

**Meeting of the Trust Board
Thursday 25th May 2017**

Dear Members

There will be a public meeting of the Trust Board on Thursday 25th May 2017 at 1:00pm in the Charles west Boardroom, Great Ormond Street, London, WC1N 3JH.

Company Secretary

Direct Line: 020 7813 8230

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AGENDA

	Agenda Item <u>STANDARD ITEMS</u>	Presented by	Attachment
1.	Apologies for absence	Chairman	Verbal
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 29th March 2017	Chairman	A
	Amendment to December 2017 Trust Board Minutes	Company Secretary	B
3.	Matters Arising/ Action Checklist	Chairman	C
4.	Chief Executive Update <ul style="list-style-type: none">• Safety and Reliability Improvement Partner Programme	Chief Executive	Verbal 4
5.	Patient Story	Chief Nurse	D
6.	Audit Committee update – April 2017 meeting and revised Audit Committee Terms of Reference and workplan	Chair of the Audit Committee	T
7.	Quality and Safety Assurance Committee update – April 2017 meeting	Chair of the Quality and Safety Assurance Committee	E
8.	Finance and Investment Committee Update – March and May 2017	Chair of the Finance and Investment Committee	F
9.	Members' Council Update – April 2017	Chairman of the Members' Council	G
	<u>ANNUAL ACCOUNTS</u>		
10.	GOSH Foundation Trust annual financial accounts and annual report 2016/17 including: <ul style="list-style-type: none">• the Annual Governance Statement• the Audit Committee Annual Report• the draft Head of Internal Audit Opinion	Audit Committee Chair/ Chief Finance Officer/ Company Secretary	H
11.	Compliance with the NHS provider licence – self assessment	Company Secretary/ Chief Finance Officer	I

12.	Compliance with the Code of Governance		J
13.	Quality Report 2016-17	Interim Medical Director	K
	<u>PERFORMANCE</u>		
14.	Integrated Quality Report – 30th April 2017	Interim Medical Director/ Chief Nurse	L
15.	Integrated Performance Report (30th April 2017)	Deputy Chief Executive	M
	• Workforce Metrics & Exception Report (30th April 2017)	Director of Human Resources &OD	N
	• Finance Update (30th April 2017)	Chief Finance Officer	O
16.	Staff Friends and Family Test results – Quarter 4 2016/17	Director of Human Resources &OD	P
	<u>ASSURANCE</u>		
17.	Annual Safeguarding Report 2016/17	Chief Nurse	Q
18.	Safe Nurse Staffing Report (March and April 2017)	Chief Nurse	R
	<u>GOVERNANCE AND RISK</u>		
19.	Board Assurance Framework Update	Company Secretary	S
Any Other Business (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)			
Next meeting The next Trust Board meeting will be held on Friday 21 st July 2017 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.			

ATTACHMENT A

**DRAFT Minutes of the meeting of Trust Board on
 29th March 2017**

Present

Baroness Tessa Blackstone	Chairman
Dr Peter Steer	Chief Executive
Mr David Lomas	Non-Executive Director
Mr Akhter Mateen	Non-Executive Director
Ms Mary MacLeod	Non-Executive Director
Mr James Hatchley	Non-Executive Director
Professor Stephen Smith	Non-Executive Director
Ms Juliette Greenwood	Chief Nurse
Ms Nicola Grinstead	Deputy Chief Executive
Dr David Hicks	Interim Medical Director
Mr Ali Mohammed	Director of Human Resources and OD
Ms Loretta Seamer	Chief Finance Officer

In attendance

Ms Cymbeline Moore*	Director of Communications
Mr Matthew Tulley	Director of Development
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Mrs Herdip Sidhu-Bevan*	Assistant Chief Nurse – Patient Experience and Quality
Miss Emma James*	Patient Involvement and Experience Officer
Dr John Hartley*	Director of Infection Prevention and Control
Mr Simon Hawrey-Woore*	Members' Council (observer)
7 public and staff observers	

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

** Denotes a person who was present by telephone

182	Apologies for absence
182.1	Apologies for absence were received from Professor Rosalind Smyth, Non-Executive Director.
183	Declarations of interest
183.1	There were no declarations of interest.
184	Minutes of the meeting on 1st February 2017
184.1	The minutes of the previous meeting were approved .
185	Matters Arising/ Action Checklist
185.1	Minutes 59.6, 59.7 and 59.8: It was noted that the work on the education plan and international education had been subsumed into the work that was taking place on the strategy and was being reported to the Board as part of normal business.
185.2	Action: Minute 156.3 – It was agreed that discussion outside the meeting would

	determine which committee would review issues with transport which had been the subject of PALS contacts.
186	Chief Executive Report
186.1	Dr Peter Steer, Chief Executive gave an update on the following matters: <ul style="list-style-type: none"> • Positive engagement had taken place with NHS England on Congenital Heart Disease. • A positive meeting had taken place between Jim Mackie, Chief Executive of NHS Improvement and the GOSH Executive Team.
187	Patient Story
187.1	The Board received a patient story by video from a parent who had experienced GOSH throughout her fourteen year old son's lifetime.
187.2	The parent gave the following recommendations: <ul style="list-style-type: none"> • A welcome pack to be provided for parents of inpatients including information such as directions to the laundry and the kitchen areas; • Sending a parking slip out with relevant appointment letters as it was difficult to manage a complex child or young person whilst having to leave the car to go to main reception; • Whole hospital accessibility in new buildings including railings on the wall for people with visual impairments, visual aids and the use of pictorial exchange; • The use of tactile timetables on which a family could use their own visual labels.
187.3	Ms Mary MacLeod, Non-Executive Director welcomed the patient story and queried the way in which transition would be planned for a complex patient. Ms Juliette Greenwood, Chief Nurse said that transition planning would take place on an individual basis and would involve discussion with commissioners and the relevant adult hospital.
187.4	Action: Ms Greenwood said that a welcome pack had been introduced since the family had first visited the Trust and agreed to look into the matter of issuing timed parking slips. It was agreed that updates on the recommendations would be considered at the Quality and Safety Assurance Committee.
188	Update from the Audit Committee in January 2017
188.1	The Board noted the written update provided and noted that a verbal update had been provided at the January 2017 meeting.
189	Update from the Finance & Investment Committee in January 2017
189.1	Mr David Lomas, Chair of the Finance and Investment Committee said that the committee had noted that the Trust was moving towards meeting its control total. Activity had been reviewed in the context of the contract and it had been confirmed that GOSH was meeting its contracted activity.

190	Members' Council Update – January 2017
190.1	Dr Anna Ferrant, Company Secretary presented the report and said that the Chairman recruitment process continued positively.
191	Integrated Quality Report – 28th February 2017
191.1	Dr David Hicks, Medical Director presented the report and said that updates had been made as requested by the Quality and Safety Assurance Committee. He said that additional data had been added to correlate quality information with patient experience and a theme analysis had been provided.
191.2	The Board discussed a Never Event which occurred in June 2016 the action plan for which was not yet complete. Mr James Hatchley, Non-Executive Director emphasised the importance of ensuring that actions were timely and lessons learnt were disseminated as quickly as possible. Dr Hicks said that there had been a national patient safety alert on the same issue and the Trust was completing the action plan as part of the overall workstream within the required timetable. He confirmed that the learning from the incident had been communicated.
191.3	Action: Mr Hatchley asked for assurance that there was not a systemic issue behind the respiratory arrests outside ICU. Dr Hicks confirmed that all incidents had been reviewed and no common theme had been found. It was agreed that the coversheet would include a summary of the issues that had potential to be of concern which were included throughout the paper.
191.4	Action: Ms Mary MacLeod, Non-Executive Director confirmed that she would provide her comments and queries in advance of the next meeting of the Quality and Safety Assurance Committee.
191.5	Mr Akhter Mateen, Non-Executive Director highlighted feedback from the Friends and Family tests which was that all staff had not introduced themselves to the patient and family. He queried why this was not standard behaviour for all staff. Ms Cymbeline Moore, Director of Communications said that the Trust had implemented SHOW which was a local version of the 'Hello my name is' campaign. Dr Peter Steer, Chief Executive said that he attended a large number of induction meetings for new staff and discussed this issue and the importance of all staff introducing themselves.
192	Integrated Performance Report (28th February 2017)
192.1	<u>Performance Scorecard</u>
192.2	Ms Nicola Grinstead, Deputy Chief Executive said that the report presented February data and highlighted that the Trust had returned to RTT reporting. Considerable work had taken place around RTT and achievement against the target had been higher than anticipated.
192.3	Action: Mr Akhter Mateen, Non-Executive Director said that an equal number of indicators had remained red over the past three months as had remained green. He drew attention to the bed occupancy metric which showed a downward trend but no target was identified in the paper. Ms Grinstead said that the data was drawn from the midnight bed census and the paper at the next meeting would

	provide a key of the meaning of the data. It was agreed that the report at the next meeting would give a target of 85% - 92%.
192.4	The Trust Board discussed theatre utilisation metrics and noted that the standard NHS target was 77%. Work was taking place on efficiency, particularly for theatres which were devolved to their own management. Ms Grinstead said that a key barrier to improved utilisation was the availability of ICU beds. Agreement had now been reached with commissioners to increase the number of beds in ICU and additional theatres were planned as part of the new Premier Inn Clinical Building, however it was important to ensure that existing theatres were being efficiently utilised before this additional investment was made.
192.5	Action: It was agreed that a report on theatre utilisation would be provided at the next meeting.
192.6	Action: It was agreed that the actual number of outpatient appointment cancellations would be provided at the next meeting rather than percentages.
192.7	Mr Hatchley highlighted that there had been 83 patients who had not been admitted to PICU and NICU due to lack of beds. Ms Grinstead emphasised that patients were not going without appropriate care within London. She said that only one patient had been transferred out of London. She confirmed that this data had been shared with commissioners.
192.8	Action: It was confirmed that the prototype scorecard would be implemented from the next meeting and Ms Grinstead asked the Board to provide any feedback in advance of this.
192.9	<u>Workforce Metrics & Exception Report</u>
192.10	Mr Ali Mohammed, Director of HR and OD said that the Trust's turnover was gradually reducing and was approaching the London average. He said that concerns had been raised around agency costs however this would be significantly reduced once there had been a reduction in the RTT validation team and remaining staff had been transferred to substantive contracts within teams.
192.11	Work was taking place to ensure that all elements of the Trust's mandatory training were relevant and efficiently delivered.
192.12	The Board discussed PDR rates which remained red rated. Baroness Blackstone, Chairman said that there were a number of areas which remained below 80% and emphasised that changes in these areas must be urgently made. She said that PDRs were an important part of good practice and the message must be disseminated to managers in these areas from the Board.
192.13	Dr Peter Steer, Chief Executive suggested that, along with mandatory training, if requirements were not met, the Board should have a policy in which after a given time, staff could not continue in their roles without a valid PDR.
192.14	Ms Mary MacLeod, Non-Executive Director welcomed the assessment of mandatory training that was taking place and said that as a substantial amount of time was taken out of the workforce for training it was vital that all training was relevant.

192.15	<u>Finance Update</u>
192.16	Ms Loretta Seamer, Chief Finance Officer said that it was likely that the Trust would meet its control total at year end however was unlikely to meet plan due to the increased depreciation of donated assets. There had been an improvement in IPP debtors with further payments being received. It was confirmed that the Trust was on plan to deliver the NHS England contract and despite having not met the productivity and efficiency target, the control total had been met due to non-recurrent savings.
193	Infection Control Report
193.1	Dr John Hartley, Director of Infection Prevention and Control presented the report. He highlighted action 129.3 on the action log around nudge theory and said that rather than using nudge theory it was vital to communicate to staff the importance of following standard precautions.
193.2	It was reported that the Trust was working well to control the incidence of MRSA and central venous line (CVL) infections. Dr Hartley said that resistant infections were increasing year on year and additional work was required to prevent and treat these. Dr Hartley highlighted the importance of compliance with CVL care bundles in reducing the number of related infections.
194	Safe Nurse Staffing Report January 2017 and February 2017
194.1	Ms Juliette Greenwood, Chief Nurse said that the Trust had met the required staffing rates and there had been no unsafe shifts in the period of the report.
194.2	Work was taking place around care hours per patient per day to calculate a recognised average and tolerance which could be used to benchmark with other paediatric hospitals.
194.3	Discussion took place around the number of cardiac and respiratory arrests in the period. It was highlighted that the figures provided were different in the safe staffing and quality reports. This was because the safe staffing report referred to arrest taking place on wards whereas the arrests in the Quality Report were Trust wide, including a number which took place on non-inpatient ward areas.
194.4	Baroness Blackstone, Chairman raised the issue of bed closures caused by refurbishment. Mr Matthew Tulley, Director of Development said that although the length of the closure was dependent on the scope of the project, considerable planning took place to minimise the impact as far as possible.
195	2016 Annual Staff Survey Results
195.1	Mr Ali Mohammed, Director of HR and OD presented the report and expressed some concern about the number of staff reporting poor behaviour from colleagues. He said that following improvements in understanding the reasons for staff leaving the Trust, further work would be conducted.
196	Deputy Chairman and Senior Independent Director roles from 1st May 2017
196.1	Dr Anna Ferrant, Company Secretary confirmed that the Members' Council had approved the proposal for Ms Mary MacLeod, Deputy Chairman to become

196.2	<p>Interim Chairman when Baroness Blackstone stepped down as Chairman at the end of April 2017. She said that it was further recommended that Mr Akhter Mateen became the Deputy Chairman, Mr James Hatchley the Senior Independent Director and Professor Stephen Smith, the Chair of the Quality and Safety Assurance Committee.</p> <p>The Board agreed to recommend the proposals to the Members' Council for approval.</p>
197	Revised Trust Board Workplan 2017/18
197.1	Dr Ferrant said that the Well Led Review had recommended that the Board Assurance Framework was reported to the Board four times per year. She said that the update workplan proposed that this took place three times annually, but that this was scheduled around the review of progress with the strategy.
197.2	It was proposed that six patient stories were reported to the Trust Board and that a number of these would be around patients and families involved in research.
197.3	Action: Mr David Lomas, Non-Executive Director said that the meeting of the subcommittee chairs had agreed that the Legal Team Report would be considered by both the Quality and Safety Assurance Committee and also the Audit Committee.
197.4	<p>Action: Mr Lomas suggested that it was important to undertake horizon scanning and to support this work, individuals from the following organisations should be invited to present to the Board:</p> <ul style="list-style-type: none"> • Commissioners • The King's Fund • Chief Executive of another Children's hospitality • Chief Executive of a referring Trust to discuss better joint working.
197.5	Action: It was agreed that feedback from the GOSH Children's Charity and UCL GOS Institute of Child Health would be provided at Trust Board seminar sessions in rotation.
198	Register of Interests and Register of Gifts and Hospitality
198.1	Action: Dr Anna Ferrant, Company Secretary said that work was taking place to implement a revised process across the Trust for both declarations of interest and declarations of gifts and hospitality. It was agreed that Dr Ferrant would circulate the newly updated NHS England guidance on the matter.
198.2	Ms Mary MacLeod, Non-Executive Director welcomed the increase in declarations received but said that there was work to be done to ensure all staff were aware of the declarations they should be making.
199	Any Other Business
199.1	There were no items of other business.

Trust Board 25th May 2017	
Amendment to the December 2016 Public Trust Board minutes	Paper No: Attachment B
Submitted by: Anna Ferrant, Company Secretary	
Aims / summary The following amendment is proposed to the public Trust Board minutes from December 2016 in order to more accurately reflect the discussion.	
135	Update from the Finance & Investment Committee in October 2016
135.1	Mr David Lomas, Chair of the Finance and Investment Committee said that the meeting had discussed data quality and the plan to produce a data quality dashboard. Concern had been expressed about the timeliness of this action.
135.2	PREVIOUS TEXT Discussion had taken place about the productivity and efficiency programme which had begun to include income generating work. Mr Lomas said that historically there had been insufficient focus on cost savings and it had been agreed that the 2016/17 programme would not include income. The Committee had agreed that both views should be presented to the committee: a programme taking only costs into consideration and the programme which also included income.
135.2	PROPOSED NEW TEXT Discussion took place about the productivity and efficiency programme. Mr Lomas said that historically the majority of actual P&E improvements had been delivered through incremental income rather than cost initiatives. At the commencement of 2016/17 it was agreed that the P&E focus would be on cost savings and that no income initiatives has been included in the target. The Board agreed that both views should be presented: a programme taking only costs into consideration and the programme including income.
Action required from the meeting The Board is asked to endorse the amendment to the minutes from the December 2016 Public Trust Board meeting.	
Contribution to the delivery of NHS Foundation Trust strategies and plans N/A	
Financial implications N/A	
Who needs to be told about any decision? Company Secretary	
Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary	
Who is accountable for the implementation of the proposal / project? Company Secretary	

ATTACHMENT C

**TRUST BOARD – PUBLIC ACTION CHECKLIST
May 2017**

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
54.3	20/07/16	It was agreed that work would take place to investigate the status of the tier 4 mental health services tender and to give consideration to highlighting the gap in services. It was agreed that an update and recommendation on these matters would be provided at the next meeting.	NG	TBC	Not yet due. An update will be provided to the Board once the national tender for the service has been published
152.1	01/02/17	Baroness Blackstone, Chairman asked whether the national tender for tier 4 mental health services had been published. Dr Peter Steer, Chief Executive said that it was expected to be received in the near future and GOSH had already begun to engage with other London organisations around the mental health landscape.			
158.8	01/02/17	It was agreed that the next research and innovation report would include focus on non-grant based direct funding such as enterprise. The report would also include the impact that the Zayed Centre for Research into Rare Disease in Children would have once on line to research as a whole and to the Trust's income.	DG	July 2017	Not yet due
187.4	29/03/17	It was agreed that updates on the recommendations from the patient story would be considered at the Quality and Safety Assurance Committee.	JG	April 2017	Actioned and ongoing

Attachment C

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
191.3	29/03/17	It was agreed that the coversheet of the Integrated Quality Report would include a summary of the issues that had potential to be of concern which were included throughout the paper.	JG	May 2017	Actioned: On agenda
192.3	29/03/17	It was agreed that the integrated performance report would include a target for the bed occupancy metric of between 85%-90%.	NG	May 2017	On agenda
192.5	29/03/17	A report on theatre utilisation would be provided at the next meeting.	NG	July 2017	Not yet due
192.6	29/03/17	An update to be provided at the next meeting on the exact numbers of outpatient cancellations rather than percentages.	NG	May 2017	Verbal Update
192.8	29/03/17	It was confirmed that the prototype scorecard would be implemented from the next meeting and the Board was asked to provide any feedback in advance of this.	ALL	May 2017	On agenda
194.3	29/03/17	The number of cardiac arrests and respiratory arrests outside of ICU in the integrated quality report and safe staffing report to be revisited to ensure they were the same.	JG	May 2017	Actioned
197.5	29/03/17	It was agreed that feedback from the GOSH Children's Charity and UCL GOS Institute of Child Health would be provided at Trust Board seminar sessions in rotation.	AF	May 2017	Under discussion with Interim Chairman
198.1	29/03/17	It was agreed that Dr Ferrant would circulate the newly updated NHS England guidance on declarations of interests and declarations and declarations of gifts and hospitality.	AF	May 2017	In progress

Trust Board 25th May 2017	
Safety and Reliability Improvement Partner Programme – the Cognitive Institute Submitted by: Peter Steer, Chief Executive	Paper No: Attachment 4
Aims / summary The Safety and Reliability Improvement Programme addresses the influence and impact of organisational climate, leadership commitment, and high performance work practices on quality and safety in healthcare. The programme will provide a framework for the development of leadership competencies, a safety culture and will emphasise the importance of professional accountability.	
Action required from the meeting Note and support the proposal to appoint the Cognitive Institute and to introduce the programme at GOSH. Board and Executive support for programme is critical.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Provide the safest, most effective care, with the best possible outcomes	
Financial implications The detailed costing will depend on the breadth and depth of leadership involved with the programme. A minimum spend of £100,000 will be necessary. Funding will be accessed via Charity commitments to Quality Improvement Program. There will be no direct losses to the Trust operating budget.	
Who needs to be told about any decision? In the first instance relevant members of divisional teams and Head of Clinical and non-clinical services.	
Who is responsible for implementing the proposals / project and anticipated timescales? Executive Team, led by the Medical Director	
Who is accountable for the implementation of the proposal / project? Medical Director	



**Safety and Reliability
Improvement Partner
Programme**

cognitiveinstitute.org

Each year **12,000 clinicians**
in more than **10 countries**
acquire **Cognitive KnowHow**



Around the world Cognitive Institute is partnering with private and public hospitals, and healthcare organisations to help deliver excellence in healthcare.

Cognitive Institute is an international provider of healthcare education.

Our commitment is to provide education that distils complex issues and challenges into relevant practical training that clinicians can put into practice.

For more than 10 years leading names in healthcare have relied on our education. Recognising the integrity of our programmes, they are now part of doctor specialty training curriculum in many countries.

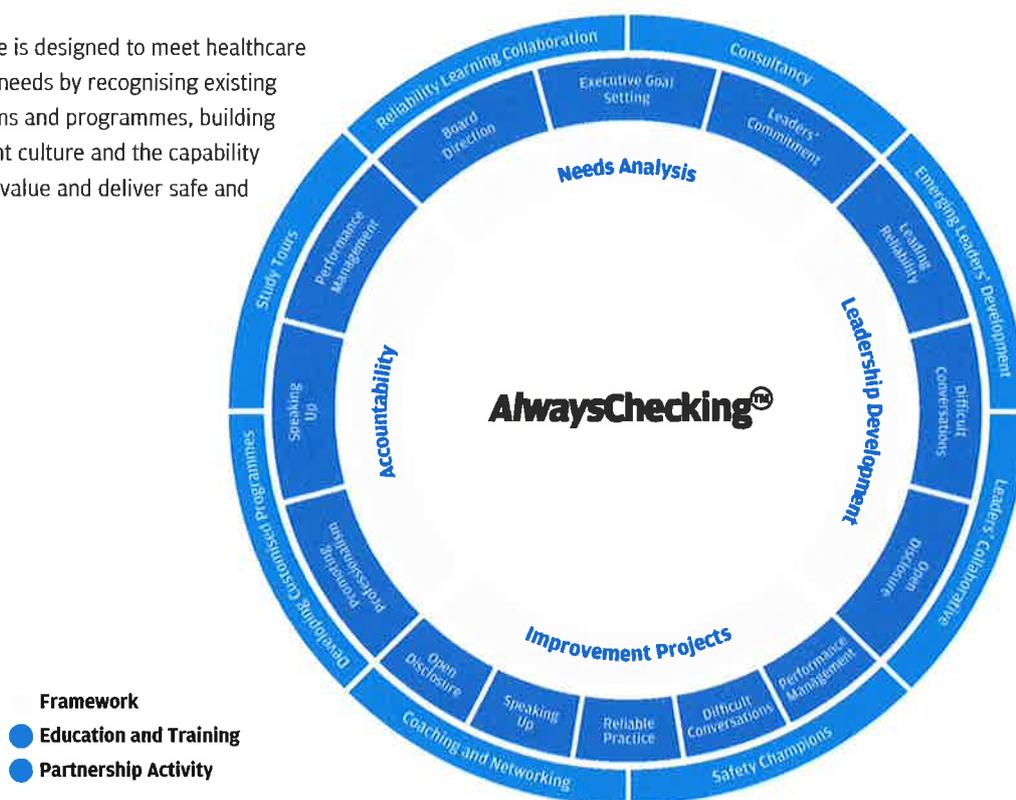
The Cognitive Institute is part of the not for profit organisation, the Medical Protection Society. We are just as committed to healthcare as you, providing independent, professional advice and education.

Introduction to the Safety and Reliability Improvement Programme (SRIP)

Safety and reliability improvement KnowHow™ for high performing health service organisations

The Safety and Reliability Improvement Programme addresses the influence and impact of organisational climate, leadership commitment, reliability science application and high-performance work practices on quality and safety outcomes in healthcare.

The programme is designed to meet healthcare organisational needs by recognising existing effective systems and programmes, building an improvement culture and the capability to understand, value and deliver safe and reliable care.



At the core of the Safety and Reliability Improvement Programme is an organisation-wide commitment to the Cognitive Institute AlwaysChecking approach. It includes board and executive, leaders, clinicians and the whole workforce. This approach identifies five principles for safe and reliable care.

AlwaysChecking™

We always check:

- Each other and welcome being checked
- What we have agreed should be done
- Message sent is message received
- We know how to work together
- Always means always.

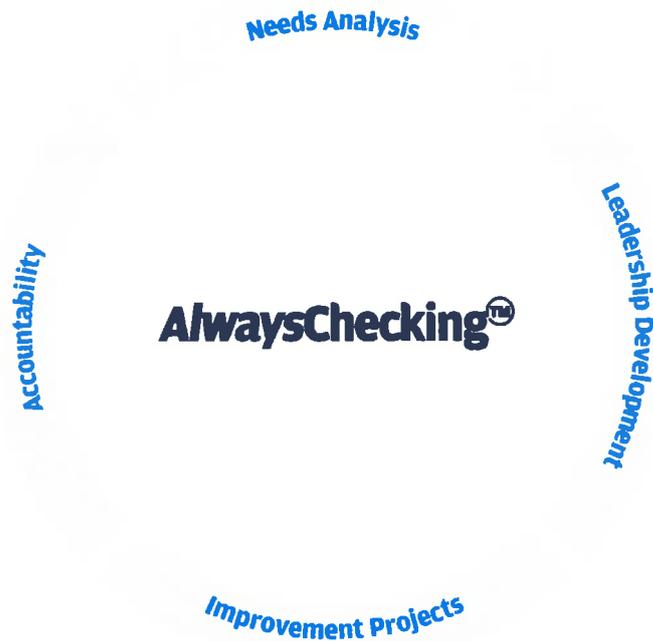
Four parameters make up the framework for the design and delivery of the education and training activity.

Our work with you as a partner:

1. Commences with a full scoping and needs analysis, recognising existing organisational systems and processes
2. Engages board executive and clinical leaders to support and develop skills, attitudes and behaviour to influence reliability and safety improvement
3. Equips clinicians with knowledge and skills required to implement improvement projects
4. Develops a safety culture which places high importance on professional accountability and equips leaders to achieve this.

The framework

Four parameters frame the design and delivery of the education and training activity in the Safety and Reliability Improvement Programme



Needs analysis

In the first stage of the programme, Cognitive Institute works with the board, executive and leadership to resolve a commitment to directions and goals for safety and reliability. We identify critical issues, risks, existing infrastructure supporting reliability improvement and organisational learning and development needs.

Leadership development

Leadership development is delivered to align clinical and non-clinical leaders across professional boundaries in a shared commitment and increased capability to lead safety and reliability improvement. Training and support is provided to advance leaders' knowledge and skills in reliability science, inter-colleague communication and safety advocacy. Leaders receive personal motivation, tools and support to lead the implementation of improvement projects, participate in peer support networks and sustain the delivery of the highest levels of reliability and safety.

Improvement projects

Improvement projects are supported by the development of knowledge, skills, attitudes and behaviour for clinicians and non-clinicians to provide safe and reliable care. We focus on creating capability to achieve quality and safety goals by applying reliability science. This includes developing non-technical skills for improved colleague interactions, open disclosure and mechanisms to support speaking up for safety.

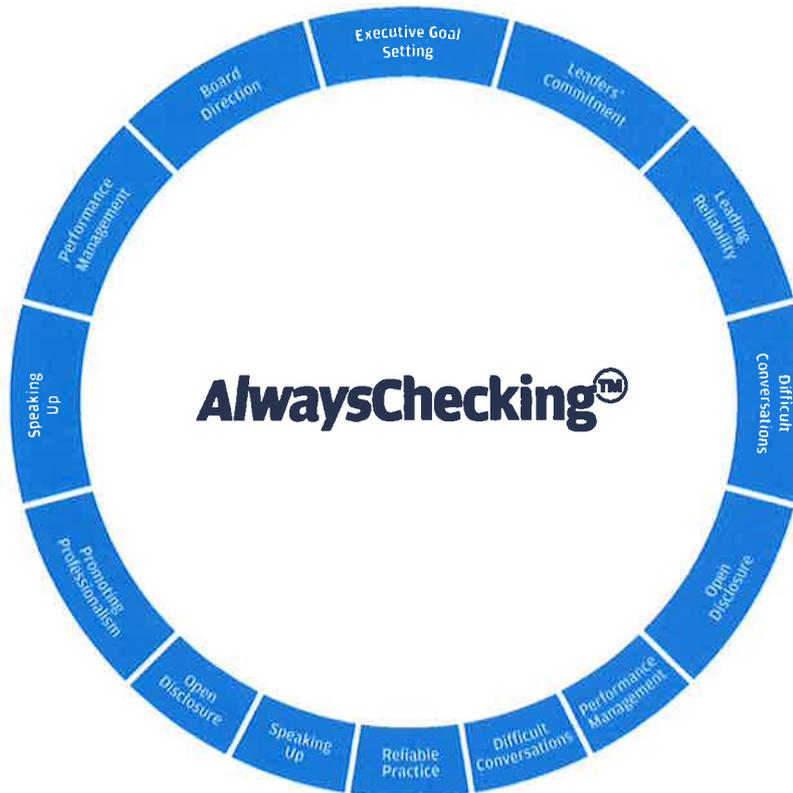
Accountability

Accountability frameworks and skills are delivered to ensure 'always means always'. The focus of training and development activity is to overcome barriers to achieving higher levels of safe and reliable care through developing processes, mechanisms and skills to support high performance work practices.

SRIP education and training

The programme comprises education and training activity within an established framework and informed by the *AlwaysChecking™* philosophy

Following the needs analysis, a review of existing systems and education requirements will inform a bespoke training programme to meet quality and safety targets and design a tailored strategy drawing from relevant programmes in the diagram below.



Board direction

Our Safety and Reliability Board Briefing is an important step in the process of engaging an organisation wide commitment to enhancing culture and capability for safety and reliability improvement. These briefings can take place at regular board meetings or extraordinary meetings and can take up to ninety minutes. We also deliver half day board training sessions on reliability and safety improvement.

Executive goal setting

As part of our Executive Goal Setting Cognitive Institute engages with the executive management team to determine organisational goals and objectives relating to safety and reliability. This involves a series of sessions and can be short duration or evolve into more extensive brainstorming and strategic workshopping. Safety and reliability briefings can also be delivered to the executive management team in the same way the board briefings occur.



Leaders' commitment

Our Safety and Reliability Leaders' Programme is designed to engage all tiers of leadership in raising awareness of and commitment to reliability and safety improvement goals. These full day workshops are highly interactive with a focus on leadership providing feedback and key messages for board and executive relating to reliability and safety improvement.

Leading reliability

Leading Reliability Improvement for Safer Healthcare - This full day workshop provides clinical leaders with the knowledge, insights and essential strategies to lead the delivery of more reliable and safer clinical care and to minimise preventable patient harm in their team or unit. This programme will be delivered to selected clinical leaders.

Difficult conversations

Difficult conversations and situations are often the biggest stressors for all who work in healthcare. However, there is added pressure when difficult conversations occur with colleagues. **Mastering Difficult Colleague Interactions** is a solution focused approach to enhancing the effectiveness and ease of dealing with difficult colleague interactions in healthcare. This workshop is suitable for all who work in the organisation and will be delivered based on outcomes from the needs analysis.

Open disclosure

An organisational culture which fosters open disclosure is an important element in managing patient confidence in the healthcare system and improving patient safety and quality. Training in **Open Disclosure** and **Clinical Incident Management** is available for organisation-wide implementation, delivered through face to face, online and train the trainer modality. Our open disclosure expert training programme enables clinical leaders to receive advanced communication skills training, including rehearsal with simulated patients. This enables effective engagement with patients, their family or carers when something goes wrong and includes training in the provision of meaningful apologies and practical steps to support patients and families.

Performance management

This workshop delivers *KnowHow* to empower clinical leaders to better performance manage staff and deal with resistance and under-performance. **Mastering Improved Clinician Performance** is a positive coaching skills workshop to increase the ease and effectiveness of managing clinicians towards improved performance. This full day workshop is recommended for executive directors, clinical managers and department heads.

Reliable practice

Our **Mastering Safer and Reliable Practice** draws on a wide range of expertise, research and experience and explores the extent to which low reliability in the delivery of healthcare has been identified as a risk for patients, clinicians and healthcare organisations. This workshop enables participants to examine a number of approaches and devices developed by the Cognitive Institute to assist them implement the science of reliability.

This half day workshop is suitable for all clinical staff.

Speaking up

A critical aspect of achieving a safe and reliable culture is a common language where clinicians support each other and speak up whenever there is a concern for safety. This necessitates replacing a blame culture with a 'looking out for' and 'having your back' culture. **Speaking up for Safety** can be delivered as a one hour seminar by Cognitive Institute or in-house through a train the trainer programme.

The train the trainer course is a core component of the Safety Champions programme, where Safety Champions undergo intensive training to deliver speaking up for safety organisation wide.

Trainees of the programme learn valuable presenting and facilitation skills and are provided with course material to deliver 60 and 90 minute seminars.

The seminar increases the ease and motivation for all staff to raise patient safety concerns with colleagues through graded assertiveness communication skills training.

Promoting Professionalism and Accountability Programme

As a partner organisation you will be one of the first organisations to benefit from the acclaimed Vanderbilt University's Promoting Professional Accountability Programme (PPA Programme). Vanderbilt University has selected Cognitive Institute to be the first organisation outside of North America to deliver this programme.

Our relationship with Vanderbilt University provides an unrivalled level of access to the resources and expertise of a world renowned team of industry leaders in the field of patient safety and professional accountability.

The PPA Programme equips healthcare leaders with the skills needed to engage with doctors, nurses and allied health professionals to change behaviours that undermine a culture of safety.

Leaders of healthcare institutions do not always have training in or effective strategies for dealing with behaviours that undermine a culture of safety. Without the proper tools, tolerance for such unsafe behaviours can undermine improvement strategies aimed at increasing reliability. Behaviours that undermine a culture of safety exhibited by healthcare professionals are first and foremost a threat to quality of care and patient safety, while also affecting staff morale and increasing cost burdens to the organisation.

Vanderbilt University's Dr Gerald Hickson and his team are widely published experts on the links between clinician behaviour and patient safety. His research led to the development of Promoting Professional Accountability, an evidence based approach for improving safety and quality outcomes in healthcare, now implemented in hospitals throughout the USA and adapted to the Australian context.

The PPA Programme has reliably achieved handwashing compliance rates of 96.6%

Talbot et al, Sustained improvement in hand hygiene adherence: utilizing shared accountability and financial incentives, *Infect Control Hosp Epidemiol* 34: 1129-36 (2013)

The appeal of the PPA Programme lies within its flexibility - the programme is not limited to hand washing compliance, the ideology and principles can be applied to any number of patient safety issues with positive effect.

This programme will give leaders essential tools and strategies to address 'unreasonable variation' in behaviour and performance, providing a comprehensive plan adaptable to all health care organisations, relevant to all staff.

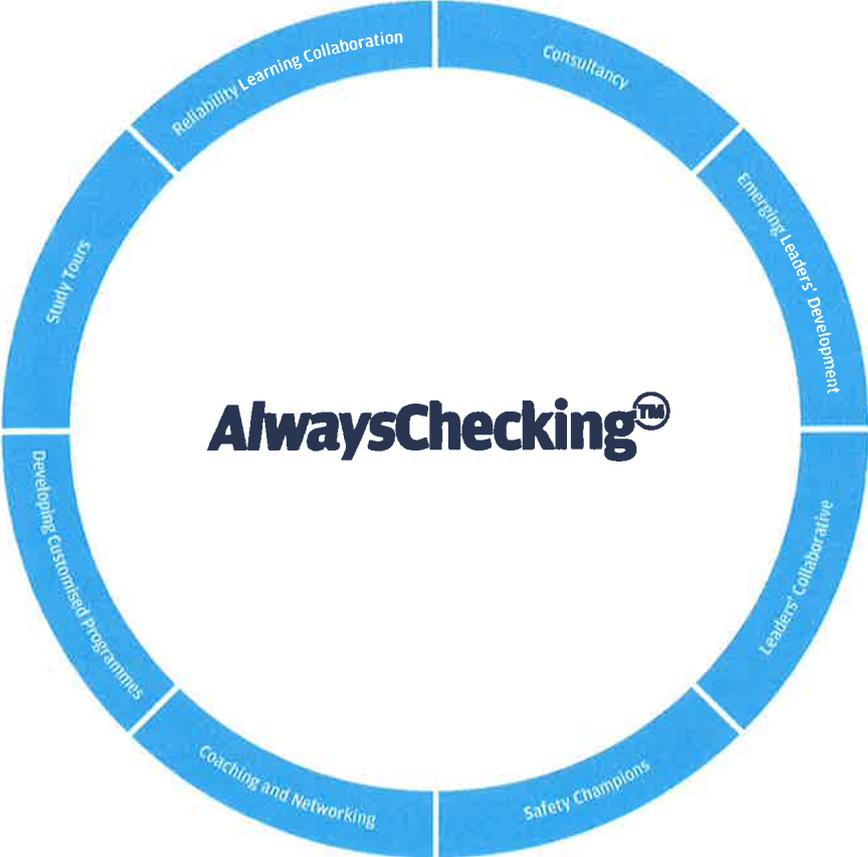
Cognitive Institute Exclusive Safety and Reliability Partner activity

A limited number of Safety & Reliability partnerships are available for leading health service organisations committed and dedicated to quality improvement.

Safety and Reliability Partners have exclusive access to a training and support programme for safety champions, leadership education and training activity and consultancy services including education intervention customisation based on an action research model of enquiry. They also automatically become members of a global Reliability Learning Collaborative facilitated by Cognitive Institute and gain access to international study tours led by Cognitive Institute faculty. Safety and reliability leaders within partner organisations have access to coaching and support from international reliability and safety experts.

Our Safety and Reliability Partners will be offered the opportunity to join in the co-designing of an evaluation process and research methodology to ensure the monitoring and measurement of safety and reliability interventions and outcomes as well as communication of the findings within project teams and a collaborative with an ultimate aim to contribute to the quality improvement literature through publication of reports, articles and research papers.

Exclusive partner activities



Emerging leaders' development

Cognitive Institute works with Partner organisations to design and deliver education, training and support for a core group of clinicians who have been identified as most likely to be acting in leadership roles for the health service within the next two decades.

The focus of this programme is developing leadership skills for safety and reliability improvement. Key workshops include **Mastering Safer and Reliable Practice**, **Mastering Difficult Colleague Interactions**, **Mastering Open Disclosure**, Leading With Emotional Intelligence and **Mastering Clinician Coaching and Feedback**.

This training is ideally delivered off-site and requires a minimum of two full days per annum plus self-guided study, reflection and informal peer networking.

Leaders' collaborative

Cognitive Institute works with Partner organisations to facilitate collaborative learning amongst their leaders. This takes the form of off-site one or two day programme. The programme for each training event is guided by organisational needs and hinges on reliability improvement objectives. The format for these events is highly interactive with the facilitation of challenging discussions, sharing stories of success and failures and a focus on actionable outcomes.

Content stimuli include reliability science, human factors, clinician performance, difficult interactions, tools for leading improvement projects, accountability mechanisms, work-life balance and emotional intelligence.

Safety Champions

Cognitive Institute works in partnership with health service partners to identify, select and train a core group of professionals to model and teach safety and reliability improvement across the health service.

Selection

Health professionals with appropriate leadership and influence, behaviours and capability will be identified and selected through a process designed to evaluate commitment to safety and reliability and capacity to lead, coach and support teams and individuals engaged in safety and reliability improvement. This small group will be trained to become Safety Champions within their organisations.

Intensive training for Safety Champions is delivered by Cognitive Institute in two stages:

Stage 1

Over three days, Safety Champions will:

- Increase their capabilities in leading reliability improvement through an advanced understanding of the principles of reliability science and the Cognitive Institute *AlwaysChecking* approach;
- Enhance their capacity to manage difficult conversations with colleagues;
- Advance their coaching and feedback skills to support peers in safety and reliability improvement;
- Understand all dimensions of their safety advocacy role within the organisation.

Stage 2

Over two days, Safety Champions will receive training suitable to present to all staff in *Speaking Up for Safety*. This seminar underpins an organisational culture that enables and encourages clinicians to 'speak up for safety' and is a key strategy in the Cognitive Institute *AlwaysChecking* approach.

Safety Champions will be trained to lead the education of staff to develop their insights and skills to respectfully raise issues with colleagues when they are concerned about a patient's safety.

Cognitive Institute will observe and assess Safety Champions deliver training in order to provide accreditation as *Speaking Up for Safety* presenters.

Ongoing support

Cognitive Institute will continue to provide support and development for Safety Champions as required.

Cognitive Institute Exclusive Safety and Reliability Partner activity (continued)

Coaching and networking

Cognitive Institute provides partner organisations with coaching and support from leadership, interpersonal skills and reliability and safety experts. This support can be delivered face to face, via Skype, teleconference, webinar or other meeting support technology.

Developing customised programmes

The partnership arrangement allows scope to create, adapt and modify training and education activities from our extensive range of programmes to specifically meet your needs. Content and delivery adaptation will be supported by an action research model of enquiry for Partner organisations engaging in research projects with Cognitive Institute.

Study tours

Partner organisation staff will have the exclusive opportunity to join Cognitive Institute's study tours. Cognitive Institute will facilitate the visiting and networking of selected staff to relevant exemplar organisations from our network of international contacts and clients.

Reliability Learning Collaborative

Cognitive Institute will establish a formal network of Safety and Reliability Partner organisations to compare data, share experience of improvement project success and failure, and reliability improvement KnowHow that develops through experience across diverse health service delivery models.

Consultancy

Cognitive Institute will provide exclusive access to expertise in safety and reliability improvement, education and research design and project management through a negotiated consultancy model.



Research

Our Safety and Reliability Partners will be offered the opportunity to co-design an evaluation process and research methodology to ensure the monitoring and measurement of safety and reliability interventions and outcomes; communication of the findings within project teams and collaborative with an ultimate aim to contribute to the quality improvement literature through publication of reports, articles and research papers.

The Safety and Reliability Improvement Programme is a non-technical (ie, not specifically focused on clinical knowledge or skills) learning and development programme combining knowledge and skill development, peer network coaching and support with an accountability framework.

It will be informed through an action research model of enquiry and will have the following intrinsic features:

- Multi-modal delivery to suit the learning needs of teams and individuals.
- Vertically and horizontally integrated through the organisation.

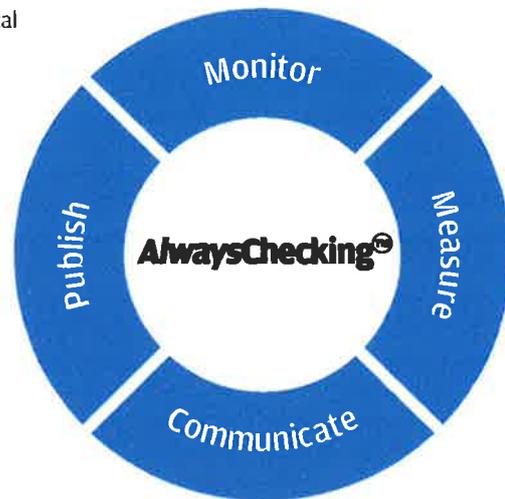
Research theory/hypotheses/assumptions are:

- The knowledge, skills and behaviours of leaders will deeply influence a safety culture and quality of service within the teams they lead as well as across the health service.
- The Safety and Reliability Improvement Programme will lead to measurable improvements in patient safety and the safety culture within the organisation.
- Applying the theory of planned behaviour, a number of assumptions can be tested:
 - Increasing knowledge and understanding of reliability and safety science is critical to influencing attitudes to practice highly reliable and safe care (and the control beliefs of participants).
 - Developing strong horizontal links (a clinical peer community/network) will exert normative pressures on leaders to perform the target behaviour (subjective norms).
 - Identifying and training influential leaders to be safety and reliability 'champions' will facilitate the spread of the target behaviour across the organisation.
 - Monitoring and sharing of individualised and cohort data will be associated with improvement efforts; 'hard edge' accountability measures will add to the success of these improvement efforts.

Evaluative process

The partnership between Cognitive Institute and health service organisations may be extended to include an academic research partner to facilitate a more rigorous study of the impact of the programme. There is a significant opportunity to go beyond qualitative review of the education experience of participants and add to the body of evidence in the literature surrounding quality improvement initiatives.

In the very least, it is intended that the programme design and delivery will respond dynamically to findings from an evaluative process implemented in parallel (conducted in real-time) with the programme and that will include a range of qualitative and quantitative measures. The action research model will rely on ethnography to illustrate the evolution of a safety and reliability culture within the organisation. Data collection methods including participant observation, field notes, interviews and surveys can be used.





For further information on the
Safety & Reliability Improvement Programme
please contact Cognitive Institute

Phone (Aus) 07 3511 5000
Phone (NZ) 0800 777 512
Email enquiries@cognitiveinstitute.org

Head Office

65 Park Road Milton Brisbane
PO Box 1013 Milton Brisbane Qld 4064
Australia

cognitiveinstitute.org

<p>Trust Board 25th May 2017</p>	
<p>Patient Story – Takeover Week at GOSH</p> <p>Submitted on behalf of Juliette Greenwood, Chief Nurse</p>	<p>Paper No: Attachment D</p>
<p>Aims / summary</p> <p>The Great Ormond Street Hospital Patient Experience Team works in partnership with ward and service managers, the Patient Advice and Liaison Service (PALS), and the Complaints and Patient Safety Teams to identify, prepare and present suitable patient stories for the Clinical Governance Committee each year, two in writing and two through a patient / family member attending or through a film clip. Each story includes information on actions which were taken to improve aspects of a service, if applicable. Stories which are selected represent a range of families' experiences across a variety of wards and service areas spanning divisions and ensuring that the families' experiences are captured.</p> <p>The story to be shared on 25 May 2017 is a video describing the experience of two adolescent patients who took part in Takeover Week 2016. As they share recollections of the day, the patients offer insights into their care and treatment at GOSH when they were inpatients in November 2016 and the impact of some of the services the Trust offers.</p>	
<p>Action required from the meeting</p> <p>Review and comment</p>	
<p>Contribution to the delivery of NHS / Trust strategies and plans</p> <ul style="list-style-type: none"> • The Health and Social Care Act 2010 • The NHS Constitution 2010 • The NHS Operating Framework 2012/13 • The NHS Outcomes Framework 2012/13 • Trust Values and Behaviors work • Trust PPIEC strategy • Quality Strategy 	
<p>Financial implications</p> <p>None</p>	
<p>Who needs to be told about any decision</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales</p> <p>Emma James – Patient Experience and Engagement Officer</p>	
<p>Who is accountable for the implementation of the proposal / project</p> <p>Herdip Sidhu-Bevan– Assistant Chief Nurse Quality and Patient Experience</p>	
<p>Author and date</p> <p>Emma James – Patient Experience and Engagement Officer – May 2017</p>	

ATTACHMENT T

Summary of the Audit Committee meeting on 18th April 2017

The Committee received updates and draft minutes from the following meetings:

- Finance and Investment Committee – January and March 2017
- Quality and Safety Assurance Committee – January 2017

Board Assurance Framework Update

Discussions took place around recommendations that had been proposed by the Executive Team to revise the risk appetite score for risk 7: recruitment and the net risk score for risk 5: operational performance and risk 10: research income. The amendments were approved however it was emphasised that the committee would not accept a weakening of controls as a result of a reduction in risk appetite.

Presentation of high level risks

The Committee received updates on the following high level risks:

- Risk 1: Failure to continue to be financially sustainable

It was confirmed that GOSH had exceeded its control total and a positive contract agreement had been reached with NHS England. A key risk for 2016/17 continued to be around productivity and efficiency however it was noted that the Trust had now moved to service line budget planning.

- Risk 3: The risk that the organisation will not deliver IPP contribution targets

The Committee discussed the key risk around IPP which they believed to be due to the significant reliance on business conducted with only two countries. It was confirmed that the most recent internal audit had provided a rating of 'significant assurance with minor improvement potential' and the recommendations from this audit were complete.

Methodology for IPP Debt Provision for 2016/17

It was noted that provisioning for IPP debt would be based on categorisation based on age of debt.

External Audit: Interim update report to the Audit Committee for the year ended 31 March 2017

The Trust's external auditors reported that NHS debt had been increasing throughout the year for all Trusts however GOSH NHS debt was high compared to the sector average. It was noted that this was due to the contract for 2016/17 having been set at a low level and delays having been experienced in receiving payments for over performance from NHS England. At the interim point, GOSH's IPP debt had been higher than other Trusts and had increased more, with the debt being concentrated within fewer payees.

Internal Audit Progress Report, Technical Update and Draft Head of Internal Audit Opinion for 2016-17

The Committee received reports on the following internal audits, all of which provided a rating of significant assurance with minor improvement potential.

- Data quality report
- Financial Controls
- Complaints
- Information Governance

Internal Audit Strategic and Operational Plan: 2017-18

The Committee approved the plan for audits in 2017-18 and KPMG confirmed that they believed the list of audits appropriately captured the areas where assurance was required. The Committee requested the review of staff recruitment and retention to particularly focus on retention.

Internal and external audit recommendations – update on progress

There had been an increase in the number of ‘overdue’ recommendations. The Committee agreed that it was important to consider the actions required from internal audits in relation to work taking place throughout the Trust and to prioritise actions in this context.

Risk Management Benchmarking

KPMG reported that the balance of the number and priority of risks which were considered by the Board and its subcommittees was an area of good practice.

Counter Fraud Annual Report and workplan 2017/18

The low level of referrals to Counter Fraud at GOSH was noted as was the good level of awareness of the service shown through staff surveys. Training was taking place with key departments. The Committee approved the workplan for 2017/18.

Whistle blowing Update

Discussion took place around bullying and harassment which had been raised as issues with freedom to speak up ambassadors and had been highlighted by the staff survey. It was agreed that a deep dive would take place at the Quality and Safety Assurance Committee.

Audit Committee Annual Effectiveness Survey Results

In response to the survey results the committee agreed to include a ‘matters to be raised to Trust Board’ item at the end of each Audit Committee agenda.

Revised Audit Committee Terms of Reference and Workplan

The Committee approved the updated documents and requested an additional annual overview of preparedness including cyber security, business continuity and preparedness for change.

Draft Annual Governance Statement 2016/17

The Committee discussed and agreed some amendments to be made to the draft document prior to its submission at the May Audit Committee and Trust Board meetings for approval.

Draft Audit Committee Report to be included in the Annual Report

The Committee agreed some minor amendments to the draft Audit Committee annual report.

Health and Safety Annual Report

It was reported that considerable progress had been made around a training needs analysis and ensuring that all front line staff had undertaken face to face fire training. While there was limited opportunity for fire drills in clinical areas, when new wards were opened evacuation tests were undertaken. Two thirds of wards had completed a table top evacuation exercise.

**GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION
TRUST**

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Authority

1.1. The Audit Committee is a non-executive committee of the Board of Great Ormond Street Hospital for Children NHS Foundation Trust (the Board), established in accordance with paragraph 36 of the Trust's Constitution and section 27 of the Trust Board's Standing Orders.

2. Remit

2.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial internal controls that supports the achievement of the organisation's objectives.

3. Authority

3.1. The Committee is authorised by the Trust Board to:

- a) investigate any activity arising within its terms of reference;
- b) to seek any information it requires from any member of staff and all members of staff must co-operate with any request made by the Committee;
- c) to request specific reports from individual functions within the Trust.
- d) to obtain independent legal or professional advice; and
- e) to request the attendance of individuals and authorities outside the Trust with relevant experience and expertise if it considers this necessary.

4. Membership

4.1. The Audit Committee shall be composed of at least three independent non-executive directors. The Chairman of the Trust shall not be a member of the Committee.

4.2. At least one of the committee members shall have recent and relevant financial experience. Two members shall constitute a quorum.

4.3. The Board may appoint an independent member of the committee in addition to the non-executive director members to bring in additional experience and expertise.

- 4.4. One of the non-executive members will be appointed as Chair of the Committee by the Board.
- 4.5. The independent member of the Audit Committee shall also sit as an independent member of the Quality and Safety Assurance Committee.

5. Attendance at meetings

- 5.1. The Chief Executive, Chief Finance Officer, Deputy Chief Executive, Head of Quality and Safety; representative of the external auditors; and the Head of Internal Audit and Counterfraud representative shall normally be invited to attend meetings.
- 5.2. The external auditors and internal auditors shall meet annually with the Committee without executive directors present, or at the Auditor's or Committee's request.
- 5.3. The Company Secretary shall be the Secretary to the Committee.
- 5.4. The Committee may invite any member of GOSH staff or directors to attend a meeting of the Committee, should it be considered necessary.
- 5.5. Two members' councillors will be invited to observe at every committee meeting.

6. Frequency of meetings

- 6.1. Meetings shall be held a minimum of four times a year at dates agreed to coincide with key stages in the accounting and audit cycle. The external auditors or Head of Internal Audit may request a meeting if they consider one is necessary.
- 6.2. Members are expected to attend a minimum of 3 meetings per year.

7. Duties

- 7.1. To discharge the Trust's duties for Audit, the Committee shall ensure that the business of the Trust is conducted fully in accordance with the principles of accountability and probity by undertaking the following duties:

8. Governance, risk management and internal control

- 8.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.
- 8.2. In particular, the Committee shall review the adequacy and effectiveness of:
 - 8.2.1. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head

of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to the endorsements by the Board.

8.2.2. The underlying processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of the principal risks and the appropriateness of the above disclosure statements.

8.2.3. The policies and strategies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

8.2.4. The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the Counter Fraud Service.

8.3. The Committee shall advise the chief executive on the effectiveness of the system of internal control.

8.4. The Assurance Framework will be used to guide the Committee's work and that of the audit and assurance functions that report to it.

8.5. The Committee shall review and make recommendations to the Board on the management of risk, and the resources required including the annual business plan.

9. Internal Audit

9.1. The Committee shall appoint the internal auditors and ensure that there is an effective internal audit function that meets mandatory Audit Standards in a Foundation Trust and provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board. This will be achieved by:

9.1.1. consideration of the provision of the internal audit service, resourcing of the service, the cost of the audit and any questions of resignation and dismissal;

9.1.2. review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that it is consistent with the audit needs of the organisation as identified in the Assurance Framework;

9.1.3. consideration of the major findings of internal audit work (and management's response) and monitoring of the implementation of audit recommendations by management;

9.1.4. ensuring coordination between the internal and external auditors to optimise audit resources;

9.1.5. an annual review of the effectiveness of internal audit.

10. External Audit

10.1. The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work.

10.2. Consideration of the appointment and performance of the external auditors will be conducted as outlined below:

10.2.1.1. The Committee will assess the external auditor's quality and value of work and the timeliness and reporting and fees on an annual basis and, based on this assessment, make a recommendation to the Members' Council with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards. To the extent that that recommendation is not adopted by the Members' Council, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

10.2.1.2. The Committee will make recommendation to the Members' Council about the remuneration and terms of engagement of the external auditor.

10.2.1.3. The Committee will oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years. It will agree with the Members' Council, the criteria for appointing, re-appointing and removing external auditors. The committee shall make a recommendation to the Members' Council with respect to the appointment of the auditor.

10.2.1.4. The Committee will develop, implement and monitor the policy on the engagement of the external auditor to supply non-audit services.

10.2.1.5. The Committee will consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal. Where the Members' Council puts forward a proposal to consider removing the auditor, the Audit Committee will investigate the issue, including allegations made against the auditor and report the findings to the Council.

10.1.2 Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy

10.1.3 Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

10.1.4 Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses and progress on implementation of the recommendations.

11 Other assurance functions

- 11.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications for the governance of the Trust.
- 11.2 The Committee will review the work of other committees in the Trust whose work can provide relevant assurance to the Audit Committee's scope of work. In particular, this will include the Quality and Safety Committee but may also include the Patient, Safety and Outcomes Committee and specific Risk Action Groups (RAGs).
- 11.3 The Committee will review the framework in place for managing, governing and monitoring data quality and information governance.

12 Counter Fraud

- 12.1 The Committee shall satisfy itself that the Trust has adequate arrangements in place for countering fraud and bribery and shall review the outcomes of counter fraud work.

13 Raising concerns

- 13.1 The Audit Committee should review arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.
- 13.2 The Audit Committee will monitor the arrangements in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. Through this work, the Audit Committee will ensure that:
- 13.2.2 safeguards for those who raise concerns are in place and operating effectively;
 - 13.2.3 individuals or groups are enabled to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations
 - 13.2.4 valid concerns are promptly addressed
 - 13.2.5 processes reassure individuals raising concerns that they will be protected from potential negative repercussions.

14 Financial reporting

- 14.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's performance.
- 14.2 The Committee shall ensure that the systems for reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

14.3 The Audit Committee shall review the content of the Annual Report and Financial Statements before submission to the Board, and advise the board on whether, taken as a whole, it is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy, focusing particularly on:

14.3.2 the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;

14.3.3 changes in, and compliance with, accounting policies, practices and estimation techniques;

14.3.4 unadjusted mis-statements in the financial statements;

14.3.5 significant adjustments in preparation of the financial statements;

14.3.6 significant adjustments resulting from the audit.

14.3.7 letter of representation

14.3.8 qualitative aspects of financial reporting.

15 Standing Orders, Standing Financial Instructions and Standards of Business Conduct

15.1 On behalf of the Board, the Committee shall:

15.1.1 review the operation of, and proposed changes to, the standing financial instructions,

15.1.2 review the scheme of delegation.

15.1.3 report to the Board on its findings and recommended amendments for approval.

16 Administration of the Committee

16.1 The Committee shall undertake an annual review of its effectiveness, which will be reported to the Board.

16.2 The Committee shall be supported administratively by the Company Secretary, whose duties shall include:

16.2.2 Agreement of the agendas with the Chair and collation of the papers;

16.2.3 Taking the minutes;

16.2.4 Keeping a record of matters arising and issues to be carried forward;

16.2.5 Advising the Committee on pertinent issues/ areas;

16.2.6 Enabling the development and training of Committee members.

16.3 The Committee shall review its terms of reference and work-plan on an annual basis and consult with the Members' Council on any revisions.

16.4 The Committee shall receive a summary of the minutes of the Risk, Assurance and Compliance Group and Quality and Safety Assurance Committee.

17 Reporting

17.1 A summary of the reports received by the Audit Committee is outlined in the work-plan attached at annex 1.

17.2 A summary of the minutes of the Audit Committee shall be submitted to a meeting of the Board.

17.3 The Chair of the Committee shall draw to the attention of the Board and the Members' Council any issue that requires disclosure to the full Board or requires action, making recommendations as to the steps to be taken.

17.4 The Committee will report to the Board at least annually on

17.4.2 its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework;

17.4.3 the completeness and extent to which the risk management framework is embedded across the Trust;

17.4.4 the completeness and extent to which the data quality framework is embedded;

17.4.5 the completeness and extent to which the information governance framework is embedded;

April 2017

GOSH Audit Committee Annual Workplan 2017-18

Agenda Item/Issue	April 2017	May 2017	October 2017	January 2018
External Auditor Reporting				
Agreement of External Audit plan			✓	
Private discussions with External Audit (including the terms of engagement and fees; ensuring independence, objectivity and effectiveness of the process; an annual review of the effectiveness of external audit) and report to the Members' Council		✓ and report to MC		
Review of non-audit work carried out by external auditors (and reported in Annual Report)		✓		
Market testing exercise for appointment of external auditor	External auditor appointed from April 2014			
Recommendation to Members' Council on appointment of external auditor including remuneration and terms of engagement	✓ - remuneration			
Agreement of annual audit letter before submission to Board and Council		✓		
Internal Auditor Reporting				
Approve Internal Audit Strategy and Operational Plan	✓			
Review of Internal Audit Progress Reports and performance against the internal audit plan	✓	✓	✓	✓
Receipt of annual internal audit report and associated opinions		✓		
Private discussions with Internal Audit (annual review of effectiveness of internal audit)			✓	
Counter fraud annual report and annual plan	✓	issues by exception	issues by exception	issues by exception
Assessment of performance of internal audit (including the cost of internal audit; ensuring that the resource is adequately resourced; an annual review of the effectiveness of internal audit)			✓	
Financial matters				
Review of audited accounts and financial statements		✓		
Year-end plan for accounts	✓			

Agenda Item/Issue	April 2017	May 2017	October 2017	January 2018
Review of working capital, losses and compensations and debtors and creditors over £5,000	✓		✓	
Annual report on waivers of Standing Financial Instructions over £5,000				✓
Risk management and controls assurance				
Joint Risk Management Meeting (with AC, CGC and F&I)	July 2017			
Board Assurance Framework (including programme of risk reviews)	✓	✓	✓	✓
Assurance of compliance with risk management strategy	✓		✓	
Annual overview of management of P&E (CIPs) for previous year and forthcoming year	✓			
Raising concerns – items reported	Policy review	✓	✓	✓
Update on data quality	✓	✓	✓	✓
Value of claims and the drivers behind the increase			✓	
Preparedness: Update on emergency planning; LSMS; fire and business continuity (tests, incidents and plans)		✓ LSMS		✓
Governance Matters				
Audit recommendations exception report	✓	✓	✓	✓
Annual review of Audit Committee	Draft	With annual report		
Annual effectiveness review of the RACG			✓ For info	
Review of Annual Governance Statement	Draft	✓ with annual report		
Information Governance Annual Report				✓ including IT system and security risk
Review terms of reference for ratification at Board of Directors	✓ and report to Members' Council			
Review of annual work-plan	✓			
Review of Standing Financial Instructions and Scheme of Delegation	✓			

Agenda Item/Issue	April 2017	May 2017	October 2017	January 2018
Note business of specified committees and review inter-relationships (summary reports) <ul style="list-style-type: none"> <li data-bbox="229 331 804 365">- Risk, Assurance and Compliance Group <li data-bbox="229 365 804 465">- Finance and Investment Committee (including an update on the robustness of the P&E programme) <li data-bbox="229 465 804 533">- Quality Safety and Assurance Committee 	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓

April 2017

ATTACHMENT E

Quality and Safety Assurance Committee Summary
12th April 2017

Integrated Quality and Safety Update

The Committee discussed the number of complaints that were related to communication issues. It was noted that a wide variety of communication problems were grouped together and it was agreed that consideration should be given to categorising these separately. The importance of benchmarking complaints' data with other Trusts was highlighted. The Committee welcomed the decrease in the total number of complaints but emphasised the importance of ensuring that it was clear to patients and their families how to raise a complaint.

Quality Report

The Committee discussed the draft version of the Quality Report and noted that the auditors would be reviewing the following indicators: 31 day cancer waits, 18 week incomplete pathways (RTT), and cancelled operations (the local indicator selected by the Members' Council).

Quarterly Safeguarding Report (January 2017 – March 2017)

The Committee noted that the newly appointed Named Doctor for Safeguarding was now in post. The appointment was welcomed and it was agreed that Dr Steele would attend future Committee meetings to provide updates.

Discussion took place around the significant increase in case conferences and it was noted that this echoed the increase in the number of child protection cases nationally. It was agreed that discussions should take place with the Named Doctor about the best and most transparent way to present the safeguarding data.

Workforce and OD update (quality related issues)

Work had taken place to ensure that there were sufficient numbers of staff in the correct roles on the correct shift and it was confirmed that the Trust had met its safe staffing and Royal College standards.

Following work which had been undertaken to understand the reason for staff leaving the Trust, it was noted that one in nine staff members reported that this was due to relationships with colleagues and managers. Listening events for staff were taking place in May 2017 and Non-Executive Directors were welcome to attend.

It was noted that 90,000 episodes of training were required from the Trust as a whole annually. The Committee emphasised the importance of ensuring training was delivered as efficiently as possible.

Nurse Recruitment and Retention

The Committee emphasised the importance of this risk to the Trust and noted that the highest number of posts had been offered. Deep dives into the reasons for nurses leaving and staying at the Trust had provided some areas of good practice to be built on but there remained some areas with

Attachment E

very high turnover. Discussion took place around innovative steps which would be used to increase recruitment and retention.

Update on quality issues in pharmacy (action from October 2016 QSAC meeting)

The Committee reviewed the Terms of Reference for a review of the pharmacy service. Discussion took place around the prioritisation of customer experience and whether or not it was appropriate to benchmark the GOSH pharmacy with busy pharmacies which were not in hospitals. The Committee emphasised that it was important to include someone on the review panel who was able to 'future scope' the service.

QSAC Annual Report

The Committee reviewed the report and said that it would be used as a starting point for the review of the effectiveness of the committee. It was agreed that work would take place to review the report against those of other Trusts. Discussion took place about whether the report should highlight the cutting edge and aspirational nature of GOSH's work.

Board Assurance Framework Update

The Committee endorsed the recommendations of the Executive Team to amend the net risk scores of some risks. It was agreed that risk 8: GOSH Strategy Position would be discussed at the July risk meeting to consider whether this should also be a QSAC owned risk.

Update on Compliance with Risk Management Strategy

The Committee discussed the report and the way in which the committee could receive assurance on the Trust Wide Risk Register. It was agreed that this would be further discussed outside the meeting along with the value that QSAC could add to the process.

Compliance Update

It was reported that all actions arising from the CQC inspection had been closed with the exception of one around mandatory training which remained on target.

Risk Management Benchmarking

The Committee noted the Internal Audit view that the number and level of risks captured on the Board Assurance Framework was an area of good practice when benchmarked against other organisations.

Internal and external audit recommendations update

Discussion took place around the number of recommendations which were overdue and the way in which the committee could differentiate the actions for which an appropriate new deadline had been negotiated from those which remained outstanding and required focus from assurance committees.

Internal Audit Progress Report (January 2017 – March 2017) and Strategic Operational Plan 2017-18

The Committee welcomed the outcome of the review of data quality which had provided significant assurance with minor improvement potential. The plan for 2017/18 was approved.

Update on quality and safety impact of Fit for the Future programme (linked to BAF risk 2: Productivity)

It was reported that, of 76 anticipated Project Outline Documents the majority had been either completed or were underway. The PMO was working to verify the number of schemes which would require a Quality Impact Assessment.

Clinical Audit update January 2017 – March 2017 including clinical audit workplan for 2017/18

The Committee welcomed the outcome of the social work audit and the clear value that families received from the service.

Health and Safety Annual Report 2016-17

It was reported that positive work on sharps compliance was taking place and a draft policy had been developed which was in the process of being approved and included a risk assessment tool. There remained some gaps, however good engagement had been generated across the organisation.

A large number of audits had taken place through walkrounds and helpful suggestions to issues had been provided by staff.

Discussion took place about the target of ensuring that 95% of staff had completed all mandatory training and whether this target was set at the correct level. It was proposed that 90% would be a more appropriate target. It was reported that the London Fire Brigade had reviewed the Trust's Fire Safety training and had been satisfied with the work. Mock evacuations took place for newly developed wards before they were open and existing wards undertook a table top exercise.

Whistle blowing update - Quality related whistle blowing cases

The Committee noted that staff concerns were being taken forward with HR and ambassadors were supporting staff to speak with line managers in the first instance however if a pattern or theme emerged a more formal route would be taken.

It was agreed that the following matters would be raised at the Trust Board:

- Safeguarding
- Nurse retention
- Quality Impact Assessments of productivity and efficiency schemes
- Pharmacy Service Review
- Internal Audit Plan

ATTACHMENT F

**Update from the Finance and Investment Committee meeting held on
23rd March 2017**

Matters arising

The Committee noted the work that was taking place on the 'model hospital' which would eventually include data on GOSH's costs. The Committee agreed that although the Trust would have a number of outliers, benchmarking costs and their composition would be useful.

Revised Phase 4 timetable

The Committee noted the revised timetable which included the points at which the Trust's decision represented a commitment to the project. The Committee highlighted the importance of being clear about the point at which the Trust's agreements would put funds at risk and requested further information about the alternative funding options.

2017 Annual Workplan Update

The Committee approved a revised workplan and agreed to undertake a deep dive at a future meeting on the use of Bank and Agency staff.

Annual Terms of Reference Review

The Committee approved the Terms of Reference subject to some minor amendments and agreed that an annual effectiveness review would be considered at the next meeting.

Finance Report and Forecast Month 11

The Committee noted the increased use of Bank and Agency staff compared with the prior year because of work on RTT and the gastroenterology service review and that their use would decrease significantly in month 12 of 16/17 financial year.

Discussion took place about year to date Divisional financial performance and levels of activity in relation to increases in workforce.

The Committee discussed the profit contribution of International Private Patients. It was noted that IPP now had increased capacity but was behind plan in terms of actual activity: partly driven by access issues due to the prioritisation of NHS patients.

Procurement Quarterly Review/Update

The Committee discussed the level of productivity and efficiency savings that were targeted within Procurements and whether at a suitable level. It was agreed that an update on the spend that Procurement could target for savings would be provided at the next F&I meeting. The Committee noted the potential for savings by carrying out good contract management practices and that the Trust is implementing a new contract management register.

Attachment F

NHS Contract Status Update 2016/17 & 2017/18

It was confirmed that NHS England had formally agreed in several areas the Trust's local price increases resulting from the price review. The Trust had met its activity targets for 2016/17 and was above target on RTT activity. It was confirmed that most material items for the 2017/18 contract had been agreed..

Annual Budget 2017/18

It was confirmed a detailed Budget had been developed and submitted based on the NHS Improvement 2 year plan. More than £14million of the better value schemes had been targeted.

**Summary of the Finance and Investment Committee
held on 11th May 2017**

Matters arising

The Committee discussed a number of actions which had arisen from a discussion on the timetable of phase 4. It was noted that a number of areas which required decisions were interlinked but the committee requested early discussions on the Trust's debt capacity.

Discussion took place around workforce productivity metrics in the context that activity remained broadly flat year on year and whole time equivalents grew by approximately 5%. The Committee noted that each area of the hospital would have diverse staffing requirements with some fixed components and some based on activity. The Committee requested that consideration be given to the indicators to support productivity metrics.

Annual Effectiveness Review

The committee discussed the outcome of the survey and agreed that there was currently not sufficient time given to the consideration of strategic matters. Consideration would be given to making links with the Chair of a Finance and Investment Committee from another Trust and inviting relevant individuals from divisions.

Phase 4 Outline Business Case Update

The Trust have been in discussions with ITFF regarding the information required to assess their lending capacity for phase 4 project. It was noted that the ITFF would also undertake an independent assessment of the Trust's debt capacity.

Overview of Trust Property Portfolio

A presentation was provided on current mix of properties within the portfolio of the Trust and Charity including an overview of the current use and ownership. Usage of buildings included clinical, office space, staff and parent/patient accommodation. Utilisation rates for accommodation was requested as additional information but it was noted there is a high occupancy rate for staff, patient and family accommodation. Consideration was being given to the way in which Barclay House and the Italian building would be used to support phase 4.

Rare Diseases Centre – Progress Report

The project is being built and managed by the Charity. The Committee noted that the project development costs were over the original estimates and requested the causes were taken into account for future development projects. However it was noted that a different procurement process of contractor led design was used for phase 4 to ensure there would be less likelihood that the project would overrun.

Better Value Programme Update 2017/18 Plan

It was reported that there had been substantial progress from the same point in 2016/17. The Committee welcomed the progress that had been made and recommended continuing to identify additional schemes to increase the likelihood that the overall target would be met. It was noted that

Attachment F

a conservative view had been taken on the risk based approach to whether or not a scheme was likely to be realised. A deep dive was undertaken into the schemes in procurement.

2016/17 Month 12 Final Performance Scorecard

Discussion took place around the Trust's agency spend. It was confirmed that once the remaining RTT validators were moved onto permanent contracts within teams GOSH would no longer be in breach of its agency cap. A key risk around agency spend was the opening of the Premier Inn Clinical Building and the substantial number of additional nurses that would be required. Work was taking place in the performance team to ensure that if any indicator deviated from the target, a deep dive review took place.

2016/17 Month 12 Final Finance report

GOSH had exceeded its control total at the end of 2016/17 but had not met the activity target. A pound for pound incentive payment had been received as well as a bonus payment from unallocated STP funds. It was agreed that a benchmarking exercise would take place against both comparable Trusts and the NHS as a whole on revenue, contribution and contribution less IPP income.

Trust Activity Summary 2016/17 Month 12

The Committee discussed activity data and suggested additional narrative on the reasons for the changes in activity trends.

NHS Contract Status Update Final 2016/17 & 2017/18

It was reported that the Trust had achieved significant over performance in 2016/17.

NHSI Governance Standards and FSRR

The Committee noted that the only change to the regulatory requirements had been the removal of the requirement to provide quarterly in year governance statements and the introduction of Board Assurance Statements which were only required when the Trust was reporting an adverse change to the forecast outturn.

Review of LTFM 3 year Plan

The revised LTFM includes the NHSI base plan, the EPR business case. The Committee reviewed the Long Term Financial Model and agreed that amendments would be considered on a biannual basis. It noted that the benefits had been included for the EPR project. The committee also reviewed and discussed the movements in working capital assumptions and noted the IPP debt did not reduce significantly considering the income growth.

ATTACHMENT G

Summary of the Members' Council meeting on 26th April 2017

Updates from the Membership Engagement, Recruitment and Representation Committee including Membership Strategy update

The Committee discussed the Annual General Meeting which would be taking place on 14th September 2017 with a theme of 'One GOSH'. The Committee reiterated the importance of Councillors completing their mandatory training.

Update from the Young People's Forum (YPF)

Two members of the YPF had taken part in the interview process for the selection of the preferred bidder for phase 4.

Update from the Patient and Family Experience and Engagement Committee (PFEEC)

The wide spread of the issues which were categorised under 'communication' for the purposes of PALS contacts and complaints was highlighted.

Councillor activities

It was reported that a Councillor had attended a Governor seminar session run by Deloitte on Sustainability and transformation Plans and Cyber Security and a number of Councillors had attended information displays for the evaluation of phase 4 and provided feedback.

Update on the GOSH Refreshed Strategy and annual plan 2017/18

The Council noted that 17 of the well led review recommendations had been completed. An overview was provided on the work that had taken place on the recommendation around the relationship between the Board and Members' Council. The Council expressed some concern that it would not be possible for those who could not be present at the engagement workshop to either dial-in or join via computer based webex session. It was agreed that a buddying system would be established to enable Councillors who could be present to both feed into the session and receive feedback.

It was reported that with the exception of one action which was being completed within its agreed timeframe, the action plan arising from the CQC inspection was complete.

Update on the GOSH Refreshed Strategy and annual plan 2017/18

The updated strategy, which had been approved by the Trust Board at its April meeting, was presented. Discussion took place about the references to children rather than children and young people and it was noted that although this had been used in the high levels of the strategy to be succinct and in recognition of 'the child first and always', young people were fully embedded in the strategy and it was recognised that optimisation of a service for a child, a young person or someone going through transition was very different and this was fully articulated.

Discussion took place around revenue received from International Private Patients (IPP) and the Council expressed some concern that an update had not been received recently from IPP. It was

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agreed that the IPP working group would meet and agree a format for information to be presented to the Members' Council.

Digital Roadmap

The Council discussed the Electronic Patient Record project and the importance of considering family experience as well as patient experience in the use of the patient portal was emphasised. It was confirmed that the Finance and Investment Committee discussed the project at each meeting and the Audit Committee regularly. Each time a gateway in the project was reached, external assurance was sought. It was reported that the cyber security strategy had been developed following review by KPMG had received a rating of significant assurance with minor improvement potential.

Congenital heart disease presentation

It was noted that there was a public consultation taking place on the outcome of the safe and sustainable review into congenital heart disease. It was reported that there was potential for GOSH to take on additional work if the outcome of the review was carried forward and GOSH was taking part in the NHS England nursing workstream to look at recruitment and retention to ensure the Trust was flexible in order to take on additional work where necessary.

Chairman Recruitment Process

It was reported that a shortlist of candidates had been agreed and stakeholder meetings for the candidates and a training session for the councillors on the interview panel had been scheduled.

Chairman and NED Objectives 2017

The Council approved the objectives subject to some minor revisions. It was confirmed that the objectives would be in place until the implementation of 360 degree appraisals and the review by the newly appointed Chairman.

Appointment process for a NED on the GOSH Board

It was noted that the Board wished to appoint a new Non-Executive Director by the end of September 2017. Discussion took place about the time commitment that was currently asked of NEDs. The Board agreed that a time commitment of 2.5 days per month was appropriate and that through conversation with the headhunter and their own experience would be aware of the requirements of the role. They added that it was important to ensure that sufficient interest in the role was received.

Chairman and NED remuneration

The Council approved the proposal for Chairman and NED remuneration to remain at current levels and be benchmarked on a three yearly basis. The Council also approved that the Interim Chairman would take on the Chairman salary pro rata.

Appointment of Deputy Chairman and Senior Independent Director at GOSH

The Council approved the appointment of Mr Akhter Mateen as Deputy Chairman and Mr James Hatchley as Senior Independent Director, both from 1st May 2017.

Reports from Board Assurance Committees

The Council noted summary reports from the following Committees:

- April meeting of the Quality and Safety Assurance Committee
- April meeting of the Audit Committee
- March meeting of Finance and Investment Committee

Chief Executive Report (Highlights and Performance)

The Chief Executive provided an update on RTT, phase 4 and the High Court case of a GOSH patient in which there had been significant media interest.

Appointment of an Interim Deputy Lead Councillor

The Council endorsed the continuation of the lead councillor in her role for a further year and the appointment of Ms Mariam Ali as Interim Deputy Lead Councillor until the end of her term.

Trust Board 25th May 2017	
GOSH Foundation Trust Annual Financial Accounts 2016/17 and Annual Report 2016/17	Paper No: Attachment H
Submitted by: Loretta Seamer, Chief Finance Officer and Anna Ferrant, Company Secretary	
Aims / summary The Trust is required to publish a Foundation Trust annual report and accounts for 2016/17. Board members will find attached the following documents: <ul style="list-style-type: none"> • A copy of the annual accounts 2016/17; • A copy of the annual report 2016/17 incorporating: <ul style="list-style-type: none"> ○ the Audit Committee Report 2016/17 (page 78) ○ the draft Head of Internal Audit Opinion (page 92) ○ the Annual Governance Statement (page 95). <p>The annual report and accounts will be submitted to NHS Improvement by 31st May 2017 and then submitted to the Department of Health at the end of June, for presenting to Parliament.</p> <p>The Audit Committee will consider the annual accounts and report at its meeting on 25th May 2017 and will provide comments at the Trust Board that day.</p>	
Action required from the meeting To consider and approve the annual accounts and report 2016/17.	
Contribution to the delivery of NHS / Trust strategies and plans The Annual Report publically reports on the Trust's performance against its strategic priorities and objectives.	
Financial implications There are no direct financial implications.	
Legal issues There are no direct legal implications.	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? A number of staff have contributed to the draft Annual Report. All Executive members have been asked to review the draft and their comments have been incorporated into this draft.	
Who needs to be told about any decision The Company Secretary will feed back any actions required to relevant staff.	
Who is responsible for implementing the proposals / project and anticipated timescales The Company Secretary is leading the coordination of the Annual Report.	
Who is accountable for the implementation of the proposal / project The Chief Executive Officer is ultimately accountable for production and publication of the Annual Report.	

Trust name:	Great Ormond Street Hospital for Children NHS Foundation Trust
This year	2016/17
Last year	2015/16
This year ended	31 March 2017
Last year ended	31 March 2016
This year beginning	1 April 2016

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

Statement of the chief executive's responsibilities as the accounting officer of Great Ormond Street Hospital for Children NHS Foundation Trust

The National Health Service Act 2006 states that the chief executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

Under the National Health Service Act 2006, NHS Improvement has directed the Great Ormond Street Hospital for Children NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Great Ormond Street Hospital for Children NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in NHS Improvement's NHS Foundation Trust Accounting Officer Memorandum.

Signed

Dr Peter Steer
Chief Executive
Date: 25 May 2017

FOREWORD TO THE ACCOUNTS

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street Hospital for Children was authorised as an NHS Foundation Trust on 1 March 2012. These accounts for the year ended 31 March 2017 have been prepared by Great Ormond Street Hospital for Children NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form which NHS Improvement, with the approval of the Treasury, has directed.

Signed

Dr Peter Steer
Chief Executive
Date: 25 May 2017

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2017

		Year ended 31 March 2017	Year ended 31 March 2016
		£000	£000
Operating income from patient care activities	NOTE 2	374,187	349,574
Other operating income	3	83,334	76,279
Operating expenses of continuing operations	4	<u>(435,280)</u>	<u>(384,979)</u>
Operating surplus		22,241	40,874
Finance costs:			
Finance income	8	149	282
Finance expenses - unwinding of discount on provisions	9	(13)	(13)
Public dividend capital dividends payable		<u>(7,411)</u>	<u>(6,985)</u>
Net finance costs		(7,275)	(6,716)
Gains on disposal of assets		<u>32</u>	<u>16</u>
Surplus for the year		14,998	34,174
Other comprehensive income			
Will not be reclassified to income and expenditure:			
- Impairments		(28,810)	0
- Revaluations - property, plant and equipment	20	<u>4,106</u>	<u>28,510</u>
Total comprehensive (expense)/income for the year		(9,706)	62,684
Financial performance for the year - additional reporting measures			
Retained surplus for the year		14,998	34,174
Adjustments in respect of capital donations	3	(32,056)	(31,493)
Adjustments in respect of impairment/(reversal of impairments)	3	<u>12,149</u>	<u>(13,771)</u>
Adjusted retained deficit		(4,909)	(11,090)

The notes on pages 5 to 32 form part of these accounts.

All income and expenditure is derived from continuing operations.
The Trust has no minority interest.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2017

		31 March 2017	31 March 2016
	NOTE	£000	£000
Non-current assets			
Intangible assets	10	8,476	6,372
Property, plant and equipment	11	416,419	427,292
Trade and other receivables	14	6,664	7,139
Total non-current assets		431,559	440,803
Current assets			
Inventories	13	8,226	7,858
Trade and other receivables	14	67,669	51,326
Cash and cash equivalents	15	42,494	63,732
Total current assets		118,389	122,916
Total assets		549,948	563,719
Current liabilities			
Trade and other payables	16	(50,623)	(55,629)
Provisions	19	(114)	(513)
Other liabilities	17	(5,611)	(4,413)
Net current assets		62,041	62,361
Total assets less current liabilities		493,600	503,164
Non-current liabilities			
Provisions	19	(860)	(964)
Other liabilities	17	(4,950)	(5,357)
Total assets employed		487,790	496,843
Financed by taxpayers' equity:			
Public dividend capital		126,718	126,065
Income and expenditure reserve		275,981	260,983
Other reserves		3,114	3,114
Revaluation reserve		81,977	106,681
Total taxpayers' equity		487,790	496,843

The financial statements on pages 1 to 32 were approved by the Board and authorised for issue on 25 May 2017 and signed on its behalf by:

Dr Peter Steer
Chief Executive

Signed:.....
Date: 25 May 2017

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2017

	Public Dividend Capital (PDC) £000	Revaluation reserve £000	Income and expenditure reserve £000	Other reserves £000	Total £000
Balance at 1 April 2016	126,065	106,681	260,983	3,114	496,843
Changes in taxpayers' equity for the year ended 31 March 2017					
-Surplus for the year	0	0	14,998	0	14,998
- Impairments	0	(28,810)	0	0	(28,810)
- Revaluations - property, plant and equipment	0	4,106	0	0	4,106
- Public Dividend Capital received	653	0	0	0	653
Balance at 31 March 2017	126,718	81,977	275,981	3,114	487,790

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2016

	Public Dividend Capital (PDC) £000	Revaluation reserve £000	Income and expenditure reserve £000	Other reserves £000	Total £000
Balance at 1 April 2015	125,357	78,171	226,809	3,114	433,451
Changes in taxpayers' equity for the year ended 31 March 2016					
-Surplus for the year	0	0	34,174	0	34,174
-Transfers between reserves	0	0	0	0	0
-Impairments	0	0	0	0	0
-Revaluations - property, plant and equipment	0	28,510	0	0	28,510
- Public Dividend Capital received	1,115	0	0	0	1,115
- Public Dividend Capital repaid	(407)	0	0	0	(407)
Balance at 31 March 2016	126,065	106,681	260,983	3,114	496,843

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2017

	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
	NOTE	
Cash flows from operating activities		
Operating surplus	22,241	40,874
Non-cash income and expense:		
Depreciation and amortisation	17,677	18,013
Net Impairments	12,149	(13,771)
Income recognised in respect of capital donations (cash and non-cash)	(32,056)	(31,493)
Increase in trade and other receivables	(17,507)	(111)
Increase in inventories	(368)	(259)
(Decrease)/increase in trade and other payables	(2,713)	9,453
Increase/(decrease) in other liabilities	791	(1)
Decrease in provisions	(516)	(11)
NET CASH (USED IN)/GENERATED FROM OPERATIONS	(302)	22,694
Cash flows from investing activities		
Interest received	149	282
Purchase of property, plant and equipment	(44,134)	(38,788)
Payments for intangible assets	(3,668)	(1,331)
Sales of property, plant and equipment	32	16
Receipt of cash donations to purchase capital assets	33,792	28,091
Net cash outflow from investing activities	(13,829)	(11,730)
NET CASH (OUTFLOW)/INFLOW BEFORE FINANCING	(14,131)	10,964
Cash flows from financing		
Public Dividend Capital received	653	1,115
Public Dividend Capital repaid	0	(407)
PDC dividend paid	(7,760)	(6,872)
Net cash outflow from financing	(7,107)	(6,164)
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS	(21,238)	4,800
Cash and cash equivalents at start of the year	63,732	58,932
Cash and cash equivalents at end of the year	42,494	63,732

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NOTES TO THE ACCOUNTS

1. Accounting policies and other information

NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2016/17 NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and certain financial assets and financial liabilities.

1.2 Going concern

International Accounting Standard (IAS)1 requires management to assess, as part of the accounts preparation process, the Foundation Trust's ability to continue as a going concern for the foreseeable future. IAS 1 deems the foreseeable future to be a period of not less than twelve months from the entity's reporting date. After making enquiries, (these are described in the Annual Report on page 95), the directors can reasonably expect that the Foundation Trust has adequate resources to continue in operational existence for the next twelve months. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.3 Segmental reporting

Under IFRS 8 Operating Segments, the standard allows aggregation of segments that have similar economic characteristics and types and class of customer.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker, which is the overall Foundation Trust Board and which includes senior professional non-executive directors. The Trust Board review the financial position of the Foundation Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process implies a single operating segment under IFRS 8.

In addition, the large majority of the Foundation Trust's revenue originates with the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust, together with the related supplies and overheads needed to establish this service. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of "provision of acute care" is deemed appropriate.

Therefore, all the Foundation Trust's activities relate to a single operating segment in respect of the provision of acute care.

1.4 Critical accounting judgments and key sources of estimation uncertainty

In the application of the Foundation Trust's accounting policies, management is required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5 Critical judgments in applying accounting policies

The following are the critical judgments, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- a. As described in note 1.10, the Trust's plant and equipment is valued at depreciated replacement cost; the valuation being assessed by the Trust taking into account the movement of indices that the Trust has deemed to be appropriate. The Trust is required to review property, plant and equipment for impairment. In between formal valuations by qualified surveyors, management make judgments about the condition of assets and review their estimated lives.
- b. Management use their judgment to decide when to write off revenue or to provide against the probability of not being able to collect debt especially in light of the changing healthcare commissioning environment. Judgment is also used to decide whether to write off or provide against International Private Patient and overseas debt.

1.6 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period not already included in note 1.5 above, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- the cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements as a provision. As the calculation involves a large number of staff, sampling techniques are used to collate the results for the entire Trust.
- the useful economic life of each category of fixed asset is assessed when acquired by the Trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets.
- For early retirements that took place before the NHS pension scheme was modified in 1995, a provision is made in the accounts incorporating inflation and the discount rate. Inflation is estimated at 2.5% and where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 0.24% in real terms.
- When arriving at the valuation for property, Trust management engages a qualified surveyor to assist them in forming estimates.
- The Trust leases a number of buildings that are owned by Great Ormond Street Hospital Children's Charity. The Trust has assessed how the risks and rewards of ownership are distributed between itself and the charity in categorising these leases as either operating or finance leases.
- The Trust has incurred expenditure relating to payments to a third party power supplier in order to increase the amount of power supplied to the Trust's main site. This expenditure is included in prepayments and is being amortised over the estimated period of use.
- a provision is recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgment is required when determining the probable outflow of economic benefits.

1.7 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Foundation Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. Income relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Other income received from commissioners may be in the form of an investment in quality. Any quality investment income surplus may be used in subsequent years to supplement any major projects / capital schemes.

1.8 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the year in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the year is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following year.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2017, is based on the valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

1.9 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

Property, Plant and Equipment is also only capitalised where:

- it individually has a cost of at least £5,000; or
- it forms a group of assets that individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation as detailed below.

The Trust commissions annual valuations from professional RICS Registered Valuers of its land and buildings in accordance with IAS16 and the DH Group Accounting Manual. This frequency is justified by the volatility of land and building values in central London and the continuing programme of building enhancements at Great Ormond Street Hospital.

The valuation bases agreed with the Trust's professional valuers and applied to the land and buildings valuation are as follows:

- Specialised buildings and land – current value in existing use/depreciated replacement cost
- Non-specialised buildings and land – market value for existing use
- Surplus land – market value for existing use

The lack of demand or market for the Trust's Property in isolation from its own use means that the Trust's land and buildings qualify as a "specialised property" under the definitions in the current International Valuation Standards (IVS) with the exception of its residential accommodation. The IVS require specialised property to be valued at depreciated replacement cost, being the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation.

1.10 Property, Plant and Equipment (cont)

Equipment is carried at depreciated historic cost, modified by the application of relevant indices published by the Office of National Statistics. The Trust has determined that this value is not materially different from current value in existing use.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value and asset life. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed during the year, with the effect of any changes recognised on a prospective basis.

Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment that has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.10 Property, Plant and Equipment (cont)

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
 - management are committed to a plan to sell the asset;
 - an active programme has begun to find a buyer and complete the sale;
 - the asset is being actively marketed at a reasonable price;
 - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale';
- and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Following the accounting policy change outlined in the Treasury FREM for 2011/12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Government grants

Following the accounting policy change outlined in the Treasury FREM for 2011/12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights.

They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust and for at least a year and where the cost of the asset can be measured reliably and is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised and expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software that is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.13 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables, whereas financial liabilities are classified as other financial liabilities.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

1.14 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to finance expenses in the Statement of Comprehensive Income.

The following is the methodology used for the re-classification of operating leases as finance leases:

Finance leases in which the Trust acts as lessee

- the finance charge is allocated across the lease term on a straight line basis.
- the capital cost is capitalised using a straight line basis of depreciation.
- the lease rental expenditure that would otherwise have been charged to expenditure under an operating lease is removed from expenditure on a straight line basis.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.15 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 0.24% in real terms.

Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in note 19.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.16 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 21 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.17 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the unaudited version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.18 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Corporation Tax

Great Ormond Street Hospital for Children NHS Foundation Trust has determined that it has no corporation tax liability as the Trust has no private income from non-operational areas.

1.20 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction that is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.21 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the Trust's cash book.

1.22 Heritage Assets

Heritage assets (under FRS30 and as required by the FT ARM) are tangible assets with historical, artistic, scientific, technological, geographical or environmental qualities, held principally for their contribution to knowledge or culture. The Trust holds no such assets as all assets are held for operational purposes - this includes a number of artworks on display in the hospital.

1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 Charitable Funds

From 2013/14, the divergence from the FReM that NHS Charitable Funds are not consolidated with bodies' own returns was removed. Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' returns. The funds of Great Ormond Street Hospital for Children's Charity are not under the control of the Foundation Trust and have not, therefore, been consolidated in these accounts.

1.25 Recently issued IFRS Accounting Standards

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) but have not yet been adopted in the Annual Reporting Manual. NHS Improvement does not permit the early adoption of accounting standards, amendments and interpretations that are in issue at the reporting date but effective at a subsequent reporting period.

IFRS 9 Financial Instruments
IFRS 14 Regulatory Deferral Accounts
IFRS 15 Revenue from Contracts with Customers
IFRS 16 Leases

2. Revenue from patient care activities

	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
2.1 Analysis of revenue from patient care activities		
Elective income	80,824	83,061
Non elective income	14,966	16,153
Outpatient income	39,698	38,197
Other NHS clinical income	177,069	158,776
Revenue from protected patient care activities	312,557	296,187
Private patient income	55,129	47,886
Other non-protected clinical income	6,501	5,501
	61,630	53,387
Total revenue from patient care activities	374,187	349,574

The Trust's Provider Licence sets out the Commissioner Requested Services that the Trust is required to provide. All of the income from activities before private patient income and other non-protected clinical income shown above is derived from the provision of Commissioner Requested Services.

	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
2.2 Analysis of revenue from patient care activities by source		
CCGs and NHS England	311,321	295,100
NHS Foundation Trusts	561	552
NHS Trusts	675	535
Non-NHS:		
Private patients	55,129	47,886
Overseas patients (non-reciprocal)	673	1,051
Injury costs recovery (was RTA)	83	25
Other	5,745	4,425
Total revenue from patient care activities	374,187	349,574

All of the Trust's activities relate to a single operating segment in respect of the provision of acute healthcare services.

	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
2.3 Overseas visitors		
Income recognised in-year	673	1,051
Cash payments received in-year	11	25
Amounts added to provision for impairment of receivables	479	425

	Year ended 31 March 2017	Year ended 31 March 2016
	£000	£000
3. Other operating revenue		
Research and development	19,411	17,448
Charitable contributions to expenditure	6,242	7,369
Charitable contributions in respect of capital expenditure	32,056	31,493
Education and training	8,340	7,853
Non-patient care services to other bodies	860	1,072
Clinical tests	4,537	3,851
Clinical excellence awards	3,045	3,071
Catering	1,204	1,176
Sustainability and Transformation Fund Scheme	4,243	0
Creche services	460	484
Staff accommodation rentals	82	44
Other revenue	2,854	2,418
	<u>83,334</u>	<u>76,279</u>

	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
4. Operating expenses		
Services from other NHS bodies	6,289	6,519
Purchase of healthcare from non-NHS bodies	4,805	2,619
Executive directors' costs*	1,781	1,899
Non-executive directors' costs*	158	162
Staff costs	224,789	206,394
Supplies and services - clinical - drugs	50,423	41,680
Supplies and services - clinical - other	54,883	54,167
Supplies and services - general	4,499	4,333
Establishment	3,183	3,096
Research and development	15,322	16,030
Transport - business travel	612	493
Transport - other	2,896	2,763
Premises - business rates payable to local authorities	2,265	2,136
Premises - other	20,882	22,133
Operating lease rentals	1,886	1,478
Provision for impairment of receivables	985	4,445
Change in provisions discount rate	54	4
Inventories write down	189	198
Depreciation	16,206	16,627
Amortisation of intangible assets	1,471	1,386
Impairment/(reversals of impairment) of property, plant and equipment	12,149	(13,771)
Fees payable to the Trust's auditor for the financial statement audit	102	102
Audit related assurance services - quality accounts	19	18
Other auditor remuneration - non audit services	47	0
Clinical negligence insurance	6,326	4,810
Redundancy costs	46	414
Consultancy costs	796	1,200
Legal fees	402	226
Increase in other provisions	0	257
Internal audit costs	109	135
Losses and special payments	7	0
Other	1,699	3,026
	435,280	384,979

* Details of directors' remuneration can be found in the Remuneration Report on page xx.

Research and development expenditure includes £12,686k of staff costs (£11,870k in 2015/16).

5. Operating leases**5.1 As lessee**

	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
Payments recognised as an expense		
Minimum lease payments	<u>1,886</u>	<u>1,478</u>
	1,886	1,478
Total future minimum lease payments	As at 31 March 2017 £000	As at 31 March 2016 £000
Payable:		
Not later than one year	2,504	1,544
Between one and five years	9,976	6,004
After 5 years	<u>7,264</u>	<u>4,566</u>
Total	<u>19,744</u>	<u>12,114</u>

6. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial year ended 31 March 2017.

7. Employee costs and numbers

7.1 Employee costs	Year to 31 March 2017			Year to 31 March 2016
	Total	Permanently Employed	Other	Total
	£000	£000	£000	£000
Salaries and wages	193,437	190,531	2,906	181,307
Social security costs	19,440	19,440	0	15,000
Pension cost - defined contribution plans employer's contributions to NHS pensions	21,194	21,194	0	19,926
Pension costs - other	82	82	0	0
Temporary staff - agency/contract staff	9,318	0	9,318	7,574
Termination benefits	46	46	0	414
Total gross staff costs	243,517	231,293	12,224	224,221
Recoveries from DH Group bodies in respect of staff cost netted off expenditure	(1,401)	0	(1,401)	(1,770)
Recoveries from other bodies in respect of staff costs netted off expenditure	(292)	0	(292)	0
Total staff costs	241,824	231,293	10,531	222,451
Included within:				
Costs capitalised as part of assets	2,522	1,549	973	1,874
Analysed into operating expenditure				
Employee expenses - staff	224,789	215,231	9,558	206,394
Employee expenses - executive directors	1,781	1,781	0	1,899
Research and development	12,686	12,686	0	11,870
Redundancy	46	46	0	414
Total employee benefits excluding capital costs	239,302	229,744	9,558	220,577

7.2 Average number of people employed*	Year to 31 March 2017			Year to 31 March 2016
	Total	Permanently Employed **	Other	Total
	Number	Number	Number	Number
Medical and dental	626	586	40	587
Administration and estates	1,200	1,029	171	1,020
Healthcare assistants and other support staff	297	269	28	291
Nursing, midwifery and health visiting staff	1,479	1,366	113	1,421
Scientific, therapeutic and technical staff	777	748	29	743
Other staff	5	5	0	6
Total	4,384	4,003	381	4,068

*Whole Time Equivalent

** Includes Bank Staff

7.3 Retirements due to ill-health

During the year there were no early retirements from the Trust on the grounds of ill-health resulting in no additional pension liabilities. (There were no early retirements in 2015/16, £0k).

7.4 Staff exit packages

Foundation Trusts are required to disclose summary information of their use of staff exit packages agreed in the year.

Exit packages number and cost	Number of Compulsory redundancies		Year to 31 March 2017		Total number of exit packages		Total cost of exit packages	
	Number	£000	Number of other departures agreed	Cost of other departures agreed	Number	£000	Number	£000
<£10,000	9	25	0	0	9	25	9	25
£10,00 - £25,000	2	21	0	0	2	21	2	21
Total	11	46	0	0	11	46	11	46

Exit packages number and cost	Number of Compulsory redundancies		Year to 31 March 2016		Total number of exit packages		Total cost of exit packages	
	Number	£000	Number of other departures agreed	Cost of other departures agreed	Number	£000	Number	£000
<£10,000	1	3	0	0	1	3	1	3
£10,00 - £25,000	5	106	0	0	5	106	5	106
£25,001 - £50,000	2	63	0	0	2	63	2	63
£50,001 - £100,000	1	70	0	0	1	70	1	70
Total	9	242	0	0	9	242	9	242

Any exit packages in relation to senior managers (should they arise) are not included in this note as these would be disclosed in the remuneration report.

The cost of ill-health retirements falls on the relevant pension scheme, not the Trust, and is included in note 7.3.

8 Finance Income	Year ended 31	Year ended 31
	March 2017	March 2016
	£000	£000
Bank interest	149	282
Total finance income	149	282

9 Finance Expenses	Year ended 31	Year ended 31
	March 2017	March 2016
	£000	£000
Provisions - unwinding of discount	13	13
Total finance expenses	13	13

10. Intangible assets**10.1 Intangible assets**

	Software licences	Licences and trademarks	Development expenditure (internally generated)	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Gross cost at 1 April 2016	3,791	496	4,790	3,834	12,911
Additions - purchased	1,054	0	0	2,594	3,648
Additions - donated	0	0	0	20	20
Reclassifications	2,937	0	0	(3,030)	(93)
Valuation/Gross cost at 31 March 2017	7,782	496	4,790	3,418	16,486
Amortisation at 1 April 2016	2,683	314	3,542	0	6,539
Provided during the year	882	29	560	0	1,471
Amortisation at 31 March 2017	3,565	343	4,102	0	8,010
Net book value					
NBV total at 31 March 2017	4,217	153	688	3,418	8,476

All intangible assets are held at cost less accumulated amortisation based on estimated useful economic lives.

	Software licences	Licences and trademarks	Development expenditure (internally generated)	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Gross cost at 1 April 2015	3,092	496	4,550	3,442	11,580
Additions - purchased	78	0	0	1,191	1,269
Additions - donated	0	0	0	62	62
Reclassifications	621	0	240	(861)	0
Valuation/Gross cost at 31 March 2016	3,791	496	4,790	3,834	12,911
Amortisation at 1 April 2015	2,193	259	2,701	0	5,153
Provided during the year	490	55	841	0	1,386
Amortisation at 31 March 2016	2,683	314	3,542	0	6,539
Net book value					
NBV total at 31 March 2016	1,108	182	1,248	3,834	6,372

10.2 Economic life of intangible assets

	Min Life Years	Max Life Years
Intangible assets		
Software	1	7
Development expenditure	1	7
Licences and trademarks	1	7

11. Property, plant and equipment

11.1 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	78,075	253,002	9,252	45,708	75,348	25,372	13,112	499,869
Additions - purchased	0	3,252	0	4,502	867	1,048	388	10,057
Additions - donated	0	478	0	28,100	3,449	0	9	32,036
Impairments charged to the revaluation reserve	(5,641)	(22,859)	(310)	0	0	0	0	(28,810)
Reclassifications	0	6,283	0	(7,292)	130	879	93	93
Revaluations	1,647	(18,174)	1,267	0	0	0	0	(15,260)
Disposals	0	0	0	0	(1,845)	0	0	(1,845)
Cost or valuation at 31 March 2017	74,081	221,982	10,209	71,018	77,949	27,299	13,602	496,140
Accumulated depreciation at 1 April 2016	0	1,090	0	0	44,974	19,664	6,849	72,577
Provided during the period	0	7,292	203	0	5,988	1,738	985	16,206
Impairments charged to operating expenses	0	12,186	0	0	0	0	0	12,186
Reversal of impairments credited to operating expenses	0	(37)	0	0	0	0	0	(37)
Revaluations	0	(19,163)	(203)	0	0	0	0	(19,366)
Disposals	0	0	0	0	(1,845)	0	0	(1,845)
Accumulated depreciation at 31 March 2017	0	1,368	0	0	49,117	21,402	7,834	79,721
Net book value at 31 March 2017								
NBV - Owned at 31 March 2017	69,387	94,190	864	5,501	8,042	5,310	1,911	185,205
NBV - Finance leased at 31 March 2017	0	3,114	0	0	0	0	0	3,114
NBV - Government granted at 31 March 2017	0	143	0	0	76	0	0	219
NBV - Donated at 31 March 2017	4,694	123,167	9,345	65,517	20,714	587	3,857	227,881
NBV total at 31 March 2017	74,081	220,614	10,209	71,018	28,832	5,897	5,768	416,419

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2015	78,057	212,853	7,903	15,271	72,149	22,432	12,716	421,381
Additions - purchased	0	2,585	0	7,702	603	415	40	11,345
Additions - donated	0	1,096	0	28,148	2,003	127	57	31,431
Impairments charged to the revaluation reserve	0	0	0	0	0	0	0	0
Reclassifications	0	1,837	0	(5,413)	879	2,398	299	0
Revaluations	18	34,631	1,349	0	0	0	0	35,998
Disposals	0	0	0	0	(286)	0	0	(286)
Cost or valuation at 31 March 2016	78,075	253,002	9,252	45,708	75,348	25,372	13,112	499,869
Accumulated depreciation at 1 April 2015	0	938	0	0	39,114	16,689	5,778	62,519
Provided during the period	0	6,265	170	0	6,146	2,975	1,071	16,627
Impairments charged to operating expenses	0	4,797	0	0	0	0	0	4,797
Reversal of impairments credited to operating income	0	(17,105)	(1,463)	0	0	0	0	(18,568)
Revaluations	0	6,195	1,293	0	0	0	0	7,488
Disposals	0	0	0	0	(286)	0	0	(286)
Accumulated depreciation at 31 March 2016	0	1,090	0	0	44,974	19,664	6,849	72,577
Net book value at 31 March 2016								
NBV - Owned at 31 March 2016	75,028	107,040	1,162	8,191	8,707	4,632	1,802	206,562
NBV - Finance leased at 31 March 2016	0	3,232	0	0	0	0	0	3,232
NBV - Government granted at 31 March 2016	0	142	0	0	85	0	0	227
NBV - Donated at 31 March 2016	3,047	141,498	8,090	37,517	21,582	1,076	4,461	217,271
NBV total at 31 March 2016	78,075	251,912	9,252	45,708	30,374	5,708	6,263	427,292

11.2 Economic life of property plant and equipment

	Min Life Years	Max Life Years
Buildings excluding dwellings	10	50
Dwellings	42	50
Plant and machinery	1	13
Information technology	1	10
Furniture and fittings	1	13

Freehold land is considered to have an infinite life and is not depreciated.

The majority of Information Technology assets are depreciated over five years.

Assets under course of construction are not depreciated until the asset is brought into use.

Great Ormond Street Hospital Children's Charity donated £32,056k towards property, plant, equipment and intangibles expenditure during the year (2015/16, £31,493).

The Trust has completed a number of agreements with Great Ormond Street Hospital Children's Charity in connection with amounts donated to fund capital expenditure on building work in relation to buildings used by the Trust for its core activities. The agreements provide that, in the event that there is a material change in use of these buildings, the amounts donated would be repayable based on a formula which takes account of the total value of donations received and the period for which the new building work has been in use by the Trust. There are no past events or events foreseen by the directors which would require the recognition of an obligation to the Charity as a result of these agreements.

For assets held at revalued amounts:

* the effective date of revaluation was 31 March 2017

* the valuation of land, buildings and dwellings was undertaken by Richard Ayres, a Member of the Royal Institution of Chartered Surveyors and a partner in Gerald Eve LLP.

* the valuations were undertaken using a modern equivalent asset methodology.

12. Commitments**12.1 Capital commitments**

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2017	31 March 2016
	£000	£000
Property, plant and equipment	6,510	29,041
Intangible assets	982	967
Total	<u>7,492</u>	<u>30,008</u>

12.2 Other financial commitments

The Trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements). The payments to which the Trust is committed are as follows:

	31 March 2017	31 March 2016
	£000	£000
Not later than one year	11,600	7,461
Later than one year and not later than five year	20,795	4,774
Total	<u>32,395</u>	<u>12,235</u>

13. Inventories**13.1 Inventories**

	31 March 2017	31 March 2016
	£000	£000
Drugs	1,113	1,359
Consumables	7,095	6,472
Energy	18	27
Total	<u>8,226</u>	<u>7,858</u>

The cost of inventories recognised as expenses during the year in respect of continuing operations was £92,196k (2015/16: £82,157k)

14. Trade and other receivables**14.1 Trade and other receivables**

	Current		Non-current	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
NHS receivables - revenue	16,446	9,782	0	0
Other receivables- revenue	36,303	31,564	0	0
Provision for impaired receivables	(8,349)	(7,448)	0	0
Receivables due from NHS charities – capital	5,382	7,118	0	0
Receivables due from NHS charities – revenue	1,521	1,453	0	0
Prepayments	3,318	2,089	6,664	7,139
Accrued income	11,730	6,322	0	0
Interest receivable	2	2	0	0
PDC dividend receivable	97	0	0	0
VAT receivable	1,219	444	0	0
Total	<u>67,669</u>	<u>51,326</u>	<u>6,664</u>	<u>7,139</u>

14.2 Provision for impairment of receivables	31 March 2017	31 March 2016
	£000	£000
Opening balance	7,448	4,574
Increase in provision	985	4,445
Amounts utilised	(84)	(1,571)
Closing balance	8,349	7,448
	31 March 2017	31 March 2016
	£000	£000
14.3 Analysis of impaired receivables		
Ageing of impaired receivables		
0 - 30 days	612	1,209
30-60 days	158	30
60-90 days	136	5
90- 180 days	1,258	990
over 180 days	6,185	5,214
	8,349	7,448
Ageing of non-impaired receivables past their due date		
0 - 30 days	4,209	5,309
30-60 days	2,821	4,066
60-90 days	3,019	2,346
90- 180 days	6,887	2,225
over 180 days	5,041	1,161
	21,977	15,107
	31 March 2017	31 March 2016
	£000	£000
15. Cash and cash equivalents		
Balance at beginning of the year	63,732	58,932
Net change in year	(21,238)	4,800
Balance at the end of the year	42,494	63,732
Made up of		
Commercial banks and cash in hand	10	13
Cash with the Government Banking Service	1,984	6,219
Deposits with the National Loan Fund	40,500	57,500
Cash and cash equivalents as in statement of financial position	42,494	63,732
Cash and cash equivalents	42,494	63,732

16. Trade and other payables**16.1 Trade and other payables**

	Current	
	31 March 2017	31 March 2016
	£000	£000
NHS payables - revenue	3,894	5,728
Other trade payables - capital	6,931	8,972
Other trade payables - revenue	7,854	4,342
Social Security costs	2,739	2,104
Other taxes payable	2,375	2,201
Other payables	10,133	10,742
Accruals	16,697	21,288
PDC dividend payable	0	252
Total	<u>50,623</u>	<u>55,629</u>

'Other payables' includes £3,156k outstanding pensions contributions at 31 March 2017 (£2,931k at 31 March 2016)

17. Other Liabilities

	Current		Non-current	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Deferred income	5,204	4,006	0	0
Lease incentives	407	407	4,950	5,357
Total	<u>5,611</u>	<u>4,413</u>	<u>4,950</u>	<u>5,357</u>

18. Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the National Health Service Act 2006 were repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statement disclosures that were provided previously are no longer required.

19. Provisions

	Current		Non-current		
	31 March 2017	31 March 2016	31 March 2017	31 March 2016	
	£000	£000	£000	£000	
Pensions relating to other staff	114	115	860	964	
Other legal claims	0	14	0	0	
Redundancy	0	170	0	0	
Other	0	214	0	0	
Total	114	513	860	964	
	Pensions relating to other staff	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2016	1,079	14	170	214	1,477
Change in the discount rate	54	0	0	0	54
Arising during the year	0	0	0	0	0
Utilised during the year	(114)	(14)	(170)	0	(298)
Reversed unused	(58)	0	0	(214)	(272)
Unwinding of discount	13	0	0	0	13
At 31 March 2017	<u>974</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>974</u>
Expected timing of cash flows:					
- not later than one year	114	0	0	0	114
- later than one year and not later than five years	456	0	0	0	456
- later than five years	404	0	0	0	404
	<u>974</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>974</u>

Provisions for capitalised pension benefits are based on tables provided by the NHS Pensions Agency reflecting years to normal retirement age and the additional pension costs associated with early retirement.

"Other Legal Claims" consists of amounts due as a result of third party and employer liability claims. The values are based on information provided by the Trust's insurer, in this case, the NHS Litigation Authority. The amount shown here is the gross expected value of the Trust's liability to pay minimum excesses for outstanding cases under the Scheme rules. Provision has also been made for cases which are ongoing with the Trust's solicitors.

The NHS Litigation Authority records provisions in respect of clinical negligence liabilities of the Trust. The amount recorded as at 31 March 2017 was £112,944k (£101,453k at 31 March 2016).

20. Revaluation reserve

	31 March 2017	31 March 2016
	£000	£000
Opening balance at 1 April	106,681	78,171
Impairments	(28,810)	0
Revaluations	4,106	28,510
Transfers to other reserves	0	0
Closing balance at 31 March	<u>81,977</u>	<u>106,681</u>

21. Contingencies

	31 March 2017	31 March 2016
	£000	£000
Contingent liabilities		
NHS Litigation Authority legal claims	0	(10)
Gross value of contingent liabilities	0	(10)
Net value of contingent liabilities	<u>0</u>	<u>(10)</u>

No contingent liability exists for potential third party claims in respect of employer's / occupier's liabilities and property expenses at 31 March 2017 (£10k at 31 March 2016). The value of provisions for the expected value of probable cases is shown in Note 19.

22. Financial instruments

The carrying value and the fair value are equivalent for the financial assets and financial liabilities shown below in notes 22.1 and 22.2. All financial assets and liabilities included below are receivable/payable within 12 months.

22.1 Financial assets by category

	31 March 2017	31 March 2016
	Loans and receivables	Loans and receivables
	£000	£000
Trade and other receivables excluding non financial assets	52,619	42,915
Cash and cash equivalents (at bank and in hand)	42,494	63,732
	<u>95,113</u>	<u>106,647</u>

22.2 Financial liabilities by category

	31 March 2017	31 March 2016
	Other financial liabilities	Other financial liabilities
	£000	£000
Trade and other payables excluding non financial assets	33,926	34,089
	<u>33,926</u>	<u>34,089</u>

22.3 Financial Instruments

22.3.1 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with NHS England and Clinical Commissioning Groups and the way those bodies are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. Although the Trust has operations overseas, it has no establishment in other territories. The Foundation Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust's cash balances are held with the Government Banking Service. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, it has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's net operating costs are incurred under agency purchase contracts with NHS England and local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust receives the majority of such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to a National / Local Tariff unit cost. The Trust receives cash each month based on an annually agreed level of contract activity and there are periodic corrections made to adjust for the actual income due under the contract.

A high proportion of private patient income is received from overseas government bodies. The Trust has a good record of collection of this income although there can be delays.

The Trust presently finances its capital expenditure mainly from donations and internally generated funds and is not, therefore, exposed to significant liquidity risks in this area.

These funding arrangements ensure that the Trust is not exposed to any material credit risk.

23. Related Party Transactions

Great Ormond Street Hospital for Children NHS Foundation Trust is a body corporate established under the National Health Service Act 2006. No Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Great Ormond Street Hospital for Children NHS Foundation Trust. Remuneration of senior managers is disclosed in the audited part of the director's remuneration report on page 33.

The Trust holds a 20% interest in UCLPartners Limited (UCLP), a company limited by guarantee, acquired by a guarantee of £1. The company's costs are funded by its partners who contribute to its running costs on an annual basis. The contributions paid by the Trust are included within operating expenditure. The most recent available signed financial statements for UCLP have been prepared for the year ended 31 March 2016; the reported assets, liabilities, revenues and profit/loss are not material to the Trust.

During the year Great Ormond Street Hospital for Children NHS Foundation Trust has had a significant number of material transactions with NHS and other government bodies as well as Great Ormond Street Hospital Children's Charity.

Where the value of transactions is considered material, these entities are listed below. All of these bodies are under the common control of central government.

2016/17

Organisation Category	Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
	NHS Barking And Dagenham CCG	457		149	
	NHS Barnet CCG	899			
	NHS Basildon And Brentwood CCG	532			
	NHS Bedfordshire CCG	604			
	NHS Bexley CCG	156			
	NHS Bracknell and Ascot CCG	155			
	NHS Brent CCG	515			
	NHS Brighton & Hove CCG	165			
	NHS Bromley CCG	225			
	NHS Cambridgeshire And Peterborough CCG	389			
	NHS Camden CCG	4,507		1,637	
	NHS Canterbury & Coastal CCG	143			
	NHS Castle Point & Rochford CCG	305			
	NHS Central London (Westminster) CCG	181			
	NHS Chiltern CCG	298			
	NHS City And Hackney CCG	673			
	NHS Coastal West Sussex CCG	145			
	NHS Crawley CCG	103			
	NHS Croydon CCG	268			
	NHS Dartford, Gravesham And Swanley CCG	178			
	NHS Ealing CCG	679			
	NHS East And North Hertfordshire CCG	833			
	NHS East Surrey CCG	130			
	NHS Eastbourne, Hailsham and Seaford CCG	147			
	NHS Enfield CCG	993		140	
	NHS Great Yarmouth & Waveney CCG	130			
	NHS Greenwich CCG	193			
	NHS Guildford & Waverley CCG	206			
	NHS Hammersmith & Fulham CCG	219			
	NHS Haringey CCG	839			
	NHS Harrow CCG	444			
	NHS Hastings & Rother CCG	111			
	NHS Havering CCG	480			
	NHS Herts Valleys CCG	960			
	NHS Hillingdon CCG	726		108	
	NHS Horsham & Mid Sussex CCG	120			
	NHS Hounslow CCG	359			
	NHS Ipswich & East Suffolk CCG	115			
	NHS Islington CCG	798		215	
	NHS Kingston CCG	169			
	NHS Lewisham CCG	209			
	NHS Luton CCG	567		109	
	NHS Medway CCG	196			
	NHS Merton CCG	132			
	NHS Mid Essex CCG	645		105	
	NHS Milton Keynes CCG	163			
	NHS Nene CCG	210			
	NHS Newham CCG	592			
	NHS North East Essex CCG	445			
	NHS North East Hampshire and Farnham CCG	141			
	NHS North West Surrey CCG	178			
	NHS Redbridge CCG	682			
	NHS Richmond CCG	280			
	NHS Slough CCG	168		170	
	NHS South Kent Coast CCG	135			
	NHS Southend CCG	396			
	NHS Southwark CCG	105			
	NHS Surrey Downs	278			
	NHS Swale	125			
	NHS Thurrock CCG	387			
	NHS Tower Hamlets CCG	532		203	
	NHS Waltham Forest CCG	493			
	NHS Wandsworth CCG	242			
	NHS West Essex CCG	595			
	NHS West Kent CCG	298			
	NHS West London (K&C & Qpp)	213			
	Cambridge University Hospitals NHS Foundation Trust	102			
	Guys And St Thomas NHS Foundation Trust	354	1,918	165	364
	Luton & Dunstable NHS Foundatio Trust	134	77		
	Moorfields Eye Hospital NHS Foundation Trust		228		
	Oxford University Hospitals NHS Foundation	145			
	Royal Brompton & Harefield NHS Foundation Trust		142		
	Royal Free London NHS Foundation Trust	236	248	379	204
	Sheffield Children's NHS Foundation Trust		102		
	St Georges University Hospital NHS Foundation Trust	152		101	
	University College London NHS Foundation Trust	828	1,149	5,719	770
	Barking, Havering & Redbridge Hospital NHS Trust	100			558
	Barts Health NHS Trust	2,876	946	564	
	Imperial College Healthcare NHS Trust	332	113	207	
	London North West Healthcare NHS Trust	118	88		
	Mid Essex Hospital Services NHS Trust		665	115	
	Portsmouth Hospitals NHS Trust		126		
	Whittington Hospital NHS Trust	115	44	108	
	NHS England - London Specialised Commissioning Hub	281,445		8,405	
	NHS England - Central Specialised Commissioning Hub	1,069			
	London Regional Office	5,028			
	NHS England - Core	4,243		2,621	
	NHS Litigation Authority		6,536		
	Health Education England	8,954			
	Department of Health - Core trading & NHS Supply Chain (excluding PDC dividend)	11,453			
	Business Services Organisation - Northern Ireland				
	Camden London Borough Council		3,064		
	Care Quality Commission		196		
	Department of Health - PDC dividend only			97	
	HM Revenue & Customs - Other taxes and duties		19,440		5,114
	HM Revenue & Customs - VAT			1,219	
	National Insurance Fund (Employer contributions - Revenue Expenditure)				
	National Loans Fund			40,500	
	NHS Blood and Transplant (excluding Bio Products Laboratory)		2,244		206
	NHS Pension Scheme (Own staff employers contributions only plus other invoiced charges)		21,194		3,153
	Health & Social Care Trust - Northern Ireland	1,393			
	Scottish Government	807		313	
	Welsh Assembly Government (incl all other Welsh Health Bodies)	2,800		349	
	Great Ormond Street Hospital Children's Charity	38,298	2,210	6,830	734

24. Events after the reporting period

There are no events after the reporting period which require disclosure.

25. Losses and special payments

	Number	£000
Stores losses	<u>3</u>	<u>188</u>
Total losses	<u>3</u>	<u>188</u>
Ex-gratia payments	<u>32</u>	<u>7</u>
Total special payments	<u>32</u>	<u>7</u>
Total losses and special payments	<u>35</u>	<u>195</u>

The amounts above are reported on an accruals basis but exclude provisions for future losses.

Great Ormond Street Hospital for Children NHS Foundation Trust

Annual Report and Accounts

2016-17

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of
the National Health Service Act 2006

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Contents

Contents page

GOSH at a Glance

Graphic spread with key facts and stats about GOSH using the below information:

- 252,389 patients in outpatient attendances
- Treated 43,778 inpatients
- 97% of inpatients would recommend GOSH
- 93% of outpatients would recommend GOSH
- 4,384 members of staff
- 58 specialities
- 1,299 research studies with more than 4,000 patient and family members involved
- 91.6% of patients seen within 18 weeks
- Over 1,000 volunteers

Chairman Foreword

Twenty-first century care built on a 19th century vision

This year, we celebrated Great Ormond Street Hospital's (GOSH) 165th birthday.. In 1852, Dr Charles West had the vision to open The Hospital for Sick Children in his terraced house on Great Ormond Street in London. From these modest beginnings the hospital has flourished to become a world-leading treatment centre for children with rare and complex diseases and, with the UCL Great Ormond Street Institute of Child Health (ICH), the largest paediatric research centre outside North America.

Today we continue to grow to meet demand and provide the best possible treatment and care for the children that need us. This year witnessed our Premier Inn Clinical Building (PICB), the second part of the Mittal Children's Medical Centre, taking shape. In parallel, we completed work on the basement construction of the Zayed Centre for Research into Rare Disease in Children. This state-of-the-art facility will add vital capacity to support our growing portfolio of clinical research. GOSH is fortunate to have exceptional and committed people leading our research programme. The work they do can only be done in partnership, a point underlined by the creation this year of a joint research strategy with colleagues from ICH and the GOSH Charity. This year the quality of our research and our ambition were further recognised in an award of £37 million from the National Institute of Health Research. This funding ensures the next five years of our unique paediatric Biomedical Research Centre, in partnership with ICH, and our Somers Clinical Research Facility.

GOSH strives to provide the very best care to children with rare and complex conditions. We also aim to make the experience of being at GOSH as positive as we can for patients and their families who may be going through the toughest times of their lives. Great importance is put on creating positive and nurturing environments, employing friendly and helpful staff and volunteers and providing high quality facilities.

Our Members' Council are crucial in ensuring the views of the wider hospital community help inform our decision-making and strategy. Thank you to all our councillors for giving their time, energy and expertise to help us continually improve. Thank you also to our skilled team of Non-Executive Directors for all their hard work, and welcome to James Hatchley who joined the team this year.

I would also like to thank the GOSH Charity and the donors that have supported the hospital this year. The contribution of the charity is absolutely crucial; without it the capital redevelopment programme and much of our research would be impossible, and GOSH would not be the place it is today.

This year, after more than eight years in post, I made the decision to step down as Chairman of the Board and Members' Council. It was not an easy decision to make. It has been an immense privilege to serve the many children, families and staff at the hospital and work with the executive team to make provide the best and most compassionate care possible.

Baroness Tessa Blackstone

Chairman

Chief Executive Foreword

A year to be proud of, and challenges ahead

GOSH is a children's hospital of international renown, and a genuine national resource. This year over 260,000 patients from all over the country attended the hospital for treatment. Every day our incredible staff helped children and young people with rare or complex conditions fulfil their potential. We also continued our work to ensure that, in the future, our expert services are accessible to every child that needs us. We are challenged in that we don't fit neatly into the place-based sustainability and transformation plans (STPs). However, we are finding our own place in the contemporary system, as a collaborator and a provider of highly specialist paediatric support for partners across the country.

Underpinning our position as an expert and innovative provider, we are committed to becoming a hospital in which research is an integral part of the working lives of our staff, and of families' experience of GOSH. By immersing our practice in research we hope to drive improvements in treatment and outcomes not just for our patients but for children and young people everywhere. I am very proud that work done over the last 12 months is having such impact.

There are many examples, including Katie's story (pX) a genetic discovery opened up a new treatment option for her debilitating dystonia. And Jake (pX) has been participating in a promising treatment trial for his type of Duchenne Muscular Dystrophy.

In 2015 it became clear that some of systems to capture data were not up to standard. Over the past year a great deal of time and hard work has gone in to improving data quality, across the Trust. I'm very pleased to report that we have transformed the quality of our referral to treatment (RTT) data and systems so they are now viewed as among the best in the sector, and we recommenced reporting in February 2017.

Our challenge now is to meet the national waiting time standards. With resourcing support from commissioners, we are confident that in all but a handful of subspecialties we will meet our targets by Christmas 2017. However, GOSH is not protected from the national skills shortages in areas such as spinal surgery and paediatric neurology which means that meeting the targets set for us in these areas will continue to be challenging.

This year we began our journey towards a more ambitious digital future, and selected a supplier our Electronic Patient Records (EPR) system supplier. Our EPR vision is that every member of the team caring for a child can always access the information they need – rapidly, confidently and from a single source. Patients, parents and carers, as well as care providers in other hospitals and care settings will also be able to see relevant records and contribute information between visits to GOSH. The programme support our mission to put 'the child first and always' by better informing our decisions about care, and engaging patients and their parents to be active partners in care.

The economic climate in the NHS remains one of the primary challenges to consistently delivering high quality, timely services. We share the financial pressures of the broader health service but, despite this, have improved our bottom line. This year we reduced our adjusted deficit to £4.909

million. We were also able to grow our International and Private Patient work, with all surpluses used to support our core NHS services, and the GOSH charity has once again made a huge contribution to funding equipment, research and capital projects – such as our redevelopment programme.

To ensure we maximise the potential of the new facilities, and to meet the increasing demand on our services, we must build on our clinical workforce by recruiting from an international pool of talent. EU citizens make an extraordinary contribution at GOSH, with nearly one third of our senior medical and research personnel, and more than one fifth of our nurses, originating from EU nations. The impact of Brexit is therefore a major threat to GOSH, and we will continue to urge the Government to ensure EU professionals are supported to come and work with us.

This year our Medical Director Dr Vinod Diwakar left us to take up the post of Regional Medical Director for NHS England (London). We are grateful for his dedication and hard work. He was succeeded in an interim capacity by Dr David Hicks who had until recently been the service director for Gastroenterology at GOSH.

This year we also learned that our Chairman Baroness Tessa Blackstone would be leaving us in April 2017. Baroness Blackstone took up the role in 2008 and brought to it an extraordinary breadth of experience in the public sector, academia and government. Under her leadership GOSH successfully navigated the process of becoming a Foundation Trust, has seen a 72% increase in annual patient visits, and begun a huge redevelopment of our capital stock. On behalf of everyone at the Trust, and the thousands of children cared for during her tenure, I would like to thank Baroness Blackstone for her exceptional commitment and service.

Dr Peter Steer
Chief Executive

Our purpose and activities

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) is an acute specialist paediatric hospital. Our mission is to provide world-class care to children and young people with rare, complex and difficult-to-treat conditions.

At GOSH we provide over 50 different specialist and sub-specialist paediatric health services; the widest range on any one site in the UK.

More than half of our patients are referred to us from outside London and a small proportion come from overseas.

We have a long tradition of clinical research, learning from our special position of treating some of the largest cohorts in the world of children with rare diseases. We host the UK's only paediatric National Institute for Health Research (NIHR) Biomedical Research Centre in collaboration with University College London Great Ormond Street Institute of Child Health.

Together with London South Bank University we train the largest number of paediatric nurses in the UK and play a leading role in training paediatric doctors and allied health professionals.

Our history

In 1852 Dr Charles West founded the Hospital for Sick Children in his terraced house on Great Ormond Street. It was the country's first specialist medical institution for children, with just 10 beds and two clinical staff.

With the generosity and foresight of early patrons such as Charles Dickens and J M Barrie, the hospital grew. Over the decades it has been at the leading edge of treatment and care of children, including pioneering paediatric cardiac surgery and treatment for childhood cancers.

Great Ormond Street Hospital for Children was authorised as an NHS Foundation Trust on 1 March 2012. Much has changed since 1852, but GOSH remains at the forefront of paediatric medicine and research. Every day we do everything in our power to give seriously ill children the best chance to fulfil their potential.

Twelve months at GOSH

Between April 2016 and March 2017 thousands more amazing stories happened at Great Ormond Street Hospital (GOSH). We welcomed patients, from the tiniest babies to young adults. Some came for an outpatient appointment, while others stayed for many months. All our young patients had a rare, complex or difficult-to-treat health problem that needed help from our world-renowned specialist teams.

Here we tell just 12 of those stories, one for each month of our year and a dozen glimpses into the life of the hospital and the amazing things that happen here.

Each story also reveals something of our work to achieve the four objectives we set ourselves this year, and we have colour coded them accordingly. Our four strategic objectives are:

- To provide the best patient experience and outcomes
- To deliver world-leading paediatric research
- To be an excellent place to work and learn
- To be sustainable and efficient.

April 2016 [S01]: A new heart for Elliott

After more than 400 days in GOSH's Bear Ward – most of his young life – in Spring 2016 heart transplant patient Elliott finally returned home. He was born with dilated cardiomyopathy – a condition that limited his heart's ability to pump blood around his body. His only hope was a transplant, and after an agonising wait a donor finally arrived.

"We had waited so long to hear this," said his mum Candace. "A full spectrum of emotions overcame us. Out of all the emotions felt, the one that weighed most heavily on our consciences was responsibility. Someone had made the decision to give Elliott a shot at a new life in the most tragic of circumstances. We had to make the most of this opportunity."

Following a successful seven-hour surgery, Elliott finally returned to his family home in Hampshire at the end of April. "I don't think we actually believed this day would ever come – to actually leave the hospital," said Candace. "We had seen so many other transplant patients come and go in our time that we had resigned ourselves to always be in limbo, waiting for a transplant. I don't think we actually believed it was happening until we were in the car and waving goodbye to everybody."

[Photo from Pioneer Summer 2016]

May 2016 [S01][S03]: A spaceman makes contact!

In May the media reported a long distance call of a lifetime for GOSH patients. British astronaut Tim Peake spoke, by video link from the International Space Station, to around 30 children. One conversation was with five-year-old Maddison, from her isolation room.

Maddison, who was having a bone marrow transplant to treat her acute lymphocytic leukaemia, discovered she and Tim had many similarities including being isolated from their families and needing restricted diets.

She was keen to find out what Tim had to eat in space as she began to try food for the first time in over a month. Her Mum explained “Maddison had been in isolation at GOSH for five and a half weeks and so she was very excited to speak to space from her room. She had just started on a special diet of milkshakes and packaged food after her treatment which she didn’t like very much.”

Tim told Maddison and the other children how he spent his days carrying out scientific research. The children asked how he stopped things floating around on the space station, how he cleaned his clothes, and what he missed about home. It was an unforgettable day for staff and patients!

[photo of Maddison speaking to Tim [on website](#)]

June 2016 [S02, S03]: Breaking down barriers to research

GOSH aspires to become a fully-fledged Research Hospital, because when research is embedded into clinical practice, patients benefit from the continual improvement that follows. It’s the very essence of our Our Always Value to be Always Expert.

But traditionally, carrying out research alongside clinical duties has largely been the preserve of doctors. Barriers including lack of time, skills, training and funding have prevented the wider workforce of nurses and Allied Health Professionals (AHPs) from getting involved.

In recent years GOSH’s Centre for Outcomes and Experience Research in Children’s Health, Illness and Disability (ORCHID) has been striving to drive up research capability across the hospital. The team deliver training, mentoring and support for nurses and AHPs to develop practical skills and build confidence in assisting, or leading, clinical research studies.

Lesley Katchburian is a Physiotherapy lead in GOSH’s Wolfson Neurodisability Service. In June she became the first of ORCHID’s trainees to win funding for a PhD project. “I’ve always been interested in research, but as a physiotherapist you usually have to make a choice; you either follow a clinical career, or you become a researcher. With support from ORCHID I applied to become an NIHR Clinical Doctoral Research Fellow which has allowed me to combine both roles. This means I have the time and funds to conduct research while my clinical position is back-filled so that there’s no impact on our service to patients.

“My PhD aims to understand the long term effectiveness of Botulinum Toxin A injections in relieving muscle stiffness in children with Cerebral Palsy. The treatment is long established, but we want to assess whether better targeting – treating the right patients at the right time, for the right length of time – could improve its impact on children’s quality of life and reduce the wait for treatment.

“AHPs are ideally placed to ask these kinds of research questions, which make sure we’re doing the very best for our patients.”

[Lesley photo]

July 2016 [S04]: Progress on pollution

GOSH is a leading centre in the UK for complex paediatric respiratory conditions and many of our patients’ symptoms are exacerbated by poor air quality. Research had shown that pollution from car

exhausts was a major cause of air pollution outside the hospital, so in 2015 we launched a project to create a local clean air zone.

The collaboration between GOSH's arts and sustainability teams, alongside Camden Council, tackled the problem in several ways. Great Ormond Street became a 'No Idling Zone', with signage designed with the help of our respiratory patients. More patients helped to draw fun walking maps from all the nearby major stations, to encourage visitors to come on foot, and we changed GOSH's taxi providers to those with hybrid and electric fleets.

When London Mayor Sadiq Khan visited GOSH in July 2016 to set out his ambitions for air quality, we proudly shared the results of our local project. Low emission travel between stations and hospital has increased from 63% to 79%, with a total of around 38,000 annual journeys making the shift. The proportion of taxis booked through the hospital that are now low and zero emission has increased from 70% to 91%. Ambulance driver idling has been eradicated and visitors are reporting that Great Ormond Street is a more pleasant place to be – quieter and less polluted.

[photo of mayoral visit on website]

August 2016 [S01, S02]: Towards defying Duchenne

Duchenne Muscular Dystrophy (DMD) is a life-threatening muscle-wasting disease affecting one in 5,000 boys in the UK. Boys like Jake (**pictured, X**), who are unable to produce dystrophin, a protein that protects our muscles. The degenerative condition starts in early childhood, and most children use a wheelchair by the time they hit their teens. Treatment options are very limited, but – as a leading UK centre in experimental medicine for DMD – we believe we can do better.

Jake, age 10, carries a genetic mutation seen in about 10% of Duchenne patients. This year he took part in a clinical trial led by Professor Francesco Muntoni, Paediatric Neurologist at GOSH, which targets this rare mutation with a new drug that was developed. The trial aims to see if the drug restores dystrophin production in muscles, and if so, whether this translates into physical improvements for the boys.

Carl, Jake's Dad, said: "We knew something was wrong when Jake wasn't hitting his milestones. He had trouble crawling and walking. Then, at about four years old and after numerous tests, the doctors told us it was DMD. We were devastated, but we made the decision that we would travel to the ends of the Earth for anything that helps him. The longer we can keep him out of a wheelchair, the better. We're under no illusion that it's going to be a miracle cure – we're just happy to see small improvements."

Exciting progress was made this year towards the wider use of gene-targeting treatments for other types of Duchenne too. In August, the first UK prescription for Ataluren was issued at GOSH, after it was approved for use in the UK. This drug – which was trialled by several GOSH patients almost a decade ago – acts by masking another genetic fault in dystrophin, carried by about 13% of Duchenne patients. Early data suggests it could help boys retain their ability to walk for several years longer, and reduce the long term complications associated with the conditions.

More good news arrived when Eteplirsen, a drug developed and first tested at GOSH for another subset of Duchenne patients, was approved in the USA. The drug works by helping the protein-making machinery in patients' muscles to 'skip over' a third fault in the dystrophin gene, and

produce a more functional form of the protein. The decision across the pond brings the prospect of UK availability of Eteplirsen one step closer.

[photo of Jake in Pioneer autumn/winter 2016]

September 2016 [S01]: On a quest to reduce stress

Blood tests are one of the most common procedures our young patients need, but also one that children worry about. We constantly seek ways to help our patients feel less anxious, and in September we launched a free app called Blood Quest. The app combines gaming, fun facts and quizzes to distract, inform and entertain children while blood is taken.

Blood Quest evolved from a GOSH research project led by Dr Kate Oulton from the Centre for Outcomes and Experience Research in Children's Health, Illness and Disability (ORCHID). This showed that a fun and informative paper-based activity had the potential to alleviate some anxiety about the procedure. Building on those findings, GOSH Arts – in consultation with patients - led the creation of the new digital distraction tool. All the app features can be played one-handed, during the blood test, and the 'quest' game lasts for three and half minutes – matching the usual procedure time.

The app is available, for free, in the iPad app store. GOSH teams are using it on hospital devices to improve their patients' experience of this frequent procedure. Parents with iPads can download it at home to help a child to prepare for a test, and it is freely available for any other paediatric healthcare setting, anywhere in the world.

[app shots and poss in-use shot]

October 2016 [S01]: A 'super' new facility

In October 2016, nine-year-old Ben became the first patient to be treated with Gamma Knife Surgery at GOSH. He'd had a bleed on the brain and a scan revealed a small ball of abnormal blood vessels (known as an AVM) in his brain, which was affecting his vision.

Because Ben's AVM was deep inside his brain it wasn't suitable for traditional surgery, and Gamma Knife Surgery was chosen as a good alternative. It's one of GOSH's newest facilities, having been awarded (with University College London Hospital) one of two UK Gamma Knife 'super centres'.

The technique uses a focused array of intersecting beams of gamma radiation, the most energetic form of electromagnetic radiation, to treat lesions in the brain. It was invented in the 1950s but the GOSH/UCLH centre is the first time it has been available to treat children in a truly paediatric set-up.

Gamma Knife will offer an effective, non-invasive, alternative for many children with AVM in the coming years. Many will be home the next day and, like Ben, back at school within a week!

[Georgina Day should have photos of Ben]

November 2016 [S03]: A bridge to the future

In November 2016 we welcomed five young people with learning disabilities onto nine-month internships at GOSH. Through a collaboration with City and Islington College, Camden Local Authority and Project SEARCH, the interns are experiencing a rotation of work placements in different teams around the hospital, such as catering and retail.

The project aims to help young people with learning disabilities to bridge the gap between school and employment. It combines on-the-job training to build confidence and capability, and classroom time to learn skills needed for the wider world of work, such as good communication and writing a CV. The interns – aged between 18 and 25 – are supported by a teacher from the College and a job coach, and each has a GOSH mentor.

The Trust's Consultant Nurse for Learning Disabilities, Jim Blair, says it's been a positive experience for everyone. "The scheme has been a wonderful opportunity for both interns and staff. We are all learning and growing together in a project that embodies our values of 'Always welcoming' and 'Always one team'. The young people we're hosting are changing and challenging perspectives because it's showcasing ability, rather than focusing on disability, and that helps us to see the person and understand what they can bring to a team."

[BOX OUT]

What our interns say:

"I've learnt it's OK to ask for help"

"Project SEARCH means a lot to me because it means I am working in a real workplace"

"I like new challenges, tasks and problem-solving."

[Bridgette Williams has photo of female intern (Ramlah) at work. Ramlah has given permission to use the photo via Bridgette]

December 2016 [SO1, SO2]: A genetic discovery with immediate impact

"Our local hospital had run out of ideas, so Katie was referred to GOSH. Once we got to Dr Kurian, we just knew Katie would be looked after, she knew her stuff; you just felt you are not at the end of the line when we came to her."

As an internationally-renowned specialist centre, GOSH has some of the largest cohorts of children with rare and complex diseases anywhere in the world. As Katie's mum testifies above, this puts us in the best position to make discoveries and improve the diagnosis and treatment of conditions like her daughter's.

In December, Dr Manju Kurian, GOSH paediatric neurologist and Wellcome Fellow, and colleagues published their discovery of a new genetic cause for a progressive movement disorder called dystonia. Children with dystonia endure repetitive twisting movement and postures due to involuntary muscle spasms, which can make walking, holding things, eating and talking increasingly difficult.

Dr Kurian regularly receives referrals of children like Katie, who have movement disorders with no known cause. She started noticing a group with some similarities and had a strong belief that a genetic culprit must link them. She collected DNA from the families and found that 27 of her patients had sections of DNA missing in a gene called *KMT2B*.

This discovery heralds the start of a long journey to untangle how faults in *KMT2B* cause dystonia, but it also has an immediate impact for patients. The diagnosis confirms 'primary dystonia', in which symptoms often improve dramatically with a treatment called Deep Brain Stimulation.

Katie (pictured) took part in the study and was diagnosed with *KMT2B* dystonia. She received Deep Brain Stimulation in January and her mum, Sarah, says they are already seeing improvements: "One and half months later and already she is walking better and she lays in a straighter position. Her physio is getting very excited about movements that she is able to see already. I just want to say a thank you to Dr Kurian for not giving up. The future is bright."

[picture of Katie [on website](#)]

January 2017 [S03]: Celebrating our amazing staff

The NHS Friends and Family Test (FFT) is an important source of continuous feedback at GOSH. The results highlight where we might need to do things differently, and they give recognition when we get it right.

Fantastic GOSH teams and wonderful GOSH individuals are often given a special mention by patients and parents. This year Lynne Oriatto's name really stood out, when she received 11 different testimonials from parents in a single month.

Lynne is a Senior Healthcare Assistant in Walrus Ward for children with heart and respiratory problems. The comments show that she epitomises GOSH's values of being Always welcoming and Always helpful:

"Lynne was extremely friendly and made my daughter feel at ease. She explained exactly what she was going to do which made my daughter feel relaxed"

"Lynne was fantastic, made our son and ourselves feel at ease with her bubbly personality. It was my son's first cannula and she made it a positive experience, highly recommended"

We celebrated Lynne's contribution by giving her a GOSH Exceptional Members of Staff (GEMS) award in January 2017. Congratulations and thanks to all our team and individual GEMS award winners this year.

February 2017 [S01]: Rosemary's story

My name is Rosemary. I volunteer every Tuesday as a Baby Buddy on Squirrel Ward.

I'm there principally to give the parents a much needed break. As a parent of a sick child, it's vital to have a few precious moments to sip a drink in peace, knowing that your child has a well-trained volunteer in the room either playing a game with them or just having a chat. The parents are incredibly grateful for that time and they so often say "thank you, that break was just what I needed".

Volunteering at GOSH is a very uplifting experience. In February I sat with two babies in the High Dependency Unit who were having time out from their beds. They lay next to each other on a play mat on the floor, smiling and holding hands as I talked and sang to them, helping them feel relaxed.

[Rosemary is in the hospital on Tuesdays – happy to be photographed]

March 2017 [SO3] [SO4]: Building tomorrow's hospital

In March staff, patients, families and our neighbours were invited to an exhibition of entries in a competition to design a new clinical building to run the length of the Great Ormond Street side of the hospital site. Some of the world's best architects and engineers submitted designs for this high-profile building and the winning design will be announced in May.

The contest marks the starting point of Phase 4 in our redevelopment programme, which took major steps forward this year. The mammoth programme – supported by Great Ormond Street Hospital Children's Charity – will replace old and inadequate buildings with world-class healthcare and research environments.

The Premier Inn Clinical building – due to complete fitting-out and welcome its first patient in August 2017 - will provide new facilities for some of the sickest children at GOSH. These will include two new theatres, intensive and high dependency care facilities, a post anaesthetic care unit and specialist inpatient wards with space for a parent or carer to stay by their child's bedside.

Work also progressed on construction of the Zayed Centre for Research into Rare Disease in Children, which will bring clinicians and scientists together to develop our understanding of paediatric rare disease and rapidly translate findings into new treatments. It will provide outpatient clinic space, research laboratories and 'cleanrooms' licensed to create specialist products for treatments and clinical trials. Construction is due to complete in late 2018.

[Louisa Desborough has pics from the design exhibition]

Performance report

Overview

Over the last year we have continued to see a high and increasing demand for many of our services with us seeing more patient visits than ever before. The Trust saw 252,389 outpatients and treated 43,778 inpatients, increases of 5% and 2.5% respectively on the previous year. Staff from across GOSH have worked hard to bring our waiting times standards and our digital technology closer to that of world-class clinical care. The work on both Referral to Treatment times (RTT) and electronic patient records has been intensive, with the former becoming a benchmark for others in the sector and the latter on track for the planned launch in 2019.

Recruitment and retention of staff – in particular nurses and junior doctors – is an increasing challenge and one that Brexit looks set to heighten. While we have taken a number of steps to address this in 2016/17, and will continue to implement our plans in 2017/18 and beyond.

We have seen some exceptional research outcomes this year, many of which have immediately improved children's lives. Our portfolio of research grants has grown once again in 2016/17, with 1,299 studies active during the year, and we have been awarded another five year's funding for our NIHR Biomedical Research Centre, and infrastructure funding for our Somers Clinical Research Facility. Alongside £1.2 million investment from GOSH and the Charity for research posts, we are well on the way to becoming a fully-fledged Research Hospital.

The Trust operating deficit (before capital donations and impairments) was £4.909m in 2016/17 which was an improvement from 2015/16 in which the Trust reported an underlying deficit for the first time in several years. This result included delivering a £12 million savings target. For further information on the financial results, refer to page xx.

Key issues and risks

The Trust's Board Assurance Framework details the principle risks to the achievement of our operational and strategic plans. It is informed by reviewing internal intelligence from incidents, performance, complaints and internal and clinical audit, as well as the changing external environment we operate in.

The top five risks to our operational or strategic plans in 2016/17 were identified as:

- The inability to recruit and retain sufficient highly skilled staff
- Completing the review of the management of Referral to Treatment and ensuring timely access to GOSH services.
- Reduced funding and increasing costs threatening financial sustainability
- Reliance on international and private patients to support financial viability
- Implementation of the new Trust wide Electronic Patient Record

More detail about these risks and our mitigating actions can be found in the Annual Governance Statement on pX

Going concern

Although we are operating in a particularly constrained financial environment, the Directors have a reasonable expectation that the Trust has adequate resources to continue to operate for the foreseeable future. For this reason, and following reasonable enquiries, the Directors continue to adopt the going concern basis for the preparation of the accounts within this report.

A summary of the Trust's financial position and plans can be found on page X. Full details of our income and expenditure in 2016/17 can be found in the Accounts from page X.

Analysis of performance in 2017/18

The Trust Board receives a monthly integrated performance report, which is used to monitor progress against our strategic objectives. The report has been redesigned in line with the Care Quality Commission's five questions (are services safe, caring, effective, responsive and well led?) in order to be assured that the Trust's services are delivering to the level that our patients and families, the Board, our commissioners and regulators expect.

Performance against our objectives

In 2015/16 GOSH's strategy was reviewed and refreshed and a new strategic plan was developed. The plan articulated how we will work to ensure access to high-quality, safe and timely care for all our patients, and how we will continue to develop new treatments and innovative practices to improve child health.

To achieve these priorities, four strategic objectives were agreed:

1. to provide the best patient experience and outcomes
2. to deliver world-leading paediatric research
3. to be an excellent place to work and learn
4. to be sustainable and efficient.

Underpinning everything we do to achieve these objectives, are Our Always Values – Always welcoming, Always helpful, Always expert and Always one team. The values were developed in consultation with patients, families, Foundation Trust members and Members' Councillors.

Always



Strategic objective 1: To provide the best patient experience and outcomes

At GOSH we strive to provide world-class care to children and young people with rare, complex and difficult-to-treat conditions. We want patients and families to have the best experience they can from the moment they come into contact with GOSH and throughout their patient journey.

Performance summary	
2016/17 priority	Evaluation
Improve processes and patient records to that Trust can recommence reporting Referral to Treatment times	Achieved
Reduce waiting times for appointments, diagnostics tests and treatment	Partially achieved – see below for further information
Fast-track procurement and implementation of an Electronic Patient Records system	Procurement completed with Full Business Case approved to commence implementation
Implement a real-time patient feedback system	Partially achieved – see below for further information
Host more events to listen to patients, family and staff	Achieved.
Improve the comfort of the hospital environment, focusing on food and play provision	Achieved
Improve patient satisfaction with overnight accommodation	Achieved
Continue developing GO Create! – the Trust’s Arts Programme, to improve staff, patient and family experience	Achieved
Play an active role in care pathways for delivering congenital cardiac surgery nationally.	Achieved
Collaborate with organisations to ensure that patients are receiving the right care, in the right location.	Achieved
Streamline care pathways across regional groups.	Ongoing
Ensure that appropriate priority is given to specialist children’s services.	Ongoing

Waiting times

In 2015 The Trust became aware of major issues with the quality of our waiting time data, due to inaccurate patient pathway data. After careful consideration we took the difficult decision to cease reporting of our Referral to Treatment Times (RTT) and diagnostic waiting times until we had addressed the issues. A Trust-wide programme to improve our processes and patient data was undertaken during 2015 and 2016 and we achieved our aim of recommencing external reporting in this financial year. We recommenced reporting of the RTT return in February 2017 and the diagnostic return in April 2016.

More information on our RTT and diagnostic waiting times can be found on pXX in the Quality Report and page XX in the Annual Governance Statement.

Patient Records

This year we began the biggest clinical transformation GOSH has ever undertaken to implement an electronic patient records system (EPR). Due to go live in 2019, the EPR will allow every member of a team caring for a child to access all the information they need, rapidly and from a single source. This project – which reflects our values of being Always expert and Always one team - will reduce the time we spend on administration and increase the time we have for clinical care. It will also make our patients and families lives easier, by providing an online booking system for appointments. In March 2017, through a procurement process, the Trust confirmed Epic Systems Corporation as the preferred supplier for its electronic patient record (EPR) system and Aridhia Informatics Limited as the preferred supplier for the research and innovation platform. We look forward to working with these providers and our staff across the hospital to implement the programme.

Engaging with patients and families

At GOSH we put ‘the child first and always’. One of the key ways we do this is to ensure that we listen to what our patients and their parents tell us about their experience at the hospital, and act on their feedback. We set ourselves a target that 95% of respondents to the Friends and Family Test (FFT) would recommend us to a loved one. In 2016/17 FFT results showed that 97% of inpatients, and 93% of outpatients, would recommend GOSH.

The Trust held a listening event in November 2016 and will continue to do this every 2-3 years. Further information can be found in the Quality Report on page **XX**.

As a result of patient engagement work, and aligned to our values of being Always Welcoming and Always Helpful we have made improvements to catering and accommodation at GOSH, based on feedback from patients and families. In order to provide more variety and choice of food, the patient menu is now rotated every three weeks, instead of every three months, and the ‘Lagoon’ restaurant offers a wider range to accommodate different diets.

The Mother’s Unit – living quarters for mums with young babies at GOSH – was refurbished so it is clean, fresh and restful. Patient accommodation in Weston House (38 rooms) was redecorated and received new flooring and furniture, and a new Freeview TV system was installed in Weston House and the Italian Building.

Play opportunities for young people have also increased with space being made available for the Crocodile Club to provide play activities in the Lagoon every day.

In 2016/17 we took steps towards the procurement of a real-time patient feedback system. This will enable us to report on and respond rapidly to issues raised by patients and families during their time with GOSH.

GOSH Arts

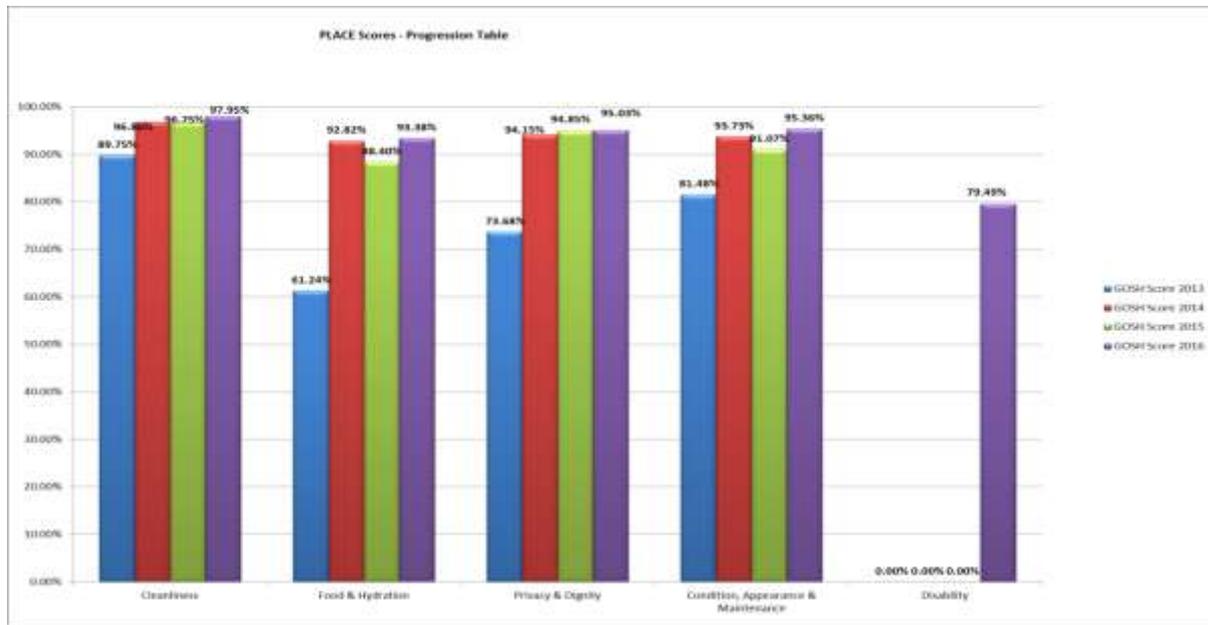
This year the Trust’s Arts Programme was rebranded GOSH Arts – previously, GO Create! – and remains a vital element of our commitment to be Always welcoming.

In 2016/17 over 12,000 individuals participated in creative activities at GOSH, with many more benefiting from arts in the hospital environment – including music and performance. Surveys showed that arts improved the hospital experience for 99.2% of families visiting GOSH. Reflecting our value of being Always one team, GOSH Arts are embedded in the hospital’s building master plan.

This year we have involved patients, staff and families in the development of new artworks for the coming Premier Inn Clinical Building. See [pXX](#) to read about a GOSH Arts digital project to help children feel less anxious during blood tests.

Patient Lead Assessment of the Care Environment (PLACE) 2016 Results

2016 saw the highest scores at GOSH since the introduction to PLACE assessments in 2013.



2016 saw the highest score yet for privacy, dignity and well-being. Assessors that spoke to patients, parents and families were encouraged in how we care for the patients, and always provide the best possible environment to ensure all our patients are treated with privacy and dignity.

Following the 2017 PLACE assessment, there were many compliments regarding the taste, selection, appearance of food. However, still some work to be done around the engagement on Clinical teams in food service during protected meal times.

High praise was given to the Housekeepers for their food presentation, attention to detail, practicing excellent food hygiene and for having to get the meals out on time.

We are confident that the scores for 2017, around cleanliness, condition, appearance and maintenance, privacy, dignity and wellbeing have been maintained and that big improvement has been made on the disability access category since last year's PLACE assessment.

We received feedback from the assessors that took part on how welcoming, friendly, professional and proud of GOSH all the staff were that they met during the assessment which demonstrates our Always Values as an organisation.

Strategic objective 2: To deliver world-leading paediatric research

2016/17 was the first year of our exciting strategy to establish GOSH as a Research Hospital. We intend that research will become an integral part of the working lives of our staff, and of families' experience of GOSH, and will improve the treatment and outcomes for our young patients.

Performance summary	
2016/17 priority	Evaluation
Successfully apply for funding for a third NIHR Biomedical Research Centre	Achieved – see below for further information
Successfully apply for independent funding for the Somers Clinical Research Facility	Achieved – see below for further information
Work closely with partners to continue to grow a sustainable research infrastructure	Achieved
Set up a process to ensure that every patient has the opportunity to participate in a research study or trial	Achieved – see below for further information
Optimise integration between research and the development of new clinical diagnostics and treatments	Achieved

Funding and investment

Hospital capacity for research was enhanced this year. The Trust, together with GOSH Charity invested £1.2 million in research posts that underpin the work of our leading research teams, such as research nurses and data handlers. We were thrilled to have been awarded a third five-year term of funding (2017-2022) for the NIHR GOSH Biomedical Research Centre (BRC). This £37 million award will drive forward our translational research into rare diseases in children. With our partner University College London’s GOSH Institute of Child Health, the BRC enables basic scientific discoveries developed in the laboratory to be turned into potentially life-saving ‘first in child’ clinical studies.

Our Somers Clinical Research Facility is a dedicated space for children taking part in clinical trials at GOSH, and is key component in delivering our BRC work. This vital piece of research infrastructure was secured for a further five years in 2016 by an NIHR awarded of £3 million.

Participants and data

During 2016/17, we have run 1,299 research projects at GOSH/ICH. In the first three quarters of 2016/17, more than 4,000 patients and family members took part in research studies.

GOSH is the lead Trust for the North Thames Genomic Medicine Centre, which is recruiting samples for the 100,000 Genomes project for rare diseases. The North Thames GMC has recruited 5,200, making up around 28% of those recruited nationally. GOSH is on course to meet our own target of 2,640 genomes by spring 2017.

For this year’s research highlights see ‘12 months told in 12 stories’ on [pX](#) and The Quality Report, [pX](#).

Strategic objective 3: To be an excellent place to work and learn

Our staff make GOSH amazing, so attracting, retaining and developing the best people across our clinical and supporting workforce is vital. Education, teaching, and learning are critical to our work and ensure we remain Always expert. We are the largest provider of pre-registration children's nursing education in the UK and a major provider of post-graduate medical education in paediatrics. The nature of GOSH specialties is such that some training may be unique to us, or only available at one or two other UK centres.

The Trust supports trainees in healthcare science, therapies, dietetics, and pharmacy and has a track record of supporting non-clinical career pathways through the introduction of apprentices, the development of competency frameworks and bespoke learning interventions.

<i>Performance summary</i>	
<i>2016/17 priority</i>	<i>Evaluation</i>
Optimise recruitment and retention processes	Partially achieved – see below for further information
Continue to develop apprentices	Achieved
Continue incident planning training and exercise programme for all staff	Achieved

Recruitment and retention

Living and working in central London can be challenging and the Trust has not seen the levels of improvement in recruitment and retention hoped for this year, particularly in our nursing workforce.

We have launched several initiatives to try to address this, including streamlining our recruitment processes to reduce our time-to-hire and marketing our vacancies across social media to capture applicants from a wide talent pool.

We are increasingly using assessment centres to test not just candidates' clinical skills, but also ensure that they share our values and are the right fit for GOSH. During 2016/17, 108 healthcare support workers/healthcare assistants and 119 newly qualified nurses joined us. This year we also significantly increased student nurse placement opportunities through partnerships with five universities.

The rotational Professional Development Programme for Newly Qualified Nurses (NQN) has helped us to increase retention from 75% to 95% at the end of two years. We now offer the programme to all NQNs joining the Trust, and this year 350 NQN's are enrolled.

Although we recognize that as a teaching hospital we will always have an element of turnover, our current turnover of nursing staff at GOSH is an average of 18 per cent, compared to overall nursing turnover in London at about 15 per cent. We are in the process finding out what is driving this through a series of staff focus groups and forums and a new improved exit survey.

Postgraduate medical education

Doctors and surgeons in recognised training posts at GOSH are invited to complete the General

Medical Council (GMC) National Training Survey annually. In 2016 we achieved our highest survey completion rate of 97%, and our best ever results.

In September 2016 oncology training posts were reinstated at GOSH. They had been removed in 2014 following a Health Education England's (HEE) assessment. HEE's quality review team returned in January 2017 and identified that considerable improvements had been made to oncology training at the Trust. The whole oncology team was thanked for their contribution to improving education and training for trainees.

Learning and development

This year we have continued to develop apprentices at GOSH, with programmes running in a number of non-clinical areas such as HR, Finance and soon Information Services. Around 80% of our apprentices go on to permanent roles within the Trust and in 2016/17 we welcomed 74 new apprentices, which exceeded the target set by the NHS locally.

Across England, over 1,000 Nursing Associates began training in January, with the aim of creating a new type of care worker with a higher skill-set to assist, support and complement the care given by registered nurses. GOSH employs seven trainees and is the Lead Partner of the only Child and Young Person Nursing Associate Pilot site, which spans North, Central and East London with placements in Chelsea and Westminster. Our prominent position in this partnership will allow us to shape this exciting new role for the nursing workforce.

We continue to offer high quality clinical placements at GOSH for up to 150 student nurses in training at our partner Higher Education Institutes

We also launched our new e-learning management system. It is a comprehensive platform that allows individuals to learn at a time, place and pace that suits them, and enables GOSH to oversee the training status of our workforce. In parallel, we began a review of all our mandatory training to ensure it is of high quality, contributes to the care and safety of our patients and staff, and can be easily accessed by our staff.

The Trust has continued to work with staff regarding training for incident planning. The NHS England (London) annual assessment reported that the Trust remains compliant against the core standards.

We know from our patient and staff surveys that making sure everyone at GOSH lives Our Always Values is essential. We continue to embed the values through leadership development and training, requiring leaders to demonstrate the values at all times, and to support their staff to do so.

Strategic objective 4: To be sustainable and efficient

Financial sustainability remains a key challenge in the context of decreasing real term funding for specialised services. This year we have found new ways to deliver efficiencies while protecting our high clinical standards and increasing clinical capacity.

GOSH is committed to looking after the environment in which our patients will grow up. For more information on environmental matters, please turn to the Sustainability Report on [pX](#).

<i>Performance summary</i>	
2016/17 priority	Evaluation
Find new schemes to deliver £12m efficiency target	Achieved
Minimize water consumption by review water uses with staff and partners	Achieved
Focus on waste management and continue improving recycling rates across the Trust	On-going
Continue advocacy work on air quality along Great Ormond Street to further reduce carbon emissions	Achieved
Successfully plan the opening of the Premier Inn Clinical Building	Ongoing
In collaboration with the Charity oversee the construction of the Zayed Centre for Research into Rare Disease in Children, opening in 2018	Ongoing

Efficiency savings

We met our £12 million savings target in 2016/17, aided by one-off and ongoing activities to boost productivity and efficiency. £6.1m was achieved through:

- A programme to reduce non-pay spending - £1.1m
- Commercial, international and private increases in revenue generated (excluding NHS clinical) - £1.1m
- Reviews of staffing and skills mix - £2.3m
- Efficiencies in other operating expenses - £1.6m

The remaining target was met through:

- Maintaining vacancies throughout the organisation for the remainder of the year without additional demands on Bank and Agency resourcing, while maintaining income.
- The overall level of NHS Income recovered and IPP was significantly greater than in the original forecast. Recognising that this income was delivered via better efficiency, the overall level of income achieved can be attributed to the Better Value programme.

A newly embedded Programme Office managed both local and cross-cutting schemes, including an extensive programme of work on non-pay spending, clinical pathway improvement, reviews of staffing mix and skills and work to ensure that we run our buildings and facilities at optimum efficiency.

Importantly, the Quality Impact Assessment process has been reviewed with the Medical Director, Chief Nurse and Head of Quality and Safety. This has ensured that all cost-saving initiatives have taken potential quality impacts into account and mitigated risks accordingly.

[BOX OUT MINI-FEATURE]

Optometry makes visible efficiencies

In 2016 GOSH expanded our one-stop optometric service for outpatients. Our aim was to consolidate our previous services to improve safety and quality for patients. We wanted to create a more efficient service that also had income-generating potential.

Patients who require optical aids are given a voucher – ranging from £39 to £215 – to cover the cost of their glasses, contact lenses or other low vision aid. Before this scheme around 30% of the vouchers dispensed by the Ophthalmology service were redeemed through our own optometric service.

By recruiting an additional optician to increase capacity, offering a wider range of accessories and promoting the service prominently, the proportion of vouchers now dispensed at GOSH is close to 50%. In its first year, the scheme has generated savings and income of over £100k for the Trust.

Redevelopment

In collaboration with the Charity, GOSH's huge redevelopment programme continued apace in 2016/17, to replace outdated and inadequate infrastructure with world-class facilities for patient care and research.

The Operational Commissioning Board for the Premier Inn Clinical Building, the second part of the Mittal Children's Medical Centre, continued to meet during this year in order to prepare the organisation for operational readiness. This culminated in a detailed review of the planned occupants to ensure that the new bed capacity is consistent with current and future demand. The date for hand over from the contractor was agreed and the patient moves will begin in August 2017.

The construction of the basement levels of the Zayed Centre for Research into Rare Diseases in Children (ZCR) continued with Erith and the construction contract for the main works were signed with Skanska in December 2016. Handover of the site between contractors took place in March 2017 with an anticipated completion date at the end of 2018.

At the end of the financial year, contenders for the design of the new clinical building that will replace GOSH's frontage went on display to the public. More information about this and the redevelopment progress made this year can be found in '12 months told in 12 stories' on [pX](#)

International and Private Patients

GOSH is internationally-renowned for cutting-edge treatment of children with rare and complex conditions. We work with governments and other sponsors to welcome 5,000 children annually from around 90 countries that lack the facilities and expertise to treat rare or complex paediatric conditions.

We have implemented our plan to develop our International and Private Patients (IPP) services and achieved significant growth in this area over the past two years. This year we met this rising demand by opening Hedgehog ward, bringing our number of dedicated beds to 53. Our development of IPP

generated income growth of 15.1% this year, to be invested in NHS services for the benefit of all our patients.

The majority of private patient service demand is from the Middle East, which carries a degree of geopolitical risk. The Trust has included provisions to cover this and continues to implement its strategic objectives to mitigate exposure to risk through market and product development opportunities.

Financial performance

The Trust financial position has improved from the previous 12 months, in which we reported an underlying deficit (before capital donations and impairments) for the first time in several years. In 2016/17 Trust earnings before interest, taxes, depreciation and amortisation (EBITDA) increased to £20.0 million (4.7% of operating income) from £13.6 million (7% of operating income). Some relief came in the form of the Sustainability and Transformation Fund, a national NHS intervention that provided £4.2 million to the Trust. At the end of 2016/17 the Trust reports an underlying deficit of £4.9 million, compared to £11.1 million in 2015/16.

In line with our business intentions, this year our income from International and Private Patient services (IPP) grew by £7.2 million (15.1 %) over the prior year, due to the opening of a new IPP Inpatient ward providing additional bed capacity.

The Trust has had to make significant one-off investments to remedy issues with reporting, particularly in respect of the RTT operating standards. This year, the cost of validating historic data was £3.4 million (£2.9 million in 2015/16). Operating costs before impairment of fixed assets have increased by 6.1% this year compared to the increase in operating income of 7.9%.

The redevelopment of our hospital facilities continued in 2016/17 in line with our published 2015 Site Masterplan. The Trust resources were generously supported by charitable donations from the GOSH Charity which provided capital funding of £32 million for buildings and equipment this financial year.

The Trust set a savings target of £12 million in 2016/17 and delivered this target (see Strategic Objective 4, above).

The Trust maintains a strong liquidity position based upon historic surpluses, careful capital expenditure management and support by the Charity. At the end of 2016/17 the Trust held £42.5 million in cash reserves and was able to meet all commitments as and when they fall due. (Also refer to page XX for the Trust's going concern statement)

The following table outlines the Trust's financial performance this year compared to the prior financial year, excluding income from capital donations and impairments.

£ million		
For the period ended:	31 March 17	31 March 16
Operating income (excluding capital donations)	425.5	394.3
Operating expenses (excluding impairments and depreciation)	(405.4)	(380.7)

EBITDA	20.1	13.6
Depreciation, interest and dividend	(25.0)	(24.7)
Net deficit	(4.9)	(11.1)

The Trust has signed a contract with commissioners for the 2017/18 and 2018/19 financial years. The plan, submitted to NHS Improvement, puts us in financial balance by the end of 2017/18 with a further increase in operating surplus by April 2019. The contracts and plan includes a growth in activity to meet demand for specialty services, and includes the opening of the new Premier Inn Clinical Building which provides additional clinical services capacity for the Trust.

The Trust plan will also need to deliver efficiencies of £15 million in 2017/18 and £12 million in 2018/19, and the Programme Office has developed a two year plan to achieve this. This includes:

- £3.4m to be delivered through a wide range of schemes developed locally within divisions and directorates, aiming to save 1% of their budgets;
- £9.2m from a range of cross-organisational schemes continuing the work begun in 2016/17 in areas such as non-pay spending, patient flow and pathway improvement, workforce initiatives such as improved rostering, and other schemes including, for example, a range of ICT-enabled efficiency projects. These are all led by identified senior scheme owners, with project management support;
- £2.5m brought forward full year effects of initiatives which began part-way through 2016/17.

Sustainability report

As an NHS organisation, largely funded by the public, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. Demonstrating that we consider social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In 2014, a target was set for the NHS, public health and social care system to reduce our carbon footprint by 34% by 2020, compared to 1990 levels. Our ambitious aim is to exceed this target by reducing our direct carbon emissions by 34% by 2020, compared to 2013 levels.

Overall strategy for sustainability

We consider sustainability in all areas of our processes and procedures, including travel, procurement and the impact of our suppliers. One of the ways in which our organisation has embedded sustainability is through the use of a Sustainable Development Management Plan (SDMP), which is visible and well known by staff.

The plan has three strands of activity.

- Strand 1 - focusing on efficiency; activities which use fewer resources, reduce waste and have a financial benefit.
- Strand 2 - focusing on sustainability activities which improve patient health and experience.
- Strand 3 - using GOSH's exemplary reputation to take a public advocacy position on children's health and sustainability with a view to benefitting children nationally and globally.

As part of our work to achieve this we train our staff on a variety of sustainability topics including modern slavery. We also continue our energy reduction program, Operation TLC, which engages staff to increase use of natural light, maintain comfortable heating levels and switch equipment off.

This year we supported NHS Sustainability Day in conjunction with Operation TLC. This raised awareness of how staff can help reduce energy use and improve patient experience. We also raised awareness of National Clean Air Day which we aim to promote further in 2017.

We plan to update our SDMP in 2017 to better reflect the Trust's vision for how we can adapt services to be more resilient to our changing climate, in particular developing new models of care with sustainability embedded. We also plan to review and improve our 67% score in the Good Corporate Citizen assessment.

We have partnered with Camden Council to reduce the impact of people driving to the hospital. This program is run in conjunction with the community under our 'Site Traffic Management Group'. This aims to reduce road transport through consolidation of deliveries and by promoting sustainable transport. It also aims to reduce the impact of the hospital on the community through review of the local permit system. For more information on our clean air project see '12 months told in 12 stories' on [pX](#).

Carbon Footprint

The hospital's environmental impact is proportional to the number of people it employs and the floor space of the Trust's buildings, and we 'normalise' the data to take account for this when assessing our progress toward our target of 34% reduction in carbon emissions by 2019/20. [Figure 1](#) shows that the Trust's improvement has not kept pace with our target (shown by the line plot) when the organisation is normalised by floor space but has performed ahead of target when normalised by number of employees.

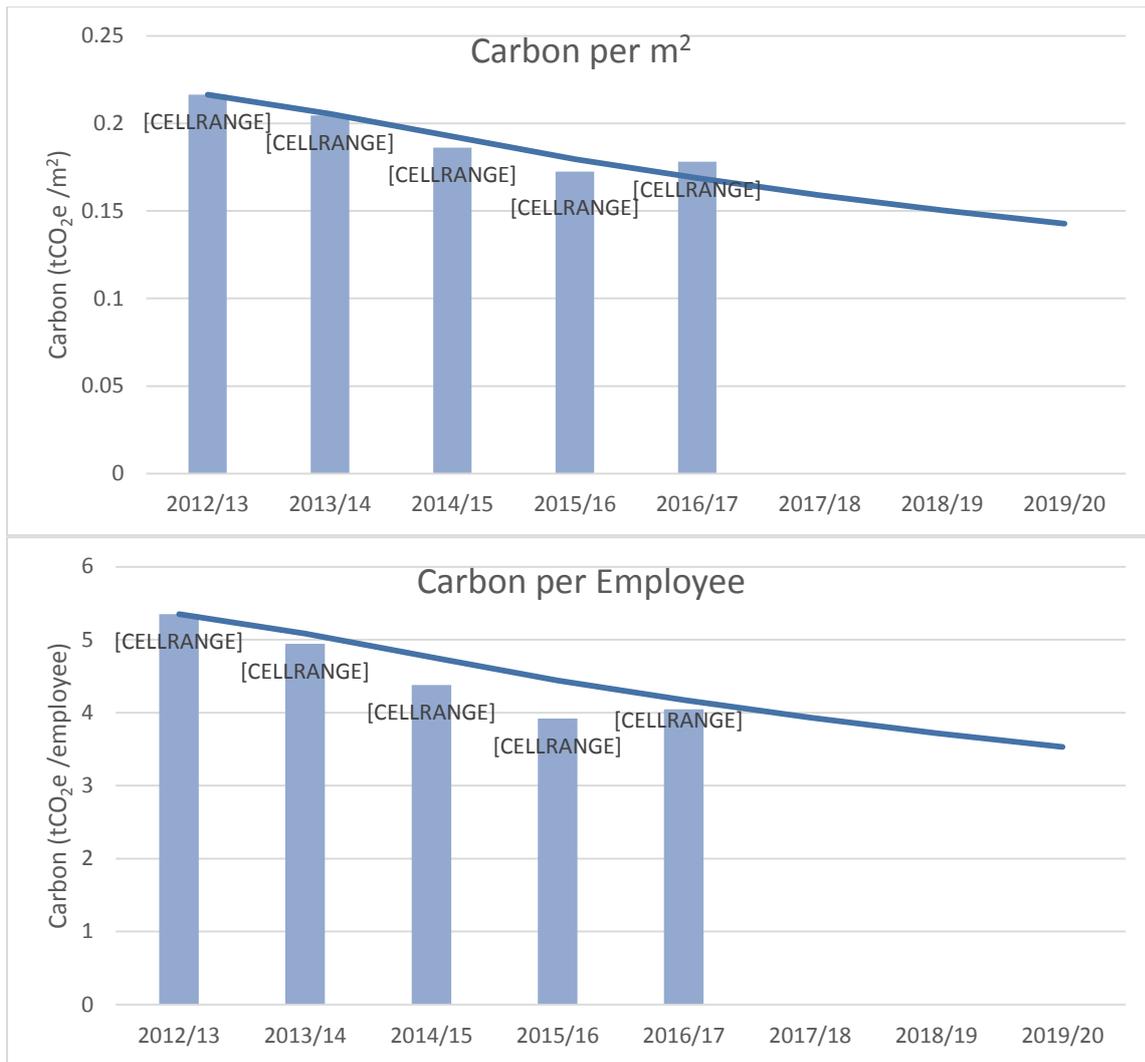


Figure 1: Normalised direct emissions - tCO₂e by m² and by employee, line shows reduction target

The increase in normalised carbon emissions from last year is due to less electrical output from the combined heat and power (CHP) engine, see below, and increased loads associated with the capital redevelopment. This meant that more electricity had to be imported from the grid, leading to higher carbon emissions. The remainder of this report uses figures that have been compared directly to the previous years with no normalisation for floor area or staff numbers so the year on year changes can be more clearly seen.

It is important to understand the carbon impact of all aspects of our work and not just our direct emissions. Table 1 shows the proportions of the carbon footprint by major usage areas, revealing that indirect emissions via procurement are the most significant contributor, followed by our direct emissions (energy), then travel.

Area	Emissions (tCO ₂ e) in 2016/17	Proportion of carbon footprint
Procurement	36,553	62.8%
Energy	16,468	27.6%
Travel	4,319	7.4%

Commissioning	1,174	2.0%
Water and sanitation	148	0.3%
Total	58,661	

Table 1: Trust Emissions Breakdown

Together, procurement and commissioning make up the largest proportion of the Trust’s carbon footprint. Using accepted SDU methodology for identifying procurement emissions, we identify that our two largest emitting categories are pharmaceuticals and medical equipment. We plan to investigate these and develop plans to reduce the carbon footprint of these areas. We have already made progress in some lower emission categories, for example our catering department endeavour to purchase food from London and the South East, where appropriate.

The Trust has undertaken a review and assessment of the whole supply chain at GOSH. This review has highlighted efficiencies can be made in materials management which we are in process of rolling out to create savings by reducing surplus stock and improving spend controls.

Energy

The biggest change to Trust energy usage profile has been the installation of a CHP engine at the end of 2011 which significantly reduced the amount of grid gas and electricity used by the Trust.

However, as Figure 2 shows, in 2016/17 the Trust saw an 8.1% increase in energy spend compared to 2015/16 (not including the operation and maintenance costs of the CHP engine). This was due to a reduction in energy generation by the CHP engine, caused by downtime in September 2016 due to a mechanical issue, which has now been rectified.

Another reason for greater use of grid energy this year is the ongoing capital redevelopment, which creates increased loads and caused interruptions to our energy centre.

Despite these challenges, the CHP engine generated 10,833 MWh, equivalent to 40% of GOSH’s electricity requirements this year, and consumed natural gas to achieve this. Additionally the Trust installed 37kW of photovoltaic cells in March 2016 to generate our own renewable energy. Over the last year these panels have generated 26,500 kWh which is equivalent to 0.1% of the sites electricity usage.

We are in the process of installing a second CHP which should further decrease our dependency on grid electricity and reduce energy costs.

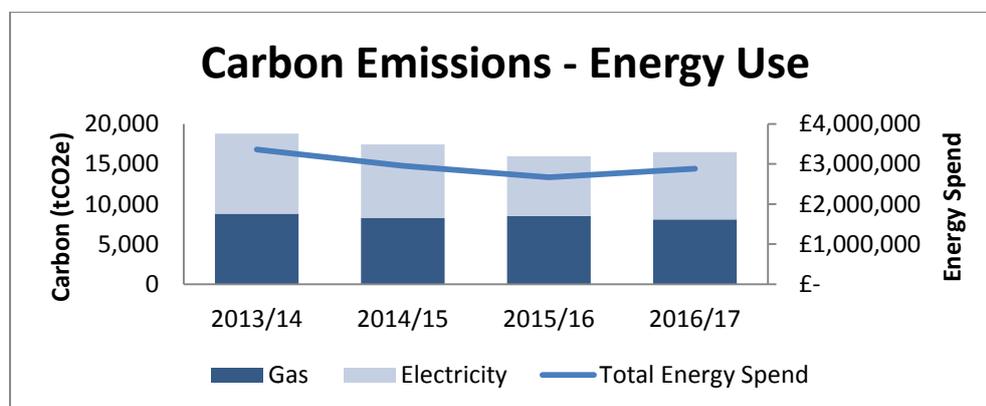


Figure 2: Carbon Emissions by year

Figure 2 shows that the overall carbon emissions from energy use have increased by 3.2% from 2015/16 but have decreased by 17.4% from the 2012/13 baseline year.

Travel

We can improve local air quality and improve the health of our community by promoting active and non-carbon intense travel – for our staff, patients and public that use our services. We also support a culture of active travel to improve staff wellbeing and reduce sickness, an example of this is providing secure cycling storage for employees. Our impact from travel is shown in Table 2.

Category	Mode	2013/14	2014/15	2015/16	2016/17
Patient Transport Mileage	miles	422,229	404,360	463,149	466,824
	tCO ₂ e	156	148	167	168
Business Travel	tCO ₂ e	2,421	2,795	2,762	2,738
Staff commute	miles	3,498,983	3,827,100	3,907,792	3,907,792
	tCO ₂ e	1,293	1,406	1,413	1,412

Table 2: Travel Impact

Staff commuting impact is estimated from total number of staff on site and average distances travelled from National Travel Survey figures. It has risen as staff numbers increase but we intend to improve the accuracy of our reporting in this area – and develop bespoke programmes of impact reduction - by understanding GOSH’s particular staff commute profile.

Our business travel impact has been estimated from the Trust spend profile. Whilst we understand how our travel spend is split as shown in Figure 3, we do not understand the carbon impact of each of the areas and we plan to improve our understanding of this in the coming year to develop mitigation strategies.

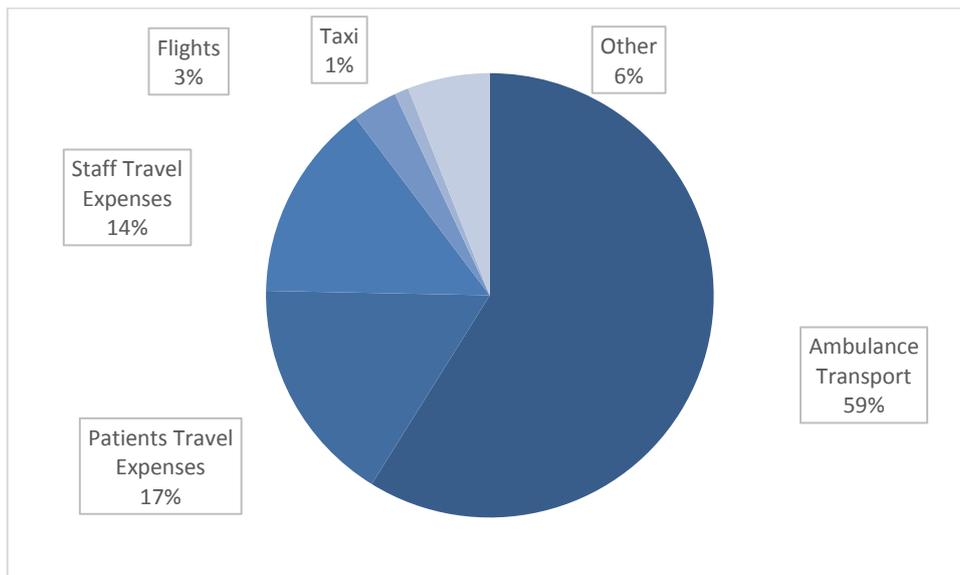


Figure 3: Travel Spend Breakdown

We also recognise the impact that patient transport has on the environment and have clear guidelines on the use of patient transport. We are in the process of engaging the wards in the importance of this and have been working to reduce unnecessary trips.

In 2014 GOSH started making use of video conferencing to connect clinicians to patients in harder to reach areas. This has helped reduce the number of journeys that patients need to take. Several departments, such as genetics and cardiac, now use video conferencing.

Waste minimisation and management

The Trust recognises the importance of reducing waste and in particular waste sent to landfill. This year 1,132 tonnes of waste were created, a 5% reduction from the previous year. Waste to landfill remains virtually zero with less than one tonne being sent to landfill. It is our aim that zero waste produced by the Trust is sent to landfill and we hope to achieve this in the next two years.

Our waste sent for recycling rose to 30% this year, up from 20% in 2014/15. This increase has been achieved through the development of a group of 'Green Champions' that helped support the implementation of a waste reduction program. Additionally we have replaced desk bins with centralised recycling units to encourage recycling.

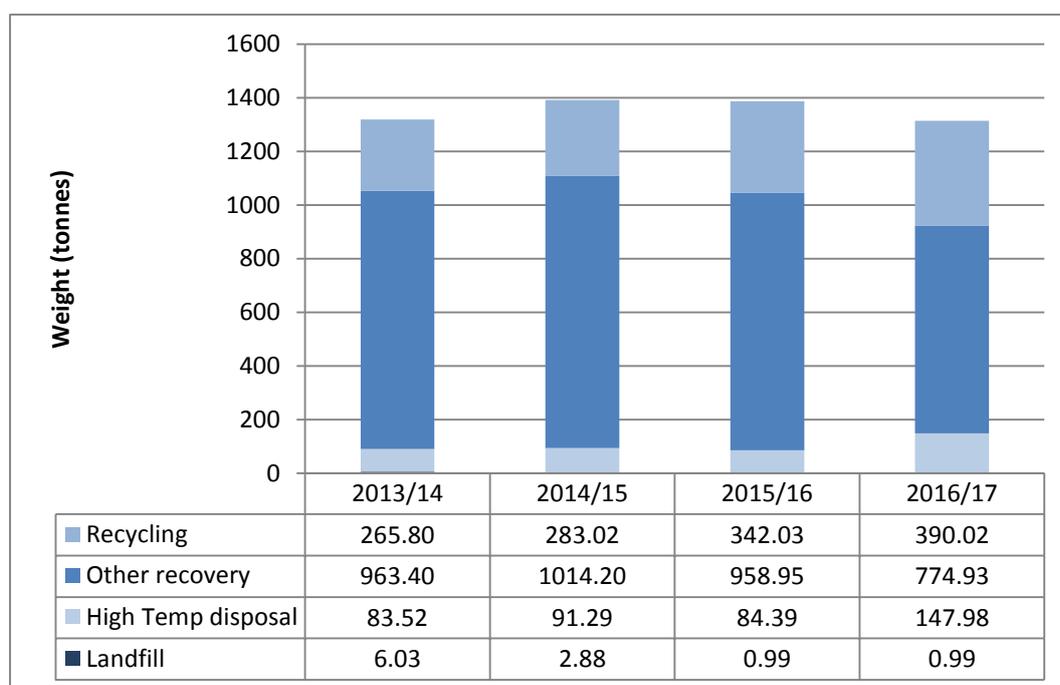


Figure 4. Destinations of Trust waste, landfill accounts for too little to be shown on the chart.

The Trust is currently investigating alternative waste disposal methods to further reduce the environmental and carbon impact of its waste. Additionally we are looking to reduce incoming packaging waste delivered to site.

Water Consumption

GOSH's focus has in the past been on our carbon use, however this year we have widened our environmental sustainability efforts to include water use. In 2016/17 we used 6.2% less water than in 2015/16. In the coming year we plan to implement further changes to reduce our water use as we recognise this is still an improvement area.

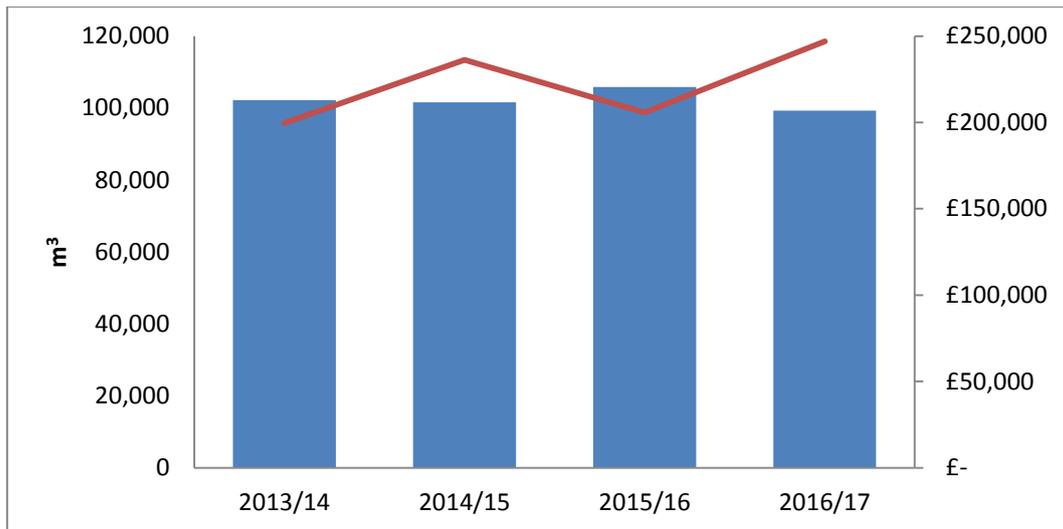


Figure 4: Mains Water use by year (m³) – Orange Line shows spend (RHS Axis)

Social, community and human rights

Good corporate citizenship means that not only do we care for our patients, their families and our staff, but we also look outside our organisational boundaries. In 2016/17 GOSH continued to expand our apprenticeship programmes and 73 apprentices started work with us.

In November 2016 the Trust welcomed five young people with learning disabilities onto nine-month internships. The students from Camden and Islington FE College are participating in Project Search, helping them to bridge the gap between school and employment. For more information see the story on [pX](#)

GOSH healthcare scientists participated in Reach Out for Healthcare Science week in June – a London-wide initiative to provide taster sessions in healthcare science to GCSE students.

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Victims are coerced, deceived and forced against their will. The Trust provides training to relevant staff on identifying victims of modern slavery and reports on case and concerns raised at the Quality and Safety Assurance Committee. Although NHS trusts are not bound by the Government's 'Duty to Notify' they are encouraged to do so in order to clarify the picture of modern slavery in the UK.

Important events since year end

Departing Chairman

After serving eight years at GOSH, in December 2016, Baroness Blackstone announced that she will be standing down as Chairman of the Trust Board and Members' Council in April 2017. Under Baroness Blackstone's leadership the Trust achieved Foundation Trust status and saw a major increase in the number of patients treated at GOSH annually. Large parts of the hospital have been developed, including the opening of the Morgan Stanley Clinical Building and construction of the

adjacent Premier Inn Clinical Building (due to open in Summer 2017), along with development of the new Zayed Centre for Research into Rare Disease in Children. Baroness Blackstone has been instrumental in the planning of phase 4 redevelopment (the frontage building). We wish to offer our sincere thanks to Baroness Blackstone for her contribution and service to GOSH.

Redevelopment

The Premier Inn Clinical Building, the second part of the Mittal Children's Medical Centre, will open to patients in August 2017. Further information can be found on page **XX**.

Research

We want more patients to have the opportunity to take part in research and from April 2017 will pilot a generic consent process to allow us to use excess tissue and blood samples for future research. We received a licence from the Human Tissue Authority on 31 March 2017 that allows us to store these samples, and will enable us to develop a unique research resource to aid discovery in paediatric rare diseases.

New Chairman

In May 2017, XXXXXXXX was appointed by the Members' Council as Chairman of Great Ormond Street Hospital from 1st November 2017.

NHS cyber attack

Following the cyber-attack on a number of NHS hospitals in May 2017, the Trust immediately took mitigating action and isolated the computer systems and closed down all external email services. The Trust IT systems were fortunately not affected by the virus that impacted other NHS trusts and there was no impact on the treatment and care of patients. At the time of writing this report, work is continuing to strengthen our security and implement our Cyber Security Plan.

Looking ahead to 2017/18 – a refreshed GOSH strategy

Like many NHS providers, GOSH is operating in a challenging environment. We continue to experience increasing costs, a requirement for stronger collaboration between care providers and commissioners, and a shortage of nurses and junior doctors.

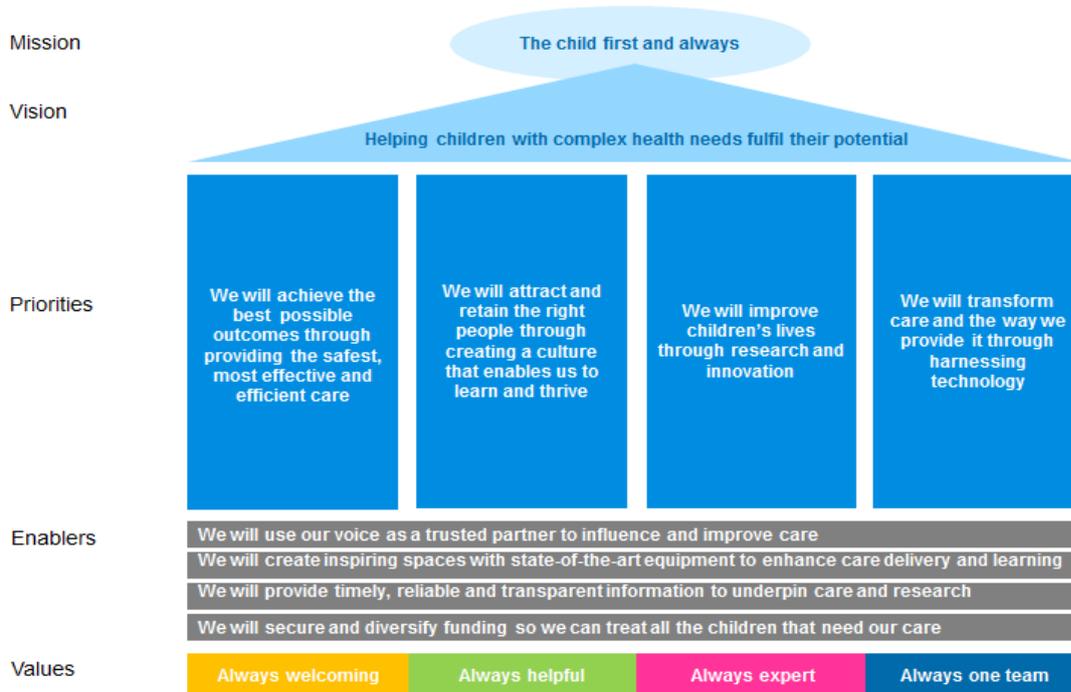
However, the environment also presents some exciting opportunities. For example, research helps us to continuously advance the treatments we offer, our services will become increasingly digital to reduce costs and improve access, and our buildings and facilities are being redeveloped to be inspiring and uplifting for our patients.

In spring 2017 we worked with our staff and Members' Council to refresh our strategy in the context of this new reality. We have assessed the issues and opportunities that face us, and thought carefully about our vision and our future. In particular, we have identified four critical priorities:

- We will provide the safest, most effective care, with the best possible outcomes.
- We will attract and retain the right people and together create a culture that enables us to learn and thrive.
- We will improve children's lives through research and innovation.

- We will harness digital technology to transform the care we provide and the way we provide it.

These priorities are presented in a ‘strategy house’ below along with our mission, vision, enablers and Our Always Values. Together, they form a framework that teams across the Trust, and our leadership, will use to plan and make decisions.



Statement from Directors

The directors consider that this Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for readers to assess the Trust’s performance, business model and strategy.

Signed by the Chief Executive on behalf of the Trust Board of Great Ormond Street Hospital for Children NHS Foundation Trust.

Dr Peter Steer
 Chief Executive
 DATE

Accountability report

Directors' report

In this section of the Accountability report we provide an overview of our governing structures. We outline how we ensure we are involving, listening and responding to the groups that have a stake in what we do, particularly our staff, our patients and their families and our members.

How GOSH is governed

The Trust Board is responsible for overseeing the Trust strategy, managing strategic risks, and providing managerial leadership and accountability. The Executive Team has delegated authority from the Board for the operational and performance management of clinical and non-clinical services of the Trust. It is responsible for co-ordinating and prioritising all aspects of risk management issues that may affect the delivery of services.

The Senior Management Team reports to the Executive Team and provides a regular forum for discussing and making decisions on a range of issues relevant to the day to day operational management, including efficiency, effectiveness and quality.

In 2015 the Trust's introduced a new 'three division' structure; two NHS divisions and one International Private Patient (IPP) division. This has helped us provide a more integrated and efficient service for the children we treat. It has also accelerated our decision making by strengthening the involvement of the clinical leadership in the management of the hospital. Corporate functions have increasingly been integrated with the operational teams – in particular through business partnering with finance and HR.

The Trust Board – who we are and what we do

The Board is normally comprised of a Chairman, Deputy Chairman, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by the UCL Great Ormond Street Institute of Child Health (ICH).

With the departure of Tessa Blackstone, Chairman on 30th April 2017 (see page xx), Mary MacLeod, Deputy Chairman was appointed by the Members' Council as Interim Chairman from 1st May 2017 whilst the appointment process for a substantive post was conducted. Until this appointment is filled, the Board will comprise an Interim Chairman and four Non-Executive Directors. With the impending departure of Mary MacLeod in October 2017, an appointment process for a new Non-Executive Director (agreed by the Members' Council) is also underway.

The Executive Directors are responsible for managing the day-to-day operational and financial performance of the Trust, while the Non-Executive Directors provide scrutiny based on Board-level experience of private and public sector organisations.

This year an independent Well Led Governance Review concluded that the Executive Directors and Non-Executive Directors bring substantial experience to the Board and come from a range of

professional backgrounds, including higher education, local authority, business and healthcare. All Board members have been assessed against the requirements of the Fit and Proper Person Test.

Trust Board members 2016/17

Non-executive directors

Baroness Tessa Blackstone

Chairman of the Trust Board and Members' Council

Term: 1 January 2009 – 30 April 2017

Attended 11 out of 11 Board meetings in 2016-17

Chairman of:

- Trust Board Nominations Committee (attended 1 meeting of 1 in 2016-17)

Member of:

- Trust Board Remuneration Committee (attended 2 meetings of 2 in 2016-17)

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Experience:

- Member, House of Lords
- Chair of the British Library Board
- Director of University College London (UCL) Partners
- Chair of Orbit Group
- Co-Chair of the Franco-British Council

Insert Tessa
Blackstone image

Ms Mary MacLeod OBE

Deputy Chairman (from 1 September 2016) and Senior Independent Director and

Interim Chairman (from 1st May 2017)

Term: 1 September 2008 – 31 October 2017

Attended 10 out of 11 Board meetings in 2016-17

Chairman of:

- Quality and Safety Assurance Committee (attended 4 meetings of 4 in 2016-17)

Member of:

- Trust Board Remuneration Committee (attended 2 meetings of 2 in 2016-17)
- Trust Board Nominations Committee (attended 1 meeting of 1 in 2016-17)

Experience:

- Non-executive Equality and Diversity lead at Great Ormond Street
- Deputy Chair of the Child and Family Court Advisory and Support Service (CAFCASS)
- Chair of the Internet Watch Foundation Ethics Committee
- Trustee of Columbia 1400
- Non-Executive Director of the Video Standards Council
- Chief Executive of the Family and Parenting Institute (1999–2009)
- Director of Policy, Research and Development and Deputy CEO of Childline (1995-99)

Insert Mary
MacLeod image

Mr Akhter Mateen

Non-Executive Director and Deputy Chairman (from 1 May 2017)

Term: 28 March 2015 – 27 March 2018

Attended 11 out of 11 Board meetings in 2016-17

Chairman of:

- Audit Committee from 1st September 2016 (attended 4 meetings out of 4 in 2016-17)

Member of:

- Finance and Investment Committee (attended 6 meetings of 7 in 2016-17)
- Trust Board Remuneration Committee (attended 1 meetings of 2 in 2016-17)
- Trust Board Nominations Committee (attended 1 meeting of 1 in 2016-17)

Experience:

- Group Chief Auditor of Unilever (2011–2012)
- Senior Global and Regional Finance roles Unilever, leading finance teams in Latin America, South East Asia and Australasia. (1984–2011)
- Independent Member of the Advisory Board of FMCG company SuperMax
- Director of The British Pakistan Foundation

Insert Akhter Mateen
image

Mr David Lomas

Non-Executive Director

Term: 1 March 2012 – 28 February 2018

Attended 11 out of 11 Board meetings in 2016-17

Chairman of:

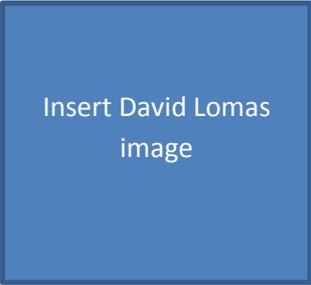
- Finance and Investment Committee (attended 7 meetings of 7 in 2016-17)
- Trust Board Remuneration Committee (attended 2 meetings of 2 in 2016-17)

Member of:

- Audit Committee (attended 4 meetings of 4 in 2016-17)
- Trust Board Nominations Committee (attended 1 meeting of 1 in 2016-17)

Experience:

- Qualified accountant
- Chief Financial Officer of Achilles
- Chief Financial Officer of Elsevier (until July 2014)
- Chief Executive of British Telecom Multimedia Services (2004–05) (previously Chief Operating Officer)
- Vice President Operational Effectiveness of British Telecom Global Services (2003–04)
- Chief Commercial and Operations Officer, ESAT British Telecom, Dublin (2002–03)



Insert David Lomas
image

Professor Rosalind Smyth CBE

Non-Executive Director

Term: 1 January 2013 – 31 December 2018

Attended 9 out of 11 Board meetings in 2016-17

Member of:

- Quality and Safety Assurance Committee (attended 4 meetings of 4 in 2016-17)
- Trust Board Remuneration Committee (attended 1 meeting of 2 in 2016-17)
- Trust Board Nominations Committee (attended 1 meeting of 1 in 2016-17)

Experience:

- Director of the UCL Great Ormond Street Institute of Child Health
- Honorary Consultant Respiratory Paediatrician at Great Ormond Street Hospital.
- Honorary Professor of Paediatric Medicine at the University of Liverpool
- Chair of the MRC Clinical Training and Careers Panel
- Chair of the Paediatric Expert Advisory Group of the Commission on Human Medicines (2002-2013)
- Previously the Director of the UK Medicines for Children Research Network



Insert Rosalind Smyth
image

Professor Stephen Smith

Non-Executive Director

Term: 1 March 2016 – 28 February 2019

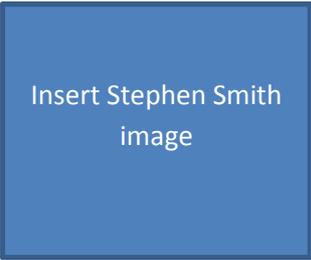
Attended 11 out of 11 Board meetings in 2016-17

Member of:

- Quality and Safety Assurance Committee (attended 4 meetings of 4 in 2016-17) – Chairman (from 1st May 2017)
- Trust Board Remuneration Committee (attended 2 meetings of 2 in 2016-17)
- Trust Board Nominations Committee (attended 1 meeting of 1 in 2016-17)

Experience:

- Professor of Obstetrics and Gynaecology
- Chief Executive, Imperial Healthcare NHS Trust (October 2007 – December 2010)
- Dean, Faculty of Medicine Dentistry and Health Sciences, University of Melbourne (September 2013 – October 2015)
- Chairman of the Melbourne Academic Centre for Health (July 2014 – October 2015)



Insert Stephen Smith
image

Mr James Hatchley

Non-Executive Director and Senior Independent Director (From 1 May 2017)

Term: 1 August 2016 – 31 July 2019

Attended 7 out of 7 Board meetings in 2016-17

Member of:

- Audit Committee (attended 2 meetings of 2 in 2016-17)
- Quality and Safety Assurance Committee (attended 2 meetings of 2 in 2016-17)
- Finance and Investment Committee (attended 4 meetings of 4 in 2016-17)
- Trust Board Remuneration Committee (attended 2 meetings of 2 in 2016-17)
- Trust Board Nominations Committee (attended 1 meeting of 1 in 2016-17)

Experience:

- Qualified accountant
- Former independent member of the GOSH Audit Committee and Quality and Safety Assurance Committee
- Group Strategy Director 3i Group
- Chief Operating Officer KKR (2014 – 2016)

Insert James Hatchley
image

Mr Charles Tilley

Deputy Chairman (until 31st August 2016)

Term: 1 March 2012 – 31 August 2016

Attended 4 out of 4 Board meetings in 2016-17

Chairman of:

- Audit Committee (attended 2 meetings of 2 in 2016-17)

Member of:

- Trust Board Remuneration Committee (attended 1 meeting of 1 in 2016-17)
- Trust Board Nominations Committee (attended 1 meeting of 1 in 2016-17)

Experience:

- Qualified accountant
- Chief Executive Officer at The Chartered Institute of Management Accountants (CIMA)
- Director (corporate representative) CIMA China Ltd
- Director (corporate representative) CIMA Enterprises Limited
- Board member of the Association of International Certified Professional Accountants
- Member of the International Integrated Reporting Council (IIRC)
- Chairman of the Professional Accountants in Business Committee (PAIBC)
- Member of the Advisory Council of HRH The Prince of Wales' Accounting for Sustainability Project (A4S)

Insert Charles Tilley
image

Executive directors

Dr Peter Steer

Chief Executive

Peter Steer is responsible for delivering the strategic and operational plans of the hospital through the Executive Team.

Attended 11 out of 11 Board meetings in 2016-17

Member of:

- Quality and Safety Assurance Committee (attended 4 meetings of 4 in 2016-17)
- Finance and Investment Committee (attended 7 meetings of 7 in 2016-17)

Attendee of:

- Audit Committee (attended 4 meetings of 4 in 2016-17)
- Trust Board Nominations Committee (attended 1 meeting of 1 in 2016-17)
- Trust Board Remuneration Committee (attended 2 meetings of 2 in 2016-17)

Experience:

- Chief Executive – Children’s Health Queensland Hospital and Health Services (2009 – 2014)
- Professor of Medicine, University of Queensland (2009-2014)
- Adjunct Professor, School of Public Health, Queensland University of Technology (2003 – 2008)
- President – McMaster Children’s Hospital, Hamilton, Ontario (2003 – 2008)
- Professor and Chair, Department of Paediatrics, McMaster University, Canada (2003-2008)

Insert Peter Steer image

Ms Nicola Grinstead

Deputy Chief Executive

Nicola Grinstead is responsible for the Trust’s strategic planning and is responsible for the operational management of the clinical services within the Trust. She is the named Senior Information Risk Owner.

Attended 10 out of 11 Board meetings in 2016-17

Member of:

- Quality and Safety Assurance Committee (attended 3 meetings of 4 in 2016-17)
- Finance and Investment Committee (attended 6 meetings of 7 in 2016-17)

Attendee of:

- Audit Committee (attended 3 meetings of 4 in 2016-17)

Experience:

- Director of Operations, Imperial Healthcare NHS Trust (2013 - 2016)
- Deputy Director of Operations, Guy’s and St Thomas’ NHS Foundation Trust (2009 – 2013)
- Chair of the World Board for the World Association of Girl Guides and Girl Scouts.

Insert Nicola Grinstead image

Dr David Hicks

Interim Medical Director (from 1 January 2017)

David Hicks is responsible for clinical performance and standards (including patient safety) and Leads on quality governance.

Attended 3 out of 3 Board meetings in 2016-17

Member of:

- Quality and Safety Assurance Committee (attended 1 meeting of 1 in 2016-17)

Experience:

- Previously consultant in sexual health
- Medical Director, Barnsley Hospital NHS Foundation Trust (2002-2009) include one year as Acting Chief Executive
- Clinical and Professional Adviser to the Care Quality Commission
- Non-Executive Director, , Mid Yorkshire Hospitals NHS Foundation Trust (2013-2017)
- Medical Director, Rotherham NHS Foundation Trust (2013-2014)

Insert David Hicks image

Ms Juliette Greenwood

Chief Nurse

Juliette Greenwood is responsible for the professional standards, education and development of nursing. She is also the Lead Executive responsible for patient and public involvement and engagement, safeguarding and infection prevention and control.

Attended 11 out of 11 Board meetings in 2016-17

Member of:

- Quality and Safety Assurance Committee (attended 4 meetings of 4 in 2016-17)

Experience:

- Registered Sick Children's Nurse
- More than 12 years' experience as a Chief Nurse, most recently at Bradford Teaching Hospitals NHS Foundation Trust (2013-2015) and prior to this at Rotherham NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust.

Insert Juliette
Greenwood image

Ms Loretta Seamer

Chief Finance Officer

Loretta Seamer responsible for the financial management of the Trust and leads on contracting

Attended 11 out of 11 Board meetings in 2016-17

Member of:

- Finance and Investment Committee (attended 7 meetings of 7 in 2016-17)

Attendee of:

- Audit Committee (Attended 4 meetings of 4 in 2016-17)

Experience:

- More than thirty years of experience in Executive Leadership, consulting and financial management including thirteen years in the hospital and health sector
- Chief Finance Officer, Children's Health Queensland and Health Services in Brisbane, Australia
- General Manger of a Health Consulting and advisory Practice, Brisbane, Australia

Insert Loretta
Seamer image

Mr Ali Mohammed

Director of HR and OD

Ali Mohammed is responsible for the development and delivery of a human resources strategy and organisational development programmes.

Attended 10 out of 11 Board meetings in 2016-17

Member of:

- Quality and Safety Assurance Committee (attended 3 of 4 meetings in 2016-17)

Attendee of:

- Trust Board Nominations Committee (attended 1 meeting of 1 in 2016-17)
- Trust Board Remuneration Committee (attended 2 meetings of 2 in 2016-17)

Experience:

- Director of Human Resources and Organisational Development (Service Design) for the NHS Commissioning Board (2012-13)
- Director of Human Resources and Organisational Development at Barts and The London NHS Trust (2009-12)
- Director of Human Resources at Brighton and Sussex University Hospitals NHS Trust (2007-08)
- Director of Human Resources at Medway NHS Trust (2001-07)

Insert Ali
Mohammed image

Dr Vinod Diwakar

Medical Director (until 31 December 2016)

Attended 5 out of 8 Board meetings in 2016-17

Member of:

- Quality and Safety Assurance Committee (attended 2 of 3 meetings in 2016-17)

Experience:

- Practicing Consultant Paediatrician
- Medical Director at Birmingham Children's Hospital NHS Foundation Trust (2010 – 2015)
- Appointed member of the London Clinical Senate
- Appointed member of the London Children and Young People's Healthy Partnership Clinical Reference Group
- Chair of the Clinical Reference Group for Paediatric Medicine in NHS Specialised Commissioning

Insert Vinod Diwakar
image

Other Directors**Ms Cymbeline Moore**

Director of Communications

Cymbeline Moore is the Director of Communications for the hospital and the GOSH Children's Charity

Mr Matthew Tulley

Director of Development

Matthew Tulley leads the work to redevelop the Trust's buildings and ensures that it is suitable to support the capacity and quality ambitions of our clinical strategy.

Professor David Goldblatt

Director of Research and Innovation

David Goldblatt leads the strategic development of clinical research and development across the Trust. He is an Honorary Consultant Immunologist and Director of the NIHR Biomedical Research Centre.

Mr Trevor Clarke

Director of International and Private Patients

Trevor Clarke is responsible for the strategic development and management of the Trust's IPP division.

Mrs Claire Newton

Interim Director of Strategy and Planning (until 21 July 2016)

Register of Interests

The Board of Directors has signed up to the Board of Directors' Code of Conduct setting out the requirement for all Board members to declare any interests that may compromise their role. This is also a standing item at the beginning of each Board and committee meeting.

A Register of Directors' Interests is published on the Trust website, gosh.nhs.uk, and can also be obtained by request from the Company Secretary, Great Ormond Street Hospital for Children NHS Foundation Trust, Executive Offices, Paul O'Gorman Building, Great Ormond Street, London WC1N 3JH.

Trust Board meetings

In 2016/17, the Board held a total of 11 meetings of which six included a session held in public. In October 2016 and February 2017 the Board held strategy development sessions. The Board did not meet in August 2016. An extraordinary Board meeting was held in November 2016. Board seminar meetings were held in April and June 2016.

Board Committees

The Board delegates certain functions to committees that meet regularly. The Board receives any amendments to committee terms of reference, annual reports and committee self-assessments. One

Non-Executive Director sits on both the Audit Committee and Quality and Safety Assurance Committee to provide a link and ensure that information is effectively passed between them. Members of both assurance committees meet annually to discuss strategic risk and consider how the committees effectively share responsibility for monitoring strategic risk on behalf of the Board.

Audit Committee

The Audit Committee is chaired by a Non-Executive Director and has delegated authority to review the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes to support the organisation's objectives. A summary of the work of the committee can be found on [page XX](#).

Quality and Safety Assurance Committee

In 2016 the Clinical Governance Committee was renamed the Quality and Safety Assurance Committee. The new name reflects its extended remit to seek assurance of the quality of care and treatment in all services, including clinical effectiveness and outcomes, safety, service user and carer experience, equality and inclusion. The committee is chaired by a Non-Executive Director and has delegated authority from the Board to be assured that the correct structure, systems and processes are in place within the Trust to manage quality and safety related matters and that these are monitored appropriately. A summary of the work of the committee can be found on [page XX](#). The committee receives regular internal audit and clinical audit reports.

Finance and Investment Committee

The Finance and Investment Committee is chaired by a Non-Executive Director and has delegated authority from the Board to oversee financial strategy and planning, financial policy, investment and treasury matters and to review and recommend for approval major financial transactions. The committee also maintains an oversight of the Trust's financial position, and relevant activity data and workforce metrics.

Trust Board Remuneration Committee

The Remuneration Committee is chaired by a Non-Executive Director and is responsible for reviewing the terms and conditions of office of the Board's Executive Directors, including salary, pensions, termination and/or severance payments and allowances. A summary of the work of the committee can be found on [page XX](#).

Trust Board Nominations Committee

The Trust Board Nominations Committee is chaired by the Chairman of the Board. It has responsibility for reviewing the size, structure and composition of the Board and making recommendations with regard to any changes – giving full consideration to succession planning and evaluating the balance of skills, knowledge and experience in relation to the appointment of both Executive and Non-Executive Directors.

During the year, following the announcement that Dr Vinod Diwakar would step down from the role of Medical Director, the committee recommended the appointment of Dr David Hicks as Interim Medical Director while the post was reviewed prior to advert and appointment.

Evaluation of Board Performance

An independent review against the Monitor Well Led Governance Framework (incorporating elements of the quality governance framework) was conducted by Deloitte in June 2016 following a competitive tender process. Deloitte LLP is the Trust's appointed external auditor. None of the engagement team undertook any external audit work at the Trust in the previous three years. In addition, a number of robust and effective safeguards were put in place to enable Deloitte to undertake this additional advisory work.

The results and action plan were presented to the Board in December 2016. The review highlighted a number of positive areas in relation to the governance and leadership of the Trust, with some recommendations for improvement around Board reporting, Board development and the relationship between the Board and Members' Council.

The Board and Council have received regular updates on progress with the action plan. A Well Led Governance Review Group has been established, with members from both the Board and the Council to oversee recommendations on roles and responsibilities of the Board and the Council and learn from other Trusts about how to facilitate effective engagement and communication.

How we govern quality at GOSH

The Trust places the highest priority on quality, measured through our clinical outcomes, patient safety and patient experience indicators. Our patients, carers and families deserve and expect the highest quality care and patient experience. Despite a range of changing and increasing pressures, we must ensure we manage and deliver services in a way that never compromises our commitment to safe and high quality care. The key elements of the Trust's quality governance arrangements are outlined in the Annual Governance Statement on page XX and include:

- Clear accountability at Trust Board level for safety and clinical quality objectives and structured reporting of performance against these objectives.
- Clear committee reporting structures with the Patient Safety and Outcomes Committee and Patient Family Experience and Engagement Committee.
- Internal processes to check that we meet our own quality standards and those set nationally.
- KPIs are presented at the Trust Board, including:
 - progress against external targets, such as how we minimise infection rates
 - internal safety measures, such as the effectiveness of actions to reduce cardiac and respiratory arrests outside of the intensive care units
 - process measures, such as waiting times
 - external indicators assessed and reported monthly by Monitor
- The Board is committed to encourage continuous improvement in safety and quality indicators and to establish mechanisms for recording and benchmarking clinical outcomes.
- Patient Stories at public Board highlighting where the quality of care could be improved and celebrating excellent practice and patient experience.

Further information can be found in the Quality Report on [page xx](#).

Following the independent review against the requirements of the Well Led Governance Framework, actions have been taken to strengthen representation of clinical risk on the Board Assurance Framework and enhance reporting to the Board via scorecards and focused reports from the assurance committees.

Through these methods, all of the data available on the quality of care in each specialty and service is considered as part of our internal and external management and assurance process.

Gastroenterology Review

The Royal College of Paediatrics and Child Health (RCPCH) was invited by the Trust in 2015 to conduct a review of the gastroenterology service, following a number of concerns expressed from within and outside the hospital about waiting times, communication and clinical governance of the service. The review found that the vast majority of our gastroenterology patients and their families received good standards of care. This included all patients being treated for inflammatory bowel diseases, motility, autoimmune gut diseases, congenital pseudo obstruction and nutritional management.

In a small group of patients with, or suspected as having, a complex condition known as Eosinophilic Lower Gastroenterology Disease or complex food allergies the reviewers acknowledged that this was a rare and complex clinical area with a lack of national or international consensus on the best way to manage these patients. There are no agreed clinical guidelines for the treatment of these patients.

The reviewers found the care of some of these patients to be of the highest standard. However, they also found some examples where care provided could have been better. In all these cases, the care packages have since been discussed with patients and their families and treatment has, where necessary, been modified. There is no evidence of any long term consequences to these patients.

The review also made recommendations to further enhance patient care and their experience particularly in our communication with patients, our administration processes and better patient and family access to psychological support. We are now implementing a robust action plan to ensure improvements in these areas take place.

Registration with the Care Quality Commission (CQC)

GOSH is registered with the CQC as a provider of acute healthcare services. The CQC visited the Trust in April and May 2015 as part of its rolling schedule of inspections. The report was published in January 2016 and services were rated as 'good' overall and 'outstanding' for being caring and for being effective. The Trust has implemented the majority of the recommendations. Further information can be found in the Quality Report on **page XX**.

The Members Council – who we are and what we do

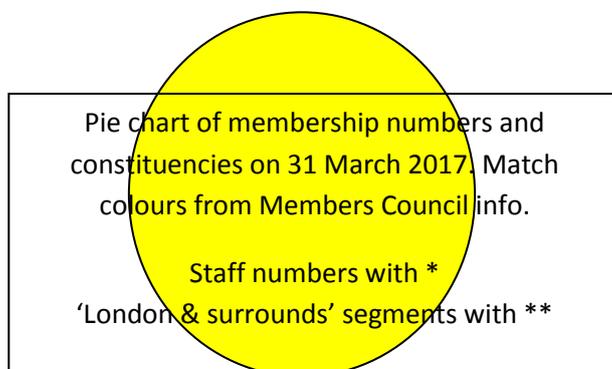
As a Foundation Trust we are accountable to our members through our Council of Governors, which at GOSH we call our Members' Council. The Members' Council is made up of 27 elected and appointed governors (councillors). They are the guardians of Our Always Values, and support and influence the strategic direction of the Trust by representing the views and interests of our members.

Membership

Anyone living in England and Wales over the age of 10 can become a GOSH member and we strive for our membership to reflect the broad and diverse public communities we serve as well as patients, their families and carers and staff. Automatic membership applies to all employees who hold a GOSH permanent contract or fixed term contract of 12 months or more. There is more on becoming a member at <http://www.gosh.nhs.uk/about-us/foundation-trust/foundation-trust-membership>.

On 31 March 2017 our membership totalled 13,910 (including staff). We have met and exceeded our estimated annual non-staff membership target of 9,481 by 45 and have increased our membership by 321 in the last year.

GOSH membership at 31 March 2017



Parents & carers, London: 2,235

Parents & carers, outside London: 3,453

Patients, London: 605

Patients, outside London: 613

Public, London and surrounds**: 1,953

Public, rest of England & Wales: 558

Out of Trust: 109

Staff*: 4,384

TOTAL: 13, 910

*Headcount of Foundation Trust staff on permanent contracts and fixed term contracts of one year and more

The electoral areas that comprise these public constituencies are detailed on **pX

In September 2016 we contracted an external membership database provider, Membership Engagement Services (MES) to hold and manage our public and patient carer data. The database enables the Trust to have direct control over data management and analysis, which supports the development of our membership strategy and evaluates the effectiveness of the Trust’s membership recruitment process. In order to ensure that our membership is current, a data cleansing exercise of our membership database was conducted on the migration to MES.

The role of the Members’ Council

The Members’ Council act as a link to the hospital’s patients, their families, staff and the wider community ensuring that their views are heard and reflected in the strategy for the hospital. Although the Council is not involved in the operational management of the Trust, it is responsible for holding the Non-Executive Directors individually and collectively to account for the performance of the Trust Board in delivering the Trust’s strategic objectives. More about the responsibilities of the Members’ Council can be found at www.gosh.nhs.uk/XXX

Councillors

Councillors represent specific constituencies and are elected or appointed to do so for a duration of three years with the option to stand for re-election for a further three years. As a specialist Trust with a UK-wide and international catchment area, GOSH does not have a defined ‘local community’. Therefore, it is important that our geographically diverse patient and carer population is represented in our membership and in the composition of our Members’ Council.

Councillors are elected or appointed from constituencies as follows:

GOSH Constituency		Members’ Council roles
Patient and carer members	Elect	10 patient/carer/parent councillors
Public members	Elect	7 public councillors
Staff members	Elect	5 staff councillors
Five appointed organisations	Appoint	5 appointed councillors

[designers to create graphic]

In November 2017 the Trust will begin the election process for 22 seats across the Patient and Carer, Public and Staff constituencies for appointment from 1 March 2018.

Councillor members 2016/17

Name	Constituency	Date role began (still active unless end date given)	Attendance at meetings		
			Members' Council (out of 5 unless otherwise stated)	Nominations & Remuneration Committee (out of 7 unless otherwise stated)	Membership Engagement Recruitment & Representation Committee (out of 5 unless otherwise stated)
Edward Green*	Patients: outside London	1 st March 2015	4	6 (6) Elected in April 2016	Not a member
George Howell*	Patients: outside London	1 st March 2015	3	Not a member	3
Sophie Talib**	Patients: London	1 st March 2015	4	Not a member	2
Susanna Fantoni~	Patients: London	1st March 2015 – February 2017	0	Not a member	0 (4)
Matthew Norris**	Parents and carers: London	1st March 2015	5	1 (1) Appointment ended in April 2016	Not a member
Lisa Chin-A-Young~	Parents and carers: London	1 st March 2015 – September 2016	2 (2)	1(1) Appointment ended in April 2016	3 (3)
Fran Stewart****	Parents and carers: London	October 2016	2 (2)	Not a member	2 (2)
Mariam Ali***	Parents and carers: London	1st March 2015	5	6 (6) Elected in April 2016	Not a member
Claudia Fisher** LEAD COUNCILLOR – endorsed in April 2016 for a further year	Parents and carers: outside London	1st March 2015	5	Not a member	2
Camilla Alexander-White**	Parents and carers: outside London	1st March 2015	3	Not a member	0 (4)
Carley Bowman***	Parents and carers: outside London	1 March 2015	4	Not a member	5
Trevor Fulcher**	Public: North London and	1 March 2015	1	Not a member	Not a member

Name	Constituency	Date role began (still active unless end date given)	Attendance at meetings		
			Members' Council (out of 5 unless otherwise stated)	Nominations & Remuneration Committee (out of 7 unless otherwise stated)	Membership Engagement Recruitment & Representation Committee (out of 5 unless otherwise stated)
	surrounding area ¹				
Rebecca Miller**	Public: North London and surrounding area ¹	1 March 2015	4	7 Re-elected in April 2016	Not a member
Mary De Sousa~	Public: North London and surrounding area ¹	1 March 2015 – April 2016	1 (1)	Not a member	Not a member
Teskeen Gilani****	Public: North London and surrounding area ¹	December 2016	0 (1)	Not a member	Not a member
Simon Hawtrey-Woore***	Public: North London and surrounding area ¹	1 March 2015	4	Not a member	4
Gillian Smith***	Public: South London and surrounding area ²	1 March 2015	5	Not a member	4
Stuart Player**	Public: The rest of England and Wales	1 March 2015	3	Not a member	Not a member
David Rose***	Public: The rest of England and Wales	1 March 2015	0	Not a member	Not a member
Jilly Hale**	Staff	1 March 2015	4	7 Re-elected unopposed in April 2016	Not a member
Clare McLaren**	Staff	1 March 2015	4	Not a member	Not a member
James Linthicum**	Staff	1 March 2015	4	Not a member	Not a member
Rory Mannion***	Staff	1 March 2015	4	Not a member	Not a member
Prab Prabhakar***	Staff	1 March 2015	4	Not a member	Not a member
Jenny Headlam-Wells**	London Borough of Camden	1 March 2015	4	Not a member	Not a member
Christine Kinnon**	University College London, Great Ormond Street Institute of Child	1 March 2015	5	Not a member	Not a member

Name	Constituency	Date role began (still active unless end date given)	Attendance at meetings		
			Members' Council (out of 5 unless otherwise stated)	Nominations & Remuneration Committee (out of 7 unless otherwise stated)	Membership Engagement Recruitment & Representation Committee (out of 5 unless otherwise stated)
	Health				
Olivia Frame ~	Self management uk	1 March 2015 – July 2016	0 (2)	Not a member	0 (2)
Lucy Moore****	Self management uk	October 2016	1 (2)	Not a member	Not a member
Muhammad Miah**	Great Ormond Street Hospital School	1 March 2015	3	Not a member	Not a member
Hazel Fisher	NHS England	31 March 2015	1	Not a member	Not a member

*Uncontested election in March 2015 for a second three-year term

** Re-elected or re-appointed in March 2015 for a second three-year term

*** newly elected in March 2015 for a three year term

**** newly elected or appointed in 2016

~stood down in 2016/17

¹The public constituency of North London and surrounding area incorporates the electoral areas of:

- North London: Barking & Dagenham, Barnet, Brent, Camden, City of London, Hackney, Ealing, Enfield, Hammersmith & Fulham, Haringey, Harrow, Havering, Hillingdon, Hounslow, Islington, Kensington & Chelsea, Newham, Redbridge, Tower Hamlets, Waltham Forest, Westminster.
- Bedfordshire: Bedford, Central Bedfordshire, Luton.
- Hertfordshire: Broxbourne, Dacorum, East Hertfordshire, Hertfordshire, Hertsmere, North Hertfordshire, St Albans, Stevenage, Three Rivers, Watford, Welwyn Hatfield.
- Buckinghamshire: Aylesbury Vale, Buckinghamshire, Chiltern, Milton Keynes, South Bucks, Wycombe.
- Essex: Basildon, Braintree, Brentwood, Castle Point, Chelmsford, Colchester, Epping Forest, Essex, Harlow, Maldon, Rochford, Southend on Sea, Tendring, Thurrock, Uttlesford.

²The public constituency of South London and surrounding area incorporates the electoral areas of:

- South London: Bexley, Bromley, Croydon, Greenwich, Royal Borough of Kingston upon Thames, Lambeth, Lewisham, Merton, Richmond upon Thames, Southwark, Sutton, Wandsworth.
- Surrey: Elmbridge, Epsom and Ewell, Guildford, Mole Valley, Reigate and Banstead, Runnymede, Spelthorne, Surrey Heath, Tandridge, Waverley, Woking.
- Kent: Ashford, Canterbury, Dartford, Dover, Gravesham, Maidstone, Medway, Sevenoaks, Shepway, Swale, Thanet, Tonbridge and Malling, Tunbridge Wells.
- Sussex: Brighton and Hove, East Sussex, Eastbourne, Hastings, Lewes, Rother, Wealden, Adur, Arun, Chichester, Crawley, Horsham, Mid Sussex, West Sussex, Worthing.

Members' Council Expenses

Councillors can claim reasonable expenses for carrying out their duties. For the year 2016/17 the total amount claimed by five councillors was £522.43.

Register of interests

Councillors sign a code of conduct and declare any interests that are relevant and material. The register of interests for all members of the Members' Council is published annually and can be found at <http://www.gosh.nhs.uk/about-us/foundation-trust/members-council/meet-councillors> and may also be obtained from the Company Secretary, Executive Offices, Paul O'Gorman Building, Great Ormond Street, London WC1N 3JH.

Contacting a Councillor

Anyone wanting to get in touch with a councillor and/or directors can email foundation@gosh.nhs.uk and the message is forwarded on to the relevant person. These details are included within the Foundation Trust 'contact us' section of the Great Ormond Street Hospital NHS Foundation Trust website, gosh.nhs.uk.

Trust Board and Members' Council working together

The Trust's Chairman is responsible for the leadership of both the Members' Council and the Trust Board. The Chairman is also responsible for effective relationship building between the Trust Board and councillors to ensure that councillors effectively perform their statutory duties and contribute to the forward planning of the organisation. There has been continued focus on developing relationships between the Members' Council and Non-Executive Directors in this reporting period with a dedicated group of councillors and Board members developing a programme of work to facilitate future engagement.

Examples of how the Council and Board work together include:

- Executive and Non-Executive Directors attend each Members' Council meeting
- Summaries of the Board Assurance Committees (Audit Committee, Quality and Safety Assurance Committee and Finance and Investment Committee) are presented by the relevant Non-Executive Director chairs of the committees at each Council meeting
- Summaries of Members' Council meetings are reported to the Trust Board
- The Members' Council has an open invitation to attend all Trust Board meetings
- The Members' Council receive the agenda and minutes of both the public and confidential Trust Board sessions
- Councillors observe at Trust Board Assurance Committee meetings
- Councillors and Board members sit on the Well led Governance Working Group.

In 2016/17 the Members' Council has:

- contributed to the development of the Trust's new Electronic Patient Record programme
- participated in the GOSH Well-Led Governance Review and Well-Led Governance Review Group
- been consulted on Phase 4 of the Trust's Redevelopment Project

- been consulted on the selection of an indicator for auditing for the Trust's Quality Report 2016/17
- developed the GOSH integrated Business Plan and strategy
- approved and conducted the appointment process for a new Chairman and a new Non-Executive Director.

Members' Council Nominations and Remuneration Committee

The Members' Council Nominations and Remuneration Committee has delegated responsibility for assisting the Members' Council in:

- reviewing the balance of skills, knowledge, experience and diversity of the Non-Executive Directors
- succession planning for the Chairman and Non-Executive Directors in the course of its work
- identifying and nominating candidates to fill Non-Executive posts
- considering any matter relating to the continuation of any Non-Executive Director
- reviewing the results of the performance evaluation process for the Chairman and Non-Executive Directors.

The committee is chaired by the Chairman of the Trust Board and Members' Council. Councillor members nominate themselves each year to sit on the Committee, and the length of tenure for a councillor will normally be three years.

Membership and attendance of councillors at meetings is detailed on page X.

Non-executive director appointments

Non-executive directors are appointed for a three-year tenure and can be reappointed for a further three years (subject to consideration and approval by the Members' Council).

In December 2016, Baroness Tessa Blackstone, Chairman of the Trust Board and Members' Council announced that she would be stepping down from role on 30 April 2017. The appointment process for a new Chairman was approved by the Members' Council in January 2017. External advisers from Harvey Nash supported the process, speaking to over 400 interested people across a range of sectors

Short-listed candidates were invited to attend the Trust to meet key stakeholders including representatives from the GOSH Children's Charity, University College London, senior GOSH clinicians and a parent representative. They were also taken on a tour of the hospital with an ex GOSH patient and a senior nurse. The interview panel included a majority of councillors (4) and the Interim Chairman. An independent panel member attended (a current Chairman of a large Foundation Trust) and the Chief Executive and representative from Harvey Nash observed the interview. The panel recommended to the Members' Council a preferred candidate. The Council were apprised of the outcome of the stakeholder panel meeting, tour, interview and information from referees. The Council approved the appointment of XXXX subject to satisfactory completion of relevant employment checks. The new Chairman will start in post on 1st November 2017 and will be invited to start a comprehensive induction programme on the lead up to his appointment.

In 2016/17, the following recommendations made by the Members' Council Nominations and Remuneration Committee were approved by the Members' Council:

- appointment of Mr James Hatchley, a new Non-Executive Director for a period of three years from 1 September 2016 – 31 August 2019
- appointment of Mary MacLeod, Non-Executive Director as Deputy Chairman from 1 September 2016
- the process for appointing a new Chairman of the Trust Board and Members' Council
- extension of the Deputy Chairman's tenure for two months ending on 31 October 2017
- the appointment of Mary MacLeod as Interim Chairman from 1st May 2017
- the appointment of James Hatchley as Senior Independent Director from 1st May 2017
- the appointment of Akhter Mateen as Deputy Chairman from 1st May 2017

The Trust Constitution explains how a Board member may not continue in the role if he/she has been:

- adjudged bankrupt
- made a composition or arrangement with, or granted a trust deed for, creditors and has not been discharged in respect of it
- in the preceding five years, convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

Annex 7 of the Constitution outlines additional provisions for the removal of the Chairman and Non-Executive Directors, which requires the approval of three-quarters of the members of the Members' Council. If any proposal to remove a Non-Executive Director is not approved at a meeting of the Members' Council, no further proposal can be put forward to remove such Non-Executive Director based upon the same reasons within 12 months of the meeting.

Other work of the committee

The Members' Council Nominations and Remuneration Committee conducted a benchmarking exercise on non-executive director remuneration packages. Further information can be found on page XX.

The committee considered the results of the appraisals of the Chairman and Non-Executive Directors as well as revised objectives for the Chairman and Non-Executive Directors for 2017-18. The Members' Council approved the results of the appraisals and the revised objectives at its meeting in April 2017.

Engaging GOSH patients, families and members

Patients and parents

We are committed to delivering the best possible patient experience and involving patients and families in making improvements. To understand how we're performing, we seek feedback from these groups in a variety of ways. Crucially, we ensure that we actively listen to both positive and

negative feedback, and respond with action when it's needed. To read about the improvements we made this year in response to comments, see [pXX](#) in the Performance Report.

Our routes for patient/parent feedback include some in common with other settings, such as the national Friends and Family Test (FFT) and the Patient Advice and Liaison Service (Pals). We also have bespoke ways through which we welcome views, such as our open Listening Events and our growing Young Peoples Forum for 11-25 year olds.

This year our Patient and Family Experience and Engagement Committee (PFEEC), which includes four parent representatives and key staff from across the hospital, drove several improvements. Parent representatives go on 'walkabouts' in the hospital, seeing the environment and feeling the atmosphere for themselves. For more information about the way we've developed the use of FFT at GOSH, see [pX](#) of the Quality Report.

Members

Members receive updates on hospital news and are invited to get involved throughout the year. We have seen an increase in members attending Members' Council Meetings as observers. Members also have the opportunity to vote in elections and stand for election to the Members' Council, [see page X](#)

The Membership and Engagement Committee, a subcommittee of the Members' Council, oversees the recruitment and retention of members and seeks to maximise engagement opportunities with members for the benefit of the Trust. The committee undertook a review of its role during the year and updated its Terms of Reference, changing its name to the Membership Engagement Recruitment and Representation Committee. This change reflects the importance of the role of Councillors in representing members.

The committee is chaired by a parent and carer councillor, with the support of a deputy chair from the public constituency. Last year's achievements included:

- development of membership case studies continued during an away day in September
- a steady growth of our patient and carer and public membership
- planning and delivery of a successful Annual General Meeting and Annual Members Meeting, including filming of the event which was published on the Trust website.

Complaints

All complaints are dealt with openly and honestly with the aim of providing appropriate remedy for the complainant. The Complaints Team coordinate the investigation of complaints to timescales agreed with the complainant, who are kept updated throughout. A final response is sent from a member of the Executive team and we usually offer a meeting with relevant staff to discuss any remaining concerns. If the complainant is not satisfied by the Trust's response, they can request the Parliamentary and Health Service Ombudsman (PHSO) to review their complaint.

As part of complaint investigations, we identify lessons learnt and areas for service improvement and devise action plans. These are logged and the Complaints Team follows up for regular progress reports from the staff responsible. Collaboration with Quality Improvement and Clinical Audit assures learning and accountability.

In 2016/17 GOSH received 103 formal complaints. Ninety-nine of these complaints were investigated in line with the NHS Complaint Regulations (some were withdrawn or related to care in previous years). During the year, one complaint was referred to the PHSO and accepted for investigation. The PHSO reached their final decision on two complaints during 2016/17 (one from a previous year). Of these, one was not upheld by the Ombudsman and one was partly upheld.

Consultations

In 2016/17, the Trust and Trust Board has consulted patients, families, members, the public and staff on a variety of issues:

- The Trust held a Listening Event in November 2016 (see page XX of the Quality Report).
- The Young Person's Forum and our staff took part in the Takeover Challenge, a national event launched by the Children's Commissioner for England, which challenges young people to take over prominent job roles within professional organisations.
- The Young Person's Forum took part in workshops to review how electronic patient records could work, including ideas for a 'patient portal' for patients to access information about appointments and test results.
- A survey was conducted about the breadth of research and interaction with research by staff, patients and parent/carers in the hospital to inform development of plans for the Research Hospital strategy.
- Some of the world's leading architects took part in a competition to design a new clinical building for the fourth phase of our on-going redevelopment programme. Staff, patients, families, carers and neighbours were invited to an exhibition showcasing their design ideas.
- An audit was conducted to learn from the experience of bereaved parents and carers whose children died at Great Ormond Street Hospital and evaluate how supportive the experience at GOSH was for the bereaved. Families noted the high quality and great value to the care they received at and following bereavement at GOSH and provided feedback on how communication between families could be further improved.
- In July 2016, NHS England published a set of proposals regarding the future commissioning of congenital heart disease (CHD) services for children and adults. They describe the actions which commissioners propose to take in order to ensure a consistent standard of care for CHD patients across the country. A consultation on the implications of the proposals started in February 2017, due to run to June 2017 to better understand how any changes might affect patients, carers and staff. The consultation outlines how GOSH is very close to meeting all of the national service standards. GOSH has submitted a response to NHS England about the implication of the standards on capacity at the Trust. In March 2017, a public event was held in partnership with NHS England, aimed at engaging staff and families in the proposals. The outcome of the consultation is awaited.

Volunteering

The Trust has an excellent reputation in the way we include, support and train our volunteers in diverse and exciting roles that add tremendous value. GOSH volunteers exemplify Our Always Values, being Always Welcoming, Helpful and One Team through all of their work.

This year we saw a significant increase in the number of people volunteering at GOSH, rising by more than 20% to just over 1,000 individuals.

Volunteers provide emotional and practical support for staff, patients and parents, as well as bringing some fun to a hospital stay for many children. Our volunteers work across 72 different roles, ranging from play volunteers and befrienders, to information desk volunteers and ward administrators.

Working with partner and stakeholder organisations

During 2016/17, the trust has entered into or continued with formal arrangements with the following organisations, which are essential to the Trust's business.

The UCL Great Ormond Street Institute of Child Health

In August 2016 the UCL Institute of Child Health became the UCL Great Ormond Street Institute of Child Health (ICH). This name change reflects the close and unique partnership between GOSH and our research partner, ICH, in driving the successful development of innovative new treatments for children with rare diseases. Together, we host the NIHR BRC and represent the largest concentration of paediatric research expertise in Europe, and the largest outside of North America.

Great Ormond Street Hospital Children's Charity

GOSH Children's Charity is a vital partner that offers tremendous support both by raising money and through its network of corporate partners. The Charity makes it possible for GOSH to redevelop its buildings, buy new equipment, fund paediatric research conducted at the hospital and at ICH, and to make the patient experience as good as it can be. In 2016/17, the Charity's total income was just over £92 million –another strong year. Further information about the work of the Charity can be found at goshcc.uk.

UCLPartners

One of five accredited academic health science systems in the UK, UCLPartners (UCLP) is an Academic Health Science Centre between UCL, Queen Mary University of London, the London School of Hygiene and Tropical Medicine, and four of London's most prestigious hospitals and research centres, including GOSH. By sharing knowledge and expertise between different specialist institutions through UCLP, GOSH can better support the advancement in scientific knowledge and ensure healthcare benefits are passed to patients as quickly as possible. Further information about UCLP can be found at uclpartners.com

Our commissioners

More than 90% of our clinical services are commissioned by NHS England, with the remaining 10% being delivered through arrangements with 205 Clinical Commissioning Groups (CCGs). The Trust has a proactive working relationship with NHS England, and holds regular contract meetings with commissioners to discuss service demand, quality indicators and finance. Many of our clinicians are engaging with the clinical reference groups established by NHS England to provide clinical input into standards and strategic planning of each specialised service.

Referrers and clinical networks

Many GOSH specialised services operate with other healthcare providers in local, regional and national clinical networks of care. GOSH teams also play a role in working with other healthcare

organisations, such as through the provision of outreach clinics, as a source of specialist clinical advice and as members of clinical reference and formulary groups. Working closely with referrers and within networks of care to strengthen shared care arrangements is a key strategic aim for the Trust.

Children's healthcare Alliance and European Children's Hospital Organisation

The Trust is a member of the Children's Healthcare Alliance, a strategic oversight body involving children's hospitals in the UK. The European Children's Hospital Organisation is a new organisation made up of different children's hospital from across Europe, providing an opportunity for hospitals that share a common mission face similar challenges to share expertise and contribute to the advancement of paediatric services. Dr Peter Steer, Chief Executive chairs both of these meetings.

Remuneration report

The Board Remuneration Committee is chaired by a non-executive director and is responsible for reviewing the terms and conditions of office of the Board's Executive Directors, including salary, pensions, termination and/or severance payments and allowances.

Directors' remuneration

Details of remuneration, including the salaries and pension entitlements of the Board of Directors, are provided on page **XX**. The only non-cash element of the most senior managers' remuneration packages is pension-related benefits accrued during membership of the NHS Pension Scheme. Contributions into the scheme are made by both the employer and employee in accordance with the statutory regulations.

Remuneration policy

The structure of pay for senior managers is designed to reflect the long-term nature of the Trust's business and the significance of the challenges we face. The remuneration should therefore ensure that it acts as a legitimate and effective method to attract, recruit and retain high performing individuals to lead the organisation. That said, the financial and economic climate across the health sector position must also be considered.

NHS Trusts, including Foundation Trusts, are free to determine the pay for senior managers, in collaboration with the Board of Directors' Remuneration Committee. Historically, reference has been made to benchmarking information available from other comparable teaching hospitals, and any recommendations made on pay across the broader NHS, when looking to recommend any potential changes to the remuneration for senior managers. This includes those under the Agenda for Change terms and conditions, and those senior managers in the NHS covered by national pay frameworks.

Our commitment to senior managers' pay is clear. Whilst consideration is given to all internal and external factors, it is important that GOSH remains competitive if we are to achieve our vision of being the world's leading children's hospital. The same principles of rating performance and behaviour will be applied to senior managers, in line with the Trust's appraisal system. This in turn may result in senior managers having potential increases withheld, and even reduced, as is the case

with senior managers under the Agenda for Change principles, should performance fall below the required standard.

Future policy

The future policy table below highlights the components of Directors' pay, how we determine the level of pay, how change is enacted and how Directors' performance is managed.

How the component supports the strategic objective of the Trust	How the component operates (including provisions for recovery of sums paid; how changes are made).	Maximum potential value of the component	Description of framework used to assess performance
Salary and fees			
Set at an internationally competitive level to attract high quality Directors to a central London base; benchmarked across other NHS Trusts in order to deliver the Trust's strategic objectives.	Salaries are reviewed annually and any changes are normally effective from 1 April each year. Such changes are proposed and made via the Board's Remuneration Committee, chaired by a Non-Executive Director. In exceptional circumstances, reviews of salary may be made outside of this cycle, but are made by the Remuneration Committee and ratified by the Board. Any sums paid in error, malus or recovered due to breach of contract are followed up with the individual.	Change to basic salary is usually enacted as a percentage increase in line with national Agenda for Change pay arrangements, to ensure parity across the Trust (Directors are proportionally not treated more favourably than the rest of the Trust).	Trust Performance and development review (PDR)/annual appraisal to set objectives linked to the Trust's strategic objectives. Failure to meet objectives is managed via the Trust's performance frameworks.
Taxable benefits			
Not applicable			
Annual performance-related bonuses			
Not applicable			
Long term-related bonuses			

Not applicable

Pension-related benefits

Pension benefits (which may be opted out of) are part of the total remuneration of Directors to attract high calibre staff to enable the Trust to meet its strategic objectives.	Pension is available as a benefit to Directors and follows national NHS Pension Scheme contribution rules (or alternative pension provider).	Pension is available as a benefit to Directors and follows national NHS Pension Scheme contribution rules (or alternative pension provider). Pension entitlements are determined in accordance with the HMRC method.	Not applicable.
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Directors with remuneration (total) greater than £142,500

The Trust balances the market forces factors for recruiting top Director talent with social responsibility in relation to executive pay. Remuneration is regularly benchmarked across peer UK NHS organisations.

Service contract obligations

The Trust does not stipulate any special terms in relation to severance arrangements for Directors. In any occasion of termination of a contract, Directors would not be treated differently from any other member of staff.

Policy on payment for loss of office

Directors' contracts primarily stipulate a minimum notice period of six-months. Payment in lieu of notice, as a lump sum payment, may be made at the discretion of the Trust and with the approval of the Trust's Remuneration Committee, in line with government limits.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

Any changes to Directors' remuneration is usually enacted as a percentage increase in line with national Agenda for Change pay arrangements to ensure parity across the Trust. Directors' remuneration is set at the Remuneration Committee and formally ratified by the Trust Board. Initial salary setting and review is undertaken by benchmarking ourselves with peer Trusts.

Remuneration for executive directors

The remuneration and conditions of service of the Chief Executive and Executive Directors are determined by the Board's Remuneration Committee. The remuneration for other staff is paid in accordance with national terms and conditions of service. The Remuneration Committee is chaired by a non-executive director and meets twice a year, in November and March. Attendance at meetings held in during 2016/17 can be found on page [xx](#)

The committee determines the remuneration of the Chief Executive and Executive Directors after taking into account uplifts recommended for other NHS staff, any variation in or changes to the responsibilities of the Executive Directors, market comparisons, and job evaluation and weightings. There is some scope for adjusting remuneration after appointment as directors take on the full set of responsibilities in their role.

Affordability is also taken into account in determining pay uplifts for directors. Where it is appropriate, terms and conditions of service are consistent with NHS pay arrangements, such as Agenda for Change.

Performance is closely monitored and discussed through both annual and on-going appraisal processes. All Executive Directors' remuneration is subject to performance – they are employed on contracts of employment and are substantive employees of the Trust. Their contracts are open-ended employment contracts, which can be terminated by either party with six months' notice. The Trust redundancy policy is consistent with NHS redundancy terms for all staff. All new directors are now employed on probationary periods in line with all non-medical staff within the Trust.

In the event of loss of office (e.g. through poor performance or misconduct), the Trust will apply the principles and policies set out in this area within its relevant employment policies. Any such termination of employment would be a matter for consideration by the Board's Remuneration Committee and subject to audit by its Audit Committee.

For the financial year 2016/17, the Committee:

- approved a correction to the Medical Director's salary (from 1 April 2016)
- approved an uplift in salary to the Director of Redevelopment's salary in recognition of additional duties through incorporation of the estates and facilities portfolio. The new role is now known as Director of Development and Property Services.
- Conducted a benchmarking exercise on executive director remuneration packages to ensure they are competitive in terms of total remuneration when compared to similar jobs in genuinely comparatively NHS organisations. To inform the benchmarking exercise, data was used from NHS Providers, the AUKUH (Association of U.K. University Hospitals - the organisation for teaching hospitals in the U.K.) and from specific requests to comparable Trusts where this data was not available through the former two means.

Remuneration for non-executive directors

The Members' Council Nominations and Remuneration Committee conducted a benchmarking exercise on non-executive director remuneration packages to ensure they are competitive in terms of total remuneration when compared to other NHS organisations. To inform the benchmarking exercise, data was used from NHS Providers. Following a recommendation from the committee, the Council approved the remuneration of the Chairman and Non-Executive Directors for 2017/18:

- Chairman's remuneration: 1 April 2017 – 31 March 2018 – £55,000pa
- Non-Executive Directors' remuneration: 1 April 2017 – 31 March 2018 – £14,000pa

- Deputy Chairman/Chairman of Audit Committee and Senior Independent Director's remuneration: 1 April 2017 – 31 March 2018 – £19,000pa for each of the two posts.

Details of remuneration for the executive and non-executive directors are provided below:

Non-executive Directors

Salary entitlements of senior managers		2016/17						2015/16					
Name	Title	Salary and Fees	Taxable Benefits	Annual Performance - related Bonuses	Long-term Performance - related Bonuses	Pension-related Benefits	Total	Salary and Fees	Taxable Benefits	Annual Performance - related Bonuses	Long-term Performance - related Bonuses	Pension-related Benefits	Total
Non-executive Directors													
Baroness Tessa Blackstone	Chairman of Trust Board	50-55	0	0	0	0	50-55	50-55	0	0	0	0	50-55
Mr James Hatchley	Non-Executive Director (from 1 September 2016)	5-10	0	0	0	0	5-10	n/a	n/a	n/a	n/a	n/a	n/a
Mr David Lomas	Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Ms Mary MacLeod OBE	Non-Executive Director	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20
Mr Akhter Mateen	Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Professor Stephen Smith	Non-Executive Director	10-15	0	0	0	0	10-15	0-5	0	0	0	0	0-5
Professor Ros Smyth	Non-Executive Director	0-5	0	0	0	0	0-5	0-5	0	0	0	0	0-5
Mr Charles Tilley	Non-Executive Director (until 31 August 2016)	5-10	0	0	0	0	5-10	15-20	0	0	0	0	15-20

Executive Directors

Salary entitlements of senior managers		2016/17						2015/16					
Name	Title	Salary and Fees	Taxable Benefits	Annual Performance-related Bonuses	Long-term Performance-related Bonuses	Pension-related Benefits	Total	Salary and Fees	Taxable Benefits	Annual Performance-related Bonuses	Long-term Performance-related Bonuses	Pension-related Benefits	Total
Mr Trevor Clarke	Director of the International and Private Patients Division	80-85	0	0	0	30-32.5	115-120	80-85	0	0	0	15-20	95-100
Dr Vinod Diwakar	Medical Director (until 31 December 2016)	80-85	0	0	0	120-122.5	205-210	90-95	0	0	0	0	90-95
Professor David Goldblatt	Director of Clinical Research and Development	7.5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Mrs Juliette Greenwood	Chief Nurse	125-130	0	0	0	32.5-35	160-165	110-115	0	0	0	65-70	180-185
Ms Nicola Grinstead	Deputy Chief Executive	135-140	0	0	0	135-137.5	275-280	n/a	n/a	n/a	n/a	n/a	n/a
Dr David Hicks	Interim Medical Director (from 1 January 2017)	95-100	0	0	0	0	95-100	n/a	n/a	n/a	n/a	n/a	n/a
Mr Paul Labiche	Director of Estates and Facilities	70-75	0	0	0	22.5-25	95-100	85-90	0	0	0	20-25	110-115
Mr Niamat (Ali) Mohammed	Director of Human Resources	120-125	0	0	0	75-77.5	200-205	120-125	0	0	0	15-20	140-145

Mrs Claire Newton	Interim Director of Strategy and Planning (until 21 July 2016)	45-50	0	0	0	7.5-10	50-55	125-130	0	0	0	15-20	145-150
Mr Ward Priestman	Interim Director of Information and Communication Technology	140-145	0	0	0	0	140-145	70-75	0	0	0	0	70-75
Mrs Loretta Seamer	Chief Finance Officer	150-155	0	0	0	0	150-155	n/a	n/a	n/a	n/a	n/a	n/a
Dr Peter Steer	Chief Executive	210-215	0	0	0	47.5-50	260-265	205-210	0	0	0	45-50	255-260
Mr Matthew Tulley	Director of Development	130-135	0	0	0	67.5-70	200-205	125-130	0	0	0	25-30	150-155

Pension entitlements of Senior managers (£000)

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000)	Cash equivalent transfer value at 1 April 2016	Real increase/(decrease) in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2017
		£000	£000	£000	£000	£000	£000	£000
Mr Trevor Clarke	Director of the International and Private Patients Division	0-2.5	5-7.5	40-45	125-130	846	88	934

Dr Vinod Diwakar	Medical Director (until 31 December 2016)	7.5-10	10-12.5	45-50	125-130	638	135	773
Mrs Juliette Greenwood	Chief Nurse	0-2.5	5-7.5	55-60	165-170	1,006	76	1,082
Ms Nicola Grinstead	Deputy Chief Executive	5-7.5	12.5-15	30-35	75-80	296	68	364
Mr Paul Labiche	Director of Estates and Facilities	0-2.5	0	10-15	20-25	216	32	248
Mr Niamat (Ali) Mohammed	Director of Human Resources	2.5-5	5-7.5	40-45	125-130	722	110	832
Mrs Claire Newton	Interim Director of Strategy and Planning (until 21 July 2016)	0-2.5	0-2.5	10-15	40-45	300	24	324
Dr Peter Steer	Chief Executive	2.5-5	0	5-10	0	65	59	124
Mr Matthew Tulley	Director of Development	2.5-5	2.5-5	30-35	80-85	419	60	479

Median Pay

	2016/17	2015/16
Band of the highest paid director's total remuneration	210-215	205-210
Median total remuneration	39,832	42,106
Ratio	5.3	4.9

The highest paid Director in 2016/17 was the Chief Executive Officer whose remuneration was in the band £210,000-£215,000. This was 5.3 times the median remuneration for all members of the Trust. The calculation is based upon full-time equivalent Trust staff for the year ended 31 March 2017 on an annualised basis.

Staff report

Staff numbers

In 2016/17, the Trust employed an average of 4,384 full-time equivalent (FTE) staff. This included 115 full-time equivalent staff on maternity leave. The main increase from the prior year was in the administration group which included approximately 100 FTE to assist in the validation of data. This project is now complete at the end of March 2017. Our staff group profile is as follows:

Average number of people employed, including agency, maternity leave and bank staff.	Year to 31 March 2017			Year to 31 March 2016
	Total	Permanently Employed	Other	Total
	Number	Number	Number	Number
Medical and dental	626	586	40	587
Administration and estates	1,200	1,029	171	1,020
Healthcare assistants and other support staff	297	269	28	291
Nursing, midwifery and health visiting staff	1,479	1,366	113	1,421
Scientific, therapeutic and technical staff	777	748	29	743
Other staff	5	5	0	6
Total	4,384	4,003	381	4,068
Staff on maternity leave included in above	115			112

Staff costs

Gross staff costs were £19.3m higher in 2016/17 compared to 2015/16. In addition to the costs of the nationally agreed 1% cost of living uplift for staff and incremental point increases, social security costs increased by £4.4m as a result of an increase in employer National Insurance costs from April 2016. Pension costs increased by £1.3m and temporary staff costs increased by £1.7m due to increased staff numbers to validate RTT activity.

Employee costs	Year to 31 March 2017			Year to 31 March 2016
	Total	Permanently Employed	Other	Total
	£000	£000	£000	£000
Salaries and wages	193,437	190,531	2,906	181,307
Social security costs	19,440	19,440	0	15,000
Pension cost - defined contribution plans employer's contributions to NHS pensions	21,194	21,194	0	19,926
Pension costs - other	82	82	0	0
Temporary staff - agency/contract staff	9,318	0	9,318	7,574
Termination benefits	46	46	0	414

Total gross staff costs	243,517	231,293	12,224	224,221
Recoveries from DH Group bodies in respect of staff cost netted off expenditure	(1,401)	0	(1,401)	(1,770)
Recoveries from other bodies in respect of staff costs netted off expenditure	(292)	0	(292)	0
Total staff costs	241,824	231,293	10,531	222,451
Included within:				
Costs capitalised as part of assets analysed into operating expenditure	2522	1,549	973	1,874
Employee expenses - staff	224,789	215,231	9,558	206,394
Employee expenses - executive directors	1,781	1,781	0	1,899
Research and development	12,686	12,686	0	11,870
Redundancy	46	46	0	414
Total employee benefits excluding capital costs	239,302	229,744	9,558	220,577

Health and safety

We are committed to effectively controlling risks and preventing harm to all patients, visitors and staff. GOSH employees reported 760 health and safety incidents in 2016/17, including 148 patient safety incidents and one serious incident. This is a reduction from 2015/16, when 822 incidents were reported, 142 of which were patient safety incidents.

In conjunction with the incident reporting system the Trust uses proactive means of identifying and subsequently mitigating risks. These include auditing the entire Trust using a tool which monitors compliance against statutory regulations and measures performance against any safety critical alerts or Trust/paediatric specific criteria. The governance structure ensures that any statutory compliance is undertaken within stated legislative guidelines.

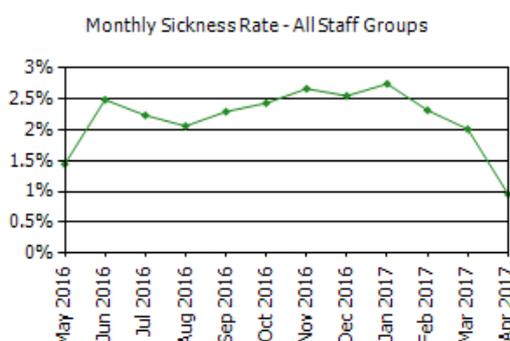
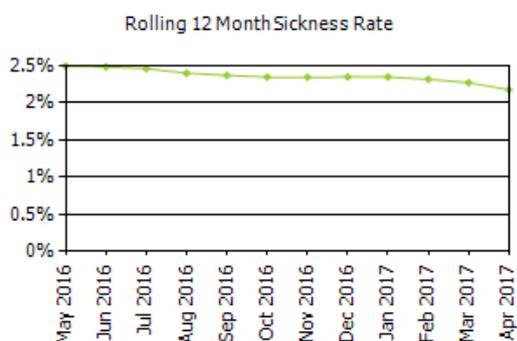
Our capital redevelopment program which brings with it inherent risks, especially as it is in such close proximity to the clinical environment. Measures are in place that put additional controls on the construction work and ensures that redevelopment work fits around the delivery of the clinical care, not vice versa.

Health and sickness

The health of our staff is a top priority and we offer a range of wellbeing support and benefits including:

- A free and on-site staff physiotherapy service
- Counselling and advice service available 24/7
- A full Occupational Health service (which helped ensure in 2016 that over 60% of our staff were vaccinated against flu)
- A wide range of sports and social activities, including yoga, netball and football teams, pilates, and a pedometer challenge.

The detailed results of our staff survey (see below) showed that our staff feel supported by their managers to manage their health (GOSH scored 3.72 out of 5, compared to an average for all NHS trusts of 3.620) and are highly committed to not letting down their patients, families and each other. This passion is a key component in our low absence rates, but the support we provide is essential in helping our workforce to keep well.



Equality, diversity and inclusion

Living Our Always Value of One Team means recognising and celebrating diversity at GOSH. In 2016 our senior leadership team participated in events on faith, ethnicity and gender, and we started to provide new unconscious bias training for our HR and OD teams and other managers. Meeting the requirements of the new NHS Workforce Race Equality Scheme, we published our extensive annual data report on equality, diversity and inclusion issues in January.

We will work with our staff in the coming year to meet the new gender pay gap reporting regulations.

On 31 March 2017 the gender mix of GOSH Directors, senior managers and staff was:

Total employees			Female	Male
78%	22%	Directors	43% (6)	57% (8)
		Senior Managers	75% (15)	25% (5)
		Staff	78% (3,402)	22% (961)

Disability

The Trust was compliant with the Two Ticks standard which recognises our commitment to employ, support and develop staff who have disabilities. This commitment remains unchanged, and in 2017/18 GOSH will become a Disability Confident employer. We have an Equal Opportunities policy and a Recruitment and Selection Policy and Procedure which support applications from disabled

candidates to receive full and fair consideration. We also provide training on fair recruitment and advice to managers.

If a GOSH employee becomes disabled, our Occupational Health department (with input from specialist agencies as necessary) advise on how we can support their needs. This might include adjustments to job roles and their training needs in order to continue working safely and effectively. Our Managing Attendance Policy has specific provision to support staff with disabilities.

We have a policy of regular appraisals for all our staff, which provides an opportunity for the training and personal development of all employees to be discussed on an individual basis, taking into account their particular needs. In the coming year we will prepare for the introduction of the Workforce Disability Equality Standard in April 2018.

Engaging and listening to staff

We provide frequent opportunities for staff across the hospital to ask questions and share ideas, particularly with senior colleagues. This is important in helping us to live our values of Always one team and Always expert.

Our monthly executive talks, led by the Chief Executive, have an open invitation to all employees. In 2016 we also introduced breakfast sessions and visibility walk rounds, where staff are able to meet with members of the executive team in a less formal setting. Another introduction was to extend monthly Senior Management Team meetings and include a wider audience of clinical leaders, such as matrons. These meetings have provided an opportunity for discussion of topical issues such as the electronic patient record programme and our refreshed strategy.

We continue to hold regular discussions with formal staff representatives through our Staff Partnership Forum and Members' Council. We consult staff on changes that may affect them, such as organisational restructures, and carefully review the feedback they give as part of the annual staff survey and Staff Friends and Family Test.

Staff survey

Our response rate of 60% in the 2016 annual staff survey is among the highest in the country. The findings are discussed by our Trust Board and senior management teams, as well as being shared widely with staff, along with the results of the quarterly Staff Friends and Family Test.

Ninety per cent of our staff would recommend GOSH as a place to be treated and over 70% as a place to work. We will ask our staff for ideas on how we can continue to make improvements in their experience at work.

We are confident from the results of the survey that our knowledgeable staff not only recognise errors and near misses when they witness them, but that they consistently report them and have high levels of confidence in the incident reporting mechanisms. We carefully review all incidents to ensure we learn from them and avoid them in the future.

We know that our young patients can sometimes express anxiety or frustration physically, and our staff may not always report this. Similarly, parents in stressful situations very occasionally become aggressive. In all circumstances, we are committed to balancing the care of the child with the

wellbeing of our staff and will continue to emphasise the importance of reporting violent incidents so that together we can improve how we prevent or manage them.

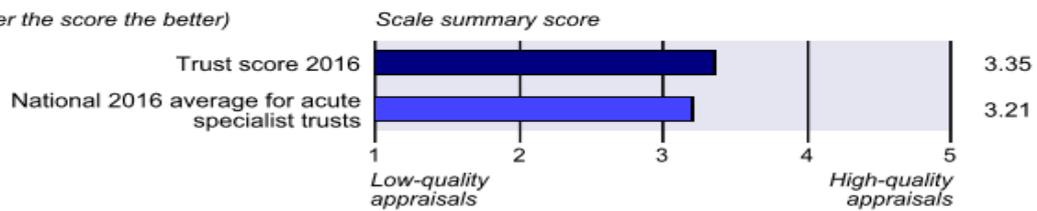
We will continue to listen to our staff as we develop our work on equality, diversity and inclusion. We aim to increasingly incorporate unconscious bias training into development for our leaders, and will be reviewing our recruitment practices in the coming year.

This evaluation trust compares most favourably with other acute specialist trusts in England.

TOP FIVE RANKING SCORES

✓ KF12. Quality of appraisals

(the higher the score the better)



✓ KF7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



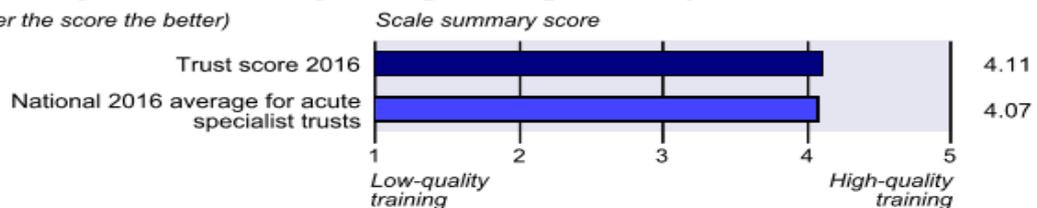
✓ KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months

(the lower the score the better)



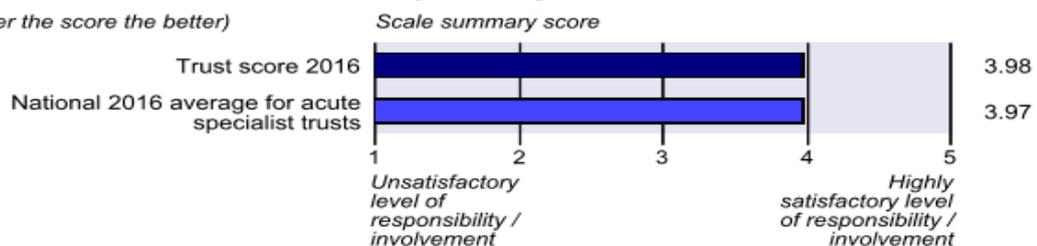
✓ KF13. Quality of non-mandatory training, learning or development

(the higher the score the better)



✓ KF8. Staff satisfaction with level of responsibility and involvement

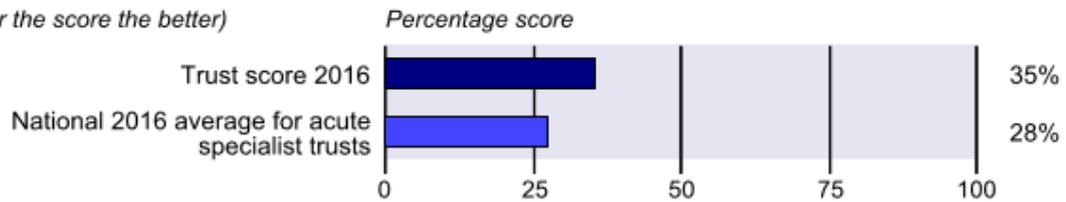
(the higher the score the better)



BOTTOM FIVE RANKING SCORES

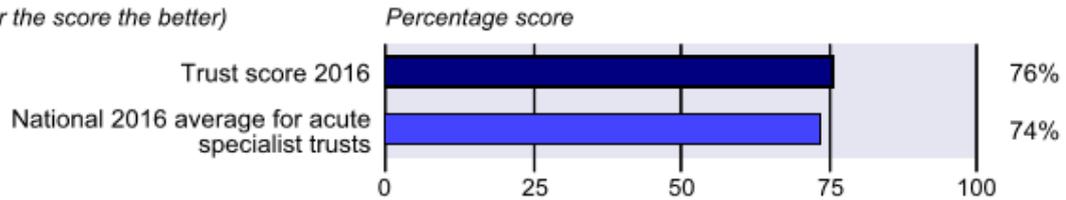
! KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



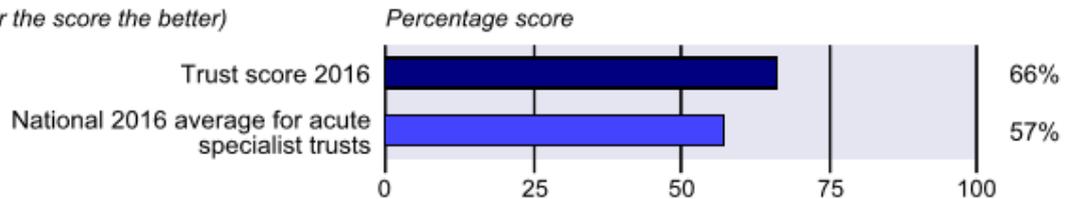
! KF16. Percentage of staff working extra hours

(the lower the score the better)



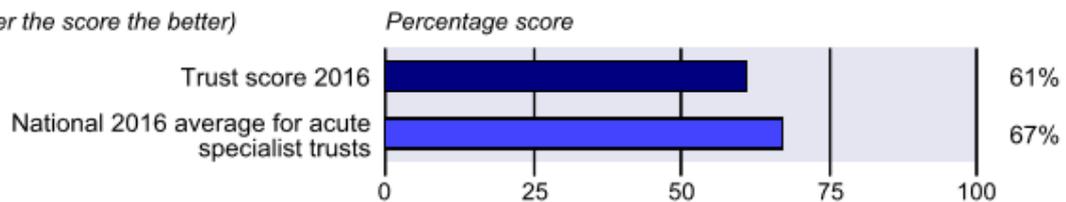
! KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



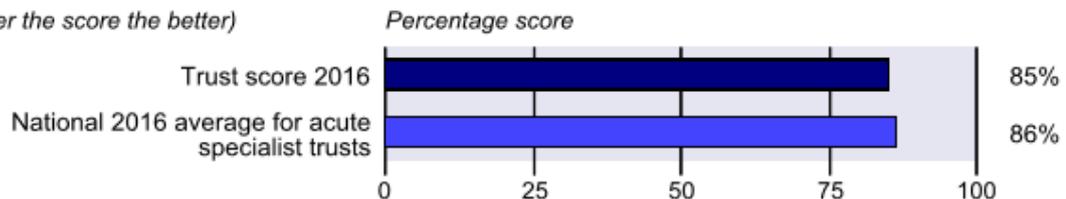
! KF24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



! KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

(the higher the score the better)



Recognising and rewarding performance

This year we emphasised the importance of regular staff appraisals as a formal opportunity for line managers to recognise the achievements of individuals. Staff rated the quality of their appraisal at GOSH higher than average (see staff survey above).

Our GOSH Exceptional Members of Staff (GEMS) awards attract high quality nominations from a wide range of clinical and non-clinical staff groups, and increasingly from patients and families (see page X under 12 months at GOSH).

In 2016, the Chief Executive started to present these awards formally at the monthly open briefing sessions, so that he and the Executive Team can visibly celebrate outstanding staff. Our annual award ceremony is one of the highlights of the GOSH year, with many clinical and non-clinical teams gathering to recognise the achievements of colleagues and hear directly from patients and parents about the difference we make to their lives through outstanding clinical care and living Our Always Values.

Raising concerns at GOSH

Implementation of the Trust's 'Raising Concerns in the Workplace' Policy is monitored by the Audit Committee. The 2016 staff survey found that 94% of our staff would know how to report a concern about unsafe clinical practice, and 71% would feel secure about raising their concerns. These results are on a par with those of other acute specialist hospitals.

Following the recommendations of *Freedom to speak up?* – a review into creating an open and honest reporting culture in the NHS – GOSH has appointed volunteer ambassadors to help staff who want to raise concerns. The new service helps signpost staff to the most appropriate informal and formal routes available for raising any concerns. The ambassadors act as a first point of contact for staff who have concerns that fall under the policy.

NHS Foundation Trust Code of Governance - Disclosures

Principal activities of the Trust

Information on the principal activities of the Trust, including performance management, financial management and risk, efficiency, employee information (including consultation and training) and the work of the research and development division and International and Private Patient division is outlined in the Performance Report. Page XX summaries GOSH's purpose and activities.

Code of Governance

Great Ormond Street Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust Board considers that from 1 April 2016 to 31 March 2017 it was compliant with the provisions of the NHS Foundation Trust Code of Governance.

The Well Led Governance Review recommended that the Board Code of Conduct (see A1.1.8) is aligned to the Trust's 'Always' values. A review of the code of conduct will be conducted in Q2 2017/18. Further information about the review can be found on page XX.

Better payment practice code

The Trust aims to pay its non-NHS trade creditors in accordance with the Prompt Payment Code and government accounting rules. The Trust has registered its commitment to following the Prompt Payment Code.

The Trust maintained its Better Payment Practice Code performance for non-NHS creditor payments and achieved payment within 30 days of 85% of non-NHS invoices measured in terms of number (85% in 2015/16) and 89% by value (88% in 2015/16).

Income from the provision of goods and services

The Trust has met the requirement in section 43(2A) of the *National Health Service Act 2006* (as amended by the *Health and Social Care Act 2012*), which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

Disclosure of information to auditors

The Trust Board directors of who held office at the date of approval of this Annual Report and Accounts confirm that, so far as they are each aware, there is no material audit information of which the Trust's auditors are unaware, and each Director has taken all the steps that he/she ought to have taken as a Director to make himself/herself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

The directors consider that this Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for readers to assess the Trust's performance, business model and strategy.

Expenditure on consultancy

Information about expenditure on consultancy can be found on page ??

Off-payroll arrangements

Information about off payroll engagements can be found on page ??

Political and charitable donations

The Trust has not made any political or charitable donations during 2016/17.

Exit packages

Information about exit packages can be found on page ??

Going concern

Our going concern disclosure can be found on page X

Directors' responsibilities

The Directors acknowledge their responsibilities for the preparation of the financial statements.

Safeguarding external auditor independence

While recognising that there may be occasions when the external auditor is best placed to undertake other accounting, advisory and consultancy work on behalf of the Trust, the Board seeks to ensure

that the auditor is, and is seen to be, independent. The Trust has developed a policy for any non-statutory audit work undertaken on behalf of the Trust to ensure compliance with the above objective. This policy has been approved by the Members' Council.

Transactions with related parties

Transactions with third parties are presented in the accounts on page ?? None of the other Board Members, the Foundation Trust's Councillors, or parties related to them have undertaken material transactions with the Trust.

Pension funding

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme, which covers all NHS employers. The Trust makes contributions of 14% to the scheme. From July 2013, staff who are not eligible for the NHS Pension Scheme are subject to the auto-enrolment scheme offered by the National Employment Savings Trust. The Trust contributes 1% for all staff who remain opted in.

Accounting policies for pensions and other retirement benefits are set out in note XX to the accounts.

Remuneration of senior managers

Details of senior employees' remuneration can be found in page XX of the Remuneration Report.

Treasury policy

Surplus funds are lodged with the National Loan Fund through the Government Banking Service.

Statement of compliance with cost allocation and charging

The Trust has complied, to the extent relevant, with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Countering fraud and corruption

The Trust has a countering fraud and corruption strategy. Counter fraud arrangements are reviewed during the year by the Local Counter Fraud Service (LCFS). The LCFS undertakes an ongoing programme of work to raise the profile of counter fraud measures and carries out ad hoc audits and specific investigations of any reported alleged frauds. This includes the use of fraud awareness presentations and fraud awareness surveys. The Audit Committee receives and approves the Counter Fraud Annual Report, monitors the adequacy of counter fraud arrangements at the Trust and reports on progress to the Board.

NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

As at May 2017, the Trust has been placed in Segment 2 by NHS Improvement. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2016/17 Q3 Score	2016/17 Q4 Score
Financial sustainability	Capital service capacity	2	1
	Liquidity	1	1
Financial efficiency	I and E Margin	2	1
Financial controls	Distance from financial plan	1	1
	Agency spend	3	3
Overall scoring		2	1

Statement of accounting officer's responsibilities

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed Great Ormond Street Hospital for Children NHS Foundation Trust ('the Trust') to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the accounting officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by NHSI, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Dr Peter Steer
Chief Executive
xx May 2017

Audit Committee Report

Introduction from the Chairman of the Audit Committee

I am pleased to present the Audit Committee's report on its activities during the year ending 31 March 2017.

The Audit Committee is a non-executive committee of the Trust Board with delegated authority to review the establishment and maintenance of an effective system of integrated governance, risk management and financial, non-financial and non-clinical internal controls, which support the achievement of the Trust's objectives. Key responsibilities include monitoring the integrity of the Trust's accounts, and the effectiveness, performance and objectivity of the Trust's external and internal auditors. In addition, the committee is required to satisfy itself that the Trust has adequate arrangements for countering fraud, managing security and ensuring that there are arrangements by which staff of the Trust may raise concerns.

The Quality and Safety Assurance Committee (QSAC) considers clinical risks and their associated controls (see page XX). An independent non-executive director member of that committee is also an independent non-executive director member of the Audit Committee to ensure that the work of each committee is complementary.

The table on page XX sets out, in detail, the responsibilities of the Audit Committee and how we have discharged those duties. The report also highlights the key areas considered by the Committee in 2016/17, but I will draw particular attention to a small number of these items here.

During 2015/16, issues were identified in relation to the data and information processes required to robustly track patients through their elective pathway, as well as a number of operational processes in place to support these. This action plan to address this issue was finalised in February 2017 with the Trust returning to reporting (see page XX). The action plan was agreed with Commissioners and is routinely monitored through a four party meeting of the Trust, NHS Improvement, CQC and Commissioner. During 2016/17, the Audit Committee received regular reports on progress with implementation of this action plan. Further information can be found in the Annual Governance Statement on page XX.

The Committee commissioned a detailed review of data quality in response to this matter. The report of our internal auditors noted a number of data quality issues and data management and reporting issues. The report recommended actions and Trust management has responded. The Audit Committee routinely monitored the implementation of the agreed actions during the year and a further internal audit was completed in March 2017 with an outcome of significant assurance.

In keeping with last year, the Trust has undertaken a review of the appropriateness of the adoption of the going concern basis for the preparation of the accounts. This effectively reflects the confidence of the Trust that the organisation remains financially viable. In December 2016 the Trust also signed a two year contract with the commissioners and has agreed a two year financial plan with NHS Improvement. As described below, we are confident that these plans support the Trust's planning period up until 31 May 2018 and that the Trust management has therefore clearly adopted the appropriate accounting basis. However, the longer term challenges facing the Trust, like the wider NHS, are significant.

I am satisfied that the Committee was presented with papers of good quality during the year, and that they were provided in a timely fashion to allow due consideration of the subjects under review. I am also satisfied that meetings were scheduled to allow sufficient time to enable a full and informed debate. Each meeting is fully minuted and summaries of the matters discussed at each meeting are reported to the Trust Board and Members' Council. Members of the Members' Council observed committee meetings throughout the year.

The Committee reviews its effectiveness annually and no material matters of concern were raised in the 2016/17 review.

The members of the Audit Committee are listed on page XX and during 2016/17 included an Independent member Mr James Hatchley until September 2016, and three independent Non-Executive members. During this financial year the previous audit committee chair and Non-Executive Director Mr Charles Tilley has retired and I have commenced in the role of Audit Committee Chair from October 2016. Two of the Non-Executive members of the committee are qualified accountants and at least three members of the Audit Committee have recent and relevant financial experience.

Mr Akhter Mateen

Audit Committee Chairman

xx May 2017

Audit Committee responsibilities

The Committee's responsibilities and the key areas discussed during 2016/17, whilst fulfilling these responsibilities, are described in the table below:

	Principal responsibilities of the Audit Committee	Key areas formally discussed and reviewed by the Committee during 2016/17
Review of the Trust's risk management processes and internal controls	<ul style="list-style-type: none"> • Reviewing the Trust's internal financial controls, its compliance with NHS Improvements guidance for Foundation Trusts, including the Code of Governance, and the effectiveness of its internal control and risk management systems. • Reviewing the principal non-clinical risks and uncertainties of the business and associated Annual Report risk management disclosures. (Clinical risks are reviewed by the Quality and Safety Assurance Committee). 	<ul style="list-style-type: none"> • The outputs of the Trust's risk management processes including reviews of: • The Board Assurance Framework • The principal risks and uncertainties identified by the Trust's management and movement in the impact and likelihood of these risks in the year. • Further developments in the Trust's risk management processes and risk reporting • An annual assessment on the effectiveness of internal control systems taking account of the findings from internal and external audit reports. • An annual report and fraud risk assessment prepared by the Trust's counter-fraud officer. • An annual report from the Trust's Security Manager • The Trust's Cyber Security Strategy • A review of Supply Chain and Inventory Management

	Principal responsibilities of the Audit Committee	Key areas formally discussed and reviewed by the Committee during 2016/17
Financial reporting and external audit	<ul style="list-style-type: none"> • Monitoring the integrity of the Trust’s financial statements and annual financial returns; reviewing significant financial reporting judgements contained within them. • Making recommendations to the Board regarding the appointment of the external auditor. • Monitoring and reviewing the External Auditor’s independence, objectivity and effectiveness. • Developing and implementing policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance. 	<ul style="list-style-type: none"> • A commentary on the annual financial statements • Key accounting policy judgements, including valuations • Impact of changes in financial reporting standards where relevant • Basis for concluding that the Trust is a going concern • External auditor effectiveness and independence • External auditor reports on planning, a risk assessment, internal control and value for money reviews • External auditor recommendations for improving the financial systems or internal controls

	Principal responsibilities of the Audit Committee	Key areas formally discussed and reviewed by the Committee during 2016/17
Internal audit	<ul style="list-style-type: none"> • Monitoring and reviewing the effectiveness of the company's internal audit function, including its plans, level of resources and budget 	<ul style="list-style-type: none"> • Internal audit effectiveness and Charter defining its role and responsibilities • Internal audit programme of reviews of the Trust's processes and controls to be undertaken, and an assurance map showing the coverage of audit work over three years against the risks • Status reports on audit recommendations and any trends and themes emerging • The internal audit reports discussed by the Committee, include: <ul style="list-style-type: none"> - key financial controls - EPR implementation - complaints - cyber security - temporary staffing reporting - revalidation of nurses - information governance - data quality

	Principal responsibilities of the Audit Committee	Key areas formally discussed and reviewed by the Committee during 2016/17
Other	<ul style="list-style-type: none"> • Reviewing the Committee’s Terms of Reference and monitoring its execution • Considering compliance with legal requirements, accounting standards • Reviewing the Trust’s Whistle-blowing Policy and operation 	<ul style="list-style-type: none"> • Updates to Audit Committee’s Terms of Reference • Annual Report sections on governance • The impact of new regulations • Updates on the management of information governance and data quality risks • Updates on staff raising concerns policy • Reporting to the Board and Members’ Council where actions are required, and outlining recommendations.

Effectiveness of the committee

The Committee reviews its effectiveness and impact annually, using criteria from the NHS Audit Committee Handbook and other best practice guidance, and ensures that any matters arising from this review are addressed.

The self-assessment for 2016/17 continues to show progress and the minor procedural issues identified by the survey respondents are addressed on an on-going basis to ensure that the effectiveness of the Committee is optimised. In particular this year the committee reviewed the workplan to ensure there was not unnecessary duplication between committees. The information from the survey was used to review and update the committee’s terms of reference in April 2017.

The Committee also reviews the performance of its internal and external auditor’s service against best practice criteria as detailed in the Healthcare Financial Management Association, and NHS Audit Committee Handbook.

Following a recommendation in the Well Led Governance Review Report (see page XX), the three Chairmen of the assurance committees at GOSH (Audit Committee, Quality, Safety and Assurance Committee and Finance and Investment Committee) established a formal committee chair meeting and met during the year to discuss the degree of duplication between the committees and reviewed the appropriateness and effectiveness of the reporting between the committees and to the Trust Board. As a result of this changes to the Audit Committee’s terms of reference and workplan were made.

External audit

A competitive tendering process of the audit contract took place during 2013, involving members of the Audit Committee and two members of the Members' Council. Deloitte LLP was appointed for a three-year term from 2014/15, with an option to extend for a further 2 years.

Their audit and non-audit fees are set, monitored and reviewed throughout the year and are included in note XX of the accounts.

Internal audit and counter-fraud services

The Board uses independent firms to deliver the internal audit and counter-fraud services:

KPMG LLP. The internal audit service covers both financial and non-financial audits according to a risk-based plan agreed with the Audit Committee. The Trust also has a team of staff carrying out clinical and health and safety audits.

The Trust's separate counter-fraud service is provided by TIAA Ltd who provide fraud awareness training, carry out reviews of areas at risk of fraud and investigate any reported frauds.

Key areas of focus for the Audit Committee in the past year

Risk reviews

The Committee reviews all non-clinical strategic and high scoring operating risks at least annually. Current significant risks include the potential reduction in the Trust's funding arising from the challenging external environment and commissioning changes and delivery of the Trust's Productivity and Efficiency (P&E) Target. In addition, the risk of delivery of the P&E targets, the contribution of the International Private Patients (IPP) Division and the risk that operational capacity is not sufficient to deliver future demands have also been assessed as part of this programme of review. For each risk, the Committee reviews the risk assessment (including risk definition, risk appetite, and likelihood and impact scores), the robustness of the controls and evidence available that the controls are operating.

Data quality reviews

In 2015/16, following suspension of reporting of waiting time data, the Committee sought assurance that the systems and processes for assuring data completeness, timeliness, relevance, accuracy and appropriateness were operating effectively. The Trust developed a detailed action plan including a significant programme of data quality reviews. This is now complete and the Trust returned to reporting referral to treatment (RTT) waiting times in February 2017.

Board Assurance Framework

The Audit Committee reviewed the Board Assurance Framework (BAF) in detail this year. The Risk Assurance and Compliance Group review each strategic risk on the BAF along with the related mitigation controls and assurances. The Audit Committee reviewed the consistency and presentation of the BAF and receives routine presentations on strategic risks at each committee meeting.

Productivity and efficiency

The Finance and Investment Committee monitors the identification, planning, monitoring, delivery and post implementation review of Trust savings schemes. The QSAC receives assurances from the Quality Impact Assessment Group that those schemes do not adversely or unacceptably affect the quality of services delivered. The Audit Committee seeks independent assurance that the systems and processes supporting those assurances are operating effectively. The Committee links closely with the Finance and Investment Committee and receives the minutes of that Trust Board Committee and the QSAC.

International Private Patient (IPP) Debtors

The Audit Committee also monitored and reviewed the IPP debt levels for each major customer and discussed with management strategies to reduce the level of exposure. The final quarter of the financial year saw a decrease in the debt exposure for the organisation but not yet reduced to remove this from a key risk that the committee will continue to monitor.

Internal controls

We focused in particular on controls relating to cyber security and credit control management; delays in debt collection. Action plans were put in place to address issues in operating processes.

The Audit Plan of the internal auditors is risk based and the Executive team work with the auditors to identify key risks to inform the Audit Plan. The Audit Committee considers the links between the Audit Plan and the Board Assurance Framework. The Audit Committee approves the Internal Audit Plan and monitors the resources required for delivery. During the course of the year the Committee considers any proposed changes to the Audit Plan and monitors delivery against the plan approved at the start of the financial year.

Fraud detection processes and whistle blowing arrangements

We reviewed the levels of fraud and theft reported and detected and the arrangements in place to prevent, minimise and detect fraud and bribery. The Trust's counter-fraud service conducted an awareness survey which demonstrated that 84% of staff are aware of the Counter-Fraud, Bribery and Corruption Policy.

Financial reporting

We reviewed the Trust's financial statements and how these are positioned within the wider Annual Report. To assist this review we considered reports from management and from the internal and external auditors to assist our consideration of:

- the quality and acceptability of accounting policies, including their compliance with accounting standards
- their compliance with accounting standards
- key judgements made in preparation of the financial statements
- compliance with legal and regulatory requirements
- the clarity of disclosures and their compliance with relevant reporting requirements

- whether the Annual Report as a whole is fair, balanced and understandable and provides the information necessary to assess the Trust's performance and strategy.

Going concern

The Trust management has carefully considered the appropriateness of reporting on the 'going concern' basis.

In 2016/17 the Trust reported an operating deficit prior to capital donations and impairments. This position is an improvement from 2015/16 in which the Trust reported an underlying deficit for the first time in several years. In 2016/17 national intervention was provided by NHS of £4.2 million via the Sustainability and Transformation Fund which provided some relief.

The Trust has signed a two year contract with its commissioners for the 2017/18 and 2018/19 financial years. The two year financial plan submitted to NHSI indicated the organisation will be in financial balance by the end of 2017/18 with a further increase in the following year. The two year plan includes growth in activity to meet the demand and access targets for specialty services, including the opening of the new Premier Inn Clinical Building capacity. To achieve the financial plan the Trust will also need to deliver efficiencies at an increased level of £15 million and £12 million respectively.

The 2016/17 financial year showed an increase in income for international private patient services of £7.2 million or 15% over the prior year. This included the opening of additional bed capacity. The majority of Private Patient service demand is from the Middle East region which carries a degree of geo-political risk which the Trust has included provisions to cover any risk but the Trust continues to actively seek other private markets to diversify to reduce exposure to one key market.

The Trust maintains a strong liquidity position based upon historic surpluses and careful capital expenditure management and support by the Charity. At the end of 2016/17 financial year the Trust held £42.5 million in cash reserves and was able to meet all commitments as and when they fell due.

Although we are operating in a particularly constrained financial environment, the Directors have a reasonable expectation that the Trust has adequate resources to continue to operate for the foreseeable future. For this reason, and following reasonable enquiries, the Directors continue to adopt the going concern basis for the preparation of the accounts within this report.

Significant financial judgements and reporting for 2016/17

We considered a number of areas where significant financial judgements were taken, which have influenced the financial statements.

We identified through discussion with both management and the external auditor the key risks of misstatement within the Trust's financial statements. We discussed these risks with management during the year, and with the auditor at the time we reviewed and agreed the external auditors' audit plan during the year and also at the conclusion of the audit. We set out in the table below how we satisfied ourselves that these risks of misstatement had been appropriately addressed.

Level of debt provisions

The financial statements include provisions in relation to uncertainty. Judgements in this area are largely related to the timing of recognition of these provisions, the quantum recognised and the

amount which has been utilised in previous years. We reviewed and discussed the level of debt and debt provisions with management. This included consideration of new provisions and any release and utilisation of existing provisions. Management confirmed to us that they have applied a consistent approach to the recognition and release of provisions. We also considered the views of the external auditors in respect of the provisions and associated disclosures in the accounts. We concluded that we were satisfied with the level of provisions carried and the disclosure in respect of those provisions.

Valuation of property assets

The Trust has historically revalued its properties each year, which combines properties held under freehold with those held under finance and operating leases. Judgements relate to the future life of these buildings, which can change the appropriate accounting treatment and affect the carrying value on the balance sheet. We reviewed reports from management which explained the basis of valuation for the most significant buildings, including the future life and rationale for any impairments associated with structural refurbishment expenditure. We also considered the auditors' views on the accounting treatment for these buildings. We are satisfied that the valuation of these properties within the financial statements is consistent with management intention and is in line with accepted accounting standards.

Other areas of financial statement risk

Other areas where an inappropriate decision could lead to significant error include:

- the recognition of commercial revenue on new contracts
- the treatment of expenditure related to capital contracts

We consider that the Trust's existing financial control systems should ensure that such items are properly treated in the financial statements. We have discussed the external auditors' findings in these areas. There were no issues of concern reported to us in these areas and consequently we are satisfied that the systems are working as intended.

Conclusion

The Committee has reviewed the content of the Annual Report and Accounts and advised the Board that, in its view, taken as a whole:

- It is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.
- It is consistent with the Annual Governance Statement, Head of Internal Audit Opinion and feedback received from the external auditors, and there are no matters that the committee is aware of at this time that have not been disclosed appropriately.
- It is appropriate to prepare accounts on a going concern basis.

Quality and Safety Assurance Committee Report

Introduction from the Chairman of the Quality and Safety Assurance Committee

I am pleased to present the Quality and Safety Assurance Committee's report on its activities during the year ended 31 March 2017.

As outlined in the report, the Quality and Safety Assurance Committee (QSAC) is a sub-committee of the Trust Board, with delegated authority to ensure that the correct structure, systems and processes are in place within the Trust to appropriately manage and monitor clinical governance and quality related matters and strategic and operational risks. The committee was previously named the Clinical Governance Committee and in May 2016 updated its terms of reference and broadened its remit to seek assurance of the quality of care and treatment in all services provided by the Trust. As part of this, the committee changed its name to the Quality and Safety Assurance Committee (QSAC).

As Chairman, I am satisfied that the committee was presented with the appropriate level of information and in a timely fashion. Each meeting is fully minuted and summaries of the matters discussed at each meeting are reported to the Trust Board and Members' Council.

The members of the QSAC are listed on page XXX and, during the first half of 2016/17, included 3 Non-Executive Directors and an independent member of the committee. In September 2016, James Hatchley was appointed as a new Non-Executive Director member on the Board and the QSAC. Representatives from the Members' Council attended the CGC and QSAC meetings throughout the year.

I have been Chairman of the committee since the Foundation Trust was authorised on 1 March 2012. In May 2017 I will step into the Interim Chairman role and Stephen Smith will take on chairing the QSAC.

Quality and Safety Assurance Committee responsibilities

The principal purpose of the QSAC is to assure the Board that the necessary structures and processes are in place to deliver safe, high quality, patient-centred care and an excellent patient experience.

The Committee requests assurance on scheduled matters as well as quality and safety issues arising during the year. The Committee's responsibilities and the key areas discussed during 2016/17 are outlined in the table below.

Principal responsibilities of the committee	Key areas formally reviewed during 2015/16
Review and seek assurance on any issues identified by the Trust Board (as requiring more detailed review that fall within the remit of the committee) including on any quality,	<ul style="list-style-type: none">• Implementation of the Trust's Quality Strategy and review of the annual Quality Report• Reports from the Clinical Ethics Committee• Regular review of performance reports• Learning from patient stories

safety or patient experience matters or shortcomings arising from the Trust's operational and quality and safety performance.

- IT issues impacting clinical work
- Updates from service areas (play service)

Review when an issue occurs which threatens the Trust's ability to enable excellent clinical care to flourish, that this is managed and escalated appropriately and actions are taken and followed through

- Assurance of maintenance of the compliance register
- A range of specific, emergent issues were considered in 2016/17 including:
 - Review of the gastroenterology service
 - Quality and safety impact of the productivity and efficiency programme
 - Access Improvement Programme workplan
 - Recruitment and retention
 - Implementation of the CQC action plan
 - Cancellations of operations

Assure the Trust Board that the controls to mitigate risk within the areas of responsibility of the committee are in place and working within a regulatory and legislative framework.

- Summary reports on the relevant risks on the Board Assurance Framework
- Reports received on specific and/or high risk areas:
 - Health and Safety
 - Safeguarding
 - Raising Concerns
 - Research Governance
 - Summary from the Patient Safety and Outcomes Committee and the Patient and Family Experience and Engagement Committee
 - Staffing information report

Review of findings and recommendations from internal audit, clinical audit and learning from external investigations and reports

- The internal audit annual plan and strategy was presented to the Committee in April 2016 with an update on progress with the plan covered at subsequent meetings
- Gastroenterology Review Progress Report
- Findings and recommendations of clinical focused internal audit reports are presented to every committee meeting. The following audits were discussed this year:
 - Education Strategy and Governance
 - IT Operations and Infrastructure
 - Discharge Arrangements
 - Self-certifications
 - Electronic Patient Record Programme Management
 - CQC Action Plan Follow Up
 - Temporary Staff Reporting
 - Revalidation of Nurses and Midwives
- Quarterly reports from the Trust's Clinical Audit Manager

Other

- Reviewed committee purpose and amended focus and name
- Reviewed Freedom of Information Annual Report

Key areas of focus for the Quality and Safety Assurance Committee in the past year

It has been a busy year for the QSAC with the committee seeking assurance on a number of quality and safety matters:

Risk reviews

The committee reviews all clinical strategic and high scoring operating risks at least annually. Following discussion at the annual Risk Management meeting and the October 2016 QSAC meeting, a new BAF risk was approved at by the Trust Board in December 2016 covering the risk to not being able to sustainably provide and deliver specialist clinical services to the required level. As at 31 March 2017, the Trust's most significant risks relating to clinical delivery include recruiting and retaining sufficient highly skilled staff; the risk of insufficient nursing graduates available to work at GOSH; and, compliance with the 2016/17 regulatory framework, particularly in relation to the national RTT standard.

Access Improvement Programme

In conjunction with the Trust Board and Audit Committee, the QSAC has sought assurance of the implementation of the Access Improvement Programme and its impact on the safety of care provided to patients.

Quality impact of the Productivity and Efficiency Programme

The QSAC has received assurance of the refreshed quality impact assessment (QIA) processes in place for productivity and efficiency schemes in 2016/17 and reviewed some specific services' productivity plans to ensure they have a robust quality governance framework and that quality and safety are not compromised.

Under the 'Better Value' programme, the committee sought assurance that QIAs will be signed off by relevant divisions and other stakeholders prior to the beginning of the year.

Gastroenterology

During the year, the committee sought assurance of the impact of the findings of the review on patients and the quality of the communications to affected families. The committee was also concerned to establish how the service would be restructured in the future and the plans in place to develop guidelines for complex conductions such as Eosinophilic Colitis where there is limited evidence-based consensus on treatment. Further information can be found on page **XX**.

CQC compliance

The Committee reviewed the actions taken to implement the recommendations arising from the CQC report of January 2016. At the end of financial year, the majority of the actions have already been closed and the one remaining is on track to be completed within agreed due dates. The QSAC will continue to monitor and support the Trust's efforts to deliver all opportunities for improvement highlighted during the CQC's 2015 inspection.

Patient Stories

The QSAC received stories from patients about their experiences of their care either in person or in writing. The stories were found to be extremely helpful in illuminating matters needing improvements as well as those that could be more widely shared across other teams. Patient stories now feature at every public Board meeting (from March 2017 onwards) and the actions agreed are monitored at the following QSAC.

Review of effectiveness

The three committee chairmen (Audit Committee, Quality and Safety Assurance Committee and the Finance and Investment Committee) have established regular meetings to discuss how the committees can operate effectively and reduce duplication. This has resulted in refreshed workplans for all three committees.

Conclusion

As Chairman, I am satisfied that the committee adequately discharged its duties in accordance with its terms of reference throughout 2016/17.

Mary MacLeod

Quality and Safety Assurance Committee Chairman

XXXXXX 2017

Draft Head of Internal Audit Opinion

Basis of opinion for the period 1 April 2016 to 31 March 2017

Our internal audit service has been performed in accordance with KPMG's internal audit methodology which conforms to Public Sector Internal Audit Standards (PSIAS). As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) or International Standard on Assurance Engagements (ISAE) 3000. PSIAS require that we comply with applicable ethical requirements, including independence requirements, and that we plan and perform our work to obtain sufficient, appropriate evidence on which to base our conclusion.

Roles and responsibilities

The Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The Assurance Framework should bring together all of the evidence required to support the AGS.

The Head of Internal Audit (HoIA) is required to provide an annual opinion in accordance with PSIAS, based upon and limited to the work performed, on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes (i.e. the system of internal control). This is achieved through a risk-based programme of work, agreed with Management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below.

The purpose of our HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist the Board in the completion of its AGS, and may also be taken into account by other regulators to inform their own conclusions.

The opinion does not imply that the HoIA has covered all risks and assurances relating to the Trust. The opinion is derived from the conduct of risk-based plans generated from a robust and Management-led Assurance Framework. As such it is one component that the Board takes into account in making its AGS.

Opinion

Our opinion is set out as follows:

- Basis for the opinion;
- Overall opinion; and
- Commentary.

Basis for the opinion

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning aspects of the risk and assurance framework and supporting processes; and
- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas.

Overall opinion

Our overall opinion for the period 1 April 2016 to 31 March 2017 is that:

‘Significant assurance with minor improvements’ can be given on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control.

Note: the opinion is currently based on our work performed to date, however we do not expect our overall assurance rating to change.

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety. Our opinion covers the period 1 April 2016 to 31 March 2017 inclusive, and is based on the 12 audits that we completed in this period.

The design and operation of the Assurance Framework and associated processes

The Trust’s Board Assurance Framework (BAF) does reflect the Trust’s key objectives and risks and is regularly reviewed by the Board. The Executive reviews the BAF on a monthly basis and the Audit Committee and Quality and Safety Assurance Committee review it on a quarterly basis. The Audit Committee reviews whether the Trust’s risk management procedures are operating effectively.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year

We issued one PARTIAL ASSURANCE WITH IMPROVEMENTS REQUIRED (AMBER-RED)’ and one ‘NO ASSURANCE (RED)’ opinions in respect of our 2016/17 assignments. The partial assurance report relates to temporary staff reporting and the no assurance report related to Electronic Patient Record implementation.

We have raised three high priority recommendations in this period and there are two high priority recommendations from our 2015-16 audit plan that have not yet been implemented. These relate to the following:

- Ensuring there was a full and up to date business case for the EPR implementation;
- Developing appropriate governance processes for overseeing and approving changes to the EPR project;
- Identifying the dependencies associated with the implementation of the EPR:
- Having an up to date contract register containing all of the Trust's contracts; and
- Ensuring there are contract managers assigned to manage the contracts with the Trust's suppliers.

We have agreed actions with management for the implementation of the high priority recommendations in our EPR report. Two of the three recommendations were implemented during the year, the remaining recommendation is on course to be implemented in July 2017. The contract management recommendations are anticipated to be implemented in July 2017 following the implementation of the Trust's new procurement and contract management software.

KPMG LLP Chartered Accountants London 25 May 2017

A handwritten signature in black ink that reads "KPMG LLP". The letters are slightly blurred and have a soft shadow effect behind them.

KPMG LLP Chartered Accountants

London

25 May 2017

Annual Governance Statement

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Great Ormond Street Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Great Ormond Street Hospital NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

As Chief Executive, I have overall responsibility for ensuring there is an effective risk management system in place within the Trust for meeting all relevant statutory requirements and for ensuring adherence to guidance issued by regulators which include NHS Improvement and the Care Quality Commission. Further accountability and responsibility for elements of risk management are set out in the Trust's Risk Management Strategy.

The Board has a formal schedule of matters reserved for its decision, and delegates certain matters to Committees as set out below. Matters reserved for the Board are:

- determining the overall strategy
- creation, acquisition or disposal of material assets
- matters of public interest that could affect the Trust's reputation
- ratifying the Trust's policies and procedures for the management of risk
- determining the risk capacity of the Trust in relation to strategic risks
- reviewing and monitoring operating plans and key performance indicators
- prosecution, defence or settlement of material incidents and claims.

The Board has a work programme which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations, and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda. The Board has carried out an internal review of its effectiveness during the year and agreed actions to improve its oversight of risk.

There are two Board assurance committees, being the Audit Committee and the Quality and Safety Assurance Committee, which assess the assurance available to the Board in relation to risk management, review of Trust non-clinical and clinical risk management processes and also raise issues requiring attention by the Board. In addition to the two assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The Chairman of each committee reports to the Board meeting following the committee's last meeting. Each Committee is charged with reviewing its effectiveness annually.

The Risk Assurance and Compliance Group (comprising executives, quality, safety and compliance leads) reports to the Audit Committee and the Quality and Safety Assurance Committee. This group monitors the effectiveness of risk management systems and the control and assurance processes and monitors the Board Assurance Framework.

The Trust has a Patient Safety and Outcomes Committee (PSOC), chaired by the Interim Medical Director (comprising executives, and senior managers and clinicians from the clinical divisions and corporate teams). This committee monitors the implementation of clinical risk management processes throughout the Trust, ensuring that risks are identified, registered and managed at appropriate levels of responsibility in the clinical divisions and corporate departments. It receives reports of risks, incidents and risk-mitigating actions from division and department groups and specialist subcommittees. In addition, each clinical division's Board considers risks, quality and safety indicators, incidents and complaints on a regular basis. These are the key senior management forums for consideration of risks.

The Trust has a central Risk Management team who administer the risk management processes. Within each clinical division, safety is championed by a clinical lead for patient safety supported by an individual within the Risk Management team. The Risk Management team also meet regularly with their peers at other Trusts to share learning.

All staff receive relevant training to enable them to manage risk in their division or department. At a Trust level, emphasis is placed on the importance of preparing risk assessments where required, on reporting, investigating and learning from incidents.

There are a range of other processes to ensure that lessons are learned from specific incidents, complaints and other reported issues. These include reports to risk action groups, divisional boards and articles within internal newsletters. There are also periodic seminars open to all staff where learning from an event is presented and discussed.

4. The risk and control framework

The risk management strategy

In early 2016, the Trust's risk management strategy, which sets out how risk is systematically managed, was reviewed and updated. This extends across the organisation, from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research, and to ensure the business continuity of the Trust.

The strategy identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk, and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process to provide assurance for the Trust Board review of the strategic organisational risks, and the local structures to manage risk in support of this policy.

The Trust has reviewed its compliance with the NHS Foundation Trust license conditions and in relation to condition four, it has concluded that it fully complies with the requirements and that there are processes in place to identify risks to compliance. No significant risks have been identified.

The strategy is integrated into the management, performance monitoring and assurance systems of the Trust, to ensure that safety and improvement is embedded in all elements of the Trusts work, partnerships and collaborations and existing service developments. This enables early identification of factors, whether internally or externally driven, which may prevent the Trust from achieving its strategic objectives of ensuring that care is provided in a cost effective way without compromising safety.

It provides the framework in which the Trust Board can determine the risk appetite for individual risks and how risks can be managed, reduced and monitored. The Board has recently reviewed and revised its risk appetite statement.

The Board recognises that the Trust's clinical services and research activity are delivered within a high risk environment. The delivery of GOSH's strategic objectives and its relationships with its patients, the public, its funders and other strategic partners determines the Trust's long term sustainability. As such, the Board has agreed that the Trust has an overall low appetite for risks relating to its clinical service and research delivery. The lowest risk appetite applies to all safety and compliance objectives, including preventable patient harm, public and employee health and safety. The Trust has a marginally higher risk appetite for the pursuit of innovation and its strategic and operations objectives. This means that the risks originating from clinical and research processes as well as meeting legal and other regulatory obligations will take priority over other business objectives.

Key elements of the Trust's quality governance arrangements

The Trust places a high priority on quality, measured through its clinical outcomes, patient safety and patient experience indicators. The Board is committed to placing quality and safety at the top of its own agenda, to encourage continuous improvement in safety and quality indicators, and to establish mechanisms for recording and benchmarking clinical outcomes.

The key elements of the Trust's quality governance arrangements are:

- There is clear accountability at Board level for safety and clinical quality objectives and structured reporting of performance against these objectives.
- Internal processes are in place to check that we meet both our own internal quality standards and those set nationally and in conjunction with our commissioners (CQUINS).
- Key performance indicators are presented, on a monthly basis to the Trust Board. This includes progress against external targets, internal safety measures, operational efficiency/process measures, well-led and other clinical quality measures. It also includes the external indicators assessed and reported monthly by the CQC.
- The Board regularly receives reports on the quality improvement initiatives and other quality information (such as complaints, incidents and reports from specific quality functions within the Trust such as the Patients Advice and Liaison Service). The Quality and Safety Assurance Committee receive reports from clinical and health and safety audits.
- Each specialty and clinical division has an internal monitoring structure to enable teams to regularly review their progress and identify areas where improvements may be required. Each specialty must measure and report a minimum of two clinical outcomes. Each division's performance is considered at quarterly strategic performance reviews.
- Patient and parent feedback is received through the Friends and Family surveys, a more detailed survey at least once a year, through the work programme of the recently reviewed Patient and Family Experience and Engagement Committee and through a range of other patient/ parent engagement activities.
- Risks to quality are managed through the Trust risk management process which includes a process for escalating issues.
- There is a clear structure for following up and investigating incidents and complaints, and disseminating learning from the results of investigations.

Through these processes all data on the quality of care in each specialty and service is considered as part of our internal and external management and assurance process. The data quality improvement plan is monitored by the Audit Committee to ensure that the Board receives assurance of the quality of this data.

Risks to data security are managed in the same way as other Trust risks but are subject to separate evaluation and scrutiny by the Information Governance Steering Group which reports to the Trust's Audit Committee. This Group uses the Information Governance Toolkit assessment to inform its review.

A never event which occurred in the Trust during the year, involving a misplaced nasogastric tube. Following a detailed investigation, it was highlighted the need to ensure staff undertake appropriate training, 'position check' a nasogastric tube on placement and document check results clearly. Audits will be undertaken in this area.

Compliance with the Foundation Trust Licence Conditions

An assessment has been carried out of the Trust's processes to ensure that it complies with the Licence Conditions, and, in particular, Licence condition four (governance). The conclusion of the review was that the Trust's governance processes and structures are effective.

In 2015 a review of information and performance indicators provided to the Finance and Investment Committee and the Trust Board was commissioned from our internal audit service, following the decision of the Trust to suspend reporting of referral to treatment (RTT) waiting times. This report identified a number of weaknesses in reporting processes and systems and therefore in 2015/16 only partial assurance was reported as to the accuracy of reporting to the Trust Board. In response, the Trust has developed a detailed action plan including a significant programme of data quality reviews which the Trust Board monitored the delivery of this action plan closely. This is now complete and the Trust has returned to reporting referral to treatment (RTT) waiting times in February 2017. Therefore only partial assurance can be reported against G6 licence condition (systems for compliance with licence conditions and related obligations).

Compliance with CQC registration

The Trust has identified an executive director and a manager who are respectively accountable and responsible for ensuring compliance with each element of the CQC registration standards. It is the responsibility of these staff to provide evidence of compliance with the standards. The evidence is reviewed periodically by compliance staff. The CQC carried out an inspection in April 2015 and the trust is fully compliant with the registration requirements of the CQC. Further information can be found on page XX in the Quality Report.

The risk management process

The Trust's Assurance and Escalation Framework sets out how the organisation identifies, monitors, escalates and manages concerns and risks in a timely fashion and at an appropriate level.

The Trust's Board Assurance Framework (BAF) is used to provide the Board with assurance that there is in place a sound system of internal control in place to manage the key risks to the Trust of not achieving its strategic objectives. The BAF is used to provide information about the controls in place to manage the key risks, and details the evidence provided to the Board indicating that the control is operating. The BAF includes cross references to assurance obtained from internal and external audits, and self-assessments of compliance with other regulatory standards. It has been monitored and updated throughout the year.

Each strategic risk on the Assurance Framework, the related mitigation controls and assurance available as to the effectiveness of the controls, is reviewed by the Risk Assurance and Compliance Group and by either of the Quality and Safety Assurance Committee or the Audit Committee at least annually. The Committees look for evidence that the controls are appropriate to manage the risk and for independent assurance that the controls are effective and monitor actions to reduce or remove control or assurance gaps.

In addition, the Trust Board recognises the need to 'horizon scan' for emerging risks and review low probability / high impact risks to ensure that contingency plans are in place, and has included such matters in Board discussions of risks.

Each division and department is required to identify, manage and control local risks whether clinical, non-clinical or financial in order to provide a safe environment for patients and staff, and to reduce unnecessary expenditure. This ensures that the early identification of risks and the devolution of responsibility for management of risks to staff at all levels of the organisation. In practice, this is achieved through the involvement of staff in risk action groups, risk training and occasional surveys.

Risks are identified through diverse sources of information such as:

- formal risk assessments
- audit data
- clinical and non-clinical incident reporting
- complaints
- claims
- patient/user feedback
- information from external sources in relation to issues which have adversely affected other organisations
- operational reviews
- use of self-assessment tools.

Further risks are also identified through specific consideration of external factors, progress with strategic objectives, and other internal and external requirements affecting the Trust.

Risks are evaluated using a '5x5' scoring system that enables the Trust to assess the impact and likelihood of the risk occurring and prioritise accordingly. Assessments are made as to whether the prioritised risks are acceptable or not.

Control measures aimed at both prevention and detection are identified for accepted risks, in order to either reduce the impact or likelihood of the risk. An assessment is then made of the effectiveness of the control on reducing the risk score, and what assurance is available to the Board that the control is both in place and operating effectively to reduce risk. A designated person becomes responsible for monitoring, reviewing and reporting on the effectiveness of the control in place. Risks and controls are evaluated periodically and when new or changed risks are identified, or if the degree of acceptable risk changes.

The principal risks for the Trust during the year and in the immediate future are:

- in an environment where it is recognised there has been a long standing issue of underfunding core services, a further reduction in funding available to NHS organisations,

coupled with the high costs of maintaining delivery of specialised services but being able to meet the two year plan control total target set by NHSI;

- recruitment and retention of sufficient highly skilled staff with specific experience;
- completing the review of the management of Referral to Treatment (RTT) administration processes (note the Trust returned to reporting in February 2017) which found no patient care issues but did cause considerable additional cost to the Trust;
- reliance on International Private Patients to support financial viability; Implementation of the new Trust wide Electronic Patient Record system approved in March 2017.

Each of these risks are broken down into a number of component parts covering the different drivers of these risks, and appropriate mitigating actions for each component identified.

A summary of the top three risks to our operational or strategic plans in 2016/17 and the mitigations in place to manage them, is outlined below.

Risk	Explanation	Mitigating actions implemented and underway
Recruitment and retention of sufficient highly skilled staff with specific experience	The inability to recruit and retain enough skilled staff could lead to a reduction in services that can be safely provided. This potential reduction could lead to GOSH being unable to accommodate all referrals to the Trust and/or result in longer waiting times.	- Specific action plans are in place for key service areas and professions including <ul style="list-style-type: none"> ○ a trust wide nursing recruitment and retention programme; ○ enhanced processes to ensure GOSH is an attractive employer ○ Tactical use of temporary staff to fill vacancies ○ Education commissioning plans to increase numbers of potential staff
Timely access to services at GOSH	Failure to treat all patients within clinically appropriate timeframes Inability to analyse data and subsequently make business decisions conducive to timely service provision.	- Implementation of a change programme across the Trust including <ul style="list-style-type: none"> ○ training for staff on the application of the Trust Access Policy; ○ regular monitoring of waiting lists, supported by on-going validation of patient lists and processes ○ initiatives to increase activity capacity including as operational bed meetings, theatre scheduling meetings. Flow work programme, outpatient redesign ○ Validation of underlying data reported to Trust Board and divisions

Risk	Explanation	Mitigating actions implemented and underway
Failure to continue to be financially sustainable	A reduction in funding and/or increasing costs will lead to a need to reduce activity which could potentially impact on our ability to deliver our vision, despite efforts to ensure excellent patient experience and outcomes.	<ul style="list-style-type: none"> - Robust financial planning including downside contingency planning, regular performance reviews and establishment of a programme management Office to support the Trust in identifying and delivering productivity and efficiency schemes - Development of commercial strategies - Monthly monitoring of capital expenditure - Working with Commissioners to support the Trust's service and growth strategy - Continued involvement in forums influencing paediatric tariff discussions - On-going cost benchmarking
Reliance on international and private patients to support financial viability	The risk that the organisation will not deliver IPP contribution targets.	<ul style="list-style-type: none"> o Clear and regular reporting against operational activity and financial targets o A range of market development and brand recognition activities underway o Recruitment and retention plan in place to ensure IPP has the quality and quantity of skilled staff to support the required activity levels. o Work underway to identify additional capacity for IPP activity in the Trust o Escalation processes in place to minimise IPP debt and aging debt
Implementation of the new Trust wide Electronic Patient Record	The risk that the EPR programme will not be delivered on time or within budget.	<ul style="list-style-type: none"> o Robust programme governance led by the EPR Programme Board, including engagement with clinical experts, patients and families, finance, IT, research and operational management o Clinical and research leadership in place o Communication strategy in place, including specific strategies to ensure thorough engagement with clinicians and to ensure all staff and stakeholders are aware of program and impacts of changes o Project closely integrated with Quality Improvement and Operations teams to ensure the EPR is delivered as a change programme o Engaged external expert advisors for legal, commercial and procurement processes

Emerging risks with medium or high scores are reported through the quality and safety and KPI performance reports and at clinical division and corporate department level through the Trust's quarterly strategic reviews.

Assurance is obtained by the Board from the results of Internal Audit reviews which are reported to the Audit Committee and Quality and Safety Assurance Committee. The Quality and Safety Assurance Committee also receive the results of clinical audits and health and safety reports. The counterfraud and security management programmes are also monitored by the Audit Committee.

Both Committees take a close interest in ensuring that system weaknesses and assurance gaps are addressed. An internal and external audit action recommendation tracking system is in place, which

records progress in closing down the recommendations. The committees also seek other forms of assurance, which include the results of regulatory and other independent reviews of compliance with standards, relevant performance information, and management self-assessments coupled with the associated evidence base.

Involvement of stakeholders

The Trust recognises the importance of the involvement of stakeholders in ensuring that risks and accidents are minimised, and that patients, visitors, employees, contractors and other members of the public are not exposed to any unnecessary risks or hazards. Risks are assessed and managed to ensure that the Trust's systems reflect consideration of all these stakeholder interests. Stakeholders are also involved in the Trust's risk management process where appropriate. For example, patient views on issues are obtained through the Patient Advice and Liaison Service and patient representatives are involved in Patient-Led Assessments of the Care Environment (PLACE) inspections. There are regular discussions of service issues and other pertinent risks with commissioners. Staff are also involved in strategic planning groups with commissioners and other healthcare providers.

Other Regulations

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of economy, efficiency and effectiveness of the use of resources

The Board has agreed Standing Orders and Standing Financial Instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. In addition, the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and, where significant, these are reviewed by the Trust Board.

The Trust implemented a new performance management framework in May 2016 aligning to the new Divisional Management structure. The framework included adopting a performance dashboard

including metrics based on the Carter Report recommendations and includes a series of performance metrics. The Finance and Investment Committee reviews the operational, productivity and financial performance, and use of resources both at Trust and divisional level. More details of the Trust's performance and some specific Trust projects aimed at increasing efficiency are included in the Performance Report.

The Trust's external auditors are required to consider whether the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They report the results of their work to the Audit Committee. Their report is on page XX.

6. Governance

The governance section within the Annual Report explains how the Trust is governed and provides details of its Board committee structure, the frequency of meetings of the Board and its committees, attendance records at these meetings and the coverage of the work carried out by committees. The Board has assessed its compliance with the Monitor Corporate Governance code (see page XX).

The Trust did declare a governance target 'at risk' in its plans for 2016/17. The Trust reported that it is unable to declare compliance through the routine governance statements to the Regulator because the Trust is unable to report on performance against the national standard for Referral to Treatment Times (RTT); that is, the requirement that 92 per cent of all patients are seen within 18 weeks of their referral. In addition, the Trust suspended reporting against the national diagnostic standard, which requires Trusts to carry out a defined list of diagnostic tests within six weeks for at least 99 per cent of patients.

Since then the Trust has had the Intensive Support Team (IST) carry out a review of its RTT systems and processes. The Trust developed and has now implemented an improvement plan (agreed with external parties including NHS Improvement and NHS England). The plan involved the Trust validating all planned and other patients on waiting lists to ensure that they comply with the RTT guidance, and that treatment is prioritised where required. Policies and processes were reviewed and revised, and clinical and non-clinical staff trained in the management of RTT pathways. A clinical review panel was set up with the primary role of overseeing the review of patients who have waited longer than the nationally required wait times, to provide assurance and rigor that the length of time any patient has waited has not been clinically disadvantageous. The Trust requested that a comprehensive review of data quality across the organisation which was conducted by the internal audit team in February 2016 which found for the majority of the indicators sampled, reported numbers could be reconciled to data sources. The review concluded the need for establishment of a robust data quality framework at the Trust. A follow up internal audit was undertaken in March 2017 and indicates significant assurance with minor improvement opportunities.

The Trust has recommenced external RTT reporting in February 2017.

The Internal Auditors conducted a review of information governance audit in April 2017 and this indicated significant assurance with minor improvement potential.

Information governance

We have significantly improved records management across GOSH this year. The Trust's information register (what information is held on all of the systems used by individual departments) has been

updated and improved and we continued to roll out an electronic document management system. The shift to electronic records reduces lost paperwork, allows the right information to be available at any time and has given us greater control over who can view the patient's records. The planned move to EPR in the coming years will improve things even further.

This year there has been one serious incident in information governance (classified as Level 2 in the Information Governance Incident Reporting Tool) involving sensitive information for one patient being sent to the wrong address. The incident has been reported to the Information Commissioner's Office and an internal root cause analysis is underway.

7. Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

There are a number of controls in place to ensure that the Quality Report presents a balanced view of the Trust's Quality agenda. Many of the measures in the Quality Report are monitored throughout the year either at the Board or the Patient and Safety Outcomes Committee which reports into the Clinical Quality & Safety Committee. The Trust has a wide range of specific clinical policies in place to ensure the quality of care. These address all aspects of safety and quality. Policies are used to set required standards and ensure consistency of care.

The Trust's annual corporate objectives include targets for quality and safety measures and performance relative to these targets is monitored by the Trust Board and also measures specific to Clinical Divisions are monitored at the quarterly strategic reviews of performance.

The Audit Committee is responsible for monitoring progress on data quality. Objectives for data quality are defined and data quality priorities are monitored. Particular focus has been directed at key measures of quality and safety, which are relied upon by the Board and are collected from locally maintained systems. These measures are reported regularly through the Trust's quality performance management processes and reviews of deterioration in any such measure are fully investigated.

As noted already, during last year, a review of the Trust's waiting list data revealed a very high level of patients on waiting lists with unknown clock starts. The Trust was asked by its commissioners to carry out an audit of this data, and support was requested from the national response team. An action plan was agreed with commissioners and is routinely monitored through a four party meeting of the Trust, Monitor, CQC and commissioner. The Trust has now completed the implementation of the action plan to correct the issues and has now returned to reporting in February 2017.

External assurance statements on the Quality Report are provided by our local commissioners and our local LINKs as required by Quality Account Regulations.

8. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and clinical quality and safety committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- the reviews of compliance with CQC standards
- consideration of performance against national targets
- the assessment against the information governance toolkit
- Health and safety reviews
- results from the PLACE assessment
- relevant reviews by the Royal Colleges.

I have also considered the reviews of the BAF risks by the assurance committees, the Risk, Assurance and Compliance Group and internal audit who seek evidence that the controls are in place and effective in mitigating the risk and by the work of clinical audit. In the 2016/17 audit program the audit work found most areas with significant assurance with minor improvements required.

The instances where the assurance was not sufficient or controls were not adequate, when subject to routine audits during the 2016/17 year were:

- A review of the Temporary Staff Reporting arrangements was undertaken and given partial assurance with improvements required. The audit identified a requirement to improve the reconciliations of the data held by the bank team to other data, such as the general ledger, to verify the completeness of the reported data are not undertaken. The Trust will be completing the implementation of the new e-roster system over the next 18 months which will improve the capture and recording of the agency and staff.
- A review of the EPR implementation programme indicated no assurance. The findings included ensuring there was a full and up to date business case for the EPR implementation; developing appropriate governance processes for overseeing and approving changes to the EPR project; identifying the dependencies associated with the implementation of the EPR: All recommendations has been actioned and completed with governance processes not significantly improved leading to the approval of a Full Business Case by the Board to implement the EPR and Research platform. All actions have now been implemented to correct any weaknesses where there was no assurance.

There is one instance that has carried over from 2015/16 where the assurance was not sufficient or controls were not adequate which have action plans to be addressed in 2016/17, specifically being:

- The Trust has identified weaknesses in the processes for managing contracts resulting in delays to procurement. A contract management system has been procured and implementation will commence in April 2017 and a revised process of contract management is being implemented ensuring contract managers are assigned to each contract.

Assurance of core systems and controls

- The Trust audit programme has identified significant assurances for financial controls and risk management, and has found that the Trust Board Assurance Framework does reflect the organisation's key objectives and risks, and is regularly reviewed by the Board.
- In all cases, action plans have been put in place to remedy any controls or assurance gaps, and the remedial action is being monitored by the assurance committees of the Board.
- In addition, the Board has reviewed the risks and assurance available in relation to both its redevelopment programme and its information technology strategy, which is focussing on the introduction of electronic patient records and moving towards a fully digital hospital. It has been agreed that due to the challenges inherent within these projects and their importance to the on-going strategy, further actions are required to ensure that both programmes can be carried out within the required timescales and achieve their objectives.

I have also considered the results of the assessment of compliance with the NHSI Code of Governance for NHS Foundation Trusts (which are set out in the Annual Report on page XX).

The Board is committed to continuous improvement and ensures there are regular reviews of the Trust's performance in relation to its key objectives and that processes for managing risks are continually developed and strengthened.

Conclusion

With the exception of the gaps in internal controls and matters where assurances can be improved, as set out above, my review confirms that GOSH has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives, and I am confident that all minor gaps are being actively addressed. In the area where there was a significant control issue identified during the period, actions from now been implemented to address the issue.

Signed.....

Dr Peter Steer

Chief Executive Date: xx May 20xx

Independent Auditor's Report

To follow

Glossary

BAF

Board Assurance Framework.

Benchmarking

Benchmarking is a process by which an organisation compares its performance and practices against other organisations. These comparisons are structured and are typically undertaken against similar organisations and against top performers. Benchmarking helps to define best practice and can support improvement by identifying specific areas that require attention.

BRC

The Biomedical Research Centre is funded by the National Institute for Health Research and supports paediatric experimental medicine research at Great Ormond Street Hospital and the UCL Institute of Health.

Capital expenditure

Expenditure to renew the fixed assets used by the Foundation Trust.

Cardiac/respiratory arrest

Cardiac arrest is the cessation of normal circulation of the blood due to failure of the heart to contract effectively. A cardiac arrest is different from (but may be caused by) a heart attack, where blood flow to the muscle of the heart is impaired. Cardiac arrest prevents delivery of oxygen to the body. Lack of oxygen to the brain causes loss of consciousness, which then results in abnormal or absent breathing. Brain injury is likely if cardiac arrest goes untreated for more than five minutes. For the best chance of survival and neurological recovery, immediate and decisive treatment is imperative.

CEWS

Children's Early Warning Score.

CICU

Cardiac Intensive Care Unit.

Clinical audit

A quality improvement cycle that involves measurement of effectiveness of healthcare against agreed and proven standards for high quality. The audit takes action to bring practice in line with these standards so as to improve the quality of care and health outcomes. (HQIP Best Practice for Clinical Audit 2011).

Clinical outcome measures

A clinical outcome is a change in health that is attributable to a healthcare intervention. Routine outcomes measurement is central to improving service quality and accountability.

Commissioners

Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Primary Care Trusts were the key organisations responsible for commissioning healthcare services for their area. However, on 1 April 2013, commissioning structures changed. GP-run Clinical Commissioning Groups, responsible to NHS England, now commission services (including acute care, primary care and mental healthcare). Commissioning of specialist services is provided directly by NHS England. From 1 April 2013, around 90 per cent of the Foundation Trust's activity is commissioned by NHS England.

CQC

The Care Quality Commission replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit www.cqc.org.uk for more information.

CQUIN

Commissioning for Quality and Innovation.

Dashboards

Information dashboards present the most important information from large amounts of data in a way that is easy for users to read and understand. Dashboards summarise information and focus on changes and exceptions in the data.

Data quality

Data quality refers to the tools and processes that result in the creation of correct, complete and valid data that is required to support sound decision-making.

Department of Health

The Department of Health is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS.

Depreciation

The process of charging the cost of a fixed asset to the Statement of Comprehensive Income over its useful life to the Trust, as opposed to recording the cost in a single year.

Division

How we group and manage our clinical services.

EBITDA

Earnings before interest, taxes, depreciation and amortisation.

Fixed assets

Land, buildings or equipment that are expected to be used to generate income to the Trust for a period exceeding one year.

Foundation trust

A foundation trust is a type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities. NHS foundation trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS foundation trusts have members drawn from patients, the public, and staff, and are governed by a board of governors comprising people elected from and by the membership base.

Friends and Family Test

The Friends and Family Test (FFT) is a feedback tool that asks people using NHS services if they would recommend the services they have used

GOSH

Great Ormond Street Hospital for Children NHS Foundation Trust.

GP

General practitioner.

Healthwatch

Healthwatch is the new consumer champion for both health and social care from 1 April 2013. It exists in two distinct forms – local Healthwatch, at local level, and Healthwatch England, at national level. The aim of local Healthwatch will be to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

HCA

Health care assistant.

HCAI

Healthcare-acquired infection.

ICH

UCL Institute of Child Health.

Impairment

A charge to the Statement of Comprehensive Income resulting from a reduction in the value of assets.

Indexation

The process of adjusting the value of a fixed asset to account for inflation.

IPP

International and Private Patients.

KPI

Key performance indicator.

MDT

Multidisciplinary team – a group of different types of clinicians who work together.

Medical Director

The Medical Director is a physician who is usually employed by a hospital to serve in a medical and administrative capacity as head of the organised medical staff. A medical director provides guidance, leadership, oversight and quality assurance.

Members' Council

GOSH's Members' Council was established when the Trust became a Foundation Trust. The council is vital for the direct involvement of members in our long-term vision and planning, as a critical friend, and as a guardian of our values. It supervises public involvement, membership recruitment, and activation. The council has specific powers, including involvement in picking the Non-Executive Directors, ratifying the appointment of the Chief Executive, receiving the accounts, and appointing the auditors.

Monitor

Now known as NHS Improvement, Monitor is the independent regulator responsible for authorising, monitoring and regulating NHS Foundation Trusts.

Multidisciplinary team meeting

A meeting of the group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

Net current assets

Items that can be converted into cash within the next 12 months (e.g. debtors, stock or cash minus creditors). Also known as working capital.

NHS

National Health Service.

NHS Choices

NHS Choices is the UK's biggest health website. It provides a comprehensive health information service to patients and the public. The website helps users make choices about their health, from decisions about lifestyle, such as smoking, drinking and exercise, to finding and using NHS services in England.

NHS England

NHS England is an executive non-departmental public body of the Department of Health. It oversees the planning, delivery and day-to-day operation of the NHS in England as set out in the Health and Social Care Act 2012.

NHS Improvement

NICU

Neonatal Intensive Care Unit.

NIHR

National Institute for Health Research.

Pals

Patient Advice and Liaison Service.

Patient pathway

The patient pathway is the route that a patient will take from their first contact with an NHS member of staff (usually their family doctor), through referral, to the completion of their treatment. It also covers the period from entry into a hospital or a treatment centre, until the patient leaves. Events such as consultations, diagnosis, treatment, medication, assessment, and teaching and preparing for discharge from the hospital are all part of the pathway. The mapping of pathways can aid service design and improvement.

PGME

Postgraduate Medical Education.

PICU

Paediatric Intensive Care Unit.

PLACE

Patient Led Assessments of the Care Environment.

Providers

Providers are the organisations that provide NHS services, for example NHS trusts and their private or voluntary sector equivalents.

Provisions

Costs treated as expenditure in the current or previous periods but where cash will actually be paid in future periods. Amounts are estimated because it is not possible to be certain about the exact timing and amount.

Public dividend capital

The NHS equivalent of a company's share capital.

QSAC

Quality and Safety Assurance Committee, the new name for the Clinical Governance Committee (effective May 2016)

R&D

Research and development.

Referral to Treatment Waiting Time Processes

The length of time from referral through to treatment. The RTT 'clock' often starts weeks before a patient arrives at GOSH. The national standard is that 92 per cent of all patients are seen and treated within 18 weeks of their referral.

Research

Clinical research and clinical trials are an everyday part of the NHS. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

Safe and Sustainable

Safe and Sustainable is the name of the national paediatric surgery reviews of children's congenital heart services and children's neurosurgical services. The purpose of Safe and Sustainable is to canvas the opinions of all stakeholders, including professional bodies, clinicians, patients and their families, to weigh the evidence for and against different views of service delivery and to develop proposals that will deliver high-quality and sustainable services into the future.

Safeguarding

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

Special review

A special review is a review carried out by the Care Quality Commission (CQC). Special reviews and studies are projects that look at themes in health and social care. They focus on services, pathways of care or groups of people. A review will usually result in assessments by the CQC of local health and social care organisations. A study will usually result in national level findings based on the CQC's research.

Transformation

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

Trust Board

The role of the Trust Board is to take corporate responsibility for the organisation's strategies and actions. The Chair and Non-Executive Directors are lay people drawn from the local community and are accountable to the Secretary of State. The Chief Executive is responsible for ensuring that the Board is empowered to govern the organisation and to deliver its objectives.

UCL

University College London.

UCLP

University College London Partners.

Audit Committee
25th May 2017

Compliance with the NHS provider licence – self assessment

Paper No: Attachment I

Submitted by: Anna Ferrant, Company Secretary and Loretta Seamer, Chief Finance Officer

Aim

To present the annual self assessment of compliance with NHS Improvement (“NHSI”) license conditions for providers of NHS services.

To approve the Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence.

Summary

The NHS provider licence is NHSI’s main tool for regulating providers of NHS services. Foundation trusts were automatically licensed from 1 April 2013.

The licence sets out important conditions that providers must meet to help ensure that the health system works for the benefit of NHS patients. These conditions gives the regulator the power to:

- set prices for NHS funded care in partnership with the NHS England and require information from providers to help them in this process;
- enable integrated care across the NHS system;
- safeguard choice and prevent anti-competitive behaviour which is against the interests of patients;
- support commissioners to protect essential health services for patients if a provider gets into financial difficulties; and
- oversee the way that NHS foundation trusts are governed

In the past, providers have been required to complete an annual self-certification that confirms their continued eligibility to hold an NHS provider licence. This year, NHSI only needs the Trust to confirm compliance with licence at a Board meeting (i.e. there will be no submission).

A review of the Trust’s compliance with the licence is attached along with a draft completed copy of the declaration.

The conclusion of the self assessment is that the Trust is currently complying with all relevant aspects of the license conditions, although risks associated with one conditions of the license have been highlighted through use of an amber RAG rating.

Action required from the meeting

The Board is asked to:

- **note** the information presented in the self-assessment and
- **approve** the conclusion and declaration.

Contribution to the delivery of NHS / Trust strategies and plans

Providers are required to complete an annual self-certification that confirms their continued eligibility to hold an NHS provider licence.

Attachment I

Financial implications None
Legal issues None
Who is responsible for monitoring the license conditions? Chief Finance Officer and Company Secretary
Who is accountable for the implementation of the proposal / project The Board is responsible for ensuring continued eligibility to hold an NHS provider licence.

GOSH Self-Assessment 2016/17 - Compliance with Monitor Licence Conditions

Licence condition	Description	Compliance (RAG status)	Assurance
GENERAL CONDITIONS			
G1- Provision of Information	The Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for any of the purposes and these documents will be accurate and a true copy.		All information required or requested by Monitor has been provided during the year. The routine information requests include performance information. We have provided routine performance information, updates on the Well Led Governance Review and information (as requested) through the Access Improvement Tripartite meetings.
G2 – Publication of Information	The Licensee shall comply with any direction from Monitor for any of the purposes to publish information about health care services provided for the purposes of the NHS and as to the manner in which such information should be published.		There is no information which we have been required to publish by Monitor during the year.
G3 - Payment of Fees to Monitor	The Licensee shall pay fees to Monitor in each financial year of such amount as Monitor may determine for each such year no later than the 28th day after they become payable.		NO FEES have been required to be paid in the current year
G4 – Fit and Proper Persons Test	This condition requires that licensees do not allow unfit persons to become or continue as Governors or Directors. <i>“Unfit persons are: undischarged bankrupts, individuals who have served a prison sentence of three months or longer during previous five years, and disqualified directors. A company may also be an unfit person”.</i>		The Trust has adopted the following: <ul style="list-style-type: none"> • Trust Constitution • Code of Conduct for Directors • Code of Conduct for Councillors Copies are held of the following: <ul style="list-style-type: none"> • Signed declarations of being a fit and proper person by all Directors • Signed Declaration of eligibility from Councillors
G5 – Monitor Guidance	This condition requires licensees to have regard to any guidance that Monitor issues.		The Chief Finance Officer and Company Secretary ensure that all relevant guidance is considered and

Licence condition	Description	Compliance (RAG status)	Assurance
			<p>applied as required through monitoring of the Monitor website, email alerts and updates from NHS Providers.</p> <p>Updates are also provided by the internal and external auditors to the Audit Committee.</p>
<p>G6 – Systems for compliance with licence conditions and related obligations</p>	<p>The Licensee shall take all reasonable precautions against the risk of failure to comply with the Conditions of this Licence, any requirements imposed on it under the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.</p> <p>Systems and processes will be established to identify risks to non-compliance and these will be regularly monitored.</p> <p>A statement shall be provided for Monitor to certify compliance with this condition no later than 2 months from the end of the financial year.</p>		<ul style="list-style-type: none"> • The Trust has systems and processes to monitor risks of failure through lack of compliance or adverse variances in performance. During 2015/16 issues were identified in relation to the Trust’s ability to report performance on referral to treatment targets were notified to Monitor, NHSE and the CQC. The Trust has now addressed the issues relating to reporting and the Trust returned to reporting in February 2017, but notes that this is not for the full year 2016/17. • The Risk Ratios set out in the Risk Assessment Framework are monitored monthly • Requirements of other regulators such as the CQC are also monitored <p>A review of the license conditions indicates that the Trust existing governance, Board and Committee work programmes and performance reporting processes cover the risks to non-compliance with the license conditions.</p>
<p>G7 – Registration with the Care Quality Commission (CQC)</p>	<p>This condition reflects the obligation in the Health and Social Care Act 2012 for licensees to be registered with the CQC. This condition allows Monitor to withdraw the licence from providers whose CQC registration is cancelled and who therefore cannot continue to lawfully</p>		<p>During 2015/16, the Trust was inspected by the CQC and achieved an overall rating of GOOD. The action plan arising from the CQC inspection is due to be completed in May 2017.</p>

Licence condition	Description	Compliance (RAG status)	Assurance
	provide services.		<p>In addition, the following review processes have taken place:</p> <ul style="list-style-type: none"> • Monitoring of CQC standards at the Quality and Safety Assurance Committee • CQC update report to the Board and the Members' Council
G8 – Patient Eligibility and Selection Criteria	This condition required licensees to set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner. This includes criteria for determining patient eligibility for particular services, for accepting or rejecting referrals, or determining the manner in which services are provided to that person.		<p>Information on eligibility and admission criteria by service and then diagnosis or procedure is published under the Health Professionals section of the GOSH website: www.gosh.nhs.uk.</p> <p>There is also a GOSH policy on eligibility to access services (Access Policy to Clinical Services).</p> <p>It is important to note that most of the children cared for by the Trust are referred from other hospitals throughout the UK and overseas and this is clearly stated on the website.</p> <p>In addition the Trust has processes to check whether all patients referred are eligible for NHS care.</p>
G9 – Application of Section 5 (Continuity of Services)			
PRICING			
P1 –Recording of Information	Under this licence condition, Monitor may require Licensees to record information particularly information on their costs, in line with approved guidance Monitor will publish. The licence condition is worded in a way that any costs and other information that may be required		The Trust reports costs of its services in line with current costing guidance and has made both required submissions covering clinical services and education to the DH during the year.

Licence condition	Description	Compliance (RAG status)	Assurance
	can be collected from both licensees and their sub-contractors. This licence condition may also require licensees to record other information, such as quality and outcome data, in line with Monitor guidance and for the purpose of carrying out Monitor's pricing functions.		
P2 – Provision of Information	Under this condition, once the information has been recorded in line with Licence Condition P1, Monitor can request licensees to submit this data.		The Trust would comply with Monitor's requests for information and this data is submitted within requested timescales.
P3 – Assurance Report on Submissions to Monitor	Under this condition, Monitor may require licensees to submit an assurance report confirming the accuracy of the data they have provided under Licence Condition P2.		The Trust has monitored the quality of its costing information under P2 during the year using the standard measure and during 2016-17 the Trust costing information was audited and has identified actions to improve.
P4 – Compliance with the National Tariff	This licence condition imposes the obligation to charge for NHS healthcare services in line with the National Tariff. The Health and Social Care Act 2012 defines the National Tariff as a document published by Monitor		Activity is charged in line with National Tariff where applicable.
P5 – Constructive Engagement Concerning Local Tariff Modifications	This licence condition requires licensees to engage constructively with commissioners and to try and reach a local agreement before applying to Monitor for modification.		Where required, local modifications of prices have been agreed with the local commissioners. It should be noted that without modifications to prices set in the national tariff, the service would be uneconomic for the Trust. The Trust has agreed some local modifications with its Commissioners in 2016/17.
CHOICE AND COMPETITION			
C1 – The Right of Patients to Make Choices	This condition: <ul style="list-style-type: none"> Requires licensees to tell their patients when they have a choice of provider and to tell them where they can find information about the choices they have – this must be done in a way that is not misleading. 		The Trust complies with the patient choice requirements of the NHS Constitution. The Trust has a " <i>Declaration of Interest and Gifts and Hospitality Policy</i> " in place and new staff are informed about this on appointment and existing staff

Licence condition	Description	Compliance (RAG status)	Assurance
	<ul style="list-style-type: none"> Requires that information and advice that licensees provide to patients about their choice of provider does not unfairly favour one provider over another and is presented in a manner that helps patients to make well-informed choices. Prohibits licensees from offering gifts and benefits in kind for patient referrals or for the commissioning of services. 		reminded on an annual basis along with the request for any declarations.
C2 – Competition Oversight	<p>This condition prohibits the licensee from entering into or maintaining agreements that have the object or effect of distorting competition to the extent it is against the interest of health care users.</p> <p>It also prohibits the licensee from engaging in other conduct which has the effect of preventing, restricting or distorting competition to the extent it is against the interests of health care users.</p>		The Trust is cognisant of the Competition Act and Merger Laws and responds accordingly.
INTEGRATED CARE			
IC1 – Provision of Integrated Care	<p>This condition requires the licensee to not do anything that could be reasonably regarded as detrimental to enabling integrated care.</p> <p>The purpose of this licence condition is to enable Monitor to step in where integrated care is not being delivered, in spite of decisions and efforts made by commissioners.</p>		<p>The Trust works in an integrated manner with commissioners, other acute providers and clinical networks and ensures that patients' interests are prioritised.</p> <p>Specifically, the Trust seeks to work closely with secondary providers through outreach and shared care arrangements and where patients require transitioning to adult care.</p>
CONTINUITY OF SERVICES			
CoS1 – Continuing provision of Commissioner Requested Services	The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with agreement with the contracting commissioner, commissioners for whom the service is		The Trust has provided the Commissioner requested services, other than where certain services at sub specialty level have been paused with the agreement of NHSE commissioners either due to a mismatch between demand and capacity or due to a review of

Licence condition	Description	Compliance (RAG status)	Assurance
	provided and terms of authorisation of regulatory bodies		parts of the service.
CoS2 –Restriction on disposal of assets	<p>The Licensee shall establish, maintain and keep up to date, an asset register which shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.</p> <p>The Licensee shall not dispose of, or relinquish control over, any relevant asset except: (a) with the consent in writing of Monitor, providing Monitor with the necessary information relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.</p>		<p>The Trust keep an up to date asset register and has policies and procedures in place to manage all assets and maintain records required.</p> <p>No such disposals have been made.</p>
CoS3 – Standards of corporate governance and financial management	<p>The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which are suitable for a provider of the Commissioner Requested Services provided by the Licensee, and provide reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.</p>		<p>The Trust has adopted systems and standards of corporate governance and financial management. These are regularly audited and monitored by the Board assurance committees (Audit Committee, Quality and Safety Assurance Committee and Finance and Investment Committee).</p> <p>The Trust is taking all steps possible to minimise the risk of being unable to carry on as a going concern but the Trust closely monitors the risk of shortage in funding across the NHS, particularly within NHSE specialised commissioning, and ensuring tariff and local prices reflect the appropriate cost of specialised paediatric services.</p>
CoS4- Undertaking from the ultimate controller	<p>The Licensee shall procure from each company or other person that the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by Monitor.</p>		This is not relevant to GOSH.

Licence condition	Description	Compliance (RAG status)	Assurance
CoS5 – Risk Pool Levy	The Licensee shall pay to Monitor any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.		No amounts have been requested.
CoS6 – Cooperation in the event of financial stress	Where Monitor has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern, the Licensee shall provide such information as Monitor may direct to Commissioners and to such other persons as Monitor may direct; allow such persons as Monitor may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and co-operate with such persons as Monitor may appoint to assist in the management of the Licensee’s affairs, business and property.		No such notice has been given by Monitor.
CoS7 – Availability of resources	<p>The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.</p> <p>The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.</p> <p>The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate.</p>		<p>The Trust monitors its financial position and resource levels on a regular basis through routine performance reporting to the Board and its Committees</p> <p>No material agreements which might create a material risk have been entered into.</p> <p>The return due in May 2017 will be submitted on time. The Board qualified its declaration on financial sustainability over the two year planning horizon in accordance with the 2017-2019 NHSI plan submission made in March 2017.</p>

Licence condition	Description	Compliance (RAG status)	Assurance
ADDITIONAL CONDITIONS FOR FOUNDATION TRUSTS			
FT1 - Information to update the register of NHS foundation trusts	The Licensee shall ensure that Monitor has available to it written and electronic copies of the following documents: (a) the current version of Licensee's constitution; (b) the Licensee's most recently published annual accounts and any report of the auditor on them, and (c) the Licensee's most recently published annual report.		Whenever changes are made to the Constitution, an approved version is forward to Monitor. No changes have been made in 2016/17. The annual report and accounts are forwarded to Monitor as per the requirements in the Annual Reporting Manual (ARM).
FT2 - Payment to Monitor in respect of registration and related costs	Whenever Monitor determines in accordance with section 50 of the 2006 Act that the Licensee must pay to Monitor a fee in respect of Monitor's exercise of its functions under sections 39 and 39A of that Act the Licensee shall pay that fee to Monitor within 28 days of the fee being notified to the Licensee by Monitor in writing.		Monitor's right to levy payments in respect of registration has not been implemented.
FT3- Provision of information to advisory panel	The Licensee shall comply with any request for information or advice made of it under Section 39A(5) of the 2006 Act.		Any requests for information are complied with and the Board informed. No requests have been received in the current year.
FT4- NHS foundation trust governance arrangements	The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.		The Trust has complied with all relevant guidance in relation to the governance processes of a Foundation Trust. A self-assessment is prepared annually against the Monitor code of Governance and will be reported to the Board in <u>May 2017</u> .

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed

OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

Please fill details in cell E22

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust monitors its financial position and resource levels on a regular basis through routine performance reporting to the Board and its Committees

No material agreements which might create a material risk have been entered into.

The return due in May 2017 will be submitted on time. The Board qualified its declaration on financial sustainability over the two year planning horizon in accordance with the 2017-2019 NHSI plan submission made in March 2017.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Signature

Name: Dr Peter Steer

Name:

Capacity: Chief Executive Officer

Capacity:

Date:

Date:

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Trust Board 25th May 2017	
Compliance with Monitor's Code of Governance	Paper No: Attachment J
<p>Submitted by: Anna Ferrant, Company Secretary</p>	
<p>Aims / summary</p> <p>Monitor (NHSI), the Independent Regulator of NHS Foundation Trusts, has drawn on the practice developed in the private sector, and, based on the Combined Code for Corporate Governance, produced the NHS Foundation Trust Code of Governance. This code consists of a set of Principles and Provisions. The Code was revised and republished in July 2014.</p> <p>Foundation trusts are required to report against Monitor's Code of Governance each year in their Annual Report, on the basis of either compliance with the Code provisions, or, an explanation where they do not.</p> <p>A review has been conducted against all the Code's provisions and an outline of the evidence to support compliance against each of the criteria is attached. The text in red highlights those criteria against which Monitor expects the Trust to explain any areas of non-compliance.</p> <p>The review has found that the Board has applied the principles and met the requirements of Monitor's Code of Governance during 2016/17. As such, the statement in the 2016/17 annual report will read:</p> <p>Compliance with the Code of Governance</p> <p>GOSH has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust Board considers that from 1 April 2016 to 31 March 2017 it was compliant with the provisions of the NHS Foundation Trust Code of Governance.</p> <p>The Well Led Governance Review recommended that the Board Code of Conduct (see A1.1.8) is aligned to the Trust's 'Always' values. A review of the code of conduct will be conducted in Q2 2017/18. Further information about the review can be found on page XX.</p>	
<p>Action required from the meeting</p> <p>To note the results of the review and the statement to be included in the annual report.</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans</p> <p>Good corporate governance</p>	
<p>Financial implications</p> <p>None</p>	

Attachment J

Legal issues Compliance with the Code is required in order to retain authorisation as a Foundation Trust
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? N/A
Who is accountable for the implementation of the proposal / project? N/A

Compliance with the Code of Governance 2016-2017

Para	Statutory Requirement	Disclosure
A.1.1	The board of directors should meet sufficiently regularly to discharge its duties effectively. There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors. These arrangements should be kept under review at least annually.	<ul style="list-style-type: none"> • A schedule of matters is in place (reviewed September 2017) • A statement about resolving disagreements is detailed in the Constitution. • The annual report includes a statement about how the Board and Council operate and the types of decision taken by the Board and the Council.
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	The annual report identifies these individuals and outlines the number of meetings attended by Board members.
A.1.3	The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.	This statement is incorporated in the Trust's Annual Plan.
A.1.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual obligations, and approved plans and objectives.	The Board receives regular reports on quality, safety, finance, patient experience and workforce. These reports monitor the Trust's plans and strategies. Corporate risks are reviewed at the Risk, Assurance and Compliance Group (an executive led group) and the actions shared with the Audit and Quality and Safety Assurance Committees. Assurance of the robustness of the controls in place to mitigate these risks is sought by the Audit Committee and Quality and Safety Assurance Committee. The annual report provides a summary of the adequacy of these systems.
A.1.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate and, in particular, in high risk or complex areas, independent advice, for example, from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	<p>The Board receives regular reports on quality, safety, finance, patient experience and workforce. These include relevant metrics, milestones and measures.</p> <p>The assurance committees seek assurance of the robustness of the controls in place to mitigate risk and direct the internal audit function to provide assurance that these controls are robust. The assurance committees approve the internal and clinical audit plan every year.</p>

A.1.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the DH, NHS England, the CQC and Monitor. The board should record where, within the structure of the organisation, consideration of clinical governance matters occurs.	<p>The Board receives an integrated quality report at each Board meeting.</p> <p>The Quality and Safety Assurance Committee, a committee of the Board, seeks assurance of the adequacy of controls in place to manage quality risks and provides a summary report of matters considered at its last meeting to the next available Board meeting.</p> <p>The Patient, Safety and Outcomes Committee monitors the development and implementation of clinical risk management processes and evidence based standards and ensures that learning is disseminated and embedded across the Trust.</p> <p>The Quality Report is published with the annual report. Progress with the Quality Strategy is reviewed by the CGC on an annual basis.</p> <p>Compliance with CQC standards and other regulatory and statutory requirements are monitored by the Compliance Working Group and reported to the Risk Assurance and Compliance Group. An Assurance and Escalation Framework has been developed including enhanced monitoring of compliance requirements. An assurance report is submitted to the QSAC and an overview of compliance with three standards reported to the Board on an annual basis.</p>
A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board of directors and the council of governors and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	The Chief Executive is aware of his role and responsibility as accounting officer for the Trust and signs the statement in the annual report.
A.1.8	The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles).	These values and standards are defined in the job descriptions of the Chairman and NEDs. The Board of Directors' Code of Conduct reflect these values and standards and all directors have signed this code which includes reference to the fit and proper person test. The Well Led Governance Review recommended that the Board Code of Conduct is aligned to the Trust's 'Always' values and a review of the code of conduct will be conducted in Q2 2017/18
A.1.9	The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision-making unless this is in conflict with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interest are dealt with.	<p>These values and standards are defined in the job descriptions of the Chairman and NEDs. The Board of Directors' Code of Conduct reflect these values and standards and all directors have signed this code.</p> <p>The directors are asked to submit a declaration of interests annually and are prompted to declare any interests at the start of every Board meeting. The register of interests for directors is published on the GOSH website.</p>
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming the governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	<p>This cover is provided under the LTPS (NHSLA).</p> <p>The Trust has also arranged top up insurance to provide additional indemnity for risks not covered by the NHSLA e.g.:</p> <ul style="list-style-type: none"> • Claims made against the Entity itself • Past Directors, Governors, Employees
A.2.1	The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the board of directors.	The responsibilities of the Chairman and Chief Executive are set out in writing in their Job Descriptions. A summary of these responsibilities are also documented as an appendix to the schedule of matters.

A.2.2	The roles of chairperson and chief executive must not be undertaken by the same individual.	The Chairman and Chief Executive roles are undertaken by two separate individuals.
A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	The Chairman meets the independence criteria and has not been chief executive of the Trust.
A.4.1	In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.	The senior independent director is James Hatchley appointed by the Board in consultation with the Council in April 2017. The deputy chairman is Akhter Mateen, appointed in April 2017. The SID attends Members' Council meeting, is available to speak with councillors individually and invites comments from councillors on the appraisal of the Chairman during the period.
A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present. Led by the senior independent director, the non-executive directors should meet without the chairperson present, at least annually, to appraise the chairperson's performance, and on other such occasions as are deemed appropriate.	The Chairman held meetings with the NEDs during the year. The SID did not conduct an appraisal of the Chairman as the Chairman stepped down from the Board in April 2017.
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chairperson for circulation to the board, if they have any such concerns.	Any matters raised are recorded in the minutes of the meetings and the minutes reviewed and approved at the next relevant Board meeting. No concerns have been submitted to the Chairman during the period.
A.5.1	The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should, where practicable, make every effort to attend the meetings of the council of governors. The NHS foundation trust should take appropriate steps to facilitate attendance.	The Members' Council meets 5 times a year as a minimum (excluding extraordinary meetings). Councillor attendance at meetings is recorded in the annual report. Councillors are provided with regular reminders about meetings via the Councillor bulletin and as an agenda item at the Members' Council.
A.5.2	The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and procedures of the council of governors should be reviewed regularly as described in provision B.6.5.	The Council is made up of 27 councillors. The Members' Council terms of reference and MC Nominations and Remuneration Committee terms of reference were reviewed and revised in April 2016. The appraisal and NED recruitment processes have been reviewed by the Council during 2016/17.
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.	This information is recorded in the annual report which is published on the website. The Constitution includes an expectation of the number of meetings that councillors should attend.
A.5.4	The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	The annual report outlines the role and responsibilities of the Council, highlighting the responsibilities of the Council towards members and stakeholders. This is also included on the GOSH website and in other promotional material. A councillor role description has been agreed by the Council and will be reviewed again in readiness for the next Council election. The schedule of matters highlights the Council's responsibilities.

A.5.5	The chairperson is responsible for leadership of both the board of directors and the council of governors (see A.3) but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. In these meetings other members of the council of governors may raise questions of the chairperson or his/her deputy, or any other relevant director present at the meeting about the affairs of the NHS foundation trust.	<p>The chief executive gives a verbal report at each meeting. All other executive and non-executive directors attend the Council meeting on a regular basis and answer questions from councillors which is recorded in the Council meeting minutes.</p> <p>Councillors receive feedback from the non-executive chairs of the Board assurance committees. Councillors are invited to attend to observe the Board and assurance committee meetings.</p>
A.5.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the <i>new provider licence</i> or other matters related to the overall wellbeing of the NHS foundation trust. The council of governors should input into the board's appointment of a senior independent director (see A.4.1).	<p>The Constitution details how such issues will be managed.</p> <p>The SID is available to discuss concerns about the performance of the board of directors and/or compliance with licence requirements.</p> <p>All of the directors attend each Council meeting and are available to answer questions about performance matters.</p> <p>The Well Led Governance Review recommended work to be undertaken around the relationship between the Board and the Council and benchmarking practical ways to develop good engagement.</p>
A.5.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	<p>Councillors are invited to attend the Board and the assurance committees as observers.</p> <p>A bulletin has is sent out every month to councillors, updating them on development opportunities, requests for information, media news stories and dates for diaries.</p> <p>The Trust seeks to spell out all acronyms in Council papers. A glossary of terms has also been circulated to councillors.</p> <p>The Well Led Governance Review recommended work to be undertaken around the relationship between the Board and the Council and benchmarking practical ways to develop good engagement.</p>
A.5.8	The council of governors should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chairperson with the senior independent director in the first instance.	The Council will seek to engage with the Board of Directors should this situation arise, through the lead councillor.

A.5.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, for example clinical statistical data and operational data.	<p>At every meeting, the Council receives a report from the Chief Executive which includes information on targets and quality indicators, workforce and a financial update. A report from the PFEEC is also presented.</p> <p>Some councillors chair/ sit on Council working groups Well Led Governance Review working group) and Trust subcommittees (Patient and Family Experience and Engagement Committee) and report back to the Council.</p> <p>Councillors receive feedback from the non-executive chairs of the Board assurance committees. Councillors are invited to attend to observe these assurance committee meetings.</p> <p>Emails are sent to councillors on significant performance matters between meetings.</p> <p>A bulletin is sent out every month to councillors, updating them on development opportunities, requests for information, media news stories and dates for diaries.</p>
A.5.10	The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.	<p>The Members' Council are aware of this duty and carry it out in a number of ways:</p> <ul style="list-style-type: none"> - raising matters with non-executive directors in Council meetings (NEDs attend every Council meeting) - Attending assurance committees chaired by NEDs and observing how they hold the executive team to account; - Holding informal meetings with the Chairman and SID -Attending public Board meetings; - Attending the AGM -Emailing the Chairman and SID with concerns and/or questions in between meetings - Working with the Board to develop responses to the Well Led Governance Review report (via the Well Led Governance Review Working Group)
A.5.11	The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the <i>NHS Foundation Trust Annual Reporting Manual</i> : (a) the annual accounts; (b) any report of the auditor on them; and (c) the annual report.	These documents are presented to the Council at the Annual Member's meeting in September.
A.5.12	The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents.	The agenda of confidential meetings of the Board is shared with the Council and the minutes are shared once approved by the Board. The public agenda and papers are available on the Trust website and Councillors are invited to attend Board public meetings.
A.5.13	The council of governors may require one or more of the directors to attend a meeting to obtain information about performance of the trust's functions or the directors' performance of their duties, and to help the council of governors to decide whether to propose a vote on the trust's or directors' performance.	The executive and non-executive directors attend most Council meetings and provide information about performance of the Trust. This includes updates from those non-executive directors who chair Board assurance committees (Audit Committee, Quality and Safety Assurance Committee and the Finance and Investment Committee).
A.5.14	Governors have the right to refer a question to the independent panel for advising governors. More than 50% of governors who vote must approve this referral. The council should ensure dialogue with the board of directors takes place before considering such a referral, as it may be possible to resolve questions in this way.	Councillors have previously been provided with a copy of the revised Code of Governance and are aware of this right.

<p>A.5.15</p>	<p>Governors should use their new rights and voting powers from the 2012 Act to represent the interests of members and the public on major decisions taken by the board of directors. These new voting powers require:</p> <ul style="list-style-type: none"> • More than half of the members of the board of directors who vote and more than half of the members of the council of governors who vote to approve a change to the constitution of the NHS foundation trust. • More than half of governors who vote to approve a significant transaction. • More than half of all governors to approve an application by a trust for a merger, acquisition, separation or dissolution. • More than half of governors who vote, to approve any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more. For example, governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the trust's total income. • Governors to determine together whether the trust's non-NHS work will significantly interfere with the trust's principal purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions. <p>NHS 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>The Constitution covers all of these rights and voting powers. The Council approved a revision to the Constitution in 2014/15.</p>
<p>B.1.1</p>	<p>The board of directors should identify in the annual report each non-executive director it considers to be independent. The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board of directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination, including if the director:</p> <ul style="list-style-type: none"> • has been an employee of the NHS foundation trust within the last five years; • has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust; • has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme; • has close family ties with any of the NHS foundation trust's advisers, directors or senior employees; • holds cross-directorships or has significant links with other directors through involvement in other companies or bodies; • has served on the board of the NHS foundation trust for more than six years from the date of their first appointment; or • is an appointed representative of the NHS foundation trust's university medical or dental school. 	<p>The annual report details the independence of all of the non-executive directors. It notes that one NED is appointed by the Institute of Child Health, University College London and is the Director of this Institute.</p> <p>All directors are asked to annually declare any interests, including the matters outlined under B.1.1. Directors are also prompted to declare any interests at the start of every Board meeting</p>

B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	<p>The Board is normally comprised of a Chairman, Deputy Chairman, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by the UCL Great Ormond Street Institute of Child Health (ICH).</p> <p>With the departure of Tessa Blackstone, Chairman on 30th April 2017, , Mary MacLeod, Deputy Chairman was appointed by the Members' Council as Interim Chairman from 1st May 2017 whilst the appointment process for a substantive post was conducted. Until this appointment is filled, the Board will comprise an Interim Chairman and four Non-Executive Directors. With the impending departure of Mary MacLeod in October 2017, an appointment process for a new Non-Executive Director (agreed by the Members' Council) is also underway.</p>
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	None of the directors are councillors on the GOSH Members' Council nor a governor on another Trust's Council of Governors.
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website.	This information is included in the annual report and on the Trust website.
B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board of directors to meet them.	There are two nomination committees: one for the appointment of the Chairman and NEDs and one for the appointment of executive directors. Both have approved terms of reference and are responsible for taking into account succession planning. In 2017/18 the Members' Council Nominations and Remuneration Committee considered and approved the updated Board skills and experience survey, in preparation for informing the appointment of a new NE Chairman.
B.2.2	Directors on the board of directors and governors on the council of governors should meet the "fit and proper" persons test described in the provider licence. For the purpose of the licence and application criteria, "fit and proper" persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations	The directors on the Board and councillors have all been required to sign a statement declaring that they meet the criteria of a 'fit and proper person'.
B.2.3	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairperson). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.	<p>There are two nominations committees - the Board of Directors' Nominations Committee and the Members' Council Nominations and Remuneration Committee.</p> <p>The Members' Council Nominations and Remuneration Committee reviewed the structure, number and skills and experience of the Chairman and NEDs in April 2017 in preparation for the Chairman appointment.</p> <p>The Board of Directors' nominations committee considered the structure of the executive team in 2015 with the appointment of the CEO, Medical Director (01/06/15), Chief Nurse (01/05/15) and Deputy CEO (01/04/16).</p>

B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chairman.	The Members' Council Nominations and Remuneration Committee is chaired by the Chairman of the Board and Council. The terms of reference state that when the chairman is being appointed or reappointed, the deputy chairman shall take his or her place, unless he or she is standing for appointment, in which case another non-executive director shall be identified and agreed prior to the meeting to take his or her place. A majority of the committee is made up of councillors (at meetings and at NED appointment panels). The Board of Directors' Nominations Committee is chaired by Mary MacLeod, Chairman
B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors. Once suitable candidates have been identified the nominations committee should make recommendations to the council of governors.	The Members' Council approved the NED appointment process to be followed by the Nominations and Remuneration Committee (appointment of James Hatchley). The appointment was approved in June 2016. A recommendation for the appointment of the SID and the Deputy Chairman was considered in April 2017 and unanimously approved. The Members' Council approved the Chairman appointment process to be followed by the Nominations and Remuneration Committee. The appointment was considered at the May extraordinary Council meeting.
B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chairperson or a deputy chairperson, are being discussed, there should be a majority of governors on the committee and also a majority governor representation on the interview panel.	The Members' Council nominations and remuneration committee comprises the chairman of the trust, the deputy chairman, two councillors from the public constituency and/or the patient and carer constituency, one staff councillor and one councillor from any constituency (patient and carer, public, staff or appointed). A majority of the committee is made up of councillors (at meetings and at appointment panels).
B.2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	The Members' Council took into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for the new NED position, the appointment of the SID and the Deputy Chairman and the appointment of the Chairman.
B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.	The annual report includes an overview of the process followed for appointment of a new NED and Chairman to the Board
B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	An independent external adviser is not a member of the nominations committees and does not have a vote. An independent external adviser was invited to attend the interview panel for the appointment of the Chairman but did not have a vote.
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	This information is presented in the annual report. The Board of Directors' Nominations Committee and the Members' Council Nominations and remuneration Committee Terms of Reference are published on the Trust website.
B.2.11	It is a requirement of the 2006 Act that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairperson, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	The Nominations Committee terms of reference details these requirements.
B.2.12	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	The Nominations Committee terms of reference details these requirements.

B.2.13	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chairperson and the other non-executive directors.	This process is documented in the Trust Constitution and outlined above.
B.3.1	For the appointment of a chairperson, the nominations committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies. A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report. No individual, simultaneously whilst being a chairperson of an NHS foundation trust, should be the substantive chairperson of another NHS foundation trust.	The Chairman appointment process was conducted in May 2017. The job specification was approved by the Council in April 2017. The Chairman's significant commitments are documented in the annual report. The Chairman is not a chairperson of another NHS Foundation Trust.
B.3.2	The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to meet what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved and the council of governors should be informed of subsequent changes.	The terms and conditions of the NEDs were revised and approved by the Council in January 2017, including reference to the Fit and Proper Persons Test. The non-executive directors' significant commitments are reported in the Trust annual report.
B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairperson of such an organisation.	None of the executive directors are NEDs or chairs of another NHS organisation or another organisation of comparable sizes.
B.4.1	The chairperson should ensure that new directors and governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek out opportunities to engage with stakeholders, including patients, clinicians and other staff. Directors should also have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme.	New directors and councillors receive information as part of their induction and are required to attend a tailored corporate induction programme. Councillors receive information on an on-going basis via presentations to meetings and separate seminar sessions. Directors have access to development programmes organised and run by NHS Providers, the Kings Fund, Deloitte etc.
B.4.2	The chairperson should regularly review and agree with each director their training and development needs as they relate to their role on the board.	The Chairman reviews the training and development needs of non-executive directors when conducting appraisals on an annual basis. The Chairman discusses the performance of executive directors with the Chief Executive and comments on any areas that may require further development, support or training. Board Development seminars are held in April and June to discuss strategic or key operational matters. The Board development programme is under review following the results of the Well Led Assessment.
B.4.3	The board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	The Council receive information upon joining the Trust plus mandatory training. Prior to each Council meeting, the Council holds a seminar where interesting topics are presented and discussed and used to update and inform councillors on how the Trust operates and issues facing the Trust. A summary of these updates will be presented at the June 2017 Board (self certification statement). Councillors attend meetings with other governors run by external organisations such as Deloitte and report back to meetings.

B.5.1	<p>The board of directors and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and the council of governors should agree their respective information needs with the executive directors through the chairperson. The information for the boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.</p>	<p>The Board agenda and information contained within the reports is under constant scrutiny to ensure that the appropriate level of information is available to directors.</p> <p>The Board receives a refreshed integrated scorecard at every public meeting. The communication team regularly send around press updates to the Board and the Council.</p> <p>The Board work calendar has been updated to mirror reporting around the refreshed Trust strategy.</p> <p>Any significant matters are communicated to the Board as soon as possible by email, rather than wait for the next board meeting.</p> <p>During the period, the Council agenda has been revised, with one part of the meeting being dedicated to patient improvement/ experience matters and another to strategic matters.</p> <p>The executive directors and the Company Secretary regularly email councillors between meetings on significant matters to ensure that information is shared in a timely way, rather than wait for the next Council meeting.</p> <p>The Council receive a regular ebuletin updating them on important matters, highlighting access to training events and other events where they can meet members.</p>
B.5.2	<p>The board of directors and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board of directors, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the NHS foundation trust. On occasion, non-executives may reasonably decide that external assurance is appropriate.</p>	<p>The non-executive directors do request deeper analysis of high risk areas such as achievement of IPP plans and debt recovery; delivery of the P&E programme; assurance on data quality and delivery of RTT and a review of the gastroenterology service.</p> <p>Access to external assurance/ advice is made available on request, for example legal advice around agreements with the Charity or on large scale contracts.</p>
B.5.3	<p>The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. Decisions to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.</p>	<p>Where requested, external advice is sought, for example legal advice or HR advice.</p>
B.5.4	<p>Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.</p>	<p>The Company Secretary, Membership Relationship and Governance Manager and Trust Board Administrator supports the duties of the Board and Council committees.</p>
B.5.5	<p>Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the board, in particular making full use of their skills and experience gained both as a director of the trust and also in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of an NHS foundation trust as they would in other similar roles.</p>	<p>Non-executive directors provide feedback on information received at Board meetings. As a result and where necessary, additional information is provided. The data included in the integrated scorecard presented to Board has been subject to a kite- marking exercise to prove assurance to the board members of the quality of the data presented.</p> <p>All non-executive directors have been subject to an appraisal which considered the application of their skills and experience.</p>

B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Members have been consulted via a listening event, held in November 2016 on relevant key issues. A statement is included in the quality report and the annual report.
B.5.7	Where appropriate, the board of directors should take account of the views of the council of governors on the forward plan in a timely manner and communicate to the council of governors where their views have been incorporated in the NHS foundation trust's plans, and, if not, the reasons for this.	The Council provided feedback on the plan and the refreshed GOSH strategy at a meeting of the Council.
B.5.8	The board of directors must have regard for the views of the council of governors on the NHS foundation trust's forward plan.	The board of directors took account of the views of the Council on the NHS foundation trust's forward plan.
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the NHS foundation trust adopted a particular method of performance evaluation.	An independent review against the Monitor Well Led Governance Framework (incorporating elements of the quality governance framework) was conducted by Deloitte in June 2016. Deloitte LLP is the Trust's appointed external auditor. None of the engagement team undertook any external audit work at the Trust in the previous three years. In addition, a number of robust and effective safeguards were put in place to enable Deloitte to undertake this additional advisory work The results and action plan were presented to the Board in December 2016. The review highlighted a number of positive areas in relation to the governance and leadership of the Trust, with some recommendations for improvement around Board reporting, Board development and the relationship between the Board and Members' Council. The Board and Council have received regular updates on progress with the action plan. A Well Led Governance Review Group has been established, with members from both the Board and the Council to oversee recommendations on roles and responsibilities of the Board and the Council and learn from other Trusts about how to facilitate effective engagement and communication.
B.6.2	Evaluation of the boards of NHS foundations trusts should be externally facilitated at least every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor. The external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	See above.
B.6.3	The senior independent director should lead the performance evaluation of the chairperson, within a framework agreed by the council of governors and taking into account the views of directors and governors.	The SID discusses the Chairman's performance with the executive directors, NEDs and councillor representatives.
B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	All directors are subject to annual performance evaluation, identifying any personal professional development requirements. Non-executive directors individually attend professional development events held by the Kings Fund, the NHS Providers, auditor companies etc.

B.6.5	<p>Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on:</p> <ul style="list-style-type: none"> • holding the non-executive directors individually and collectively to account for the performance of the board of directors. • communicating with their member constituencies and the public and transmitting their views to the board of directors; and • contributing to the development of forward plans of NHS foundation trusts. <p>The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.</p>	<p>Members can communicate with councillors via the foundation trust GOSH email address (emails are sent on to the relevant councillor). This information is also presented in the annual report. Councillors have been involved in drafting the letters accompanying the Member Matters publication.</p> <p>The Members' Council was consulted on development of the trust annual plan.</p> <p>The Membership Engagement and Representation Committee continues to review the effectiveness of communication tools with members.</p> <p>The work conducted by the Well Led Governance Review Working Group is focusing on best practice across the NHS for Board and Council engagement.</p>
B.6.6	<p>There should be a clear policy and a fair process, agreed and adopted by the council of governors, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council of governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors. In addition, it may be appropriate for the process to provide for removal from the council of governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise.</p>	<p>The Constitution details the process for removal of a councillor, including the requirements to attend a certain number of council meetings and management of potential conflicts of interest. The Constitution will be reviewed and revised in Q2 2017/18.</p>
B.7.1	<p>In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g., two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may, in exceptional circumstances, serve longer than six years (e.g., two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence.</p>	<p>The Trust is compliant with this requirement. The appraisal process for the NEDs was conducted in December 2016 and confirmed that the performance of these individuals continued to be effective. The Council approved the output of the appraisal process in January 2017.</p>
B.7.2	<p>Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.</p>	<p>The Foundation Trust will conduct its next election in January 2018. The information presented to members for the elected councillors wishing to be re-appointed will include information about the prior performance attendance at meetings and involvement in committees and other activities.</p>
B.7.3.	<p>Approval by the council of governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairperson and non-executive directors. All other executive directors should be appointed by a committee of the chief executive, the chairperson and non-executive directors.</p>	<p>The Trust is compliant with this requirement. The Board of Directors' Nominations Committee Terms of Reference details the appointment process for executive directors.</p>
B.7.4	<p>Non-executive directors, including the chairperson should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.</p>	<p>The Trust is compliant with this requirement.</p>
B.7.5	<p>Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.</p>	<p>The Trust complies with this requirement. Elections are administered by the Electoral Reform Services on behalf of the Trust. The Trust will conduct its next election in January 2018.</p>

B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	The Board is aware of this requirement and has carefully planned where executive directors have stepped down from their post during the year (Medical Director)
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	These statements are presented in the annual report.
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	This statement is presented in the annual report and states that the Trust is a going concern.
C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	<p>The Trust publishes an annual report, including a quality report, outlining financial, quality and operating objectives for the NHS foundation trust.</p> <p>The Council receives performance and financial information at each meeting and all directors attend Council meetings to answer any questions.</p> <p>The annual plan is consulted on with the Council.</p> <p>Public Board meetings and Members' Council meetings are advertised and the papers are available on the GOSH website.</p>
C.1.4	<p>The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.</p> <p>The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in:</p> <ul style="list-style-type: none"> • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. 	<p>The directors maintain an open dialogue with the regulators (both Monitor and CQC), reporting any significant matters and ensuring that these are also flagged with the Council</p> <p>The Board has informed the Council and Monitor of issues relating to achievement of the RTT target.</p> <p>Monitor and the Council has been kept informed about the development and funding of the Centre for Research into Rare Disease in Children.</p>
C.2.1	The board of directors should maintain continuous oversight of the effectiveness of the NHS foundation trust's risk management and internal control systems and should report to members and governors that they have done so in the annual report. A regular review should cover all material controls, including financial, operational and compliance controls.	<p>The Trust is compliant with preparing and reviewing the assurance framework and the annual governance statement. The internal auditors conducted an audit into the systems in place for managing risk and awarded significant assurance' for 2016-17.</p> <p>The Non-executive directors meet once a year to focus on risk management, including how the Trust scans for emerging risks, risk appetite, escalation of risk and the relationship between incident reporting and risk management.</p>

C.2.2	<p>A trust should disclose in the annual report:</p> <p>(a) if it has an internal audit function, how the function is structured and what role it performs; or</p> <p>(b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.</p>	The annual report presents this information.
C.3.1	<p>The board of directors should establish an audit committee composed of at least three members who are all independent non-executive directors. The board should satisfy itself that the membership of the audit committee has sufficient skills to discharge its responsibilities effectively, including ensuring that at least one member of the audit committee has recent and relevant financial experience. The chairperson of the trust should not chair or be a member of the audit committee. He can, however, attend meetings by invitation as appropriate.</p>	The Trust is compliant with this requirement.
C.3.2	<p>The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference. The council of governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly. It should include details of how it will:</p> <ul style="list-style-type: none"> • Monitor the integrity of the financial statements of the NHS foundation trust, and any formal announcements relating to the trust's financial performance, reviewing significant financial reporting judgements contained in them; • Review the NHS foundation trust's internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust's internal control and risk management systems; • Monitor and review the effectiveness of the NHS foundation trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements; • Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements; • Develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and • Report to the council of governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken. 	The Audit Committee's terms of reference outline its role and responsibilities and are published on the GOSH website. The terms of reference have been subject to review and approved by the Audit Committee in April 2016 and the Council in June 2016.
C.3.3	<p>The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the audit committee, which provides information to the governors on the external auditor's performance as well as overseeing the NHS foundation trust's internal financial reporting and internal auditing.</p>	The Members' Council was involved in the appointment of Deloitte LLP for a 3 year term from 2014/15.
C.3.4	<p>The audit committee should make a report to the council of governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable to council of governors to consider whether or not to re-appoint them. The audit committee should also make recommendation to the council of governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.</p>	The Council receives an annual report on the performance of the external auditors. Both the Audit Committee and the Council were satisfied with their independence and objectivity and the effectiveness of the audit process.

C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	This statement is not applicable for 2016/17.
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three- to five-year period of appointment.	Deloitte LLP have been appointed for a three year term from 2014/15, following a competitive tender process.
C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	The Trust will be compliant with this requirement, should the situation arise. Deloitte were re-appointed as the Trust's external auditors following a competitive tender process.
C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.	This matter is the responsibility of the Audit Committee and documented in its terms of reference. The Committee receives a quarterly report on an whistle blowing cases and actions taken to address issues raised. The QSAC considers any reports that are related to the quyality of care.
C.3.9	A separate section of the annual report should describe the work of the committee in discharging its responsibilities. The report should include: <ul style="list-style-type: none"> • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. 	The annual report includes an Audit Committee report and covers the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed and the effectiveness of the external audit process. The Audit Committee considers application of the non audit services policy.

D.1.1	<p>Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions:</p> <p>i) The remuneration committee should consider whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.</p> <p>ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in some key indicators, and the taking of independent and expert advice where appropriate.</p> <p>iii) Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed.</p> <p>iv) The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.</p>	Executive directors are not awarded annual bonuses or subject to any incentive schemes.
D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	In 2017, the Members' Council approved a recommendation for the Chairman and NEDs not to receive a pay increase or cost of living increase for 2017/18. The terms and conditions of service of the Chairman and the NEDs were considered in January and April 2017 including the time commitment for both roles.
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	No executive director has been released on this basis during the period.
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	<p>All executive director contracts require 6 months' notice period.</p> <p>Chief Executive and executive director terms and conditions of employment are set by the Board Remuneration Committee (except for pension entitlements which are managed in accordance with the provisions of the NHS Pension Scheme). Contracts issued to directors allow the Trust to terminate employment in accordance with employment legislation (for instance, for unsatisfactory performance, capability, ill health). On termination due to poor performance, directors would receive their right to notice of dismissal (except in cases of gross misconduct where dismissal without payment of notice can occur) and any other relevant contractual entitlement (such as payment of outstanding annual leave). Non-contractual payments on dismissal cannot occur without the explicit authorisation of the Remuneration Committee and other external bodies (Monitor and the Treasury); the Committee, therefore, can ensure Directors are not financially rewarded (beyond their contractual entitlements) if their employment is terminated on the grounds of poor performance.</p>
D.2.1	The board of directors should establish a remuneration committee composed of non-executive directors which should include at least three independent non-executive directors. The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.	The Board of Directors have established a Remuneration Committee, chaired by David Lomas (NED) and including all non- executive directors as members (therefore complying with the requirement for at least three independent NEDs). Terms of reference are in place. Remuneration consultants were not employed during the period.

D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose should be determined by the board, but should normally include the first layer of management below board level.	The terms of reference of the Board of Directors Remuneration Committee covers these areas.
D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	In 2017, the Members' Council approved a recommendation for the Chairman and NEDs not to receive a pay increase or cost of living increase for 2017/18. This approval was based on a benchmark review of remuneration via survey results from NHS providers.
D.2.4	The council of governors is responsible for setting the remuneration of non-executive directors and the chairperson.	See above.
E.1.1	The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	The Patient and Family Experience and Engagement Committee is responsible for overseeing involvement of members, patients and the local community at large. Information from the committee is reported to the Board and the Council.
E.1.2	The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums (e.g. Local Healthwatch, the Overview and Scrutiny Committee, the local League of Friends, and staff groups)	A Trust listening event was held in November 2016. A summary of patient engagement activity is included in the annual report.
E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole. The chairperson should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested by governors. The senior independent director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.	<p>The Chairman presents a summary report of the previous Council meeting to the Trust Board.</p> <p>NEDs (and executive directors) regularly attend Council meetings (including the SID). The SID received feedback on the Chairman's performance as head of the Council from councillors via a number of councillor representatives.</p> <p>The SID has met with individual councillors during the year. The Chairman and SID provided opportunities for groups of councillors to meet with them for focused meetings throughout the year (outwith the normal general meetings)</p> <p>Emails from councillors raising any concerns are shared with the executive and non-executive directors.</p>
E.1.4	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	<p>All councillors are promoted on the Trust website and members can communicate with them via the foundation trust GOSH email address (emails are sent on to the relevant councillor). This information is also presented in the annual report. Councillors have been involved in drafting the letters accompanying the Member Matters publication. In 2015/ 16 the MEC has been developing methods for engaging directly with members, and collating feedback. The annual survey on the Trust annual plan included questions on engaging with members.</p> <p>See B.5.6 for information about consultation held during the year with members.</p>

E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	All directors, including NEDs attend Members' Council meetings. Individual meetings and email communications have been conducted between councillors and directors. The Council and the Board have reviewed how they work together and made recommendations for enhanced communication. Consultation and survey results are shared with the Board and the Council. Councillors attend the Board assurance committees and the public Board as observers. The annual report outlines how the Board and the Council have worked together during the year.
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. This information should be used to review the trust's membership strategy, taking into account any emerging best practice from the sector.	The Membership Engagement and Representation Committee (MERC) routinely reviews the representation of the membership and report this to the Council. This information is also presented in the annual report and in the annual membership report. The Council reviewed and approved the revised Trust membership strategy in September 2015 and progress is monitored via the MERC.
E.1.7.	The board of directors must make board meetings and the annual meeting open to the public. The trust's constitution may provide for members of the public to be excluded from a meeting for special reasons.	The Constitution details that there will be Board meetings held in public and provides for the exclusion of members of the public for special purposes. Six board meeting are held in public a year. The annual meeting is also held in public.
E.1.8	The trust must hold annual members' meetings. At least one of the directors must present the trust's annual report and accounts, and any report of the auditor on the accounts, to members at this meeting.	The annual members' meeting is held in September every year and the directors present the annual report and accounts and the report from the auditors. All FT members and members of the public are invited.
E.2.1	The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.	A schedule of third parties is in place and maintained.
E.2.2	The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	The Board and its committees and the executive team review the mechanisms in place for cooperating with third parties on a regular basis, including referrers, Monitor, CQC, commissioners, external auditors, the Charity etc. The Chief Executive regularly discusses involvement and attendance at key stakeholder meetings at the EMT.

Trust Board 25th May 2017	
Quality Report 2016/17	Paper No: Attachment K
Submitted by: Dr David Hicks, Interim Medical Director	
<p>Aims / summary The Quality Report is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. Its aim is to enhance accountability and engage leaders of NHS organisations in their quality improvement agendas. The Quality Report is a mandated document, which is laid before Parliament before being made available to patients, their families, and the public on the NHS Choices website.</p> <p>The production of the document is in line with Department of Health and Monitor published requirements. One document has been produced, which meets the requirements of both.</p>	
<p>Action required from the meeting Sign off of Quality Report</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans This document describes quality improvement work that has taken place in line with Trust strategic aims and in line with quality as defined in the Next Stage Review. The document also outlines the Trust's quality improvement work for 2017/18.</p>	
<p>Financial implications None</p>	
<p>Who needs to be told about any decision? Deloitte</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales? The delivery of the report is the responsibility of the Clinical Outcomes Development Lead. The deliveries of the projects therein are the responsibility of the individual project teams.</p>	
<p>Who is accountable for the implementation of the proposal / project? Dr David Hicks, Interim Medical Director</p>	

Patient image to be added at a later date

Quality Report 2016/17

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Patient image to be added at a later date

Understanding the *Quality Report*

We recognise that some of the information provided may not be easily understood by people who do not work in healthcare. So, for clarity, we have provided explanation boxes alongside the text.

This is a 'what is' box

It explains or describes a term or abbreviation found in the report.

"Quotes from staff, patients and their families can be found in speech bubbles."

What is the *Quality Report*?

The *Quality Report* is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. Its aim is to enhance accountability and engage leaders of NHS organisations in their quality improvement agendas. The *Quality Report* is a mandated document, which is laid before Parliament before being made available to patients, their families, and the public on the NHS Choices website.

What does it include?

The content of the *Quality Report* includes:

- Local quality improvement information, which allows trusts to:
 - demonstrate their service improvement work
 - declare their quality priorities for the coming year and how they intend to address them
- Mandatory statements and quality indicators, which allow comparison between trusts
- Stakeholder and external assurance statements

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) has a long-standing reputation as one of the finest paediatric hospitals in the world. We are keen to share information publicly about the quality of our services and about our continuous improvement work.

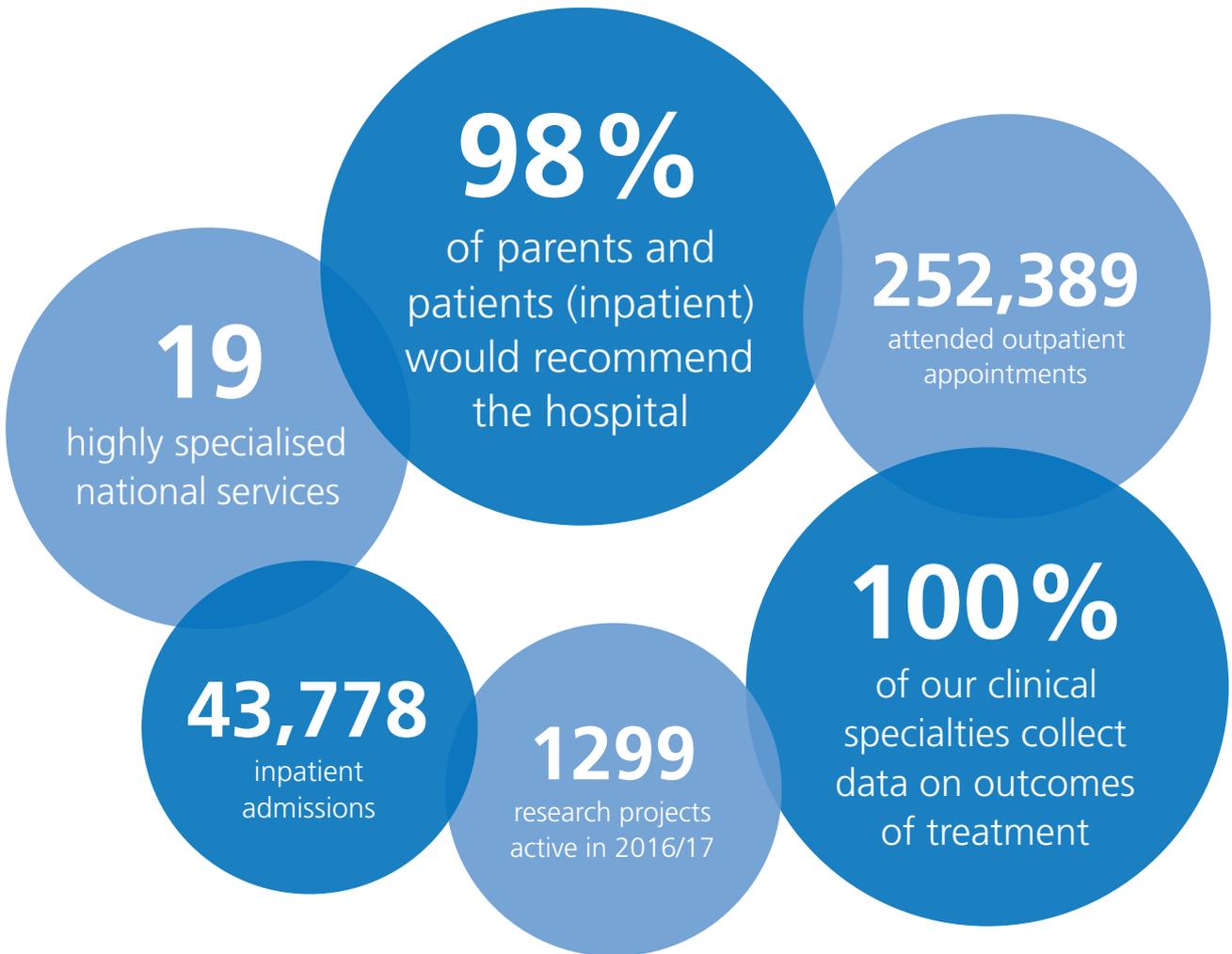
What is NHS Choices?

NHS Choices is the UK's biggest health website. It provides a comprehensive health information service to patients and the public.

What is a Foundation Trust?

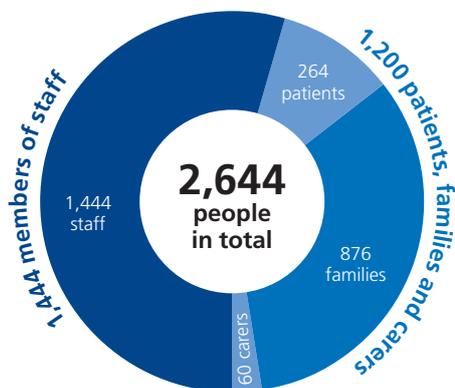
A Foundation Trust is a type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities. NHS Foundation Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public, and staff, and are governed by a board of governors comprising people elected from and by the membership base.

Our hospital



Our Always Values

We consulted very widely with staff, patients and families to derive our values:



After an extensive consultation and development period on values and the behaviours that demonstrate them, we formally launched *Our Always Values* in March 2015. Since then, *Our Always Values* has been a visible representation of our commitment to our patients, families and staff. These logos appear throughout the report where work described reflects *Our Always Values*.

Always



Part 1:

A statement on quality from the Chief Executive

At GOSH we are committed to continual improvement in everything we do. The *Quality Report* details our performance in the year's key improvement projects aligned to our three quality priorities, which are:

- **Safety** – to eliminate avoidable harm
- **Clinical effectiveness** – to consistently deliver excellent clinical outcomes, with the vision to be the leading children's hospital in the world
- **Experience** – to deliver kind and compassionate care, and communicate clearly to build confidence and ease

Areas for improvement are spotlighted in a number of ways. Issues may be flagged via internal or external audit or review, or via any of the gamut of ways through which we invite feedback from our patients and their families.

As detailed in Part 2c and Part 3, we have performed well against quality indicators set by Department of Health and met nearly all of our reportable healthcare targets set by NHS improvement. An urgent overhaul of our processes and systems for data collection and handling means we have been unable to report referral-to-treatment (RTT) for 2016/17. We are back on track to have complete waiting time data for 2017/18.

I am particularly proud of the further progress made this year to prevent and identify deterioration in our young patients (see below). Over recent years this programme of work has brought together a wide range of initiatives – from new technology and better equipment, to staff training and awareness raising – to deliver the excellent quality of care our patients deserve.

Safety

A new protocol was introduced at GOSH, and supported by staff training, to increase timely recognition and treatment of sepsis, which is a life-threatening condition that can arise as a result of infection. Swift action is vital in sepsis, so it is very encouraging that in the first few months of the protocol being rolled out hospital-wide, nearly 70% of actions were taken within one hour – far in excess of the international average.

Work was also undertaken this year to cut preventable cardiac and respiratory arrests. By reviewing our monitoring systems, improving staff's preparedness for a clinical emergency and bringing in new equipment, potentially preventable arrests reduced substantially over the 12 months.

Finally, we built on last year's introduction of electronic Patient Status at a Glance (ePSAG) boards, by establishing safety huddles into the daily routine of inpatient wards. These short meetings of clinical staff take place at the ward ePSAG. They ensure that all staff understand each patient's status, and that there is collective awareness of those children that may be at risk of deterioration.

An audit of neonatal care at GOSH spotlighted some areas for safety improvement that we intend to address in the coming year. This work will focus on three main areas: bloodspot testing for early detection of serious conditions, identification and evidence-based treatment of neonatal jaundice, and management of neonatal intravenous fluids.

Clinical effectiveness

In 2015 the quality of our Referral to Treatment (RTT) data began to cause concern. It was failing to accurately reflect waiting times, so we were unable to keep track of our performance against national targets. Over the past year a great deal of time and hard work has gone in to transforming the quality of our data and systems so they are now viewed as among the best in the sector. We recommenced reporting in 2017, and the first few months of data put us well ahead of our recovery trajectory. This gives me great confidence that in all but a handful of sub-specialties we'll meet the national standard in 2017/18 – that 92% of patients should wait less than 18 weeks from referral to treatment.

To be truly world-leading in our practice it is crucial we care for the whole child, rather than treating a patient's condition in isolation. Evidence shows that people with long term conditions are at high risk of mental health problems, so this year we proactively, but unintrusively, increased our psychological support services across four clinical areas. Mental health screening – in the form of a questionnaire offered to families – confirmed that our patients with long term conditions do exhibit a higher rate of mental health difficulties than children in the general population. Our psychological services staff followed up every patient whose screening caused concern. Going forward, we plan to refine and establish mental health support as part of the patient journey in high risk clinical areas at GOSH.

In 2017/18 we will bring clinical outcomes to the forefront. Currently, Trust-wide access to teams' outcome data is patchy. We will take a consistent approach to collecting and reporting outcome information internally through the Clinical Outcomes Hub. This will enable teams to more readily use this evidence in decision-making and service improvement.

Experience

The views of our patients and families are paramount in informing the continual improvement of clinical and support services across GOSH. We place the results from the NHS Friends and Family Test (FFT) in high regard, and have worked hard to make it easy for more of our patients and parents to tell us what they think. It is encouraging to see a 7% increase in comments received this year. Crucially, we have established practices to ensure teams throughout the Trust use the feedback to recognise their achievements as well as understand where improvement is needed.

The FFT results from inpatients have this year exceeded our own ambitious target of a 95% rate of recommendation for the hospital, but for outpatients it stands at 93%. Work continues to address this shortfall in outpatient responses, and we will soon begin a demographic analysis of FFT results. This will help us to identify and address any differences in the quality of experience at GOSH according to ethnicity, age and additional needs.

Many of GOSH's patients have conditions that persist beyond their time in our care. We therefore have a duty to ensure that the transition from paediatric to adult services is as positive as it can be. It's a complex challenge, and an area that GOSH patients and parents have told us needs improvement. This year we laid the foundations of our trust-wide Transition Improvement Project. This work included the identification of a doctor in each specialty who will be the transition lead, and an audit of relevant data and information about our transitioning or near-transition patients. There is a great deal of work to do now to improve the experience of transition, and the project will remain a priority in the coming year and beyond.

Accuracy of data

We are very mindful that much of the information we have provided in this report is dependent on the quality of the data we can obtain. In preparing the Quality Accounts, there are a number of inherent limitations which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year
- Data is collected by a large number of teams across the trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might reasonably have classified a case differently
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data

Where we have been unable to provide accurate data in relation to key healthcare targets, it is clearly stated.

The Trust and its executive team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.

Following these steps, to my knowledge, the information in the document is accurate.



Peter Steer
Chief Executive

Patient image to be added at a later date

Part 2a:

Priorities for improvement

This part of the report sets out how we have performed against our 2016/17 quality priorities. These have been determined by a combination of national priorities as well as local priorities identified by staff, patients and their families, and wider stakeholders such as referrers and commissioners. The quality priorities fall into three categories: safety, clinical effectiveness and experience. These categories were defined by Lord Ara Darzi in his NHS review for the Department of Health, in which he emphasised that quality should be a central principle in healthcare.



Safety

We are committed to reducing avoidable harm and improving patient safety as rapidly as possible. Our safety initiatives aim to ensure that each patient receives the correct treatment or action the first time, every time.

Clinical effectiveness

At GOSH, we seek to provide care for our patients commensurate with the best in the world. As a major academic centre, we work with our patients to improve the effectiveness of our care through research and innovation. We use national and international benchmarks to measure our effectiveness whenever possible, and we publish this outcomes data on our website and in renowned academic journals. To measure our effectiveness from the patient's perspective, we use Patient-Reported Outcome Measures (PROMS).

Experience

We want our patients and their families to have the best possible experience of our treatment and care. Therefore, we measure patient experience across the hospital and seek feedback from our patients, their families and the wider public to improve the services we offer. We do this via:

- Membership, patient and member surveys
- Focus groups and events
- Social media
- Asking patients and families about their experience within 48 hours of discharge

Reporting our quality priorities for 2016/17

The six quality priorities reported for 2016/17 are:

Safety

- Improving the monitoring and escalation of the deteriorating child
- Implementing safety huddles

Clinical effectiveness

- Reducing the number of patients with incomplete pathways at 18 weeks
- Implementing mental health screening in children and young people with long-term physical health conditions

Experience

- Improving young people's experience of transition to adult services
- Utilising Friends and Family Test data for improvement

This section reports on our performance against each quality priority by outlining:

- What we said we'd do
- What we did
- What the data shows
- What's going to happen next
- How this benefits patients

In this section, we also provide information about other ways we have sought the views of our patients and families in 2016/17.

Improving the monitoring and escalation of the deteriorating child

What we said we'd do

We said we would further improve the monitoring of patients on the ward to ensure early identification every time when a child's health is deteriorating. Effective monitoring means staff can seek support early on to provide intervention to stabilise the child. The improvement work had two strands:

1. Improving sepsis awareness
2. Preventing cardiac and respiratory arrests

1. Improving sepsis awareness

What we did

Since a national report in November 2015¹, sepsis awareness has grown as an NHS priority to avoid preventable health problems or death through early detection and treatment. Research shows that for every hour of delay in treatment of a septic patient, mortality increases by 7%. We've always been conscious of the risk of sepsis, but this report has influenced us to further our efforts to identify these cases early.

As part of our improvement workstream on the deteriorating child, we developed and implemented a new sepsis protocol in 2016/17 to increase timely recognition and treatment of sepsis in our patients.

In July 2016, a project team was set up to implement the 'Sepsis 6' protocol at GOSH. The steering group was led by a specialist neonatal and paediatric surgeon and had representation from intensive care units (ICU), resuscitation services, clinical site practitioners, frontline nursing and medical teams and the Quality Improvement team. The GOSH Sepsis 6 protocol was adapted from the national Paediatric Sepsis 6, developed by the UK Sepsis Trust.

What is sepsis?

Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death, especially if not recognised early and treated promptly.

UK Sepsis Trust

What is 'Sepsis 6'?

Sepsis 6 is a list of six actions that can double the chances of survival, if applied within the first hour of presentation. The actions are:

1. Provide high flow oxygen
2. Obtain intravenous (into vein)/intraosseous (into bone marrow) access and take bloods (gas, lactate and blood cultures)
3. Give intravenous/intraosseous antibiotics
4. Consider fluid resuscitation
5. Involve senior clinician early
6. Consider inotropic support early (medicines that change the force of heart contractions)

What is a Clinical Site Practitioner?

A Clinical Site Practitioner (CSP) is a senior nurse in charge of the day-to-day operational management of the hospital.



¹ National Confidential Enquiry into Patient Outcome and Death (2015). Just Say Sepsis! A review of the process of care received by patients with sepsis. London: NCEPOD

The protocol was piloted on Squirrel (surgical) ward and then rolled out to Elephant, Lion and Giraffe (haematology and oncology) wards. The pilot included:

- Ward-based training for nursing and medical teams
- A hotline for support to staff implementing the sepsis care protocol
- Data collection on the timeliness of delivery of the protocol

Following the positive results of the pilot, the Sepsis 6 protocol was rolled out Trust-wide at the end of January 2017. Sepsis champions were recruited from all clinical specialties and participated in a train-the-trainer programme. A Sepsis Awareness Week was held in the hospital to promote knowledge among all staff, parents and patients about the signs of sepsis. This was delivered through lunchtime lectures, information stands and simulation exercises on the wards.

What the data shows

The current international average for completing the Sepsis 6 protocol within one hour is 47%². Figure 2 demonstrates compliance with the protocol significantly above the international average now that it has been rolled out to all inpatient areas.

These early results are encouraging. In addition, staff reported that they felt empowered by the protocol and that it facilitated fast response to deterioration and good communication across the multi-disciplinary team.

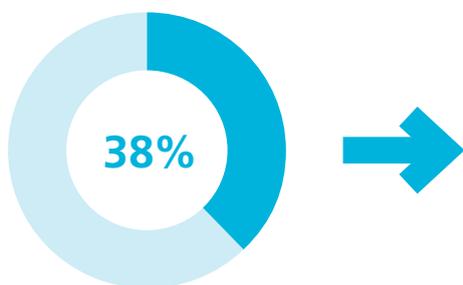


Figure 1: Sepsis 6 protocols completed within one hour in the pilot areas (Squirrel, Elephant, Lion and Giraffe wards) from September 2016 to January 2017.

What's going to happen next?

We will continue to make improvements within our system to facilitate early recognition of the signs of sepsis and fast delivery of the protocol. Next steps are:

- Ensure all first-line antibiotics are stocked on every ward so that they can always be delivered within the first hour
- Incorporate an automated alert for sepsis into our electronic patient observation system, which will guide staff through to an electronic Sepsis 6 tool when a patient triggers against the flag signs for sepsis
- Provide further education to ward areas to overcome specific challenges in delivering the Sepsis 6 protocol in one hour
- Raise greater awareness among parents through leaflets given post-surgery and in outpatients, and via general communications on the hospital website



One Team

“Sepsis 6 means that I don’t need to ask permission to do what I know is right. I can take the bloods and start treatment without waiting to ask someone. We could never have delivered the treatment so quickly before this protocol. It is so clear and makes it really easy to do the right thing.”

Senior Staff Nurse,
Squirrel Ward

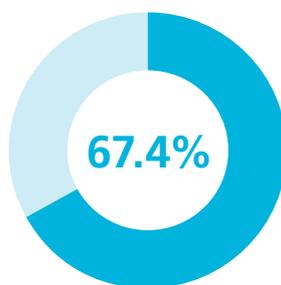


Figure 2: Sepsis 6 protocols completed within one hour in all inpatient areas (including ICUs) from January to March 2017.

² Levy MM et al (2014). Surviving Sepsis Campaign: association between performance metrics and outcomes in a 7.5-year study. Intensive Care Medicine 40(11) pp 1623-33.

2. Preventing cardiac and respiratory arrests

What we did

Cardiac and respiratory arrest is sometimes inevitable in the care of very sick patients. However, we want to ensure any arrest that could be prevented is prevented. We divided this workstream into three projects:

- Evaluation of Early Warning Score systems to determine the best scoring system for our patients
- Establish Just-in-Case training to prepare in advance for predicted clinical emergencies
- Roll out new defibrillators (devices that deliver electric current to the heart to correct life-threatening cardiac rhythms)

Early Warning Score: We undertook an in-depth evaluation of the Childrens' Early Warning Score (CEWS) that we use at GOSH to identify patients at risk of deterioration. We compared it with the Bedside Paediatric Early Warning Score (B-PEWS) developed by SickKids, the children's hospital in Toronto, Canada. By the assessment parameters, B-PEWS was found to be superior to CEWS for identifying clinical deterioration in children. We are now planning our replacement of CEWS with B-PEWS.

Just-in-Case training (JIC): We implemented a JIC training programme on non-ICU wards that look after the highest number of very sick children. Using the safety huddles and the clinical emergency team brief, the sickest patients are identified on these wards and the bedside nurses are trained to prepare for a clinical emergency, enabling them to be specifically equipped, whether the child deteriorates or not.

New technology in defibrillators:

Supported by the GOSH Charity, we installed new defibrillators across the Trust. Two styles were introduced:

- A top-specification defibrillator with full advanced life support features. This was installed in areas of high clinical risk such as theatres, interventional labs, ICUs and high dependency areas
- A first-responder defibrillator, which may be used in either automated external defibrillation or manual mode for all age groups. This was installed in all other clinical areas including outpatients, and in public areas around the Trust with high footfall

The higher-specification defibrillator has been used to help clinical staff in the recognition and management of the acutely unwell by being used early in an arrest event. The technology of the defibrillator enables us to monitor the quality of ventilation and chest compressions by the defibrillator. It also provides real-time feedback to the resuscitating team.

What the data shows

We reviewed all respiratory and cardiac arrests outside ICU and theatre, using a classification system devised to reflect the complexity of our patients and the degree of certainty we can have about whether an arrest could have been prevented. We use the term 'probably' to show a level of certainty greater than 50%, and the term 'potentially' to show a level of certainty less than 50%.

This simple classification of three categories seeks to identify any practice that could be improved in relation to a cardiac or respiratory arrest at GOSH:

1. Probably not preventable
2. Probably not preventable but with modifying factors
3. Potentially preventable

The 'probably not preventable but with modifying factors' category enables us to identify improvements we can make to the process, even where it wouldn't have changed the outcome. Modifying factors are defined as:

1. Mismanagement of deterioration

- Failure to act on or recognise deterioration
- Failure to give ordered treatment/support in a timely way
- Failure to observe

2. Failure of prevention

- For example, healthcare associated infections, pressure sores, etc

3. Deficient checking and oversight

- Medication error
- Misinterpretation or mishandling of test results

4. Dysfunctional patient flow

- Inappropriate discharge
- Poor/inadequate handover
- Unavailability of ICU beds

5. Equipment-related errors

- Necessary equipment failed or faulty
- Necessary equipment misused or misread by practitioner
- Necessary equipment not available

6. Other

- Other modifying factor specified

What is cardiac and respiratory arrest?

Cardiac and respiratory arrest, also known as cardiopulmonary (heart and lungs) arrest, is a term used to describe the sudden loss of heart function, breathing and consciousness. It can occur due to an electrical disturbance in the heart, but can also be caused by structural heart abnormalities that disrupt the heart's normal pumping action. This loss of function stops blood flowing to the rest of the body and stops lung function.

What is an Early Warning Score?

There are several Early Warning Score tools available in paediatrics to support staff to recognise and respond to children who may be deteriorating. Early Warning Scores are generated by combining the scores from a selection of routine observations of patients including pulse, respiratory rate, blood pressure, oxygen saturation and consciousness level.

All cardiac and respiratory arrests outside ICU and theatres – by review category:



2016/17 shown in 6-month blocks:



Every event that we determine as potentially preventable undergoes a comprehensive process that includes a root cause analysis. Potentially preventable arrests have reduced over the last 12 months, as have arrests that are probably not preventable but with modifying factors.

The higher number of arrests in August 2016 and January 2017 is due to a small number of extremely sick children in these months having multiple events. This is not reflective of the hospital-wide trend.

We continue to review and monitor this data closely. This enables us to use the findings in our work to eliminate potentially preventable arrests and to address modifying factors, where they are present in arrests that are probably not preventable.

What's going to happen next?

Preventing cardiac and respiratory arrests:

- Implement the B-PEWS at GOSH by the end of September 2017
- Continue to roll out JIC training across the Trust
- Further develop our dashboard of measures to identify issues in escalation of the deteriorating child
- Work with the high-specification defibrillator manufacturer to improve the accuracy of its clinical feedback for paediatric patients as part of an international study

How this benefits patients

Earlier detection of patients who deteriorate means:

- Better outcomes
- A safer environment
- Better communication and clarity between families and medical teams in the delivery of end-of-life care

"It's been great to recap my skills and be better prepared for any event."
Nurse on JIC training

"The metronome helps keep me to the right compression rate."
"Quality CPR feedback from the defibrillator pads is amazing."
"It is very clear, no confusion."
Staff on defibrillator training



Expert

Implementing safety huddles

Over the past two years, GOSH has been involved in a national programme called Situational Awareness For Everyone (SAFE), a joint initiative between the Royal College of Paediatrics and Child Health and the Health Foundation. The purpose of SAFE was to increase the ability to recognise and manage the deteriorating patient. As part of the programme, the Quality Improvement team rolled out electronic Patient Status at a Glance (ePSAG) boards in 2015/16 to enable staff to access clear, accurate and real-time patient information. The new 'watcher' category was also introduced on the ePSAG boards for monitoring. 'Watchers' are patients whose Early Warning Scores do not trigger an alert, but where the patient's family/carer or a clinical member of staff has a concern.

What we said we'd do

As part of the situational awareness programme, we also committed to implement safety huddles across all GOSH inpatient wards.

The first safety huddle took place in October 2012. But without the visual aid of electronic patient boards, traction was difficult on our busy wards. The safety huddle workstream was re-launched in September 2015, after the implementation of the ePSAG boards. This meant staff were better able to access in real-time the clinical information they needed to inform their safety huddle discussions.

What we did

In 2016/17, safety huddles were successfully rolled out to every inpatient³ ward using a staggered approach. The project steering group included clinical leads from each division to ensure local champions were engaged from the outset. Key figures such as matrons, practice facilitators and nursing leads were also identified to ensure the overarching strategy for rollout was clear. Ward staff were trained and key departmental meetings were attended for dissemination of information about the project before the intervention was fully implemented. Spread was facilitated by the Quality Improvement team and medical leads.

The analysts/developers in the Quality Improvement team also created a number of tools and documents to improve the success of the project:

- A 'huddle attendance' monitoring tool was provided to assist in assessing the attendance and timeliness of the huddles
- A reflection tool helped us analyse different aspects of the huddle to support the embedding of the practice
- An education and situational awareness video provided accurate and succinct information for all new clinicians during their induction at GOSH
- A four-week training package was developed and distributed to all ward managers as part of the implementation. The documentation provides all information necessary to commence, test and sustain the huddles at a ward level

What are safety huddles?

At GOSH, a safety huddle is defined as a five-minute daily gathering at the ePSAG board at a specified time. They are attended by all nurses on the ward, the lead doctors and any other appropriate staff members to discuss all patients' Early Warning Scores and escalation plans, and to identify the sickest patient on the ward and identify any 'watchers'.

"I feel the safety huddles have made my ward more organised with better team work and awareness."

Medical Registrar

"I think that nurses' confidence in raising their concerns has improved since the introduction of the huddle, especially the more junior nurses."

Ward Manager

"As long as I am around at GOSH I will always be looking at the ePSAG boards, or watching a huddle, and feeling a deep sense of pride that I was able to work with you all and to contribute freely."

Parent representative on the project group

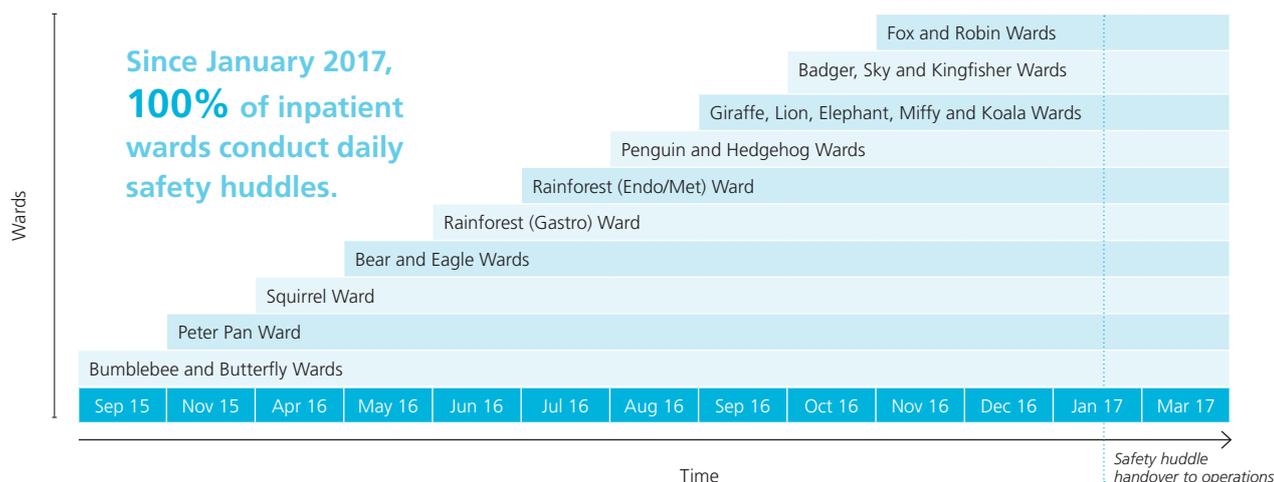


One Team

³ Except intensive care units, which already have specific safety procedures embedded as part of their 1:1 care.

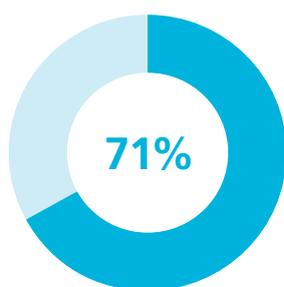
What the data shows

1. Inpatient wards that have daily safety huddles:



The project team is currently handing over the formal management of the safety huddles to operational staff to ensure sustainability of practice.

2. Inpatient wards currently fulfilling all of the 'gold standard' huddle criteria:



The GOSH 'gold standard' huddle takes place daily using an agreed script, with medical and nursing attendance. The multi-disciplinary team identifies all patients with an elevated EWS and or who fit the 'watcher' definition, and agree an escalation plan. The remaining 29% of wards (six wards) perform safety huddles daily but do not always have the wider multi-disciplinary team in attendance. Local clinical managers are working with these wards to achieve consistent attendance by the full multi-disciplinary team.

What's going to happen next?

To support a smooth transition from project status to 'business as usual' throughout 2017/18, we will:

- Develop a more sensitive safety indicator dashboard, devised in partnership with clinicians, which will focus on key indicators of timely intervention and avoidance of preventable deterioration in a child's condition
- Give a 'watcher' leaflet to all parents and families of children admitted to GOSH
- Finalise and include the situational awareness content in both the junior doctor induction programme and the Trust induction programme
- Hand over to wards the monitoring of their huddles for frequency and quality, so that they are locally owned and proactively sustained

How this benefits patients

- Early detection of deterioration
- Accurate and timely escalation of concerns
- Shared decision-making and contingency planning to mitigate risk of child deterioration
- Improved safety culture and staff confidence

"Safety huddles improve patient safety and communication between the team. They also help us to acknowledge who may be at risk of deteriorating and to consider patient dependency. If we do identify someone as a watcher it helps us to think about whether to share information with the CSPs, if we have not already done so."

Practice Educator

"Being up to date with all patients on the ward has definitely improved the safety culture, as we are now all aware of each other's concerns about patients."

Staff Nurse

Clinical effectiveness

Reducing the number of patients with incomplete pathways at 18 weeks

Incomplete referral-to-treatment (RTT) pathways are the care pathways of those patients who are still awaiting treatment for their condition. This is measured against the national 'incomplete' standard, which states that 92% of patients waiting at any point in time should be waiting less than 18 weeks from referral (the length of time defined as a patient's constitutional right). This measure ensures that patients on an RTT pathway are seen and treated within 18 weeks and thus receive timely care.

What we said we'd do

Having paused our reporting of RTT incomplete pathways in August 2015 in order to address issues with our data and processes, we committed to resuming reporting in this financial year. To achieve this, we said we would launch new operational processes to ensure our waiting list management complies with national best practice, and continue to work with commissioners to ensure sufficient capacity for the referrals that we receive into the Trust.

Part of this work included the roll out of the electronic Clinic Outcome Form system (eCOF) to support the timely and accurate capture of outcomes related to the patient pathway.

What we did

A considerable amount of improvement work has been completed by the organisation over the last year in relation to the delivery of elective care. The Trust returned to reporting against the incomplete RTT standard in January 2017, almost at target with a performance of 91.2% for the month and above the Trust's recovery trajectory that was agreed with our commissioners.

We established a clinical review process for all our children and young people who had waited longer than they should have, which was chaired by the Trust's Medical Director. Following the completion of our transformation work, we have reviewed this and formalised a process for review of any child who waits longer than their constitutional right of 18 weeks.

We entirely re-wrote our processes, from data handling through to management and reporting of RTT to ensure it was robust and in line with national guidance. The new reporting system tracks all elective care patients across all parts of the elective care pathway to ensure total transparency. An external review of the

reporting solution was completed by the NHS Improvement Intensive Support team, who endorsed the product as "best practice".

Particular focus has been placed on receiving complete information from referring organisations about the length of time patients have already waited prior to their referral to GOSH. As a specialist centre, 85% of our patients are first seen at a local hospital before being referred to us for more complex care. The date the patient was originally referred to their first hospital is known as the 'clock start'. In April 2016, we had an 'unknown clock start' position for 78% of all patients on the incomplete waiting list. Despite this being a difficult problem to influence directly, we sent communications to our many referrers to ensure they understood the importance of providing this information to us when they refer.

In order to improve the accuracy and completeness of outcome codes, the eCOF system was designed and implemented. Appointment outcomes and follow-up appointment requests were historically recorded by clinicians on paper and taken by patients to reception staff. We found that paper forms were not always returned, creating a risk of losing patients to follow up and challenges in being able to track where a patient was in their RTT pathway.

eCOF was developed for clinicians to record RTT outcomes and request follow-up appointments electronically at the time of the appointment, eliminating paper forms and providing real time information on incomplete outcomes and outstanding follow-up requests for administration. Patient experience is improved as patients are now more likely to have their follow-up booked before they leave the hospital.

What is a care pathway?

A care pathway is an outline of anticipated care in an appropriate timeframe to treat a patient's condition or symptoms.

"Much better system."

"Faster than paper."

"Recording outcomes is easier."

Clinicians

"Good way of tracking patients."

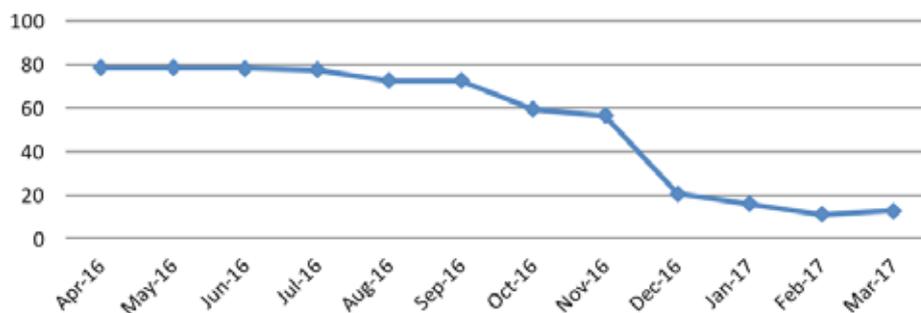
*Specialty
Administrative staff*

"This should stop the follow-ups being missed."

*Outpatients department
reception staff*

What the data shows

1. Percentage of unknown clock starts on RTT pathways:



After working hard with our many referrers to reduce 'unknown clock starts', much progress has been made in receiving referrals that have complete information to enable us to know how long the patient has already been waiting.

2. Percentage of appointments with RTT outcome within five working days:



eCOF has been fully implemented and the improvement has sustained as the chart above shows. Outpatient appointment outcomes were recorded within five days for 80.4% of appointments in January 2016. In March 2017, we recorded 92.6% of appointment outcomes within five days.

Any remaining outcomes and appointments that are outstanding are booked through weekly outpatient performance meetings, which will in future form part of the permanent Trust Patient Tracking List meetings.

3. RTT incomplete pathways:

As we only returned to reporting against the RTT standard in January 2017, we are continuing to monitor our position. However, 91.2% is a very encouraging return position against the 92% standard, with 91.6% achieved in February 2017 and 91.85% achieved in March 2017.

What's going to happen next?

The RTT standards work is now focused on a number of dedicated areas to embed good practice and sustain improvement. This includes the establishment of the Data Assurance team, who will focus on the prevention and correction of errors at source. This team will also be responsible for the establishment of training in the processes to support delivery of elective care, including RTT, cancer pathways, eCOF, and discharge summaries.

Finally, the Trust will return to compliance with the 92% incomplete pathway standard in 2017/18.

How this benefits patients

Improving our processes for elective care and strengthening assurance of our data means that patients can be seen within the most clinically appropriate timescales.



"Providing timely access to care for all GOSH patients is one of the organisation's key priorities and I am immensely proud of the improvement work completed over the last year. The Trust has not only returned to reporting, but we have been cited as a "best practice" organisation related to the tracking and managing of our patients through their pathway with absolute transparency across all aspects of care.

"We have now a solid foundation established and the future focus needs to be on making our processes sustainable to ensure that we provide timely elective care for all our patients going forward."

*Nicola Grinstead,
Deputy Chief Executive*



Helpful

Implementing mental health screening in children and young people with long-term physical health conditions

Introducing a standardised mental health screening tool as part of routine clinical practice is in line with the government's strategy to improve the mental health and wellbeing of the nation and to improve outcomes for people with mental and physical health problems. Physical health and mental health are related, with a compelling body of evidence highlighting that people with long term conditions (LTCs) are particularly vulnerable to mental health problems.

At GOSH, we have well-established psychosocial services offering a good level of support related to specific physical conditions, which includes adjustment to illness and adherence to treatment regimes. However, we wanted to improve our recognition and treatment of mental health problems, such as depression and anxiety, where these co-occur with physical health problems. Ultimately, our aim is to strive for optimal holistic care of children, young people and their families and to be leaders in the field.

What we said we'd do

We said we would introduce and then embed routine mental health screening and linked provision of mental health input across four identified LTC areas: Nephrology, Metabolic Medicine, Cardiology and Cleft/Craniofacial. Over the year we wanted to increase the number of inpatients offered the Strengths and Difficulties Questionnaire (SDQ) as part of routine care. The SDQ is a robust, well-validated, standardised screening measure that identifies children and young people at risk of significant mental health problems.

We also wanted to introduce a standard pathway to follow up those patients whose scores indicated they were likely to be experiencing mental health difficulties. This approach would enable us to initiate treatment as required with our trained paediatric mental health professionals.

What we did

Firstly, we worked across clinical, administrative and management staff groups to introduce routine screening to supplement our existing provision. With the help of colleagues in our Quality Improvement team, we were able to offer families the option of completing the SDQ electronically with support by nurses and other clinical staff on the ward as needed. This was easier for patients and families, more efficient for us, and allowed us to keep careful track of which children and young people needed a follow-up conversation and support from our psychological services staff. Over the year we were slowly able to build up the number of patients screened. We successfully followed up every screened patient who flagged as being at risk of mental health problems.

"Great to see that all patients have their outcomes completed on the eCOF."

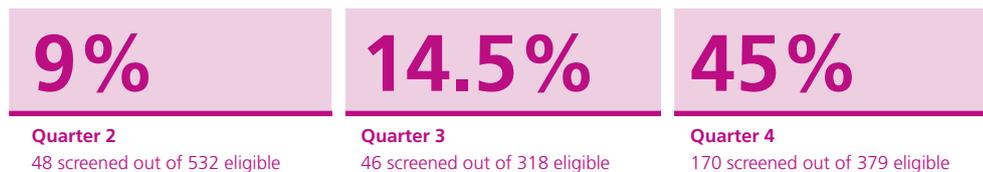
Outpatients department reception staff



Expert

What the data shows

1. Number of children under a physical health specialty who received a mental health screening:



2. Number of mental health-screened children, who scored above the SDQ threshold:

Of the total of 264 individuals offered the SDQ, 30 scored above the SDQ threshold. In quarter four, which was most representative, 17% of Metabolic Medicine patients screened, 13% of Nephrology patients screened, and 12% of Cardiology patients screened scored above the SDQ threshold. National research indicates that one child in 10 in the UK has a diagnosable mental health problem⁴. So, the figures are slightly higher than the general population, as we expected. This indicates a significant opportunity to attend to our patients' mental health as well as their physical healthcare needs.

3. Number of mental health-screened children, who scored above the SDQ threshold, who were followed up by a member of the Psychological Services team:



Of the 30 patients who scored above threshold, all were followed up.

What's going to happen next?

While we want to ensure that we identify mental health problems so we can offer intervention or support, we want to be careful that we offer screening at a time that is appropriate for families. We are exploring the best ways to do this, including the commencement of screening before children reach the stage of admission to an inpatient bed. Over the coming year we aim to:

- Commence screening earlier in the patient journey
- Increase our screening rates further
- Develop further the protocol for assessment type after a child scores 'above threshold'
- Standardise our approach across screening areas
- Develop a shared protocol for assessing the value of our mental health interventions and support to children, young people and their families

How this benefits patients

- Improved care of our patients through an integrated mental and physical health approach
- Increased opportunities to improve wellbeing of patients and their families

"This initiative allows patients to be assessed in a way that does not rely on staff judgement or opinion. The family do not have to approach the team to vocalise their need for help and it helps to avoid waiting for crisis before intervention. Children and their families at GOSH will be aware of our views on the importance of an integrated physical and mental health approach to improve their health-related quality of life."

*Carly, Matron,
Barrie Division*

⁴ Green H et al (2005). Mental health of children and young people in Great Britain, 2004. Basingstoke: Palgrave MacMillan.

Experience

Improving young people's experience of transition to adult services

How young people with long-term conditions and their families are prepared for their move from paediatric to adult services has come under increasing scrutiny nationally. In 2016, NICE published the guidelines, *Transition from Children's to Adults' Services for Young People Using Health or Social Care Services*. The CQC also started to include transition in their inspections.

At GOSH, transition to adult care has long been a challenge that we have sought to improve in different ways. More recently, transition was raised as an area that required attention by our Young People's Forum and by parents at the GOSH Listening Event held in November 2016.

What we said we'd do

We said we would commence a Trust-wide transition improvement project, led by the Assistant Chief Nurse for Patient Experience and Quality and coordinated by a full-time transition improvement manager.

In accordance with NICE recommendations, we said we would identify a transition lead in every clinical specialty at GOSH, with the intention of building consistency of approach within and across teams.

To understand the scope of the project ahead of us, we said that we would determine the number of young people being treated by each specialty aged 13, 14, 15, 16 and 17+. To understand the complexity of coordination required, we also said we would identify the percentage of young people in this data set who were being cared for by three or more clinical specialties.

What we did

The Chief Nurse is the executive lead for transition and has overall responsibility for transition and the transition improvement project.

Transition lead

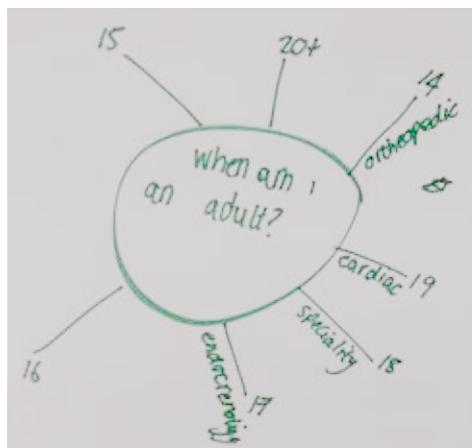
We have confirmed a doctor in every specialty to take forward the leadership role of medical transition lead for their specialty. We are currently working on the reporting requirements to meet national guidance.

Data and feedback

We completed a data snapshot in August 2016 on:

- The number of young people aged 13, 14, 15, 16 and 17+
- The specialty of first open referral received
- The consultant to whom the first open referral was made
- The number of these young people under the care of three or more specialties
- The number of these young people with a future inpatient admission or outpatient appointment

We ran a discussion group with our young people as part of the GOSH Listening Event in November 2016. The group explored the many challenges of transition from paediatric to adult health services. This diagram created by the young people during the discussion demonstrates how complex transition can be, especially for those who are cared for by multiple specialties.



What is transition?

Transition is 'the purposeful, planned process of preparing young people under paediatric care and their families or carers for, and moving them to, adolescent- or adult-oriented healthcare'

GOSH, 2017, adapted from Blum et al, 1993⁵

What is the National Institute for Health and Care Excellence?

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care in England and the rest of the UK.

What is the Care Quality Commission?

The Care Quality Commission (CQC) is the independent regulator of health and social care in England.



Helpful

⁵ Blum RW, Garell D, Hadgman CH et al. Transition from child-centred to adult health-care systems for adolescents with chronic conditions. A position paper of the Society for Adolescent Medicine. *J Adol Health* 1993; 14: 570-6.

Comments gathered at the listening event also helped us to understand the experience of our young people and their families in transition to adult services. This feedback helps us to prioritise our next steps in getting transition right at GOSH:

"It happens at different times in different departments. You may still be treated at GOSH even if you have transitioned in other departments. This is confusing – am I an adult or not?"

"GOSH is a bubble – there is an outside world. You can feel lost when you leave GOSH – no-one should be lost in the system or be transitioned without a bye."

"I'm just so scared. We've been coming to GOSH since he was a baby – he knows everyone and everyone knows him and what he's like. GOSH is like our second home."

In addition, our Transition Improvement Manager visits our transition clinics to support staff, to gather examples of good practice to learn from, and to identify improvement opportunities. The following comments were from transition clinics:

"It was really good, really reassuring. We had the chance to meet the other team and they seem really nice. It feels good knowing who we'll be seeing."
Parent after Gastro Transition Clinic appointment

"It was different. Better. I was scared at first, but one thing they did – they talked to me, it felt like it was my appointment. At GOSH they always talked to my mum. I really felt they were treating me like an adult."
18 year old, after attending first adult appointment

Understanding current practice

We also undertook an audit of all transition information and Transition Plans developed and currently used by specialties in the Trust. The Transition Improvement Steering Group, working with young people and parents/carers, is reviewing the information to ensure that processes and information are of a consistently high quality that meets the needs of young people and their parents/carers.

What the data shows

1. A data snapshot from August 2016 shows the numbers of young people aged 13 years and above:

Age	Total
13 year olds	903
14 year olds	826
15 year olds	876
16 year olds	552
17 and over	3,592

By examining the data, we found that the higher number of 13 year old patients is because many attended GOSH for diagnosis only or second opinion. The majority of these patients return to their local services for treatment and support, so do not need a GOSH transition plan.

The higher figure for those aged 17+ years old was examined in detail. This has allowed us to identify services and groups for whom transition is not relevant so that these can be excluded from subsequent data sets. For example, our Clinical Genetics Service provides testing and advice for people of all ages, and the Cardiac Foetal Heart Service is a service for parents-to-be.

We are refining our data use to further inform the order of project priorities. We know that focusing on our young people who are 17+ is the first priority.

2. Of the patients in table 1, these are the numbers receiving care under three or more specialties:

Age	Total	As a % of total
13 year olds	467	37%
14 year olds	209	16%
15 year olds	189	15%
16 year olds	165	13%
17 and over	240	19%

The higher number of 13 year olds was expected, as young people aged 14 and 15 are more likely to be referred directly to adolescent services. The Trust generally does not accept initial referrals for 16 year olds and over. The higher number in the 13 year old group also helps us to understand more about the complexity of transition planning for our young people whose health problems require them to be seen across multiple specialties.

The care of patients accessing three or more specialties is complex, and there are conditions treated at GOSH for which there is no equivalent adult specialist service. The challenge of identifying appropriate services often causes delayed transfer to adult services, resulting in slightly higher numbers in the 17+ age group. The transfer of some young people is also delayed until the course of treatment, such as those involving multiple surgeries, is completed.

What's going to happen next?

We aim to:

- Define and set standards for Transition Plans
- Focus on putting Transition Plans in place for young people aged 16 and over in 2017/18, and from 14 and over in 2018/19
- Work in partnership with Barts Health NHS Trust and University College London Hospitals NHS Foundation Trust to improve support for young people with learning disabilities or additional needs
- Build IT infrastructure to better support planning and documentation of transition

The Transition Improvement Project is anticipated to continue for a minimum of three years and we will report the coming year's progress in next year's *Quality Report*.

How this benefits patients

Well-coordinated transition empowers young people to be as involved in their future health and healthcare as they are able, and supports them to develop to their full potential.

Utilising Friends and Family Test data for improvement

We began to use the national Friends and Family Test (FFT) at GOSH in April 2014, starting with inpatient areas before extending to outpatient and day care areas six months later. Since then, we have collected nearly 33,000 pieces of feedback from patients and their families.

What we said we'd do

Initially, the NHS FFT programme required feedback from adult patients and service users. We said we wanted to extend the use of the FFT to children and young people too, because we need to hear their voices to have a full picture of experience here at GOSH.

We said we wanted to collect demographics on all FFT cards so that we can better understand experience and determine if there are any differences in quality of experience by ethnicity, age, and additional needs.

We also said we wanted to make sure that the data collected from the FFT was used throughout the Trust to inform service improvement work.

The core component of FFT is the percentage of respondents to recommend the hospital. For this, we set ourselves an ambitious target of 95%.

What we did

After conducting focus groups with patients and their families and consulting with our Young People's Forum in late 2015/16, we had information that could guide us. Our young people told us that they were happy to complete the adult cards, but felt that child-friendly feedback cards were needed. In 2016/17, we used a combination of their input and NHS England guidance to produce our own feedback cards for children eight years and under. We began using our new cards for children from July 2016. By 31 March 2017, 1,028 cards had been completed by children and young people, giving us a unique view of their experience as patients.



Inpatient (above) and Outpatient (right) feedback cards for young children.

We have also increased awareness of FFT among children, young people and families at GOSH through high visibility feedback stations in all areas.

We worked with the Quality Improvement team to design and implement a new FFT database to enable collection of additional demographic information and improve reporting. We began collecting demographic data in December 2016. Once we have enough data, we will begin to look for trends so that we can target improvements in the equity of services and experience.

All the data and comments received are reported back to the areas they concern on a monthly basis. Positive comments about individual members of staff are passed to their manager and used to support nomination for staff awards. We also provide word clouds of comments to boost staff morale.



Word cloud of feedback about Eagle Ward, April 2016.

Now that we hold so much experience data, teams have been encouraged to review this before undertaking other surveys. In addition, FFT data has been used to support workstreams at GOSH, including development of the patient portal for the Electronic Patient Record programme, support of nurse revalidation, and use of *Our Always Values*. FFT data was also used to inform the topics discussed at our listening event in November 2016.

What is FFT?

The Friends and Family Test is a national feedback tool for NHS service users to provide feedback on their experience of the care they receive.

What is the Young People's Forum?

The Young People Forum (YPF) is a group of young people aged 11–25 who are or have been patients, or siblings of patients, at GOSH. The mission of the YPF is to improve the experience of teenage patients at GOSH. The group meets formally six times a year, as well as participating in Trust projects and consultations, and meeting with the executive team and other key decision-makers.



Helpful



Welcoming

"The food is very repetitive."

Parent – Badger Ward

The catering team has now amended the menu cycle from weekly to three weekly, so it is less repetitive for long-stay patients.

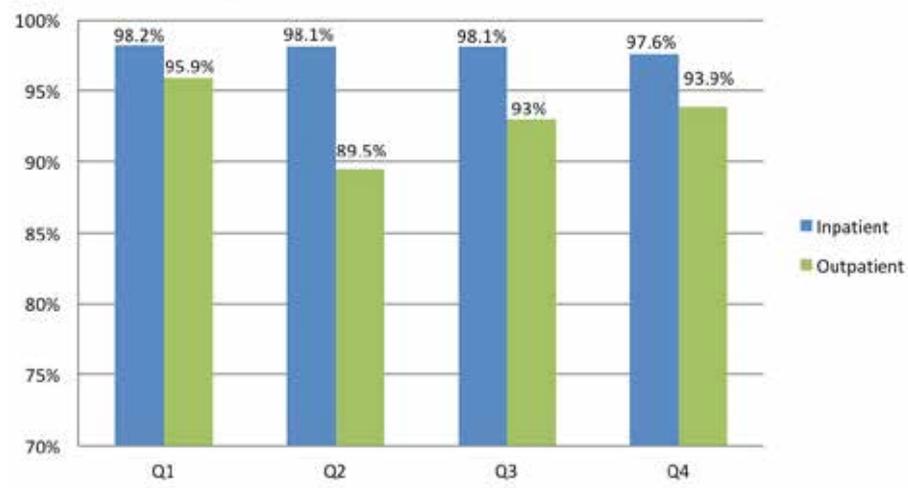
What the data shows

1. Response rate:

Feedback through FFT has increased from around 6,300 comments in 2014/15 to more than 13,000 in 2016/17. In the last year, the number of comments received has increased by 7%. We have a total response rate of 24% (inpatient) for 2016/17. While our response rate is lower than our challenging chosen target of 40%, it is broadly similar to the response rates of other children's hospitals. We continue to widely promote the FFT cards to patients and families, while being sensitive to the complex and, at times, difficult circumstances for families with a sick child.

2. Percentage of respondents to recommend the Trust:

The percentage of inpatients to recommend GOSH has remained above 97% throughout 2016/7. The percentage of outpatients to recommend GOSH has been slightly lower at an average of 93%, and we have used these responses to define an improvement project in outpatients that is currently underway.



3. Percentage of feedback that is provided to departments:



100% of feedback that specifies wards, specialties or individuals is fed back to managers in those areas for sharing with staff, to encourage with the positive feedback and to target improvement through feedback about what could be better.

What's going to happen next?

We will start to analyse demographic data for experience trends, to enable us to better understand differences and target improvement work to achieve greater equity in our service delivery.

As FFT is currently delivered in paper form, we are exploring ways to provide it electronically to improve ease and accessibility, and increase uptake.

In 2017/18 we plan to implement a real-time feedback system, which will enable comment at any time throughout a patient's stay or visit using mobile phones and tablet computers. This will enable staff to respond to negative feedback and/or problems in a much timelier manner. We want the system to be interactive, with separate modules for different ages, as well as adaptations to enable feedback from non-English speakers and those with additional needs.

How this benefits patients

- Listening to the experience of our children, young people and families helps us improve the services we provide – according to what matters to them
- The 'percentage to recommend' measure gives the Trust a broad view of patient experience, but the qualitative comments allow further analysis to target improvements where needed
- The data also allows us to monitor positive themes, so that we can celebrate individual wards and departments who provide an excellent experience

"Lynne was fantastic. With her bubbly personality, she made all of us feel at ease. It was my son's first cannula and she made it a positive experience, highly recommended."

Parent – Walrus Ward

Lynne, Senior Healthcare Assistant, was nominated for a GOSH Gems award as a result of many comments like this. Lynne successfully won the individual Gems award in January 2017. Read Lynne's story on **PXX** the Annual Report.

"The only thing that needs improving is the Wi-Fi. We rely on technology while our child is in hospital."

Parent – Bumblebee Ward

The GOSH ICT department are working closely with a mobile telecommunications company to install Wi-Fi boosters across the site to tackle the Wi-Fi signal weak spots.

"The staff were very open and professional, and communicated really well with us and responded to all of our questions/needs. There was always a nurse available, which is so important to help with feelings of anxiety in hospital. Thank you."

Parent – Penguin Ward

This feedback was communicated to the Matron and Penguin team to celebrate their excellent approach and compassionate manner.

Other ways that we listen to our patients and families

Listening event

On Saturday 19 November 2016, GOSH held an outer-space-themed listening event where patients and parents shared their ideas and experiences of the hospital.

The day centred on four topics identified through FFT feedback and social media. The key areas chosen by the children, young people and parents were: communication, food, transition and outpatients.

A range of senior members of staff attended the day, including the Chief Executive, Deputy Chief Executive, Medical Director and Chief Nurse.

There was also a marketplace area so families could meet a number of our teams and learn about other projects taking place at the hospital. There were representatives from the following teams: Chaplaincy, Charity, Digital, Electronic Patient Records programme, GOSH Arts, Hospital School, Patient Advice and Liaison (PALS), Redevelopment, Research, Sustainability, Volunteers and Learning Disabilities.

Everything we learned about the four topics during the day was themed to help us understand what matters most to our patients and families. The themes included:

Communication

- Face-to-face communication
- Staff-to-staff communication
- Fewer and more comprehensive letters, and more use of text and email

Food

- More information on ingredients
- More variety of meals
- Flexible mealtimes

Transition

- Clearer communication
- Transition spoken about sooner
- More support when going through transition

Outpatients

- Advising of delays
- Staff to introduce themselves to children and young people more
- More things for older children to do while waiting
- Appointments requested at early mornings or weekends

The themes that emerged from our listening event have been shared with families. Staff are working on short- and long-term actions, which will also be shared with families as we progress.



Breakout room for children and young people to discuss the four chosen topics.



Peter Steer, Chief Executive, receiving feedback from children and young people on the topic of communication.



Ruth Evans, Involvement and Engagement Officer for Research, teaching attendees about research at GOSH and biology.

Video booth

As there is no 'one size fits all' when it comes to feedback, GOSH piloted a video booth to allow families who may not want to fill out surveys or attend focus groups, to share about their experiences at the hospital.

The video booth was placed in the GOSH entrance for four days in November, with the Patient Experience team and PALS supporting booth use by answering questions and offering outer space props!

Inside the video booth, the screen displayed a series of steps to record a message if the participant provided their name and email address. There was a disclaimer that if anyone had any specific questions or urgent worries they should speak to a member of staff, as the booth was for non-urgent messages.

In four days (17–21 November), 101 videos were recorded and 175 people took part. One hundred of those (57%) were children and young people and the other 75 (43%) were adults.

91%

of comments were positive and all were themed to inform our improvement work.

A wide variety of people left messages, ranging from patients to their siblings, aunts, uncles, cousins, other family members and friends. A range of ethnicities was represented by contributors. Feedback was also collected from two people who had not felt able to engage in other feedback mechanisms – one adult who could not read or write and one child whose multiple health conditions meant a video recording made giving feedback more achievable.

Following the video booth pilot, videos that contained specific staff, ward, or team feedback (whether praise or comments about what can be improved) were collated. Consent was obtained so that the films could be shared with staff, and a compilation video is due to be completed shortly. Any concerns raised (eg comfort of parent beds) were shared with the teams responsible.

A number of individuals have also been offered the opportunity to share their experience as part of our patient story programme.

GOSH's space station-themed video booth.



2017/18 Quality priorities

The following table provides details of three of the quality improvement projects that the Trust will undertake in 2017/18. These priorities were determined with input from staff, patients and their families, and commissioners. This input was sought through a range of mechanisms including a survey, consultation and use of established meetings such as our Members' Council, Young People's Forum, and Patient and Family Engagement and Experience Committee. The new quality improvement projects are in line with our strategic priority to provide the safest, most effective and efficient care, with the best possible outcomes.

Safety

To eliminate avoidable harm.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
<p>Improving the quality and safety of care for inpatient neonates/small infants – this work will focus on three main areas: bloodspot screening, neonatal jaundice and intravenous fluid management.</p> <p>This work is to act upon a need for improvement that was identified through an audit of neonatal care.</p>	<p>Bloodspot testing, which is part of the national newborn screening programme, ensures early detection and treatment for nine rare but serious conditions. It is essential that all newborn babies at GOSH receive bloodspot screening if this has not already happened prior to their admission.</p> <p>We also want to ensure that ward staff are able to effectively identify and manage the treatment of neonatal jaundice in line with evidence-based practice.</p> <p>We have developed a Trust guideline for the management of neonatal intravenous fluids with speciality, pharmacy and neonatal leads. We will be working to implement this and raise awareness of the importance of neonatal fluid management – both in terms of safety and to ensure that we are able to provide a standardised approach for all babies.</p>	<ol style="list-style-type: none"> 1. By the number of blood spot screening tests carried out 2. By the number of blood spot tests not taken within the appropriate timeframe 3. By the number of blood spot tests that could have been avoided 4. Audit compliance with neonatal jaundice guidelines 5. Audit compliance with the neonatal intravenous fluid management guidelines <p>The data will be published on our intranet dashboards, and reported to the Quality Improvement Committee.</p>

Clinical effectiveness

To consistently deliver excellent clinical outcomes, with the vision to be the leading children's hospital in the world.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Developing Trust-wide access to outcomes data through the Clinical Outcomes Hub.	<p>Clinical outcomes are broadly agreed, measurable changes in health or quality of life that result from our care.</p> <p>Here at GOSH, every speciality collects outcomes and many teams have published outcomes to the Trust website. But, we need greater visibility of that data internally to enable teams to more readily use outcomes data in decision-making, to notice trends, and in service improvement.</p> <p>By working closely with the specialties, the Clinical Outcomes Hub will display effectiveness data in ways the clinical teams find most informative.</p>	<ol style="list-style-type: none"> 1. By the number of specialities with a dashboard of outcome measures published on the Hub 2. By the total number of outcome measures published on the Hub 3. By the number of patient-reported outcome measures collected via an electronic survey tool linked from the Hub <p>Progress will be reported monthly to the Quality Improvement Committee.</p>

Experience

To deliver kind and compassionate care, and communicate clearly to build confidence and ease.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improving young people's and parents'/carers' experience of transition to adult services.	<p>Good experiences of transition from paediatric to adult healthcare services are associated with improved levels of independence for young people with long-term conditions. A good transition also increases engagement with adult services, improving health in adulthood.</p> <p>Features of a good transition include:</p> <ul style="list-style-type: none"> • Ongoing incremental preparation, from the age of 14 at the latest • Use of a Transition Plan to inform a programme of education and support including the opportunity to meet the adult service(s) prior to the transfer of care • Good communication between the paediatric team, local primary care services and the receiving team • Consistency of approach, especially for young people who are under the care of multiple specialties 	<ol style="list-style-type: none"> 1. By the numbers of young people aged 16 and over with a Transition Plan in place, identifying specialty and consultant initially referred to (for focused improvement work in 2017/18) 2. By the numbers of young people aged 13 and over under three or more specialties, identifying specialties and consultants involved (for continuing to enhance our understanding of our population of young people) <p>Monthly reports will be sent to the Specialty Transition Leads and Divisional Boards.</p> <p>In addition, the Transition Improvement Steering Group will report to the Quality Improvement Committee and the Patient and Family Engagement and Experience Committee on a monthly basis.</p>

Patient image to be added at a later date

Part 2b:

Statements of assurance from the board

This section comprises the following statements:

- Review of our services
- Participation in clinical audit
- Participation in clinical research
- Use of the Commissioning for Quality and Innovation (CQUIN) payment framework
- Care Quality Commission (CQC) registration
- Data quality
- Implementation of the duty of candour

Review of our services

GOSH is commissioned by NHS England to provide 58 specialised, or highly specialised, paediatric services. These services account for approximately 90% of the Trust's healthcare activity. The remaining 10% of our activity is typically care which, although not specialist, is provided to patients with complex conditions and is commissioned by Clinical Commissioning Groups.

In order to ensure that we maintain excellent service provision, we have processes to check that we meet our own internal quality standards and those set nationally. These processes include scrutiny by committee. One example is our Quality, Safety and Assurance Committee, where there is a focus on improvements in quality, safety and patient experience. Assurance is provided through reports on compliance, risk, audit, safeguarding, clinical ethics, and performance. Patient stories are often presented to this forum and to the Trust Board.

As a matter of routine, key measures relating to the Trust's core business are presented to the Trust Board. These include measures of quality and safety, patient and referrer experience, and patient access to services.

The Trust's performance framework enables clinical divisions to regularly review their progress, to identify improvements, and to provide the Trust Board with appropriate assurance.



Expert



One Team

Participation in clinical audit

During 2016/17, 12 national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. The Trust has participated in them all and data submissions are outlined below.

Name of national audit/clinical outcome review programme	Cases submitted, expressed as a percentage of the number of registered cases required
Cardiac arrhythmia – National Institute for Cardiovascular Outcomes Research (NICOR)	100% (186/186)
Congenital heart disease including paediatric cardiac surgery – NICOR	100% (1,372/1,372)
Diabetes (paediatric) – National Paediatric Diabetes Association	100% (34/34)
Inflammatory bowel disease – Royal College of Physicians	100% (34/34)
Maternal, Newborn and Infant Clinical Outcome Review Programme – Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)	100% (18/18)
Medical and Surgical Clinical Outcome Review Programme – National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Cases have been submitted for the three outcome reviews that cover GOSH services. The deadlines for submissions are in 2017/18.
National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH)	No clinical reviews were identified for GOSH in 2016/17.
National Cardiac Arrest Audit – Intensive Care National Audit and Research Centre (ICNARC)	100% (33/33)
National Neurosurgical Audit Programme	Data is taken from national Hospital Episode Statistics rather than submitted by the Trust.
Paediatric Intensive Care Audit Network	100% (1,881/1,881)
Renal replacement therapy – UK Renal Registry	100% (197/197)
UK Cystic Fibrosis Registry – Cystic Fibrosis Trust	100% (183/183)

The following National Audit reports have been published during 2016/17, which are relevant to GOSH practice:

- Cardiac Rhythm Management Audit Report 2015/16
- Congenital Heart Disease (CHD) Audit Annual Report 2012–2015
- Inflammatory Bowel Disease Programme: Biological Therapies Report 2016
- National Cardiac Arrest Report
- National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH) Annual Report 2016
- National Neurosurgical Audit Programme: Continuous Outcome Data
- National Paediatric Diabetes Audit Report 2015/16
- Paediatric Intensive Care Audit Network (PICANET) Annual Report 2016
- Pulmonary Hypertension Audit Report 2016
- UK Cystic Fibrosis Registry Annual Data Report 2015

The reports have been reviewed by appropriate professionals within the organisation and any relevant actions completed.

The Congenital Heart Disease annual report highlights excellent clinical outcomes reported at GOSH for paediatric cardiac surgery. This also highlights the outstanding work of the Clinical Information team for the West Division, which maintains systems that have allowed high-quality data to be reviewed as part of this registry.

⁶ <https://www.england.nhs.uk/ourwork/qual-clin-lead/clinaudit/>

What is clinical audit?

“Clinical audit is a way to find out if healthcare is being provided in line with standards, and lets care providers and patients know where their service is doing well and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits) and local clinical audits can also be performed locally in trusts, hospitals or GP practices.”

NHS England⁶

“It is also noteworthy and reassuring to families that five centres have results with an overall risk-adjusted survival at 30 days higher than predicted level, one of whom (Great Ormond Street Hospital) at a much higher than predicted level.”

Congenital Heart Disease annual report

Key learning from clinical audit in 2016/17

The Clinical Audit team sits within the Quality and Safety team to ensure that there is integrated clinical governance. A central clinical audit plan is used to prioritise work to support learning from serious incidents, risk and patient complaints, and to investigate areas for improvement in quality and safety. A selection of this work is highlighted below.

Quality of World Health Organization (WHO) Surgical Safety Checklist

The Trust collects data continuously on WHO checklist completion. The mean average for completion of all three stages of the checklist across the Trust is 94%. While the data is useful, we also wanted to understand how *effectively* the checklist is being used to promote quality and safety in the operating theatres.

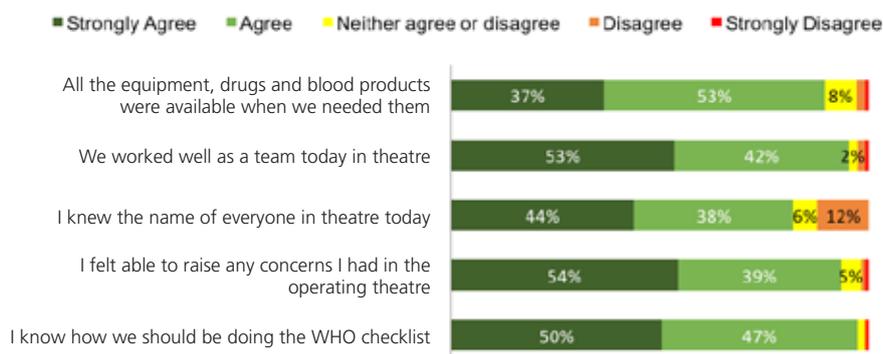
The following audit helps to answer the question: ‘How well are we doing the checklist?’

What is the WHO Surgical Safety Checklist?

The WHO Checklist is a three-stage set of documented safety checks that are performed by clinical staff in the operating room to enhance safety practices and ensure communication and teamwork.

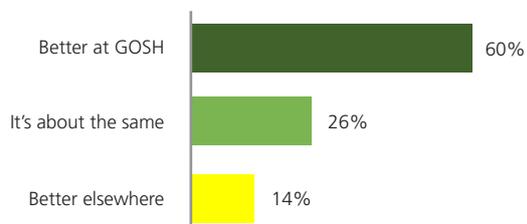
Key findings

Theatres checklist culture



GOSH compared with other centres

“How well are the team briefs and the WHO checklist observed at Great Ormond Street Hospital compared with where else you currently practice, or have practised in the last three months?”



The audit shows good engagement in the team brief and WHO Checklist, and a positive safety checklist culture. An area for improvement that the audit highlighted was that checks should always be performed with reference to the checklist rather than at times performed from memory.

Action taken

- Theatre staff were asked to identify solutions as to how the checklist can be better used for each case. This took the form of an electronic suggestion box to engage staff energy and ideas for improvement
- The Lead Nurse for Theatres has introduced an additional minute into the morning theatres handover for communication with the sisters about using the checklist each day

Clinical emergency trolley audit

Background

Resuscitation services audited the contents of emergency trolleys across the Trust in January 2017.

Results

84% of trolleys reviewed met the required quality standard. This is a 24% increase on the 2016 results. All trolleys not meeting the standard were corrected as part of the audit and later re-audited.

How have we improved?

- Ownership from the ward staff to ensure their trolley is safe and well-maintained
- Nursing Visible Leadership programme included the raising of awareness about emergency trolleys
- New defibrillators were introduced, requiring extra training that included highlighting with staff the importance of their emergency equipment



One Team



Helpful



Expert

Bereaved parent survey

Aim

The purpose of this audit is to learn from the experience of bereaved parents and carers whose children have died in hospital and to evaluate the support offered.

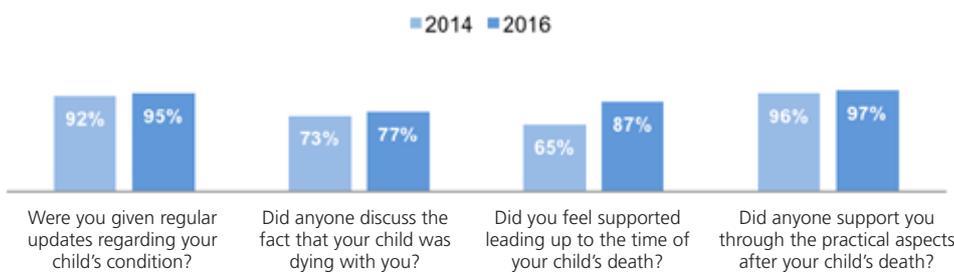
Key findings

The audit demonstrates the excellence of the support that is provided to children and their families. The feedback from parents highlights the high praise and esteem that our staff have received for the support they provide to families:

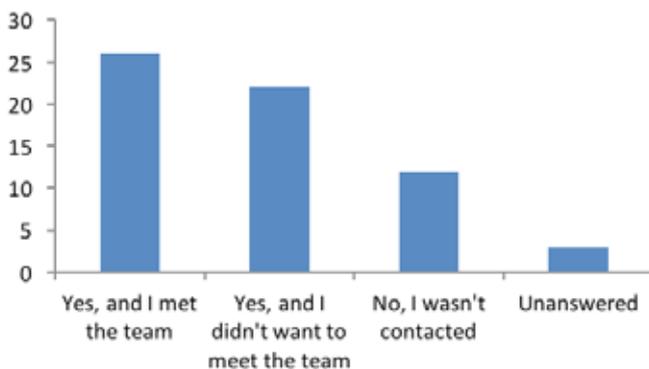


Improvements have been noted in a number of key measures when compared with results from 2014.

Percentage of positive responses



Have you been contacted by your child's medical team and offered a follow up meeting?



98%

of respondents who answered the question reported that they had been contacted by bereavement services since their child had died.

Recommendations for improvement included:

- Developing and improving the hospital information available to families
- Delivering training opportunities for staff in communicating with families about the death of their child, particularly on our ICU
- Delivering training opportunities for doctors to feel more comfortable and confident in discussing post-mortem examinations with families
- Ensuring that families are contacted by the medical team within 6–8 weeks following their child's death

These recommendations have been reviewed by the End of Life Care Committee and by the Patient and Family Experience and Engagement Committee. Actions will be taken forward by the Bereavement Services Manager.

Learning from complaints

As part of the complaint investigation process, lessons learnt and areas for service improvement are identified and actions plans are devised. This section of the report shows a selection of completed audits in 2016/17 to assess the implementation and effectiveness of learning from patient complaints.

Background

Multiple attempts at cannulation (insertion of a thin plastic tube into a vein for blood sampling and giving of medicines and fluids) were made on a patient who was difficult to cannulate.

What we said we would do

We said we would identify whether the complaint reflected a wider patient safety issue.

What did the audit tell us?

The data showed an increased prevalence over time of patients having multiple attempts at cannulation, contrary to our escalation policy.

Actions

Learning from the audit was circulated as a Trust Safety Message of the Week. The data shows challenges with cannulae and is being used to inform a Quality Improvement project to reduce extravasation, a particular kind of harm associated with cannulae.

Background

A patient was discharged without blood tests being reviewed and subsequently deteriorated.

What we said we would do

Improve the process of requesting urgent blood tests and improve the recording of the correct contact details on the blood test request form on one inpatient ward.

What did the audit tell us?

100% of standards to minimise the risk of this event from reoccurring had been implemented.

Background

A variation in a patient's DNA was incorrectly transcribed onto a report. This single variation altered the interpretation of the result.

What we said we would do

Improve the process of checking DNA variants forms, by changing the protocol to include an additional level of review by an independent reviewer.

What did the audit tell us?

In 98% (98/100) of cases variant forms were independently reviewed. 98% of cases (98/100) were correctly transcribed onto the report. Actions have been taken to reinforce the process of independent reviews, and to implement an automated report to reduce human error. A re-audit is planned.

Local clinical audit

The summary reports of 134 completed clinical audits by clinical staff were reviewed at GOSH during 2016/17. Our data shows we are improving our completion and sharing of local clinical audit:



To promote the sharing of information and learning, a summary of completed projects is published on the Trust's intranet and shared with the Patient Safety and Outcomes Committee.

Examples of actions intended to improve the quality of healthcare, or work that has made a difference as a result of local clinical audit, are listed below:

Audit name	Key findings	How did the clinical audit help patients and staff
Oxygen levels in children with severe lung disease in the paediatric intensive care unit	Children with severe lung disease are unable to maintain their oxygen levels without intensive care support. Current guidelines based on adult evidence suggest that patients with severe lung disease should have oxygen saturations (measure of how much oxygen is carried by the blood) between 88–94%. We examined the amount of time spent by patients with the most severe lung disease at different levels of oxygen saturation. Overall, children spent over 40% of the time with oxygen saturations above 97%.	While a lack of oxygen is not good for patients, emerging research suggests that high levels of oxygen may also not be good for patients. This piece of work helped us obtain a GOSH Children's Charity grant to study the impact of different oxygen saturations in children in a randomised controlled trial. The trial will test feasibility for a larger-scale trial and is currently underway in three UK paediatric intensive care units. We believe that the knowledge gained from this wider work will improve the care given to children on intensive care units at GOSH and worldwide.
Indications for use of parenteral nutrition in bone marrow transplant patients	Earlier nutrition intervention via tube feeding may help reduce the number of patients starting intravenous nutrition. This would cut overall costs, reduce line infection risk, and potentially reduce the length of hospital stay.	This has provided the team with a greater awareness when considering intravenous nutrition and greater confidence to encourage earlier tube feeding wherever possible.
Time to clinical remission in juvenile idiopathic arthritis (JIA) patients commencing on Etanercept and Adalimumab (biologics)	Area of improvement identified to achieve the standard of regular review after starting biologic treatment.	Plan to set up shared care with local hospitals in order to review JIA patients after commencing new biologics.
Continuous assessment of basic gastrostomy care in the Trust	Higher levels of confidence were reported in: <ul style="list-style-type: none"> • Determining why a gastrostomy may be required • Identifying gastrostomy devices • Providing basic care • Escalating concerns 	There was significant improvement across the Trust.
Trends in obesity amongst patients undergoing general anaesthesia	A significant proportion of patients were found to be obese (12.9%), which represents an immediate risk during operations.	Development of a peri-operative protocol for the management of the obese child undergoing general anaesthesia.
Use of cuff pressure manometers and review of cuff pressures during anaesthesia	We used this audit to identify that we could reduce the risk to patients in theatre associated with cuffed airway devices.	More cuff pressure monitors have been purchased following these results.
Review of the feeding outcomes of children with a diagnosis of posterior laryngeal cleft	The audit enabled better understanding of the type of swallowing problems children with a laryngeal cleft have pre- and post-surgery, their feeding prognosis and the need for ongoing support and/or intervention.	It helped to inform parents, children and the multi-disciplinary team about feeding problems and resulted in refinement of the clinical care pathway.

Clinical Audit Heroes

As part of National Clinical Audit week in November 2016, the Healthcare Quality Improvement Partnership launched 'Clinical Audit Heroes' to celebrate individuals who make a positive difference in audit and quality improvement across the NHS. Of 25 NHS staff members nominated nationally, three nominees were GOSH staff. This signals our commitment to clinical audit here at GOSH, and the integration of audit with quality improvement, outcomes and research. It also demonstrates the peer support of colleagues in their work to improve the care of our children.



Participation in clinical research

At GOSH, we understand the immense importance to patients and their families of pushing the edges of medical understanding to make advancements in the diagnosis and treatment of childhood diseases. As a specialist hospital with strong academic links, many of our doctors are clinician-scientists who specialise in research and we are dedicated to harnessing opportunities for collaboration between clinicians and scientists to deliver more research findings from 'bench to bedside' and 'bedside to bench'. In other words, medical research is a two-way process that allows us to offer the very latest treatments for our patients. Much of what we do is at the forefront of research in diseases of children and young people and we are also working to implement new evidence-based practice beyond GOSH, so that more patients can benefit in the UK and abroad.

GOSH's strategic aim is to be a leading children's research hospital. We are in the unique position of working with our academic partner, the University College London (UCL) Great Ormond Street Institute of Child Health (ICH), to combine enviable research strengths and capabilities with our diverse patient population. This enables us to embed research in the fabric of the organisation. In addition to ICH, GOSH benefits from access to the wealth of the wider UCL research capabilities and platforms.

Together, GOSH and ICH form the largest paediatric research centre outside North America. Continued investment in research infrastructure is critical, with current examples including:

- The National Institute for Health Research (NIHR) GOSH Biomedical Research Centre has been awarded a further five-year term of funding. A total of £37m has been awarded, which will drive forward translational research into rare diseases in children. The successful application is part of our ongoing partnership with ICH as the UCL Great Ormond Street Institute of Child Health
- For a period of five years, £3m has been awarded by the NIHR to support our Somers Clinical Research Facility (CRF). The CRF is a dedicated space for children taking part in clinical trials at GOSH. This funding will allow the CRF to support more complex early phase research for some of the rarest childhood conditions
- The Trust together with GOSH Children's Charity invested £1.2m into research infrastructure posts, which underpin the work of our leading research teams
- The Trust also received £1.9m from the NIHR Clinical Research Network to support key research delivery posts

GOSH also hosts one of the few centres dedicated to supporting nurses and allied health professionals in research activity. This team of researchers prioritises understanding the patient and family experience, helping to describe the care that families receive, and exploring both processes and outcome.

Together, GOSH and ICH form the largest paediatric research centre outside North America.



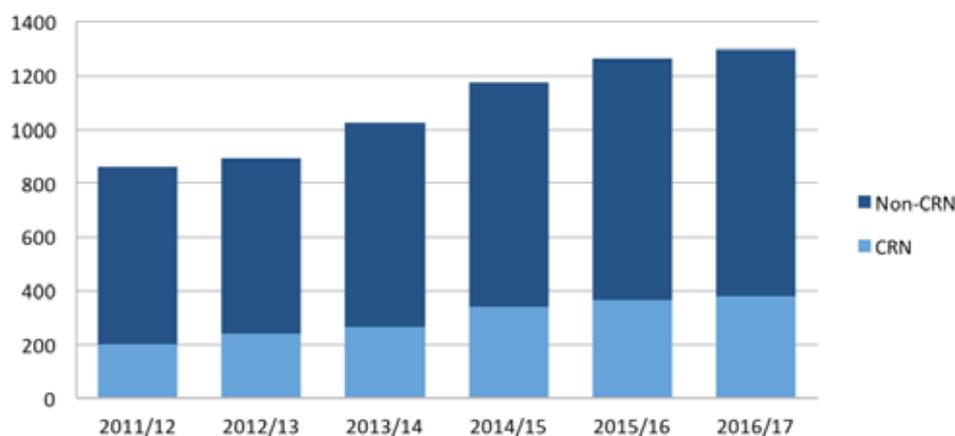
Research activity

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

During 2016/17, we ran 1,299 research projects at GOSH/ICH. Of these, 379 were adopted onto the NIHR Clinical Research Network (CRN) Portfolio, which is a grouping of high-quality clinical research studies. In the first three quarters of 2016/17, more than 4,000 patients and family members took part in research studies. In addition to these, GOSH is the lead trust for the North Thames NHS Genomic Medicine Centre (GMC), which is sequencing patient genomes for the 100,000 Genomes project for rare diseases. The North Thames GMC has recruited 5,200 participants, making up around 28% of those recruited nationally.

Our already extensive research activity has consistently increased year-on-year. The chart below shows the numbers over time of all our research, including the high-quality CRN portfolio projects:

GOSH/ICH research projects 2011/12–2016/17



Year	CRN	Non-CRN	Total
2011/12	199	662	861
2012/13	239	653	892
2013/14	266	758	1,024
2014/15	339	835	1,174
2015/16	367	898	1,265
2016/17	379	920	1,299

Note: These figures may differ from those previously reported due to a change in the measure of research activity from 'Number of active research projects at year end' to the more representative 'Number of research projects active within a financial year'.

Journal publication

In addition to high levels of research activity, we also have high citation impact. This means that our published research papers are often referenced in others' research. An analysis by Thomson Reuters of our publication output for the five years to 2014 showed that GOSH and ICH has the highest citation impact of the top children's hospitals we compared ourselves with internationally. This analysis is undertaken periodically and is currently underway for the five years to 2016. We will report the result in next year's *Quality Report*.



Research highlights include

Researchers at GOSH and ICH have discovered a new genetic mutation that causes a rare form of epilepsy. The faulty gene was identified in seven out of 32 children with a rare strain of vitamin B6-dependent epilepsy who are unresponsive to standard anti-epilepsy drugs. These findings are extremely important as they will allow easier identification of patients who will benefit from treatment with vitamin B6.

A study has identified a set of 614 genetic markers that can be used to speed up diagnosis of suspected neurometabolic disease. Currently, patients can undergo extensive and often invasive testing, and delays or difficulties in establishing a diagnosis are commonly encountered. A GOSH team showed that testing for defects in 614 different genes could at least partially diagnose neurometabolic conditions in up to 89% of cases. This powerful tool could assist timely diagnosis in many patients, meaning that crucial treatment can begin more quickly.

Pharmaceutical company BioMarin has pre-released promising results from a novel trial testing a new treatment for CLN2 disease. CLN2 disease is a subtype of the fatal neurodegenerative condition called Batten Disease, which is caused by a genetic mutation that results in reduced activity of the CLN2 protein. In this trial, an active copy of the protein was administered directly into patients' brains. One year after treatment, affected patients showed an 80% reduction in the progression of the disease. It is expected that BioMarin will now look to implement an early access programme to enable additional CLN2 patients to have access to this novel treatment.

We've seen promising results in a pilot project at GOSH to test whether genome sequencing of patients' blood samples can be used as a diagnostic tool in the clinic. The project aimed to test 10 patients (and their parents) from GOSH's paediatric intensive care unit whom consultants suspected may have a rare genetic disease. For five of the first eight patients, definite or possible genetic causes of the disease were returned within five days, helping clinicians to take rapid and appropriate action to treat these patients.

In collaboration with the University of Cambridge, researchers at GOSH/ICH have identified a new genetic cause of complex early-onset dystonia. Dystonia is a movement disorder, characterised by abnormal body movements and postures. The condition affects around 70,000 people in Britain. However, for a large proportion of children with childhood-onset dystonia, the underlying cause remains unknown. This research demonstrated that children with the faulty gene could be treated using 'deep brain stimulation' – a new therapy where electric impulses are delivered to specific areas of the brain.

<Cross-references to research stories in AR to be added>

Use of the CQUIN payment framework

A variety of CQUINs have been undertaken by the Trust in 2016/17. Some of these are national indicators, which may also be undertaken by other trusts across the country, and some were locally defined in order to improve our individual performance. Due to the specialist nature of our care, some of the national CQUINs needed to be adapted to fit with the services we provide for our patients.

CQUIN schemes 2016-17	Overview
National schemes	
Clinical Utilisation Review system	The Clinical Utilisation Review is a pilot to improve the flow of patients through GOSH. This CQUIN involves the procurement, installation and implementation of a system, and the reporting of results and evaluation of the pilot.
Antimicrobial resistance – Part 1 (20%)	To increase the number of patients’ antibiotic prescriptions that are reviewed in hospital, in order to prevent overuse of antibiotics.
Antimicrobial resistance – Part 2 (80%)	To reduce the use of specific antibiotics when they are no longer needed.
HAEMTRACK	The HAEMTRACK system is a patient-reported record of usage of self-managed blood and blood-product home therapy. The aim of the CQUIN is to encourage patients to record their treatment at home, on a device that enables viewing from a central system. In turn, the necessary drugs are delivered straight to the patient’s home.
Optimal devices (Cardiac)	The optimal devices scheme relates to the maintenance and improvement in optimisation of cardiac device usage, while the service is moving to a centralised national procurement and supply chain arrangement.
Critical care	This CQUIN is for collection of information about bed utilisation on our paediatric ICU. The aim of this is to obtain a better understanding of potential flow issues and how these could be improved, for example to support optimal scheduling of surgical patients.
Difficult asthma	This CQUIN scheme aims to ensure assessment and investigation of children with difficult-to-control asthma, by a multi-disciplinary team, within 12 weeks of referral.
Univentricular home monitoring	This CQUIN scheme implements home monitoring programmes for children following palliative cardiac surgery. These are aimed at patients with certain primary diagnoses that collectively are referred to as univentricular hearts or univentricular circulations.
Child and Adolescent Mental Health Service (CAMHS) – long term conditions	This CQUIN is to support the screening of patients aged 2–17 with one or more of four specified long-term conditions, when they are admitted as inpatients. The screening tool used, the Strengths and Difficulties Questionnaire (SDQ), enables the identification of patients who may have mental health needs. Once identified, the swift initiation of additional support is facilitated, as well as input from psychological and mental health services as appropriate.
CAMHS – pathways	This CQUIN concerns the implementation of good practice regarding the involvement of family and carers through a CAMHS journey to improve longer-term outcomes.

What is CQUIN?

The Commissioning for Quality and Innovation (CQUIN) payment framework makes a proportion of NHS healthcare providers’ income conditional upon improvement. The framework aims to support a cultural shift by embedding quality and innovation schemes as part of the discussion between service commissioners and providers, and constitutes 2.5% of the Actual Contract Value between commissioner and provider.

CQUIN schemes 2016-17	Overview
NHS staff health and wellbeing	
Introduction of staff health and wellbeing initiatives (30%)	<ul style="list-style-type: none"> • Introducing a range of physical activity schemes for staff • Improving access to physiotherapy services for staff • Introducing a range of mental health initiatives for staff
Healthy food for NHS staff, visitors and patients (30%)	The aim of this indicator is to change the organisational behaviour and culture towards the food and drink sold on NHS premises. This is to be achieved by focusing on making healthier food and drink more widely available.
Improving the uptake of 'flu vaccinations for frontline staff (40%)	61% or more of frontline healthcare workers to have received the 'flu vaccine by 31 December 2016.
Internal schemes	
Patient access improvement – complaints	To increase the number of complaint responses sent out within agreed timescales, and to reduce the number of concerns relating to lack of communication with patients.
Patient access improvement – discharge summaries	To measure the content of the discharge summaries against best practice standards, and to improve the timescales for the dispatch of summaries from the Trust.
Patient access improvement – clinic letters	To measure the content of the clinic letters against best practice standards, and improve timescales for the dispatch of summaries from the Trust.
Patient access improvement – cancelled operations	To review the Trust's processes for recording cancelled operations, along with the implementation of an agreed improvement plan to reduce cancellations.
Patient access improvement – consultant-to-consultant referrals	To reduce unnecessary consultant-to-consultant referrals by producing a Standard Operating Procedure (SOP) of consultant-to-consultant referrals, and undertaking a clinical audit of three specialties to test against the SOP.
Cryopyrin-Associated Periodic Syndrome (CAPS), haemophilia, factor VIII bloods	To deliver more efficient utilisation of pass-through drugs and blood products.
Telemedicine	To pilot the replacement of physical outpatient attendances, where appropriate, with virtual contact through telephone calls, video calls or other technology-facilitated methods.
Transition to adult services	To design a clear transition pathway for young people aged 13 years and above that will be used across the Trust.



Welcoming



Helpful



Expert



One Team

In 2016/17, 2% of GOSH's NHS income (activity only) was conditional upon achieving CQUIN goals agreed with NHS England for the above schemes. If the Trust achieves 100% of its CQUIN payments for 2016/17, this will equate to £4.8 million.

During Q1 to Q3 of the financial year, we reported high compliance against all our CQUIN indicator milestones. We expect to report approximately 95% compliance at year-end.

CQC registration

GOSH is required to register with the CQC and is currently registered, without conditions, as a provider of acute healthcare services. GOSH has not participated in any special reviews or investigations by the CQC in 2016/17.

The CQC visited the Trust as part of its rolling schedule of inspections in April 2015. The report was published in January 2016 and services were rated as 'good' overall and 'outstanding' for being caring and for being effective. The report identified concerns about the Trust's management of referral-to-treatment (RTT) and associated data and required action to be taken via a Requirement Notice. The Trust and the Board is committed to making the improvements to fully address the issues identified. Our efforts in 2016/17 and the improvements achieved can be read about on pages 16–17.

What is the CQC?

The Care Quality Commission (CQC) is the independent healthcare regulator for England and is responsible for inspecting services to ensure they meet fundamental standards of quality and safety.

Data quality

Good quality data is crucial to the delivery of effective and safe patient care and to the running of GOSH. Data is vital to enable us to run our services efficiently as well as to identify any care quality issues and predict trends in order to take early action.

In the past year, we have embarked on an improvement programme to enhance the provision of good quality data. We have also introduced data quality 'kitemarking' for key metrics used by senior managers so they can at a glance see how reliable and robust the information used for decision-making is.

In early 2017/18, GOSH will take the following actions to improve data quality:

- We will establish a dedicated Data Assurance team who will work closely with staff to improve data quality. This will be achieved through improved training and coaching as well as tailored initiatives to target common problem areas.

Secondary Uses Service

As required by NHS Digital, GOSH submitted records during 2016/17 to the Secondary Uses Service (SUS) for inclusion in the national Hospital Episode Statistics. These are included in the latest published data.

The table below shows key data quality performance indicators within the records submitted to SUS:

Indicator	Patient group	Trust score	Average national score
Inclusion of patient's valid NHS number	Inpatients	99.1%	99.4%
	Outpatients	99.6%	99.5%
Inclusion of patient's valid General Practitioner Registration Code	Inpatients	99.9%	99.9%
	Outpatients	100%	99.9%

Notes:

- The table reflects the most recent data available (April 2016–January 2017 at month 10 SUS inclusion date)
- Nationally published figures include our international private patients, who are not assigned an NHS number. These published figures are consequently lower at 91.4% for inpatients and 93.6% for outpatients
- Figures for accident and emergency care are not applicable as the Trust does not provide this service

Clinical coding

GOSH has a dedicated and highly skilled clinical coding team which continues to maintain high standards of inpatient coding. Due to the complexities of our patients, each inpatient stay tends to have a higher than average number of codes applied. GOSH carries out internal audits to ensure that accuracy and quality are maintained. The most recent audit showed results of over 96% accuracy for all of the areas audited. GOSH was not subject to the Payment by Results clinical coding audit during the 2016/17 reporting period.

Information governance

The Information Governance Toolkit provides NHS organisations with a set of 45 standards, against which we declare compliance annually. GOSH's Information Governance Assessment Report overall score for 2016/17 was 76% and was graded red. This is an improvement on our score for 2015/16. However, we did not meet the minimum standard of training all staff every year in information governance. To address this in the coming year, we will communicate directly with staff who have not completed their training and also underscore the importance of this training via managers.

Implementation of the duty of candour

The Trust formalised its approach to openness and transparency in 2009 with the introduction of its Being Open Policy. This policy informed staff of the expectations of the Trust, that open and honest communication would take place with patients, parents and their families throughout all aspects of their care, including when patient safety events may have occurred.

The policy was updated to encompass the legal requirements that came into force on 1 April 2015, which described a legal responsibility to be open with patients and/or their families when a patient safety event caused harm graded as moderate, severe or death.

The Trust continues to engage in transparent communication with patients, parents and families and has robust processes to manage patient safety events that are reported at the Trust.

What is data quality?

Data quality refers to the tools and processes that result in the creation of accurate, complete and valid data that is required to support sound decision-making.

What is NHS Digital?

NHS Digital is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

What is the Secondary Uses Service (SUS)?

The SUS is a single source of specified data sets to enable analysis and reporting of healthcare in the UK. SUS is run by NHS Digital and its reporting is based on data submitted by all provider trusts.

What is an NHS number?

Everyone registered with the NHS in England and Wales has their own NHS number, a unique 10-digit number that helps healthcare staff to find a patient's health records. The NHS number increasingly helps to identify the same patient between organisations.

"The culture was very open and transparent. Parents and children were kept fully involved in their treatment. There was an evident commitment to continually improve the quality of care provided.

"Children and young people were involved in decision-making as far as possible."

Quotes from GOSH's CQC report, published January 2016

Patient image to be added at a later date

Part 2c:

Reporting against core indicators

NHS trusts are subject to national indicators that enable the Department of Health (DH) and other institutions to compare and benchmark trusts against each other. Trusts are required to report against the indicators that are relevant to them. The table below shows the indicators that GOSH reports against on a quarterly basis to our Trust Board and also externally. The data is sourced from NHS Digital, unless stated otherwise. Where national data is available for comparison, it is included in the table.

What is the Department of Health?
The Department of Health (DH) is a department of the UK government with responsibility for government policy for England alone on health, social care and the NHS.

Performance against Department of Health quality indicators

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2016/17	2015/16	2014/15	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Domain 4: Ensuring that people have a positive experience of care									
				Source: NHS Staff Survey					
				Time period: 2016 calendar year					
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	90% (2016)	88% (2015)	87% (2014)	90%	95%	87%	90% (median score)	The survey is carried out under the auspices of the DH, using their analytical processes. GOSH is compared with other acute specialist trusts in England.	Ensuring that divisions and directorates develop and implement local action plans that respond to areas of weakness.
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	25% (2016)	25% (2015)	24% (2014)	25%	17%	30%	25% (median score)		
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	85% (2016)	87% (2015)	89% (2014)	85%	94%	81%	86% (median score)		

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2016/17	2015/16	2014/15	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm									
				Source: Public Health England Time period: 2015/16 financial year					
Number of clostridium difficile (C.difficile) in patients aged 2 and over†	1	7	14	7	0	139	33.5	The rates are from Public Health England.†	Continuing to test stool samples for the presence of C.difficile, investigate all positive cases, implement isolation precautions and monitor appropriateness of antimicrobial use across the organisation.
Rate of C.difficile in patients aged 2 and over (number of hospital acquired infections/100,000 bed days)	1.79	8.3	12.2	8.5*	0	66	14.9		
<p>Note: C.difficile colonisation is common in children and, while severe disease may occur at any age, it is rare. At GOSH, we test for C.difficile toxin in all diarrhoeal stool that 'conforms to the shape of the pot' (minimal national standard), as well as other stool where diarrhoea, fever or blood in stool was reported; where a request is made for enteric viruses; and as part of the surveillance programme in children with congenital immunodeficiency and undergoing bone marrow transplants. On agreement with our commissioners, we investigate all positive detections and report to Public Health England those aged 2 and above with diarrhoea (or a history of diarrhoea) where no other cause is present or, if another possible cause is present, clinical opinion led to treatment as a possible case. We report on the Healthcare Acquired Infection database according to a locally agreed paediatric modification of the national definition, to enable year-on-year comparison in our specialist trust. Our approach means we find more positive samples compared with the number of cases that we report.</p> <p>* One case of C.difficile was attributed (due to onset after third day of admission) to GOSH for 2016/17, but was not classed as a lapse of care in line with guidance published by NHS Improvement. Of the seven cases of C.difficile attributed to GOSH for 2015/16, two were attributed to a lapse of care, and of the 14 cases of C.difficile attributed to GOSH for 2014/15, one was attributed to a lapse of care.</p> <p>† National report used estimated bed days at time of reporting.</p> <p>‡ https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis</p>									
Patient safety incidents reported to the National Reporting and Learning System (NRLS):				Source: National Reporting and Learning Service (NRLS) Time Period: 1/04/2016 to 31/03/2017					
Number of patient safety incidents	5,429	5,338	5,231	5134	-	-	-	GOSH uses electronic incident reporting to promote robust reporting and analysis of incidents. It is expected that organisations with a good safety culture will see higher rates of incident reporting year-on-year, with the severity of incidents decreasing.	Initiatives to improve the sharing of learning to reduce the risk of higher-graded incident recurrence. Initiatives are reported and monitored by the Patient Safety and Outcomes Committee.
Rate of patient safety incidents (number/100 admissions)**	12.40	12.50	12.83	-	-	-	-		
Number and percentage of patient safety incidents resulting in severe harm or death	8 (0.1%)	11 (0.2%)	26 (0.5%)	5	-	-	-		
<p>Note: There is a time lag between NHS Trusts uploading data to the NRLS (performed twice a month at GOSH) and the trend analysis reports issued by the NRLS.</p> <p>** An inaccuracy in the rate calculation reported in 2015/16 was detected and has been corrected here.</p>									

Explanatory note on patient safety incidents resulting in severe harm or death

It is mandatory for NHS trusts in England to report all serious patient safety incidents to the CQC as part of the CQC registration process. GOSH also reports its patient safety incidents to the NRLS, which runs a national database designed to promote learning.

There is no nationally established and regulated approach to reporting and categorising patient safety incidents. Different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a lengthy investigation, which could result in the classification being changed. This complexity makes it difficult to do a formal comparison.

What is the median?

The median is an average that is derived by finding the middle point in a sorted range of values. Unlike the mean average, which is the total divided by the number of values, the median provides an average that is not skewed by 'outlier' or extreme data points.

Part 3:

Other information

NHS Improvement uses a limited set of national mandated performance measures, described in its *Single Oversight Framework*, to assess the quality of governance at NHS Foundation Trusts.

Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the appropriate threshold each month. Consequently, any failure in one month is considered to be a quarterly failure. The table below sets out the relevant national performance measures used to assess the Trust's quality governance rating.

What is NHS Improvement?
NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

Performance against key healthcare targets 2016/17

Domain	Indicator	National threshold	GOSH performance for 2016/17 by quarter				2016/17 mean	Indicator met?	
			Q1	Q2	Q3	Q4			
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment	96%	97.5%	97.9%	100%	100%	98.9%	Yes	
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:								
	· surgery	94%	95%	100%	100%	100%	98.8%	Yes	
	· anti-cancer drug treatments	98%	100%	100%	100%	100%	100%	Yes	
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	Following the identification in 2015/16 of challenges with delivery of the RTT standards, GOSH agreed with NHS England a pause in the reporting of its RTT figures until confidence in the data had been returned. The improvement work (see pages 16–17) has progressed and reporting resumed in February 2017.				Jan: 91.2% Feb: 91.6% Mar: 91.85%	N/A as the indicator is a snapshot at a given census date.	No
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved

Additional indicators – performance against local improvement aims

In addition to the national mandated measures identified in the above tables, the Trust has implemented a range of local improvement programmes that focus on the quality priorities as described in Part 2a. The table below sets out the range of quality and safety measures that are reviewed at each Trust Board meeting. Statistical Process Control charts are used to measure improvements in projects over time and to identify areas that require further investigation. All measures remain within expected statistical tolerance.

Domain	Indicator	GOSH performance for 2016/17 by quarter				2016/17 mean
		Q1	Q2	Q3	Q4	
Safety	Central Venous Line (CVL) related bloodstream infections (per 1,000 line days)	1.7	1.8	1.7	1.4	1.65
Effectiveness	Inpatient mortality rate (per 1,000 discharges) [†]	4.2	5.6	7.0	5.7	5.6
Experience	Friends and Family Test (FFT) – % of responses (inpatient)	25.4%	17.7%	26.0%	26.2%	23.8%
Experience	FFT – % of respondents who recommend the Trust (inpatient)	98.2%	98.1%	98.1%	97.6%	98%
Experience	Discharge summary completion time (within 24 hours)	87.4%	88.7%	86.6%	89.9%	88.2%
Effectiveness	Last minute non-clinical hospital cancelled operations: Breach of 28 day standard					
	· cancellations	197	191	157	180	725 (total)
	· breaches	32	32	23	25	112 (total)
Experience	Formal complaints investigated in line with the NHS complaints regulations	33	22	26	18	99 (total)
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge	1.73%	1.67%	1.86%	1.39%	1.66%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge	1.35%	1.60%	0.68%	3.91%	1.80%

Performance against key healthcare targets 2015/16

Domain	Indicator	National threshold	GOSH performance for 2015/16 by quarter				2015/16 mean	Indicator met?
			Q1	Q2	Q3	Q4		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment [^]	96%	97.1%	100%	98%	100%	98.8%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:							
	· surgery [^]	94%	94.9%	100%	90.9%	100%	96.5%	Not in Q3
	· anti-cancer drug treatments	98%	100%	100%	100%	100%	100%	Yes
Experience	Maximum time of 18 weeks from point of referral-to-treatment in aggregate – patients on an incomplete pathway	92%	2015/16 was a challenging year for the Trust related to delivery of the RTT standards, with a number of significant issues identified following an Elective Care Intensive Support team review in May 2015. As a result, GOSH agreed with NHS England a pause in the reporting of its RTT figures until confidence in the data had returned.					
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements [*]	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

Additional indicators – performance against local improvement aims

Domain	Indicator	GOSH performance for 2015/16 by quarter				2015/16 mean
		Q1	Q2	Q3	Q4	
Safety	CVL related bloodstream infections (per 1,000 line days)	0.9	1.3	1.8	1.7	1.4
Effectiveness	Inpatient mortality rate (per 1,000 discharges) ^{**}	7.0	5.0	7.3	5.0	6.0
Experience	FFT – % of responses (inpatient)	28.1%	19.9% ^{**}	19.2% ^{**}	24.2%	22.8%
Experience	FFT – % of respondents who recommend the Trust (inpatient)	98.7%	98.7%	98.3%	98.8%	98.6%
Experience	Discharge summary completion time (within 24 hours)	81.0%	80.8%	79.3%	76.8%	79.5%
Effectiveness	Last minute non-clinical hospital cancelled operations: Breach of 28 day standard ^{††}					
	· cancellations	11	39	17	309	376 (total)
	· breaches	0	0	0	52	52 (total)
Experience	Formal complaints investigated in line with the NHS complaints regulations	36	44	32	39	151 (total)
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge	1.82%	1.83%	1.77%	1.69%	1.78%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge	0.93%	0.56%	4.32%	0.76%	1.62%

^{*} Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008).

[‡] Does not include day cases.

[†] 'Last minute' is defined as: on the day the patient was due to arrive, after the patient has arrived in hospital, or on the day of the operation or surgery. The Trust is working to minimise its level of last minute cancelled operations for non-clinical reasons and the 'Better Value' work over the next year will help to provide more clarity on what expected levels should be.

[^] Reporting corrections from 2015/16 *Quality Report* included.

^{**} Does not include day cases, thus producing higher figures than the previous Hospital Mortality Rate. This new definition provides a more accurate measure of inpatient mortality.

^{**} Percentage dropped as a result of Trust including from Q2 all ward discharges in the denominator, including frequently returning patients who had previously been excluded from the figures as per the national definition.

^{††} As part of the trust's ongoing review of submissions and returns, an issue was identified with the methodology used to capture data items related to cancellations and 28 day breaches. The Trust developed a robust methodology for the capture and reporting of the standard, which was supported through a CQUIN programme of work in 2016/17.

Annex 1:

Statements from external stakeholders

Statement from NHS England (London), Specialised Commissioning Team

NHS England would like to thank Great Ormond Street Hospital NHS Foundation Trust for the opportunity to review and provide a response to the 2016/17 Quality Account.

NHS England is the lead commissioner and has a very positive relationship with the Trust. We continue to work together to consider improvements in the quality of care and accessibility for those children whose healthcare needs are ideally managed by GOSH.

We continually reviewed feedback from families and other stakeholders, clinical quality review meetings and other external sources including the Care Quality Commission, Health Education North Central and East London, and Public Health England to inform decisions about where improvements can be delivered; notable examples this year include the gastroenterology and spinal surgery services.

We commend the Trust for the considerable work undertaken to improve access to elective care, to return to national reporting during 2016/17 and we note that the development of a reporting solution which has been identified as best practice by the NHS Improvement Intensive Support Team. The Trust will continue to manage its patient tracking processes and will embed clinical harm reviews as business as usual. We are confident that the Trust will also continue to work with referring hospitals to improve the position with unknown clocks and that it has a plan in place to achieve the national standard for diagnostic waits.

We acknowledge the areas of achievement reported this year which includes the implementation of the Sepsis 6 superheroes and the focussed work to prevent and manage cardiac arrests, both of which will continue into the coming year.

There are a number of areas where work to facilitate the improvements outlined in the quality account are underway, that is:

- Good transition of children and young people to adult services
- Improving the quality and safety of care for inpatient neonates/ small infants
- Developing Trust-wide access to outcomes data
- More broadly, the Trust is also focusing on improvements with:
 - Late cancellation of operations
 - Patient flow and productivity with some changes in capacity occurring with the opening of the Premier Inn Clinical Building
 - Sustaining better staff appraisal and statutory and mandatory training rates

We look forward to considering these areas of work and values to ensure continuous improvement for patients are delivered in 2017/18.

Statement from Healthwatch Camden, incorporating comments from Camden Health and Adult Social Care Scrutiny Committee

The draft *Quality Report* is commendable. Although only a small percentage of GOSH's patients are Camden residents, Healthwatch Camden has always found the Trust to be open and welcoming of our input. Camden Health and Adult Social Care Scrutiny Committee also welcomes the Trust's Quality Accounts. We would have liked to have seen further detail about collaborating with, and reaching out to, North Central London Councils to share learning about working with and supporting vulnerable children and families.

We have some specific comments on the report.

We commend the 'safety huddles' and particularly incorporating the parents' concerns in the 'watchers' list. We note the very positive feedback from the patient representative. 29% of wards are not yet at 'gold standard' and we would welcome more specific information on actions to get all wards to the gold standard most wards are already at.

Although significant improvements have been made to reach the 92% national target for referral-to-treatment (RTT) pathways, we note the last result was still below 92%. We suggest feedback from parents be built into the process to gain insight from this key group to further support improvements.

Friends and Family Test (FFT) data for inpatients was above the 95% target, but for outpatients it was below the target. Some commentary in the final report as to why the outpatients result was below target would be welcome, as would some brief indications of what specific actions to improve the figure are being undertaken. We would imagine direct input from patient groups could well provide useful input into this. The way GOSH went about the gathering FFT information to engage patient feedback was highly innovative and impressive (the child friendly forms, listening event and video booths clearly demonstrate this). Some more detailed analysis (beyond the themes on page 24), with specific actions against each identified area would be welcome additions to the report.

With regard to the engagement quality improvement project around transition to adult services that the Trust will undertake in 2017/18 we feel some further and ongoing direct feedback from young adults themselves into proposed improvements would be helpful. The Patient and Family Engagement and Experience Committee could give guidance on how this might occur.

The data from the Bereaved Parent Survey was positive. This surely must be the most challenging of areas, so the training identified to support staff is welcome. We note the data showed that 77% responded yes to "Did anyone discuss the fact that your child was dying with you", so 33% would have responded no. Perhaps this might be one of the areas where additional staff training might be targeted. We presume the End of Life Care Committee, the Patient and Family Experience and Engagement Committee and the Bereavement Services Manager would be able to feed into what this training might entail.

GOSH's Information Governance Assessment Report overall score for 2016/17 was 76% and was graded red. We suggest a quality improvement project around this could be something to consider for 2017/18.

There does seem to be an excellent learning culture with GOSH that looks to people's real experiences of the Trust, and some excellent engagement of both parents and children. We would encourage even more of these innovative and excellent engagement processes, but also encourage more openness of the actual results and particularly what actions will be undertaken as a result of the feedback. We would encourage parents and patient groups to be involved in the analysis of the feedback as well as disseminating of the outcomes and resultant actions.

Comments from patient councillor:

It is clear to see the outstanding work that GOSH carries out daily to improve services for children and young people. Furthermore, the innovative research the Trust has undertaken demonstrates how GOSH is at the forefront of advancements in medical treatments. Having been a patient at GOSH, and now representing patients outside of London, it has been extremely heartening to read how a significant amount of work has been undertaken over the last year to improve the safety, clinical effectiveness and experience of patients and parents at GOSH.

Safety:

The work the Trust has done to improve the awareness of sepsis is fantastic. As detailed in this report, the variety of events undertaken by the Trust, such as the Sepsis Awareness Week and the creation of Sepsis Champions has all helped to raise awareness of what sepsis is, and the protocol to follow at GOSH. It is noted that staff feel empowered by GOSH's Sepsis Protocol, and that work has been undertaken to raise awareness of sepsis with parents and carers. Furthermore, the classification system for respiratory and cardiac arrests outside ICU and theatre appears to be effective in steadily reducing the number of arrests on a monthly basis. It is reassuring to have read that a detailed analysis is undertaken on arrests that are 'probably not preventable but with modifying factors' and arrests that are classed as 'potentially preventable', thus helping to improve patient safety.

Additionally, the successful implementation of the daily safety huddle across every inpatient ward is pleasing. It is of vital importance to get nurses, lead doctors and other relevant staff members together as one team to help reduce deteriorating child incidences. The aid of the electronic Patient Status at a Glance boards appear to be pivotal in ensuring that staff members have relevant and timely information on patients, thus helping to inform the huddle discussions. Of particular note is the 'watcher' category, which enables parents'/carers' concerns to be recognised and listened to, even if the Children's Early Warning Score doesn't trigger an alert. Next year, I would hope to see 100% of inpatient wards fulfilling all of the GOSH 'gold standard' huddle criteria.

Clinical effectiveness:

The issues surrounding Referral to Treatment at GOSH has been an area that the Members' Council has taken a keen interest in, and it is something that we have regularly been briefed on. The hard work, persistence and dedication shown by GOSH staff in investigating this issue, looking at processes and re-writing guidance is outstanding. I am delighted that this has been reflected not only by the fact that GOSH is back reporting ahead of recovery trajectory, but that GOSH has also been referred to as a "best practice" organisation. Many congratulations to all who have been involved in this significant area of work.

It is good to see the proactive approach that GOSH has taken to introduce a standardised mental health screening tool for patients. This approach helps to ensure that mental health is not neglected and patients feel able to talk about it, thus helping recognition and treatment of mental health problems. There has been a significant increase in the number of children and young people who received a mental health screening, from 9% in Quarter 2 to 45% in Quarter 4, which is brilliant. However, I hope that work will be ongoing to ensure that all eligible patients are screened. The use of the Strengths and Difficulties Questionnaire, and the ability to complete it electronically, with face-to-face support from clinical staff, is welcome. It is encouraging to see that the hard work that has gone into this project is having a great benefit for patients and families.

Experience:

I have read with interest the work that GOSH has undertaken to improve young people's experience of transition to adult services. Having recently been through this process, and having spoken to other young people who have recently been through transition, feedback has varied from poor to excellent. It is important to recognise that this is an extremely challenging area to get right, as there is no one correct way to transition a patient, as every patient is unique. I strongly welcome the work that the Trust has undertaken to introduce a 'Transition Lead' in each specialty, and the involvement of young people in the Transition Improvement Steering Group. I am confident that this will lead to a more 'joined-up' approach to transition. However, as the figures in the *Quality Report* detail, with thousands of patients between 13–17 years old, I am concerned whether there is enough resource being put behind this project with one transition improvement manager. I hope that the Chief Nurse, in her role as executive lead for transition, will actively drive forward this vital area of improvement work. The section has been largely focussed on the perspective of the patient, which I am really pleased to see. However, it is important not to neglect the views of parents as it can often be a worrying time for them as well.

A significant amount of work has also been undertaken with regards to the Friends and Family Test (FFT). It is vital that patients and parents feel able to give honest feedback, and the increase in response rate highlights that this is the case. The introduction of feedback cards for patients aged 8 or under is fantastic, as this ensures that the Trust is able to capture feedback in an age-appropriate manner. Over the next year, I hope to see the use of technology in capturing patient and parent/carer feedback, which will help to increase accessibility and may help to increase the number of patients responding to the FFT. The percentage of those who recommend the Trust has remained extremely high, and is a testament to the many dedicated staff at GOSH who go above and beyond every day, making a difference to very sick children and young people.

The listening event, held in November 2016, was a great success as it enabled patients and parents to discuss four key topics. It is clear that the Trust was able to get a lot out of the day and it is vital that there is ongoing communication with the attendees as to the improvements made following their feedback. Thanks must go to all the staff who made this event a great success.

Other comments:

I am concerned that the GOSH Information Governance Assessment score for 2016/17 has remained at red. It would be interesting to read what plans are in place for 2017/18 to improve this grade.

Whilst there has been a change in methodology, I have noted that the mean number of last minute non-clinical hospital cancelled operations has increased from 94 in 2015/16 to 181 in 2016/17. This is disappointing to have read; however, it is good that GOSH has recognised that this figure is higher than it would like and it is actively undertaking work to reduce the number of hospital cancelled operations. I hope to see this figure decline over the next year as last minute cancellations can cause significant inconvenience for families.

Many of the strands of work covered in the 2016/17 GOSH *Quality Report* are ongoing. It would be useful to have a reflection on how these areas have further improved in the 2017/18 *Quality Report*, as well as having an update on the quality priorities detailed in the 2015/16 *Quality Report*.

The exciting medical innovations detailed at length in this *Quality Report* are far too many to comment on in this brief statement, but they highlight that GOSH continues to be a world-leading research hospital, which is something that everyone should be incredibly proud of.

In conclusion, I have found this *Quality Report* extremely interesting and informative. It clearly demonstrates that there are many achievements to celebrate. One must pay tribute to all the dedicated members of staff who have worked so hard to implement these improvements, all whilst delivering outstanding care to patients. I believe that this *Quality Report* can be summed up by simply saying that in everything GOSH does, it puts 'the child first and always'.

Comments from parent councillor:

GOSH is an internationally recognisable institution with dedicated staff serving some of the most ill children and young people and providing support to their families and carers. The research that GOSH does is vital for the continued understanding of child ill health and improvement in treatment. The annual *Quality Report* provides an excellent opportunity to explain and highlight the quality of services delivered over the past 12 months against predetermined criteria (safety, clinical effectiveness and experience), whilst giving a foretaste of the priorities for the current year. As a parent of two children who have received treatment at GOSH and now a Council Member, I am pleased to add my own contribution to this *Quality Report*.

Reading the 2015/16 *Quality Report* as part of the preparation to write this piece, I was delighted to see certain priorities such as electronic patient status and referral-to-treat incomplete pathways, also featuring in this current year's *Quality Report* albeit with further progress made in each. It would be helpful in each year's report if a brief reference could be made to progress or developments occurring in each of the previous year's priorities. They ought to be embedded into the 'normal' work of the hospital and/or are a necessary precursor to enable other developments to occur.

The re-introduction of 'safety huddles' adds another dimension of clinical awareness regarding the patients on that ward and utilises the capabilities of the electronic Patient Status at a Glance boards. The 'watcher' category also recognises the role parents and other family members can play in spotting a change in their child's health. The proposal to develop this further during 2017/18 with a 'watcher' leaflet provided to all parents and families of children admitted to GOSH is welcome. Similarly, the commitment to include this situational awareness content in junior doctor induction and Trust induction programme is a positive step towards gaining ownership and emphasising the importance of the 'safety huddle' practice to the six wards and staff yet to be fully persuaded of its role.

The return to reporting in January 2017 against the incomplete referral-to-treatment pathways national 'incomplete' standard marked a huge step forward for GOSH after the difficulties previously uncovered in data and processes. The amount of work undertaken to prepare and introduce new processes, create sufficient capacity to manage referral demand, improve communication from referring organisations and ensure compliant data recording systems has been enormous. It is to the credit of all those involved in this work that from a dire situation in 2015/16 the reporting system implemented by GOSH is now cited as demonstrating "best practice" by the NHS Improvement Intensive Support team. The benefit to patients and families in terms of more transparency and certainty over care provided and planned is obviously welcome and should assist in reducing worry over potentially missing appointments and follow-ups.

The transition from child to adult care is fraught with difficulties at the best of times. For young people with long-term conditions who may have only known GOSH as 'their' hospital it can be particularly stressful and uncertain. For parents/carers 'letting go' and seeing your child as an adult who is now meant to be capable of making decisions over their care is a real concern. The vignettes from the listening event cited in the report aptly capture this level of uncertainty and loss. It is vital that GOSH take these comments and others from the Young People's Forum on board over the next 12 months and actively determine, across all specialisms, the age when, as part of each patient's consultation, discussion turns towards planning for leaving GOSH and how this transition can be made as painless as possible. The inclusion of transition as a 2017/18 priority is a positive step.

The report is full of examples where developments in technology and data collection have been harnessed to improve patient care, improve service and receive feedback such as:

- Automatic alerts for sepsis in the electronic patient observation system
- Timeliness of delivery of the sepsis protocol
- Use of defibrillators with built-in feedback which prompt a change in use to facilitate better outcomes
- Introduction of electronic completion of questionnaires for mental health screening for those with long-term physical health conditions

This work is essential not least as the patients GOSH treats are tech savvy and expect technology to be used as a matter of course, both in their treatment and as a means of recording their views, booking appointments, communicating etc. To continue to attract and retain the best staff and stay at the forefront of medical research through keeping pace with the data world whilst maintaining security of systems is an ongoing challenge for GOSH, but one they have to both succeed and invest in. The commitment to improving accessibility to outcomes data during 2017/18 and to establish a dedicated Data Assurance team is welcome.

GOSH launched the *Our Always Values* in March 2015; Always: Welcoming, Helpful, Expert, One Team. These values are "a visible representation of our commitment to our patients, families and staff". The *Quality Report* contains excellent examples of these values being upheld such as:

- GOSH Listening Event November 2016: 'Welcoming'
- Participation in all 12 national clinical audits and clinical outcome review programmes, clinical research and contributing to journals: 'Expert'
- Learning from complaints: 'Helpful'

and provides some direct reference to the Values themselves and linking of the work described to the Values. It was however disappointing that in the Surgical Safety Checklist survey of theatre staff 12% of staff respondents disagreed with, and 6% neither agreed nor disagreed with the statement that 'I knew the name of everyone in theatre today'. Having said that, the same survey did show that 95% of respondents considered "they had worked well as a team today in theatre".

Specific reference was made by the Lead Councillor in her comments on the 2015/16 *Quality Report* about the limited coverage of these Values in that document and how the wholesale adoption of these Values could improve services, including clinical, improve outcomes and patient and family experiences. The current report has sought to positively respond to this comment with visual signifiers included where particular initiatives in each priority accord with one or more of the 'Always Values'. Although a step in the right direction, there can be no resting on laurels. During 2017/18 more has to be done to fully embed these 'Values' into the working of the hospital and behaviours of all those working in and associated with GOSH.

The report touches on the work of the Quality Improvement team and that of the GOSH Charity during 2016/17. This is appreciated as the Quality Improvement team have been instrumental in developing and supporting the implementation of a range of initiatives to assist with patient care. The charity raises significant funds for the hospital each year and provides a mechanism for supporters of GOSH to get involved and put something tangible back.

The report is, I think, a fair assessment of the progress made against the identified priorities and provides statements of assurance from the Board as well as details of the wider engagement by GOSH, both within the NHS and internationally. There is much to be proud of and to celebrate. Thank you to all the staff at GOSH for continuing to try your best and to push the boundaries in the care and treatment of our children and young people.

Here, we provide more information on points in response to statements from our stakeholders.

GOSH Listening Event

At the listening event, we made sure that an executive and a professional in the subject area were at each table, listening to parents and patients. The discussion and feedback drawn from the day was summarised in a report and sent to the teams involved in the four subject areas. Staff from these areas of work will report to the Patient and Family Engagement and Experience Committee in July on actions agreed after time spent investigating and costing ideas that were proposed on the day.

Friends and Family Test

Our response rate within outpatients has always been lower compared to inpatients. Though similar to other Trusts' rates, it is something we have tried to address. We have:

- Deployed our survey volunteers in the outpatient areas on an *ad hoc* basis. This human interaction (and the provision of a pen) often increases the number of responses we receive on a short term basis but we are not able to deploy volunteers permanently to this as they are needed in other areas too
- Asked for staff in the reception teams to hand out feedback cards to the patients and their families on arrival
- Attend regular huddles held for the outpatient staff, so we will continue to do this to emphasise the importance of FFT being a team effort

From our informal conversations with families, we have found that regular attenders are understandably reluctant to complete a card on every outpatients visit. Families have also told us that now they can book their follow up appointment through the electronic Clinic Outcome Form (eCOF), they can leave without waiting so no longer have the reminder at reception.

We will continue dialogue with patients and their families and seek to improve response rates in our outpatients department.

Transition

The figures in the report do not represent the numbers of young people who will need to have transition plans. Each age group includes those attending GOSH for diagnosis or second opinion, those who will be referred back to local services for treatment, and those whose treatment will be completed prior to their 18th birthday.

The Trust fully recognises the anxiety that the prospect of leaving GOSH and paediatric services can cause to young people and their families. The definition of transition developed by the Trust goes beyond that used in the NICE Transition Guidelines (NICE, 2016) and explicitly acknowledges the preparation needs of families and carers as well as our young people. We are collaborating with representatives from both groups to ensure their needs will be included in any transition plans. We firmly believe that preparation for adult services and adulthood should be a partnership between professionals, parents/carers and young people that relies on the transition process starting as early as reasonably possible.

Referral-to-treatment

We provided updates to our Members' Council on the work to improve the 18-week pathways and took on board their suggestions and feedback on the approach that we were taking to reduce our waiting times and improve our processes.

Information governance toolkit

To address the shortfall in IG training we will continue to remind staff and their managers through the learning and development system. Specific staff groups where training compliance is hard to enforce, for example agency and honorary staff, are being reviewed to make sure that there are processes to support these groups being monitored for training.

The requirement about logging and including information governance clauses for all supplier contracts will be addressed by including as a mandatory part of the procurement logs an assessment of whether there is any information sharing and if the relevant terms have been included within contracts. Guidance will be provided to the procurement department to enable them to make this assessment.

Annex 2:

Statements of assurance

External assurance statement

Independent auditor's report to the Members' Council of Great Ormond Street Hospital for Children NHS Foundation Trust on the Quality Report

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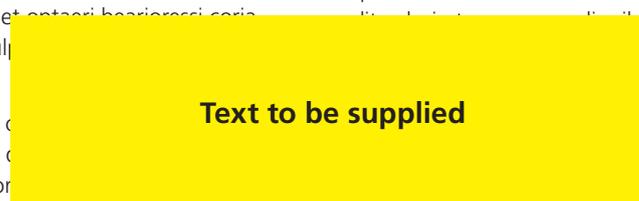
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Statement of directors' responsibilities in respect of the *Quality Report*

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the *Quality Report*.

In preparing the *Quality Report*, directors are required to take steps to satisfy themselves that:

- The content of the *Quality Report* meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance
- The content of the *Quality Report* is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2016 to May 2017
 - Papers relating to Quality reported to the board over the period April 2016 to May 2017
 - Feedback from commissioners dated 18 May 2017
 - Feedback from governors dated 9 May 2017 and 10 May 2017
 - Feedback from local Healthwatch organisation dated 12 May 2017
 - Feedback from the Health and Adult Social Care Scrutiny Committee dated 12 May 2017
 - The Trust's annual complaints report 2016/17 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
 - The CQC-commissioned National Paediatric Outpatient Survey 2016
 - Data from the CQC-commissioned Children and Young People's Inpatient and Day Case Survey 2017 is being collected currently and is not available for this report
 - The national NHS Staff Survey 2016
 - The Head of Internal Audit's annual opinion of the Trust's control environment dated 25 May 2017
 - CQC inspection report dated 8 January 2016

- The *Quality Report* presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the *Quality Report* is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the *Quality Report*, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the *Quality Report* is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The *Quality Report* has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the *Quality Report*

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the *Quality Report*.

By order of the board

25 May 2017

Chairman



25 May 2017

Chief Executive

<Awaiting chairman's
signature>

**Trust Board
 25 May 2017**

Integrated Quality Report at 30 April 2017

Paper No: Attachment L

Submitted by:

Dr David Hicks, Medical Director
 Juliette Greenwood, Chief Nurse

Aims / summary

The Quality and Safety report has been revised and combined in to an Integrated Quality report to provide information on whether:

- patient care has been safe in the past and safe in the present time
- how the Organisation is hearing and responding to the feedback and experience of our children and young people and parents
- what the Organisation is doing to ensure that we are implementing and monitoring the learning from our data sources e.g. (PALS, FFT, Complaints and external reports as appropriate).

Response to actions from previous Trust Board:

Including

- **March action: The Board requested a fuller summary on the coversheet of the integrated quality and safety report to highlight any potential areas of concern.**

The IQR information has been reviewed and discussed; there are no areas of significant concern within the report at this time which requires specific escalation to the Board. Should there be any areas of concern in the future, these will be highlighted clearly on the coversheet for the report.

- **Deep dive on learning from deaths at GOSH (DH stated at EMT)**

A separate paper entitled 'Learning from Deaths' has been submitted to Trust Board which addresses this action.

- **Ensure all figures quoted on cardiac arrests are the same throughout this report and safe staffing report (March Trust Board action)**

The figures within the Safe Staffing Report only refers to arrests on in-patient Wards whilst the arrest data within the Integrated Quality Report includes arrests within all areas outside of ICUs (including day case Wards, day units, outpatient areas and non-clinical areas e.g. main reception). The data will therefore be different between the two reports as the integrated quality report includes additional areas.

- **Friends & Family Test Q4 2016/17 Report - experience of children, young people and their families at GOSH**

Data from Q4 Friends and Family Test have been included in the report; please see slides 8-12.

Action required from the meeting

To note the style of the report, providing any feedback or requested changes to the Medical Director and Chief Nurse to note the on-going work supporting any suggested changes to work streams.

Contribution to the delivery of NHS Foundation Trust strategies and plans

The work presented in this report contributes to the Trust's objectives.

Financial implications

No additional resource requirements identified

Attachment L

Who needs to be told about any decision?

Quality and Safety team, Patient Experience team, Divisional Management teams

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

Divisional Management teams with support where needed, Quality and Safety team, Patient Experience team

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

Medical Director and Chief Nurse



Integrated Quality Report

Dr David Hicks, Interim Medical Director

Juliette Greenwood, Chief Nurse

May 2017

Safety

Has patient care been safe in the past? Measures where we have no concerns	Page 3
Has patient care been safe in the past? Serious incidents and never events	Page 4-5

Care/ Experience

Are we delivering high quality care today? Trust measures for complaints	Page 6
Are we responding and improving? patient and family feedback; red complaints	Page 7
Are we responding and improving? Learning from friends and family test data- inpatient data	Page 8
Are we responding and improving? Learning from friends and family test data- outpatient data	Page 9
Are we responding and improving? Friends and family test updates/ benchmarking	Page 10
Are we responding and improving? Friends and family test positive feedback	Page 11
Are we responding and improving? Friends and family test- 'you said', we did	Page 12

Outcomes/ Effectiveness

Are we responding and improving? Featured project; outpatient clinic flow	Page 13
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Improvement

Are we responding and improving? Quality improvement project updates (with Executive sponsorship)	Page 14-15
Appendix 1: Methodology for key Trust measures	Page 16-17
Appendix 2: SPC FAQs	Page 18-25

Has patient care been safe in the past?

Measures where we have no concerns

This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Measure	Comment									
Never Events	The last never event was in June 2016 (more than 320 days ago) and performance remains stable at an average of 220 days between never events; this is within normal variation and is not statistically significant. Work is on-going to complete the actions from the investigation; these are in line with the agreed timescales for completion.									
Non-2222 patients transferred to ICU by CSPs** ** patients should be transferred to ICU before they have an arrest where possible which would indicate the early identification of a deterioration prior to an arrest.	Performance remains stable at an average of 8 per month; this is within normal variation and is not statistically significant. The data has been reviewed and no trends or themes were identified at this time; the data will continue to be monitored.									
Cardiac and respiratory arrests** **The figures within the Integrated Quality Report includes arrests within all areas outside of ICUs (including day case Wards, day units, outpatient areas and non-clinical areas e.g. main reception) whilst the Safe Staffing Report arrest data only refers to arrests on in-patient Wards. The data will therefore differ between the two reports as the Integrated Quality Report includes additional areas.	Overall, performance remains stable for both measures at 2 cardiac arrests per month and 2.7 respiratory arrests per month; this is within normal variation and is not statistically significant.									
	<table border="1"> <thead> <tr> <th></th> <th>Cardiac arrests outside of ICU</th> <th>Respiratory Arrests outside of ICU</th> </tr> </thead> <tbody> <tr> <td>March 2017</td> <td>3 (Badger x2, Walrus)</td> <td>1 (Giraffe)</td> </tr> <tr> <td>April 2017</td> <td>4 (Badger x3, Robin)</td> <td>2 (Squirrel (SNAPS), Koala)</td> </tr> </tbody> </table>		Cardiac arrests outside of ICU	Respiratory Arrests outside of ICU	March 2017	3 (Badger x2, Walrus)	1 (Giraffe)	April 2017	4 (Badger x3, Robin)	2 (Squirrel (SNAPS), Koala)
	Cardiac arrests outside of ICU	Respiratory Arrests outside of ICU								
March 2017	3 (Badger x2, Walrus)	1 (Giraffe)								
April 2017	4 (Badger x3, Robin)	2 (Squirrel (SNAPS), Koala)								
Mortality	Performance remains stable at 6.3 deaths per 1000 discharges; this is within normal variation and is not statistically significant.									
Serious Incidents** **by date of incident not declaration of SI	The data has shown a reduction in serious incidents reported per month from 1.2 to 0.63 however further data is required before it can be established if this is a sustained change.									
Hospital acquired pressure ulcers reported (grades 2+)	While the increase in pressure ulcers previously reported has been sustained in March and April and currently averaging 6.7 per month, this is within normal variation and is not statistically significant. There have been no new grade 3 or 4 pressure ulcers since the last report. There is now an electronic referral process to inform the Tissue Viability team when there is a pressure ulcer. An RCA process for the review of pressure ulcers has been developed and is being piloted.									

Has patient care been safe in the past?

Serious Incidents and Never Events

Serious Incidents and Never Events March- April 2017

No of new SIs declared in March-April 2017:	3	No of new Never Events declared in March-April 2017:	0
No of closed SIs/ Never Events in March- April 2017:	1	No of de-escalated SIs/Never Events in March- April 2017:	1

New SIs/Never Events declared in March-April(3)

STEIS Ref	Incident Date	Date Report Due	Description of Incident	Divisions Involved	Senior Responsible Officer (SRO)	Patient Safety Manager	Executive Sign Off	Divisional Contact
SI 2017/9747	06.04.17	10/07/17	Preventable aspiration cardiac arrest secondary to ventilator operation	JM Barrie	Associate Medical Director- Quality, Safety and Patient Experience	Lead Patient Safety Manager	Interim Medical Director	Divisional Chair, JM Barrie
SI 2017/10146	Identified on 07/04/17	13/07/17	Human tissue sent to incorrect location	Charles West	Deputy Medical Director/ Caldicott Guardian	Patient Safety Manager	Interim Medical Director	Divisional Co-Chair, Charles West
SI 2017/10169	13/03/17	13/07/17	Migrated needle during cardiac procedure	JM Barrie and Charles West	Associate Medical Director- Quality, Safety and Patient Experience	Lead Patient Safety Manager	Chief Nurse	Divisional Assistant Chief Nurse, JM Barrie



The child first and always

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Learning from closed/de-escalated SIs in March-April 2017 (2):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
SI 2016/31065 (de-escalated 17/03/17)	The patient was referred to this centre for shared care management of an aortic coarctation with the local hospital in Cambridge, Addenbrookes. The patient underwent a series of screening investigations and subsequent multidisciplinary reviews where the consensus opinion was to proceed to surgical repair. The patient was admitted to theatre but the procedure was not completed as the surgeon with the support of a senior cardiology colleague felt the degree of aortic narrowing evident on macroscopic inspection was not sufficiently severe to justify surgical repair. Although the repair was not carried out, the patient underwent surgery and required post-operative management on cardiac intensive care and then the cardiac ward for three days ahead of discharge. It is possible that a coarctation repair may still be required in the future.	The findings from the pre operative serial echocardiograms and MRI were not supported by the intraoperative clinical findings and it was thus felt there was potentially more risk associated with proceeding with a modified surgical procedure than would be gained by not undertaking a modified repair.	<ul style="list-style-type: none"> • Divisional Director to discuss with consultant body, who chair the JCC, to ensure that a summary of all the discussion is outlined to the designated recorder and not just the outcome of the discussion. • Senior management team to propose and plan the consent clinic with the appropriate support, resources and membership. • Complete the consent audit on the cardiac day care unit and collate the data. • Present the data to the cardiac services in appropriate forums e.g.: Cardiac Board , consultants meeting, M&M • Review the information provided to families ahead of admission for elective procedures, how it is presented to them and when it is presented to them. 	Staff should ensure that there is consistent recording of any discussions, not just outcomes, held at multi-disciplinary meetings to ensure that the decision process and rationale is clear to all.
SI 2016/33178 (closed 19/04/2017)	Information Governance Breach- information was sent to the birth parents of a patient where a court order was in place restricting information from being shared with them.	The PIMS record with contact details for the patient's birth parents was not amended once the Trust became aware that ongoing information should not be shared with them.	<ul style="list-style-type: none"> • PIMS alert for care orders to ensure that potential issues are flagged to all staff reviewing the patient record <ol style="list-style-type: none"> a) Create PIMS alert which would signify there is a relevant care order b) Create process for ensuring these are regularly reviewed (ongoing process) c) The member receiving information about a change in care details should be directly responsible for checking that PIMS information is updated accordingly. • Review all the records of all patients with a 'secure address' on PIMS for the last 2 years, to ensure that there are no other patients for whom we hold contact details on PIMS of parties who should no longer receive information about the child <ol style="list-style-type: none"> a) Collate list of those with secure address from Information Services b) Review information held on PIMS alongside information held by social work team • A new tab has been created on EDM (Electronic Document Management System for care orders to be uploaded and stored in. 	<p>If a patient has a secure address staff should be more vigilant.</p> <p>Demographic details to be checked at each visit and please ask for help from a manager if unsure</p>

Are we delivering high quality care today?

Trust measures for Complaints

Great Ormond Street Hospital for Children **NHS**

NHS Foundation Trust



This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Measure	Comment
All complaints	The number of complaints has reduced from 11 per month to 7.6 (This is a sustained reduction)
Red complaints	Performance remains stable at 0.4 per month
Amber complaints	Performance remains stable at 2.3 per month Note: the last 3 months are all below the process mean. Although too early to say this is an improvement we remain optimistic (we look for 7 consecutive months all above or below the mean)
Yellow complaints	Performance remains stable at 6.8 per month. Note: the last 4 months are all below the process mean. Although too early to say this is an improvement we remain optimistic (we look for 7 consecutive months all above or below the mean)

The child first and always

Are we responding and Improving?

Patient and Family Feedback: Red Complaints

Red Complaints in March-April 2017

No of new red complaints declared in March- April2017:	1	No of re-opened red complaints in March- April 2017:	0
No of closed red complaints in March-April 2017:	2		

Learning from closed red complaints in March-April 2017 (2):

Ref:	Summary of complaint:	Outcomes/Learning:
16/075	The complainant raised concerns regarding the decision making regarding the need for a surgical repair for aortic narrowing and the consent process. The complainant also raised concerns that the patient received an unnecessary procedure as the surgical repair was not undertaken as it was found to be not clinically needed during the procedure and therefore not undertaken.	This complaint was linked with a serious incident investigation (SI 2016/ 31065 de-escalated 17/03/17); the complaint was answered via the serious incident root cause analysis report. The learning from the SI can be found on slide 5.
16/079	The complainant raised concerns that there were complications post procedure including septic shock and heart failure. Concerns were raised regarding the procedure undertaken, consent and post operative care provided.	A full investigation was undertaken and a report was shared with the family on completion. The report provided a detailed explanation for the care and management provided and the rationale for the clinical decisions made.



Are we responding and improving?

Learning from Friends and Family Test- Inpatient Data



Inpatient Results March 2017

Inpatient Results April 2017

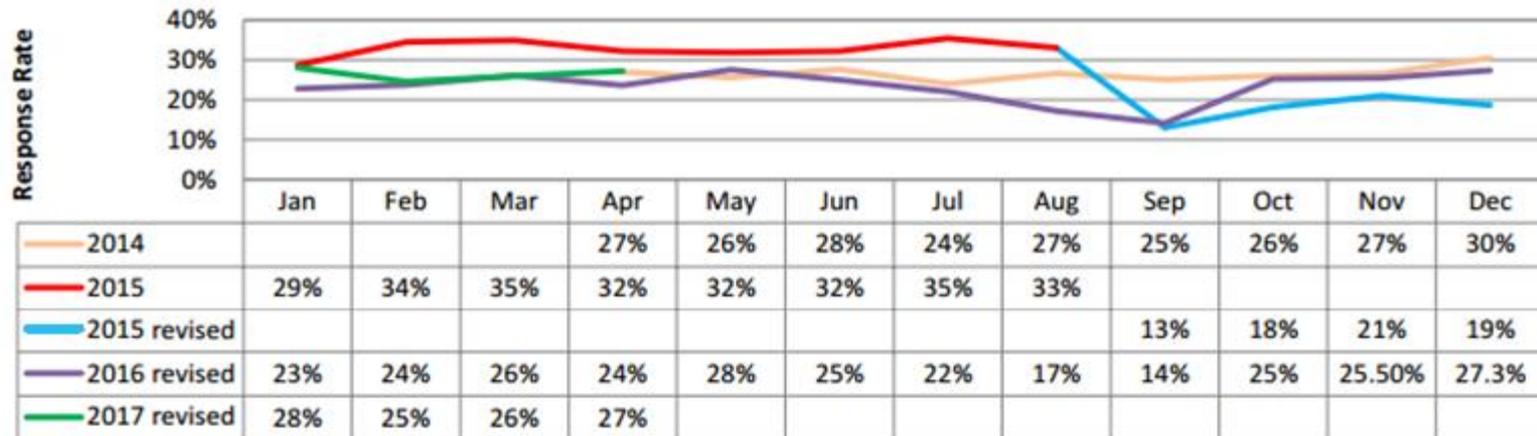
March 2017

Overall FFT Response Rate = 25.9%
Overall % to Recommend = 97.3%

April 2017

Overall FFT Response Rate = 27.2%
Overall % to Recommend = 97.7%

FFT Responses over time



Q4 2016/17 Top 3 Themes

April 2017 Top 3 Themes

Positive Themes:	No +ve comments	Total comments	Positive Themes:	No +ve comments	Total comments
Always Helpful (Understanding, Helps Others, Patient, Reliable)	771	779	Always Helpful (Understanding, Helps Others, Patient, Reliable)	242	243
Always Welcoming (Respect, Smiles, Friendly, Reduce Waiting)	537	555	Always Expert	190	198
Always Expert	648	700	Always Welcoming (Respect, Smiles, Friendly, Reduce Waiting)	136	141
Negative Themes:	No -ve comments	Total comments	Negative Themes:	No -ve comments	Total comments
Access / Admission / Transfer / Discharge	50	76	Staffing Levels	2	2
Staffing levels	13	26	Access / Admission / Transfer / Discharge	11	17
Environment & Infrastructure	117	393	Catering	7	21

Are we responding and improving?

Learning from Friends and Family Test- Outpatient Data



Outpatient Results March 2017

Outpatient Results April 2017

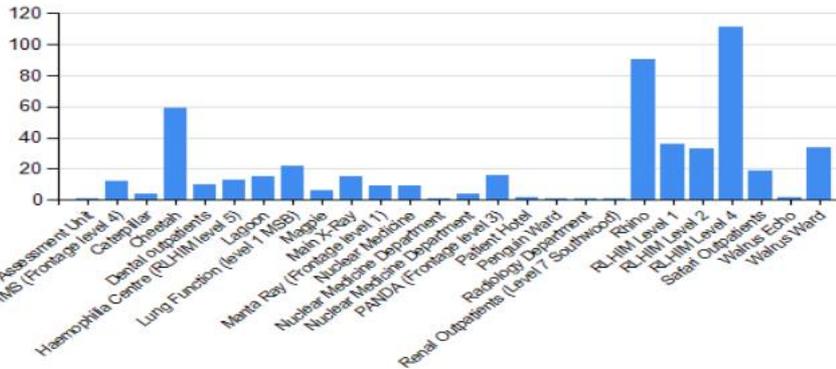
March 2017

Overall % to Recommend = 94.5%

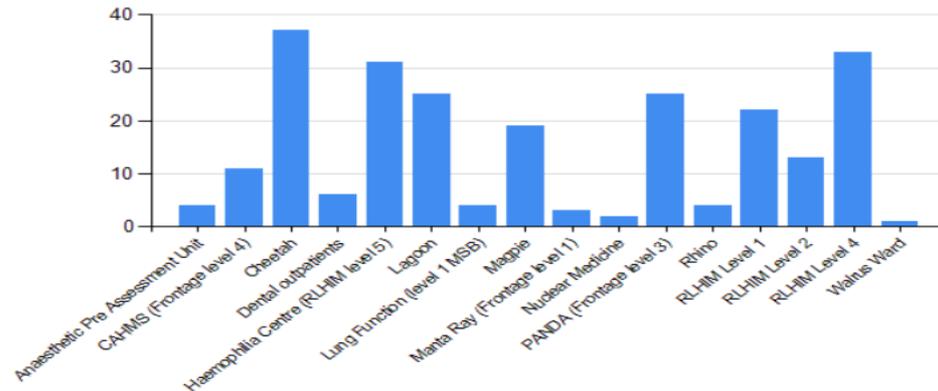
April 2017

Overall % to Recommend = 89.9%

FFT Responses by Area



FFT Responses by Area



Q4 2016/17

The average percentage to recommend for Outpatient in Q4 2016/17 was 93.93%.

The decrease in percentage to recommend has been reviewed by the team and established that the primary reason is due to waiting times in clinic.

(Other data is not available at the time of report completion due to data issues resulting from the NHS cyber attack).

Are we responding and improving?

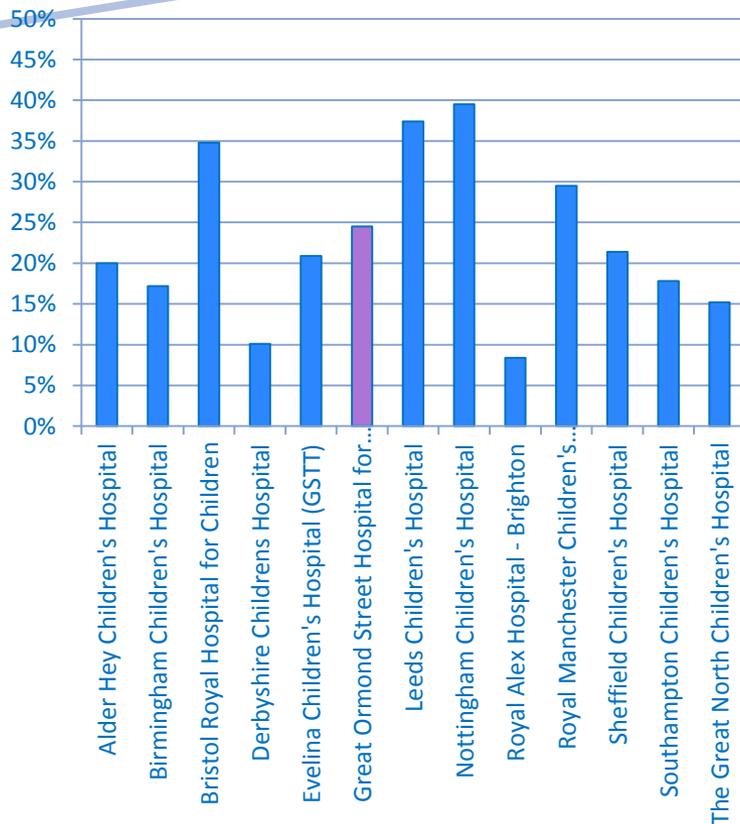
FFT Updates / Benchmarking



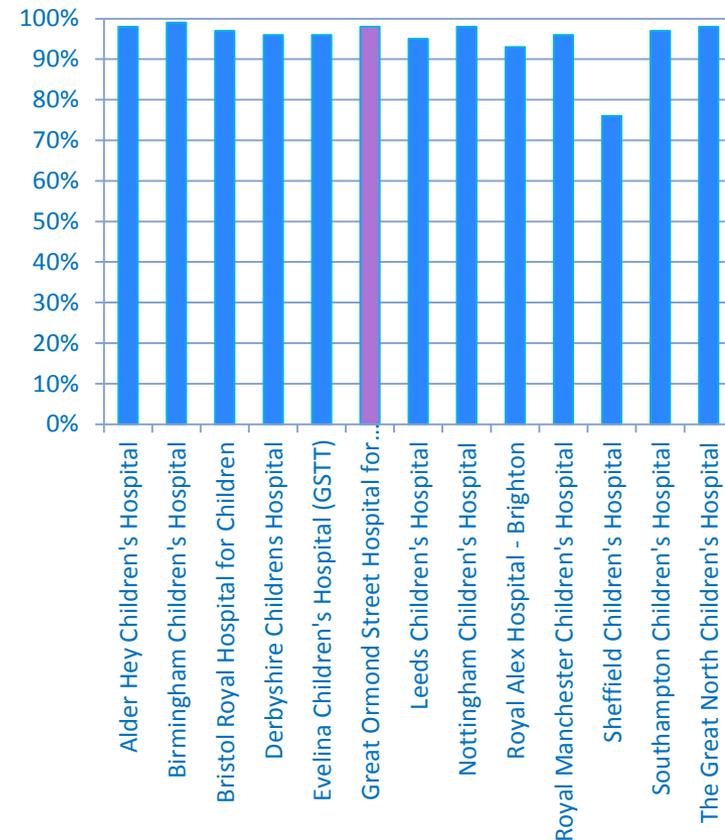
- FFT comments feature in roundabout each month.
- Real Time Feedback supplier has been chosen.

*Based on NHS Choices Data – Feb 2017 (this is the most current data available at report production)

Response Rates



Percentage to Recommend



Are we responding and improving?

Learning from Friends and Family Test- Positive Feedback

Below is a snapshot of some of the positive received via FFT during the reporting period. Positive feedback is shared with the relevant teams for dissemination.

Patient Feedback

Parent/Carer Feedback

Our son is highly anxious. He attended his first appointment at GOSH, which he found to be very traumatic such that he has refused to come for his follow up appointment or to attend the hospital again. The first appointment did not cater for the extremeness of his needs as he was bombarded with questions and we his parents were in front of him. The whole appointment was very clinical, impersonal and terrifying for our son.

CAMHS



Doctor was very polite. Information was given clearly. I felt comfortable at all times. Very good environment

Good care, Friendly, Less stress because of the welcome environment, encouragement, good explanation.

Everything was fantastic we are so grateful for the incredible expertise care, compassion we have received whilst as GOSH The nurse are exceptional very special people what an incredible hospital doing such an amazing work. THANK YOU our baby was born at UCLH and the connect to GOSH care fluidity was exceptional. a template for all other hospitals"



I have been extremely impressed by the endless patience and caring of the nurses and staff. Nothing is ever too much trouble. We feel lucky to be looked after by such wonderful professionals.

Everyone is so friendly and makes you feel welcome, they do anything to help.



Are we responding and improving?



Learning from Friends and Family Test- 'You Said, We Did' Feedback

Below is a snapshot of some of the negative feedback received via FFT during the reporting period and the subsequent actions taken. There is a process in place for the management of negative feedback to ensure that this is acted upon appropriately.



*"We do see the negative effects of the short staffing and turnover of nurses. New nurses take about six months to be trained and agency nurses from other wards often do not give the same quality of care. They are not used to the work load and urgency/ timing that is so important on this ward. We have spent a few weeks on other wards such as Penguin & Elephant and the nurses there were also kind, but not used to the "difficult" patient that my son is and were overwhelmed/ stressed despite being clearly less busy (based on time spent on lunches and the desk chatting).
The Fox nurses need incentive + more compensation for the heavy work load they have to increase retention and drive the work on such an intense ward. Our care is usually worse and filled with anxiety if we have an agency nurse that is not from Fox or Robin originally"*

This has been escalated to ICT and the Manager responsible for Patient Bedside Entertainment to review.

"No TV, no entertainment."

The Ward Sister has reviewed the concerns raised:
The dependency of complex patients on the Ward is higher than other wards in ICI. Nurses external or new to this speciality can require additional support as they become familiar with the area which is given as needed. Vacancies have been highlighted and recommendations for higher staffing levels have also been discussed. The positive feedback within the e-mail has been well received by the Ward.
The email will be shared with the Ward Managers on Elephant Ward and Penguin Ward to investigate the issues with long breaks and chatting at the desk.

"The treatment area is the waiting area - It is hugely overcrowded, Dirty. Patient treatment chair/beds are not cleaned before or after patients are treated in them. Patient's relatives and other patients are crowded around giving no privacy to patients being treated. Supplies of medical equipment are out of stock (sticky plasters removing gel) Staff opened a window while wearing examinations gloves and then proceeded to examine/treat my daughter without changing them. Chairs are broken - it is awful to be a patient on this ward - truly terrible."

"Not allowed go outside the room. No Wii games. Baby programme repeated movies (the jungle book), hurting doctor."

The Ward Sister and Play team have been informed of the comments and are reviewing the support in place. The lack of Wii Games and lack of suitable programmes/movies has been escalated to ICT and the Manager responsible for Patient Bedside Entertainment to review.

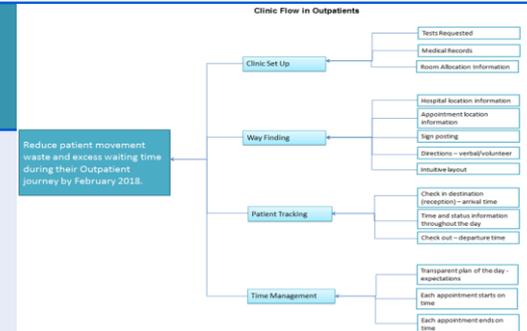
The e-mail has been received by the Ward Sister and the matter is being reviewed as a matter of urgency.
Regarding the overcrowded infusion room, this has been ongoing issue but staff on the Ward always try to ensure the privacy policy is adhered to. Examination of patients are always carried out in the cubicles. In the treatment room, there are 3 recliner chairs which enables staff to administer infusions to 3 patients at a time.
Regarding the staff not following infection control guidance with regards to use of gloves, this will be discussed with all of the clinical team on the Ward to remind them the importance of following guidelines for infection control.
This particular shift was busy due to staff sickness; we are sorry that this had an impact on patient experience.

Are we responding and improving?

Featured Project: Outpatient Clinic Flow

Project aim:

To reduce excess movement waste and waiting times for patients and families in the Outpatients Department by February 2018.



The Outpatient Clinic Flow Project seeks to improve patient waiting times in Outpatient clinics by addressing physical and process issues within the department. It was developed from the final arm of the closed 'Access to Outpatients' programme of work (paused in 2015) in response to growing concerns around patient waiting times highlighted from patient surveys and listening events. The project is led by the multidisciplinary nursing and administrative OP team, including medical representatives from specialties and Quality Improvement support. The project works closely with the OP Space project, which seeks to move clinics into specialty grouped zones.

Expected Benefits of the Project:

- Patients to be seen at their booked appointment time
- Apply LEAN principles to prioritise value adding clinical tasks during clinic and maximise clinic prep
- Improved visibility for staff and patients of the patient journey on appointment day, and the patient's progress through this
- Clear signage to support easy wayfinding for families
- Agreed resources available to ensure clinics start on time
- Clinicians to receive required patient information in a timely manner
- Standardise practice across the main Outpatient areas to support equity of care and rotation of Outpatient staff

Primary Drivers

- Clinic Set Up
- Wayfinding
- Patient Tracking
- Time Management

Measures for Improvement:

Audit and survey data will be used to measure results of the project.

Outcome measures:

- Time in mins of global avoidable patient waiting time to see clinician
- Distance travelled by patient during Outpatient journey
- Patient experience (surveys)

Process measures:

- % Missing health records
- Time in mins patients wait for H&W measurement
- Time in mins of lag between H&W and appointment time
- % of pts requiring signposting assistance

Balancing measure:

- Clinic slot utilisation

Progress to date:

- New Outpatient Clinic Flow Project Team established
- Process mapping session and feedback from patient and families used to inform the project
- New project scope agreed by QIC in January 2017
- Spread planned in tandem with the OP Space project (clinic moves)
- Manta Ray (first area) audit and patient/family survey completed
- Manta Ray area working group established to formalise PDSA ideas
- Cheetah Reception working group established to improve patient access and patient flow, seating changed, await new desk
- New blood room established to reduce patient journey, audits underway

Next Steps:

- Finalise and share the audit analysis of Manta Ray and Rhino with the project team and parent rep
- Diagnostics and process mapping with the Neurodisability, Ophthalmology and OP teams, involving health records to identify issues and ideas
- PDSA practice changes in Manta Ray and Rhino
- When ENT move to Manta Ray, H&W service to be established
- New desk to be repositioned in Cheetah – PDSA waiting area to maximise patient access and flow
- Ongoing audits across the Outpatient areas according to planned spread, working with specialties and the Outpatient team to identify issues for improvement

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Project	Project Aims	Project Leads	Project Timescales and Progress
Nursing Quality Measures	To demonstrate Ward Nursing Quality Measures	Executive Sponsor- Chief Nurse Clinical Lead- Assistant Chief Nurse	<u>Progress to date:</u> <ul style="list-style-type: none"> Development will continue through to 30th June 2017. While progress has been made in identifying the metrics the project is delayed against the timeframes agreed. <p>The delay is due to:</p> <ul style="list-style-type: none"> Access to PANDA and LMS data. Difficulties in linking the national safety thermometer data with the dashboard. Challenges around displaying real time information. <p>As a first step the QI team are going to pull through all the current measures that are accessible into the QI Nursing quality measures dashboard site. This will enable ward sister to view considerably more of their ward metrics in one place.</p> <ul style="list-style-type: none"> Visits have been made to Salford, UCLH and Birmingham children's hospitals to share practice and learn from others.
Neonates	To improve the quality and safety of care within inpatient neonates/small infant* at GOSH by 1 June 2017 [*<28 days or 4kg]. The three areas of focus are to: <ul style="list-style-type: none"> Reduce the number of avoidable bloodspot test repeats Increase the recognition and management of neonatal jaundice Improve documentation and delivery of IV fluid management 	Executive Sponsor- Chief Nurse Nursing Lead- Neonatal Nurse Advisor Medical Lead- Head of Clinical Service	June 2017 <u>Progress to date:</u> <ul style="list-style-type: none"> Neonatal Intranet section in development Presenting project at the IHI GOSH Experience Day Developed e-learning for bloodspots, jaundice and fluids – working with Learning and Development team to develop GOLD packages Neonatal fluid management guideline developed and due to be published Reviewed and updating neonatal information sheets provided to families Currently testing process and access to NHS Spine for ICU Ward Admins to identify and complete missing NHS numbers on PiMS for neonatal admissions to reduce avoidable bloodspot repeats Developing and testing Neonatal Standard of Care, to replace birth History form Updating and testing neonatal information folders on NICU

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Project	Project Aims	Project Leads	Project Timescales and Progress
Transition	Specialties are working on the short-term requirements of the Transition CQUIN and work is on-going on longer-term improvement strategies with specialties to ensure the Trust meets the recommendations of the NICE Transition Guidelines.	Executive Sponsor- Chief Nurse	<p>On-going project</p> <p><u>Progress to date:</u></p> <ul style="list-style-type: none"> • Q4 CQUIN submitted (target achieved but will need confirmation from Commissioners) • 6 young people have now joined Steering Group • Minimum standards for a Transition Plan being agreed • Project underway with UCLH and Barts to improve transition for YP with an LD or additional needs- 1st draft of joint information leaflet • Pilot underway of dedicated Transition tab on PIMS showing which YP have a Transition Plan in place • Pilot of Consultant alert list showing date of next appointment and frequency of appointments for YP over 16 <p><u>Next steps:</u></p> <ul style="list-style-type: none"> • Finalise minimum standards that must be met in any specialty-specific Transition Plans • Revision of Trust Transition Policy
Extravasation	To reduce the incidence of extravasation injury at GOSH	Executive Sponsor- Chief Nurse Clinical Lead- Consultant Anaesthetist	<p><u>Progress to date:</u></p> <ul style="list-style-type: none"> • Six work streams underway • VHP Framework & Tool – currently on Koala, Eagle & Bumblebee wards, commencing on Bear ward in April 2017. • Discussions are underway for roll out on Peter Pan and Hedgehog Wards. • VHP Tool – Feedback survey underway for Staff and Families • Communication group started – Soft Focus day planned for June 17 • Training video – storyboard agreed and filming due to commence April 2017 pending funding

Appendix 1

Methodology for key Trust measures

Measure	Methodology	
Never Events	Note that the most recent data point indicated the number of days since the most recent never event. Never events are defined here - https://www.england.nhs.uk/ourwork/patientsafety/never-events/	
Non-2222 patients transferred to ICU by CSPs**	Unplanned non-2222 patient transfers to ICU, admitted as deteriorating patients from ward areas by the CSP team. Parameterised by ward (May 2015 onwards).	
Cardiac and respiratory arrests	<p>Cardiac arrests outside of ICU: The monthly number of cardiac arrests outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team). Cardiac arrests are defined by any patient requiring cardiac compressions and/or defibrillation. Cardiorespiratory arrests count towards the cardiac arrests total, not the respiratory arrests total.</p>	<p>Respiratory arrests outside of ICU: The monthly number of respiratory arrests outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team). Respiratory arrest is defined by any patient requiring bag mask ventilation. (Previous to May 2013 this was defined as any patient requiring T-piece and/or Bag Valve Mask.) Cardiorespiratory arrests count towards the cardiac arrests total, not the respiratory arrests total.</p>
Mortality	The inpatient mortality rate per 1000 discharges. The numerator is the number of patients who die whilst inpatients at GOSH. The denominator is the number of inpatients who are discharged each month. Day case admissions (as specified by a patient classification of 2 or 3) are excluded from the denominator. CATS patients who are not admitted to GOSH are excluded from this measure.	
Serious Incidents	<p>This is the monthly count of serious incidents (SIs), by date of incident (as opposed to date incident was reported). A serious incident is defined as an incident that occurred in relation to care resulting in one of the following:</p> <ul style="list-style-type: none"> • Unexpected or avoidable death of one or more patients, staff visitors or members of the public. • Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm • Allegations of abuse • One of the core sets of 'Never Events' <p>http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/</p>	

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Measure	Methodology
All complaints	All complaints added together (red, amber and yellow).
Red complaints	A count of all red complaints per month. Red complaints are defined as severe harm to patient or family or reputation threat to the Trust.
Amber complaints	A count of all amber complaints per month. Amber complaints - lesser than severe but still poor service, communication or quality evident.
Yellow complaints	A count of all yellow complaints per month. Yellow complaints - issues or difference of opinion rather than deficient service.
Number of PALS cases	A simple count - the number of PALS cases.

Appendix 2: SPC Frequently Asked Questions

Contents

[What is a Dashboard?](#)

[What is SPC?](#)

[What is a Run chart?](#)

[What is a Control chart?](#)

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[What are the 9 different types of control charts?](#)

[What is Common Cause Variation?](#)

[What is Special Cause Variation?](#)

[What is a Run?](#)

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[What is an Outlier?](#)

[What is a Baseline?](#)

[What happens when you have a Special Cause? - Step Changes](#)

[Any other tips for interpreting SPC at GOSH?](#)

[Why is it so important that we measure things?](#)

[How can you find out more?](#)

What is a Dashboard?

A dashboard is a way of organising and presenting data in an easy to understand way. In the same way that a car dashboard lets you check your speed, revs, temperature and petrol with one quick glance, an improvement dashboard lets you check quickly whether your area is improving. Unlike a car dashboard, our dashboards let you see what is happening over a period of time, in the form of a graph. At GOSH, most dashboards are a collection of graphs, mainly in the form of statistical process control (SPC) charts.

Where are the Quality Improvement dashboards?

You can find the Quality Improvement improvement dashboards by following the links in the Quality Improvement intranet homepage. (double click the Quality Improvement logo, or find via GOS Web under 'Commonly Used Links'. Alternatively, [click here](#) to take you to the Quality Improvement Dashboards and Data Collection contents page.

What is SPC?

Statistical Process Control (SPC) charts were first developed by an industrial engineer called [Walter Shewhart](#) while he was working for Bell Telephones in the 1920s. He was concerned with eliminating the two most common problems in manufacturing:

- Type 1 error – “false positive” – Over-reacting to natural variation
- Type 2 error – “false negative” – Under-reacting to an actual problem

Shewhart wanted a way of distinguishing [natural cause variation](#) from [special cause variation](#). Nearly all processes exhibit some level of natural variability - for example your commute to work will take a



different length of time each day, in fact you would consider it strange if it didn't. Special causes occur because of a significant change in the underlying process - in the case of your commute, this might be a tube strike, or because the bus has started taking a longer route.

Process control charts were developed to allow easy differentiation between common and special cause variation. In the case of Bell Telephones, this would be to prevent engineers being called out to look at some equipment that was actually just varying as normal, and on the other hand to know when something was genuinely malfunctioning and required attention. In the case of a hospital it might be to tell if your theatre utilisation had improved, or if DNA rates had dropped.

SPC charts:

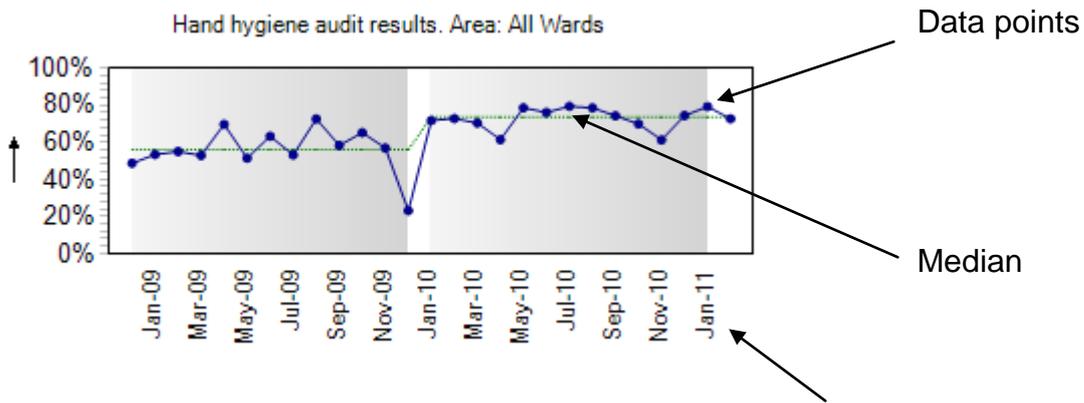
- are an excellent way of **measuring for improvement**
- Use the pattern of events in the past to predict with some degree of certainty where future events should fall.
- distinguish between the [natural/common cause variation](#) and [special cause variation](#)
- enable you to look for problems when they are there, not when they are not
- can motivate staff to improve practice thereby reducing adverse events and minimising variation

There are two types of SPC charts: [run charts](#) and [control charts](#).

What is a Run Chart?

A run chart is used when analysing more than one process, when the data is summed (or aggregated). For instance, if we want to analyse medication errors Trust wide, we would use a run chart - there is more than one process because there are multiple wards in a the Trust with each ward having its own medication process.

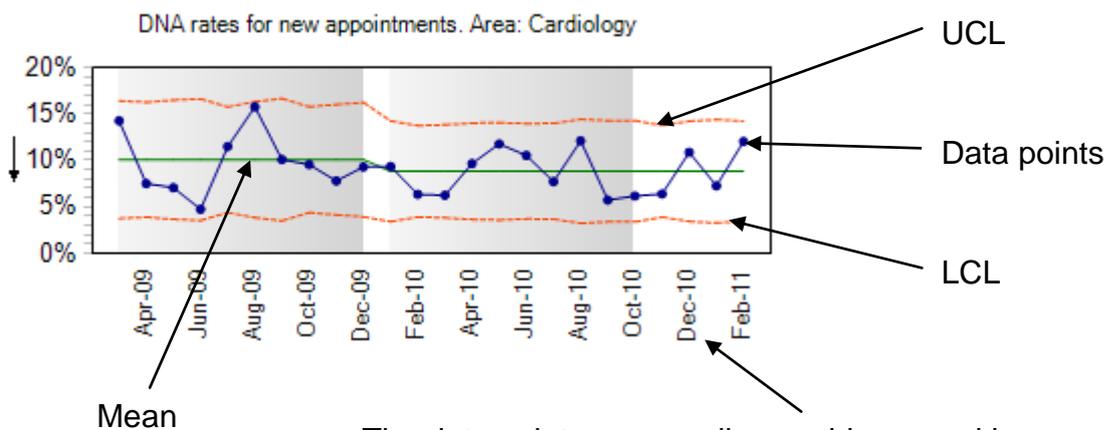
Run charts consist of your data points plotted against time, plus the median of your data points within a specified time period (within a single process). The mean can sometimes be used instead of the median, but at GOSH we usually plot the median, as it will be less affected by system-wide outliers.



The data points are usually monthly or weekly averages / aggregates, plotted against time

What is a Control Chart?

A control chart is used when analysing a single process. They consist of your data points plotted against time, alongside the mean (or average) of your data, plus the upper control limit (UCL) and lower control limit (LCL).



The data points are usually monthly or weekly averages / aggregates, plotted against time

The purpose of control charts is to allow simple detection of events that are indicative of actual process change. This simple decision can be difficult where the process characteristic is continuously varying; the control chart provides statistically objective criteria of change. When change is detected and considered positive its cause should be identified and possibly become the new way of working, where the change is negative then its cause should be identified and eliminated.

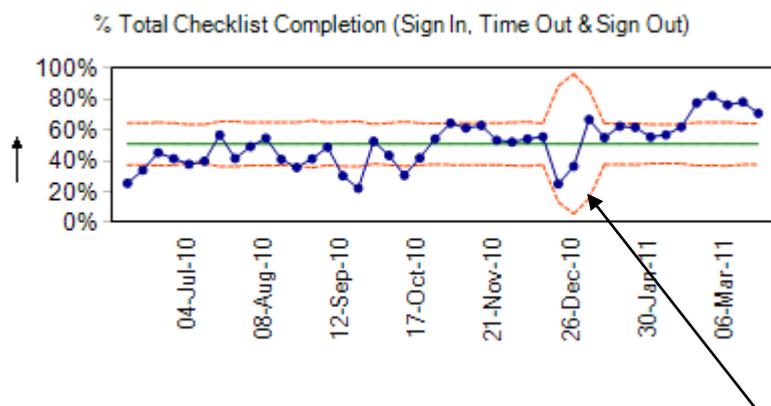
What are the Upper and Lower Control Limits?

The upper and lower control limits help you to analyse and interpret the chart. The limits are calculated based on the data, and the formulas used to calculate them depend on the measure used.

The control limits are set three standard deviations away from the mean (although this is often an approximation, depending on the type of control chart used) so that at least 99% of the data should fall within the limits.

Why are the control limits sometimes wiggly?

Wiggly control limits are used on **U-charts** and **P-charts** only. They wiggle because they are calculated using the sample size which can vary from period to period. For example, the number of patients seen in a clinic will change from week to week.



The control limits are wider here which tells us that there was a smaller sample size for this period

What are the 9 different types of control charts?

1. **XMR chart.** Used for individual measurements with only 1 subgroup. (Example of a subgroup is a theatres, clinic or ward.) Example: How many medication orders do we process each week?
2. **X-bar and R chart.** This monitors the average value over time where your variables dataset is made of multiple subgroups of less than 10 observations per subgroup. Example: For a daily sample of five medication orders, what is the turnaround time?
3. **X-bar and S chart.** Similar to an 'X-bar and R' chart but its used when you have lots of measurements in each sample (over 10) Example: For a daily sample of 25 medication orders, what is the turnaround time?
4. **C-chart.** This is used when you count the number of incidents when there is an equal opportunity for the incident to occur. Example: For a sample of 100 medication orders each week, how many errors were observed?
5. **U-chart.** Similar to a C-chart but where your sample size is not the same. This makes the control limits wiggly! Example: For all medication orders each week, how many errors were observed?
6. **P-chart:** Used to represent the fraction or percentage of the samples that are unacceptable where the sample size varies from period to period (making the control limits wiggly) Example: For all medication orders each week, what percentage have one or more errors?
7. **nP-chart:** Like a P-chart but the sample size is always the same. So rather than the percentage of units, you measure the number of units. Example: For a sample of 100 medication errors each week, how many have one or more errors?

8. **G-chart:** Is used when the occurrences are rare. Example: To measure the number of surgeries between SSI infections.

9. **T-Chart:** Is used when your measure is time between rare occurrences. Example: The time between serious incidents.

XMR and P charts are the most commonly used [SPC charts](#) for improvement at GOSH.

What is Common Cause Variation?

Common (or natural) cause variation is where the data points are between the upper and lower control limits, evenly spaced around the mean. Common cause variation does not mean either “bad variation” or “good variation”. Common cause variation merely means that the process is stable and predictable.

What is Special Cause Variation?

Special cause variation can be spotted using three simple rules:

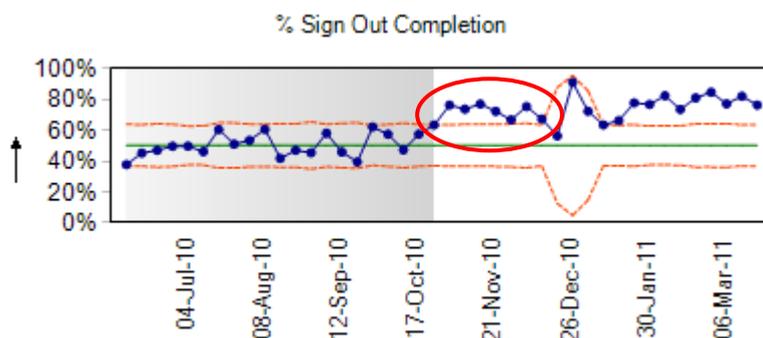
- a. **Runs.** A [run](#) is defined as seven consecutive points above or below the mean/median.
- b. **Trends.** A [trend](#) is defined as seven consecutive points all increasing or decreasing.
- c. **Outliers.** An [outlier](#) is a data point which is outside of the control limits.

Special cause variation should not be viewed as either “bad variation” or “good variation”. You could have a special cause that represents a very good result which you would want to emulate, or a very bad result which you would want to avoid.

All special causes should be investigated to see whether they are an indication of [process change](#) and / or improvement.

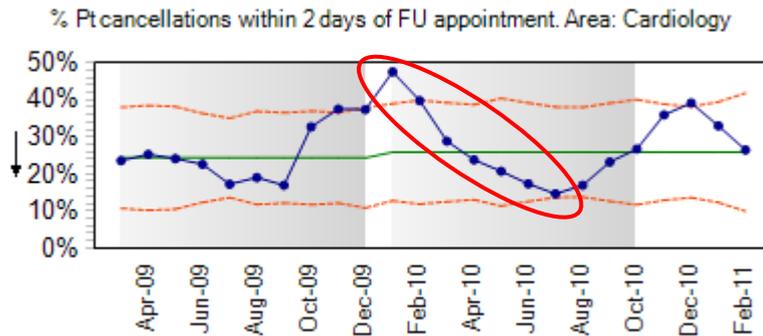
What is a Run?

A run is defined as seven consecutive points above or below the mean/median. Here's an example:



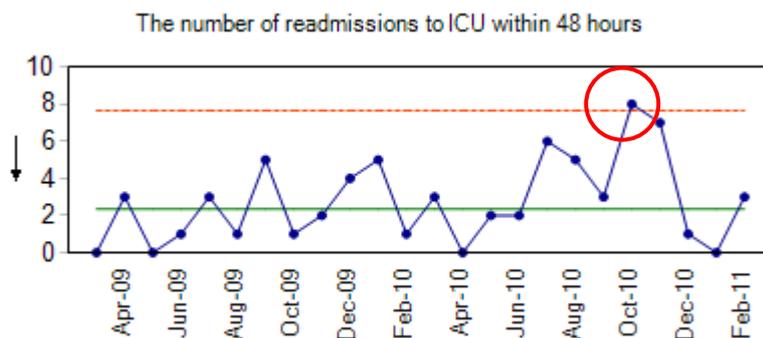
What is a Trend?

A trend is defined as seven consecutive points all increasing or decreasing. Here's an example:



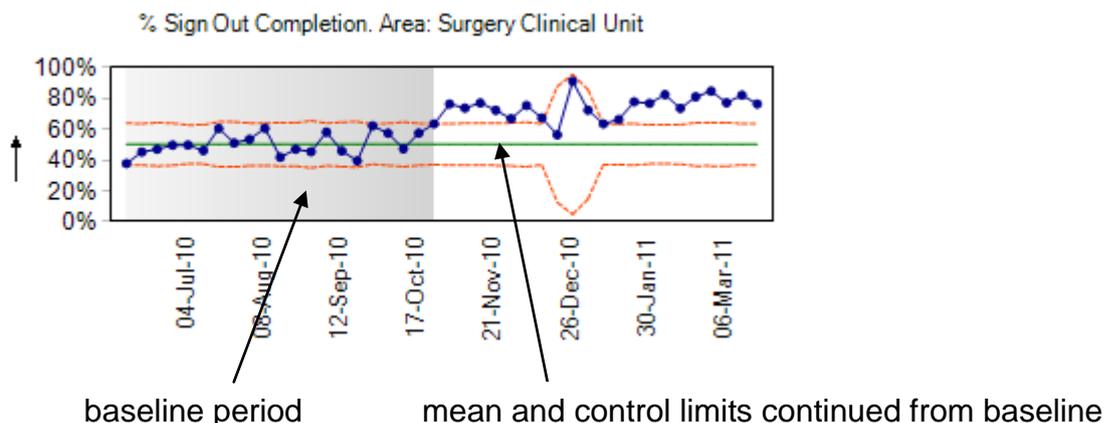
What is an Outlier?

An outlier is a data point which is outside of the **control limits**. Here's an example:



What is a Baseline?

When measuring for improvement on an **SPC chart**, you should aim to collect at least 21 points worth of data as a baseline (although this is not always possible – e.g. for monthly data this might take too long). Calculate the mean and **control limits** for this baseline data, and use this baseline mean and control limit lines to measure future data against:

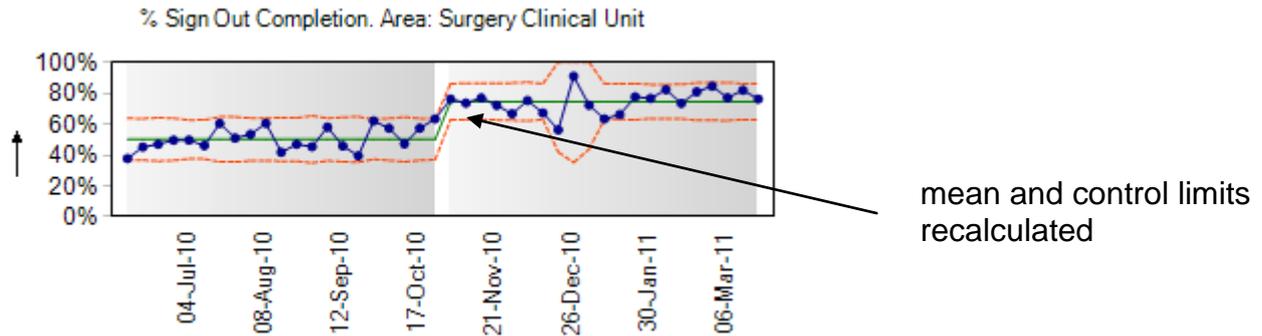


What happens when you have a Special Cause?

Step / Process Changes: When you have spotted a **run** or a **trend** for a measure, you can be statistically sure that the process has changed.

The **control limits** can be re-calculated from the date the run or trend started (or from when a process change was implemented, after further investigation of the measure).

For example, with the Sign Out Completion measure above (where there has actually been a run of 16 consecutive points above the mean after the baseline, we can recalculate the mean and limits as below, so we have an improved process with **common cause variation** about the mean again:



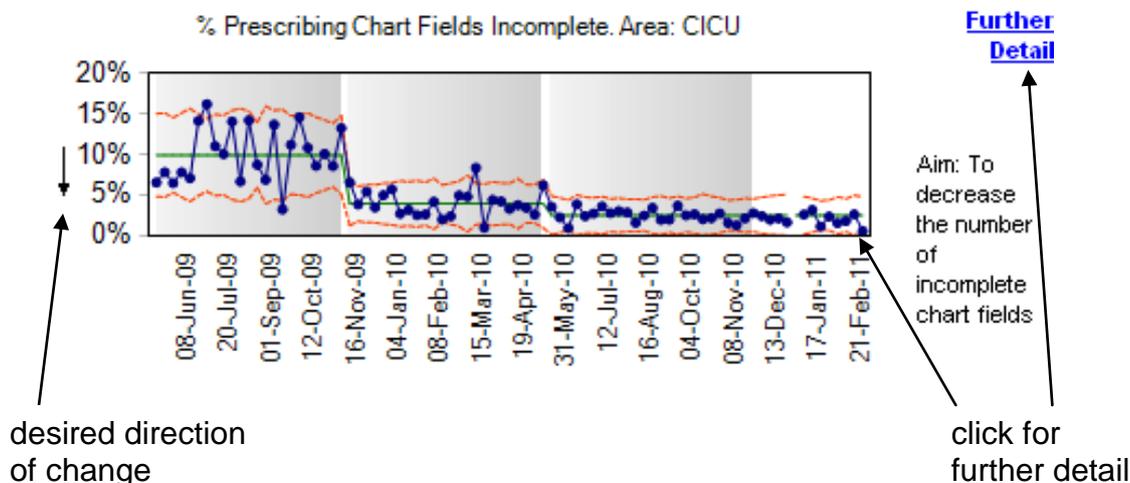
Outliers: If you spot an **outlier**, it must be investigated. It indicates that something either very good or very bad has happened and action needs to be taken either to correct the problem so that it doesn't happen again, or to learn from the good practice so that it can be applied in future.

If you spot a **special cause** on an **SPC chart**, alert your clinical unit improvement coordinator/manager or one of the Quality Improvement analysts, who can recalculate the mean and control limits and add annotations to the charts.

Any other tips for interpreting SPC at GOSH?

The **arrow** to the left of each chart represents the desired direction of change.

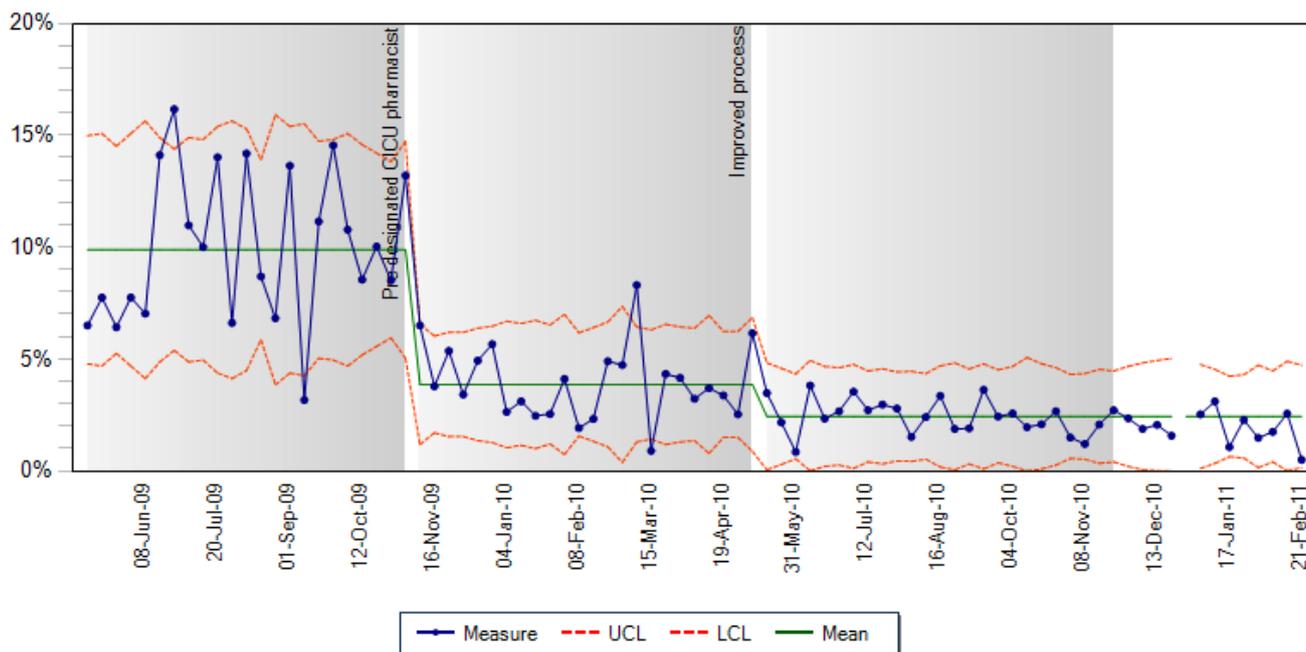
To access **Further Detail and Definitions** for a particular measure on one of the improvement **dashboards**, either click on a data point or the 'Further Detail' link next to the dashboard charts



Here you can view a page with a larger version of the **SPC chart** (see below), plus the following:

- Measure definition, definition source and data source
- Labelled baselines / processes and annotations
- A table containing the figures that make up the measure; including date, data, UCL, LCL, mean (or median if it's a **run chart**), numerator and denominator (where applicable)

% Prescribing Chart Fields Incomplete. Area: CICU



Definition: The percentage of front of prescribing chart (5s and 6s) fields not completed. There are 11 fields on each prescribing chart. Data is collected Monday to Friday, excluding weekends and bank holidays.

Definition Source: CICU team

Data Source: CICU Prescribing

Week Start Date	% Prescribing Chart Fields Incomplete	Upper Control Limit	Lower Control Limit	Mean	Incomplete 5s and 6s fields	Total chart fields
21-Feb-11	0%	5%	0%	2%	2	407
14-Feb-11	3%	5%	0%	2%	9	352
07-Feb-11	2%	4%	0%	2%	9	517

Why is it so important that we measure things?

Improvement is not about measurement, but without measurement, how do we know if a change has led to an improvement? **SPC** is an excellent method of showing that a process change has led to a statistically significant improvement, and that you should therefore carry on working in this new improved way.

How can you find out more?

For more further (and more in-depth information), here are two useful guides to SPC charts and how we measure for improvement:

- [Measuring for Improvement](#) (NHS Institute for Innovation and Improvement)
- [Basics of Statistical Process Control](#) (David Howard, Management-NewStyle)

Alternatively, contact the Quality Improvement analysts or your clinical unit's improvement coordinator/manager.

National Guidance on Learning from Deaths, National Quality Board, 2017

*Salina Parkyn, Head of Quality and Safety
April 2017*

Background

- CQC published their review of the way NHS Trusts review and investigate the deaths of patients in England – December 2016
- There were 7 recommendations from this report;
- The National Quality Board published the National Guidance on Learning from Deaths in response to recommendation 1 of the CQC report in April 2017

Board Leadership

The Board should ensure that their organisation:

- Has an existing board level leader acting as Patient Safety Director to take on the responsibility for the learning from deaths agenda.
- Has an existing non-executive director to take oversight of the process.
- Pays particular attention to the care of patients with a learning disability or mental health needs.
- Has a systematic approach to identifying those deaths requiring a review and selecting patients whose care they will review.
- Adopts a robust and effective methodology for case record reviews of all selected deaths to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
- Ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;

Board Leadership

- Ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised.
- Ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and that this is reported in its' annual Quality Accounts.
- Shares relevant learning across the organisation and with other services where the insight gained could be useful.
- Ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths.
- Offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death.
- Acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted,
- Works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services.

Action Plan

No:	Description:	Actions :	Lead:	Deadline:	Update:
1.	<p>Policy on responding to deaths: Each Trust should publish an updated policy by September 2017 on how it responds to, and learns from, deaths of patients who die under its management and care.</p>	<p>The Policy should include:</p> <ol style="list-style-type: none"> (1) How its processes respond to the death of an individual with a learning disability, an infant or child death. (2) The Trust's approach to undertaking case record reviews. Acute Trusts should use an evidence-based methodology for reviewing the quality of care provided to those patients who die. The Structured Judgement Review (SJR) case note methodology is one such approach. (3) Categories and selection of deaths in scope for case record review: As a minimum and from the outset, Trusts should focus reviews on in-patient deaths 	<p>Associate Medical Director for Quality and Safety</p> <p>Or</p> <p>Head of Quality and Safety</p>		
2.	<p>Data collection and reporting</p>	<p>From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards).</p> <p>Changes to the Quality Accounts regulations will require that the data providers publish be summarised in Quality Accounts from June 2018 .</p>	<p>Associate Medical Director for Quality and Safety</p> <p>Or</p> <p>Head of Quality and Safety</p>	<p>June 2018</p>	

Further Developments

In 2017-18, further developments will include:

- **The Care Quality Commission will strengthen its assessment of providers learning from deaths** including the management and processes to review and investigate deaths and engage families and carers in relation to these processes.
- **NHS England, led by the Chief Nursing Officer, will develop guidance for bereaved families and carers.** This will support standards already set for local services within the Duty of Candour and the *Serious Incident Framework* and cover how families should be engaged in investigations. Health Education England will review training of doctors and nurses on engaging with bereaved families and carers.
- **Acute Trusts will receive training to use the Royal College of Physicians' Structured Judgement Review case note methodology.** Health Education England and the Healthcare Safety Investigation Branch will engage with system partners, families and carers and staff to understand broader training needs and to develop approaches so that NHS staff can undertake good quality investigations of deaths.
- **NHS Digital is assessing how to facilitate the development of provider systems and processes** so that providers know when a patient dies and information from reviews and investigations can be collected in standardised way.
- **The Department of Health is exploring proposals to improve the way complaints involving serious incidents are handled** particularly how providers and the wider care system may better capture necessary learning from these incidents.

Trust Board 25th May 2017	
Integrated Performance Report: April 2017 (Month 1 2017/18) Submitted by: Nicola Grinstead, Deputy Chief Executive	Paper No: Attachment M
Aims / summary The Integrated Performance Report (IPR) is focused on the key areas/ domains in line with the CQC, in order to be assured that the Trust's services are delivering to the level our patients & families, Trust Board and our commissioners & regulators expect. The indicators included are those that have been recommended by the Trust Board, Clinical Divisions and other relevant parties. It is expected that these will evolve and iterate overtime. The narrative provides provide more detail / analysis from the IPR of those indicators not meeting the required standards or where they warrant further mention.	
Action required from the meeting Board members to note and agree on actions where necessary	
Contribution to the delivery of NHS Foundation Trust strategies and plans All the indicators within the IPR contribute to the delivery of either regulatory or commissioner requirements, and as such are aligned to the objectives and strategy of the Trust	
Financial implications For indicators that have a contractual consequence there could be financial implications for under-delivery	
Who needs to be told about any decision? Where appropriate and applicable: Internal stakeholders, NHS Improvement and NHS England Special Services Commissioners	
Who is responsible for implementing the proposals / project and anticipated timescales? Each Domain / Section has a nominated Executive Lead	
Who is accountable for the implementation of the proposal / project? As above	



Integrated Performance Report

Nicola Grinstead, Deputy CEO
April 2017

Executive Summary		Page 3
Integrated Performance Dashboard		Appendix I
	Caring	Page 4
	Safe	Page 5
	Responsive	Page 6-8
	Well-Led	Page 9
	Effective	Page 10
	Productivity	Page 11
	Our Money	Page 12
Appendix I:	Integrated Performance Dashboard	Attached
Appendix II:	Definitions	Attached
Appendix III:	Data Quality – Overview	June 2017

APRIL 2017 (MONTH 1 2017/18)

The Trust Integrated Performance Report (IPR) is designed to focus on the key areas/ domains below, in order to be assured that our services are delivering to the level our patients & families, Trust Board and our commissioners & regulators expect.

The domains are consistent with the Care Quality Commission and cover:

- Caring
- Safe
- Responsive
- Well-led
- Effective

The IPR additionally includes further indicators and metrics with regard to Our Money (Finance) and Productivity. These indicators are those that have been recommended by the Trust Board, Clinical Divisions and other relevant parties. The IPR is attached as an appendix to this supporting narrative. The narrative is continuing to be revised, in accordance with the update to the last Trust Board. This report and narrative should continue to be looked at in conjunction with other Trust Board reports (i.e. the Quality and Safety, HR & OD and Finance).

2017/18 provides the Trust with a number of exciting opportunities and challenges, whilst looking to maintain the delivery of excellent patient care and to improve in a number of areas (e.g. continued EPR procurement, Better Value Programme, returning to the delivery of the national Referral to Treatment Time standard of 18 weeks, as a well as to continue to develop and improve services and patient & family experiences).

At the time of writing the Trust Board report for April, this is prior to a number of key national submissions (most notably Diagnostics, RTT and Cancer), so reference is made to the March 2017 (M12) position and intelligence in month thus far.



Friends & Family Test (FFT)

Headlines via the Performance Report for these measures are:

- Continued very positive recommendation responses for those undertaking the Inpatient FFT (97.7% for April 2017)
- The rate (%) of those responding (for Inpatients) remains below the local 40% standard set by the Trust, at 27.2% (for April 2017)

A comprehensive over-view and assessment of the Inpatient FFT delivery is provided in the Integrated Quality and Safety Report, tracking response rates over time and also in comparison to other organisations. This is reviewed and assessed in the relevant Trust Committees, and Divisional Nursing leads provide regular updates at their monthly Divisional Performance meetings.

Access to Healthcare for people with Learning Disabilities

The Trust continues to report compliance with this requirement against the measure outlined in the supporting appendix which provides an over-view of the definitions for each indicator.





Serious Incidents and Never Events

As confirmed in the Performance Dashboard and in the Quality & Safety Report, the number of reported incidents for April 2017 are:

- Serious Incidents = 2
- Never Events = 0

These are further detailed in the Quality and Safety Report

Healthcare Associated Infections (HCAIs)

Incidents of C. Difficile

As reported the Trust has seen 3 incidents of C Difficile in April, all of which are assigned to the Trust (in comparison with 4 reported and 1 assigned to the Trust for the whole year). These cases continue to be investigated as to whether they resulted from a lapse of care (the Trust last year reported no lapses of care following review with Commissioners).

Incidents of MRSA

The Trust reported no incidents in April 2017 (which is a continuation of the trend from the last few months, and where only 3 cases were reported in 2016/17)

CV Line Infections

These have returned to the required levels in April 2017, having risen in March 2017. The increase in incidents have been investigated by the lead nursing staff with involvement from the Infection Control team.

WHO Surgical Checklist Completion (> 98%)

The last 3 months have shown a steady improvement in the completion rate of the WHO Surgical Checklist, up to 95.1% in April (towards the target pf 98%). In main theatres, the drive is to ensure there is a sustained level of completion rates, following the NatSIPPs programme. Outside of main theatres, the focus have been on Dermatology where significant improvements have been seen in April (with the recent review of process and updating the checklist to be more fit for purpose)



Responsive

Diagnostics (99% < 6 weeks)

As per the March 2017 (M12 16/17) position the Trust continues to see improvements in this area, as it moves towards delivery of the 99% standard for the 15 diagnostic modalities reported against. As at March this was 96.62%

From the table opposite which shows performance by modality, the main area of focus currently not delivering the standard is Audiology. Due to the volumes reportable for GOSH (in a typical month) any more than 5-6 patients waiting longer than 6 weeks, means the Trust is outside the 99% requirement. In March the Trust reported 18 > 6 weeks, of which 11 were in Audiology (the others in MRI, ultrasound and cystoscopy where predominantly associated with patient choice or were complex cases).

The issues previously raised in regard to Audiology are being progressed and the infrastructure changes for the inclusion of an additional sound-proof booth, are being finalised, with the service aiming for compliance in May.

The standard remains challenging for the service with regard to the complexity of some tests that are undertaken, and the associated specialist resourcing required. Additionally, across the whole range of modalities where patient's choosing the be seen greater than 6 weeks presents a constant challenge. Services though are ensuring reasonable appointments are offered to all patients and families.

Modality	% < 6 weeks
Sleep Study	100%
Magnetic Resonance Imaging	97.7%
Computed Tomography	100.0%
Non-obstetric ultrasound	98.2%
Barium Enema	100.0%
DEXA Scan	100.0%
Audiology - Audiology Assessments	78.8%
Neurophysiology - peripheral neurophysiology	100.0%
Urodynamics - pressures & flows	100.0%
Colonoscopy	100.0%
Cystoscopy	87.5%
Gastroscopy	100.0%
Trust Total	96.62%

Cancer Wait Times

For the reporting period up until March the Trust has not reported any breaches of the Cancer Wait time standards applicable to the Trust.



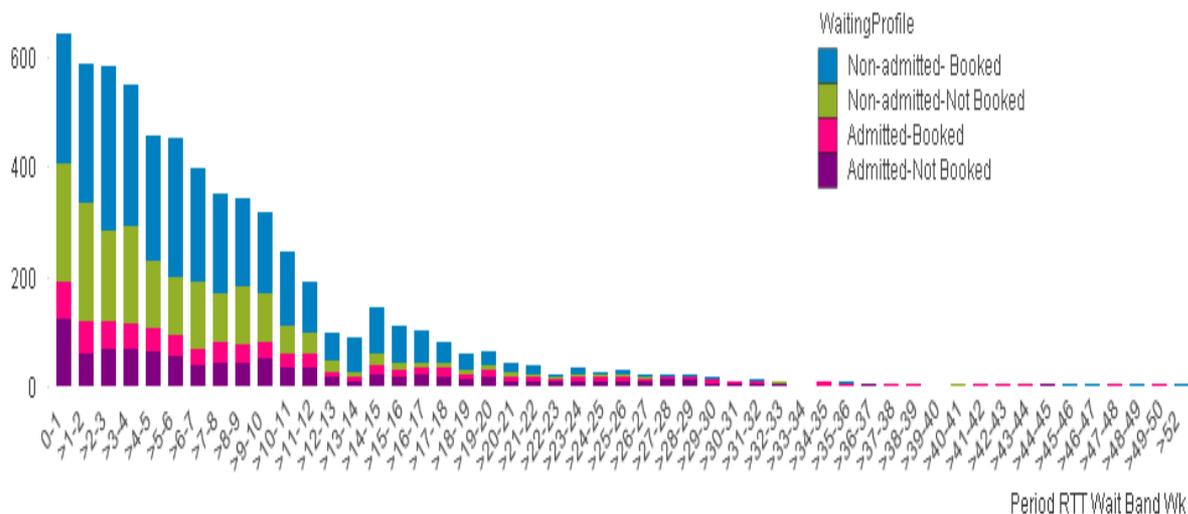
Responsive

Referral to Treatment Time (incomplete standard > 92%)

Since returning to reporting the Trust continues to make good progress against the agreed improvement trajectory. As at March the Trust's performance against the 92% incomplete pathway standard was 91.85%, which is in excess of the trajectory of 86.9% for the same period.

The areas contributing most to the non-delivery of the standard are those previously highlighted pressure specialties (Orthopaedics, Spines, Plastics, Urology and SNAPS). Plans are in place and being revisited to ensure clarity remains on when these services are expected to become compliant. Much of the delivery are associated with change projects across the Trust and with PICB opening.

The graph below provides an overview of the distribution of the Trust's RTT wait times (for those with known clock start pathways). As is evident a high proportion of pathways are booked early on in their wait, with those remaining un-booked reducing appropriately over time (reflecting good booking practice).



52 week waits:

For March the Trust reported 2 pathways waiting in excess of 52 weeks – these resulted from an inherited waiting time from another provider (and this has been taken up directly with the provider concerned) and as a consequence of patient choice (having been able to treat < 52 weeks).

Both patients were treated in April 2017.

Unknown clocks starts:

As at March the proportion of pathways with an unknown clock start (i.e. referred to the Trust without confirming the start date of the pathway) is 12%. This is broadly in line with previous months and a significant improvement on historic levels, following the change in process and resource to target these referrers.



Last minute non-clinical hospital cancelled operations (and associated 28 day breaches)

Reported in the Dashboard are the monthly breakdowns for this quarterly reportable indicator.
For Quarter 4 of 2016/17 the Trust reported the following (the full year is provided for completeness):

As is evident from the data, the Trust has seen an improvement from the start of the year, however the downturn seen in Q3 has not been sustained into Q4. Positively however 28 day breaches (i.e. those rebooked after a non-clinical last minute hospital cancellation) have been maintained at the Q3 levels.
Focused work is underway within key areas to build on the improvements in year, and where there are further opportunities. The on-going balance between urgent / emergency cases versus elective bed capacity remains a challenge. Certain specialties are additionally being reviewed (e.g. Radiology), and further escalation steps are being put in place with operational senior management teams

2016/17	Last minute Non-clinical cancellations	28 day breaches
Q1	197	32
Q2	191	32
Q3	157	23
Q4	180	25

Analysis is currently underway to propose an appropriate level of cancellations for Trust (i.e. as a proportion of the elective work load of the Trust), and how this is comparable to other specialist paediatric hospitals. From the reported levels by the likes of Birmingham Children's, Alder Hey and Sheffield Children's, the Trust's volumes are higher (however this could be down to how those providers also record and report these – which is being investigated).





Well-Led

(to be reviewed alongside the Workforce Metrics & Exception Report)

Turnover Rate (Total & Voluntary)

As per the Performance Dashboard and reported on in the Workforce report, for April 2017 this stood at 15.7% for voluntary and 18.8% for standard. Which is a marginal increase in the rate from March to April

Trust wide efforts are underway to reduce turnover and there is a separate work stream overseen by the Nursing Workforce Programme Board specifically targeted at reducing turnover of nurses.

Appraisal (PDR) rate

The Trust this month has achieved the total appraisal rate of 90%

Considerable effort and focus has been given to achieving this requirement– which has been delivered in the following areas: West Division, IPP, Nursing & Patient Experience, Development & Property Services and Research and Innovation.

This needs to be sustained and for those areas not at 90% yet to be so in future months.

Mandatory Training

The compliance for Statutory and Mandatory training in April was 90%, as confirmed in the Workforce report, this is being delivered across the Trust (with the exception of one area).

Agency Spend

As at April this was 2.3% of the total pay bill. Further information is contained within the Workforce report

Vacancy Rate

At the time of writing this information was not available for M1, for the contracted rate.

For Nursing specifically, this is at 8.4%, which is an improvement on the last few months.





Discharge Summaries

Over the course of the last year there has been an improvement in the turn around time for Discharge Summaries being sent within 24 hours of discharge (as can be seen in the SPC chart below). Unfortunately there was a slight down turn in March (89.5%) and this has continued into April 2017 (86.9%).

The Clinical Divisions throughout the year have been focusing on particular specialties, with action plans in place to improve these turnaround times.

In JM Barrie Division these include: Gastroenterology, Nephrology, Dental MaxFac, Neurology / Epilepsy and Neuro-disability

In C West: Oncology, BMT, infectious diseases and Rheumatology.

The plans have included piloting different systems and approaches, reviewing roles & responsibilities, and appropriate escalation.



An audit was carried out during Q3 of 2016/17 with regard to the quality of the content of the discharge summaries, assessing these across a range of specialties against best practice standards. The results were positive evidencing good practice across the Trust. These findings were presented to the Patient & Safety Outcomes Committee and with Commissioners.

Clinic Letter Turnaround times

Much like the above, the Trust has seen modest improvements in this area over the course of the last year, reporting in April 2017 against 14 days 75.53%. Key specialties are again being targeted to ensure there is sustained improvements.

Positively again however, following an audit in 2016/17, of key specialties (which provided a cross section across the breadth of services) using the a tool developed by the Royal College of Paediatrics and Child Health (RCPCH) known as the Sheffield Assessment Instrument for Letters (SAIL). Overall the audit showed the letters being produced at GOSH are of a high quality



Theatres

As updated for the last Trust Board, the Performance Report now includes the total number of theatres alongside the utilisation metric.

For utilisation – over the last few months there has been an improvement with April showing indicative utilisation of 75.5% (for main theatres).

As part of the Better Value work streams, theatres is one of the major programmes of work and as such increased focus on process and systems is underway. In support of this programme a new theatres dashboard is being developed, and the way in which utilisation is being reviewed. This will provide increased transparency on theatre productivity in future months.

Beds

The metrics supporting bed productivity are to be improved for future months, however for now reflect occupancy and (as requested) the average number of beds closed over the reporting period.

Occupancy: For the month of April 2017 has dropped from the levels shown in March to 82.8%. Further analysis will be required with regard to day and overnight occupancy levels, and what the range of occupancy is across the Trust, whether this can be understood because of the case mix and patients using those beds, and where opportunities exist to improve.

This indicator and methodology is currently under-review as part of the statutory returns review, and as such the metrics should be used as a guide at this time, pending completion of this exercise

Activity

Across the 3 main points of operational delivery (inpatients – discharges, Critical Care bed-days and outpatients) a comparison is provided looking at year on year differences, cumulatively YTD and individual month on month.

As at Month 1 (April 2017) Day Case and Outpatient Attendances are down on the same month last year (however there were fewer working days over this period). Overnight IPs and Critical Care Beddays are showing a slight increase.



Summary

This section of the IPR includes a year to date position up to and including April 2017 (Month 1). In line with the figures presented, the Trust has a deficit of £2.4m at Month 1, which is in line with plan.

- Clinical Income (exc. International Private Patients and Pass through Income) is £0.3m lower than plan
- Non Clinical revenue is £0.8m lower than plan
- Private Patients income is £0.1m higher than planned
- Staff costs are £0.4m lower than plan
- Non-pay costs (excluding pass-through costs) are £0.6m lower than plan.

		Feb	Mar	Apr	Trend	Plan	NHS Standard
Caring	Access to Healthcare for people with Learning Disability				→		
	% Positive Response Friends & Family Test: Inpatients	98.00%	97.36%	97.69%	↑		95%
	Response Rate Friends & Family Test: Inpatients	24.46%	25.90%	27.24%	↑		40%
	% Positive Response Friends & Family Test: Outpatients	92.55%	94.74%	89.94%	↓		95%
	Mental Health Identifiers: Data Completeness	99.38%	99.12%	99.31%	↑		97%
Safe	Serious Patient Safety Incidents	In-month: 0 YTD: 10	1 11	2 2			
	Never Events	In-month: 0 YTD: 1	0 1	0 0	→		0
	Incidents of C. Difficile	In-month: 1 YTD: 4	0 4	3 3	↓		1
	C.Difficile due to Lapses of Care	In-month: 0 YTD: 0	0 0	0 0	→		1
	Incidents of MRSA	In-month: 0 YTD: 3	0 3	0 0	→		0
	CV Line Infection Rate (per 1,000 line days)	0.99	1.68	1.28	↑		1.6
	WHO Checklist Completion	92.11%	93.05%	95.10%	↑		98%
	Arrests Outside of ICU	Cardiac Arrests: 0 Respiratory Arrests: 6	3 1	4 2	↓		5
	Total hospital acquired pressure / device related ulcer rates grade 3 & above	0	0	0	→		0
Responsive	Diagnostics: Patients Waiting >6 Weeks	95.73%	96.62%		↑		99%
	Cancer 31 Day: Decision to Treat to First Treatment	100%	100%		→		96%
	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery	100%	100%		→		94%
	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs	100%	100%		→		98%
	Last Minute Non-Clinical Hospital Cancelled Operations	60	67		↓		
	Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard	8	7		↑		0
	Same day / day before hospital cancelled outpatient appointments	1.11%	1.25%	1.14%	↑		
	RTT: Incomplete Pathways (National Reporting)	91.57%	91.85%		↑		92%
	RTT: Number of Incomplete Pathways (National Reporting)	<18wks: 5494 >18wks: 506	5723 508	TBC	#VALUE!		-
	RTT: Incomplete Pathways >52 Weeks - Validated	7	2		↑		0
Number of unknown RTT clock starts	Internal Referrals: 29 External Referrals: 705	23 867	TBC	#VALUE!		-	
RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks: 6205 >18 weeks: 529	6588 533	TBC			-	

Trend Arrow Key (based on 2 most recent months' data)

↑ Improvement On / above target
 → Consistent trend Below target
 ↓ Deterioration No target

		Feb	Mar	Apr	Trend	Plan	NHS Standard
People, Management & Culture: Well-LED	Sickness Rate	2.27%	2.23%	2.18%	↑		3%
	Turnover	Total: 18.8% Voluntary: 14.5%	18.6% 15.4%	18.8% 15.7%	↓		18% 14%
	Appraisal Rate	82% 83%	85% 83%	90% 84%	↑		90%
	Mandatory Training	87%	86%	90%	↑		90%
	% Staff Recommending the Trust as a Place to Work: Friends & Family Test		77%				61%
	Vacancy Rate	Contractual: 3.1% Nursing: 12.8%	0.1% 13.0%	8.4%	↑		10%
	Bank Spend	6.0%	6.1%	5.4%	↑		
	Agency Spend	3.78%	3.90%	2.34%	↑		2%
	Effective	Discharge Summary Turnaround within 24hrs	90.43%	89.56%	86.99%	↓	
Clinic Letter Turnaround within 7 working days		46.19%	48.71%		↑		
within 14 working days		73.61%	75.53%		↓		100%
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)		6.86%	7.29%	7.71%	↓		8.36%
Productivity	Main Theatres	Theatre Utilisation: 67.6% No. of theatres: 12	70.7% 12	75.5% 12	↑		77%
	Outside Theatres	Theatre Utilisation: 55.1% No. of theatres: TBC	57.1% TBC	55.7% TBC	↓		77%
	Trust Beds	Bed Occupancy: 82.6% Number of Beds: TBC	85.7% TBC	82.8% TBC	↓		
	Average number of beds closed	Wards: 9.5 ICU: 0.1	11.3 0.2	10.8 0.0	↑		
	Refused Admissions	Cardiac refusals: 1 PICU / NICU refusals: 14	3 19	2 9	↑		
	Daycase Discharges (YOY comparison)	In-month: 1,936 YTD: 22,507	2,174 24,681	1,787 1,787	↓		1,787 2,082
	Overnight Discharges (YOY comparison)	In-month: 1,556 YTD: 17,358	1,733 19,091	1,507 1,507	↓		1,507 1,540
	Critical Care Beddays (YOY comparison)	In-month: 1,099 YTD: 12,649	1,272 13,921	1,108 1,108	↓		1,108 1,169
	Excess Bed Days >=100 Days	No. of patients: TBC No. of beddays: TBC	TBC TBC	TBC TBC			
	Outpatient Attendances (All) (YOY comparison)	In-month: 21,073 YTD: 229,380	23,084 252,464	17,573 17,573	↓		17,573 19,891
Our Money	Net Surplus/(Deficit) v Plan			(2.5)		(2.5)	0.0
	Forecast Outturn v Plan			0.2		0.2	0.0
	Better value			TBC		TBC	
	Pay Worked WTE Variance to Plan			TBC		TBC	
	Debtor Days (IPP)			183.0		120.0	63.0
	Quick Ratio (Liquidity)			1.88		1.73	0.12
	NHSI KPI Metrics			3.0		3.0	0.0

TRUST BOARD PERFORMANCE DASHBOARD: KPI DEFINITIONS

Measure	Definition	Standard	Calculation formulae	Reporting Frequency
 Access to Healthcare for people with Learning Disability	Covers the NHS Standard for organisations to meet the 6 criteria for people with a learning disability: 1. Does the NHS foundation trust have a mechanism to identify and flag patients with learning disabilities and protocols that ensure pathways of care are reasonably adjusted to meet the health needs of these patients? 2. Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria? • Treatment options? • Complaints procedures? • Appointments? 3. Does the NHS foundation trust have protocols to provide suitable support for family carers who support patients with learning disabilities? 4. Does the NHS foundation trust have protocols to routinely include training on providing healthcare to patients with learning disabilities for all staff? 5. Does the NHS foundation trust have protocols to encourage representation of people with learning disabilities and their family carers? 6. Does the NHS foundation trust have protocols to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Yes	Does the service meet the six criteria for meeting the needs of people with a learning disability, based on recommendations in Healthcare for all (DH 2008):29?	Quarterly
Caring	% Positive Response Friends & Family Test: Inpatients	>95%	Numerator: respondents who would be extremely likely or likely to recommend the service Denominator: total respondents	Monthly
	Response Rate Friends & Family Test: Inpatients	>40%	Numerator: Total number of patients that have completed the FFT Questionnaire. Denominator: Total number of patients eligible to respond.	Monthly
	% Positive Response Friends & Family Test: Outpatients	>95%	Numerator: respondents who would be extremely likely or likely to recommend the service Denominator: total respondents	Monthly
	Mental Health Identifiers: Data Completeness	>97%	Denominator for NHS number, DOB, postcode, gender, GP practice: count of distinct patients in that submission Numerator: does the patient have a valid NHS number, DOB, postcode, gender, GP practice Denominator for Commissioner Code: Count of referrals in submission Numerator: Does each referral have a valid commissioner code. All denominators and numerators are added up to create the overall Monitor measure	Monthly
	Discharge Summary Turnaround within 24hrs	The percentage of patients with a completed Discharge Letter and sent within 24hours of the patients Discharge	100%	Numerator: number of discharge summaries sent for eligible patients within 24 hours Denominator: total number of discharge summaries required for eligible patients
Effective	Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)	8.36%	Numerator: number of non-attendances Denominator: total number of expected attendances	Monthly
	Clinic Letter Turnaround within 7 Working Days	The percentage of patients with a completed Clinic Letter within 7 working days of attendance	100%	Numerator: number of clinical letters sent for eligible patients within 7 working days Denominator: total number of matching clinical letters for eligible patients on Clinical Documents Database

Measure	Definition	Standard	Calculation formulae	Reporting Frequency		
 Diagnostics: Patients Waiting >6 Weeks	The percentage of patients waiting greater than 6 Weeks for a Diagnostic Test at the given month end census date based on the National DM01 Key 15 groupings	99%		Monthly		
Cancer 31 Day: Decision to Treat to First Treatment	The percentage of patients receiving first definitive treatment from diagnosis within 31 days	96%		Monthly		
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery	The percentage of patients receiving subsequent treatment of surgery for new cases of primary or recurrent cancer within 31 Days	94%		Monthly		
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs	The percentage of patients receiving subsequent treatment of drugs for new cases of primary or recurrent cancer within 31 Days	98%		Monthly		
Last Minute Non-Clinical Hospital Cancelled Operations	Count the number of last minute cancellations by the hospital for non clinical reasons in the quarter. Last minute means on the day the patient was due to arrive, after the patient has arrived in hospital or on the day of the operation or surgery.			Monthly		
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard	Count of the number of patients that have not been treated within 28 days of a last minute cancellation	0		Monthly		
Responsive	RTT: Incomplete Pathways (National Reporting)	Patients waiting below 18 Weeks on an Incomplete RTT Pathway at month end with a known clock date (i.e. clock start and no stop) expressed a percentage	92%	Numerator: number of patients waiting below 18 weeks Denominator: total number of patients waiting	Monthly	
	RTT: Total Number of Incomplete Pathways (National Reporting)	Under 18 Weeks	Patients waiting below 18 Weeks on an Incomplete RTT Pathway at month end with a known clock date (i.e. clock start and no stop).	Total number of patients waiting below 18 weeks	Monthly	
		Over 18 Weeks	Patients waiting above 18 Weeks on an Incomplete RTT Pathway at month end with a known clock date (i.e. clock start and no stop).	Total number of patients waiting above 18 weeks	Monthly	
	RTT: Incomplete Pathways >52 Weeks	Validated	Patients waiting 52 Weeks and above on an Incomplete RTT Pathway waiting at month end with a known clock date (i.e. clock start and no stop)	0	Total number of patients waiting 52 weeks and above	Monthly
	RTT: Number of Unknown Clock Starts	Internal Referrals	Patients referred internally within Great Ormond Street where the RTT Clock Start Date cannot be verified		Total number unknown clock starts from an internal referral	Monthly
		External Referrals	Patients referred by other organisations to Great Ormond Street where the RTT Clock Start Date cannot be verified		Total number unknown clock starts from an external referral	Monthly
	RTT: Total Number of Incomplete Pathways	Under 18 Weeks	Patients waiting below 18 Weeks on an Incomplete RTT Pathway at month end with a known and unknown clock date (i.e. clock start and no stop)		Total number of patients waiting below 18 weeks	Monthly
		Over 18 Weeks	Patients waiting above 18 Weeks on an Incomplete RTT Pathway at month end with a known and unknown clock date (i.e. clock start and no stop)		Total number of patients waiting above 18 weeks	Monthly
	 Serious Patient Safety Incidents	Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.	N/A	Total number of Serious Patient Safety Incidents reported in month.	Monthly	
	Never Events	Never Events are serious incidents that are wholly preventable Never Events include incidents such as wrong site surgery, retained instrument post operation or wrong route administration of chemotherapy	0	Total number of Never Events reported in month.	Monthly	
Incidents of C. Difficile	This is the number of C.Difficile infections that have been reported in the Trust, regardless of whether they are hospital acquired and/or categorised as infection due to lapses of care.	0	Total number of C. Difficile infections that have been reported in month, in the Trust.	Monthly		

Measure	Definition	Standard	Calculation formulae	Reporting Frequency
SAFE	C.Difficile due to Lapses of Care	0	Total number of C. Difficile infections that have been reported in the Trust.	Monthly
	Incidents of MRSA	0	Total number of MRSA infection the have been reported in the Trust in month.	Monthly
	CV Line Infection Rate (per 1,000 line days)	1.6	Numerator: Number of GOS acquired CVC related infections in month x 1,000 Denominator: Number of line days in month.	Monthly
	Arrests Outside of ICU	5 (total)	Total number of cardiac and total number of respiratory arrests that have occurred outside ICU in the reportable month. Cardiorespiratory arrests count towards the cardiac arrests total, not the respiratory arrests total.	Monthly
	Total hospital acquired pressure / device related ulcer rates grade III & above	N/A	Monthly number of hospital acquired pressure/device related ulcers, Grade III or above.	Monthly
People, Management & Culture: Well-Led	 Sickness Rate	3%	Numerator: Number of calendar days lost to sickness Denominator: Total available working calendar days.	Monthly
	Total Turnover	18%	Numerator: All employees that the Trust must replace (excluding Junior Doctors) Denominator: Total amount of employees across the Trust (excluding Junior Doctors).	Monthly
	Turnover Rate	14%	Numerator: All employees that the Trust must replace due to voluntary resignation (Excluding Junior Doctors) Denominator: Total amount of employees across the Trust (excluding Junior Doctors).	Monthly
	Voluntary Turnover		Voluntary Turnover represents the number of employees that the Trust must replace (due to: Flexi Retirement, Mutually Agreed Resignation, Pregnancy or Retirement due to Ill Health/Retirement Age) as a ratio to the total number of employees across the Trust (excluding junior doctors).	
	Appraisal Rate	90%	Numerator: Number of staff members with a complete PDR Denominator: Total number of staff members eligible for a PDR.	Monthly
	Mandatory Training	90%	Numerator: Number of staff members who have successfully completed all the necessary training courses for their role. Denominator: Total number of substantial staff members.	Monthly
	% Staff Recommending the Trust as a Place to Work: Friends & Family Test	61%	Numerator: Total number of staff members that have indicated that they are likely or very likely to recommend the Trust as a place to work. Denominator: Total number of patients that have completed the Staff FFT questionnaire	Quarterly
	Vacancy Rate	10%	Numerator: Established FTE Denominator: Actual Budget FTE	Monthly
	Bank Spend	N/A	Numerator: Total amount that has been spent on Bank staff. Denominator: Total pay bill.	Monthly
	Agency Spend	2%	Numerator: Total amount that has been spent on Bank staff. Denominator: Total pay bill.	Monthly

	Measure	Definition	Standard	Calculation formulae	Reporting Frequency
Our Money	 Net Surplus/(Deficit) v Plan	Variance between YTD Net Surplus/(Deficit) - Excluding Capital Donations and Impairments compared to YTD Plan Surplus/(Deficit) - Excluding Capital Donations and Impairments			Monthly
	Forecast Outturn v Plan	Variance between Forecast month 12 Net Surplus/(Deficit) - Excluding Capital Donations and Impairments compared to Annual Plan as at month 12 Surplus/(Deficit) - Excluding Capital Donations and Impairments			Monthly
	P&E Delivery	Actual YTD recurrent savings delivered v YTD Planned Savings			Monthly
	Pay Worked WTE Variance to Plan	Variance between worked WTE in period and plan WTE in period			Monthly
	Debtor Days (IPP)	IPP Debtors / Total Sales x365			Monthly
	Quick Ratio (Liquidity)	Cash + Receivables divided by current liabilities			Monthly
	NHS KPI Metrics	Composite metric based on performance against plan of the following NHS Improvement Measures: <ul style="list-style-type: none"> • Liquidity • Capital Service Coverage • I&E Margin • Variance in I&E Margin as % of income • Agency Spend • Each measure is rated 1 to 4 (and RAG rated 1 Green, 2 Amber and 3/4 Red) 			Monthly
Productivity	 Theatre Utilisation (NHS UO4)	Theatre Utilisation based on the percentage of original scheduled session hours that were used for operating	77%		Monthly
	Bed Occupancy	KH03 definition- day and night occupied bed days divided by total no of available bed days			Monthly
	Number of Beds	KH03 definition of total number of available beds			Monthly
	Average Number of beds closed	Average number of day and night beds closed in the reporting month.			Monthly
	Refused Admissions	Admissions refused due to non clinical reasons. Data excludes refusals based on medical grounds and refusals to a GOSH ICU/Ward that were accepted to a different GOSH ICU/Ward			Monthly
	Trust Activity: Trust activity (Daycase discharges, Overnight Discharges, Critical Care bed days and OP attendances)	Discharges based on spells. Overnight discharges include elective, non elective, non elective non emergency and regular attenders. OP attendances include both new and follow up. Critical care bed days include elective, non elective and non elective non emergency.			Monthly
	Excess Bed Days >=100 days	No of patients with an extra ordinary length of stay (100 days+) at the end of the reporting period.			Monthly

Trust Board 25th May 2017	
Workforce Metrics and Exception Report Submitted by: Ali Mohammed, Director of HR and OD	Paper No: Attachment N
Aims / summary To provide an update on the latest workforce metrics, exception reports and performance	
Action required from the meeting To note the actions	
Contribution to the delivery of NHS Foundation Trust strategies and plans Workforce performance to deliver against Trust strategy including Well-Led plans	
Financial implications None	
Who needs to be told about any decision? Director of HR and OD	
Who is responsible for implementing the proposals / project and anticipated timescales? Director of HR and OD	
Who is accountable for the implementation of the proposal / project? Director of HR and OD	

TRUST BOARD WORKFORCE METRICS & EXCEPTION REPORTING – APRIL 2017

Introduction

This suite of workforce reports includes:

- Voluntary turnover and total turnover;
- Sickness absence;
- PDR appraisal rates;
- Statutory & Mandatory training compliance;
- Temporary staffing usage as a percentage of paybill (split by bank and agency).

Each report shows divisional and directorate performance and an exception report that indicates the cost centres which are the most statistically significant outliers against average performance. Where data exists to provide an external comparator (London trusts) this is indicated on each graph.

Headlines

Contractual staff in post GOSH decreased its contractual FTE (full-time equivalent) figure by 11 in April to 4105 compared to February 2017 (4116).

Sickness absence has decreased to 2.2% and is below the London average figure of 2.8%. Short-term sickness (STS) (episodes of sickness up to 4-weeks) has decreased to 1.26% across the Trust whilst long-term sickness has also decreased to 0.92%.

Unfilled vacancy rate: The Trust's unfilled vacancy rate is currently unavailable as the 2017/18 budgets have not yet been confirmed.

Agency usage for 2017/18 (year to date) stands at 2.3% of total paybill. The Trust has established a Better Value Scheme scrutinising all agency spend. Significant progress has already been made in converting agency staff to either permanent contracts or bank. All RTT validators will be converted by the end of May and the Trust has extensive recruitment campaigns underway for specific target staff groups in order to reduce agency further. NHS Improvement (NHSI) have set an agency spend ceiling for all Trusts (3% for GOSH, £6.525 million) and the Better Value Scheme aims to achieve overall savings of £250K.

Agency Measure	Spend YtD (April 2017)	Shifts breaching agency cap
RTT agency staff	£176k	0
Gastro review agency staff	£0	0
Business as usual agency staff	£467k	740
Total agency staff	£643k	740
Agency ceiling	£7,068k	

PDR completion rates The Trust overall appraisal rate stands at 90% - an increase of 6% since February 2017. Areas meeting the in-year target of 90% are West Division, IPP, Human Resources & OD, Nursing & Patient Experience, Development & Property Services and Research and Innovation.

Statutory & Mandatory training compliance: In April the compliance across the Trust remained at 90%. Currently, all but one of the directorates/divisions are meeting the in-year 90% compliance requirement, with the exception of West (at 89%). The significant improvements to StatMan compliance has been driven by:

- A Trust-wide focus to drive up compliance at all levels (accessibility of information, publicity via screensavers);
- Specific challenge to the appropriateness of training requirements per post within the training needs analysis.

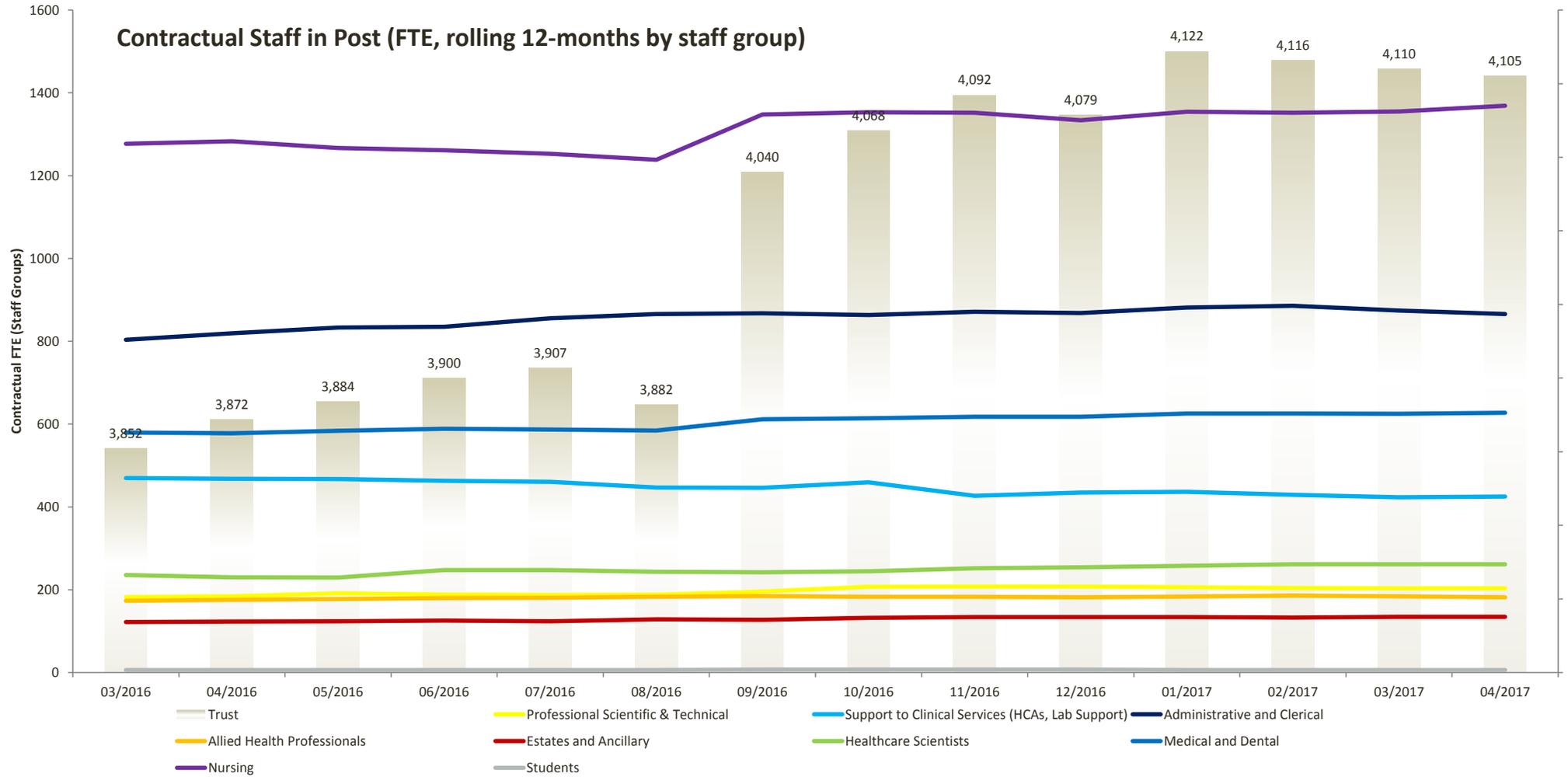
These reviews will continue over the forthcoming weeks including modelling supply and demand of training to ensure capacity is available and reviews to the methods of training to best fit demand and quality requirements

Turnover is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands at 15.7%; this reported value excludes non-voluntary forms of leavers (e.g. dismissals, TUPE, fixed-term and redundancies). Total (voluntary and non-voluntary) turnover has remained at 18.8% in April 2017. The (unadjusted) London benchmark figure is 15.1% (which includes voluntary and non-voluntary leavers).

Trust wide efforts are underway to reduce turnover and there is a separate work stream overseen by the Nursing Workforce Programme Board specifically targeted at reducing turnover of nurses.

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT

Division	Contractual Staff in Post (FTE)	Voluntary Turnover Rate (% FTE) <small>(voluntary leavers in 12-months in brackets, 14% green)</small>	Total Turnover Rate (% FTE) <small>(number of leavers in 12-months in brackets, 18% green)</small>	Sickness Rate (%) <small>(0-3% green)</small>	PDR Completion (%) <small>(target 90%)</small>	Statutory & Mandatory Training Compliance (%) <small>(target 90%)</small>	Agency (as % of total paybill, £) <small>(Max 0.5% Corporate, 2% Clinical)</small>	Bank (as % of total paybill, £) <small>(target 8%) (RAG TBC)</small>
West Division	1640	16.0% (262.2)	18.8% (277.9)	2.3	93%	89%	1.0%	5.7%
Barrie Division	1661	14.0% (231.6)	17.5% (259.5)	1.8	86%	90%	0.6%	4.5%
International	199	18.8% (37.4)	21.8% (39.4)	3.4	96%	98%	-0.2%	15.1%
Corporate Affairs	8	12.5% (1.0)	22.7% (2.0)	0.1	75%	91%	1.7%	0.0%
Clinical Operations	112	15.0% (16.8)	17.7% (16.8)	2.9	86%	92%	5.8%	10.1%
Human Resources & Organisational Development	78	23.9% (23.5)	31.4% (25.5)	2.9	90%	98%	0.0%	3.6%
Nursing & Patient Experience	81	7.4% (6.0)	13.2% (9.8)	1.7	94%	94%	0.0%	-0.5%
Medical Directorate	45	10.1% (4.6)	12.7% (5.0)	2.1	78%	93%	0.0%	2.0%
Finance	37	43.1% (16.0)	40.8% (19.0)	2.6	82%	100%	41.9%	2.9%
Development & Property Services	147	12.9% (18.9)	13.9% (19.9)	2.9	97%	95%	-2.5%	5.0%
Research & Innovation	95	24.8% (23.6)	26.6% (23.6)	1.8	91%	94%	1.3%	5.2%
Trust	4105	15.7% ▲ (643.6)	18.8% ► (698.3)	2.2% ▼	90.0% ▲	90.0% ►	2.3% ▼	5.4% ▼



**HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT**

Highlights & Actions

Sickness Rate

Actions

- Continued support to encourage line managers to attend the ER Bitesize training sessions, and bespoke sessions within the Divisions. On a monthly basis the Er team continue to report on the Bradford triggers for those staff that have reached the trigger. Regular meetings are held with Ward Sisters to discuss sickness management. Health and wellbeing; a number of initiatives are being launched in order to support employees at work such as mental health awareness and healthy activities over the next month.
- IPP - Regular meetings held with managers in IPP to discuss employees with sickness concerns which has improved over recent months. This is predominantly made up of short term sickness as they have a very low long term sickness rate.
- Regular meetings set up with service leads to provide additional support in managing sickness cases.

Agency Spend

Actions

- HRBPS are working within the Divisions to reduce agency usage by converting individuals from agency to permanent or bank contracts. This work is inline with NHSI requirements to reduce agency and breaches of payrates and duration.

Voluntary Turnover Rate

Actions

- There has been a significant amount of work undertaken over the past few months to better understand the broader turnover position - with specific focus on areas of low stability and high turnover. Whilst this is work in progress, there have been developments in also understanding the reasons why people leave and where they go. In addition, the work around nurse recruitment and retention is now a focused project under the Nursing Workforce Programme Board.
- A retention survey is on-going to obtain feedback from staff after they have been in post for 3 months
- Developing B5s into vacant B6 roles helps to decrease turnover of B5s
- Focus groups have been held and feedback is being reviewed from Band 6 nurses to support retention

PDR Completion

Actions

- Simplifying the reporting process of PDRs has supported managers in working towards their PDR targets. The HRBPs are continuing to support managers in identifying the PDRs that are required for completion.
- Performance management via divisional reviews continues.
- PDR rates now regularly reported and accessible via the intranet. Significant increases across all divisions
- Continued reminders to individuals and line managers

Statutory & Mandatory Training Compliance

Actions

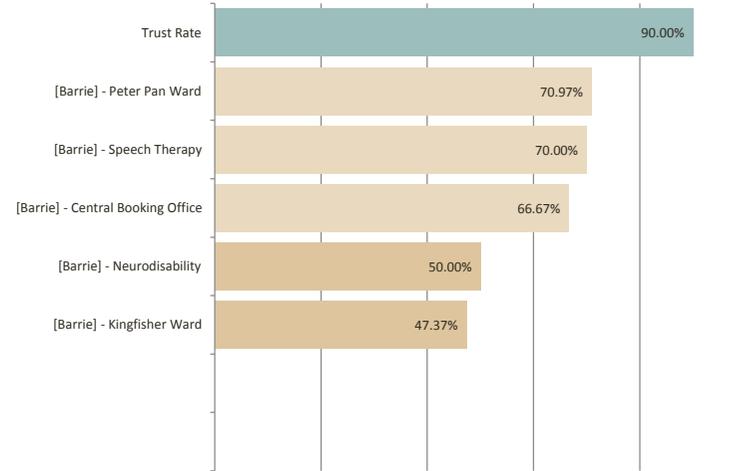
- More visibility through LMS
- Learning and Development & ER team will work with managers to identify those who are non-compliant including further developments to the new LMS
- Additional face to face sessions have been run for DPS staff. Information sheets sent out for online courses.
- Simplicity in reporting process to improve compliance

**HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT**

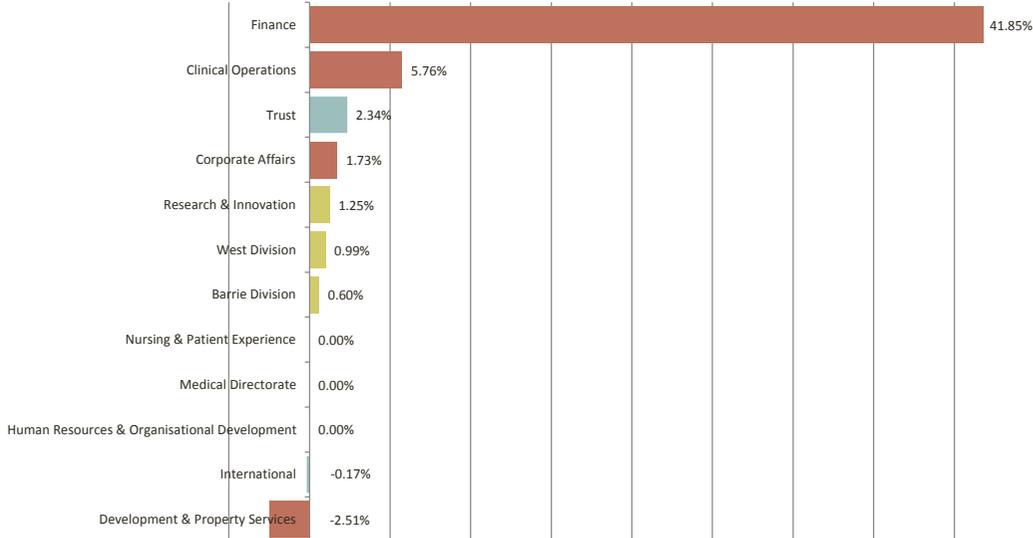
Divisional PDR (Target 90%)



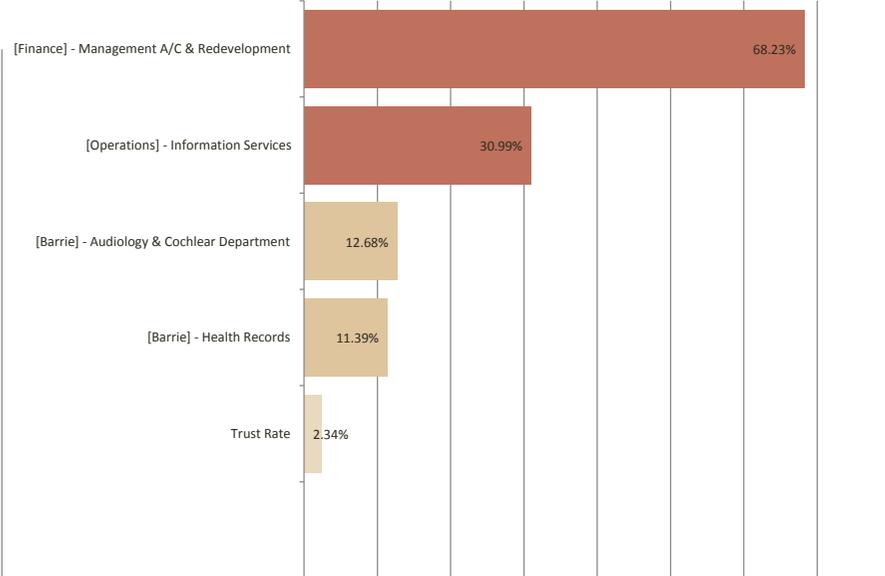
Exception Reporting PDR



Divisional Agency as % of paybill

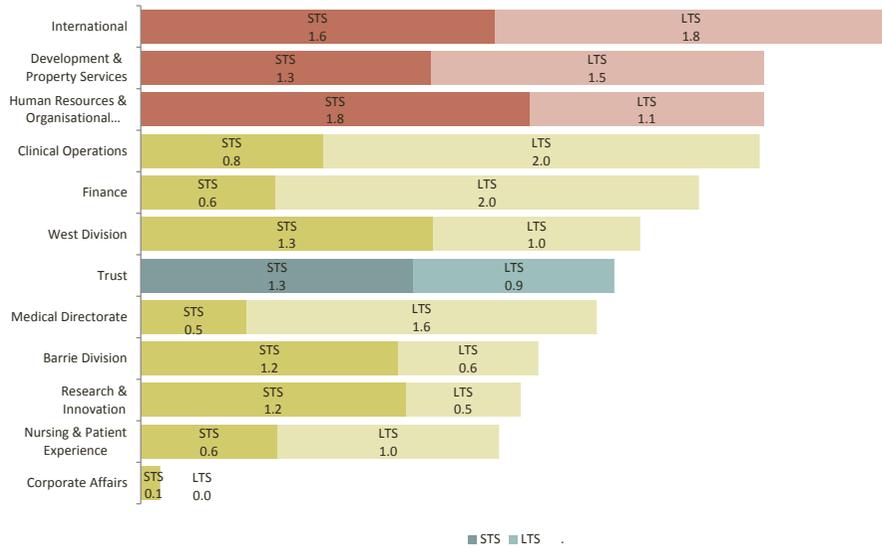


Exception Reporting Agency as % of Paybill

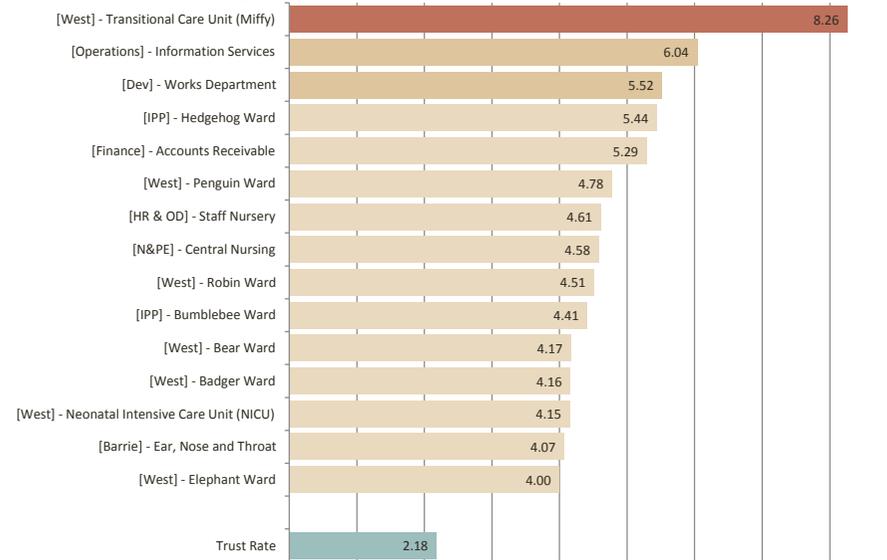


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT

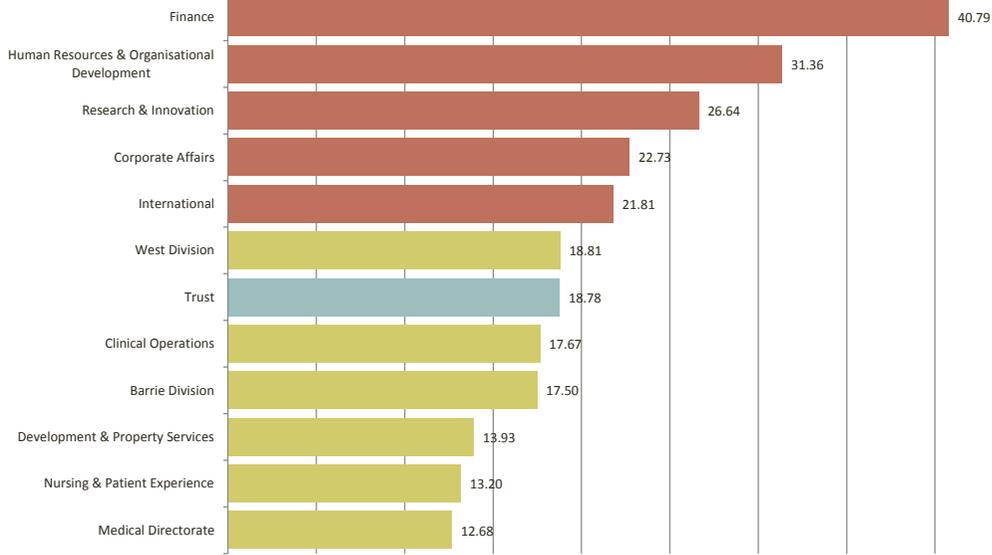
Divisional Sickness



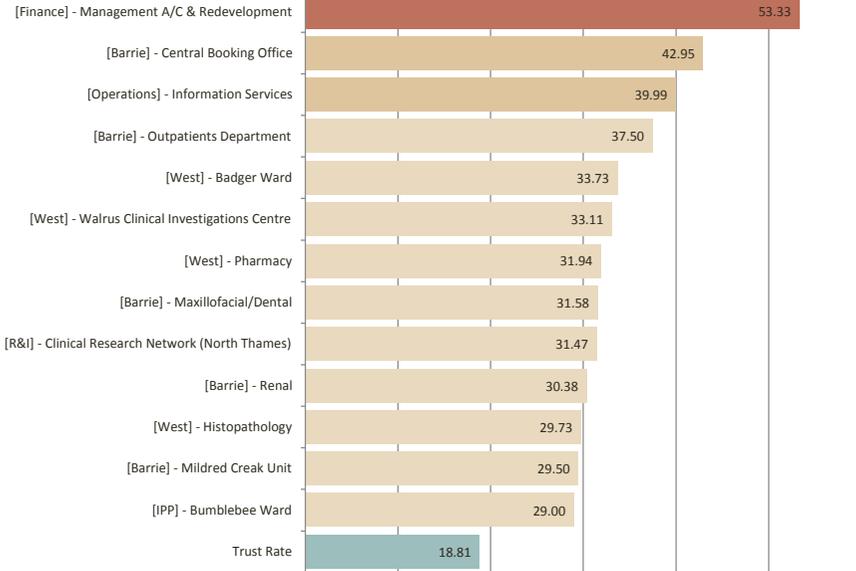
Exception Reporting Sickness



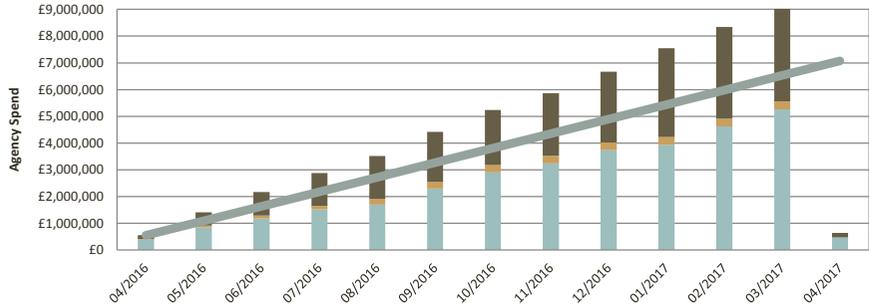
Divisional Turnover (Voluntary & Non-Voluntary)



Exception Reporting Turnover

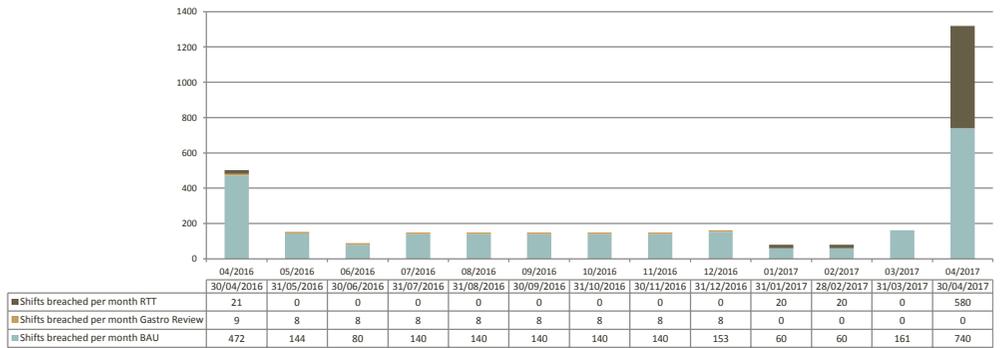


Agency Spend Ceiling (NHS Improvement Directive, Cumulative)



	30/04/2016	31/05/2016	30/06/2016	31/07/2016	31/08/2016	30/09/2016	31/10/2016	30/11/2016	31/12/2016	31/01/2017	28/02/2017	31/03/2017	30/04/2017
RTT	£153,012	£499,693	£873,238	£1,222,238	£1,601,238	£1,872,000	£2,056,000	£2,327,206	£2,647,649	£3,323,868	£3,435,807	£3,727,017	£176,196
Gastro Review	£27,447	£66,513	£110,233	£134,029	£214,638	£249,747	£278,685	£288,186	£290,176	£290,176	£290,176	£290,176	0
Agency BAU	£378,796	£845,945	£1,179,401	£1,516,005	£1,694,201	£2,297,941	£2,898,875	£3,243,474	£3,734,751	£3,934,848	£4,618,715	£5,266,128	£467,340

NHS Improvement Agency Rule Breaches (shifts per month, target zero)



Statutory & Mandatory Training Compliance (%)
(target 90%)



HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
 WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT

Division	Total Turnover Rate (% FTE) <small>(number of leavers in 12-months in brackets, <18% green)</small>	Total Turnover Rate (% FTE) <small>Monthly variation trend over 12 months</small>	Sickness Rate (%) <small>(0-3% green)</small>	Sickness Rate (% FTE) <small>Monthly variation trend over 12 months</small>	Contractual Staff In Post Trend (FTE) <small>Monthly variation trend over 12 months excludes temporary staff</small>
West Division	18.8% (277.9)		2.4		
Barrie Division	17.5% (259.5)		1.8		
International Division	21.8% (39.4)		3.4		
Corporate Affairs	22.7% (2.0)		1.0		
Clinical Operations	17.7% (16.8)		2.9		
Human Resources & OD	31.4% (25.5)		2.9		
Nursing & Patient Experience	13.2% (9.8)		1.7		
Medical Directorate	12.7% (5.00)		2.1		
Finance	40.8% (19.0)		2.6		
Development & Property Services	13.9% (19.9)		2.9		
Research & Innovation	26.6% (23.6)		1.8		
Trust	18.8% ▶ (698.0)		2.2% ▼		

The scale varies per division to enable a trend view for 12-month with sufficient detail (blue line). The red 'direction of travel' indicates the overall direction of travel across each of the 12-months. The 'total turnover rate' approximates to the total of each individual's months' turnover rate.

**Trust Board
25 May 2017**

2017/18 Finance Report – Month 1

Paper No: Attachment O

**Submitted by:
Loretta Seamer, Chief Finance Officer**

Enc: 1 – Finance Report

Purpose

The purpose of this paper is to update the Trust Board on progress at month 1 against the Trust financial plan for 2017/18.

Financial Position – Month 1

The Trust is reporting a year to date deficit of £2.5m (excluding capital donations and impairments); this is in line with plan. At the end of Month 1 the Trust is forecasting that it will achieve the NHSI Plan that was submitted for 2017-18.

Forecast Outturn and Control Total

The Control Total set for 2017/18 is £9.7 million and excludes depreciation on donated assets of £9.5 million.

Mth 1 Forecast Control Total	2017/18 Plan	FOT	Difference
Net Result (as per report)	72.3	72.3	0.0
Less Capital Donations	-72.1	-72.1	0.0
Net (Deficit) exc Donations, Inc STF	0.2	0.2	0.0
Plus depreciation on donated assets	9.5	9.5	0.0
Adjusted financial performance (control total basis)	9.7	9.7	0.0

Income

At the end of month 1, year to date income is £1.2m lower than plan. NHS Pass-through income and Private Patient Income were in line with plan. NHS income was £0.7m behind plan along with Non-Clinical Revenue, mainly R&D (which is offset by reduced expenditure) which was £0.5m behind plan.

The level of under delivery is relative to a significantly increased plan which relates to over delivery of clinical income in 2016/17 outturn. The under delivery is against a range of specialties and it is anticipated that this will be recovered throughout the remainder of the financial year.

Expenditure

Pay costs for the year to date are £0.4m lower than plan. Overall, the Trust's pay budget has increased in line with the anticipated increases for income for 2017-18 and not all posts have been filled to match the current establishment. Overall the Trust underspent on substantive staff by £1.8m though this was in part used to fund agency staff (£0.4m) and bank Staff (£1.0m).

Overall, Non-Pay was £0.7m lower than plan. Trust non pay costs are lower than plan on Blood and Drugs and other Clinical Supplies (£0.4 m), in part driven by the under delivery of income.

Other non-pay expenses are £0.3m lower than plan

Better Value

No actual spend reporting has been made against the Better Value this month. A full set of reports for monitoring the Better Value programme is being developed between informatics, finance and the PMO and reporting will follow in subsequent reports.

Risks

The delivery of the financial plan throughout 2017-18 is not without risk. The key areas of risk being monitored for 2017/18 are:

Risk/Assumption	Comment
£15m delivery of P&E savings	The full Better Value programme continues to be worked up in more detail and there is limited activity data at this stage of the financial year.
Achievement of CQUIN Income	The negotiation of CQUIN schemes are currently not finalised with the commissioner. Discussions have included a request for locally developed schemes relevant to GOSH.
IPP Income £1.4m higher than plan	The Plan includes the full year effect of the new Hedgehog ward and increase in IPP income on NHS wards. Overall the growth assumption is 10% or £5.6m on last year.
NHS activity and income	NHS income in the plan assumes the full QIPP amount of £7.5 million. The plan includes an adjustment to the final outturn of 2016/17. This was an agreement in the contract but yet to be finalised with NHSE.

Cash

The cash balance was £40.9m at the end of April a decrease of £1.55 million from the previous month. The main movements in cash were:

- Increase in cash from operating activities £1.2m;
- capital expenditure £2.76m;
- net increase in working capital £0.02m.

NHS Debt

NHS Debt was £14m of which the majority is within 30 days. There was slight decrease to debtor days which still remains within target at 14 days. The NHS debt over 365 days was £0.6m which increased from £0.4m in the prior period.

IPP Debt

IPP Debt was £31.1m and debtor days increased in month to 183 from 182. The IPP debt over 365 days was £4.1m which was an increase over the prior month of £0.2m

Creditor Days

Creditor days decreased in month to 28 days.

Capital Expenditure

M1 YTD capital expenditure was less than plan by £3.9m. The expenditure variance is analysed on the capital expenditure schedule in the attached report.

Inventory Days

Drug inventory days increased in month to 8. Non-Drug inventory days decreased in month to 62 days largely due to the level of inventory held for Audiology stock (42% increase); and

Haemophilia stock (26% decrease).
Action required from the meeting <ul style="list-style-type: none">To note the year to date financial position as at 30 April 2017.To note the risks to achievement of the 2017/18 plan.
Contribution to the delivery of NHS / Trust strategies and plans This paper details the Trusts delivery against its agreed Financial Plan for 2017/18.
Financial implications Non delivery of plan would affect receipt of STF funding.
Legal issues None
Who is responsible for implementing the proposals / project and anticipated timescales Chief Finance Officer/Executive Management Team
Who is accountable for the implementation of the proposal / project Chief Finance Officer

Finance and Activity Performance Report Month 1 – 2017/18

19 May 2017

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Summary	3
Income & Expenditure Financial Performance Summary	4
Income & Expenditure – Run Rate Analysis	5
Statement of Financial Performance & Capital Summary	6
Cash & Working Capital Summary	7
Agency Spend Summary	8
Income and Activity Summary	9
YOY Activity Summary	10

Finance Scorecard

	Our Money	April	YTD Target	Variance
Net Surplus/(Deficit)		(2.5)	(2.5)	0.0
Forecast Outturn		0.2	0.2	0.0
*P&E Delivery		TBA	TBA	
Pay Worked WTE Variance to Plan		TBA	TBA	
Debtor Days (IPP)		183.0	120	(63.0)
Quick Ratio (Liquidity)		1.9	1.7	0.2
**NHSI KPI Metrics		3.0	3.0	0.0

NHSI Key Performance Indicators				
KPI	Annual Plan	M1 YTD Plan	M1 YTD Actual	Rating
Liquidity	1	1	1	G
Capital Service Coverage	1	1	2	R
I&E Margin	1	4	4	A
Variance in I&E Margin as % of income	1	1	2	R
Agency Spend ^{mm}	1	1	1	G
Overall	1	2	2	G
Overall after Triggers	1	3	3	A

Comments

- For Month 1 (month ending 30 April 2017) the Trust is reporting a £2.5m deficit, excluding capital donations which is £3.1m less than plan due to lower capital expenditure on Charity funded projects (refer to page 6).
- The overall weighted NHSI rating for Mth1 was a 3. The main driver of the NHSI score is the I&E margin which the plan had anticipated as a deficit in month driven by the reduced working days in April that would lead to a reduced level of overall income.
- The IPP debtor days increased by 1 day from March 2017.

Trust Income and Expenditure Performance Summary

Year to Date for the 1 month ending 30 April 2017

2017/18											2016/17	CY vs PY	CY vs PY	
Annual Budget (£m)	Income & Expenditure	Month 1				Year to Date				Rating	YTD Actual (£m)	Variance		
		Budget	Actual	Variance		Budget	Actual	Variance		Actual		£m	%	
		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%					Current Year Variance
277.7	NHS & Other Clinical Revenue	20.6	19.9	(0.7)	-3.4%	20.6	19.9	(0.7)	-3.4%	R	1	19.8	0.1	0.5%
67.8	Pass Through	5.4	5.5	0.1	1.9%	5.4	5.5	0.1	1.9%			4.7	0.8	17.0%
60.7	Private Patient Revenue	4.9	4.8	(0.1)	-2.0%	4.9	4.8	(0.1)	-2.0%	A	2	5.0	(0.2)	-4.0%
47.9	Non-Clinical Revenue	3.8	3.3	(0.5)	-13.2%	3.8	3.3	(0.5)	-13.2%	R		3.4	(0.1)	-2.9%
454.1	Total Operating Revenue	34.7	33.5	(1.2)	-3.5%	34.7	33.5	(1.2)	-3.5%			32.9	0.6	1.8%
(248.4)	Permanent Staff	(20.2)	(18.4)	1.8	8.9%	(20.2)	(18.4)	1.8	8.9%			(17.1)	(1.3)	-7.6%
(0.2)	Agency Staff^	(0.1)	(0.5)	(0.4)	0.0%	(0.1)	(0.5)	(0.4)	0.0%	R		(0.6)	0.1	16.7%
(0.2)	Bank Staff^	(0.2)	(1.2)	(1.0)	0.0%	(0.2)	(1.2)	(1.0)	0.0%			(1.5)	0.3	20.0%
(248.8)	Total Employee Expenses	(20.5)	(20.1)	0.4	2.0%	(20.5)	(20.1)	0.4	2.0%	G	3	(19.2)	(0.9)	4.7%
(12.4)	Drugs and Blood	(1.0)	(0.6)	0.4	40.0%	(1.0)	(0.6)	0.4	40.0%	G		(0.7)	0.1	14.3%
(36.9)	Other Clinical Supplies	(3.1)	(3.0)	0.1	3.2%	(3.1)	(3.0)	0.1	3.2%	G		(3.0)	0.0	0.0%
(60.1)	Other Expenses	(5.1)	(4.8)	0.3	5.9%	(5.1)	(4.8)	0.3	5.9%	G		(4.1)	(0.7)	17.1%
(67.8)	Pass Through	(5.4)	(5.5)	(0.1)	-1.9%	(5.4)	(5.5)	(0.1)	-1.9%			(4.7)	(0.8)	-17.0%
(177.1)	Total Non-Pay Expenses	(14.6)	(13.9)	0.7	4.8%	(14.6)	(13.9)	0.7	4.8%	G	4	(12.5)	(1.4)	-11.2%
(425.9)	Total Expenses	(35.1)	(34.0)	1.1	3.1%	(35.1)	(34.0)	1.1	3.1%	G		(31.7)	(2.3)	-7.3%
28.2	EBITDA (exc Capital Donations)	(0.4)	(0.5)	(0.1)	25.0%	(0.4)	(0.5)	(0.1)	25.0%	R		1.2	(1.7)	-141.7%
(28.0)	Depreciation, Interest and PDC	(2.1)	(2.0)	0.1	-4.8%	(2.1)	(2.0)	0.1	-4.8%			(2.0)	0.0	0.0%
0.2	Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	(2.5)	(2.5)	0.0	0.0%	(2.5)	(2.5)	0.0	0.0%	G		(0.8)	(1.7)	-212.5%
6.2%	EBITDA %	-1.2%	-1.5%			-1.2%	-1.5%					3.6%	-5.1%	-140.9%
0.0	Impairments	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0%			0.0	0.0	0%
72.1	Capital Donations	4.8	1.7	(3.1)	-64.6%	4.8	1.7	(3.1)	-64.6%		5	3.3	(1.6)	-48.5%
72.3	Net Result	2.3	(0.8)	(3.1)	-134.8%	2.3	(0.8)	(3.1)	-134.8%			2.5	(3.3)	-132.0%

Notes

- NHS income (excluding pass through) YTD is adverse to plan by £0.7m.
- Private patient income YTD is £0.1m adverse to plan.

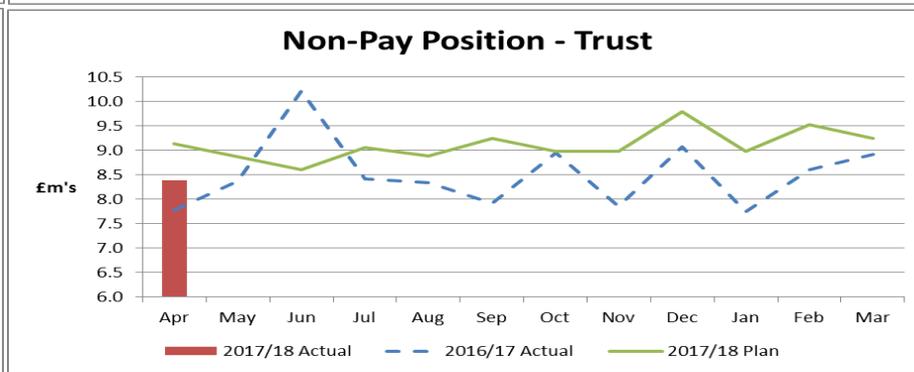
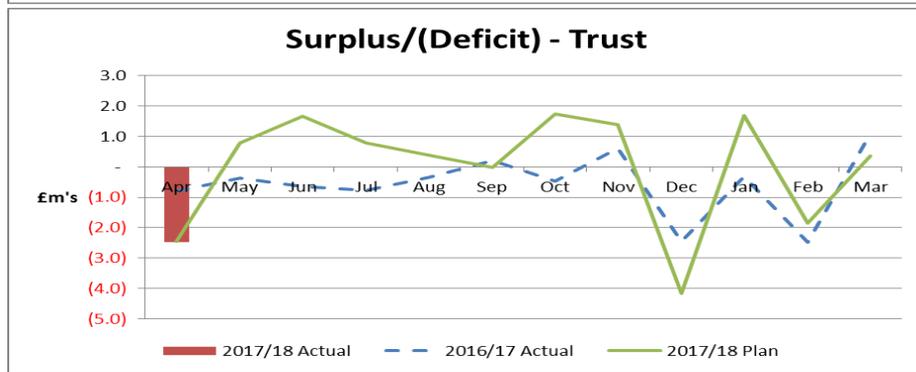
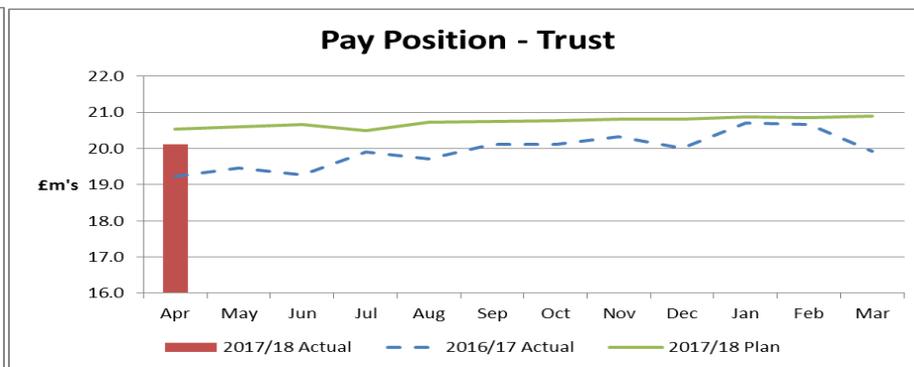
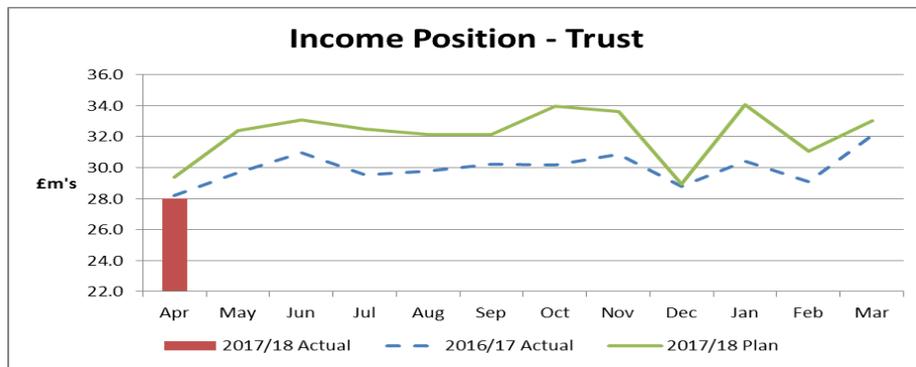
Note: a detailed NHS income and activity breakdown is provided on Page 9.

- Pay is favourable to plan in Month 1 by £0.4m, with agency spend below the agency NHSI ceiling.
- Non pay excluding pass through in Month 1 is £0.8m favourable to plan.
- Capital Donations of £1.7m in Month 1 which was £3.1m lower than plan.

^Agency ceiling for 2017/18 is £6.5m

^This is measured against the agency ceiling of £6.5m

Trust Income and Expenditure Performance Summary Year to Date for the 1 month ending 30 April 2017



Income

- Private Patient income in Month 1 is £0.1m behind plan largely due to revised bad debt provision (£0.6m).
- NHS & Other Clinical Revenue is £0.7m behind plan due to the reduced working days in April 2017 and therefore reduced activity although income targets have been phased to reflect this. This reduced activity includes SNAPS cancellation and Neurosurgery (£0.7m) The main drivers of this are the phasing of RTT growth and the impact of the HRG4+ casemix..

Pay

- For Month 1 the pay spend is £0.7m favourable to plan. There was a reduction of pay spend in PICU/NICU as the expansion nursing posts are still in the process of recruitment.
- The Trust pay budget profile assumes no agency RTT validation staff. The pay relating to PICB opening is phased from Month 5.

Non Pay

- For Month 1 the non pay spend is £0.8m favourable to plan due to the reduced activity in Month 1.

Surplus/Deficit

- In Month 1 the surplus is on plan with the reduced operating income offset by decrease pay and non pay spend.

Trust Income and Expenditure Performance Summary

Year to Date for the 1 month ending 30 April 2017

Statement of Financial Position	31 Mar 2017 Actual	30 Apr 2017 Plan	30 Apr 2017 Actual
	£m	£m	£m
Non-Current Assets	430.2	475.7	432.7
Current Assets (exc Cash)	74.4	82.9	77.8
Cash & Cash Equivalents	42.5	42.2	40.9
Current Liabilities	(56.1)	(67.7)	(58.7)
Non-Current Liabilities	(5.8)	(5.7)	(5.7)
Total Assets Employed	485.2	527.5	487.0

Capital Expenditure	Annual Plan	30 Apr 2017 Plan	30 Apr 2017 Actual	YTD Variance
	£m	£m	£m	£m
Redevelopment – Donated	37.8	1.9	0.9	1.0
Medical Equipment – Donated	19.1	2.2	0.8	1.4
Estates – Donated	0.0	0.0	0.0	0.0
ICT – Donated	15.2	0.7	0.0	0.7
Total Donated	72.1	4.8	1.7	3.1
Redevelopment & equipment - Trust Funded	11.1	0.9	0.4	0.5
Estates & Facilities - Trust Funded	3.7	0.4	0.1	0.3
ICT - Trust Funded	7.2	0.3	0.4	(0.1)
Contingency	1.0	0.1	0.0	0.1
Total Trust Funded	23.0	1.7	0.9	0.8
Total Expenditure	95.1	6.5	2.6	3.9

Redevelopment donated

There was a reduced spend in Development – Donated against plan due to a time slippage in the following projects:

- Bernard Street 1st floor (may become Trust-funded) £0.2m
- IMRI £0.5m
- Phase 4 £0.3m

Medical Equipment – Donated

There was a reduced spend against plan due to Phase 2B equipment delivery needing re-phasing due to building project delays (£0.8m). There was also a delivery slippage in NICU/PICU (£0.2m)

Trust Income and Expenditure Performance Summary

Year to Date for the 1 month ending 30 April 2017

Bridge M1 Cash Plan to Actual (£m)

Cash

The closing cash balance was £40.9m, £1.3m lower than plan. This was largely due to higher than planned EBITDA (£1.8m); lower than planned trust funded capital expenditure (£0.8m); and the movement on working capital (£3.9m).

The movement on working capital (£3.9m) largely relates to lower than planned non capital payables (£6.4m); Capital payables (£2.6m);

In addition, trade receivables were £5.1m lower than plan.

NHS Debtor Days

There was slight decrease to debtor days which still remains within target at 14 days.

IPP Debtor Days

IPP debtor days decreased in month to 183.

Creditor Days

Creditor days decreased in month to 28 days.

Non-Current Assets

Non-current assets increased by £1.2m in month, the effect of capital expenditure of £2.6m less depreciation of £1.4m. The closing balance is £43.0m lower than plan. This is largely due to the opening balance for the year being £39.2m less than plan of which the movement on buildings valuation represents £36.9m and the remainder (£2.3m) being capital expenditure slippage compared to the forecast on which the plan was based. In addition M1 YTD capital expenditure was less than plan by £3.9m and depreciation less than plan by £0.2m. The expenditure variance is analysed on the capital expenditure schedule.

Inventory Days

Drug inventory days increased in month to 8.

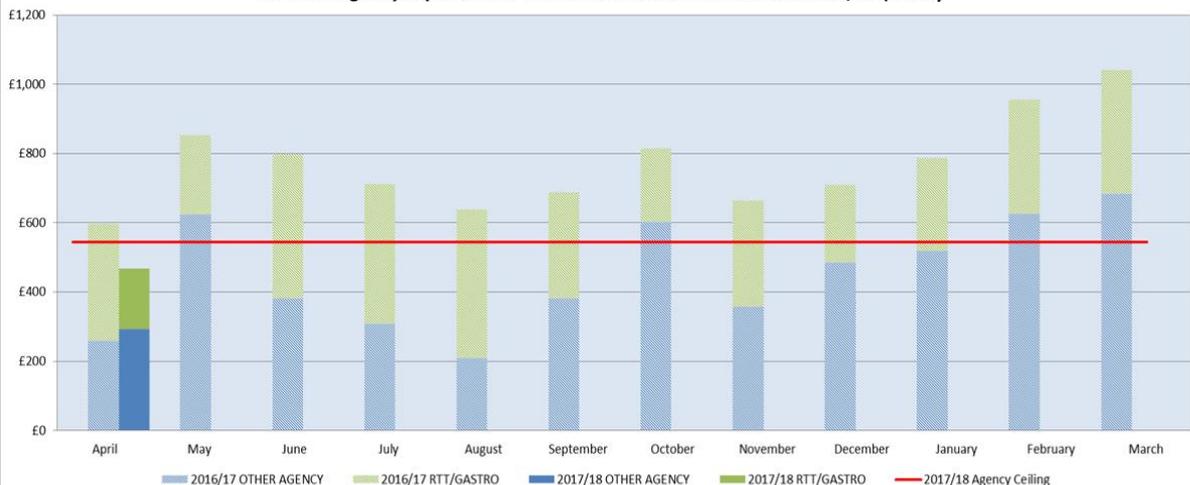
Non-Drug inventory days decreased in month to 62 days largely due to the level of inventory held for Audiology stock (42% increase); and Haemophilia stock (26% decrease)

Working Capital	31-Mar-16	31-Mar-17	30-Apr-17	RAG
NHS Debtor Days (YTD)	11.8	19.4	14.8	G
IPP Debtor Days	197.1	182.0	183.0	R
IPP Overdue Debt (£m)	13.0	22.5	24.2	R
Inventory Days - Drugs	6.0	4.0	8.0	G
Inventory Days - Non Drugs	51.0	63.0	62.0	R
Creditor Days	35.0	34.5	28.7	G
BPPC - Non-NHS (YTD) (number)	85.2%	82.3%	88.8%	R
BPPC - Non-NHS (YTD) (£)	87.8%	87.8%	91.6%	R

Trust Income and Expenditure Performance Summary

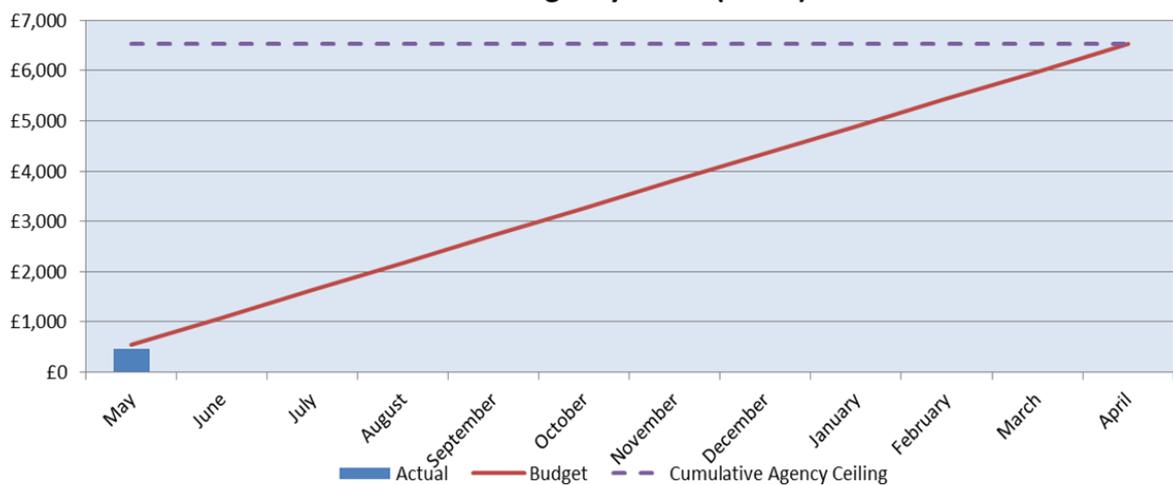
Year to Date for the 1 month ending 30 April 2017

All Staff Agency Expenditure - 12 Months Actual and Forecast 2017/18 (£'000)



- As at 30 April across the Trust, there are approximately 22 agency staff still working on RTT, (compared to 65 agency staff at 31 December 2016)
- In Month 1 the Trust is currently running below its NHSI notified cost ceiling for agency staff.

Cumulative Agency Trend (£'000)



Trust Income and Expenditure Performance Summary

Year to Date for the 1 month ending 30 April 2017

	2017/18 YTD								2016/17 YTD					
	Income				Activity				Income			Activity		
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan	Actual *	Variance	Variance %	Actual £'000	Variance 16/17 to 15/16 £'000	Variance 16/17 to 15/16 %	Actual	Variance 16/17 to 15/16	Variance 16/17 to 15/16 %
Day case	1,873	1,730	(143)	-7.6%	1,565	1,290	(275)	-17.6%	2,149	(419)	-19.5%	1,730	(440)	-25.4%
Elective	4,247	4,870	623	14.7%	1,390	885	(505)	-36.3%	4,603	267	5.8%	1,074	(189)	-17.6%
Elective Excess Bed days	213	20	(193)	-90.5%	545	38	(507)	-93.0%	299	(278)	-93.2%	540	(502)	-93.0%
Elective	4,460	4,890	430	9.6%					4,902	(11)	-0.2%			
Non Elective	1,399	1,024	(375)	-26.8%	421	113	(308)	-73.1%	859	165	19.2%	123	(10)	-8.1%
Non Elective Excess Bed Days	167	4	(163)	-97.6%	416	6	(410)	-98.6%	196	(192)	-98.0%	412	(406)	-98.5%
Non Elective	1,565	1,028	(537)	-34.3%					1,056	(27)	-2.6%			
Outpatient	2,847	2,677	(170)	-6.0%	11,425	10,479	(946)	-8.3%	3,056	(379)	-12.4%	11,903	(1,424)	-12.0%
Undesignated HDU Bed days	396	269	(126)	-31.9%	585	209	(376)	-64.3%	426	(157)	-36.8%	414	(205)	-49.5%
Haem/Onc Other	0	0	0	0.0%	0	0	0	0.0%	0	0	0.0%	0	0	0.0%
Non Consortium HDU Bed days	0	0	0	0.0%	0	0	0	0.0%	0	0	0.0%	0	0	0.0%
Picu Consortium HDU	214	242	28	13.2%	289	243	(46)	-15.9%	273	(30)	-11.1%	286	(43)	-15.0%
HDU Beddays	610	512	(98)	-16.1%	874	452	(422)	-48.3%	699	(187)	-26.8%	700	(248)	-35.4%
Non Consortium ITU Bed days	0	0	0	0.0%	0	0	0	0.0%	0	0	0.0%	0	0	0.0%
Picu Consortium ITU	2,590	2,836	246	9.5%	924	1,025	101	10.9%	2,199	637	29.0%	915	110	12.0%
PICU ITU Beddays	2,590	2,836	246	9.5%	924	1,025	101	10.9%	2,199	637	29.0%	915	110	12.0%
Ecmo Bedday	80	58	(22)	-27.3%	15	11	(4)	-26.7%	54	4	7.2%	10	1	10.0%
Psychological Medicine Bedday	93	102	9	9.3%	231	253	22	9.5%	84	18	21.1%	212	41	19.3%
Rheumatology Rehab Beddays	124	92	(32)	-26.0%	217	161	(56)	-25.8%	94	(3)	-2.8%	168	(7)	-4.2%
Transitional Care Beddays	238	223	(15)	-6.2%	164	154	(10)	-6.1%	246	(23)	-9.2%	172	(18)	-10.5%
Total Beddays	535	475	(60)	-11.2%	627	579	(48)	-7.7%	479	(3)	-0.7%	562	17	3.0%
Packages Of Care Elective	(615)	(671)	(57)	9.2%					581	(1,252)	-215.6%			
Highly Specialised Services (not above)	2,416	2,398	(18)	-0.7%					2,204	194	8.8%			
Other Clinical	3,236	2,879	(357)	-11.0%					2,107	772	36.7%			
Outturn adjustment	0	0	0	0.0%					0	0	0.0%			
STF Funding	0	0	0	0%					0	0	0%			
Pricing Adjustment	248	383	136	54.8%					0	383	0%			
Non NHS Clinical Income	646	815	169	26%					386	429	111%			
NHS and Other Clinical Income	20,411	19,952	(459)	-2.2%					19,816	136	0.7%			

Elective/Non Elective

- Bone Marrow Transplant income has increased in Month 1 with 9 transplants in month of which 5 were unrelated donor's.

Day case

- There was reduced day case activity in Month 1 due to the reduced working days in Month.

Outpatients

- There is currently a better value scheme (£0.3m) being held centrally however this will be allocated in year.

Bed Days/ITU bed days

- Critical care had one of its strongest performing months for bed days.

Other Clinical

- This includes income for CQUIN and the target for the local pricing review.
- CQUIN income is below plan to take account of risk to full delivery.

*Activity = Billable activity

*Activity is an extract from SLAM taken at Day 1 and is subject to changes following coding completion

Total Trust Inpatient and Outpatient Activity

Year on Year trend analysis

Prior Year 2016/17													Activity Analysis		Year 2017/18		Change YOY	%Change YOY
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Apr	Total YTD				
													Inpatients					
													Number of Discharges					
2,082	2,061	2,229	2,040	2,162	2,031	1,972	2,075	1,800	2,129	1,949	2,205	24,735	Day Case	1,787	1,787	(295)	-14.2%	
													Overnight:					
1,155	1,153	1,256	1,248	1,170	1,177	1,101	1,195	1,064	1,083	1,142	1,269	14,013	Elective	1,086	1,086	(69)	-6.0%	
64	67	65	63	59	75	62	71	75	75	51	74	801	Non Elective	73	73	9	14.1%	
164	175	178	152	158	169	156	188	214	197	163	159	2,073	Non Elective (Non Emergency)	171	171	7	4.3%	
157	171	182	188	181	180	165	186	159	194	189	204	2,156	Regular Attenders	177	177	20	12.7%	
3,622	3,627	3,910	3,691	3,730	3,632	3,456	3,715	3,312	3,678	3,494	3,911	43,778	Total Discharges	3,294	3,294	(328)	-9.1%	
													Beddays					
760	733	841	760	829	847	736	748	651	793	703	774	9,175	Day Case	639	639	(121)	-15.9%	
0.37	0.36	0.38	0.37	0.38	0.42	0.37	0.36	0.36	0.37	0.36	0.35	0.37	Day ALOS	0.4	0.4	(0)	-2.0%	
													Overnight:					
4,686	5,197	5,577	5,565	5,470	5,456	5,680	5,478	5,174	5,447	5,398	5,503	64,632	Elective	5,447	5,447	761	16.2%	
561	713	610	494	526	687	808	668	668	589	606	710	7,639	Non Elective	709	709	148	26.5%	
2,133	2,267	2,044	2,324	2,181	2,033	2,160	2,218	2,395	2,453	2,229	2,330	26,767	Non Elective (Non Emergency)	2,185	2,185	52	2.5%	
0	1	1	1	1	4	1	2	1	22	100	101	235	Regular Attenders	105	105	105	105.0%	
7,380	8,178	8,232	8,383	8,178	8,180	8,649	8,366	8,238	8,511	8,333	8,645	99,273	Total Overnight Beddays	8,446	8,446	1,066	14.4%	
4.79	5.22	4.90	5.08	5.22	5.11	5.83	5.10	5.45	5.49	5.39	5.07	5.2	Overnight ALOS	5.6	5.6	0.4	17.0%	
													Midnight Census (ON Bed days)					
4,452	4,853	4,543	4,785	4,557	4,472	4,523	4,866	4,192	4,330	4,243	4,904	54,720	Elective	4,587	4,587	135	3.0%	
643	557	494	428	424	373	425	403	458	508	559	757	6,029	Non Elective	636	636	(7)	-1.1%	
1,891	1,973	1,980	2,040	2,105	1,928	2,076	1,854	2,011	2,059	1,766	1,762	23,445	Non Elective (Non Emergency)	1,999	1,999	108	5.7%	
			1									1	Regular Attenders		0	0	0.0%	
6,986	7,383	7,017	7,254	7,086	6,773	7,024	7,123	6,661	6,897	6,568	7,423	84,195	Total	7,222	7,222	236	3.4%	
233	238	234	234	229	226	227	237	215	222	235	239	231	Average ON Beds Utilised	241	241	10	4.4%	
													Critical Care Beddays					
359	397	299	337	346	345	327	474	368	446	414	497	4,609	Elective	345	345	(14)	-3.9%	
196	132	82	90	120	63	62	71	80	162	163	233	1,454	Non Elective	200	200	4	2.0%	
482	468	596	575	582	612	627	487	625	509	415	428	6,406	Non Elective (Non Emergency)	563	563	81	16.8%	
1,037	997	977	1,002	1,048	1,020	1,016	1,032	1,073	1,117	992	1,158	12,469		1,108	1,108	71	6.9%	
35	32	33	32	34	34	33	34	35	36	35	37	34		37	37	2	6.9%	
													Outpatients					
19,890	19,858	21,229	20,293	20,176	22,067	21,050	23,342	18,434	22,013	21,130	24,047	253,529	Outpatient Attendances (All)	17,573	17,573	(2,317)	-11.6%	
3,821	3,872	4,125	3,880	3,839	4,169	3,913	4,304	3,340	4,109	3,970	4,352	47,694	First Outpatient Attendances	3,393	3,393	(428)	-11.2%	
16,069	15,986	17,104	16,413	16,337	17,898	17,137	19,038	15,094	17,904	17,160	19,695	205,835	Follow Up Outpatient Attendances	14,180	14,180	(1,889)	-11.8%	
4.2	4.1	4.1	4.2	4.3	4.3	4.4	4.4	4.5	4.4	4.3	4.5	4.3	New to Review Ratio	4.2	4.2	(0.0)	-0.6%	

Inpatients:
The total number of inpatients discharged year on year by 9.1%. This has been offset by the increased overnight beds in particular non elective patients 5.7%. Total Overnight bed days have increased by 14.4% Year on Year due to the growth in inpatient elective activity.

Outpatients:
The total number of outpatients has decreased by -11.6%.

* Note that this is all Trust activity

Trust Board 25th May 2017	
Staff Friends and Family Test results – Quarter 4 2016/17	Paper No: Attachment P
Submitted by: Director of HR&OD	
Aims / summary To provide a report of latest Staff Friends and Family test results and actions	
Action required from the meeting To note the actions	
Contribution to the delivery of NHS Foundation Trust strategies and plans Staff FFT is an NHS England requirement and allows the Trust to monitor staff satisfaction and awareness of Values and Vision in-year.	
Financial implications None	
Who needs to be told about any decision? Feedback is communicated to staff	
Who is responsible for implementing the proposals / project and anticipated timescales? Deputy Director of HR&OD	
Who is accountable for the implementation of the proposal / project? Director of HR&OD	

Great Ormond Street Hospital for Children NHS Foundation Trust

Staff Friends and Family Test results – Quarter 4 2016/17

Introduction and background

GOSH surveys a third of its staff each quarter for the Staff Friends and Family Test. In quarter 3, the annual staff survey replaces Staff FFT.

The national survey is made up of two questions which ask staff if they would be likely to recommend GOSH as a place to be treated, or as a place to work. In addition, GOSH has added specific questions relating to Our Always Values and the GOSH vision.

Results

Over 600 staff completed the survey in quarter 4 2016/17.

Recommending GOSH as a place to be treated and as a place to work

	Q1 2015	Q2 2015	Q4 2015/16	Q1 2016	Q2 2016	Q4 2016/17
Recommended for care	94%	96%	95%	97%	97%	96%
Recommended as place to work	71%	71%	74%	76%	75%	77%

The data indicates a consistency of scoring across the two questions. GOSH is within the upper quartile of all NHS trusts for scores in both questions, but staff score the Trust particularly highly as a place to receive treatment.

Narrative from staff

Staff are invited to give reasons for their responses and these are now analysed to illustrate key themes. The key themes arising this quarter include:

Care or Treatment:

- Patient care – second to none, professional and friendly staff
- General high satisfaction with care / treatment
- High staff expertise and skill
- Research and specialism – excellent services offered

Place to work

- Good levels of safety are recognised
- Colleagues are appreciated and enjoyable to work with. They are friendly and helpful
- Management support was appreciated by many respondents but comments were made around about general management / staffing and pay related issues

Awareness of Our Always Values and Trust Vision

Question	% Score Q1 2015	% Score Q2 2015	% Score Q4	% Score Q1 2016	% Score Q2 2016	% Score Q4
I am aware of Our Always Values – Always Welcoming, Helpful, Expert and One Team	93%	97%	97%	98%	98%	97%
I see staff at GOSH demonstrating Our Always Values in how they behave	75%	75%	81%	79%	82%	79%
I know what the GOSH vision for 2020 is	42%	47%	42%	43%	44%	42%
I understand how my work contributes to achieving the GOSH vision	63%	67%	65%	63%	67%	65%

- The questions relating to Our Always Values continue to show a very high level of awareness of Our Always Values, which were launched in March 2015.
- Comments relating to this question suggest that staff are largely very supportive of Our Always Values and recognise their importance in both how we deliver care and how we work with each other. However, there is a clear theme that the behaviours which underpin the values are not always displayed by all staff.
- Communication around the GOSH vision including the Strategy Refresh is in its early stages, which is reflected in the lower awareness levels. Staff often express a desire to know more and be involved in developing and delivering the vision.

A consistent theme of the one team value being the hardest to achieve was apparent in the comments made by respondents.

Next steps

- Divisional and Directorate-level feedback (which includes staff comments) is being shared with the respective management teams by their respective HR Business Partners in order to allow them to develop local responses or inform existing work streams, especially local plans to address the annual staff survey findings.
- At a corporate level, the results and comments inform ongoing work on Our Always Values.

Action required

The Trust Board is asked to note the results of the Staff Friends and Family test and the actions outlined above.

Trust Board 25 May 2017	
Safeguarding Annual Report 2016-17	Paper No: Attachment Q
Submitted by: Juliette Greenwood	
Aims / summary Provide a summary report of Trust progress, activity and achievements 2016-2017 and identify challenges and priorities for 2017-2018.	
Action required from the meeting The Board of Directors are asked to note the priorities for the year ahead and continue to support the development of safeguarding children and young people arrangements.	
Contribution to the delivery of NHS Foundation Trust strategies and plans CQC Core Standard 2 Child Protection. Requirement also from NHS England (London), Camden Safeguarding Children Board and Camden Clinical Commissioning Group for Trusts to provide a Safeguarding Annual Report.	
Financial implications None	
Who needs to be told about any decision? Juliette Greenwood - Executive Lead for Safeguarding	
Who is responsible for implementing the proposals / project and anticipated timescales? Juliette Greenwood	
Who is accountable for the implementation of the proposal / project? Juliette Greenwood	

Safeguarding Children & Young People Annual Report 2016 / 2017

By

Juliette Greenwood

Chief Nurse & Executive Lead for Safeguarding

With support from the Named Professionals and Head of Social Work



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4. Challenges and Key Priorities for 2017 / 2018	Page 9

Executive Summary:

Strengths:

Substantive Named Doctor appointed for 6 Programmed Activities (a programmed activity consists of 4 hours), and joined the Trust on 20/02/2017.

Increased activity delivered in most areas resulting in significant pressure on resources throughout the year.

A new bespoke e-learning training package completed and launched for staff requiring Level 3 safeguarding children training.

Diversifying learning opportunities for staff; for example the Child Abuse Pathology Meeting which incorporates learning from Serious and other Case Reviews and promotes discussion from a multi-agency perspective with input from external professionals.

Key areas for Development:

Continue to improve collaborative working and interface between Safeguarding and Social Work Services.

Complete the substantial review of Safeguarding Children and Young People Policy.

Revision of the under 2 Non-accidental Head Injury Pathway to be integrated into a general Unintentional Injury Pathway.

Establishing a consistent social information collection system which will include informing parents about Information Sharing practice within the Trust.

Building upon and expanding the system for complex case supervision and tracking already well embedded within the Gastroenterology Service to cover the whole Trust.

To build upon our current training programme to staff who require an enhanced knowledge of Safeguarding Children in line with the Intercollegiate Document Safeguarding Children and Young People; roles and competences for healthcare staff.

To further increase the provision and uptake of safeguarding supervision across the Trust.

1. Introduction and Overview

Great Ormond Street Hospital (GOSH) is an international centre of excellence in child healthcare. It receives more than 268,000 patient visits every year across 58 different specialties. Most of the children we care for are referred from other hospitals throughout the UK and overseas.

The Children Act 2004 (Section 11) places a duty upon all NHS Provider Services to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children. The Trust is expected to ensure that its' provider arrangements are robust and that safeguarding and promoting the welfare of children is integral to clinical governance and audit arrangements.

This annual report relates to the period from 01/04/2016 – 31/03/2017.

The Safeguarding Children and Young People Annual Report seeks to inform the Trust Board of the responsibilities and value delivered by the Trust Safeguarding Team and will update on progress on work streams agreed within the work plan for 2016 / 2017.

2. Governance and Accountability arrangements

2.1 Safeguarding Team

The Safeguarding Team is accountable to the Chief Nurse / Executive Lead for Safeguarding Children and Young People.

The structure of the Children and Young People Safeguarding Team has been enhanced by the appointment of a substantive Named Doctor position in February 2017, providing an increase from 4 to 6 programmed activities. A six month full time secondment of an experienced Band 7 Safeguarding Nurse Specialist will commence in April. The Safeguarding Team as of 31.03.17 consists of:-

- Head of Safeguarding and Named Nurse 1 WTE (whole time equivalent)
- Named Doctor (substantive) 6 programmed activities (24 hours week).
- Band 7 Safeguarding Nurse Specialist 1 WTE
- Senior Safeguarding Team Administrator 1 WTE
- Team Administrator 0.7 WTE

In line with Lampard Recommendation 5, the Trust undertook a review of safeguarding resources, structures and processes. A number of recommendations were made which are in the process of being adopted, including the appointment of the Named Doctor with increased PAs. In addition the Trust Board requested a peer review of safeguarding cases to provide further assurance that the organisation's arrangements are robust and operate effectively.

The team have been involved in 854 cases this year which is an increase from 491 cases in the year 2015/16. There have been 29 requests for chronologies from external organisations. The Trust has contributed to 6 Serious Case Reviews (SCRs).

2.2. GOSH Social Work Service

The service consists of a Head of Profession/Service post, 5 senior Social Work(SW) Practitioner (clinical / management posts), 12.5 Social Work WTEs, 1 Family Support Worker, 2 Family Support Officers and 1 Psycho-Social Liaison worker. A successful recruitment of 4 new social work posts has completed a full establishment of staff. Over the last year there has been a review of the social work attachments across the hospital and a review of social work capacity versus family support and a decision has been made to convert one social work post into a family support worker post.

The service is funded from the GOSH charity and NHS funding with a dedicated CLIC (Cancer and

Leukaemia in Childhood) Sargent Service that works as part of the social work service but with a particular remit. Of the total composition of the social work service 4.5 WTE posts are funded by CLIC Sargent and this includes a dedicated senior practitioner. There is a service level agreement which requires this service to be overseen by the GOSH Head of Social Work.

The social work service maintains links with the local authority to ensure that GOSH takes account of developments within the social work profession which is undergoing significant developments in terms of new accreditation requirements and the Children and Social Work Act 2017.

The service is also relooking at the current recording practice to ensure that we are compliant with social work professional standards and as part of this we are undertaking an audit to identify any areas requiring improvement and we have introduced a regular auditing programme. We have also ensured that all staff within the service have updated their Camden Local Authority Child Protection (CP) training.

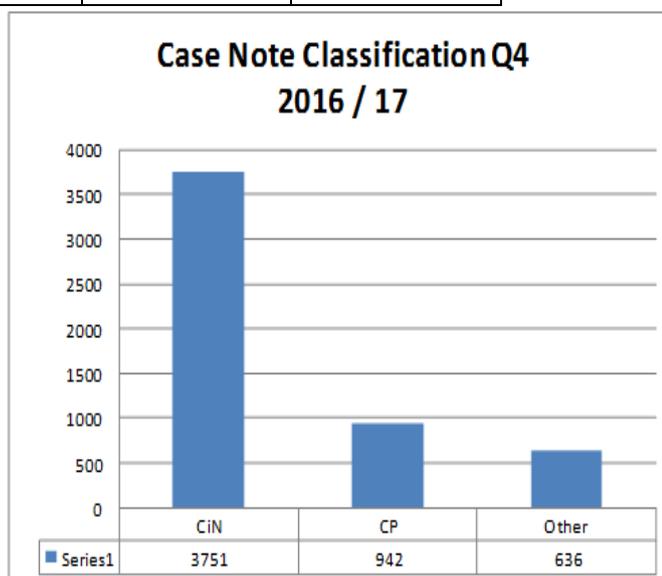
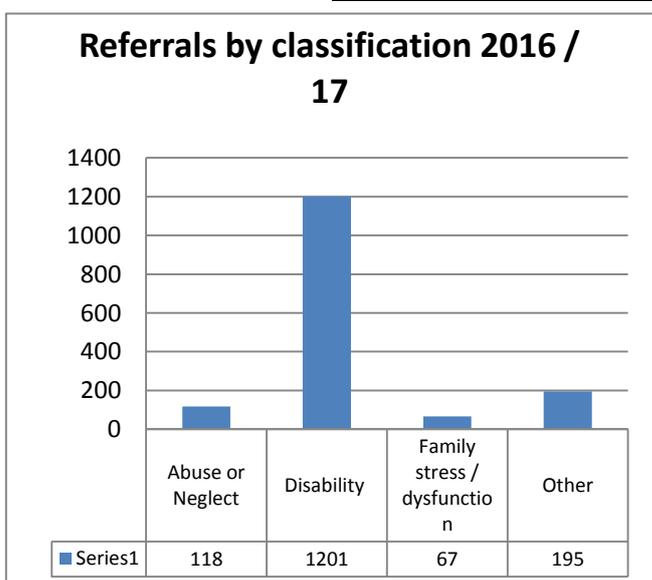
The Social Work service at GOSH provides support to all wards and units within the hospital, operating a 9-5 duty service which ensures that there is always a social worker and a senior practitioner available. When any member of staff identifies child protection concerns, they make an electronic referral to the Social Work Service.

The Social Work and Safeguarding teams have worked closely together to ensure that there is an integrated response to referrals identifying safeguarding/child protection concerns with information being shared routinely across both teams. We are undertaking further work to strengthen information sharing working closely with the new Named Doctor.

We have also undertaken a social work survey. This does not relate specifically to safeguarding activity albeit a significant proportion of the social work service activity involves safeguarding in its broadest sense. 96% of families surveyed said that the social work service met or exceeded their expectations and 98% of families reported that they would be extremely likely or likely to recommend the Social Work Team to someone in a similar situation.

Referrals have increased significantly in 2016/17 compared with 2015/16, which can be partly explained by significant staff vacancies but also by greater compliance from staff in recording all activity that is referred into the social work service.

2013/14	2014/15	2015/16	2016/17
1287	1183	945	1510



Work is being undertaken to improve the efficiency and reliability of data collection across the department. There are several different software systems deployed into which data is inputted by, or gleaned from, which future data management solutions are seeking to simplify.

2.3 Internal Governance Structure

The Safeguarding Children Group (SCG) is chaired by the Chief Nurse or her deputy. The Designated Safeguarding Professionals from Camden attended quarterly.

The priority of the SCG has been to ensure compliance with the requirements of the commissioners and the internal Trust reporting structure. Within the past year the group has focussed on:–

- Undertaking a comprehensive review of the Safeguarding Children and Young People Policy.
- Monitoring and evaluating the professional input into Child Protection Conferences.
- Preparing for the implementation of the Child Protection Information Sharing System
- Ensuring compliance with the requirements of the Independent Inquiry into Child Sexual Abuse and themed external inspections.

The Quality and Safety Committee (QSAC) receives quarterly reports from the Safeguarding and Social Work Teams, outlining the breadth of safeguarding activity delivered within the Trust and providing assurance of compliance against required standards and the statutory framework.

Patient Safety Outcomes Committee (PSOC) receives reports quarterly from the Safeguarding Children Group in relation to identified areas of learning for the Trust. A presentation was delivered following an audit of learning from recent SCRs that GOSH have been involved with.

3. Achievements and Activities

The year has seen a continued increase in activity across all work streams, with challenges generated by the pressure on resources to deliver on the standards required by the Trust and the external Commissioners, NHS England (London) and Camden Clinical Commissioning Group.

This Annual Report sets out to identify and describe the key risks that were managed during the year and provide a summary of some key activities undertaken each quarter.

In addition, as part of the summary and conclusion, the Annual Report describes the key priorities and areas identified for improvement in relation to safeguarding activity for implementation during 2017-2018.

Performance against key priorities for 2016/17

3.1 Achievement of external regulatory and contractual standards required by external inspectorates and commissioners

The Trust provides external assurance to the commissioners in both NHS England (London region) and Camden Clinical Commissioning Group (CCG). A quarterly report on monthly activity is provided to the CCG on the required standards set for training, supervision, involvement in Child Protection Conferences and audit.

3.1.1 Training

Aim: To ensure progress with Levels 1-3 is maintained and the Trust moves towards the gold standard of 95% compliance. Members of staff are trained to the required competency level which exceeds the requirements of our commissioners (80%).

The Trust ensures that its' staff are trained to the required competency outlined in the Intercollegiate document 2014: Safeguarding Children and Young People: Roles and Competences for health care staff. At the beginning of the year the data base was transferred to a new Learning Management System. Initial difficulties with data retrieval led to a gap in provision of compliance figures each month. This has now been rectified.

The training figures as of 31.03.2017 are:-

- Level 1 87%
- Level 2 83%
- Level 3 70%
- Level 4 100%
- Level 5 100%

The Trust has accepted the recommendations from Learning and Development on the arrangements for safeguarding training to identify a more sustainable model for staff including honorary consultants. The programme now provides annual 2 hour updates for staff that require safeguarding training level 3 as opposed to one triennial training day.

The change in the Training Strategy has led to a temporary drop in Level 3 compliance causing some staff that were previously compliant to move temporarily into non-compliance during the transition period. The situation is improving and will be self-resolving within the next few months as staff undertake their updates either through e-learning or face to face sessions.

Themed study days have been delivered on:

- Perplexing Presentations and Fabricated or Induced Illness.
- Neglect and Emotional Abuse
- Female Genital Mutilation
- Child Sexual Exploitation
- Domestic Violence and Abuse

The bespoke e-learning programme has been finalised this year and early evaluations from users have been very favourable.

Work has continued to ensure that staff that hold an Honorary Contract are trained to the required level.

The current figures for Level 3 as of 31.03.2017 are:-

- 73 % for Institute of Child Health (ICH) Consultants
- 31% for non ICH Consultants

Some staff that hold Honorary Contracts at GOSH are Consultants primarily trained in adult medicine and solely support an on-call system here. A review of the competency levels for the diverse roles of this group of consultants is taking place to clarify whether the clinical work being undertaken requires a level 3 competency.

Prevent Training

The trajectory for training compliance has remained on course to meet the Home Office requirements for NHS Trusts to ensure their workforce is 85% compliant by July 2018. The promotion of safeguarding training has consequentially increased the levels of Prevent training as the sessions run consecutively.

As of 31.03.2017:-

- 51% staff have received Basic Prevent training
- 63% staff have attended the Workshop to Raise Awareness of Prevent

Safeguarding Adults

Level 1 compliance as of 31.03.2017 was 94%.

A review of training programmes is being completed to identify further training for staff that require an enhanced level of competence.

3.1.2 Supervision

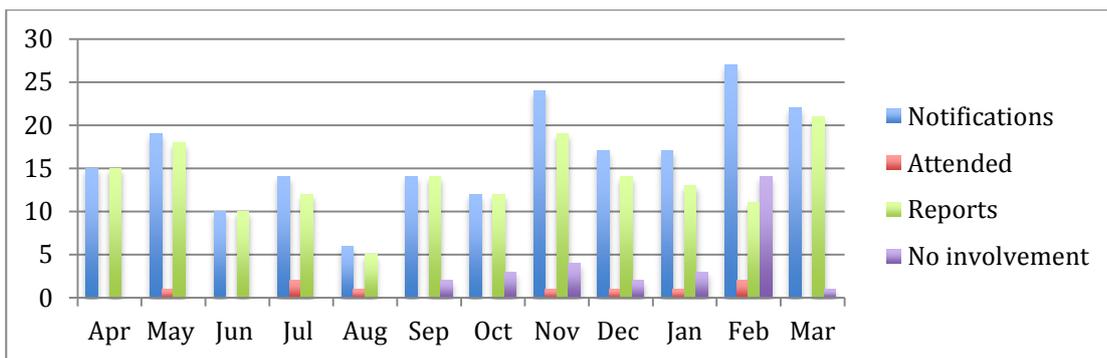
Aim: All eligible staff are supervised as set out in the Trust Supervision Policy.

The programme for supervision has expanded throughout the year. Overall the numbers of staff receiving supervision has increased by 33%. A total of 1028 staff received supervision during this period, either in planned sessions on wards, departmental areas, disciplines, specialities, either on a one to one basis or in a group which can be ad-hoc or on a regular basis. Some staff will have received supervision on more than one occasion.

The majority of supervision is delivered in a planned way. The 'Drop in' clinics for staff to discuss their concerns was largely underutilised. The majority of staff prefer to access support on an ad hoc basis, taking into account their clinical commitments.

3.1.3 Involvement of Trust staff in Child Protection Conferences

Aim: To improve the attendances at Case Conference and the quality of reports.



The Trust has received invites to 202 Child Protection Conferences this year, which represents an increase of 173% on the previous year. Staff awareness has been raised through training and having a single point to contact where activity is coordinated. The increase is in line with the national increase in numbers of children who meet the threshold for significant harm.

There are a small number of cases attended in person due to the distances involved. However when it is assessed that more direct involvement is required, this is in the main being achieved by the use of video link and teleconference.

There were 25 cases where there was no involvement by staff, which was largely due to late notification of the Conference, or in some cases no notification was received at all.

3.1.4 Audit

The Trust has participated in multi-agency audits with Camden and other Local Safeguarding Children Boards. During the past year, the themed audits have been in relation to self-harm, parental mental health, and responding to the additional needs and vulnerabilities for disabled children. Recommendations have been included in training and will be incorporated into the Safeguarding Policy review which is in progress.

Internal audits have been limited due to resource pressures on the Safeguarding team.

The results of an internal audit on Learning from Serious Case Reviews that the Trust were involved with were reported on in the first half of the year. Findings from the audit identified the need to remind staff about the management of bruising in non-ambulant children, and the importance of highlighting concerns in a timely manner and completion of referrals to the GOSH Social Work Service. The audit will be repeated in 2017/18 to assess progress.

3.2 Camden Safeguarding Children Board (CSCB) and sub group meetings

The Trust is represented at the Board meeting by the Chief Nurse / Executive Lead for Safeguarding Children. The Named or Specialist Professionals attend CSCB Sub groups for NHS, Quality Assurance and Learning & Development. Attendance at meetings was above 80% for 2016/17, except for the Learning and Development Group where attendance was significantly lower.

3.3. Mandatory reporting

Female Genital Mutilation (FGM)

Quarterly data has been provided to NHS England.

The Trust has had one concern raised in relation to a parent with confirmed FGM.

Prevent

The mandatory reporting of concerns and training compliance commenced in July 2015 to NHS England who in turn report to the Home Office.

There were six enquiries to the Safeguarding Prevent Operational Lead, of which one was referred to the Channel Coordinator via Children's Social Care. There was no further action undertaken in this case.

Modern Slavery

There has been one case identified within the year in which a referral was made. Although NHS trusts are not required to report on a mandatory basis they are encouraged to do so.

3.4 Multi agency working

- The Safeguarding and Social Work teams meet Monday-Friday to achieve and maintain the safety of children through a high level of collaborative working and information sharing to promote better outcomes. On Mondays and Fridays they are joined by a Clinical Site Practitioner whose team take responsibility for Child Protection out of hours.
- The Named Professionals meet regularly with the Head of Social Work and Senior Practitioners to discuss complex cases and develop the collaborative working between both services.
- The Safeguarding Team are supported in their training and supervision functions by GOSH Social Workers.
- The Named Professionals and Head of Social Work meet regularly to discuss any complex cases requiring a senior management decision and to develop Policy, Procedure and Practice across the Trust.

3.5 Risks

3.5.1 The Disclosure and Barring Service

The Trust undertakes checks at recruitment of all staff, which was 100% as of 31.03.2017. Existing staff have rechecks which are currently at 96%.

3.5.2 Persons Who Pose a Risk

The Patient Safety Team were consulted about nineteen families in relation to safeguarding concerns; and for sixteen of these families a meeting took place to consider appropriate management of the risk posed.

3.5.3 Risk Register

With the appointment of the substantive Named Doctor, this risk has now been closed. There is one risk remaining in relation to failure to safeguard children and young people from maltreatment and neglect, which recognises that safeguarding children always carry a risk.

3.5.4 Independent Inquiry into Child Sexual Abuse

There have been no cases identified to the Trust from the Inquiry to date. The Trust is compliant with the Action Plan which is updated annually.

3.5.5 Child Protection Information Sharing System

This is a national information sharing system between local authorities and NHS Trusts to identify those children who are at risk of significant harm and are subject to an individual child protection plan. Work has commenced to enable the Trust to utilise this system, involving Safeguarding, Social Work and Information Technology Leads to ensure we can access the system appropriately for the organisation.

3.6 Serious Case Reviews (SCRs)

- The Trust has contributed to six SCRs during 2016/17 involving eight children and one young adult.
- There has been one new case, five cases have been published and four have been closed.
- There is one case awaiting a decision from the SCR Panel.
- There have been three learning events attended by Named Professionals, Head of Social Work and /or practitioners involved in cases.
- The Trust provides a robust system of support for those practitioners involved in these cases throughout the process and thereafter if required.
- Action Plans from recommendations of reviews are monitored regularly through the SCG and Local Safeguarding Children Boards.

Learning from SCRs

The identified learning is incorporated into mandatory training programmes, themed study days, the bi-annual Safeguarding Newsletter and intranet resource pages for all staff.

These have included:

- The importance of supervision for staff
- Managing parental non-compliance
- Medical professionals to ensure partner agencies understand when they consider the possible or likely explanation for a child's presentation is that they have suffered NAI (non-accidental injury).

4. Challenges and Priorities

4.1 Challenges

The Safeguarding Team continue to experience significant pressures with the increase in activity and the additional requirements to deliver on national priorities and standards alongside their statutory responsibilities.

4.2 Key Priorities for 2017/18

A robust work plan has been created to action priorities for 2017/2018 and to fulfil our Safeguarding statutory, strategic and operational objectives.

1. To achieve all Safeguarding Contracting Standards and Key Performance Indicators
2. To complete all actions identified in the work plan to demonstrate that the Strategy for Safeguarding is embedded within the Trust
3. To implement the Strategic and Operational Safeguarding Children Groups following review of the Terms of Reference and membership of the groups in order to promote robust involvement from divisions and key disciplines across the Trust.
4. To complete the extensive review of the Safeguarding Policy to ensure that it captures all recent national and local changes to procedures and provides guidance about best practice across the organisation.
5. To build upon our current training programme to staff who require an enhanced knowledge of Safeguarding Children in line with the Intercollegiate Document Safeguarding Children and Young People; roles and competences for healthcare staff.
6. To further increase the provision and uptake of safeguarding supervision across the Trust.
7. Identification of Safeguarding Champions across all areas.
8. Continue to improve collaborative working and the interface between Safeguarding and Social Work Services.
9. Revision of the under-2 Non accidental Head Injury Pathway to be integrated into a general Unintentional Injury Pathway.
10. Establishing a consistent social information collection system which will include informing parents about Information Sharing practice within the Trust.
11. Building upon and expanding the system for complex case supervision and tracking already well embedded within the Gastroenterology Service to cover the whole Trust.

Recommendation:

The Board of Directors is asked to note the priorities for the year ahead and continue to support the delivery and development of safeguarding children and young people arrangements.

<p>Trust Board 25th May 2017</p>	
<p>Safe Nurse Staffing Report for March and April 2017</p> <p>Submitted by: Juliette Greenwood Chief Nurse</p>	<p>Paper No: Attachment R</p>
<p>Aims / summary This paper provides the required assurance that GOSH has safe nurse staffing levels across all in- patient ward areas and appropriate systems in place to manage the demand for nursing staff. In order to provide greater transparency the report also includes appropriate nurse quality measures and details of ward safe staffing reports. The paper includes a brief summary of nursing vacancies, nurse turnover and patient acuity data.</p>	
<p>Action required from the meeting The Board is asked to note:</p> <ul style="list-style-type: none"> • The content of the report has been significantly reduced to provide a concise overview of nurse staffing information but be assured that appropriate information is being provided to meet the national and local requirements. • The information on safe staffing and the impact on quality of care. 	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.</p> <p>Compliance with <i>How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing and capability</i> (NHS England, Nov 2013) and the <i>Hard Truths Commitments Regarding the Publishing of Staffing Data</i> issued by the Care Quality Commission in March 2014. In July 2016 there was further guidance – <i>Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time</i> (National Quality Board, July 2016). This guidance provides an updated set of NQB expectations for nurse staffing to help Trust boards make local decisions that will deliver high quality care for patients within the available staffing resource.</p>	
<p>Financial implications Already incorporated into 16/17 Division budgets</p>	
<p>Who needs to be told about any decision? Divisional Management Teams Finance Department Workforce Planning</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales? Chief Nurse; Assistant Chief Nurses, Head of Nursing</p>	
<p>Who is accountable for the implementation of the proposal / project? Chief Nurse; Divisional Management Teams</p>	

GOSH Safe Nurse Staffing Report March and April 2017

- Capacity:**
 MARCH: 2 beds closed on Sky ward in March; 1-3 on Butterfly because of staffing. 2 on Koala for infection control purposes.
 APRIL: 1-2 beds closed on Squirrel Urology and SNAPS wards, and 3 on Butterfly and Bumblebee in April due to staffing and patient acuity; 2 beds on Sky and 1 on MCU due to staffing; 2 on Bear due to infection control; and 1 on Giraffe for emergency works.
- Staffing:**
 Sickness levels have reduced slightly since January, but stabilised over the past three months. Turnover rate has reduced since the beginning of this year.
- Temporary Staffing:**
 Nursing bank usage in March was up, 2477 shifts against 2235 shifts in February, but similar to the usage this time last year. Bank usage went down in April with 1786 shifts. We had no agency use between November 2016 and February 2017 but had a total of 3 shifts in March and April 2017, 2 in March and 1 in April, all in IPP.

There were no unsafe shifts reported in March and April 2017.

Nursing Workforce Summary:

Month	UNIFY Actuals vs plan	CHPPD Trust average (excl. ITUs)	PANDA Acuity (weighted for cubicle and complexity)				Sickness (RN)	Turnover FTE (RN)	Vacancies (RN)	Vacancies unregistered
			WIC	HD	Normal under 2	Normal over 2				
January	93.4%	12.4	38.1%	19.6%	14.3%	27.9%	3.8%	17.2%	109.1	74.5
February	94.4%	11.8	36.2%	18.5%	14.6%	30.8%	2.8%	16.9%	99.1	50.8
March	92.9%	11.5	36.4%	18.6%	14.7%	30.4%	2.8%	16.3%	92.3	53.8
April	91.1%	11.6	39.0%	20.9%	13.1%	27.0%	2.7%	16.4%	110.1	31.7

Ward	Nursing Staffing Actual vs Planned					Care Hours per Patient Day			Key Indicators							
	Registered Day	Care Staff Day	Registered Night	Care Staff Night	Total	Comments	Registered	Care Staff	Total	Pressure Ulcer, grade 2	Cardiac Arrest	Respiratory Arrest	PALS	Complaints	Datix	Unsafe shift
Charles West Division																
Badger	97.1%	130.2%	93.6%	84.4%	97.1%	Badger have backfilled their vacancies with Healthcare Assistant shifts	10.8	1.9	12.7	0	2	0	0	0	0	0
Bear	124.4%	133.1%	115.5%	59.5%	117.9%	High dependency patients had to be nursed in cubicles due to closed beds in the HDU bay for infection control purposes, which required more nursing staff. We're underestablished on care staff and deliberately over-establishing on trained staff in preparation for the move. Two of the care staff we have are now picking up our SSI work, hence a higher rate on days than nights.	10.9	1.7	12.6	0	0	0	0	0	0	0
Flamingo	96.9%	39.1%	84.0%	77.2%	89.1%	Unit safely staffed	20.0	0.5	20.5	1	0	0	0	0	0	0
Miffy	112.5%	77.3%	88.1%	92.9%	91.0%	Miffy have HCa vacancies and had sickness and maternity leave with the Band 2,3,4's.	9.4	9.8	19.2	0	0	0	0	0	0	0
NICU	127.1%	35.5%	105.2%	-	111.9%	During the month of March there was an increased number of both long term and short term sickness, necessitating an increase in the number of staff required to fill vacant shifts.	28.4	0.5	28.9	0	0	0	0	0	0	0
PICU	108.9%	52.0%	92.9%	9.7%	97.0%	During the month of March, there was less sickness; however an increase in maternity leave and leavers necessitated bank staff to fill vacant shifts. Where possible, we increased our capacity as required, however there were a number of	29.1	0.5	29.6	2	0	0	0	0	0	0
Elephant	79.2%	54.9%	68.9%	57.6%	71.1%	Same as Giraffe	6.5	1.1	7.6	0	0	0	0	0	1	0
Fox	67.3%	52.0%	51.8%	64.1%	59.6%	Same as Giraffe	8.6	1.4	10.0	0	0	0	0	0	0	0
Giraffe	99.9%	73.6%	80.2%	56.8%	83.8%	Giraffe are under establishment, and also, due to shortages elsewhere within Haem Onc, regularly have to move staff between units to maintain safe levels elsewhere, hence the low numbers on most of their shifts. My feeling is that that is	10.0	2.4	12.4	0	0	1	0	0	0	0
Lion	82.4%	77.5%	82.4%	71.7%	81.0%	Same as Giraffe	8.3	1.7	10.0	0	0	0	0	0	0	0
Penguin	133.6%	202.3%	73.2%	31.4%	110.7%	Same as Giraffe	11.2	5.1	16.3	0	0	0	0	0	0	0
Robin	84.7%	89.0%	66.1%	110.5%	79.7%	Same as Giraffe	10.5	2.5	13.0	0	0	0	0	0	0	0
International Private Patients Division																
Bumblebee	81.9%	216.6%	79.5%	90.8%	90.5%	Qualified staffing deficit and associated risks were mitigated by additional bank HCA's, careful allocation. Staff were moved across the division to account for unfilled bank shifts and to cover sickness and vacancies. Some reduction in the 1:1 specials, but increased patient acuity elsewhere, and failure to fill qualified bank shifts has meant increase in HCA bank usage. Beds were closed for three days where staffing was reduced and bank shifts did not fill.	7.4	2.8	10.2	0	0	0	0	0	0	0
Butterfly	89.6%	236.3%	82.3%	201.0%	103.0%	Qualified staffing deficit and associated risks were mitigated by additional use of bank and careful allocation. Increased amounts of blood products and chemotherapy administered in day requiring more qualified staff. The ward has seen an increase in patient acuity, and has utilised additional bank staff both registered and unregistered. Increased unqualified bank usage as cubicalised patient requiring 1:1 special. 3 beds were closed to complete a redecoration programme which also allowed for safe staffing levels.	8.5	3.1	11.5	0	0	0	0	0	0	0
Hedgehog	81.2%	107.4%	86.5%	85.4%	86.4%	Some reduced patient numbers especially at nights, due to some day cases, has allowed for staff to move across the division and still ensure safe staffing levels on the ward. No closed beds.	9.4	3.1	12.5	0	0	0	0	0	0	0
JM Barrie Division																
Eagle	86.4%	65.3%	94.4%	96.7%	86.4%	Below 10% Tolerance due to staff sickness and moving qualified staff off the day to cover nights and HCA - long term sickness. Eagle currently has vacancies so ward not up to full establishment.	8.7	2.1	10.8	0	0	0	0	0	0	0
Kingfisher	70.8%	43.0%	125.9%	-	74.0%	Below 10% Tolerance due to staff sickness and staff on maternity leave. The HCA average is below 10% because they now work nights and this was not factored into their off duty before.	8.6	2.9	11.6	0	0	0	0	0	0	0
Rainforest Gastro	130.0%	45.2%	99.3%	46.0%	84.4%	Increased patient activity and acuity on day shifts requiring more registered nurses.	8.9	2.9	11.8	0	0	0	0	0	0	0
Rainforest Endo/Met	124.1%	38.7%	75.2%	76.4%	83.5%	Unit safely staffed	9.2	2.4	11.5	0	0	0	0	0	0	0
Mildred Creak	126.7%	88.8%	88.3%	75.6%	102.1%	Unit safely staffed	7.4	3.6	11.0	0	0	0	0	0	0	0
Koala	110.1%	157.7%	97.8%	81.3%	105.6%	Unit safely staffed	10.5	1.3	11.8	1	0	0	0	0	0	0
Peter Pan	105.7%	58.3%	86.5%	-	90.4%	Unit safely staffed	9.1	1.1	10.3	0	0	0	0	0	0	0
Sky	108.6%	116.4%	94.0%	-	104.5%	Unit safely staffed	9.3	2.0	11.3	1	0	0	0	0	0	0
Squirrel	83.5%	107.4%	82.6%	-	91.4%	Below 10% tolerance due to vacancies but staff have been moved as required to ensure safe staffing levels	8.5	2.0	10.5	0	0	0	0	0	0	0

Ward	Nursing Staffing Actual vs Planned					Care Hours per Patient Day			Key Indicators							
	Registered Day	Care Staff Day	Registered Night	Care Staff Night	Total	Comments	Registered	Care Staff	Total	Pressure Ulcer, grade 2	Cardiac Arrest	Respiratory Arrest	PALS	Complaints	Datix	Unsafe shift
Charles West Division																
Badger	91.4%	108.2%	84.8%	86.2%	89.5%	There are a number of nursing vacancies across Badger and Miffy and these have tried to be filled with PulseBank or Band 3 PulseBank where appropriate.	10.4	1.8	12.2	0	3	0	0	0	0	0
Bear	141.3%	98.7%	116.8%	67.3%	123.0%	Increased number of HDU patients requiring additional registered nurses	10.1	1.1	11.2	0	0	0	0	0	0	0
Fleming	115.9%	73.3%	101.2%	23.5%	106.7%	Unit safely staffed.	24.9	0.5	25.4	2	0	0	0	0	0	0
Miffy	143.9%	81.4%	73.5%	96.2%	96.8%	There are a number of nursing vacancies across Badger and Miffy and these have tried to be filled with PulseBank or Band 3 PulseBank where appropriate.	10.6	10.6	21.2	0	0	0	0	0	0	0
NICU	115.2%	20.0%	102.4%	-	104.5%	The unit has a number of HCA vacancies which are currently in the recruitment process	26.9	0.4	27.3	0	0	0	0	0	0	0
PICU	107.5%	36.7%	91.8%	6.7%	95.3%	The figures provided are a true reflection of the staffing requirements for PICU.	31.2	0.4	31.6	1	0	0	0	0	0	0
Elephant	96.1%	60.0%	78.6%	76.6%	84.3%	Some vacancies and staff on essential study days, resulting in staff moves from other areas in the Trust to assist. the ward had third year students on the ward this month & this supports the required HCA workforce numbers but it is not reflected in Rosterpro.	8.9	1.6	10.5	0	0	0	0	0	0	0
Fox	92.8%	90.4%	70.4%	106.4%	84.4%	Significant number of very busy which had been supported by staff moves and using non ward based staff to support the ward.	11.7	2.4	14.2	0	0	0	0	0	0	0
Giraffe	94.8%	43.4%	78.2%	54.8%	77.2%	Some vacancies & more than usual number of staff on essential study days, resulting in staff moves from other areas in the Trust to assist. 1 bed closed in Giraffe due to maintenance work. We have allocation of third year students & this supports the required HCA workforce numbers but it is not reflected in Rosterpro.	9.1	1.7	10.9	0	0	0	0	0	0	0
Lion	84.0%	82.5%	78.1%	76.6%	81.0%	As with the other Heam/Occ wards the ward has some vacancies and staff on essential study days and nurses from other wards in the Trust have been moved to ensure the ward was safely staffed.	8.7	2.0	10.7	0	0	0	0	0	0	0
Penguin	131.0%	151.0%	89.6%	31.5%	106.7%	Figures for the day shift includes the establishment for Penguin Ambulatory Day Care hence the registered nurses & care staff for the day shifts fill rate reflect >100%. 1 HCA on long term sickness absence. Third year students support the required HCA workforce numbers but this is not reflected in Rosterpro.	9.9	3.4	13.3	0	0	0	0	0	0	0
Robin	88.4%	77.1%	71.0%	102.4%	81.8%	Staff moved from other areas in the Trust not reflected on Rosterpro. Increased activity has been supported by staff moves and using non ward nurses to support the ward team.	10.1	2.1	12.2	0	1	0	0	0	0	0
International Private Patients Division																
Bumblebee	85.5%	217.8%	84.0%	102.2%	95.3%	Qualified staffing deficit and associated risks were mitigated by additional bank HCA's, careful allocation. Staff were moved across the division where possible to account for unfilled bank shifts and to cover sickness and vacancies. Increase in patients requiring 1:1 specials, significant increase in patient acuity and failure to fill qualified bank shifts has meant increase in HCA bank usage. Bank shifts have been escalated to external agency when unfilled, and a bespoke advert placed with the nursing bank to try and attract regular bank workers. 3 beds were closed to mitigate staffing an acutely unwell complex-needs patient and to ensure safe staffing for the rest of the ward.	7.5	2.9	10.4	0	0	0	0	0	1	0
Butterfly	112.1%	326.5%	76.8%	162.0%	115.4%	Qualified staffing deficit and associated risks were mitigated by additional use of bank and careful allocation. Increased fill rate of bank shifts at night, so many rostered staff were moved to day shifts where appropriate. Increased amounts of blood products and chemotherapy administered in day requiring more qualified staff. The ward has seen an increase in patient acuity, and has utilised additional bank staff both registered and unregistered. Increased unqualified bank usage as cubicalised patient requiring 1:1 special. Increasing numbers of BMT patients requiring nurse transfers for TBI and close monitoring during marrow/cells infusions. 3 beds have been closed to allow a period for newly registered staff to become familiar with ward, competent in some clinical skills and to ensure safe staffing levels.	10.7	3.8	14.5	0	0	0	0	0	0	0
Hedgehog	86.6%	121.1%	94.9%	89.1%	93.5%	Some reduced patient numbers especially at nights, due to some day cases, has allowed for staff to move across the division and still ensure safe staffing levels on the ward. Additional bank shifts were put out and if filled substantive ward staff moved across division to ensure safe staffing across entire division.	13.8	4.6	18.4	0	0	0	0	0	0	0
JM Barrie Division																
Eagle	84.2%	65.0%	88.9%	85.7%	82.9%	Below 10% tolerance due to short staffed with vacancies and further impeded with short term sickness.	8.3	2.0	10.3	0	0	0	0	0	0	0
Kingfisher	57.3%	42.7%	104.3%	-	63.5%	No wards were deemed unsafe because extra measures were put in place such as swapping staff around or closing beds.	8.1	3.4	11.5	0	0	0	0	0	0	0
Rainforest Gastro	112.8%	46.7%	89.3%	50.4%	77.7%	Slight variance in qualified on days, this is due to needing to have 1:1 for dependency over a 5 shift period. The unqualified is in the 50% due to one vacant position.	7.8	3.2	11.0	0	0	0	0	0	0	0
Rainforest Endo/Met	116.3%	41.7%	76.2%	50.1%	79.0%	Increase in Registered nurses on days due an increase in activity and patient acuity. Ward Safely staffed and assessed daily	8.8	2.0	10.8	0	0	0	0	0	0	0
Mildred Creak	97.6%	101.8%	73.6%	123.6%	98.4%	Unqualified on nights has had to be increased due to the care needs of a patient on the unit. Qualified on nights is down, this is due to qualified vacancies. The regular qualified staff have been concentrated onto days shifts to ensure that the therapeutic sessions and key work can continue and regular bank staff have been covering the nights that were not covered.	5.0	4.0	9.0	0	0	0	0	0	0	0
Koala	106.0%	174.8%	89.0%	59.0%	99.5%	Koala ward did not declare any unsafe shifts. Care workers up at 174.8% as they are utilised more in the daytime for telemetry patients, down at 59% on night. Trained staff - vacancies and sickness has resulted in 89% on nights.	9.7	1.3	11.0	0	0	1	0	0	0	0
Peter Pan	104.2%	80.3%	90.6%	-	95.7%	The ward staffing is adjusted and monitored daily, staff swapped to ensure that the area was always safely staffed.	9.5	1.7	11.1	0	0	0	0	0	0	0
Sky	125.2%	116.6%	93.6%	-	112.6%	Sky ward did not declare any unsafe shifts. They too have several vacancies. Trained staff up 125% due to increased patient dependency. Care workers up 116% due to patient load	9.8	2.1	11.9	0	0	0	0	0	0	0
Squirrel	51.3%	50.3%	51.7%	-	57.6%	Currently awaiting staffing establishment review and transfer of budgets for Squirrel Ward Urology now that the ward has split from Squirrel SNAPS, and prior move into PICB.	5.3	1.4	6.7	0	0	1	0	0	0	0

Trust Board 25th May 2017	
Update on Board Assurance Framework Submitted by: Dr Anna Ferrant, Company Secretary	Paper No: Attachment S
Aims / summary The purpose of this paper is to provide an update for the Board on the Board Assurance Framework (BAF). A detailed BAF update is provided at Attachment 1. The key updates made since the April Board assurance committee meetings are outlined in the separate report below.	
Action required from the meeting To note the BAF update and changes to the risks approved by the assurance committees.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Effective management of risk, particularly BAF risks, is critical to the achievement of all of the Trust's strategic objectives.	
Financial implications There are no direct financial implications.	
Who needs to be told about any decision? Anna Ferrant, Company Secretary will liaise with staff affected by any decisions related to this paper.	
Who is responsible for implementing the proposals / project and anticipated timescales? The risk owners are identified alongside each BAF risk.	
Who is accountable for the implementation of the proposal / project? The Chief Executive Officer is accountable for the implementation of the Risk Management Strategy.	

Board Assurance Framework Update

Throughout March and April 2017, the Company Secretary met with the BAF risk owners and reviewed the controls, assurances and actions for each risk. As a result of these reviews, the following changes to the scores for specific risks were presented to the Audit Committee and Quality and Safety Assurance Committee:

- Changes to risk appetite:
 - **Risk 7: Recruitment - The risk that due to external factors, there will be insufficient nursing graduates available to work at GOSH.** As a result of the extenuating external factors facing GOSH (reductions in bursaries, the cost of living in London etc.), it was agreed that the factors directly impacting the attractiveness of a nursing career are out-with the Trust's control. In light of this, it was agreed that the current risk appetite of 'low' is at present unobtainable and as such it should be raised to 'medium' for the foreseeable future. The Audit Committee emphasised that it would not, as a result, accept a weakening of controls or assurances.

- Changes to net risk scores:
 - **Risk 5: Operational Performance - The trust is unable to demonstrate compliance with the 2016/17 regulatory framework, particularly in relation to the national RTT standard.** In light of the Trust recently returning to RTT reporting following a positive assurance report from IST (as well as the significant assurance received around data quality from the internal audit team), the likelihood net score for this risk is reduced from 4 to 2, taking the total risk score from 16 to 8.

 - **Risk 10: Research Income - The Trust may not be able to provide the required level of research infrastructure or leverage additional research income if core research funding streams are reduced.** In light of the enhanced monitoring and reporting systems in place around research income; the recent 5 year NIHR Biomedical Research Centre (BRC) award (£37m – a £1.5m increase); and, the NIHR Clinical Research Facility (CRF) award (£3.04m), the likelihood of the net score for this risk is reduced from 3 to 2, taking the total risk score from 9 to 6.

The Audit Committee and Quality and Safety Assurance Committee approved the amendments to the scores for reporting to the Trust Board and these have been recorded in the attached Board Assurance Framework.

The Audit Committee has proposed that members of the Trust Board attending the Annual Risk Management meeting in July 2017 will review the risks in light of the refreshed GOSH strategy and propose any changes to the risks for 2017/18.

The Board is asked to note the controls and assurances documented for each risk on the Board Assurance Framework.

2016/17 Board Assurance Framework (as at 27 April 2017)

No.	Short Title	Risk type and description		Gross Risk		Net Risk		Risk Appetite	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
				L x C	T	L x C	T						
1	Financial Sustainability	Strategic & Operational	Failure to continue to be financially sustainable due to: <ul style="list-style-type: none"> • Significant reductions in tariff; • Challenges in completing contracts with NHS Commissioners for 2016/17 • Lack of capacity to deliver growth in activity /income targets for NHS and non NHS activities (including IPP); • Challenges is obtaining appropriate growth funding in Contract in 2016/17; • Inadequate local pricing in NHS contract; • Costs of remedial action plans and imposition of fines by commissioner; • Delivery of financial efficiency targets 	4 x 5 =	20	4 x 4 =	16	Low	Chief Finance Officer	Loretta Seamer, Chief Finance Officer	02/03/2017	Audit Committee	April 2017
2	Productivity	Operational	The risk that the organisation will not deliver productivity and efficiency targets and that targets indirectly impact on patient care	4 x 4 =	16	4 x 4 =	16	Low	Deputy Chief Executive Officer	Jon Schick, Programme Director, PMO	14/03/2017	Audit Committee	April 2017
3	IPP Contribution	Strategic & Operational	The risk that the organisation will not deliver IPP contribution targets	4 x 5 =	20	3 x 4 =	12	Low	Deputy Chief Executive Officer	Chris Rockenbach, General Manager, IPP	21/03/2017	Audit Committee	May-16 April 2017
4	Recruitment and Retention	Operational	The risk that the organisation will be unable to recruit and retain sufficient highly skilled staff (especially nursing) with specific experience to meet its objectives	4 x 5 =	20	3 x 5 =	15	Med	Director, Human Resources/ Chief Nurse	Lynn Shields, Ass Dir of Education, Nursing & Polly Hodgson, Asst Chief Nurse	09/03/2017	Audit Committee/ Quality & Safety Assurance Committee	July 2016
5	Operational Performance	Operational	The trust is unable to demonstrate compliance with the 2016/17 regulatory framework, particularly in relation to the national RTT standard.	5 x 4 =	20	2x4 =	8	Low	Deputy Chief Executive Officer	Graham Terry, Head of Performance; & Peter Hyland, Director, Planning & Information	14/03/2017	Audit Committee/ Quality & Safety Assurance Committee	Oct-16
6	Delivery of excellent clinical outcomes	Operational	The risk that the Trust is unable to sustainably provide and deliver specialist clinical services to the required level.	4 x 5 =	20	2 x 5 =	10	Low	Medical Director/ Chief Nurse	Dr David Hicks, Interim, Medical Director & Juliette Greenwood, Chief Nurse	08/03/2017	Quality & Safety Assurance Committee	January 2017
7	Recruitment	Strategic & Operational	The risk that due to external factors, there will be insufficient nursing graduates available to work at GOSH	4 x 4 =	16	4 x 4 =	16	Med	Chief Nurse	Lynn Shields, Ass Dir of Education, Nursing & Polly Hodgson, Asst Chief Nurse	09/03/2017	Quality & Safety Assurance Committee	Jul-16

No.	Short Title	Risk type and description		Gross Risk L x C = T		Net Risk L x C = T		Risk Appetite	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
8	GOSH Strategic Position	Strategic	Lack of priority given to specialist paediatrics in the NHS wide strategies leading to lack of progress in developing appropriate system wide services and support for GOSH's role	3 x 3 =	9	3 x 3 =	9	Med	Deputy Chief Executive Officer	Peter Hyland	27/03/2017	Audit Committee	January 2017
9	Unreliable Data	Operational	Failure to manage data recording and data management processes in a way which supports timely, relevant, accurate, consistent and appropriate reporting, billing and decision making across all segments of the Trust.	4 x 4 =	16	3 x 3 =	9	Low	Deputy Chief Executive Officer	Pippa Mullan, Head of Information, & Peter Hyland, Director, Planning & Information	14/03/2017	Audit Committee	Oct-16 May 2017
10	Research Income	Strategic	The Trust may not be able to provide the required level of research infrastructure or leverage additional research income if core research funding streams are reduced	3 x 3 =	9	2 x 3 =	6	Med	Director, Research & Innovation	Emma Pendleton, Dep Dir, R&I	13/03/2017	Audit Committee	April 2017
11	Research Hospital Status	Strategic	The Trust may not deliver its full Research Hospital vision if key research alliances are not fostered	3 x 3 =	9	2 x 3 =	6	Med	Director, Research & Innovation	Emma Pendleton, Dep Dir, R&I	13/03/2017	Quality & Safety Assurance Committee	Oct-16
12	Electronic Patient Records	Operational	Short – Term – 2 years) The risk that the EPR programme will not be delivered on time or within budget. Key risks being monitored by programme board: • Programme costs • Procurement risks • Capability/ resource risks • Clinician and other staff engagement • Risks associated with multiple clinical systems • Project Budget • The risk that at go live the system is not available for a period of time, data migration issues or operation of system causes data quality issues post go live impacting on reporting. (Long – Term) The risk that the EPR system will not realise the benefits to the organisation as outlined in the Business Case.	4 x 4 =	16	3 x 4 =	12	Low	Chief Finance Officer	Loretta Seamer, Chief Finance Officer	02/03/2017	Audit Committee	Oct-16
13	Business Continuity	Operational	The trust is unable to deliver normal services and critical functions during periods of significant disruption.	3 x 4 =	12	3 x 3 =	9	Low	Deputy Chief Executive Officer	Noel James, Emergency Planning Officer/ Nicola Grinstead, DCEO	14/03/2017	Audit Committee	May-16 May 2017
14	Redevelopment	Operational	Inadequate planning or management of infrastructure redevelopment may result in poor VFM or failure to deliver expected business benefit.	3 x 4 =	12	2 x 3 =	8	Med	Dir, Development & Property Services	Stephanie Williamson, Dep Dir of Development & Property Services	06/03/2017	Audit Committee	Jan-17

2016/17 BAF Risks – Gross Scores

Likelihood	Consequences				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain				5. Operational Performance	
4 Likely				7. Nursing Graduates, 9. Unreliable data, 12. EPR, 2. Productivity	3. IPP Contribution, 6. Clinical Outcomes, 4. Recruitment & Retention, 1. Financial Sustainability
3. Possible			11. Research Hospital, 10. Research Income, 8. GOSH Strategic Position	13. Business Continuity, 14. Redevelopment	
2. Unlikely					
1. Rare					

2016/17 BAF Risks – Net Scores

Likelihood	Consequences				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain					
4 Likely				7. Nursing Graduates, 1. Financial Sustainability, 2. Productivity	
3. Possible			8. GOSH Strategic Position, 9. Unreliable data, 12. EPR, 13. Business Continuity	3. IPP Contribution	4. Recruitment & Retention
2. Unlikely			11. Research Hospital, 10. Research Income, 14. Redevelopment	5. Operational Performance	6. Clinical Outcomes
1. Rare					



BAF Risk 1: Financial Sustainability Failure to continue to be financially sustainable due to: <ul style="list-style-type: none"> • Significant reductions in tariff; • Challenges in completing contracts with NHS Commissioners for 2016/17 • Lack of capacity to deliver growth in activity /income targets for NHS and non NHS activities (including IPP); • Challenges is obtaining appropriate growth funding in Contract in 2016/17; • Inadequate local pricing in NHS contract; • Costs of remedial action plans and imposition of fines by commissioner; • Delivery of financial efficiency targets • Shortfall in capital funding available from Charity to support major capital projects 			Executive Owner: Chief Finance Officer	
Risk Domain (NPSA): Financial	Gross (strategic) risk score: 20 (L = 4 x C = 5)	Net (current) risk score: 16 = (L = 4 x C = 4)	Target risk score (risk appetite): Low (1 – 6)	
Strategic Objective: 4.1 GOSH will develop a funding model which reflects its costs, the new collaborative clinical pathways and allows capacity to be flexed for variable levels of demand.	CQC Domain Well-led	Assurance Committee: Audit Committee	Date of last review by Committee: N/A	
Current Controls and Assurance			Actions to Further Enhance Risk Management	
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
a. National tariff: On-going engagement with the working groups set up by the central policy team at NHSI / NHSE to work with other providers, particularly the Children’s Alliance in contesting any changes to top up levels and the MFF which would materially adversely impact the Trust’s funding level.	a.N/A	a.No specific further actions required at this time.		
b. Agreement with NHSE on local tariff for 4 services for 2016/17 to address underfunding. Additional service reviews to be completed in 2017/18 and this is referenced in the Contract	b. The new contract for 2017/18 & 2018/19 has included a change in PICU pricing, additional block funding for the 3 other services where a review was completed in 2016/17. The completion of the additional service review in 2017/18.	b. Continue to improve our patient level costing information to inform pricing and tariffs with commissioners. Work being undertaken through project Diamond to review local prices across the London Trusts.	b. CFO	b. On-going
c. 2016/17 contract is signed. Progress has been made with finalising the CQUINs which will affect contract negotiations.	c. Signed contract with CV for finalised CQUIN’s.	c. While the majority of CQUINs have been agreed, there are some that are yet to be finalised. It should be noted that the Trust is monitoring performance against the CQUINs despite them not yet being finalised.	c. CFO	c. March 2017

<p>d. Establish programme office to assist in the development and implementation of key projects to improve operational efficiencies, control expenditure and reduce costs (fit for the Future programme developed). (Also refer to BAF risk 2: Productivity).</p>	<p>e. N/A</p>	<p>e. A number of specific projects and initiatives to deliver further efficiencies and costs expenditures are underway, particularly in the following areas – financial control; procurement and supply chain; contract management</p> <p>e. In relation to workforce, further work is required to ensure the Trust has an efficient and effective workforce. Benchmarks (against other Trusts) to provide assurance of the Trust’s efficiency should also be developed/introduced.</p> <p>e. Review and benchmark corporate services against other trusts and national averages and identify opportunities to partner with other Trusts to minimise costs</p> <p>e. Complete review of facilities costs</p>	<p>CFO</p> <p>Director, HR & OD</p> <p>CFO</p> <p>CFO/ED Facilities</p>	<p>On-going</p> <p>On-going</p> <p>March 2017</p> <p>March 2017</p>
<p>f. The Trust has implemented a Performance Management Framework (PMF) to monitor operational and financial performance monthly.</p>	<p>f. Performance against the PMF is monitored at monthly Divisional Performance Review meetings, which is overseen by the F&I Committee</p>	<p>f. While it is also implemented and being embedded, the PMF document needs to be finalised and published.</p>	<p>DCEO</p>	<p>March 2017</p>
<p>g. The Trust continues to monitor the level and age of non NHS patient debt (see IPP debt) see risk 4 below for specific interventions.</p>	<p>h. Reduction in debt levels</p>	<p>h. No specific further actions required at this time.</p>		<p>On-going</p>
<p>h. The Trust has established a strategy group to increase commercial (non-NHS) income and develop an IPP market strategy. As part of the work of the group an IP Board has been established to review research, innovation and commercial opportunities</p>	<p>i. N/A</p>	<p>i. No specific further actions required at this time.</p>		<p>On-going</p>
<p>i. The trust and charity continue to review the five year forecast for requirements for Charity funding to support key capital projects, research and revenue projects supporting families, patients and staff.</p>		<p>j. Develop detailed 5 year charity funding plan linked to Trust capital and revenue plan requirements.</p> <p>k. Deliver robust business case for major projects in particular, EPR and Phase 4 Redevelopment projects.</p>	<p>CFO for Trust and Charity</p>	<p>March 2017</p>
<p>k. Monitoring of Trust expenditure</p>		<p>l. Ensure the Trust has a robust budgeting and financial monitoring and reporting programme</p>		<p>June 2017</p>

Risk Reviewed By: Loretta Seamer, Chief Finance Officer

Date Reviewed: 2 March 2017

BAF Risk 2. Productivity			Executive Owner:		
The risk that the organisation will not deliver productivity and efficiency targets/ and that targets indirectly impact on patient care			Deputy Chief Executive Officer		
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):		
Finance	16 (L = 4 x C = 4)	16 = (L = 4 x 4)	Low (1 – 6)		
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:		
4.1 GOSH will develop a funding model which reflects its costs, the new collaborative clinical pathways and allows capacity to be flexed for variable levels of demand.	Well-led	Audit Committee	April 2016		
Current Controls and Assurance			Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance		Action required to close any gaps in controls and assurances	Action owner	Action review date
1. P&E performance addressed as part of overall financial performance, through the monthly integrated performance meetings with divisions as well as dedicated additional finance and P&E meetings held with each division and chaired jointly by the Deputy CEO and the CFO	1. Monthly financial performance reports to the Board (and its committees) New Fit for the Future programme now implemented with regular reporting to Trust Board and at monthly meeting of EMT				
2. PMO working with divisions to identify additional mitigating schemes in year in order to address gaps in P&E performance. Risks of P&E under-delivery partly mitigated by other in-year positive variances including pay underspends and IPP income over-performance	2. Monthly financial performance reports to the Board as above. Divisions have access to detailed milestone trackers from the PMO database in order to ensure their schemes are on track				
3. Additional PMO business partners recruited to assist divisions with tracking, delivery and unblocking of key issues stopping P&E progress	3. N/A				
4. Enhanced Quality Impact Assessment process implemented to address the recommendation of the QIA internal audit. The QIA process is led by the Chief Nurse and Medical Director. The QIA panel meets frequently (at least monthly) and reports to the Quality and Safety Assurance Committee.	4. Series of 'deep dives' and post implementation reviews are planned, as well as routine tracking of quality KPIs, to ensure there is no adverse impact on quality as a result of the P&E programme. Two recent deep dives and first report on KPIs provided to October QSAC. Next round due January 18 th 2017				

Risk Reviewed By: Jon Schick, Director, Programme Management Office

Date Reviewed: 14 March 2017

BAF Risk 3: IPP Contribution			Executive Owner:	
The risk that the organisation will not deliver IPP contribution targets			Deputy Chief Executive Officer	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Finance	20 (L = 4 x C = 5).	12 (L = 3 x C = 4).	Low (1 – 6)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
4.3 Develop and grow new sources of commercial income within the UK and internationally by leveraging specialist expertise in patient care, education and diagnosis	Well-led	Audit Committee	May 2016	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. Reporting: Clear and regular reporting against operational and financial targets	A detailed operational performance report/scorecard is issued to Executive team members, Divisional Operations Directors and Senior IPP team on a monthly basis. Challenge and discussion occurs at the monthly Performance Review Meetings. YTD, IPP contribution is in line with expected levels.	No further actions required at this time.		
2. Demand and capacity: Referrals and activity are monitored by the IPP General Manager to ensure the referral activity remains at required and manageable levels and the activity mix includes both short-stay and long-stay patients (to optimise financial performance). The bed requirement continues to be mixed between IPP dedicated wards and IPP funded beds on NHS speciality wards.	Detailed referrals and activity reports are monitored by the IPP General Manager and reported to the IPP Senior Management Team on a weekly basis to identify trends that require intervention. A separate monthly competitor analysis report is received and reviewed by the IPP Senior Management Team. New commercial opportunities are being reviewed with the teams around developing GOSH as a preferred provider for using novel procedures. International opportunities being reviewed with external partners.	Relationship management is imperative with both referrers (who choose where to send the patient) and consultants (who choose where to operate their private practice). The following actions along with those under marketing are being progressed: <ul style="list-style-type: none"> • Communication with key individuals. • New markets being explored to secure additional patient flows. • Discussions with consultants re: transfer of work from other London private facilities. • Identify opportunities to increase weekend activities. 	Director, IPP	On-going
3. Marketing and PR: A range of market development and	Repatriation of activity from competitors.	There are a number of on-going marketing activities, to ensure the referrals to IPP are sufficient to enable to the	Director, IPP	

<p>brand recognition activities are underway (via a PR agency) to support increased clinical team visits overseas and attendance at key overseas exhibitions.</p>	<p>Press presence/stories around patient cases and clinical innovation compared to last year. This is monitored in the monthly Operational report presented to the IPP Senior Management Team.</p> <p>A referral app has been launched in both English and Arabic. This increases brand awareness and helps develop existing and new referral opportunities.</p> <p>Agreed digital marketing strategy including identification of appropriate social media channels</p>	<p>delivery of financial targets. These include:</p> <ul style="list-style-type: none"> • Implement social media channels roll-out plan for target audiences. • Improved brand awareness via targeted marketing (increased GOSH stories and patient case studies) . • Facilitate clinician to clinician engagement through “marketing road shows”. • Attendance at appropriate trade exhibitions 		<p>June 2017</p> <p>On-going</p>
<p>4. Recruitment and retention plan: To ensure IPP has the quality and quantity of skilled staff to support the required activity levels.</p>	<p>Workforce KPIs, aligned to the Recruitment and Retention Strategy, are reported monthly to the IPP Senior Management Team. These KPIs include the number of starters and leavers, statistics around future starters and leavers, vacancies out to advert and un-actioned vacancy numbers.</p> <p>IPP mandatory training is at 97% (March 2017) and PDR compliance at 89% (March 2017)</p>	<ul style="list-style-type: none"> • Workforce retention working group established across all clinical Divisions to review plan with aim of improving retention of nurses. • Contribute and engage with Trust wide initiatives and corporate nursing team to maximise benefit to Division on all Trust recruitment and retention projects. • The Division will continue to focus on staff PDR and mandatory training to ensure compliance. 	<p>Director, IPP and Chief Nurse</p>	<p>On-going</p>
<p>5. Strategy: Work is underway to operationalise the IPP strategy to identify additional beds</p>	<p>Allocation of circa 10 additional dedicated IPP beds to deliver phase 1 (Hedgehog ward).</p>	<p>IPP will work with the Divisions and Executive Team to determine how to increase market share in specific specialities.</p>	<p>Director, IPP</p>	<p>June 2017</p>
<p>6. NHS division’s financial performance: The IPP Division supports the NHS Clinical Divisions to ensure they meet their respective IPP targets and also providing bed capacity to assist with RTT waits.</p>	<p>Formal quarterly meetings occur between General Manager, IPP and Divisional Operational Directors.</p> <p>A detailed operational performance report/scorecard is issued to Executive team members, Divisional Operations Directors and Senior IPP team on a monthly basis. Challenge and discussion occurs at the quarterly review meetings.</p>	<p>Continued access to outlier ward beds to maintain referrer relationship.</p> <p>IPP have mitigated the full impact of RTT by delaying redevelopment of four cubicles until new bed capacity is available.</p>	<p>Director, IPP</p>	<p>On-going</p> <p>March 2018</p>
<p>7. Debt: IPP work to minimise the debt value and aging debt. The activities include: regular visits to Health offices; agreed escalation triggers with escalation</p>	<p>A detailed operational performance report/scorecard with dedicated page on debt is issued to Executive team members, Divisional Operations Directors and Senior IPP team on a monthly basis.</p>	<p>In addition to existing controls the following are either occurring or are being considered:</p> <ul style="list-style-type: none"> • Escalation in home country. • Escalation through British embassy. 	<p>Director, IPP and CFO</p>	<p>Immediate and On-going</p>

<p>actions; and management meetings to review individual clients and agree actions.</p>	<p>IPP agrees actions required to reduce debt levels. This meeting comprises a debt update paper, which highlights performance and issues impacting on debt levels and age for each major client plus detailed discussion.</p> <p>In February 2017 the Trust collected the highest level of cash in relation to private patient debt ever recorded (9£8 million). This was achieved through a number of actions identified for this control.</p> <p>Involved the FCO and escalated to the ambassador with an overseas client.</p>			
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Risk Reviewed By: Chris Rockenbach, General Manager, IPP

Date Reviewed: 21 March 2017

BAF Risk 4: Recruitment and Retention			Executive Owner:	
The risk that the organisation will be unable to recruit and retain sufficient highly skilled staff (especially nursing) with specific experience to meet its objectives			Chief Nurse / Director, Human Resources & Organisational Development	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
HR/OD	20 = (L = 4 x C = 5).	15 = (L = 3 x C = 5). ↔	Moderate (8 – 10)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
2.1 Appropriate Clinical professional resource for all clinical teams	Safe	Audit Committee and QSAC	July 2016	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
<p>1. A Trust wide Nursing Recruitment and Retention Program is in place, comprised of a number of specific workstreams, with targeted actions for specialist workforce in key areas (e.g. ICU; nurse recruitment activities). Two project leads have been appointment to lead the recruitment and retention workstreams.</p> <p><i>Recruitment strategies and workstreams include:</i></p> <ul style="list-style-type: none"> - Streamlining the on-boarding process to ensure GOSH is able to offer positions and commence staff (particularly nurses) quickly/ faster than competitors - Supporting greater recruitment of overseas and adult trained nurses choosing to transition to paediatric work and/or the UK - Introducing automatic fill for third year nurses. <p><i>Retention strategies and workstreams include:</i></p> <ul style="list-style-type: none"> - Investing in sisters and matrons, as evidence shows this makes work environments happier and more productive - Redefining ward sisters role to make it more appealing and sustainable - Design the PDR process to have a greater focus on staff wellbeing 	<p>Monitored by the Nursing Workforce Program Board and the Education and Workforce Board</p> <p>A recruitment and retention engagement event was hosted by GOSH in January 2017 and 259 applicants were shortlisted for band 5 newly qualified nurse (NQN)posts.</p> <p>A monthly recruitment and retention bulletin has been circulated to all ward areas updating on local vacant posts</p> <p>On-going monitoring of workforce KPIs to identify and address issues.</p> <p>Quarterly review of all available HENCEL education funding opportunities. GOSH then develops and submits all relevant bids</p> <p>GOSH has successfully bid to be the Lead employer to become a test site for a CYP Nursing Associate training programme in partnership with 6 other London trusts. This enables GOSH to widen the access for</p>	<p>a. Assessment centres for NQN in progress</p> <p>b. An education initiative around the role of Ward Sisters in the retention of their staff is commencing in Q1 2017/18. First dates planned for May 2017</p> <p>c. Complete a Training Needs Analysis for all clinical professional development of staff</p>	<p>a. Asst Chief Nurse, Nursing Workforce</p> <p>b & c. Associate Director of Education</p>	<p>a. March 2017</p> <p>b. April 2017</p> <p>c. June 2017</p>

	<p>potential staff into nursing and will eventually utilise the apprenticeship levy in the future</p> <p>Reporting impact through NWPB & Staff Welfare workstreams</p> <p>Monthly operational meeting with other partner organisations</p>			
2. Implementing a range of actions to ensure GOSH is an attractive employer (across all work/professional streams)	<p>Moved from a paper based process to electronic; saving paper, time and reduced the risk of misplacing documentation</p> <p>Implemented improvements to tools and processes for managing appointments to streamline the process – shorter timeframes for advertising, shortlisting, interviewing and conditional offers; template letters to reduce errors.</p> <p>Leveraged social media to reinforce messages around the GOSH Always values, making people more aware of our job opportunities and getting in front of passive candidates.</p> <p>The @GoshJobs twitter page has 500 followers and is growing, GOSH LinkedIn has 7,829 followers</p> <p>Marketing our vacancies on Facebook, LinkedIn and Twitter ensures that we capture applicants from a wide talent pool and build a diverse workforce.</p>	<p>a. Implement improvements to the website to use it more effectively as a marketing tool and to provide potential staff, especially nurses, with more targeted and motivational information on their opportunities at GOSH</p> <p>b. Implement tools for developing pre application questions and competency checking</p> <p>c. Finalise the analysis of staff surveys to understand staff expectations regarding benefits and accommodation.</p> <p>d. Working with the charity to employ a temporary marketing manager to support nursing recruitment activities</p>	<p>a. and b. Director, HR & OD</p> <p>b. Associate Director of Education</p> <p>c. Associate Director of Education and Asst. Chief Nurse, Nursing Workforce</p>	<p>a. October 2017</p> <p>b. June 2017</p> <p>c. May 2017</p> <p>d. October 2017</p>
3. Tactical use of temporary staff to fill vacancies.	<p>Monitoring of temporary staffing usage as part of the Divisional Performance.</p> <p>Weekly updates to HR&OD Senior Team regarding agency cap position</p>	<p>Currently gathering data from other children's facilities to benchmark bank rates in similar organisations</p>	<p>Dir, HR & OD</p>	<p>Data available end of Jan</p>

4. Develop relationships with Further Education Institutes (FEIs) to establish a supply of suitable individuals who can access employment on the 'Talent for Care' pathway (bands 2- 4)	Monitored by the newly established Education and Workforce Board Quarterly meetings between Associate Dir of Edu'n and GOSH Apprenticeship lead	a. Consider opportunities to better use apprenticeships, internships and work experience programs to attract young future professionals before they are 18 and choosing training and studying programs	a. Associate Director of Education	a.On-going
5. For more specific actions relating to recruitment and retention of graduate nurses, refer to BAF Risk 7: Nursing Graduates risk				

Reviewed By: Lynn Shields, Associate Director of Education

Date Reviewed: 09 March 2017

Reviewed By: Ali Mohammed, Director of HR and OD

Date Reviewed: 14 March 2017

BAF Risk 5: Operational Performance			Executive Owner:	
The trust is unable to demonstrate compliance with the 2016/17 regulatory framework, particularly in relation to the national RTT standard.			Deputy Chief Executive Officer	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Statutory duty/ inspections or quality	20 = (L =5 x C = 4).	8 = (L = 2 x C = 4). ↔	Low (1 – 6)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
1.2 Provide the highest quality patient care, experience and health outcomes for patients and families.	Well-led	Audit Committee and Quality and Safety Assurance Committee	October 2016	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. The Trust has a Performance Management Framework process through which the performance of individual divisions under each of the CQC domains are reviewed and managed.	Monthly Divisional and Trust-wide Integrated Performance Report Agreed actions/outcomes from Divisional Performance meetings are submitted to EMT for review and oversight.	No gaps		
2. On-going monitoring of agreed delivery trajectories to achieve the incomplete RTT standard and diagnostics– which will include: <ul style="list-style-type: none"> Reduction in long waiting pathways Identify additional capacity where possible 	Weekly Trust wide Patient Tracking List (PTL) meetings with all clinical areas (supported by weekly local PTL meetings in the local divisional teams). PTL shows all RTT, cancer and diagnostic pathways and the length of time waiting, supported by speciality level action plans by the operational teams where necessary. Audits to provide assurance of progress. In particular: National Elective IST cohort closure audit (Sept 16) National Elective IST – data assurance audit (Oct 16) National Elective IST – data assurance re-audit (Jan 17)	a. Work to transition the Refreshed demand and capacity work is required to support services to sustainably deliver access standards.	a-b. Director, Operational Performance and Information	a. On-going

	<p>KPMG Data Quality Audit (Jan 17) KPMG – Info Governance Audit (Jan 17) KPMG – internal audit into the Performance Review Structure (Jan 2017) KPMG – RTT Data Quality audit (Mar 17)</p> <p>PTL process has been refreshed from a reactive to a more proactive, once returned to reporting.</p> <p>Quarterly “tripartite” assurance meetings with NHS England, NHS Improvement and CQC Trust returned to statutory reporting (January 2017 data)</p>			
3. Fortnightly Internal Access Improvement Board – tracking progress and delivery of the Access Improvement Programme, which includes RTT and diagnostics	Reporting against the Access Improvement Plan including delivery and Monitoring of agreed improvement trajectories	<p>a. Develop and implement DQ KPIs and dashboard to provide assurance of the Trust’s position against RTT standards</p> <p>b. Establish an Elective Care Steering Group to oversee waiting times and patient flow once the project phase of the Access Improvement work is completed.</p>	<p>a. Head of Performance</p> <p>b. Director, Operational Performance and Information</p>	<p>a. March 2017</p> <p>b. April 2017</p>
4.Refresh Access Policy (for Elective and Cancer access) by the Trust, Commissioners, NHS Improvement and the Elective National Intensive Support Team.	Published Access Policy on GOSHWeb.	No further action required	Director, Operational Performance and Information	April 2017
5. An RTT Training Programme is in place. Level 3 training (to support the roll-out of SOPs for RTT, cancer and diagnostics) has commenced.	<p>Training compliance rates are reported to Access Improvement Board and the Tripartite meeting.</p> <p>All required staff have completed Level 1 training, level 2 is substantially progressed (96% of staff have completed)</p>	<p>a. Continue implementing and monitoring training compliance rates particularly level 3 training</p> <p>b. Development and roll out for a BAU RTT training solution</p>	A&bDirector, Operational Performance and Information	<p>a.On-going</p> <p>b.End of April 2017</p>
6. Implementing a range of initiatives to increase activity capacity such as operational bed meetings, theatre scheduling meetings. Flow work programme, outpatient redesign	Programmes of work, with deliverables, key milestones dates, and identified operational leads, reported to the (to be established) Elective Care Programme Board	Refreshed demand and capacity work is required to support services to sustainably deliver access standards. A review of the constraints including beds and staffing will be looked at as part of this work.	Directors of Operations (supported by Director, Operational Performance and Information)	On-going

<p>7. A range of activities are underway to reduce the likelihood of last minute, non-clinical hospital cancelled operations</p>	<p>Monitored via the PMF and monthly Divisional Performance meetings</p> <p>Linked additionally to CQUIN delivery</p>	<ul style="list-style-type: none"> a. Redesigning the Bed Management Policy and meetings to reduce the risk of last minute hospital cancelled operations b. Reviewing cancellation reasons and developing an action plan / trajectory to improve and reduce their occurrence c. Development of cancelled operations portal by Quality Improvement Team. 	<ul style="list-style-type: none"> a & b. Divisional Directors of Operations c. Divisional General Managers; QI Team 	<ul style="list-style-type: none"> a. May 2017 b. On-going until March 2017 c. On-going
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Risk Reviewed By: Peter Hyland, Director, Planning & Information

Date Reviewed: 14 March 2017

BAF Risk 6: Delivery of excellent clinical outcomes			Executive Owner:	
The risk that the Trust is unable to sustainably provide and deliver specialist clinical services to the required level.			Medical Director/Chief Nurse	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Impact on Safety	20 = C = 5 x L = 4	10 = C = 5 x L = 2	Low (1 – 6)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
1.2 Provide the highest quality patient care, experience and health outcomes for patients and families.	Safe/ Effective	Quality and Safety Assurance Committee	N/A – On January 2017 agenda	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. The Trust has in place a robust Risk Management Strategy , Incident Reporting policy, Safeguarding policy, and Serious Incident Management policy	- Implementation of the Risk Management Strategy is overseen by RACG and the Audit Committee. - The Strategy and processes are audited approximately every two years.	a. Review the Strategy to ensure it reflects any changes required as a result of the Divisional restructure. b. Children’s safeguarding policy under review following consideration of the safeguarding review report c. Adult safeguarding policy and associated reporting arrangements needs review and adoption	a. Head of Quality & Safety b & c. Deputy Chief Nurse (Head of Safeguarding) Chief Nurse	a. February 2017 b. Q2 2017/18 c. Q2 2017/18
2. Redefining quality priorities in the strategy and determining actions to deliver these priorities	N/A. Once developed and approved, the Strategy will be overseen by Trust Board.	a. The strategy needs to be finalised and approved, and a plan for achieving quality goals needs to be written b. Quarterly quality reports (produced for PSOC, QSAC and Performance Review meetings) need to align with strategy once developed	a & b. Director, Operational Performance and Information	a. 29 th March 2017 b. Q1 2017/18
3. The Trust has in place integrated performance dashboards that monitor performance against national and local KPIs	Overseen by Divisional Performance Review Meetings, Finance & Investment Committee and Trust Board. The QSAC and Board receive a regular quality and safety report.	Final agreement on the GOSH quality objectives and associated quality KPIs is yet to be reached. Refresh of content of revised integrated quality and safety report to be finalised	Director, Operational Performance and Information Medical Director	Q1 2017/18 Q1 2017/18
4. Use of benchmarking and peer reviews to evaluate clinical performance and outcomes	Externally submitted national datasets (e.g. cardiac database / NICOR)	a. Improve the integration of the peer review and benchmarking work into the quality outcomes work	a. Med Dir	a. Once Strategy is developed
5. Implementation and maintenance of a proactive and integrated Compliance Framework that monitors compliance with regulatory requirements, service accreditations, NICE guidance and	- Monthly compliance updates to clinical Divisions, Executive team and QSAC. - 2015 internal audit of NHS mapping processes (all recommendations	Continued consultation and promotion of the Compliance Framework with Clinical Division	Compliance & Governance Manager	On-going

professional standards.	<ul style="list-style-type: none"> - have been implemented) - Recent audit of CQC follow-up processes (all internal audit recommendations have been completed) - Establishment of the Compliance Review Group 			
6. Listening to patient and family feedback and learning from patient experience	<ul style="list-style-type: none"> - Overseen by the PFEEC - Internal audit of complaints processes is underway - Introduction of a standardised framework for use of Patient Stories from Board to Ward - Introduction of 'You said we Did' ward displays. 	<ul style="list-style-type: none"> a. Development of & introduction of a ward nursing quality dashboards b. Development of a Matron's ward round to support the delivery of the Ward to Board quality reporting framework to better inform the Board of the issues facing patients and staff. c. Introduce a real time patient monitoring system d. Development of a Trust wide Complaints Review Group e. Consider and implement any recommendations of the Complaints internal audit f. Development & delivery of a Trust wide improvement plan for Transition 	a-h. Assistant Chief Nurse – Patient Experience & Quality	<ul style="list-style-type: none"> a. Q1 2017/18 b. End Q1 2016/17 c. Q1 2017/18 d. Q4 2016/17 e. TBD on receipt of internal audit report f. On-going
7. Listening to staff feedback and concerns via line management route, Freedom to Speak up Ambassadors and committee structure.	Overseen by the HR Management Team and QSAC Staff survey results	Work through the outcomes of the Well-led review		
8. Strategies and processes to ensure all services have access to the suitably trained staff required to provide a safe, high quality service.	Refer to BAF Risk 4. Recruitment & Retention	Refer to BAF Risk 4. Recruitment & Retention		
9. Robust and integrated data and information intelligence systems to ensure Management has oversight of all clinical performance	The Trust has an endorsed Assurance & Escalation Framework which is reported on to Trust Board twice a year. Refer to BAF Risk 9. Unreliable Data	Refer to BAF Risk 9. Unreliable Data		

Risk Reviewed By: Dr David Hicks, Interim Medical Director & Juliette Greenwood, Chief Nurse

Date Reviewed: 8 March 2017

BAF Risk 7: Nursing Graduates			Executive Owner: Chief Nurse	
The risk that due to external factors, there will be insufficient nursing graduates available to work at GOSH				
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
HR/OD	16 = (L = 4 x C = 4).	16 = (L = 4 x C = 4). ↔	Moderate (8 – 10)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
2.1 Appropriate Clinical professional resource for all clinical teams	Safe	Quality and Safety Assurance Committee	July 2016	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. Implementation of strategies to ensure the Trust has a sustainable approach to funding its nursing graduate recruitment and retention program. Particularly given the decreases in HEE NCEL funding, given HEE NCEL funding supports the central team that provides the educational support and development of nursing undergraduates.	<p>A specific risk around HENCEL funding is on the local risk register and is monitored by the newly established Education and Workforce Board</p> <p>In addition, the Education and Workforce Board monitor placement weeks, as these attract placement tariffs and funding</p> <p>Recent achievements and initiatives in relation to funding include: – successful bid for post graduate nursing funding (attracted £490k) – Education Team attends available HEE and HENCEL seminars regarding strategic and funding issues and opportunities</p> <p>Quarterly reporting to NWPB & forthcoming Education Programme Board</p> <p>Monitor recruitment to student nurse training and attrition and causation of attrition</p>	<ul style="list-style-type: none"> a. Improving the relationship with media agencies to ensure GOSH retains a strong presence in the recruitment market b. Implement improvements to the website to use it more effectively as a marketing tool and to provide potential staff, especially nurses, with more targeted and motivational information on their opportunities at GOSH c. Working with the charity to employ a temporary marketing manager to support nursing recruitment activities d. A review of current education spaces has been completed and has been considered by EMT in March 2017. Further consideration to be given to the proposals 	A – c Associate Director of Education	<ul style="list-style-type: none"> a. On-going b. & c. October 2017 d. October 2017

<p>2. Work to develop a 'brand and package' to attract future fee paying student nurses to choose GOSH & London Southbank University (LSBU) as their preferred place to train and study. As of September 2016, only 29% of nurses in their first week at LSBU had chosen GOSH as their preferred place to train.</p>	<p>Quarterly update reports to Nursing Workforce Program Board (NWPB) & forthcoming Education and Workforce Board</p> <p>Recent achievements include:</p> <ul style="list-style-type: none"> - Increased placement numbers from 4200 in Sept 2016 to 4900 in Sept 2017 - The Trust now receives students from 5 universities, compared to the one university sending students last year <p>The Trust has held 2 open days and attended 4 since April 2016.</p>	<p>a.Continue work to increase appropriately supported student nurse placements to support increased training numbers.</p> <p>b.Implement improvements to the website to use the website as a marketing tool and to provide potential graduate nursing with more targeted and motivational information on their opportunities with GOSH. A marketing manager JD has been created, which will be advertised in Jan, with a view to have someone in post in April.</p> <p>c.Continue to talk to other universities to explore opportunities to work with them to take more students (e.g. University of Herfordshire, and City University London)</p> <p>d.Pursuing opportunities to attend university open days, as well as hosting GOSH open days</p>	<p>a-d Associate Director of Education</p>	<p>a.On-going</p> <p>b.October 2017</p> <p>c.On-going</p> <p>d. ongoing</p>
<p>3. To work with universities to increase the numbers of student nurses supported at GOSH. Recent achievements include:</p> <ul style="list-style-type: none"> – confirmed GOSH will support 110 first year students, which is up from 90 last year – confirmed GOSH will support 79 second year students, which is up from 48 last year – increased interest from elective students 	<p>Annual reporting to NWPB & future Education Programme Board</p>	<p>a. To confirm with LSBU GOSH's education commissioning requirements beyond 2017, specifically plans to increase the numbers of student nurses supported.</p> <p>b. Continue discussions with other universities (e.g. City) to plan for doing more students than LSBU could take.</p>	<p>a.Associate Director of Education</p> <p>b.Associate Director of Education</p>	<p>a. On-going</p> <p>b. On-going</p>
<p>4. On-going work to apply the learning from HEE 'Mind the Gap' to ensure student nurse and newly qualified nurses employment needs are identified and responded to.</p>	<p>Quarterly reporting to NWPB</p> <p>To date the Trust has introduced a comprehensive, 24 month Preceptorship program currently funded by HEE NCEL with additional divisional support</p>	<p>Follow the 'lives' of student nurse's to learn first-hand their training and experience.</p>	<p>Associate Director of Education / Assistant Chief Nurse - Workforce</p>	<p>Sept 2017</p>

Risk Reviewed By: Lynn Shields, Associate Director of Education, Nursing and Non-Medical

Date Reviewed: 09 March 2017

BAF Risk 8: GOSH Strategic Position Lack of clarity around positioning of GOSH in the broader NHS wide strategies leading to lack of progress and momentum in developing appropriate system wide services and support for GOSH's role			Executive Owner: Deputy Chief Executive Officer	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Business objectives/ projects	9 = (L = 3 x C = 3).	9 = (L = 3 x C = 3).	Moderate (8 – 10)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
1.3 To be recognised as (1.3.1) an expert in diagnosis and treatment for children with rare diseases; (1.3.2) for continuing clinical innovation; (1.3.3) as a leader of national and regional specialist paediatric services	Well-led	Audit Committee	N/A – on January 2017 agenda	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. Joint strategic programme board with NHSE commissioners	Minutes of meetings – f/back to EMT/ Board by CEO			
2. Partnership established with the Specialist Children's Alliance members on common strategic issues to ensure a stronger paediatric position on key strategic issues affecting the Trust	Minutes of meetings – feedback to EMT/ Board in CEO verbal update GOSH CEO now chairs this meeting			
3. Developing collaborative arrangements with other providers i.e. UCLH.	Membership of UCLP CHD collaboration Approach to p/ship working formalised in revised strategy	Continue exploring the opportunity to develop, in partnership with the UCLH, shared pathways around urology	DCEO	On-going
4. Establishing relationships with key decision makers and evidencing leadership positions on relevant policies	PS attendance at specialised STP			
5. Trust representation at NCL STP Engagement with partners on implementation of safe and sustainable review				
6. Revised strategy developed with support from McKinsey	October 2016 and February 2017 strategy sessions to discuss with Board members			

Risk Reviewed By: Nicola Grinstead, Deputy Chief Executive Officer

Date Reviewed: 27 March 2017

BAF Risk 9: Unreliable data Failure to manage data recording and data management processes in a way which supports timely, relevant, accurate, consistent and appropriate reporting, billing and decision making across all segments of the Trust.			Executive Owner: Deputy Chief Executive Officer	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Statutory duty/ inspection	16 = (L = 4 x C = 4).	9 = (L = 3 x C = 3). ↔	Low (1-6)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
1.1 To provide timely access to care for all GOSH patients	Well-led	Audit Committee	October 2016	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance (by control number)	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. A Data Quality Strategy has been approved	The Strategy was approved by Trust Board via the DQRG.	Identifying and securing the necessary resourcing and expertise to deliver the DQ work is on-going.	Director, Operational Performance and Information	On-going
2. The KMPG Data Quality Action plan sets out actions to review the quality of data reported to the Board and externally.	Progress against the action plan is monitored by the DQRG. The DQRG reports to the Information Governance Steering Group and also the Audit Committee A follow up review by KPMG has taken place providing the trust with assurance of progress to date			
3. To support performance management of data quality, approval to purchase a new DQ dashboard has been given. This will support the existing KPI report that has been implemented at Trust-wide and Divisional levels. In the meantime, improved reporting processes and templates for reports to DQRG to be implemented.	Consultation on Kitemarking proposal is complete and implementation started in January 2017 (and being rolled out continually), which provides assurance around the quality of data KPIs and performance information within the Board reports	a. Implement the DQ dashboard	a Director, Operational Performance and Information	a. March 2017

4. The information warehouses used by the Trust have been reviewed and streamlined.	A follow up review by KPMG has taken place providing the trust with assurance of progress to date	Complete the transition to the new GOSH data warehouse in line with the DQ action plan	Director, Operational Performance and Information	May 2017
5. A programme of training to support staff around implementation of (RTT) SOPs has been developed	Training compliance is reported to the Access Improvement Board and the Tripartite meeting.	Developing a dedicated data quality training package as part of induction	Director, Operational Performance and Information	April 2017
6. Aligning DQ work and the EPR Project to ensure the EPR takes full account of known DQ issues and addresses these through changes in processes.	The Director, Planning & Information role is included in relevant EPR Project governance processes and meetings			On-going

Risk Reviewed By: Peter Hyland, Director, Planning & Information

Date Reviewed: 14 March 2017

BAF Risk 10: Research Income			Executive Owner:	
The Trust may not be able to provide the required level of research infrastructure or leverage additional research income if core research funding streams are reduced			Director, Research and Innovation	
Risk Domain (NPSA): Finance	Gross (strategic) risk score: 9 = (L = 3 x C = 3).	Net (current) risk score: 6 = (L = 3 x 2 x C = 3). ↔	Target risk score (risk appetite): Moderate (8 – 10)	
Strategic Objective: 3.2 Define a Research Funding Model within GOSH that supports clinical and translational research and raises further commercial income	CQC Domain Well-led	Assurance Committee: Audit Committee	Date of last review by Assurance Committee: April 2016	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
(1) Research Hospital Vision and 5 year plan, including financial targets is being implemented	Six monthly reporting to Trust Board on performance against income targets R&I Board oversight, reporting to Executive Management Team Local financial performance reports as part of Divisional Performance reviews and specific commercial finance reports (to provide assurance locally to divisions they are receiving funding appropriately for their involvement in research activity). Engagement event with Med City R&I KPIs included in the Divisional Performance Review scorecards	(1) Work to implement the new BRC strategy is underway, with full commencement occurring in April 2017. (2) Consider further opportunities for industry engagement events (topic specific) planned for early 2017 (3) Review model for supporting time in job roles for research (4) Continue to proactively manage the impact of BREXIT with respect to future EU funding opportunities	Director, Research & Innovation / Deputy Director of Research & Innovation	(1) On-going until April 2017 (2) On-going (3) On-going (4) On-going
(2) New 5 year NIHR Biomedical Research Centre (BRC) Award, £37m (£1.5m increase)	BRC Science Board which reports to a BRC Strategy Board to oversee the delivery of the BRC as well as regular reporting to the R&I Board. In addition independent assurance from an external BRC Advisory Board.	As detailed above work to implement the new BRC strategy is underway.		Ongoing
(3) New NIHR Clinical Research Facility (CRF) award (£3.04m)	Regular reporting to the R&I Board Shortfall in funding has been met through the GOSH Research Capacity Fund, commercial research revenue and the BRC (agreed).		Director, Research & Innovation / Deputy Director of Research & Innovation	Ongoing

<p>(4) Implementation of the commercial funding model and an enhanced financial performance systems to incentivise clinical teams to support research</p>	<p>Improved reports to local areas on research costs and income</p> <p>R&I KPIs included in the Divisional Performance Review scorecards</p> <p>Recruitment to the new R&I Finance and Performance team to enable more robust research cost tracking recovery systems across Trust departments, including Laboratory Medicine and Gene Therapy GMP.</p>	<p>(1)Implementation of new finance module (in Qlikview) to provide more meaningful reports to budget managers across the Trust to enable them to better understand research costs, budgets, grants and contracts in their local areas</p>	<p>Deputy Director of Research & Innovation</p>	<p>(1) March 2017</p>
<p>(5) Continued investment in research infrastructure through the GOSH Research Capacity Fund (including matched funding by GOSH CC), to underpin a growing portfolio of research. New award letters issued (£1.1m awarded, clear guidance for research support departments and expectations around cost recovery). The process to review and allocate funding has been refined and will be introduced in 2017</p>	<p>Funding bid is overseen by the GOSH Research Capacity Committee</p>		<p>Deputy Director of Research & Innovation</p>	<p>Ongoing</p>
<p>(6) GOSH is a member of the Quintiles (Clinical Research Organisation) Prime Site Agreement, which is intended to provide the Trust with new commercial research opportunities as soon as possible, to optimise opportunities to participate in studies in an increasingly competitive environment.</p>	<p>R&I Board monitors number of commercial contracts and income</p>	<p>No further specific action required at this time.</p>	<p>Deputy Director of Research & Innovation</p>	<p>Ongoing</p>
<p>(7) Partnership working and horizon scanning with the Clinical Research Network: North Thames to maximise financial support to deliver research.</p>	<p>Recently awarded funding via the Clinical Research Network for two posts</p>	<p>Continue to explore opportunities for joint investment in posts with the Clinical Research Network: North Thames</p>	<p>Dir, R&I / Dep Dir, R&I</p>	<p>On-going</p>
<p>(8) Research Accelerator and Grants Advice service is in place, to support researchers at any stage in their careers and research projects with grant applications</p>	<p>R&I Board monitors performance of the service, including grant success rates</p>	<p>No further specific action required at this time.</p>		

Risk Reviewed By: Emma Pendleton, Deputy Director, R&I

Date Reviewed: 13 March 2017

BAF Risk 11: Research Hospital Status			Executive Owner:	
The Trust may not deliver its full Research Hospital vision if key research alliances are not fostered			Director, Research and Innovation	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Finance	9 = (L = 3 x C = 3).	6 = (L = 2 x C = 3). ↔	Moderate (8 – 10)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
3.1 Establish GOSH as a Research Hospital	Effective	Quality & Safety Assurance Committee	October 2016	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
(1) Research Hospital Vision and 5 year plan is being implemented	R&I Board oversight, reporting to Executive Management Team Six monthly reporting to Trust Board on research income; research recruitment, international standing and performance against NIHR metrics. Appointment of research communications manager	(1) Each Division to define and own their research aims and objectives under the Research Hospital vision and new Divisional structure (2) Continue to increase research infrastructure, e.g. Integrated laboratory services strategy (3) Research to be embedded in decision making of the organisation (works well in some areas e.g. EPR but not all areas) (4) Identify and establish additional thematic areas / cross programme infrastructure for example laboratory medicine to bring together clinicians and basic scientists (5) Implementation of generic consent, starting with a pilot	Dir, R&I / Dep Dir, R&I	(1) March 2017 (2) April 2017 (3) On-going (4) On-going (5) April 2017
(2) Annual delivery plans are in place to support the operationalization of the Research Hospital vision. Business partnering model to support this is in place	Oversight of delivery through R&I Board, reporting to EMT Six monthly reporting to Trust Board on research income; research recruitment, international standing and performance against NIHR metrics.	No further specific action required at this time	Dir, R&I / Dep Dir, R&I	Ongoing
(3) Working closely with the UCL Group to ensure a cohesive strategy and partnership in day to day working wherever possible	The Child Health Campus Group (Joint GOSH and UCL Group) oversees and monitors the effectiveness of this partnership	No further specific action required at this time		
(4) New 5 year NIHR Biomedical Research Centre award	Oversight of delivery through R&I Board, reporting to EMT.	Work to implement the new BRC strategy is underway, with full commencement occurring in April 2017		

Risk Reviewed By: Emma Pendleton, Deputy Director, R&I

Date Reviewed: 13 March 2017

BAF Risk 12: EPR (Short – Term – 2 years) The risk that the EPR programme will not be delivered on time or within budget. Key risks being monitored by programme board: <ul style="list-style-type: none"> • Programme costs • Procurement risks • Capability/ resource risks • Clinician and other staff engagement • Risks associated with multiple clinical systems • Project Budget • The risk that at go live the system is not available for a period of time, data migration issues or operation of system causes data quality issues post go live impacting on reporting. 			Executive Owner: Chief Finance Officer	
(Long – Term) The risk that the EPR system will not realise the benefits to the organisation as outlined in the Business Case.				
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Finance (5) and Impact of Safety (4)	16 = (L = 4 x C = 4).	12 = (L = 3 x C = 4). ↔	Low (1 – 6)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by C'tee:	
4.5 Develop a five year investment plan for business critical assets (e.g. equipment) required to deliver the strategy	Well-led	Audit Committee	October 2016	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. Robust programme governance led by the EPR Programme Board, including engagement with clinical experts, patients and families, finance, IT, research and operational management The EPR Programme Board has oversight of: <ol style="list-style-type: none"> statements of vision, changed operating model (blueprint) and comprehensive system specification programme and project-based risk management to manage key risks to quality, time and budget procurement processes and contract management of supplier partners full business case, organisationally-owned benefits plan and tracking interdependencies with other strategies such 	1. Gateway review process at key points to provide assurance of the project's governance and performance. 1. Weekly EPR updates are provided to key Executives to provide additional oversight and assurance of progress.	1. Development of programme blueprint showing all the changes involved in becoming a digital hospital and highlighting programme interdependencies. 1. Include additional sub-groups to focus on operational process and data migration and reporting	EPR Programme Director EPR Programme Director	March 2017 January 2017

as RTT/Data Improvement, the Research Hospital, ICT/infrastructure and the P&E programme.				
2. Clinical and research leadership and engagement is incorporated via the Chief Clinical Information and Research officers	2. The effectiveness of engagement with clinicians is overseen by the Clinical Design Authority group	2. No further actions required at this time.		N/A
3. Communication strategy in place, including specific strategies to ensure thorough engagement with clinicians and to ensure all staff and stakeholders are aware of program and impacts of changes	3.Approved communications strategy 3.Stakeholder engagement plan	3.No further actions required at this time		N/A
4. The project is closely integrated with Quality Improvement and Operations teams to ensure the EPR is delivered as a change programme, rather than an ICT project	4.EPR Programme Board oversees assurance 4. Weekly EPR updates are provided to key Executives to provide additional oversight and assurance of progress.	4.No further actions required at this time		N/A
5. Working through the recommendations of the Internal Audit on EPR Governance and Project Management	5.Updates will be provided to EPR Programme Board, Audit Committee and Trust Board.	5. Continue to complete final recommendations. All other recommendations have been actioned on time as agreed in management plan.	5.CFO	March 2017.
6. Engaged external expert advisors for legal, commercial and procurement processes.	6.EPR Programme Board oversees risks and performance 6. Weekly EPR updates are provided to key Executives to provide additional oversight and assurance.	6. KPMG has been engaged to conduct a review of supplier financial standing and to prepare the business case, including benefits realisation and financial assurance. An external firm has also been engaged to undertake Gateway reviews throughout the project and post go-live	6.CFO	Reviewers engaged.
7. Linking with data quality review and system to manage data migration (refer to BAF risk 8: Unreliable data).	7. Refer to BAF risk 8: Unreliable data	7. Refer to BAF risk 8: Unreliable data		
8. Development of Financial Business Case including financial benefits and funding options	a) Consultation with clinical and non-clinical groups undertaken to develop and approve financial benefits with ownership assigned. b) Grant application to Charity for partial funding		8.CFO	March 2017
9. Establishing strong operational engagement, leadership and change control management and processes to support effective implementation	9.	9. Clarify processes and pathways requiring change 10.Clarify how staff can be released and backfilled to support business as usual.	Executive Team	April 2019

Risk Reviewed By: Loretta Seamer, Chief Finance Officer

Date Reviewed: 2 March 2017

BAF Risk 13: Business Continuity			Executive Owner:	
The trust is unable to deliver normal services and critical functions during periods of significant disruption. Due to: Gaps in planning, logistical challenges or unexpected events causing difficulties for staff and patients. Impact: An adverse effect on the trust's operational performance			Deputy Chief Executive Officer	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Service continuity and environmental impact	12 = (L = 3 x C = 4).	9 = (L = 3 x C =3). ←→	Low (1 – 6)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
1.2 Provide the highest quality patient care, experience and health outcomes for patients and families.	Safe	Audit Committee	May 2016	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
1.A Trust wide business continuity plan has been completed and signed off by the Major Incident Planning Group.	The Major Incident Planning Group meets on a quarterly basis to oversee the management of the BC plan and emergency preparedness for the Trust.	A deputy chair for the Major Incident Planning Group is to be identified (currently the Emergency Planning Officer (EPO) is deputy Chair, but there is agreement the deputy should be senior clinical/operational staff member.	DCEO	April 2017
2. Each department/service has completed the revised BC template.	Completed service plans in place. These are reviewed by the Major Incident Planning Group and are expected to be reviewed annually (tracked by the EPO) or when there are significant changes to the service or estate.	BC leads are to provide the Emergency Planning Officer with updates to the BC plans at ward level – working with Charles West at present to finalise these at ward level.	Divisional BC leads	March 2017
3. A robust emergency planning training program is in place to raise awareness across the Trust on how staff should respond in an emergency.	EPO presents reports to the Major Incident Planning Group on lessons learned from all training exercises. A number of Live' and 'table top' exercises have been held and are planned to explore business continuity issues. A live exercise took place in 27 January 2017.	Continue to conduct training and exercise sessions to test local plans. A series of fire table-top exercise will be completed by all wards by end December 2016. Re-commence EPO presentations to Senior Managers to SMT to raise awareness of major incident initiatives and responsibilities.	EPO EPO/DCEO	On-going April 2017
4.A workplan outlining compliance against the NHS Core Emergency Preparedness Standards is managed on an on-going basis.	NHS England provides external assurance on compliance with Emergency Planning core standards. Confirmed feedback from NHSE states the Trust remains Substantially compliant against the core standards. The Emergency Preparedness workplan and is shared at every Major Incident Planning Group meeting	EPO completed an action plan to address the gaps for completion expected March 2017.	EPO	March 2017

Risk Reviewed By: Noel James, Emergency Planning Officer

Date Reviewed: 14 March 2017

BAF Risk 14: Redevelopment			Executive Owner:	
Inadequate planning or management of infrastructure redevelopment may result in poor VFM or failure to deliver expected business benefit.			Director, Development and Property Services	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Business objectives/ projects	12 = (L = 3 x C = 4).	8 = (L=2 x C=4) ↑	Medium	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
4.4 To ensure the capital investment plan	Safe	Audit Committee	N/A – on January 2017 agenda	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance (by control number)	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. Effective and well informed Project Boards	<ul style="list-style-type: none"> - Senior Responsible Officer chairs - Programme, cost, market conditions and risk formally reported by Project Manager and interrogated by Project Board - Project Initiation Document (PID) provides benchmark and is updated throughout the project cycle as required to reflect change - External and independent evaluation of governance provided as required – audit / gateway 	Gateway review to be requested	Deputy Director, Redevelopment	Summer 2017
2. Project leadership	<ul style="list-style-type: none"> - GOSH retains clear leadership role for client body through the CEO and the Project Director - Reporting mechanisms and accountability clearly defined in PID - Role and remit of scrutinising stakeholders clearly explained in PID 	None		
3. Commercial Management	<ul style="list-style-type: none"> - Professional contract management (Employer’s Agent) procured from recognised and qualified providers and held to account through the Project Director and Project Board - Professional cost management procured from recognised and qualified providers and held to account through the Project Director and Project Board - Project Costs benchmarked against other schemes - Project Costs peer reviewed as part of the procurement strategy - Market conditions monitored and reported to project 	NEC Contract Manager to be procured for Phase 4	Director, D&PS/ CFO	Sep 2017 (Mar 2017 will be a checkpoint)

	<p>Board</p> <ul style="list-style-type: none"> - Procurement process encourages early engagement with contractors to drive buildability and more proactive construction management 			
4. Business case process	<ul style="list-style-type: none"> - Compliance with NHS I capital regime guidance for FTs. - 5 case model - Sensitivity analysis to reflect fluctuations in activity, income or market conditions 	ASPECT (audit tool) will be used to undertake an audit with patients, families and staff for P4 throughout design process	Deputy Director, Redevelopment	Summer 2017

Risk Reviewed By: Stephanie Williamson, Deputy Director, Redevelopment

Date Reviewed: 6 March 2017