

**Meeting of the Trust Board
 Wednesday 23 May 2018**

Dear Members

There will be a public meeting of the Trust Board on Wednesday 23rd May 2018 at 2:00pm in the Charles West Boardroom, Great Ormond Street, London, WC1N 3JH.

Company Secretary

Direct Line: 020 7813 8230

Fax: 020 7813 8218

AGENDA

	Agenda Item <u>STANDARD ITEMS</u>	Presented by	Attachment
1.	Apologies for absence	Chairman	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 28th March 2018	Chairman	F
3.	Matters Arising/ Action Checklist	Chairman	G
4.	Chief Executive Update	Chief Executive	Verbal
5.	Patient Story	Chief Nurse	4
6.	Board Assurance Committee reports <ul style="list-style-type: none"> • Audit Committee update – April 2018 meeting • Quality and Safety Assurance Committee update – May 2018 meeting • Finance and Investment Committee Update – March and May 2018 	Chair of the Audit Committee Chair of the Quality and Safety Assurance Committee Chair of the Finance and Investment Committee	H I J
7.	Members' Council Update – April 2018 And Update on review of Constitution	Chairman of the Members' Council/ Company Secretary	K
<u>ANNUAL REPORT ACCOUNTS</u>			
8.	GOSH Foundation Trust annual financial accounts and annual report 2017/18 including: <ul style="list-style-type: none"> • the Annual Governance Statement • the Audit Committee Annual Report • Representation Letter • the Draft Head of Internal Audit Opinion 	Audit Committee Chairman/ Chief Finance Officer/ Company Secretary	L

9.	Compliance with the NHS provider licence – self assessment	Company Secretary/ Chief Finance Officer	M
10.	Compliance with the Code of Governance	Company Secretary	N
11.	Quality Report 2017/18	Medical Director	O
	<u>STRATEGY and RISK</u>		
12.	Board Assurance Framework Update	Company Secretary	P
13.	2017/18 NHSI Plan and budget	Deputy Chief Executive	Q
14.	GOSH Learning Academy – Briefing Paper	Medical Director/ Chief Nurse	R
15.	CQC Inspection Report	Medical Director/ Company Secretary	S
	<u>PERFORMANCE</u>		
16.	Integrated Quality Report – 30th April 2018	Medical Director/ Chief Nurse	T
	Learning from Deaths Mortality Review Group - Report of deaths in Q3 2017/2018	Medical Director	U
17.	Integrated Performance Report (30th April 2018)	Deputy Chief Executive	V
	Finance Update (30th April 2018)	Chief Finance Officer	W
	<u>ASSURANCE</u>		
18.	Annual Reports		
	• Annual Freedom to Speak Up Report 2017/18	Freedom to Speak Up Guardian	X
	• Annual Health and Safety and Fire Report 2017/18	Director of HR and OD	Y
	• Annual Safeguarding Report 2017/18	Chief Nurse	Z
19.	Safe Nurse Staffing Report (March and April 2018)	Chief Nurse	1
20.	Annual Staff Survey results 2017	Director of Human Resources & OD	2
21.	Report from the Guardian of Safe Working	Guardian of Safe Working	3
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 Wednesday 25 th July 2018 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.			

ATTACHMENT F

**DRAFT Minutes of the meeting of Trust Board on
28th March 2018**

Present

Sir Michael Rake	Chairman
Dr Peter Steer	Chief Executive
Lady Amanda Ellingworth	Non-Executive Director
Mr Akhter Mateen	Non-Executive Director
Mr James Hatchley	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Dr Andrew Long	Interim Medical Director
Ms Helen Jameson	Interim Chief Finance Officer
Ms Nicola Grinstead	Deputy Chief Executive
Mr Ali Mohammed	Director of HR and OD
Ms Polly Hodgson	Interim Chief Nurse

In attendance

Mr Matthew Tulley	Director of Development
Ms Cymbeline Moore	Director of Communications
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Mr Paul Balson	Deputy Company Secretary
Ms Herdip Sidhu-Bevan*	Deputy Chief Nurse
Ms Emma James*	Patient Involvement and Experience Officer
Dr Dorothy Thompson*	Consultant Clinical Scientist, Ophthalmology
Ms Stephanie Williamson*	Deputy Director of Development
Dr John Hartley*	Director of Infection Prevention and Control
Dr Renee McCulloch*	Guardian of Safe Working and Consultant in Paediatric Palliative Medicine
1 member of GOSH staff	

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

** Denotes a person who was present by telephone

160	Apologies for absence
160.1	Apologies for absence were received from Professor Stephen Smith, Non-Executive Director and Mr David Lomas, Non-Executive Director.
161	Declarations of Interest
161.1	No declarations of interest were received.
162	Minutes of Meeting held on 7th February 2018
162.1	The Board approved the minutes
163	Matters Arising/ Action Checklist
163.1	The actions taken since the last meeting were noted.

164	Chief Executive Report
164.1	Dr Peter Steer, Chief Executive highlighted the latest National Institute for Cardiovascular Outcomes Research (NICOR) report which had noted GOSH's outstanding outcomes for a second consecutive three year cycle.
164.2	GOSH continued to engage with North Thames specialist paediatric planning process and had been approached to be the strategic lead for the North Central London Sustainability and Transformation plan. The Board would be kept updated.
164.2	Sir Michael Rake, Chairman welcomed the excellent cardiac work.
165	Patient Story
165.1	A patient story was received by video from GOSH patient, Devan, and his father Sanjay about their experiences visiting the hospital over the past six years whilst Devan has been under the care of ophthalmology.
165.2	Devan and Sanjay made the following positive comments about their time at GOSH: <ul style="list-style-type: none"> • Access to an en suite bathroom • Access to wi-fi • Excellent facilities • Kind nurses • Games to play • Consistent consultant • Able to speak to other patients
165.3	The following recommendations were made: <ul style="list-style-type: none"> • Pharmacy waits were often around two hours which had a significant impact on Devan being able to go back to school for the rest of the day. • Academic resources or activities requested in outpatient areas. • Booking follow up appointments through medical secretaries was often challenging and appointment letters could be received at quite short notice. • Healthier food and drink options to be available in the Lagoon restaurant.
165.4	Action: Ms Nicola Grinstead, Deputy Chief Executive said that work would take place to look at Devan and Sanjay's appointment booking process as this should take place through the bookings team rather than individual medical secretaries. She said that the pharmacy review project, which was being reviewed by the Quality and Safety Assurance Committee, was working to reduce long waits. Educational materials had been purchased and Ms Grinstead confirmed that these could also be used in outpatient areas.
165.5	Mr James Hatchley, Non-Executive Director asked how the Board could be assured that there was not a positive bias to the stories received. Ms Herdip Sidhu-Bevan, Deputy Chief Nurse said that families were approached to provide their stories once they had come into contact with the Trust via PALS, the Young People's Forum, through visits to wards or in a variety of other ways. She said that patients and families were not asked leading questions as it was important to hear their thoughts and issues.

166	Update from the Quality and Safety Assurance Committee in January 2018
166.1	Mr James Hatchley, member of the Quality and Safety Assurance Committee highlighted the appointment of the Freedom to Speak Up Guardian which was fundamental to the Freedom to Speak up process. He said he was working with the HR team to put in place a monthly reporting system to raise any issues to the Senior Independent Director.
166.2	Mr Andrew Long, Interim Medical Director said that 18 patient safety champions were being appointed and work was taking place to review how they would work alongside freedom to speak up ambassadors. Mr Hatchley said it was important to ensure that HR was appropriately resourced to handle this work.
166.3	Action: The Committee had received a presentation on the pharmacy review which had been undertaken by an external expert who had been embedded into the team. A number of recommendations had been made and the Committee had welcomed progress. It was agreed that the Board would send a note of thanks to the external expert who had undertaken the pharmacy review.
167	Update from the Finance & Investment Committee in March 2018
167.1	Mr James Hatchley, Member of the Finance and Investment Committee said that the last meeting had considered the budgets for the commissioning period 2018/19 and the process for developing the Long Term Financial Model (LTFM) and updating the required assumptions.
167.2	Mr Akhter Mateen, Chair of the Audit Committee said that between the two committees progress with the Electronic Patient Record implementation continued to be monitored and a further independent gateway review would be received in April. <i>Ms Polly Hodgson left the meeting.</i>
168	Members' Council Update – February 2018
168.1	Dr Anna Ferrant, Company Secretary said that the most recent meeting had been the final meeting for a number of Councillors, due to it being the end of their tenure. Positive work continued with the constitution working group and the work would be complete in time to be approved at the AGM.
168.2	Sir Michael Rake, Chairman highlighted the work that was taking place on the draft Lead Governor Role Description and emphasised the importance of having a simple document. It was noted that the Council would be reviewing the draft role description that evening.
169	Draft Annual Business Plan 2018/19 including operational and finance plan
169.1	Ms Helen Jameson, Interim Chief Finance Officer said that since the plan had been provided to the Board, a contract offer had been received from NHS England of £314 million based on cost and volume and there remained the opportunity to receive payments for activity above contract. Ms Jameson highlighted that NHS England remained concerned about the total contract value for organisations nationally.

169.2	Ms Nicola Grinstead, Deputy Chief Executive confirmed that there would be no quality impact required as a result of signing a contract of that value.
169.3	Mr Akhter Mateen, Non-Executive Director asked for assurance that GOSH would be paid in full for its activity in 2017/18 as this included significant over-performance. He queried whether there was likely to be a similar level of over-performance in 2018/19. Ms Jameson said that the final value of the 2017/18 outturn would be agreed in the first week of April 2018 and said that over-performance in the following period was likely to be a much smaller proportion of the contract value.
169.4	Mr James Hatchley, Non-Executive Director highlighted the previous discussions which had taken place around theatre utilisation which had improved but was not yet at the target rate. He queried the likely impact of an improvement in this area on the Trust's activity. Ms Grinstead said that although more activity would be delivered, the additional expenditure required to support this activity had not been factored in. Dr Peter Steer, Chief Executive agreed that it was important to be as efficient as possible but said that there was no reliance on increasing this rate in order to meet the Control Total.
169.5	The Board agreed to continue to support the recommendation that the Trust should agree to the Control Total for 2018/19 and to delegate authority to the Chief Executive to sign off the final version of the document. The Board confirmed that they were satisfied that adequate governance measures were in place to ensure the accuracy of information included within the plans.
170	Better Value Update
170.1	Ms Nicola Grinstead, Deputy Chief Executive said that the Better Value Programme was forecasting a year-end outturn of £10.7million and although this was an underperformance against the target, this had been a substantial increase in the delivery of efficiency contributions in recent years. Ms Grinstead said that the same process for defining efficiencies would be applied for 2018-19.
170.2	Dr Peter Steer, Chief Executive said that positive work had taken place to review the leadership of this work which had provided better assurance as to the deliverability of schemes.
170.3	Mr Akhter Mateen, Non-Executive Director noted that previously GOSH had delivered Better Value targets as a result of increased activity as well efficiencies and queried how far this was likely to be the case in 2018-19. Lady Amanda Ellingworth, Non-Executive Director asked how far longer term plans over more than one year were being developed. Ms Grinstead said that it was anticipated that going forward a smaller proportion of the Better Value target would be comprised of increased activity. She added that team had been asked to develop plans over two years, however discussion was taking place around increasing the term to be more in line with the LTFM.
171	Strategy Deep Dive: Quality including recruitment and retention update
171.1	Dr Andrew Long, Interim Medical Director gave a presentation on four key areas of the Trust's quality strategy: safety and reliability improvement programme, comparative clinical outcomes data, recruitment and retention and learning from deaths.

171.2	Sir Michael Rake, Chairman noted that the Trust was working with the Cognitive Institute to implement a cultural change programme and asked how this would be used to reach out to staff throughout GOSH. Dr Peter Steer, Chief Executive said that having visited organisations which were more advanced in working with the Cognitive Institute, there was a clear cultural difference. He said that 160 GOSH leaders had already been briefed on the programme and this would continue. Sir Michael said it was important not to underestimate the time and commitment required to embed a change in culture. He emphasised the importance of senior leaders adopting the programme and recognising the outcome of individual behaviours.
171.3	Professor Rosalind Smyth, Non-Executive Director said that previous discussions at Trust Board had been around collaborating with other UK centres to develop comparable outcome metrics and asked for an update on this work. Dr Steer said that GOSH was part of a European Children's Hospital organisation, ECHO and one of the key pillars of this work was health outcomes benchmarking.
171.4	Discussion took place around the recruitment and retention of nurses and Professor Smyth highlighted the report that had previously been received by the committee on the outcome of nurse exit surveys which had shown that a number of nurses had left the Trust due to lack of support from their line manager and lack of career progression. She queried the action that had been taken as a result of these tangible issues. Ms Polly Hodgson, Interim Chief Nurse said that the action plan arising from the work was being embedding including leadership work and the impact leaders have on teams along with advertising available training.
171.5	Dr Andrew Long, Interim Medical Director said that the Mortality Review Group had done excellent quality work since 2012 and GOSH was ahead of other organisations in this respect. He said that there was an expectation as part of the learning from deaths guidance about the involvement of referring practitioners which was a different process for GOSH. Dr Long said that it was important that the relevant individuals were involved and informed but that the key immediate processes were not delayed.
172	Sight and Sound Centre - Full Business Case
172.1	Ms Stephanie Williamson, Deputy Director of Development said that the current experience for ophthalmology and audiology patients attending GOSH was reduced as a result of the space not having been designed to suit their needs. She said that the proposed Sight and Sound Centre would provide a high quality patient environment alongside the opportunity to enhance services and meet increasing demand.
172.2	Mr Akhter Mateen, Non-Executive Director said that the Finance and Investment Committee had reviewed the business case and had been supportive but had emphasised the importance of delivering the development in full, in time and On budget. Dr Peter Steer, Chief Executive said that GOSH Children's Charity (GOSHCC) had already identified support for the project.
172.3	Mr Matthew Tulley, Director of Development said that the P22 Department of Health framework had been used to appoint contractors and that Kier had been appointed and provided initial costs. It was anticipated that final costs would be provided in two to three weeks' time which was in line with the GOSHCC approvals process.

172.4	Sir Michael Rake, Chairman said that the Non-Executive Directors had highlighted the importance of ensuring that sufficient due diligence was carried out with contractors. It was noted that the Department of Health carried out monthly checks on contractors on the P22 framework, however Sir Michael stressed that GOSH must assure itself that companies were sufficiently robust.
172.5	The Board approved the Sight and Sound Centre full business case.
173	Integrated Quality Report – 28th February 2018
173.1	Dr Andrew Long, Interim Medical Director said that work continued to ensure that Serious Incident reports were completed within the appropriate timeline. He said a key factor was ensuring that the relevant clinicians prioritised these meetings.
173.2	Ms Polly Hodgson, Interim Chief Nurse said that a theme had arisen from the Friends and Family Test responses around staffing levels. She said that this seemed to be related to the new Premier Inn Clinical Building space which provided cubicles for patients and nurses were not in view as much. Ms Hodgson said GOSH continued to benchmark well against other organisations for families who recommended the Trust.
173.3	The Trust had moved to the use of the Paediatric Early Warning System (PEWS) following the recommendation by the Out of Hours Steering Group and the roll out of this had been positive. This was being embedded into 'business as usual' and listening events would be taking place with staff to identify any learning to be applied to the roll out of future Quality Improvement projects.
174	Regular Director of Infection Prevention and Control (IPC) Report
174.1	Dr John Hartley, Director of Infection Prevention and Control presented the report and highlighted the positive work results in terms of antimicrobial stewardship and noted that issues in reportable areas had decreased.
174.2	Dr Hartley said he felt least assured in the area of cleaning in the Trust, particularly since a new contract had been put in place. Mr Matthew Tulley, Director of Development said that following a recent audit conducted jointly by IPC and DPS some incorrect processes had been identified. The initial management response from the cleaning contractor had been reviewed and this matter had been addressed. Implementation of the action plan was being overseen by a multi-disciplinary group which included representation from nursing, IPC and facilities. A new Director of Estates and Facilities was now in post which was having a positive impact and work was taking place to address the issues with the contractor. Dr Peter Steer, Chief Executive said that the issue had been acknowledged and it was recognised that substantial improvement was required. He added that robust contract management was also a factor.
174.3	Mr James Hatchley, Non-Executive Director emphasised the importance of a clean environment particularly in some areas of the hospital. He asked whether the contract was sufficiently robust to hold the contractor to account. Mr Tulley said he believed it was and confirmed that there were specific cleaning standards set for each area of the hospital which had been defined by the IPC team.
174.4	Action: Mr Akhter Mateen, Non-Executive Director asked for more information about the hand hygiene audits which showed poor compliance. Dr Hartley

174.5	<p>emphasised that the data represented compliance with hand hygiene audits. He said that the audits that had taken place had shown hand hygiene compliance of approximately 95%. It was agreed that consideration would be given to different ways of measuring and representing the data, outside the meeting.</p> <p>Action: Discussion took place around the lessons learnt exercise that was taking place with the DPS and IPC teams around issues related to the opening of the Premier Inn Clinical Building and it was agreed that an update would be provided at the next meeting.</p>
175	Integrated Performance Report (28th February 2018)
175.1	Ms Nicola Grinstead, Deputy Chief Executive presented the report and highlighted that the Trust had achieved the RTT target for two consecutive months which made GOSH a positive outlier. The Board congratulated the team for the significant work which had led to this compliance.
175.2	Action: It was agreed that a list of definitions on the data quality dashboard would be provided at the next meeting.
175.3	Action: The next report would provide context and highlight any risks for metrics which had been persistently rated red.
175.4	<u>Finance Report (28th February 2018)</u>
175.5	Ms Helen Jameson, Chief Finance Officer said that the Trust's overall surplus had reduced in comparison to budget. Ms Jameson said she was confident that GOSH would meet the Control Total, but the level by which it had been exceeded would reduce. IPP activity had reduced as a result of the bad weather London had experienced in February along with fewer days in the month, however IPP debtor days had reduced.
175.6	Sir Michael Rake, Chairman highlighted the £13million deficit reported by the JM Barrie division and queried the reason for this. Ms Grinstead said that an ambitious business case had been included in the budget for patients who were often cancelled due to the availability of HDU beds. She added that PICU underperformance against projections was driven by the availability of nursing skill mix.
175.7	Mr James Hatchley, Non-Executive Director said that the JM Barrie management team had presented their financial case, however there had been further deterioration since this point.
176	Update on Gastroenterology Review (RCPCH report and GOSH response)
176.1	Dr Andrew Long, Interim Medical Director said that throughout the three year period of the independent review it had been vital to communicate well both internally and externally. He said that further work had taken place on internal communication around this issue and the team was now satisfied that this had been done well. Dr Long said that the review had resulted in a considerably better experience and outcome for patients.
176.2	The number of new gastroenterology referrals to the Trust had been reduced and a conservative approach would be taken to increasing referrals. Discussions were

	taking place with commissioners about a London network which provided the appropriate support for patients. Dr Peter Steer, Chief Executive said that the task and finish group had met on 27 th March and the action plan was now complete.
176.3	Sir Michael Rake, Chairman emphasised the importance of members of GOSH staff adhering to expected behaviours.
176.4	The Board thanked Dr Long for his work on the gastroenterology review.
177	2017 GOSH Annual Staff Survey Results
177.1	Action: Mr Ali Mohammed, Director of HR and OD said that the next Board meeting would receive the action plan arising from the staff survey results. He said that the response rate had reduced since 2017 and although this had been experienced across Trusts, GOSH's had been greater.
177.2	The key areas to be considered in the action plan were members of staff's experience of bullying and harassment, senior management communication with staff and a perception of staff not being supported by their immediate manager. Mr Mohammed said that feedback had been received at a staff partnership was that good work had taken place around Executive visibility. A commitment had been made to work in partnership with unions on actions.
177.3	Action: It was agreed that options for surveying the staff body as a whole would be provided at the next meeting.
177.4	Action: Professor Rosalind Smyth, Non-Executive Director expressed concern that a number of issues raised by staff were around safety and it was agreed that results would be separated into clinical and non-clinical areas for the next meeting. Mr James Hatchley, Non-Executive Director added that it would be helpful to identify whether responses were provided from a particular hospital area.
178	Guardian of Safe Working – quarterly report
178.1	Dr Renee McCulloch, Guardian of Safe Working presented the report and said that the guardian role was a new one arising from the change to Junior Doctor contracts. Part of the role involved reporting around rotas and hours for Junior Doctors, the mechanism of which was challenging as it required almost real time reporting. A survey of Junior Doctors had confirmed they were uncomfortable with this process as reports were provided directly to educational supervisors; work was taking place to establish a different system.
178.2	Professor Rosalind Smyth, Non-Executive Director welcomed the report and highlighted that although many of the issues were national, GOSH was a challenging working environment and it was vital to have good consultant support and encouragement to not work excessive hours.
178.3	Discussion took place around the junior doctor vacancy rate and it was noted that national recruitment in paediatrics was low.
178.4	Dr McCulloch invited members of the Board to the next Junior Doctor Forum on Thursday 19 th April.

179	Register of Interests and Register of Gifts and Hospitality
179.1	Dr Anna Ferrant, Company Secretary presented the registers and said that positive work had taken place with the research and innovation team to look at potential or actual conflicts of interest and develop guidance.
180	Compliance with Emergency Preparedness, Resilience and Response standards
180.1	Ms Nicola Grinstead, Deputy Chief Executive said that the Trust had a statutory responsibility to respond at a high level to major incidents. It was confirmed that Mr Akhter Mateen was the Non-Executive Director with responsibility in this area and Ms Grinstead was the responsible officer.
180.2	Across 66 mandatory standards which were subject to self-assessment and then peer reviewed, 63 standards had been rated green for GOSH, two amber and one red. The red standard was around attendance at a national event and the requirement for this had now been changed. The two amber standards had resilience plans in place. Ms Grinstead said that focus was being placed on how this worked would be impacted by the 'go live' of the Electronic Patient Record.
181	Equality & Diversity Annual Report and Update against Equality Objectives
181.1	Action: Mr Ali Mohammed, Director of HR and OD said that progress was being made with objective six: improving the representation of BME staff in senior posts. He added that a number of staff had been accepted onto national programmes which was very positive and consideration would be given to how this information would be provided to the Board.
182	Any Other Business
182.1	Sir Michael Rake, Chairman noted that it was last meeting of Mr David Lomas, Non-Executive Director, Dr Andrew Long, Interim Medical Director and Ms Polly Hodgson, Interim Chief Nurse. He thanked them for their contribution and the work that had taken place.

ATTACHMENT G

**TRUST BOARD – PUBLIC ACTION CHECKLIST
May 2018**

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
10.1	28/11/17	GOSH Learning Academy: It was agreed that a refreshed paper would be considered by the Board at the next meeting which would include information about funding mechanisms. Board members should contact the Chief Executive or Company Secretary to feed their questions into the project.	Andrew Long and all Board members	May 2018	On agenda
110.2		Professor Rosalind Smyth, Non-Executive Director and Director of the UCL GOS Institute of Child Health requested that discussion took place between the two organisations to capitalise on work that could be done collaboratively.			
135.8	07/02/18	Professor Rosalind Smyth, Non-Executive Director highlighted the important pharmacy review which was taking place and had been discussed by the Quality and Safety Assurance Committee and it was agreed that the Trust Board would receive an update on this work.	Andrew Long/Matthew Shaw	June 2018	Not yet due
135.10	07/02/18	Mr David Lomas, Chair of the Finance and Investment Committee said that the meeting had considered the use of Patient Level Costing to allow patient level data to be cut in many ways giving an insight into the negative NHS contribution. The Committee had also reviewed the drivers of revenue in terms of	HJ	November 2018	Not yet due

Attachment G

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		activity volumes and tariff and it was agreed that both these topics would be discussed by the Board during 2018/19.			
137.13	07/02/18	It was agreed that a snapshot of current divisional performance for all divisions and targets which were set but had not been achieved would be circulated outside the meeting.	NG	May 2018	In progress for end of year – on agenda
165.4	28/03/18	Work to take place to look at why some appointments, as highlighted in the patient story, were being booked by consultants' medical secretaries rather than the appointments team.	NG	July 2018	Not yet due
166.3	28/03/18	It was agreed that the Board would thank the external pharmacist who had been embedded in the pharmacy team to conduct the review.	MR	May 2018	In progress
	28/03/18	It was agreed that the draft Lead Governor role description would be considered at the May Trust Board.	AF	May 2018	On agenda
174.4	28/03/18	The Board discussed the hand hygiene audit results as part of the infection prevention and control report and it was agreed that discussion would take place outside the meeting to look at a different way of presenting the data.	John Hartley	September 2018	Not yet due
174.5	28/03/18	Discussion took place around the lessons learnt exercise that was taking place with the DPS and IPC teams around issues related to the opening of the Premier Inn Clinical Building and it was agreed that an update would be provided at the next meeting.	MT/ AR	May 2018	Please see response attached to action checklist

Attachment G

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
175.2	28/03/18	It was agreed that the list of definitions which were used for data quality kitemarking and for the use of 'executive judgement' would be provided at the next meeting.	NG	May 2018	On agenda
175.3	28/03/18	Persistent red rated metrics on the performance dashboard to be given context and risk issues highlighted in future reports.	NG	Ongoing	On agenda
177.1	28/03/18	It was agreed that the action plan for the staff survey would be considered at the next meeting.	AM	May 2018	On agenda
177.3	28/03/18	The next update on staff survey results to include options around the proportion of staff surveyed each time and to consider surveying the whole staff body.	AM	May 2018	On agenda
177.4	28/03/18	Staff survey themes to be divided into clinical and non-clinical areas.	AM	May 2018	On agenda
181.1	28/03/18	Mr Ali Mohammed, Director of HR and OD said a number of staff in the Trust had been awarded a place on national development programmes which was very positive. Consideration would be given to how this information would be provided to the Board.	AM	July 2018	Not yet due

Action 174.5

At the last Trust Board meeting the DIPC report raised a number of environmental issues about which the Trust Board requested further information. The information below provides this detail. The key message is that we provide a safe environment for our patients and that the IPC and DPS teams work collaboratively to deliver this safe environment. The communication process generally works well but has not always been as systematic as it should be. Additional measures have been put in place to ensure this occurs consistently and that any identified issues are dealt with swiftly.

a. Cleaning – there have been difficulties this year (see IPC committee report) with an improvement action plan currently in place.

The DPS and IPC teams work closely on monitoring cleaning standards. The cleaning audits and observation of cleaning practice identified some areas of poor practice which had not been picked up by OCS supervision. As noted in the IPC report an action plan is in place to remedy these failings and deliver high quality services. This plan was developed jointly by IPC, DPS facilities team, nursing teams and OCS. Implementation is regularly monitored by the multi-disciplinary team.

b. Water Safety Management

- Heater cooler units for cardiac bypass - mycobacterium infection risk has been significantly reduced with change of machines. Water surveillance continues.

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- Low temperature silver/copper control system in PICB has not been commissioned adequately. There is no legionella present, but currently risk of control failure.

The safety of water systems are monitored at the monthly Water Monitoring Committee. The Water Safety Management committee is chaired by the DIPC and meets every quarter. As noted in the DIPC report there is no legionella present in PICB. Prior to handover of the building water systems were tested and demonstrated to be legionella free. All subsequent tests for legionella have been negative.

The primary (but not only) legionella control throughout Mittal Children's Medical Centre (MSCB and PICB) is the use of silver/ copper ionisation. Testing has shown good levels of silver/ copper in the water as it enters PICB but on the return flow tests, post occupancy, show levels of silver only are below where they ideally should be. A similar situation occurred when MSCB became operational which was resolved through increasing flow rates. The estates team is investigating the cause. The most likely cause is that flow rates in the occupied building are lower than modelled – possibly caused by the work on Level 4 PICB. Recent work to increase the flow has seen levels of silver increase above target levels. The situation is monitored to identify whether this is a sustained change.

If the silver/ copper control was failing and legionella was identified in the system, the water system would be pasteurised.

Attachment G

- c. Ventilation systems –Verification schedule has improved compliance. Good process with theatres.
- Verification of specialist ventilation in PICB not completed before occupancy. Further work necessary.

The GOSH Approved Person for ventilation (Brian Needham) signed off the newly commissioned specialist ventilation system prior to the occupation of PICB. All PPVL rooms in the building (levels 2, 5 and 7) and both theatres underwent microbiological testing before occupation. In cases where areas/rooms did not pass on the first attempt (level 7 and level 2), the cleaning and plate testing process was repeated until a satisfactory result was achieved. Room 13 on level 7 repeatedly failed and remedial work was undertaken to address the ventilation issues. This room was not occupied until this work was complete and plate testing passed. As can happen, the commissioning period prior to occupation became tight and there were some delays in getting the final verified test results to the IPC team but, as advice from IPC was followed to restrict the use of the room, patient safety was not put at risk.

The L7 PPVL rooms will be used to accommodate BMT patients during the summer to facilitate the annual verification of ventilation systems in VCB. It has been agreed with IPC and the operational team to undertake a re-verification exercise of the PPVL rooms prior to the patient decants to confirm the performance of these areas.

- d. Decontamination – risk due to age of endoscopy decontamination unit and mattress cleaning. This was hoped to be mitigated through the business case for new endoscopy unit and MEDU, but this has not progressed.

The scope of the project has expanded including consideration of a new unit in the Phase 4 project, which therefore requires additional review. The decontamination team has identified an alternative location and option which is currently being discussed with IPC.

- Risk will arise from shortage of staff with specialist knowledge to fulfil Head Decontamination.

The previous head of decontamination retired after many years of service and fulfilled an extended notice period, including detailed handover. A plan was implemented and communicated to IPC prior to her retirement. The Trust has appointed a new experienced post holder who works across two London NHS Trusts. The Trust has access to qualified resources to ensure appropriate oversight of the decontamination service.

Lessons learnt from the PICB commissioning process

A debrief has been undertaken between DPS and IPC on the commissioning process and where the teams can work together more effectively. Two key themes of resources and communication were identified as areas for the teams to improve. Several actions have been implemented:

- 1) One of the major issues discussed was the resource requirement to commission new facilities and the stretch this places on the IPC team whilst undertaking business as usual. We are looking at projects funding additional IPC resource to overcome this capacity issue.
- 2) Clearer checklist of what technical commissioning information IPC need to review and when during the process (e.g. pre or post contractor handover). Some ambiguity in what the teams thought was required and agreed was also identified. (The checklist is being trialed during the handover and commissioning of Alligator Ward).

Attachment G

- 3) A stricter approach to the handover process with contractors with the requirement to provide all final test certificates prior to accepting building handover. In the past interim certificates of test data witnessed by the Approved Person would be acceptable.
- 4) A more formal documentation process recording IPC has reviewed and confirmed all of the relevant test data prior to building handover and patient occupation.
- 5) A monthly meeting has been established between the Director of Estates and Facilities and the DIPC. The Chief Nurse also meets with the DIPC fortnightly and will directly raise any relevant issues with the Development Director.

Matthew Tulley – Development Director

Alison Robertson – Chief Nurse

15th May 2018

Trust Board 23 May 2018	
Patient Story – Transition	Paper No: Attachment 4
Submitted on behalf of Alison Robertson, Chief Nurse	
<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 experience of families are captured.</p> <p>The story to be shared on 23 May has been pre-recorded and details five patient's (some now ex patients) experiences of transition whilst at Great Ormond Street Hospital. These patients span a number of specialties. There are examples of challenges which many young people face when transitioning to adult services.</p> <p>3 key messages to take away from this story are:</p> <ol style="list-style-type: none"> 1) Young People (YP) who have recently moved to adult services from GOSH feel they were underprepared 2) YP and their families are unaware of the skills and knowledge needed to manage their healthcare 3) Clinical engagement is essential to improve the situation for GOSH patients and families 	
Action required from the meeting Review and comment	
<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 	
Financial implications None	
Who needs to be told about any decision	

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

Emma James – Patient Experience and Engagement Officer

Who is accountable for the implementation of the proposal / project

Herdip Sidhu-Bevan– Assistant Chief Nurse Quality and Patient Experience

Author and date

Nigel Mills – Transition Improvement Manager, Emma James – Patient Experience and Engagement Officer – April 2018

ATTACHMENT H

Summary of the Audit Committee meeting held on 16th April 2018

The Committee noted the draft minutes of the January Finance and Investment Committee meeting and the January meeting of the Quality and Safety Assurance Committee.

Board Assurance Framework Update

The Committee discussed the large number of BAF risks with a net risk score which were higher than the risk appetite and the time frame within which it was proposed that these scores would be reduced. It was agreed that discussion took place at the Trust Board to scrutinise the risk appetite scores.

Presentation of high level risks

The Committee reviewed the following high level risks:

- Risk 8: 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

Discussion took place around whether the likelihood score should be reduced in light of the excellent work which had taken place on RTT and the Trust's best practice status in this area. It was agreed, however, that reductions should be considered post Electronic Patient Record implementation due to the risk associated with moving data to this platform and existing challenges.

- Risk 9: 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

It was noted that good consent processes were in place around research which would mitigate the risk around GDPR compliance however work was taking place to ensure that the correct consent was in place for sharing data, particularly with commercial companies. The opportunities provided to the Trust by opening of the Zayed Centre for Research into Rare Disease in Children were emphasised.

- Risk 13: Inadequate planning or management of infrastructure redevelopment may result in poor VFM or failure to deliver expected business benefit

Discussion took place around the Trust's ability to complete projects within the expected timeframe and on budget. The Committee expressed some concern about the risk score and suggested the risk was high rather than medium in light of the increasing sunk costs for Phase 4 and the on-going possibility that the development could be paused.

Update on Cyber Security

Good work continued to take place to ensure that appropriate technology, governance and policies were in place and that staff were aware of their responsibilities in relation to cyber security. An independent third party company had undertaken a phishing exercise and no staff had failed the phishing exercise. It was noted that the Trust had not been affected by the global cyber security incident in 2017 due to steps taken to protect the GOSH network.

Update on GDPR Preparation

NHS GDPR guidance had been recently issued and a low level action plan was being developed. The Trust was engaging widely with organisations across London as part of an information governance

Attachment H

network. Discussion took place around the potential impact of the response by families to the right to access data and it was noted that an influx of requests would place substantial strain on resources.

Changes to accounting policy – IFRS 15

It was noted that IFRS 15 would impact the Trust through changes in the timing of recognising income. The Committee discussed the way in which this change would affect contract negotiations.

Valuation of Trust's Estate

It was noted that there had been an improvement in the impairment required following the valuation of the estate.

External Audit: Interim update report to the Audit Committee for the year ended 31 March 2018

The Committee noted that following the audit of the 31 day cancer wait metric no issues had been found, however in terms of RTT some errors had been noted which were in the process of being validated. The significant improvement in GOSH's position was highlighted as was the assurance of scrutiny of systems by the Intensive Support Team. The external auditors stated that they would confirm the final opinion once validation had been completed.

Internal Audit Progress Report, Technical Update and Draft Head of Internal Audit Opinion for 2017-18

The Trust's draft Head of Internal Audit Opinion was 'significant assurance with minor improvement opportunities'. It was noted that although some amber-red reports had been received with high priority recommendations, the key areas were well controlled.

The Committee received two internal audit reports: Cancelled operations and financial controls for which both were provided with ratings of 'significant assurance with minor improvement opportunities'.

Internal and external audit recommendations – update on progress

The Trust continued to make good progress with implementing recommendations.

Internal Audit Strategic and Operational Plan: 2018-19

It was agreed that a separate meeting would take place with the auditors prior to finalising the 2018-19 plan.

Counter Fraud Annual Report and Counter Fraud Workplan 2018/19

It was noted that levels of referrals and prosecutions had dropped across the NHS. The Committee approved the workplan.

Whistle blowing and Freedom to Speak Up Ambassador update

A Freedom to Speak Up Guardian had been appointed in line with CQC recommendations and they had access to the Senior Independent Director and Chief Executive. They would report straight to the Quality and Safety Assurance Committee. Discussion took place around the low number of issues raised through FTSU channels and responses to staff surveys which indicated that staff had been subject to bullying and harassment. It was noted that a deep dive on this would be taking place at the QSAC.

Attachment H

Draft Annual Governance Statement 2017/18

It was agreed that any comments would be passed to the Company Secretary.

Draft Audit Committee Report to be included in the Annual Report

The Committee agreed to circulate the document with changes prior to the next meeting.

Process for appointment of external auditor, internal auditor and counterfauud service

The Committee discussed the timing for the process and noted the impact of the Christmas period.

Performance Report – Month 11 (2017/18)

The report, which was provided for information, was noted.

ATTACHMENT I

**Summary of the meeting of the Quality and Safety Assurance Committee
held on 9th May 2018**

Matters arising/ Action point checklist

The Committee discussed consent clinics and it was noted that this process had been implemented in cardiac surgery however there was variability in the process across the Trust. It was confirmed that the Trust was working towards this process for all interventions and the committee requested an update on progress at the next meeting.

Integrated Quality and Safety Update

Work was taking place to deep dive into cardiac arrest trends at GOSH which, although static, were higher than at other Trusts although survival rates were significantly higher also. The Committee noted that GOSH carried out substantially more cardiac surgery than other centres and was a significant positive outlier in terms of mortality. It was confirmed that all arrests were reviewed and no themes had emerged.

Following concerns raised about the timeliness of the completion of Serious Incident reviews, one report remained outstanding and assurance was given that timelines would be adhered to going forward.

Draft Quality Report 2017/18

The committee noted the positive transformation projects which had taken place in 2017/18

Quarterly Safeguarding Report (January 2018 – March 2018)

The expanded number of posts in the safeguarding team had now been filled and one team member would lead on adult safeguarding. Discussion took place around honorary contract holders' safeguarding training compliance and it was confirmed that of those whose training in this area was outstanding, some honorary consultants had their contracts ended after repeated contact with no response and the remainder were working with HR to complete the training. It was confirmed that compliance was much improved.

Clinical Audit update January 2018 – March 2018 including clinical audit workplan for 2018/19

An audit of compliance with management of naso-gastric tubes had taken place following the implementation of learning as a consequence of a Never Event in 2016. Good clinical practice had been found with no safety concerns. Discussion took place around the appropriate use of intravenous fluid therapy and it was noted that an audit had shown that 98% of prescriptions were appropriate and the remaining 2% accounted for one patient. The Committee emphasised the importance of this clinical issue in paediatrics.

Whistle blowing and freedom to speak up to update - Quality related cases

The Committee noted that the Freedom to Speak Up Guardian role was primarily focused around safety and the importance of having clear processes to filter other concerns raised through this mechanism into the correct routes was emphasised.

Board Assurance Framework Update

The Committee received updates on the following high level risks:

- Risk 4: 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

Significant work had taken place on recruitment and whilst maintaining this work, focus would now be placed on retention. Discussion took place about the net risk score and it was noted that GOSH's

position in terms of recruitment of nurses and vacancy rates was significantly better than many other Trusts.

- Risk 5: The trust is unable to demonstrate compliance with Performance Management Framework/ Monitor's licence

It was reported that the ongoing risk areas were around financial performance and mandatory training. Substantial savings had been assumed within divisional budgets and work was taking place to ensure schemes were attributed to these.

QSAC Annual Report 2017/18

A review of the work of the Committee would take place in July once the new Chairman of the Committee was in place.

Update on Compliance with Risk Management Strategy

It was noted that the general trend was a reduction in total risks but an increase in high risks and work was taking place to ensure that risks were reviewed in line with the requirements set out in the strategy.

Compliance Update

The Trust's PLACE inspection had taken place at the end of April and positive initial feedback had been received. A mechanism to continually review CQC action plans within each service line was being put in place.

Bullying and harassment Update

Reporting of bullying and harassment was increasing and the committee expressed concern at the number of reports received. The importance of ensuring sufficient manager training was in place was emphasised and it was reported that managers had been asked to develop an action plan for their area.

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

The KPIs showed that there had been no negative impact on quality and safety resulting from Better Value schemes in 2017/18. It was noted that the 2018/19 anticipated that savings would be delivered from month 2 and therefore timings around implementing schemes were crucial.

Internal Audit Progress Report (January 2018 – March 2018) and Strategic Operational Plan 2018-19

Two internal audit reports had been finalised since the last meeting: cancelled operations which had received a rating of 'significant assurance with minor improvement opportunity' and nursing recruitment and retention which had received a rating of 'partial assurance with improvements required'. The Committee expressed some surprise at the rating of the recruitment and retention review and expressed concern that HR processes were not performing optimally. KPMG confirmed that they felt assured this was around documentation rather than a failure of process. The Committee approved the Strategic Operational Internal Audit Plan for 2018-19.

Internal and external audit recommendations update

The Committee welcomed the progress in closing outstanding recommendations. It was agreed that the following matters would be raised at the Trust Board:

- Bullying and harassment
- Mandatory training completion rates
- Freedom to speak up
- Triangulation issue around recruitment and retention and the outcome of the KPMG audit.

ATTACHMENT J

Summary of the Finance and Investment Committee meetings held on 20 March 2018 and 14 May 2018

Summary of purpose and scope of report

This report summarises the Finance and Investment Committee's (FIC) work since its last written report to the Trust Board in January 2018 and the verbal report in March 2018. Since January 2018, the FIC met on 20 March 2018 and 14 May 2018.

Trust Board members are asked to note the key issues highlighted by the Committee, note the rest of the report, and pursue any points of clarification or interest.

Key issues for the Board's attention

- The Trust ended the 2017/18 financial year £0.2m ahead of its control total.
- Noted the finance, performance, activity trend, contract update and better value reports.
- Reviewed and endorsed the 2018/19 budgeting approach.
- Received an Intra-operative MRI (iMRI) update and approved £950k for initial mobilisation. The full business case would be presented to the July Trust Board after further review by FIC.
- Reviewed the strategy for the GOSH Learning Academy and approved a request to proceed with a detailed business case.

Performance and finance standing updates

Finance report 2017/18 Month 12

The Committee noted that the Trust ended the 2017/18 financial year with a £9.9m surplus against a target of £9.7m; this was £0.2m ahead of the control total agreed with NHS Improvement (NHSI). Committee Members noted that this performance made the Trust eligible for a £3.5m incentive payment or 'bonus share' received from NHSI Sustainability and Transformation Funds (STF).

The Committee:

- Congratulated the finance team for achieving the financial surplus.
- Considered additional areas to enhance future financial reporting.
- Requested additional information on the alignment of governance process and timetabling for the approval of charity funded projects and revenue streams.

Performance scorecard Month 12

The Committee noted that the Trust had achieved the Referral to Treatment (RTT) national standard for the third consecutive Month. Theatre utilisation underachieved against the national standard of 77%, the division commenced a piece of work to focus on the booking processes, theatre planning and productivity. The Trust reported 100% achievement against all four national indicators applicable to GOSH.

The Committee:

- Requested that the reporting of 'Never Events' move to a real time basis.

- Recommended that the Committee received the most accurate and up to date information as part of the scorecard even if such information was still subject to final ratification.

Activity Trends 2017/18 Month 12

The Committee noted that outpatient activity increased by 1% from 2016/17, and day cases and elective activity increased by 2%. This was partly enabled by the additional capacity made available through the opening of The Premier Inn Clinical Building (PICB).

NHS Contract value monthly update

The Committee noted that as part of agreeing a year-end position with commissioners, a block contract of £313.2m was signed with NHS England for 2017/18.

Better Value Monthly update

The Committee noted the progress to date and the plans for identifying further local schemes. The Committee advised that it was essential that schemes were owned by divisions in order for them to achieve the savings.

Charles West and J M Barrie Divisional review

The Committee noted the two divisional reviews, discussing the following items:

Charles West

- There was no material double counting in Charles West, during the establishment of PICB.
- It was hoped the capacity issues would be eased by the opening of Alligator Ward.
- Strong financial performance was noted

J M Barrie

- A PICU / NICU review to examine capacity in critical care would be finished by August 2018
- Continuing underperformance was noted albeit at an improved level from the last FIC update

Annual Planning

2018/19 NHS Improvement annual plan update

The Committee noted the final submission of the Financial Plan 2018/19 and Operational Plan. The Committee noted that it had reviewed previous iterations.

2018/19 draft budget review

The Committee noted the development process for the 2018/19 budget and budget envelopes for each division. Specifically:

- The budget aimed to achieve the NHS Improvement control total of a £12.1m surplus (as notified to the Board).
- That a series of challenge sessions had been held with the deputy chief executive, senior operational leads and senior finance staff. The sessions identified saving opportunities and addressed historical issues. Once completed, a consolidated position will be presented to the Trust Executive for review and agreement.

The Committee discussed the number of budget holders in the Trust and the support they received from their finance partners in the finance directorate and education and training.

The Committee was given assurance that there is a process in place such that the budget holders are fully aligned to the delivery of the budget outcome for the year; whilst there were still a number of small steps required to finalise the last details of the budget these were progressing in line with plan.

Project Update / Reviews

The following project reviews and updates were reported and discussed:

Electronic Patient Record (EPR) Programme Update

In March 2018, the Committee noted that the progress for the programme in February was reported as 'Good' and the project remained in line with the budget and broadly on track. Opportunities for collaboration were reviewed. The Committee requested that no additional risk was placed on the GOSH programme.

In May 2018, the Committee noted the update.

Post Implementation Review – Southwood Imaging Suite

In March 2018, the Committee reviewed the paper on lessons learned from the Southwood Imaging suit and requested further financial analysis on the project. The Committee noted the qualitative analysis and asked that a post-implementation review template be created that includes detailed financial analysis information and which confirmed the lessons learnt from the implementation of the project.

In May 2018 the Committee reviewed the new template and the list of current projects scheduled for review. The Committee requested that the template be completed for a current project and triangulated back to include a complete list of current projects, so that any pertinent lessons learned could be shared.

Intra-operative MRI (iMRI) update (May 2018)

The Committee noted the update and raised two comments for discussion:

1. The programme was first discussed in May 2016 as a critical need for the Trust. However, two years later the Trust has not initiated construction. Committee members were informed that the paper presented in May 2016 was a feasibility study and several delivery issues had been resolved since then.
2. The final cost quote is £14.07m. The Committee requested assurance that no quality compromises had been made. The savings had been identified through the redesign of a less complicated structure. It was confirmed that there were no clinical quality compromises.
3. Management confirmed that the project was still very important to the Trust and that the business case was still relevant and a priority

The Committee approved £950k to ensure the project was not subject to further delay , which would enable mobilisation on the project (specifically to order items that will take time to arrive) have a long order time, while the final the business case is completed.

It was noted that the full business case would be presented to the July meeting of the Trust Board after a further iteration was presented to FIC.

The Committee identified the iMRI project as a future post-implementation review area.

Learning academy business case (May 2018)

The Committee reviewed the strategy for a GOSH Learning Academy, where the preferred option was to move to a dedicated 'off-site' facility close to the GOSH campus in which the entire service could be housed and add capacity to the Trust's education provision. The Committee agreed to progress to a more detailed business case and requested more commercial context on the delivery of education across London (e.g. demand and external provision) and as it relates to paediatrics as well as detail on what other delivery options could be and information on how other hospitals deliver their training.

Governance and assurance

The May meeting of the Committee was the first to be chaired by James Hatchley – Non-Executive Director. The previous Chairman David Lomas' last meeting was March 2018.

Mr Chris Kennedy, Non-Executive Director joined the Committee as a member and attended the Confidential meeting on 14 May 2018.

The Committee reviewed its forward plan for 2018/19, identifying areas of focus.

The Chair requested that all reports clearly state the salient points on the coversheet. This was implemented for the May Committee and was endorsed as a format for future papers.

The Committee would undertake a self-assessment of effectiveness survey in June and review the findings at the next meeting of the FIC.

Colin Simcock, Governor was an observer at the May 2018 meeting.

End of report

ATTACHMENT K

Summary of the Council of Governors' meeting held on 25th April 2018

Declarations of interest

The Council of Governors noted the register of Governors' declared interests which would be uploaded to the GOSH website.

The Council and Board working together

The Council approved the proposal that the former Deputy Lead Governor take on the role of Lead Governor (Mariam Ali) for a period of one year in order to support the continuation of knowledge in the Council. Discussion took place about the timetable of meetings and it was agreed that the key up to date information would be provided to Governors.

Update on the work of the Constitution Working Group

It was reported that the positive and constructive work had taken place to review the constitution and it was agreed that Governors who were interested in sitting on the working group should contact the Company Secretary. The Council approved the updated Group's Terms of Reference.

Draft Lead Governor (and Deputy Lead Governor) Role Description

It was agreed that Governors should provide any comments on the role descriptions outside the meeting and this would be considered for approval by the next meeting of the Constitution Working Group.

Nominations for appointment to Council of Governors Nominations and Remuneration Committee

The Council approved the Terms of Reference for the committee and endorsed the appointments of four Governors to the Committee.

Nominations for appointment to Membership Representation, Recruitment and Engagement Committee (MERRC)

The Council endorsed the appointment of six Governors to the Committee.

Process for the appointment of a Non-Executive Director

The Council of Governors noted a self-assessment of Board knowledge and noted that the proposed process was the same as the one which had been approved by the Members' Council Nominations and Remuneration Committee for the appointment of two previous Non-Executive Directors. It was confirmed that young people would continue to be involved in the appointment. The Council approved the process.

Non-Executive Director Appraisal process

It was agreed that a formal 360 degree appraisal process would be implemented by Spring 2019 to ensure that Governors were able to work with Non-Executive Directors before providing feedback.

The Chairman agreed to speak with the Lead Governor for informal feedback in advance of the July meeting for 2018 appraisals. The process was approved.

Chief Executive Report (Highlights and Performance) including integrated quality report and finance report

The Chief Executive provided updates on the following areas:

- Outstanding performance for a second three year cycle by cardiac surgical team highlighted in NICOR report
- GOSH has been invited to lead the work on fragmentation of paediatric services in North Thames
- The contract with NHS England for 2018/19 has been signed.
- GOSH was moving ahead with the renovation of the Italian Hospital

CQC report and actions in response to recommendations

The 2018 CQC inspection focused on Surgery, Outpatients and the aspect of 'well led' in the Trust as a whole and showed significant improvement in outpatients. The CQC had noted many outstanding services and excellent multidisciplinary team working. The CQC had highlighted that work was required to give staff ownership and to ensure that nursing colleagues had a clear voice within the organisation. Discussion took place around the importance of ensuring that staff were engaged and felt valued and the importance of good leadership in contributing to this.

The Council discussed the way in which GOSH could use its high profile nature to encourage change within the NHS. It was noted that a consultation was planned around a divisional restructure in order to combined services in a way that aligns patient pathways and collaboration.

Reports from Board Assurance Committees

- Quality and Safety Assurance Committee (January 2018 agenda)

The Committee had discussed the pharmacy review and welcomed the work taking place. A detailed report had been received on a number of high level risks and the committee continued to monitor actions arising from patient stories. The Council noted that Lady Amanda Ellingworth would take the Chair from the next meeting in July.

- Finance and Investment Committee (March 2018 agenda)

Focus was placed on financials and financial sustainability and the committee reviewed budgets and divisional performance including the challenging better value programme. The committee continued to scrutinise the implementation of the Electronic Patient Record.

- Audit Committee (April 2018 agenda)

The Committee had noted a draft Head of Internal Audit Opinion of significant assurance with minor improvement potential which was positive. The meeting had reviewed strategic risks, data quality and research and innovation and were assured that risks were sufficiently mitigated. The Committee continued to review readiness for GPPR.

Update on review of the Trust Constitution

The Trust's Constitution Working Group has been set up as a short life working group to complete a review of the Constitution and proposed amendments where appropriate. The Group is made up of a mix of Governors, a NED and Trust staff and is chaired by the Deputy Chief Executive. Support is provided by an external governance team.

The Constitution was last revised in September 2014. The Group has met three times between January and March 2018 and has agreed a workplan. Items discussed and recommended for consideration/ by the Board and the Council in July will include:

- A standard operating procedure (SOP) should be drafted outlining the expected availability and use of telephone, webex, portal and internet access for governors and including etiquette in using these media. [To be drafted]
- Staggering of election is essential to ensure the Council is refreshed regularly whilst at the same time preventing a large-scale change of governors at one time. A mix of 2 year and 3 year terms should be used and the Trust should aim for approximately a third of councillors coming up for election each year. It was noted that this would have resource implications for the Trust (staff time and election costs). The Council and Board would need to agree whether to implement the phasing in 2018 or wait until 2020 and the next election. [Options being worked up by Group]
- Maintain the patient/ carer constituency: The Group agreed that recent experience of the Hospital as a patient or carer is key. The views of young people are particularly important and any revision to the criteria should support this principle. The 6 year rule for patients and carers remaining in this constituency (from the final appointment date) should be amended to a 10 year rule as it was felt that such an extension continued to support the principle of capturing recent experience of Hospital services. Members would be asked to verify they can be placed in the patient /carer constituency on joining the FT. Reminders would also be sent out during the year asking members to update their personal details.
- Attendance by governors at meeting is important: The Chairman, Lead Governor and Company Secretary should consider whether the reason for non-attendance cited by a governor is 'reasonable'. A standard operating procedure should be drafted including examples of accepted reasons for non-attendance should be drafted [To be drafted].
- Investigation of complaints about governors: The current criteria for removal of a governor (a breach of the code of conduct; acting in a manner detrimental the interests of the Trust; or if it is not in the Trust's best interests for him/her to continue as a governor) should be added to, using examples of serious/ material breaches from the other trusts. The Council should continue to vote on the removal of a councillor - the $\frac{3}{4}$ majority should be retained for governors present and voting with the need for a public councillor majority as is the case now. Depending on the seriousness of the breach, mediation should always be sought where appropriate. The Group agreed that the Code of Conduct needs to be reviewed ad updated to include reference to dealing with complaints [on the next Group meeting agenda]. Managing complaints that are not material or serious should be aligned with the Trust policy as close as possible. The need for clarity about how a suspension is invoked is needed. [For discussion by the Group]. Where an investigation is proposed, a monitoring panel should be established (proposed the Chairman, SID and Lead Governor). The panel could review the

breach, propose the terms of reference of the investigation and timelines and report back to the Council on the rationale for and progress with the investigation. A standard operating procedure should be drafted for consideration.

It is envisaged that the Group will meet 3-4 times between May and July 2018 to complete the work. It is planned that the work will be completed by mid-July in time for presentation of a revised Constitution at the July 2018 Board and Council meetings and the Annual General Meeting (where some proposed changes will need to be approved (2 October 2018)).

Trust Board 23 May 2018	
GOSH Foundation Trust Annual Financial Accounts 2017/18 and Annual Report 2017/18	Paper No: Attachment L
Submitted by: Helen Jameson, Chief Finance Officer Anna Ferrant, Company Secretary	
Aims / summary The Trust is required to publish a Foundation Trust annual report and accounts for 2017/18. Board members will find attached the following documents: <ul style="list-style-type: none"> • A copy of the annual accounts 2017/18; • A copy of the annual report 2017/18 incorporating: <ul style="list-style-type: none"> ○ the Audit Committee Report 2017/18 including the going concern statement (page 96) ○ the draft Head of Internal Audit Opinion (page 110) ○ the Annual Governance Statement (page 113). • A copy of the representation letter to Deloitte, the external auditor is also attached. The Board is required to declare in writing that the financial statements and other related documents have been properly prepared and without omission of material facts to the best of the management's knowledge and belief. It is also used by the auditor to obtain the Board's confirmation that all necessary information has been provided to them and to confirm judgments made by management where there is no other means of obtaining definitive evidence. <p>The Audit Committee will consider the annual accounts, report and representation letter at its meeting in the morning of 23 May 2018 and will provide any comments raised at the meeting to the Trust Board that afternoon.</p> <p>The annual report and accounts will be submitted to NHS Improvement by 30 May 2018 and then submitted to the Department of Health at the end of June, for presenting to Parliament.</p>	
Action required from the meeting To consider and approve the annual accounts and report 2017/18.	
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 any comments have been incorporated into this draft.	

Attachment L

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	2017/18
Last year	2016/17
This year ended	31 March 2018
Last year ended	31 March 2017
This year beginning	1 April 2017

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.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require 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 required by those Directions. 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 Department of Health Group Accounting 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 (and the Department of Health Group Accounting 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 the NHS Foundation Trust Accounting Officer Memorandum.

Signed

Dr Peter Steer
Chief Executive
Date: 23 May 2018

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 2018 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: 23 May 2018

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

		Year ended 31 March 2018	Year ended 31 March 2017
		£000	£000
Operating income from patient care activities	NOTE 2	402,226	374,187
Other operating income	3	87,986	83,334
Operating expenses of continuing operations	4	<u>(456,559)</u>	<u>(435,280)</u>
Operating surplus		33,653	22,241
Finance costs:			
Finance income	8	138	149
Finance expenses - unwinding of discount on provisions	9	(12)	(13)
Public dividend capital dividends payable		<u>(7,454)</u>	<u>(7,411)</u>
Net finance costs		(7,328)	(7,275)
(Losses)/gains on disposal of assets		<u>(184)</u>	<u>32</u>
Surplus for the year		26,141	14,998
Other comprehensive income			
Will not be reclassified to income and expenditure:			
- Impairments		(1,480)	(28,810)
- Revaluations - property, plant and equipment	20	<u>16,432</u>	<u>4,106</u>
Total comprehensive income/(expense) for the year		41,093	(9,706)
Financial performance for the year - additional reporting measures			
Retained surplus for the year		26,141	14,998
Adjustments in respect of capital donations	3	(24,653)	(32,056)
Adjustments in respect of impairments	3	<u>2,939</u>	<u>12,149</u>
Adjusted retained surplus/(deficit)		4,427	(4,909)

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 2018

		31 March 2018	31 March 2017
	NOTE	£000	£000
Non-current assets			
Intangible assets	10	18,429	8,476
Property, plant and equipment	11	438,672	416,419
Trade and other receivables	14	6,188	6,664
Total non-current assets		<u>463,289</u>	<u>431,559</u>
Current assets			
Inventories	13	8,853	8,226
Trade and other receivables	14	77,071	67,669
Cash and cash equivalents	15	55,695	42,494
Total current assets		<u>141,619</u>	<u>118,389</u>
Total assets		<u>604,908</u>	<u>549,948</u>
Current liabilities			
Trade and other payables	16	(62,359)	(50,623)
Provisions	19	(1,264)	(114)
Other liabilities	17	(6,329)	(5,611)
Net current assets		<u>71,667</u>	<u>62,041</u>
Total assets less current liabilities		<u>534,956</u>	<u>493,600</u>
Non-current liabilities			
Provisions	19	(968)	(860)
Other liabilities	17	(4,543)	(4,950)
Total assets employed		<u>529,445</u>	<u>487,790</u>
Financed by taxpayers' equity:			
Public dividend capital		127,280	126,718
Income and expenditure reserve		306,494	275,981
Other reserves		3,114	3,114
Revaluation reserve		92,557	81,977
Total taxpayers' equity		<u>529,445</u>	<u>487,790</u>

The financial statements on pages 1 to 32 were approved by the Board and authorised for issue on 23 May 2018 and signed on its behalf by:

Dr Peter Steer
Chief Executive

Signed:.....
Date: 23 May 2018

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2018

	Public Dividend Capital (PDC) £000	Revaluation reserve £000	Income and expenditure reserve £000	Other reserves £000	Total £000
Balance at 1 April 2017	126,718	81,977	275,981	3,114	487,790
Changes in taxpayers' equity for the year ended 31 March 2018					
-Surplus for the year	0	0	26,141	0	26,141
-Transfers between reserves	0	(1,388)	1,388	0	0
- Net impairments	0	(1,480)	0	0	(1,480)
- Revaluations - property, plant and equipment	0	16,432	0	0	16,432
- Transfer to retained earnings on disposal of assets	0	(2,984)	2,984	0	0
- Public Dividend Capital received	562	0	0	0	562
Balance at 31 March 2018	127,280	92,557	306,494	3,114	529,445

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
-Net 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 CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
	NOTE	
Cash flows from operating activities		
Operating surplus	33,653	22,241
Non-cash income and expense:		
Depreciation and amortisation	17,582	17,677
Net Impairments	2,939	12,149
Income recognised in respect of capital donations (cash and non-cash)	(24,653)	(32,056)
Increase in trade and other receivables	(9,810)	(17,507)
Increase in inventories	(627)	(368)
Increase/(decrease) in trade and other payables	12,287	(2,713)
Increase in other liabilities	311	791
Increase/(decrease) in provisions	1,246	(516)
NET CASH GENERATED FROM/(USED IN) OPERATIONS	32,928	(302)
Cash flows from investing activities		
Interest received	138	149
Purchase of property, plant and equipment	(27,074)	(44,134)
Payments for intangible assets	(11,536)	(3,668)
Sales of property, plant and equipment	15	32
Receipt of cash donations to purchase capital assets	25,579	33,792
Net cash outflow from investing activities	(12,878)	(13,829)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	20,050	(14,131)
Cash flows from financing		
Public Dividend Capital received	562	653
PDC dividend paid	(7,411)	(7,760)
Net cash outflow from financing	(6,849)	(7,107)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	13,201	(21,238)
Cash and cash equivalents at start of the year	42,494	63,732
Cash and cash equivalents at end of the year	55,695	42,494

15

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 2017/18 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.

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 xx), 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 reviews 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 majority of the Foundation Trust's revenue originates from 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:

- a. 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.
- b. 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.
- c. 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 0.1% in real terms.
- d. When arriving at the valuation for property, Trust management engages a qualified surveyor to assist them in forming estimates.
- e. 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.
- f. 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.
- g. 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 2018, is based on the valuation data as 31 March 2016, updated to 31 March 2018 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 and Social Care 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 DHSC 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 (continued)

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 (continued)

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 1.3% in real terms.

Clinical Negligence Costs

The NHS Resolution (NHSR) operates a risk pooling scheme under which the Foundation Trust pays an annual contribution to the NHSR, which, in return, settles all clinical negligence claims. Although the NHSR 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 NHSR on behalf of the Trust is disclosed in note 18.

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 NHSR 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 20 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 and Social Care (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 currency of the Trust is 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	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 15 Revenue from Contracts with Customers	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 16 Leases	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17 Insurance Contracts	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted
IFRIC 22 Foreign Currency Transactions and Advance Consideration	Application required for accounting periods beginning on or after 1 January 2018
IFRIC 23 Uncertainty over Income Tax Treatments	Application required for accounting periods beginning on or after 1 January 2019

2. Revenue from patient care activities

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
2.1 Analysis of revenue from patient care activities		
Acute Services		
Elective income	88,164	80,824
Non elective income	20,788	14,966
First outpatient income	15,897	13,587
Follow up outpatient income	19,717	21,921
High cost drugs income from commissioners (excluding pass-through costs)	59,761	59,671
Other NHS clinical income	130,391	116,157
Mental Health Services		
Cost and volume contract income	5,164	5,431
Revenue from protected patient care activities	<u>339,882</u>	<u>312,557</u>
Private patient income	57,260	55,129
Other non-protected clinical income	5,084	6,501
	<u>62,344</u>	<u>61,630</u>
Total revenue from patient care activities	<u><u>402,226</u></u>	<u><u>374,187</u></u>

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 2018 £000	Year ended 31 March 2017 £000
2.2 Analysis of revenue from patient care activities by source		
NHS England	314,816	280,204
Clinical commissioning groups	23,536	31,117
NHS Foundation Trusts	574	561
NHS Trusts	956	675
Non-NHS:		
Private patients	57,260	55,129
Overseas patients (non-reciprocal)	1,011	673
Injury costs recovery (was RTA)	181	83
Other	3,892	5,745
Total revenue from patient care activities	<u><u>402,226</u></u>	<u><u>374,187</u></u>

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 2018 £000	Year ended 31 March 2017 £000
2.3 Overseas visitors		
Income recognised in-year	1,011	673
Cash payments received in-year	36	11
Amounts added to provision for impairment of receivables	599	479

	Year ended 31 March 2018	Year ended 31 March 2017
	£000	£000
3. Other operating revenue		
Research and development	24,227	19,411
Charitable contributions to expenditure	6,179	6,242
Charitable contributions in respect of capital expenditure	24,653	32,056
Education and training	9,643	8,340
Education and training - notional income from apprenticeship fund	48	0
Non-patient care services to other bodies	889	860
Clinical tests	5,644	4,537
Clinical excellence awards	2,832	3,045
Catering	1,375	1,204
Sustainability and Transformation Fund Scheme	9,067	4,243
Creche services	472	460
Staff accommodation rentals	91	82
Other revenue	2,866	2,854
	87,986	83,334

The Trust received £9,067k of Sustainability and Transformation funding. This was made up of: £5,384k core, £219k Incentive Scheme (Finance), £1,733k Incentive Scheme (Bonus) and £1,731k General Distribution.

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
4. Operating expenses		
Services from other NHS bodies	6,161	6,289
Purchase of healthcare from non-NHS bodies	4,479	4,805
Staff and executive directors costs	232,851	224,139
Non-executive directors' costs*	155	158
Supplies and services - clinical - drugs	72,136	71,644
Supplies and services - clinical - other	37,041	33,662
Supplies and services - general	4,803	4,499
Establishment	3,860	3,183
Research and development - staff costs	16,254	12,686
Research and development -non-staff	3,095	2,636
Education and training - staff costs	3,302	2,431
Education and training - notional expenditure funded from apprenticeship fund	48	0
Transport - business travel	695	612
Transport - other	2,927	2,896
Premises - business rates payable to local authorities	3,540	2,265
Premises - other	25,428	20,882
Operating lease rentals	2,548	1,886
Provision for impairment of receivables	2,342	985
Provisions arising in year	1,353	0
Change in provisions discount rate	6	54
Inventories write down	324	189
Depreciation	15,807	16,206
Amortisation of intangible assets	1,775	1,471
Impairment of property, plant and equipment	2,939	12,149
Fees payable to the Trust's auditor for the financial statements audit	105	102
Other auditor remuneration	26	66
Clinical negligence insurance	7,492	6,326
Redundancy costs	0	46
Consultancy costs	874	796
Legal fees	720	402
Internal audit costs	117	109
Losses and special payments	10	7
Other	3,346	1,699
	456,559	435,280

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

£21,221k of blood products including Factor 8 have been reclassified from 'Supplies and services - clinical -other' to 'Supplies and services - clinical - drugs' for 2016/17.

5. Operating leases**5.1 As lessee**

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Payments recognised as an expense		
Minimum lease payments	<u>2,548</u>	<u>1,886</u>
	2,548	1,886
Total future minimum lease payments	As at 31 March 2018 £000	As at 31 March 2017 £000
Payable:		
Not later than one year	2,455	2,504
Between one and five years	9,655	9,976
After 5 years	4,905	7,264
Total	<u>17,015</u>	<u>19,744</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 2018.

7. Employee costs and numbers

7.1 Employee costs	Year to 31	Permanently	Other	Year to 31
	March 2018			March 2017
	Total	Employed		Total
	£000	£000	£000	£000
Salaries and wages	209,549	202,644	6,905	193,437
Social security costs	20,933	20,933	0	19,440
Apprenticeship levy	938	938	0	0
Pension cost - defined contribution plans employer's contributions to NHS pensions	23,063	23,063	0	21,194
Pension costs - other	61	61	0	82
Temporary staff - agency/contract staff	4,819	0	4,819	9,318
Termination benefits	0	0	0	46
Total gross staff costs	259,363	247,639	11,724	243,517
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	(1,844)	(1,844)	0	(1,401)
Recoveries from other bodies in respect of staff costs netted off expenditure	(839)	(839)	0	(292)
Total staff costs	256,680	244,956	11,724	241,824
Included within:				
Costs capitalised as part of assets	4,273	3,834	439	2,522
Analysed into operating expenditure				
Employee expenses - staff and executive directors	232,851	224,400	8,451	224,139
Research and development	16,254	13,420	2,834	12,686
Education and training	3,302	3,302	0	2,431
Redundancy	0	0	0	46
Total employee benefits excluding capital costs	252,407	241,122	11,285	239,302

7.2 Average number of people employed*	Year to 31	Permanently	Other	Year to 31
	March 2018			March 2017
	Total	Employed **		Total
	Number	Number	Number	Number
Medical and dental	634	611	23	626
Administration and estates	1,239	1,162	77	1,200
Healthcare assistants and other support staff	292	291	1	297
Nursing, midwifery and health visiting staff	1,526	1,516	10	1,479
Scientific, therapeutic and technical staff	780	724	56	777
Other staff	5	5	0	5
Total	4,476	4,309	167	4,384

*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 was one early retirement in 2016/17, £160k).

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	Cost of compulsory redundancies	Year to 31 March 2018			
			Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
	Number	£000	Number	£000	Number	£000
<£10,000	0	0	10	34	10	34
£10,000 - £25,000	0	0	1	19	1	19
£25,001 - £50,000	0	0	1	35	1	35
£50,001 - £100,000	0	0	1	60	1	60
Total	0	0	13	148	13	148

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

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 March 2018	Year ended 31 March 2017
	£000	£000
Bank interest	138	149
Total finance income	138	149

9 Finance Expenses	Year ended 31 March 2018	Year ended 31 March 2017
	£000	£000
Provisions - unwinding of discount	12	13
Total finance expenses	12	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 2017	7,782	496	4,790	3,418	16,486
Additions - purchased	255	0	0	1,666	1,921
Additions - assets purchased from cash donations	26	0	0	9,781	9,807
Reclassifications	1,036	127	0	(1,163)	0
Valuation/Gross cost at 31 March 2018	9,099	623	4,790	13,702	28,214
Amortisation at 1 April 2017	3,565	343	4,102	0	8,010
Provided during the year	1,529	32	214	0	1,775
Amortisation at 31 March 2018	5,094	375	4,316	0	9,785
Net book value					
NBV total at 31 March 2018	4,005	248	474	13,702	18,429

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 2016	3,791	496	4,790	3,834	12,911
Additions - purchased	1,054	0	0	2,594	3,648
Additions - assets purchased from cash donations	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

10.2 Economic life of intangible assets

	Min Life Years	Max Life Years
Intangible assets		
Software	1	9
Development expenditure	1	6
Licences and trademarks	1	6

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 2017	74,081	221,982	10,209	71,018	77,949	27,299	13,602	496,140
Additions - purchased	0	2,144	0	6,998	645	1,283	330	11,400
Additions - assets purchased from cash donations	0	2,381	10	5,235	4,431	1,028	1,761	14,846
Impairments charged to operating expenses	0	(8,542)	(13)	(127)	0	0	0	(8,682)
Impairments charged to the revaluation reserve	(1,480)	0	0	0	0	0	0	(1,480)
Reversal of impairments credited to operating expenses	0	5,743	0	0	0	0	0	5,743
Reclassifications	0	67,024	0	(69,207)	705	453	1,025	0
Revaluations	0	9,425	772	0	0	0	0	10,197
Disposals	0	(62)	0	0	(996)	0	(8)	(1,066)
Cost or valuation at 31 March 2018	72,601	300,095	10,978	13,917	82,734	30,063	16,710	527,098
Accumulated depreciation at 1 April 2017	0	1,368	0	0	49,117	21,402	7,834	79,721
Provided during the period	0	6,284	207	0	6,479	1,611	1,226	15,807
Impairments charged to operating expenses	0	0	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	0	0	0	0	0	0	0	0
Revaluations	0	(6,028)	(207)	0	0	0	0	(6,235)
Disposals	0	(62)	0	0	(799)	0	(6)	(867)
Accumulated depreciation at 31 March 2018	0	1,562	0	0	54,797	23,013	9,054	88,426
Net book value at 31 March 2018								
NBV - Owned at 31 March 2018	68,651	104,347	926	7,945	7,188	5,694	2,042	196,793
NBV - Finance leased at 31 March 2018	0	3,275	0	0	0	0	0	3,275
NBV - Government granted at 31 March 2018	0	152	0	0	66	0	0	218
NBV - Donated at 31 March 2018	3,950	190,759	10,052	5,972	20,683	1,356	5,614	238,386
NBV total at 31 March 2018	72,601	298,533	10,978	13,917	27,937	7,050	7,656	438,672

	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 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 - assets purchased from cash donations	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 income	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

11.2 Economic life of property plant and equipment

	Min Life Years	Max Life Years
Buildings excluding dwellings	3	52
Dwellings	41	49
Plant and machinery	1	15
Information technology	1	9
Furniture and fittings	1	12

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 £24,653k towards property, plant, equipment and intangibles expenditure during the year (2016/17, £32,056k).

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 2018

* 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; and

* 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 2018	31 March 2017
	£000	£000
Property, plant and equipment	6,371	6,510
Intangible assets	15,670	982
Total	22,041	7,492

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 2018	31 March 2017
	£000	£000
Not later than one year	11,101	11,600
Later than one year and not later than five year	14,324	20,795
Total	25,425	32,395

13. Inventories**13.1 Inventories**

	31 March 2018	31 March 2017
	£000	£000
Drugs	1,214	1,113
Consumables	7,619	7,095
Energy	20	18
Total	8,853	8,226

The cost of inventories recognised as expenses during the year in respect of continuing operations was £96,331k (2016/17: £92,196k)

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

	Current		Non-current	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Trade receivables	21,957	17,967	0	0
Capital receivables	4,456	5,382	0	0
Provision for impaired receivables	(10,657)	(8,349)	0	0
Prepayments (revenue)	3,314	3,318	6,188	6,664
Prepayments (capital)	85	0	0	0
Accrued income	12,555	11,730	0	0
Interest receivable	0	2	0	0
PDC dividend receivable	54	97	0	0
VAT receivable	985	1,219	0	0
Other receivables	44,322	36,303	0	0
Total	77,071	67,669	6,188	6,664

14.2 Provision for impairment of receivables	31 March 2018	31 March 2017
	£000	£000
Opening balance	8,349	7,448
Increase in provision	2,342	985
Amounts utilised	(34)	(84)
Closing balance	10,657	8,349

14.3 Analysis of impaired receivables	31 March 2018	31 March 2017
	£000	£000
Ageing of impaired receivables		
0 - 30 days	651	612
30-60 days	154	158
60-90 days	141	136
90- 180 days	922	1,258
over 180 days	8,789	6,185
	10,657	8,349
Ageing of non-impaired receivables past their due date		
0 - 30 days	8,162	4,209
30-60 days	6,626	2,821
60-90 days	2,523	3,019
90- 180 days	4,361	6,887
over 180 days	7,522	5,041
	29,194	21,977

15. Cash and cash equivalents	31 March 2018	31 March 2017
	£000	£000
Balance at beginning of the year	42,494	63,732
Net change in year	13,201	(21,238)
Balance at the end of the year	55,695	42,494
Made up of		
Commercial banks and cash in hand	11	10
Cash with the Government Banking Service	55,684	1,984
Deposits with the National Loan Fund	0	40,500
Cash and cash equivalents as in statement of financial position	55,695	42,494
Cash and cash equivalents	55,695	42,494

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

	Current	
	31 March 2018	31 March 2017
	£000	£000
Trade payables	11,823	11,748
Capital payables	6,380	6,931
Social Security costs	3,001	2,739
Other taxes payable	2,506	2,375
Other payables	13,513	10,133
Accruals	<u>25,136</u>	<u>16,697</u>
Total	<u>62,359</u>	<u>50,623</u>

'Other payables' includes £3,544k outstanding pensions contributions at 31 March 2018 (£3,156k at 31 March 2017)

17. Other Liabilities

	Current		Non-current	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Deferred income	5,922	5,204	0	0
Lease incentives	<u>407</u>	<u>407</u>	<u>4,543</u>	<u>4,950</u>
Total	<u>6,329</u>	<u>5,611</u>	<u>4,543</u>	<u>4,950</u>

18. Provisions

	Current		Non-current	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Pensions relating to other staff	111	114	968	860
Other legal claims	11	0	0	0
Other	1,142	0	0	0
Total	1,264	114	968	860

	Pensions relating to other staff £000	Legal claims £000	Other £000	Total £000
At 1 April 2017	974	0	0	974
Change in the discount rate	6	0	0	6
Arising during the year	200	11	1,142	1,353
Utilised during the year	(113)	0	0	(113)
Reversed unused	0	0	0	0
Unwinding of discount	12	0	0	12
At 31 March 2018	1,079	11	1,142	2,232

Expected timing of cash flows:

- not later than one year	111	11	1,142	1,264
- later than one year and not later than five years	443	0	0	443
- later than five years	525	0	0	525
	1,079	11	1,142	2,232

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" consist 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 Resolution. 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.

NHS Resolution records provisions in respect of clinical negligence liabilities of the Trust. The amount recorded as at 31 March 2018 was £154,508k (£112,944k at 31 March 2017).

19. Revaluation reserve

	31 March 2018	31 March 2017
	£000	£000
Opening balance at 1 April	81,977	106,681
Net impairments	(1,480)	(28,810)
Revaluations	16,432	4,106
Transfers to other reserves	(1,388)	0
Asset disposals	(2,984)	0
Closing balance at 31 March	<u>92,557</u>	<u>81,977</u>

20. Contingencies

	31 March 2018	31 March 2017
	£000	£000
Contingent liabilities		
NHS Resolution legal claims	0	0
Gross value of contingent liabilities	0	0
Net value of contingent liabilities	0	(10)

No contingent liability exists for potential third party claims in respect of employer's / occupier's liabilities and property expenses at 31 March 2018 (£0k at 31 March 2017). The value of provisions for the expected value of probable cases is shown in Note 19.

21. 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.

21.1 Financial assets by category

	31 March 2018	31 March 2017
	Loans and receivables	Loans and receivables
	£000	£000
Trade and other receivables excluding non financial assets - with NHS and DHSC bodies	22,942	16,446
Trade and other receivables excluding non financial assets - with other bodies	38,121	36,173
Cash and cash equivalents (at bank and in hand)	55,695	42,494
	<u>116,758</u>	<u>95,113</u>

21.2 Financial liabilities by category

	31 March 2018	31 March 2017
	Other financial liabilities	Other financial liabilities
	£000	£000
Trade and other payables excluding non financial assets - with NHS and DHSC bodies	10,275	12,163
Trade and other payables excluding non financial assets - with other bodies	21,441	21,763
	<u>31,716</u>	<u>33,926</u>

21.3 Financial Instruments

21.3.1 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 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

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.

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

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.

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.

22. 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 xx.

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.

2017/18

Organisation Category	Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
Clinical Commissioning Groups	NHS Barking And Dagenham CCG	409			
	NHS Barnet CCG	708			
	NHS Basildon And Brentwood CCG	364			
	NHS Bedfordshire CCG	437			
	NHS Brent CCG	396			
	NHS Bromley CCG	156			
	NHS Cambridgeshire And Peterborough CCG	252			
	NHS Camden CCG	4,320		2,344	
	NHS Canterbury & Coastal CCG	131			
	NHS Castle Point & Rochford CCG	242			
	NHS Central Lonson (Westminster) CCG	107			
	NHS City And Hackney CCG	445			104
	NHS Coastal West Sussex CCG	148			
	NHS Croydon CCG	280			
	NHS Dartford, Gravesham And Swanley CCG	126			
	NHS Ealing CCG	433			
	NHS East And North Hertfordshire CCG	649			
	NHS Enfield CCG	672			
	NHS Greenwich CCG	106			
	NHS Hammersmith & Fulham CCG	130			
	NHS Haringey CCG	584			
	NHS Harrow CCG	330			
	NHS Havering CCG	408			
	NHS Herts Valleys CCG	745		255	
	NHS Hillingdon CCG	537			
	NHS Hounslow CCG	275			
	NHS Islington CCG	496			
	NHS Luton CCG	477			
	NHS Medway CCG	238		142	
	NHS Mid Essex CCG	478			
	NHS Milton Keynes CCG	116			
	NHS Nene CCG	276		146	
	NHS Newham CCG	399			
	NHS North East Essex CCG	368			
	NHS North West Surrey CCG	124			
	NHS Redbridge CCG	508			
	NHS Richmond CCG	151			
	NHS Slough CCG	1,198			134
	NHS South Kent Coast CCG	192			
	NHS Southend CCG	266			
NHS Surrey Downs	165				
NHS Thurrock CCG	283				
NHS Tower Hamlets CCG	262				
NHS Waltham Forest CCG	411				
NHS Wandsworth CCG	238		112		
NHS West Essex CCG	372				
NHS West Kent CCG	293		135		
NHS West London (K&C & Qpp)	176				
NHS Foundation Trusts	Birmingham Women's & Children's NHS Foundation Trust	161			
	Cambridge University Hospitals NHS Foundation Trust	104			
	Chelsea & Westminster NHS Foundation Trust	128			
	Frimley Health NHS Foundation Trust				135
	Guys And St Thomas NHS Foundation Trust		1,491	113	393
	Luton & Dunstable NHS Foundatio Trust	136			202
	Manchester University Nhs Foundation Trust	104			
	Moorfields Eye Hospital NHS Foundation Trust		141		
	Oxford University Hospitals NHS Foundation	165	100		
	Royal Brompton & Harefield NHS Foundation Trust		148		111
	Royal Free London NHS Foundation Trust	255	226	413	388
	Sheffield Children's NHS Foundation Trust				120
	St Georges University Hospital NHS Foundation Trust	162			
University College London NHS Foundation Trust	834	1,440	5,813	2,071	
NHS Trusts	Barking, Havering & Redbridge Hospital NHS Trust				
	Barts Health NHS Trust	2,741	934	814	584
	Imperial College Healthcare NHS Trust	498	114	554	192
	London North West Healthcare NHS Trust	147			104
	Mid Essex Hospital Services NHS Trust		593		612
	Newcastle Upon Tyne Hospitals Trust		111		
	Portsmouth Hospitals NHS Trust		123		
	Royal National Orthopaedic Hospital Trust		114		
Whittington Hospital NHS Trust		494	140		
NHS England & Clinical Support Units	NHS England - London Specialised Commissioning Hub	329,199		12,361	
Other NHS Bodies	NHS Resolution		7,663		
	Health Education England	8,793			
	Department of Health and Social Care : Core trading & NHS Supply Chain (excluding PDC dividend)	12,020	3,630		100
Other Related Parties	Camden London Borough Council		3,435		
	Care Quality Commission		289		
	Hertfordshire County Council	219			
	HM Revenue & Customs - Other taxes and duties		21,871		5,507
	HM Revenue & Customs - VAT			985	
	National Insurance Fund (Employer contributions - Revenue Expenditure)				
	NHS Blood and Transplant (excluding Bio Products Laboratory)		2,437		137
	NHS Pension Scheme (Own staff employers contributions only plus other invoiced charges)		23,063		3,544
	Southern Health and Social Care Trust - Northern Ireland	403			
Scottish Government	922				
Welsh Assembly Government (incl all other Welsh Health Bodies)	1,960				
Other Related Parties	Great Ormond Street Hospital Children's Charity	30,832	2,242	6,287	339

23. Events after the reporting period

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

24. Losses and special payments

	Number	£000
Bad debts relating to private patients	106	21
Bad debts relating to other debtors	29	24
Stores losses	3	324
Total losses	<u>138</u>	<u>369</u>
Ex-gratia payments	34	9
Total special payments	<u>34</u>	<u>9</u>
Total losses and special payments	<u>172</u>	<u>378</u>

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

25. Off-Payroll engagements

As at 31 March 2018, the Trust had eight off-payroll engagements for more than £245 per day lasting for longer than six months. Of these, six have existed for less than 1 year at the time of reporting and two have existed for between one and two years.

Great Ormond Street Hospital for Children NHS Foundation Trust

Annual Report and Accounts

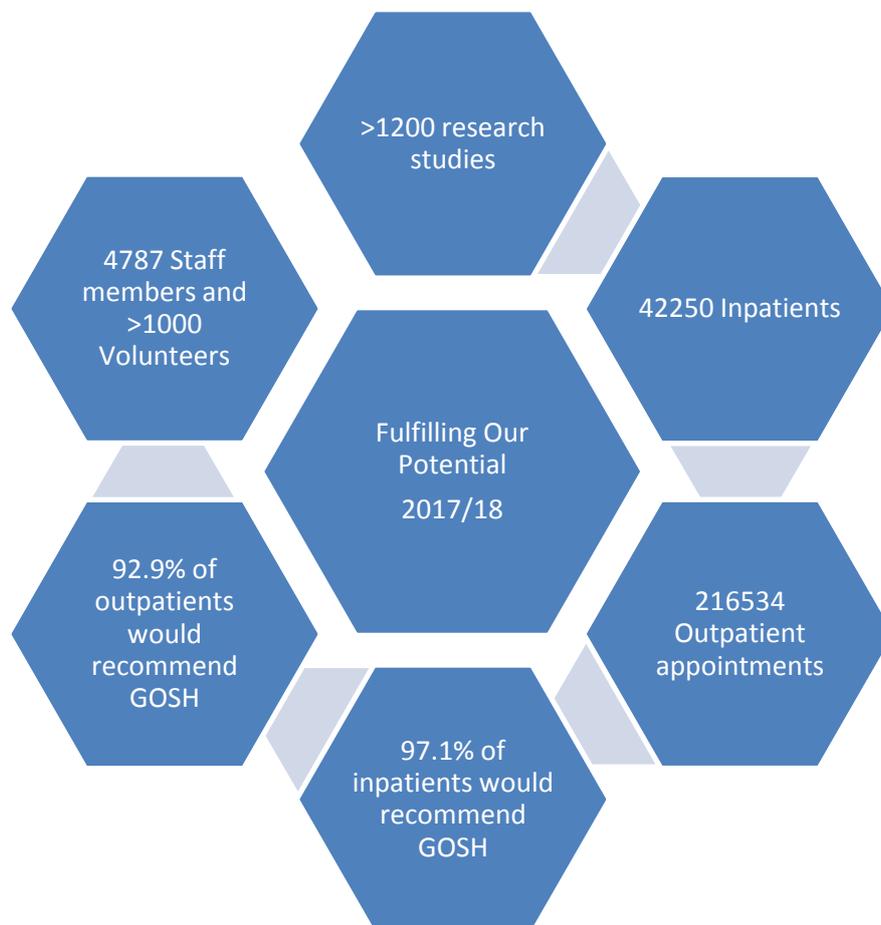
2017/18

Version control		
Version	Changes	By
0.0	Set up template from Excel project plan	Paul Balson 03/04/2018
0.1	First round of additions added - New format for key priorities	Paul Balson 05/04/2018
0.2	Governance sections added	Anna Ferrant 09/04/2018
0.3	Addition of James Scott, Joseff sections and a tweak of the format	Paul Balson 10/04/2018
0.4	Anna Ferrant change of format requested	Anna Ferrant 19/04/2018
0.5	Addition of 4.1 from Ward, revision of format and start of content edit	Paul Balson 20/04/2018
0.6	First full review of content and highlighting of missing sections – colour coded by author	Paul Balson 24/04/2018
0.7	AF amendments	Anna Ferrant 26/04/2018
0.8	Addition of Membership data and correction of sickness absence data Review of whole report – formatting, adding in AGS and AC annual report and reviewing for duplication	Paul Balson 26/04/2018 Anna Ferrant 27/04/2018
0.9	No tracks sent to executives	Anna Ferrant 27/04/2018
1.0	Version with tracks plus staff survey section and QSAC annual report; changes to Research priority	Anna Ferrant 30/04/2018
1.1	Added Voice section and conducted a compliance check against the ARM: added in end of year matters, anti-bribery, business model section. Sent to Comms on 2 May 2018	Anna Ferrant 01/05/2018
2.0	Finance sections inserted (not accounts or rem director pay) – using tracks. Sent to auditors	Anna Ferrant 08/05/2018
2.1	50% of proofed changes made and sent to Cym Moore for Forwards	Paul Balson 09/05/2018
2.2	100% of proofed changes made and PICB, Research and technology patient stories added.	Paul Balson 09/05/2018
2.3	Cross check of versions	Paul Balson 10/05/2018
2.4	Amendments from Proof reader number 1 Addition of a YPF story (edited by PB)	Paul Balson 14/05/2018
2.5	Version back to EA with EA comments responded to and additional text added and highlighted since last version to EA (v. 2.0) – v.2.5 sent to comms with no tracks or highlights on 16 May 2018	Anna Ferrant 16/05/2018
3.0	The comms version of v.2.5 plus some tracked amendments on going concern	Anna Ferrant 17/05/2018

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

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GOSH at a glance in 2017/18



Contents

Chairman foreword	5
Chief Executive foreword	7
Our purpose and activities	Error! Bookmark not defined.
Performance Report	14
Overview	Error! Bookmark not defined.
Analysis of Performance.....	Error! Bookmark not defined.
Our Strategic priorities in 2018-19	47
Accountability Report	49
Directors' report.....	49
Remuneration report.....	69
Staff report	75
Disclosures.....	84
Audit Committee Report.....	96
Quality and Safety Assurance Committee Report.....	106
Head of Internal Audit Opinion.....	110
Annual Governance Statement.....	113
Independent Auditor's report.....	128
Quality Report 2017/18	129
Annual accounts	129
Glossary	129

Chairman Foreword

Great Ormond Street Hospital remains the UK's only specialist paediatric hospital for the research into, and treatment of, rare and complex diseases. The children and young people it sees come from all across the UK, Europe and beyond often because they have exhausted treatment options elsewhere and taking part in pioneering research or novel treatments represent their only hope. It is therefore an enormous privilege and responsibility to take up the position of Chairman and ensure that the hospital does everything it can help all of its patients fulfil their potential.

For our families a visit to hospital can be a stressful so it is crucial we provide welcoming and spacious environments with up-to-date facilities. This year we were delighted to open the Mittal Children's Medical Centre home to the new Premier Inn Clinical Building. This 240-bed facility was opened by HRH Duchess of Cambridge and has enabled us to move children out of old facilities - many from the 1930s - and into brand new, modern wards with en suite bedrooms and room for parents to stay comfortably with their child overnight.

In parallel, we have continued work to construct the Zayed Centre for Research into Rare Disease in Children. The Centre, the only one of its kind, will see clinicians and researchers come together to discover novel treatments and cures for children with life limiting and life-threatening conditions. Clinical research has been a pillar of the hospital's work since its inception. This new centre will not only bring together a critical mass of researchers to aid collaboration but also provide the facilities to power new gene therapies and personalised medicine.

This year we were subject to a scheduled inspection by the Care Quality Commission. The organisation was rated as good overall. The inspectors found many areas of outstanding practice and recognised the excellent work undertaken to address our waiting time data and management issues. However, they did find a small number of areas as needing improvement including around how we manage and govern our services. We recognise this is an area where we have work to do and I am pleased to say that much of the improvement work is already in train. This includes work to address nurse morale and ensuring nurses feel their voice is being heard throughout the organisation.

Ensuring an organisation has the right safety culture is of paramount importance. This year we were delighted to be accepted as the first UK hospital to partner with the Cognitive Institute in their Safety and Reliability Improvement Programme. Signing up to this partnership recognises our commitment to achieving zero preventable harm and delivering the best possible outcomes through providing the safest, most effective and efficient care. We started this work with a series of orientation workshops and the process to recruit 18 Safety Champions. These are members of staff who are passionate about patient safety and over the next year will model, teach and coach every member of the organisation to speak up for safety.

An important part of our governance structure is our Council of Governors (formerly known as the Members' Council). This group of 27 elected representatives acts 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. We held elections for these voluntary roles in January and are now working with the new Council of Governors. I would like to

thank all our previous Councillors and current Governors for giving considerable amounts of their time and energy to help improve our work.

So much of what GOSH is able to deliver would not be possible without our amazing Charity and the donors who have supported the hospital. It is thanks to them that our new buildings and facilities have been built. Their support also helps to ensure our patients and their families are looked after in the broadest sense by funding a range of services including parent accommodation, the play service, the Citizens Advice Bureau and our Chaplaincy service. I would like to thank each and every supporter for their contribution.

We would also not be the institution we are today without our academic partner UCL, and in particular the Great Ormond Street Institute for Child Health. We will be working together even more closely in the Zayed Centre for Research into Rare Disease in Children which is due to be fully operational in early 2019.

Until I joined the Trust in November, Mary Macleod served as the interim Chairman. Mary has provided exceptional service to the Trust in a variety of roles since becoming a non-executive director on the board in 2012 including as the Senior Independent Director, Deputy Chairman and Chairman of the Quality and Safety Assurance Committee. I would like to pay particular tribute to the tremendous leadership she provided to the Trust as interim Chairman at a particularly challenging time. I would also like to thank David Lomas for his dedication and support as a non-executive director on the Board and as Chair of the Finance and Investment Committee from 2012 until the end of his tenure in March.

In January Lady Amanda Ellingworth joined the Board as a non-executive director. Chris Kennedy also joined as a non-executive director from 1 April 2018. I am very much looking forward to working with them both over the coming year.

Finally, I must thank all our dedicated staff who carry out their work with tremendous skill and compassion. As we enter the NHS's 70th year they are what makes our hospital and the care it provides world-class.

Chief Executive Foreword

The Hospital's 166th year has presented opportunities and challenges in equal measure and throughout, I have remained humbled by the courage of our patients and their families and the dedication and skill of our staff.

Within the body of this report, we have shone a spotlight on the journeys of some of our extraordinary patients. One young person who kindly shared her experience with us is Nikki Lilly. Nikki is a regular visitor to GOSH having had more than 300 appointments and dozens of procedures to treat Arteriovenous malformation (AVM). She is now on a research trial in an attempt to arrest the growth of her AVM.

Nikki is an impressive young person who tackles issues of self-image and bullying on television and social media. Her positivity and bravery serves as a reminder of why we must always seek new and better ways to treat our patients and ensure that the treatment we deliver is delivered in the safest and most effective way possible.

One way in which we are seeking to do this is through the use of new technologies. This year we continued our journey to introduce an electronic patient record (EPR) and an integrated research and innovation platform. The EPR vision is that every member of a team caring for a child can access the information from a single source. Patients and parents will also be able to view and contribute to records between visits to the hospital. It will transform the way we communicate with our patients and families, further improve care by providing sophisticated decision support and care pathways and dramatically enhance our ability to conduct research. The momentum and clinical engagement we have built up over this past year stands us in good stead as we move into the new financial year and 12 months from 'go-live'.

We are also building a Digital Research, Informatics and Virtual Environment Unit (DRIVE). This will see data scientists, clinicians, PhD students and industry partners come together to explore how new technologies such as Artificial Intelligence can improve paediatric care. Industry giants such as Microsoft, Samsung and ARM are already partnering with us in this very exciting area.

Both digital initiatives are being supported by our fantastic charity. I would like to thank the Charity and the thousands of donors it represents for all its vital support across a wide range of projects.

We have a responsibility to deliver both safe and timely care. In recent years we have spent a great deal of time and energy ensuring that the way we record and manage waiting time data is accurate and allows us to manage our waiting lists effectively. I am very pleased to report that for the first time since we returned to reporting our data we were achieved the national standard of treating 92 per cent of our patients within 18 weeks. Our progress has been noted by the Secretary of State who informed us that in January this year we were the most improved Trust in the country. This is a significant achievement given the pressures across the NHS and the fact that patients come to us towards the end of the 18 week time limit. It is a testament to the enormous amount of work undertaken by the clinical and operational teams across the Trust.

Our mission to put the child first and always remains at the heart of everything we do. Over the last year this has come under a great deal of scrutiny as what we believed to be right for one of the children under our care became part of an international debate. This was an extremely distressing time for everyone involved particularly the child's family and the nursing and medical staff on our intensive care units. We have spent time reflecting on the experience and its impact and are now beginning to work with other paediatric hospitals and parts of the healthcare system to share learnings.

As a specialist paediatric hospital with a national and international footprint we do not always neatly fit into NHS structures such as the sustainability and transformation partnerships. It is therefore incumbent on us to carve out a place in the world where we can support the NHS and other health and social care systems to improve child health. We are therefore working with national and international bodies such as the Children's Alliance and the European Children's Hospital Organisation to improve care. Over the next year we will also be progressing the development of a learning academy where we feel we may be able to take on a very active role in helping grow paediatric knowledge and skills not just within our local geography but across the healthcare system.

To thrive we need to be efficient with our use of resources. In 2017/18 we delivered more than £10 million of efficiency schemes and reported a small operating surplus before capital donations and impairments.

This year saw a number of changes in the executive team. Our Chief Nurse Juliette Greenwood retired and Alison Robertson joined us substantively in April. Matthew Shaw joined us at the end of the financial year as substantive medical director and Helen Jameson joined as substantive chief finance officer following Loretta Seamer moving overseas. I would like to thank all members of the team for their contribution including Janet Williss, Polly Hodgson, David Hicks and Andrew Long who all provided interim support during the recruitment to the above positions.

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 (BRC) in collaboration with University College London Great Ormond Street Institute of Child Health (ICH).

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 (AHPs).

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 ten 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.

Our structure

To help Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) provide a more integrated and efficient service for the children we treat, as well as improve the responsiveness of our decision-making, we are structured into three clinical divisions:

- Charles West – NHS division
- JM Barrie - NHS division
- International Private Patients - Private division

In addition there are eight corporate areas– Clinical Operations, Corporate Affairs, Development and Property Services, Medical, Nursing, Human Resources, Organisational Development, Research and Finance.

Our strategy

Great Ormond Street Hospital for Children NHS Foundation Trust's (GOSH) vision, which sets our direction, is 'helping children with complex health needs fulfil their potential'. Our mission is to put 'the child first and always', which is supported by our 'Always Values' - to be always welcoming, always helpful, always expert and always one team.

In spring 2017 we worked with our staff and Members' Council to refresh our strategy. We assessed the issues and opportunities that face us and thought carefully about our vision and our future. In particular, we 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.

Our 'Always Values'

At a listening event in 2013, our patients, families and staff asked us to develop a shared commitment and values to help make people's experience at GOSH more consistently great. This event helped us identify four overarching values that reflect and reinforce our mission and commitment to put children at the heart of everything we do. We call them our 'Always Values', as we will:

- Always be Welcoming
- Always be Helpful
- Always be Expert
- Always be One Team



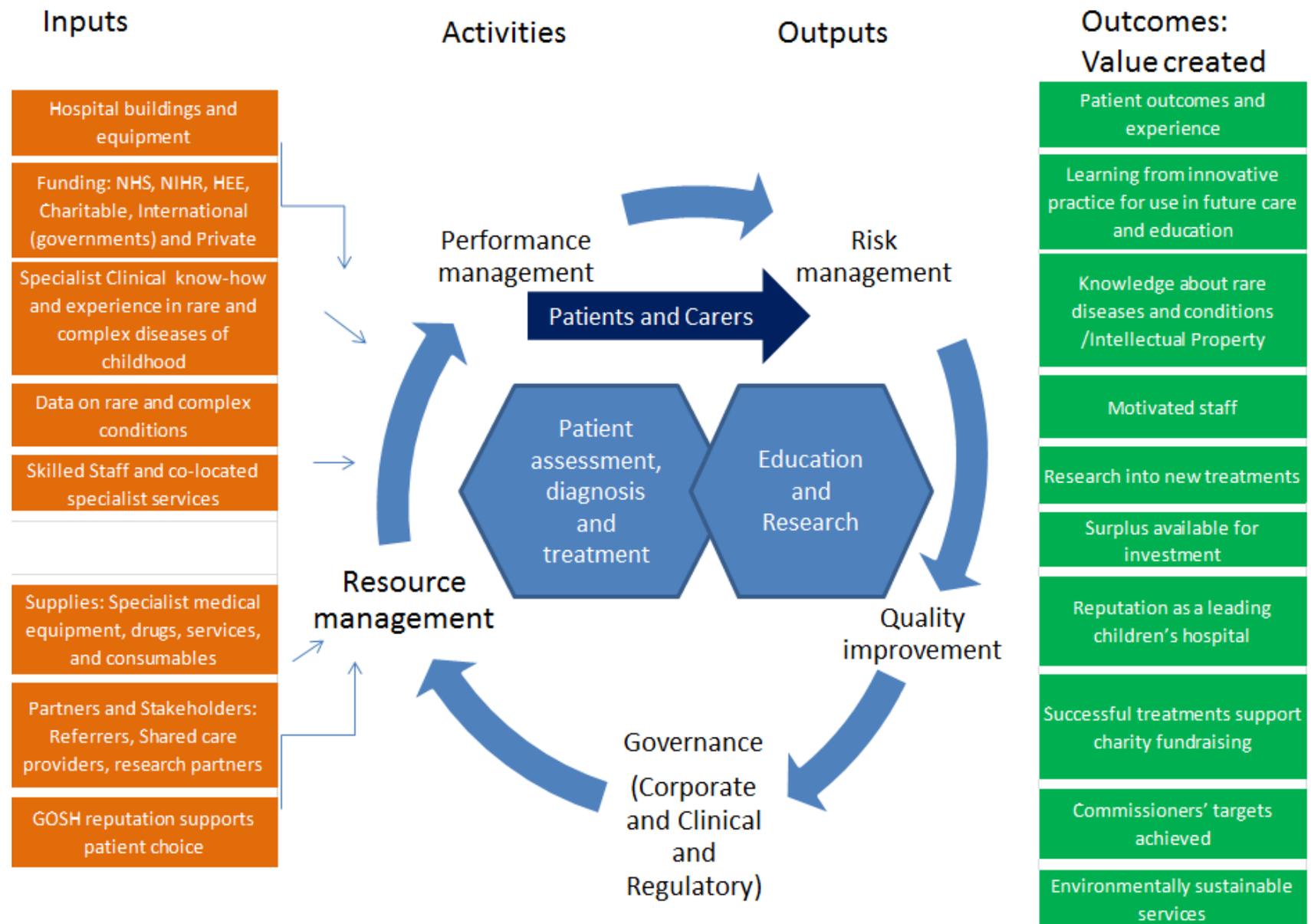
Our business model

Our business model demonstrates how we create value for our stakeholders through our activities. The model shows the critical inputs and the immediate outputs for its NHS services, education and research, and international and private patient activity, and how these create value. The model provides a key focus for strategy development and identification of strategic risks.

The key outcomes we aim to deliver from our business model are as follows:

- Clinical outcomes – world-class clinical outcomes for our specialised services
- Patient and family satisfaction – high levels of patient satisfaction with our services
- Research translated into clinical practice – new and innovative specialist treatments for children with complex or rare diseases
- Education – the largest programme of specialist paediatric training and education in Europe

- Financial – financially sustainable activities with the contribution from our private patient business supporting investment in developing our services.
- Reputation – a hospital for the NHS to be proud of with a worldwide reputation for excellence in providing specialist healthcare for children



Performance Report

Overview

In 2017/18, 216,534 outpatients and 42,250 inpatients from all over the country attended GOSH, around half from outside London. We provide over 50 different specialist and sub-specialist paediatric services – the widest range on any one site in the UK. Ninety percent of our funding is from NHS England specialised commissioning. These factors do set us apart from other providers, but they do not hide us from the very challenging environment across the NHS. GOSH continues to experience pressures such as increasing operating costs; rising demand across core services like cardiac, neuroscience, and cancer; staff shortages; and a requirement to find a place in the new structures and reforms and wider-NHS strategies. Our operating surplus (before capital donations and impairments) was £4.4m in 2017/18 which was an improvement from 2016/17. For further information on the financial results, refer to page [xx](#).

However, the environment also presents exciting opportunities. We are committed to becoming a hospital where research is integral and drives treatment and outcomes. 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 2017/18, with over 1,200 studies active during the year – see page [xx](#) for further information.

During treatment, patients and their families might be going through the toughest times of their lives, so we place great importance on creating nurturing environments. It is critical that we provide specialised and highly-specialised care in high-quality estates and facilities. The opening of the new Premier Inn Clinical Building, for example, brings multiple services into one brand new facility from across the current estate. We will use technology to move towards a digital future, to access information and share information.

Key issues and risks

Our Board Assurance Framework (BAF) details the principal risks to the achievement of our operational and strategic plans. It is informed by internal intelligence from incidents, performance, complaints and internal and clinical audit, as well as the changing external environment in which we operate.

The top four risks to our operational or strategic plans in 2017-18 were identified as:

- **Recruitment and retention of sufficient highly skilled staff with specific experience** - 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 several steps to address this in 2017/18, we will continue to implement our plans in 2018/19 and beyond.
- **Failure to continue to be financially sustainable** - In the context of decreasing real-term funding for specialised and highly specialised services, as well as the high costs associated with providing specialised and highly specialised services, funding and financial stability remain critical. It helps us to continue to grow our portfolio of research grants and research posts and fund infrastructure for our Somers Clinical Research Facility, while the GOSH charity helps to fund buildings and equipment.

- **Reliance on IPP to support financial viability** - Private patient work is also key to providing financial support for our NHS paediatric services. The majority of private patient service demand is from the Middle East, which carries a degree of geopolitical risk. We continue to implement our strategic objectives to mitigate exposure to this risk through market and product development opportunities.
- **Implementation of the new Trust-wide Electronic Patient Record (EPR)** - see page XX for further information.

More detail about these risks and our mitigating actions can be found in the annual governance statement on page X.

Going concern

Although we are operating in a particularly constrained financial environment, the directors have a reasonable expectation that we have 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 our financial position and plans can be found on page X. Full details of our income and expenditure in 2017/18 can be found in the accounts from page X.

Important events since year-end

CQC Report: Our scheduled CQC report was published on 6 April 2018. Further information can be found on page xx.

PLACE: The PLACE assessment took place on 25 April 2018. The final scores will be published in 2018/19.

Appointment of the Chief Nurse: On 9 April 2018, Alison Robertson was appointed to the position of substantive Chief Nurse at GOSH. See page xx for more information about Alison.

Appointment of the Chief Finance Officer: On 23 April 2018, Helen Jameson was appointed to the position of substantive Chief Finance Officer (CFO) at GOSH. See page xx for more information about Helen.

Performance Analysis

Key achievements in 2017/18 and plans for 2018/19

Teams across the Trust have made significant progress and achievements in the first year of the operational plan 2017-2019, in line with these key areas of focus. These achievements include:

- Opening of the new Premier Inn Clinical building
- Achieving the national referral to treatment (RTT) target
- Delivered £10.7 million of 'Better Value' schemes (target £15m)
- Establishing the work programme to design and build the new EPIC Electronic Patient Record (EPR) system

- Ongoing progress in developing the business case for construction of 'Phase 4' in line with our master plan.

In 2018/19, these key areas will continue to be developed – with a plan to:

- Continue to deliver the national RTT target
- Deliver a £15m Better Value Programme
- Complete work on EPR for 'go live' in April 2019
- Continue progress on Phase 4 development
- We will also continue work with the Cognitive Institute to deliver a Safety & Reliability Improvement Programme that will improve the culture of safety and accountability within the Trust.

We align our strategic objectives with eight areas of focus that reflect challenges and opportunities – care, people, research, technology, voice, space, funding, and information. On the following pages, you will find more information about these eight priorities, specifically: what they are, what we have achieved and what the challenges have been.



Our Care priority: We will achieve the best possible outcomes through providing the safest, most effective and efficient care.

We ensure that our expert services are accessible, so we can provide the best possible treatment and care for the children that need us. 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.

Some of our 2017/18 achievements against this priority were:

Objective	Achievements
Be recognised for our expertise and clinical innovation in developing, delivering and leading specialised paediatric services.	<ul style="list-style-type: none"> Established three new flow programmes covering outpatients, theatres, and patient placement to increase treatment times and improve the ‘flow’ of patients through the system. Introduced several templates and tools that improved business planning and activity monitoring.
Be recognised for our quality of care, positive health outcomes and experience for children and families.	<ul style="list-style-type: none"> Introduced education and training for improving tracheostomy care.
Provide timely access to care for all GOSH patients.	<ul style="list-style-type: none"> Supported development of referral to treatment (RTT) specialty-level trajectories.
Deliver efficient care in order to generate a sustainable surplus and allow us to invest in our transformation.	<ul style="list-style-type: none"> Our Better Value Programme helped us deliver its £10.7m ‘better value’ target for the year.

Improvement of neonatal care

We successfully completed the neonatal card project, improving the care of neonatal jaundice and reducing repeated newborn screening.

A parent’s experience of neonatal care

Alison Baum, CEO of Best Beginnings, and mum to Joshua, explains her experience of Joshua being treated at GOSH.

“Joshua was born in October 2015 at 31 weeks with a congenital mesoblastic nephroma – a renal tumour. Four days later, he had a nephrectomy, a procedure to remove his kidney and the attached tumour which measured 11 x 8 x 5cm. Joshua became very sick and almost didn’t make it. Incredibly, he pulled through and went on to make a remarkable recovery.

It was stressful and overwhelming at times, but the attentiveness of the staff in NICU and the support we received really helped us.

Joshua spent eight weeks in NICU and eventually came home on Christmas Eve. He relapsed a few months later, but fortunately he was very responsive to treatment and is now in remission.

He is quite small for his age and has a bit of catching up to do but is making progress and we couldn't be more proud. Our overriding memory of our time at NICU was the outstanding care that Joshua received and the tremendous support we as parents were given – especially during the tough days.”

Care of sepsis

Sepsis is a life-threatening, overwhelming response to an infection. We rolled out the Sepsis 6 campaign in 2017, which aimed to support the early identification and treatment of sepsis. The Sepsis 6 is a set six of interventions that can be delivered by any healthcare professional and must be implemented within the first hour. Further information is on page [XX](#).

A quick response – Ben's story

Twins Ben and Toby were born premature at 27 weeks, weighing 1,100 grams and 978 grams respectively. Three weeks later, Ben developed necrotising enterocolitis (NEC) and he was rushed to GOSH for emergency surgery.

While Ben was recovering from surgery on Squirrel Ward, he contracted sepsis. The potentially life-threatening infection was recognised early and, by the next morning, Ben had made a full recovery. His fathers, Joe and Mark, tell us about the care Ben received while at GOSH.

“One morning, Ben's temperature spiked to 38.1°C and he was immediately identified as at risk. Various hospital teams came to see him and it was clear that everything he needed was swiftly prescribed. I could see a commitment to respond within an hour and he was closely monitored as the infection progressed.

“It was very worrying to see that Ben was not himself and clearly getting worse. Obviously, it was hard, but I could see he was getting everything he needed and that the support was consistently present. By the morning, Ben was much more himself and seemed more comfortable.

“In hospital, the risk of infection is, in many ways, higher than at home because you have lots of different people coming in: all the staff, volunteers, friends. It's important for your child to see all those people, but they can all potentially bring infection in from the outside world.”

Ben needed multiple operations to treat NEC and also an operation on his heart. Joe and Mark were able to stay in parent accommodation while Ben was in intensive care. They balanced caring for Ben on Squirrel Ward with caring for Toby at home, bringing Toby to see his brother at GOSH as often as possible. Now age seven months, the twins are beginning to smile and gurgle at each other.

Consulting and engaging with patients on the quality of their care

The Young People's Forum (YPF) is a group of current and ex-patients (aged 10 to 25) who guide and support the hospital on a range of topics and issues, ensuring that any changes or developments align with the users of the services. Further information about the work of the YPF can be found on page [XX](#).

On Saturday 14 October 2017, young people from Birmingham, Bristol, Derby, Leeds, Manchester, Nottingham, Oxford and other London hospitals joined members of our Young People's Forum (YPF) to organise the first ever Big Youth Forum Meet Up.

With the help of the Great Ormond Street Hospital (GOSH) Patient Experience team, more than 80 young people came together to discuss the big issues surrounding their health and hospital care.

The morning kicked off with laughter at a Q&A session with comedian and ex-GOSH patient Alex Brooker. Alex shared positive memories of his time at GOSH and told young people that they play an important part in their healthcare, and if they stay quiet they won't be able to have an impact.

The young people then divided themselves into groups of mixed up ages and geographical locations for a 'share and steal' activity. They shared their thoughts on the rights of children and young people in healthcare, practical issues for children and young people in hospital and the emotions of children and young people in hospital.

At the end of the day, attendees could choose to take a tour of GOSH, receive first aid and CPR training, a course on advocating for themselves, public speaking skills and others.

To close the first ever Big Youth Forum Meet Up, everyone voted on the issue they wanted to be taken forward by the NHS Youth Forum. They decided that everyday mental wellbeing should be everyone's responsibility and that communication should be a two-way conversation amongst equals.

Excitingly, the Nottingham University Hospitals Youth Service and Derby Teaching Hospitals Kite Team agreed to co-host the next Big Youth Forum Meet Up in 2018

Improving access to services

Throughout the past three years, we have focused on improving the quality of our waiting list data, establishing robust processes to manage elective care waits and ensuring that assurance processes are in place to provide early warning of any future issues.

The main focus in 2017-18 was to reduce the waiting times for all our patients, providing prompt treatment and achieving the defined national requirements as an organisation.

We worked on improving the waiting times associated with referral to treatment, in line with the hospital's agreed recovery trajectory with NHS England. We achieved the 92% standard for the first time since returning to reporting in January 2018, with a performance position of 92.96%. This was a testament to the work completed by the clinical and operational teams.

In 2018-19 we will focus on maintaining delivery of the RTT standard and delivering compliance in the small number of speciality areas under the 92% standard.

We improved our performance in the delivery of the diagnostic six-week standard, achieving the standard in November 2017, the first time since returning to reporting. Unfortunately, we struggled to maintain this position due to the small allowance of breaches we are permitted to have against the 1% tolerance allowance. Typically we are only permitted to have five breaches or less on a monthly basis, we usually have less than ten on a monthly basis. We continue the work necessary to improve the position as much as possible, however sustainable delivery of the six-week standard is going to continue to be a challenge for the organisation.

We achieved and anticipate we will continue to achieve, all the cancer standards appropriate to our children in 2017/18 and 2018/19 respectively.

Delivering efficient care to invest in our transformation

Our Better Value Programme helped us to deliver the highest contribution from efficiency achieved in recent years. Better Value schemes valued at £10.7m were delivered over the year. This was achieved through:

- £1.4m was delivered by new cross-organisational initiatives to improve patient flow through outpatients, inpatient beds and operating theatres.
- £1.1m resulted from a central programme to reduce non-pay spending, with a further £2.0m generated through local schemes led by the divisions.
- £1.5m related to new initiatives to increase commercial, international and private revenues generated (non-NHS);
- £3.1m resulted from a review of staffing and skill-mix.
- £0.4m was achieved from information technology enabled efficiencies, in advance of the implementation of our new EPIC electronic patient record system.
- £1.2m was delivered from other efficiencies.

The Programme Office also oversees the quality impact assessment process, which reports to the Medical Director and Chief Nurse. This arrangement ensures that we consider the quality impact of all cost-saving initiatives and mitigate any emerging risks. The Finance and Investment Committee and the Quality and Safety Assurance Committee oversee the progress and impact of the Better Value Programme, on behalf of the Board.



Our People priority: We will attract and retain the right people through creating a culture that enables us to learn and thrive.

Every day our staff help children and young people with rare or complex conditions fulfil their potential. Attracting, retaining and developing the best people across our clinical and supporting workforce is vital. Additionally, education, teaching and learning are critical to our work.

Some of the ways we have attracted and retained the best staff are:

Objective	Achievements
Use our values and behaviours to build a positive and diverse culture where staff are inspired to give their best	<ul style="list-style-type: none"> Delivered mindfulness training and piloted a resilience programme to improve staff mental health and wellbeing Continued to recruit new volunteers to the largest volunteer programme of any NHS Trust in greater London
Be renowned for our talented staff and for the ever-improving quality of work they do	<ul style="list-style-type: none"> Ran a newly qualified nursing campaign and recruited 206 nurses while reducing vacancy rates from 13.36% in August 2017 to 0.7% in October 2017.
Have leaders at all levels of the Trust who are effective, visible, supportive and respected by their teams	<ul style="list-style-type: none"> Partnered with the Cognitive Institute - a safety, reliability & improvement programme with leadership orientation workshops for all leaders
Provide our staff with the skills and capabilities needed to deliver exceptional care from world-class facilities	<ul style="list-style-type: none"> Increased Planning, Development & Review (PDR) rate to 90% helping our staff to focus on their jobs and career and identify their future personal and professional development needs.

Impact of Brexit

A key challenge for us has been that our workforce relies on staff from the European Union (EU) and European Economic Area (EEA); therefore, Brexit presents a potential risk that lose staff and find it harder to recruit to posts. To ensure we can cope with these changes, we have: undertaken workforce and succession plans for EU and EEA-reliant staff groups, worked with Health Education England (HEE) on training provisions for high-risk roles, worked closely with services and areas (e.g. nursing) to develop strategies to reduce turnover, and, designed and run leadership development programmes.

Volunteering at GOSH

GOSH has largest volunteer programme of any NHS Trust in greater London. In the last year, we increased our total number of active, regular volunteers to 1,093. We attract skilled, motivated and enthusiastic people to the GOSH volunteer programme and offer extensive, valuable training and support to individual volunteers. We also increased the variety of roles that people can choose as a volunteer, from 72 last year to 127. These roles range from those working directly with patients and families, to those supporting back office staff and departments.

We estimate that our volunteers donated approximately 220,000 hours of their time to supporting the hospital, providing services for patients and families. This volunteer effort equates to £2,244,000 of donated time, based on the London Living Wage.

Leadership

This year, an organisational-wide learning needs assessment, identified leadership and management development needs across the Trust, and offered leadership training and advice to identified staff. The staff report on page xx gives detailed information on how we have improved leadership at all levels.

Education and training at GOSH

We continue to embed the GOSH Learning Management System (GOLD LMS) which has enabled us to provide more visible access to learning opportunities and has improved the recording of learning records. The staff report on page xx shows how we have improved the skills and capabilities of all our staff.

In 2017/18 Nursing and Non-Medical Education (NNME) supported 641 staff members from across the clinical nursing and non-medical workforce to continue their education and development. Our main achievements include:

- Delivery of our two-year bespoke Professional Development Programme, incorporating preceptorship for newly qualified nurses within GOSH, facilitating a smooth transition from student to qualified nurse.
- The launch and delivery of the first GOSH child and young person (CYP) clinical apprenticeship for our band 2 healthcare support workers.
- Offered ten graduate and post-graduate modules across cardiac, renal and high dependency care specialties.
- Delivered professional development programmes to all nursing, allied health, radiography, pharmacy, psychology and social work staff.
- Over 3000 multi-professional candidates have taken part in clinical simulations designed to reflect organisational safety needs. The simulations led to positive changes and the identification of latent errors in clinical practice.
- The Healthcare Science Education Working Group was nominated and shortlisted for national leadership and advancing healthcare awards.

Post-Graduate Medical Education (PGME)

The PGME department delivered 51 courses with over 1,500 attendees - a 50% increase in course output over last year.

The inaugural GOSH Conference 'Advances in Paediatrics' brought all departments and professions together to share their work across the Trust. It embodied the Trust and will now be an annual fixture in our calendar.

Dr Sanjiv Sharma, Deputy Medical Director for Medical Education received the UCLPartners Director of Medical Education of the Year Award 2017.

The department has undertaken many projects to improve the experiences and education of the junior doctor workforce at GOSH.

Mildred Creak – A safe space for recovery

The Mildred Creak Unit – named after Dr Mildred Creak, the first consultant psychiatrist and the first female consultant at GOSH – looks after young people with mental health problems. Young people are referred through their child and adolescent mental health service (CAMHS) and are admitted onto the ward from anywhere between a few weeks up to a year.

Sam Gardiner, a Senior Staff Nurse, shares how the ward helps the people who stay there. "We work as a community. Unlike other wards where you'll have a patient allocated to each member of staff, we nurse all the young people together as a group," explains Sam. "My role, like all of the staff here, is to be involved in every aspect of the daily living for the young people on the ward."

There is still a stigma around mental health problems – especially in young people. Sam explains that it can be hard for families going through diagnosis and treatment on Mildred Creak. Parents sometimes feel responsible and blame themselves for mental health problems in younger people, and they might feel judged.

It's important for Sam that the ward staff do not judge parents in this way and that they create a safe space for the young people they look after. "We have the ethos that the majority of families are doing 100% the best for their child," she adds.

For Sam, the positives of working on the ward far outweigh the challenges she faces.

"The relationships we have with our young people are different compared to other wards because we see the same people all the time. We have visiting nights where all the families visit and we all eat together. We get the privilege of watching what a family experience might be like.

"Every young person we see – no matter how hard they're finding it – there's always hope that they can walk out of this place and put it all behind them.

Cognitive Institute

We have partnered with the Cognitive Institute to implement the Safety and Reliability Improvement Programme. The programme provides a framework for the development of leadership competencies, a safety culture and emphasises the importance of professional

accountability. Patient Safety Champions are being appointed from across staff groups in 2018 to take the work forward.



Our Research priority: We will improve children’s lives through research and innovation

GOSH is committed to becoming a hospital in which research is integral to the work of our staff and the experience of families. By immersing our practice in research, we will drive improvements in treatment and outcomes not just for our patients, but for children and young people everywhere.

Some of the ways we have successfully implemented research and innovation are:

Objective	Achievements
Accelerate the translation of all research into improved patient outcomes	<ul style="list-style-type: none"> GOSH and ICH (University College London Great Ormond Street Institute for Child Health) published over 1,500 papers a year, in the 5 year period 2012-2016. GOSH and ICH research papers together have had the second highest citation impact compared to international paediatric comparator organisations.
Build a culture of innovation and continuous improvement where the talent and creativity of all staff is harnessed	<ul style="list-style-type: none"> Began work to launch a control hub to improved data management and visualisation as well as our predicted analytics capabilities.

At GOSH our aim is for research to be an integral part of the working lives of our staff, and for the families who we treat and see.

Our ambition is to learn from every patient we see, using the knowledge gained to improve health for patients at GOSH and children worldwide. In 2017/18 we launched our generic consent pilot, an opportunity for families to donate surplus tissue and blood samples for our pioneering research.

With our academic partner the University College London Great Ormond Street Institute of Child Health (ICH) we published over 1500 papers a year, in the five-year period 2012-2016 GOSH & ICH research papers together had the second highest citation impact compared to international paediatric comparator organisations.

Participant recruitment

During 2017/18, we ran over 1,200 research projects at GOSH/ICH, with over 3,400 patients and family members taking part in research.

GOSH leads the North Thames Genomic Medicine Centre (GMC), one of 13 regional centres that are responsible for coordinating the recruitment of patients to the 100,000 Genomes Project. This pioneering project aims to improve our understanding and treatment of rare conditions and cancers. This year the project reached its halfway point, over 14,500 genomes have been collected by the North Thames GMC including 4,310 rare disease genomes. GOSH has collected 84 cancer genomes and recruited over 1500 GOSH families.

Funding

We saw an overall 18% growth in our research income to £20m in 2017/18, this fund supports research infrastructure and projects across the Trust.

This year also marked the start of our third funding term of the National Institute for Health Research (NIHR) GOSH Biomedical Research Centre (BRC) and the commencement of our new NIHR Clinical Research Facility (CRF) funding.

Our BRC funding enables basic scientific discoveries made in laboratories to be translated into 'first in child' clinical studies. We aim to accelerate discoveries into the basis of rare childhood diseases and to develop new diagnostics, imaging techniques and treatments, including cellular and gene therapies. The BRC is ideally positioned to deliver this, as GOSH is the largest recipient of nationally commissioned NHS services in the UK.

Our NIHR CRF provides expert research care and support to patients and families who have volunteered to take part in research, as well as guiding researchers and research sponsors and funders in clinical research design and delivery. In the last year, the NIHR GOSH CRF has supported research trials across 26 specialties at GOSH. More than 295 families have taken part in NIHR GOSH CRF research trials this year, which has included more than 1300 patient visits.

This year also saw the launch of 'Innovation at GOSH' and our 'Innovation Accelerator' competition. Our staff are best placed to come up with new ideas to improve patient care or save resources, however taking an idea to the next stage can be difficult without specialist knowledge of intellectual property, regulatory legislation and how to get funding. Innovation at GOSH will help encourage and nurture new ideas with the ultimate aim of benefitting patients at GOSH and across the NHS and improving the working lives of our staff.

Cancer drugs could transform the lives of children with serious facial disfigurements

Research by GOSH and the UCL Great Ormond Street Institute of Child Health (ICH) has found the genetic cause of a blood vessel disorder called arteriovenous malformation (AVM) that can cause severe bleeding and strokes. The research team discovered that four faulty genes can trigger the condition. These genes are also involved in growth of cancers and there are already several licensed cancer drugs that target the genes meaning that doctors have the potential to treat AVMs with the same drugs.

This research is led by Dr Veronica Kinsler, consultant paediatric dermatologist at GOSH and ICH. Nikki Lilly was diagnosed with AVM when she was six years old, after being referred to Dr Veronica Kinsler at GOSH.

Now 13, Nikki has had more than 330 appointments and undergone dozens of procedures at GOSH.

Nikki has high-flow craniofacial AVM on the right side of her face and, as part of Professor Kinsler's research, was found to have a fault in the RAS/MAPK genes. In the six months since Nikki began taking medication, there has been no growth in her AVM. However, it's too early to say whether the treatment has been effective.

Nikki says: "I was excited to take part in the study as I thought being able to take a drug to control or shrink my AVM would be a lot less painful than having regular operations. As I've only been on the drug for just over six months, it's not enough time to tell, but the first scans have been positive and show no further growth."



Our Technology priority: We will transform care and the way we provide it through harnessing technology.

We have begun our journey towards a more ambitious digital future, transforming the way in which our patients and families experience our services. Through enhanced technology across our hospital, we will ensure we have the facility to improve our productivity and patient outcomes. For example, DRIVE (Digital Research Innovation Virtual Environment) will increase our focus on digital research, innovation, and other technologies.

In 2017/18 we successfully harnessed technology in the following ways:

Objective	Achievements
Become a digitally mature organisation, radically transforming patient, family and staff experience of our services	<ul style="list-style-type: none"> Increased GOSH’s focus on digital research and innovation through DRIVE (Digital Research Innovation Virtual Environment). The unit is expected to be open in late June 2018.
Ensure rapid uptake of the latest clinical and non-clinical technologies to improve patient outcomes and our productivity	<ul style="list-style-type: none"> Implemented a successful Cyber Security Strategy to tackle and manage cyber threats. The Aridhia platform has been designed solely for research and was selected following a comprehensive procurement process, which evaluated dozens of systems available.

Harnessing technology in healthcare with a clear strategy is important; it will allow us to improve service delivery for our patients, as well as our external partners and networks. We seize opportunities to use technology to deliver better services, through electronic patient records, digital outpatients services, and digital care networks. We also manage technology risks facing us, including: the pace and scale of social media, hacking and spyware. Our strategy is to minimise these risks by developing a responsible use of social media, and embedding it in our culture, and ensuring that our security systems are up to date.

Becoming a digitally mature organisation

Following the agreement of the digital strategy in 2017, we continued to work on improving our overall digital maturity. We have made tremendous progress in the areas of supporting infrastructure, governance and readiness in preparation for the move to the full Electronic Patient Record next year.

In the most recent National Digital Maturity Assessment (2017) GOSH had moved into the top section for readiness and infrastructure on the Digital Maturity Index. Following the Electronic Patient Record System (EPIC) go-live date, we expect to become one of the top-rated organisations nationally for digitisation in 2019. This digital sophistication will transform the experience for all our patients, staff and partners.

Increasing productivity through technology

We are investing and developing a Digital Research, Informatics and Environment Unit (GOSH DRIVE), to focus on numerous aspects of the Digital Strategy. Focusing on research and innovation is strategically essential for us to obtain full benefits from the investments being made around the EPR, Digital Research Platform, Network Infrastructure, VNA and overall Digital Strategy.

GOSH patients are 'digital natives'. The average age of our patients (<10 years old) and their parents (20-30 years old), is in stark contrast to general adult NHS hospitals (70 years old+), and therefore the patient and family population are digital natives and early adopters of technologies. By observing how our patients and families use devices and apps, we can learn more about the use of these technologies by future adults.

We have been able to invest in state-of-the-art IT infrastructure including a dedicated, scalable, cloud based digital research environment to host and manage the programme, the only such centre architecture in a UK hospital.

Life-changing brain surgery

Diagnosed with epilepsy at seven years old, Bailey was referred to Great Ormond Street Hospital (GOSH) for life-changing brain surgery

He underwent five days of monitoring at GOSH's telemetry unit on Koala Ward, so that the neurology and neurosurgery teams could understand which part of his brain was causing the seizures, as well as undergoing more MRI scans.

"That was a really hard week. You don't want to see your child having a seizure, but at the same time you want the doctors to be able to witness them so they can get all the information they need," says Sam.

Following Bailey's telemetry monitoring, doctors suggested to Sam and Tony that Bailey undergo brain surgery in January 2015. Mr Martin Tisdall, Consultant Paediatric Neurosurgeon at GOSH, met with Sam and Tony and explained that an operation could help Bailey's seizures.

"Even with medication, Mr Tisdall explained that, without surgery, Bailey's seizures were likely to get worse, so we decided to go for it," says Sam.

"On the day we were travelling to the hospital for the operation, Bailey ended up having one of his biggest seizures ever. We knew then that we had made the right decision."

Bailey's operation took nearly 10 hours, but went extremely well. Mr Tisdall was able to successfully disconnect and remove the affected parts of Bailey's brain. After just four days, Bailey was able to leave GOSH to recover at home. Since his surgery, Bailey has not had a single seizure.

“Every now and then, Bailey asks me how many seizure-free days he’s had, as I have a tracker on my phone,” says Sam. “We still go to GOSH for regular check-ups, but Bailey is doing so well. He still has autism, attention deficit hyperactivity disorder and left hemianopia [loss of vision on his left field of vision], but he goes to a specialist school, which is working really well. Life really is a lot better for him now. He’s such a happy boy.”



Our Voice priority: We will use our voice as a trusted partner to influence and improve care.

We are finding our place in the contemporary system of healthcare in the UK, as a collaborator and provider of highly specialist paediatric support for partners across the country. We will continue to use our voice to advocate for issues that directly affect the children and families who need us the most.

Examples of how we have used our voice to influence care positively include:

Objective	Achievements
Use the voice of GOSH to promote issues that directly affect the children and families who need us the most	<ul style="list-style-type: none"> Led GOSH's relationship with NHS Benchmarking Club (for example in pharmacy and corporate services), including engaging with the Advisory Board on the nursing workforce and theatres programme.
Play a leading role in the UK system and international children's alliance, and to ensure our networks across the UK best serve the patient's needs	<ul style="list-style-type: none"> Continued to strengthen networks and partnerships. Examples include: (I) Establishing the EpiCARE group, recognised as a European Reference Network (ERN) on rare and complex epilepsies; (II) Working with NHS England's Sign up to Safety campaign to peer review in-hospital deaths of children and young people; (III) Continuing academic research partnerships with UCL Institute of Child Health, UCL Partners, and National Hospital; (IV) Leading the Children's Alliance to ensure we hold an influential position on the national paediatric strategy.

The NHS landscape is changing. We see the continued development of National Sustainability and Transformation Plans (STPs), Accountable Care Networks (ACNs), the Forward View, national programmes of care and clinical reference groups. On a local level, GPs and local acute hospitals are changing through primary service redesign, with hospital trusts based over several sites, and increased partnering with local GPs. As an acute specialist paediatric hospital, there is a risk, that GOSH will not fit well with future visions and plans for the health service and national priorities. To ensure this does not happen, GOSH has embraced the principles of 'integrating care locally' such as:

- Co-producing major national improvement strategies
- Working more closely with commissioners and local governments
- Continuing to engage with communities and patients
- Involving front-line clinicians in service changes
- Driving improvements in strategically important services (e.g. cardiac, neuro, and oncology)
- Maintaining involvement in national programmes of care and clinical reference and formulary groups.
- Continuing to provide services such as outreach clinics and act as a source of expert advice.
- Continuing to work closely with referrers in our networks of care to strengthen care arrangements.

ECHO

Caring for children with increasingly rare and complex conditions makes international collaboration an essential feature of life at GOSH. The opportunities presented by the European Research Networks combined with uncertainties presented by Brexit means that exploring and formalising relationships with our European peers has never been more important.

Children's hospitals across Europe experience similar challenges needs and contributions can get overlooked in a system primarily focused on adults. Naturally, we have much to learn from each other and by joining forces we can achieve more.

GOSH Chief Executive Dr Peter Steer chairs a steering committee of nine CEOs from leading European children's hospitals who are building a membership organisation to co-ordinate this important work.

ECHO has created a network of task forces to develop and grow the organisation and progress its early priorities, such as creating a framework for members to share data and best practice to improve patient outcomes. The organisation creates a testimonial of friendship between professionals working in different countries, and a platform to help them network, share innovation and learn from each other. It promotes the adoption of evidence-based policies and a holistic approach to caring for children to improve the quality, safety, sustainability and patient experience offered by its members.

Over time, the collaboration will support member organisations in advocating more effectively on issues including research, innovation and training at a pan-European and international level.

Children's Alliance

GOSH is part of the Children's Alliance – a strategic group of children's hospitals across the UK that includes Alder Hey, Birmingham, Southampton, The Royal Manchester, Evelina London, Leeds, Sheffield Children's Hospitals, The Great North Children's Hospitals and Bristol Royal Hospital for Children.

We recognise that children's services can be incredibly complex, so it's vital that our UK paediatric services work closely to share knowledge, expertise and learning. Areas of work across the Alliance include our workforce, the safety of our patients, national service reviews, and integrated models of care. In the past, the Alliance has been successful in reviewing tariffs and payments for children's services through working with the Department of Health. The Alliance also works closely with NHS England, formally receiving and responding to proposed guidance and frameworks such as the National Guidance on Learning from Deaths.

GOSH has been working with an alliance member on peer benchmarking opportunities within the Children's Alliance. This includes exploring the feasibility of establishing a system for comparison of data submitted to national specialised services dashboards.

EpiCARE

Diagnosing different types of epilepsy and deciding on the best course of treatment could become a much faster process thanks to a newly formed European network, coordinated by Great Ormond Street Hospital.

The network, known as EpiCARE, will allow collaborative working across Europe and more access to innovative and highly-specialised diagnostics. This will mean faster and more accurate diagnoses for patients and hopefully better treatments. By doing this, the project aims to increase the number of seizure-free patients over the next five years.

The EpiCARE network will run over a five-year period from 2017 to 2021 and is one of 23 projects funded by the European Commission that allows professionals and centres of expertise in different countries to share knowledge and tackle rare diseases that require specialised care.

The European Research Network will, in the first instance, comprise of 28 recognised health care providers from across Europe. They will share information, experience, and knowledge via e-registries and in virtual multidisciplinary meetings. They will also work to increase accessibility of epilepsy surgery for carefully selected individuals.



Our Spaces priority: We will create inspiring spaces with state-of-the-art equipment to enhance care delivery and learning.

We are committed to creating world-class, leading facilities for patient care and research. Great importance is placed on creating environments providing high-quality facilities and cutting-edge equipment. For example, the Premier Inn Clinical Building (PICB) (successfully opened) in 2017 is achieving an ‘excellent’ BREEAM standard. BREEAM is an independent assessment of the sustainability performance of buildings, communities, and infrastructure.

Below is a summary of how we have enhanced care and learning at GOSH in 2017/18:

Objective	Achievements
Be recognised as the most environmentally sustainable healthcare provider in the UK with all staff recognising their stewardship role	<ul style="list-style-type: none"> PICB was successfully opened and achieved an ‘excellent’ score on the BREEAM rating benchmarks – an independent assessment of the sustainability performance of buildings, communities, and infrastructure.
Maximise our hospital site’s potential to meet the current and future healthcare needs.	<ul style="list-style-type: none"> Developed a detailed, prioritised and costed plan, in line with clinical and research strategies, including the introduction of new technologies, increases in core capacity and the replacement of life assets.
Provide our clinical teams with the equipment they need to deliver cutting-edge care to our patients.	<ul style="list-style-type: none"> Implemented a three-year capital plan, meeting the statutory and mandatory requirement.

There is a risk that inadequate planning or management of infrastructure redevelopment may result in poor value for money or failure to deliver expected business benefit. To reduce this risk, GOSH has established a Redevelopment Programme Board with oversight of all redevelopment work which reports to the Finance and Investment Committee to assure the Trust Board about the scale of development, cost and affordability of projects. GOSH retains clear project leadership role through the Chief Executive and the Project Director, including reporting mechanisms and accountability.

PLACE

PLACE is a national assessment allowing patient representatives to assess the quality of the care environment in five categories: cleanliness; food and hydration; privacy and dignity; condition, appearance and maintenance of building and disability compliance. It is an

opportunity for the patient representatives to voice their views and be heard and become a part of our journey towards the best possible patient experience. The PLACE assessment took place on 25 April 2018. The final scores will be published and will feed into CQC.

We are proud of our care environment and recognise the impact it has on patient care and patient experience. Therefore the Development Team, clinical teams and Patient Experience Team have been working collaboratively to review, assess and improve our hospital environment. All suggestions for improvement raised during the PLACE audit last year have been reviewed and actioned. We have also been conducting mock PLACE audits and trained various clinical and non-clinical members of staff on how to assess the environment and take action so we can keep improving patient experience.

A royal visit

Her Royal Highness, The Duchess of Cambridge visited patients, families and hospital staff at GOSH in January 2018 to officially open the Mittal Children's Medical Centre, home to the new Premier Inn Clinical Building.

The event marks a significant milestone in the history of the hospital. The completion of the Mittal Children's Medical Centre has taken eight years and is transforming our ability to help more seriously ill children fulfil their potential. The Premier Inn Clinical Building was operational from November 2017, seeing our patients move out of old facilities and into brand new, modern wards with ensuite bedrooms where parents can stay comfortably with their child overnight.

Fourteen-year-old patient Oriel Gray, and her mum Fiona also had a special visit from the Duchess. Oriel is in hospital recovering from surgery to reconstruct her ear. Oriel said of the meeting: "She was really friendly and very beautiful. I told her that the hospital feels like a second home because my mum can stay with me and I have my own bathroom. As a teenager that's really important. The new ward is amazing and all the nurses and doctors make you feel welcome. After my surgery yesterday, it was great to take my mind off everything. She said I must be very brave."

Speaking at the opening event, her Royal Highness the Duchess of Cambridge said: "I just wanted to say a huge thank you for having me here today. It's been my first trip to Great Ormond Street Hospital and I've been so impressed with everything I've seen and the scale of the work that's going on here."

Sustainability report

As an NHS organisation, we must work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, using natural resources efficiently, and building healthy, resilient communities. By demonstrating that we consider social and environmental impacts, we ensure that the legal requirements in the *Public Services (Social Value) Act 2012* are met.

As a part of the NHS, public health and social care system, we must contribute towards the target set in 2014: reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. We aim to exceed this target by reducing our direct (scope 1 & 2) carbon emissions from 2012/13 levels by 34% in 2019/20.

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 we have embedded sustainability is through the sustainable development management plan (SDMP).

The Board approved our SDMP in 2010, and we reviewed progress against the document in 2014, which included a consultation with staff. Our plans for a sustainable future are laid out and well-known within the organisation, and we are continuing to work to drive this vision.

The plan has three strands of activity:

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

NHS Improvement (NHSI) has started work via the NHS Sustainability Leads Network to support us in this period to achieve improved reporting against our SDMP. The impact of this work will be evident next year. We continue to train our staff on sustainability topics.

We also continued with our energy reduction programme, Operation TLC, in partnership with Global Action Plan (GAP). It engages staff to increase use of natural light, maintain comfortable heating levels and switch equipment off.

Operation TLC has focused mainly on wards and laboratories to reduce energy consumption and make the hospital a more comfortable environment for staff and patients. This year it was also rolled out to non-clinical areas, including offices such as the Paul O'Gorman building and the Nurses' Home.

GAP produced an Operation TLC report in 2017 summarising progress since the start of the programme in 2014. Highlights include a summary of impacts showing the campaign changed the following target behaviours:

Lighting

- On TLC wards, lights in unused areas were turned off 11% more often.
- Staff and patients reported increased satisfaction with lighting
- On average we consumed 5% less energy during the lighting campaign.

Temperature

- We reduced the use of fans by 16%.
- Fewer windows were left open (from 3.25% to 2%).

Switch off

- The equipment switch-off rate in laboratories improved by 25%.

Green Champions

The Green Champions network relaunched with a focus on taking simple actions on sustainability that help to improve the experience of GOSH patients, staff and visitors while reducing our environmental impact.

We set up a Green Champions stand in the Lagoon to promote our sustainability aims and take pledges from staff to become champions. We hosted a visiting artist at the stand from InstitchYou.

NHS Sustainability Day 2017 was a successful collaboration with our waste contract partner and GAP. Engagement opportunities for staff, patients and families included using an electric-car simulator for an efficient driver challenge, creating plant pots from reusable materials for children, and making smoothies using the pedal-power generated by an adapted bicycle.

In June 2017 we launched a National Clean Air Day event in collaboration with the UK Health Alliance on Climate Change. We hosted a variety of events including a new taskforce to tackle air pollution. Camden facilitated a vehicle-idling workshop for GOSH staff and volunteers. As part of the campaign, ten staff from across the Trust wore pollution monitors to track their exposure to pollutants while commuting.

GAP will process the results as part of a wider data-collection exercise.

Carbon footprint

Data normalisation

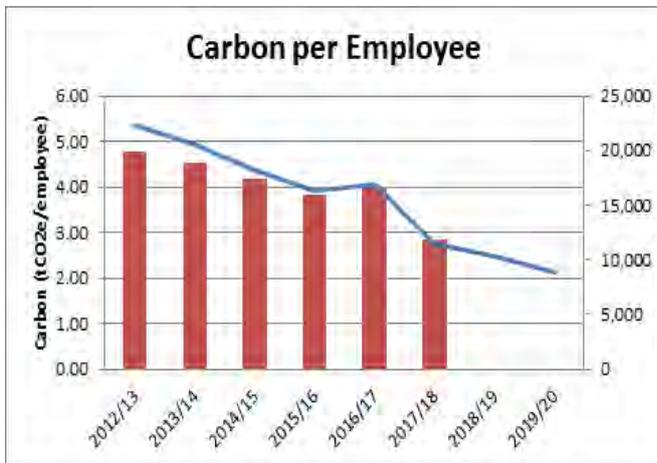
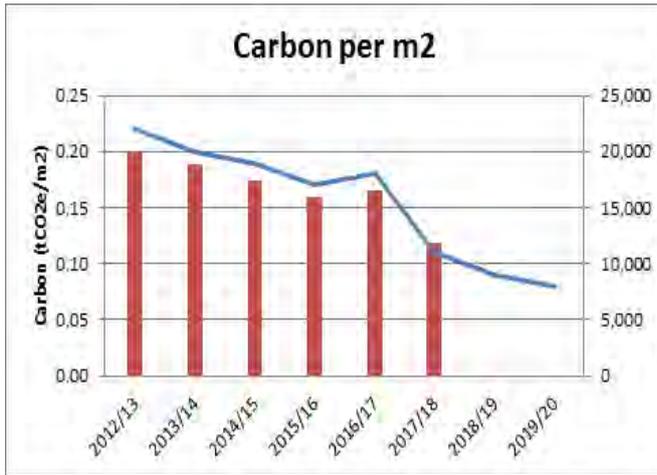
Our environmental impact is proportionate to the number of people we employ and the floor space of our buildings. **Error! Reference source not found.** shows how floor space has remained relatively unchanged over the last four years; even though our staff numbers increased by nearly 10%.

Context info	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Direct Emissions (tCO ₂ e)	19,947	18,836	17,448	15,950	16,468	11,893
Floor Space (m ²)	92,199	92,125	93,752	92,501	92,501	111,913
Number of Staff	3,728	3,811	3,984	4,068	4,068	4,300

Direct emissions, staff & floor space

This data has been used to normalise our direct emissions and compare progress against our target of 34% reduction by 2019/20. The figure below shows that we still retain an on-target profile despite the changes to the estate. The organisation is normalised by floor space and better when normalised by the number of employees.

The percentage reduction for each year is shown in the corresponding bar.



Normalised direct emissions - tCO₂e by m² (LHS) and by employee (RHS), line shows reduction glide path

The increase in normalised carbon emissions from last year is due to a minor reduction in electrical output from the Combined Heat and Power plant (CHP) against its full potential. This is due to the PICB construction by way of connecting into the pipelines of the second new CHP, due to come online mid-2018.

The commissioning of PICB also saw an increase in both electrical and heating demands associated with the new building. 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.

Energy

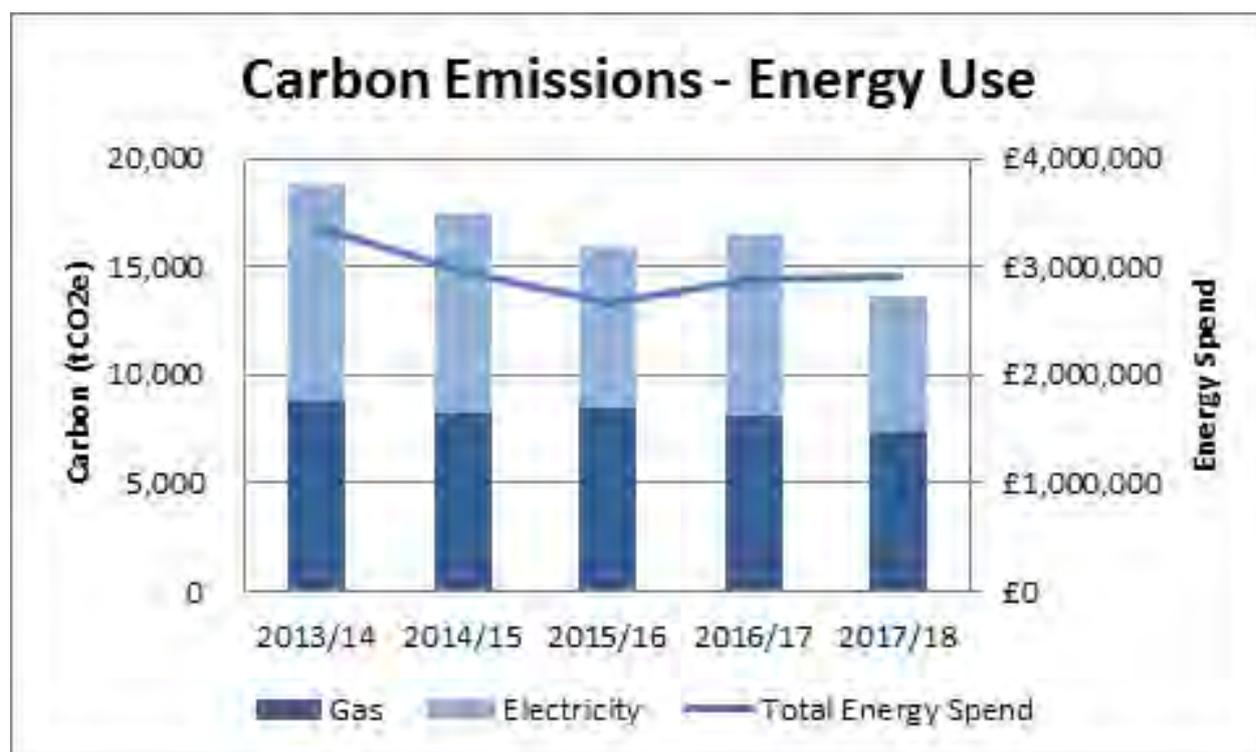
This section looks at our carbon emissions from energy and total energy spend, and provides a top-line view of the types of energy we are using. The biggest change to Trust energy usage profile has been the installation of a CHP engine at the end of 2011 which significantly changed the proportions of gas and electricity used by the Trust. In 2017/18 the CHP engine generated 37% of electricity requirements but consumed natural gas to achieve this.

The table shows that we spent £2.88m on energy in the last financial year, an increase of 8.1% from the previous year. The PICB building used more electricity when it came online,

and the CHP engine could not meet increased demands, because it was offline during interconnection works to connect the second new engine. As a result, we relied on energy imported from the grid and incurred higher utility costs than expected.

In mid-2017, we completed the works. Our energy use should normalise with an increase in electrical power and a decrease in gas volume due to the decommissioning of the Enpod Energy Centre.

It is also important to remember that the costs do not factor in the operation and maintenance costs of the CHP engine.



Carbon Emissions by year

Resource		2013/14	2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	41,492,485	39,444,385	40,657,465	38,603,045	39,587,133
	tCO ₂ e	8,802	8,276	8,530	8,068	7,335
Electricity	Use (kWh)	27,649,236	25,675,114	24,828,164	27,087,839	22,042,240
	tCO ₂ e	9,993	9,172	7,441	8,400	6,262
Total Energy tCO ₂ e		18,836	17,448	15,971	16,468	13,597
Energy Spend		£3,360,678	£2,952,472	£2,663,725	£2,881,300	£2,900,919

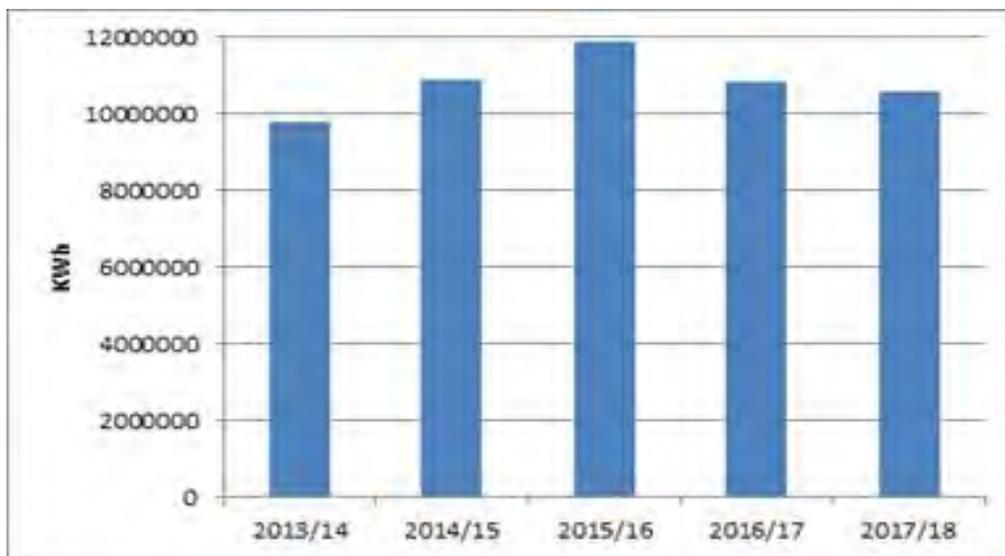
Carbon emissions and energy spend

Last year 10,598Mwh of electricity was generated from the CHP engine equivalent to 37% of our usage. The site consumed all the generated electricity, reducing the carbon emissions from the use of grid power.

Generated electricity from the CHP is shown below in Electricity Generated from CHP. The CHP system generated less electricity than last year due to the unit being offline for nine weeks while the pipework connections were made to connect in the second CHP engine.

We expect an output of between 10,500- 12,000 MWh per year depending on performance and maintenance requirements. We are in the process of installing a second CHP to reduce energy costs further.

Additionally we installed 37kW of photovoltaic cells in March 2016 to generate our own renewable energy. The PV cells have not achieved target due to shading from scaffolding from the VCB Chiller project and a fault in the system which only provided a saving 17,300kWh, equivalent to less than 0.1% of the sites electricity usage.



Electricity Generated from CHP

Waste Minimisation and Management

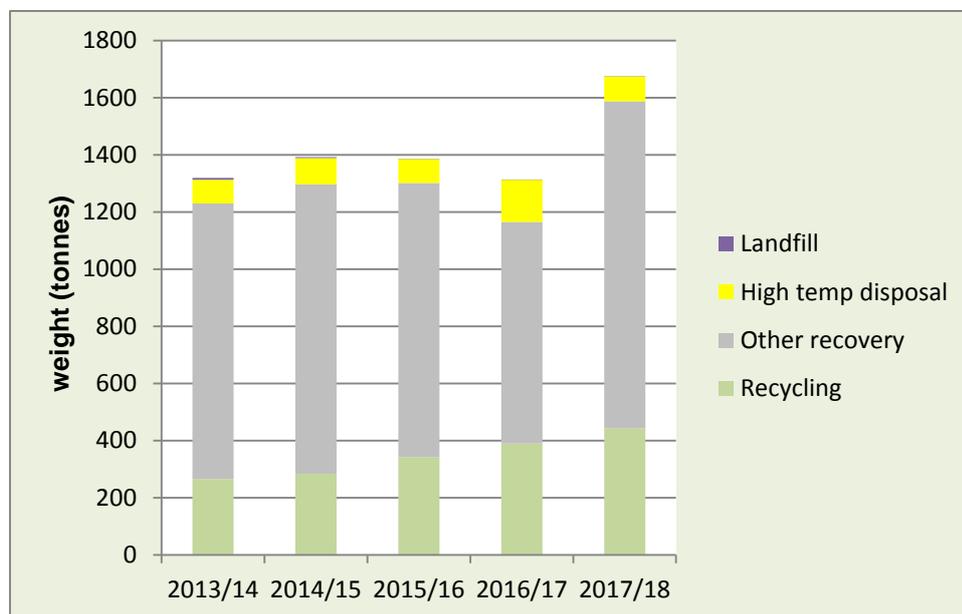
Last year 1,675 tonnes of waste was created; this is more waste than the previous year, but the increase is due to development work we are undertaking. We are proud that we recycled or recovered 94% of waste, up from 88% in 2016/18. We send virtually zero waste to landfill, (less than 1 tonne, which is 0.06% of our overall waste). The figure is so small that it does not show on the chart. It's even less than the 2016/2017 figures of 0.08%. We aim to produce and send zero waste to landfill.

The figure below shows the waste destinations.

This year we have taken additional steps to minimise waste. We have installed new recycling units and food composting caddies into office areas. There are also new clinical bins across the site.

The sustainability team have been looking at new ways to divert our waste, with the focus on how we can reuse and redistribute unwanted furniture and equipment. We have been using

an online platform called Reyooz that enables us to redistribute large items internally across the hospital or redirect unwanted items externally to charitable organisations. We have established a repair and refurbishment service for furniture and equipment to extend their useful life.



	2013/14	2014/15	2015/16	2016/17	2017/18
Recycling	265.8	283.02	342.03	390.02	442.67
Other recovery	963.4	1014.2	958.95	774.93	1144.07
High temp disposal	83.52	91.29	84.39	147.98	87.71
Landfill	6.03	2.88	0.99	0.99	0.99

Historical waste destinations

Opening of the Premier Inn Clinical Building (PICB)

The 2017 opening of the Premier Inn Clinical Building (PICB) marks the halfway stage in our redevelopment programme, supported by the charity, to replace our outdated and inadequate infrastructure with inspiring spaces.

Hospital buildings and equipment is one of our ten recognised critical planning factors that determine our ability to drive care and treatment through research. It is essential to our strategic vision of helping children with complex health needs to fulfil their potential.

Patients and staff moved into the PICB, which forms the second part of the Mittal Children's Medical Centre, in November 2017. HRH Duchess of Cambridge joined in GOSH Arts activities and met patients and staff when she opened the building in January 2018. Mittal family members and Premier Inn were among the guests.

In the recent Friends and Family Test feedback, patients and families showed their delight with the new facilities. One Chameleon Ward parent commented, “wonderful facilities which make a huge difference at stressful times”.

The construction of the Zayed Centre for Research into Rare Disease in Children (ZCR) has continued with Skanska, which took over the site in March 2017, and is set to complete in the next financial year 2018/19.

ZCR will bring clinicians and scientists together to develop our understanding of rare paediatric diseases 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.

Key milestones achieved in the realisation of Phase 4 of the redevelopment programme during 2017/18 include the selection of John Sisk & Son with BDP as the preferred partner for a 23,000m² scheme on Great Ormond Street. Patients’ and the local community’s views of the bidders’ designs were taken into account. Ongoing stakeholder engagement is essential to our redevelopment.

The winning design inspired with its vision for the new hospital front entrance and a state-of-the-art centre for cancer care.

Other projects include new physiotherapy accommodation, an integrated iMRI theatre facility at the Southwood Building Courtyard and the conversion of the Italian Building on Queen Square into an exemplar Sight & Sound Centre for Great Ormond Street for children with sight or auditory impairment.

Providing the Right Equipment

We are committed to providing our clinicians with the state-of-the-art equipment they need to provide the best and safest patient care. Often this is supported by the generous help of the charity, including where new equipment forms part of broader redevelopment in the hospital. At all times, we seek to get the best value in the equipment we buy; we work with NHS Supply Chain to secure the best value purchasing from national frameworks. We also secure value by strategically timing and aggregating the purchase of equipment and maintenance contracts, creating economies of scale with other trusts where possible and appropriate. A bulk purchase for cardiac theatres earlier this year saved 17% on the list price for ultrasound machines.

To ensure charitable and NHS funds are directed where they can have the greatest positive impact, we are developing new systems for prioritising the replacement of aged equipment. We have a significant amount of equipment that will come to the end of its planned life in the next few years, and we intend to carry out the replacement programme in the most clinically and cost-effective way.



Our Information priority: We will provide timely, reliable and transparent information to underpin care and research.

We are transforming the quality of our data and systems so they are better placed to support care and research. The key development will be the implementation of an Electronic Patient Record. This will radically transform how we currently operate.

Examples of how we have provided timely, reliable and transparent information are below:

Objective	Achievements
Develop the Business Intelligence Unit to be the single integrated source of accurate, timely and reliable performance data (incorporating operations, finance and workforce)	<ul style="list-style-type: none"> • Transferred 75% of job plans into electronic format.
Create a comprehensive, unified electronic single patient record, providing the single reliable source of clinical data to maximise staff productivity and deliver excellent care	<ul style="list-style-type: none"> • Established effective programme governance and strong relationships with system providers. • Facilitated significant input and collaboration with clinicians. • Agreed a clear streamlined process to use routine clinical data for research, • Introduced the Ethics Application for the use of routine clinical data for research • Established a data access committee • Agreed SoPs (standard operating procedures) for data access
Combine advanced analytics with a comprehensive set of data to inform and improve care for our patients	<ul style="list-style-type: none"> • Recruited 1,565 participants to the 100,000 genomes programme

Providing accurate, timely and reliable performance data

With the implementation of EPIC, we are taking the opportunity to review the roles, management and positioning of the wide range of experienced and talented informatics professionals working within the Trust. For our benefit we must maximise these talents, maintaining localised knowledge and support while ensuring consistency, national compliance and accountability.

We are is in the process of establishing a Centralised Informatics Unit. This unit will be responsible and the authority on data warehouse development and maintenance, statutory reporting and development of and adding value to Business Intelligence. The unit will work to

best practice standards, carry out regular reviews and where necessary provide development and support to maintain these standards.

The unit will assure us that relevant reporting is compliant and fulfils our statutory requirements.

Members of the unit will play an integral part in the success and on-going development of EPIC - they will have clearly defined and mutually agreed on development plans which will allow them to take ownership of their future careers and give them opportunities to work across divisions and specialisms.

Electronic Patient Record

The deployment of an Electronic Patient Record System (EPR) and Research and Innovation Platform are critical and core requirements in our progression as a digital research hospital, enabling improvements in quality of care, operational efficiencies and the development of new models of care. The EPR will improve communication with our families and patients and enhance innovative research. It will enable us to embrace significant opportunities to deliver change across the organisation, allow flexibility to respond to future developments within paediatric healthcare, transform the way we care for our patients and improve the care of children worldwide.

The introduction of the EPR will provide sophisticated decision support and care pathways, reducing unwarranted clinical variation. We will have the opportunity to design and embed standard treatment protocols and best practice guidance within the system, enabling clinicians to become more efficient in the way they administer day-to-day patient care, removing some of the current administrative burdens. Qualitative benefits will release additional 'time to care' including wider engagement with families and an increased focus on improving the patient experience.

The patient portal will transform the way we communicate with patients and families, empowering them to plan and manage their own care. We will be better informed about patients' preferences, and patients will be fully aware of the next steps in their treatment plan. Improved process management will ensure patients benefit from improved operating efficiency across all services.

To deliver this ambitious programme of clinical transformation, we have selected Epic Systems Corporation as our EPR partner and Aridhia Informatics Ltd. as our research platform partner, signing contracts with both organisations in May 2017.

Epic has a paediatric foundation system and a wealth of experience in implementing enterprise-wide clinical systems within similarly complex healthcare organisations, including nine out of the ten top children's hospitals in the world. We have employed and trained an implementation team, both from within our own operational/clinical teams and externally, ensuring we combine an appreciation of our current processes and systems with the experience of implementing systems elsewhere within the NHS. The EPR team is on track to go live with the EPR in April 2019. During the past 12 months, we have been working with the Epic teams, our clinical and operational colleagues and those leading transformation programmes within the Trust, to configure the system, so it enables all elements of our broader organisational strategy.

Use data to inform and improve care for our patients

The cloud-based research platform and digital research environment (DRE) is now established with more than 50 allocated workspaces and users for the early adopter program and a range of exemplar projects underway. The focus for the remainder of 2018 will be on thorough testing of functionality and workflows, completion of specialist infrastructure development such as the FHIR architecture, and completion of exemplar projects to demonstrate the feasibility of the research platform and its potential benefits.

Also, a collaborative programme of research with UCL computer science and the UCL Institute of Digital Health has been established; we have already hosted 33 BSc computer science students, more than ten MSc students' projects are planned and two joint PhD studentships have been appointed. Finally, the clinical informatics research programme within the Digital Research, Informatics and Virtual Environment unit (DRIVE) is planned to commence in late 2018, while the DRIVE unit itself will open in summer 2018.

The DRE and DRIVE units have allowed us to develop industry links with leaders in the field including ARM, Samsung and Microsoft for future collaborative projects and development, in addition to leveraging significant external funding for support of the research data infrastructure and ongoing project work.



Our Funding priority: We will secure and diversify funding so we can treat all the children that need our care.

Financial sustainability remains a key challenge in the context of decreasing real-term funding for specialised services. We will continue to look for new ways to deliver efficiencies while protecting our high clinical standards and increasing our clinical capacity. For example, we have worked closely with the charity, accumulating a total of £26.3m to fund medical equipment (£1.6m); infrastructure (£18.8m) and; patient, family and staff support revenue projects (£5.9m).

Objective	Achievements
Develop and negotiate a funding model which reflects the true cost of care, the new collaborative clinical pathways, and allows capacity to be flexed for variable levels of demand.	<ul style="list-style-type: none"> Developed a long-term financial model to support analysis and decision- making.
In conjunction with GOSHCC, maximise value and impact of charitable funding in support of the GOSH strategy.	<ul style="list-style-type: none"> Supported process/governance and preparation of charity applications, resulting in charity awarding Trust a total of to £26.3m fund: medical equipment (£1.6m); infrastructure (£18.8m), and patient, family and staff support revenue projects (£5.9m).
Develop and grow new sources of commercial income within the UK and internationally by making the best use of our specialist expertise in patient care, education, diagnosis and research.	<ul style="list-style-type: none"> Started exploring international opportunities and other commercial markets.

GOSH funding model

During the year, we have developed and implemented a long-term financial model that enables us to analyse the impact of our portfolio of investments and make informed decisions about the opportunity cost of future developments. This model reflects our variety of different income sources and the cost drivers linked to capacity and demand modelling.

Further to this, we have refined and relaunched the PLICS costing model, to give a greater understanding of cost drivers across the Trust. PLICS enables both finance professionals and clinicians to understand the true cost of individual care pathways at a patient level. We have put in place a dedicated programme to ensure that we maximise the use of this system.

Maximise value and impact of charitable funding

We continue to work closely with the GOSH Children's Charity (GOSHCC) to align our strategies and develop a medium to long-term view about funding requirements. Together we have developed a research strategy to support additional activity across Research and Investment, and bid for the provision of other services, including education. We will continue to work with GOSHCC on the development of the Sight and Sound Hospital, the equipment replacement programme and development of our education academy.

International Private Patient Service

We are 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.

The International and Private Patient Service treated over 2,600 inpatients and 18,354 outpatients in 2017/18 in dedicated facilities. The service generated income of £57.7m, with all proceeds our NHS activities. We continue to explore ways of bringing in additional income. We are in discussions with overseas hospitals about several collaborative opportunities, where we may enable these hospitals to develop their specialist paediatric services by accessing the expertise and experience which we can offer. We can assist in the training of medical and other clinical staff, assist with complex case diagnosis and treatment and help to develop research capability.

We have also introduced a new medical fellowship programme offering overseas doctors from the opportunity to receive sub-specialty training from us through 1 or 2-year fellowship appointments with clinical teams at GOSH. Interest in this programme has been encouraging, and the first trainee joined in November 2017.

Anti-bribery

We are committed to delivering good governance and have always expected our directors and staff to meet the highest standards of business conduct.

The Bribery Act 2010 came into force on 1 July 2011. The act aims to tackle bribery and corruption in both the private and public sector. We are committed to ensuring compliance with the Act and has a zero tolerance approach to fraud, corruption and bribery.

We follow the Ministry of Justice guidance and NHS Counter Fraud service guidance to prevent and detect fraud, corruption and bribery and have robust controls, policies and procedures in place to prevent fraud, corruption and bribery. Our Local Counter Fraud Specialist can be contacted if members of staff have any concerns of fraud corruption or bribery.

Our strategic priorities in 2018/19

As part of our strategic planning process, we have defined a set of strategic programmes for 2018/19. Some examples of our strategic programmes are presented below. We will re-examine all programmes each year as part of our planning process

Priority	Strategic Programme
Care	Cognitive Institute Partnering with the Cognitive Institute as the first UK partner in their Safety and Reliability Improvement Programme.
People	GOSH Learning Academy Developing a GOSH Learning Academy that will provide first-choice, multi-professional paediatric education and training, available through state-of-the-art technologies and in contemporary evidence-based designed learning environments.
Research	Zayed Centre for Research Undertaking research into rare diseases so we can more accurately diagnose, treat and cure children with rare conditions.
Voice	Young People's Forum Exploring the thoughts and ideas of our teenage patients to improve their experience.

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 our 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

23 May 2018

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 patients and their families, our staff and our members.

How we are governed

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

Our Operational Delivery and Performance Group (ODPG) reports to our 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.

Between 2015 and 2016, we introduced a new 'three-division' structure; two NHS divisions and one IPP division. The structure enhanced the involvement of the clinical leadership in the management of the hospital and integrated corporate functions with the operational teams through business partnering with Finance and HR. During the implementation of the structure, the senior management team consulted with staff on the effectiveness of the structure. This evaluation is underway to ensure we continue to operate in such a way that allows our leaders, line managers, and teams to operate effectively, making important strategic decisions and engaging with our strategy. We held a series of drop-in consultation sessions with staff in April 2018 to focus on how we can achieve further improvements and increased effectiveness.

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 ICH.

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 their board-level experience in private and public sector organisations.

Chairman Tessa Blackstone departed on 30 April 2017 (see page xx), and Deputy Chairman Mary MacLeod was appointed by the Members' Council as Interim Chairman from 1 May 2017 while the appointment process for a substantive postholder was conducted. Until the appointment of the substantive Chairman, Sir Michael Rake on 1 November 2017, the Board comprised an interim chairman and four non-executive directors.

In October 2017, an appointment process for two new non-executive directors was conducted. Lady Amanda Ellingworth joined the Board on 1 January 2018, and Mr Chris

Kennedy joined as a non-executive director on 1 April 2018. Professor Stephen Smith joined East Kent Hospitals NHS Foundation Trust as Chairman on 1 March 2018, and it was agreed that he would remain on the GOSH Board until 31 May 2018. The fulfilment of his responsibilities in both roles presented a limited opportunity for conflict for Professor Smith or the Trust, and this agreement ensured effective Board stewardship (handover in his role as chair of a Board Assurance Committee). From 31 May 2018 until the appointment of a new non-executive director, the Board will comprise a chairman and five non-executive directors.

All Board members have been assessed against the requirements of the fit and proper person test.

Trust Board members 2017/18

Non-executive directors

<p>Sir Michael Rake FCA FCGI Term: 1 November 2017 – 31 October 2020 (First term) Chairman of the Trust Board and Council of Governors Attended 5 out of 5 Board meetings in 2017-18</p> <p>Chairman of:</p> <ul style="list-style-type: none"> Trust Board Nominations Committee (0 meetings during period of tenure in 2017-18) Council of Governors' Nomination and Remuneration Committee (1 meeting of 1 in 2017-18) <p><u>Experience:</u></p> <ul style="list-style-type: none"> Chairman of BT Group Plc until 2017 Chairman (both UK and international), KPMG (2002 – 2007) Chairman, Easyjet (2009 – 2013) Chairman, Phoenix Global Resources Director, Worldpay Group plc (Chairman 2015-2018) Qualified accountant 	<p>Insert Michael Rake image</p>
<p>Insert Akhter Mateen image</p>	<p>Mr Akhter Mateen Deputy Chairman (from 1 May 2018) and Chairman of the Audit Committee Term: 28 March 2018 – 27 March 2021 (Second term) Attended 11 out of 11 Board meetings in 2017-18</p> <p>Chairman of:</p> <ul style="list-style-type: none"> Audit Committee (attended 4 meetings of 4 in 2017-18) <p>Member of:</p> <ul style="list-style-type: none"> Finance and Investment Committee (attended 7 meetings of 7 in 2017-18) Trust Board Remuneration Committee (attended 2 meetings of 2 in 2017-18) Trust Board Nominations Committee (attended 1 meeting of 1 in 2017-18) <p><u>Experience</u></p> <ul style="list-style-type: none"> 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) Non-Executive Director, Centre for Agriculture and Biosciences International Trustee, Malala Fund UK Trustee, Developments in Literacy (DIL) UK
<p>Mr David Lomas Non-Executive Director and Chairman of the Finance and Investment Committee Term: 1 March 2012 - 31 March 2018 (Tenure ended) Attended 9 out of 11 Board meetings in 2017-18</p> <p>Chairman of:</p> <ul style="list-style-type: none"> Finance and Investment Committee (attended 7 meetings of 7 in 2017-18) Trust Board Remuneration Committee (attended 2 meetings of 2 in 2017-18) <p>Member of:</p> <ul style="list-style-type: none"> Audit Committee (attended 4 meetings of 4 in 2017-18) Trust Board Nominations Committee (attended 1 meeting of 1 in 2017-18) <p><u>Experience</u></p> <ul style="list-style-type: none"> Qualified accountant Chief Financial Officer of Achilles (until 2017) Chief Financial Officer of Elsevier (until July 2014) Chief Executive of British Telecom Multimedia Services (2004–05) (previously Chief Operating Officer) 	<p>Insert David Lomas image</p>

<ul style="list-style-type: none"> • Vice President Operational Effectiveness of British Telecom Global Services (2003–04) • Chief Commercial and Operations Officer, ESAT British Telecom, Dublin (2002–03) • Board of Directors' Nominations Committee member 	
<p>Insert Rosalind Smyth image</p>	<p>Professor Rosalind Smyth CBE FMedSci Non-Executive Director Term: 1 January 2015 – 31 December 2018 (Second term) Attended 11 out of 11 Board meetings in 2017-18</p> <p>Member of:</p> <ul style="list-style-type: none"> • Quality and Safety Assurance Committee (attended 4 meetings of 4 in 2017-18) • Board of Directors' Remuneration Committee (attended 2 meetings of 2 in 2017-18) • Board of Directors' Nominations Committee (attended 0 meetings of 1 in 2017-18) <p><u>Experience:</u></p> <ul style="list-style-type: none"> • Director of the UCL Great Ormond Street Institute of Child Health • Honorary Consultant Respiratory Paediatrician at Great Ormond Street Hospital. • 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 • Trustee, Cystic Fibrosis Trust
<p>Professor Stephen Smith DSc FMedSci FRCOG Non-Executive Director and Chairman of the Quality and Safety Assurance Committee (from 1 May 2017) Term: 1 March 2016 – 31 May 2018 (Tenure ended) Attended 10 out of 11 Board meetings in 2017-18</p> <p>Chairman of:</p> <ul style="list-style-type: none"> • Quality and Safety Assurance Committee (attended 4 meetings of 4 in 2017-18) <p>Member of:</p> <ul style="list-style-type: none"> • Trust Board Remuneration Committee (attended 1 meeting of 2 in 2017-18) • Trust Board Nominations Committee (attended 0 meetings of 1 in 2017-18) <p><u>Experience:</u></p> <ul style="list-style-type: none"> • Chairman of East Kent Foundation NHS Trust from 1 March 2018 • Professor of Obstetrics and Gynaecology at University of Cambridge Clinical School. • 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) 	<p>Insert Stephen Smith image</p>
<p>Insert James Hatchley image</p>	<p>Mr James Hatchley Senior Independent Director (from 1 May 2017) Term: 1 September 2016 – 31 August 2019 (First term) Attended 11 of 11 Board meetings in 2017-18</p> <p>Member of:</p> <ul style="list-style-type: none"> • Audit Committee (attended 4 meetings of 4 held in 2017-18) • Quality and Safety Assurance Committee (attended 4 meetings of 4 held in 2017-18) • Finance and Investment Committee (attended 7 meetings of 7 held in 2017-18) • Trust Board Remuneration Committee (attended 2 meetings of 2 held in 2017-18) • Trust Board Nominations Committee (attended 0 meetings of 1 held in 2017-18) <p><u>Experience:</u></p> <ul style="list-style-type: none"> • Qualified accountant

	<ul style="list-style-type: none"> • Former independent member of the GOSH Audit Committee and Quality and Safety Assurance Committee • Group Strategy Director 3i Group and member of the 3i Investment Committee • Chief Operating Officer KKR (2014 – 2016)
<p>Lady Amanda Ellingworth Non-Executive Director Term: 1 January 2018 – 31 December 2020 (First term) Attended 3 of 3 Board meetings in 2017-18</p> <p>Member of:</p> <ul style="list-style-type: none"> • Quality and Safety Assurance Committee (attended 1 meeting of 1 held in 2017-18) • Trust Board Remuneration Committee (attended 1 meeting of 1 held in 2017-18) • Trust Board Nominations Committee (0 meetings held during tenure in 2017-18) <p><u>Experience:</u></p> <ul style="list-style-type: none"> • Background as a senior social worker focusing on children and families • Deputy Chair, Barnardo's • Chair, Plan International UK • Lay Adviser, Royal College of Medicine 	<p>Insert Amanda Ellingworth image</p>
<p>Insert Tessa Blackstone image</p>	<p>Baroness Tessa Blackstone BSc (Soc) PhD Chairman of the Trust Board and Members' Council Term: 1 March 2012 - 30 April 2017 (Tenure ended) Attended 1 of 1 Board meetings in 2017-18</p> <p>Chairman of:</p> <ul style="list-style-type: none"> • Trust Board Nominations Committee (0 meetings held during tenure in 2017-18) • Council of Governors' Nominations and Remuneration Committee (0 meetings held during tenure in 2017-18) <p>Member of:</p> <ul style="list-style-type: none"> • Trust Board Remuneration Committee (0 meetings held during tenure in 2017-18) <p><u>Experience</u></p> <ul style="list-style-type: none"> • Member, House of Lords • Chair of the British Library Board • Director of UCL Partners • Chair of Orbit Group • Co-Chair of the Franco-British Council
<p>Ms Mary MacLeod OBE MA CQSW DUniv Interim Chairman (from 1 May 2017) Deputy Chairman and Senior Independent Director (1 September 2016 – 30 April 2017) Term: 1 March 2012 – 31 October 2017 (Tenure ended) Attended 7 of 7 Board meetings in 2017-18</p> <p>Chairman of:</p> <ul style="list-style-type: none"> • Trust Board Nominations Committee from 1 May 2017 (attended 1 meeting of 1 held in 2017-18) • Council of Governors' Nominations and Remuneration Committee from 1 May 2017 (attended 3 meetings of 3 held in 2017-18) • Quality and Safety Assurance Committee until 30 April 2017 (attended 1 meeting of 1 in 2017-18) • Trust Board Remuneration Committee from 1 May 2017 (0 meetings during tenure in 2017-18) <p>Member of:</p> <ul style="list-style-type: none"> • Trust Board Nominations Committee (1 meeting attended of 1 in 2017-18) <p><u>Experience</u></p> <ul style="list-style-type: none"> • Non-executive Equality and Diversity lead at Great Ormond Street • Deputy Chair of the Child and Family Court Advisory and Support Service (CAFCASS) until 30 April 2017 	<p>Insert Mary MacLeod image</p>

<ul style="list-style-type: none">• 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)• Trustee, Refugee Trauma Initiative	
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Executive directors

<p>Insert Peter Steer image</p>	<p>Dr Peter Steer Chief Executive (from 1 January 2015) Peter Steer is responsible for delivering our strategic and operational plans through the Executive Team. Attended 11 out of 11 Board meetings in 2017-18 Attendee of:</p> <ul style="list-style-type: none"> • Quality and Safety Assurance Committee (attended 3 meetings of 4 in (2017-18) • Finance and Investment Committee (attended 5 meetings of 7 in 2017-18) • Audit Committee (attended 4 meetings of 4 in 2017-18) • Trust Board Remuneration Committee (attended 2 meetings of 2 in 2017-18) • Trust Board Nominations Committee (attended 1 meeting of 1 in 2017-18) <p><u>Experience</u></p> <ul style="list-style-type: none"> • 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) • Non-executive Director, Children's Hospital Group Board, Ireland (2017 – present)
<p>Ms Nicola Grinstead Deputy Chief Executive (from 1 April 2016) Nicola Grinstead is responsible for our strategic planning and the operational management of our clinical services. She is the named Senior Information Risk Owner. Attended 9 out of 11 Board meetings in 2017-18 Attendee of:</p> <ul style="list-style-type: none"> • Quality and Safety Assurance Committee (attended 4 meetings of 4 in 2017-18) • Finance and Investment Committee (attended 7 meetings of 7 in 2017-18) • Audit Committee (attended 4 meetings of 4 in 2017-18) <p><u>Experience</u></p> <ul style="list-style-type: none"> • 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 until 2017 	<p>Insert Nicola Grinstead image</p>
<p>Insert Ali Mohammed image</p>	<p>Mr Ali Mohammed Director of Human Resources and Organisational Development (from 1 April 2013) Ali Mohammed is responsible for the development and delivery of our human resources strategy and organisational development programmes. Attended 10 out of 11 Board meetings in 2017-18 Attendee of:</p> <ul style="list-style-type: none"> • Quality and Safety Assurance Committee (attended 4 meeting of 4 in 2017-18) • Trust Board Remuneration Committee (attended 1 meeting of 2 in 2017-18) • Trust Board Nominations Committee (attended 1 meeting of 1 in 2017-18) <p><u>Experience:</u></p> <ul style="list-style-type: none"> • 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)

<p>Mr Matthew Shaw Medical Director (from 1 March 2018) Matthew Shaw is responsible for our performance and standards (including patient safety) and leads on clinical governance. Attended 0 Board meetings of 1 in 2017-18 Attendee of:</p> <ul style="list-style-type: none"> Quality and Safety Assurance Committee (0 meetings held during tenure in 2017-18) <p><u>Experience</u></p> <ul style="list-style-type: none"> Practicing orthopaedic surgeon Clinical Director of the spinal unit at the Royal National Orthopaedic Hospital (2011 – 2018) Medical Director for Health Provision, BUPA UK until April 2018. 	<p>Insert Matthew Shaw image</p>
<p>Insert Helen Jameson image</p>	<p>Ms Helen Jameson Interim Chief Finance Officer from 5 March 2018 Helen Jameson is responsible for our financial management and leads on contracting and information technology. Attended 2 Board meetings of 2 held in 2017 - 18 Attendee of:</p> <ul style="list-style-type: none"> Finance and Investment Committee (attended 1 meeting of 1 held in 2017-18) Audit Committee (0 meetings held during tenure in 2017-18) <p><u>Experience:</u></p> <ul style="list-style-type: none"> Director, UCL Partners Established the North Central and East London office of Health Education England Lead on finance and governance of the London wide education commissioning system for NHS England (London Region) Former Deputy Director of Finance and Joint Divisional Manager for Surgery and Critical Care at Kingston Hospital NHS Trust Former assistant Director of Financial Planning and Reporting for South East Coast Ambulance Service NHS Trust
<p>Ms Loretta Seamer Chief Finance Officer until 4 March 2018 Attended 8 Board meetings of 9 in 2017-18 Attendee of:</p> <ul style="list-style-type: none"> Finance and Investment Committee (attended 6 meetings of 6 held in 2017-18) Audit Committee (attended 4 meetings of 4 held in 2017-18) <p><u>Experience:</u></p> <ul style="list-style-type: none"> Chief Finance Officer at Children's Health Queensland and Health Service in Brisbane, Australia (until March 2016) 	<p>Insert Loretta Seamer image</p>
<p>Insert Juliette Greenwood image</p>	<p>Ms Juliette Greenwood Chief Nurse until 31 October 2017 Attended 4 Board meetings of 6 held in 2017-18 Attendee of:</p> <ul style="list-style-type: none"> Quality and Safety Assurance Committee (attended 3 meetings of 3 in 2017-18) <p><u>Experience</u></p> <ul style="list-style-type: none"> Registered Sick Children's Nurse <p>More than 12 years' experience as a Chief Nurse, most recently at Bradford Teaching Hospitals NHS Foundation Trust (2013–15) and before this at Rotherham NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust</p>
<p>Dr David Hicks Interim Medical Director (until 31 December 2017) Attended 5 Board meetings of 8 held in 2017-18 Attendee of:</p> <ul style="list-style-type: none"> Quality and Safety Assurance Committee (attended 3 meetings of 3 in 2017-18) <p><u>Experience</u></p> <ul style="list-style-type: none"> Consultant in Genitourinary Medicine Has held Executive level posts since 2002 Medical Director and Acting Chief Executive of Barnsley Hospital NHS Foundation Trust 2002-2009 	<p>Insert David Hicks image</p>

<ul style="list-style-type: none"> • Non-Executive Director, Mid Yorkshire Hospitals NHS Trust 	
<p>Insert Janet Williss image</p>	<p>Janet Williss Interim Chief Nurse (from 1 November 2017 – 31 December 2017) Janet Williss was responsible for our professional standards, education and development of nursing and allied health professionals. She was also the lead executive responsible for patient and public involvement and engagement, safeguarding and infection prevention and control. Attended 1 Board meeting of 1 in 2017-18</p> <ul style="list-style-type: none"> • Registered children's nurse, registered adult nurse • Deputy Chief Nurse, GOSH (2004-2018) • Fitness to Practice Panellist at Nursing and Midwifery Council (2008-2016).
<p>Ms Polly Hodgson Interim Chief Nurse (from 1 January 2018 – 8 April 2019) Polly Hodgson was responsible for our professional standards, education and development of nursing. She was also the lead executive responsible for patient and public involvement and engagement, safeguarding and infection prevention and control. Attended 3 Board meetings of 3 in 2017-18 Attendee of:</p> <ul style="list-style-type: none"> • Quality and Safety Assurance Committee (1 meeting of 1 in 2017-18) <p>Experience</p> <ul style="list-style-type: none"> • Registered children's nurse • Led on establishing the Paediatric Intensive Care Unit at St Mary's Hospital • Lead Nurse for Children's Services, Evelina (2006 – 2016) • Assistant Chief Nurse for Workforce, GOSH (2016 – 2018) 	<p>Insert Polly Hodgson image</p>

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 our buildings and ensures that our estate 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.

Register of Interests

The Board of Directors has signed up to and approved 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, www.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

The Board of Directors held a total of 11 meetings between 1 April 2017 and 31 March 2018, of which five included a session held in public. In October 2017 the Board held a strategy

development session. Extraordinary board meetings were held in October 2017 and February 2017. Board seminar meetings were held in April and June 2017.

Following a review of board reporting, a revised board calendar has been introduced. From 1 April 2018 the Board will meet seven times in public with an annual strategy session in October each year.

Evaluation of Board performance

Deloitte conducted an independent review of the Monitor Well-Led Governance Framework (incorporating elements of the quality governance framework) in June 2016. The Board and Council have received regular updates on progress with the action plan, with the final actions due for completion early 2018/19.

As part of their routine scheduled inspection programme, the CQC conducted an independent well-led inspection of the Trust in January 2018. Further information can be found on page **xx**.

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 our systems of internal control and our arrangements for risk management, control and governance processes to support our objectives. A summary of the work of the committee can be found on page **XX**.

Quality and Safety Assurance Committee

The Quality and Safety Assurance Committee is chaired by a non-executive director and has delegated authority from the Board to be assured that we have the correct structure, systems and processes are in place 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 about 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 the following executive appointments to the Board were made:

- The appointment of Ms Janet Williss as Interim Chief Nurse on 1 November 2017 following departure of Ms Juliette Greenwood, Chief Nurse on 31 October 2017
- The appointment of Ms Polly Hodgson as Interim Chief Nurse on 1 January 2018 following Ms Janet Williss stepping down to her previous role.
- The appointment of Dr Andrew Long as Interim Medical Director on 1 January 2018 following the departure of Mr David Hicks, Interim Medical Director on 31 December 2017.
- The appointment of Mr Matthew Shaw as substantive Medical Director on 1 March 2018 (part-time) and full time from 1 April 2018 following the departure of Dr Andrew Long
- The appointment of Ms Helen Jameson as Interim Chief Finance Officer on 1 March 2018 following the departure of Ms Loretta Seamer, Chief Finance Officer on 28 February 2018
- The appointment of Ms Alison Robertson as substantive Chief Nurse on 9 April 2018
- The appointment of Ms Helen Jameson as substantive Chief Finance Officer on 23 April 2018.

Members' Council

As a foundation trust we are accountable to our members through our Council of Governors, (called the Members' Council during 2017/18). In February 2018 the Council and the Board agreed that the Members' Council would be renamed the Council of Governors and councillors referred to as governors from 2018/19.

The 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.

The Council acts 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 Council can be found at gosh.nhs.uk/XXX.

Constituencies of the Members' Council

Councillors represent specific constituencies and are elected or appointed to do so for a period 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, We do 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
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

Councillors' attendance at meetings

Name	Constituency	Date role began	Members' Council (out of 8 unless otherwise stated)	Nominations and Remuneration Committee (out of 4 unless otherwise stated)	Membership Engagement Recruitment and Representation Committee (out of 5 unless otherwise stated)
Edward Green ¹	Patients: outside London	1 March 2015 – 28 February 2018	1	0 (1)	Not a member
George Howell ¹	Patients: outside London	1 March 2015 – 28 February 2018	7	Not a member	4
Sophie Talib ¹	Patients: London	1 March 2015 – 28 February 2018	5	Not a member	1
Mariam Ali ²	Parents and Carers: London	1 March 2018	6	4	Not a member
Matthew Norris ¹	Parents and Carers: London	1 March 2015 – 28 February 2018	8	3 (3)	Not a member
Fran Stewart ²	Parents and Carers: London	1 March 2018	8	Not a member	2

Name	Constituency	Date role began	Members' Council (out of 8 unless otherwise stated)	Nominations and Remuneration Committee (out of 4 unless otherwise stated)	Membership Engagement Recruitment and Representation Committee (out of 5 unless otherwise stated)
Carley Bowman ¹	Parents and Carers: outside London	1 March 2015 – 28 February 2018	5	Not a member	4
Claudia Fisher ¹	Parents and Carers: outside London	1 March 2015 – 28 February 2018	6	Not a member	3
Camilla Alexander-White ¹	Parents and Carers: outside London	1 March 2015 – 28 February 2018	6	Not a member	Not a member
Trevor Fulcher ³	Public: North London and surrounding area	1 March 2015 – 31 May 2017	0 (2)	Not a member	Not a member
Simon Hawtrey-Woore ²	Public: North London and surrounding area	1 March 2018	6	Not a member	1
Rebecca Miller ¹	Public: North London and surrounding area	1 March 2015 – 28 February 2018	3	4	Not a member
Teskeen Gilani ²	Public: North London and surrounding area	1 March 2018	1	Not a member	Not a member
Gillian Smith ¹	Public: South London and surrounding area	1 March 2015 -28 February 2018	5	Not a member	3
Stuart Player ¹	Public: The rest of England and Wales	1 March 2015 – 28 February 2018	3	Not a member	Not a member
David Rose ¹	Public: The rest of England and Wales	1 March 2015 – 28 February 2018	0	Not a member	Not a member
Jilly Hale ¹	Staff	1 March 2015 – 28 February 2018	5	1 (1)	Not a member
James	Staff	1 March	8	Not a member	1 (1)

Name	Constituency	Date role began	Members' Council (out of 8 unless otherwise stated)	Nominations and Remuneration Committee (out of 4 unless otherwise stated)	Membership Engagement Recruitment and Representation Committee (out of 5 unless otherwise stated)
Linthicum ¹		2015 – 28 February 2018			
Rory Mannion ¹	Staff	1 March 2015 – 28 February 2018	6	3 (3)	Not a member
Clare McLaren ¹	Staff	1 March 2015 – 28 February 2018	4	Not a member	Not a member
Prab Prabhakar ¹	Staff	1 March 2015 – 28 February 2018	3	Not a member	Not a member
Jenny Hedlam Wells ¹	London Borough of Camden	1 March 2015 – 28 February 2018	5	Not a member	Not a member
Christine Kinnon ¹	University College London Great Ormond Street	1 March 2015 – 28 February 2018	7	Not a member	Not a member
Muhammad Miah ¹	Great Ormond Street Hospital School	1 March 2015 – 28 ¹ February 2018	1	Not a member	Not a member
Hazel Fisher	NHS England	1 March 2018 – 23 April 2018	2	Not a member	Not a member
Lucy Moore ²	self management uk	1 March 2018	2	Not a member	Not a member

¹ Stood down at the end of the term on 28 February 2018

² Re-elected or re-appointed for a second three year term on 1 March 2018

³ Stood down during 2017-18

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

- North London: Barking and Dagenham, Barnet, Brent, Camden, City of London, Hackney, Ealing, Enfield, Hammersmith and Fulham, Haringey, Harrow, Havering, Hillingdon, Hounslow, Islington, Kensington and 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.

In January 2018, the Trust conducted an election process for 22 seats across the patient and carer, public and staff constituencies for appointment from 1 March 2018. All seats were filled. One seat has since become vacant. The names of the governors from 1 March 2018 are:

Name	Constituency	Date of appointment
Mariam Ali*	Parents and Carers from London	1 March 2018
Stephanie Nash	Parents and Carers from London	1 March 2018
Emily Shaw	Parents and Carers from London	1 March 2018
Lisa Allera	Parents and Carers from outside London	1 March 2018
Claire Cooper-Jones	Parents and Carers from outside London	1 March 2018
VACANT	Parents and Carers from outside London	

Name	Constituency	Date of appointment
Alice Rath	Patients from outside London	1 March 2018
Elena-May Reading	Patients from London	1 March 2018
Zoe Bacon	Patients from London	1 March 2018
Joan Francesca Stewart*	Public: South London and surrounding area	1 March 2018
Simon Hawtrey-Woore*	Public: North London and surrounding area	1 March 2018
Teskeen Gilani*	Public: North London and surrounding area	1 March 2018

Name	Constituency	Date of appointment
Faiza Yasin	Patients from outside London	1 March 2018

Name	Constituency	Date of appointment
Theo Kayode-Osiyemi	Public: North London and surrounding area	1 March 2018

Name	Constituency	Date of appointment
Yu Tan	Public: North London and surrounding area	1 March 2018
Colin Sincok	Public: Rest of England and Wales	1 March 2018
Julian Evans	Public: Rest of England and Wales	1 March 2018
Sarah Aylett	Staff	1 March 2018
Michael Glynn	Staff	1 March 2018
Nigel Mills	Staff	1 st March 2018
Paul Gough	Staff	1 March 2018

Name	Constituency	Date of appointment
Quen Mok	Staff	1 March 2018
Lazzaro Pietragnoli	Appointed: London Borough of Camden	1 March 2018
Lucy Moore	Appointed: self management uk	1 March 2018
Jugnoo Rahi	Appointed: UCL GOS Institute of Child Health	1 March 2018
Hazel Fisher	Appointed: NHS England	1 March 2018 – 30 April 2018
VACANT	Appointed: Great Ormond Street Hospital School	

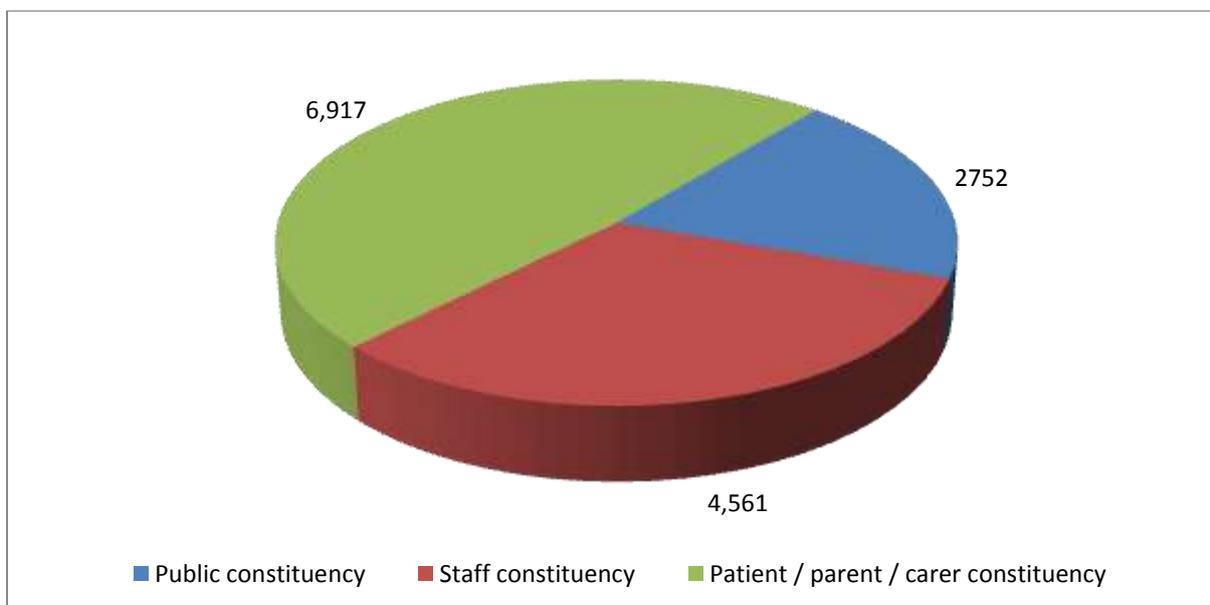
*Second three year term

Membership at GOSH

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 gosh.nhs.uk/about-us/foundation-trust/foundation-trust-membership.

Membership constituencies and membership numbers 2018

On 31 March 2018, our membership totalled 13,783 (including staff). We met and exceeded our estimated public membership target of 2,699 by 53 and have increased our public membership by 132 in the last year. Although we increased our patient, parent and carer constituency by 11 (from 6,906 to 6,917) this was 197 short of our target of 7,144. Overall, we increased our membership by 447.



Membership Engagement Services (MES) is our membership database provider and holds and manages our public and patient and carer data. The Trust is reviewing how we manage this data in line with the General Data Protection Regulations.

Members' Council expenses

Councillors can claim reasonable expenses for carrying out their duties. For the year 2017/18, the total amount claimed by 5 councillors was £556.85.

Register of interests

Councillors are asked to sign a code of conduct and declare any interests that are relevant and material. The register of interests for the Members' Council is published annually and can be found at 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 for Children NHS Foundation Trust website, gosh.nhs.uk.

Membership engagement

Members receive updates on hospital news and are invited to get involved throughout the year. Members also have the opportunity to vote in elections and stand for election to the Members' Council.

The Membership and Engagement Representation and Recruitment 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. In 2017/18, the committee was chaired by a parent and carer councillor, with the support of a deputy chair from the public constituency. Last year's achievements included a steady growth of our patient and carer and public membership and planning and delivery of a successful annual general meeting and annual members' meeting.

Trust Board and Members' Council working together

The Trust's Chairman is responsible for the leadership of both the 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. Following a joint meeting of the Board and the Council to discuss how the Board and Council could work together in the future, proposals for future working were approved in April 2018. The plans include a buddying programme for councillors with NEDs, scheduled meetings with the Chairman and the Council to discuss key matters prior to Council meetings and a comprehensive induction programme for new councillors.

Examples of how the Council and Board worked together in 2017/18 included:

- 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 Council has an open invitation to attend all Trust Board meetings.
- The 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
- Councillors and Board members sit on the Constitution Working Group.
- A joint meeting of the Council and the Board was held in February 2018 to learn how other Councils and Boards work together, and to agree on future working arrangements that hold NEDs to account for the performance of the Board, induction and training for councillors and the representation of members.

In 2017/18 the Members' Council has:

- Contributed to the development of our new Electronic Patient Record (EPR) programme and digital roadmap.
- Commented on our redevelopment plans including the plans for phase 4.
- Participated in the selection of an indicator for auditing our quality report 2017/18.
- Commented on the development of our operational plan.
- Participated in the International Private Patients Working Group and was invited to comment on the proposed strategy
- Approved and conducted the appointment process for the Chair and two non-executive directors.

- Worked with Board members to review and update the Trust's Constitution. The Trust's Constitution is an ongoing piece of work that will engage the new councillors (now called governors) and ensure the document is fit for purpose for our future governance.

Members' Council Nominations and Remuneration Committee

The Members' Council Nominations and Remuneration committee has delegated responsibility for assisting the 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 is normally 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 term and can be reappointed for a further three years (subject to consideration and approval by the Members' Council).

On 30 April 2017, Baroness Tessa Blackstone, Chairman of the Trust Board and Members' Council stepped down from her role. Following a comprehensive appointment process, Sir Michael Rake was appointed by the Council as Chairman of the Trust and started in the post on 1 November 2017. From 1 May 2017, Ms Mary MacLeod stepped up from Deputy Chairman of the Board and was appointed as Chairman for the interim period.

In 2017/18, the following recommendations made by the Members' Council Nominations and Remuneration Committee were approved by the Members' Council:

- The appointment of Mary MacLeod as Interim Chairman from 1 May 2017.
- The appointment of James Hatchley as Senior Independent Director from 1 May 2017.
- The appointment of Akhter Mateen as Deputy Chairman from 1 May 2017.
- The appointment Lady Amanda Ellingworth as a Non-Executive Director from 1 January 2018.
- The extension of Mr David Lomas' appointment for one month ending 31 March 2018.
- The reappointment of Mr Akhter Mateen as a Non-Executive Director for a further 3-year appointment until 26 March 2021.

- The appointment of Mr Chris Kennedy as a Non-Executive Director from 1 April 2018.

Since April 2017, an external search company and open advertising have been used for all non-executive director appointments (including the Chairman appointment).

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/her.

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.

Remuneration Report

The Board of Directors' Remuneration Committee is chaired by a non-executive director. The committee is responsible for reviewing the terms and conditions of office of our most senior managers, including salary, pensions, termination and/or severance payments and allowances. The committee meets twice a year, in November and March. Attendance at meetings held in during 2017/18 can be found on page **xx**.

Under the terms of reference of the Committee and for the report below, in 2017/18 voting executive and non-executive members of the Trust Board are defined as 'senior managers'. Authority for approval of changes to other senior management roles on Trust contracts of employment has been delegated by the Remuneration Committee to the Chief Executive. With effect from 2018/19, the Remuneration Committee will consider the remuneration of the executive (voting) directors only.

Information on remuneration for non-executive directors, are outlined below on page **X**.

Senior Manager Remuneration

The committee determines the remuneration of the chief executive and voting executive directors (referred to as ' ') after taking into account uplifts recommended for other NHS staff, any variation in or changes to the responsibilities of the senior managers, market comparisons, and job evaluation and weightings. There is some scope for adjusting remuneration after appointment as senior managers take on the full set of responsibilities in their role.

The only non-cash element of the remuneration package 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.

Affordability is also taken into account in determining pay uplifts for senior managers. 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 ongoing appraisal processes. All senior managers' 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's redundancy policy is consistent with NHS redundancy terms for all staff. All new senior managers 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.

Senior Manager Remuneration policy

The structure of pay for senior managers is designed to reflect the long-term nature of our 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 position across the health sector 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 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; while consideration is given to all internal and external factors, it is important that GOSH remains competitive so we can achieve our vision of being a 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.

Senior Manager Future Remuneration 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	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 (senior managers are proportionally not treated more	Trust performance and development review (PDR)/annual appraisal to set objectives linked to the our strategic objectives. Failure to meet objectives is managed via our performance frameworks.

of salary may be made outside of this cycle, but are made by the Remuneration Committee. favourably than other staff).

Any sums paid in error, malus or recovered due to breach of contract are followed up with the individual.

Taxable benefits

Not applicable

Annual performance-related bonuses

Not applicable

Long term-related bonuses

Not applicable

Pension-related benefits

<p>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.</p>	<p>Pension is available as a benefit to directors and follows national NHS Pension Scheme contribution rules (or alternative pension provider).</p>	<p>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.</p>	<p>Not applicable.</p>
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Directors with remuneration (total) greater than £150,000

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 requires all senior managers to take continuing responsibility for their roles and requires executive directors to provide on-call cover for the hospital on a rostered basis which broadly equates to one week in every six. Details about length of service can be found on page xx.

Senior managers' contracts primarily stipulate a minimum notice period of six months. Payment in lieu of notice, as a lump sum payment, may be made at our discretion and with the approval of the Trust's Remuneration Committee, in line with government limits. There have been no payments for loss of office or payments to past senior managers in 2017/18.

Remuneration for Senior Managers in 2017-18

Details of remuneration, including the salaries and pension entitlements of the board of directors, are provided on page [XX](#).

For the financial year 2017-18, the committee:

- Approved an uplift to the Chief Executive and Chief Finance Officer's remuneration based on data from a benchmarking exercise.
- Conducted a benchmarking exercise on senior manager's remuneration packages to ensure they are competitive in terms of total remuneration when compared to similar jobs in genuinely comparable NHS organisations. To inform the benchmarking exercise, data was used from NHS Providers, the AUKUH (Association of UK University Hospitals – the organisation for teaching hospitals in the UK) and from specific requests to comparable trusts.
- Agreed uplifts to remaining posts within its remit consistent with the cost of living award made to staff on Agenda for Change contracts.

Remuneration advisers were consulted in 2017/18 and did not have any connection with the Foundation Trust.

Evaluation and Remuneration for Non-Executive Directors

The Members' Council considered and approved the performance evaluation framework for non-executive directors in 2017. With the appointment of a new Chairman and two new non-executive directors, the Council has agreed that the process will run in Q2 2018/19 for existing non-executive directors, with the new appointees being evaluated in Q3 2018/19.

The Members' Council Nominations and Remuneration Committee is responsible for recommending remuneration levels for non-executive directors to the Members' Council. In April 2017, following analysis of benchmarking information, the committee recommended that the remuneration levels for both the Chairman and the NEDs for 2017/18 were set at an appropriate level. The Council agreed and approved the proposed the policy for benchmarking salaries and reviewing the cost of living allowances for the Chairman and NEDs on a three yearly basis.

Non-executive director remuneration for 2018/19 remains the same as for 2017/18:

- Chairman's remuneration: 1 April 2018 – 31 March 2019 – £55,000pa
- Non-executive directors' remuneration: 1 April 2018 – 31 March 2019 – £14,000pa

- Deputy chairman/chairman of Audit Committee and SID's remuneration: 1 April 2018 – 31 March 2019 – £19,000pa for each of the two posts.

Details of remuneration for the executive and non-executive directors are provided in the tables below.

Dr Peter Steer

Chief Executive

Date: 23 May 2018

Remuneration Report 2017/18													
Salary entitlements of senior managers													
Name	Title	2017/18						2016/17					
		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	0-5	0	0	0	0	0-5	50-55	0	0	0	0	50-55
Sir Michael Rake	Chairman of Trust Board (from 1 November 2017)	20-25	0	0	0	0	20-25	n/a	n/a	n/a	n/a	n/a	n/a
Lady Amanda Ellingworth	Non-Executive Director (from 1 January 2018)	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a
Mr James Hatchley	Non-Executive Director	15-20	0	0	0	0	15-20	5-10	0	0	0	0	5-10
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 (to 30 April 2017); Interim Chairman of the Trust Board (from 1 May to 31 October 2017)	25-30	0	0	0	0	25-30	15-20	0	0	0	0	15-20
Mr Akhter Mateen	Non-Executive Director	20-25	0	0	0	0	20-25	10-15	0	0	0	0	10-15
Professor Stephen Smith	Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Professor Ros Smyth	Non-Executive Director	5-10	0	0	0	0	5-10	0-5	0	0	0	0	0-5
Executive Directors													
Mr Trevor Clarke	Director of the International and Private Patients Division	80-85	0	0	0	35-40	120-125	80-85	0	0	0	30-32.5	115-120
Professor David Goldblatt	Director of Clinical Research and Development	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Mrs Juliette Greenwood	Chief Nurse (until 31 October 2017)	70-75	0	0	0	0	70-75	125-130	0	0	0	32.5-35	160-165
Ms Nicola Grinstead	Deputy Chief Executive	140-145	0	0	0	40-45	180-185	135-140	0	0	0	135-137.5	275-280
Dr David Hicks	Interim Medical Director (until 31 December 2017)	140-145	0	0	0	0	140-145	95-100	0	0	0	0	95-100
Mary (Polly) Hodgson	Interim Chief Nurse (from 1 January 2018)	80-85	0	0	0	0	80-85	n/a	n/a	n/a	n/a	n/a	n/a
Miss Helen Jameson	Interim Chief Finance Officer (from 1 March 2018)	10-15	0	0	0	0	10-15	n/a	n/a	n/a	n/a	n/a	n/a
Mr Andrew Long	Medical Director (from 1 January to 28 February 2018)	115-120	0	0	0	0	115-120	n/a	n/a	n/a	n/a	n/a	n/a
Mr Niamat (Ali) Mohammed	Director of Human Resources	125-130	0	0	0	0	125-130	120-125	0	0	0	75-77.5	200-205
Mr Ward Priestman	Interim Director of Information and Communication Technology	140-145	0	0	0	0			0	0	0	0	
Mr Matthew Shaw	Medical Director (from 1 March 2018)	5-10	0	0	0	0							
Mrs Loretta Seamer	Chief Finance Officer (until 28 February 2018)	155-160	0	0	0	0	155-160	150-155	0	0	0	0	150-155
Dr Peter Steer	Chief Executive	235-240	0	0	0	55-60	295-300	210-215	0	0	0	47.5-50	260-265
Mr Matthew Tulley	Director of Development	130-135	0	0	0	35-40	165-170	130-135	0	0	0	67.5-70	200-205
Janet Willis	Interim Chief Nurse (from 1 November until 31 December 2017)	65-70	0	0	0	0	65-70	n/a	n/a	n/a	n/a	n/a	n/a

Staff Report

Our staff

Fulfilling our potential

We will only achieve delivery of our strategy by ensuring that we attract and retain the right people, working together to create a culture that enables us to learn and thrive. In 2017/18, we saw improvements in many of our workforce metrics that show our work towards that goal. We welcomed our largest ever cohort of nursing recruits in September 2017 and saw a reduction in turnover rates. We also saw improvements in training and appraisal rates through the year.

Equality, diversity and inclusion

We can only provide the highest quality healthcare to children and their families if we recruit the best possible staff, and if all these staff are treated with respect and are valued. The Trust has developed our Always Values, a set of shared values and behaviours which characterise all our dealings with each other, our patients and families (see page xx). Recognising, respecting and valuing diversity are important in order to underpin these expectations.

In 2017 we supported black and minority ethnic staff to successfully apply for national leadership development programmes. We are actively working with our LGBT+ staff to progress key initiatives, and we are pleased that our staff will be at Pride 2018 for the first time. During early 2018, we surveyed LGBT+ staff to understand their experience of working at GOSH and are currently collating the responses to inform future actions.

We published our extensive Annual Staff Data Report, our Workforce Race Equality Scheme Report and Action Plan as well as our first Gender Pay Gap Report in March, and will be working with our staff in the coming year to understand the data and implement required actions.

Our staff

In 2017/18, the Trust employed an average of 4,392 full-time equivalent (FTE) staff.

Average number of people employed, including agency, maternity leave and bank staff	Year to 31 March 2018			Year to 31 March 2017
	Total Number	Permanently employed Number	Other Number	Total Number
Medical and dental	634	595	39	626
Ambulance staff	0	0	0	0
Administration and estates	1,181	1,081	100	1,200
Healthcare assistants and other support staff	291	263	28	297
Nursing, midwifery and health visiting staff	1,522	1,418	104	1,479
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	759	743	16	777

Healthcare science staff	0	0	0	0
Social care staff	0	0	0	0
Agency and contract staff	0	0	0	0
Bank staff	0	0	0	0
Other	5	5	0	5
Total	4,392	4,105	287	4,384
Staff on maternity leave included in above				115

On 31 March 2018, the gender mix of GOSH Directors, senior managers and staff was:

	Female	Male
Director	38% (5)	62% (8)
Senior managers	57% (12)	43% (9)
Staff	77% (3656)	23% (1062)

The table below provides analysis of the cost of staff for the year 2017/18.

	Year to 31 Mar	Per
	Total	e
	£000	
Employee costs		
Salaries and wages	209,549	
Social security costs	20,933	
Apprenticeship levy	938	
Pension cost - employer contributions to NHS pension scheme	23,063	
Pension cost - other	61	
Termination benefits	0	
Temporary staff - agency/contract staff	4,819	
Total gross staff costs	259,363	
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	(1,844)	
Recoveries from other bodies in respect of staff cost netted off expenditure	(839)	
Total staff costs	256,680	
Included within:		
Costs capitalised as part of assets	4,273	
Operating expenditure analysed as:		
Employee expenses - staff & executive directors	232,851	
Research & development	16,254	
Education and training	3,302	
Redundancy	0	
Total employee benefits excluding capitalised costs	252,407	

Disability

During 2017, our first cohort of Project Search interns, formed of young people with learning disabilities, successfully graduated from the scheme and a second intake commenced at the Hospital. This scheme provides young people with both valuable work and life experiences to prepare them for employment.

We have a Recruitment and Selection Policy and an Equality at Work Policy which supports the employment, training and development of all our staff including those staff who have disabilities. We make managers aware of their own unconscious bias; we now cover the topic in our managers' training programmes for recruitment and selection and appraisal.

In 2017 GOSH became Disability Confident Committed. This is a new government scheme, replacing the two-tick scheme, to help people with disabilities secure employment.

In the coming year we will prepare for the introduction of the Workforce Disability Standard.

Staff Survey

The staff survey is an important indicator of our staff experience, which is vital to our ability to attract and retain staff, deliver our strategy, Fulfilling Our Potential, and ensure we have high-quality leadership and provide safe care. Our overall response rate to the 2017 survey was 45.8%.

We take the staff survey very seriously. The findings are discussed by our Trust Board and senior management teams and with our staff side partners through our Staff Partnership Forum. We also discuss our results at a Chief Executive monthly briefing session, which is open to all staff. In 2017 we held staff listening events to discuss and explore our survey findings and we continue to listen to our staff as we develop actions to address our latest survey findings.

Of the 32 key findings, four were better than the 2016 staff survey, while two remained the same and 26 deteriorated from the previous year. We saw an improvement in the percentage of staff appraised in the last 12 months and a small reduction in the number of staff reporting working extra hours. We also saw an improvement in the percentage of staff reporting their most recent experience of either violence or harassment & bullying.

The results show that 87% of respondents would be happy for a friend or relative to be treated at the Trust and 67% would recommend GOSH as a place to work. Our staff engagement score remains above the NHS average as does the score for staff motivation at work and satisfaction with levels of resourcing and support.

2017 Staff Survey Response rate

2016/17	2017/18 (current year)		Trust improvement/ deterioration
	Trust	Benchmarking group average	Change since previous year
60%	46%	53%	-14%

Top 5 ranking scores (against benchmark group)

	2016/17	2017/18 (current year)		Trust improvement/ deterioration
	Trust	Trust	Benchmarking group average	Change since previous year
KF27: % of staff / colleagues reporting most recent experience of harassment, bullying or abuse	48%	54%	47%	+6%
KF12. Quality of appraisals	3.35	3.18	3.16	-0.17
KF11. Percentage of staff appraised in last 12 months	88%	86%	88%	+2%
KF7. % of staff able to contribute towards improvements at work	76%	73%	73%	3%
KF4. Staff motivation at work	4.00	3.94	3.94	-0.06

Bottom 5 ranking scores (against benchmark group)				
	2016/17	2017/18 (current year)		Trust improvement/ deterioration
	Trust	Trust	Benchmarking group average	Change since previous year
KF28. % of staff witnessing potentially harmful errors, near misses or incidents in last month	35%	36%	27%	+1%
KF10. Support from immediate managers	3.80	3.70	3.81	-0.1
KF31. Staff confidence and security in reporting unsafe clinical practice	3.73	3.57	3.71	-0.16
KF9. Effective team working	3.83	3.69	3.79	-0.14
KF29. % of staff reporting errors, near misses or incidents witnessed in the last month	92%	88%	92%	-4%

We have identified the following priorities to address as part of the action plan currently in development:

- % of staff witnessing potentially harmful errors, near misses or incidents in the last month
- % of staff reporting errors, near misses or incidents witnessed in the last month
- Staff confidence and security around reporting unsafe clinical practice
- Support from immediate managers
- Effective team working

A number of initiatives are currently being progressed that will address the areas of concern:

- Safety and Reliability Improvement Project
- Trust-wide Leadership Learning Needs Analysis
- Development of an Equality, Diversity and Inclusion strategy
- Management development Strategy refresh
- Bullying and Harassment Policy refresh

We know that working with our patient groups can sometimes be stressful, and also that staff push themselves to attend work when they are unwell. We offer a range of health and wellbeing benefits including access to counsellors 24/7. We have established a multi-disciplinary health and wellbeing group which has led on a health and wellbeing week, with more activities planned over the coming year. We are developing a Mindfulness App bespoke to GOSH; this will be launched in May 2018.

The results of the staff survey findings will be a key input into the Trust-wide learning needs analysis (LNA). The LNA aims to identify leadership and management capabilities required across all levels of leadership across the Trust. One already key management capability that requires development is staff engagement. As we work with our local management teams to produce action plans to address specific findings, further priorities will be identified as well as working with our senior managers to develop a Trust-wide action plan. The actions identified will be monitored through Divisional Performance Boards with regular reporting to the Trust Executive of progress.

For the first time, we asked survey respondents about the Always Values. Our results showed that over 99% of respondents to this question were aware of the Values and 60% said that managers demonstrated the values at work always or often; 66.9% said that their colleagues also displayed them always or often. From our results, we know that we need to continue our focus on embedding the values and the behaviours that underpin them.

Recognising reward & performance

We continue to emphasise the importance of appraisals as an opportunity for line managers to recognise the achievements of individuals. During 2017/18 PDR (appraisal) rates increased to an average of 88% from 77% in 2016/17. In the most recent staff survey, respondents rated the quality of appraisals higher than the national average. Consultant appraisals increased in the second half of the year to 88%.

Our GOSH GEMS awards attract high-quality nominations from staff as well as patients and families, and during the year we were delighted to award 26 individual and 20 team awards. In 2018 we will continue to promote GEMS nominations to our colleagues to embed a culture that recognises staff.

In September, staff came together to celebrate the achievements of all those who work at GOSH at the annual award ceremony. The awards, which have been running for ten years, received almost 500 nominations. Nominations present an opportunity to hear directly from patients and parents about the difference we can make to their lives through outstanding clinical care and living our Always Values.

Engaging and listening to staff

We provide frequent opportunities for staff across the hospital to ask questions and share ideas, particularly with senior colleagues. Engagement is important; it helps us live our Always Values of 'always one team' and 'always expert'.

Our monthly executive talks, led by the Chief Executive, have an open invitation to all employees. Our monthly senior management meetings have been extended to include a wider audience of clinical leaders as well as managers.

We continue to hold regular discussions with formal staff representatives through our Staff Partnership Forum and Members Council.

Raising concerns at GOSH

The Audit Committee monitors implementation of our Raising Concerns in the Workplace Policy. In the 2017 Staff Survey, 94% of staff said they would know how to report a concern about unsafe clinical practice, and 71% said they would feel secure about raising their concerns. These results are similar to other acute specialist hospitals.

We continue to embed the role of GOSH Freedom to Speak Up (FTSU) Ambassador service to enable staff to raise concerns. This service is provided by a multi-professional group of GOSH staff across the Trust, so representatives are easily accessible. In January 2018, we appointed a FTSU Guardian to lead the service.

Learning and development

This year we have continued to develop apprentices at GOSH – we have increased the number of non-clinical apprentices, started our first cohort of clinical apprentices as healthcare support workers and are now developing programmes for healthcare science apprentices. In 2017/18 we have had over 90 apprentice starts, achieving our annually set public sector target.

We continued to embed the GOSH Learning Management System (GOLD LMS) which was launched last year. It has enabled us to provide more visible access to learning opportunities and has improved the recording of learning records.

A comprehensive review of our statutory and mandatory training portfolio was completed, and we are continuing to redesign training so it is timely, relevant, effective and, importantly, that the learning can be applied. We are also collaborating with the STP to work in partnership with other north and central London trusts to streamline the administration of statutory and mandatory training.

The case to create a 'GOSH Learning Academy' is being scoped with the vision to provide an inspirational space which is new and innovative, in support of enabling our staff to learn and thrive.

Leadership

Having leaders with the right capabilities at all levels across the Trust is key to enabling us to deliver the strategic direction of the hospital. This year we have conducted an analysis to identify the leadership and management development needs across the Trust. This year we will be building upon our leadership and management development portfolio to support our leaders to fulfil their potential.

We piloted a new tool, 'Axiometrics', for senior leader recruitment, onboarding, personal development and team development. We continue to offer apprenticeships in leadership and management, supporting the development of those new to their position.

We are delighted that GOSH has been selected to work in partnership with the Cognitive Institute (and their UK agents, the Medical Protection Society) in the Safety and Reliability Improvement Programme (SRIP) to implement a Speaking Up for Safety (SUFS) programme in 2018. As an essential part of our launch, some 180 senior leaders, both clinical and non-clinical, attended SRIP Leaders' Orientation workshops.

Health and sickness

The health and wellbeing of our staff is a top priority. We have established a multi-disciplinary health and wellbeing group to oversee a range of wellbeing support and benefits including:

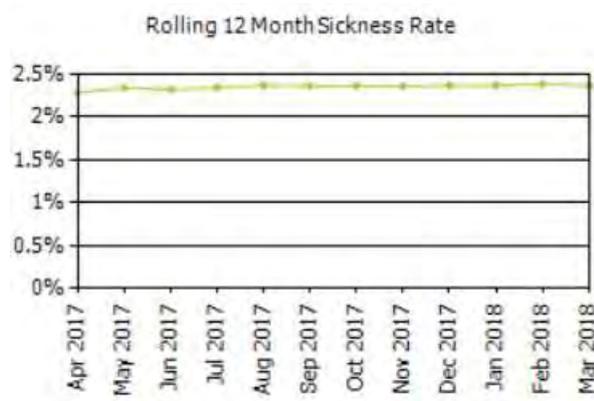
- Free on-site staff physiotherapy service
- 24/7 counselling and advice service
- Full occupational health service (vaccinating 61% of our staff against flu in 2017)
- Subsidised massage service

We have continued to offer a wide range of sports and social activities, including yoga, golf days, historical walking tours, a running club, and netball and football teams.

Due to popular demand, we repeated the pedometer challenge with large uptake from our more sedentary employees.

We took part in mental health week and secured some high profile speakers to help raise awareness of mental health. In January we ran our first health and wellbeing week promoting hydration and physical and mental wellbeing through a range of activities and taster sessions, including a roving trolley to take information to the clinical areas.

Below is a graph showing our sickness rate for all staff groups over 2017/18.





Our sickness rate in 2017/18 has increased from 2.3% in March 2017. However this remains well below the target of 3%, and the most recently reported NHS rate for 2016/17 at 4.16%.

The Trust has invested in a new scheduling system to be rolled out in 2018/19 that will allow for improvements to absence reporting.

Staff safety and occupational health

We are committed to effectively minimising risks, controlling hazards and preventing harm to all. This is done through a proactive programme of risk assessment and audit. There are clear processes for incident reporting, and we encourage a culture in which people report incidents. In 2017/2018 GOSH employees reported 800 health and safety incidents, including 135 patient safety incidents. One was a 'serious incident'. This has increased from 760 incidents in 2016/2017.

Our governance structure ensures statutory compliance is undertaken within legislative requirements. The Health and Safety Committee provided assurance on a range of subjects such as violence against staff, sharps compliance, COSHH and fire. Maintaining compliance in a complex and diverse environment can present challenges. We have developed an auditing tool specific to the Trust that allows us to review and develop our systems to manage risk more effectively.

Following the fire incident at Grenfell Tower, the Trust reviewed its fire plans and procedures. These were confirmed to be safe and compliant. The London Fire Brigade commissioned a specialist contractor to review the cladding throughout London including a visit to GOSH. The cladding on the Trust's buildings was confirmed to be safe.

Countering fraud and corruption

We have 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 carry out ad hoc audits and specific investigations of any reported alleged frauds. The LCFS delivers 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.

Expenditure on consultancy

Consultancy expenditure can be found in note 4 of the annual accounts on page xx.

Exit packages

Information about exit packages can be found on page ??.

Disclosures

Principal activities of the Trust

Information on our principal activities, including performance management, financial management and risk, efficiency, employee information (including consultation and training) and the work of the research and development division and IPP is outlined in the performance report. Page XX summarises GOSH's purpose and activities.

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 our behalf, the Board seeks to ensure that the auditor is, and is seen to be, independent. We have developed a policy for any non-statutory audit work undertaken on our behalf, to ensure compliance with the above objective. The Members' Council has approved this policy, and it is monitored on an annual basis, or as a query arises.

Code of Governance

Great Ormond Street Hospital for Children 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 2017 to 31 March 2018 it was compliant with the provisions of *The NHS foundation trust Code of Governance* providing an explanation against the following provisions:

:

- **A.4.2: 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** and **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.**- In view of the appointment of a new Chairman and two non-executive directors, the performance evaluation of the Chairman and existing NEDs is being conducted in Q2- Q3 2018/19. The Senior Independent Director (SID) will lead the performance

evaluation of the Chairman and the new NEDs in Q4 within a framework agreed by the Council of Governors.

- **B.1.2: At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent** – From 1 May 2018 to 31 October 2018 the Board comprised 6 executive directors (including the Chief Executive), the Interim Chairman and four non-executive directors (see page xx).
- **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 have all been required to sign a statement declaring that they meet the criteria of a ‘fit and proper person’. Following the election to the Council in January 2018, the new governors are in the process of completing the fit and proper persons test.
- **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** - The CEO was invited by the government of Ireland to serve as a NED on the Children's Hospital Group Board, Ireland. This position and time requirement is not considered a conflict of interest. The CEO as a consequence of his position is also a member of the Board of UCLPartners, an academic health science partnership.
- **B.6.5: Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities** – An evaluation of the Council will be conducted in Q4 2018/19 to provide time for new working arrangements between the Board and the Council (agreed in April 2018) to be established.
- **B.6.6: There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties**- As part of the work of the Constitution Working Group, this policy is being reviewed and updated.

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.

Off payroll engagements

Information about off-payroll engagements can be found on page **x**.

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.

Consultations in year

In 2017/18, we have consulted patients, families, members, the public and staff on a variety of issues:

- We held a listening event for patients, parents and carers within the Gastroenterology Service to hear about their experiences and inform the review of the service.
- The Young People'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. Takeover 2017 was even bigger than the previous year, with more teams and younger children gaining an insight into how decisions are made and services are run. A Teen Café was set up to help inpatients meet other teenagers, and to give them time away from the ward.
- To learn from other hospitals about how best to cater for young people in the hospital, the YPF hosted the first ever meet-up of 14 hospital forums in October 2017 to discuss the big issues surrounding their health and hospital care. The event was so successful that Derby and Nottingham hospitals will be co-hosting a Big Meet Up 2018.
- In October, young people from Birmingham, Bristol, Derby, Leeds, Manchester, Nottingham, Oxford and other London hospitals joined members of our Young People's Forum (YPF) for the first ever Big Youth Forum Meet Up (see page xx).
- We consulted with staff about the structure of the operational divisions.
- Our charity conducted a consultation with staff on the hospital's brand and website.

Statement on better payment practice code

The Trust aims to pay its 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's Better Payment Practice Code performance for non-NHS creditor payments in year was 85% in terms of number, (61,091 of 71,866 invoices were paid within 30 days) and 89% in terms of value, (£244,951k of a total £274,314k were paid within 30 days). The performance for NHS creditor payments in year was 70% in terms of number, (1,322 of a total 3,053 invoices were paid within 30 days) and 43% in terms of value, (£14,200k of a total £20,206k were paid within 30 days).

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 14.3% to the scheme. From July 2013, staff who are not eligible for the NHS Pension Scheme have been subject to the auto-enrolment scheme offered by the National Employment Savings Trust. In 2017/18, the Trust contributed 1% for all staff who remain opted in. In addition to the above, the Trust has members of staff who are in defined contribution pension schemes for which it makes contributions.

Accounting policies for pensions and other retirement benefits are set out in note 1.8 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 cash balances are lodged on a short term basis 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.

Information governance

The Information Governance Steering Group (IGSG) monitors implementation of the information governance framework at GOSH. We manage risks to data security in the same way as other Trust risks, but they are also subject to separate evaluation and scrutiny by the IGSG, which provides assurance to the Trust's Audit Committee. This group uses the Information Governance Toolkit assessment to inform its review.

Our information governance strategy has been driven by forthcoming changes to legislation, specifically the introduction of the General Data Protection Regulations (GDPR) 2018, an update to the Data Protection Directive 1995. Many of the required changes are already established within the Trust due to our commitment to patient confidentiality and compliance with NHS guidelines, but specific areas will now become legal requirements. We are using this as an opportunity to review all personal data processing, such as how individuals can access the data GOSH holds on them, and how patients are informed of their options with regards to data sharing.

Our Information Governance Steering Group continues to monitor information governance compliance, reporting monthly on areas affecting data quality, records management and information security. We are undertaking additional work to ensure all staff are fully aware of

their responsibilities to data security and protection and understand how they may be affected by the new regulations.

Another focus for the coming year will be the relaunch of the Information Governance Toolkit as the Data Security and Protection Toolkit. The toolkit will be aligned with the National Data Guardian's ten data security standards and the forthcoming General Data Protection Regulation (GDPR) and will be a full redesign of how we demonstrate compliance. Over the coming year, GOSH will ensure that all appropriate evidence is available to measure performance against the data security and information governance requirements mandated by the Department of Health and Social Care.

As part of the information governance agenda, we are also overseeing the adoption of the new EPIC Electronic Patient Record. The enhanced privacy and security functionality within the system will allow greater controls for GOSH to protect patient data. The Information Governance Team will ensure that any potential privacy concerns are identified and appropriately monitored.

Further information can be found in the annual governance statement on page **XX**.

How we govern quality

We place 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 our 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 reporting structures for the Patient Safety and Outcomes Committee and Patient Family Experience and Engagement Committee.
- Internal processes to check that we meet our quality standards and those set nationally.
- KPIs that 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
- Board commitment to continuous improvement in safety and quality indicators and the establishment of mechanisms for recording and benchmarking clinical outcomes. Outcomes are collected by each specialty, and many teams have published outcomes to the Trust website. The Trust has developed an internal Clinical Outcomes Hub, which enables teams to more readily use this evidence in decision-making and service improvement.
- Patient stories at the public Board meeting highlight where the quality of care could be improved and celebrate excellent practice and patient experience. Learning is

shared with teams across the hospital and progress with actions is reported at the Quality and Safety Assurance Committee.

Further information can be found in the quality report on page xx.

Gastroenterology review

In 2015 we commenced a review into the gastroenterology service at GOSH to ensure it provides the highest standards of care to the children, young people and families it looks after. This review was of particular importance to us as we had seen a disappointing and sustained number of complaints about the service we offered.

We engaged with national and international peer reviewers throughout the process. We delivered improvement work based on recommendations and held a listening event for patients and parents to ensure that their views were captured. The set of reviews has now been concluded and the process and outcome is described on page xx of our 2017/18 Quality Report.

Registration with the CQC

GOSH is registered with the CQC as a provider of acute healthcare services. The CQC visited the Trust in January 2018 as part of its rolling schedule of inspections. The report was published in April 2018 and services were rated as 'good' overall and 'outstanding' for being caring and for being effective. The also CQC conducted a well led inspection and the Trust was rated 'requires improvement' – further information can be found on page XX. The Trust has developed an action plan in response to the recommendations. This includes actions in response to a requirement notice related to accessibility of clinical information for staff planning to undertake procedures.

Complaints and how we handle them

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 is 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 2017/18, GOSH received 87 formal complaints with 86 of these complaints being investigated in line with the NHS complaint regulations (one was withdrawn). During the year, four complaints were referred to the PHSO and two have currently been accepted for investigation.

Detail of political and charitable donations

The Trust has not made any political or charitable donations during 2017/18.

NHSI'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 of 2016/17 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 2018, 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	2017/18 scores			2016/17 scores		
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	1	1	1	1	1	2
	Liquidity	1	1	1	1	1	1

Financial efficiency	I&E margin	1	1	1	1	1	2
Financial controls	Distance from financial plan	1	1	1	1	1	1
	Agency spend	1	1	1	1	3	3
Overall scoring		1	1	1	1	1	2

NHSI well-led framework

As part of their routine scheduled inspection programme, the CQC conducted a well-led inspection of the Trust in January 2018. The Trust was rated as 'requires improvement'. The inspectors identified the areas of good practice including:

- recognition of the excellent work undertaken to address our waiting time data and management issues (see page XX)
- All staff were proud to work at Great Ormond Street Hospital.
- Effective systems are in place to identify and learn from unanticipated deaths, serious incidents and complaints.

The report identified issues with nursing leadership and said that nurses feel that they don't have a voice. There were perceptions of an overly complicated divisional structure, and the need for further engagement with local stakeholders particularly around sustainability and transformation partnerships (STPs).

We are developing an action plan in response to the points raised in the report, noting that for some, we had already identified the issue and started to put plans in place. The action plan will be monitored by the Trust Board.

Working with partner and stakeholder organisations

During 2017/18, we have 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 us and our research partner, ICH, in driving the successful development of innovative new treatments for children with rare diseases. Together, we host the National Institute for Health Research (NIHR) Great Ormond Street Biomedical Research Centre (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 directly and through its network of corporate partners. The Charity makes it possible for us to redevelop our buildings, buy new equipment, fund paediatric research conducted at the hospital and ICH, and to make the patient experience as good as it can be. In 2017/18, the Charity's total income was just over £xx million – another strong year. Further information about the work of the Charity can be found at gosh.org.

UCLPartners

One of five UCLPartners (UCLP) is an accredited academic health science systems partnership 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 five of London's most prestigious hospitals and research centres, including GOSH. By sharing knowledge and expertise between different specialist institutions through UCLP, we can better support the advancement of 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). We have a proactive working relationship with NHS England, and hold 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 of our specialised services operate with other healthcare providers in local, regional and national clinical networks of care. Our teams also play a role in working with other healthcare organisations; 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 us.

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 hospitals from across Europe, providing an opportunity for hospitals that share a common mission and face similar challenges, to share expertise and contribute to the advancement of paediatric services. Dr Peter Steer, Chief Executive, chairs both of these meetings. Further information can be found on page xx.

Fees and charges (income generation)

Neil Redfern 150 See page 26 of ARM (new) To be confirmed

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.

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

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 NHS Improvement.

NHS Improvement, in an exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require 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 required by those Directions. 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 Department of Health Group Accounting 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 (and the Department of Health Group Accounting 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.

Signed.....

Chief Executive

Date: 23 May 2018

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 2018.

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 internal controls, which support the achievement of the organisation's objectives.

Key responsibilities of the committee include monitoring the integrity of the Trust's annual report and accounts, and the effectiveness, performance and objectivity of the Trust's external and internal auditors. Also, the committee is required to satisfy itself that the Trust has adequate arrangements for counter fraud, managing security and ensuring that there are arrangements by which staff of the Trust may raise concerns.

The Quality and Safety Assurance Committee consider 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 2017/18, but I would like to draw particular attention to the following items:

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. The Trust continues to deliver the majority of its services as part of the two-year contract signed with NHS England in December 2016. An updated plan to meet the 2018/19 control total has been submitted to NHS Improvement, which aligns with the contract variation agreed with the commissioners in March 2018. We are confident that the Trust management has clearly adopted the appropriate accounting basis and recognises that the financial challenges the wider NHS faces are significant.

The committee met four times over the financial year, and I am satisfied that it was presented with papers of good quality, 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 Council of Governors. Members of the Council of Governors also observed committee meetings throughout the year.

The committee reviewed its effectiveness annually and no material matters of concern were raised in the 2017/18 review.

The Audit committee is composed of three independent non-executive directors. These are listed on page XX. Two of the non-executive members of the committee are qualified accountants and all three members have recent and relevant financial experience.

Mr Akhter Mateen

Audit Committee Chairman

23 May 2018

Audit Committee responsibilities

The committee's responsibilities and the key areas discussed during 2017/18, 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 2017/18
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 Improvement's 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 • Assurance of controls in place for emergency planning and business continuity • Mitigations in place as a result of a cyber security incident • Assurance of plans to manage <ul style="list-style-type: none"> ○ Debt provisioning ○ IR35 compliance

	Principal responsibilities of the Audit Committee	Key areas formally discussed and reviewed by the committee during 2017/18
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 • Review of non-audit work conducted by the external auditors • Plan for tendering of the external audit contract in 2018/19 including approval by the Members' Council

	Principal responsibilities of the Audit Committee	Key areas formally discussed and reviewed by the committee during 2017/18
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 included: <ul style="list-style-type: none"> - key financial controls - data quality - information governance - board assurance framework - business continuity - workforce planning - review of annual leave payments • Plan for tendering of the internal audit contract in 2018/19

	Principal responsibilities of the Audit Committee	Key areas formally discussed and reviewed by the committee during 2017/18
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"> • Review of SFIs and Scheme of Delegation • Review of Audit Committee's terms of reference and workplan • 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 (Whistleblowing) and issues raised with Freedom to Speak Up Ambassadors • Reporting to the Board and Members' Council where actions are required and outlining recommendations • Assurance of compliance with the Bribery Act 2011 • Plan for tendering of the counterfraud contract in 2018/19

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 information from the committee self-assessment survey 2017/18 was used to review and update the committee's terms of reference in May 2018 with no major changes being made.

The committee also reviews the performance of its internal and external auditor's service against best practice criteria as detailed in the *NHS Audit Committee Handbook*.

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 two years. The Members' Council approved the extension to the external auditor until the end of

2018/19. A procurement process for the external auditors, internal auditors and counterfraud specialist will be conducted in 2018/19 for commencing their programmes of work in 2019/20.

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

Internal audit services are provided by KPMG LLP and cover both financial and non-financial audits according to a risk-based plan agreed with the Audit Committee.

The Trust's 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. Significant risks included the potential reduction in our funding, arising from the challenging external environment and commissioning changes and delivery of our productivity and efficiency (better value) target. For each risk, the committee reviewed the risk assessment (including risk definition, risk appetite, and likelihood and impact scores), the robustness of the controls and the evidence available that the controls were operating.

Data quality reviews

During the year, the committee sought assurance that the systems and processes for assuring data completeness, timeliness, relevance, accuracy and appropriateness were operating effectively.

Board Assurance Framework (BAF)

The Audit Committee reviewed the BAF in detail this year. The Risk Assurance and Compliance Group reviewed 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 received routine presentations on strategic risks at each committee meeting.

Preparing for GDPR

The Audit Committee received updates on progress against the Trust's plan to prepare for the introduction of GDPR on 25 May 2018. The committee will continue to review progress against the plan as the implementation date approaches.

Productivity and efficiency

The Finance and Investment Committee monitored the identification, planning, monitoring, delivery and post-implementation review of Trust's savings schemes. The Quality and Safety Assurance Committee received assurances from the Quality Impact Assessment Group that those schemes do not adversely or unacceptably affect the quality of services delivered. The Audit Committee sought independent assurance that the systems and processes supporting those assurances were operating effectively. The Audit Committee linked closely with the Finance and Investment Committee and received the minutes of that Trust Board committee and the Quality and Safety Assurance Committee.

IPP debtors

The Audit Committee also monitored and reviewed the IPP debt levels for each major customer and discussed with management, strategies to minimise the level of exposure. The final quarter of the financial year saw a decrease in the debt exposure for the organisation, but this remains a key risk that the committee will continue to monitor.

Internal controls

We focused in particular on controls relating to cyber-security, credit control management and 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 works with the auditors to identify key risks to inform the audit plan. The Audit Committee considers the links between the audit plan and the BAF. The Audit Committee approves the internal audit plan and monitors the resources required for delivery. During 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.

Financial reporting

We reviewed the Trust's financial statements and determined how to position these within the annual report. We considered reports from management and the internal and external auditors in our review of:

- The quality and acceptability of accounting policies, including their compliance with accounting standards.
- 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

Our management team has carefully considered the appropriateness of reporting on the 'going concern' basis.

In 2017/18, the Trust reported a small operating surplus prior to capital donations and impairments, which includes £9.1m funding via the NHS sustainability and transformation fund. The Trust delivered efficiency savings to support this position.

In 2018/19 the Trust will enter into the second year of the two-year contract with its commissioners. This contract aligns to the plan submitted to NHS Improvement, and the agreed business plans to meet demand and deliver access targets through additional capacity, including the new Premier Inn Clinical Building. It demonstrates the organisation will deliver a £0.5m surplus which is in part achieved through £15m efficiency savings.

In 2017/18 IPP turnover continued to increase (3.8%), with the majority of demand originating from the Middle East (greater than 80% of IPP income came from government agency sponsored activity within the Middle East). It is recognised this is a risk to the organisation so the Trust continues to seek other markets to diversify income sources and reduce its exposure.

As at the 31 March 2018 the Trust held £55.7m in cash reserves and it remains able to meet all commitments as and when they fall due, demonstrating strong liquidity. The Trust continues to carefully manage any investment in capital assets and ensure that the support provided by the Charity is appropriately reflected in the accounts.

Funding within the NHS remains constrained and it is recognised that the organisation is operating in a difficult financial climate. However, 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 2017/18

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.

Mr Akhter Mateen

Audit Committee Chair

23 May 2018

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 2018.

The Quality and Safety Assurance Committee 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.

As chairman, I am satisfied that during the year, 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 Quality and Safety Assurance Committee are listed on page XXX. Representatives from the Members' Council attended the Quality and Safety Assurance Committee meetings during the year.

I have been chairman of the committee since June 2017. I will step down from my role as non-executive director on the GOSH Board at the end of May 2018 to join East Kent Foundation NHS Trust as Chairman. Lady Amanda Ellingworth will take on the responsibility of chairing the Quality and Safety Assurance Committee.

Quality and Safety Assurance Committee responsibilities

The principal purpose of the Quality and Safety Assurance Committee 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 2017/18 are outlined in the table below.

Principal responsibilities of the committee	Key areas formally reviewed during 2017/18
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, safety or patient experience matters or shortcomings arising from the Trust's operational and quality and safety performance.	<ul style="list-style-type: none">• Review of the annual quality report 2017/18• Reports from the Clinical Ethics Committee• Regular review of performance reports• Monitoring of actions arising from patient stories• Updates on quality issues arising in Pharmacy Department

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 2017/18 including:
 - Update on the gastroenterology service review process
 - Quality and safety impact of the productivity and efficiency programme
 - Recruitment and retention with a particular focus on nurses at GOSH
 - Update on Health Education North Central and East London (HENCEL) and educating junior doctors
 - Implementation of the CQC action plan and preparation for future inspection

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 BAF
- Compliance with the risk management strategy
- Reports received on specific and/or high risk areas:
 - Health and safety
 - Safeguarding
 - Raising concerns (whistleblowing and freedom to speak up) – quality related cases
 - Education and training update
 - Research governance
 - Update on the transition
 - Update on learning from deaths
 - Integrated Quality Report including update on incidents, complaints and patient experience feedback

Review of findings and

- The internal audit annual plan and strategy was

recommendations from internal audit, clinical audit and learning from external investigations and reports

presented to the committee in April 2017 with an update on progress with the plan covered at subsequent meetings

- Findings and recommendations of clinical focused internal audit reports are presented to every committee meeting. The following audits were discussed this year:
 - Data quality
 - Complaints
 - Business continuity plans
 - Workforce planning
 - Board assurance framework
 - Cancelled operations
- Quarterly reports from the Trust's clinical audit manager and annual plan for 2017/18

Risk reviews

The committee reviews all clinical strategic and high- scoring operating risks at least annually. As at 31 March 2018, the Trust's most significant risk relating to clinical delivery was recruiting and retaining sufficient highly skilled staff.

Quality impact of the productivity and efficiency programme

The Quality and Safety Assurance Committee QSAC has received assurance of the refreshed quality impact assessment (QIA) processes in place for productivity and efficiency (Better Value) schemes in 2017/18. The committee also reviewed some specific services' productivity plans to ensure quality and safety is not compromised.

CQC compliance

The committee reviewed the actions taken to implement the recommendations arising from the CQC report of January 2016. In September 2017, the action plan was completed and reported to the Trust Board for final sign off. The committee was kept apprised of plans in place to prepare for future inspections, including updates on progress with the Well Led action plan.

Patient stories

The Trust Board receives patient stories at every public Board meeting. Matters that arise from these stories are documented and acted upon; the QSAC then reviews progress on these matters at every meeting.

Review of effectiveness

The chairmen of three committees (Audit Committee, Quality and Safety Assurance Committee and the Finance and Investment Committee) discussed how the QSAC could operate more effectively. The new Chairman, Lady Amanda Ellingworth, will conduct a review in Q2 2018/19.

Conclusion

As Chairman of the QSAC, I am satisfied that the committee adequately discharged its duties in accordance with its terms of reference throughout 2017/18.

Professor Stephen Smith

Quality and Safety Assurance Committee Chairman

23 May 2018

Head of Internal Audit Opinion

Basis of opinion for the period 1 April 2017 to 31 March 2018

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.

Our overall opinion for the period 1 April 2017 to 31 March 2018 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 2017 to 31 March 2018 inclusive, and is based on the 10 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 four PARTIAL ASSURANCE WITH IMPROVEMENTS REQUIRED (AMBER-RED)' opinions in respect of our 2017/18 assignments. We did not issue any NO ASSURANCE (RED) opinions from our 2017/18 assignments. The partial assurance reports related to workforce planning, divisional governance and divisional financial management, nursing recruitment and retention and HPTP governance.

Our divisional governance and divisional financial management report identified that revised divisional governance structures had not been fully embedded, with performance not consistently being considered at a divisional level.

We have not raised any high priority recommendation in this period and all outstanding high priority recommendations from prior period have been implemented. We have agreed actions with management for the implementation of the recommendations from our partial assurance with improvements required reports and are satisfied that appropriate action has been agreed with management to improve the robustness of the control environment in these areas.

TO BE SIGNED

KPMG LLP

Chartered Accountants

London 23 May 2018

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, while 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 for Children 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 for Children NHS Foundation Trust for the year ended 31 March 2018 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 CQC. 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 the Trust's non-clinical and clinical risk management processes and raise issues that require the attention of the Board. In addition to the two assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The chair 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, chaired by the 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. Locally, risks are reported to relevant Risk Action Groups, which report to Divisional Boards. These RAGs are multi-disciplinary groups and receive information on a monthly basis on their clinical and non-clinical incidents (reported through the central reporting system) to consider actions to control risks and identify key themes. These are the key management forums for consideration of risks.

The Trust has a central Risk Management Team that administers 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, we emphasise the importance of preparing risk assessments where required, on reporting, investigating and learning from incidents.

There is 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.

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 are 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 delivers clinical services and research activity 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.
- Under the executive directorship of the Medical Director, quality improvement at the Trust is part of the broad remit of the Quality and Safety Team which incorporates clinical audit, patient safety, clinical outcomes and complaints. This team of quality improvement specialists work together to ensure an organisational approach to maintaining and improving our quality governance processes.
- Executive oversight of patient experience and engagement is through the Chief Nurse who, with the Medical Director, ensures an organisation-wide approach to the integrated delivery of the quality governance agenda. They are supported in this work by a number of senior managers including the Assistant Chief Nurse for Quality, Safety and Patient Experience, the Head of Quality and Safety and the Associate Medical Director for Quality, Safety and Patient Experience. Patient and parent feedback is received through: the Friends and Family Test (FFT), a more detailed survey carried out at least once a year, the work programme of the Patient and Family Experience and Engagement Committee and through a range of other patient/parent engagement activities.
- Each specialty and clinical division has an internal monitoring structure so teams 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 monthly performance review meetings.
- Working with the divisional management teams, the aim is to continue to develop a culture of continual identification of learning from events and making changes that are effective, sustainable and improve the quality of the service and experience of our children, young people and their families.
- The Quality and Safety Team work collaboratively with the Trust's Project Management Office (PMO) to ensure the right resources are available to the right work streams at the right time. This will reduce duplication of effort and support the transition of projects to 'business as usual' while providing effective support to sustain changes and monitor outcomes.
- Each of the priority quality improvement projects have an allocated executive director, operational lead and allocated specialist from the Quality and Safety Team, who, along with other key specialists, form a steering group to oversee and support delivery.
- Each improvement project has a steering group that reports to relevant Trust committees such as the Quality Improvement Committee (QIC), the Patient Safety and Outcomes Committee (PSOC) or the Patient Family Experience and Engagement Committee (PFEEC). These committees, alongside a newly-established Education and Workforce Committee, provide assurance to the Trust Board on the quality and safety programme.
- Using the Institute for Health Improvement (IHI) model for improvement, the Quality and Safety Team use data to encourage improvement activity and to demonstrate and evidence the impact of the improvement programme.

- Key performance indicators are presented on a monthly basis to the Trust Board. The report 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 Patient Advice and Liaison Service (PALS).
- 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. A data quality dashboard has been developed which provides visibility of potential data quality issues across the organisation. This 'kite-mark report' is reported at every Board meeting.

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. This group uses the Information Governance Toolkit Assessment to inform its review. The Audit Committee seeks assurance of progress with the Trust's Cyber Security Strategy including the management of risks to delivering the strategy and operational risks and incidents.

There were three never events reported in the Trust during the year, as follows:

Removal of the wrong tooth in a child: The patient had an incorrect molar tooth removed. It was not necessary for the tooth originally planned for removal to be removed, and the patient did not require an additional procedure. A detailed investigation concluded that while a team brief and the WHO surgical safety checklist were completed, a dedicated maxillofacial safety checklist was needed to ensure that all teeth are appropriately identified, and the method for removal agreed. There was no harm to the patient.

Retained object: The patient had posterior spinal fusion surgery which at the time was thought to have been uneventful and surgical counts were thought to be correct. Post-operatively an object (metallic reduction head known as a 'pair of ears') was noticed on a routine x-ray- it had been left attached to a screw which had been inserted during surgery and should have been removed. The patient did not need to have any additional treatment or investigations as a result of the incident. The clinical team have advised that the retained object will not cause any harm to the patient but it is recognised that the incident has caused considerable anxiety for the patient's parents.

Retention of a swab following surgery: A patient had a bowel perforation so underwent a laparoscopy, followed by a laparotomy. A single site of perforation was found in the small bowel and resection and primary anastomosis were performed. At the end of the procedure, the post-operative checklist was completed and all swab counts were reported as correct. An abdominal x-ray confirmed the position of the nasogastric tube demonstrated a radiopaque foreign body projected over the abdomen consistent with surgical gauze. The patient was returned to theatre. Laparoscopy revealed a retained intra-abdominal swab, which was removed through the umbilical incision.

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 CQC Well-Led Inspection found that staff spoken with did not feel that there were clear lines of accountability under the Trust's divisional structure. A staff consultation is underway to review and update divisional reporting structures in Q1 2018/19.

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 collate evidence of compliance with the standards. The evidence is reviewed periodically by compliance staff.

The Trust is compliant with the registration requirements of the Care Quality Commission. In January 2018, the CQC conducted a scheduled unannounced inspection of two services (surgery and outpatients) and an announced inspection against the well-led criteria. The report was published in April 2018. The Trust was rated 'Good' overall. An action plan is in development to respond to the recommendations, including a requirement notice related to accessibility of clinical information for staff planning to undertake procedures. Further information about the well-led inspection can be found on page ??

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 BAF is used to provide the Board with the assurance that there is a sound system of internal control in place to manage the risks of the Trust 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. The internal auditors conducted an audit into the management of the BAF audit in DATE and this indicated significant assurance with minor improvement potential.

Each strategic risk on the assurance framework, including 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 independent assurance that the controls are effective. The committees monitor progress with actions to reduce or remove control or assurance gaps.

In addition, the Trust Board recognises the need to 'scan the horizon' for emerging risks and review low-probability/high-impact risks to ensure that contingency plans are in place. The Board has included such matters in Board discussions of risks as well as holding an annual risk management meeting and inviting external speakers on future risk matters relevant to

paediatric and wider healthcare, including Brexit, health policy changes, and the role and impact of technology in the provision of healthcare.

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 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, 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:

- Being able to meet the two-year plan control total target set by NHS Improvement, in an environment where core services are underfunded, money available to NHS organisations is reduced, and the cost of delivering specialised services is high
- Recruitment and retention of sufficient highly skilled staff with specific experience

- Reliance on IPP to support financial viability
- Implementation of the new Trust-wide Electronic Patient Record (EPR) system

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 four risks to our operational or strategic plans in 2017/18 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.	<ul style="list-style-type: none"> - Specific action plans are in place for key service areas and professions including: <ul style="list-style-type: none"> o A Trust-wide nursing recruitment and retention programme. o Enhanced processes to establish GOSH as an attractive employer. o Tactical use of temporary staff to fill vacancies o Education commissioning plans to increase numbers of potential staff.
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. - Ongoing cost benchmarking.
Reliance on International and Private Practice (IPP) contributions 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 EPR	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

Risk	Explanation	Mitigating actions implemented and underway
		<p>staff and stakeholders are aware of programme and impacts of changes.</p> <ul style="list-style-type: none"> ○ Project closely integrated with Quality Improvement and Operations teams to ensure the EPR is delivered as a change programme. ○ 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 the clinical division and corporate department level through the Trust’s quarterly strategic reviews.

The Board obtains assurance 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 receives the results of clinical audits and health and safety reports, while the Audit Committee monitors the counter-fraud and security management programmes.

The annual audit plan of the internal auditors is risk based; the Executive Team works 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.

Both committees ensure 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 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 (PALS) 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 Trust is fully compliant with the registration requirements of the CQC.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure we comply with all the employer obligations contained within the scheme regulations. 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 the Trust meets obligations under equality, diversity and human rights legislation.

The 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 Trust complies with obligations under the Climate Change Act and the Adaptation Reporting requirements.

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. Also 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's performance management framework is aligned to the divisional management structure. 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 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**.

Code of governance

Great Ormond Street Hospital for Children 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. Information about the Trust's compliance with the Code 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 internal auditors conducted a review of information governance audit in April 2017 and this indicated 'significant assurance with minor improvement potential'.

Information governance

The Trust has undertaken a focused programme of work on the introduction of the General Data Protection Regulations (GDPR) 2018, an update to the Data Protection Directive 1995. The Trust is using this as an opportunity to review all personal data processing – such as how individuals can access the data GOSH holds on them; and how we inform patients of their options with regards to data sharing. Further work is being undertaken to ensure all staff are fully aware of their responsibilities to data security and protection and how they may also be affected by the new regulations.

An additional focus for the coming year will also be the relaunch of the Information Governance Toolkit as the Data Security and Protection Toolkit.

This year there have been four serious incidents in information governance (classified as Level 2 in the Information Governance Incident Reporting Tool) involving sensitive information. Details are as follows:

- Two folders containing confidential information were misplaced on a ward.
- A letter containing sensitive details was sent to the old address of a patient.
- An encrypted email was sent to a private medical insurer for patients with unpaid bills. The attached spreadsheet accidentally included other patients with an unpaid bill and not just those for this insurer.
- A member of staff emailed patient identifiable information to their personal email.

The incidents have all been reported to the Information Commissioner's Office and an internal root cause analysis commenced for each incident.

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 provides assurance to the Trust's Audit Committee. The Trust has approved and is implementing a cyber-security strategy including threat detection technology and monitoring of the cyber environment 24/7.

7. Annual quality report

The directors are required under the *Health Act 2009* and the *NHS (Quality Accounts) Regulations 2010* (as amended) to prepare quality accounts for each financial year. NHS Improvement (in an 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 Quality and Safety Assurance 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. They are reviewed and approved by the Policy Approval Group and accessible via the Trust intranet pages to all staff.

A data quality dashboard has been developed which provides visibility of potential data quality issues across the organisation. This 'kite-mark report' is reported at every Board meeting.

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.

External assurance statements on the quality report are provided by our local commissioners and our local LINKs as required by quality account regulations.

Throughout the past three years, we have focused on improving the quality of our waiting list data, establishing robust processes to manage elective care waits and ensuring that assurance processes are in place to provide early warning of any future issues.

The main focus in 2017-18 was to reduce the waiting times for all our patients, providing prompt treatment and achieving the defined national requirements as an organisation. We worked on improving the waiting times associated with referral to treatment, in line with the hospital's agreed recovery trajectory with NHS England. We achieved the 92% standard for the first time since returning to reporting in January 2018, with a performance position of 92.96%. This was a testament to the work completed by the clinical and operational teams.

Following completion of the audit of our Quality Report 2017/18, a number of data quality issues were identified related to the small sample undertaken. Further information can be found in the Quality Report on page **xx**.

A number of actions are already underway that will address these issues, including the roll out of a refreshed RTT (and cancer) training package to ensure staff are fully aware of the rules as well as their application across GOSH. Many of these issues were the result of our patient administration system not being compliant with the RTT rules and therefore tracking and managing of patient pathways has to be completed outside the system with limited visibility of pathway status. This specific issue will be addressed with the implementation of the new electronic patient record (Epic) and the Trust is currently working to configure the RTT rules, providing a fully integrated tracking system for staff to use.

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 Quality and Safety Assurance 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 and other external bodies

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.

The instances where the assurance was not sufficient or controls were not adequate when subject to routine audits during the 2017/18 year were:

- A review of the processes for the development and monitoring of workforce plans within divisions and across the Trust was undertaken and given partial assurance with improvements required. The audit found that strategic workforce planning to consider the long-term workforce requirements of the Trust had not been formally undertaken in line with a recognised academic model to consider the longer-term workforce needs of the Trust. However, the Trust does follow the recognised workforce planning processes in accordance with NHS business planning guidance. The audit identified a requirement to develop a workforce strategy to set out how workforce will be used to support delivery of the Trust strategy. A workforce strategy is under development.
- As part of this, through the priorities identified in the Trust strategy and in particular the people priority, an emphasis is being placed on
 - rolling out development programmes for leaders, ensuring we can respond to national challenges, via recruitment, retention and education of staff;
 - continuing the programme to embed our Always Values, which underpins both patient and staff safety, experience and satisfaction,
 - working with the Cognitive Institute to deliver a Safety and Reliability Improvement Programme that will improve the culture of safety and accountability within the Trust.
- A review of the divisional governance and financial management framework. The auditors found that consistent divisional governance structures have not been established following the formation of divisions and there was a disconnect between the divisional performance considered by the Executive and the management of performance undertaken within divisions. A gap in control around the sign off of

budgets was also raised. The Trust is in the process of carrying out a planned review of the divisional framework involving consultation meetings with staff and managers within the divisions and those who support the divisions (business partners).

- A review of nursing recruitment and retention highlighted that although a strategy has been developed to understand the driving factors behind nursing turnover and reduce the level of turnover and vacancies within nursing, there is not a formal action plan in place to monitor implementation of the strategy. Also while appropriate authorisation and selection processes have been developed, there was insufficient evidence to provide assurance that controls established within the recruitment process had consistently operated with regard to completion of interviews, assessment centres and local inductions. The management team have put in place an action plan to respond to these assurance gaps including the development of formal plans to monitor progress with the strategy.

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 BAF 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 focusing on the introduction of electronic patient records and moving towards a fully digital hospital.

I have also considered the results of the assessment of compliance with the NHS Improvement 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 have now been implemented to address the issue.

Signed.....

Dr Peter Steer

Chief Executive

Date: 23 May 2018

Independent Auditor's report

To add

Quality Report

Annual accounts

Glossary

See last year's

Great Ormond
Street
London WC1N 3JH
T: +44 (0)20 7405 9200
www.gosh.nhs.uk

Deloitte LLP
3 Victoria Square
Victoria Street
St. Albans
AL1 3TF

23 May 2018

Our Ref: CAW/RF/2018

Dear Sirs

This representation letter is provided in connection with your audit of the annual financial **statements and consolidation schedules (together "the financial statements")** of Great Ormond Street Hospital for Children NHS Foundation Trust for the year ended 31 March 2018 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view of the financial position of Great Ormond Street Hospital for Children NHS Foundation Trust as of 31 March 2018 and of the results of its operations, other recognised gains and losses and its cash flows for the year then ended in accordance with the directions given by NHS Improvement - Independent Regulator of NHS Foundation Trusts in accordance with paragraph 25 of Schedule 7 of the National Health Service Act 2006. It is also provided in connection with your limited assurance report on the quality report for the year ended 31 March 2018.

As Accounting Officer and on behalf of the board of directors, I confirm, to the best of my knowledge and belief, the following representations:

Financial statements

1. I understand and have fulfilled my responsibilities for the preparation of the financial statements in accordance with the directions given by NHS Improvement - Independent Regulator of NHS Foundation Trusts in accordance with paragraph 25 of Schedule 7 of the National Health Service Act 2006 which give a true and fair view, as set out in the terms of the audit engagement letter.
2. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
3. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of ***IAS24 "Related party disclosures"***.

Attachment L

With regard to the transactions and balances listed in the notes to the financial statements, we confirm that to the best of our knowledge and belief these transactions are not significant to the related party or to the Trust such that they would influence decisions made by a user of the financial statements.

4. All events subsequent to the date of the financial statements and for which the applicable financial reporting framework requires adjustment of or disclosure have been adjusted or disclosed.
5. The effects of uncorrected misstatements and disclosure deficiencies are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the disclosure deficiencies is detailed in the appendix to this letter.
6. We confirm that the financial statements have been prepared on the going concern basis. We also confirm the completeness of the information provided regarding events and conditions relating to going concern at the date of approval of the financial statements, including our financial plan and future actions to deliver the plan. This includes the status of contract negotiations with commissioners. After consideration of the financial plan and making reasonable enquiries, the Directors have a reasonable expectation that despite the uncertain environment the Trust has adequate resources to continue as a going concern for the next 12 months.

Information provided

7. We have provided you with all relevant information and access as agreed in the terms of the audit engagement letter and required by the National Health Service Act 2006
8. All transactions have been recorded and are reflected in the financial statements and the underlying accounting records.
9. We acknowledge our responsibilities for the design, implementation and maintenance of internal control to prevent and detect fraud and error.
10. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
11. We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the entity or group and involves:
 - (i) management;
 - (ii) employees who have significant roles in internal control; or
 - (iii) others where the fraud could have a material effect on the financial statements.
12. We have disclosed to you all information in relation to allegations of fraud, or **suspected fraud, affecting the entity's financial statements communicated by** employees, former employees, analysts, regulators or others.

Attachment L

13. We have disclosed to you all known instances of non-compliance, or suspected non-compliance, with laws, regulations and contractual agreements whose effects should be considered when preparing financial statements
14. **We have disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which we are aware.**
15. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with the applicable financial reporting framework. On the basis of legal advice we have set them out in the attachment with our estimates of their potential effect. No other claims in connection with litigation have been or are expected to be received.
16. We have no plans or intentions that may materially affect the carrying value or classification of assets and liabilities reflected in the financial statements.
17. We acknowledge our responsibility for ensuring the Trust has put in place arrangements for securing economy, efficiency and effectiveness in its use of resources.
18. **We are not aware of any deficiencies in the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources.**
19. All grants or donations, the receipt of which is subject to specific restrictions, terms or conditions, have been notified to you. We have evaluated whether the restrictions, terms or conditions on grants or donations have been fulfilled with and deferred income to the extent that they have not.
20. Based on discussions with other NHS bodies, we consider that the resolution of disputed balances and accrued over performance will not result in a material adverse effect on the reported financial position.
21. With respect to the revaluation of properties in accordance with the Group Accounting Manual:
 - a) the measurement processes used are appropriate and have been applied consistently, including related assumptions and models;
 - b) the assumptions appropriately reflect our intent and ability to carry out specific courses of action on behalf of the entity where relevant to the accounting estimates and disclosures;
 - c) the disclosures are complete and appropriate.
 - d) there have been no subsequent events that require adjustment to the valuations and disclosures included in the financial statements.

Attachment L

22. We confirm that we consider that depreciated historic cost is an appropriate proxy for the fair value of non-property assets, and are not aware of any circumstances that would indicate that these assets require revaluation.

Quality report

23. We understand and have fulfilled our responsibilities for the preparation of the quality report in accordance with the NHS Foundation Trust Annual Reporting Manual.
24. We have made available to you all records, correspondence, information and explanations necessary for you to perform your work. All the records have been made available to you for the purpose of your work and all the data collected by the Foundation Trust has been properly reflected and recorded.
25. Significant assumptions that have been made by us in determining the indicators are reasonable.
26. All events subsequent to the date of the quality report and for which the NHS Foundation Trust Annual Reporting Manual requires adjustment of or disclosure have been adjusted or disclosed.
27. The effects of uncorrected misstatements and disclosure deficiencies are immaterial, both individually and in aggregate, to the quality report as a whole. A list of the uncorrected misstatements and disclosure deficiencies is detailed in the appendix to this letter.
28. We acknowledge our responsibilities for the design, implementation and maintenance of internal control to prevent and detect fraud and error when preparing the quality report.
29. We are not aware of any instances of non-compliance, or suspected non-compliance, with laws and regulations whose effects should be considered when preparing the quality report.
30. We are not aware of any deficiencies in internal control over the collection and reporting of the measures of performance included in the quality report.

We confirm that the above representations are made on the basis of adequate enquiries of management and staff (and where appropriate, inspection of evidence) sufficient to satisfy ourselves that we can properly make each of the above representations to you.

Yours faithfully

Dr. Peter Steer, Chief Executive Officer
Signed as Accounting Officer, and on behalf of the Board of Directors

Appendix 1

Schedule of Uncorrected Misstatements

Description	Assets	Liabilities	Equity	Income Statement
	DR / (CR) £	DR / (CR) £	DR / (CR) £	DR / (CR) £

Appendix 2

Disclosure deficiencies

#	Disclosure title	Description of the deficiency and explanation of why not adjusted	Amount (if applicable)
1	None noted		

**Trust Board
 23 May 2018**

Compliance with the NHS provider licence – self assessment

Paper No: Attachment M

Submitted by: Anna Ferrant, Company Secretary

Aim

To present the annual self assessment of compliance with NHS Improvement (“NHSI”) license conditions for providers of NHS services.

Summary

The NHS provider licence is NHSI’s main tool for regulating providers of NHS services. 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.

An FT Board is required by NHSI to annually declare compliance or otherwise with a small number of FT licence conditions and a requirement under the Health and Social Care Act as follows:

Licence condition	Deadline and comment
Condition G6(3): Providers must certify that their board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution.	The deadline for this declaration is 31 May 2018 . The G6 self-certification also needs to be published within one month of sign off by the Board.
Condition CoS7(3): Providers providing commissioner requested services (CRS) must certify that they have a reasonable expectation that the required resources will be available to deliver the designated service.	The deadline for this declaration is 31 May 2018 .
Condition FT4(8): Providers must certify compliance with required governance standards and objectives	The deadline for this declaration is 30 June 2018 . Board is required to identify risks to achieving the governance standards and any mitigating actions taken to avoid those risks.
NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, as required in s.151(5) of the Health and Social Care Act to ensure that they are equipped with the skills and knowledge they need to undertake their role.	The deadline for this declaration is 30 June 2018 .

NHSI require that an FT Board must take into account the views of governors when considering whether the Trust confirms compliance with the above declarations. Appendix 1 documents evidence against the four conditions. The Council of Governors have been asked for their views on the attached conditions and evidence cited and their comments will be reported to the Board at the meeting.

In the past, providers have been required to complete and return an annual self-certification for the above. This year, NHS Improvement does not require a submission. Instead, from July 2018, the regulator will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified using completed templates provided by NHSI, or relevant board minutes and papers recording sign-off.

Evidence has been provided against the remaining licence conditions (see Appendix 2). These do not require the Board to make a formal declaration. The Executive Team recommend conformation of compliance against these remaining conditions.

Action required from the meeting

The Board is asked to:

- **consider and agree** the Trust's response to the four conditions (confirm/ not confirm), taking into account the views of the governors reported to the Board at the meeting. Where the Board does not conform compliance with a condition, it is required to document the reason for this (see Appendix 1)
- **consider and accept** the recommendation from the executives that the Trust complies with the other licence conditions (these do not require a formal declaration) – see Appendix 2.

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.

Financial implications

None

Legal issues

None

Who is responsible for monitoring the license conditions?

Company Secretary and Chief Finance Officer

Who is accountable for the implementation of the proposal / project

The Board is responsible for ensuring continued eligibility to hold an NHS provider licence.

Appendix 1: FT Licence self-certification – four requirements that must be signed off by the Board

The board must sign off on self-certification for the following licence conditions and H&SCA requirement, taking into account the views of governors.

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
<p>G6 – Systems for compliance with licence conditions and related obligations (scope = past financial year 2017/18)</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>The steps that the Licensee must takeshall include: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and (b) regular review of whether those processes and systems have been implemented and of their effectiveness.</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>	<p>To be considered by the board in light of assurance provided here and taking into account the views of the governors</p>	<p>The Trust has systems and processes to monitor risks of failure through lack of compliance or adverse variances in performance:</p> <ul style="list-style-type: none"> • There is clear accountability at Board level for safety and clinical quality objectives and structured reporting of performance against these objectives. (see Annual Governance Statement in annual report) • 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 (currently under review) • The Trust’s risk management strategy, which sets out how risk is systematically managed, 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’s Board Assurance Framework is used to provide the Board with assurance that there is a sound system of internal control in place to manage the key risks to the Trust of not achieving its strategic objectives. The BAF records the controls in place to manage

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>the key risks, and highlights how 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 by the assurance committees and updated throughout the year. The internal auditors conducted an audit in to the management of the BAF audit in 2017/18 and this indicated 'significant assurance with minor improvement potential'. The CQC report stated (April 2018): <i>“Risk registers and the board assurance framework were reviewed regularly by the executive management team and board committees. They were reflective of risks facing the organisation and clearly listed all control measures set out to manage risks and what means of assurance were in place. Documents were informed by divisional risks registers and highlighted both strategic and operational risks. The risk management framework allowed staff to effectively escalate risks and their concerns.”</i></p> <ul style="list-style-type: none"> • Divisional performance reviews take place on a monthly basis, attended by divisional management and Trust executives. These reviews are designed to facilitate a triangulated and risk-focused discussion across a number of key domains: Caring, Safe, Responsive, Well-led (people, management and culture), Effective, Finance, Productivity. The review packs contain an integrated dashboard which provides a one page summary of key metrics across the domains, allowing rapid identification of linked risks and issues. The packs also contain more in-depth dashboards for each domain. An integrated performance report is then scrutinised at each Board meeting. This provides a summary of the key issues in each domain and actions planned to resolve, as well as an integrated dashboard – this provides trust level data using the same format as the divisional integrated dashboard reviewed in the monthly performance reviews. • The Trust has identified an executive director and a manager who are

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>respectively accountable and responsible for ensuring compliance with each element of the CQC registration standards. The Trust is developing an action plan in response to the recent CQC inspection and actively monitors progress with this at operational level and provides assurance to the Board. The remaining outstanding actions from the Well led Review in October 2016 will be completed by Q2 2018/19 and are already in progress.</p> <ul style="list-style-type: none"> • The Trust assesses compliance with the FT licence annually.
<p>CoS7 – Availability of resources (scope = next financial year 2018/19)</p>	<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, in one of the following forms:</p> <p>(a) “After making enquiries the</p>	<p>To be considered by the board in light of assurance provided here and taking into account the views of the governors</p>	<p>The Trust sets its budget on an annual basis and actively manages and monitors its financial position and resource levels on a regular basis throughout the year through routine performance reporting to the Board and its Committees. Both External and Internal Audit services provide assurance that reporting is accurate and there is no material mis-statement.</p> <p>No material agreements which might create a material risk have been entered into.</p> <p>The Trust Audit Committee and Board reviewed and approved the 2017/18 annual report and accounts (23 May 2018), on a going concern basis. Therefore, confirming that the Directors of the Licensee have a reasonable expectation that the organisation as the required resources available for the next 12 month licence.</p>

Attachment M

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
	<p>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.”</p> <p>OR</p> <p>(b) “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 which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services”.</p> <p>OR</p> <p>(c) “In the opinion of the Directors of the Licensee, the Licensee will not have</p>		

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
	the Required Resources available to it for the period of 12 months referred to in this certificate”.		
<p>FT4- NHS foundation trust governance arrangements (scope = next financial year 2018/19)</p> <p>PLEASE NOTE – all four parts need to be confirmed for an overall ‘confirmation’</p>	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.	To be considered by the board in light of assurance provided here and taking into account the views of the governors	<p>A self-assessment is prepared annually against the Monitor code of Governance and will be reported to the Board in May 2018. The Trust Board considers that from 1 April 2017 to 31 March 2018 it was compliant with the provisions of The NHS foundation trust Code of Governance and proposes to explain its compliance (on a comply or explain basis) for the following criteria in the annual report – to be approved by the Board:</p> <ul style="list-style-type: none"> • A.4.2: 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 and 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 performance evaluation of the Chairman and NEDs is being conducted in Q2- Q3 2018/19 in view of the recent scheduled turnover of the Chairman and two non-executive directors. The Senior Independent Director (SID) will lead the performance evaluation of the Chairman within a framework agreed by the Council of Governors. • B.1.2: At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent – From 1 May 2018 to 31 October 2018 the Board comprised 6 executive directors (including the Chief Executive), the Interim Chairman and four non-executive directors (NHSI were aware of this at the time). • 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

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>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 have all been required to sign a statement declaring that they meet the criteria of a 'fit and proper person'. Following the election to the Council in January 2018, new governor intake for 2018 will be asked to complete the fit and proper persons test.</p> <ul style="list-style-type: none"> • 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 - The CEO is a NED on the Children's Hospital Group Board, Ireland (invited by the Irish Government to serve on the Board). This position and time requirement is not considered a conflict of interest. The CEO, as a consequence of the position of CEO at GOSH, is also a member of the Board of UCLPartners, an academic health science partnership. • B.6.5: Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities – An evaluation of Council will be conducted in Q4 2018/19 to provide time for new working arrangements between the Board and the Council (agreed in April 2018) to be established. • B.6.6: There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties- As part of the work of the Constitution Working Group, this policy is being reviewed and updated. <p>The Trust has a range of governance and assurance structures and systems in</p>

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>place including a Trust wide strategy, scheme of delegation, performance management framework, policy framework, risk management framework, accountability framework, compliance framework, escalation framework and assurance framework and a financial management framework.</p> <p>The directors and governors are asked to sign a code of conduct and are required to declare any interests annually.</p>
	<p>The Licensee shall:</p> <p>(a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time;</p> <p>(b) comply with the following paragraphs of this Condition.</p>	<p>To be considered by the board in light of assurance provided here and taking into account the views of the governors</p>	<p>The Trust has regard to guidance on good corporate governance as issued by NHS Improvement.</p>
	<p>The Licensee shall establish and implement:</p> <p>(a) effective board and committee structures;</p> <p>(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and</p> <p>(c) clear reporting lines and accountabilities throughout its organisation.</p>	<p>To be considered by the board in light of assurance provided here and taking into account the views of the governors</p>	<p>The Trust has terms of reference and work plans in place for the Board, Council; and relevant committees. The Trust's assurance and escalation framework details how the Trust presents a single, comprehensive picture of the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance (currently subject to review and update). This includes the range of forums and processes available to staff, patients, families and other stakeholders to raise and escalate concerns or risks which could threaten the delivery of the Trust's objectives, service delivery or patient safety strategy and planning processes, performance management framework, policy framework, risk management framework, accountability framework, compliance framework, escalation framework and assurance framework).</p> <p>In 2018, management of the Board Assurance Framework was audited by the Internal Auditors and provided with a rating of 'significant assurance with minor improvements'. The CQC Well Led assessment highlighted that <i>risk</i></p>

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p><i>registers and the board assurance framework were reviewed regularly by the executive management team and board committees. They were reflective of risks facing the organisation and clearly listed all control measures set out to manage risks and what means of assurance were in place. Documents were informed by divisional risks registers and highlighted both strategic and operational risks. The risk management framework allowed staff to effectively escalate risks and their concerns.</i></p> <p>The Board committee terms of reference are reviewed annually and their effectiveness analysed for any improvements to the effective conduct of the committee.</p> <p>The Well Led inspection found that some staff spoken with did not feel that there were clear lines of accountability under the divisional structure. A scheduled staff consultation is underway to review and update divisional reporting structures in Q1 2018/19.</p>
	<p>The Licensee shall establish and effectively implement systems and/or processes:</p> <p>(a) to ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively;</p> <p>(b) for timely and effective scrutiny and oversight by the Board of the Licensee’s operations;</p> <p>(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS</p>	<p>To be considered by the board in light of assurance provided here and taking into account the views of the governors</p>	<p>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.</p> <p>The Trust’s performance management framework is aligned to the divisional management structure. 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</p>

Attachment M

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
	Commissioning Board and statutory regulators of health care professions;		<p>some specific Trust projects aimed at increasing efficiency are included in the performance report.</p> <p>The external auditors envisage issuing an unmodified audit opinion for 2017/18, with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources.</p> <p>The external auditors plan to issue a qualified quality report conclusion due to finding a number of errors in the samples tested on the 18 weeks RTT indicator. All but two of the errors relate to either user error, or not uploading decision making documentation to EDM that can be used to provide evidence. The importance of uploading clinical documentation will be reiterated to staff and the Trust is in the process of launching a new RTT Training Programme to the organisation that will retrain all staff in the rules around the RTT standard and how to apply them at GOSH. Unfortunately as the Trust's RTT processing occurs outside the patient administration system, the PiM's system allows any outcome code to be entered regardless of previous pathway status. This will be mitigated with the use of EPIC to record RTT status.</p> <p>In January 2018, the Trust was inspected by the CQC and achieved an overall rating of GOOD. An action plan has been developed in response to the recommendations raised and issues highlighted. This included a requirement notice (Regulation 17) related to accessibility of clinical information for staff planning to undertake procedures. The Trust has taken immediate action in response to this matter including the Medical Director emailing all clinical and operational management staff reminding them of their responsibilities. Assurance of the timely scanning of notes has been received, datix incident reports are being monitored for any similar events and an audit will be conducted on the completeness and accessibility of patient notes.</p>

Requirement	Description	Confirmation	Assurance
<p>s.151(5) of the Health and Social Care Act (not a licence condition) (scope = past financial year 2017/18)</p>	<p>NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, to ensure that they are equipped with the skills and knowledge they need to undertake their role.</p>	<p>To be considered by the board in light of assurance provided here and taking into account the views of the governors</p>	<p>Governor Induction and training and development: During 2017/18, councillors received mandatory Trust training and were provided with access to the Trust's internal on line training portal (GOLD) to update their training during their tenure. Councillors were provided with ongoing development opportunities by attending tailored information sessions delivered by key Trust staff and others prior to and during Council meetings. Councillors attended NHS Providers events and Deloitte Governor Workshops and fed back to the Council. Training on conducting the Chairman's interview was provided by an external provider to councillors appointed to the Chairman recruitment panel. Information has also been provided to councillors appointed to the Constitution Working Group during the meetings from an external provider.</p> <p>The Trust Board and Council of Governors (previously known as the Members' Council) held a joint meeting in February 2018 to discuss how both bodies can work together effectively, taking in to account the recommendations in the Well Led Review report from October 2016. It included a presentation on the different roles and responsibilities of the Board, Council, directors and governors. It also highlighted the information gathered from other trusts by members of the Well Led Working Group on how Boards and Councils work together. Feedback from that meeting was used to inform the proposals for effective working between the Council and Board. This included a review of the governor induction programme, commitment to the development of a buddying system for governors run by the non-executive directors and establishment of a portal for Governor information; and, Governor meetings with the Chairman prior to Council meetings.</p> <p>The Trust held an election for 22 Governor seats in January 2018, with new governors elected from 1 March 2018. A comprehensive induction and development programme is in place for new governors to support them in their role and ensure that they have the appropriate information available to discharge their duties. The Trust has held two half day induction sessions with new governors and received supportive and encouraging feedback from attendees. The sessions have included presentations from internal and external speakers, tours of the Trust site as well as training on the role of governor.</p>

Appendix 2

Assessment of compliance against remaining FT Licence conditions (*NHSI declaration not required and Board not required to take into account the views of governors*)

Licence condition	Description	Confirmation	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.	Recommendation: Confirmed	All information required or requested by NHS Improvement has been provided during the year. The routine information requests include performance information. We have provided routine performance information and updates on the Well Led Governance Review.
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.	Recommendation: Confirmed	There is no information which we have been required to publish by NHS Improvement 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</i>	Recommendation: Confirmed	The Trust has adopted the following: <ul style="list-style-type: none"> • Trust Constitution • Code of Conduct for Directors • Code of Conduct for Governors Copies are held of the following: <ul style="list-style-type: none"> • Signed declarations of being a fit and proper person for

Licence condition	Description	Confirmation	Assurance
	<i>previous five years, and disqualified directors. A company may also be an unfit person”.</i>		<p>all Directors</p> <p>Following the recent election, all Governors are in the process of being asked to complete the following:</p> <ul style="list-style-type: none"> • Declaration of eligibility forms to be a Governor • Fit and Proper person Test form <p>The Fit and Proper Person Test Procedure is being reviewed and updated.</p>
G5 – Monitor Guidance	This condition requires licensees to have regard to any guidance that Monitor issues.	Recommendation: Confirmed	<p>The Chief Finance Officer and Company Secretary ensure that all relevant guidance is considered and applied as required through monitoring of the NHS Improvement 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>
G7 – Registration with the Care Quality Commission (CQC)	This condition reflects the obligation in the Health and Social Care Act 2012 for licensees to be registered with the CQC and to notify Monitor promptly if registration is cancelled. This condition allows Monitor to withdraw the licence from providers whose CQC registration is cancelled and who therefore cannot continue to lawfully provide services.	Recommendation: Confirmed	In January 2018, the Trust was inspected by the CQC and achieved an overall rating of GOOD. An action plan has been developed in response to the recommendations raised and issues highlighted. This included a requirement notice (Regulation 17) related to accessibility of clinical information for staff planning to undertake procedures.
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	Recommendation: Confirmed	<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>

Licence condition	Description	Confirmation	Assurance
	referrals, or determining the manner in which services are provided to that person.		<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)	Management of continuity of commissioner requested services including provision of notice by the commissioner for a licensee to provide such a service and continuity of provision of service when a contract has expired and not been renewed.	Recommendation: Confirmed	Not relevant to GOSH
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 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.	Recommendation: Confirmed	The Trust reports costs of its services in line with current costing guidance and has made both required submissions covering clinical services and education during the year, as well as voluntarily submitting patient level costing information.
P2 – Provision of Information	Under this condition, once the information		The Trust would comply with Monitor’s requests for

Licence condition	Description	Confirmation	Assurance
	has been recorded in line with Licence Condition P1, Monitor can request licensees to submit this data.		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.	Recommendation: Confirmed	The Trust complies with the enhanced guidance required under the costing transformation programme and has been fully audited for its compliance with national costing standards. As such, it is deemed compliant.
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	Recommendation: Confirmed	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.	Recommendation: Confirmed	Where required, local modifications of prices have been agreed with the 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 agreed some local modifications with its Commissioners in 2016/17, which still remain in place.
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. Requires that information and advice that licensees provide to patients about their choice of provider does not unfairly favour 	Recommendation: Confirmed	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 reminded on an annual basis along with the request for any declarations.

Licence condition	Description	Confirmation	Assurance
	<p>one provider over another and is presented in a manner that helps patients to make well-informed choices.</p> <ul style="list-style-type: none"> Prohibits licensees from offering gifts and benefits in kind for patient referrals or for the commissioning of services. 		
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>	Recommendation: Confirmed	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>	Recommendation: Confirmed	<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> <p>GOSH has a large number of clinical networks and outreach services which cover a wide range of services (including Cardiology, Genetics etc.), provided through a large number of</p>

Licence condition	Description	Confirmation	Assurance
			other Providers.
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 provided and terms of authorisation of regulatory bodies		The Trust has provided the Commissioner requested services in-line with our Acute Services Contract. The organisation would not cease a service unless it was on the grounds of clinical safety or due to the organisation being able to sustainably provide the service, typically due to capacity or staffing issues.
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:</p> <p>(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>	Recommendation: Confirmed	<p>The Trust maintains 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	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	Recommendation: Confirmed	<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</p>

Attachment M

Licence condition	Description	Confirmation	Assurance
	being unable to carry on as a going concern.		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.
CoS4- Undertaking from the ultimate controller	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.		This is not relevant to GOSH.
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.	Recommendation: Confirmed	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	Recommendation: Confirmed	No such notice has been given by Monitor.

Licence condition	Description	Confirmation	Assurance
	Monitor may appoint to assist in the management of the Licensee's affairs, business and property.		
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.	Recommendation: Confirmed	Whenever changes are made to the Constitution, an approved version is forwarded to NHSI. No changes have been made in 2017/18. The annual report and accounts are forwarded to NHSI 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.	Recommendation: Confirmed	Any requests for information are complied with and the Board informed. No requests have been received in the current year.

Trust Board 23 rd May 2018	
<p>Compliance with Monitor's Code of Governance</p> <p>Submitted by: Anna Ferrant, Company Secretary</p>	<p>Paper No: Attachment N</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 Code of Governance during 2017/18 with the exception of providing an explanation against the following provisions in the annual report as follows:</p> <p>Compliance with the Code of Governance</p> <p>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.</p> <p>The Trust Board considers that from 1 April 2017 to 31 March 2018 it was compliant with the provisions of <i>The NHS foundation trust Code of Governance</i>, providing an explanation against the following provisions:</p> <ul style="list-style-type: none"> • A.4.2: 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 and 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.- <p>In view of the appointment of a new Chairman and two non-executive directors, the performance evaluation of the Chairman and existing NEDs is being conducted in Q2- Q3 2018/19. The Senior Independent Director (SID) will lead the performance evaluation of the Chairman and the new NEDs in Q4 within a framework agreed by the Council of Governors.</p>	

<ul style="list-style-type: none"> • B.1.2: At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent – From 1 May 2017 to 31 October 2017 the Board comprised 6 executive directors (including the Chief Executive), the Interim Chairman and four non-executive directors (see page xx of the annual report). • 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 have all been required to sign a statement declaring that they meet the criteria of a ‘fit and proper person’. Following the election to the Council in January 2018, the new governors are in the process of completing the fit and proper persons test. • 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 - The CEO was invited by the government of Ireland to serve as a NED on the Children's Hospital Group Board, Ireland. This position and time requirement is not considered a conflict of interest. The CEO as a consequence of his position is also a member of the Board of UCLPartners, an academic health science partnership. • B.6.5: Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities – An evaluation of Council will be conducted in Q4 2018/19 to provide time for new working arrangements between the Board and the Council (agreed in April 2018) to be established. • B.6.6: There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties- As part of the work of the Constitution Working Group, this policy is being reviewed and updated.
<p>Action required from the meeting 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 Good corporate governance</p>
<p>Financial implications None</p>

Attachment N

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 2017-2018

Key		
	Fully compliant with the requirement	
	Partially compliant with the requirement	
Red text	Criteria against which Monitor expects the Trust to explain any areas of non-compliance.	
Para	Code of Governance 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 2016) and subject to review in 2018 • 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.	<p>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.</p> <p>External sources of assurance are sought on high risk/ complex areas such as compliance with maintenance requirements for the estate.</p>
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 (subject to review) 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. Following joint meetings between the Board and the Council, the Code of Conduct is under review for governors and a similar review will be undertaken for the Board Code.
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 and governors is published on the GOSH website.</p>

Para	Code of Governance Requirement	Disclosure
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.	This cover is provided under the LTPS (NHSLA). The Trust has also arranged top up insurance to provide additional indemnity for risks not covered by the NHSLA e.g.: • Claims made against the Entity itself • Past Directors, Governors, Employees A review of insurance cover across the Trust will be conducted in 2018/19
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 governors individually and invites comments from governors 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. In view of the appointment of a new Chairman and two non-executive directors, the performance evaluation of the Chairman and existing NEDs is being conducted in Q2- Q3 2018/19. The Senior Independent Director (SID) will lead the performance evaluation of the Chairman and the new NEDs in Q4 within a framework agreed by the Council of Governors.
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 Council of Governors now meets 4 times a year as a minimum (excluding extraordinary meetings). Governor attendance at meetings is recorded in the annual report. Governors are provided with regular reminders about meetings via the Governor bulletin and as an agenda item at Council meetings.
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 governors The Council of Governors has a terms of reference the Nominations and Remuneration Committee terms of reference were reviewed and revised in April 2018. The appraisal and NED recruitment processes have been reviewed by the Council in April 2018
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 made 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 governors 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 was agreed by the Council for the recent 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.	The chief executive gives a verbal report at each meeting. Non-executive directors attend the Council meeting on a regular basis and answer questions from governors which is recorded in the Council meeting minutes. Executive Directors are invited to present on relevant reports. Governors receive feedback from the non-executive chairs of the Board assurance committees. Governors are invited to attend to observe the Board and assurance committee meetings.
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 new provider licence 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).	The Constitution details how such issues will be managed. The SID is available to discuss concerns about the performance of the board of directors and/or compliance with licence requirements. All of the Non-Executive directors attend each Council meeting and are available to answer questions about performance matters. 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. A joint meeting of the Board and Council was held in February 2018 where future working arrangements were discussed. These were agreed by the Board and Council in April 2018.

Para	Code of Governance Requirement	Disclosure
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.	Governors are invited to attend the Board and the assurance committees as observers. A bulletin has is sent regularly to governors, updating them on development opportunities, requests for information, media news stories and dates for diaries. The Trust seeks to spell out all acronyms in Council papers. A glossary of terms has also been circulated to governors 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. A joint meeting of the Board and Council was held in February 2018 where future working arrangements were discussed. These were agreed by the Board and Council in April 2018.
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.	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. Governors receive feedback from the non-executive chairs of the Board assurance committees. Governors are invited to attend to observe these assurance committee meetings. Emails are sent to governors on significant performance matters between meetings. A bulletin is sent out regularly to governors, updating them on development opportunities, requests for information, media news stories and dates for diaries.
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.	The Council is aware of this duty and carry it out in a number of ways: - 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
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 governors 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 (when appropriate) 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.	Governors are provided with a copy of the Code of Governance and are aware of this right through their induction
A.5.15	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: • 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. 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.	The Constitution covers all of these rights and voting powers. The Council approved a revision to the Constitution in 2014/15. The Constitution is subject to a review in 2018.

Para	Code of Governance Requirement	Disclosure
B.1.1	<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	<p>At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.</p>	<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>Tessa Blackstone, departed as Chairman on 30th April 2017, Mary MacLeod, Deputy Chairman was appointed by the Members' Council as Interim Chairman from 1st May 2017 until the substantive appointment of Sir Michael Rake on 1 November 2017.</p> <p>From 1 May 2017 to 31 October 2017 the Board comprised 6 executive directors (including the Chief Executive), the Interim Chairman and four non-executive directors.</p> <p>An appointment process for a new Non-Executive Director (agreed by the Council) is currently underway.</p>
B.1.3	<p>No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.</p>	<p>None of the directors are governors on the GOSH Members' Council nor a governor on another Trust's Council of Governors.</p>
B.1.4	<p>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.</p>	<p>This information is included in the annual report and on the Trust website.</p>
B.2.1	<p>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.</p>	<p>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 2018/19 the Council of Governors considered and approved the updated Board skills and experience survey, in preparation for informing the appointment of a new Non-Executive Director</p>
B.2.2	<p>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</p>	<p>The directors on the Board have all been required to sign a statement declaring that they meet the criteria of a 'fit and proper person'. Following the election to the Council in January 2018, the new governors are in the process of completing the fit and proper persons test.</p>
B.2.3	<p>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>	<p>There are two nominations committees - the Board of Directors' Nominations Committee and the Council Nominations and Remuneration Committee.</p> <p>The Council Nominations and Remuneration Committee reviewed the structure, number and skills and experience of the two NED recruitment and appointment processes and the reappointment of the Deputy Chairman NED.</p> <p>The Board of Directors' nominations committee considered the structure of the executive team in 2017/18 with the recruitment of the Chief Nurse, Medical Director and Chief Finance Officer.</p>
B.2.4	<p>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.</p>	<p>The 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 governors (at meetings and at NED appointment panels).</p> <p>The Board of Directors' Nominations Committee is chaired by Sir Michael Rake, Chairman</p>
B.2.5	<p>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.</p>	<p>The Council of Governors approved the appointment process for an additional NED to be followed by the Nominations and Remuneration Committee on 24 April 2018. 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 approved at the May 2018 extraordinary Council meeting.</p>

Para	Code of Governance Requirement	Disclosure
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 Council of Governors nominations and remuneration committee comprises the chairman of the Trust, the deputy chairman, lead governor, two governors from the public constituency and/or the patient and carer constituency, one staff governor and one governor from any constituency (patient and carer, public, staff or appointed). A majority of the committee is made up of governors (at meetings and on 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 two new NED positions 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 two new NEDs 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 Council of Governors' 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 JD and person specification was approved by the Members' Council in April 2017. The Chairperson'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 April 2018, 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.	The CEO was invited by the government of Ireland to serve as a NED on the Children's Hospital Group Board. This position was approved by the Chairman at the time of the appointment on the basis that it was not considered a conflict of interest and the time requirement was assessed and not felt to be burdensome. The CEO as a consequence of his position is also a member of the Board of UCLPartners.
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 governors receive information as part of their induction and are required to attend a tailored Trust corporate induction programme. The Governor induction process has been refreshed including external speakers attending and training on roles and responsibilities. Governors 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 held meetings with the NEDs during the year. The appraisal of Chairman and NEDs is being conducted in Q2 2018/19 in view of the turnover of Chairman and NEDS.
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.	New directors and governors receive information as part of their induction and are required to attend a tailored Trust corporate induction programme. The Governor induction process has been refreshed including external speakers attending and training on roles and responsibilities. Governors receive information on an on-going basis via presentations to meetings and separate seminar sessions. Governors attend meetings with other governors run by external organisations such as Deloitte and report back to meetings.

Para	Code of Governance Requirement	Disclosure
B.5.1	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>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 an 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>The executive directors and the Company Secretary regularly email governors between meetings on significant matters to ensure that information is shared in a timely way, rather than wait for the next Council of governors meeting.</p> <p>The Council of governors receive a regular ebulletin updating them on important matters, highlighting access to training events and other events where they can meet members.</p>
B.5.2	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>The non-executive directors do request deeper analysis of high risk areas during board and assurance Committee meetings.</p> <p>Access to external assurance/ advice is made available on request, for example legal advice around agreements regarding large scale development contracts.</p>
B.5.3	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.	Where requested, external advice is sought, for example legal advice or HR advice.
B.5.4	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.	The Company Secretary, Deputy Company Secretary and Trust Board Administrator supports the duties of the Board and Council committees.
B.5.5	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.	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.
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.	<p>An open house event was held for staff in November 2017 to communicate and gather views on the implementation of the Trust strategy.</p> <p>The Council fed comments into development of the GOSH operational plan 2018/19. The corporate affairs team will actively work with the planning and patient experience teams to develop a framework for canvassing member views in 2018/19.</p>
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 of Governors provided feedback on the plan and the refreshed GOSH strategy at the April 2017 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 of Governors 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.	<p>An independent review against the Monitor Well Led Governance Framework (incorporating elements of the quality governance framework) was conducted by Deloitte in June 2016. The Board and Council have received regular updates on progress with the action plan with the final actions due to be completed early 2018/19.</p> <p>As part of their routine scheduled inspection programme, the CQC conducted an independent well led inspection of the Trust in January 2018.</p> <p>The review highlighted a number of areas in relation to the governance and leadership of the Trust, with some recommendations for improvement.</p> <p>The Board and Council of Governors received regular updates on progress with the action plans.</p>
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. In view of the appointment of a new Chairman and two non-executive directors, the performance evaluation of the Chairman and existing NEDs is being conducted in Q2- Q3 2018/19. The Senior Independent Director (SID) will lead the performance evaluation of the Chairman and the new NEDs in Q4 within a framework agreed by the Council of Governors.

Para	Code of Governance Requirement	Disclosure
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 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	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: <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. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.	Members can communicate with governors via the foundation trust GOSH email address (emails are sent on to the relevant councillor). This information is also presented in the annual report. Governors have been involved in drafting the letters accompanying the Member Matters publication. An evaluation of Council will be conducted in Q4 2018/19 to provide time for new working arrangements between the Board and the Council to be established. The Council was consulted on development of the trust annual plan. The Membership Engagement Recruitment and Representation Committee continues to review the effectiveness of communication tools with members. 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. A joint meeting of the Board and Council was held in February 2018 where future working arrangements were discussed. These were agreed by the Board and Council in April 2018.
B.6.6	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.	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. A Constitution review was initiated in Q4 2017/18 by the Constitution Working Group. A policy for the removal of governors including the requirements to attend a certain number of council meetings is being reviewed and updated.
B.7.1	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.	Following the performance evaluation and at the time of reappointment, the chairperson confirms to the governors the performance of the individual proposed for re-appointment continues to be effective and demonstrates commitment to the role. Mr Akhter Mateen was subject to this process in 2017/18. No non-executive director serves longer than six years on the Board.
B.7.2	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.	The Foundation Trust conducted its last election in January 2018. The information presented to members for the elected governors who wished to be re-appointed included information about the prior performance attendance at meetings and involvement in committees and other activities.
B.7.3	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.	The Trust is compliant with this requirement. The Board of Directors' Nominations Committee Terms of Reference details the appointment process for executive directors.
B.7.4	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.	The Trust is compliant with this requirement.
B.7.5	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	The Trust complies with this requirement. Elections are administered by the Electoral Reform Services on behalf of the Trust. The last Trust election was conducted in January 2018.
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.	The Trust publishes an annual report, including a quality report, outlining financial, quality and operating objectives for the NHS foundation trust. The Council of Governors receives performance and financial information at each meeting and all directors attend Council meetings to answer any questions where required. The annual plan is consulted on with the Council. Public Board meetings and Council of Governors meetings are advertised and the papers are available on the GOSH website.

Para	Code of Governance Requirement	Disclosure
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. 	The directors maintain an open dialogue with the regulators (both NHS Improvement and CQC), reporting any significant matters and ensuring that these are also flagged with the Council
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 management of the Board Assurance Framework as well as the systems in place for managing risk and awarded 'significant assurance with potential for minor improvements' for 2017-18.</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	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (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.	The annual report presents this information.
C.3.1	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.	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 were subject to review and approved by the Audit Committee in April 2017. They will be reviewed by the Committee in May 2018.
C.3.3	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.	The Members' Council was involved in the appointment of Deloitte LLP for a 3 year term from 2014/15 and will be involved in the appointment of the External auditor in 2018/19.
C.3.4	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.	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 2017/18.
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. The contract was extended for 1 year in 2017/18.
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.

Para	Code of Governance Requirement	Disclosure
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 and Freedom to Speak up cases and actions taken to address issues raised. The QSAC considers any reports that are related to the quality 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	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>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.	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. The Members' Council Nominations and Remuneration committee is responsible for recommending remuneration levels for non-executive directors to the Members' Council. In April 2017, following analysis of benchmarking information, the committee recommended that the remuneration levels for both the Chairman and the NEDs for 2017/18 were set at an appropriate level. The Council agreed and approved the proposed the policy for benchmarking salaries and reviewing cost of living allowances for the Chairman and NEDs on a three yearly basis.
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.	All executive director contracts require 6 months' notice period. 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.
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 a 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 employed during the period and did not have any connection with the Foundation Trust..
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.	The Members' Council Nominations and Remuneration committee is responsible for recommending remuneration levels for non-executive directors to the Members' Council. In April 2017, following analysis of benchmarking information, the committee recommended that the remuneration levels for both the Chairman and the NEDs for 2017/18 were set at an appropriate level. The Council agreed and approved the proposed the policy for benchmarking salaries and reviewing cost of living allowances for the Chairman and NEDs on a three yearly basis.
D.2.4	The council of governors is responsible for setting the remuneration of non-executive directors and the chairperson.	This is the case.
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 (via the integrated quality report) and the Council.

Para	Code of Governance Requirement	Disclosure
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 summary of patient and local community 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).</p> <p>The SID has met with individual governors during the year. The Chairman and SID provided opportunities for groups of governors to meet with them for focused meetings throughout the year (outwith the normal general meetings)</p> <p>Emails from governors 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 governors are promoted on the Trust website and members can communicate with them via the foundation trust GOSH email address. This information is also presented in the annual report. Governors will be provided with GOSH emails in Q2 2018/19.</p> <p>Hovernors have been involved in drafting the letters accompanying the Member Matters publication.</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 NEDs attend Council of Governors meetings and executives attend where required. Individual meetings and email communications have been conducted between governors and directors. The Council of Governors 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. Governors attend the Board assurance committees and the public Board as observers. The annual report outlines how the Board and the Council of Governors 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, Recruitment and Representation Committee (MERRC) 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 Trust Membership Strategy will be reviewed in 2018/19.
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. Seven 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 every year (October in 2018) 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, NHSI, CQC, commissioners, external auditors, the Charity etc. The Chief Executive regularly discusses involvement and attendance at key stakeholder meetings at the EMT.

Trust Board 23 May 2018	
Quality Report 2017/18	Paper No: Attachment O
Submitted by: Mr Matthew Shaw, Medical Director	
<p>Aims / summary</p> <p>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</p> <p>Sign off of Quality Report</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans</p> <p>This document describes quality improvement work that has taken place in line with Trust strategic aims of 'Fulfilling Our Potential' and in line with quality as defined in the Next Stage Review. The document also outlines the Trust's quality improvement work for 2018/19.</p>	
<p>Financial implications</p> <p>None</p>	
<p>Who needs to be told about any decision?</p> <p>Deloitte</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales?</p> <p>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?</p> <p>Mr Matthew Shaw, Medical Director</p>	



Quality Report 2017/18

Contents

What is the <i>Quality Report</i> ?	04
Part 1: A statement on quality from the Chief Executive	10
Part 2a: Priorities for improvement	12
• Reporting our Quality priorities for 2017/18	13
Safety	14
– Improving sepsis awareness	
– Improving the quality and safety of care for inpatient neonates and small infants	
Clinical effectiveness	20
– Developing Trust-wide access to outcomes data through the Clinical Outcomes Hub	
– Optimising our capacity to improve patient access and flow	
Experience	24
– Improving our young people’s and their parents’ and carers’ experience of transition to adult healthcare services	
– Improving the quality of our food	
• 2018/19 Quality priorities	30
Part 2b: Statements of assurance from the Board	33
Part 2c: Reporting against core indicators	46
Part 3: Other information	48
Annex 1: Statements from external stakeholders	50
• Statement from NHS England (London), Specialised Commissioning team	
• Statement from Healthwatch Camden	
• Statement from Camden Health and Adult Social Care Scrutiny Committee	
• Feedback from Members’ Council governors	
Annex 2: Statements of assurance	54
• External assurance statement	
• Statement of directors’ responsibilities for the <i>Quality Report</i>	56

Cover: Naveen, age seven.

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."



Juliana, age one.

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.

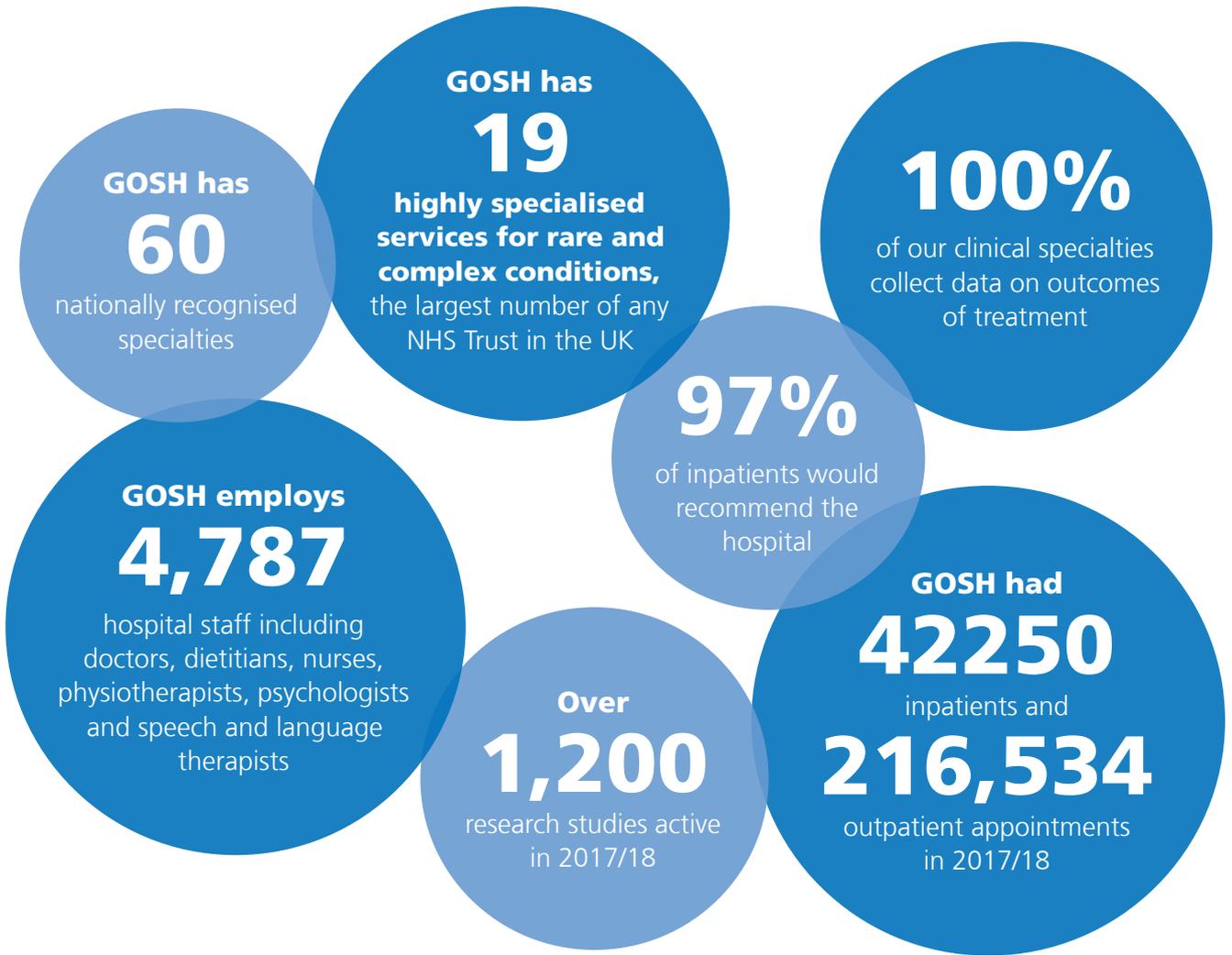
What is NHS Choices?

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?

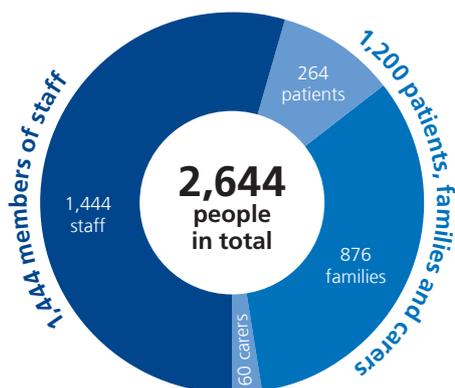
A Foundation Trust is a type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities. NHS Foundation Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability 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



Our strategy – fulfilling our potential

In spring 2017, the Strategy and Planning Team worked with our staff and Members' Council to review and refresh the GOSH strategy. We assessed the issues and opportunities we face, and thought carefully about our vision and future.

Our work identified the following priorities:

- We will achieve the best possible outcomes through providing the safest, most effective and efficient **care**.
- We will attract and retain the right **people** through creating a culture that enables us to learn and thrive.
- We will improve children's lives through **research** and innovation.
- We will transform care and the way we provide it through harnessing **technology**.
- We will use our **voice** as a trusted partner to influence and improve care.
- We will create inspiring **spaces** with state-of-the-art equipment to enhance care delivery and learning.
- We will provide timely, reliable and transparent **information** to underpin care and research.
- We will secure and diversify **funding** so we can treat all the children that need our care.

These priorities are presented in a 'strategy house' along with our mission, vision and *Our Always Values*. Together, they form a framework for our staff and leadership team for planning, decision-making and the daily care of our patients. See opposite page for 'strategy house'.

In November 2017, the Trust ran its first ever 'Open House' – a week of activities to celebrate how we at GOSH help children and young people with the most complex needs to fulfil their potential.



Ali Mohammed and Nicola Grinstead get to grips with strategy characters to help launch GOSH Open House week in the Lagoon.



Nursing staff with the team from our Clinical Simulation Centre during GOSH Open House.

Fulfilling our potential.

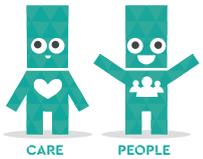
Our mission is to put the child first and always – this describes why GOSH exists.

The child first and always

Our vision has been updated to better describe what lies at the heart of the work we do at GOSH – to help the sickest children with complex health needs to fulfil their potential.

Helping children with complex health needs fulfil their potential

To turn our vision into goals we have defined four areas of focus around care, people, research, and technology.



CARE ♥

We will achieve the best possible outcomes through providing the safest, most effective and efficient care.

PEOPLE 👤

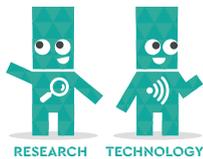
We will attract and retain the right people through creating a culture that enables us to learn and thrive.

RESEARCH 🔍

We will improve children's lives through research and innovation.

TECHNOLOGY 📡

We will transform care and the way we provide it through harnessing technology.



To deliver our work we need to have the right capabilities, resources, and programmes of work.



VOICE 🗣️

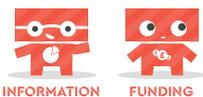
We will use our voice as a trusted partner to influence and improve care.

SPACES 🏠

We will create inspiring spaces with state-of-the-art equipment to enhance care delivery and learning.

INFORMATION 📊

We will provide timely, reliable and transparent information to underpin care and research.



FUNDING 💰

We will secure and diversify funding so we can treat all the children that need our care.

Our Always Values are the guiding principles for everything we do and will help us deliver our ambition.

Always welcoming

Always helpful

Always expert

Always one team



Three-month-old Ethan.

Electronic Patient Record programme

We are part way through an ambitious programme to implement a comprehensive, state-of-the-art, futureproof Electronic Patient Record (EPR) system. 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 EPR, alongside the Digital Research Environment, will support a transformational change programme across the Trust and benefits will be realised through cultural change and full engagement from all staff and the leadership team. The EPR programme is being carefully managed in phases, in partnership with our EPR system provider, to ensure the best possible system is built for go-live in April 2019.

The three main benefits of our new EPR system are:

- Improved quality of care and enhanced patient safety
- Patients and their families become partners and the patient experience is improved
- Enabling research breakthroughs

Digital Research Environment

As part of the Research and Innovation Strategy, the Trust has procured a data store and digital research platform, called the Digital Research Environment (DRE), to work alongside the new EPR system. The DRE will provide a rich source of data for audit and will underpin pioneering research to find cures for complex and rare conditions.

The platform will allow us to keep pace with our peers regarding recruitment to clinical trials and also enable GOSH to capitalise on future digital developments such as artificial intelligence and advanced clinical decision support, underpinning research studies for many years to come.

FUTURE PROOF

ELECTRONIC
PATIENT RECORDS

Part 1:

A statement on quality from the Chief Executive

At GOSH, we are committed to fostering a culture of continuous improvement in everything we do. The *Quality Report* details our performance in the year's key improvement projects aligned to our three quality priorities:

- **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 identified in a number of ways. Issues may be flagged via staff, internal or external audit or review, or via any of the myriad 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 our reportable healthcare targets set by NHS Improvement.

After considerable work to overhaul our processes and systems for data collection, I am pleased that we are now able to report referral-to-treatment (RTT) times (since January 2017) and for every month of quarter 4 2017/18, we met the national target of treating 92 per cent of patients within 18 weeks.

I am proud of the further progress made this year to identify and prevent deterioration in our young patients. This programme of work continues to draw together expertise from across the Trust, supporting our teams to deliver the excellent quality of care our patients deserve.

Safety

The Sepsis 6 protocol at GOSH was introduced last year to increase timely recognition and treatment of sepsis. This year we developed and launched an app to allow staff to complete the protocol electronically. For sepsis, we know that swift action is vital, so it is encouraging to see that with the app there have been continued improvements in actions being taken within one hour. To continue greater visibility of patients at risk of sepsis, an alert has been developed which links to the relevant ward's electronic patient status at a glance (ePSAG) board to notify the clinical team of any patient who may be at risk of developing sepsis, and our Clinical Site Practitioner team has a Trust-wide sepsis list to ensure they are informed and aware of those patients at risk.

Following our previous audit of neonatal care, we have continued to focus on the areas highlighted for improvement. As our neonatal patients can be located across more than 20 different wards, many teams and wards are involved in their care and it is key that our systems are coordinated. We have developed a real-time report to identify where neonates are in the hospital at any time, and streamlined the admission processes, which includes an automated prompt to alert the nursing leads when a baby on their ward is eligible for screening, reducing the risk of missing patients who need a bloodspot test. As a result of our efforts, we have seen an increase in the percentage of babies admitted who had a bloodspot test within the required timeframe from an average of 93 per cent to 98 per cent.

As so many specialties and teams are involved in caring for our neonates, education and training for all these teams is critical. This year we launched a programme of neonatal education, including the appointment of a dedicated neonatal practice educator to deliver face-to-face training, an online hub for standardised resources, and e-learning modules in neonatal jaundice and bloodspot screening. Following these interventions, we have seen a sustained improvement in how we manage neonatal jaundice.

For many of the children who come to GOSH, one of the most daunting experiences of their stay is when a needle needs to be introduced to draw blood or give medication. This anxiety and fear can lead to distress which further intensifies their pain and can interfere with their procedure. If ongoing venous access such as a peripheral cannula is required, there is also a risk of extravasation, which is the inadvertent leakage of a medicine or fluid from its intended vein into the surrounding tissue. This has the potential to cause severe tissue injury or necrosis. To improve the safety and experience of our children and young people, we have developed a paediatric version of the national Vessel Health and Preservation Framework, and over the next year will be implementing it across all of our clinical areas.

Clinical effectiveness

In 2016 we developed the Clinical Outcomes Hub. This year, we focused on expanding its use to more clinical teams, developing dashboards of the key clinical measures for their services. This data enables clinical teams to more readily use this information in decision-making, to notice trends, and for service improvement.

As demand for our services remains high, we need to rise to the challenge of ensuring that we have sufficient capacity to see and treat all the patients that need our care. This means very careful management of patient flow through the hospital and back home or to local hospitals. Only then can we keep waits for treatment as low as possible and ensure operations are only rescheduled for clinical reasons.

This year we found that optimum decision making around how patients should be best managed was being hampered by incomplete or out-of-date information. There were multiple systems for providing key data such as current bed occupancy, expected admissions, and discharges. Over the last year a team of expert users from across the Trust has come together to redesign our systems. They developed a single source that captures all necessary information and improves the management of our patients and services. We also increased on-the-ground support to surgical specialties by expanding the operational team who were tasked with helping problem solve in real-time and better coordinate services. I am pleased to say that these initiatives have already seen results with on-the-day cancellations falling from an average of six per week in 2016 to two per week since January 2018.

In 2018/19 we will be working to improve the early recognition of deteriorating children and young people through the electronic Paediatric Early Warning System (PEWS), a score-based system which uses a combination of factors, such as physiological findings, escalation responses and a strong communication framework, to identify potential deterioration.

Experience

The views of our patients and families are paramount in informing the continual improvement of clinical and support services across GOSH.

Many of our patients have conditions that impact on their lives beyond their time being cared for at GOSH. We therefore have a duty to ensure that the transition from paediatric to adult services is as positive an experience 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 focused on developing our *Growing Up, Gaining Independence* programme to ensure it meets the needs of all young people regardless of which specialty or specialties provide their care. We are now rolling this out across the Trust and over the next year we will be working to embed the programme into practice, aiming for all patients aged 12 and over to be started on the *Growing Up, Gaining Independence* programme.

We also know that the quality of our food is something that matters to our patients and families, and it is important to us that we provide food that is nutritious and appropriate for our patients. We have taken into account feedback from a range of sources to adapt our menus and increase the variety and flexibility of our menus. We will continue to work to improve the options for our patients, including new ways of ordering and food packaging as well as menu choice by age and variety.

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 Report 2017/18*, there are a number of inherent limitations that 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 this document is accurate.



Peter Steer
Chief Executive

Part 2a:

Priorities for improvement

This part of the report sets out how we have performed against our 2017/18 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 2008 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 patient care that is amongst 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 wish 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

To learn about the opening of the Premier Inn Clinical Building as part of our hospital site redevelopment work, see [page xx](#) of the GOSH Annual Report 2017/18

Reporting our quality priorities for 2017/18

The six quality priorities reported for 2017/18 are:

Safety

- Improving sepsis awareness
- Improving the quality and safety of care for inpatient neonates and small infants

Clinical effectiveness

- Developing Trust-wide access to outcomes data through the Clinical Outcomes Hub
- Optimising our capacity to improve patient access and flow

Experience

- Improving our young people's and their parents' and carers' experience of transition to adult healthcare services
- Improving the quality of our food

In this section, we report 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

Immanuela, age 13.

SUNRISE
MEDICAL

Improving sepsis awareness

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 of sepsis. Research shows that for every hour of delay in treatment of a septic patient, mortality increases by 7%.

What we said we'd do

Having developed and implemented a new sepsis protocol in 2016/17 to increase timely recognition and treatment of sepsis in our patients, we said that in 2017/18 we would build on this work by:

- Ensuring all first-line antibiotics are stocked on every ward so that they can always be delivered within the first hour.
- Incorporating 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.
- Providing further education to ward areas to overcome specific challenges in delivering the Sepsis 6 protocol in one hour.
- Raising greater awareness among parents through leaflets given post-surgery and in outpatients and via general communications on the hospital website.

What we did

Initially the Sepsis 6 protocol was introduced as a paper-based tool and data collection was manual and time-intensive. To improve this process, we began developing an in-house Sepsis 6 app which would allow staff to complete the Sepsis 6 electronically using their ward devices, and for Trust-wide data to be collected in a central database. This significantly improved the opportunity for data analysis and for support and further education to be directed to the wards that needed it most. The app was launched across the hospital in September 2017. Since the launch of the app, we have seen an improvement in the timeliness of the Sepsis 6 bundle delivery within one hour and the level of documented decision-making amongst the clinical teams.

While the Sepsis 6 app allowed for some improvements once sepsis risks had been identified by staff, further support was required for staff in first recognising the patients who may be at risk of developing sepsis. Utilising the patient observation data we have available through our electronic system, we began creating and testing an algorithm that would auto-search the observation data for the risk signs of sepsis.

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 if applied within the first hour of presentation can double the chances of survival. They are the following:

1. High flow oxygen
2. Obtain intravenous (in to vein)/intraosseous (in to the bone) 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.

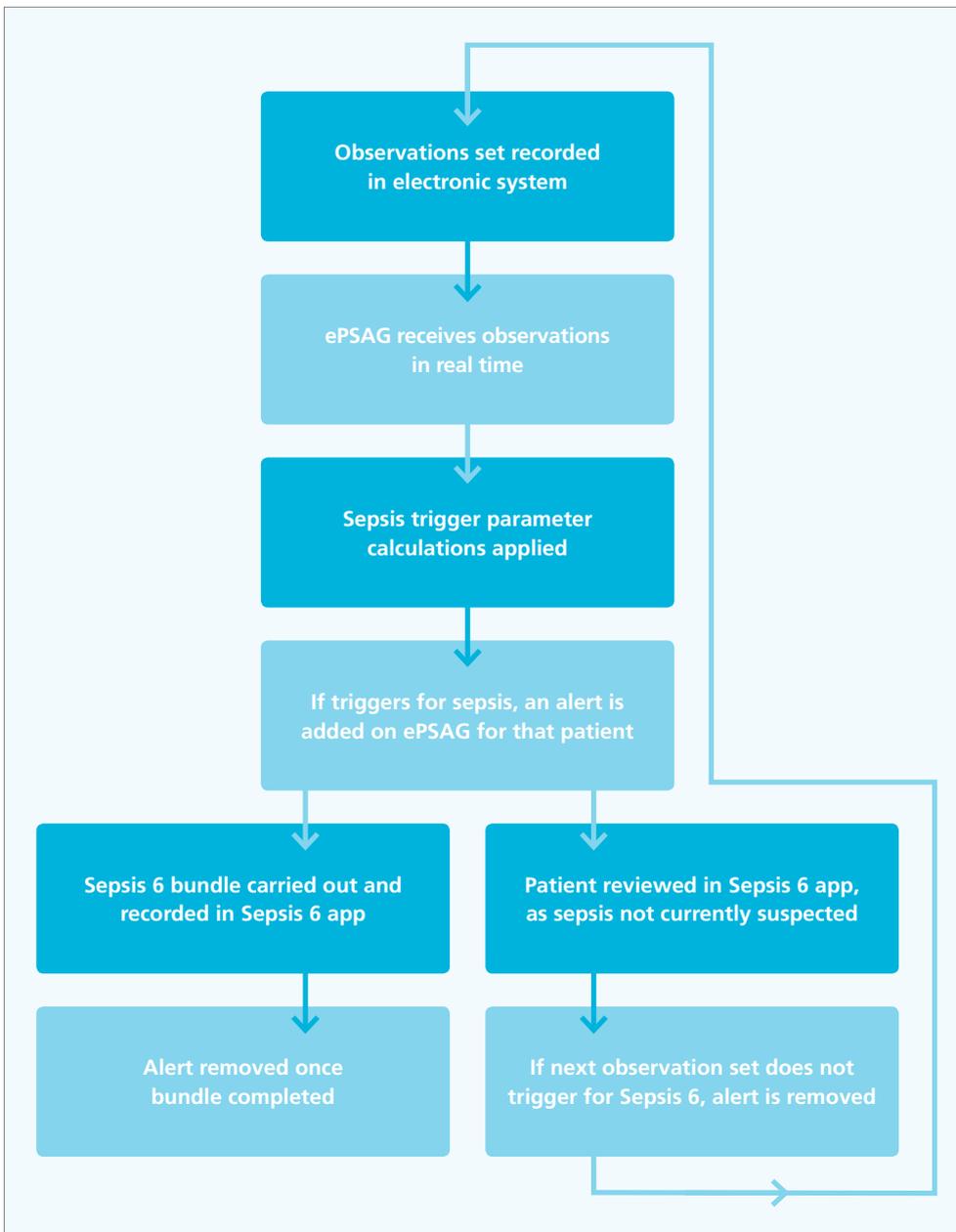


¹ National Confidential Enquiry into Patient Outcome and Death (2015) Sepsis: Just Say Sepsis! London: NCEPOD. Available online at www.ncepod.org.uk/2015report2/downloads/JustSaySepsis_FullReport.pdf [Last accessed April 2018].



Risk factors found by the system then flag an alert on the relevant ward's electronic patient status at a glance (ePSAG) board to notify the clinical team of any patient who may be at risk of developing sepsis so they can initiate clinical review without delay. The alert was then linked to any data inputted on the Sepsis 6 app so it would change colour or be removed from ePSAG when a Sepsis 6 bundle was completed or when sepsis was ruled out by the clinical team. After testing on three pilot wards, the alert was rolled out across all wards in November 2017. This has ensured greater visibility of patients at risk of sepsis on each individual ward. In addition, a Trust-wide 'sepsis list' was developed for our Clinical Site Practitioner team in the new clinical operations room, to ensure their oversight was supported by our technology.

Screenshot of Sepsis 6 app.



Electronic alert process for suspected sepsis.

In addition to the implementation of sepsis alerts on our electronic patient observation system, we have also made the following improvements:

1. All first-line antibiotics are now stocked and easily accessible on every ward to ensure that there is no unnecessary delay in patients receiving the antibiotics they need within one hour of recognition that they may be at risk of sepsis.
2. A comprehensive sepsis training package is now a required competency for all clinical staff at GOSH. Facilitated simulation training sessions are now available to any ward that requires further education to overcome specific challenges in delivering the Sepsis 6 protocol. Ward-level and specialty-level dashboards have also been created to enable teams to look at their recognition and management performance and to highlight areas for improvement.
3. At the point of discharge, all families at GOSH receive an information leaflet about the signs and symptoms of sepsis with their discharge summary. This, alongside information on our hospital website and social media accounts, aims to raise greater awareness amongst the public of what sepsis is, how to spot it, and what to do if you have a concern.

"The introduction of the Sepsis 6 pathway has provided a structured approach in recognition and management of the septic child. It is straightforward to use for staff of all levels, and ensures that our patients receive the appropriate care in a timely manner."
*Practice Facilitator,
 Barrie Division*

What the data shows

Sepsis 6 protocols completed within one hour

The current international average for completing the Sepsis 6 protocol within one hour is 47%². Figures 1-3 demonstrate compliance with the protocol, which is significantly above the international average since it has been rolled out to all inpatient areas. The improvements have sustained with the highest percentage of Sepsis 6 protocols completed within one hour for 2017/18³.



One Team



TECHNOLOGY

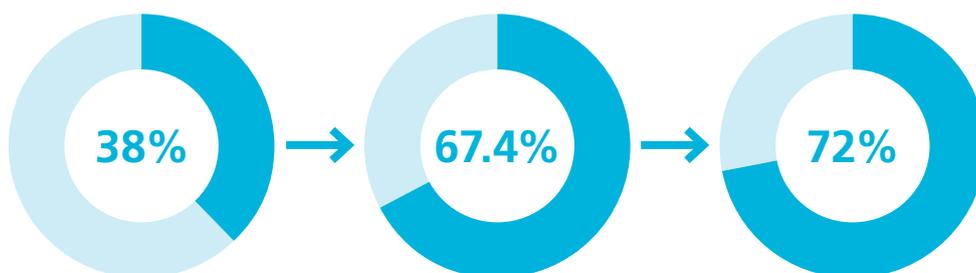


Figure 1: Sepsis 6 protocols completed within one hour in the pilot areas (Squirrel, Elephant, Lion and Giraffe Wards) from September 2016 to January 2017.

Figure 2: Sepsis 6 protocols completed within one hour in all inpatient areas (including ICUs) from January to March 2017.

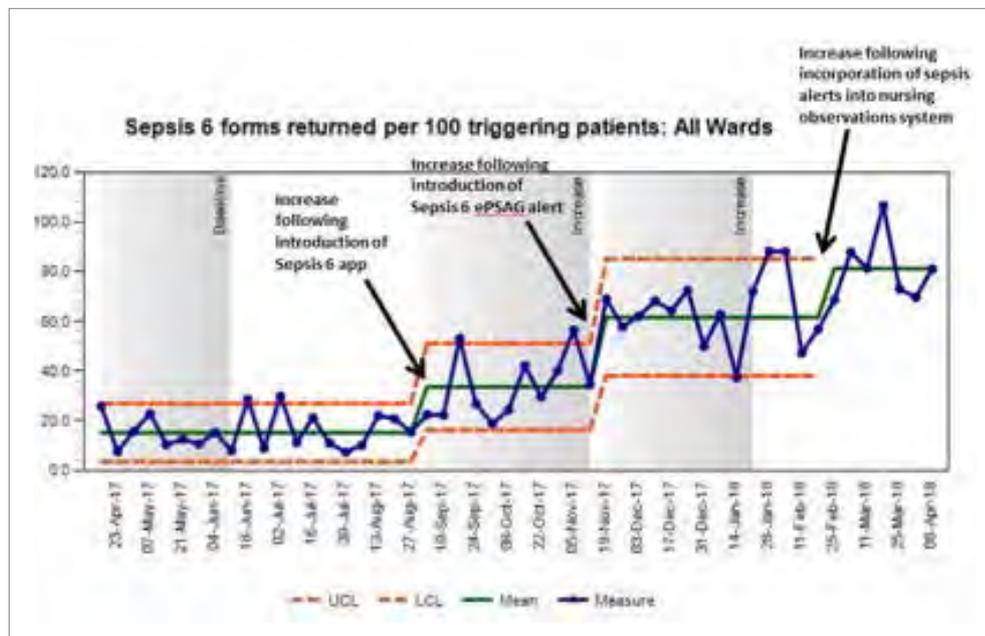
Figure 3: Sepsis 6 protocols completed within one hour in all inpatient areas (including ICUs) from April 2017 to March 2018.

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.

³ The indicator applies to children who are inpatients on wards that use the electronic observation system.

Sepsis 6 forms returned per 100 patients that met the risk criteria

An average of 62% of patients on the ward who met the risk criteria from November 2017 to February 2018 were screened for sepsis. The average increased to 81% from late February 2018 and has sustained for the last seven weeks. The annotated SPC chart below shows the improvements made and the data from the past year:



What's going to happen next?

This improvement work has now become 'business as usual' and is managed by each clinical division. There is a nominated Medical Sepsis Lead for the Trust to ensure capacity to respond to any further national guidance that is published and to ensure best practice is reflected here at GOSH. The hospital successfully delivered a CQUIN focused on sepsis and antibiotic use in 2017/18 and agreement has been made for a further CQUIN in 2018/19 to continue to support this important work.

How this benefits patients

Earlier detection of patients at risk of developing sepsis:

- Reduces potential harm and risk of mortality
- Reduces likelihood of a prolonged hospital admission due to a sepsis-related complication
- Can reduce a patient's course of antibiotic treatment

What is a Statistical Process Control chart?

Statistical Process Control (SPC) charts are used to measure variation and improvement over time.

Importantly, SPC takes into account natural variation of data, which, if acted upon without analysis, is an inefficient approach to improvement work. Upper control limits (UCL) and lower control limits (LCL) are calculated to help with data analysis. SPC methodology enables us to focus on 'special cause' variation, which identifies areas that require further investigation and action.

What is a baseline period?

A baseline is the period of measurement to establish 'how things are' before changes are made to a process, to enable comparison 'before' and 'after'. An average (mean) of the data from the baseline period would be used for that comparison.

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 as part of the discussion between service commissioners and providers, and constitutes 2.5% of the Actual Contract Value between commissioner and provider.

Improving the quality and safety of care for inpatient neonates and small infants

When babies are born very prematurely, or with a complex medical or surgical condition, they may require specialist or intensive care at GOSH. We don't have a dedicated neonatal ward, as babies are admitted to the most appropriate ward to provide the expert care they require. This means our neonatal patients can be located across more than 20 different wards, so it is really important that we coordinate our neonate care across wards to deliver the care every newborn baby needs, in addition to the specialist input they receive for their condition.

What we said we'd do

We said we would improve the quality and safety of care for inpatient neonates. This work was in response to findings from a clinical audit of our neonatal care, which identified three key areas for improvement:

- Reduce the numbers of avoidable repeat samples for bloodspot screening, and ensure every baby at GOSH eligible for screening receives this within the required timeframe so any serious conditions can be diagnosed and treated in a safe and timely manner.
- Ensure ward staff are able to effectively identify and manage the treatment of babies with neonatal jaundice in line with evidence-based practice.
- Raise awareness of the importance of neonatal fluid management and provide a standardised approach for babies.

What we did

We set up a project team led by the Consultant Neonatologist and Neonatal Nurse Advisor to implement improvements in the areas identified and standardise neonatal care across the hospital.

To help the neonatal team identify where neonates are in the hospital, we developed a real-time report on the intranet, using data from our patient information system that highlights current inpatient neonates and details such as age and weight.

We streamlined admission processes for neonates to ensure staff are able to access the demographic information required to complete bloodspot screening.

An automated prompt system was introduced that alerts the nursing leads when a baby on their ward is eligible for screening. This helps reduce the risk of missing patients who need a bloodspot test.

A comprehensive programme of neonatal education was launched to improve medical and nursing staff skills in the key areas of focus. This included the appointment of a dedicated neonatal practice educator to deliver face-to-face training, information folders on every ward and an online hub to improve staff access to standardised resources. E-learning modules in neonatal jaundice and bloodspot screening have been developed, aimed at both medical and nursing staff.

A Trust guideline for the management of neonatal intravenous fluids has been developed and implemented with specialty, pharmacy and neonatal leads. This has improved standardisation of care, although on-going work is needed to raise awareness of the importance of neonatal fluid management.

A new neonatal care pathway was developed for use on each ward so every infant receives the required neonatal care and screening at the right time. A standardised process for documentation means staff are better able to confirm that neonates have received the care they need.

We held 'Neonatal November', an awareness-raising month, across the hospital to highlight the core aspects of neonatal care and promote the new resources and training opportunities. This was delivered through information stands and drop-in teaching sessions for staff and parents.

What is a neonate?

'Neonate' means newborn – a full term baby under 28 days, or a baby born at less than 37 weeks gestation until they have reached a corrected gestational age of 44 weeks.

What is bloodspot testing?

Bloodspot testing is carried out as part of the national newborn screening programme when a child is 5 to 8 days old, to ensure early detection of nine rare but serious conditions. All newborn babies at GOSH in specialist care are tested if this has not already happened prior to their admission so any conditions can be diagnosed and treated in a safe and timely manner. If the original sample doesn't meet requirements due to practitioner error or delays in testing, repeat samples are sometimes required. This is referred to as an 'avoidable repeat'.

What is jaundice?

Jaundice is the medical word used to describe a yellowing of the skin and white parts of the eyes due to high levels of bilirubin, a waste product formed from our blood. Neonatal jaundice is a very common condition, particularly in babies born prematurely. In the majority of cases, jaundice is harmless and fades without treatment. A very small number of babies can develop more significant jaundice that requires treatment.



Expert

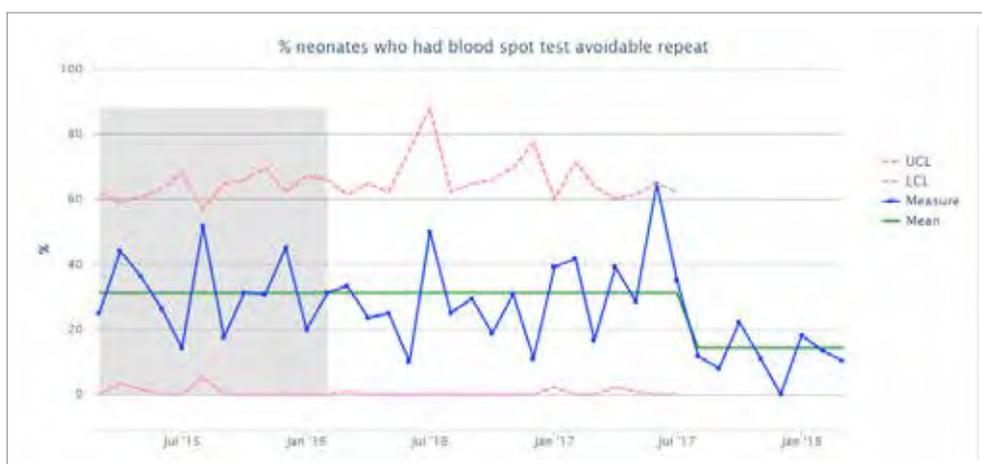
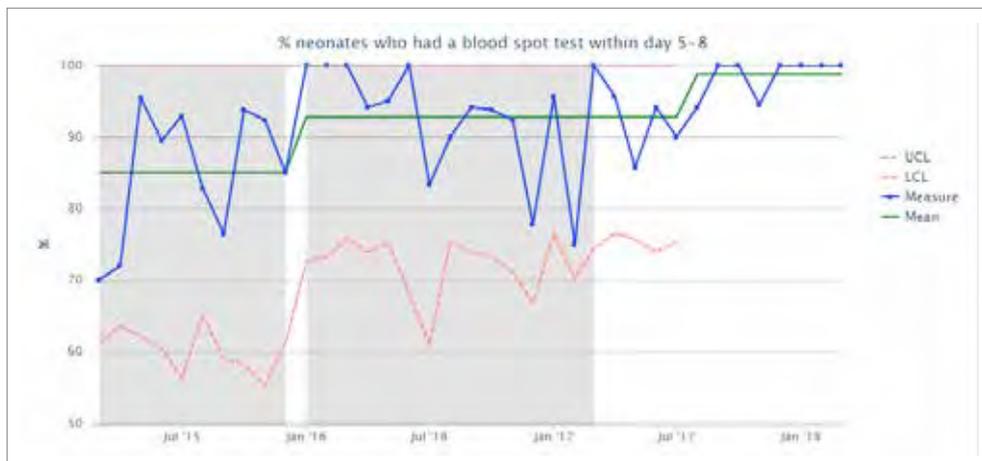


CARE

What the data shows

The neonatal nurse advisor reviews every case of neonatal jaundice to identify whether it has been managed in line with evidence-based guidelines. We have seen a sustained improvement in how we manage neonatal jaundice, increasing from an average of 62% of neonates managed in line with National Institute for Health and Care Excellence (NICE) guidelines to 80% since June 2017 following the introduction of the new education package.

We have seen an improvement in the percentage of babies admitted who had a bloodspot test within the required timeframe, increasing from an average of 93% to 98%. We have also decreased the percentage of neonates who required an avoidable repeat screening from an average of 31% to 11%.



What's going to happen next?

We will continue to monitor our data closely to make sure improvements are sustained. The project was completed in March 2018. Each ward is now operationally responsible for ensuring they have skilled staff able to deliver safe neonatal care using the new resources and education package.

Compliance with the new fluid management guideline was audited and further work will be carried out by individual wards to improve awareness and education in the areas identified.

We are currently developing an electronic solution to help reduce the risk of errors when plotting babies' bilirubin blood results onto treatment charts. We plan to launch this in the summer 2018.

How this benefits patients

- Timely identification of infants requiring treatment
- Reduction in the risk of potential harm through standardisation of care
- Ward staff better supported to provide safe neonatal care

Why is neonatal fluid management important?

Fluid and electrolyte therapy can play an essential role in caring for unwell children. The physiology of premature and newborn babies means they have higher total body water content than older children, particularly in their first month of life, which means their fluid therapy needs to be managed differently.

What is the National Institute for Health and Care Excellence (NICE)?

NICE provides national guidance and advice to improve health and social care in England and the rest of the UK.

"The new 'Current Neonates' report makes it so much easier for me to see where all the neonatal patients are around the Trust at a glance. Access to additional information such as current weight is especially useful when I am trying to look for premature infants and has helped me ensure they are receiving the care and screening they need."
Neonatal Nurse Advisor

"This work has made a huge difference to the care of the neonatal patient at the hospital. There have been significant improvements in compliance of both the management of neonatal jaundice in line with best practice guidelines and newborn bloodspot screening as a result of the project."
Consultant Neonatologist

Clinical effectiveness

Developing Trust-wide access to outcomes data through the Clinical Outcomes Hub

Clinical outcomes are broadly agreed, measurable changes in health or quality of life that result from healthcare. Clinical outcomes data is essential to the understanding of treatment effectiveness and efforts to improve clinical care.

Here at GOSH, every specialty collects outcomes data and many teams have published their outcomes to the Trust website. But, we also strive for greater visibility of outcomes data *within* the hospital, to enable our clinical teams to more readily use that information in decision-making, to notice trends, and for service improvement.

What we said we'd do

We said that by working closely with our specialties, we would develop our Clinical Outcomes Hub to display effectiveness data within the hospital in ways the clinical teams found most informative. We said that wherever possible, we would establish direct data feeds to enable these dashboards to update automatically.

What we did

In 2016, the Clinical Outcomes Hub platform was built and existing content was migrated to it, including charts of readmission rates for surgical specialties and a range of resources for clinical staff who wanted to make their outcomes data electronically available.

In 2017/18, we focused on working closely with clinical teams to develop dashboards of key clinical measures for their services. The work was underpinned by a commitment to the clinical teams to make their data available to them in ways they found most useful. This meant taking an iterative approach with each team until we had it right – both in terms of data analysis and in terms of visual display. In this past year, we have developed bespoke dashboards for the following services:

- **Neurosurgery**
Adverse event rate by severity grade and by sub-specialty, surgical site infection rates, non-elective readmissions, shunt infections and early shunt re-operations.
- **Specialist Neonatal and Paediatric Surgery**
Non-elective readmissions, unscheduled returns to theatre, inguinal hernia repair re-do surgery, surgical site infections, and also a link to the Friends and Family Test data for patient experience.
- **Child and Adolescent Mental Health**
A range of 15 clinician, parent/carer and patient-reported outcome measures.
- **Urology**
Non-elective readmissions, pyeloplasty revision surgery, hypospadias repair revision surgery, primary closure revisions and bladder neck reconstruction revisions for bladder exstrophy, unscheduled returns to theatre after stones procedures, surgical site infections, and also a link to the Friends and Family Test data for patient experience.



Clinical Outcomes Hub homepage.



Specialist Neonatal And Paediatric Surgery – Inguinal hernia repair recurrence rate.

What is the Clinical Outcomes Hub?

The Hub provides a one-stop-shop for:

- Information about the outcomes programme
- Outcomes dashboards
- Links to a range of data input tools
- Access to GOSH's national Specialised Services Quality Dashboard reports
- Links to outcomes on the Trust website

What are PROMs?

Measures of treatment outcome from the patient's perspective are called patient-reported outcome measures (PROMs). PROM questionnaires are important because they bring the patient voice to the understanding of treatment effectiveness.

"Having data from our departmental database presented on the Hub means we can easily refer to the figures. The dashboard updates automatically, so we have the most recent data at our fingertips without taking staff time to prepare it for meetings. The outcomes team also worked with us to ensure that the data was presented in ways that were most meaningful to us as a clinical team, enabling us to spot trends quickly."
Mr Martin Tisdall, Consultant Paediatric Neurosurgeon

We also worked closely with the Infection Prevention and Control Team to upload and display data that is collected by the Trust-wide Surgical Site Surveillance (SSI) Programme. The programme collects and analyses the incidence and severity of surgical site infections to inform ongoing work to reduce their occurrence. This data is now part of the dashboards that we've developed for the surgical specialties.

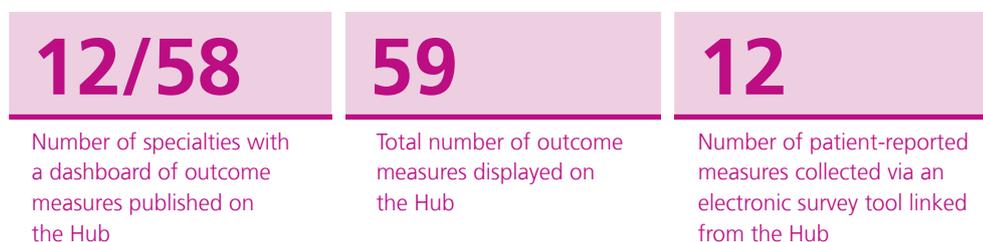
Wherever possible, we've created links to data sources so that the data is refreshed automatically, saving staff time within services and ensuring the data is always up-to-date.

Working in partnership with another project, we've linked to an electronic survey tool, built to capture a range of information by questionnaire. We've built several PROMs within this system, to enable clinical teams to collect outcomes data from the patient or family perspective using electronic handheld devices. For three services, we've created an interface on the Clinical Outcomes Hub that links to the survey tool, enabling a single point of access for outcomes data collection.



Landing page for collection of Craniofacial outcomes data sets.

What the data shows



What's going to happen next?

- We will continue to add specialties' data to the Clinical Outcomes Hub, developing bespoke dashboards for all.
- Working in partnership with the Infection Prevention and Control Team, we will publish more SSI data to the Hub.
- We will increase the number of PROMs collected on the electronic survey tool via the Hub interface, with the aim to double that figure in the next year.
- We will work with the Electronic Patient Record programme team to ensure that all centrally-collected outcomes data is displayed on the Hub.
- We will develop a questionnaire for staff to discover what they find most – and least – useful about the Hub and what else they would like to be available on the Hub.

How this benefits patients

Visibility of outcomes data:

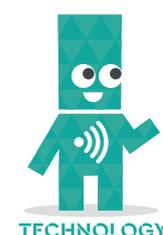
- Supports clinical care
- Enables detection of trends for clinical learning or action
- Promotes openness and collaboration for patient benefit
- Presents opportunities for research and development

"As a surgeon on the international working group that agreed a standard set of outcome measures for craniofacial microsomia, I wanted to see us implement this data collection robustly. The sets incorporate detailed clinical assessments, parent-reported outcome measures and patient-reported outcome measures. The implementation had to be in a workable and inviting format for our very busy clinic, so data collection on paper was not an option. We worked closely with the outcomes team and QI analyst/developers to translate the outcome measures into electronic sets, available on an in-house survey tool. Now, we're collecting rich and complete data that will build our knowledge of treatment outcomes for these conditions, and inform future research. This has been an exciting project to lead with exceptional and inspiring results from the Outcomes Team."

Ms Justine O'Hara, Consultant Craniofacial and Plastic Surgeon



Expert



Optimising our capacity to improve patient access and flow

With high demand for our care comes the challenge of managing patient access and flow through the system. We must ensure that the practical aspects of complex healthcare are well-managed so that waits are as low as possible, operations are only rescheduled for clinical reasons, and we can accept as many patients as possible who need our care.

What we said we'd do

We said that in 2017, we would launch the patient placement programme to explore and deliver system adjustments to improve efficiency and optimise capacity.

What we did

In the first few months, we learned that our ability to make excellent operational decisions was hindered by information that was often out-of-date or incomplete. This was because our systems for capturing and monitoring current bed occupancy, expected admissions, transfers, discharges and staffing levels for 'today, tonight and tomorrow' were an assortment of paper, spreadsheets and local databases. This meant that there was duplication, and that the complete picture was not available from any one source.

To address this, we brought together a group of expert users including bed managers, ward nurses, admission coordinators and information analysts to redesign our systems. The focus was on reliably capturing all necessary information electronically, in a timely manner, and in one system.

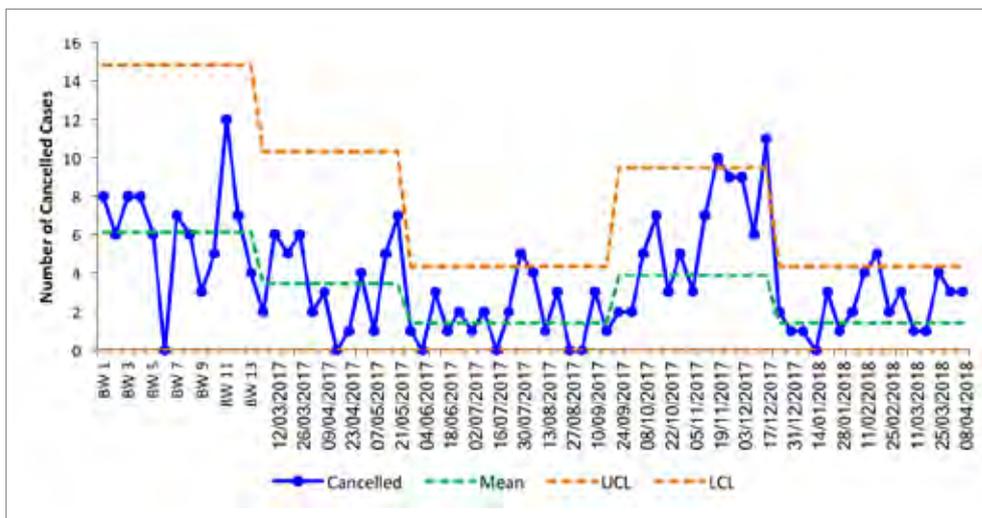
We also expanded our operational team to provide more on-the-ground support to the surgical specialties, to problem-solve in real time when issues arose, and to act as a coordinator to meet different clinical teams' priorities for their patients.

Through strengthening our operational team and developing a system to support day-to-day management of patient admissions, transfers and discharges, we have been able to treat more children and young people and reduce the number of patients we have had to reschedule at short notice.

What the data shows

1. Number of on-the-day elective operation cancellations for bed capacity reasons

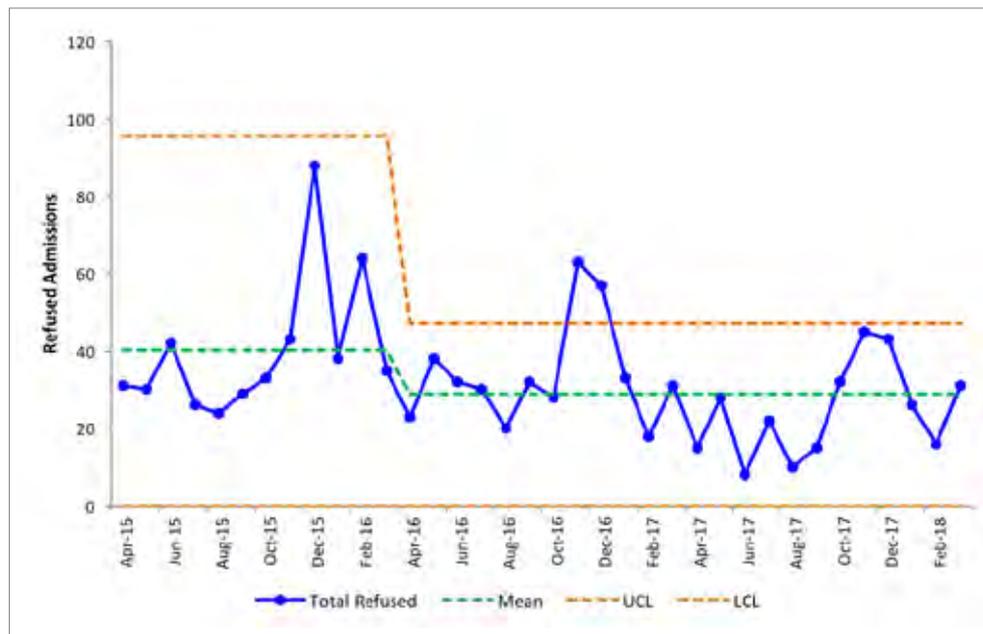
On-the-day cancellations of elective operations have fallen from an average of 6 per week in the best performing weeks (BW) of February to May 2016, down to an average of 2 per week since January 2018.



"Having the planned admission lists in a standard format and available electronically is good for both our patients and our staff. Nursing teams report that now they have the right information to hand to place the patient on the ward that best meets their individual needs and in turn deliver the most appropriate care."
Clinical operations manager

2. Number of clinically appropriate emergency referrals refused for non-clinical reasons

The data shows that the average refused admissions for non-clinical reasons was 40 per month for April 2015 to March 2016. The average reduced to 29 refused admissions per month from April 2016. Though there has not yet been a further reduction in refused admissions according to SPC methodology, there has been a clear reduction in seasonal variation, with the lowest number of refusals in the high-demand winter months for 2017/18.



“The introduction of the clinical operations managers has markedly reduced the time taken to transfer a patient to another care provider when the provider is declaring they have no capacity to admit. As this liaison role was traditionally done by the nurse in charge on the ward, this has enabled nurses to focus on what they do best – providing clinical care.”
Bed manager



One Team



INFORMATION

What's going to happen next?

In 2018/19, we plan to extend our work with the electronic solution. We will build an Operational Hub, which will be a dedicated system where the operational teams can view real-time information across the whole hospital to support their decision-making. Once the Operational Hub is established, we will work closely with the Trust's Electronic Patient Record implementation team to maximise the benefits of a dedicated system and environment. We will also use the latest data science techniques such as predictive analytics to help us better plan our admission lists and staffing rosters.

How this benefits patients

- Fewer referrals refused
- More patients treated
- Fewer same-day cancellations of surgery

Experience

Improving our young people's and their parents' and carers' experience of transition to adult healthcare 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 in recent years. In 2016, NICE published the guidelines, *Transition from Children's to Adults' Services for Young People Using Health or Social Care Services*. One of the underlying principles is that young people should start to be prepared for adult health services by the age of 14 at the latest.

As a stand-alone paediatric hospital providing highly specialised care, this presents a challenge for GOSH. It is not always clear by this age whether transfer to specialist adult health services will be necessary. In addition, some young people move to dedicated adolescent services located in other Trusts. In doing so, they may encounter similar challenges as those who move to adult services (including different environments, procedures and personnel) and consequently have similar preparation needs. In our transition improvement work, we wanted to follow the NICE guidelines as well as find solutions to the mix of challenges we face.

What we said we'd do

We said that we would:

- 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.

NICE guidelines describe transition as the preparation of a young person for adult services. The age at which specialist children's services finish and adult services start is sometimes determined by service commissioning and/or geographical location.

List of transition circumstances GOSH is involved with:

1. GOSH patients who move to dedicated adolescent services usually move to a different hospital.
2. GOSH patients are often under more than one specialist team.
3. Adult services may be located in different hospitals, and the age of transfer can be different.
4. There are specialist services that exist at GOSH without a directly comparable adult service.
5. Some young people attend GOSH for:
 - a. A course of treatment and are then discharged back to primary care. This can occur at any age.
 - b. Diagnostic tests only; results will determine the need for ongoing care at GOSH.
 - c. Second opinion only.
6. Referrals received after the age of 14 can follow any of the above pathways. NICE states that transition must start by the age of 14 at the latest.
7. Some young people are seen at GOSH several times each year; others are seen only once each year.

The complexity of transition needs at GOSH.

⁴ 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.

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, 1993⁴.

"I used the Part One information sheet in clinic. I found it a very useful prompt and easy to use. It was well received by the young person and his mother."
GOSH clinician

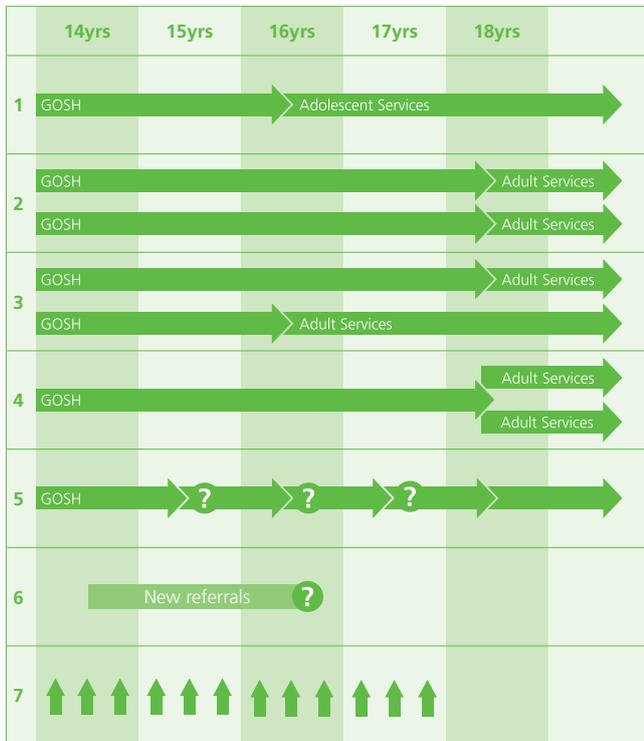
"This is really helpful. I really hadn't thought about any of this."
Parent after receiving the GUGI information sheet

"This will really make a difference. I wish GUGI was around when I was being transitioned."
Transition Improvement Steering Group member, 21 yrs



Welcoming





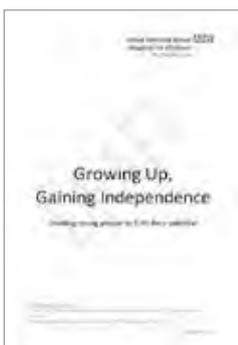
Variety of transition types and timings.

We knew from our mapping of the transition circumstances our patients face, that we must ensure that any system we designed would work with this variety.

What we did

Following on from the work we began in 2016/17, we worked with young people, parents, carers and healthcare professionals to define minimum standards for all transition plans. These standards have been incorporated into a two-part programme entitled *Growing Up, Gaining Independence (GUGI)* that all young people at GOSH will be introduced to from the age of 12. GUGI will encourage and support all young people to become as independent with their healthcare as they can be. Part One of GUGI focuses on encouraging the development of life skills required by all young people regardless of whether they will transfer to specialist adolescent or adult health services. It will also inform them, and their parents and carers, of their changing legal responsibilities and entitlements. Part Two of GUGI will specifically prepare those who will, or might, need to transfer to specialist adolescent or adult healthcare services.

This year's work has focused on developing the GUGI programme and its supporting information to ensure it meets the needs of all young people regardless of which specialty or specialties provide their care. We focused our efforts on GUGI to build a strong and inclusive foundation that would meet the diverse transition needs of our patients.



GUGI is in effect a transition plan, but it replaces the traditional model. We have avoided using the term 'transition plan' to describe GUGI because of its wider purpose – to support and equip *all* of our young people, whether they transfer to other specialist services or not.

We established a Learning Disabilities Transition Steering Group with Barts Health NHS Trust, University College

London Hospitals NHS Foundation Trust, and Barking, Havering and Redbridge University Hospitals NHS Trust to explore the particular needs of our young people with learning disabilities and to share transition best practice across centres.

The Growing Up Gaining Independence (GUGI) programme has been developed to:

- Make all young people and their parents/carers aware of the skills and knowledge they need to engage with adult health care services.
- Support the young person to develop these skills.
- Prepare those who need to continue onto specialist adolescent or adult healthcare services.

New dashboards have been developed that allow staff to identify future clinic attendees. The dashboards show:

- How old the patient will be at the time of the appointment
- How frequently patients are seen each year (information essential for effective transition planning)
- If a patient is recorded as having a learning disability or additional need

As GUGI is rolled out across the Trust, we will also record and display who has started on the GUGI programme.

What the data shows

This chart shows the total number of people aged 12–19 years who had outpatient appointments at GOSH in 2017/18.

Age	Unique Patient
12	3911
13	3952
14	3735
15	3491
16	2795
17	1848
18	714
19	263
Total	20709

Over the same period, a total of 74350 patients aged 0-19 years were seen. Therefore, 28% of our patients were in the 12-19 age bracket. Not all of these patients will need to transition to specialist adult care but we recognise that the majority will need to engage with health services as adults.

What's going to happen next?

In 2018/19, the GUGI programme will be rolled out across the Trust and embedded into practice. The aim is for all patients aged 12 and over to be started on GUGI part one. Those older than 16 will commence on part two. We are currently developing further supporting information in a variety of formats (written, 'easy read' and video). Specialties are being supported to develop dedicated clinics for young people, which are designed to support their readiness for transition to adult healthcare services.

The Transition Improvement Project will run for a further year and we will report the coming year's progress in the *Quality Report 2018/19*.

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.

Improving the quality of our food

The quality of our food is important to us, whether hospital food delivered to our patients on the wards, or meals sold in our Lagoon restaurant for families, visitors and staff. Good food is a fundamental part of inpatient healthcare and is an aspect of NHS hospital services that has been commonly criticised.

What we said we'd do

Here at GOSH, we are committed to ensuring that the food we provide is nutritious, appropriate for our patients, and tasty. We also want to ensure sufficient variety, especially for those with longer hospital stays. We said we would listen to feedback by patients and families, our Young People's Forum, and by regulators, and that we would act to improve our food provision in the areas highlighted.

What we did

We examined feedback from a range of sources:

- Patients and families through our listening event in November 2016 and our Pals service data
- Young People's Forum
- Patient stories shared at our Trust Board
- PLACE assessments
- CQC reports

We found that the priorities for improvement were:

- Greater variety of food served
- Flexible mealtimes
- Maintain and improve nutritional value
- Maintain and improve flavour
- Ability to promptly provide information on ingredients when requested

Salt, sugar and saturated fat reduction

We adjusted our recipes and production methods in patient catering to reduce salt, avoid added sugar, and to use oils such as cold-pressed rapeseed, which are lowest in saturated fats.

We participated in a CQUIN scheme, Healthy Food for NHS Staff, Visitors and Patients, to effect change on the organisational behaviour and culture towards the food and drink sold at GOSH. Through NHS England's Healthy Workforce Programme, we also participated in a voluntary sales reduction scheme, to reduce the volume of sugar-sweetened drinks sold.

In retail catering, we have removed the majority of sugar-sweetened fizzy drinks and reduced to below 10% the overall sales of other sugar-sweetened drinks by offering alternatives. We no longer offer loyalty points on sweetened hot beverages and have also removed the 'extra sugar' option from all machine-vended hot beverages. Most confectionery has been removed from the till areas in our Lagoon restaurant.

Fresh alternatives and nutrition

Fresh fruit is displayed prominently in The Lagoon. There is now a daily fresh salad bar. In May 2017, a weekly 'theme bar' was established, offering a range of additional freshly-prepared meal options. Themes include: Lebanese; Vietnamese; Italian; Indian; 'Yum Buns'; and the 'Naked Detox' range. Theme bar meals offer a variety of freshly prepared salads as well as raw toppings, all included in the price.

Information about ingredients

We are better able to provide this information when asked. However, it is still done in response to requests, rather than provided as standard. We will include details of ingredients on all our new menus, which we plan to introduce in 2018/19.

What is Pals?

The Patient Advice and Liaison Service (Pals) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers, and are available in all NHS hospitals.

What is the Young People's Forum?

The Young People's 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 meet 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.

What is a PLACE assessment?

Patient-led assessments of the care environment (PLACE) began nationally in 2013.

'PLACE assessments put patient views at the centre of the assessment process, and use information gleaned directly from patient assessors to report how well a hospital is performing in the areas assessed – privacy and dignity, cleanliness, food and general building maintenance.'

NHS England

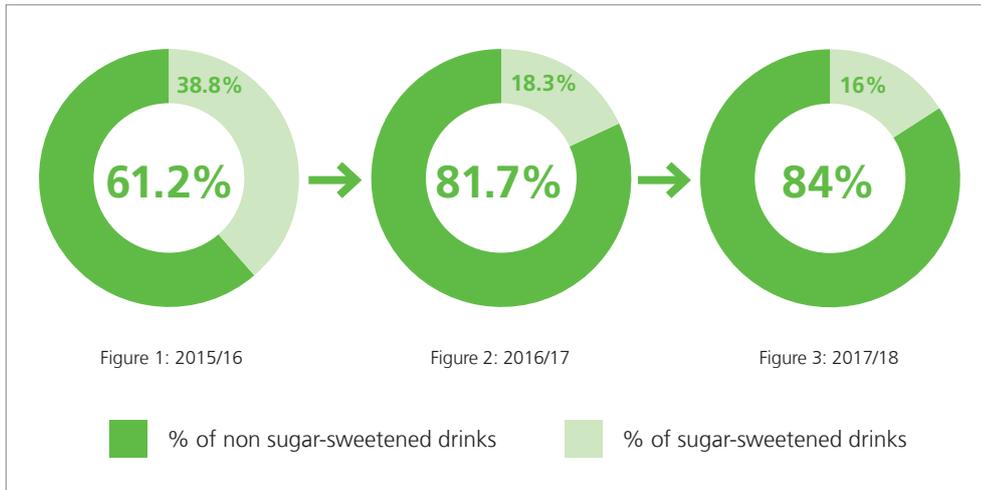
What is the CQC?

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.

What the data shows

Sugar sweetened beverages voluntary sales reduction

	2015/16		2016/17		2017/18	
	Count	%	Count	%	Count	%
Total sugar-sweetened	102118	38.8	51676	18.3	3811	16
Total non sugar-sweetened	161216	61.2	230611	81.7	20018	84

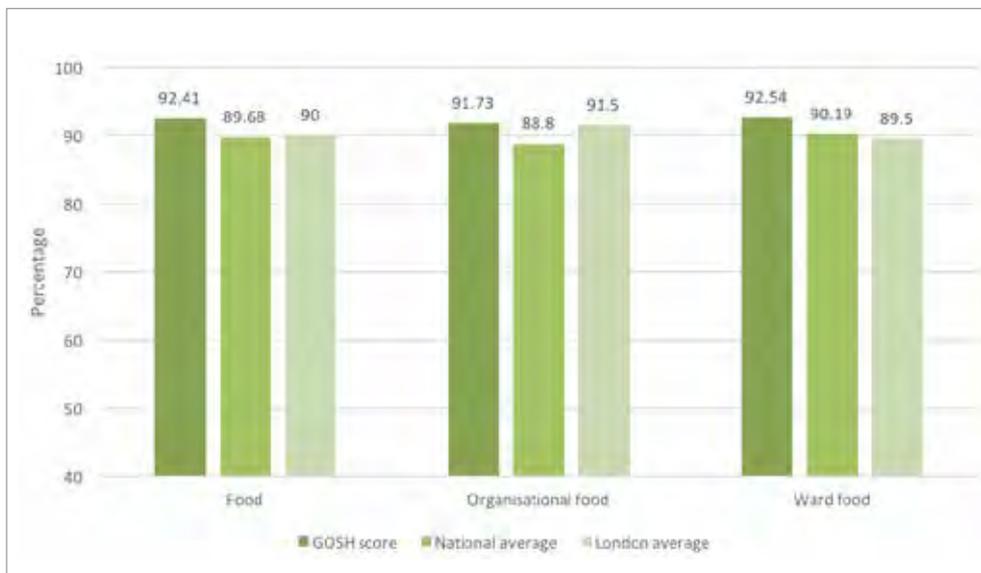


"I look forward to the theme bar days! The food tastes so good, and I end up eating a lot more raw vegetables than I ordinarily would in a working day."
Project Manager, Corporate Services

2017 PLACE comparative scores

Key:

- Food: overall food score
- Organisation food: organisational questions relating to the catering service e.g. choice of food, 24-hour availability, meal times and access to menus.
- Ward food: assessment of food at ward level including the taste, texture and appropriateness of serving temperature.



Source: NHS Digital

2017 PLACE results show that GOSH scores higher than both the national average and the London average for the three assessment components related to food. We still do receive feedback about areas for improvement by our families and patients, so despite good results from PLACE we are committed to an ongoing programme of improvements in our catering and retail food provision and management.

2018 PLACE results will be available after this report is published, and they will be used to inform ongoing improvements.

Feedback from inpatients and from visitors to the Lagoon



What's going to happen next?

- We're designing a set of menus by age group, working in partnership with the specialist paediatric dieticians to ensure that meals meet patients' nutritional needs as well as their tastes. New menus will include lists of ingredients.
- We are planning to provide ordering on iPad by picture as well as description.
- We are exploring options for personalised menus, where e.g. meals containing gluten are not offered for selection to a patient whose diet is gluten-free.
- We are going to adjust our protected meals times on the ward so they better meet the needs of all ages, with age-appropriate food available in between mealtimes as required.
- We are reviewing how our food is packaged, transported and served to the patient, to ensure hot food is served hot every time and to present food in ways that are more appealing.

How this benefits patients

- Better tasting, better quality food supports wellbeing
- More responsiveness to individual needs



Helpful



CARE

Arthur, age eight.

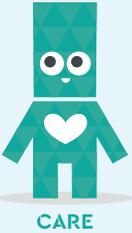


2018/19 Quality priorities

The following table provides details of three of the quality improvement projects that the Trust will undertake in 2018/19. 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 safety and experience of children and young people at GOSH when venous access is needed for their care.</p>  	<p>For many of the children who come to GOSH, one of the most daunting experiences of their stay is when a needle needs to be introduced into a vein to draw blood or give medication. This anxiety and fear can lead to behavioural distress which further intensifies their pain and can interfere with their procedure. If ongoing venous access such as a peripheral cannula is required, there is also a risk of extravasation, which is the inadvertent leakage of a medicine or fluid from its intended vein into the surrounding tissue. This has the potential to cause severe tissue injury or necrosis.</p> <p>To improve the safety and experience of our children and young people, GOSH developed a paediatric version of the national Vessel Health and Preservation Framework, and are systematically implementing it across all of our clinical areas.</p> <p>The framework supports staff to choose the right device, make sure the right procedure is considered based on the child's individual needs, help prepare the child and family for the procedure and, make sure the right person is performing the task.</p>	<ol style="list-style-type: none"> 1. Number of extravasation injuries referred to Plastics Team 2. The percentage of patients with more than two unsuccessful cannulation attempts before referral to Venous Access Team 3. Missed medication administration due to reason of 'no IV access available' <p>Progress is reported quarterly 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?
<p>Improving the early recognition of the deteriorating child and young person at GOSH through the introduction of the electronic Paediatric Early Warning System (PEWS).</p>  <p>One Team</p>  <p>INFORMATION</p>	<p>PEWS is a score-based system designed to identify potential deterioration in children and young people using a combination of factors such as physiological findings, escalation responses and a strong communication framework.</p> <p>It's designed to support clinical judgement and help reduce adverse patient outcomes by enhancing multi-disciplinary team working, communication, and confidence in recognising, reporting and making decisions about a child at risk of deterioration.</p> <p>Integrating PEWS electronically means clinicians are able to access live patient scores at both a ward and Trust level. This contributes to improved situational awareness and supports the early identification and prompt review of patients at risk of clinical deterioration.</p>	<ol style="list-style-type: none"> 1. Number of Cardiac and Respiratory arrests outside of ICU 2. The number of clinical emergency calls outside of ICU wards 3. The number of unplanned internal transfers to ICU by the CSP team 4. The number of Cardiac and Respiratory Arrests in high-dependency and non-high-dependency beds 5. The number of clinical emergency calls classified as 'not preventable' <p>Project progress is reported quarterly to the Quality Improvement Committee and Patient Safety and Outcomes 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?
<p>Improving our young people's and their parents' and carers' experience of transition to adult healthcare services.</p>  <p>Helpful</p>  <p>INFORMATION</p>	<p>Young people and their families consistently told us that they felt inadequately prepared for adult health services and unaware of the changing responsibilities and rights of young people.</p> <p>National Guidelines recommend that young people should start on a transition plan to prepare them for adult health services by the age of 14. For GOSH patients, it's not always clear at that age how many will need to transfer to specialist adult care.</p> <p>The Growing Up, Gaining Independence (GUGI) programme developed by GOSH is relevant to all young people aged 12 or above. It will better prepare young people and their families for their futures.</p>	<ol style="list-style-type: none"> 1. Numbers and percentage of young people aged 12–16 started on Part one of the GUGI. 2. Numbers of young people aged 12–16 started on Part two of the GUGI. <p>This will be reported at specialty and divisional meetings and at Trust Board, and presented at the Patient and Family Experience and Engagement Committee.</p>



Leo, age 17.

Part 2b:

Statements of assurance from the Board

This section comprises the following statements:

- Review of our services
- Participation in clinical audit
- Learning from deaths
- Participation in clinical research
- Use of the CQUIN payment framework
- CQC registration
- Data quality
- Gastroenterology service review
- Priority clinical standards for seven-day hospital services

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.

Participation in clinical audit

During 2017/18, 13 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 have been 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 (NICOR: National Institute for Cardiovascular Outcomes Research)	100% (186/186)*
Congenital heart disease including paediatric cardiac surgery (NICOR)	100% (1,372/1,372)**
Diabetes (Paediatric) (National Paediatric Diabetes Association)	100% (36/36)
Inflammatory Bowel Disease Registry (British Society of Gastroenterology (BSG), The Royal College of Physicians (RCP), and Crohn's and Colitis UK via IBD Registry Ltd)	100% (85/85)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)	100% (28/28)
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Chronic Neurodisability study	71% (5/7)
NCEPOD Cancer in Children, Teens and Young Adults Study	93% (38/41)
NCEPOD Adolescent Mental Health Study	100% (2/2)
National Cardiac Arrest Audit (ICNARC: Intensive Care National Audit and Research Centre)	100% (21/21)
National Neurosurgical Audit Programme	Data is taken from national Hospital Episode Statistics rather than submitted by the Trust.
Paediatric Intensive Care Audit Network (PICANet)	100% (1747/1747)
Renal replacement therapy (UK Renal Registry)	100% (185/185)***
UK Cystic Fibrosis Registry (Cystic Fibrosis Trust)	100% (180/180)

The three NCEPOD studies collecting data in 2017/18 involved care provided to children and young people. The Cancer in Children, Teens and Young Adults study aims to identify areas for improvement nationally in the care of children and young people who receive chemotherapy. A GOSH consultant is the national clinical lead for this study.

*2016/17 data, as the submission deadline for the 2017/18 audit is 30 June 2018

**2016/17 data, as the submission deadline for the 2017/18 audit is 25 May 2018

***2016 data, as the submission deadline for the 2017 audit is 31 May 2018

⁵ www.england.nhs.uk/ourwork/qual-clin-lead/clinaudit/

⁶ The Patient Safety and Outcomes Committee (PSOC) is the Trust-wide committee responsible for the monitoring, sharing and decision-making about quality and safety at the Trust.

⁷ The Standardised Mortality Ratio (SMR) is the ratio of observed deaths in the ICU compared to the expected number of deaths based upon the PIM2r score: the SMR is calculated periodically and is used as a method of benchmarking the outcomes between ICUs nationally via PICANet.

⁸ Variable Life Adjusted Display (VLAD) is a statistical monitoring tool that provides a visual method for monitoring clinical outcomes continuously over time, based on the SMR. The VLAD plot provides a mechanism for rapidly identifying outcomes that deviate from the norm, either favourably or unfavourably.

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.'

NHS England⁵

The following national clinical audit reports were published and reviewed in 2017/18, which are relevant to GOSH practice:

Name of national audit/clinical outcome review programme	Relevance to GOSH practice
<p>Congenital heart disease including paediatric cardiac surgery</p> <p>National Institute for Cardiovascular Outcomes Research (NICOR)</p>	<p>Data published in March 2018 shows that survival 30 days after paediatric cardiac surgery for children with congenital heart disease has continued to improve for children in recent years and is currently close to 98%.</p> <p>GOSH performance highlighted exemplar clinical outcomes, and was highlighted in the report which looked at data between 2013 and 2016:</p> <p><i>“Best practice: Overall risk adjusted survival at 30 days was much higher than the predicted level at one centre: Great Ormond Street Hospital in London for the second three year cycle in a row. This is indicative of good performance and should present an opportunity for sharing best practice across specialist centres.”</i></p>
<p>Diabetes (Paediatric)</p> <p>National Paediatric Diabetes Association</p>	<p>The audit compares outcomes for seven standards of care for patients with type 1 diabetes. Individual data is available for each centre for 2015/16. GOSH did not have any type 1 patients in the reporting period, therefore no outcome data can be compared.</p> <p>The report makes recommendations for the management of type 1 and type 2 diabetes in children and young people. All recommendations were reviewed and assessed. No changes to clinical practice at GOSH were required.</p>
<p>MBRRACE Term, Singleton, intrapartum stillbirth and intrapartum-related neonatal death</p>	<p>Recommendations are primarily aimed at maternity services but have been reviewed by the Trust neonatal service.</p>
<p>MBRRACE - Perinatal Mortality Surveillance 2015</p>	<p>The report assesses outcomes for centres where babies were born.</p> <p>Recommendations mainly address perinatal mortality, and no clinical practice changes are directly required at GOSH. The report has been reviewed by the neonatology service. A refinement has been made to how GOSH uploads data to ensure all case are reported on as required.</p>
<p>National Cardiac Arrest Audit</p> <p>Intensive Care National Audit and Research Centre (ICNARC)</p>	<p>Data and recommendations are included in resuscitation reports to the Trust Patient Safety and Outcomes Committee⁶. No specific actions were identified as necessary in response to the report.</p>
<p>Paediatric Intensive Care Audit Network (PICANet)</p>	<p>The primary outcome measure used in Intensive Care Units (ICU) is the survival rate for patients, recorded at the time of discharge. Raw survival/mortality rates may be challenging to interpret as patients that are admitted in a sicker condition are at greater risk, and therefore the outcomes need to be ‘adjusted’ to consider the level of severity of the patients in respect of case mix.</p> <p>The most recent PICANet report was published in September 2017 and compares Trusts Standardised Mortality Ratio⁷ for the calendar years of 2014-16.</p> <p>The data in this report shows GOSH mortality as within what would be expected based on case mix.</p> <p>ICU mortality is reviewed on an ongoing basis using the Variable Life Adjusted Display⁸ (VLAD) at ICU Mortality and Morbidity meetings. This allows the ICU teams to notice any trends in real time and explore reasons for any change.</p>

Key learning from clinical audit in 2017/18

We use clinical audit as a way to provide assurance about the quality of care provided and identify areas where quality improvement is required. A central clinical audit plan prioritises audits to support learning from incidents, risk, patient complaints, and to investigate areas for improvement in quality and safety.

Two examples of Trust-wide audit completed in 2017/18 are outlined below.

Quality of World Health Organization (WHO) Surgical Safety Checklist

Background

In our *Quality Report 2016/17*, we highlighted audit work to identify how effectively staff engaged in the WHO Surgical Safety Checklist⁹ to promote safety in the operating theatre. The audit showed good engagement in the checklist, and a positive safety culture.

The audit highlighted an area for improvement – that checks should always be performed with reference to the checklist rather than at times being performed from memory.

We have followed up on this area for improvement with a re-audit in 2017/18. This audit work and the improvements made are highlighted in the GOSH CQC inspection report published in April 2018:

"The Trust had significantly improved the use of the World Health Organisation surgical safety checklist in theatres. Quality and safety staff had audited the work to improve this safety tool, which resulted in a demonstrable trajectory of better practice."

Results

Our re-audit in December 2017 showed that 84% of surgical sign-ins¹⁰ were being completed with reference to a checklist, rather than checks being done from memory. The 2016 audit showed 35% of staff confirming that checklists were used.

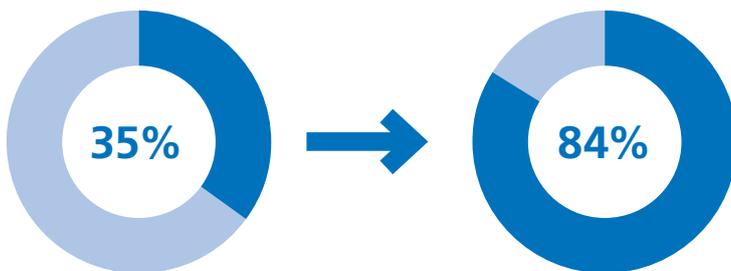


Figure 1: 2016, staff who reported competing checks with reference to the checklist

Figure 2: December 2017, staff observed to be competing sign-ins using a checklist

Another area for improvement noted in this audit is the completion of debriefs. Debriefs are an opportunity for teams to reflect at the end of operating lists and discuss any learning points. This is done by a whole team discussion which might focus on:

- What went well
- Any problems with equipment or other issues that occurred
- Any areas for improvement

A debrief was completed for 48% of operating lists observed in the audit in December 2017. 20% of lists were using debriefs in 2016. Debriefs have not yet been adopted nationally into routine clinical practice but they are very welcome as an opportunity for staff to reflect and learn.

Plans for improvement

Improvement interventions to support the further roll out of team debriefs are being managed through the National Safety Standards for Invasive Procedures¹¹ workstream, which has senior clinician engagement and is overseen by the Medical Director. A follow-up audit will further promote engagement and monitor improvement.

⁹ 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.

¹⁰ All patients undergoing invasive procedures under general, regional or local anaesthesia, or under sedation, must undergo safety checks on arrival at the procedure area.

¹¹ National Safety Standards for Invasive Procedures (NatSSIPs) have been developed by a multidisciplinary group of clinical practitioners, professional leaders, human factors experts and lay representatives brought together by NHS England. They set out the key steps necessary to deliver safe care for patients undergoing invasive procedures and will allow organisations delivering NHS-funded care to standardise the processes that underpin patient safety.

Nasogastric Tube Testing

Background

This is an audit of best practice of naso-gastric tube¹² management in line with Trust policy and an NHS Improvement safety alert. There was a Never Event (a patient safety incident listed by the NHS as an event that should never happen) in 2016 at GOSH involving naso-gastric tube management. The audit is part of the Trust commitment to check if lessons have been learned from past harm.

Key findings

The audit showed:

- 85% of standards were met in the Trust.
- Best practice was found in testing the position of a naso-gastric tube, and awareness of the techniques that should be avoided.
- No practice or safety concerns were raised through this audit. The areas of non-compliance in this audit were about documentation of practice. These have been fed back to action by relevant wards.

Specialty-led Clinical Audit

A total of 96 clinical audits led by clinical staff were completed at GOSH during 2017/18. To promote the sharing of information, a summary of completed projects is published on the Trust's intranet and shared with the Patient Safety and Outcomes Committee. In this report it is not possible to list every clinical audit completed in 2017/18 that has had a positive impact on quality and safety. A summary of completed clinical audits in 2017/18 can be obtained on request by contacting the Clinical Audit Manager on 020 7405 9200 extn 5892 or by emailing clinical.audit@gosh.nhs.uk.

Three examples of completed clinical audit led by specialties are outlined below.

Clinical audit on medication overuse among patients presenting at headache clinic (Neurology Team)

The audit assessed if NICE guidelines were being met in prescribing medication for headache treatment among paediatric patients above the age of 12.

The audit has made contributions in the following three areas:

- Helped develop a baseline assessment of compliance to NICE guidelines on medication overuse by patients.
- Helped develop understanding of incidence of medication overuse in headache clinic.
- Identified the demographic profile of medication overuse patients, including underlying primary headache disorders.

Medication overuse incidence was found to be 9.5% in the assessed cohort of patients. Compliance with NICE guidance on advice to patients was observed in 90% of cases. The audit has highlighted the frequency of patients overusing their medication in the management of headaches, and interventions are planned in the GOSH headache clinic to address this.

Satisfaction of patients undergoing orthodontic and orthognathic¹³ treatment

This audit assessed patient satisfaction with orthodontic treatment and whether it met their expectations. The audit highlighted that:

- Patient satisfaction with treatment is high.
- Orthodontic and orthognathic treatment are making significant contributions to improving patient confidence and improving their bite, smile and facial appearance.
- Patients are finding it difficult to make contact with the department to reschedule appointments or speak to a member of the administrative/secretarial team.
- Patients reported that they felt they sometimes had to wait a long time to be seen when they attended their appointment.

As a result of this audit, changes have been implemented to improve patient experience by ensuring a clinical waiting time board is used, and that reception staff are trained to relay messages to clinical staff as needed.

Audit of Lean Protocoling for Children with Multiple Sclerosis (Radiology)

This audit evaluated a change in protocol to ensure patients are being scanned using the correct protocol. This has highlighted the need for teaching of radiographers on terms used for scanning patients with multiple sclerosis.

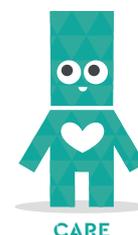
A re-audit is planned to monitor improvements.

¹² A plastic tube through the nose, past the throat, and down into the stomach to allow food and fluids to be administered.

¹³ Surgery to correct conditions of the jaw and face related to structure, growth, sleep apnea, temporomandibular joint and muscle disorders, malocclusion problems owing to skeletal disharmonies, or other orthodontic problems that cannot be easily treated with braces.



One Team



CARE

Learning from deaths

Death in childhood is a rare event. Whenever a child dies, it is important to reflect and to learn if anything could be done differently in the future.

Background

In March 2017, the National Quality Board published guidance, 'National Guidance on Learning from Deaths', which aims to initiate a standardised approach to reviewing and learning from deaths.

The GOSH Mortality Review Group (MRG) is a multidisciplinary group of senior clinicians that conducts routine, independent structured case record reviews of all deaths that occur at GOSH. The MRG has been in place since 2012.

The purpose of the MRG is to provide a Trust-level overview of all deaths to identify themes and risks and take action, as appropriate, to use these to shape quality improvement activities in the Trust. This process is linked with local case reviews undertaken by specialty teams and provides an additional oversight of deaths in the Trust. The MRG reviews the patient care pathway to identify whether there are modifiable factors¹⁴, and identify any learning for the Trust.

Deaths in 2017 and case record reviews

- Between 1st January 2017 and 31st December 2017, 110 children died at GOSH. 109/110 deaths have been subject to a case record review by the Mortality Review Group. One case cannot be reviewed until the completion of additional investigations.
- 10/109 (9.17%) of the patient deaths had modifiable factors at GOSH that may have contributed to vulnerability, ill health or death.
- No deaths in 2017 had modifiable factors at GOSH that provided a complete and sufficient explanation for death.

Learning from Clinical Case Reviews

The learning points from case record reviews are shared at the Trust Patient Safety and Outcomes Committee, and at Trust Board. Modifiable factors identified outside of GOSH are shared with the Child Death Overview Panel.¹⁵

Where modifiable factors or other issues are identified about GOSH care, these are fed back in an appropriate manner to the relevant clinical team and/or the Divisional Director(s) for action. The feedback mechanism will be determined based on the nature of the information to be shared, but could include via specialty case review meeting, email, and/or Divisional Board meeting.

Some key themes have been identified, including the recognition and response to the deteriorating patient, and the identification and management of sepsis. The Trust has existing priority quality improvement work to ensure that early warning systems are in place to support staff to identify the deteriorating patient, and that the Sepsis 6 protocol is applied.

See page 14 for our reporting on improving sepsis awareness.



Expert



INFORMATION

¹⁴ Modifiable factors are defined as those factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths

¹⁵ The purpose of a child death overview panel is to undertake an overview of all child deaths within the locality.

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. 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.

GOSH also hosts one of the few centres dedicated to supporting nurses and allied health professionals (AHPs) 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

During 2017/18, we have run over 1200 research projects at GOSH/ICH. Of these, 374 were adopted onto the NIHR Clinical Research Network (CRN) Portfolio, a prestigious network that helps deliver research across the NHS.

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 Clinical Research Network portfolio projects:



In 2017/18, over 3400 patients and family members took part in research at GOSH. In addition, GOSH leads the North Thames Genomic Medicine Centre (GMC), one of 13 regional centres that are responsible for coordinating recruitment of patients to the 100,000 Genomes Project. This pioneering project aims to better understand and treat rare conditions and cancers and this year reached its halfway point. Over 14,500 genomes have been collected by the North Thames GMC including 4,310 rare disease and 84 cancer genomes collected at GOSH, with over 1500 GOSH families recruited.

Funding

This year we saw an overall 18% growth in our research income to £20m in 2017/18, which supports research infrastructure and projects across the Trust.

2017/18 also marked the start of our third funding term of the National Institute for Health Research (NIHR) GOSH Biomedical Research Centre (BRC) and the commencement of our new NIHR Clinical Research Facility (CRF) funding.

Innovation

This year also saw the launch of *Innovation at GOSH* and our Innovation Accelerator competition. Our staff are best placed to come up with new ideas to improve patient care or save resources, but taking an idea to the next stage can require specialist knowledge of, amongst

other topics, intellectual property, regulatory legislation and how to obtain funding. *Innovation at GOSH* offers support and technical expertise to nurture new ideas with the ultimate aim of benefiting patients at GOSH and across the NHS, and improving the working lives of our staff.

In 2017/18, we also launched our Generic Consent pilot. This enables families to donate surplus tissue and blood samples to support our pioneering research.

Journal Publications

With our academic partner, we publish over 1500 papers a year. In the five year period 2012-2016, GOSH and ICH research papers together had the second highest citation impact compared to international paediatric comparator organisations.



One Team



RESEARCH

In the five year period 2012-2016, GOSH and ICH research papers together had the second highest citation impact¹⁶ compared to international paediatric comparator organisations

Research highlights

A daily tablet has been shown to reduce the debilitating symptoms experienced by children with Multiple Sclerosis (MS) and cut the chance of relapse by 82%. GOSH coordinated the UK arm of this study, which was the first time that an MS drug had been trialled specifically in young people. The results are extremely significant as there are currently no treatments specifically approved for young people with MS. Based on the findings, the pharmaceutical company that makes the drug is now applying for a licence to prescribe it to children.

A trial of 120 children across Europe and the USA showed that cannabidiol – derived from cannabis but with the psycho-active elements removed – reduces seizures by nearly 40% in children with a form of drug resistant epilepsy, known as Dravet syndrome. For 5% of patients, seizures stopped completely. Further trials have also been completed in another type of complex epilepsy, Lennox Gastaut syndrome, and are planned in infantile spasms.

Nusinersen, the first drug for Spinal Muscular Atrophy (SMA) is now being offered to children affected by Type 1 SMA on an Expanded Access Programme following a phase 3 trial led by GOSH. Children who received the drug displayed a significant improvement in the achievement of motor milestones compared to those who did not receive treatment. Currently there is no cure for SMA, so this step represents a significant breakthrough for patients. The drug has been granted early approval by the US Food and Drug Administration (FDA) and the European Medicines Agency (EMA).

A new test to help diagnose and predict a range of serious childhood eye conditions has been developed by researchers at GOSH and ICH. The gene panel test, known as 'Oculome', screens for mutations in more than 400 genes that are known to lead to eye disease, including those that can cause malformations of the eyeball and those linked to inherited retinal degeneration and cataracts. The test can help pinpoint the exact mutation that is causing the condition, enabling a faster, more accurate diagnosis and access to the most appropriate care. The test is currently available at GOSH and has been approved to be offered on a national basis.



¹⁶ GOSH citation impact = 1.997. The average citation impact is calculated from the number of citations for reviews and original papers normalised for research field and year of publication

Use of the CQUIN payment framework

A variety of CQUINs have been undertaken by the Trust in 2017/18. 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 Reporting 2017/18	
CQUIN title	Overview
Anti-microbial resistance/Sepsis	The aim of the project is to improve the timeliness of both identification and treatment of sepsis, as well as reducing inappropriate antibiotic usage within the Trust.
Child and Adolescent Mental Health Services – Long-term conditions	The aim is to establish screening and provision of mental health services for specialised paediatric inpatients with a chronic and severely disabling medical condition.
Cardiac Devices	This scheme seeks to ensure that device selection for patients remains consistent with the commissioning policy, service specification, and relevant NICE guidance. It also aims to ensure that contractual requirements are in place for providers while new national procurement and supply chain arrangements are embedded.
Critical care – Paediatric Networked Care	This scheme aligns with the national Paediatric Intensive Care service review. It aims to gather information which allows the demand across the whole paediatric critical care pathway to be considered.
Haemtrack	This scheme intends to improve adherence, timeliness, and accuracy of patient data submissions to the Haemtrack patient reporting system.
Medicines Optimisation	This CQUIN scheme aims to support the procedural and cultural changes required to optimise use of medicines commissioned by specialised services. A number of priority areas for implementation have been identified nationally by clinical leaders, commissioners, Trusts, the Carter Review and the National Audit Office.
Neuroscience Network	The scheme aims to support the development of the North Thames Neurosciences Paediatric Network.
Enhanced Supportive Care	This scheme aims to better integrate the work of the disease-specific Clinical Nurse Specialists and Advanced Nurse Practitioners with the Paediatric Oncology Outreach Nurses in the Palliative Care Team. The aim is to review the cancer clinical pathways and identify where it would be expected for Palliative Care to be involved.
Severe Asthma	The Severe Asthma scheme aims to ensure that assessment and investigation of children with difficult-to-control asthma is completed within twelve weeks of referral. This is so that all eligible children have appropriate and timely intervention in order to improve asthma control, reduce hospital admissions and avoid inappropriate escalation of therapy including the initiation of expensive monoclonal antibodies.
Transition Planning	The aim is to increase the number of transition plans for young people aged 13 years and above that will be used across the Trust.
Univentricular home monitoring	This scheme involves implementation of home monitoring programmes for children following palliative cardiac surgery for patients with a primary diagnosis of: hypoplastic left heart syndrome, functionally univentricular heart or pulmonary atresia with intact ventricular septum. Collectively, these conditions are referred to as univentricular hearts or univentricular circulations.

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 as part of the discussion between service commissioners and providers, and constitutes 2.5% of the Actual Contract Value between commissioner and provider.

In 2017/18, 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 2017/18, this will equate to £5.29 million. During Q1 to Q3 of the financial year, we reported high compliance against all our CQUIN indicator milestones. We expect to report approximately 78.7% 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 2017/18.

In January 2018, the CQC conducted a scheduled unannounced inspection of two services (surgery and outpatients) and an announced inspection against the Well Led criteria. The report was published in April 2018. The Trust was rated 'Good' overall. An action plan is in development to respond to the recommendations, which includes a requirement notice related to accessibility of clinical information for staff planning to undertake procedures (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17).

NHS Improvement well-led framework

As part of their routine scheduled inspection programme, the CQC conducted a well-led inspection of the Trust in January 2018. The Trust was rated as 'requires improvement'. The inspectors identified the areas of good practice including:

- Recognition of the excellent work undertaken to address our waiting time data and management issues (see page 48 of this report and [page xx](#) of the GOSH Annual Report 2017/18.)
- Effective systems are in place to identify and learn from unanticipated deaths, serious incidents and complaints.

The report identified issues with nursing leadership and said that nurses feel that they don't have a voice. There were perceptions of an overly complicated divisional structure, and the need for further engagement with local stakeholders particularly around sustainability and transformation partnerships (STPs). We are developing an action plan in response to the points raised in the report, noting that for some, we had already identified the issue and started to put plans in place. The action plan will be monitored by the Trust Board.

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 made significant progress in our data quality action plan which was completed in December 2017. Some of the key highlights were:

- The establishment of a dedicated data assurance team that works closely with staff to improve data quality through training and coaching.
- The data quality dashboard has now been rolled out across the organisation and enhanced further to include data quality reporting for theatres. The dashboard now encompasses 158 individual data quality indicators and as such we continue to prioritise work around these.
- The establishment of regular weekly data quality focus groups with each division to tackle and prioritise data quality measures.

For 2018/19, we have developed a new data quality improvement plan which allows us to focus on the improvement work that is needed as we progress towards going live with the Epic system in April 2019.

Secondary Uses Service

As required by NHS Digital, GOSH submitted records during 2017/18 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	97.8%	99.4%
	Outpatients	98.8%	99.5%
Inclusion of patient's valid General Practitioner Registration Code	Inpatients	99.7%	99.9%
	Outpatients	99.8%	99.8%

Notes:

- The table reflects data from April 2017 – January 2018 at month 10 SUS inclusion date.
- Nationally published figures include our international private patients, who are not assigned an NHS number. Therefore the published figures are consequently lower at 92.7% for inpatients and 93.8% 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 number of codes applied compared to the national average. GOSH carries out internal audits to ensure that accuracy and quality are maintained, and complied with the Information Governance Toolkit clinical coding audit requirements for 2017/18. The most recent audit for the Information Governance Toolkit showed results of over 97% accuracy, representing the highest level of achievement recognised in the toolkit. GOSH was not subject to a national Payment by Results clinical coding audit during the 2017/18 reporting period.

Information Governance

The current 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 2017/18 improved from last year to 77% and was graded green, 'Satisfactory'. The improvements over last year's submission related to a full action plan for staff training and an improvement in the documentation and identification of contracts which required additional information sharing controls.

For 2018/19, the Information Governance Toolkit is to be relaunched as the Data Security and Protection Toolkit. This will be aligned with the National Data Guardian's ten data security standards and the forthcoming General Data Protection Regulation (GDPR) and will be a full redesign of how the Trust demonstrates compliance. Over the coming year, GOSH will ensure all appropriate evidence is available to measure performance against the data security and information governance requirements mandated by the Department of Health and Social Care.

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 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 NHS Digital?

NHS Digital (formerly known as the Health and Social Care Information Centre) is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

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 and different areas of the country.



Gastroenterology service review

In 2015 we commenced a review into our gastroenterology service to ensure we provide the highest standards of care to the children, young people and families we look after. This review was of particular importance to us as we had seen a disappointing and sustained number of complaints about the service we offered.

The initial stage of the review was led by the Royal College of Paediatrics and Child Health (RCPCH), who we invited in 2015 to visit and independently assess the service to identify areas for improvement. The RCPCH's recommendations included improving communications with families, improving administration, and enhancing access to psychological support for families. We initiated a programme of work to address these recommendations.

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.

They recommended we review the care packages of a small group of patients suspected of having this complex condition. We also held a listening event in July 2017, to capture the views of our patients and their families in the review.

At the start of the review, we committed to commissioning a follow-up external review to make sure progress was being sustained to address the RCPCH's original recommendations. To that end, we invited the RCPCH to revisit the service in 2017. We are pleased that they recognised the journey the department has been on, and the progress that has been made since their first visit in 2015.

The reviewers were assured by very good senior clinical and operational leadership, significant improvements in the administration of patient communications, the organisation of clinics, and improved team working. We have also seen a fall in the number of issues and complaints raised, and we believe that patients see the tangible benefits of these improvements.

We are aware that there is still room for further improvement, and we have carefully considered the RCPCH's findings from their second visit, together with what we heard from the listening event we held last year. Patients and families who attended our listening event told us they wanted to see better communication and clearer information available, that is easier to understand. The RCPCH echoed similar feedback. To that end, we are reviewing and improving the leaflets and web guides for patients and parents, to enhance their understanding of the service. We will also be focusing on improving the transition for patients as they move from paediatric to adult healthcare. We communicated these findings to the families involved in the review.

We also agreed with the RCPCH recommendations that we improve the ward environment. To that end, we have now moved all gastroenterology patients from the unsatisfactory environment in Rainforest Ward and will soon be relocating them to a much better accommodation with new, modern facilities.

Priority clinical standards for seven-day hospital services

The seven-day services programme is designed to ensure patients that are admitted as an emergency receive high quality consistent care, whatever day they enter hospital.

GOSH does not have an accident and emergency department and therefore our 'emergency' workload relates to non-elective patients admitted directly from other hospitals into our critical care units. We have reviewed the implementation of the priority clinical standards for our unplanned critical care admissions. This has been through participation in the NHS England seven-day service audit, which is required twice a year. Our most recent audit was completed for eight admissions in October 2017. All cases met the standard for patients being seen by a consultant within 14 hours of arrival at GOSH. In order to further implement the priority clinical standards, the job planning process for ICU consultants is being reviewed to formalise arrangements for twice-daily ward rounds at weekends to take place. We will continue to participate in the seven-day services national audit for our unplanned intensive care admissions.



Part 2c:

Reporting against core indicators

NHS trusts are subject to national indicators that enable the Department of Health and Social Care (DHSC) 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 and Social Care (DHSC)?

The DHSC 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:
	2017/18	2016/17	2015/16	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: 2017 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	87% (2017)	90% (2016)	88% (2015)	87%	93%	79%	89% (median score)	The survey is carried out under the auspices of the DHSC, using their analytical processes. GOSH is compared with other acute specialist trusts in England.	The introduction of a Trust-wide safety and reliability improvement project, and the development of a programme to ensure quality leadership of our staff, which includes reviewing how we support managers and staff to address harassment and bullying and a commitment to an Equality, Diversity and Inclusion strategy supported by new governance arrangements.
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	29% (2017)	25% (2016)	25% (2015)	29%	18%	30%	23% (median score)		
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	81% (2017)	85% (2016)	87% (2015)	81%	91%	80%	88% (median score)		

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' data points.

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:
	2017/18	2016/17	2015/16	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: 2016/17 financial year					
Number of clostridium difficile (C.difficile) in patients aged 2 and over	11	1	7	1	0	46	30.2 (mean score)	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)	18.8	1.79	12.5 [^]	1.2 [*]	0	82.7	12.9 (mean score)		
<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>* National report used estimated bed days at time of reporting.</p> <p>[†] www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data</p> <p>[^] Previously published rate for 2015/16 was incorrectly calculated as 8.3 using all bed days. It has been corrected here to show bed days of patients aged two and over.</p>									
Indicator	From local trust data			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:	
	2017/18	2016/17	2015/16						
Patient safety incidents reported to the National Reporting and Learning System (NRLS):									
Number of patient safety incidents	6,345	5,429	5,338	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 such as Risk Action Groups, local training (human factors, RCA) and "Learning from..." events and posters 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)	10.90	12.40	12.50						
Number and percentage of patient safety incidents resulting in severe harm or death	12 (0.2%)	8 (0.1%)	11 (0.2%)						

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 a mean?

The mean is the average of a set of numbers. It is calculated by adding up all the values and then dividing the answer by the total number.

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 2017/18

Domain	Indicator	National threshold	GOSH performance for 2017/18 by quarter				2017/18 mean	Indicator met?
			Q1	Q2	Q3	Q4		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment***	96%	100%	100%	100%	100%	100%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:***							
	· surgery	94%	100%	100%	100%	100%	100%	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%	Apr: 90.31% May: 90.36% Jun: 89.26%	Jul: 89.84% Aug: 90.07% Sep: 89.67%	Oct: 90.59% Nov: 90.72% Dec: 90.75%	Jan: 92.96% Feb: 93.53% Mar: 92.91%	90.91%	Yes, for Q4 but not for Q1-3. Improvement work continues.
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

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 (SPC) charts are used to measure improvements in projects over time and to identify areas that require further investigation (see definition on page 17). All measures remain within expected statistical tolerance.

Domain	Indicator	GOSH performance for 2017/18 by quarter				2017/18 mean
		Q1	Q2	Q3	Q4	
Safety	Central Venous Line (CVL) related bloodstream infections (per 1,000 line days)	1.57	1.47	1.31	1.54	1.47
Effectiveness	Inpatient mortality rate (per 1,000 discharges) [†] (From data submitted to Hospital Episode Statistics (HES))	8.8	5.7	6.7	4.2	6.3
Experience	Friends and Family Test (FFT) – % of responses (inpatient)**	28.6%	23.1%	22.4%	24.1%	24.6%
Experience	FFT – % of respondents who recommend the Trust (inpatient)**	97.7%	97.3%	96.8%	96.4%	97.1%
Experience	Discharge summary completion time (within 24 hours)	87.8%	87.1%	88.1%	88.1%	87.7%
Effectiveness	Last minute* non-clinical hospital cancelled operations: Breach of 28-day standard***					
	· cancellations	137	119	176	105	537 (total)
	· breaches	14	7	27	24	72 (total)
Experience	Formal complaints investigated in line with the NHS complaints regulations***	29	21	14	22	86 (total)
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge **	1.93%	1.99%	2.23%	1.23%	1.83%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge **	0%	0%	0.81%	1.55%	0.54%

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 referral to treatment (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 (reported last year) progressed and reporting resumed in February 2017.				Jan: 91.2% Feb: 91.6% Mar: 91.85%	N/A	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 (SPC) charts are used to measure improvements in projects over time and to identify areas that require further investigation (see definition on page 17). All measures remain within expected statistical tolerance.

Domain	Indicator	GOSH performance for 2016/17 by quarter				2016/17 mean
		Q1	Q2	Q3	Q4	
Safety	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) [†] (From data submitted to HES)	4.2	5.6	7.0	5.7	5.6
Experience	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%

* Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008). Quarterly performance is from information submitted to NHS Improvement.

[†] 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.

** Source: NHS England

*** Source: NHS Digital

^{†††} Source: HES

^{††††} Throughout the past three years, we have focused on improving the quality of our waiting list data, establishing robust processes to manage elective care waits and ensuring that assurance processes are in place to provide early warning of any future issues. The main focus in 2017–18 was to reduce the waiting times for all our patients, providing prompt treatment and achieving the defined national requirements as an organisation. We worked on improving the waiting times associated with referral to treatment, in line with the hospital's agreed recovery trajectory with NHS England. We achieved the 92% standard for the first time since returning to reporting in January 2018, with a performance position of 92.96%. This was a testament to the work completed by the clinical and operational teams.

Following completion of the audit of our *Quality Report 2017/18*, a number of data quality issues were identified related to the small sample undertaken. Four of the errors were identified as high priority, with the remainder flagged as medium priority. Although disappointed with the number of errors identified, GOSH was reassured to see that all but two of the errors related to staff interaction and interpretation of the RTT rules and processes, rather than systemic process issues (which were addressed during previous improvement work). Some related to understanding of RTT rules and their application, while many others related to the storing of documentation to confirm the dates applied to the RTT pathway.

A number of actions are already underway that will address these issues, including the roll out of a refreshed RTT (and cancer) training package to ensure staff are fully aware of the rules as well as their application across GOSH. Many of these issues were the result of our patient administration system not being compliant with the RTT rules and therefore tracking and managing of patient pathways has to be completed outside the system with limited visibility of pathway status. This specific issue will be addressed with the implementation of the new electronic patient record (Epic) and the Trust is currently working to configure the RTT rules, providing a fully integrated tracking system for staff to use. Although the number of errors were more than the organisation expected, GOSH notes the context of other Foundation Trusts and their performance against this indicator. It is clear this is a significant challenge to the wider NHS also. GOSH will continue to work to improve the quality of its data across all areas as it progresses towards Epic go-live in April 2019.

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 *Quality Report 2017/18*. We continue to work together to consider improvements in the quality of care and accessibility of services for those children whose healthcare needs are managed by GOSH. NHS England continually review feedback from: patients and families, clinical quality review meetings and other external sources including the Care Quality Commission, Health Education England (North Central and East London), and Public Health England to inform decisions about where improvements can be delivered. Notable examples of positive achievements this year include sustained improvements to referral to treatment times and Transition planning supported by CQUIN transformation funding.

NHS England recognise the considerable work undertaken by the Trust to improve Paediatric Early Warning Scores and the implementation of new IT systems to provide a stronger evidence base to data and reporting. NHS England acknowledges the areas of achievement reported this year which includes compliance with the 7 day standards.

NHS England recognises the efforts made by the Trust in relation to infection prevention and control including work on anti-microbial stewardship, recognition and treatment of sepsis, and line care.

There are a number of areas where work to facilitate the improvements outlined in the Quality Report are underway.

- Improving the quality and safety of care for inpatient neonates and small infants.
- Developing Trust-wide access to outcomes data through the Clinical Outcomes Hub.
- Implementing the Outpatient Transformation Project.

Following the publication of the Trust's CQC Report in April 2018 we recognise the achievements of the Trust and look forward to working with and supporting the Trust in areas for development, our intention being to ensure through collaborative working that continuous improvement for patients are delivered in 2018/19. We note the Trust has also responded to the CQC's Well Led Report, published in February and we are actively working with the Trust on the implementation of the actions needed to deliver improvements. We note the recent appointment of two permanent Trust Executives: Quality Posts of a Director of Nursing and a Medical Director. Given the very challenging year the Trust has had with a number of difficult and complex cases that have been in the national spotlight, we welcome the benefits that new senior experienced clinical leadership will bring to both staff and patients and look forward to continuing to build an effective working partnership with the Trust.

Statement from Healthwatch Camden

Healthwatch Camden is pleased to see that some areas of improvement in the Trust have progressed. The better food was noted by one of our volunteers who visited. Framing transition as 'Growing Up Gaining Independence' seems a helpful approach.

We have not been able to take as much part in GOSH's stakeholder engagement this year as we would like, our own priorities have focused us elsewhere this year. Nonetheless, we are always pleased to stay in touch with the Trust and to learn about your work to improve patient experience. We are not able to comment on the clinical quality and safety priorities.

Statement from Camden Health and Adult Social Care Scrutiny Committee

The Camden Health and Adult Social Care Scrutiny Committee regrets that due to the local elections and the new committee not meeting until July 2018, it was unable to review and comment on the GOSH *Quality Report* this year. It looks forward to resuming this voluntary role for the 2018/19 *Quality Report*.

Feedback from Members' Council governors

Comments from Public Governor, south London and surrounding area

Doesn't time fly? It seems barely credible that it was a year ago I was commenting on the 2016/17 annual *Quality Report* and now here we are another year has gone. The 2017/18 report clearly identifies the emphasis GOSH places on Quality against the predetermined criteria of Safety, Clinical Effectiveness and Experience and presents this in a readily accessible format with clear definition of terms used, clear diagrams, tables and graphs. Reading the report, you get a real sense of the huge range of services and research GOSH provides and undertakes on a daily basis at the heart of which is the 'Always Values' and the ethos 'The child first and always'.

Having commented in last year's report that "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", it is particularly pleasing that, to an extent, this has been acted upon. Two of the priorities from last year; improving sepsis awareness and the transition from paediatric to adult healthcare services also feature in this year's report whilst actions promised in the Listening Event in November 2016 to improve the quality of food have been taken. Given how quickly a child or young person can deteriorate it would have been useful to know whether the 'safety huddle' highlighted as one of the safety priorities in 2015/16 is now fully embedded in each ward's practice and part of the junior doctors' induction and Trust-wide induction.

Being the parent of a child born unexpectedly nine weeks early, I am delighted at the focus in the safety section on neonates and small infants. Becoming a parent can be a fraught experience without the added worry of not knowing whether your child is also suffering from a serious and / or rare condition or jaundice and if so knowing treatment has commenced as soon as possible. A simple bloodspot test can provide that reassurance so knowing GOSH has harnessed technology to develop an automated prompt system that alerts nursing leads that a baby on their ward is eligible for screening is very welcome. Similarly, ensuring that a neonate is properly hydrated and receiving the correct fluid and electrolyte therapy is essential but not easy. The multi-disciplinary approach to developing a Trust guideline for management of neonatal intravenous fluids is commendable and provides the basis for the continual raising of awareness of this important subject.

Technology is such a key part of medicine today and whilst I'd suggest it can never take the place of 'gut' feel, the work that has gone into the development of the Clinical Outcomes Hub is formidable. The emphasis on making data available to clinical teams in ways they found most useful and not adopting a 'one size fits all' approach encourages buy in from clinicians

and provides a means for feedback from patients and parents which improves the currency and accuracy of data, facilitates trend analysis and improves treatment and clinical outcomes. A virtuous circle.

The decision to cancel an operation is not taken lightly. The impact on a patient, family, staff and waste of resources is significant. At a time when demand continues to outstrip resources and the resources themselves are being reduced, the fact that the number of elective operations cancelled for bed capacity reasons has halved in the past year through system redesign is great news. The commitment to continue this work to improve patient access and flow in 2018/19 makes sense.

Turning to the current year, GOSH has continued its commitment to listen to patients, families and staff by using various mechanisms to assist in determining which Quality Improvement projects should be undertaken. The choices relating to improving safety and experience when venous access is needed as part of care management, improving the early recognition of the deteriorating child and young person, and continuing the work on improving the transition to adult services build upon similar initiatives, work and technology undertaken in previous years. I look forward to reading about progress made on these in the next annual *Quality Report*.

My thanks to all at GOSH who continue to look after our children and young people, push the boundaries of research, treatment and technology and take those hard decisions. There is much in this annual *Quality Report* to be proud of as well as clear pointers for future priorities and where improvements can be made.

Comments from Public governor, north London and surrounding area:

The extensive work carried out by the Trust to improve the services it provides to neonates and the great emphasis it has placed on training staff to ensure that patients can get the very best specialised care is truly laudable. As the sister of a former patient in the neonatal department, the developments in response to the clinical audit of neonatal care are incredibly heartening to read about. It is reassuring to see that the Trust has taken the audit results very seriously and has responded with tangibility. The standardisation of neonatal care and the availability of demographic information and prompting has increased the percentage of babies receiving a bloodspot test within the required time from 93% to 98% – a commendable result. In addition, the comprehensive staff training and availability of new resources has led to an increase in the percentage of neonates managed in line with the NICE guidelines for jaundice from 62% to 80%. This is very encouraging, and I look forward to the launch of the new electronic solution this summer which will be instrumental in the effective treatment of neonatal jaundice. The Trust acknowledges

that more can be done to raise awareness of the importance of neonatal fluid management, which I anticipate will be followed through. Holistically, it has been a very rewarding and exciting year for the Trust, and one that has seen significant advancements in the medical and care services provided by GOSH, ensuring that it continues to be a formidable force in the clinical world.

There have been significant developments in the provision of sepsis treatment in light of last year's advancements. The introduction of the Sepsis 6 app has proven incredibly successful in ensuring that staff are able to fulfil the Sepsis 6 protocol and administer treatment within an hour. The introduction of the sepsis list and the algorithm which manifests on the ePSAG board has led to a much more efficient approach in the treatment of sepsis and one that both staff and patients have benefited greatly from. This has been supported by raising public awareness of sepsis, the introduction of first-line antibiotics to all wards and comprehensive training of staff, including facilitated simulation training. The delivery of a CQUIN focused on sepsis and antibiotic use and its ongoing provision will ensure a quality focused result, thus fulfilling the quality priorities as highlighted in the first section of the report. The result of these developments is that the percentage of sepsis treatment carried out within an hour at GOSH currently stands at 72%. This is significantly higher than the international average of 47% and is a further testament to the clinical excellence that GOSH exhibits on an international scale.

The measures taken to develop and update the Clinical Outcomes Hub has given staff confidence that their services are being administered efficiently, whilst allowing them to track progress. The PROMs system is an effective way for staff to receive direct feedback from patients and their families and allows them to incorporate this into future services, further driving improvement. It is reassuring to read about the planned developments for bespoke dashboards and the availability of more SSI data, which will allow for sustained development in this area.

The updating of electronic systems in reference to patient access data and management have led to greater efficiency and the availability of more current information for use as the basis of making informed clinical decisions. Consequently, the number of same-day elective operation cancellations has fallen from 6 to 2 per week which is very encouraging. The introduction this year of the Operational Hub is anticipated to increase patient capacity and extend the Trust's services to more children - a testament to the Trust's dedication to 'The Child First and Always'.

The implementation of the GUGI programme will enable young people to gain the skills necessary to ensure that their transition to adult services takes place smoothly. The emphasis GOSH places on ensuring that its young people are able to cope in a changing clinical environment even after they have left GOSH is evidence of

the Trust's tailored and patient-centric approach which makes it truly outstanding. I look forward to reading about the Transition Improvement Project in next year's Quality Report.

The Trust has established the areas for improvement in its catering. I have full confidence that the Trust will respond swiftly to this - particularly the ability to provide ingredient information promptly, which is especially important for children with allergies. However, the Trust's endeavour to improve the nutritional value and variety of its food is greatly appreciated.

The Trust's quality priorities for the next year are well presented through the safety, clinical effectiveness and experience framework. Improvements in the services provided to children needing venous access are welcomed, particularly in children with anxiety where this can taint their hospital experience. Early recognition of symptoms signalling deterioration and the introduction of PEWS is fundamental to risk reduction and to ensure maximisation of successful outcomes. It is reassuring to see transition to adult services as a priority for the following year too, demonstrating the Trust's commitment to its 'Always' ethos. I look forward to the next annual Quality Report, which will detail developments in the aforementioned areas.

Overall, it is excellent to see that these developments are being well received by staff, patients and the public, and that they are being incorporated into the Trust's framework seamlessly. The rapid pace of development in the past year - with particular emphasis on the redesign of technological systems, which has paved the way for a more modernised clinical approach, has been astonishing. On behalf of the governors, I'd like to thank everybody involved in the daily administration of the Trust and for working tirelessly to deliver on its pledges. The result is felt by the many children that are given a chance at life, and the families that have been given a solution to their suffering.

Annex 2: Statements of assurance

**External assurance statement
To be supplied**

**External assurance statement
To be supplied**

Statement of directors' responsibilities for 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 2017/18* 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 2017 to May 2018
 - Papers relating to Quality reported to the board over the period April 2017 to May 2018
 - Feedback from commissioners dated 11 May 2018
 - Feedback from governors dated 24 and 25 April 2018
 - Feedback from local Healthwatch organisation dated 10 May 2018
 - Feedback from Overview and Scrutiny Committee dated 26 April 2018
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27 April 2018
 - National Paediatric Outpatient Survey 2016
 - Children and Young People's Inpatient and Day Case Survey 2016
 - The national NHS Staff Survey 2017
 - The Head of Internal Audit's annual opinion of the Trust's control environment dated xxxx
 - CQC inspection report dated 6 April 2018

- 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

23 May 2018

Chairman

23 May 2018

Chief Executive

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street
London WC1N 3JH
020 7405 9200
gosh.nhs.uk

Designed and produced by Great Ormond Street Hospital
Marketing and Communications.

Thank you to everyone who was interviewed for, or gave
permission for their picture to be used in, this report, as well
as the many members of Great Ormond Street Hospital staff
who helped during its production.

The *Annual Report and Accounts* is available to view at
www.gosh.nhs.uk.

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

Trust Board 23 May 2018	
Update on Board Assurance Framework	Paper No: Attachment P
Submitted by: Dr Anna Ferrant, Company Secretary	
<p>Aims / summary</p> <p>The purpose of this paper is to provide the Board with an update on the Board Assurance Framework (BAF). The Board assurance committees (Audit Committee and Quality and Safety Assurance Committee) review the risks on the BAF at every committee meeting during the year.</p> <p>A high level summary of the risks on the BAF is provided at Appendix 1. Information on the controls and assurance are provided at Appendix 2 (<u>for information only</u>).</p> <p>BAF risk owners update their relevant BAF risk on a quarterly basis, reviewing the controls, assurances and actions for each risk and any other internal/ external matters that may inform/ impact the risk. The Audit Committee has proposed that the risks documented in the BAF are subject to a review by Board members at the annual Risk Management Meeting (to be held in July 2018 and chaired by the Audit Committee Chairman). The committee proposes that the risk appetites for the risks are also reviewed.</p> <p>The Audit Committee recommended the following changes to the BAF:</p> <ul style="list-style-type: none"> • The time horizon over which the gross risk score and net score is based – the committee has agreed that the gross risk score is be over a period of 3-5 years and net risk score is related to the risk – i.e. for the finance risk it is over two years due to there being a two year operating and financial plan in place. A column has been added to the summary page on the BAF documenting the time horizon for each risk; • The definition of ‘catastrophic’ for the consequence risk score in financial terms – the Audit Committee recommends that a potential variance in excess of £4.5million should be considered ‘catastrophic’ for GOSH and the application of the NPSA guidance applied in light of this. 	
<p>Action required from the meeting</p> <p>The Board is asked note the BAF update and approve the Audit Committee recommendations.</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans</p> <p>Effective management of risk, particularly BAF risks, is critical to the achievement of all of the Trust’s strategic objectives.</p>	
<p>Financial implications</p> <p>There are no direct financial implications.</p>	
<p>Who needs to be told about any decision?</p> <p>Anna Ferrant, Company Secretary will liaise with staff affected by any decisions related to this paper.</p>	

Attachment P

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.

Appendix 1: 2018/19 Board Assurance Framework (as at 08 May 2018)

No.	Short Title	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	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"> • Reductions in tariff; • Challenges in completing contracts with NHS Commissioners • 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; • Inadequate local pricing in NHS contract; • Delivery of financial efficiency targets; • Failure to collect IPP debt; • Shortfall in capital funding available from the Charity to support major capital projects • Robust financial management across all operational and corporate teams 		4 x 5 =	20	3 x 4 =	12	Low (1-6)	1-2 years	Chief Finance Officer	Helen Jameson, Chief Finance Officer	06/04/2018	Audit Committee	April 2017 January 2018
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 2 =	8	Low (1-6)	1 -2 years	Deputy Chief Executive Officer	Jon Schick, Programme Director, PMO	04/04//2018	Audit Committee	April 2017 Jan 2018
3	IPP Contribution	Strategic & Operational	The risk that the organisation will not deliver IPP contribution targets		4 x 5 =	20	4 x 3 =	12	Low (1-6)	1-2 years	Deputy Chief Executive Officer	Chris Rockenbach, General Manager, IPP	11/04/2018	Audit Committee	May-16 April 2017 Jan 2018
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 (8-10)	1-2 years	Director, Human Resources/ Chief Nurse	Lynn Shields, Ass Dir of Education, Nursing & Alison Robertson, Chief Nurse	06/04//2018	Audit Committee/ Quality & Safety Assurance Committee	July 2016 April 2017 Oct 2017 May 2018
5	Operational Performance	Operational	The trust is unable to demonstrate compliance with Performance Management Framework/ Monitor's licence		5 x 4 =	20	2x4 =	8	Low (1-6)	1 year	Deputy Chief Executive Officer	Peter Hyland, Director, Planning & Information/ Anna Ferrant, Company Secretary	10/04/2018	Audit Committee/ Quality & Safety Assurance Committee	Oct-16 Oct 2017 (AC) May 2018
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 (1-6)	1-5 years	Medical Director/ Chief Nurse	Mr Matthew Shaw Medical Director & Alison Robertson, Chief Nurse	10/04/2018	Quality & Safety Assurance Committee	Jan 2017 Oct 2017 April 2018

No.	Short Title	Risk type and description		Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
				L x C = T		L x C = T								
7	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 (8-10)	5-10 years	Deputy Chief Executive Officer	Peter Hyland	10/04/2018	Audit Committee	Jan 2017 Jan 2018
8	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 (1-6)	1-2 years	Deputy Chief Executive Officer	Pippa Mullan, Head of Information, & Peter Hyland, Director, Planning & Information	10/04/2018	Audit Committee	Oct-16 May 2017 April 2018
9	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 (8-10)	1-2 years	Director, Research & Innovation	Emma Pendleton, Dep Dir, R&I	03/04/2018	Audit Committee	July 2017 April 2018
10	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 (8-10)	3-5 years	Director, Research & Innovation	Emma Pendleton, Dep Dir, R&I	03/04/2018	Quality & Safety Assurance Committee	Oct-16 July 2017 April 2018
11	Electronic Patient Records	Operational	<p><u>Short – Term – Project Implementation and Go-Live-2 years</u> The risk that the EPR programme will not be delivered on time or within budget. Key risks being monitored by programme board:</p> <ul style="list-style-type: none"> • Programme budget • Procurement risks • Capability/ resource risks • Clinician, Executive and other staff engagement • Risks associated with multiple clinical systems • 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. • Change management is effective to ensure adoption of best practice. <p><u>Long – Term – Optimisation and Benefits Realisation</u> The risk that the 18 month period following EPR system implementation is not maximised to ensure optimisation of the system and the benefits are not maximised for the organisation as outlined in the Business Case.</p>	4 x 4 =	16	3 x 4 =	12	Low (1-6)	1-2 years	Medical Director	Mat Shaw Medical Director/ Richard Collins/ EPR Programme Director	08/05/2018	Audit Committee	Oct-16 Oct 2017 May 2018
12	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 (1-6)	1 year	Deputy Chief Executive Officer	Emergency Planning Officer/ Nicola Grinstead, DCEO	11/04//2018	Audit Committee	May-16 May 2017 April 2018 (TB)
13	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	3 x 3 =	9	Med (8-10)	1-5 years	Dir, Development & Property Services	Stephanie Williamson, Dep Dir of Development & Property Services	27/03/2018	Audit Committee	May-17 Jan 2017 Oct 2017 April 2018

GOSH BAF Risks – Gross Scores May 2018

		Consequences				
Likelihood		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	5 Almost Certain				5. Operational Performance	
	4 Likely				11. EPR 8. Unreliable data 2. Productivity	3. IPP Contribution 6. Clinical Outcomes 4. Recruitment & Retention 1. Financial Sustainability
	3. Possible			10. Research Hospital 9. Research Income 7. GOSH Strategic Position	12. Business Continuity 13. Redevelopment	
	2. Unlikely					
	1. Rare					

GOSH BAF Risks – Net Scores May 2018

		Consequences				
Likelihood		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	5 Almost Certain					
	4 Likely		2. Productivity	3. IPP Contribution		
	3. Possible			7. GOSH Strategic Position 8. Unreliable data 13. Redevelopment 12. Business Continuity	1. Financial Sustainability 11. EPR	4. Recruitment & Retention
	2. Unlikely			10. Research Hospital 9. Research Income	5. Operational Performance	6. Clinical Outcomes
	1. Rare					



**Trust Board
 23rd May 2018**

2018/19 NHSI Plan (final submission)

**Submitted by:
 Helen Jameson, Chief Finance Officer
 Nicola Grinstead, Deputy Chief Exec**

Paper No: Attachment Q

**Attachment i – NHSI Finance Narrative
 Attachment ii – NHSI Operational Plan
 narrative**

Key Points to take away

1. The Trust met all expected deadlines around the submissions required by NHSI of operational plans and budgets. The final financial plan meets the NHS Improvement control total.
2. The Trust has made minimal changes to the plans submitted to NHSI since the first submission in March. The main updated figures surround the updated outturn rather than forecast within the financial figures and the agreed contract plan with NHSE which was £314m (with £318m assumed in the first submission).
3. The Trust is now working to ensure that the overall divisional envelopes set out within the wider plan are agreed at a divisional level and allocated out appropriately to individual services.

Introduction

This paper summarises the submission to NHSI and the associated paper reviewed by FIC on 14 May 2018. The plan was produced in line with guidance issued by NHSI and updated for the final contract agreed with commissioners for 2018-19.

The two narrative documents that are appended to this report were uploaded along with the detailed financial, activity and workforce returns to give an overview of the means by which the Trust will achieve its performance and financial objectives for the coming financial year.

In particular, the financial narrative provides an overview of how the budgets have been set for next year and provide assurance that the Trust will achieve its control total. The key deliverable for next year is attainment of the control total that has been set for the following year relative to the 2017-18 outturn. This is:

Year	Forecast outturn / Outturn	Net variance to control total
2017/18 Forecast outturn included in prior return (based on M9 position)	£11.4 million surplus	£1.7 million surplus
2017/18 unaudited OT excluding STF bonus and incentives	£9.9 million Surplus	£0.2 million surplus
2017/18 unaudited OT including STF bonus and incentives	£13.6 million Surplus	£3.7 million surplus

Beyond this, the Operational Plan narrative provides detail of the Trust's activity, quality and workforce plans. These all align to the finance plan and the 2018/19 activity plan can be summarised as follows:

	17/18 forecast outturn	18/19 Plan	Growth	Original plan assumption
Consultant led first outpatient attendances	33,788	34,162	1.1%	1.4%
Consultant led follow up outpatient attendances	171,691	172,994	0.8%	1.4%
Elective admissions	34,746	35,608	2.5%	2.7%
Non-elective admissions	2,283	2,316	1.4%	1.4%

Trust Budget setting

The work above ensured that the Trust was able to establish a financial envelope that achieved the NHSI control total that reflected agreed contracts, Better Value targets for the year, inflation and approved business cases.

Through this work divisional and departmental envelopes were set which are being confirmed via a 'line by line' level review process to ensure that 2018/19 budgets reflective of need, deliverable and realistic.

The first round detailed challenge sessions will conclude in May 2018 so budget holders can review and agree the revised detailed budget envelopes. This will include any unallocated better value savings on separate financial codes, which will be allocated as schemes are confirmed. A consolidated position will be presented to the Trust Executive for review and agreement. Finally Budget Holders are then expected to sign up to their annual budgets as part of the normal annual budget setting cycle. The Trust will then report against these detailed budgets from Month 2 onwards.

The FIC reviewed this approach and confirmed it was happy for the Trust to proceed on this basis, recognising:

- It will not change the overall plan, as submitted to NHS Improvement, but
- Will ensure each area has been through a robust process,
- Will provide additional support to identifying the Better Value Programme savings.

Action required from the meeting

- To **note** the commentary submitted to NHSI and reported throughout delivery to FIC.
- To **note** the work being undertaken to assign budgets at a divisional level.

Contribution to the delivery of NHS / Trust strategies and plans

The delivery of the financial plan is a key strategic objective to ensure we have sufficient funding to meet the needs of our delivery of care. The Trust will be assessed against its performance objectives for 2018-19 based on the metrics set out within the operating plan.

Financial implications

Not delivering the Control Total would have led to the Trust losing the S&T Fund. Other affects include the NHSI ratings of the Single Oversight Framework.

Legal issues

None

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

Chief Finance Officer/Deputy Chief Executive, with support from the Executive Management Team

Who is accountable for the implementation of the proposal / project

Chief Finance Officer/Deputy Chief Executive

Final Submission
Year 2 of NHSI 2 Year Financial Plan
2018/19

Financial narrative to accompany the 2018/19 plan

1. Executive Summary

The NHS planning and contracting process for 2017/18 and 2018/19 required GOSH to submit an initial two-year plan. Following the revised guidance in line with the updated control totals, the trust has now submitted a final version of the financial plan.

Following the publication of the guidance, the initial phase of the financial planning that has been undertaken is considered a 'top-down' approach and will provide the bridge and key assumptions between the current year forecast outturn and 2018/19. The targeted control total for 2018/19 is as follows:

	£ million		
Current 2018/19 control total (including allocated STF)	11.005	Current STF allocation (from the £1.6 billion STF General Fund)	5.384
	Surplus		
Net impact of CNST income and spend changes	1.214	Additional STF allocation (from the additional £650 million STF)	2.187
Risk Reserve (available for deployment)	-1.060	Total allocated STF – the enhanced provider sustainability fund (included in revised 2018/19 control total above)	7.571
Additional STF allocation	2.187		
2018/19 control total (including allocated STF) before flexibility	13.346	Agency ceiling for 2018/19	6.123
	Surplus		
CT flexibility changes made if 2017/18 control total (excluding STF) is delivered	-1.281		
Revised 2018/19 control total (including allocated STF) after flexibility	12.065		
	Surplus		

The Trust proposes to meet its proposed control total for 2018/19 subject to the following assumptions:

- The NHSE Contract for 2017/18 includes the impact of the Local Price Review, demographic growth, high cost drugs and devices growth, tariff inflation, activity to maintain RTT performance, commissioner QIPP of £7.6m and business cases. The contract value that has been proposed by NHSE is £314m and this has notionally been accepted by the Trust though is below the level that had been submitted in the original submission of the NHSI plan and is somewhat short of the level the Trust would have endeavoured to agree a final figure.
- The Better Value Programme from which CIP's are governed and undertaken will need to deliver £15m of tangible savings for 2018/19. This is being forecast to be delivered in full but the detail behind specific schemes remains in development at the time of the submission and given the nature of such programmes may be subject to change in year for which any changes will be clearly highlighted.
- Inflation is funded for pay, non-pay and income (where appropriate) in line with OBR forecasts. This amounts to £6.3m for pay and £2.2m for non-pay.
- A separate contingency of £5m has been set aside to account for cost pressures arising in year, and fund any developments arising. This will be managed exclusively by the chief executive.
- The return makes no provision for changes to the standards around IFRS15 on revenue recognition which the Trust is in the process of validating.
- There is no adjustment within the current return for the proposed pay award for Agenda for Change staff for which it has been assumed that all costs will be funded via a separate allocation.

2. Background

The control total numbers can be found in the table below and show the 2017/18 control total, 2018/19 control total and the 2017/18 final year end position (subject to confirmation by external audit). The 2018/19 intention is to achieve the control total that was set within the submission of the two-year plan and adjusted per the revised control totals target set by NHSI in February 2018.

The year-end position includes over delivery of income across NHS contracts and include a final settlement of £313.2m with NHSE. The final position was somewhat short of the Month 9 forecast outturn submitted in the previous return due principally to under delivery of income and activity in the last quarter within NHS activity and within IPP.

The final position was as follows:

Year	Forecast outturn / Outturn	Net variance to control total
2017/18 Forecast outturn included in prior return (based on M9 position)	£11.4 million surplus	£1.7 million surplus
/2017/18 unaudited OT excluding STF bonus and incentives	£9.9 million Surplus	£0.2 million surplus
2017/18 unaudited OT including STF bonus and incentives	£13.6 million Surplus	£3.7 million surplus

In addition to the above, the Trust was in receipt of a combined £3.7m of STF bonus and incentive funding for 2017/18 which were not factored into prior months and ultimately led to an improvement in the year end outturn position.

3. Approach to financial forecasts/planning

Initial Submission Phase

The initial phase of the financial planning was considered a 'top-down' approach and provided the bridge and key assumptions between the current year forecast outturn and the 2018/19 plan. This has been evolved at a detailed level to take account of changes within individual services and in line with detailed budget setting to take account of local needs across the Trust's divisional structure.

The plan has however been derived for 2018/19 from in principle, a roll forward of the 2017/18 budgets, updated based on latest forecasts and challenged against draft financial outturn and noting that the following additional adjustments were made for:

- non-recurrent income and expenditure;
- changes in proposed contract activity and tariff, private income, other income and assumptions for CQUIN;
- known changes to costs for future years;
- cost inflation, productivity and efficiency targets and unavoidable cost pressures;
- any business cases approved in year in line with the Trust mandated approval process; and specifically;
- annualised cost pressures from the opening in 2017/18 of Phase 2b of the Trust's Capital Masterplan (Premier Inn Clinical Building).

Detailed Budget Development Phase

The development of the detailed budgets by cost centre is based on a rolled budget from the 2017/18 position but these have been reviewed at a line by line basis with divisions. The detailed allocations to

divisions will continue to be refined after the submission of the final NHSI plan as there has been a concerted effort to ensure that the appropriate level of detailed allocations has occurred at all expenditure lines so that budgets are clear and transparent and don't just balance at a bottom line level.

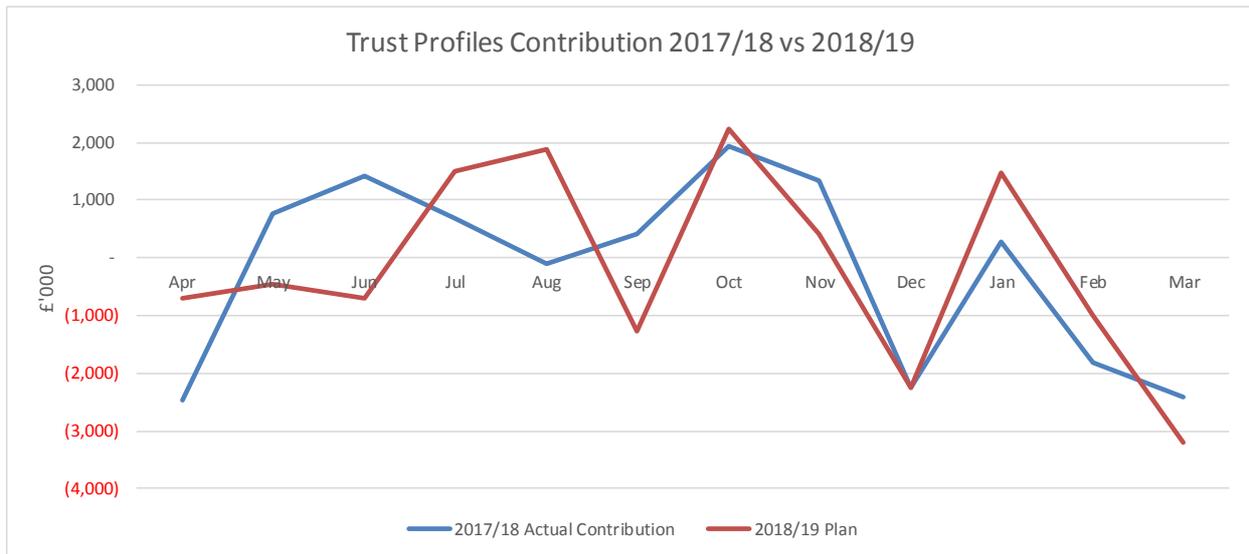
These will not affect delivery of the overall bottom line and the Trust is still forecasting to achieve its overall control total.

Profiling

The Trust has aligned the 2018/19 plan in line with an agreed proposal that in summary assumes:

- Elective income is principally driven by working days.
- Non elective income is driven by calendar days in month.
- Controllable non-pay is linked to activity when there is a demonstrable link to activity and this has been refreshed in this round of budgeting to take account of outturn.
- Business Cases and Pay / Non-Pay etc. are phased according to each case as they were set out and will be monitored in year to ensure they meet the original requirements of the case.
- Specific seasonality has been incorporated for Christmas and an allowance has been made for Eid and Ramadan which have specific effects on delivery of IPP income as the majority of IPP work is derived from the Middle East.

The net effect of the proposed changes indicates a plan that is comparable with prior years:



4. Summary Financial Statements 2018/19

Control Total Targets

Year	Control Total	Adjustment for Depreciation on Charity Funded Assets	Net Surplus (Deficit) including Dep'n for charity funded assets
2017/18	£9.7 million Surplus	£9.5 million	£0.2 million Surplus
2018/19	£12.1 million Surplus	£11.6 million	£0.5 million Surplus

Income Statement

The statement below lays out the original 2017/18 plan, year-end outturn and the new revised plan incorporating the forecast outturn.

£m	2017/18 Plan	2017/18 Outturn	2018/19 NHSI Return
NHS & Other Clinical Revenue	276.6	280.6	280.6
Pass Through	63.5	64.3	63.5
Private Patient Revenue	60.7	57.3	63.5
Non-Clinical Revenue	53.3	63.3	62.9
Total Operating Revenue	454.1	465.4	470.5
Permanent Staff	(225.5)	(232.0)	(239.9)
Agency Staff^	(6.4)	(4.4)	(6.0)
Bank Staff^	(17.0)	(17.3)	(16.7)
Total Employee Expenses	(248.8)	(253.7)	(262.6)
Drugs and Blood	(13.1)	(12.4)	(12.0)
Other Clinical Supplies	(46.4)	(43.7)	(39.1)
Other Expenses	(54.1)	(62.0)	(64.4)
Pass Through	(63.5)	(64.3)	(63.5)
Total Non-Pay Expenses	(177.1)	(182.4)	(179.0)
Total Expenses	(425.9)	(436.1)	(443.2)
EBITDA	28.2	29.3	28.8
Depreciation on Trust-funded assets	(11.2)	(8.3)	(9.3)
Interest	0.2	0.1	0.1
PDC	(7.5)	(7.5)	(7.5)
Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	9.7	13.6	12.1
Depreciation on Donated Assets	(9.5)	(9.3)	(11.6)
Impairments	(8.0)	(2.9)	(2.5)
Net (Deficit)/Surplus after adj for dep on donated assets	(7.8)	1.4	0.5
Capital Donations	72.1	24.7	45.0
Net Result	64.3	26.1	42.4

Statement of Financial Position

£m	2017/18 Plan	2017/18 Outturn	2018/19 NHSI Return
Non-Current Assets	536.7	463.3	512.3
Inventory	7.3	8.9	9.5
Debtors	67.2	77.1	77.3
Cash	53.8	55.7	39.1
Creditors	(70.5)	(70.1)	(60.6)
Provisions & Non-Current Liabilities	(5.1)	(5.5)	(5.3)
Total Assets Employed	589.4	529.4	572.3
PDC Reserve	126.0	127.3	127.3
I&E Reserve	353.6	305.1	348.0
Revaluation Reserve	106.7	93.9	93.9
Other Reserves	3.1	3.1	3.1
Total Taxpayers' Equity	589.4	529.4	572.3

Statement of Cash flow

£m	2017/18 Plan	2017/18 Outturn	2018/19 NHSI Return
Cash flows from operating activities			
Operating (deficit) / surplus - excluding charitable capital expenditure	9.0	11.9	7.9
Impairment and Reversals	(8.0)	(2.9)	(2.5)
Charitable capital expenditure contributions	33.8	24.7	45.0
Operating surplus	34.8	33.7	50.4
Non-cash income and expense			
Depreciation and amortisation	17.7	17.6	21.0
Impairments and Reversals	0.0	2.9	2.5
Gain on disposal	0.0	0.0	0.0
Increase in trade and other receivables	(22.3)	(9.8)	0.3
(Increase) / Decrease in inventories	(0.2)	(0.6)	(0.7)
Increase in trade and other payables	6.9	12.3	(9.4)
Decrease in other current liabilities	(0.4)	0.3	(0.1)
Decrease in provisions	(0.1)	1.2	(1.2)
Net cash inflow (outflow) from operating activities	1.6	23.9	12.4
Cash flows from investing activities			
Interest received	0.1	0.1	0.1
Purchase of property, plant and equipment and Intangibles	(50.4)	(37.7)	(71.9)
Net cash used in investing activities	(50.3)	(37.6)	(71.8)
Cash flows from financing activities			
Public Dividend Capital received	0.0	0.6	0.0
PDC dividend paid	(7.5)	(7.4)	(7.5)
Net cash outflows from financing activities	(7.5)	(6.8)	(7.5)
Increase/(decrease) in cash and cash equivalents	(21.4)	13.2	(16.5)
Cash and cash equivalents at period start	63.7	42.4	55.6
Cash and cash equivalents at period end	42.4	55.6	39.1

Annual Plan 2018/19

The plan assumes a reduction in cash of £16.5m; this includes a Trust-funded capital plan of £5.9m above depreciation for the year and a reduction of payables by £9.4m. NHS debtors is planned to increase at the beginning of the year before improving in November once over-performance invoices are settled with commissioners.

Template Reclassifications (technical changes)

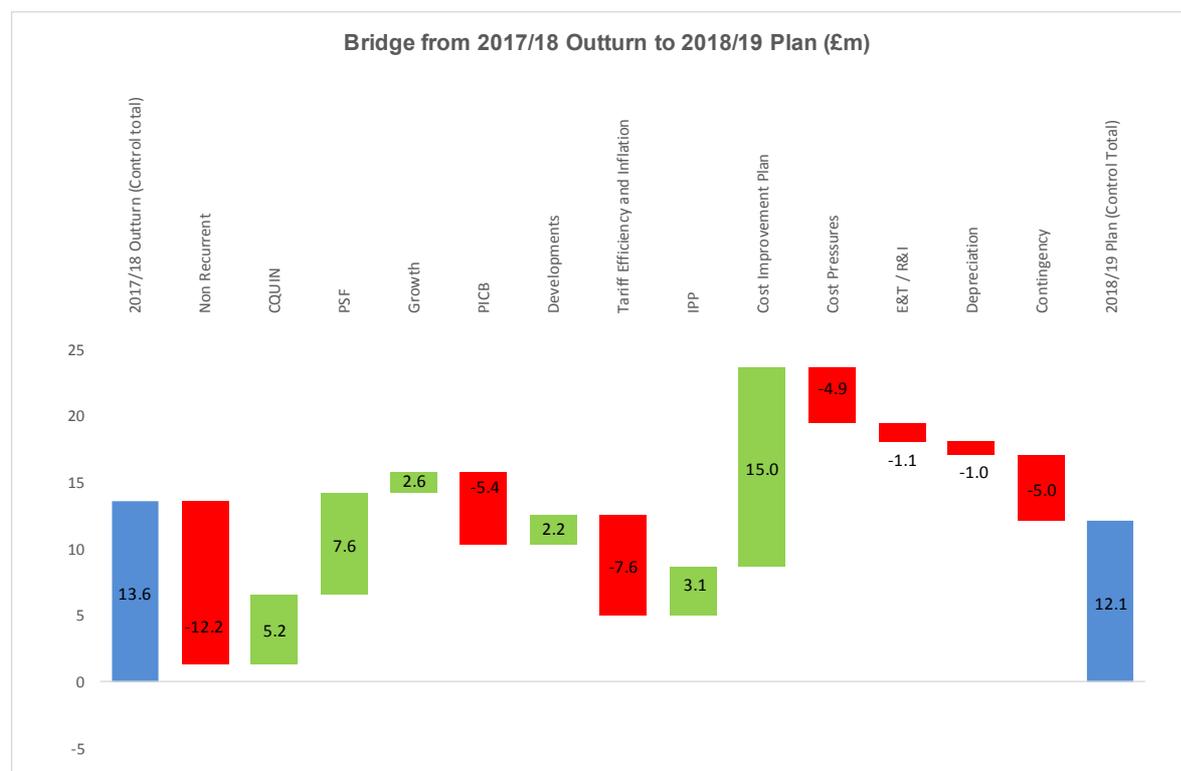
From prior year submissions, the following changes have been made:

- Other Non-Current Financial Assets has been reclassified into Trade and other receivables (NHS and Non-NHS)
- Other Financial Assets has been reclassified into Trade and other receivables
- Other Financial Liabilities has been reclassified into Trade and other payables - non capital

Please note that the accounts have been prepared excluding any impact associated with Revenue Recognition under IFRS15; the sum extent of the impact on the proposed changes is being determined for 2018/19 via peer review and in line with an assessment of the impact on the Trust on 2018/19. If any material changes arise from the implementation of IFRS15 to the delivery of the Trust position in 2018/19, this will be updated via the submission of templates throughout 2018/19.

5. Bridging/Planning Assumptions

The assessment including bridging adjustments from out-turn to plan 2017/18 and 2018/19 is presented below.



The plan includes the following assumptions.

2017/18 M9 FOT (Control total)	£13.6m	This aligns with the Trust reported year end outturn and included the £9.9m of surplus delivered in year but uplifted by the £3.7m of income received for STF incentive and bonus funding.
Non Recurrent Adjustments	(£12.2m)	STF (inclusive of bonus and incentive) of £9.0m was removed along with CQUIN of £4.2m, RTT delivery of £2.5m, offset with the £3.5m contingency set aside at the start of the year to fund in year initiatives..
CQUIN	£5.2m	This has been added back at £5.2m with an adjustment of £1m to account for non-delivery in 2018/19 assumed within cost pressures. <i>Note: this equates to 80% delivery of plan.</i>
Provider and Sustainability Funding	£7.6m	In line with the revised NHSI plan, this has been set in line with the revised control totals at £7.6m. <i>Note: this replaces Sustainability and Transformation Funding</i>
Growth	£2.6m	The income associated with the outturn from 2017/18 has been factored into our recurrent plans net of cost.
Premier Inn Clinical Building (PICB)	(£5.4m)	PICB was opened in 2017/18 and the part year effects of opening the facility were included in the 2017/18 outturn. There are additional recurrent costs of staffing and running the new building which are factored into the 2018/19 plans and from part of the divisional budget envelopes for the divisions.

Developments	£2.2m	There were a number of initiatives arising in 2017/18 that were agreed as changes to the provision of services via the Trust's Business Case approval process that have been funded recurrently in 2018/19.
Tariff Efficiency and Inflation	(£7.6m)	These were increased in line with OBR and NHS forecasts for Income, Pay and Non-Pay. These were set at £0.9m for income, £6.3m for pay and £2.2m for non-pay.
International private patients (IPP)	£3.1m	The Trust has delivered year on year growth associated with its increased IPP capacity. There are a number of stretch targets agreed for 2018/19 and subsequent years and these have been reflected appropriately in the plan.
Cost Improvement Plan	£15.0m	The Better Value Programme for the Trust has been set to 2017/18 levels. The breakdown of savings in the indicative plan is: Non-NHS Income £3.5m, Pay £5.3m, Non-Pay £6.2m.
Cost Pressures	(£4.9m)	Cost pressures have only been funded where the position has been deemed unavoidable. There have been a number of estates costs incurred by the Trust due to increased rent and rates and several other corporate pressures arising in year that have agreed to be budgeted for in 2018/19.
E&T / R&I	(£1.1m)	Reductions in HEE funding have been assumed at 10% and a revised reduction of £0.1m for grant income.
Depreciation	(£1.0m)	This is assessed only on Trust owned assets and the level of spend has increased by £1.0m within the plan due predominantly to equipment purchases.
Contingency	(£5.0m)	£5m contingency has been included for 2018/19; this is an increase of £1.5m from 2018/19 and adds further resilience to the Trust for issues arising in year.

6. NHS England Contract

NHS Improvement and NHS England published the NHS Operational Planning and Contracting Guidance 2017/19 on 22 September 2016. Joint NHS England/NHS Improvement guidance setting out the expectations for updating operational plans for 2018/19 was published on 2 February 2018.

The joint guidance stipulated that contract variations to the existing 2017/19 contract should be signed no later than 23 March 2018. Local decisions to enter into mediation for 2018/19 contract variations were required by 2 March 2018.

Due to the significant and material financial difference between the Trust and NHS England on 2 March 2018, a mutual agreement to enter mediation had been undertaken with expectations that NHS England would provide an updated contract value offer during the week commencing 5 March 2018.

Negotiations continued through March once the mediation process had begun in earnest and a revised settlement was ultimately received from NHSE for 2018/19 for £314m. This has been accepted by the Trust and is the basis for the inclusion of the clinical income target within the 2018/19 budget.

Principles and Assumptions

The following principles and assumptions have been applied in arriving at the proposed Trust contract value for 2018/19.

1. National Pricing

The 2017/18 and 2018/19 National Tariff Payment system was published on 22 December 2016. The Trust has grouped activity using the current tariff grouper and priced PbR activity according to the 2018/19

national prices. Local prices are uplifted by 0.1% in line with the net tariff inflator outlined by NHS Improvement.

2. Starting Baseline

The baseline activity is the 2018/19 activity plan, prior to RTT activity requirements, with local knowledge from individual specialties on any changes for 2018/19.

3. Growth

Specific growth has been applied in line with local knowledge from individual specialties, an overall adjustment for demographic growth for children has not been undertaken. Non demographic growth on pass through drugs costs has been applied at 10% based on the growth levels over the past two financial years,

4. Other adjustments

The baseline has been adjusted for the full year effect of the outcome of the pricing review jointly undertaken in 2016/17. Both NHS England and the Trust now need to work to agree the revised prices and activity levels for those services already reviewed.

Achievement of commissioner QIPP is increasingly difficult. The Trust has included 2.75% or £8.6m for 2018/19 as this is the current contractual requirement.

The Trust has included internally agreed business cases, including the potential impacts of changes arising from the CHD review, within the NHS England contract proposal for 2018/19.

5. CQUIN

2.0% has been included on all points of delivery apart from pass-through costs. The current local GOSH specific schemes are expected to continue from 2017/18 where appropriate and proposals for alternative schemes are under development. The current expectation is that 80% of the CQUIN contract value will be achieved.

Comparison of NHSE Contract Value, NHSI Plan and GOSH Proposal

Following a series of conversations with NHSE, the Trust agreed on a settlement of £313.2m for 2017/18 which was significantly in excess of the signed contract variation issued to the Trust midway through 2017/18 for £306m.

The Trust assumed delivery of £318m of NHSE activity in the original 2018/19 plan that was submitted to NHSI in March but has since set the contract value in line with the latest contract offer of £314m.

The table below summarises the variances:

	2017/18			2018/19	
	NHSE Contract £'m	NHSI Plan £'m	GOSH Forecast £'m	Original NHSI Plan £'m	NHSE Contract £'m
Activity	243.1	244.0	246.6	253.3	248.9
Pass through	65.6	69.9	70.3	68.9	68.8
CQUIN	4.9	4.0	3.9	5.1	5.0
QIPP	-7.6	-7.6	-7.6	-8.9	-8.7
TOTAL	306.0	310.3	313.2	318.4	314.0

Great Ormond Street Hospital			
	Activity £'000	Pass through £'000	TOTAL £'000
GOSH 18/19 opening baseline	249,209	62,998	312,207
RTT	2,500		2,500
Inflation	5,130		5,130
Efficiency	-4,886		-4,886
Growth	1,447	5,891	7,338
Impact of HRG 4+	455		455
QIPP		-8,744	-8,744
			0
TOTAL	253,855	60,145	314,000

7. Capital plan

Capital is funded by a combination of charity funds which are almost exclusively donated by the Great Ormond Street Hospitals Children's Charity (GOSHCC) and Trust funds. Charity funding assumed in this plan has been allocated based on grants committee approvals on final business cases and specific known schemes.

The budget for Trust-funded capital is set at the level of forecast depreciation for the year plus any agreed slippage brought forward from the previous year.

The Trust has undertaken significant charity funded capital investment in prior years following the implementation of the Trust's Masterplan which has included the opening of Phase 2a (Morgan Stanley Clinical Building), Phase 2b (the Premier Inn Clinical Building opened in 2017) and a number of significant capital projects are forecast for this and future years to enable the delivery of Phase IV of the Master Plan which encompasses the redevelopment of the frontage of the hospital and the subsequent enabling works required before then. For 2018/19, there are additional capital costs associated with these projects.

The Trust is also mid-way through the implementation of the Electronic Patient Records (EPR) Project and there are significant Trust and Charity funded drawdowns required in this and future years to support that scheme of work. These are included within the capital plan.

A summary of the capital plan is provided in Appendix 1.

Trust Funded Schemes

Following this initial review of capital budgets, the following notional allocations have been agreed to be put forward:

- Schemes already approved in prior years (£15.9m)
- Additional funding required for schemes approved in prior years (£2.9m)
- New schemes, including Phase 4 (£9.2m)

Donated funding

Capital funding from the charity is defined according to projects that have been agreed at the Grants committee to cover multiple years or for which an annual allocation of funding is made.

Projects funded by the GOSHCC for 2018/19 are estimated at £45m and currently fall into the following groups:

- EPR (£16.0m)
- Major construction projects for which funding has been agreed, including, Sight & Sound Hospital, Southwood Courtyard (IMRI), Nursery (Total £24.4m)
- Major imaging equipment refresh programme agreed in principle (£2.5m)
- Other medical equipment (£2.0m)

The timing in each of the next five years for this will be determined by the Equipment Replacement Plan which seeks to prioritise equipment replacement according solely to clinical need.

8. The Better Value Programme (CIP's)

The Trust takes a thematic approach to risk profiling around the development of CIP's. The approach is set out below:

Learning from experience and feedback from divisions in 2017/18, we have rebalanced the programme for 2018/19, with an increased (2.5%/£8.3m) target for local schemes and reduction of the target (£6.7m) for cross-organisational initiatives. This more closely reflects what has been found to be realistic and deliverable over the course of the current year.

The following are the targets for the cross-organisational initiatives. Each cross-organisational scheme has an executive SRO supported by a senior implementation lead and nominated PMO input. The majority of the schemes will also be supported by a named clinical lead with dedicated sessional time allocated.

Cross organisational area	Target 2018/19
Outpatients flow	£0.2m
Patient placement	£0.8m
Theatres	£0.8m
Non pay and waste reduction	£1.3m
Medicines management	£0.4m
Workforce – medical	£0.4m
Workforce – nursing	£0.3m
Workforce – other	£0.4m
ICT enabled (non EPR)	£0.3m
Commercial – IPP	£1.0m
Commercial – other	£0.8m
Total	£6.7m

Schemes under final development include:

Flow

Three major flow programmes have been established, each comprising several workstreams and individual projects.

Some of the flow activities anticipated to form larger features of the Better Value flow programme for next year include:

- **Outpatients** – improvements to referral management, outpatient letters and the text reminder system; rollout of self-service kiosks and systems to improve patient flow and movement within the hospital; revised outpatient space utilisation policy; and actions to reduce staff turnover;
- **Theatres** – increased rollout of pre-operative assessment, installation of automated scrubs dispensing, improved list utilisation including focus upon on-time start for first cases of the day, conversion of some sessions to full day lists, improved list booking arrangements;
- **Patient placement** – establishment of new control hub/visual management; increased early focus on discharge through rollout of DART round pilot; improved use of data analytics eg on ward dynamics and load and bank shift fill predictions; development of nursing pools.

Non pay and waste reduction

In addition to continued rollout of inventory management and improved stock control arrangements, plus ongoing work to negotiate the best prices, work over the coming year will focus on minimising unnecessary practice variation and increasing product standardisation (led by newly established clinician led reference groups). There is also a new focus on diagnostics and investigations – with the development of updated test order sets and avoidance of unnecessary and/or repeat testings. in part linked to the use of PLICS.

Workforce

A wide range of workforce schemes are under development, including focus on reducing time to hire coupled with more rapid induction programmes; a review of additional pay and overpayments; review of supernumerary periods; focus on management of sickness absence and annual leave; programme to improve retention; review of shift patterns; increased use of the apprenticeship levy; and benefits from the introduction of a new eRostering system (building upon this year's work to improve adherence to rostering rules).

Local schemes

Examples of local schemes include: partnering arrangements for cochlear care, care pathway redesigns, improved maintenance contracts, reductions in blood product wastage, condensed GIU lists, non-NHS incomes schemes and IPP growth.

Better Value governance and next steps:

Governance and reporting

Progress on development of the programme is overseen by the weekly business planning working group chaired by the Deputy CEO and delivery of the programme will be overseen by a newly-established executive level Better Value Programme Board. Quality Impact Assessment will continue to be overseen by the QIA Panel chaired by the Chief Nurse and the Medical Director. Assurance to the Board is provided through regular reports on the programme, both to the Board itself and to its committees – Audit and Risk, Quality and Safety Assurance and Finance and Investment.

Approach to delivery risk

In addition to the QIA process, before schemes are signed off within the programme, they will be risk-assessed with projected financial benefits adjusted as a result. Where this results in reductions to savings, divisions will need to work either to improve likelihood of full delivery of their schemes, or to find additional projects to fill the gap. The approach to be adopted is summarised as follows:

Level of confidence of delivery	Description	Risk adjustment when counting planned savings
Certain	<ul style="list-style-type: none"> Plan already fully developed and all actions taken to give assurance of full delivery of the full projected value 	100%
High	<ul style="list-style-type: none"> Plans to deliver the scheme are running to schedule, or have not yet started but there are no material concerns Milestones are understood and preparatory work on track There are no major risks that could affect scheme delivery There is a low level of scheme complexity There is high confidence of the scheme being delivered in full and on time There is clarity on how financial benefits will be evidenced and delivered 	90%
Medium	<ul style="list-style-type: none"> Plans are broadly on track or not yet started but there are no significant concerns There are some risks/unknowns to delivery but manageable with strong mitigations Moderate level of scheme complexity within divisional control Milestone delivery is on track or missed milestones are not mission critical There is reasonable confidence of the scheme being delivered in full and on time or with only minimal slippage 	75%

Low	<ul style="list-style-type: none"> • There is a high level of confidence that an approach to evidencing financial delivery will be achieved 	30%
	<ul style="list-style-type: none"> • Plans are behind schedule or not started and there are concerns that will require close management • There are significant risks to delivery which could cause delays • Milestones have been missed or preparatory work to deliver the scheme is not complete • There is a high level of complexity with multiple stakeholders or external factors • There is belief the scheme can be delivered but there are material concerns about timing and scale • Measurement of financial benefits is unclear 	

Appendix 1 – Capital Plan

		2018/19	2019/20	2020/21	2021/22	2022/23
Funding	Scheme category	£000	£000	£000	£000	£000
Trust	Fire safety	750	700	530	490	335
	Information technology (IT)	5,635	2,724	1,781	2,831	1,736
	Routine Maintenance (non-backlog) - Land, buildings and dwellings	5,106	6,792	9,440	9,499	10,345
	New build – land, buildings and dwellings	6,663	1,571	0	0	0
	Other - Intangible assets	9,776	7,713	8,219	7,675	8,575
	Plant and machinery/equipment/transport/fittings/other	70	0	0	0	0
Trust Total		28,000	19,500	19,970	20,495	20,991
Donated	Routine Maintenance (non-backlog) - Land, buildings and dwellings	4,957	0	0	0	0
	New build – land, buildings and dwellings	18,687	14,771	17,350	17,707	43,014
	Other - Intangible assets	16,034	2,178	0	0	0
	Plant and machinery/equipment/transport/fittings/other	5,287	6,087	3,500	4,500	5,300
Donated Total		44,965	23,036	20,850	22,207	48,314
Grand Total		72,965	42,536	40,820	42,702	69,305

Great Ormond Street Hospital for Children NHS Foundation Trust Operational Plan 2018/19 refresh

Introduction

Strategic context

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) is an acute paediatric provider of specialised and highly specialised treatment and care for children presenting with rare and complex diseases and conditions. This is why our vision, which sets our direction, is 'helping children with complex health needs fulfil their potential'. Our mission is to put 'the child first and always', which is supported by our 'always values' - to be always welcoming, always helpful, always expert and always one team.

Since the two year Operational Plan (2017/18 to 2018/19) was set in December 2016, the Trust has been undertaking a programme of work to update and embed its strategy, with this mission and vision as its starting point. The revised strategy is formed around the framework set out in the diagram below.



In 2017 more than 260,000 patients from all over the country attended GOSH, around half from outside London – so our population is not local. We provide over 50 different specialist and sub-specialist paediatric services – the widest range on any one site in the UK. 90% of our funding is from NHS England specialised commissioning. These factors do set us apart from other providers, but they do not hide us from the very challenging environment across the NHS. GOSH continues to experience pressures such as increasing operating costs; rising demand across core services like cardiac, neuroscience, and cancer; staff shortages; and a requirement to find a place in the new structures and reforms and wider-NHS strategies.

However, the environment also presents exciting opportunities. We are committed to becoming a hospital where research is integral and drives treatment and outcomes. We have seen some exceptional research outcomes this year, many of which have immediately improved children's lives. During treatment patients and their families might be going through the toughest times of their lives, so great importance is put on creating nurturing environments, and high-quality facilities for providing specialised and highly-specialised care, so our estates and facilities are critical. The opening of the new Premier Inn Clinical Building, for example, brings a number of services into one brand new facility from across the current estate. We will use technology to move towards a digital future, to access information and share information, make decisions, engage patients and partners and drive safety. In the context of decreasing real-term funding for specialised and highly specialised services as well as the high costs associated with providing specialised and highly specialised services, funding and financial stability remains critical. It helps us to continue to grow our portfolio of research grants and research posts, fund infrastructure funding for our Somers Clinical Research Facility, while the GOSH charity helps to fund buildings and equipment. Private patient work is also key to providing financial support for our NHS paediatric services.

Our strategic objectives are aligned to eight areas of focus that reflect these challenges and opportunities – care, people, research, technology, voice, space, funding, and information.

Key achievements in 2017/18 and plans for 2018/19

Teams across the Trust have made significant progress and achievements in the first year of the Operational Plan (2017/18 to 2018/19, in line with these key areas of focus. These achievements include:

- Opening of the new Premier Inn Clinical building
- Achieving the national RTT target
- Delivery of the Trust's 'Better value' programme
- Establishing of the work programme to design and build the new EPIC Electronic Patient Record (EPR) system
- Ongoing progress in developing the business case for construction of 'Phase 4' in line with the Trust's master plan

As part of our strategic planning process we have defined a set of strategic programmes for 2018/19 that focus on GOSH's current situation and represent the best set of programmes now and for 2018/19.

Therefore, a rapidly changing environment means we will re-examine all programmes each year as part of our planning process. Some examples of our strategic programmes and areas include:

- Continue to deliver the national RTT target
- Deliver a £15m Better Value programme
- Complete work on EPR for 'go live' in April 2019
- Continue progress on 'Phase 4' development
- We will also continue work with the Cognitive Institute to deliver a Safety & Reliability Improvement Programme that will improve the culture of safety and accountability within the Trust
- Develop a GOSH Learning Academy
- Zayed Research Centre, undertaking research into rare diseases to diagnose, treat, and cure children with rare conditions
- Continue to develop alliances, partnerships and networks to influence and improve care as well as build commercial opportunities

The following sections of this operational plan refresh set out further details relating to these and other areas, following the format and prescribed content areas required by NHS Improvement

Operational Plan

2018/19 Refresh

1 Approach to activity planning

1.1 Activity plan

The two year Operational plan for 2017/18 to 2018/19 was set in December 2016. The 2018/19 activity plan within this has now been reviewed and updated.

The table below sets out the revised assumptions for the Trust's activity plan for NHS England and CCG activity:

	17/18 forecast outturn	18/19 Plan	Growth	Original plan assumption
Consultant led first outpatient attendances	33,788	34,162	1.1%	1.4%
Consultant led follow up outpatient attendances	171,691	172,994	0.8%	1.4%
Elective admissions	34,746	35,608	2.5%	2.7%
Non-elective admissions	2,283	2,316	1.4%	1.4%

Key assumptions for 2018/19:

- First and follow up outpatient growth is predominantly due to two factors: additional activity required to deliver national access targets (see section 1.2 below) and the impact of specific areas of identified growth mainly relating to cardiac, and particularly inherited cardiovascular disease (ICVD).
- Elective (including day case) growth relates to additional activity required to deliver national access targets (see section 1.2) and cardiac growth.
- Based on review of activity trends, and given the nature of services at GOSH, material impacts of activity change have been identified for specific services only – for example, for ICVD and other cardiac services. A generic demographic assumption has not been applied.

Changes from original 2018/19 plan:

- As presented in the table above, the refreshed activity assumptions are not significantly different from the original plan submitted for 2018/19 in December 2016. The reductions in outpatients and elective admissions relate to refreshed assumptions for RTT, and more specific allocation of demographic growth assumptions.

The following sections set out further detail in relation to activity changes, in terms of activity and physical capacity.

1.2 Access targets

Delivering the activity changes required for sustainable delivery of access targets has continued to be a focus throughout 2017/18, and the Trust has worked closely with its specialist commissioner, NHS England, the CQC and NHI, to address the associated challenges and requirements. The 2018/19 plan has been updated to reflect the most recent expectations around this.

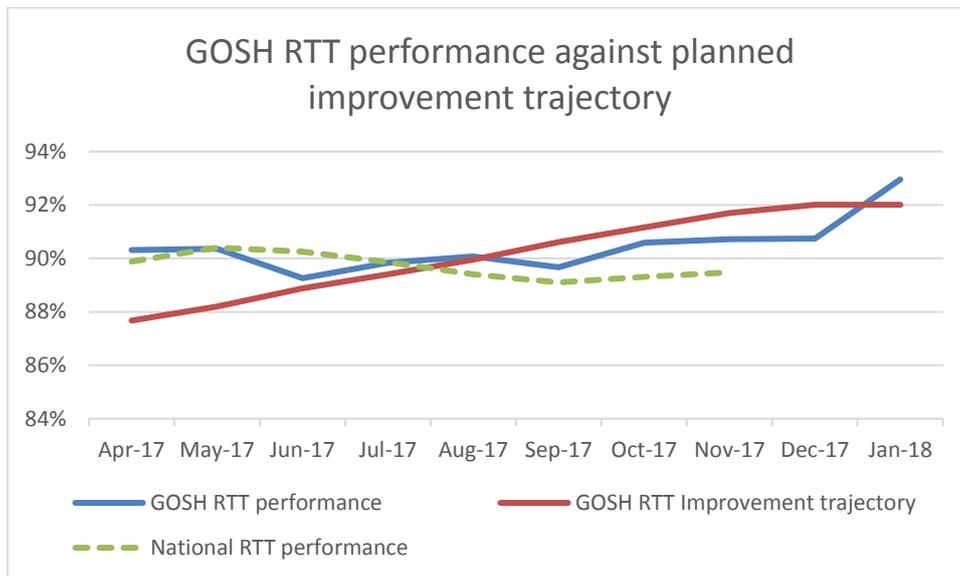
Referral to Treatment target (RTT)

Following support from the NHS Improvement Intensive Support Team (IST) in 2015/16, the Trust has used IST tools to model demand and capacity, particularly focusing on key challenged specialties for RTT compliance including:

- Orthopaedics
- Spinal
- Urology
- Specialist neonatal and paediatric surgery (SNAPS)
- Plastic Surgery
- Neurology

For each speciality, these models have been used to determine the level of activity and the associated capacity needed to support delivery.

As of January 2018, the Trust is now achieving the national RTT target. This was later than the improvement trajectory planned as part of the original two year operational plan for 2017/18 to 2018/19. This was due to the delayed opening of additional capacity, a number of staffing issues in highly specialised areas, and also partly due to the resolution of some additional data quality issues, now resolved.



The additional capacity was opened in November/December 2017 (delayed from August 2017) – this will enable the sustainable delivery of increased levels of activity in challenged specialties, and thereby support the ongoing achievement of the RTT target in 2018/19.

Diagnostics target

Significant work has taken place to improve performance against the diagnostics target during 2017/18, with the Trust achieving the target in November, missing by 1 breach in December and achieving again in January. However, this continues to be a challenge, partly due to the very small margin allowed in terms of number of patients breaching (the target will be failed if there are c. 5 breaches in a month). The plan is to achieve this target throughout 2018/19 – however, this will continue to be at risk on a monthly basis, due to the small numbers involved.

Cancer target

The Trust has delivered against the applicable cancer targets throughout 2017/18 and this is expected to continue throughout 2018/19.

1.3 Expansion of PICU and NICU

The original operational plan for 2017/18 to 2018/19 set out the intention to open two additional NHS PICU/NICU beds (and one further bed relating to private patient activity) in 2017/18, following on from the an increase of two beds at the end of 2016/17. This would bring the total number of staffed beds to 29. The aim was to support the delivery of additional activity required to meet the RTT target, and to meet demand for emergency referrals (in 15/16 190 referrals were refused).

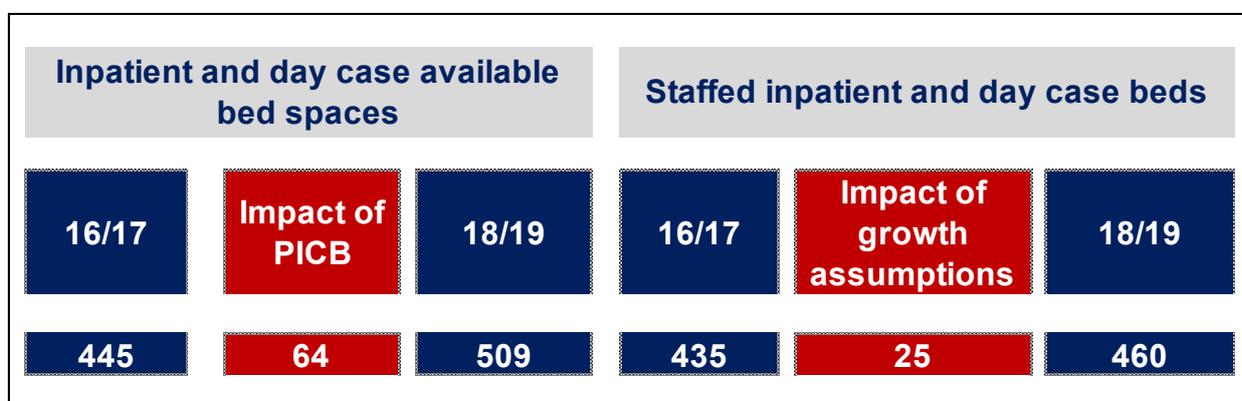
During 2017/18 there have been a number of challenges in implementing this plan, both in terms of lower than expected demand (replicated across other London paediatric centres) and in our ability to staff the beds. Further work is being undertaken for 2018/19 to reassess demand and the appropriate level of resource required in this area to deliver the plans.

1.4 Premier Inn Clinical Building

The Premier Inn Clinical Building (PICB) opened in November 2017 (delayed from the original planned date of August 2017). Further detailed work continued to take place after the setting of the original two year operational plan which led to a number of changes regarding plans for relocating beds and opening new beds.

Under the final plans, this will allow 77 beds to be relocated to the brand new facilities, and the potential to open an additional 64 beds in future. Of these, the 2017/18 and 2018/19 plans involve opening an additional 25 beds, principally focused in RTT challenged specialties and cardiac.

The impact of PICB on the trust’s overall capacity is set out below:



1.5 Other significant assumptions – transfer of congenital heart disease patients

At the time of setting the Operational Plan for 2017/18 to 2018/19, the Trust was in ongoing discussion with NHS England regarding the transfer of an estimated 150 congenital heart disease patients to GOSH, as a consequence of a national review of congenital heart disease services. The transfer had not yet been agreed, and therefore was excluded from the plan at that stage.

On 30 November 2017, NHS England published initial conclusions from its review, which did not recommend that the transfer take place at that stage. However, it set challenging requirements on those trusts from which activity would have been transferred. It remains uncertain whether the trusts will be able to meet these requirements in the set timeframe, and therefore the transfer of this activity continues to remain uncertain. Given this ongoing uncertainty, no assumption regarding this transfer has been assumed in the plan at this stage.

However, in 17/18 (and prior to this) the Trust has had insufficient capacity to meet the demand for non-elective cardiac activity – this is being addressed in 18/19 and will lead to an increase non-elective activity.

2 Quality planning

2.1 Approach to Quality Governance

Under the Executive directorship of the Medical Director, Quality Improvement at the Trust is part of the broad remit of the Quality and Safety team which incorporates Clinical Audit, Patient Safety, Clinical Outcomes and Complaints in addition to a team of Quality Improvement specialists working together to ensure an organisational approach to maintaining and improving our quality governance processes.

Executive oversight of Patient Experience and Engagement is through the Chief Nurse who, with the Medical Director, ensures an organisation wide approach to integrated delivery of the Quality Governance agenda. They are supported in this work by a number of senior roles including the Assistant Chief Nurse for Quality, Safety and Patient Experience, the Head of Quality and Safety and the Associate Medical Director for Quality, Safety and Patient Experience.

Working with the divisional management teams the aim is to continue to develop a culture of continual identification of learning from events and making changes that are effective, sustainable and improve the quality of the service and experience of our children, young people and their families.

The Quality and Safety team work collaboratively with the Trust's Project Management Office (PMO) to ensure the right resources are available to the right work streams at the right time. This will reduce the risk of duplication of efforts and support the transition of projects to 'business as usual' whilst providing effective support to sustain changes and monitor outcomes.

Each of the priority quality improvement projects have an allocated Executive Director, operational lead and allocated specialist from the quality and safety team, who, along with other key specialists, form a steering group to oversee and support delivery.

Each improvement project has a steering group that reports to relevant Trust committees such as the Quality Improvement Committee (QIC), the Patient Safety and Outcomes Committee (PSOC) or the Patient Family Experience and Engagement Committee (PFEEC). These committees, alongside a newly-established Education and Workforce Committee, provide assurance to the Trust Board on the quality and safety programme.

Using the Institute for Health Improvement (IHI) model for improvement, the Quality and Safety team use data to encourage improvement activity and to demonstrate and evidence the impact of the improvement programme.

2.2 Summary of Quality Improvement plan

The Quality Improvement specialists work to support, enable and empower teams to continuously improve the quality of care provided to patients across GOSH. In the past year the teams have successfully completed the Neonatal Care project which had two stands: one was improving the care of neonatal jaundice the other being a reduction in repeated newborn screening tests. Both of these projects have seen a sustained improvement in the care that is provided to our patients.

This year also saw the roll out of the Sepsis 6 campaign and the Improving Tracheostomy care and education. These projects have been closed following sustained improvement and handed over to operational 'business as usual'

The team continue to focus on the following projects:

- Improvement activities requested as part of Commissioning for Quality and Innovation (CQUIN)
- Transition
- Intensive Care Unit flow (focussing on Respiratory and Spinal Pathways)
- Safety Huddles and Electronic Patient Status at a Glance (EPSAG)
- Extravasation project
- Early Warning Scores project
- Reduction in Healthcare associated infections

In addition there are a number of locally led quality improvement projects which may receive mentorship and guidance from the Quality Improvement specialists.

Participation in national clinical audits is monitored by the Clinical Audit Manager within the Quality and Safety Team. There is a central clinical audit plan where work is prioritised to provide assurance and to review implementation of learning from serious incidents, risk, patient complaints, and to identify areas for improvement.

2.2.1 Extending collection of clinical outcomes and safety measures and ensuring they are appropriately benchmarked

The Trust has historically defined a range of clinical outcome measures for each specialty and published them on our website. In order to ensure continuing improvement with outcome measurement and reporting we will:

- refocus outcome development on value and patient reported outcome measures as well as clinical outcomes;
- bring outcome data sources into the reporting infrastructure to facilitate timely reporting;
- develop resources for validation and benchmarking of outcomes; and
- publish outcome measures in a way that incentivises quality and allows choice.

2.2.3 Recognition of the deteriorating child

Through the process of reviewing respiratory and cardiac arrests across the Trust it was identified that some children were having unplanned admissions to Intensive Care Units (ICU) yet this was not predicted or reflected in the patient's Early Warning Score. A systematic review of different scores was conducted and found the predictive performance of PEWS to be greater than the current CEWS score in this respect. Plans are now underway to roll this change out across the Trust for completion during 2017. The Trust continues to emphasise the importance of clinical observations, nurses "global professional judgement" and parental observations for identifying the deteriorating child.

The Trust is progressing a number of work streams to review its other processes and ensure they are effective. In particular we have completed the roll out of ePSAG (electronic Patient Status at a Glance) boards into every inpatient ward and bespoke ambulatory areas and will complete the roll-out of the use of clinical safety huddles across all inpatient ward areas to increase situational awareness by 31 December 2016.

2.2.4 Cognitive Institute (Safety, Reliability and Improvement Programme)

The Trust is committed to and signed up to the Cognitive Institute's safety and reliability improvement partner programme which include:

- Emerging leaders' development
- Leaders' collaborative
- Safety Champions

The Trust is about to embark on this new partnership and will be investigating in a robust training package to ensure success.

2.2.5 Quality Improvement

The priorities of our Quality Improvement Programme are as follows:

- **Enable delivery of our strategic objectives**
 - Enable change that will help us to achieve our strategic aims whilst also supporting innovation and creative ideas from the front line
 - Align with other enablers of transformational change such as our redevelopment programme, electronic patient records and research and innovation

- **Facilitate continuous improvement in clinical outcomes and the experience of our children, young people and families**
 - Have a direct impact on outcomes, safety and the experience of patients and staff
 - Design and implementation of a Real Time Patient Experience system
 - Strengthen partnerships through co-leadership with patients and families
 - Transform operational management and business intelligence through the use of data

- **Transform the culture of Great Ormond Street Hospital so that everyone is looking for ways to improve patient care every day**
 - The programme is overseen by the QIC and is currently supporting various projects to improve patient flow (ICU & Outpatients), improving clinical processes through automation, e.g. e-Patient Status at a Glance.

2.2.6 Annual publication of avoidable deaths and Learning from Deaths

The Trust is well placed to participate in publication of avoidable deaths. All deceased patients are discussed at a Local Case Review Meeting, with an outcomes form completed and shared with the Trust-wide Mortality Review Group (MRG) which reviews all deaths in the hospital. Every case is then independently reviewed by MRG within 8 weeks of the child's death. This provides a Trust-level overview of themes/risks which would be used to identify improvement actions where relevant. The MRG also functions to provide assurance that the patient pathway has been managed appropriately by the organisation, and coordinates information for relevant programmes e.g. national audits, Child Death Overview Panels where appropriate. The Trust published its interim policy on Learning from Deaths as agreed with NHSI, the policy will be reviewed once statutory guidance on how child deaths should be reviewed is published.

The Trust is also working with NHS England to establish a national system for peer review of in-hospital deaths of children and young people.

2.2.7 Seven day services

GOSH does not have an A&E department and the majority of its inpatient admissions are on an elective basis. Certain services such as paediatric critical care, acute transport and non-elective surgery are staffed by consultants all days of the week. We have comprehensive on call arrangements, in some cases shared with other Trusts in order to ensure the Trust can access specialised skills at all times. We will continue to participate in NHS England's national audits of emergency admission throughout this planning period.

The Trust now offers some outpatient and diagnostic appointments on Saturdays and extended a daycase ward to admit patients over six days. All new medical staff are recruited on flexible contracts. International Private Patients Division already offers a wide range of services on Saturdays and Sundays.

2.2.8 Risk Management

The Trust has a robust corporate governance function which identifies, assesses, mitigates and monitors the key risks to its strategic objectives. The evolving process links with the clinical governance function of clinical risk management to ensure that risks are escalated and deescalated as appropriate.

2.3 Summary of Quality Impact Assessment

The Trust has continued the work described in the 2016/17 business plan to enhance and embed its approach to Quality Impact Assessment (QIA). Following the input and advice from an external consultancy partner, a new Programme Management Office (PMO) has been established to oversee the Trust's CIP (and other major) plans for the next 3 years, and business partners have been recruited to support divisions with the scoping and delivery of their contributing projects.

The PMO has a well-developed integrated system to scope each plan and assess its quality impact. The PMO - working with the Medical Director, Chief Nurse and QI Team - has substantially revised the QIA

process in line with Internal Audit recommendations from 2015/16. In support of the new divisional structure with its reinforcement of greater divisional responsibility, development of QIAs has been devolved to Divisional (Clinical) Chairs and Corporate Directors, subject to a related QIA scheme of delegation, with:

- Proposals likely to have more significant potential impact (including for example those of a cross-cutting nature) always requiring formal assessment and sign off by the QIA panel (co-chaired by the Medical Director and Chief Nurse);
- The QIA panel to be kept informed of the approval status of all schemes including those signed off at divisional level, and to oversee a regular audit process including those approved locally.

QIAs are required for any scheme with a potential to directly or indirectly impact quality. This includes back office and support services. The required framework considers impacts on patient safety, clinical outcomes, patient experience and staff experience.

According to the Trust's agreed policy, if any of the following criteria are applicable to a scheme then a QIA will be required:

- Change to skill mix and/or headcount
- Service redesign
- Change to a business process or service delivery
- Cross-divisional schemes
- Over £50k in value

These schemes are then subject to the QIA process reporting to the QIA Panel as described above.

In addition to regular meetings of the QIA panel, QIA reports are provided to each meeting of the Quality & Safety Assurance Committee (QSAC) which reports to the Trust Board. The QSAC is provided with updates on completion of QIAs and any concerns arising, undertakes deep dives and receives post implementation reviews into individual schemes at each of its meetings, and considers reports on quality key performance indicators which could be used to provide early warning of impacts (both positive and negative) that may be attributable to the Better Value programme. A wide range of such indicators is already reported through monthly dashboards as part of the divisional performance review process. In addition, a set has now been developed for routine reporting in QIA updates to the QSAC, covering issues such as:

- patient feedback (Friends and family test feedback, 'red' complaints – with plans to include patient Real Time Patient Feedback in future);
- workforce issues (Sickness absence, turnover, vacancies and temporary staffing);
- clinical indicators (Serious incidents, outpatient DNA rates, incomplete RTT pathways over 18 weeks, cancelled operations, theatre utilisation rates and late starts).

Further, the Trust has agreed a revised approach to assessing risk to delivery for all new schemes. For schemes now being signed off into the 2018-19 programme, before they go live on the PMO tracker, they will – in addition to the QIA process – be risk assessed in terms of likelihood of delivery, with projected financial benefits risk adjusted as a result. There are clear criteria to explain how the risk adjustments will work ranging from low level of delivery confidence (30% of CIP value in live programme) to complete certainty (100%). The application of this process, overseen by the Better Value Programme Board, means scheme owners are incentivised either to improve the likelihood of delivery of their identified schemes or to find additional projects to fill the gap.

2.4 Summary of triangulation of quality with workforce and finance

Divisional performance reviews take place on a monthly basis, attended by divisional management and Trust executives. These reviews are designed to facilitate a triangulated and risk-focused discussion across a number of key domains: Caring, Safe, Responsive, Well-led (people, management and culture), Effective, Finance, Productivity.

The review packs contain an integrated dashboard which provides a one page summary of key metrics across the domains, allowing rapid identification of linked risks and issues. The packs also contain more in-depth dashboards for each domain.

An integrated performance report is then scrutinised at each Board meeting. This provides a summary of the key issues in each domain and actions planned to resolve, as well as an integrated dashboard – this provides trust level data using the same format as the divisional integrated dashboard reviewed in the monthly performance reviews. Examples of metrics contained in the integrated dashboard are:

- **Caring:** Friends and family scores and number of complaints
- **Safe:** serious incidents and never events
- **Responsive:** performance against access targets
- **Well led:** sickness, turnover, appraisal rates
- **Effective:** DNA rate
- **Productivity:** theatre utilisation
- **Finances:** variance to plan

The Board intend to use this data:

- to identify emerging linked risks and issues across domains (and therefore provide opportunity to quickly address quality and operational issues in a balanced way)
- to identify and provide challenge over areas of potential productivity improvement (e.g. theatre utilisation)
- as part of assurance over the impact of change processes (for example, the impact of CIPs and QI programmes on quality, workforce and finances together)

2.5 Care Quality Commission (CQC) inspections and action plans

The CQC conducted a scheduled acute hospital inspection between 14 and 17 April 2015, with further unannounced inspections occurring between 1 and 3 May 2015. The Trust agreed an action plan to respond to the CQC's requirement notice and areas for improvement. On 27 September 2017 the Trust board reviewed a final update on the CQC action plan, concluding that all actions were complete and processes in place to maintain the standards set by the recommendations.

In January 2018, the CQC conducted a scheduled unannounced inspection of two services (surgery and outpatients). The Trust was rated 'Good' overall. A Well Led scheduled announced inspection was held a few weeks later and the Trust was rated 'requires improvement'. An action plan is in development to respond to the recommendations, which include a requirement notice (regulation 17) related to accessibility of clinical information for staff planning to undertake procedures.

2.6 Clinical sign-off for staffing element of plans

The Medical Director and Chief Nurse are engaged throughout the planning process – developing plans have been presented to the Medical Director and Chief Nurse for challenge, QIAs for savings schemes are reviewed and signed-off, and business cases are approved through the Executive Management Team meeting.

Ward establishments are reviewed on an annual basis as per National Quality Board standard. Each review sees if there have been any significant changes in patient activity, acuity, case mix, prof judgement etc. requiring an change in ward establishment. This is reported to the Chief nurse, EMT and then taken to Trust Board. Removing or changes to any nursing posts has to be signed off Chief Nurse.

3 Workforce planning

3.1 Workforce plan summary

	17/18 forecast outturn	18/19 plan	% change
Medical	634	648	2.2%
Non-medical clinical	3179	3186	0.2%
Non-clinical	773	762	-1.4%
Total	4586	4596	0.2%

Growth in WTEs mainly relates to activity growth, particularly in cardiac activity. This is offset by efficiencies, particularly focused on non-clinical WTEs.

3.2 Workforce planning methodology and alignment to integrated plans

The Trust undertakes workforce planning throughout the organisation as part of its business planning and operational activities in order to support the Trust's strategic approach to workforce. The plan is informed by activity and finance planning to establish demand requirements at POD/specialty level for future years. Furthermore, considerations regarding national, international and local drivers are included in the drawing up of plans. A gap analysis, in conjunction with a risk analysis, is carried out to support the Trust's business plans to meet the level of anticipated demand. New positions and business developments identified through this process are aligned with our operational plans.

Business developments, either within the activity planning cycle, or outside are subject to scrutiny by clinical and corporate professionals to ensure business plans are fit for purpose, have considered risk and mitigations, considered downside strategies and retain or improve quality and outcomes – with regards to workforce. Similarly, organisational change across the Trust is subject to similar considerations, prior to and during consultations.

The key changes to local workforce plans for the period of this operational plan are due to the implications at a service level of the opening of PICB and the reconfiguration of services as a result. A model of care document has been produced by service management for each affected service, which includes the current and planned workforce model. This has been reviewed centrally by corporate clinical and workforce staff, and the impact of each of these has then been included in the overarching trust plan.

The Trust recognises the challenging financial environment it must adapt to and, as such, stresses quality and workforce risk as an integral part to its productivity and efficiency programme. Proposed schemes, during scoping and revisited throughout the programme, have an associated Quality Impact Assessment (QIA) undertaken to address consequence and likelihood of risk occurring (described in section 2.4 above).

3.3 Workforce strategy and staff involvement

During 2017, the Trust refreshed its strategy "Fulfilling our Potential" which, working with staff at all levels of the trust and the Members Council, identified the priorities for the Trust in the coming years

The proposals were tested widely with staff who influenced the design, process and future development, including a Trustwide strategy "Open House" series of events to engage and inform staff about how we will deliver the strategy.

Our workforce will be key to delivering all of the priorities identified and in particular the **People** priority (*We will attract and retain the right people and through creating a culture that enables us to learn and thrive*)

In 2018-19, our emphasis will be on:

- Standardisation of processes and roles where possible (including roll out of Standard Operating Procedures associated with patient flow);
- Roll out of development programmes for leaders;

- Ensuring we can respond to national challenges, via recruitment, retention and education of staff;
- Continuation of the programme to embed Our Always Values, which underpins both patient and staff safety, experience and satisfaction.
- Work with the Cognitive Institute to deliver a Safety & Reliability Improvement Programme that will improve the culture of safety and accountability within the Trust.

3.4 Workforce governance

The Trust Board regularly receives workforce analysis and key performance indicators, benchmarking, including staffing profile, voluntary and non-voluntary turnover, sickness, agency usage (as percentage of pay bill) and vacancies. Monthly divisional performance reviews are Executive-led and consider this workforce data at a drill-down level in conjunction with finance, activity and quality data to identify themes or impact on service delivery. Nurse recruitment and retention work streams are overseen by the Nursing Workforce Programme Board which reports to the Executive team.

The Education and Workforce Development Board ensures the alignment of clinical and non-clinical education and development with our workforce requirements. This Board additionally has oversight of identified workforce risks in the organisation.

As part of its workforce planning processes and safe staffing assessments, the Trust also uses PANDA (the paediatric acuity and nurse dependency assessment tool), which the Trust co-designed, as an acuity tool for inpatient paediatric services.

Services, specialties and divisions hold risk registers that are reviewed and updated to provide a feedback mechanism to Trust risk registers. Trust-wide strategies to mitigate workforce risks are formulated which include nurse recruitment strategies, an integrated Nursing Workforce Programme Board, overseas fellowship programme (for medical staff) and other actions which all form part of the Trust's developing workforce plans.

3.5 Workforce efficiencies

In 2017/18, the Trust rolled out a new e-rostering system for medical staff, and established plans to replace its current nursing rostering system, and roll out a single integrated rostering system during 2018. The new system will improve the quality of rota management across individual specialties and the Trust more generally, as well as facilitating much greater multi-professional working and supporting integrated clinical care. In addition, we will launch a new e-job planning module which will enable staff such as Clinical Nurse Specialists to record their job plans in a single system, facilitating demand and capacity planning. Nurse rosters are based upon agreed establishments with the Assistant Chief Nurse (Workforce) and finance representatives and reviewed on a regular six-month basis. The Trust also complies with the publication of the safe staffing monthly report which includes:

- fill rate assessments by ward, shift time and staff type;
- divisional reporting of unsafe shifts (including assessment of vacancies and recruitment pipeline, temporary staffing usage and staffing flexibility across services);
- recruitment and retention issues and recommendations;
- linkage to infection control, safety incidents, family concerns and Friends and Family Test (FFT) data.

Recommendations and actions are taken to Board to address workforce issues and in turn update the workforce plans for the organisation (<http://www.gosh.nhs.uk/about-us/our-corporate-information/publications-and-reports/safe-nursing-staffing-reports>).

In relation to temporary staffing, the Trust has undergone a dramatic profile change over the previous six years. The Trust continues to have low agency spend on clinical staff. The Trust has made good progress on reducing its usage of non-clinical Agency workers during 2017, and is currently spending significantly below its NHS I mandated cap. Further work will be undertaken in 2018/19 to reduce this spend further and support Divisions to move Agency staff to bank or terminate arrangements with the Trust where appropriate.

The Trust implemented the changes to the Junior Doctors contract in 2017/18 without the need for additional staff to achieve compliance.

The Trust is implementing a comprehensive state of the art Electronic Patient Record (EPR) system in 2018/19, which will deliver improvements to the patient experience, which in turn may lead to changes in how we deliver care, with potential changes to the workforce.

3.6 Workforce initiatives and staff development

The Trust has developed an ambitious multi-year Leadership programme focussed on the delivery of a Safety culture with the organisation. This programme will involve working together to develop our leadership capability, deliver improvement projects and improve our accountability practices across the Trust. This will ensure that we are in line with the ambitions articulated in our strategy – we always deliver the safest, most reliable treatment and care for our patients, from the moment they come into contact with GOSH and throughout their patient journey.

The development of new roles and our education strategy are integral to delivering our workforce requirements. We will continue the development of Talent for Care to build our band 2-4 clinical support workforce, and scope the role of Physicians Assistant to allow our registered clinical workforce to focus on direct patient care and deliver greater productivity and quality. We are the host Trust for a North Central London pilot of the new Nursing Associate and we will also review the role, education requirements and frameworks for development of Advanced Nurse Practitioners with the aim of developing nurse-led services where clinically appropriate.

Our Education and Workforce Development Plan reflects the Trust's increased emphasis on multi-professional education and recognises the criticality of education in meeting the Trust's current and future workforce needs. It also responds to the challenges of changes to funding, including maximising our income-generating capability as a leader in paediatric education. Work is underway to ensure that the Trust has suitable space available for delivery of its education plans.

Following the removal of the student bursary from 2017, the Trust refreshed its attraction strategy for newly qualified nurse (NQN) recruits, concentrating upon providing an excellent, high-quality interactive learning environment including simulation training and welcomed its largest ever cohort of NQNs in September 2017. Through earlier student recruitment, we are able to offer regular contact and education opportunities giving them a GOSH identity prior to starting their academic education. Our aim is to recruit our student nurses for their career here at GOSH from the day they first apply online to study. In addition we will continue to explore the opportunities around clinical apprenticeships, ensuring full use of our Trust Levy, to support both undergraduate training and post graduate Clinical Professional development for our workforce. We have been successful in our bid to become a pilot site for the Child and Young Person Nursing Associate role in response to the Shape of caring review. The Trust has developed and implemented targeted development plans for Band 5 (NQN) and Band 6 Nursing staff to improve their experience and improve retention rates at the Trust.

Once again in 2016/17 we exceeded our apprenticeship target and we are currently on plan to achieve our Government set 2017/18 public sector apprenticeship starts target. GOSH is working in partnership with other trusts in the STP footprint to implement a new joint policy for apprenticeships. We have now achieved the status of a supporting provider – this has allowed us to introduce and start the delivery of our first clinical apprenticeships. We continue to be involved in a number of trailblazer employer groups to develop new apprenticeship standards including nursing, nursing associate, advanced clinical practitioner and clinical coding, as well as the new national pilot for a paediatric Nursing Associate role.

3.7 Workforce resourcing

We continue to deliver structured fixed term International Fellowship roles which provide outstanding clinical experience for overseas medics, allow us to recruit to service delivery roles in a planned way, and bring in income. These roles are filled from outside the European Union. We are and will continue to review our approach to recruitment from overseas in the light of the Brexit vote. Whilst timescales and impact on EU nationals in UK employment remain unclear, we will continue to use overseas recruitment tactically, whilst minimising the impact of changes should changes in labour market regulation occur.

Despite the Trust's low vacancy rate, the ability to recruit and retain nursing staff in particular remains a critical challenge, and is recognised as a risk to our activity plans. Following on from our largest ever Newly Qualified Nurse induction in September 2017, the Trust has established a similar programme for 2018, with a lower target of recruits (100-120), as we have seen an improvement in retention rates. Activity on recruitment will include: ensuring we market the Trust as a provider of outstanding employment and education; actively participating with other employers as part of Capital Nursing (for example to promote

career pathways within London) and; identifying greater opportunities for safely appointing adult-trained nurses with high quality paediatric experience, which will expand our potential applicant pool.

We will continue to work on improving the recruitment experience both for recruiters and applicants, with a focus on ensuring a reduction in transactional times taken to bring new recruits into the trust.

The retention of talented staff within the workforce is a key issue for the Trust. The Trust has developed new leadership programmes for Band 5 nurses looking to develop a career with us, as well as programmes for ward sisters and matrons, recognising the critical role they play in shaping the employment experience of staff. Our Non-medical education team have also introduced new leadership development initiatives to support our allied health professionals. Further to this our non-clinical managers have established a forum for managers from assistant service manager level to general managers, which meets to share best practice and has a complementary competency framework to support skills and career development. We have established a trustwide learning needs analysis survey which will further help inform the development needs of our leaders during 2018.

The Trust has developed a retention plan to deliver further improvements to retention rates and continues to meet its internal targets for turnover. During 2018, we plan to embed a buddy programme as part of the induction process, to improve retention rates of new joiners and ensure all staff feel supported as soon as they join the Trust. A review of the staff benefits is underway to ensure that we are maximising the financial and on-financial benefits which we can offer staff and that these are communicated effectively. On a local level the OD & HR teams are providing bespoke support for managers and teams experiencing high turnover to identify and address the reasons.

The Trust has a strong record in controlling temporary staffing costs and will continue to monitor all long term agency usage (more than 6 months) with the intention to convert these staff to bank roles or recruit substantively if there is no planned end date.

The Trust is a signatory to the London Procurement Partnership pan London Agreement, to agree bank rates lower than the NHSI Agency capped rates, and work collaboratively to further reduce agency spend.

The improvements in rostering systems outlined above will allow for increased efficiency in the management of clinical resource allocation. As part of the rostering system implementation, the Trust will implement improved patient acuity monitoring tools, and continue to use its patient dependency tool to identify appropriate nurse staffing levels based on acuity. New divisional structures, including revised Matron roles, will enable more effective resource utilisation across specialisms, with nurse staffing levels continuing to be monitored at Board level in Safe Staffing reports.

4 Financial Planning

See separate financial planning narrative

5 Membership and Elections

6.1 Members' Council elections in previous years and plans for the coming 12 months

There are 27 elected and appointed councillors on the GOSH Members' Council.

Members' Council representation by constituency

<i>Patient and Carer</i>	Councillors
Patients from London	2
Patients from outside London	2
Parents and Carers from London	3
Parents and Carers from outside London	3
<i>Public</i>	
North London and surrounding areas	4
South London and surrounding areas	1
Rest of England and Wales	2
<i>Appointed</i>	5
<i>Staff</i>	5

The Trust has held five Members' Council elections to date:

- November 2011 (in readiness for FT authorisation on 1 March 2012) - 22 seats in Patient and Carer, Public and Staff constituencies.
- November 2013 - Staff By-election for 1 seat.
- February 2015 - 20 seats in Patient and carer, Public and Staff constituencies. (2 uncontested seats in Patients from outside London constituency).
- December 2016 – Public By-election for 1 seat: North London and surrounding areas class
- February 2018 - 22 seats in Patient and Carer, Public and Staff constituencies.

6.2 Councillor recruitment, training and development, and activities to facilitate engagement between councillors, members and the public

Councillor Induction and training and development: A comprehensive induction and development programme is in place for new councillors to support them in their role and ensure that they have the appropriate information available to discharge their duties. On appointment, councillors receive mandatory Trust training and continued development by attending tailored information sessions delivered by key Trust staff. Councillors are also encouraged to attend NHS Providers events and Deloitte Governor Workshops. Councillors access GOLD on-line training during their appointment.

Councillor Recruitment: Pre election information sessions are held for councillor recruitment alongside a dedicated election page on the Trust website, including podcasts etc. Membership communication tools such as the Membership Newsletter (Member Matters) and monthly membership emails are used to keep members informed of upcoming elections.

Membership and public engagement: The monthly Members' Council eBulletin offers a variety of opportunities for councillors to engage with their members including:

- regular "meet your councillor" engagement sessions in the hospital
- visits to schools and universities including the Hospital School and Activity Centre

- hosting membership stalls at community events, GOSH Children's charity events, and key Trust events
- attending Trust committees and Patient forums
- writing personalised letters and articles in *Member Matters* Membership Newsletter, *Roundabout Staff Newsletter* and Welcome Pack for new members
- online link to contact a councillor is included in all eCommunications on the Trust website and in all printed membership publications and on the Annual Plan surveys to membership
- Councillors also have the opportunity to send personalised emails to their constituent members to engage with them around elections and for key trust events such as the AGM.

In 2017 some of the world's leading architects took part in a competition to design a new clinical building for the fourth phase of our ongoing redevelopment programme. Staff, patients, families, carers, councillors and neighbours were invited to an exhibition showcasing their design ideas

6.3 Membership Strategy

The Trust's Membership Strategy sets out the methods that will be used to continue to develop and grow, engage and involve our membership, taking into account our geographical spread.

The Trust has moved to a new specialist provider of membership databases. This has enabled a more detailed reporting system to analyse membership data and map under representation in constituencies so we will be able to target our future recruitment and engagement activities. The strategy will be subject to review in 2018.

6 Link to the local sustainability and transformation plan

The Trust is located within the footprint for North Central London. The Trust is heavily engaged in the specialised STP planning process, leading most recently to GOSH's suggested leadership of the North Thames specialised paediatric plan. Trust is also fully supportive of a joined up local planning process to deliver transformational change and continues to engage with local plans to improve processes and deliver efficiencies – for example, taking part in an STP-wide benchmarking exercise of back office services and working in partnership with other trusts in the STP footprint to develop a joint status as an Apprenticeship Provider and to reduce bank rates and agency spend.

The Trust believes that over the next five years, further collaborative service models should be developed to include tertiary paediatric services and that GOSH has a pivotal role to play in developing and in many cases leading such networks. In a number of services there are already informal shared care and network arrangements being developed. Exemplars already exist for Epilepsy Surgery and Cystic Fibrosis by which the Trust provides leadership for the system in a particular region. The models of operation will depend on the service and the types of collaborative partners and may range across a spectrum from basic outreach models, through to integrated networks with services commissioned from the network lead provider.

Trust Board 23 May 2018	
GOSH Learning Academy – Briefing Paper	Paper No: Attachment R
<p>Submitted by:</p> <p>Lynn Shields, Associate Director of Education Sanjiv Sharma, Deputy Medical Director for Medical & Dental Education</p> <p><i>Executive Sponsors:</i> Alison Robertson, Chief Nurse Matthew Shaw, Medical Director Ali Mohammed, Director of HR&OD</p>	<ol style="list-style-type: none"> 1. GLA – Briefing Paper 2. For information: Appendix 1 – Strategic Plan 3. For information: Appendix 2 – Operating Model Narrative 4. For information: Appendix 2 – Operating Model Blueprint – Current 5. For information: Appendix 2 – Operating Model Blueprint – Future 6. For information: Appendix 3 – Summary of Financial Case
<p>Aims / summary</p> <p>The complex and highly-specialised nature of services at Great Ormond Street Hospital means education and training is vital. It strengthens our organisational capacity to retain and develop new competencies and experience with rare diseases, improve performance, create opportunities for strong partnerships and networks, deliver a broad-base of research and innovation, and use simulation to train away from the work place.</p> <p>This briefing paper and the Strategic Plan, Operating Model, and Financial Case supporting it (available as appendices) have been developed by Central Education and Training (CE&T) in collaboration with: Corporate affairs, Medical Directorate, Central Nursing Office, Human Resources and Organisational Development, Finance, Development and Property Services, and the Great Ormond Street Hospital Charity.</p> <p>We seek to develop a GOSH Learning Academy that will provide first-choice, multi-professional paediatric education and training, available through state-of-the-art technologies, and in modern environments.</p> <p>These documents have been reviewed and approved at EMT and OPDG, and, as of submission, are pending approval at FIC.</p>	
<p>Action required from the meeting</p> <ol style="list-style-type: none"> 1. Approve Strategic Plan 2. Approve Operating Model 3. Approaching GOSHCC over a proposed purchase of a dedicated E&T facility in and around the GOSH campus with associated capital works to develop a world-class facility, along with associated policies around the means by which the building is let to the Trust. 4. To support the move towards a more commercially-focused funding model, recognising the additional revenue pressures arising in the short to medium term. 5. To consider how external funding may aid the bridging of this gap, whether by bidding for additional funding from external agencies such as HEE; or through a wider programme budget allocation from the GOSHCC; or through concessions on new costs (e.g. reduced rental costs within the new building). 	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans</p> <p>These documents support <i>Fulfilling Our Potential</i> through the development of a GOSH Learning Academy that will provide first-choice, multi-professional paediatric education and training, available through state-of-the-art technologies, and in modern environments.</p>	

Financial implications

Capital case:

Capital cost of acquiring new facility for GOSH	2018/19
Freehold property purchase (1,965 m ² @ £10,800/m ²)	(£21,222,000)
Construction costs and fees	(£5,175,301)
Simulation Equipment, ICT and Furniture	(£2,036,440)
Contribution to public art - as per Trust policy (1% construction costs)	(£29,475)
Total Capital Costs of Acquisition	(£28,463,216)

Revenue case:

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
'Business as Usual' Income	£4,506,642	£3,197,870	£3,040,443	£2,925,145	£2,926,530	£2,896,780
'Business as Usual' Pay	(£2,914,416)	(£2,887,276)	(£2,911,958)	(£2,988,507)	(£3,066,970)	(£3,147,394)
'Business as Usual' Non-Pay	(£2,897,332)	(£2,048,573)	(£2,051,156)	(£2,079,152)	(£2,126,513)	(£2,175,058)
Additional Costs of new facility	£0	£0	(£729,098)	(£729,749)	(£750,911)	(£772,631)
Additional Commercial Revenue	£0	£0	£394,189	£557,934	£728,371	£938,430
Total Contribution	(£1,305,106)	(£1,737,980)	(£2,257,580)	(£2,314,329)	(£2,289,492)	(£2,259,872)
Trust Contribution to Education	£1,595,488	£1,634,972	£1,759,409	£1,847,608	£1,847,608	£1,893,798
Total Education variance	£290,382	(£103,007)	(£498,171)	(£466,721)	(£441,884)	(£366,074)

Who needs to be told about any decision?

- Nursing & Non-medical Education
- Postgraduate Medical Education
- Learning & Development
- Redevelopment
- Finance
- Executive Management Team

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

Lynn Shields, Associate Director of Education
Sanjiv Sharma, Deputy Medical Director for Medical & Dental Education

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

Alison Robertson, Chief Nurse
Matthew Shaw, Medical Director
Ali Mohammed, Director of HR&OD

GOSH Learning Academy – Briefing Paper

This briefing paper presents three sections: (I) a strategic plan setting out why a GOSH Learning Academy (i.e. a first-choice, multi-professional paediatric education and training service, available through state-of-the-art technologies, and in modern environments) is the right direction for education and training; (II) an operating model describing what we will be doing to deliver the Academy; and (III) a financial case. The full version of each section is included in the appendices.

1. GOSH Learning Academy – Strategic Plan (Appendix 1)

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) is a tertiary and quaternary hospital that provides specialised and highly-specialised services to Children and Young People (CYP) with rare and complex conditions. The diseases we treat can be life threatening and debilitating, making learning, walking, talking, and eating difficult, so our mission is “the child first and always,” and our vision is “helping children with rare and complex health needs fulfil their potential.”

The complex and highly-specialised nature of our services means education and training is vital. It strengthens our organisational capacity to retain and develop new competencies and experience with rare diseases, improve performance, build strong partnerships and networks, deliver a broad-base of research and innovation, and use simulation to train away from the work place.

Education and training at GOSH

Education and training (E&T) at GOSH serves 4,313 Whole Time Equivalent (WTEs) through three separate divisions (collectively, Central Education & Training – CE&T):

1. **The Medical Directorate** includes Post Graduate Medical Education (PGME) and is responsible for undergraduate and postgraduate medical and dental E&T.
2. **Central Nursing Office** includes Nursing and Non-Medical Education (NNME) and is responsible for undergraduate and postgraduate nursing and non-medical education.
3. **Human Resources and Organisational Development** includes Learning and Development (LE&D) and is responsible for statutory and mandatory training, Trust induction, and leadership development.

E&T has always been essential at GOSH, and we are one of the largest E&T providers, but we must turn our internal weaknesses into strengths and external threats into opportunities.

Internally:

1. **Structure and governance.** Delivering E&T through three distinct divisions is an outdated model. It means staff groups are educated and trained in silos, limiting the multi-professional collaboration that is recognised as best practice, creating unnecessary duplication, and preventing sharing processes and resources and aligning priorities.
2. **Facilities and resources.** E&T is delivered in a mix of environments that are inadequate for the needs of staff and/or allow for only a basic level of education and training, so expensive external venues and converted storage rooms are used regularly as learning environments. We also know other national and international providers' facilities and resources are superior to GOSH (e.g. dedicated lecture theatres, tiered classrooms, meeting spaces, medical libraries, simulation theatres, and briefing rooms.)

Externally:

- Immigration rule changes and (to date) pay increases capped at 1%.
- Since 2014 there has been a reduction in HEE (Health Education England) funding.
- The UK's departure from the EU will have an unknown impact on recruitment and retention.
- Various reports, Royal Colleges, and public bodies have raised the importance of enhancing the working lives of trainees, developing new roles, and addressing the shortfall of consultants as well as paediatric services' heavy reliance on non-UK graduates.
- A growing expectation that healthcare professionals should have the professional capabilities to work in new structures and reforms (e.g. STPs). The reshaped paediatric curriculum (2018) stresses the need to focus on capabilities in the current climate.

Setting a future direction for Central Education & Training (CE&T) as a GOSH learning academy

Our future direction will address the issues described above through delivering a **first-choice, multi-professional paediatric education and training service, available through state-of-the-art technologies, and in modern environments**. Amongst other things it will also: support *Fulfilling Our Potential* and our organisation's highest priorities; meet the expectations and requirements of our patients and stakeholders; deliver multi-professional collaboration; provide state-of-the-art facilities and resources; and establish new opportunities for commercial partnerships and revenue streams.

We will concentrate on three things:

1. Establishing a single operating division, under one Executive Director for Education, allowing us to achieve multi-professional collaboration and stronger leadership.

2. Working closely with stakeholders (e.g. Higher-Education Institutes to franchise a portfolio of specialised and highly-specialised post-graduate modules and other commercial opportunities).
3. Embedding clinical simulation and proper learning environments to help meet the future specialised service standards, reduce the (48%) reliance on non-UK graduates, and focus on professional capability development.

2. GOSH Learning Academy – Operating Model (Appendix 2)

Our operating model focuses on the six areas shown below in figure 1 to set out what we will do to deliver the Academy.



Figure 1: Learning Academy Operating Model

Starting with our current operating model and using our strategic plan, we held workshops and spoke with stakeholders to identify that CE&T provides 27 core education and training activities that range from leadership training and apprenticeships to resuscitation services and clinical simulation. These activities capture approximately 120+ instances of education and training courses and 50+ processes. The latter covers a variety of processes from room booking, procurement, and course materials through to commissioning, training plans, and learning needs analysis. This is all provided through three different departments and across a variety of offices, rooms, and a lecture theatre—total space 727m². Supporting this is a variety of software applications and databases; critical relationships with other NHS organisations, King’s Fund, GOSH Children’s Charity, High Education institutes, etc; and various management systems.

The operating model has helped us to identify where we will now:

- Eliminate unnecessary duplication across E&T;
- Maximise our education and training competencies and capabilities for all staff groups;
- Further strengthen our relationships and collaboration with institutions and regulators;
- Strengthen our provision of training and courses through commercial opportunities; and
- Set out our requirements for space and buildings to strengthen our resources and facilities.

3. GOSH Learning Academy – Summary of Financial Case (Appendix 3)

Currently, E&T is funded through a mix of sources:

- Specific charity support grants for discrete projects;
- Commercial income from the selling of courses that it has established;
- External NHS-based funding relating to E&T (predominantly from HEE);
- Its own resources where historic budgetary allocations have been set for the provision E&T and funded via operating revenue.

As outlined briefly in our strategic plan, we recognise there will be a reduction in the overall level of funding GOSH receives in future years, relative to the level of cost that is required to maintain existing levels, and of course to increase in line with normal inflation.

The only means by which these could be mitigated are as follows:

1. Reduce the provision of education within the Trust. *This is not deemed to be in line with Fulfilling Our Potential.*
2. Develop more commercial courses and increase revenue through increased provision of E&T to other Trusts and services. *There is limited scope to do this given the current restrictions within the E&T departments.*
3. Developing a new approach to the delivery of education within the Trust that allows for the development of the growth of commercial income and provides better resources for providing education, not available within the existing estate. *This is our preferred option.*

Case for a new facility

The Trust has insufficient facilities to meet its strategic need. In order to meet this need, it is proposed that a new facility be found that offers more space and a more appropriate environment for delivering courses.

A new facility offers many benefits. The Charity/Trust will retain an asset that could be sold to fund additional capital in future years. It is recognised this would lead to additional revenue costs, and these are set out in the figures below. For example, we will work towards enhancing the profile of education and developing a more commercially-focused service that leads the way in providing education for the provision of children's healthcare across London, the UK, and internationally.

Acquiring the new building will allow for the Trust to commercialise opportunities for generating further revenue through the development and delivery of additional courses, for which the Trust is well-placed given its strong national and international reputation for excellence. This additional commercial income will facilitate E&T services to increase across the Trust.

The capital costs of this acquisition are set out below:

Table 1: Capital case

Capital cost of acquiring new facility for GOSH	2018/19
Freehold property purchase (1,965 m ² @ £10,800/m ²)	(£21,222,000)
Construction costs and fees	(£5,175,301)
Simulation Equipment, ICT and Furniture	(£2,036,440)
Contribution to public art - as per Trust policy (1% construction costs)	(£29,475)
Total Capital Costs of Acquisition	(£28,463,216)

The full impact of the new running costs of the new facility, relative to the assumed continuing income streams and new revenue opportunities is set out as follows:

Table 2: Revenue case

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
'Business as Usual' Income	£4,506,642	£3,197,870	£3,040,443	£2,925,145	£2,926,530	£2,896,780
'Business as Usual' Pay	(£2,914,416)	(£2,887,276)	(£2,911,958)	(£2,988,507)	(£3,066,970)	(£3,147,394)
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Additional Costs of new facility	£0	£0	(£729,098)	(£729,749)	(£750,911)	(£772,631)
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Total Education variance	£290,382	(£103,007)	(£498,171)	(£466,721)	(£441,884)	(£366,074)

Recommendations

The Trust is asked to consider supporting the preferred option with specific consideration of the following points:

1. Approaching GOSHCC over a proposed purchase of a dedicated E&T facility in and around the GOSH campus with associated capital works to develop a world-class facility, along with associated policies around the means by which the building is let to the Trust.
2. To support the move towards a more commercially-focused funding model, recognising the additional revenue pressures arising in the short to medium term.
3. To consider how external funding may aid the bridging of this gap, whether by bidding for additional funding from external agencies such as HEE; or through a wider programme budget allocation from the GOSHCC; or through concessions on new costs (e.g. reduced rental costs within the new building).

Trust Board 23 May 2018	
CQC Report – April 2018	Paper No: Attachment S
<p>Submitted by: Matthew Shaw, Medical Director and Anna Ferrant, Company Secretary</p>	
<p>Aims / summary To formally note receipt of the scheduled GOSH CQC report published on 6 April 2018. Services were rated as ‘good’ overall and ‘outstanding’ for being caring and for being effective. The CQC conducted a well led inspection and the Trust was rated ‘requires improvement’.</p> <p>Actions in response to recommendations: The Trust is developing an action plan in response to the recommendations in the report (these cover surgery and outpatient services). This includes actions in response to a requirement notice related to accessibility of clinical information for staff planning to undertake procedures. Immediate action was taken in response to the requirement notice as follows:</p> <ul style="list-style-type: none"> • On 17 April 2018, the Medical Director wrote to all consultants, divisional directors, general managers, heads of clinical services and service managers reconfirming the Trust position regarding availability of notes and undertaking procedures; reminding staff that no procedure should be undertaken in the hospital if there are any concerns regarding the completeness of the notes; and, in addition, reminding staff of their responsibility to report any incident where notes were not available on Datix, so that such instances can be monitored and investigated. • The backlog of scanning of notes referred to in the inspection report is now cleared. All notes are scanned within 48 hours of being collected from clinical areas. • In December 2017 a trial was undertaken in IR recovery of scanning anaesthetic charts in recovery before patients returned to the wards. Anaesthetic charts were scanned to a network drive and then uploaded to Electronic Document Management (EDM) system. The trial was successful, and the system is being rolled out to recovery areas in the Trust from early May. • An audit will be conducted on the completeness of the patient notes in inpatients and outpatients, including theatres. This will include: <ul style="list-style-type: none"> ○ the accessibility of patient information from the various hard-copy and electronic sources; ○ an audit against the operational scanning process; ○ the accuracy of filing and accessibility of information on the EDM system. <p>The audit will include speaking with staff to understand their concerns with accessibility of patient information and reviewing Datix incident reports on accessibility of patient notes over the past 12 months.</p> <p>The purpose of the audit will be to document the challenges to accessing patient information and identify improvements to the system to support staff to access information in an ordered and timely way.</p> <p>Well Led assessment: Whilst there were no recommendations in the CQC report made with reference to the well led assessment, the Trust has documented all of the relevant commentary from this section of the report and started to develop an action plan to respond to these matters and make necessary improvements.</p>	

<p>Other Trust services: In addition, the Medical Director and Chief Nurse are using this opportunity to develop quality improvement plans for all of the other services across the Trust which were not subject to the inspection, using the CQC key lines of enquiry as the benchmark. Each of the services will meet regularly with the executive directors to explore the current operational, quality and transformation plans in place and understand where there may be gaps, developing new plans where required.</p> <p>It is proposed that the Quality, Safety and Assurance Committee will receive assurance of progress with the actions in response to the CQC recommendations, the requirement notice and the quality improvement plans highlighted above. The Audit Committee will maintain oversight of a small number of non-clinical matters arising from the report. The Board will receive assurance of progress with the well led assessment plan.</p> <p>A copy of the CQC report is attached for information.</p>
<p>Action required from the meeting To note the report provided.</p>
<p>Contribution to the delivery of NHS / Trust strategies and plans Compliance with CQC registration requirements is a critical for the Trust to provide services and achieve the Trust's strategies and plans.</p>
<p>Financial implications There are no direct financial implications associated with this paper, unless raised by the relevant plans that are developed.</p>
<p>Legal issues There are no specific legal implications associated with this paper.</p>
<p>Who is responsible for implementing the proposals / project and anticipated timescales Medical Director, Chief Nurse, Company Secretary and relevant divisional leads</p>
<p>Who is accountable for the implementation of the proposal / project With respect to CQC requirements, Dr Peter Steer, Chief Executive is the accountable lead.</p>

Great Ormond Street Hospital for Children NHS Foundation Trust

Inspection report

Great Ormond Street Hospital
Great Ormond Street
London
WC1N 3JH
Tel: 0207 405 9200
www.gosh.nhs.uk

Date of inspection visit: 09 Jan to 11 Jan 2018
Date of publication: This is auto-populated when the report is published

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust

Good 

Are services safe?

Good 

Are services effective?

Outstanding 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Requires improvement 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Great Ormond Street Hospital for Children NHS Foundation Trust was established in 1852 in the London Borough of Camden and was the first hospital providing in-patient beds specifically for children in England. Great Ormond Street Hospital for Children NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. The trust achieved foundation trust status on 1 March 2012.

The trust operates from a single site in central London. The hospital has approximately 482 beds, and is registered with CQC for caring for children (0 - 18yrs year olds). Great Ormond Street Hospital and the UCL Institute of Child Health form the UK's only academic biomedical research centre specialising in paediatrics.

The trust is the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants. There are 63 different clinical specialties at GOSH. Children are also treated from overseas in the international and private patients' wing (IPP). Great Ormond Street Hospital received 252,389 outpatient visits and 43,778 inpatient visits in 2016/17. The trust mostly cares for children that are referred from other hospitals throughout the UK and overseas. More than half of their patients come from outside of London.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good ● → ←

What this trust does

The trust runs services at Great Ormond Street Hospital site (GOSH). It provides surgery, medical care, critical care, end of life care, outpatients services, and children and young people's services. The hospital has 482 beds including 47 open intensive care beds and eight beds used by the clinical research facility.

It is the only specialist biomedical research centre for paediatrics, the largest centre in the UK for children with heart or brain problems, and the largest centre in Europe for children with cancer. The hospital is the only specialist children's hospital in the UK that does not have an accident and emergency department and only accepts specialist referrals from other hospitals and community services. In the trust 45% of patients are from London and over 55% are from outside of London, including 7% from overseas. The population of children served by the hospital is characterised by those with multiple disabilities and/or health problems and rare and congenital conditions (present at birth). The hospital receives over 260,000 patient visits a year (inpatient/day-case admissions or outpatient attendances), and carries out approximately 18,800 surgeries each year.

The Mittal children's medical centre which includes the Premier Inn clinical building was officially opened on 17 January 2018. The centre has 240 beds, spans two connecting wings, including the new Premier Inn clinical building. The centre has brand new, modern wards with ensuite bedrooms where parents can stay with their child overnight.

The trust leads the North Thames Genomic Medicine Centre, one of 13 regional centres which is responsible for coordinating recruitment of more than 100 patients a month. The project aims to help doctors better understand, and ultimately treat, rare and inherited diseases and various cancers.

GOSH is one of only two centres in the world developing the thymus tissue treatment. The thymus gland produces several hormones, closely associated with the immune system and serves a vital role in the training and development of T-lymphocytes (T cells) which is an important type of white blood cell. The thymus tissue treatment involves removal of thymus tissue as a standard from children undergoing cardiac surgery for congenital heart defects in order to allow the surgeons to perform the heart procedure.

Summary of findings

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We last inspected Great Ormond Street Hospital for Children NHS Foundation Trust in April 2015. All core services were inspected (medical care, neonatal services, transitional services, surgery, critical care, services for children and young people) this included child and adolescent mental health services), end of life care and outpatients.

All core services were rated as good or outstanding with the exception of Surgery and Outpatients Departments (OPD) which were rated as requires improvement (RI).

Between 9 and 11 January 2018 we inspected two core services at Great Ormond Street Hospital for Children NHS Foundation Trust. These were outpatients department and surgery.

We decided to inspect OPD and surgery as during the previous inspection we rated those services as requires improvement (RI). The trust informed us that they had made necessary changes to both services to rectify issues raised within the report published in January 2016. There had been sufficient time for the trust to act upon the findings and we decided that re-inspecting would allow us to assess changes implemented by the trust.

We decided not to inspect the other core services at this time as they were previously rated as 'Good' or 'Outstanding'; the decision was made on a risk based approach under the new methodology not to inspect at this time. Other concerns raised within these core services are continually monitored at quarterly regulatory meetings with the trust.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed 'Is this organisation well-led?'

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- We rated effective and caring as outstanding, well-led as requires improvement, safe and responsive as good.
- We rated two of the trust's eight core services as outstanding, five as good and one as requires improvement. In rating the trust, we considered the previous ratings of the six services not inspected this time.
- We rated well-led for the trust overall as requires improvement.

Summary of findings

Are services safe?

Our rating of safe stayed the same. We rated it as good because:

- There were systems in place to manage patient safety incidents well. Staff knew how to report incidents and we saw evidence of incidents investigation and learning.
- The trust controlled infection risk well and provided staff with the use of Personal protective equipment.
- The trust had clearly defined systems and processes to keep patients safe and safeguard them from abuse. Staff had access to the clinical site practitioners and safeguarding lead nurses who provided dedicated safeguarding support and additional training.
- The trust planned for emergencies and we noted that staff understood their roles if an emergency should occur.
- During the previous CQC inspection, we noted that the equipment used to transport patient records between departments was frequently not fit for purpose. During this inspection we saw that these had been replaced with patient record trollies on wheels which had a key pad system and were easy to move from area to area.
- During the previous inspection, we were told that a significant number of referrals from other NHS trusts and embassies did not include adequate medical or clinical information. During this inspection, staff told us they had since adapted a robust approach to this which had resulted in significantly improved quality of referral information.

However:

- Medicines were not appropriately managed and prescription pads were not stored appropriately and were left out on staff desks.
- The trust did not always meet their target for completion of mandatory training.

Are services effective?

Our rating of effective stayed the same. We rated it as outstanding because:

- The trust provided care and treatment based on national professional standard, national guidelines and evidence based practice to achieve the best patient outcomes.
- Staff we spoke to understood their roles and responsibility to adhere to the Mental Health Act 1983 and the Mental Capacity Act 2005.
- We saw evidence of very good multidisciplinary working between departments in the hospital and other hospitals and external agencies such as GPs and community teams to provide holistic care.
- The trust ensured staff were competent and supported for their roles.

Are services caring?

Our rating of caring stayed the same. We rated it as outstanding because:

- Staff showed compassion and respect to patients and their loved ones.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Patients and their relatives told us staff showed empathy and were sensitive to their needs when breaking bad news and offered reassurance when needed.
- Staff provided emotional support to patients to minimise their distress.

Summary of findings

- The trust recently developed a pilot project where a learning disability link nurse did a home visit to a patient who persistently refused to come to their appointments. The nurse used communication aids to prepare the patient for their next appointment and ensured they were on duty to welcome them into the department.

Are services responsive?

Our rating of responsive improved. We rated it as good because:

- The trust planned and provided services in a way that met the needs of the patients from the local area, country and abroad.
- The trust took account of patient's individual needs when planning and delivering care.
- The trust provided an extensive translation and interpreting service in recognition of the wide range of languages spoken by their patients and families.
- Staff used a hospital passport system to help them understand and communicate with young people where they presented with complex communication needs.
- Carers who travelled by car to the hospital were given a parking voucher for use in the area surrounding the hospital, the length of which depended on the nature of their visit. In addition, where the patient had a number of appointments over the course of more than one day, they were offered hotel accommodation close to the hospital.
- During the previous CQC inspection in May 2015, we recorded concerns over the reliability of referral to treatment (RTT) data reporting of which was suspended after our inspection. Various measures were put in place since then to address the problem and the trust returned to reporting in January 2017 in agreement with commissioners. Dedicated specialists in data collection, analysis and validation worked with clinical colleagues to ensure data was accurate and high quality. A demand and capacity model for all specialty services was in place and senior teams used this to improve waiting times.

Are services well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. However, there had been frequent executive leadership changes which affected staff morale. Since the previous CQC inspection in 2015 most of the executive and non-executive directors had changed. The trust had an interim medical director for approximately 12 months with a further temporary change made at the end of 2017. There was an interim chief and deputy chief nurse in post and the chief finance officer was leaving their post in February 2018.
- Staff told us they felt divisional structures were overly complicated. Staff felt it did not allow for clear lines of accountability and for cross divisional learning. Staff we spoke with on the wards were not clear who their divisional leaders were. The percentage of staff reporting good communication between senior management and staff was much worse than the national average in the NHS staff survey. Trust leaders did not appear to be aware of the wide concerns raised with the inspection team by nursing staff about leadership and morale.
- Nurses felt they lacked leadership and they did not feel retention of nursing staff had been addressed by trust's leaders. Staff were not aware of the trust's approach to future workforce decisions and how they mitigated the long-term risks associated with workforce planning.
- The trust had not fully demonstrated their commitment to support the freedom to speak up. They did not fully comply with recommendations set in freedom to speak up guidance issued by the National Guardian's Office. No trust guardian had been appointed.

Summary of findings

- Some staff we spoke to were unable to describe learning implemented in relation to serious incidents. There was limited evidence of shared understanding of key learning issues throughout the trust. For example, surgeons we spoke with were unaware of the never event which took place in another surgical speciality. Learning from incidents, never events and clinical reviews were not shared widely.
- The trust missed opportunities for engagement with some of the local stakeholders. The trust does not demonstrate open and positive relationships with key stakeholders. It was not sharing information promptly and was often defensive when challenged on performance and safety.
- The trust missed opportunities for engagement with some of the local stakeholders. The trust does not demonstrate open and positive relationships with key stakeholders. It was not sharing information promptly and was often defensive when challenged on performance and safety.

However:

- Research was well established within the hospital and there were robust policies and processes to promote innovation and safeguard patients taking part in trials and receiving innovative treatment. Staff were encouraged and supported to undertake research projects.
- Risk registers and the board assurance framework were reviewed regularly by the executive management team and board committees. They were reflective of risks facing the organisation and clearly listed all control measures set out to manage risks and what means of assurance were in place. Documents were informed by divisional risks registers and highlighted both strategic and operational risks. The risk management framework allowed staff to effectively escalate risks and their concerns.
- All staff were proud to work at Great Ormond Street Hospital. The trust scored above the England average for recommending the trust as a place to receive care from October 2016 to September 2016.
- Following the suspension of reporting its referral to treatment (RTT) waiting times, the trust completed a significant amount of work relating to the RTT access standards. The additional work has led to the improvement of the quality of the data, with staff re-trained to correctly manage RTT data.

Ratings tables

The ratings tables show the ratings overall and for each key question for each service, and for the whole trust. They also show the current ratings for services not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in surgery and outpatients.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including one breach of legal requirements that the trust must put right. We also found areas that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of services.

For more information, see the 'areas for improvement' section of this report.

Summary of findings

Action we have taken

We issued one requirement notice to the trust. Our action refers to breaches of Regulation 17 which relates to good governance requirements, related to one service: Surgery

For more information on action we have taken, see the sections on 'areas for improvement' and 'regulatory actions'.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

In Outpatients:

- Staff told us the wide ranging and innovative measures introduced to improve the experience of patients with a learning difficulty enhanced their practice.
- The hospital was known to treat patients with the rarest of diseases and conditions from around the world. This enabled staff to develop skills and expertise in areas previously untreatable. Clinicians told us they shared this expertise with colleagues around the world for the advancement of medicine.
- Planning for transitional care from paediatric to adult care began when the child was 12 and followed trust policy which included regular contact and training as appropriate with the adult service to which the child would move.

In Surgery:

- The clinical site practitioner (CSP) team provided a multidisciplinary and highly responsive service to all specialties and disciplines. This team undertook specialty training in safeguarding and child protection and meant all ward teams had access to senior support for deteriorating patients at any time. The CSPs had developed a system of peer review within the team to develop standards of best practice and learn from the most complex care cases.
- The Woodpecker ward team had established a teaching and education system that engaged each staff group. This involved a group planning a topic of the month and delivering a training session to their colleagues, including the multidisciplinary team. In January 2018 the nominated team had chosen Makaton as their topic and were preparing to deliver a teaching and learning session.
- Fox ward had been recognised with a 'GOSH Gold' award by the trust for the team's work in improving mandatory training and supervision. This reflected significant work across the hospital by the practice education team to engage staff with training and improved development opportunities.
- The hospital had an extensive range of non-clinical, holistic services in place to help patients' recovery and to improve their experience whilst an inpatient. A team of volunteers worked across all clinical specialties seven days a week. This team provided relief for parents, such as looking after or playing with children while they had a coffee break. Transition specialists provided a wide range of activities with patients of all ages, including teenagers. The hospital also hosted regular social events for young people, such as a teenager café on a Wednesday and an in-hospital school was available.
- A clinical nurse specialist had been recognised for their work in emergency paediatric tracheostomy support by the National Tracheostomy Safety Project. They provided specialised, one-to-one care and treatment support to babies and children with a tracheostomy and had sourced information for parents in Greek and Arabic as well as providing a podcast for deaf mothers.

Summary of findings

- Surgical clinical teams were research active and as of January 2018, 37 research projects were active. Research projects represented multiple surgical areas including cardiothoracic surgery and neurosurgery and represented an international clinical practice profile that clinical teams used to drive improvement and innovation. Clinicians led research projects that aimed to understand the experience of patients in addition to clinical treatment and outcomes. For example, one project explored the decision-making process of young people who were due to have orthognathic surgery and another project considered the mental health and emotional needs of children with ophthalmological needs.
- There was a culture of reflection, assessment and audit amongst teams and services who led projects to improve patient care. For example, before relaunching a new nutrition pathway the dietetics team completed an audit of patient documentation. As part of a quality of documentation week, the clinical audit lead had engaged with staff across the trust to secure 88 pledges for quality improvement. The ear, nose and throat team had a significant track record of reviewing service experiences with patients and their parents. Examples such as these were evident across the hospital.
- The tracheal team had established the service as leading-edge in innovation and the provision of evidence-based, research-led surgical development. This included a quality of life assessment for physical and psychosocial factors post-procedure, which was the first of its kind internationally. The team worked with national and international multidisciplinary partners to measure patient clinical outcomes and share learning at international meetings.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust **MUST** take to improve

We told the trust that it must take action to bring services into line with legal requirements.

In Surgery:

- The trust must establish safe systems of working for access to medical records and patient medical histories. This must result in surgeons and other clinicians always having access to past medical notes prior to a planned procedure.

Action the trust **SHOULD** take to improve

We told the trust that it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

In Outpatients:

- Improve staff hand hygiene and adherence to bare below the elbows.
- Consider the use of disposable tourniquets.
- Ensure procedure rooms are clutter free and not used to store staff clothing.
- Ensure there is consistent fridge temperature monitoring and actions taken where temperatures are regularly outside of the recommended range.
- Ensure patient identifiable information is kept confidential and secured at all times.

Summary of findings

In Surgery:

- The trust should improve opportunities for engagement and communication between the executive team and clinical teams.
- The trust should ensure the transfer processes for patients moving from or to IPP inpatient wards continue to improve to ensure transfers are always led by a medical fellow.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our assessment of well-led at the trust-wide level included trust board and executive-level leadership and governance, the effectiveness of non-executive directors, the overall organisational vision and strategy, organisation-wide governance and management, and organisational culture and engagement (with patients, staff, stakeholders and so on).

We took account of what we found in all the core service inspections. We explored the flow of information, assurance, and governance from ‘ward to board and board to ward’, and how trust-wide strategies and leadership were reflected in services. We considered cross-trust systems and processes alongside local and service-level leadership, systems and processes.

We rated well-led at the trust as requires improvement because:

- The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. However, there had been frequent executive leadership changes which affected staff morale. Since the previous CQC inspection in 2015 most of the executive and non-executive directors had changed. The trust had an interim medical director for approximately 12 months with a further temporary change made at the end of 2017. There was an interim chief and deputy chief nurse in post and the chief finance officer was leaving their post in February 2018.
- Nurses felt they lacked leadership and they did not feel retention of nursing staff had been addressed by trust’s leaders. Staff were not aware of the trust’s approach to future workforce decisions and how they mitigated the long-term risks associated with workforce planning.
- The trust had not fully demonstrated their commitment to support the freedom to speak up. They did not fully comply with recommendations set in freedom to speak up guidance issued by the National Guardian’s Office. No trust guardian had been appointed.
- Staff told us they felt divisional structures were overly complicated. Staff felt it did not allow for clear lines of accountability and for cross divisional learning. Staff we spoke with on the wards were not clear who their divisional leaders were. The percentage of staff reporting good communication between senior management and staff was much worse than the national average in the NHS staff survey. Trust leaders did not appear to be aware of the wide concerns raised with the inspection team by nursing staff about leadership and morale.

Summary of findings

- Some staff we spoke to were unable to describe learning implemented in relation to serious incidents. There was limited evidence of shared understanding of key learning issues throughout the trust. For example, surgeons we spoke with were unaware of the never event which took place in another surgical speciality. Learning from incidents, never events and clinical reviews were not shared widely.
- The trust missed opportunities for engagement with some of the local stakeholders. The trust does not demonstrate open and positive relationships with key stakeholders. It was not sharing information promptly and was often defensive when challenged on performance and safety.
- The trust did not proactively engage and lead on paediatric care and treatment locally. Senior leaders stated the sustainability and transformation plans model (STP) did not directly correlate with the trust's tertiary services model which extended both across London but also throughout England. The chief executive told us the trust maintained an "observer role" on the STP. It was not clear how they were planning to become a system leader in the UK and international children's alliance as described in the trust strategy as there was no evidence of clear objectives, or measures of success and deliverables set out in the strategy.
- Staff did not always feel engaged or that they had a say in decisions taken by senior leaders of the organisation. Staff said that major decisions were made by the board and then communicated to them to implement. There was no clear strategy for staff engagement and organisational development.
- Pharmacy services did not report any key performance indicators directly to the board meaning there was a limited accountability or oversight of this service.
- The trust did not provide assurances that all incidents were being properly recorded in a central database of patient safety incident reports and shared with external partners. The trust did not resolve an issue with uploading information into the central system which was brought to their attention as early as August 2017.
- Staff felt learning from high profile cases had not always been implemented or sufficiently considered by the trust leaders. High profile cases often impacted on day to day service oversight and the trust's leaders did not always fully plan for additional operational pressures nor implement prevention mechanisms to minimise this impact.
- The trust was in a process of addressing findings from an independent review of their governance framework which took place in 2016. They were still to complete work required to facilitate improvements in relationships between trust's board and members' council, as well as ensure inclusivity and address potential concerns of the members council. Evidence from the well-led inspection indicated that there had not been a dynamic pace of change in the past and additional support from the board is required to achieve this.

However:

- Research was well established within the hospital and there were robust policies and processes to promote innovation and safeguard patients taking part in trials and receiving innovative treatment. Staff were encouraged and supported to undertake research projects.
- Clinical audits were shared across specialities and had positive impact on quality. There was a central clinical audit plan where work was prioritised to provide assurance and to review implementation of learning and identify areas for improvement.
- Risk registers and the board assurance framework were reviewed regularly by the executive management team and board committees. They were reflective of risks facing the organisation and clearly listed all control measures set out to manage risks and what means of assurance were in place. Documents were informed by divisional risks registers and highlighted both strategic and operational risks. The risk management framework allowed staff to effectively escalate risks and their concerns.

Summary of findings

- All staff were proud to work at Great Ormond Street Hospital. The trust scored above the England average for recommending the trust as a place to receive care from October 2016 to September 2016.
- The trust's financial performance had been consistently strong with cash and revenue plans being delivered broadly in line with plans in 2015/16, 2016/17 and 2017/18 year to date.
- The trust had established appropriate processes to support delivery of elective care including the establishment of governance structures to support delivery of the RTT standards as well as improved patient flow across the elective care pathway. This was a significant improvement on the previous inspection.
- There were effective systems to identify and learn from unanticipated deaths, serious incidents and complaints.
- The board reviewed performance reports that included data about the services. The information provided was reliable and sufficiently detailed to support informed decision making. The trust had developed clear operational performance quality indicators and had effective monitoring systems to allow reporting and support better understanding at divisional and board levels. The trust regularly shared performance data with staff.
- The trust had identified the strategic priorities for pharmacy services. There were systems of accountability for medicines via the trusts drug and therapeutics group.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↔ Jan 2018	Outstanding ↔ Jan 2018	Outstanding ↔ Jan 2018	Good ↑ Jan 2018	Requires improvement ↔ Jan 2018	Good ↔ Jan 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Great Ormond Street Hospital for Children NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015
Surgery	Requires improvement ↓ Jan 2018	Good ↔ Jan 2018	Good ↓ Jan 2018	Good ↑ Jan 2018	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018
Critical care	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Requires improvement Apr 2015	Good Apr 2015
Neonatal services	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Good Apr 2015	Good Apr 2015
Transition services	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Requires improvement Apr 2015	Good Apr 2015
Services for children and young people	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Good Apr 2015	Good Apr 2015
End of life care	Good Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015
Outpatients	Good ↔ Jan 2018	Not rated	Outstanding ↔ Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018
Overall*	Good ↔ Jan 2018	Outstanding ↔ Jan 2018	Outstanding ↔ Jan 2018	Good ↑ Jan 2018	Requires improvement ↔ Jan 2018	Good ↔ Jan 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Great Ormond Street Hospital

Great Ormond Street
London
WC1N 3JH
Tel: 0207 405 9200
www.gosh.nhs.uk

Key facts and figures

Great Ormond Street Hospital (GOSH) was established in 1852 in the London Borough of Camden and was the first hospital providing in-patient beds specifically for children in England. The hospital has been dedicated to children's healthcare and to finding new and better ways to treat childhood illnesses.

In partnership with the University College London (UCL) Institute of Child Health, GOSH forms academic biomedical research centre specialising in paediatrics. The hospital is the only specialist Biomedical Research Centre for paediatrics, the largest centre in the UK for children with heart or brain conditions, and the largest centre in Europe for children with cancer. Its status as a Specialist Children's Hospital means that most of the children treated are referred from other hospitals or overseas. GOSH receives 252,389 outpatient visits and 43,778 inpatient visits every year (figures from 2016/17). The hospital has 482 beds including 47 open intensive care beds and eight beds used by the clinical research facility. There are 63 different clinical specialties at GOSH. The hospital has the UK's widest range of specialist health services for children on one site.

We inspected surgery and outpatients over three unannounced inspection days to enable us to observe routine activity between 9 and 11 January. We returned between 30 January and 1 February to undertake an inspection of the trusts leadership team.

We spoke with members of staff including doctors, nurses, allied health professionals, administrative and other staff. We spoke with members of the divisional leadership teams as well as local service leads and senior managers. We reviewed patient records and spoke with patients, their parents and carers.

Summary of services at Great Ormond Street Hospital

Good   

Our overall rating of services stayed the same. We rated surgery as requires improvement and outpatients as good.

Surgery

We rated safe and well-led as requires improvement, and effective, caring and responsive as good. The rating of responsive improved while outstanding for caring went down since our last inspection. Our overall rating of this service stayed the same. We rated it as requires improvement because:

- Insufficient staffing in some clinical areas had led to delays in treatment and prescribing and the closure of some inpatient beds.

Summary of findings

- There was inconsistent management of risks related to medicines management.
- Clinical governance, risk management and incident investigation systems did not follow a coherent or effective structure in which learning was shared between teams and specialties. Although there was local evidence of improvements in practice as a result of incidents and morbidity and mortality meetings, shared learning was not evident outside of the immediate specialty or service.
- Between August 2016 and September 2017, the trust took an average of 59 calendar days to investigate and close complaints; which was significantly longer than the target of 25 days.
- There was a disconnect between specialty and divisional teams and the senior trust and executive team. A cross-section of 14 clinical staff, including senior clinicians, said the senior team was difficult to communicate and engage with and they did not feel listened to. Although the executive team demonstrated efforts to engage with staff, very few of the individuals we spoke with had been able to participate. The senior team had a track record of high levels of staff turnover, which service-level staff told us meant there was little consistency.
- There was limited evidence risks were regularly scrutinised or reviewed in a timely manner. We found the highest risk to clinical treatment related to the medical records system, which resulted in surgeons and anaesthetists sometimes carrying out treatment without access to the patients' medical history.

However:

- There were established safeguarding procedures appropriate to patient age groups. Although nurse and medical staff teams did not meet the trust's 90% standard, at 75%, for completion of safeguarding children level 3, specialists across the hospital provided dedicated support and training opportunities.
- The trust had significantly improved the use of the World Health Organisation surgical safety checklist in theatres. Quality and safety staff had audited the work to improve this safety tool, which resulted in a demonstrable trajectory of better practice.
- Staff used a range of systems to monitor and care for patients whose condition was deteriorating. This included electronic calculation of early warning scores and automatic escalation to senior clinical staff.
- An electronic monitoring system was in place across all clinical areas which enabled staff to monitor and track their patients throughout their care and treatment pathway.
- Some teams and services, such as ear, nose and throat and clinical site practitioners, had implemented peer reviews or audits to assess their service and improve care for patients with complex needs.
- Staff had access to extensive training and development opportunities and dedicated support from a practice education team. This team worked across the hospital and provided targeted, specialised training to staff. This was alongside simulation training and leadership development opportunities.
- All surgical areas scored consistently well in the NHS Friends and Family Test, with all recommendation scores at 90% or above in 2017.
- We saw an embedded culture of staff involving patients and parents when planning care and treatment. Staff took time to explain options and risks and patiently took time to answer questions.
- Substantial work had been completed in relation to delivery of referral to treatment times (RTT) following a suspension prior to 2016. Dedicated data, clinical and quality teams worked together to improve data quality and reporting.

Summary of findings

- The trust had a target of full compliance with RTT national standards and no 52 weeks breaches by January 2018. Each specialty had a recovery trajectory aimed at achieving this. There was evidence of sustained improvements in the RTT with 29 of 49 recorded specialities achieving the RTT standard in December 2017 and 39 achieving it in January 2018.
- There was evidence of effective, inclusive leadership at service level. Staff in all departments, wards and clinical services spoke positively of the support and leadership they received and said this contributed to a very welcoming culture.

Outpatients

We rated safe, responsive and well-led as good and caring as outstanding. The rating of responsive and well-led had improved since our last inspection. Our overall rating of this service improved. We rated it as good because:

- We saw evidence of the use of national clinical guidelines and a culture of evidence based practice in the specialties we observed in outpatients.
- The service made sure staff were competent for their roles. All nurses in the outpatients department had an appraisal within the last year. Staff told us they found it of benefit to take time out and reflect on their work and possible career development.
- Staff cared for patients with compassion. We saw several examples of staff from all disciplines being supportive and kind to patients and their relatives. We saw staff comforting patients and carers and a high level of engagement with children and young people.
- Patients and their relatives felt included in their plan of care. Patients told us nurses and clinicians spoke directly with them rather than just to their parents and carers. They felt included in discussions about their treatment and staff took time to ensure they understood what was discussed.
- The service took account of patients' individual needs. There were link nurses for patients with a learning disability, who staff and patients could contact for advice and support. Reasonable adjustments were made to provide a better patient experience for learning disabled patients.
- The department supported people to be as engaged in their own health and wellbeing as possible. For example, speech and language therapists ran a group once a month for parents of children who recently had a cleft palate repair. Advice and information was shared about speech development, good oral hygiene and diet.
- Staff we spoke with were very positive about the current leadership team and told us their biggest strength was their honesty and visibility. Staff told us there was good teamwork and they felt valued and got recognition for their work.
- There was general consensus amongst managers and staff about what the departments' top risks were. These included increasing demand on services and capacity in clinics, as well as the unplanned for arrival of inpatients from other hospitals to the outpatients department. Staff told us risks were discussed at staff meetings and managers shared information about what was being done to mitigate these risks.
- Leaders developed a business strategy which was designed to increase the efficiency of the department and enhance patient experience. For example, providing extra space for clinics that had become too full.
- The trust returned to reporting referral to treatment times in January 2017 in agreement with commissioners with noticeable improvements to the quality of the data. This showed that the trust's referral to treatment time (RTT) for non-admitted pathways was similar to the England overall performance. Data on RTT for admitted pathways showed that 91% of patients were seen within 18 weeks with the between August and December 2017.

However:

Summary of findings

- We observed inconsistent adherence to infection prevention and control practice and recent hand hygiene results were poor. Hand hygiene audits from January to December 2017 demonstrated that the average compliance rate was 78%, with results varying between 50% and 96%. We observed doctors were not always 'bare below the elbow'.
- We noted there were no single use tourniquets in use which increased the possibility of infection.
- We found inconsistencies in fridge temperature monitoring; we also saw that ambient temperature monitoring was not taking place in areas where medicines were being stored. There was no action plan in place to address this issue.
- Patient identifiable information was left unattended in consulting rooms. This created the risk of private patient information being accessed inappropriately.

Surgery

Requires improvement   

Key facts and figures

Surgery services at Great Ormond Street Hospital are provided within three divisions; JM Barrie, Charles West and International and Private Patients. There are 12 surgical specialties represented within the hospital and provided across 14 operating theatres and a range of surgical inpatient wards, a pre-operative assessment unit and a day case ward. Theatres one to six include a nine-bedded recovery and infectious patient bay. A 24-hour emergency theatre and anaesthetic bay room are always available and the inpatient wards are equipped to provide care for patients who need high dependency care.

The trust had 11,058 surgical admissions from August 2016 to July 2017. Emergency admissions accounted for 668 admissions (6%), 5,032 (46%) were day cases, and the remaining 5,358 (48%) were elective. Across the 13 specialties, 32% of procedures were carried out in urology, 16% in ear, nose and throat and 12% in general surgery. Other proportions ranged from 8% in plastic surgery to fewer than 0.5% (six procedures) in day case anaesthetics.

During our inspection we visited the main theatres, Ocean theatres and all inpatient wards that provide care to NHS, international and private surgical patients. In addition, we spent time in the pre-surgery assessment unit, the discharge lounge and the anaesthetic pre-operative assessment unit. A CQC pharmacist inspector visited Sky ward, Hedgehog ward, Panther ward and Bumblebee ward.

To come to our ratings we spoke with 39 members of staff across clinical areas and services and management teams. We spoke with 24 patients and/or their parents and looked at 19 patient records. We also reviewed over 80 additional documents.

We last inspected surgical services at Great Ormond Street Hospital in April 2015 and May 2015. At that inspection we rated the service as requires improvement. Applicable to surgery, we told the trust they must:

- Resume World Health Organisation checklist audits in surgery
- Ensure referral to treatment time (RTT) data is robust
- Ensure greater uptake of mandatory training

At this inspection we found significant work had been completed to make demonstrable progress in the implementation of consistent surgical safety checklists and improvements in RTT data. However mandatory training compliance remained variable.

Summary of this service

We rated safe and well-led as requires improvement, and effective, caring and responsive as good. The rating of responsive improved and while outstanding went down since our last inspection. Our overall rating of this service stayed the same. We rated it as requires improvement because:

- Short staffing in some clinical areas had led to delays in treatment and prescribing and the closure of some inpatient beds.
- There was inconsistent management of risks in medicines management.

Surgery

- Clinical governance, risk management and incident investigation systems did not follow a coherent or effective structure in which learning was shared between teams and specialties. Although there was local evidence of improvements in practice as a result of incidents and morbidity and mortality meetings, shared learning was not evident outside of the immediate specialty or service.
- Between August 2016 and September 2017, the trust took an average of 59 calendar days to investigate and close complaints; which was significantly longer than the target of 25 days.
- There was a disconnect between specialty and divisional teams and the senior trust and executive team. A cross-section of 14 clinical staff, including senior clinicians, said the senior team was difficult to communicate and engage with and they did not feel listened to. Although the executive team demonstrated efforts to engage with staff, very few of the individuals we spoke with had been able to participate. The senior team had a track record of high levels of staff turnover, which service-level staff told us meant there was little consistency.
- There was limited evidence risks were regularly scrutinised or reviewed in a timely manner. We found the highest risk to clinical treatment related to the medical records system, which resulted in surgeons and anaesthetists sometimes carrying out treatment without access to the patients' medical history.

However:

- There were established safeguarding procedures appropriate to patient age groups. Although nurse and medical staff teams did not meet the trust's 90% standard, at 75%, for completion of safeguarding children level 3, specialists across the hospital provided dedicated support and training opportunities.
- The trust had significantly improved the use of the World Health Organisation surgical safety checklist in theatres. Quality and safety staff had audited the work to improve this safety tool, which resulted in a demonstrable trajectory of better practice.
- Staff used a range of systems to monitor and care for patients whose condition was deteriorating. This included electronic calculation of early warning scores and automatic escalation to senior clinical staff.
- An electronic monitoring system was in place across all clinical areas which enabled staff to monitor and track their patients
- Staff had access to extensive training and development opportunities and dedicated support from a practice education team. This team worked across the hospital and provided targeted, specialised training to staff. This was alongside throughout their care and treatment pathway.
- Some teams and services, such as ear, nose and throat and clinical site practitioners, had implemented peer reviews or audits to assess their service and improve care for patients with complex needs.
- simulation training and leadership development opportunities.
- All surgical areas scored consistently well in the NHS Friends and Family Test, with all recommendation scores at 90% or above in 2017.
- We saw an embedded culture of staff involving patients and parents when planning care and treatment. Staff took time to explain options and risks and patiently took time to answer questions.
- Substantial work had been completed related to the delivery of the referral to treatment times (RTT) following a suspension prior to 2016. Dedicated data, clinical and quality teams worked together to improve data quality and reporting.

Surgery

- The trust had a target of full compliance with RTT national standards and no 52 weeks breaches by January 2018. Each specialty had a recovery trajectory aimed at achieving this. There was evidence of sustained improvements in the RTT with 29 of 49 recorded specialities achieving the RTT standard in December 2017 and 39 achieving it in January 2018.
- There was evidence of effective, inclusive leadership at service level. Staff in all departments, wards and clinical services spoke positively of the support and leadership they received and said this contributed to a very welcoming culture.

Is the service safe?

Requires improvement ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- Completion rates of mandatory training varied from 58% to 100% and neither medical nor nursing staff met the trust's 90% completion rate in all subjects. However there was extensive evidence of programmes to improve this by the end of 2018.
- Nursing and medical staff groups met the trust's standards for the completion of safeguarding adults level 1 training but not for safeguarding children level 3 training, in which compliance was 74%.
- Between April 2016 and March 2017, surgical wards reported three cases of hospital-acquired MRSA. Results from the Saving Lives audit in 2017 indicated 88% overall compliance with a wide variance in individual results.
- Persistent short-staffing of nurses on Sky ward and clinical fellows in Bumblebee ward had led to delays in treatment and prescribing.
- Risks relating to medicine management were not always mitigated on each ward. For example, we found inconsistent medicines management on inpatient wards, such as unlocked storage areas and a lack of temperature monitoring. Risk action groups and specialty review meetings reviewed medicines risks on a monthly basis and so it was not evident why this had not resulted in more consistent ward practices.
- Learning from serious incidents and never events was limited to specialist clinical areas and there was very little sharing of learning or outcomes between specialties and services.
- Clinical staff had identified a serious potential risk to patient safety relating to access to medical histories and patient notes. This occurred as the trust moved to an electronic patient record system, which meant staff accessed previous patient records from a range of different sources. There were delays in this interim system, which meant procedures sometimes took place without clinicians having a full picture of the patient's medical history. This risk had remained on the trust risk register for over 12 months and multiple senior clinical staff we spoke with said escalating the risk had not resulted in improved practice or safety mechanisms. After our inspection the trust provided details of a trial project that would improve the scanning and availability of patient notes, which was due to be launched in April 2018 ahead of the full electronic system in April 2019.

However:

- There was a significant improvement in the use of the World Health Organisation surgical safety checklist in theatres. We saw evidence of this from observing practice, speaking with staff and reviewing progress audits the trust had completed.

Surgery

- Clinical site practitioners and safeguarding lead nurses provided clinical teams with dedicated safeguarding support and additional training. This reflected an overall comprehensive approach to safeguarding that included the recognition of radicalisation and multidisciplinary working with social workers, psychologists and the security team.
- Staff demonstrated consistently good standards of infection prevention and control, including when caring for patients who were isolated due to infectious conditions.
- Staff on inpatient wards demonstrated detailed knowledge of emergency procedures relating to fire and evacuation. Some staff had completed scenario-based evacuation simulations and could demonstrate how this applied to the specific needs of their patients.
- The biomedical engineering, facilities and estates teams managed a programme of planned and preventative maintenance for theatres. All maintenance was up to date or planned on schedule.
- Clinical staff used the child early warning scores (CEWS) system to monitor patients whose condition was deteriorating. This was an electronic system that escalated care needs to senior clinicians. In addition staff used an electronic patient monitoring board on each ward and daily safety huddles to provide additional risk monitoring for patients. These systems ensured patients at risk of increasing medical needs received timely and appropriate care.
- Staff vacancy, turnover and sickness rates were all significantly better than trust targets.
- Staff were confident in reporting incidents and we found evidence of improvements in practice as a result of incident investigations.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- The clinical audit team reviewed updates to national clinical guidance and quality standards on a monthly basis. This included a review of all hospital policies and protocols to identify where updates were needed.
- The hospital participated in national and international benchmarking, including as part of an international network for surgical interventions in patients living with epilepsy.
- A tracheostomy nurse specialist had led a range of improvements to patients who needed tracheostomy care. This included, targeted specialist training for nurses, the implementation of nurse link roles and remote reviews for patients after discharge.
- Staff in the ear, nose and throat specialty recognised a need for better benchmarking of care and treatment and had established clinical groups to drive this forward.
- The clinical site practitioner team had implemented a peer review system as a strategy to discuss complex cases and identify areas for improvement in care.
- Staff used evidence-based tools to monitor nutrition and hydration and ensure patients received appropriate support. Dieticians were available in the hospital and the gastroenterology service had recruited a food allergist as part of a new feeding pathway.
- Staff had reviewed starving times and implemented new care protocols for patients that enabled them to have a drink before surgery.
- A specialist pain control team was available 24-hours a day, seven days a week.

Surgery

- From July 2016 to June 2017, patients at the trust had a lower than expected overall risk of readmission for elective admissions.
- Effective discharge processes were in place in inpatient wards and consultants always provided discharge summaries for patients to take away with them and sent a copy to the patient's GP.
- A dedicated team of practice facilitators and practice educators provided specialist training, simulations, ad-hoc support and facilitated learning across all surgical areas.
- Patients were cared for by coordinated teams of clinicians who worked with therapies and rehabilitation staff and met regularly to review care planning. Multidisciplinary working was clearly embedded in all clinical pathways such as through consultants working cross-specialties and a team of psychologists reviewing patients in all inpatient wards.
- The child and family information group worked with clinical teams to develop health promotion materials and strategies to help patients and their parents during their stay and after discharge.
- An extensive range of non-clinical services and teams worked together to provide holistic care to patients and their relatives. This included a school with teachers who visited wards, a team of volunteers and dedicated play specialists. Staff in each team adapted their service to the age of patients and there was a demonstrable focus on improving facilities and services for adolescents.
- Play specialists had worked with the infection control and nurse teams to ensure they could use recreational resources with young people who were treated in isolation due to infectious risks.

However:

- Between April 2016 and March 2017, 85% of staff within surgery at the trust had received an appraisal compared to a trust target of 90%.
- Staff told us they did not routinely receive training in the Mental Capacity Act (2015) and there was limited understanding of mental capacity in some teams and departments. However after our inspection the trust told us this was included as part of their safeguarding level 1 mandatory training.
- Although multidisciplinary working was clearly embedded in services, this did not extend to the wider trust. This was because there was a lack of learning between services, departments and specialties.

Is the service caring?

Good ● ↓

Our rating of caring went down. We rated it as good because:

- The results of the NHS Friends and Family Test (FFT) indicated people scored surgery services consistently well for recommendation rates. Several areas had a track record of achieving 100% recommendation rates from respondents.
- The trust had adapted the FFT questionnaire into a child-friendly format so that children could contribute their thoughts.
- During all of our observations, staff spoke to patients, parents and visitors with kindness and respect.
- Staff demonstrated understanding of the principles of privacy and dignity and adapted care to the age and needs of their patients.
- Staff in theatres offered children visits to theatres ahead of planned treatment as a strategy to reduce anxiety.

Surgery

- A chaplaincy and spiritual care team provided emotional support to parents and children of all faiths or no faith.
- There was a culture of involving patients and parents in care planning and decision-making. We saw this demonstrated by staff in all specialties and roles. Parents and patients we spoke with persistently cited this as a positive aspect of their interactions with staff.

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good because:

- The hospital benchmarked length of stay times for surgical specialties with three other specialist children's hospitals. Between April 2016 and September 2017, the average length of stay was 6.6 days, which was comparable to or better than similar hospitals.
- Staff used a hospital passport system to help them understand and communicate with young people where they presented with complex communication needs.
- Sensory rooms were available and activities rooms were located on each ward. Age-specific activities and relaxation spaces were provided and play specialists ensured they were 'safe spaces' away from medical procedures and medication administration.
- In 2016, the trust resumed reporting referral to treatment (RTT) times following a suspension to review data quality processes. Dedicated specialists in data collection, analysis and validation worked with clinical colleagues to ensure data was accurate and high quality. A demand and capacity model for all specialty services was in place and senior teams used this to improve waiting times and there was significant evidence of improvement, including 100% compliance with national standards in eight sub-specialties in December 2017 and January 2018.
- Work was ongoing in each specialty to address waiting lists and this involved improving recruitment to administrative roles and involving matrons in planning.
- In the second quarter (Q2) of 2017/2018, the trust cancelled 119 surgeries, 94% of which were treated within 28 days.

However:

- Some clinical specialties, including spinal surgery, were not expected to achieve the trust's RTT targets until 2019/20 due to persistent gaps in staffing and demand higher than capacity.

Between August 2016 and September 2017, there were 31 complaints in surgical specialties. The trust took an average of 59 calendar days to investigate and close complaints; which was not in line with the complaints policy standard of 25 days.

Is the service well-led?

Requires improvement Same rating

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Divisional structures were operating according to an interim model. This meant fewer senior staff provided oversight to increasing areas, including the director of operations who was responsible for five sub-divisions and all 52 specialties and services. We received consistently negative feedback about the functioning of senior executive teams from senior clinical staff.

Surgery

- Staff told us they did not understand the trust senior teams' roles or purpose and said efforts to engage were often very challenging because they were timed to conflict with their clinical responsibilities.
- Understanding of the trust's vision and strategy was variable amongst staff. Some teams had developed their own local vision to enable staff to work towards a common purpose.
- Some specialties had limited systems in place to ensure risk management and learning was shared amongst the whole team.

However:

- Divisional risk registers were regularly scrutinised, reviewed and updated. This included in relation to significant patient safety risks relating to poor records access control and management.
- All of the staff we spoke with said they were supported at a local level by their immediate supervisors and managers.
- Clinical governance systems at specialty level demonstrated leadership to improved practice and safety.
- Ward managers, senior nurses and doctors were empowered to develop the working culture in their respective areas of work. This led to high levels of job satisfaction, which contributed to highly dedicated patient care.
- Staff said good working relationships enabled them to develop professionally and work effectively with colleagues in a culture that rewarded good work and facilitated positive learning from mistakes.
- A clinical audit manager worked with staff to embed safety culture into theatres in a way clinicians thought was meaningful. This formed part of a quality improvement and engagement exercise to develop safety systems.
- A young people's forum operated for patients from age 11 and provided them with a voice within the trust to ensure their' needs were catered for.

Outstanding practice

We found an example of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Good ● ↑

Key facts and figures

Great Ormond Street Hospital for Children NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. The trust operates from a single site in central London and provides outpatient clinics to children funded by the NHS and privately funded patients from overseas and the UK. It is the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants and has more than 50 different clinical specialties. Great Ormond Street Hospital forms the UK's only academic biomedical research centre specialising in paediatrics in conjunction with another hospital. Outpatient services are provided in various settings throughout the main hospital and across three floors in an adjoining building that is on the main hospital site but managed by another London trust.

There were 255,651 first and follow up outpatient appointments between August 2016 and July 2017 compared with 104,581,336 for the whole of England in the same period. This was an increase of over 20,000 patients seen between July 2013 and June 2014 (233,462) as recorded at the previous CQC inspection in June 2015.

We inspected the service over three unannounced inspection days, 9 to 11 January 2018.

During our inspection, we visited a range of clinical areas including Cheetah, Hippo, Rhino, Manta Ray, Caterpillar, Hare and Zebra. We spoke with staff and patients in a range of clinics; for example cardiology, endocrinology, gastroenterology, rheumatology, ophthalmology, neuro-disability and speech and language therapy. We spoke with 37 members of staff including doctors, nurses, allied health professionals, administrative and other staff. We spoke with the director of operations and clinical director for the ICSU as well as the head of nursing and operational lead for the service. We reviewed four patient records and spoke with 12 children and young people and 18 relatives.

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated safe, responsive and well-led as good. The rating of responsive and well-led had improved since our last inspection. Our overall rating of this service improved. We rated it as good because:

- We saw evidence of the use of national clinical guidelines and a culture of evidence based practice in the specialties we observed in outpatients.
- The service made sure staff were competent for their roles. All nurses in the outpatients department had an appraisal within the last year. Staff told us they found it of benefit to take time out and reflect on their work and possible career development.
- Staff cared for patients with compassion. We saw several examples of staff from all disciplines being supportive and kind to patients and their relatives. We saw staff comforting patients and carers and a high level of engagement with children and young people.

Outpatients

- Patients and their relatives felt included in their plan of care. Patients told us nurses and clinicians spoke directly with them rather than just to their parents and carers. They felt included in discussions about their treatment and staff took time to ensure they understood what was discussed.
- The service took account of patients' individual needs. There were link nurses for patients with a learning disability, who staff and patients could contact for advice and support. Reasonable adjustments were made to provide a better patient experience for learning disabled patients.
- The department supported people to be as engaged in their own health and wellbeing as possible. For example, speech and language therapists ran a group once a month for parents of children who recently had a cleft palate repair. Advice and information was shared about speech development, good oral hygiene and diet.
- Staff we spoke with were very positive about the current leadership team and told us their biggest strength was their honesty and visibility. Staff told us there was good teamwork and they felt valued and got recognition for their work.
- There was general consensus amongst managers and staff about what the department's top risks were. These included increasing demand on services and capacity in clinics, as well as the unplanned for arrival of inpatients from other hospitals to the outpatients department. Staff told us risks were discussed at meetings and managers shared information about what was being done to mitigate these risks.
- Leaders developed a business strategy which was designed to increase the efficiency of the department and enhance patient experience. For example, providing extra space for clinics that had become too full.
- The trust returned to reporting in January 2017 in agreement with commissioners with noticeable improvements to the quality of the data. This showed that the trust's referral to treatment time (RTT) for non-admitted pathways was similar to the England overall performance. Data on RTT for admitted pathways showed that 91% of patients were seen within 18 weeks with the between August and December 2017.

However:

- We observed inconsistent adherence to infection prevention and control practice and recent hand hygiene results were poor. Hand hygiene audits from January to December 2017 demonstrated that the average compliance rate was 78%, with results varying between 50% and 96%. We observed doctors were not always 'bare below the elbow'.
- We noted there were no single use tourniquets in use which increased the possibility of infection.
- We found inconsistencies in fridge temperature monitoring; we also saw that ambient temperature monitoring was not taking place in areas where medicines were being stored. There was no action plan in place to address this issue.
- Patient-identifiable information was left unattended in consulting rooms. This created the risk of confidential patient information being accessed inappropriately.

Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- Nursing staff were 100% compliant with safeguarding children level 3 training and were confident about how to escalate any concerns they had about the safety of the child.
- Medicines were stored securely and resuscitation trolleys in all areas we visited were in line with the Resuscitation Council's recommendations. Trolleys had been checked daily and these checks were recorded. All trolleys were situated in areas without obstruction and could be easily accessed.

Outpatients

- Staff told us they were confident to report any identified risks and log incidents without any fear of blame.
- There were hand washing facilities including hand wash basins and hand gel sanitisers widely available around general areas of the department and within the clinical areas.
- Staff were able to demonstrate in detail how they decontaminated isolation rooms after each use. We observed a morning handover, which identified patients who required isolation.
- There was a robust system in place to ensure toys in play areas were decontaminated after use. We were told that parents were encouraged to bring the child's own toys if they had to go into an isolation room to reduce the possibility of cross-contamination.
- During the last CQC inspection, we noted the equipment used to transport patient records between departments was frequently not fit for purpose. During this inspection we saw that these had been replaced with patient record trollies on wheels which had a key pad system and were easy to move from area to area.
- During the previous inspection, we were told that a significant number of referrals from other NHS trusts and embassies did not include adequate medical or clinical information. During this inspection, staff told us they had since adapted a robust approach to this which had resulted in significantly improved quality of referral information.

However:

- The most recent hand hygiene audit showed there was just 57% compliance. We observed good hand hygiene by all staff when they were examining patients, which was confirmed by parents we spoke with.
- There were times when demand for isolation rooms was between 16 and 35 cases per day for five rooms.
- The trust reported a 25% turnover of nursing staff which was higher than the trust average was 16%.
- Hospital-only outpatient prescription pads were left out on desks in all consulting rooms we visited. This was not in line with the NHS security of prescription forms guidance (updated August 2015).

Is the service effective?

We do not rate this domain.

- We found a culture of evidence-based practice in the specialties we inspected in outpatients. Clinicians told us of an audit which was now accepted National Institute for Health and Care Excellence (NICE) based practice.
- Many clinical services provided outcomes data to national or international registries. These registries monitored incidence of disease, clinical management of conditions and treatment outcomes.
- Data collected on patients with inflammatory bowel disease in May 2017 showed that 73% of registered patients were in remission. This was a significant improvement from 46% when the last data was collected in March 2011.
- The 2016-17 patient-related outcome measurement related to Osteogenesis imperfecta (OI), also known as brittle bone disease, showed that 100% of parents and 75% of young people understood the answers given to their questions. 100% of both parents and young people felt involved in decisions taken which related to their care.
- The speech and language department held monthly groups to support parents of patients who had recently undergone a cleft palate repair. Information was shared about ways in which to improve speech and maintain good nutrition and oral hygiene. Speech therapists told us there was positive feedback from parents about the efficacy of this group.

Outpatients

- Staff told us how training provided by the trust enhanced their ability to do their job well. For example, we were told how training in conflict resolution recently enabled them to diffuse a situation with a parent and therefore avoided the need to call the police.
- Volunteers were trained to enable them to provide a service to parents and patients who we observed to be helpful and informative.
- Appraisal rates for qualified nursing staff, healthcare assistants and administrative staff were 100% compliant with trust standards.
- We saw evidence of multidisciplinary working between the department and the rest of the hospital as well as with other hospitals and outside agencies such as GPs and community-based healthcare teams.
- Play workers engaged with patients in the waiting areas and a play therapist was frequently asked to provide distraction for distressed children during their appointment.
- The trust had a 'Transition to Adult Care' policy, which we saw was initiated on some patient records we reviewed.
- Staff we spoke with were clear about their responsibility to adhere to legislation and trust policy in relation to consent. We saw how a clinician applied the trust policy with regard to telephone consent which was clearly documented in patient records.

However:

- Trust data showed that turnaround time of discharge summaries within 24 hours varied between 85% and 89% between April and November 2017, which was below the NHS standard of 100%.

Is the service caring?

Outstanding   

Our rating of caring stayed the same. We rated it as outstanding because:

- We received only positive comments from patients or their carers about staff throughout this inspection. They told us of the sensitivity demonstrated by staff when breaking bad news. They said they could, and frequently did, ring staff when they needed reassurance.
- Parents told us doctors and nurses made them feel like partners in their child's care. They told us they felt that when their views were sought, this was not just a token exercise and they were really taken into consideration.
- Young people told us how staff asked for their opinions and gave them the opportunity to speak without their parents present. They told us they were treated in a respectful way and made to feel their views were valued and taken into consideration when discussing their treatment plans.
- We observed many occasions when staff showed tremendous understanding and sensitivity towards patients and their carers. They anticipated situations which had the potential to be upsetting and provided distraction to the patient.
- Parents told us how staff were discreet and sensitive when they had to break bad or unexpected news to them. They told us they appreciated the way in which they were taken to a private area away from busy areas to absorb the information shared with them.
- Parent and carers of children with special needs told us how staff adapted their service in order to ensure the best possible experience. This included consistency of staff whom they saw on return visits.

Outpatients

- A pilot project had been developed where a learning disability link nurse did a home visit to a patient who persistently refused to come to their appointments. The nurse used communication aids to prepare the patient for their next appointment and ensured they were on duty to welcome them into the department.
- A professional carer told us they were given comprehensive information by doctors about the patient which they included in the person's residential care plan in order to better support their healthcare needs.
- We saw medical, nursing and administrative staff greet all patients and carers, many by their name and welcome them into clinics. We also saw that staff went to great lengths to ensure that treatment plans and medicine regimes were fully understood by patients and carers before leaving the department.
- The trust proactively sought to improve the service. There were numerous comments boxes throughout the department which encouraged people to leave their feedback on the service.
- A young people's forum operated for patients aged 11 to 25, and provided them with a voice within the trust, and to ensure all patients were catered for, regardless of their age.

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good because:

- During the previous CQC inspection in May 2015, we recorded concerns over the reliability of referral to treatment (RTT) data. Various measures were put in place since then to address the problem and the trust returned to reporting in January 2017 in agreement with commissioners.
- Measures put in place included a clinical harm review of patients on the waiting list, the re-training of staff in the management of RTT and the RTT guidelines and embedding necessary processes to ensure the organisation was robustly tracking and managing its patients, in line with the standards.
- From January to September 2017, the trust's referral to treatment time (RTT) for non-admitted pathways and admitted pathways was similar to the England overall performance.
- Data submitted to CQC showed improvements to call handling performance and a reduction in the number of abandoned calls.
- Patients and carers told us they found the booking system to be efficient and flexible. They were given a follow-up appointment without having to pursue it and it was simple to arrange appointments which fitted in with their work pattern or their child's school schedule.
- The trust provided an extensive translation and interpreting service in recognition of the wide range of languages spoken by their patients and families.
- There was an extensive support system in place for patients living with a learning difficulty. This included a nurse consultant and link nurses who were available to patients, carers and staff. They worked collaboratively to ensure that reasonable adjustments were made to make the patient's hospital experience as positive as possible.
- There was publicly available information on health related matters including epilepsy, diabetes, autistic spectrum disorder, living with visual impairment and healthy eating.
- Carers who travelled by car to the hospital were given a parking voucher for use in the area surrounding the hospital, the length of which depended on the nature of their visit. In addition, where the patient had a number of appointments over the course of more than one day, they were offered hotel accommodation close to the hospital.

Outpatients

- Certain specialties offered telemedicine to patients who lived far away. This allowed clinicians to make an assessment of their patients over the telecommunications infrastructure and reduced the frequency with which the patient was required to attend the hospital in person.

However:

- Complaints to the outpatient departments took on average 42 calendar days to investigate and close, which exceeded the trust target of 25 calendar days.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Following the suspension of reporting its referral to treatment (RTT) waiting times, the trust completed a significant amount of work relating to the RTT access standards. The additional work has led to the improvement of the quality of the data, with staff retrained to correctly manage RTT data.
- There were robust governance systems in place for identifying risk and monitoring quality against national standards. Local audits informed actions required to continuously improve service delivery.
- There was consistency in what staff raised as concerns and what were recorded as risks. The senior leadership team identified risks which staff also identified, including unplanned for arrival of inpatients from other hospitals to the outpatients department and capacity in clinics. We saw that risks were reviewed regularly and actions identified to address them.
- Staff were very positive about the local leadership of the outpatients department. They told us they were visible, supportive and had an open door policy.
- The departmental leadership team had a vision for the department and an improvement plan put in place to achieve this.
- Staff told us they felt valued and their views were listened to. They described the department as a good place to work where strong teamwork ensured good service delivery to patients.
- Staff said equality and diversity training, which was mandatory, helped them to offer better support to patients from diverse backgrounds.
- The trust developed an action plan in response to aspects of the 2016 staff survey which scored significantly worse than the rest of the trust.

However:

- Many staff told us they were unfamiliar with those members of the leadership team above departmental sisters and matrons and most did not know the names of board members and told us they would not recognise them.
- We were told that the frequent changes to the organisational structure were confusing and some staff told us they were not made fully aware of the reasons for them.
- The outpatient's staff survey scored worse than the rest of the trust in certain areas. For example, 24% of outpatient staff reported experiencing physical violence from patients, relatives or the public in last 12 months against a trust-wide rate of 7%. In addition, 60% of outpatient staff felt able to contribute towards improvements at work against a trust rate of 76%.

Outpatients

- We found patient-identifiable information on view in offices, including a patient identifiable letter on an unlocked computer screen and clinic lists with patient names on desks in three consulting rooms.

Outstanding practice

We found an example of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

Regulation

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Amanda Stanford, Deputy Chief Inspector and Nicola Wise, CQC Head of Hospital Inspection chaired this inspection. David Harris, CQC Inspection Manager took the lead for both parts of the inspection and was supported by Klaudiusz Zembrzuski, CQC Inspector.

The core service inspection team included nine CQC Inspectors, six specialist professional advisors (SPAs), two experts by experience (Exbyex) and one inspection planner.

The well-led inspection team included three inspectors, four SPAs, one executive reviewer and one inspection planner.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

Trust Board 23 May 2018	
Integrated Quality Report	Paper No: Attachment T
Submitted by: Mr Matthew Shaw, Medical Director Alison Robertson, Chief Nurse	
Aims / summary The Integrated Quality Report will provide information on: <ul style="list-style-type: none"> • 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) • data quality kite-marking has now been added to the report as per the Trust Board's request <p>Three Take Away Messages</p> <ul style="list-style-type: none"> • The reporting of 2 Grade 3 Pressures Ulcers (one in February 2018 and one in March 2018) are being investigated • Review underway on cardiac/respiratory arrests and return of children to intensive care • Significant quality and safety improvements were demonstrated in recently closed neonatal project. 	
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	
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

Mr Matthew Shaw, Medical Director

Alison Robertson, Chief Nurse

May 2018

(covering January- March 2018)



Safety

Has patient care been safe in the past? Measures where we have no concerns	Page 3-5
Has patient care been safe in the past? Learning from closed serious incidents and never events	Page 6-7

Care/ Experience

Are we responding and improving? Patient and family feedback; open red complaints	Page 8
Are we responding and improving? Patient and family feedback; learning from closed red complaints	Page 9
Are we responding and improving? PALS data	Page 10
Are we responding and improving? Learning from friends and family test data- inpatient data	Page 11-12
Are we responding and improving? Learning from friends and family test data- outpatient data	Page 13-14
Are we responding and improving? Friends and family test updates/ benchmarking	Page 15
Are we responding and improving? Friends and family test positive feedback	Page 16
Are we responding and improving? Friends and family test- 'you said', we did	Page 17
Are we responding and improving? Featured project; PEWS (Paediatric Early Warning System)	Page 18

Outcomes/ Effectiveness

Improvement

Are we responding and improving? Quality improvement project updates (with Executive sponsorship)	Page 19-20
Appendix A: PALS grading definitions	Page 21
Appendix 1: Methodology for key Trust measures	Page 22
Appendix 2: SPC FAQs	Page 23-30

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.

Data Quality Kite-mark	Measure	Comment
	<p>Non-2222 patients transferred to ICU by CSPs**</p> <p>** 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.</p>	<p>There has been a recently identified increase in the number of non 2222 patients transferred to ICU by the CSP team. The previous process mean was 7 patients per month. Since September 2017 there has been a statistically significant increase – a run of 7 consecutive months above the previous process mean. This increase is yet to be sustained, but the current mean for this 7 month period is just under 10 per month. There were 9 such incidents in January, 12 in February and 8 in March.</p>
	<p>Cardiac arrests**</p>	<p>Overall, the data remains stable for this measure at 2 cardiac arrests per month; this has remained stable since 2015 with the exception of one outlier in January 2017. There were 2 cardiac arrests outside ICU in both January and February 2018, with 0 in March 2018. The process is currently in normal variation at GOSH; there have been no runs, trends or recent outliers identified.</p>
	<p>Respiratory arrests**</p> <p>**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.</p>	<p>The data remains stable for this measure at 3 respiratory arrests per month; this has remained stable since June 2015 (when there was a decrease) with the exception of an outlier in November 2015 and August 2017 (both high). The most recent 3 months indicate no change – there were 2 respiratory arrests outside ICU in January, 1 in February and 0 in March 2018. The process is currently in normal variation at GOSH; there have been no runs, trends or recent outliers identified, though there has recently been a reduction in the number of respiratory arrests classified as preventable.</p>
	Cardiac arrests outside of ICU	Respiratory Arrests outside of ICU
January 2018	2 (IR and Theatres)	2 (Panther ENT and Chameleon)
February 2018	2 (IR and Kangaroo)	1 (Panther Urology)
March 2018	0	0

Has patient care been safe in the past?

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Please see appendix 1 for the methodology used for the measures below.

Data Quality Kite-Mark	Measure	Comment
	Never Events	<p>The last Never Event was on 26th March 2018. The mean time between never events is unchanged at 220 days. The baseline for this data is from 2010 until 2014.</p> <p>The Never Event declared in March 2018 was for retained foreign object while the previous never event in October 2017 was for wrong site surgery.</p>
	Serious Incidents** **by date of incident not declaration of SI	<p>The number of serious incidents remains stable, with a mean of 0.76 per month. This mean is based on a baseline between September 2016 and January 2018, and is a statistically significant reduction compared to the previous mean (taken from a baseline ending in August 2016, which was also a reduction compared to the previous baseline). There were no SIs reported in January or February, with 2 reported in March.</p> <p>If we look at a more sensitive measure (days since previous SI) then we see that SIs have become less frequent. Before August 2016 we would expect an SI to be reported every 13 days, since then we have had an SI reported every 33 days</p>
	Mortality	<p>The data remains stable at 6.3 deaths per 1000 discharges; the process is in normal variation and has been since 2014. The rate for January was 6.25 per 1000 discharges, 5.35 per 1000 discharges in February and 2.06 per 1000 discharges in March 2018. There have been no runs, trends or outliers identified.</p> <p>Over 80% of GOSH inpatient deaths are on ICU, and ICU deaths must be risk adjusted to properly determine a trend. Raw survival/mortality rates do not take account of severity of illness and case mix so outcome data needs to be adjusted to take these factors into account. All ICU data is submitted, after risk adjustment, to the national Paediatric Intensive Care Audit Network (PICANET). This process will allow any trends or outlier performance to be determined. Internal monitoring of Variable Life Adjusted Plots (VLAD) from January – June 2017 showed an increase in the number of deaths on PICU compared to expected. A comprehensive internal review of cases did not suggest any obvious patterns or concerns about the quality of care in PICU/NICU, and no single cause that could explain the trend. GOSH has been informed by PICANET it will not be a statistical outlier for 2017 and the full PICANET data for the calendar year 2017 is due to be published on 31 March 2018. The most recent VLAD data suggests that the negative trend has not continued.</p>

Has patient care been safe in the past?

Measures where we have no concerns

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Please see appendix 1 for the methodology used for the measures below.

Data Quality Kite-Mark	Measure	Comment																		
	<p>Hospital acquired pressure ulcers reported (grades 2+)</p>	<p>Performance remains within normal variation at 6.67 per month.</p> <table border="1" data-bbox="795 439 1918 635"> <thead> <tr> <th></th> <th>January 2018</th> <th>February 2018</th> <th>March 2018</th> </tr> </thead> <tbody> <tr> <td>Grade 2 hospital acquired pressure ulcers</td> <td>6</td> <td>3</td> <td>2</td> </tr> <tr> <td>Grade 3 hospital acquired pressure ulcers</td> <td>0</td> <td>1</td> <td>1</td> </tr> <tr> <td>Grade 4 hospital acquired pressure ulcers</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>				January 2018	February 2018	March 2018	Grade 2 hospital acquired pressure ulcers	6	3	2	Grade 3 hospital acquired pressure ulcers	0	1	1	Grade 4 hospital acquired pressure ulcers	0	0	0
	January 2018	February 2018	March 2018																	
Grade 2 hospital acquired pressure ulcers	6	3	2																	
Grade 3 hospital acquired pressure ulcers	0	1	1																	
Grade 4 hospital acquired pressure ulcers	0	0	0																	
	<p>GOSH-acquired CVL infections</p>	<p>We have identified a reduction in the measure of CVL infections per 1000 line days. This reduction started in January 2017 and has been sustained – the current baseline mean from January 2017 to January 2018 shows a rate of 1.38 CVL infections per 1000 line days, compared to a previous mean of 1.78 CVL infections per 1000 line days. (The figures for January, February and March 2018 are 1.27, 1.38 and 1.99 CVLS per 1000 line days respectively.)</p>																		
	<p>The number of PALS cases</p>	<p>The number of PALS cases reported per month remains stable, with an average of 149. Since the outliers in summer 2017 (June and July), the process is currently in normal variation; there have been no runs, trends or recent outliers identified. There were 193 cases in January 2018, 195 in February 2018 and 193 cases in March 2018, but despite being higher than the mean these are both within expected limits based on previous baseline data.</p>																		

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Serious Incidents and Never Events January - March 2018

No of new SIs declared in January - March 2018:	3	No of new Never Events declared in January - March 2018:	1
No of closed SIs/ Never Events in January - March 2018:	1	No of de-escalated SIs/Never Events in January - March 2018:	0

New SIs/Never Events declared in January – March (4)

STEIS Ref	Incident Date	Date Report Due	Description of Incident	Divisions Involved	Senior Responsible Officer (SRO)	Patient Safety Manager	Executive Sign Off	Divisional Contact
2018/7556	12/03/18	21/06/2018	Report sent to BUPA which contained information of nonBUPA patients – ICO reportable	IPP	Associate Medical Director	Patient Safety Manager	Medical Director	IPP Head of Business and Finance
2018/7559	21/01/18	21/06/2018	Patient level data has been sent using unencrypted email transfer from a GOSH email account to personal email and back to a GOSH email account. It is against Trust policy to transfer patient identifiable data to a non-secure email address and also safe any patients on a non-Trust device.	JM Barrie	Associate Medical Director	Lead Patient Safety Manager	Medical Director	Consultant Neurology
2018/7616	08/02/18	22/06/2018	Information governance breach – Letter containing highly sensitive information sent to wrong address.	JM Barrie	Associate Medical Director	Patient Safety Manager	Medical Director	General Manager
2018/7762	23/03/18	25/06/2018	Retained Foreign Object (swab) during bowel surgery.	JM Barrie	AMD	Patient Safety Manager	Medical Director	Matron

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Learning from closed/de-escalated SIs/Never Events in January – March 2018 (1):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2017/26155	<p>A patient was electively admitted for extraction of six teeth. During this procedure, an incorrect molar tooth was extracted. The patient had an incorrect molar tooth removed. It has not been necessary for the tooth originally planned for removal to be removed at this time and the patient has not needed an additional procedure. The patient will be monitored to observe the progress of this tooth which may need to be removed at a later stage.</p>	<p>The root cause was identified as a failure to identify the correct tooth for removal by the maxillofacial SpR. This failure was due to the retention of the LRE which was confused with the LR6</p>	<p>A dedicated surgical safety checklist for maxillofacial surgery will ensure that a second check of all teeth for removal is implemented as well as identifying which equipment is necessary for the tooth removal. This will reinforce the use of imaging during team brief and the procedure itself.</p> <ul style="list-style-type: none"> a) Implementation of a safety checklist for use prior to maxillofacial procedures. b) Use of checklist to be audited to ensure this is embedded for use by the maxillofacial and theatres teams. <p>Action Update: Checklist devised.</p> <p>It is necessary to raise awareness to all dental, maxillofacial and theatres staff of this type of incident and actions which need to be taken to prevent recurrence.</p> <ul style="list-style-type: none"> a) Internal safety alert to be devised and disseminated to staff. <p>Action Update: Complete.</p> <p>Whilst the responsibility of identifying and removing the correct tooth lies with the surgical team, education of the theatre nurses regarding tooth counts and types of equipment required will empower them to query surgical decisions should this be necessary.</p> <ul style="list-style-type: none"> a) Education sessions to be organised for relevant theatres nurses. Please note this action isn't due for completion until 01/04/2018, however we have requested an update and are awaiting details. 	<p>There may be a need for dedicated safety checklists for specific types of surgery to improve planning and communication amongst surgical teams.</p>

Are we responding and Improving?

Patient and Family Feedback: Red Complaints

Red Complaints in January - March 2018

No of new red complaints declared in January-March 2018:

1

No of re-opened red complaints in January-March 2018:

0

No of closed red complaints in January-March 2018:

2

New red complaints (1)

Ref	Opened Date	Report Due	Description of Complaint	Divisions Involved	Exec Lead	Division Lead
17/069	23/01/18	27/02/18	Father raises concerns regarding the nursing care provided to his child on Eagle Ward prior to the child's death. He believes that had certain symptoms been further investigated it may have prevented his child's deterioration. The complaint is currently under investigation, led by JM Barrie division	JM Barrie	Interim Medical Director	General Manager- JM Barrie



The child first and always

Are we responding and Improving?

Patient and Family Feedback: Learning from Red Complaints

Learning from closed red complaints in January – March 2018 (2):

Ref:	Summary of complaint:	Outcomes/Learning:
17/002	<p>During cardiac surgery a needle was left inside the patient, which necessitated the patient's chest being reopened to remove it. The patient did not leave the theatre between the two procedures. This was investigated as a Serious Incident. The Social Worker on behalf of the local authority raised concerns, and the outcome is identified in the Outcomes/Learning section.</p>	<p>There were a number of actions from this complaint:</p> <ul style="list-style-type: none">- A review has taken place of the surgical count policy to ensure the first surgical count is completed and signed before the chest is closed- The way information is recorded in the peri-operative careplan will be reviewed by the Theatres matron and the learning disseminated via newsletter, email, staff meetings and noticeboard <p>In addition it is noted that the planned Trust partnership with the Cognitive Institute may lead to the implementation of a universally recognised safety language to improve safety culture within theatres.</p>
17/040	<p>Patient raises concerns that a complication during renal surgery as a teenager may have had an effect on her fertility and ability to conceive as an adult.</p>	<p>The investigation found that there was a complication during surgery in 2005, however it is unlikely that this would have any effect on the patient's long term fertility. Her underlying condition and the medicine used to manage it can reduce fertility and this was the likely cause. Due to the time that has passed processes have changed a great deal and there was no change to practice as a result of the complaint.</p>



Comparison of PALS cases received by the Trust during Q4 17/18

Table showing Pals cases by grading comparing Q4 in 17/18 in comparison to previous quarters.

Cases	Q4 16/17	Q3 17/18	Q4 17/18
Promptly resolved	353	316	473
Complex cases	58	76	88
Escalated to formal complaints	3	1	5
Compliments about specialities	5	7	18
*Special cases	8	0	8
Total	427	400	592

*See Appendix at the end for definitions

Top 5 Specialties arising in PALS cases received	Q4 16/17	Q3 17/18	Q4 17/18
Cardiology	14	27	38
General surgery	23	22	31
Gastroenterology	36	8	29
Neurosurgery	8	20	27
Neurology	11	31	21

Top 5 themes arising in PALS cases received	Q4 16/17	Q3 17/18	Q4 17/18
Lack of communication with families	154	118	187
Cancellation	49	59	66
Waiting times	9	26	38
Accommodation	12	12	29
Failure to arrange appointment	13	15	24

Are we responding and improving?

Learning from Friends and Family Test- Inpatient Data



Data Quality Kite-Mark

Inpatient Results January 2018

Inpatient Results February 2018

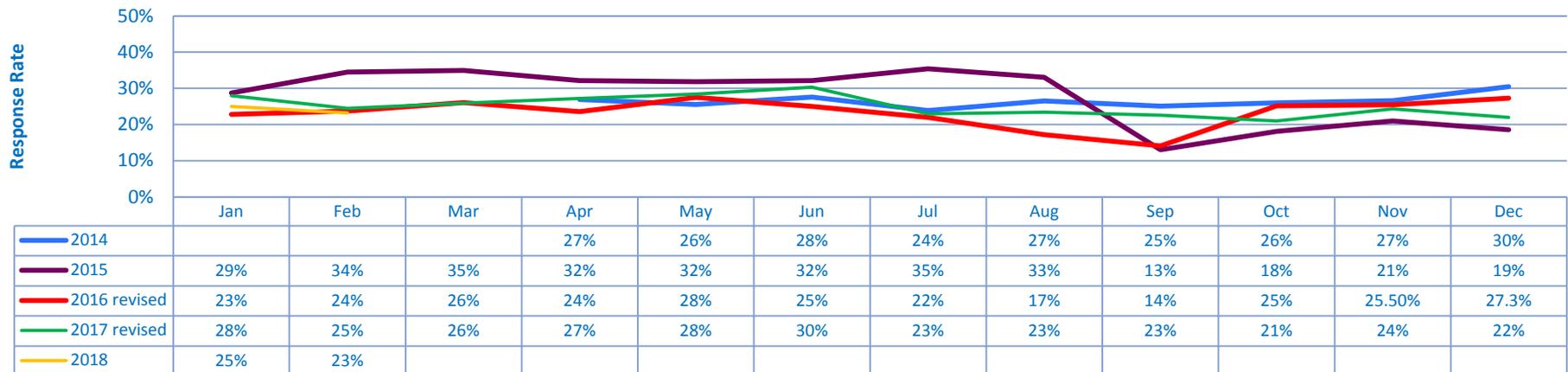
January 2018

Overall FFT Response Rate = 25.1%
Overall % to Recommend = 97.4%

February 2018

Overall FFT Response Rate = 23.2%
Overall % to Recommend = 95.7%

FFT Responses over time



January 2018 Top 3 Themes (by %)

February 2018 Top 3 Themes (by %)

(Not all comments had been themed a time of report production, however the order will not be affected)

Positive Themes:

No +ve comments Total comments

Always Helpful

291 298

Always Expert

191 204

Always Welcoming

177 189

Negative Themes:

No -ve comments Total comments

Staffing Levels

11 12

Access / Admission / Discharge / Transfer

20 23

Always One Team

9 29

Positive Themes:

No +ve comments Total comments

Always Helpful

288 294

Always Welcoming

125 135

Always Expert

61 75

Negative Themes:

No -ve comments Total comments

Access / Admission / Discharge / Transfer

5 5

Staffing Levels

4 4

Catering / Food

6 18

Are we responding and improving?

Learning from Friends and Family Test- Inpatient Data



Data Quality Kite-Mark

Inpatient Results February 2018

Inpatient Results March 2018

February 2018

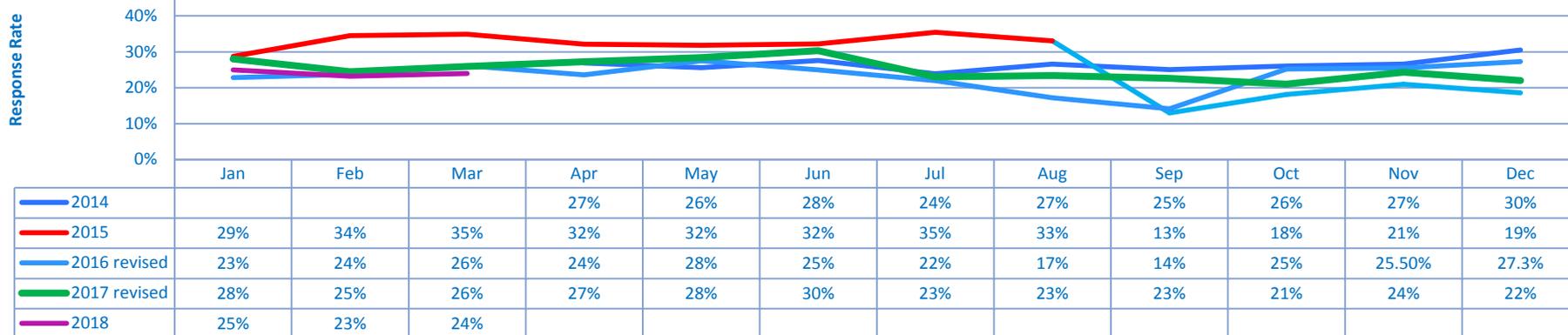
Overall FFT Response Rate = 23.2%
Overall % to Recommend = 95.7%

March 2018

Overall FFT Response Rate = 24.1%
Overall % to Recommend = 96.1%



FFT Responses over time



February 2018 Top 3 Themes (by %)

March 2018 Top 3 Themes (by %)

Positive Themes:

No +ve comments Total comments

Always Helpful

288

294

Always Expert

125

135

Always Welcoming

61

75

Negative Themes:

No -ve comments Total comments

Staffing Levels

5

5

Access / Admission / Discharge / Transfer

4

4

Always One Team

6

18

Positive Themes:

No +ve comments Total comments

Always Welcoming

156

156

Always Helpful

286

289

Always Expert

186

198

Negative Themes:

No +ve comments Total comments

Access / Admission / Discharge / Transfer

25

30

Catering / Food

12

23

Staffing Levels

1

3

Are we responding and improving?

Learning from Friends and Family Test- Outpatient Data



Data Quality Kite-Mark

Narrative:



The average percentage to recommend for Outpatients reduced to 92.4% in February. The total number of cards collected within Outpatients was significantly lower for this month (n= 566) but there were also 2881 fewer attended appointments due to the severe weather conditions.

Outpatient Results January 2018

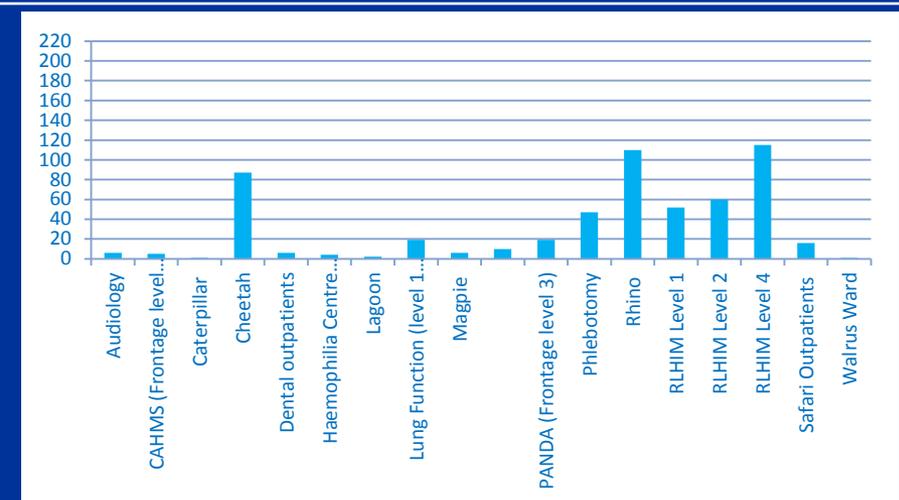
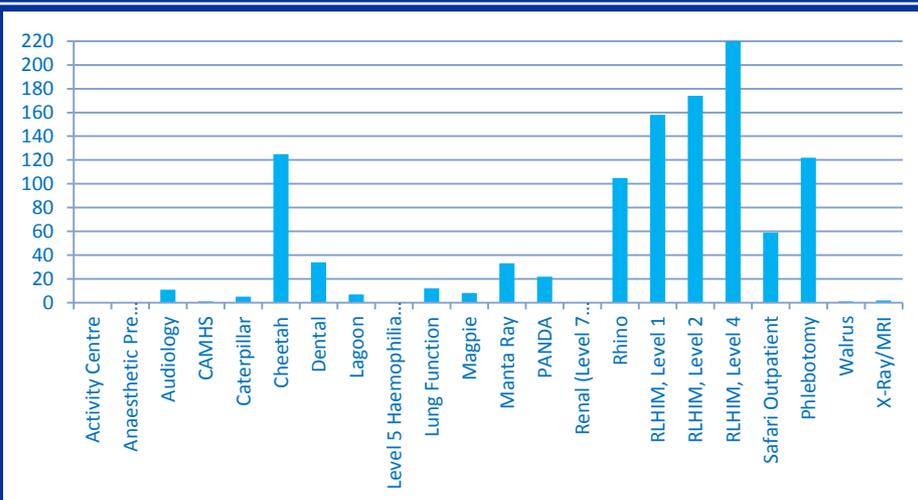
Outpatient Results February 2018

January 2018

Overall % to Recommend = 93.7%

February 2018

Overall % to Recommend = 92.4%



Are we responding and improving?

Learning from Friends and Family Test- Outpatient Data



Data Quality Kite-Mark

Narrative:



The average percentage to recommend for Outpatients increased slightly to 93.1% in March. This is still below the Trust target of 95%.

Outpatient Results February 2018

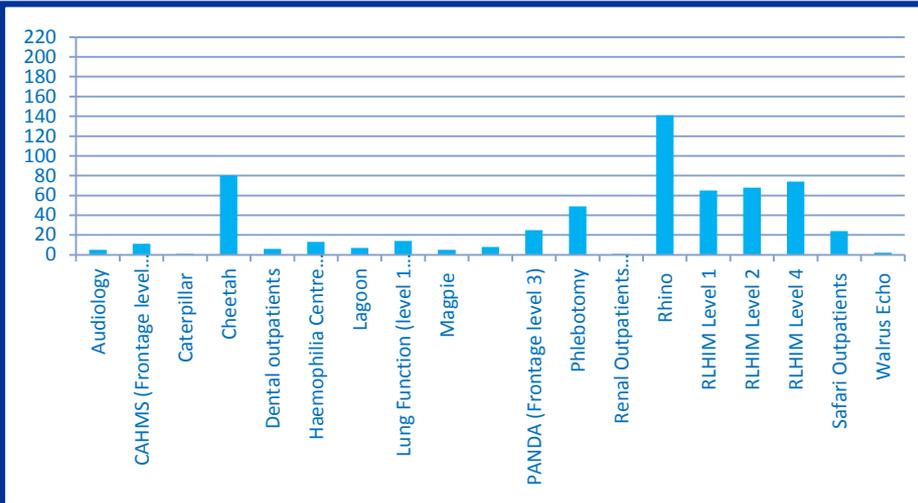
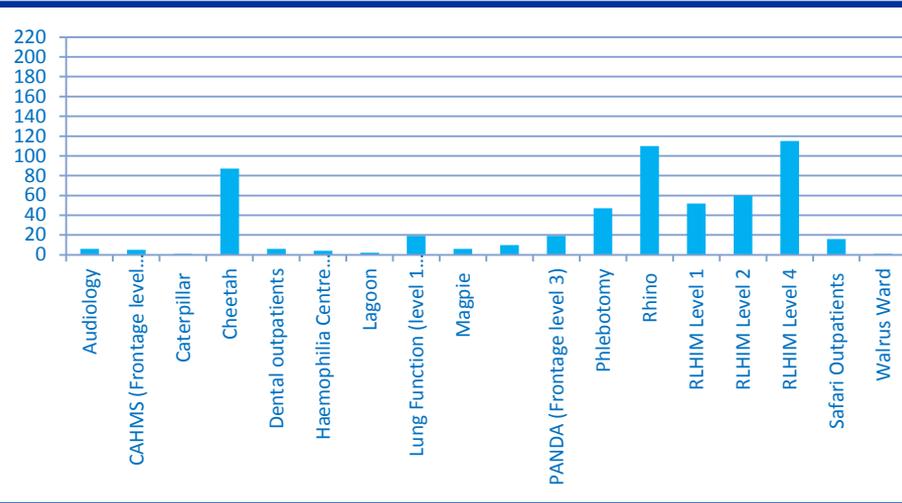
Outpatient Results March 2018

February 2018

Overall % to Recommend = 92.4%

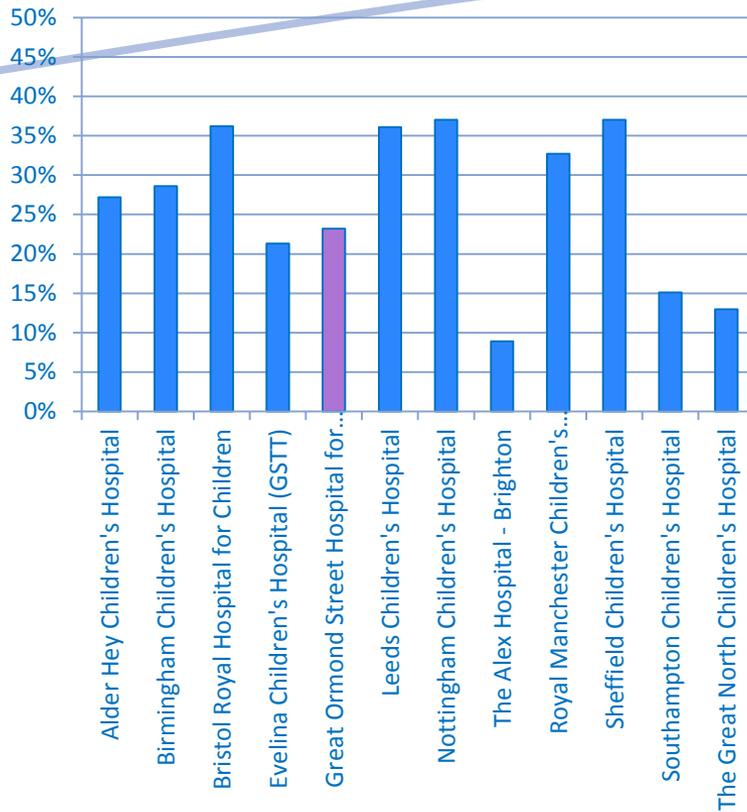
March 2018

Overall % to Recommend = 93.1%

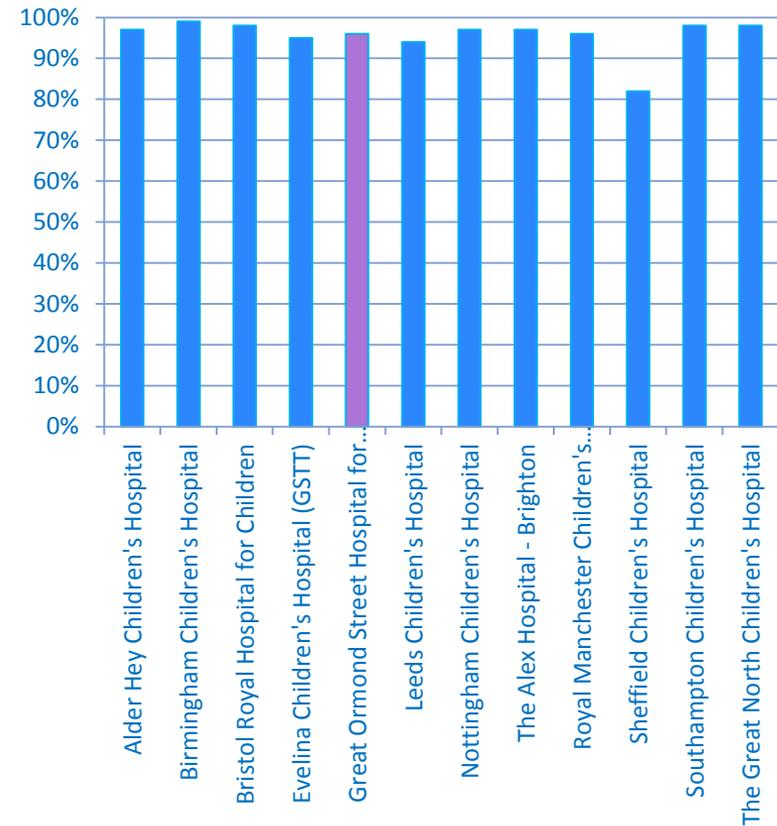


Data from NHS Choices – February 2018

Response Rates



Percentage to Recommend



Are we responding and improving?

Learning from Friends and Family Test



Below is a snapshot of some of the positive and negative feedback received via FFT during the reporting period. Feedback is shared with the relevant teams for dissemination.

Patient Feedback

Parent/Carer Feedback

Everything was good. Nurses, doctors, literally everyone was amazing and polite. Nothing was bad and I wouldn't change anything about my experience.

Bear Ward



Nurses were great very caring, fast, super service, 5*

Starfish

Nurses/doctors were very nice.

Walrus

Entertainment- I love the dogs! and lollipop radio.

Elephant

The only thing we would say is that the pain management wasn't always good because there were only two nurses for the ward. We had to keep asking for pain relief for our son after his operation and even when we asked we often had to remind them up to 1 hour later.

Possum



Waiting times can be really problematic for my autistic child. I understand why, but it is very difficult to explain why it is taking so long to progress. I hate to raise this but I'm sure it applies to others too.

Pelican Ward

Parents area toilet - This has been blocked for 2 days! Why does it take so long to get a toilet unblocked!

Bear Ward



Are we responding and improving?



Learning from Friends and Family Test- 'You Said, We Did' Feedback

'You Said'

We did

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.

It saddens me to be the one to bring the following to your attention, as it really should be recognised by staff. Without generalising, the treatment our baby daughter has received at times whilst staying on Chameleon, has been lazy, negligent and dangerous. Some of the most basic care appears to fall well short of the reputation the rest of this hospital has established itself. Twice today, we have arrived on the ward to find our daughter laying in a pool of green DRY vomit. On one of these occasions her blanket was also pulled over her head completely. On both occurrences, there were staff on that had not even realised this had happened. I'm not surprised as on one occasion, there was not even a nurse present in the room. Our daughter could quite easily have choked to death and there would be nobody in sight. I'm also sure she would still have laid in it until the following morning had we not brought it to the attention of staff. It seems that come, and I would like to highlight the appoint NOT ALL, much prefer to congregate in the area outside of the room and have a good old natter to one another, rather than actually check on, care for or assist with their patients needs. We are unhappy with some of the most basic and fundamental care. Small babies should not be left unattended for long periods, its so careless. We have taken pictures to demonstrate the extent to which we found our baby in. If you would like us to forward them please let me know. On the flipside, we have also been very happy with some of the care provided by Chameleon at times. It is the lack of consistency which is alarming.

Response from Ward Sister.

The family were contacted where I apologised to them for the poor care they had received on this day. They are currently re-admitted and post op and I will meet with them again once the patient is not immediately post op to discuss their concerns in more detail.

The Patient Experience Team will follow up with the Ward Sister to ensure the family are happy and the issues have been resolved.

Project aim:

To implement PEWS across all inpatient wards at GOSH by April 2018.

Project Initiation and Leadership:

Project Initiated in May 2017, currently led by the Chief Nurse

Background:

Professor Mark Peters presented research comparing the predictive performance of 18 paediatric track and trigger systems to the Out of Hours Steering Group in 2017. On the basis of the research, the Steering Group chaired by the Medical Director, recommended that the Trust change to PEWS.

THE PEWS TOOL

PEWS is a validated scoring system designed to identify potential deterioration in children and young people using a combination of factors such as physiological findings, escalation responses and a strong communication framework.

- There are **7** PEWS parameters. All of which must be recorded **every time** an observation is required, for every patient.

There are Four Special Circumstance charts (Nervecentre);

1. **Non-acute monitoring** - For patients who do not require constant monitoring
2. **End of Life Care** – Observations to be agreed between the child’s nursing / medical teams and with the child and family.
3. **PCA / NCA Chart** - For CYP on an NCA or PCA
4. **Doppler Chart** - This chart has BP split into systolic and diastolic pressure, with diastolic as a non-mandatory field



CEWS	PEWS
Temperature	X
Respiratory rate	✓
SpO2	✓
Heart rate	✓
Systolic blood pressure	✓
AVPU	X
	Oxygen
	Capillary Refill
	Work of Breathing
Additional Elements: (no score attached)	Sepsis Criteria Watcher Status

Measurements

- The ‘Deteriorating Patient Dashboard’ combines the measures for cardiac / respiratory arrests, 2222 calls and unplanned ICU transfers across the Trust, broken down by ward / location.
<http://qst/dashboards#/dashboards/dashboard/GetDashboards/125>
- The ‘PEWS Dashboard’ details Nervecentre observations, chart types and PEWS scores at both a ward and patient level. <http://sql-rep01/ReportServer/Pages/ReportViewer.aspx?%2fQI%2fProduction%2fReports%2fCEWSToPEWS%2fPEWS+Post+Rollout+Reports&rs:Command=Render>

Next Steps

- Continuing to embed the new scoring system within GOSH to support the detection and escalation of the deteriorating child.
- Acting on staff feedback of PEWS by submitting a change request through our digital platform provider Nervecentre.
- Developing our PEWS measures (Nervecentre and CareVue) to further support evidence based practice around clinical care and targeted educational programmes e.g. observation completeness.

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children



NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
Neonates	To improve the quality and safety of care within inpatient neonates/ small infants* at GOSH by January 2018[*<28 days or 4kg]	Executive Sponsor- Chief Nurse Nursing Lead- Neonatal Nurse Advisor Medical Lead- Head of Clinical Service	<u>Progress to date:</u> <ul style="list-style-type: none"> Project closure and sustainability recommendations presented at February QIC Operational sustainability plan shared at Nursing Board Sustained improvements identified: <ul style="list-style-type: none"> increased from an average of 62% to 80% of neonates managed in line with NICE guidelines increased from an average of 93% to 98% of neonatal admissions who had a bloodspot within the required timeframe decrease from an average of 31% to 11% of neonates who required an avoidable repeat screening
PEWS	To replace the Children's Early Warning System (CEWS) with the Paediatric Early Warning System (PEWS) for wards across GOSH by January 2018	Executive Sponsor- Chief Nurse Medical Lead- Consultant Intensivist Nursing Lead- Clinical Site Practitioner	<u>Progress to date:</u> <ul style="list-style-type: none"> PEWS went live on 7th March 2018 Nervecentre and CareVue have completed the changes required to enable PEWS scores to be calculated and flagged as per the algorithm PEWS measures have been developed to indicate impact on clinical practice Sepsis alerts have been added to both Nervecentre and Carevue (Bear Ward), but there will be no automatic alert from the calculations – clinicians will need to observe for amber and red flags and escalate accordingly PEWS Nursing Education package has been developed and cascaded to staff Medical training video has been developed Post-implementation feedback has been obtained from staff and a change request is being actioned based on feedback from the frontline

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children



NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
Transition	<p>To enable clinicians to start all young people a Transition Plan by the age of 14 in line with NICE recommendations</p> <p>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.</p>	<p>Executive Sponsor- Chief Nurse</p>	<p>On-going project</p> <p><u>Progress to date:</u></p> <ul style="list-style-type: none"> • Growing Up, Gaining Independence (GUGI) programme developed • GUGI reporting tab on eCOF currently being piloted • GUGI information sheets being piloted in transition clinics • Template for specialty transition information completed • Draft of teaching /information video completed and has been presented to NHSI <p><u>Next steps:</u></p> <ul style="list-style-type: none"> • Further information videos for YP and families • LD information • Staff training needs analysis • Template for 'Welcome to the XYZ service at GOSH' to include information about age limit of service and set expectations from outset being developed • Transition Policy update
Extravasation	<p>To reduce the incidence of extravasation injury at GOSH by 31st July 2018</p>	<p>Executive Sponsor- Chief Nurse Clinical Lead- Consultant Anaesthetist</p>	<p><u>Progress to date:</u></p> <ul style="list-style-type: none"> • VHP Framework & Tool - now in use on Eagle, Bumblebee, Koala, Bear, Walrus, Butterfly, Giraffe, Lion, Elephant, Hedgehog, Leopard, Kangaroo and Safari wards and MRI • Implementation plan underway for roll out Trust-wide by July 2018 • Adaptions made to Endoscopy Care Pathway and Radiology Care Pathway to incorporate vein grade and cannulation attempts information • Updated IV record chart incorporating documentation for vein grading signed off by IP&C Committee and being rolled out alongside VHP framework. Documentation for day cases being tested on Safari • Training video incorporated into IV Study Day & Cannulation/ Venepuncture Course • Planning underway for staff awareness event in June 2018 • Comparison work underway between plastics referrals and Datix of extravasation harm • Development underway of VAF system to log referrals to VAF team and enable prioritization and oversight from CSP team • New cannulation training pathway for junior doctors being piloted in May 2018

Appendix A

PALS grading definitions:

- **Complex Cases**
Cases that involve multiple questions / longer than 48 hours to resolve
- **Promptly Resolved**
These cases are resolved promptly (24-48hr)
- **Escalated to Formal complaint**
Families who want a formal escalation to their concerns
- ***Special cases**
- During the financial year 17/18 there were two separate large contacts following interest by media and public regarding GOSH

Appendix 1

Methodology for key Trust measures

Measure	Methodology	
Never Events	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.	
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>	
GOSH-acquired CVL infections per 1000 line days	<p>The definition for this measure is complex and can be found here: http://goshweb.pangosh.nhs.uk/clinical_and_research/qi/Infection%20Prevention%20and%20Control/CVL%20Infection/Pages/default.aspx</p>	

Appendix 2: SPC Frequently Asked Questions

Contents

[What is a Dashboard?](#)

[What is SPC?](#)

[What is a Run chart?](#)

[What is a Control chart?](#)

[What are the upper and lower control limits?](#)

[What are the different types of control charts?](#)

[What is Common Cause Variation?](#)

[What is Special Cause Variation?](#)

[What is a Run?](#)

[What is a Trend?](#)

[What is an Outlier?](#)

[What is a Baseline?](#)

[What happens when you have a Special Cause? * Step Changes](#)

[Any other tips for interpreting SPC charts?](#)

[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 GO ! , most dashboards are a collection of graphs, mainly in the form of statistical process control " # \$ % 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 GO (tab 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 " # \$ % charts were first developed by an industrial engineer called Walter Shewhart while he was working for Bell Telephone 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. In early 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 Telephone, 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 A rates had dropped.

SPC charts:

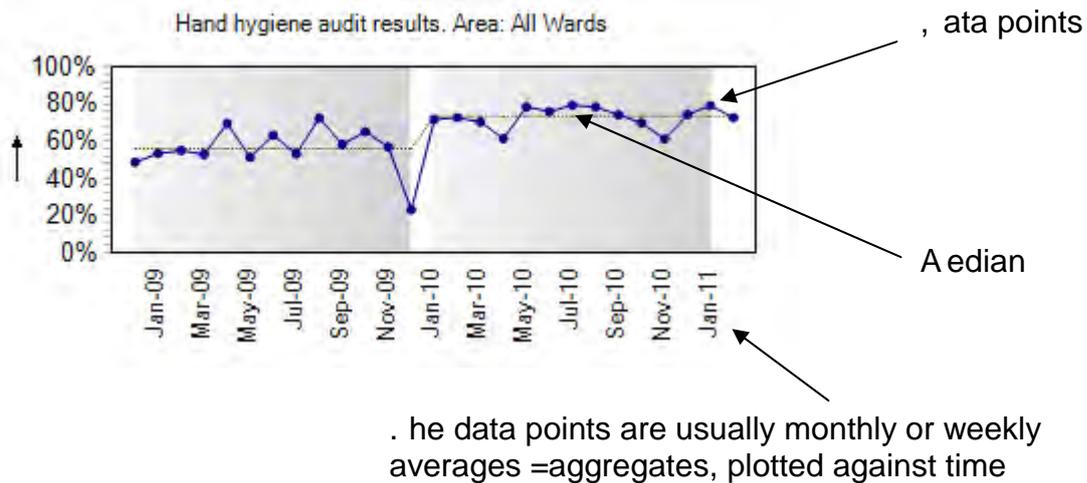
- < are an excellent way of measuring performance
- < Use the pattern of events in the past to predict with some degree of certainty where future events should fall.
- < distinguish between the natural=common cause variation and special cause variation
- < enable you to look for problems when they are there, not when they are not
- < can motivate staff to improve practice thereby reducing adverse events and minimising variation

There are two types of # \$ charts: run charts and control charts.

What is a Run Chart?

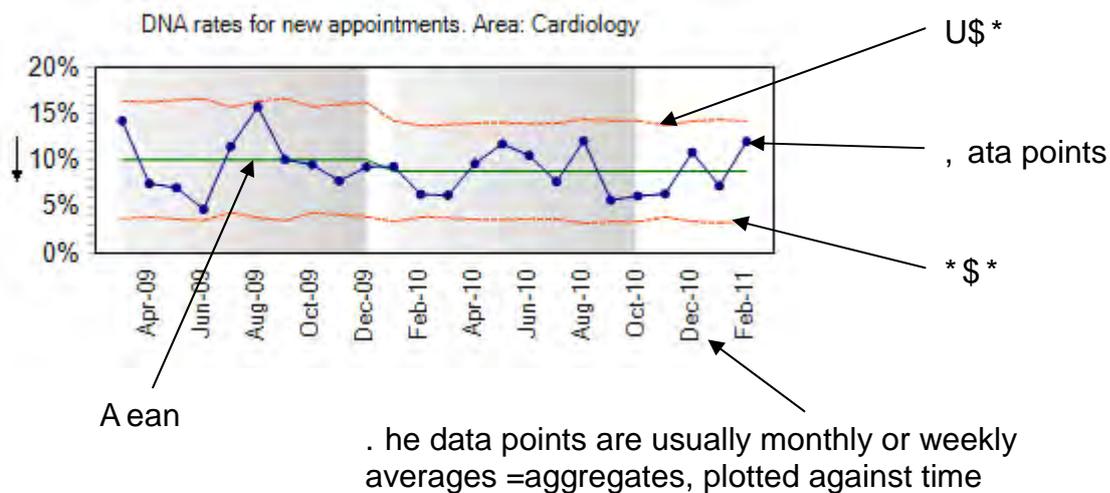
A run chart is used when analysing more than one process, when the data is summed "or aggregated" or instance, if we want to analyse medication errors . rust wide, we would use a run chart 7there is more than one process because there are multiple wards in a the . rust with each ward having its own medication process.

? un 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 GO ! we usually plot the median, as it will be less affected by system-wide outliers.



What is a Control Chart?

A control chart is used when analysing a single process. . hey consist of your data points plotted against time, alongside the mean "or average"of your data, plus the upper control limit "U\$ * %and lower control limit " * \$ * %



. he purpose of control charts is to allow simple detection of events that are indicative of actual process change. . his simple decision can be difficult where the process characteristic is continuously varying@he control chart provides statistically ob;ective criteria of change. (hen 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.

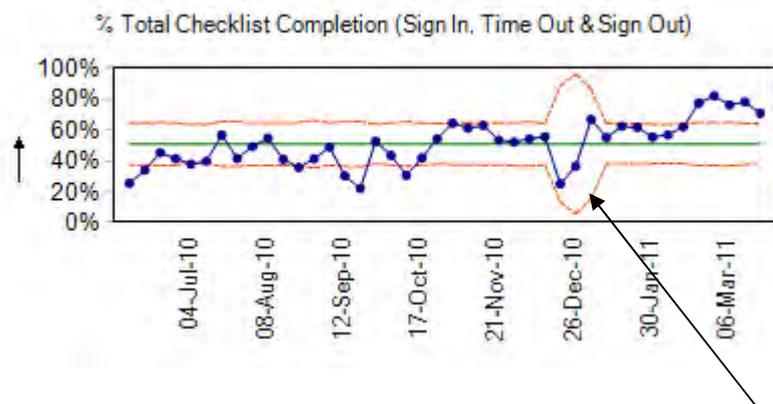
What are the 2 pper and 3o! er Control 3i" its?

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 99.7% of the data should fall within the limits.

Why are the control limits sometimes wiggly?

Wiggly control limits are used on **U-charts and #7charts** 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 # different types of control charts?

1. P-chart Used for individual measurements with only 1 subgroup. Example of a subgroup is a theatre, 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 12 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. Example: For a daily sample of 10 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. NP-chart Similar to a P-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 #7chart 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 orders each week, how many have one or more errors?

M, * hart: Is used when the occurrences are rare. E9ample3. o measure the number of surgeries between I infections.

0. &*Chart: Is used when your measure is time between rare occurrences. E9ample3. he time between serious incidents.

GA ? and # charts are the most commonly used # \$ charts for improvement at GO ! .

What is Co" " on Cause %ariation?

\$ ommon "or natural%cause variation is where the data points are between the upper and lower control limits, evenly spaced around the mean. \$ ommon cause variation does not mean either 5bad variation6or 5good variation6 \$ ommon cause variation merely means that the process is stable and predictable.

What is Spe ial Cause %ariation?

pecial cause variation can be spotted using three simple rules3

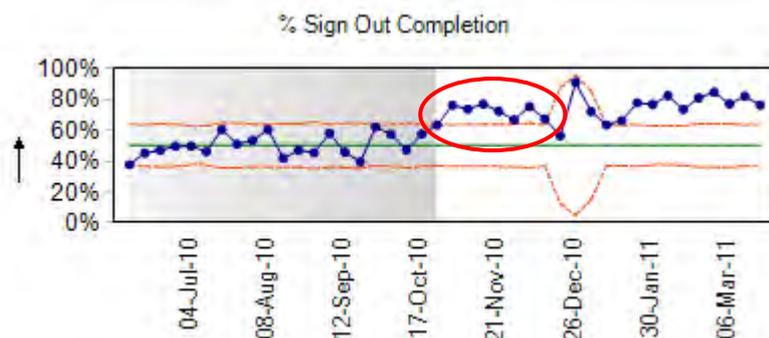
- Runs. A **run** is defined as seven consecutive points above or below the mean=median.
- &trends. A **trend** is defined as seven consecutive points all increasing or decreasing.
- ' outliers. An **outlier** is a data point which is outside of the control limits.

pecial cause variation should not be viewed as either 5bad variation6or 5good variation6 &ou 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.

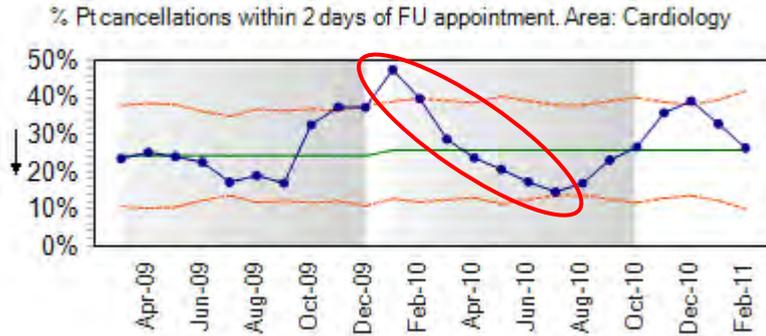
What is a Run?

A run is defined as seven consecutive points above or below the mean=median. ! ere-s an e9ample3



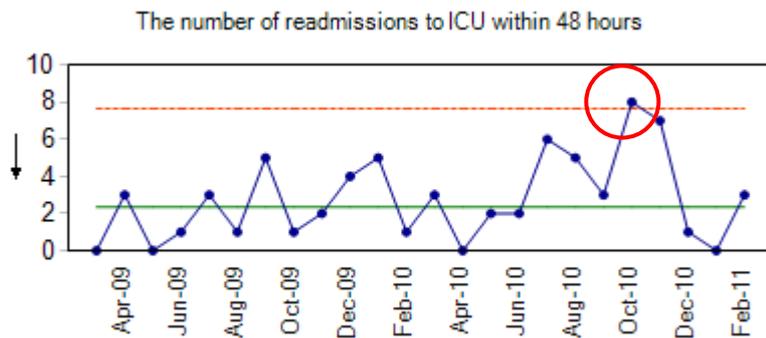
What is a trend?

A trend is defined as seven consecutive points all increasing or decreasing. Here's an example



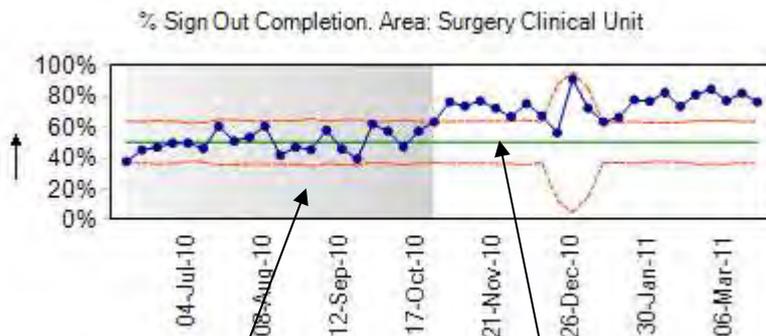
What is an outlier?

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 \bar{x} chart, you should aim to collect at least 10 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.



baseline period

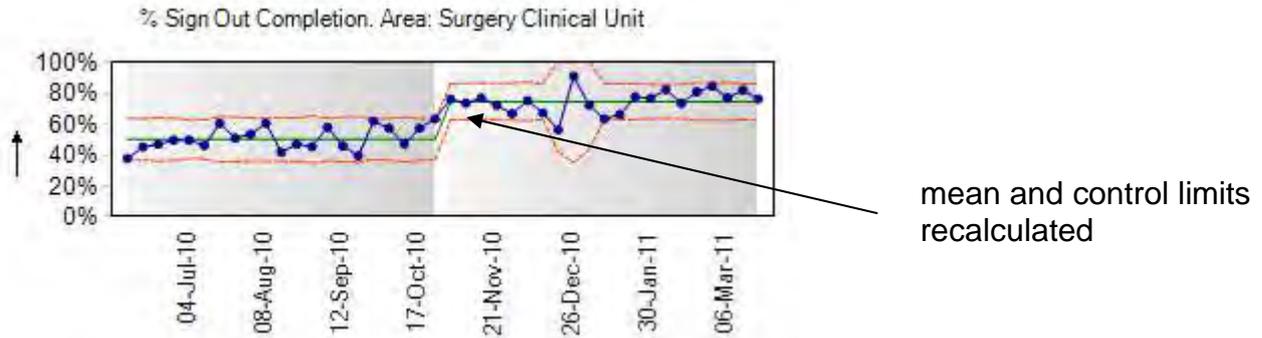
mean and control limits continued from baseline

What happens ! hen you ha)e a Spe ial Cause?

Step 4 Process Changes: (hen you have spotted a **run** or a **trend** for a measure, you can be statistically sure that the process has changed.

. he **control limits** can be recalculated from the date the run or trend started "or from when a process change was implemented, after further investigation of the measure%

>or e9ample, with the Sign Out \$ompletion measure above "where there has actually been a run of / K 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 again3



' 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 **#\$ chart**, alert your clinical unit improvement coordinator=manager or one of the ' uality Improvement analysts, who can recalculate the mean and control limits and add annotations to the charts.

Any other tips \$r interpretin+ SPC at , ' S- ?

. he arro! to the left of each chart represents the desired direction of change.

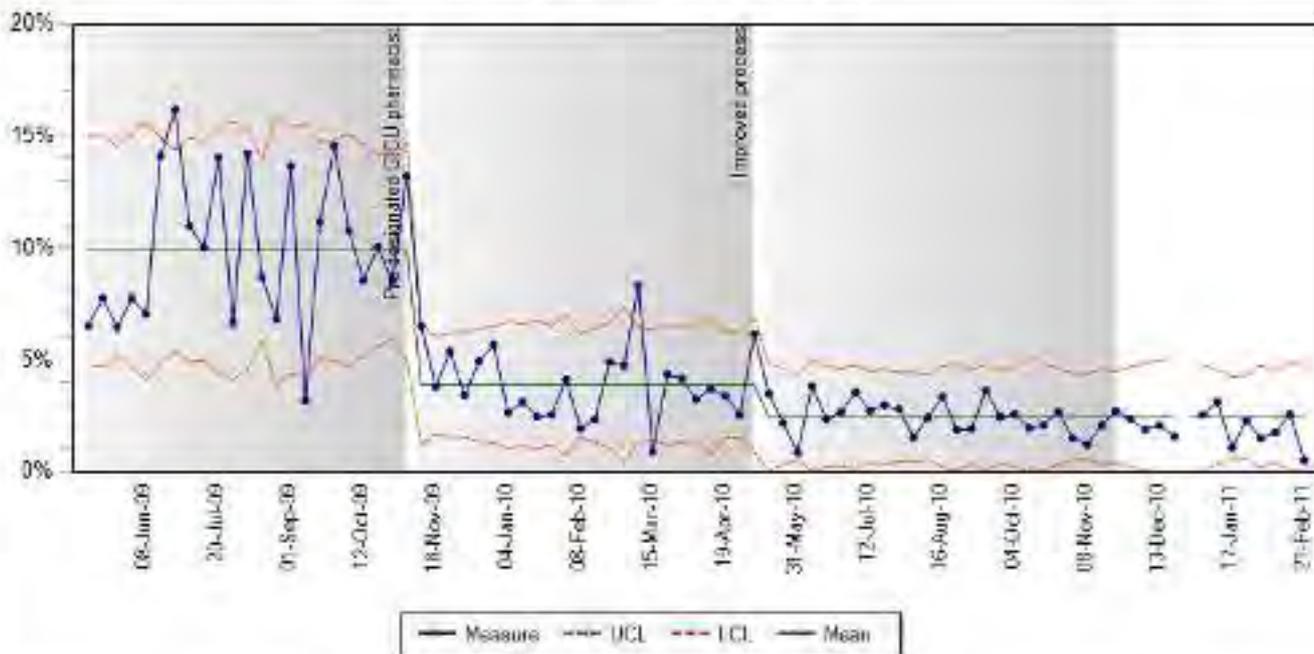
. o access Further Detail and De\$initions for a particular measure on one of the improvement **dashboards**, either click on a data point or the >urther , etail+link ne9t to the dashboard charts



! ere you can view a page with a larger version of the **#\$ chart** "see below%plus the following3

- 7 A measure definition, definition source and data source
- 7 * abelled baselines =processes and annotations
- 7 A table containing the figures that make up the measure@ncluding date, data, U\$* , *\$* , 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	362
07-Feb-11	2%	4%	0%	2%	8	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? A run chart 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 run charts and how we measure for improvement:

- [Measuring for Improvement](#) - Institute for Innovation and Improvement
- [Basics of Statistical Process Control](#), David I. Woodward, Management Review

Alternatively, contact the Quality Improvement analysts or your clinical unit's improvement coordinator/manager.

Trust Board 23 May 2018	
Learning from Deaths. Mortality Review Group - Report of deaths in Q3 2017/2018	Paper No: Attachment U
<p>Submitted by: Mr Matthew Shaw, Medical Director. Andrew Pearson, Clinical Audit Manager; Dr Isabeau Walker, Consultant Anaesthetist and co-chair of the MRG</p>	
<p>Aims / summary In March 2017, the National Quality Board published national standards for the reviewing of inpatient deaths and learning from the care provided to patients. The guidance requires that Trusts share information on deaths to be received at a public board meeting.</p> <p><i>“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). This data should include the total number of the Trust’s in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.”¹</i></p> <p>The Mortality Review Group (MRG) was established in 2012 to review the deaths that occur at Great Ormond Street Hospital (GOSH). The purpose of the MRG is to provide a Trust level overview of all deaths to identify themes and risks, and take action as appropriate to address those risks.</p> <p>This report meets the requirements of the National Quality Board by</p> <ul style="list-style-type: none"> • Outlining the Trusts approach to undertaking case reviews • Including data and learning points from case reviews. <p>The National Guidance on Learning from Deaths requires trusts to have a policy for reviewing and learning from deaths and for this to be available on the trust website. The Trust published an interim policy in March 2018 and is awaiting publication of HM Government Child Death Review Statutory Guidance expected in May 2018. Once the Child Death Review guidance is published, the Trust will review the interim policy and make any changes required.</p> <p>This is a summary version of a report reviewed at the Patient Safety and Outcomes Committee in March 2018.</p>	
<p>Action required from the meeting The board is asked to note the content of the paper.</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans This report meets the requirements of the National Quality Board to report learning from deaths to a public board meeting.</p>	
<p>Financial implications None.</p>	

¹ National Guidance on Learning from Deaths, National Quality Board, published March 2017

Attachment U

Who needs to be told about any decision?

N/a

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

The Medical Director is the executive lead with responsibility for the learning from deaths agenda.

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

Mortality Review Group: Report of deaths in Q3 2017/2018

Dr Isabeau Walker, Consultant Anaesthetist & Co-Chair of MRG; Dr Finella Craig, Palliative Care Consultant & Co-Chair of MRG; Nicole Douglas, Clinical Governance and Audit Assistant. Andrew Pearson, Clinical Audit Manager

Summary

Background

The Mortality Review Group (MRG) was established in 2012 to review the deaths of inpatients at Great Ormond Street Hospital (GOSH). The purpose of the MRG is to provide a Trust level overview of all deaths to identify any learning points, themes and risks and take action as appropriate to address any risks. This process is linked with local case reviews undertaken by specialty teams and provides an additional oversight of deaths in the Trust.

Aim of report

The purpose of the report is to highlight modifiable factors and any learning from case record reviews at GOSH, in accordance with recommendations included in draft HM Government Child Death Review Statutory Guidance. Modifiable factors are defined as factors, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths. This report describes the findings from MRG reviews of deaths at GOSH between 1st October and 31st December 2017.

Headlines

The MRG reviews continue to highlight the excellent care provided by the multidisciplinary teams at GOSH for children, young people and their families, including at the end of life.

Between 1st October and 31st December 2017, 27 children died at GOSH. Case notes have been reviewed for 26 patients. One case cannot be reviewed until police investigations have been completed.

Of the 26 cases that have been reviewed from deaths occurring in Q3 17/18:

- There was one case where the review team felt that there had been a modifiable factor at GOSH that may have contributed to vulnerability, ill health or death (influence score¹two). The case highlighted that suspected sepsis in a child colonised with a resistant organism can be difficult to manage and specialist microbiological advice should be sought. In response to this there has been feedback from the MRG to the specialty team, and this learning has been identified in the Trust wide learning summary. GOSH has a priority Quality Improvement project to implement the Sepsis 6 protocol to support the early identification and treatment of sepsis.
- There were no deaths where modifiable factors at GOSH provided a complete and sufficient explanation for the death (influence score 3).

The table below provides a summary of the deaths that occurred during the quarter using NHS England reporting guidance and guidance included in the draft HM Government Child Death Review Statutory Guidance.

¹ An influence score offers an interpretation of the extent to which the factor may have contributed to the death of the patient: 0 – Information not available 1 - No factors, or unlikely to have contributed to death 2 - Factors may have contributed to vulnerability, ill health or death 3 - Factors provide a complete and sufficient explanation for death

Total number of deaths at GOSH between 1 October 2017 – 31 December 2017	27
Number of those deaths subject to case record review by the MRG	26 ²
Number of those deaths investigated under the serious incident framework and declared as serious incidents	0
Number of deaths where a modifiable factor was identified at GOSH with an influence score of 2	1
Number of deaths where a modifiable factor was identified at GOSH with an influence score of 3	0
Number of deaths of people with learning disabilities	6
Number of people with learning disabilities that have been reviewed	6
Number of deaths of people with learning disabilities with where a modifiable factor was identified at GOSH with an influence score of 2 or more	0

Meeting the requirements of the National Quality Board (NQB) National Guidance on Learning from Deaths and HM Government Child Death Review Statutory Guidance

The NQB National Guidance on Learning from Deaths requires trusts to have a policy for reviewing and learning from deaths and for this to be available on the trust website. The Trust published an interim policy in March 2018 and is awaiting publication of HM Government Child Death Review Statutory Guidance expected in May 2018. Once the Child Death Review guidance is published, the Trust will review the interim policy and make any changes required.

Learning points for deaths occurring in Q3 17/18

The following general learning points have been derived from the case note reviews. This does not imply that any factors were directly linked to the death of the child, rather that an awareness of these points will help us to continuously improve the care provided in the Trust.

Clinical Case Management

- It is important for parents to be closely involved in the care of their children when they are in-patients, particularly children with long-term illnesses. An important aspect of this is for parents to learn how to manage their child's medication, particularly as part of discharge planning. This means that parents may be administering medication on the ward. Please note that parent/carer administered medication must be reviewed when a child who is an in-patient has deteriorated or is acutely unwell. The Pharmacy has an information sheet, assessment tool and consent form for Patient/Carer administered medication.
- High-risk patients and those with long-term illnesses who become critically unwell may benefit from early introduction to the Palliative Care Team. The Palliative Care Team can provide additional support through the admission, as well as on discharge and can support changing goals of care.
- On admission to GOSH, and on transfer between clinical areas, history and examination should include full clinical assessment, including baseline neurological assessment. Changes from baseline should be investigated.
- Children with congenital heart disease are at risk of infective endocarditis when they undergo complex dental surgery.

Communication

- Clear communication between clinical teams and families is at the heart of everything that we do. This is particularly important in children with critical illness or complex disease who are managed by multiple teams, both at GOSH and elsewhere. We have encountered numerous examples where the standard of documentation by trainees and consultants has been exemplary.

² 1 case is pending review by the MRG, as it is presently subject to a police investigation and awaiting conclusion to avoid contamination of witness evidence.

- Rapid and comprehensive death summaries must be completed and uploaded onto EDM following the death of a child, particularly for children who have had a long-term illnesses. This standard is achieved by most but not all teams at GOSH.

Training

- Sepsis is a life-threatening overwhelming response to infection. The 'Sepsis 6' protocol highlights the importance of early recognition and appropriate management of patients with sepsis, including appropriate antibiotics, ideally within one hour of diagnosis.
- Suspected sepsis in a child colonised with a resistant organism can be difficult to manage and specialist microbiological advice should be sought.
- Source control is an essential component of sepsis management. This may include timely removal of central lines where blood cultures remain positive, particularly in immunocompromised patients.
- Clinicians should have a low threshold for performing a neonatal sepsis screen, particularly where there are risk factors for neonatal sepsis: fever, abnormal movements, meconium stained liquor, and parental concern. Observation alone is an insensitive measure.

Sharing learning points from the MRG

The learning points from case record reviews are shared at the Trust Patient Safety and Outcomes Committee. Modifiable factors identified outside of GOSH are shared with the relevant Child Death Overview Panel. Where modifiable factors or other issues are identified about GOSH care, these are fed back in an appropriate manner to the relevant clinical team and/or the Divisional Director(s) for action. The feedback mechanism will be determined based on the nature of the information to be shared, but could include via specialty case review meeting, email, Divisional Board meeting etc.

A learning summary has been presented to the Patient Safety and Outcomes committee to ensure that Trust wide themes can be shared with appropriate specialty, team, and local governance meetings.

Trust Board 23rd May 2018	
Integrated Performance Report: May 2018 (Reporting Month 1 2018/19)	Paper No: Attachment V
Submitted by: Nicola Grinstead, Deputy Chief Executive / Peter Hyland, Director of Operational Performance and Information	
<p>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.</p> <p>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.</p> <p>The narrative provides provide more detail / analysis from the IPR of those indicators not meeting the required standards or where they warrant further mention.</p> <p>In addition, this report included a deep dive related to improve the Trust theatre utilisation, as well as a report detailing the Kite Marking scores for the Trust Performance Report.</p>	
<p>Action required from the meeting Board members to note and agree on actions where necessary</p>	
<p>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</p>	
<p>Financial implications For indicators that have a contractual consequence there could be financial implications for under-delivery</p>	
<p>Who needs to be told about any decision? Where appropriate and applicable: Internal stakeholders, NHS Improvement and NHS England Special Services Commissioners</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales? Each Domain / Section has a nominated Executive Lead</p>	
<p>Who is accountable for the implementation of the proposal / project? As above</p>	



Integrated Performance Report

Nicola Grinstead, Deputy CEO
May 2018
(Month 1 2018/19)

The child first and always

Executive Summary	Page 3
Integrated Performance Dashboard	Appendix I
 Caring	Page 4
 Safe	Page 5
 Responsive	Page 6-8
 Well-Led	Page 9-15
 Effective	Page 16
 Productivity	Page 17
 Our Money	Page 18
Appendix I: Integrated Performance Dashboard	Attached
Appendix II: Data Quality – Overview	Attached
Appendix III: Definitions	Attached

May 2018 (Month 1 2018/19)

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. As per previously for other elements his report and narrative should continue to be looked at in conjunction with the Quality and Safety Report and Finance Report.

At the time of writing the Trust Board report, not all Month 1 (April 2018) data was available, as this falls prior to a number of key national submission deadlines or the data has not been reviewed in time for inclusion.



Friends & Family Test (FFT)

Headlines via the Performance Report for these measures are:

- Continued positive recommendation responses for those undertaking the Inpatient FFT (96.73% in April compared to 96.14% in March)
- The rate (%) of those responding (for Inpatients) has seen fluctuation over the last six months with average response rate of 23.04%, April performance at 24.54%. There remains variability across the three Divisions and the wards. The IPP division returned to compliance in April (45.9%), after seeing a deterioration in March. The West division saw an improvement in April at 21.07%, compared to 18.03% in March. Despite Barrie division improving its position in March at 28.18%, response rate dropped to 26.72%. An action plan is in place in both divisions to improve the response rate. Following the discussion regarding the target response rate being reviewed to assess if it can be more in line with other Trusts and peers it has been agreed that a target will be set for non-frequent flyer wards and frequent flyer wards shown separately.
- In terms of whether the Trust is an outlier in FFT response rate nationally, the Trust continues to perform above the National Inpatient response rate (23%)

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, there was one serious incident and zero never events reported in April. We ended the last financial year, 2017-18, with a total of 16 Serious Incidents and three never events.

Further detail is provided in the Quality and Safety report.

Healthcare Associated Infections (HAIs)

Incidents of C. Difficile

The Trusts did not report any cases of C Diff in April. The total for 2017/18 currently stands at 18 C diff cases. Eleven out of the eighteen cases of C Diff were trust acquired i.e. they occurred on or after the fourth day of the patients' admission. At this time, none of these have been found to have resulted in lapses of care, and these will be reviewed with Commissioners. The Trust's total allowance for 2018/19 is 14 cases, as set nationally.

Incidents of MRSA

The Trust did not report any incidents of MRSA in April and the 2017/18 position currently stands at one Trust assigned MRSA case. It should be noted that three cases were reported in 2016/17.

CV Line Infections

There has been an improvement in compliance against the standard in April (1.11 against 1.6 per 1000 line days) compared to March when the Trust reported 1.99 per 1000 line days. All incidents have or will be investigated by the lead nursing staff with involvement from the Infection Control team. As per the Quality & Safety report, the ongoing trend / position over time is within expected levels showing no sustained outlying behaviour.

WHO Surgical Checklist Completion (> 98%)

The Trust continues to not deliver against the 98% standard as seen from November (97.45%). Compliance in April was 93.99%, a slight deterioration from March when the Trust reported 94.84%. Work continues within divisions to understand reasons as to why checklists aren't fully completed for some specialties.

Hospital Acquired pressure / device related ulcer: Grade 3 & above

The Trust reported one grade 3 pressure ulcer in April, which occurred in PICU. An RCA is being completed to understand why this occurred. Further detail is provided in Quality & Safety report.



Responsive



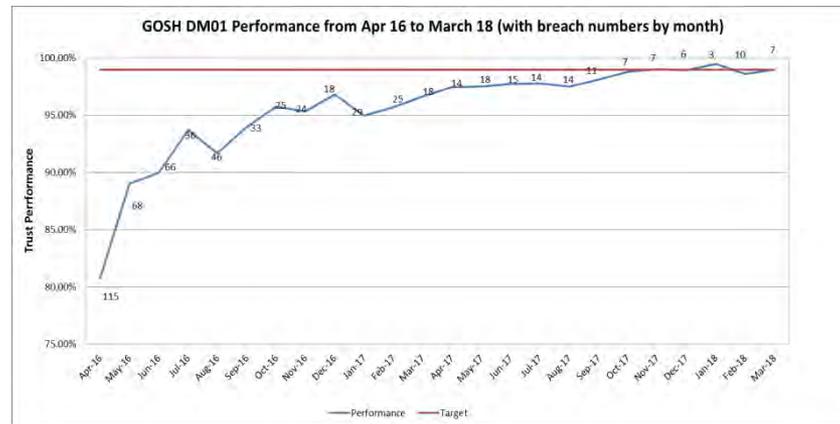
Diagnostics (99% < 6 weeks) – April 2018 position

At the time of writing, the Trust had not finalised and submitted the April position. In March, the Trust underachieved against the standard of 99% for patients accessing the 15 diagnostic modalities within 6 weeks of referral / request at 98.98%. Unfortunately, the Trust was unable to sustain the performance in January having achieved 99.51%, which illustrates the volatility in the denominator and breach numbers. However the Trust still continues to reduce the number of breaches, reporting seven in March, compared to ten in February.

As shown in the table opposite, the overall number of breaches for March was seven (decrease of three from February). Breaches occurred in MRI (2), Non Obstetric Ultrasound (2), CT (2) and Cytoscopy (1)

Four of the seven breaches could potentially have been prevented: Two breaches were due to process / booking issues, one breach occurred due to delay in request form and one patient incorrectly listed as a planned diagnostic. One breach occurred due to failed sedation, another breach occurred due to a list overrun and the remaining breach was due to a complex patient with safeguarding issues.

The breach reasons are currently undergoing a deep dive and any resulting actions will be addressed by the services.



Contextually when comparing GOSH with other Children’s Trusts or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 369 providers reporting against the standard (NHS and Independent sector) 271 in March were delivering 99% or better (it must be noted that 118 of these trusts reported a waiting list of less than 100 and a number are also providers just offering certain specific diagnostics, rather than a full range). 29 providers reported 98-99%, 19 at 97-98% and 51 reported <97%.

Diagnostic test	Breach	No Breach	Grand Total	Performance
Audiology - Audiology Assessments		30	30	100.00%
Barium Enema		13	13	100.00%
Colonoscopy		8	8	100.00%
Computed Tomography	2	56	58	96.55%
Cystoscopy	1		1	0.00%
DEXA Scan		4	4	100.00%
Gastroscopy		53	53	100.00%
Magnetic Resonance Imaging	2	218	220	99.09%
Neurophysiology - peripheral neurophysiology		23	23	100.00%
Non-obstetric ultrasound	2	170	172	98.84%
Urodynamics - pressures & flows		21	21	100.00%
Respiratory physiology - sleep studies		81	81	100.00%
Grand Total	7	677	684	98.98%

Cancer Wait Times

For the reporting period up to March 2018, there have been zero patient pathway breaches reported against the Cancer Wait time standards applicable to the Trust. This means that the Trust achieved 100% across all cancer standards for the entirety of 2017/18.



Referral to Treatment Time (incomplete standard > 92%) – April 2018

At the time of writing, April performance had not been submitted, but early indications show that the Trust will be compliant against this indicator (in excess of 93.5%) . For the month of March the Trust achieved the RTT 92% standard, submitting performance of 92.91%. January was the first time since returning to reporting that the Trust has met the standard. Significant improvements have been made across a number of specialties with Orthopaedics, ENT and Neurology meeting 92% standard. Spinal Surgery reported 80.33% in March, a significant improvement in performance compared to previous months. Specialties which continue not to meet the standard are Plastic Surgery (sub-specialisation within the service), SNAPS (bed capacity) and Urology (complex patients and capacity).

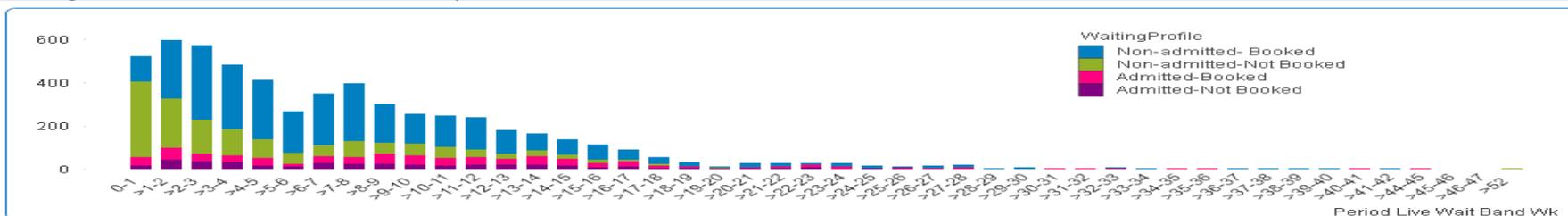
Revised improvement trajectories are currently being drafted and will be finalised with the divisions shortly.

The number of patients waiting 40 weeks+ has further decreased since the start of the financial year. We reported 43 patients waiting over 40 weeks in April 2017 and in March 2018, there were 8 patients waiting over 40 weeks.

Contextually when comparing GOSH with other Children’s Trusts or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 146 providers reporting against the standard (NHS Trusts only) 46 in March were delivering 92% or better. 15 providers reported 90-92%, 73 at 80-90% and 12 reported <80%.

Nationally, GOSH is ranked as the 21st best performing Trust out of 146 providers. In London, GOSH is the 6th best performing Trust out of 21 Providers reporting RTT performance.

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 the number of long waiters >18 weeks continues to improve.



52 week waits:

The Trust did not report any patients waiting over 52 weeks in March, however it looks like we will have a 52 week breach patient for April.

Unknown clocks starts:

The number of pathways with an unknown clock start (i.e. referred to the Trust without confirming the start date of the pathway) saw a slight increase in March in comparison to what the Trust reported in February. Divisions have been asked to further push in engaging with referring Trusts and escalate where necessary.



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 Q4 2017-18, the Trust reported an improvement in performance in this area. There were 105 last minute non-clinical hospital cancelled operations, compared to 176 in Q3 17-18. The areas contributing most to these were Radiology, Cardiac Surgery, Spinal Surgery, Gastroenterology, Haematology and Cardiology. Some of the reasons for cancellations were theatre lists overrunning, ICU beds unavailable and cancellations due to emergency patients.

The Trust reported an improvement in rebooking last minute cancelled operations within 28 days of the cancellation, 24 (compared to 27 in Q3 17-18). There are plans to set up a joint working group for both divisions on cancelled operations where processes around cancelling and rebooking operations will be reviewed.





Workforce Headlines

- **Contractual staff in post:** Substantive staff in post increased to 4466 FTE (full-time equivalent) in April. This is 360.6 FTE (8.8%) higher than the same month last year.
- **Unfilled vacancy rate:** Vacancy data is not yet available for April, as new budgets are being confirmed. This will be completed during May. The Trust vacancy rate finished 2017/8 at 2.86% (2017/8 average was 6.15%). The 2018/9 target will remain at 10%.
- **Turnover** is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands below target at 13.96%; this reported value excludes non-voluntary forms of leavers. Total (voluntary and non-voluntary) turnover increased slightly in April to 18.2%, which is above target but is lower than the same month last year (18.6%). For 2018/19 the Trust KPI will be reported as Voluntary turnover only, with the target remaining at 13.96%. Total turnover will continue to be monitored locally.
- **Agency usage** for 2018/19 (year to date) stands at 0.8% of total paybill, which is below the local stretch target, and is also well below the same month last year (2.34%). Human Resources Business Partners continue to work with the divisions and corporate areas to address local pockets of agency usage. The target for 2018/19 remains 2% of total paybill.
- **Statutory & Mandatory training compliance:** In April the compliance across the Trust was 89%. The dip is in part related to the reporting of additional topics. Divisions with below average compliance are being offered targeted support. The target for 2018/19 remains 90%.
- **Sickness absence** remains below target at 2.4% and below the London average figure of 2.8%. During 2018, the Trust will implement an integrated rostering system. The system will support improvements in the accuracy of absence reporting, which may lead to fluctuations in reported rates. The 2018/19 target remains 3%
- **Appraisal/PDR completion** The non-medical appraisal rate has reduced to 84% which is below the Trust target, however the Trust continues to benchmark well and is above its long term average. Consultant appraisal rates have increased in recent months and now stands at 88%. Targets this year remain at 90%.





Trust KPI performance April 2018

Metric	Plan	Apr 2018	3m average	12m average
Voluntary Turnover	14%	14%	13.9% □	14.7% □
Sickness (12m)	3%	2.4%	2.4%	2.3%
Vacancy	10%	N/A*	2.9%	6.2%
Agency spend	2%	0.8%	1.4%	2.0%
PDR %	90%	84%	86%	87%
Consultant Appraisals	90%	88%	88%	82%
Statutory & Mandatory training	90%	88%	89%	90%

*Month 01 budgets not available yet.

Key:

■ Achieving Plan ■ Within 10% of Plan ■ Not achieving Plan



Divisional KPI performance April 2018

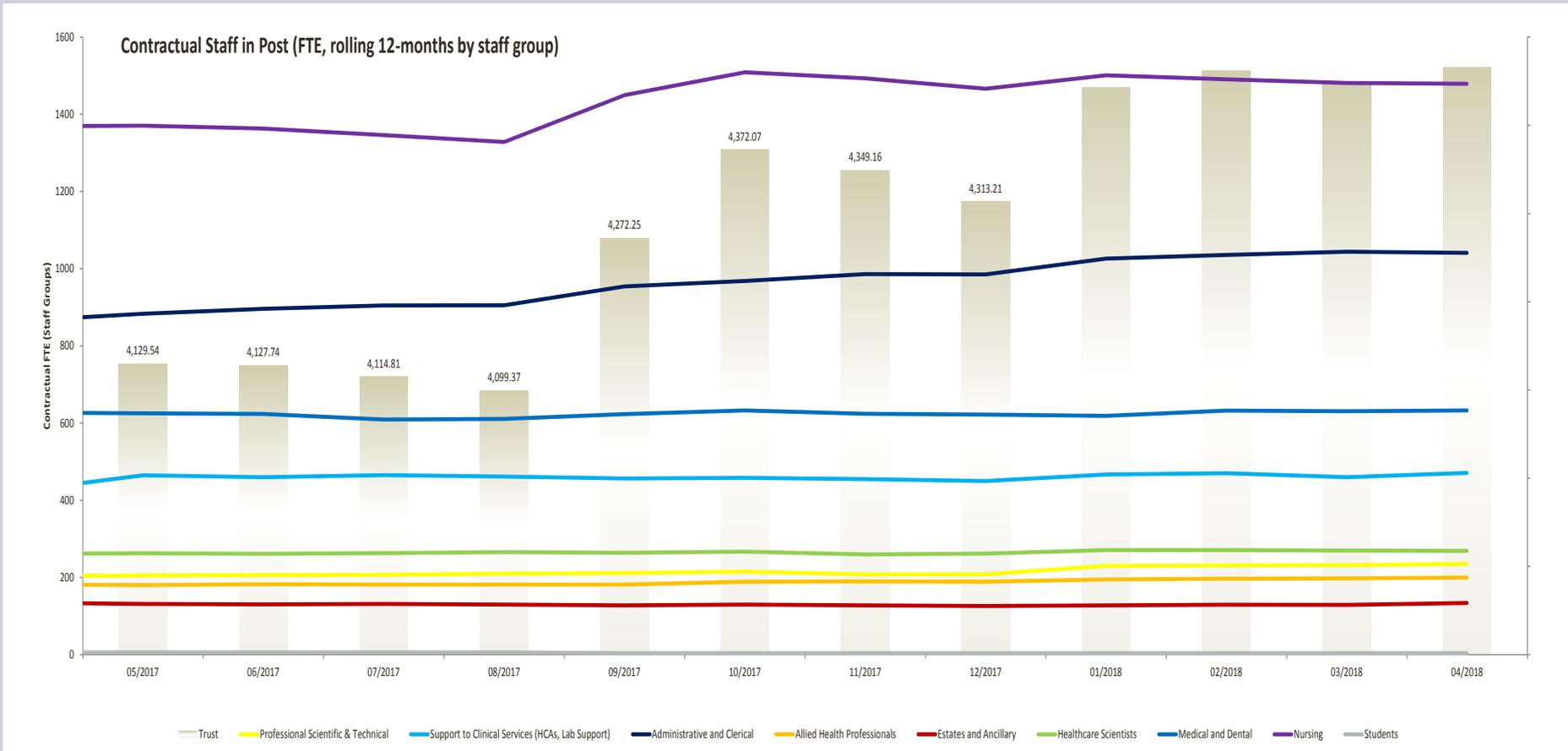
Metric	Plan	Trust	Barrie	West	IPP	Clinical Ops	Corp Affairs	Dev & Property Services	Finance	HR&OD	Medical Director	Nursing & Patient Exp	Research & Innov.
Voluntary Turnover	14%	14%	12.2%	14.4%	19.0%	9.5%	37.5%	14.9%	12.2%	30.5%	14.6%	10.5%	26.2%
Sickness (12m)	3%	2.4%	2.3%	2.6%	3.4%	2.6%	0.7%	1.7%	1.9%	3.2%	1.8%	1.5%	2.0%
Vacancy	10%	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*
Agency spend	2%	0.8%	0.2%	1.3%	0.0%	0.9%	-0.6%	1.0%	-5.5%	12.7%	0.0%	0.0%	0.0%
PDR %	90%	84%	82%	86%	92%	68%	63%	82%	91%	93%	85%	84%	90%
Stat/Mand Training	90%	89%	88%	85%	97%	93%	69%	92%	92%	93%	89%	89%	92%

Key:
■ Achieving Plan ■ Within 10% of Plan ■ Not achieving Plan

*Month 01 budgets not available yet.



Substantive staff in post by staff group





Workforce: Highlights & Actions

Sickness %

- Monthly sickness absence reports distributed to managers from the HR Advisors to encourage a proactive approach to managing sickness absence.
- Regular meetings are held with Ward Sisters, service leads and departmental managers to discuss and provide support for sickness absence management.
- Health and wellbeing; a number of initiatives have been launched in order to support employees at work such as mental health awareness and healthy activities. Nutrition and Hydration week at GOSH took place in March 2018;
- HRBP working with management teams in Finance and ICT to ensure sickness absence is being logged using the correct system so reporting can be accurate.

Voluntary Turnover Rate

- There has been a significant amount of work undertaken to better understand the broader turnover position - with specific focus on areas of low stability and high turnover. 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.
- Developing B5s into vacant B6 roles helps to decrease turnover of B5s
- All Nurses within R&I on fixed term contracts have been transitioned over to permanent contracts to support retention of Nurses



Workforce: Highlights & Actions

Agency Spend

- HRBPs continue to work within the Divisions to reduce agency usage. This includes 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.

PDR Completion

- PDR rates now regularly reported and accessible via the intranet with continued reminders to individuals and line managers
- Simplifying the reporting process of PDRs has supported managers in working towards their PDR targets.
- HRBPs are continuing to support managers in identifying the PDRs that are required for completion, this includes consultant appraisals.
- PDR rates are a rolling agenda item for Performance Meetings within the Divisions / Directorates.

Statutory & Mandatory Training Compliance

- Improved visibility through LMS - staff encouraged to check their own records on GOLD
- Learning and Development & ER team work with managers to identify those who are non-compliant including further developments to the Trust GOLD LMS
- Simplicity in reporting process to improve compliance
- StatMan rates are a rolling agenda item for Performance Meetings within the Divisions / Directorates.

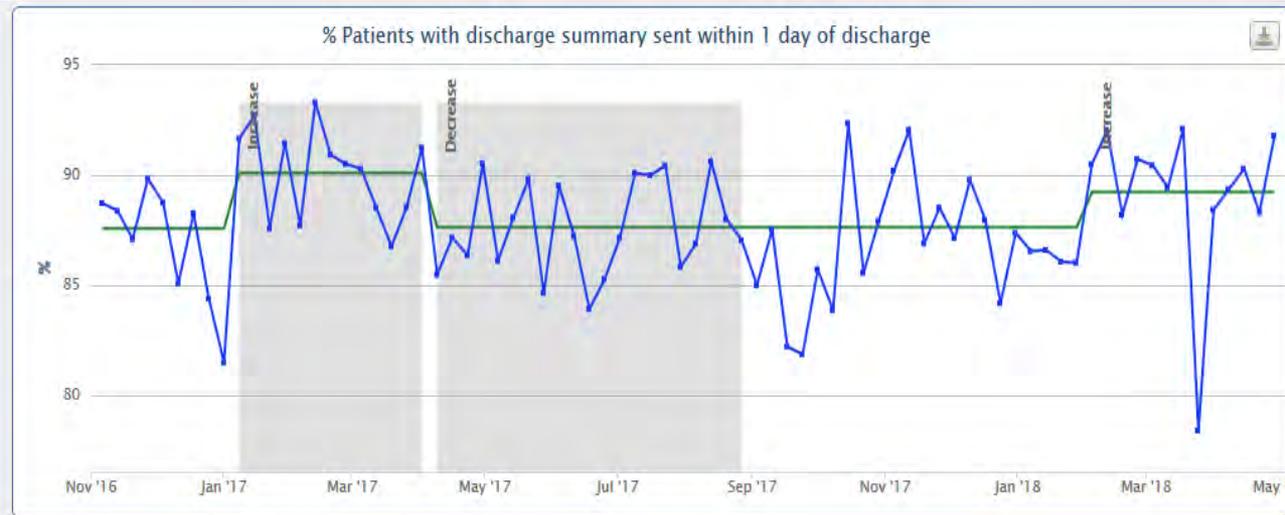


Discharge Summaries

As is evident from the SPC chart and the dashboard, performance in this area continues to fluctuate. For April 2018, the position was 89.12% sent within 24hrs of discharge, which is an improvement from March's performance. As per definitions of this metrics, the expectation for the Trust is to send all discharge summaries within 24 hours.

The Clinical Divisions continue to keep this as an areas of focus, and reported into their monthly performance meetings. It should also be noted that 93% of patients and referrers receive a discharge summary within 48 hours of discharge

Some of the on going actions in place in divisions include daily reminders to HoCS/SM/fellows to complete the DS within 24 hours, a training refresher course for Junior Doctors, weekly reports generated and sent to the Service and Ward Clerks, ensure discharges flagged as exclude are clinically validated and documented. There is also a lack of adequate clinical cover between all specialties and recruitment is ongoing with support of HR.



Clinic Letter Turnaround times

For March (as this indicator is reported a month in arrears), there has been some deterioration in performance in relation to 14 day turnaround, 71.70% from 72.16% in February. For those sent within 7 working days, performance has improved, 42.14% from 39.34% in February. As with the above, specific specialties are being targeted by the service management teams to ensure turnaround is improved. Some of the actions in place in divisions include weekly reminders for clinical teams to sign off letters, providing remote access to clinicians so they can sign off letters electronically, create and administer a robust monitoring system for administrators to be used on a weekly basis to check the upload and downloading of letters, and extra admin time to work through the backlog of letters in specific areas.



Theatres

Reporting in this area has now migrated is solely based on the Trust Theatres Dashboard. The reported positions have changed marginally, however remains largely in line. The dashboard, now provides theatres and operational teams with much more accessible and detailed information on their usage of Trust theatres.

Utilisation of main theatres has slightly decreased in April to 66.7% from 68.6% (March). Both JM Barrie and Charles West divisions have seen a dip in utilisation in April, 68.3% and 61.0% respectively. Particularly affected specialties are Neurology (18.5%), Spinal Surgery (51.3%), Gastroenterology (41.5%), Haematology (42.4%), Cardiology (53.6%), Cleft (48.2%).

One of the main reasons for non compliance include poor theatre booking management around specialties not utilising complete capacity- this is being addressed by weekly targeted theatre planning sessions attended by the theatres Service Manager and General Manager. Utilisation is also being reviewed for the next five weeks.

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 reporting period of April, occupancy has decreased from previous levels to 80.4%. 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.

Bed closures: There has been a decrease in the average number of beds closed in April (18) compared to 22 in March. This was mainly due to staffing shortages. Sky, Fox, Mildred Creek and Butterfly wards have had bed closures for the whole of March

Activity

Trust activity: April activity across day case discharges, overnight discharges, outpatient attendances critical care bed days are above the same reporting period for last year. Further detail will be provided within the Finance Report.

Long stay patients: This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For April, the Trust had six patients discharged that had amassed a combined LOS of 986 days. Most of the long stay patients were PICU, and Cardiology and Cardiothoracic transplantation patients. As reported previously, the West division looked at a sample of patients who had an excess stay of > 100 days, and found the reasons for their stay were clinically appropriate due to many having complex conditions and comorbidities warranting that LOS.



PICU Metrics

The metrics supporting PICU shared in this month's IPR are the first iteration of KPIs. The KPIs have been agreed collaboratively with the Trusts PICU consultants and are designed to provide a triangulated picture of the service. Further analysis and intelligence will be added in future reports.

CATS PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during April has decreased to eight from a March position of 25. The final position for 17/18 was 188 compared 238 in 16/17, a reduction of 50 (-21%) refusals.

It should be noted that although April has seen an improvement in the number of refusals, the Trust is a national outlier. As part of the specialised services Quality Dashboard, a KPI is monitored on emergency admission refusals. It clearly shows the Trust refuses a higher percentage of patients than the national average, as demonstrated in the table below.

Quarter	GOSH PICU/NICU/CICU refusals	GOSH admission requests	GOSH % refused	National % refused
Q3 17/18	99	226	43.8	19.8
Q2 17/18	32	148	21.6	7.14
Q1 17/18	28	164	17.1	7.12
Q4 16/17	66	163	40.5	9.45

PICU Emergency Readmissions: Readmissions back into PICU within 48 hours remains low with only 2 patients in both months of March and April. This indicator illustrates patients being safely discharged from unit by the clinical teams.

PICU Delayed Discharges: Delayed discharges over 8 hours from PICU can demonstrate the challenges being faced internally and externally with regards to capacity issues on accessing beds. April saw a slight improvement in the total number of delays with 33 reported compared to 36 in March. Over the last 7 months, 42% of patients have been delayed due to accessing another Provider, and 58% accessing a bed internally within the hospital.





Summary

This section of the IPR includes a year to date position up to and including April 2018 (Month 1). In line with the figures presented, the Trust has a YTD deficit of £0.7m which is on plan. The Trust is generating a surplus control total of £0.2m which is on plan.

- Clinical Income (exc. International Private Patients and Pass through Income) is £0.7m higher than plan
- Non Clinical revenue is £0.8m lower than plan
- Private Patients income is £0.3m lower than plan
- Staff costs are £0.6m lower than plan
- Non-pay costs (excluding pass-through costs) are £0.1m higher than plan

Appendix I – Integrated Performance Dashboard

Please see attached covering all the domains in line with this supporting narrative

Appendix II – Data Quality Kite-Marking

Please find attached the supporting DQ Kite-marking for each of the reportable indicators within the Trust Board report

This is in line with previous updates provided to the Board and Trust Audit Committee, which assesses each of the indicators for:

- Accuracy
- Validity
- Reliability
- Timeliness
- Relevance
- Audit
- Executive Judgement

Any areas where there is insufficient assurance an action plan is needed or is in place, approved and signed off for the relevant SRO / Executive lead for that metric. These will then be monitored by the SRO and then re-assessed at a set point in the year.

A more detailed summary is provided as part of the dashboard.

Appendix III – Definitions

Please see attached the supporting definitions and methodologies for each of the metrics reported upon

	Feb	Mar	Apr	Trend	Plan	NHS Standard
Caring						
Access to Healthcare for people with Learning Disability				→		
% Positive Response Friends & Family Test: Inpatients	95.68%	96.14%	96.73%	↑		95%
Response Rate Friends & Family Test: Inpatients	23.24%	24.06%	24.54%	↑		40%
% Positive Response Friends & Family Test: Outpatients	92.40%	92.98%	94.03%	↑		95%
Mental Health Identifiers: Data Completeness	99.16%	99.04%	99.08%	↑		97%
Safe						
Serious Patient Safety Incidents	In-month: 1 YTD: 14	In-month: 2 YTD: 16	In-month: 2 YTD: 2	→		
Never Events	In-month: 0 YTD: 2	In-month: 1 YTD: 3	In-month: 0 YTD: 0	↑		0
Incidents of C. Difficile	In-month: 4 YTD: 18	In-month: 0 YTD: 18	In-month: 0 YTD: 0	→		
C.Difficile due to Lapses of Care	In-month: 0 YTD: 0	In-month: 0 YTD: 0	In-month: 0 YTD: 0	→		14
Incidents of MRSA	In-month: 0 YTD: 1	In-month: 0 YTD: 1	In-month: 0 YTD: 0	→		0
CV Line Infection Rate (per 1,000 line days)	1.38	1.99	1.11	↑		1.6
WHO Checklist Completion	93.33%	94.84%	93.99%	↓		98%
Arrests Outside of ICU	Cardiac Arrests: 2 Respiratory Arrests: 1	Cardiac Arrests: 0 Respiratory Arrests: 0	Cardiac Arrests: 0 Respiratory Arrests: 4	→		5
Total hospital acquired pressure / device related ulcer rates grade 3 & above	1	1	1	→		0
Responsive						
Diagnostics: Patients Waiting <6 Weeks	98.60%	98.98%		↑		99%
Cancer 31 Day: Referral to First Treatment	100%	100%		→		85%
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%
Cancer 62 day: Consultant Upgrade of Urgency of a referral to first treatment	100%	100%		→		
Last Minute Non-Clinical Hospital Cancelled Operations	34	31		↑		
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard	5	4		↑		0
Same day / day before hospital cancelled outpatient appointments	1.37%	1.20%	1.20%	↑		
RTT: Incomplete Pathways (National Reporting)	93.53%	92.91%		↑		92%
RTT: Number of Incomplete Pathways (National Reporting)	<18wks: 5154 >18wks: 356	<18wks: 4758 >18wks: 363		↓		-
RTT: Incomplete Pathways >52 Weeks - Validated	1	0		↑		0
RTT: Incomplete Pathways >40 Weeks - Validated	14	8		↑		0
Number of unknown RTT clock starts	Internal Referrals: 0 External Referrals: 842	Internal Referrals: 5 External Referrals: 924		↓		-
RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks: 5986 >18 weeks: 366	<18 weeks: 5689 >18 weeks: 363		↓		-

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	2.28%	2.37%	2.37%	→		3%
Turnover	Total: 17.4% Voluntary: 13.9%	Total: 17.3% Voluntary: 13.8%	Total: 17.3% Voluntary: 14.0%	↓		18%
Appraisal Rate	88%	85%	84%	↓		90%
Mandatory Training	90%	88%	88%	↑		90%
% Staff Recommending the Trust as a Place to Work: Friends & Family Test		72%		→		61%
Vacancy Rate	Contractual: 2.6% Nursing: 1.1%	Contractual: 2.9% Nursing: 1.1%		→		10%
Bank Spend	5.9%	6.0%	6.0%	→		
Agency Spend	1.79%	1.75%	0.75%	↑		2%
Effective						
Discharge Summary Turnaround within 24hrs	89.26%	87.49%	89.12%	↑		100%
Clinic Letter Turnaround within 7 working days	39.34%	42.14%		↓		100%
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)	7.32%	8.60%	8.26%	↑		7.73%
Productivity						
Main Theatres	Theatre Utilisation: 67.6% No. of theatres: 14	Theatre Utilisation: 68.6% No. of theatres: 14	Theatre Utilisation: 66.7% No. of theatres: 14	↓		77%
Outside Theatres	Theatre Utilisation: 54.2% No. of theatres: 7	Theatre Utilisation: 49.3% No. of theatres: 7	Theatre Utilisation: 56.8% No. of theatres: 7	↑		77%
Trust Beds	Bed Occupancy: 84.7% Number of available beds: 406	Bed Occupancy: 81.3% Number of available beds: 403	Bed Occupancy: 80.4% Number of available beds: 408	↓		
Average number of trust beds closed	Wards: 20.2 ICU: 1.3	Wards: 22.7 ICU: 2.0	Wards: 18.0 ICU: 1.0	↑		
Refused Admissions	Cardiac refusals: 7 PICU / NICU refusals: 7	Cardiac refusals: 6 PICU / NICU refusals: 25	Cardiac refusals: 2 PICU / NICU refusals: 8	↑		
Number of PICU Delayed Discharges	Internal 24 hours: 7 External 8 - 24 hours: 1 External 24 hours+: 5 Total 8 - 24 hours: 6 Total 24 hours+: 11	Internal 24 hours: 1 External 8 - 24 hours: 5 External 24 hours+: 15 Total 8 - 24 hours: 6 Total 24 hours+: 30	Internal 24 hours: 2 External 8 - 24 hours: 2 External 24 hours+: 10 Total 8 - 24 hours: 4 Total 24 hours+: 29	↑		
PICU Emergency Readmissions < 48 hours	1	2	2	→		
Activity						
Daycase Discharges (YOY comparison)	In-month: 1,978 YTD: 22,831	In-month: 2,204 YTD: 25,176	In-month: 2,110 YTD: 2,110	↓		2,082
Overnight Discharges (YOY comparison)	In-month: 1,390 YTD: 16,037	In-month: 1,555 YTD: 17,291	In-month: 1,409 YTD: 1,409	↓		1,383
Critical Care Beddays (YOY comparison)	In-month: 1,004 YTD: 11,770	In-month: 1,093 YTD: 12,856	In-month: 1,192 YTD: 1,192	↑		1,038
Bed Days >=100 Days	No. of patients: 9 No. of beddays: 1,656	No. of patients: 5 No. of beddays: 618	No. of patients: 6 No. of beddays: 986	↓		
Outpatient Attendances (All) (YOY comparison)	In-month: 19,701 YTD: 234,145	In-month: 19,763 YTD: 255,056	In-month: 20,558 YTD: 20,558	↑		19,893
Our Money						
Net Surplus/(Deficit) v Plan	(1.8)	0.4	0.2	↓	0.2	0.0
Forecast Outturn v Plan	0.0	TBC	12.1	→	12.1	0.0
Better value	1.2	1.2		→		TBC
Debtor Days (IPP)	205	219	202.0	↑	202	(82.0)
Quick Ratio (Liquidity)	1.70	1.90	1.8	↓	1.60	0.2
NHS KPI Metrics	1.0	1.0	1.0	→	1.0	0.0

KITE MARKING SUMMARY SEPTEMBER 2017*

Domain	Lead	Total Count	Sufficient Assured		Insufficient Assured		Yet to be Assured		Action Plans Req'd	Action Plans Outstanding		Action Plans Over Due	
			Count	%	Count	%	Count	%		Count	%	Count	%
			Caring	Juliette Greenwood, David Hicks	49	35	71.4%	0		0.0%	14	28.6%	0
Safe	Juliette Greenwood, David Hicks	70	61	87.1%	2	2.9%	7	10.0%	2	3	100%	3	100%
Responsive	Nicola Grinstead	98	65	66.3%	33	33.7%	0	0.0%	14	3	21%	4	29%
People, Management & Culture: Well-Led	Ali Mohammed	63	45	71.4%	9	14.3%	9	14.3%	5	0	0%	0	0%
Effective	Nicola Grinstead	28	16	57.1%	12	42.9%	0	0.0%	4	0	0%	4	100%
Productivity	Nicola Grinstead	98	65	66.3%	33	33.7%	0	0.0%	14	4	29%	10	71%
Our Money	Loretta Seamer	49	48	98.0%	1	2.0%	0	0.0%	1	0	0%	3	100%
Grand Total		455	335	73.6%	90	19.8%	30	6.6%	40	9	23%	21	53%

*To be reviewed December 2017

Domain	Metric	Accuracy	Validity	Reliability	Timeliness	Relevance	Executive Judgement	Action Plan Req'd	Action Plan In Place	Action Plan Due Date
Caring	Access to Healthcare for people with Learning Disability	3	3	3	3	3	3	NK	NK	
Caring	% Positive Response Friends & Family Test: Inpatients	1	1	1	1	1	1	N	N/A	N/A
Caring	Response Rate Friends & Family Test: Inpatients	1	1	1	1	1	1	N	N/A	N/A
Caring	% Positive Response Friends & Family Test: Outpatients	1	1	1	1	1	1	N	N/A	N/A
Caring	Number of Complaints	1	1	1	1	1	1	N	N/A	N/A
Caring	Number of Complaints -Red Grade	1	1	1	1	1	1	N	N/A	N/A
Caring	Mental Health Identifiers: Data Completeness	3	3	3	3	3	3	NK	NK	
Safe	Total hospital acquired pressure / device related ulcer rates grade II & above	1	1	1	1	1	1	N	N/A	N/A
Safe	Reported cases of MRSA bacteremia to the Public Health England mandatory reporting system	1	1	1	1	1	1	N	N/A	N/A
Safe	Reported cases of Clostridium difficile associated disease to the Public Health England mandatory re	1	1		1	1	1	Y		
Safe	Serious Patient Safety Incidents	1	1	1	1	1	1	N	N/A	N/A
Safe	Never Events	1	1	1	1	1	1	N	N/A	N/A
Safe	C.Difficile due to Lapses of Care	1	1		1	1	1	Y		
Safe	CV Line Infection Rate (per 1,000 line days)	1	1	1	1	1	1	N	N/A	N/A
Safe	WHO Checklist Completion	3	3	3	3	3	3	NK	NK	
Safe	Cardiac Arrests Outside of ICU	1	1	1	1	1	1	N	N/A	N/A
Safe	Respiratory Arrests Outside of ICU	1	1	1	1	1	1	N	N/A	N/A
Responsive	RTT: Incomplete Pathways >52 Weeks (Validated)				1	1	1	Y	Y	On-going through DO Dashboard
Responsive	RTT: Incomplete Pathways >52 Weeks (Unvalidated)				1	1	1	Y	Y	On-going through DO Dashboard
Responsive	RTT: Incomplete Pathways		1		1	1	1	Y	Y	On-going through DO Dashboard
Responsive	RTT: Number of Incomplete Pathways (Over 18 Weeks)		1		1	1	1	Y	Y	On-going through DO Dashboard
Responsive	RTT: Number of Incomplete Pathways (Under 18 Weeks)		1		1	1	1	Y	Y	On-going through DO Dashboard
Responsive	Number of unknown RTT clock starts (Internal Referrals)	1	1		1	1	1	Y	Y	On-going audits
Responsive	Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 98 Day Standard	1	1		1	1	1	Y		
Responsive	Number of unknown RTT clock starts (External Referrals)	1	1		1	1	1	Y	Y	On-going audits
Responsive	Same day / day before hospital canceled appointments	1	1	1	1	1	1	Y	Y	On-going audits
Responsive	Diagnostics: Patients Waiting >6 Weeks				1	1	1	Y		
Responsive	Cancer 31 Day: Decision to Treat to First Treatment		1		1	1	1	Y	Y	audits not yet started
Responsive	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery		1		1	1	1	Y	Y	audits not yet started
Responsive	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs		1		1	1	1	Y	Y	audits not yet started
Responsive	Last Minute Non-Clinical Hospital Cancelled Operations	1	1		1	1	1	Y		
People, Management & Culture: Well-Led	Sickness Rate			1	1	1	3	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Turnover - Total	1	1	1	1	1	3	NK	NK	
People, Management & Culture: Well-Led	Turnover - Voluntary	1	1	1	1	1	3	NK	NK	
People, Management & Culture: Well-Led	Appraisal Rate		1	1		1	3	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Mandatory Training	1	1	1	1	1	3	Y	Y	
People, Management & Culture: Well-Led	% Staff Recommending the Trust as a Place to Work: Friends & Family Test	1	1	1	1	1	3	NK	NK	
People, Management & Culture: Well-Led	Vacancy Rate		1	1	1	1	3	Y	Y	31-Mar-18
People, Management & Culture: Well-Led	Bank Spend		1	1	1	1	3	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Agency Spend		1	1	1	1	3	Y	Y	01-Jul-18
Effective	Discharge Summary Turnaround within 24hrs	1	1	1	1	1	3	Y	Y	01-Jul-18
Effective	Clinic Letter Turnaround within # - 7 working days				1	1	3	Y	Y	31-Jul-17
Effective	Clinic Letter Turnaround within # - 14 working days				1	1	1	Y	Y	31-Jul-17
Effective	Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)	1	1	1	1	1	3	Y	Y	30-Jul-17
Productivity	Excess Beddays >=100 days - number of patients	1	1	1	1	1	3	Y		
Productivity	Excess Beddays >=100 days - number of beddays	1	1	1	1	1	3	Y		
Productivity	Critical Care Beddays	1	1	1	1	1	3	Y	Y	31-Aug-17
Productivity	Outpatient Attendances (All)	1	1	1	1	1	3	Y	Y	31-Jul-17
Productivity	Overnight Discharges	1	1	1	1	1	3	Y	Y	31-Jul-17
Productivity	Theatre Utilisation (NHS UO4) - Main theatres				1	1	3	Y	Y	31-Jul-17
Productivity	Average numbers of beds closed - Wards				1	1	3	Y	Y	31-Aug-17
Productivity	Daycase Discharges	1	1	1	1	1	3	Y	Y	31-Aug-17
Productivity	Average numbers of beds closed - ICU				1	1	3	Y	Y	31-Aug-17
Productivity	Theatre Utilisation (NHS UO4)				1	1	3	Y	Y	31-Jul-17
Productivity	Bed Occupancy				1	1	3	Y	Y	31-Jul-17
Productivity	Number of Beds				1	1	1	Y	Y	31-Aug-17
Productivity	Cardiac Refusals	1	1		1	1	1	Y		
Productivity	PICU/NICU Refusals	1	1		1	1	1	Y		
Our Money	Net Surplus/(Deficit) v Plan	1	1	1	1	1	1	N	N/A	N/A
Our Money	Forecast Outturn v Plan	1	1	1	1	1	1	N	N/A	N/A
Our Money	P&E Delivery	1	1	1	1	1	1	N	N/A	N/A
Our Money	Pay Worked WTE Variance to Plan		1	1	1	1	1	Y	Y	01-Aug-17
Our Money	Debtor Days (PPP)	1	1	1	1	1	1	N	N/A	N/A
Our Money	Quick Ratio (Liquidity)	1	1	1	1	1	1	N	N/A	N/A
Our Money	NHS KPI Metrics	1	1	1	1	1	1	N	N/A	N/A

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	100%	Numerator: number of discharge summaries sent for eligible patients within 24 hours Denominator: total number of discharge summaries required for eligible patients	Monthly
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	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	Monthly

	Measure	Definition	Standard	Calculation formulae	Reporting Frequency	
Responsive	 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	
	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: Monthly 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
 23rd May 2018**

Month 01 2018/19 Finance Performance Report

**Submitted by:
 Helen Jameson, Chief Finance Officer**

Paper No: Attachment W

**Attachment i – Finance Performance Report
 Month 1 2018/19**

Key Points to take away

1. The month one finance position of a £0.23m control total surplus is in line with plan.
2. The overall weighted NHSI rating for Month 1 is a 1
3. Cash remains strong (£57.1m) although IPP debtor days have increased to 202 days.
4. NHS activity is higher than the previous year, which is reflected in £0.7m overachievement against plan. This is in part due to increased activity in Bone Marrow Transplants and Haematology / Oncology.

Introduction

This paper reports the Trust Financial Position as at the end of April 2018 (Month 1). The Trust is required to achieve an overall control total surplus of £12.1m for the year which is an increase from 2017/18. In order to achieve this, the Trust must deliver additional income from the prior year and achieve the Better Value program of £15m.

Financial Position – Summary Points

Income and Expenditure

In Month 1, the Trust has met its control total (£0.2m surplus) and has a net deficit (before capital donations and impairments) of £0.7m, which is line with the NHSI plan.

Overall, income for the Trust is £0.6m behind plan. NHS clinical Income of £22.9m was delivered in month (excluding pass through) which is £0.7m favourable to the NHSI plan. This is predominantly due to increased activity in BMT, Haematology and Oncology. Overseas income within Clinical Income was higher than plan by £0.4m due to additional Immunology and Cardiac patients that required additional critical care bed days.

Private patient income for Month 1 across the Trust was £4.6m (£0.3 below plan). Activity in Month 1 is lower than the same period last year although the patient acuity was higher leading to an increased demand for ICU beds.

Non-Clinical Income in Month 1 is lower than plan by £0.8m. R&I income was behind plan due to slippage across a number of research programmes. This is offset by lower than anticipated expenditure in pay and non-pay.

Pay expenditure is better than plan by £0.6m, due to vacancies within the establishment. These mainly relate to business cases including PICB. In addition, agency staff spend is lower than anticipated (£0.3m) as a result of focused work. The main reduction is in corporate areas.

Non-Pay expenditure (excluding pass through) is overspent by £0.1m, which is a result of the additional clinical supplies costs linked to the case-mix of income delivery with increased activity in high spend areas e.g. spinal and orthopaedics.

Balance Sheet											
Indicator	Comment										
NHSI Financial Rating	All KPI ratings are Green.										
Cash	<p>The closing cash balance was £57.1m, £0.8m higher than plan.</p> <table border="1"> <thead> <tr> <th>Variance/movement</th> <th>Cash variance vs plan YTD (£m)</th> </tr> </thead> <tbody> <tr> <td>Inventories – higher than plan</td> <td>(0.3)</td> </tr> <tr> <td>Trade and other Receivables – higher than plan</td> <td>(4.0)</td> </tr> <tr> <td>Trade and Other Payables - higher than plan</td> <td>5.1</td> </tr> <tr> <td>Increase to cash position</td> <td>0.8</td> </tr> </tbody> </table>	Variance/movement	Cash variance vs plan YTD (£m)	Inventories – higher than plan	(0.3)	Trade and other Receivables – higher than plan	(4.0)	Trade and Other Payables - higher than plan	5.1	Increase to cash position	0.8
Variance/movement	Cash variance vs plan YTD (£m)										
Inventories – higher than plan	(0.3)										
Trade and other Receivables – higher than plan	(4.0)										
Trade and Other Payables - higher than plan	5.1										
Increase to cash position	0.8										
NHS Debtor Days	Debtor days remained the same as the previous month at 19 days and remains within target.										
IPP Debtor Days	IPP debtor days increased in month from 189 days to 202 days.										
Creditor Days	Creditor days remained the same as the previous month at 35 days.										
Inventory Days	Drug inventory days increased in month from 5 days to 11 days Non-Drug inventory days increased in month from 70 days to 95 days										
<p>Cash remains strong and is £0.8m ahead plan, due to slower than expected payments to suppliers, which have slipped in to May 2018 and the capex programme being £0.3m (18%) behind plan in month.</p> <p>IPP debtor days have increased in month, due to aging Embassy debt. Work continues to collect overdue payments.</p> <p>Inventory days increased significantly in the month, predominantly due to the value of the spinal metal stock increasing in month.</p>											
<p>Action required from the meeting</p> <ul style="list-style-type: none"> To note the Month 1 Financial Position 											
<p>Contribution to the delivery of NHS / Trust strategies and plans</p> <p>The delivery of the financial plan is a key strategic objective to ensure we have sufficient funding to meet the needs of our delivery of care.</p>											
<p>Financial implications</p> <p>Not delivering the Control Total would result in the loss of the PSF (previously STF). This is £7.6m for 2018/19 without which, the Trust would struggle to achieve financial balance.</p>											
<p>Legal issues</p> <p>None</p>											
<p>Who is responsible for implementing the proposals / project and anticipated timescales</p> <p>Chief Finance Officer / Executive Management Team</p>											
<p>Who is accountable for the implementation of the proposal / project</p> <p>Chief Finance Officer</p>											

Board Finance Report

Month 1 - 2018/19
(April 2018)

	Slide
Executive Summary	3
Income & Expenditure Financial Performance Summary	4
Income & Expenditure – Run Rate Analysis	5
Workforce Summary	6
Statement of Financial Position	7
Statement of Cash Flow	8
YOY Activity Summary	9

Finance Scorecard

TRUST					
	Our Money	March	April	YTD Target	Variance
Control total		1.2	0.2	0.2	0.0
Forecast outturn control total			12.1	12.1	0.0
Debtor days (IPP)		189	202	120	(82)
Quick ratio (Liquidity)		1.9	1.8	1.6	0.2
**NHSI KPI Metrics		1	1	1	0

NHSI Plan Risk Ratings				
KPI	Annual Plan	M1 YTD Plan	M1 YTD Actual	Rating
Liquidity	1	1	1	G
Capital Service Coverage	1	1	1	G
I&E Margin	1	2	2	G
Variance From Control total	1	1	1	G
Agency rating	1	1	1	G
Overall	1	1	1	G
Overall after Triggers	1	1	1	G

Key Highlights

- The Trust is reporting a M1 control total surplus of £0.2m which is on plan.
- The overall weighted NHSI rating for Month 1 is a 1.
- Income is behind plan overall but this is mitigated by underspends on pay. Non-pay was in line with plan.
- The closing cash balance was £57.1m, £0.8m higher than plan.

Trust Income and Expenditure Performance Summary

Year to Date for the 1 month ending 30 April 2018

2018/19										Notes	2017/18		CY vs PY	
Annual Budget	Income & Expenditure	Month 1				Year to Date					Rating	YTD Actual	Variance	
(£m)		Budget (£m)	Actual (£m)	Variance (£m)	%	Budget (£m)	Actual (£m)	Variance (£m)	%	Current Year Variance	(£m)		%	
280.59	NHS & Other Clinical Revenue	22.30	22.97	0.67	3.00%	22.30	22.97	0.67	3.00%	G	1	20.00	2.97	14.85%
63.49	Pass Through	5.02	4.82	(0.20)	(3.96%)	5.02	4.82	(0.20)	(3.96%)			5.50	(0.68)	(12.36%)
63.55	Private Patient Revenue	4.97	4.65	(0.32)	(6.50%)	4.97	4.65	(0.32)	(6.50%)	R	2	4.80	(0.15)	(3.12%)
62.93	Non-Clinical Revenue	4.79	4.01	(0.78)	(16.32%)	4.79	4.01	(0.78)	(16.32%)	R	3	3.30	0.71	21.52%
470.55	Total Operating Revenue	37.09	36.45	(0.64)	(1.71%)	37.09	36.45	(0.64)	(1.71%)			33.60	2.85	8.48%
(239.90)	Permanent Staff	(19.59)	(19.38)	0.21	1.07%	(19.59)	(19.38)	0.21	1.07%			(18.40)	(0.98)	(5.33%)
(5.98)	Agency Staff^	(0.50)	(0.18)	0.32	63.64%	(0.50)	(0.18)	0.32	63.64%			(0.50)	0.32	64.00%
(16.77)	Bank Staff	(1.39)	(1.36)	0.03	2.02%	(1.39)	(1.36)	0.03	2.02%			(1.20)	(0.16)	(13.33%)
(262.65)	Total Employee Expenses	(21.47)	(20.92)	0.55	2.58%	(21.47)	(20.92)	0.55	2.58%	G	4	(20.10)	(0.82)	(4.08%)
(11.99)	Drugs and Blood	(0.95)	(0.87)	0.08	8.03%	(0.95)	(0.87)	0.08	8.03%	G		(0.80)	(0.07)	(8.75%)
(39.50)	Other Clinical Supplies	(3.02)	(3.26)	(0.24)	(8.02%)	(3.02)	(3.26)	(0.24)	(8.02%)	R		(2.90)	(0.36)	(12.41%)
(64.06)	Other Expenses	(5.07)	(5.03)	0.04	0.73%	(5.07)	(5.03)	0.04	0.73%	G		(4.80)	(0.23)	(4.79%)
(63.49)	Pass Through	(5.02)	(4.82)	0.20	3.96%	(5.02)	(4.82)	0.20	3.96%			(5.40)	0.58	10.74%
(179.04)	Total Non-Pay Expenses	(14.05)	(13.98)	0.07	0.50%	(14.05)	(13.98)	0.07	0.50%	G	5	(13.90)	(0.08)	(0.58%)
(441.69)	Total Expenses	(35.52)	(34.90)	0.62	1.75%	(35.52)	(34.90)	0.62	1.75%	G		(34.00)	(0.90)	(2.65%)
28.86	EBITDA (exc Capital Donations)	1.56	1.55	(0.01)	(0.77%)	1.56	1.55	(0.01)	(0.77%)	G		(0.40)	1.95	487.50%
(16.79)	Owned depreciation, Interest and PDC	(1.35)	(1.32)	0.03	2.15%	(1.35)	(1.32)	0.03	2.15%		6	(1.26)	(0.06)	(4.76%)
12.07	Control total	0.21	0.23	0.02	7.93%	0.21	0.23	0.02	7.93%	G		(1.66)	1.89	113.86%
(11.60)	Donated depreciation	(0.92)	(0.91)	0.01	0.55%	(0.92)	(0.91)	0.01	0.55%			(0.74)	(0.17)	(22.97%)
0.47	Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	(0.70)	(0.68)	0.02	3.12%	(0.70)	(0.68)	0.02	3.12%	G		(2.40)	1.72	71.67%
(2.52)	Impairments	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%			0.00	0.00	0%
44.97	Capital Donations	1.96	1.64	(0.32)	(16.37%)	1.96	1.64	(0.32)	(16.37%)		7	1.70	(0.06)	(3.53%)
42.91	Adjusted Net Result	1.26	0.96	(0.30)	(23.75%)	1.26	0.96	(0.30)	(23.75%)			(0.70)	1.66	237.14%

Notes

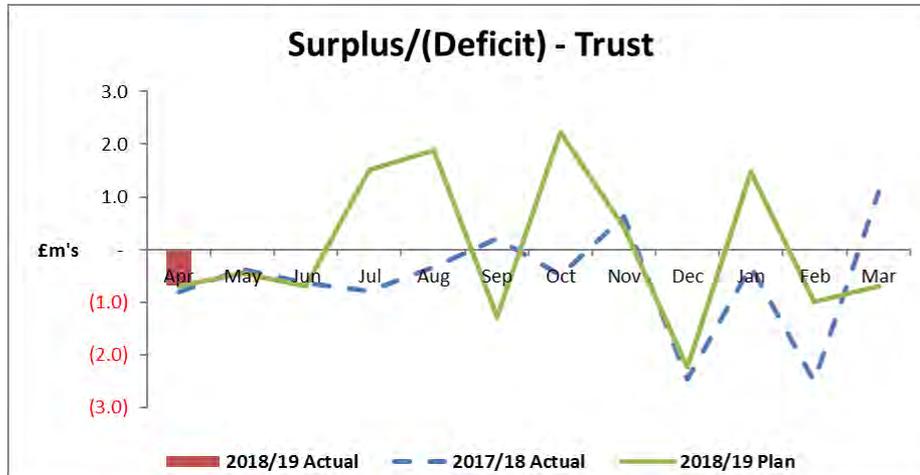
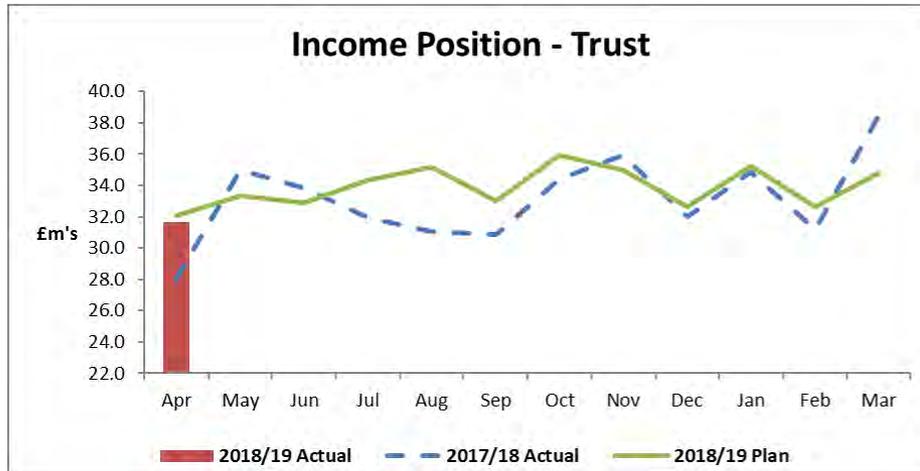
- NHS & other clinical revenue (excluding pass through) is £0.7m favourable to plan (£23.0m). This increase is a result of increased BMT and Neurosurgery activity.
- Private patient income in M1 is £4.7m which is £0.3m adverse to plan, due to a lower number of patients than planned.
- Non Clinical Revenue underperformed in M1 by £0.8m. This is due to both Research and Charitable grants not having started in month.
- Pay is favourable to plan by £0.6m, in part due to agency spend which is both below the ceiling and plan in month. This has been driven by focused work on reducing agency usage and a reduction in the corporate areas..
- Owned depreciation, interest and PDC was slightly favourable to plan.
- Income from capital donations is £0.3m lower than plan due to slippage in the capital program.

Footnotes:

^ The Trust has only set bank and agency budgets for planned short term additional resource requirements.

Trust Income and Expenditure Trends

Year to Date for the 1 month ending 30 April 2018



Workforce Summary

For the 1 month ending 30 April 2018

	NHSI M1 Plan (£m)	2018/19 M1 pay cost (£m)	Variance (£m)	NHSI M1 Plan WTE	2018/19 M1 WTE	Variance WTE	NHSI M1 Plan Annualised £000/WTE	2018/19 M1 Annualised £000/WTE
Permanent (Incl. Apprenticeship Levy)	20.05	19.92	0.13	4,215.90	4,152.22	63.68	57.07	57.56
Bank	1.39	1.26	0.13	273.90	275.14	(1.24)	60.81	55.00
Agency	0.52	0.22	0.29	77.40	39.23	38.17	79.84	67.60
Total	21.95	21.40	0.55	4,567.20	4,466.59	100.61		

In month one we have spent £0.55m less than plan and staffing numbers are 101wte below plan. This is due to:

- Reduced number of research posts in month one
- Reduced use of agency
- A number of business case posts that have been fully funded that are not yet occupied

Further to this the average cost of bank and agency used is below the original plan

Trust Statement of Financial Position as at Month 1 2018/19

	Unaudited Actual as at 31 Mar 2018	Actual as at 30 Apr 2018	Change in month	Forecast Outturn 31 Mar 2019
	£000	£000	£000	£000
Non Current Assets				
Property, plant and equipment - purchased	200,068	201,189	1,121	210,886
Property, plant and equipment - gov granted	218	267	49	218
Property, plant and equipment - donated	238,386	238,422	36	253,260
Intangible assets - purchased	12,322	12,161	(161)	20,139
Intangible assets - donated	6,107	6,802	695	22,081
Trade and other receivables	6,188	6,149	(39)	5,713
Total Non Current Assets	463,289	464,990	1,701	512,297
Current Assets				
Inventories	8,853	9,250	397	9,500
Invoiced Debtors	54,512	55,392	880	55,102
Accrued income	12,454	14,277	1,823	12,597
PDC dividend receivable	54	0	(54)	0
Other receivables - revenue	1,329	2,731	1,402	1,333
Receivables due from NHS charities - capital	4,338	3,616	(722)	4,353
Prepayments	3,382	4,662	1,280	3,394
VAT receivable	985	356	(629)	488
Investments	0	50,000	50,000	30,000
Cash and cash equivalents	55,695	7,056	(48,639)	9,137
Total Current Assets	141,602	147,340	5,738	125,904
Total Assets	604,891	612,330	7,439	638,201
Current Liabilities				
NHS payables - revenue	(6,599)	(6,529)	70	(5,490)
Other trade payables - capital	(6,380)	(6,716)	(336)	(7,498)
Other trade payables - revenue	(5,076)	(3,921)	1,155	(4,223)
Social Security costs	(3,001)	(3,039)	(38)	(3,096)
Other taxes payable	(2,506)	(2,593)	(87)	(2,546)
Other payables	(8,700)	(8,174)	526	(7,179)
Private Patient Cash on Account	(4,926)	(4,905)	21	(4,098)
Other payables - PDC	0	(572)	(572)	0
Expenditure accruals	(25,152)	(31,178)	(6,026)	(19,929)
Other liabilities	(6,329)	(7,565)	(1,236)	(6,681)
Provisions for liabilities and charges	(1,284)	(1,284)	0	(227)
Total Current Liabilities	(69,933)	(76,456)	(6,523)	(60,967)
Net Current Assets	71,669	70,884	(785)	64,937
Total Assets Less Current Liabilities	534,958	535,874	916	577,234
Non Current Liabilities				
Lease incentives	(4,543)	(4,510)	33	(4,111)
Provisions for liabilities and charges nca	(970)	(961)	9	(764)
Total Non Current Liabilities	(5,513)	(5,471)	42	(4,875)
Total Assets Employed	529,445	530,403	958	572,359
Financed by Taxpayers' Equity				
Public dividend capital	127,280	127,280	0	127,280
Retained earnings	306,494	307,452	958	348,020
Revaluation reserve	92,557	92,557	0	93,945
Other reserves	3,114	3,114	0	3,114
Total Taxpayers' Equity	529,445	530,403	958	572,359

NHSI Financial Rating

All KPI ratings are Green.

Cash

The closing cash balance was £57.1m, £0.8m higher than plan.

Variance/movement	Cash variance against YTD plan £m
Inventories – higher than plan	(0.3)
Trade and other Receivables – higher than plan	(4.0)
Trade and Other Payables - higher than plan	5.1
Increase to cash position	0.8

NHS Debtor Days

Debtor days remained the same as the previous month at 19 days and remains within target.

IPP Debtor Days

IPP debtor days increased in month to 202 days from 189 days.

Creditor Days

Creditor days remained the same as the previous month at 35 days.

Inventory Days

Drug inventory days increased in month to 11 days from 5 days
Non-Drug inventory days increased in month to 95 days from 70 days,
relating to increased stock within orthopaedics for spinal metal

	Plan For YTD Ending 30 Apr 2018 £000	Actual For YTD Ending 30 Apr 2018 £000	Actual For Month Ending 30 Apr 2018 £000	Forecast Outturn 31 Mar 2019 £000
<u>Cash flows from operating activities</u>				
Operating surplus - excluding charitable capital expenditure contributions	(83)	(78)	(78)	7,896
Impairment and Reversals	0	0	0	(2,519)
Charitable capital expenditure contributions	1,961	1,640	1,640	44,965
Operating surplus	1,878	1,562	1,562	50,342
<u>Non-cash income and expense</u>				
Depreciation and amortisation	1,645	1,630	1,630	20,963
Impairments and Reversals	0	0	0	2,519
Proceeds on disposal	0	1	1	1
(Increase)/decrease in trade and other receivables	53	(3,995)	(3,995)	277
Increase in inventories	(97)	(397)	(397)	(647)
Increase/(decrease) in trade and other payables	(1,560)	4,378	4,378	(9,418)
Increase/(decrease) in other current liabilities	2,032	1,203	1,203	(79)
Decrease in provisions	(17)	(9)	(9)	(1,241)
Net cash inflow from operating activities	2,056	2,811	2,811	12,375
<u>Cash flows from investing activities</u>				
Interest received	7	22	22	84
Purchase of property, plant and equipment and Intangibles	(3,284)	(3,034)	(3,034)	(71,847)
Net cash used in investing activities	(3,277)	(3,012)	(3,012)	(71,763)
<u>Cash flows from financing activities</u>				
Public Dividend Capital received	0	0	0	0
PDC dividend paid	0	0	0	(7,512)
Net cash outflows from financing activities	0	0	0	(7,512)
Increase/(decrease) in cash and cash equivalents	657	1,361	1,361	(16,558)
Cash and cash equivalents at period start	55,695	55,695	55,695	55,695
Cash and cash equivalents at period end	56,352	57,056	57,056	39,137

Trust Inpatient and Outpatient Activity

Year on Year trend analysis

NHS and IPP Activity (Combined)												
Prior Year 2017/18			Current Year 2018/19				NHS Activity			IPP Activity		
Mth 01	Total	YTD Mth			Change	% Change	NHS YTD	Change	% Change	IPP YTD	Change	% Change
Apr	17/18	01 17/18	Apr	Total YTD	YOY	YOY	18/19	YOY	YOY	18/19	YOY	YOY
Activity Type												
Inpatients												
Number of Discharges												
1,789	25,192	1,789	2,110	2,110	321	17.9%	2,027	318	18.6%	83	3	3.8%
176	2,214	176	178	178	2	1.1%	178	3	1.7%	0	(1)	-100.0%
Inpatient:												
1,084	14,272	1,084	1,123	1,123	39	3.6%	1,027	24	2.4%	96	15	18.5%
71	808	71	100	100	29	40.8%	87	26	42.6%	13	3	30.0%
169	2,214	169	186	186	17	10.1%	179	10	5.9%	7	7	100.0%
3,289	44,700	3,289	3,697	3,697	408	12.4%	3,498	381	12.2%	199	27	15.7%
Beddays												
638	7,698	638	510	510	(128)	-20.1%	479	(131)	-21.5%	31	3	10.7%
0.36	0.31	0.36	0.24	0.24	(0.11)	-32.2%	0.24	(0.12)	-33.8%	0.37	0.02	6.7%
104	1,308	104	106	106	2	1.9%	106	2	1.9%	0.0	(2.0)	-100.0%
Inpatient:												
5,412	67,192	5,412	5,494	5,494	82	1.5%	4,350	68	1.6%	1,144	14	1.2%
710	6,748	710	526	526	(184)	-25.9%	485	(128)	-20.9%	41	(56)	-57.7%
2,136	26,783	2,136	2,158	2,158	22	1.0%	2,087	11	0.5%	71	11	18.3%
8,258	100,723	8,258	8,178	8,178	(80)	-1.0%	6,922	(49)	-0.7%	1,256	(31)	-2.4%
6.24	5.82	6.24	5.80	5.80	-0.43	-6.9%	5.35	-0.30	-5.3%	10.8	-3.3	-23.4%
9,000	109,729	9,000	8,794	8,794	-206	-2.3%	7,507	-178	-2.3%	1,287	-28	-2.1%
6,739	86,795	6,739	7,805	7,805	1,066	15.8%	6,684	541	8.8%	1,121	525	88.1%
Midnight Census (ON Bed days)												
5,182	64,195	5,182	5,261	5,261	79	1.5%	4,132	60	1.5%	1,129	19	1.7%
699	6,687	699	520	520	(179)	-25.6%	482	(121)	-20.1%	38	(58)	-60.4%
2,150	26,963	2,150	2,162	2,162	12	0.6%	2,093	3	0.1%	69	9	15.0%
0	3	0	0	0	0		0	0		0	0	100.0%
8,031	97,848	8,031	7,943	7,943	(88)	-1.1%	6,707	(58)	-0.9%	1,236	(30)	-2.4%
259	268	29	256	29	(0)	-1.1%	18	(0)	-0.9%	41	38	1087.8%
Critical Care Beddays (NICU PICU CICU)												
376	5,120	376	411	411	35	9.3%	289	22	8.2%	122	13	11.9%
210	1,110	210	66	66	(144)	-68.6%	66	(114)	-63.3%	0	(30)	-100.0%
596	8,032	596	715	715	119	20.0%	691	123	21.7%	24	(4)	-14.3%
1,182	14,262	1,182	1,192	1,192	10	0.8%	1,046	31	3.1%	146	(21)	-12.3%
38.1	39.1	4.3	38.5	4.3	0.0	0.8%	2.9	0.1	3.1%	0.4	(0.1)	-12.3%
Outpatients												
18,409	256,444	18,409	20,558	20,558	2,149	11.7%	19,030	1,957	0.8%	1,528	192	14.4%
3,501	47,236	3,501	3,764	3,764	263	7.5%	3,111	193	6.6%	653	70	12.0%
14,908	209,208	14,908	16,794	16,794	1,886	12.7%	15,919	1,764	12.5%	875	122	16.2%
4.3	4.4	4.3	4.5	4.5	0.2	4.8%	5.1	0.3	5.5%	1.3	0.0	3.7%

Trust Board 23 May 2018	
Freedom to Speak Up Guardian Annual Report	Paper No: Attachment X
Submitted by: Luke Murphy, Freedom to Speak Up Guardian	
Aims / summary The aim of this paper is to provide an update on cases/actions, and to provide assurance to the committee that there is a robust and effective framework in place to support staff wishing to raise concerns in the workplace.	
Action required from the meeting The committee are asked to record their satisfaction that there are robust governance and assurance frameworks in place with regard to the Freedom to Speak Up.	
Contribution to the delivery of NHS / Trust strategies and plans	
Financial implications None at present	
Legal issues None at present	
Who is responsible for implementing the proposals / project and anticipated timescales Luke Murphy, Freedom to Speak Up Guardian	
Who is accountable for the implementation of the proposal / project Matthew Shaw, Medical Director	

**Trust Board
23 May 2018**

1. Introduction

The Freedom to Speak Up service began in November 2016 with GOSH staff volunteering their time, these were called Freedom to Speak Up Ambassadors. The goal was to have a range of staff from across staff groups to encourage access to the service regardless of role at the Trust.

In a recent CQC report they stated that “The Trust had not fully demonstrated their commitment to support the freedom to speak up agenda. They did not fully comply with recommendations set in freedom to speak up guidance issued by the National Guardian’s Office. No trust guardian had been appointed.”

The Trust has now appointed a Freedom to Speak Up (FTSU) Guardian as recommended by the National Guardians Office and the CQC. The new Guardian took up post from 5th March 2018.

The FTSU Guardian is a paid post for two days per week and supported by six staff (2 new recruits) who volunteer as FTSU Ambassadors. The Ambassadors come from a range of roles and professions across the Trust. This new structure is designed to combine the strengths of the previous arrangement with the support of a paid staff member to develop the service further.

2. Case Summary: Financial Year 2017/18

In the financial year 2017/18 there were 13 cases. Each staff member coming to the service might raise more than one issue and may approach more than one Ambassador. The primary purpose of the service is to support staff concerned about safety but staff may also look for support with raising concerns about bullying and harassment.

Themes: 6 were concerned about safety, 9 were concerned about colleague’s behaviour, 4 were concerned about leadership and three were concerned about a negative team culture.

Staff Groups: The staff breakdown included 5 administrators/managers, 2 nurses, 5 allied health professionals including health care assistants, and 1 doctor.

Outcomes: Following a review of the cases by the new FTSU Guardian all cases in 2017/18 were appropriately responded to and received appropriate advice.

3. Further Assurances & Next Steps

Staff are continuing to access the service via the Guardian and by the volunteer Ambassador roles, two of whom have been recently appointed.

Attachment X

New ways of contacting the FTSU service have been included such as a single service email account and mobile number although staff can continue to meet the FTSU Guardian/Ambassadors face to face if this provides them with more support.

Further work needs to be done to promote the service and to do so in a way that promotes the Trusts commitments to other "Speak Up" roles such as the new work with the Cognitive Institute and the ongoing work with the Guardian for safe working and others.

The role will sit within the Medical Directors office to ensure the safety concerns are shared promptly and the concerns managed in line with Trust policies. The FTSU Guardian will work closely with others in the Trust on Safety and consider how the FTSU data will relate to the work of others, particularly the Quality and Safety team.

Trust Board 23 May 2018	
Health and Safety/Fire Annual Report 2017 - 2018	Paper No: Attachment Y
Submitted by: Chris Ingram, Fire, Health and Safety Manager	
Aims / summary To inform the Trust Board of the on-going issues, themes and priorities faced by the Trust and the progress and problems in relation to health and safety in 2017 - 2018.	
Action required from the meeting None	
Contribution to the delivery of NHS Foundation Trust strategies and plans Zero Harm	
Financial implications Possibility of unlimited fines if safety legislation is breached.	
Who needs to be told about any decision? Director of Human Resources and Organisational Development/ Fire, Health and Safety Manager	
Who is responsible for implementing the proposals / project and anticipated timescales? Fire, Health and Safety Manager	
Who is accountable for the implementation of the proposal / project? Fire, Health and Safety Manager	

	<p>have fire training by e-learning every other year or but practical training is still required.</p> <p>4. Face to Face fire training is mandatory for all staff when they join via the induction training.</p> <p>A more detailed proposal was requested to be presented at the Health and Safety Committee in June</p>			
Fire Risk Assessments	All fire risk assessments will be complete by April 2018. Clinical Fire Risk Assessments currently stand at 95% with non clinical areas at 88%.	Apr 2018		
<p>Risk Impact Assessments and Fire risk assessments are undertaken when a project is ready to begin. Local staff will receive training prior to taking over the area.</p> <p>Staff in all areas of PICB received fire evacuation training prior to handover of the ward. This training has also taken place in the Clinical Research Facility. A further 20 sessions are planned for Alligator Ward (L4 PICB) and the new Rainforest Ward (L5 VCB) All new/refurbished clinical areas will receive similar training in the future.</p>	100% completion (Chris Ingram)			
Estates and Facilities risks are discussed at a monthly Risk Action Group.	The group initially had 47 risks to review but this has been reduced to 34 risks on the Estates and Facilities Risk Register.	On-going		
An on-going monthly meeting with the Institute of Child Health continues to happen. Any safety issues are raised which has led to increased co-operation between the 2 organisations. The latest action log is presented at the Health and Safety Committee.	(Chris Ingram/Kate Thornton)			

<p>All clinical areas have been invited to undertake a fire evacuation table top exercise. An app has been sourced to allow a review of the exercise. The app allows the effectiveness of the session to be measured in the form of a quiz.</p>	<p>Exercise Flambe is ongoing and takes the place of the normal fire safety training. The session is more in-depth and concentrates information for the clinical areas. A further exercise is being designed for the new nursery.</p>	<p>On-going July 2018 Chris Ingram</p>		
<p>Fire drills across all non-clinical areas were scheduled for February and March 2018. Some buildings drills were cancelled due to inclement weather. They will be rescheduled for April and May 2018.</p>	<p>May 2018 Chris Ingram</p>	<p>May 2018</p>		
<p>Sharps - The Trust is required to comply with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 (the regulation), which is monitored by the Health and Safety Executive (HSE). The elements the Trust must meet are as follows:</p> <ol style="list-style-type: none"> 1. Complete a risk assessment 2. Implementing control measures 3. Information, instruction and training on safe use of sharps 4. Ensure that suitable clinical waste disposal procedures, including use of sharps containers, are followed 5. Ensure standard precautions for infection control are in place 6. Have clear procedures for response to sharps injuries, including speedy access to appropriate prophylaxis treatments 7. Reporting work-related sharps injuries 	<p>A working group has been set up to tackle all issues relating to sharps. Action plan updated monthly.</p> <p>The measures taken by 31/3/18 include:</p> <ul style="list-style-type: none"> • Sharps Policy in situ • Risk Assessment Tool in place and has been used to allow use of some standard sharps • Standard Cannulas have been replaced with safer products. • Where standard cannulas are still being used a risk assessment is in place. • A table top exercise for safer blunt needles and butterfly needles is being arranged for April. This will allow further safety products to be used in the Trust. • A robust risk assessment process is now in place 	<p>On-going</p>		

Number and severity of incidents reported (Pan Trust)

GOSH employees reported 800 (760 – last year) health and safety incidents in the year from April 2016. These included including 135 patient safety incidents. 1 incident was reported as causing serious harm.

- WEB48349 – Patient fell from bed and banged head.

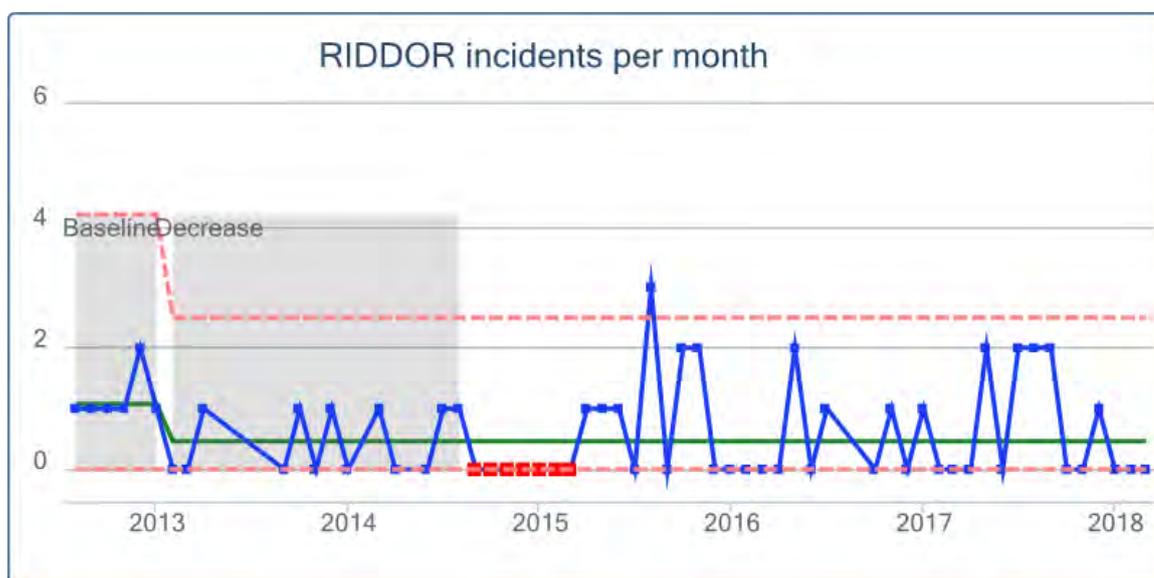


Reporting of Injuries, Diseases and Dangerous Occurrence Regulations

The Trust is required by law to report specified workplace incidents, such as work-related deaths, major injuries, over 7-day injuries, work related diseases, and dangerous occurrences (near miss accidents)

6 incidents were reported to the Health and Safety Executive (HSE) under RIDDOR.

- WEB50841 – Staff nurse slipped in Theatres and banged knee on bench. Away from the Trust for > 7 days.
- WEB46936 – Chef slipped and her banged face on side of equipment. Away from the Trust for > 7 days.
- WEB50770 – Staff nurse ran over foot with a baby therm cot. Fractured foot.
- WEB46769 – Nurse hurt back whilst caring for patient. Away from the Trust for > 7 days.
- WEB47885 – Staff member hurt knee in CIVAS whilst putting on overshoes. Away from the Trust for > 7 days.



Main aims for 2018/2019

- Creation of Trustwide Audit to measure compliance with legislative requirements and then completion of the audit
- Increase fire safety training compliance to > 90%.
- Review fire safety training needs analysis
- Complete all fire risk assessments
- Ensure the continued 100% compliance with COSHH Assessments
- Respond to all Health and Safety incidents within 1 working day.

Conclusion

Overall, the health, safety and fire performance of the Trust has been good. There have been some challenges mainly due to 2 long term members of staff taking a leave of absence from the Trust. Despite this the Trust continues to maintain the highest standards of safety whilst juggling the needs of a world class paediatric centre and a large scale redevelopment project.

Trust Board 23 May 2017	
Safeguarding Annual Report 2017-18	Paper No: Attachment Z
Submitted by: Alison Robertson, Chief Nurse	
Aims / summary Provide a summary report of Trust progress, activity and achievements 2017-2018 and identify challenges and priorities for 2018-2019.	
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? Alison Robertson - Executive Lead for Safeguarding	
Who is responsible for implementing the proposals / project and anticipated timescales? Alison Robertson, Chief Nurse	
Who is accountable for the implementation of the proposal / project? Alison Robertson, Chief Nurse	

Safeguarding Children, Young People and Adults Annual Report 2017 – 2018



Alison Robertson Chief Nurse
Assisted by
Named Safeguarding Professionals & Head of Social Work
May 2018

Key Achievements 2017/18

- The Safeguarding Team reached a full complement of staff in March 2018, which has raised the profile of safeguarding across the organisation.
- Improved oversight of data relating to safeguarding activity across the Trust for the past 12 months and an enhanced data set is provided quarterly to QSAC.
- The Named and Deputy Named Doctors have provided cross-Trust supervision for cases of perplexing presentations in addition providing input to the complex gastro Multi Disciplinary Team. This was not previously possible due to team capacity.
- A review of the safeguarding children training requirement has taken place and future plans for 2018/2019 include increasing the number of staff who are required to complete an enhanced level 3 training to ensure a competent workforce.
- Progress has been made towards implementing the recommendation from an external safeguarding review to develop an integrated referral pathway for social work and safeguarding. A full update will be provided to the Quality Assurance Safeguarding Committee (QSAC) in July 2018.
- Safeguarding training has been extended with input from the social work team to include such topics as risk assessment, difficult conversations and sexual abuse.
- In response to the identified numbers of adult patients, a specific Lead for Safeguarding Adults has been appointed who is working closely with the interim Mental Capacity Act Lead to ensure the needs of this group are met, as directed by statutory requirements. (6057 adults patients were seen in outpatients in 2017/2018 and 670 were admitted for a procedure, as a day case or overnight)
- The levels of safeguarding adult training requirements have been reviewed against the Intercollegiate Document for Safeguarding Adults 2016 and the Level 2 programme is now mandated for appropriate staff.
- Prevent e-learning and face to face training programmes have been included in the mandatory suite of training for the first time.
- Bi-annual safeguarding newsletters are sent to all staff to ensure they remain updated with key national and local developments.
- The Safeguarding Children and Young people Policy has been completely revised and was launched in January 2018.
- The Strategic and Operational Safeguarding Groups are now in place, enabling robust involvement from divisions and key disciplines across the Trust.
- There has been an increase in the areas of the Trust that have a Safeguarding Link and Safeguarding Link meetings are scheduled quarterly

- Great Ormond Street Hospital (GOSH) is an international centre of excellence striving to provide the very best care for children with rare and complex conditions to enable them to achieve their full potential.
- More than 296,252 admissions and appointments were made, across 63 different specialties, supported by a workforce of over 5,300 healthcare staff and volunteers. 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.
- The Care Act 2014 sets out the statutory principles which apply to all health and care settings to safeguard vulnerable people over the age of 18 years.
- The Safeguarding Children, Young People and Adults Annual Report relates to the period from 01/04/2017 – 31/03/2018, and seeks to provide high level assurance to the Trust Board of the responsibilities and value delivered by the Trust Safeguarding Team and Social Work Service.
- The report updates on progress on work streams agreed within the work plan for 2017/ 2018.

Reviews of the Safeguarding Service: Following an internal and external review of the safeguarding service, additional resources were identified for the Safeguarding Team.

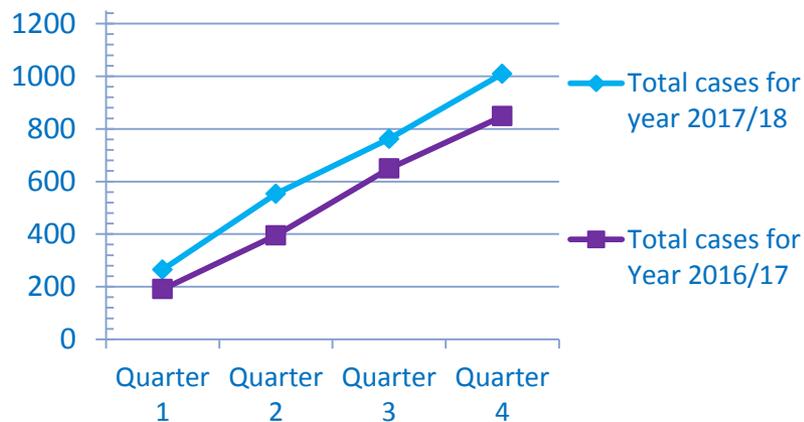
- A full time Band 8A commenced in November 2017 in the role of Safeguarding Senior Nurse Specialist with a Lead for Safeguarding Adults, and 0.8 WTE Band 7 Safeguarding Nurse Specialist.
- In addition the team administrator role has increased from 0.7WTE to 1WTE.
- The additional resource allows for greater visibility across the Trust wards and departments to enhance early identification of any safeguarding concerns.
- The Safeguarding and Social Work teams are working with greater collaboration than ever before
- A joint away day was held in October 2017 to plan a more collaborative strategy and resulting in a Task and Finish Group established to implement the recommendations of the reviews.
- Both teams are:
 - ❖ Co located for 2 hrs daily Monday – Friday. The time period will increase once suitable accommodation is secured.
 - ❖ Co facilitating an increasing number of supervision sessions to staff.
 - ❖ Providing a Multi agency delivery of training at level 3.
 - ❖ Meeting fortnightly at senior level to address any challenges.
 - ❖ Working with EPIC and Onbase teams to ensure appropriate access to safeguarding records.

The Named Professionals and Head of Social Work meet regularly and are working together to implement the wider recommendations of both safeguarding reviews.

- Safeguarding is everyone's responsibility. The Chief Nurse is the Executive Lead for Safeguarding and is supported by the Named Professionals and Head of Social Work. The Named Nurse provides strategic oversight and is assisted by the Senior Nurse Specialist with operational management of the safeguarding service to ensure both statutory and local requirements are achieved.
- The Executive Lead and Named Professionals attend Camden Safeguarding Children's Board (CSCB) and its subgroups to ensure that the Trust is actively involved with local multi-agency developments and provision of assurance at all levels.
- The Strategic Safeguarding Committee (SSC) meets quarterly and Camden's designated safeguarding professionals are invited. The Operational Safeguarding Group (OSG) meets twice between each SSC. The aims of both groups are to provide assurance that the Trust promotes the safeguarding of children young people and vulnerable adults at all times.
- A quarterly report is compiled for the Quality Assurance Safeguarding Committee (QSAC), and an annual report for Trust Board.
- The Clinical Quality Review Group (CQRG) meets quarterly with commissioners from NHSE and receives safeguarding updates.
- The Trust provides quarterly metrics to its commissioners from North West Central London reporting on four key areas;
 - training
 - audit
 - safeguarding supervision
 - participation in Child Protection Conferences.
- The Care Quality Commission have safeguarding as a Key Line of Enquiry in their inspections. CQC inspected the Trust in January 2018.
- Safeguarding was judged to be good within the areas inspected with a challenge identified to improve Safeguarding Children compliance at Level 3. (see Training data)

Case Activity

- The activity incorporates advice, support, attendance at child protection meetings and multi-disciplinary team meetings as well as constructing chronologies and section 17/47 requests for information from Local Authorities. (Requests for information relating to Children in Need and Child Protection)
- Overall activity for this year has increased by 19% and there has been a year on year increase since activity data was formally reported in 2015.
- Case activity has increased for every quarter, compared to 2016/17 and there has been a year on year increase
- The co-location of the safeguarding and social work teams which enhance the single duty team approach continue daily but remain limited to part time, due to space restraints. Additional space is unlikely to be available in the interim.



Child Protection Conference

- The Safeguarding Team coordinate and review reports provided by GOSH professionals to ensure appropriate contribution to the multi agency process.



- Non involvement by GOSH professionals is primarily due to late notification of conference or non engagement of professionals.
- The Trust takes its responsibilities for safeguarding children very seriously and the cases of non-engagement are escalated to Divisional Management to achieve compliance. Information is submitted but this may be post conference.

Serious Case Reviews

- The Trust has been asked to contribute to 5 new SCRs in 2017/18 involving 9 children. 4 cases remain active with independent overview reports in progress.
- 4 cases have been published but 2 have been in a redacted format to protect the identity of the children.
- Learning is disseminated to staff and included in training and supervision.
- For the first time the majority of open SCRs with GOSH involvement have actual or suspected Fabricated or Induced Illness as their main factor, these require significant resources from the Safeguarding Team.

The Operational Lead for Safeguarding Adults has been in post since November 2017. This role is incorporated into the Senior Nurse Specialist for Safeguarding Children and Adults position.

Adult patients seen at GOSH in 2017:

Type of contact	Numbers
Admitted for 1 night or more (longest admission was 38 days)	69
Admitted for a procedure / as a day case. (Includes cardiac MRI)	601
Outpatients (2017/2018)	6057
TOTAL	6727
Top 5 admitting specialties:	
Cardiology	549
Urology	22
Dental & Maxillary Facial	15
Neurology	13
Plastic Surgery	10

Training

Level 2 Safeguarding Adults training will become mandatory for all qualified staff at GOSH from June 2018. Initially this will be an assessed 30 minute e-learning module.

This is consistent with the draft intercollegiate document covering Safeguarding Adults training, which states that Level 2 is the minimum level of Safeguarding Adults training required for all qualified healthcare staff.

Safeguarding Adult Reviews (SARs)

Safeguarding Adult Boards (SABs) have a statutory duty to arrange a SAR when an adult in its area who has care and support needs dies as a result of abuse or neglect, and there is concern that agencies could have worked more effectively to protect the adult.

Over the past year the Trust has completed one Individual Management Review for Islington SAB regarding an adult who had historic contact with GOSH. We are waiting to hear whether this will progress to a SAR.

Mental Capacity Act / Deprivation of Liberty Safeguards (DoLS)

A scoping exercise looking at the role of the MCA Lead at GOSH has been undertaken by the Interim GOSH MCA Lead, supported by the Senior Nurse Specialist for Safeguarding Children and Adults. Gaps in compliance with the legislation have been identified. These include the need for a permanent MCA Lead, a MCA Policy and issues with capacity assessment and consent. Recommendations made to address these and to prepare for changes to the DoLS legislation are being acted on.

Policy and procedures

The existing Safeguarding Adults Policy will be comprehensively reviewed over the next few months to reflect current legislation and practice, and a new policy to provide guidance around the MCA (2005) is being developed.

Supporting the local safeguarding system

GOSH is now represented on Camden SAB's Learning and Communications Subcommittee and reports on safeguarding adults training compliance to Camden CCG.

The Senior Nurse Specialist for Safeguarding Adults and Children also represents GOSH at the London Safeguarding Adults Provider Forum and the London MCA/DoLS Network.

Substantive Contract Holders

- A new model for Safeguarding Children Level 3 was introduced in February 2017. Staff are required to complete 2 hours of Safeguarding Children Level 3 training each year to maintain compliance. This is achieved through either attending a face to face course or completing an online module. Staff must attend a face to face session at least once over a 3 year period. One of the challenges of this model is that the learning management system (GOLD) cannot automate this process. Responsibility sits with the learner to ensure that they are doing the right course at the right time. The introduction of this new model has had a positive impact on compliance figures. In February 2017, compliance for Safeguarding Children Level 3 was 66%. In March 2018 it had climbed to 78%.
- The Safeguarding Team and the Learning and Development team completed a review of all Safeguarding Children training content in November 2017, updating content where appropriate.
- The external training resource was decommissioned in March 2017. All Safeguarding and Prevent training going forward will be delivered using internal resource.
- Prevent training moved from being a required competency to a mandatory requirement on 26th March 2018. Compliance for Prevent Level 3 stands at 79%. This is on track with NHS England's directive to be 85% compliant in this topic by July 2018.
- A decision was made at the Education and Workforce board in March 2018 to make Safeguarding Adults Level 2 a competency for staff in the target audience (as defined by the Core Skills Training Framework and the Intercollegiate document) from April 2018. This will be moving to be a mandatory requirement from 1st June 2018.

Honorary Contract holders

In December 2017, medical Honorary contract holders were identified as the staff group with the lowest compliance across the Trust.

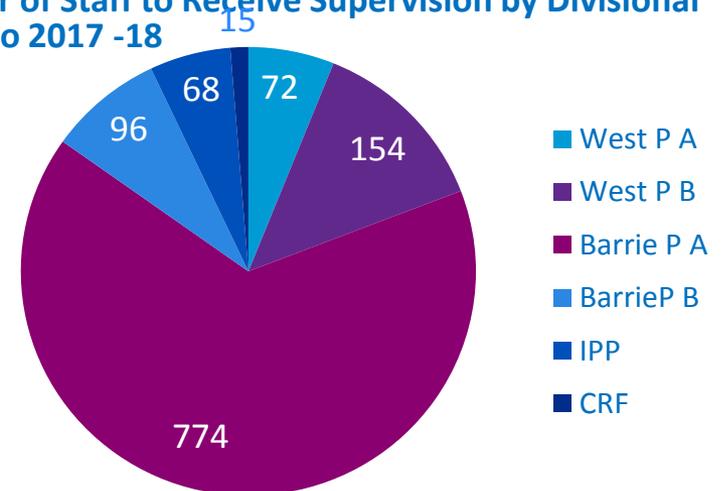
In January 2018 an extensive piece of work was undertaken to ensure all Honorary Consultants contract holders were compliant with the required training by the end of March 2018, as follows:

- HR conducted an audit/data cleanse of honorary contract holders with HOCS and specialist teams
- Contract holders were contacted by email on 11th January requesting them to submit evidence of compliance in their statutory and mandatory training (from their substantive trust) by 25th January 2018
- In addition, HR also contacted the substantive Trusts and to request that they provide copies of the relevant training records
- All evidence received by the Learning & Development Team has been uploaded/recorded in the GOLD Learning Management System
- Contract holders who did not respond to the first email were contacted again on 19th February and 14th March stating if evidence was not provided (or it is not current/compliant), they must complete the relevant training by the end of March 2018 in order to retain their honorary contracts.
- If compliance was not demonstrated by the end of March, individual's honorary contracts will be withdrawn along with system access etc.
- To support this initiative, additional budget was agreed and the Learning & Development Team planned in 8 additional Safeguarding Level 3 Multi-Professional Study Days (from mid-February to end to March) to accommodate any consultant requiring to attend the face to face training.
- Uptake of this training by Honorary Consultants was poor – only 6 honorary contract holders booked on and attended this training.

- Effective supervision has a significant function in maintaining the focus on the child (HM Government, 2015: 25) and is therefore integral to providing an effective person/child centred service. Supervision enables staff to see “the whole picture” by “thinking family” and to recognise the impact that parental and family behaviours have on children and young people and vulnerable adults.
- We recognise that clinical supervision is essential to professional development and helps the supervisee develop confidence in decision making.
- The Safeguarding Team can offer responsive supervision and guidance to any member of staff who asks for it. Clinical supervisors must have an advanced level of knowledge and understanding of safeguarding children and adults including (but not limited to) identification of concerns, vulnerability factors, remedies, and statutory responsibilities.
- In 2017/18 the number of staff that received planned and unplanned supervision was 1213, up from 1008 the previous year; an increase of 20.3%.
- The number of cases brought to supervision was 314 compared to 268 previously an increase of 17%.
- The number of sessions did not increase, 142 compared with 147.
- Although difficult to hypothesise supervision appears to be provided to a greater number of staff, with more cases being brought for discussion.

- With additional staff who are all fully trained supervisors it is envisaged that the next year will increase access further across the workforce.
- This will include the attendance at psycho social meetings in wards and departments to strengthen and standardise the model employed across the Trust. This will complement the presence of social work colleagues who currently provide a level of safeguarding oversight, and ensure that safeguarding concerns are identified and responded to in a timely and appropriate manner.
- Additional groups will be targeted, including medical staff and clinical nurse specialists.
- The Named Doctor will investigate developing a system of peer review for inflicted injury cases.

Number of Staff to Receive Supervision by Divisional Portfolio 2017 -18



Internal Audits:

The Was Not Brought Audit (WNB)

To determine compliance with the Trust Patient Access Policy and whether safeguarding issues were a factor, constituting neglect of health need. Patients who did not attend (DNA) an appointment in a 12 month period were identified and cross referenced against the number of DNAs per patient, which was up to 15.

20 of these cases were randomly selected and reviewed against the Patient Access Policy.

This showed a low level of compliance with the principles and highlighted that there is not currently an effective system for prompting or documenting any consideration of safeguarding concerns.

Recommendations:

- Review of OPD systems for documenting action taken following a WNB – to include developing a system for EPR for capturing safeguarding concern
- Review of WNB Policy, protocols and pathways
- Incorporate into training and re-audit

Think Family Audit

A sample of 54 Family Forms were reviewed, to determine whether key social and demographic information is being collected when patients are admitted. The results showed that there was a low level of completion of the key fields of information – between 0-17%. There is an overlap over between the information collected on the Family Forms and that collected on PIMs and this is to be cross referenced before the report is finalised and recommendations are made.

Action:

- The Safeguarding Team have contributed to the redevelopment of the Family Form

Recommendations:

- Establish a consistent social information collection system which will include informing parents about Information Sharing practice within the Trust and re-audit the social information that is collected. This should be embedded in EPR
- Incorporate into training and re-audit

Supervision Audit

The audits were conducted with staff who had received supervision over two quarters.

Safeguarding supervision is generally well received and felt to be beneficial; staff valued a 'safe space' and felt more confident to raise safeguarding concerns.

Group supervision was felt to be beneficial. Future audits will focus on specific staff groups to identify future training needs.

External Audits:

Section 11:

The Trust were asked by Camden LSCB to complete an audit on Children with Disabilities. The panel did not require any further attendance at their 'Challenge Panel'.

Multi-agency themed audits

Regular multi agency themed audits are completed, with information provided about cases as requested.

Camden: Children with Disabilities – 4 GOSH cases

Identified the limitation of the GOSH IT system which automatically sends correspondence to a patient's General Practitioner as the single point of contact within the primary care sector.

Camden: Youth reoffending – 3 GOSH cases

Although three patients were known to the Trust there was minimal involvement historically and no specific learning.

Hackney: Potential sexual abuse – 1 GOSH case

Holistic consideration of need with involvement of wider psychosocial team including child psychology/child psychiatry and social work.

There was good liaison between GOSH and LA in outlining ongoing concerns and potential risks despite the restriction from applied to disclosure to mother of the referral from the transferring hospital.

Reporting

Female Genital Mutilation (FGM)

There is continued national and international work being undertaken to eliminate new cases of FGM in the UK in a generation. The Serious Crimes Act 2015 placed a mandatory duty on all regulated professionals to report FGM to the police on 101 if they have a direct disclosure from a child under the age of 18 that is a victim of FGM. There is a requirement for staff to undertake this reporting if they are the recipient of a direct disclosure. All staff are made aware of this duty within all levels of safeguarding training. The Trust are required to report such cases to NHSE.

There have been 3 concerns raised within the past year but no confirmed cases.

Prevent

The Trust has remained responsive to the counter terrorism strategy and we recognise that all members of staff have a duty under the Counter Terrorism and Security Act (2015) to have due regard to the need to prevent people being drawn into terrorism and to act positively to report concerns.

There have been 2 concerns raised during the year one of which resulted in a referral to the local Prevent Channel Co-ordinator.

Modern Slavery

The Modern Slavery Act 2015 requires all employees to be committed to ensuring that there is no modern slavery or human trafficking in any part of our business activity, including externally contracted suppliers.

There have been no identified victims of modern slavery or trafficking.

Risks

The Disclosure and Barring Service

- The Trust undertakes checks at recruitment of all staff, which was 100% as of 31.03.2018. Existing staff have rechecks which are currently at 95%.

Persons Who Pose a Risk

- The Safeguarding Team works closely with the Risk, Social Work, Security and Divisional Nursing Teams to ensure a safeguarding perspective is included in the risk assessment where there are concerns about a person who may pose a risk.

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. We will review this risk this year.

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.

- The Safeguarding Links are staff from across the Trust who are key to promoting good safeguarding practice across the Trust. In 2017 their role has been reviewed to ensure they have an overview of safeguarding within the team to ensure that staff are working towards best practice.
- The Links meet every quarter with the Senior Safeguarding Nurse Specialist to ensure they cascade information to update staff within their areas on policy, procedures and supporting staff on early identification of concerns and referring to the safeguarding and social work teams, or clinical site practitioners (out of hours).
- The Named Professionals attend the Divisional Clinical Governance Committees to ensure that local safeguarding information is fed back to relevant teams including any learning from Serious Case Reviews.

Developing the support for Clinicians

- The Named Doctor supports medical and other colleagues both in supervision and case management. This has also involved the development of bespoke safeguarding level 3 training to some clinical teams
- Discussion of gastro and non- gastro complex cases which have a perplexing presentation continues and a Trust-wide system is being developed
- The Named Doctor is continuing to work with colleagues to revise the procedural pathways attached to Safeguarding Children and Young People Policy.
- The Named Doctor attends Strategy Meetings whenever possible , particularly to support medical colleagues in sharing information to inform the Child Protection process

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, 3 Family Support Officers and 1 Psycho-Social Liaison worker. We have a partnership agreement with CLIC Sargent who provide a dedicated service to children with a cancer diagnosis.

We have a full establishment of staff. Following a review of social work across the clinical attachments 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

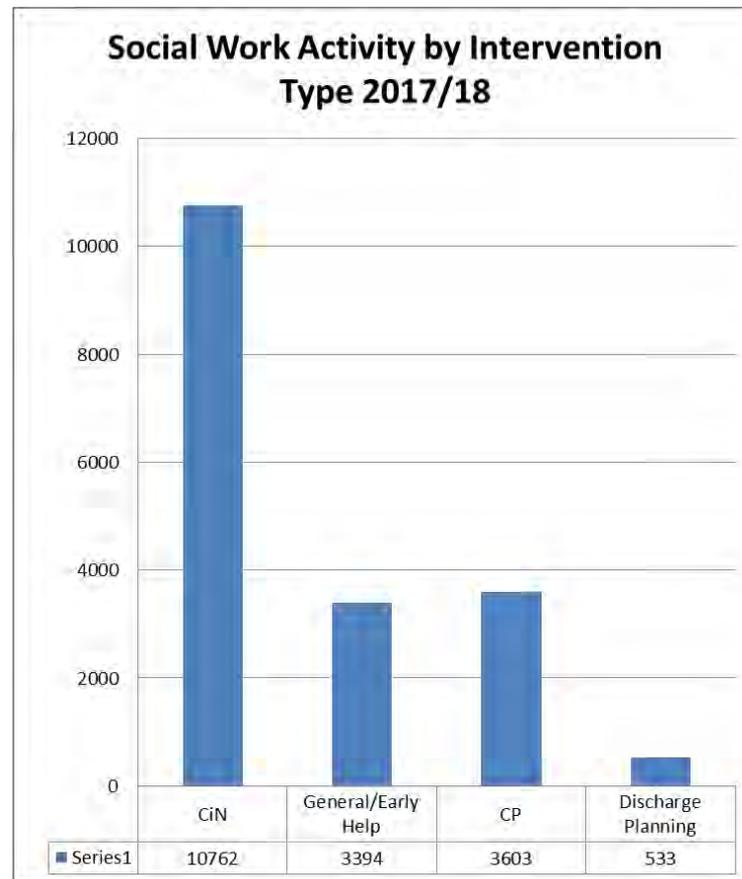
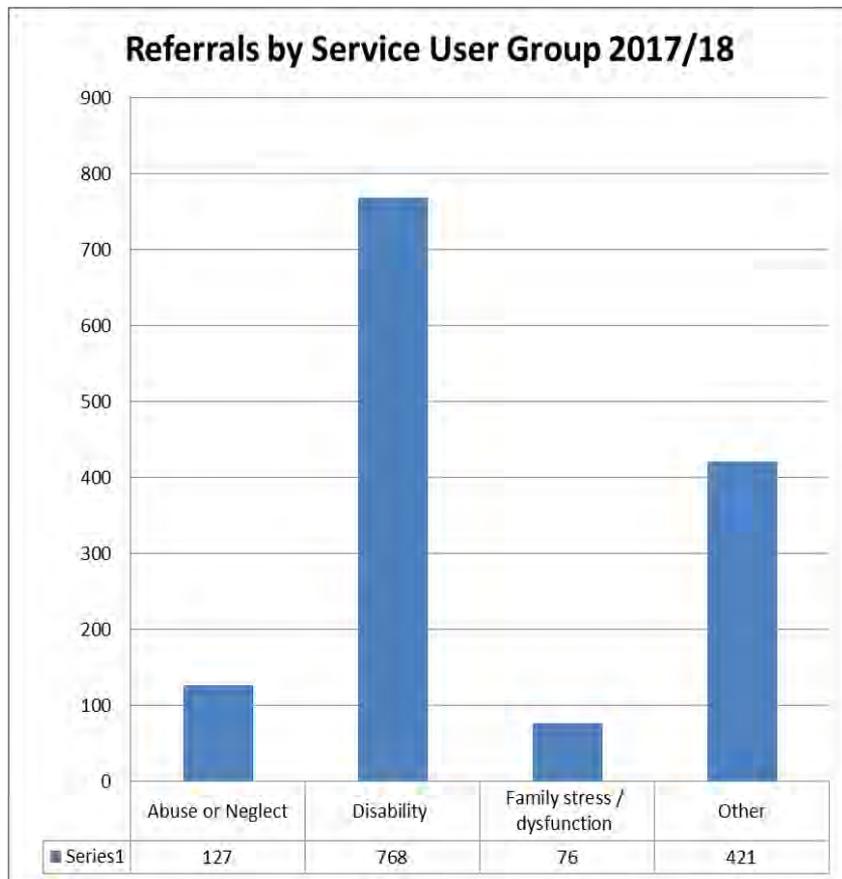
The service is working with the GOSH EPIC team to look at developing an integrated record with the rest of the gosh multidisciplinary team. We have ensured that all staff within the service have updated their Camden Local Authority Child Protection(CP) training.

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 Named Doctor.

We plan to undertake an annual 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 previously surveyed said that the social work service met or exceeded their expectations and 98% of families previously reported that they would be extremely likely or likely to recommend the Social Work Team to someone in a similar situation. Referrals have decreased slightly in 2017/18 compared with 2016/17.

2014/15	2015/16	2016/17	2017/18
1183	945	1510	1392



Work is being undertaken with EPIC to improve the efficiency and reliability of data collection across the department.

Policy development

- Safeguarding is a rapidly changing and growing area of work.
- The Trust Policies and procedures are required to be reviewed and updated in line with national and local policy.
- The Trust responded to the consultation on the proposed changes to the statutory document Working Together to Safeguard Children which is due for publication imminently.
- The Pan London Procedures are the overarching policy that supports local safeguarding policies to which Trust policy should be complementary.

Over the past 12 months the following policies have been reviewed

- Safeguarding Children & Young People Policy
- Prevent

In progress:

- Safeguarding Supervision
- Safeguarding Adults
- Mental Capacity (stand alone)
- Safeguarding Children and Young People procedural appendices.

Themed Safeguarding children training at Level 3 .

In addition to the core training programme , themed face to face sessions are delivered to staff by subject matter experts including;

Emotional Abuse and Neglect

Perplexing Presentations and Fabricated / Induced Illness

Talking to children and parents

Domestic Violence and Abuse

Child Sexual Abuse

Safeguarding and People with Learning Difficulties

Working with families who are challenging

Female Genital Mutilation

Child Abuse Pathology Meeting

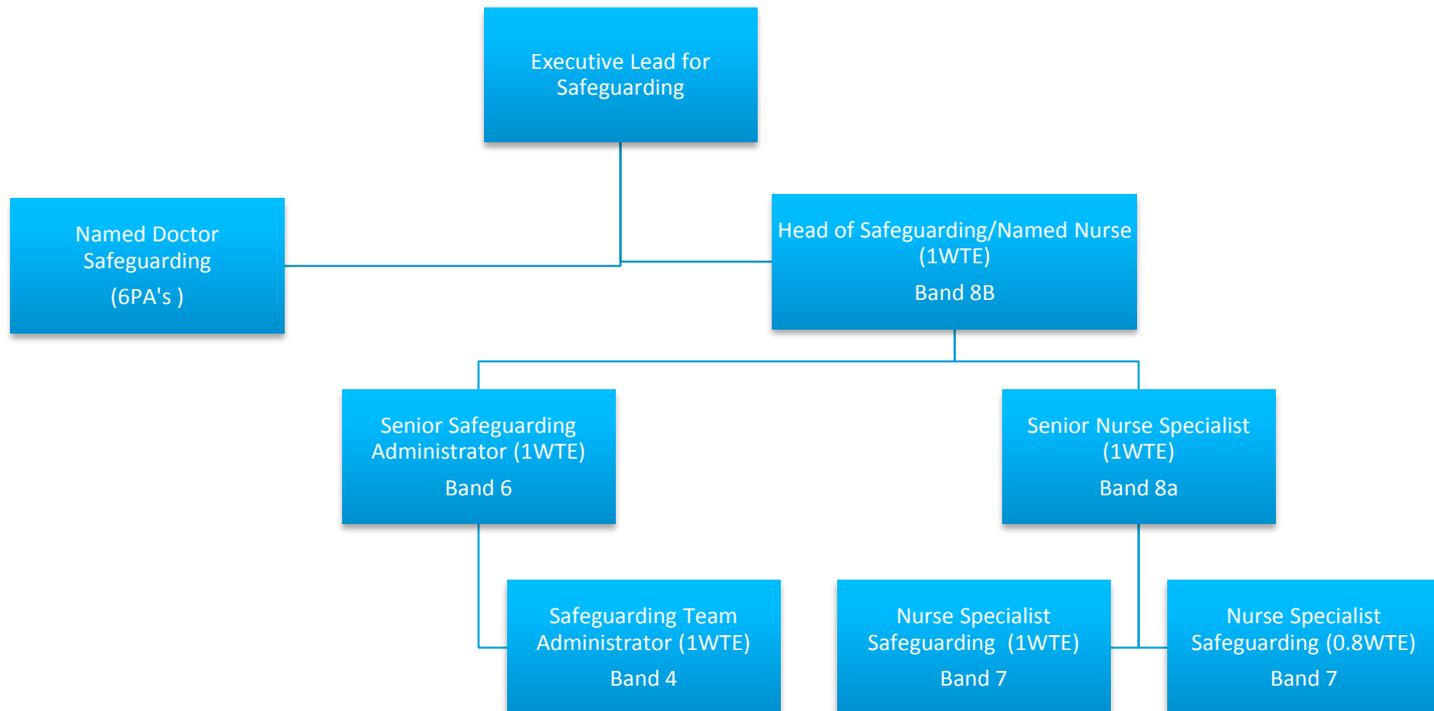
Engages with broader teams i.e. Radiology and Neuro-radiology, pathology, intensivists and acute transfer teams (CATS). Provides a forum for discussion but also engages with the wider multi agency network to consider safeguarding in its broadest context.

Child Protection Information Sharing System (CP-IS).

The Trust is on target to implement the national initiative for NHS Trusts and Local Authorities to 'Go Live' in April 2019.

- Review of Trust safeguarding policies and procedures to ensure compliance with the changes in Working Together to Safeguard Children (2018).
- Ensure the Trust embeds the Camden Local Safeguarding Board priorities within training and practice . These are:
 - Vulnerable adolescents
 - Domestic abuse
 - Neglect
 - Preventing radicalisation and extremism
- Complete the recommendations action plan from the safeguarding reviews.
- Continue to improve compliance with mandatory training and extend the current training programme to include specialist safeguarding training for key staff groups.
- Review of Trust Safeguarding Supervision Policy to ensure a robust system is in place for raising and reflecting on safeguarding concerns.
- Revision of the under-2 Non-accidental Head Injury pathway to be integrated into a general Unintentional Injury pathway.
- To establish a 24/7 medical rota for safeguarding support.
- Establish a consistent social information collection system which will include informing parents about Information Sharing practice within the Trust and re-audit the social information that is collected.
- To work with the interim MCA Lead to:
 - define the role and scope of the MCA Lead
 - develop a MCA and DoLS policy for the Trust
 - Develop training packages and Provide guidance and advice in relation to mental capacity assessments, best interest decisions and documentation
 - Further analyse issues relating to deprivation of liberty and prepare for future safeguards for 16-17yr olds.
- Develop the Looked After Children agenda at GOSH to meet the needs of this vulnerable group who can often enter the care system with a worse level of health than their peers, in part due to the combined effects of the impact of poverty, poor parenting, abuse and neglect.
- Continue to work with our partners in IT and NHS Digital to ensure a robust system is in place to meet the NHS contract deadline of April 2019. In addition working with the EPIC team to promote a smooth transition to the new recording system.
- Consolidating the work done on developing a system for complex case supervision and tracking to extend this to cover the whole Trust.
- Increase the number of staff who are required to complete enhanced Level 3 Safeguarding Children training
- Review policies, protocols and pathways relating to ‘Was Not Brought’

Safeguarding Team Structure Chart



Trust Board 23 May 2018	
Safe Nurse Staffing Report for March/April 2018	Paper No: Attachment 1
Submitted by: Alison Robertson, Chief Nurse.	
Aims / summary	
<ol style="list-style-type: none"> 1. Unify v Actual CHPPD data that provides the actual number of nursing and HCA hours available for each patient for everyday for the month. 2. Assurance of Safe Staffing Levels including patient acuity, staff sickness and appropriate measures are undertaken to ensure patient safety. 3. Recognition of vacancies and prospective staff numbers. 	
Action required from the meeting	
To note the information in the report on safe staffing, the continued improvement in retention and the progress of the recruited newly qualified nurses and the effect on the staffing numbers.	
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>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>	
Financial implications	
Already incorporated into 17/18 Division budgets	
Who needs to be told about any decision?	
Divisional Management Teams Finance Department Workforce Planning	
Who is responsible for implementing the proposals / project and anticipated timescales?	
Chief Nurse; Assistant Chief Nurses and Head of Nursing	
Who is accountable for the implementation of the proposal / project?	
Chief Nurse; Divisional Management Teams	

1.
 - Unify v Actual CHPPD is the data that provides the actual number of nursing and HCA hours available for each patient for everyday for the month and is another way of displaying staffing levels.
 - There are still bed closures being report across IPP, Koala, Sky and Fox. These have been for improvement works, unfilled bank shifts and references made to an increase in staff sickness. There has been reports of Norovirus on Wards and this could explain the reported staff sickness rate, although there is only an increase of 0.1% (15 episodes) reported
2.
 - There were no unsafe shifts reported in March or April. There have been shifts where staff were utilised and allocated accordingly throughout the Trust to ensure areas are safely staffed and acuity of patients was taken into account. During March this was for 30% of the overall shifts while in April it was 50%.
 - Care hours per patient per day decreased slightly in March by 0.2% and for April it has increased by 0.4% thus reflecting the continued fluctuation in patient acuity.
 - The trend in patient acuity requiring a nurse to patient ratio of 1:1 or 1:2 level of care has been consistent and is currently reporting at 62.7%, this is consistent with the trends for the last few months whereas the 1:3 and 1:4 has been consistently in the mid 30% with the trend slightly increasing month on month since December 2017, March is reported at 35.27% and April is 33.23% against Decembers figure of 35% respectively.
3.
 - Turnover rate has increased for the period of this report and the vacancy rate has also increased for both registered and unregistered nurses, this is a known phenomenon for this time each year. The Pipeline figures are, at present, on an upward trajectory, this is taking into account the posts offered to the September 2018 Cohort. Another Band 5 advert has generated another 28 possible new starters. The Pipeline figures for April also recognises the natural expected attrition which is less than expected at 3%. The staffing figures reported for April are the most up to date figures available at the time of writing the report.

Month	UNIFY * Actual s vs plan	CHPPD** Trust average	PANDA Acuity (weighted for cubicle and complexity)				Maternity leave (RN)	Sickness (RN) (Absence Days in month)	Turnover FTE -RN (Annual %)	Vacancies (RN)	Vacancies (un-registered)	Pipeline recruits (RN)	Pipeline recruits (un-registered)
			WIC (1:1)	HD (1:2)	Normal under 2 (1:3)	Normal over 2 (1:4)							
Jan	108%	15.5	43.9%	19.9%	11.3%	24.7%	52.8 FTE (3.3%)	2.93% (1,651)	15.9 FTE (15.8%)	110 FTE (6.9%)	57.7 FTE (17.9%)	65.9	7
Feb	91%	15	45.28%	18.41%	10.75%	25.6%	53.0 FTE (3.56%)	2.9% (1,453)	13.2 FTE (15.95%)	47 FTE (2.9%)	59 FTE (18.3%)	82.9	14
Mar	98.4%	14.8	47.55%	19.19%	10.12%	23.1%	57.9 FTE (3.91%)	2.8% (1,276)	19.6 FTE (16.2%)	54.6 FTE (3.4%)	65.1 FTE (20.2%)	245.9 (inc 165 B5's)	20
Apr	99.5%	15.2	48.79%	17.97%	9.92%	23.31%	57.9 FTE	2.9%	22 FTE	Not	Not	216.4	2

Glossary

Glossary

UNIFY - Unify is an online collection system used for collating, sharing and reporting NHS and social care data.

Care Hours Per Patient Day (CHPPD) - CHPPD is calculated by adding the hours of registered nurses and healthcare support workers available in a 24 hour period and dividing the total by the number of patients at midnight. CHPPD is reported as a total and split by registered nurses and HCAs to provide a complete picture of care and skill mix. CHPPD data is uploaded onto the national Unify system and published on NHS Choices on a monthly basis.

Care hours per patient day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers
	Total number of inpatients

CHPPD provides more granular data providing the actual number of nursing and HCA hours available for each patient for everyday for the month and is another way of displaying staffing levels.

Defining Staffing levels

- **Normal dependency Under 2 Years - 1 Nurse: 3 Patients**
- **Normal dependency Over 2 Years - 1 Nurse: 4 Patients**
- **Ward High Dependency (HD) - 1 Nurse: 2 Patients**
- **Ward Intensive Care (WIC) - 1 Nurse: 1 Patient**

Defining staffing levels for Children's and Young People's services (Royal College of Nursing, July 2013)

Reporting Month		Nursing Staff Actual vs Planned					Care Hours per Patient Day				NHS Key Indicators						
Mar-18		Day		Night		Comments	Patients	Registered Staff	Care Staff	Total	Pressure Ulcers: Grade 2	Cardiac Arrest	Respiratory Arrest	PALS	Complaints	Datix	Unsafe shift
Division	Ward name	Fill rate - registered nurses %	Fill rate - care staff (%)	Fill rate - registered nurses (%)	Fill rate - care staff (%)												
Charles West Division	Leopard Ward	114.5%	118.8%	94.9%	107.2%	Ward safely staffed	388	12.3	2.1	14.4	0					1	
	Bear Ward	141.4%	143.7%	116.5%	60.7%	Acuity, including both Specialising and HDU patient, has dictated the requirements for nurses. Under-establishments of staff are reflected in the Report	682	10.8	1.6	12.4	0						
	Flamingo Ward	104.0%	38.8%	97.4%	41.9%	Unit was safely Staffed	568	24.2	0.4	24.6	1						
	Kangaroo Ward	178.2%	90.6%	114.5%	91.1%	Ward safely staffed	170	12.2	9.5	21.7	0						
	Neonatal Intensive Care Unit	108.9%	0.0%	87.9%	-	Unit was safely Staffed	221	28.4	0.0	28.4	0						
	Paediatric Intensive Care Unit	89.9%	30.4%	80.8%	-	Unit was safely Staffed	430	24.0	0.3	24.3	1						
	Elephant Ward	107.0%	64.2%	81.0%	31.0%	Elephant, Giraffe & Lion reported numbers reflects the activity for both staff and patient numbers. Staffs were appropriately redeployed as required.	253	10.7	1.2	12.0	0						
	Fox Ward	81.7%	53.2%	59.3%	42.3%	Fox and Robin, multiple vacancies (B5, B3), 4 beds closed across 2 units and further empty beds, decrease of patient dependency.	203	11.4	1.3	12.7	0						
	Giraffe Ward	109.7%	42.0%	72.1%	30.3%	see Elephant Ward	160	12.1	1.6	13.8	0						
	Lion Ward	99.0%	94.9%	85.0%	26.1%	see Elephant Ward	266	10.0	1.5	11.5	0						
Pelican Ward	122.9%	210.8%	99.7%	80.6%	Acuity, including both Specialising and HDU patient, has dictated the requirements for nurses.	213	8.9	4.9	13.8	0						2	
Robin Ward	92.7%	52.5%	75.3%	68.4%	see Fox Ward	218	11.8	1.6	13.4	0							
International Private Patients	Bumblebee Ward	95.0%	173.2%	83.3%	91.5%	Ward safely staffed and all staff allocated accordingly, incorporating the acuity and numbers of patients and their specific requirements. Day case and short stay activity increased and again staffs were deployed both locally and Trust wide. There was a shortfall in filled Bank shifts which is reflected in the numbers reported.	459	9.0	2.7	11.7	0						
	Butterfly Ward	87.6%	205.5%	76.2%	85.6%	Appropriate staffs staffing levels were maintained and all levels of nurses were utilised Staffing was also purposefully reduced at night due to increased numbers of day cases patients discharged in evenings. Intermittent beds closed overnight for staffing and acuity, and also to protect bed state for chemotherapy admissions the following morning.	419	8.8	2.2	11.0	0						
	Hedgehog Ward	123.6%	132.7%	76.0%	95.9%	The Ward merged with Bumblebee, for a short period due to improvement works. Ward safely staffed and all staff allocated accordingly, incorporating the acuity and numbers of patients and their specific requirements. Day case and short stay activity increased and again staffs were deployed both locally and Trust wide. There was a shortfall in filled Bank shifts which is reflected in the numbers reported.	163	12.4	4.7	17.2	0						
JM Barrie Division	Eagle Ward	90.8%	75.8%	101.6%	115.6%	Eagle Ward moved staff across the unit to ensure safe staffing levels on Haemodialysis.	393	9.0	2.4	11.4	0						
	Kingfisher Ward	79.0%	31.5%	101.6%	-	Kingfisher had reduced patient throughput due to Easter.	171	10.2	2.6	12.8	0						
	Rainforest Ward (Gastro)	156.2%	33.9%	137.7%	40.5%	Ward safely staffed, reported figures are indicative of current vacancies and utilisation of staff.	239	10.4	2.2	12.6	0						
	Rainforest Ward (Endo/Met)	140.9%	49.6%	97.4%	109.3%	Ward safely staffed, reported figures are indicative of current vacancies, sickness levels and utilisation of staff with the increase in the acuity of the complex patients.	211	11.7	3.4	15.1	0						
	Mildred Creak Unit	106.8%	105.1%	99.0%	69.7%	Staff utilised over the full twenty four hour period to ensure staff usage appropriate.	239	6.4	3.6	10.0	0						
	Koala Ward	103.2%	126.2%	89.0%	41.9%	Both Sky ward and Koala ward are a true reflection of the staffing requirements for these specialities. During the month of March there were a significant number of staff off sick and sometimes the inability to fulfil outstanding shifts necessitated bed closures. There is a slightly higher fill rate for days v nights, as fewer staff are required for the night shift, potentially due to increased discharges, cancellations etc. Also during this month, Sky ward had an increased acuity requiring additional nursing staff. On occasion, beds were closed during the month of March to reflect staffing issues.	570	10.7	1.0	11.7	0						
	Panther Ward	126.4%	93.5%	111.4%	-	Acuity, including both Specialising and tracheostomy patients and some staff sickness, has dictated the requirements for nurses.	283	10.8	1.9	12.7	0						
	Sky Ward	123.7%	148.6%	103.2%	-	see Koala Ward	359	9.9	2.8	12.8	1						
	Panther Urology	200.2%	66.5%	124.9%	59.3%	Panther Urology reported figures reflect the workload, this is due to complex surgical cases and	222	12.2	1.8	14.0							
	Chameleon Ward	171.7%	89.0%	207.4%	63.4%	The establishment change clearly is not reflected.	309	11.8	1.5	13.3							

Reporting Month		Nursing Staff Actual vs Planned				Care Hours per Patient Day				Key Indicators							
Apr-18		Day		Night		Comments	Patients	Registered Staff	Care Staff	Total	Pressure Ulcers Grade 2	Cardiac Arrest	Respiratory Arrest	FALS	Complaints	Datix	Unsafe shift
Fill rate - registered nurses %	Fill rate - care staff (%)	Fill rate - registered nurses (%)	Fill rate - care staff (%)														
Division	Ward name																
Charles West Division	Leopard Ward	106.9%	86.4%	91.3%	91.7%	Ward safely staffed	327	13.7	1.9	15.7	1						
	Bear Ward	126.2%	104.7%	105.3%	57.8%	Although currently slightly under established the Ward was staffed safely. Deficits backfilled with appropriate staff including Practice Educators.	611	10.8	1.4	12.2	0						
	Flamingo Ward	117.2%	51.7%	108.7%	36.7%	Flamingo went slightly over due to acuity of children and running 21 beds instead of 19 funded.	547	28.2	0.5	28.7	5	1					
	Kangaroo Ward	154.3%	88.8%	118.4%	83.0%	Ward safely staffed	181	10.7	8.5	19.3	0						
	Neonatal Intensive Care Unit	111.8%	0.0%	97.5%	-	Unit safely staffed	241	27.0	0.0	27.0	0						
	Paediatric Intensive Care Unit	102.8%	27.0%	92.0%	0.0%	Unit safely staffed	405	28.0	0.2	28.2	3						
	Elephant Ward	102.1%	51.7%	83.7%	43.8%	The average Actual V Planned Staff Hours reflects a varied patient activity & dependency throughout April, with some unoccupied beds. Staff including senior nursing staff & CNS . moved to other areas to support deficits in staffing skill mix.	317	9.2	1.1	10.2	0						
	Fox Ward	89.1%	54.6%	71.7%	48.5%	see Elephant Ward	224	12.3	1.4	13.7	0						
	Giraffe Ward	122.0%	58.3%	89.4%	43.0%	see Elephant Ward	184	12.2	2.0	14.2	0						
	Lion Ward	84.0%	77.5%	85.2%	52.0%	see Elephant ward	268	9.8	1.7	11.5	0						
Pelican Ward	114.9%	176.1%	86.9%	96.4%	see Elephant Ward	192	9.0	5.1	14.1	0							
Robin Ward	94.5%	61.6%	83.8%	78.2%	see Elephant Ward	260	12.4	1.8	14.2	0							
International Private Patients	Bumblebee Ward	91.7%	185.4%	86.3%	95.8%	Saw an increase in terms of the number of 1:1 specials being managed in cubicles from two to four and then back to three over the month this accounts for the increase to 185.4% with regards to the use of care staff on the day shift to safely care for these patients. Nursing lost two staff during the month of march (internal transfer and external transfer) and not all bank filled on the night resulting in a drop to 86.3% at night, however this was covered by moving staff from across the Division to support. When not in use the three RTT beds were closed to admissions but could be flexed open as required	410	9.8	3.2	13.0	0		1				
	Butterfly Ward	88.7%	102.1%	74.3%	102.7%	Qualified and unqualified staffing vacancies/deficits and the associated risks were mitigated by additional use of bank. Increased numbers of unregistered staff during day to support registered staff in providing safe care for cubicalised patients. Staffing also purposefully reduced at night as increased numbers of day case patients. This discharged in evenings. Intermittent beds closed overnight for staffing and acuity.	383	9.2	2.8	12.0	0						
	Hedgehog Ward	122.0%	90.4%	86.2%	88.4%	Saw an increase in through put of day cases and short stay patients. They also were required to deliver 1:2 care to a patient in a cubicle this resulted in a requirement of 122% in registered nurses, especially on the day shifts. This was able to drop down to 86.2% at night and 88.4% for care staff at night due to discharging the daycase patients. Again staff moved across the Division to help. No beds needed to be closed during this time period.	203	11.0	3.1	14.1							
JM Barrie Division	Eagle Ward	84.4%	51.0%	93.2%	74.8%	Eagle Ward had Norovirus so figures below 10% tolerance due to sickness and ward closure. Norovirus contained, ward cleaned to a high level and staff did not work elsewhere to help containment.	327	9.5	1.8	11.3	0						
	Kingfisher Ward	85.5%	27.7%	91.4%	-		205	8.9	2.0	10.9	0						
	Rainforest Ward (Gastro)	160.1%	40.5%	134.9%	46.9%	Kingfisher below 10% tolerance on day shifts for qualified staff due to moving to nights to cover short term sickness.	218	11.5	2.8	14.3	0						
	Rainforest Ward (Endo/Met)	137.0%	38.5%	88.9%	103.1%		230	10.5	2.8	13.3	0						
	Mildred Creak Unit	130.7%	76.4%	96.3%	60.4%		215	8.2	3.1	11.3	0						
	Koala Ward	102.2%	63.9%	84.0%	46.0%	Both Sky ward and Koala ward are a true reflection of the staffing requirements for these specialties. During the month of April fewer beds were closed on Sky ward, necessitating a greater number of staff, patient acuity was also greater on Sky ward. There is a slightly higher fill rate for days v nights, as fewer staff are required for the night shift, potentially due to increased discharges, cancellations etc.	595	10.4	0.7	11.0	0			1			
	Panther Ward	125.9%	116.2%	107.7%	-	Ward safely staffed	276	11.0	2.6	13.6	0						
	Sky Ward	114.3%	124.1%	91.5%	-	Ward safely staffed	363	9.3	2.4	11.7	2						
Panther Urology	225.2%	101.6%	132.3%	38.9%	Panther Urology had very complex Urological cases in April requiring 1:1 nursing and extra Bank spend demonstrating the above tolerance figures.	221	13.7	2.0	15.7	0							
Chameleon Ward	190.2%	99.5%	213.1%	77.3%	Ward safely staffed	328	12.0	1.7	13.7	0							

Trust Board 23 May 2018	
Staff Survey Results 2017 Update Submitted by: Ali Mohammed, Director of HR&OD	Paper No: Attachment 2
Aims / summary To update on action planning in response to the Staff Survey 2017 results	
Action required from the meeting A) To note the contents of the report and actions within the Trust Wide plan B) Approve the recommendation to move to a full census (all staff) with mixed methodology (online and paper questionnaire) approach to the 2018 survey.	
Contribution to the delivery of NHS / Trust strategies and plans Supports the CQC 'Well Led' Domain	
Financial implications None	
Who needs to be told about any decision? None	
Who is responsible for implementing the proposals / project and anticipated timescales Director of HR&OD	
Who is accountable for the implementation of the proposal / project Director of HR&OD	

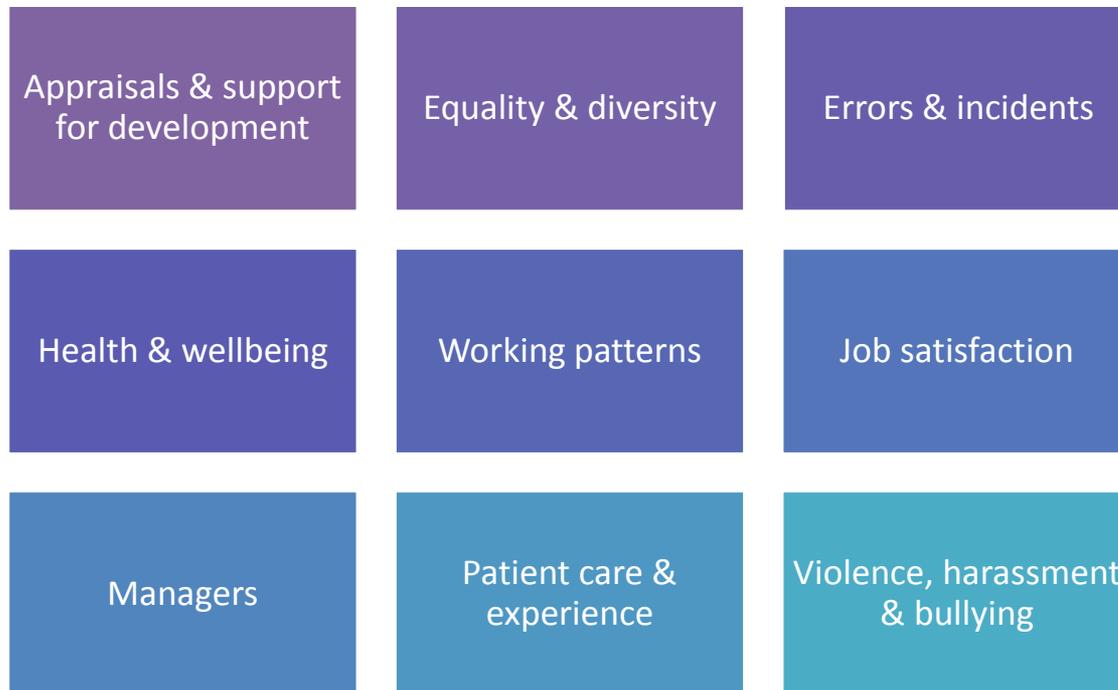


Staff Survey 2017 update

May 2018

Background

- Survey carried out autumn 2017 – random sample of 1,250 GOSH staff invited to take part.
- 536 responses received – 45.6% response rate (10.7% of total GOSH staff). Results published March 2018.
- The survey is grouped into 32 key findings (KF) across nine themes:



Results

When benchmarked against other Acute Specialists Trusts:



Better than average:
% of staff reporting most recent experience of harassment, bullying or abuse

- Worse than average & deteriorated:
- Effective team working
 - Recognition & value by managers and the org
 - Experiencing discrimination at work
 - Fairness & effectiveness of procedures for reporting errors, near misses and incidents
 - Confidence and security in reporting unsafe clinical practice
 - Feeling unwell due to work related stress

Results

When benchmarked against other Acute Specialists Trusts

5 most favourable key findings:



5 least favourable key findings:



Action Plans – Local

Divisions and directorates have been asked to identify top issues arising from their staff survey data, and produce plans to address these:

	Issues / Key findings	Actions
Charles West	<ul style="list-style-type: none"> • Communication between staff and senior managers • Physical violence from patients/relatives • Harassment, bullying or abuse from patients/relatives/public • Health and well being • Quality of appraisals 	<ul style="list-style-type: none"> • Management team walkarounds • Planned team talks – “meet the senior team” sessions • Clear communications of protocols re: abuse, violence • Debrief & shared learning for abuse/violence incidents • Conflict resolution and customer service training • Scenario based training for managers re: stressed staff • Appraisal skills training for managers
JM Barrie	<ul style="list-style-type: none"> • Support from immediate line managers • Communication between staff and senior managers • Recognition and value of staff by managers and org • Quality of appraisals 	<ul style="list-style-type: none"> • Increased 1-2-1 meetings (with templates to support) • Team meetings with standard items • Wider use / promotion of PRAISE • Training sessions on communication skills for managers • Senior team visits to wards / departments • Appraisal skills training for managers
Research & Innovation	<ul style="list-style-type: none"> • Support from immediate line managers • Communication between staff and senior managers • Physical violence from patients/relatives/public • Quality of appraisals 	<ul style="list-style-type: none"> • Map communication streams – review effectiveness, include as part of local induction • Agree key document cascade process • Raise awareness of reporting mechanisms for abuse violence, and dignity at work route maps • Appraisal skills training for managers

Action Plans – Local

	Issues / Key findings	Actions
Development & Property Services	<ul style="list-style-type: none"> Staff able to contribute to improvements at work Effective team working Staff agreeing their role makes a difference to patients 	<ul style="list-style-type: none"> Follow up refurbishment of porters rest room, follow up listening events Clarify team structure, escalation methods, information cascade routes Team huddles, information sharing events, divisional meeting
HR & OD	<ul style="list-style-type: none"> Communication between staff and senior managers Flexible working opportunities 	<ul style="list-style-type: none"> Refresh of team huddles, information sharing events, directorate meeting – structured brief back from senior team meetings Review agile and flexible working arrangements – develop directorate protocol
Planning, Performance & Information	To ensure anonymity no specific results are available for areas with less than 11 respondents. Despite 100% response rate – PPI did not meet 11 respondent threshold.	Continue actions from 2016/17 plan: <ul style="list-style-type: none"> Manager coaching sessions Directorate away day/planning sessions 360 degree appraisal for all team
Finance	To ensure anonymity no specific results are available for areas with less than 11 respondents. Despite 100% response rate – Finance did not meet 11 respondent threshold.	To obtain local data, a tailored survey monkey to go to whole Finance Directorate, to receive specific results and create an appropriate action plan
ICT	No plan provided	

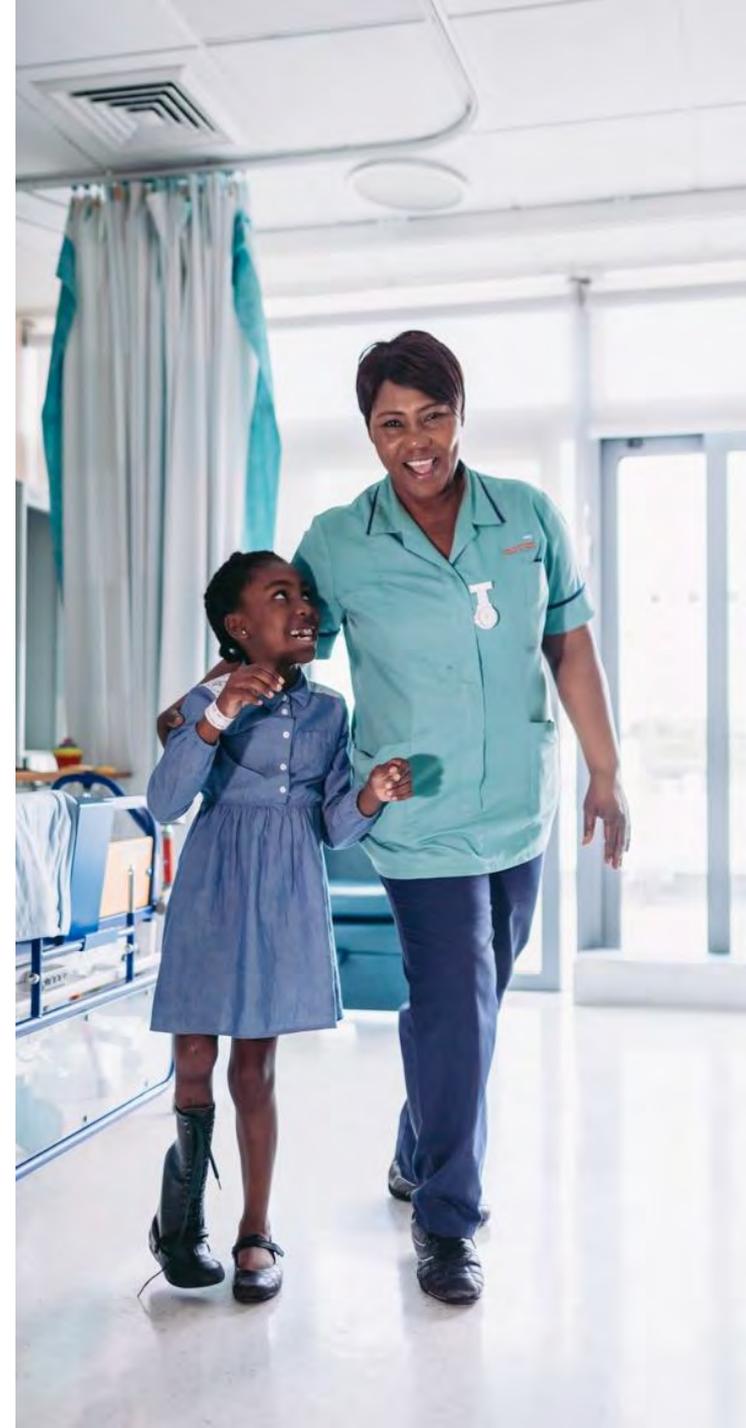
Trust wide action plan

Based on recurrent themes from local plans or from trust level data – a cross cutting action plan has been developed:

Theme	Key Finding	Actions
Errors & Incidents	<ul style="list-style-type: none"> • Witnessing potentially harmful errors, near misses, incidents • Reporting errors, near misses or incidents • Fairness and effectiveness of procedures for reporting errors, near misses and incidents • Staff confidence and security in reporting unsafe clinical practice 	<ul style="list-style-type: none"> • Implementation of Safety and Reliability Improvement Programme
Managers	<ul style="list-style-type: none"> • Recognition and value of staff by managers and the organisation • Good communication between senior managers and staff 	<ul style="list-style-type: none"> • Develop and promote instant recognition scheme, complementary to GEMS • Management development programme refreshed – focus on supportive, compassionate management and communication • Divisional restructure to include clear cascade and communication channels
Violence, Harassment & Bullying	<ul style="list-style-type: none"> • Experiencing harassment, bullying or abuse from staff 	<ul style="list-style-type: none"> • Refresh of trust provisions around harassment and bullying • Management development programme refreshed – focus on supportive, compassionate management skills, and addressing the bystander effect
Job Satisfaction	<ul style="list-style-type: none"> • Effective team working 	<ul style="list-style-type: none"> • Launch toolkit for teams to be produce Values based team charters • Effective teams management resources to be designed and launched
Appraisals and support for development	<ul style="list-style-type: none"> • Quality of appraisals 	<ul style="list-style-type: none"> • Refresh of PDR policy and forms • Refresh manager guidance and training on conducting constructive appraisal meetings

Planning ahead for 2018 survey

- Since inception of the NHS staff survey in 2003, GOSH has undertaken a sample (25% of staff invited to complete) – via paper questionnaires
- Many trusts conduct a full census, inviting all staff to complete, generating greater evidence base and allowing for more detailed (departmental level) analysis and targeted actions
- Online e-questionnaires are available, a change to mixed method (paper and online), and full census would support generation of greater evidence base
- Communication of actions taken as a result of staff survey feedback to be developed (“You said, We did”) to increase engagement



Trust Board May 2017	
Guardian of Safe Working report	Paper No: Attachment 3
Submitted by: Dr Renée McCulloch, Guardian of Safe Working	Appendix 1: Exception Report Work Plan
Aims / summary This report is the third report to the Board regarding Junior Doctor working practice at GOSH. This report covers the period March to April 2018 inclusive.	
Action required from the meeting The board is asked to note the report and the issues influencing junior doctor's working and the challenges in monitoring compliance with the TCS 2016.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Guardian of Safe Working supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.	
Financial implications Continuing payment for overtime hours documented through the exception reporting practice.	
Who needs to be told about any decision? n/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Renee McCulloch, Guardian of Safe Working Dr Sanjiv Sharma, Deputy Medical Director for Medical & Dental Education Sarah Ottaway, Head of Medical HR & PGME Services	
Who is accountable for the implementation of the proposal / project? Matthew Shaw, Medical Director	

**Trust Board Report
Guardian of Safe Working
May 2018**

1. Purpose

1.2. To inform the board on issues arising relating to the junior doctors 2016 contract and the work of the Guardian of Safe Working (GOSW).

1.3. The GOSW is directly accountable to the Trust Board.

2. Background

2.2. From 2nd October 2017, all junior doctors in training have transferred to the 2016 Terms & Conditions (TCS). There are 45 different rota patterns currently in place within the Trust.

2.3. The TCS clearly indicate the importance of appropriate working hours and attendance at training and education. Both issues have a direct effect on the quality and safety of patient care.

2.4. The role of 'Guardian of Safe Working' (GOSW) includes;

- overseeing the safeguards outlined in the 2016 contract
- ensuring that issues of compliance with safe working hours are addressed by the doctors and/or the employer
- facilitating the reporting structures
- supporting the wellbeing of the junior doctors.

2.5. Exception reporting is the contractually mandated mechanism used by doctors to inform the Trust when their day-to-day work varies significantly and/or regularly from the agreed work schedule of their post. The purpose of exception reports is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained.

2.6. Exception reporting is now fully established for ALL GOSH junior doctors (training doctors on the 2016 contract and Trust doctors on local TCS) from October 2017. GOSH is the only Trust in the country to have extended the implementation of exception reporting to all junior doctors.

- Number of Trust Doctors as of 30 April 2018 = 171
- Number of Training Doctors as of 30 April 2018 = 141

3. GOSH Junior Doctor Rotas

3.2. Rota design

All GOSH rotas are compliant with the 2016 TCS.

4. Rota Gaps

Significant issues arise with rota gaps (due to unfilled positions and sickness). Any gap puts pressure on the system.

4.2.As of the 30 April 2018 the following junior doctor posts were vacant:

Specialty	Rota grade	Rota establishment	Vacant posts	Vacancy rate %
Cardiology	SHO	7	1	14.2
Neurology	SHO	4	1	25
Orthopaedic Surgery	SHO	3	2	66.6
Urology	SHO	4	0	0
Plastic Surgery	SHO	3	2	66.6
ENT	SHO	2	1	50
Gastroenterology	SpR	5	0.4	8
Gastroenterology	SHO	3	1	33.3
Metabolic	SpR	3	1	33.3
Metabolic	SHO	2	1	50
Rheumatology	SpR	4	0.4	10
MEGGA 2	SpR	7	1	14
Immunology	SpR	6	1	17
PICU	SpR	16	2	32
ICON	SpR	8	4	50
ECMO	SpR	7	1	14
Cardiothoracic Surgery	SpR	8	4	50
International Private Patients	SpR	14	7	50

The overall vacancy rate across junior doctor rotas is 10.8% **with 30.8 FTE** vacant out of a total of 284 rota slots.

5. Exception Reports

5.2.The GOSW is required to regularly provide reports to Trust board regarding exception reporting.

5.3.The GOSW is providing quarterly reports to Heads of Clinical Service with anonymised data re ER

5.4.Numbers of ERs Jan to April 2018

Date:	Number of Exception reports:	Number of Episodes:	No closed / completed
Jan - April 2018	57	67	40

5.5.Exception Report Outcomes:

Exception Report Outcomes (Per Episode) Jan to April 18					
Compensation with payment	TOIL	No further action	Further information	Pending ES meeting	Level 1 review
21	12	4	1	*25	4
*All pending educational supervisors meetings are in progress (some have occurred but not been closed on system)					

5.6. Exception Report by Specialty and Grade

Exception reports Jan to April 2018 Details by specialty; grade and reason for ER				
Specialty	Rota grade		Exceptions relating to hours of work	Exceptions relating to educational opportunities
	SHO	SpR / Fellow		
Neurology	1	3	4	
HaemOnc	7		7	
CAMHS		2	2	
Cardiothoracic		1	1	
Endocrine		22	22	
Imm/ID		3	3	
IPP		13	13	
PICU/ NICU		1	1	
Respiratory		1		1
Neurosurgery		1		1
Surgery	2		2	
Total	10	47	55	2

5.7. Exception Report Themes

The predominant themes behind the extra hours being worked are:

5.7.1. Staying late to complete clinical duties

“Worked late due to busy ward, patient referred late in the afternoon requiring review the same day, need for ceiling of care discussions, cross covering reg in clinic, no sho’s on the ward all week, need to ensure adequate handover as not working the following day due to rota requirements for rest days, need to get through today”

5.7.2. Rota gaps putting pressure on time to complete daily workload or attend training opportunities

“Due to gaps on rota, was required to be on-call for ward/emergencies and to be in outpatient clinic at same time - all day. There were two emergency operations that would have provided good training opportunities for me. I was unable to attend theatre to assist/perform these operations under supervision, as I was required in the outpatient clinic.”

“Extra work required because of sickness and need to cover for colleagues. The requirement for Rota requires rest days with problems for continuity and clinical care so staying longer is justified. I would have given time off in lieu however at present because of rota gaps this is not possible”.

5.7.3. Dependencies / poor work flow systems

“Consult Consultant working in clinic therefore routine discussions can only occur after clinic. This is not an uncommon occurrence in my experience with different consultants, and it is difficult for the consultant to cover consults and clinic. In my opinion the consultant needs more time /pa/allowance for the fact they are covering, even if this just means that the first / last clinic slots do not have patients booked in, or more recognition of the time commitment required when a consultant is assigned to consult.”

“Clinics are heavily overbooked and do not finish on time. We discussed the educational element to the meeting after clinic and we both agree that this is a voluntary educational opportunity. However we need to ensure that clinics finish on time”.

All quotes from ERs Jan to April 2018.

5.8.Exception Reporting Work Plan

Please see Appendix 1

A GOSW ER work plan has been in place since January 2018 and has been further developed following a special ER focus meeting on April 19th 2018.

6. Speciality Focus

6.2.GOSW has **specifically raised the lack of an on call room for Urology middle grade rota as a safety risk**. The Trust is not obliged to provide an on call room to these doctors however the location of GOSH and the requirement to be within 30 minutes of GOSH for urgent surgical review/ procedures requires the doctors to stay on site. Urology is the only surgical speciality without an on call room available. Two doctors have repeatedly reported to the GOSW on several occasions that they have regularly slept on the floor of offices due to being unable to book rooms in the patient hotel. GOSW has escalated to management level on multiple occasions. The medical director is escalating this issue however it has now been an outstanding matter for six months.

6.3.GOSW has identified specific specialities that require further support and is working alongside the teams to improve rotas, examine work flow systems and processes and facilitate access to learning opportunities.

7. Locums - Bank and Agency use

7.2.Below is a breakdown of locum (Bank and agency) usage across junior doctor rotas, for the period 1 March 2018 to 30 April 2018.

Specialty	Number of Shifts	Cost
CAMHS Juniors	2	£593.18
Cardiology SHOs	11	£5,188.92
Cardiology SpRs	2	£770.25
Cardiothoracic SpRs	12	£12,978.50
CATS	25	£14,865.26
CICU	33	£23,353.01
Dermatology	2	£606.00
ENT SpRs	3	£473.50
Haematology/Oncology	49	£23,684.50
MEGGA	141	£54,319.52
Metabolics	5	£731.19
Neurology	15	£4,664.63
NeuroResp Nights	4	£2,676.50
Neurosurgery	38	£13,372.50
NICU PICU ICON	100	£75,393.90
Ortho Spinal SpRs	7	£2,496.60
Orthopaedics	1	£65.00
IPP	100	£45,816.13

Radiology Consultants	3	£748.65
Rheumatology	4	£1,242.74
Surgery SHOs	209	£79,053.67
Urology SpRs	2	£1,262.50
Total	768	£364,356.65

Of the 768 shifts covered as locums, 767 were covered by Doctors directly engaged via the GOSH in-house bank, with 1 shift covered by locums via agencies.

8. Trust Doctors

8.2. Plans to enable financial compensation through exception reporting for extra hours worked by Trust doctors have been agreed in principle by the LNC.

9. Compliance with 2016 TCS

The existing reporting system makes it impossible to determine whether doctors are working beyond the limits set out in schedule 3 of the 2016 TCS. Reasons for this are:

9.2. The GOSH survey from Jan 2018 found that of the 48% of GOSH junior doctors who completed the survey only 12% are working within their scheduled hours, with 19% and 38% working above their hours on a daily or weekly basis respectively. However only 13% of doctors surveyed have completed an exception report

9.3. Responsibility to work with the schedule 3 limits lies with the doctors. Many GOSH doctors are actively encouraged to work on bank shifts. Recording and assimilation of these extra bank hours in conjunction with scheduled working hours is not routine.

9.4. Analysis of data is extremely cumbersome. The existing Allocate software does not support longitudinal data collection comparison against individual doctor's working rotas. This has been fed back to the software designers who report that they are working on several of the issues raised by GOSH.

10. Fines and Payments

10.2. GOSW along with HR has ensured payment process for overtime compensation is streamlined.

10.3. No 'Higher' fines have been levied by GOSW against non-compliant departments. **This is not to say that all GOSH departments are compliant.** Unless the doctors report all their hours (including bank duties) on every shift across several weeks the GOSW cannot determine these breaches.

11. Junior Doctors' Forum

11.2. The JDF and DocsReps Committee have merged to form one representative group, maintaining the JDF title. It is anticipated that this merger will:

- Facilitate an effective voice for junior doctors at GOSH
- Ensure representation of Junior Doctors in an efficient way with best use of time and resource
- Enable GOSH to meet the terms and conditions of the 2016 Junior Doctor's Contract
- Guarantee that issues raised by junior doctors have a constructive and supportive senior forum that can assist in problem solving and project development.

12. Summary

- 12.1. Rotas are theoretically compliant at GOSH however rota gaps put pressure on departmental working practices and will directly affect compliance and safety in addition to education and training opportunities and satisfaction with working.
- 12.2. The exception reporting system in isolation cannot offer assurance of compliance with the 2016 contract.
- 12.3. Exception reports have increased and are being used appropriately and constructively. In general more doctors are using the system. However, overall the exception reporting system continues to be used by the minority and has many challenges with respect to implementation, efficiency and delivery.
- 12.4. All junior doctors, including Trust Fellows (non-training grades) can exception report at GOSH. Equal financial compensation for Trust doctors is expected to be finalised in the near future. GOSH is the only Trust nationally to implement this.
- 12.5. The GOSH experience regarding ER will continue to be communicated to external organisations. We hope to raise awareness of issues associated with ER and aim to influence national policy.
- 12.6. The lack of an on call room for the Urology Middle Grade Rota has been raised by GOSW as a significant safety concern.
- 12.7. The new format junior doctor's forum is ratified and underway.
- 12.8. GOSW is continuing to work to support the junior doctors at GOSH.

Appendix 1: Guardian of Safe Working; Exception Reporting Work Plan as of May 2018

	Objective	Outcome	Timescale	Lead	Status (completion date)
1	ER Survey	Aim for 50% response rate	End of Jan 2018	RM/ EP /JP /SS	Jan 2018
2	RCPCH Presentation	National feedback/ representation/ benchmark	March	GM/ RD/ EP/ RM /VC	Match 2018
3	Communicate a) Survey results b) Action plan	a) JDs/ Executive team/ Trust Board/ PGME committee/Ed Supers b) Whole medical workforce	End of April End of May	RM	a) April 2018
4	JDF ER themed meetings	March JDF/ April meeting	April	RM	April 2018
5	Feedback to Allocate	Arrange meeting; software development support	June	VC/ RM	
6	Trust Doctors	Policy to ER Equal remuneration	July	LNC/ VC/ RM// SS	
7	Training for JDF reps	Establish formal training for Reps to enable supportive leadership role	July	RM/ PGME	
8	Internal Communications	Web site/ Trust notifications	July	RM/ PGME	
9		RCPCH training committee	August	JDs	

Appendix 1: Guardian of Safe Working; Exception Reporting Work Plan as of May 2018

	External Communications	presentation/ BMA GOSW London		GM/ RD/ RM	
10	Departmental meetings and support; quarterly divisional report	Updates and Feedback	August	RM /VC /PS /JP/ SS	
11	Rest facilities review	Audit GOSH facilities against national standard	July		
12	Behavioural management work plan		September	RM /MS	
13	Work Flow Review for JDs		December	RM/ MS/ VC /HR All departments	

KEY:	Achieved	In progress	Yet to commence
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