

**Meeting of the Trust Board
Wednesday 24th April 2013**

Dear Members

There will be a public meeting of the Trust Board on Wednesday 27th April 2013 at 2:00pm in the **Conference Room, York House**, Great Ormond Street, London, WC1N 3JH.

Company Secretary

Direct Line: 020 7813 8230

Fax: 020 7813 8218

AGENDA

| | Agenda Item <u>STANDARD ITEMS</u> | Presented by | Attachment |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| 1. | Apologies for absence | Chairman | |
| Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it. | | | |
| 2. | Minutes of Meeting held on 27th March 2013 | Chairman | F |
| 3. | Matters Arising/ Action Checklist | Chairman | G |
| 4. | Chief Executive Report | Chief Executive Officer | Verbal |
| | <u>PRESENTATION</u> | | |
| 5. | Clinical Speciality Presentation - Pharmacy | Chief Pharmacist and General manager for MDTs | H |
| | <u>STRATEGIC ISSUES</u> | | |
| 6. | Annual Plan 2013/14 | Acting Chief Operating Officer | I |
| | <u>PERFORMANCE REPORTS</u> | | |
| 7. | Summary of performance for the period: <ul style="list-style-type: none"> • Targets and indicators, including CRES • Finance and Activity • Quality and Safety • Infection Prevention and Control • Patient Experience | Chief Executive Acting Chief Operating Officer Chief Finance Officer Co-Medical Director Director of Infection, Prevention and Control Chief Nurse | J Ji Jii Jiii Jiv |
| | <u>ASSURANCE REPORTS</u> | | |
| 8. | Initial impact report on the Morgan Stanley Clinical Building | Director of Communications | K |

| | <u>GOVERNANCE</u> | | |
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| 9. | Changes to the Constitution | Company Secretary | L |
| 10. | Quality Governance Framework self-assessment | Chief Finance Officer | M |
| 11. | Registers <ul style="list-style-type: none"> • Register of Interests- Board of Directors • Register of Interests- Staff • Register of gifts and hospitality | Company Secretary | N O |
| 12. | Register of Seals | Company Secretary | P |
| 13. | Summary report of a meeting of the <ul style="list-style-type: none"> • Audit Committee – April 2013 • Clinical Governance Committee – April 2013 • Finance and Investment Committee – March 2013 • Board of Directors’ Remuneration Committee (and revised terms of reference) • Board of Directors’ Nominations Committee • Members’ Council | Member of the Audit Committee Chair of CGC Chair of F&I Committee Chair of Remuneration Committee Chairman Chairman | Verbal Verbal Q R, Ri S T |
| 14. | 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.) | | |
| 15. | Next meeting The next Trust Board meeting will be held on Friday 24 th May 2013 in the Charles West Room, Level 2, Paul O’Gorman Building, Great Ormond Street, London, WC1N 3JH. | | |

ATTACHMENT F

**DRAFT Minutes of the meeting of Trust Board held on
 27th March 2013**

Present

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

In attendance

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| Dr Anna Ferrant | Company Secretary |
| Mr Matthew Tulley | Director of Redevelopment |

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

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| 676 | Apologies for absence |
| 676.1 | Apologies were received from Mr David Lomas, Non-Executive Director. |
| 677 | Declarations of interest |
| 677.1 | No declarations of interest were received. |
| 678 | Minutes of the meeting held on 30th January 2013 |
| 678.1 | The minutes were approved with the following amendment. |
| 678.2 | Minute 629.2 – “Ms Mary MacLeod, Non-Executive Director asked whether the review would look at how children had died.” |
| 679 | Matters arising and action checklist |
| 679.1 | Minute 629.4 – It was reported that a team would be visiting Chelsea and Westminster Hospital NHS Foundation Trust to understand how they achieve the five day target. |
| 679.2 | Minute 632.3 – Professor Martin Elliott, Co-Medical Director reported that the Quality Strategy had been updated with the Board amendments. |
| 679.3 | Minutes 640.4 and 640.5 – Mrs Liz Morgan, Chief Nurse reported that the team |

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| 679.4 | <p>were looking at changing the patients' day to allow them to get down to the school earlier. Ms MacLeod reported that she had visited the School and had asked the teachers if they were able to be more flexible when attending the wards to provide teaching and they agreed. Baroness Blackstone, Chairman stressed that a concern had also been raised with her about teachers not being allowed access on to the wards to teach children. Ms Morgan stated that she was looking into this and would report back at the next meeting.</p> <p>Minute 633.10: Mrs Morgan reported that in the last month, 20 nurses had been recruited from Ireland and Portugal and were undertaking the Nursing Midwifery Council registration process. They were expected to start work in June 2013. A survey was underway in the hospital to understand the reasons for nurses leaving their posts. Initial findings had shown that the reasons for leaving were related to the culture of work in the divisions as opposed to personal financial issues. Work was underway to address these matters. Mrs Morgan confirmed that the Portuguese nurses have been through an English language test.</p> |
| 679.5 | <p>Minute 619.2: Mr Robert Burns, Acting Chief Operating Officer reported that the kitchens had been working on improved recipe management, implementation of quality monitoring, temperature control, waste management and having a floor manager on each of the wards. Continuous monitoring was underway. There had been a marginal increase in the results from the IPSOS Mori survey but there was a lot of work still to do. In the restaurant, issues had been raised about the cost and availability of food. There had been an improvement in the satisfaction scores since the work started. A programme of work had commenced with Guts and St Thomas' Hospital NHS Foundation Trust to look at the joint provision children's catering. A report would be presented to the Board and the Council in September 2013.</p> |
| 680 | <p>Summary of a meeting of the Finance and Investment Committee – March 2013</p> |
| 680.1 | <p>Mr John Ripley, Non-Executive Director presented the report. The Finance and Investment Committee had focused on the delivery of the CRES plan, the finance plan and discussed the reasons why Trust's fail their financial assessments.</p> |
| 680.2 | <p>The Board noted the report.</p> |
| 681 | <p>Chief Executive Report</p> |
| 681.1 | <p>Mr Jan Filochowski, Chief Executive presented the report and informed the Board that the Trust had appointed a new Chief Operating Officer, Rachel Williams. Mr Ali Mohammed had been successful at interview in being appointed to the permanent position of Director of Human Resources and Organisational Development. A new divisional director for neurosciences had also been appointed – Dr Jane Valente would succeed Carlos de Souza on his retirement and commence in post at the beginning of May. The post of General manager for surgery was about to be advertised.</p> |
| 681.2 | <p>Mr Filochowski stated that a review of committees was scheduled to be conducted over the next month. A review of the Trust strategy had also commenced. Work was continuing to streamline the Trust Board papers.</p> |
| 681.3 | <p>Mr Filochowski informed the Board that the Trust had experienced some serious</p> |

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| 681.4 | operational IT problems over the last few weeks, which had resulted in slowing down access to networks by clinical users. Work had been conducted and the access issues greatly improved. The IT team were working to risk assess and monitor access to the network to prevent future problems. Teams were working hard to reduce the number of staff with outstanding mandatory training. The Education and Training team was focusing on the Level 3 child protection training and information governance training targets. |
| 682 | Content of Phase 3A Building |
| 682.1 | Mr Matthew Tulley, Director of Redevelopment presented the report. The architects had advised the Trust that the amount of space made available could be increased and put to better use. Following a consultation with clinical teams and other interested parties, it had been proposed that the space could be used for outpatient clinics for rare diseases. An additional 3,500 square metres had been added to the building following revisions to the architectural plans. The Overall Management Group had approved the new designs and use of space and the Trustees property development committee was supportive of this, subject to financial constraints. |
| 682.2 | Baroness Blackstone raised a concern about the selection criteria for the outpatient department, in that it did not appear to take into account the current restricted space for other outpatient services. She accepted that the need for proximity to support services such as pharmacy was a key factor in determining the type of outpatient clinic to use the 3A building but that this should not be the only factor. Mr Tulley stated that the final decision had not yet been made and the design of the facility would be as generic as possible to enable flexibility of use of the building. |
| 682.3 | Action: It was agreed to add as additional criteria the adverse quality of existing outpatient spaces in the hospital. It was important to reflect the hospital's mission statement of the child first and always. |
| 682.4 | The Board approved the design of the building and the criteria for selecting how the space would be used subject to the amendment outlined above. The Chief Executive would advise the Trustees that the proposal had been endorsed by the Board and to commence discussions about funding of the design. |
| 683 | Redevelopment governance |
| 683.1 | Mr Filochowski presented the redevelopment governance review. |
| 683.2 | Mr Charles Tilley, Non-Executive Director stated that the Audit Committee and Finance and Investment Committee also had a role in scrutinising the plans for redevelopment of the hospital and that this should be reflected in the paper and the governance diagram. Mr Filochowski agreed to update the paper accordingly. |
| 683.3 | Subject to this amendment, the Board approved the paper. Mr Filochowski reported that this would now be submitted to the Charity. |
| 683.4 | Ms MacLeod asked how patients and parents experience would be built into the design of new buildings. Mr Tulley stated that parents and patients would be on |

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| | user groups of new buildings. |
| 684 | Progress Report on Francis Report Recommendations |
| 684.1 | Ms Sarah Dobbing, General Manager for Neurosciences presented the report and highlighted that approach taken by the project team was to focus on the child first and always. |
| 684.2 | The Board welcomed the plan to review the Trust against the recommendations arising out of the Francis report and agreed that the approach should involve all clinical and corporate services across the hospital. |
| 684.3 | Mr Tilley suggested that the project team link the candour and culture recommendations in the Francis Report to the GOSH staff survey findings. |
| 684.4 | Baroness Blackstone advised the Board that she had received a letter from Secretary of State for Health, The Right Honourable Jeremy Hunt asking the Trust to ensure that openness and candour was evident in everything that the organisation does. |
| 685 | Finance Plan |
| 685.1 | Mrs Newton presented the draft plan and informed the Board that the Finance and Investment Committee had also reviewed the plan and made some amendments. She emphasised that the plan relied on a high level of growth should the Safe and Sustainable review not be implemented. |
| 685.2 | Following removal of the private patients' cap, IPP services had rapidly expanded but were unable to grow any further due to space restrictions on the site. This growth could therefore not be used to offset CRES. |
| 685.3 | The Board was advised of the high cost base for education. It was expected that some capital projects would slip into next year. |
| 685.4 | The Board noted the draft finance plan. |
| 686 | Approval of business rates |
| 686.1 | Mrs Newton presented the report requesting approval of the Trust's annual business rates bill and the NHSLA insurance premium (£2.8 million). Both amounts are over £1million and under the current Standing Finance Instructions (SFIs), require Board approval. |
| 686.2 | The Board was advised that the annual business rates bill for 2013-14 had still not been received but would not be in excess of £2.3-2.4 million. Ms Newton requested that two directors are authorised to approve the expenditure up to £2.4 million once the assessment had been received and validated. |
| 686.3 | The Board approved the NHSLA premium expenditure and authorised the Chief Executive and Chief Finance Officer to approve the annual business rates bill up to £2.4 million. The Board was advised that the SFIs were due for review in the forthcoming |

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| 686.4 | months. |
| 687 | Performance |
| 687.1 | Mr Filochowski presented a summary of the report and informed the Board that there were no issues of significant concern to report. |
| 687.2 | Mr Burns stated that activity was higher than the previous year's activity. The Trust continued to meet the 18 week target and work was underway to improve performance against the discharge planning target. |
| 687.3 | The Trust had received 100% compliance across all milestones for CQUINs for quarters 1-3. In quarter 4, one division would not achieve a 10% decrease in CVC infections. In total, the Trust was expected to report approximately 95% total compliance at year end. |
| 687.4 | The Board noted the target and indicators report, the CRES report and the Finance and Activity Report. |
| 688 | Staff Survey |
| 688.1 | Mr Mohammed presented the top level findings of the staff survey and informed the Board that the team had sent out survey results for each team to discuss and develop actions. |
| 688.2 | The Trust was looking to increase the response rate to 55% in 2013. |
| 688.3 | The Board noted the survey results and on-going work. |
| 689 | Deloitte Quality Governance Review |
| 689.1 | Mrs Newton presented the report. The Board noted the findings of the quality governance review. |
| 690 | Summary report of a meeting of the Audit Committee – January 2013 |
| 690.1 | Mr Charles Tilley, Chairman of the Audit Committee informed the Board that the tender for the Internal Auditor was underway. |
| 690.2 | Mr Tilley asked the board if there was anything the committee should specifically look at during the next year. The Board recommended that the committees work plan would cover all relevant areas. |
| 690.3 | The Board noted the report. |
| 691 | Summary report of a meeting of the Clinical Governance Committee – January 2013 |
| 691.1 | The Board noted the report. |
| 692 | Any other business |

Attachment F

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| 692.1 | There were no items of any other business raised. |
| 693 | Date of next meeting |
| 693.1 | It was noted that the next Trust Board meeting will be held on Wednesday 24 th April 2013 in the Charles West Room. |

ATTACHMENT G

TRUST BOARD - ACTION CHECKLIST
24th April 2013

| Paragraph Number | Date of Meeting | Issue | Assigned To | Required By | Action Taken |
|-------------------------|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|--------------------|---------------------|
| 682.3 | 27/03/13 | Content of Phase 3A Building: It was agreed to add as additional criteria the adverse quality of existing outpatient spaces in the hospital. It was important to reflect the hospital's mission statement of the child first and always. | MT | April 2013 | Verbal update |

ATTACHMENT H

Clinical Speciality Presentation - Pharmacy

General Background

The department aims to ensure the safe, effective and economic use of medicines in the particularly challenging area of paediatrics. The majority of inpatients receive a medicine and we provide on-going clinical care to specialist outpatients often via homecare. Pharmacists work as part of our clinical teams on the wards. Some clinical specialties have their own specialist pharmacist who has developed detailed knowledge of the medicines used in that area of medicine.

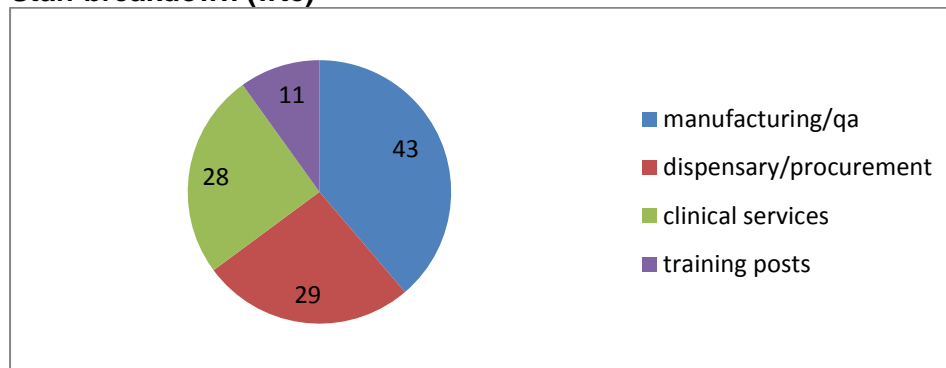
The specialty is led by Judith Cope, and managed within the Medicine and Diagnostics and Therapeutics Division.

There are 40.88wte pharmacists; 42.5 technicians; 16.5 unqualified staff; 11 preregistration pharmacists/technicians.

The department provides pharmacy services to all patients within the hospital. These include: dispensing; procurement; ward based clinical pharmacy and medicines management; manufacturing and quality assurance; research (with the School of Pharmacy, UCL) and clinical trials; provision of medicines information to staff and patients; training and the development of electronic prescribing and medicines administration; support for Drugs and Therapeutics Committee and for commissioning.

The department holds a MHRA licence to make 'specials' and to make investigational medicinal products in gene therapy.

Staff breakdown (wte)



Dispensing/distribution issues: 16615 average per month

Parenteral nutrition: 45 bespoke patients per day capacity

Centralised Intravenous additive Service: 1050 units per weekday/100units per weekend daycapacity

Cytotoxic preparation: 100 units per weekday capacity

Clinical Outcomes

Pharmacy contributes to the clinical outcomes of most groups of patients including helping to ensure that the commissioners fund medicines approved by Drugs and Therapeutics Committee.

The Chief Pharmacist meets regularly with others from the specialist paediatric hospitals in the UK so there is a potential to benchmark some of the outputs.

Safety & Risk

CIVAS – formally assess the application of robotics to production at GOSH

With Transformation/CQUIN projects:

Prescribing error rates in ICI and IPP; transcribing errors on transfer in and out of PICU;
Pharmacy bundle across ICUs

With Estates:

Intelligent storage – implemented in MSCB.

With Nursing:

IV administration - complete policy and guidelines and define high risk medicines for independent double checking

With Clinical Audit:

Never events: Methotrexate (non-malignant use); insulin

Storage of medicines

Antimicrobial - monthly

SI involving Pharmacy: an intravenous medicine was prepared in Pharmacy using an incorrect strength of the preparation. The patient recovered.

Patient Experience

No formal complaints in last year or PALS complaints in last 6 months.

Ipsos Mori Outpatient Survey (2012):15%(13% in 2010) asked for shorter waiting times at hospital/pharmacy. 83% (84% in 2010) said they had sufficient information about their medicines.

Finances

The budget for Pharmacy is £4892k. At month 11 this was 230k overspent. However this is mitigated by £146k expected from R&I; CQUIN cost pressure of 24k; allocation of business case monies.

CRES plans for 2013/14:

- procurement activities
- outsourcing of outpatient dispensing
- increased provision of homecare – savings shared with commissioners
- ensuring all prescriptions have linked activity on PiMs
- restricting TTA prescribing to contract limits

Future:

- potential for income stream from Project London (a possible joint venture through UCLP to manufacture medicines for a group of Trusts and for sale to others).

Integrated Business Plan

‘Increasing productivity

- Develop tailored clinical support worker roles to respond to needs in individual wards and departments. These may include:
 - o Developing pharmacy roles to support ward nursing staff, relieving them of the significant workload involved in calculating and making up drugs.
- Work with UCL Partners to develop shared back office functions for transactional finance, workforce and procurement services, pharmacy, facilities management, and research and development’

Pharmacy has contributed to the above by extending CIVAS operations to produce dose banded intravenous medicines in ready to use form.

Project London (see above) and contributing to the formation of the NCL Joint Formulary Committee are outputs from UCLP work.

Any Other Relevant Information

Pharmacy played an important role in moving into MSCB ensuring that: pharmaceuticals were available in the new wards and implementing intelligent systems for their storage; the quality of medical gases and water prepared on site for haemodiafiltration were both of suitable quality.

Unlike many Trusts, there is a resident pharmacist on site 24/7 which is a valuable resource to medical and nursing staff.

Challenges in recruitment are the continued shortage of pharmacists who wish to work in hospitals and in central London. The majority of the profession work in community pharmacy where salaries at the early part of a career are substantially higher. There is a continued increase in demand for hospital pharmacy staff as Trusts invest in these services to improve throughput and safety.

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| Trust Board 24th April 2013 | |
| Annual Plan | Paper No: Attachment I |
| Robert Burns, Acting Chief Operating Officer | |
| Aims / summary The Annual Plan sets out our priorities and plans for the delivering our strategic objectives and details how will manage associated clinical, governance and financial risks. The plan is in line with Monitor's recently published requirements for Foundation Trusts and has been updated following comments from March Trust Board. | |
| Action required from the meeting Trust Board to agree the Annual Plan | |
| Contribution to the delivery of NHS Foundation 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 N/A | |
| Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? The 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? Specified Executive Leads | |
| Who is responsible for implementing the proposals / project and anticipated timescales? Specified Executive Leads | |
| Who is accountable for the implementation of the proposal / project? Robert Burns, Acting Chief Operating Officer. April 2013 | |

Annual Plan 2013/14

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1. Introduction

1.1 Past year performance

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

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

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

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

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

We have continued to meet the national waiting time standards with over 90% of our admitted patients and over 95% of our non-admitted patients being seen within 18 weeks. We have also continued to achieve 100% compliance against all relevant cancer waiting standards and have consistently met the 6 week diagnostic waiting time target over the last 7 months.

The Commissioning of Quality Innovation (CQUIN) payment framework makes 2.5% of providers' contract income value conditional on achieving quality and innovation goals in a CQUIN scheme. Over the first three quarters of the financial year we have reported 100% compliance against all our CQUIN indicator milestones against a number of measures relating to reducing harm and infection and improving patient experience, public health and patient flow. We expect to report over 95% compliance at year end.

In terms of our workforce, we have received positive feedback from our annual staff survey. Our overall staff engagement score, which considers staff members' perceived ability to contribute to improvements at work; their willingness to recommend the trust as a place to work or receive treatment and the extent to which they feel motivated and engaged with their work, is reported at 3.99 compared to the national average for acute specialist trusts of 3.92. The survey also highlighted better

¹The NHS Litigation Authority (NHS LA) is a Special Health Authority, which was established in 1995. The NHS LA 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).

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

The results of our annual IpsosMORI inpatient survey highlight that we have retained an overall high patient satisfaction rate of over 90%. Patient and family advocacy rates i.e. those that would recommend the hospital to a friend or family are reported above 95% and the overall confidence in our doctors is reported at 97% and nurses 94%.

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

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

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

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

Last year we outlined our growth plans for 2012/13 and identified a number of priority growth areas where we anticipated an increase in market share. We have realised much of this growth, with particularly significant increases across Cardiac Surgery and Cardiology, Neurosurgery and Spinal Surgery.

The total number of outpatient appointments that we saw in 2012 increased by over 2,000 against the previous year to 195,350 and the total number of admissions also rose by over 1,000 to 36,650 for the same period.

Our income has grown by 6% in the year and we are forecasting achievement of an EBITDA of 7.7% compared with the EBITDA in the plan of 6.8%. Last year we set an ambitious savings target of £16.7m across the organisation for 2012/13, of which we realised £12.2m, £4m more than we had achieved in 2011/12. 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

2. Vision and objectives

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

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

Our well established record of achieving clinical excellence, quality improvement and financial stability are summarised in our Redesign and Process Improvement Delivery Programme goals of Zero Harm, No Waste and No Waits, which underpin our objectives.

In developing our priority objectives for the year ahead we have considered our purpose and values and the internal and external contexts in which we will be operating during 2013/14 and beyond. Together with a review of our past year performance we identified drivers, opportunities and threats and reviewed our own organisational capacity and capability to manage these effectively (Figure 1).

As a Foundation Trust, we want to continue to give greater say in how we’re run to local people, staff and all those who use our services, including patients, their families and carers. Our Members reflect these groups and are represented by 28 elected and appointed Councillors on the Trust’s Members’ Council. The Council has been involved in the annual plan development process and in the coming year we want to continue to strengthen involvement of our Members and the Council in the running of the organisation. A particular objective is to better facilitate direct engagement and communication between Councillors and the Members they represent.

We are starting to promote Councillors via publications and personalised letters to encourage communication with Members and are also planning to undertake listening events in the coming year. Members can also contact Councillors via our website and social media options will be explored to facilitate communication. The Membership Engagement Committee, chaired and attended by Councillors, will help to direct and co-ordinate this work.

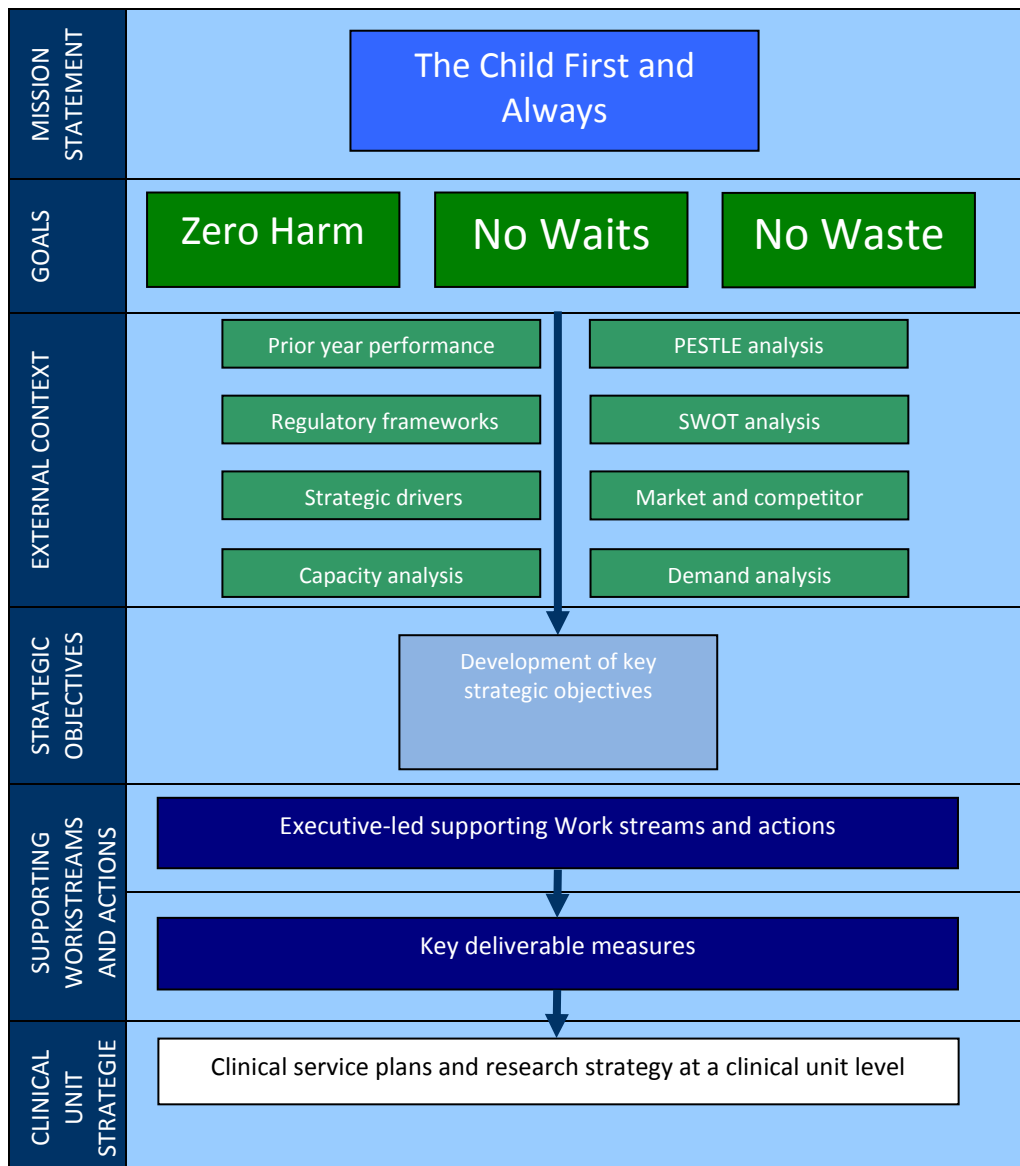
Following this process we have slightly revised our strategic objectives, notably to reflect a greater appreciation of the importance of our workforce and clinical interfaces with health care partners. Our objectives for 2013/14 are:

1. Consistently deliver an excellent and compassionate experience for our patients and their families
2. Consistently deliver world class clinical outcomes
3. Work with clinical networks, partner providers and referrers to deliver streamlined patient pathways
4. With partners maintain and develop our position as the UK’s top children’s research and innovation organisation
5. Continue to deliver high quality specialist paediatric multi-professional healthcare education.
6. Equip all staff with the knowledge, skills and training to deliver high quality compassionate care
7. Continue to redevelop and improve the hospital’s estate to provide high quality accommodation for current and future patients
8. Be a financially stable organisation and promote the sustainable use of resources

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

- Developing an overarching strategy of the Trust, with the aim of bringing together and linking individual strategies including: people, research, information technology, clinical and quality
- Within that develop a long term information/IT strategy, agree an investment profile with the board and a project implementation schedule
- Continue to expand our Intensive Care Unit (ITU) facilities which minimise intra and inter hospital waiting and reduce the refusal to take patients due to capacity
- Ensure the redevelopment of the hospital, moves forward on schedule, meeting the Trust stated objectives and including arrangements which enable existing services to continue at current levels in an acceptable way
- Improve the efficiency of theatres and outpatients in terms of resource and capacity use by at least 10%

Fig. 1 Annual Planning Process



3. Strategic context

Due to the nature of our work, we operate primarily within a regional and national (rather than local) health economy. For example, over half of our patients come from outside of London and over 90% of patients are referred by other hospitals. Our position is therefore a complex one, acting as a quaternary, tertiary and specialist secondary provider for different services for a large number of local health economies.

However, the vast majority of our clinical activity is tertiary (referred to us by specialist paediatricians) or quaternary (referred by other tertiary sub-specialist paediatric services). This type of workload can only be managed in a small number of other centres in the UK.

Our competitors therefore vary widely for each service. For some services within the Trust there are defined referral catchment areas already in place and GOSH is a clearly designated service provider within the care pathway. However, for many services we compete with other tertiary providers, and there is pressure within local health economies to keep patients and funding locally wherever possible.

To date, our strategies of providing clinically excellent services, demonstrating value for money to commissioners and focussing on referrers' expectations have been successful in mitigating this potential threat and our clinical activity has grown by over 3% this year. We plan to continue to grow within our role as a specialised paediatric services provider over the coming year.

Our primary market aims are to attain market leadership for:

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

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

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

We have identified our strategic challenges as:

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

We have developed plans to address each of these areas in order that we might continue to improve our strategic position. These include undertaking international recruitment, improving timeliness of

discharge summaries and clinic letters, a clinical outcomes programme and an ambitious capital redevelopment programme, as well as focused work around productivity (section 6).

3.1 Forecast health, demographic, and demand changes

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

3.1.2 Demographic

The population in London, the East and South East is projected to grow at a faster rate than England as a whole. The London and South East England population of 0-14 year olds will increase by an average of 1.5% per year according to Office of National Statistics (ONS) estimates. This will lead to a proportionate increase in demand for specialist paediatric services. Our referral catchment areas include highly cosmopolitan populations and it is likely that significant numbers of presentations of complex genetic diseases will remain a key feature of demand on our services. In contrast, we have also recognised that demand is decreasing in some areas, such as paediatric HIV services, and will review service models accordingly.

3.1.3 National NHS financial position

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

3.1.4 National service designations

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

3.1.5 Paediatric networks

Within London, the development of two tertiary paediatric networks is underway in order to deliver services in line with the NHS London publication "Children's and Young People's Project – London's Specialised Children's Services: Guide for Commissioners", which recommended a rationalisation of the number of providers of specialist children's services whilst enabling as much care as possible to be provided closer to home. Project progress remains slow however we see these changes as a positive development for children and families and at the same time providing some growth opportunities for the hospital.

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

3.2 Market share

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

Market share for key specialties is tracked on a quarterly basis and reported to the senior management team. Where any significant changes occur these are discussed further with specialty teams to identify any actions required. In addition, market analysis is required to be undertaken for all

business cases and service developments to ensure that developments are referenced clearly against demand and market impact.

3.3 Threats and opportunities from changes in local commissioning intentions

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

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

In addition, the significant changes to commissioning this year with the development of NHS England and its role in commissioning specialist services will naturally impact on the Trust. The majority of our work (approximately 90%) will be covered by the Specialist Definitions Set and will be commissioned by NHS England. NHS England may also commission the Trust on behalf of London patients for non-specialised activity, with the remaining Trust activity (approximately 5%) commissioned by Clinical Commissioning Groups (CCG) nationally.

We will therefore work closely with NHS England to develop an effective working relationship and our clinicians are involved in many of the relevant Clinical Reference Groups in order to best ensure a close connection with the strategic direction of commissioning and ensure that the clinical services for our patients are fully represented in commissioning decisions. The reduced number of commissioners for our services is anticipated to assist in joint strategic planning and may enable further clarity regarding designation of specialist centres, greater consistency in service provision for patients and in funding for specialised services nationally. Within the strategic planning at specialty level the new service specifications have been reviewed to ensure that services either already meet the specifications or have planned developments in order to do so. However, there may be a short term commissioning risk where commissioning responsibility between specialist and non-specialist commissioners is not clear due to the timescales for finalisation of service specifications. This could lead to a disconnect between commissioning responsibility and funding allocations. However, we have recognised this risk and that both CCG and NHS England commissioner engagement is therefore crucial.

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

3.4 Collaboration, Integration and Patient Choice

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

Where formalised commissioned networks already exist, in cancer services for example, the strategic focus of the organisation will be on working with other organisations to agree and implement the new specialised service specifications. In addition, we will develop our clinical leadership role as the hub or primary centre healthcare organisation in supporting shared care providers, working with commissioners to ensure robust governance arrangements exist across the network and to ensure optimal configurations of networks are in place for patients and families. In some cases, such as for

Haemophilia services, we are preparing to become the lead organisation for distribution of specialised network funding. We will also be developing more formalised networks, with shared outcome measures, in response to the reconfigurations in specialised services, including in Neurosciences for example.

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

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

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

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

3.5 Commissioning and regulation

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

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

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

We have undertaken a review of the five offers across all of our clinical divisions and have identified those most appropriate to the organisation - ensuring that the main elements are embedded within our existing strategies. We have already made excellent progress in identifying and publishing clinical outcome measures and have a firm plan in place to increase these over the coming year. We have an extensive patient experience and involvement plan, which we continue to build on (see section 4). One of the key areas that we will be developing over the coming year is to extend working hours across a number of services. For example we plan to implement a 7 day haemodialysis service for our renal patients and will also provide Radiology services for 6 days a week with Interventional Radiology on-call 7 days/24 hours. Additionally we have restructured our supporting services such as pathology and pharmacy to best cover out of hours periods in support of the clinical teams. Within

Neurosciences we plan to trial keeping the telemetry unit open 6/7 days a week with a potential roll-out later in year.

4. Quality strategy

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

4.1 Safety (Zero Harm)

Zero Harm is the part of our strategy aimed at minimising harm to patients; safety improvement. We are committed to reducing harm year-on-year, and to doing so as rapidly as possible.

We will ensure that care and services are patient-centred, and that access is equitable to all. The elements of this work, led by example from the Board include:

- Monitoring and review of the Trust's safety culture
- Leadership for safety (Executive WalkRound™, Safety on the Board agenda, Safety climate and culture surveys)
- Learning from, and decreasing the incidence of, Serious Incidents
- Training in improvement methodology
- Human factors and the impact on clinical care training
- Improving standardisation of processes and eliminating variation where possible
- Coaching programmes to develop and support staff
- Child Protection and Safeguarding training²
- Listening to, and actively involving, patients, families and referrers in the management and improvement of care and services
- Development of systems and processes to identify and improve health inequalities in relation to protected groups

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

| Zero Harm Standard | Aim of programme |
|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Maintain high levels of medication safety | <ul style="list-style-type: none"> • Decreasing risk from High-risk medications • Continued reduction of prescribing errors • Safe dispensing • Defect-free administration of medications • Reconciliation of medication prescription charts as a child passes through the system³ |
| Decrease and eliminate hospital acquired infections | Reduce the incidence of the following infections: <ul style="list-style-type: none"> • Ventilator Associated Pneumonia • Central line Infections • Methicillin Resistant Staphylococcus Aureus (MRSA) • Clostridium Difficile (C Diff) • Surgical Site Infections. (SSIs) • Urinary Tract Infections from indwelling catheters |
| Improve clinical handover and documentation | <ul style="list-style-type: none"> • Improve handover of all information at any point in the patient journey • Standardise handover information using the SBARD guidelines⁴ |

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

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

4 SBAR is a standardised format of transferring clinical information at each point of handover and is an acronym for *Situation Background Assessment Recommendation and Decision*.

| | |
|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | <ul style="list-style-type: none"> • Ensure Briefings for all procedures including the surgical checklists • Improve the quality of medical and nursing record keeping |
| Eliminate all pressure injuries | <ul style="list-style-type: none"> • Identify children at risk, implement interventions and reduce all pressure injuries. |
| Recognise and respond to deterioration | <ul style="list-style-type: none"> • Early detection and situation awareness early warning scores - CEWS⁵ • Communication and escalation using SBARD, • Intervention and outreach rapid response team from ICU to proactively monitor the deteriorating child. |

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

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

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

4.2 Effectiveness

Delivering effective care is, and always has been, a primary focus of GOSH. Over the last couple of years we have been evidencing the effectiveness of our care through the identification of measures that demonstrate the outcome of treatment, including clinical measures such as survival rates, complication rates or measures that demonstrate clinical improvement. In addition we have measured the effectiveness of care from the patient’s own perspective through the use of patient-reported outcome measures (PROMs). Wherever possible we will use established national or international measures that allow us to benchmark our results with other services.

We have asked each of our specialties to define clinical outcome measures and to identify centres against which they should be compared in order that we can provide evidence of the clinical quality of our services. We have established a clinical outcome programme to support specialties in the development of measures and we will further develop mechanisms to publish our outcomes on the internet in “real time”. We expect all of our specialties to report at least 3 outcome measures this year.

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

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

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

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

4.3 Experience

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

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

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

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

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

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

4.4 Access

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

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

4.5 Commissioning of Quality and Innovation

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

1. Department of Health national mandated CQUINS
 - Improving patient experience – friends and family advocacy test
 - Reducing pressure ulcers
 - Reducing line infection rates
2. Service CQUINS (agreed between commissioners and providers)
 - Monitoring and minimising the number of children transferred out of region to a PICU

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

3. Quality Dashboards

A national work programme for specialised services quality improvement has been established to assist decision making about the future oversight and governance of quality improvement under NHS England from April 2013. Our lead commissioners have specified a range of quality standards to be achieved for selected services and have developed quality dashboards that incorporate measures of clinical outcome, patient experience and service effectiveness and efficiency for completion in 2013/14. These include:

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

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

4.6 Response to Francis Report

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

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

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

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

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

Staff listening and engagement events, our continued work on maximising patient and family engagement and our development and implementation of a People Strategy across the organisation

will be initial elements of our response to the report. A detailed action plan is being developed and will be submitted to the Board in May 2013, with regular progress updates to the Board planned thereafter.

5. Clinical Strategy

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

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

The wider NHS / national benefits of our strategy are:

- Providing services for patients with the most rare and complex conditions, who have limited (or no other) healthcare options
- Saving costs for the NHS and other public services as we deliver high quality care in a timely manner avoiding waste and harmful delays in both diagnostic and therapeutic services
- Offer the widest range of paediatric specialties on one site, which suit a complex case mix by delivering integrated care from one location
- As the leading paediatric research provider, the concentration of complex cases at GOSH delivers the optimum environment for developing new techniques through translational research
- Worldwide evidence suggests that higher volumes deliver better clinical outcomes for the most complex cases

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

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

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

5.1 Service Line Management Strategy

The Trust is adopting an incremental approach to the implementation of Service Line Management (SLM). For example, service line reporting (SLR) is in place in the organisation and the information is

capable of drill down analysis to point of delivery and to individual transaction, patient or pathway level. Financial information is shared with senior clinical leads, finance teams and managers.

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

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

The majority of the clinical specialties make a positive financial contribution, but there are some areas including cancer services, general and neonatal surgery, gastroenterology and nephrology where further work to ensure that services are profitable is required. This informs where we focus work around ensuring correct income is received for services, for example through coding, and that productivity is maximised for key cost drivers for particular patient groups e.g. theatre utilisation, in order to ensure that our core services are sustainable over the long term. Each service is also conducting productivity analysis in terms of activity and cost per staff member in order to drive productivity improvements within service lines. SLR data also supports negotiation with commissioners about the true cost of treatment at a patient level for some of the areas where services are underfunded by the tariff.

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

5.2 Research:

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

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

5.2 Clinical workforce strategy

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

Through our workforce strategy, we aim to:

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

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

- Ensuring registered nursing workforce deliver appropriate tasks and work-loads, safely and to the highest standards. This includes moving to an 80:20 split (where clinically appropriate) of registered and non-registered rostered ward staff; reviewing non-registered roles to ensure consistency and appropriacy; ensuring the roll out of the Centralised Intravenous Additive Service (CIVAS) and intelligent storage to reduce unnecessary time away from the bedside.
- Ensuring the medical workforce is able to target its activities most effectively to meet Trust objectives. This includes reviewing planned activities through a refreshed job planning process; reviewing how clinical activity is delivered in particular at night to ensure the right activities are being conducted by the right member of staff, including the availability of consultant staff and reviewing junior doctor rotas.
- Developing more structured Service Level Agreements (SLAs) and activity plans for the Allied Health Professional (AHP) workforce, supported by activity collection and analysis.
- Through the roll out of the Electronic Document and Record Management System (EDRMS) and greater clinical involvement in IT development/procurement, achieve efficiencies in the use of clinical and support staff.
- Co-ordinated work in response to the Francis Report which considers the recommendations for and with the GOSH workforce, including contractual and cultural factors. We will ensure that initiatives we are already undertaking are congruent with recommendations from the Francis report.

5.2.1 Key workforce pressures

5.2.1.1 Recruitment and retention

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

5.2.1.2 Managing pay costs/achieving efficiencies

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

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

5.2.3 Impact of the Workforce Strategy on Costs

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

Where growth cannot be absorbed within existing staffing costs, improvements in our use of staffing resource and how we monitor this – such as job planning, further development of e-Panda, AHP activity recording tool – will ensure staffing requirements are fully evidence-based.

5.2.4 Benchmarking

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

facilitate internal benchmarking between individuals within specialties, with the intention of achieving greater understanding of differences in activity and improved productivity

The GOSH-designed ePanda system (Paediatric Acuity and Nursing Dependency Assessment Tool) allows the Trust to measure nursing staffing levels against nationally agreed criteria to ensure that these are both safe and efficient.

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

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

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

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

6. Productivity & Efficiency

6.1 Operational efficiency

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

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

1. Improving theatres

Theatre productivity is a key area of focus for the Trust. Targets of 77% utilisation for surgical specialties and 70% utilisation for non-surgical specialties have been set to be achieved over the next 3 years with a clear focus on increasing the total number of cases being undertaken through our theatre capacity. We will undertake a detailed audit to identify the reasons for late starts, early finishes and extended turnaround times with short cycles of improvements being implemented to address key themes. In addition, capacity for staffed theatre sessions will be re-examined and may be closed or re-allocated to ensure best use of the theatre resource.

A new pre-assessment model is in development for implementation in the coming year in order to better assess fitness for procedures and reduce short notice cancellations. New theatre and procedure areas and a Same Day Admissions Unit and Post Anaesthesia Care Unit will additionally be operational in January 2014, further facilitating better use of resources.

3. Improving Admissions and Discharge

This project aims to improve and standardise our admission and discharge processes both within and outside PICU for both elective and non-elective patients and to never refuse a clinically appropriate referral due to insufficient bed availability.

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

- NICU & PICU Flow Project– to improve flow through ICU, by reducing non-clinical delays
- Improving out-patient flow
- Improving timeliness of discharge summaries

- Improving complex patient pathways
- Reducing waits for Pharmacy in out-patients

6.2 Workforce efficiency

6.2.1 Staff Productivity

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

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

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

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

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

6.2.2 Temporary staff

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

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

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

Figure 2 Bank and agency spend



6.2 Cost Improvement Programmes (CIP)

In 2012/13 our programme of CIP delivered £12.2m against a target of £16m. This represents an improvement on our 2011/12 position of £8.2m.

Planned savings for 2013/14 currently total £17.5m, with a risk adjusted value of £16.0m. We propose to address the current risk adjusted gap of £1.7m by increasing the value of expenditure savings and have identified scope for further pay savings, particularly in a number of our Clinical Divisions.

CIP schemes are identified through both a bottom up approach within the Divisions and corporate departments. For 2013/14 we have additionally identified seven key CIP themes that we believe will realise significant benefits to the organisation. These themes will require pan-Trust coordination and are closely linked to our wider objectives of quality, safety and growth. These include:

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

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

We are also preparing to implement an electronic document management system (EDRMS). In preparation for this a review of key administrative processes that support the patient pathway has been conducted. Processes will be standardised and optimised with support from the Trust's Transformation team. The implementation of EDRMS will enable further refinement of process through the introduction of workflow technology. This will enable workforce efficiencies while also supporting the flow project.

The roll out of a Centralized Intravenous Additive Service (CIVAS) service continues and is one of the key dependencies of the Nursing theme. This theme seeks to improve the productivity of our wards by ensuring that the right workforce is in place to deliver patient care, supported by the right infrastructure.

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

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

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

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

7. Financial & Investment Strategy

7.1 Financial strategy and goals

We are forecasting to start the year 2013/14 with a liquidity position of [42.7] days, [27.1] days excluding the working capital facility based on the forecast March 2013 statement of financial position. The forecast revenue account shows a delivery of 1.1% growth in clinical income excluding pass through and 42.6% growth in Non NHS income with an overall EBITDA margin of 7.7%. We have delivered our productivity targets in full through a combination of cost reduction and revenue generation schemes. Key contributors to the growth achieved in clinical income was the opening of the new Morgan Stanley Clinical building at the beginning of the financial year and the opening of new capacity in the existing private patient wards.

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

The goals over the next three years are to:

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

A key element of which has yet to be concluded is the impact of the review of Safe and Sustainable review of children's heart services, expected to result in growth primarily from 2014/15 onwards. Growth is achievable through further leverage of new capacity afforded through our redevelopment programme, and improving productivity in all clinical areas.

Key actions

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

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

Key actions

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

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

Key actions

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

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

Key actions

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

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

Key actions

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

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

Key actions

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

7.2 Key risks to achieving the financial strategy and mitigations

7.2.1 NHS Economic environment

We are assuming ongoing tariff decline of 1.8% and further significant efficiency and productivity targets which will continue to be challenging to achieve

There will also be changes in tariff following Monitor assuming responsibility for the tariff which are currently unpredictable.

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

7.2.2 Levels of International activity

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

7.2.3 Failure to deliver on cost improvement and revenue generation plans

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

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

7.2.4 Completion of redevelopment projects

There are risks associated with our redevelopment building projects being carried out on operating sites, it is important that levels of care are not impacted. The phases of the projects are carefully monitored to avoid, where possible, impacting levels of patient care. Contingency plans have been prepared to minimise the impact of any down time in access to imaging equipment caused by the work close to the imaging department

7.2.5 IT investment

The Trust needs to build upon its existing IT infrastructure and clinical applications to implement projects which drive process efficiencies. Managing the change associated with these projects to ensure efficiencies are realised is a significant risk

The Trust intends to continue to use robust project management processes and ensure there is strong clinical leadership both in the central project team and in each clinical division

7.2.6 R&D funding

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

7.2.7 Education Funding

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

8. Organisational Risk

Our Board Assurance Framework (BAF) is currently built up from local Clinical Division risk registers and external intelligence and is continuously updated from incidents, complaints and audit. We have used this model for a number of years with assurance on the management of these risks presented on a rolling basis at Board Assurance Committees. However, it is an appropriate time to refresh the process to ensure that the organisation's highest level risks are reflected and encompass both internal and external related risks to the organisation.

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

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

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

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

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

Appendix 1: Financial commentary (NOT FOR PUBLICATION)

The forecast and plan for the three years from April 2013 is as follows:

| | 12/13 F'cast | 13/14 Budget | 14/15 Plan | 15/16 Plan |
|-----------------------------------------------------------|-----------------|-----------------|---------------|---------------|
| NHS Clinical income: | | | | |
| - activity | 221.5 | 234.7 | 247.4 | 250.0 |
| - pass through | 45.4 | 46.4 | 48.5 | 50.0 |
| | 266.9 | 281.1 | 295.9 | 300.0 |
| Priv. pt clinical income | 41.0 | 43.4 | 45.0 | 46.6 |
| R&D | 19.9 | 17.2 | 17.2 | 17.2 |
| Education | 12.8 | 13.8 | 13.8 | 13.9 |
| Other income | 15.3 | 15.1 | 15.1 | 15.1 |
| Total income | 355.8 | 370.6 | 387.0 | 392.8 |
| | | | | |
| Pay | (198.1) | (204.3) | (213.0) | (213.0) |
| Non pay | (86.6) | (94.6) | (98.9) | (101.4) |
| Pass through | (45.4) | (46.4) | (48.5) | (50.0) |
| Total operating expenditure | (330.0) | (345.3) | (360.4) | (364.4) |
| EBITDA | 25.8 | 25.2 | 26.5 | 28.4 |
| | 7.2% | 6.8% | 6.9% | 7.2% |
| NET SURPLUS (excl cap donations, impairment/gains) | 3.8 | 1.1 | 0.0 | 0.3 |

Income

The principal drivers of income in the Strategic Plan are:

- Tariff (national and locally determined)
- Activity growth plan
- Levels of on-NHS income;

All clinical specialties anticipate growth in services in line with demographic growth; for neuro and cardiac surgery, growth assumptions over the three years are based on the implementation of safe and sustainable plans which support increased centralisation of specialist activity. In addition some specialties have additional income generation schemes where there is unmet demand for their services or staff with new expertise have been recruited or new capacity is being created through restructuring service delivery.

There are risks to planned levels of income due to the uncertainty surrounding the basis on which services will be contracted, compounded by the lack of clarity on commissioning strategy. All providers are subject to commissioner PE (productivity/efficiency) initiatives, non-performance contractual penalties and have to achieve the range of applicable CQUIN targets).

Within R&D the level of central support funding from NIHR has reduced for the second year in succession.

Strategic developments

The main strategic developments for the Trust include the impact of any changes as a result of the Safe and Sustainable recommendations and a progressive expansion of Non NHS activity at a higher contribution level

The redevelopment programme is also proceeding with most of the projects within 2B enabling scheduled to be finished within 2013/14. Subsequently the demolition of the Cardiac wing and

commencement of the rebuild of the “2B” clinical building with provide significant improvements in the quality of inpatient facilities.

Transactions

The following transactions may take place in the three year period.

Phase 2B of the site wide redevelopment programme. The Trust is expecting to receive and conclude on tenders to carry out Phase 2B of the redevelopment programme in November 2013 which will involve demolition of an existing building on site.

The Trust has responded to a tender request to manage specialist paediatric services in a hospital overseas and is still waiting for a response. In the event that the response is favourable the Trust will be developing a detailed implementation plan and business case for discussion with the Members Council. This has not been addressed within the financial plan

Activity

Clinical care is assumed to grow, on average by 5.0% in 1314; 5.7% in 1415 and 1.7% in 1516. The key drivers of growth will be by opening new critical care capacity, reducing the levels of appropriate referral refusals, and reducing over long waiting lists coupled with the impact of the national and regional strategies for centralising specialist tertiary services.

Workforce priorities

The actions outlined below build on the work already delivered in 2012/13 and set out key priorities to provide an HR and Organisational Development infrastructure to support the achievement of our vision for 2013/14 and beyond. Whilst many of the actions are pan-Trust, in some cases specific activity will take place in areas of critical strategic importance such as ICU.

Recruit and retain staff with the right skills and experience to deliver high quality care in line with the Trust’s activity plans, developing targeted staffing strategies where required.

Actions will include:

- Complete an analysis of hard-to-recruit and retain posts in the Trusts and establish appropriate action plans in each case.
- Ensure the recruitment and retention work within ICU is continued and developed to ensure sustainable staffing levels
- Continue to develop the use of flexible testing as part of the recruitment process to ensure the highest quality applicants

Key risks:

Inability to recruit and retain into key roles/in sufficient numbers, impacting on clinical activity/income and costs (that is, increased use of agency staff)

Mitigation:

An analysis of the issue in each case will be the basis for targeted action plans. These will include education and training (both to support development of staff and to ensure appropriate numbers of key clinical staff are commissioned for the future; marketing campaigns tailored to specific staff groups, focusing on career development opportunities, education and training, staff benefits (e.g. childcare, accommodation) as appropriate; role redesign to reduce need for numbers of shortage roles; service and process redesign to ensure skilled staff are not undertaking inappropriate work; addressing reasons for staff leaving; continuing to grow the staff bank so that high quality staff can fill vacancies rather than using higher cost agency staff. All these actions are already being taken within ICU in a planned programme to ensure vacancy levels are reduced and maintained at a sustained level, including during periods of activity growth.

The Trust will also explore the opportunities provided by changes to Face terms and conditions and its status as a Foundation Trust if reward packages will demonstrably address recruitment and retention issues without destabilising other areas of the organisation.

Continue to reduce expenditure on all staff groups through the management of temporary staffing costs.

Actions will include:

- Full implementation of the new nurse bank contract, with particular focus on financial Key Performance Indicators (KPI's) at the same time as continuing to deliver high quality.
- Implement new mechanisms within the in-house bank for all other staff groups, such as e-bank system and weekly pay, in order to deliver greater efficiencies of process and client management
- Create action plans for areas with continuing high agency spend

Key risks:

Inability to recruit appropriate staff onto the banks

Posts are unfilled, or the Trust is forced to use higher cost agency staff

Mitigation:

The nursing, medical and all other staff banks have grown considerably in the last 12 months, with a commensurate increase in the numbers of posts being filled by bank rather than agency. This includes migrating staff from agency to bank.

The Trust is introducing new systems and processes, including weekly pay, which will be a further incentive for staff to join the bank

Bank pay rates have been pegged at levels that would allow some tactical increase

The Trust has successfully implemented agency bans to date

The Trust is using methods similar to those to recruit substantively to attract bank staff, for example offering the staff hotel to bank staff who live at a considerable distance

Support clinical units and directorates in ensuring the most effective use of their staffing resources, including workforce planning that includes numerical plans as well as redesigning staffing around service needs; creation of new roles and working patterns; outsourcing/shared services where appropriate.

Actions will include:

- Ensure the workforce/OD implications of EDRMS are fully integrated into the project process so that sustainable benefits are realised
- Support the move to extended working hours for specific services
- Ensure high quality HR/OD support to major initiatives such as Safe and Sustainable reviews
- Further develop work on productivity, including the use of tools such as job planning to help staff to be as effective as possible
- Outsourcing/moving to shared service models for identified services (In 2013/14 procurement and supply chain, switchboard, and sterile services)

Key risks:

Delay in implementation of EDRMS or failure to realise benefits

Staff resistance to extending working hours, changed roles or service delivery models

Failure of outsourcing/shared service to deliver savings/service levels

Failure to deliver continuing productivity gains

Patient care negatively affected by service changes.

Mitigation

Dedicated project management is in place for delivery of EDRMS, with close alignment with ICT and Workforce

High quality change management processes, with full engagement with staff side, to ensure changes that impact staff are achieved fairly and effectively. The Trust has achieved this in the past, for example in moving to a shift system in Pathology in 2010.

The learning for the Trust from recent outsourcing episodes will inform further projects. Partnership working with other NHS organisations provides risk sharing/greater transparency of process

The Trust has a record of achieving productivity improvements. Staff, including medical staff, are engaged in/leading work to facilitate greater productivity.

There is clinical input into all projects that have a clinical impact. Service delivery levels, contract monitoring and the continual review of KPI's including complaints, incidents are built into projects.

Lead the Trust in an examination of its approach to OD in the context of a new longer term strategy and a vision of the future.

Actions will include:

- Development of an OD strategy
- The application and transfer of behavioral science, knowledge and practice such as leadership development, work design and group dynamics to improve team working/assist dysfunctional teams; so that our hospital system is capable of carrying out more planned change in the future
- Improving our organisational effectiveness by promoting high performance including excellence in clinical and customer care, a safe and open culture and environment, sound finances, high productivity as benchmarked against peer hospitals, continuous improvement as the norm and a high quality of working life for our staff.

Key risks

Failure to deliver changes in behaviour/culture required in order to support Trust's strategic development

Mitigation

Changes in leadership roles in the Trust provide an opportunity for review and refresh. The Trust already invests in a range of high quality leadership development activities which can be built on at all levels and across the organisation

Changes to Face terms and conditions provide an opportunity for open discussion with staff about achieving high performance as individuals and collectively

This is a medium term strategy that will be achieved incrementally.

Resource requirements

The Workforce and Learning and Development functions, in partnership with departments such as Transformation and the units/directorates, contain considerable expertise to take this work forward. However, where specific expertise or resource is required, for example to support OD work or to project manage significant staff moves, this will be procured on a time-limited basis and built into the overall costs of project delivery.

Service growth plans are already considered within workforce plans and associated costings.

Monitoring delivery and quality

The Trust has established workforce and clinical KPI's and a governance framework which includes active risk registers which are regularly reviewed locally and by Executives for red risks. These include patient complaints and staffing issues.

The Trust monitors performance against workforce plans, productivity and key workforce KPI's such as absence, vacancies and turnover. KPI reports are benchmarked against performance of comparable London trusts and show performance at ward and departmental level. Drill down reports, providing narrative for reasons underlying poor performance, are undertaken for outlying departments. In 2013/14, workforce KPI's will be enhanced to allow forecasting as well as retrospective analysis, with the opportunity for closer alignment with clinical KPI's to highlight linkages. ePanda, will continue to be used to monitor ward nursing levels are appropriate to the acuity of our patients.

Our response to the Francis report includes a comprehensive project, led by the Co-Medical Director, which will include ensuring that we listen to and act on feedback; engage staff in identifying and addressing problems; have systems to monitor and measure what we do; and ensure that we report clearly on quality, incidents and outcomes. This infrastructure review will further ensure that changes within the workforce strategy are closely monitored for their impact on patients.

Key areas of work, such as EDRMS, are being formally managed within a project management structure which will ensure delivery, escalation and appropriate governance. Large scale workforce projects report to the Workforce Delivery Group, which is joint-chaired by the Director HR and the Director of Nursing. The Trust has recognised the scale of these projects and the need for co-ordination between them over the next three years and is reviewing the WDG in this light.

Capital Expenditure

The 2B Enabling Works programme (to enable the vacation of the Cardiac Wing and construction of our next clinical building – 2B) is underway and is due to complete in spring 2014. This work is funded by the GOSH Children's Charity (GOSHCC) and includes: a new respiratory ward; re-provision of angio suites; creation of a

Post Anaesthetic Care Unit (PACU); the redevelopment of the main entrance area including additional space for outpatient clinics.

Maintenance or replacement Capex

We have a detailed backlog maintenance register which was compiled in 2010 and has formed the basis of current expenditure plans. A significant proportion of investment needs are being met as part of the Trust Redevelopment Programme which is well underway and in particular opportunities are being taken to maximise the benefits in relation to the elimination of backlog through the Phase 2B main scheme, and associated enabling works. A refresh of the backlog plan is planned for 13/14 to take stock of investments made and to rebase funding requirements moving forward.

All capital expenditure is generally funded from cash surpluses although some specific projects including the 2B enabling project may be funded by the GOSH Charity. Within current capital investment plans a recurrent sum of £700k per annum has been set aside for backlog investment which will meet the immediate investment needs for engineering and building plant replacement, including investment needed in services infrastructure, and this is supplemented by the wider site redevelopment plans.

There are minimal risks associated with delivery of the current backlog plans and any that do materialise due to slippage or cost creep will be managed through a combination of re-phasing and reprioritisation.

Other capital expenditure

We have a three year investment plan for IT which has been developed to support the Trusts strategy. The Technical Delivery Board (TDB) is responsible for approving capital expenditure from a capital allocation granted by the Capital and Space Planning committee (CASP). We are entering a phase where large scale cyclical renewal is required (replacement of near end of life equipment related to network, server and storage) which will cause constraints on wider IT related programmes of work. TDB and CASP will need to balance wider Trust priorities against the need to sustain existing services, as well as introduce new services to deliver efficiency and other wider benefits.

For the acquisition or replacement of medical equipment, we have a very robust process for assessing all cases. All requests are subject to outline business cases which are then considered by a clinician lead committee who determine priorities and make recommendations to the Capital and Space Planning Committee. These are typically all GOSHCC funded. Significant projects in 2013-14 include the provision of 3-Tesla MRI and the purchase of a Next Generation DNA Sequencer.

There are no immediate negative impacts on quality if the redevelopment projects are delayed although this would impact the Trust in the medium term. Timely execution of IT projects is important in terms of CIP delivery

Appendix 2: Cost Improvement Plans (CIPs) - Top 5 CIP Schemes (NOT FOR PUBLICATION)

| Ref | Scheme | Scheme description including how scheme will reduce costs | Underpinning IT / information or management systems | Total savings £m | Phasing over three-year period (£) | | | WTE Reduction | Has the scheme been subject to a quality impact assessment (Y/N) | Who is responsible for signing off on the quality impact assessment | Key measure of quality for plan | Scheme Lead |
|-----|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------|-------|-------|---------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------|--------------------------------------|
| | | | | | Yr. 1 | Yr. 2 | Yr. 3 | | | | | |
| 1 | Patient flow | This scheme aims to optimise the use of resources to deliver the Trust's activity plan at an improved contribution margin. | Transformation projects to streamline patient pathways and improve theatre utilisation. Increased critical care capacity. | £11.4m | 37 | 40 | 23 | | Y - Individual schemes with value greater than £100k undergo formal quality impact assessment. Growth strategy and Transformation objectives have been approved by Trust Board. | Chief Nurse Co-Medical Director | Patient satisfaction levels Readmission rates | Director of Planning and Information |
| 2 | Procurement and contract management | Delivers savings through better procurement of equipment and by building efficiency requirement into service and maintenance contracts | Review of procurement systems and engagement in partnership work. | £10.8m | 25 | 30 | 45 | | Y - Individual schemes with value greater than £100k undergo formal quality impact assessment. Workforce plan has been approved by Trust Board. | Chief Nurse Co-Medical Director | Lack of medical equipment incidents | Chief Finance Officer |

| | | | | | | | | | | | | |
|---|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|----|----|----|---|------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------|----------------------------------|
| 3 | Clinical workforce and productivity – Medical, Nursing and AHP themes | These themes aim to increase the productivity of the clinical workforce. It will deliver savings through skill mix changes, some headcount reduction and by increasing capacity | Development of support services to wards including CIVAS and new housekeeping service. Review of medical job planning. Workforce redesign of allied health services. | £5.9m | 40 | 35 | 25 | | Y - Individual schemes with value greater than £100k undergo formal quality impact assessment. | Chief Nurse Co-Medical Director | Staff sickness and turnover rates Patient satisfaction | Chief Nurse, Co-Medical Director |
| 4 | Admin workforce and productivity | Delivers savings through headcount reduction and skill mix change enabled by IT investment and process redesign. | Investment in IT systems, process redesign and Transformation projects | £4.0m | 33 | 33 | 33 | 0 | Y - Individual schemes with value greater than £100k undergo formal quality impact assessment. | Chief Nurse Co-Medical Director | Staff sickness and turnover rates Patient satisfaction | Co-Medical Director |
| 5 | Medicines | Delivers savings through better procurement of drugs and pharmacy related services | | £1.7m | 33 | 33 | 33 | 0 | Y - Individual schemes with value greater than £100k undergo formal quality impact assessment. | Chief Nurse Co-Medical Director | Incidents of lack of medications | Chief Operating Officer |

Appendix 3: Commercial or other confidential matters (NOT FOR PUBLICATION)

Our international strategy recognises that our private activities on our London site have almost reached capacity. We believe that future development will require commitments to advise or support developments in tertiary paediatric services overseas. A series of options have been considered by a strategy group which included executives, senior staff from the International Division, Members from our Members Council and a NED. The conclusion of the group is that the Trust should continue to explore and respond to approaches to develop activities overseas whilst ensuring that the risk of conflict with our NHS activities is minimised.

A further small commercial venture is being explored in conjunction with four other NHS Trusts in London, primarily through combining activities and jointly pursuing a strategy to market services to other NHS providers and to private providers

**Trust Board
 24th April 2013**

Performance summary report

Paper No: Attachment J

Submitted by: Jan Filochowski, Chief Executive

Aims / summary

Board members are provided with a performance summary report outlining key issues requiring Board attention and assurance of action being taken. The report covers:

Targets, Indicators and Cash Releasing Efficiency Savings (CRES) (Attachment Ji)

- 18 weeks and diagnostic waits achieved
- Reduction in average number of days clinic letters sent from 27 to 16 days over the past year
- C Diff (4 for year) and MRSA (7 for year) within contractual target limits
- Monitor governance risk rating remains green – score of 0
- Discharge summaries remain challenging – reduction in performance primarily in MDTS division this month – partly data entry but primarily issues with regarding staffing, weekend and bank holiday arrangements which are being addressed.
- £12.2m CRES delivered against target of £16.7m. CRES plans for 13/14 total £17.5m.
- Increase in number of complaints this month compared to trend – primarily in Surgery and Neurosciences. 3 of the complaints relate to a particular issue that is being addressed.

Finance and Activity

March financial results and activity information not yet finalised due to the need to ensure a precise cut off of the financial year end. Results are expected to be better than previous recent forecasts and a larger than planned surplus will be delivered.

Quality and Safety (Attachment Jii)

Within the new structure, the Transformation team will report to the Director of Planning and Information and the Quality and Safety team will report to the Co-Medical Director. This report outlines progress for both teams, but in future may be separated.

- As at end March 2013, there were no statistically significant changes to Zero Harm indicators.
- More targeted approach to improvement priorities being implemented
- Recurrent issue with ‘lost to follow up’ serious incidents requires further investigation
- Improved process for managing SIs in development
- Quality report being finalised (will be presented at Board in May)
- Apart from diagnostic services, all specialties have identified 3 outcome measures
- Decrease in total number of complaints this year (115) compared to last year (134)

| |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><u>Infection Prevention and Control (Attachment Jiii)</u></p> <p>This report provides an update on progress with the annual infection prevention and control plan and important issues which have arisen since last report.</p> <ul style="list-style-type: none"> • No further reduction in CVL related infections this year on last year – further work planned to identify preventable infections and develop care bundle • Drop in standard of cleaning across Trust – action plan in place <p><u>Patient Experience (Attachment Jiv)</u></p> <ul style="list-style-type: none"> • New patient led inspections (PLACE) of care environment and food replace the previous PEAT inspections. PLACE Board established to oversee the process. • Developing a Trust wide patient experience promise in collaboration with the Members' Council <p>Those directors accountable for delivery for the above areas will provide further assurance of aspects of performance during the meeting.</p> |
| <p>Action required from the meeting</p> <p>The Trust Board is asked to comment on performance for the period.</p> |
| <p>Contribution to the delivery of NHS / Trust strategies and plans</p> <p>To assist in monitoring performance against internal and external defined objectives and NHS targets.</p> |
| <p>Financial implications</p> <p>Failure to achieve contractual performance measures may result in financial penalties.</p> |
| <p>Legal issues</p> <p>None</p> |
| <p>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?</p> <p>Our lead commissioner receives a sub-section of the performance report on a monthly basis.</p> |
| <p>Who needs to be told about any decision</p> <p>Senior Management Team</p> |
| <p>Who is responsible for implementing the proposals / project and anticipated timescales</p> <p>Executive Directors and relevant senior managers.</p> |
| <p>Who is accountable for the implementation of the proposal / project</p> <p>Executive Directors</p> |

Targets, Indicators and CRES

Year to Date Performance

At year end we over delivered on spells and for intensive care beds we witnessed an increase of two occupied ITU beds in the second half of the year over the first.

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

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

The overall discharge summary completion rate (within 24hrs) is reported at 70.2%, which represents a deterioration of approximately 6% against the previous month. This is primarily due to a significant reduction in performance in one Clinical Division, Medicine & DTS, who report a drop of 32%. The reasons for this are currently being investigated but it is thought to be the result of data recording error rather than an actual decline in performance.

Performance is sustained across Surgery, ICI-LM & Cardiology. A significant improvement of 8% is reported in Neurosciences. Clinical divisions continue to work on their plans to reduce the total time taken to complete and send discharge summaries.

The percentage of clinic letters sent within 5 working days following clinic attendance has improved since April 2012 from 14% to 21% in month. More significant is the reduction in the average number of days in which letters are sent, which has fallen from 27 days to 16 days over the same period. This issue has been subject to a specific improvement project involving all Clinical Units but further work is required to achieve our targets.

A higher than average number of complaints was reported in month compared to the rest of the year. Five complaints were attributed to Surgery and four to Neurosciences. Within surgery three complaints relating to a single clinician were received within one week. The Clinical Division is currently investigating this issue. Whilst the overall number of complaints for the year was higher than the previous year, the number of high level complaints reported has more than halved.

At year end we reported 4 cases of MRSA against a target 0. 7 cases of C.Difficile were reported against a target of 8. Both measures remain within the contractual agreement and within Monitor's de minimis limits.

Monitor Governance Risk Rating

We remain Green in quarter 4 with the best possible score of 0. We anticipate this continuing into 13/14. Monitor is considering the inclusion of a number of additional new metrics and standards within the governance risk matrix following the publication of the National Mandate, NHS Constitution and NHS Outcomes Framework. Indicators identified as relevant to GOSH

include: Referral to diagnostic time (6weeks), 30 day emergency readmissions and medication errors causing serious harm.

Clinical Unit Performance Escalation

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

| Measure | Change | Clinical Unit | Narrative |
|-------------------------------------------------------------|--------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Percentage of Clinic Outcome forms complete | | ICI-LM | ICI Performance in March for COF is 90.71%. Out of 2400 forms required, 2177 were completed (223 missing: 102 Rheumatology, 88 Dermatology). Performance in Rheumatology & Dermatology over the last 2 months has deteriorated as a result of staffing issues which are now resolved. The team have prioritised clinic letter turnaround and discharge summary targets and as a result clinic outcome form performance has dropped (however still maintaining 83% for dermatology and 79% for rheumatology). The backlog of outcome forms is currently ~60 for both teams and a target of 2 weeks to clear this has been set. Performance across many other specialties remains consistently high (e.g., in March BMT was 93%, Haematology 99%, Oncology 99%). |
| Percentage of Clinic Outcome forms complete | | Surgery | The deterioration in performance has been identified as a temporary issue related to high staff turnover and sickness. The Unit have recently implemented a major change in the administration structure, which has resulted in some disruption to normal service. There has also been a lot of focus on improving the turnaround time of clinic letters. Office managers will be ensuring that all outstanding outcome forms are completed over the next two weeks with performance expected to return to normal high levels. |

International and Private Patients report a statistically significant improvement in the total rate of hospital acquired CVL infections for every 1,000 line days from 7.59 in April 2012 to 1.49 in February 2013.

CRES Programme April 2013

In 2012/13 CRES schemes with a value of £12.2m were delivered. This is a considerable improvement on the £8.2m delivered in 2011/12 but falls short of both the £13.3m LTFM requirement and the £16.7m delivery target. There has been a reduction in the value of savings over the final month of the year from a risk adjusted position of £13.8m reported to March Board.

Overall we have delivered a larger than planned surplus despite missing the £13.3m CRES requirement. This may in part reflect the fact that 30% of clinical income contribution is taken

centrally to mitigate risk before units are credited with CRES.

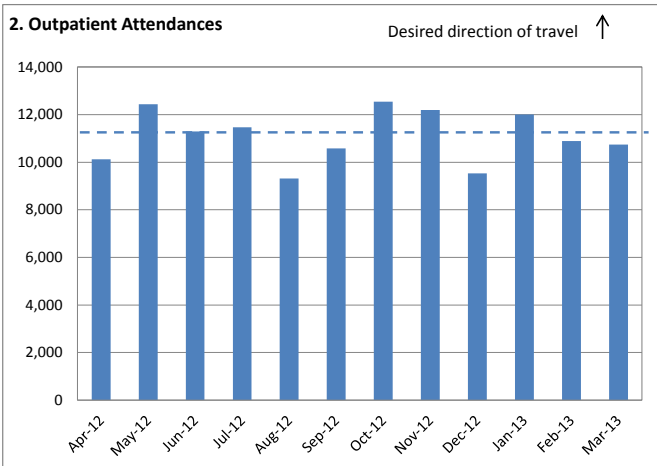
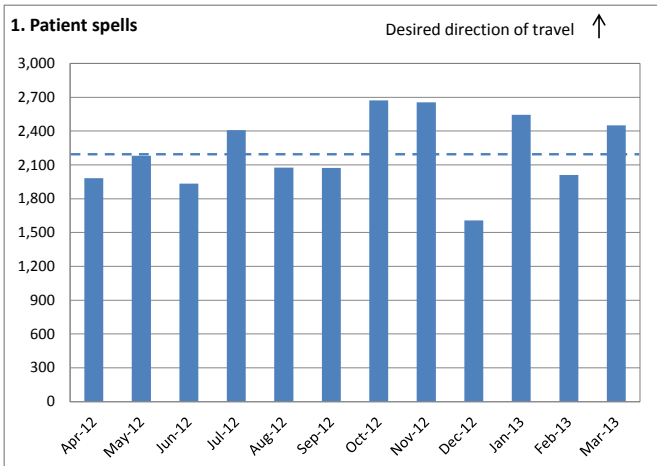
Planned savings for 2013/14 currently total £17.5m, with a risk adjusted value of £16.0m. It is proposed to address the current risk adjusted gap of £1.7m by increasing the value of expenditure savings and a review of current plans has highlighted scope for further pay savings, particularly in some of the clinical Divisions.

In light of the 2012/13 experience, avoiding a drop in the value of schemes late in the year will be a key challenge for CRES programme going forward. It is proposed that an increased focus on and scrutiny of higher value schemes (> £100k) will be one way to achieve this.

Targets & Indicators Report

| | Indicator | Graph | YTD Target | YTD Performance | Monthly Trend | | | | | | | | | | | |
|-------------------------------|-----------------------------------------------------------------------------------------------------------|-------|------------------|-----------------|---------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| | | | | | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Nov-12 | Dec-12 | Jan-13 | Feb-13 | Mar-13 |
| Activity & Use of Resources | Number of patient spells | 1 | 26,100 | 26,596 | 1,983 | 2,182 | 1,934 | 2,409 | 2,076 | 2,072 | 2,671 | 2,654 | 1,608 | 2,545 | 2,010 | 2,452 |
| | Number of outpatient attendances | 2 | 137,273 | 133,333 | 10,122 | 12,443 | 11,295 | 11,463 | 9,322 | 10,587 | 12,544 | 12,190 | 9,527 | 12,010 | 10,887 | 10,742 |
| | DNA rate (new & f/up) (%) | | <10 | 8.9 | 8.8 | 8 | 9.5 | 8.8 | 9.4 | 8.6 | 8.9 | 8.5 | 8.8 | 9.5 | 8.7 | 8.8 |
| | Number of ITU bed days | 3 | 9,563 | 9,072 | 772 | 749 | 684 | 726 | 637 | 789 | 836 | 808 | 814 | 791 | 664 | 802 |
| | Number of unused theatre sessions | 4 | Baseline year | 244 | 15 | 7 | 18 | 32 | 26 | 23 | 16 | 9 | 60 | 14 | 16 | 8 |
| Patient Access | 18 week referral to treatment time performance - Admitted (%) | 5 | 90 | 91.3 | 90.5 | 90.1 | 90.4 | 90.5 | 91.4 | 91.7 | 92.8 | 93.8 | 90.6 | 91.1 | 90.1 | 92.1 |
| | 18 week referral to treatment time performance - Non-Admitted (%) | 5 | 95 | 95.9 | 97.4 | 96.4 | 96.1 | 95.6 | 95.1 | 95.4 | 96.2 | 95.3 | 95.5 | 95.4 | 97.1 | 95.6 |
| | 18 week referral to treatment time performance - Incomplete Pathways (%) | 5 | 92 | 93.0 | 91.8 | 93.4 | 93.2 | 92.0 | 92.0 | 92.8 | 93.3 | 94.5 | 93.9 | 93.7 | 92.8 | 92.5 |
| | Cancer patients waiting no more than 31 days for second of subsequent treatment (%) | | 98 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| | Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%) | 6 | <=1 | 3.28 | 6.00 | 5.80 | 9.00 | 7.93 | 6.62 | 0.84 | 0.17 | 0.63 | 0.77 | 0.57 | 0.28 | 0.75 |
| Patient / Referrer Experience | Number of complaints | | <99 | 112 | 8 | 13 | 11 | 7 | 12 | 9 | 10 | 5 | 6 | 5 | 9 | 17 |
| | Number of complaints - high grade | | <11 | 5 | 1 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | Discharge summary completion (%) | 7 | 85 | 77.3 | 79.8 | 82.6 | 80.4 | 81.1 | 78.3 | 70.8 | 78.4 | 76.7 | 75.9 | 77.4 | 76.3 | 70.2 |
| | Clinic Letter Turnaround, % letters on CDD - sent within 5 working days | 8 | 50 | 19.1 | 13.8 | 15.9 | 19.3 | 21.5 | 18.1 | 21.5 | 19.5 | 19.6 | 21.7 | 20.7 | | |
| | Clinic Letter Turnaround, letters on CDD - average no. working days sent | 8 | To reduce | 20.1 | 26.7 | 23.5 | 21.1 | 21.1 | 19.8 | 19.7 | 19.0 | 18.2 | 16.2 | 16.0 | | |
| Quality & Safety | Combined Harm Index | 9 | Within Tolerance | 23.1 | 26.8 | 23.7 | 27.9 | 19.6 | 20.3 | 22.3 | 22.0 | 24.0 | 22.7 | 16.9 | 22.6 | |
| | Paediatric Trigger Tool (adverse events per 1000 bed days) | | Within Tolerance | 159 | 157 | 122 | 115 | 91 | 73 | 28 | 159 | 31 | 0 | | | |
| | Number of serious patient safety incidents | 10 | Within Tolerance | 32 | 4 | 6 | 5 | 1 | 4 | 1 | 1 | 2 | 0 | 3 | 2 | 3 |
| | Hospital mortality rate (per 1000 discharges) | | Within Tolerance | 3.3 | 1.8 | 2.9 | 4.5 | 3.4 | 4.4 | 2.9 | 2.3 | 3 | 5.1 | 2.2 | 3.4 | 3.8 |
| | Combined infection index | | Within Tolerance | 3.1 | 4.3 | 4.2 | 4.1 | 3.2 | 2.4 | 2.7 | 2.5 | 2.9 | 3.7 | 2.1 | 2.3 | |
| | Incidence of C.difficile | | 8 | 7 | 1 | 0 | 1 | 1 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 |
| | Incidence of MRSA | | 0 | 4 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| | CV Line related blood-stream infections (per 1,000 line days) | 11 | 1.5 | 2.0 | 3.1 | 2.8 | 2.1 | 1.2 | 0.7 | 1.8 | 2.1 | 2.3 | 2.3 | 1.9 | 2.0 | |
| | Number of arrests outside ICU (cardiac or respiratory) | 12 | Within Tolerance | 75 | 5 | 6 | 5 | 6 | 5 | 4 | 5 | 11 | 7 | 8 | 6 | 7 |

Activity and Use of Resources



Description: The total number of patient spells (including day case, elective and non-elective)

Target: Contractual target: 2,175 spells per month

Trend: Reduction in activity in February reflects fewer working days. Activity reported above target in March

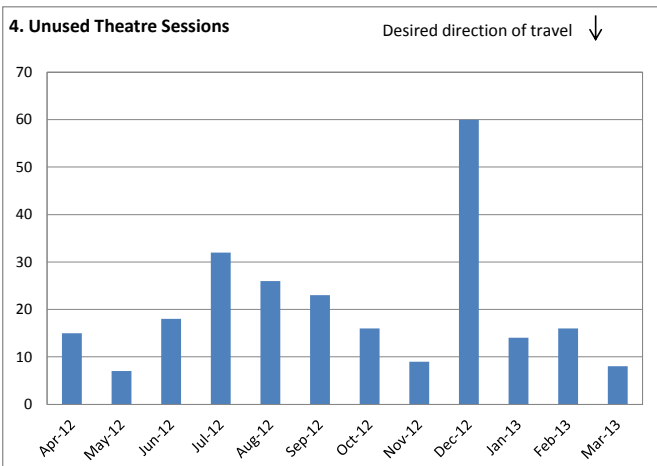
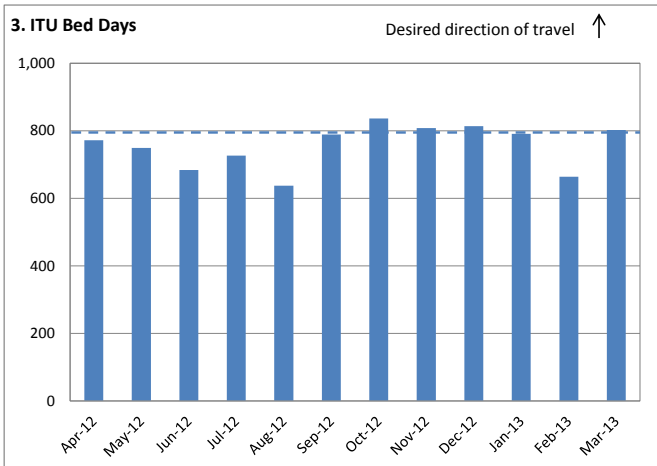
Comment: Year end performance above target

Description: Total number of new & follow-up consultant-led chargeable appointments

Target: Contractual target: 11,439 attendances per month

Trend: Activity remains under target in March

Comment: Year end performance just below target



Description: Total number of ITU bed days used per month

Target: Contractual target: 797 bed days per month

Trend: Upward trend, particularly in second half of year

Comment: Recruitment much improved in PICU & CICU

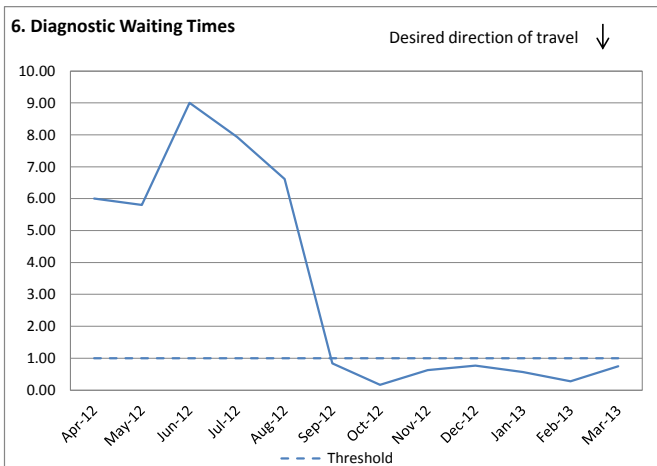
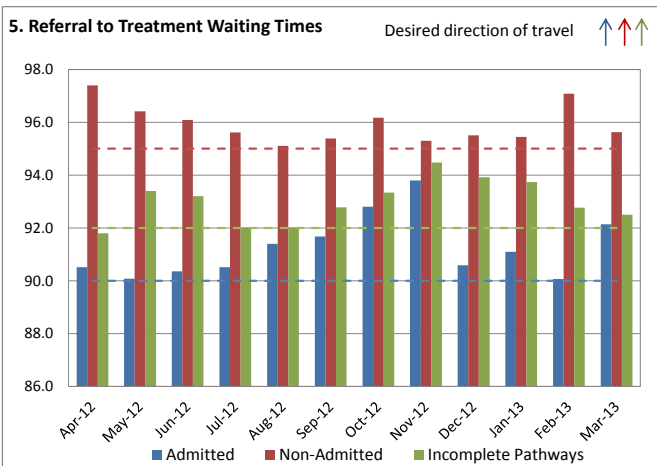
Description: Total number of scheduled theatre sessions not used

Target: Internal target: To be confirmed

Trend: Continued general improvement since July 12 with exception of anticipated increase in December

Comment: December was as expected with Christmas holiday period, and consultant/medical leave. Plans in place to reduce in future through new consultant leave policy from April 2013.

Patient Access



Description: Referral to treatment waiting times for admitted and non-admitted patient pathways

Target: Monitor/Contractual target: Admitted 90%, Non-admitted 95%, Incomplete pathways 92%

Trend: Performance sustained above standards. Trend tends to mirror activity levels

Comment: Higher number of breaching admitted patients identified in Surgery impacting on performance. Plan in place to reduce.

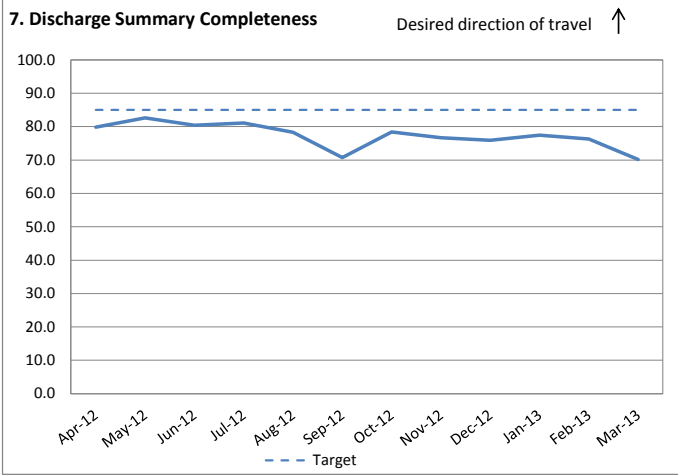
Description: The proportion of patients waiting no more than 6 weeks for diagnostic test (across 15 national key diagnostic areas)

Threshold: Contractual target (likely to be Monitor target 2013/14): <1%

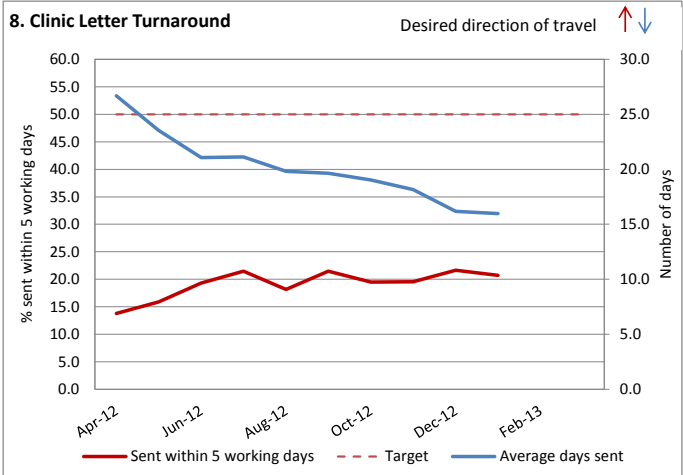
Trend: Small negative movement against previous month

Comment: Performance sustained under 1% threshold for seventh consecutive month.

Patient / Referrer Experience

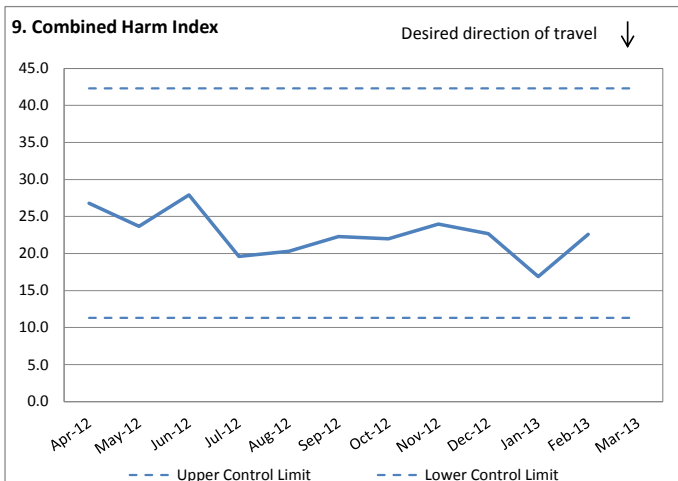


Description: The percentage discharge summaries completed and sent within 24 hours of patient discharge
Target: Internal target: 85%
Trend: Negative movement in month
Comment: Performance impacted by signification reduction in MDTS. Issue being investigated but thought to be recording error rather than actual decline in performance

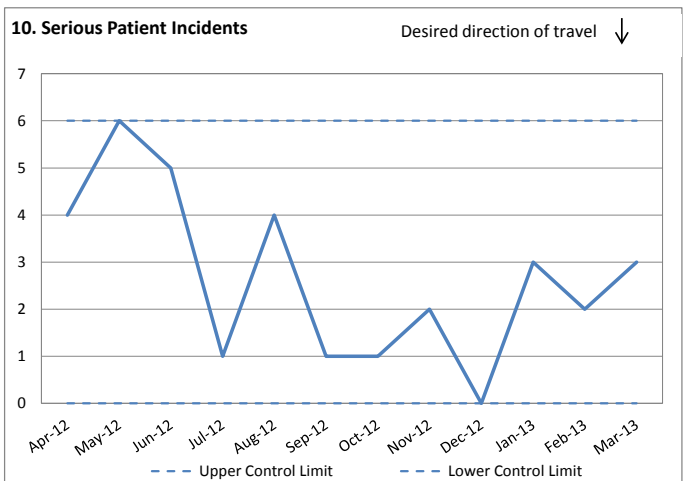


Description: The percentage of clinic letters sent within five working (and average days) following patient clinic attendance & recorded on the Clinical Document Database (CDD)
Target: Internal target: 50%
Trend: Continued improved performance
Comment: A working group in place to progress performance

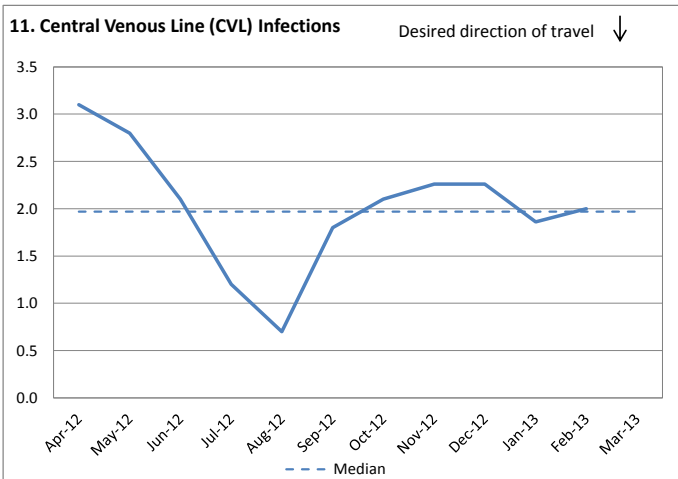
Quality and Safety



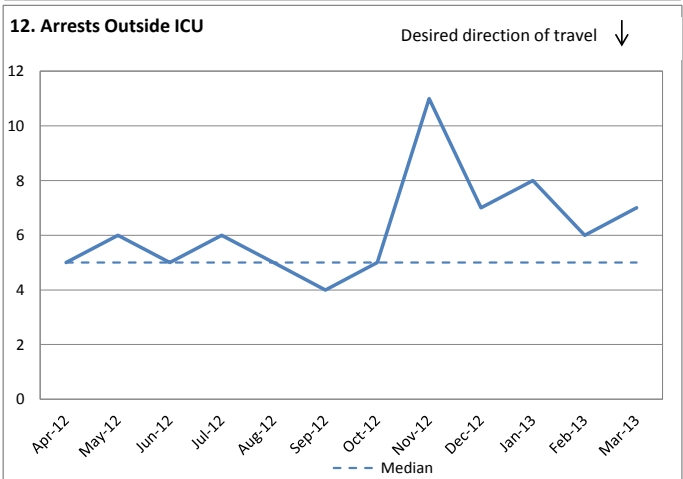
Description: Harm index comprised of hospital acquired infections (CVL, serious incidents, non-ICU arrests, medication errors, falls, and pressure ulcers).
Target: Internal target: Year on year reduction
Trend: Small reduction in performance
Comment: No statistical change



Description: Defined as either - Unexpected/avoidable death of patient(s), staff visitors or members of public. Serious harm to patient(s), staff, visitors or members of public. Allegations of abuse. One of the core sets of 'Never Events'
Target: Internal target: To remain within control limits
Trend: Performance deteriorated with 3 SIs reported in March
Comment: Performance remains within statistical tolerance



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



Description: The monthly number of arrests (cardiac or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team)
Target: Internal target: 50% reduction
Trend: Continued improvement in performance since December with small negative movement in March

Monitor Governance Risk Rating

| Targets - weighted (national requirements) | | Threshold | Score Weighting | Reporting Frequency | Score Weighting Q1 | | | | Score Weighting Q2 | | | | Score Weighting Q3 | | | | Score Weighting Q4 | | | | |
|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------|-----------------|---------------------|----------------------|--------------|--------------|--------------------|--------------------|--------------|--------------|--------------|--------------------|--------------|--------------|--------------|--------------------|--------------|--------------|--------------|--------------|
| | | | | | M1 | M2 | M3 | Q1 | M1 | M2 | M3 | Q2 | M1 | M2 | M3 | Q3 | M1 | M2 | M3 | Q4 | |
| 1 | MRSA - meeting the MRSA objective * | 0 | 1 | Quarterly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 2 | Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)** | 0 | 1 | Quarterly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 3 | All cancers: 31-day wait for second or subsequent treatment comprising either: | | 1 | Quarterly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | Surgery | 94% | | | | | | | | | | | | | | | | | | | |
| | Anti cancer drug treatments | 98% | | | | | | | | | | | | | | | | | | | |
| | Radiotherapy (from 1 Jan 2011) | 94% | | | | | | | | | | | | | | | | | | | |
| 4 | Non Admitted within 18 weeks | 95% | 1 | Quarterly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 5 | 92% - 18 week referral to treatment time Incomplete Pathways Performance | 92% | | Quarterly | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 6 | Maximum waiting time of 31 days from diagnosis to treatment of all cancers | 96% | 0.5 | Quarterly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7 | Certification against compliance with requirements regarding access to healthcare for people with a learning disability | N/A | 0.5 | Quarterly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | | | | | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Overall governance risk rating | | | | | Amber - Green | Green | Green | Amber-Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green | Green |

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

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

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

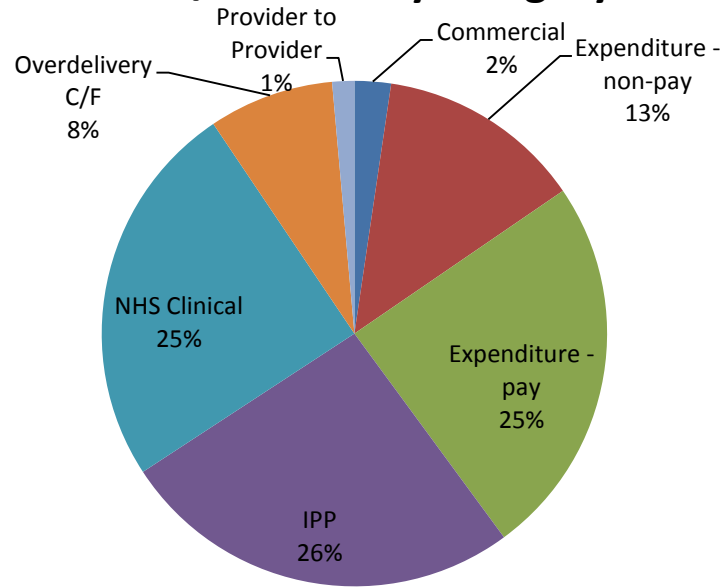
**Monitor's annual de minimis limit for cases of C. difficile is set at 12

Appendix A - CRES Summary

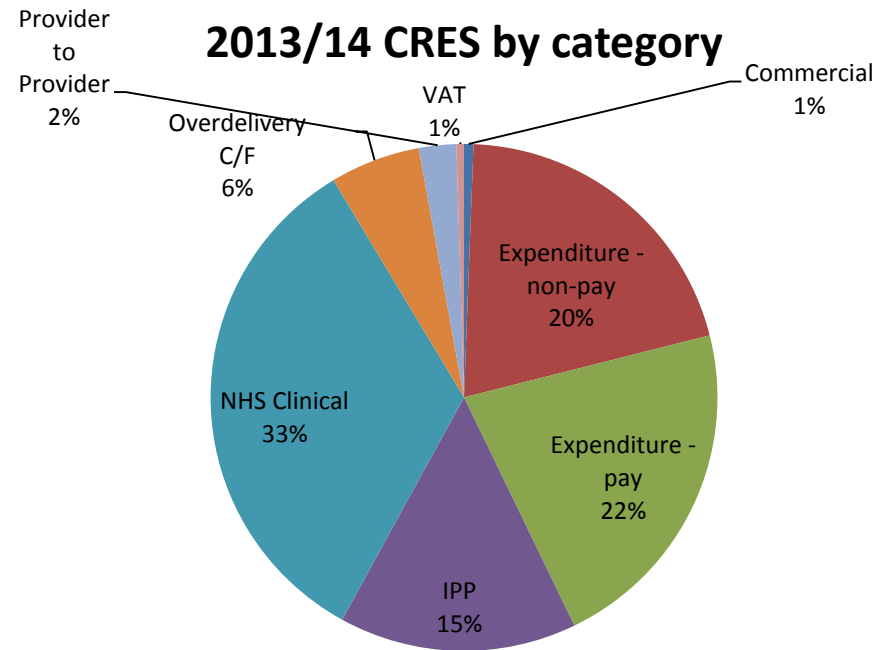
| Division | 2012/13 | | | | 2013/14 | | | | |
|-------------------------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|---------------------|------------------------|-------------------|
| | Delivery target | Total identified | Schemes completed | Final variance | Delivery target | Total identified | Risk adjusted total | Risk adjusted variance | Schemes completed |
| Critical Care and Cardiorespiratory | 3,576,600 | 1,384,394 | 1,384,394 | -2,192,206 | 4,118,632 | 3,493,635 | 3,183,544 | -935,088 | 0 |
| ICI | 2,678,200 | 1,939,427 | 1,939,427 | -738,773 | 1,912,123 | 1,306,417 | 1,336,417 | -575,706 | 0 |
| International | 1,022,000 | 1,827,153 | 1,827,153 | 805,153 | 1,297,066 | 2,127,781 | 2,016,100 | 719,034 | 805,152 |
| MDTS | 2,154,000 | 1,272,512 | 1,272,512 | -881,488 | 3,130,099 | 2,788,431 | 2,336,521 | -793,578 | 0 |
| Neurosciences | 1,383,000 | 1,248,667 | 1,248,667 | -134,333 | 1,303,473 | 1,735,989 | 1,780,894 | 477,421 | 0 |
| Surgery | 2,039,326 | 1,949,440 | 1,949,440 | -89,886 | 2,033,919 | 2,189,381 | 1,824,069 | -209,850 | 0 |
| Corporate facilities | 1,214,900 | 819,192 | 819,192 | -395,708 | 1,080,070 | 1,088,855 | 1,003,731 | -76,339 | 0 |
| Clinical & Medical Operations | 281,400 | 382,569 | 382,569 | 101,169 | 302,339 | 484,216 | 456,736 | 154,397 | 75,076 |
| Corporate affairs | 152,600 | 146,635 | 146,635 | -5,965 | 104,053 | 115,975 | 99,167 | -4,886 | 0 |
| Estates | 749,300 | 154,886 | 154,886 | -594,414 | 947,217 | 705,254 | 615,827 | -331,391 | 0 |
| Finance & ICT | 810,082 | 439,459 | 439,459 | -370,623 | 877,363 | 838,119 | 767,185 | -110,178 | 0 |
| HR & workforce | 256,200 | 307,008 | 307,008 | 50,808 | 167,636 | 224,656 | 198,655 | 31,019 | 0 |
| Nursing & Education | 347,200 | 322,049 | 322,049 | -25,151 | 305,913 | 382,800 | 352,813 | 46,900 | 0 |
| R&I | 53,200 | 28,000 | 28,000 | -25,200 | 80,066 | 30,000 | 24,000 | -56,066 | 0 |
| Total | 16,718,008 | 12,221,389 | 12,221,389 | -4,496,619 | 17,659,971 | 17,511,510 | 15,995,659 | -1,664,311 | 880,228 |
| | | | 73% | | | | 91% | | 5% |

Appendix B - CRES by category and year

2012/13 CRES by category



2013/14 CRES by category



Quality, Safety & Transformation Report

Safety Report

Safety & Risk Management

- Number of days since last Serious Incident (at 16/04/13) 21 days

Of the twelve current open SIs, some have similarities to previously investigated incidents and serious incidents and 3 themes are apparent – pressure sores, patients 'lost to follow up' and information governance breaches. Investigations identify that there many different processes for arranging surgery or follow up appointments across the Trust. The team are reviewing whether this is a factor in patients being lost to follow up and if standardisation would provide benefits.

- Number of days since last red complaint (at 16/04/13) 41 days

There are 20 open complaints, with 0 being red rated. Staff attitude, communication (with families) and organisation (arranging tests before procedures) have all been themes of the complaints this quarter and this is consistent with previous periods. However, the total number of complaints received in 2012/13 has decreased from 134 (in 2011/12) to 115.

There are currently 7 complaints that the Parliamentary Health Service Ombudsman are reviewing. Due to a change in the acceptance criteria for the PHSO to review complaints the Trust can expect to see an increase in the number of complaints being reviewed by the PHSO. A paper with more detail has been sent to the Quality and Safety Committee.

Improved process for managing Serious Incidents

The Quality, Safety & Transformation (QST) team manage the process for reporting and responding to serious incidents. There have been a number of issues with the SI process and much work has been undertaken to understand these, improvements have been suggested which include the following:

- Improved process management
- Clarity around roles and responsibilities
- More support for those involved in Serious Incidents
- Improved structure for shared learning and monitoring improvements
- Early escalation to avoid delays

A new process is being developed.

Improved process for managing risks

We are planning to revise the process of risk management reporting at Board level and proposals are being developed to share with the assurance committees prior to the presentation to Trust Board in June 2013.

Quality Report

The Quality report is being finalised with key stakeholders and will be presented at Trust Board in

May for sign off.

Clinical Outcomes Development

43 out of 45 specialties had identified three or more outcome measures by 31st March 2013. The two that have not are diagnostic services, which do not have standalone measures in the same way that medical and surgical specialties do. A discussion forum has been arranged for mid-April to consider more suitable approaches for diagnostics. In the last quarter, two additional measures have been published to the Trust website and more are in preparation.

Of 15 international centres that registered their interest in participating in a GOSH-led benchmarking project, 14 have provided their responses to phase 1 (common conditions and procedures; existing outcome measures and where they are reported; if there is interest in developing additional measures). Responses received indicate common ground from which to identify measures with the richest potential for benchmarking. Most of the participating centres have agreed to their responses being shared within group, to enable peer evaluation.

Transformation

The Transformation programme continues to support agreed zero harm priorities. However, in order to deliver a more targeted programme, a recent review has been undertaken. Following this a number of centralised projects have been agreed by Overall Management Group to deliver a *rapid* improvement programme. These projects focus on flow through theatres, ICU and improving admission and discharge processes, with additional work streams to be developed for improving timeliness of discharge summaries and to improve waits for pharmacy. This work will be reported to Overall Management Group with highlights provided to Trust Board.

Infection Prevention and Control

Infection Prevention and Control (IPC) management arrangements

Staff – The team were unsuccessful in their bid to gain funding from Transformation to replace their Practice Educator. Therefore, there are two WTE nurses in the IPC team. We understand that there is a plan to a Zero Harm Improvement Manager to oversee patient outcomes Trust wide that would assist the IPC team with reviewing Zero harm in relation to infection prevention & control.

Surgical Site Surveillance (SSI) – the central team was disestablished on January 31st 2013. The divisions undertaking surveillance are setting up their surveillance systems locally and are expected to report at the Divisional monthly divisional infection control boards.

Divisional IPC Meetings and action plans: The Divisions, with exception of MDTs, have produced local IPC plans and have regular meetings. Attendance and actions continue to improve.

There has been a noticeable improvement in medical involvement. MDTs have chosen to include the function of a Divisional IPC group in the Divisional Board, rather than establish a separate Group. IPC Team to be invited. This has not happened yet.

External Peer Review by SHA into HCAI's on January 2012. Action plan being implemented:

- ensuring all staff (including medical) are trained and assessed as competent when dealing with vascular access lines
- re-launch of central and peripheral line care bundles with new recording forms
- draft Trust Wide Policy for Intravascular catheter insertion was prepared and discussed at OMG; this was passed to HR and progression is awaited.
- implementation of DH guideline on antimicrobials (Start smart, stay focused) being implemented through an Antimicrobial stewardship programme (first meet July 2012)
- initial audits completed;
- plan to create a CQUIN around this area;
- Lead Nurse for IPC from North Central London Commissioning is expected to review our evidence.

Health care associated infection (HCAI) statistics and prevention programmes

1. HCAI mandatory reporting for financial year 2012/13

a. MRSA bacteraemia (target = 0) – 2 cases since last report,

Total for financial year = 3 Trust apportioned (1 spontaneous bacteraemia, 1 contaminant, and one line related (but source never found).

b. C. difficile infection (Target < 9) – 0 apportioned cases since last report

Trust apportioned for financial year = 7 (No definite cases)

c. Methicillin sensitive S. aureus (MSSA) bacteraemia (no national 'target') – 15 episodes

since last report

MSSA bacteraemias (divided by time in hospital before onset):

| | 2010 | 2011 | 2012 | 2013 (Jan to March 2013) |
|-------------------|------|------|------|--------------------------|
| In for < 48 hours | 12 | 14 | 9 | 3 |
| In for > 48 hours | 24 | 9 | 16 | 4 |

RCAs have been performed for all episodes and a summary report will be produced.

d. E. coli bacteraemia (no national 'target') – 10 episodes since last report, so 19 episodes in the last financial year. 6 present on admission.

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

Ongoing surveillance shows no annual reduction in CVL infections for financial year

| Financial year | 6/7 | 7/8 | 8/9 | 9/10 | 10/11 | 11/12 | 12/13 |
|---------------------------------------------|-----|-----|-----|------|-------|-------|-------|
| Rate per 1000 line days (= 108 episodes) | 9.9 | 4.3 | 3.7 | 3.3 | 2.6 | 2.0 | 2.1 |

One fifth of the Blood stream infection – CVC related bacteraemia CQUIN will not be met (total value for this CQUIN £180,143; £36028 not achieved).

A targeted 10% rate reduction was achieved in Surgery, CCCR and IPP, but not in ICI or MDTS. While there is undoubtedly some difficulty in classification of events, especially with the immunocompromised patients in ICI at risk of bacteraemia of uncertain origin coded as line infection or translocation subsequently seeding the line and effectively unpreventable, we feel there are some preventable infections and continued effort is still required in ensuring 100% compliance with the care bundle and we will work with ICI to develop the care bundle further where possible.

3. Surgical site infection prevention and surveillance

Central surveillance has ended. Divisional reports will be required. Review of surveillance data has demonstrated association of significant risk of infection or disordered wound healing (ASEPSIS score) with recognised risk factors

- Younger
- Lower intra-operative core temperature
- Longer operation
- Incision left open
- Antibiotic protocol not followed (ASEPSIS not SSI)
- Emergency surgery
- Implant
- Lower weight
- Higher ASA score and wound class

Theatres have elected to focus on improving intra-operative core temperature.

Outbreaks

The IPC team closed one ward last November for 3 days due to staff and patients reporting diarrhoea.

Since last report, the Trust has seen approximately 150 patients with confirmed viral diarrhoea and vomiting, 40 of whom possibly acquired infection in hospital, and 250 confirmed viral respiratory infections, with 50 acquired in trust. Control of these infections is a high issue, requiring early recognition in staff, parents and patients and implementation of standard precautions from onset.

Cleaning

Environmental and equipment decontamination remains essential; new audit system introduced. There have been two new contract managers appointed from MITIE since our last report.

There was a significant drop in the standard of cleaning across the Trust; this was escalated to the exec team. The Chief Nurse was very concerned by the concerns raised to her by the IPC team, that cleaning became a regular feature on visible leadership days. An action plan is now in place with Mitie to address the issues raised

Implementation of isolation precautions and 'infection cleans'

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

Policy for the haematology / oncology outpatients department (Safari) was debated at IPC in November - It was decided to tailor the policy to help ease the throughput of patients, although this will increase the risk of cross transmission. This area has a full time cleaner during the day to facilitate these cleans.

However, other concerns are being raised by families who are concerned regarding the lack of isolation facilities in areas such as outpatients and radiology. Some of these families feel that they are receiving less than satisfactory service in these areas. The IPC team are often implicated in complaints which have in fact arisen due to the structural constraints of these facilities.

Implementation of Trust policy in radiology was debated at the March IPC Committee. It was acknowledged that the policy cannot be implemented. Further debate and work is needed on how the Trust assesses the risk balanced and importantly how this is communicated to patients, staff and families. This will be taken to the next IPC Committee and new parent leaflets will be developed.

Infection prevention and control regular audits and data display

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

Estates

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

Detailed external legionella audit of building by building is underway, with action plans where required.

b. Detailed surveillance of taps in ICUs for *Pseudomonas aeruginosa* commenced in line with DH guide. Small number of outlets were contaminated and action taken to successfully resolve this. Regular (6 monthly) retesting has been agreed and will be taking place.

c. Critical ventilation systems – good progress has been made in the implementation of annual verification of the critical ventilation systems, although all areas are not yet up to date.

Resources will be required to maintain this.

Training, updates and competencies

Face to face IPC update has been removed from regular sessions – on-line material was provided. The Learning & Education team are meeting with the IPC team later this month to discuss the content of the IPC training package in line with Skills for Health, which has developed a national package.

Electronic recording of training is not complete; although Trust is hoping to move to a new data system.

Competencies for all staff on common procedures – Individual Divisions are implementing this for IV line care and access. There are Divisional procedures for insertion but implementation of Trust policy is awaited.

Morgan Stanley Clinical Building - See legionella.

Occupational Health - Good Flu vaccine uptake this year additional doses were ordered and administered during the winter.

Health and safety

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

Patient Experience

Young People's Forum

The fourth meeting of the Young People's Forum will be on 28th April and will focus on Branding and Identity. The Forum has requested a Facebook page and work is in progress to enable this. In addition, work is underway with the Charity to create a web page for the Forum which will give it an external facing profile and promote its work.

In-patient Survey

The results of the Ipsos Mori annual in-patient survey for 2012 are now available and were presented to April's Trust Board.

Patient led inspections (PLACE)

There has been a very positive response from patients and parents to participate in PLACE inspections and training took place in March. There will be 5 inspection teams comprising staff and patient/parent representatives who will select 2 wards to inspect. The ward environment and the food that is being served on the day will be inspected. Three inspection teams will form the morning assessment and two inspection teams will form the afternoon assessment. GOSH has not yet been notified of the week it should conduct its inspection. A 6 week notice period will be given.

Patient Experience Standards

Work has started with the Training department to plan the roll out of the Experience Standards which were developed through the Front of House project. This includes the feasibility of promoting the Standards during Induction, having bespoke sessions with staff other than those who work on main and Outpatients receptions e.g. health care assistants, as well as other Bands 1-4 staff.

Kingfisher/Rainforest Wards

A major project intended to improve the services and capacity on Kingfisher and Rainforest Wards is being planned. This will entail looking at all aspects of the patient's journey, policies, protocols, pathways, communication, nursing and medical care. There is a real opportunity to make changes that will benefit the patient, family and Trust. The PPI Officer is working with staff to ensure that patients and families are able to fully express their views and preferences.

Cardio-Respiratory Focus Group

The PPI Officer supported staff in conducting a focus group to assess the experiences of patients and families using Cardio-respiratory services. The broad areas for discussion were Buildings, Environment and Facilities, Care and People/Staff. A summary of initial findings will be presented at the April PPIEC meeting.

Listening Event

A small working group reporting to a sub-group of the Members' Council has been established

to plan a 'Listening Event' focusing on the development of a universal patient experience promise. This is likely to take place in June 2013. The PPI Officer is supporting the working group.

Neurosciences, Kings Fund Project

Further to previous updates on this project, which is concerned with ensuring the experience of families with complex needs - and in particular those who have Duchenne's Muscular Dystrophy – is as positive as it can be, further insight work has been undertaken with around 30 families. Two volunteers conducted in depth telephone interviews with parents to capture their views on communication, what happens before, during and after the appointment, waiting times and general experiences of attending GOSH for the day. The interviews are being collated into one report and a focus group will be held with families in late April.

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| Trust Board 24th April 2013 | |
| Feedback on the Morgan Stanley Clinical Building Submitted by: Lesley Miles Director of Marketing and Communications | Paper No: Attachment K |
| Aims / summary To provide Trust Board with feedback from families and staff on the new clinical building. To report against the objectives established in the business case/case for support. To identify learning for the next phase of the redevelopment – phase 2B. | |
| Action required from the meeting To note information | |
| Contribution to the delivery of NHS Foundation Trust strategies and plans Part of redevelopment programme to increase capacity and improve the patient, family and staff experience | |
| Financial implications None | |
| Legal issues None | |
| Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? Surveys were conducted amongst families pre and post MSCB and staff post MSCB. | |
| Who needs to be told about any decision? Information has been shared with redevelopment team, clinical operations and nursing board. Information will now be shared with clinical teams in the MSCB and as part of impact reporting programme within the charity. | |
| Who is responsible for implementing the proposals / project and anticipated timescales? Redevelopment team has noted feedback and taken action on issues/will be incorporating feedback into 2B plans. Marketing and communications team to share information internally and provide impact reporting to donors and other key stakeholders. | |
| Who is accountable for the implementation of the proposal / project? Matthew Tully – Director of Redevelopment Lesley Miles – Director of Marketing/communications | |

Initial impact report on the Morgan Stanley Clinical Building (MSCB)

Background

The MSCB became operational in spring 2012 with its official opening in summer 2012. It is the first part of the Mittal Children's Medical Centre with the second building due to open in 2017 (subject to necessary approvals). The Mittal Children's Medical Centre was budgeted to cost £321m with a £75m contribution from the Department of Health and the balance to be raised through fundraising (note: £45m still to be raised at the time of writing).

The primary objectives of the Mittal Children's Medical Centre were established as:

- To increase capacity in line with demand – up to 20% more patients treated
- To upgrade inpatient and parent facilities – specifically around privacy, space and comfort
- To improve models of care for patients – co-locating teams and work stations
- To improve the working environment for staff – improve staff recruitment and retention

The purpose of this paper is to provide an initial report against these objectives so that feedback can be given to key stakeholders including donors to the building and also that any initial learning from families and staff can be incorporated into planning for the next building.

Methodology

- Patient data has been provided by the planning and information team.
- Surveys were conducted amongst parents of children and young people on wards prior to moving to the new facilities and then the same survey carried out amongst parents on the new wards – please note that they weren't the same families. The surveys took place in November 2011 and November 2012. (approx. 20 surveys per ward in each round)
- Staff were invited to answer questions on their views on the new facilities. Staff were asked for feedback in January 2013.

Note: This paper does not include any environmental benefits (post 2B), staff turnover or recruitment data (to be provided at a later date), any project specific clinical or research outcomes arising from co-location of teams/new facilities. Furthermore, there is a separate study being undertaken on the Lagoon restaurant and kitchen which will be presented by the facilities team.

1. Patient activity levels

The business case and the fundraising case for support set out that there would be increased demand for the hospital's services and that the hospital needed to plan to treat up to 20% more patients by 2016, the original date scheduled for the opening of the 2B building.

The following data looks at overall activity levels within the hospital and includes inpatients, outpatients and day cases. The MSCB has cardiac including intensive care, neuro and renal centres and includes an additional operating theatre. Therefore we have looked at specific data for these areas as well.

Actual patient activity levels show significant increases in the number of patients treated now and also forecast increases in activity in future:

- Patient activity has increased by 125% since 2000, accelerating most quickly since 2006/7 when the business case was generated and the fundraising campaign initiated.
- There has been a 40% increase since 2006/7 in the number of surgical and non-surgical procedures

- There will be an estimated 30% increase in cardiac patient activity 2012/13 vs 2011/12.
- There will be an estimated 9% increase in neuro patient activity 2012/13 vs 2011/12.
- There will be an estimated 10% increase in renal activity 2012/13 vs 2011/12.
- Projected patient activity is forecast to increase by 25% in the next 10 years.
- Demand for critical care services is forecast to increase by 62% in the next 10 years, most notably in the next 3 years.

What do we know now vs the original business case/case for support

- Demand for the hospital's services is even higher than originally forecast.
- Medical advances mean that we can help more children and young people. We are also treating more patients as day cases and many in-patients now need to be in hospital for shorter periods of time.
- There is greater demand for in-patient facilities for children who need the highly specialist care provided at GOSH – this is reflected in the NHS move to fewer, larger specialist centres and the increasing demand for our critical care services.

How has the MSCB helped?

- Three of the hospital's largest specialties have already moved into the new facilities and experiencing increased activity – there will be further benefits with the opening of 2B.
- The additional operating theatre is in use.
- There are more cardiac intensive care beds on Flamingo (subject to staff recruitment)
- The vacated CICU space will be used to create additional intensive care facilities of NICU and PICU.
- GOSH has played a leading role as a national service provider for epilepsy surgery (new telemetry suite) and a factor for the GOSH case in the Safe and Sustainable Cardiac Surgery review (although outcome still uncertain at the time of writing).

2. Feedback from parents

Please note that there are charts to support each of the points made below which are available if you would like to see them. However, in the interests of brevity, the key differences between the before and after set of results are as follows:

Inpatient wards

- Space: Inpatient wards on the MSCB are much more spacious – and this is most evident in the renal and cardiac wards. Benefits including being able to manoeuvre buggy/wheelchairs around, space for parents to sleep at night if they want to, enough space when people are visiting patients.
- Privacy: Inpatient wards on the MSCB have significantly more privacy than previous wards.
- Noise: Inpatient wards on the MSCB are nice and quiet compared with previous wards. Note, that this is most marked on Eagle (vs Victoria) and Flamingo (vs old CICU).
- Comfort: Parents noted that there were more comfortable chairs to sit by their child's bed. Facilities to make drinks and snacks were better (other than neuro which was more or less the same). Significant improvements in all in-patient wards for access to private bathrooms. Significant improvements in all in-patient wards for areas for families to wait together.
- Play: There is a marked improvement in availability of a room for older patients vs the young. Some feedback that there weren't enough toys and games in the playrooms but it should be noted that this survey was conducted prior to Christmas (when we had large volumes of donated toys).

What could be better on the new in-patient wards?

We gave parents on the MSCB wards the opportunity to tell us what improvements they would like to make. There were a range of snagging issues which have subsequently been addressed. These included TVs not working, more play stuff for older children, more help needed explaining how things work, automatic windows annoying, shortage of crockery.

The most important feedback is that parents found it less easy to meet other parents (due to the number of single rooms) and the fact that they view the kitchen as outside the ward. The 'hub' space is not used consistently although some parents like it – particularly at night.

The redevelopment team are carrying out a separate study of the use of this space. It should be noted that the hub space was always designed to work between the two parts of the Mittal Children's Medical Centre.

Daycare and clinical investigations

Walrus contains a new lung function unit, ECHO and ECG and also cardiac day care. Responses to the new facilities vary amongst each of these areas.

- The Lung Function Unit has been very well received – compared with the old unit.
- ECHO/ECG has been less well received – less spacious and privacy than previously.
- Cardiac day care response is mixed. Privacy and access to treatment rooms are better but the ward, waiting areas and playroom is not considered better. It should be noted that this was always envisaged as a temporary move given the original plan for ambulatory care in Phase 2B.

3. Initial feedback from staff

We asked staff to feedback anonymously on what they thought of the new facilities. The summary of their feedback is as follows:

- Staff working on inpatient wards recognise and are delighted that the new facilities have improved the situation for patients and families.
- The facilities built specifically for staff (staff rooms and meeting areas) are very well received although it should be noted that staff room on Flamingo is considered too small for the number of staff using it. (staff rooms get smaller as you go down the building).
- There are a range of defects and considerations which have already been reported to the redevelopment team (toilets broken, temperatures on floors, work stations too small for paper based work (they were planned for paper free working)).
- The increases in the size of wards have created challenges for staff – mainly for trying to find their colleagues. The potential of new ways of working, co-locating teams and volunteer stations are yet to be realised but recognition that this will happen over time.
- The feedback from staff is best summarised in this quote: 'Better than the old unit. Few teething problems to be expected. Overall has great potential.'

4. Conclusions

This initial review confirms that the new building has gone a long way to meet some of the original objectives established for the Mittal Children's Medical Centre.

- Demand for the hospital's services have and continue to increase. The MSCB has already played a part in helping to meet this increasing demand.

Attachment K

- Facilities for in-patients and their families are better with space, privacy and comfort much improved.
- Cardiac day care/ECHO and ECG has been less well received and the redevelopment and clinical teams need to work together to try and find various solutions to work around the space.
- Staff facilities are much improved but there are also challenges created by the larger space and it takes time to settle in and adjust to a new environment.

5. What happens next?

- These findings have been shared with the redevelopment team and the nursing board. They are now being shared with the individual clinical teams.
- These findings will be shared with the charity team to enable them to provide feedback to donors who have funded the building and also to help develop fundraising propositions to fund 2B.
- Further feedback will be sought from staff at a later date.

Lesley Miles

Director of Marketing and Communications

April 2013

Appendix – some of the verbatim quotes we received

“When I first saw Eagle Ward I was amazed - it’s so much bigger and lighter and I feel so much more comfortable in the new facilities. Having your own en-suite makes such a huge difference to families and with the additional space I’m able to get Charlie out of the cot and he can play like a baby should. Everything has been really well thought out for both the child and their families. Simply having built-in lockers to store belongings not only improves the space for the staff when they’re caring for Charlie but also just makes it a more pleasant space to stay in. The breakout area for families is a wonderful area away from the ward where I can chat to other parents and it means I am able to make a cup of tea if Charlie is sleeping.”

Yvette

Mum of Charlie

“For the most part I used to stay on Tiger Ward. The staff always made the ward as nice as possible but it was quite dull and felt and looked like a hospital. There were also one or two issues like not having your own bathroom. It meant that to go to the toilet I had to unplug myself from my monitoring equipment every single time which was a real pain. My dad used to get frustrated as well, as he didn’t have a proper place to sleep and he has a bad back, so that caused real problems for him.

Earlier this year I moved over to the new Koala Ward which is so much better than the old ward. I like the cool pictures on the wall and larger rooms. Also the problems with the bathroom and parent sleeping situation have been solved. During my stay I had my own en suite which was much more convenient and my dad had a much more padded and comfortable sofa bed so he could stay next to me easily.”

Susanna, teenage patient

“When the new Flamingo Ward opened Indy was one of the first patients to be transferred. Even though the new ward is much bigger in comparison, the intimate feel with the one-to-one care still exists, and the extra privacy afforded by the space really does make a difference. When your child is in intensive care, having your own space becomes really important as it means you can discuss things properly with the staff and as a family. Also, when Indy moved out from intensive care into the new cardiac unit, Bear Ward, there was a similarly big improvement with en-suite facilities and a sofa bed so we could stay close to her at night.”

Paul

Dad of Indy

“As a parent, one of the things I love about Koala Ward is the sofa bed with privacy curtain that I get to sleep on. I know Oliver does find it reassuring when I stay next to him at night, although being a young boy he won’t admit it! Not only are the beds comfortable but it’s nice that the curtain gives you your own space, for example if you want to read when your child is sleeping.

Oliver loves Koala Ward as well. Having an adolescent chill out room separate to the young children’s playroom is his favourite bit. He finds it upsetting being around younger children who can sometimes be much more ill than him. I know he really enjoys having that extra space to enjoy himself when he’s not in his room.”

Cherie

Mum of Oliver, teenager

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| Trust Board 24th April 2013 | |
| Changes to the Constitution Submitted by: Anna Ferrant, Company Secretary | Paper No: Attachment L |
| Aims / summary To provide the Board with a summary of the statutory changes and other amendments to the Trust Constitution. The implementation of the Health and Social Care Act 2012 (the “HSCA”) will bring about substantial changes to the way in which NHS foundation trusts (“FTs”) are governed, and to the functions of the regulator, Monitor. This will be done primarily through amendments to the National Health Service Act 2006 (the “NHS Act”). The HSCA provisions affecting FT constitutions have now come into force pursuant to the five HSCA commencement orders made so far. The changes to the Constitution have been added using tracked changes and a summary paper detailing the amendments is included for reference. A full copy of the Constitution has been provided separately with these Board papers. Board members serving on the Constitution Working Group and Audit Committee are asked to refer to the copy of the Constitution sent with these papers). The Constitution Working Group met on 16 th April 2013, chaired by the Chief Executive, and attended by Ms Mary MacLeod, Non-Executive Director, four councillor representatives, the Chief Finance Officer and the Company Secretary. The remit of the Group was to consider the amendments and recommend them for approval to the Trust Board (via the Audit Committee) and the Members’ Council. The Group agreed with the proposed definition of a significant transaction but suggested that the Trust should also inform the Council of any other transactions over 10% (noting that Council approval is not required at this level). The Group agreed with the proposal to appoint a member of the National Commissioning Board onto the Council, replacing the PCT and National Specialist Commissioning Group positions. The following additional amendments were also proposed at the meeting: <ul style="list-style-type: none"> • To make the rules the governing removal of councillors more consistent with the process for the removal of NEDs. Amendments are included on page 56 and 57 of the constitution, providing a councillor with a right to respond to a resolution to remove him/her and, in prescribed circumstances, only allowing a proposal to be put forward to remove the councillor based upon the same reasons within 12 months of the meeting. Any such resolution would be approved by not less than three-quarters of the council (rather than three quarters of the council present at the meeting). <u>Lawyers are in the process of reviewing the proposed amendments and an update will be provided at the meeting.</u> | |

- Clarification is awaited on a suitable organisation to be named to nominate an arbitrator under the disputes resolution procedure (previously the SHA) – see page 95;
- The Group queried the term ‘members of the Members’ Council’ and suggested that this is changed to ‘councillors’. Advice is being sought from the lawyers as this term is used in the DoH Model Election Rules.

The Audit Committee reviewed all of the proposed amendments and recommended the draft changes for approval by the Board and the Members’ Council.

Because some of the amendments relate to the role and duties of the Council, these particular amendments will also need to be taken to a members’ meeting – it is proposed that these are presented at the Annual General Meeting in July 2013.

Action required from the meeting

The Board is asked to review and approve the amendments to the Constitution in light of the comments from the Constitution Working Group and the recommendation from the Audit Committee.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Statutory amendments to the Constitution

Financial implications

None

Legal issues

As detailed in the summary report.

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

The Trust Board and Members’ Council

Who needs to be told about any decision?

The Trust Board and Members’ Council

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

The Company Secretary is responsible for overseeing compliance with the Constitution.

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

All directors

GOSH FT Constitution Updates

Health and Social Care Act 2012

The implementation of the Health and Social Care Act 2012 (the “HSCA”) will bring about substantial changes to the way in which NHS foundation trusts (“FTs”) are governed, and to the functions of the regulator, Monitor. This will be done primarily through amendments to the National Health Service Act 2006 (the “NHS Act”). The HSCA provisions affecting FT constitutions have now come into force pursuant to the five HSCA commencement orders made so far.

Set out below is a summary of the key amendments which have been made to the GOSH constitution to reflect changes in law flowing from implementation of relevant HSCA provisions. These changes are currently in draft for consideration, and are shown in tracked changes in the accompanying updated version of the constitution.

FOR DISCUSSION

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| Page 18 | Constitution/ para 48 and 4.8.3 | <p><u>Significant transactions</u></p> <p>Once the provisions of the 2012 Health and Social Care Act are in place (date to be determined), <u>more than half of the members of the council of governors of the trust</u> must vote to approve the trust entering into any significant transaction, as specified in the trust’s constitution.</p> <p>Foundation trusts are permitted to decide themselves what constitutes a “significant transaction” and may choose to set out the definition(s) in the trust’s constitution. Alternatively, with the agreement of the governors, trusts may choose not to give a definition but this would need to be stated in the constitution.</p> <p>Examples of definitions of significant transactions might include any contract valued over a certain monetary value, or over a certain percentage of the trust’s annual turnover. Monitor’s <i>Compliance Framework</i> gives a definition of what Monitor has used to define significant transactions for the purpose of risk ratings:</p> <p><i>“for UK healthcare investments, divestments or other transactions comprising > 25% of the assets, income or capital of the NHS foundation trust”</i></p> <p>The Board has discussed the matter and concluded that it would be beneficial to all parties to define a significant transaction, reflecting the definition by Monitor. Most Trusts have adopted a definition based on > 25% of the assets, income or capital of the NHS foundation trust”. The definition used here has been reviewed by external lawyers.</p> <p><u>Mergers, acquisitions, separations, dissolutions</u></p> <p>More than half the members of the council of governors must also approve any application by the trust to merge with another trust,</p> |
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| | | <p>acquire another trust, separate the trust into two new foundation trusts or dissolve the trust. This means <u>more than half of the total number of governors</u> (not just half the number that attends the meeting at which the decision is taken).</p> <p>Appendix 1 provides an explanation of the terms significant transactions, mergers, acquisitions, separations and dissolutions.</p> |
| Page 54 and page 70 | Annex 6 - Additional Provisions - Members' Council and Annex 8 - Standing Order for the Council | <p>There is no longer a requirement for a PCT governor under the Act. The Trust may, but is not required to, replace the PCT governor with a governor from another commissioning body. This enables foundation trusts to tailor their governance to local circumstances.</p> <p>At a previous meeting of the Board it was agreed that the Chairman write to the Regional Director (London) at the National Commissioning Board to invite a nomination to the Members' Council. The Board stressed that the person nominated should be a representative who is a senior manager at the National Commissioning Board but who is not directly responsible for contracting with Great Ormond Street Hospital (to avoid potential conflicts of interest).</p> <p>This post will replace the appointed PCT councillor from North Central London (John Carrier) and the appointed councillor from the National Specialised Commissioning Team (Jo Sheehan).</p> <p>The number of councillors on the Council changes to 27 (from 28) – see page 24</p> |

OTHER UPDATES (Un-shaded updates are statutory – those shaded amendments are proposed to update existing requirements)

| Page | Annex/ Para | Change and commentary |
|--------|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Page 5 | Constitution/ para 11 | At paragraph 11 a provision has been included stating that GOSH will hold an annual meeting of its members which will be open to the public. This is now a statutory requirement for FTs under Schedule 7 of the NHS Act, but the inclusion of the paragraph in the constitution is not mandatory. |
| Page 7 | Constitution/ para 16 and para 24 | <p>Paragraph 16: The 2012 Act confirms that the Council of Governors has a duty to hold the non-executive directors, individually and collectively, to account for the performance of the board of directors. It also has the duty to represent the interests of the members of the trust as a whole and the interests of the public. This includes a requirement for the trust to take steps to ensure that councillors have the skills and knowledge they require to undertake their role. This reflects paragraph 10A and 10B of Schedule 7 of the NHS Act, as amended by the HSCA.</p> <p>Paragraph 24: This reflects paragraph 18A of Schedule 7 of the NHS Act, as amended by the HSCA.</p> |

| Page | Annex/ Para | Change and commentary |
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| Page 7 | Constitution/ para 17.5 | The council may require one or more of the directors to attend a council meeting for the purpose of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and for deciding whether to propose a vote on the trust's or directors' performance). |
| Page 7 | Constitution/ para 19 | <p>Section 39A of the NHS Act as amended provides that an FT governor may refer a question to a panel of persons appointed by Monitor regarding the following:</p> <ul style="list-style-type: none"> • whether an FT has acted in accordance with its constitution; or • whether an FT has acted in accordance with a provision made under Chapter 5 (which deals with NHS FTs) of the NHS Act. <p>Accordingly, wording has been inserted at paragraph 19 to reflect this. A referral to the panel may only be made if more than half of the members of the Members' Council voting approve the referral.</p> |
| Page 8 | Constitution/ para 23 | The Trust Board has recently appointed Mr Ali Mohammed into the new post of Director of Human Resources and Organisational Development. This appointment has been approved by the Board and will have a vote on the Board, taking the number of voting executives to 6 (from 5). This appointment retains the Code of Governance requirement for at least 50% of board members to be made up of independent NEDs. |
| Page 11 | Constitution/ paras 32 and 32.3 | <p>A provision has been inserted at paragraph 32 stating that meetings of the Board of Directors shall be open to the public, unless excluded for special reasons. This provision is mandatory.</p> <p>Paragraph 32.2 sets out the mandatory requirement to provide the Members' Council with agendas and minutes relating to directors' meetings.</p> |
| Page 12 | Constitution/ para 34 | <p>The current GOSH constitution is drafted in a way that prohibits any director from voting, or counting towards the quorum of a vote, should s/he have a conflict of interest. The current constitution's drafting is stricter than the provisions of the HSCA.</p> <p>Provisions have therefore been included to allow for the participation of a director in a meeting where s/he has a conflict of interest in specified circumstances. These circumstances are as follows:</p> <ul style="list-style-type: none"> • where the Board of Directors, by majority, allows the director (who would otherwise be prohibited from participating) to participate in the decision-making process; • where the director's interest cannot reasonably be regarded as likely to give rise to a conflict of interest; or |

| Page | Annex/ Para | Change and commentary |
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| | | <ul style="list-style-type: none"> • where the director's conflict of interest arises from a permitted cause. <p>“Permitted cause” would include, without limitation (paragraph 34.10.3) where a guarantee is given, or to be given, by or to a director in respect of an obligation incurred by or on behalf of the Trust or any of its subsidiaries, or a situation where business relates to employee benefits that relate to executive directors and other employees alike, i.e. there is no special benefit for directors.</p> <p>These carve outs are drawn from approaches used by public limited companies. They build on the Monitor Model Core position, which envisages that conflicts may be authorised in accordance with the constitution, but which does not then go on to give any further specifics about that authorisation. The carve outs are not compulsory but are suggestions, and can be removed or amended as desired.</p> |
| Page 14 | Constitution/ para 39.2 | Under the NHS Act 2006 (as amended), the Trust must make available to the public documents relating to a special administration of the Trust. Drafting has been incorporated in the constitution to reflect this. |
| Page 16 | Constitution/ para 44 | This paragraph clarifies presentation of the annual accounts and reports to the Members’ Council and members. The trust may combine the annual members’ meeting with the governors’ meeting which is held for the purpose of considering the trust’s annual accounts and reports. |
| Page 17 | Constitution/ para 46 | <p>New wording has been included to reflect Monitor’s revised Model Core Constitution, which reflects section 37 of the NHS Act as amended on the procedures for changing the Constitution. Amendments to the trust’s constitution must be approved by the Members’ Council. Approval means more than half of the councillors voting to agree with the amendments. Amendments will no longer need to be submitted to Monitor for approval.</p> <p>Where an amendment is made to the constitution in relation the powers or duties of the Members’ Council, at least one member of the Members’ Council must attend the next Annual Members’ Meeting and present the amendment, and the Trust must give the members an opportunity to vote on whether they approve the amendment.</p> |
| Page 18 | Constitution/ para 47 | This paragraph formally documents arrangements for the Board of Directors to adopt procedures and protocols as it shall deem to be appropriate for the good governance of the Trust from time to time. |
| Page 56 | Annex 6 - Additional Provisions - Members’ Council | New wording has been inserted at paragraph 4 of Annex 6 stating that a person that is the subject of a disqualification order made under the Company Directors Disqualification Act 1986 may not become or continue as a councillor on the Members’ Council. This is to ensure consistency with licence condition G4 (which applies to |

| Page | Annex/ Para | Change and commentary |
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| | | governors). |
| Page 60 | Annex 7 – additional provisions – Board of Directors | Paragraph 1.2.3 reflects the role of the Members' Council nominations and remuneration committee (as outlined in its terms of reference) in the process of removal of a non-executive director |
| Page 67 | Annex 8 – Standing Order for the Council | Given the requirement for approval by half of all members of the Members' Council, language providing for written resolutions or electronic voting (i.e. to facilitate voting and mitigate the prospect of a resolution not passing due to governors not being able to attend a meeting) is included in paragraph 4.8.3. |
| Page 68 | Annex 8 – Standing Order for the Council | Paragraph 4.8.4 has been clarified to make clear that the Chairman would not ordinarily vote other than in a casting vote situation. |
| Page 73 | Annex 8 – Standing Order for the Council | Paragraph 43 has been updated to reflect the statutory position with regards approval of changes to the Constitution (including the SOs). |
| Page 82 | Annex 9 – Standing Order for the Board | Paragraph 23.4 clarifies that voting by proxy by the Board is not allowed. |
| Page 84 | Annex 9 – Standing Order for the Board | Paragraph 27.1.4 details the role of the Board of Directors Nominations Committee |
| Page 89 | Annex 9 – Standing Order for the Board | Paragraph 43 has been updated to reflect the statutory position with regards approval of changes to the Constitution (including the SOs). |
| Page 93 | Annex 10 – Further Provisions - Members | Paragraph 4.3 includes the approved wording of the quorum for members' meetings (approved by the Council in June 2012) |
| | | <p><u>Miscellaneous</u></p> <p>Square brackets have been removed throughout the document [].</p> <p>The word '<i>appointed</i>' has been replaced in paragraph 1.2.21 under Annex 9.</p> |

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| Trust Board 24th April 2013 | |
| Monitor Quality Governance Framework self-assessment | Paper No: Attachment M |
| Claire Newton, Chief Finance Officer | |
| <p>Aim</p> <p>To provide the Board with an overview of the results of a self-assessment against Monitor's Quality Governance Framework (QGF) undertaken in April 2013.</p> <p>Summary</p> <p>The Trust has undertaken a full self-assessment of its position against Monitor's QGF. This work follows a recent independent review undertaken by Deloitte of the Trust's governance arrangements against a number of best practice recommendations in relation to the QGF, which was presented to March Trust Board. Whilst the report found a number of unfinished actions and one outstanding action, it concluded that there are no material gaps or omissions in relation to overall progress.</p> <p>Monitor set out ten questions relating to four key areas of Organisational Strategy, Capabilities and Culture, Processes and Structures and Measurement to underpin their QGF. The Trust has self-assessed itself against each of the questions and against good practice samples.</p> <p>With the exceptions of whether the Board actively engages patients, staff and stakeholders on quality (3c) and the level of Board assurance against the robustness of quality information (4b), (both rated Amber/Green), all other questions are rated Green.</p> <p>A Board effectiveness review has been undertaken with an action already agreed to invite a patient representative the Board. The Board are additionally exploring ways to increase engagement with the Members' Council and with Parents directly in a focussed way.</p> <p>A review of information quality was carried out in 2012/13. A process to assess and report the quality of critical Board key performance indicators – particularly in information coming from local rather than central services - is in progress.</p> <p>A detailed report describing supporting evidence against each of the 10 questions is available from Alex Faulkes, Head of Planning and Performance Management. Alexander.Faulkes@gosh.nhs.uk</p> | |
| <p>Action required from the meeting</p> <p>To note the summary results of the self-assessment</p> | |
| <p>Contribution to the delivery of NHS Foundation Trust strategies and plans</p> <p>Good governance</p> | |
| <p>Financial implications</p> <p>N/A</p> | |

Attachment M

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| Legal issues N/A |
| Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? N/A |
| Who needs to be told about any decision? N/A |
| Who is responsible for implementing the proposals / project and anticipated timescales? Executive Team |
| Who is accountable for the implementation of the proposal / project? Co-Medical Director |

Attachment M

Monitor Quality Governance Framework: Self-assessment overall summary, April 2013

| Strategy | Capabilities and Culture | Processes and Structures | Measurement |
|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| 1A: Does Quality drive the Trusts' strategy? RAG rating: Green | 2A: Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? RAG rating: Green | 3A: Are there clear roles and accountabilities in relation to quality governance? RAG rating: Green | 4A: Is appropriate quality information being analysed and challenged? RAG rating: Green |
| 1B: Is the Board sufficiently aware of the potential risks to quality? RAG rating: Green | 2B: Does the Board promote a quality focused culture throughout the Trust? RAG rating: Green | 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? RAG rating: Green | 4B: Is the Board assured of the robustness of the quality information RAG rating: Amber/Green |
| | | 3C: Does the Board actively engage patients, staff and stakeholders on quality? RAG rating: Amber/Green | 4C: Is quality information used effectively? RAG rating: Green |

| Risk rating | Definition | Evidence |
|-------------|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Green | Meets or exceeds expectations | Many elements of good practice and there are no major omissions |
| Amber/Green | Partially meets expectations but confident in management's capacity to deliver green performance within a reasonable timeframe | Some elements of good practice, has no major omissions and robust action plans to address perceived shortfalls with proven track record of delivery |
| Amber/Red | Partially meets expectations but with some concerns on capacity to deliver within a reasonable timeframe | Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in early stage of development with limited evidence of track record of delivery |
| Red | Does not meet expectations | Major omission in Quality Governance identified. Significant volume of action plans required and concerns on management capacity to deliver. |

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| <p>Trust Board 24th April 2013</p> | |
| <p>Register of Conflicts of Interest Declarations (Directors and Staff)</p> <p>Submitted by: Anna Ferrant, Company Secretary</p> | <p>Attachment N</p> |
| <p>Aims / summary</p> <p>Great Ormond Street Hospital's Conflict of Interest Policy requires that all members of staff (including temporary and agency staff) and directors of the Board declare any potential or actual conflict on joining the organisation or when the potential for conflict arises.</p> <p>Paragraph 31 of the Board of Director's Standing Orders outlines the requirements for directors to disclose any pecuniary, personal or family interest, whether that interest is direct or indirect, in any proposed contract or other matter that is under consideration or is to be considered by the Board</p> <p>A conflict of interest occurs when the private or personal interests of a member of staff/ member of the Board could affect their role at the Trust in terms of bringing some possible advantage to them or close relatives.</p> <p>Any declared interests are reconfirmed annually until such time as either the member of staff/ member of the Board leaves GOSH or the potential for a conflict of interest no longer exists.</p> <p>Details and examples of potential conflicts of interests are set out in the Conflict of Interest Policy.</p> <p>The Company Secretary is required to draw up a register of interests declared by members of staff and members of the Board and to report on this annually in the public part of a Trust Board meeting. The returns are maintained in a register which is open for inspection. The registers for Trust Board members and staff are attached with this report.</p> | |
| <p>Action required from the meeting</p> <p>To note the content of the report.</p> | |
| <p>Contribution to the delivery of NHS / Trust strategies and plans</p> <p>Transparency</p> | |
| <p>Financial implications</p> <p>None</p> | |
| <p>Legal issues</p> <p>None</p> | |
| <p>Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has</p> | |

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| taken place? All staff and members are advised of the need to declare any actual or potential conflicts each year. |
| Who needs to be told about any decision N/A |
| Who is responsible for implementing the proposals / project and anticipated timescales N/A |
| Who is accountable for the implementation of the proposal / project N/A |

**Register of Interests: Great Ormond Street Hospital for Children NHS
Foundation Trust**

Directors 2012/13

Non – Executive Directors

| Name | Declared Interests |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Baroness Tessa Blackstone | Member, House of Lords Member, Royal Opera House Board and Chair of the Education, Engagement and Access Committee Chair, British Library Board Director of UCL Partners Chair Orbit Group |
| Ms Yvonne Brown | Panel Member – Architect’s Registration Board (investigation Panel) Independent Board Member – Royal Institute of Chartered Surveyors UK and Ireland Regulatory Board Council Member – Law Society of England and Wales Panel Chair - Nursing & Midwifery Council Fitness to Practice Committee Consultant – Legal Management Consulting |
| Professor Andrew Copp (until 31 st December 2012) | Director Institute of Child Health, University College London Honorary Director of Research, Children’s Trust, Tadworth Associate Editor, Birth Defects Research Part A, USA Board Member, Bo Hjelt Foundation, Amsterdam |
| Mr David Lomas | Chief Finance Officer of Elsevier |
| Mrs Mary MacLeod OBE | <u>Chair</u> Gingerbread Safenetwork Advisory Board <u>Deputy Chair</u> Child and Family Court Advisory and Support Service (Cafcass) <u>Board Member</u> Internet Watch Foundation Video Standards Council Independent consultancy on child and family policy. |
| Mr John Ripley | Director of CAB International Governor of Kingston University Director / governor of The Howard of Effingham School, The Howard Partnership Education Trust and The Howard Partnership Trust Governor of Eastwick Schools (Junior + Infants) Director / trustee of Church Mission Society and The South American Mission Society Director / trustee of Feba Radio Director / trustee of the Christian Association of Business Executives |

**Register of Interests: Great Ormond Street Hospital for Children NHS
Foundation Trust**

Directors 2012/13

| Name | Declared Interests |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Professor Rosalind Smyth (from 1st January 2013)</p> | <p>Director, UCL Institute of Child Health (ICH) As Director of ICH, I have overall responsibility for all research funding applications and awards to staff in ICH.</p> <p>Honorary Consultants, Great Ormond Street Hospital for Children NHS Foundation Trust</p> <p>Board Director, Public Library of Science</p> <p>Honorary Consultant, Alder Hey Children's Hospital NHS Foundation Trust (until Sept 2013)</p> <p>Honorary Professor, University of Liverpool</p> <p>[Husband is a Consultant at Alder Hey Children's Hospital NHS Foundation Trust, and an Honorary Senior Lecturer at the University of Liverpool]</p> |
| <p>Mr Charles Tilley</p> | <p>Chief Executive, Chartered Institute of Management Accountants Director (Corporate representative) CIMA China Ltd Director (Corporate representative) CIMA Enterprises Limited (CEL) Board member of the Association of International Certified Professional Accountants Non-Executive Director and Member of Asset and Liability and Chairman of the Audit Committees – Ipswich Building Society Director of Seaview Yacht Club Limited</p> |

Executive Directors

| Name | Declared Interests |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Dr Barbara Buckley</p> | <p>None</p> <p>[Husband is a GP in North London]</p> |
| <p>Mr Robert Burns (Note - as Acting Chief Operating Officer 11th August – 11th November 2012 and 2nd March – present)</p> | <p>None</p> <p>[Wife is a GP in West Hampshire and Clinical Commissioning Lead for West Hampshire Clinical Commissioning Group. She is also Clinical Assistant in Dermatology at Hampshire Hospitals NHS Foundation Trust]</p> |
| <p>Dr Jane Collins (until 24th August 2012)</p> | <p>Advisory Board Member, Judge Business School, Cambridge University Chief Executive GOSH Children's Charity Trustee - Child Health Research Appeal Trust and the General Charitable Trust of ICH Director of UCL Partners Director (trustee) of Girls Day School Trust</p> |
| <p>Ms Fiona Dalton</p> | <p>None</p> |

**Register of Interests: Great Ormond Street Hospital for Children NHS
Foundation Trust**

Directors 2012/13

| Name | Declared Interests |
|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Professor Martin Elliott | Member , Congenital Heart Services CRG |
| Mr Jan Filochowski | None [Wife is Professor of Health Care Organisation and Management, Epidemiology & Public Health, Institute of Epidemiology & Health, University College London] |
| Mr Ali Mohammed (from 21 st January 2013) | None |
| Mrs Liz Morgan | Member of Well Child Research Strategy Advisory Panel |
| Mrs Claire Newton | None |
| Mr Matthew Tulley (from 3 rd December 2012) | None |
| Professor David Goldblatt | Committee Member, Wellcome Trust Expert Review Group "Immunology in Health and Disease" Sub-Committee member, Department of Health Joint Committee on Vaccination and Immunisation – Pneumococcal and Meningococcal Subcommittees UCL-ICH Laboratory performs contract research for GSK, Sanofi Pasteur, Novartis, Merck Occasional role as member of Expert Panel Advisory Board/Consultant or in receipt of speaker honorariums from Pfizer, Sanofi Pasteur, Novartis, Merck, and GlaxosmithKline. |
| Mr William McGill (until 27 th July 2012) | None |
| Mr Mark Large | None [Son - works for Block Solutions as a support engineer as of April 2012] |

| Name | Role | Declaration | Declared/ Renewed |
|----------------------|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| ASHWORTH, Michael | | I pay my private earnings into a private company known as 'Repath' of which I am a director. The income is derived entirely from the International Private Patients Wing, which is managed by the NHS. The fees are for expert opinion. The Company is essentially a handling mechanism for the consultants' private fees. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, e.g. training fees for non-medical staff. The remainder is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others. However, it has come to my attention that a formal declaration should be made to the Trust, and this I now do. | Mar-13 |
| BARCLAY, Sarah | DoH Service Development Project Lead | It is possible that I may in future be invited to undertake mediation work at GOSH. As Vice-Chair of the Clinical Ethics Committee, I would regard this as a potential conflict of interest which would need to be discussed both with GOSH and the CEC before undertaking such work. | Nov-10 |
| BARNACLE, Alex | Consultant Paediatric Radiologist | <p>I have practising privileges at the Portland Hospital for Women and Children but this poses no conflict of interest involving patient care. I undertake diagnostic imaging sessions at the Portland Hospital averaging 3 hours per fortnight, which is done in my own time.</p> <p>I am currently the lead clinician for the Radiology department at the Portland Hospital and represent the department on the Portland Hospital Medical Advisory Committee.</p> <p>I am looking to develop a small interventional radiology service at the Portland Hospital in the next 12 months which will involve at least one monthly clinic and operating list but this is yet to be established or formalised.</p> <p>I have no involvement in any financial institutions that would cause a conflict of interest.</p> | Mar-13 |
| BRIERLEY, Joe | Consultant Paediatric Intensivist | I undertake private practice at the Portland Hospital PICU. This is undertaken outside my GOSH hours and I do not personally perceive a conflict as I also undertake private practice | Mar-13 |
| BROXHOLME, Catherine | Principal Clinical Scientist, Cochlear Implant | Attending a 2-Day Workshop organised and paid for by Advanced Bionics Ltd. Workshop is to launch a new speech processor that will be used by our clinic. | Feb-13 |

| Name | Role | Declaration | Declared/ Renewed |
|-------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| BYRON, Mandy | Consultant Clinical Psychologist | I offer a private clinical psychology practice in an office in Wimbledon but see patients that would not normally access clinical psychology by me as part of my post at Great Ormond Street Hospital. I have been requested on occasions to give advice to television companies on recruitment policies when using children in programmes, BBC and Channel 4. I have been given payment for this service. | Mar-13 |
| CALDER, Alistair Duncan | Consultant Paediatric Radiologist | Undertakes sessions at the Portland Hospital in paediatric Radiology, averaging 3 sessions per month. These do not occur during scheduled NHS sessions, are included in my job plan and do not otherwise conflict with work at GOSH. | Mar-13 |
| CALE, Catherine | Consultant Immunologist | Husband (Mr K MacLachlan) is a corporate account manager for Thermo Fisher Scientific who supply GOSH with some laboratory equipment and reagents. | Mar-13 |
| CANTWELL, Michelle | PD Clinical Nurse Specialist, Renal | I will be an advisor to Baxter who make peritoneal dialysis machines. The current adaptations are not suitable for children so they have approached myself to help with their redesign. | Mar-12 |
| CHAPMAN, Sue | Nurse Consultant, Nursing & Workforce Development | I am a panellist on the NMC's Fitness to Practise Panel. | 17/02/2011 |
| CORBET, Carmel Maria | Sister, PICU | I have been asked to make bed quilts for PICU. I make these quilts in my own time at home as an existing business and have supplied these to other private customers and to a shop in the town of Ware, Herts. The appropriate cost of making these quilts is £1700 for 10 quilts. This is paid from PICU Charity Fund and agreed by the sisters. The quilts have been tested for robustness in the washing cycle. | Feb-12 |
| COX, Stephen | Chief Press Officer | Occasional freelance journalism and PR consultancy. | Feb-12 |
| CROSS, Nigel | Senior Perfusionist | I shall be giving a training lecture on perfusion for Medtronic for which I am paid a small remuneration, flights and accommodation. | Mar-12 |
| DUNAWAY, David | Associate Specialist, Urology and Urodynamics | I was engaged by GlaxoSmithKline (in May 2012) to provide expert advice and to explore the potential implications of adult safety data use of Retigabine / Ezogabine particularly regarding urinary retention in order to help inform GlaxoSmithKline's clinical development programme and strategy. | Mar-13 |
| DUNAWAY, David | Consultant Plastic Surgeon, Craniofacial Department | I am a Trustee of Facing Africa (a charity providing care to children in Africa). I am a Director and 25% shareholder of 152 Harley Street Ltd (A registered day hospital providing consulting facilities, radiology and local anaesthetic and sedation operating facilities and also registered for paediatric care). I am a Director and 50% shareholder of the London Craniofacial Unit Ltd (a company co-ordinating local, private and overseas craniofacial care). | Mar-13 |
| EASTWOOD, Deborah | Trustee | Trustee of registered Charity Humanitas. Currently also Vice President of the European Paediatric Orthopaedic Society | |

| Name | Role | Declaration | Declared/ Renewed |
|-------------------------|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| EASTY, Marina | Consultant Paediatric Radiologist | Takes sessions at the Portland Hospital, performing ultrasound scans, screening, general reporting and MRI. Also GOSH in-house private patient work, as requested by the referring clinicians. There is no conflict of interest because the work is done out of NHS time. | Mar-13 |
| ELWOOD, Jonathan | Legal Advisor | Married to a GOSH Clinical Site Practitioner. | Mar-13 |
| FORD, Katrina | Cardiac, Respiratory, Critical Care and Medicines information | Payment from Astellas Pharma Ltd for participation on an advisory board (Modigraf) | Jan-13 |
| GIBSON, Lorna | Head of Research and Innovation | From December 2010 for one year in the first instance, I am a Non Executive Director/Trustee of the Chartered Management Institute | Dec-11 |
| GUNNY, Roxana | | My work external to GOSH is conducted at the University College Hospital (NHS consultant contract), the Portland Hospital, and West Middlesex Alliance MRI. | 15/10/2009 |
| HEALES, Simon | Clinical Lead, Chemical Pathology | Consultancy fees from Vitaflo UK. Honoraria for speaking - Genzyme, Shire, Orphan Europe. Travel Grants - Genzyme, Shire, Biomarin. | Mar-13 |
| HILL, Robert | Consultant Orthopaedic Surgeon | I am writing to inform you that I have been requested by Smith and Nephew, a company that manufactures surgical devices, to provide them with consultancy services in connection with the development of a new device. The contract is currently for one year. As you may know Great Ormond Street Hospital uses products manufactured by this company. The work I have been asked to undertake does not involve any product currently used by Great Ormond Street Hospital. I believe the Company may also inform the hospital directly of this relationship. If you have any questions that I am in a position to answer please do not hesitate to contact me. | Jan-12 |
| HINDMARSH, Peter | Professor of Paediatric Endocrinology | Paid the sum of £600 for consultancy to Medtronic Diabetes UK. | Feb-12 |
| HIORNS, Melanie | Consultant Radiologist, Radiology | Carries out some limited private practice at the Portland Hospital, which in no way conflicts with her work at Great Ormond Street Hospital. | Feb-12 |
| HOLLINGSWORTH, Georgina | Genetic Research Co-ordinator | That I have a distant relative by marriage who works as a paediatrician at GOSH. Dr Alison Salt is my second cousin by marriage. I have no other potential conflicts of interest. | Jan-13 |
| HUGHES, Joanne | | Related to Ray Conley, Head of HR Operations. | Mar-13 |

| Name | Role | Declaration | Declared/ Renewed |
|-----------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| JACQUES, Thomas | Honorary Consultant, Histopathology | <p>I pay my private earnings into a private company known as 'Repath Ltd' of which all the consultant histopathologists, including myself are directors and shareholders. I am the Company Secretary. The Company is essentially a mechanism for handling the consultants' private fees, which are requests for opinions regarding reporting of specimens. The income is derived from the International Private Patients Wing of GOSH, which is managed by the NHS. I also provide reports to HM Courts, and provide lectures for which I am paid fees through Repath Ltd. The accounts are audited and subjected to company tax. The remainder of the income is paid to the consultants as annual dividends. I declare these earnings in my own income tax return.</p> <p>I am an executive editor at the journal, Neuropathology and Applied Neurobiology. This is a medical and scientific journal and is the journal of the British Neuropathological Society. I am paid a fee for each manuscript I handle at the journal and have the potential to access travels funds from the journal.</p> <p>I am one of the pathologists responsible for reviewing cases as part of the HERBY trial. The trial is sponsored by Roche. When I take part in meetings related to this trial, the costs associated with my travel and accommodation are met by Roche.</p> <p>I derive some income from royalties from authoring medical books or chapters thereof.</p> | Mar-13 |
| LARCHER, Victor | Consultant in General Paediatrics & Clinical Ethics | Member of the Royal College of Paediatrics and Child Health Ethics and Law Advisory Committee, which meets for 2 hours twice yearly and has one virtual meeting. Contributes opinions on ethical issues as required for the College. | Mar-13 |
| LENCH, Nicholas | Director, Genetics Laboratories | Clinical diagnostic adviser to Canon U.S. Life Sciences Inc. | Mar-13 |
| LISTER, Paula | Consultant Paediatric Intensivist | Private practice at the Portland Hospital PICU. The work will be entered on my new Job Plan (currently waiting for Zircadian to complete the proforma for PICU and NICU. This work is conducted outside of the time I am contracted to Great Ormond Street Foundation Trust. It does not conflict with my NHS work and is not detrimental to it. | Mar-13 |
| MALONE, Marian | | I pay my private earnings into a private company known as 'Repath' of which all the consultant histopathologists are directors. The Company is essentially a handling mechanism for the consultants' private fees, which are requests for expert opinions. The income is derived from the International Private Patients Wing, which is managed by the NHS. The accounts are audited and subjected to company tax. The fees are used to pay for | Mar-13 |

| Name | Role | Declaration | Declared/ Renewed |
|-------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| MCCULLOCH, Renée | Consultant, Paediatric Palliative Care | Works with Helen and Douglas House, Oxford, outside GOSH hours. Remained employed by the Oxford Radcliffe NHS Trust until 31 July 2007. Began work as a locum consultant at GOSH on 9 July 2007, prior to taking up substantive post. Awaiting amended form as hours have changed. | Feb-10 |
| MCHUGH, Kieran | Consultant Paediatric Radiologist | Occasionally reports MRDs, x-rays and ultrasounds at the Portland Hospital. Occasional radiology reporting within formal trials for Hoffman La Roche (BERNIE study) for which Hoffman La Roche pay 250 Swiss Francs per hour. | Mar-13 |
| MOON, Jacqueline | Training and Practice Co-ordinator for Child Death Helpline/End of Life Care Support Worker | I am working as a Locum Psychotherapist and Honorary Psychotherapist at East London NHS Foundation Trust | Feb-11 |
| MUNTONI, Francesco | Chair & Honorary Consultant, Paediatric Neurology, Neurosciences | During the last year I have performed ad-hoc consultancies for scientific advisory work for GSK and for Servier. I have been now also asked to attend a SAB meeting for Roche and for Summit, which will happen later on this spring. I currently receive research grants from PTC, GSK, Trophos and Prosensa. I am negotiating a research grant with Summit. | Mar-13 |
| OLSEN, Oystein | Consultant, Radiology | I have admission rights at The Portland Hospital for Women and Children where, along with colleagues in Radiology I provide an average of 3 hours per fortnight of paediatric plain film reporting, ultrasound, fluoroscopy and MRI reports. I have acted as a consultant for Bayer-Schering Healthcare and Guerbut Laboratories. This does not conflict on either a financial or a time basis with any of my work at GOSH. I therefore have no conflict of interest. | Mar-13 |
| OWENS, Catherine | Consultant Radiologist | Employed at the Portland Hospital where, along with her colleagues in Radiology, she provides an average of 3 hours per fortnight of paediatric plain film reporting, ultrasound and fluoroscopy, and occasional MRI reports. Has taken on some administrative tasks attending 4 Consultants' meetings per annum. Not perceived as a conflict to GOSH Practice as | Mar-13 |
| PETERS, Mark | Senior Lecturer in Paediatric and Neonatal ICU | I provide occasional medical expert witness reports for a variety of legal cases including medical negligence cases within my expertise. I have provided professional and expert reports to the family, criminal and appeal courts in response to both prosecution and defence instructions predominantly in cases of suspected inflicted head injury. I now | Mar-13 |
| RAJPUT, Kaukab | Consultant Audiovestibular Physician | I have been invited to attend a meeting organised by Advanced Bionics workshop for introducing and updating on their new products including the water proof speech processor. Dates 30th May - 1st June. | May-12 |
| RAMNARAYAN, Padmanabhan | Consultant, CATS | I act as a part-time Medical Advisor for Isabel Healthcare Ltd, a diagnostic software system | Mar-13 |

| Name | Role | Declaration | Declared/ Renewed |
|-------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
| RAMNARAYAN, Padmanabhan | Consultant Paediatric Intensivist | I have begun private practice at the Portland Hospital PICU. This will be entered on my Zircadian Job Plan. This work is conducted outside of the time I am contracted to Great Ormond Street Foundation Trust. It does not conflict with my NHS work and is not | Mar-13 |
| REES, Lesley | Consultant, Nephrology | I am on the drug safety monitoring committee, reviewing the safety for patients of a trial of erythropoietin (long acting) Mircera. I will be an advisor to Baxter who make peritoneal dialysis machines. The current adaptations that they have just made are not suitable for children so they have approached myself to help with redesign. | 22/03/2009 01/03/2012 |
| SEBIRE, Neil | | I pay my private earnings into a private company known as 'Repath' of which all the consultant histopathologists, including myself are directors and shareholders. The Company is essentially a mechanism for handling the consultants' private fees, which are requests for opinions regarding reporting of specimens. The income is primarily derived from the International Private Patients Wing of GOSH, which is managed by the NHS. I also perform occasional reporting work to cover for colleagues in other centres who may be off-work, for which I also get paid on a case by case basis. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, such as training fees for non-medical staff. The remainder of the income is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others. However, it has come to my attention that a formal declaration should be made to the Trust, and this I now do. | Mar-13 |
| SHARMA, Sanjiv | Consultant Paediatric Intensivist | I continue to do private work at the Portland Hospital PICU and this has been recorded on my job plan. The work continues to be done outside of the time I am contracted to Great Ormond Street Hospital NHS Foundation Trust. It does not conflict with my NHS work and is not detrimental to it. | Mar-13 |
| SHARP, James | Lead Audiologist, Audiology Department | I will be house sitting for my friend who works as a Business Manager for the company Cochlear. | Mar-13 |
| SHAW, Vanessa | Head of Dietetics | Consultancy work for Abbott Nutrition and Danone Group concerning the development of new infant and paediatric special formulas. | Mar-13 |
| SINCLAIR, Deborah | Clinical Nurse Specialist, Plastic Surgery, Dinosaur Ward | Work 1/2 day a week with a plastic surgeon outside of the Trust. This has no bearing on my current role as it is in relation to cosmetic surgery dealing with mainly adult patients. This is always undertaken on my day off from the Trust. | Mar-13 |
| SKELLETT, Sophie | Consultant Paediatric Intensivist | I have begun private practice at the Portland Hospital PICU. The work has been entered on my new Job Plan. This work is conducted outside of the time I am contracted to Great Ormond Street Foundation Trust. It does not conflict with my NHS work and is not detrimental to it. | Mar-13 |

| Name | Role | Declaration | Declared/ Renewed |
|------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| TEUTEN, Beatrice | DoH Project Researcher | RCPCH, Member Ethics and Advisory group RCPCH, Member Parents and Carers group Nursing and Midwifery Council, Lay Member of Council – Jan 2011 – Dec 2013 Medical Mediation – Freelance Work | Nov-10 |
| TINKER, Lorraine | Head of Nursing, Neurosciences | I am a registrant Fitness to Practice Panellist for the Nursing and Midwifery Council. I was selected to represent my nursing fields and hear conduct, competence and health cases by the Audit Commission with the NMC in 2007. I undertake this work in my own time, I receive payment on a daily basis for this. If there is a conflict of interest, or a perceived/potential in any way i.e.: registrants or witnesses known to me or an organisation that I have worked for or there is any possible link/connection it is declared to the NMC and I remove myself from the case in fairness to the registrant. | Feb-12 |
| VELLODI, Ashok | Consultant, Metabolic | I have received grants and sponsored invitations to attend and speak at conferences from Actelion Pharmaceuticals, Shire HGT, Genzyme Corporation and Biomarin. | Mar-13 |
| WATERS, Jonathan | Consultant Clinical Scientist and Head of Service (Cytogenetics), NE Thames Regional Genetics Laboratory | At the invitation of Dr Sandra Edwards, Head of Laboratory, Cytogenetics Laboratory, Norfolk and Norwich Hospital, Norwich, Norfolk, I act as a Consultant to the Cytogenetics laboratory on an occasional basis. This involves advising of the content of complex reports and e-authorisation (electronic authorisation) of reports viewed by secure means (via nhs.net) as requested by the Head of Service in her absence. There is no managerial involvement or responsibility. I am confident that providing this service does not constitute a direct conflict of interest for the this Trust. | Mar-13 |
| WEBER, Martin | | I pay my private earnings into a private company known as 'Repath' of which I am a director. The income is derived entirely from the International Private Patients Wing, which is managed by the NHS. The Company is essentially a handling mechanism for the consultants' private fees. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, such as training fees for non-medical staff. The remainder of the income is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others. | Feb-11 |
| WILLISS, Janet | Deputy Chief Nurse, Nursing & Education Department | I am a fitness to practice panellist with the Nursing and Midwifery Council. | Mar-13 |

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| <p>Trust Board 24th April 2013</p> | |
| <p>Register of Gifts and Hospitality</p> <p>Submitted by: Anna Ferrant, Company Secretary</p> | <p>ATTACHMENT O</p> |
| <p>Aims / summary</p> <p>The Trust is directly responsible for ensuring that staff and board members are impartial and honest in the conduct of their official business, and that they do not abuse their official positions for personal gain or to the benefit of their family and friends.</p> <p>The Trust complies with the requirement in the Constitution that board members and members of staff are required to declare hospitality and sponsorship offered by and accepted from contractors, suppliers and others.</p> <p>The Company Secretary holds and maintains the Trust's 'Register of Gifts and Hospitality'. All staff should complete the "Gifts, Hospitality and Sponsorship Form" if they accept or refuse any gifts, inducement or hospitality.</p> <p>The Register of Gifts and Hospitality for 2012/13 is attached to this report.</p> | |
| <p>Action required from the meeting</p> <p>The Board is asked to note the entries in the Register.</p> | |
| <p>Contribution to the delivery of NHS / Trust strategies and plans</p> <p>Transparency where gifts/ hospitality are offered</p> | |
| <p>Financial implications</p> <p>None</p> | |
| <p>Legal issues</p> <p>None</p> | |
| <p>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?</p> <p>All staff and members are advised of the need to declare where gifts or hospitality have been accepted or declined.</p> | |
| <p>Who needs to be told about any decision</p> <p>N/A</p> | |
| <p>Who is responsible for implementing the proposals / project and anticipated timescales</p> <p>N/A</p> | |
| <p>Who is accountable for the implementation of the proposal / project</p> <p>N/A</p> | |

Great Ormond Street Hospital for Children NHS Foundation Trust

Register of Gifts and Hospitality 2012-13

| <i>Name of recipient</i> | <i>Host</i> | <i>Event (for sponsorship/ hospitality)</i> | <i>Accepted/declined</i> |
|--------------------------|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| ABALEKE, Eugenia | | 2 Lady Gaga concert tickets. This was a gift from the parents of a baby that died as a token of appreciation for the care and support given by staff. | Accepted |
| BOOTH, Claire | CSL Behring | Conference and tour of Immunoglobulin purification factory in Bern Switzerland. CSL Behring paid for travel to and from Bern, 1 night's accommodation and subsistence during the trip. The trip included a series of lectures describing the purification process and safety checks performed on Ig production, and a guided tour of the production facility. As a regular prescriber of immunoglobulin, the conference and tour has significantly increased my knowledge of the production and safety profile of immunoglobulin. | Accepted |
| BROCK, Penelope | | Olympics - Tickets given by the parent of a child I treated. The parent has been working at the Olympic site for all the period of treatment and received these tickets for free. | Accepted in parent's place - tickets had been given to parent free of charge. |
| COLDWELL, Fiona | | 1 Lady Gaga concert ticket. This was a gift from the parents of a baby that died as a token of appreciation for the care and support given by staff. | Accepted |
| FILOCHOWSKI, Jan | Capsticks | HSJ Awards | Accepted |

| | | | |
|--------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| FORBES, Marianne | | 2 Lady Gaga concert tickets. This was a gift from the parents of a baby that died as a token of appreciation for the care and support given by staff. | Accepted |
| GODDARD , Victoria | GOSHCC/Channel 4 | Channel 4 Comedy Gala ticket | Accepted |
| JOHNSON, Helen | Family of patient | Voucher - £50 | Declined / returned to family |
| KELLY, Laura | | 2 Lady Gaga concert tickets. This was a gift from the parents of a baby that died as a token of appreciation for the care and support given by staff. | Accepted |
| LAWLOR, Catherine | GOSHCC/Channel 4 | Channel 4 Comedy Gala ticket | Accepted |
| MCCARTY, Shannon | | 1 Lady Gaga concert ticket. This was a gift from the parents of a baby that died as a token of appreciation for the care and support given by staff. | Accepted |
| MOLONEY, Kate | | 2 Lady Gaga concert tickets. This was a gift from the parents of a baby that died as a token of appreciation for the care and support given by staff. | Accepted |
| PARSONS, Heather | | 2 Lady Gaga concert tickets. This was a gift from the parents of a baby that died as a token of appreciation for the care and support given by staff. | Accepted |
| POWNALL, Sophie | Junior Anaesthetists GOSH/ Dr | 1 Bottle of wine in thanks for giving lecture | Accepted |

| | | | |
|------------------|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| POWNALL, Sophie | Ethics Seminar | 1 Bottle of wine in thanks for giving lecture | Accepted |
| PUGA IGLESIAS, T | Respiratory Sleep Unit | £50 note left on bedside table after declining their gift offer | Accepted |
| RUTT, Marianne | | 2 Lady Gaga concert tickets. This was a gift from the parents of a baby that died as a token of appreciation for the care and support given by staff. | Accepted |
| SEYMOUR, Jane | Father of patient | Olympics tickets (x2) | Accepted |
| WORTH, Austen | CSL Behring | Conference and tour of Immunoglobulin purification factory in Bern Switzerland. CSL Behring paid for travel to and from Bern, 1 night's accommodation and subsistence during the trip. The trip included a series of lectures describing the purification process and safety checks performed on Ig production, and a guided tour of the production facility. As a regular prescriber of immunoglobulin, the conference and tour has significantly increased my knowledge of the production and safety profile of immunoglobulin. | Accepted |

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| Trust Board 24th April 2013 | | |
| Register of Seals | Paper No: Attachment P | |
| Submitted by: Anna Ferrant, Company Secretary | | |
| Aims / summary Under paragraph 39 of the NHS Foundation Trust Standing Orders, the Trust is required to keep a register of the sealing of documents. The attached table details the seal affixed and authorised since end September 2012. | | |
| Date | Description | Signed by |
| 27/09/12 | POA for Dubai – approved at September 2012 Trust Board | Fiona Dalton Claire Newton |
| 29/11/12 | Finance Agreement relating to the enabling works and design fees for phase 2b of the redevelopment of Great Ormond Street Hospital for Children – between GOSHFT and GOSHCC | Jan Filochowski Claire Newton |
| 30/11/12 | Lease of anvil land within GOSH main site – between GOSHFT and GOSHCC | Jan Filochowski Claire Newton |
| 03/12/12 | POA for Rouse & Co to act as agents in Dubai for purposes of protecting intellectual property | Jan Filochowski Claire Newton |
| 24/01/13 | Lease of part 3 rd floor offices at Ormond House, 26/27 Boswell Street, WC1 (Starway Corporation – landlord) | Jan Filochowski Claire Newton |
| Action required from the meeting To endorse the application of the common seal and executive signatures. | | |
| Contribution to the delivery of NHS / Trust strategies and plans N/A | | |
| Financial implications N/A | | |
| Legal issues To ensure the Trust complies with its standing orders. | | |
| 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 N/A | | |
| Who is responsible for implementing the proposals / project and anticipated timescales N/A | | |
| Who is accountable for the implementation of the proposal / project N/A | | |

ATTACHMENT Q

Finance & Investment Committee

Summary of meeting for Trust Board

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of Meeting: | 20 th March 2013 |
| Names of attendees: | David Lomas (Non-Executive Director), John Ripley (Non-Executive Director), Jan Filochowski (Chief Executive), Robbie Burns (Interim Chief Operating Officer), Claire Newton (Chief Finance Officer) In attendance: Carla Hobart (Interim Deputy Chief Operating Officer), Andrew Needham (Deputy Director of Finance), Neil Redfern (Financial Controller) |
| Quorum? | Yes |
| Matters considered: | <u>Main agenda items:</u> <ul style="list-style-type: none"> ▪ Three year financial plan ▪ CRES ▪ Foundation Trusts in breach and learning points ▪ Process for approval of the EDRMS Business Case ▪ Constitution change re significant transactions ▪ Service Line Reporting information for Q3 2012/13 |
| Decisions reached: | <ul style="list-style-type: none"> • Action to obtain further advice re the proposed 3A rental structure • Three year financial plan to be refined before presentation to the Board • Action for CRES leads to review the level of revenue generation schemes and prepare contingency plans should activity growth not be realised • EDRMS business case to be circulated to F&I members ahead of the paper deadline for the Trust Board • Proposed constitution change to be updated and circulated before presentation to the Trust Board • Specialty leads to be invited to future meetings to discuss SLR for their units Follow up to Board meeting: <ul style="list-style-type: none"> ○ Network tender decision approved |
| Risks/ issues to be raised with Trust Board: | <ul style="list-style-type: none"> • None |
| Actions required of Trust Board: | <ul style="list-style-type: none"> • To note the minutes of the meeting |
| Date Next Meet: | 24 July 2013 |
| Signed: (CFO): | C Newton |

ATTACHMENT R

**Update from the Board of Directors' Remuneration Committee meeting
held on 27th March 2013**

Terms of Reference

The committee reviewed the revised the terms of reference. The changes are minimal, removing reference to clinical excellence awards and making sure that it is clear that the committee considers executive director remuneration.

The revised terms of reference were approved, with minor amendments and are attached. The Board is asked to ratify the revised terms of reference.

Director's pay

The committee **approved** an increase of 1% to all salaries set by the Board of Directors' Remuneration Committee, including the Chief Executive and executive directors with effect from 1st April 2013, in line with all other staff in the NHS.

The committee **approved** the salaries for the Chief Operating Officer, Director of Human Resources and Organisational Development and the Director of Planning and Information.

Redundancy and severance payments

Mr Ali Mohammed stated that he would keep the committee informed of the relativity of redundancy figures for GOSH through his HR networks.

Board of Directors' Remuneration Committee**Terms of Reference****1. Authority**

- 1.1 The board of director's remuneration committee is constituted as a standing committee of the foundation trust's board of directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors' meetings.
- 1.2 The remuneration committee is authorised by the trust's board of directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the remuneration committee.
- 1.3 The remuneration committee is authorised by the trust's board of directors to instruct professional advisors and request the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise its functions.
- 1.4 The remuneration committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. Role

- 2.1 Determine and agree with the board the framework of remuneration for the board executive directors and designated senior managers;
- 2.2 To decide and review the terms and conditions of office of the foundation trust's board executive directors in accordance with all relevant foundation trust policies, including:
 - Salary, including any performance-related pay or bonus
 - Provisions for other benefits, including pensions;
 - Termination and/or severance payments
 - Allowances.
- 2.3 To monitor and evaluate the performance of individual board executive directors.
- 2.4 Where appropriate to authorise
 - Any contractual and/or non-contractual payments (including payments made on termination of employment) to chief executive and executive directors.
 - Any non-contractual payment to other members and/or ex members of staff in excess of £100,000
 - Any redundancy/capitalised pension cost made to members of staff.
- 2.5 To monitor redundancy/ capitalised pension costs for all staff groups.

2.6 To adhere to all relevant laws, regulations and policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate executive directors whilst remaining cost effective.

2.7 The chair and another non-executive director are authorised to approve the following outside the meeting:

- any redundancy/ capitalised pension cost in excess of £100,000;
- total remuneration for newly advertised executive director posts.

2.8 Where such actions are taken, these will be reported to the next meeting of the committee.

3. Membership and attendance

3.1 A non-executive director will chair the committee.

3.2 All other non-executive directors, including the chair of the board of directors shall be members of the committee.

3.3 The chief executive, director of human resources and organisational development and the head of operational human resources shall normally be invited to attend meetings in an advisory capacity.

3.4 Other members of staff and external advisers may attend all or part of a meeting by invitation of the committee chair where required.

4. Quorum

4.1 The quorum necessary for the transaction of business shall be 3 members including the chair or senior independent director of the Trust.

5. Secretary

5.1 The company secretary shall be secretary to the committee.

6. Frequency of meetings

6.1 The committee shall meet at least twice a year, normally in March and November.

7. Minutes and reporting

7.1 The minutes of all meetings of the remuneration committee shall be formally recorded.

7.2 The remuneration committee will report to the full board of directors after each meeting.

7.3 The remuneration committee shall ensure that board of directors' emoluments are accurately reported in the required format in the foundation trust's annual report.

8. Performance evaluation and training

8.1 The remuneration committee shall review its collective performance and that of its individual members on a regular basis.

8.2 Members of the remuneration committee should seek continually to develop and refresh their knowledge of current remuneration practices.

9. Review

9.1 The terms of reference of the committee shall be reviewed by the board of directors at least annually.

March 2013

ATTACHMENT S

**Update from the Board of Directors' Nominations Committee meeting
held on 27th March 2013**

The committee noted the process followed for the appointment of the Chief Operating Officer and approved the appointment of Ms Rachel Williams to the post.

The committee noted the process followed for the appointment of the Director of Human Resources and Organisational Development and approved the appointment of Mr Ali Mohammed to the post.

The committee approved the appointment of Mr Robert Burns to the new post of Director of Planning and Information. The committee was advised that this post had been created to oversee the annual business planning process and hold Trust wide responsibility for information and direct managerial responsibility for the transformation team.

ATTACHMENT T

Update from the Members' Council meeting held on 30th January 2013

Gastroenterology Team Presentation

Dr Mamoun Elawad, Consultant of Gastroenterology presented objectives, challenges and issues facing the Gastroenterology Service.

International Private Patient (IPP) Strategy

The Members' Council agreed with the recommendations for plans for the IPP strategy, noting that all developments would be progressed in accordance with the Trust's Business Case process and that NHS services would not be adversely affected.

The Council noted that the current plans for IPP development did not exceed the growth limits as set down in legislation and therefore did not require explicit Councillor approval.

Reappointment of the chair and Non-Executive Directors and biographies

Mr Conley, Head of HR Operations summarised the reappointment process. The Council unanimously reappointed Baroness Blackstone, Ms Mary MacLeod and Ms Yvonne Brown until 29th February 2016.

Outline of annual planning process 2013/14

Ms Fiona Dalton, Chief Operating Officer informed the Council that the final Annual Plan for 2013/14 would be brought to the April Council meeting. Dr Anna Ferrant, Company Secretary, agreed to request the names of 5 councillors willing to be part of the annual plan review process to be held in mid-March 2013.

Chief Executive's Report

Mr Jan Filochowski, Chief Executive reported that the performance reports were being reviewed to make them simpler and shorter to read. The Council was informed that it was proposed to focus the listening event on the development of a universal GOSH patients' promise. The forum would also be used to attract new members and would be held in the summer.

Report from Board assurance committees

Mr Charles Tilley, Audit Committee Chair reported that the three main areas covered at the recent committee were risk, internal audit and external audit. Ms Mary MacLeod Clinical Governance Committee Chair reported that one of the main issues covered at the recent committee was the quality and safety of the Trust's efficiency-saving plans.

CGC Report

Mrs Liz Morgan, Chief Nurse and Director of Education reported that GOSH was compliant with all standards reviewed at the last CQC inspection on 25 September 2012. Mr Jan Filochowski, Chief Executive stated that a report on the review of the quality of food would be presented at the next Council meeting in April 2013.

Report from Members' council subcommittees

Ms Lisa Chin-A-Young, Patient and Carer Councillor presented the first update on the Membership and Engagement committee and confirmed that recruitment of members was on track.

Ms Camilla Pease, Patient and Carer Councillor, presented the update from the Membership Communications Committee. The committee looked at publications across the hospital and the potential to use social media to communicate with members.

Summary of work schedule of the Members' Council

Dr Anna Ferrant, Company Secretary presented the Members' Council work schedule which was noted by the Council.

Any Other Business

The AGM would be moved to July in 2013 and be reassessed in 2014 and beyond.

It was agreed that PALS quarterly reports be circulated with council papers.

Ms Fiona Dalton, Chief Operating Officer, reported that there was an action plan in place to improve the Appointments Service.

Baroness Blackstone informed the Council of Mr Mason Moore's resignation and that an election would be called for his position as a Patient Councillor from London.