Great Ormond Street Hospital for Children NHS Foundation Trust

Operational Plan Document for 2014-16

Great Ormond Street Hospital for Children NHS Foundation Trust

1.1 Operational Plan for y/e 31 March 2015 and 2016

This document completed by (and Monitor queries to be directed to):

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Date	**March 2014**

The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Tessa Blackstone

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Julian Nettel

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Claire Newton

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1. Executive Summary

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) strives to be one of the top 5 children's hospitals in the world and it is this objective that drives us to achieve our goals. GOSH has completed the 2013 - 2014 year operating more effectively while at the same time treating more patients than ever before. We have delivered high quality and cost-efficient services for our patients and will continue to do so into the future.

The Trust has developed a two year operational plan that outlines the projected activity, resources and performance to ensure services to patients remain high quality and resilient. Each division of GOSH will have its own two year operational plan in support of the GOSH Operational Plan and this will ensure that we all contribute in our objective of achieving our goals.

We have defined a plan for sustainability and excellent patient outcomes by developing key initiatives which will underpin our objectives. We have set out a plan for delivery of financial projections which are internally consistent and based on credible assumptions. Importantly, this plan was developed through consultation with GOSH staff and wider stakeholders. Inclusive consultation was designed to ensure that GOSH has a strategy that is relevant, robust and consistent with priorities for specialist children's healthcare and the wider NHS.

Over the next two years GOSH will deliver high quality services to its patients but also understands the challenges associated with achieving them in the coming years. Maintaining financial sustainability and ensuring we have sufficient skilled health care professionals in certain key areas will be our two greatest challenges of the next couple of years.

Our patient case mix is at the most complex end of the spectrum with many patients being referred to us as the only centre who can treat them. Whilst offering this highly specialised service is fundamentally part of what GOSH is about; it does present significant financial challenges in a funding environment that is largely based on national average tariffs. Some of our key NHS clinical services run at a significant financial loss. This loss is often driven by small numbers of patients who consume very high levels of resources which are not appropriately funded by current tariff mechanisms. We are also finding that reliance on specialist children's hospitals such as us are increasing as both budgetary and clinical governance constraints are reducing capabilities in community and secondary care providers.

To address the financial situation we have robust plans to deliver savings of £14.8m in 2014/15 and £15m in 2015/16, these are outlining in section 5.

Recruitment and retention of key health care professionals is our second major challenge for the next 2 years. This is most evident with the nursing workforce, particularly for our Intensive Care Units (ICUs). As an employer, we are in direct competition with London Trusts and other centres nationally for staff . The national shortage of highly skilled paediatric nurses is exacerbated by the high cost of living in London. As a specialist centre we need to recruit high calibre expert children's nurses to meet the complex needs of the children and young people we treat. We will explore new advertising and recruitment strategies, and through values based recruitment ensure recruits are tested and display the core values and behaviours we expect. These are outlined in section 3.

Our overarching aim is summarised in our mission statement "The Child First and Always". We are an international centre of excellence in paediatric healthcare, specialising in children and young people with complex, rare or highly specialised illnesses or disabilities. We do not have an Accident and Emergency department and chiefly accept specialist referrals from other hospitals and community services. Working with University College London Institute of Child Health (UCL ICH), we are also one of the largest centres for research into childhood illness in the world and with ICH and London South Bank University (LSBU), a significant trainer of children's healthcare specialists.

Our vision is that through the work undertaken at Great Ormond Street Hospital (GOSH) more sick children across the world get better and have a higher quality of life than is possible today. We wish to be seen by all our stakeholders as absolutely committed to delivering this, in partnership with families, other healthcare providers and other agencies.

The children treated at GOSH often have complex, rare or highly specialised illnesses or disabilities. They are referred to us by other hospitals that do not have the expertise or specialist care needed. Since its foundation GOSH has been dedicated to children and their specific and often unique healthcare needs. It is this single-minded approach to specialist children's care that continues to drive the hospital's vision and strategy. We have the UK's widest range of health services for children co-located on one site and we are the largest number (19) of nationally commissioned services in the country, in recognition of the doctors seeing more children with rare diseases than probably anywhere else in the world.

Our well established record of achieving clinical excellence, quality improvement and financial stability are summarised in our Transformation goals of Zero Harm, No Waste and No Waits. These goals have served us well, however as part of our work to develop our long-term strategy we are now additionally undertaking an extensive consultation into the values and behaviours of the organisation. This has involved a comprehensive engagement process with staff, patients, families, Foundation Trust members and other stakeholders. Known as Our Commitment, a final statement of values will be developed in the first quarter of 2014/15 and a programme of work will be undertaken over the subsequent 2 years to embed revised values and behaviours across the organisation.

2. The short term challenge

Due to the nature of our work, we operate primarily within a regional and national (rather than local) health economy. For example, over half of our patients come from outside of London and over 90% of patients are referred by other consultants. Our position is therefore a complex one, acting as a quaternary, tertiary and specialist secondary provider for different services for a large number of local health economies. However, the vast majority of our clinical activity is tertiary (referred to us by specialist paediatricians) or quaternary (referred by other tertiary sub-specialist paediatric services) and this type of workload can only be managed in a small number of other centres in the UK.
Our competitors therefore vary widely for each service. For some services within the Trust there are defined referral catchment areas already in place and GOSH is a clearly designated service provider within the care pathway. However, for many services we compete with other tertiary providers, and there is pressure within local health economies to keep patients and funding locally wherever possible.

Our strategies of providing clinically excellent services, demonstrating value for money to commissioners and focussing on referrers' expectations have been successful in mitigating this potential threat and we have seen year on year growth across our services.

We have identified a number of external changes that will directly impact on or provide an opportunity to strengthen and grow our existing services and affect our strategic position as follows:

Demographic

The population in London, the East and South East is projected to grow at a faster rate than England as a whole. The London and South East England population of 0-14 year olds will increase by an average of 1.8% per year according to Office of National Statistics (ONS) estimates. We anticipate growth higher than just demographic levels as neonatal survival, disease detection rates and diagnosis (particularly genetics) all improve.

Paediatric networks

Within London, the development of tertiary paediatric networks is underway to deliver services in line with the NHS London publication “Children’s and Young People’s Project – London’s Specialised Children’s Services: Guide for Commissioners” - which recommends a rationalisation of the number of providers of specialist children’s services whilst enabling as much care as possible to be provided closer to home and by the right staff. This work is being led through the Children’s Strategic Clinical Network Leadership Group (SCLG). We see these changes as a positive development for children and families and at the same time providing some growth opportunities for the hospital.

Rare diseases strategy

In November 2013 the Department of Health (DH) set out its UK Strategy for Rare Diseases. The strategy aims to ensure that people living with a rare disease have the best quality of evidence based care and treatment possible across the whole patient journey - building upon best research, diagnosis and service provision that is already taking place in the UK and elsewhere, whilst achieving value for money through the effective use of resource. To this end a series of commitments across 5 areas have been developed to ensure the strategy’s vision becomes a reality by 2020. These include:

- empowering those affected by rare diseases
- identifying and preventing rare diseases
- diagnosis and early intervention
- coordination of care
- the role of research

We will continue to work closely with NHS England on meeting the strategy’s vision. As part of our extensive redevelopment programme we are already working on developing a Centre for Children's Rare Disease Research. This facility for the hospital and UCL ICH, which is due to open in 2017, will be used to discover new and improved ways to treat children with rare diseases and speed up the process "from bench to bedside". The Centre will house three laboratories, including manufacturing facilities, outpatients and office space for bio-informatics experts and clinical teams and will contain the necessary equipment to enable researchers to:

- increase diagnostic capabilities
- develop more new therapies to clinical standards
- analyse the results of the increased volume of trials and testing

We have experienced less pressure than other providers to reduce activity levels, as the majority of our work is not amenable to traditional demand management initiatives or community provision. It is also unlikely that potential ‘any qualified provider’ tenders would present a significant threat to the hospital due to the significant barriers to entry and the co-dependencies in the provision of highly specialised paediatric services. However, this may present an opportunity to bid for other services in the future – and could therefore support our overall growth strategy.

Rather than local commissioning intentions therefore, the most significant overall external factors for our strategic position have been identified as the wider NHS financial situation and the rationalisation of specialist paediatric services as described. Uncertainty regarding the outcome of specialist paediatric reconfiguration, in Cardiac surgery for example, does present a challenge however we are developing alternate scenarios pending the outcome of the NHS England review process in order that our strategy enables us to meet the needs of patients.

In addition, the significant changes to commissioning in 2013 with the development of NHS England and its role in commissioning specialist services has naturally impacted on the Trust. The majority of our services (approximately 90%) have been classified as specialist and are being commissioned by NHS

England. The North and East London Clinical Support Unit are our host lead for commissioning non-specialist activity funded by Clinical Commissioning Groups.

We will therefore continue to work closely with NHS England to strengthen our relationship. Our clinicians are involved in many of the relevant Clinical Reference Groups in order to best ensure a close connection with the strategic direction of commissioning and ensure that the clinical services for our patients are fully represented in commissioning decisions. The reduced number of commissioners for our services is anticipated to assist in joint strategic planning and may enable further clarity regarding designation of specialist centres, greater consistency in service provision for patients and in funding for specialised services nationally.

NHS England has assessed our compliance with the new service specifications to ensure that our services either already meet the qualifications or have planned developments in order to do so. 8 of our services are currently subject to temporary derogation and we have already developed comprehensive action plans with clear timescales to achieve all outstanding requirements in 2014 (appendix 1). It should be noted that the issues identified will not impact on our ability to provide services on an on-going basis.

Commissioning and regulation

In 2013/14 NHS England published its planning guidance, which aims to help local clinicians deliver more responsive health services, focused on improving outcomes for patients, addressing local priorities and meeting the rights people have under the NHS Constitution.

The document entitled Everyone Counts: Planning for Patients 2013/14 outlines the incentives and levers that will be used to improve services from April 2013 - the first year of the new NHS where improvement is driven by clinical commissioners. The guidance covers a clear set of outcomes against which to measure improvements and outlines five offers:

1. Move toward seven-day a week working for routine NHS services
2. Greater transparency and choice for patients
3. More patient participation
4. Better data to support the drive to improve services
5. Higher standards and safer care

We have undertaken a review of the five offers across all of our clinical divisions and have identified those most appropriate to the organisation - ensuring that the main elements are embedded within our existing strategies. We have already made excellent progress in identifying and publishing clinical outcome measures and have a firm plan in place to increase these over the coming year. We have an extensive patient experience and involvement plan, which we continue to build on. One of the key areas that we will be developing over the coming year is to extend working hours across a number of services. We are currently undertaking a comprehensive survey to identify what types of service and when in the week that patients and families would like routine services to be offered. Early results of the survey indicate that their preference would be for diagnostic tests and outpatient appointments to be available on Saturday. As such during 2014 we are implementing routine outpatient clinics across a number of specialities and an MRI scanning service on a Saturday.

3. Quality plans

We are devoted to the care of children and young people and they and their families are at the centre of our culture. Our intention is to be one in the Top Five children's hospitals in the world. To demonstrate this we have placed quality and safety at the top of our agenda. To achieve our goals we will utilise the three key domains identified by Darzi (Next Stage Review, Department of Health (DH) 2008), including

Safety (Zero Harm), Effectiveness and Experience to drive continuous improvements.

Safety (Zero Harm)
Zero Harm is the part of the strategy aimed at minimising harm to patients; safety improvement. We aim to achieve zero harm, but recognise that this will be a long process. However, we are committed to reducing harm year-on-year, and to doing so as rapidly as possible. We will ensure that care and services are patient-centred and that access is equitable to all. The elements of this work, led by example from the Board include:

- Monitoring and review of the Trust's safety culture
- Leadership for safety (Executive WalkRound, Safety on the Board agenda, Safety climate and culture surveys).
- Learning from, and decreasing the incidence of Serious Incidents
- Training in the science and methodology of improvement
- Human factors and the impact on clinical care training
- Improving standardisation of processes and eliminating variation where possible.
- Coaching programmes to develop and support staff
- Child Protection and Safeguarding training[1]
- Listening to, and actively involving, patients, families and referrers in the management and improvement of care and services.
- Development of systems and processes to identify and improve health inequalities in relation to protected groups
- Learning from other hospitals and industries

The implementation of the Zero Harm component of the strategy follows the interventions recommended by the Patient Safety First Campaign. The standards GOSH have chosen to prioritise are described in the table below.

Table 1. Zero Harm quality standards

Zero Harm Standard	Aim of programme
Maintain high levels of medication safety	• Decreasing risk from High-risk medications • Elimination of prescribing errors • Safe dispensing • Defect-free administration of medications • Reconciliation of medication prescription charts as a child passes through the system[2]
Decrease and eliminate hospital acquired infections	Focus on the elimination the following infections: • Ventilator Associated Pneumonia • Central line Infections • Methicillin Resistant Staphylococcus Aureus (MRSA) • Clostridium Difficile (C Diff) • Surgical Site Infections. (SSIs) • Urinary Tract Infections from indwelling catheters
Improve reliability in	• Improve handover of all information at any point in the patient

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

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

clinical handover and documentation	journey • Standardise handover information using the SBARD guidelines[3] • Ensure briefings for all procedures including the surgical and procedure checklists takes place • Improve the quality of medical and nursing record keeping at all levels to improve communication
Eliminate all pressure injuries occurring in hospital	• Identify children at risk, implement interventions and reduce all pressure injuries.
Recognise and respond to unexpected deterioration of children	• Early detection and situation awareness early warning scores - CEWS[4] • Communication and escalation using SBARD • Huddles on the ward at key times in the day • Improved handover at night and over weekends • Implementation of outreach rapid response teams from the Intensive Care Unit (ICU)

We will seek year-on-year improvement on our current results and will continue to benchmark against our peers.

We widely use Statistical Process Control (SPC) Charts across a number quality and safety measures to facilitate reporting and permit a visual stimulus for continuous improvement and target setting. The topics under scrutiny, the data collected to monitor performance, and the subsequent SPC charts are visible on our Intranet for all staff to see and are used for divisional performance.

We are committed to expanding the list of safety items that we monitor, identified from national and international safety reports, critical incident analysis, complaints and common sense.

Effectiveness

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

We have developed a programme for identifying key outcomes for each of the specialties, and at least two such outcomes per division are published on our Website. Several specialties have many more measurable outcomes than others, and the good practice they have developed will be spread throughout the Trust.

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

To facilitate this process we have established relationships with the leading children's hospitals in the world and made agreements about data sharing and benchmarking.

[3] SBARD is a standardised format of transferring clinical information at each point of handover and is an acronym for *Situation Background Assessment Recommendation and Decision.*

[4] CEWS is a clinical early warning score to detect deterioration in children

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

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

We also wish to ensure that we record and report effectively those outcomes reported by patients. Patients' perception of treatment and care is a major indicator of quality and there has recently been a huge expansion in the development and application of questionnaires and rating scales that purport to measure health outcomes from the patient's perspective.

We are keen to develop and use Patient-reported outcome measures (PROMs) across the hospital to ensure that we measure and understand how patients perceive the outcomes of their care and we see this as a vital improvement initiative. Annual targets will be presented in the Quality Account.

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

Patient experience

Over the last year we have made significant progress in placing patient experience at the heart of our work and we remain committed to engaging with patients and families as well as obtaining and acting on feedback.

The results of independent surveys have consistently shown excellent feedback scores from the patients and the parents who visit GOSH. However in 2012 there was a small decline in satisfaction across a range of measures within our inpatient survey that were treated as an early warning that perhaps our patients and families experiences were not as satisfactory as they once were.

All clinical divisions and corporate departments were tasked with providing action plans to address areas of concern including satisfaction with food, knowing how to feedback and complain, planning of care for patients with special needs and our discharge processes. We are pleased to report that provisional results from the 2013/14 inpatient survey show positive improvement in a range of measures.

We have started to implement the national Friends and Family test to obtain information and feedback from patients and families at the point of discharge on their experiences of our services. This is currently in place for the parents of inpatients and will be expanded to include responses from children and young people; those cared for in day care areas and those who attend outpatients. We also aim to increase the mechanisms through which people can feedback and respond to the test.

Research shows a strong correlation between staff experience at work and the patient experience received. Therefore, we will also be implementing the Friends and Family test for staff in line with national recommendations.

In the spring of 2013 we established a Young Members forum to improve engagement with young people and improve their experiences of the hospital. The forum has been actively involved in a range of initiatives in the hospital and young members are now actively consulted on a wide range of issues. The plan for the coming year is to continue to embed young member's engagement in the organisation and to improve the ways in which they can feedback about their experiences. We also intend to explore how children under the age of 10 can be engaged in sharing their experiences.

In June 2013 the Trust held a listening event for 100 patients, families and staff. The event was very successful in identifying what the Trust does well but also what needs to be improved. There was a very clear imperative from all participants that GOSH needed to clearly articulate the organisations values and behaviours. An extensive piece of work has been commenced to consult more widely on what these values and behaviours should be. This will feed into the wider work on 'Our commitment' that everyone will sign up to. Over the coming year this will be implemented and embedded across the organisation to facilitate the cultural change required.

In addition to priorities outlined above we will:

- Ensure that patient experiences are improved as a result of feedback.
- Ensure a range of opportunities are provided for patients, families and staff to be listened through engagement events, consultations and open forums
- Ensure targeted focus groups and activities are undertaken to make certain those in hard to reach groups are listened to and their experiences improved e.g. bringing together patient and families of a faith, or sharing a particular disability in order to learn how these groups currently experience our services and agree priority areas for improvement with them.
- Ensure that mechanisms are in place to keep patients, families and our staff informed of the feedback received and actions taken to improve people's experiences.

The information obtained will be reported bimonthly to the Patient and Public Involvement and Experience Committee with a high level summary presented to Trust Board quarterly.

Our work to achieve Zero Harm, along with our role as a leader and innovator in the field of Patient Safety, has been recognised by the awarding of the Patient Safety in Paediatrics Award at the Health Service Journal and Nursing Times 2013 Patient Safety and Care Integration Awards. Teams across the hospital have worked together to build a culture of safety and accountability which has led to a real decrease in harm. A key factor in the recognition of our success was how we have involved parents, families and children in our Zero Harm programme.

As a Foundation Trust, we always want to continue to give greater say in how we're run to local people, staff and all those who use our services, including patients, their families and carers. Our Members reflect these groups and are represented by 28 elected and appointed Councillors on the Trust's Members' Council. Since becoming a Foundation Trust the Members' Council has been actively involved in developing our annual plan priorities and this year we have sought to strengthen our membership involvement wider.

In February 2014 we held an engagement session with a representative sub-group of the Members' Council to seek their views of our initial priorities and plans for 2014/15 and beyond.

Our priorities

To meet demand for our services we aim to open more ICU beds and have recently implemented a new model of Neonatal ICU beds. We will open our Southwood imaging suite, which will see the addition of modern CT and 3-Tesla MRI scanners. This will provide an enhanced imaging service, delivering clinical

and research benefits, and significantly mitigate the operational risks associated with the delivery of our redevelopment programme. In 2014 we will also be adding a new outpatient facility, opening 3 new Angiography laboratories and expanding our respiratory ward.

Our extensive patient experience and quality programme is detailed in the previous section. In addition to this we will aim to improve the support and coordination for complex patients and we will continue to review our safeguarding requirements and processes. We will develop a comprehensive health and well-being programme for children and young people with learning disabilities to promote good physical and mental health and to ensure our services work in person centred ways.

We are looking to extend the days and times that we offer routine booked appointments and treatments. We want to do this to increase the amount of time we use our facilities enabling us to treat more patients and to offer patients and families a wider range of appointment / treatment times (e.g. evenings and weekends). As outlined in section 2 we will be implementing a routine Saturday operation and MRI services during 2014/15.

In 2014 we are opening a comprehensive and standardised pre-operative assessment which will includes a clinic for planned patients who will require a general anaesthetic. This will help identify patients at particularly high risk to ensure that any specialist tests/assessments required for anaesthetics review are recognised in a timely manner; improve the patients experience and reduce cancellations on the day of surgery.

We recognise that moving from GOSH to adult care should be a planned process addressing the needs of young people as they move from child centred to adult oriented healthcare systems. It is evident from research that effective transition improves the health outcomes for young people. We want to ensure that we prepare young people as they move from child centred to adult oriented healthcare and will seek the best ways to do this.

A large proportion of patients at GOSH have complex conditions, which involves receiving care from numerous different specialties. We recognise that families are currently travelling to GOSH multiple times in a month for appointments, which can cause financial and emotional strain. Patient and family satisfaction with coordination and management of care for these families remains a priority for the organisation and we aim to improve their care and experience and reduce unnecessary visits.

We have developed a major IT investment plan that will commence from April 2014 following an external review of our systems and networks. A key part of this will see the introduction of an Electronic Document Management System (EDRMS) to replace our paper records by 2015. This will be the first stage in our ambitious transformation programme to fully digitalise the hospital having a complete Electronic Patient Record (EPR). During 2014/15 we will be developing the business case for this and commencing procurement.

Following the membership engagement session, 5 specific areas for further exploration and engagement with the wider foundation membership, patients, families and carers. This was facilitated through an online and internal face to face survey that focussed on:

- Extending working hours
- Improving our pre-assessment service
- Transition to adult care
- Managing patients with long term conditions
- Developing our clinical outcome measure

We were delighted to receive over 300 completed surveys from Foundation Trust members, patients,

families and carers. In summary the results of the survey showed that 68% of people thought extending routine booked appointments was very important and approximately 65% thought that we should focus on extending our diagnostic services and outpatient appointments. 41% thought that the pre-operative assessment screening tool for should be completed by the main carer but with access to staff assistance if needed and over 50% said that the tool should be available both in paper format and electronically. Whilst there was no clear response as to the most appropriate age that people thought transition should start, over 50% did feel that having a clinic specifically for teenagers at GOSH from 13 years until they leave would be the best option to support moving from child centred to adult oriented services. In relation to patients with long term conditions responses showed that having a single point of contact was key to ensuring effective management of care, although views were split as to whether this should be facilitated through a single clinician or single clinical team. Unfortunately over 50% of people surveyed did not know that we publish our outcomes on the Trust Website.

The results of the surveys were analysed and an open feedback session held in March 2014 gave foundation members, patients, families and carers an opportunity to meet their counsellors and further engage on our priorities. The outcome of the survey will form a key part of our wider strategic planning which is currently underway.

Response to Francis Inquiry

An independent inquiry by Robert Francis QC published a report into the severe failings in the care provided by Mid Staffordshire NHS Foundation Trust between 2005 and 2008. The final report, published in February 2013, called for a "fundamental change" in culture whereby patients are put first. The report makes a number of recommendations covering a broad range of issues relating to patient care and safety in the NHS.

It is our intention to ensure that in everything we do, across every department and for every patient we provide the quality of care that we would want for our own family. To this end, an executive working group has been established to co-ordinate our response to the report. Following a review of the report recommendations we have identified and prioritised those which apply most directly to the organisation and categorised these into 5 key themes, which include: Values, Culture and Compassion, Listening, Openness, Quality and Experience and Monitoring. We have developed a set of clear actions against each of these themes that will enable us to communicate coherently with staff, parents, families and the public about our plans. The table below outlines the key actions that will be completed and fully implemented by September 2014. Each action has an overall responsible executive member lead. Plans are monitored closely against milestones at each Clinical Governance Committee meeting with further updates provided quarterly to the Trust Board. We anticipate this also to apply in 2015/16.

Table 2. Francis Report action plan

Theme	Action
Values, culture and compassion	• Implement nursing vision that focuses on 6 Cs[5]. Embed this vision across the hospital. • Develop appraisal refresher training that focuses on compassion, listening and openness. Focus on understanding feelings around bullying. Ensure line-managers attend every 2 years.

[5] 6Cs (Care, Compassion, Communication, Competence, Commitment and Courage) are the principle values underpinning Compassion in Practice the three year vision and strategy for nursing, midwifery and care staff was launched by the Chief Nursing Officer for England (CNO) the Director of Nursing at the Department of Health in December 2012.

	• Roll-out values-based recruitment to all staff groups.
Listening	• All divisional senior management teams to perform weekly 'walkabouts' of their areas to listen to staff and patients concerns • Introduce 'real time' feedback for parents and patients, and ensure there are mechanisms in place to act on information swiftly. • Develop training on 'active listening' for staff. Consider how we can use and evaluate 'what matters most to you?' into daily clinical care.
Openness	• Develop guidelines and training for clinicians to support communication when families give feedback, or when errors have been made. • Publish feedback, complaints and incident information on the GOSH website. • Introduce team brief to share information and encourage engagement with staff.
Quality and experience	• Ensure all teams and departments include items on all meetings agenda's to discuss openness, listening (to staff and parents), and compassion. • Pilot 'lead clinician' model for complex patients in one specialty and evaluate how this could be rolled out across the Trust.
Monitoring	• Implement monthly performance reviews that review performance against key quality indicators. Ensure specialties have meaningful metrics for quality and safety. • Redevelop board Key Performance Indicator (KPI) reports to ensure transparency.

In addition to our action plan we have identified several important pieces of work that are already being undertaken, which provide further assurance that the organisation is performing well and listening to staff and parents. For example, each clinical division has developed action plans in response to the annual patient survey and the staff survey; a new performance monitoring structure has been implemented to ensure that divisions are reviewed each month against quality, safety and financial information; the KPI report has been reviewed and adapted to make it easier for the Board to assess performance and a review of nursing establishments was undertaken in 2013 to ensure that safe levels of staffing are always met.

Regulation and performance

We have an excellent record of consistently achieving key national quality standards as set out in the NHS Operating Framework and will seek year on year improvements on these.

In 2013 we retained full Care Quality Commission (CQC) registration demonstrating that we have continued to meet essential standards of quality and care across all our services. The Trust also received the lowest possible risk rating by the CQC in October 2013. The assessment was based on data which includes patient survey results, mortality rates and the number of serious incidents.

We have continued to meet the national waiting time standards with over 90% of our admitted patients and over 95% of our non-admitted patients being seen within 18 weeks. The percentage of patients who are yet to be seen but have not waited longer than 18 weeks (i.e. incomplete pathways) has also remained above the 92% standard for the year. We have continued to achieve 100% compliance against

all relevant cancer waiting standards and have consistently met the 6 week diagnostic waiting time target over the last year.

The Trust remains 'green' against Monitor's risk rating at Quarter 3 demonstrating compliance against all relevant service performance measures. The governance risk rating reflects the quality of governance at the Trust and is made up of a number of elements including: Performance against a range of national performance measures; third party reports including the Trust's compliance with the CQC essential standards of care; and a declared risk of failure to deliver mandatory services. We have analysed and declared our risk of not meeting all targets and indicators as minimal for 2014/15.

Table 3. Monitor Governance Risk Framework

Indicators	Target/threshold	Rating and score		
		Q1	Q2	Q3
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	90.5%	90.4%	92.9%
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	95.5%	95.8%	95.5%
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	92.7%	92.9%	92.3%
Cancer 31 day wait for second or subsequent treatment - surgery	94%	100%	100%	100%
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	100%	100%	100%
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	100%	100%	100%
Cancer 31 day wait from diagnosis to first treatment	96%	100%	100%	100%
Clostridium Difficile -meeting the C.Diff objective	12 or fewer cases per annum	Achieved	Achieved	Achieved
MRSA - meeting the MRSA objective[6]	6 or fewer cases per annum	Achieved	N/A	N/A
Compliance with requirements	Compliance with	Achieved	Achieved	Achieved

[6] MRSA standard no longer applicable under Monitor's Risk Assurance Framework from Quarter 3 2013/14

regarding access to healthcare for people with a learning disability	6 national standards			
Governance risk rating		**Green**	**Green**	**Green**

Commissioning of Quality and Innovation (CQUIN)

The CQUIN payment framework makes £5.5m (3.5%) of providers' contract income value conditional on achieving quality and innovation goals in a CQUIN scheme. Over the first three quarters of the financial year we have reported high compliance against all our CQUIN indicator milestones against a number of measures relating to reducing harm and infection and improving patient experience, public health and patient flow. We expect to report over 95% compliance at year end. For 2014/15 the national CQUIN framework mandates a number of themes and measures that organisations are required to report against. We are currently reviewing these but themes are likely to focus on:

- Friends and family test
- NHS Paediatric Safety thermometer (grade 2-4 pressure ulcer reduction monitoring)
- Highly specialised clinical outcome audit workshops
- Chemotherapy (reducing drug waste)
- Perinatal reporting times
- Locally agreed measures

A national work programme for specialised services quality improvement has additionally been established to assist decision making about the future oversight and governance of quality improvement under NHS England. Our lead commissioners have specified a range of quality standards to be achieved for selected services and have developed quality dashboards that incorporate measures of clinical outcome, patient experience and service effectiveness and efficiency for completion in 2014/15.

These include:

- Genetics
- Neurosurgery
- Paediatric Cardiac Surgery
- Paediatric Intensive Care
- Cystic Fibrosis
- Haemophilia

A CQUIN monitoring group that is chaired by an Executive Director and attended by CQUIN leads is already in place. The group review progress and identify remedial actions where performance is not being achieved. High level performance is also monitored through a monthly performance report to Lead Commissioners. A quarterly performance exception report is additionally provided to our Trust Board.

Risk management

Last year we made a number of improvements to our risk management processes and will continue to do so in the coming year. We completely revised the Board Assurance Framework (BAF) to ensure that both operational and strategic risks are included. Each risk has a lead director and is updated at least quarterly including a narrative on controls, assurances and actions being taken to further mitigate the risk. Additionally for each risk we have added a risk appetite score which shows the level of risk the organisation we are prepared to tolerate. The risks with the highest current scores, potentially catastrophic consequences and those with the greatest variance between the current risk score and risk appetite and

reviewed at least annually by one of the Trust's Board Assurance Committees (Audit Committee and Clinical Governance Committee). All the other risks are reviewed at least annually by the executive led Risk, Assurance and Compliance Group. During the next year the BAF will be further realigned to ensure that it appropriately reflects the key risks with delivering the updated Trust Strategy.

The bottom up risk registers are managed in line with our Risk Management Strategy, by the various Risk Actions Groups (RAGs) across the Trust. All high level risks should be formally reviewed at least every 4 weeks, all medium level risks at least every 8 weeks and low level risks at least every 12 weeks. The timeliness of reviews in line with this policy is performance monitored on a monthly basis and all divisions attend the RACG at least twice per year to discuss their highest risks and management of their risk registers.

A challenge with risk registers is ensuring that they are actually an accurate reflection of the key risks of the organisation, rather than a group of specific issues raised by discrete groups of staff. To address this potential problem we undertake a twice yearly "top 3 risk" exercise where key leaders across the organisation are asked to identify their top 3 risks without direct reference to their department's risk register. The results are compared to both the Board Assurance Framework (BAF) and departmental risk registers to ensure that these risks are included. We aim to reduce the number of risks that have been on the risk registers for a considerable period of time, these risks should either have been completed mitigated against or mitigated to a level which is will enable them to be accepted. The aim is to eradicate a culture of the identification of risks being an end to it being the beginning of the process.

We are currently implementing a method of accepting risks. Where departments have reduced the risk to a level which is acceptable to the Trust they may request that a risk becomes accepted. This risk is not removed from the risk register but greater focus and resources can concentrate on the risks which have not been reduced to an adequate level. Our top organisational risks from the BAF are detailed in appendix 2.

Board assurance

Each year we will undertake a comprehensive self-assessment of our governance assurance activity against Monitor's Quality Governance Framework, assessing our position against good practice examples under each of the framework domains of Strategy, Capabilities and Culture, Processes and Structures and Measurement.

In March 2013 Deloitte undertook a review of our progress against best practice recommendations and concluded that, on the basis of information supplied and on the basis of detailed interviews undertaken in relation to this work, there were no material gaps or omissions in relation to the Trust's progress.

We are currently in the process of reviewing our position for 2014/15 against the Quality Governance Framework and will compare this to Monitor's additional assurance questions, which focus on themes of engagement, insight, accountability of quality as well as risks to quality as detailed in their quality governance guidance document. Whilst we do not envisage any significant gaps or omissions in our level of assurance, we will provide a summary of our self-assessment within our Five year strategic and sustainability plan in June 2014.

Education

The Trust's Education Strategy is to ensure that our education provision is the best it can be and in line with the Trust's mission and strategic direction. An internal stakeholder event was held in February 2014, attended by staff from a wide variety of disciplines and specialties. The aim of the event was to scope a mission statement for the education strategy and address some key questions about the purpose of education at GOSH, the potential business model and the imperatives and aspirations for education. The

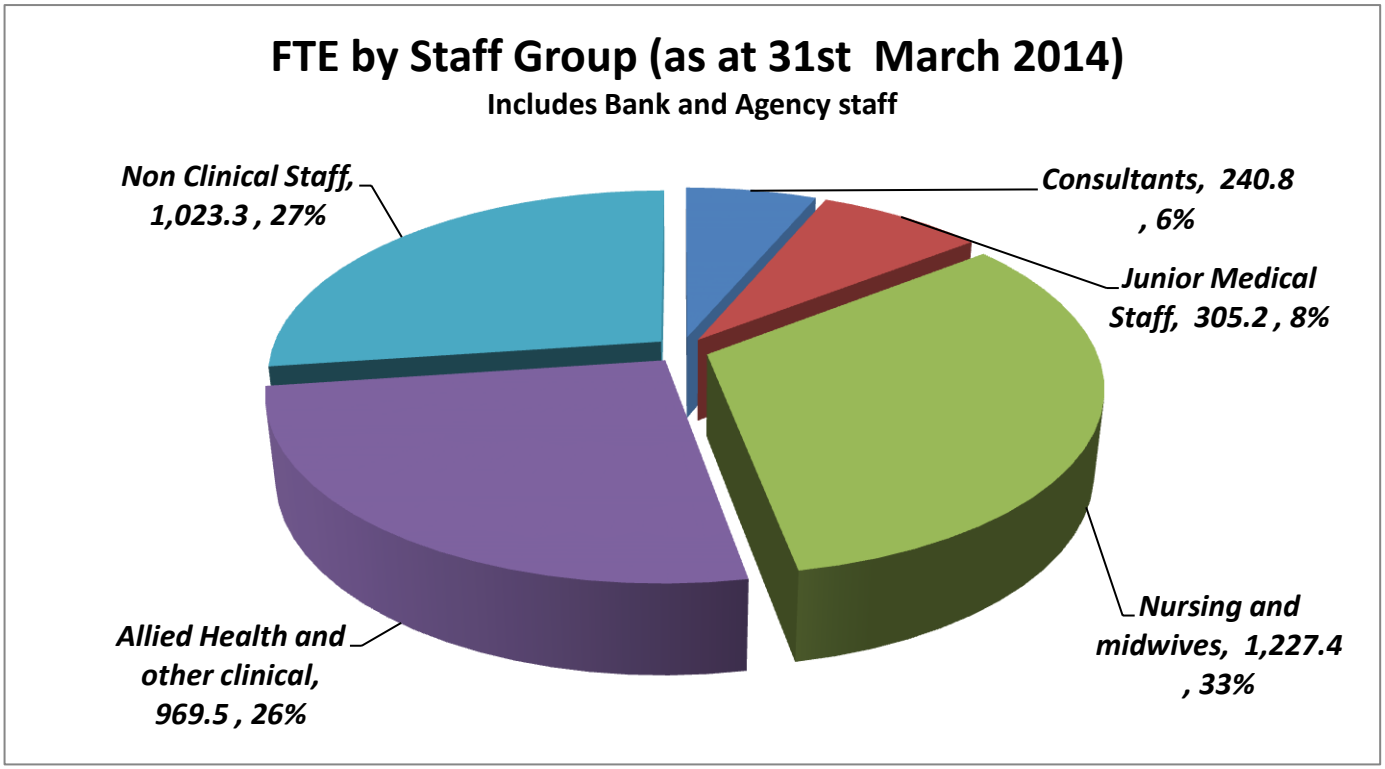
findings from this event will be used to inform a strategic conversation event to be held in May, with a wide range of stakeholders from within the Trust and our key external partners.

Workforce

The total full time equivalent (FTE) at GOSH for the end of March 2014 was 3,766. Over the next two years we are predicting a reduction in FTE in our non-clinical staff and increased clinical staffing mainly in nursing. This incorporates all the efficiencies that we will make and include the forecasted growth plans outlined in the operational requirements and capacity.

GOSH (FTE) staffing March 2014 to March 2016 (figures include Bank and Agency staff)

Staff Grouping	*31st March 2014*	*31st March 2015*	*31st March 2016*
Consultant	240.8	250.4	252.8
Junior Medical Staff	305.2	311.4	307.5
Nursing and midwives	1,227.4	1,293.5	1,323.9
Allied Health and other clinical	969.5	983.7	971.4
Non Clinical Staff	1,023.3	950.0	909.7
	3,766.2	**3,789.0**	**3,765.3**



We report on a standard set of workforce KPIs: turnover, absence, vacancies, and agency spend as a percentage of pay-bill. Where data is available, we will benchmark these against a basket of London Trusts on a quarterly basis; where data is not available, we will benchmark against the Trust average. These reports identify outlying departments to ensure hotspot areas are targeted and monitored.

In 2014/15, we propose to further develop these standard reports to include voluntary and non-voluntary turnover; and data on levels of statutory and mandatory training completed across the Trust. Overall, Trust absence rates remain low and show a downward trend.

Table 4. Trust sickness rates (%)

Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
2.90	2.87	2.84	2.82	2.81	2.41	2.73	2.69	2.67	2.69

We have continued to closely monitor our turnover and vacancy rates. We have a large number of staff on fixed term contracts and in 2013/14 we also saw a larger number of staff than is typical leave the organisation under Transfer of Undertakings (Protection of Employment) (TUPE) arrangements. For that reason in 2014/15 we will be introducing a new report that indicates both the national calculation for turnover but also indicates the figure adjusted for non-voluntary leavers so that we can identify more accurately what is driving our turnover and take appropriate actions.

Table 5. Trust turnover rates (%)

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14
National T/O	16.78	16.98	17.56	17.86	18.2	17.91	17.8	18.06	17.81	17.61
T/O excluding non-voluntary leavers	12.31	12.51	13.09	13.39	13.73	13.44	13.33	13.59	13.34	13.14

Table 6. Trust vacancy rates (%)

Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
9.63	9.10	10.76	11.54	11.21	12.10	8.65	10.11	8.13	9.18

Staff who are working on a temporary basis (e.g. through the Trust bank) in substantive positions are not reported in this data. The bank is continuing to provide large numbers of staff who are being utilised to fill vacancies flexibly but the conversion rate of bank staff into substantive employees indicates that this is providing an alternative route into the Trust for employment.

We do not forecast any significant increases in turnover or vacancies in the next 12-24 months, but recognise that to maintain staffing levels in central London we need to continuously focus on effective recruitment and retention. From February 2014 we have amended our calculations to Bank staff FTE which has changed the overall vacancy rates and we will report these numbers moving forward.

Whilst we have proven success over the last 12 months in our nurse recruitment and retention activities, continuing to recruit nursing staff will remain a key focus area in 2014/15. On the basis of the effectiveness of these methodologies (as outlined below) they will continue to be important elements in our recruitment work over the coming 12-24 months.

Recruitment of newly qualified nursing staff

Newly qualified staff form a substantial core of the ward workforce. We run a number of job fairs each year to market GOSH to new nurses who are graduating. In 2013 we introduced an assessment centre approach to ensure high quality recruits. The Trust received 275 applications following job fairs, and after a rigorous assessment centre approach appointed 88 staff. We have since invested in a support infrastructure to develop these newly registered staff into high quality independent practitioners. A further 2 newly qualified job fairs and subsequent assessment centres will be run in 2014/15.

Overseas recruitment

We have identified a specialist commercial partner to target high quality nurses particularly from Ireland and Portugal. The initiative was initially focused on staff for ICU areas, but has proved so successful that staff have been recruited to specialisms in Medicine, and to International and Private Patients.

To date, 30 international nurses have commenced employment (25 to the Intensive Care Units and 5 to International and Private Patients). A further 26 international recruits are due to start in April 2014 (8 in Medicine, 7 in the Intensive Care Units and 11 in Cardio-respiratory wards).

We have developed a programme for these staff which includes welcome packs, orientation to London as well as to the Trust, guaranteed low cost accommodation local to the hospital, pastoral support, follow up at set periods to ensure good settling and retention. Feedback from these staff has been very positive, and existing staff on the wards have commented favourably on the skill and enthusiasm of their overseas colleagues. Over the next 12 months we will continue to utilise our specialist commercial partner to source nurses from Ireland, Portugal and Spain.

In 2014/15 we will regularly review establishments to ensure we comply with the National Safe Nurse Staffing toolkit and that all our wards have nurse staffing ratio's that comply with national guidance on children's services as set out in 'Defining staffing levels for children and young people's services' (RCN 2012). We will review and create new roles to ensure we continue to improve productivity and deliver efficient, quality care to our children and young people. To support this e will establish an annual recruitment drive schedule to include: national recruitment, newly qualified, and international nursing staff. This will mitigate the risk associated with having large cohorts of newly qualified and international nurses starting at the same time.

Marketing of GOSH as an employer

Through marketing educational activities and the benefits of working at GOSH, such as subsidised accommodation, health, wellbeing and childcare benefits, the Trust will aim to develop its reputation as an employer of choice. We will develop our web pages to make them more accessible and attractive to all staff.

Temporary staffing

We have continued to take concerted action in 2013/14 to manage our overall temporary staffing costs by displacing costly agency staff and replacing them with bank workers. 51% of the current agency usage is in non-patient facing areas (mainly ICT, finance and estates).

Over the next three years we will reduce overall spend by shifting bank: agency spend ratio from the current 74:26 to 82:18 and decreasing total usage by 10.14%

During 2014/15, we will implement action plans to analyse the drivers of temporary staffing usage in each of these areas and reduce it to the average level of Trust spend as percentage of pay bill. Some specialist

areas, such as ICT projects, will continue to require the tactical use of temporary staff but improved controls will be put in place to ensure that best value for money is being achieved at all times.

We will go live with an e-bank system in Q3 2014/15 which will allow improved demand analysis and control; improved governance through electronic timesheets; improved detail and timeliness of data.

Within this overall picture, nursing shifts continue to be filled predominantly by bank staff, allowing us greater control of cost and quality. In 2013, after analysis of competitor pay rates and a review of income projections and cost, a decision was taken to increase ICU bank pay rates. This has led to greater numbers of shifts filled with bank rather than agency staff, and improvements in team working as a result

In close consultation with operational nursing staff, we have also implemented bespoke training for Health Care Assistants staff on the bank, so that ward teams can book staff with key skill sets instead of a registered nurse where this is clinically appropriate.

We will continue to drive towards improved rostering and booking practices over the next 12 months to ensure the most effective use of temporary staff. In particular, a six-monthly establishment review of all ward nursing staff will take place, using data from our rostering and patient acuity tools, to ensure we have the correct numbers and bands of staff in each specialty and rostering practices are using these staff effectively.

Talent management

Over the next 24 months we will use a revised appraisals process and the identification of mission-critical roles to develop a more formal approach to talent management and succession planning. This will inform education and training planning and commissioning, as well as improve our ability to identify talent internally and plan for future needs.

Workforce productivity and quality

We have developed key indicators of workforce productivity to measure activity shown against actual FTE's and against consultant programmed activities, both of which have shown a sustained improvement in since 2010/11. Our workforce plans forecast incremental improvements in productivity, with limited staffing growth against an increase in predicted activity.

As part of our wider commitment work we aim to strengthen our workforce processes. This will include a new appraisals process, which will measure individual behaviours against Trust standards and introduce a link between performance and pay (2014); Values based recruitment; a clear Measurement process and a communications and engagement plan.

The Trust is preparing to roll out the workforce expectations set out by the Chief Nursing Officer for England. Many of these are already well established although some will require a more formal process to be put in place to demonstrate clear governance. The Trust has developed e-Panda, its patient acuity and dependency tool which, in conjunction with its e-rostering system, will facilitate the reporting of timely and accurate staffing data. Although a national timescale for implementation has not been published, the Trust is working towards implementation of all expectations during summer 2014.

The Trust is preparing to trial the workforce element of the quarterly Friends and Family Test in Q1 of 2014/15, with the intention to roll this out fully in Q2. It is in discussion with commissioners to agree this timetable. Data from the 2013 annual staff survey shows 87% of staff would recommend GOSH to a family or friend to be treated and 84% of staff say that Care of patients/service users is the organisation's top priority. GOSH increased its response rate for the staff survey from 42% in 2012 to 62% in 2013. The Trust aims to maintain this level of response rate in 2014. All clinical divisions and corporate departments

will develop action plans based on the feedback their own staff provided, and will monitor progress through performance management processes.

Research

Research is integral to the Trust's overall strategy; With partners maintain and develop our position as the UK's top children's research organisation. The Trust attracts approximately £15m per annum in direct research funding; our primary funder is the National Institute for Health Research (NIHR) providing around £11m per annum, in addition we receive funding from the GOSH Children's Charity, commercial partners and the European Commission. Research is overseen, managed and supported by the Division of Research and Innovation which comprises the NIHR GOSH-University College London Biomedical Research Centre (BRC), the Somers Clinical Research Facility (CRF) and the Joint Research and Development Office. The Division also works very closely with our NIHR Local Comprehensive Research Network.

Our plans for 2014-16 include:

- Work with our key academic partner, the UCL Institute of Child Health (ICH), to develop a joint research strategy
- Work closely with our clinical divisions to ensure research and innovation is an integral part of the Trust's activity, including the development of a research communication and awareness plan
- GOSH and UCL are the recipients of funding for the only dedicated paediatric BRC and a key priority is to ensure that we deliver the against the objectives of our BRC Strategy; as part of this we have clear targets for research income growth and engagement with industry, leveraged from BRC investment in clinical research infrastructure at GOSH and ICH
- We will continue to support and grow our research capacity and infrastructure; this includes facilities such as our CRF and the Centre for Translational Genomics - GOSgene, as well as supporting dedicated posts through our new Research Capacity Fund
- Continue to build capacity in research, and build and expand our research training programmes. We will develop a specific strategy for nursing and allied health professionals
- Development and implementation of a new research grants advice service to help researchers select appropriate funding opportunities and streams, and to assist them with the preparation of high quality applications.
- Deliver against our strategy for patient and public involvement and engagement in research
- Continue to work closely with our local comprehensive research network to maximise research support funding and will further develop links with our commercial partners to produce more evidenced based research in a paediatric setting to allow our clinicians to make more informed choices about use of unlicensed medicines and to work towards having more medicines licensed for paediatric use
- In partnership with UCL Business, develop a strategy for identifying and supporting innovation across the Trust.
- To meet our national targets for performance and delivery of Clinical Research with a robust Research Governance and Ethics support service.

4. Operational requirements and capacity

We have undertaken detailed activity and capacity modelling to inform our growth plans and the resources required to deliver them over the next 2 years and beyond. Using month 6 forecast outturn data we have determined the full year effect of our activity across all services and applied growth assumptions based on a detailed understanding of changes over the next 2 years for each speciality in terms of known and anticipated clinical developments, market shifts and population changes. The table below summarises our growth plans at point of delivery over the next 5 years.

Table 7. Inpatient spells

Year	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Spells	30,816	32,094	33,088	33,749	34,424	35,113

Table 8. Outpatient activity

Year	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Outpatient	148,540	149,908	155,528	156,390	159,376	162,010

In determining the resources required to deliver planned growth we additionally considered the resource relationship between departments and services and in particular the impact of growth on our ICU beds. The tables below outline our demand for beds and theatres over the next 3 years.

Table 9. Demand and capacity analysis, Ward beds

Division	2014/15		2015/16		2016/17	
	Demand	Capacity	Demand	Capacity	Demand	Capacity
Medicine	41	42	42	43	42	43
Surgery	54	66	57	66	59	66
Cardio-Respiratory	38	39	40	39	40	39
Neurosciences	32	34	33	34	34	34
Infection, Cancer and Immunology	63	68	64	68	65	68
Intensive Care Units	40	44	44	48	46	50
Trust total	**270**	**293**	**279**	**298**	**286**	**300**

We have sufficient capacity within our existing bed pool and anticipated increase in the number of beds over the next 2 years to meet additional demand.

Table 11. Capacity analysis, Theatre sessions

Specialty	Sessions per week		
	2013/14 Actual	2014/15 Planned	2015/16 Planned
Neurosurgery	10	10	12
Ophthalmology	4.25	4.25	4.25

Cardiac Surgery	18	19	20
Cleft	5	5	5
Craniofacial	3	3	3
Dental/MaxFax	5.5	5.5	5.5
ENT	12	12	12
Orthopaedics	5.5	5.5	7.5
Plastic Surgery	6.5	6.5	7.5
Spinal Surgery	6	6	7
General Surgery	11	11	12
Urology	11	11	12

The table above outlines weekly theatre sessions needed to meet demand until 2015/16 for our main elective operating lists. The additional demand for sessions will be delivered by opening an eleventh theatre in 2014/15.

Our workforce plans have additionally been derived from activity plans, with assumptions about absorbing levels of growth within existing establishments being built into the plans. These inputs for the workforce plans have been owned by clinical divisions, with oversight and challenge from the Workforce, Finance and Planning teams.

Redevelopment programme

In 2013/14 we made good progress in delivering the next phase of the redevelopment programme. The procurement process for the second phase of the Mittal Children's Centre, The Premier Inn Clinical Building, was completed as well as a complex programme of works to decant the Cardiac Wing progressed. These works include the creation of a new angio suite, refurbished facilities for a number of wards and a new main entrance complete with welcoming and colourful art work, furniture, way finding kiosks and a pirate ship.

5. Productivity, efficiency and Cost Improvement Programmes (CIPS)

With the continued real term reduction in NHS funding we recognise the absolute imperative of fully delivering our planned savings for 2014/15 and 2015/16. Delivering these savings will be essential to maintaining our financial viability. Our 2 year financial plan requires us to deliver £14.8m in 2014/15 and £15m in 2015/16. These amounts consider the impact of tariff deflation, pay increments and cost inflation as well as unavoidable cost pressures, and they represent approximately 5.5% of our influenceable expenditure.

To ensure full delivery of the CIPS we have established a three pronged approach to identify, scope and deliver the savings.

Firstly, CIP schemes are identified and developed through a bottom up approach with clinical divisions and corporate departments with an emphasis on delivering cost reduction through improvements in the efficiency and effectiveness of services and the elimination of wasteful activities. Over the past few years our high growth levels have enabled us to deliver some CIPs through the contribution between additional income and the marginal increase in cost. Whilst we are still planning for some of our CIPs to be delivered in this way in the next 2 years we have set minimum expenditure reduction targets for each clinical division.

The delivery of CIPs will be performance managed through a dedicated Performance Management Office (PMO) and will be a key element of the performance management regime with each clinical division and corporate department.

We have instigated a system of "earned autonomy", where departments who have identified their full CIPs target and are delivering a balanced budgetary position will have freedoms to recruit to budgeted levels. Departments that have not gained earned autonomy will be required to have recruitment to all non rostered staff assessed by an executive led panel.

Whilst the responsibility for delivery of CIPs must ultimately lie with the budget holder we recognise the role in supporting the delivery of CIPs with a number of Trust wide projects which provide the catalyst to delivering savings and ensure consistency across the organisation.

We have established 9 of these projects with each having an assigned executive director supported by the appropriate management teams including financial, general managers, clinical and HR. Each of these schemes has an indicative target which is related to a proportion of the annual expenditure on the theme. It is the expectation that many of these themes will be multiyear and also support the delivery of CIPs in 2015/16 and beyond.

These nine themes are detailed in Appendix 3

The third aspect of the support to deliver the CIPs is with dedicated Transformation (improvement) resource to deliver improved efficiencies across the organisation. These will facilitate the ability to deliver additional activity and income at a low marginal cost and also to reduce resources in specific areas whilst maintaining activity levels.

The specific efficiency projects are;

a) Theatre / Procedure Utilisation

This improvement project covers all theatres, MRI scanners, angiography labs, endoscopy suites and procedure rooms. It aims to maximise list throughput by reducing late starts, turnaround times and early finishes

b) Reduced Length of Stay

We will ensure that all patients have a specific management plan that is tailored towards them being discharged at the earliest time. Gateways for each patient will be monitored and we will address or escalate immediately any delays. We will also actively plan for the transfer of complex patients on admission to reduce the number of patients who ultimately end up as delayed discharges.

c) Reduced ICU Flow Delays

We will ensure that patients within our ICUs that are fit for discharge are transferred out promptly to enable capacity for new admissions (either elective or emergency)

d) Outpatient Utilisation

We have recently conducted a review of the utilisation of clinics across all our specialties. This has presented many opportunities to increase activity with the same resource. This will assist our growth plans by delivering at a low marginal cost

Quality Assurance

We have a well-established formal process of ensuring that CIP schemes do not adversely impact on patient safety and quality. All schemes over £50k are required to be signed off by the Divisional management team (director, head of nursing and general manager) and the Chief Nurse and Co-Medical Director. Each of these schemes identifies key performance indicators that would be a measure of any adverse impact from the CIP scheme and these are monitored. Each quarter a sample of CIP schemes are audited by representatives of the board level Clinical Governance Committee to ensure that the schemes have had no adverse impact on quality and safety.

Long Term Strategic CIPs

We are also developing a number of themes that will deliver transformational change to the way that we deliver services in the medium to long term more efficiency. These themes will become our CIPs of the future and be pivotal to GOSH playing its part in the long term financial viability of the NHS. These themes include the following;

- Digital hospital with radical process and workflow benefits
- Consideration of the potential for more widespread outsourcing of support services
- Review of all product lines to ascertain the optimal mix of services at GOSH and the potential for key strategic alliances with other partners
- Step change in private patient activity either within London or overseas or both

All of these themes and more will be described in more detail in our subsequent strategic plan

Current Progress

We are making good progress towards our 2014/15 target of £14,793,447 and have identified savings of £11,907,000 which represents 80.5% of the total. If adequate savings are not being delivered from day 1 of the financial year we will be implementing controls to ensure the organisation remains on financial plan whilst recurrent savings become realised.

Appendix 3 details our top 5 expenditure and income schemes by value.

6. Financial plan

High Level Summary of the Two Year Financial Plan (this summary excludes donations to fund capital expenditure)

Statement of Comprehensive Income						
				GROWTH		
£'m	Forecast	Plan		Forecast	Plan	
	2013/14	**2014/15**	2015/16	2013/14	**2014/15**	2015/16
NHS Clinical Revenue	280.3	**287.8**	293.8	*7.1%*	***2.7%***	*2.1%*
Private Patient Income	41.9	**45.3**	46.9	*1.5%*	***8.1%***	*3.5%*
Other Clinical Income	6.1	**7.0**	7.4	*15.9%*	***15.7%***	*5.0%*
R&D Income	20.2	**21.1**	21.1	*2.7%*	***4.6%***	*0.0%*
E&T Income	10.0	**10.7**	10.6	*2.3%*	***6.7%***	*-0.7%*
Charitable Contributions to Expenditure	5.1	**6.1**	5.9	*-12.7%*	***19.5%***	*-3.1%*
Other Operating Revenue	13.5	**13.0**	13.0	*-8.1%*	***-3.6%***	*0.0%*
Total Revenue	**377.1**	**391.1**	**398.8**	***5.3%***	***3.7%***	***2.0%***
Pay	(206.9)	**(215.8)**	(220.0)	*4.4%*	***4.3%***	*2.0%*
Drugs	(58.5)	**(59.5)**	(60.1)	*4.6%*	***1.6%***	*1.1%*
Other Clinical Supplies	(26.6)	**(28.4)**	(29.1)	*4.4%*	***6.7%***	*2.3%*
Non-Clinical Supplies	(14.6)	**(15.2)**	(15.2)	*9.2%*	***4.4%***	*0.2%*
Other Expenditure	(38.5)	**(41.2)**	(41.7)	*0.4%*	***7.2%***	*1.0%*
Total Expenditure	**(345.1)**	**(360.1)**	**(366.1)**	***4.2%***	***4.4%***	***1.7%***
EBITDA	32.1	**31.0**	32.7			
Depreciation	(23.9)	**(18.1)**	(18.8)	*26.7%*	*-24.2%*	*4.0%*
Investment Interest	0.2	**0.2**	0.2	*104.9%*	*14.8%*	*20.0%*
PDC Dividend	(6.3)	**(7.0)**	(7.4)	*8.6%*	*11.5%*	*4.7%*
Operating Surplus before Impairments and Capital Donations	**2.1**	**6.1**	**6.8**			
Operating Margin %	0.5%	**1.6%**	1.7%			
EBITDA %	8.5%	**7.9%**	8.2%			

Key Assumptions and areas of Uncertainty

We have used the national economic assumptions incorporating a modification for the announcement on 13 March 2014 of the agreed pay award for staff paid under Agenda for Change.

The tariff deflator for activity funded under Payment by Results (PbR) is based on the average price changes for the Trust's current year activity re-priced using the 2014/15 tariff and grouper. The tariff deflator for locally priced activity is currently subject to negotiation with the Trust's commissioners in line with the national guidance.

Activity growth is based on specialty by specialty service plans which incorporate demographic growth, external service changes and in some cases reductions in waiting lists to ensure targeted waiting times can be met.

We only have a small number of derogations in relation to our wide range of specialist services and the costs of becoming fully compliant during 2014/15 have been included in the Plan.

We have major building redevelopment works occurring during 2014/15 and there may be some associated impact during the period that the access to the radiology suite is limited. Detailed plans have been compiled to minimise the reductions in service and knock on effect on patient care.

We have set a combined productivity target derived from CIP and revenue generation schemes of £14.8m in 2014/15 and £15.0m in 2015/16. It is assumed that the programme will be fully delivered.

Service developments

There are no major service developments included in the Plan. During the two year period, there will be a construction of the "2B" Clinical building. The enabling works for this project will complete in 2014/15 ensuring that disruption to clinical services is minimised.

Engagement with commissioners

The Trust is 90% commissioned by NHS England. We sent a financial proposal to NHS England incorporating our internal activity growth assumptions and service changes and we are currently in discussions with the NHS England Commissioning Team. NHS England have proposed lower growth rates in specialist activity than we currently believe are likely to occur based on the drivers of growth explained above. In all cases where different activity growth is anticipated, the activity is funded on a cost and volume basis in the current year.

In most areas where there are non-demographic growth plans, there has been clinical engagement with the commissioners to explain the underlying reasons for the Trust's view.

Risks

- In common with all London research active Trusts; we have received funding from the DH under arrangements known as the Project Diamond funding. This has been reported in R&D income. These funding streams were committed three years ago after discussion with the DH. We have included £4.7m of funding within each year of the Plan although we have recently received notice from the DH that this funding could no longer be paid from the R&D budget. All London Trusts in this position are challenging the decision.

- We have not yet agreed a contractual financial baseline with NHS England or CCG Commissioners for 2014/15 although proposals have been sent out by the Trust.

- We have not yet received notification of R&D funding allocations for our National Institute for Health Research - Research Capacity Funding (NIHR RCF) or Comprehensive Local Research Networks (CLRN) funding streams.

- We have experienced a significant increase in NHS Litigation Authority (NHSLA) premiums in 2014/15 and it is likely there will be a further increase coupled with a loss of the discount currently benefiting the Trust due to achieving NHSLA level 3. The increase in the NHSLA premium in 2015/16 will not be determined until the end of the current calendar year.

- The consequences of the limited access to the imaging suite during the major development during 2014/15 are worse than anticipated. The contingency plan involves increased costs for temporary facilities but these are not included in the Plan.

- We have set a challenging productivity target and there is risk relating to deliver of the benefits in the required timescales as virtually all major schemes have a lead in period.

Risk rating

We expect to maintain a Continuity of Service Risk Rating of 4 through the two years of the Financial Plan.