Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
Friday 24th May 2013

Dear Members

There will be a public meeting of the Trust Board on Friday 24th May 2013 at 2:15pm in the **Conference Room, York House,** Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment
1.	**Apologies for absence**	Chairman	
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 24th April 2013**	Chairman	**D**
3.	**Matters Arising/ Action Checklist**	Chairman	**E**
4.	**Chief Executive Report**	Chief Executive	**Verbal**
	STRATEGIC ISSUES		
5.	**Electronic Document and Record Management System (EDRMS) Business Case**	Co-Medical Director	**F**
	PERFORMANCE ISSUES		
6.	**Summary of performance for the period:** • **Targets and indicators including update on workstreams for quarter 4 2012/13** • **Finance and Activity** • **Quality and Safety**	Chief Executive Acting Chief Operating Officer Chief Finance Officer Co-Medical Director	**G**
	GOVERNANCE		
7.	**Compliance with Monitor's Code of Governance**	Company Secretary	**H**
8.	**Corporate Governance Statement**	Chief Finance Officer	**I**
9.	**Annual Risk Report 2012-13**	Co-Medical Director	**J**
10.	**Safeguarding Annual Report 2012-13**	Chief Nurse and Families' Champion	**K**

11.	**CQC Compliance Update**	Company Secretary	**L**
12.	**Update on local action planning in response to 2012 national Staff Survey**	Director of Human Resources and OD	**M**
13.	**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.)		
14.	**Next meeting** The next Trust Board meeting will be held on Wednesday 24th July 2013 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT D

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes template of the meeting of Trust Board held on 24th April 2013

Present

Baroness Tessa Blackstone	Chairman
Mr Jan Filochowski	Chief Executive
Ms Mary MacLeod	Non-Executive Director
Ms Yvonne Brown	Non-Executive Director
Mr David Lomas	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Mr John Ripley	Non-Executive Director
Dr Barbara Buckley	Co-Medical Director
Professor Martin Elliott	Co-Medical Director
Mrs Liz Morgan	Chief Nurse and Director of Education
Mrs Claire Newton	Chief Finance Officer
Mr Ali Mohammed	Director of Human Resources and OD

In attendance

Dr Anna Ferrant	Company Secretary
Mr Trevor Clarke*	Director of International Patients
Mr Matthew Tulley	Director of Redevelopment
Ms Carla Hobart	Acting Deputy Chief Operating Officer
Ms Judith Cope*	Chief Pharmacist
Mr John Hartley*	Director of Infection, Prevention and Control
Ms Lesley Miles*	Director of Communications
Mrs Chucks Golding	Interim Trust Board Administrator (Minutes)

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

1.	**Apologies for absence**
1.1	Apologies were received from by Mr Charles Tilley, Non-Executive Director; Professor Rosalind Smyth, Non-Executive Director and Mr Robert Burns, Acting Chief Operating Officer.
2.	**Declarations of interest**
2.1	No declarations of interest were received.
3.	**Minutes of the meeting held on 27th March 2013**
3.1	The minutes were approved as an accurate record of the meeting.
4.	**Matters arising and action checklist**
4.1	Minute 682.3 – The Chairman noted the action and highlighted that it would be discussed later in the meeting under agenda Item 8.

5.	**Chief Executive Report**
5.1	Mr Jan Filochowski, Chief Executive stated that there were significant difficulties with the ICT service provision for the hospital over the last few days, however the situation had been resolved.
5.2	Mr Filochowski referred to the commencement (from 1st April 2013) of the new NHS commissioning structure. The first meeting with Dr Anne Rainsberry, Regional Director (London) of NHS England had been productive and she had explained the ways of working and the arrangements for GOSH.
5.3	Mr Filochowski stated that the review of Board governance and performance management is underway. He provided an update on the Wayfinding project. Mrs Liz Morgan, Chief Nurse and Director of Education highlighted that this issue was being discussed at the Members' Council which had noted the problems some parents were having finding their way around the hospital. Mr Filochowski said a small group was looking at how improvements can be made. Mrs Morgan stated that volunteers are now more focused in assisting the public to find their way during this period of refurbishment. Mr Filochowski was grateful for the input received from the Members' Council.
5.4	Mr Filochowski informed the Board that two events had been held since the last meeting. A British Medical Association (BMA) "Science in Improvement" conference and a Institute for Healthcare Improvement (IHI) forum on "Quality & Safety in Healthcare - Experience Day" at GOSH on 16th April 2013. Mr Jeremy Hunt, Secretary of State for Health spoke at the BMA conference which was attended by both national and international delegates, where he highly commended the work performed by GOSH.
5.5	The Board noted the verbal report.
6.	**Clinical Speciality Presentation – Pharmacy**
6.1	Ms Judith Cope, Chief Pharmacist, presented the report. Ms Cope highlighted the challenges of prescribing and preparing medicines for children. Ms Cope confirmed that it is critical for communication between local hospitals and GPs and with patients and families to be made clear and simple.
6.2	Ms Cope informed the Board that the Trust spends about £35million on medicines a year and 60% of these medicines are provided via a homecare service. The service prevented children from having to travel to GOSH. About £20 million of these medicines are accounted for as pass through in the accounts.
6.3	Professor Martin Elliott, Co-Medical Director, asked if there was any financial benefit for GOSH in the preparation of these medicines, even if it is minimal. Mrs Newton confirmed that there was no financial gain for GOSH in the preparation of these expensive medicines. Mr Filochowski asked if GOSH produced TPN for use externally to the hospital. Ms Cope stated that GOSH did not due to the fact that the Trust has a high demand for inpatients requiring TPN . A business case was being written to develop a model for production of drugs at GOSH in partnership with other Trusts.
6.4	Ms Cope highlighted GOSH's partnership with the School of Pharmacy and the initiative to have a pharmacist on site 24/7. The ward based pharmacist model in

	ICI has been very successful and received continued support through a Charity grant. Professor Elliott stated that this scheme had greatly reduced errors in prescribing.
6.5	Ms Cope informed the Board that technology contributed to the safe use of medicine including the introduction of a robot in pharmacy. Intelligent storage and security had also been introduced and plans were being considered to establish a pharmacy in the main entrance, run by a commercial partner.
6.6	The Ipsos MORI survey had raised concerns about the waiting time for the outpatient pharmacy service. The pharmacy department was working with Safari ward on a pilot scheme to determine the drugs required before the child visits the hospital.
6.7	Mr David Lomas, Non- Executive, stated that after the visit to the pharmacy he felt that the area was quite challenging to work in. He asked if the use of technology would ease the working conditions. Mrs Newton highlighted that investment in technology support in pharmacy is to be implemented in June 2013.
6.8	The Board noted the report.
7.	**Annual Plan 2013/14**
7.1	Ms Carla Hobart, Acting Chief Operating Officer, presented the report confirming that the changes from the last meeting had been implemented and had been shared with the clinical divisions.
7.2	Mr John Ripley, Non-Executive Director, congratulated the Executive Team on the revisions to the report.
7.3	**Action**: Ms Brown observed that there was limited reference to the role of the GOSH Charity in the plan. Ms Hobart stated that the criteria from Monitor did not require the Charity to be mentioned. Dr Buckley and Mr Ripley noted the guidance that was set by Monitor however encouraged reference to be made about the Charity in the plan.
7.4	The Board agreed the plan.
8.	**Performance Reports**
8.1	Mr Filochowski informed the Board that the targets and indicators including CRES and finance and activity were satisfactory. **Targets and indicators, including CRES**
8.2	The Trust had achieved over 99% of the CQUIN targets.
8.3	**Action**: The Board noted that the number of clinically appropriate patients refused treatment at GOSH was no longer reported and asked for this to be back in the report. **Finance and Activity**
8.4	Mrs Newton reported that the Trust exceeded its income plan due to the growth in

	International Private Patients. There had also been a consequential increase in costs. There had been some accelerated depreciation because phase 2B was underway. The Trust had a high cash balance.
8.5	The Trust had delivered £12.4 million of CRES against a target of £13.1 million.
8.6	**Quality and Safety**
8.7	Professor Elliott reported on quality and safety noting that there were 12 serious incidents that were open; pressure sores had reduced and the number of serious complaints had dramatically reduced. The Ombudsman's complaints criteria had been widened which would mean that there would be an overall increase in the complaints investigated by the Ombudsman. Forty three out of forty five specialities have identified outcomes to be measured. The remaining specialties are diagnostic specialties for which appropriate outcome measures are being reviewed.
8.8	**Infection, Prevention and Control**
8.9	Mr John Hartley, Director of Infection, Prevention and Control presented the report. He stated that the Trust was re-launching the Central Venous Line (CVL) and Peripheral Line care bundles. There had been 108 CVL infections in last financial year. There had been a reduction across the Trust with the exception of ICI. It was believed that this was a reflection of the intensity of treatment that the children on ICI are receiving. The Trust had failed its annual MRSA target by one case, for which a source of infection could not be found. Mr Hartley stated that there had been a drop in cleaning standards and Mitie had bought in its own transformation team to improve this.
8.10	Mr Hartley emphasised that the standard infection control isolation practice can hamper a patient's care due to the lack of space and so the estates team were reviewing how space could be better used to support this. Mr Hartley stated that he was working with the Education Team to develop improved information systems to be able to know how many staff have been trained in infection control. **Action:** The Board asked that information on hand washing be included in the indicator report to the Board.
8.11	**Patient Experience**
8.12	Mrs Morgan reported on patient experience and informed the Board that the Ipsos Mori Survey results would be presented to the Board in May 2013. The staff working on the Rainforest and Kingfisher wards had been given 6 weeks' notice period and would be informed about their allocation to the separate wards.
8.13	Mrs Morgan highlighted the Listening Event to develop a universal GOSH 'promise' which is due to take place on June 2013.
8.14	Mr Filochowski updated the Board on the refurbishment of the radiology offices. The Board was interested in this transformation which is being well received by staff and has encouraged improvements in their service delivery.

8.15	**Action**: The Board asked Mr Filochowski to report departmental refurbishment completions when they occurred and for the NEDs to visit these areas. Mr Tulley would be asked to organise these visits.
8.16	Ms Mary MacLeod, Non-Executive Director stated that an internal audit into patient experience had given significant assurance of the controls in place to capture patient views and recommended the need for the patient voice to come to the Board. The Clinical Governance Committee was looking at this matter.
8.17	The Board noted the report.
9.	**Initial impact report on the Morgan Stanley Clinical Building**
9.1	Ms Lesley Miles, Director of Communications presented the report which showed that the objectives of the design and build of the new building had been met around increased activity and enhanced environment. Further work was required to ensure that care pathways operated effectively and that greater visibility of staff was enabled.
9.2	It was expected that more day case space would be required if the Trust was looking to be more efficient and not have children staying overnight in the hospital but in hotel accommodation. Professor Elliott informed the Board that patients were pleased with the space that the refurbishment had provided and they enjoyed the peace and quiet.
9.3	Baroness Blackstone, Chairman asked if extra bed space was being considered, Mr Filochowski stated that this was constantly under review.
9.4	**Action**: The Board asked for an update, when available, on the impact of the space and facilities provided for in the Lagoon.
9.5	The Board noted the report.
10.	**Changes to the Constitution**
10.1	Dr Anna Ferrant, Company Secretary, presented the report. Dr Ferrant informed the Board that the Constitution Working Group had met on 16th April 2013 and had agreed with the proposed definition of a significant transaction but suggested that the Trust should also inform the Council of any other transactions over 10% (noting that the Council approval was not required at this level).
10.2	Dr Ferrant informed the Board that Mr Alastair Whittington would join the Council from NHS England.
10.3	The Board approved the proposed changes to the Constitution.
11.	**Quality Governance Framework self-assessment**
11.1	Mrs Claire Newton presented the report. Mrs Newton stated that the Trust has undertaken a full self- assessment of its position against Monitor's Quality Governance Framework (QGF). The majority of the criteria were rated Green. The Board noted the report.

12.	**Registers - Conflicts of Interest and Gifts and Hospitality**
12.1	Dr Ferrant presented the registers of interest and gifts and hospitality for staff and directors.
12.2	**Action**: Mr Lomas asked if GOSH is subsiding private patients as they utilise the service of GOSH employed consultants. Mrs Newton agreed to report back to the Board on this matter.
12.3	Professor Elliott made the observation that the register did not appear to have been fully completed by all staff. Dr Ferrant confirmed that staff were reminded to self-report any declarations of interest or receipt of gifts on a number of occasions. Dr Buckley agreed that more information should be required from clinicians undertaking private work.
12.4	**Action**: Dr Ferrant was asked to look at the possibility of asking all senior clinical staff to complete a nil return.
12.5	The Board noted the entries in the Register.
13.	**Register of Seals**
13.1	Dr Ferrant presented the report.
13.2	The Board endorsed the application of the Common Seal and executive signatures.
14.	**Committee reports**
14.1	Audit Committee – 17th April 2013 Mr Ripley presented a verbal summary and highlighted that the external auditor's contract was coming to an end and a tender would need to be prepared. The committee proposed that in light of the recent tender for the appointment of the internal auditor, the external auditor tender should be conducted later this year. The Board was advised the Head of Internal Audit Opinion had given significant assurance of the controls in place at the Trust to manage risks.
14.2	Clinical Governance Committee – 10th April 2013 Mrs MacLeod presented a verbal summary and highlighted that actions were being followed through. The issues about cleaning were being taken forward.
14.3	Finance and Investment Committee – 20th March 2013 Mr Lomas presented the summary and highlighted the issues that the committee had discussed.
14.4	**Action:** Mr Ripley asked for the paper on why Trusts fail, to be circulated to all Board members.
14.5	Board of Directors' Remuneration Committee (and revised terms of reference) – 27th March 2013 Ms Brown presented the summary and stated that the committee had recommended an increase of 1% to all executive staff salaries in line with other NHS staff.

14.6	Board of Directors' Nominations Committee – 27th March 2013 Baroness Blackstone, Chair, confirmed the appointment of Mr Ali Mohammed, Director for Human Resources and Organisational Development, Mr Robert Burns as Director of Planning and Information and Ms Rachel Williams as Chief Operating Officer.
14.7	Members' Council – 30th January 2013 Baroness Blackstone presented the summary.
14.8	The Board noted the summaries and verbal reports of these meetings.
15.	**Any Other Business**
15.1	There were no items of any other business.
16.	**Next meeting**
16.1	The next Trust Board meeting will be held on Friday 24th May 2013 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London WC1N 3JH

ATTACHMENT E

Attachment E

TRUST BOARD - ACTION CHECKLIST
24th May 2013

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
7.3	24/04/2013	Ms Brown observed that there was limited reference to the role of the GOSH Charity in the plan. Ms Hobart stated that the criteria from Monitor did not require the Charity to be mentioned. Dr Buckley and Mr Ripley noted the guidance that was set by Monitor however encouraged reference to be made about the Charity in the plan.	RB	May 2013	A brief note has been added into the annual plan referencing the role of the Charity
8.3	24/04/2013	The Board noted that the number of clinically appropriate patients refused treatment at GOSH was no longer reported and asked for this to be placed be back in the report.	RB	May 2013	This indicator is included in the report
8.15	24/04/2013	The Board asked Mr Filochowski to report departmental refurbishment completions when they occurred and for the NEDs to visit these areas. Mr Tulley would be asked to organise these visits.	JF & MT	On-going	Noted - reports to be provided on an on-going basis
9.4	24/04/2013	The Board asked for an update, when available, on the impact of the space and facilities provided for in the Lagoon.	LMiles	TBC	A date for this review to be determined
12.2	24/04/2013	Mr Lomas asked if GOSH is subsiding private patients as they utilise the service of GOSH employed consultants. Mrs Newton agreed to report back to the Board on this matter.	CN	May 2013	Verbal update

Attachment E

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
12.4	24/04/2013	Dr Ferrant was asked to look at the possibility of asking all senior clinical staff to complete a nil return.	AF	May 2013	Verbal update
14.4	24/04/2013	Mr Ripley asked for the paper on why Trusts fail, to be circulated to all Board members.	AF	May 2013	To be circulated

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
24th May 2013

Electronic Document and Record Management System (EDRMS) Business Case **Submitted by:** Martin Elliott (project sponsor) Robert Burns & Claire Newton as members of the project board	**Paper No: Attachment F**

Aims

To request approval for the investment of £4.3m (£3.963m+ VAT) in an electronic document record management system (EDRMS).

The business case will be considered by the F&I Committee on 20th May 2013 and recommendations will be made by that Committee to the Board.

Summary

- The Electronic Document and Records Management System (EDRMS) will replace the current paper patient blue case notes with an electronic record.
- This will dramatically improve the way the Trust's health records are organised, stored and presented. Implementing an EDRMS will significantly free up clinical staff time
- Launching the new system and its associated processes will require the Trust to make radical changes to working practices and engagement with staff is vital in delivering a system that is used to its full potential.
- If approval is received, the targeted go live date is Q4 2013/14.

Action required from the meeting

To approve the investment in an EDRMS

Contribution to the delivery of NHS Foundation Trust strategies and plans

This project represents an important step on the Trust's path to implementing a full electronic patient record.

Financial implications

An initial capital investment of £4.3m including VAT is required.

The project does not achieve a cash pay back over five years, the estimated net cash outflow over this period is £ (1.7)m but the estimated non cash benefits in savings of clinical time in that period exceed this by £1.1m

Legal issues - None

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

Staff have been invited to system demonstrations and have provided feedback throughout the procurement process. This consultation will continue throughout the lead up to go live.

Who needs to be told about any decision?

Staff and nearer to go live, patients.

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

A programme team has been established along with a Project Board chaired by Peter Wollaston, Head of Facilities.

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

Martin Elliott, Co-medical Director

Summary of Full Business Case for Trust Board – 29 May 2013

1.1 Introduction

1.1.1 The implementation of an Electronic Document and Records Management System (EDRMS) is a key part of the Information Strategy and the ICT Strategy and will assist with advancing the access and use of clinical information within the Trust. The EDRMS has the potential to radically improve how the Trust's health records are organised, stored and presented.

1.1.2 Records will be more complete, consistent and structured which will increase patient safety, security of patient information and support clinical decision making. The system will replace the current functions of the clinical document database as well as providing electronic forms which will be completed on-line and saved to the patient record. Some forms will incorporate workflow which will allow us to move them around the Trust in a more efficient way.

1.1.3 A Clinical Advisory Forum has been established by the project Clinical Lead and includes a representative from each speciality. An Administrative Advisory Forum is currently being setup and both these groups will be involved in the configuration of the system to the Trust's specific requirements.

1.1.4 The business case has been scrutinised by the Project Board, the Business Case Review Group, and Capital and Space Planning. The Finance & Investment Committee are considering the business case on 20th May 2013.

1.2 Moving Towards an Electronic Patient Record (EPR)

1.2.1 EDRMS is a key component of the strategy to move towards an EPR and will provide the Trust with the opportunity to make a step change in managing its document content and use of that content. An EDRMS is the first step to eventually creating a fully integrated EPR.

1.2.2 The system we are proposing to implement will allow us to radically change working practices and will dramatically impact the way we work. Investing in a change management programme, and investing in the workforce,will ensure that staff can contribute to the change, feel part of it and assist in the transition to new ways of working for now and for the future.

1.2.3 As well as providing electronic access to the scanned case notes we also plan to develop electronic forms with workflow. This will allow us to consolidate and standardise existing electronic forms and processes and enable us to become more efficient.

1.3 GOSH's Vision for EDRMS

1.3.3 A growing number of trusts are implementing EDRM services to mitigate the increasing challenges surrounding health records management. At GOSH the vision for EDRMS is to create a **high quality, safe and efficient** healthcare service by transforming the way patients' information is accessed, collected, and used. This will replace patients' paper blue case notes with scanned, electronic records that are **accurate, complete and accessible** across the whole of the Trust, thereby ensuring an improved experience for patients.

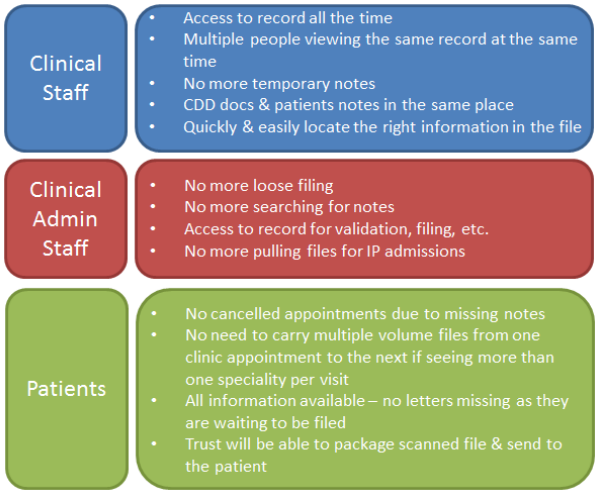
1.3.4 The introduction of an EDRMS will constitute a major change to the way documents are stored and accessed within the Trust and will have a significant impact on the way staff interact with the patient record. The procurement of a new data integration engine (now part of this business case) will give us the opportunity to make use of new and better technology than is currently available to us, to link systems and share information across systems. EDRMS will be the first system to use the new data integration engine.

1.3.5 This will be a staged implementation and the table below shows the planned work for Stage 1 and the anticipated developments beyond that:

Stage 1	An electronic system which will provide access to health records and will • Replace blue case notes with an electronic record with existing files being scanned offsite • Replace Clinical Document Database (CDD) functions: • Introduce automated forms:
Beyond Stage 1	• Continued development of forms and workflow to meet clinical and organisational needs • Integration of systems allowing access to patient information in other clinical systems which could be used to build discharge summaries for example. • Potential to develop a clinical portal allowing clinicians to access patient information across a variety of clinical systems.

1.4 Benefits of this Investment

1.4.3 The cash (CRBs) and non-cash releasing benefits (NCRBs) of this project are shown in detail in the section 1.6 below. This business case is largely a qualitative business case and the diagram below shows the benefits for staff and patients.



Clinical Division Savings

1.4.4 In order to confirm the CRBs in the business case for the Clinical Divisions, which shows a total of £0.3m per annum, an exercise was conducted with the ICI-LM General Manager and administration staff. A number of patient journey processes were reviewed and tasks relating to the management of case notes were identified. These tasks were then reviewed post implementation of the EDRMS and time saving efficiencies were identified and calculated.

1.4.5 A separate benefits realisation plan will be developed for the remainder of the cash releasing benefits. These predominately relate to the management of Health Records and lie within the Corporate Facilities department.

Scanning Savings

1.4.6 The Trust has been scanning blue case notes since 1994 and this requirement has an annual budget of £60,000. The current method of scanning means that each file is scanned as a single PDF file. However the business case provides a much higher level of case note scanning which means all files will be indexed, searchable with an agreed set of documents and scanned in colour.

1.4.7 The FBC also details the NCRBs relating to the implementation. We know that staff spend time looking for files to cover a range of tasks from patient treatment purposes to clinical coding. The time savings for these have been calculated and included.

1.4.8 Non cash releasing benefits

- Improved speed and accuracy of clinical coding
- Reduction in staff time outside Health Records tracking notes
- Improve facilities to support legal cases

1.5 Scanning & System Suppliers

1.5.3 Offsite scanning services and an EDRMS have been procured as part of this project. Hugh Symons Information Management Limited has been awarded the contract to scan the existing 90,000 patient blue case notes at a cost of £400,000. They will be responsible for scanning the existing blue case notes and making them available to the EDRMS. Post go live of the EDRMS all patient case notes generated on paper will be scanned via the in-house scanning bureau and it is anticipated that new documentation will be scanned and made available within 24 hours of the documents being produced.

1.5.4 The chosen system supplier for the EDRMS is Kainos and their 'Evolve' system. The cost of the system along with implementation, development of e-forms and training costs is £807,000. The annual revenue cost is £63,000. The 'Evolve' system has been implemented in a number of trusts such as Ipswich Hospital. They are also currently implementing their system at Chelsea & Westminster Hospital and Luton & Dunstable.

1.6 Financial Implications

1.6.3 An initial capital investment of £4.3m including VAT is required. Annual revenue costs over the first five years total £4.8m, offset by cash releasing savings of £4.6m giving a net loss of £0.2m. However the following should be noted:

1.6.5 The net cash outflow for the five years is £1.7m but this is more than offset by the estimated non cash benefits as described above, principally savings in clinical staff of £2.8m

1.6.4 The project costs include a contingency of £0.2m

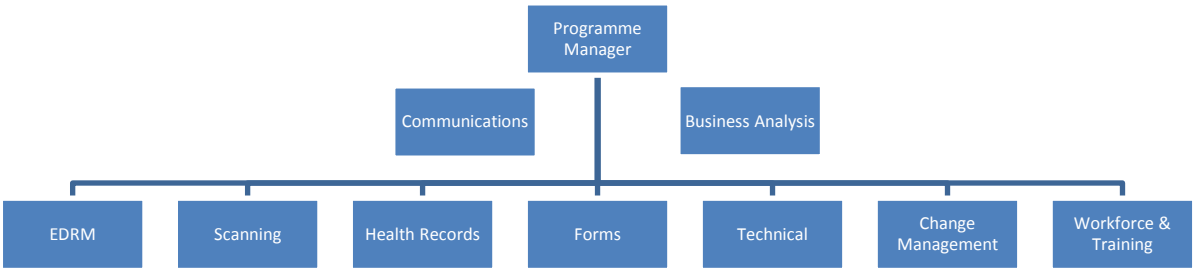
1.6.7 In addition the project costs include all the scanning requirements for the Trusts "live patients" and a separate Data Integration Engine for £0.35m which will have wider applications within the Trust

1.6.5 Over time, as use of the full functionality of the system develops, it is likely that

further savings beyond those in the business case can be leveraged through improved staff productivity.

1.7 Managing the Investment

1.7.3 The project is a large programme of work and has been organised as such. The size and complexity of it along with the cultural change it will bring means that there are many facets that need to be managed to provide the intended outcome. The SRO is Martin Elliott and the Project Board meets each month to review progress. The diagram below shows the programme structure and the workstreams.



1.7.4 A brief description of each of the workstreams is below:

- **EDRM:** Configuration of system through to acceptance testing and go live
- **Scanning:** Set up of in-house scanning bureau with associated processes
- **Health Records:** Preparation of existing records for scanning through to scanned image provided to the system
- **Forms:** Development of electronic forms and workflow within the system
- **Technical:** Management of hardware, installation and required access to for receipt of scanned files
- **Change Management:** Development of required changes in working practice including development of new processes and management of the benefits realisation planning
- **Workforce & Training:** Development of the necessary changes in the workforce and the training required for implementation
- **Communications:** Planning and delivery of communications throughout the programme lifecycle.

1.8 Timescales

1.8.3 It is estimated that the go live date of the EDRMS will be Q4 2013/14. This is based on contracts being signed with the system supplier in June 2013. Detailed planning work will be required with the supplier and GOSH staff to agree the full details of the deployment.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 24th May 2013	
Performance Summary Report **Submitted by:** Jan Filochowski, Chief Executive	**Paper No: Attachment G**

Aims / summary

Targets, Indicators and CRES

- 18 week standards for non-admitted pathways and incomplete pathways achieved
- Admitted pathway position being validated following high number of breaching patients within Surgery
- Volume of long waiting inpatients remains a risk and Planning & Performance Department working closely with Surgery to ensure managed
- Discharge summary completion rate 80%, an increase of 8%
- Percentage of clinic letters sent within 5 working days static, but significant progress in reducing the average number of days in which letters sent from 27 days to 16 days.
- In 2012/13 19 key workstreams developed, each with supporting actions towards achievement of the 7 strategic objectives. Good progress made with 26 of the 36 actions assessed as being 'achieved' and 10 assessed as 'partially achieved' at year end.

Financial Performance

NHS clinical income excluding pass through was £17.9m against an ambitious plan of £19.0m. Private patient income at £3.7m was on plan. The total adverse income variance of £1.7m was substantially offset by favourable expenditure variances resulting in an EBITDA of £1.7m or 6%, £0.3m below plan. It is early days but this result does emphasise the significant need for focus on delivering both the activity growth plans and the Efficiency targets.

Quality & Safety

- Quality Report will be presented at Audit committee and Trust Board
- 43 out of 45 specialties identified three or more outcome measures by end March 2013.
- 3 serious incidents involving lost to follow up patients have occurred. Divisions involved have identified actions to address this issue.

Transformation

- Rapid improvement flow projects underway for theatres and ICU. Bed management project under review and will refocus on admissions and discharge.
- Meridian Productivity have proposed an implementation programme for improvements to out-patient services. More detailed proposal will be presented to OMG on 23rd May.
- Transformation team hosted GOSH Experience Day, held for delegates to the BMJ/IHI International Forum on Quality and Patient Safety
- GOSH shortlisted in two categories in the National Patient Safety Awards 2013

Action required from the meeting Trust Board to note performance for the period
Contribution to the delivery of NHS Foundation Trust strategies and plans To assist in monitoring performance across external and internal objectives
Financial implications Failure to achieve contractual performance measures may result in financial penalties
Legal issues N/A
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? Commissioners receive sub section of performance report monthly. Members Council receive performance report.
Who needs to be told about any decision? Executive Directors
Who is responsible for implementing the proposals / project and anticipated timescales? Executive Directors
Who is accountable for the implementation of the proposal / project? Executive Directors

Targets and indicator report

Year to date performance

The Finance Department are currently validating month one activity and income figures. This issue will be resolved in time for month two reporting.

No cases of MRSA or C. difficile were reported for April.

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

The admitted pathway position is currently being validated following a high number of breaching patients within Surgery. The volume of long waiting inpatients remains a key risk to the organisation. The Planning & Performance Department are working closely with the Division to ensure this is managed in the most effective way with least impact on Trust performance.

The proportion of patients waiting no more than 6 weeks for a key diagnostic test remains within the tolerance of 1%.

The overall discharge summary completion rate (within 24hrs) is reported at 80%, which represents an increase of 8% against the previous month. Improvements are reported across all Divisions with the exception of Neurosciences, who report a rate 14% reduction against the previous month. Specific issues relating to weekend discharges have been identified within Neurosurgery. The Division are working with the Corporate Facilities team and Junior Doctors to resolve these issues. Performance expected to return to normal levels in the next month. Surgery report the largest increase from a March position of 47% to 74% in month. Clinical Divisions continue to work on their plans to reduce the total time taken to complete and send discharge summaries.

The percentage of clinic letters sent within 5 working days following clinic attendance has remained static at approximately 20%. However, significant progress has been made in reducing the average number of days in which letters are sent from 27 days to 16 days. The project team continue to progress performance with the aim of achieving the 50% target by September 2013. This includes, for example, working with other providers to identify and learn from areas of good practice. Following a recent visit Chelsea & Westminster NHS Foundation Trust we are investigating the option of implementing digital dictation software such as 'Big Hand' as a more efficient alternative to outsourcing typing.

Clinical Unit Performance Escalation

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

Measure	Change	Clinical Unit	Narrative
% Patients with discharge summary complete within 1 day of discharge	RED	Critical Care and Cardiorespiratory	Whilst performance has improved in-month the average completion rate has dropped over the last six months. Data entry issues have been identified on Bear Ward. A number of clinics have also been identified as not needing a discharge summary and therefore will be removed from the overall calculation i.e. MRI, Cystic Fibrosis

			and Sleep Studies. A focussed project group has been established to resolve these issues and performance is expected to improve over the next month.
CICU Total prescribing errors per Bed Day	RED		The overall error rate remains low however some deterioration in performance has been identified specifically following the move to the new larger facilities. The Division are working with ICT to ensure dedicated prescribing desks are re-introduced. All prescribing errors continue to be clinically reviewed each week.

Statistically significant improvements were reported across a number of Divisions, including:

- ICI-LM: Haematology-Oncology Electronic Prescribing Errors per 100 items prescribed
- IPP: Hospital acquired CVL infections per 1000 line days
- MDTS: Hand hygiene audit results
- Neurosciences: % Total WHO Checklist Completion (Sign In, Time Out & Sign Out)

CQUIN

The Trust report a year end position of 99.3% achievement across all indicators and milestones.

CRES Programme April 2013

At month one, CRES schemes with a value of £16.4m have been identified (91% of target), with a risk adjusted total of £14.9m. Savings equivalent to 40% of target are blue or green and 51% are amber or red.

Divisions with the largest variances are CCCR, MDTS and ICI-LM. These Divisions have been challenged to identify further expenditure savings and are currently scoping these. An enhanced focus on the performance of high value schemes will be implemented by June with the aim of avoiding a reduction in the value of savings late in the year.

Quality and patient safety risk assessments are currently being conducted for all high value schemes prior to Chief Nurse and Medical Director sign-off and a central risk register is being developed to supplement the monitoring of CRES quality impact.

2012/13 Strategic objectives review

In 2012/13 we developed 19 key workstreams, each with a series of supporting actions that would move us towards achievement of our seven strategic objectives. We have made good progress against the milestones that we set with 27 of the 36 actions assessed as being ‘achieved’ and 9 assessed as ‘partially achieved’ at year end.

The table below outlines those areas identified as partially achieved. We will continue to ensure all outstanding workstreams are progressed.

Work-stream action	Comments
Continue our work to reduce drug errors.	Short term goals have been achieved; however the long term CIVAS future is yet

	to be agreed.
Ensure consenting processes for treatment meet necessary standards and exceed patient and family expectations.	Progress has been slower than planned. A revised approach has commenced prioritising the top 10 procedures.
Invest within our 10 year capital programme to improve the patient environment within our existing buildings and continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the agreement of the full business case for 2B and the continuing progress of the case for 3A.	Progress has been slower than planned. This is primarily due to the delay starting the 2B enabling works and the complexity of other large capital projects such as the hybrid-angio move and 3-T MRI.
Increase research activity and income for the Trust, and measure and report impact.	Although better systems are in place the number of research active projects have reduced.
Continue to improve the mechanisms for the management of research within the Trust in line with NIHR requirements.	Further improvements against NIHR performance metrics are required.
Deliver education, training and organisational development to support service transformation at GOSH.	Delay in developing/procuring a training Learning Management System.
Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.	Further engagement from information asset owners in managing data quality locally is required.
Develop a robust Information Strategy including appropriate SMART objectives and a clear delivery plan.	Delivery plan is yet to be agreed.
Deliver the Trust's Information Technology plan - including successful implementation of CareVue, PACs and Order Comms.	A number of key projects have not yet been implemented.
Continue to develop management and leadership across the Trust including specific plan to target Specialty Leads.	A review of specialty lead roles is still required although we have recruited a permanent HR director and clarified the Divisional Director roles.

Quality, Safety & Transformation

Safety

Serious Incidents

- Number of days since last serious incident: 17 (at 10/05/13)
- Number of serious incidents currently open:10 (at 10/05/13)

Complaints

- Number of days since last red complaint: 65 (at 10/05/13)
- Number of open formal complaints: 15 (amber 12, green 3)
- One red complaint is waiting for further information from external sources before investigation can proceed. (Date of complaint 11/03/13)
- Additional complaints where the family have re-approached the Trust and accepted the offer of a meeting to discuss the complaint further: 4
- Complaints being reviewed by the Parliamentary Health Service Ombudsman: 7
- Communication is still a common theme for complaints and work is underway through divisional plans and transformation to address these issues.

Common Themes

In the April report, it was noted that there have been 3 serious incidents involving lost to follow up patients. The Divisions involved have identified a number of actions to address this issue:

- Local action plans are in place and are monitored through monthly Risk Action Groups
- Written guidance for booking patients, which removes person dependent processes and improves secretarial standards.
- Procedures for cross checking and flagging of patients in a weekly safety-net meeting
- Project to improve discharge information (cardiology)
- Retrospective study to capture any other patients that may have been lost to follow up (surgery)
- Longer term work to be undertaken to address IT solutions

Quality Report

The report has been designed and is awaiting final figures and external stakeholder comments. It will be presented at Audit committee and Trust Board in May for sign off. The finished report will be brought to Members' Council in June, and to Patient and Public Involvement and Experience Committee and Young People's Forum, for discussion and feedback. Later in the year, the Members' Council will help identify quality priorities for the coming year.

Clinical Outcomes Development

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

Forty-three out of forty-five specialties had identified three or more outcome

measures by 31st March 2013. The two that have not are diagnostic services, which do not have standalone measures in the same way that medical and surgical specialties do. A discussion forum in mid-April achieved consensus in terms of a shared measure approach. These measures are currently being agreed. In the last quarter, data for two additional measures have been published to the Trust website and more are in preparation.

Seventeen international centres are participating in the GOSH-led benchmarking project. Three of six GOSH specialties have formally reviewed the responses and identified which they think hold the richest potential for benchmarking. Shortly, the international sharing group will do the same. A 'principles of engagement' document is currently being prepared as a first step to a data-sharing agreement.

Transformation

Project updates
Rapid improvement flow projects are now fully underway for theatres and ICU. The bed management project is currently under review and will refocus on admissions and discharge, with the first rapid improvement cycles commencing shortly.

Meridian Productivity have proposed an implementation programme for improvements to out-patient services. This proposal will be presented to OMG on 23rd May. The transformation team will then work with Meridian, providing support to their team required.

Further improvement projects start in the coming weeks to address waits for pharmacy in out-patients, complex patient pathways and timeliness of discharge summaries. It is necessary to identify executive sponsorship, divisional and project leads and to agree clear aims and objectives for each of these projects.

The improvement managers and co-ordinators will dedicate their time to centralised rapid improvement projects, but will continue to maintain relationships with individual divisions.

GOSH Experience Day
In April, the transformation team hosted a GOSH Experience Day, held for delegates to the BMJ/IHI International Forum on Quality and Patient Safety. Over 150 international delegates came to hear how GOSH has managed its journey to improve. GOSH was chosen as one of the five site visits for the Forum.

On the day, delegates were able to attend sessions that were themed as Improving Patient Flow, Zero Harm, Laying the Foundations and Building Capacity for Improvement. Feedback received during and after the event was incredibly positive.

"Speaking with other delegates in attendance, there was a strong feeling that GOSH was making great advances in improving quality and safety in paediatric care and processes and everyone I spoke to thoroughly enjoyed the day." Roger Durack, Head of Quality Improvement, NHS England.

In recognition of the work put into this event, GOSH were awarded with 10 free places at the BMJ/IHI International Forum.

Patient Safety Awards
GOSH has been shortlisted in two categories in the National Patient Safety Awards 2013, Improving Safety in Medicines Management and Patient Safety in Paediatrics. The nominees will be interviewed and the winners are announced in July at a celebratory ceremony.

The Measurement and Monitoring of Safety
GOSH features as a case study organisation in The Health Foundation publication "The Measurement and Monitoring of Safety", drawing together academic evidence and practical experience to produce a framework for safety measurement and monitoring, by Charles Vincent, Susan Burnett and Jane Carthy.

Great Ormond Street Hospital for Children NHS Foundation Trust

Targets & Indicators Report

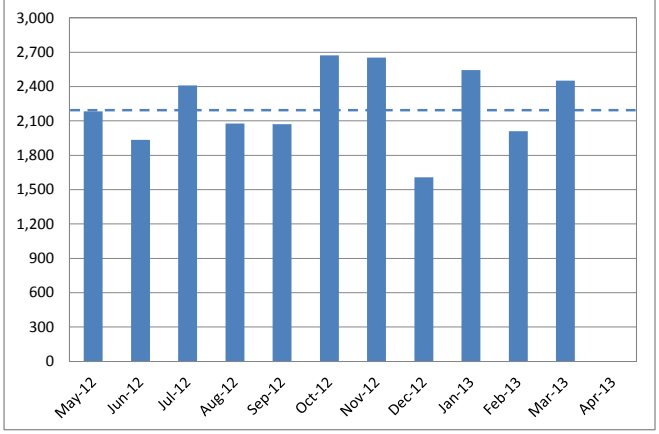
	Indicator	Graph	YTD Target	YTD Performance	Monthly Trend													
					Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Activity & Use of Resources	Number of patient spells	1	N/D	N/D	2,545	2,010	2,452	N/D											
	Number of outpatient attendances	2	N/D	N/D	12,010	10,887	10,742	N/D											
	DNA rate (new & f/up) (%)		<10	8.5	9.5	8.7	8.8	8.5											
	Number of ITU bed days	3	N/D	N/D	791	664	802	N/D											
	Number of unusued theatre sessions	4	244	26	14	16	8	26											
Patient Access	18 week referral to treatment time performance - Admitted (%)	5	90	TBC	91.1	90.1	92.0	TBC											
	18 week referral to treatment time performance - Non-Admitted (%)	5	95	95.2	95.4	97.1	95.7	95.2											
	18 week referral to treatment time performance - Incomplete Pathways (%)	5	92	92.2	93.7	92.8	92.9	92.2											
	Cancer patients waiting no more than 31 days for second of subsequent treatment (%)		98	100	100	100	100	100											
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	6	<=1	0.54	0.57	0.28	0.75	0.54											
Patient / Referrer Experience	Number of complaints		<99	6	5	9	17	6											
	Number of complaints - high grade		<11	0	0	0	1	0											
	Discharge summary completion (%)	7	85	80.6	77.4	76.3	72.7	80.6											
	Clinic Letter Turnaround, % letters on CDD - sent within 5 working days	8	50	18.6	20.7	18.6	N/D	N/D											
	Clinic Letter Turnaround, letters on CDD - average no. working days sent	8	To reduce	16.3	16.0	16.3	N/D	N/D											
	Patient refusals		520	43	37	43	35	43											
Quality & Safety	Combined Harm Index	9	Within Tolerance	19.2	16.9	22.8	22.9	19.2											
	Number of serious patient safety incidents	10	Within Tolerance	2	3	2	3	2											
	Hospital mortality rate (per 1000 discharges)		Within Tolerance	3.1	2.2	3.4	3.8	3.1											
	Combined infection index		Within Tolerance	2.5	2.1	2.2	3.2	2.5											
	Incidence of C.difficile		7	0	0	0	0	0											
	Incidence of MRSA		0	0	0	0	1	0											
	CV Line related blood-stream infections (per 1,000 line days)	11	1.5	2.2	1.9	2.0	3.2	2.2											
	Number of arrests outside ICU (cardiac or respiratory)	12	Within Tolerance	5	8	6	7	5											

*N/D - No Data for month 1

Activity and Use of Resources

1. Patient spells

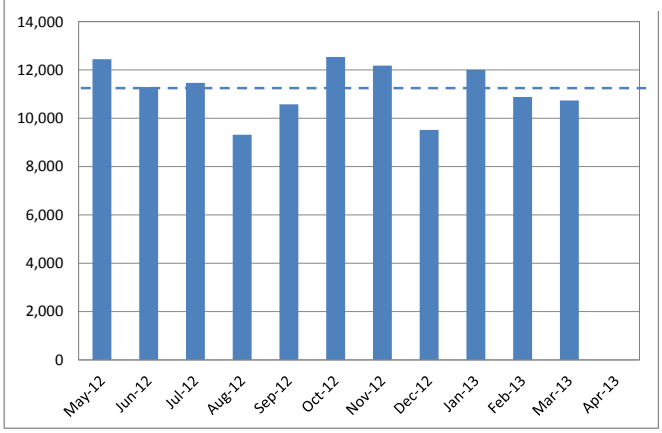
Desired direction of travel ↑



Description:	**The total number of patient spells (including day case, elective and non-elective)**
Target:	*Contractual target*: 2,175 spells per month
Trend:	Reduction in activity in February reflects fewer working days. Activity reported above target in March
Comment:	Data unavailable for month 1 at time of reporting

2. Outpatient Attendances

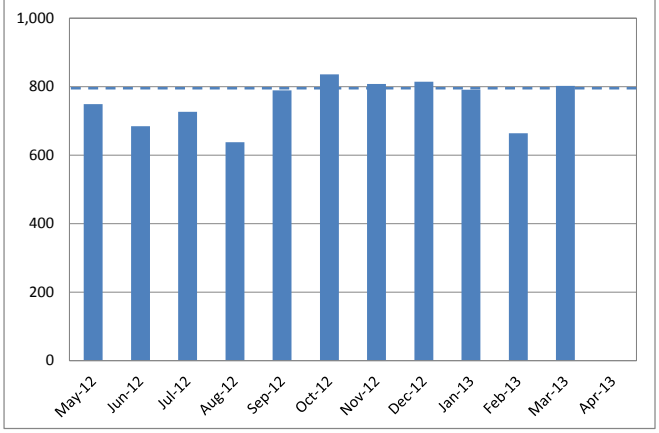
Desired direction of travel ↑



Description:	**Total number of new & follow-up consultant-led chargeable appointments**
Target:	*Contractual target:* 11,439 attendances per month
Trend:	Activity remained under target in March
Comment:	Data unavailable for month 1 at time of reporting

3. ITU Bed Days

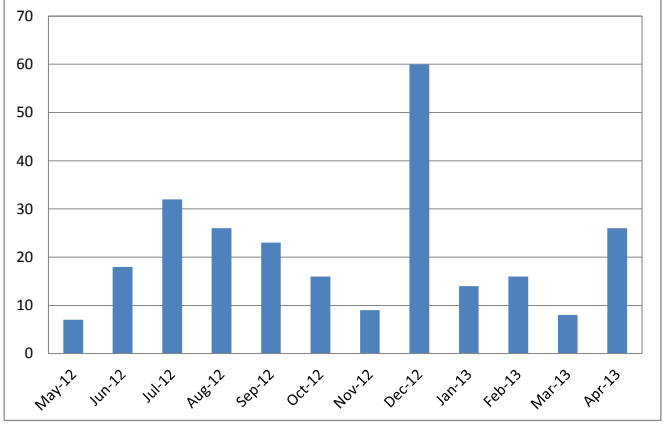
Desired direction of travel ↑



Description:	**Total number of ITU bed days used per month**
Target:	*Contractual target:* 797 bed days per month
Trend:	Upward trend, particulalry in second half of year
Comment:	Data unavailable for month 1 at time of reporting

4. Unused Theatre Sessions

Desired direction of travel ↓

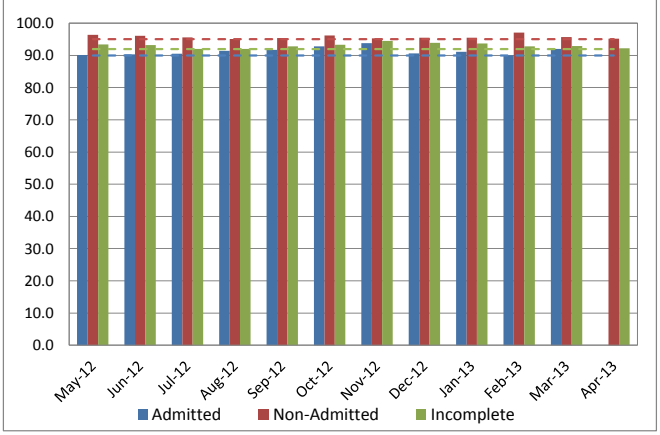


Description:	**Total number of scheduled theatre sessions not used**
Target:	*Internal target:* To be confirmed
Trend:	Downward Trend
Comment:	Further investigation required

Patient Access

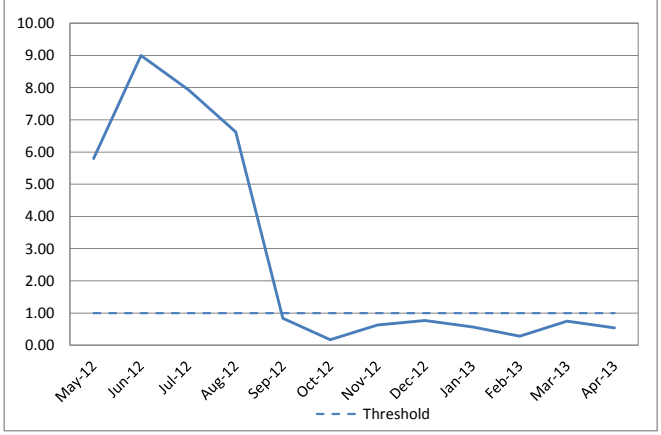
5. Referral to Treatment Waiting Times

Desired direction of travel ↑↑↑



Description:	**Referral to treatment waiting times for admitted and non-admitted patient pathways**
Target:	*Monitor/Contractual target:* Admitted 90%, Non-admitted 95%, Incomplete pathways 92%
Trend:	Performance sustained above standards. Trend tends to mirror activity levels
Comment:	Higher number of breaching admitted patients identified in Surgery impacting on performance. Plan in place to reduce

6. Diagnostic Waiting Times

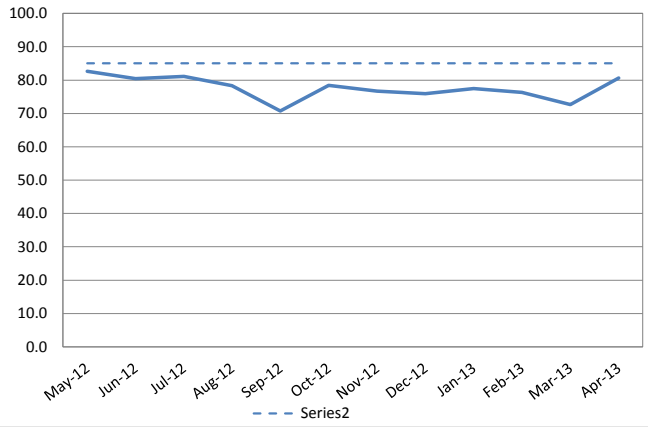


Description:	**The proportion of patients waiting no more than 6 weeks for diagnostic test (across 15 national key diagnostic areas)**
Threshold:	*Contractual target (likely to be Monitor target 2013/14):* <1%
Trend:	Small negative movement against previous month
Comment:	Performance sustained under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

Patient / Referrer Experience

7. Discharge Summary Completeness

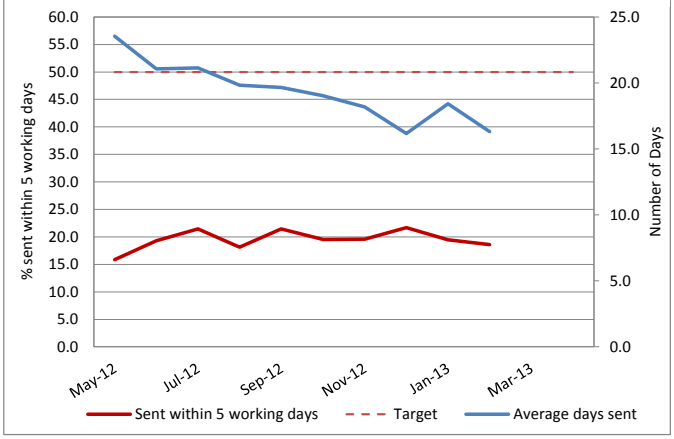
Desired direction of travel ↑



Description: **The percentage discharge summaries completed and sent within 24 hours of patient discharge**
Target: *Internal target:* 85%
Trend: Positive movement in month
Comment: Performance impacted by signification reduction in Neurosciences. Plan in place to improve

8. Clinic Letter Turnaround

Desired direction of travel ↑↓

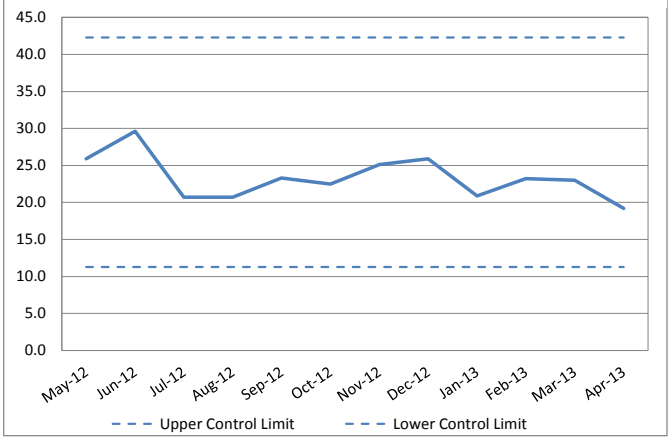


Description: **The percentage of clinic letters sent within five working (and average days) following patient clinic attendance & recorded on the Clinical Document Database (CDD)**
Target: *Internal target:* 50%
Trend: Performance remains relatively static following period of improvement
Comment: A working group in place to progress performance

Quality and Safety

9. Combined Harm Index

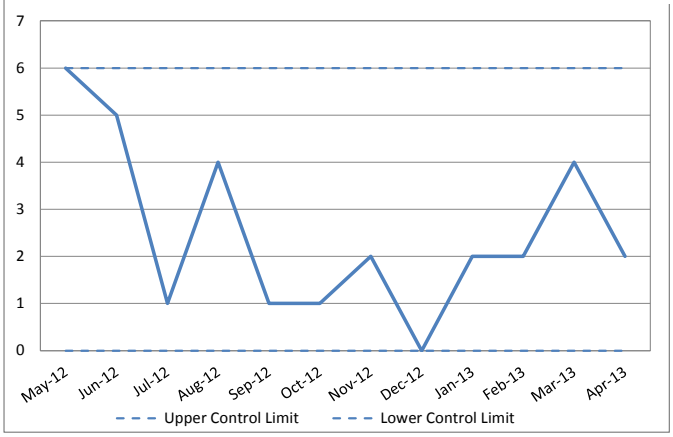
Desired direction of travel ↓



Description: **Harm index comprised of hospital acquired infections (CVL, serious incidents, non-ICU arrests, medication errors, falls, and pressure ulcers.**
Target: *Internal target:* Year on year reduction
Trend: Improvement in performance
Comment: Performance remains within statistical tolerance

10. Serious Patient Incidents

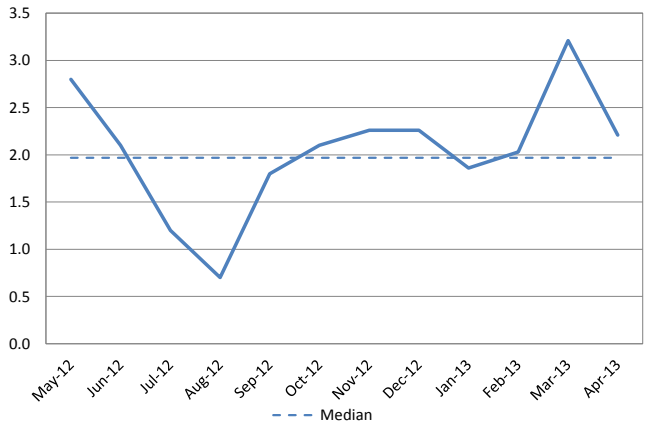
Desired direction of travel ↓



Description: **Defined as either - Unexpected/avoidable death of patient(s), staff visitors or members of public. Serious harm to patient(s), staff, visitors or members of public. Allegations of abuse. One of the core sets of 'Never Events'**
Target: *Internal target:* To remain within control limits
Trend: Performance improved with 2 SIs reported in April
Comment: Performance remains within statistical tolerance

11. Central Venous Line (CVL) Infections

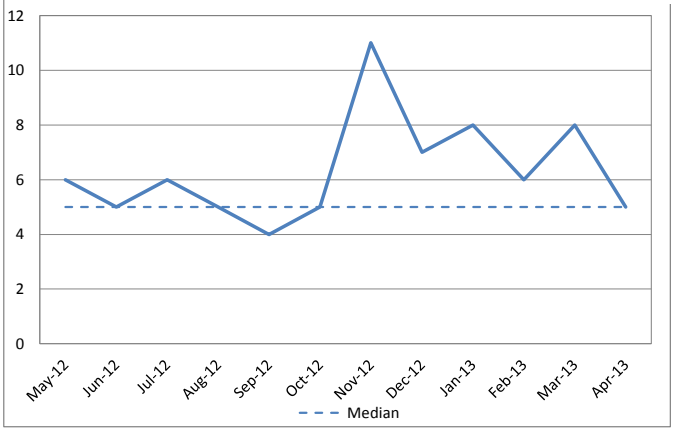
Desired direction of travel ↓



Description: **The number of CVLInfections for every 1000 Bed Days acquired at the Trust**
Target: *Internal target:* <=1.5
Trend: Positive movement in performance against previous month
Comment: Performance remains within tolerance

12. Arrests Outside ICU

Desired direction of travel ↓



Description: **The monthly number of arrests (cardiac or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clincal Emergency Team)**
Target: *Internal target:* 50% reduction
Trend: Continued improvement in performance
Comment: Performance remains within tolerance

Monitor Governance Risk Rating 13/14

Targets - weighted (national requirements)		Threshold	Score Weighting	Reporting Frequency	Score Weighting Q1 M1	M2	M3	Q1
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0			
2	Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)**	0	1	Quarterly	0			
3	All cancers: 31-day wait for second or subsequent treatment comprising either:		1	Quarterly	0			
	Surgery	94%			0			
	Anti cancer drug treatments	98%			0			
	Radiotherapy (from 1 Jan 2011)	94%			0			
4	Non Admitted within 18 weeks	95%	1	Quarterly	0			
5	Admitted within 18 weeks	90%	1	Quarterly	TBC			
6	92% - 18 week referral to treatment time Incomplete Pathways Performance	92%		Quarterly	0			
7	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0			
8	Certification against compliance with requirements regarding access to healthcare for peopl e with a learning disability	N/A	0.5	Quarterly	0			
				Total	**TBC**			
				Overall governance risk rating	**TBC**			

Monitor governance rating matrix	
Green	from 0 to 0.9
Amber-green	from 1.0 to 1.9
Amber-red	from 2.0 to 3.9
Red	4.0 or more

Risk rating	**Description (risk of significant breach of authorisation)**
Green	No material concerns
Amber-green	Emerging concerns
Amber-red	Potential future significant breach if not rectified
Red	Likely or actual significant breach

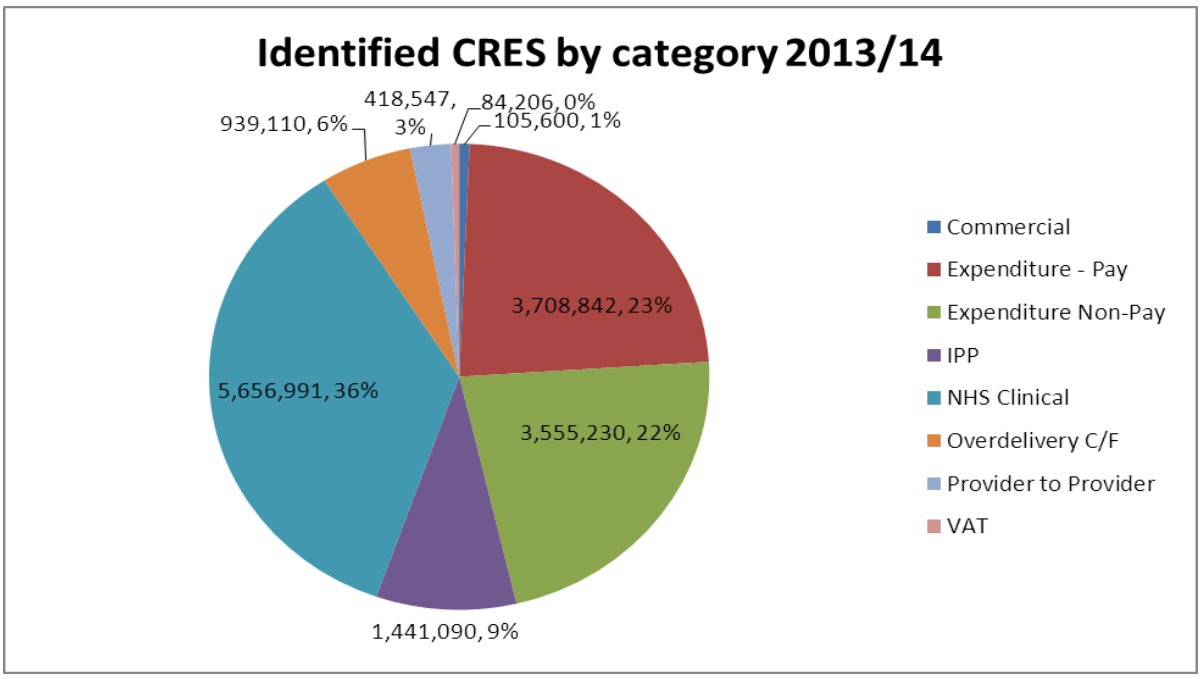
*Where an NHS foundation trust has an annual MRSA objective of six cases or fewer (the de minimis limit) and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of Monitor's Compliance Framework

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

Appendix 1 - CRES Summary 13/14

	2013/14				
Division	**Delivery target**	**Total identified**	**Risk adjusted total**	**Risk adjusted variance**	**Schemes completed**
Critical Care and Cardiorespiratory	4,286,706	2,903,189	2,573,061	-1,713,646	0
ICI	1,912,123	1,404,523	1,432,149	-479,974	40,774
International	1,297,066	1,731,647	1,613,525	316,459	0
MDTS	3,193,407	2,727,770	2,286,154	-907,253	0
Neurosciences	1,437,806	1,411,872	1,615,252	177,446	0
Surgery	2,033,919	2,363,425	1,861,172	-172,747	0
Corporate facilities	1,080,070	1,137,855	1,050,281	-29,789	0
Clinical & Medical Operations	281,400	483,695	462,246	159,907	225,182
Corporate affairs	104,053	115,975	99,167	-4,886	0
Estates	947,217	639,254	553,127	-394,091	0
Finance & ICT	881,933	869,709	774,370	-107,563	0
HR & workforce	167,636	174,563	151,066	-16,570	0
Nursing & Education	306,402	383,289	355,803	49,401	0
R&I	80,066	30,000	24,000	-56,066	0
Total	**18,009,806**	**16,376,768**	**14,851,372**	**-3,158,434**	**265,956**
			82%		**1%**

Appendix 2


Identified CRES by category 2013/14
418,547, 3%
84,206, 0%
105,600, 1%
939,110, 6%
3,708,842, 23%
5,656,991, 36%
3,555,230, 22%
1,441,090, 9%
Commercial
Expenditure - Pay
Expenditure Non-Pay
IPP
NHS Clinical
Overdelivery C/F
Provider to Provider
VAT

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 24th May 2013	
Compliance with Monitor's Code of Governance **Submitted by: Anna Ferrant, Company Secretary**	**Paper No: Attachment H**

Aims / summary

Monitor, the Independent Regulator of NHS Foundation Trusts, has drawn on the practice developed in the private sector, and, based on the Combined Code for Corporate Governance, produced the NHS Foundation Trust Code of Governance. This code consists of a set of Principles and Provisions.

Foundation trusts are required to report against Monitor's Code of Governance each year in their Annual Report, on the basis of either compliance with the Code provisions, or, an explanation where they do not.

A review has been conducted against all the Code's provisions and the Audit Committee has reviewed an outline of the evidence available to support compliance against each of the criteria. The review has found that the Board has applied the principles and met the majority of the requirements of Monitor's Code of Governance during 2012/13.

The Board is asked to note that the intention is to explain our compliance in the annual report for the following criteria:

Requirement in Code	Explanation and action to be taken
A.1.1 There should be a formal schedule of matters specifically reserved for decision by the board of directors.	A schedule of matters was in place following a review in May 2012. This is subject to further review following restructuring of governance framework.

The Board is asked to note the actions taken and future actions for the following criteria:

Requirement in Code	Explanation and action to be taken
B.1.4 The roles and responsibilities of the board of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the board of governors towards members and other stakeholders and how governors will seek their views and inform them.	An information leaflet is sent to all nominees explaining the role of councillors and the Council. All councillors receive induction. The Membership Engagement Committee is working to enhance communication with members. Further guidance will be provided to councillors on their role and responsibilities under the HSCA.

B.1.7 The board of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the terms of authorisation or other matters related to the general wellbeing of the NHS foundation trust. The board of governors should consider the advantages of there being a senior independent director on the board of directors (see A.3.3).	The Constitution details how such issues will be managed. The SID is available to discuss concerns about the performance of the board of directors/ compliance with licence requirements. All of the directors attend each Council meeting and are available to answer questions about performance matters.
D.1.5 Governors should canvass the opinion of their members, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors.	The Trust presented a review of initial 2013/14 priorities and objectives to the Members' Council for consideration in February 2013. Following this, further detailed discussions regarding a draft plan were held with two representative volunteer Councillors before a final Annual Plan was re-presented back to the Members' Council and Trust Board in March 2013. A sub-group of the Members' Council are currently undertaking a focussed piece of work to understand how they can better engage with the wider foundation trust membership, which will include greater input into the Annual Planning process.

Action required from the meeting
To confirm that the actions documented are sufficient to determine compliance with Monitor's Code of Governance

Contribution to the delivery of NHS Foundation Trust strategies and plans
Good corporate governance

Financial implications
None

Legal issues
Compliance with the Code is required in order to retain authorisation as a Foundation Trust

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

N/A
Who needs to be told about any decision? N/A
Who is responsible for implementing the proposals / project and anticipated timescales? N/A
Who is accountable for the implementation of the proposal / project? N/A

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
24th May 2013

Corporate Governance Statement **Prepared by:** Claire Newton, CFO	**Paper No: Attachment I** FOR DISCUSSION AND APPROVAL

Aim

Monitor introduced Standard Licensing Conditions on 1st April 2013. A license was issued to GOSH. The license deals with governance of the Trust, continuity of services, compliance with Monitor requirements and some specific areas relating to pricing and competition.

One of the conditions of the license is that the Board approve an annual governance statement. This is to be submitted alongside the Trust's Annual Plan and the forecast financial and operating targets and indicators for the year.

The Board is requested to approve this statement.

Please note that the targets and indicators section has not yet been completed but will be tabled at the meeting.

Action required from the meeting
The Board is asked to consider and approve the attached governance documents

Contribution to the delivery of NHS Foundation Trust strategies and plans
To achieve best practice governance processes.

Financial implications
N/A

Legal issues
N/A

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

Who needs to be told about any decision?
Members' Council

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

Who is accountable? The Chair of the Trust Board

SUPPORT FOR APPROVAL OF THE CORPORATE GOVERNANCE STATEMENT

It is proposed that the Directors can confirm that each statement in the Corporate Governance statement is correct based on the work done by the Board and its Committees during the year and the Annual Plan considered by the Board and the Members Council in April.

In particular;

- the Board has considered its compliance with the Monitor Quality Governance Framework and been satisfied that it is green on all areas except two where it is amber green. In both these areas action plans are in place.
- The Board has received regular reports relating to the CQC assessment and visits
- The Board has put in place processes to endure all medical practitioners are meeting the registration and revalidation requirements
- Our Annual Planning document indicates that the Trust will achieve a risk ratio of at least 3 and remain a going concern
- A review of the license is taking place and the Trust has recently reviewed its Constitution
- Risks are regularly reviewed at the Audit and Clinical Governance Committee and the risk management strategy clearly sets out the processes within the trust.
- The Annual Governance Statement has been reviewed by the Audit Committee and will be reviewed by the Board on 24th May and concludes that there are no material control issues
- There are no issues arising from the membership of UCLP
- Briefing sessions have been held with Councillors to help provide them with the knowledge to perform their role
- A skills assessment has been carried out of Board members and no significant gaps identified

Appendix :

Corporate Governance Statement
Financial Risk indicators
Targets and Indicators

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

The board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each (see notes below)

		Response, Risks and mitigating actions
	For quality, that:	
1	The board is satisfied that, to the best of its knowledge and using its own processes and having assessed against Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Confirmed
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Confirmed
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Confirmed
	For finance, that:	
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3, as defined in Monitor's Compliance Framework, over the next 12 months	Confirmed
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Confirmed
	For governance, that:	
6	The board will ensure that the trust remains at all times compliant with its licence and has regard to the NHS Constitution	Confirmed
		0
7	All current key risks to compliance with the trust's licence have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	Confirmed
		0
8	The board has considered all likely future risks to compliance with its licence and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.	Confirmed
		2
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Confirmed
10	An Annual Governance Statement is in place pursuant to the requirements of the NHS Foundation Trust Annual Reporting Manual, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Confirmed

11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix B; and a commitment to comply with all known targets going forwards.	Confirmed
12	The board is satisfied that its NHS foundation trust can operate in an economic, efficient and effective manner.	Confirmed
13	The board will ensure that the trust will at all times operate effectively within its constitution. This includes: maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; that all board positions are filled, or plans are in place to fill any vacancies; and that all elections to the board of governors are held in accordance with the election rules.	Confirmed
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience, skills and training to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Confirmed
17	The board is satisfied that plans are in place to ensure that the trust will at all times comply with all applicable legal requirements	Confirmed
18	**The board is satisfied that during 2013 the Trust has provided the necessary training to its governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role**	Confirmed
19	**EITHER:**	
	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed
	OR	
	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services	
	OR	

Signed on behalf of the board of directors, **and having regard to the views of the governors**

Signature		Signature	
Name		**Name**	
Capacity	Chairman	**Capacity**	Chief Executive Officer
Date		**Date**	

Finance Risk Indicators for Great Ormond Street Hospital for Children

Please respond "True" or "False" to the following statements

	Finance Risk Indicators	Response
1	**Finance Declaration 2 signed (Trust unable to certify that Board anticipates that the Quarterly FRR will be at least 3 over the next 12 months)**	**FALSE**
2	**Planned FRR 2 (or less) for any one quarter in 13/14**	**FALSE**
3	**Working capital facility (WCF) was used at any point in 13/14 financial year**	**FALSE**
4	**Two or more changes in Finance Director in a twelve month period**	**FALSE**
5	**Interim Finance Director in place over more than one quarter end**	**FALSE**
6	**Quarter end cash balance <10 days of *(annualised)* operating expenses**	**FALSE**
		0

Notes: *As set out in Monitor's Compliance Framework 2012-13, Monitor will separately consider this limited set of indicators to highlight the potential for any future material financial*

	Other indicators for Risk	Response
1	**How many interim (voting) Directors are there on your Board at 31 May 2013**	**0**
2	**How many acting (voting) Directors are there on your Board at 31 May 2013**	**13**
3	**How many of the following posts are interim or acting or both (Chair, CEO, Finance Dir, Medical Dir) at 31 May 2013**	**0**
4	**How many changes in Finance Director have you had in the twelve month period to 31 May 2013**	**0**
5	**How many governors posts (filled and unfilled) does your FT have (i.e in constitution)**	**27**
6	**How many governors posts are vacant (unfilled) at 31 May 2013**	**2**
		0

Declaration of risks against healthcare targets and indicators for 2013-2014 by Great Ormond Street Hospital for Childr

Target or Indicator (per Compliance Framework 13/14)	Threshold	Weighting	At Risk?	Score
Referral to treatment time, 18 weeks in aggregate, admitted patients	>90%	1.0	No	
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	>95%	1.0	No	
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	>92%	1.0	No	0
A&E Clinical Quality- Total Time in A&E under 4 hours	>95%	1.0	No	0
Cancer 62 Day Waits for first treatment (from urgent GP referral)	>85%	1.0	No	
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	>90%	1.0	No	0
Cancer 31 day wait for second or subsequent treatment - surgery	>94%	1.0	No	
Cancer 31 day wait for second or subsequent treatment - drug treatments	>98%	1.0	No	
Cancer 31 day wait for second or subsequent treatment - radiotherapy	>94%	1.0	No	0
Cancer 31 day wait from diagnosis to first treatment	>96%	0.5	No	0
Cancer 2 week (all cancers)	>93%	0.5	No	
Cancer 2 week (breast symptoms)	>93%	0.5	No	0
Care Programme Approach (CPA) follow up within 7 days of discharge	>95%	1.0	No	
Care Programme Approach (CPA) formal review within 12 months	>95%	1.0	No	0
Admissions had access to crisis resolution / home treatment teams	>95%	1.0	No	0
Meeting commitment to serve new psychosis cases by early intervention teams	>95%	0.5	No	0
Ambulance Category A 8 Minute Response Time - Red 1 Calls	>75%	0.5	No	0
Ambulance Category A 8 Minute Response Time - Red 2 Calls	>75%	0.5	No	0
Ambulance Category A 19 Minute Transportation Time	>95%	1.0	No	0
Clostridium Difficile -meeting the C.Diff objective	as agreed	1.0	No	0
MRSA - meeting the MRSA objective	as agreed	1.0	No	0
Minimising MH delayed transfers of care	<=7.5%	1.0	No	0
Data completeness, MH: identifiers	>97%	0.5	No	0
Data completeness, MH: outcomes	>50%	0.5	No	0
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	0.5	No	0
Risk of, or actual, failure to deliver mandatory services	N/A	4.0	No	0
CQC compliance action outstanding (as at 31 May 2013)	N/A	special	No	
CQC enforcement action within last 12 months (as at 31 May 2013)	N/A	special	No	
CQC enforcement notice currently in effect (as at 31 May 2013)	N/A	4.0	No	
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 31 May 2013)	N/A	special	No	
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 31 May 2013)	N/A	2.0	No	0
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate	N/A	2.0	No	0
Score of 7 or less in standard 1 assessment at last NHSLA CNST inspection (maternity or all services)	N/A	special	No	
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A	special	No	

Indicative Governance risk rating GREEN

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **24th May 2013**	
Annual Risk Report 2012-13 **Submitted by:**Robert Burns Acting Chief Operating Officer	**Paper No: Attachment J**
Aims / summary This report provides a summary and overview of patient safety incident activity over the last year	
Action required from the meeting To note the content of the report	
Contribution to the delivery of NHS Foundation Trust strategies and plans Contributes to the zero harm agenda	
Financial implications None of note	
Legal issues None of note	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision? Salina Parkyn, Assistant Head of Quality, Safety and Transformation – 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	

Annual Risk Management Report
April 2012 – March 2013

Executive Summary

This report provides a summary and overview of patient safety incident activity over the last year.

1. Incident Reporting Levels

1.1 Internal Analysis

There were 4128 patient safety incidents reported in the last year (April 12 – March 13) via the Trust's incident reporting System. **Fig. 1** demonstrates the trends in the numbers of incidents reported year on year since 2010.

The graph shows that there has been an increase in incident reporting by 33% between January and March 2011 and January and March 2012.

It is likely that the decrease in incidents being reported during January and December 2010 is due to the introduction of the web based incident reporting system. By December 2010 there were 2 pilot areas in the Trust using the system. However other areas were aware of this system and it is possible that there was some initial confusion over the route to be used to report incidents.

The national trends when changing the process for reporting incidents is for incident reporting to decrease during the implementation period of the new system. The official launch date for the trusts new electronic incident reporting system was April 2011, however due to piloting the system and pre-launch training sessions being held there were a moderate number of areas using the system intermittently during the period of December 2010 – March 2011.

1.2 Analysis of incident reporting Trends following implementation of web reporting

The Trust implemented an online incident reporting system (DATIXWeb) in April 2011. This was to improve on the timeliness of incident reporting to aid accurate analysis of trends.

Since the implementation of DATIXWeb the Risk Management team have been monitoring the effectiveness of the system. Between April 2010 and March 2011 the Trust received 3389 patient safety incident reports. After implementation of DATIXWeb in April 2011 the number of patient safety incidents rose to 3559 (April 2011-March 2012). This was an increase of 5%. Between April 2012 and March 2013 there has been a further increase of 13.7% from 2011-12.

There has been an increase in the time taken to report incidents after they occur and an increase in the time taken to process these incidents once they have been reported. This has an impact on the time taken to close the incident from the date of submission.

2. Analysis of reported incidents (including level of harm)

Of the 4128 incidents reported in this period, 117 were reported as causing significant harm. 1330 were reported as causing minor harm and 2681 were reported as causing no harm.

In 2011/12 96% of incidents that were reported resulted in no harm or low harm. This year the Trust has achieved 98% of no or low harm incidents reported.

Severity of incident	Number of incidents	Percentage of incidents
No harm	2681	66%
Low	1330	32%
Moderate	92	2%
Major	16	0%
Catastrophic	9	0%

Incident reporting levels can be used as an indication of an organisation's safety culture. The sign of a safe reporting culture is one in which there continues to be high numbers of incidents reported, but that the level of harm caused by those incidents decreases. The overall Trust picture is shown in **Fig. 4** below.

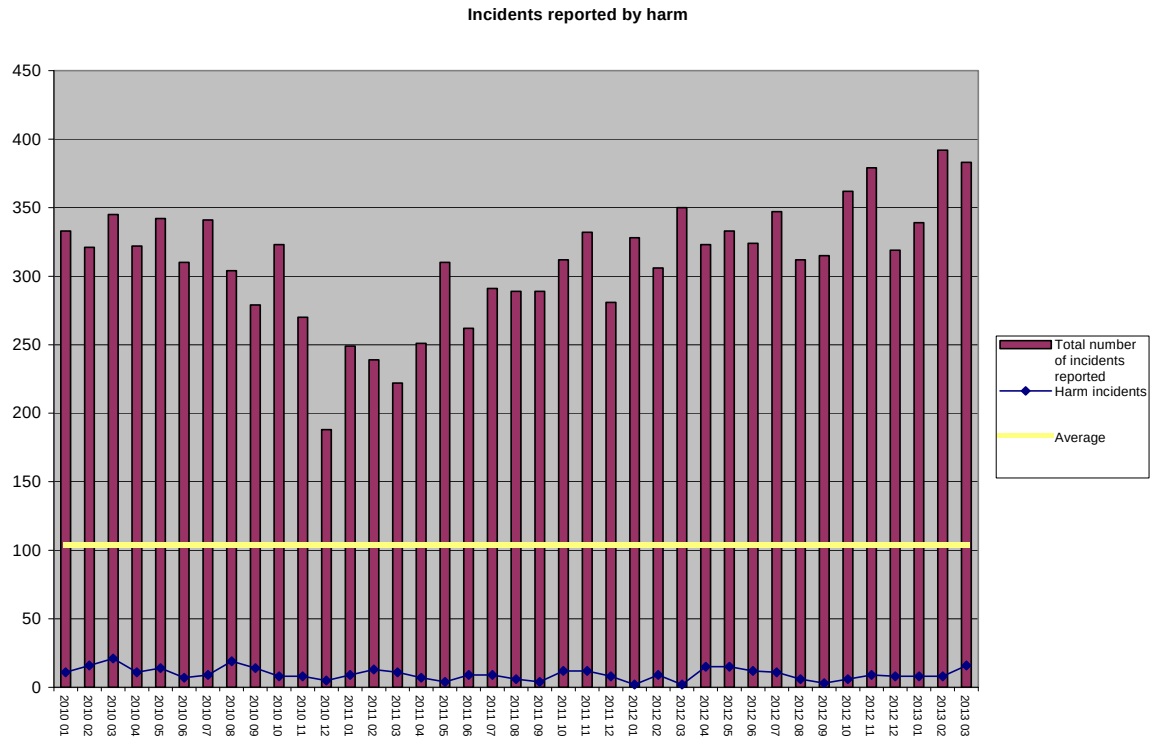


Fig. 4 above shows that the total number of harm incidents reported has been decreasing since 2010 where there were 143 incidents reported, in 2011 there were 104 and in 2012 there were 98 harm incidents reported. This shows that the Trust is making significant progress towards its zero harm goals and is due to hard work in all areas at implementing effective measures to reduce the levels of harm being caused to patients.

3. Type of harm caused

In 2012-13 the top 3 types of harm caused by reported incidents were:

- Infection Control

- Treatment, procedure
- Skin/Pressure issue

Infection Control
There were 27 infection control incidents during this period. The breakdown for these is as follows:

- 7MRSA/MSSA positive patients on admission
- 15 hospital acquired MSSA/MRSA patients
- 4 patients contracted influenza A
- 1 patient contracted chicken pox from sibling

There are currently 19 Infection Control risks on the Trusts wide risk register which are being managed at a local level. These include:

- 7 Low risks
- 8 Medium risks
- 4 High risks

9 of these were opened between April 2012 and March 2013.

10 of these risks have been opened for over 12 months.

	HIGH	MEDIUM	LOW	Total
Cardio-respiratory Services	1	2	0	3
Facilities(inc. OPD)	0	1	0	1
ICI-LM	0	0	1	1
Neurosciences	0	0	1	1
Surgery	0	0	4	4
Totals:	1	3	6	10

1 of these incidents was investigated as part of a SI investigation.

Treatment/Procedure
Treatment/Procedure incidents accounted for 24 of the incidents reported in the Trust.

The types of incidents included in this category were:

- Delay/failure to monitor
- Delay / failure in recognising complication of treatment
- Delay / difficulty in obtaining clinical assistance
- Treatment / procedure - delay / failure
- Extravasation injury
- Treatment / procedure - inappropriate

There are currently 14 Treatment, procedure risks on the Trusts wide risk register which are being managed at a local level. These include:

- 6 Low risks
- 6 Medium risks
- 2 High risks

4 of these were opened between April 2012 and March 2013.

10 of these risks have been opened for over 12 months.

	HIGH	MEDIUM	LOW	Total
Cardio-respiratory Services	1	1	0	2
ICI-LM	0	1	0	1
MDTS	0	0	1	1
Neurosciences	1	2	1	4
Surgery	0	0	2	2
Totals:	2	4	4	10

8 of these were investigated as part of SI investigations. The learning from SIs closed for this period is included in **Appendix 1.**

Skin/Pressure issues
Skin/Pressure issue incidents accounted for 15 of the incidents reported in the Trust.

The types of incidents included in this category were:

- Hospital acquired pressure ulcer
- Pressure ulcer on admission

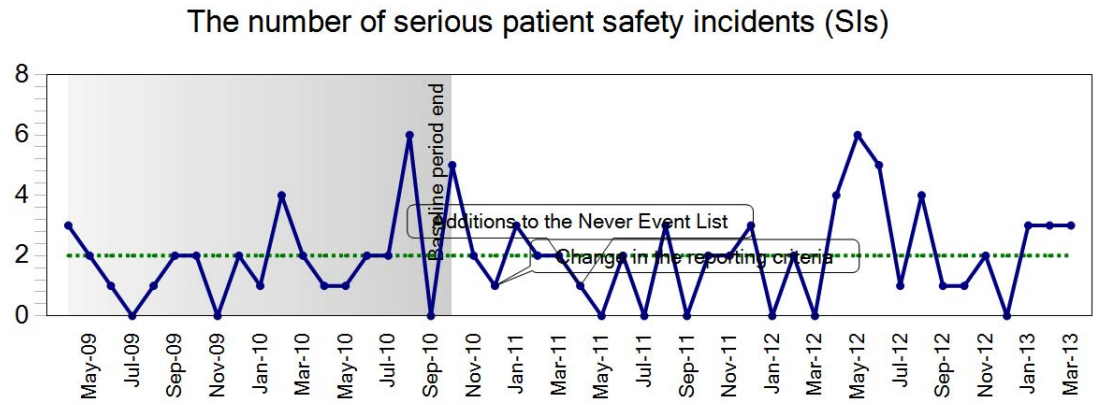
This is a new category that has been added to Datix, there are currently no risks categorised as Skin/Pressure issue.

8 of these were investigated as part of SI investigations. The learning from SIs closed for this period is included in **Appendix 1.**

4. External Reporting
NHS London
To enable the Trust to achieve the goal of zero harm it is important that all staff is able to openly report and discuss incidents which result in harm to patients. By reporting incidents of all levels of severity it is possible to analyse and identify the systemic changes that the Trust needs to make in order to improve the safety of our patients and staff. It is important that the Trust Board is aware of all SIs.

The Trust has reported 33 SIs in 2012-13. 31 of these incidents were directly related to patient care.

The chart below indicates the occurrence of SIs in the Trust between May 2009 and March 2013. SIs are not just concerned with incidents that cause harm to patients; they include incidents relating to the loss/misuse of confidential information, fires, child protection, ward closures and incidents likely to attract adverse media attention.



The data above is presented in Statistical Process Control (SPC) charts, which allow you to see the difference between common cause (normal) variation and special cause variation. The red lines are the upper and lower control limits and data which falls within these limits are within common cause variation. When using SPC charts, we are looking for special causes, which result from a significant change in the underlying process.
SPC is the tool that we use to determine where a change in practice has led to an improvement.

MHRA Alerts
The MHRA send frequent alerts to the Trust via the Central Alerting System (CAS). Each alert specifies a different timescale for action and completion depending on the severity of the alert and the actions required.

Between April 2012 and March 2013 the Trust received 89 MHRA Alerts. 19 of the alerts received were relevant to the Trust and the actions required were completed. There were a further 6 received which were relevant to the Trust, these remain under review.

The other alerts received may be Rapid Response Reports or Patient Safety Alerts from NPSA or Estates Notices from the Department of Health. 3 Alerts of this type were received by the Trust during 2012-13. 2 of these required action by the Trust and were completed. 1 is still under review.

5. Risk Register Analysis
5.1 General
There are currently 339 open risks on the Datix Risk Management system. 217 of these were opened between April 2012 and March 2013.
Of the 217 risks opened:

- 67 were graded as high
- 101 were graded as medium
- 49 were graded as low

There were 371 risks closed during this period. Of the 371 risks that were closed:

- 40 were graded as high
- 149 were graded as medium
- 182 were graded as low

5.2 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, and Low) can be seen in the chart below.

The top risks opened in 2012-13:

- Infrastructure
  The majority of these risks (65) are regarding lack of maintenance of equipment.
  Other types of infrastructure risks are regarding:
  - Lack of maintenance of equipment
  - Lack of staff
  - Environmental issues

- **Information Governance**
  All (19) of these incidents are regarding the risk of patient confidentiality breaches.

In total there are 23 Information Governance risks open.

	HIGH	MEDIUM	LOW	Total
Clinical Research Facility	0	1	0	1
Finance	3	11	3	17
MDTS	0	1	2	3
Surgery	0	1	0	1
Trust wide	0	1	0	1
Totals:	3	15	5	23

4 of these have been opened for over 12 months.

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 24th May 2013	
Safeguarding Annual Report 2012-13 **Submitted by:** Liz Morgan, Chief Nurse and Families Champion	**Paper No: Attachment K**
Aims / summary Provide a summary report of Trust progress, activity and achievements April 2012-March 2013 and identify areas of development for 2013-2014.	
Action required from the meeting Ratify report; raise any issues or areas of concern the report raises.	
Contribution to the delivery of NHS Foundation Trust strategies and plans CQC Core Standard 2 Child Protection. Requirement also from NHS London that all Trusts are reported to on an annual basis on Child Protection.	
Financial implications None	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? Named Child Protection Staff and Management Leads	
Who needs to be told about any decision? Liz Morgan - Board Lead for Child Protection	
Who is responsible for implementing the proposals / project and anticipated timescales? Liz Morgan	
Who is accountable for the implementation of the proposal / project? Liz Morgan, Chief Nurse and Families Champion	

Great Ormond Street Hospital for Children NHS Foundation Trust

GREAT ORMOND STREET HOSPITAL NHS FOUNDATION TRUST

SAFEGUARDING CHILDREN and YOUNG PEOPLE

ANNUAL REPORT

2012- 2013

Author: Liz Morgan - Chief Nurse / Executive Lead for Safeguarding

Trust Board: 24 May 2013

Camden LSCB:

1. Introduction

Great Ormond Street Hospital NHS Foundation Trust (GOSH) requires consistently delivered clinical outcomes that place us amongst the top 5 Children's Hospitals in the world.

The annual report relates to the period from 1/4/2012 – 31/3/2013.
During this period there were 42,133 inpatient episodes and 195,737 outpatient attendances.

The Children Act 1989 and 2004 (Section 11) places a duty upon all NHS Provider Services to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children. From 15/4/2013 Working Together to Safeguard Children 2013 replaces the statutory guidance of Section 11 of the Children Act 2004.
The Trust is expected to ensure that its' provider arrangements are robust and that safeguarding and promoting the welfare of children is integral to clinical governance and audit arrangements. Service specifications drawn up by our commissioners Camden Clinical Commissioning Group (formerly North Central London) include clear service standards for safeguarding and promoting the welfare of children.

2. Summary of progress and achievements

2.1 Priorities for 2012–2013

2.1.1 To develop a Safeguarding Metrics in line with the requirements of the North Central London (NCL) Health cluster.
This has reflected GOSH progress against national safeguarding standards.

2.1.2 To achieve North Central London (NCL) Safeguarding metrics on; record keeping, CP supervision; training, and attendance at Case conferences.
Training compliance has exceeded the 80% target at all levels. At level 3 - the workforce trained over the past year has increased by more than 40% to achieve the shorter timescale that was set by NCL, reflecting a significant increase in training activity. The metrics are monitored quarterly within the Child Protection Management Group (CPMG).
The Safeguarding Team has completed quarterly record keeping audits.

2.1.3 Review new requirements for Serious Case Review (SCR) systems in relation to Munro review and revised "Working Together" (2010) to ensure compliance.
This has been commensurate with the delayed publication of Working Together and is currently in progress.

2.2 Safeguarding Team Review

A Trust wide consultation on the Safeguarding Service was undertaken, following transfer of North Middlesex University Hospital (NMUH) Children's Services to NMUH and Haringey Community Services to Whittington Health. The outcome was a restructuring of the safeguarding team which was felt to be more attuned to meeting the needs of the workforce to ensure delivery of a high quality service to our patients and their families, which was implemented on 01/01/13. The safeguarding administrative team has provided an unfaltering service during a difficult period of transition and limited resources.

2.3 Serious Cases Review

2.3.1 January 2013 The Trust submitted a medical report that was requested by Harrow Local Safeguarding Children Board (LSCB), outlining our involvement that took place following the serious head trauma of a child under the age of 1 year.

2.3.2 March 2013 Participation in a second review involving a 9 week old baby with a head trauma injury who died, which is being progressed under the new guidance within Working Together.

The learning from the reviews will be disseminated to professionals across the Trust and where appropriate external networks, and audited to ensure embedding into practice has occurred.

2.4 Chronologies
In response to external and internal requests 9 chronologies have been completed this year.

3. Governance and Accountability Arrangements

3.1 Safeguarding Service as of 01/01/2013

Liz Morgan	Chief Nurse / Executive Lead for Safeguarding	1.0 WTE
Jan Baker	Head of Safeguarding / Named Nurse	1.0WTE
Nick Lessof	Named Doctor Safeguarding	4 PAs
Kim Whitchurch	Nurse Specialist Safeguarding	0.5WTE
Secondment (TBA)	Nurse Specialist Safeguarding	0.5WTE
Andrée Hughes	Safeguarding Administration Manager	1.0 WTE
Maternity leave cover	Administrator	0.5 WTE

With the implementation of the new structure there has been an increase in collaborative working between the Safeguarding Team and Social Work Service (SWS) with fortnightly meetings between senior managers established.

3.2 Social Work Service GOSH
The service provides a psychosocial needs-based service to patients and their families, together with specific advice and support to staff. Social Workers (SW)are ward allocated and work as part of the multi-disciplinary team, and provide a Trust wide duty service which deals with urgent or child protection cases, where the specialty has no allocated SW or that SW is not on site. The service consists of a team manager, 3 senior practitioner (clinical/ management) posts (one external charity funded), 18 SW posts, 6 of which are external charity funded, 3 Family Support Workers and 2 Family Support Officers. This year has seen the introduction of new social work posts on the surgical wards, in palliative care and renal service (2 of which are external charity funded).

3.3 Safeguarding Children Committees / Governance Meetings
The Trust is currently reviewing the role and value of all meetings.

3.3.1 Child Protection Management Group (CPMG)/Strategic Child Protection Management Group (SCPMG)
The focus has been on compliance with electronic and written referrals to SWS, record keeping in child protection cases and chronologies for complex cases. Future meetings will be combined, with external designate safeguarding professionals attending quarterly.

3.3.2 Quality & Safety Committee received quarterly reports outlining Safeguarding activity within the Trust.

3.3.3 Unit CPMG (3-6 monthly) Meetings have been under review and the newly established divisions will be consulted with as to their future format.

3.3.4 Safeguarding Children & Young People Link Networks for Nurses and Allied Health Professionals (AHP). A review of the role and responsibilities of link nurses has been completed and that for AHPs is in progress. The network convenes quarterly and is now jointly facilitated by the Named Nurse and SW Manager, providing a supervisory and learning function in addition to disseminating current research policy and information sharing, and enhancing additional competencies that are expected of members to fulfil their functions locally.

3.4 Multi-Agency arrangements
Camden Safeguarding Children Board (CSCB) is attended by GOSH Executive Lead for Safeguarding. CSCB Sub groups for Safeguarding Children, Quality Assurance and Learning &

Development Group are attended by Named or Specialist Professionals. The attendance has increased from 50% in Quarter 1 to 100% in the last quarter.

4. Monitoring and Evaluation/ Quality Assurance Activity

4.1 Safeguarding Metrics Camden CCG

The metrics has been agreed as a monitoring tool to aid collection and reporting of assurance data for Camden's NHS providers.

4.2 Policies and Procedures

GOSH Child Protection (CP) Procedures (2012) complement Working Together Guidance and the London Child Protection Procedures 2011. A review of our procedures is in progress following recent publication of the reviewed Working Together (2013) statutory guidance.

4.3 Training

GOSH has agreed a training strategy, based upon the Intercollegiate document (RCPCH 2010), which sets out; responsibility for training, content and requirements for each training levels and which staff should attend. The revised document has posed challenges to organisations in terms of the increase in the numbers of staff required to complete level three training.

Progression of training compliance throughout the year.

	Q1	Q2	Q3	Q4	Target
Level 1	86.2%	92.2%	92.3%	96%	>80%
Level 2	51.19%	65%	71%	85%	>80%
Level 3	38.3%	50%	60%	83.2%	>80%
Level 4	100%	100%	100%	100%	>80%

Camden CCG agreed to extend the deadline by one month for the Trust to achieve 80% compliance at Level 3 to 30th April, 2013. Work has been on-going through the year to increase training provision and also to ensure accurate data capture. The one day training has consistently evaluated well for staff at all grades and provides an alternative to the e learning option.

Performance for training is routinely reviewed via the CPMG and SCPMG. Monthly reports are available to Operational Management Group, quarterly to Quality & Safety and Clinical Governance Committee and annually to Trust Board to provide assurance on progress.

4.4 Supervision

- All staff can access supervision from the Safeguarding Team Professionals. In addition specific staff groups are targeted for regular structured supervision sessions.
- Group supervision is expanding to ward based supervision has been offered where possible in conjunction with the attached SW.
- Recently, professionals making electronic referrals to the SWS are offered supervision from the Named Professionals. The data will be reported on within the quarterly reports.
- Further development of supervision to a broader range of professionals will continue during this year including monitoring the level of compliance.
- A new supervision system is being implemented which will allow central auditing.
- The Supervision Policy is currently being reviewed to ensure that it incorporates changes within Working Together.

4.5 Audit and Monitoring

- A Safeguarding Audit plan is in place, and has drawn on areas within the scorecard.

- The Record Keeping Audit showed that standards of record keeping are largely being maintained. However, some areas of decreased compliance were noted partly due to a change in the mode of referrals to Social Work. The changes will be captured within the revised audit plan for 2013–2014.
- A database of all children who are subject to CP Conference is maintained to ensure that GOSH professionals make a contribution with the provision of a report or attendance at conference. The safeguarding team were notified of 18 CP Conferences in the past year in which a report or attendance from a representative of GOSH was provided. Plans are being developed to better understand and capture the expected number of conference invitations and responses in 2013-14.
- In July 2012 the Section 11 Audit (Annual agency self-evaluation against statutory guidance standards) was completed at the request of Camden LSCB and demonstrated compliance with all relevant requirements.
- GOSH continues to participate in the Camden LSCB Multi Agency Audit Process. The cases identified with GOSH involvement, highlighted the need to improve notification to the Trust of children who are subject to CP Plans (see 4.8.1).

4.6 Government Response to Savile allegations
Sir David Nicholson (Chief Executive NHS) wrote to all NHS Trust Chief Executives on 12th November 2012 to request they review their Trust arrangements and practices relating to vulnerable people, particularly in relation to: safeguarding; access to patients (including that afforded volunteers or celebrities); and listening to and acting on patient concerns.
The Trust responded with a robust Action Plan which was completed by 31st March 2013.

4.7 Social Work Referral Activity
The new data activity recording system used in Social Work since October 2012 has improved identification and targeting work undertaken by SW staff. There has subsequently been an increase in referral activity and good compliance with electronic submission.
From January- March 2013, 581 referrals were received by GOSH Social Work Service -116 (20%) identified as child protection, while 465 were Child in Need.

4.8 External Inspections

4.8.1 February 2012; Camden Ofsted/ Care Quality Commission Inspection
The overall effectiveness of arrangements was judged to be GOOD.
The inspection recommended:

- **Camden CCG ensures that performance monitoring metrics for safeguarding children and young people are embedded across all service providers.**
  Compliance with the Metrics is in place and reported on a monthly and quarterly basis to commissioners including information regarding the Trust flagging system.

- **GOSH to review challenges, local and national initiatives for flagging and provide a plan in regards to this review.**
  - External referrers were asked to notify GOSH if a child is subject to a CP plan. A letter was sent to all Hospital Chief Executives, Designated Professionals and LSCBs.
  - Key internal staff provided with a simplified pathway of process of flagging children subject to CP plans.
  - Outpatient staff were provided with additional information on enquiring of all parents/carers as to whether the child was subject to a CP Plan.
  - GOSH met with representatives from the Department of Health (DOH) in September 2012 and have been invited to participate in the pilot of a DOH Information Sharing Project, which would enable healthcare staff to view information on the statutory position of children subject to a CP Plan or Statutory

Order. This would be dependent on available financial support from within the Trust.

- **Assurance that safer recruitment policy and practice is embedded in all provider services.**
  GOSH has a Safer Recruitment Policy in place.
  Currently, 98.51% staff have been cleared through The Disclosure and Barring Scheme
  Remaining staff are applications in progress or those who are on long term sick leave.

4.8.2 December 2012; Unannounced Pilot Ofsted multi inspection of Camden Local

Authority arrangements for the protection of children.
The overall effectiveness of arrangements was judged to be GOOD.**The inspection recommended that all health providers strengthen regular supervision arrangements for staff.**

- GOSH has a supervision policy in place, and all staff can access supervision on an ad hoc basis.
- At the point of referral the practitioner will be offered supervision from the safeguarding team.
- Regular supervision has been offered to identified teams on a regular (6-12 weekly) basis. This will be expanded with an increased resource to other wards and departments who would benefit from regular reflection.

5. Key Priorities for 2013 – 2014
5.1 Achievement of external regulatory/contractual standards and metrics.
Meet required safeguarding standards of our commissioners and external inspectorates i.e. CQC; Camden CCG; DH

5.2 GOSH Safeguarding Scorecard: Further development of the use of the scorecard to ensure it fits with reporting plan. The metrics is being utilised with the GOSH scorecard for internal and external monitoring of safeguarding children indicators.

5.3 Supervision: Ensuring identified health practitioners receive regular structured safeguarding supervision.

5.4 Training: To ensure progress with Levels 1-3 is maintained and the Trust moves towards the gold standard of 95%.

5.5 Completion of the Record Keeping Audit review in order to capture the recommendations from Munro, changes in Working Together and Ofsted/CQC Inspection standards.

5.6 Understand the anticipated likely number of invitations and monitor professionals input to CP Conferences. Staff receiving an invitation are expected to provide a written report for conference whether they attend or not.

5.7 Provide quarterly safeguarding reports to Divisional Directors.

5.8. Ensure that GOSH organisational policy and procedures are compliant with Working Together,NHS Accountability Framework, and London CP Procedures
5.9 Complex cases to have an identified lead professional where multiple medical teams are involved and development of a management pathway. Complete development of a flexible chronology template and providing guidance for completion.
5.10 Develop a clinical database for outcome tracking.

6. Recommendation

The Trust Board are asked to note the priorities for the year ahead and continue to support the development of safeguarding children arrangements.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 24th May 2013	
CQC Compliance Update **Submitted by:** Dr Anna Ferrant, Company Secretary	**Paper No: Attachment L**
Aims / summary To provide the Trust Board with an update on compliance against the Care Quality Commission Essential Standards of Quality and Safety.	
Action required from the meeting To review and note compliance and progress with implementation of an internal process to monitor CQC outcomes.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Aligned against Trust Objectives and Assurance Framework	
Financial implications Possible penalty fines for any non-compliance.	
Legal issues Enforcement action can be taken if found to be non-compliant	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision? Trust Board	
Who is responsible for implementing the proposals / project and anticipated timescales? Operational Leads	
Who is accountable for the implementation of the proposal / project? Director Leads	

Attachment L

CQC Compliance – Annual Audit
May 2013

A review against the Care Quality Commission (CQC) 'Essential Standards of Quality and Safety' has been undertaken to determine the Trusts' level of compliance.

The following sources of information were reviewed as part of this audit:

- Trust Completed Provider Compliance Assessment (PCA) Tools
- NHSLA Level 3 Assessment Evidence
- Assurance Framework
- Minutes and Reports (including performance reports):
  - Trust Board
  - Audit Committee
  - Clinical Governance Committee
  - Quality and Safety Committee
  - Risk Assurance and Compliance Group
- Internal Audit Report (May 2013)
- CQC Inspection Report (September 2012)

From an initial review of this evidence, the Trust is fully compliant with the CQC essential standards. Further assurance against the standards will be monitored by internal annual self-assessment inspections overseen by the Compliance and Governance Manager.

These inspections will be conducted in conjunction with the work already in place by the Nursing, Infection Control and Corporate Facilities' Teams. The information resulting from these inspections will be fed back to the Wards and monitored by the Risk Assurance and Compliance Group with any recommendations being monitored via an action plan.

To further monitor the current position against the CQC standards, a database for the assurance of compliance has been developed. The database will look at the controls and assurances in place against each outcome including any gaps with actions to be completed.

The database will be requested to be updated by Operational Leads on a quarterly basis with monitoring of the process being managed by the Risk Assurance and Compliance Group. Updates on assurance and compliance will be reported to the Clinical Governance Committee with the first version being presented to the June 2013 Clinical Governance Committee meeting.

The current position against the CQC Quality and Risk Profile can be found on **Appendix A** detailing the Risk Estimates over time and **Appendix B** detailing the Trust's current position against the latest (March 2013) document published.

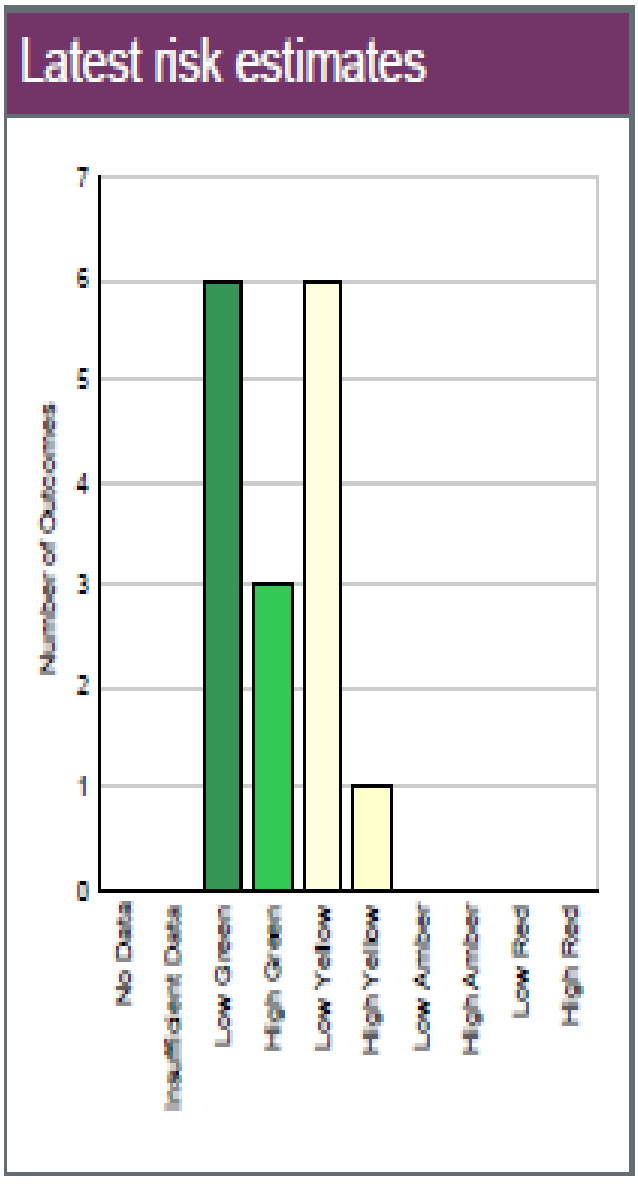
The CQC conducted an unannounced inspection on the 25th September 2012. The CQC reviewed Outcomes 1, 4, 5, 7, 8, 9, 14 and 17 and found the Trust to be fully compliant.

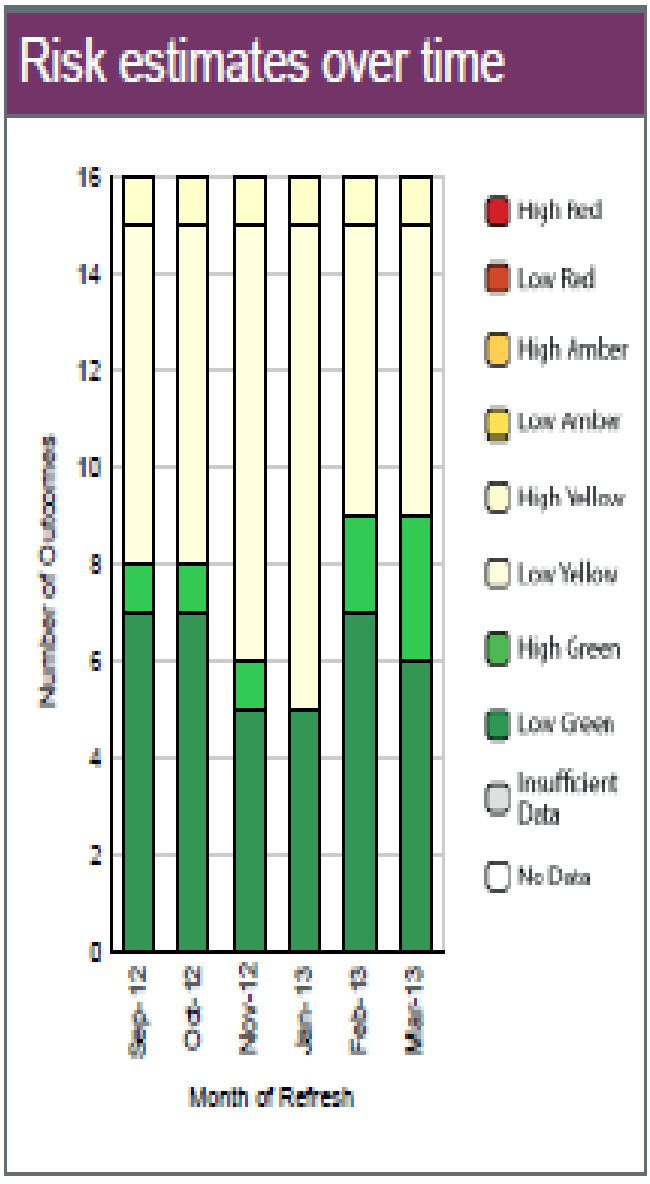
Internal Audit completed an audit of the CQC Compliance Monitoring Arrangements in May 2013 reviewing the process in its entirety and elements of Outcomes 8, 9 and 13. The audit opinion showed Significant Assurance.

A summary page, including Operational and Director Leads, and example template of the new assurance process can be found on **Appendix C** and **Appendix D**.

Attachment L

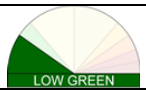
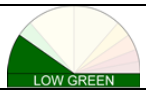
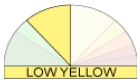
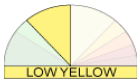
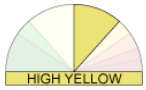
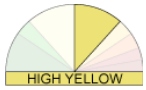
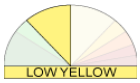
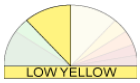
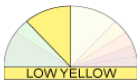
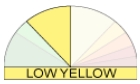
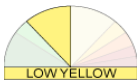
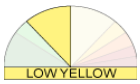
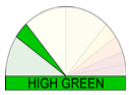
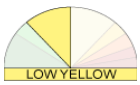
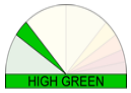
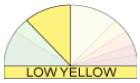
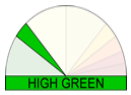
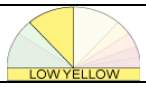
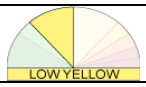
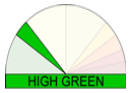
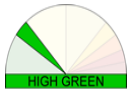
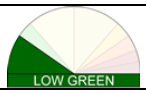
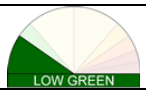
Appendix A





Great Ormond Street Hospital for Children NHS Foundation Trust

Appendix B

Outcome	February 2013	March 2013	Trend	CQC Inspection Outcome
Outcome 1: Respecting and Involving People Who Use Services			⟷	Inspected as Compliant: June 2011, September 2012
Outcome 2: Consent to Care and Treatment			⟷	Inspected as Compliant: June 2011
Outcome 4: Care and Welfare of People Who Use Services			⟷	Inspected as Compliant: June 2011, September 2012
Outcome 5: Meeting Nutritional Needs			⟷	Inspected as Compliant: June 2011, September 2012
Outcome 6: Cooperating With Other Providers			⟷	Inspected as Compliant: June 2011
Outcome 7: Safeguarding People Who Use Services from Abuse			⟷	Inspected as Compliant: June 2011, September 2012
Outcome 8: Cleanliness and Infection Control			⟷	Inspected as Compliant: June 2011, September 2012
Outcome 9: Management of Medicines			⟷	Inspected as Compliant: June 2011, September 2012
Outcome 10: Safety and Suitability of Premises			↓	Inspected as Compliant: June 2011
Outcome 11: Safety, Availability and Suitability of Equipment			↑	Inspected as Compliant: June 2011
Outcome 12: Requirements Relating to Workers			↑	Inspected as Compliant: June 2011
Outcome 13: Staffing			⟷	Inspected as Compliant: June 2011
Outcome 14: Supporting Staff			⟷	Inspected as Compliant: June 2011, September 2012
Outcome 16: Assessing and Monitoring the Quality of Service Provision			⟷	Inspected as Compliant: June 2011
Outcome 17: Complaints			⟷	Inspected as Compliant: June 2011, September 2012
Outcome: 21 Records			⟷	Inspected as Compliant: June 2011

Great Ormond Street Hospital for Children NHS Foundation Trust

Appendix C

CQC Assurance of Compliance - Summary

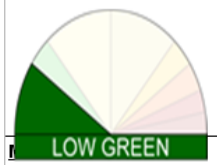
Outcome	Operational Lead	Director Lead	Operational Committee	Compliance Rating	Date Reviewed	NHSLA Standard(s)
Section 1 - Involvement and Information						
Outcome 1 - Respecting and Involving People Who Use Services	Assistant Chief Nurse	Chief Nurse	PPIEC			5.2 / 5.6 / 5.7
Outcome 2 - Consent to Care and Treatment	Associate Medical Director	Medical Director	Quality and Safety Committee			5.2 / 5.3
Section 2 - Personalised Care, Treatment and Support						
Outcome 4 - Care and Welfare of People Who Use Services	Assistant Head of Quality, Safety and Transformation - Risk	Medical Director	Quality and Safety Committee			2.2 / 2.4 / 2.5 / 2.6 / 2.7 / 2.10 / 4.4 / 4.5 / 4.8 / 4.9 / 5.6 / 5.7 / 5.8 / 5.9
Outcome 5 - Meeting Nutritional Needs	Assistant Chief Nurse	Chief Nurse	Nutrition Group			N/A
Outcome 6 - Cooperating With Other Service Providers	Director of Planning and Information	Chief Operating Officer	Quality and Safety Committee			1.6 / 4.9 / 4.10
Section 3 - Safeguarding and Safety						
Outcome 7 - Safeguarding People Who Use Services From Abuse	Named Nurse - Child Protection	Chief Nurse	Child Protection Management Group			N/A
Outcome 8 - Cleanliness and Infection Control	Consultant - Bacteriology	Chief Nurse	Infection Control Committee			4.6 / 4.7
Outcome 9 - Management of Medicines	Chief Pharmacist	Medical Director	Drugs and Therapeutics Committee			5.10
Outcome 10 - Safety and Suitability of Premises	Estates	Chief Operating Officer	Health and Safety Committee			4.1 / 4.2 / 4.3 / 4.4
Outcome 11 - Safety, Availability and Suitability of Equipment	Chief Pharmacist	Chief Operating Officer	CESC / MESG			5.4 / 5.5
Section 4 - Suitability of Staffing						
Outcome 12 - Requirements Relating to Workers	Head of Operational HR	Director of HR	HR & Operations Board			1.10 / 1.9 / 3.10 / 4.7
Outcome 13 - Staffing	Head of Workforce Planning and Development	Director of HR	HR & Operations Board			N/A
Outcome 14 - Supporting Workers	Head of Education and Training	Director of HR	Education and Training Committee			3.1 / 3.2 / 3.3 / 3.4 / 3.5 / 3.6 / 3.7 / 3.8 / 3.9 / 4.6 / 5.1 / 5.3 / 5.5
Section 5 - Quality of Management						
Outcome 16 - Assessing and Monitoring the Quality of Service Provision	Head of Quality, Safety and Transformation	Medical Director	Quality and Safety Committee			1.1 / 1.2 / 1.3 / 1.4 / 1.5 / 1.6 / 2.1 / 2.2 / 2.4 / 2.5 / 2.6 / 2.7 / 2.8 / 2.9 / 2.10
Outcome 17 - Complaints	Assistant Head of Quality, Safety and Transformation - Risk	Medical Director	Quality and Safety Committee			2.3
Outcome 21 - Records	Head of Corporate Facilities	Chief Operating Officer	Records Management Committee			1.7 / 1.8

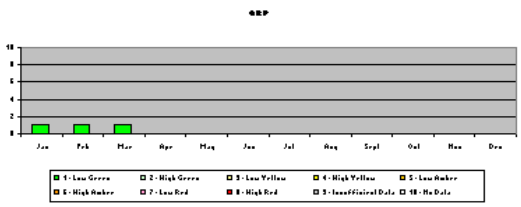
Great Ormond Street Hospital for Children NHS Foundation Trust

Appendix D

CQC Assurance of Compliance

Section 1: Involvement and Information	**Date Last Reviewed:**	
Outcome 1 - Respecting and Involving People Who Use Services		
People who use services: ▪ Understand the care, treatment and support choices available to them ▪ Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support ▪ Have their privacy, dignity and independence respected ▪ Have their views and experiences taken into account in the way the service is provided and delivered.	**This is because providers who comply with the regulations will:** ▪ Recognise the diversity, values and human rights of people who use services ▪ Uphold and maintain the privacy, dignity and independence of people who use services ▪ Put people who use services at the centre of their care, treatment and support by enabling them to make decisions ▪ Provide information that supports people who use services, or other acting on their behalf, to make decisions about their care, treatment and support ▪ Support people who use services, or others acting on their behalf, to understand the care, treatment and support provided ▪ Enable people who use services to care for themselves where this is possible ▪ Encourage and enable people who use services to be involved in how the service is run ▪ Encourage and enable people who use services to be an active part of their community in appropriate settings.	
Director Lead: Chief Nurse	**Operational Lead:** Assistant Chief Nurse	
Operational Committee: Nursing Board	**NHSLA Standard:** 5.2 Patient Information and Consent / 5.6 Screening Procedures / 5.7 Diagnostic Testing Procedures.	
Month: March 2013	**Rationale / Trend for QRP Rating**	





M	**Monitoring Scores (Indicator Results)**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Controls	**Gaps in Control (Including Actions)**	Initial	Date
1.	1.		
2.	2.		
3.	3.		
4.	4.		
5.	5.		

Assurances	**Gaps in Assurance (Including Actions)**	Initial	Date
1.	1.		
2.	2.		
3.	3.		
4.	4.		
5.	5.		

Additional Comments	**Compliance Rating**

Compliance Rating Key:	COMPLIANCE	Minor Concern	Moderate Concern	Major Concern

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
24th May 2013

Update on local action planning in response to 2012 national Staff Survey **Submitted by:** Director of HR&OD	**Paper No: Attachment M**

Aims / summary
To update the Board on progress of each directorate/division in developing action plans to address issues raised by staff locally.

Action required from the meeting
To note the contents of the paper and support ongoing work.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Staff survey results contribute to the Quality Account and are monitored by CQC. Staff satisfaction supports high levels of recruitment, retention and performance. Staff survey results inform work in response to Francis report.

Financial implications
None

Legal issues
None

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?
Results have been publicised widely to all staff. Local plans include actions on engagement with teams over the results and the plans.

Who needs to be told about any decision?
Overall Management Group

Who is responsible for implementing the proposals / project and anticipated timescales?
Director of HR&OD

Who is accountable for the implementation of the proposal / project?
Overall Management Group

Great Ormond Street Hospital for Children NHS Foundation Trust
Paper to the Trust Board from the Director of HR & OD
24th May 2013

Update on local action planning in response to 2012 national Staff Survey

Introduction and Background

This paper provides an update to the Trust Board on local action plans developed by divisions and directorates in response to the 2012 annual staff survey.

The results of the survey were published on 28th February 2013 and considered by Overall Management Group (OMG) and Trust Board in March. OMG agreed that all directorates and divisions should develop local action plans to respond to issues raised by their staff. The rationale for this approach is:

- Local teams are able to directly address the concerns raised by their own staff rather than simply being included in corporate actions which may not be relevant to their area.
- Actions and progress can be communicated and monitored more effectively if owned locally.
- Staff are more likely to see a direct correlation between the views they expressed and resulting action, therefore promoting confidence in the survey process and improving overall response rates.

Summary of action to date

All divisions and directorate management teams received copies of information in March 2013 which allowed them to identify priority areas for action. The table below sets out the status of action plans for each area:

	STATUS OF ACTION PLAN		
DIVISION/DIRECTORATE	**In place**	**In development**	**No action plan**
Surgery and Theatres	✓		
ICI/LM	✓		
Medicine/DTS	✓		
Critical Care and Cardio-Respiratory	✓		
Neurosciences	✓		
IPP	✓		
Finance/ICT		✓	
HR&OD	✓		
Redevelopment			✓
Estates	✓		
Nursing	✓		
Medical Director			✓
Operations (inc QST and Planning)	✓		
Facilities	✓		

NB – Discussions have only recently commenced with the R&D General Manager regarding developing a local action plan.
OMG will continue to monitor the development and delivery of action plans, requiring progress reports from all directorates and divisions.

Action required

Trust Board is asked to note the progress towards delivery of local action plans across the organisation.