Meeting of the Trust Board

25th May 2011

Dear Members

There will be a public meeting of the Trust Board on Wednesday 25th May 2011 commencing at **2:30pm** in the **Charles West Room, Level 2, Paul O'Gorman Building,** Great Ormond Street, London, WC1N 3JH.

Company Secretary

Direct Line: 020 7813 8230

Fax: 020 7813 8218

AGENDA

	Agenda Item	Presented by	Attachment
	STANDARD ITEMS		
1.	**Apologies for absence**	Chair	
	Declarations of Interest The Chair and members of this meeting are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must, as soon as practicable after the commencement of the meeting disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.		
2.	**Minutes of Meeting held on 27th April 2011**	Chair	**E**
3.	**Matters Arising / Action point checklist**	Chair	**F**
4.	**Chief Executive's Update** • **Haringey Children's Services Update** • **Safe and Sustainable Review Update** • **UCL Partners Update**	Chief Executive	**Verbal**
5.	**Zero Harm Report**	Co-Medical Director (RE)	**G**
	ITEMS FOR APPROVAL		
6.	**Annual Plan 2011-12**	Chief Operating Officer	**H**
7.	**Quality Account 2011-12**	Chief Operating Officer	**I**
8.	**Phase 2B Enabling Works Full Business Case**	Chief Operating Officer	**J**
9.	**VCB Lifts replacement**	Director of Redevelopment	**K**
10.	**Trust Board membership**	Company Secretary	**L - To follow**
	FOR DISCUSSION		
11.	**Example CRES schemes related to quality – how risks and safety are addressed**	Chief Operating Officer	**Presentation**

UPDATES

12.	**Performance Report – Month 1**	Chief Operating Officer	**M**
13.	**Finance Report – Month 1**	Chief Finance Officer	**N**
14.	**Foundation Trust Update**	Chief Operating Officer	**O**
15.	**Review of key deliverables for 2010-11**	Chief Operating Officer	**P**
16.	**Education Strategy Update**	Chief Nurse and Director of Education	**Q**
17.	**Child Protection Annual Report 2010-11**	Chief Nurse and Director of Education	**R**
18.	**Equality and Diversity Annual Report 2010-11**	Chief Operating Officer/ Co Medical Director (BB)	**S**
19.	**Trust Board Members' Activities**	Chair	**Verbal**

ITEMS FOR RATIFICATION

20.	**Consultant appointments**	Chair	**Verbal**

ITEMS FOR INFORMATION

(These items will not be discussed unless a Member gives prior notification of an intention to do so.)

21.	**Patient Experience Action Team (PEAT) assessment 2011**	Chief Operating Officer	**T**
22.	**Overview of committees as an FT (minute 198.3)**	Company Secretary	**U - To follow**
23.	**Management Board minutes – 17th March 2011**	Chief Executive	**W**

24. Any Other Business

(Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)

25. Next meeting

The next public Trust Board meeting will be held on Wednesday 29th June 2011 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT E

Draft Minutes of the meeting of Trust Board held on 27 April 2011

Present

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

In attendance

Mr Stephen Cox	Head of Communications
Dr Anna Ferrant	Company Secretary
Mrs Elle Schlaphoff	Minutes Secretary

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

14.	**Apologies for Absence**
14.1	Apologies for absence were received from Professor Martin Elliott.
15.	**Declarations of Interest**
15.1	No Declarations of Interest were made.
16.	**Minutes of the Meeting Held on 30 March 2011**
16.1	The minutes of the Trust Board meeting held on 30 March 2011 were received and the Chairman requested the Board Members to check them for accuracy.
16.2	Mr Fane requested minor changes to be made to minute 286.1 and Ms MacLeod requested the addition of a word to minute 286.3.
16.3	Subject to the requested amendments, the minutes were **approved** as an accurate record.

17.	**Matters Arising/Action Point Checklist**
17.1 17.2	**Minute 293.15 – Six Day Working Proposal** A verbal update was received from the Deputy Chief Executive regarding a recent proposal to examine options for Six Day Working. She said that work had initially concentrated on working with departments that had shown interest in developing the concept further. She said that she would provide an update on the matter later in the year. **Action:** Deputy Chief Executive
17.3 17.4	**Minutes 196.4 and 198.3 – Clarification of Reporting Structures** Ms MacLeod said that a presentation received prior to the meeting about working with governors had highlighted the need for further work to clarify how patient, carers and the public members of the Trust engaged with the board and its subcommittees. It was agreed that the work would be revisited in the autumn once the Member's Council had been formed. **Action:** Company Secretary
18.	**Chief Executive Update**
18.1	**Haringey Community Children's Services (HCCS) Update** The Chief Executive reported that the management of HCCS had been successfully tendered for by Whittington Health. She said that transfer of the service had been scheduled to take place on the 1 April but delays had occurred due to the simultaneous transfer of Haringey Adult Services and Islington Adult & Children's Services.
18.2	The Chief Executive said that 1 May had been agreed as the new date for the service transfer and the issue was being currently discussed at a meeting of the Whittington Health Board. She said she hoped to be able to communicate the outcomes of their discussions and the timetable for the service transfer to Board Members prior to the forthcoming bank holiday.
18.3	The Chief Executive said that she had spoken to the Chief Executive of Whittington Health regarding her concerns about the risks of delaying the transfer. She said that if discussions at the Whittington Health Board indicated that further delays to the transfer were to be expected she would also contact the Chief Executive of the North Central London Cluster.
18.4	**Safe and Sustainable**
	The Chief Executive said that a national consultation on the delivery of congenital heart services to children in England and Wales was continuing. She said that the current proposals would see the numbers of centres offering the services in London fall from three to two. She confirmed that Great Ormond Street had been included in all of the formal options.
18.5	The Chief Executive reported that the Royal Brompton and Harefield NHS Foundation Trust (RBHFT) had applied for a Judicial Review of the

	processes undertaken to develop the formal options proposed for services in London. It was noted that the RBHFT had not been included in any of the formal options and a decision on whether the review would be granted would not be made until July 2011.
18.6	The Chief Executive said that an event for the children and families affected by the consultation would be held at the Emirates Stadium and a meeting had been held to discuss ways to make it as informative as possible. She said that event would include a panel to explain the rationale behind the review and senior representatives from each of the Trusts would also be in attendance.
18.7	It was noted that the Trust would be required to provide a formal response to the consultation and this would be prepared in due course.
19.	**Zero Harm Report**
19.1	The Zero Harm Report was received from the Co-Medical Director (BB) on behalf of the Co-Medical Director (ME). She said that data obtained via the Paediatric Trigger Tool indicated that the rate of harm had continued to fall.
19.2	The Co-Medical Director (BB) said that the highlighted measure of the month was the use of the World Health Organisation (WHO) Surgical and Procedure Checklist. She said that there had been sustained improvement in its usage and it was now being routinely used in more areas.
19.3	Board Members discussed the current format of the report. It was agreed that the information could be presented with more clarity and further explanation of its relevance could be provided. It was noted that data in some of the graphs was not as current as others and it was suggested that the use of additional legends would help to enhance understanding.
19.4	The Chairman asked Board Members what measures they would like to feature on the system wide dashboard in future reports. The Chief Executive suggested that a measure on drug errors would be useful. The Chief Finance Officer suggested that the contents could reflect current Commisioning for Quality and Innovation targets (CQUINs) and the Co-Medical Director (BB) said the measures could be aligned with the content of the Assurance Framework.
19.5	The Chairman asked why there was a particular focus on Surgical Site Infections in Urology. The Co-Medical Director (BB) said that the work had been initiated in the Urology Department.
20.	**NHS Blood and Tissue Authority (NHSBT) Contract**
20.1	A paper requesting approval for a new three year contact with the NHSBT for the supply of blood and other specialist products was received from the Chief Finance Officer. She said that the values specified in the paper were indicative of costs for previous years and confirmed that the prices were not negotiable.

20.2 20.3	Ms Brown asked if the products could be purchased at a lower cost on an International basis. The Chief Finance Officer said that she would investigate this. **Action:** Chief Finance Officer
21.	**Trust Objectives 2011/12 – Key Deliverable Outcome Measures**
21.1	A paper on the key deliverables against the strategic objectives for 2011/12 was received from the Deputy Chief Executive. She said that outcome measures had been considered at the previous Board Meeting and she had also made revisions to the section on Research and Development as requested.
21.2	The Chief Executive said that the Trust had been shortlisted for renewal of its status as a Biomedical Research Centre (BRC). She said that BRC status had previously attracted funding of approximately £7 million per annum and interviews for renewal would be conducted by an International panel in July 2011.
21.3	Ms Brown asked if the Trust would be asked to demonstrate its current achievements as a BRC during the application for renewal of its status. The Chief Executive said that regular reports on achievement were produced and had formed part of the preliminary application stages.
21.4	The Chairman asked about the competition the Trust faced in relation to its renewal application for BRC status. The Chief Executive said that it would be difficult to apply if BRC status had not previously been attained. Professor Copp said that introduction of a new lower level funding stream was designed to enable Trusts who were not currently designated as BRCs to continue to develop their research portfolios.
21.5 21.6	The Deputy Chief Executive said that the Chief Finance Officer had previously requested a summary of outcomes achieved relative to the objectives set for 2010/11. She confirmed that a paper on the matter would be prepared for the next meeting. **Action:** Deputy Chief Executive
21.7	The Board **approved** the Key Deliverable Outcome Measures for the 2011/12 Trust Objectives.
22.	**Assurance Framework – Revised Risks 2011/12**
22.1	A paper on the revised Assurance Framework risks for 2011/12 was received from the Deputy Chief Executive. She said that the paper contained two sections which reviewed progress against the current risks and suggested revisions to create the new risks for 2011/12.
22.2	The Deputy Chief Executive reported that only one risk within the Assurance Framework was rated Amber (1F Lack of appropriate clinical response to the deterioration in children). She said that the risk had been considered in detail at the last meeting of the Risk and Assurance Compliance Group (RACG).

22.3	The Deputy Chief Executive said that in the revised risks for 2011/12 some of the former risks had been included under a newer broader risk 1E. She said that the Audit Committee had discussed the revisions prior to the meeting had requested her to consider reinstating some of the previous risks.
22.4	Mr Tilley advised Board Members that a recent review of the Assurance Framework by the Internal Auditors had received a grading of significant assurance. He said that the Audit Committee had also discussed whether a particular focus was required on the risk related to staff competency and whether additional risks on ability to utilise new technology to improve patient outcomes and failure to follow processes should be considered.
22.5	Mr Tilley said that the Audit Committee had requested a presentation from the RACG to understand how the group reviews risk registers and how they are fed into the Assurance Framework.
23.	**Performance Report**
23.1	The final performance report for 2010/11 was received from the Deputy Chief Executive. She said that the last page of the report showed progress against the criteria for the Monitor Governance Risk Rating for Foundation Trusts and if it had been measured against it, the Trust would currently have an overall rating of Amber-Green.
23.2	It was noted that if any of the Monitor Governance Risk Rating targets were not achieved in 3 consecutive quarters, the risk rating would change to red.
23.3	The Deputy Chief Executive advised Board Members that performance against inpatient and outpatient waiting times targets was discussed at the last meeting of the Management Board. She said that recent government directives had caused confusion over how waiting times would be monitored and families still should still be able to expect to be seen within previously agreed timescales.
23.4	It was noted that the Management Board had made a renewed commitment to ensuring the achievement of waiting times targets and additional work would be undertaken to remedy issues that had been identified in specific areas.
23.5 23.6	The Chief Executive said that there were too many graphs on ICT performance included on the last page of the report and only key ones should be included in the future. The Chief Finance Officer said that she would ensure they were reviewed. **Action:** Chief Finance Officer
24.	**Finance Report – End of Year Report 2010/11**
24.1	A paper on the unaudited financial results for 2010/11 was received from the Chief Finance Officer. She said that the draft results had been

	submitted to the Department of Health (DoH) on 21 April and were unchanged from the previous forecast.
24.2	The Chief Finance Officer said that the Trust was expecting to report a net surplus of £7.2m after impairments relating to building revaluations. She said that a full report on the annual accounts would be submitted to the next Board meeting and the Audit Committee had been satisfied with the preliminary results.
25.	**Foundation Trust Update**
25.1	An update on the status of the Foundation Trust application was received from the Deputy Chief Executive. She said that a meeting regarding the application had taken place with the DoH and NHS London and the Trust had been able to answer questions about the application.
25.2	The Deputy Chief Executive reported that a meeting would be held at the DoH on the following day to decide whether the application would be submitted to the final phase of the application process.
26.	**Trust Wide Risk Register**
26.1	A summary report on the Trust Wide Risk Register was received from the Co-Medical Director (BB) on behalf of the Co-Medical Director (ME). The Chief Executive said that the same report had been discussed by the Audit Committee and concerns had been raised by the number of risks that were currently on the register.
26.2	The Co-Medical Director (BB) said that many of the problems resulted from the duplication of risks and at present sharing mechanisms did not exist between the local risk registers. The Chief Executive said that she believed the ways in which local risks were recorded, monitored and analysed were being considered as part of a review of the Clinical Governance and Staff Safety team.
26.3	Mr Tilley said that he felt that it was important to show how the local risks linked to the strategic risks featured on the Assurance Framework.
26.4	It was suggested that a better understanding of the key themes identified across the high rated local risks was required.
27.	**Care Quality Commission (CQC) Registration Update**
27.1	An update on CQC registration was received from the Company Secretary on behalf of the Chief Executive. She explained that the CQC currently assessed progress against 16 key outcomes and provided the Trust with a risk rating for each ranging from ‘low green to ‘high red’. It was noted that progress was reported via a document called the Quality Risk Profile (QRP)
27.2	The Company Secretary reported that for the period between February and March 2011, risk ratings against 15 outcomes did not change. She said that the rating for Outcome 14 (Supporting Staff) moved down by one position and she was investigating the reasons for this.

27.3	The Company Secretary said that she had received notification of the Trust's risk ratings for April prior to the meeting. She said the rating for Outcome 8 (Cleanliness and Infection Control) had moved up by one position and the rating for Outcome 16 (Assessing and Monitoring Quality of Service Provision) had moved down by one position.
27.4	The Company Secretary said that the overall contextual risk estimate for the Trust was a 'low green'. She advised Board Members that the Clinical Governance Committee would review the QRP in detail at each meeting and it would also be submitted to the board on 3 occasions per year.
28.	**Summary of Results from 2010/11 Staff Survey**
28.1	The Summary Results for the 2010/11 Staff Survey was received from the Deputy Chief Executive. She said that survey sample was relatively small and 346 staff had responded giving an overall response rate of approximately 41%.
28.2	The Chief Finance Officer said that response rates for other Trusts varied and could have implications for the usefulness of making comparisons with their data.
28.3	The Deputy Chief Executive said that the results had been analysed and the following areas had been highlighted for action:- o Handwashing o Equality and Diversity training and equality of opportunity particularly for BME staff o Stress and staff health
28.4	The Chief Nurse and Director of Education said that she had requested more information regarding the results of the survey element on handwashing. She said that many of the staff who had felt that handwashing facilities were inadequate worked in corporate areas. She confirmed that work had been undertaken to rectify the problems that had been identified such as refilling of gel dispensers and access to hot water. The Deputy Chief Executive said that work was also planned to improve the facilities available to staff in Intensive Care.
28.5	The Deputy Chief Executive said that the survey results suggested that the Trust performed worse than average in relation to provision of Equality and Diversity training and fewer BME staff felt that the Trust provided equal opportunities for career progression. She said that the Trust already had an established BME Network and a suitable action plan was being developed.
28.6	Ms MacLeod asked if the Deputy Chief Executive investigated why data previously received by the Board had shown that a disproportionate number of disciplinary cases involved BME staff. The Deputy Chief Executive said that the Annual Equality and Diversity report was due for submission to the next Board Meeting and a full analysis of the data would be included.

28.7	**Action:** Deputy Chief Executive
28.8	Mr Tilley said that he was concerned that a below average number of staff felt satisfied with the quality of their work and patient care that they were able to deliver. The Chief Executive said that staff at the Trust had very high expectations and the result was appeared to be contradicted by the patient and family satisfaction survey that suggested a very high number of respondents would recommend treatment at Great Ormond Street to others. Ms MacLeod suggested that considering the type of services provided by the hospital and the type of people who usually choose to work in Paediatrics could offer further explanation of the results.
28.9	The Chief Executive said that it would be important to understand more about why the number of staff reporting good communication between themselves and senior management was below average.
28.10	The Deputy Chief Executive said that the results had also been reviewed by the Management Board and they had been concerned by the high number of staff reporting incidents of harassment and bullying. She said that they had requested a further paper on the matter at their next meeting.
28.11	Board Members asked if further breakdowns of the data could be obtained to enable identification of areas where certain issues were particularly prevalent. The Deputy Chief Executive said that the results could be viewed by department. The Chairman said that a way of making genuine comparisons with other Trusts needed to be explored.
29.	**Trust Board Members Activities**
29.1	The Chairman said that she had received 30 applications in response to an advertisement for a Non Executive Director to replace Mr Fane who was due to step down at the end of October 2011. She said that six candidates had been shortlisted and interviews would take place on the 6th May 2011.
29.2	The Chief Executive said that she would be attending a 3 day conference for International Children's Hospital Chief Executives in Dublin starting on 1st May 2011.
29.3	Ms Hackman said that the final meeting of the Members Forum taking place on the 14 July would now start 30 minutes later than previously advised. She said that work on the legacy document for the group had commenced.
30.	**Consultant Appointments**
30.1	The Chairman advised Board Members that the following Consultants had been appointed since the last meeting:- Dr Wellesley - Consultant in Paediatric Anaesthetics Dr Stockton - Consultant in Paediatric Anaesthetics

	Dr Hepburn - Consultant in Paediatric Anaesthetics with a Cardiac Interest
30.2	The Board approved the new Consultant appointments.
31.	**Patient and Family Satisfaction Survey Results 2011**
31.1	Board Members were asked to note the positive response received in the recent Patient and Family Satisfaction Survey. The Chief Nurse and Director of Education said that a small number of areas had been identified for improvement and the Patient and Public Involvement and Experience Committee would be developing an appropriate action plan.
32.	**Summary of Audit Committee Meeting on 27 April October 2011**
32.1	It was noted that the Audit Committee had met immediately prior to the Board meeting. Mr Tilley said that in addition to the review of the Assurance Framework discussed earlier, the Internal Audit Plan for 2011/12 had also been reviewed and approved. He said that a confidential meeting had been held with the Trust internal auditors and no matters of concern had been raised.
33.	**Management Board – Minutes February 2011**
33.1	It was noted that the Management Board – Minutes February 2011 had been included for information. The Chairman asked if there were any questions or comments. There were none.
34.	**UCL Partners Management Report**
34.1	It was noted that the' UCL Partners Management Report' had been included for information. The Chairman asked if there were any questions or comments. There were none.
35.	**Any Other Business**
35.1	**<u>2B Enabling works</u>** A paper regarding the full business case for the phase 2B Enabling works was tabled. The Chairman said that the Board had previously agreed the outline business case but it had been decided that a subgroup should be nominated to consider the business case in full to enable final approval to take place at the Board meeting in May.
35.2	The Chief Finance Officer and the Deputy Chief Executive said that a project board had been formed to steer the work and would be responsible for presenting the business case to the subgroup.
35.3 35.4	It was agreed that Mr Tilley and Mr Fane would be members of the subgroup and the Company Secretary would liaise with them outside of the meeting to arrange a suitable date for the presentation. **Action:** Company Secretary

35.5	**<u>Clinical Ethics Committee</u>** The Chief Executive advised Board Members that the current Chair of the Clinical Ethics Committee (CEC) would be retiring and discussions regarding his successor had concluded that Ms MacLeod would be an ideal candidate for the role. Ms MacLeod said that her membership of the Clinical Governance Committee (CGC) would provide useful links between the groups.
35.6	Board Members agreed that the appointment of Ms MacLeod to the role of Chairman of the CEC would be appropriate.
35.7	The Co-Medical Director (BB) confirmed that administrative support for the Committee had now been arranged. It was noted that the Committee currently met on a monthly basis and also provided a rapid response service. Ms MacLeod said that she would like to review frequency of meetings when her chairmanship had commenced.
35.8	Mr Fane said that role of the CEC had been discussed at previous meetings of the CGC. Professor Copp said that revised terms of reference for the CEC should be reviewed by the CGC as soon as possible. Ms MacLeod said that she wished to seek a range of views on the role of the CEC in the future.
35.9	**<u>UCL Partners Back Office Programme</u>** The Chief Executive said that she had received notification that recommendations on the future direction of the UCLP Back Office Programme were due to be received in June 2011.
40.	**Date of the Next Meeting**
40.1 40.2	The date of the next meeting was confirmed as 25 May 2011. The Chairman requested for confirmation of session times to be sent to Board Members. **Action:** Company Secretary

ATTACHMENT F

ATTACHMENT F

TRUST BOARD - ACTION CHECKLIST
25 May 2011

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
193.7	24/11/10	The Chairman said that the Education Strategy paper was currently aspirational and would require milestones and implementation markers. She suggested that 4 or 5 priorities were selected for development and the strategy should be resubmitted to the Board in 6 months time.	LM	May 2011	On agenda
195.6	24/11/10	The Chairman thanked Professor Goldblatt for his report and asked if his next report could include information on how the research conducted by UCL Partners was linking with global health initiatives.	DG	June 2011	Not Yet Due
196.4	24/11/10	It was noted that a further report on the Management Board reporting structure would be submitted to the Trust Board Away Day in February.	AFe	Deferred to June 2011	Not Yet Due
198.3	24/11/10	Ms MacLeod suggested that further work would be required to clarify the roles and responsibilities of the different hospital committees outlined in the Constitution. The Chairman said that it was important that there were no misunderstandings.	AFe	May 2011	On agenda
17.2	27/04/11	An update on the six day working proposal would be provided later in the year.	FD	Sept 2011	Not Yet Due
17.4	27/04/11	Ms MacLeod said that a presentation received prior to the meeting about working with governors had highlighted the need for further work to clarify how patient, carers and the public members of the Trust engaged with the board and its subcommittees. It was agreed that the work would be revisited in the autumn once the Member's Council had been formed.	AFe	Oct 2011	Not Yet Due

ATTACHMENT F

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
20.3	27/04/11	Ms Brown asked if the blood and tissue products could be purchased at a lower cost on an International basis. The Chief Finance Officer said that she would investigate this.	CN	May 2011	Verbal update
21.6	27/04/11	The Deputy Chief Executive said that the Chief Finance Officer had previously requested a summary of outcomes from the objectives set for 2010/11. She confirmed that a paper on the matter would be prepared for the next meeting.	FD	May 2011	On agenda
23.6	27/04/11	The Chief Executive said that there were too many graphs on ICT performance included on the last page of the report and only key ones should be included in the future. The Chief Finance Officer said that she would ensure they were reviewed.	CN	May 2011	
28.7	27/04/11	Ms MacLeod asked if the Deputy Chief Executive investigated why data previously received by the Board had shown that a disproportionate number of disciplinary cases involved BME staff. The Deputy Chief Executive said that the Annual Equality and Diversity report was due for submission to the next Board Meeting and a full analysis of the data would be included.	FD	May 2011	On agenda
35.4	27/04/11	It was agreed that Mr Tilley and Mr Fane would be members of the subgroup to consider the business case for redevelopment of phase 2B and the Company Secretary would liaise with them outside of the meeting to arrange a suitable date for the presentation.	AFe	May 2011	Actioned – meeting arranged for 11th May 2011
40.2	27/04/11	The date of the next meeting was confirmed as 25 May 2011. The Chairman requested for confirmation of session times to be sent to Board Members.	AFe	May 2011	

Trust Board Meeting May 2010	
Title of document: **Zero Harm Report** **Peter Lachman** **Associate Medical Director** **On behalf of** **Martin Elliot Co-Medical Director**	**Paper No: Attachment G** **Date: 17 May 2011**
Summary This paper provides an update on the following issues: ▪ Measures for Zero Harm programme ▪ Patient and front line stories ▪ Zero Harm Dashboard ▪ Unit improvement data	
Action required from the meeting To note the aims for the zero harm programme To anticipate and advise on the new system wide dashboard	
Contribution to the delivery of NHS / Trust strategies and plans This is one of the strategic objectives of the Trust	
Financial implications Nil	
Legal issues Nil	
What consultation has taken place Not applicable	
Who needs to be told about the policy? Not applicable	
Who is accountable for the monitoring of the policy? Not applicable	
Author and date: Peter Lachman 18th May 2011	

Zero Harm Report for the Trust Board
May 2011

A. An approach to patient safety

The Quality Strategy approved by the Trust Board in July 2010 defines how Great Ormond Street Hospital will deliver its principal objectives to provide safe, effective and timely care for patients and to enhance the experience of children, young persons and their families who use our services. The aim is to deliver the right care, at the right time in the right way, by well-trained and competent staff within a framework of integrated governance and safe systems. One of the issues facing the Board is to know which measures to use to assure itself of the safety of the service provided. Thus the Trust needs further to develop its measurement strategy, which should deliver a unified system of measurement for improvement from the frontline to the Unit to the Board.

Whilst simple measures are desirable, healthcare is so complex that there is no single measure of harm and no universally tested framework on which to base safety assessments. The journey from risk measurement via clinical governance to current concepts of harm reduction and mitigation implies that the measurement of safety is a changing concept. Reliance on assurance from clinicians alone is insufficient. As accountability for safety has increased, the Board requires more sophisticated ways to assess safety.

In this paper a new approach is given to the way the Board can assure itself that there are ongoing improvements to reduce harm to children and staff.

In the past the quality of available data has been variable. Outcomes were often not completely known or reported and collection of data was inconsistent. Metrics used by Boards in the past have not clearly demonstrated what was happening in the front line.
Our partners in Cincinnati use a model that aims to capture harm on a different level.

Measures

Measures	Triangle level
SI rate or days since last SI	Serious Incident
Serious Harm Index Infection Index Medication Index	Serious preventable events • VAP SSI CVL Etc
Trigger Tool	Events causing minimal or moderate harm
Not measured as yet	Near misses

- The reporting system and traditional risk has focused on the top of the triangle.
- The trigger tool and other reporting systems aim at the precursor events
- Currently near misses are not recorded in detail.

As the measurement system develops and becomes more sophisticated we will be able to move down the triangle. The Trust needs to eliminate the top of the triangle at the same time as moving on the middle section.

B. Measurement and the Zero Harm aims for the Trust 20111-2012

The system-wide dashboard is currently being reviewed by the Transformation Team, taking into account learning from other organisation. Over the last two years, great progress has been made and new modes of monitoring safety and specific measures require a redesign of the dashboards.

The review process is considering the following areas: -

- Understanding what information is available at all levels in the organisation
- Standardisation and improvement of the quality of information
- Prioritisation of the data needed at different levels in the Trust
- Requirement of Units to ensure the continual improvement of data and the application of learning from data.
- Integrating dashboards from Clinical Team (speciality) to Unit to Board (or visa versa).
- Strengthening the commitment to transparency

Proposed measurement 'Themes'

Measurement Group to provide an overview of harm

1. <u>Harm detected by the Paediatric Trigger Tool</u>

This method uses a retrospective review of a randomly selected set of notes look for triggers[1] that can point to harm, It usually reveals harm at a rate of 10x that of conventional reporting methods. The measure is harm per 1000 patient days or as a percentage of all inpatient admissions, and the harm can be categorized on a scale from minor to major. The identification of patterns of harm informs to the development of preventative, interventions.

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[1] There 32 tiggers that cover general care, surgical care medications intesive care, and laboratory investigations. Thsee then lead the reviewer to look for possible harm.

2. Harm Index[2]

This measure is reported either as a rate per 1000 patient days or as a number per month. The index conflates selected harm incidents e.g. all Hospital Acquired infections, serious safety events, medication induced harm, Non-ICU cardiac arrests, significant complications after surgery, serious falls, inpatient/outpatient serious safety events. The inclusion list will match that of our sister organisation, Cincinnati Children's Hospital, to allow us work with them to reduce learn how to reduce harm.

The aim is to decrease the Harm Index month on month.

3. Serious Incidents (SIs)

These are reported to the Patient and Staff Safety Team and are investigated in detail as per national guidelines. The aim is to ensure organisational learning and change in practice so that they do not recur. Currently a rate has not been developed since the number of reportable SIs is constantly changing. However, our overall aim is to reduce to zero all SIs and after each incident action plans are implemented to prevent recurrence. SIs are reported as the number of days since the last SI or the number per 10000 adjusted patient days, which takes into account all patients.

4. Crude Mortality rate

This remains a crude 'barometer' of the state of the hospital, and provides good baseline information, but is not really sensitive to issues of complexity or case-mix. Thus, detailed review of the notes of ***all*** children who die is an important aid adjunct. This review will be added this year.

[2] This is based on *The Preventable Harm Index: An Effective Motivator to Facilitate the Drive to Zero*. Brilli et al. Journal of Pediatrics. Vol 157 no 4 p 681.

Specific measures

5. Culture

A safety culture must come to underpin all our work. Measuring culture is notoriously difficult, but would reflect the long-term impact of the Safety and Improvement programme. A methodology has been evolved and will be finalised shortly but will need to be tested over the next year. The aim is to demonstrate improvement in the culture of safety within the Trust over time.

6. Combined Hospital Acquired Infection Index

This is a subset of the Harm Index. This index is the combined number of specified hospital acquired infections (HAI). This would include, for example, MRSA, CDiff, CVL, SSI and VAP. It will provide an overview of how the Trust is performing in the reduction and elimination of HAI. The measure will be developed with the Infection Prevention and Control team.

7. Combined Medication index

This is a subset of the Harm Index. This will include the different aspects of medication harm along the different parts of the medication pathway. This will be developed with the Medicines Management leaders within the Trust.

Where possible we will attempt to match index measure definitions with other children's hospitals, so that we can work together to decrease harm.

8. Deteriorating Child

This measure reflects how the Trust is improving care for the most ill of all children. The aim is to reduce all non-ICU crash call (resuscitation) of children. This is via the interventions for early detection of deterioration and escalation.

All these measures will be presented as a System Wide Dashboard which we expect to be available in its first iteration within two months. An example of what it might look like is given below.

The Board is requested to consider proposed system wide dashboard and approve its development over the next 2 months.

System Wide Safety Dashboard

Desired direction of change ↓↑

For each chart, click on a data point to display further detail.

A series of measures that together give a view of the harm within the Trust

Harm via Paediatric Trigger Tool

Adverse Events per 1000 bed days

Harm Index

Combined Harm Index

Serious Untoward Incidents

The number of serious patient safety incidents. Area: System Wide

Mortality

The mortality rate per 1000 discharges. Area: System Wide

Combined Infection Index

Combined Infection Index

Deteriorating Child

The number of crash calls outside ICU

Culture

Culture

Medication Index

Medication Index

Additional Measure 1

Additional Measure 1

Additional Measure 2

Additional Measure 2

DRAFT

C. Use of patient and front line staff stories[3]

One of the most effective ways to understand safety is to listen to patient and front line staff stories at the Board. This can be in person, by video link or via a recording.

"Patient Safety First's 'Leadership for Safety' intervention suggests that organisations working to improve patient safety should bring the patient's voice to the Board. Whilst the idea of starting each Board meeting with a patient story may initially sound easy to accomplish, in reality it is a challenging goal that requires careful planning, consideration of a number of ethical issues and skilled presentation."

It is our considered view that the measurement systems used by the Board would be enhanced by the use of stories at the start of each Board meeting. This is now standard practice at many Trusts around the United Kingdom.

The aim is:

- To connect with patients.
- To connect with front line staff.
- Improve understanding of human factors in harm and error.
- Make patient safety more personal.

The Board is requested to consider the use of staff and patient stories at all Board meetings.

[3] Guidance for patient stories can be obtained from:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=781&pid=41303
http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/GuidelinesforUsingPatientStorieswithBoardsofDirectors.htm
http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/interventions/Leadership

D. Use of the Unit zero harm reports

In August 2010, the Trust mandated the individual Clinical Units to report on their Safety programmes, indicators of risk and harm at the monthly Management Board meeting. The reports have been automated and now take up the first part of the Management Board meeting. The approach that has been adopted is to make patient safety the key priority for the Unit management. The provision of good quality data is fundamental to this approach; The Units then use the data to inform their clinical teams of the challenges faced and to be made.

The Board could examine one of the Unit reports each month to gain a deeper understanding of safety and the improvement projects.

E. Aims of the Zero Harm Programme

The Transformation team is now in position to recommend the aims for the Zero Harm part of the transformation programme. This is due to the ongoing development of our measurement tools due the funding of the data analysts. This places GOSH at the forefront of NHS Trusts addressing the harm that can happen to patients.

The baselines have been set and the Transformation Board has accepted the recommended aims. It should be remembered that the aim is to use the data for *improvement* rather than as it is usually used, to judge performance. The goals that are set are aspirations and we should aim to reach them. However they are difficult to attain and will require a change in the way care is provided

The Proposed Aims

Situation: Jez Phillips and Peter Lachman, propose the following aims based on targets set in the Trust Objectives, past data and suggestions from the Transformation Board during the past 3 months.

Background: Harm of our patients is never acceptable. We aim to reduce year on year the number of children harmed at GOSH, the aspiration is for us to say that we are truly a **ZERO HARM** organisation.

Assessment: In previous years there have been differing versions of aims for several measures, with no single document of aims agreed and approved by the Transformation Board. Furthermore, there has not been a defined method to determine whether an aim has been achieved, or what action should be taken if either the aim was met or not.

Recommendation: The recommendation to the Trust Board is that by the end of 31st December 2011, we aim to reach the following targets in the outcome measures:

Overall Measures of Harm	50% reduction year on year
Infection Prevention and Control	50% reduction year on year.
Medication Errors (except high-risk drugs	25% reduction year on year
Medication Errors (high risk drugs)	100% reduction
Surgical “never events”	100% reduction
Deteriorating child	50% reduction year on year
Serious Events	50% reduction year on year

Comment: The setting of such ambitious targets can be counter productive if the data is used as a KPI or for judgment. If the goal is not met one should examine the causes and barriers in order to encourage further improvement. One could extend the time to 24 months as of now but maintain the high bar.

Proposed Aims

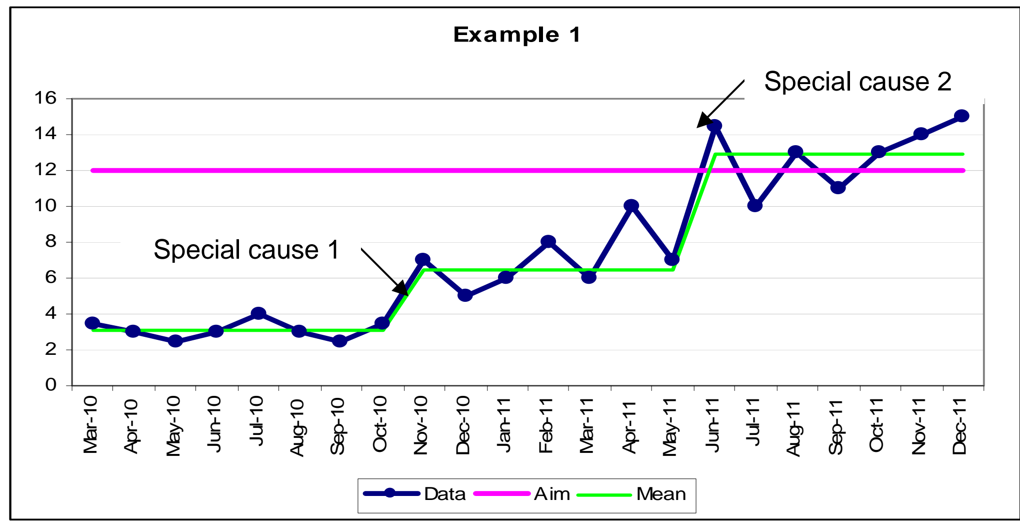
	Baseline	Baseline Comment	Target
Overall Measures of Harm			
Measure of harm - via the PTT	100 adverse events / 1000 bed days	15 months from Nov-09 to Jan-11	50 adverse events / 1000 bed days
Serious Incidents - Level 3, 4 and 5	Measure to be developed by end May 2011		
Combined Harm Index	Measure to be developed during 2011		
Infection Prevention and Control			
CVL infections/1000 line days	3.02	11 months from Mar-09 to Jan-10	1.5
SSIs			
Spinal (% of operations)	2.35%	11 months from Jan-10 to Nov-10	1.175%
Cardiac	8.5%	9 months from Apr-10 to Dec-10	4.25%
Neuro	Initial baseline available May 2011		
Cranio	Initial baseline available May 2011		
Urology	0.5%	21 months from Aug-08 to Apr-10	0.25%
VAPs (PICU and NICU)	71 days between VAPs	10 VAPS from Nov -08 to Oct- 10	142 days between VAPs
Hand Hygiene audit results	75%	14 months from Dec-09 to Jan-11	100%
CVL bundle compliance	50%	11 months from Mar-09 to Dec-10	100%
SSI bundle compliance	There is not a Trust wide SSI bundle		
VAPs bundle compliance	There is no resource in PICU to audit the bundle compliance.		
Medication Errors - (except high risk drugs)			
CICU - Drug errors per prescription	0.05	21 weeks from 17-May-10 to 18-Oct-10	0.0375
PICU – Prescribing errors (clinical) per bed day	0.09	23 weeks from 27-Apr-09 to 28- Sep-09	0.0675
PICU – Prescribing errors (non-clinical) per bed day	0.22	23 weeks from 10-May-10 to 11-Oct-10	0.165
NICU	Awaiting data. Date unknown		
Haem/Onc – Prescribing errors per 100 items prescribed	7.6	15 weeks from 31-Oct-10 to 06-Feb-11	3.8

Medication Errors - High Risk Drug errors (days between drug errors for the following drugs)			
Morphine	7 days	21 errors from 07-Jan-09 to 25-Jul-09	Never
Insulin	22 days	12 errors from 07-Jan-09 to 19-Oct-09	Never
Heparin	21 days	15 errors from 10-Jan-10 to 10-Mar-10	Never
Amikacin and Vancomycin	21 days	19 errors from 28-Sep-09 to 23-Sep-10	Never
Surgical "Never Events"			
The number of surgical never events	Measure to be developed during 2011		0
Total WHO procedure checklist completion	55%	7 weeks from 02-Jan-11 to 13-Feb-11	100%
Deteriorating child			
The number of crash calls outside ICU	12 per month	21 months from Apr-08 to dec-09	6 per month
Internal emergency admissions to ICUs	13.4 per month	14 months from Oct-08 to Nov-09	6.7 per month
The number of readmissions to ICU within 48 hours	1.8 per month	9 months from Mar-09 to Nov-09	0.9 per month
Use of CEWS (audit completeness)	Initial baseline available September 2011		100%
CEWS scored correctly (audit results)	Initial baseline available September 2011		100%

Examples of Aim Success

The following 3 examples are scenarios (not exhaustive) where measures could be considered to have reached their aims.

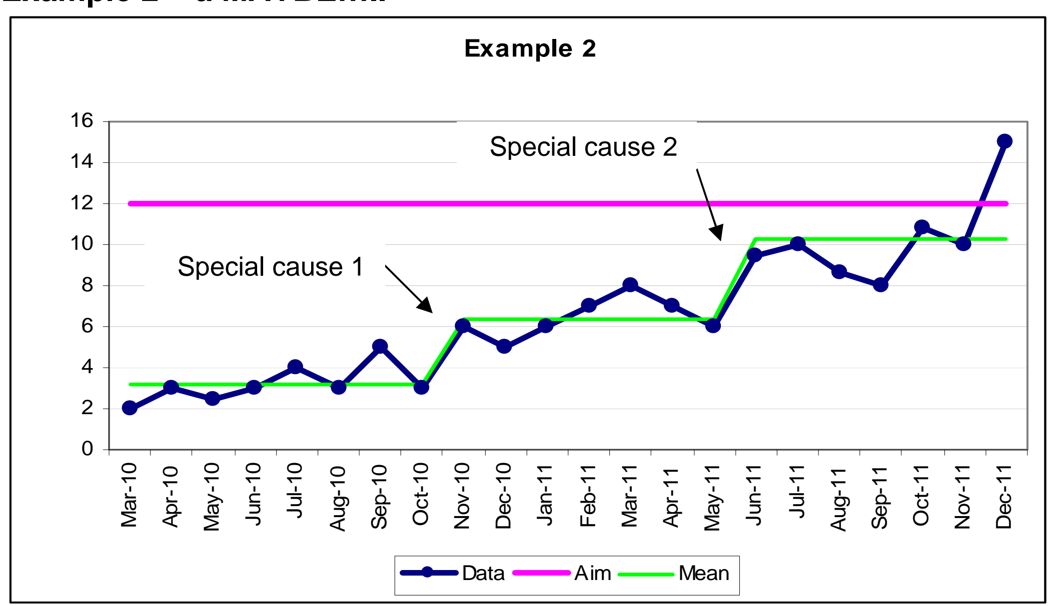
Example 1 – a definite YES



This example shows a measure that has undergone 2 special causes. The most recent in Jun 2011 has led to a sustained improvement (7 or more data points), and the new mean is now greater than the project aim. To achieve this, the new improved process has to producing good results from June 2011.

Yes, this example measure has successfully achieved its aim.

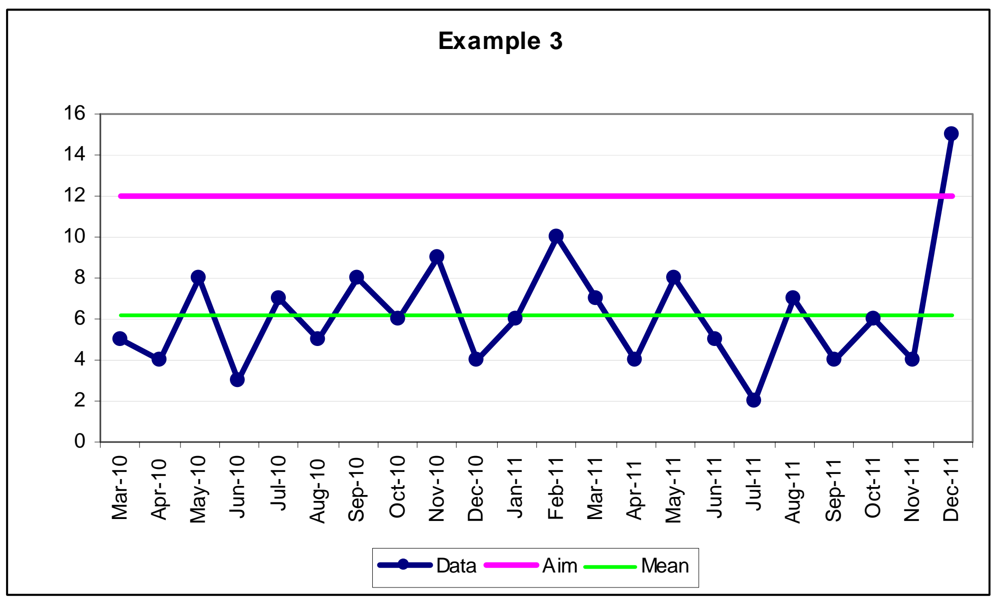
Example 2 – a MAYBE…..



This example measure has also undergone 2 special causes. The most recent has resulted in a sustained improvement but the new mean is less than the aim. The most recent data point is greater than the aim but more data is needed to prove that this is sustained.

Maybe. This example measure has successfully achieved its aim BUT for 1 month only. As we have seen a series of significant improvements we should be cautious. It remains to be seen whether an improved process is in place and will be sustained.

Example 3 – a definite NO



This example shows no special causes. The process has been consistent until the most recent month when a single data point is greater than the aim.
The single data point above the aim in December 2011 cannot be considered to show a process improvement at this time.

No, this example measure cannot be considered to have achieved its aim.

After-Action Review (AAR)
The next question that arises is 'Regardless of whether the aims are achieved or not, what happens as a result?' There are invaluable lessons to be learned from all projects - those that have gone well and those that haven't.

"An After-Action Review (AAR) is a discussion of an event that enables the individuals involved to learn for themselves what happened, why it happened, what went well and what can be improved. AAR is a timely intervention that seeks to understand the expectations and perspectives of all those involved. It generates insight, lessons learned and leads to greater awareness, changed

behaviours and agreed actions. (Steve Andrews - UCLH 2008)" "AAR is often described as a learning tool and a mainstay of Knowledge Management processes. This does not do it justice or seek to understand the real power of the framework. To achieve learning the AAR requires attributes such as leadership, teamwork, communication, courage, and values; the elusive elements in many leadership or cultural change programmes. AAR is a leadership tool which influences culture by understanding the dialogue of the organisation. It has remained very grounded in its allegiance to the organisations goals of safe and effective care. (Steve Andrews – UCLH 2008)"

Decision made:

F. National recognition for Great Ormond Street Hospital

GOSH has been well represented at the National Patient Safety Congress in Birmingham on 17-18 May 2011

A session on paediatric patient safety was developed by GOSH with the conference organisers. Speakers included:

1. Reducing medication errors in the ICU and lessons for paediatrics Dr Allan Goldman, Paediatric Intensive Care Consultant and Chair of The Cardio-respiratory Unit and Dr Mark Peters, Clinical Lead, PICU,
2. Deteriorating children: Interventions to prevent harm. Sue Chapman, Associate Safer Care, NHS Institute for Innovation and Improvement and Nurse Consultant at GOSH with Lorraine Major, Advanced Nurse Practitioner, Basingstoke and North Hampshire NHS Foundation Trust
3. Why children are at greater risk of harm: How to develop a safety programme for your hospital. Peter Lachman Associate Medical Director, Great Ormond Street Hospital for Children NHS Trust with Derek Burke, Medical Director, Sheffield Children's Hospital NHS Foundation Trust

G. Concluding comment

In this paper an enhanced way to assess harm is proposed. It must be stressed that this is an organic approach that will continue to evolve as our understanding of safety and harm improves and develops. As we expand our clinical outcome framework, clinical outcomes measures for the Board can be introduced.

Great Ormond Street Hospital for Children NHS Trust

Trust Board May 2011	
Title of document Annual Plan 2011/12 **Submitted on behalf of** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment H**
Aims / summary The annual plan sets out our priorities and plans for the delivering the final year of our three year strategic objectives and details how will manage associated clinical, governance and financial risks. The plan is in line with Monitor's requirements for Foundation Trusts. Clinical units and departments have additionally developed their local plans to deliver the Trust objectives. These are attached as appendix 2 to the annual plan document. It should be noted that several unit plans are currently in draft form and will be signed off by their clinical unit management team shortly.	
Action required from the meeting Trust Board is asked to agree the attached plan as a reasonable summary of last year's achievements and this year's plans.	
Contribution to the delivery of NHS / Trust strategies and plans The Annual Plan is structured to demonstrate how it moves the Trust towards achievement of the agreed Strategic Objectives.	
Financial implications The Annual Plan is congruent with agreed budgets, developments, capital investments and CRES plans.	
Legal issues NA	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? The Strategic Objectives have been discussed with the Members Forum. Specific plans will be subject to full, appropriate consultation.	
Who needs to be told about any decision The proposed governance arrangement for monitoring progress and assuring the Trust Board on risks is included adjacent to workstreams.	
Who is responsible for implementing the proposals / project and anticipated timescales Specified Exec Lead	
Who is accountable for the implementation of the proposal / project Specified Exec Lead	
Author and date Alex Faulkes, Head of Planning & Performance Management. May 2011.	

Annual Plan 2011/12

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1. Introduction to the Trust

Our hospital first opened its doors in 1852 as the Hospital for Sick Children. With only 10 beds, it was the first hospital in the UK dedicated to children. Today Great Ormond Street Hospital (GOSH) is an international centre of excellence in child healthcare. Working with the University College London (UCL) Institute of Child Health (ICH), we are one of the largest centres for research into childhood illness in the world and a significant trainer of children's health specialists.

The children treated at the hospital 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 formation the hospital 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 drives the hospital's vision and strategy.

Great Ormond Street Hospital, together with London South Bank University (LSBU), trains the largest number of children's nurses in the United Kingdom (UK). We also play a leading role in training paediatric doctors and other health professionals.

The hospital does not have an Accident and Emergency department and chiefly accepts specialist referrals from other hospitals and community services.

Interesting facts about the Great Ormond Street Hospital

GOSH has the UK's widest range of health services for children on one site, a total of 49 different specialities.

Many of the hospital's services are designated by the National Commissioning Group (NCG) as national services. That means we receive funding nationally to treat children from all over the UK who need our specialist care.

We are the country's largest centre for children's heart operations and we are one of the largest heart transplant centres for children in the world.

We are the country's largest centre for children's intensive care.

We are the country's largest centre for children's brain operations. For example, we carry out about 60 percent of all UK operations for children with epilepsy.

With University College London Hospitals (UCLH) we are one of the largest centres for children with cancer in Europe.

We are the UK's only academic Biomedical Research Centre specialising in paediatrics.

We are the country's largest centre for paediatric craniofacial surgery.

We are a leading member of UCL Partners, an alliance for world-class research benefiting patients, joining UCL with four hospitals.

We are the country's largest centre for children with kidney problems.

Great Ormond Street Hospital has developed gene therapy for life threatening immune diseases; new, gentler ways of delivering bone marrow transplants in very sick children; new surgery to cure children born with extremely narrow windpipes; and a host of other new treatment and techniques used around the world.

We employ more than 3,500 staff.

We have more than 200,000 patient visits a year (outpatient appointments and inpatient admissions). More than half of our patients come from outside London.

2 Past year performance

2.1 Chief Executive's summary

2010/11 has been a challenging but successful year for GOSH. In 2009/10 we reviewed the annual planning framework with a specific focus on developing a set of three year strategic objectives each with a series of executive-led critical workstreams and actions to ensure close monitoring and successful delivery. 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. We have made good progress against the second year of our three year programme with 61 out of 78 actions being rated as achieved against the milestones set.

In 2010/11 we retained full Care Quality Commission 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 and risks through both reflective organisational learning and a proactive programme focussing on areas of harm that can occur in children. This includes, for example, understanding the nature of harm through the implementation of the paediatric trigger tool and review of patient records; improving medication administration; and decreasing hospital acquired infection rates such as MRSA, central line and surgical site infections.

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. All our specialties have now identified at least two clinical outcome measures, some of which we have already published on our internet site. A plan to measure, analyse and publish all identified outcome measures over the next year is firmly in place.

Last year the Trust made a formal decision to apply for Foundation Trust (FT) status. We strongly believe that becoming an NHS FT will allow us to retain our independence and thus be able to protect our exclusive focus on children's healthcare needs. We want this because we believe it will help us deliver better care for children and their families, and increase the number of children we can help at GOSH, in the UK and across the world.

Furthermore, we recognise additional benefits for our families that arise from FT status. Becoming a membership organisation helps us to work even better with our key stakeholders and to seek new ways to actively involve young people and their families in our decision making. We have already recruited more than 7,000 members, and we have begun to use them in a variety of ways to help us improve our services. Greater financial flexibility as an FT will additionally allow us to seek wider funding options for our work and support our mission to deliver world-class and pioneering clinical care and research and to collaborate with others to share that knowledge.

We submitted our FT application to the Department of Health in February 2010 and we are now preparing for the final Monitor assessment process.

One of our key aims of 2010/11 was to ensure that we achieved better than average satisfaction scores in the national staff survey by ensuring that all staff work in a supportive team environment with good education and training opportunities. We achieved better than average scores across a large number of satisfaction measures. Our staff members told us that they felt valued by work colleagues, that there was a strong quality of job design and that they received good support from immediate managers. Our staff members also told us they were very pleased with the level of education and support available and reported strong overall job satisfaction. However, staff did report lower than average satisfaction rates against the quality of work they were able to deliver. The feedback from the report will support our workforce development plans over the coming year.

Last year I outlined our ambitious estate and capital redevelopment programme, which will see the construction of the Morgan Stanley Clinical Building and the refurbishment of the Cardiac Wing replacing part of the ageing Southwood building. The new centre will allow us to treat up to 20 per cent more children and will contain: 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. Tele-medicine and tele-education facilities will be installed, enabling peer practitioners around the world to observe surgical interventions and other treatments via video linkup.

I am please to report that the operational commissioning effort for the Morgan Stanley Clinical Building that is due to be handed over by the contractor in December 2011 has started and services will begin to move to the new facility between March and May next year. Furthermore the enabling works for the next stage of the project, stage 2B, are planned for August 2011.

We set an ambitious savings target of £17m across the organisation for 2010/11, of which we realised £11.7m, over £1m more than we had achieved in 2009/10. By making good progress against our efficiency savings and by increasing our income through treating more patients we were able to deliver our planned financial surplus. We will continue to strengthen our efficiency savings programme and develop schemes on a Trust wide basis in order to achieve the stretching targets we have set ourselves in the coming years. We are also working closely with the University College London Partnership (UCLP) to ensure that we are able to leverage maximum efficiency benefits from the programme.

This annual plan sets out our priorities and plans for the current year and details how we will manage the associated clinical, governance and financial risks.

Jane Collins

Dr Jane Collins
Chief Executive

2.2 Progress against our objectives

We have made good progress against our 2010/11 objectives. For the year we had 78 actions grouped into 22 work streams. These were identified as necessary to move us towards achievement of our strategic objectives. We have reviewed these actions at the end of the year. Of the 78 actions 61 were rated Green, 14 Amber and 3 Red. Those rated Red include actions relating to Advanced Access to outpatients, which has progressed slower than planned, compliance with infection control standards (specifically C.difficile) and Business Process Management (BPM) which did not gain Board approval.

The tables below outline our progress against both our strategic objectives and our key deliverable measures.

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

Workstream	Action	RAG
Maintain our focus on Zero Harm		
Continue the development of systems to decrease adverse drug events by concentrating on high risk medications and high risk areas in the Trust with the aim of a 50% reduction in adverse drug events in each high risk clinical area.	Progress during year focused on Paediatric Intensive Care Unit (PICU) and the Cardiac Intensive Care Unit (CICU), with good progress on CICU. Work to create a dedicated medicines management post has been slow to move forward and progress in other high risk areas across the Trust has been slow.	Amber
Achieve 50% reduction in each specific hospital acquired infections including Central Venous Line infections (CVL), Surgical Site infections (SSI) and Ventilator Associated Pneumonia (VAP) from current baseline over the next year.	Much progress has been made against collecting baseline data for SSI. We have continued to make good progress in reducing infection rates in the targeted areas but CVL rates were above the target we set ourselves.	Amber
Continue weekly Executive walkabouts and audit actions quarterly.	Executive walkabouts are happening every week. A new model for the monthly review of new and outstanding actions has been agreed.	Green
Review the Intensive Care Outreach team (ICON) pilot and the current 'Hospital at Night Team' and build on the successes of these two services to deliver integrated support for the sickest children on our ward.	ICON has been agreed as a permanent service. The Standard Operating Procedure for the Hospital at Night team has been finalised and the General Paediatric Consultants have been appointed.	Green
Maintain Child Protection structures and processes to support safe child protection practice. Child protection supervision policies to be fully implemented	Progressing as per plans. No priority actions. Haringey SIT visit very successful. Plans for GOSH SIT and Haringey OFSTED in January on track.	Green
Achieve compliance with infection control national standards.	For the year the Trust has reported 11 cases against a year trajectory of 9. Therefore we have not achieved the CDI Target as currently set. The DH have not yet agreed to a paediatric target different from adult. The DH advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) will be presenting our opinion on this again soon. A single case of MRSA was reported in the year against a target of 2.	Red

Spread the Situation, Background, Assessment, Recommendations and Decision (SBARD) communication tool and the Children's Early Warning Score (CEWS) throughout the Trust to ensure it is used by all staff.	Considerable work has been done to agree a Trust approach to CEWS. Awareness has been raised and the tool has been disseminated across clinical areas. Further work has been identified to improve the level of observation, interpretation and action for all staff.	Amber
Ensure Safety First is a key agenda item for all appropriate meetings.	Safety is a top agenda item on the Trust Board (TB) and Management Board (MB) agendas. The Trust has agreed that at least 25% of all main committee work is related to quality issues - this is already in place for the TB, MB and the Clinical Governance Committee..	Green
Introduce surgical check list before 100% theatre sessions.	At the end of February 62% of surgical cases had all elements of the surgical safety checklist completed. There has been a steady upward trend over the year.	Green
Establish the level of harm as determined by the paediatric trigger tool.	This has been completed. Monthly monitoring is ongoing.	Green
Implement the Priority Actions for Health Plan for phase 2 (Jan - June 2010) and phase 3 (July 2010 onwards) identified in the safeguarding plan for Haring	This task has been incorporated into Task 2016 which details the overall strategic management of safeguarding children and young people across all GOSH sites	Green
Report Clinical Outcomes/Patient-Reported Outcome Measures (PROMS) through operational performance reviews and agree actions to improve.	Action plans have been developed for the clinical units to aid with the development and publication of the outcome measures in each of the units. All units March performance reviews have included a sample of outcome measures currently available and at the end of March 2011 some of these outcome measures will be available on the external website.	Amber
Continue to monitor new National Institute for Clinical Excellence / National Service Framework (NICE/NSF) guidance through the Quality and Safety meetings	The NICE and NSF guidance continue to be monitored through the Quality and Safety Committee on a quarterly basis.	Green
Develop benchmarking standards with international best practice across all units.	An outcomes database is in development to incorporate publications, presentations and research on clinical outcomes which will identify areas where there is explicit benchmarking standards. A system previously identified a suitable to support this process was found to be unviable.	Amber
To develop and publish a trustwide Quality Account by June 2010 in line with the Department of Health (DH) Quality Account Toolkit Advisory guidance.	The 2010 Quality Account was published in June 2010. Good progress is being made and we are on track to produce the quality account 2010\11 in June 2011.	Green
To finalise our Quality and Innovation (CQUIN) measures with our lead commissioners and start reporting against these by May 2010.	CQUIN measures have been in place for most of the year except where it has been agreed with commissioners that they needed to be redesigned.	Green

2. Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations

Workstream	Action	RAG
2.1 Develop a consistent monitoring system to measure expectations, and whether we meet these.		
Implement Patient and Public Involvement/Engagement Strategy	Progress is on schedule; all 2010-11 targets were met. Year 3 of the action plan has been agreed and will be implemented in 2011-12.	Green

2.2 Continue to reduce waiting times further through our 'no waits' programme		
Complete the roll out of Advanced Access OPD across all specialties	Target was for all specialties to have graduated by December 2010. By January 2011 19 out of 35 had achieved this. Responsibility for delivery has now been devolved to the Clinical Units and recovery plans are being confirmed and reported via Transformation Board. We now expect that this work to continue over the summer.	Red
Ensure we have a robust action plan to continue to meet all national access targets as described in the Trust Access Policy	18 weeks continues to be achieved. We are reporting a number of waits across some services of over 13 and 26 weeks.	Green
2.3 Improve the standard of customer service that we offer patients and families		
Continue to improve the patient and family experience and measure effectiveness, specifically focussing on areas highlighted in the Ipsos MORI survey.	We have approved a Patient Experience strategy and action plan. The plan will be implemented in 2011-12	Green
Ensure all staff receive an appropriate level of customer service training via inductions, update or bespoke events.	Actions on target	Green
2.4 Improve our understanding of our referrers, and their requirements and improve our service to meet these requirements		
Achieve contractual standards for discharge summaries	Performance for the completion of discharge summaries improved substantially in year and settled around 70%. Work continues although the support from PCTs around GP details is hindering the move to an electronic system.	Amber
Undertake an analysis of our referral patterns, market share and competitors across all specialties to better understand our key referrers.	Market share information was presented quarterly. Meetings and action plans developed for specialties that are not achieving market share progress as planned.	Green
Review this analysis in conjunction with our pattern of outreach clinics and consider a more formalised model of partnership with referring hospitals	We have had only one response to referrer's newsletter request for outreach clinics. We are looking to develop more targeted outreach clinics in Cardiology. We need to formally review the potential for outreach in Neurology.	Green
Develop an action plan for improvement following the results of the Referrer Survey.	Many actions were completed, including, publication of first newsletter, updated discharge summary templates, key referrers database and much improved timeliness. Projects underway include Trust wide bed management project, trial of PiMS cc list in two specialties and revising family information form. Generally good progress has been made.	Green

2.5 Continue to improve the patient environment through major upgrades, working closely with our charitable partners		
Continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the development of the Morgan Stanley Clinical Building due to complete in December 2011 and the continued development of the Phase 2b Full Business Case for final submission in July 2011.	The operational commissioning effort for the Morgan Stanley Clinical Building - due to be handed-over by the Contractor in December 2011 - has started and services will move to this new clinical facility between March and May 2012. The Enabling Works for Phase 2B will start on site in August 2011 and the Full Business Case for Phase 2B itself will be submitted in September 2011, following authorisation as a Foundation Trust."	Green
Invest within our 10 year capital programme to improve the patient environment within our existing buildings. Key deliverables will include at least one ward refurbishment; enhancement of out Patient facilities; upgrading public toilets in the Variety Club Building (VCB) and the start of renewing the patient entertainment system trust wide.	Robin, Fox, Woodland and RANU wards were all refurbished along with level 1 outpatient facilities and public toilets in the variety Club Building. Work commenced in December on a programme of engineering and building fabric works to theatres and will run till September.	Green
2.6 Through the Foundation Trust process increase membership and develop a strategy to involve members effectively		
Achieve required membership trajectory.	Membership target (8,000) achieved in December. Recruitment will continue.	Green
Formally agree constitution including election.	Our constitution has been approved by Trust Board and signed off by our solicitors.	Green
Integrate members into our management and governance processes.	Work continues on streamlining approaches to membership. The engagement strategy is now drafted and work is underway to establish communication events for potential new councillors	Green

3. Successfully deliver our clinical growth strategy

Workstream	Action	RAG
3.1 Deliver our planned in year growth		
Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).	Some growth was witnessed in 2010/11.	Green
Monitor compliance with new Access policy to minimise refusals.	All refusals are being recorded and reported at Management Board. A Bed Management workstream commenced with a specific aim to minimise and eventually eradicate refusals.	Green
Supported by the Transformation Team, deliver growth by redesigning processes to: Better utilise our assets; increase working hours e.g. Saturday; continue to reduce length of stay; improve theatre utilisation and increase day case rates.	The devolved Transformation restructure is now in place. New teams working well and key project commenced in bed management. Surgical pathway project progressing well with good increase in theatre utilisation.	Green
Identify early in year and work up potential future National Commissioning Group (NCG) bids. This includes the timely submission of phase 1 and 2 proposals	We have now had formal confirmation that services for Osteogenesis Imperfecta and Pseud-obstruction will be nationally designated for 2011-12. 8 stage 1 applications were submitted in December. The decision meeting has been postponed till April after which we should hear which are to be worked up as full cases.	Green

3.2 Revise future activity and growth plans		
Revise and update our IBP growth plan, considering general population increase, clinical and market share growth.	The third iteration of our activity and capacity model has been completed and letters of support have been received from all key commissioners for our plans.	Green
3.3 Maintain IPP service growth		
Review IPP workforce	Recruitment and retention improvements have enabled the opening of additional capacity within IPP and although there are continuing problems with recruiting band 6 nurses, the workforce turnover reduced from 23.9% to 12.9% during 2010/11. Sickness levels also fell from 4.1% to 4.0%. Recruitment continues via focussed recruitment campaigns as well as the Trust recruitment fares.	Green
Increase IPP physical capacity	During 2010/11 IPP implemented an increase in open beds by 18.5%, taking total inpatient beds to 32. In additional two business cases have been approved which will enable an additional 3 beds to be opened in 2011/12 and a further 9 beds in 2012/13.	Green
Review activity and improve efficiency	The activity was reviewed with particular focus on increasing accessibility to beds (patient numbers), increasing occupancy via improved bed management and increasing accessibility to outpatient facilities. All these targets have been achieved, as all types of patient activity has increased during 2010/11 when compared to 2009/10. Inpatient bed days have increased by 15.7%, day care bed days have increased by 5.3% and patients treated have increased by 3.4%. The outpatient attendances have also increased by 4.2%.	Green
Develop a formal IPP strategy and agree an action plan to deliver the strategy.	The IPP strategy was agreed at Trust Board in January 2011.	Green
3.4 Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards		
Work with the BLT to support the development of a paediatric trauma centre	We are working well with BLT. Still awaiting tender to be issued.	Amber
3.5 Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards		
Work with local government partners and other statutory bodies to ensure Haringey community paediatric services are working in partnership for the benefit of children	Work has gone to plan and we have achieved notable improvements in services in Haringey. The PCT has now re-commissioned the service with the Whittington Hospital to start in May.	Green
Work with partners to implement the agreed North West London Paediatric Surgery network.	The service has been established and is running under the oversight of the network board. GOSH are in attendance at each board meeting. Further milestones relate to establishing internal measures of success for the service and establishing a more formal SLA for 2011-12.	Green

Pending the outcome of consultation, work with North Middlesex University Hospital NHS (NMUH) to implement the new organisational model for paediatric services.	This work has been completed. All Service Level Agreements are signed and subject to biannual review.	Green
Achieve accreditation as a national paediatric cardiac centre through the new national processes, and plan to accommodate any further growth that arises from this process.	GOSH is included in all the options. Public Consultation on options is now underway.	Green
Establish a north London tertiary paediatric network.	Our response to the consultation is due shortly.	Amber
3.6 Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards		
Achieve accreditation as a national paediatric neuro centre through the new national processes, and plan to accommodate any further growth that arises from this process.	We received feedback from the national review on 8th October 2010. This confirmed that GOSH is the largest centre for Paediatric Neurosurgery in England, and provides the most comprehensive cover (in terms of dedicated paediatric neurosurgery staff). We continue to work within the review to gain benefits.	Green

4. Currently partnered with ICH, and moving to UCL Partners with AHSC, maintain and develop our position as the UK's top children's research organisation

Workstream	Action	RAG
4.1 Continue to develop partnership working		
Continue to work with University College London Partners (UCLP) and leverage benefits from this.	Positive working relations with UCLP continue, including close collaboration with other R& D units within the partnership.	Green
Agree operational and management arrangements for Great Ormond Street Hospital / Institute of Child Health (GOSH/ICH) joint research activity administered	A Service Level Agreement between ICH and the R& D office is to be signed off shortly, outlining operational and management arrangements.	Green
4.2 Develop and agree R&D strategies at clinical service level		
Agree the Trust's R& D strategy and ensure Clinical Unit R& D strategies fit with this.	Implementation of the strategy and closer working relations with clinical units is taking place.	Green
4.3 In year delivery (research)		
Strengthen our grant-writing infrastructure to increase our success in obtaining research grants	We have recruited to the new research facilitator posts are expect to see improvements in th equality of research applications.	Green
Continue to develop our R&D activities and ensure it is adequately funded. Carry out a review of the progress made in the first year of the Clinical Research Facility (CRF) and confirm strategy for the next five years.	The review of the R & D Office is complete and the new structure will be implemented. Considerable staff change process is required and is underway.	Green

Agree a financial plan for R&D which is consistent with The National Institute for Health Research (NIHR) priorities and facilitates development of successful research studies.	Transition of responsibility for R& D office to GOSH has enabled the review of all financial processes, documentation of procedures and by the end of the year the general ledger will include more specific accounting structure for R& D. A financial plan for R& D will be completed once the work to identify the accountability for existing grants has been completed.	Amber
Ensure there is an appropriate funding transition for activities currently funded by GOSH Children's Charity.	Applications have been made to the GOSH CC for the targeted value	Green

5. To work with our academic partners to ensure that we are provider of choice for specialist paediatric education and training in the UK

Workstream	Action	RAG
5.1 To work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK		
Commissioning of high quality educational programmes from Higher Education Institute (HEI).	GOSH remains the largest commissioning organisation for paediatric nurse education. Working in partnership with HEI's GOS continue to offer undergraduate modules, degree top up, postgraduate degree and doctoral programmes for all staff groups.	Green
Ensure successful bids for Multi Professional Education and Training Levy (MPET) funding, Medical & Dental Education Levy (MADEL) and Non Medical Education and training (NMET) – including additional recognition of specialist national paediatric activity.	PGME have been successful in submitting two London Deanery bids to support Simulation training.	Green
Continue to develop the use of new technologies for innovative delivery of educational programmes	We have continued to develop GOSHs Online Learning & Development Campus (GOLD). New packages support learning in Information Governance, Situation, Background, Assessment, Recommendation, Decision (SBARD) and Children's Early Warning Scores (CEWS), ePanda and pain management. In addition we have launched an online community that has a membership of over 3,000	Green
Understand and fulfil a lead role within University College London (UCL) Partners and realise potential for training in child health by ensuring developments in the treatment of the patient are fed into the education and training prospectus for medical and clinical workforce.	GOS part of sub-group being set up to look at Induction training across UCLP. In addition GOS and UCLH working together on designing a joint assessment centre to support UCLP Sterilization project.	Green
Develop our role as a leading education and training provider for other organisations e.g. North Middlesex University Hospital and Kuwait.	NMUH SLA has now been signed off. The Kuwait contract has commenced and the first training programmes have been delivered.	Green

Realise potential of Health Innovation and Education Cluster (HIEC) to ensure GOSH meets obligation to play a key national and international role in the development of child health professionals.	GOS recognises it plays a key national and international role in developing child health professionals for the future whilst ensuring the continued professional development of existing staff. We have developed various learning material and delivery opportunities designed for national and international uptake and access. This has led to the successful commencement of a 3 year partnership with the Kuwait Health Ministry to provide learning to their Haematology and Oncology paediatric services. In addition, GOS medical and clinical leads regularly speak at national and international conferences. We have also opened up selected internal training programmes to external delegates. We have worked to maximise our role in UCLP and the North Central London, North East London and Essex HIEC through working with our partners to ensure we share the learning and good practice. We are currently working across UCLP to develop an integrated approach to the provision of statutory and leadership training across UCLP.	Green

6. Deliver a financially stable organisation

Workstream	Action	RAG
6.1 Agree achievable CRES plan and ensure delivery through robust project and performance management		
Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered through clear project management	To date £11.9m of savings have been identified, of which £10.1m has been delivered (2010/11 target it £16.6m). £1.8m worth of further savings are progressing and are likely to be realised as finance assess the end of year activity position.	Amber
Agree a robust 5 year CRES programme, with external scrutiny, to fit with our overall Integrated Business Plan.	The Trust has agreed a robust 5 year CRES programme which is in line with the Integrated Business Plan, this been subjected to external scrutiny through the Foundation Trust application process. The focus will now shift to maintaining and updating this 5 year CRES programme.	Green
Manage services within budget, delivering efficiency e.g. reducing agency spend.	Projected year end surplus was achieved as planned.	Green
Invest within our capital programme to support increased revenue and decreased costs, including: Additional bed in Badger ward; additional outpatient capacity; reorganisation of Genetics and release of savings from the core lab development.	A range of projects are being considered prior to start of the new financial year. New guidance has been issued in December 2010, This has stimulated a range of ideas which are currently Genetics have moved to York House and are currently going through a rationalisation programme(six Months) Badger Ward approved at October Management Board currently being briefed and designed.	Amber
6.2 Improve efficiency through rolling out Managing Variability Programme		
Continue the roll-out of Variability and Flow (V& F) projects across the Trust, continuing to monitor the success of the cardiac project and completing	Programme to be revised with engine room projects - surgical pathway progressing and bed management commencing.	Amber

Ensure issues with Service line Reporting (SLR) system are resolved by Quarter 1 and the system is fully implemented and in use by the units by Quarter 3.	SLR and Patient Level Costings are now available centrally and SLR is being used by units to identify areas requiring financial improvement	Amber
Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.	This has been monitored with commissioners throughout the year.	Green
Complete revisions of funding baselines for the remaining National Commissioning Group (NCG) services (Transplant, Neuromuscular, Extracorporeal membrane oxygenation (ECMO) & Bridge to transplantation (BTT).	This was completed and increased funding secured.	Green
6.3 Ensure appropriate funding for our clinical services from commissioners		
Work within the GOSH charity to support their work to achieve the targeted level of fund-raising.	At the end of the year total charity income for 2011/12 was £57.9 million nearly £10 million ahead of the original target. This performance was assisted by a number of significant one-off donations.	Green

7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation

Workstream	Action	RAG
7.1 Make progress towards becoming a Foundation Trust		
Submit Foundation Trust (FT) application by agreed timetable with SHA.	Application documents were sent to Department of Health on 31 January 2011. The preparation for Monitor assessment has commenced.	Green
Ensure the Trust has a robust Long Term Financial Model (LTFM) for use in the FT application process. Ensure all financial matters required to achieve FT status are delivered e.g. working capital facility; insurance programme.	The various due diligence reviews of the LTFM by independent accountants have been completed successfully.	Green
7.2 Ensure that the Trust is compliant with regulatory requirements		
Ensure that the Trust retains registered status with CQC.	Work is ongoing to review an IT tool to support the process. Clinical Governance Committee and Audit Committee continue to seek assurance of compliance with the standards.	Green
Ensure that Information Governance (IG) processes are strengthened and the self assessment score in the IG toolkit is improved.	Head of IG appointed who is dedicated to improving IG processes. Information flows have been charted and used to identify IG risks. Critical systems have been identified and Information Asset owners and risk registers should be in place by end of March.	Green
The Public Health Action Plan is delivered in line with the Health and Adult Social Care Registration System.	Progress towards our Public Health objectives has been slow but steady over the past year, mainly due to staffing and resourcing issues. However, work continues with the Pharmacy department to raise awareness of public health issues and medicines literacy. Preliminary work towards the coming year's key pieces of work - improving immunisation of our patients and understanding the father-friendliness our services - has been completed and we are on schedule to meet the time lines set.	Green
Work towards achieving NHS Litigation Authority (NHSLA) level 3 Risk Assessment early in 2011.	No date has been confirmed regarding the Level 3 assessment.	Green

Ensure delivery of specific Information Governance requirements e.g. Pseudonymisation, NHS No, Data quality.	Priority has been given to developing the pseudonymisation work plan and targets for all workstreams have been met but there will remain further work to do to ensure all critical systems have been addressed. A new training module on GOLD has been developed but it is likely the national targets won't be achieved during 2010/11 and so work will continue to increase no of staff completing IG training assessment in 2011/12.	Amber
Ensure that the Trust achieves best practice in Data Quality standards for all information supporting decision making.	A Data Quality group was formed and met regularly during the year and a work plan established and followed. A new information tool was purchased to enable DQ processes to be carried out more effectively and is now working successfully.	Green
Deliver all projects included as current year projects within the Information Technology (IT) investment strategy approved by Trust Board in March 2010.	Currently on track Key projects include: - Server Virtualisation (Green) - Citrix Upgrade (Green) - Order Communications (Green) - ICT Storage and SAN migration (Green) - Asset tracking wireless (Green) - Microsoft Exchange (yellow due complexity of developing business case but progressing)	Green
If approved by Board, ensure Business Process Management (BPM) project progresses and meets all milestones in first year of implementation and there is a recognised improvement in Referral to Treatment (RTT) processes as a result of the pilot.	Trust Board did not approve the project. The fact that there was no other health provider who had implemented such a scheme limited the assurance available. As a result, a revised ICT Strategy was presented in March.	Red

Key deliverable measures	Year end position
Ensure GOSH retains full CQC registration by delivering key safety improvements and governance structures.	Achieved
Publish the Quality Account and demonstrate world-class benchmarked clinical outcomes.	Achieved
Progress Foundation Trust application.	Achieved
Improve congruency of clinical and R & D strategies.	Achieved
Leverage R&D and non R&D benefits from UCLP	Partially achieved
Secure advantages from the national paediatric cardiac & neuro surgery reviews.	Achieved
Complete the referrer survey and progress an agreed action plan.	Achieved
Deliver planned financial surplus through achieving income and efficiency goals.	Achieved
Deliver IT improvements to plan (including BPM if Trust Board approves).	Partially achieved
Progress Phase 2A building and 2B planning to meet future clinical needs.	Achieved
Achieve better than NHS average staff satisfaction scores by ensuring all staff work in a supportive team environment with good training and education opportunities.	Achieved
Ensure GOSH retains full CQC registration by delivering key safety improvements and governance structures.	Achieved

2.3 Our financial performance

The Trust's unaudited accounts report a retained surplus of £7.2M before impairments to property and £8.6M before these are accounted for – this is broadly in line with the forecast position.
Total revenue was £336.3M in 2010/11, an increase of £18.2M and 5.7% over the comparable values in 2009/10. It is important to note the North Middlesex service was discontinued effective May 2010.

NHS Inpatient activity increased by 4.5%
NHS day case activity increased by 0.9%
NHS outpatient increased by 11.5%

IPP inpatient activity increased by 15.7% on a bed day measure

IPP day case activity increased by 5.3% on a bed day basis
IPP outpatient activity increased by 4.2%

Operating expenditure was 4.5% higher than 2009/10 at £323M
The main changes relate to increased pay reflecting pay awards and agenda for change, higher drugs and clinical supplies, higher education costs, higher clinical negligence fees and higher costs of services bought from other NHS trusts net of reduced consultancy, depreciation and impairment charges.

Impairment was recorded following a review of asset valuations totalling £1.4M net.

Unaudited Position for 2010/11 outturn	£K
Revenue from patient care activities	283,881
Other operating revenue	52,426
Operating expenses - pay	-192,272
Operating expenses – non pay	-130,719
Operating Surplus	**13,316**
Investment revenue	68
Other gains and losses	**-633**
Finance costs	-31
Surplus for the financial year	**12,720**
PDC dividend	-5,551
Retained surplus for the year	**7,169**
Impairment	1,448
Position excluding impairment	**8,617**

2.3.1 Cash Releasing Efficiency Schemes (CRES)

We delivered £11.7m of efficiency savings across the organisation in 2010/11 against an ambitious target of £17m. We will continue to strengthen our efficiency savings programme and develop schemes on a Trust wide basis in order to achieve the stretching targets we have set ourselves in the coming years. We are also working closely with the University College London Partnership (UCLP) to ensure that we are able to leverage maximum efficiency benefits from the programme. In addition, we have improved the performance management of our CRES programmes, specifically in relation to greater analysis and more sophisticated reporting on the likelihood of schemes successfully delivering savings.

2.4 Improving quality

2.4.1 Care quality Commission (CQC)

From April 2010, all health and adult social care providers who provide regulated activities were required by law to be registered with the CQC under the new regulations of the Health and Social Care Act 2008. To remain registered providers must demonstrate that they are meeting new essential standards of quality and safety across all of the regulated activities they provide. The new system will make certain that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights. The system is focused on outcomes, rather than specific standards and processes, and places the views and experience of people who use services at the centre.

The CQC assessments of quality and safety are based on a range of external sources of information, some of which we are required to provide from our performance management systems, which are considered with information from other external monitoring sources. These data items are drawn together to create a quality risk profile for the Trust, which provides an estimate of the risk of non compliance with registration requirements.

To be registered, each trust must meet essential standards of quality and safety, which include:

- Involvement and information
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management

GOSH is registered with the CQC with no conditions attached to its registration. The CQC has not taken enforcement action against GOSH during 2010/11.

2.4.2 NHS Performance Framework

In April 2009, the Department of Health (DH) introduced the NHS Performance Framework to provide an assessment of the performance of NHS providers (that are not yet NHS Foundation Trusts) against a set of minimum standards. The Performance Framework identifies poor performance on an ongoing basis using a series of indicators from the domains of Finance and Quality of Service (which is comprised of Standards & Vital Signs, CQC Registration Status and User Experience) to trigger intervention as required.

The Framework sets clear thresholds for intervention in underperforming organisations and a rules-based process for escalation, including defined timescales for demonstrating improved performance. Organisational performance is assessed against a series of indicators using the most current data available, and the results trigger intervention by Strategic Health Authority and PCT commissioners in the case of performance concerns.

The table below sets out our performance over the year against the NHS Performance Framework indicators relevant to specialist paediatric hospitals. We have achieved all inpatient and outpatient waiting time and access targets. In terms of infection control we reported 1 case of MRSA in year against a year trajectory of 2. However, we did report 11 cases of C.difficile over the year against a locally agreed low trajectory of 9. It should be noted that the Department of Health advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) will be presenting our opinion on the relevance of this standard for specialist paediatric hospitals soon.

Performance Indicator	Numerator	Denominator	Target	Trust Performance			
				Q1	Q2	Q3	Q4
Cancelled ops - breaches of 28 days readmission guarantee as % of cancelled ops	The number of patients whose operation was cancelled, by the hospital, for non-clinical reasons, on the day of or after admission, who were not treated within 28 days	The number of patients whose operation was cancelled, by the hospital, for non-clinical reasons on the day of or after admission	5.0%				
MRSA	Actual number of MRSA	Planned number of MRSA	1				
C difficile	Actual number of C difficile cases	Planned number of C difficile	9				
Referral to Treatment - admitted - median			<=11.1				
Referral to Treatment - 95th percentile			<=27.7				
Referral to Treatment - non-admitted including audiology - 95th percentile			<=18.3				
RTT - incomplete - 95th percentile			<=36.1				
31 day second or subsequent treatment - surgery ~	Number of patients receiving subsequent/adjuvant treatment (surgery) within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer	Total number of patients receiving subsequent/adjuvant treatment (surgery) within a given period, including patients with recurrent cancer	94%				
31 day second or subsequent treatment - drug	Number of patients receiving subsequent/adjuvant treatment (drug) within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.	Total number of patients receiving subsequent/adjuvant treatment (drug) within a given period, including patients with recurrent cancer	98%				
31 day diagnosis to treatment for all cancers	Number of patients receiving first treatment within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer	Total number of patients receiving first treatment within a given period, including patients with recurrent cancer	96%				
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	Number of patients receiving subsequent/adjuvant treatment (radiotherapy) within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.	Total number of patients receiving subsequent/adjuvant treatment (radiotherapy) within a given period, including patients with recurrent cancer.	94%				

2.4.3 Monitor governance risk rating

In preparation for operating as a Foundation Trust (FT) we have also considered how we would have performed against the governance risk requirements of the FT independent regulator, Monitor. Monitor use a scoring system for assessing governance risk taking account of service performance, clinical quality and patient safety, and mandatory services. The implications associated with each level of governance risk are set out in the tables below.

Monitor rating matrix

Green	= a score of less than	1.0
Amber-green	= a score from	1.0 to 1.9
Amber-red	= a score from	2.0 to 3.9
Red	= a score of	4.0 or more

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

Monitor takes a proportionate approach where NHS FTs have increased levels of governance risk. For example, if the reason for the deterioration of a rating is a weakness in risk management processes, Monitor may require the Trust to provide a plan detailing how it proposes to address this. Failure to address issues on a timely basis (e.g. three consecutive quarters' failure to achieve the same national requirement) may result in a red rating and could lead to a significant breach of the Authorisation and possible regulatory action.

The table below describes our performance against the Monitor governance risk rating over 2010/11. Based on our performance we would have achieved a rating of Green over 1 of the quarters and Amber-Green over 3 of the quarters. This is due to not achieving our C. difficile trajectory.

Targets - weighted 1.0 (national requirements)	Thresholds	Weighting	Monitoring period	Q1	Q2	Q3	Q4
Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)	0	1	Quarterly	1	0	1	1
MRSA - meeting the MRSA objective	0	1	Quarterly	0	0	0	0
All cancers: 31-day wait for second or subsequent treatment comprising **either:**	TBC	1	Quarterly	0	0	0	0
Surgery	94%			0	0	0	0
anti cancer drug treatments	98%			0	0	0	0
radiotherapy (from 1 Jan 2011)	94%			0	0	0	0
Maximum time of 18 weeks from point of referral to treatment in aggregate and by specialty for admitted patients	90%	0.5/1.0	Quarterly	0	0	0	0
Maximum time of 18 weeks from point of referral to treatment in aggregate and by specialty for non- admitted	95%	0.5/1.0	Quarterly	0	0	0	0

patients							
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0	0	0	0
Screening all elective in-patients for MRSA	100%	0.5	Quarterly	0	0	0	0
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	0.5	Quarterly	0	0	0	0
Overall governance rating				**Amber -Green**	**Amber -Green**	**Green**	**Amber-Green**

2.4.4 Commissioning of Quality and Innovation (CQUIN)

The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation. The framework aims to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion. Each provider on a national standard contract is entitled to earn 1.5% of contract value subject to achieving goals in a CQUIN scheme. For 2010/11 we agreed 13 CQUIN measures for the Trust with our commissioners. These are described in the table below. We achieved 7 of the measures over the last year, partially achieved against 1 and did not meet 5.

We have now finalised and agreed a series of CQUIN measures for 2011/12 with our lead commissioners, which are detailed in appendix 1.

	Summary	Achieved	Evidence	Comments
Patient Surveys	An increase of 5% who strongly agree or agree that they felt they could complain and they would be taken seriously over 09/10 inpatient survey results	No	IPSOS MORI Inpatient Survey Results	The survey results showed a 1% reduction
	Not less than 90% who were very satisfied or fairly satisfied with their last visit to hospital over 09/10 inpatient survey results	Yes	IPSOS MORI Inpatient Survey Results	The survey results were up 2% to 96%
	An increase in the % who were very satisfied or fairly satisfied with the quality and variety of food from 57% to 65%, excl. oncology patients, patients on TPN and patients that are on non-solid food regimes over 09/10 inpatient survey results	No	IPSOS MORI Inpatient Survey Results	Satisfaction increased by 3% to 60%
	Report 2010-11 Inpatient and Outpatient Surveys	Yes	Presentation to CQRG	Presentation Date to be Confirmed - Suggest CQRG on the 6th June
Paediatric Trigger Tool	Publication of a report reviewing 160 cases auditing adverse events	Yes	Presentation to CQRG	Presentation Date to be Confirmed - Suggest CQRG on the 6th June

Discharge Information	% of discharge letters achieving the content criteria	Yes	Internal Trust Audit Report	
	% of elective patients with an EDD within 24 hours of admission	Yes	Internal Trust Audit Report	
	% of outpatient letters sent within 5 days of attendance and within the content standards	No	Internal Trust Audit Report	
TPN	Increase in the percentage of children with severe intestinal failure who are receiving parenteral nutrition who have recorded measurement of nutritional blood tests (Cu, Zn, Se, vitamins A and E) in accordance with best practice guidelines. A systematic method of monitoring of complications from parenteral nutrition administration to be implemented during Q1 and reports on complications identified to be sent to the Agency quarterly thereafter.	No	The Trust has not reported this CQUIN	
Surgical Site Infections	Implementation of continuous (12 month from April 1 2010 to March 31 2011) surgical site infection surveillance (SSIS) for all inpatients and 30 days post-discharge in two specialties: spinal implant surgery and urology. Monitoring of cardiac surgery (open and closed) for inpatients for 3 months during 2010/11.	Yes/No	Report from the Director of Infection Control	Established in neurosurgery, craniofacial surgery and tracheal and thoracic surgery
	Reduction in Urology SSI's from 8-6.	No	Report from the Director of Infection Control	The level of SSI's in urology remained at 8
Central Venous Catheter Infections	20% reduction in the rate of CVC related blood stream infections. Rates reduced to 2.4% per 1000 line days	Yes	Report from the Director of Infection Control	The Trust reduced the CVC Infection rate from 3.26/ 1000 line days to 2.61/1000 line days
Ventilator Associated Pneumonia on PICU	Remain 50% below baseline rate of 7	Yes	Report from the Director of Infection Control	2 episodes were detected in year

2.4.5 Managing risk

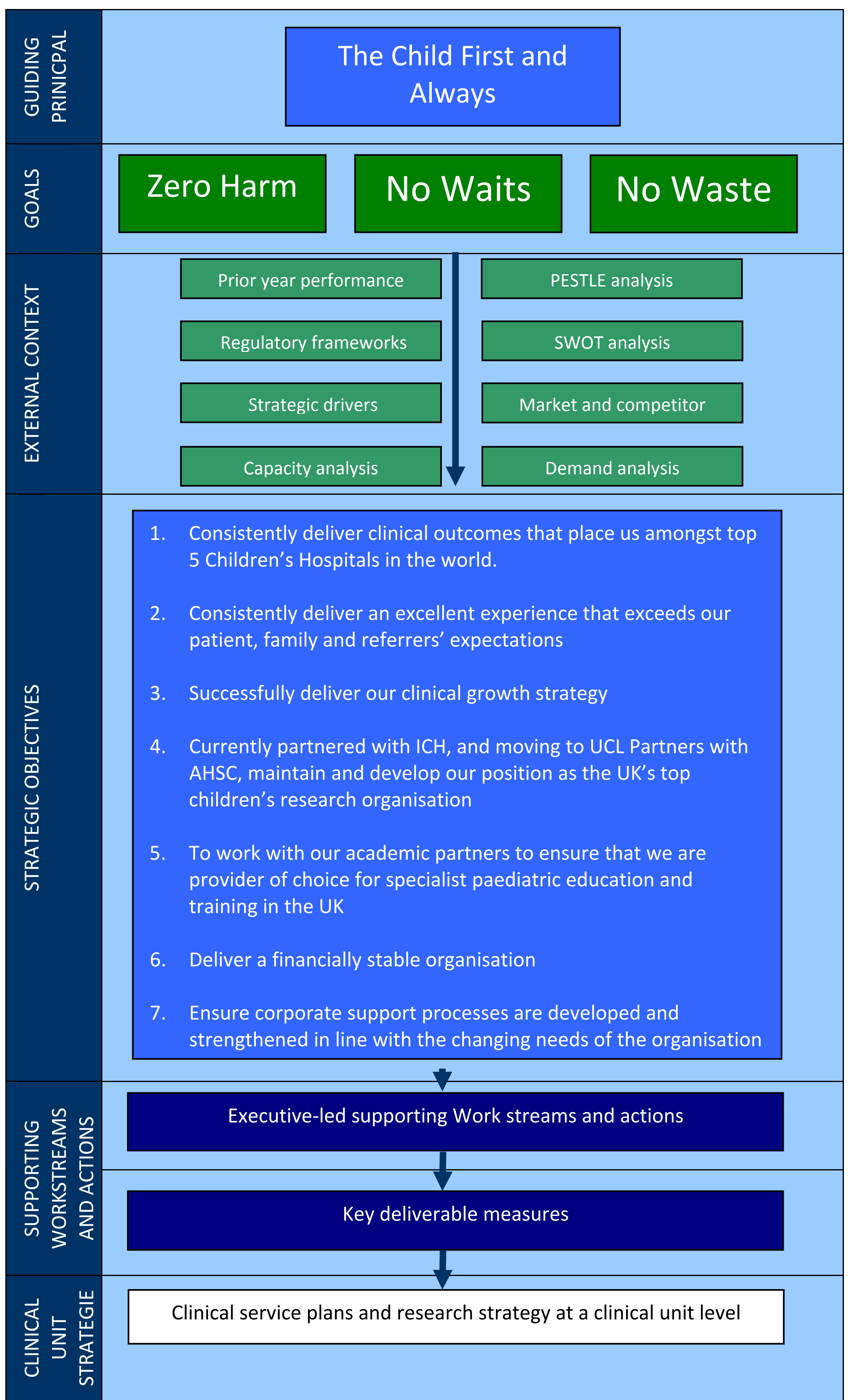
In November 2009, Great Ormond Street Hospital was assessed by the National Health Service Litigation Authority[i] against the Level 2 Risk Management Standards for Acute Trusts. This is an NHS risk based insurance scheme that assists Trusts in the management of claims and litigation. The assessment 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

[i] The 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).

including infection control and the ways that we ensure we learn from experience. The Trust was successful in achieving Level 2 compliance, scoring 49 out of a possible 50 in total. This is an important achievement as it assists the Trust to demonstrate compliance with other regulatory bodies including the CQC. The Trust maintained Level 2 compliance in 2010/11 and will be applying for Level 3 in the near future.

3. Our Priorities and Plans for the Future

Fig. 1 Summary of the planning process



The diagram on the previous page summarises the process we went through as an organisation to identify our priority workstreams and supporting actions for the year ahead.

We considered our purpose and values and the internal and external contexts in which we will operating during 2010/11. 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. We additionally confirmed that our strategic objectives remain fit for purpose going forward into the new financial year.

The following sections outline the work that we undertook in relation to each of the areas above.

- Past year performance
- Analysing the external environment
  - PESTLE Analysis
  - Strengths, weakness, opportunities and threats (SWOT) analysis
  - Analysis of regulatory requirements and policy
  - Drivers for change
- Strategic drivers
- Review and forecast of activity and demand
- Review of our internal capacity

3.1 Analysing the External Environment

The Trust Board has considered a 'PESTLE' analysis, identifying key changes to the political, economic, social, technological, legal and environmental landscapes that may potentially impact on the Trust. We have used this analysis to support and inform our strategic and development plans for the forthcoming year and in the longer term for our FT business plan application.

Influence	Analysis	Competitive response
Political (at DoH or more local levels, NHS reform, national reviews etc)	GOSH is the most famous brand in the NHS and as such attracts much political and media attention. Current NHS policy is to localise services where possible and to centralise complex services where this delivers better clinical outcomes. This is highlighted by national Safe and Sustainable reviews in Paediatric Cardiac and Neurosurgery and the London wide review of complex paediatric services. The Government has introduced a greater "test" for reconfiguration proposals, particularly involving primary care. The government also plan to move the vast majority of commissioning to GPs, and at this stage it is unclear what proportion of the GOSH income this will apply to.	GOSH is acutely aware of the strength of its brand and will ensure that any strategic decisions reached that have the potential to impact on the brand are appropriately considered. If these involve a partnership arrangement with another organisation then GOSH will adhere to the Partnerships policy (see Annex 4-4). GOSH will actively participate in any local or national processes which review the provision of specialist paediatric services. To facilitate change GOSH will support and work proactively and sensitively with any other provider which may be adversely affected by any reconfiguration. GOSH will develop a close working relationship with new commissioning organisations.
Economic (NHS funding, private / overseas, credit availability, wage rates etc)	The economic situation means that the NHS will need to make efficiency savings of around £20billion to meet expected demands and increased costs. For GOSH this will manifest itself in reduction in tariff and pressure from commissioners to reduce activity levels. The latter is likely to have less of an impact on GOSH then other acute Trusts for several reasons: 1. With the exception of NSCG, GOSH is a relatively small provider in financial terms and as such the focus of a commissioner's drive is to reduce	One of the key GOSH competitive strategies is to improve efficiency. This will assist GOSH is remaining financially viable in a climate of declining tariffs and other economic challenges for providers. GOSH has increased resources to support the delivery of Cost Reduction and Efficiency Savings (CRES) and will maintain the delivery of these as a high priority for the organisation. The GOSH strategy is growth in services that

	contract activity with their larger providers. 2. The move towards centralisation of complex services will increase the demands for activity at GOSH, whilst actually saving the commissioners money by providing the right treatment in a timely manner. 3. GOSH has a very broad specialty base across a very broad commissioner base and as such the commissioners needs to deliver demand management schemes or the rationalisations of treatments are highly unlikely to affect services provided by GOSH. The GOSH charity provides extensive funding (mostly capital) to the Trust and this support is expected to continue for the foreseeable future. GOSH also has the financial support of a sizeable R & D function, private and international business and other charities. The centrally imposed restrictions on NHS pay increases could lead to increased difficulties in the recruitment and retention of staff.	it already provides. This strategy is the least challenging in ensuring the improvement of contribution of clinical services to counter the depression of tariff in a PbR led system. GOSH will retain its broad commissioner and specialty base thus spreading financial risk across the organisation and across the health economy.
Sociological (cultural attitudes, demographics etc)	The London and south east England population of 0-14 year olds will increase by an average of 1% per year according to ONS estimates. This will lead to a proportionate increase in demand for specialist paediatric services.	GOSH will continue to service the populations with the greatest underlying clinical need and actively reach out to support ethnic groups with intrinsically higher levels of complex paediatric health needs
Technological (changes to treatments, new technologies etc)	Technological changes will affect all specialties but this will be on a specialty by specialty basis. The likely overall impact of these will be increased work rather than any radical new developments that lead to the decline in demand for treatments at GOSH.	GOSH is a member of the UCL Partners AHSC, with a dedicated UCL departmental partner in the Institute of Child Health. This will ensure that GOSH is at the forefront of any technological developments that will change the way that healthcare is provided in GOSH services. GOSH has an ambitious R & D strategy (see Annex 3-4) which will ensure that GOSH retains and indeed enhances its position as the leading UK provider of paediatric research and development.
Legal (EWTD, safety legislation etc)	EWTD is causing continuing problems with junior doctor staffing, in terms of maintaining adequate training opportunities, the ability to achieve safe and compliant emergency rotas and the ability to service the elective workload.	GOSH is about to implement an innovative approach to the continuing challenges of the EWTD on training grade medical teams by establishing a hospital wide general paediatric team to support key specialties within the Trust.
Environmental (probably not much for services, maybe travel)	Further demands for patients to be treated as close to home as feasible, with care closer to home being a pivotal stream of NHS philosophy.	GOSH will continue to embrace and actively develop treatments closer to home – this is exemplified by GOSH developing Europe's first home haemodialysis service.

3.2 Regulatory Frameworks

3.2.1 NHS Operating Framework

The 2011/12 NHS Operating Framework sets out the challenge of continuing to deliver high quality care for our patients, while beginning in earnest the transition to the new system envisaged in *Equity and excellence: Liberating the NHS*. The over-arching goal in this period will to build strong foundations for the new system by maintaining and improving quality, by keeping tight financial control and delivering on the quality and productivity challenge, and by creating energy and momentum for transition and reform.

The framework additionally sets out the national priorities for 2011/12, including maintaining performance on key waiting times, continuing to reduce healthcare associated infections, and reducing emergency readmission rates. The DH will continue to develop the quality framework in 2011/12 in anticipation of the new role of the NHS Commissioning Board in driving quality improvement across the system and NICE will begin work on 31 new Quality Standards next year to add to the 15 already completed or in development. Meanwhile quality accounts will be extended to cover community services for the first time.

The DH has made it clear that local commissioners should hold providers to Constitutional rights and contractual commitments. This includes achievement of a maximum waiting time of 18 weeks for admitted and non admitted patients in addition to recently published additional thresholds for the median and 95th percentile pathway waits. NHS London will also continue to monitor (and DH will continue to publish) waiting times for diagnostic procedures, which, as a key element of the 18 week pathway, should be no longer than 6 weeks.

3.3 Monitor compliance framework

We have considered the requirements set out in Monitor's compliance framework in preparation for being authorised as an FT later in year. Monitor's *Compliance Framework* sets out the approach Monitor will take to assess the compliance of NHS foundation trusts with their terms of Authorisation ("the Authorisation") and to intervene where necessary.

The most recent version of the *Compliance Framework* was published in March 2011 and includes the following revisions:

- changes to board statements to reflect Monitor's *Quality Governance Framework*;
- the inclusion, as in previous years, of relevant priorities from the *Operating Framework for the NHS 2011/12*, which was published on 15 December 2010, including new referral-to-treatment time measures and A&E clinical quality indicators;
- a refinement of our approach with regard to incorporating asset efficiency within our financial risk ratings;
- a revision of how Monitor will incorporate Care Quality Commission judgements in its governance risk ratings;
- the inclusion of NHS Litigation Authority Clinical Negligence Scheme for Trusts (CNST) levels in Monitor's governance risk rating;
- the impact of material data submission failures or misrepresentations by NHS foundation trusts; and
- the regulatory consequences of a financial risk rating of 2.

This revised *Compliance Framework* applies from 1 April 2011 and forms the basis on which annual plan submissions and subsequent in-year reports will be made in 2011 onwards.

3.4 Porter's Five Forces

Porter's Five Forces analysis is a measure of the competitive intensity of a market. It analyses the potential influence that external factors could have upon the services we provide. Used along side our

SWOT analysis (below) it reveals the areas and competitors that we must consider when devising our service strategy.

Competitive Force	Analysis	Competitive response
Referrer Power (what power and likelihood is there of referrers changing allegiance)	Referral to GOSH will almost always be decided by the referring secondary care clinician, with this decision being based on many factors, including clinical care, location, service provision, historical referrals routes, and quality of communication from the specialist centre. In the last referrer survey, GOSH rated extremely well for clinical quality, but had many areas of improvement with its communication to referrers and shared care providers. Ensuring GOSH maintains and grows excellent relationships with referrers and provides quality and timely communication links is the single most important factor in determining the future level of GOSH activity and hence overall viability. Referrer power is especially strong for international workload with many competitors especially in Germany and the US.	GOSH has recently commissioned an external survey of referrers to GOSH, which highlights communication as being an area for improvement. GOSH take this very seriously and as such has included referrer's experience as one of the key competitive strategies in this IBP. Additionally implementing an action plan from the survey is one of the Trust's key deliverables for 2010/11.
Patient / Parent Power (what power and likelihood is there of patients / parents exerting choice)	Although the development of patient choice is a key NHS priority, few of GOSH's services are directly affected because of the low levels of primary care referrals. However, the impact of patient (or parent) decision in tertiary care cannot be underestimated. With the explosion of information through the internet more and more patients are making informed choices about where to be treated. Targeted marketing for specialised services would result in more families requesting to be referred to GOSH.	GOSH will continue to work with the charity to retain the hospital's high profile in the media. This is highlighted by recent BBC programmes set on GOSH and numerous positive press stories.
Suppliers Power (what influence could inputs to the service have – e.g. consumables and most importantly workforce)	The key area of potential suppliers' power is in the availability of appropriately trained staff, this affects most clinical staff groups. This has the potential to have a significant restriction on growth objectives.	GOSH is well aware that the level of growth aimed for within the IBP will require the improved recruitment and retention of the key staffing groups. Strategies to deliver the workforce required is covered in the workforce strategy (see section 8)
Threat of New Entrants (could another hospital move into this service – either NHS or private)	This depends on the specialty, but in the majority of areas this is unlikely. The set up costs and ongoing minimum infrastructure costs for viable safe specialist children's services would be very prohibitive. The most likely new entrant would be an expansion of certain "missing" specialties from the paediatric portfolio at Guys.	The greatest risk of this is the expansion of "missing" paediatric specialties at Guy's. This risk is significantly reduced if GOSH and Guy's being designated as specialist paediatric hubs north and south of the Thames. Additionally the GOSH activity plan does not aim to pursue additional workload from South London and surrounding area which can be provided by Guy's.
Threat of Substitution Products (could a new drug or less invasive treatment replace parts of the	This will be completely dependent on each specialty and disease type within each specialty. However, across the whole medical spectrum gene therapy and stem cell transplantation are the developments most likely to cause a radical change in the delivery	GOSH is a world leader in development in the two most likely areas of product substitution - gene therapy and stem cell transplantation and any developments will gain workload at the Trust rather than present a risk of reduced activity

service)	of healthcare. GOSH is at the forefront of developments in both these fields (e.g. Duchenne MD for gene therapy and tracheal stem cell transplantation) and any developments will gain workload at the Trust rather than present a risk of reduced activity	

3.5 SWOT Analysis and response

The table below details a SWOT analysis that has been completed by the Executive Team. The issues included are addressed to ensure that strengths and opportunities are being used to our advantage and threats and weaknesses are mitigated. These are shown in the tables below.

	Strengths	Optimise Strength	Opportunities	Optimise Opportunity
Brand	• Strong reputation / public loyalty and brand name for clinical excellence	• Ensure that all partnership arrangements consider this aspect – Partnership Policy	• Foundation Trust membership provides opportunity to leverage brand reputation more effectively	• Dedicate resources to FT application • Open additional IPP resources to utilise strength of the brand.
Clinical services	• Offer the widest range of paediatric services supported by specialist paediatric-focused infrastructure; critical mass of services in terms of staffing.	• No plans to decommission any specialties. • Continued development of clinical services. • Develop a General Paediatric team to assist with the management of complex multi specialty patients.	• Involving membership in the development of new ideas and plans for the hospital • Growth of specialist services from other providers as part of rationalisation. • GOSH 2010 Transformation Programme • National reviews of paediatric cardiac and neurosurgery services	• Extensive consultation during FT application and membership strategy • Develop capacity to be able to accept workload from any reconfiguration. If reconfiguration does not occur then gain business through proactive marketing. • Transformation programme to progress as planned
Staff	• Dedicated, highly sub-specialised clinicians working in multi-disciplinary teams	• Continue to support staff with Education Strategy	• Recruitment strategy helps to grow sustainable staffing levels in the medium to long term	• Market the Trust and attract candidates to posts at GOSH, specifically focusing on the world class opportunities in research, education, and training.

	Strengths	Optimise Strength	Opportunities	Optimise Opportunity
Referrers	• Strong referral base, supported by outreach and shared care arrangements • Broad commissioner base	• Objective to increase market share for quaternary services, and in North London and surrounding area for tertiary services. • Develop further formal shared care arrangements • Review outreach clinics from the referrer's survey supporting a strategy of tactical development – for example in Neurology	• Growth of specialist services, particularly those which generate surplus income through patient choice and stronger links with referrers	• Priority specialties identified from those with greatest opportunity to grow. • Competitive strategy developed in IBP
Research	• Research and Development, academic input and innovation demonstrated by Biomedical Research Centre award • Member of the UCL Partners Academic Health Sciences Centre (AHSC)	• Maintain UCLP focus	• Clear strategy for translational research attracts new funding streams • Development of income-generating support services and R&D ventures	• Invest in additional resources in the R & D office to support researchers. • Developed an R & D strategy to increase activity in the organisation.
Education	• Educational activity with Institute of Child Health, London South Bank University and higher education institutions and internal blended learning approach	• Use UCL partners and the health innovation and education cluster (HIEC) to develop the quality and range of educational services provided.	• Development of training services to offer to third parties	• Update and review the training prospectus to ensure it remains relevant to the needs of staff, patients and partners. • Review our prospectus for opportunities to develop commercial opportunities for the Trust.

	Strengths	Optimise Strength	Opportunities	Optimise Opportunity
Resources	• GOSH Children's Charity fundraising capacity	• Continue to support the efforts of the Charity with congruent aims, proactive marketing in GOSH and clinical engagement	• Hospital redevelopment programme to expand capacity and facilitate new models of care • Foundation Trust financial freedoms	• Starting development of 2B business case • Dedicate resources to FT application • Reviewing 2 A redevelopment to ensure that capacity matches demand

	WEAKNESSES	Weakness mitigations	THREATS	Threat Mitigations
Brand	• Inconsistent communication on priorities and development plans	• IBP and annual plan will become the single Trust plan and is being well communicated	• Failure to achieve Foundation Trust status and the potential for the hospital to lose its independence • Performance issues lead to reputation damage	• Dedicate resources to FT application • High level emphasis on performance with regular board level reporting
Clinical services	• Large patient population with multiple needs	• Service development of general paediatric team to help manage patients with multiple needs • ICON service development – providing a rapid response to deterioration in children. • CEWS system development • IBP outlines priority specialties for management and resource focus	• Risk from hospital acquired infection (includes decontamination & cleanliness)	• Transformation project focus on reducing SSIs, VAPs and CLIs. • Decontamination review and subsequent business case • Key aspect of zero harm agenda

	WEAKNESSES	Weakness mitigations	THREATS	Threat Mitigations
Staff	• Availability of staff. Recruitment problems in some key clinical and non clinical areas, exacerbated by central London location, creating clinical capacity issues	• Train and develop staff with the skills to work in acute paediatric settings. • Continue to develop the range of staff benefits which encourage and reward staff who join GOSH and remain at the Trust.	• Competition for qualified staff from other providers • Recruitment and retention difficulties due to planned public sector pay rise constraints	• Range of staff benefits targeted to address the reasons staff give for leaving, such as subsidised accommodation, childcare vouchers; on site nursery and play scheme; subsidised season ticket loans and cycle vouchers; social activities and awards to encourage staff to feel part of the GOSH "family".
Referrers	• Ability to accept all appropriate referrals • Timeliness of communication with referrers	• Launch of Referrers Experience Programme • Establishing sufficient capacity to cope with peaks and troughs of demand.	• Competition for national and regional market share • Competition for international market share	• Referrers experience programme • Ensure world class outcomes • Proactive marketing
Research	• Measuring outcomes for some specialist work	• Dedicated outcomes project and post holder.	• On-going need to bid for research funding	• Invest in the R & D office • R & D strategy to increase activity in the organisation • Maintain leading role in UCLP
Education	• Insufficient capacity to respond quickly to service re-design • Poor facilities for simulated learning • Lack of integration of all learning opportunities	• Development of transformation learning programme. • Business case for simulated learning facility. • Development of integrated learning programmes.	• Economic situation will affect funding and potential market development.	• Focus on statutory requirements distinctive services. • Business development in markets less affected by the economic situation (e.g. Kuwait).

	WEAKNESSES	Weakness mitigations	THREATS	Threat Mitigations
Resources	• Space constraints on Great Ormond Street site, including inflexible buildings • Sub-optimal use of key resources (e.g. beds, theatres)	• Saturday operating and procedures • Extended cardiac surgery operating • Continuation of Transformation Project	• Financial instability driven by changes to NHS funding systems • Failure to meet efficiency improvement targets • Requirement to reduce expenditure in the public sector due to recession • Validity of PbR system for highly specialised children's services	• Maintain active involvement in Children's Hospitals Group • Transformation programme • Efficiency is a competitive strategy

3.6 Strategic drivers

3.6.1 Equity and Excellence: Liberating the NHS

Following publication of the White Paper "Equity and Excellence: Liberating the NHS", we have assessed how the proposed development will affect GOSH.

The key changes for GOSH are:

- Focus on quality and safety; driven by commissioning
- Extension of clinical and patient reported outcome measures
- Extension of choice
- Development of the National Commissioning Board
- Removal of the private patient income cap

The paper sets out how quality is expected to be rewarded financially. Tariffs will be refined and the implementation of best-practice tariffs will be accelerated. Key changes relevant for GOSH include a mandate in 2011/12 for national currencies for neonatal critical care; a review of the payments system to support end-of-life care (including options for per-patient funding); and an accelerated development of pathway tariffs. The CQUINs payment framework will also be extended and poor quality care may be penalised by fines, focussing in particular on an extended list of 'never events'.

The development of a National Commissioning Board (NCB) has been proposed, which has a role in commissioning national specialist services and regional specialist services as set out in the Specialist Services National Definitions Set. The majority of our work will be covered by the Definitions Set with fewer of our services being covered by the GP consortia. We expect that at least 81% of our activity will be commissioned by the NCB, and possibly over 90%, depending on interpretation of the definitions. In addition, the current private patient income cap for foundation trusts will be removed. This will provide us with an opportunity to increase our international work and thereby increase money to invest in our NHS services.

3.6.2 Strategic national reviews

The National Specialised Commissioning Group (NCG) is currently leading a number of service development programmes. These include: The Safe and Sustainable Children's Cardiac Surgery Services Programme and the Safe and Sustainable Children's Neurosurgical Services Review.

The objective of the Cardiac Surgery Services programme is the delivery of a safe and sustainable service into the future. There are currently 11 children's heart surgery centres in England. Approximately 30 surgeons conduct children's heart operations across the country and between them

they carry out around 3800 procedures a year. The review aims to reduce the number of centres providing care within England to ensure services have enough critical mass to be of the highest quality and sustainable.

The Safe and Sustainable programme has based its agenda on the following core principles:

- The NHS must provide the very highest standard of care for all children in England who need heart surgery regardless of where they live or which hospital provides their care
- The care that every centre provides must be based around the needs of each child and family, taking account of the transition to adult services
- Other than surgery and interventional cardiology all relevant treatment (including follow-up) must be provided as close as possible to where each family lives
- NCG will develop a set of quality standards and ensure that services deliver the best care by meeting these standards

The recommendations of the review are currently subject to public consultation. All four options for reconfiguration include GOSH as one of two centres in London, with the Royal Brompton discontinuing Paediatric Cardiac Surgery.

The aim of the Neurosurgical Services Review is to deliver, within two years, robust proposals that will secure a safe, sustainable and world class service for children and their families. Similar to the Cardiac review it is likely that the number of centres providing neurosurgery will reduce. The Programme will initially:

- review current arrangements for children's neurosurgical services including levels of need and activity in each of the 15 centres in England
- Develop criteria for a formal designation process that ensures that children's neurosurgical services meet service specification standards, as well as meet national demand
- Develop service specification standards that will form a national quality framework within which children's neurosurgery centres will be assessed
- Canvass the views of stakeholders on the future shape of children's neurosurgical services

The expectation is that the number of centres will reduce, with the probable outcome being around 5 centres nationally undertaking neurosurgery.

Aside from GOSH, two other centres in London undertake paediatric neurosurgery; Kings and St George's, with both undertaking small numbers compared to GOSH. We expect the outcome of the national review to rationalise the number of centres undertaking neurosurgery.

3.7 Demand and capacity analysis

3.7.1 Clinical strategy

Our overarching clinical strategy focuses on treatment and care for complex conditions and on providing services which are available at a limited range of centres. GOSH is fully committed to providing health care locally where it can be done so safely and efficiently, and delivering cost effective care pathways to commissioners. The following schemes show examples of where this is being planned or delivered

- Established Europe's first paediatric home haemodialysis service. This will deliver much improved clinical outcomes due to more frequent dialysis and better quality of life for the patients and families. GOSH are delivering this at the same cost as attending hospital haemodialysis.
- Undertaking numerous follow up outpatients by telephone and is continuously transferring more follow ups from clinic to telephone.
- Commitment to streamlining patient pathways and improving key performance metrics of this such as new to follow up outpatient ratios.

- Using non invasive expandable growth rods for some spinal surgery to radically reduce the number of inpatient procedures that a patient requires.
- Developing telemedicine clinics in a number of specialties to reduce both patient and clinician travel time and costs

Our approach will be based on the development of clear clinical pathways, working in partnership with local services, and building on the well established GOSH 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 complex conditions, who have limited (or no other) healthcare options.
- Saving costs for the NHS and other public services as we deliver the right 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 we have undertaken a detailed 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 GOSH, has identified some priority specialties where the external need for GOSH to further develop its services is highest.

3.7.2 Priority specialty plans

We have defined a number of priority specialties where the external environment determines that demands for services at GOSH will increase most. 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 a largest material change in terms of activity and income to GOSH are as follows;

3.7.2 Cardiac Surgery

Whilst we are not anticipating additional clinical growth in cardiac surgery we do expect to increase our market share. The national Safe and Sustainable Paediatric Cardiac Surgery Review aims to rationalise the numbers of centres undertaking paediatric cardiac surgery across the country. In addition, The NHS London publication, "*Children's and Young People's Project – London's Specialised Children's Services: Guide for Commissioners*" also recommends a strategic direction of rationalisation of the number of providers of this specialist children's service.

The planned growth in cardiac services will increase the demand for all acuities of beds: ITU, HDU, and ward. To accommodate these plans the Trust has recently approved the first wave of expansion; 2 additional ITU beds and 4 additional HDU beds, which can be accommodated in the current footprint. The second phase of expansion will be accommodated by the Morgan Stanley Building due to open in 2012.

3.7.3 Neurosurgery

GOSH is the largest provider of paediatric neurosurgery in the UK, delivering the highest quality of emergency and planned neurosurgery to children throughout the country, with a dedicated paediatric clinical team.

Clinical growth is expected in neurosurgery for a number of reasons. New techniques are continuously being developed and a wider portfolio of surgical treatments is expected in epilepsy surgery, spinal surgery and surgical spasticity interventions such as intrathecal baclofen and deep brain stimulation. GOSH will also develop surgical spasticity services which are currently not provided at GOSH and is the formal neurosurgery support centre for the paediatric London trauma centre at Barts and The London Trust. In addition, the national "Safe and Sustainable" paediatric neurosurgery review aims to rationalise the numbers of centres undertaking paediatric neurosurgery across the country.

The current demands for Neurosciences beds (Neurosurgery, Neurology and Craniofacial) are greater than the supply and will deteriorate further as demand increases.

We will effectively increase number of beds available for neurosurgery beds by increasing the day case neurology capacity and moving appropriate craniofacial patients to surgical beds. However, we are still predicted to be short of bed capacity for neurosciences and are working on rectifying this by a combination of new working practices, smoothing the occupancy variation across the week and accessing additional bed capacity within the Trust.

3.7.4 Spinal Surgery

The spinal orthopaedic service aims to provide a comprehensive multidisciplinary service for the care and management of children with both congenital and acquired spinal deformity. There is a considerable neuromuscular workload. In 2008 GOSH had to restrict referrals to the service due to patients waiting longer than the national inpatient standard of 26 weeks. GOSH is now fully accepting referrals and has good waiting times, whilst other providers are struggling to achieve waiting times targets for this specialty. The market share aims have been adjusted from the Trust wide objectives to reflect the non specialist paediatric nature of the service at Stanmore and the collaborative spinal services with Guys.

Clinical growth will occur as more spinal surgery techniques are developed and currently underlying demand within the population is not being met due to a national lack of capacity.

The NHS London publication, "*Children's and Young People's Project – London's Specialised Children's Services: Guide for Commissioners*" also recommends a strategic direction of rationalisation of the number of providers of this specialist children's service.

In response, we propose to increase the available spinal surgery beds by increasing the number of spinal cases undertaken as day cases and expanding the respiratory ward to be able to take spinal surgery patients who require non invasive ventilation.

3.7.5 Haematology / Oncology / Bone Marrow Transplant (BMT)

GOSH provides comprehensive haematology, oncology and bone marrow transplant (BMT) services for all children in North London and for children under 1 across the whole of London. The service is well respected with a good established network of shared care providers. Research and development output is extensive, with high numbers of publications. However, capacity problems exist which often delay or lead to the refusal of admissions from shared care providers. Referrals have been diverted to other providers and the GOSH market share has contracted as a result of these capacity constraints, with an example being the loss of referrals from North Kent to the Royal Marsden hospital.

The underlying clinical demand for services is expected to increase from a number of new / developing therapies:

- Radio isotope therapy
- Transplants for re-lapsed leukaemia
- Increased intensity of some treatment regimes
- Tumour vaccine therapy
- Increased range of specialties for which BMTs can be of clinical benefit

- Increased demand for metabolic and gastroenterology patients receiving BMTs

Again, the NHS London publication, "*Children's and Young People's Project – London's Specialised Children's Services: Guide for Commissioners*" recommends a strategic direction of rationalisation of the number of providers of this specialist children's service. Some of the other providers within the geographical zones also serviced by GOSH do not currently meet key clinical interdependences.

To accommodate additional growth the service will expand its capacity in haematology / oncology / BMT to ensure that all referrals can be accepted and all shared care transfers can be accommodated in a timely manner. This physical expansion will be complemented by a reduction in the planned occupancy of the wards (to manage variation in demand) and by targeted service improvement work. In addition, the day case / outpatient ward undertook a specific Variability and Flow Management Project which increased capacity without the need to increase the physical space.

3.7.6 Gastroenterology

GOSH is the largest provider of specialist gastroenterology services to North London and surrounding area and a provider of some quaternary services, e.g. auto immune gut disease, small bowel transplants (jointly provided with Kings) and neuromuscular gut disease.

We anticipate that the demand for Gastroenterology beds will grow by approx 4 inpatient beds and a near trebling of day case beds over the next 5 years. This will be accommodated by a planned reorganisation of medical specialty beds over the coming years. Currently the 3 wards delivering these services are not used to their optimum capability and work is currently occurring to redesign patient pathways in the 5 specialties involved, which will then be followed by a review of the specialty delivery location and possible redistribution. A potential outcome will be the creation of a dedicated Gastroenterology facility which will accommodate all in patients, day cases and endoscopies with increased in patient beds. Currently there is one endoscopy suite and a co-located area has been identified to develop a 2nd suite in the next couple of years.

3.7.7 Specialist neonatal and paediatric surgery (SNAPS)

Referrals for neonatal surgery are taken from units within the north London and surrounding region as well as other units within London. Tertiary referrals are received from throughout the United Kingdom as well as international referrals. The department of surgery provides a comprehensive service with special emphasis on the management of congenital abnormalities as well as diseases of the gastro-intestinal tract including oesophageal atresia, ano-rectal abnormalities, surgical oncology and minimally invasive surgery (Laparoscopy).

Whilst no clinical growth is expected we do anticipate increasing our market share through The NHS London publication, "*Children's and Young People's Project – London's Specialised Children's Services: Guide for Commissioners*", which recommends a strategic direction of rationalisation of the number of providers of this specialist children's service.

SNAPS has recently benefited from an extensive process review as part of a transformation project. The MVP project has generated a significant number of integrated care pathways which have contributed to a reduced length of stay for many of the common surgical procedures. This has resulted in a 15% reduction in length of stay (LOS) across SNAPS. In addition, there has been a focus on all stages of the pathway to and from surgery including booking, pre-op assessment and theatre utilisation which it is anticipated will also offer a significant gain. There are huge improvements in bed management, staff effectiveness through SBARD handover and soon through ICPS and a general understanding of the growth that is possible within current capacity which we are rapidly reaching the maximum level of.

3.7.8 Paediatric and neonatal intensive care

The intensive care unit at Great Ormond Street Hospital is the lead centre for Paediatric Intensive Care in North Thames and a recognised centre for training in Paediatric Intensive Care medicine. It is one of the largest units for children in the UK and Europe.

There are two distinct units - the Neonatal Intensive Care Unit (NICU) and the Paediatric Intensive Care Unit (PICU) however they work closely together. The nursing and medical teams work closely together allowing great flexibility and are led by a team of eight consultants. Approximately 1,200 patients per year are admitted to PICU.

Almost all children and infants admitted to PICU are ventilated (> 90%). We have a number of ventilators to allow different ventilator techniques appropriate to the care of the child. A full range of renal replacement therapies are also available should any child require it.

Our patients come from the North Thames area and also further afield from all over the UK and abroad. This reflects the wide range of specialist services that can be provided for critically ill children in our unit.

No clinical growth is expected, however we do expect to realise an increase in market share. The NHS London publication, "*Children's and Young People's Project – London's Specialised Children's Services: Guide for Commissioners*" recommends a strategic direction of rationalisation of the number of providers of this specialist children's service. One of the other providers within the geographical zones also serviced by GOSH do not currently meet key clinical interdependences. Our current PICU / NICU footprint has 23 bed spaces and increased demand will be accommodated in these in the foreseeable future.

3.7.9 Summary

GOSH caters for the most complex patients in the paediatric health care needs spectrum and through the NHS strategic direction of rationalising highly specialist services it is logical that GOSH will be required to expand. Many of our activity plans are based on specific commissioning objectives e.g. The National Safe and Sustainable reviews and Healthcare for London's Specialised Children's Services. We firmly believe that increasing clinical activity at GOSH will assist commissioners in reducing total healthcare expenditure for the group of patients that we treat.

3.8 Trust objectives

In response to our analysis of past year performance and review of the external environment in which we will be operating in we have revised and developed our workstreams and actions that will deliver our strategic objectives. The following tables set out our development plans for the future, describing our seven key objectives and associated workstreams and actions to deliver them. Each workstream has a responsible Executive lead and Committee to monitor progress.

Clinical Units and Nursing have additionally developed their local plans to deliver the trust objectives. These are detailed in appendix 2.

1. Consistently deliver clinical outcomes that place us amongst top 5 Children's Hospitals in the world			
Workstream	Action	Action: Continued / Revised / New	Executive lead
Maintain our focus on Zero Harm	Continue the development of systems to decrease adverse drug events by targeted actions such as the expansion of the CIVAS service and other strategies aimed at concentrating on named high risk medications and named high risk areas in the Trust with the aim of a 25% reduction against the 2010 baseline.	Revised	Co-Medical Director
	Continue our work to reduce specific hospital acquired infections including Central Venous Line infections (CVL), Surgical Site infections (SSI) and Ventilator Associated Pneumonia (VAP) from current baseline over the next year.	Revised	Co-Medical Director
	Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.	Revised	Chief Nurse and Director of Workforce Development
	Develop and monitor new structure for managing and learning from Serious Incidents (SIs)	New	Co-Medical Director
	Ensure effective provision of nutritional care for all patients	New	Chief Nurse and Director of Workforce Development
	Ensure provision of safe services for the deteriorating and critically ill child.	New	Chief Nurse and Director of Workforce Development
Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	Gather and report outcome data and information to demonstrate the clinical effectiveness of the organisation and benchmark against comparable organisations	Revised	Co-Medical Director
	Ensure accountability for delivery of CQUIN targets are fully devolved operationally and monitored regularly	Revised	Chief Finance Officer
2. Consistently deliver an excellent experience that exceeds our patient, family and referrer' expectations			
Continue to reduce waiting times further through our 'no waits'	Continue to meet national and commissioning standards and improve the utilisation and efficiency of our resources.	Revised	Chief Operating Officer

programme			
Improve the standard of customer service that we offer patients and families	Ensure the effective measurement and improvement of patient experience through agreement and implementation of a patient experience action plan	Revised	Chief Nurse and Director of Workforce Development
Continue to improve our relationships with referrers in order to achieve our market share objective	Continue to implement the actions for improvement following the results of the Referrer Survey including producing a directory, holding referrer days along	Revised	Co-Medical Director
	Invest within our 10 year capital programme to improve the patient environment within our existing buildings and continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the development of the Morgan Stanley Clinical Building (MSCB) due to complete in December 2011 and the continued development of the Phase 2b Full Business Case for final submission in July 2011.	Revised	Director of Redevelopment
	Prepare to move into the Morgan Stanley Clinical Building including workforce redesign.	New	Chief Operating Officer
3. Successfully deliver our clinical growth strategy			
Deliver our planned in year growth	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP)	Revised	Chief Operating Officer
Maintain IPP service growth	Improve patient access and staff recruitment and retention to ensure IPP income target is achieved	Revised	Director of International Patients
Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	Achieve accreditation as a national paediatric centre for cardiac and neuro-surgery through the new national processes, and plan to accommodate any further growth that arises from this process.	Revised	Chief Operating Officer
	Work with partners in the region to deliver paediatric tertiary care in light of NHS London proposals.	Revised	Chief Operating Officer
4. Currently partnered with ICH, and moving to UCL Partners AHSC, maintain and develop our position as the UK's top children's research organisation			
Deliver the Research Strategy	Renew and deliver the Biomedical Research Centre in paediatrics	New	Director of Clinical Research and Development
	Continue to develop partnership working with ICH, University College London Partners (UCLP) and UCL Business	Revised	Director of Clinical Research and Development
	Increase research activity and income for the Trust by 10%	New	Director of Clinical Research and Development

In year delivery (research)	Continue to improve the mechanisms for the management of research within the Trust	Revised	Director of Clinical Research and Development
5. To work with our academic partners to ensure that we are provider of choice for specialist paediatric education and training in the UK			
Deliver the Education & Training Strategy	Implement the Trust's Education and Training Strategy through the delivery of an innovative and effective programme of blended learning using the on-line campus, classroom & work-based teaching and simulator learning.	New	Chief Nurse and Director of Workforce Development
6. deliver a financially stable organisation			
Agree achievable CRES plan and ensure delivery through robust project and performance management	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.	Revised	Chief Operating Officer
	Deliver surplus to plan.	Continue	Chief Operating Officer
Improve efficiency through our Transformation Programme	Deliver operational efficiencies through the devolved Transformation team and engine-room projects.	New	Chief Operating Officer
Ensure appropriate funding for our clinical services from commissioners	Work with other specialist paediatric providers on work streams which will provide evidence to DH to support maintenance of specialist top up or targeted tariff design changes.	Revised	Chief Finance Officer
	Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.	Revised	Chief Finance Officer
Support the charity to raise targeted funds	Continue to strengthen communication between GOSH and GOSH Charity at all levels to ensure fund-raising targets are met	Revised	Chief Executive
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation			
Make progress towards becoming a Foundation Trust	Complete monitor assessment, attain authorisation status and establish an effective members' council.	Revised	Chief Operating Officer
Ensure that the Trust is compliant with regulatory requirements	Ensure that the Trust retains registered status with CQC.	Revised	Chief Executive
	Ensure that Information Governance (IG) processes are strengthened and the self assessment score in the IG toolkit is improved.	Revised	Chief Finance Officer
Improve efficiency of business processes	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.	New	Chief Finance Officer
	Deliver the first year of an agreed medium term IT strategy which ensures robust IT infrastructure and a credible and fundable replacement strategy for critical business applications.	Revised	Chief Finance Officer
	Continue to develop management and leadership including Specialty Leads, Clinical Unit Teams and Trust Board.	New	Chief Executive

In order to ensure that we are achieving the strategic elements of our plans the trust Board have developed 8 key deliverable measures for 2011/12 – a series of 'must-do's'. These include:

4.1 Key deliverable measures 2011/12

	Key Deliverable
1	To achieve a 10% reduction in harm as defined by the global trigger tool
2	To double the number of specialties that have clinical outcome measures published on our internet site
3	Ensure the Morgan Stanley Clinical Building ready for occupation
4	To meet our growth targets for both NHS and International and Private Patient activity
5	To increase our research publications and income for the Trust by 10%
6	To achieve excellent ratings in the Post Graduate Medical Education and Training Board and Quality Assurance Agency for higher education reviews
7	To meet our budget
8	To attain authorisation as a Foundation Trust

4.2 Performance management

Progress against Trust objective workstreams and 'key deliverable' measures will be monitored through the Management Board and Trust Board on a monthly basis.

4.3 CIMA strategic scorecard

Following the development of the Trust strategic direction and key strategic objectives, and in order to help the Trust Board to fulfil their responsibility to contribute and challenge the strategy effectively, the organisation has adopted the CIMA strategic scorecard TM. The scorecard provides the Board with a monthly assessment of strategic issues by regularly summarising the key aspects of the environment in which the organisation is operating to ensure that the Board is aware of the ongoing changing competitor, economic and other factors; and identifying the (key) strategic options that could have material impact on the strategic direction of the organisation.

The objectives of the scorecard are to:

- Assist the Board, in particular the non-executive directors, in the oversight of an organisation's strategic process. In effect, it gives the Board the big picture.
- Provide an integrated and dynamic framework for dealing with strategy at Board level that focuses on the major strategic issues facing the organisation and ensures that the strategy is discussed at Board level on a regular basis.
- Provide strategic information in a consistent and summarised format to help directors to obtain sufficient grasp of the material so that they can offer constructive, informed input.
- Assist the Board in dealing with strategic choice and transformational change and the attendant risks.
- Provide assurance to the Board in relation to the organisation's strategic position and progress.
- Assist the Board in identifying key points at which it needs to take decisions.

Although the scorecard is primarily aimed at Board level for use as an agenda item at Board meetings, it offers considerable benefits to the organisation's management:

- The discipline of having to prepare and update the scorecard helps management to keep its focus on the key strategic issues.
- It facilitates discussion within the management team and helps the team to refine its proposals prior to exposure to the Board.

- It can help to identify gaps in knowledge and analysis and can improve the quality of information presented to the Board.
- Because the scorecard improves the quality of the Board's contribution, this will lead to more constructive engagement with management. The strategic process and content are thus enriched. This makes for better governance and performance

The scorecard uses four dimensions to assess the strategic position and identify strategic options and risks. These are summarised in the diagram below.

CIMA Strategic Scorecard

Strategic position This focuses on information that is required to assess the organisation's current and likely future position. It covers externally focused information such as economic and market developments and market share as well as internal issues such as competences and resources.	**Strategic options** Having set the scene with relevant background and information, the focus of the scorecard shifts towards decision making. Strategic options can be defined as those options that have the greatest potential for creating or destroying stakeholder value.
Strategic implementation At this point, the emphasis of the scorecard is to identify key milestones for the Board and to monitor implementation of the agreed strategy. Decisions on appropriate action may be required if things are not proceeding as planned.	**Strategic risks** This dimension underpins the others by focusing specifically on the major strategic risks that pose the greatest threat to the achievement of the organisation's strategy as well as key issues such as the organisation's risk appetite.

The scorecard will bring all the high-level strategic information together in a summarised, but coherent form for the Board's use within a robust framework. This will be supported by a strong foundation of high quality management information which the Board can access if it is felt necessary to explore a particular issue in greater depth.

4.4 Financial Implications of our plans

The financial plan for 2010/11 has been compiled on the basis of;

- Expected outturn activity
- Demographic growth
- Known and forecast demand for services – NHS and IPP
- Known service changes – I.e. Haringey transfer
- Operating plan assumptions – these are detailed later
- Local and national tariff for PCT activity
- Agreed/estimated contract values with other commissioners
- IPP tariff prices
- MFF and Specialist top up 2010/11 rates
- Known or best estimates of other income sources
- A CIP target of 4% - higher internal target to mitigate risk to delivery

Financial summary – revenue statement

Overall position				
£000	**Actual 2009/10**	**Actual 2010/11**	**Plan 2011/12**	**Plan 2012/13**
Revenue from Patient care activities	267.5	283.9	286.5	301.4
Other operating revenue	50.6	52.4	51.4	59.8
Operating expenses	(309.9)	(323.0)	(330.9)	(357.5)
Operating surplus	**8.2**	**13.3**	**7.0**	**3.7**
Other gains and losses	0.03	(0.6)	0	0
Investment revenue	0.5	0.1	0.1	0
Finance costs	(0.03)	(0)	0	0
PDC dividends payable	(5.2)	(5.6)	(5.8)	(5.7)
Retained surplus for the year	**3.5**	**7.2**	**1.3**	**(2.0)**
Impairments included (net)	3.8	1.4	5.6	4.7
Retained surplus excluding impairments	**7.3**	**8.6**	**6.9**	**2.7**

£'m	**2009/10 Actual**	**2010/11 Actual**	**2011/12 Plan**
EBITDA %	8.5%	8.3%	8.3%
Net surplus %	2.2%	2.5%	2.0%
ROA	4.9%	5.0%	3.7%
Private patient %	8.0%	8.8	9.7%

Key points are:

2009/10 to 2010/11

- GOSH at NMH service transferred back to NMH in May 2010 and is not part of the 2011/12 plan
- The Haringey paediatric service is not in the plan for 2011/12 although at the time of writing a formal agreement for the service to be transferred to another provider has not been agreed
- Growth in NHS activity, including demographic growth, is reflected in the plan
- Growth In IPP activity is reflected in the plan, this includes the FYE of the Kuwait education contract
- R&D funding reflects the best estimate of income from this income stream including any known allocations
- The 2010/11 tariff is modelled into all activity projections to determine planned income levels

Key assumptions

The assumptions that are derived from the NHS Operating framework are:

Assumption	% change	baseline
Inflation (Clinical income) - deflation	-1.5	Relative to 2010/11
Income includes demographic growth	1.0	
Quality performance payments known as CQUIN	1.0	
Pay inflation – pay awards only apply to staff below £21K * 0.15% of overall pay bill	0.15*	
2010/11 Tariff is modelled and reflected incl. emergency threshold and readmissions	NA	
Contingency	0.5	
CIP minimum (from cost reductions)	4.0	of total expenditure

Income

- The Trust has modelled and reflected the effect of the MFF changes at 29% (31% previously)
- The Trust has modelled and reflected the Paediatric top up at 60% (78% previously) and its extension to additional HRGs
- The plans reflects the 1.5% deflation in priced activity
- Growth reflects 1% demographic growth
- Other growth is reflected based on known and forecast demand for certain clinical services
- New cardiac outpatient procedures are modelled and reflected in line with PBR guidance
- The divestment of the Haringey service is reflected
- No financial penalties become payable due to non-achievement of metrics or income lost from not achieving the CQUIN targets
- CQUINS is included at 1% to reflect risk to delivery

Expenditure

- Pay inflation has been applied to salaries of £21K or less in line with the operating plan – this equates to 0.15% of the pay bill
- Non-pay inflation: Drugs is included at 5% and all other non pay is at 2.9%
- CIP is applied at 4% although units have a higher target to deliver to ensure that at least the 4% is delivered
- Cost pressures have been funded to units where these are not activity related - activity related cost pressures are funded by increased levels of income to units

Statement of Financial Position (SFP)

£'m	Mar-10		Mar-11		Mar-12
	Actual		Actual		Projected
Total Fixed Assets	**258.1**		**329.6**		**344.6**
Stocks & Work in Progress	5.2		5.2		5.0
Debtors	36.5		30.3		29.8
Cash at bank and in hand	8.5		32.6		25.3
Total Current Assets	**50.2**		**68.1**		**60.1**
Creditors	-37.6		-53.9		-42.8
NET CURRENT ASSETS	**12.6**		**14.2**		**17.3**
TOTAL ASSETS LESS CURRENT LIABILITIES	270.7		343.8		361.9
Provisions for liabilities and charges	-1.3		-1.2		-1.1
Other non-current liabilities	-7.7		-7.3		-6.9
TOTAL ASSETS EMPLOYED	**261.7**		**335.3**		**353.9**

The major movements on the SFP are:

- Continued expenditure on the phase 2 a Hospital development in addition to non-hospital development for buildings, IT and medical equipment
- Higher levels of creditors at year
- Reduced levels of debtors as old performance debt and Haringey and LPP debt is cleared by March 2011
- Higher cash levels reflecting the creditor and debtor movements

The current financial plan shows a small net outflow of funds in 2010/11

Summary Cash Flow

	Actual		Actual
	2009/10		2010/11
Cash from operating activities	15.8		38.7
Tangible and non tangible assets	-36.9		-72.5
PDC received	15.4		15.0
Other capital receipts	12.9		48.5
Proceeds from disposals	0.5		
Dividends paid	-5.1		-5.7
Net change in cash	2.6		24.0

Investments in service developments

The plan includes continued spend on phase2A of thee hospital redevelopment – from 2011/12 this will be entirely donated with the last of the PDC now utilised
The Trust will continue to invest in IT as well as ongoing maintenance and medical equipment investment – this includes the investment required for Phase 2A medical equipment

Capital expenditure

	Expenditure year to 31 March 2011	Planned expenditure 2011/12
	£'M	£'m
Hospital redevelopment	15.0	0
Hospital redevelopment - donated	47.2	34.7
Estates Maintenance	8.5	7.7
Estates - donated	0.5	1.3
IT	4.5	6.6
IT - donated	0	3.3
Medical equipment	0.3	0
Medical –donated	1.5	3.5
Total	**77.5**	**57.1**

5. Risk Analysis

5.1 Financial risk

Key risks included within the plan		
Explanation of the risk	High/ Medium/ Low risk	Mitigating actions
Delivering CRES	Medium	The trust will plan for CRES above required levels to mitigate risks.
Insufficient skilled staff to deliver our strategic objectives	High	Continuing to market GOSH as an attractive employer Developing in house succession and education and training programmes to "grow our own" Developing new roles and care pathways to reduce unnecessary dependence on hard to recruit roles
CQUIN	Medium	The value included in the plan is 1% and this is lower than the maximum that could be achieved of 1.5%. The Trust will also actively work to ensure targets are delivered.
Ensuring the Trust is paid for the work carried out – current contracts reflect lower levels of activity than the Trust anticipates it will see	Medium	The Trust is expecting to be paid for the work it does under tariff arrangements and will discuss with commissioners the likely and forecast performance with a view to ensuring that the commissioners are fully aware of the financial resources needed to satisfy for the work undertaken
Commissioning risks including non payments for readmissions and reduced rates i.e. marginal rates	Medium	A financial provision has been made within the financial plan. All risk areas will be monitored quarterly and audits carried out where agreed with the commissioners

Opportunities

There are likely to be opportunities from the Trust emerging from service reconfiguration within London.

5.2 Risks to services provided

The Trust provides a full range of tertiary paediatric services across surgical and medical specialities. Current risks identified are:

- Difficulties in recruiting specialised staffing and skilled senior admin and clerical staff due to the competitive forces in central London
- Difficulties in obtaining adequate reimbursement for low volume highly specialised services through the standard NHS funding structures
- Loss of non-London activity to regional providers
- Lack of pace and clarity in the strategy to concentrate specialised services
- Restrictions in respect of the building programme to ensure that service disruption is kept to a minimum.
- The private patient cap could restrict growth in private patient care.

Commissioners are seeking ways of restricting "low priority treatments". GOSH only carries out treatments falling within these definitions if the child has multiple complex needs and it would be a significant clinical risk for such procedures to be carried out in a general hospital

Contingency reserve 2011/12

The plan provides for a 0.5% contingency reserve.

5.3 Governance risk

The Trust has a governance structure in place identified within the Risk Management Strategy and approved by the Trust Board. The strategy ensures appropriate structures are in place at all levels of the organisation to identify, mitigate and control risk and to manage for safety as well as risk reduction. It describes the operational framework that is required to deliver the strategy and how it links into the wider assurance and governance processes of the Trust. This is to ensure that quality assurance; quality improvement and patient safety are central to the activities of the Trust and fully embedded in the management processes.

The governance structure identifies the roles and responsibilities of committees and groups that have responsibility for risk and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process for Trust Board review of the strategic organisational risks from the risk register and the local structures to manage risk in support of this strategy. The Audit Committee and Clinical Governance Committee monitor both operational and strategic risks and assure the Trust Board that the necessary controls are in place and assurances sought.

The Trust's Assurance Framework is based on a structured and ongoing assessment of the key risks to the Trust of not achieving its objectives. The Assurance Framework is used to provide information of the controls in place to manage the key risks and details the evidence provided to the Board indicating that the control is operating.

The Assurance Framework is mapped to the Care Quality Commission's Registration Standards and to other internal and external risk management processes such as the NHS Litigation Authority Standards, Internal and External Audit recommendations and the Information Governance Toolkit. It is monitored and updated throughout the year by the Risk Assessment and Compliance Group and reported and challenged at both Board assurance committees.

The safety of children in hospital is a Trust strategic objective with established links into the Assurance Framework, regular review of high level risks by the Executive team and local monitoring and reporting systems. Clinical and non clinical incidents are analysed by type, severity, location and frequency to identify patterns and to enable early identification of problems and action to be taken. In the event of a serious incident, the Trust engages with external agencies as required to investigate at an appropriate level. Reports are received by the Clinical Governance Committee on all aspects of clinical risk and risk reduction and to support proactive management and non clinical risks are reported to the Audit Committee.

The operational framework sets out how this occurs and how this process integrates with other management, performance monitoring and assurance systems of the Trust. This is to ensure that effective risk management for improved safety is embedded in all elements of the Trust's work and enables early identification of factors whether internally or externally driven, which may prevent the Trust from achieving its strategic objectives of ensuring care is provided in a safe and effective way. The Trust is committed to this positive approach to the consistent management of risk, where managing for safety, in a culture that is open and fair, supports learning, innovation and good practice for the benefit of the child.

Regulatory and legislative compliance is monitored through an audit and reporting process, to identify deficiencies and reduce any assurance gaps identified. Wherever possible, links to the performance management systems in the Trust are used to assess compliance. The Risk Assessment and Compliance Group oversees operational compliance and reports into the Management Board. Committee members sit on Management Board and ensure that compliance matters are addressed within the operational decision making process.

6. Declarations and Self-Certification

6.1 Board statements

The board is required to confirm the following (subject to update in the final amended Compliance Framework):

For clinical quality, that:

• The board is satisfied that, to the best of its knowledge and using its own processes (supported by any relevant Care Quality Commission metrics and including any further metrics it chooses to adopt), its NHS foundation trust has and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

• The board can confirm that its NHS foundation trust has met and will continue to meet the requirements for registration with the Care Quality Commission in accordance with the *Health and Social Care Act 2008*.

For service performance, that:

• The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) and national core standards and with all known targets going forwards;

• The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the *Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections* (the Hygiene Code).

For other risk management processes, that;

• Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;
• All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;
• The necessary planning, performance management and risk management processes are in place to deliver the annual plan;
• A Statement of Internal Control ("SIC") is in place, and the NHS foundation trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk); and
• All key risks to compliance with its Authorisation have been identified and addressed.
For compliance with its Authorisation, that:
• The board will ensure that the NHS foundation trust remains compliant with its Authorisation and relevant legislation at all times;
• The board has considered all likely future risks to compliance with its Authorisation, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks; and
• The board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance with its Authorisation.

For board roles, structures and capacity, that:

• The board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the board;
• The board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability;

- The selection process and training programmes in place ensure that the nonexecutive directors have appropriate experience and skills;
- The management team has the capability and experience necessary to deliver the annual plan; and
- The management structure in place is adequate to deliver the annual plan objectives for the next three years.

Appendix 1 2011/12 CQUIN measures

Appendix 2 Clinical unit and departmental annual plans

Appendix 1 2011/12 CQUIN measures

Primary Care Trust

CQUIN measure		Indicator Splits	Financial Value	Contract %
Overall			2,020,790	1.500
Patient Experience: Undertake further inpatient and outpatient surveys and achieve improvement in key areas most notably communication with parents and patients during admission to hospital on issues such as medication side effects, patients fears and concerns and decision making	1	100%	202,080	0.150
Composite Score on IPSOS Moris Survey:	1a	10%	20,208	0.015
Implementation Plan and Monitoring:	1b	30%	60,624	0.045
Composite Score on IPSOS Moris Survey	1c	50%	101,040	0.075
Qualitative Benchmarking	1d	10%	20,208	0.015
Surgical Site Infections: Reduction of current rate of surgical site infection in 4 specialties and the establishment of surveillance in 5 new specialties	2	100%	363,742	0.270
Reduction or maintenance of infection rate in 5 specialties	2a	50%	181,871	0.135
Establish Implementation of 5 new specialties	2b	50%	181,871	0.135
CVC Infections: Further reduction in the rate of central venous catheter (CVC) infections from latest reported rate of 2.8/1000 line days	3	100%	363,742	0.270
Maintain CVC rate at 2010-11 Levels	3a	50%	181,871	0.135
Improve CVC Infection Rate	3b	50%	181,871	1.135
Nutrition Screening: To implement and evaluate GOSH nutrition flowchart; monitor patient outcomes using Z weight scores; full audit of height measurement	4	100%	363,742	0.270
Implement GOSH Flowchart	4a	40%	145,497	0.108
Monitor patient outcomes using Z weight scores	4b	20%	72,749	0.054
Full audit of height measurement	4c	40%	145,497	0.108
Child protection: Strengthen the quality of the annual audit of child protection cases; achieve improvement in levels of group supervision for staff; increase the % of staff achieving level 3 training	5	100%	363,742	0.270
Record Keeping	5a	20%	72,749	0.054
Supervision	5b	60%	218,244	0.160

Level 3 Training	5c	20%	72,749	0.054
Paediatric Trigger Tool: Continue to review 20 sets of case notes per month and undertake a peer review of the implementation of the tool	6	100%	363,742	0.270
Review process and continue to undertake tool	6a	100%	363,742	0.270
TOTALS			2,020,790	1.500

London Specialised Commissioning Group

Paediatric Haemophilia	7			
Optimal dosage of prophylactic clotting factor for children with haemophilia A and B	7a		199, 662	
Paediatric and Cardiac Intensive Care	8			
Reducing the % of unplanned readmissions into Intensive Care within 48 hours of the initial admission and reducing the number of accidental exubations	8a		199, 662	
Optimal dosage of prophylactic clotting factor for children with haemophilia A and B	9			
Reduce prescribing errors in haematology and oncology through improved training, improved patient information and drug pre-preparation. Also to map the usage of antifungal drugs and costs from Allogeneic BMT patients	9a		199, 662	

Cardio-respiratory Unit Business Plan 2011-12

2011-12 Trust objectives				Local Plan		Milestones/Metrics			
Strategic Objective	Work-stream		Trust Action	Department Lead	Department Action(s)	Qtr 1	Qtr 2	Qtr 3	Qtr 4
1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	**Maintain our focus on Zero Harm**	1.1	Continue the development of systems to decrease adverse drug events by targeted actions such as the expansion of the CIVAS service and other strategies aimed at concentrating on named high risk medications and named high risk areas in the Trust with the aim of a 25% reduction against the 2010 baseline.	1. Dr Thiruchelvam, R Booth & L Cochrane	1. Implement electronic infusion calculator in the pharmacy bundles on CICU. 2. Explore the expansion of CIVAS on CICU.	Implement electronic infusion calculator on CICU	25% reduction in infusion prescribing errors. Recruit additional Pharmacist for Ladybird and Pharmacy Technician		
		1.2	Continue our work to reduce specific hospital acquired infections including Central Venous Line infections (CVL), Surgical Site infections (SSI) and Ventilator Associated Pneumonia (VAP) from current baseline over the next year.	Dr Karimova	1. Continued surveillance of ventilator associated pneumonia infection 2. Further CVL Infection care bundle training and reviews. 3. Implement Wound Infection Care Bundle	90% ward compliance for hand hygiene and CVL care bundle.	5% reduction in CVL and SSI infection rates	100% ward compliance for hand hygiene and CVL care bundle. 10% reduction in CVL infection rates	10% reduction in SSI infection rates
		1.3	Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.	Dr Goldman, S Cullen	All unit staff to receive level 1 child protection training. Increasing levels of senior staff with direct patient contact to receive level 3 child protection training.				All staff with level 1. More senior staff with patient contact with level 3.
		1.4	Develop and monitor new structure for managing and learning from Serious Untoward Incidents (SUIs)	Dr Hoskote	Continue to review and report on SUIs through the Cardiorespiratory Unit Risk Management Group. Identifying and implementing corrective actions, training etc as required.	0% never events	0% never events	0% never events	0% never events 25% reduction in SUIs
		1.5	Ensure effective provision of nutritional care for all patients	S Cullen	Ensure compliance with CQC standards across the unit.	Implement CICU CQC action plan.			
		1.6	Ensure provision of safe services for the deteriorating and critically ill child.	S Cullen	1. Implement CEWs for each set of patient observations at Badger and Ladybird wards. 2. Implement SBARD reporting for all Cardiorespiratory inpatients 3. Review the provision of care for Non-Invasively Ventilated patients across the trust.		Complete Non-invasively ventilated patient review.	CEWs for every patient observation.	Complete SBARD training across the unit.
			Other unit zero harm projects	Mr Tsang	Reduce the number of surgical re-explorations for bleeding (excluding ECMO and LVAD patients).	Establish regular meeting to review and audit patients with bleeding.			
				O Waller	Introduce Gold Standard for Cardiorespiratory Inpatient medical notes.		50% Compliance with gold standard for notes		70% Compliance with gold standard for notes
				Dr Ng	Reduce the number of ECMO cannulae complications by 5%	Determine current levels of complications and create plan to deliver reductions	Implement reduction plan		Achieve 5% reduction in cannulae complications.
				P Whitmore	Adherence to the WHO safety checklist for theatres			100% compliance with WHO safety checklist.	
	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	1.7	Gather and report outcome data and information to demonstrate the clinical effectiveness of the organisation and benchmark against comparable organisations, moving towards measuring clinical effectiveness in real time.	1. Dr Brown 2. Dr Burch 3. Dr Suri, A Prasad 4. Dr Ng, M O'Callaghan 5. Mr Tsang	1. Continue to report cardiac CCAD outcomes benchmarked nationally. Identify and implement audits and improvements as required. 2. Report cardiac transplant outcomes benchmarked internationally. Identify and implement audits and improvements as required. 3. Continue to report CF outcomes benchmarked nationally. Identify and implement audits and improvements as required. 4. Continue to report ECMO outcomes benchmarked internationally. Identify and implement audits and improvements as required. 5. Benchmark specific surgical outcomes against Boston Children's Hospital.				Maintain cardiac surgery and transplant patient outcomes at current levels Improve FEV1 measures for CF patients by 10%. Facilitate the creation of an international benchmark for ECMO.
		1.8	Ensure accountability for delivery of CQUIN targets are fully devolved operationally and monitored regularly	1. Dr Ng 2. Dr Karimova	1. Ensure 48 hour readmissions to CICU meet the CQUIN target. 2. Ensure central line infections remain below 2.8 per 1,000 line days.				Achieve target for 48 hour CICU readmissions and central line infections.
2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations	**Continue to reduce waiting times further through our 'no waits' programme**	2.1	Continue to meet national and commissioning standards and improve the utilisation and efficiency of our resources.	1. T Stockton 2. T Stockton 3. A Prasad	1. Implement Advanced Access for new Respiratory outpatient referrals. 2. Continue to manage inpatient/surgical waiting lists within the diagnostic and treatment targets. 3. Deliver efficiencies in CF patient care through reducing the number and duration of inpatient episodes.		Graduate from Advanced Access programme		Maintain number of patient waiting list breaches within national targets. Demonstrate reduced CF inpatient episodes and bed days.
	Improve the standard of customer service that we offer patients and families	2.2	Ensure the effective measurement and improvement of patient experience through agreement and implementation of a patient experience action plan	1 to 3. Dr Brown 4. Ward Managers 5. Jo Wray	1. Produce "Family Friendly" version of Cardiac Annual Report 2010.11. 2. Repeat annual patient surveys for Ladybird, PH, SleepCICU and ECMO and introduce a number of new surveys including CF. 3. Review and update all available patient information. 4. Improve the standard of cleanliness of patient, family and carer toilets and bathrooms. 5. Undertake Quality of Life study with PH patients.	Produce "Family Friendly" Annual Report 2009.10			Produce "Family Friendly" annual report 2010.11. Complete all patient surveys and analysis. Update all patient information.
			Other unit customer service projects.	Dr Brown	Produce Cardiorespiratory Annual Report 2010.11.			Annual Report Produced	
	Continue to improve our relationships with referrers in order to achieve our market share objective.	2.3	Continue to implement the actions for improvement following the results of the Referrer Survey including implementing a bed management solution.	1. Dr Suri, A Prasad 2. T Stockton 3. S Cullen 4. Dr Burch 5. New consultant.	1. Improve and standardise the quality of care received in the GOSH CF Network, working with network clinics to standardise practice across the network and arranging forums for all stakeholders. 2. Ensure patient communication is send to the appropriate stakeholders in a timely manner. 3. Adopt the new GOSH Bed Management activity proposals when agreed. 4. Further develop relationships with referrers. 5. Review cardiac outreach network.	Adopt GOSH Bed Management proposals Undertake referrer away day	Review patient communications and introduce target of 90% clinic letters sent out within 5 working days of clinic taking place.	Develop a standardised package of care for CF patients across the outreach network.	
	Continue to improve the patient environment through major upgrades, working closely with our charitable	2.4	Invest within our 10 year capital programme to improve the patient environment within our existing buildings and continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the development of the Morgan Stanley Clinical Building (MSCB) due to complete in December 2011 and the continued development of the Phase 2b Full Business Case for final submission in July 2011.	S Cullen	Develop operational policies for the move to Morgan Stanley Clinical Building				Operational policies in place

Objective	Sub-objective	No.	Action	Lead	Description	Q1	Q2	Q3	Q4
	partners	2.5	Prepare to move into the Morgan Stanley Clinical Building including workforce redesign.	Dr Taylor	Develop plans and business case to expand cardiac and respiratory ward capacity as wards relocate under plans for Phase 2a and 2b.				Plans in place
			Other unit patient environment improvement projects.	Dr Suri, A Prasad	Develop a proposal for CF patients to routine in-patient care with overnight accommodation not the wards.			Produce proposal	
				M O'Callaghan	Develop a dedicated Care team for Berlin Heart Patients	Identify requirements for team	Recruit and train team.		
3. Successfully deliver our clinical growth strategy	**Deliver our planned in year growth**	3.1	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).	1. Dr Goldman 2. A Laverty 3. Dr Burch 4. Dr Ng 5. Dr Suri, A Prasad 6. Dr Taylor 7. Dr Burch 8. Dr Ng 9. Dr Giardini, L Smith 10. Mr Tsang	1. Fully implement the Cardiac and Respiratory expansion plans to have 16 CICU beds, 8 Cardiac HDU beds and 13 Respiratory beds. 2. Undertake 1,500 sleep studies. 3. Expand outpatient clinic provision to meet respiratory (240 appt, 120 new patients pa), transition (72 appts, 18 new patients pa), general (600 appts, 100 new patients pa) and inherited cardiac conditions (80 appts, 20 new patients pa 4. Reduce the proportion of ECMO referrals refused for non-medical reasons from 14%. 5. Reduce the number and duration inpatient stays for moderate to severe CF patients (20 most frequent inpatients) by 13%. 6. Investigate options for alternative accommodation for integrated research and teaching facilities, the Fetal service and unit administration. 7. Continue to undertake activities to bid for the establishment of a new Nationally Commissioned Heart Failure Service. 8. Review the provision of ECMO services, particularly with regard to where these services are provided. 9. To reduce the average length of stay per patient by 5% through improved discharge planning. 10. To undertake 539 cardiac bypass cases.	Establish new Outpatient clinics	16 staffed CICU beds 8 staffed Ladybird HDU beds 13 staffed Badger beds	5% reduction in average length of cardiac inpatient stay. Produce proposals for Fetal and unit admin accommodation. Submit full business case for Heart Failure service (if required)	20% reduction in inpatient bed days for selected group of moderate to severe CF patients. Demonstrate a reduction in number of ECMO refused referrals on non-clinical grounds. Introduce capacity for 1,500 Sleep Studies per year. Develop strategic plan for alternative accommodation.
	Maintain IPP service growth	3.2	Improve patient access and staff recruitment and retention to ensure IPP income target is achieved		Establish 2 cardiac cubicles on Bumblebee ward.				Cardiac cubicles ready for patients
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	3.3	Achieve accreditation as a national paediatric centre for cardiac and neuro-surgery through the new national processes, and plan to accommodate any further growth that arises from this process.	Dr Goldman	Work with the National Commissioning team to plan for the implementation of the recommendations of the Safe and Sustainable Paediatric Cardiac Review.		Conclude review of outreach networks and start implementing recommendations.	Decision about the future configuration of paediatric cardiac services.	Draft plans for the implementation of the Safe and Sustainable recommendations for GOSH
		3.4	Work with partners in the region to deliver paediatric tertiary care in light of NHS London proposals.	New consultant	Review model of service delivery and governance across outreach networks.	Appoint new consultant	Undertake review of outreach networks and produce recommendations	Implement recommendations	
4. With partners maintain and develop our position as the UK's top children's research organisation	**Continue to develop partnership working**	4.1	Continue to work with University College London Partners (UCLP) and leverage benefits from this.						
		4.2	Extend collaboration with UCL Business to include GOSH commercial contracts and leverage benefits from this.	S Quinn	Explore opportunities for reductions in the cost of equipment maintenance contracts through direct supplier negotiation through UCLP.	Identify opportunities for reductions and implement.			
		4.3	Implement a new governance structure which spans the Division of Research and Innovation and includes all the major stakeholders	Dr Taylor	Work closely with the Trust Research and Innovation board to ensure the CardioRespiratory unit works closely with the Research and Innovation unit to maximise the research opportunities.		Investigate opportunities and make recommendations for working with the R&I unit	Implement recommendations	
		4.4	Agree operational and management arrangements for Great Ormond Street Hospital / Institute of Child Health (GOSH/ICH) joint research activity administered by the Research and Development (R&D) office and clarify systems and processes for ensuring funding	Dr Taylor	Develop operational and management arrangements for working with the Institute of Cardiovascular Sciences and ICH.	Develop and agree proposals for operational and management arrangements	Implement recommendations		
	In year delivery (research)	4.5	Strengthen our grant-writing infrastructure to increase our success in obtaining research grants.						
		4.6	Strengthen Communications with GOSH and ICH to ensure that press and publicity of the Division of R&I is adequately reflected internally and externally.						
			Other unit in-year delivery research projects.	Dr Ng	Establish long term outcome research programme for post ECMO patients.		Develop and agree proposals for long term research programme.	Implement programme.	
				Dr Suri, A Prasad	Participate in a research study on cystic fibrosis screening at 1 year in collaboration with the London Collaborative Cystic Fibrosis Group	Continue to submit data to the study.			
				Dr Taylor	Investigate options for alternative accommodation for integrated research and teaching facilities				Develop strategic plan for alternative accommodation.
				Prof Deanfield	Undertake research activities covering the following: - Develop Institute of Cardiovascular Sciences with Links to adult programmes across UCL campus. - Develop Cardiovascular Preventative and Outcomes Centre. - Conduct large scale studies of cardiovascular consequences of obesity in the young. - Develop linked programme with Yale University on genetics of complex Congenital Heart Disease.		Establish location of Cardiovascular Preventative and Outcomes Centre.		Establish Institute of Cardiovascular Sciences.
5. Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	**To work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK**	5.1	With our partner Higher Education Institutes (HEI) develop appropriate curricula to meet the professional standards required to drive excellence at GOSH.	Dr Taylor	Support the development and implementation of an MSc in Cardiology with the Institute of Cardiovascular Science.		Develop proposals for MSc in Cardiology		MSc Cardiology available.
		5.2	Implement the Trust's Education and Training Strategy through the delivery of an innovative and effective programme of blended learning using the on-line campus, classroom & work-based teaching and simulator learning.	Dr Taylor and L Leonard	Provide a unified unit medical and nursing education and training programme.			Develop and implement a unified programme of medical and nursing education in the unit.	
	Agree achievable CRES plan and ensure delivery through robust project and performance management	6.1	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.	1. A Layther and Dr Goldman 2. A Layther and Dr Goldman	1. Identify CRES savings of £2.073M in 2011.12 and 2012.13. 2. Deliver CRES efficiencies and income growth of £2.073M in 2011.12.	Agree 2011.12 CRES plan. Identify >75% savings for 2012.13 CRES plan			Deliver 2011.12 CRES savings 10% reduction in drugs wastage 10% reduction in the cost of per patient blood and blood product wastage.

6. Deliver a financially stable organisation		6.2	Deliver surplus to plan.						
	Improve efficiency through our Transformation Programme	6.3	Deliver operational efficiencies through the devolved Transformation team and engine-room projects.	O Waller	1. Investigate and implement new ways of working. 2. Evaluate Intelligent Storage of Drugs and Consumables on Ladybird ward. 3. Implement infection control improvement programme. 4. Introduce Advanced Access in Respiratory. 5. Introduce trust wide bed management policy. 6. Improve theatre utilization.	Investigate opportunities for new ways of working Work with theatres to identify opportunities to improve theatre utilization.	Implement recommendations for new ways of working. Implement recommendations to improve theatre utilization.	Commence Intelligent Storage evaluation Implement Advanced Access in Respiratory.	Achieve infection control targets.
	Ensure appropriate funding for our clinical services from commissioners	6.4	Work with other specialist paediatric providers on work streams which will provide evidence to DH to support maintenance of specialist top up or targeted tariff design changes.	Dr Suri, A Prasad	Ensure that commissioning for the service takes in to account the mandated currency for CF and prepare for mandatory tariff introduction in 2012-13	Track CF income to ensure it includes mandated currency		Prepare plans to manage introduction of mandatory tariff for CF	
		6.5	Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.	1. Dr Ng and Dr Karimova 2. T Stockton	1. Meet all CQUIN targets (infection rates and 30 day readmissions) 2. Meet Discharge summary targets.				Unit to achieve all commissioning targets.
	Support the charity to raise targeted funds	6.6	Continue to strengthen communication between GOSH and GOSH Charity at all levels to ensure fund-raising targets are met						
				Dr Brown	To provide better quality of care at lower cost, reduce utilisation through standardisation of out patient care by 2013. To reduce current unit outpatient costs by 2013. (SCAMPS)			Commence introduction of SCAMPS	
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	**Make progress towards becoming a Foundation Trust**	7.1	Complete monitor assessment, attain authorisation status and establish an effective members council.						
	Ensure that the Trust is compliant with regulatory requirements	7.2	Ensure that the Trust retains registered status with CQC.						
		7.3	Ensure that Information Governance processes are strengthened and the self assessment score in the IG toolkit is improved.	All managers	Ensure Information Governance training is undertaken by all unit staff.				100% compliance with Information governance training requirements
	Improve the ability of the organisation to deliver efficient business processes	7.4	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.	T Stockton	Continue to validate all critical unit information relating to strategic and operational objectives.	Continue to undertake validation of all unit critical information			
		7.5	Deliver the first year of an agreed medium term IT strategy which ensures robust IT infrastructure and a credible and fundable replacement strategy for critical business applications.	1. TBD 2. Dr Suri, A Prasad 3. Dr Burch 4. New consultant	1. Support the implementation of the 'carevue replacement' project: electronic notes, pathways online, electronic prescribing and variance tracking 2. Prepare a bid for a major re-development of the CF Database to allow data entry at source, improve clinical efficiency and explore the opportunities for patient information to be accessible eg in outpatients. 3. Explore the opportunities for enabling access to Transplant patient information eg in outpatients. 4. Investigate opportunities for access to outreach patient documentation eg patient letters.			Submit bid for CF database to TDB Develop recommendations for Transplant patient notes access.	Commence development of CF database Develop recommendations for access to outreach patient documentation.
		7.6	Continue to develop management and leadership including Specialty Leads, Clinical Unit Teams and Trust Board.	All managers	Continue to clearly identify staff personal objectives through the IPR process.				All staff to have current IPR with defined objectives.

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2011-12 Trust objectives				Local Plan		Milestones/Metrics			
Strategic Objective	Work-stream	Trust Action		Department Lead	Department Action(s)	Qtr 1	Qtr 2	Qtr 3	Qtr 4
1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	**Maintain our focus on Zero Harm**	1.1	Continue the development of systems to decrease adverse drug events by targeted actions such as the expansion of the CIVAS service and other strategies aimed at concentrating on named high risk medications and named high risk areas in the Trust with the aim of a 25% reduction against the 2010 baseline.	Julie Bayliss	Continue to establish medicines management inititatives in collboration with pharmacy Develop Unit wide intravenous therapy administration guidelines	Develop a robust plan following on form the work achieved in 10/11 and inlcude key targets	Ensure adherance to plan, including feeding back to individuals around any specific errors	Release impact following CVAS provision	Demonstrate improved quality of care and release of nursing time
		1.2	Continue our work to reduce specific hospital acquired infections including Central Venous Line infections (CVL), Surgical Site infections (SSI) and Ventilator Associated Pneumonia (VAP) from current baseline over the next year.	Julie Bayliss	Continue our work to reduce specific hospital acquired infections including Central Venous Line infections (CVL), Surgical Site infections (SSI) and Ventilator Associated Pneumonia (VAP) from current baseline over the next year.	Achieve key targets	Achieve key targets	Achieve key targets	Achieve key targets
		1.3	Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.	Julie Bayliss	Develop a named child protection link within the Unit	Recruit to the child protection lead post	Ensure Unit representation at key meetings and that all info is disseminated	Ensure Unit representation at key meetings and that all info is disseminated	Ensure Unit representation at key meetings and that all info is disseminated
		1.4	Develop and monitor new structure for managing and learning from Serious Untoward Incidents (SUIs)	Toral Pandya	Utilise transformation co-ordinator to develop and monitor new structure for managing and learning from Serious Untoward Incidents (SUIs)	Ensure all clinical staff are aware of the Transformation Co-ordinator and her role	Utilise TC to ensure robust plan is established following any SUI's and is actioned appropriately.	Utilise TC to ensure robust plan is established following any SUI's and is actioned appropriately.	Utilise TC to ensure robust plan is established following any SUI's and is actioned appropriately.
		1.5	Ensure effectivce provision of nutritional care for all patients	Julie Bayliss	Ensure effective provision of nutritional care for all patients	Ensure all wards have access to the appropriate height and weight equipment	Ensure protected meal times are established	Monitor protected meal times	Set up nutritional screening and assessment
		1.6	Ensure provision of safe services for the deteriorating and critically ill child.	Julie Bayliss	Bed utilisation - working with ICON / PICU / CEWS - use them within ICI to establish child deterioration	Ensure CEWS are in place and that effective proactive commuication is taking place with ICON	Establish regular review meetings with ICON	Montior communication with PICU and ICON, utilising work done by Outreach teams	Montior communication with PICU and ICON, utilising work done by Outreach teams
	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	1.7	Gather and report outcome data and information to demonstrate the clinical effectiveness of the organisation and benchmark agains comparable organisations, moving towards measuring clinical effectiveness in real time.	Sarah Crawshaw / James O'Brien	Gather and report outcome data and information to demonstrate the clinical effectiveness of each speciality and benchmark against comparable services at an international level, where possible.	Develop 2 clinical outcoem measures for each specialty	Ensure robust data collection processes are in place for each measure	Source and collect data from comparable benchmarks	Work to develop additional measures for each specialty
		1.8	Ensure accountability for delivery of CQUIN targets are fully devolved operationally and monitored regularly	Sarah Crawshaw / James O'Brien	Establish effective and useful CQUINS and QIDIS targets across the Unit, ensuring accountability and regular monitoring is established.	In collaboration with commissioners, agree CQUINS targets for 11/12	Develop mid year report ensuring performance against target	necessary measures to ensure performance against taregts are put in	year report ensuring perfromance against original
2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations	**Continue to reduce waiting times further through our 'no waits' programme**	2.1	Continue to meet national and commissioning standards and improve the utilisation and efiiciency of our resources.	Sarah Crawshaw / James O'Brien	Continue to meet national and commissioning standards and improve the utilisation and efficiency of our resources through advcanced access, 18 weeks and CWT compliance	Achieve targets	Achieve targets	Achieve targets	Achieve targets
	Improve the standard of customer service that we offer patients and families	2.2	Ensure the effective measurement and improvement of patient experience through agreement and implementation of a patient experience action plan	Sarah Crawshaw / Julie Bayliss	Ensure the Unit is aware of how satisfied patients and families are across our wards and outpatient areas, based on realistic expectations and ensure this is monitored and developed (with a view to improving) throughout the year.	Develop an annual plan including milestones and targets	Ensure performance against plan	Ensure performance against plan	Review plan in conjunction with parent representatives and develop this for the year ahead
	Continue to improve our relationships with referrers in order to achieve our market share objective.	2.3	Continue to implement the actions for improvement following the results of the Referrer Survey including implementing a bed management solution.	James O'Brien / Mary Foo Cabellero	Continue to implement the actions for improvement following the results of the Referrer Survey including implementing a bed management solution.	Identify admission criteria for each specialty followign work with bed management project group	Work with Referrers Experience Project Group to work up clear discharge standards (meeting CQC compliance)	Continue to identify improvement actions and implement locally	Continue to identify improvement actions and implement locally
	Continue to improve the patient environment through major upgrades, working closely with our charitable partners	2.4	Invest within our 10 year capital programme to improve the patient environment within our existing buildings and continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the development of the Morgan Stanley Clinical Building (MSCB) due to complete in December 2011 and the continued development of the Phase 2b Full Business Case for final submission in July 2011.			e			
		2.5	Prepare to move into the Morgan Stanley Clinical Building including workforce redesign.						
3. Successfully deliver our clinical growth strategy	**Deliver our planned in year growth**	3.1	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).	General Manager	Deliver planned growth in line with our Integrated Business Plan (IBP).	Ensure growth is split between specialties and there is ownership/understanding of activity levels required and that this growth can be achieved within costs assumed.	Review growth progress and adjust plans accordingly, ensuring any slippage from plan is addressed (where possible - within control of unit) with a remedial action plan outlined.	Assess growth delivered to date for Q1 & Q2 and apply learning to support delivery in Q3 & Q4	Analyse growth delivered by unit and ensure remaining 11/12 growth is delivered, reflect and use to inform growth plans for 12/13.
	Maintain IPP service growth	3.2	Improve patient access and staff recruitment and retention to ensure IPP income target is achieved						
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	3.3	Achieve accreditation as a national paediatric centre for cardiac and neuro-surgery through the new national processes, and plan to accommodate any further growth that arises from this process.						
		3.4	Work with partners in the region to deliver paediatric tertiary care in light of NHS London proposals.	Julie Bayliss / Sarah Crawshaw / Haem and Onc Specialty Leads	Work with partners in the region to deliver paediatric Haematology and Oncology tertiary care plan.	Work closely with our POSCU's to ensure partnership delivers the required service plan	Ensure performance and demonstartion of the Children's Cancer Measures and support POSCU's to achieve the same where possible	Achieve peer review accrediatationa gainst cancer measures	Following peer review develop any measures which require further work.

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4. With partners maintain and develop our position as the UK's top children's research organisation	**Continue to develop partnership working**	4.1	Continue to work with University College London Partners (UCLP) and leverage benefits from this.						
		4.2	Extend collaboration with UCL Business to include GOSH commercial contracts and leverage benefits from this.						
		4.3	Implement a new governance structure which spans the Division of Research and Innovation and includes all the major stakeholders	Nicholas Goulden	Implement a new governance structure which spans the Division of Research and Innovation and includes all the major stakeholders	Estabish a new structure for Clinical Trials	Appoint to the team leader role	Recruit to posts beneath team leader	Ensure accountability of all staff
		4.4	Agree operational and management arrangements for Great Ormond Street Hospital / Institute of Child Health (GOSH/ICH) joint research activity administered by the Research and Development (R&D) office and clarify systems and processes for ensuring funding	Nicholas Goulden, Kathy Pritchard Jones, Myra Bluebond	Agree operational and management arrangements for Great Ormond Street Hospital / Institute of Child Health (GOSH/ICH) joint research activity administered by the Research and Development (R&D) office and clarify systems and processes for ensuring funding				
	In year delivery (research)	4.5	Strengthen our grant-writing infrastructure to increase our success in obtaining research grants.	Nicholas Goulden	Strengthen our grant-writing infrastructure to increase our success in obtaining research grants.	Appoint a Translational Research Co-ordinator to work with the Research Lead.	Develop a robust plan for grant writing with the Haem / Onc Unit	Ensure performance against plan and review this with finance dept	Ensure performance against plan and review this with finance dept
		4.6	Strengthen Communications with GOSH and ICH to ensure that press and publicity of the Division of R&I is adequately reflected internally and externally.						
5. Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	**To work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK**	5.1	With our partner Higher Education Institutes (HEI) develop appropriate curricula to meet the professional standards required to drive excellence at GOSH.	Catherine Cale / Sarah Crawshaw / James O'Brien / Educational Leads	In collabroation with our Educational Leads develop relationship with Deanery	Develop criteria and associated communication methods for the continual assessment of junior doctors across the Unit.			
		5.2	Implement the Trust's Education and Training Strategy through the delivery of an innovative and effective programme of blended learning using the on-line campus, classroom & work-based teaching and simulator learning.						
6. Deliver a financially stable organisation	**Agree achievable CRES plan and ensure delivery through robust project and performance management**	6.1	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.	Catherine Cale / Sarah Crawshaw / Terry Whittle	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.	Complete robust plans for 12/13 CRES plan	Ensure at least 60% of our 11/12 CRES plans are green	Ensure at least 75% or our 11/12 CRES plans are green and 50% are blue and ensure our 12/13 plans are robust, achievable and account for at least 70% of the target	Ensure at least 95% of our 11/12 CRES plans are blue and ensure our 12/13 plans are robust, achievable and account for at least 85% of the target
		6.2	Deliver surplus to plan.						
	Improve efficiency through our Transformation Programme	6.3	Deliver operational efficiencies through the devolved Transformation team and engine-room projects.						
	Ensure appropriate funding for our clinical services from commissioners	6.4	Work with other specialist paediatric providers on work streams which will provide evidence to DH to support maintenance of specialist top up or targeted tariff design changes.						
		6.5	Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.						
	Support the charity to raise targeted funds	6.6	Continue to strengthen communication between GOSH and GOSH Charity at all levels to ensure fund-raising targets are met						
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	**Make progress towards becoming a Foundation Trust**	7.1	Complete monitor assessment, attain authorisation status and establish an effective members council.						
	Ensure that the Trust is compliant with regulatory requirements	7.2	Ensure that the Trust retains registered status with CQC.	Julie Bayliss	Ensure that the Trust retains registered status with CQC.	Ensure we have robust Unit plans in place to ensure we are compliant	Set up education sessions to ensure all staff are clear as to what we need to achieve	Work with infection control to ensure we meet the standard	Montior against targets
		7.3	Ensure that Information Governance processes are strengthened and the self assessment score in the IG toolkit is improved.	Sarah Crawshaw / James O'Brien	Ensure that Information Governance processes are strengthened and the self assessment score in the IG toolkit is improved.	Establish a Unit wide data quality plan ensuring governance is key, and monitor targets against staff IG completion	Ensure performance against plan	Ensure performance against plan	Ensure performance against plan
	Imrove the ability of the organisation to deliver efficient business processes	7.4	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.	Sarah Crawshaw / James O'Brien	Improve the quality and access to critical information across the Unit.	Establish a Unit wide data quality plan with associated targets	Ensure performance against plan	Ensure performance against plan	Ensure performance against plan
		7.5	Deliver the first year of an agreed medium term IT strategy which ensures robust IT infrastructure and a credible and fundable replacement strategy for critical business applications.						
		7.6	Continue to develop management and leadership including Specialty Leads, Clinical Unit Teams and Trust Board.	Catherine Cale	1. Ensure the stability of the Unit's management team following the departure of the General Manager. 2. Develop the role of the Specialty Lead	all work streams is established and advertise substantive GM post 2. Estalish a Unit a plan to develop the role of the	1. Recruit to the substantive GM post 2. Deliver specialty lead training / development day	2. Assess the role of the Specialty Leads against the job description	survey to establish satisfaction with senior management team and specialty leads.

MDTS Business Plan 2011-12

2011-12 Trust objectives MDTS				MDTS Local Plan		Milestones/Metrics			
Strategic Objective	Work-stream	Trust Action		Department Lead	Department Action(s)	Qtr 1	Qtr 2	Qtr 3	Qtr 4
1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	**Maintain our focus on Zero Harm**	1.1	Continue the development of systems to decrease adverse drug events by targeted actions such as the expansion of the CIVAS service and other strategies aimed at concentrating on named high risk medications and named high risk areas in the Trust with the aim of a 25% reduction against the 2010 baseline.	J Cope	Pharmacy } Electronic Prescribing in Outpatients	Training	Implementation		
				J Cope	Pharmacy } Expansion of CIVAS	Recruit staff & set up system	Implementation of phase 1	Review Medicines for Phase 2	Implement Phase 2
				J Cope	Establish a work programme for Medicines Transformation post	Recruit to post	Agree work programme	Monitor work programme	Monitor work programme
				M Goninon	Monitoring: Administration/Prescribing Errors to be collated on a monthly basis and entered onto Transformation dashboard. Results to be audited every 3 months and action plans developed to address areas of concern	To establish good practice in data collection through Lead nurse and ward Sisters monitoring	Commence monitoring of pharmacists interventions	Collate results and identify areas of concern; formulate action plans	Review progress made in relation to action plans
		1.2	Continue our work to reduce specific hospital acquired infections including Central Venous Line infections (CVL), Surgical Site infections (SSI) and Ventilator Associated Pneumonia (VAP) from current baseline over the next year.	M Goninon	Use of CVL care bundles audited monthly. RCA's for MRSA and MSSA line infections. Hand hygiene audits monthly. Ensuring Trust Policies adhered to eg Bare Below the Elbows. Training programme instigated to ensure high levels of competence in central line care	Review monthly audits and RCA's within agreed timeframes.Teaching protocol reviewed and changes made. CVL champions identified, and trained	Review monthly audits and RCA's within agreed timeframes. Senior staff identified from ward area to be trained by the CVL champions, and to commence family training for home PN	Review monthly audits and RCA's within agreed timeframes. Audit of training process in relation to CVL infections and waiting times for family training for Home PN	Review monthly audits and RCA's within agreed timeframes. Evaluate the audit data
		1.3	Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.	M Goninon	Child Protection Link nurses. Trust is planning to instigate level 3 training for all clinical staff. Ward Sister and Specialty Leads aware of requirement to followup staff not up to date with mandatory training	Set up meetings with CP Named Nurse to discuss training requirements	Commence training of staff	Commence training of staff	Audit of staff numbers trained
		1.4	Develop and monitor new structure for managing and learning from Serious Untoward Incidents (SUIs).	M Goninon	Lead Nurse trained to investigate RCA's and SUI's. Feedback is within RAG's	Lead Nurse training complete	Process ongoing	Process ongoing	Process ongoing
		1.5	Ensure effective provision of nutritional care for all patients	M Goninon	All staff to be aware of protected meal times; nutritional risk assessment/screening tool and Policy to be implemented once developed	Action plan to be produced by each ward area with regards to protected meal times	Implement nutritional assessment /screening tool once developed		
		1.6	Ensure provision of safe services for the deteriorating and critically ill child.	M Goninon	Monitoring on use of CEWS and SBARD audited monthly as part of KPI's	Named responsible person identified in each area to audit	Action training needs as identified from audit data	Process ongoing	Process ongoing
				S Grunewald	Metabolic Medicine: working with PSST to produce alert for all notes of metabolic patients at risk of acute decompensation whilst undergoing surgical procedure		Alert produced by PSST	Metabolic Medicine trial of the alert	Metabolic Medicine using the alert
	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	1.7	Gather and report outcome data and information to demonstrate the clinical effectiveness of the organisation and benchmark against comparable organisations, moving towards measuring clinical effectiveness in real time.	L Davies / M Davidson	MDTS }Clinical Outcome Measures				MDTS Clinical Outcomes available on external website
				M Elawad	Gastroenterology } Working on ImproveCareNow project with 30 GI centres in the US to improve the care of our IBD patients. this will be an on going project	Ongoing	Ongoing	Ongoing	Ongoing
				M Elawad	Gastroenterology } Three clinical audits to start:a) clinical records for GI patients. b) National IBD audit for inpatients. c) National audit on success rate of colonoscopy.	Ongoing	Ongoing	Ongoing	Ongoing
		1.8	Ensure accountability for delivery of CQUIN targets are fully devolved operationally and monitored regularly	J Cope	Pharmacy } Continue with ICI CQUIN - reduction of prescribing errors and medicines reconciliation	If agreed with Commissioners, recruit staff for whole year	Ongoing monitoring and reporting	Ongoing monitoring and reporting	Ongoing monitoring and reporting
2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations	**Continue to reduce waiting times further through our 'no waits' programme**	2.1	Continue to meet national and commissioning standards and improve the utilisation and efiiciency of our resources.	A Cuff	Advanced Access - to continue to reduce waits ensure sustainability across all graduated specialties	Ongoing review of referral pooling. Weekly monitoring of wait times and communication to Service Leads. Weekly monitoring of transition patients with Service Leads. Implementation of telephone appointments for Endocrinology and Gastroenterology	Ongoing review of referral pooling. Weekly monitoring of wait times and communication to Service Leads. Weekly monitoring of transition patients with Service Leads. Identify demand for nurse/dietician led clinics	Ongoing review of referral pooling. Weekly monitoring of wait times and communication to Service Leads. Weekly monitoring of transition patients with Service Leads. Commence nurse/dietician led clinics	Ongoing review of referral pooling. Weekly monitoring of wait times and communication to Service Leads. Weekly monitoring of transition patients with Service Leads.
				A Cuff	-Clinic Outcome form completeness - work with clinical teams and central outpatient department to improve Clinic Outcome completeness to	Meet with OPD and Clinical teams to identify reasons for poor performance. Agree & implement action plan. Agree monitoring & communication strategy. Achieve 60% completeness.	Monitor progress against action plan. Produce weekly exception report for action by clinicians. Achieve 80% completeness	Monitor progress against action plan. Produce weekly exception report for action. Achieve 100% completeness	Monitor progress against action plan. Produce weekly exception report for action. Sustain 100% completeness
				A Cuff	-Discharge Notification completion within 24hrs - implement robust streamlined processes to ensure discharge notifications are sent to referrers, GP, patient & families wtihin 24 hour of their discharge from GOSH	Establish baseline performance for each ward area. Review admin process, process for clinical sign off, outcome form. Agree & implement action plan. Achieve 80% completion. Educate clinic teams re outcome form	Monitor progress against action plan. Produce daily exception report for action. Achieve 90% completeness. Review full discharge summary to be sent within 24 hrs for long stay ward	Monitor progress against action plan. Produce daily exception report for action. Achieve 100% completeness. Agree and implement action plan for full discharge summary completion within 24 hrs (long stay wards)	Monitor progress against action plan. Produce daily exception report for action. Sustain 100% completeness. Monitor progress against action plan for full discharge summary within 24 hrs (long stay wards)
				M Elawad	Gastroenterology } Changing consultant working patterns to provide twice a day consultant led ward round and robust coding and discharge summary and follow up	Commences April 2011			
				L Rees / M Goninon	Nephrology } Establishment of Apheresis Service within nephrology	Training and equipment identified	Training programme agreed and commenced	Purchase of equipment	Commencement of Apheresis service in Renal unit only
				J Allan / Radiology Specialty Lead	Radiology } MRI waiting times – review of processes Optimise utilisation of equipment - Change practice to improve utilisation	Demand and Capacity Plan	Work with Clinical Units to streamline service	Make Changes and monitor	
				S Gruenwald	Metabolic -Review / restructure of new referrals to teams with overlapping patients' cohorts (Metabolic, neurometabolic, neuromuscular, genetic eg): development of pathways to get the patients been seen by the most appropriate team (s) and / or multidisciplinary clinics - 'less wait, no waste, increased efficiency, improved streamlining of tests.	Project team formed, Project terms of reference scoped	Review of current referral patterns	Review of current referral patterns	Redesign referral pathways and acceptance pathways
				N Lench / A Barnicoat	Clinical Genetics } Develop integrated clinical laboratory genetics service and look at opportunities to share administrative team and other resources	Develop proposal for shared A&C resource. Consult stakeholders and make recommendations for change	Proposal out for Consultation	Integrate budgets and implement Plan	Monitor new A&C structure and performance
				A Barnicoat	Clinical Genetics } Introduce KPIs and performance of waiting times	KPI's identified , report format agreed and data collection pilot commences	Review of Pilot, finalise KPI report		
				J Cope (Radiology Specialty Lead)	Radiology } Introduce KPIs and performance of waiting times	KPI's in place			
	Improve the standard of customer service that we offer patients and families	2.2	Ensure the effective measurement and improvement of patient experience through agreement and implementation of a patient experience action plan	All	Specialty patient and family / user surveys	Ongoing	Ongoing	Ongoing	Ongoing
				M Ismach / R Cooke	Psychosocial and Family Services / Therapies } Bereavement Services - Coordination of work towards introduction of Medical Certification of Cause of Death - Trust wide legal change	Plan & begin implementation with DH, & reps from ICU, Palliatve care & Histopathology	Plan, review & begin implementation with DH,& reps from ICU, Palliatve care & Histopathology	Plan, review & begin implementation with DH,& reps from ICU, Palliatve care & Histopathology	Plan, review & begin implementation with DH,& reps from ICU, Palliatve care & Histopathology

MDTS Business Plan 2011-12

2011-12 Trust objectives MDTS				MDTS Local Plan		Milestones/Metrics			
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				S Grunewald	Metabolic - Detailed review metabolic test batteries, protocols and guidelines (avoiding unnecessary tests, duplications to ensure that these conform to national guidelines, - 'no harm, 'no waste), maximum use of ORDERCOM	Project team formed, Project terms of reference scoped	Review of current test batteries, protocols and guidelines	Review of current test batteries, protocols and guidelines	Redesign test batteries, protocols and guidelines
	Continue to improve our relationships with referrers in order to achieve our market share objective.	2.3	Continue to implement the actions for improvement following the results of the Referrer Survey including implementing a bed management solution.	M Goninon / H Sidhu / A Cuff / G Kang	Implementation of inpatient plan of care forms to be used for communication with DGH, PCT's. Monday Bed meetings with representation by consultants from Gastro/Endo/Met to prioritise urgent admissions. Lead Nurse on Bed Improvement Project Board	Admission criteria developed to measure delay on emergency admissions. Review of current admission policy	Guidelines developed by each specialty on length of stay for particular conditions. Inpatient plan of care forms to be utilised for communication with DGH's	Audit and review on patient turn over, length of stay, use of EDD. Action plans identified	Implementation of action plans
	Continue to improve the patient environment through major upgrades, working closely with our charitable partners	2.4	Invest within our 10 year capital programme to improve the patient environment within our existing buildings and continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the development of the Morgan Stanley Clinical Building (MSCB) due to complete in December 2011 and the continued development of the Phase 2b Full Business Case for final submission in July 2011.	J Cope	Pharmacy } Implementation of Intelligent Storage business case, (effect on Pharmacy staffing)	Tender by Procurement	Option Appraisal by Project Manager	Agree Pharmacy staffing model	Implement plan in preparation for opening of MSCB.
				J Cope (Radiology Specialty Lead)	Radiology } Replacing plain X ray room	Project complete			
				J Cope (Radiology Specialty Lead)	Radiology } Replacing ultrasounds, image intensifier (April 2011)	Project complete			
		2.5	Prepare to move into the Morgan Stanley Clinical Building including workforce redesign.	L Rees / M Goninon	Nephrology } Plan for Phase 2A – workforce changes, joining of dialysis and acute wards. Implementation of Eagle Core Group and Eagle Clinical Unit Group. Consider potential model of care flexible enough to adjust to fluctuating demand for Peritoneal Dialysis, Haemodialysis, Acute Patients and Outpatient clinics	Eagle Core Group and Eagle Clinical Unit Group meetings commenced	Issues / concerns linked back to MSCB Commissioning Board; specific plans action agreed	Issues / concerns linked back to MSCB Commissioning Board; specific plans action agreed	Move to Morgan Stanley Building April 2012
3. Successfully deliver our clinical growth strategy	**Deliver our planned in year growth**	3.1	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).	A Barnicoat	Clinical Genetics } Review of clinic provision across North London	Review of clinics continues	Publish recommendations and implement revised clinic structure		
				M Dattani	Endocrinology } Review Kingfisher – improvement of efficiency re ways of working of Endocrinology on Kingfisher Ward		Introduce change in Endocrine working practices		
				M Dattani	Endocrinology } Endocrinology } Future AGNSS bids :Craniopharyngioma; CHARGE syndrome; CHI transition; Septo-optic dysplasia service		Submit final bids for 2012/13 designation	Submit outline bids for 2013/14 designation	
				M Dattani	Endocrinology } Submit Business case for expansion of Diabetes service - Additional support additional 5PAs Endocrine Consultant (CNS for Diabetic service)	Submit Business Case		If Business Case approved set up new service	
				M Dattani	Endocrinology } Specialist clinics in complex midline brain and pituitary disorders			Establish specialist clinics	
				M Elawad	Gastroenterology } AGNSS / NCG funded Pseudo Obstruction Gut Disorders (motility assessment) service.	Commencement of service			
				M Elawad	Gastroenterology } Future AGNSS bids, Paediatric Intestinal Enhancement and Rehabilitation, Swachman Diamond Syndrome		Submit final bids for 2012/13 designation	Submit outline bids for 2013/14 designation	
				N Lench	Genetics Laboratories } Expansion of service (BRACA):	Advertising and recruitment for staff	Staff working notice period. Formalise service implementation plan	Introduce BRCA1/2 testing	Audit performance of service
				N Lench	Genetics Laboratories } Plan for collaboration with Kennedy Galton Centre "KGC"	Meet with KGC and explore options - make "go"/"no-go" decision	If "go" - draft strategy document. If "no-go" - watching brief for KGC	Meet with LSCG (commissioners) to discuss proposals	Implement plan
				N Lench	Genetics Laboratories } Collaboration with Institute of Neurology	Collaborate on service development for mitochondrial DNA sequencing	Review send-away costs for neurology tests	Implement measures to reduce neurology send away test costs. Review options for neuromuscular NCG diagnostics service	Implement actions re: NCG neuromuscular service
				S Grunewald / M Goninon	Metabolic Medicine } Introduction of Nurse led clinics * Familial Hypercholesterolemia (resources / staff needed)	Review demand and resources required	Redesign workforce, book additional clinic space for pilot	Pilot using shadow clinics	Commence Nurse led clinics
				J Cope	Pharmacy } Improve PN service - implement PN business case (Jan 2011)	Recruit staff & set up system	Implement and monitor drug savings		
				S Grunewald / M Davidson	Metabolic Medicine } Potential application for NCG/AGNESS funding for Methylmalonic aciduria			Submit outline bids for 2013/14 designation	
				S Grunewald	Metabolic - Continue to develop partnership working: Laboratory Medicine Active translational and basic research programme between GOSH and NHNN (Prof P Clayton / Prof S Heales / Dr P Gissen / Dr S Rahman / Dr S Grunewald / Dr K Mills)	Ongoing	Ongoing	Ongoing	Ongoing
				M Ismach / J Wilcox	Psychosocial and Family Services / Therapies} Volunteer Services - to double number of volunteers - including rolling out parent patient support (PPS) vols across all wards	PPS on 4 more wards. Recruit / train 160 new vols	PPS on 2 new wards. Recruit / train 40 new vols	PPS on 4 new wards. Recruit / train 60 new vols	PPS on 2 new wards. Recruit / train 40 new vols
				J Allan / Radiology Clinical Lead	Radiology } IR expansion plans, implement IR business case (Feb 2011)	Recruit staff	Begin implementation	Full implementation if staff recruited and space available	Monitor Activity
				Caroleen Shipster	Speech and Language } Future AGNSS bids for designstion, MDT Beckwith Wiedermann Syndrome with Macroglossia Syndrome		Submit final bids for 2012/13 designation	Submit outline bids for 2013/14 designation	
	Maintain IPP service growth	3.2	Improve patient access and staff recruitment and retention to ensure IPP income target is achieved	M Dattani / A Cuff	Endocrinology } Review opportunities for additional IPP activity				Identify additional activity by December 11
				M Elawad	Gastroenterology } Start of extra IPP endoscopy list and conversion of one of the 2 sedation lists to short acting list, this will lead to increase of total endoscopy list to 8 lists per week.	IPP List running. Conversion of Friday AM sedation list to short acting list	Conversion of 2nd sedation list (Wednesday AM) to short acting list		
				M Goninon / H Sidhu	IPP lists to commence in Gastro suite	List commenced March 2011	Review and decide action plans	Implement action plans, continue to review	Implement action plans, continue to review
				S Grunewald / A Cuff	Metabolic Medicine } Review of workload and activity (IPP and NHS)	Review current level of demand and resource supply	Business case for increased resource (if required)	Commence recruitment if business case approved	
				L Rees / M Goninon	Nephrology } Increase in IPP work			Monitor Activity	

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2011-12 Trust objectives MDTS				MDTS Local Plan		Milestones/Metrics			
Strategic Objective	Work-stream	Trust Action		Department Lead	Department Action(s)	Qtr 1	Qtr 2	Qtr 3	Qtr 4
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	3.3	Achieve accreditation as a national paediatric centre for cardiac and neuro-surgery through the new national processes, and plan to accommodate any further growth that arises from this process.						
		3.4	Work with partners in the region to deliver paediatric tertiary care in light of NHS London proposals.	A Gregorowski	ADM } Continue review of working in collaboration with UCLH		Review completes		
				M Elawad	Gastroenterology } Planned collaborative work with C & W hospital with aim to expand our intestinal failure, IBD and motility service.	Ongoing	Ongoing	Ongoing	Ongoing
4. With partners maintain and develop our position as the UK's top children's research organisation	**Continue to develop partnership working**	4.1	Continue to work with University College London Partners (UCLP) and leverage benefits from this.	J Allan / J Cope	Pharmacy } BME review - Work with UCLP on back office functions.	Ongoing	Ongoing	Ongoing	Ongoing
				J Allan / J Cope	Pharmacy } Work with UCLP on back office functions.	Ongoing	Ongoing	Ongoing	Ongoing
				R Schmale	Physiotherapy: 1.1wte funded for 3 year project to collect normal gait data in children and identify diagnostic and prognostic gait characteristics in clinical populations	Set up R&D project structure Obtain ethics approval and recruit staff	Set up R&D project structure Obtain ethics approval and recruit staff	Commence data collection	Continue data collection
				N Jessop	OT & physio: 0.5 wte for each therapist for GVHD research project to start when ethics have been agreed. Funded by research grant for 1 year.	Set up R&D project structure Obtain ethics approval	Recruit staff	Commence data collection	Continue data collection
		4.2	Extend collaboration with UCL Business to include GOSH commercial contracts and leverage benefits from this.						
		4.3	Implement a new governance structure which spans the Division of Research and Innovation and includes all the major stakeholders						
		4.4	Agree operational and management arrangements for Great Ormond Street Hospital / Institute of Child Health (GOSH/ICH) joint research activity administered by the Research and Development (R&D) office and clarify systems and processes for ensuring funding						
	In year delivery (research)	4.5	Strengthen our grant-writing infrastructure to increase our success in obtaining research grants.	J Cope	Pharmacy } Establish robust funding for clinical trial workforce.	Provide information for funding bid			
		4.6	Strengthen Communications with GOSH and ICH to ensure that press and publicity of the Division of R&I is adequately reflected internally and externally.	M Elawad	Gastroenterology } 5 year programme research project directed to understand disease impact on children with GI disorders and diagnostic tools to understand path physiology of gut disease... this is charity funded project for three years with more than 10 new research staff recruited to carry out clinical and academic research.	Ongoing	Ongoing	Ongoing	Ongoing
				J Cope (Radiology Specialty Lead)	Radiology } Establish a method for recording research investigations	Completion of methodology report	Implementation of agreed actions from report	Ongoing monitoring of impact	Ongoing monitoring of impact
				M Elawad	Gastroenterology } The start of the paediatric gastroenterology academy at GOSH...this will host 8 national and international conferences led by the unit	Ongoing	Ongoing	Ongoing	Ongoing
5. Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	**To work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK**	5.1	With our partner Higher Education Institutes (HEI) develop appropriate curricula to meet the professional standards required to drive excellence at GOSH.	S Grunewald	Metabolic Medicine - active involvement in the newly establish College Specialty Advisory Committees (CSACs) for Metabolic Medicine (accreditation). Position ourselves as a pan-London leader of networked paediatric metabolic services, providing co-ordination, training and education and setting standards	Develop portfolio of educational portfolio of trainees.	Develop portfolio of educational portfolio of trainees.	Review availability of resources to meet training requirements	Put training resources in place as necessary
				M Dattani	Endocrinology } Together with UCLH lead in education and training in Endocrinology throughout London. Networks already in place and ongoing collaboration with Barts and the London		Develop and produce an educational syllabus		
				R Schmale	Physiotherapy: provide training and education placements for graduate and post graduate students within London consortium, national and internation. Audit and monitor feedback	8-10 students on placement	8-10 students on placement	8-10 students on placement	8-10 students on placement
		5.2	Implement the Trust's Education and Training Strategy through the delivery of an innovative and effective programme of blended learning using the on-line campus, classroom & work-based teaching and simulator learning.						
6. Deliver a financially stable organisation	**Agree achievable CRES plan and ensure delivery through robust project and performance management**	6.1	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.	J Allan	MDTS CRES Plans 2011/12 & 2012/13	MDTS CRES Plan agreed and 2011/12 monitored	MDTS CRES Plan 2011/12 monitored	MDTS CRES Plan 2011/12 monitored	MDTS CRES Plan 2011/12 monitored
				J Cope (Radiology Specialty Lead)	Radiology } CRES released from changes to out of hours rotas	Establish value of savings	Release CRES savings		
				S Grunewald	Metabolic Medicine } Detailed review metabolic test batteries, protocols and guidelines (avoiding unnecessary tests, duplications to ensure that these conform to national guidelines * needs resources, - 'no harm, 'no waste), maximum use of ORDER COM			Complete Review	
				M Dattani	Endocrinology } Complete review of Endocrine protocols to ensure that they are safe and cost effective.		Complete review of protocols, amend protocols as necessary and implement	Monitor amended protocols	
		6.2	Deliver surplus to plan.	A Cuff	Monitor activity increases , (see above re Activity increases)	Monitor Activity	Monitor Activity	Monitor Activity	Monitor Activity
	Improve efficiency through our Transformation Programme	6.3	Deliver operational efficiencies through the devolved Transformation team and engine-room projects.	M Ismach	Psychosocial and Family Services New ways of working to deliver - development of Psychosocial SLA - pilot in Cardiac	Agree SLA. Implement new structure	monitor, amend and review	monitor, amend and review	monitor, amend and review
				H Sidhu	Rainforest drug room redesign	Liase with ward sister and Transformation for quotes for work required	Agree date for work to commence	Orientation of staff to new lay out	
				H Sidhu	GI Suite} GIU new materials management system	Building work to commence April 2011; Materials management project to also commence	Works completed; stock levels controled by materials management	Review of new system	
				M Elawad	Gastroenterology Sub specialisation of consultant teams Consultant on call to take sole responsibility for carrying out daily ward rounds making admission and discharge decisions	New oncall / offcall system commences	Review of oncall / offcall system		

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2011-12 Trust objectives MDTS				MDTS Local Plan		Milestones/Metrics			
Strategic Objective	Work-stream	Trust Action		Department Lead	Department Action(s)	Qtr 1	Qtr 2	Qtr 3	Qtr 4
				A Cuff / A Barnicoat	Maximise the utilisation of Clinical Genetics clinics by reducing the DNA rate	Establish DNA baseline. Establish causes for DNA rates. Develop action plan	Implement action plan. Monitor utilisation/dna on a weekly basis	Monitor performance weekly. Achieve 10% DNA rate	Monitor performance weekly. Sustain 10% DNA rate
				M Ismach	TP&FS - Social Work ◦ Review of service & implementation of identified changes to the delivery of social work across GOSH. Achieve new contract with Camden.	1. Specific activities/detailed plan. Working groups formed/information gathered/pilots starting. 2. Work with Camden on contract.	1. Monitor, review & Implement plan. 2. Complete contract with Camden	Monitor, review & Implement plan	Monitor, review & Implement plan
				M Ismach / M Bryon / M Cullen	TP&FS Contribute to development of cross Trust system to improve management of Medically Unexplained Symptoms (MUS)	Attend meetings & contribute to development	Attend meetings & contribute to development	Attend meetings & contribute to development	Particpate in implementation
				M Goninon / H Sidhu	Transforming Care on Your Ward Offering same day assessment on Kingfisher	Planning bed usage for extra bed days when neuro patients move to Starfish	Implementing plan	Review and refine	
	Ensure appropriate funding for our clinical services from commissioners	6.4	Work with other specialist paediatric providers on work streams which will provide evidence to DH to support maintenance of specialist top up or targeted tariff design changes.						
		6.5	Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.						
	Support the charity to raise targeted funds	6.6	Continue to strengthen communication between GOSH and GOSH Charity at all levels to ensure fund-raising targets are met						
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	**Make progress towards becoming a Foundation Trust**	7.1	Complete monitor assessment, attain authorisation status and establish an effective members council.						
	Ensure that the Trust is compliant with regulatory requirements	7.2	Ensure that the Trust retains registered status with CQC.						
		7.3	Ensure that Information Governance processes are strengthened and the self assessment score in the IG toolkit is improved.						
	Imrove the ability of the organisation to deliver efficient business processes	7.4	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.	A Barnicoat / A Cuff	Clinical Genetics } Electronic filing of notes		Review current process and implement any necessary changes to processes		
		7.5	Deliver the first year of an agreed medium term IT strategy which ensures robust IT infrastructure and a credible and fundable replacement strategy for critical business applications.						
		7.6	Continue to develop management and leadership including Specialty Leads, Clinical Unit Teams and Trust Board.	M Hiorns / J Allan	Development plans as per PDRs	Ongoing	Ongoing	Ongoing	Ongoing
				M Hiorns / J Allan	Radiology } Appointment of specialty lead	Appointment of Radiology Specialty Lead			
				M Hiorns / J Allan	ADM }Funding for 2 Consultant Pas to support the Adolescent Medicine service provided through the general paediatric team.		Appointment of ADM Consultant		
				M Hiorns / J Allan	Appoinmtment of MDTS Unit Patient Safety Officer (PSO) and MDTS Unit Improvement Clinical Lead	Appointment of MDTS Unit Patient Safety Officer (PSO) and MDTS Unit Improvement Clinical Lead			
				M Hiorns / J Allan	Appointment of a deputy for the MDTS Clinical Chair		Appointment of MDTS Deputy Chair		
				M Hiorns / J Allan	Clinical Genetics } Appointment of a Clinical Genetics Specialty Lead,			Appointment of a Clinical Genetics Specialty Lead	
				M Ismach/Heads of Service	Psychosocial and Family Services / Therapies } Therapies Management structure	Implementation of consultation	Implementation of consultation	Implementation of consultation	Implementation of consultation
				M Ismach / M Bryon / D Hearst	Psychosocial and Family Services / Therapies } Psychology Management of Play Service	Develop plan	Develop plan - begin implementation	Develop plan - begin implementation	Develop plan - begin implementation
				M Ismach / J Allan / L Morgan	AHP closer links with professional lead (Chief Nurse)	development meetings	development day	development of plan	Implementation of action plans
				M Ismach / Heads of Service /TP&FS Managers	To use new system of collection of activity data to collect information which supports effective, efficient & costed working	TP&FS staff commence use of new activity data collection system	Business manager recruited - oversee analysis of data	Data is used to inform management decision making & development of SLA	Monitor and review

Neurosciences Business Plan 2011-12

2011-12 Trust objectives				Local Plan		Milestones/Metrics			
Strategic Objective	Work-stream	Trust Action		Department Lead	Department Action(s)	Qtr 1	Qtr 2	Qtr 3	Qtr 4
1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	Maintain our focus on Zero Harm	1.1	Continue the development of systems to decrease adverse drug events by targeted actions such as the expansion of the CIVAS service and other strategies aimed at concentrating on named high risk medications and named high risk areas in the Trust with the aim of a 25% reduction against the 2010 baseline.		Develop action plan for CIVAS / intelligent storage, and link to unit workforce redesign. Consider appointment of unit Pharmacist. Put in place a risk management for medication errors that includes robust process for acting on all incidents and near misses.	workforce redesign plan and medication risk management plan all in place	workforce redesign plan and medication risk management plan all in place	workforce redesign plan and medication risk management plan all in place	workforce redesign plan and medication risk management plan all in place
		1.2	Continue our work to reduce specific hospital acquired infections including Central Venous Line infections (CVL), Surgical Site infections (SSI) and Ventilator Associated Pneumonia (VAP) from current baseline over the next year.		Implement all recommendations from RCA of SSI in neurosurgery. Audit dressing use on Parrot / Tiger.	Recommendations agreed and action plan in place	Actions completed. Dressing audit completed.		
		1.3	Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.		**Neurology / Neurosurgery:** Engage in NSPCC work on education regarding shaken baby syndrome **General Paediatricians** / Named Doctor to review CP processes. **CAMHS** - bespoke training across unit. CIPP high risk patients all have CPA	ALL: % staff with recorded CP training. CIPP patients all with CPA Completed	ALL: % staff with recorded CP training	ALL: % staff with recorded CP training	ALL: % staff with recorded CP training
		1.4	Develop and monitor new structure for managing and learning from Serious Untoward Incidents (SUIs)		**All:** ensure SI investigations are instigated within 24 hours of notification, and completed within 8 weeks.	Completion of SI / RCA investigations. All with action plans	Completion of SI / RCA investigations. All with action plans	Completion of SI / RCA investigations. All with action plans	Completion of SI / RCA investigations. All with action plans
		1.5	Ensure effectivce provision of nutritional care for all patients						
		1.6	Ensure provision of safe services for the deteriorating and critically ill child.		**General Paediatricians:** deliver project plan to reduce the number and severity of incidents for surgical patients, to reduce the LOS for complex patients, to improve the hospital handover process and improve paediatric education to junior doctors	Measures to be defined: critical incidents occurring out of hours and relating to patients who were not flagged; emergency admissions to PICU (including daytime readmissions); patient satisfaction and number of complaints from patients accessing multiple (>5) specialties; critical incidents relating to post-op patients; readmissions/admissions to PICU for post-op patients; LOS of complex patients; communication with local hospitals (satisfaction); national trainee survey; internal trainee survey; % of education supervisors trained to agreed standard; educational environment; % of medical staff with training on GOLD.			
	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	1.7	Gather and report outcome data and information to demonstrate the clinical effectiveness of the organisation and benchmark against comparable organisations, moving towards measuring clinical effectiveness in real time.		**Neuromuscular**: Continue to engage in NorthStar registry to collate national information on outcomes.On going work on Clinical Outcome measures for children with Congenital Myasthenia to gain more objective data on response to pharmacological treatments**Neurology:** Repeat NEUGEN outcome audit. **Neurosurgery:** continue to monitor surgical complications, Epilepsy Surgery audit: Review of the incidence and characteristics of post operative chronic headache in patients with Rasmussen's encephalitis who have undergone epilepsy surgery. PROMS: Prospective study examining the effects of epilepsy surgery on seizure severity and QOL, in children with refractory epilepsy. Currently collecting data -aim to complete in 12 months time.Currently collecting data - aim to complete Sept 11. **CAMHS** - Clinic Outcome Database implemented across unit. **Neurodisability**: 1. Further develop the Parent Understanding of Neurodisability Questionnaire (Joint Holoway and ICH Doctorate project) and introduce as routine outcome measure for clinics in Neurodisability Service 2.Develop Benchmarking measures for movement disorder, autism services against similar services	**Neurosurgery:** <15% adverse event rate **CAMHS** - database collection implemented. **NDS** Design and commence PUNQ project	**Neurology:** NEUGEN audit results **Neurosurgery:** <15% adverse event rate **CAMHS** Data reviewed with action plan. **NDS** Complete PUNQ doctorate dissertation, design benchmarking measures	**Neurosurgery:** <15% adverse event rate Rasmussens audit completed and shared. **CAMHS** data reviewed **-** Implement plan. **NDS** Implement PUNQ in clincial practice, Design benchmarking measures	**Neurosurgery:** <15% adverse event rate. Refractory epilepsy audit completed. **CAMHS** data reviewed **NDS** Report first outcomes using PNUQ and benchmarking exercise
		1.8	Ensure accountability for delivery of CQUIN targets are fully devolved operationally and monitored regularly		**All:** continued improvement on quality and timeliness of discharge summaries**OPG** - Review clinic templates and codes in light of patient pathways, working on DNA's and cancellations by the introduction of reminder calls. **CAMHS** Audit of Letter turnaround times	**All:** discharge summaries contain basic dataset and sent in 24 hours. **OPG** Base line developed **CAMHS** Audit start	**All:** discharge summaries contain basic dataset and sent in 24 hours. **OPG** Introduction of reminder calls **CAMHS** action plan and implementation	**All:** discharge summaries contain basic dataset and sent in 24 hours. **OPG** Results collated with necessary action plan	**All:** discharge summaries contain basic dataset and sent in 24 hours. **OPG** Action plan implemented with service improvements
	Continue to reduce waiting times further through our 'no waits' programme	2.1	Continue to meet national and commissioning standards and improve the utilisation and efiiciency of our resources.		**OPG** - Theatre Utilization project undertaken. **CAMHS** D&C model completed and lookat cross cover and cross working across the Unit **Neurodisability**: 1. Working with transformation lead increase automation and efficiency of administrative porcesses with support from IT and making better use of CDD 2.Use requested new clinic space to ensure most efficient use of staff to meet increased demand and waiting list targets	**OPG** Data gathering and input **CAMHS** feasaiblity of cross working **NDS** Meeting with transformation lead to develop new porceses	**OPG** Action plan formed to move forward on Consultant lists **CAMHS** - Review and action plan. **NDS** Implement new admin and support processes	**OPG CAMHS** Implement plan	**OPG CAMHS NDS** Review action plan. Measure improvement in key targets
	Improve the standard of customer service that we offer patients and families	2.2	Ensure the effective measurement and improvement of patient experience through agreement and implementation of a patient experience action plan		**Neuromuscular**: audit of patient experience for Duchene children on steroid treatment. **Neurosurgery:** audit of patient recall of information given to families of tumour patients to improve information and engagement. **OPG** - Patient satisfaction questionnaires to be introduced **Neurodisability**: 1. Continue with regular audit of parent satisfaction in all clinics, design new immediate feedback / comment card, recruit parent advisers fhe service. 2. Respond to sugestions and implement imrpovementsthrough improvement programme	**OPG** Plan the questionnaire with help from Lisa Davis **NDS** Design parent feedback card and implement	**OPG** Implement questionnaire **NDS** Regular review of comments at staff meetings	**OPG** Results collated with necessary action plan	**OPG** Action plan implemented with service improvements **NDS** Report on improvements achieved

Neurosciences Business Plan 2011-12

2011-12 Trust objectives				Local Plan		Milestones/Metrics			
Strategic Objective	Work-stream		Trust Action	Department Lead	Department Action(s)	Qtr 1	Qtr 2	Qtr 3	Qtr 4
2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations	**Continue to improve our relationships with referrers in order to achieve our market share objective.**	2.3	Continue to implement the actions for improvement following the results of the Referrer Survey including implementing a bed management solution.		**OPG -** Letter and Note audit to continue **Neurodisability:** Design and complete an audit of referrers for NDS, including some quesitons from Trust wide survey for benchmarking purposes	**OPG** Re- assess previous audits and implementation of action plans. **NDS** Design Audit	**NDS** Implement audit	**NDS** Report on findings and plan for any improvements suggested	
	Continue to improve the patient environment through major upgrades, working closely with our charitable partners	2.4	Invest within our 10 year capital programme to improve the patient environment within our existing buildings and continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the development of the Morgan Stanley Clinical Building (MSCB) due to complete in December 2011 and the continued development of the Phase 2b Full Business Case for final submission in July 2011.						
		2.5	Prepare to move into the Morgan Stanley Clinical Building including workforce redesign.		**Koala Project** board established with objectives to By redesigning and streamlining ward processes and environments, this project aims: 1.increase direct care time provided to patients 2.reduce patient LOS 3. reduce patient harm 4. increase bed utilisation and throughput 5. improve discharge planning (reduction in delayed discharges) 6. improve patient experience. This will be achieved through workstreams including : equipment and procurement; non-clinical space utilisation and storage; workforce redesign; and service delivery and clinical space utilisation We will also: Review and continuation of TCOYW initiatives. Improve communication on the ward e.g. by piloting 'Patient Status at a Glance' boards and promoting use of SBARD tool .	Board meetings	Board meetings, and actionplan in place	Board meetings, action plan in progress	Board meetings, action plan complete
3. Successfully deliver our clinical growth strategy	**Deliver our planned in year growth**	3.1	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).		**Neurosurgery:** Engage with Safe and Sustainable review. Expand theatre capacity to ensure we are able to expand our market share.**Neuromuscular:** deliver growth in line with NCG projections. **Neurology:** Deliver Starfish businesscase benefits. Establish effective outreach and network model. **CAMHS** - Social Communications Disorder, Eating disorder day hospital, Feeding disorder CNS post **Neurodisability** : Business Case	Assess Unit budget. Prepare business case	Business case for Management Board, review and action plan		
	Maintain IPP service growth	3.2	Improve patient access and staff recruitment and retention to ensure IPP income target is achieved		**Neurology:** Expand neurology IPP work**CAMHS** - Private Patient work - The Feeding Team **Neurodisability:** Consider how NDS can deliver private practice activity	**CAMHS** gather information and feasibility of the project	**CAMHS** prepare business case for Review	Prepare action plan and implement	
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	3.3	Achieve accreditation as a national paediatric centre for cardiac and neuro-surgery through the new national processes, and plan to accommodate any further growth that arises from this process.		**Neurodisability**: Support Neurosurgery development through development of services not currently provided but would be expected in a national Neurosurgery centre as set out in Business cases for Developmental epilepsy clinic supproting epilepsy surgery, traumatic brain injury outpatinet rehabilitation service, Intrathecal baclofen and deep brain stimulation spasticity management	**NDS** Submit business cases	**NDS** Recruit staff	**NDS** Commence additional services	
		3.4	Work with partners in the region to deliver paediatric tertiary care in light of NHS London proposals.		**Neurosurgery:** Engage in Safe and Sustainable review.**Neurology:** Develop neurology network. Continue to engage and lead Epilepsy network**Neurodisability**: Work with South London (Eveleina Children's Hospital) Autism service to consider development of joint services or shared trainign nad protocols				
4. With partners maintain and develop our position as the UK's top children's research organisation	**Continue to develop partnership working**	4.1	Continue to work with University College London Partners (UCLP) and leverage benefits from this.		**All:** ensure all research projects are documented in Neurosciences research project database. **Neurodisability**: Continue close working with Augmentative Communication research				
		4.2	Extend collaboration with UCL Business to include GOSH commercial contracts and leverage benefits from this.						
		4.3	Implement a new governance structure which spans the Division of Research and Innovation and includes all the major stakeholders		Agree unit plans for research for CAMHS, Neurology, Neuropsychology, Ophthalmology	Plans in place	Plans in place	plans in place	Plans in place
		4.4	Agree operational and management arrangements for Great Ormond Street Hospital / Institute of Child Health (GOSH/ICH) joint research activity administered by the Research and Development (R&D) office and clarify systems and processes for ensuring funding						
	In year delivery (research)	4.5	Strengthen our grant-writing infrastructure to increase our success in obtaining research grants.		**Neurodisability:** Continue to develop our research strategy and support services to develop research projects and obtain funding and support current projects				
		4.6	Strengthen Communications with GOSH and ICH to ensure that press and publicity of the Division of R&I is adequately reflected internally and externally.						
5. Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	**To work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK**	5.1	With our partner Higher Education Institutes (HEI) develop appropriate curricula to meet the professional standards required to drive excellence at GOSH.						
		5.2	Implement the Trust's Education and Training Strategy through the delivery of an innovative and effective programme of blended learning using the on-line campus, classroom & work-based teaching and simulator learning.		**CAMHS** - Social Communications Disorder Education Course **Neurodisability**: Continue to provide training to Specialist registrars, medical students, speech therapy and clinical psychology and undergraduate psychology students and contribute to Trust wide paediatric training	**CAMHS** Prepare information for the course and action plan	**CAMHS** Review plan and implement	**CAMHS** Review implementation	
6. Deliver a financially	**Agree achievable CRES plan and ensure delivery through robust project and performance management**	6.1	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.		**All:** identify 100% of CRES target for years 2 and 3. Continue to monitor on regular basis and implement innovative and efficient ways of ways through workforce project and service redesign.	100% of year 2 target identified	50% of year 2 target green	75% of year 2 green or blue	100% of CRES achieved. 100% of year 3 identified
		6.2	Deliver surplus to plan.		**Neurosurgery**: Engage in S&S review and increase market share through increase in theatre capacity. Establish TBI and spasticity services**CAMHS**: deliver growth in SCD and EDT through delivery of business cases. Improve efficiency through implementation of actions from Demand and Capacity review. **Neurodisability**: deliver growth through expanded services and engagement with TBI. **Neuromuscular:** increase capacity through service and workforce redesign.	Complete business cases needed for growth. Deliver on recommendations from workforce project	Monitor activity through financial reviews	Monitor activity through financial reviews	Monitor activity through financial reviews

2011-12 Trust objectives				Local Plan		Milestones/Metrics			
Strategic Objective	Work-stream	Trust Action		Department Lead	Department Action(s)	Qtr 1	Qtr 2	Qtr 3	Qtr 4
stable organisation	Improve efficiency through our Transformation Programme	6.3	Deliver operational efficiencies through the devolved Transformation team and engine-room projects.		**All:** Deliver workforce redesign project and enact recommendations.**Koala project:** deliver project and streamline services,**Neurodisability:** improve administrative processes.**Neuromuscular:** deliver service redesign.**CAMHS** - Demand & Capacity - implement recommendations.				
	Ensure appropriate funding for our clinical services from commissioners	6.4	Work with other specialist paediatric providers on work streams which will provide evidence to DH to support maintenance of specialist top up or targeted tariff design changes.		Engage in coding reviews and continue to audit care pathways.				
		6.5	Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.		**Neurodisability:** Additional space and business case investment will ensure waiting time targets are met				
	Support the charity to raise targeted funds	6.6	Continue to strengthen communication between GOSH and GOSH Charity at all levels to ensure fund-raising targets are met						
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	Make progress towards becoming a Foundation Trust	7.1	Complete monitor assessment, attain authorisation status and establish an effective members council.						
	Ensure that the Trust is compliant with regulatory requirements	7.2	Ensure that the Trust retains registered status with CQC.						
		7.3	Ensure that Information Governance processes are strengthened and the self assessment score in the IG toolkit is improved.						
	Imrove the ability of the organisation to deliver efficient business processes	7.4	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.						
		7.5	Deliver the first year of an agreed medium term IT strategy which ensures robust IT infrastructure and a credible and fundable replacement strategy for critical business applications.		**CAMHS** - work with AHP in time and motion study with hand held computers	**CAMHS** Work as part of the study	**CAMHS** Ensure Review and party to the action plans	**CAMHS** Help with any implmentation	
		7.6	Continue to develop management and leadership including Specialty Leads, Clinical Unit Teams and Trust Board.		**All:** ensure CUB and unit meetings function effectively in line with Governance Structure. Ensure all meetings have terms of reference and agreed objectives.	Governance structure in place all meetings with TOR	Governance structure in place all meetings with TOR	Governance structure in place all meetings with TOR	Governance structure in place all meetings with TOR

SURGERY UNIT ANNUAL PLAN 2011-12 DRAFT Version 2

SO3. Successfully deliver our clinical growth strategy

Workstream		Trust action (For information)		Description of Surgery Objectives and actions	Lead	Milestones Q1	Milestones Q2	Milestones Q3	Milestones Q4
Deliver our planned year growth	3.1	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).	a)	Appoint second hand surgeon	SM	Advertise Post Hold Interviews	Plan start and induction for new surgeon	Surgeon to start at GOS	
			b)	Seek MB approval for development of expanded head and neck tumour service	SM	submit bid for theatre space	Submit bid to hospital	Hold interview	surgeon to start 30 april
			c)	Appoint into 2 vacant spinal surgery consultant surgeon posts	SM	Advertise joint post with Guy's	Interview for joint post	Advertise for 4th surgeon (dependant on 3rd vacancy interviews/appt	Interview for 4th surgeon
			d)	Seek MB approval for development of pain service	AMC	Develop business case inc tarrif assessment	Take to mgmt board. If approved begin to action.	Complete new structure and begin new assessments & charging.	
				Neonatal laser service - ? Provide at GOS in collaboration with ophthalmology	SM	Write outline business case	dependant on outcome of Unit		
Maintain IPP service growth	3.2	Improve patient access and staff recruitment and retention to ensure IPP income target is achieved	e)	Increase ICU bed capacity for IPP	SM	undertake baseline assessment of current IPP use and costings for additional 365 bed days	discuss at ICU board in July. Meet with IPP to finalise plans	Recruit for additioanl bed	Open additional bed (if agreed)
			f)	Increase audiology testing capacity for IPP	SM	-	Develop case and costings for discussion at Aud gov meeting in August	Work with estates on costs, milestones and actio plan (if agreed)	take forward plans (if agreed)
			g)	Increase Urodynamics testing capacity for IPP	AMC		Set up new clinics and agree staffing.	Launch new service and start charging.	Review service growth and income going fwd.
Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	3.3	Achieve accreditation as a national paediatric centre for cardiac and neuro-surgery through the new national processes, and plan to accommodate any further growth that arises from this process.							
	3.4	Work with partners in the region to deliver paediatric tertiary care in light of NHS London proposals.	h)	Undertake a review of the maxillofacial service	AMC	Review OP and IP activity at GOSH and UCLH. Formalise out of hours cover.	Explore plan for 2nd surgeon/funding and elimination of single handed service.	If in plan - recruit to 2nd job.	
			i)	Develop the speech prosthetic service (bulb service)	AMC	Appoint to vacant restorative job.	Set up clinics and start running clinics. Agree adult provision.		
			j)	Undertake a review of the cleft service	SM	Plan away day to discuss future of the	Hold away day on 5 july and formulate action	implment actions	

		k)	Newham Audiology Clinic	SM	Have final agreed future plan by 30 June	Implement plan - appontment of consultant or withdrawal from service by 1 Sept	final solution in place by 1 Sept	

International Business Plan 2011-12

2011-12 Trust objectives				Local Plan		Milestones/Metrics			
Strategic Objective	Work-stream		Trust Action	Department Lead	Department Action(s)	Qtr 1	Qtr 2	Qtr 3	Qtr 4
1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	**Maintain our focus on Zero Harm**	1.1	Continue the development of systems to decrease adverse drug events by targeted actions such as the expansion of the CIVAS service and other strategies aimed at concentrating on named high risk medications and named high risk areas in the Trust with the aim of a 25% reduction against the 2010 baseline.	JA	• The Division is committed to reducing the number of adverse drug events that cause preventable harm to patients by 50% by the end of 2011. • The Trust wide methodology (Patient Safety First Campaign) will continue to be used to establish an annual baseline, identify high risk areas and high risk medications and focus efforts upon these areas by working with the clinical teams. • An area the Division will focus upon is a zero tolerance for prescribing errors, analysing the cause and monitoring the effect of interventions such as a quiet area for prescribing. • Division baselines to be established by April 30th as part of the divisional Transformation Improvement Plan	1. Form working group 2.Quantify current state 3. Agree key objectives 4. Agree measurable outcomes	1 Form recommendations 2 Form action plan 3 Implement any 'quick' wins 4 Develop evaluation tools	Implementation programme	1 Evaluate 2 Disseminate findings 3 Further recommendations for ongoing improvement
		1.2	Continue our work to reduce specific hospital acquired infections including Central Venous Line infections (CVL), Surgical Site infections (SSI) and Ventilator Associated Pneumonia (VAP) from current baseline over the next year.	JA	• The Division will continue to closely monitor Central venous line infections (CVL) and surgical site infections (SSI). • Analysis within the Division will be completed and any training needs identified. • The dashboard for both areas will be reviewed at the Division's monthly Risk Action Group. • The target for CVL is a 20% reduction from the previous year measured in terms of CVL infections per 1000 line days, ensuring compliance with hand hygiene and CVL care bundle will be part of the continuous monitoring.	• Ensure dashboards re CVL, handwashing are completed monthly • Clarify infection control link role for each ward • Develop process/algorithm for escalation surrounding non compliance • HON to meet monthly with ward manager and infection control link for each area to review progress and outcomes • Report findings at monthly RAG	HON to report dashboard findings and actions at quarterly meetings with Chief nurse and Sisters/Infection control link	Review any CVL infections over past 6 months at RAG. Analyse RCA ensuring recommendations have been actioned. Pull out consistent themes. Involve trainers/practice educators to ensure standards are maintained	1 Evaluate 2 Disseminate findings 3 Further recommendations for ongoing improvement
		1.3	Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.	JA	• Child Protection policies and staff training plans are in place with attendance centrally monitored. • The division will work towards all clinical staff achieving level 3 child protection training as required by the Trust.	1) Review and ensure system is in place for each clinical unit re: tracking CP training statusfor each member of staff 2) Achieve CP level 3 training for senior members of nursing and clinical team	Audit practice and disseminate findings and recommendations	Formulate recommendations and implement	Review
		1.4	Develop and monitor new structure for managing and learning from Serious Untoward Incidents (SUIs)	JA	• The divisional transformation project will undertake a review of current processes. • The division will ensure timely and appropriate escalation of SUI's and ensure the right staff are in the right place to manage SUI's in the right way. • A clear pathway for reporting SUI's, escalation, communication and reporting structures will be developed	Identify current practice. Develop guidelines for IPP based on existing and agreed trust policy	All senior nursing staff trained to undertake and contribute to RCA's	Audit process and outcomes	Review
		1.5	Ensure effectivce provision of nutritional care for all patients	JA	• Staff will develop close links with dietician service • Heights and weights will be recorded for all patients to adhere to Trust policy. • Action plans will be developed to link with these services to ensure optimum growth	Work with Trust in ensuring that CQC outcome 5 concerning nutrition is met within IPP. Undertake gap analysis. Benchmark current practices against published standards/outcome in order to identify gap	Develop recommendation and action plan with time line. Ensure all staff are trained in Food handling	Identify Nutritional link for each clinical area. Work alongside and involve Housekeepers/HCA's in ensuring outcome 5 is achieved. Escalate any identified risk which may hinder outcome	Anticpate visit from CQC. Evaluate ongoing practice. Incorporate and deliver recommendations for further improvement

		1.6	Ensure provision of safe services for the deteriorating and critically ill child.	JA	• SBARD is used for all clinical handovers in the division and ensures a timely report with clarity with an electronic shared handover sheet to assist. • Training will be given to all new members of staff to ensure this reporting system is continued. • CEWS will continue to be used in conjunction with SBARD to identify the severity of the child's condition. A review of the tool will be completed to ensure appropriate action is taken at the right time, for example to the named doctor following an assessment of the child's condition. • The division will receive information from ICON re: how many cals made and whether this has made a difference in terms of a reduction in the number of crash calls made. • The aim is to increase patient situational awareness amongst front line staff	Ensure CEW audit/dashboard is completed monthly. Clarify role of CEWS/SBARD link for each clinical area. Report findings at monthly RAG	HON to meet monthly with ward manager and CEWS link for each area to review progress and outcomes	Review any CES deviation over past 6 months at RAG. Understand why deviation occurs and implement action to resolve. Involve trainers/practice educators to ensure standards are maintained	Audit procedures
	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	1.7	Gather and report outcome data and information to demonstrate the clinical effectiveness of the organisation and benchmark against comparable organisations, moving towards measuring clinical effectiveness in real time.	JA	• The division will take part in trust wide audits. • New processes will be implemented to increase utilisation and decrease LOS. • Baselines will be established by 31 March and divisional targets set for decrease in LOS , numbers of treatment plans and whether these are correct will be monitored reasons and throughput for each ward.	Roll out project programme surrounding surgical patient pathway. Ensure outcome objectives address patient flow including timely discharge planning and discharges. Allocate senior nurse to engage with project	Project implentation	Review progress against project plan	Ensure project objectives are met by end Q4
		1.8	Ensure accountability for delivery of CQUIN targets are fully devolved operationally and						
	Continue to reduce waiting times further through our 'no waits' programme	2.1	Continue to meet national and commissioning standards and improve the utilisation and efiiciency of our resources.	JL	• Integral to the success of the division is the ability to admit and meet the expectations of referrers. For this reason, the division equates 'no waits' to 'no deferred' admissions. • The division will maximise capacity potential through development of business case expansion plans. Both IPP wards have expansion cases either board approved or in progress. Commencement date will depend upon the cap. • Improved referral and discharge management plans ensure patient's episodes are better managed, discharge is timely and access improved for others • Treatment plans will be prepared in advance of admission and filed in medical notes prior to admission / appointment	• Develop business case to increase surgical beds • Open 3 beds Butterfly ward. Submit business case Bumblebee ward	• Monitor business plan targets • Prepare works schedule • Prepare recruitment campaign	Refurbishment commences Bumblebee. Recruitment to posts commences	Refurbishment finishes. Recruitment requirements met
2. Consistently deliver an excellent experience that	**Improve the standard of customer service that we offer patients and families**	2.2	Ensure the effective measurement and improvement of patient experience through agreement and implementation of a patient experience action plan	JL	• A systematic survey of IPP patients will be undertaken by International Division. This will further inform departmental plans to improve patient experience which have been initiated based on work with parent groups and embassy representatives. • A plan will be put in place to address a wide range of areas that have been identified as offering scope for further improvement. • A patients satisfaction questionnaire will be developed and action taken to address concerns. • The majority of staff have attended a Communication Study day with plans to provide Customer Service training for all staff	• Develop patient satisfaction questionnaire • All staff to have completed communication study day training	Implemement Questionnaires. Develop plan for customer care training	Collate results and action plan as a result of questionnaires. Deliver training for sll staff	Implement identified improvements . Review staff training

Objective	Sub-objective	No.	Action	Lead	Commentary	Q1	Q2	Q3	Q4
exceeds our patient, family and referrer expectations	**Continue to improve our relationships with referrers in order to achieve our market share objective.**	2.3	Continue to implement the actions for improvement following the results of the Referrer Survey including implementing a bed management solution.	JL	• Improving experience for referrers is a key element of competitive strategy. • Work is underway with the transformation programme to change processes and procedures for referral management to ensure they meet the needs of referrers. • A specific initiative to ensure appropriate communication with referring doctors as well as payor embassies is also underway. • IPP will link with the Trust wide Referrers Experience Improvement Programme to ensure shared learning. • Direct relationship management with referrers is ongoing. • The GOSH Dubai office staff continue to develop face-to-face relationships with key referrers in the key referring countries, UAE and Kuwait through regular meetings	Scoping areas to survey	Review information from Embassies	Identify recommendations	Develop action plan based on outcomes
	Continue to improve the patient environment through major upgrades, working closely with our charitable partners	2.4	Invest within our 10 year capital programme to improve the patient environment within our existing buildings and continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the development of the Morgan Stanley Clinical Building (MSCB) due to complete in December 2011 and the continued development of the Phase 2b Full Business Case for final submission in July 2011.	JL	• The division continues to monitor patient environment and explore potential to improve areas. • A business plan is being submitted for an increase in capacity on Bumblebee ward which will provide better use of the current space in the open bay area.	Submit business case for ward expansion	Prepare works schedule. Prepare recruitmentcampaign	Refurbishment commences Bumblebee. Recruitment to posts commences	Refurbishment finishes. Recruitment requirements met
		2.5	Prepare to move into the Morgan Stanley Clinical Building including workforce redesign.						
3. Successfully deliver our clinical growth strategy	**Deliver our planned in year growth**	3.1	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).	JL	• Key to IPP growth will be the promotion of quaternary specialist services to international markets and the development of relationships with key referring countries to increase market share for tertiary and quaternary services. • Analysis shows these services are proportionately under-represented in the IPP caseload. • In parallel medical and surgical bed capacity will be further increased to accommodate demand. Extended Saturday and evening theatre working will provide operating time for surgical patients. (Income will be controlled within the cap) • Outpatients will see new services being developed with a target to increase general paediatric services currently provided and a joint gastro/allergy service. Other new services will be explored. • International education and training programmes have been developed for Kuwait which can be developed for other countries according to need. Growth in this area will be explored e.g. Oman and Qatar where we know there is potential to collaborate. • International has recently seen growth in numbers of patients from Qatar (13 new cases since January 2011) Despite the government's hospital affiliation with Toronto SickKids, there has been high level interest shown in re-engaging in discussions • The appointment of a marketing manager is key to promoting the profile of the Trust and its services in key markets. The we • New literature will be produced for varying audiences and healthcare events will be supported to showcase the services avai	• Appoint marketing manager. • Develop marketing plan • IPP Strategy to be reviewed	• Implement marketing plan priorities. • Scope Qatar • Develop Drs training plans for attachments to GOS	Develop proposal for Qatar collaboration. Develop proposal for Dr's training opportunities	Prepare activity growth for 12/13
	Maintain IPP service growth	3.2	Improve patient access and staff recruitment and retention to ensure IPP income target is achieved	JL	Patient access will be improved through revised processes in referral managment, admission procedures and the administration around the patient pathway. Treatment plans and anticipated LOS will be in place for every admission whilst the relevent letters of guarantee and financial assurances will be dealt with prior to day of admission to ensure no delays. The Case manager will monitor admissions and plan timely discharge to ensure there are no unncessary delayed discharges. A recruitment and retention plan has been identified as key to the divisions growth strategy. The division will continue with its current success at recruiting a skilled workforce and will target band 5 and 6 nurses. A commissioned project to review retention identifed issues and associated problems and a work programme established to address talent management, leadership, management, communication and relationships with a focus on middle management. Vacancies will be monitored and establishments reviewed. Current turnover rate 12.9%	Monitor all cancellations / delays / refusals. Review establishment	Recruit to vacant posts. Develop plan to improve administration and patient pathways	Analyse activity months 1-9 by consultant, by payer. Turnover rate in line with Trust average	Develop plan for 12/13
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	3.3	Achieve accreditation as a national paediatric centre for cardiac and neuro-surgery through the new national processes, and plan to accommodate any further growth that arises from this process.						
		3.4	Work with partners in the region to deliver paediatric tertiary care in light of NHS London proposals.						

4. With partners maintain and develop our position as the UK's top children's research organisation	**Continue to develop partnership working**	4.1	Continue to work with University College London Partners (UCLP) and leverage benefits from this.						
		4.2	Extend collaboration with UCL Business to include GOSH commercial contracts and leverage benefits from this.						
		4.3	Implement a new governance structure which spans the Division of Research and Innovation and includes all the major stakeholders						
		4.4	Agree operational and management arrangements for Great Ormond Street Hospital / Institute of Child Health (GOSH/ICH) joint research activity administered by the Research and Development (R&D) office and clarify systems and processes for ensuring funding						
	In year delivery (research)	4.5	Strengthen our grant-writing infrastructure to increase our success in obtaining research grants.						
		4.6	Strengthen Communications with GOSH and ICH to ensure that press and publicity of the Division of R&I is adequately reflected internally and externally.						
5Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	**To work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK**	5.1	With our partner Higher Education Institutes (HEI) develop appropriate curricula to meet the professional standards required to drive excellence at GOSH.	BC	The division provides training and education overseas with options for attachments to GOSH as an observer which are not currently accredited. The division is also working with training and education department to create 'off thre shelf' training modules for delivery overseas which is practical in the international market	Explore opportunities iwith PGME, clinical divisions in clinical placements	Review supervision elements of training	Review appraisal systems	Develop plans for 2012/13
		5.2	Implement the Trust's Education and Training Strategy through the delivery of an innovative and effective programme of blended learning using the on-line campus, classroom & work-based teaching and simulator learning.	JL	The division is exploring the potential for clinical placements and training opportunities at GOSH. With strict criteria , the opportunities are being explored. There is demand for this type of education: the division has been approached from various health ministries and medical centres overseas	Scope potential for education provision	Develop proposal	Agree proposal and market	Engage contracts
	Agree achievable CRES plan and ensure delivery through robust project and performance management	6.1	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.	JL	The division will put forward CRES plans that will enable targets to be achieved.	Monitor progress on Butterfly additional beds open. Implement 2011-12 tariff	Monitor performance against Income targets including CRES, taking corrective action if required	Monitor performance against Income targets including CRES, taking corrective action if required	Monitor performance against Income targets including CRES, taking corrective action if required. Review tariff and CRES requirements 2012/13
		6.2	Deliver surplus to plan.	JL	In 2010/11 International achieved surplus to plan post delivery of CRES of circa £664k. Provided the cap is lifted the division anticipates this level of performance to continue	Monitor business performance against target	Monitor business performance against target	Monitor business performance against target	Monitor business performance against target

International Business Plan 2011-12

Objective	Sub-objective	No.	Action	Lead	Divisional plan	Q1	Q2	Q3	Q4
6 Deliver a financially stable environment	Improve efficiency through our Transformation Programme	6.3	Deliver operational efficiencies through the devolved Transformation team and engine-room projects.	JL	The division is defining the clinical unit transformation improvement plan looking at key areas in reducing medicartion errors, zero harm, transforming care on the wards, surgical pathways, risk reporting, clinical casenotes and administration.	Establish baseline and identify outcomes and measures. Scoping isues, asess information needs and engage staff	Review of curent processes and proposition of new pathways	Pilot new pathways	Assess outcomes and review with key stakeholders
	Ensure appropriate funding for our clinical services from commissioners	6.4	Work with other specialist paediatric providers on work streams which will provide evidence to DH to support maintenance of specialist top up or targeted tariff design changes.						
		6.5	Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.						
	Support the charity to raise targeted funds	6.6	Continue to strengthen communication between GOSH and GOSH Charity at all levels to ensure fund-raising targets are met	JL	Collaborate with the charity in raising profile of GOSH and in development of marketing information to raise profile of GOSH and attract more referrals. Appoint a marketing manager which will be a joint post with the charity	Establish marketing key objectives with charity involvement	Produce marketing strategy	Continuing implementation and monitoring	Continuing implementatio n and monitoring
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	Make progress towards becoming a Foundation Trust	7.1	Complete monitor assessment, attain authorisation status and establish an effective members council.	JL	In collaboration with finance provide a robust business plan which identifies profitability	Scope profitability	Review business plan to ensure profitability	Monitor delivery	Develop plans 2012/13
	Ensure that the Trust is compliant with regulatory requirements	7.2	Ensure that the Trust retains registered status with CQC.	JL	Ensure fee information is available for clients to enable them to decide upon treatment @GOSH and allow time to cancel	Review information sent to patients re; fees	Update information	Audit process and outcomes	Ensure any recommendat ions are implemented
		7.3	Ensure that Information Governance processes are strengthened and the self assessment score in the IG toolkit is improved.	JL	The division will ensure all staff have completed e-learning governance training by 17 June 2011	Scope number of staff	Ensure compliance	Scope staff lists new starters	Ensure all new staff have completed training
	Imrove the ability of the organisation	7.4	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.	JL	Monitor KPI's relevent to the division and ensure circulation to the executive committee	Ensure 2/12 meeting with exec team	Continue to validate data	Analyse data	Propose plan for 12/13
		7.5	Deliver the first year of an agreed medium term IT strategy which ensures robust IT infrastructure and a credible and fundable replacement strategy for critical business applications.						

	of the organisation to deliver efficient business processes	7.6	Continue to develop management and leadership including Specialty Leads, Clinical Unit Teams and Trust Board.	JL	The division has developed a governance framework to ensure efficient business processes. All staff to have an appraisal within division timescales. All staff to have a current PDR	Review Information Governance Framework. Set timetable to monitor PDR	Review divisional objectives ensuring progress within agreed timescales. Ensure personal objectives reflect divisional	Commence business planning preparation for 2012/13. Review training plan	Prepare IPP business plan 2012/13. Prepare training plan for 12/13

Nursing Education Business Plan 2011-12

2011-12 Trust objectives					Nursing & Education Local Plan		Milestones/Metrics			
Strategic Objective	Work-stream		Trust Action	Clinical Unit Action	Department Lead	Department Action(s)	Qtr 1	Qtr 2	Qtr 3	Qtr 4
1. Consistently deliver clinical outcomes that place us amongst the top 5 Children's Hospitals in the world	Maintain our focus on Zero Harm	1.1	Continue the development of systems to decrease adverse drug events by targeted actions such as the expansion of the CIVAS service and other strategies aimed at concentrating on named high risk medications and named high risk areas in the Trust with the aim of a 25% reduction against the 2010 baseline.	- All Heads of nursing to support Ward sisters to Implement the 'independent double check' standard for IV medication as part of drive to standardis medication practice - CU Management team to deliver local and Trust-wide responsibilities related to the extension of CIVAS service	Janet Williss	Continue to work with Heads of Nursing and Ward Sisters to reduce medication administration errors - Implement and evaluate the 'independent double check' standard for IV medication - Support the extension of CIVAS service - Support the Heads of Nursing with the standardisation of medicine adminstration practice.		30.09.11		01.03.12
		1.2	Continue our work to reduce specific hospital acquired infections including Central Venous Line infections (CVL), Surgical Site infections (SSI) and Ventilator Associated Pneumonia (VAP) from current baseline over the next year.	Heads of Nursing to hold lead nurses and ward sisters to account for collecting and submitting data in a timely manner, reviewing Nursing KPIs and infection prevention and control KPIs, monitoring performance against targets and implementing action plans where improvement required	Janet Williss	Through monthly Head of Nursing / Lead Nurse meetings hold them to account for their role related responsibilities Establish Quarterly performance reviews for Chief Nurse, HoNs, lead nurses and ward sisters to review Nursing KPIs and infection prevention and control KPIs, monitor performance against targets and agree action plans where improvement required		30.09.11		31.3.12
		1.3	Maintain child protection and broader safeguarding structures and processes to ensure effective safe guarding of all children and young people.	Clinical Unit Management Teams to hold managers to account for delivery of Trust safeguarding requirments specifically CQUIN target of: Improve CP record keeping by 10% from 70% compliance to 80% Improve compliance with CP clinical supervision by 30% from 20% to 50% Improve clinical staff compliance with level 3 CP training by 20%	Sonia Jenkins	Deliver Trust safeguarding strategy - Implement annual action plan (including SIT action plan, CQC requirements and level 3 training) - Deliver CQUIN target Improve CP record keeping by 10% from 70% compliance to 80% Improve compliance with CP clinical supervision by 30% from 20% to 50% Improve compliance with level 3 CP training by 20% - Review structure of Safeguarding team post Haringey service transfer		30.09.11		31.3.12
		1.4	Develop and monitor new structure for managing and learning from Serious Untoward Incidents (SUIs)							
		1.5	Ensure effectivce provision of nutritional care for all patients	Improve compliance with CQC outcome 5 Meeting Nutritional Needs and ensure delivery of Nutrition CQUIN: Implement the GOSH nutrition screening flowchart for all patients Improve compliance with height monitoring as per CQUIN Implement protected feeding/mealtimes for all patients Ensure the delivery of a monitoring audit for malnutrition levels in patients admitted for more than 7 days as per CQUIN	Caroline Joyce	Improve compliance with CQC outcome 5 Meeting Nutritional Needs and ensure delivery of Nutrition CQUIN Implement and evaluate the GOSH nutrition screening flowchart (quarterly reports to commissioners on progress) Improve compliance with height monitoring (audit and baseline to be conducted in quarter 1 with target from improvement to be achieved at the end of quarter 4 Implement protected feeding/mealtimes for all patients Ensure the delivery of a monitoring audit for malnutrition levels in patients admitted for more than 7 days as per CQUIN		30.09.11		31.3.12
		1.6	Ensure provision of safe services for the deteriorating and critically ill child.	Support the work to manage the care of the deteriorating child by: - ensuring CEWS and SBARD are implemented locally (including data collection and review of CEWS KPI as process outlines in 1.2 above) - ensure all children have physiological observations taken as per plan (including correct measurement and monitoring of blood pressure) - ensure all staff who access them (doctors and nurses) are competent in accessing, care and management of femoral and other central venous lines - ensure all staff are up to date with appropriate resucitation / life support training as per Trust strategy and training plan - support and engage in the trust processes for managing deteriorating patients including in situ simulation training, CSP / general paediatric team / ICON services	Sue Chapman (John Courtney)	Support the work to manage the care of the deteriorating child - CEWS and SBARD - physiological observations (including blood pressure - femoral / iv line access -Implement resuscitation review action plan 11/12 -Develop joint understanding of CSP / general paediatric team / ICON roles and how they all interface		30.09.11		31.3.12
	Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	1.7	Gather and report outcome data and information to demonstrate the clinical effectiveness of the organisation and benchmark against comparable organisations, moving towards measuring clinical effectiveness in real time.	Ensure that there is a clear and congruent vision for the role of the CNS at Unit and speciality level to optimise quality of care to patients - establish outcome measures for CNS effectiveness at Unit and speciality level - ensure that CNss are collecting activity data and support the business plan to introduce a real time electronic activity recording tool for CNSs - ensure HoNs deliver cost savings from CNS workforce as per Unit CRES plans whilst maintaining quality of patient care	Chris Caldwell	Establish Trust vision for the CNS role - establish outcome measures for CNS effectiveness - introduce a real time electronic activity recording tool for CNSs - support HONs to deliver cost savings from CNS workforce		30.09.11		31.03.12
		1.8	Ensure accountability for delivery of CQUIN targets are fully devolved operationally and monitored regularly		Caroline Joyce Sonia Jenkins	see 1.1, 1.5 and 2.2		30.09.11		31.3.12
	Continue to reduce waiting times further through our 'no waits' programme	2.1	Continue to meet national and commissioning standards and improve the utilisation and efiiciency of our resources.							

Nursing Education Business Plan 2011-12

Objective	Priority	No.	Action	Nursing education action	Lead	Measure				
2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations	Improve the standard of customer service that we offer patients and families	2.2	Ensure the effective measurement and improvement of patient experience through agreement and implementation of a patient experience action plan	Support the implementation of the patient experience action plan for 11/12 and delivery of the Patient Experience CQUIN	Caroline Joyce	Deliver / Implement the patient experience action plan for 11/12 Deliver the Patient Experience CQUIn as follows- Deliver the patient experience action plan Maintain composite score of 90% or more for 5 equivalent national CQUIN questions Improve satisfaction with quality and variety of food by 5% Improve satisfaction with knowing how to offer feedback or complain by 5% Undertake qualitative benchamrking with other specialist hospitals on measures of patient experience		30.09.11		31.3.12
	Continue to improve our relationships with referrers in order to achieve our market share objective.	2.3	Continue to implement the actions for improvement following the results of the Referrer Survey including implementing a bed management solution.							
	Continue to improve the patient environment through major upgrades, working closely with our charitable partners	2.4	Invest within our 10 year capital programme to improve the patient environment within our existing buildings and continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the development of the Morgan Stanley Clinical Building (MSCB) due to complete in December 2011 and the continued development of the Phase 2b Full Business Case for final submission in July 2011.							
		2.5	Prepare to move into the Morgan Stanley Clinical Building including workforce redesign.	Manage loal project groups to eliver service and workforce changes required for timely transfer of services to MSCB, e.g the neurosciences workforce project, SADU/PACU project, extension of CIVAS engaging with corporate nursing and education team as appropriate to ensure Trust-wide congruence and maximise opportunities for efficiency saving	John Courtney (Chris Caldwell)	Offer strategic leadership support to Heads of Nursing in delivering local and Trust-wide workforce re-design projects and implement local workforce plans linked to MSCB, including education and training underpinning e.g the neurosciences workforce project, SADU/PACU project, extension of CIVAS		30.09.11		31.3.12
3. Successfully deliver our clinical growth strategy	Deliver our planned in year growth	3.1	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).							
	Maintain IPP service growth	3.2	Improve patient access and staff recruitment and retention to ensure IPP income target is achieved							
	Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	3.3	Achieve accreditation as a national paediatric centre for cardiac and neuro-surgery through the new national processes, and plan to accommodate any further growth that arises from this process.							
		3.4	Work with partners in the region to deliver paediatric tertiary care in light of NHS London proposals.							
4. With partners maintain and develop our position as the UK's top children's research organisation	Continue to develop partnership working	4.1	Continue to work with University College London Partners (UCLP) and leverage benefits from this.							
		4.2	Extend collaboration with UCL Business to include GOSH commercial contracts and leverage benefits from this.							
		4.3	Implement a new governance structure which spans the Division of Research and Innovation and includes all the major stakeholders							
		4.4	Agree operational and management arrangements for Great Ormond Street Hospital / Institute of Child Health (GOSH/ICH) joint research activity administered by the Research and Development (R&D) office and clarify systems and processes for ensuring funding							
	In year delivery (research)	4.5	Strengthen our grant-writing infrastructure to increase our success in obtaining research grants.							
		4.6	Strengthen Communications with GOSH and ICH to ensure that press and publicity of the Division of R&I is adequately reflected internally and externally.	HoNs to contribute to and support Delivery of Nursing and AHP research strategy action plan 11/12	Janet Williss Liz Morgan	Develop and implement the research strategy for patient benefit action plan 11/12 - finalise strategy - agree action plan for 11/12 - take forward different funding options - submit annual report and seek extension of ICH funding - increase numbers of articles submitted to peer reviewed journals - support MSc, doctoral and post doctoral studies / research training - maximise benefits of restructure R&I unit		30.09.11		31.3.12

Nursing Education Business Plan 2011-12

5. Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	**To work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK**	5.1	With our partner Higher Education Institutes (HEI) develop appropriate curricula to meet the professional standards required to drive excellence at GOSH.	Heads of Nursing to hold Ward sisters/Charge Nurses to account for ensuring high quality placement learning support for pre registration nursing students	Chris Caldwell	Continue to enhance placement learning support for pre registration nurse education - support curriculum development and prepare placement areas for students following the new undergraduate curriculum - complete role profile project with LSBU to improve selection of student nurses - continue to strengthen systems to enhance mentorship preparation and on going support - work with HoNs to consider benefits realisation and new role potential of new graduate nurses - continue to work with LSBU to develop a pre-registration masters programme - continue to work with London Deanery and Clinical speciality to teams to deliver excellent medical training in all specialities		30.09.11		31.3.12
		5.2	Implement the Trust's Education and Training Strategy through the delivery of an innovative and effective programme of blended learning using the on-line campus, classroom & work-based teaching and simulator learning.	Complete Clinical Unit actions required to deliver year 1 of the Trust 5 year education strategy (see Year one plan)	Chris Caldwell	Implement year 1 of the Trust 5 year education strategy (see Year one plan)		30.09.11		31.3.12
6. Deliver a financially stable organisation	**Agree achievable CRES plan and ensure delivery through robust project and performance management**	6.1	Agree robust plans for the delivery of the Cash Releasing Efficiency Scheme (CRES) programme and ensure that these plans are delivered.	Deliver local CRES plans and contribute to delivery of trust-wide plans through collaborating with corporate nursing team	Janet Williss	Action 11/12 CRES within Nursing and Education by April 11 Ensure 12/13 CRES schemes are identified and costed by May 2011 Agree with Heads of Nursing trust wide 'principles' for CNSs working clinical shifts to support unit based CRES Ensure robust Management Information on Nurse Bank and Agency Spend Work with Bank to reduce reliance on High Cost Agencies. Identify and plan with high level Bank and Agency users ways of reducing Bank and Agency Spend		30.09.11		31.3.12
		6.2	Deliver surplus to plan.							
	Improve efficiency through our Transformation Programme	6.3	Deliver operational efficiencies through the devolved Transformation team and engine-room projects.							
	Ensure appropriate funding for our clinical services from commissioners	6.4	Work with other specialist paediatric providers on work streams which will provide evidence to DH to support maintenance of specialist top up or targeted tariff design changes.							
		6.5	Ensure performance monitoring requirements of the Commissioners contract are delivered and the financial penalties are minimised.							
	Support the charity to raise targeted funds	6.6	Continue to strengthen communication between GOSH and GOSH Charity at all levels to ensure fund-raising targets are met							
7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation	**Make progress towards becoming a Foundation Trust**	7.1	Complete monitor assessment, attain authorisation status and establish an effective members council.							
	Ensure that the Trust is compliant with regulatory requirements	7.2	Ensure that the Trust retains registered status with CQC.	Ensure that systems and processes are in place to evidence achievement of and compliance with all CQC standards which relate to services provided within the Unit and support others	Caroline Joyce Chris Caldwell Sonia Jenkins	Ensure that systems and processes are in place to evidence achievement of and compliance with the CQC standards for which Nursing and Education lead				
		7.3	Ensure that Information Governance processes are strengthened and the self assessment score in the IG toolkit is improved.							
	Imrove the ability of the organisation to deliver efficient business processes	7.4	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.							
		7.5	Deliver the first year of an agreed medium term IT strategy which ensures robust IT infrastructure and a credible and fundable replacement strategy for critical business applications.							
		7.6	Continue to develop management and leadership including Specialty Leads, Clinical Unit Teams and Trust Board.							

Attachment I

Trust Board Meeting **25th May 2011**	
Title of document Quality Account 2010-2011	**Paper No: Attachment I**
Submitted on behalf of Professor Martin Elliott, Co-Medical Director	**Date considered by Management Board** 21st April 2011

Aims / summary

The requirement for production of the Quality Account is set out by the National Health Service (Quality Accounts) Regulations 2010. This is the second Quality Account for GOSH. Quality Accounts are available to the public via NHS Choices and our external GOSH website. The purpose of the Quality Account is to make information available to our stakeholders on the quality of care we provide and our priorities for improving this quality over the next year.

Within this year's Quality Account we are required to report back on the performance in the priorities we identified for improvement in last years Quality Account as well as identify improvement areas for 2011/12. The layout of the document is set out by the National Health Service (Quality Accounts) Regulations 2010, which is as follows:

Part 1 requires a statement by the Chief Executive on the quality of care of the organisation

Part 2 of the Quality Account describes the three broad quality priorities that were identified last year of:

1. Safety – Zero Harm reduce all harm to zero
2. Effectiveness - Demonstrate Clinical Outcomes that place us amongst the top five in the world
3. Experience - Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations

In this year's Quality Account we have identified specific improvement initiatives in each of these priority areas that will support the overall achievement of the priority and how these will be measured and monitored. These improvement initiatives have been developed either from feedback from staff and programmes in the organisation; national targets or campaigns; our commissioners; NHS London and our Members Forum.

Part 3 requires that we complete a number of mandatory written statements which cover the review of our services; participation in clinical audit; research; CQUINs; CQC; data quality, information governance and clinical coding. We also include statements from external stakeholders regarding the content of the Quality Account. Please note that the statement from NHS North Central London is still in draft.

Part 4 reports back on our performance in the priorities we identified for improvement in last years Quality Account. This year we achieved 4 out of the 6 safety priorities identified; 2 out of 2 of the effectiveness priorities identified and for experience we achieved 5 out of the 8 measures identified and a further 2 were improved but not to the initial aim.

Attachment I

Action required from the meeting Approval of the Quality Account 2010-11 for publication on NHS Choices and external website in June 2011
Contribution to the delivery of NHS / Trust strategies and plans The Quality Accounts are intended to assess and monitor the quality of the care we deliver and identify improvement initiatives which are applicable across the Trust to continue to improve the quality of services at GOSH. We are required to make this information available to the public via a formal publication as set out in the National Health Service (Quality Accounts) Regulations 2010.
Financial implications None
Legal issues None
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? The Clinical Outcomes Board which is chaired by Professor Martin Elliott and reports to Management Board has overseen the development and publication of this year's Quality Account. Feedback has been gathered from various staff across the hospital; volunteer services; our members forum; our commissioners, NHS London SHA and Camden Council to inform this publication. Our lead commissioner and the Commissioners Clinical Quality Review group members, Camden Council and Camden LINk received a draft version of the Quality Account in April as required in the NHS legislations and have provided statements accordingly.
Who needs to be told about any decision Professor Martin Elliott
Who is responsible for implementing the proposals / project and anticipated timescales Formal publication of the Quality Account is required by the end of June 2011 on NHS choices and the GOSH website. The document will also be incorporated into the Trust's Annual Report 2010-11. After discussion and approval at this Trust Board, any amendments will be made and the Quality Account will be proof read and checked again for accuracy and consistency before publication on the websites The Clinical Outcomes Development Lead is co-ordinating the publication which is overseen by the Co-Medical Director.
Who is accountable for the implementation of the proposal / project The Clinical Outcomes Development Lead is co-ordinating the publication which is overseen by the Co-Medical Director
Author and date Lisa Davies Clinical Outcomes Development Lead May 2011

Attachment I

Overall Summary of the Development and Production of the Quality Account

Month	Steps of the Quality Account production	Documentation of the meetings and communication that took place with stakeholders regarding the development and publication of the Quality Account	Action
Middle of December - February	Ideas of information and priorities for inclusion within the Quality Account	**Formal Trust Meetings** Clinical Outcomes Board – 13th December 2010 27th January 2011 Members Forum 18th January 2011 Commissioners Clinical Quality Review Meeting 25th February 2011 **Individual Meetings** Engagement with a variety of stakeholders - see appendix 1 for further details **External events** Quality Account Conference 1st February 2011	For comment and discussion
End of February – March	Draft template proposed of sections of the Quality account and information to be used	**Formal Trust Meetings** Clinical Outcomes Board - 22nd February 2011 Quality and Safety Committee – 11th March 2011 Members forum as written feedback - 21st March 2011 Commissioners Clinical Quality Review Meeting - 21st March 2011 **Individual Meetings** Engagement with a variety of stakeholders – see appendix 1 for further details **External Communication** Email from NHS London SHA regarding priority areas for inclusion in our Quality Account	For comment and further ideas see Appendix 2 for rationale of improvement priorities
End of March - April	Draft Quality Account produced	**Formal Trust Meetings** Clinical Outcomes Board - 31st March 2011 General Managers Meeting as a briefing - 11th March 2011 Management Board – 21st April 2011 Commissioners Clinical Quality Review Meeting – 28th April 2011 **Internal communication** Identified individuals for each relevant section were sent draft – see appendix 3 for further details **External communication** Draft sent to Commissioners Clinical Quality Review Group; Camden Scrutiny Committee and Camden Local Involvement Network **External events** Camden Scrutiny Committee – presentation – 21st April 2011	For comment, amendment and approval
May - June	Quality Account approved and published	**Internal communication** Formatted publication of Quality Account circulated to Clinical Outcomes Board Members – 7th May 2011 **Formal Trust Meetings** Trust Board – 25th May 2011	For approval and publication

Attachment I
Appendix 1

Individual Meetings with a variety of stakeholders regarding the development and content of the Quality Account are as follows:

Date of Meeting	Name	Position
20th December 2010	Jez Phillips	Acting Transformation Programme Manager
5th January 2011	Grainne Morby	Head of PPI and Pals
5th January 2011	Geoff Bassett	Interim Head of Information
6th January 2011	Andrew Pearson	Clinical Audit Manager
10th January 2011	Nick Wright	Head of Contracts
10th January 2011	Dr Peter Lachman	Associate Medical Director – Patient Safety
12th January 2011	Maureen Jarvis	Haringey Service Manager
20th January 2011	Caroline Joyce	Assistant Chief Nurse for Nursing & Workforce
27th January 2011	Robert Burns	Deputy Chief Operating Officer
3rd February 2011	Anna Ferrant	Company Secretary
9th February 2011	Sophie Lusby	Lead Commissioner for GOSH, NHS North Central London
10th February 2011	Salina Parkyn	Head of Clinical Governance and Safety
15th February 2011	John Hartley	Director Infection Control and Prevention
7th March 2011	Jamie Wilcox	Volunteer Service Manager
8th March 2011	Helen Cooke	Head of Workforce Planning and Development

In the initial phases of gaining information regarding the content of the Quality Account we requested a meeting with a representative from Camden LINks and Camden Scrutiny Committee which was turned down.

Appendix 2
Summary of Improvement Initiatives and rationale for inclusion this year

Improvement Initiative	Rationale for inclusion this year
Safety	
Improvement Initiative 1 – Reducing infection rates	From last year's Quality Account Transformation project with aims for improvement in 2011/12 CQUIN target which commissioners wanted to reflect in our account
Improvement Initiative 2 – routine use of CEWS to detect deteriorating children across wards and use of SBARD to communicate across teams effectively	Suggested at Quality and Safety Committtee Transformation project with aims for improvement in 2011/12
Improvement Initiative 3 -Use of the World Health Organisation (WHO) Surgical Safety Checklist	Transformation project with aims for improvement in 2011/12 National campaign for improving safety and other Trust's have used in Quality Accounts
Improvement Initiative 4 - Reduce the number of medication errors	Transformation project with aims for improvement in 2011/12 Birmingham Children's Hospital reference in Quality Accounts last year
Improvement Initiative 5 - To ensure the hospital	Feedback from Clinical Governance and Safety

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Improvement Initiative	Rationale for inclusion this year
continues to learns from reported incidents and implements best practice patient safety guidance	Requested by NHS London SHA
Improvement Initiative 6 – Improving Safeguarding	Requested by NHS London SHA CQUIN target which commissioners wanted to reflect in our account
Effectiveness	
Improvement Initiative 1 - Development of clinical outcomes for each of the specialities and publication of these on the website	From last year's Quality Account Clinical Outcomes project with aims for improvement in 2011/12
Improvement Initiative 2 - Development and use of Patient Reported Outcome Measures across the specialities	Clinical Outcomes project with aims for improvement in 2011/12 National campaign for measuring outcomes and other Trust's have used in Quality Accounts
Improvement Initiative 3 – To measure outcomes in specialities that can be benchmarked against other hospitals	From last year's Quality Account Clinical Outcomes project with aims for improvement in 2011/12
Experience	
Improvement Initiative 1 - Development of clinical outcomes for each of the specialities and publication of these on the website	From last year's Quality Account PPI and Experience project with aims for improvement in 2011/12 CQUIN target
Improvement Initiative 2 - Development and use of Patient Reported Outcome Measures across the specialities	PPI and Experience project with aims for improvement in 2011/12 CQUIN target
Improvement Initiative 3 – improve our communication with patients, family and referrers	Requested by Members Forum Specific project and teams in place in hospital with aims for improvement in 2011/12
Improvement Initiative 4 – ensure that patients with a learning disability have equal access to healthcare	Requested by NHS London SHA Specific project in place in hospital with aims for improvement in 2011/12
Improvement Initiative 5 – Offer patients timely access to services at GOSH	Referenced in last year's Quality Accounts Requested by NHS London SHA National campaign for measuring outcomes and other Trust's have used in Quality Accounts

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Appendix 3

Quality Accounts 2010/11
Draft Template

Quality Account Section	**Overall Sign off**	**Reviewed and amendments by**
Part 1		
Statement on quality from the Chief Executive	Jane Collins, Chief Executive Officer	Clinical Outcomes Board Members
About the Quality Account	Lisa Davies, Clinical Outcomes Development Lead	Clinical Outcomes Board Members
Part 2		
Summary of improvement initiatives	Lisa Davies, Clinical Outcomes Development Lead	Clinical Outcomes Board Members
Part 2 Safety Priority		
Improvement Initiative 1 – Reducing infection rates	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Dr Peter Lachman Jez Phillips Dr John Hartley
Improvement Initiative 2 – routine use of CEWS to detect deteriorating children across wards and use of SBARD to communicate across teams effectively	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Andrew Pearson Sue Chapman Dr Peter Lachman Jez Phillips
Improvement Initiative 3 -Use of the World Health Organisation (WHO) Surgical Safety Checklist	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Liz Ball Dr Peter Lachman Jez Phillips
Improvement Initiative 4 - Reduce the number of medication errors	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Dr Peter Lachman Jez Phillips
Improvement Initiative 5 - To ensure the hospital continues to learns from reported incidents and implements best practice patient safety guidance	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Salina Parkyn Roisin Mulvaney Dr Peter Lachman
Improvement Initiative 6 – Improving Safeguarding	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Sonia Jenkins Caroline Joyce Sophie Lusby

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Quality Account Section	Overall Sign off	Reviewed and amendments by
Part 2 – Effectiveness Priority		
Improvement Initiative 1 - Development of clinical outcomes for each of the specialities and publication of these on the website	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members
Improvement Initiative 2 - Development and use of Patient Reported Outcome Measures across the specialities	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Specific speciality leads of identified PROMS have signed off their information
Improvement Initiative 3 – To measure outcomes in specialities that can be benchmarked against other hospitals	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Specific speciality leads of identified benchmarking outcomes have signed off their information
Part 2 – Experience Priority		
Improvement Initiative 1 – Improve patient experience specific areas and maintain high levels of patient and parent satisfaction	Liz Morgan, Chief Nurse	Clinical Outcomes Board Members Grainne Morby Caroline Joyce
Improvement Initiative 2 – Establish frequent feedback system for ongoing measurement of patient satisfaction/experience	Liz Morgan, Chief Nurse	Clinical Outcomes Board Members Grainne Morby Caroline Joyce
Improvement Initiative 3 – improve our communication with patients, family and referrers	Fiona Dalton, Chief Operating Officer	Clinical Outcomes Board Members Grainne Morby Caroline Joyce Dr Jane Valente
Improvement Initiative 4 – ensure that patients with a learning disability have equal access to healthcare	Alex Faulkes, Head of Planning and Performance	Clinical Outcomes Board Members Beki Moult
Improvement Initiative 5 – Offer patients timely access to services at GOSH	Alex Faulkes, Head of Planning and Performance	Clinical Outcomes Board Members
Part 3 – Mandatory Statement		
Review of services	Nick Wright/Lisa Davies	Clinical Outcomes Board Members
Participation in clinical audit	Andrew Pearson	Clinical Outcomes Board Members
Participation in clinical research	Lorna Gibson	Clinical Outcomes Board Members

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Quality Account Section	Overall Sign off	Reviewed and amendments by
Use of the Commissioning for Quality and Innovation (CQUIN) payment framework	Nick Wright and Caroline Joyce	Clinical Outcomes Board Members
Statements from the Care Quality Commission	Anna Ferrant and Caroline Joyce	Clinical Outcomes Board Members
Data Quality	Geoff Bassett	Clinical Outcomes Board Members
Secondary Uses Service (SUS)	Geoff Bassett	Clinical Outcomes Board Members
Information Governance Toolkit	Geoff Bassett	Clinical Outcomes Board Members
Clinical coding	Geoff Bassett	Clinical Outcomes Board Members
Statement from our commissioners	NHS North Central London	
Statements from LINks	Camden LINk	
Statement from Camden Scrutiny Committee	Camden Scrutiny Committee	
Part 4		
Zero harm performance 2009/10	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Dr John Hartley Dr Peter Lachman Jez Phillips
Executive Safety Walkaround case study	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Tony Higgins
Clinical Outcomes performance 2009/10	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members
GOSH in Haringey Quality of Practice Audit Tool	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Maureen Jarvis
Metabolic and dietetics outcomes	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Dr Lara Abulhoul Rachel Skeath Jacky Stafford
Radiology Accreditation	Martin Elliott, Co-Medical Director	Clinical Outcomes Board Members Melanie Hiorns
Experience performance in 2009/10	Liz Morgan, Chief Nurse	Clinical Outcomes Board Members Caroline Joyce Grainne Morby
Saturday Club	Liz Morgan, Chief Nurse	Clinical Outcomes Board Members Caroline Joyce Grainne Morby

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Quality Account Section	**Overall Sign off**	**Reviewed and amendments by**
		Jamie Willcox
Equality and Diversity Genetics example	Liz Morgan, Chief Nurse	Clinical Outcomes Board Members Caroline Joyce Grainne Morby Dr Elisabeth Rosser
Staff Awards	Liz Morgan, Chief Nurse	Clinical Outcomes Board Members Caroline Joyce Grainne Morby Helen Cooke
Variability and Flow Management	Robbie Burns, Deputy Chief Operating Officer	Clinical Outcomes Board Members Caroline Wells

Quality Account 2010/11

The child first and always

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07 Reducing infection rates
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11 Use of the World Health Organisation surgical and procedural safety checklist
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14 Reporting and learning from incidents
16 Improving safeguarding

18 Effectiveness priority – Demonstrate clinical outcomes
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20 Using and developing patient reported outcome measures
22 Benchmarking clinical outcomes against other organisations

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25 Maintaining high levels of patient and parent satisfaction
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53 Glossary

Cover: Four-year-old Chloe has recently been diagnosed with juvenile dermatomyositis, a very rare autoimmune disease that attacks the skin and muscle. She has had a tough year, but her mum says that since coming to Great Ormond Street Hospital four weeks ago, she is back to her old self, dancing, singing and dressing up as a princess.

Part 1 – Statement on quality from the Chief Executive

Great Ormond Street Hospital for Children NHS Trust (GOSH) is an international centre of excellence in children's healthcare. Every year, GOSH treats thousands of children and young people from many different parts of the UK and abroad. Our staff are dedicated to making sure the service we give children and their families is the best it can be.

This is the second annual Quality Account produced by GOSH. This account details the areas we want to focus on quality improvement in 2011/12 and provides information on the progress we have made to improve the quality of our services since our last Quality Account.

In last year's Quality Account we introduced the following three broad priorities that we felt were important to improving the quality of care:

- **Priority 1 –** Zero harm – reducing all avoidable harm to zero.
- **Priority 2 –** Consistently deliver clinical outcomes that place us amongst top five children's hospitals in the world.
- **Priority 3 –** Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations.

These priorities are embodied in our hospital's core objectives. This ensures that our commitment to delivering high quality patient care is at the very heart of all we do.

Keeping our patients safe is central to providing high quality care. We've made good progress over the last year by developing systems to accurately measure safety throughout the hospital. For example, we use statistical process charts to measure improvement in our infection rates.

This data can be accessed by all staff in the hospital via online safety dashboards. These dashboards are being used routinely in meetings at all levels across the hospital to inform discussion and focus our efforts on areas for improvement.

We have continued to work with other hospitals and organisations on implementing safety initiatives. For example the development and use of the Paediatric Trigger Tool has been invaluable to help us measure harm and allows us to focus on the most important areas that need to be improved to benefit our patients.

We want to demonstrate the effectiveness of our patient care. To do this, we have been continuously defining and measuring clinical outcomes across all specialities. Last year we identified that we would provide information on our clinical outcomes that would be available to our patients, parents and our referrers. We have now developed a section on our GOSH website that provides information and examples of outcomes in a variety of specialities.

Improving everyone's experience of GOSH is an intrinsic part of our day-to-day work. In 2010/11, independent patient, parents and referrers' surveys of GOSH have demonstrated a consistently high level of satisfaction with the services we provide.

Importantly, the most recent independent inpatient patient and parent survey identified that 96 per cent of patients and parents were likely to recommend Great Ormond Street Hospital to a friend or relative if their child needed treatment.

The improvement in the quality of services at GOSH over the last year would not have been possible without the commitment, dedication and skill of our staff. The results of the recent national staff survey reveal that we have a high level of staff engagement, which is above the average of other specialist hospitals. I am delighted that staff feel able to take initiatives and improvements in their work and are motivated in their job. This is fundamental in improving the quality of our services. We also have valuable support from volunteers who improve the experience of patients and families that come to the hospital. Over the last year, the Volunteer Service has recruited 200 additional volunteers that will start work in April 2011.

In 2011/12, we will continue to improve the quality of our services across our key priority areas and have identified specific improvement initiatives in each area which are set out in this Quality Account. I hope that you will find this information helpful and that it gives you the confidence that we are dedicated to ensuring the highest quality of care to all of our patients.

I, Jane Collins, confirm that to the best of my knowledge the information in this document is accurate.

Jane Collins

Dr Jane Collins
Chief Executive

About the Quality Account

Why we are producing a Quality Account?
All NHS Trusts were required to produce an annual Quality Account from 2010. The requirement was set out in the *Next Stage Review* in 2008[1].

Great Ormond Street Hospital for Children NHS Trust (GOSH) has a long-standing reputation as one of the finest paediatric hospitals in the world. We are keen to share information about the quality of our services and our plans to improve even further, with patients and families.

What are the required elements of a Quality Account?
The National Health Service (Quality Accounts) Regulations 2010 specified the requirements for all quality accounts. We have used the requirements as a template around which our account has been built.

This Quality Account is laid out as follows:

Part 1
A statement from the Chief Executive.

Part 2
Priorities for improvement in 201/12 – this section identifies the three priority areas for improvement and associated improvement initiatives.

Part 3
Mandatory statements as set out in the National Health Service (Quality Accounts) Regulations 2010.

Part 4
Review of our quality priorities in 2010/11, and case studies to evidence improvement.

How did we produce our Quality Account?
We have used the Department of Health's Quality Account toolkit as the basic template for our Quality Account[2].

In addition to ensuring that we have all the mandatory elements of the account, we have engaged with staff, patients, parents, volunteers, commissioners and our Strategic Health Authority to ensure that the account gives an insight into the organisation and reflects the priorities that are important to all. Following feedback on our Quality Account last year, we have identified specific and measurable improvement initiatives in each of our priority areas. These improvement initiatives will support improvement in the priority areas.

We appreciate that some of the language used may be difficult to understand if you don't work in healthcare. We have therefore included a glossary at the back of our Quality Account to explain some of the words that we use everyday.

We are keen to ensure that the account is a useful document that helps patients, families and the public to understand the priorities we have at GOSH for delivering quality care to our patients. If you have any suggestions for next year's Quality Account, or any queries about this year's document, please contact us at enquiries@gosh.nhs.uk4

[1] Darzi. *Next Stage Review*, June 2008, Department of Health. This was a document that was published to coincide with the sixtieth anniversary of the NHS. The document developed a vision for how the NHS would continue to serve the needs of the public in the 21st century.

[2] *Quality Accounts toolkit*, February 2010, Department of Health. This document was published by the Department of Health to assist with the production and publication of their Quality Accounts in 2010.

Part 2 – Priorities for improvement in 2011/12

This section identifies the three priority areas we identified in 2009/10 and the associated improvement initiative we will focus on in 2011/12 to improve the quality of the care we provide. Our overarching priorities are fundamentally linked to the three dimensions of quality as set out by Lord Darzi in the *Next Stage Review* (Department of Health, 2008). The following diagram illustrates our priorities:

The following table summarises our priorities and associated improvrmrnt initiative and aims for 2011/12:

Quality dimension and key priority	Improvement initiative	Aim for 2011/12
Safety Zero harm – reducing all harm to zero	Infection rates: • Reduce the number of Great Ormond Street Hospital acquired central venous catheter (CVC) line infections • Reduce surgical site infections (SSIs) in identified specialties and introduce surveillance in other areas • Reduce or maintain the low levels of incidence for Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia	Reduce the number of CVC by 50 per cent against the identified baseline Reduce the number of SSI by 50 per cent against the identified baseline for each specialty
	Effective monitoring and communication of the deteriorating child	All ward staff using CEWS (children early warning system) for monitoring patients and SBARD (situation background, assessment, recommendation, decision) for communicating concerns

Part 2 – Priorities for improvement in 2011/12
continued

Quality dimension and key priority	Improvement initiative	Aim for 2011/12
Safety Zero harm – reducing all harm to zero (continued)	Use of the World Health Organisation surgical safety checklist	All relevant teams use and record the surgical safety checklist in every procedure
	Reducing the number of medication errors	Reducing the established baseline of medication errors by 10 per cent
	Reporting and learning from incidents	Staff to record incidents when they happen and implement the NPSA National Framework for Serious Incidents
	Improving safeguarding	Implement a balanced scorecard and improve our performance in • record keeping • child protection supervision • Level 3 training
Effectiveness Demonstrate clinical outcomes	Publication of clinical outcomes	To make a further nine specialities clinical outcomes available on the Great Ormond Street Hospital (GOSH) website
	Using and developing patient reported outcome measures (PROMs)	Continue to measure PROMs in the six specialities identified
	Benchmarking outcomes against other organisations	Measure outcomes in the nine specialities identified
Experience Deliver excellent experience to our patients, parents and referrers	Maintain high levels of patient and parent satisfaction	Maintain at least 90 per cent overall satisfaction in our service Improve scores in “I knew how to complain or offer feedback” and satisfaction in the quality and variety of hospital food
	Establish frequent feedback systems	Capture and record regular local feedback through trialling electronic systems
	Improving communication to patients, parents and referrers	Reduce number of complaints about our communication Improve the timeliness and quality of our outpatient letters and discharge summaries
	Ensuring equal access to all patients	Identify patients with a learning disability and ensure reasonable adjustments are made for them to access our services
	Maintaining timely access to service	Ensure our waiting times are within the national standards

Safety priority – Zero harm
Reducing all harm to zero.

Last year we identified that reducing avoidable harm to all patients treated at GOSH was a top priority. To support this we implemented the paediatric trigger tool. This tool was developed by the NHS Institute for Innovation and Improvement in collaboration with a number NHS children's hospitals including GOSH. The tool helps staff to measure and understand the nature of harm that takes place in the hospital. We can use this information to develop interventions that aim to improve the safety of children being treated.

We review 20 patients' medical records on a monthly basis using the Paediatric Trigger Tool. The medical records are chosen at random from across all specialties, therefore the themes of harm identified are applicable to the whole hospital.

In addition to using the Paediatric Trigger Tool to identify safety areas for improvement, we have received national targets and campaigns, and used feedback from staff, parents and our commissioners.

The following diagram summarises the safety improvement initiatives we want to focus on in 2011/12:

Safety improvement initiative 1
Reducing infection rates

Last year we identified that we would:
- reduce the number of GOSH-acquired central venous catheter (CVC) line infections
- establish monitoring of SSIs in cardiothoracic, spinal and urology specialties
- reduce the number of surgical site infections for Urology
- reduce or maintain low numbers of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia
- reduce or maintain low numbers of Clostridium difficile-associated diarrhoea.

Part 4 of our Quality Account reviews our performance on last year's priorities. This shows that we improved performance in four out of the six areas identified

We will continue to aim to reduce the number of the identified infection rates or maintain the low levels already achieved.

For SSI, we also aim to start monitoring across other surgical specialties.

Safety priority – Zero harm continued

How will we plan to improve in 2011/12?
Staff from surgical teams, Infection Control and Surveillance, and Transformation have worked together to develop driver diagrams on each area of infection. Driver diagrams enable us to visualise a particular issue and understand the factors that influence this issue. We can then identify the steps that are needed to improve the outcome of the issue.

For example, for our surgical site infection reduction programme the following driver diagram has been developed:

Primary outcome measure	Primary drivers	Secondary drivers
Zero harm Infection prevention and control surgical site infection (SSI)	To improve pre-admission screening and information	• Implementation of screening policy eg Methicillin-resistant Staphylococcus aureus (MRSA) screening • Providing parents information on SSI.
Aim To achieve zero avoidable organ space SSI infection by December 2013	To improve pre-operative preparation and care practices	• Pre-operative wash • Hair removal: use electric clippers with a single-use disposable head on the day of surgery • Timely pre-operative antiboiotics prophylaxis when in protocol (measure: percentage of antibiotics administered within 0–60 minutes prior to incision) • Staff preparation.
	To improve intra-operative preparation and care practices	• Operating team preparation • Antiseptic skin preparation • Glucose control • Adequate perfusion • Adequate saturations • Normothermia • Wound dressing.
	To improve post-operative care practices	• Dressing and cleansing of the wound • Surveillance. (measure: percentage of compliance of care bundle) (measure: percentage of compliance of record keeping)

Definition: A driver diagram is used to conceptualise an issue and determine its system components which will then create a pathway to get to the goal.
Primary drivers are system components which will contribute to moving the primary outcome.
Secondary drivers are elements of the associated primary driver. They can be used to create projects or change packages that will affect the primary driver.

Data source: Transformation website.

In aid of these diagrams, we have modified and implemented care bundles to ensure staff follow best practice when treating patients and these will help to reduce the number of infections.

How will we measure and monitor performance in 2011/12?
The Infection Prevention and Surveillance team works with all specialties and wards to implement systematic monitoring systems to identify patients with infections. Each healthcare infection is reviewed and monitored by the Infection Prevention and Surveillance team. The monthly numbers of infection are then reported monthly to our operational and improvement board meetings.

The use of care bundles across the wards is measured via routine audits. The results of these audits can then be accessed via our online dashboards by all staff and are reviewed on a frequent basis by the clinical units.

Who is responsible for this improvement initiative?
The Assistant Medical Director and Director for Infection Prevention and Control is responsible for co-ordinating and directing the actions required to deliver this improvement. This improvement initiative is overseen by the Co-Medical Director who is the Executive Lead for Quality and Safety at Great Ormond Street Hospital.

Safety improvement initiative 2

Effective monitoring and communication of the deteriorating child
CEWS and SBARD are two key components that are fundamental to achieving zero harm and make the hospital safer for children. These are simple and effective safety and communication improvement techniques

Children's early warning score (CEWS)
CEWS is used to identify, record and report signs of deterioration in patients by using a simple scoring system based on observations. Any scores above a certain level mean the patient must be referred to senior staff such as a Clinical Site Practitioner (CSP) and reviewed within a set time frame. By recognising early on that a patient is deteriorating, and implementing the appropriate measures, further deterioration or even cardio-pulmonary arrest may be prevented.

SBARD (situation, background, assessment, recommendation, decision)
SBARD is a universal communication tool that was implemented to improve safety, efficiency and effectiveness of patient care. It is thought that around 10 per cent of all critical incidents in healthcare stem from communication issues, so identifying ways to improve how teams relay information is crucial to safe and efficient performance. This ensures fundamental information is communicated in a standardised and consistent way.

This improvement initiative was identified by reviewing the key themes of the Paediatric Trigger Tool and from feedback from staff.

What do we aim to improve in 2011/12?
We aim to ensure that all ward staff use CEWS to monitor their patients and use SBARD to communicate a deteriorating child to their clinical team and senior staff such as the CSPs.

"It is very important to pick up patients as they start to deteriorate rather than at the point where it's too late. If we can prevent them being admitted to intensive care, then it's a good thing."

Helen McKee
Resuscitation Training Officer

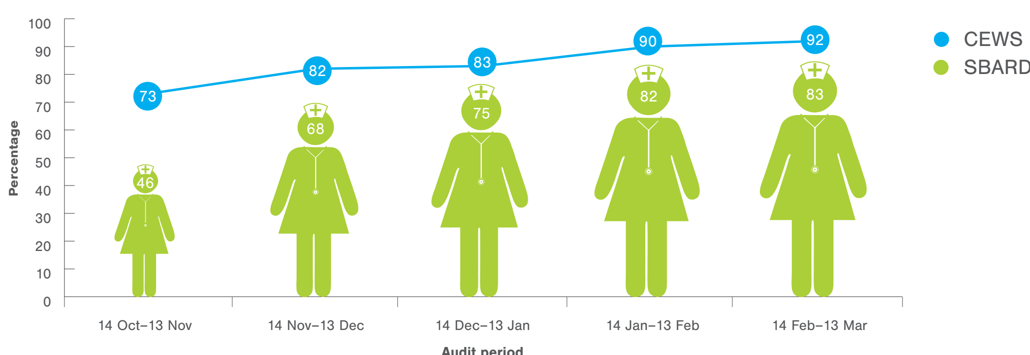
Safety priority – Zero harm
continued

How will we plan to improve in 2011/12?
A hospital action plan was agreed with our Senior Clinical and Management Unit Leads in September 2010. This recommended that local trainers for SBARD (situation, background, assessment, recommendation, decision) and CEWS (children early warning score) were identified for each area. In total, 126 individuals attended the train the trainer sessions. These individuals are now responsible for training staff in local teams and championing the use of these tools for monitoring and managing patients.

Posters and awareness campaigns are also used throughout the hospitals to reinforce the use of these tools in practice. Information is also provided at local induction.

How will we measure and monitor performance in 2011/12?
Since October 2010 all calls from wards to the Clinical Site Practitioners (CSPs) have been recorded and monitored. This reports if a CEWS is given for a patient referral and if the call is made using SBARD. The results to date are shown as follows:

Percentage of calls to CSPs where CEWS were given and information was communicated using SBARD



Data source: CSP callsheets.

The results from this ongoing audit are reported to the Quality and Safety Committee on a quarterly basis. Further work is being developed to provide reports to each ward and department on their ongoing performance as well as benchmarking their results against other wards. This information will also be available via an online dashboard for all staff to access and monitor.

In addition, every month each ward in the hospital looks at five patient observation charts and assesses whether:
- the child has a monitoring plan which is being followed
- CEWS is completed
- CEWS is correct.

An 'all or nothing' approach is used to evaluate performance so even if just one element of the assessment is missing this is recorded as a fail. This approach is known to drive improvements in the quality of care and sets the highest standards for us to measure ourselves against.

Who is responsible for this improvement initiative?
The Nurse Consultant for Acute and High Dependency Care and Clinical Workforce Manager are responsible for overseeing and directing the actions to deliver this improvement. This improvement initiative is overseen by the Co-Medical Director who is the Executive Lead for Quality and Safety at Great Ormond Street Hospital.

Safety improvement initiative 3
Use of the World Health Organisation (WHO) surgical and procedural safety checklist
In June 2008, WHO launched a global patient safety challenge, Safe Surgery Saves Lives, to reduce the number of surgical deaths across the world which included the development of the surgical safety checklist.

As a result, since 1 February 2010 all NHS Organisations are required to ensure that:
- an executive and a clinical lead are identified in order to implement the surgical safety checklist within the organisation.
- a checklist is completed for every patient undergoing a surgical procedure.
- the use of the checklist is entered in the clinical notes or electronic record by a registered member of the team, for example, surgeon, anaesthetist, nurse, ODP.

This improvement initiative was identified by reviewing national campaigns and targets which inform our safety agenda and from feedback from staff.

What do we aim to improve in 2011/12?
We aim to ensure that all surgical and interventional teams across the hospital use and record the surgical and procedural safety checklist in every procedure by the end of December 2011.

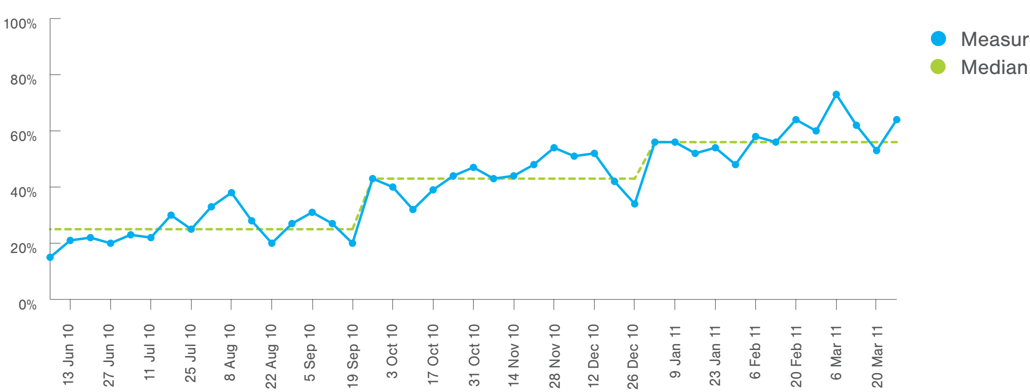
How will we plan to improve in 2011/12?
A multidisciplinary group formed of staff representing surgical, interventional, theatre and information teams meets on a monthly basis. This group identifies actions and resolves issues to achieve our aim. We are also in the process of purchasing Safe Surgery software which will not only support the Trust's ability to complete and record the surgical safety checklist electronically, but also provide an electronic audit trail. The implementation of this system will provide an opportunity to address any final issues to implementation via a targeted training programme.

Safety priority – Zero harm continued

How will we measure and monitor performance in 2011/12?
For each procedure, a member of the operating team record the use of the safety checklist electronically via our patient administration system.

The use of the surgical safety checklist is then measured and published on our online dashboard system which all staff can access. There has been significant improvement in the use of the surgical safety checklist since January 2010 as shown in the graph below:

Percentage of total checklist completion
Area: all theatres and interventional teams, and all specialties



Data source: Patient information management system.

Further data is also available demonstrating completion rates at each step, and can be broken down by team and location.

This data, and plans for improvement are discussed at regular operational and management board meetings throughout the hospital.

Who is responsible for improving performance?
Each Clinical Unit Lead is responsible for overseeing and directing the actions to deliver this improvement. This improvement initiative is overseen by the Co-Medical Director who is the Executive Lead for Quality and Safety at Great Ormond Street Hospital.

Safety improvement initiative 4

Reduce the number of medication errors that cause preventable harm to the patient

The National Service Framework states that patients should have access to safe medicines which are effective at treating their illness. We recognise that medication errors are caused by both human and system error and can cause harm to patients. By focusing on how and why our systems fail we can put in place improvements that aim to reduce medication errors.

This improvement initiative was identified by reviewing national campaigns and targets which inform our safety agenda and from feedback from staff.

What do we aim to improve in 2011/12?
We aim to reduce medication errors in the Paediatric Intensive Care Unit (PICU) and Cardiac Intensive Care Unit (CICU) by 25 per cent from the initial baseline by the end of 2011.

How will we plan to improve in 2011/12?
We recognise that staff at all levels of the hospital needs to be involved in reducing medicine errors. Each clinical unit has an improvement lead who is tasked with working with the relevant staff in their area and follows the guidance from the Patient Safety First Campaign including:

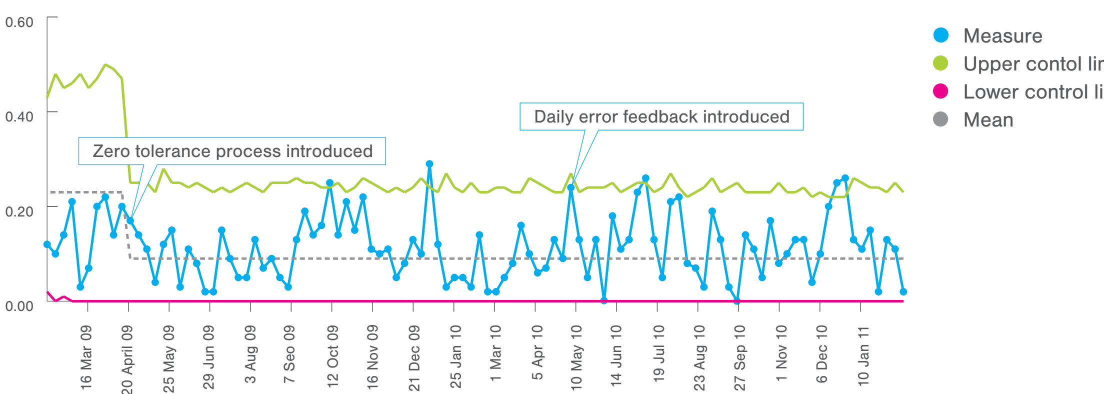
- establishing a baseline measurements for medication errors
- identifying high risk areas in the hospital and focusing efforts in these areas
- identifying high risk medications in the hospital and decreasing the harm caused by these drugs
- working with clinical teams to reduce medication error.

We will also be appointing a Medicine Management Specialist who will provide specialist expertise and support to all the clinical units across the hospital.

How will we measure and monitor performance in 2011/12?
Ward staff record any medication error that causes harm to a patient. This data is then reported via online dashboards which can be accessed by all staff. The graph overleaf shows an example of an intervention in a high risk area within PICU and the improvement in reducing prescribing clinical errors. In this particular case, a zero tolerance approach is taken to prescribing errors.

Safety priority – Zero harm
continued

Paediatric Intensive Care Unit: Clinical prescribing errors per 1,000 bed days



Data source: Transformation medicines management dashboard.

This data, and plans for improvement are discussed and agreed at regular operational and improvement board meetings throughout the Trust.

Who is responsible for improving performance?
Each Clinical Unit Chair has identified a local project lead for overseeing and directing the actions to deliver this improvement in their area. This improvement initiative is overseen by the Co-Medical Director who is the Executive Lead for Quality and Safety at Great Ormond Street Hospital.

Safety improvement initiative 5

Reporting and learning from incidents
The National Patient Safety Agency (NPSA) has set up the National Reporting and Learning Service (NRLS) portal which allows NHS organisations to report all their patient safety incidents. This enables the NPSA to review incidents across hospitals and develop national guidance to help improve the safety of patients. This guidance is circulated in the form of alerts which should be implemented in all hospitals.

In 2008 a briefing from NPSA evidenced that high reporting can be a sign of a safe organisation that is keen to identify problems as soon as they occur and put plans in place to make things right, promoting a safer environment. We recognise that in order to aim for zero harm we need to get staff to record and learn from incidents that take place in the hospital

This improvement initiative was identified by reviewing national campaigns and targets which inform our safety agenda and from feedback from staff; our commissioners and strategic health authority.

What do we aim to improve in 2011/12?
We aim to ensure hospital staff report incidents as they happen and this is reviewed and where required actions are put in place to prevent it happening again. We also aim to continue to implement the relevant national safety guidance including the NPSA National Framework for reporting and learning from serious incidents requiring investigations.

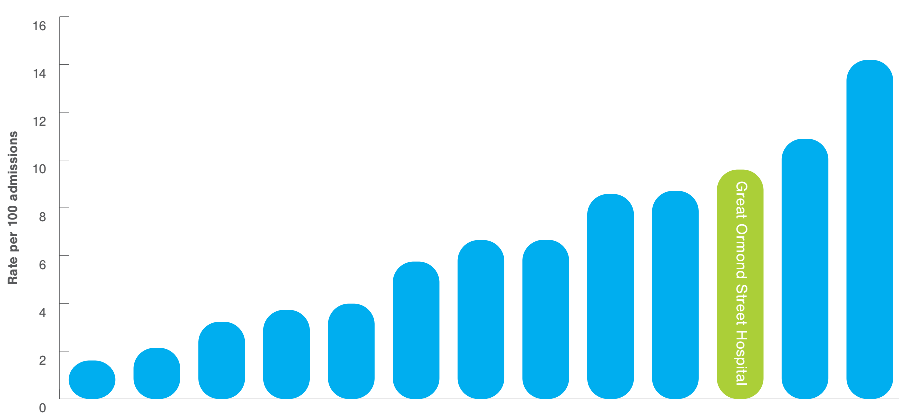
How will we plan to improve in 2011/12?
We are introducing a web based incident reporting system to replace the existing paper system. The intended aims of the new system are to:

- introduce 'real time' reporting
- improve communication regarding incidents, particularly across different areas in the hospital and feeding back directly to staff the outcome of reporting an incident
- provide an auditable trail of all actions taken following an incident
- improve the quality and sensitivity of reports.

We have developed a plan to implement the National Framework for Managing Serious Incidents. This identifies the local responsible officers, the expected actions required at each stage of the investigation and the timeframes required.

How will we measure and monitor performance in 2011/12?
We have demonstrated a strong organisational culture of safety through consistently reporting high levels of incident reporting. This is illustrated in the most recent report from the NRLS which compares the number of incidents reported by organisation:

Rate of reported incidents per 100 admissions during 1 April 2010–September 2010 for specialist hospitals



Data source: NPSA *Safety Incidents Report*, 1 April–30 September 2010.

The results of the staff survey 2010 show that a high percentage of our staff reported that in the last month they had witnessed potentially harmful errors, near misses or incidents. However, 97 per cent of these staff confirmed that they reported these incidents.

With the introduction of a new reporting system we will monitor the following on a monthly basis:
- Number of incidents reported
- Number of open incidents
- Number of closed incidents and learning
- Outstanding actions.

Incidents and actions are monitored locally via the risk and action groups and then fed back quarterly at the Quality and Safety Committee.

For serious incidents, the investigations and action plans are monitored weekly by the Clinical Governance and Safety team and relevant Executive Directors, and on a monthly basis by the Quality and Safety Committee and the commissioners clinical quality review meetings.

Who is responsible for delivering this improvement initiative?
The Patient Safety Manager is responsible for overseeing and directing the actions to deliver this improvement in their area. This improvement initiative is overseen by the Co-Medical Director who is the Executive Lead for Quality and Safety at Great Ormond Street Hospital (GOSH).

Safety improvement initiative 6

Improve the quality of care of children and young people attending GOSH where there are safeguarding concerns

The NHS London Safeguarding Improvement Team (SIT) visited GOSH in January 2011 as part of a London wide initiative to assess safeguarding. This review was aimed at supporting and improving safeguarding children in the NHS. The SIT team were impressed with our approach to safeguarding and felt it was strongly embedded and well resourced.

The outcome of the SIT review included some helpful recommendations of how we could improve. In particular the hospital aims to develop a balanced scorecard which will give a comprehensive view of performance on safeguarding across key areas.

This improvement initiative was identified by reviewing national campaigns and targets which inform our safety agenda and from feedback from staff; our commissioners and Strategic Health Authority.

What will we aim to improve in 2011/12?
We will aim to improve our performance across the three areas of:
- record keeping
- supervision
- Level 3 training.

We will implement a balanced scorecard for use within the hospital and then evaluate the impact on the quality of care of young people where there are safeguarding concerns.

How will we plan to improve in 2011/12?
Following the serious case review into the death of baby Peter Connelly, GOSH in Haringey worked in partnership with Haringey Primary Care Trust to develop a balanced scorecard which for the first time focused on safeguarding. Following the OFSTED review in 2009, the use of this balanced scorecard for safeguarding was commended as a 'good practice'. We plan to adapt and implement this balanced scorecard for use in the hospital from April 2011.

The balanced scorecard will focus on three performance indicators which have been identified as posing the most challenge to our hospital. It is intended that the use of the scorecard will increase focus in these areas and indicate the progress in our safeguarding improvement against specific targets over the year. We also have a hospital wide action plan which will identify actions that are aimed to improve the performance.

How will we measure and monitor performance in 2011/12?
The following three performance indicators will be measured within the balanced scorecard.

Indicator and information	What will we measure?	Where are we now?	What is the target for 2011/12?
Record keeping – regular audit of child protection cases is carried out to ensure they follow best practice	We will measure the number of records that have the correct referral form via regular audit	70 per cent have the correct information	80 per cent
Child protection supervision – all trust staff have access to the named nurse and named doctor for child protection supervision as required or if identified via live child protection cases. In addition to the standard requirements for child protection supervision, the Trust are currently trialling an innovative 'group supervision model' for identified groups	We will measure the uptake of child protection supervision training in specialist groups	20 per cent of staff trained in specialist groups	50 per cent
Level 3 training – Currently 100 per cent of GOSH staff have achieved Level 1 training, however national standards recommend that 80 per cent of staff that treat children should have level 3 training	We will measure the number of staff with Level 3 training	20 per cent of staff trained in Level 3	40 per cent

Data source: CQUIN target.

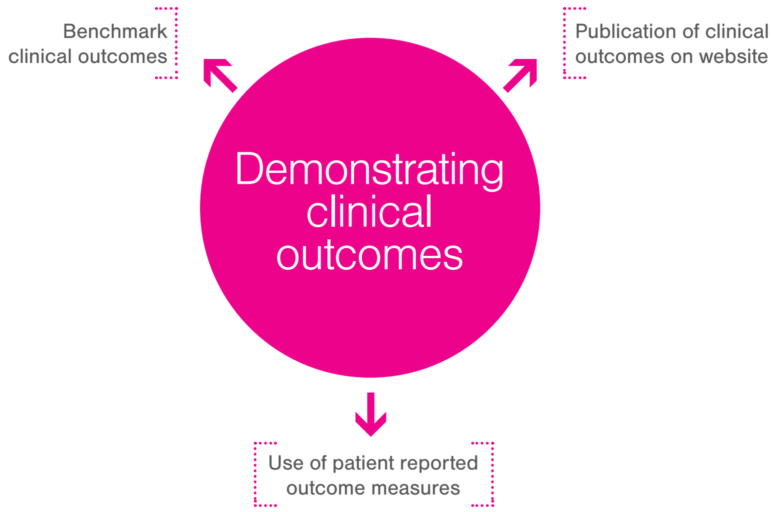
The balanced scorecard will be monitored and reviewed in operational board meetings on a monthly basis.

Who is responsible for delivering this improvement?
The Child Protection Co-ordinating Manager is responsible for overseeing and directing the actions to deliver this improvement in their area. This improvement initiative is overseen by the Chief Nurse/Director of Education.

Effectiveness priority – Demonstrate clinical outcomes
Consistently deliver clinical outcomes that place us amongst top five children's hospitals in the world.

Last year we identified that we are committed to evidencing the effectiveness of our care and that we wanted to compare ourselves against other hospitals. This remains a key priority for 2011/12.

We have used national targets and campaigns, parent, commissioner and staff feedback to inform the areas we would like to improve in 2011/12 to achieve our priority of demonstrating clinical outcomes. These are set out below:



Effectiveness improvement initiative 1
Development of clinical outcomes for each of the specialities and publication of these on the website

In last year's quality accounts we discussed our progress in identifying measures to demonstrate the effectiveness of the care that we provide. Whilst the specialist nature of the care given sometimes means we can't always compare our performance against other hospitals we have been working hard to identify measures that allow internal comparison and the ability to measure outcomes over time.

In 2010/11 we have developed a section on our Great Ormond Street Hospital (GOSH) website to make some of our clinical outcome information available to the public. This information includes outcome measures for the following services.

Cardiac	Thirty-day and one-year mortality rates for all catheter and surgical procedures **benchmarked**
Intensive care	Paediatric intensive care standardised mortality rate **benchmarked** Cardiac intensive care standardised mortality rate **benchmarked**
Cystic fibrosis	Lung function Levels **benchmarked** Nutrition function Levels **benchmarked**
Renal	Number of functioning kidneys **benchmarked** Peritonitis and line infection rates **benchmarked**
Adolescent medicine	Functional disability inventory Global wellness score School attendance
Bone marrow transplant	Survival rates
Cleft	Need for revision surgery Dental arch growth **benchmarked**
Rheumataology and physiotherapy	CHAQ scores VAS pain scores Parental VAS pain scores Muscle strength Walking time School attendance Sporting activity

Data source: GOSH website.

These can be found on www.gosh.nhs.uk/publications/clinical_outcomes_quality_account/

Part 4 of the Quality Account gives a few further examples of ways specialities have developed measures to assess outcomes in the services they offer.

What do we aim to do in 2011/12?
We will aim to provide further information on our outcome measures via our GOSH external website. In particular we will increase the number of specialities that demonstrate their outcomes from nine to 18.

How will we plan to improve in 2011/12?
We will work with staff and patients and their parents over the next year to get feedback and advice on the best way to present further information on our clinical outcomes on the website.

We have developed clinical unit action plans to identify the next steps required for measuring and publishing clinical outcomes.

The Clinical Outcomes Development Lead will continue to support specialities with the development, measurement and publication of clinical outcomes.

Effectiveness priority – Demonstrate clinical outcomes continued

How will we measure and monitor performance in 2011/12?
We will measure the number of specialities and their associated clinical outcomes that are available on the website.

Progress on the development, measurement and publication of these clinical outcomes are reviewed and monitored on a monthly basis by the Clinical Outcomes Board.

Each clinical unit is required to present information on their progress and provide examples of clinical outcomes at quarterly performance reviews to the Executive team.

Who is responsible for delivering this improvement initiative?
The Clinical Outcomes Development Lead is responsible for overseeing and directing the actions to deliver this improvement in their area. This improvement initiative is overseen by the Co-Medical Director who is the Executive Lead for Quality and Safety at Great Ormond Street Hospital (GOSH).

Effectiveness improvement initiative 2

Development and use of patient reported outcome measures across the specialties
Patients' perception of treatment and care is a major indicator of quality and recently there has been a huge expansion in the development and application of questionnaires and rating scales that measure health outcomes from the patient's perspective.

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. These instruments can be completed by a patient or individual about themselves, or by others on their behalf.

There is a national PROM programme run by the Department of Health, however to date, we have not treated any patients eligible to take part in this programme. Nonetheless we are keen to use PROMs across the hospital to ensure that we measure and understand how patients perceive the outcomes of their care and see this as an improvement initiative for 2011/12.

What do we aim to do in 2011/12?
We aim to continue the use of PROMs in identified specialities and where possible publish these results. We also aim to develop and implement further PROMs across the hospital.

How will we plan to improve in 2011/12?
The following specialities have identified or developed service specific PROMs that will be used within their service over the next year:

Specialty	Name	Information on the measure	Period of assessment
Cystic fibrosis	Cystic fibrosis questionnaire	International measure – is a questionnaire that measures the impact of treatment on quality of life	Three to four months
Epilepsy surgery	Quality of life childhood epilepsy (QOLCE)	International measure – is a questionnaire that measures the impact of epilepsy surgery on quality of life	One to two years
Neurodisability	Parental understanding neurodisability questionnaire	Locally developed – is a questionnaire that is intended to measure the level of parental understanding of a child's condition and the level of anxiety	At set intervals
Dermatology	Laser surgery PROM	Locally developed – is a questionnaire that is intended to measure the improvement of the appearance of port wine stains for the patient and the anxiety associated	One to two years
Adolescent medicine	EQ-5D	International measure – is a standardised instrument for use as a measure of health outcome. It provides a simple descriptive profile and a single index value for health status	One to two years
Orthopaedics	Children's Hospital Oakland hip evaluation study	International measure – evaluates patients with hip dysplasia and their associated outcomes. It measures the patients' ability to walk and function but also the level of pain	One to two years

We will review the best way to capture data from patients and the systems we can use to do this in the most effective way. We will also continue to review national guidance and advice on the use of PROMs. We will develop local guidance on the design and implementation of a speciality specific PROM.

The Clinical Outcomes Development Lead will continue to support specialities with the development, measurement and publication of PROMs.

How will we measure and monitor performance in 2011/12?
The numbers of patients participating in the identified PROMs will be monitored on a quarterly basis with each of the specialities to ensure that when necessary follow up questionnaires are sent out and completed as far as possible.

Each clinical unit is required to present information on their progress and provide examples of clinical outcomes at quarterly performance reviews to the Executive team.

Who is responsible for delivering this improvement initiative?
The Clinical Outcomes Development Lead is responsible for overseeing and directing the actions to deliver this improvement in their area. This improvement initiative is overseen by the Co-Medical Director who is the Executive Lead for Quality and Safety at GOSH.

Effectiveness priority – Demonstrate clinical outcomes continued

Effective improvement initiative 3

To measure outcomes in specialities that can be benchmarked against other hospitals

We identified our Quality Account last year that the current Dr Foster Hospital Standardised Mortality Ratio used by many hospitals in the UK to demonstrate outcomes was not applicable to paediatric care. We continue to work with experts to explore an alternative risk adjusted measure that could be used in the hospital.

We also provide a range of services on a national basis, meaning that Great Ormond Street Hospital (GOSH) is either the only or one of a very few providers nationally. However, increasingly commissioners of these services are recognising the importance of evidencing clinical outcomes and encouraging the few providers to report against the same measures to enable comparisons.

For example, the Cardiorespiratory Directorate is a national service provider for extra corporeal membrane oxygenation (ECMO). ECMO is used to support patients in the Paediatric Intensive Care Unit who have severe cardiac and respiratory failure by oxygenating the blood through an artificial heart-lung machine. The following graph shows the survival data of patients treated at GOSH compared to the international survival rate of patients treated in other ECMO centre worldwide that submit data to the ECLS registry.

Cardiac ECMO example of survival rate benchmarked against international data

Data source: Extra Corporeal Life Support Registry.

Other specialist services at GOSH are working with other hospitals to develop registries to collect data and measure the same outcomes. We are keen to encourage this development as it allows us to compare our services and improve the quality of service we offer.

What do we aim to do in 2011/12?

To encourage specialities in GOSH to use outcome measures that can be benchmarked with other providers and/or to lead on the development of outcome measures that can be used by other centres.

How will we plan to improve in 2011/12?

The following specialities have identified registries or networks to develop outcome measures against which we can benchmark in 2011/12:

- 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 nedicine – through the National Outcomes Database
- Gastroenterology IBD – through the ImproveCare Now registry
- Haemophilia – through the specialist commissioning forum
- Infectious diseases – through the Collaborative HIV Paediatric Study
- Ophthalmology – an early implementer of the Royal College of Ophthalmologists quality standards and quality indicators.

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

The Clinical Outcomes Development Lead will continue to support specialities with the development, measurement and publication of benchmarked outcomes.

How will we measure and monitor performance in 2011/12?

Progress on the development, measurement and publication of these clinical outcomes are also reviewed and monitored on a monthly basis in the Clinical Outcomes Board.

Each clinical unit in the hospital is required to present information on their specialities clinical outcomes at quarterly performance reviews to the Executive team.

Who is responsible for delivering this improvement initiative?

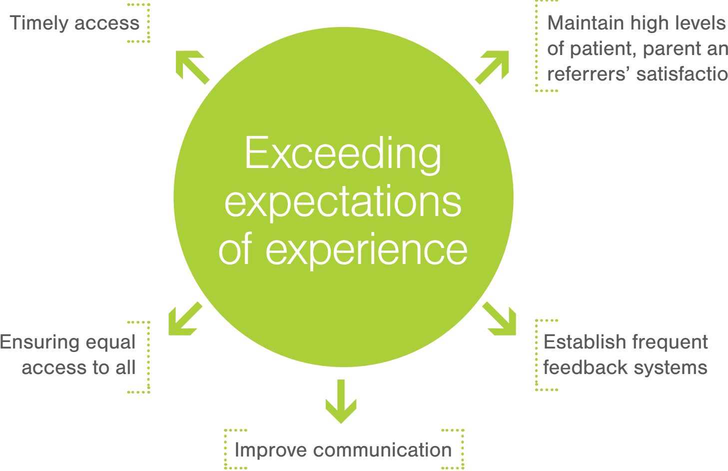
The Clinical Outcomes Development Lead is responsible for overseeing and directing the actions to deliver this improvement in their area. This improvement initiative is overseen by the Co-Medical Director who is the Executive Lead for Quality and Safety at GOSH.

Experience priority – Deliver excellent experience
Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations.

We recognise that the memories and perceptions that families and patients have of Great Ormond Street Hospital (GOSH) are heavily influenced by the quality of their experience. Therefore we are keen to measure patient experience across the hospital and ensure we use this information to continuously improve the services that we offer.

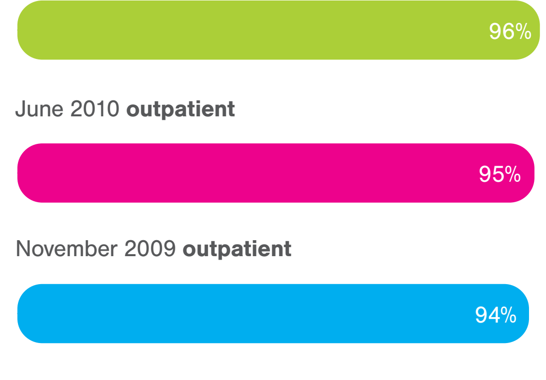
We have developed a patient and public involvement and engagement strategy to encourage parents, patients and members of the public to become engaged in activity in the hospital. It was developed after extensive consultation with staff, patients and parents.

We have used national targets and campaigns, parent, commissioner and staff feedback to inform the areas we would like to improve in 2011/12 to achieve our priority of delivering excellent experience. The following diagram summarises our improvement initiatives for 2011/12:



Experience improvement initiative 1
Maintain high levels of patient and parent satisfaction
Results from our independent inpatient and outpatient survey over the last couple of years demonstrate excellent feedback scores from our patients and the parents that visit GOSH. For example the following graph shows the overall satisfaction score with the services we provide:

Overall patient and parent satisfaction with services at GOSH recorded by our independent annual survey



Data source: Ipsos MORI.

This improvement initiative was identified by reviewing the results of our independent surveys and feedback from our parents and commissioners.

What do we aim to do in 2011/12?
We aim to implement hospital wide plans to improve patient experience in the key areas identified by the recent results of our independent inpatient 2010/11 survey.

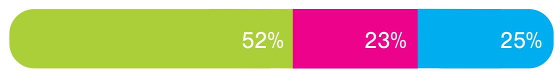
Experience priority – Deliver excellent experience continued

How will we plan to improve in 2011/12?

In particular with our commissioners, we have identified the following improvement areas to focus on:

- "I knew how to complain" – a new question introduced in 2011 survey showed that 25 per cent of patients and parents did not agree that they knew how to complain.

"I knew how to complain or offer feedback" results of independent inpatient survey



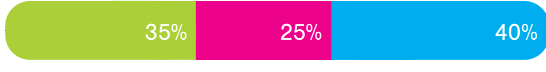
- Strongly agree
- Tend to agree
- Other

Data source: Ipsos MORI.

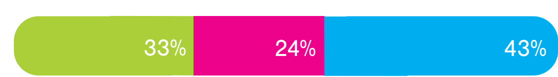
- "Improving satisfaction with the quality and variety of hospital food" – whilst there was an improvement in 2011 survey results 40 per cent of patients and parents were not satisfied with the food we provide.

"The quality and variety of hospital food" results of independent inpatient survey

February 2011 **independent inpatient survey**



November 2009 **independent survey**



- Very satisfied
- Fairly satisfied
- Other

Data source: Ipsos MORI.

This year we plan to have an increasing focus on nutrition for children and young people to not only implement nutrition screening but to monitor patient's nutritional outcomes through regular audit and to improve patient's experience of the quality and variety of food, and the way it is provided at Great Ormond Street Hospital (GOSH).

We will develop an action plan to make changes and improvement in these areas.

We will also use the results of the latest survey to identify any other areas that may require improvement across the hospital or between areas

We do not take part in the national independent patient experience survey that most hospitals in England take part in as this only includes adult patients. However some of the questions we ask are similar to the key areas that are measured by this survey and we are keen to reflect how we perform in these areas too.

The following table shows these areas and the percentage of patients and parents that responded positively or agreed with the question:

National key areas	The question we ask	National benchmark 2009	Positive results Feb 11	Positive results Nov 09
Were you involved as much as you wanted to be in decisions about your care and treatment?	Last time you saw a doctor or a nurse at the hospital how good were they at involving you in decisions about your child's care/involving you and your parents in decisions about your care?	89 per cent	94 per cent	93 per cent
Did you find someone on the hospital staff to talk to about your worries and fears?	Last time you saw a doctor or a nurse how good were they at asking you questions about how you and your child were feeling?	79 per cent	88 per cent	88 per cent
Were you given enough privacy when discussing your condition or treatment?	My child had enough privacy when the doctors/nurses talked to his/her treatment/you had enough privacy/ I had enough privacy	92 per cent	92 per cent	92 per cent
Did a member of staff tell you about medication side effects to watch out for when you went home?	I had enough information about any medicine [in relation to leaving the hospital]	54 per cent	90 per cent	88 per cent
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the hospital?	I knew who to contact if I had a question when I got home	75 per cent	91 per cent	89 per cent

Data source: Ipsos MORI.

We are working hard to maintain the high level of positive results in these areas.

How will we measure and monitor performance in 2011/12?

We will continue to use the information from the recent independent surveys as our comparative baseline for our performance standard and carry out a further annual survey towards the end of 2011/12 to measure improvement.

Local experience improvement plans for each of the units will be reviewed and progress monitored in the Patient and Public Involvement and Experience Committee on a quarterly basis.

The Head of Volunteer Services will evaluate the impact of the volunteer programmes on services across the hospital and the added value to the patient and family experience.

Who is responsible for delivering this improvement initiative?

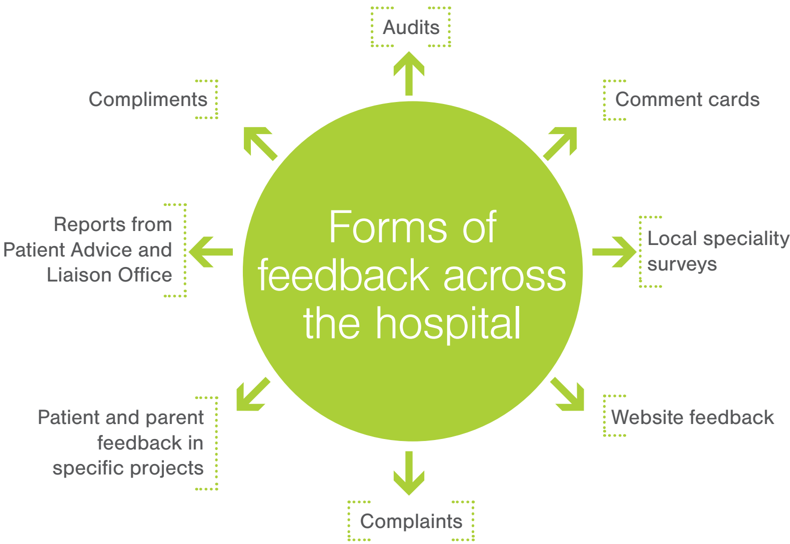
The Patient and Public Involvement and Patient Liaison Officer is responsible for overseeing and directing the actions to deliver this improvement in their area. This improvement initiative is overseen by the Chief Nurse and Director of Education.

Experience improvement initiative 2

Establish frequent feedback system for ongoing measurement of patient satisfaction/experience

The results of our independent inpatient and outpatient surveys have given us benchmarks that we did not have before, and an indication of some areas where we need to improve. However these surveys are only reflective of a snap shot of patients and families that visit Great Ormond Street Hospital (GOSH) at a short period of time.

We recognise that we also collect feedback from patients and families in a number of different ways as shown below:



Ongoing feedback gives a more regular indication of how we are doing and local feedback to teams regarding the quality of the service they offer, and areas that need improvement.

This improvement initiative was identified by reviewing national campaigns which inform our experience agenda and from feedback from staff; our commissioners and parents and patients.

What do we aim to do in 2011/12?

We aim to develop systems which can capture and record frequent feedback which measures ongoing patient satisfaction and experience through 2011/12.

How will we plan to improve in 2011/12?

The ways in which we plan to establish frequent feedback systems is outlined in the Patient and Public Involvement and Experience Action Plan and includes the following:

- Develop and circulate standards for local department surveys including best practice guidance; identify core questions, frequency and response rates for surveys
- Review the potential of using the new patient bedside entertainment system to incorporate a survey for patients and parents to undertake whilst they are in hospital
- Explore the use of volunteers and hand held devices to capture patient survey results whilst in outpatients or on the wards.

A new PPI and Patient Liaison Officer will be appointed to support with the delivery of the above actions.

How will we measure and monitor performance in 2011/12?

We will evaluate the use of different feedback systems and the results from such initiatives including:

- the number of responses from each system
- analysis of the results from the questions asked
- feedback of how the systems are used in practice
- further improvements that are needed.

The implementation of the action plan will be monitored and reviewed by the Patient and Public Involvement and Experience Committee on a quarterly basis. A high level summary is also shared with the Trust Board.

Who is responsible for delivering this improvement initiative?

The Patient and Public Involvementand Patient Liaison Officer is responsible for overseeing and directing the actions to deliver this improvement in their area. This improvement initiative is overseen by the Chief Nurse and Director of Education.

Experience improvement initiative 3

Improve communication with patients, family and referrers

Many of the patients treated at GOSH have complex needs and are often under the care of several specialities within the hospital in addition to consultants at their local hospital. This means that it is fundamental that clinicians across GOSH communicate effectively with all those teams that are involved in the patient's care, in addition to the patient and family.

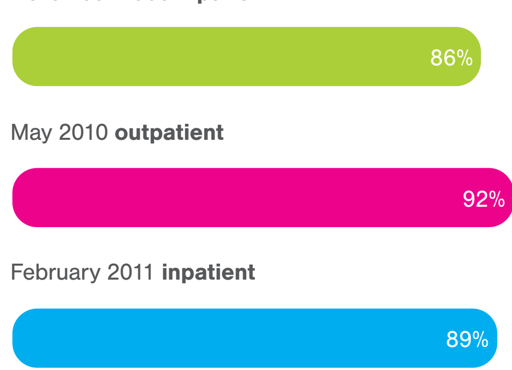
Information from our inpatient and outpatient surveys over the last few years shows that the majority of those patients and families that were surveyed felt that they did have the relevant information on what would happen next or further care that the child might need. This is shown in the graph overleaf:

Experience priority – Deliver excellent experience continued

I had enough information about what would happen next/any other care my child might need when attending Great Ormond Street Hospital (GOSH)

Percentage that agreed with the statement

November 2009 **inpatient**



Data source: Ipsos MORI.

However, information taken from our complaints and reports from our Patient Advice and Liaison Office shows that at times we are not always as good as we could be at communicating effectively with all the relevant people involved in the child's care.

During March to April 2010 we commissioned an independent survey for our referrers, who are mainly consultants in other hospitals, to understand what they thought of the service we provided to them and their patients, and where they felt we needed to improve.

Ninety-five per cent of those surveyed were satisfied with the clinical care we provide, however only 79 per cent of the referrers were satisfied with our service to them. Although there was high satisfaction with the quality of our letters and discharge summaries, it was highlighted that the timeliness of our communication was not as efficient as it should be and we do not always include all the relevant teams. We therefore see improving our communication as a fundamental improvement initiative to ensure the quality of the care that we offer at GOSH and meets the expectations of patients, their families and our referrers.

This improvement initiative was identified by feedback from staff, parents, patients and referrers.

What do we aim to do in 2011/12?
We aim to improve how we communicate with patients, parents and our referrers including ensuring the timeliness and quality of the information we communicate.

How will we plan to improve in 2011/12?
Following a review of our medical structure it was recognised that the quality of care at GOSH would be enhanced by employing a team of general paediatricians. It is envisaged that one role of the general paediatricians is to support the patients and their families that have multiple needs and are treated by several specialities. They will directly liaise with the patients and their families and identify the relevant teams to communicate with and help co-ordinate the patient's care with all involved.

This role will support improvement in communication and quality of care for patients supported.

We have also established a referrer's experience improvement programme aimed to address and improve the issues highlighted in the survey. Through this programme we will:

- continue to review our processes in order to improve the timeliness and quality of written and verbal information to the relevant teams, patients and their parents
- ensure that circulation lists for information is up to date and cross referenced with the patient's medical records
- review our bed management systems to enable us to accept more emergency patients
- host a referrers open day in May 2011.

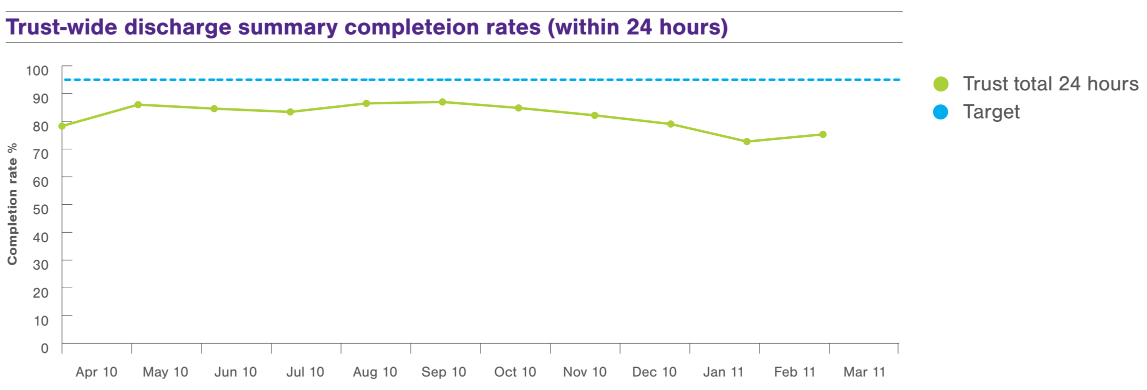
This improvement will be achieved through widespread involvement and focus across all the clinical units at all levels and a hospital wide steering group.

How will we measure and monitor performance in 2011/12?
We will measure and monitor:

- the timeliness and quality of our outpatient letters and discharge summaries
- the number of complaints and frequency of common themes
- the input of the General Paediatric team via specific measured goals
- feedback from the referrers open day.

The following graph shows our performance in completing our discharge summaries within 24 hours of a patient being discharged:

Trust-wide discharge summary completeion rates (within 24 hours)



We will review all of the above measures in our operational board meetings. The hospital referrers steering group will also monitor the performance of this improvement initiative.

Who is responsible for delivering this improvement initiative?
The General Paediatrics team and the Referrers Steering Group are responsible for overseeing and directing the actions to deliver this improvement in their area. This improvement initiative is overseen by the Chief Operating Officer.

Experience improvement initiative 4

Ensuring equal access to all

Equality in access to healthcare is central to the delivery of healthcare. The Independent Inquiry into Access to Healthcare for People with Learning Disabilities, led by Sir Jonathan Michael, published its findings *Healthcare for all* on 29 July 2008. The inquiry was ordered following Mencap's *Death by indifference* report, which told the stories of six people with a learning disability who died while receiving NHS care. The Inquiry sought to identify the action needed to ensure adults and children with learning disabilities receive appropriate treatment in acute and primary healthcare in England.

We know that how well and how quickly children recover not only depends on their clinical treatment but also on whether they and their families feel comfortable, safe, understood, respected and listened to during their time with us. This is why we believe that promoting equality and diversity at Great Ormond Street Hospital (GOSH) is not only right but it also makes clinical and business sense.

This improvement initiative was identified by reviewing national campaigns which inform our experience agenda and from feedback from staff and our commissioners.

What do we aim to do in 2011/12?

We will ensure that reasonable adjustments are made in the delivery of our services to ensure equal access for our patients with a learning disability.

How will we plan to improve in 2011/12?

We have developed a learning disabilities group with staff from across the hospital. This group has reviewed the Inquiry report and its recommendations and developed an action plan to make improvement in the services we offer.

This includes using these recommendations to review the services we provide and give us an initial baseline.

We will initially develop our systems to enable us to identify patients that have a leaning disability. We will then ensure that the views and interests of people with learning disabilities and their carers are included in the planning and development of our services.

This forms part of our ongoing work to ensure that GOSH meets the requirements of the Equality Act 2010.

How will we measure and monitor performance in 2011/12?

We plan to have completed a review of our current position regarding service provision for people with learning disabilities by April 2011 and will aim to demonstrate significant improvements in those areas identified as 'weak' by April 2012.

The delivery of this work will be led by the Co-Medical Director and progress will be monitored through the Trust Family Equality and Diversity Group.

Who is responsible for delivering this improvement initiative?

The Learning Disabilities Working Group is responsible for overseeing and directing the actions to deliver this improvement in their area. This improvement initiative is overseen by the Co-Medical Director.

Experience improvement initiative 5

Offer patients timely access to services at GOSH

We recognise that timely access to services is an important factor in the way people rate the quality of the service they receive. The Department of Health NHS Improvement Plan in June 2004 set out the requirement that there should be a maximum acceptable waiting time of 18 weeks from referral to start of hospital treatment.

Over the last two years, GOSH has consistently maintained a maximum waiting time of 18 weeks from referral to start of treatment in line with the national standards. We have continued to meet the cancer target of a maximum of 31 days between diagnosis and treatment.

This improvement initiative was identified by reviewing national targets which inform our experience agenda and from feedback from staff, our commissioners and parents and patients.

What do we aim to do in 2011/12?

We aim to continue to maintain our waiting times, and where possible reduce these, in line with the relevant targets set out in the NHS operating framework standards.

How will we plan to improve in 2011/12?

In last year's Quality Account, we introduced the Advanced Access programme that was being implemented across the hospital. This aimed to enable specialities to offer first appointments to new patients within two weeks of referral acceptance. This is done by looking at the entire patient pathway and streamlining processes where possible. As of the end of March 2011, 15 specialties across the hospital are able to offer a first appointment within 10 working days.

This programme will continue into 2011/12 and is seen as one initiative that will enable the hospital to ensure our waiting times remain low. The remaining 22 specialties are redesigning their services to ensure that they can offer this advanced access by the end of 2011/12.

We will also review our processes to reduce the number of did not attends and cancellations to ensure appointments are utilised.

Operational managers within clinical units are responsible for reviewing waiting times and ensuring patients are seen within the above standards.

How will we measure and monitor performance in 2011/12?

Advanced access performance is measured and monitored via online dashboards and reports which all staff in the hospital have access to and the performance in each speciality is updated on a monthly basis. The delivery of this programme is also monitored and reviewed by the Transformation Board.

We will continue to monitor our progress against the revised referral to treatment time standards across all services. This performance will be monitored through monthly operational board meetings and quarterly clinical unit strategic performance review meetings.

Who is responsible for delivering this improvement initiative?

The Head of Planning and Performance is responsible for overseeing and directing the actions to deliver this improvement in their area. This improvement initiative is overseen by the Chief Operating Officer.

Part 3 – Mandatory statements

Review of services
During 2010/11, Great Ormond Street Hospital (GOSH) provided and/or sub-contracted 38 NHS services. The income generated by the NHS services reviewed in 2010/11 represents 100 per cent of the total income generated from the provision of NHS services by the GOSH for 2010/11.

Our services incorporate medical and surgical services as well as those offering support, therapy, diagnosis and investigation. As a tertiary quaternary centre, we see patients from across the country, and our aim is to provide access for children with specific needs to a range of services within one site whenever possible. In addition to this, we also provided community services in Haringey.

In order to ensure that we maintain excellent service provision, we have internal processes to check that we meet both our own internal quality standards and those set nationally. Key performance indicators relating to each of the Trust's strategic objectives are presented, on a monthly basis, to the Trust Executive and Management Boards. This includes progress against external targets such as how we keep our hospital clean, the effectiveness of actions to reduce infections and ensure patients have access to our services when they need them.

Each specialty and clinical unit has an internal monitoring structure so that teams can regularly review their progress and identify areas where improvements may be required. This information links into wider Trust governance framework where the units report on the progress of the care they provide at least once a year.

These updates are recorded through the quarterly operational performance reviews and the committee structure of the Trust to ensure the quality of service delivery and monitoring is discussed and acted upon at the appropriate level within the Trust.

Delivery of healthcare is not risk free and the Trust has a robust system for ensuring that the care delivered by our services is as safe and effective as possible. Our process has been externally assessed and we achieved level two in the National Health Service Litigation Risk Management Standards in November 2009.

Unless events are reported when the outcome of care is not as expected, the Trust cannot learn and make improvements. A good safety culture is one with high levels of reporting and where the severity of the event is low. The National Patient Safety Agency has consistently identified the Trust as meeting this criteria. Analysis of the types of risks identified by staff are incorporated into our assurance process to ensure management, performance and safety are closely aligned

GOSH has reviewed all the data available to them on the quality of care in 38 of these NHS services.

Participation in clinical audit
Clinical audit is an evaluation of the quality of care provided against agreed standards. The aim of clinical audit is to provide assurances about services provided and stimulate improvement to them where necessary. The Trust has a central Clinical Audit team which considers the:

- national clinical audits which the Trust must participate in
- audits to support our Care Quality Commission registration
- NHLSA directed audit
- NPSA alerts where compliance testing is recommended by the Risk Management team
- Trust's strategic objectives with regard to patient safety.

The Clinical Audit team provides additional support and expertise to ensure that clinicians are supported to undertake good quality clinical audit which leads to improved practice. The number of local audits registered and supported in the organisation has increased significantly.

We have identified three types of clinical audit at GOSH:

1. International/national ones that we are asked to become involved in.
2. Local audits undertaken within GOSH – identified by clinical teams to ensure patients get the best possible care.
3. Clinical audits directed and managed by the Clinical Audit Department which address controls associated with known risks and best clinical practice.

During 2010/11, 22 national clinical audits and one national confidential enquiry covered NHS services that GOSH provides.

During that period, GOSH participated in 82 per cent of applicable national clinical audits and 100 per cent of the applicable national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The Clinical Audit Department at GOSH annually reviews the participation in national audits. Engagement with national audits is essential in ensuring that improvements are made across a wide range of medical and surgical aspects and to encourage delivery of better outcomes in the quality of care that is provided.

The table on the right demonstrates GOSH participation towards all the national audits released by HQIP and the Department of Health 2010-2011. The table is split into two sections:

1. Applicable national audit participation 2010/11.
2. Non-applicable national audits 2010/11.

1 Applicable national audit participation 2010/11

Audit title	Participation	Percentage of cases requested from national body	Percentage of cases submitted by Great Ormond Street Hospital
Per- and neonatal			
CEMACH: perinatal mortality	Yes	All applicable	100 per cent (17 cases in 2010)
Children			
PICANet: paediatric intensive care	Yes	All applicable	100 per cent (12,275 cases)
Congenital heart disease: paediatric cardiac surgery	Yes	All applicable	100 per cent (9,948 cases)
Acute care			
NHS blood and transplant: potential donor audit	Yes	All applicable	100 per cent (94 cases)
ICNARC NCAA: cardiac arrest	Yes	All applicable	100 per cent (119 cases)
Long-term conditions			
National inflammatory bowel disease: ulcerative colitis and Crohn's disease	Yes	100 per cent (50 cases)	12 per cent (six cases)
British Society of Gastroenterology	Yes	100 per cent	100 per cent (33 cases)
Elective procedures			
National elective surgery PROMs: four operations	Yes	All applicable cases	Currently no cases have been applicable
NHS blood and transplant: UK transplant registry: cardiothoracic	Yes	All applicable	100 per cent
Cardiovascular disease			
National clinical audit of management of familial hypercholesterolemia	Yes	All applicable	100 per cent (21 cases)
Pulmonary hypertension audit	Yes	All applicable	100 per cent (approximately 300 cases)
Renal disease			
Renal registry: renal replacement therapy	Yes	All applicable	100 per cent
National kidney care audit: vascular access, patient transport	Yes	100 per cent (one day worth of applicable cases)	100 per cent (16 cases)
NHSBT UK transplant registry: renal transplantation	Yes	All applicable	100 per cent (140–150 cases)

Audit title	Participation	Percentage of cases requested from national body	Percentage of cases submitted by Great Ormond Street Hospital
Blood transfusion			
National comparative audit of blood transfusion: o negative blood use	Yes	100 per cent (40 cases)	100 per cent (40 cases)
National comparative audit of blood transfusion: platelets	Yes	100 per cent (40 cases)	100 per cent (40 cases)
NHSBT UK cryo precipitate	Yes	100 per cent (40 cases)	100 per cent (over 40 cases)

Audit title	Participation
British Thoracic Society: paediatric asthma	No
British Thoracic Society: paediatric pneumonia	No
British Thoracic Society: bronchiectasis	No
TARN: severe trauma	No

2 Non-applicable national audits 2010/11

The following national audits are not applicable to Great Ormond Street Hospital as they are either not relevant to children or we do not provide the service or there are too few admissions to participate.

Audit title
Adult cardiac interventions: coronary angioplasty
Adult cardiac surgery: CABG and valvular surgery
British Thoracic Society: adult asthma
British Thoracic Society: adult community acquired pneumonia
British Thoracic Society: COPD
British Thoracic Society: emergency use of oxygen
British Thoracic Society: non-invasive ventilation (NIV)
British Thoracic Society: pleural procedures
Carotid intervention audit
College of Emergency Medicine: renal colic
College of Emergency Medicine: vital signs in majors
DAHNO: head and neck cancer
Heart failure audit
ICNARC CMPD: adult critical care
National audit of dementia
National audit of pharmacological treatment of schizophrenia
National audit of psychological therapies: depression, anxiety
National falls and bone health audit
National pain database audit: chronic pain services
National sentinel stroke audit
National vascular database: peripheral vascular surgery
NHFD: hip fracture
NLCA: lung cancer
College of Emergency Medicine: paediatric fever
NDA: national diabetes audit
National audit of heavy menstrual bleeding
National parkinson's audit
NHS blood and transplant: UK transplant registry: liver
NJR: hip, knee and ankle replacements
MINAP (inc ambulance care): acute myocardial infarction (AMI) and other acute coronary syndromes (ACS)
RCPH: national paediatric diabetes audit
SINAP: acute stroke
POMH: Prescribing topics in mental health services
NNAP: neonatal care
National childhood epilepsy audit (epilepsy 12)

The table below demonstrates Great Ormond Street Hospital (GOSH) participation in the National Confidential Enquiries, and is split by those applicable and those that aren't applicable.

1 Applicable national confidential enquiries 2010/11

Audit title	Participation	Percentage of cases requested from national body	Percentage of cases submitted by Great Ormond Street Hospital
Surgery in children	Yes	52 surgical reviews identified	63 per cent returned
		55 anaesthetic reviews identified	84 per cent returned

2 Non-applicable national confidential enquiries 2010/11

Audit title	Participation	Reason for not partcipating
Peri-operative care	No	The study is relevant to patients over the age of 16. Only one suitable patient met the inclusion criteria from the study. The NCEPOD clinical researcher for the project advised that GOSH should not participate in this study on 5 March 2010
Cardiac arrests	No	Confirmed with NCEPOD lead researcher on 27 October 2010 that study was not applicable for our patients

The reports of national clinical audits were reviewed by the provider in 2011/12. In 2011/12, we intend to develop a central system which records the actions associated with national clinical audits to report back in next year's Quality Account.

The reports of 23 local clinical audits were reviewed by the provider in 2010/11 and GOSH intends to take the following actions to improve the quality of healthcare provided.

The following table shows some examples from all those reviewed:

Specialty	Audit title	Project description	Actions
Dermatology	Review of guidelines for treatment of infantile haemangiomas with propranolol	Review of patients who have been started on propranolol to assess whether observing for four hours post first dose and after increasing dose is necessary. If monitoring of BP and HR twice weekly by community teams/GP is necessary and what adverse effects	Standard period of observation to be changed from four hours to two hours. Infants thought to require four hours observation must have four hour requirement clearly stated on admission form
General surgery	Time taken to get cannulas sited within surgery	To look at problems with cannulas being resited at the right time	Trust-wide monitoring and workshop to look at cannulation led by Chief Nurse
Neurodisability	Audit of the use of the botulinum toxin service integrated care pathway documentation	The movement disorder service has used an integrated care pathway (ICP) for several years for the procedure of botulinum toxin injections to capture four appointments, pre-assessment, injection day, three-week follow-up and 17-week follow-up	Integrated care pathway to be revised
Neurology	Audit of osteopenia prevention and treatment in children taking antiepileptic drugs	Previously there have been no local guideline for bone health of children attending the complex epilepsy service. Service has drafted guidelines and now wanted to audit practice before and after their implementation to check the standard	Implementation of proposed guidelines. Develop and provide educational leaflets to children and familes about epilepsy and bone health. Information sheet from the National Society of Epilepsy
Occupational therapy	Audit of standards set out for six months post bone marrow transplant (BMT) developmental assessments for the under fives	To audit if children under five, who have undergone a BMT, are seen at six months post BMT for a developmental assessment, as set out in the OT BMT standards. Time to be audited March 2007–March 2010	Standards to be reassessed and action plan in place. Reaudit in 2012
Pathology	Audit of post mortem investigations performed in sudden death in infancy	National recommendations outlines investigations to take place when a child suddenly dies. Audit of compliance 2006–9 of autopsies	Establishment of a checklist for use in the mortuary
Pharmacy	Audit of outpatient prescriptions	Aim of OPD department prescriptions audit is to evaluate the most commonly incomplete fields in the prescriptions in order to design and develop improvement programme	Electronic prescribing is being rolled out to outpatients

Participation in clinical research
With our dedicated research partner the UCL Institute of Child Health (ICH), Great Ormond Street Hospital (GOSH) now forms the largest paediatric centre in Europe dedicated to both clinical and basic scientific research. We are committed to carrying out pioneering research, to find treatments and cures for some of the most complex illnesses, for the benefit of children in the UK and worldwide. Commitment to research is a key aspect for improving the quality of care and patient experience.

In 2007, GOSH was awarded National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) status which recognises the quality and importance of the research conducted within the organisation, and is the only paediatric BRC in the UK. In addition to the BRC, the Division includes the Joint Research and Development Office, the Somers Clinical Research Facility, and the Medicines for Children's Research Network which is hosted within GOSH.

Our research activity is conducted with a range of national and international academic partners and we work very closely with industry to support the development and introduction of new therapeutics, devices and diagnostics for the NHS.

Our recent research activity is described below:

- Over 300 clinical trials being set up, 27 of which are commercially funded.
- Over 2050 patients have been included in studies adopted by the Comprehensive Local Research Network onto their portfolio
- We currently have five active NIHR funded research projects
- We have five active EU funded research projects
- Sixty-four research projects have been internally peer-reviewed through the Clinical Research Advisory Committee
- Forty research studies are conducted in our Clinical Research Facility, with more than 420 patients attending 766 research appointments
- Two hundred and forty-one patients have been recruited through the MCRN to GOSH, of which 36 MCRN studies are administered via the CRF.

The number of patients receiving NHS services provided or sub-contracted by GOSH in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 2,283.

Areas of forthcoming development include engaging UCL Business Plc (UCLB) for provision of intellectual property management and commercialisation services for staff across the Trust. UCLB currently work closely with the ICH, and we anticipate seeing added value to GOSH through alignment of this activity with our dedicated research partner.

GOSH's commitment to clinical research is further evidenced by our membership of UCL Partners, which is one of the UK's first five Academic Health Science Partnerships. Through the partnership, we continue to strengthen our links with other centres of excellence in clinical research.

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework
The CQUIN Payment Framework is an arrangement between provider NHS trusts and their commissioners. The aim is to incentivise improvement work. This shows that we are working closely with commissioners of our services.

A proportion (1.5 per cent) of GOSH NHS clinical income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between GOSH and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2010/11 and for the following 12-month period are available on request from the Assistant Director of Nursing or the Head of Contracts.

The following table summarises the CQUIN targets for 2010/11 and 2011/12.

2010/11 CQUIN targets	2011/12 draft CQUIN targets
Undertake further inpatient and outpatient surveys and achieve specific levels of satisfaction in certain areas	• Implement the patient experience strategy and action plan • Maintain and improve satisfaction on nationally prioritised questions, knowing how to feed back, and quality and variety of food in annual independent inpatient satisfaction survey
Implement the Paediatric Trigger Tool	Continue to review 20 sets of case notes per month using the Paediatric Trigger Tool and undertake a peer review of the implementation of the tool
Improve the quality and timeliness of discharge information	Improve compliance with child protection record keeping; achieve improvement in levels of group supervision of staff; increase the number of staff achieving Level 3 training
Improve percentage of children on total parenteral nutrition (TPN) who have blood recorded measurements. Improving the monitoring of patients on TPN for complications	To implement and evaluate GOSH nutrition screening flowchart, monitor patient nutrition outcomes using weight scores; complete a full audit of height measurement and set a target for improvement
Reduction in surgical site infections in urology and the introduction of surgical site infection surveillance in urology and spinal surgery	Reduction of current rate of surgical site infection in four specialties and the establishment of surveillance in five new specialties
Reduction in the rate of central venous catheter (CVC) infections	Further reduction in the rate of CVC infections
Reduction in ventilator associated pneumonia (VAP) on the Paediatric Intensive Care Unit	

The CQUINs for 2011/12 are reflected in the improvement initiatives that we have set out in part 2 of this account.

Statements from the Care Quality Commission (CQC)
The CQC is the organisation which regulates and inspects health and social care services in England. Great Ormond Street Hospital (GOSH) is registered with the CQC with no conditions attached to its registration. The CQC has not taken enforcement action against GOSH during 2010/11.

Part of the CQC role is monitoring the quality of services provided across the NHS and taking corrective action where necessary. Their assessment of quality is based on a range of external sources of information, some of which we are required to provide from our performance management systems, which are considered with information from other external monitoring sources. These data items are drawn together to create a quality risk profile for the Trust, which provides an estimate of the risk of non compliance with registration requirements.

GOSH is subject to periodic reviews by the Care Quality Commission. No such reviews were undertaken in 2010/11.

If any issue was raised as part of the data review process or based on other information received that might indicate the quality of services had been compromised or was not meeting the required standard, a special review to look at the area of concern would be triggered.

GOSH has participated in special reviews or investigations by the CQC relating to the following areas during 2010/11:
- Looking at support for families with disabled children.

GOSH has made the following progress by 31 March 2011 in taking such action:
- The results of this review will be made available in Spring 2011.

Data quality
NHS managers and clinicians are dependent upon good quality information, using data derived from operational systems, to ensure that appropriate services are delivered to patients. It is strongly held view amongst NHS staff, including clinicians, administrators and managers, that they must have access to all of the data, whenever they need it, in a useable and accessible format, to support them in the delivery of high quality care. It is crucial that all data captured about patients is accurate, timely and of good quality.

Secondary Uses Service (SUS)
The SUS is the single source of comprehensive data to enable a range of reporting and analysis of healthcare in the UK. The SUS is run by the NHS Information Centre, and based on data that is submitted by all provider trusts.

GOSH submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - 98 per cent for admitted patient care
  - 98 per cent for outpatient care
  - not applicable for accident and emergency care
- which included the patient's valid general medical practice code was:
  - 100 per cent for admitted patient care
  - 100 per cent for outpatient care
  - not applicable for accident and emergency care.

Note: The percentages for NHS number compliance have been adjusted locally to exclude international private patients which do not require an NHS number.

Information Governance Toolkit
The Information Governance Toolkit is a device that supports organisations in managing the data they have about patients. The score that organisations get reflects how well they have followed the guidance.

GOSH score for 2010/11 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 75 per cent.

Clinical coding
Clinical coding is the process by which the notes that clinical staff record are categorised to reflect the activity that happens to patients.

GOSH was not subject to the payment by results clinical coding audit during 2010/11 by the Audit Commission.

Statement from our commissioners
NHS in North Central London has reviewed this document and is pleased to assure this Quality Account for GOSH. We are responsible for the commissioning of services from eight acute hospital trusts that are located in North Central London.

In this review, we have taken particular account of the identified priorities for improvement for the Trust during 2011/12 and how this work will enable real improvements for patients and their relatives. We have also taken account of the views of the main Primary Care Trusts where their local residents access services from the Trust.

The Clinical Quality Review Group which is made of representation of commissioners of GOSH and both clinical and DRAFT COPY meets on s have pro engage on a frequent basis with GOSH and gain a better understanding and appreciation of the quality of services provided. These meetings have enabled us to discuss the development and publication of the Quality Account as well as develop relevant and appropriate CQUIN targets. These targets are reflected throughout the improvement initiatives identified in the Quality Account.

We have made comments about the Trust's Quality Account and have discussed these directly with the Trust. These comments focus on:
- minor textual and diagrammatic changes to make the Quality Account easier to read and understand
- consideration of how the improvement initiatives will be monitored and taken forward.

We look forward to continuing our partnership with the Trust in the agreement of how services are provided for its patients.

Statement from LINk
Once again the Trust should be complimented on producing a comprehensive report detailing how the hospital measures quality and maintains a policy of continued improvement. The LINk has confined its comments in this response to the child/parent experience as we are not competent to scrutinise medical processes. The high level of patient/parent satisfaction specified in the report, the comments on NHS Choices and the presentation made by the Trust to the Camden Health Scrutiny Committee demonstrates the overall competency of the organisation.

Camden LINk has made a number of valuable suggestions regarding areas to incorporate in our future Quality Account.

Statement from overview scrutiny
Thank you for attending the Health Scrutiny Committee on 21 April 2011 and sharing the draft of Great Ormond Street Hospital NHS Trust's Quality Account with the Committee.

On behalf of the Committee, I am pleased to formally add our comments on the draft Quality Account provided at the meeting. The Committee supports the Trust's aspiration to become one of the top five children's hospitals but would like to be confident that there are reliable international metrics that this aspiration can be measured against. Perhaps this is an issue to be addressed in future years' Quality Account when the Committee would expect more detail on how this objective is being achieved.

The Committee had some concern about the accessibility of the report but it understands the complexities involved in writing accounts aimed at both health professionals and lay readers.

Overall, the Committee was impressed with the detail and content of the report and was grateful for your candid responses to the Committee members' questions on the evening.

On behalf of the Committee, I would like to offer our full support to the Quality Account and appreciate the time that you took to go through these with us.

Yours sincerely,

SIGNATURE

Cllr John Bryant
Chair, Health Scrutiny Committee

In response to the feedback at the Health Scrutiny Committee, GOSH has reviewed the draft Quality Account and simplified where possible the language used and added further terms to the glossary. We have also included an executive summary table at the start of the Quality Account.

Part 4 – Review of our quality priorities and examples in 2010/11

The following section reviews the priorities that were included in our Quality Account in 2009/10 and the associated performance over the last year and whether our target was achieved as well as illustrating some examples of initiatives to improve the quality of our services at Great Ormond Street Hospital (GOSH).

Safety priority 2009/10

Zero harm – reducing all harm to zero

Reducing healthcare-acquired infection

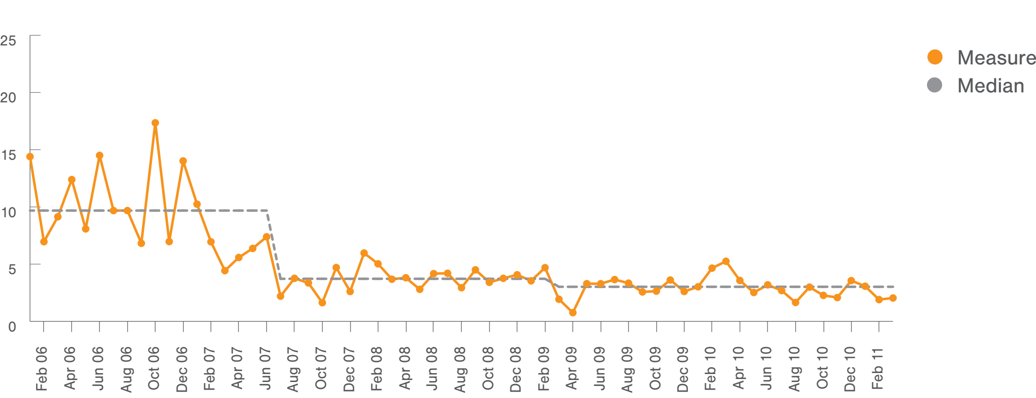
Safety priority	Target for 2010/11	Performance		Target achieved
		2009/10	2010/11	
Reducing GOSH-acquired central venous catheter line (CVC) infections (for every 1,000 line days)	Twenty per cent reduction in number of CVC infections compared to 2009/10	3.26 per 1,000 line days	2.61 per 1,000 line days	✔ 20 per cent reduction. Please see our CVL infection graph below
Implement surgical site infection continuous surveillance in two specialties	Identify baseline for two specialties over 12 months		Baseline identified for: • spinal implant • cardiac surgery (open and closed	✔
Reduction in specialty-based urology surgical site infections	Reduction from eight infections to six infections in 1,000 procedures	Established baseline of eight infections	Eight infections	✗ While we have not achieved the desired reduction, it represents a low rate that is within normal variation
Reduce the number of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia	Maximum of two cases	One case	One case	✔
Reduce the annual number of Clostridium difficile-associated diarrhoea	Maximum of nine cases	12 cases	10 cases	✗ No – please see below
Achievement of target for ventilator-associated pneumonia (VAP) on PICU unit	Target of less than seven cases per year for PICU		Two cases	✔

The target for Clostridium difficile for last year was based on adult evidence and not paediatric. It is acknowledged by the Department of Health advisory committee on antimicrobial resistance and healthcare-associated infection (ARHAI) that a separate paediatric target should be set. We are still committed to monitoring this area and improving.

The following graph shows the number of CVL infections since January 2006. We use these graphs to monitor and measure improvement in reducing healthcare and infections. There was an improvement identified in March 2009 which produced a step change and a new process. The average for this new process is 3.02 CVL infections per 1,000 line days, and it is this average which we are comparing against in order to find the next step change. So far, none have been identified but we continue to work to reduce the incidence of CVL infections.

GOSH-acquired CVL infections for every 1,000 line days

Area: all areas



During 2009/10, GOSH has also built on some key safety initiatives to improve the quality of services for both patients, their families and staff:

Executive Patient Safety Walkround case study example

As part of the Trust's zero harm strategy, the Executive Patient Safety Walkround programme has made almost 150 visits to wards and other clinical areas of the hospital over the past three years. Each Tuesday morning, the Executive Patient Safety Walkround team visits a clinical area and meets staff, patient and families to explore how safety can be improved. The team is made up of an Executive Director, a member of the Clinical Governance and Safety team, a representative from Estates and Facilities and an Improvement Co-ordinator from the Transformation team for that clinical unit.

Patient safety walkrounds are a way of ensuring that executives are informed first hand, regarding the safety concerns of frontline staff. They are also a way of demonstrating visible commitment by listening to and supporting staff when issues of safety are raised. Walkrounds can be instrumental in developing an open culture where the safety of patients is seen as the priority of the organisation.

Part 4 – Review of our quality priorities and examples in 2010/11 continued

In summary, walkrounds can:
- demonstrate top level commitment to patient safety
- establish lines of communication about patient safety among employees, executives, and managers
- provide opportunities for senior executives to learn about patient safety
- identify opportunities for improving safety
- encourage reporting of issues, errors, and near misses
- promote a culture for change pertaining to patient safety
- establish local solutions to minimise risk.

The issues identified during the walkround are categorised as either low, medium and high, with low and medium issues handled at unit level. Three high priority actions are allocated to a named Executive Patient Safety Walkround team member to follow up and resolve within one month.

All issues and actions are recorded on an electronic Executive Patient Safety Database.

In 2010, the key issues were as follows:

Area of concern	Number of reports	Percentage of reports
Admissions/discharges	Two	0.6 per cent
Communication	16	4.5 per cent
Environment	93	26.1 per cent
Equipment	81	22.8 per cent
Hygiene	35	9.8 per cent
Incident reporting	Eight	2.3 per cent
Leadership	Three	0.8 per cent
Process	71	19.9 per cent
Staffing	32	9.0 per cent
Team work	Three	0.8 per cent
Training	11	3.1 per cent
Transport	One	0.3 per cent

For example, the safety walkround to Badger Ward on 17 August 2010, identified that a leak in the main corridor had meant overhead tiling has had to be removed, leaving a large hole and exposed piping. This was unsightly and cause of concern for infection control issues. The hole had been there for over two weeks as there had been some difficulty sourcing the correct ceiling tiles. Our Deputy Chief Operating Officer took responsibility for liaising with the relevant team to expedite the repairs and it was fixed by 27 August 2010.

"Usually issues have to be raised by email making it difficult to actually visualise how the issue impacts on patient care or staff safety. Having the walkround makes this much easier."

Ward Sister

Effectiveness priority 2009/10

Consistently deliver clinical outcomes that place us amongst top five children's hospitals in the world

Priority	Target	Performance	Target achieved
To make clinical outcomes from across the specialities available on the website	To have at least 20 measures available on our website by the end of 2010/11	Clinical outcome measures for the following specialities are identified on the Great Ormond Street Hospital (GOSH) website: • Cardiac • Intensive care • Cystic fibrosis • Renal • Bone marrow transplant • Adolescent medicine • Cleft • Rheumatology and physiotherapy	✔
Maintain success rate for *Hickman®* catheter insertion in interventional radiology	Expected rate of success as 95 per cent	We had a success rate of 99.9 per cent for *Hickman®* catherers insertion rate between April 2010 and March 2011	✔

Examples of outcomes developed and measured in 2010/11
GOSH in Haringey Children's Community Health Services
Quality of Practice Audit Tool

A case record is an instrument for the practitioner and a record of practice in terms of information gathered and evidence obtained to support a professional assessment. A case record is not only evidence of work undertaken but also a record of the involvement of the child and family in the decision-making process. The case records should provide the analysis of a child's needs and the plan for intervention.

The Quality Practice Audit Tool is used to assess the quality of the case records of vulnerable children under the care of the Health Visiting and School Nursing Service. This tool is an enhancement to previous audit tools which focused primarily on quantitative information and national standards for writing medical records. This new audit tool enables the team to drill down into the quality of the assessment and action of the practitioner. By doing so it is intended to encourage continuous improvement of outcomes for children and ensure the spread of good practice right across the system.

Part 4 – Review of our quality priorities and examples in 2010/11 continued

The audit tool looks at 10 key practice episodes within the period of intervention in the life of the child and family. These are significant or pivotal points in a case, which influence the planned, and unplanned, outcome. Each key practice episode is scored and then rated out of inadequate, adequate, good or outstanding.

The Quality Practice Audit is carried out quarterly and the audit is conducted by senior ataff within Great Ormond Street Hospiatl (GOSH) in Haringey. Case records are selected at random.

Overall analysis of the results and then recommendations for change in practice and the use of tool are shared with the Children's Management team accordingly. Individual results are discussed at a more local level and the results of each audit filed in the child's record.

Metabolic and dietetics outcomes
Phenylalanine control in patients with phenylketonuria (PKU)
Phenylketonuria (PKU) is a rare condition in which a baby is born without the ability to properly break down an amino acid called phenylalanine. Without the enzyme, levels of phenylalanine and two closely-related substances build up in the body. These substances are harmful to the central nervous system and cause brain damage.

Affected babies are identified on neonatal screening and treatment is commenced immediately. PKU is treated by a very low protein diet with phenylalanine (Phe) free amino acid supplementation. Parents, and later the children are taught about management of PKU and families are encouraged to achieve optimal phenylalanine control; currently the best measure of compliance with treatment. With early treatment and good subsequent metabolic control children with PKU have near-normal intelligence although executive function difficulties are recognised.

As we serve a multi-ethnic society it is increasingly important to ensure that ethnic inequalities are recognised and addressed. We have a large PKU clinic comprising patients from a mixture of ethnic backgrounds. The predominant ethnic group is white British. Other ethnic groups represented in our clinic include Turkish, Arab and Asian.

We looked at the phenylalanine levels of all the patients with PKU that attended the clinic over a five-year period (2005–2009) to examine their phenylalanine control and compare the adequacy of control in the different ethnic groups with national guidelines. The following table illustrates the results of the median Phe in each age band:

	Age one to four years Target range 120–360 µmol/L		**Age five to nine years** Target range 120–480 µmol/L		**Age 10–16 years** Target range 120–700 µmol/L	
	Ethnic majority	**Ethnic minority (Turkish)**	**Ethnic majority**	**Ethnic minority (Turkish)**	**Ethnic majority**	**Ethnic minority (Turkish)**
Number of patients	25	12 (3)	40	14 (5)	60	8 (3)
Number of patients with median Phenylalanine in target range	20	7 (2)	30	11 (2)	53	5 (1)
Percentage patients with median Phe in target range	80 per cent	58 per cent (66 per cent)	79 per cent (40 per cent)	88 per cent	60	8 (3)
Median time interval between blood tests (weeks)	1.6	1 (1.2)	2.9 (1.8)	5.1 3.9	60	8 (3)

This shows that phenylalanine control deteriorates with increasing age in all groups and it appears to be even worse in our ethnic minority patients, particularly our Turkish patients. As a result of this analysis the multidisciplinary team have decided to implement a Turkish clinic to focus on the needs of this group and improve the outcomes.

Radiology accreditation
The Imaging Services Accreditation Scheme (ISAS) is a patient-focused scheme based on the principle of independent assessment against a recognised standard. Accreditation is the formal recognition that an imaging services provider has demonstrated that it has the organisational competence to deliver against key performance measures related to patient experience, clinical outcomes, patient and staff safety, and efficient use of resources.

The College of Radiographers and The Royal College of Radiologists developed ISAS to ensure that patients consistently receive high quality imaging services delivered by competent staff working in safe environments.

GOSH Radiology is one of the first NHS providers in the UK to achieve this accreditation in 2010/2011.

Part 4 – Review of our quality priorities and examples in 2010/11 continued

Experience priority 2009/10

Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations

Improving results from the inpatient survey

What we said	What we did	Performance from Ipsos MORI survey		Achieved
		Nov 2009	Feb 2011	
Improve the information for parents about the available accommodation options so that more parents felt that they were able to stay overnight	The production of a new leaflet and poster by August 2010	77 per cent felt that they could stay overnight	78 per cent felt that they could stay overnight	✔
Improve the number of staff that introduced themselves	An audit undertaken of at least one ward per month for 2010/11, checking that all staff are wearing their name badges	93 per cent agreed staff introduced themselves	94 per cent agreed staff introduced themselves	✔
Improve the staff that explained their role to patients and parents		90 per cent agreed staff explained their role	94 per cent agreed staff explained their role	✔
Improve the number of parents and patients that thought the process of leaving hospital was easy	Ran a detailed survey regarding discharge for cardiac surgery and cardiology families and identified actions to improve	86 per cent agreed the process was easy	89 per cent agreed the process was easy	✔
Improve waiting times at hospital	Offer magnetic resonance imaging (MRI) and outpatient appointments on the same day for neurology patients	The provision of an MRI appointment on the day of the outpatient visit was implemented in March 2011		Yes, but outside specified date
Improve satisfaction with the quality and amount of toys, games and things to do on the ward	The plan was to roll out a bedside entertainment system to over 200 beds	80 per cent satisfied with things to do	78 per cent satisfied with things to do	✗ No, delay in the roll-out of the bedside entertainment
An increase of five per cent who strongly agree or agree that they felt they could complain and they would be taken seriously	Provided more information available on the complaint process	83 per cent agreed	82 per cent agreed	✗ No, this is a continued improvement target for 2011/12
Not less than 90 per cent who were very satisfied or fairly satisfied with their last visit to hospital	Developed overall improvement plans across hospital	94 per cent satisfied with their last visit	96 per cent satisfied with their last visit	✔
An increase in the percentage of respondents who were very satisfied or fairly satisfied with the quality and variety of hospital food from 57 per cent to 65 per cent	New food menu intoduced	57 per cent satisfied with the quality and variety of food	60 per cent satisfied with the quality and variety of food	We achieved an increase in satisfaction but not to the target level – this is a continued target for 2011/12

Improving patient experience in 2010/11

There have been some fantastic initiatives from all services across the hospital to develop ideas and implement services to help make a meaningful difference to the patients treated at GOSH and their experience. The following give some information about a few of these new services:

Saturday Club

The Volunteer Service at GOSH is a valuable support and aims to improve the experience of patients and families that come to the hospital. Over the last year, the service has implemented a number of projects including the Saturday Club.

The Volunteer Services and Great Ormond Street Hospital (GOSH) Charity Corporate Partnerships introduced a Saturday Club project which took between July and November 2010.

The main objective of the Saturday Club was to provide a half-day service for patients and their siblings based on play and arts and crafts activities on the weekend when there is limited things for patients and their families to do. Play is an important and vital distraction technique for patients and is widely used across the hospital. Patients would be distracted from their health condition, have a fun outlet for energies, thus providing a help to ward staff and parents and enable some of our sickest patients the opportunity to meet other children and not feel isolated whilst in the hospital.

The Saturday Club was run by volunteers who were carefully selected and trained. The volunteers wanted to be part of the work of the hospital and bring an element of fun to the patients who are unable to go home at weekends. The volunteers were enthusiastic and supportive as well as creative and flexible. Their expectations were mixed initially, but all volunteers believed their expectations to have been 'blown away' by the end of the project. An average of 13 children attended each session, accompanied by parents or guardians. Most patients stayed for one to two hours. Parent feedback was extremely positive – they enjoyed the club as much as the children and welcomed the opportunity to speak with other parents and volunteers or to take a break and leave their children in the centre.

Overall the Saturday Club project was seen as a success meeting its objective of providing a fun and relaxed environment for patients/siblings to play. Feedback from parents and ward contacts support this, with many hoping for the club to be available weekly. This was underpinned by excellent team work by all parties involved.

Part 4 – Review of our quality priorities and examples in 2010/11 continued

Equality and diversity example
Genetics crossed the language barrier
Many people find the thought of genetics challenging. The prospect of talking about genetics in a foreign language is even more challenging, especially when that language does not even have words for 'gene', 'chromosomes' or 'genetics'. About one in six families seen by the Clinical Genetics Department at Great Ormond Street Hospital (GOSH) need interpreters so we and our patients face this challenge every day.

To try to improve the service offered to these families the service organised two training days in May 2010 for interpreters. More than 60 interpreters and health advocates attended, mainly from interpreting service Language Line and more than 30 languages were represented from Albanian to Vietnamese.

Feedback was extremely positive with comments such as, "It is such a rare opportunity for us to have medical lectures. I hope other departments can also give us lectures in the future".

Working as a team to support children and family – example of good communication
Staff Awards 2010 – winner of the child and family award, Richard Hayward and the Craniofacial team
Nominations for this award come only from patients, parents and carers and Richard and his team were put forward by Mum Nicola Robertson. She said they did a great job when her two-year-old daughter Sophie had her operation in 2009.

"We were kept informed and looked after every step of the way, with letters, emails and phone calls and on the day itself we were well looked after," she told the staff award judges. "Sophie was treated with the utmost care and attention, and our precious daughter was taken through her operation safely and smoothly, and recovered very quickly thanks to the care and attention of the team."

"They monitored her afterwards, and kept coming round to the ward to see her and check how she was progressing. At our follow-up appointments everyone is very kind and helpful. We can't thank this team enough for how they've taken care of our daughter".

Richard said he and the Craniofacial team were all very excited to have even been nominated. "This was very much a team effort. The craniofacial team has always made involvement of the family the cornerstone of its dealing with children with such complex needs, not just the doctors but the clinical nurse specialists, secretaries and the various therapy departments."

Variability and Flow Management (VFM) Programme to 'Engine room' projects
In the 2010 Quality Account, we reported on the launch of the VFM programme. The Neurosciences project aimed to reduce waiting times and improve access to the Neurology service by planning and communicating more effectively. The project has resulted in several improvement initiatives including:

- the development of a new admissions planner which was successfully implemented in April 2010 and has been effective in streamlining the admissions process.
- the development of a bedside communications timetable to improve the planning of investigations for patients. This was implemented in February 2010 and is currently being reviewed and updated to maximise its effectiveness.
- the introduction of a new process for managing children requiring MRI brain scans to ensure that patients are clerked and consented on time. This was implemented in March 2011 and will be evaluated post implementation.
- the provision of an MRI appointment date on the day of the outpatient visit (also implemented in March 2011).
- the transfer of botox and dysphagia patients from Kingfisher Ward to Starfish RANU. We are currently working on plans to implement this change following the re-opening of the refurbished Starfish ward in June 2011.

These changes are being monitored, further improved and evaluated by staff and parent representatives at the neurology modernisation meeting.

Initially we aimed to look at 24 major patient pathways across the hospital. As we began implementing this programme we found that it was not as effective and efficient at making the improvements than we originally envisaged. We reflected on this experience and adapted our initial programme to reflect 'Engine room' projects instead which focus energies on working across the hospital. We currently have two projects – one focuses on improving the use of our beds and the other looking at the pathway for patients requiring surgery to ensure that we offer a safe and efficient service.

Glossary

Balanced scorecard
A performance management tool

Care bundles
Are a small set of clinical practices that when performed collectively, reliably and continuously have been proven to improve patient outcomes

CEWS
Children early warning system score

CICU
Cardiac Intensive Care Unit

Commissioners
The organisations who purchase services from Great Ormond Street Hospital.

CQC
Care Quality Commission. The organisation that regulates and inspects health and social care services in England.

CQUIN
Commissioning for Quality and Innovation

CSP
Clinical Site Practitioners – an experienced intensive care nurse with expertise in assessing and caring for seriously ill children and works across the hospital

Clinical Unit Chair
Lead clinician for a unit

CVC
Central venous catheter

DH
Department of Health

ENT
Ears, nose and throat

General Manager
Lead Manager for a unit

GOSH
Great Ormond Street Hospital

GOSLON
The GOSLON (Great Ormond Street, London and Oslo) yardstick is a clinical tool that allows categorisation of dental relationships into five categories.

HES
Hospital Episode Statistics

HPA
Health Protection Agency

HSMR
Hospital Standardised Mortality Ratio. A measure of quality that indicates whether the death rate at a hospital is higher or lower than you would expect based on a number of factors relating to patients and their conditions.

HRG
Healthcare Resource Group. Activity relating to hospitals is illustrated by codes that are based on these groups.

MDT
Multi-Disciplinary Team. A group of different types of clinicians who work together.

MRI
Magnetic resonance imaging

MRSA
Methicillin-resistant Staphylococcus aureus

NCEPOD
National Confidential Enquiry into Patient Outcome and Death

NHS
National Health Service

NHS Institute for Innovation and Improvement
The NHS's own improvement agency which facilitates change management to improve care for patients.

NICU
Neonatal Intensive Care Unit

NIHR
National Institute for Health Research

NPSA
National Patient Safety Agency

Paediatric Trigger Tool
A tool that measures harm caused by healthcare. Through using the tool it is possible to calculate the adverse event rate and identify areas of care where most harms are occurring.

PICANET
The Paediatric Intensive Care Audit Network (PICANet) is a national audit co-ordinated by the Universities of Leeds and Leicester which collects data on all children admitted to paediatric intensive care units (PICUs) across the UK.

PICU
Paediatric Intensive Care Unit

PROM
Patient Reported Outcome Measures are measures of a patients health status or health-related quality of life.

Glossary
continued

Safeguarding
Keeping children safe from harm such as illness, abuse or injury (Commissioner for Social Care Inspection et al. 2005:5).

SBARD
Situation, background, assessment, recommendation and decision

SHA
Strategic Health Authority. Regional organisations that are responsible for ensuring that all NHS Trusts adhere to Department of Health rules and regulations.

SMR
Standardised Mortality Ratio. This is similar to the HSMR figure – in that it shows the level of observed deaths compared to expected deaths. Different methods of working on SMR attach differing weights to various factors.

SSI
Surgical site infection. An infection in a wound that is identified after surgery.

SUS
Secondary Uses Service. Central dataset about all NHS provision in England.

Transformation
Is a service redesign programme that aims to improve the quality of care that we provide to children and enhance the working experience of staff.

TPN
Total parenteral nutrition

UCL
University College London

Unit
How we group and manage our clinical services.

Great Ormond Street Hospital for Children NHS Trust
Great Ormond Street
London WC1N 3JH
020 7405 9200
www.gosh.nhs.uk

Bengali
অনুরোধ করলে নিম্নলিখিত ঠিকানায় থেকে এই লেখার অনুবাদ, বড় অক্ষর, ব্রেল বা অডিও বিবরন পাওয়া যাবে|

English
Translations, large print, Braille or audio versions of this report are available upon request from the address below.

French
Traductions disponibles sur demande à l'adresse ci-dessus. Des versions en gros caractères, en braille ou audio sont également disponibles sur demande.

Polish
Tłumaczenia są do uzyskania na żądanie pod podanym powyżej adresem. Dokumenty w formacie dużym drukiem, brajlem lub audio są także do uzyskania na żądanie.

Punjabi
ਇਸ ਰਿਪੋਰਟ ਦੇ ਤਰਜਮੇ, ਅਤੇ ਇਹ ਰਿਪੋਰਟ ਵੱਡੇ ਅੱਖਰਾਂ ਜਾਂ ਬ੍ਰੇਲ ਵਿਚ, ਜਾਂ ਸੁਣਨ ਵਾਲੇ ਰੂਪ ਵਿਚ ਹੇਠ ਲਿਖੇ ਪਤੇ ਤੋਂ ਮੰਗ ਕੇ ਲਏ ਜਾ ਸਕਦੇ ਹਨ।

Somali
Turjubaan ayaa cinwaanka kor ku qoran laga heli karaa markii la soo codsado. Daabacad far waa-wayn, farta indhoolaha Braille ama hab la dhegaysto ayaa xittaa la heli karaa markii la soo codsado.

Tamil
பெரிய அச்சில், இந்த அறிக்கையின் மொழிபெயர்ப்புகள்,பெரய்லி அல்லது ஒலி பதிப்புகள் விண்ணப்பித்தால் கீழ்கண்ட விலாசத்தில் கிடைக்கும்

Turkish
Talep edilirse yukarıdaki adresten çevirileri tedarik edilebilir. Talep edilirse, iri harflerle, Braille (görme engelliler için) veya sesli şekilde de tedarik edilebilir.

Urdu
گزارش کرنے پر یہ رپورٹ ترجمے، بڑے حروف کی چھپائی، بریل یا آڈیوپردرج ذیل پتے سے حاصل کی جا سکتی ہے۔

Design Manager
Great Ormond Street Hospital
Fourth floor
40 Bernard Street
London WC1N 1LE
E design.work@gosh.org

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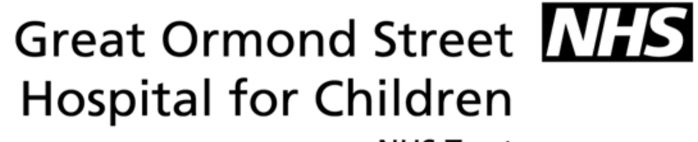
This Annual Report is available to view at www.gosh.nhs.uk

Attachment J



Trust Board Meeting **25th May 2011**	
Title of document: Phase 2B Enabling Works FBC performance against Key Criteria **Submitted on behalf of:** William McGill: Director of Redevelopment & Estates	**Paper No: Attachment J** **Date considered by Management Board:** 21 April 2011
Aims / summary: this is the case for investment in the relocation/decanting works required to vacate the Cardiac Wing ready for the scheduled start of Phase 2B in August 2013. The works include the creation of Angio/PACU facilities at VCB Level 3, the principles of which were endorsed at Management Board in February 2011. The investment required is £25,082,551.00 [outturn], the funding for which is being requested from GOSHCC Special Trustees.	
Action required from the meeting: approval of funding for this investment by Special Trustees. This FBC has also been endorsed by the P2B Enabling Works Project Board and Redevelopment Programme Steering Board.	
Contribution to the delivery of NHS / Trust strategies and plans: this investment is necessary for implementation of GOSH Redevelopment Phase 2B; this case is being bought in advance of that for Phase 2B itself to allow the established start date for Phase 2B [August 2013] to be maintained. This investment also delivers: the Level 3 patient flows sought by the Trust for improving surgical pathways; enables increased capacity in certain specialities/procedures in line with the Trust's IBP/LTFM; other estate management-related efficiencies.	
Financial implications: Capital: the £25m investment comprises the funding for the Phase 2B Enabling Works identified in the Phase 2 Outline Business Case [approved by NHS London in 2006] together with that required for providing the Angio/PACU facility at Level 3. The capital cost is in line with the parameters established in the P2 OBC –on a like for like basis. Value for Money [VFM]: the DH Generic Economic Model [small GEM] has been used to confirm the Preferred Option as best in terms of VFM. Affordability: the analysis shows this as within the LTFM envelope with the potential for further savings [which otherwise could accrue for the P2B FBC]; Commissioner support has been gained via the Foundation Trust [FT] Consultation process. FT Downside scenario: this investment would allow the vacated Cardiac Wing to be used to rationalise the estate by disposal of off-site accommodation.	

Legal issues: The construction programme is let under the P21 plus Framework Agreement, this is the preferred procurement route within the NHS for this size and value of works.
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, members, children and families) and what consultation is planned/has taken place? Clinical Units, Clinical Operations and Corporate Directorates: communication about these enabling works is included in the Phase 2 Stakeholder Management strategy.
Who needs to be told about any decision: P2B Enabling Works Project Board and Project Team; clinical service users + support services; members, children, young people & families; fundraising
Who is responsible for implementing the proposals / project and anticipated timescales: Graham Mills [Deputy Director: Estates] –P21+ Contract; construction start planned for September 2011 with completion July 2013
Who is accountable for the implementation of the proposal / project: William McGill [Director: Redevelopment & Estates]
Author and date: Natalie Robinson [Deputy Director: Redevelopment] 100511

Attachment J

GOSH Redevelopment Phase 2

Phase 2B Enabling Works Full Business Case

Trust Board 25th May 2011

Phase 2B Enabling Works FBC performance against Key Criteria

This paper shows how the FBC performs against the key criteria generally used to assess the effectiveness of business cases [paras 1- 8].

The Executive Summary from the FBC is attached for further reference.

The Trust Board are asked to approve the FBC

1. Does the FBC demonstrate an effective model of care that is sustainable and provides safe high quality services?

1.1 This investment will allow the Trust to progress further with the implementation of its Model of Care, which aims to keep sick children out of hospital where possible. The new Model of Care shifts elements of the patient's journey to alternative settings through expanded day care, patient hotel and transitional care, thus releasing inpatient capacity. The foundation for this has been laid with Phase 1 Redevelopment and Phase 2A -the MSCB. These works will enable the decant of the Cardiac Wing in order to allow its dismanting and refurbishment for completion of the facilities which provide the greater flexibility needed from our inpatient facilities by replacing the small (9/10) bed groupings remaining in our estate with larger (23/24) inpatient bed pools.

1.2 The new Model of Care can only be fully implemented with expanded capacity in alternative settings such as daycare. The creation of greater flexibility through larger bed pools will address waiting time problems and the redevelopment itself will provide a built environment, which can support a modern service model.

1.3 The Trust Board has previously as part of a option appraisal workshop in 2006 considered the overall estates strategy with respect to the alternative option of relocating all services away from Great Ormond Street, and concluded that this was not a viable option given the value of existing assets on the site, and not desirable given the advantages of transport links to central London.

This overall strategy was re-confirmed as part of the Development Control Plan Review of 2010, which was considered by Trust Board in November 2010

The Outline Business Case for Phase 2, which was agreed by the Trust Board in 2006, included this Enabling Project, which crucially vacates the existing Cardiac Wing (with the exception of the basement, which accommodates the MRIs) to enable its demolition and rebuilding from level 4.
Following approval of this OBC in 2006, the Department of Health agreed a government contribution of £75 million, demonstrating their considerable support of the overall project.

- The overall progress of the Phase 2 scheme has been regularly reviewed by the Department of Health through gateway and design reviews the OBC and FBC stages in 2006 and 2007
- The last of these was in 2007. Since then our strategy has not changed.

2. Does the FBC demonstrate a strategic fit against NHS targets?

2.1 The Objectives set out in the Case for Change will enable the Trust to support the Service Developments planned to meet those targets;

- increased daycase
- maintain 18 week targets
- reduced infection rates
- cleaner/safer buildings
- improved facilities for patients, families and staff
- effective use of staff

3. Does the model reflect the demand and capacity assumptions as outlined by the Trust and its commissioners?

3.1 The Enabling Works required for Phase 2B have been supported by the Trust's key Commissioners as part of the consultation process for Foundation Trust status. As such, the investment supports the capacity projections in the IBP/LTFM

4. Does the proposed option represent Value for Money?

4.1 At the OBC stage of the Phase 2 redevelopment business case the DH Generic Economic Model (GEM) was used to assess the Options and confirm the Preferred Option as best in terms of Value for Money. The FBC for the enabling works programme has no measurable impact on the Preferred Options and it therefore remains robust. The VFM for the investment in the Enabling Works has also been tested and the Preferred Option shown as robust.

5. Does the FBC demonstrate affordability to the Trust and its commissioners and are the final capital and revenue costs in line with the affordability parameters established in the Outline Business Case?

5.1 The Affordability analysis shows that there are revenue efficiencies as a result of this investment, along with income opportunities from delivering the increased capacity

5.2 The analysis confirms that the capital costs are in line with the parameters established in the OBC on a like for like basis

5.3 The key change from the agreed OBC arises from a decision taken in December 2009 of December made at an Executive Awayday where DoR presented the case and executives approved a plan to change one of the planned Angiography rooms into an additional Operating Theatre. The decision needed to be taken quickly as the construction element of the Theatres was imminent. The repercussions of this decision would be reviewed as part of the Enabling works programme for Phase 2B.

This decision was made on the basis of anticipated activity growth levels, as expressed in the Integrated Business Plan.

A consequence of this decision is the need to re-provide the Angiography Suite: this is included within the Enabling Works FBC and utilises the vacated Tiger/Parrot wards, with a knock-on disruption to the Hospital's Main Entrance. The Charity have agreed this additional funding at their meeting in March 20011.

The Revenue impact of the project has been further assessed and an updated I&E account is included in the FBC

The interest rate of 3.5% used by the Department has been changed to a rate more suitable for current financial models

The impact of the impairment of the Cardiac Wing may impact on the approval date for the Phase 2b FBC.

6. Does the Business Case outline the sensitivity analysis highlighting the exposure to risks?

6.1 A full risk assessment has been carried out and the results of the sensitivity analysis confirm the OBC Preferred Option still represents best value for money within a range of realistic risk scenarios

It was noted that the current project risk register was focused on construction risk, and that this was currently being expanded to include broader organisational risk.

The particular issue of the MRIs has been raised. The risk of continuing to rely on using these vital machines whilst the building above was being demolished was acknowledged. Whilst this risk would technically be a consequence of the 2B project, not the 2B enabling project (as the demolition work is not included within the enabling project), the fact that the enabling project does not include a relocation of the MRIs indicates a tacit acceptance by the Trust of this future risk.

The Sub-Committee asked to see written advice from appropriately qualified Trust advisors that

- the foundations of the cardiac wing would tolerate the planned work
- it was a realistic plan to maintain the operation of MRI scanners whilst undertaking the planned work in the building above them.

The Structural Engineers WSP Structures have assessed the suitability of existing Cardiac Wing structure and assessed it as being designed to take the intended load of the new Phase 2b structure. They cannot take liability for the construction of the existing foundations and structure but will take further structural tests as and when the building is vacated.
The issue of demolition of the upper floors whilst the Imaging department is still in use has been discussed with the users prior to development of this plan in 2006. It should be noted that such demolitions on live buildings was discussed with Demolition companies and assessed as being a viable operation.
In doing this work we can mitigate structural failure, water and vibration, the issue of noise and its disruptive effects will be discussed in detail with imaging managers at a meeting on 24th May. The principle approach will be to separate as much of the demolition and clinical activity during the periods of risk and to risk manage key activities.

7 Does the funding for Phase 2B Enabling Works develop enhancement to the GOSH estate and improvement to clinical services even if the Phase 2B project does not proceed?

7.1 The investment allows the Trust to:

- Increase its capacity for respiratory inpatients in line with the IBP/LTFM
- Deliver the angiography capacity required to support the reduced LoS identified in the IBP/LTFM as enabling increased activity
- Provide more effective patient flows for procedures –including an enhanced patient and family experience
- Further reduce its Backlog Maintenance
- Realise other Estates efficiencies –eg. carbon savings

8 Does the profile of expenditure on the future redevelopment projects remain at a positive cashflow throughout the whole of the programme?

8.1 In discussions with the charity FD and the project Cost Consultants we have established that the current expenditure commitments for the whole of the Phase 2 programme remains at a positive variance. This means that at the time the Special Trustees commit to expenditure on any of the proposed contracts, there is always enough money in the cashfow to cover commitments including required reserves.

[Read with Phase 2B Enabling Works FBC Executive Summary, attached for separate reading]

Attachment J

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1 EXECUTIVE SUMMARY

1. Background

1.1.1 Great Ormond Street Hospital (GOSH) for Children NHS Trust is a national centre of excellence in the provision of specialist children's health care, currently delivering the widest range of tertiary care of any children's hospital in the UK. It is also the largest children's hospital in the UK. It works in partnership with the Institute of Child Health (ICH), (part of the University College London). Together they form the largest paediatric research and teaching centre in the UK and – as members of UCL Partners- are parts of one of the 5 Academic Health Sciences Centres in the UK. GOSH aims to become a Foundation Trust that will enable all three strands of its work (specialist children's health care, research and teaching and training) to move forward more quickly.

1.1.2 GOSH intends to fully modernize its facilities through a four-phased Redevelopment. Phase 1 - fully funded by the Special Trustees of GOSH Children's Charity (GOSHCC) at a cost of £75 million- was completed in 2006.

1.1.3 GOSH's Strategic Outline Case (SOC) for Phase 2 of the Redevelopment was approved in July 2004 at cost of £224m including decanting and enabling works. This programme is being funded by the Special Trustees and a capital contribution of £75m from NHS exchequer funds. Delivery of the new/improved building stock is programmed for 2012 and 2016 and a key objective is the provision of all inpatient accommodation in modern facilities. Please see **Appendix 1A – 1E** inclusive of current and previous approvals. A summary of the Redevelopment Phases is as follows:

Phase	CONTENT
1	Patient Hotel, Medical Day Care, Orthopaedic facilities and International and Private Patients Unit
2	**Phase 2A: Morgan Stanley Clinical Building;** provides 92 inpatient beds including 21 Cardiac Critical Care, 3 Theatres, 1 Hybrid Angio, Restaurant & Kitchen and Facilities Management facilities **P2B Enabling Works: relocations and decants necessary to vacate the site of Phase 2B –the Cardiac Wing Levels 2-8** **Phase 2B: Refurbished Cardiac Wing;** providing 93 inpatient beds, 2 Theatres, Post Anaesthetic Care Unit, Ambulatory Care [complex outpatient consultations] and additional Magnetic Resonance Imaging capacity
3	Redevelopment of the UoL Computing Centre site for Translational Research related facilities followed by Ambulatory Care Centre: including Outpatients; Daycare for Haematology/Oncology, Nephrology, and Neurosciences; related diagnostics and Pharmacy; GOSH School and Play services: followed by the new Main Entrance
4	Additional Clinical Research facilities.

1.1.4 The approved Strategic Outline Case (SOC) has at its core a new model of care that seeks to dramatically change the way care is delivered. The new model of care shifts elements of the patient journey to alternative settings through expanded day care, patient hotel and transitional care, thus releasing inpatient capacity, and creates greater flexibility through larger inpatient bed pools. This approach is consistent with the delivery of services in line with the children's NSF and enables the strategies set out in GOSH's Integrated Business Plan [2010/11]

2. Service Profile

1.2.1 The population of children served by GOSH is characterised by those with multiple disabilities, co-morbidities, rare and congenital conditions. Improvements in neonatal care and diagnostics mean that many children have improved survival rates and greater therapeutic options than was the case 10 years ago.

1.2.2 The catchment population for GOSH extends across the UK and beyond.

As a national centre GOSH has a very diverse range of commissioners, made up of PCTs, specialist commissioning consortia, and the National Commissioning Group together with Overseas SLA's. Every PCT will have children referred to GOSH. In the radical change to commissioning envisaged in the 2010 White Paper "Equity and Excellence: Liberating the NHS", GOSH anticipates a significant number of its services as being commissioned by the National Commissioning Board

1.2.3 GOSH provides Tertiary and quaternary services and only accepts referrals from secondary and other tertiary providers. GOSH's IBP projects growth in its services as a result of demographic change, concentration of specialist services [Safe & Sustainable & other similar reviews] and technological development

3. Vision for the Future

1.3.1 Phase 1 of the redevelopment provided capacity to enable the new Model of Care (MOC) through the creation of a Patient Hotel, Medical Day Care and Transitional Care facilities. These new facilities allowed more treatment on a day or sequential day basis and enabled longer stay patients who no longer require close medical supervision to be cared for in more appropriate and less clinical settings.

1.3.2 Phase 2 of the redevelopment will deliver further improvement in the environment and facilities for specialist paediatric services, including:

- Further shift towards ambulatory care
- Improved access to imaging modalities
- Larger groupings of acute inpatient beds
- Increased provision for specialist surgery and facilities for interventional angiography
- Improved facilities for staff

1.3.3 In addition to providing high quality appropriately sized and configured accommodation, Phase 2 will provide larger, flexible inpatient bed pools, improved co-location of clinical services and appropriate horizontal and vertical linkages.

4. Redevelopment Phase 2

1.4.1 The Phase 2 objectives are being realised through 2 major construction projects:

- Phase 2A: The Morgan Stanley Clinical Building – now under construction (due for completion in December 2011)

followed by

- Phase 2B: comprehensive redevelopment/refurbishment of the existing Cardiac Wing to provide a 2nd New Clinical Building

1.4.2 To create the site for the 2nd New Clinical Building, a sequence of Enabling Works is required. This work programme also provides the Trust with the opportunity to implement other key strategic changes (in the estate), which support strategically important service developments. To meet the timescale planned for dismantling the Cardiac Wing and subsequent construction, it is necessary to promote the FBC for these Enabling Works in advance of presenting the FBC for Phase 2B.

1.4.3 To vacate the Cardiac Wing, a number of department/function relocations are required; some will move into the completed Morgan Stanley Clinical Building [MSCB] in 2012, but others need to relocate to other buildings on this highly congested site.

1.4.4 The current occupants of the Cardiac Wing are relocated into 5 other buildings on the island site

- Main Nurses Home (MNH)
- Frontage Building (FB)
- Boiler House
- Southwood (SW)
- Variety Club Building (VCB)

Level 1 of the Cardiac Wing will remain in operation [MRI, CT and Nuclear Medicine] during Phase 2B and is not included in the Enabling Works, except providing services to level 1 during the Construction Phase. This assumption will be risk assessed with an alternative contingency plan in place if required.

1.4.5 The Enabling Works plan and programme include 28 individual projects and associated moves over a period of approx 21 months – the timescale required to enable the start of Phase 2B in accordance with the programme. The planning for these Enabling Works will be going on in parallel with briefing and design for the 2nd New Clinical Building [Phase 2B]. Some of the future occupants/beneficiaries of this building will be involved in relocation but many other specialities/departments will need to move without this benefit as major improvement to their facilities will only be addressed by Phase 3. The Trust is taking the opportunity to include some essential improvements to clinical services in the Enabling Works Strategy and these have been defined. Otherwise, a policy of no betterment will be applied to the moves to enable investment in the Phase 2B to be maximised.

1.4.6 Also there are a number of strategic service developments/ improvements, which the Enabling Works programme provides service opportunities to implement. These include the Angio Suite, PACU and Same Day Admissions Unit.

The Trust will continue to invest in Backlog Maintenance as included in the Integrated Business Plan.

Planned Department of Health finding to reduce Building Maintenance and plant replacement during the timescale of this business case is as follows

2011/12	£7,702,000
2012/13	£5,749,000
2013/14	£8,388,000

1.4.7 An Executive Summary of the Condition Survey (October 2010) in **Appendix 4H.**

5. Enabling Works Strategy

1.5.1 The strategic objectives addressed by this business case are:

- Department moves within the existing site vacating the building to be dismantled – the Cardiac Wing
- Provides a limited amount of Service Developments to provide clinical flexibility and capacity during the construction period of Phase 2B

6. Economic Appraisal

1.6.1 A short-list of options was developed by the Project Board. This is set out below:

	Options	Comments
1	Do minimum	• There will be no redevelopment programme • This does not address the future clinical development of the trust
2	Develop services off site to enable redevelopment to go ahead	• This will put clinical services in accommodation with no clinical linkages to site. • The availability of off site accommodation in one area may be limited
3	Develop decant strategy on site	• Major disruption to site • Maintains clinical services on one site • Decanting of clinical services can be completed over time

1.6.2 **A detailed economic appraisal exercise was carried out on all 3 options this produced the following results**:

Options	NPV Cost (000)	Benefits Score	Costs per Benefit Score	Rank
Option 1 Do minimum	26,079	0	N/A	3
Option 2 Decant off site	85,382	305	280	2
Option 3 Develop decanting strategy on site	24,816	615	40	1

Option 3 provides an acceptable Cost/Benefit score and remains the preferred option.

1.6.3 Option 3 provides the optimum Cost/Benefit score and is the preferred option.

1.6.4 The results of the economic appraisal have been tested through sensitivity analysis to identify at which value the economic preference for the preferred option.

1.6.5 The economic appraisal has been conducted in accordance with guidance issued by HM treasury and the Department of Health.

1.6.6 Financial Overview

Financial overview of the preferred option	**£**
Funded capital expenditure requirement (at MIPS 480 FP, including VAT)	25,082,551

	2011/2012	**2012/2013**	**2013/2014**
Revenue Savings	£'000	£'000	£'000
Reduction in operating costs of preferred option			
Capital Charges Owned Assets	207	415	0
Reduced Rates in areas under construction		60	30
Reduced Energy Costs		162	162
Reduced Backlog Maintenance (£4M) over 10 years	400	400	400
Sub Total	**607**	**1037**	**592**
Income loss and incremental beds required			
4 additional beds on Badger Ward (Net Income)	0	0	608
Additional beds required with no additional Angio	0	343	686
Cardiology growth not possible without Angio	0	0	0
Sub Total	**0**	**343**	**1294**
Total	**607**	**1380**	**1886**

The Net Present Value calculated over a 10 year period taking into consideration the total Capital Cost, Revenue Savings, and Potential Income Opportunities outlined above at a discount rate of 3.5% is **£8.72M**

Key revenue implications;

- **Energy**

The saving in energy costs have been calculated by WSP our Engineering Consultants and they have assumed in their calculations that the 2A energy centre will serve the whole site rather than just the Morgan Stanley Building. This will enable the old boiler house to be decommissioned which would not happen if Phase 2B was not implemented.

- **4 Additional badger beds that result from 2B enabling**

Badger beds, the operating plans assumes the additional capacity provided by 2b enabling will be available. If 2b enabling does not happen the equivalent of 4 beds of activity would be lost - this is therefore booked as a benefit of 2b in terms of income not being lost

- **Angio capcity lost if 2 B enabling does not occur**

The FT plan assumes an additional Angio is in place and without this there would be an impact on LOS of the equivalent of 6 beds of staffing amounting to £686K per annum

- **Cardiology growth**

Additionally, the operating plan assumes an Angio plan to deliver the 25% growth in inpatient cardiology activity expected over a 5 year period.
This is assumed to grow evenly with years 1,2 and half of year 3 able to accommodate the planned growth and the remainder of the growth could not be accommodated as there is insufficient angio capacity

- **Vacated CICU capacity**

The vacated CICU space, is below the line of possible benefits from being able to utilise these beds, is included for information. This is **not included in the modelling due to uncertainty and as there are** no current plans for incremental activity from these at present. They could however be used for any service transfers and two scenarios have been modelled at a high level

- A total of 16 beds could deliver a contribution of £15M
- A total of 8 beds would produce a lower net contribution of perhaps £7M

1.6.7 The capital cost of £25,082,551 (MIPS 480 FP) is funded from the Special Trustees

This is subdivided into the following funding stream

2B Enabling works	£16,301,504
Angio/PACU Additional Scheme	£8,781,007
Total (MIPS 480)	**£25,082,551**

1.6.8 The estimated cash flow for the 2B Enabling Works from the funding stream is as follows:

	Special Trustees Funding
2011/12	£5,000,000
2012/13	£15,000,000
2013/14	£5,082,551
Total (MIPS 480)	**£25,082,551**

7. Capital and Revenue Costs

1.7.1 The costs included in the OBC have been analysed and linked back to the current FBC costs These are shown within the Cost Schedules but are summarised below:

Additional Works to the OB1

Angio and PACU Scheme	£7,473,043
Main Entrance Reinstatement	£1,307,964
Additional Project Costs	£8,781,007
Full Business Case	£25,082,551
Less Additional Projects	£8,781,007

2B Enabling Works	**£16,301,544**

Analysis against OB and FB Costs

Costs from OB1 (July 2006) (MIPS 445 VOP)	£17,306,324
Uplift to MIP 480 FP	£1,361,171
	£18,667,495
FBC Costs (April 2011)	
Total (MIPS) 480 FP	**£25,082,551**

To Analyse Costs on an equivalent basis

OBC		£18,667,495
FBC		£16,301,544
Difference		**£2,365,951**
% Difference	12.67% lower than OBC approval	

1.7.2 For the 2B Enabling Works, and in accordance with the advice from the Department of Health Quarterly Briefing Volume 18 No. 4 (March 2010), Business Cases are to be submitted at MIPS 480 FP. This was changed to a fixed price(FP) cost since the work will be completed within 2 years.

1.7.3 This provides an out-turn indication of the Capital Costs based on fixed prices agreed at the date the works will commence. We have assumed that the possible inflation over the period of this contract estimated at 3.3% (MIPS 49%) will be adequately covered by the 5% Optimism Bias.

1.7.4 These costs are summarised below:

	2B Enabling Cost	**Angio & PACU Scheme**	**Total**
Construction & Engineering	£9,379,980	£3,766,620	£13,146.600
Fees	£1,688,396	£677,991	£2,366,388
On Cost	£532,500	£40,000	£572,500
Equipment	£1,117,497	£2,164,993	£3,282,490
Sub total	£12,718,373	£6,649,604	£19,367,978
Contingency @ 15%	£1,907,756	£997,440	£2,905,196
VAT @ 20%	£2,587,546	£1,393,810	£3,981,357
Sub total	£15,525,279	£8,362,864	£23,888,144
Optimism @ 5%	£776,263	£418,143	£1,194,407
Total	**£16,301,543**	**£8,781,008**	**£25,082,551**

1.7.5 The revenue costs will be neutral, as the planned service developments will make better use of existing resources and release funds for the Trust's Cost Improvement Plans. There is an expectation that an 18 months saving of £621,597 from the Capital Charges being liberated from non – operational building during the Enabling Works between March 2012 and August 2013.

1.7.6 We anticipate a reduction in VAT paid due to recovery on this type of Building Works i.e. refurbishment/repair. This is estimated as a minimum of 25% of VAT payable i.e. £1m refundable of the £3.98m payable against VAT.

1.7.7 The Enabling Works, provide the following operational financial benefits:

- Make better use of the Estate across a reduced floor area

- Removing redundant Boiler Plant, which substantially reduces energy costs. This has been estimated in the region of £160,000 per annum as assessed by the WSP Energy Report

- Identified areas being upgraded will remove elements of risk as backlog maintenance and health and safety will be addressed by upgrading the areas identified

- Backlog maintenance is estimated to be reduced by approximately £4million as a direct result of the Enabling Works Project.

1.7.8 The Enabling Works is paramount to allow Phase 2B to be realised.

8. Contract Structure and Key Aspects

1.8.1 The Enabling Works will follow NEC (Edition 3) form of contract. It has been debated and accepted that the Procure 21+ route for procuring the Enabling Works is the most effective way to achieve the Trust's objectives.

1.8.2 The Project structure will be consistent with the structure already in place for developing Phase 2B and will inform the Full Business Case being developed for Phase 2B in parallel with this Business Case.

Trust Project Plan

Indicative Timetable for the preferred option

Milestone	Date
Business Case Production	November 2010 – April 2011
Enabling Works Project Board	11th April 2011
Present at Management Board	21st April 2011
Present at Redevelopment Board	21st April 2011
Present at Trust Board	25th May 2011
Present to Special Trustees	18th May 2011
Production of GMP	April 2011 – September 2011
Start on Site	September 2011
Completion of Enabling Works and Demolition	July 2013

1.8.3 Minutes approving the Business Case at the various Trust Boards are included in **Appendix 1A, 1B 1C and 1D.**

Attachment J

Conclusion

Executive Summary - Conclusions
• ***The scheme is affordable, provides value for money and meets the Trusts Case for Change.*** • ***This business case supports the Trust's redevelopment programme and is vital to allow the next phase of developments to continue.*** • ***Both capital and revenue costings have been maintained within the parameters of the Phase 2 Outline Business Case*** • ***Both risk assessment and sensitivity analysis confirms the preferred option represents best value for money.***

Draft Minutes of the Sub-Committee of the Trust Board held on 11th May 2011

Extra-ordinary Meeting to Review the Full Business Case for the 2B Enabling Works Project

Present

Mr Charles Tilley	Non-Executive Director – Chairing the meeting
Mr Andrew Fane	Non-Executive Director
Ms Fiona Dalton	Deputy Chief Executive
Mrs Claire Newton	Chief Finance Officer

In attendance

Mr Graham Mills	Deputy Director Estates

1.	**Introduction and Purpose of the Meeting**
1.1	The Sub-Committee agreed that the purpose of the meeting was to examine the business case and review the governance processes undertaken to date, including the risk assessment, such that the Sub-Committee would be in a position to make a recommendation to the May Trust Board as to whether or not this Full Business Case should be approved.
2.	**Strategic Fit**
2.1	The Sub-Committee discussed the strategic background to this business case and noted the following: - The Trust Board has previously as part of a option appraisal workshop in 2006 considered the overall estates strategy with respect to the alternative option of relocating all services away from Great Ormond Street, and concluded that this was not a viable option given the value of existing assets on the site, and not desirable given the advantages of transport links to central London. - This overall strategy was re-confirmed as part of the Development Control Plan Review of 2010, which was considered by Trust Board in November 2010 - The Outline Business Case for Phase 2, which was agreed by the

	Trust Board in 2006, included this Enabling Project, which crucially vacates the existing Cardiac Wing (with the exception of the basement, which accommodates the MRIs) to enable its demolition and rebuilding from level 4. - Following approval of this OBC in 2006, the Department of Health agreed a government contribution of £75 million, demonstrating their considerable support of the overall project. - The overall progress of the Phase 2 scheme has been regularly reviewed by the Department of Health through gateway and design reviews **the OBC and FBC stages in 2006 and 2007** - The last of these was in 2007. Since then our strategy has not changed.
2.2	On the basis of the above the Sub-committee agreed that they felt able to assure the Trust Board that this FBC fits with the agreed Trust strategy, and with previous Trust Board decisions
3.	**Changes from the OBC**
3.1	The key change from the agreed OBC arises from a decision taken in December 2009 of December made at an Executive Awayday where DoR presented the case and executives approved a plan to change one of the planned Angiography rooms into an additional Operating Theatre. The decision needed to be taken quickly as the construction element of the Theatres was imminent. The repercussions of this decision would be reviewed as part of the Enabling works programme for Phase 2B. This decision was made on the basis of anticipated activity growth levels, as expressed in the Integrated Business Plan. A consequence of this decision is the need to re-provide the Angiography Suite: this is included within the Enabling Works FBC and utilises the vacated Tiger/Parrot wards, with a knock-on disruption to the Hospital's Main Entrance. The Charity have agreed this additional funding at their meeting in March 20011.
4.	**Solution for Relocated Services**
	The Sub-Committee questioned the proposed plan for re-providing facilities currently located within the Cardiac Wing. They were reassured that formal project groups exist for each of the 28 projects, and that there was clinical agreement for each re-location. They noted that there were several important benefits which arose from the re-provision, notably: - the ability to expand Badger Ward (respiratory services) as required - improved patient and parent accommodation for respiratory patients - increased capacity for Cardiac Angiography and Interventional Radiology, enabling the planned growth within the IBP - current Cardiac Intensive Care Unit is not used under the current plans, and is therefore available for future expansion as required.

5.	**Project Governance**
5.1	Arrangements for project management were discussed and the Sub-Committee were reassured by the information regarding project resources detailed in the FBC, the arrangements for a formal project board and individual project groups for each project, including full user representation. It was agreed that clarity was required regarding the reporting route of the Redevelopment Steering Group, and the relationship between this group and the Phase 2B Enabling Project Board. **Action:** Deputy Chief Executive to speak to the Company Secretary
6.	**Finances**
6.1	It was noted that the capital costs contained within the business case were estimates based on floor spaces; however they had been agreed with external Quantity Surveyors, and the business case also included both an Optimism Bias and a Contingency sum. With regards to the revenue impact, the Sub-Committee concluded that not all the consequent benefits had yet been included (specifically including the additional operating theatre) and these figures could be further refined. **Action:** Chief Finance Officer Completed and included in FBC Mr Tilley requested that Mrs Newton re-consider whether 3.5% was an appropriate discount rate for this business case. **Action:** Chief Finance Officer Completed Although this changes the numbers it does not affect the VFM analysis provided the same discount rate is used in all options Where other discount rates are used they have been amended to a more appropriate rate The impact on the Trust's accounts of the impairment arising from the demolition of the cardiac wing, and the year in which this would be accounted for also needed to be considered. **Action:** Chief Finance Officer This will be further developed as part of the Phase 2b FBC, the approval date may impact on which year the impairment starts.
7.	**Procurement Solution**
7.1	It was noted that the procurement route (P21Plus) had been previously agreed by the Trust Board on 29th September 2010 and was being appropriately followed.
8.	**Project Risks**
8.1	It was noted that the current project risk register was focused on construction risk, and that this was currently being expanded to include

	broader organisational risk. Action: Deputy Director of Estates & Redevelopment The particular issue of the MRIs was discussed. The risk of continuing to rely on using these vital machines whilst the building above was being demolished was acknowledged. Whilst this risk would technically be a consequence of the 2B project, not the 2B enabling project (as the demolition work is not included within the enabling project), the fact that the enabling project does not include a relocation of the MRIs indicates a tacit acceptance by the Trust of this future risk. The Sub-Committee asked to see written advice from appropriately qualified Trust advisors that - the foundations of the cardiac wing would tolerate the planned work - it was a realistic plan to maintain the operation of MRI scanners whilst undertaking the planned work in the building above them. **Action:** Deputy Director of Estates and Redevelopment This work will form part of the Phase 2b Business Case The Structural Engineers WSP Structures have assessed the suitability of existing Cardiac Wing structure and assessed it as being designed to take the intended load of the new Phase 2b structure. They cannot take liability for the construction of the existing foundations and structure but will take further structural tests as and when the building is vacated. The issue of demolition of the upper floors whilst the Imaging department is still in use has been discussed with the users prior to development of this plan in 2006. It should be noted that such demolitions on live buildings was discussed with Demolition companies and assessed as being a viable operation. In doing this work we can mitigate structural failure, water and vibration, the issue of noise and its disruptive effects will be discussed in detail with imaging managers at a meeting on 24th May. The principle approach will be to separate as much of the demolition and clinical activity during the periods of risk and to risk manage key activities.
9	**Financing**
9.1	It was noted that the legal advisers of GOSH Charity had drafted Heads of Terms for a finance agreement for the enabling works. The draft terms were similar to those included in previous finance agreements for Phase 1 and Phase 2A ie involving "suspension events" by which the Trustees might in certain circumstances withhold further funding during construction and also "repayment triggers" by which the Trustees might require repayment of the funding after the construction was completed in certain circumstances, some of which were outside the direct control of the Trust Board. The intention of the finance agreement is to enable the Trustees to ensure that money donated to the Trust is used and continues to be used for the purposes within the charity's objects. CN informed the meeting that she had agreed with the CEO and

	representatives of the Trustees that she would seek legal advice for the Trust Board in relation to the draft terms particularly in respect of implications for the Trust as a Foundation Trust (when it becomes financially independent) and the Monitor regulations.
10.	**Conclusions**
10.1	Mr Tilley, as Chair of the Sub-Committee, asked Mrs Newton and Ms Dalton, as two Executives present, whether they felt able to recommend to their Chief Executive that this Full Business Case be approved. They both confirmed that, subject to the agreed actions above, they would.
11.	**Next Steps**
11.1	It was agreed that a short summary (maximum 5 pages) of the FBC, risks and assurances was required as a cover-sheet for the Trust Board. This would include the assurances requested by this Sub-Committee (listed as actions throughout the minutes). **Action:** Deputy Chief Executive, Chief Finance Officer, Deputy Director of Estates and Redevelopment

Attachment K

Trust Board Meeting

25th May 2011

Title of document Replacement of VCB Lifts **Submitted on behalf of** Director of Redevelopment and Estates	**Paper No: Attachment K**
Aims / summary To replace the current lifts as the current lifts have passed their economic life. They also need to be replaced, as they will be used by all visitors entering the 2a building.	
Action required from the meeting To approve the recommendation in the attached report.	
Contribution to the delivery of NHS / Trust strategies and plans This will improve with access vertically throughout VCB and Phase 2a and will support vertical traffic to this part of the site when Cardiac Wing lifts are decommissioned from August 2013.	
Financial implications The project costs of £1,263,054 (including £100,000 contingency) is affordable from 2011/12 Capital plan.	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place N/A	
Who needs to be told about any decision CSP's and all departments who use the lifts in VCB.	
Who is responsible for implementing the proposals / project and anticipated timescales Graham Mills – Deputy Director, Estates	
Who is accountable for the implementation of the proposal / project Graham Mills – Deputy Director, Estates	
Author and date William McGill, May 2011	

Attachment K

VCB Lifts Replacement – Condition B funding 2011/12 and 2012/13

1. Introduction

From February 2011 CASP meeting, it was agreed to proceed to GMP the replacement of lifts in VCB as the work was prioritised from Condition B funding due to the condition and continual poor performance of the lifts. The scheme is affordable within this year's allocation of Capital

2. Progress of GMP

We have tendered the work through Mansell to 6 companies and the lowest cost were received from

- Elan Lifts
- Jackson Lifts

After interviews with the above companies, we have decided to proceed with negotiations with Elan Lifts

The current expectation of the cost for lift replacement is **£1,263,054.40.** This includes a risk/contingency sum of £100,000 held by the Trust.

It was agreed via Chairs Action to proceed with letter of intent for £150,000 to allow the company to start producing working drawings and ordering materials on long delivery items to ensure the programme was not affected, since the work needs to be completed before May 2012.

3. Cost Analysis

A total of £850,000 had been set aside in the Condition B budget. The actual cost of the 5 lifts and lift contractors design costs are £788,355.

The additional cost relate to:-

- Managing the work on site on all levels of VCB ensuring lift operations continue and the areas are safely hoarded and secure.
- Improving heating/cooling to lift plant rooms
- Improve the quality of the doors due to the high use and impact of daily use.
- Managing the water ingress in lift pits and installing sump pumps to eradicate ground water due to the high water table.

The Quality Surveyors have analysed the costs and the purchase of the lifts are less than those being purchased through Phase 2A. The costs of 26 passenger bed lift bought under the Phase 2A project is £220,568 per lift where the lifts bought under the replacement lifts project is £788,355 which equates to £157,671 per lift. The costs also include the removal and disposal of the existing lifts and ensuring the 2 operational lifts are continually in use. The cost of this work is £1,163,054.

4. Recommendation

That CASP approves the funding of £1,263,054.40 and we seek full Trust Board approved on 25th May 2011 to proceed with an order of £1,163,054 to Mansells to procure the 5 replacement lifts for VCB.

Attachment K

BUDGET GMP

	VCB Lift replacement
Design Fees phase 2 and 3 (excluding lift design)	
WSP Design Fees - See attached activity schedule	40,210.42
WGI Design Fees budget	5,000.00
WSP Structural Fees budget	10,000.00
Mansell Design Fees see attched	
(Site Manager)	10,657.50
(Qualified Surveyor)	16,646.03
Asbestos Survey	1,950.00
Prelims (possible betterment)	147,814.61
Lift figure (Elan (best case)) including lift design	788,355.00
Heating/ Cooling to lift motor room	10,000.00
EO cost for pegusus door upgrade	5,000.00
Works to lift pit due to water ingress	20,000.00
Replace sump pumps	25,000.00
Contingency Say 1%	9,961.70
Sub total	1,090,595.25
Add 6.644% Balfour Beatty PSCP OH&P	72,459.15
Total	1,163,054.40
GOSH Contingency	100,000.00
Total funding required by GOSH	1,263,054.40

Attachment K

Month	**Cash Flow**
July 2011	£256,340.89
August 2011	£65,420.34
September 2011	£43,878.25
October 2011	£81,506.15
November 2011	£92,347.95
December 2011	£192,986.45
January 2012	£54,649.29
February 2012	£68,722.41
March 2012	£103,118.99
April 2012	£76,191.38
May 2012	£30,440.98
June 2012	£54,415.13
July 2012	£43,036.19
Total	**£1,163,054.40**

Graham Mills
Deputy Director, Estates
May 2011

Great Ormond Street Hospital for Children
Capital Accounts "Condition B" Impact Assessment

	Total	Fees	Provisional Costs	Firm Costs	Notes
Design Fees phase 2 (excluding lift design					
WSP Design Fees - See attached activity schedule	40,210.42	40,210.42			
WGI Design Fees Budget	5,000.00	5,000.00			
WSP Structural Fees	10,000.00	10,000.00			
Mansell Design Fees (Site Manager)	10,657.50	10,657.50			
Mansell (Qualified Surveyor)	16,646.03	16,646.03			
Mansells Asbestos Survey	1,950.00		1,950.00		
Mansells Prelims (possible betterment)	147,814.61			147,814.61	Site Management Costs
Lift figure (Elan (Best Case)) including lift design	788,355.00			788,355.00	
Heating Cooling to Lift motor room	10,000.00		10,000.00		
EO Cost for pegasus door upgrade	5,000.00		5,000.00		Stronger Doors
Works to lift pit due to water ingress	20,000.00		20,000.00		
Replace Sump Pumps	25,000.00		25,000.00		
Contingency Say 1%	9,961.70		9,961.70		
	1,090,595.26				
Add 6.644% Balfour Beatty PSCP OH& P	72,459.15			72,459.15	
	1,163,054.41	82,513.95	71,911.70	1,008,628.76	
GOSH Contingency	100,000.00		100,000.00		
Total Project Costs	1,263,054.41	82,513.95	171,911.70	1,008,628.76	

Current Value of Existing Lifts per DV Report	**1,126,577.00**
Less 12 months Depreciation 19 Year Life	**59,293.53**
Potential Impairment Operating Statement Impact 2012/2013	**1,067,283.47**

New Asset Depreciation (DV 30 year life)	42,101.81
Current Annual Depreciation	59,293.53
New Asset Depreciation Saving per annum	17,191.71

	Year One	Year Two	Thereafter
Current Annual Maintenance Costs	120,000.00	144,000.00	172,800.00
New asset Maintenance Costs 3rd Year	0.00	0.00	60,000.00
Estimated Maintenance Cost Savings per annum	120,000.00	144,000.00	112,800.00

Mike Purcell-Jones
Capital Accounting Manager
16th May 2011

ATTACHMENT L – TO FOLLOW

<table>
<tr><td colspan="2">Trust Board
May 2011</td></tr>
<tr><td>Title of document
Key Performance Indicator Report

Submitted on behalf of.
Fiona Dalton, Chief Operating Officer</td><td>Paper No: Attachment M</td></tr>
<tr><td colspan="2">Aims / summary
The Key Performance Indicator (KPI) report monitors progress against the Trust's seven strategic objectives, providing traffic light analysis against each of the supporting work streams with further supporting graphs representing key outcome measures.
Remedial actions, where performance is not being maintained or achieved, are being addressed through Management Board.</td></tr>
<tr><td colspan="2">Action required from the meeting
Trust Board to note progress.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
To assist in monitoring performance against internal and external defined objectives and NHS Plan targets.</td></tr>
<tr><td colspan="2">Financial implications
None</td></tr>
<tr><td colspan="2">Legal issues
None</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Our lead Commissioner receives a copy of the executive summary on a quarterly basis.</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
Senior Management Team.</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Each Trust objective task has an identified person responsible for implementation and an Executive Director nominated as the accountable officer.</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
As above.</td></tr>
<tr><td colspan="2">Author and date
Janine Gladwell, Capacity and Access Manager. May 2011</td></tr>
</table>

Attachment M

KPI Exception report

1. C. difficile and MRSA (Report page 2 Graph 1)
In April the Trust reported 2 cases of C. difficile, against a year-to-date target of 0.75. The Trust trajectory for the year is 9 cases.

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

The trust has already breached the MRSA annual trajectory of 0 cases for 2011 by reporting 1 case in April.

2. Inpatients waiting list profile by weeks waiting (Report page 4, Graph 13)
Performance has decreased in month with 100 patients reported as waiting over 26 weeks for inpatient treatment. Over 77% of these belong to a surgical specialty.

April shows an un-validated waiting list position which is anticipated to improve once the validated information is reported.

4. Clinic outcome form completeness. (Report page 5, Graph 16)
The overall performance for clinic outcome form completeness has remained steady over the last few months at around 60%, with performance deteriorating to 50% in April.

Due to lack of achievement in this area an 18 week pathway project group has been established – with all pathway managers and operational managers invited. One of this groups key aims is to review and improve the process for how clinic outcomes are recorded, as well as education and training in this area.

5. Staff who have a current Personal Development Review (PDR) in the last 13 months (Report page 12, Graph 42).
Both clinical and non-clinical PDR rates have remained level at 73% against a target of 80%. Services and departments are encouraged to continue to review staff currently identified as not receiving an appraisal.

6. Information governance training (Report page 12, Graph 43).
The deadline for all staff to complete this mandatory training is 17th June. There has been a significant increase in number of staff completing the training in the last month, with the total rate now recorded at 43%. However this is still well below the 95% required.

There have been a number of queries about the accuracy of these reports and underlying figures. The vast majority of these are explainable in particular where users haven't passed the assessment. The only known issues are being investigated but effect only a very small minority of staff, approximately 30 across the whole Trust. Staff are encouraged to continue to raise queries they have with the Head of Information Governance and each will be investigated.

The possibility of hosting alternative ways to deliver the training, including face to face sessions, is currently being investigated.

7. Mixed Sex Accommodation
There were no formal breaches reported last month.

8. Financial KPIs
The April month end position for a number of KPIs is not yet available, as the department are still finalising the position. It is anticipated that this information will be available and up-to-date in the next KPI report.

Great Ormond Street Hospital for Children
NHS Trust

Trust Board
25 May 2011

Report on the financial year 2010/11 (unaudited) **Submitted by:** Claire Newton	**Paper No: Attachment N** *For information*

Aims

To brief the Trust Board on the draft unaudited financial results for 2010/11 and provide annual trend data.

Summary

This report supplements the high level information provided to the Trust Board in april 2011 and attaches the year end management accounts.

The draft financial results – subject to audit –report a net surplus after impairments relating to building revaluations **of £7.2m or £8.6m (2.6% margin) excluding the impairment**;

- ⇒ Income at £336m (0910 £318m) is ahead of Plan of £323m
- ⇒ Patient activity has grown relative to 0910; Inpatients 5.0%; Daycases 1.0% and Outpatients 11%
- ⇒ Fixed assets excluding long term debtors have increased by £71m to £320m, **£77.5m** being capital additions, a net increase in valuation of **£8.0m** less depreciation of £**13.5m & disposals of £0.6m.**
- ⇒ Capital expenditure is within the planned CRL
- ⇒ Capital expenditure on the Redevelopment programme was behind Plan due to delays and rephrasing of expenditure but the completion date for Phase 2A is expected to remain the same
- ⇒ Year end cash has increased to over £32m from £8m due to the combined effect of the net operating surplus, reductions in debtors, increases in creditors, receipt of funding in advance which will be matched by cash expenditure early in 2011/12 and some much quicker payments from PCTs of invoices immediately prior to the year end
- ⇒ The Trust achieved its CRES target
- ⇒ An overall financial risk ratio of 3 can be achieved.

These preliminary figures are in line with previous forecasts .

Action required from the meeting To note the report

Contribution to the delivery of NHS / Trust strategies and plans
The Trust needs to deliver a surplus and build cash reserves in order to be in a strong position for FT status

Financial implications No direct financial implications.

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

Who needs to be told about any decision The Trust Board

Who is responsible for implementing the proposals and anticipated timescales? DFD and CFO
Who is accountable for the implementation of the proposal CEO
Author and date Claire Newton 16.05.11

A Activity underlying the financial performance

NHS patient activity:
- Inpatient FCE increased by 4.8%
- Day case FCE increased by 1.0%
- Outpatient attendances increased by 11.9%

This approximates to an overall increase in activity of 5.5%.

Private patients:
- Inpatient FCE increased by 7.4%
- Day case FCE increased by 0.6% (measured using episodes)
- Outpatient attendances increased by 6.5%

NB Patient activity does tend to vary with the number of working days (excluding bank holidays in the year and 2010/11 had 1% more working days than in 0910

Haringey activity:
There are no simple high level measures of Haringey activity which represent the whole service. Expenditure on the community services in Haringey increased from £9.9m to £10.8m. In both years there were non-recurring elements of expenditure.

R&D funding + 2.2%
- Income streams were relatively consistent year on year although in the final quarter of 1011, some new external grants were recorded

B Financial summary – revenue statement

As the Trust only managed NMH paediatrics for the first month in 2010/11 (but for 12 months in 0910) these activities have been included from income and expenditure in the two right hand columns to allow a like for like comparison between 0910 and 1011

On a like for like basis, income and expenditure have grown by approximately 8.8/8.5% whereas NHS acute episode activity has increased on average by 5.5% and private patient activity by 7.0%.

Income growth is higher than activity growth due to the full year effect of the local price increases implemented in October 2009 and a 1% increase in drugs which is over and above the activity increase, following a shortage of a high cost drug in 0910. In addition, there has been an increase in NCG services.

The Trust received approximately 65% of its CQUIN funding, the areas where CQUIN was not achieved included nutrition targets, OP letters and two areas of the patient survey.

The Trust also lost c £450k on marginal rates on non-elective growth on certain SHA PCT contracts although in overall terms there was only slight overall growth.

Expenditure growth is higher as a result of the drug increase referred to above, the increase in Haringey and R&D, which are not reflected in acute activity, and cost pressures such as the investment in the ICON service.

Summary revenue statement					
	As reported		Excluding NMH		Like for like growth
£m	***Actual 2009/10***	***Actual 2010/11***	**Actual 2009/10**	**Actual 2010/11**	
NHS clinical income	*241.5*	*254.1*	234.2	253.3	**+8.2%**
International	*21.0*	*25.0*			**+19.2%**
Other non-NHS clinical	*5.0*	*4.8*			
Total patient care	***267.5***	***283.9***	**260.2**	**283.1**	+8.8%
Other operating revenue	*50.6*	*52.4*	50.3	52.4	
Total revenue	***318.1***	***336.3***	**310.5**	**335.5**	**+8.1%**
Operating expenses	*(290.8)*	*(307.7)*	(283.0)	(307.0)	**+8.5%**
EBITDA	***27.4***	***28.5***	**27.4**	**28.5**	
Normalised EBITDA	***20.0*** ***6.4%***	***21.5*** ***6.5%***	**20.0** **6.6%**	**21.5** **6.5%**	
Depreciation	(15.3)	(13.6)			
Other gains and losses	0.03	(0.6)			
Investment revenue	0.5	0.1			
Finance costs	*(0.03)*	*(0)*			
PDC dividends payable	*(5.2)*	*(5.6)*			
Retained surplus for the year Excluding impairment	***7.3***	***8.6***			
Impairments included (net)	*(3.8)*	*(1.4)*			
Retained surplus	***3.5***	***7.2***			

Increases in other operating revenue include the Kuwait Education and Training fees, and increased funding for patient transport which was subject to block funding in 0910.

Increases in pay expenditure reflect:

- pay awards
- pay increments (agenda for change and consultant awards)
- increases in WTE including agency of c 6%, primarily in clinical units and private patients to support delivery of increased activity and including additional staff in Haringey, R&D and ICON

Increases in non-pay

Above inflation increases in:
drugs (See above, 0910 was abnormally low due to a one off correction and due to shortage of LSD drugs) and clinical supplies,
education costs,
clinical negligence fees and
higher costs of services bought from other NHS trusts

An impairment was recorded following a review of asset valuations totalling £1.4M net.

The CIP target of 4% of expenditure or 5.5% of influenceable expenditure was achieved through the combination of improved productivity and reductions in costs.
Other key ratios:

£'m	**2009/10 Actual**		**2010/11 Actual**
Net surplus %	2.2%		2.5%
ROA	4.9%		5.0%
Private patient %	8.0%		8.8%

C Statement of Financial Position

£'m	Mar-10 Actual	Mar-11 Actual
Total Fixed Assets	**258.1**	**329.6**
Stocks & Work in Progress	5.2	5.2
Debtors	36.5	30.3
Cash at bank and in hand	8.5	32.6
Total Current Assets	**50.2**	**68.1**
Creditors	-37.6	-53.9
NET CURRENT ASSETS	**12.6**	**14.2**
TOTAL ASSETS LESS CURRENT LIABILITIES	270.7	343.8
Provisions for liabilities and charges	-1.3	-1.2
Other non-current liabilities	-7.7	-7.3
TOTAL ASSETS EMPLOYED	**261.7**	**335.3**

The major changes between year ends are:

- Continued expenditure on Phase 2A redevelopment in addition to other capital investment
- Increase in net assets as a result of the operating surplus
- Higher levels of creditors and deferred income at the end of the financial year
- Reduced levels of debtors as old performance debt and Haringey and LPP debt was cleared by March 2011
- Higher cash levels (See below)

Better Payment Practice Code

The Trust made 87% of payments on non-NHS payables within targets but only 57% by value on NHS payables

D Summary Cash Flow

	Actual 2009/10	Actual 2010/11
Cash from operating activities including movements on year end debtors and creditors	15.8	38.7
Capital expenditure	-36.9	-72.5
DH funding for redevelopment	15.4	15.0
GOSH CC, Friends C and other capital receipts	12.9	48.5
Proceeds from disposals	0.5	
Dividends paid	-5.1	-5.7
Net increase in cash deposits	2.6	24.0

The Trust's cash balances have increased significantly in the year due to the net operating surplus and in addition, good recovery of prior year debt and a significant increase in deferred income at March 2011.

Capital investments

The Trust remained within its "CRL" (Capital Resources Limit).

During 2010/11 the construction expenditure on the Phase 2A redevelopment project was at its maximum and the final tranche of £15m within the total DH funding of £75m was received. In addition there were further significant Estates projects, Robin and Fox wards duct cleaning and refurbishment, Outpatients, public toilets, the start of the Woodland ward refurbishment, CBL chillers and the theatres doors project.

There was continued investment on IT infrastructure (network, servers, virtual storage and the equipment tracking system); investment in new IT systems such as Ordercomms and charity funded medical equipment and the installation of patient bedside systems.

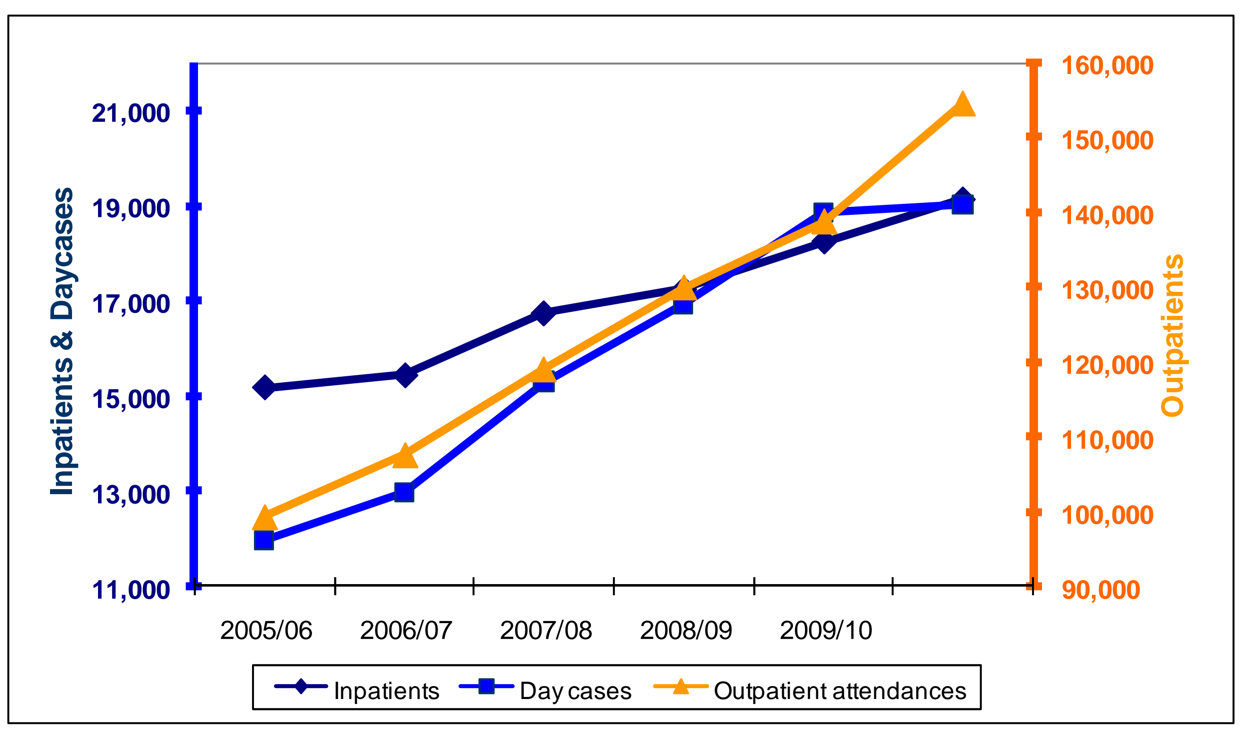
	Expenditure year to 31 March 2010		Expenditure year to 31 March 2011
	£'M		£'M
Hospital redevelopment	9.0		15.0
Hospital redevelopment - donated	5.9		47.2
Estates Maintenance	10.7		8.5
Estates - donated	8.5		0.5
IT	3.8		4.5
IT - donated	1.7		0
Medical equipment			0.3
Medical –donated	2.1		1.5
Other	1.4		
Total	**43.0**		**77.5**

Note the totals will not agree to the cash flow in the proceeding section due to some expenditure being included in creditors at the year ends.

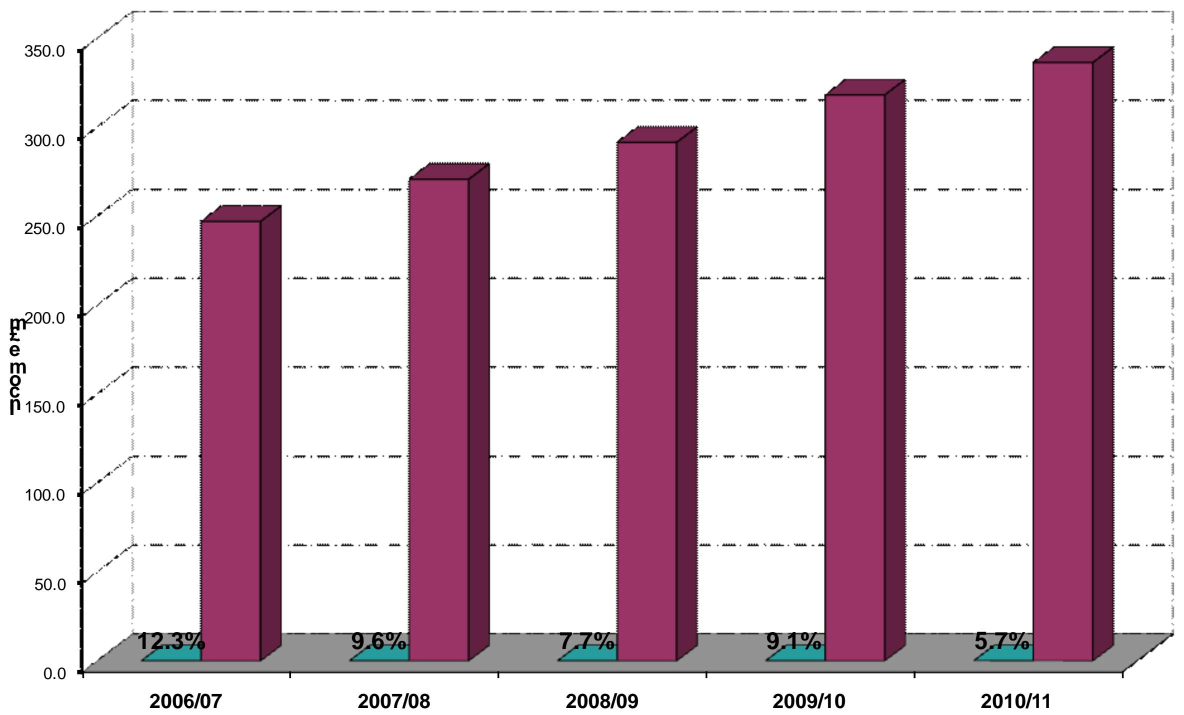
E GRAPHICAL ANALYSIS

Five year trends and income and expenditure analysis is set out overpage

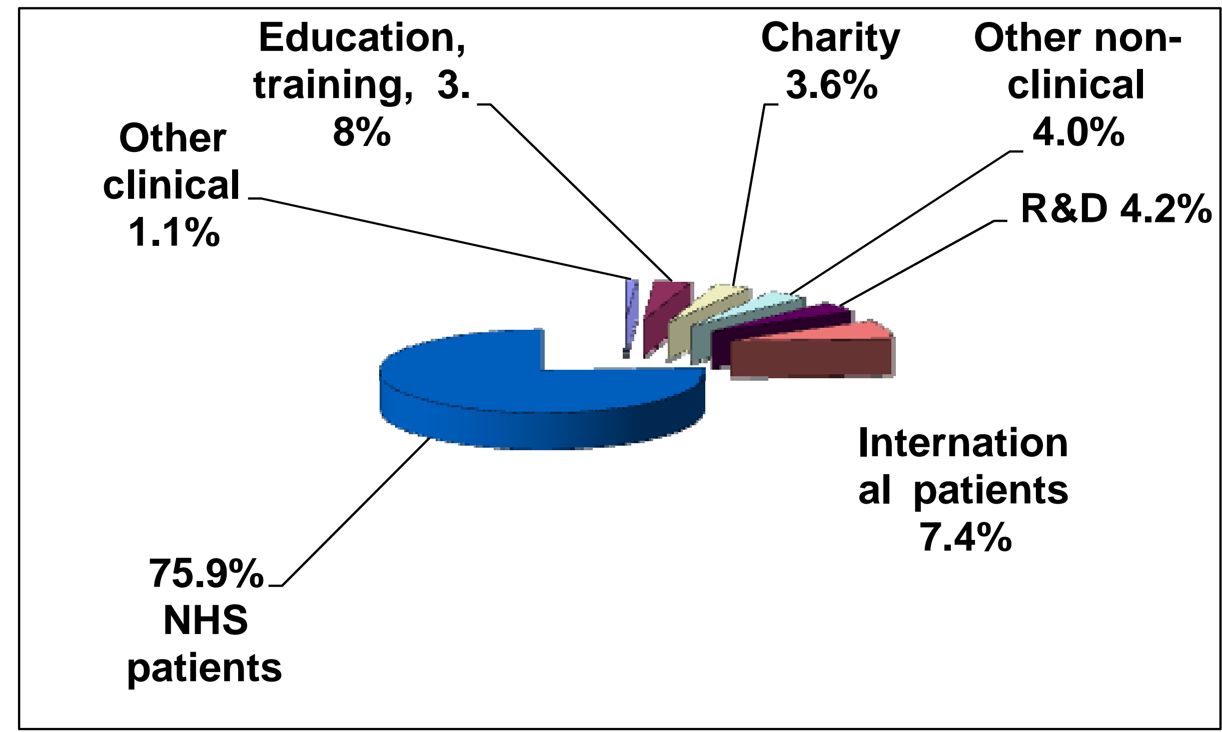
FIVE YEAR ACTIVITY TREND



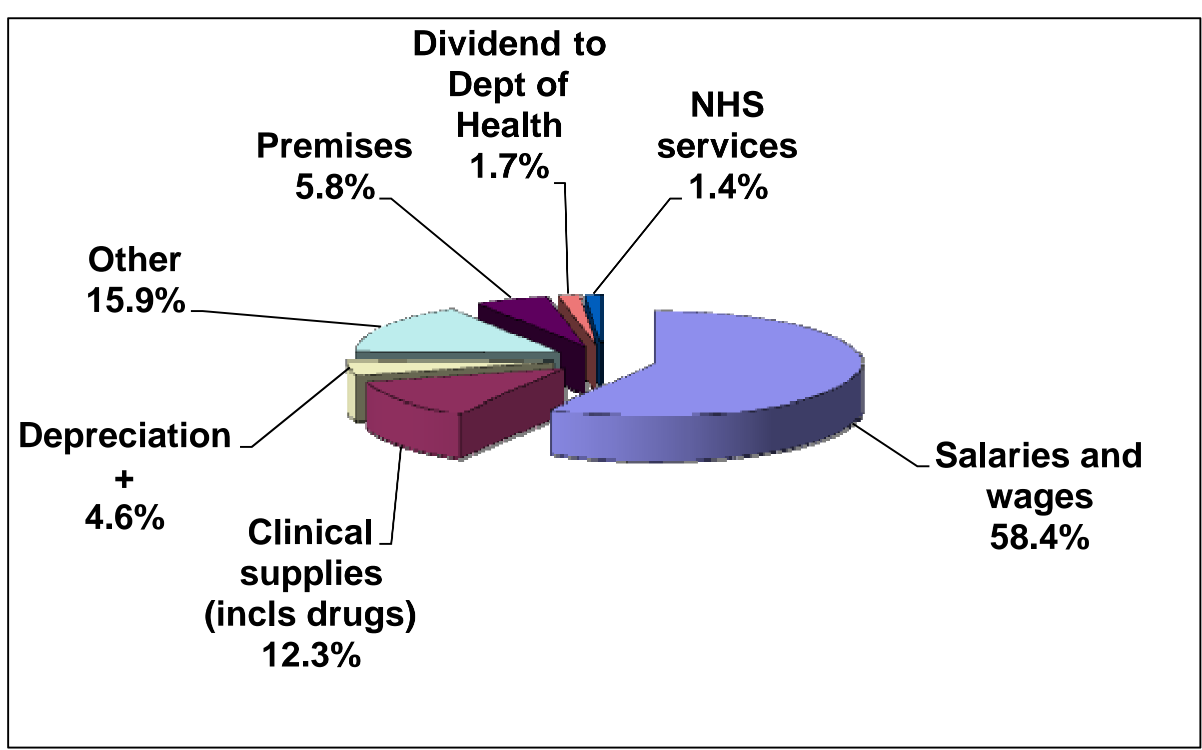
FIVE YEAR INCOME TREND WITH GROWTH %



ANALYSIS OF INCOME SOURCEs



ANALYSIS OF EXPENDITURE



Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Contents

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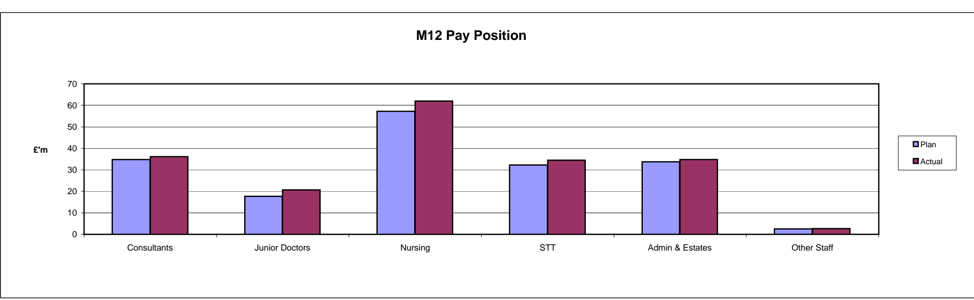
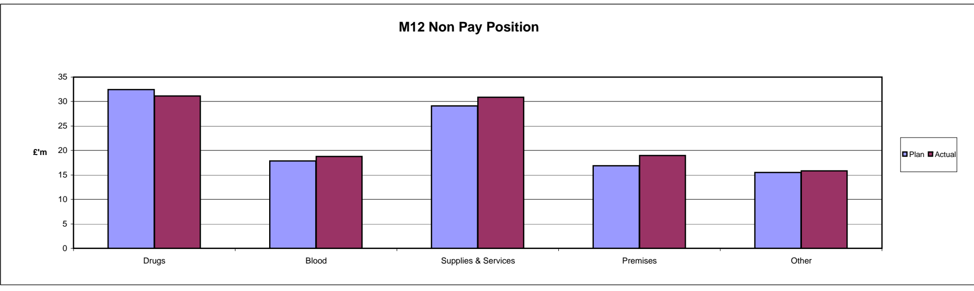
Statement of Financial Position	7
Statement of Cashflow	8
Activity	9
Cash Management	10
Receivables Management	11
Capital	12
WTE	13

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Trust Summary

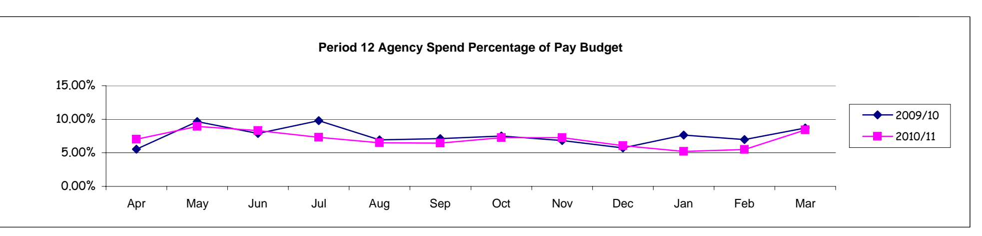
Statement of Comprehensive Income

	Current Month Actual £000	Current Month Plan Variance £000	YTD Actual £000	YTD Plan Variance £000
Revenue				
Revenue from patient care activities	26,124	1,565	283,881	6,064
Other operating revenue	5,947	2,045	52,426	4,854
Operating expenses	(31,585)	(5,272)	(322,991)	(10,658)
Operating surplus	**486**	**(1,662)**	**13,316**	**260**
Investment revenue	9	6	68	32
Other gains and (losses)	(579)	(579)	(633)	(633)
Finance costs	(2)	(1)	(31)	(7)
Surplus for the financial year	**(86)**	**(2,236)**	**12,720**	**(348)**
Public dividend capital dividends payable	(199)	288	(5,551)	302
Retained surplus for the year	**(285)**	**(1,948)**	**7,169**	**(46)**
Other comprehensive income				
Impairments put to the reserves	4,367	4,367	4,139	4,139
Gains on Revaluation	5,030	5,030	5,030	5,030
Receipt of donated and government grant assets	3,988	759	49,233	(9,862)
Reclassification adjustments:				
- Transfers from donated and government grant reserves	(320)	275	(6,996)	145
Total comprehensive income for the year	**12,780**	**8,483**	**58,575**	**(594)**
Retained Surplus against FIMS	**(285)**	**(1,948)**	**7,169**	**(46)**
Total Comprehensive Income against FIMS	**12,780**	**8,483**	**58,575**	**(594)**





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



Staffing Staff Numbers	Budgeted Posts	WTE Paid	Maternity Paid	Temp Paid	Overtime Paid	Total Paid	WTE above plan
Admin and Other Support	869	815	15	86	6	922	(53)
Clinical Support	745	720	28	51	5	804	(59)
Medical	476	471	18	54	0	543	(67)

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Unit Summary and CRES Performance

	YTD						
	Income*			Expenditure			Overall Unit Position
	2009 £000	Actual £000	Variance £000	2009 £000	Actual £000	Variance £000	Variance £000
Clinical Units							
Cardiac	42,527	54,609	1,367	(27,815)	(29,903)	181	1,548
Surgery	56,733	64,697	717	(56,059)	(59,233)	(1,849)	(1,132)
DTS	1,503	1,576	(738)	(21,817)	(19,400)	(118)	(856)
ICI	50,126	57,128	(138)	(46,179)	(54,048)	(498)	(636)
International	21,269	26,656	889	(9,390)	(10,950)	(205)	685
Medicine	39,492	41,193	1,835	(33,237)	(38,556)	300	2,134
Neurosciences	22,254	27,858	3	(18,942)	(20,688)	(461)	(459)
Haringey	9,176	9,575	74	(9,617)	(10,452)	(950)	(876)
North Mid.	7,673	821	166	(7,369)	(690)	(35)	131
Total Clinical Units	**250,753**	**284,112**	**4,174**	**(230,424)**	**(243,920)**	**(3,635)**	**539**
Central Departments							
Operations & Facilities	1,761	1,671	(109)	(16,557)	(17,200)	(870)	(979)
Corporate Affairs	103	102	(1)	(1,258)	(1,436)	314	314
Estates	699	1,027	13	(11,975)	(12,082)	(791)	(777)
Finance & ICT	216	247	57	(9,947)	(9,776)	240	297
Human Resources	527	788	60	(2,526)	(2,883)	7	67
Medical Director	247	115	(85)	(3,644)	(4,533)	(560)	(646)
Nursing And Workforce Development	1,729	1,923	(33)	(5,512)	(5,488)	301	268
Research And Innovation	12,725	14,383	770	(6,871)	(7,696)	(640)	130
Redevelopment Revenue Costs	917	534	(362)	(206)	(520)	164	(198)
Total Central Departments	**18,924**	**20,790**	**311**	**(58,497)**	**(61,615)**	**(1,836)**	**(1,525)**
Corporate Budgets	**48,468**	**31,405**	6,414	**(25,676)**	**(23,603)**	**(5,476)**	**939**
Net Position	**318,145**	**336,306**	**10,900**	**(314,597)**	**(329,138)**	**(10,946)**	**(46)**

CRES 2010/11		Analysis of CRES Scheme Deliverability					
	TARGET	Released from Budgets	Deliverable Schemes	Feasible Schemes	Potential Schemes	Unidentified Schemes	Total Risk
CRES 2010/11 Target	**16,604**	**11,960**	**0**	**0**	**0**	**4,644**	
Status		**Delivered**	**RISK**	**RISK**	**RISK**	**RISK**	
Recurrent 2010/11		**10,689**	**0**	**0**	**0**		
Non recurrent 2010/11		**1,271**	**0**	**0**	**0**		
Expenditure		**6,176**	**0**	**0**	**0**		
Income		**5,784**	**0**	**0**	**0**		
CRES 2011/12	**15,893**		**3,118**	**10,092**	**1,712**	**971**	**15,893**
CRES 2012/13			**270**	**1,615**	**11,343**		**13,228**

Analysis	Month 12			*	Month 12 New CRES	Schemes in progress	
CLINICAL	Target	BLUE	Variance	Posts released	New BLUE	On target (Green)	Feasible (Amber)
Cardiac	1,904	**1,904**	0	0.00	**1,020**	0	0
ICI	1,730	**1,790**	60	1.00	**172**	0	0
IPP	1,114	**1,242**	128	2.00	**302**	0	0
MDTS	3,121	**1,544**	-1,577	5.40	**332**	0	0
Neurosciences	1,229	**622**	-607	3.00	**0**	0	0
Surgery	3,790	**1,956**	-1,834	4.39	**0**	0	0
Total	**12,888**	**9,058**	**-3,830**	**15.79**	**1,826**	**0**	**0**
CORPORATE							
Clinical Ops	149	**197**	48	2.00	**0**	0	0
Corporate Facilities	1,222	**898**	-324	11.57	**6**	0	0
Corporate Affairs	125	**241**	116	0.00	**0**	0	0
Estates	813	**781**	-32	0.00	**217**	0	0
Finance	837	**275**	-562	5.00	**0**	0	0
Medical Director	125	**50**	-75	0.00	**50**	0	0
Nursing and Education	236	**251**	15	4.62	**64**	0	0
HR	172	**173**	1	2.00	**0**	0	0
Reseach and Development	38	**38**	0	0.20	**0**	0	0
Total	**3,717**	**2,904**	**-813**	**25.39**	**337**	**0**	**0**
Grand Total	**16,604**	**11,960**	**-4,644**	**41.18**	**2,163**	**0**	**0**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Revenue Statement

	10/11 Annual Budget £000	10/11 Mth 12 Actual £'000	10/11 Mth 12 Variance to Plan £'000	10/11 YTD Actual £'000	10/11 YTD Variance to Plan £'000	Actual Variance to 09/10 YTD Actual £'000
Primary Care Trusts Tariff	60,085	**6,427**	930	**61,149**	1,064	**5,482**
Primary Care Trusts Non Tariff	115,561	**10,315**	272	**119,899**	4,338	**13,224**
Primary Care Trusts Mff	23,080	**1,943**	-248	**19,333**	-3,748	**-176**
Strategic Health Authorities	41,025	**3,448**	30	**42,791**	1,766	**4,088**
Nhs Trusts	1,198	**226**	181	**1,733**	536	**-6,078**
Department Of Health	1,046	**191**	104	**951**	-95	**-95**
Nhs Other	8,284	**691**	0	**8,267**	-17	**-3,866**
Activity Revenue Nhs	**250,279**	**23,241**	**1,269**	**254,123**	**3,844**	**12,579**
Local Authorities	1,009	**89**	5	**1,059**	49	**49**
Private Patients	22,133	**2,557**	445	**24,989**	2,856	**4,026**
Non Nhs Other	4,413	**236**	-172	**3,710**	-703	**-321**
Activity Revenue Non Nhs	**27,556**	**2,883**	**278**	**29,758**	**2,202**	**3,754**
Patient Transport Services	861	**139**	60	**1,267**	406	**390**
Education And Training	11,727	**1,196**	218	**12,672**	945	**1,451**
Research And Development	12,363	**2,503**	1,472	**14,127**	1,764	**311**
Charitable & Other Contrib	5,029	**574**	186	**5,054**	25	**-125**
Depreciation Income Transfer	7,141	**320**	-275	**6,996**	-145	**-369**
Non Patient Care Services	4,106	**351**	9	**3,789**	-318	**25**
Revenue Generation	1,346	**155**	43	**1,873**	527	**557**
Other Revenue	4,999	**711**	331	**6,649**	1,650	**-411**
Other Operating Revenue	**47,572**	**5,948**	**2,045**	**52,426**	**4,854**	**1,828**
Directors & Senior Managers	-8,785	**-699**	25	**-8,001**	783	**-987**
Consultants	-36,615	**-3,231**	-183	**-36,170**	446	**-393**
Junior Doctors	-18,588	**-1,566**	-53	**-17,970**	619	**310**
Junior Doctors Agy	0	**-261**	-261	**-2,633**	-2,633	**-516**
Administration & Estates	-26,022	**-1,952**	272	**-22,404**	3,617	**-1,594**
Administration & Estates Agy	-678	**380**	437	**-4,382**	-3,703	**557**
Healthcare Assist & Supp	-2,311	**-191**	2	**-2,142**	169	**-6**
Healthcare Assist & Supp Agy	-41	**-22**	-19	**-241**	-201	**185**
Nursing Staff	-60,109	**-4,966**	-21	**-59,106**	1,003	**-856**
Nursing Staff Agy	0	**-363**	-363	**-2,820**	-2,820	**-771**
Scientific Therap Tech	-33,896	**-2,799**	47	**-32,509**	1,387	**-2,686**
Scientific Therap Tech Agy	0	**-209**	-209	**-1,907**	-1,907	**1,028**
Other Staff	-269	**-42**	-20	**-265**	4	**-7**
Pay Reserves	-4,881	**-83**	115	**-1,722**	3,159	**-1,752**
Cips And Cres Unidentified - P	9,043	**0**	-591	**0**	-9,043	**0**
Pay Costs	**-183,151**	**-16,002**	**-823**	**-192,271**	**-9,121**	**-7,487**
Drugs Costs	-34,073	**-2,750**	445	**-31,160**	2,914	**-3,288**
Blood Costs	-18,742	**-1,786**	-204	**-18,758**	-16	**-795**
Supplies & Services - Clinical	-22,332	**-1,904**	64	**-21,563**	769	**-2,568**
Services From Nhs Organisation	-4,512	**-746**	-337	**-4,645**	-134	**-686**
Healthcare From Non-Nhs Bodies	-1,556	**-717**	-580	**-2,165**	-609	**-520**
Supplies & Services - General	-2,219	**-308**	-118	**-2,487**	-269	**-40**
Consultancy Services	-2,545	**-829**	-676	**-2,068**	477	**-480**
Clinical Negligence Costs	-1,712	**-143**	0	**-1,714**	-2	**-251**
Establishment Costs	-2,560	**-348**	-129	**-2,779**	-218	**30**
Transport Costs	-2,453	**-360**	-150	**-2,787**	-334	**-615**
Premises Costs	-17,715	**-2,527**	-1,085	**-18,985**	-1,270	**-278**
Auditors Costs	-353	**-48**	-19	**-389**	-36	**-65**
Education And Research Costs	-2,871	**-1,206**	-951	**-2,744**	127	**-379**
Expenditure - Other	-3,819	**-286**	10	**-3,331**	487	**329**
Non Pay Reserves	-3,062	**0**	124	**0**	3,062	**0**
Cips And Cres Unidentified - N	5,673	**0**	-371	**0**	-5,673	**0**
Non Pay Costs	**-114,849**	**-13,959**	**-3,977**	**-115,574**	**-726**	**-9,606**
P & L On Disp Of Fixed Assets	0	**-579**	-579	**-633**	-633	**-1,120**
Fixed Asset Impair & Reversals	0	**-1,219**	-1,219	**-1,448**	-1,448	**2,370**
Depreciation & Amortisation	-14,351	**-395**	774	**-13,641**	710	**1,707**
Interest Receivable	36	**8**	5	**68**	32	**32**
Other Revenue / Expenditure	-24	**-3**	-1	**-31**	-7	**0**
Pdc Dividend Payable	-5,853	**-199**	288	**-5,551**	302	**-379**
Corporation Tax	0	**-8**	-8	**-56**	-56	**-56**
Other Revenue / Expenditure	**-20,192**	**-2,395**	**-739**	**-21,292**	**-1,100**	**2,554**
Retained Surplus / (Deficit)	**7,215**	**-285**	**-1,948**	**7,169**	**-46**	**3,621**

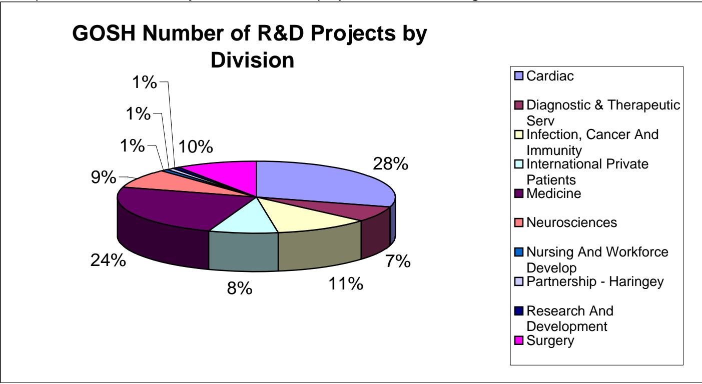
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Research and Development Activity

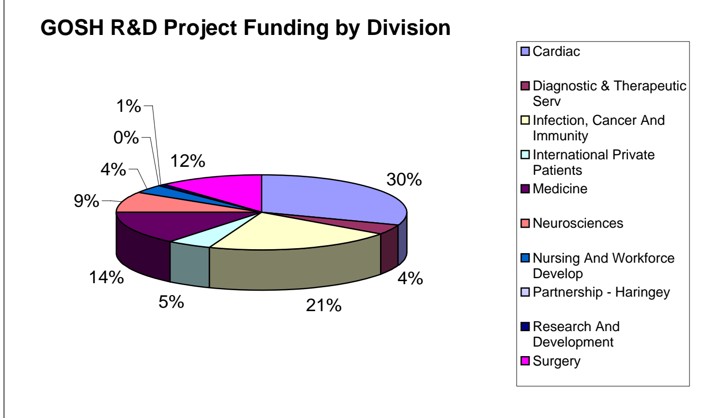
	Full Year Forecast	Full Year Budget	YTD Actuals	YTD Variance
Biomedical Research Centre including Clinical Research Facility				
- Income	(7,704)	(7,718)	(7,813)	95
- Income deferred from 09-10	(508)	(508)	(508)	0
- Commercial Trials Income	(420)	0	(392)	392
- Expenditure	3,134	3,484	3,292	192
	(5,498)	(4,742)	(5,421)	679
CLRN (PCRN) Income				
- Income CLR Activity Based (Non DH R&D)	(1,100)	(1,604)	(1,100)	(504)
- Income PCRN (R M&G, KSS, SS)	(137)	0	(164)	164
- Income PCRN (R M&G, KSS, SS) 09-10 C/FWD	(34)	0	(34)	34
- Income Non R&D (cc **CLR**)	0	(336)	0	(336)
- Expenditure CLR	122	123	137	(14)
	(1,150)	(1,817)	(1,161)	(656)
NIHR GRANTS				
- Income	(172)	(405)	(354)	(51)
- Income deferred from 09-10	(433)	0	(433)	433
- Expenditure	605	405	813	(408)
	0	0	26	(26)
R&D GOSH Charity Funded Projects				
- Income	(2,861)	(2,396)	(2,629)	233
- Expenditure	2,250	1,748	2,116	(367)
	(610)	(648)	(514)	(134)
R&D Development Office				
- Expenditure	465	651	383	267
	465	651	383	267
TOTAL RESEARCH & DEVELOPMENT DIRECTORATE				
- R&D Income	(9,114)	(9,728)	(9,431)	(296)
- R&D Income Deferred from 09-10	(975)	(508)	(975)	467
- R&D Charitable Contribution	(2,861)	(2,396)	(2,629)	233
- Non DH Research Income	(420)	(336)	(392)	56
- Expenditure	6,577	6,411	6,741	(330)
	(6,793)	(6,557)	(6,687)	130
- Expenditure in Clinical Areas	6,129	6,633	6,129	504
Total R&D Division	(664)	76	(558)	634
		(10,356)	(10,305)	(51)
Centrally Held and Devolved Income				
- Flexibility & Sustainability Funding (Central) STANDARD	(2,501)	(2,501)	(2,501)	0
- DTS : From CLRN Additional 09-10 Support	(204)	(189)	(201)	11
- Medicine : From CLRN Additional 09-10 Support/NIHR Fellowship	(55)	0	(53)	53
- ICI : From MCRN 09-10 Support	(85)	(66)	(76)	10
- Surgery : From Charitable Donation	(21)	0	(18)	18
Total Centrally Held and Devolved Income	(2,866)	(2,756)	(2,848)	92
TOTAL R&D INCOME				
R&D Income	(12,955)	(12,992)	(13,254)	263
Income Generation GOS / Direct Credits	0	1,256	0	1,256
Total Income	(12,955)	(11,735)	(13,254)	1,519
Local Research Network MCRN *				
- Income	(570)	(628)	(662)	34
- Income DH FSF F&S (cc **LRN**)	(122)	0	(122)	122
- Income R&D Non DH (cc **LRN**) CLR Network	(89)	0	(89)	89
- Income Other Non R&D (cc **LRN**)	(80)	(17)	(82)	65
- Expenditure LRN	861	645	955	(310)
	0	0	0	0

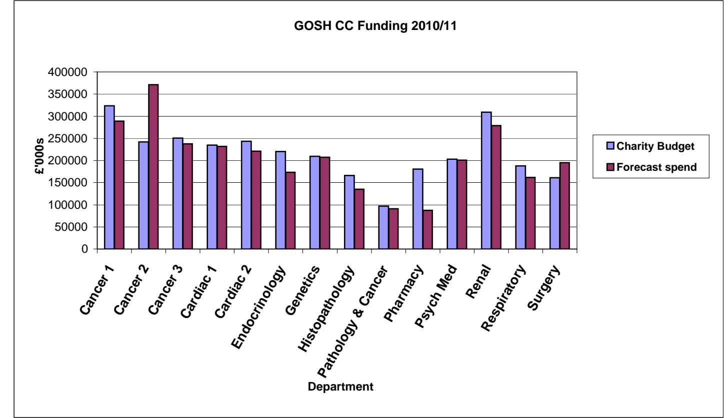
* GOSH is Hosting this service for Central and North East London

	Full Year Forecast	Full Year Budget	YTD Actuals	YTD Variance
TOTAL R&D INCOME (as per Board Report)				
- R&D Income	(13,735)	(12,363)	(14,127)	1,764

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







Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Ratio Analysis

Provider Agency Rating	**Target for FT Status**	**M12 Actual - FT**	**M11 Actual - FT**	**Forecast Outurn - FT**	**M12 FT Score**
EBITDA Margin	5%	8.5%	8.7%	8.5%	3
EBITDA % Achieved	70%	103.8%	109.4%	103.8%	5
ROA	3%	5.0%	4.5%	5.0%	4
I&E Surplus margin	1%	2.8%	2.5%	2.8%	4
Liquidity Days	15.0	10	12	10	2
Weighted Average	3.0	3.4	3.2	3.4	3.4
Overall Rating	**3**	**3**	**3**	**3**	3
IPP Cap (Max 9.7%)	9.7%	8.8%	8.7%	8.8%	

Salary Overpayments		
Unit	**No.**	**Amount £'000**
Medicine	8	10
Surgery	3	7.2
ICI	2	1.3
Nursing & Workforce	1	0.5
Cardiac	1	0.5
TOTAL	15	19.5

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Statement of Financial Position

	Actual as at 01/04/10 £000	Actual as at 28/02/11 £000	Actual as at 31/03/11 £000	Change in month £000
Non Current Assets :				
Property Plant & Equipment - Purchased	151,335	167,958	177,238	9,280
Property Plant & Equipment - Donated	97,078	135,496	141,526	6,030
Property Plant & Equipment - Gov Granted	193	366	363	(3)
Intangible Assets - Purchased	423	783	971	188
Intangible Assets - Donated	48	26	25	(1)
Trade & Other Receivables	9,039	9,028	9,505	477
Total Non Current Assets :	***258,117***	***313,656***	***329,628***	***15,972***
Current Assets :				
Inventories	5,173	5,289	5,156	(133)
NHS Trade Receivables	15,038	8,263	3,521	(4,742)
Non NHS Trade Receivables	9,691	11,730	10,359	(1,371)
Capital Receivables	5,851	5,694	6,571	877
Provision for Impairment of Receivables	(1,435)	(1,393)	(1,498)	(105)
Prepayments	2,314	2,402	2,321	(81)
Accrued Revenue	2,556	8,639	6,533	(2,106)
HMRC VAT	1,630	643	1,895	1,252
Other Receivables	909	360	807	447
Cash & Cash Equivalents	8,485	32,065	32,371	306
Total Current Assets :	***50,212***	***73,690***	***68,036***	***(5,654)***
Total Assets :	**308,329**	**387,346**	**397,664**	**10,318**
Current Liabilities :				
NHS Trade Payables	(586)	(4,831)	(7,722)	(2,891)
Non NHS Trade Payables	(3,716)	(2,937)	(2,519)	418
Capital Payables	(7,084)	(9,691)	(12,179)	(2,488)
Expenditure Accruals	(14,490)	(14,712)	(14,866)	(154)
Deferred Revenue	(3,326)	(12,446)	(6,281)	6,165
Tax & Social Security Costs	(3,816)	(4,017)	(4,022)	(5)
Other Payables	(48)	(2,425)	0	2,425
Payments on Account	(231)	(228)	(228)	(0)
Lease Incentives	(400)	(400)	(400)	(0)
Other Liabilities	(2,376)	(3,494)	(2,754)	740
Provisions for Liabilites & Charges	(1,549)	(2,624)	(2,866)	(242)
Total Current Liabilities :	***(37,621)***	***(57,804)***	***(53,837)***	***3,967***
Net Current Assets / (Liabilites) :	**12,591**	**15,886**	**14,199**	**(1,687)**
Total Assets Less Current Liabilities :	**270,708**	**329,542**	**343,827**	**14,285**
Non Current Liabilities :				
Lease Incentives	(7,728)	(7,361)	(7,327)	34
Provisions for Liabilites & Charges	(1,304)	(1,101)	(1,250)	(149)
Total Non Current Liabilities :	***(9,032)***	***(8,463)***	***(8,577)***	***(114)***
Total Assets Employed :	**261,676**	**321,080**	**335,250**	**14,171**
Financed by Taxpayers Equity :				
Public Dividend Capital	109,732	123,114	124,732	1,618
Retained Earnings	9,515	17,118	16,868	(250)
Revaluation Reserve	41,996	41,846	48,623	6,778
Donated Asset Reserve	97,126	135,522	141,550	6,028
Government Grant Reserve	193	366	363	(3)
Other Reserves	3,114	3,114	3,114	0
Total Funds Employed :	**261,676**	**321,080**	**335,250**	**14,171**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Statement of Cash Flow

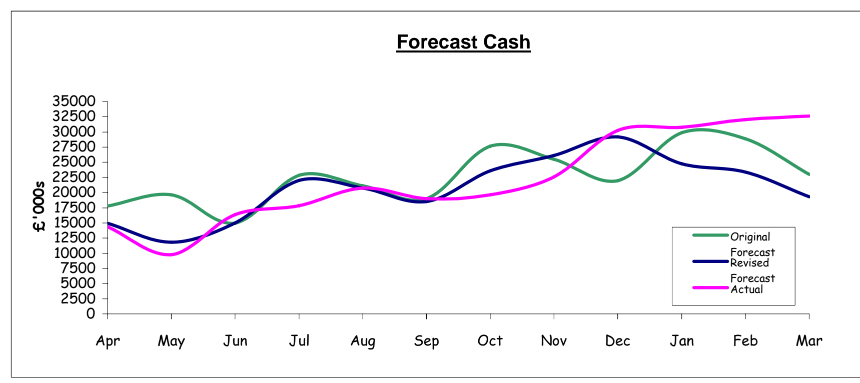
Statement of Cash Flows	Actual For Month Ending 31/03/11 £000	Actual For YTD Ending 31/03/11 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating Surplus	488	13,316
Depreciation and Amortisation	395	13,641
Impairments and Reversals	1,220	1,448
Transfer from the Donated Asset Reserve	(317)	(6,966)
Transfer from the Government Grant Reserve	(3)	(30)
PDC Dividend Paid	(2,689)	(5,664)
Decrease in Inventories	133	17
Decrease in Trade and Other Receivables	6,233	6,305
(Decrease)/Increase in Trade and Other Payables	(3,465)	9,541
Decrease in Other Current Liabilities	(778)	(27)
Increase in Provisions	389	1,233
Net Cash Inflow from Operating Activities :	***1,606***	***32,814***
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	4	63
Payments for Property, Plant and Equipment	(5,840)	(71,857)
Payments for Intangible Assets	(193)	(647)
Net Cash Outflow from Investing Activities :	**(6,029)**	**(72,441)**
NET CASH OUTFLOW BEFORE FINANCING :	**(4,423)**	**(39,627)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	1,618	15,000
Other Capital Receipts	3,111	48,513
Net Cash Inflow from Financing :	**4,729**	**63,513**
NET INCREASE IN CASH AND CASH EQUIVALENTS :	**306**	**23,886**

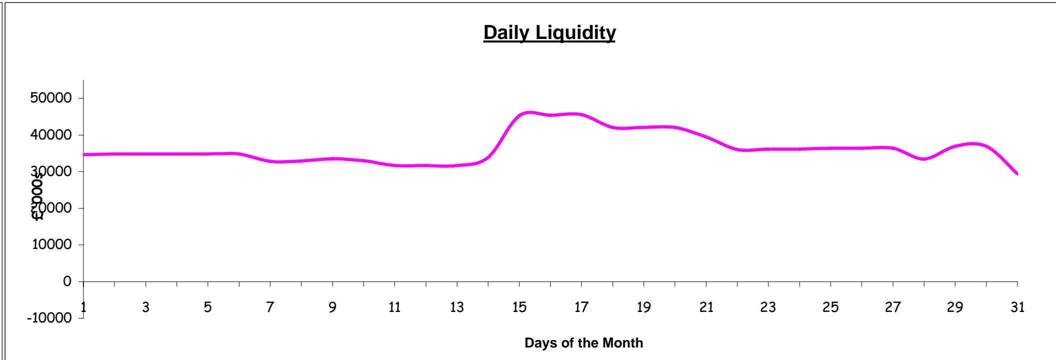
Cash and Cash Equivalents at the Beginning of the current period	**32,065**	**8,485**
Cash and Cash Equivalents at the End of the current period	**32,371**	**32,371**
Net Increase in Cash and Cash Equivalents per SOFP :	**306**	**23,886**

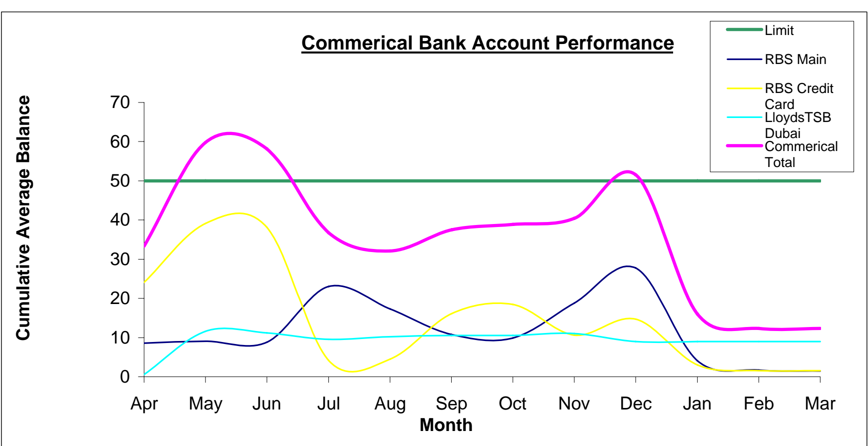
Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/2011
Activity

	April	May	June	July	August	September	October	November	December	January	February	March	YTD 10/11 Actual	YTD 10/11 Plan	YTD 10/11 Variance	YTD 09/10	Variance 10/11 to 09/10
Elective PBR	1,432	1,310	1,517	1,531	1,374	1,483	1,482	1,628	1,195	1,364	1,501	1,702	17,519	18,626	-1,107	18,696	-1,177
Elective Non PBR	149	192	186	186	156	200	189	202	126	163	176	187	2,112	1,526	586	1,470	642
TOTAL ELECTIVE	1,581	1,502	1,703	1,717	1,530	1,683	1,671	1,830	1,321	1,527	1,677	1,889	19,631	20,152	-521	20,166	-535
Non Elective PBR	121	146	129	147	127	137	150	144	187	167	137	130	1,722	1,507	215	1,687	35
Non Elective Non PBR	2	2	3	4	2	5	2	2	3	3	3	2	33	53	-20	78	-45
TOTAL NON ELECTIVE	123	148	132	151	129	142	152	146	190	170	140	132	1,755	1,560	195	1,765	-10
Outpatients PBR	5,579	5,652	5,825	5,808	5,385	5,945	5,479	6,128	4,593	5,575	5,816	6,476	68,261	64,335	3,926	71,570	-3,309
Outpatients Non PBR	4,784	4,950	5,481	5,183	4,659	5,341	5,408	5,578	4,229	5,064	4,990	5,882	61,549	50,815	10,734	52,344	9,205
TOTAL OUTPATIENTS	10,363	10,602	11,306	10,991	10,044	11,286	10,887	11,706	8,822	10,639	10,806	12,358	129,810	115,150	14,660	123,914	5,896
POC (Non Consortium)	941	936	1,016	1,021	996	1,006	844	849	853	866	866	812	11,006	13,048	-2,042	12,260	-1,254
BEDDAYS (includes PICU Consortium)																	
Panda HDU (PBR HDU)	616	507	922	1,002	896	863	681	580	647	581	494	670	8,459	8,680	-221	9,694	-1,235
Transitional Care	120	123	136	181	170	150	144	77	62	101	112	119	1,495	1,942	-447	1,340	155
Rheumatology Rehab	191	187	175	188	187	164	231	181	125	155	174	203	2,161	2,080	81	2,034	127
CAMHS	210	209	201	197	220	226	247	239	254	241	224	261	2,729	1,549	1,180	1,748	981
Cardiac ECMO	5	12	5	0	8	4	34	11	12	0	0	5	96	153	-57	94	2
Neurosurgery HDU (NC)	0	0	0	3	11	14	1	6	0	0	4	0	39	41	-2	0	39
Neurosurgery (PICU Consortium-ITU & HDU)	39	43	22	105	93	133	87	52	17	19	85	68	763	949	-186	691	72
Neurosurgery ITU (NC)	0	0	0	0	0	0	8	0	2	12	0	0	22	41	-19	0	22
Cardiac HDU (NC)	34	40	30	16	22	19	27	53	64	49	31	10	395	251	144	222	173
Cardiac ITU (NC)	105	108	144	93	137	134	164	140	113	76	71	70	1,355	754	601	673	682
Cardiac (PICU Consortium-ITU)	135	211	196	227	209	169	201	214	200	216	153	291	2,422	2,103	319	2,285	137
Paediatric ITU (NC)	21	62	54	41	36	25	129	74	79	40	53	45	659	729	-70	741	-82
Paediatric ITU (PICU Consortium)	371	387	333	378	427	389	339	380	442	384	325	400	4,555	4,007	548	3,962	593
TOTAL BEDDAYS	1,847	1,889	2,218	2,431	2,416	2,290	2,293	2,007	2,017	1,874	1,726	2,142	25,150	23,279	1,871	23,484	1,666
HaemOnc Consortium*																	
PBR	42	43	41	41	50	59	57	48	55	58	48	55	597	797	-200	1,149	-552
NON PBR	117	52	129	120	111	139	170	161	133	134	152	161	1,579	22	1,557	0	1,579
Panda HDU (PBR HDU)	88	139	177	309	248	281	285	269	273	238	168	129	2,604	2,511	93	0	2,604
TOTAL HAEMONC	247	234	347	470	409	479	512	478	461	430	368	345	4,780	3,330	1,450	1,149	3,631

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Cash Management





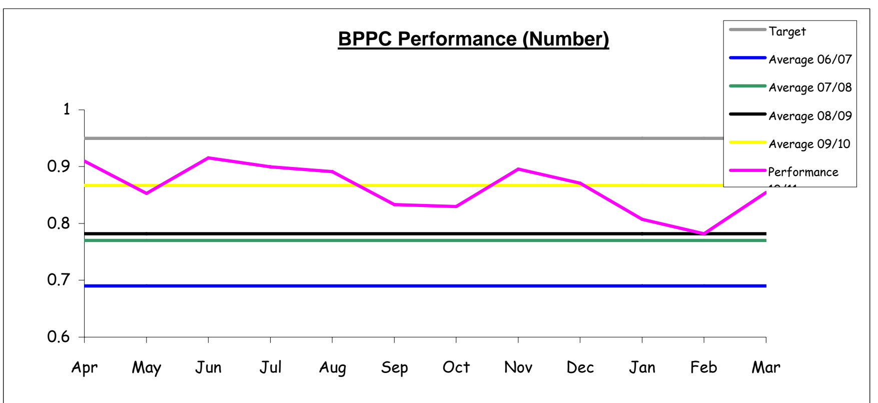


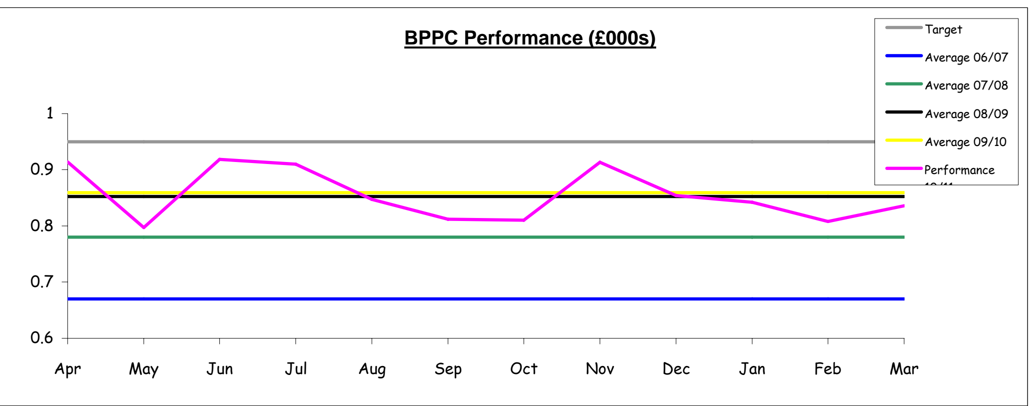
Payables Analysis

Days	Current Month	Previous Month	Movement in Month
	£000s	£000s	£000s
Not Yet Due	9,884	4,214	5,670
1-30	2,045	2,300	(255)
31-60	880	981	(101)
61-90	722	495	227
91-120	466	340	126
121-180	1,515	468	1,047
180-360	991	1,021	(30)
360+	1,598	1,543	55
	18,101	**11,362**	**6,739**

Better Payment Practice Code (BPPC)

	Number	£000s
Non-NHS Payables		
Invoices paid in the year	86824	217,118
Invoices paid within target	76545	189,378
% of Invoices paid within target	88.2%	87.2%
NHS Payables		
Invoices paid in the year	3673	19,645
Invoices paid within target	1968	12,621
% of Invoices paid within target	53.6%	64.2%





Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Receivables Management

Net Receivables in £'000's	Total	Cash on Account	Not Yet Due	Overdue						
				0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	**4543**	-910	3664	152	181	154	93	203	852	154
NHS Credit Note Provision	-1034	0	0	0	0	0	-22	-32	-472	-509
Specific NHS Debt Provisions	0									
NHS Net Receivables	**3509**	**-910**	**3664**	**152**	**181**	**154**	**72**	**172**	**379**	**-355**
Non-NHS	**2830**	-17	1589	400	115	31	190	177	181	165
Bad Debt Provision-Non NHS	-710	0	-183	-42	-53	-9	-44	-20	-193	-167
Specific Non-NHS Debt Provisions	0									
	0	0	0	0	0	0	0	0	0	0
Non-NHS Net Receivables	**2120**	**-17**	**1405**	**358**	**62**	**22**	**146**	**157**	**-12**	**-2**
International	**7053**	-819	5078	935	481	338	140	135	348	415
Bad Debt Provision-International	-788	0	-3	-1	-0	-1	-28	-27	-304	-423
International Net Receivables	**6265**	**-819**	**5075**	**935**	**481**	**337**	**112**	**108**	**45**	**-8**
GOSH Charity Receivables	**1055**	-1	987	63	3	0	-0	0	4	0
Specific Activity Provisions	0	0	0	0	0	0	0	0	0	0
Net Trust Receivables	**12949**	**-1747**	**11131**	**1508**	**726**	**514**	**330**	**436**	**416**	**-365**

Trust Receivables in £'000's	Total	Cash on Account	Not Yet Due	Overdue						
				0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
NHS	4543	-910	3664	152	181	154	93	203	852	154
Non-NHS	2830	-17	1589	400	115	31	190	177	181	165
International	7053	-819	5078	935	481	338	140	135	348	415
Gross Trading Receivables	**14426**	**-1745**	**10330**	**1487**	**777**	**524**	**423**	**515**	**1381**	**734**
GOSH Charity Receivables	1055	-1	987	63	3	0	-0	0	4	0
Total Trust Receivables	**15481**	**-1747**	**11317**	**1550**	**779**	**524**	**423**	**515**	**1385**	**734**

Movement in £'000's	Total	Cash on Account	Not Yet Due	Overdue						
				0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
Gross Trading Receivables (as above)	15481	-1747	11317	1550	779	524	423	515	1385	734
Gross Trading Receivables (last month)	22397	-1537	10518	3419	3953	896	1468	744	2050	886
Movement in Month	**-6916**	**-209**	**799**	**-1869**	**-3174**	**-373**	**-1044**	**-229**	**-665**	**-151**
Gross Trading Receivables (year end 09/10)	24,225	-922	15,403	2,627	1,990	1,802	373	691	1,392	869
Movement in Financial Year	**-2,816**	**-1,076**	**-7,585**	**994**	**2,174**	**738**	**-139**	**1,713**	**-170**	**535**

Systems Schedule

Receivables in £'000's	Gross Receivables	Cash on Account	Not Yet Due	Overdue						
				0 - 30 Days	31 - 60 Days	61 - 90 Days	91 - 120 Days	121 - 180 Days	181 - 360 Days	Over 360 Days
eFinancial	8428	-928	6240	615	299	185	283	380	1036	319
Compucare	7053	-819	5078	935	481	338	140	135	348	415
Trust Receivables	**15481**	**-1747**	**11317**	**1550**	**779**	**524**	**423**	**515**	**1385**	**734**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Capital Expenditure (£000s)

Spend by Project		Year to Date (YTD)		
		Revised Plan (YTD) £'000	**Actual (YTD)** £'000	Variance (YTD) £'000
Redevelopment Projects				
	Trust/DH Funded	15,000	**15,000**	(0)
	Donated Funded	56,230	**47,224**	9,006
	Total :	**71,230**	**62,224**	**9,006**
Estates Maintenance Projects				
	Trust/DH Funded	7,572	**8,506**	(934)
	Donated Funded	0	**479**	(479)
	Total :	**7,572**	**8,985**	**(1,413)**
IT Projects				
	Trust/DH Funded	5,426	**4,525**	901
	Donated Funded	1,365	**0**	1,365
	Total:	**6,791**	**4,525**	**2,266**
Medical Equipment Projects				
	Trust/DH Funded	252	**334**	(82)
	Donated Funded	1,500	**1,531**	(31)
		1,752	**1,865**	**(113)**
	Total Additions in Year	**87,345**	**77,599**	**9,745**
Asset Disposals		**0**	**(633)**	**633**
Donated Funded Projects		(59,095)	(49,234)	(9,861)
	Charge Against CRL Target	**28,250**	**27,732**	**517**

Great Ormond Street Hospital for Children NHS Trust
Finance and Activity Performance Report Period 12 2010/11
Staffing WTE

Permanent (Excludes Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Period 12	Plan*	Variance
Cardiac	310	311	310	309	318	319	329	334	331	339	341	342	378	36
Surgery	599	610	618	622	616	627	635	638	642	643	645	646	697	50
DTS	498	496	500	502	514	511	512	344	343	343	344	349	338	-11
ICI	283	282	281	282	280	284	289	458	462	466	471	460	483	23
International	104	101	101	103	108	110	115	115	119	116	116	115	131	16
Medicine	258	227	262	260	262	261	263	272	273	275	277	282	249	-33
Neurosciences	240	241	245	235	233	241	246	240	244	241	248	255	275	21
Haringey	159	160	170	171	170	176	187	185	183	181	184	183	208	24
North Mid.	126	3	0	0	0	0	0	0	0	0	0	0	0	0
Children's Population Health	6	6	6	6	6	6	7	7	6	8	7	7	4	-4
Operations & Facilities	211	207	205	209	208	207	201	200	201	202	203	208	239	31
Corporate Affairs	14	18	13	13	14	14	15	14	12	15	15	13	13	0
Estates	38	38	38	36	38	41	46	47	46	45	47	48	59	11
Finance & ICT	130	125	124	129	130	132	134	133	133	136	134	134	160	26
Human Resources	57	56	54	50	55	57	57	59	59	58	58	57	58	1
Medical Director	18	18	18	18	17	17	17	21	20	16	14	15	20	6
Nursing And Workforce Development	72	75	73	72	79	83	77	75	76	77	82	80	87	7
Research And Innovation	75	74	67	68	67	69	67	72	73	75	75	77	67	-9
Redevelopment Revenue Costs	0	0	0	0	8	9	7	8	8	8	7	7	0	-7
TOTAL	3197	3050	3087	3,086	3,124	3,165	3,203	3,223	3,229	3,245	3,271	3,279	3467	188

Overtime

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Period 12	Plan	Variance
Cardiac	4.2	1.9	3.3	2.2	2.8	3.0	3.4	3.6	2.7	2.4	2.2	2.6	0.0	-2.6
Surgery	6.9	4.6	2.7	2.7	3.5	3.3	2.6	3.3	3.5	2.5	2.8	2.6	0.0	-2.6
DTS	2.7	0.7	1.5	1.1	0.6	1.0	0.9	0.6	1.5	1.1	0.9	0.5	0.0	-0.5
ICI	2.8	2.8	1.8	1.8	1.9	2.7	1.2	0.8	0.6	0.4	0.5	0.5	0.0	-0.5
International	1.9	1.7	1.8	1.4	3.0	1.7	2.1	1.7	1.7	1.5	2.0	1.8	0.0	-1.8
Medicine	2.9	2.5	2.2	2.7	1.7	1.5	1.3	1.3	0.6	0.4	0.3	0.3	0.0	-0.3
Neurosciences	1.5	0.3	0.4	0.9	0.6	0.7	0.7	0.4	0.6	0.3	0.5	0.8	0.0	-0.8
Haringey	0.4	0.0	0.2	0.0	0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0
North Mid.	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Children's Population Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Operations & Facilities	2.6	9.8	6.1	6.5	6.1	6.5	4.3	4.1	3.8	3.6	3.0	4.2	0.0	-4.2
Corporate Affairs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates	2.3	1.9	2.4	1.9	2.9	1.3	2.3	3.4	2.8	1.7	2.0	2.3	0.0	-2.3
Finance & ICT	1.8	1.0	0.9	0.7	1.1	0.9	1.9	1.1	1.5	1.9	1.1	1.2	0.0	-1.2
Human Resources	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medical Director	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Nursing And Workforce Development	0.3	0.1	0.2	0.2	0.0	0.2	0.0	0.0	0.1	0.2	0.2	0.2	0.0	-0.2
Research And Development	1.1	0.1	0.1	0.0	0.0	0.2	0.0	0.0	0.4	0.1	0.1	0.1	0.0	-0.1
Redevelopment Revenue Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	31.7	27.4	23.7	22.0	24.2	23.0	20.9	20.3	19.9	16.1	15.5	17.0	0.0	-17.0

Agency/Locum/Bank

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Period 12	Plan	Variance
Cardiac	31	42	36	37	38	39	49	42	39	35	31	50	0	-50
Surgery	77	79	88	89	79	69	84	77	65	50	65	80	0	-80
DTS	22	26	25	27	20	24	20	13	15	19	11	19	0	-19
ICI	32	47	40	32	34	43	40	47	42	36	41	58	0	-58
International	29	32	30	31	33	31	38	40	39	30	34	35	0	-35
Medicine	24	33	30	21	22	19	28	27	23	23	23	28	0	-28
Neurosciences	15	20	18	21	22	23	24	25	25	23	32	33	0	-33
Haringey	32	41	34	24	22	23	21	29	10	5	5	14	0	-14
North Mid.	18	2	0	0	1	0	0	0	0	0	0	0	0	0
Children's Population Health	0	1	0	0	1	0	1	1	1	1	0	0	0	0
Operations & Facilities	17	16	16	23	17	21	23	24	14	31	14	22	0	-22
Corporate Affairs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Estates	5	9	11	19	11	12	9	13	10	11	5	5	0	-5
Finance & ICT	16	15	17	16	16	14	13	14	14	16	18	14	0	-14
Human Resources	6	5	8	6	6	3	4	3	6	2	4	8	0	-8
Medical Director	3	1	1	1	1	1	1	2	1	4	1	2	0	-2
Nursing And Workforce Development	3	3	3	3	2	1	1	4	0	1	0	5	0	-5
Research And Development	0	0	2	1	1	1	2	0	5	1	2	5	0	-5
Redevelopment Revenue Costs	0	1	1	1	1	2	2	1	3	0	1	4	0	-4
TOTAL	331	374	361	355	326	325	358	362	311	289	289	383	0	-383

TOTAL STAFFING (Excluding Maternity Leave)

Unit	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Period 12	Plan	Variance
Cardiac	345	355	350	349	359	361	382	379	373	376	374	395	378	-17
Surgery	683	694	709	714	698	700	721	719	710	696	713	729	697	-33
DTS	522	523	526	530	534	536	532	358	359	364	356	369	338	-31
ICI	317	332	322	316	316	330	331	506	504	503	513	519	483	-36
International	134	135	132	136	144	143	154	157	159	148	152	151	131	-20
Medicine	285	262	294	284	285	281	292	300	297	298	301	311	249	-61
Neurosciences	256	261	264	257	255	265	271	266	270	264	281	289	275	-13
Haringey	191	201	203	196	192	199	208	214	192	186	190	198	208	10
North Mid.	144	5	0	0	1	0	0	0	0	0	0	0	0	0
Children's Population Health	6	7	7	7	7	7	7	8	7	9	7	7	4	-4
Operations & Facilities	231	233	227	238	231	234	229	228	219	236	220	234	239	5
Corporate Affairs	15	18	14	13	14	14	15	14	12	15	15	13	13	0
Estates	45	50	52	56	53	54	57	63	59	58	53	55	59	3
Finance & ICT	148	141	143	146	147	147	148	148	148	155	154	149	160	11
Human Resources	63	61	62	56	62	61	61	63	65	60	62	65	58	-7
Medical Director	21	19	20	20	18	18	18	23	21	20	16	16	20	4
Nursing And Workforce Development	75	78	76	75	82	84	78	79	76	78	82	85	87	2
Research And Development	77	74	69	69	68	70	69	73	78	77	77	81	67	-14
Redevelopment Revenue Costs	1	2	1	2	10	10	9	9	11	9	9	12	0	-11
TOTAL	3,559	3,452	3,471	3,462	3,475	3,513	3,582	3,605	3,560	3,550	3,575	3,679	3,467	-212

* Wte plan has been adjusted pro rata across Units to reflect the unallocated pay CRES target.

Great Ormond Street Hospital for Children NHS Trust

Trust Board
25 May 2011

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

Aims / summary

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

The "Evidence of meeting statutory targets" criteria have been rated amber (no change). Both hospital acquired infection indicators (c. diff – 2 cases; MRSA – 1 case) are above trajectory. It is also noted that the 95th centile of admitted pathway waiting time was over 23 weeks in Nov 10 and Feb 11. This indicator replaces the previous 18 week waiting time indicator.

The overall "Financially viable" assessment is rated amber (no change). The main financial risks are CRES delivery and commissioner contract requirements.

A response following the Department of Health review of the application is due by 20 May. The delay in receiving the response is likely to cause further delay to the whole programme. The earliest possible authorisation date is 1 October 2011.

Key actions for the next month:

- Complete DH assurance process
- Commence election process for the Members' Council
- Commence Monitor assessment process.

Action required from the meeting
To note the current position

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

Financial implications: None

Legal issues: None

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

Who needs to be told about any decision Not required

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

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

Author and date
Sven Bunn
16 May 2011

Attachment O

Foundation Trust application – May 2011 position

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

1. Legally constituted and representative		**Green**
The trust's proposed NHS foundation trust application is compliant with current legislation	• Draft constitution completed and approved by Trust Board (July 2010). Confirmation of compliance with NHS Act 2006 received from Capsticks (Jan 2011). • Principles for membership and representation agreed (age limits and constituencies). • Members' Council and Board of Directors' standing orders drafted.	Green
The trust has carried out due consultation process	• Consultation commenced on 9 Feb 10 and was completed on 18 June 2010. • A broad range of consultation meetings were held for both public and staff consultation processes. • Consultation feedback was provided on 13 August 2010.	Green
Membership is representative and sufficient to enable credible governor elections	• Currently ~7,500 members. • Opt-out system for staff membership; appointment of FT ambassadors to promote involvement • Face to face and direct mail recruitment activities have been restarted to replace members who have moved.	Amber
2. Good business strategy		**Green**
Strategic fit with SHA direction of travel	• Participation in London specialised children's services review. Support development of specialist paediatric networks. • Paediatric cardiac review • Paediatric neurosurgery review	Green
Commissioner support to strategy	• Meetings held with NCG, NHS London and local commissioners supported principles of growth • **Reconfirmation of support received** from NHS North Central London, London SCG, East of England SCG and National Commissioning Group (84% of NHS contract income).	Green
Takes account of local/national issues	• Thorough and detailed market assessment completed • Involved in national service reviews • Anticipate tougher economic conditions from 11/12 onwards.	Green
Good market, PEST and SWOT analyses	• Specialty based market assessments which encompass portfolio, strategic and competitor analysis. • SWOT and PEST analyses updated as part of IBP development. • External assurance of market assessment completed.	Green
3. Financially viable		**Amber**
FRR of at least 3 under a downside scenario	• Currently 3 in all years • Risks from CRES delivery	Amber
Surplus by year three under a downside scenario and reasonable level of cash	• As above.	Green
Above underpinned by a set of reasonable assumptions	• Assumptions generated and downside modelling completed. • External assurance completed.	Green
Commissioner support for activity and service development assumptions	• Support letters received from NHS North Central London, London SCG, East of England SCG and National Commissioning Group (84% of NHS contract income) • Risks to income from 11/12 commissioner proposals.	Amber

Attachment O

4. Well governed		Green
Evidence of meeting statutory targets	• Current CQC assessment: Fair – quality of service; Good – financial performance. • Would have achieved "Excellent" rating for quality of service in 2009/10. • **HAI Performance (c. diff – 2 cases; MRSA – 1 case).** • **95th centile of admitted pathway waiting time was over 23 weeks in Nov 10 and Feb 11.**	Amber
Declaring full compliance or robust action plans in place	• Achieved full CQC registration. • Robust action plan has been developed as a result of boiler failure. HSE improvement notice now lifted.	Green
Comprehensive and effective performance management systems in place	• Well developed corporate and clinical unit level performance management and risk management systems. • Further work is required on specialty and service level systems.	Green
5. Capable board to deliver		**Green**
Evidence of reconciliation of skills and experience to requirements of the strategy	• Board effectiveness assessment and board development process completed. Board skills analysis will be completed by December 2010. • Clinical unit development started in March 10. • External support for board development has been provided.	Green
Evidence of independent analysis of board capability/capacity	• Board effectiveness assessment completed. • External assurance programme completed. • On-going board development programme.	Green
Evidence of learning appetite via NHS foundation trust processes	• Board development programme. • External board assessment	Green
Evidence of effective, evidence based decision making processes	• Governance structure • Existing TB and MB minutes	Green
6. Good service performance		**Green**
Evidence of meeting all statutory and national/local targets	• Good performance management system • **HAI Performance (c. diff – 2 cases; MRSA – 1 case)** • **18 admitted patient pathway over target**	Amber
Evidence of no issues, concerns, or reports from third parties, e.g. HCC and in future CQC	• HSE improvement notice relating to boiler incident has been lifted (July 2010). • Awaiting final HSE report.	Green
Evidence that delivery is meeting or exceeding plans	• Good performance management system	Green
7. Local health economy issues / external relations		**Green**
If local health economy financial recovery plans in place, does the application adequately reflect this?	• Participation in London specialised children's services review. • Participation in national reviews	Green
Any commissioner disinvestment or contestability	• None	Green
Effective and appropriate contractual relations in place	• Commissioner Forum • Risk to commissioner agreement with growth plans	Green
Other key stakeholders such as local authorities, SHAs, other trusts, etc.	• Good working relationships	Green

Sven Bunn
16 May 2011

Attachment P

Trust Board **May 2011**	
Title of document Review of key deliverables for 2010-11 **Submitted on behalf of.** Fiona Dalton, Chief Operating Officer	**Paper No: Attachment P** **Date considered by Trust Board** May 2011
Aims / summary For 2010-11 the Trust Board agreed 11 key deliverable outcomes by which we could judge our performance over the year. Overall the Trust performed well. Out of the 11 key deliverables, 9 were rated green and 2 rated amber. The amber rated deliverables related to Business Process Management (BPM) not gaining Board approval and to the organisational model for UCLP back office functions not yet being finalised. The report summarises our assessment of each deliverable outcome.	
Action required from the meeting Trust Board are asked to note the report.	
Contribution to the delivery of NHS / Trust strategies and plans To ensure that the Trust is working coherently and effectively towards our Strategic Objectives	
Financial implications None	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? Senior Management Team	
Who needs to be told about any decision Senior Management Team	
Who is responsible for implementing the proposals / project and anticipated timescales Executive Team	
Who is accountable for the implementation of the proposal / project Executive Team	
Author and date Daniel Dacre, Planning and Performance Manager May 2011	

Progress against Trust Objective Key Deliverable Measures 2010/11

	Key deliverable measure	RAG	Assessment of progress	More detail
1	Ensure GOSH retains full CQC registration by delivering key safety improvements and governance structures.	Green	We have retained CQC registration for 2010-11	GOSH has a safety programme that aims to minimise serious incidents and risk through reflective organisational learning as well as an proactive programme focussing on the areas of harm that can occur to children. This includes understanding the nature of harm through the trigger tool and review of notes, improving medication administration (PICU and CICU leading), and decreasing hospital acquired infections such as MRSA, central line and surgical site infections. A major success over the past year has been the gradual integration of safety as part of the day to day management of the hospital along with other operational activity.
2	Publish the Quality Account and demonstrate world-class benchmarked clinical outcomes.	Green	The Quality Account was published on time.	Every speciality has identified two clinical outcomes and a plan to measure, analyse and publish these over the next year is in place. We have published 20 clinical outcomes from nine specialities on the GOSH external website and plan to increase the number of clinical outcomes available from at least a further nine specialities over the next year. Of the clinical outcomes that are published, 8 are benchmarked against either national standards or other organisations.
3	Progress Foundation Trust application.	Green	We have made good progress with our FT application.	Our application was submitted to the Department of Health at the end of January and we are preparing for the Monitor assessment
4	Improve congruency of clinical and R & D strategies.	Green	The research strategy which is congruent with our clinical strategy has been agreed at Trust Board.	We have established a new Research & Innovation division to deliver the strategy.
5	Leverage R&D and non R&D benefits from UCLP	Amber	Progress has been made in rationalising support services and back office functions across UCLP	We have not yet agreed a finalised organisational model for back office functions. A proposed model is due shortly.
6	Secure advantages from the national paediatric cardiac & neuro surgery reviews.	Green	We are in a strong position within both reviews.	For cardiac-surgery we are in all four options undergoing consultation and would grow significantly under each. For neuro-surgery we have had good feedback from the visit that confirms us as the largest centre and continue to work within the review to get benefits.
7	Complete the referrer survey and progress an agreed action plan.	Green	The referrer survey was completed and an agreed action plan is being progressed by a multi-disciplinary group.	Key areas of improvement include our discharge summaries and we have initiated a project to establish a real time bed management system
8	Deliver planned financial surplus through achieving income and efficiency goals.	Green	We delivered a surplus as planned.	This was supported by the delivery of CRES and increased income through treating more patients.
9	Deliver IT improvements to plan (including BPM if Trust Board approves).	Amber	Good progress was made on planned infrastructure projects but BPM did not gain Board approval.	Key projects that were completed include; wireless asset tracking (1200 assets tagged), deployment of virtualisation technology, replacement of CareVue workstations and the Clinical Documents Database. We also moved to twin server room operation improving business continuity (all IT systems continued operating during recent site wide power outage).
10	Progress Phase 2A building and 2B planning to meet future clinical needs.	Green	We have made planned progress on Phase 2A and 2B	The operational commissioning effort for the Morgan Stanley Clinical Building - due to be handed-over by the Contractor in December 2011 - has started and services will move to this new clinical facility between March and May 2012. The Enabling Works for Phase 2B will start on site in August 2011 and the Full Business Case for Phase 2B itself will be submitted in September 2011
11	Achieve better than NHS average staff satisfaction scores by ensuring all staff work in a supportive team environment with good training and education opportunities.	Green	Overall we did well. We scored better than average on three of the satisfaction scores and average on the fourth.	GOSH also scored better than average in feeling valued by work colleagues, quality of Job design, Support from immediate managers, overall job satisfaction and all of the education and training section. Effective teamworking rated average while we scored below average for staff feeling satisfied with the quality of work they were able to deliver.

Attachment Q

<table>
<tr><td colspan="2">Trust Board Meeting
25 May 2011</td></tr>
<tr><td rowspan="2">Title of document
Action plan for delivering Trust Education Strategy 2011-2012

Submitted on behalf of
Liz Morgan</td><td>Agenda item: Attachment Q

Paper No:</td></tr>
<tr><td>Date considered by Management Board
19th May 2011</td></tr>
<tr><td colspan="2">Aims / summary
The Trust Education five year strategy was approved by Management Board and Trust Board in November 2010.This paper details an action plan to deliver the first year of the strategy. The paper also describes a framework for managing the delivery of the plan as well as detailing a Board assurance framework.</td></tr>
<tr><td colspan="2">Action required from the meeting
Management Board is asked to approve the 2011/12 objectives and action plan.
Management Board is asked to note and support the need for alternative Simulation space in light of the planned Phase 2B re-development.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
An element of the Trust mission is: ‘To share our expertise through education and the training of children’s healthcare professionals so that more children benefit from our work’. This strategy underpins that goal whilst also supporting the delivery of world-class clinical care and innovative clinical research as reflected in the Trust strategic aim to ‘recruit, train and retain the very best staff’.</td></tr>
<tr><td colspan="2">Financial implications
The action plan has been developed within the context of the current agreed financial package. It also sets out to establish stronger processes for additional income generation from GOSH education and the delivery of the Trust education commitments within an ever more efficient and cost effective way.</td></tr>
<tr><td colspan="2">Legal issues
In order to comply with UK legislation and European regulations there are certain general training requirements which the Trust needs to provide all staff. In addition, the NHS Constitution pledges to provide all staff with “personal development, access to appropriate training for their jobs and line management support”</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, members, children and families) and what consultation is planned/has taken place?
The draft paper was circulated to all key stakeholders. Any comments received have been considered and the document updated.</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
The main principles of strategy should be cascaded down to all staff. It should also be shared with FT members and counsellors at the appropriate time.</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
• Asst Director of Nursing Education & Organisational Development
• Head of Education & Training</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
Education & Training Committee</td></tr>
<tr><td colspan="2">Author and date
Chris Caldwell & Geoff Speed
05.05.11</td></tr>
</table>

Attachment Q

Delivering the Trust Education Strategy: Action plan for 2011-2012

1. Introduction and Background

In November 2010 Management Board approved the Education Strategy for 2010-2015. The strategy was subsequently approved by Trust Board.

This paper sets out an action plan for implementing the key strategic priorities for education at GOSH in 2011-2012. It also outlines a revised governance and assurance process to ensure the smooth delivery of the strategy and future annual action plans.

2. GOSH Education Strategy

The five year vision for learning and development at GOSH is summarised below:

The aim of this strategy is to create to create '*A Learning Organisation without Walls'.* The strategy sets out to support organisational development and transformation at GOSH, as well as excellence and innovation in learning for all, to improve the health of children and young people globally. Simulated learning is recognized as a key methodology for ensuring staff safely develop expert and advanced clinical and team working skills.

The full strategy document is included as an appendix to this plan (Annex 3).

3. Education Action Plan 2011-2012

The action plan is presented in order of priority. It is not exhaustive but includes the priorities which will require most action where there is greatest potential risk or where substantial support from managers and Trust Board will be required during the year. The full action plan is presented in Annex 1.

4. Education Governance and Assurance

A revised governance and assurance framework will be introduced as outlined above to support the implementation of the education strategy in line with the recent changes to the strategic leadership of Education at GOSH (Annex 2). The current Education and Training committee will be replaced by a quarterly Strategic Education Committee and a monthly Department Operational Management Board. Data reports from the Education dashboard will be presented at the Operational Board and progress will be reported quarterly to Management Board and Trust Board for information. An annual evaluative report will also be produced.

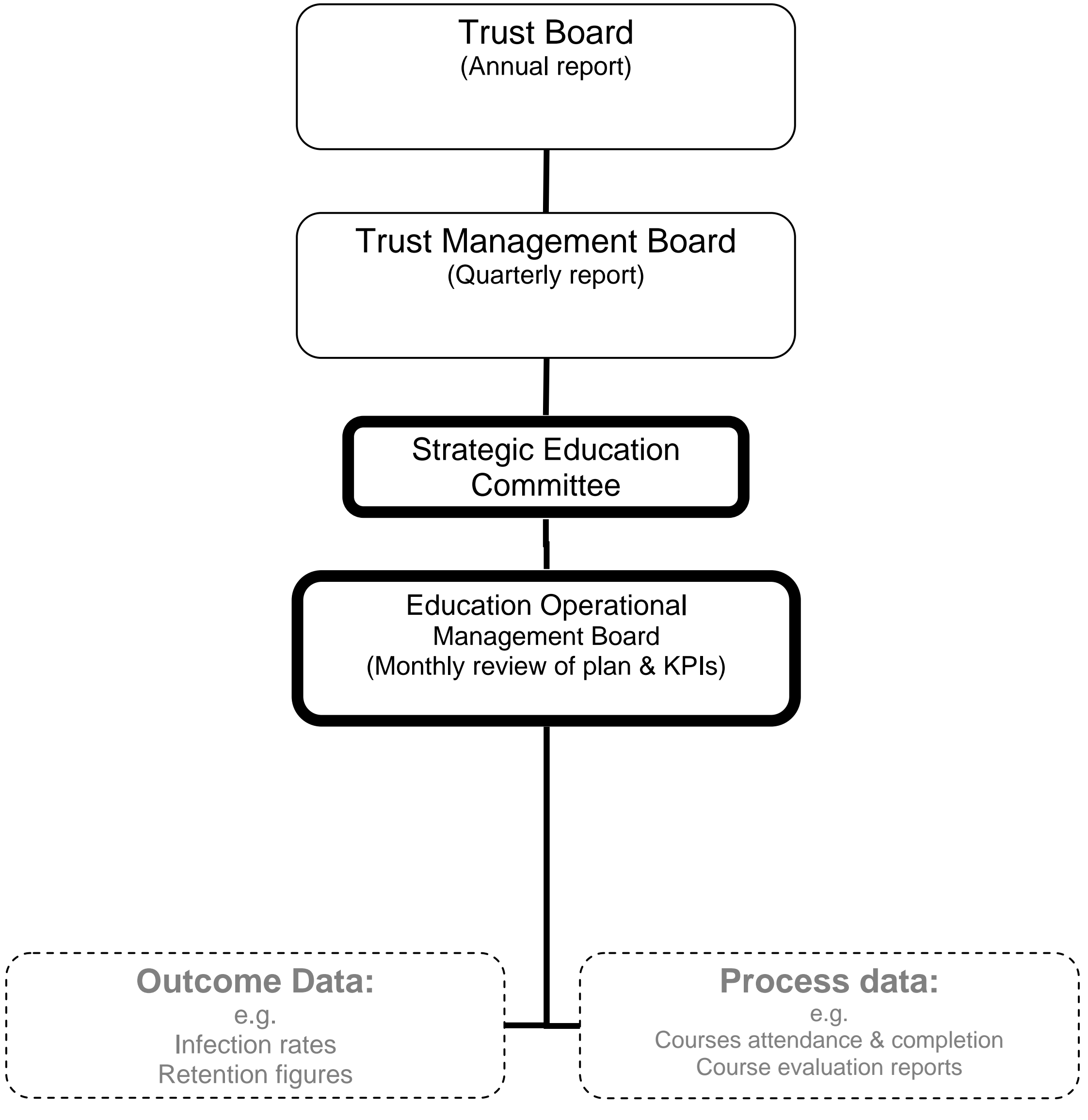
5. Recommendations and Action

Management Board is asked to approve the action plan and associated governance structures.

Author

Liz Morgan
Chief Nurse & Director of Education

Annex 2 Structure for Education Governance and Assurance



Strategic Education Committee (quarterly)
Indicative membership:
Chief Nurse and Director of Education (Chair)
Co-Medical Director (Education)
Assistant Director of Education & Organisational Development (Assistant Chief Nurse)
Operational Head of Education & Training
HR/ Workforce rep (Head of Workforce Planning)
Transformation Programme Manager
General Manager
Clinical Unit Chair

Attachment Q

Educational Operational Management Board

Indicative membership:

Assistant Director of Education & Organisational Development (Assistant Chief Nurse)
Operational Head of Education & Training
Head of PGME
Head of Non-medical Clinical and Nursing Education
Assistant Head of Education & Training
Reps from academic partners
Patient Safety
Unit Operations Manager
Practice Educator rep
Ward Sister / Department Manager rep
Therapies rep
Clinical Scientists rep

Attachment Q

Education Action Plan 2011 -2012

This document sets out the actions planned for the first full year of the Trust's Education strategy 2010-2015. Actions and measures of progress or deliverables are identified to deliver six key objectives. A number of further objectives are listed for information.

The Education strategy was created in response to the Trust Mission: *'To share our expertise through education and the training of children's healthcare professionals so that more children benefit from our work'* As well as the overall Trust strategic objectives: *To 'Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK' and to 'recruit, train and retain the very best staff'.*

The core principles of the education strategy aims to integrate learning and development within GOSH and across academic partners so that:

- All learning must support safety, clinical outcomes and the patient experience.
- The strategy will support continuing clinical competence and clinical excellence by ensuring staff develop the knowledge and skills required to fulfil their role through equitable access to appropriate learning
- Ensure all statutory and mandatory training obligations are met
- We will continue to develop the leadership, management and team-working capacity of Trust
- The learning portfolio will facilitate organisational development and workforce redesign
- All learning can be seen to have a positive impact in the workplace.
- Good practice and success is celebrated and shared.
- Support Staff to develop their careers and fulfil potential
- GOSH will be a lead provider of educational opportunities for child health professionals locally nationally and international
- Explore the commercial potential of GOSH education through the utilisation of the specialist knowledge of our workforce, learning facilities, on-line learning and course places

Attachment Q

Education Action Plan 2011 -2012

No	Objective	Actions	Deliverable / Metric	Timescales
1	Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	• Working in partnership with academic partners, Clinical Unit education leads and Heads of Nursing, General Managers and corporate leads, continue to enhance the quality of the clinical learning environment for all professional learners • Support curriculum development and external education quality reviews • Work with academic partners to ensure the recruitment of high quality learners	• Achieve excellent ratings in the Post Graduate Medical Education and Training Board (Deanery) and and other external reviews (e.g. NMC, CQC) • New LSBU pre-registration BSc (Hons) Children's Nursing programme validated and first two student cohorts commence	31.03.12 31.03.12
2	All staff will have access to essential education and training indicated in their PDR which is required to attain and maintain the skills required to undertake their role	• Support clinical units and corporate departments to undertake annual training needs assessment (TNA) • Design and deliver Internal training programmes and commission external learning in response to TNA • Undertake biannual review of Trust induction and update programmes • Undertake benchmarking of learning provision with external organisations (eg UCLP, Birmingham Children's Hospital, Cincinnati Children's Hospital) • Lead and contribute to UCLP back office programme for statutory/mandatory and management/leadership	• Each Clinical Unit and department produces a Training Needs Analysis (TNA) • At least 90% of staff have had a PDR in the last 12 months • Learning prospectus in place - all programmes delivered[1] , 95% places taken up, 20% reduction in non-attenders • Review of induction and update completed and revised programme in place • Positive evaluation of programmes • Benchmarking and reviews completed and action plans in place • GOSH contribution delivered as planned	31.03.12 31.03.12 01.04.11 – 31.03.12 30.09.11 31.03.12 30.09.11 31.03.12

No	Objective	Actions	Deliverable / Metric	Timescales
		development programmes • Continue to develop GOLD and other innovative cost effective quality learning solutions • Begin to create career development 'route maps' for managers and staff to support personal and role development	• At least 3 additional GOLD programmes launched • Route map for nursing roles created [1] 90 % tolerance to take into account realities of service delivery and ongoing changes required in prospectus to respond to service changes	31.03.12 31.12.11
3	Managers will have access to robust information systems to efficiently monitor staff education and training	• Develop a set of 3 process measures for learning and development (engagement with and quality of learning provision) and identify 3 outcome measures (to demonstrate impact of learning on patient care quality and service efficiency) • Commission and introduce more robust education activity database to replace outdated system • Work with Information Services to create a dashboard to present learning activity undertaken (Trust, Unit, department and individual level) • Discuss with Chief Operating Officer education representative to attending CU and corporate department quarterly reviews to review performance against measures	• 3 process measures identified • 3 outcome measures identified • New database commissioned and implementation plan underway • Dashboard developed and plan to train managers to use it in place • Decision agreed and actioned	30-09.11 30.09.11 31.03.12 31.03.12 31.03.12
4	GOSH will be a leading UK centre for simulated learning in paediatrics	• Create a strategy for the use of simulated learning to improve patient safety and workforce development	• Strategy published and delivery action plan commenced • Scoping completed and simulated learning programme in place	31.03.12 31.03.12 31.03.12

Attachment Q

No	Objective	Actions	Deliverable / Metric	Timescales
		• Scope current simulation activity and identify internal simulation training requirements • Establish fit for purpose simulated learning facilities at GOSH to deliver simulation strategy	• One Clinical Emergency Team (CET) in situ simulation session delivered per month • Managed clinical learning facility in place to replace and further expand the existing temporary space in Cardiac Block • Business case for longer term facilities completed	30.09.11 31.03.12
5	All staff will have the leadership and management skills they require to effectively deliver the service and Trust improvement plans	• In partnership with local managers, review and re-launch GOSH Leadership development framework in the light of the new DH framework • Continue to enhance the provision of coaching and mentoring at GOSH to support service transformation and talent management • Lead the review of leadership training across UCLP • Further develop quality improvement training programmes at GOSH and externally (including UCLP) • Deliver human factors training programme and strategy • Develop training prospectus to reflect lessons of Risky Business	• Revised leadership framework in place • Fourth wave of coaching programme delivered • Internal coaching service launched with at least coaches available • Information about coaching & mentoring at GOSH available on GOLD • 2 cohorts of TIMP programme delivered to at least 25 improvement leaders • Adaptation of TIMP delivered for UCLP • Human factors programme delivered in anaesthetics • See 2. above	30.09.11 31.03.12 01.06.11 01.06.11 31.03.12 31.03.12 31.03.12
6	Commercial potential of GOSH education and training locally, nationally and internationally is fully exploited	• Undertake external market analysis of GOSH programmes • Work with finance department and GOSH charity to begin to build a business model and marketing strategy • Map local education training activity and scope out an accreditation framework for key	• Market analysis complete • Business model and marketing strategy underway • Mapping underway (plan to complete by 31.07.12)	31.12.11 31.03.12 31.03.12

Attachment Q

No	Objective	Actions	Deliverable / Metric	Timescales
		elements of the education portfolio (developing a GOSH education quality 'kitemark') • Work with IPP to market GOSH education programmes internationally	• Year 1 of Kuwait education programme delivered	31.07.11
7	Understand the economic impact of staff education and training activities on service delivery (linked to 2. Above)	• Undertake comparative benchmarking with other NHS and non-NHS organisations (see 2. Above) • Work with General Managers to review and strengthen systems for allocating and monitoring non-medical and study leave allocation and funding • Review Trust Study Leave policy	• Benchmarking exercise completed • Paper summarising the review, recommended actions and revised study leave policy prepared for Trust Management Board	31.12.11 31.03.12
8	Design and implement Trust training framework for Bands 2, 3 and 4 clinical support roles	• Appoint Project Lead • Establish steering group • Develop project plan • Review existing Trust programme in the light of outcomes and experiences of other organisations nationally and internationally • Work with Education team to establish Trust-wide programme • Pilot Trust-wide programme	• Project Lead appointed • Steering group established and meeting as outlined in project plan • Project plan agreed and actioned • Review completed Trust-wide programme established and Trust-wide Pilot programme launched	01.05.11 30.06.11 30.06.11 31.10.11
9	Explore how GOSH can pro-actively respond to the DH reform of workforce development funding	• Engage with NHS London, UCLP, paediatric and North Central London partner organisations to influence emerging structures and processes	• GOSH represented at all key groups and events • GOSH submits reponses to proposals in a timely manner	31.03.12 31.03.12

Great Ormond Street Hospital for Children NHS Trust

NHS

Trust Board Meeting 25th May 2011	
Title of document Annual Safeguarding Report **Submitted on behalf of** Liz Morgan	**Paper No: Attachment R** **Date considered by Management Board: 19th May 2011**
Aims / summary Provide a summary report of Trust progress, activity and achievements April 2010-March 2011 and identify areas of development for 2011-2012.	
Action required from the meeting Ratify report, raise any issues or areas of concern report raises.	
Contribution to the delivery of NHS / Trust strategies and plans CQC Core Standard 2 Child Protection. Requirement also from NHS London that all Trusts are reported to on an annual basis on Child Protection.	
Financial implications None	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, members, children and families) and what consultation is planned/has taken place? Named Child Protection Staff and Management Leads on all sites (GOSH main site, GOSH in Haringey)	
Who needs to be told about any decision Liz Morgan - Board Lead for CP	
Who is responsible for implementing the proposals / project and anticipated timescale Liz Morgan	
Who is accountable for the implementation of the proposal / project Liz Morgan	
Author and date Sonia Jenkins 28th April 2011	

Attachment R

Annual Safeguarding Report

May 2011

Author: Liz Morgan, Chief Nurse/Director of Education

Quality & Safety Committee: 13 May 2011
Management Board: 19 May 2011
Trust Board: 25 May 2011
Camden LSCB:

1. Executive Summary

Safeguarding remains a high priority within both Great Ormond Street Hospital main site as well as its remaining partnership site in Haringey. Continued and consistent commitment to ensuring the Trust responsibilities are fulfilled, have ensured that Safeguarding remains central to the zero harm initiative during 2010/2011.

The agreed annual objectives have been achieved through the dedication and commitment of all GOSH staff, ensuring more robust safeguarding systems are embedded within our systems, processes and structures. Although this has been a successful year safeguarding will always remain a high risk as it is for all services working with children. However, we are confident that we have robust child protection systems in place, alongside a strong assurance framework and appropriate senior child professionals who are able to challenge systems and practice,

External reviews of our safeguarding practice provide additional assurance to the Trust that services, both at GOSH and Haringey comply with national standards. 2010/11 saw heightened activity surrounding the Peter Connelly case and the publication of the Serious Case Review. Trust recommendations from the Joint Area Review (JAR) Action Plan have now all largely been achieved and the next phase of work has moved into a joint Haringey Health Action plan. In GOSH in Haringey both Ofsted's unannounced inspection in August 2010, announced inspection of 2011, and NHS London's peer review of safeguarding arrangements (Safeguarding Improvement Team) in December 2010, noted marked improvements and good practice in Safeguarding.

At GOSH main site, the NHS London's peer review of safeguarding arrangements (Safeguarding Improvement Team) in January 2011 noted a very impressive approach to safeguarding.

Our achievements for 2010-2011 were:-

- Recruitment to key posts in safeguarding team at GOSH
- Overwhelming positive SIT visit to both sites
- The establishment of a First Response Team at Haringey
- Design of Level 3 modular training programme
- Expansion of supervision programme to key specialists groups

This year our priorities for Safeguarding on GOSH main site are:-

- Expand level 3 training towards compliance with national guidelines.
- Identification of a management structure which better reflects the roles and responsibilities of staff with responsibilities for child protection at GOSH.
- Continue to focus on the implementation of group supervision across identified groups.
- Enhance identified areas of development within safeguarding on GOSH main site following the transfer of GOSH in Haringey services to Whittington Health.

2. Background and Introduction

Safeguarding children and young people is central to the care provided by Great Ormond Street Hospital for Children NHS Trust (GOSH). The organisational values 'The child first and always' recognises that all children have the right to grow up unharmed, to have the opportunity to develop to their full potential and to have their essential needs met. It is in this context that the 2010/2011 Safeguarding Annual Report covers activity across the main GOSH site and GOSH in Haringey. Full accounts of this work can be found in the documents referred to in the report.

The aims of the Trust Safeguarding Strategy and the 2010/11 Action Plan are:

- To safely recruit, train, and educate staff, so that children and their families are safely cared for by a competent and capable workforce

- To protect and safeguard children according to national and pan-London policies and procedures, with clarity around action to take when any safety concerns are raised or observed
- To work in effective partnership with all agencies to safely care for and safeguard children, engaging as appropriate with children and their families
- To ensure that the welfare and safety of the children and young people who use the services of GOSH are promoted by all staff and they are aware of their roles and responsibilities within the safeguarding framework
- To provide a framework of supervision and support for staff working with children and families where there are safeguarding concerns.
- To ensure robust oversight, monitoring and assurance processes remained in place in spite of continued focus on the Peter Connelly Serious Case Review.

3. Safe recruitment, education, training, supervision and support of staff

3.1. Child Protection Structure

3.1.1 Changes in Personnel 2010-2011 - GOSH Main site and GOSH in Haringey

Name	Commenced	Left	Role
Liz Morgan	1/06/10		Executive Lead for CP, Chief Nurse & Director of Education
Jan Baker	2/05/10		Named Nurse Child Protection GOSH
Vic Larcher		Retired March 2011	Named Dr Child Protection
Nick Lessof	1/03/11		Named Dr Child Protection
Stan Brandon	February 2010		CP Administrator
Suzanne McFarlane		End of Contract 31/03/11	Practice Educator for Child Protection
Monica King		Resigned May 2010	Named Nurse Child Protection GOSH in Haringey
Teresa Murray	May 2010		Named Nurse Child Protection GOSH in Haringey (Interim post- returned from retirement to provide stability in service until successful hand over to new organisation).

We would like thank Dr Vic Larcher, previous Named Doctor for Child Protection at GOSH who retired in March after many years of service at GOSH, The Royal London Hospital and the Queen Elizabeth Hospital in Hackney.

3.1.2 The General Paediatric Team

The new team of Consultant General Paediatricians (including Dr Lessof) at GOSH started at the beginning of February 2011. Their responsibilities include liaising with the surgical specialities in the in-patient care of children with complex disorders, providing medical leadership to the hospital at night team, increasing the availability of child protection support for the hospital and providing a general paediatric resource for training. The General Paediatric Team sit within the Neurosciences Unit.

3.1.3 Named and Designated Doctor post Camden PCT

Dr Deborah Hodes Named and Designated Doctor for Child Protection Camden resigned her post as Designated Doctor and has now resumed her post of Named Doctor following recommendations from Camden Safeguarding Improvement Team (SIT) visit in July 2010. The post of Designated Doctor is now held by Dr Peter Lachman.

3.1.4 Management & Administration

The Trust administrative structure has proved highly beneficial and successful and has ensured good co-ordination of the administration aspects of strategic safeguarding across the partnership sites particularly in relation to inspections and Serious Case Reviews and external requests/enquiries.

3.1.5 Legal

Trust solicitor Sophie Pownall was appointed in June 2011. The legal team provides effective support to the Safeguarding Team.

3.2 Learning & Development

3.2.1 2010-11 Activity

At 31/03/11

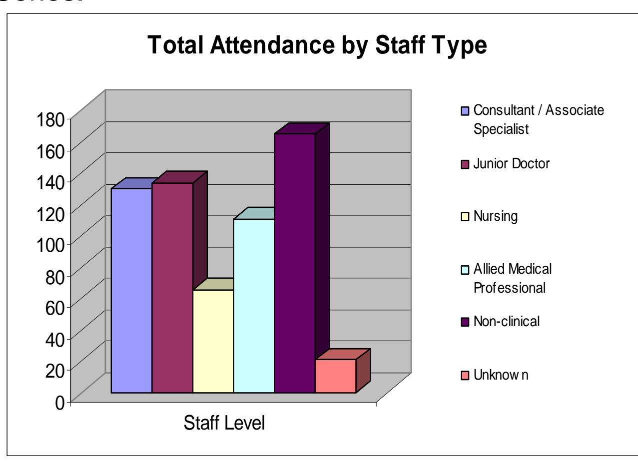
- 84.5% of Trust staff were up to date with their safeguarding learning
- 2474 completed the Trust's safeguarding on-line learning module in the last 18 months (18 months being the Trust's update cycle).

The overall picture for GOSH staff having accessed some form of safeguarding training over the last 3 years (as recommended in the Intercollegiate Guidance Safeguarding Children & Young People: Roles and Competencies for Health Care Staff 2010) is illustrated below:

	Total Staff Trained in skill Child Protection	Total Staff In Staff Group	Percentage
Admin & Clerical	695	845	82%
AHPs	359	403	89%
Clinical Support Ancillary	294	318	92%
Consultant	196	285	69%
Junior Doctor	134	285	47%
Non-Clinical Ancillary	94	116	81%
Nursing	1141	1208	94%
Scientists	233	253	92%
Volunteers or Other	12	17	71%
Not Defined	11	18	61%
Total	**3169**	**3748**	**84.55%**

Managers acknowledge the usefulness of a quarterly report from Education & Training identifying those staff in need of training. This will be enhanced by providing a more detailed breakdown into levels of safeguarding training in line with the SIT recommendation.

The figure below illustrates the attendance at the 2010 PGME level 3 Safeguarding Winter Lecture Series.



The January 2011 SIT visit at GOSH main site commended the Trust safeguarding education provision but recommended increasing provision of level 3 learning. The SIT recommendation requires 80% of the clinical workforce be trained at level 3 (Medical + Nursing + AHPs), which in agreement with Commissioners will be a 2011/12 CQUIN. An action plan is in place to work towards 80% of the clinical workforce meeting this standard by 2014 - 20% per annum over the next three years. Currently the central training database records 618 or 31.26% staff as having attended level 3 training in the past 3 years. (The 2010 PGME safeguarding lecture series and any local activity are currently being merged onto the training database to provide a baseline figure for the Trust).

A safeguarding training needs analysis was repeated in 2010 to attain an overview of staff awareness and confidence in relation to their safeguarding responsibilities, ascertain what progress has been achieved since 2006 and inform what our priorities should be for the future. An analysis of the results is in progress and will form the basis of a report to be presented shortly to Child Protection Management Group (CPMG). However, initial findings indicate an improvement in understanding relevance and confidence with the majority of respondents who require level 3 knowledge expressing confidence in this area.

3.2.2 The Training Strategy for 2011-12

- The focus will be on the level 3 development of the medical and clinical workforce in addition to continuing training at levels 1&2 to ensure staff remain up to date.
- A specific schedule of training at Level 3 has been designed and will be delivered in a variety of modalities to ensure flexibility and ease of access:
  - a) A series of level 3 study days which will also be open to external practitioners enabling us to train up to 100 delegates per event. .
  - b) A series of 1½ hour modules which may be accessed individually or combining four modules in to a one day safeguarding event. .
- PDR's will include a specific question around level 3 training, prompting managers to confirm training has been completed or booked.
- Our review of external on-line level 3 learning modules (e.g. NSPCC, e-learning for Health) will judge whether it is more cost effective to offer these to staff rather than develop further GOSH modules.
- A full Education & Training report is available on request.

3.3 Child Protection Supervision

- Priority area of development on both sites during 2010/2011.
- Supervision arrangements are in place for Child Protection Named Professionals with support from Designate Professionals in the PCT's.
- At GOSH main site, a programme of group supervision was introduced focussing on key groups who encounter high levels of child protection cases namely Clinical Site Practitioners, Children's Acute Transport team, Clinical Nurse Specialist's, Allied Health Professionals, and Band 6 nurses. The Clinical Site Practitioners have been receiving regular supervision since the latter part of 2010 on a 6 weekly basis provided jointly by the Named Nurse and Senior Social Work Practitioner.
- On Rainforest Ward (Gastroenterology, Endocrinology & Metabolic Medicine) reflective sessions are planned for complex cases.

4. Implementing national and pan-London policies and procedures to ensure clear roles and responsibilities for the welfare and safety of children and young people

4.1 GOSH Child Protection Policy Procedures & Guidance 2010

The GOSH Child Protection Policy and Procedure was updated in November to reflect procedures on the GOSH main site only following the transfer of NMUH in April 2010.

4.2 Governance structures

4.2.1 Strategic Safeguarding Committee

- Strategic direction and leadership committee for safeguarding and child protection activity across the Trust, with membership from relevant social care and health partner agencies, reports directly to the Trust Management Board and Trust Board via the Clinical Governance Committee and the Quality and Safety Committee.
- Following a review in March 2011 and with the planned transfer of GOSH in Haringey services in May 2011, it was decided to disband this committee in its current format and incorporate a strategic focus into the CPMG every 4 months. The reporting/assurance structures will be amended to reflect this change.

4.2.2 GOSH main site

Trust Child Protection Management Group

- The Child Protection Management Group (CPMG) meets monthly, with the audit manager now attending the relevant section of meetings. All aspects of responsibility for child protection on the GOSH main site are covered in the meetings.
- CPMG monitors all child protection activity and our responsibilities, on the main site, reviewing issues arising from cases as necessary.

Unit Child Protection Management Groups

- Unit based meetings where senior staff from each specialty take responsibility for child protection and are locally accountable for implementation of policies and procedures, and supervision and training attendance.
- These meetings were audited for feedback in 2010 and the analysis demonstrated a need to have increased ward based meetings in some units to address individual operational issues.

CP Daily briefings

- Circulated on GOSH main site Monday to Friday at 5p.m via a password protected update of high profile or child protection cases of concern, to key members of the 24 hour clinical management team namely the Clinical Site Practitioners, on call Manager and Chief Nurse/Deputy.

4.2.3 GOSH in Haringey

Health Leadership Group for Safeguarding

- This subgroup of the Haringey Local Safeguarding Board is responsible for ensuring the health elements of the multi agency Health Safeguarding Action plan. The group also supported Haringey through a successful second SIT visit in December 2010 and a CQC/Ofsted inspection in January 2011.

5. Effective partnership working with all agencies including engaging with children and their families

5.1 Local Safeguarding Children Board (LSCB) meetings

GOSH is currently not represented on any Safeguarding Children's Board but participates in the Camden SCB subgroups for Quality and Safety and Training and Education. The NHS London SIT highlighted this issue which has been incorporated into the Trust SIT action plan which is for discussion at the Camden Safeguarding Children's Board.

5.2 Social Work Service GOSH

Camden Local Authority announced they plan to withdraw funding for social work provision from the end of July 2011 in response to nationwide reductions in public services. An impact assessment has been undertaken on the provision of Child Protection and wider social work service affecting both safety and quality of outcomes for patients and families needing social work intervention. GOSH have secured alternative funding for two years after which a further review will take place.

5.2.1 Social Care Referral Activity
The total number of referrals (Child Protection and Child in Need) for 2010/11 is 595, an increase of 11.4% since 2009/10.

5.3 First Response in Haringey
This is a multi-agency team including GOSH in Haringey which has been set up to manage all new referrals for children where there are child protection concerns and consists of professionals from health, children's social care and the police. The service has been fully operational since July 2010.

5.4 Case Conference attendance
At GOSH main site during the period April 2010-April 2011, 25 invitations to attend case conferences were received. Of these, 13 were attended, 12 were not attended but reports were submitted.

6. Evidence of improvement and success

Child Protection remains high on our assurance agenda with audit and monitoring activity a priority for the team. We have collated and monitored the various recommendations arising from reports, inspections and reviews by the continued use of the co-ordinated Trust Child Protection Action Plan to monitor and assure against performance/compliance. In addition the action plan reflects ongoing audit activity across all partnership sites and identifies additional areas of development as outlined above.

6.1 External Review Activity / Inspections and Audit
External review activity has continued to be constant in 2010/2011 and reviews have concluded positively that all safeguarding standards have been met, notably OFSTED reviews of safeguarding within both Haringey Children's Services (2010) as well as the NHS London Safeguarding Improvement Team review for both sites (GOSH in Haringey in December 2010 and GOSH main site in January 2011).

6.1.1 Ofsted inspections GOSH in Haringey
August 2010
Ofsted conducted an unannounced inspection on 17th and 18th August 2010 of contact, referral and assessment arrangements within the London Borough of Haringey Children's services. There was positive feedback for the First Response Team which is a multi professional team which screen referrals. This service went live in April 2010. GOSH in Haringey staff are part of this team. Ofsted did not identify any "priority actions" during the inspection.

Ofsted identified strengths as being;
- Rigorous screening of referrals by multidisciplinary team
- Low re–referral rates, good quality/accuracy of assessments and risk analysis.
- Strong community networks and joint working enabling rapid response
- Integration of Common Assessment Framework
- Commitment of all staff, performance and capacity monitoring arrangements

GOSH in Haringey have been working in partnership with a multiagency steering group that designed the service. GOSH provides 4 specialist Health Visitors as part of the service which are integral to assessments. All GOSH in Haringey services are part of community services that respond to children's needs. GOSH in Haringey staff are also members of the Haringey Common Assessment Framework panel.

Parallel auditing of performance management systems in the Local Authority are carried out by GOSH in Haringey which forms the Health scorecard which they have developed. This scorecard system is in the process of being adapted for the GOSH main site.

Areas of Development

- Workload pressures affecting transfer of cases
- Case closure summaries not always demonstrate implementation of agreed plans
- Reporting back to referrers re outcome of initial assessments

These areas of development will be taken forward by the steering group. The inspection demonstrates the good progress made by the Local Authority but also GOSH in Haringey staff.

January 2011
Ofsted inspection (including CQC review) awarded a mixture of 'Adequate' and 'Good' grades. No aspects of the service were graded inadequate.

The contribution of 'Health' to 'Keeping Children Safe' was graded 'adequate'. There were some good examples/comments about GOSH in Haringey Health Visitors, School Nurses and Therapists in particular (as well as some other areas in health e.g. teenage pregnancy, alert systems in both Whittington and North Middlesex Hospitals' Emergency Departments).

Judgements on Leadership & Management, Partnership Working and Capacity to Improve were all graded good. The Trust is very pleased with this result and commend the work of all those involved in the service across all agencies for the huge progress that has been shown.

6.1.2 Safeguarding Improvement Team (SIT) visit at Haringey - December 2010

NHS London was extremely positive about safeguarding children services in Haringey, noting previous improvements had continued apace and been sustained, with evidence of effective systems and processes.

GOSH main site

6.1.3 Safeguarding Improvement Team (SIT) visit at GOSH - January 2011

There were numerous areas highlighted as good practice. The overall view was that the Trust has a very impressive approach to safeguarding, which is given a very clear priority and which is strongly embedded and well resourced.

Five areas for improvement were identified as below and progress will be reported through the quarterly Child Protection report:

1. Consideration of role clarification in safeguarding leadership and unintended impact of the comprehensive social work service.
2. Finalising criteria for receiving L3 training, and setting a target for compliance.
3. Establishing a role on one LSCB.
4. Produce criteria for the lead doctor role in safeguarding.
5. Conclude thinking on board metrics to measure safeguarding performance.

6.2 Serious Case Reviews and Internal Management Reviews

6.2.1 GOSH main site

- In 2010/2011 GOSH main site wrote two Individual Management Reviews (Child C and Child W), liaising with the authorities across the UK holding the Serious Case Review (SCR) to agree recommendations.
- Initial briefings took place with the relevant Clinical Unit Chairs, General Managers and staff directly involved in the two cases. Six learning events for both of these SCR's took place between February and March 2011 which were accessible to all staff.
- Overall there continues to be a reduction in the number of requests for IMR's to all GOSH sites which is in line with national trends.

6.2.2 Reporting arrangements for Serious Case Reviews to NHS London

Following amendments to Chapter 8 of The Working Together to Safeguard Children in March 2010, all Trusts are required to notify NHS London of any request for involvement in SCR's under the Serious Incident process. It has been agreed with NHS London that:

- For those children from outside London GOSH will provide e-mail notification only.
- We will continue to notify NHS London of those SCR's where children are resident in London via the existing Serious Incident process.

The GOSH Child Protection Policy and Procedures 2010 have been updated to incorporate this new guidance.

6.2.3 GOSH in Haringey

- GOSH in Haringey staff were involved in compiling one IMR (Q family) (submitted in November 2010) and were involved in SCR compilation and implementation of subsequent recommendations.
- Staff have also contributed to a review within the pilot of the SCIE (Social Care Institute in Excellence) model which forms part of The Munro Review of Child Protection report 2010 and 2011.
- The redacted versions (1 and 2) of the Peter Connelly Serious Case Review were published on 26 October 2010.

6.3 Audit Activity

The audit plan repeated key areas from the previous year.

- The preliminary results of the 2010 audit for Compliance with Laming Recommendations show a mean compliance with each standard of 61%.
- The CP link audit (which is the audit which ascertains whether standard practice and knowledge in child protection is evident throughout the Trust) is currently underway and will be reported in the next quarter.

6.4 Integration of child protection into the Trust processes for Clinical Governance and Safety

The child protection office continues to work jointly with the Clinical Governance and Safety team. In addition, child protection team continues to report into both the Quality and Safety Committee and the Clinical Governance Committee on a quarterly basis.

6.4.1 The GOSH in Haringey Safeguarding Scorecard

NHS Haringey continues to use an integrated scorecard through which providers report progress quarterly on a range of audited activities to provide performance and quality assurance to the Commissioning Board.

6.4.2 Transfer of services back to North Middlesex University Hospital NHS Trust.

NMUH Children's' Services were transferred back to the Trust on 1st May 2010. The Child Protection Service Level Agreements were agreed in June 2010 and outline GOSH's continued input to support safeguarding children arrangements at NMUH.

7. Looking forward to 2011/12

7.1 Key priorities for Safeguarding

Safeguarding activity plans for the next year are outlined in full in the Annual Trust Child Protection Action Plan. Key features for next year will include continued focus on the identified areas within the GOSH Safeguarding Scorecard and embedding this indicator led focus as a key component of performance.

This year our priorities for Safeguarding are:-

- Expand level 3 training towards compliance with national guidelines and achieve CQUIN 2011/2012.

- Identification of a management structure which better reflects the roles and responsibilities of staff with responsibilities for child protection at GOSH.
- Continue to focus on the implementation of group supervision across identified groups including a monthly “drop-in” clinic with the Named Nurse due to commence in May 2011.
- Enhance identified areas of development within safeguarding on GOSH main site following the transfer of services from GOSH in Haringey.
- To complete the review of the roles, responsibilities and competencies of CP Link Group members.
- Increase the scope of the audit plan to incorporate additional identified themes including those from Serious Case Reviews that GOSH were involved with in 2010.

7.2 GOSH handover of responsibility for GOSH in Haringey community services
Whittington Health NHS Trust will take responsibility for the health visiting, school nursing, Child Development Centre and Child Protection medical service and all related staff from May 2011. We would like to thank our GOSH in Haringey colleagues for all their hard work during the partnership.

7.3 Development of GOSH Safeguarding Scorecard
From May 2011 GOSH main site is adapting the Balanced Scorecard developed in partnership with Haringey which Ofsted commended in 2009 as good practice.
The scorecard focuses on Safeguarding and provides directors and managers with a comprehensive review of organisational performance in relation to quality, delivery, customer satisfaction and financial measures.

Performance indicators to be measured
1. Record Keeping)
2. Child Protection Supervision) CQUIN targets
3. Level 3 training)
4. Internal Management reviews
5. Case Conferences
6. Staffing

The Scorecard will form the basis of future reports.

Documents available on request

- Child Protection Action Plan
- CP work plan
- SCR recommendations action plan
- Audit Plan for 2011-2012

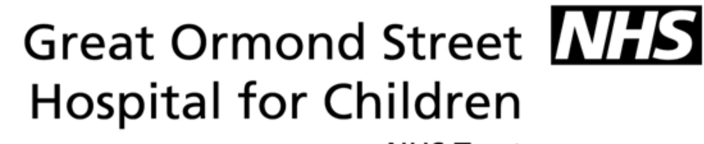
Key staff involved in Safeguarding

Strategic
Dr. Jane Collins – Chief Executive Officer
Liz Morgan –Chief Nurse and Director of Education (Board Lead for Safeguarding from June 2010)
Chris Caldwell – Assistant Director (Acting Board Lead for Safeguarding April-May 2010)
Sonia Jenkins - Child Protection Coordinating Manager

GOSH Main site
Jan Baker – Named Nurse Child Protection
Dr Vic Larcher - Named Doctor Child Protection (Until March 2011)
Dr Nick Lessof - Named Doctor Child Protection (From March 2011)
Andrée Hughes- Senior Child Protection Administrator
Madeline Ismach - Head of Psychosocial and Family services
Marion Cullen - Team Manager GOSH Social Work Department
John Courtney – Assistant Chief Nurse
Sophie Pownall –Trust Solicitor
Jonathan Elwood - Legal Advisor
Salina Parkyn – Acting Assistant Director of Clinical Governance
Geoff Speed - Head of Education and Training
Andrew Pearson- Clinical Audit Manager

GOSH @Haringey Children and Young Peoples Service
Jane Elias - Director of Operations for GOSH in Haringey
Teresa Murray – Acting Senior Named Nurse for Child Protection

Attachment S



Trust Board Meeting **25 May 2011**	
Title of document: Equality and Diversity Report **Submitted on behalf of:** Fiona Dalton and Barbara Buckley	**Paper No: Attachment S**
Aims / summary To provide Trust Board with assurance that the Trust is meeting its statutory obligation under equalities legislation, and to provide a summary of key equality and diversity activity.	
Action required from the meeting To note the contents of the paper	
Contribution to the delivery of NHS / Trust strategies and plans Meeting statutory duty to report publically on this activity. Work promotes fairness and equity in service delivery and employment.	
Financial implications None	
Legal issues Statutory duty to report on this activity	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? Families are represented on the Family Equality and Diversity Group and staff on both FED and the Staff Equality and Diversity Group	
Who needs to be told about any decision N/A	
Who is responsible for implementing the proposals / project and anticipated timescales Family and Staff Equality and Diversity Groups	
Who is accountable for the implementation of the proposal / project Fiona Dalton for staff and Barbara Buckley for families	
Author and date Sue Lyon Beki Moult 10 May 2011	

Attachment S

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS TRUST

Trust Board Meeting
25 May 2011
Annual Equality and Diversity Report

Background

The Equality Act came into force from 1st October 2010. This Act simplified existing equalities law into one single source of Statute. The Act also changed and refined certain concepts and definitions, as well as introducing some new provisions such as employers being liable for third party harassment. In addition to the Act, a new statutory duty (the Equality Duty) came into force in April 2011 and this is applicable to all public sector bodies. Some requirements of the Duty, notably the creation of equality objectives, will come into force from April 2012.

As a Trust we must demonstrate that we comply with the Equality Act and are meeting the Equality Duty through the work we do, the involvement we have of the Trust Board in this work and through publishing a range of equalities data on an annual basis. This paper provides a summary of information to demonstrate to the Trust Board that our duties and responsibilities are being met.

Appendix 1 provides core data, Appendix 2 provides a fuller perspective of data and analysis.

FAMILY EQUALITY AND DIVERSITY GROUP

This annual report covers the period April 2010 – March 2011.

Key Achievements 20010/11

- ***Welcome to GOSH DVD and Essential information booklet:*** The Essential information booklet and DVD continue to be sent to new patients and has been warmly received. Plans for reviewing and updating the DVD are in place for late 2011.
- ***Patient/parent experience:*** Cardiac Services now have a dedicated page on their clinical service web section devoted to patient/parent stories - http://www.gosh.nhs.uk/gosh/clinicalservices/Cardiac_services/CustomMenu_02 . It is not yet known how this will transfer to the new combined website (One Site) currently being planned.
- ***Podcasts:*** Only a few podcasts have been in production this year due to pressure of the One Site project.
- ***Surveys:*** Additional analysis of Urdu speakers was undertaken following this year's inpatient Ipsos MORI inpatient survey. Generally, the responses were similar to the rest of the interviews, with lower satisfaction scores received regarding confidence and trust in doctors and nurses. A stand alone exercise is being planned to hold focus groups with our non-English speaking families although funding has not yet been secured.
- ***Services for families of children with learning disabilities:*** This has been the main focus of work in the previous few months. A baseline audit of current practices has been undertaken and will form the basis of an action plan for the next two years. Initial results from the audit show that, as suspected, there are pockets of very good practice but with little in terms of written policies/procedures to reinforce this.

Key Activity Planned for 2011/12

- Continue to seek funding for focus groups for non-English speaking families.
- Work with Department of Health to implement Equality Delivery System.

STAFF EQUALITY AND DIVERSITY GROUP

Data relating to staff, their employment and corresponding equality and diversity issues can be found contained within Appendix 1. Appendix 2 provides more detailed data and information.

Key achievements in 2010/11

- Previous and ongoing improvements in the data quality for recruitment and selection activity with the introduction and roll out of the electronic recruitment system.
- Development and the introduction of a Trust Equality Policy which clearly sets out individual and collective responsibilities and expected behaviours, as well as the Trust's beliefs and values with respect to employment equality issues.
- The Black and Asian Minority Ethnic Network (BAMEN) has continued to remain well established, continued to attract members and provided targeted development for staff. This has included BME staff participating on the BEL programme which aims to enhance leadership competencies, career planning and professional development.
- In terms of volume, staff from all ethnic groups (except Chinese) have attended more training sessions in the last 12 months.
- Significantly higher numbers of staff across the Trust have received a PDR appraisal in the last 12 months. The figures demonstrate that this has improved equity of access to PDR appraisals, such that more equal numbers staff by ethnic group, and age, are having a PDR in percentage terms.
- Review of the Equalities Impact Assessment policy to ensure continued compliance following the recent legislative changes.
- Commissioning a legal review of GOSH compliance with the new legislation. This review is due to be concluded shortly and will inform the work of the Staff Equality and Diversity group over the next year.

Key Activity Planned for 2011/12

These activities respond to the environment outside GOSH (for example, legislative changes), issues which are highlighted through the staff survey, and the data reflected in Appendix 1 and 2.

- Continue to maximise the potential of the electronic recruitment tool to better understand and utilise recruitment data to support fair and robust decision making. Data in Table 2 (Appendix 1) indicates inequity between the numbers of BME people applying for and then being appointed to job vacancies. It is felt that improved methodologies for self-selection at pre-shortlisting stage may help to address this inequity. The HR Department are also developing a suite of selection methodologies which recruiters can use to help inform their selection decisions.

- The 2010 staff survey showed that proportionally fewer BME staff than their white counterparts believe there are good opportunities to develop their potential at work, for career progression or promotion. To help address these concerns BAMEN (Black Asian and Minority Ethnic Network) will be supported to continue to provide a targeted development programme to BME staff in order to ensure they feel more confident and are equipped to apply for, and be appointed to, more senior roles. BAMEN will offer keynote speakers to update staff on issues of interest and will look to create a network of mentors as well as facilitating shadowing opportunities for BME staff.

- The 2010 staff survey also showed that respondents rated the Trust worse than average in providing Equality and Diversity training. In 2011 the Trust is looking to develop modules within existing management development programmes which promote improved skills, knowledge and awareness of dealing with people from different cultural and ethnic backgrounds and people with disabilities. There will also be a review of how and when Equality and Diversity training is provided to staff during their induction and mandatory update periods. The Education and Training team are also working with other Departments to support the purchase an interactive disability awareness e learning package for front-line staff such as receptionists and porters.

  - Continue to work with clinical and corporate units to ensure staff across all professional groups, ethnic groups, age groups and gender a) receive a PDR appraisal, b) the PDR appraisal is good quality, and c) have access to appropriate learning opportunities for their

role and personal development. Reports will be generated which look at this data on a per unit basis.

- Continue to focus on training and development for managers in the management of employee relations issues.
- Work with the Department of Health to embed the Equality Delivery System. This national programme will bring together equality and diversity alongside patient outcomes and experiences.
- Develop in conjunction with stakeholders equality objectives for the Trust in line with the requirements of the Equality Duty.

Note on BME staff and disciplinary action

The Board has particularly asked for a report into the apparent differential in disciplinary rates between white and BME staff. The University of Bradford Centre for Inclusion and Diversity was commissioned by the NHS to undertake research work on this subject. They published their report in September 2010. Their findings showed that: Of 80 NHS trusts who published data, BME staff were significantly overrepresented in disciplinary proceedings.

The reasons for this were complex and unlawful discrimination could not be ruled out. However, reasons also seemed to include:

- Lack of competence and confidence amongst line managers in applying performance and disciplinary policies to staff. For example, applying an informal process to a white member of staff but feeling insecure about taking anything other than formal steps with BME staff.
- Lack of differential between competence and disciplinary issues, so that performance issues are treated punitively through a disciplinary route rather than more supportively
- Core organisational values and expectations of behaviour are not made clear, and staff with different cultural norms may fall foul of these expectations if they are not made explicit
- BME staff are less aware of/do not access sufficiently appropriate support e.g. union representation
- BME staff appear disproportionately in lower bands, where there may be a more rigid disciplinary culture and where disciplinary action is more likely to take place
- Staff trained overseas may not have experience of the expectations of the NHS

Whilst the report did not provide recommendations, it noted that in other public sector settings, such as the police and local government, actions to address similar problems have included: access to mediation; reverse mentoring (i.e. pairing a senior manager with a talented member of more junior staff from a BME group to share experiences and enhance mutual understanding); clearer performance appraisal systems; simplification of disciplinary procedures; improved training in equality and diversity issues.

GOSH has already separated the management of disciplinary and competence issues; raised its rates for performance appraisals; offers access to mediation; provides training in equality and diversity issues. It is currently discussing mentoring with the Black, Asian and Minority Ethnic Network; and reviewing more innovative training and education in equality and diversity. For example using specialist trainers to support managers to develop skill, sensitivity and confidence in managing staff from BME backgrounds. As part of changes in the HR Department, there will be more emphasis placed on high quality selection methodologies which will aid managers to test competencies of applicants.

Appendix 1: Key Equalities Data for GOSH [narrative relating to this data and more detailed breakdown can be found in Appendix 2]

Nb Percentages in all tables have been rounded up or down and so may not always add up to 100.

Table 1 Comparison of ethnicity of GOSH staff

Ethnic Group	2007/8	2008/9	2009/10	2010/11
White	72%	71%	70%	71%
BME	26%	28%	30%	29%
Not known	2%	1%	0%	0%

Recruitment activity

Table 2 Recruitment activity broken down by ethnicity

Ethnic Origin	% of total applicants 2010/11	(2009/10)	Of which, % appointed 2010/11	(2009/10)
White	37%	(39%)	68%	(68%)
BME	60%	(59%)	31%	(30%)
Not stated	3%	(2%)	1%	(1%)

Table 3 Recruitment activity broken down by gender

Gender Origin	% of total applicants 2010/11	(2009/10)	Of which, % appointed 2010/11	(2009/10)
Male	32%	34%	25%	24%
Female	65%	65%	75%	76%
Not stated	0%	12%	0%	0%

Table 4 Recruitment activity broken down by disability

Disability Origin	% of total applicants 2010/11	(2009/10)	Of which, % appointed 2010/11	(2009/10)
Non-disabled	96%	(96%)	91%	(97%)
Disabled	2%	(3%)	2%	(3%)
Undefined	1%	(1%)	7%	(0%)

Attachment S

Education and Training activity

Table 5 - Breakdown of training uptake by ethnic group

Ethnic Group	Current Staff trained (10/11)	Diff to 09/10	Current Staff in group (10/11)	Diff to 09/10	Current staff trained as % of current staff in group	% Difference compared to 09/10
White	2310	+175	3173	+241	72.8%	nil
Mixed	97	+6	131	+8	74.0%	-0.7
Asian	340	+21	500	+27	68.0%	+0.6
Black	312	+2	452	+19	69.0%	-2.5
Chinese	46	-8	79	+1	58.2%	-11.0
Other/ Undef.	65	+5	85	+11	76.4%	-5.3
TOTAL	3170	+201	4420	+307	71.7%	-0.5

Table 6 - Breakdown of PDR Appraisals by ethnic group, gender and age

Ethnic Group	Total Staff with PDR Appraisal	Diff to 09/10	Percentage of staff with Appraisal in 12 month period	% Diff to 09/10
White	1531	+555	72.5%	+24.9
Mixed	69	+24	75.0%	+18.1
Asian	154	+49	66.3%	+27.8
Black	233	+104	68.3%	+31.8
Chinese	29	+7	72.5%	+18.3
Other/undef	52	+15	63.4%	+17.8

Gender	Total Staff with PDR Appraisal	Diff to 09/10	Percentage of staff with Appraisal in 12 month period	% Diff to 09/10
Female	1684	+618	70.8%	+25.2
Male	392	+142	73.1%	+28.8

Age Group	Total Staff with PDR Appraisal	Diff to 09/10	Percentage of staff with Appraisal in 12 month period	% Diff to 09/10
16-24	190	+46	73.4%	+13.6
25-34	815	+280	73.2%	+23.8
35-44	495	+167	69.1%	+25.6
45-54	380	+153	68.8%	+26.4
55-64	183	+108	71.2%	+43.3
65+	11	+6	78.6%	+47.3

Table 7 – The Gender Pay Gap

Contract type	Gender pay gap
Agenda for Change staff	-6.3%
Local e.g. Executives and TUPE transferees	8.3%
Medical and dental staff	19.2%
Trust total	8.9%

The calculation used = (Median of male hourly pay - Median of female hourly pay) / (Median of male hourly pay) - based on pensionable pay (inclusive of pay elements such as basic, London

weighting, enhancements, Clinical Excellence Awards but excludes overtime, expenses and APAs). This calculation is used by the EU to determine the gender pay gap.
Table 8 - Employee Relations Activity by gender, ethnicity and disability

	2010/11	2009/10	2008/9
Number of Disciplinary Hearings	28	43	22
Gender	11 (39%)		
• Male	17 (61%)	19 44%	6 27%
• Female	0	24 56%	15 68%
• Not known		0	1 5%
Ethnicity	13 (46%)		
• White	15 (54%)	19 44%	14 64%
• BME	0	24 56%	7 32
• Not known		0	1 5
Disability	8 (29%)		
• Non disabled	2 (7%)	32 74%	19 86%
• Disabled	20 (64%)	1 2%	1 5%
• Not known		10 23%	2 9%

Band	Disciplinaries 2010/11	White Trust Profile	BME Trust Profile	White Disciplinary	BME Disciplinary
Band 1	0 (0%)	35.7%	64.3%	0	0
Band 2	4 (14%)	48.9%	51.1%	2 (50%)	2 (50%)
Band 3	6 (21%)	52.3%	47.3%	3 (50%)	3 (50%)
Band 4	7 (25%)	60%	40%	2 (29%)	5 (71%)
Band 5	7 (25%)	74.3%	25.3%	4 (57%)	3 (43%)
Band 6	2 (7%)	76.1%	23.9%	1 (50%)	1 (50%)
Band 7	1 (4%)	78.2%	21.8%	0	1 (100%)
Band 8	1 (4%)	89.6%	10.4%	1 (100%)	0

Table 9 – Grievances by ethnicity

Grievances		
Basis of claim	**Outcome**	**Ethnic Origin**
Inappropriate behaviour from colleagues	Not upheld	White
Age Discrimination, bullying and harassment, victimisation after making a protected disclosure, damaging assertions about mental health.	Ongoing	White

Appendix 2: Equality and diversity pertaining to staff

Comprehensive data

Nb Percentages in all tables have been rounded up or down and so may not always add up to 100.

Table 1 – Comparison of ethnicity of GOSH staff

Ethnic Group	2007/8	2008/9	2009/10	2010/11
White	72%	71%	70%	71%
BME	26%	28%	30%	29%
Not known	2%	1%	0%	0%

Table 2 – Breakdown of ethnic origin of GOSH staff

Ethnic Group	2007/8	2008/9	2009/10	2010/11
Asian	10%	11%	11%	12%
Black	10%	11%	12%	11%
White	72%	▪ 71%	70%	71%
Other (inc Mixed)	6%	6%	7%	6%
Not known	2%	1%	0%	0%

The last census for which we have published data revealed that London boroughs comprising the North Central London sector (within which GOSH is situated) have a BME population of 27%. This is comparable to the categories of BME and other staffing employed by GOSH, which in 2010/11 stands at 29%.

Table 3 – Ethnic origin by staff group

	White		**BME**		**Unknown**	
STAFF GROUP	2010/11	(09/10)	2010/11	(09/10)	2010/11	(09/10)
Whole Trust						
Administrative and Clerical	64%	(63%)	36%	(37%)	0%	(0%)
Allied Health professionals	90%	(88%)	10%	(12%)	0%	(0%)
Estates, ancillary and unqualified clinical support	57%	(56%)	43%	(44%)	0%	(0%)
Medical and dental	66%	(67%)	34%	(32%)	0%	(1%)
Nursing and midwifery registered	80%	(79%)	20%	(21%)	0%	(0%)
Scientific and technical	71%	(70%)	29%	(30%)	0%	(0%)
Students	33%	(50%)	67%	(50%)	0%	(0%)

The trends noted in last year's report continued in 2010/11. BME staff continue to be very significantly disproportionately **under** represented in Nursing and Allied Health professional staff groups with little change compared to last year, and significantly **over** represented in the Estates, Ancillary and unqualified clinical support staff groups. 2010/11 also saw a marked increase in percentage terms of students from a BME background.

Table 4 – Ethnic origin by pay band

Pay Band	White	BME	n=
Band 1	35.7%	64.3%	19.6
Band 2	48.9%	51.1%	190.11
Band 3	52.3%	47.3%	257.41
Band 4	60%	40%	343.94
Band 5	74.3%	25.3%	677.83
Band 6	76.1%	23.9%	594.99
Band 7	78.2%	21.8%	488.77
Band 8	89.6%	10.4%	350.04
Band 9	100%	0%	5.8
Local manager	100%	0%	10.6
Local non-manager	82.4%	17.6%	5.69
M&D Career grade	32.9%	67.1%	14.3
M&D Consultant	77.2%	22.1%	230.74
M&D Junior	57.8%	41.8%	251.11

This Table shows that a disproportionate number of staff from BME groups are in lower Agenda for Change banded jobs. This is likely to be indicative of the disproportionate numbers of BME staff who hold 'non-professional' jobs which attract a lower banding.

The proportion of male to female staff at the end of March 2011 was 22.5% : 77.5% compared to 25.1% : 74.9% in 2009/10.

The promotion of NHS and more specifically GOSH careers to both genders is aimed at addressing this imbalance, although societal drivers with regard to gender-related career choices are clearly influencing this picture.

Table 5 – Breakdown of GOSH staff by age

Age Range	% of total FTE workforce 2009/10	2010/11
16 to 29	27%	28%
30 to 49	56%	56%
50 to 59	14%	13%
60+	3%	3%

Attachment S

Table 6 – Breakdown of GOSH staff groups by age

	16 to 29		30 to 49		50 to 59		60+	
Staff Group	2010/11	(09/10)	2010/11	(09/10)	2010/11	(09/10)	2010/11	(09/10)
Administrative and Clerical	26%	(27)	52%	56	17%	14	5%	3
Allied Health professionals	28%	(31)	62%	60	9%	9	1%	0
Estates, ancillary & unqualified clinical support	33%	(33)	46%	47	a) 15%	b) 15	6%	5
Medical and dental	4%	(6)	77%	77	15%	14	4%	3
Nursing/midwifery registered	38%	(36)	51%	53	10%	9	1%	2
Scientific and technical	22%	(18)	59%	60	15%	16	4%	6
Students	33%		67%		0%		0%	
Total	28%	(27%)	56%	56%	13%	14%	3%	3%

This data reflects the historically young age profile of GOSH staff. With the statutory removal of the default retirement age in October 2011 we may be able to anticipate a gradual redistribution of the age profile of staff towards greater numbers in the over 60 age group.

Pay

Table 7 - Breakdown of salary by age

	16-29		30-49		50-59		60+	
	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10
<£25,000	47%	(47%)	39%	(39%)	10%	(10%)	4%	(4%)
>£40,000	1%	(1%)	70%	(73%)	24%	(22%)	5%	(4%)

This table shows that the percentage of staff in particular earnings categories according to their age remains largely unchanged since 2009/10. These figures tally with older staff being in more senior (and therefore higher paid) bands.

Table 8 – Breakdown of salary by ethnicity

Salary	White		BME		Unknown	
	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10
<£25,000 p.a.	62%	(62%)	38%	(38%)	0%	(0%)
>£40,000 p.a.	79%	(78%)	21%	(22%)	0%	(0%)

Following the trend of previous years, a disproportionate number of staff from BME groups continue to earn lower salaries. This is likely to be indicative of the disproportionate numbers of BME staff who hold 'non-professional' jobs which attract a lower salary.

Initiatives such as providing BME staff with development opportunities through the work of the BAMEN group are aimed at addressing this inequity.

Table 9 – The Gender Pay Gap

Attachment S

Contract type	Gender pay gap
Agenda for Change staff	-6.3%
Local e.g. Executives, previous TUPE transferees	8.3%
Medical and dental staff	19.2%
Trust total	8.9%

The calculation used = (Median of male hourly pay - Median of female hourly pay) / (Median of male hourly pay) - based on pensionable pay (inclusive of pay elements such as basic, London weighting, enhancements, Clinical Excellence Awards but excludes overtime, expenses and APAs). This calculation is used by the EU to determine the gender pay gap.

Whilst it is clear that GOSH is doing well in terms of the equity in pay between male and females, given that in the UK the Gap is 21.9% (and in the EU it stands at 17.5%), it is also apparent that we still have work to do to uncover the causes behind the inequity in the pay given to male and female medical and dental staff.

Clinical Excellence Awards

In common with all NHS employers of doctors, GOSH is required to consider each year whether its staff are eligible for clinical excellence awards. The process for making the awards is made by a panel which has had diversity training and the results are reported to the Department of Health for monitoring. In 2010, 190 consultants were eligible for an award, including 22 consultants in academic posts. The proportions of staff who are eligible for and who hold an award are as follows:

	Eligible for an award	**Granted an award**
Male	51%	57%
Female	49%	43%
BME	22%	17%
White	78%	83%

There is clearly currently a disproportion in these figures especially in terms of ethnicity. The Trust will monitor this situation closely.

Recruitment

Table 10 – Breakdown of recruitment by ethnic origin

Ethnic Origin	% of total applicants 2010/11	(2009/10)	Of which, % appointed 2010/11	(2009/10)
White	37%	(39%)	68%	(68%)
BME	60%	(59%)	31%	(30%)
Not stated	3%	(2%)	1%	(1%)

The availability of consistent data for recruitment episodes has continued to improve in 2010/11, as has recording of ethnicity, with the roll out of the electronic recruitment tool. As the tool becomes used in all recruitment episodes, data collection will improve further as will the Trust's ability to produce comprehensive reports. It is not clear why disproportionately fewer BME staff are appointed than their white counterparts. The Trust will monitor this closely to see whether this continues into the future. The HR Department are also working towards the development of a recruitment service to managers which offers access to comprehensive impartial candidate tests and other selection methodologies.

Attachment S

Table 11 – Breakdown of recruitment by gender origin

Gender Origin	% of total applicants 2010/11	(2009/10)	Of which, % appointed 2010/11	(2009/10)
Male	32%	34%	25%	24%
Female	65%	65%	75%	76%
Not stated	0%	12%	0%	0%

The Trust employs more women than men and it is not unexpected to see such a large imbalance in the proportions of men and women applying for jobs in healthcare. It is less clear why the proportion of women who are appointed is greater than that of men. In its work with students the Trust is keen to encourage men to consider careers in traditionally female-dominated professions such as nursing, psychology etc.

Table 12 – Breakdown of recruitment by disability origin

Disability Origin	% of total applicants 2010/11	(2009/10)	Of which, % appointed 2010/11	(2009/10)
Non-disabled	96%	(96%)	91%	(97%)
Disabled	2%	(3%)	2%	(3%)
Undefined	1%	(1%)	7%	(0%)

Continued improvements in the collection of data on disabled applicants has been achieved with the use of the electronic recruitment system. However, the Trust is aware that many people who may fall within the legal definition of disabled do not class themselves as such and continues to work with Occupational Health to ensure that the best candidates can continue into employment wherever possible and all reasonable adjustments are made to ensure this happens, whether they are defined as disabled or not. The Trust has for many years been a Positive About Disabled People symbol user and this means that all disabled applicants who meet the essential criteria as contained on the person specification are guaranteed an interview.

Table 13 – Breakdown of recruitment by age

Age Origin	% of total applicants 2010/11	(2009/10)	Of which, % appointed 2010/11	(2009/10)
16-29	55%	54%	48%	51%
30-49	39%	40%	46%	43%
50-59	5%	6%	5%	5%
60+	1%	0%	1%	1%
Not stated	0%	(0)	0%	0%

Recruitment data on age shows there is broad equity in the ages of applicants and those successfully appointed especially for those in the over 50 age range.

Table 14 – Breakdown of recruitment by religious belief

Religion Origin	% of total applicants 2010/11	Of which, % appointed 2010/11	% of total applicants 2009/10	Of which, % appointed 2009/10
Atheism	7%	10%	7%	12%
Buddhism	1%	0%	1%	1%
Christian	49%	40%	49%	53%
Hinduism	9%	6%	10%	5%
Islam	15%	3%	14%	4%

Religion Origin	% of total applicants 2010/11	Of which, % appointed 2010/11	% of total applicants 2009/10	Of which, % appointed 2009/10
Jainism	0%	0%	0%	0%
Judaism	1%	1%	1%	1%
Sikhism	2%	1%	2%	2%
Religion – other	7%	6%	7%	9%
Religion – undisclosed	9%	33%	9%	13%

This is the second time the Trust has captured this data. Our legal advice is that not to do so would leave the Trust vulnerable to Employment Tribunal claims of discrimination on the grounds of religious belief. Further analysis will be required to identify whether recruitment patterns reflect the religious origin of existing staff; and whether any further conclusions can be drawn or analysis undertaken.

Table 15 – Breakdown of recruitment by sexual orientation

Sexual Orientation Origin	% of total applicants 2010/11	Of which, % appointed 2010/11	% of total applicants 2009/10	Of which, % appointed 2009/10
Lesbian	0%	0%	0%	1%
Gay	1%	1%	1%	3%
Bisexual	1%	0%	2%	0%
Heterosexual	89%	69%	87%	89%
Undisclosed	9%	30%	10%	7%

This question is asked as standard by NHS organisations at recruitment. Our legal advice is that not to do so would leave the Trust vulnerable to Employment Tribunal claims of discrimination on the grounds of sexual orientation. It is difficult to draw conclusions from this data due to the sensitivities associated with the question. However, the Trust will continue to monitor this information and use national guidance to develop its work in this area.

Student Nurses

Table 16 - Student nursing 2010 cohorts

Gender	**2010/11**	2009/10
Female	139 : 96%	132 : 96%
Male	6 : 4%	4 : 4%

Disability	**2010/11**	2009/10
Disabled	13 : 9%	11 : 9.5%
No known disability	132 : 91%	124 : 90.5%

	2010/11
White	116 : 80%
BME	29 : 20%

Education and Training

Table 17 - Breakdown of training uptake by ethnic group

Ethnic Group	Current Staff trained (10/11)	Diff to 09/10	Current Staff in group (10/11)	Diff to 09/10	Current staff trained as % of current staff in group	% Difference compared to 09/10
White	2310	+175	3173	+241	72.8%	nil
Mixed	97	+6	131	+8	74.0%	-0.7
Asian	340	+21	500	+27	68.0%	+0.6
Black	312	+2	452	+19	69.0%	-2.5
Chinese	46	-8	79	+1	58.2%	-11.0
Other/ Undef.	65	+5	85	+11	76.4%	-5.3
TOTAL	3170	+201	4420	+307	71.7%	-0.5

This data shows that overall we have engaged in more training activity in the last year by providing an additional 201 spaces on training courses compared to 09/10. This is encouraging as it shows we have increased the number of training opportunities for all ethnic groups/clusters in line with the increase in the number of staff working at GOSH. This is unfortunately with the exception of the Chinese ethnic group, whose numbers employed have remained fairly static, but access to courses by this group has dropped by 11%. In contrast, staff attending from the Asian ethnic group has increased access by 0.6%. Ironically, PDR appraisal completions are amongst the highest for Chinese staff (72.5%), and lowest for Asian staff (66.3%) - see below.

Table 18 - Breakdown of PDR Appraisals by ethnic group, gender and age

In 2010/11 we worked hard with managers across all units to increase PDR appraisal completion rates.

There was an increase from 45% to 75% of Trust staff (Medical staff excluded from these figures) having a current PDR appraisal (in the previous 13 months and future 2 months). We continue to build on this in 2011/12 – our goal is to reach 90% completion rate by March 2012. We will be working with managers to ensure that all staff from all professional groups, and all staff with protected characteristics, receive fair and equitable access to having a proper appraisal. This will enable improved access to learning opportunities appropriate to role and personal development.

Ethnic Group	Total Staff with PDR Appraisal	Diff to 09/10	Percentage of staff with Appraisal in 12 month period	% Diff to 09/10
White	1531	+555	72.5%	+24.9
Mixed	69	+24	75.0%	+18.1
Asian	154	+49	66.3%	+27.8
Black	233	+104	68.3%	+31.8
Chinese	29	+7	72.5%	+18.3
Other/undef	52	+15	63.4%	+17.8

The data shows that all ethnic groups have benefitted, in particular the Black and Asian ethnic groups saw the largest percentage increase in staff having a PDR appraisal.
The range of appraisal completion in 09/10 by ethnicity was 20.4 – from 36.5% (Black) to 56.9% (Mixed). In 10/11 this has improved to 11.6 – from 63.4% (Other) to 75.0% (Mixed).

Gender	Total Staff with PDR Appraisal	Diff to 09/10	Percentage of staff with Appraisal in 12 month period	% Diff to 09/10
Female	1684	+618	70.8%	+25.2
Male	392	+142	73.1%	+28.8

The figures here demonstrate that proportionally more men than women have a PDR appraisal.

The following Table shows that staff of all ages across the Trust are proportionally receiving an appraisal compared to the previous year.

Age Group	Total Staff with PDR Appraisal	Diff to 09/10	Percentage of staff with Appraisal in 12 month period	% Diff to 09/10
16-24	190	+46	73.4%	+13.6
25-34	815	+280	73.2%	+23.8
35-44	495	+167	69.1%	+25.6
45-54	380	+153	68.8%	+26.4
55-64	183	+108	71.2%	+43.3
65+	11	+6	78.6%	+47.3

The range of appraisal completion in 09/10 by age was 28.5 – from 31.3% (65+) to 59.8% (16-24). In 10/11 this has improved to 9.8 – from 68.8% (45-54) to 78.6% (65+).

Employee Relations Activity

Table 19 - Employee Relations Activity

	2010/11	2009/10
Number of Disciplinary Hearings	28	43
Gender		
Male	11 (39%)	19
Female	17 (61%)	24
Not known	0	0
Ethnicity		
White	13 (46%)	19
BME	15 (54%)	24
Not known	0	0
Disability		
Non disabled	8 (29%)	32
Disabled	2 (7%)	1
Not known	20 (64%)	10

Band	Disciplinaries 2010/11	White Trust Profile	BME Trust Profile	White Disciplinary	BME Disciplinary
Band 1	0 (0%)	35.7%	64.3%	0	0
Band 2	4 (14%)	48.9%	51.1%	2 (50%)	2 (50%)
Band 3	6 (21%)	52.3%	47.3%	3 (50%)	3 (50%)
Band 4	7 (25%)	60%	40%	2 (29%)	5 (71%)
Band 5	7 (25%)	74.3%	25.3%	4 (57%)	3 (43%)
Band 6	2 (7%)	76.1%	23.9%	1 (50%)	1 (50%)
Band 7	1 (4%)	78.2%	21.8%	0	1 (100%)
Band 8	1 (4%)	89.6%	10.4%	1 (100%)	0

Table 20 – Grievances

Grievances		
Inappropriate behaviour from colleagues	Not upheld	White
Age Discrimination, bullying and harassment, victimisation after making a protected disclosure, damaging assertions about mental health.	Ongoing	White

Table 21 – Employment Tribunals

Employment Tribunals		
Basis of claim	Outcome	Ethnic Origin
Witholding of redundancy pay	Ongoing	White
Unfair dismissal on grounds of race	Case dismissed	BME
Offer of employment withdrawn when discrepancies found in application form	Ongoing	BME
Race, religion and disability discrimination	Ongoing	BME

It should be noted that cases which are settled outside the tribunal hearing do not indicate an acceptance of culpability on the part of the Trust. Rather, the Trust's HR and legal team make an assessment of costs which are likely to be incurred in responding to an application at an employment tribunal and may decide that it is a more effective use of public money to settle a case rather than contest it.

Information related to ER activity is routinely reported by HR to SIF and the Staff Equality and Diversity group. These groups are currently considering the potential reasons why BME staff are disproportionately represented at formal disciplinary hearings. Representatives from the BAMEN group are also involved in this work.

Trust Board Meeting
25th May 2011

Title of document: PEAT 2011 Formal Audit Report **Submitted on behalf of:** Fiona Dalton	**Paper No: Attachment T**

Aims / summary

To confirm the findings of the Annual PEAT Audit for 2011.
The report details the scores achieved, specific positive and negative details and an associated set of recommendations and actions.

The report also notes that the work stream currently being delivered by the CNS for Nutrition under the governance of the Nutritional Steering Committee has impacted the score for Food but will deliver a significant impact in the PEAT score for 2012 (and the remaining internal PEAT scores for the quarterly audits in 2011)

Action required from the meeting
For Information

Contribution to the delivery of NHS / Trust strategies and plans
Maintaining our focus on Zero Harm:
Continue to meet national and commissioning standards and improve the utilisation and efficiency of our resources.

Financial implications
None

Legal issues
Compliance with PEAT and CQC standards

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

Who needs to be told about any decision
Quality and Safety Committee and Infection Control Committee

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

Who is accountable for the implementation of the proposal / project
Head of Corporate Facilities

Author and date: Anna Cornish (Head of Facilities)

Attachment T

PEAT 2011 Results

4-8 Maple Street
London
W1T 5HD

Tel: 020 7927 9500
Fax: 020 7927 9501
www.npsa.nhs.uk

April 2011

Dear Chief Executive

PATIENT ENVIRONMENT ACTION TEAM ASSESSMENTS 2011

We are now able to confirm the PEAT results 2011 for environment, food and privacy and dignity for each hospital within your Trust. Note that we do not intend to send copies of your PEAT assessment as you already hold this information locally.

Site Name	Environment Score	Food Score	Privacy & Dignity Score
Great Ormond Street Hospital	Good	Acceptable	Good

The date for national publication of the individual PEAT scores has not yet been confirmed. Further notice will be sent to all PEAT contacts when this has been arranged.

If you have any queries regarding the factual accuracy of your PEAT results, please send these by e-mail to peat@ic.nhs.uk. Queries should identify the Trust, hospital(s) affected and the nature of the enquiry.

Once again – my thanks to you all (and your staff and colleagues) for again making the PEAT programme a continued success.

A review of PEAT will begin in June 2011 and the named PEAT contacts for your trust will be invited to contribute. I will write to you with details of any changes to be made to the process for 2012.

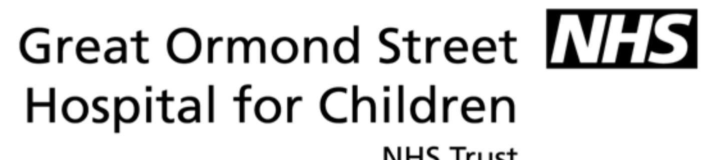
Yours faithfully

Graham Jacob
Patient Safety Lead, Healthcare Cleanliness
NPSA

ATTACHMENT U – TO FOLLOW

ATTACHMENT W

Attachment W



MANAGEMENT BOARD
Thursday 17th March 2011

MINUTES

Present:

Jane Collins (JC)	Chief Executive (Chair)
Jacqueline Allan (JA)	General Manager, Medicine and DTS
Barbara Buckley (BB)*	Co-Medical Director
Sven Bunn (SB)	FT Programme Director
Carlos De Sousa (CDS)	CU Chair, Neurosciences
Sarah Dobbing (SD)	GM Neurosciences
Martin Elliott (ME)	Co-Medical Director
Lorna Gibson (LG)	GM Research and Innovation
Allan Goldman (AG)	CU Chair, Cardio-Respiratory
Melanie Hiorns (MH)	CU Chair MDTS
Elizabeth Jackson (EJ)	CU Chair, Surgery Clinical Unit
Mark Large (ML)	Director of ICT
Anne Layther (AL)	GM, Cardiac
Joanne Lofthouse (JL)	International Division
William McGill (WM)	Director of Redevelopment
Liz Morgan (LM)	Chief Nurse and Director of Education
Claire Newton (CN)	Chief Finance Officer
Tom Smerdon (TS)	GM, Surgery
Rachel Williams (RW)	GM, ICI
Peter Wollaston (PW)	Head of Corporate Facilities, General Facilities

In Attendance

Judith Armstrong (JAr)	
Julie Bayliss (JB)	
Bridget Callaghan (BC)	
Alex Faulkes (AFa)	
Catherine Lawlor (CL)	PA to Chair & Chief Executive (minutes)
Marian Malone (MM)	

**Denotes meeting part attended*

888	**Apologies**	
888.1	Apologies had been received from Robert Burns, Deputy Chief Operating Officer; Cathy Cale, ICI Unit Chair and Anna Ferrant, Company Secretary. Julie Bayliss and Marian Malone attended on behalf of Cathy Cale.	
889	**IPP report & Deep Dive**	
889.1	JC introduced Bridget Callaghan (BC) to the Board as being responsible for the general medical care of patients in IPP. BC presented the deep dive on IPP which looked at achieving Trust and IPP objectives, understanding and quantifying identified and perceived risk, demonstrating risk reduction by identifying measurable outcomes, improvement initiatives, ways of involving all levels of staff and, lastly, a continuous cycle of improvement.	
889.2	JC remarked that the Board was keen to roll out Electronic incident reporting.	
889.3	SB enquired why the Canadian CEWS scores was mentioned during the presentation. BC explained that the team wanted to see whether using this tool might engage staff even further. BC also highlighted to the Board that CEWS scores would need to be adjusted as patients generally have abnormal parameters.	
889.4	LM stated that it was not appropriate to have different systems in use in the Trust and suggested that IPP speak to Sue Chapman to discuss why they thought the existing system didn't meet their needs.	
890	**Minutes of Management Board meeting held on 17 February 2011**	
890.1	The minutes were approved as an accurate record.	
891	**Action Log and other matters arising**	
891.1	The following updates were received on the documented actions:	
891.2	FD updated the Board on the up-coming Royal Wedding in relation to staff pay. FD informed the Board that as a result of a breakdown in national negotiations, each trust was left to decide on their staff pay. The Trust had decided, after discussion with the unions, that GOSH staff working that day would get paid at normal rates with a day off in lieu which seemed to be in line with other Trusts.	
891.3	891.3 - AL informed the Board that three of the six volunteers had been identified and would receive an induction pack by July 2011 in order to start service in August.	
891.4	**Action:** AL agreed to give an update on the new volunteers in November.	AL
891.5	849.3 - It was decided that AFa would report back to the Board in April on the progress of the pilot in Nephrology around the use of a generic email address for correspondence with patients.	
891.6	**Action:** AFa agreed to clarify progress on the pilot in Nephrology around the use of a generic email address for correspondence with patients.	AFa
891.7	849.4 – It was agreed that this action would be brought back to April Management Board.	
891.8	**Action:** AFa agreed to clarify progress on the expected date of delivery of the final draft of the policy on End of Life Care Decision Making Policy (including DNAR Orders).	AFa

891.9	725.4 - It was agreed that this action would be brought back to April Management Board.	
891.10	**Action:** SC to feedback further CEC responses on Marketing and Communications – Documentaries and Ethics of Filming to Management Board	SC
891.11	728.3 - It was agreed that this action would be brought back to April Management Board.	
891.12	**Action:** Anna Ferrant (AF) to review the subcommittees reporting to Management Board	AF
891.13	**Action:** CN to circulate a tool for evaluating effectiveness of a committee.	CN
891.14	849.6 – FD gave an update to the Board. FD reported that the Trust had 18 certificates and had one left until the end of March. Some changes had been made to the law including extensions no longer being counted and that if a non-European worker earned more than £150, 000 they would not require a certificate.	
891.15	780.6 – It was agreed that this action would be brought back to April Management Board.	
891.16	**Action:** PL to report back to Management Board on the progress on record keeping, a project to improve patient notes and improved documented observations of patients.	PL
891.17	849.11 It was agreed that this action should be corrected. TS were not to prepare a letter. Instead, CN should bring a paper on Commissioning to the Board for next month.	
891.18	**Action**: CN to bring a paper on Commissioning in April.	CN
891.19	849.14 – This action was to be removed as the matter was now being dealt with by Fiona Dalton and Andy Needham, outside of Management Board.	
891.20	817 – FD updated the Board that there were currently discussions going on regarding the LSD service. JC gave thanks to MH, FD and BB for their hard work on this issue.	
891.21	849.21 – It was agreed that this action would be brought back to April Management Board.	
891.22	**Action:** BB to give an update on Honorary Contracts at GOSH at the April Management Board.	BB
891.23	872.3 – BB reported that the following actions were currently being taken: Firstly new paperwork family & history questionnaires (including relevant questions) have been ordered (NW) and secondly, once new paperwork and policy was ready to be launched she would ask Clinical Units to ensure education and knowledge within their units.	
891.24	859.8 It was agreed that this action would be brought forward to the May Management Board rather than the April Board.	
	Clinical Unit and Zero Harm Reports	
892	**IPP**	
892.1	JL presented the report. The deep dive looked at trust wide initiatives, the unit's	

	surgical patient pathway, quality and safety strategy, zero harm priorities, MSSA Strategy, medication errors, outcomes, care quality commission and clinical notes.	
892.2	JL highlighted that the current unrest in the Middle East had not affected any of the areas IPP received patients from. However the situation would be closely monitored.	
892.3	JL also reported the CRES target had been achieved for the year to date. There had been no delayed or refused patients in February and 139 days since last SUI.	
892.4	Management Board **noted** the content of the report.	
893	**Cardio Respiratory**	
893.1	AG updated the Board on the Safe and Sustainable Review. The proposal was to reduce cardiac children's' centres from 11 to 6/7. Four options were out for consultation and in all 4 options GOSH had been recommended as one of the London centres. GOSH delivered the largest paediatric cardiac service and was ranked best unit for innovation and research and the only centre that could offer ECMO, Berlin hearts, transplantation and tracheal work, with room for expansion. AG informed the Board that Brompton had requested a Judicial review of the decision making process.	
893.2	A web site had been set up using a voting system for which hospital voters would like to see remain open. AG asked the Board to try to encourage staff, friends and families to vote for GOSH.	
893.3	JC asked CL to send the link round to all staff.	
893.4	**ACTION:** CL would send round the link to everyone.	CL
893.5	AG also reported no delays and one refusal for the month of February and 21 days since last SUI.	
893.6	Management Board **noted** the content of the report.	
894	**Infection, Cancer and Immunity**	
894.1	RW presented the report. The last SI occurred 38 days ago.	
894.2	RW highlighted two risks, inpatient bed capacity and prescribing errors. There had been Haem-Onc EP Errors per 10 items prescribed. FD asked RW to look into this.	
894.3	**Action:** RW to look in to Unit's risk - Haem-Onc EP Errors per 10 items prescribed.	RW
894.4	Management Board **noted** the content of the report.	
895	**MDTS**	
895.1	MH presented the paper and reported it was 226 days since the last SUI occurred. MH also reported that there were 6 refusals for renal patients to Victoria Ward and 2 for dialysis. There were also 4 delays. There would be however, 2 more beds opening next week, alleviating this risk.	
895.2	Management Board **noted** the content of the report.	
896	**NEUROSCIENCES**	
896.1	CDS presented the report. CDS reported that it was 105 days since the last SUI	

	occurred. CDS also reported no refusals and delays for patients to the Unit.	
896.2	CDS reported that data on medication errors was being collected and an action plan was being developed to address any issues identified. Also the Unit had an IR business case awaiting implication and finally the leaking roof in MCU remained an ongoing issue. WM assured CDS the roof was a priority and would be fixed shortly.	
896.3	Management Board **noted** the content of the report.	
897	**Surgery**	
897.1	EJ presented the report. EM reported that the last SUI had occurred 37 days ago. EJ also reported 13 patient refusals to the unit for the month of February.	
897.2	EJ identified the Unit's top three risks. Firstly, the general issue of complex patients - a recent death had raised further concern around this issue and that of post-operative ventilation capacity. As a result of this and other deaths in complex spinal patients the unit had suspended major spinal surgery on complex patients whilst an external review was carried out and improved provision for preoperative support was put in place. EM also reported the Unit was pursuing the introduction of a pre-assessment service for all patients undergoing a procedure (being overseen by the Surgical Pathway Project group).	
897.3	Secondly medication errors EP- Anaesthetics was planning to use a mixture of paper and EP for prescriptions. At the Orthopaedics, SNAPS & Urology meeting it was noted that there was widespread resistance to EP. Some of the concerns included the time taken to use EP, inconsistency with electronic and paper records being used, omission of information, which could all potentially lead to medication related errors. Anaesthetics would carry out a risk assessment as discussed at the Theatre RAG Group.	
897.4	Lastly, MSSA infections on Woodland- 6 infections in one year. There was work identified around training and documentation of training in this area. There would also be an increased focus on Bare Below the Elbows.	
897.5	Management Board **noted** the content of the report.	
898	**GOSH IN HARINGEY**	
898.1	FD presented the report which highlighted: • the need for an increase in Health Visiting to manage an increased in demand in Child Protection work in a climate of financial restraint; This issue had been brought to the attention of the commissioners. • ensuring appropriate management of Child Protection and, lastly, • financial risks to the provision of current community health services to children in Haringey.	
898.2	FD reported that the local authority may be taking money out of speech therapy and that the consultation for staff transferring to Whittington had been completed last week. Staff had felt it went well.	
898.3	BB also reported that one long term locum would finish in early summer and all posts were filled bar one.	
898.4	Management Board **noted** the content of the report.	

899	**R & I Divisional Report**	
899.1	LG presented the report, which included the divisional current activity and forthcoming workplan. The reapplication for the NIHR Biomedical Research Centre was underway, which was a two stage process, with the first being submitted on the 21st March 2010. Arrangements for the MHRA inspection (to take place 10th-12th May) were also underway including submission of the dossier by the end of March. The clinical research facilitators were commencing work within clinical units with hot desking facilities being put in place. Arrangements for the Human Tissue Act (HTA) inspection for the ICH tissue licence in June were also on-going.	
899.2	Management Board **noted** the content of the report.	
900	**Key Performance Report January 2011**	
900.1	AFa presented the report. The following was noted: • In month, the Trust reported 2 cases of C. difficile. Year to date the total rate was reported at 10 against trajectory of 8.25 and a year end trajectory of 9. The Department of Health (DH) had not yet agreed to a paediatric target different from adult. The DH advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) would be presenting our opinion on this again soon. • Inpatients waiting list profile by weeks waiting - performance had decreased slightly in month with 46 patients reported as waiting over 26 weeks for inpatient treatment following data validation.	
900.2	**ACTION:** AFa and CN to approach each unit and bring to the Board a Deep dive report on waiting times for the April meeting. • Outpatient's waiting list profile - GP to first consultant appointment. The number of patients waiting over 13 weeks for a first consultant outpatient appointment decreased slightly from a January position of 47 to 42 following data validation. • Clinic outcome form completeness -There were clear differences across Clinical Units and Specialties in the current level of outcome form completeness with some achieving near 100% and others well below 50%. This had meant that overall level was stalled around 60%. The Transforming Outpatients Group had discussed and disseminated two methods for achieving improvement in scores currently being carried out by Cardiac and Surgery. Operational and Service Managers had been tasked with using the method best suited to their teams in order to achieve improvement. • Staff who had a current Personal Development Review (PDR) in the last 13 months (Report page 12, Graph 41) - both clinical and non-clinical PDR rates remained relatively constant at 74%. The Trust had set a target of achieving 80% compliance by March 2011. Services and departments were encouraged to continue to review staff currently identified as not receiving an appraisal. • Information governance training - the total uptake of training remained low at 19%. New staff continued to undertake training as part of their induction. Work to improve the access and usability of training material by hosting on GOLD would be completed by end March. Departmental reporting to managers would additionally begin in March.	AFa & CN

900.3	Management Board **noted** the contents of the Key Performance Indicator Report for February 2011.	
901 901.1 901.2 901.3 901.4 901.5 901.6	**Finance and Finance and Activity Report January 2011** CN presented the report and the following was noted: The Trust had a surplus of £7.5M – £1.9M favourable to budget and £1.3M favourable to the original Provider plan NHS Clinical income, IPP Income and Other Operating Revenue were all higher than budget, and non pay costs were lower than budget. There were over spends on pay budgets particularly junior doctors and nursing. The forecast was for an £8.8M surplus as adjusted for the effect of any impairment on property values. This was originally estimated at £1.5M though indications from the valuer were that the index had moved since this estimation and it was likely to be much lower. JC congratulated the Board on a good year and expressed thanks. Management Board **noted** the contents of the report.	
902 902.1 902.2 902.3	**Foundation Trust Application Update January 2011** SB presented the report and highlighted the main risks for the FT application was C-Diff issues, commissioners and CRES deliveries. SB reported that Ernst & Young gave positive feedback about people's understanding about the Foundation Trust application. SB asked the Board to encourage staff to become councillors. It was also noted that there would be a parent councillor meeting on Saturday 19th March 2011. Management Board **noted** the report.	
903 903.1	**Review of three year Strategic Objectives** FD notified the Board that this paper had been given sufficient airing last month and there was no need to comment further on it.	
904 904.1 904.2	**Same Sex accommodations** LM presented the report to make Management Board aware of the increased requirements for compliance with DH same sex accommodation regulations and seek approval for re declaration of compliance on 1st April 2011, as required by the Secretary of State. There was some discussion about choices for 16 to 19 year olds. Management Board **approved** the report pending clarification on choice for 16-19 year olds.	
905 905.1 905.2	**Making procurement more effective in the Trust** CN presented the report which summarised proposals for strengthening the Trust's approach to procurement across all functions. The paper was presented alongside the paper on Proposed Supply Change processes authored by Peter Wollaston. Management Board **approved** the report	

906	**Corporate Facilities Consultation**	
906.1	PW presented the report which outlined changes to the Structure and some roles within the Corporate Facilities Management team to support three key projects: Supply Chain Project, UCLP Procurement and Supply Chain Merger and UCLP Soft FM Tender	
906.2	Management Board **approved** the report.	
907	**GOSH Patient Experience Background and Action plan 2011/12**	
907.1	LM presented the report, action plan plus background paper which represent a key part of Year 3 of the Trust's patient and public involvement and engagement strategy. It highlighted a positive patient experience as a key aspect of quality along with safety and clinical effectiveness, and proposed an approach to measurement that combines a qualitative and quantative approach.	
907.2	AG reported that the Cardio Respiratory Unit would be using touch technology to ask patients to complete a short questionnaire and results would then simultaneously feed back directly on to a screen in their unit. They would trial this with 20 patients.	
907.3	Management Board **approved** the action plan.	
908	**Capital Plan & Status report on Financial planning process for 2011/12**	
908.1	CN presented the report which requested approval from Management Board for the proposed capital spend for 2011/12.	
908.2	RW queried the figure reported in the report for Penguin ward. CN advised that the report may not have the latest estimates.	
908.3	A question about the lifts (particularly in Camelia Botnar) was also raised and WM reported that facilities were aware of the issues and would be looking in to this shortly.	
908.4	Management Board **approved** the direction of travel of the Capital Plan.	
909	**Cardiorespiratory Consultant Post**	
909.1	AG presented the report which requested approval for four Cardio & one intensive care post. JC clarified that essentially the unit had the funding to implement all these posts and some are filled by locums.	
909.2	Management Board **approved** the report. JC requested that the interviews be done in stages.	
910	**Expansion of CIVAS (Centralised IV Additive Service)**	
910.1	JC presented the paper. In February 2011 Management Board approved the strategy that all medicines for IV administration should where possible be prepared in a CIVAS or other aseptic facility.	
910.2	The business case quantified the significant periods of nursing time that are spent on the preparation of IV medicines at ward level and proposed that these resources were released and reinvested in the current CIVAS service. This reinvestment would fund the extension of the CIVAS service to provide the additional capacity needed to achieve the primary aim that IV medicines are prepared in a CIVAS or other aseptic facility.	

910.3	RW queried how the message would be managed and the transition time. JC highlighted to the Board that the Department of Health expected us to make cost savings and this proposal was safer for children too.	
910.4	The Board **approved** the Business Case with further work on how to manage the transition. It was agreed the transfer of budget and sign off by Finance would take place outside of Management Board.	
911	**Salary Overpayments options**	
911.1	CN presented the paper which reported salary overpayments were in excess of £300K outstanding although for a small number repayment plans were in place.	
911.2	The Board discussed various options relating to manager and personal responsibilities to help alleviate this issue WM suggested that a reminder of personal responsibility be printed on payslips.	
911.3	The Board **supported** the report with new options noted and review in 6 months.	
911.4	**Action:** CN to report back to the Board with an update on Salary Overpayments in September.	CN
912	**Domestic Services Operational Policy 2011**	
912.1	PW presented the annual review of the Domestic Services Policy 2011 including improved process for escalation of non compliance of Cleaning standards.	
912.2	The policy was **approved**.	
913	**IT Strategy**	
913.1	ML presented the policy on the Trust's IT Strategy.	
913.2	The policy was **approved**.	
914	**Internet Use Policy**	
914.1	ML presented the policy on the Trust's Internet use.	
914.2	FD queried the staff internet policy as it appeared to contradict itself in regards to staff usage of the internet and asked that this be clarified.	
914.3	LM highlighted the Internet Policy didn't make reference to the use of webcams - safeguarding risks. It was agreed that IT would look at this.	
914.4	**Action:** ML to bring back to the Board a policy on Webcam and guest wireless usage.	ML
914.5	The policy was **approved** subject to the amendments suggested above.	
915	**Email Use Policy**	
915.1	ML presented the policy on the Trust's Email Use.	
915.2	The policy was **approved**.	

916 916.1 916.2	**Encryption Policy** ML presented the policy on Encryption The policy was **approved**.	
917 917.1 917.2	**Network Access Policy** ML presented the policy on the Trust's Network Access. The policy was **approved**.	
918 918.1 918.2	**Clinical Document Database (CDD) Access Policy** ML presented the CDD Access Policy which proposed to ensure that staff have appropriate access to clinical documents when needed. The policy provided clear guidance on user responsibility as well as informing users of the audit practice and the process for managing usage breaches. The policy was **approved**.	
919 919.1 919.2 919.3	**Record Management Policies** PW presented the policies on record management. **Action:** PW come back to the Board with a further clarification on the definition of a "record" The policy was **approved**.	 PW
920 920.1 920.2	**Update on NCG Funding** FD presented the report which gave an update on NCG Funding. Management Board **noted** the report.	
921 921.1 921.2	**Waste Annual Report 2010** PW presented the report which gave a summary of the Waste activity in 2010 and the trust's objectives for 2011. Management Board **noted** the report.	
922 922.1	**Patient and Public Involvement and Experience Committee (PPIEC)** Management Board **noted** the contents of the above document.	
923 923.1	**Capital and Space Planning Committee** Management Board **noted** the contents of the above document.	
924 924.1	**Technical Delivery Board** Management Board **noted** the contents of the above document.	
925 925.1	**CRES Steering Board** Management Board **noted** the contents of the above document.	

926 926.1 926.2 926.3 926.4	**Waivers** CN request approval for waivers from the following suppliers: ThermoFisher Scientific; Bio-Rad Laboratories Ltd and Applied Biosystems. CN further requested the Board's approval of a waiver for an ENT stack to the value of £37,000. CN also requested approval of a high value invoice for GOSH Refurbishment of Woodland Ward - Cumulative Gross Valuation Less Cumulative Retention Management Board **approved** the waivers and invoice.	
927	**Any other business**	
928.1	There were no items of any other business.	