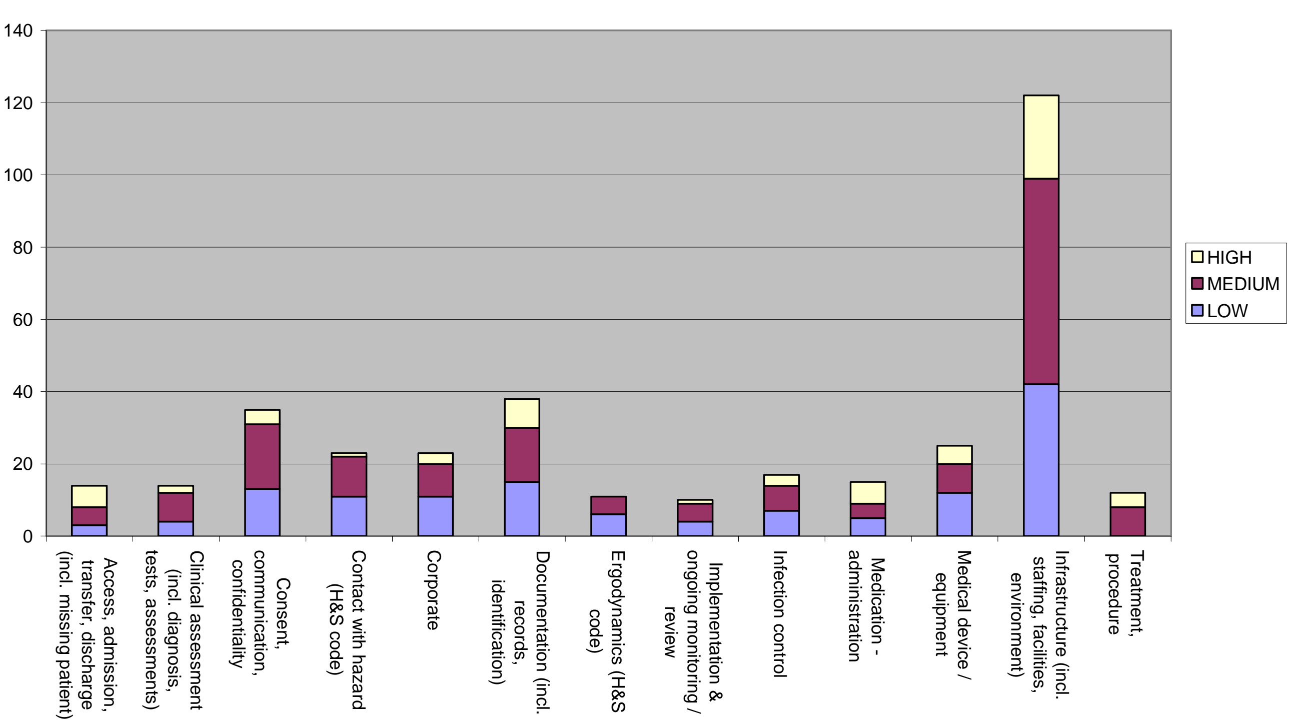
- There are currently 429 risks recorded on the Datix Risk Management System.
- 200 risks have been closed between April 2011 and October 2011
- There have been 135 new risks added between April 2011 and October 2011

	Closed	Open
High	30	32
Medium	69	64
Low	101	69
TOTAL	200	135

The table below shows the number of risks by grade and the movement with risks from April 2011 – October 2011.

Risk Types

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



High Risks

- There are 77 high risks on the Datix system
- There have been 45 new high risks added between April and October 2011. 9 of these have already been reduced to medium and 5 reduced to low.
- 30 high risks have been closed in between April and October 2011 on the basis of controls introduced and actions taken.

Medium Risks

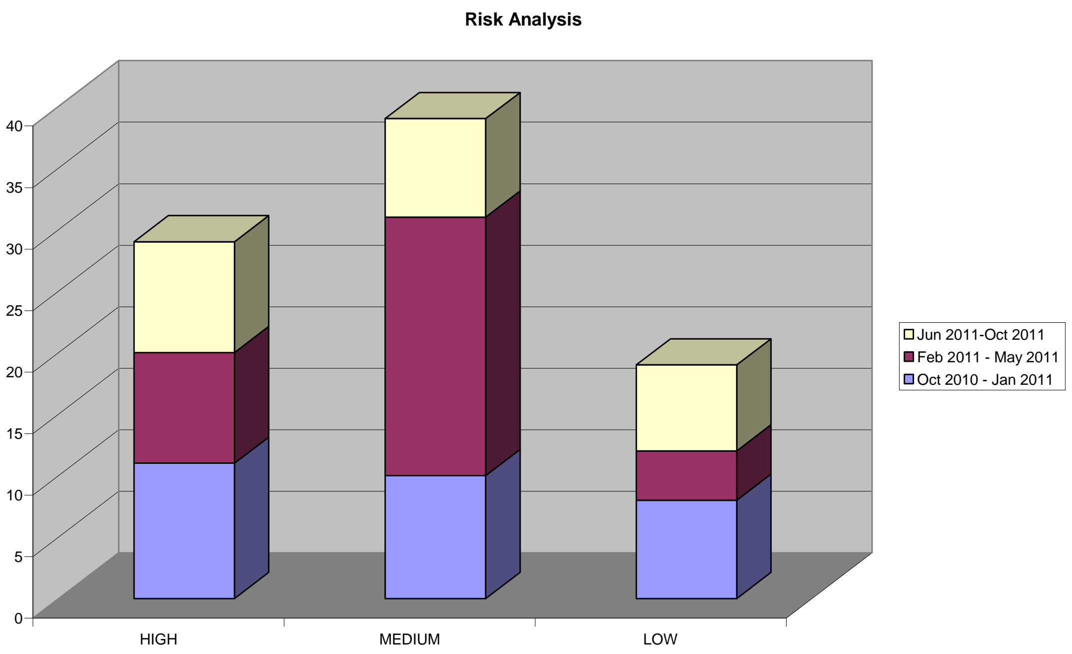
- There are 189 medium risks on the Datix system
- There have been 63 new medium risks added between April and October 2011. 25 of these have been already reduced to low and 2 have been increased to high.
- 69 Medium risks were closed on the basis of controls introduce and actions taken.

Low Risks

- There are 163 low risks on the Datix system
- There have been 57 new low risks added between April and October 2011. 1 of these has been increased to high.
- 101 low risks were closed on the basis of controls introduce and actions taken.

Analysis of Risks

The majority of risks in the Trust fall under the '**Infrastructure**' Category. This includes staffing, facilities and environment. Over the last year, we have continued to see an increase in the total number of infrastructure risks reported. Within that total, we appear to be seeing a decrease in the number of high risks. The rise in the number of medium risks may be attributable to the implementation of controls to manage these previously high risks. The number of low risks also seems to be seeing a slow but steady increase.



121 infrastructure risks were closed between April – October 2011. 22 were high, 52 were medium and 47 were low.

87 new infrastructure risks were opened between April – October 2011. 29 were high, 39 were medium and 19 were low.

During this period there have also been 111 incidents reported by local teams which have also been classified as infrastructure. This represents 6% of incidents processed during that time.

The top types of infrastructure incidents reported:

Failure / delay in collection / delivery systems	16
Staff shortage - nursing	15
Inadequate check on equipment / supplies	21

7 of the infrastructure incidents have been graded locally as being of high risk
Key themes include:

- Use/availability of Electronic Prescribing
- Inadequate checks on Emergency Trolley

Documentation

13 documentation risks have been closed and removed from the register and 9 new risks have been added between April – October 2011.

9 new documentation risks were opened between April – October 2011. 2 were high, and 5 were medium.

There were 127 incidents reported by the Trust between in for this period. This represents 6% of incidents processed during that time.

The top types of documentation incidents reported:

Documentation - delay in obtaining healthcare record / card	16
Documentation - misfiled	13
Documentation - missing/inadequate healthcare record/card	23
Patient incorrectly identified / not identified	13

1 of these have been risk assessed locally as being high risk.
Key themes include:

- Lack of documentation
- Loose filing

Consent, Communication and Confidentiality

12 Consent, Communication and Confidentiality risks have been closed and removed from the register and 9 new risks have been added between April – October 2011.

15 new Consent, Communication and Confidentiality risks have been opened between April – October 2011.

There were 158 incidents reported by local teams which have also been classified as Consent, Communication and Confidentiality. This represents 8% of incidents processed during that time.

The top types of incidents reported:

Communication failure - outside of team	26
Communication failure - with patient / parent / carer	20
Communication failure - within team	40
Breach of patient confidentiality	13

4 of these incidents were graded as high risk.

The key themes include:

- Incorrect information provided for procedure booking
- Patient confidentiality breach of 7 patient's details sent to family with request for medical records due to misfiling.

Effectiveness of controls to manage risks on Trust Wide Register

One of the ways in which the Trust can assess the effectiveness of the controls currently in place to manage the risks on the Trust Wide Risk Register is through review and analysis of reported incidents, complaints and informal concerns. Incidents, complaints or informal concerns in which patients have suffered significant harm or had a significant impact on their experience at the Trust may be seen as indications that the controls are not working effectively or are not sufficiently robust to prevent the incident. It will not be possible to eradicate all risks in the Trust, but it is important to ensure that our controls are adequate in the circumstances.

1984 incidents have been processed in the Trust between April and October 2011. There are currently 10 SI's open in the Trust. These all relate to significant incidents in which patients

- have suffered significant harm
- there has been a significant near miss
- there has been a significant impact on the patient's experience of the Trust.

Key issues that these identified:

- Difficulties with communication between specialities
- Receiving relevant information from external referrals
- Following procedures as required by the Trust
- Documentation and filing of records

Leigh Gibson
Risk Management Assistant
22nd November 2011

Great Ormond Street Hospital for Children
NHS Trust
NHS

<table>
<tr><td colspan="2">Trust Board
30th November 2011</td></tr>
<tr><td>UCLP research activities update

Submitted on behalf of

Professor David Goldblatt, Director of Research and Innovation</td><td>Paper No: Attachment 3</td></tr>
<tr><td colspan="2">Aims / summary
To provide a summary of recent research activity including UCLP and an update on plans for using the Computer Centre.</td></tr>
<tr><td colspan="2">Action required from the meeting

For information and discussion.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans

With partners maintain and develop our position as the UK's top children's research organisation.</td></tr>
<tr><td colspan="2">Financial implications
N/A</td></tr>
<tr><td colspan="2">Legal issues
N/A</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?

N/A</td></tr>
<tr><td colspan="2">Who needs to be told about any decision

N/A</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales

Prof David Goldblatt and Lorna Gibson</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project

Prof David Goldblatt and Lorna Gibson</td></tr>
<tr><td colspan="2">Author and date

Lorna Gibson – 21/11/2011</td></tr>
</table>

Division of Research and Innovation

**Division of Research and Innovation Report to Trust Board – UCLP and research update
November 2011**

UCLP

- The UCLPartners second Child Health Symposium on "Improving the Management of Chronic Conditions in Childhood" was held on the 17th October. The event included academic sessions presented by Prof Peter Hindmarsh, Dr Deborah Christie, Dr Caro Minasian and Prof Russell Viner. The key note address was from UCLP Managing Director, David Fish, entitled "UCLPartners; from Academic Health Science Centre to Academic Health Science System".
- R&D activities within UCLP are being taken forward via a new committee of senior managers within the current UCLP Trusts to discuss topics such as improving project approval times, cross-Trust R&D sign off mechanisms, and delivery of other key NIHR initiatives.

Computer Centre

- Functional content of the Computer Centre is crystallising around a rare disease initiative to reflect the GOSH/ICH research strategy with a focus on development of diagnostics, particularly molecular diagnostics and the development of novel therapies including gene, stem and cellular therapies.
- Arrangements are in place for a workshop to be held on 5th December 2011, chaired by John Kelly (from Harris Health Strategy) to include discussion groups on topics such a constraints, and interaction with clinical units.

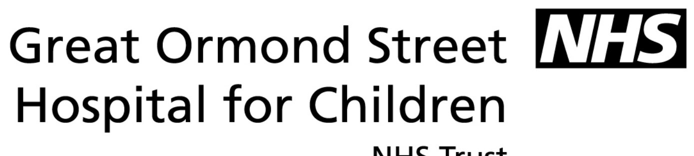
BRC update

- We have successfully been awarded funding for 2012-7 for £36 million which includes the addition of a new theme (Diagnostics and Imaging). The UCL Vice-Provost for Health, Prof Sir John Tooke, is to have oversight of the finance and governance for our new BRC award. Arrangements for Terms of Reference for our existing BRC Board and new Strategic Advisory Board, and review of the current BRC's financial management, are now being taken forward.
- We are contributing with Moorfields and UCH BRCs with a pilot Public Patient Involvement event which is being hosted by the Macmillian Cancer Support in early December.
- We are also organising a "GOSH/ICH BRC Young Scientist Seminar" day with over 100 children from local schools to attend.

Joint R&D Office update

- With the exception of a BRC Manager's post (currently at advertisement), the staffing of the Joint R&D Office is now complete; teams specialize in research governance, clinical trials, industrial collaborations, costings and contracts, data management, and research facilitation (of the pre-award processes).
- The Division of R&I roadshow will be hosting 3 sessions whereby the Joint R&D Office, BRC, CRF, and MRCN teams will be available to outline current arrangements for research, and provide an opportunity for GOSH/ICH colleagues to meet the new team. These are being held on Monday 5th December 5th (1-5pm) in the conference room of York House, Tuesday 6th December (1-5pm) in the Somers Clinical Research Facility Meeting Room, and Wednesday 7th December (9-12.30pm) in the Phillip Ullman Wing,
- Arrangements are also in place for Divisional workshops for GOSH colleagues to take place in January to outline research processes and provide assistance with topics such as applying for research funding, setting up clinical trials, liaising with industry, the research governance processes, how to use the Clinical Research Facility, etc.
- Arrangements are in place for Good Clinical Practice training to be undertaken in-house (which is a legislative requirement for those working on Clinical Trials of Investigational Medical Products and recommended for all those undertaking clinical research within the Trust).
- Discussions are taking place with the UCL's Clinical Trials Unit with regards to facilitating collaboration with the Division of R&I.

Prof David Goldblatt & Lorna Gibson – 21st November 2011



Trust Board 30th November 2011
Redevelopment Report

1.0 Phase 2A New Clinical Building

1.1 Contract Details

- The Form of Contract is JCT 2005 Design and Build
- The contract period is agreed at 159 calendar weeks (including Advance Works)
- Commencement date (subsuming Advance Works) was 24th November 2008
- The revised Completion Date is 20th December 2011
- The current anticipated Completion forecast as 12th December 2011
- Planned building occupation by GOSH is Easter 2012
- The contract sum is £88,500,000

1.2 Summary

- The total extension of time granted to date is now 8 working days , all in respect of exceptionally inclement weather over the last three winters

- There have been no further requests for an extension of time

- At the Contractors progress meeting on 11th October 2011, BAM Construction assessed their progress as being three weeks in delay against their original contract construction programme (i.e. excluding the 8 days Extension of Time awarded to date) which is a recovery of one week from the position reported in September 2011

- BAM Construction continue to report that they are still planning to complete on the original contract Completion date (12th December 2011), although the revised Completion date is now 22nd December 2011

- BAM continue to monitor the critical path activities on the target recovery programme and any activity which is within two weeks of becoming critical. The critical path activities are currently the M&E commissioning and the completion of the level 2 restaurant fit out

- It should be noted that the target critical path programme still contains three weeks of float at the end of the critical path programme as Contractor Contingency on the main building but no float on the level 2 restaurant fit out

- 163 Employers Agent Instructions have been issued to date, 1 of which has been issued since the July 2011 report

- Of the 163 Employers Agent Instructions issued, 108 have been issued as a result of a Change to the Client Brief , the remainder consist of Provisional Sums (14no), unforeseen site conditions (16 no) and contractors alternative proposals resulting in costs savings

- Of the 163 Employers Agent Instructions issued, 122 no are anticipated to result in additional costs , the remainder are savings or nil cost

- The current anticipated Final Account is still estimated to be well within the approved contingency allowances.

1.3 Principal Outstanding Risks (and actions to mitigate)

- We have received no further technical information relating to the Disney ‘juke box’ installation and have had to make ‘informed guesses’ to Disney’s requirements to avoid delaying the contractor (The Charity have been advised and have been asked to pursue Disney)

- The sedum roof does not meet our expectations of a ‘green roof’ (We have deducted payment for this element of the work. We have now received via BAM a proposal from a sedum roof maintenance contractor to replace the sedum roof. This is currently being assessed)

- There is noticeable humming sound on the upper clinical floors when the stand by generators and the CCHP generator is running , despite these items of plant being constructed on a floating concrete slab and having vibration mounts (BAM have received an initial report from WSP acoustic and are awaiting a further report from independent specialists. The problem has been identified as vibration borne. We are awaiting the Contractors proposals for further acoustic isolation)

- Late delivery of the level 4,5,6,7 link building reception desks caused by late change of design instructed on EAI. (We have agreed with BAM that this item would not constitute a reason to delay the issue of the Completion Certificate - they are effectively a group 3 furniture item)

- Satisfactory completion of M&E commissioning (Currently on programme in accordance with the BAM recovery programme and needs to be monitored on a weekly basis)

2.0 Phase 2B

Introduction

The Outline Business Case for both of these works was approved in December 2006 and reported to the Special Trustees in January 2007. The Special Trustees further approved the continuation and development of the Phase 2B design and Business case at their meeting on 20th October 2010. Due to delays in the design development for the Enabling Works and the intention to submit the FBC when the Trust is a fully constituted Foundation Trust, the programme dates have changed with regard to the FBC submissions (but not for the construction programmes).

Phase 2B Programme

The design have delivered the scheme design (plus) report in accordance with the original programme FBC submission date of September 2011

GTMS have developed a master programme for Phase 2B. There are ongoing discussions with GOSH Estates regarding the timing and scope of Phase 2B decants and Phase 2B M&E enabling works

The scope of the M&E enabling works has now been agreed and GTMS have issued a draft programme which links all the 'decant and enabling' works with Phase 2B main works.

There are now monthly meetings to monitor these programmes.

Programme Key Dates

Draft Scheme Design report	issued June 2011
Final Scheme Design to complete , including costs , for FBC	September 2011
GOSH final comments required	October 2011
FBC drafting to commence	January 2011
Submit Phase 2B FBC to Trust Board	January 2012
Submit Phase 2B FBC to Monitor	January 2012
FBC approval deadline	May 2012
Enabling works programme commence	August 2011
Enabling works programme complete	June 2013
Demolition and Rebuild of Phase 2B commence	August 2013
Demolition and Rebuild of Phase 2B complete occupation	August 2016
Earliest delivery of MRI 3T (pre-Phase 2B)	November 2012

Phase 2B Advance Works

Works	June to December 2012

The clinical planning brief is now completed with the exception of level 1 (south west new build extension).

The remainder of level 1 remains as the current occupied areas of imaging (MRI and CT) to the south of the hospital street and nuclear medicine to the north of the hospital street

A more detailed Client Brief potentially changing the occupation at level 2 from an ambulatory care ward to a 10 bed cystic fibrosis ward north of the Hospital Street and a 14 bed respiratory ward south of the hospital street was issued on 4th August 2011 to enable the design team to commence feasibility studies in August 2011. A first draft of potential layouts will be issued by the end of August and further discussions will take place relating to this potential change in September 2011

The design team are also undertaking further studies in respect of the complex supply and extract ventilation that would be necessary if the level 1 theatre co-joined to the MRI 3T suite is confirmed as a further change to the brief

The 1:200 layouts at all levels (2 to 7 inclusive) have all been through reviews with the clinical planners and the end users and have all now been signed off

The design team issued the draft Scheme Design report to GOSH Estates, GOSH Clinical Planning and GTMS (based on the original ambulatory care Client Brief at level 2) on 30 June 2011.

A series of review meetings has taken place during July and August to consider architecture, clinical planning, structural engineering and M&E services and the final draft of the Scheme Design report will be issued in early September 2011

Scheme design at level 1 (new build) is currently ‘on hold’ awaiting confirmation from GOSH whether the co-joined theatre forms part of the revised Client Brief .

Risks

The Trust have partially commented on the first draft of Phase 2B Client Brief issues which has been amended and issued to the design team

However, a number of GOSH response are urgently required before the Client Brief is concluded

This information is critical to the start of detail design in September 2011

Further meetings have taken place with the Trust to conclude the Client Briefing documents to test for their validity (or amendments) for Phase 2B , These will be issued by mid September 2011

Phase 2B Risk Register

The key risks which require further action are

* confirmation of the Client Brief at levels 1 and 2
* Phase 2B demolition
* Phase 2B new build over existing occupants
* air quality / supply & extract ventilation solutions

These will be the focus of attention in the next few months

DCP 2010 / Phase 3 Schemes

The Phase 2B design team has completed a review of the 2010 Development Control Plan for the whole site and taking into account the purchase of the University of London Computer Centre at 20, Guilford Street.

This report was submitted to the November Trust Board, the January Trust Board and the Executive away day meeting on 2nd February 2011 and recommends the way forward for site development in the long term (10-20 years) and GOSH Redevelopment

Phase 3 development and investment in the short term (2-10 years)

GOSH / ICH are currently reviewing the occupancy requirements of the ULCC site and a workshop with GOSH/ICH staff will be held in December 2011

3. 0 Cardiac Wing Level 6&7 Report

Birth Defects Centre

The Project Status report at 08 August 2011 showed the project continuing to run to time and within identified budgets.

ICH Guildford Street works: noise and vibration parameters have been agreed with UCL/ICH and the Home Office and are now included in the Contract Conditions issued for Tender to the 5 short-listed Contractors on 24 January 2011 Keir have been selected as the preferred contractor , contracts signed on 19th July 2011. Strip out has commenced and is on programme . A number of discovery items have been found during demolition , these are being managed from the project contingency.

Wolfson site development: the Contractor appointed for the project –including the enhanced works- is Peak Construction who took possession of the site 10 January 2011. The programme date achieved completion on 15th July 2011.

Portex Offices and GOS Relocations: These are part of the enabling works sequence for Phase 2B, the programme for which has now been confirmed. The location for Portex Offices has been established as Southwood L 4C and GOSH P21+ team are actively progressing the design

Risk summary,

The risks around stoppages and unachievable noise constraints on 30 Guildford St are rated as red –the latter being potentially mitigated by identifying a cost for contract termination, the works are currently 90% completed in this area with no cost issues having been raised.. Other Guildford St risks remain amber. Enhanced Scheme related to funding are now rated green

William McGill
Director of Redevelopment
30th November 2011

Trust Board **30th November 2011**	
Redevelopment Update **Submitted on behalf of Redevelopment Directorate**	**Paper No: Attachment 4**
Aims / summary The purpose of this report is to update the Board on the progress of our Redevelopment Programme	
Action required from the meeting This paper is an update for information.	
Contribution to the delivery of NHS / Trust strategies and plans The Redevelopment Programme is a Key Deliverable as part of our objective to provide the best equipment, technology and buildings to deliver care	
Financial implications The financial implications are included in the Business Case Documents	
Legal issues There are no legal issues	
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 The Special Trustees, Trust Executive Team, and the Redevelopment Committee	
Who is responsible for implementing the proposals / project and anticipated timescales GOSH Redevelopment Board.	
Who is accountable for the implementation of the proposal / project Director of Redevelopment	
Author and date William McGill Director of Redevelopment 30th November 2011	

Trust Board Meeting **30th November 2011**	
Register of Seals **Submitted on behalf of: Jane Collins, Chief Executive**	**Paper No: ATTACHMENT 5**
Aims / summary Under Standing Order 8.3, the Chief Executive is required to keep a register of the sealing of documents. The attached table details those seals affixed and authorised between 12th October 2011 and 23rd November 2011.	
Action required from the meeting To endorse the application of the common seal and executive signatures.	
Contribution to the delivery of NHS / Trust strategies and plans N/A	
Financial implications N/A	
Legal issues To ensure the Trust complies with its standing orders.	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision N/A	
Who is responsible for implementing the proposals / project and anticipated timescales N/A	
Who is accountable for the implementation of the proposal / project N/A	
Author and date Anna Ferrant Company Secretary November 2011	

Attachment 5

Great Ormond Street Hospital for Children NHS Trust

Register of use of Seal from 12th October 2011 – 23rd November 2011

Date	Description	Signed
12/10/11	Great Ormond Street Hospital NHS Trust and Gardiner and Theobald LLP – deed of appointment of Construction Design and Management (CDM) Coordinator	Jane Collins Claire Newton
12/10/11	Great Ormond Street Hospital NHS Trust and Great Ormond Street Hospital Children's Charity – York House Umbrella Agreement (minor works where Charity is employer)	Jane Collins Claire Newton
25/10/11	Great Ormond Street Hospital NHS Trust and Norland Managed Services Limited for the provision of building and engineering facilities operation and maintenance services at Great Ormond Street Hospital NHS Trust	Jane Collins Claire Newton
23/11/11	Form of Scheme Proposal – scheme of contract – phase 3 between Great Ormond Street Hospital NHS Trust and Balfour Beatty Group Ltd for Theatre Staff Change Facilities	Jane Collins Claire Newton
23/11/11	Form of Scheme Proposal – scheme of contract – phase 4 between Great Ormond Street Hospital NHS Trust and Balfour Beatty Group Ltd for Theatre Staff Change Facilities	Jane Collins Claire Newton
23/11/11	Form of Scheme Proposal - P21+GOSH Multiple Projects Scheme Contract– GOSH 2b Enabling and Annual Programme of Minor Works 2011-2014 between Great Ormond Street Hospital NHS Trust and Balfour Beatty Group Ltd – executed as a deed (no seal)	Jane Collins Claire Newton
23/11/11	Form of Scheme Proposal – scheme of contract – phase 3 between Great Ormond Street Hospital NHS Trust and Balfour Beatty Group Ltd for VCB Hospital Street Works Level 1-6	Jane Collins Claire Newton
23/11/11	Form of Scheme Proposal – scheme of contract – phase 4 between Great Ormond Street Hospital NHS Trust and Balfour Beatty Group Ltd for VCB Hospital Street Works Level 1-6	Jane Collins Claire Newton

Great Ormond Street Hospital for Children NHS Trust NHS

<table>
<tr><td colspan="2" align="center">Trust Board
30th November 2011</td></tr>
<tr><td>Annual Audit Letter for year ended 31 March 2011

Submitted on behalf of:
Claire Newton, Chief Finance Officer</td><td>Paper No: Attachment 6</td></tr>
<tr><td colspan="2">Aims / summary
To summarise the key issues arising from audit of the year ended 31 March 2011.</td></tr>
<tr><td colspan="2">Action required from the meeting
For information.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
N/A</td></tr>
<tr><td colspan="2">Financial implications
N/A</td></tr>
<tr><td colspan="2">Legal issues
N/A</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
N/A</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
N/A</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
N/A</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
N/A</td></tr>
<tr><td colspan="2">Author and date
Deloitte LLP,
October 2011</td></tr>
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Great Ormond Street Hospital for Children NHS Trust

Trust Board 30th November 2011	
UCL Partners Board Minutes and Update **Submitted on behalf of** Dr Jane Collins, Chief Executive	**Paper No: Attachment 7**
Aims / summary To provide Trust Board with an update on the work of UCL Partners.	
Action required from the meeting To note the UCL Partners September Board Minutes and the October Update.	
Contribution to the delivery of NHS / Trust strategies and plans All strategic objectives.	
Financial implications N/A	
Legal issues N/A	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision N/A	
Who is responsible for implementing the proposals / project and anticipated timescales N/A	
Who is accountable for the implementation of the proposal / project N/A	
Author and date Anna Ferrant Company Secretary November 2011	

UCL PARTNERS

MINUTES OF THE BOARD MEETING HELD ON 26th September 2011

Present
Sir Cyril Chantler (Chair)
Dr Jane Collins
Dominic Dodd
Professor David Fish
Professor Chris Fowler
Professor Malcolm Grant
Rudy Markham
Richard Murley
Sir Robert Naylor
Professor Sir John Tooke

In attendance
Lord Kakkar
Ed Lavelle
Andrew Whalley

1. **The Chairman welcomed members to the meeting.** Apologies for absence were received from Tessa Blackstone, Ruth Carnall, Paula Kahn, John Pelly and David Sloman.

2. **Minutes of the meeting held on 25th July 2011** were agreed as a correct record.

3. **Matters arising from the minutes.**
NOTED that a seminar will be held on 21st November 2011 to discuss progress on UCL Partners' programmes. All members, executive partners, founding partners and Programme Directors will be invited to attend. The key address – on 'the Spread of Innovation' - will be delivered by Dr Amanda Bagley.

4. **Managing Director's Report**

4.1 Items from the September Executive meeting
NOTED good progress in the development of *Cancer London*, with positive engagement and endorsement from all oncology units. NOTED that *the Crescent* network was still awaiting designation. Also NOTED that *the Crescent* appeared likely to align its activities with the Francis Crick Institute and it is important we continue to support the development of cancer R&D and continue to enhance our own links to the Crick.

UCLP needed to consider its own position in the context of cancer academic leadership across London. DF and JT have discussed with Chris Boshoff and will have a further meeting now there is greater clarity on the system and associated population platform.

NOTED that the successful bid for London Cancer had assumed that QMUL-BLT will join UCLP to co-create an enlarged AHSS for patient and population health gain. In that context, important

discussions had been taking place between UCLP and QMUL-BLT, with good engagement and progress across all our institutions.

NOTED that the Proton Beam Therapy initiative is likely to be announced shortly. This may present an opportunity for UCLP to launch a further communications strategy in respect of cancer.

AGREED JT, DF and RN to take this forward, developing a coherent cancer communications message.

ACTION JT, DF & RN

4.2. David Nicholson Innovation Review

NOTED that the full report was due later this year. The report would likely express interest in expanding the AHSS model. NOTED that AHSSs at Cambridge, KCL and UCL have been invited to write a paper on the AHSS model to feed into the Review. NOTED also that the Shelford Group (ten CEOs of the largest UK teaching hospitals) has advocated for some time the benefits of AHSCs and is beginning to influence public policy on this issue.

NOTED the current five AHSCs act as powerhouses to further enable the translation of biomedical research into population health gain. The Board AGREED that top class biomedical research and its scientific bedrock are an essential pre-requisite to the population health benefits that the AHSS model helps to promote and the two fed off each other as a virtuous circle.

4.3. Consolidation of corporate and clinical support

NOTED by EL that some partners had been slow initiating the workstreams that form this programme, but are now ready to move forward with some urgency.

AGREED to report to November Board detail of progress.

ACTION: EL to report progress to November Board

4.4 Relocation to 170 Tottenham Court Road

NOTED that this was agreed and detailed planning is underway, with UCLP currently awaiting the resolution by Camden Council of some minor planning issues. The Camden officer was due to visit on 3rd October 2011.

4.5 Cardiovascular activities

NOTED that Ruth Carnall had indicated her support for the proposed reconfiguration of vascular services in NCL and also their alignment with wider opportunities for cardiac surgery.

4.6 Technology Innovation Centre

NOTED that the bid had been submitted and the outcome was expected in November 2011.

4.7 Health impact of 2012 Olympics and Paralympics

NOTED UCLP had been successful in its tender to assess the health impact of next year's Olympic games.

4.8 An enlarged AHSS to include as Founding Partners QMUL and BLT

NOTED there was unanimous strong support for the proposed expansion of UCL Partners by the four organisations that have to date met to consider the issue. GOSH Board was due to meet on Wednesday 28th September to consider the issue; a resoundingly positive endorsement was expected.

REPORTED by CF that BLT was very supportive of the proposal. So too was QMUL, though the latter had not had the necessary Council meeting at that point. Overall, CF was very optimistic that both organisations would confirm their wish to join.

MG REPORTED that he had met with the Principal of QMUL that morning and confirmed both his optimism that the QMUL Council would endorse the proposal, and Professor Gaskell's personal commitment to the expansion. It would nonetheless be helpful to communicate the positive messages of support from each of UCLP's five current partners.

EL REPORTED on a range of detailed issues relating to the proposed expansion, as set out in annexes 1-4 of the agenda. The Board endorsed the contents of the annexes as a blueprint for progressing the expansion.

Annex 2 proposed a review process for UCLP Programme Directors that would affect about half of the 11 current PDs in the next year. This review process would allow expression of a stronger focus for UCLP and would facilitate early leadership in some areas by QMUL-BLT staff through a clear and transparent process. NOTED that the current PDs had seen and agreed the proposals contained in annex 2. NOTED that the Cancer Programme Directorship (Chief Medical Officer) was being advertised presently.

NOTED annex 3 set out how UCLP might change from a new to a mature organisation without compromising its overarching mission. The annex focused on governance issues, especially the roles of the Board and the Executive.

NOTED that annex 4 was essentially an action plan for annex 3. The Board CONSIDERED whether a year was needed in order to construct an effective business plan, or whether that might be achieved more quickly. Other comments included the need to highlight the importance of education, which would likely be a major source of future strategic focus and income; also the need to focus more on the partnership's global competitiveness. Also, the business case needed to reflect what happens to areas of low priority – strategy is expressed as much by disinvestment as by investment.

AGREED to shorten the business planning process and to complete the high level strategy as soon as reasonable – probably phase 1 by December 2011 and Phase 2 by the Spring of 2012. Also AGREED that changes in governance needed to follow the business plan, not to precede it.

ACTION: DF to lead high level vision and strategic planning process as soon as possible. Changes to governance structure should be guided by the outcome of that process.

EL REPORTED that the legal reviews by QMUL and BLT of existing UCLP governance documents has been useful. Some short-term minor changes to the Memorandum of Agreement and Articles of Association would likely be needed.

The Board AGREED to grant CC and DF the authority to progress the expansion and to sign any documentation necessary to achieve that aim.

4.9 BACS payment

The Board AGREED with the proposal to establish BACS functionality in order to streamline UCLP's payment of salaries and invoices.

5. The next meeting will take place on Monday 28th November 2011 at 4pm, venue to be confirmed.

UPDATE: October 2011

2011 has seen a step change in the pace and scale of our activities with progressive expansion of the partnership – and in October the joining with both Queen Mary, University London (QMUL) and Barts and The London NHST to help us all collectively create a single Academic Health Science System supporting a local population in excess of 3m people with clear national/international relevance. This was celebrated through an official launch at Westminster during which we talked through the breadth of our activities and our shared aspiration for patient and population health gain with the Secretary of State for Health (**http://tinyurl.com/3lu7wp9**). This re-iterated the essence of our partnership – patient led, population focused, working across boundaries and harnessing the breadth of academia beyond biomedicine to support the spread of innovation. It also highlighted our drive to maximise value (outcomes that matter to patients per pound spent), and wealth creation for London and nationally through the strong biomedical research base working in tandem with the major clinical platforms of the AHSS and better support to develop successful industrial partnerships.

Stroke has been an early exemplar for UCLPartners' quality focus, with whole pathway metrics that span from prevention through to rehabilitation –agreed with patients and clinicians and being delivered across NCL and NEL. Additionally, in October we completed the health economics evaluation of the pan London changes to stroke care. Preliminary findings highlight substantial reduced mortality, acute costs constrained within the previous funding envelope due to shorter length of stay, and the long term benefits of reduced morbidity.

The partnership wide "Quality Forum" continues to focus on earlier diagnosis and better care for the deteriorating patient - with a goal to reduce by 50% cardiac arrests occurring in hospital wards. This is a vibrant sharing/learning community across the partners many of whom already demonstrate some of the lowest in-hospital mortality figures nationally (Partner Trusts show 4 of the lowest 5 mortality rates. Particular congratulations to The Whittington who were the lowest nationally).

Following the creation of a single AHSS across NEL and NCL we intend to develop a single proposal as lead provider of postgraduate medical education. This is in line with the NHS London plan towards 3 sectors for workforce development instead of the traditional 5, and will allow us to provide much greater depth of experience and delivery of innovative programmes for trainees. At the same time we are exploring how to create similarly progressive postgraduate training schemes for nurses, midwifes and other professions that can "fast-track" and support the most talented newly qualified staff to become future leaders – building multi-professional training schedules from the outset around the teams that deliver patient pathways.

Our next biannual workshop on the afternoon of Nov 21st will focus on how we can achieve earlier diagnosis using examples from cancer, cardiac, stroke and COPD, how we can systematically enhance the spread of innovation using the learning from our simulation studies, and build on existing synergies to co-create the strategy that will maximise patent and population gain from the enlarged AHSS (agenda and registration at http://www.uclpartners.com/events/uclpartners-ahss-seminar/