Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Meeting of the Trust Board
Wednesday 27th November 2013

Dear Members

There will be a public meeting of the Trust Board on Wednesday 27th November 2013 at 2:45pm in the **Charles West Boardroom, Level 2, Paul O'Gorman,** 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 25th September 2013**	Chairman	**L**
3.	**Matters Arising/ Action Checklist** • **Update on Outpatient 'Do Not Attends' (DNAs) and Clinic Cancellations**	Chairman Director of Planning and Information	**M** **N**
4.	**Chief Executive Report**	Chief Executive	**Verbal**
	PRESENTATIONS		
5.	**Clinical presentation – Nephrology**	Dr Lesley Rees, Consultant Nephrologist	**O**
	STRATEGIC ISSUES		
6.	**Update on Action Plan for Extending Working**	Director of Planning and Information	**P**
7.	**Annual Plan Mid-Year Review**	Director of Planning and Information	**R**
	PERFORMANCE		
8.	**Performance Report** • **Targets and Indicators** • **Finance** • **Quality and Safety** • **Patient Experience (and PALS report)**	Chief Executive Chief Operating Officer Chief Finance Officer Co-Medical Director Chief Nurse and Families' Champion	**S**

9.	**Bed Management Update**	Director of Planning and Information	**Q**
10.	**Regular Infection Prevention & Control Update**	Chief Nurse and Families' Champion/Director of Infection Prevention and Control	**T**
11.	**Proposed changes to the Trust's Cash Releasing Efficiency Savings (CRES) delivery processes**	Chief Finance Officer	**U**
	GOVERNANCE		
12.	**Timetable for Trust Board Evaluation**	Company Secretary	**X**
13.	**Register of Seals**	Company Secretary	**V**
14.	**Medical Revalidation and Appraisal Update**	Co-Medical Director (BB)	**W**
	REPORTS FROM COMMITTEES		
15.	**Clinical Governance Committee update – October 2013 meeting**	Chair of the Clinical Governance Committee	**1**
16.	**Finance and Investment Committee update – October 2013 meeting**	Chair of the Finance and Investment Committee	**2**
17.	**Audit Committee update – October 2013 meeting**	Chair of the Audit Committee	**3**
18.	**Members' Council Update – November 2013**	Chairman	**Verbal**

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.)

Next meeting
The next Trust Board meeting will be held on Tuesday 28th January 2014 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT L

Great Ormond Street Hospital for Children NHS Foundation Trust NHS

DRAFT Minutes of the meeting of Trust Board on Wednesday 25th September 2013

Present

Baroness Tessa Blackstone	Chairman
Mr Jan Filochowski	Chief Executive
Ms Mary MacLeod	Non-Executive Director
Ms Yvonne Brown	Non-Executive Director
Mr John Ripley	Non-Executive Director
Mr David Lomas	Non-Executive Director
Mr Charles Tilley	Non-Executive Director
Prof Rosalind Smyth	Non-Executive Director
Mr Robert Burns	Director of Planning and Information
Professor Martin Elliott	Co-Medical Director
Mrs Liz Morgan	Chief Nurse and Families' Champion
Mrs Claire Newton	Chief Finance Officer
Mr Ali Mohammed	Director of Human Resources and OD
Ms Rachel Williams	Chief Operating Officer

In attendance

Mr Robert Burns	Director of Planning and Information
Professor David Goldblatt	Director of Research and Innovation
Ms Emma Pendleton	Deputy Director of Research and Innovation
Mrs Liz Rippon	Strategy Lead
Mr Matthew Tulley	Director of Redevelopment
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Three members of the public	

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

83	**Apologies for absence**
83.1	Apologies for absence were received from Dr Barbara Buckley, Co-Medical Director.
84	**Declarations of interest**
84.1	No declarations of interest were received.
85	**Minutes of previous meetings**
85.1 85.2	**Action:** It was agreed that further discussion would take place around minute 60.4: provision on the Board for a Non-Executive Director with a medical background at the next Board review. Minute 62 – **Action:** It was agreed that an action would be added to the minutes to

	request a paper at the November meeting to consider how further progress could be made in implementing more evening and Saturday working.
85.3	**Action:** It was agreed that discussion would take place around extended working at the next senior staff meeting on 15th and 17th October.
85.4	**Action:** Mrs Mary MacLeod, Non-Executive Director requested that a discussion take place around extended working at the Trust Board strategy day in October.
85.5	The minutes were **approved** subject to the above amendments.
86	**Matters arising/Action checklist**
86.1	Minute 62.3 Benchmarking with other Trusts on activity outside normal working hours
86.2	Mr Robert Burns, Director of Planning and Information reported that other hospitals were paying enhanced rates to consultants for working extended hours at around £500 per session. One organisation had amended its contracts for new consultants but had met resistance in doing so and no organisation had amended or considered amending existing contracts.
86.3	Mr Burns confirmed that GOSH had issued a new radiology contract which including provision for extended working.
86.4	Minutes 63.3 - Assessment of 2A benefits realisation – red rated benefits
86.5	Mr Burns reported that one issue (theatre utilisation) had been deemed red rated as a result of the planned way in which the theatres were made available at one time. He confirmed that of four specialties which had gained theatre space all but one saw a reduction in theatre utilisation. Mr Burns added that these had all now seen a statistical increase.
86.6	Minute 63.4 Crash calls outside of ICU
86.7	Mr Burns reported that there had been no reduction in crash calls outside of ICU. It was confirmed that work was taking place to ensure calls were appropriate which they were in most cases. He added that there was a focus on reducing cardiac and respiratory arrests outside of ICU.
86.8	Updated terms of reference
86.9	The Company Secretary reported that she had updated the terms of reference incorporating comments received at the last Trust Board and outside the meeting.
86.10	The Board **approved** the amended terms of reference.
86.11	Minute 64.3 – Update on progress with Francis Report
86.12	Professor Martin Elliott confirmed that work was on-going to incorporate findings of the Keogh and Berwick reports into the Trust's action plan.
86.13	The Board **noted** the updates provided.

87	**Chief Executive Report**
87.1	Update on Listening Event
87.2	Mr Jan Filochowski, Chief Executive reported that he had sent both an initial and follow up letter to attendees of the Listening Event explaining the work was committed to and progress made.
87.3	Mr Filochowski reported that a full update would be provided at the Members' Council meeting that afternoon.
87.4	PLACE – Patient-Led Assessments of the Care Environment
87.5	Ms Rachel Williams, Chief Operating Officer reported that the Trust had not performed well in the assessment which had taken place in May 2013. She confirmed that work had been on-going but improvements were still to be made.
87.6	Baroness Blackstone stressed that more radical work around food needed to take place as this was an area of underperformance for the Trust.
87.7	Chief Executive report
87.8	**Action:** Mrs Mary MacLeod, Non-Executive Director reported that she would be visiting Boston Children's Hospital and would focus particularly on their approach towards Clinical Governance and Clinical Ethics. It was agreed that Mrs MacLeod would provide an update at the next Board meeting.
88	**Research Performance Report**
88.1	Professor David Goldblatt, Director of Research and Innovation reported that the joint GOSH and ICH research strategy would be presented to the GOSH Overall Management Group and the equivalent group at the Institute of Child Health in October. A full consultation would be conducted in January 2014.
88.2	The Board discussed the importance of the visibility of the research carried out at GOSH and ICH and agreed that it needed to form part of the strategy.
88.3	**Action:** Baroness Blackstone, Chairman requested information on the number of papers published; lectures given and research undertaken by consultants working at GOSH and ICH as a means to demonstrate that world class research is taking place.
88.4	Discussion took place around the level of research conducted by GOSH and ICH in comparison to other organisations. It was noted that direct comparison was difficult as comparable organisations were not within the UK.
88.5	Professor Goldblatt reported that research activity had continued to be stable year on year despite the reduction in available funding. He added that he did not have concerns around the level of funding received or activity undertaken in comparison with other organisations.
88.6	**Action:** The Board agreed that future reports should: • focus less on research income

88.7	• provide a better understanding of the impact of research on children's medicine, for example by linking number of publications with improvements for children • provide clarity around the areas of the hospital which are strong or weak in terms of research • provide a plan to improve areas which are less successful in research terms The Board **noted** the report.
89	**Investment in respiratory ward on south wood**
89.1	Mr Robert Burns, Director of Planning and Information reported that the Trust had the opportunity to increase the size of the respiratory ward to 20 beds at a cost of £1.18m which had been included in the phase 2b business case.
89.2	It was noted that the Finance and Investment Committee had provided comments on the business case.
89.3	The Chairman queried the validity of a spending £1.18m on temporary provision.
89.4 89.5 89.6	In reply, Mr Burns reported that it would be difficult to provide a solution which was not based either in cardiac or respiratory. He added that patients were being turned away daily which, if continued for four years, would have a negative impact on the Trust. **Action:** It was agreed that the Chief Operating Officer would provide a paper on the work being done around bed closures, including an update on the recruitment of necessary staff and based on the principle that the Trust should always work to ensure that beds are never closed. The Board **approved** the business case.
90	**Update on Outpatient Improvement Project**
90.1	Mr Robert Burns, Director of Planning and Information reported that Meridian had concluded that there was opportunity to be more efficient in 43 specialties which would improve income by £1.4m.
90.2	Meridian reported that clinical clerk staffing levels were insufficient both in terms of numbers and quality. The Board was advised that the Trust was also looking at the ratio of registered to unregistered nursing staff.
90.3	**Action:** It was agreed that formal feedback would be provided by Meridian in six months' time.
90.4	Mr Burns reported that six specialties had volunteered to conduct weekend clinics and that 33 clinics would eventually work all day on a Saturday.
90.5	Discussion took place around clinic start times. The Board stressed the importance of utilising the full clinic time available.
90.6	Mr Burns reported that an intelligent booking system would be in place which could book patients in at suitable times based on location in the country and clinical need. He added that a three month audited pilot would take place.

90.7	The Board **noted** the update.
91	**Progress with strategic review**
91.1	Professor Martin Elliott, Co-Medical Director reported that two key drivers were being embedded into all strategies: 'quality, safety, experience' and 'resources'.
91.2	It was reported that the first round of strategies would be completed by the end of the calendar year and would be drawn together in January 2014.
91.3	The Board noted that although the items in the 'honeycomb' diagram were listed separately, there were key interdependencies and it was important to see the flow between them.
91.4	The Board **noted** the report.
92	**Admission of London School of Hygiene and Tropical Medicine to UCL Partners**
92.1	The Board supported the endorsement of the proposal for the London School of Hygiene and Tropical Medicine to be admitted to UCL Partners as a founding member.
93	**Summary of performance for the period**
93.1	The Chief Executive reported that there was some concern around increasing infection rates. He added that there was an indication that improvements had been made in discharge summary completion rates and confirmed the Trust was in a good financial position but that it was underperforming on Cash Releasing Efficiency Savings (CRES).
93.2	Quality and Safety
93.3	Professor Elliott presented the report.
93.4	Mrs Mary MacLeod queried whether an increase in CVL infections could be related to a shift to an 80:20 ratio of health care assistants to nurses.
93.5	Mrs Liz Morgan, Chief Nurse and Families' Champion confirmed that the areas with an increase in CVL infections did not operate an 80:20 ratio although they had experienced a higher staff turnover.
93.6	Professor Elliott reported that the rise in infection CVL infections was likely to be due to a lack of nursing staff; a complex case mix of patients; and reduced compliance with the CVL care bundle. He reported that work has begun in the relevant units to address these issues.
93.7	Activity
93.8	Ms Rachel Williams reported that activity was above plan. She added that there had been an improvement in discharge summaries but stressed that this needed to

	be sustained. It was confirmed that a prepopulated summary template was being piloted.
93.9	**Action:** It was agreed that work would be undertaken to reduce the Do Not Attend (DNA) target and an update provided at the next meeting.
93.10	Finance
93.11	Mrs Claire Newton, Chief Finance Officer reported that the current focus was on debt and CIP delivery and added that IPP debt would be further discussed at the Audit Committee meeting in October.
93.12	Mr John Ripley, Non-Executive Director expressed some concern that CRES was further below target than at the same point during 2012/13.
93.13	Mrs Newton suggested that this was due to a change in value given to CRES schemes which had not been fully scoped.
93.14	The Chief Executive confirmed that a review of CRES was taking place which would provide a clear way forward.
93.15	The Board **noted** the report.
94	**Patient Experience, Patient and Public Involvement and PALS (Annual Report 2012/13 and Q1 2013 report)**
94.1	Mrs Liz Morgan, Chief Nurse and Families' Champion highlighted the success of the Young People's Forum.
94.2	It was reported that PALS has seen an increase in clinic appointments being cancelled at short notice.
94.3	**Action:** It was agreed that the outpatient improvement project would be used to develop performance measures.
94.4	**Action:** It was agreed that trend information would be provided at the next meeting around clinics which were more likely to be cancelled.
94.5	The Board thanked the PALS team for the excellent service they deliver.
94.6	The Board **noted** the reports.
95	**Risk management – the timeliness of risk reviews**
95.1	Mr Robert Burns, Director of Planning and Information presented the report.
95.2	The Board **noted** the report.
96	**Redevelopment Report**
96.1	Mr Matthew Tulley, Director of Redevelopment reported that there was a risk of the planned handover to the contractor of the Cardiac Wing over-running the 6th May 2014 deadline. He added that the risk was being mitigated through the 2b contract with no penalty.

96.2	**Action:** It was agreed that the Trust Board would consider a recommendation on the main contractor.
97	**Health and Safety Annual Report 2012/13**
97.1 97.2 97.3 97.4 97.5	Mr Ali Mohammed, Director of HR and Organisational Development reported that he had recently taken on responsibility for non-clinical health and safety. He confirmed that the Trust was compliant with health and safety directives. The Board emphasised the importance of good practice in terms of responsiveness to fire. **Action:** It was agreed that both the Audit and Clinical Governance Committees would receive fire reports and the meetings would be attended by Mr Mohammed. The Board **noted** the report.
98	**CQC registration update**
98.1 98.2	The Company Secretary presented the report. The Board **noted** the current level of registration and the new CQC inspection scheme.
99	**Register of seals**
99.1	The Board **endorsed** the use of the seal and executive signatures.
100	**Any other business**
100.1	There were no other items of business.

ATTACHMENT M

TRUST BOARD - ACTION CHECKLIST
November 2013

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
85.1	25/09/13	It was agreed that further discussion would take place around minute 60.4: provision on the Board for a Non-Executive Director with a medical background at the next Board review.	TB	TBC	This will be considered as part of the Board evaluation process
85.2	25/09/13	It was agreed that an action would be added to the minutes to request a paper at the November meeting to consider how further progress could be made in implementing more evening and Saturday working.	RB	November 2013	On agenda
85.3	25/09/13	It was agreed that discussion would take place around extended working at the next senior staff meeting on 15th and 17th October.	JF	October 2013	Actioned and update to be provided as part of progress report against minute 85.2
85.4	25/09/13	Mrs Mary MacLeod, Non-Executive Director requested that a discussion take place around extended working at the Trust Board strategy day in October.	RB	October 2013	See action 85.2 above
87.8	25/09/13	Mrs Mary MacLeod, Non-Executive Director reported that she would be visiting Boston Children's Hospital and would focus particularly on their approach towards Clinical Governance and Clinical Ethics. It was agreed that Mrs MacLeod would provide an update at the next Board meeting.	MM	November 2013	Verbal Update

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
88.3	25/09/13	Baroness Blackstone, Chairman requested information on the number of papers published; lectures given and research undertaken by consultants working at GOSH and ICH as a means to demonstrate that world class research is taking place.	DG	January 2014	Not yet due - Response to be provided as part of R&D report to the Trust Board in January 2014
88.6	25/09/13	The Board agreed that future research performance reports should: • focus less on research income • provide a better understanding of the impact of research on children's medicine, for example by linking number of publications with improvements for children • provide clarity around the areas of the hospital which are strong or weak in terms of research • provide a plan to improve areas which are less successful in research terms	DG	January 2014	Not yet due - Response to be provided as part of R&D report to the Trust Board in January 2014
89.5	25/09/13	It was agreed that the Chief Operating Officer would provide a paper on the work being done around bed closures, including an update on the recruitment of necessary staff. It was agreed that the Trust should always work to ensure that beds are never closed.	RW	November 2013	On agenda
90.3	25/09/13	It was agreed that formal feedback on the outpatient improvement project would be provided by Meridian who would give a presentation around improvements in six months' time.	RB	March 2014	Not yet due

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
91.3	25/09/13	It was agreed that some strategies would be brought to the November Trust Board meeting and some to the meeting in January.	ME	November 2013 & January 2014	To be reviewed
93.2	25/09/13	It was agreed that a paper would be considered at the next meeting around the actions taken to improve CRES performance.	CN	November 2013	On agenda
93.10	25/09/13	It was agreed that work would be undertaken to reduce the Do Not Attend (DNA) target and an update provided at the next meeting.	RW	November 2013	On agenda
94.3	25/09/13	It was agreed that the outpatient improvement project would be used to develop performance measures for short notice cancellation of outpatient clinics.	RB	March 2014	To be developed
94.4	25/09/13	It was agreed that trend information would be provided at the next meeting around outpatient clinics which were more likely to be cancelled.	RB	November 2013	On agenda under matters arising
96.2	25/09/13	It was agreed that the Trust Board would consider a recommendation on the main contractor.	MT	November 2013	To be considered by the Board

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Trust Board
27th November 2013

Update on Outpatient 'Do Not Attends' (DNAs) and Clinic Cancellations **Submitted by:** Mr Robert Burns Director of Planning and Information	**Paper No: Attachment N**
Aims / summary This paper is to inform the Trust Board of the progress on Outpatient DNAs and Clinic Cancellations.	
Action required from the meeting To note the report	
Contribution to the delivery of NHS Foundation Trust strategies and plans Consistently deliver an excellent and compassionate experience for our patients and their families. Be a financially stable organisation and promote the sustainable use of resources.	
Financial implications Potential financial benefits from reducing DNAs and Clinic Cancellations	
Who needs to be told about any decision? Clinical Divisions	
Who is responsible for implementing the proposals / project and anticipated timescales? Divisional General Managers	
Who is accountable for the implementation of the proposal / project? Rachel Williams, Chief Operating Officer	

Outpatient Efficiency: Clinic Cancellations and DNAs

1. DNAs

Background

To ensure outpatient efficiency it is important that we minimise the number of patients who 'do not attend' (DNA) clinic appointments. A nationally recognised way of doing this is to discharge patients who DNA an appointment. However, this is not straightforward in paediatrics as it could result in children missing out on healthcare because of their parent's ability to cope with appointment schedules. The GOSH trust policy is to discharge patients who DNA three appointments, but it is best practice to ensure families are contacted after every DNA to ask them why they missed the appointment and ensure we have the correct contact details for them. Communicating to referrers and other health care professionals (e.g. GP) that a patient has DNA'd an appointment is really important from a safeguarding perspective. Often a GP will be better placed to understand the family context to consider whether other interventions are required to ensure the safety of the child concerned.

Another key method of reducing DNAs is reminding families of the appointment, across the country this is increasingly being achieved with text reminders.

Current Performance

If we review the Trust-wide status on the percentage of appointments that are DNA'd we can see that this is 8-9%. This compares favourably to other specialist children's hospitals and key teaching hospitals in London.

Data from NHS England on Outpatient KPIs for April - June 2013

	New Appointment DNA	Follow-up appointment DNA
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	13%	17%
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	10%	15%
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST	10%	10%
BARTS HEALTH NHS TRUST	13%	13%
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	12%	14%
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	9%	8%
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	11%	12%
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	16%	15%

To understand this rate we have conducted some further analysis. We have looked in particular at whether there are patients who DNA repeatedly. This data indicates that for a small number of patients clinicians are not following the Trust policy to discharge patients who fail to attend appointments. :

Attachment N

Specialty	2 DNAs	3 DNAs	4 DNAs	5 DNAs	6 DNAs	7 DNAs	9 DNAs	11 DNAs	Total
Audiological Medicine	8	4	1						13
Bone Marrow Transplant	1								1
Cardiac Surgery		1							1
Cardiology	50	27	3	4	2		1		87
CAMHS	5	1							6
Chiropody	1								1
Cleft	2	7	2	1					12
Clinical Neurophysiology	3								3
Cochlear Implant	2	1						1	4
Community Paediatrics	2								2
Craniofacial	4		2						6
Dental and Maxillofacial Surgery	20	5	2	1		2			30
Dermatology	37	9		2					48
Dietetics		1							1
Ear Nose and Throat	19	17	4						40
Endocrinology	19	7	2						28
Gastroenterology	16	6							22
General Paediatrics	1								1
Genetics	22	5							27
Haematology	19	3		2					24
Immunology	5	3	1						9
Infectious Diseases	2	3	2		1				8
Metabolic Medicine	6	1	3						10
Nephrology	10		1		1				12
Neurodisability	1	2	1						4
Neurology	13					1			14
Neurosurgery	4	3	2	2					11
Oncology	12	2							14
Ophthalmology	27	16	15	4	5	2			69
Orthopaedic Surgery	10	1	2						13
Physiotherapy	2	1	1						4
Plastic Surgery	27	6	3						36
Psycho-Social & Family Services	2								2
Pulmonary Hypertension	3	2		1					6
Respiratory Medicine	5	2	1	1	1				10
Rheumatology	18	8		1	1				28
Speech and Language Therapy	1	1		1					3
Spinal Surgery	8	2							10
Surgery	20	13	5	1	2	1			42
Urology	19	16	5	1					41
Grand Total	**426**	**176**	**58**	**22**	**13**	**6**	**1**	**1**	**703**

(Patients with two or more consecutive DNAs where the latest DNA has been between 1/4/2013 – 11/11/2013)

It is worth noting that the patient who DNA'd 11 consecutive appointments was discharged at one point, but was later reinstated after intervention from a local clinician who felt the patient needed to see the team at GOSH.

The number of patients who have DNA'd and have previously missed with more than 3 appointments is small, so it is clear that most clinicians are discharging patients appropriately. However, a small proportion of patients are not discharged, or successfully encouraged to attend their appointment, and this represents a clinical risk for patients and an inefficient use of time for GOSH staff.

Initiatives to reduce DNAs

There have been several initiatives to reduce repeated DNAs. These include ensuring clinicians understand the policy to discharge patients who repeatedly DNA and encouraging clinic staff in outpatients to highlight repeat DNAs to clinicians. We will further enhance this by establishing a routine report which Divisions will receive on patients that have DNA'd 3 or more appointments and have a future outpatient booking.

In terms of reducing DNA's through a reminder service. We have introduced a text reminder service but have witnessed high numbers of undelivered messages. In order to reduce this number we need to ensure that our demographic information including mobile phone numbers is accurate on PIMS. Ensuring we have robust systems of checking these at each outpatient appointment is the first phase of this. We are also appraising automated check in systems for outpatients which mandate patients checking their information and have proved successful in other hospitals.

Attachment N

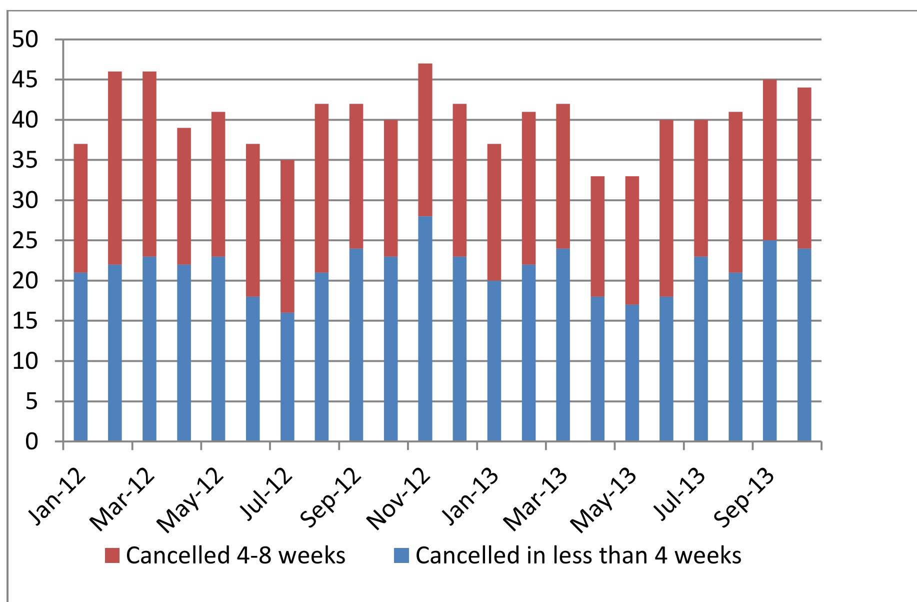
2. Clinic Cancellations

Background

Late notice clinic cancellations cause considerable inconvenience to families as appointments have to be rescheduled. They also create additional work for administrative staff as appointments need to be reshuffled. The Trust's Access Policy states that clinicians should give a minimum of 8 week's notice for all study and annual leave, so that clinics can be cancelled with plenty of notice for families and giving administrative staff sufficient time to rearrange appointments.

Current performance

Interpreting data from PIMS shows that a significant number of clinics are cancelled with less than 8 week's notice, and half of these are within 4 weeks of the clinic date. It should be noted that this does not necessarily mean that clinicians are not booking their leave with sufficient notice; it may mean that administrative processes take some time to cancel and rearrange clinics on PIMS.



There is variation by specialty. The top five specialties for late-notice cancellations are:

Specialty	2011	2012	2013	Total
Neurology	**17**	**24**	**19**	**60**
4	9	12	10	31
8	8	12	9	29
Dental and Maxillofacial Surgery	**16**	**22**	**19**	**57**
4	8	12	9	29
8	8	10	10	28
Gastroenterology	**17**	**19**	**20**	**56**
4	9	12	10	31
8	8	7	10	25
Rheumatology	**16**	**20**	**19**	**55**
4	8	8	9	25
8	8	12	10	30
Oncology	**16**	**23**	**16**	**55**
4	9	11	9	29
8	7	12	7	26

Initiatives to improve the timeliness of Clinic Cancellations

We have mandated that each specialty must have a process for booking annual and study leave in line with Trust policy. We now need to review practices for ensuring that this information flows onto the outpatient booking office in a timely manner. This action will be taken forward by the Chief Operating Officer and the General Managers.

ATTACHMENT O

Specialty – Nephrology

General Background

The unit covers every aspect of Paediatric Nephrology with special expertise in congenital renal anomalies, nephrotic syndrome, hypertension, vasculitis, tubular, metabolic and stone disorders. It is the largest centre in the UK for the treatment of children with chronic kidney disease stage 5, caring for around 20% of the country's dialysis and transplant patients.

Quaternary services are provided for very complex transplantation, difficult vascular access home haemodialysis, complex vascular disease and vascular surgery. Referrals are received from across Europe.

In 2012/13 there were 716 acute admissions, 7061 outpatient attendances and 2542 in-centre haemodialysis sessions. Approximately 150 patients were cared for in the community post-transplant (149 at year end), 25 patients on peritoneal dialysis and 10 on home haemodialysis. There were 23 new renal transplants in the year

Nephrology is led by Lesley Rees and managed within the MDTS Clinical Unit.

There are 4 full time consultants – Dr Rees Dr Tullus, Dr Marks and Dr Shroff. Dr van't Hoff is jointly appointed with the CRF/MCRN, Dr Bockenhauer and Dr Waters hold joint appointments with ICH and Dr Hothi is the Division's Improvement and Patient Safety lead in addition to her role in Nephrology.

A team of 6 surgeons based at Guys support the transplant and vascular access programme and 1 PA of vascular surgery support is provided by the surgeons from Royal Free. There is a weekly half-day theatre list for elective surgical cases.

Clinical Outcomes

Outcomes for transplantation (patient and graft survival), peritoneal dialysis (growth) and haemodialysis (proportion dialysed via a fistula) are measured and reported on the GOSH website. More comprehensive audit data is published annually on outcomes for renal replacement therapy and published in the unit's annual report.

These are benchmarked against other centres using data from NHSBT and the Renal Registry. The speciality is also part of an international registry for peritoneal dialysis and so these outcomes are benchmarked against international standards.

Implementation of a renal Information system will enhance the unit's ability to demonstrate its outcomes and ensure that data is submitted in a timely fashion to the Renal Registry.

Safety & Risk

2 serious Incidents this year related to information governance. Action plans are in place and further work will be guided by the Trust wide work on clinic letter cc lists.

Patient Experience

Nephrology achieves all national waiting time targets with a median referral to treatment wait of 5.00 weeks.

The SHINE project is piloting a electronic tool to enable patients and families on Eagle Ward to report both positive experiences and patient safety concerns. This project recently won an HSJ patient safety award.

Finances

The renal unit has an expenditure budget of £3,946,349.

The NHS income target is £4,462,706 and the IPP target is £983,780.

The renal unit currently performs poorly on SLR, making a significant loss on in-centre haemodialysis. We are currently conducting a deep dive into this to ascertain whether a case can be made for an increase in tariff.

In 12/13 Nephrology delivered a CRES of £112k through NHS over-performance and £51k through IPP over-performance. A business case was approved to expand beds on Eagle Ward to15 to enable expansion of private work however delivery has been delayed by due to limited haemodialysis capacity.

Integrated Business Plan

NHS activity is not expected to grow above demographic and Nephrology is not an identified priority speciality.

The development of networks and further development of the home haemodialysis programme may lead to some future growth.

Any Other Relevant Information

Through the move into Eagle Ward, the haemodialysis unit has now been incorporated into the renal ward. Recruitment and retention of nursing staff able to perform haemodialysis continues to be a challenge and has delayed delivery of the IPP business case.

Trust Board **27th November 2013**	
Update on Action Plan for Extending Working **Submitted by: Robert Burns, Director of Planning & Information**	**Paper No: Attachment P**
Purpose To update Trust board on the feedback from the senior staff meetings to discuss extended working and subsequent action plan	
Action required from the meeting Trust Board to note progress	
Contribution to the delivery of NHS Foundation Trust strategies and plans Meeting the needs of the patients and families we treat and using our assets efficiently	
Financial implications Staff costs outside core hours are higher	
Legal issues Contractual restrictions over working times	
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?	
Who needs to be told about any decision? Executive Directors.	
Who is responsible for implementing the proposals / project and anticipated timescales? Robert Burns, Director of Planning & Information Cymbeline Moore, Director of Communications Rachel Williams, Chief Operating Officer	
Who is accountable for the implementation of the proposal / project? Robert Burns, Director of Planning & Information	

Introduction

Following the Trust Board session on this subject we arranged for the October Senior Staff meetings to be dedicated to the issue of extended working.

Over 80 senior staff attended the 2 meetings and we received extremely valuable feedback on their thoughts and suggestions.

There was a widespread feeling of anxiety around the move towards extending the working hours with concerns over the impact on the lives of both families and staff. However, there was good engagement with the debate and the meeting produced a number of positive suggestions of how to move forward.

Following the meeting the feedback has been analysed and an action plan has been developed;

Action Plan

1. Larger and Comprehensive Patient & Family Survey

There was an overwhelming feeling from the senior staff that we should be developing extended hour services in line with what patients and families want. Whilst we have conducted an initial survey, this was a relatively small sample size and limited in its questions. As such we will conduct a much larger survey of patients and families seeking their views on extended hour services. Pulling out specialties, service types (e.g. outpatients, inpatients, and diagnostic tests), age of patient, where they live, etc.

Timescale: Completed by February 2014

Executive Owner: Robert Burns, Director of Planning & Information

2. Communications Strategy

As mentioned there was considerable anxiety amongst the senior staff around extended working and a good proactive communication strategy will be essential. This should start with communicating the action plan followed by regular updates to ensure continuing engagement.

Timescale: November 2013

Executive Owner: Cymbeline Moore, Director of Communications

3. Developing a Vision

We need to set a clear vision of what we want to ultimately offer in terms of extended hours working and a timescale for achieving this. The senior staff were united in considering that this should be primarily derived from the wishes of the patients and families and as such the survey results need to be a key factor in developing the vision. Other factors such as economics, physical capacity and service demands must also be considered in developing the vision. A working group will be set up by Director of Planning & Information to review the survey results and draft a vision with timescales for approval by Overall Management Group and Trust Board.

Timescale: Completed by March 2014
Executive Owner: Robert Burns, Director of Planning & Information

4. Initial Developments

Some elective services are now being offered in extended hours, generally developed through constraints on capacity. A notable example would be regular evening working in MRIs which has now been extended to Saturdays in Radiology and will shortly be also provided in Cardiac on Saturdays.

It will be important to continue the momentum of expanding the number of extended services concurrently with developing the long term vision. It is logical to focus this expansion onto the current bottlenecks and areas that have staff support.

We have a large waiting list for outpatient clinics, which will have some associated additional income and we have several specialties willing to run clinics on Saturdays. As such we are including establishing a regular Saturday outpatient service as part of our current Outpatient Development Business Case.

The senior staff raised the issue of looking at what patient pathways are slowed by the absence of certain services at weekends and exploring this issue will benefit staff engagement. We will consider the extension of patient pathways due to the absence of certain services at weekends against the cost of introducing the services.

We have already implemented an additional statement on all new consultant contract offer letters as follows;

“The Trust is moving towards a seven day service in line with NHS England requirements. As such it is likely you will be required to work some of your contracted hours in the evenings and / or weekends in line with service requirements. To this extent that there is any conflict with any subsequent term of your contract of employment, the requirement in this letter shall take precedence”

Timescale: Saturday outpatient service introduced early 2014 & Review of patient pathways slowed by absence of weekend services completed by December 2013

Executive Owner: Rachel Williams, Chief Operating Officer

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th November 2013

Annual Plan Mid-Year Review **Submitted by: Robert Burns, Director of Planning & Information**	**Paper No: Attachment R**

Introduction

This papers sets out our mid-year progress against the key strategic elements of the Trust Annual Plan.

Background

In developing our Annual Plan priorities for 2013/14 we considered our purpose and values and the internal and external contexts in which we will be operating during the year and beyond. Together with a review of our past year performance we identified drivers, opportunities and threats and reviewed our own organisational capacity and capability to manage these effectively. To ensure that we are meeting the main elements of our plans we additionally identified a number of key deliverable measures for the year, a series of 'must-do's', which focus on developing our strategy, improving IT systems, developing the site, expanding services and improving efficiency.

The paper additionally includes progress against key measures of quality, safety and patient experience.

Overall all key measures remain on course with the exception of the delivery of an overarching strategy for the Trust. The strategy has largely been delayed as a result of the priority given to a new project although several individual strategies are progressing well.

Action required from the meeting
Trust Board to note progress

Contribution to the delivery of NHS Foundation Trust strategies and plans
The key deliverable measures enable the Trust to monitor progress against the main elements of the Annual Plan

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?

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

Attachment R

Progress against key deliverable measures

1. Developing an overarching strategy for the Trust, with the aim of bringing together and linking individual strategies including: people and organisational development, research, information technology, clinical and quality

The overarching strategy project has been delayed due to the priority and importance placed upon a new project. Due to the focus of the Co-Medical Director on this project executive responsibility for the overarching strategy will be transferred to the Director of Planning & Information.

There remains some debate about how best to present the strategy and it is unlikely that a completed integrated strategy will be ready before the end of the financial year. However, several individual strategies are progressing well and are at a position where more open discussion can take place.

2. Develop a long term information/IT strategy - agree an investment profile with the board and a project implementation schedule

The development of a long term information/IT strategy remains on track with an external consultant team in place. An interim status report will be made available shortly. The draft interim report has confirmed that the investment to date in IT infrastructure leaves us with strong foundations for the future strategy. However, there is further work to be done to stabilise power supply, overcome barriers to the rapid deployment of new hardware and expand our IT governance model to ensure that strategic development, monitoring of project deployment and stakeholder involvement can all be appropriately addressed.

3. Continue to expand our Intensive Care Unit (ITU) facilities and minimise intra and inter hospital waiting and minimise the number of refusals to take patients due to capacity

A Director of ITU has now been appointed and is in post. Capacity has increased across the Paediatric Intensive Care Unit (PICU) and the Cardiac Intensive Care Unit (CICU) by approximately 1 bed per unit in the last 6 months and the Neo-natal unit has increased by 2-3 beds. This has had noticeable beneficial effects on the number of surgery admissions and refused referrals. The future model of all staffing is now being discussed; however plans to appoint 7 consultants in critical care are underway.

4. Ensure the redevelopment of the hospital, moves forward on schedule, meeting the Trust stated objectives and including arrangements which enable existing services to continue at current levels in an acceptable way

The proposal process for the Phase 2B main is proceeding with tenders now received. Enabling work is also proceeding well although the delivery date of May 2014 remains challenging. This continues to be monitored closely through the Enabling Board. A feasibility study for Phase 3A has been completed and a strategy group and governance structure have been approved.

5. Improve the efficiency of theatres and outpatients in terms of resource and capacity use by at least 10%

A revised theatre utilisation project was launched in April 2013, which has delivered sustained increases in total operating hours and overall utilisation. This has been achieved through decreasing fallow sessions, late starts, overruns and on-the-day cancellations. The next stage of the project will aim to address the planning and allocation of beds for elective admissions, coupled with a reduction in list order changes.

The recent Meridian outpatient productivity review of 42 specialities has identified £2m of opportunities for the Trust. Good progress is currently being made against the 153 review actions and in the increase of clinic room utilisation.

The Trust has additionally increased its weighted outpatient equivalent activity[1] by approximately 8.7% year to date against 2012/13 outturn position - with a workforce increase of just 0.8%. This represents an increase in workforce productivity of approximately 8% against a target increase of 5% for the year.

6. Clearly articulate the requirements for safe high quality nursing care at GOSH and lead and deliver a programme of quality improvement and practice development to support the delivery of safe high quality nursing care to patients at GOSH

The GOSH Vision for Nursing was launched in May. This is based on the national 6Cs for compassionate care. Work stream priorities have been identified and are being developed to ensure the vision is embedded and supports excellent nursing care and practice.

As recommended by the Francis report an extensive piece of work has been undertaken to review all ward nursing staff establishments and skill mix to ensure that staffing levels reflect national standards and guidance, patient acuity, complexity. This work is almost complete.

All existing Healthcare Assistant (HCA) staff were issued with the Code of Conduct in June 2013 and line managers were asked to ensure that staff had read and understood it. This document links to the Nursing Vision and sets out expectations for Health Care Assistants in the delivery of high quality nursing care. The Trust now requires all HCAs to complete the Foundation Development Programme, a one year programme of monthly 'day release', supported by competencies completed in practice. Learning is reinforced by guided clinical supervision. The Cardiac and Neurology Divisions have additionally piloted a development day for HCAs which evaluated positively

The Goals and standards for a nurse led work- stream, to recognize and respond to the deteriorating ward patient, have been reviewed and agreed. An assessment of accuracy of recording and responding to Children's Early Warning Scores (CEWS) has been undertaken and a review of the escalation policy commenced. Funding has been obtained to trial the 'Nerve Centre Proof of Concept', an electronic observation tool with a trial due to commence on Koala Ward in November 2013. The purpose of this tool is to enable observations to be taken at the bedside and recorded on a mobile device which will then be transmitted to the appropriate medical team immediately alerting them of the deterioration. This will allow quicker, more effective communication between members of the team giving confidence to patients and their families that any deterioration will be dealt with speedily.

The collection of data regarding 2222 calls is discussed at weekly Patient Safety Team meetings to identify any action required and a close collaboration project of data sharing with the University College London Partnership (UCLP) adult equivalent is in place. The Nurse Leads for this work are also working with NHS England and other paediatric Trusts to look as Paediatric Early Warning Scores (PEWS) and CEWS in Europe as an initiative for spreading good practise. This work is being taken forward by the corporate nursing team.

7. Achieve a target of 90% or better for improving hand hygiene everywhere by end Q2 and 95% by end March 2014.

Each Division is completing their required number of Hand Hygiene audits each month and the Trust has achieved an overall rate of 95%. These audit results are

[1] Outpatient Equivalent Activity (OEAs) weights outpatient, inpatients and critical care bed days to give an overall activity figure.

discussed at each Divisional Infection Control Unit Board, where actions required to address compliance are taken forward by the Head of Nursing or Practice Educator. The Infection Prevention and Control (IPC) team discuss hand hygiene as part of induction. The team are also working with the Learning & Developing department to compile an e-learning package, which includes a podcast on hand washing. Hand hygiene training is delivered locally by the Practice Education team although the IPC team will deliver training to departments which do not have a Practice Educator.

The team are also encouraging peer audit across the Divisions, with Surgery as the pilot, and the Clinical Audit Team are assisting in the validation of monthly scores. The next steps are to review the audit process and tool for hand and adapt its use for other departments e.g. Theatres, X-Ray, IR.

8. Revise Safeguarding & Child Protection Procedures

The Chief Nurse; Head of Safeguarding and Social Work Team Manger are leading an extensive review of the Trust and update of the Safeguarding Children and Child Protection Procedures following publication of the revised national guidance 'Working Together to Safeguard Children published by the Government in March 2013. The procedures will be ready for presentation to the Policy Approval Group (PAG) in January 2014 before being launched across the Trust.

9. Deliver year 2 of the Trust Patient Participation, Involvement and Experience strategy

A Listening Event has taken place and workstreams have been established to address issues raised including a working group to review the Trust Values and develop a 'Shared Commitment'. Plans to consult on draft values and behaviours are well under way and should be completed by end Dec 2013. The Trust is required to introduce the 'Friends and Family Test' (FFT) from April 2014. A process for this is currently being piloted in Surgery and a working group established to rollout the project across the Trust. A project manager post for real time patient experience and sustainable FFT is currently being recruited to. It is unlikely that a real-time system beyond FFT will be in place by March 2014.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
27th November 2013

Performance Summary Report	Paper No: Attachment S
Submitted by: Jan Filochowski, Chief Executive	

Overview (Jan Filochowski)
For my last performance report as Chief Executive I am pleased to be able to say our overall performance remains amongst the very best nationally in terms of all key national standards:

- The Trust remains 'green' against Monitor's governance risk rating at Quarter 2 demonstrating compliance against all service performance measures including all cancer, elective admitted and non-admitted treatment waiting times.
- The Trust received the lowest possible risk rating (out of 6) by the Care Quality Commission in October 2013. The assessment was based on data which includes patient survey results, mortality rates and the number of serious incidents.
- The new Monitor Continuity of Services financial risk rating is at the highest of any Foundation Trust at "4". This new rating particularly focuses on liquidity measures.
- At Month 7, our financial position is good and we fully expect to meet our year-end target.
- Activity continues to exceed plan.
- On 19th November 2013, the Trust won the Health Service Journal's Patient Safety Award for the work of its Shine Team for the project '*Engaging Families to Report Safety Concerns'*.

Quality and Safety (Co-Medical Director)
There has been an increase in Central Venous line (CVL) infections this financial year, notably within the Immunology, Cancer, Infectious Disease and Laboratory Medicine Division (ICI-LM) and intensive care wards. Both of these areas have firm improvement plans and monitoring arrangements in place to address identified issues. Sky Ward has been without a line infection for over 2,000 days.

No cases of MRSA or C.difficile were reported in month.

Targets and Activity (Director of Planning & Information on behalf of the Chief Operating Officer)
Outpatient attendances and patient spells remain above plan year to date. The Trust continues to deliver above plan on Intensive Care Unit bed days reflecting our successful implementation of our plan to increase Intensive Care Unit beds.

Since the beginning of the year there has been a continuing improvement in discharge summary completeness rates from 75% to a current level of low to mid 80%, although more remains to be done. Medicine continues to report high rates for the fourth month in succession. With the exception of August, Surgery has additionally reported rates above target since April 2013. Cardiac and Neuro have seen general improvements since April 2013, although both remain below target. The lowest rate is reported with ICI-LM. This is largely due to one specialty, Rheumatology. In this specialty a project is underway to improve the quality and timeliness of discharge summaries, which were previously taking approximately 6 days to complete and send out. Following a number of interventions the position has now improved to an average of 1.4 days (although still outside the 24 hour standard). This was largely achieved through the introduction of an electronic discharge summary template that has reduced administration time and an increase in clinical engagement. It is anticipated that the target within the speciality will be achieved shortly and sustained. If it is, the Trust compliance rate will comfortably exceed the 85% target. This process will then be rolled out further to other specialties where necessary. Discharge Summary progress continues to be closely monitored on a weekly basis.

Finance and CRES (Chief Finance Officer)
The Trust continues to report EBITDA (Earnings before interest, tax and depreciation) above plan. EBITDA at the end of October was £15.9m (7.4% margin) compared with a plan of £13.1m (6.1% margin). This is the result of income being slightly ahead of plan but primarily because pay expenditure is below plan.

Agency costs, CRES delivery and private patient debt remain areas for close monitoring.

Patient Experience & Pals
Work continues to address the key issues that arose from the Listening Event in June 2013. A report is appended to update the Board on work in relation to the shop/retail space, way-finding, and improvements to reception desks.

The Director of Human Resources and the Chief Nurse & Families Champion are leading work to develop a shared commitment statement. Details are included in the appended report, which also includes a summary of Pals activity for Q2.

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?
The Members' Council receive a copy of the performance report and Commissioners receive a sub-section of the performance report monthly.

Who needs to be told about any decision?
Executive Directors.

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

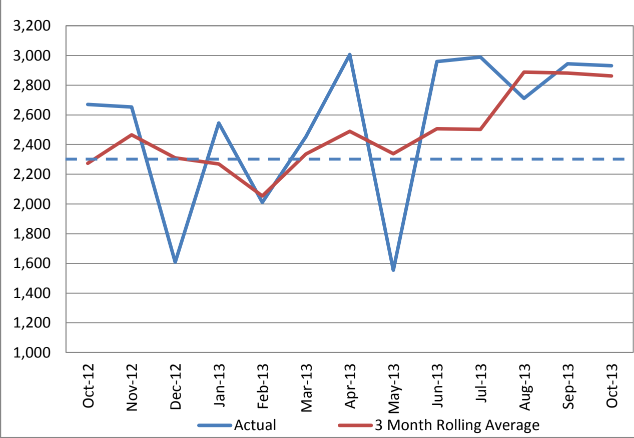
Who is accountable for the implementation of the proposal / project?
Executive Directors.

Targets & Indicators Report

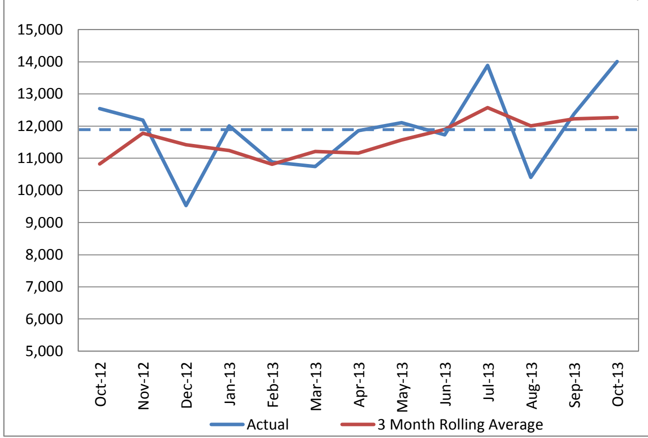
Section	Indicator	Graph	YTD Target	YTD Performance	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Activity & Use of Resources	Number of patient spells	1	16,275	**19,098**	2,545	2,010	2,452	3,007	1,555	2,960	2,990	2,711	2,943	2,932					
	Number of outpatient attendances	2	83,881	**86,369**	12,010	10,887	10,742	11,857	12,106	11,729	13,891	10,400	12,380	14,006					
	DNA rate (new & f/up) (%)		<10	**8.3**	9.5	8.7	8.8	8.5	8.5	8.0	7.7	8.2	8.6	8.4					
	Number of ITU bed days	3	5,749	**5,629**	791	664	802	738	679	826	812	890	842	842					
	Number of unused theatre sessions		137	**135**	14	16	8	26	25	7	15	14	21	27					
Patient Access	18 week referral to treatment time performance - Admitted (%)	4	90	**90.4**	91.1	90.1	92.0	90.4	90.3	90.7	90.5	90.2	90.5						
	18 week referral to treatment time performance - Non-Admitted (%)	4	95	**95.6**	95.4	97.1	95.7	95.3	95.9	95.3	95.4	95.7	96.2						
	18 week referral to treatment time performance - Incomplete Pathways (%)	4	92	**92.8**	93.7	92.8	92.9	92.5	92.8	92.9	93.9	92.5	92.3						
	Cancer patients waiting no more than 31 days for second of subsequent treatment (%)		98	**100**	100	100	100	100	100	100	100	100	100	100					
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	5	<=1	**0.44**	0.57	0.28	0.75	0.54	0.36	0.65	0.50	0.28	0.59	0.15					
Patient / Referrer Experience	Number of complaints		70	**70**	5	9	17	6	10	12	14	10	7	11					
	Number of complaints - high grade		4	**6**	0	0	1	0	0	0	2	3	1	0					
	Discharge summary completion (%)	6	85	**81.7**	77.4	76.3	72.7	77.1	77.1	81.4	87.8	80.5	85.8	82.2					
	Clinic Letter Turnaround, % letters on CDD - sent within 5 working days	7	50	**21.2**	19.0	17.6	15.2	19.4	20.7	22.3	14.0	29.6							
	Patient refusals		<259	**219**	37	43	35	43	36	49	28	17	25	21					
Work-force	Sickness Rate (%)		2.8	**2.7**	3.0	2.9	2.9	2.9	2.8	2.7	2.6	2.8	2.6	2.6					
	Trust Turnover (%)		14.79	**17.6**	16.3	16.5	16.7	16.8	17.0	17.5	17.9	18.1	17.8	17.8					

Monitor	YTD Target	YTD Performance	Quarter 4			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Monitor governance risk rating 13/14	0 - 0.9	0	0	0	Green	0	0	Green	0	0	Green						

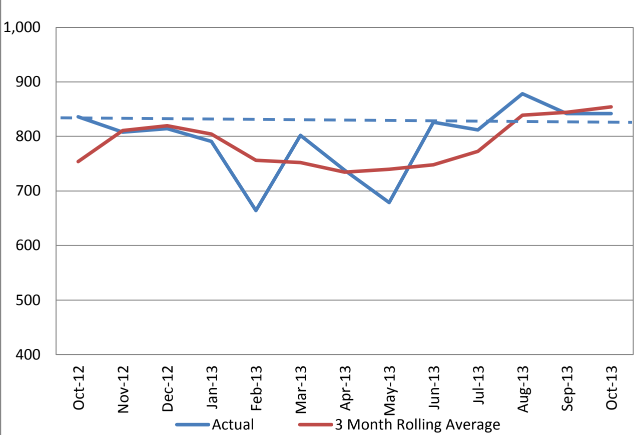
Activity and Use of Resources



Description: **The total number of patient spells (including day case, elective and non-elective)**
Target: *Contractual target:* 2325 spells per month
Trend: Upward Trend
Comment: Performance remains above plan year to date, which is largely due to a significant increase in daycases

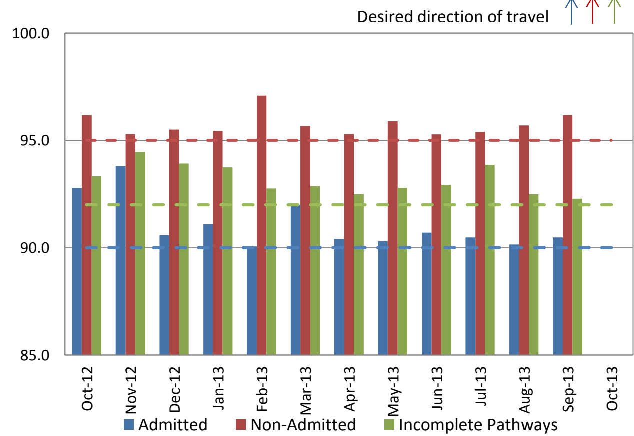


Description: **Total number of new & follow-up consultant-led chargeable appointments**
Target: *Contractual target:* 11,983 attendances per month
Trend: Upward trend against previous month
Comment: Performance remains above plan year to date

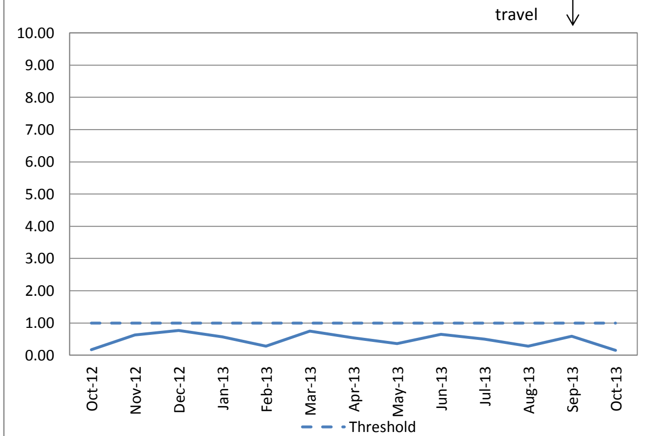


Description: **Total number of ITU bed days used per month**
Target: *Contractual target:* 821 bed days per month
Trend: Increase in ITU Bed days since May 13
Comment: Year to date performance remains above plan

Patient Access

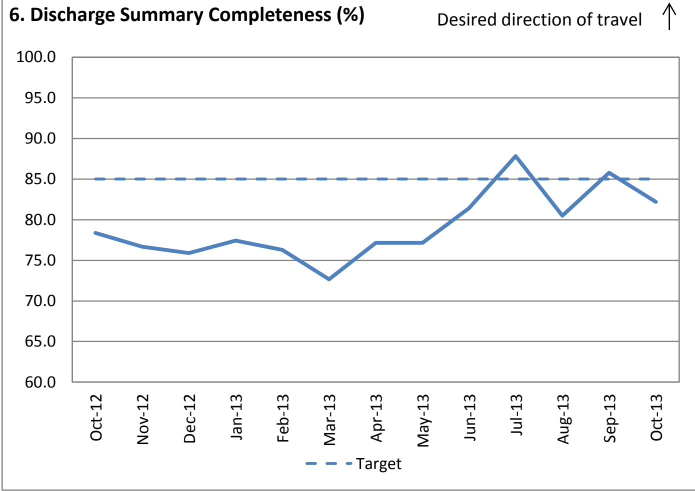


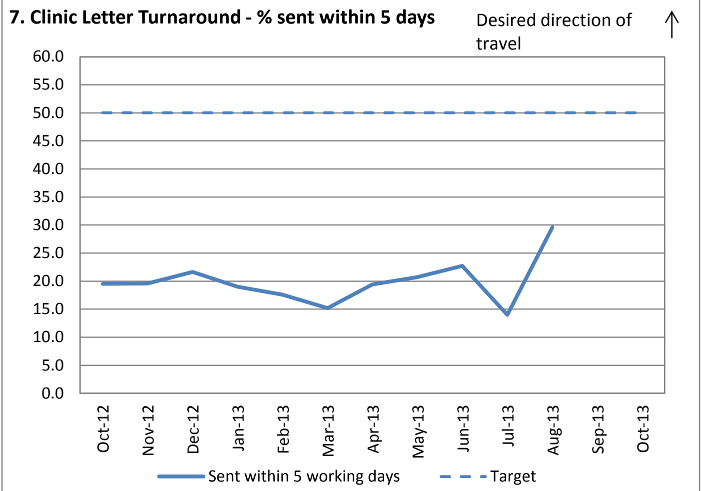
Description: **Referral to treatment waiting times for admitted and non-admitted patient pathways**
Target: *Monitor/Contractual target:* Admitted 90%, Non-admitted 95%, Incomplete pathways 92%
Trend: Performance sustained above standards. Trend tends to mirror activity levels
Comment: Higher number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



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

Patient / Referrer Experience





Description:	**The percentage discharge summaries completed and sent within 24 hours of patient discharge**
Target:	*Internal target:* 85%
Trend:	Downward Trend
Comment:	Decline in performance seen against previous month. Key specialty for inmprovment identified as Rheumatology with plans in place to improve.

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:	Significant improvement on previous month
Comment:	The project team continue to progress performance with the aim of achieving the 50% target by year end.

Great Ormond Street Hospital for Children NHS Foundation Trust
Financial Performance Report - Seven months to 31 October 2013

Commentary:
* The Performance in month 8 is continuing the trend of previous months although private patient income dipped slightly against plan
* The apparent adverse variance on pay is due to realignment of budgets between pay and non pay in the month. It is largely offset by the positive variance in non-pay
* Cash remains above plan but this is partly due to delays in Trust Funded capital expenditure.
* CRES delivery is below the gross target but is just under the amount included in the Plan
* Agency costs and private patient debt remain an area of close scrutiny

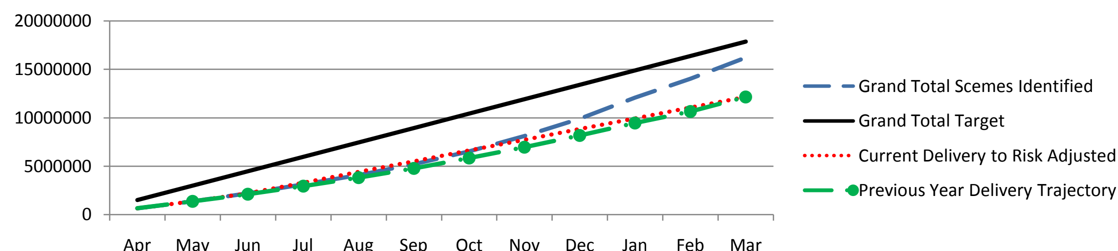
* The new Continuity of Services Rating is below the Financial Risk Rating and is the best score possible for an FT.

I&E	Current Month			Year to Date			
	Budget (£m)	Actual (£m)	Variance (£m)	Budget (£m)	Actual (£m)	Variance (£m)	RAG Rating
NHS Clinical Revenue	19.3	19.9	0.5	132.2	134.4	2.2	G
Pass Through	4.1	4.3	0.2	27.2	26.8	(0.4)	
Private Patient Revenue	3.6	3.2	(0.4)	25.3	24.8	(0.5)	G
Non-Clinical Revenue	4.5	4.5	0.0	31.2	30.4	(0.8)	A
Total Operating Revenue	31.4	31.9	0.4	215.8	216.4	0.6	
Permanent Staff	(13.8)	(15.7)	(1.8)	(121.4)	(109.3)	12.1	G
Agency Staff	(0.0)	(0.5)	(0.5)	(0.2)	(2.9)	(2.7)	R
Bank Staff	(0.1)	(1.1)	(1.1)	(0.4)	(7.3)	(6.9)	G
Total Employee Expenses	(13.9)	(17.3)	(3.4)	(122.1)	(119.5)	2.6	
Drugs and Blood	(1.4)	(1.0)	0.4	(8.9)	(7.8)	1.1	G
Other Clinical Supplies	(2.1)	(2.3)	(0.2)	(13.8)	(14.5)	(0.7)	A
Other Expenses	(7.9)	(4.9)	3.0	(30.8)	(31.9)	(1.1)	G
Pass Through	(4.1)	(4.3)	(0.2)	(27.2)	(26.8)	0.4	
Total Non-Pay Expenses	(15.4)	(12.5)	3.0	(80.6)	(80.9)	(0.3)	
EBITDA (exc Capital Donations)	**2.1**	**2.1**	**0.0**	**13.1**	**15.9**	**2.8**	
Depreciation, Interest and PDC	(2.7)	(2.7)	(0.0)	(18.7)	(17.6)	1.1	G
Net Surplus (exc Capital Donations)	(0.6)	(0.6)	0.0	(5.6)	(1.7)	4.0	
EBITDA %				6.1%	7.4%		
Capital Donations	3.7	1.6	(2.0)	16.0	9.3	(6.7)	

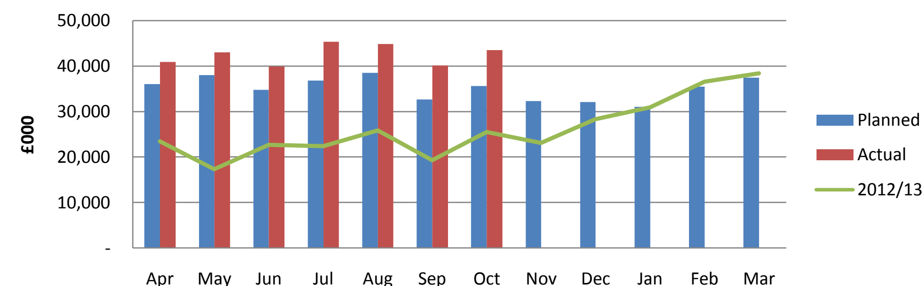
Statement of Financial Position	31-Mar-13 £m	30-Sep-13 £m	31-Oct-13 £m
Non-Current Assets	336.5	336.1	335.7
Current Assets (exc Cash)	39.9	53.9	54.9
Cash & Cash Equivalents	38.4	40.1	43.5
Current Liabilities	(43.9)	(52.9)	(55.9)
Non-Current Liabilities	(7.8)	(7.5)	(7.5)
Total Assets Employed	**363.1**	**369.7**	**370.7**

Capital Expenditure	Annual Plan £m	Actual YTD £m	Forecast Outturn £m
Redevelopment - Donated	24.2	7.4	21.3
Medical Equipment - Donated	8.7	1.4	4.6
Estates - Donated	1.2	0.5	0.6
Total Donated	34.1	9.3	26.5
Estates & Facilities - Trust Funded	6.7	1.9	6.6
IT - Trust Funded	6.5	2.3	7.3
Medical Equipment - Trust Funded	2.3	0.0	2.0
Total Trust Funded	15.5	4.2	15.9
Total Expenditure	**49.6**	**13.5**	**42.4**

Financial Risk Rating	2013/14 Plan	30-Sep-13	31-Oct-13	RAG Rating
Underlying Performance	3	3	3	G
Achievement of Plan	5	5	5	G
Return on Assets	2	2	2	G
I&E Margin	5	5	5	G
Liquidity	4	4	4	G
Overall	4	3.7	3.7	G
Continuity of services risk rating	**4**	**4**	**4**	G



Closing Cash Balance



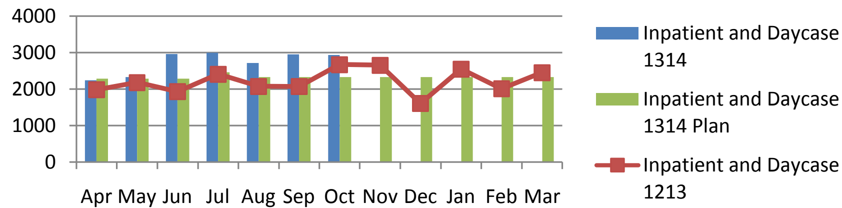
Financial Performance Report - Seven months to 31 October 2013

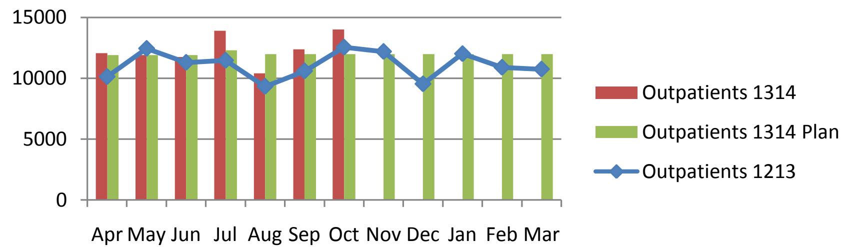
ACTIVITY AND INCOME

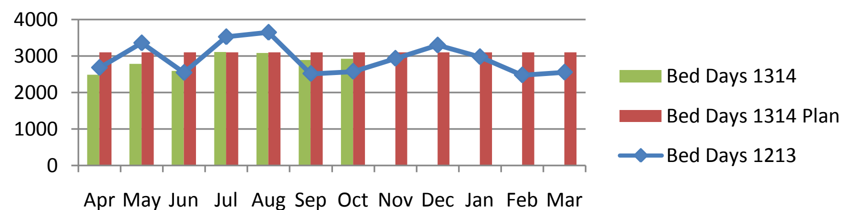
	Income from NHS clinical activity £M year to date				
	YTD 13/14 Actual	Var v plan		Var v LY	
Inpatients/ Daycases	**53.9**	0.6	1.1%	8.4	18.4%
Bed days	**25.5**	(0.6)	-2.3%	(0.7)	-2.7%
Outpatients	**21.5**	0.2	0.9%	1.9	9.6%
Other eg. Highly Specialised	**33.4**	1.9	5.7%	(0.5)	-1.6%
Total	**134.2**	**2.1**	**1.5%**	**9.0**	**7.2%**

Activity				
YTD 13/14 Actual	Var v plan		Var v LY	
19,098	2,823	14.8%	3,771	24.6%
19,887	(1,854)	-9.3%	(955)	-4.6%
86,369	3,457	4.0%	8,593	11.0%

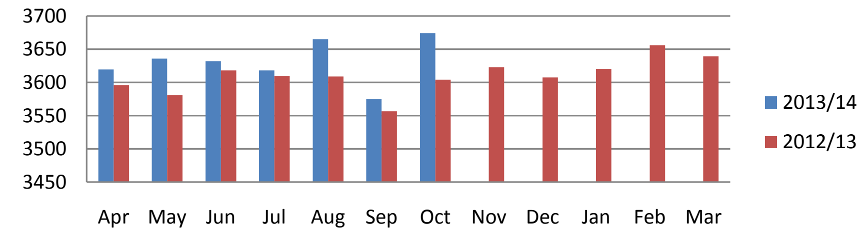
PATIENT ACTIVITY

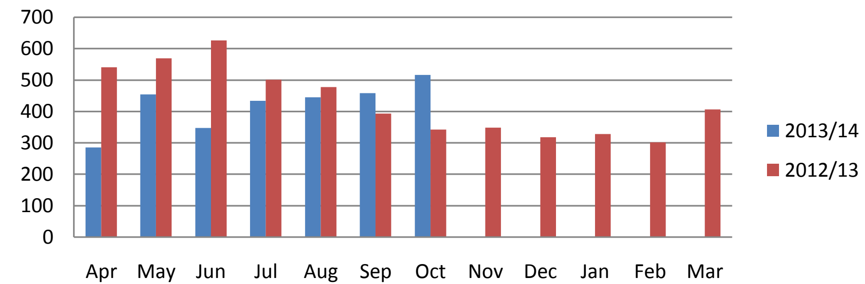






STAFF

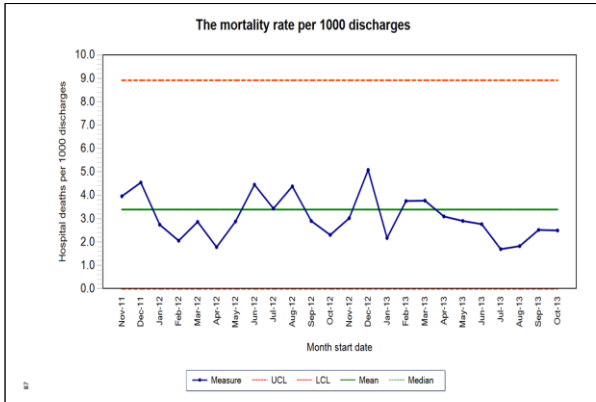


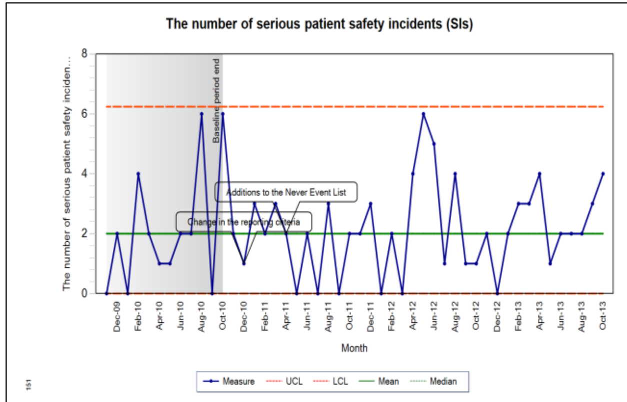


	31-Mar-13	30-Sep-13	31-Oct-13	RAG Rating
NHS Debtor Days (YTD)	9.87	11.71	12.48	G
IPP Debtor Days	130.92	154.70	156.76	R
Creditor Days	29.88	25.15	27.94	G
BPPC (YTD) (number)	83.9%	86.6%	84.4%	A
BPPC (YTD) (£)	83.4%	91.9%	88.7%	G

Quality and Safety
Report to Trust Board

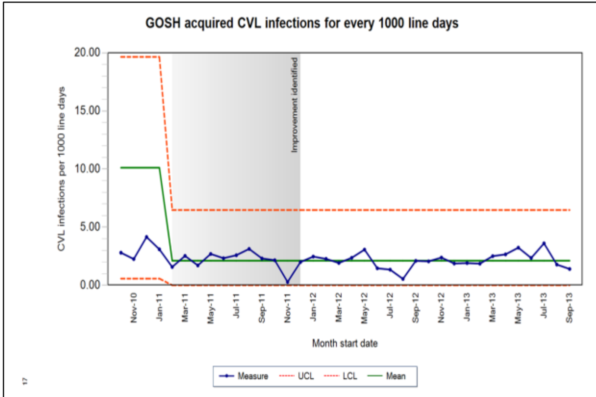
Quality and Safety Indicators

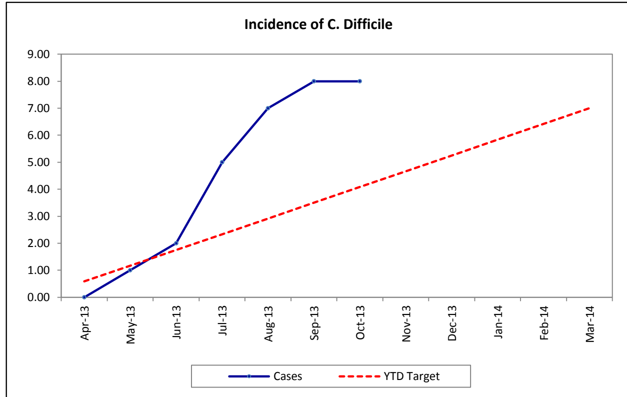




Description: The mortality rate per 1000 discharges
Target: Internal target: Year on year reduction
Trend: Performance sustained
Comment: Performance remains within statistical tolerance

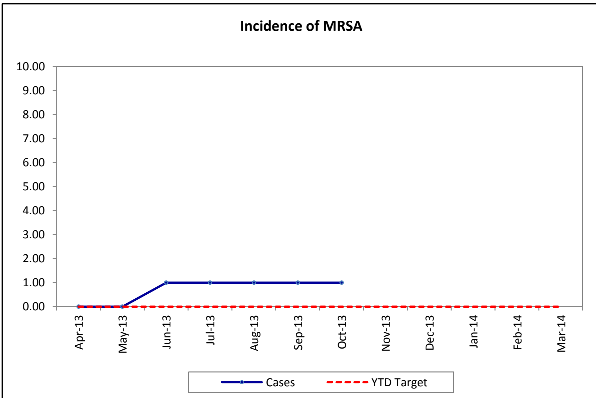
Description: Defined as either - Unexpected/avoidable death of patient(s), staff visitors or members of public. Serious harm to patient(s), staff, visitors or members of public. Allegations of abuse. One of the core sets of 'Never Events'
Target: Internal target: To remain within control limits
Trend: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

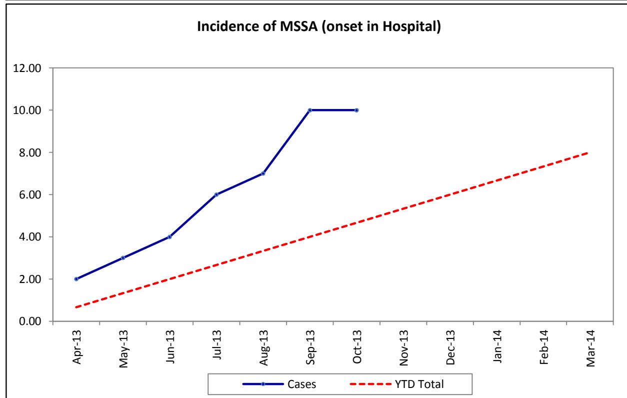




Description: The number of CVLInfections for every 1000 Bed Days acquired at the Trust
Target: Internal target: <=1.5
Trend: Negative movement in performance. If the next month's figure is greater than 1.99, statistical significance will be met and the mean will rise accordingly.
Comment: Performance remains within tolerance.

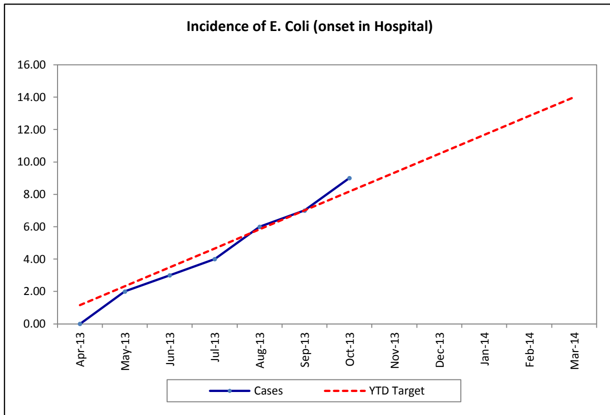
Description: **Cases detected after 3 days (admission day = day 1) are assigned against trust trajectory**
Target: No more than seven cases per year
Trend: Trend above trajectory
Comment: 7 cases reported at m5. Further reported cases will be reviewed by NHS England to identify any weakness in systems and care provided. An action plan to resolve any findings will need to be put in place and resourced.



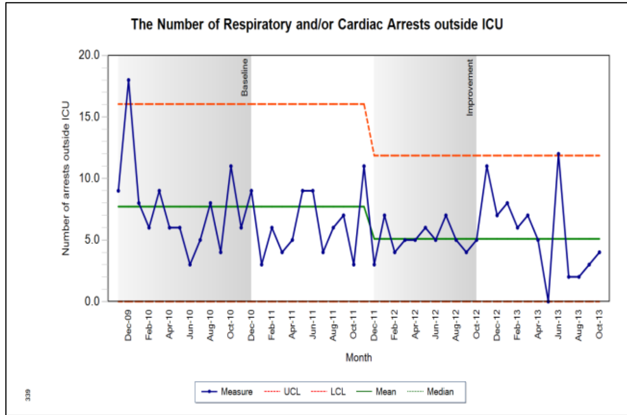


Description: MRSA bacteraemias
Target: Zero cases
Trend: One case reported to date
Comment: Over contractual target of zero. No financial penalty. However within Monitor de minimus level.

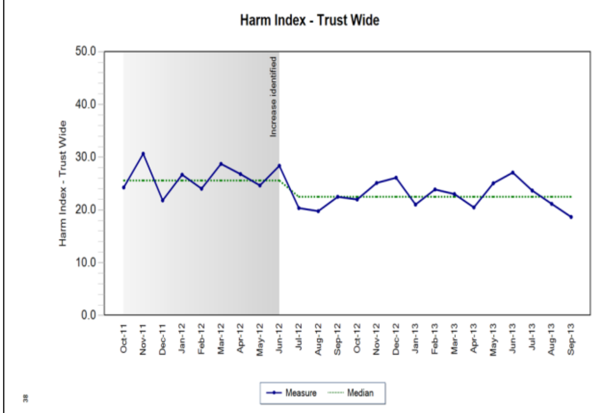
Description: Cumulative incidence of MSSA bacteraemia episodes (Methicillin sensitive S. aureus)
Target: Internal Target no more than eight cases
Trend: Performance continues above trajectory
Comment: Performance being monitored closely



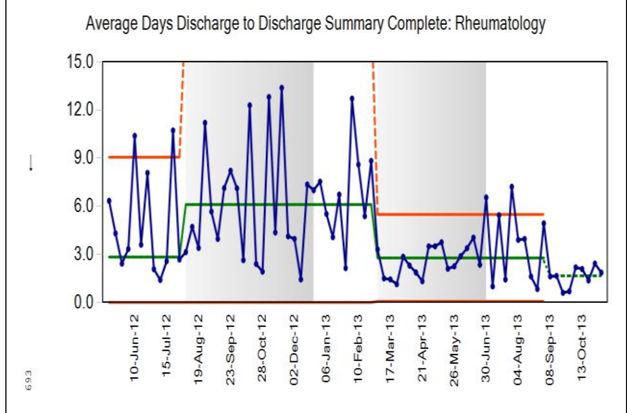
Description: **Cumulative incidence of E. coli bacteraemia**
Target: Internal Target no more than fourteen cases
Trend: Performance reported above trajectory at m5
Comment: Performance being monitored closely



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: Performance sustained
Comment: Incidents of arrests being investigated



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: Performance sustained
Comment: Performance remains within statistical tolerance



Description: Harm index comprised of hospital acquired infections (CVL, serious incidents, non-ICU arrests, medication errors, falls, and pressure ulcers
Target:
Trend:
Comment: The discharge summaries project in Rheumatology has made a significant reduction in the time from patient discharge to sending the discharge summary. The major intervention has been the development of an electronic discharge summary.

Patient Experience and PALS Report for Trust Board
November 2013

1. Introduction

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

This report also includes themes identified through Pals Q2 casework (July - September 2013) and brief details on case activity. Pals role is to resolve concerns informally for patients and families and to ensure that the Trust is made aware of issues where services could be improved. It is therefore a useful barometer of patient experience.

2. Patient and Public Involvement & Patient Experience activity
Follow-up to the 'Listening Event' June 2013

This section provides an update across a number of key issues identified following the 'Listening Event' that was held earlier this year.

2.1 **Update on shop/retail**

In response to the event and other feedback from patients, families, and staff, a review is currently underway to see how we can enhance and improve the retail offering available on site, and how we can ensure that we maintain retail facilities throughout the main entrance improvement works.

There are currently two parallel pieces of work underway to underpin this. The first is the provision of temporary retail space when the current shop closes to allow the next phase of the main entrance improvement works to commence. Options are being progressed to provide an interim shop area adjacent to the Lagoon restaurant in order that patients, families and staff still have on-site access to essential provisions, and that the charity can continue to sell its branded merchandise.

The second is a review of the requirements for the new shop retail space that is proposed for the main entrance area. Currently the works proposed will provide up to 100 square meters of space for a shop/retail unit. A survey is due to commence in November 2013 that will inform the use of this space and the final proposals. A presentation of findings expected on 13 December 2013.

2.2 **Way-finding**

Owing to the pace of the redevelopment plan the signage through the hospital is constantly under review. Specific signs have been installed to mark the boundary between each building to assist in way-finding. On completion of the Main Entrance refurbishment an interactive system will be installed. This is currently due for completion by February 2014. Prior to completion there will be a number of training events to ensure staff are familiar with the new system and able to assist families.

Prior to the opening of the Main reception, Board and Members Councillors will be invited to a guided tour of the new reception area. With the new main entrance, we will be developing an Operation Policy for Outpatients (in particular detailing check-in and patient flows). This will enable us to make sure the signage complements the policy, and staff and volunteers will be trained accordingly.

Working with Camden Council we have negotiated with Transport for London (TfL) to adopt their two maps on the Trust website – one covers a 15 minute walking radius and the second a 5 minute walking radius. We are also working with TfL to adapt the maps to show the quickest and safest walking routes from Holborn and Russell Square tube stations and Euston and Kings Cross/St Pancras mainline stations as these appear on the map.

There are on-going discussions with Camden with a view to increasing the number of finger posts to the hospital. These posts, alongside directional bollards, can be found outside the tube stations and at other strategic points and form part of TfL's Legible London campaign. This is the way-finding approach that must be adhered to across all London boroughs so as to maintain consistency in the signage and reduce the proliferation of street furniture.

To assist the above, the Trust has also commissioned three new external signs to help our visitors locate GOSH and these will be strategically placed on our own and our neighbour's properties. In addition the Charity Digital team and Patient Information Officer have worked closely with the working group to improve information and directions on the hospital and charity websites and in future patient information.

2.3 **Estates development**

A 'pop in' session held in the Lagoon to inform the choice of furniture resulted in a successful selection for the new seating in the new main entrance. This includes the creation of a 'quiet' zone.

An action plan for the improvements to reception desks has also been developed, which includes a plan for refurbishment by June 2014. A Trust standard for reception desks based on the Morgan Stanley Clinical Building (MSCB) brief has been established. Following this an audit tool has been developed and will be piloted (on MSCB) by mid November 2013. The standard and the tool will then be shared with Members for comment before further roll-out of the audit across the entire site by March 2014. This work is being led by the Deputy Director of Redevelopment.

2.4 **Shared commitment**

The working group has engaged the services of a market research company 'April Strategy' to assist with an engagement exercise with patients, families and staff. This will include a training workshop for staff for each Division as facilitators, discussion groups in Divisions to ascertain feedback; surveys for staff, patients and families geared to different age groups and a development session with the Executive team and Members' Council to test the current values statements. The engagement process will run to the end of February, the feedback will then be used to refine the value statements to reflect the comments and to capture the essence of GOSH.

3. PALS July 2013 – September 2013
The following issues /themes were identified from Pals Q2 casework and discussed at November Patient and Public Involvement & Experience Committee.

3.1. Poor communications about admissions and clinics in Surgery – 17 issues concerning admission planning, 7 concerning lack of pre-admission information
(These issues were highlighted last quarter. There has been a decrease in cases to Pals this quarter but it remains a concern).

Surgery	Admission Planning and lack of pre-admission information	Update from service manager
10040, 9944, 10145, 9867, 9913, 10114, 10068, 9839, 10077, 10047, 10035, 10125, 10036, 10067, 10025, 9885,9226,9948,10058 99499936,9941,10135 9976,	Waiting for admissions date. Wanting to change admission date. Wanting to "share" admission with another team. Unreturned calls about admissions. Lack of information on who can attend the admission. Family not advised to bring own oxygen for Weston House.	Over the summer months the surgery division suffered from a high rate of staff turnover, combined with some long term sickness. Since August there has been a full establishment and all staff have had induction and training. In recognition of the increased workload General Surgery has an additional full time post. The Office manager started in May and has worked hard to establish a set of office standards which focus on timely communication with families, such as telephone response times, phone messages and faster production of clinic letters.

3.2. A rise in families concerns about services provided by Facilities & Outpatients – parents accommodation and fares reimbursement (distress levels as well as volume)

Accommodation 9952, 9923, 9951, 10086, 9934, 9980, 9844, 10065, 9871,		**Update from Service Manager**
	Family given accommodation at the Imperial Hotel which family feels is not child appropriate. Unhappy with self-catering provision in Weston House. Unwelcoming staff. Father given wrong information and had no accommodation provided.	Facilities recognises that accommodation is key to providing help to patients and their families in coming to London improving their experience whilst at GOSH and relieving some of the stress. Demand for accommodation has risen, especially in patient accommodation - an increase of 2% utilisation of rooms in Weston House in the first half of this year in comparison to last year, and a 36% increase in external hotel costs when Weston House is fully occupied. A satisfaction survey was carried out in early 2013 of Weston House users. Key actions identified included improving staff customer service skills, improving the communication of eligibility for accommodation (website), as well as better facilities such as guest Wi-Fi in some of the accommodation. Provision of rooms is a big

		problem as activity increases across the Trust and discussions with the Charity and other organisations such as Whitbread are ongoing to try and identify solutions to help solve the demand issues that we face.
Fare Reimbursement 9964, 10052, 9887, 10064, 9991, 10079, 9920, 9870, 10109, 10113, 10029, 9881, 9909,	Families unaware they could have claimed travel costs. Parents with no/wrong/out of date evidence of eligibility (this is common). Congestion Charge 'scams' on the increase leaving parents upset, out of pocket and unable to be reimbursed through national transport reimbursement scheme.	An updated information booklet has been produced which will be provided to all new patients with their first appointment letter detailing procedure and eligibility for fares reimbursement. This will be launched in November 2013 and provided to all new families with their first appointment letter circulated by the Central Bookings Office, and will also be provided with appointment reminder letters over a six month period. TFL are monitoring unauthorised sites and will be closing down all illegal sites promoting congestion charge payment. GOSH website will give accurate information and direct families to the TFL site. There will also be new signage within the fares reimbursement waiting area as a final check for families when they arrive. The fares reimbursement office is experiencing increased postal and face to face claims in line with the increased growth in Outpatient activity.

3.3. Families experiencing long waits and unanswered calls to the Central Bookings/Appointments line (20 families)

Central Bookings	Delays	Update from Service Manager
10059, 10074, 10060 9889, 10002, 9988 9990, 10031, 10051 9892, 9845, 10154 10119, 10134, 10101 9912, 10049, 10005 10057, 10104	Families experiencing unanswered calls and long waits on the Central Bookings/Appointments line	The appointment lines have just 2 staff allocated to cover the service from 8.30am to 6pm. The staff require a complex knowledge of appointment bookings and Trust procedures. A third member of staff who works from a reception desk also covers the appointment

		line during peak periods. There has been an increase in outpatient activity over the past 3 years with no additional staffing. An increase of 10% activity was seen last year. The appointment line calls average 300 per day.

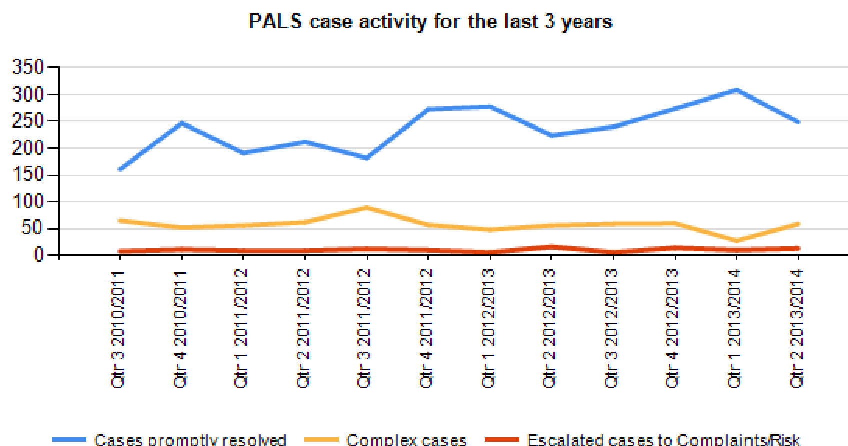
3.4. Families prefer to know in advance if they will be required to attend X ray before they attend their clinic appointment

Multiple specialties	**Need for X-rays**	**Update from Service Manager**
This issue comes up regularly in Pals – often as an adjunct to another issue.	Families not told about need to attend Xray before clinic – families feel that they have wasted time waiting in a clinic when they could have been getting the Xray done	Xray service does not book appointments – it is a walk-in service and patients requiring Xrays are identified by clinicians. An Xray can be noted as needed before a clinic appointment or on the day of the consultation but this varies by clinic. In order to arrange for families to either have their Xray before, or after an appointment, and direct them to the main GOSH site if needed before coming to RLHIM (Xray in RHLIM is not always open) clinicians would have to identify whether an Xray is required prior to that appointment.

4. Pals Casework Activity in Q2

- 260 Information enquiries
- 249 Promptly resolved cases
- 59 Complex cases
- 13 Formally escalated cases to Complaints/Patient Safety

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



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

- **Communication:** mother unhappy/worried that there may have been a confidentiality breach when a letter about taking part in a research project came to her from an external body as well as from GOSH; family requesting audio recording of clinic appointments and unhappy that patient information shared with school.

- **Clinical Care:** patient recovering from ENT surgery with stomach pain – ENT team's bleeps not responded to by General Surgery for 3 days; mother concerned about delay to antibiotics being administered due to cannulation difficulties; father concerned about procedure in CICU that left staple marks on child's legs; mother concerned that child's teeth were broken during resuscitation following cardiac arrest; father wanting legal advice as GOSH seeking to withdraw treatment/change care goals

- **Inpatient experience:** noise of building works from 6.30am and dust coming through child's bay window; father alleging that ward student nurses having 'water play fights' on ward; family concerns about pain management; mother feels that staff "are picking on her husband unfairly, that they are being spied upon" and that team have "accused father of tampering with child's medication and water intake".

- **Out-patient experience:** referral initially turned down due to lack of evidence of entitlement to NHS treatment; patient brought to cardiac clinic to review ultrasound scan assessment which had not yet been done

- **Admission/Discharge:** mother concerned that ward contacted her ex-partner with admission information; family with concerns about lengthy delay between arrival and bed.

- **Care Connect**: Pals is fielding responses to public postings on pilot of NHS England's Care Connect website. This quarter saw its first(anonymous) posting 'the best hospital I ever visited ! Nice, caring doctors and nurses, state of the art equipment and access to research protocols".

- **Clinical Ethics Committee:** Pals attended the Committee on two occasions to support the parents of families whose treatment decisions were subject to a consultation with the Trusts' Clinical ethics committee.

5. Update on 'themes' identified by Pals in Q1

Issue	Update
Cardiac: Parents unable to make contact with GOSH regarding admissions and some families unhappy about difficulty in contacting the team about appointment cancellations/rearrangements.	There has been a marked reduction in numbers of families contacting Pals about both the admissions and the secretarial teams.
Surgery: Parents unable to make contact with GOSH about admissions and parents reporting difficulty in contacting secretaries about appointment cancellations, rearrangements and action following clinic appointments.	There has been continued high numbers of contacts on these administrative issues – see para. 3.1

6. Cases formally escalated to Complaints or Risk teams

Pals identified 13 cases in Q2 which were escalated to Formal Complaints or Risk teams under agreed protocols. These cases and their outcomes will be reported to committee under Complaints and Risk reporting protocols.

Trust Board **27th November 2013**	
Bed Management Update **Submitted by:** **Rachel Williams, Chief Operating Officer**	**Paper No: Attachment Q**
Aims / summary This paper explains the current situation for the management of inpatient beds across the hospital.	
Action required from the meeting To note the report.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Efficient bed management improves the quality of patient care, reduces waiting times and reduces refusals of emergency work.	
Financial implications None	
Who needs to be told about any decision? No one at present. General Managers, Heads of Nursing and Divisional Directors are all involved in this work.	
Who is responsible for implementing the proposals / project and anticipated timescales? Rachel Williams	
Who is accountable for the implementation of the proposal / project? Rachel Williams	

Bed Management Update to Trust Board

Background

Trust-wide bed management is co-ordinated by the Bed Management team. During the working week, two bed managers (non-clinical) run the service between 8am and 8pm, during evenings and weekend the Clinical Site Practitioners (CSPs) deal with any bed management issues.

There is a daily operational bed meeting at 9.30am each day, which reviews the current bed state, bed closures, delayed discharges and staffing levels across the trust. At this meeting bed managers will allocate emergency patients who cannot be admitted to their home ward. The meeting also reviews infection control and cleaning issues, as well as MRI and theatre operational problems. At the meeting the bed status is agreed based on a set of triggers (as outlined in the bed management policy). The definition for each status is:

Status	Definition
Green status. Trust fully operational	All elective patients are allocated beds, and no patient referral requests are outstanding with the bed managers. Capacity is available to accommodate the expected numbers of daily emergency & elective admissions.
Amber Alert Trust experiencing some pressure	The current number of predicted available beds is less than the number of elective and emergency patients requiring admission.
Red Alert	Beds are not available for any patient admissions.
Blue Alert No ICU capacity for internal or external referrals	Ward beds are available, but the ICUs are full, no ICU patients are ready for discharge, the ICUs cannot accept internal or external transfers.

There is a Trust-wide bed management policy which sets out the principles by which patients should be allocated to beds. This emphasises the need to ensure patient safety, whilst maximising our capacity by using our inpatient beds as flexibly as possible.

Current situation:

Since July 2013 there have been increased pressures on Trust beds, and the Trust is frequently declared as amber or red. If we compare the status for October 2013, with the situation in October 2012, there are more red and amber.

	Red	Amber	Green
October '12	0	9	14
October ' 13	4	10	10

This has been caused by a number of factors:

- Increased inpatient activity across the Trust
- High vacancies in some wards leading to beds being closed (see appendix 2 – bed closures for October)

- Case-mix change in some areas meaning staffing ratios are not sufficient to keep all beds open

This has meant that we have not been able to accept as many emergency referrals as would like to, and it has also led to an increase in elective cancellations.

The reasons for divisions closing beds are:

- Cardiac – low numbers of short-term closures for staff sickness. ICU bed closures because of long-term vacancies.
- Surgery – high number of closures for a range of reasons. Sky has been temporarily relocated and this led to beds being reduced. Island has had to close beds every Wednesday because of vacancies. Other wards also have vacancies.
- Neurosciences – closures due to staff sickness and vacancies caused by staff turnover.
- Medicine – long-term closures because of vacancies and ward reconfiguration.
- ICI – long-term closures because of vacancies caused by difficulties in recruiting to posts.
- IPP – short-term closures because of vacancies and sickness.

Current work to address bed management issues:

We have established the Bed Management Forum, which is made up of Heads of Nursing and General Managers from all divisions to review the bed management processes, and identify how we can make this better. This will allow for greater scrutiny of bed management across the hospital and ensure there is pan-division agreement on how to apply the bed management policy.

We have reviewed the bed management policy to address problems with the way the bed status is determined. This is a work in progress.

The establishment for all wards has been review by the Assistant Chief Nurse and this has been agreed with Heads of Nursing. In some areas this identified that establishments were not correct for some areas, meaning they could not achieve the required activity. General Managers now report that the establishments for their areas are now sufficient.

The challenges with recruiting specialist paediatric staff are being addressed in a number of different ways:

- Areas where it has traditionally been difficult to recruit have been allowed to over-recruit when additional staff are available, to allow surplus for staff turn-over.
- All areas are now able to recruit continuously throughout the year, and no vacancies have to be ‘held’ for annual recruitment events or trainees (this is only possible because some areas are able to over-recruit)
- There have been initiatives to recruit specialist ICU staff from abroad, and this has proved successful to date, although staff do require additional induction time to familiarise themselves with the NHS.

Next steps

It is clear that there is a need for more medical engagement in bed management, both in terms of improving the planning of elective and emergency work, and working to resolve capacity problems when the trust is on Amber and Red. We are working with nominated Consultants to improve medical engagement in bed management.

There is on-going work to ensure that workforce planning anticipates vacancies and reduces the length of time that it takes to replace nursing staff.

Appendix 1 : Bed Closures

Ward Bed Closures	01-Oct	02-Oct	03-Oct	04-Oct	07-Oct	08-Oct	09-Oct	10-Oct	11-Oct	14-Oct	15-Oct	16-Oct	17-Oct	18-Oct	21-Oct	22-Oct	23-Oct	24-Oct	25-Oct	28-Oct	29-Oct	30-Oct	31-Oct
Cardiac Wards	1	0	0	0	0	0	4	0	1	0	0	0	0	0	0	0	0	0	1	2	1	0	0
Surgery	8	17	10	8	8	8	17	8	8	8	8	17	8	8	8	8	10	18	10	8	8	8	8
Medicine	5	5	5	4	4	4	4	4	4	4	4	4	4	5	4	4	4	4	4	4	4	4	4
ICI	2	2	4	7	4	2	2	0	3	1	1	2	1	2	1	1	1	4	2	1	2	3	2
IPP	1	6	3	1	2	2	1	1	1	3	1	2	1	1	2	4	1	1	1	7	2	1	2
Neurosciences	4	3	4	4	4	2	4	4	4	4	0	0	2	2	4	2	0	0	6	2	0	0	0
Intensive Care Units	1	1	1	7	1	5	3	4	2	1	2	0	1	2	2	1	2	1	1	2	2	2	3
Total	22	34	27	31	23	23	35	21	23	21	16	25	17	20	21	20	18	28	25	26	19	18	19

Bed Pool	
Cardiac Wards	40
Surgery	79
Medicine	52
ICI	60
IPP	43
Neurosciences	42
Intensive Care Units	39
Total	355

DRAFT

Great Ormond Street Hospital for Children
NHS Foundation Trust

<table>
<tr><td colspan="2">Trust Board
27th November 2013</td></tr>
<tr><td>Regular Infection Prevention & Control (IPC) update to Trust Board

Submitted by:
Dr John Hartley, Consultant Microbiologist & DIPC
Deirdre Malone, Lead Nurse IPC / Deputy DIPC</td><td>Paper No: Attachment T</td></tr>
<tr><td colspan="2">Aims / summary
To inform Board of progress with the annual infection prevention and control plan and important issues which have arisen in IPC since last report</td></tr>
<tr><td colspan="2">Action required from the meeting
Feedback on any area.
Opinion on difficulties implementing IPC policy in all areas of Trust when isolation facilities are not available.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS Foundation Trust strategies and plans
Essential to achieve zero harm; minimising risk of infection is a central Trust goal</td></tr>
<tr><td colspan="2">Financial implications
Failure to prevent or control infections leads to harm and cost.
Individual penalties may follow specific HCAIs in future</td></tr>
<tr><td colspan="2">Legal issues
Compliance with the Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance (from 1 April 2010) is a Statutory requirement for registration with the Care Quality Commission</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?
On going programme</td></tr>
<tr><td colspan="2">Who needs to be told about any decision?
Infection prevention and control is responsibility of all staff.</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales?
Divisional and Corporate Units and all staff
Infection Prevention and Control Team.</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project?
Director of Infection Prevention and Control</td></tr>
</table>

Great Ormond Street Hospital for Children NHS Foundation Trust

Regular Infection Prevention & Control Report to Trust Board

Infection Prevention and Control (IPC) management arrangements
Staff – The Lead Nurse has resigned, advertisement will go out to fill this position. The IPC team are also writing a business case to support the recruitment of a whole time equivalent (WTE) Band 7 nurse to strengthen the team from a clinical and educational perspective,

Surgical Site Surveillance (SSI) – the central team was disestablished on January 31st 2013. The divisions undertaking surveillance are setting up their surveillance systems locally and are expected to report at the Divisional monthly divisional infection control boards. This process has been slow as both the Surgical and CCCR Divisions have encountered difficulties in recruiting and retaining staff to undertake surveillance. Both have surveillance underway again as of November.

Divisional IPC Meetings and action plans: All Divisions have now established their local process with local IPC plans and regular meetings. Attendance and actions continue to improve. There has been a noticeable improvement in medical involvement, especially within Medicine MDTS, Surgery & International and Private Patients (IPP)

External Peer Review by SHA into healthcare acquired infections (HCAI's) on January 2012. Action plan being implemented:
- ensuring all staff (including medical) are trained and assessed as competent when inserting or dealing with vascular access lines. Each Division was asked to describe how they would comply locally with an overarching Trust Vascular Access Policy by October 31st. Executive lead is awaiting these responses.
- DH guideline on antimicrobials (Start smart, stay focused) is being implemented through an Antimicrobial Stewardship Programme, with a programme of education and audit. Compliance has improved but not yet reached the target set as a CQUIN.

Health care associated infection (HCAI) statistics and prevention programmes
Figures after 7 months:

1. **HCAI mandatory reporting for financial year 2013/14:**

a. **MRSA bacteraemia** (target = 0) – 1 case. Trust apportioned. The PiR (post infection review) process was completed. This was a contaminant. Commissioners decision of financial penalty not decided yet.
b. ***C. difficile* infection** (Target </= 7) – Trust apportioned for financial year = 8 (No definite cases). Each discussed with Commissioners; no firm decision made on penalties yet.
c. **Methicillin sensitive *S. aureus* (MSSA) bacteraemia** (no national 'target') – 18 cases this financial year. RCAs have been performed for all episodes. Audit to be undertaken
d. **E. coli bacteraemia** (no national 'target') – 13 cases this financial year

2. **GOSH acquired Central venous line related blood stream infection**.

Rate per 1000 line days for financial year 13/14 (7 months data) = 2.2
(Rate last financial year = 2.1; CQUIN target = 2.0)
There had been an increase in rate during first 5 months; and additional attention was given to compliance with care bundles. The Sept and October rate has improved considerably.

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

Trust wide systematic surveillance is currently not available. Individual specialties are implementing improvements based on previous surveillance, in particular: anaesthetics are concentrating on preventing low body temperature. All teams are ensuring pre-operative washing is completed.

4. **Outbreaks**

The Trust has not declared any outbreaks of infection since the last Trust Board report in July.

5. Viral episodes and drug resistant bacteria

We are detecting and increase in the number of patients admitted with enteric and respiratory infections, especially October and November; probable hospital transmission has also occurred. This is putting increased pressure on our isolation facilities. We continue to remind staff regarding the need for continuous implementation of Standard and Isolation precautions.

Cleaning

Environmental and equipment decontamination remains essential; following previous report there has been a new audit system introduced. Cleaning standards have improved but continue to require close monitoring.

Implementation of isolation precautions and 'infection cleans'

Disruption to patient care or provision of services remains a risk due to the implementation of isolation precautions and 'infection cleans' in 'alerted' children. Balance of maintaining capacity and risk reduction requires continuous support and review.

However, other concerns are being raised by families who are concerned regarding the lack of isolation facilities in areas such as outpatients and radiology. Further risk assessment is required to establish the optimal approach in each area (as compromise is unavoidable) and how the Trust communicates this to patients, staff and families.

Infection prevention and control regular audits and data display

Regular planned audit cycle continues with additional results displayed on dashboard and feed back to Divisions for action. Results are not consistently 100% in all areas. Local review and action is essential to maintain high compliance and this is performed through the Divisional IPC groups.

Estates

a. Legionella control in tap water – outlets from some non-critical areas continue to test positive and ongoing work is underway (replacing boilers, surveying pipes, maintenance of mixer valves). No legionella has been detected in MSCB but risk remains as water system not yet performing to plan. Detailed external legionella audit of building by building is underway.

b. Detailed surveillance of taps in ICUs for *Pseudomonas aeruginosa* commenced in line with DH guide. Small number of outlets were contaminated and action taken to successfully resolve this; however, colonisation has recurred and further action is required.

c. Critical ventilation systems – annual verification has detected issues with individual rooms in Robin and Fox that are not yet resolved. There may be problems with the building fabric. This has resulted in room closures and impacted on activity.

Training, updates and competencies

Face to face IPC update has been removed from regular sessions – on-line material was provided. A new Skills for Health online learning package will be introduced in Jan 2014..
Electronic recording of training is not complete; although Trust is hoping to move to a new system.
Competencies for all staff on common procedures – Individual Divisions are expected to implement this for IV line care and access (see above on Vascular Access policy).

Occupational Health - Good Flu vaccine uptake this year, exact figures will be produced by Occupational Health later this year.

Health and safety

The Trust is working towards compliance with the European Directive on prevention from sharps injuries (Council Directive 2010/32/EU) in Member States, by May 11th 2013. There is a year for implementation after this date. This work is being led by the Health & Safety department.

J C Hartley Consultant Microbiologist and Director of Infection, Prevention and Control (DIPC)
D Malone Lead Nurse IPC and Deputy DIPC 18/11/2013

Great Ormond Street Hospital for Children
NHS Foundation Trust
NHS

Trust Board
27th November 2013

Proposed changes to the Trust's CRES delivery processes

Submitted by:
Claire Newton, Chief Finance Officer
Rachel Williams, Chief Operating Officer

Paper No: Attachment U

For information

Aims
To brief the Board on the proposed actions following an independent review of the Trust's CRES delivery processes

Summary

The recommendations arising from the independent review highlighted improvements that could be made to the effectiveness of the existing processes used to manage the CRES programme. These covered programme governance; information and reporting; communication throughout the Trust, monitoring and management of performance. Suggestions were also made as to how to improve identification and sponsorship of new cost improvement initiatives.

Actions to address the recommendations have been discussed with divisional directors and managers and changes are in the process of being implemented.

Action required from the meeting
To support the changes being made to the Trust's processes

Contribution to the delivery of NHS Foundation Trust strategies and plans
The Trust needs to be financially sustainable but also needs to demonstrate to its commissioners and other stakeholders that it is operating efficiently.

Financial implications
Delivery of cost improvement targets is critical if the Trust is to remain financially sustainable.

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?
Divisional Directors and Divisional General Managers have been briefed on the proposed changes

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

Who is responsible for implementing the proposals / project and anticipated timescales?
All managers of cost centres.

Who is accountable for the implementation of the proposal / project?
Chief Operating Officer

1 Summary of issues identified by the review

Changes are required to the ***organisational culture***:

- There needs to be increased management/staff engagement outside of the senior management teams
- Cost improvement initiatives should not be separated from the Trust's transformation aqenda

Changes are required to cost improvement delivery and management ***processes***:

- Too high a proportion of the programme is based on activity growth
- Programme management has not been entirely effective
- There is insufficient communication of the rationale for delivering cost improvements; better and wider communication is required

Issues with ***delivery*** of current year targets:

- Some divisional targets, where undelivered targets were brought forward from the previous financial year are not achievable

2 Recommendations

Culture

- The programme should be based on improving efficiency
- A new communication strategy needs to engage all levels of staff
- CIP delivery should be a core component of the Trust's transformation programme

Governance

- Change membership and agenda of the CRES Steering group

Processes:

- Strengthen PM process and consider integration with the Trust's improvement programme
- Reconsider targets for 2013/14
- Simplify the database underlying the delivery programme and improve access and reporting capability
- Ensure that all major cost improvement initiatives are based on a project document which includes timescales, deliverables and impact assessments

  NB reporting and access to reports has already been improved.

Delivery:

- Greater focus on staff costs when developing the 2014/15 programme
- Target other initiatives on increasing utilisation of core capacity
- Re-establish pan Trust efficiency programme themes:

  E.g. Medicines management
  Non pay procurement
  Estates and space costs…. etc.

3 Proposed actions in response to recommendations

All of the recommendations in Section 2 will be acted upon and in place by the end of the calendar year. In addition we intend to:

- improve access to information on operational productivity including staff productivity ratios etc.
- Agree a programme of options to develop staff cost improvements
- Strengthen workforce planning processes across the Trust
- Develop workstreams aimed at improving the cost effectiveness of business processes and eliminating duplication
- Review target setting for clinical and corporate support departments

- Other initiatives which will be progressed, following discussion with the senior management group, are as follows:
  - Ensure there is a better understanding amongst clinicians of the cost impact of their day to day decisions e.g. diagnostic tests; non standard consumables etc.
  - Ensuring the cost of delivering gold standard services are understood
  - Identify activities being carried out due to gaps in other providers services which may not be GOSH's direct responsibility
  - Identify activities which are part of the overall GOSH service but are not directly funded e.g. internal and external consultations
  - Use of SLR information to engage clinicians in reducing costs.

4 Development of the 2014/15 cost improvement programme

Indicative planning assumptions have been issued recently. The minimum cost improvement target for the Trust is 4%, to offset tariff deflation of 1.9% and cost inflation of 2.1%, but this may need to be increased to address any quality improvement cost pressures identified during the planning process..

Development of planning assumptions for 2014/15 and 2015/16 is underway and part of that process will involve agreeing targets and ensuring that the cost improvement programme is populated.

Pan Trust Themes will be scoped and leads appointed prior to the end of the calendar year so that any pan trust initiatives can be factored into planning processes.

Communications to engage all staff and potentially some engagement workshops will be organised in January

Attachment X

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
27th November 2013

Timetable for Trust Board Evaluation **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment X**

Aims / summary

Monitor's Code of Governance states:

"*The board of directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors."*

At the June 2012 meeting, the Board agreed it would conduct an annual evaluation of its own performance. An external organisation would be invited to carry out this evaluation every three years and an internal paper-based exercise conducted in the interim years.

An external evaluation of the Board was conducted in March 2010 and included an appraisal of the Board as a whole (by the NHS Institute), involving questionnaires, interviews with Board members and Board observation.

In December 2012, an internal evaluation was conducted using a self-assessment questionnaire and the results presented in February 2013.

It is proposed that the next Board evaluation is conducted by an external independent organisation in 2014. In light of the recent announcement of the retirement of the Chief Executive and the consultation underway on Monitor's revised Code of Governance it is proposed that this evaluation is conducted later in 2014.

The Board's committees are evaluated annually against their terms of reference. At the end of 2013/14, the committees will undergo a similar evaluation by questionnaire, including asking for responses from senior managers reporting to these committees.

Action required from the meeting

To approve the proposed timetable for the Board evaluation in 2014.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Strategic Objective 7 – ensures compliance with Monitor's Code of Governance

Financial implications

Every 3 years, an external organisation will be invited to conduct an independent evaluation of the Trust Board

Who needs to be told about any decision?

The results of the analysis will be considered by the Board of Directors

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

Baroness Blackstone, Chairman.

Great Ormond Street Hospital for Children NHS

NHS Foundation Trust

Trust Board
27th November 2013

Register of Seals

Submitted by: Anna Ferrant, Company Secretary

Paper No: Attachment V

Aims / summary

Under paragraph 39 of the NHS Foundation Trust Standing Orders, the Trust is required to keep a register of the sealing of documents. The attached table details the seal affixed and authorised since end September 2013.

Date	Description	Signed by
10/09/13	Lease of second floor premises at 55-57 Great Ormond Street, London from the GOSH Children's Charity	Jan Filochowski and Claire Newton
29/10/13	Agreement for the appointment of architects for phase 2B redevelopment – Llewelyn Davies Weeks Limited	Claire Newton and Matthew Tulley
29/10/13	Deed for transfer agreement between Llewelyn Davies Limited, the Liquidators (KPMG), GOSH FT and Llewelyn Davies Weeks Limited	Claire Newton and Matthew Tulley

Action required from the meeting

To endorse the application of the common seal and executive signatures.

Contribution to the delivery of NHS / Trust strategies and plans

Compliance with Standing Orders and the Constitution

Financial implications

N/A

Legal issues

Compliance with Standing Orders and the Constitution

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

N/A

Who is accountable for the implementation of the proposal / project

Anna Ferrant, Company Secretary oversees the register of seals

Great Ormond Street Hospital for Children NHS Foundation Trust NHS

Trust Board **27th November 2013**	
Medical Revalidation and Appraisal Update **Submitted by:** **Dr Barbara Buckley, Co-Medical Director**	**Paper No: Attachment W**
Aims / summary To provide an update to Trust Board on Medical Appraisal and Revalidation and highlight any ongoing risks	
Action required from the meeting To note the report To support implementation of suggested actions when medical staff fail to engage with regular appraisals To support ongoing provision of good HR and other necessary support to the Co-and deputy medical directors to ensure the organisation can fulfill its obligations.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Good appraisal supports innovation and quality improvement.	
Financial implications Failure of Doctors to revalidate will result in loss of their licence and thus income to the Trust.	
Who needs to be told about any decision? Responsible Officer (BB)	
Who is responsible for implementing the proposals / project and anticipated timescales? Deputy Medical Director (CC)	
Who is accountable for the implementation of the proposal / project? Responsible Officer/Co-medical Director (BB)	

Trust Board November 2013
Medical Revalidation and Appraisal Update

Background

1. Revalidation for doctors commenced in December 2012. All doctors currently on the medical register will require revalidation within the next 3 years. This is being done as a phased approach (20% 2013-14, 40% 2014-15, 40% 2015-16) so that all Doctors will be revalidated by March 2016. A failure to revalidate will result in the loss of a doctor's licence to practice.

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

3. GOSH is responsible for revalidation of all Consultants, Trust doctors, jointly-contracted doctors where the majority of their work is at GOSH, locums, and Clinical Academics who undertake the majority of their clinical work at GOSH. For GOSH this numbers about 400 individuals.

4. Revalidation of Trainees (Deanery posts) was via the Deaneries, now transferred to LETBs. The Trust is required to submit information via an online database every 6 months on all trainees stating if there are any concerns. This is another significant increase in workload for the revalidation and PGME teams.

5. Appraisals must be undertaken annually to satisfy GMC requirements and must include formal patient and 360 degree colleague feedback at least once in every 5 year cycle.

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

Appraisal and Revalidation Support

1. The Revalidation and Appraisal team is led by Dr Barbara Buckley (Co-medical Director and Responsible Officer), with support from Dr Catherine Cale (Deputy Medical Director) and Mrs Christine Lowe (Medical HR Manager). They were initially supported by a part time Administrator (left October 2013) and an additional fixed term (July to March 2014) band 6 post is now in place. Ongoing support will need to be identified.

2. A new web based appraisal system was procured in early 2013, and has been used for the current appraisal cycle. This allows storage of all appraisals and associated documents, and provides a dashboard and other functionality to support administration and tracking of appraisals.

Completed Appraisals and Revalidation

1. As of 17th November 2013 193 appraisals had been completed (61% of consultant and associate specialist staff). Of the remaining 121, approximately half were in progress, bringing us up to an anticipated completion rate of 75% for the current appraisal year. This is in line with the National rate for Hospital Consultants of 75.1%.

2. All Consultants who have partially completed an appraisal have been contacted by the revalidation support officer. All Consultants who had not commenced their appraisal by 16th October 2013 received a letter from Drs Cale and Buckley stating explicitly that if not undertaken this would be noted in their appraisal record and may affect future revalidation, pay progression and CEA applications.

3. Of the Consultants due revalidation from April – End October 2013, 24 have had a positive recommendation made and 3 have been deferred. All 3 individuals were participating in appraisal but had not gathered sufficient information due to the more stringent requirements of appraisal for revalidation (principal difficulty being the time taken to collect patient feedback).

Issues

1. Collecting formal patient feedback is difficult in a number of specialties (eg ICUs, anaesthetics). Liaison is being maintained with other Trusts to identify better ways of doing this.

2. The consequences of not participating in appraisal must be robustly implemented. Those currently suggested are limiting pay progression, CEAs and IPP Practice Privileges.

3. Mechanisms to supply necessary supporting information (eg complaints, incidents) are currently inadequate and need improving.

4. Good systems are in place for Consultant/AS staff. Systems for ensuring good appraisal of non-training Junior medical posts are being developed, but are variably supported within specialties.

5. Adequate resource within HR must continue to be available to support the RO and Deputy MD in fulfilling the statutory requirements around appraisal and revalidation

Risks to Provision of Successful Medical Appraisal and Revalidation at GOSH

Risk	Mitigation	Level
Lack of medical staff engagement	Provision of regular communication Local clear consequence of a failure to participate	Medium
Adequate recruitment and training of appraisers	Active recruitment High quality training	Low
Poor consistency and quality of appraisals	Quality Assurance system with feedback	Low
Inadequate administrative support for R and A team	Fixed term post only	High
Inadequate provision of required information to Drs by Trust	Work with IS/QST	Medium
Inadequate IT facilities/support (eg scanners) for preparation of appraisal portfolio	Work with specialties to ensure support available	Low
Difficulties in obtaining required information(especially patient feedback) for some specialties	Links with other organisations via RO network.	Medium

Dr Catherine Cale, Deputy Medical Director (Appraisal and Revalidation)
17th November 2013

ATTACHMENT 1

Great Ormond Street Hospital for Children
NHS Foundation Trust

Update from the Clinical Governance Committee meeting held on 22nd October 2013

Patient Stories

The Committee stressed the importance of receiving patient stories in different formats to illustrate patient experience themes.

Assurance Framework

The Director of Planning and Information reported that 24 risks were monitored by the Clinical Governance Committee. He set out the criteria under which risks would be annually reviewed by the Committee and stressed that those risks which did not meet these criteria would be reviewed by the Risk Assurance and Compliance Group.

It was confirmed that work was on-going to review the process of managing honorary contracts. The Committee asked that this review develop a process for the emergency admissions of patients at very short notice who require staff to attend from from external organisations.

It was confirmed that a new consent policy had been developed, highlighting legal issues. Training is being provided during induction.

Impact of ICT outages on clinical systems

It was stressed that any planned outages were mitigated as far as possible. The Committee asked the Audit Committee to consider the timeliness of the review of the business continuity plan.

CRES safety overview

The Committee agreed that the notes from a recent Clinical Ethics Committee discussion would be sent to the National Institute of Clinical Excellence (NICE) for review as the case discussed could lead to a potential review of guidelines.

The Committee agreed that they would consider a progress report of a CRES scheme which would ensure a change in process in Cardiac Intensive Care Unit step down in six months' time.

Update from the Clinical Ethics Committee (CEC)

It was agreed that the CEC terms of reference would be reviewed to include more explicit consideration of safeguarding issues. It was stressed that the members of the committee had sufficient experience in safeguarding to pick up these issues in referred cases.

Wi-fi access to patients

Work is on-going on phase two of the project called 'my GOSH' which will enable parents to allow additional wi-fi access for their children.

CQC compliance summary report

The Committee noted the update about the pilot CQC inspections underway.

Health and Safety Update

Some concern was expressed about availability of lifts at the Royal London Hospital for Integrated Medicine (RLHIM). The Chief Operating Officer was in the process of following this up.

Update on progress with Francis Report

It was agreed that the values arising from the Francis Report should be embedded in every discussion about strategy. It was agreed that the next report would consider whether the Trust should be looking at ratios of nurses to patients.

Safeguarding Report

It was reported that that the Trust was continuing to achieve full compliance with Camden CCG safeguarding metrics.

Internal Audit Progress Report

It was reported that seven final reports had been issued since the last meeting of which six had provided significant assurance and one had provided reasonable assurance.

Clinical Audit Update

The Clinical Audit Manager reported that a dashboard had been developed to help ensure that learning from specialty lead audits is captured. The Committee requested further information around NICE recommendations which had not yet been implemented.

Quality Strategy Progress Report

It was reported that further work needed to be undertaken on medical records. It was agreed that the Members' Council would receive a presentation on progress with the Quality Strategy.

Revised terms of reference and annual workplan

The Committee approved the revised terms of reference and workplan.

The following other items were noted:

- Performance report
- Audit Committee Summary – May and October 2013
- Summary report of the Risk Assurance and Compliance Group – July, September and October 2013

ATTACHMENT 2

Great Ormond Street Hospital for Children NHS Foundation Trust

Report from the Finance & Investment Committee following an extraordinary virtual meeting in September and an ordinary meeting on 28th October 2013

September extraordinary meeting

This involved a review of the business case for £1.18m for an expansion of the existing plans within the 2B enabling programme to upgrade the new respiratory ward.

It was confirmed that the project should enable the Trust to treat more patients, it was affordable and that the additional revenue costs arising from this project could be accommodated. After detailed discussion it was agreed to approve the proposal.

October meeting

Review of Half year results and revenue forecast 2013/14

It was noted that the forecast for the full year was that the Trust would finish the year ahead of plan at the EBITDA level but that within the forecast performance in the second half of the there were a number of challenges included costs pressures from business development and quality improvement projects begun in the first six months, and risks around certain income growth streams.

Concern was expressed that in common with some other NHS organisations the cost base is rising faster than income and efficiency savings were essential to bridge the gap. The importance of targeting a higher EBITDA margin, in spite of further tariff reductions was emphasised.

A number of detailed questions were discussed in relation to the supporting financial information for the results for the first half year and follow up actions agreed.

Indicative financial results by segment

The importance of the contribution from private patients in support of other activities in the Trust was noted.

It was also noted that further work was taking place on Education costs as part of a national project to establish tariffs for education.

There was a discussion of the various reasons that certain activities cost more than the amount funded and it was noted that action was being taken as part of the Trust's strategy development to address major areas of underfunding.

Productivity and Capacity Progress Report

The Committee noted the various measures of productivity and discussed theatre utilisation, bed utilisation and the utilisation of the patient hotel.

It was noted that a report of the workforce review would be available for the January meeting of the Committee.

Capital Expenditure Forecast

It was noted that there was a large amount of slippage in planned expenditure which resulted in the forecast outturn now being just above plan but that this would create challenges in managing expenditure within the capital envelope for 2014/15.

The Committee approved an increase to the capital budget of up to £1m.

Audit Committee referred matter: IPP credit control

The Committee noted that weekly meeting were being held and that commitments made by customers were being tracked and meetings would be followed up in writing.

Escalation processes were also discussed.

Cost improvement Programme status for 2013/14

It was noted that there was still risk relating to delivery due to the number and size of schemes which had not yet been fully implemented. The risk would be mitigated by other cost savings where practicable.

The process changes recommended by the independent consultant were also discussed. In addition a number of cross cutting themes were being developed further

Draft Outline Business Case for the Rare Diseases Centre

It was noted that in addition to research activity and clinical office space the case included the construction of modern and appropriate outpatient space .

The assumptions on which the financial business case was based were fully discussed and a number of actions raised for follow up by the sponsor.

Kuwait Contract Renewal

The current status of negotiations was discussed and noted.

Investment in new IT Server Room

It was suggested that a faster move towards off site servers may be a viable and lower cost alternative and it was agreed that this would be further investigated.

ATTACHMENT 3

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Report from the Audit Committee following a meeting on 2nd October 2013

RISK

The Committee discussed the criteria for reviewing risks at a Board level committee and asked that mitigating actions be added for each risk rated amber or red.

It was agreed that where there were risks which had been on the risk register for some time, which needed to be more fully explained with clarification of whether or not the risk had been "accepted" with no further mitigation possible.

Four high level risks were discussed in detail with the responsible senior manager:

1 the risk that the site is not maintained at a safe and sustainable level

The Committee sought assurance that all areas of risk had been captured and was assured that NHS best practice documents and a self-assessment tool had been used.

2 the risk that commercial contracts and contracted services were not managed effectively.

It was agreed that there needed to be more robust processes to ensure that contracts were finalised and legal advice taken where necessary.

3 the risk that the Trust does not have adequate contingency plans in the event of an unforeseen funding shortfall

It was noted that the existing contingency plans were being reviewed by executives and would be updated by January 2013

4 Savings Programme ("CRES")

All recommendations arising from the independent review of the programme were being acted on. The report would be discussed at the next Finance & Investment Committee and a summary circulated to Audit Committee members.

It was noted that the Clinical Governance Committee reviewed CRES schemes to ensure there was no detrimental effect on quality.

EXTERNAL AUDIT

The Committee reviewed the external audit planning report to the Audit Committee for the year ending 31st March 2014 Audit and it was noted that the scope was unchanged from 2012/13 however Monitor guidelines around the quality accounts for 2013/14 were yet to be published.

INTERNAL AUDIT AND COUNTERFRAUD

New Internal Auditors

The Committee welcomed the new internal auditors, KPMG who were appointed as of 1st October 2013.

Draft Internal Audit Annual Plan 6m to March 2014

The Committee approved the outline plan subject to it being developed further following discussions with senior staff over the next two months and circulated for final approval by the end of November.

Internal Audit Interim Progress Report September 2013

The committee were disappointed that limited assurance had been provided in the draft report of Medical Devices Management Staff Training follow up and requested clarity around the reasons for the lack of improvement.

The Committee noted the reasonable level of assurance had been provided in terms of performance management of outsourced contracts but that there were some issues requiring follow up (See risk number two above).

Internal and external audit recommendations update

It was agreed that actions which could not be implemented quickly should have interim actions reported.

Counter Fraud update report

There had been no significant developments since the previous report. The Trust would not be subject to a full or focused assessment following the self-review of counter fraud arrangements.

GOVERNANCE

Update of Standing Financial Instructions and Standing Orders

The Committee agreed the proposed changes other than that it was agreed that the under the scheme of delegation, approval of capital expenditure of over £1m would continue to be agreed by the Finance & Investment Committee and Trust Board.

Audit Committee Performance Evaluation

It was noted that actions arising from the performance evaluation would be progressed by the Chairman.

OTHER REPORTS DISCUSSED AND NOTED

- Update on referrers' survey and open day
- Information Governance and Data Quality Update – Actions were in place to further improve the assessment scores within the toolkit.
- Fire and Security Quarterly Reports (April – June 2013 and July – September 2013): It was noted that certain risks had been highlighted and they were being addressed with a report back to the Committee in January.
- The Local Security Manager Annual Workplan 2013/14 was noted
- Working capital - It was agreed that credit limits needed to be determined for private patient debtors and further discussion would take place at the next meeting of the Finance and Investment Committee.