



Strategic Plan Document for 2013-14

**Great Ormond Street Hospital for Children NHS Foundation
Trust**

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

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Date	May 2013

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three 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 Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic 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 Strategic 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;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name (Chair)	Tessa Blackstone
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Jan Filochowski
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Claire Newton
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Signature



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1. Introduction

1.1 Past year performance

2012/13 has been a challenging but successful year for Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH). Our well established goals that focus on Zero harm, No waste and No waits continue to underpin our objectives which run, like a thread, through every part of the organisation and inform everything we do.

In 2012 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. This has been supported by our safety programme that aims to minimise incidents, harm and risks through reflective organisational learning and which includes, for example, understanding the nature of harm through the continuous use of the paediatric trigger tool (PTT); improving prescribing and administration of medications and decreasing hospital acquired infection rates such as MRSA, central line and surgical site infections. Some of our key achievements include reducing prescribing errors by up to 60% in a number of high risk areas and maintaining a reduced rate of 2 line infections per 1,000 bed days from 2.8 in 2011.

In October 2012, we were assessed by the National Health Service Litigation Authority¹ against the Level 3 Risk Management Standards for Acute Trusts. The assessment provides an external, independent benchmark for the processes in place to manage risk. Five key areas were assessed including; governance, competence and capability of our workforce, the safety of the environment in which care is delivered, the management of clinical care including infection control and the ways that we ensure we learn from experience. We were successful in achieving the highest rating possible - Level 3 compliance, which is an important achievement and assists the Trust in demonstrating compliance with the standards of other regulatory bodies, including CQC.

Last year we were appointed as one of only four centres in the country for the provision of specialist epilepsy services following the first phase of the National Safe and Sustainable Paediatric Surgery reviews. The reviews aim to rationalise the number of specialist centres to ensure the best outcomes for children who need congenital cardiac surgery and neurosurgery.

Our drive to deliver the highest quality of services is also demonstrated in the significant progress we have made in the identification and publication of our clinical outcome measures. Most of our specialties have now identified three clinical outcome measures, some of which we have already published on our internet site. Plans to collect, analyse, publish and benchmark further outcome measures over the next two years is firmly in place.

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. We have also 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 8 months.

The Commissioning of Quality Innovation (CQUIN) payment framework makes 2.5% of providers' contract income value conditional on achieving quality and innovation goals in a CQUIN scheme. At year end we reported over 99% compliance against all our CQUIN indicator milestones relating to reducing harm and infection and improving patient experience, public health and patient flow.

In terms of our workforce, we have received positive feedback from our annual staff survey. Our overall staff engagement score, which considers staff members' perceived ability to contribute to improvements at work; their willingness to recommend the trust as a place to work or receive treatment and the extent to which they feel motivated and engaged with their work, is reported at 3.99

¹The NHS Litigation Authority (NHSLA) is a Special Health Authority, which was established in 1995. The NHSLA administers the Clinical Negligence Scheme for Trusts (CNST) and the Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES), together known as the Risk Pooling Schemes for Trusts (RPST).

compared to the national average for acute specialist trusts of 3.92. The survey also highlighted better than average scores in the percentage of staff who feel able to contribute towards improvements at work; the percentage of staff receiving an appraisal in the last 12 months; job motivation at work and job satisfaction. However, the survey also emphasised a number of areas for improvement – in particular a higher percentage of staff witnessing potentially harmful errors, near misses or incidents than last year. Local action plans are being developed to address issues and concerns raised in the survey.

The results of our annual IpsosMORI inpatient survey highlight that patient and family satisfaction rates remain strong (93%), despite a small decrease in satisfaction compared to last year (96%). Our results are very positive when compared to the NHS national average rate of 60% (Kings Fund 2013). However, in some questions there has been a reduction in some scores and we are considering why this has happened and putting plans in place for improvement. Confidence in our doctors (97%) and nurses (94%) remains extremely high with previous work identifying these criteria as the most important drivers of satisfaction for parents and young people.

An additional outpatient survey, also undertaken by IpsosMORI in 2012 reported high satisfaction rates with 95% of patients and their parents being satisfied with the service we provided. 96% of patients and parents surveyed would also recommend the hospital to a friend or family.

As part of our broad patient experience programme, and using the Department of Health's You're Welcome Quality Criteria, we have undertaken a Trust-wide project to assess the young person-friendliness of the hospital in order to improve the experiences of our adolescent patients. As a result we have identified a number of priorities for improvement, including: transition to adult services, provision of age-appropriate information, improved age-appropriate facilities, involvement in service evaluation and ensuring that staff who have contact with young people receive appropriate training. This work will be taken forward in 2013/14 through our Young People's Forum.

We also now have 650 volunteers that worked approximately 140,000 hours during 2012/13 to help the Trust to improve patient and family experience.

In 2012/13 our charity raised £67.8m, the highest amount ever raised in a single year. Money raised through the charity enables the hospital to redevelop its estate, buy new equipment, support specific welfare projects such as family accommodation and fund paediatric research conducted at both the hospital and with our research partner, the University College London (UCL) Institute of Child Health (ICH). In year, the charity made grants to the hospital of £62.7m; much of this was towards our redevelopment programme, however the charity also funded approximately £4m worth of medical equipment, including a mass spectrometer for new born screening, a cardiac 3D echocardiogram and beds and equipment for the Paediatric Intensive Care Unit (PICU).

Our extensive redevelopment programme saw the construction and opening of the Morgan Stanley Clinical Building complete in 2012. Our redevelopment programme allows us to treat up to 20% more children and contains new kidney, neurosciences and heart and lung centres; seven floors of modern inpatient wards for children with acute conditions and chronic illnesses; state-of-the-art operating theatres enabling us to carry out more operations on children with complex conditions; and enhanced diagnostic and treatment facilities offering faster and more accurate services for patients.

Our redevelopment programme is continuing over the next three years. This year the most significant works will see the creation of the Angiography Unit and the Same Day Admissions Unit. The most visible work will be the extensive refurbishment of the main entrance that will create a bright and welcoming entrance for our patients, visitors and staff.

Last year we outlined our growth plans for 2012/13 and identified a number of priority growth areas where we anticipated an increase in market share. We have realised much of this growth, with particularly significant increases across Cardiac Surgery and Cardiology, Neurosurgery and Spinal Surgery. The total number of outpatient appointments in 2012/13 increased by 1.4% to 187,705 and the total number of admissions rose by 5% to 36,909 for the same period.

Our income, excluding capital donations, has grown by 6% in the year and we achieved an EBITDA of 7.5% compared with the EBITDA in the plan of 6.8%. We realised efficiency improvements of £13.2m across the organisation, 4.6% of non-pass through expenditure. By making good progress against our efficiency savings, and by increasing our income through treating more patients, we were able to deliver EBITDA higher than planned.

2. Vision and objectives

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 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 health specialists.

Our vision is that through the work undertaken at 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.

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, which underpin our objectives.

As a Foundation Trust, we 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. The Council has been involved in the annual plan development process and in the coming year we want to continue to strengthen involvement of our Members and the Council in our activities. A particular objective is to better facilitate direct engagement and communication between Councillors and the Members they represent.

We are starting to promote Councillors via publications and personalised letters to encourage communication with Members and are also planning to undertake listening events in the coming year. Members can also contact Councillors via our website and social media options will be explored to facilitate communication. The Membership Engagement Committee, chaired and attended by Councillors, will help to direct and co-ordinate this work. We are also routinely assessing the impact of our significant level of volunteers and increasing roles and numbers to support service quality improvement.

In developing our priority objectives for the year ahead we have considered our purpose and values and the internal and external contexts in which we will be operating during 2013/14 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 (Figure 1).

Following this process we have slightly revised our strategic objectives, notably to reflect a greater appreciation of the importance of our workforce and clinical interfaces with health care partners. Our objectives for 2013/14 are:

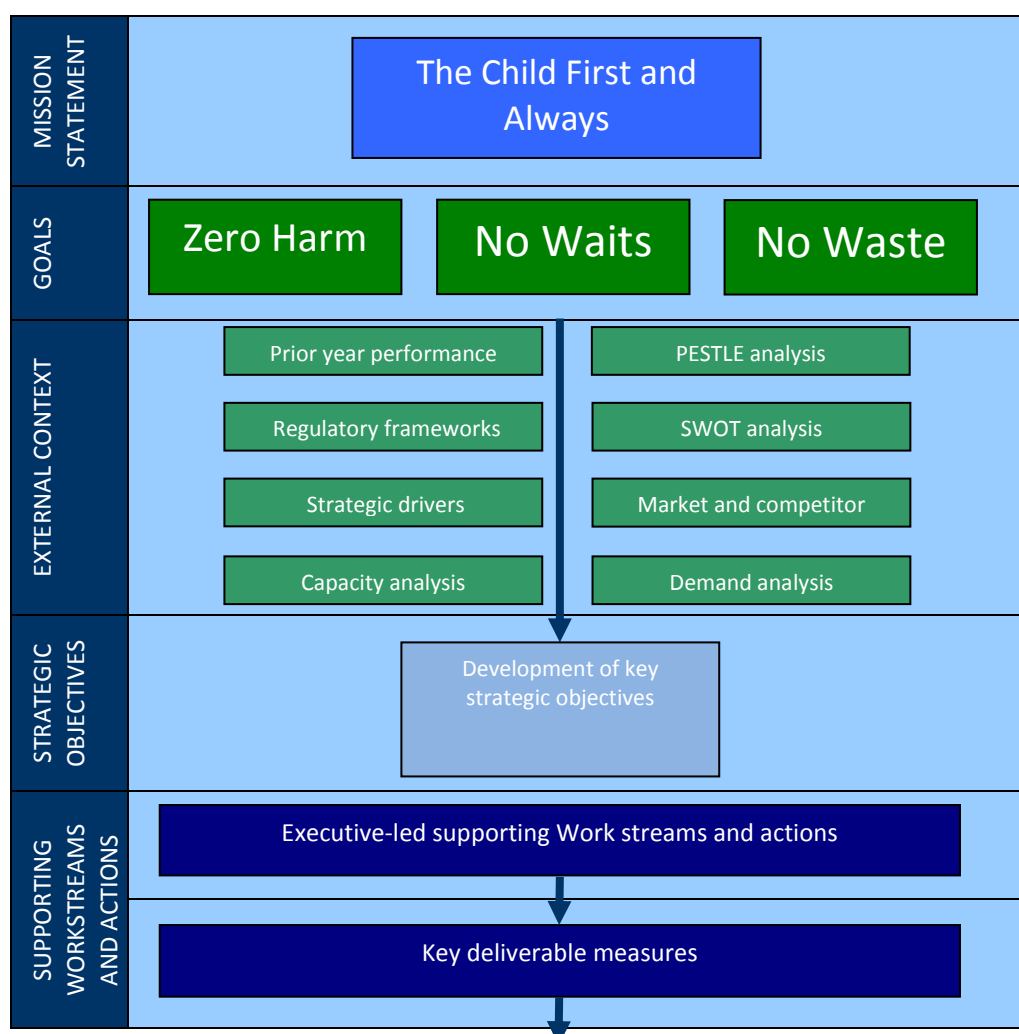
1. Consistently deliver an excellent and compassionate experience for our patients and their families
2. Consistently deliver world class clinical outcomes
3. Work with clinical networks, partner providers and referrers to deliver streamlined patient pathways
4. With partners maintain and develop our position as the UK’s top children’s research and innovation organisation
5. Continue to deliver high quality specialist paediatric multi-professional healthcare education.

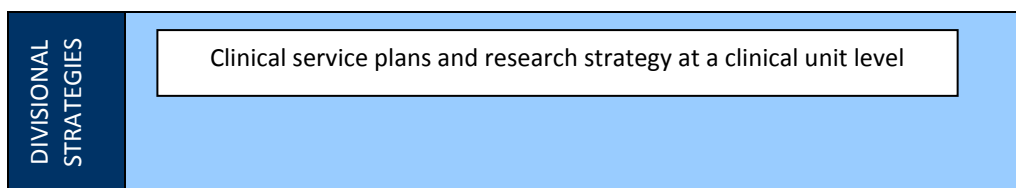
6. Equip all staff with the knowledge, skills and training to deliver high quality compassionate care
7. Continue to redevelop and improve the hospital's estate to provide high quality accommodation for current and future patients
8. Be a financially stable organisation and promote the sustainable use of resources

In order to ensure that we are achieving the strategic elements of our plans we have additionally developed a number of key deliverable measures for the year – a series of 'must-do's'. These include:

- 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
- Develop a long term information/IT strategy, agree an investment profile with the board and a project implementation schedule
- 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
- 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
- Improve the efficiency of theatres and outpatients in terms of resource and capacity use by at least 10%

Fig. 1 Annual Planning Process





3. Strategic context

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 hospitals. 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). 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.

To date, 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 our clinical activity has grown by over 3% this year. We plan to continue to grow within our role as a specialised paediatric services provider over the coming year and beyond.

Our primary market aims are to attain market leadership for:

- All quaternary services across London and its neighbouring counties.
- Tertiary services in the North London and surrounding zone.

In order to achieve this, we have analysed our strengths, weaknesses, opportunities and threats in the context of internal and external factors. In comparison to competitors we have identified the following key strengths of the organisation:

- The strength of the GOSH brand, providing national and international recognition for the organisation which engenders public loyalty and represents a reputation of clinical excellence
- Provision of a very broad range of specialised clinical services and comprehensive, paediatric focused infrastructure services such as specialised therapies and diagnostics, together on one site
- Leader in the provision of paediatric education and training – enabling the Trust to attract and retain staff with the required specialised skills and to achieve prominence amongst healthcare professionals working in paediatrics
- Being part (with UCL Institute of Child Health) of the largest centre for paediatric research outside of North America - enabling the organisation to develop and offer the broadest possible range of translational research, treatments and interventions within clinical trials and generating referrals on this basis, as well as enabling us to recruit and retain highly skilled staff
- Well-resourced organisation, supported by the GOSH Children's Charity fundraising capacity, enabling us to make significant investments in services, equipment and our estate

- Dedicated, highly skilled clinicians working in multi-disciplinary teams
- Strong referral base, supported by outreach and shared care arrangements

We have identified our strategic challenges as:

- Availability of staff - recruitment problems in some specific clinical areas, exacerbated by our central London location, creating clinical capacity issues
- Timeliness of communication with referrers
- Space constraints on the Great Ormond Street site
- Sub-optimal use of some key resources (e.g. theatres)

We have developed plans to address each of these areas in order that we might continue to improve our strategic position. These include undertaking international recruitment, improving timeliness of discharge summaries and clinic letters, a clinical outcomes programme and an ambitious capital redevelopment programme, as well as focused work around productivity (section 6).

3.1 Forecast health, demographic, and demand changes

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

3.1.2 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 1.5% per year according to Office of National Statistics (ONS) estimates. This will lead to a proportionate increase in demand for specialist paediatric services. Our referral catchment areas include highly cosmopolitan populations and it is likely that significant numbers of presentations of complex genetic diseases will remain a key feature of demand on our services. In contrast, we have also recognised that demand is decreasing in some areas, such as paediatric HIV services, and will review service models accordingly.

3.1.3 National NHS financial position

Every local health economy within the NHS is facing a challenging economic situation, with the overall requirement on the NHS to make efficiency savings of around £20billion to meet expected demands and increased costs. We face the impact of this in terms of tariff decline. Accordingly, we have a savings plan in place, together with plans to improve productivity and achieve growth in profitable services in order to offset this impact.

3.1.4 National service designations

The National Safe and Sustainable Paediatric Cardiac Surgery and Neurosurgery reviews aim to rationalise the numbers of centres undertaking paediatric surgery across the country. All options consulted on in relation to Cardiac Surgery include a reduction of centres in London to two, with GOSH as one of the centres. Though the process has not yet concluded and is subject to further review, we have put in place plans to expand capacity to meet the additional demand that is likely to be generated. For Neurosurgery a rationalisation of centres, particularly those undertaking highly specialised procedures, and more formal networks are proposed. The first phase of this has been through the tendering process with GOSH appointed as one of only four centres in the country for specialist epilepsy services. We will continue to engage with commissioners on future plans.

3.1.5 Paediatric networks

Within London, the development of two tertiary paediatric networks is underway in order 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 recommended 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. Project progress remains slow however we see these changes as a positive development for children and families and at the same time providing some growth opportunities for the hospital.

We have identified the main growth areas for the Trust, together with the clinical teams, in consideration of these key strategic drivers.

3.2 Market share

It is anticipated that market share particularly across the 3 specialties of Cardiac surgery, Intensive Care and Neurosurgery will grow over the next 3 years. Capacity planning for these areas has been undertaken, and will include additional beds, theatre capacity and step changes in staffing as well as capital investment in specialised MRI equipment. In addition, there are other specialised services seeking to impact upon market share through development of new services such as Selective Dorsal Rhizotomy and in response to innovations within Genetics and new treatments for Graft versus Host Disease for example.

Market share for key specialties is tracked on a quarterly basis and reported to the senior management team. Where any significant changes occur these are discussed further with specialty teams to identify any actions required. In addition, market analysis is required to be undertaken for all business cases and service developments to ensure that developments are referenced clearly against demand and market impact.

3.3 Threats and opportunities from changes in local commissioning intentions

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 independent review process in order that our strategy enables us to maximise the opportunity presented.

In addition, the significant changes to commissioning this year with the development of NHS England and its role in commissioning specialist services will naturally impact on the Trust. The majority of our services (approximately 90%) have been classified as specialist and will be commissioned by NHS England. NHS England may also commission non-specialist services from the Trust on behalf of London Clinical Commissioning Groups (CCGs), with the remaining Trust activity (approximately 5%) commissioned by other CCGs nationally.

We will therefore work closely with NHS England to develop an effective working relationship and 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. Within the strategic planning at specialty level the new service specifications have been reviewed to ensure that services either already meet the specifications or have planned developments in order to do so. However, there may be a short term commissioning risk where commissioning responsibility between specialist and non-specialist commissioners is not clear due to the timescales for finalisation of service specifications. This could lead to a disconnect between commissioning responsibility and funding allocations. However, we have recognised this risk and that both CCG and NHS England commissioner engagement is therefore crucial.

Current block commissioning arrangements within the Clinical Genetics service will be mainstreamed this year also, which presents both a risk and an opportunity as referrers will be free to choose any provider laboratory, and are likely to consider cost as a key driver when considering their preferred laboratory. The genetics service therefore continues to maintain good networks with referring hospitals and is actively engaged in specialist networks such as cancer and dysmorphology both in North East Thames and UK.

3.4 Collaboration, Integration and Patient Choice

Working closely with referrers and within formal and informal networks of care provision, has been recognised as increasingly important within the organisation. This is a key strategic aim over the coming year to strengthen shared care arrangements and to build our relationship with our referrers in terms of access to services and proactive communication in order to ensure that the services we provide are co-ordinated for patients and are first choice for referrers.

Where formalised commissioned networks already exist, the strategic focus of the organisation will be on working with other organisations to agree and implement the new specialised service specifications. In addition, we will develop our clinical leadership role as the hub or primary centre healthcare organisation in supporting shared care providers, working with commissioners to ensure robust governance arrangements exist across the network and to ensure optimal configurations of networks are in place for patients and families. In some cases, such as for Haemophilia services, we are preparing to become the lead organisation for distribution of specialised network funding. We will also be developing more formalised networks, with shared outcome measures, in response to the reconfigurations in specialised services, including in Neurosciences for example.

We have plans to drive forward the development of network arrangements across services that do not yet have clear shared care pathways in order that we can define and consolidate our role, together with other providers, in the care of complex children, ensuring there is a balance between the Trust providing the specialised care and advice required, but that wherever possible elements of the child's care are delivered locally in partnership with local providers. This will help to improve communication and co-ordination of care, ensure families can access as much care close to home as possible and facilitate safe and prompt discharge to local services.

Beyond the consolidation of existing networks and development of new networks, we also play a broader role in working with other providers including through provision of outreach clinics, as a source of specialist clinical advice and playing a role in clinical reference, formulary and discussion groups for example. We will work to develop appropriate processes internally for quantifying the advisory work we do, capturing advice given to ensure robust clinical governance and improved communication. We will also continue to promote our teaching and training role within the wider NHS and internationally.

Collaborating with other organisations in order to improve the transition pathways for patients from the paediatric services at GOSH to adolescent and adult services is also an important area of development in order to provide better care for patients and families. Our Adolescent Medicine service has developed close links with our key partners and is supporting specialties to achieve improved transition including appropriate capacity planning, agreed documentation and secure transfer of information, and joint transition clinics. Engagement with and involvement of adolescent patients underpins this work as demonstrated by the implementation of the 'Your Welcome' quality criteria for young-people friendly health services.

We also have an active programme of engagement with referrers and will again be running a referrer survey and annual open day this year to continue to build links and improve our service to referring clinicians.

3.5 Commissioning and regulation

NHS England has recently published its planning guidance for 2013/14, 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:

- Move toward seven-day a week working for routine NHS services
- Greater transparency and choice for patients
- More patient participation
- Better data to support the drive to improve services
- 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 (section 4). One of the key areas that we will be developing over the coming year is to extend working hours across a number of services. For example we plan to implement a 7 day haemodialysis service for our renal patients and will also provide some Radiology services for 6 days a week with Interventional Radiology on-call 7 days/24 hours. Additionally we have restructured our supporting services such as pathology and pharmacy to best cover out of hours periods in support of the clinical teams. Within Neurosciences we plan to trial keeping the telemetry unit open 6/7 days a week with a potential roll-out later in year.

4. Quality strategy

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 of the leading children's hospitals in the world and 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.

4.1 Safety (Zero Harm)

Zero Harm is the part of our strategy aimed at minimising harm to patients; safety improvement. 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 improvement methodology
- 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 training²
- 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

² Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate document (2010) the Royal College of Paediatrics and Child Health London.

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 are described in the table below.

Zero Harm Standard	Aim of programme
Maintain high levels of medication safety	<ul style="list-style-type: none"> Decreasing risk from High-risk medications Continued reduction of prescribing errors Safe dispensing Defect-free administration of medications Reconciliation of medication prescription charts as a child passes through the system³
Decrease and eliminate hospital acquired infections	Reduce the incidence of the following infections: <ul style="list-style-type: none"> 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 clinical handover and documentation	<ul style="list-style-type: none"> Improve handover of all information at any point in the patient journey Standardise handover information using the SBARD guidelines⁴ Ensure briefings for all procedures including the surgical checklists Improve the quality of medical and nursing record keeping
Eliminate all pressure injuries	<ul style="list-style-type: none"> Identify children at risk, implement interventions and reduce all pressure injuries.
Recognise and respond to deterioration	<ul style="list-style-type: none"> Early detection and situation awareness early warning scores - CEWS⁵ Communication and escalation using SBARD Intervention and outreach rapid response team from ICU to proactively monitor the deteriorating child.

We will seek year-on-year improvement on our current results and will continue to benchmark against our peers. A recognised leader in the field at present is Cincinnati Children's Hospital and we will continue to compare ourselves against them to identify our performance and new measures of quality.

Improvement is identified by the decrease in harm as measured by the Paediatric Trigger Tool (PTT) and by individual measures in specific programmes. In conjunction with Cincinnati Children's Hospital, we are developing a 'Zero Harm Index', which will provide a stronger tool for reporting the incidence of harm than the PTT. Validation of this method will take place over the next three years.

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.

4.2 Effectiveness

Delivering effective care is, and always has been, a primary focus of GOSH. Over the last couple of years we have been evidencing the effectiveness of our care through the identification of measures that demonstrate the outcome of treatment, including clinical measures such as survival rates, complication rates or measures that demonstrate clinical improvement. In addition we have measured the effectiveness of care from the patient's own perspective through the use of patient-

³ 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.

⁴ 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*.

⁵ CEWS is a clinical early warning score to detect deterioration in children

reported outcome measures (PROMs). Wherever possible we will use established national or international measures that allow us to benchmark our results with other services.

We have asked each of our specialties to define clinical outcome measures and to identify centres against which they should be compared in order that we can provide evidence of the clinical quality of our services. We have established a clinical outcome programme to support specialties in the development of measures and we will further develop mechanisms to publish our outcomes on the internet in “real time”. We expect all of our specialties to report at least 4 outcome measures for 2013/14.

We will also continue to develop the reporting and monitoring of outcomes against established national and international registries where they exist, such as in paediatric Intensive Care and Cardiothoracic surgery. During the coming years we will develop and share with other centres the full portfolio of clinical outcomes that we report and will seek agreement to create common baseline datasets with world leading centres.

Patients’ perception of treatment and care is a major indicator of quality and therefore we will ensure that we record and report effectively those outcomes reported by patients. Patient-reported outcome measures (PROMs) provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life.

We are keen to develop the use of PROMs across the hospital to ensure that we measure and understand how patients perceive the outcomes of their care, and can make improvements to our services as a result. Annual targets will be presented in the Quality Report.

4.3 Experience

We aim to consistently deliver an excellent experience that exceeds our patients’, families’ and referrers’ expectations. We recognise that the memories and perceptions that patients and families have of the hospital and our services are heavily influenced by the quality of their experience. Therefore, we will continue to seek ways to involve and engage our patients, their families and members in shaping healthcare we provide, ensuring it is appropriate to their needs and by making best use of the knowledge and skills of our staff.

Over the next three years we want to create more meaningful opportunities for engagement with our patients, their families and the public. The elected Members’ Council also provides us with a great opportunity to work in closer partnership with patient, parent, public and staff representatives, and members as well as local community agencies and representatives of patient groups. We will listen and hear what they tell us about the care that they receive.

We therefore need to know the ‘good and the bad’ about current experiences as well as more about the expectations people bring with them when they come to the hospital. To ensure that we are able to do this effectively we have developed a three year plan that will enable us to regularly obtain feedback that we can use to help us improve. Our principles for involving patients and families and other Members are based upon being:

- Open about what can and cannot be influenced
- Genuine about our commitment to making improvements
- Transparent about how decisions are made
- Timely in our consultation, engagement and feedback

To help us deliver our plan we have identified a cycle of objectives each with a defined set of actions that we will complete in 2013. In summary these include:

- Listening and responding to the views of children, young people parents/carers and members
- Responding to external reports and recommendations relating to patient experience or PPI
- Recruiting engaged Members for the future
- Developing an actively involved and engaged membership
- Obtaining feedback from patients and families on a frequent basis, and a periodic basis
- Responding to the needs of specific patient groups facing barriers to good health care

- Responding to the need for improved patient information

4.4 Access

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. Key measures include:

- Referral to treatment waiting time standards: 90% of admitted patients and 95% of non-admitted patients receiving treatment within 18 weeks
- 6 week diagnostic waiting time standards
- All applicable national cancer waiting time standards including the maximum waiting time of one month from diagnosis to treatment for all cancers and cancer patients waiting no more than 31 days for second of subsequent treatment for surgery, drug treatments and radiotherapy
- Compliance with requirements regarding access to healthcare for people with a learning disability

4.5 Commissioning of Quality and Innovation

For 2013/14 the national CQUIN framework mandates a number of themes and measures that organisations are required to report against. We are currently reviewing these but measures are likely to include:

1. Department of Health national mandated CQUINS

- Improving patient experience – friends and family advocacy test
- Reducing pressure ulcers
- Reducing line infection rates
- Improving of life care planning
- Implementing antimicrobial stewardship

2. Service CQUINS (agreed between commissioners and providers)

Monitoring and minimising the number of children transferred out of region to a PICU

- Improving transition from paediatric to adult care
- Registration and communication with GPs about the care of HIV patients
- Reducing the incidence of preventable acute kidney injury (AKI)
- Access to and impact of clinical nurse specialist (CNS) support on patient experience
- Bone Marrow Transplant (BMT) – Donor acquisition measures
- Increasing the use of renal patient view (RPV) by all dialysis patients

3. Quality Dashboards

A national work programme for specialised services quality improvement has been established to assist decision making about the future oversight and governance of quality improvement under NHS England from April 2013. 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 2013/14. These include:

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

A CQUIN monitoring group that is chaired by the Co-Medical 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.

4.6 Response to Francis Report

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, calls 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, for every patient, we provide the quality of care that we would want for our own family. In light of the Francis report a working group has been set up to enable us to build upon the passionate commitment of our staff to ensure that we consistently deliver this aim. The group is chaired by the co-medical director and has senior clinical and management representation.

We will be taking a thematic approach to the report and recommendations in order to enable us to communicate coherently with staff, patients, families and the public about our response to the report and our planned actions.

The themes we have identified as particularly relevant to the organisation are:

- Values – culture, our promise to patients/families/the public, our commitment to staff
- Candour – reporting information on quality, incidents, outcomes
- Listening – to complaints, to both patients and staff, to identify and recognise good practice
- Compassion - Clinical responsibility and leadership for care, competence of staff, responsibility of staff. Staff engagement and involvement in identifying problems in patient care, and implementing solutions
- Quality and excellence - Training and development for excellence, processes and systems that promote high-quality services, and good outcomes
- Monitoring and measuring – systems for monitoring what we're doing and assuring us that it is of good quality, a communication plan to show what we're doing, and an on-going commitment to embed the recommendations in our work

Staff listening and engagement events, our continued work on maximising patient and family engagement and our development and implementation of a People Strategy across the organisation will be initial elements of our response to the report. A detailed action plan is being developed and will be submitted to the Board in June 2013, with regular progress updates to the Board planned thereafter.

5. Clinical Strategy

Our overarching clinical strategy focuses on treatment and care for complex conditions and on providing specialised services. We are fully committed to providing health care locally where it can be done so safely and efficiently, and delivering cost effective care pathways to commissioners.

Our approach is based on the development of clear clinical pathways, working in partnership with local services, and building on our well established strengths in providing nationally and internationally significant specialist paediatric healthcare services.

The wider NHS / national benefits of our strategy are:

- Providing services for patients with the most rare and complex conditions, who have limited (or no other) healthcare options
- Saving costs for the NHS and other public services as we deliver high quality care in a timely manner avoiding waste and harmful delays in both diagnostic and therapeutic services
- Offer the widest range of paediatric specialties on one site, which suit a complex case mix by delivering integrated care from one location

- As the leading paediatric research provider, the concentration of complex cases at GOSH delivers the optimum environment for developing new techniques through translational research
- Worldwide evidence suggests that higher volumes deliver better clinical outcomes for the most complex cases

With these criteria established, and as outlined in section 3, we have undertaken a market assessment of every specialty at GOSH to determine the external factors that will affect each particular specialty over the coming year and beyond. Based on the overarching principle of focusing on the most complex cases, we have identified specialties where the external need to further develop services is highest. We aim to develop the capacity to meet these demands and ensure that we provide the paediatric population with the services it requires in the most efficient manner. The key specialties with the largest material change in terms of activity and income to the hospital include Cardiac services, Neurosciences and Intensive Care. Together with this additional growth clinical specialties are also implementing improved patient pathways to ensure we deliver the best possible care. For example a new pathway for our spinal patients has been developed to ensure optimal treatment planning across the number of clinical specialties involved and appropriate pre-operative assessment for children undergoing this complex surgery.

We also plan to undertake a significant project to change how inpatient care is delivered in Gastroenterology, Endocrinology and Metabolic Medicine to improve patient care and experience and enable us to treat more patients now and build capacity for the future. This work will involve ward refurbishment, expansion of bed capacity, opening more beds on a 7 day a week basis and cohorting patients of the same specialty together. Currently in these areas the clinical team support management of some patients through working with other hospitals and remote advice, but by expanding capacity in our inpatient areas the clinical team will better be able to pro-actively admit patients for inpatient management.

In addition to expanding existing services, we continue to develop the capacity to offer new treatments. For example, the Neurosurgery team will be developing a Selective Dorsal Rhizotomy (SDR) service – a procedure which is undertaken with the aim of easing muscle spasticity and improving mobility in children with cerebral palsy. This service is currently only offered by very few centres in the UK and there is significant unmet need at present. We will be able to offer this surgical intervention as part of an integrated comprehensive and multidisciplinary patient pathway which also includes other treatment modalities already available at GOSH, such as botulinum toxin injection and multi-level orthopaedic surgery.

5.1 Service Line Management Strategy

The Trust is adopting an incremental approach to the implementation of Service Line Management (SLM). For example, service line reporting (SLR) is in place in the organisation and the information is capable of drill down analysis to point of delivery and to individual transaction, patient or pathway level. Financial information is shared with senior clinical leads, finance teams and managers.

Over the coming year we plan to more actively engage teams at service level in order that clinical and managerial staff can collaborate with the finance team to improve the quality of the SLR information and that the organisation can make more widespread the understanding of and use of the information in order to better inform bottom up clinical service developments and changes as well as more high level strategic discussion.

Our approach to annual planning includes input from specialty teams who are best placed to identify a service's opportunities and threats are able to input into its objectives, which are then aligned with our overarching aims. In the coming year these objectives will be reflected more clearly through job planning and therefore in team and individual performance goals.

The majority of the clinical specialties make a positive financial contribution, but there are some areas including cancer services, general and neonatal surgery, gastroenterology and nephrology where further work to ensure that services are profitable is required. This informs where we focus work

around ensuring correct income is received for services, for example through coding, and that productivity is maximised for key cost drivers for particular patient groups e.g. theatre utilisation, in order to ensure that our core services are sustainable over the long term. Each Clinical Division is also conducting productivity analysis in terms of activity and cost per staff member in order to drive productivity improvements within service lines. SLR data also supports negotiation with commissioners about the true cost of treatment at a patient level for some of the areas where services are underfunded by the tariff.

Profitable services are a particular focus for growth plans, including Cardiac and Neurosurgery as outlined, and also sub specialty areas of profitable work are being expanded such as laser procedures within Dermatology.

5.2 Research:

Research remains integral to our strategy, and attracts approximately £13m per annum. Our Research and Innovation Division comprises the GOSH-University College London Biomedical Research Centre (BRC), the Clinical Research Facility (CRF) and the Joint Research and Development Office; the Division also hosts the Medicines for Children Local Research Network.

In 2013/14 we plan to continue to support research infrastructure (such as the CRF and GOSgene) and training programmes and will develop a patient and public involvement strategy for research. We will work closely with our local comprehensive research network to maximise research support funding and will further develop links with our commercial partners and develop a strategy for identifying and supporting innovation within the Trust.

5.3 Clinical workforce strategy

We are currently reviewing our workforce strategy with a specific focus on developing our approach to Organisational Development (OD) in the context of a longer term strategy and a vision of the future. The key components of the strategy will include a systematic approach to changes in structure and processes; the application and transfer of behavioural science, knowledge and practice such as leadership development, work design and group dynamics. We will utilise the freedoms available to us as an NHS Foundation Trust to best effect to improve our performance and deliver a better service to children, families and stakeholders and improve our organisational effectiveness by helping our staff to gain the skills and knowledge necessary to solve problems through appropriate development programmes and interventions.

Through our workforce strategy, we aim to:

- Achieve improved productivity and quality without increasing overall staff costs
- Ensure the right staff are doing the right jobs
- Use technology and automation where possible and appropriate
- Reduce avoidable costs
- Find best value models for delivering transactional services
- Deliver high quality education and training to our own staff and to others
- Achieve high performance in all aspects of care, culture, behaviour and working life

These objectives will be delivered through a series of actions over the next three years. In summary these include:

- Ensuring registered nursing workforce deliver appropriate tasks and work-loads, safely and to the highest standards. This includes moving to an 80:20 split (where clinically appropriate) of registered and non-registered rostered ward staff; reviewing non-registered roles to ensure consistency and appropriacy; ensuring the roll out of the Centralised Intravenous Additive Service (CIVAS) and intelligent storage to reduce unnecessary time away from the bedside.
- Ensuring the medical workforce is able to target its activities most effectively to meet Trust objectives. This includes reviewing planned activities through a refreshed job planning process; reviewing how clinical activity is delivered in particular at night to ensure the right activities are

being conducted by the right member of staff, including the availability of consultant staff and reviewing junior doctor rotas.

- Developing more structured Service Level Agreements (SLAs) and activity plans for the Allied Health Professional (AHP) workforce, supported by activity collection and analysis.
- Through the roll out of the Electronic Document and Record Management System (EDRMS) and greater clinical involvement in IT development/procurement, achieve efficiencies in the use of clinical and support staff.
- Co-ordinated work in response to the Francis Report which considers the recommendations for and with the GOSH workforce, including contractual and cultural factors. We will ensure that initiatives we are already undertaking are congruent with recommendations from the Francis report.

5.3.1 Key workforce pressures

5.3.1.1 Recruitment and retention

An analysis of all hard to recruit and retain posts is being undertaken so that targeted solutions can be put in place. These include: overseas recruitment for hard to recruit staff groups; targeted action to address reasons for leaving; education commissioning; leadership development; developing extended roles; restructuring/reallocation of tasks; developing junior staff and promoting unique research opportunities.

5.3.1.2 Managing pay costs/achieving efficiencies

We will continue to implement agency controls and develop the in house bank scope and infrastructure to facilitate recruitment to the bank and reporting on and managing temporary staffing use.

Controlling staffing numbers is a key priority and will be enabled by triangulating growth and savings plans to develop and update workforce plans for each Division. Improvement in staff productivity will be a key aim so that activity growth can be managed within existing establishments/staff costs wherever possible.

5.3.1.3 Impact of the Workforce Strategy on Costs

We will enable reduced costs per staff member through further reductions in temporary staffing costs which will be achieved by further development of the in-house bank for all non-nursing staff and controls of use of temporary staff overall, including agency bans being rolled out and award of a new bank contract from April 2013 which will incentivise savings.

Where growth cannot be absorbed within existing staffing costs, improvements in our use of staffing resource and how we monitor this – such as job planning, further development of the Paediatric Acuity and Nursing Dependency Assessment Tool (ePanda) , AHP activity recording tool – will ensure staffing requirements are fully evidence-based.

5.3.1.4 Benchmarking

Finding appropriate comparators for clinical workforce measures can prove difficult for highly specialist clinical activities. We currently participate and engage with Civil Eyes and the Workforce Assurance Tool, but these are of limited applicability when considering issues such as consultant activity within a unique sub-specialty. The refresh of job planning that started in March 2013 will facilitate internal benchmarking between individuals within specialties, with the intention of achieving greater understanding of differences in activity and improved productivity

The GOSH-designed ePanda system allows the Trust to measure nursing staffing levels against nationally agreed criteria to ensure that these are both safe and efficient.

CQC and NHSLA assessments further provide an opportunity for evaluation of our activities against clear external standards. As previously described we achieved NHSLA level 3 in 2012 and CQC reviews in 2011 and 2012 found that we were meeting the standards relating to workforce.

We take careful cognisance of comparative staff survey data, both for other acute specialist trusts and from the Association of UK University Hospitals. We scored better than average in 8 key findings, in addition to overall staff engagement, worse than average in 9, and average in 6. Increasing the response rate to 55% (in 2012 it was slightly below average at 42%) is being set as goal for 2013, with greater local ownership of issues as a means of tackling long standing areas of concern over the next 2 years.

As an organisation we maintain highly accurate workforce information systems, ranking 6 out of 436 acute trusts in the Information Centre's 2012 National Data Quality Assurance Report.

As a participant in the UCLP Streamlining Staff Movements programme we are benchmarking our induction processes to ensure that it follows best practice; (currently green against plan). We are also discussing with other UK children's hospitals the opportunity to benchmark workforce data such as employee relations activity (i.e. where there is little geographical effect).

6. Productivity & Efficiency

6.1 Operational efficiency

The Trust has a dedicated Transformation Team that provides support to front line teams in the delivery of our No Waits, No Waste, Zero Harm goals.

A new streamlined work plan has now been developed for the team that will support the Trust priorities through rapid cycles of improvement, with an intense focus on agreed projects. These projects will aim to deliver improved performance and efficiency. A number of projects have been identified in the first phase of improvement work:

- Improving theatres. Theatre productivity is a key area of focus for the Trust. Targets of 77% utilisation for surgical specialties and 70% utilisation for non-surgical specialties have been set to be achieved over the next 3 years with a clear focus on increasing the total number of cases being undertaken through our theatre capacity. We will undertake a detailed audit to identify the reasons for late starts, early finishes and extended turnaround times with short cycles of improvements being implemented to address key themes. In addition, capacity for staffed theatre sessions will be re-examined and sessions may be closed or re-allocated to ensure best use of the theatre resource. A new pre-assessment model is in development for implementation in the coming year in order to better assess fitness for procedures and reduce short notice cancellations. New theatre and procedure areas and a Same Day Admissions Unit and Post Anaesthesia Care Unit will additionally be operational in January 2014, further facilitating better use of resources.
- Improving Admissions and Discharge. This project aims to improve and standardise our admission and discharge processes both within and outside PICU for both elective and non-elective patients and to minimise refusals for clinically appropriate referrals due to insufficient bed availability.

Further programmes that have been identified but which are currently being developed include:

- NICU & PICU Flow Project– to improve flow through ICU, by reducing non-clinical delays
- Improving out-patient flow
- Improving timeliness of discharge summaries
- Improving complex patient pathways
- Reducing waits for Pharmacy in out-patients

6.2 Workforce efficiency

6.2.1 Staff Productivity

Some improvements have already been made in staff productivity with activity per whole time equivalent (WTE) having increased 1.4% over the last 2 years and average cost per staff member having remained static despite incremental pay increases as outlined in the tables below. Over the course of the coming year, each area will undertake productivity analysis focused on activity per staff member and cost per staff member at service level in order to identify where productivity gains can be maximised and where focused workforce interventions are required.

Measure	2010/11	2011/12	2012/13	2010/11 – 2012/13 % increase
Total OEA's*	727,337	777,068	807,432	11.01
Total workforce	3,286	3,486	3,597	9.46
OEA's* per WTE	221	223	224	1.41

*Outpatient Equivalent Activity (OEAs). Weights outpatient, inpatients and critical care bed days to give overall activity figure

Measure	2010/11	2011/12	2012/13	2010/11 – 2012/13 % change
Total pay bill excluding redundancies (£m)	192	194	198	2.8
Average Trust WTE (Excl overtime)	3,489	3,516	3,595	3
Average WTE cost (£k)	55.11	55.16	55.01	-0.16

A target of 5% increase in productivity has been identified this year for the divisions to achieve. This productivity increase will be supported by the IT and workforce strategies across the organisation.

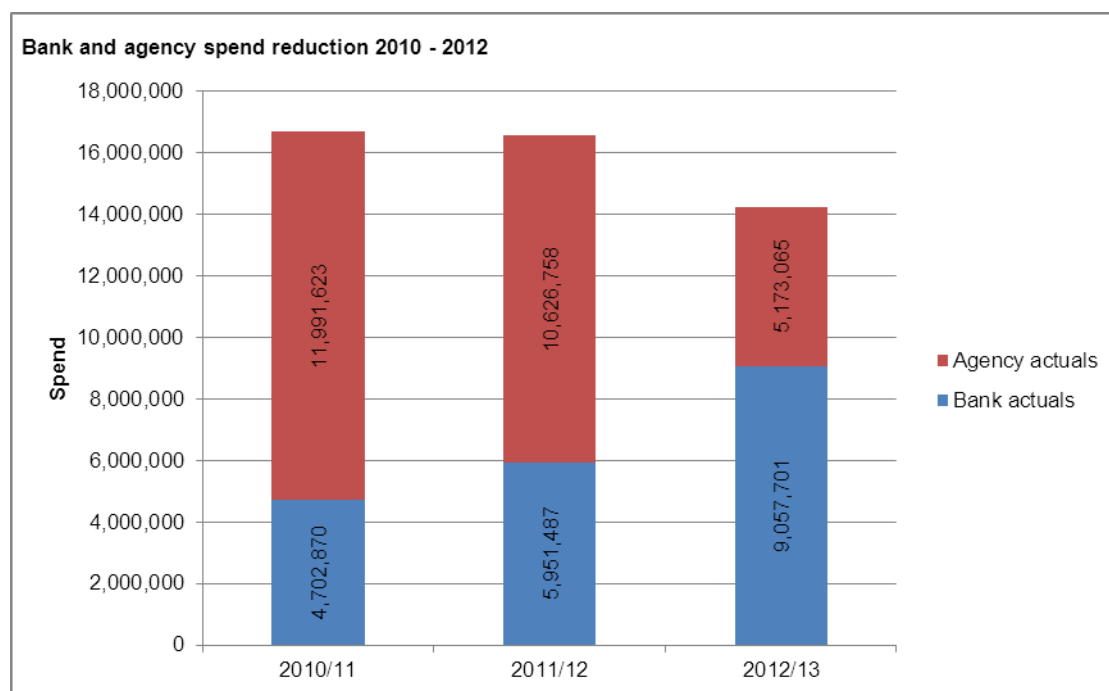
6.2.2 Temporary staff

Despite an overall increase in temporary staffing usage we have seen temporary staffing costs decrease by 15% over the last 2 years (Figure 2). This is due to the establishment of more cost effective temporary staff arrangements i.e. the introduction of an 'In-house bank' for non-nursing staff groups and the development of the established nurse bank.

We project a further 5% decrease in temporary staffing spend by March 2016, which will be achieved by:

- Continuing to convert agency usage to more cost effective bank usage
- Managing demand for temporary staff
- Developing alternatives for covering long and short-term shortfalls in staffing levels
- Minimising the need for high cost temporary staff via effective deployment of substantive staff

Figure 2 Bank and agency spend



6.3 Cost Improvement Programmes (CIP)

As previously outlined, our 2012/13 CIP delivered £12.2m. Planned savings for 2013/14 currently total £13.6m. CIP schemes are identified through both a bottom up approach within the Divisions and corporate departments. For 2013/14 we have additionally identified seven key CIP themes that we believe will realise significant benefits to the organisation. These themes will require pan-Trust coordination and are closely linked to our wider objectives of quality, safety and growth. These include:

- Patient flow
- Administrative workforce and process review
- Medical staffing, nursing
- Allied health professionals
- Medicines
- Procurement and contract management

The work on patient flow draws together a number of work streams that seek to improve the patient pathway, particularly for patients requiring elective surgery and those referred as emergencies in need of intensive care. The commissioning of a Same Day Admission Unit (SADU) and Post Anaesthetic Care Unit (PACU) will improve the efficiency of our operating theatres. An expansion of intensive care capacity will help to support a higher throughput of surgical cases and enable us to meet our aim of eliminating emergency refusals.

In preparation for the implementation of EDRMS we are reviewing a number of key administrative processes that support the patient pathway. Processes will be standardised and optimised with the support of our Transformation team. The implementation of EDRMS will enable further refinement of process through the introduction of workflow technology. This will, in turn, enable workforce efficiencies whilst supporting the flow project.

The roll out of the CIVAS service continues and is one of the key dependencies of the nursing theme. This theme seeks to improve the productivity of our wards by ensuring that the right workforce is in place to deliver patient care, supported by the right infrastructure.

Both the administrative and nursing themes are dependent on the delivery of projects that require capital investment and this is provided for in the capital plan.

Clinicians are engaged in the CIP process through participation in Divisional boards and speciality team meetings and through process improvement work.

Wherever possible, CIP schemes are identified that will benefit positively on the quality of service offered to patients. Work on flow not only ensures that resources are used most effectively, and that opportunities to increase revenue can be exploited, but also ensures that patients are treated in a timely fashion.

High value schemes (greater than £100k) undergo a formal quality and patient safety risk assessment. The impact of schemes is also monitored using a series of key performance measures in order that any adverse trends that may be linked to the implementation of CIP schemes can be identified and addressed. A CIP risk register is being implemented.

7. Financial & Investment Strategy

7.1 Financial strategy and goals

We started the year 2013/14 with a liquidity position of 46.5 days, 30.2 days excluding the working capital facility based on the March 2013 statement of financial position. The revenue account shows a delivery of 2.2% growth in NHS clinical income from continuing activities excluding pass through and 41.6% growth in Non NHS income with an overall EBITDA⁶ margin of 7.5%. We have delivered our productivity targets in full through a combination of cost reduction and revenue generation schemes. Key contributors to the growth achieved in clinical income included the opening of the new Morgan Stanley Clinical building at the beginning of the financial year and the opening of new capacity in the existing private patient wards.

Our overall financial strategy is to maintain contribution on existing activities in spite of the continuing challenge from the national economic assumptions and ensure our growth strategy is achieved with minimal increase in fixed cost. This will also ensure we maintain Financial Risk Ratios at 4.

Our goals over the next three years include:

7.1.1 We will deliver growth in NHS activity through improvements in utilisation of capacity and patient flow and as a result of the national and regional strategies to increase centralisation of specialist services.

A key element of this, which has yet to be concluded, is the impact of the Safe and Sustainable review of children's heart services. The outcome of the review is expected to result in growth from 2014/15 onwards which, together with an improvement in productivity across all clinical areas, will be met through new additional capacity afforded by our redevelopment programme.

Key actions include:

- Continue to reduce the number of referrals we are not able to accept due to resource constraints
- Ensure our activity and capacity plans are capable of flexing should there be more significant transfers of activity as a result of the Safe and Sustainable workstreams
- Ensure the major building works are carefully managed so as to reduce the likelihood of temporary reductions in capacity
- Continue to seek transformation changes which result in improvements in activity and capacity metrics
- Partnering with other providers to optimise the patient pathway and leadership of specialist paediatric networks

⁶ EBITDA: Earnings before Interest, Taxes, Depreciation, and Amortization

7.1.2. We will work with other paediatric providers and commissioners to manage the risk of price erosion over and above the national price deflator which might arise due to the continuing uncertainty around the appropriate level of tariff for specialist services.

Key actions include:

- Continue to work with the UK Children's Hospital Alliance to influence developments in tariff which recognise the differences in costs of services for complex and rare conditions, very young patients and children with multiple comorbidities
- Work in collaboration with NHS England commissioners to better understand specialist pathways and establish and lead network structures where appropriate
- Further develop the use of our Patient Level Information and Costing Systems (PLIC) to gain a better understanding of the drivers of high cost patients.

7.1.3. We will deliver CIP and income generation plans in line with the targeted values, which require some significant changes in how we use our resources and improvements in the effectiveness of our underlying business processes through increased automation and standardisation.

Key actions include:

- Continue to closely monitor the development and delivery of CIP plans and ensure risks of non-delivery are appropriately assessed, early warning indicators monitored and contingency plans put in place
- Use SLR to develop specialty specific actions to improve contribution by specialty
- Progressive implementation of new technologies aimed at reducing administrative costs and streamline processes, particularly patient facing processes
- Ensure benefits are realised from the recent investments in IT applications specifically CareVue in critical care and Order Comms for ordering and reporting on diagnostic tests
- Continue to explore options for reducing support costs through the use of shared services
- Ensure procurement processes are optimised working with other NHS Trusts

7.1.4. We will grow our international private patients activity, both specialist care and education, in line with our strategy and in order to provide financial support for our NHS services.

Key actions include:

- Progress the international strategy, developed in conjunction with our Members Council, to optimise the support to our NHS services from our international activities whilst ensuring the growth in the non-NHS proportion of our activities is in line with planned levels

7.1.5. We will achieve increased Research and Innovation funding through expanding the range of grant funders leveraging on our position as the only paediatric Biomedical Research Centre and the Trust's Clinical Research Facility.

Key actions include:

- Continue to expand the sources of funding particularly from EU, charities and Commercial sponsors and address reasons for unsuccessful grant applications

7.1.6. We will continue to invest in our estate through the redevelopment programme, primarily funded from charitable donations, but also continue to invest in IT applications towards our goal of implementing electronic patient records by April 2015. The IT investment will largely be funded from internally generated cash.

Key actions include:

- Ensure cash is effectively managed so that in month and end of month liquidity measures stay within planned ranges and cash is available to fund capital investments
- Maintain robust systems for prioritising and monitoring capital investment

7.2 Key risks to achieving the financial strategy and mitigations

7.2.1 NHS Economic environment

We are assuming on-going tariff decline of 1.8% and further significant efficiency and productivity targets which will continue to be challenging to achieve. There will also be changes in tariff following Monitor assuming responsibility for the tariff which are currently unpredictable.

This will be addressed through the ongoing work programme with the team setting national tariff and hopefully successor teams in Monitor so that the national tariff is more closely aligned to specialist work. Similar work will also be necessary with specialist commissioners on services traditionally funded from local specialist tariffs.

7.2.2 Levels of International activity

It is important that the patient activity growth achieved in 2012/13 is maintained and wherever capacity is available further growth in our contracts with our major customers is achieved. This is being addressed through the establishment and monitoring of a specific strategy for international patients.

7.2.3 Failure to deliver on cost improvement and revenue generation plans

As a low volume/ high complexity specialist provider, we have particular challenges in achieving efficiencies in our cost base without impacting quality.

We believe that there are opportunities to improve the effectiveness of our existing capacity and resources and our transformation and CIP programmes are aimed at identifying areas where this is possible. Internal benchmarking will also be used to identify best practice examples of efficient services.

7.2.4 Completion of redevelopment projects

We recognise that there are risks associated with our redevelopment building projects being carried out on operating sites. The phases of the projects are being carefully monitored to avoid, where possible, impacting on patient care. Contingency plans have been prepared to minimise the impact of any down time in access to imaging equipment caused by the work close to the imaging department

7.2.5 IT investment

We will continue to build upon our existing IT infrastructure and clinical applications to implement projects which drive process efficiencies. Managing the change associated with these projects to ensure efficiencies are realised is a significant risk. We intend to continue to use robust project management processes and ensure there is strong clinical leadership both in the central project team and in each clinical division

7.2.6 R&D funding

Levels of National Institute for Health Research (NIHR) funding, other than BRC funding, have continued to fall and the risk is that these will not be replaced by new funding streams. A robust R&D strategy has been developed and research facilitators are being recruited to support R&D active staff in applying for grants.

7.2.7 Education Funding

The changes in education arrangements, with the introduction of Local Education and Training Boards (LETBs) and reduction in funds available to London providers of education, will result in reduced levels of funding available for education, particularly specialist medical posts. There is a risk of destabilising our education activities. We are developing a plan to mitigate this should the funding gaps increase.

8. Organisational Risk

Our Board Assurance Framework (BAF) is currently built up from local Clinical Division risk registers and external intelligence and is continuously updated from incidents, complaints and audit. We have used this model for a number of years with assurance on the management of these risks presented

on a rolling basis at Board Assurance Committees. However, it is an appropriate time to refresh the process to ensure that the organisation's highest level risks are reflected and encompass both internal and external related risks to the organisation.

In February 2013, the Executive Team reviewed the key risks to the organisation. This generated a revised list of risks which were categorised into four sections; Emerging areas, Core external risks, Business change and Core operations

Following this meeting, each risk has been scored at a corporate level to ensure a consistent approach to the assessment of impact versus likelihood (higher scores represent higher risk) and allocated a lead executive director.

Our Trust Board will receive a quarterly report of the revised BAF which will also be updated to be more visual and will track the changing risk scores over time. The Board Assurance Committees (Audit Committee and Clinical Governance Committee) will assurance review the highest risks and the externally focussed risks.

The table below sets out our three highest organisational risks and the actions in place to mitigate against these.

Link to strategic objective	Risk category	Description of risk (including timing)	Mitigating actions / contingency plans in place
Consistently deliver world class clinical outcomes	Core operations	Difficulties in recruiting and retaining highly skilled staff with specific experience (e.g. ICU nurses)	Workstreams to improve : <ul style="list-style-type: none"> Dedicated recruitment and retention in challenging areas (e.g. ITU nursing) Targeted innovative incentives to work in these areas
Be a financially stable organisation and promote the sustainable use of resources	Emerging areas	Reduction in funding available to NHS organisations	<ul style="list-style-type: none"> Continuously seek efficiency improvements Proactive management and monitoring of our CIP programme Work with commissioners to ensure we are appropriately funded for all our patient groups
Consistently deliver world class clinical outcomes	Core operations	We may not work effectively across multiple teams or with parents to manage complex patients	<ul style="list-style-type: none"> Specific improvement program on the management of complex patients Enhancing the role of our general paediatric team to assist in coordinating the care of multi-specialty patients