# Meeting of the Trust Board
# Tuesday 26 May 2020

Dear Members

There will be a public meeting of the Trust Board on Tuesday 26 May 2020 at 2:10pm by video conferencing.

Company Secretary Direct Line: 020 7813 8230

## AGENDA

| | Agenda Item<br>STANDARD ITEMS | Presented by | Attachment | Timing |
|---|---|---|---|---|
| 1. | **Apologies for absence** | Chair | **Verbal** | **2:10pm** |
| **Declarations of Interest**<br>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 1 April 2020** | Chair | **I** | **2:15pm** |
| 3. | **Matters Arising/ Action Checklist** | Chair | **J** | |
| 4. | **Chief Executive Update** | Chief Executive | **K** | **2:20pm** |
| | **ANNUAL REPORT AND ACCOUNTS** | | | |
| 5. | **GOSH Foundation Trust Annual Financial Accounts 2019/20 and Annual Report 2019/20 Including:**<br>○ **the Annual Governance Statement**<br>○ **the Audit Committee Annual Report**<br>○ **Draft Head of Internal Audit Opinion**<br>○ **Draft Representation Letter** | Chief Finance Officer<br>Company Secretary<br><br>Audit Committee Chair | **Li and Lii**<br><br>**Liii** | **2:30pm** |
| 6. | **Compliance with the Code of Governance 2019/20** | Company Secretary | **M** | **2:45pm** |
| 7. | **Compliance with the NHS provider licence – self assessment 2019/20** | Company Secretary | **N** | **2:50pm** |
| 8. | **Draft Quality Report 2019/20** | Medical Director | **O** | **2:55pm** |
| | **STRATEGY and RISK** | | | |
| 9. | **CQC Always Improving Update** | Medical Director | **P** | **3:05pm** |
| 10. | **Safety Strategy** | Medical Director | **Q** | **3:15pm** |
| 11. | **Quality Strategy** | Medical Director | **R** | **3:25pm** |
| | **PERFORMANCE** | | | |

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| **12.** | **Integrated Quality and Performance Report – Month 1 2020/21**<br><br>**Update on Data Kite Marking for Board Reports** | Medical Director/ Chief Nurse/ Interim Chief Operating Officer<br>Interim Chief Operating Officer | **S**<br><br>**7** | **3:35pm** |
| **13.** | **Month 1 2020/21 Finance Report** | Chief Finance Officer | **T** | **3:50pm** |
| **14.** | **Learning from Deaths Mortality Review Group - Report of deaths in Q2 and Q3 2019/2020** | Medical Director | **U** | **4:00pm** |
| **15.** | **Safe Nurse Staffing Report (April 2020)** | Chief Nurse | **V** | **4:10pm** |
| | **ASSURANCE** | | | |
| **16.** | **Annual Reports**<br>• **Annual Freedom to Speak Up Report 2019/20**<br>• **Annual Health and Safety and Fire Report 2019/20**<br>• **Gender Pay Gap Report 2019/20**<br>• **Guardian of Safe Working Annual Report 2019/20** | Freedom to Speak Up Guardian<br>Director of HR and OD<br>Director of HR and OD<br>Medical Director | **W**<br>**X**<br>**Y**<br>**Z** | **4:20pm** |
| **17.** | **Board Assurance Committee reports**<br>• **Audit Committee update – April 2020 meeting and May 2019 (verbal)**<br>• **Quality, Safety and Experience Assurance Committee update – April 2020 meeting**<br>• **Finance and Investment Committee Update –March 2020**<br>• **People and Education Assurance Committee – February 2020** | Chair of the Audit Committee<br>Chair of the Quality and Safety Assurance Committee<br>Chair of the Finance and Investment Committee<br>Chair of People and Education Assurance Committee | **1**<br>**2**<br>**3**<br>**4** | **4:40pm** |
| **18.** | **Council of Governors' Update – April 2020** | Chair/ Company Secretary | **5** | **4:55pm** |
| | **GOVERNANCE** | | | |
| **19.** | **Declaration of Interest Register** | Company Secretary | **6** | **5:00pm** |
| **20.** | **Any Other Business**<br>(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.) | | | **5:05pm** |
| **21.** | **Next meeting**<br>The next confidential Trust Board meeting will be held on Wednesday 15 July 2020 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH. | | | |

**DRAFT Minutes of the meeting of Trust Board on 1st April 2020**

**Present**

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| Sir Michael Rake | Chair |
| Lady Amanda Ellingworth | Non-Executive Director |
| James Hatchley | Non-Executive Director |
| Chris Kennedy | Non-Executive Director |
| Kathryn Ludlow | Non-Executive Director |
| Akhter Mateen | Non-Executive Director |
| Prof Rosalind Smyth | Non-Executive Director |
| Sanjiv Sharma | Medical Director |
| Professor Alison Robertson | Chief Nurse |
| Helen Jameson | Chief Finance Officer |
| Caroline Anderson | Director of HR and OD |

**In attendance**

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| Cymbeline Moore | Director of Communications |
| Dr Shankar Sridharan | Chief Clinical Information Officer |
| Stephanie Williamson | Interim Director of Built Environment |
| Peter Hyland | Director of Operational Performance and Information |
| Richard Collins | Director of Transformation |
| Anna Ferrant | Company Secretary |
| Victoria Goddard | Trust Board Administrator (minutes) |

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

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| **9** | **Apologies for absence** |
| 9.1 | Apologies for absence were received from Matthew Shaw, Chief Executive and Phillip Walmsley, Interim Chief Operating Officer. It was noted that Alison Robertson was acting Chief Executive during this time and Peter Hyland was in attendance in Phillip Walmsley's stead. |
| **10** | **Declarations of Interest** |
| 10.1 | No declarations of interest were received. |
| **11** | **Minutes of Meeting held on 6 February 2020** |
| 11.1 | The Board **approved** the minutes of the previous meeting. |
| **12** | **Matters Arising/ Action Checklist** |
| 12.1 | Actions take since the last meeting were noted. |
| **13** | **Integrated Quality and Performance Update Report –February 2020** |

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| 13.1 | The Board discussed theatre utilisation and it was noted that the optimum rate for GOSH was 77% reflecting the Trust's complexity. Other Trusts were able to use day cases to complete lists however this was not possible due to GOSH's complex paediatric population. |
| 13.2 | Epic was being used for the newly transferred patients and GOSH had been the only Trust so far which had been able to integrate the output of virtual meetings directly into the records system. Dr Shankar Sridharan, Chief Clinical Information Officer said that Epic had played a key part in the Trust's ability to adapt at speed and good feedback was being received from clinicians. Good work had taken place with pharmacy and improvements had been made in the way that Epic could be used in the service. Richard Collins, Director of Transformation said that work taking place to reprioritise Epic activity would have an impact on the optimisation phase of the programme. |
| 13.3 | Kathryn Ludlow, Non-Executive Director asked whether reporting would continue to take place in the same way. Alison Robertson, Chief Nurse confirmed that Friends and Family Test returns had been suspended from 1st April and GOSH was reviewing existing feedback and ensuring that responses were provided to families. Complaint deadlines could also be paused and the team would be reviewing the status of all existing complaints to ascertain whether information to close them could be made available. Those which could be closed would be and new complaints would be reviewed as they were received and where teams did not have capacity to undertake investigations and provide information families would be informed. Peter Hyland said that Trusts continued to be required to make monthly performance submissions on diagnostic waits, RTT and cancer performance and monitoring was on-going however any fines for non-compliance had been paused. |
| 13.4 | Sanjiv Sharma, Medical Director emphasised the importance of continuing to adhere to safety processes and reporting and said that it was vital to continue learning lessons during this time. James Hatchley, Non-Executive Director asked how staff from other Trusts who had come to GOSH would become aware of these policies and Sanjiv Sharma confirmed that a robust on-boarding process had taken place. |
| 13.5 | Peter Hyland said that teams had worked hard to considerably reduce the number of 52 week waiting patients to nine, of which seven had chosen to wait and the remaining two were complex, however this would be significantly impacted by COVID-19. |
| **14** | **Finance Update –February 2020 (Including National Cost Collection Presubmission update)** |
| 14.1 | Helen Jameson, Chief Finance Officer said that the year to date position was £0.9million favourable to control total with NHS and other clinical income on plan in month. Passthrough was £1.8milion above plan as a result of new drugs approved in year. IPP income was £0.2million lower than plan as a result of lower activity driving the IPP income year to date being below plan by £4million. |
| 14.2 | James Hatchley asked how the auditors would approach their work on the accounts and Helen Jameson said she had reviewed the key areas of concern with Deloitte who were satisfied that most information could be shared through Microsoft Teams. Concerns had been raised around the stock take as they could not be physically present although a plan was in place to undertake this in all but |

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| | two areas by 3rd April. Concern had also been raised around the valuation of land and buildings and it was likely that a statement would be made around the inability to guarantee the accuracy of the valuation. In this case the GOSH's accounts would be qualified along with those of other Trusts. |
| 14.3 | Discussion had taken place with Deloitte and GOSH would continue to work to the original timescales despite these having been delayed. |
| 14.4 | The Board reviewed and **approved** the approach to national cost collection for 2019/20 and agreed to delegate authority to the Chief Finance Officer in conjunction with the Executive Team to approve the return. |
| **15** | **Safe Nurse Staffing Report (December and January 2020)** |
| 15.1 | Alison Robertson said that the Nursing Workforce Assurance Group, which had begun to validate nursing workforce data, had been paused as a result of the work required for COVID-19. She confirmed that the Trust had operated within the recommended parameters for staffing levels in December 2019 and January 2020. She highlighted that going forward there would be a change in the data from which vacancies would be calculated and HR data would be used rather than finance which may lead to an initial change in the vacancy rate reported. |
| 15.2 | Kathryn Ludlow asked whether the Trust still planned to move forward with international nurse recruitment and Alison Robertson confirmed that this would continue and added that there were 6 nurses scheduled to fly to the UK in April however this was no longer possible and was being kept under review. |
| **16** | **2020-21 Budget Sign off** |
| 16.1 | Helen Jameson said that due to COVID-19 the operational planning process had been suspended and changes were being made to the way in which funding would be provided to NHS Trusts in 2020/21. Contract negotiations had not been finalised prior to this suspension. |
| 16.2 | The paper had been recommended for approval by the Finance and Investment Committee and was based on the assumption that the level of income required would be received. |
| 16.3 | The Board **approved** the budget and capital plan. |
| **17** | **Improving the experience of children, young people and families visiting Great Ormond Street Hospital during 2019: Meeting the duties of the Equality Act 2010** |
| 17.1 | Alison Robertson said that the Trust was required to demonstrate the ways in which it complied with the Equality Act. Amanda Ellingworth, Non-Executive Director noted that the paper would be published on the website and said she felt that it was more descriptive of the activity that had taken place rather than the outcomes and impact of the work. Alison Robertson agreed that work was required to refresh objectives and set measureable goals however unfortunately this work has been paused until the Family Equality and Diversity Group was able to meet. |

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| **18** | **Any other business** |
| 18.1 | James Hatchley asked whether the Executive Team was satisfied that that the Trust had access to adequate levels of personal protective equipment (PPE) and that it was being used appropriately. Alison Robertson said that there was anxiety amongst staff around the availability of PPE however GOSH's policy was in excess of the Government guidance in this area. The next all staff briefing would focus on the way staff were being protected. It was confirmed that although there had been some initial national issues with procurement and delivery of PPE, the Trust did have sufficient supplies to comply with existing guidance. |
| 18.2 | Sir Michael Rake, Chair thanked the Executive Team for their work under challenging circumstances. |

Attachment J

**TRUST BOARD – PUBLIC ACTION CHECKLIST**
**May 2020**

| Paragraph Number | Date of Meeting | Issue | Assigned To | Required By | Action Taken |
|---|---|---|---|---|---|
| 228.6 | 06/02/20 | Prof Alison Robertson, Chief Nurse said that there had been a change in guidance for Friend and Family Tests and it was agreed that a briefing would be provided at the next meeting. | AR | April 2020 | Actioned in February and March 2020 Integrated Quality and Performance Report |
| 228.7 | 06/02/20 | It was agreed that a view on data quality for the metrics provided in the Integrated Quality and Performance Report would be provided in the next report. | PW | April 2020 | On agenda |

Attachment K

Great Ormond Street Hospital for Children
NHS Foundation Trust

| Trust Board<br>26 May 2020 | |
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| **Chief Executive Update**<br><br>**Submitted by:**<br>Matthew Shaw, Chief Executive | **Paper No: Attachment K** |
| **Aims / summary**<br>Update on key operational and strategic issues. | |
| **Action required from the meeting**<br>For noting. | |
| **Contribution to the delivery of NHS Foundation Trust strategies and plans**<br>• Compliance with CQC Well-Led framework<br>• Delivery of trust strategy<br>• Delivery of Project Rainbow (GOSH recovery & service restoration strategy) | |
| **Financial implications**<br>• None (business as usual) | |
| **Who needs to be told about any decision?**<br>Not applicable | |
| **Who is responsible for implementing the proposals / project and anticipated timescales?**<br>CEO and executive colleagues | |
| **Who is accountable for the implementation of the proposal / project?**<br>CEO | |

## Part 1: COVID-19 response

### 1.1 Health system response - work with partners and stakeholders

During the early response to the pandemic GOSH has broadened its focus on advancing care for children and young people with complex health needs to play a broader role in supporting the local care system to deal with the public health emergency.

In response to the NHS crisis we have paused non-urgent activity, shifted the majority of outpatient activity to virtual and accommodated patients who would normally be seen in other hospitals – including all the acute inpatient beds for children in the North Central London (NCL) Sustainability and Transformation Partnership.

We have also had to dramatically scale up our activities to support adult healthcare, provide staff and family testing, an extensive set of staff health and wellbeing services, support to establish the first Nightingale field hospital, training to upskill critical care staff and deployment of our staff to other hospitals.

To support the local care system we have worked closely with our NHS partners, in particular the North Central London (NCL) Sustainability and Transformation Partnership. I have taken the lead for two work streams:

- The NCL ITU Expansion Group, which devised the plan for the first Nightingale field Hospital and was able to significantly expand ITU capacity.
- The Operational Implementation for reinstating services across NCL, which is developing a coherent, logical plan, the success of which largely depends on the availability of PPE and drugs.

As the Board is aware, we have received great feedback from our London partners around the contribution we have made towards dealing with the public health emergency.
In planning for recovery across NCL and London partners recognise that service resilience is more important than ever and we are actively advocating for any service redesign – whether temporary or permanent – to place the needs of children and young people at the forefront.

An STP-led project has been instigated by NHSE out of the conversations to redefine what the new normal will be in relation to paediatric care, exploring what the best emergency model and elective models should look like. We are actively participating in these discussions to help ensure services are as resilient as possible going into a second wave, that access for children in NCL is improved and that they are not disadvantaged in the response to (and recovery from) a pandemic which largely affects the adult population.

### 1.2 GOSH Operational Response and Project Rainbow (recovery strategy)

To address the public health emergency the organisation implemented an incident management command and control structure in early March. To expedite the emergency response, we put strategic programmes of work on hold and cancelled the launch of the new Above and Beyond strategy.

In April we re-established many key strategic meetings virtually and created a Restoration Strategy Delivery Group to plan for recovery and a Clinical Prioritisation Group to ensure our decision-making is clinically appropriate. We have called our recovery and service restoration strategy Project Rainbow and we will discuss the emerging approach in our confidential session.

We hope this will give the Board assurance that we are actively managing the Covid response (which will naturally dominate our activities some considerable time to come), while also pushing forward our strategic objectives.

### 1.3 Internal Performance

The Covid crisis has naturally had a significant impact on key performance metrics including waiting times and diagnostic performance. I am satisfied that we are starting to see some improvements and fully acknowledge that there is a great deal outside of our control. However, we now have some work to do as an Executive team to identify what we can influence and improve and what our priorities are going to be in this new operating environment. I am expecting to see more focus on internal metrics such as discharge summaries and clinical letters.

The crisis has brought to the fore several issues around internal audit reports, data quality, data strategy and ICT resilience and we have not made the improvements that we should have done in the last six months. To address this we have brought forward the appointment of a Chief Data Officer to improve assurance around managing data quality and address data infrastructure. We will also look to appoint a senior Information Governance lead. Both these roles are being advertised and we will be looking at how best to structure our informatics and analytics functions going forwards.

### 1.4 Post-Covid Financial position

The financial support made available through NHS England during recent weeks has been essential to enable the Trust to make the right decisions in response to the Covid pandemic to protect staff, patients and families. Going forwards, there is an awful lot of uncertainty with regards to our financial position. We are not yet clear on the settlement position and how this will play into our month-to-month finances. Our CFO and her team are working hard to help us develop some visibility of our baseline income month-by-month as we work to a new steady state. Naturally, this is extremely challenging as it is not yet clear how quickly we will be able to restore services, what support our NHS partners will need from us to recover things for children and young people in the region, and how quickly our research and international private patient activity will be able to recover.

In addition, there is some uncertainty around what our capacity will be within this radically different operating environment. Large parts of the workforce will continue to experience issues with coming back to work and we will have to comply with tight infection control restrictions that will limit our use of space and productivity. For example, efficiency losses in theatres and scanning will potentially result in a decrease in activity per unit time of 20-50%. Our operational teams are actively considering new ways of working to ensure we can care for as many patients as possible, including extended opening hours.

As we work this through over the next couple of weeks, the capacity and demand mismatch will become clearer and we may need to consider solutions such as partnering with the private sector to help meet the gap in diagnostic capacity.

## Part 2: People

### 2.1 Recognising the efforts of teams and progress with the People Strategy

During the Covid crisis, we have really turbo-charged many of the aspects of our People Strategy – fast-tracking a comprehensive health and wellbeing support offer and providing support to help them cope with operational and logistical challenges and the emotional toll of a turbulent few weeks.

We have had some real success in how we have communicated with staff and received some really positive feedback with regards to communications, which I have passed on to the communications team.

I also want to recognise the hard work of the whole executive team, all our senior management and lots of wonderful teams including PALs, the new multi-professional health and wellbeing group, those distributing staff food and gifts and, of course, our frontline clinical staff, cleaners and porters.

So many of our colleagues have been inspirational in their courage, commitment and energy to be visible, to reach out and to support each other and to care for our patients and families. And they have done all of this while managing the fear, uncertainty, personal discomfort, grief and loss that has affected so many of us during this time. We are now working on how best to maintain support as we move forward into the next period.

### 2.2 Welcome to Professor Viner

We are delighted to welcome Professor Russell Viner to the Trust Board as a non-executive director. As paediatrician, Professor of Adolescent Health at the UCL GOSH Institute of Child Health and President of the Royal College of Paediatrics and Child Health, Russell is a skilled and passionate advocate for children and young people. We are excited to work more closely with Russell in the months to come – his advice and oversight will be tremendously valuable.

## Part 3: Service quality

### 3.1 Mental health service provision

To support services across North Central London in the wake of the pandemic, the Board will be aware that GOSH took on mental health services for children who have been sectioned or are in great distress, while they await tier 4 beds.

As part of our due diligence around this the trust has commissioned and received a report from the Tavistock and Portman NHS Foundation Trust on the quality of care that GOSH is provided for these patients. I am pleased that the report concluded that these services are of a high standard and commended the Trust for the speed at which we made these services available. Some recommendations to further improve safety of staff have been immediately acted upon and we are undertaking further risk assessments in line with the findings.

### 3.2 Pharmacy

Our pharmacy services are currently being inspected by the MHRA and we hope to be in a position to provide a verbal update at the meeting.

## Part 4: Partnerships

### 4.1 Great Ormond Street Hospital Children's Charity

I continue to enjoy a close working relationship with the charity's CEO Louise Parkes and an active role on the charity's assurance committees. I want to say a big thank you to them for their extraordinary efforts to support hospital staff and families through an extremely challenging period, and in maintaining so many of their core activities in spite of the requirement to switch to a virtual business model.

We are working in tandem with the charity to assess impacts and progress plans for our Children's Cancer Centre and expect to receive the RIBA Stage 2 designs in June.

### 4.2 Federation of Specialist Hospitals, UK Children's Hospitals Alliance and the European Children's Hospitals Organisation (ECHO)

Although formal meetings are in abeyance we have continued to participate in discussions with the other children's hospitals throughout the epidemic to share learning and information and to collaborate on ongoing work on paediatric tariffs. The Federation of Specialist Hospitals has just started work to draw together members' reflections so they can reset their annual work plan and we are progressing several other pieces of work with the alliance and ECHO.

We remain committed to shaping these alliances, encouraging more focused and formalised streams of work and will assess our progress and objectives as we review and reframe our partnerships strategy in the Autumn.

### 4.3 Risky Business

Our DRIVE team is working with our Risky Business partners and support from the BMJ, Medical Protection Society, Zoom and Slido to run a three hour online learning event on 2 June 2020 entitled 'Lessons from Covid 19 – making sense of the pandemic'.

Speakers include GOSH clinicians and Don Berwick (Health Advisor to President Obama and the founder of the Institute for Healthcare Improvement) who will give his insights into how COVID might change global healthcare. Board members who wish to register can obtain their unique joining code by emailing bookings@riskybusiness.events.

**Ends**

Great Ormond Street Hospital for Children NHS Foundation Trust

**Trust Board**
**26 May 2020**

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| **GOSH Foundation Trust Annual Financial Accounts 2019/20 and Annual Report 2019/20**<br>**Submitted by:**<br>Helen Jameson, Chief Finance Officer<br>Anna Ferrant, Company Secretary | **Paper No:** Attachment L |

**Aims / summary**

The Trust is required to publish a Foundation Trust annual report and accounts for 2019/20. Board members will find attached the following documents:

- A copy of the annual accounts 2019/20;
- A copy of the annual report 2019/20 incorporating:
  - the Audit Committee Report 2019/20 including the going concern statement
  - the draft Head of Internal Audit Opinion
  - the Annual Governance Statement.

The annual report will be desk top published once approved by the Trust Board. The report has been audited and any final changes arising from the audit will be raised verbally at the meeting. .

A copy of the representation letter to Deloitte, the external auditor is also attached (Attachment Liii). 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.

The Audit Committee will consider the annual accounts, report and representation letter at its meeting in the morning of 26 May 2020 and will provide any comments raised at the meeting to the Trust Board that afternoon.

The annual report and accounts will be submitted to NHS Improvement by **end May 2020** and then submitted to the Department of Health and Social Care.

**Action required from the meeting**

To consider and approve the annual accounts and report 2019/20.

**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.

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| **Who needs to be told about any decision**<br>The Company Secretary will feed back any actions required to relevant staff. |
| **Who is responsible for implementing the proposals / project and anticipated timescales**<br>The Company Secretary is leading the coordination of the Annual Report. |
| **Who is accountable for the implementation of the proposal / project**<br>The Chief Executive Officer is ultimately accountable for production and publication of the Annual Report. |

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| Trust name: | Great Ormond Street Hospital for Children NHS Foundation Trust |
| This year | 2019/20 |
| Last year | 2018/19 |
| This year ended | 31 March 2020 |
| Last year ended | 31 March 2019 |
| This year beginning | 1 April 2019 |

**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

Matthew Shaw
Chief Executive
Date: xx May 2020

## 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 2020 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

Matthew Shaw
Chief Executive
Date: xx May 2020

**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2020**

| | NOTE | **Year ended 31 March 2020 £000** | Year ended 31 March 2019 £000 |
|---|---|---|---|
| Operating income from patient care activities | 2 | **450,234** | 415,765 |
| Other operating income | 3 | **99,974** | 104,634 |
| Operating expenses | 4 | **(526,494)** | (482,160) |
| **Operating surplus** | | **23,714** | 38,239 |
| | | | |
| **Finance costs:** | | | |
| Finance income | 9 | **456** | 369 |
| Finance expenses | 10 | **(18)** | (11) |
| Public dividend capital dividends payable | | **(8,398)** | (7,799) |
| **Net finance costs** | | **(7,960)** | (7,441) |
| Gains on disposal of assets | | **9** | 28 |
| **Surplus for the year** | | **15,763** | 30,826 |
| | | | |
| **Other comprehensive income** | | | |
| **Will not be reclassified to income and expenditure:** | | | |
| - Impairments | 7 | **(4,841)** | (150) |
| - Revaluations - property, plant, equipment and intangible assets | 20 | **28,064** | 10,169 |
| **Total comprehensive income for the year** | | **38,986** | 40,845 |

| | | | |
|---|---|---|---|
| **Financial performance for the year - additional reporting measures** | | | |
| Retained surplus for the year | | **15,763** | 30,826 |
| Adjustments in respect of capital donations | 3 | **(31,220)** | (32,780) |
| Adjustments in respect of impairments | 4 | **6,994** | 7,939 |
| **Adjusted retained (deficit)/surplus** | | **(8,463)** | 5,985 |

The notes on pages 5 to 33 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 2020

| | NOTE | **31 March 2020** **£000** | 31 March 2019 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 11 | **38,195** | 30,830 |
| Property, plant and equipment | 12 | **498,051** | 461,929 |
| Trade and other receivables | 15 | **7,621** | 6,267 |
| **Total non-current assets** | | **543,867** | 499,026 |
| **Current assets** | | | |
| Inventories | 14 | **11,144** | 10,033 |
| Trade and other receivables | 15 | **104,071** | 93,849 |
| Cash and cash equivalents | 16 | **61,314** | 48,606 |
| **Total current assets** | | **176,529** | 152,488 |
| **Total assets** | | **720,396** | 651,514 |
| **Current liabilities** | | | |
| Trade and other payables | 17 | **(95,157)** | (68,879) |
| Provisions | 19 | **(147)** | (299) |
| Other liabilities | 18 | **(7,012)** | (5,827) |
| **Net current assets** | | **74,213** | 77,483 |
| **Total assets less current liabilities** | | **618,080** | 576,509 |
| **Non-current liabilities** | | | |
| Provisions | 19 | **(2,747)** | (695) |
| Other liabilities | 18 | **(4,016)** | (4,512) |
| **Total assets employed** | | **611,317** | 571,302 |
| | | | |
| **Financed by taxpayers' equity:** | | | |
| Public dividend capital | | **129,321** | 128,292 |
| Income and expenditure reserve | | **356,197** | 340,434 |
| Revaluation reserve | | **125,799** | 102,576 |
| **Total taxpayers' equity** | | **611,317** | 571,302 |

The financial statements on pages 1 to 33 were approved by the Board and authorised for issue on xx May 2020 and signed on its behalf by:

Matthew Shaw
Chief Executive

Signed:……..
Date: xx May 2020

## STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2020

| | Public Dividend Capital (PDC) | Revaluation reserve | Income and expenditure reserve | Other reserves | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Balance at 1 April 2019** | 128,292 | 102,576 | 340,434 | 0 | **571,302** |
| **Changes in taxpayers' equity for the year ended 31 March 2020** | | | | | |
| -Surplus for the year | 0 | 0 | 15,763 | 0 | **15,763** |
| - Net impairments | 0 | (4,841) | 0 | 0 | **(4,841)** |
| - Revaluations - property, plant and equipment | 0 | 27,593 | 0 | 0 | **27,593** |
| - Revaluations - intangible assets | 0 | 471 | 0 | 0 | **471** |
| - Public Dividend Capital received | 1,029 | 0 | 0 | 0 | **1,029** |
| **Balance at 31 March 2020** | **129,321** | **125,799** | **356,197** | **0** | **611,317** |

## STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2019

| | Public Dividend Capital (PDC) | Revaluation reserve | Income and expenditure reserve | Other reserves | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Balance at 1 April 2018** | 127,280 | 92,557 | 306,494 | 3,114 | **529,445** |
| **Changes in taxpayers' equity for the year ended 31 March 2019** | | | | | |
| -Surplus for the year | 0 | 0 | 30,826 | 0 | **30,826** |
| -Transfers between reserves | 0 | 0 | 3,114 | (3,114) | **0** |
| -Net Impairments | 0 | (150) | 0 | 0 | **(150)** |
| -Revaluations - property, plant and equipment | 0 | 10,054 | 0 | 0 | **10,054** |
| - Transfer to retained earnings on disposal of assets | 0 | 115 | 0 | 0 | **115** |
| - Public Dividend Capital received | 1,012 | 0 | 0 | 0 | **1,012** |
| **Balance at 31 March 2019** | **128,292** | **102,576** | **340,434** | **0** | **571,302** |

## STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2020

| | NOTE | Year ended 31 March 2020 £000 | Year ended 31 March 2019 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| **Operating surplus** | | **23,714** | 38,239 |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | | **24,574** | 20,672 |
| Net Impairments | | **6,994** | 7,939 |
| Income recognised in respect of capital donations (cash and non-cash) | | **(31,220)** | (32,780) |
| Increase in trade and other receivables | | **(9,381)** | (14,827) |
| Increase in inventories | | **(1,111)** | (1,180) |
| Increase in trade and other payables | | **22,668** | 4,845 |
| Increase/(decrease) in other liabilities | | **689** | (533) |
| Increase/(decrease) in provisions | | **1,882** | (1,249) |
| **NET CASH GENERATED FROM/(USED IN) OPERATIONS** | | **38,809** | 21,126 |
| **Cash flows from investing activities** | | | |
| Interest received | | **426** | 369 |
| Purchase of property, plant and equipment | | **(37,430)** | (32,976) |
| Purchase of intangible assets | | **(10,856)** | (19,536) |
| Sales of property, plant and equipment | | **22** | 28 |
| Receipt of cash donations to purchase capital assets | | **29,055** | 30,611 |
| **Net cash outflow from investing activities** | | **(18,783)** | (21,504) |
| **NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING** | | **20,026** | (378) |
| **Cash flows from financing** | | | |
| Public Dividend Capital received | | **1,029** | 1,012 |
| PDC dividend paid | | **(8,347)** | (7,723) |
| **Net cash outflow from financing** | | **(7,318)** | (6,711) |
| **NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS** | | **12,708** | (7,089) |
| **Cash and cash equivalents at start of the year** | | **48,606** | 55,695 |
| **Cash and cash equivalents at end of the year** | 16 | **61,314** | 48,606 |

# NOTES TO THE ACCOUNTS

## 1. Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

### 1.1 Accounting convention

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

### 1.2 Going concern

International Accounting Standard (IAS)1 requires management to assess, as part of the accounts preparation process, the Foundation Trust's ability to continue as a going concern for the foreseeable future. IAS 1 deems the foreseeable future to be a period of not less than twelve months from the entity's reporting date. After making enquiries, (these are described in the Strategic Report section of 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 review the financial position of the Foundation Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process implies a single operating segment under IFRS 8.

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

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

### 1.4 Critical accounting judgments and key sources of estimation uncertainty

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

### 1.5 Critical judgments in applying accounting policies

The following are the critical judgements, 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) IAS 38 specifies that an intangible asset is complete and subject to amortisation at the date the asset is available for use, i.e. when is it is in the location and condition necessary for it to be capable of operating in the manner intended by management. The Epic EPR system is undergoing development and is carried as an incomplete asset at 31 March 2020, based on the conclusion of a Trust Board sub-committee which reviews the evidence of completeness each month.

The Trust tests all intangible assets not yet brought into use for indications of impairment annually, in accordance with the requirements of IAS36, and as referred to in Note 11.2. A review was conducted in March 2020 using a methodology developed for the 2018/19 accounts.
The impairment test involves a review of each constituent activity of each incomplete intangible asset, and an impairment is indicated if the actual costs incurred are materially greater than the costs which would be incurred under current conditions and knowledge.

c) 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 Foundation Trust.

b. The useful economic life of each category of fixed asset is assessed when acquired by the Foundation 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 -0.5% 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.

### 1.7.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

**Revenue from NHS Contracts**

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

**Provide sustainability fund (PSF)**

The PSF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

**Revenue from research contracts**

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

### 1.7.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

### 1.7.3 Other income

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.

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 period 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 period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following year.

## 1.8 Expenditure on employee benefits (continued)

**Pension costs**

**NHS Pension Scheme**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that 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 scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. 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 schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

**NEST Pension Scheme**

Where staff are not eligible for, or choose to opt out of, the NHS Pensions Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme.

NEST is a government-backed, defined contribution pension scheme set up to make sure that every employer can easily access a workplace pension scheme.

The employer's contribution rate in 2019/20 was 3% which equated to £21k (2018/19: 2%, £3k).

## 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**

Under IAS16 assets should be revalued when their fair value is materially different from their carrying value. NHS Improvement requires revaluation at least once every 5 years.

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
• Land and non-specialised buildings – market value for existing use
• Specialised buildings – depreciated replacement cost

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.

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 IAS23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing 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 Foundation Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Foundation 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.

## 1.10 Property, Plant and Equipment (continued)

**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'.

**Impairments**

In accordance with the DHSC Group Accounting Manual impairments that are due to a clear consumption 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**

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**

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.

## 1.10 Property, Plant and Equipment (continued)

**Useful lives of property, plant and equipment**

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

| | Min life Years | Max life Years |
|---|---|---|
| Buildings excluding dwellings | 2 | 50 |
| Dwellings | 39 | 47 |
| Plant & machinery | 1 | 20 |
| Information technology | 1 | 9 |
| Furniture & fittings | 1 | 10 |

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

## 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 Foundation 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. Where no active market exists, this is interpreted as depreciated replacement cost. 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'.

### 1.11 Intangible assets (continued)

**Impairment**

Intangible assets not yet available for use are tested for impairment annually at the financial year end.

**Amortisation**

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

**Useful lives of intangible assets**

The estimated useful life of an asset is the period over which the Foundation Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Foundation 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.

| | Min life Years | Max life Years |
|---|---|---|
| **Intangible assets - internally generated** | | |
| Development expenditure | 1 | 4 |
| **Intangible assets - purchased** | | |
| Software licences | 1 | 12 |
| Licences & trademarks | 3 | 4 |

### 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.

The Trust provides at 3% for goods with a limited shelf life.

### 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

### 1.14 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

## 1.15 Financial assets and financial liabilities

### Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a f
instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financ
The GAM expands the definition of a contract to include legislation and regulations which give rise to ar
all other respects would be a financial instrument and do not give rise to transactions classified as a tax

This includes the purchase or sale of non-financial items (such as goods or services), which are entered
accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, an
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 lease
and measured in accordance with the accounting policy for leases described below.

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

### De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expire
Foundation Trust has transferred substantially all of the risks and rewards of ownership. Financial liabili
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
liabilities.

### Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are
active market. They are included in current assets. The Foundation Trust's loans and receivables comp
investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'. Loans and
recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised
effective interest method. The effective interest rate is the rate that discounts exactly estimated future c
through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying
financial asset.

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

The Foundation Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and me
allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime ex
losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expect

HM Treasury has ruled that central government bodies may not recognise impairments against other go
departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds'
repayment is ensured by primary legislation. The Foundation Trust therefore does not recognise loss all
impairments against these bodies. Additionally, the Department of Health provides a guarantee of last r
debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Foundation Trust do
loss allowances for impairments against these bodies.
For financial assets that have become credit impaired since initial recognition, expected credit losses at
are measured as the difference between the asset's gross carrying amount and the present value of the
cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognise
as an impairment gain or loss.

## 1.15 Financial instruments and financial liabilities (Continued)

**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.

## 1.16 Leases

**Finance leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the Foundation 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 Costs 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.

## 1.17 Provisions

The Trust recognises a provision where it has a present legal or constructive obligati
timing or amount; for which it is probable that there will be a future outflow of cash or
and a reliable estimate can be made of the amount. The amount recognised in the S
Financial Position is the best estimate of the resources required to settle the obligatic
effect of the time value of money is significant, the estimated risk-adjusted cash flows
using HM Treasury's discount rates effective for 31 March 2020:

| | |
|---|---|
| Short-term | Up to 5 years |
| Medium-term | After 5 years up to 10 years |
| Long-term | Exceeding 10 years |

Early retirement provisions and injury benefit provisions both use the HM Treasury's
rate of minus 0.5% in real terms.

### Clinical Negligence Costs

The NHS Resolution (NHSR) operates a risk pooling scheme under which the Found
an annual contribution to the NHSR, which, in return, settles all clinical negligence cla
NHSR is administratively responsible for all clinical negligence cases, the legal liabilit
Foundation Trust. The total value of clinical negligence provisions carried by the NHS
the Foundation Trust is disclosed at note 18.

### Non-clinical risk pooling

The Foundation Trust participates in the Property Expenses Scheme and the Liabiliti
Scheme. Both are risk pooling schemes under which the Foundation Trust pays an a
to the NHSR and in return receives assistance with the costs of claims arising. The a
membership contributions, and any ‘excesses’ payable in respect of particular claims
operating expenses when the liability arises.

## 1.18 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the e
over liabilities at the time of establishment of the predecessor NHS trust. HM Treasu
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 divid
dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) or
relevant net assets of the Trust during the financial year. Relevant net assets are cal
value of all assets less the value of all liabilities, except for (i) donated assets, (ii) ave
balances held with the Government Banking Services (GBS) and National Loans Fur
(iii) any PDC dividend balance receivable or payable and (iv) Provider Sustainability F
bonus and incentives. In accordance with the requirements laid down by the Departr
the issuer of PDC), the dividend for the year is calculated on the actual average relev
set out in the unaudited version of the annual accounts. The dividend thus calculate
should any adjustment to net assets occur as a result of the audit of the annual acco

### 1.21 Foreign exchange

The functional and presentational currencies of the Foundation Trust are sterling.
A transaction that is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the Foundation 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.

### 1.22 Cash, bank and overdrafts

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

### 1.23 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 Foundation Trust holds no such assets as all assets are held for operational purposes - this includes a number of artworks on display in the hospital.

### 1.24 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).

### 1.25 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.

### 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

**IFRS 16 Leases**

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

## 2. Revenue from patient care activities

| 2.1 Analysis of revenue from patient care activities | Year ended 31 March 2020 £000 | Year ended 31 March 2019 £000 |
|---|---|---|
| **Acute Services** | | |
| Elective income | **99,043** | 89,980 |
| Non elective income | **24,382** | 21,557 |
| First outpatient income | **17,477** | 16,669 |
| Follow up outpatient income | **21,711** | 21,075 |
| High cost drugs and devices income from commissioners (excluding pass-through costs) | **75,479** | 62,387 |
| Other NHS clinical income* | **126,790** | 130,691 |
| **Mental Health Services** | | |
| Cost and volume contract income | **4,849** | 4,827 |
| Revenue from protected patient care activities | **369,731** | 347,186 |
| Private patient income | **64,847** | 62,187 |
| AfC pay award central funding** | **0** | 2,736 |
| Other non-protected clinical income | **4,100** | 3,656 |
| Additional pension contribution central funding*** | **11,556** | 0 |
| Revenue from non-protected patient care activities | **80,503** | 68,579 |
| **Total revenue from patient care activities** | **450,234** | 415,765 |

*Other NHS clinical income includes £1,890k relating to Covid-19 funding. This was not applicable in 2018/19.

**Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

***The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

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.

| 2.2 Analysis of revenue from patient care activities by source | Year ended 31 March 2020 £000 | Year ended 31 March 2019 £000 |
|---|---|---|
| NHS England | **356,435** | 321,953 |
| Clinical commissioning groups | **23,590** | 23,818 |
| NHS Foundation Trusts | **297** | 72 |
| NHS Trusts | **0** | 65 |
| Local Authorities | **94** | 43 |
| Department of Health | **0** | 2,736 |
| NHS Other | **97** | 0 |
| Non-NHS: | | |
| Private patients | **64,847** | 62,187 |
| Overseas patients (non-reciprocal) | **637** | 424 |
| Injury costs recovery | **119** | 67 |
| Other | **4,118** | 4,400 |
| **Total revenue from patient care activities** | **450,234** | 415,765 |

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

| 2.3 Overseas visitors | Year ended 31 March 2020 £000 | Year ended 31 March 2019 £000 |
|---|---|---|
| Income recognised in-year | **637** | 424 |
| Cash payments received in-year | **180** | 29 |
| Amounts added to provision for impairment of receivables | **120** | 274 |
| Amounts written off in-year | **0** | 332 |

| 3.1 Other operating income | Year ended 31 March 2020 £000 | Year ended 31 March 2019 £000 |
|---|---|---|
| **Other operating income recognised in accordance with IFRS 15** | | |
| Research and development (IFRS 15) | **9,769** | 9,512 |
| Education and training | **8,740** | 9,226 |
| Non-patient care services to other bodies | **1,834** | 2,003 |
| Provider sustainability fund | **4,107** | 12,763 |
| Clinical tests | **7,698** | 5,817 |
| Clinical excellence awards | **2,140** | 2,431 |
| Catering | **1,290** | 1,434 |
| Creche services | **487** | 424 |
| Staff accommodation rentals | **65** | 60 |
| Other revenue * | **3,182** | 2,152 |
| | **39,312** | **45,822** |
| * 'Other revenue' includes £963k in respect of royalty payments received in the year (2018/19: £0) | | |
| **Other operating income recognised in accordance with other standards** | | |
| Research and development (non IFRS 15) | **18,222** | 18,290 |
| Education and training - notional income from apprenticeship fund | **486** | 238 |
| Charitable contributions in respect of capital expenditure | **31,220** | 32,780 |
| Charitable contributions to expenditure | **10,734** | 7,504 |
| | **60,662** | 58,812 |
| **Total other operating income** | **99,974** | 104,634 |
| **of which** | | |
| Related to continuing operations | **99,974** | 104,634 |

The Trust received £4,107k of Provider Sustainability Funding. This was made up of: £3,760k core and £347k of 2018/19 PSF reallocation.

**3.2 Additional information on revenue from contracts with customers recognised in the period**

| | **Year ended 31 March 2020 £000** | **Year ended 31 March 2019 £000** |
|---|---|---|
| Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end | 1,478 | 2,549 |

**3.3 Transaction price allocated to remaining performance obligations**

| Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised: | **Year ended 31 March 2020 £000** | **Year ended 31 March 2019 £000** |
|---|---|---|
| within one year | 6,903 | 7,843 |
| after one year, not later than five years | 5,593 | 8,612 |
| after five years | 489 | 420 |
| Total revenue allocated to remaining performance obligations | 12,985 | 16,875 |

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

| 4. Operating expenses | Year ended 31 March 2020 £000 | Year ended 31 March 2019 £000 |
|---|---|---|
| Services from other NHS bodies | **7,101** | 5,682 |
| Purchase of healthcare from non-NHS bodies | **4,443** | 4,633 |
| Staff and executive directors costs | **273,689** | 247,115 |
| Non-executive directors' costs* | **152** | 163 |
| Supplies and services - clinical - drugs | **81,496** | 69,805 |
| Supplies and services - clinical - other | **37,787** | 37,883 |
| Supplies and services - general | **4,773** | 5,509 |
| Establishment | **3,984** | 4,385 |
| Research and development - staff costs | **18,805** | 18,000 |
| Research and development -non-staff | **4,249** | 4,965 |
| Education and training - staff costs | **3,126** | 2,871 |
| Education and training - notional expenditure funded from apprenticeship fund | **486** | 238 |
| Transport - business travel | **993** | 799 |
| Transport - other | **3,655** | 3,448 |
| Premises - business rates payable to local authorities | **4,611** | 3,914 |
| Premises - other | **33,458** | 26,467 |
| Operating lease rentals | **2,262** | 2,619 |
| Movement in credit loss allowance: contract receivables/assets | **(518)** | 3,577 |
| Movement in credit loss allowance: all other receivables & investments | **(59)** | 238 |
| Provisions released in year | **(53)** | (290) |
| Change in provisions discount rate | **(48)** | 5 |
| Inventories write down | **339** | 271 |
| Depreciation | **21,031** | 18,550 |
| Amortisation of intangible assets | **3,543** | 2,122 |
| Impairment of property, plant and equipment | **6,994** | 7,939 |
| Fees payable to the Trust's auditor for the financial statements audit | **130** | 132 |
| Other auditor remuneration | **5** | 5 |
| Clinical negligence insurance | **6,801** | 7,083 |
| Redundancy costs | **30** | 471 |
| Consultancy costs | **679** | 802 |
| Legal fees | **223** | 219 |
| Internal audit costs | **122** | 114 |
| Losses and special payments | **5** | 25 |
| Other | **2,200** | 2,401 |
| | **526,494** | 482,160 |

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

## 5. Operating leases

### 5.1 As lessee

| Payments recognised as an expense | Year ended 31 March 2020 £000 | Year ended 31 March 2019 £000 |
|---|---|---|
| Minimum lease payments | **2,262** | 2,619 |

| Total future minimum lease payments | Year ended 31 March 2020 £000 | Year ended 31 March 2019 £000 |
|---|---|---|
| Payable: | | |
| Not later than one year | **2,797** | 1,883 |
| Between one and five years | **13,306** | 7,251 |
| After 5 years | **19,775** | 5,755 |
| Total | **35,878** | 14,889 |

## 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 2020.

**8. Employee costs and numbers**

| **8.1 Employee costs** | **Year ended 31 March 2020 Total** | Year ended 31 March 2019 Total |
|---|---|---|
| | **£000** | £000 |
| Salaries and wages | **238,072** | 224,600 |
| Social security costs | **24,334** | 22,957 |
| Apprenticeship levy | **1,090** | 1,032 |
| Pension cost - defined contribution plans employer's contributions to NHS pensions | **26,421** | 25,288 |
| Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%) | **11,556** | 0 |
| Pension costs - other | **46** | 64 |
| Temporary staff - agency/contract staff | **2,356** | 3,436 |
| Termination benefits | **30** | 471 |
| **Total gross staff costs** | **303,905** | 277,848 |
| Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure | **(2,090)** | (1,706) |
| Recoveries from other bodies in respect of staff costs netted off expenditure | **(413)** | (804) |
| **Total staff costs** | **301,402** | 275,338 |
| **Included within:** | | |
| Costs capitalised as part of assets | **5,752** | 6,881 |
| Analysed into operating expenditure | | |
| Employee expenses - staff and executive directors | **273,689** | 247,115 |
| Research and development | **18,805** | 18,000 |
| Education and training | **3,126** | 2,871 |
| Redundancy | **30** | 471 |
| **Total employee benefits excluding capital costs** | **295,650** | 268,457 |

| **8.2 Average number of people employed*** | **Year ended 31 March 2020 Total** | Year ended 31 March 2019 Total |
|---|---|---|
| | **Number** | Number |
| Medical and dental | **700** | 681 |
| Administration and estates | **1,346** | 1,335 |
| Healthcare assistants and other support staff | **284** | 283 |
| Nursing, midwifery and health visiting staff | **1,526** | 1,552 |
| Scientific, therapeutic and technical staff | **960** | 920 |
| Other staff | **9** | 5 |
| **Total average numbers** | **4,825** | 4,776 |
| **of which:** | | |
| Number of employees (WTE) engaged on capital projects | **87** | 113 |

*Whole Time Equivalent

**8.3 Retirements due to ill-health**

During the year there were no early retirements from the Trust on the grounds of ill-health resulting in no additional pension liabilities. (There were no early retirements in 2018/19).

**8.4 Staff exit packages**

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

| | Year to 31 March 2020 | | | | | |
|---|---|---|---|---|---|---|
| **Exit packages number and cost** | **Number of Compulsory redundancies** | **Cost of compulsory redundancies** | **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** | **6** | **37** | **6** | **37** |
| £10,00 - £25,000 | **0** | **0** | **6** | **101** | **6** | **101** |
| £25,001 - £50,000 | **1** | **30** | **1** | **27** | **2** | **57** |
| £50,001 - £100,000 | **0** | **0** | **0** | **0** | **0** | **0** |
| £100,001 - £150,000 | **0** | **0** | **0** | **0** | **0** | **0** |
| £150,001 - £200,000 | **0** | **0** | **0** | **0** | **0** | **0** |
| **Total** | **1** | **30** | **13** | **165** | **14** | **195** |

| | Year to 31 March 2019 | | | | | |
|---|---|---|---|---|---|---|
| Exit packages number and cost | Number of Compulsory redundancies | Cost of compulsory redundancies | 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 | 6 | 23 | 6 | 23 |
| £10,000 - £25,000 | 0 | 0 | 2 | 32 | 2 | 32 |
| £25,001 - £50,000 | 0 | 0 | 1 | 30 | 1 | 30 |
| £50,001 - £100,000 | 0 | 0 | 2 | 124 | 2 | 124 |
| £100,001 - £150,000 | 0 | 0 | 2 | 254 | 2 | 254 |
| £150,001 - £200,000 | 0 | 0 | 1 | 165 | 1 | 165 |
| **Total** | 0 | 0 | 14 | 628 | 14 | 628 |

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.

| **Exit packages: other (non-compulsory) departure payment** | **Payments agreed 2019/20** | **Total value of agreements 2019/20** | Payments agreed 2018/19 | Total value of agreements 2018/19 |
|---|---|---|---|---|
| | **No.** | **£000** | No. | £000 |
| Voluntary redundancies including early retirement contractual costs | **1** | **12** | 0 | 0 |
| Mutually agreed resignations (MARS) contractual costs | **0** | **0** | 4 | 419 |
| Contractual payments in lieu of notice | **11** | **150** | 9 | 155 |
| Exit payments following employment tribunals or court orders | **1** | **3** | 1 | 54 |
| | **13** | **165** | 14 | 628 |

| **9 Finance Income** | **Year ended 31 March 2020** | Year ended 31 March 2019 |
|---|---|---|
| | £000 | £000 |
| Bank interest | **456** | 369 |
| Total finance income | **456** | 369 |

| **10 Finance Expenses** | **Year ended 31 March 2020** | Year ended 31 March 2019 |
|---|---|---|
| | £000 | £000 |
| Provisions - unwinding of discount | 18 | 11 |
| Total finance expenses | **18** | **11** |

**11. Intangible assets**

**11.1 Intangible assets**

| | Software licences | Licences and trademarks | IT (internally generated and 3rd party) | Development expenditure (internally generated) | Intangible assets under construction | Total |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **Gross cost at 1 April 2019** | 11,347 | 623 | 67 | 4,790 | 25,910 | **42,737** |
| Additions - purchased | 219 | 0 | 0 | 0 | 9,074 | **9,293** |
| Additions - assets purchased from cash donations | 0 | 0 | 0 | 0 | 1,563 | **1,563** |
| Impairments charged to operating expenses | 0 | 0 | 0 | 0 | (68) | **(68)** |
| Revaluations | 0 | 0 | 0 | 0 | 471 | **471** |
| Reclassifications | 6,182 | 0 | 0 | 0 | (6,533) | **(351)** |
| **Valuation/Gross cost at 31 March 2020** | **17,748** | **623** | **67** | **4,790** | **30,417** | **53,645** |
| **Amortisation at 1 April 2019** | 6,901 | 398 | 67 | 4,541 | 0 | **11,907** |
| Provided during the year | 3,313 | 23 | 0 | 207 | 0 | **3,543** |
| **Amortisation at 31 March 2020** | **10,214** | **421** | **67** | **4,748** | **0** | **15,450** |
| **Net book value** | | | | | | |
| **NBV total at 31 March 2020** | **7,534** | **202** | **0** | **42** | **30,417** | **38,195** |

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

| | Software licences | Licences and trademarks | IT (internally generated and 3rd party) | Development expenditure (internally generated) | Intangible assets under construction | Total |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **Gross cost at 1 April 2018** | 9,099 | 623 | 0 | 4,790 | 13,702 | **28,214** |
| Additions - purchased | 915 | 0 | 2 | 0 | 6,875 | **7,792** |
| Additions - assets purchased from cash donations | 4 | 0 | 0 | 0 | 11,237 | **11,241** |
| Impairments charged to operating expenses | 0 | 0 | 0 | 0 | (3,880) | **(3,880)** |
| Revaluations | 0 | 0 | 0 | 0 | 115 | **115** |
| Reclassifications | 1,329 | 0 | 65 | 0 | (2,139) | **(745)** |
| **Valuation/Gross cost at 31 March 2019** | **11,347** | **623** | **67** | **4,790** | **25,910** | **42,737** |
| **Amortisation at 1 April 2018** | 5,094 | 375 | 0 | 4,316 | 0 | **9,785** |
| Provided during the year | 1,807 | 23 | 67 | 225 | 0 | **2,122** |
| **Amortisation at 31 March 2019** | **6,901** | **398** | **67** | **4,541** | **0** | **11,907** |
| **Net book value** | | | | | | |
| **NBV total at 31 March 2019** | **4,446** | **225** | **0** | **249** | **25,910** | **30,830** |

International Accounting Standard 36 (IAS 36) and the DH Group Accounting Manual require entities to test intangible assets which have not yet been brought into use to determine whether their carrying values exceed the service potential value of each asset. The Trust is currently implementing its Electronic Patient Record system, which is an intangible asset under construction at 31 March 2020. The Trust has reviewed the asset and estimated the cost of replacing the assets taking account of the knowledge and experience which it has acquired since starting the implementations of these assets, following a methodology used in the audited accounts to 31 March 2019. The outcome of the review of the EPR intangible carrying value of £29,854k was that certain activities should be impaired by £68k and others indexed upward by £471k. The impairment is a charge to the income and expenditure account and the indexation a credit to the revaluation reserve.

Had the valuation not been undertaken, the carrying value of intangible AUC at 31 March 2020 would have been £30,015k

Other intangible assets not integrated with the EPR solution were also reviewed and neither impairment nor indexation of these was considered appropriate.

## 12. Property, plant and equipment

### 12.1 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 2019** | 78,941 | 302,099 | 10,877 | 27,796 | 88,839 | 34,696 | 17,620 | **560,868** |
| Additions - purchased | 0 | 2,789 | 0 | 6,949 | 965 | 532 | 97 | **11,332** |
| Additions - assets purchased from cash donations | 0 | 7,391 | 0 | 11,897 | 7,366 | 1,009 | 1,994 | **29,657** |
| Impairments charged to operating expenses | 0 | (6,956) | (6) | 0 | 0 | 0 | 0 | **(6,962)** |
| Impairments charged to the revaluation reserve | (4,841) | 0 | 0 | 0 | 0 | 0 | 0 | **(4,841)** |
| Reversal of impairments credited to operating expenses | 0 | 36 | 0 | 0 | 0 | 0 | 0 | **36** |
| Reclassifications | 0 | 7,617 | 0 | (16,889) | 4,073 | 5,028 | 522 | **351** |
| Revaluations | 0 | 20,191 | (220) | 0 | 0 | 0 | 0 | **19,971** |
| Disposals | 0 | 0 | 0 | 0 | (343) | 0 | 0 | **(343)** |
| **Cost or valuation at 31 March 2020** | **74,100** | **333,167** | **10,651** | **29,753** | **100,900** | **41,265** | **20,233** | **610,069** |
| | | | | | | | | |
| **Accumulated depreciation at 1 April 2019** | 0 | 2,131 | 0 | 0 | 61,019 | 25,420 | 10,369 | **98,939** |
| Provided during the period | 0 | 8,471 | 230 | 0 | 6,581 | 4,394 | 1,355 | **21,031** |
| Revaluations | 0 | (7,392) | (230) | 0 | 0 | 0 | 0 | **(7,622)** |
| Disposals | 0 | 0 | 0 | 0 | (330) | 0 | 0 | **(330)** |
| **Accumulated depreciation at 31 March 2020** | **0** | **3,210** | **0** | **0** | **67,270** | **29,814** | **11,724** | **112,018** |
| | | | | | | | | |
| **Net book value at 31 March 2020** | | | | | | | | |
| NBV - Owned at 31 March 2020 | 72,300 | 118,473 | 883 | 12,238 | 5,961 | 7,106 | 1,807 | **218,768** |
| NBV - Finance leased at 31 March 2020 | 0 | 3,507 | 0 | 0 | 0 | 0 | 0 | **3,507** |
| NBV - Government granted at 31 March 2020 | 0 | 153 | 0 | 0 | 48 | 0 | 0 | **201** |
| NBV - Donated at 31 March 2020 | 1,800 | 207,824 | 9,768 | 17,515 | 27,621 | 4,345 | 6,702 | **275,575** |
| **NBV total at 31 March 2020** | **74,100** | **329,957** | **10,651** | **29,753** | **33,630** | **11,451** | **8,509** | **498,051** |

| | 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 2018** | 72,601 | 300,095 | 10,978 | 13,917 | 82,734 | 30,063 | 16,710 | **527,098** |
| Additions - purchased | 0 | 4,064 | 0 | 6,797 | 341 | 2,449 | 27 | **13,678** |
| Additions - assets purchased from cash donations | 0 | 2,344 | 0 | 14,472 | 4,248 | 70 | 405 | **21,539** |
| Impairments charged to operating expenses | 0 | (4,968) | (2) | 0 | 0 | 0 | 0 | **(4,970)** |
| Impairments charged to the revaluation reserve | (150) | 0 | 0 | 0 | 0 | 0 | 0 | **(150)** |
| Reversal of impairments charged to operating expenses | 0 | 451 | 0 | 460 | 0 | 0 | 0 | **911** |
| Reclassifications | 0 | 3,960 | 0 | (7,850) | 2,043 | 2,114 | 478 | **745** |
| Revaluations | 6,490 | (3,847) | (99) | 0 | 0 | 0 | 0 | **2,544** |
| Disposals | 0 | 0 | 0 | 0 | (527) | 0 | 0 | **(527)** |
| **Cost or valuation at 31 March 2019** | **78,941** | **302,099** | **10,877** | **27,796** | **88,839** | **34,696** | **17,620** | **560,868** |
| | | | | | | | | |
| **Accumulated depreciation at 1 April 2018** | 0 | 1,562 | 0 | 0 | 54,797 | 23,013 | 9,054 | **88,426** |
| Provided during the period | 0 | 7,852 | 227 | 0 | 6,749 | 2,407 | 1,315 | **18,550** |
| Revaluations | 0 | (7,283) | (227) | 0 | 0 | 0 | 0 | **(7,510)** |
| Disposals | 0 | 0 | 0 | 0 | (527) | 0 | 0 | **(527)** |
| **Accumulated depreciation at 31 March 2019** | **0** | **2,131** | **0** | **0** | **61,019** | **25,420** | **10,369** | **98,939** |
| | | | | | | | | |
| **Net book value at 31 March 2019** | | | | | | | | |
| NBV - Owned at 31 March 2019 | 75,141 | 108,748 | 904 | 9,558 | 6,151 | 7,924 | 1,802 | **210,228** |
| NBV - Finance leased at 31 March 2019 | 0 | 3,169 | 0 | 0 | 0 | 0 | 0 | **3,169** |
| NBV - Government granted at 31 March 2019 | 0 | 143 | 0 | 0 | 57 | 0 | 0 | **200** |
| NBV - Donated at 31 March 2019 | 3,800 | 187,908 | 9,973 | 18,238 | 21,612 | 1,352 | 5,449 | **248,332** |
| **NBV total at 31 March 2019** | **78,941** | **299,968** | **10,877** | **27,796** | **27,820** | **9,276** | **7,251** | **461,929** |

**12.2 Valuation of Land and Buildings**

For assets held at revalued amounts:

* the effective date of revaluation was 31 March 2020

* 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.

## 13. Commitments

### 13.1 Capital commitments

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

| | **31 March 2020** | 31 March 2019 |
|---|---|---|
| | **£000** | £000 |
| Property, plant and equipment | **4,071** | 27,431 |
| Intangible assets | **599** | 8,436 |
| **Total** | **4,670** | **35,867** |

### 13.2 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 2020** | 31 March 2019 |
|---|---|---|
| | **£000** | £000 |
| Not later than one year | **10,507** | 9,818 |
| Later than one year and not later than five year | **6,793** | 9,019 |
| **Total** | **17,300** | 18,837 |

## 14. Inventories

### 14.1 Inventories

| | **31 March 2020** | 31 March 2019 |
|---|---|---|
| | **£000** | £000 |
| Drugs | **3,445** | 2,119 |
| Consumables | **7,678** | 7,881 |
| Energy | **21** | 33 |
| **Total** | **11,144** | 10,033 |

The cost of inventories recognised as expenses during the year in respect of continuing operations was £106,834k (2018/19: £94,266k)

## 15. Trade and other receivables

| **15.1 Trade and other receivables** | **Current** | | **Non-current** | |
|---|---|---|---|---|
| | **31 March 2020** | 31 March 2019 | **31 March 2020** | 31 March 2019 |
| | **£000** | £000 | **£000** | £000 |
| Contract receivables: invoiced | **84,328** | 78,720 | **0** | 0 |
| Contract receivables: not yet invoiced / non-invoiced | **11,653** | 15,687 | **0** | 0 |
| Capital receivables | **8,790** | 6,625 | **0** | 0 |
| Allowance for impaired contract receivables | **(13,353)** | (13,871) | **0** | 0 |
| Allowance for impaired other receivables | **(179)** | (238) | **0** | 0 |
| Prepayments (revenue) | **4,101** | 4,964 | **6,400** | 6,267 |
| Interest receivable | **35** | 5 | **0** | 0 |
| VAT receivable | **964** | 521 | **0** | 0 |
| Clinician pension tax provision reimbursement funding from NHSE | **0** | 0 | **1221** | 0 |
| Other receivables | **7,732** | 1,436 | **0** | 0 |
| **Total** | **104,071** | 93,849 | **7,621** | 6,267 |

**15.2 Allowances for credit losses on receivables**

| | Total 2019/20 | Contract receivables and contract assets |
|---|---|---|
| | £000 | £000 |
| **Allowance for credit losses at 1 April 2019 - brought forward** | **14,109** | **13,871** |
| New allowances arising | **7,233** | 7,161 |
| Changes in the calculation of existing allowances | **(1,414)** | (1,322) |
| Reversals of allowances (where receivable is collected in-year) | **(6,396)** | (6,357) |
| Utilisation of allowances (where receivable is written off) | **0** | 0 |
| **Total allowance for credit losses at 31 March 2020** | **13,532** | **13,353** |

**15.3 Allowances for credit losses on receivables**

| | Total 2018/19 | Contract receivables and contract assets |
|---|---|---|
| | £000 | £000 |
| **Allowance for credit losses at 1 April 2018 - brought forward** | **10,657** | **0** |
| **Allowances for credit losses at 1 April 2018 - restated** | **10,657** | **0** |
| Impact of IFRS9 implementation on 1 April 2018 balance | | 10,657 |
| New allowances arising | **3,815** | 3,577 |
| Utilisation of allowances (where receivable is written off) | **(363)** | (363) |
| **Total allowance for credit losses at 31 March 2019** | **14,109** | **13,871** |

| **16. Cash and cash equivalents** | **31 March 2020** £000 | 31 March 2019 £000 |
|---|---|---|
| Balance at beginning of the year | **48,606** | 55,695 |
| Net change in year | **12,708** | (7,089) |
| **Balance at the end of the year** | **61,314** | 48,606 |
| **Made up of** | | |
| Commercial banks and cash in hand | **15** | 13 |
| Cash with the Government Banking Service | **61,299** | 10,593 |
| Deposits with the National Loan Fund | **0** | 38,000 |
| **Cash and cash equivalents as in statement of financial position** | **61,314** | 48,606 |
| **Cash and cash equivalents** | **61,314** | 48,606 |

## 17. Trade and other payables

### 17.1 Trade and other payables

| | Current | |
|---|---|---|
| | **31 March 2020** | 31 March 2019 |
| | **£000** | £000 |
| Trade payables | **18,635** | 13,571 |
| Capital payables | **11,592** | 8,033 |
| Social Security costs | **3,515** | 3,372 |
| Other taxes payable | **2,826** | 2,767 |
| Other payables | **10,637** | 9,148 |
| Accruals | **47,879** | 31,966 |
| PDC dividend payable | **73** | 22 |
| **Total** | **95,157** | 68,879 |

## 18. Other Liabilities

| | Current | | Non-current | |
|---|---|---|---|---|
| | **31 March 2020** | 31 March 2019 | **31 March 2020** | 31 March 2019 |
| | **£000** | £000 | **£000** | £000 |
| Deferred income: Contract liability (IFRS 15) | **5,581** | 4,684 | **0** | 0 |
| Deferred income: other (non-IFRS 15) | **914** | 647 | **0** | 0 |
| Lease incentives | **517** | 496 | **4,016** | 4,512 |
| **Total** | **7,012** | 5,827 | **4,016** | 4,512 |

## 19. Provisions

| | Current | | Non-current | |
|---|---|---|---|---|
| | **31 March 2020** | 31 March 2019 | **31 March 2020** | 31 March 2019 |
| | **£000** | £000 | **£000** | £000 |
| Pensions relating to other staff | **113** | 110 | **641** | 695 |
| Legal claims | **34** | 12 | **0** | 0 |
| Clinician pension tax reimbursement | **0** | 0 | **1,221** | 0 |
| Other | **0** | 177 | **885** | 0 |
| **Total** | **147** | 299 | **2,747** | 695 |

| | **Pensions relating to other staff** | **Legal claims** | **Clinician pension tax reimbursement** | **Other** | **Total** |
|---|---|---|---|---|---|
| | **£000** | **£000** | **£000** | **£000** | **£000** |
| At 1 April 2019 | 805 | 12 | 0 | 177 | **994** |
| Change in the discount rate | (48) | 0 | 0 | 0 | **(48)** |
| Arising during the year | 91 | 22 | 1,221 | 885 | **2,219** |
| Utilised during the year | (112) | 0 | 0 | (124) | **(236)** |
| Reversed unused | 0 | 0 | 0 | (53) | **(53)** |
| Unwinding of discount | 18 | 0 | 0 | 0 | **18** |
| At 31 March 2020 | 754 | 34 | 1,221 | 885 | **2,894** |
| **Expected timing of cash flows:** | | | | | |
| - not later than one year | 113 | 34 | 0 | 0 | **147** |
| - later than one year and not later than five years | 452 | 0 | 1221 | 885 | **2,558** |
| - later than five years | 189 | 0 | 0 | 0 | **189** |
| | 754 | 34 | 1,221 | 885 | **2,894** |

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.

"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.

'Other' provisions of £885k relates to a provision for dilapidations (£0k at 31 Mar 2019). Provisions brought forward which have been utilised in year relates to ongoing tribunal matters (£10k at 31 Mar 2019) and £114k for redundancy provisions. In addition, £53k relating to provisions for enhancements have been reversed unutilised in year)

NHS Resolution records provisions in respect of clinical negligence liabilities of the Trust. The amount recorded as at 31 March 2020 was £170,257k (£159,897k at 31 March 2019).

## 20. Revaluation reserve

| | **31 March 2020** | 31 March 2019 |
|---|---|---|
| | **£000** | £000 |
| Opening balance at 1 April | **102,576** | 92,557 |
| Net impairments | **(4,841)** | (150) |
| Revaluations | **28,064** | 10,169 |
| Closing balance at 31 March | **125,799** | 102,576 |

## 21. Financial instruments

The carrying value and the fair value are equivalent for the financial assets and financial liabilities shown below in notes 20.1 and 20.2. All financial assets and liabilities included below are receivable/payable within 12 months.

### 21.1 Financial assets by category

| | **2019/20** | 2018/19 |
|---|---|---|
| **Carrying values of financial assets at amortised cost** | **£000** | £000 |
| Trade and other receivables excluding non-financial assets | **98,971** | 88,364 |
| Cash and cash equivalents at bank and in hand | **61,314** | 48,606 |
| **Total at 31 March** | **160,285** | 136,970 |

### 21.2 Financial liabilities by category

| | **2019/20** | 2018/19 |
|---|---|---|
| | **£000** | £000 |
| **Carrying values of financial liabilities at amortised cost** | | |
| Trade and other payables excluding non-financial liabilities | **88,743** | 62,292 |
| **Total at 31 March** | **88,743** | 62,292 |

**22. Financial Instruments (continued)**

**22.3.1 Financial Risk Management**

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

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

**Currency risk**

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

**Interest rate risk**

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

**Credit risk**

Because the majority of the Trust's income comes from contracts with other public sector bodies, it has low exposure to credit risk. The maximum exposures as at 31 March 2020 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.

**23. Related Party Transactions**

Paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures. Note also that IAS 24 is interpreted such that DHSC group bodies must disclose the Department of Health as the parent department and provide a note of the main entities within the public sector with which the body has had dealings, but that no information needs to be given about these 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.

The Trust has a revenue sharing agreement with University College London and UCL Business plc in respect of an invention developed by research for which the Trust provided support and sponsorship. The agreement does not constitute a partnership or joint venture and the financial transactions relating to the invention are accounted for by UCL Business plc. However, the Trust is entitled to royalty payments in respect of net receipts deriving from the invention. In the financial year the Trust received a royalty payment of £963k; this is included in Other income shown at note 3.1.

During the year the Trust has had a significant number of material transactions with the following organisations which fall within the Whole of Government Accounting Bodies and Local Authorities:

NHS England
- NHS Clinical Commissioning Groups
- NHS Foundation Trusts
- NHS Trusts
- Department of Health and Social Care
- Health Education England
- NHS Pension Scheme
- Local Authorities

The Trust also had significant transactions with Great Ormond Street Hospital Children's Charity. The total values are below:

| | £000 |
|---|---|
| Income | 41,954 |
| Expenditure | 2,487 |
| Receivables (31 March 2020) | 14,535 |
| Payables (31 March 2020) | 1,022 |

### 22. Events after the reporting period

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

### 23. Losses and special payments

| | Number | £000 |
|---|---|---|
| Bad debts relating to private patients | 193 | 47 |
| Bad debts relating to other debtors | 0 | 0 |
| Stores losses | 14 | 339 |
| Total losses | **207** | **386** |
| Ex-gratia payments | 36 | 5 |
| Total special payments | **36** | **5** |
| **Total losses and special payments** | **243** | **391** |

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

### 24. Off-Payroll engagements

As at 31 March 2020, the Trust had no off-payroll engagements for more than £245 per day lasting for longer than six months.

# Great Ormond Street Hospital for Children NHS Foundation Trust

# Annual Report and Accounts

# 2019 to 2020

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# Great Ormond Street Hospital for Children NHS Foundation Trust

# Annual Report and Accounts

# 2019 to 2020

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

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## Contents

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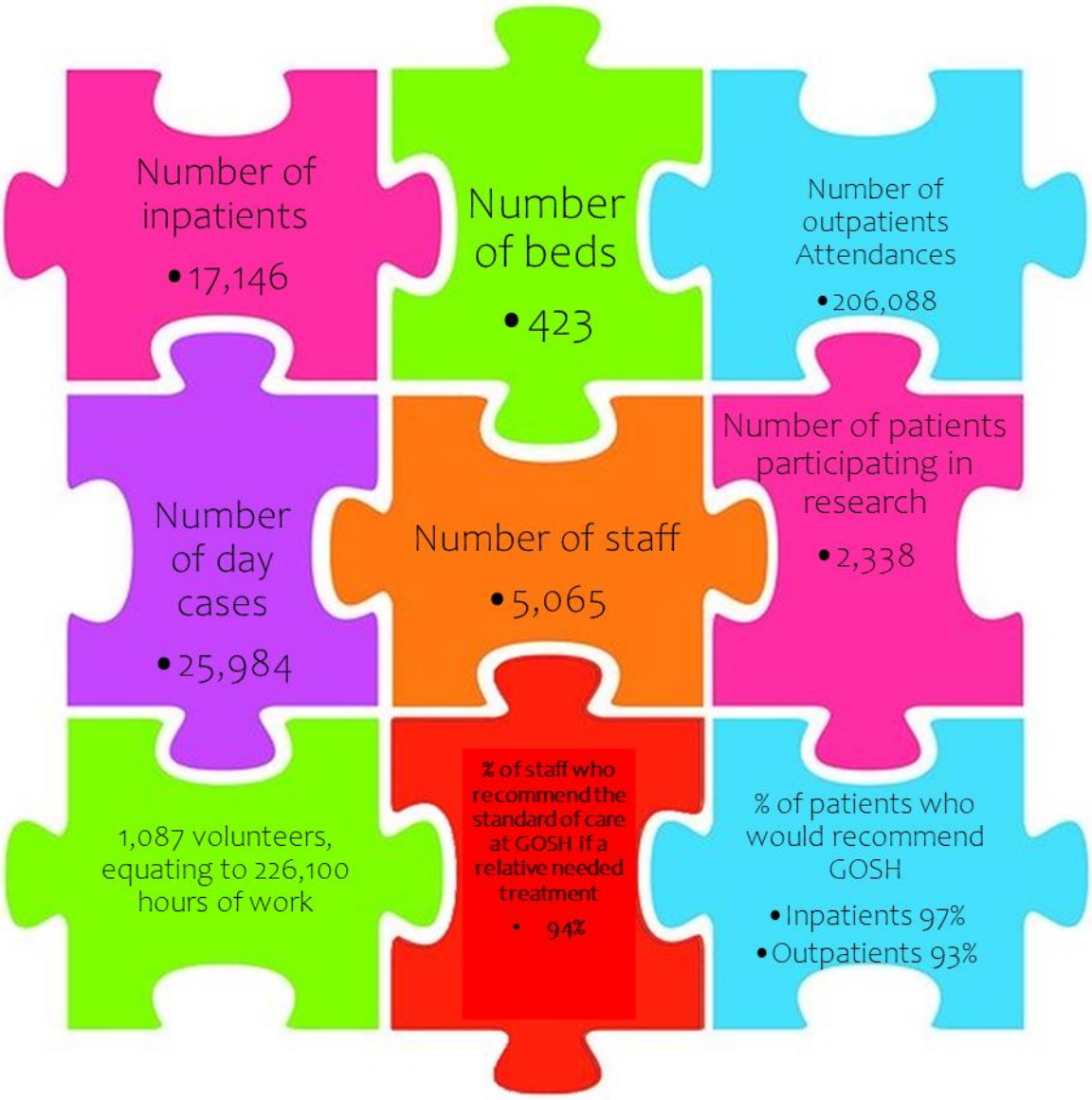
# Great Ormond Street Hospital (GOSH) at a glance



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# Chair foreword

Having a clear and compelling purpose is fundamental to the success of any organisation. In a year which was deeply unstable and ended in national crisis this sense of purpose has been critical to keeping our organisation focused.

Our purpose is to care for children and young people with complex health needs so they can fulfil their potential. This is as true today as it was when we were founded by Charles West in 1852. This year we have faced the instability of the protracted Brexit negotiations, the challenges of securing funding that reflects the true cost of care and, finally, the COVID-19 pandemic. Throughout, we have focused not just in delivering care for our children but on conducting important research.

Matthew Shaw, our CEO, will provide some detail on how the Trust has responded to the pandemic in his foreword. I would like to pay tribute to our staff and all our colleagues across the NHS who have provided care in these extremely difficult conditions. While it is recognised that in general the impact on children is much less than on adults, at GOSH we have treated a number of children with COVID-19. We appreciate that many staff have been worried about the health and safety of their colleagues, friends and families. A number of staff have contracted the virus and at the time of writing very sadly we have lost three members of staff. Throughout this time, our staff have remained absolutely committed to the organisation and the children and families we serve.

When dealing with a challenge of such proportions, it is essential to look outwards, and collaborate. The Trust has sought to learn from the response of other specialist paediatric facilities across the world and has been in active dialogue with colleagues in Wuhan. I am particularly proud of how the Trust has worked with healthcare partners across London to try and provide the best possible care for patients. This has included being part of the team that developed the Nightingale Hospital, taking patients from other hospitals, and sending our staff and equipment where they are needed most. I would like to thank all staff for their tremendous contribution.

We continue to be pride of the important role we play in conducting research and during the crisis we have been actively engaged in a number of research studies and clinical trials to advance the global understanding of the impact of this pandemic on children and specifically those with complex health conditions. Prior to the pandemic, we had been focused on delivering word-class research to improve the lives of children not just in the UK but worldwide. Working with our academic partner UCL, and in particular the UCL Great Ormond Street Institute of Child Health, there have been almost 1,300 active research projects involving more than 2,300 patients. We have also been able to translate research into care. This year, successful trials at GOSH in collaboration with other global centres resulted in NHS approval of a novel treatment for Batten Disease and a pioneering new gene therapy was manufactured at GOSH that in a world-first was used to treat a patient with Sanfilippo syndrome.

In July we opened the Zayed Centre for Research into Rare Disease in Children. This joint GOSH/UCL venture will see hundreds of clinicians and researchers brought together under one roof to accelerate progress of new diagnoses, treatments and cures for children with rare diseases. It is a hugely impressive building with laboratory facilities that are unparalleled

in the UK. These facilities will allow us to make further strides in the development of novel cell and gene therapies. The Centre was made possible by the incredibly generous gift from Her Highness Sheikha Fatima bint Mubarak which is transforming our ability to carry out research. We were honoured that Sheikh Theyab bin Mohamed bin Zayed, officially launched the Centre on behalf of his grandmother.

Our amazing Charity was instrumental in making the Centre a reality. It is also supporting us to redevelop the Italian Hospital on Queen's Square into the Sight and Sound Centre for GOSH and we are working together on plans for a Children's Cancer Centre. Both parties remain deeply committed to realising this vision and over the last year we have started the process of detailed design and enhanced clinical engagement. The contribution of our Charity in providing funds for redevelopment, equipment, research and other elements to support the patient and staff experience cannot be overstated. The uncertain economic times ahead will undoubtedly bring challenges for our Charity and we will work closely together to ensure it continues to thrive.

At the start of this year we began work on refreshing our strategy. A thorough consultation process shaped our approach which builds on the work of our existing strategy Fulfilling our Potential. Within the new strategy we looked to better define the role we will play in local, national, and international healthcare both now and in 10 years' time and the areas of work we will need to prioritise to achieve our ambitions. The resulting strategy – Above and Beyond - gives the organisation a much clearer sense of where it is going and how it is going to get there. Its official launch was delayed because of the pandemic and I very much look forward to us being able to launch it formally in this coming year.

A key component of both the existing and new strategy is culture, and ensuring we have the right conditions for our people to thrive. In our new strategy our Always Values remain unchanged while our commitment to ensuring they are lived through everything we do has strengthened. Our roadmap to achieving transformative culture change is our People Strategy. Launched this year, this brings together all our people-related issues and activities to ensure they are delivering on our organisational priorities and our commitment to our people. This year we have made substantial progress including: establishing the Disability and Long-term Health Conditions Forum and continuing to support the thriving additional staff forums; implementing our Speak Up for Safety programme and preparing for the next stage of our behavioural change programme, Speak Up for Our Values; developing a leadership and management framework; and improving our programmes to enhance the skills and capabilities of our staff. An organisation's culture does not change overnight. This year's staff survey results represented an overall improvement but there is still much more to be done.

Our progress in addressing aspects of our culture was, I am pleased to say, recognised in our CQC inspection which saw us move from 'requires improvement' to 'good' for being well-led. In particular the investment we have made in developing our clinical leaders was seen to have borne fruit with strong leadership practices noted across the organisation. The inspection saw us retain our rating of 'good' overall with a rating of 'outstanding' in the areas of 'effective' and 'caring'. The Young People's Forum, which helps to ensure our children and young people's voice is heard and that our care is centred around the patient, was recognised as an area of 'outstanding practice'.

Our ability to lead effectively comes in part from the contribution of our Council of Governors. These people, who give up their time for the benefit of the Hospital, provide fresh perspectives on how we could and should do things differently. I would like to thank each and every one of them for their energy and commitment. In particular I would like to thank Emma Beeden one of our Appointed Governors from the Young People's Forum, and Nigel Mills, a Staff Governor, who both stepped down this year. I am very pleased to welcome Shelby Davies as a representative of the Young People's Forum. We are in the process of planning our elections which will take place at the beginning of 2021.

On the Board this year we were sorry to have to say farewell to Professor Rosalind Smyth and I would like to thank her for her significant contribution. As the director of the UCL Great Ormond Street Institute of Child Health she will remain a key and trusted colleague. We have further strengthened the management team: Dr Sanjiv Sharma was appointed to the role of medical director; Phillip Walmsley was appointed interim chief operating officer; and Zoe Asensio-Sanchez has been appointed to the role of director of development. I would like to thank Professor Andrew Taylor who was acting chief operating officer prior to Phillip's arrival and Stephanie Williamson who has been acting as director of development. At the time of going to print, Professor Russell Viner was nominated by University College London to be a Non-Executive Director on the GOSH Trust Board. He will officially start at the beginning of May 2020.

Next year promises to be challenging as our organisation attempts to resume services that have been paused while it continues to deal with the reality of the pandemic. We should draw strength from our response to date. This year we have changed the way we work and continued to deliver services, conduct research and develop innovative treatments with the child and the families at the centre of everything we do. None of this could have been achieved without the commitment and resilien**ce of our staff and volunteers.**

# Chief Executive foreword

We exist to provide patient-centred care and treatments to children and young people with complex and rare conditions. Faced with COVID-19, a health crisis the likes of which our generation has never seen before, we have reaffirmed this as our primary purpose and sought to offer our expertise in different ways to support the system at this time of crisis.

At GOSH we provide more than 50 different specialist and sub-specialist paediatric services – more than any other hospital in the country. For many of these services we work in partnership with other UK centres and for others we provide a national service. The specialist nature of our work is reflected in the way we are funded. More than 90% of our NHS funding is received from NHS England specialised commissioning.

The ability of our multidisciplinary teams to provide specialist care was highlighted this year when, through a number of operations and many months in hospital, our staff were able to separate a very complex pair of craniopagus conjoined twins. We are also able to offer many of our patients pioneering treatments. In a UK first, and working in partnership with Moorfields Eye Hospital, we treated children with a rare inherited retinal disorder with a new gene therapy. Their condition, which could have seen them lose their vision completely, was untreatable before this point.

When the Coronavirus outbreak occurred, the scale and nature of the health crisis in the UK for both adults and children was unknown. What was clear was that all parts of the NHS , social care and the wider public sector needed to work together to save lives and look after the broader needs of those for whom they have a duty of care. At multiple levels in our organisation we worked extensively with the North Central London STP and other London Partners to plan a collective response. At GOSH, this initially meant almost doubling our intensive care capacity and being prepared to take children that needed specialist treatment from across London.

As the pandemic evolved it became clear that, thankfully, this extra capacity was not needed for paediatric patients. So as primarily adult hospitals came under increasing pressure we agreed to accept all general paediatric patients from the NCL region so that other hospitals could increase their capacity to treat adults. We knew this would mean our team taking on older patients, and some who might have significant mental health needs, and the Trust prepared fully for this. We also housed the paediatric haematology and oncology service from neighbouring UCLH. More than 80 staff who felt their skills could be of help elsewhere volunteered to work in neighbouring hospitals including NHS Nightingale. We also transferred ventilators and other equipment to where it was most needed and our Children's Acute Transport Service (CATS) transferred adult patients between other trusts.

Within the hospital, a herculean effort has been made to provide COVID testing, run 7 –day a week fit testing and provide PPE and scrubs to all staff who need them. I am immensely proud of the way our workforce has responded to this challenge. They have truly embodied the one team spirit. I cannot thank them enough.

It has been a difficult time for a large number of our staff too. Many colleagues have been ill with COVID-19, and many more anxious or isolated. Three colleagues have passed away, which has had a profound effect on our GOSH community. Our staff are the hands and heart

of our organisation and being kind to them and looking after them is of utmost importance. We have launched a well-being hub - a one-stop shop for access to advice and support - and together with our amazing charity we were able to open a pop up shop stocked with donated ready meals and other essential provisions.

The Coronavirus crisis came towards the end of a year in which great strides had been made in areas that required some attention. Teams delivered consistently on waiting time targets for cancer patients throughout the year and worked hard to meet the national target for the maximum amount of time any patient should wait for treatment. We had, very successfully, implemented our Electronic Patient Record (EPR) and were beginning to realise the benefits. These included to the ability to fully integrate virtual consultations which proved critical during the COVID crisis.

Our teams had also delivered unprecedented efficiency savings, which meant we were on track to break-even by the end of the financial year. We had also undertaken substantial work to refresh our strategy. This involved working with patients, families, staff, governors and partners to understand their views on what our role should be in the future and how we should best get there. Their input resulted in our new Above and Beyond strategy, which reaffirms our commitment to advancing care for children and young people with complex health needs. The strategy makes digital innovation a part of our purpose and identifies a number of new distinct priority programmes including making GOSH a great place to work, developing the GOSH Learning Academy and becoming the first-choice provider for paediatric training.

Digital innovation is essential from a patient care and experience perspective. As I have mentioned previously, our EPR provides a fantastic platform to do much of this work, particularly as it is coupled with a digital research environment (DRE) which can safely harness the data it creates. I n this endeavour we will also be helped by the newly established DRIVE unit. This unique facility aims to bring industry experts, clinical teams and scientists together to use the latest technologies such as Artificial Intelligence to solve healthcare’s biggest challenges.

Our new strategy also states that we won’t be caring for our children if we don’t protect the environment. Taking action to address climate change and wider environmental issues is incredibly important to our patients. We were delighted that this year to mark Clean Air Day we opened our first Play Street which saw the road outside the hospital transformed into a traffic free playground. It aimed to highlight the issue of air quality and its impact on child health as well as showcasing the therapeutic power of play. Over the next year we aim to declare a Climate Emergency with the intention of reaching carbon neutrality by 2030.

We will look to launch our strategy over the coming months. It was finalised just before a time of great change in the NHS and it is important that we review its deliverables to ensure they take into account our changed context.

The COVID-19 crisis will mean that many things will not go back to the way they were. Our new normal will be dealing with COVID-19 alongside the re-starting of services. This will mean we will not be able to operate in the same way we once did.

I hope the way we have worked collaboratively within our region, across organisational boundaries, will mean that services can be restructured in the best interests of patients.

There may also be a greater willingness to pool resources. Within our organisation, some of the changes - such as seeing more patients virtually - will be of great benefit to our families. The focus on staff wellbeing was identified as a priority area in our new People Strategy and this should be maintained and further enhanced as we move to the next phase. We will also carefully consider what role homeworking should play for some of our staff going forward.

To assist us in our transformation agenda this year we appointed Richard Collins as our Director of Transformation. He previously led on the introduction of our EPR, the successful implementation of which has given us great confidence in our ability to change the way we work.

And as we transform this organisation, we must also be careful not to risk the things in which we have a strong track record, such as translational research and ensuring the child is first and always. We must demonstrate compassionate inclusive leadership throughout our organisation. Our people are our organisation. The last year has shown just how committed and dedicated they are. I would like to thank every single member of staff - and their families - for their service and support.

# Overview

On the following pages we provide a summary of the organisation, its purpose, the key risks to the achievement of its objectives and highlight how the Trust has performed during the year.

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. Our vision, which sets our direction, is 'helping children with complex health needs fulfil their potential'. Our mission, 'the child first and always', is supported by our Always Values: always welcoming, always helpful, always expert and always one team.

At GOSH we provide over 60 different specialist and sub–specialist paediatric health services. This is 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 our partner Higher Education Institutes, we train the largest number of paediatric nurses in the UK and play a leading role in training paediatric doctors and allied health professionals.

## Our history

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

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

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

## Our structure in 2019/20

The hospital has eight clinical directorates that support our vision to help children and young people with the most complex health needs fulfil their potential. The directorates were named following consultation with our patients and shown below:


In addition there are 10 corporate areas–Clinical Operations, Corporate Affairs, Built Environment, Medical, Nursing, Human Resources and Organisational Development, Research and Innovation, Finance, Communications and Transformation.

During Q4 the directorate structure was aligned to support planning for the COVID-19 pandemic–more information can be found on page xx.

## Our strategy

2019/20 was the final year of our three-year Strategy House, *Fulfilling Our Potential*. Alongside commitments to put 'the child first and always' and 'help children with complex health needs fulfil their potential', the strategy set out four important 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.

Insert image of strategy house

Over the past three years, we have embedded the strategy through designing local, service–led strategies. We have restructured our clinical directorates (see above) to ensure we are fit for purpose for delivering against the strategy, and developed internal campaigns to share strategic insights across the Trust. Two successful week-long strategy events showcased the amazing things we do in our hospital.

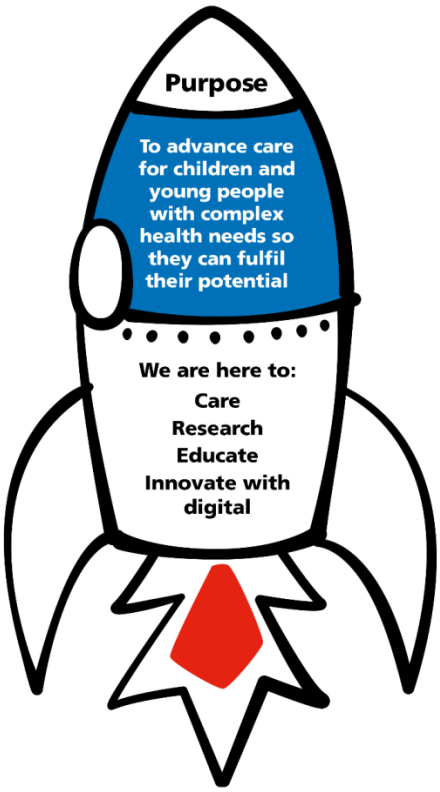
The Performance Report presents a summary of some of the strategic successes this year.

## Redefining our strategy: Above and Beyond

During 2019 we worked with our patients, families, staff, governors and partners to consult on a new five year GOSH strategy. The feedback received was used to refine our vision and the strategic choices and priorities of our hospital in the future.

The new strategy is called *Above and Beyond* and seeks to build on the work of *Fulfilling Our Potential,* which provided the essential building blocks for the exciting new strategy.

In preparing our new strategy, the Trust considered its direction of travel for the future as a provider of specialist and highly–specialist paediatric services and what this meant for the shape of the services we provide. This helped us to define the role we will play within local, national, and international healthcare both now and in 10 years' time.




'Above and Beyond' documents our refreshed purpose as:

- We are here to CARE; to meet the physical, emotional, social, educational and spiritual needs of children, young people and their families.
- We are here to RESEARCH; to learn from all we do, collaborate with the global child health community, and develop the treatments, cures and holistic approaches to care that will offer children and young people a brighter future.
- We are here to EDUCATE; to be a stimulating place for children and young people, to help colleagues build rewarding careers and to provide outstanding training to drive improvements in paediatric care.

- We are here to INNOVATE WITH DIGITAL; to embrace and master digital technologies that will help us save and improve lives and make support available to children and families around the clock.

Our strategy consultation has shaped our statement of purpose. It reflects a clear strategic choice to focus on advancing better, safer, kinder care for children and young people with complex health needs to save and improve more lives. It is our role and our duty to support children and young people who rely on specialist care for their health and wellbeing–those who are seriously ill, those who have multiple complex needs and those with rare or undiagnosed conditions. See page xx for further information about *Above and Beyond*.

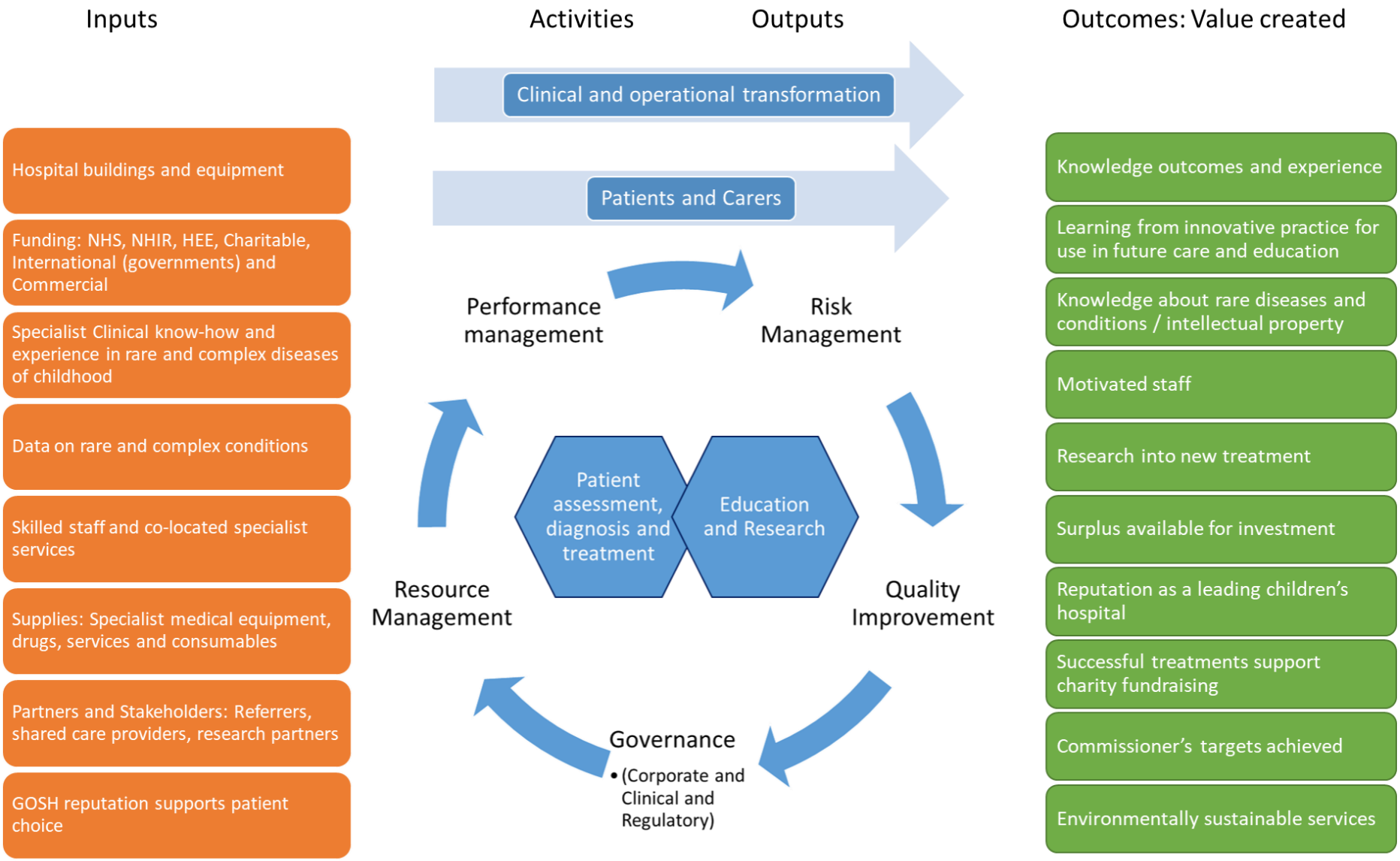
## Our business model

Our business model demonstrates how we create value for our stakeholders through our activities. The model (see page XX) shows the critical inputs and the immediate outputs for NHS services, education and research, and international and private patient activity, and how these create value. The model provides a clear 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.

The business model in 2019/20 was enhanced with the addition of a transformation workstream and a commercial workstream which will drive innovation and strengthen and refine the Trust's outputs.


Inputs
Activities
Outputs
Outcomes: Value created
Hospital buildings and equipment
Funding: NHS, NHIR, HEE, Charitable, International (governments) and Commercial
Specialist Clinical know-how and experience in rare and complex diseases of childhood
Data on rare and complex conditions
Skilled staff and co-located specialist services
Supplies: Specialist medical equipment, drugs, services and consumables
Partners and Stakeholders: Referrers, shared care providers, research partners
GOSH reputation supports patient choice
Clinical and operational transformation
Patients and Carers
Performance management
Risk Management
Quality Improvement
Governance
• (Corporate and Clinical and Regulatory)
Resource Management
Patient assessment, diagnosis and treatment
Education and Research
Knowledge outcomes and experience
Learning from innovative practice for use in future care and education
Knowledge about rare diseases and conditions / intellectual property
Motivated staff
Research into new treatment
Surplus available for investment
Reputation as a leading children's hospital
Successful treatments support charity fundraising
Commissioner's targets achieved
Environmentally sustainable services

## Key risks and issues

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 eight risks to our operational or strategic plans in 2019/20 were identified as:

- Business continuity and planning/management of COVID-19.
- Management and monitoring of medicines.
- Financial sustainability (being able to meet the control total target set by NHS Improvement, in an environment where 1) the NHS is fighting the COVID-19 pandemic. 2) Core services are underfunded and money available to NHS organisations is reduced. 3) The cost of delivering specialised services is high. 4) There is increasing need to rely on international and private patients to support financial viability, but COVID-19 has suspended air travel and there is a focus on essential NHS treatments)
- Stabilisation of the Electronic Patient Record and the consequent impact on changes to working practices, finances and data quality improvement.
- Robustness of systems to retain compliance with referral to treatment standards
- Management of personal and sensitive data.
- The culture across the hospital in relation to levels of staff engagement and motivation in alignment with the Trust strategy and values.
- The political instability caused by Brexit and the ongoing reconfiguration of the health economy and its impact on delivery of services.

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

## Going concern

In 2019/20, the Trust reported an operating surplus prior to capital donations, depreciation in respect of donated assets and impairments, which includes £4.1m funding via the NHS Provider Sustainability Fund. The Trust delivered efficiency savings to support this position.

In 2019/20 the Trust entered into a new three year contract with NHS England Specialised Commissioning. This contract aligns to the plan submitted to NHS Improvement, and the agreed business plans to meet demand and deliver access targets. It demonstrates the organisation will deliver breakeven control total, which is in part achieved through £20m efficiency savings.

As a result of the Covid-19 pandemic, a new financial framework has been introduced in the NHS. This new framework has been created to ensure that all bodies have sufficient cash to meet their outgoings. The guidance issued by NHSE/I for month 1 reporting also directed trusts to show a break even position against their control totals for the first four months of the new financial year.

The most recent information from NHSE/I is that this new framework will remain in place until the end of October, though it is likely to extend to beyond that date.

Providers have been asked to start planning for an increase in elective activity and delivery of the activity backlog created by the Covid-19 pandemic. NHSE/I has indicated it may take

up to 18 months to bring the healthcare system back into the position it was before Covid-19,the Trust has been working with NHSE/I and the STP about how this will be achieved and the calculation of the costs in doing so.

As part of this planning, the Trust has set up a working group which is developing plans to increase activity as soon as it becomes possible to do so as part of a service restoration strategy. This covers a number of areas including:-

- Clinical Services
- People Strategy
- Health and Wellbeing
- Recovery Communication Strategy
- Commercial Strategy
- Research and Innovation
- GOSH Learning Academy
- Children's Cancer Centre
- Medical Directorate Strategies
- Corporate Governance

In addition, the 2020/21 capital allocation for the local STP has been agreed with the DHSC.

The Trust has introduced new processes to ensure that all of its Covid-19 costs are captured and can be evidenced in order to ensure that all such costs can be recovered from NHSE/I.

The Trust is actively engaging and working with the Children's Alliance and the NHSE/I Pricing Team to ensure that the costs relating to the complexity of care are reflected in tariffs to 2021/22 and beyond.

In considering all the factors mentioned above, the directors have a reasonable expectation that the Trust has adequate resources to continue to operate for the foreseeable future. For this reason, and following reasonable enquiries, the directors continue to adopt the going concern basis for the preparation of the accounts within this report

A summary of our financial position and plans can be found on page X. Full details of our income and expenditure in 2019/20 can be found in the accounts from page X.

## Important events since year-end

### COVID-19 planning and restoration of clinical services

The planning for COVID-19 continues into 2020/21. An update on how the Trust deployed its resources and collaborated with partners to deliver paediatric services in North Central London can be found on page xx.

### Non-executive director appointment

Professor Russell Viner was nominated by University College London to be a Non-executive director on the GOSH Trust Board. His appointment was approved by the Council of Governors on 22 April 2020 and officially started as a GOSH Non-executive director on 1 May.

## Changes to Council of Governors

On 13 February 2020 Emma Beeden–one of the two appointed Governors from the Young People's Forum–stood down. On 17 April 2020, Shelby Davies was elected to be a Young Person Forum's appointed Governor.

On 19 February 2020, Nigel Mills stood down as Staff Governor. The position will be kept vacant until the 2021 Council of Governor elections.

# Performance report

## Overview of our performance in 2019/20

2019/20 continued to be a very busy year for GOSH with 249,000 visits to the Trust across inpatient and outpatient services, with just over half of these being from outside London. As an organisation we provide 62 different specialist and sub-specialist paediatric services, the widest range on any one site within the UK. We continue to operate within a difficult NHS financial environment, with funding challenges persisting throughout 2019/20 and beyond. These include the affordability of specialist work, problems attracting and retaining a specialist workforce, and new reforms and structures. This is further compounded by the COVID-19 pandemic.

## Key achievements in 2019/20

Teams across the Trust have continued to make significant progress and achievements with delivery of the 2019/20 plan. These achievements include:

- Board approval of the Trust strategy 'Above and Beyond' and the new People Strategy.
- Go-live of the Epic Electronic Patient Record (EPR) system in April 2019.
- Gradual improvement in the Trust referral to treatment position until the end of Q4 (due to COVID-19) following a planned reduction as part of EPR go-live and specific speciality capacity issues.
- Consistent delivery of all cancer access standards for the year.
- Progress in our redevelopment programme, including:
    - opening of the Zayed Centre for Research into Rare Disease in Children.
    - continued development of the new Sight and Sound Hospital which is due to open in 2021
    - progress with the business case for construction of a new Children's Cancer Centre, noting all works paused during the pandemic (see page xx).

## Impact of COVID-19 on GOSH

The COVID-19 pandemic has had a significant impact on the NHS. GOSH sought to immediately redeploy its resources and support the North Central London sustainability and transformation partnership (STP) and other London partners. The pandemic has served to test NHS and social care's resilience and resources. It has also revealed how services can respond comprehensively and collaboratively to a crisis through the sheer determination and will of its staff. At GOSH, this has been demonstrated by the extensive partnership working across all levels, directorates and departments in the Trust, as well as the commitment to respond to the needs of its own and other patients across the STP. It has done this by redesigning clinical pathways and introducing innovative solutions to delivering patient and corporate services in a safe and efficient way.

Below we outline how the Trust operated and continues to operate during the pandemic. It includes an overview of how we are seeking to restore services so that we are prepared for

any future outbreaks of the virus, whilst at the same time maintaining our specialist services and ensuring children and young people's care is not delayed.

## Working with partners

During the COVID-19 crisis GOSH was and remains committed to supporting the NHS and our North Central London (NCL) network, to care for all paediatric patients. At the beginning of the pandemic, and based on the data available at that time, we modelled the GOSH workforce to support an increase in intensive care paediatric beds. We significantly increased our intensive care bed capacity, expanding from 48 to 81 beds in readiness. As the pandemic developed, it became clear that there were capacity issues building in partner trusts, with an immediate need for space to treat adult patients. GOSH requested from the Care Quality Commission (CQC) an extension to the age of our patients, in readiness to accept patients with COVID-19 up to the age of 65 as a back-up capacity plan. We also held discussions with partners on how to ensure that children and young people had access to immediate and effective care during the pandemic. We agreed to take all general paediatric inpatients from our NCL partners during this period. In addition, University College London Hospitals (UCLH) has transferred its paediatric haematology and oncology service to GOSH. Some NCL provider staff also transferred over to GOSH with these patients and we are grateful for their support.

GOSH recognised that the transfer of paediatric inpatients from across NCL would affect both medically and mentally ill children and young people. We were keen to avoid a situation where children and young people with mental health issues would be held in unsuitable surroundings within Accidence & Emergency, when general paediatric services had moved to GOSH. In order to hold and treat these patients, we requested and was granted a temporary amendment to its registration by CQC for assessing and/or treating patients detained under the Mental Health Act 1983. Collaboration with our partners has been key to ensuring that patients with mental health issues who have been transferred to GOSH are provided with access to safe and effective care.

Key executive members (Chief Executive, Chief Nurse, Medical Director and Director of HR and OD) engage daily with regional leads across the STP to determine the best way to use resources effectively and efficiently. Other senior members of staff have supported wider NCL planning and response teams. We are proud that, through the Chief Executive, GOSH played a key role in planning the establishment of the Nightingale Hospital in London.

GOSH continues to engage with, and support, our international partners. We recently hosted an international video conference with children's hospitals in China, discussing their experiences, what they have learnt, and how we could apply that knowledge to our own response. We are actively engaged in a number of research studies and clinical trials in order to advance the global understanding of the impact of this pandemic on children, and specifically those with complex and urgent health conditions who we continue to support (see below).

Due to the workforce modelling and the ability to flex and upskill staff, GOSH has been able to release staff to support its partners. We are proud that over xx staff put themselves forward to work in other provider trusts across the STP and support these trusts' COVID-19

response on adult wards. XX staff also volunteered to work at the Nightingale Hospital in London.

Over the period, GOSH has sent equipment and food across to partner sites. We also received consumables, for which we were extremely grateful.

## Internal planning

GOSH planned for the pandemic as a major incident in accordance with national direction. The hospital's Gold, Silver and Bronze planning groups have met multiple times every week, with Gold reporting into the Executive Management Team and the Board being appraised of developments on a regular basis. We realigned our directorate structure to manage the revised services, moving from eight directorates to four: heart and lung, operations and images, general paediatrics and GOSH specialities.

The provision of safe care to all our patients is one of GOSH's key principles. During the pandemic, we changed the way we worked to preserve our philosophy 'the child first and always', and ensure children who require inpatient support are appropriately cared for. Examples include:

- We modelled our workforce and clinical pathways services to ensure delivery of safe and effective services. Junior doctor and nursing rotas were reviewed, and we built resilience into the system so as to take account of staff sickness; upskilling staff to work and provide support where needed.
- The Trust has worked hard to ensure that sufficient and appropriate personal protection equipment (PPE) has been available for relevant clinical staff. We have provided ongoing communication, education, training and support for staff throughout this period, as guidance on the use of PPE received from NHS England developed. A fit-testing service has been established in Weston House and has always been accessible to provide support and guidance, particularly with the constant changes to products from central stock and the need for refreshed fit-testing in these circumstances.
- The infection control team has provided daily advice to the Trust and clinical staff on queries about both patient and staff matters, including guidance on PPE and symptom management.
- Our practice educators have supported staff on the wards, especially with developing guidance on the appropriate use of PPE.
- The laboratory service has worked in partnership with the infection control team and ICH to establish a testing facility for patents and staff. This has helped with the safe management of patients on the wards and enabled staff to know when to self-isolate for the protection of their patients, colleagues and family members. The GOSH staff testing programme helped to reduce the burden on the national testing facilities. Further information about the work of the laboratories on COVID-19 can be found below.
- A clinical hub was set up on the intranet providing links to national, royal college and academic society guidelines, guidelines for patients from network hospitals during their stay at GOSH and providing a repository of key papers relating to conditions in children, with a weekly literature review.

## Impact on NHS services and patient experience

Nationally, NHS elective work was postponed. Since 16 March 2020, a large proportion (64%) of GOSH's outpatient work was conducted virtually, using telephone or video conferencing where clinically possible to do so. Our move to an Electronic Patient Record system in April 2019 made this relatively easy to do in a safe and secure way. This is something the Trust will consider continuing, where clinically appropriate, post COVID-19.

These different ways of working have had a direct implication for the delivery of referral to treat (RTT) and diagnostic wait targets for 2019/20. Throughout the period of reduced activity to support the COVID-19 response, our RTT position deteriorated by an average of 1.6% per week against the 92% incomplete standard. Our diagnostic position deteriorated by a weekly average of 6% against the 99% six week standard. Our 52 week position has also been impacted, with us reporting 33 patients having breached the 52 week standard at the end of March 2020, compared to the projected position of nine. Our compliance against our cancer standards has remained consistent, although the volume of our referrals has fallen by 43%.

GOSH has been keen to provide support to patients and families during the pandemic, particularly for those with long-term health conditions. We established an information hub on our website, where patients and families could access information about how the Trust was operating, and the impact on services. We provided guidance on isolating and shielding, and resources for children and young people to help cope with the changes related to coronavirus. By end of April 2020, the website had been visited XX times. The hospital has worked in partnership with GOSH charity to support patients and their families whilst staying on the wards. The charity provided a large number of tablet devices to enable patients and their carers to communicate with family and friends while there are visiting restrictions in the hospital. Recognising changes in the way that patients are able to play, the charity also provided items for arts, craft, music and sensory activity packs and pamper packs. In addition, they provided toiletries, toothbrushes and other items to support families at the hospital.

In order to reduce the risk of infection, we made the difficult decision to limit hospital visitors to one carer per family per day, with siblings unable to visit the hospital.

In response to the COVID-19 pandemic, the EPR was reconfigured to support admission of general paediatric patients from across NCL and oncology patients from a number of other sites. It also provided access to NHS staff from other Trusts, who were caring for patients admitted to GOSH. A video visit solution, fully integrated within the EPR and the MyGOSH patient portal was safely deployed within two weeks, enabling vital patient visits to continue virtually without the need to bring families to the hospital. The EPR team will continue to support GOSH's clinical and operational teams in their response to the pandemic, and the transition back to a steady state as and when this is possible.

We had concerns about the extension to suspension of elective clinical work and the growing backlog of untreated children, coupled with a general reluctance by the public to bring children into hospital. This has been found to lead to delays to treatment with evidence of poor outcomes for some children. We were pleased that NHS England agreed that elective work could recommence from end of April 2020. Working with colleagues across

NCL, we will make any necessary adjustments to patient pathways set up during the COVID-19 surge, to maximise access to children's services and minimise health inequalities.

## Impact on staff

Our response to the pandemic could not have been mobilised so effectively and quickly without the dedication, commitment and team spirit of all of our staff and volunteers.

During the pandemic, the Trust had the expertise and capacity to support staff by providing coronavirus testing facilities. By the end of April 2020, we offered two types of diagnostic testing for all staff:

- Staff with symptoms suggestive of COVID-19 could be swabbed to identify if they were currently infected.
- Staff who were interested to know if they have been exposed to the virus could have a blood test to look for antibodies, and had the opportunity to take part in a research study that would help understand the coronavirus.

During this time, the importance of flexibility of our staff to work under increasing pressure, sometimes in environments they were not used to, was paramount. Approximately 1,500 staff were provided with refresher training to work across different areas of the Trust (see below).

Staff who have not been required on site have worked from home and developed new systems to deliver daily changing priorities, and maintain contact with colleagues. We will review how effective this has been, and whether any learning can be applied in the future to improve working practices.

We recognise the additional stress placed on staff during the pandemic. Not only from constantly changing working practices and the impact on patients and families, but also anxiety caused by the potential impact on their own families. We have sought to make available support and links to services through a Staff Well-being Hub. This includes access to information and services for physical and mental wellness, support in working at home, and for those suffering from domestic abuse.

We are extremely grateful to GOSH Charity for their help in sourcing support, equipment and consumables. Practical support came in the form of food donations from local companies, accommodation for staff, well-being packs for parents, free car parking for staff. With the extensive range of food donated, the Trust was able to open a pop-up staff shop on site, offering ready cooked meals and other provisions. We are extremely grateful for all of the support and kindness shown to our staff by our donors and stakeholders. The Built Environment Team supported the distribution of these items across the hospital and to those self-isolating at home.

In light of the geographical spread of staff across the Trust, at home and working in other hospitals, maintaining regular and accurate communication was essential. At the peak of the pandemic, the daily Gold, Silver and Bronze discussions were cascaded out to the rest of the hospital via a daily coronavirus email and a weekly live blog with the CEO and executives. The blog was viewed by several hundred staff each week. Topics included infection control and availability of PPE, support for staff in managing and helping patients

and carers, self-isolation guidance for all staff, vulnerable groups and pregnant women as well as home working.

We were extremely sad to hear of the untimely death of treasured GOSH colleagues as a result of COVID-19, and our sympathies are with their families and friends.

## Impact on IPP services

As part of the NHS response to the COVID-19 pandemic, our International & Private Patients Service (IPP) wards suspended non-essential treatment. Some of the wards and clinical teams were integrated with the wider hospital, and we worked with international sponsors to repatriate international patients that were able to travel. During this period, IPP have provided additional capacity for GOSH cancer services, as well as dedicated general paediatric services supporting the wider London population and local NHS Trusts. IPP worked very closely with UCLH to host their cancer services in the Octav Botnar Wing. Children and young people from abroad requiring specialist care at GOSH have been unable to travel to the UK on normal routes, and we have continued to work closely with overseas clinical teams providing remote and virtual support.

The IPP central team are continuing to support our international inpatients. They are working with their embassies to repatriate those patients who can travel as soon as the travel situation allows. We have worked closely with our patients and families who have needed to remain in the UK for ongoing essential care and treatment.

The pandemic has had a detrimental impact on the level of IPP income we receive. This income is essential as it is used to support many of our NHS specialist services (see below) and we are reviewing how this work will recommence in the current climate.

## Impact on research

During the pandemic, the majority of GOSH research studies have been paused. Only essential studies continued, for those children already on new treatments that needed to continue for safety reasons, or if starting a new treatment has been the only option for their care.

Researchers at GOSH and ICH been unable to start new research studies. This will have a detrimental impact on the pace of understanding, diagnosis and treatments for children with rare and complex diseases. We will also see a vastly reduced research income, particularly from commercial sources.

Some of our research workforce have been re-deployed to support COVID-19 (clinical and non-clinical) as well as consultants and research fellows. Approximately 20 COVID-19 studies are either approved or in the pipeline. We have linked up with scientists and clinicians around the globe and are working alongside organisations like the NIHR and Public Health England (PHE), to support research into COVID-19 in any way we can.

Examples of studies include:

- The World Health Organisation (WHO) has launched a worldwide study to track the health of people with severe COVID-19 infections as their illness progresses. This study will look at how symptoms change over time, and whether they respond to

different treatments. With the support of our patients and families, GOSH is contributing to the study by providing samples from children diagnosed with COVID-19, including blood samples and swabs taken from the nose or throat.

- GOSH researchers are looking at how COVID-19 affects different groups of children and young people, including those whose immune systems are less able to fight off infection, and those who have had bone marrow transplants.
- In another study, a GOSH team is looking at how a child's response to COVID-19 is influenced by their unique genetic code.
- Public Health England (PHE) are coordinating a nationwide effort to collect and compare samples from COVID-19 patients, looking for key characteristics and patterns in how the virus spreads. This could help to identify geographical hotspots - areas where the virus is likely to spread quickly or affect many people. It might be possible to put additional protective measures in place to reduce the impact on vulnerable communities. GOSH is contributing to this study by providing a large number of patient samples from London. Work to analyse these samples will take place in our brand new Zayed Centre for Research into Rare Disease in Children, in a partnership between GOSH, University College London (UCL) and GOSH Charity.
- COVID-19 care and research requires the collection of various samples from patients. As part of this, we are asking some families if they'd like to sign up for the GOSH Sample Bank. This initiative allows for the use of patient samples that are no longer required as part of their direct care to be used for child health research, rather than being disposed of.

## Impact on education and learning

In response to the urgency of the pandemic, Learning Academy programmes of work were put on hold in order to prioritise the needs of our clinical services and redeployment of critical staff. However, the Learning Academy strategy and structure has proved very effective at responding to this immense task. Resources were promptly redirected to design and implement up-skilling and update programmes to equip our staff for increases in critical care patients as well as cohorts of general paediatric patients arriving from hospitals within London. Teams also worked hard to ensure essential training continued, redesigning many courses to be conducted without face-to-face components, while still assuring delivery of fit-for-purpose education. By 30 April 2020, over 2,000 clinical and non-clinical staff have attended COVID-19 up-skilling and update sessions, including many colleagues joining us from external Trusts. A wide range of audiences have been targeted, from clinical staff currently out of practice, to staff requiring critical care skills, to non-clinical staff who have not worked previously in clinical environments.

## Impact on capital projects

During the pandemic, the focus of the clinical staff, leadership team and estates and facilities, was on maintaining and expanding operations to provide for the required additional clinical space. Risk assessments took into account the stage of the individual project, the likelihood of disruption to the site infrastructure, and the Trust's ability to maintain responsiveness to contractors. As a result, some redevelopment programmes were paused including the respiratory sleep unit and planning for the Children's Cancer Centre and

related decant and enabling works. Other works continued as they were close to completion and activity could be conducted, safely applying social distancing working arrangements.

## Impact on finances

We have established clear financial governance arrangements for managing spend during the COVID pandemic. These operated in accordance with guidance received from NHS England, the Trust's Standing Financial Instruction, Scheme of Delegation and Standing Orders whilst being agile to the ever changing response to COVID-19 by adopting a suitable approach to maintain safe and effective care and working practices across the Trust.

The NHS has suspended the commissioning system for the period April–July 2020 and agreed to fund costs where appropriate evidence is available. We have provided mandatory returns to NHS Improvement (NHSI) and NHS England (NHSE) on the cost of COVID-19. These cover, for example, laboratory equipment and consumables, PPE equipment, staff travel and IT investment to enable homeworking and telemedicine. For GOSH, the costs of COVID-19 are further complicated by the high levels of non NHS income that have historically supported the delivery of NHS services, including income from research and IPP.

## Restoration of our services

In April 2020 the executive management team established a Restoration and Strategy Delivery Group to review the delivery of existing programmes of work (pre COVID-19) and actions required to return GOSH to a new 'steady state'. The remit of the group is to assess the impact of and response to COVID-19 on the Trust and the wider system, and oversee and make appropriate plans for delivering elements of our strategy. This work will be conducted within the context of the current operating environment, which has shifted significantly. Including, where some working practices and processes have changed and are closer to the future state described in the new strategy *Above and Beyond* (see page xx). Benefits arising from the new ways of working should not be lost, but boosted and improved.

As outlined above, we have delayed and reduced our activity in line with NHS England requirements. In order to bring services back on-line, we are working to ensure that we have a robust methodology to appropriately and safely clinically prioritise the treatment of our patients. This needs to be conducted in an evidence-based way. For this reason we have established a Clinical Prioritisation Group and are benchmarking our approach to be taken against the Royal College of Surgeon's guidance. In order to deliver safe and effective care, our approach will also be reflective of the availability of required drugs, PPE and other resources, as well as the external environment and clinical support available for our patients outside of GOSH.

## Our research

We remain 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 research income has grown by 25% in the year to £25 million, with over 1,300 studies active during the year. See page xx for further information.

## Sustainability

GOSH has a longstanding commitment to the careful management of its resources having created its first Sustainable Development Management Plan (SDMP) in 2010. This identified objectives against the social, economic and environmental pillars of sustainability. Updated in 2014, the plan evolved to make important links between healthcare and sustainability.

In 2019, we created our third and most ambitious SDMP. It laid out a significant and holistic range of activities to transform GOSH's impact and culture on sustainability and the health emergency arising from climate change. These internal commitments dovetail with a commitment to face outwards and lead publicly on this fundamental crisis for child health.

In March 2020, we cemented the strategic importance of this work by incorporating it as one of five principles underpinning our vision for 2025.

Highlights of GOSH's sustainability actions in 2019/20 included:

## Clean Air Hospital Framework


- In March 2019, in partnership with Global Action Plan, GOSH launched the Clean Air Hospital Framework (CAHF) which sets out over 200 measurable actions alongside our SDMP. As a result, clean air activity has advanced rapidly.

## Play Streets

- One example from the CAHF, was the transformation of Great Ormond Street into a car-free play street. Taking place on National Clean Air Day in June, over 200 local children, community groups, GOSH patients, families and staff played in what is usually a congested and polluted space. Air quality was monitored and a further play street took place in September 2019, to help mark London's Car Free Day.
- We also used the opportunity to recruit new members and engage patients and their families on our new five year strategy

## Green Champions: Office Sustainability Programme


- Staff involvement is vital for embedding change. One stand-out example includes our Electronic Patient Records team which has driven a wide-ranging programme of office-based sustainability initiatives.

## Plant and Infrastructure: Operational Energy Efficiency Programme


- A programme of upgrade and adjustment work on our electrical and mechanical plant and control systems has had a significant impact on operational efficiency and meeting our carbon reduction targets to date. This will continue throughout the life of this SDMP.

## The Gloves are off

- 'Gloves off' is a campaign to improve patient safety by ensuring that patients and their families see staff with clean hands. Through incredible engagement, staff have questioned and changed practices, resulting in a hugely successful and educational programme. Since being devised and delivered over the last two years, the number of non-sterile plastic gloves has reduced by 3.7 million, saving £90,000 and reducing plastic waste by 18 tonnes.

## Our estate

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. Our redevelopment programme aims to transform the estate to provide world-class facilities for patients, opportunities for new models of care and collaborative research environments. See page xx for further information.

## Our digital future: implementation of an Electronic Patient Record

In the 12 month's since the Epic Electronic Patient Record (EPR) system went live, we have been optimising it to further support staff in delivering complex clinical care. We've worked with clinical and operation teams to build new features both at system-level and at a speciality level. We are able to use the EPR as a key enabler to wider hospital transformation programmes such as Patient Flow, Outpatient Flow and Clinical Pathway Redesign. Most recently, the EPR has been able to rapidly react to the COVID-19 situation. It has aided staff and clinicians by supporting remote working, video visits, workflows, orders for COVID testing, and producing real-time dashboards and reports.

## Our funding

In the context of funding pressures faced by NHS organisations, financial stability remains critical. Over 90% of our NHS funding is received from NHS England specialised commissioning. Our operating surplus (before capital donations, depreciation in respect of donated assets and impairments) was £0.9m in 2019/20. For further information on the financial results, refer to page xx.

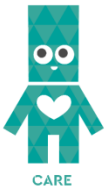
The funding we receive for NHS activity is not sufficient to cover the cost of delivering it, and we rely on the contribution from private patients to support the delivery of NHS services. The Trust also receives income from a portfolio of research, while GOSH Charity helps to fund buildings, equipment and a number of other areas.

Additional funding was received from NHSE and NHSI for the costs incurred in relation to the COVID-19 pandemic.

## Performance analysis

We aligned 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; what they are, and what we have achieved in 2019/20.

## Our performance in 2019/20




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

We aim to deliver high-quality specialised care to our patients every day. We also continuously look to the future to innovate the care that we provide. This year we have seen outstanding examples of innovation from collaboration with national and international partners to deliver world-leading paediatric care.

| Objective | Achievements |
|---|---|
| Be recognised for our expertise and clinical innovation in developing, delivering and leading specialised paediatric services. | • A set of twins conjoined at the top of the head were successfully separated following pioneering surgery. The team included approximately 100 individuals from over 15 disciplines throughout GOSH.<br>• GOSH and UCL welcomed the first patients into the Zayed Centre for Research into Rare Disease in Children. The Centre brings together pioneering research and clinical care in one centre to drive forward new treatments for patients across the UK and internationally.<br>• The first paediatric patients received a new gene therapy that can restore eyesight at GOSH.<br>• In partnership with GOSH Charity, the outline business case for a new Children's Cancer Centre was approved, setting out ambitious vision for the cancer services at GOSH. It was developed focusing on the tripartite mission of clinical services, research and education.<br>• The OGC Gateway Review was completed by the Infrastructure & Projects Authority in September and rated the Delivery Confidence Assessment as amber. The review found 'that the Children's Cancer Centre (CCC) programme is being managed and led by a highly experienced and committed team with an impressive depth of experience and expertise.' The action plan focusses on key areas around project governance and the roles and |

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| | responsibilities of key stakeholders; benefits realisation and resources. |
| Be recognised for our quality of care, positive health outcomes and experience for children and families. | • The CQC rated GOSH as 'outstanding' in the areas of effective and caring, and recognised the encouragement towards innovation and participation in research. CQC also recognised our Young People's Forum as an area of 'outstanding practice', ensuring patients' views and experiences were taken into account. All services were rated either 'good' or 'outstanding'.<br>• An online system was implemented to receive patient and family feedback in real time following feedback that patients and families would like to have choice in the way they submit feedback to the GOSH.<br>• A new Music Therapy service joined the play department to provide care for patients across the hospital. Initial results suggest that this service is having a positive impact on patients and families in terms of reduced anxiety, improved mood and increased engagement during treatment and care.<br>• Twice a year, we run a careers festival for young people aged 13–20 who are, or have been, GOSH patients. This event gives them the opportunity to meet people from a variety of industries and hear their unique career insights. At this one-day event the GOSH teens learn new skills to improve their CV, join in with interactive workshops, meet a variety of companies, find out about exciting career avenues, sign up for work experience and meet other GOSH patients. A designated Parents' Area means parents can get just as much out of the festival as their children and siblings are welcome to come along as well. |
| Provide timely access to care for all GOSH patients. | • GOSH has consistently delivered all the cancer standards throughout 2019/20 ensuring that all patients are treated in line with required standard.<br>• A project was implemented to reduce the number of rejected samples for laboratory testing, reducing delays in diagnosis, treatment and discharge, negative patient experience, and cost. |


## 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. Our people are the head, the heart, the hands and the face of GOSH. They make us who we are and allow us to do extraordinary things. We value and respect them individually and collectively for who they are, as well as what they do. As a Trust, we are committed to ensuring our people are well led and well managed, but also, supported, developed and empowered to be and do their best.

We recognised that the organisational culture was primarily defined by our regulatory framework as it is with all hospitals. Uniquely, GOSH's culture is also defined by our reputation, our research and clinical outcomes, our undeniable commitment to our patients and our staff's strong value-based commitment to their work..

However, these positive characteristics have been being undermined by infrastructure, and a failure to clearly articulate a commitment to our people. This includes setting and upholding standards of behaviour, and creating an environment which actively promotes and values teamwork and collaboration, and where everybody irrespective of their role, feels valued, heard, supported, safe and connected. This was reflected in our staff survey results in 2018.

In November 2019, the Board approved the new People Strategy. It visibly brought together all of the people-related issues and activities, and ensured they are aligned, co-ordinated and focused on delivering GOSH's priorities, alongside our commitment to our people. Further information can be found in the staff report on page xx.

Shifting organisational culture requires continued focus on, and investment in, promoting the characteristics which contribute to a positive working environment, as well as dealing with the negative characteristics which detract from it. A one-year work programme has been developed and is in the process of being delivered. Some of our achievements in 2019/20 include:

| Objective | Achievements |
|---|---|
| Use our values and behaviours to build a positive and diverse culture where staff are inspired to give their best | Continued to support the following staff forums: Black Asian and Minority Ethnic (BAME) Staff Forum; Lesbian, Gay, Bisexual and Trans and Allies Forum (LGBT+); Women's Forum<br><br>Established the Disability and Long-term Health Conditions Forum in 2019.<br><br>On Thursday 31 October 2019, the GOSH BAME Forum held its first Annual General Meeting and first anniversary celebration. It included lunch and |

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| | networking, a panel discussion and sharing of personal stories.<br><br>In May 2019, the hospital lit up some of its buildings with green light to support Mental Health Awareness Week. The initiative was organised by the Mental Health Foundation as part of a range of activities across the hospital, from practical sessions on overcoming fears and phobias, to mindfulness sessions for staff. |
| Ensuring all our staff feel well led and well managed, but also valued, developed, supported and empowered to be and do their best. | Implemented the Speak up for Values programme, with Peer Messengers trained and in place<br><br>Consulted with our colleagues regarding delivery of the People Strategy in Open House Week<br><br>Staff survey responses published, with improved results seen in 8 of 11 themes<br><br>Launched our Disability and Long Term Conditions Forum<br><br>Promoted the use of apprenticeships for more senior non-clinical roles including the establishment of a steering group and guidance for managers<br><br>Developed a nursing retention programme in collaboration with NHSI |
| Be renowned for our talented staff and for the ever-improving quality of work they do. | Our GOSH Exceptional Members of Staff (GEMS) awards attract high quality nominations from staff as well as patients and families and in 2019 we received over 213 nominations for exceptional teams and individuals, with 22 awards given.<br><br>In November 2019, the GOSH annual award ceremony was held. The awards, which have been running for 12 years, received almost 339 nominations. They are 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. See page xx for further information.<br><br>A team from UCLH, UCL and GOSH won the Clinical Leadership Team Award at the BMJ awards for their work to operate on babies diagnosed with Spina Bifida in the womb.<br><br>GOSH was officially recognised as a Centre of Clinical Excellence by Muscular Dystrophy UK in July 2019 at an awards ceremony at the hospital.<br><br>Dr Vesna Pavasovic, Consultant in Malignant Paediatric Haematology and Late Effects Lead, and Dr Helen Spencer, Consultant in Respiratory Medicine and Clinical Lead for Lung Transplant were shortlisted in *The Sun* newspaper's Who Cares Wins Health Awards.<br><br>A GOSH consultant neurologist coordinated the EpiCARE European Reference Network for Rare and |

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| | Complex Epilepsies. The network was recently awarded a Silver Dolphin Award at the 10th Cannes Corporate Media & TV Awards for a short film which demonstrated a Europe-wide collaboration that helped a four-year-old Finnish child diagnosed with hypothalamic hamartoma.<br><br>Critical care staff were lead authors on four of the eight multiple centre trials published globally in paediatric intensive care in 2018 and 2019. They were the largest global contributor from any the paediatric intensive care unit.<br><br>GOSH cardiac surgeons have begun using pioneering 3D heart modelling and virtual reality. A virtual reality model of a patient's heart can assist clinicians to virtually plan and practice complex procedures ahead of surgery, contributing to improved patient outcomes |
| Have leaders at all levels of the Trust who are effective, visible, supportive and respected by their teams. | A Leadership and Management Framework has been developed. It focuses on building and maintaining whole organisational capability, supported by a competency framework which sets out standards, knowledge, skills and behaviours required at each level of leadership across the Trust. The framework recognises that inclusive, compassionate and competent leadership and line management is essential in delivering the culture we want and the ambitions set out in the GOSH strategy. |
| Provide our staff with the skills and capabilities needed to deliver exceptional care from world-class facilities. | The GOSH Learning Academy programme launched, embarking on a three-year journey to become the first choice for multi-professional paediatric healthcare education, training, and development for the whole workforce, utilising state-of-the-art technology in contemporary learning environments.<br><br>Maintained above target statutory and mandatory training throughout the year.<br><br>Designed and developed a Leadership and Management Framework with associated behaviours<br><br>Established the Executive Leadership development programme<br><br>Designed and delivered multi-professional leadership programmes for aspiring and developing leaders<br><br>Implemented a senior leadership programme for directorate teams<br><br>All education and training corporate departments have sustained planned growth and development and increased activity as part of the Learning Academy Delivery Plan, including the Clinical Simulation Centre, Nursing and Non-Medical Education, Organisation and Employee Development, and Postgraduate Medical Education.<br><br>In Q4 2019/20, over 2,000 clinical and non-clinical staff |

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| | attended COVID-19 up-skilling and update sessions, including many colleagues joining from external Trusts. The audiences targeted ranged from clinical staff currently out of practice or needing critical care skills, to non-clinical staff who have not worked previously in clinical environments. |


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

With our research partner the UCL Great Ormond Street Institute of Child Health (ICH), we form the largest paediatric centre in Europe dedicated to both clinical and basic scientific research. We are focused on delivering world-leading research for patient benefit. Over recent years the major focus has been on embedding research across the Trust to further develop GOSH as a Research Hospital.

In the last year there have been 1,290 active research projects, 2,338 patients participating in research and 399 papers published in collaboration with UCL, all helping to accelerate the translation of research into improved patient outcomes.

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

| Objective | Achievements |
|---|---|
| Accelerate the translation of all research into improved patient outcomes.<br><br>Build a culture of innovation and continuous improvement where the talent and creativity of all staff is harnessed. | The Zayed Centre for Research into Rare Disease in Children opened in October 2019 and brought together pioneering research and clinical care. The centre will accelerate the progress of new diagnoses, treatments and cures for rare and complex diseases. Facilities with this capability are extremely rare, with no comparable labs in the UK at present.<br><br>Successful clinical trials at GOSH (in collaboration with other centres from across the world) resulted in NHS approval of a novel treatment for Batten Disease; cerliponase alfa (or Brineura). Batten Disease affects between 30 and 50 children in the UK, and causes seizures, loss of mobility, sight problems and progressive dementia. Patients given the treatment had 80% less decline in motor and language skills and the new therapy also reduced loss of brain tissue. GOSH's role in the approval of Brineura exemplifies our Research Hospital in action, with cross-team working, including the Clinical Research Facility and other clinical areas (wards, PICU, radiology, pharmacy and others).<br><br>A key project for achieving our Research Hospital vision is GOSH Sample Bank. We are asking patients/families to consent to us retaining and storing surplus tissue, instead of these being discarded. This then provides samples for use, alongside associated clinical data, in future research.<br><br>A pioneering new stem cell gene therapy treatment for MPSIIIA (Sanfilippo syndrome) was manufactured at GOSH |

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| | and ICH, after being developed at the University of Manchester with funding from GOSH Charity. It was used to treat the world's first patient with the severe life-limiting genetic condition.<br><br>Research awareness and education remains key in engaging staff, patients and families in Research Hospital. We have a robust research communication strategy, and ensure internal and external engagement through events, newsletters, articles in the staff magazine and newsletters, research updates at Senior Leadership Team meetings, and use of the digital screen in reception. We also have a research session in the Trust-wide, Junior Doctor and Newly Registered Nurse inductions, and featured research patients in the most recent series of *Paul O'Grady's Little Heroes*.<br><br>The Research Hospital strategy is aligned across GOSH, GOSH Charity and ICH, to provide the environment and infrastructure to support research led by our outstanding research leaders.<br><br>Over the last few years, research income has increased by 38%, from a total of £20.3M in 2016/17 to £28M in 2019/20. Of particular note is the significant growth in commercial income, which has increased more than threefold from £2.6M to £8M. |


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

We are continuing on 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, the Digital Research, Informatics and Virtual Environments (DRIVE) unit has increased our focus on digital research, innovation, and other technologies. Through these technological improvements, we remain committed to ensuring the integrity and safety of all our data.

In 2019/20 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. | Launched the EPR enabling a patient's whole clinical team to access their most up-to-date clinical record in one place (see page XX for more information).<br><br>Our Digital team have revamped the GOSH website (gosh.nhs.uk) with a refreshed colour palette, more readable font and added engaging icons which illustrate our key content areas.<br><br>To help celebrate our 167th birthday, we shared a look at GOSH through a 360° video. The video allows viewers to see the hospital and the impact it has on the young people we treat. |
| Ensure rapid uptake of the latest clinical and non-clinical technologies to improve patient outcomes and our productivity. | NHSX officially launched on 1 July 2019 with the goal to drive digital transformation across the NHS and social care, giving patients and staff the technology they need. GOSH DRIVE hosted a launch event and we were pleased to welcome the Secretary of State for Health and Social Care the Rt Hon Matt Hancock and NHSX CEO Matthew Gould along with the wider NHSX team, NHS and social care leaders, colleagues from professional medical bodies and royal colleges, big tech companies, SMEs, charities and NHSX staff.<br><br>In 2019/20, its first year of operation, the Trust |

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| | has established the DRIVE unit as a leading example within the NHS of integrating technology. Key achievements included:<br>• The establishment of over 250 research workspaces deployed and over 390 users deployed<br>• 20 years of legacy patient data curated (roughly over 100,000,000 records) and made available via Fast Healthcare Interoperability Resources (FHIR) to accelerate both operational use and research.<br>• Tested and validated a 'Did Not Attend' predictor model in conjunction with UCL<br>• Worked with the Industry Exchange Network and UCL to establish a pipeline for DRIVE's project portfolio with projects ranging from BSc students working on app design through to artificial intelligence and virtual environment MSc projects.<br>• Established DRIVE's Clinical Informatics Research Programme (CIRP) offering an academic programme in clinical informatics. To-date the programme has leveraged over £500,000 funding for academic research creating 10 PhD studentships and supporting a clinical electives programme<br>• As part of the national COVID-19 response, supported the establishment of the London Nightingale Hospital and GOSH's Digital Research Environment now hosts the data science-workforce tenancy which has been replicated at other centres<br>• Established a COVID-19 workspace to allow modelling and impact evaluation of the COVID-19 emergency on GOSH.<br>The achievements have attracted attention and support from senior stakeholders across the NHS, academia and industry, generating an impressive network of potential collaborators and partners.<br>Looking ahead, DRIVE will become one of the key enablers in delivering digitally enabled care as part of the Trust's Future Hospital Programme. |


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

GOSH cares for more children with rare and complex conditions than anywhere else in the UK and most of Europe, together with our research partnership with ICH. The reputation and reach of the organisation combine with a powerful brand that is carefully cultivated by our charity partners to support essential fundraising for research, equipment, buildings and patient experience.

We aim to use this profile responsibly to draw attention to the issues that are important to our patients, families and staff and advance a wide range of causes that will support them in fulfilling their potential.

In 2019, the Board approved a Stakeholder Relations Strategy detailing how GOSH will use its voice to influence and improve care and manage partnerships effectively.

| Objective | Achievements |
|---|---|
| Use the voice of GOSH to promote issues that directly affect the children and families who need us the most. | *Paul O'Grady's Little Heroes* returned in autumn. The show shone a light on the inspiring patients across the hospital. Some are highlighted below.<br><br>The 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 patient stories to the Trust Board at every public meeting. An update on actions taken following patient stories is presented at the Quality, Safety and Experience Assurance Committee.<br><br>The Young People's Forum (YPF) is a group of current and recent patients, aged 10 to 21, 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. During the year, YPF:<br><br>• 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.<br><br>• Contributed to the Clean Air Hospital Framework by considering ways GOSH could improve air quality.<br><br>• Influenced the GOSH Teens Careers Festival by suggesting the industries and companies that |

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| | should attend.<br>• Shared their experiences of being teenagers at GOSH with apprentice healthcare assistants (HCAs) and newly qualified nurses.<br>• Assisted the Trust to evaluate how young people were heard via PALS and the complaints service.<br>• Attended the first Youth Voice Summit hosted by NHSE. The summit brought together young people and senior NHS leaders to co-create ideas and strategies around the 10 year plan, and how they can be implemented.<br>• Spoke with the CQC to discuss their experiences of the hospital during the routine hospital inspection.<br>• Co-developed a transition workbook in collaboration with GOSH Arts and the Trust Transition lead.<br>• Formed a young people's stakeholder panel for the Head of Patient Experience and Engagement interviews.<br>• Worked with the Redevelopment Team on the plans for the Children's Cancer Centre.<br>To mark Clean Air Day 2019, GOSH opened its first Play Street for patients and the local community, as part of pioneering work to improve air quality. In a collaborative project between GOSH and clean air campaigners, the street outside the hospital was closed to traffic for four hours and transformed into a rainbow-themed play area, with a host of activities championing the therapeutic, emotional and psychological benefits of play, in a safe, clean-air environment.<br><br>GOSH Arts collaborates with a number of high-profile cultural partners to develop bespoke projects for GOSH families and staff. Recent partnerships include Peut-Être Theatre, Foundling Museum, House of Illustration, V&A Museum, Drake Music, Wellcome Collection and Theatre Rites. Through workshops, performances, projects and art commissions GOSH Arts develops connections with clinical staff from a large number of specialist departments as well as hospital services such as the Children's Hospital School and Play team. |
| Play a leading role in the UK system and International Children's Alliance, and ensure our networks across the UK best serve the patient's | Memberships of various national and international partnerships and organisations including UCL Partners; North Central London Sustainability and Transformation Partnerships (STP), Children's Alliance, administering the North Thames Paediatric Network for Specialist |

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| needs | Paediatric Services, European Children's Hospital Organisation (ECHO) (see page XX).<br><br>As a community of healthcare leaders, our people are represented across hundreds, if not thousands, of regional, national and international committees. This is evidence of their passion for learning from others, sharing their own knowledge, and working collaboratively towards solutions.<br><br>During 2019/20 our clinicians were able to contribute to raising awareness of some essential child health debates. They shared their knowledge to help ensure balanced media reporting and well-informed academic and policy statements. For example:<br><br>• Dr Jon Goldin, Consultant Child and Adolescent Psychiatrist discussed child mental health in the wake of the coronavirus pandemic on the Association of Child and Adolescent Mental Health Podcast<br><br>• GOSH and ICH held the first Young Voices in Research event which invited members of the YPF and current GOSH patients to share their ideas and thoughts on how children and young people can be better involved in research.<br><br>• We the 3rd GOSH Conference with a theme of Caring for the Complex Child with a focus on research and innovation, education and lifelong learning' and leadership and service transformation'. |

## Paul O'Grady's Little Heroes–A unique insight into GOSH

- Cora, aged six, received injections of botox as part of a research study at GOSH. More commonly known as a cosmetic procedure, botox can also be used to reduce muscle stiffness for children with cerebral palsy.

Developing resilience through botox

- Seven-year-old Oliver woke up one morning last year with a swollen knee which gradually got worse. At GOSH he started on an intensive course of physiotherapy, with sessions twice a day and lots of exercises.

The power of physiotherapy

- After a previous emergency operation, Noah was very concerned about going through another procedure.
- Noah was offered therapeutic play sessions with specialist staff, tours of clinical areas on Saturday mornings, meetings with the teams involved in their care and demonstrations of medical procedures using toys to prepare him for his hospital stay.

The importance of easing anxiety around treatment

- Seventeen year old Gavriel has a rare muscle condition called Duchenne Muscular Dystrophy (DMD). Together with his brother Joshua, aged eight, he is taking part in an innovative new clinical trial looking at how artificial intelligence (AI) can be used to track movement ability in boys with DMD.

Gavriel's story: helping future generations

- Ten-year-old Oscar was diagnosed with Tourette syndrome and functional neurological disorder.
- Having finished a 12 week programme of Cognitive Behavioural Therapy with Exposure and Response Prevention (ERP), Oscar is now much more confident and his anxiety has reduced considerably.

Oscar's time to shine


## 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 including cutting-edge equipment. This year we celebrated the completion of a major programme of work with the opening of the Zayed Centre of Research into Rare Disease in Children. We also began detailed design and stakeholder engagement for the next phase, the Children's Cancer Centre.

Below is a summary of how we have enhanced our spaces at GOSH in 2019/20

| Objective | Achievements |
|---|---|
| Be recognised as the most environmentally sustainable healthcare provider in the UK with all staff recognising their stewardship role. | Now in its 10th year, GOSH's Sustainable Development Management Plan demonstrates our long standing commitment to more sustainable practices which are reducing our carbon impacts and making the best use of resources (see below).<br><br>In March 2020, the Trust cemented the strategic importance of this work by incorporating it as one of five principles underpinning our vision for 2025. |
| Maximise our hospital site's potential to meet the current and future healthcare needs. | The Zayed Centre for Research into Rare Disease in Children welcomed first patients for treatment at the new Falcon outpatient facility on the site in October 2019.<br><br>Work continues to redevelop the Italian Hospital on Queen Square into the Sight and Sound Centre for GOSH to treat patients with visual and/or hearing impairments.<br><br>We began the complex process of detailed design and stakeholder engagement for a new Children's Cancer Centre at GOSH.<br><br>The Disney Reef won the top prize for Best Collaborative Approach at the Corporate Engagement Awards on 12 June 2019, which recognise the most successful and innovative corporate partnerships and sponsorships. The project was recognised for the successful partnership between the Walt Disney Company, GOSH Charity and GOSH.<br><br>Specially-commissioned artworks have enhanced the spaces in the Premier Inn Clinical Building and the Zayed Centre for Research. The Together Festival, which took place in September 2019 showcased inspirational artwork in the Zayed Centre for Research. |

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| | In addition, it provided an opportunity to cement the position of GOSH Arts as an exemplar programme of arts in public healthcare |
| Provide our clinical teams with the equipment they need to deliver cutting-edge care to our patients. | We completed work on the Southwood Courtyard Building to enable the installation of new iMRI facilities and a new physiotherapy space. |

## Zayed Centre for Research into Rare Disease in Children

The purpose-built Zayed Centre for Research brings together pioneering research and clinical care under one roof in a world-first that will help to drive forward new treatments and cures for seriously ill children.

As well as a new outpatient facility, the Zayed Centre for Research includes:

- A cardiac research suite with facilities for 3D modelling.
- Specialist facilities which allow the manufacture of ground-breaking cell and gene therapies.
- Multiple tissue culture rooms for testing potential new treatments.
- An open plan laboratory with more than 150 laboratory bench positions.

The new facilities were designed especially with children in mind. A sensory room allows children to relax before appointments, and educational play activities help children understand what's happening with their bodies and how research can help them. The child-friendly outpatient consultation area offers views down into the Centre's main laboratory creating a unique and direct connection between patient families and the research that will benefit them.

The values of curiosity, collaboration and innovation are at the heart of the Zayed Centre for Research and are reflected in a series of artworks specially commissioned to create an engaging and welcoming environment for patients, their families, visitors and staff.

Picture of Zayed Centre

## Southwood Courtyard Building

Work at the Southwood Courtyard Building has completed and includes the installation of an interoperative MRI (iMRI) scanner and operating theatre. This new facility allows surgical teams to ensure they have performed the correct interventions, ultimately reducing the risk of repeat operations for neurosurgery patients. A new physiotherapy gym opened on the site on 6 March 2020.


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

Below is a summary of how we have enhanced the use and accuracy of our information at GOSH in 2019/20:

| 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) | Formation of a Business Intelligence Steering Group with input from across the organisation to support the development of a standardised approach to data analytics with an integrated governance structure in place.<br><br>Principles and framework of the approach established and defined as part of the group and decisions taken around which teams need to be part of the process and designed framework.<br><br>Work was paused in March 2020 due to COVID-19 but will be picked up again and informed by the review of the digital infrastructure in place across the organisation. |
| Create a comprehensive, unified electronic single patient record, providing the single reliable source of clinical data to maximise staff productivity and deliver excellent care. | Over 13,000 patients are now communicating with their clinicians, and have access to records, letters and results via the MyGOSH patient portal<br><br>Epic is now integrated with the Child Protection Information Sharing system (CP-IS) so that when a child is known to social services and is a Looked After Child or on a Child Protection Plan, the Safeguarding team are alerted in Epic and can process that alert into an FYI flag.<br><br>A fully integrated and secure Video Visits solution has been implemented using Zoom (the first in the UK) which has allowed us to hold the majority of our face-to-face appointments via video conference during the COVID-19 pandemic. It will allow us to consider different, more efficient ways of working in the future<br><br>We have connected over 15 hospitals and 1,600 individual clinicians who can now access patient records via EpicCare Link to support shared care across the North Central London Paediatrics and Paediatric Oncology networks, as well as 338 UK laboratories |
| Combine advanced analytics with a comprehensive set of data to inform and improve care for our patients. | In 2018/19 GOSH invested and delivered a world leading data platform and innovation hub with DRIVE. DRIVE offers world-leading data infrastructure alongside a data engineering and analytics team. The main aim of DRIVE is to transform care and the way we provide it through better harnessing of data. |


## 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 for NHS organisations particularly in specialist services where real-term funding continues to decrease alongside increasing costs and medical and technological advancements. We continue to review our cost base and look for new ways to deliver efficiencies whilst ensuring high clinical standards and patient and family experience.

| 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. | Continued to refine the long-term (five year) funding model linked to agreed strategic revenue and capital initiatives.<br>Continued to work with the Children's Alliance to develop further understanding and implications of the current funding system for children's specialist services<br>Agreed a one year fixed price contract with commissioners to support the implementation of the new EPR system, reducing the risk to the Trust of loss of income<br>Worked with commissioners to develop funding models for new services in-year<br>Submitted Patient Level Costing (PLiCs) as part of the first mandatory return<br>Scored 1 for finance and use of resources under NHSI's Single Oversight Framework |
| In conjunction with GOSH Charity, maximise value and impact of charitable funding in support of the GOSH strategy. | Worked with the charity to develop a prioritisation process aligned to both organisations' strategies to enable medium to long-term investments that will maximise value for money and impact.<br>Actively linked and liaised with the charity around investment in the Children's Cancer Centre<br>Worked closely with the charity during the COVID-19 pandemic to ensure the donations aligned to staff, patient and parents needs at this time |
| 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. | The organisation has successfully continued to grow private patients with a focus on new UK and international markets, whilst identifying education and research opportunities, including fellowships.<br>A Commercial Director has been appointed to maximise the benefit to the organisation around commercial partnerships and any intellectual property we develop |

## GOSH funding model

For many years GOSH has received income from a variety of sources that has enabled it to provide high quality of care to children and young people with complex and rare diseases. Unfortunately NHS funding alone has not enabled the totality of these costs to be covered. In 2019/20 alternative funding sources over and above NHS income (393m) included:

- Contribution from private patients.
- Commercial research.
- Investment from the GOSH Charity in the hospital's infrastructure enabling the estate and equipment to be of much better quality. This included a contribution towards the EPR infrastructure.
- Charity funding for services over and above those in the NHS service specification that enable an improved patient experience, for example parent accommodation, chaplaincy, Play Services

In 2019/20 this approach has continued to enable the Trust to remain within financial balance and meet the financial and performance targets set by the NHS. While the NHS is covering costs during the COVID-19 pandemic, the future funding model of the organisation will need to be considered. This will include how the NHS may change and develop its tariff systems, stability of commercial markets, and the economic position of the country.

## Maximise value and impact of charitable funding

We have developed a prioritisation steering group which includes members of the Trust Board and charity Trustees, to ensure maximum impact and value for money from any investments made in the medium and long-term.

## International and Private Patients Service

We are internationally-renowned for cutting-edge treatment of children and young people with rare and complex conditions. In 2019/20, we worked with foreign governments and other international sponsors to welcome 5,742 children (5,034 in 2018/19) from overseas. The children came from 107 different countries (116 in 2018/19) that lacked the facilities and/or expertise to treat rare and complex paediatric conditions.

The International and Private Patients Service (IPP) treated 1,114 inpatients (1,113 in 2018/19) and delivered 16,482 outpatient appointments (18,206 in 2018/19) in dedicated and funded facilities at GOSH. This generated an income of £64.96m (£62.2m in 2018/19).

Until the COVID-19 pandemic required us to reconfigure our private service in March 2020 to support the NHS response, we had continued to develop new international markets and diversify our offering. Our aim was to continue the year-on-year income growth that has supported the development the wider Trust plans. In addition to patient treatment and care, we can assist in the training of medical and other clinical staff from other countries, assist with complex case diagnosis and treatment, and help to develop research capability.

## Procurement

The procurement service at GOSH is now in its second year as part of the SmartTogether shared service led by Guy's and St Thomas's NHS Foundation Trust. Over the course of the last 12 months, GOSH has seen sustained improvements in the management of transactional procurement. We operate at Carter Report target levels in both purchase order and catalogue compliance. Material savings have been realised for larger scale procurements and we enjoy best-in-class prices in many areas. Plans are in place to further improve performance in non-clinical sourcing in 2020/21.

In line with Carter Report, in 2019 we installed a new digital contract register and instituted new protocols and training to improve the quality of our contract management. The register now includes some 2,500 contracts and related documents and all new relevant documents are added as soon as they are signed.

GOSH's in-house Materials Management function had a very successful year, extending stock control processes across more areas of the Trust. This generated significant savings (c£714,000) by reducing stock levels, particularly in areas such as theatres and individual wards. Materials Management has also played a vital role in managing PPE stocks during the COVID-19 pandemic. The Trust continues to look at ways in which efficiency of stock management can be further improved.

## Anti–bribery

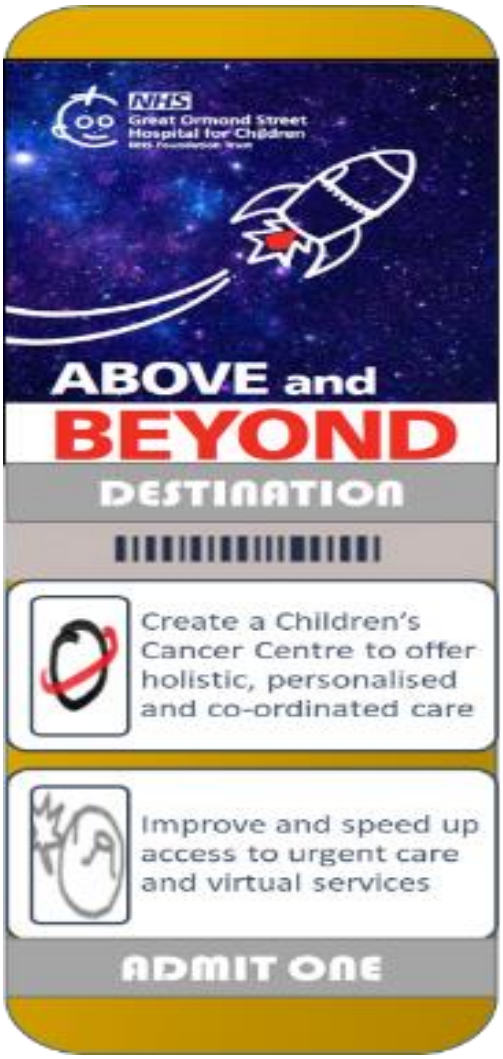
We are committed to delivering good governance and have always expected our directors and staff to meet the highest standards of business conduct.

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 have 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.

## Preparing for take-off in 2020/21

Picture of boarding pass–where we are going




2020/21 will be the first year of GOSH's refreshed strategy *Above and Beyond*. The strategy is based upon six principles to guide our planning, our decision making and our day-to-day work from 2020/21 all the way through to delivery of the whole strategy in 2025.

## PRINCIPLE 1: Children and young people first, always

GOSH in 2025 will be a very different to the hospital established in 1852. But while our founders would have marvelled at our progress and wondered at our technology, our ethos will be quite familiar. Fulfilling the potential of children and young people has always, and will always, drive us on to achieve great things.

**Above and beyond in our CULTURE**

## PRINCIPLE 2: Always Welcoming, Expert, Helpful and One Team

In 2025, GOSH will be a tolerant, inclusive, open and respectful place where staff are valued for who they are as well as what they do. Our people will enjoy coming to work and will live the GOSH Always Values–Always Kind and Welcoming, Always Helpful, Always Expert and Always One Team. We will form strong, supportive multi-disciplinary teams in which everyone has the freedom to learn and contribute and no one is afraid to speak up.

**Above and beyond for QUALITY**

## PRINCIPLE 3: Safe, kind, effective care and an excellent patient experience

In 2025 we will be world-leading in clinical outcomes and service design that puts patients first. Patients and families will be confident in their care because clinical outcomes across all our services will be scrutinised and benchmarked against our international peers and made publicly available on our website. We will develop our capabilities in cancer, cardiac, neurology and rare diseases and nurture the broad base of services that are essential to high quality, holistic care in the specialist children's hospital setting. Complex patient pathways through the hospital will become efficient and integrated 'super-highways' that deliver consistently great care, with patients seen promptly by the right specialist teams, discharged as quickly as possible with the appropriate support, information and co-ordinated follow-up to minimise impact on school and family life.

**Above and beyond for FINANCIAL STRENGTH**

## PRINCIPLE 4: Stronger finances support better outcomes for more children and young people

In 2025 we will be a more efficient, resourceful and resilient organisation. We will take a proactive and enterprising approach to developing long-term partnerships, seizing opportunities and creating secure and diverse streams of income. Our charity will always play an essential role in helping us to extend our reach, helping more children and advancing the pace of discovery. We will leverage our influence and expertise to champion evidence-based public policy, championing a fair funding deal for children who need complex care.

**Above and beyond for the ENVIRONMENT**

## PRINCIPLE 5: We aren't caring for children if we don't protect the environment

In 2025, sustainable business practices will be embedded across our organisation so that our people find it easier to make the right choices. Sustainability will be central to our purpose, given the widely acknowledged impact of climate change on child health across the globe. Our sustainable development action plan will underpin our commitment to planetary health, every day.

**Above and beyond in our PARTNERSHIPS**

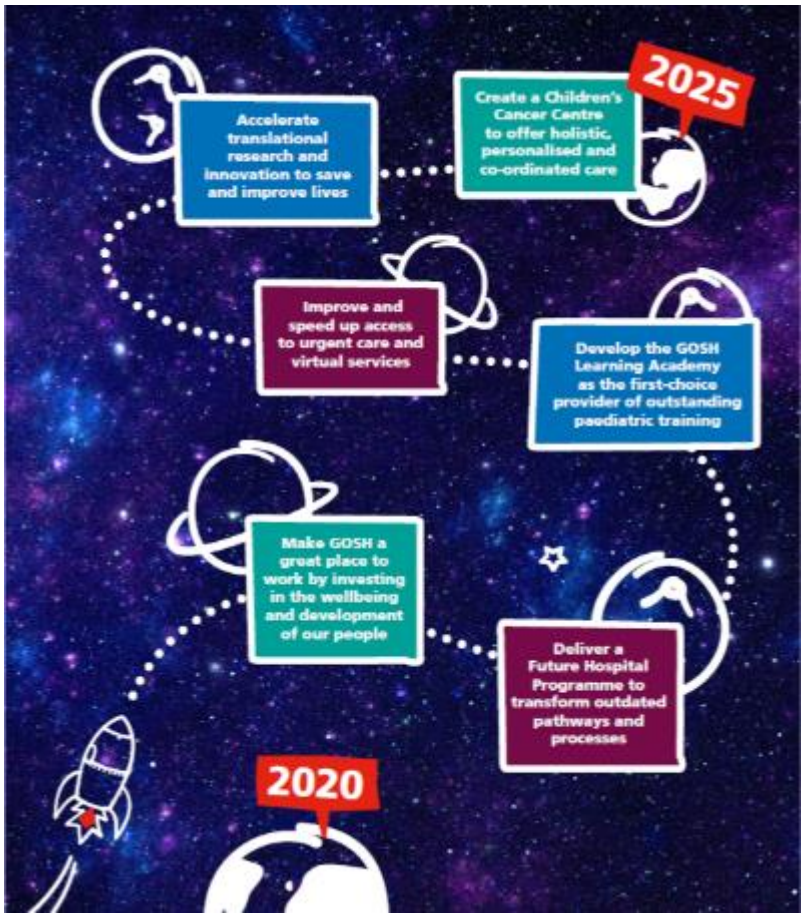
## PRINCIPLE 6: Together we can do more

In 2025, we work with regional and national partners and our patients and families, to co-design the pathways of care that work best for children and young people. By partnering with academia and industry, we will accelerate research and innovation into clinical practice to save and improve more children's lives. Our NHS, charitable, academic and business partnerships will allow us to make faster progress–connecting us to the global effort to advance care for children and young people living with rare and complex conditions, driving us to contribute where we are strongest and bring in expertise where we need it.

We will complete six bold and ambitious programmes of work to help us deliver better, safer, kinder care and save and improve more lives. For more information on how we plan to go about this, see pages xx.

## Plans for take-off

We will complete programmes of work to arrive at six bold and ambitious milestones which will help us to deliver better, safer, kinder care and save and improve more lives.




Below, we have detailed what we plan to achieve in 2020/21 against each milestone.

## Improve and speed up access to urgent care and virtual services

We will maintain and develop the Trust's Capital Projects programme to ensure that the site is fit for purpose, future-proofed and sustainable.

We will open new clinical facilities, including the Sight and Sound centre in 2021 and Respiratory Sleep Unit in 2020.

## Create a Children's Cancer Centre to offer holistic, personalised and coordinated care

Our next major phase of redevelopment will remodel the frontage of the hospital on Great Ormond Street and construct a new clinical building on the site. It will create a national resource for children with rare and difficult-to-treat cancers, thereby improving outcomes for children through holistic, personalised and coordinated care, across the entire cancer journey.

Key to the design will be inspiring and flexible spaces that can respond rapidly to the changing nature of cancer care and allow patients to benefit easily from the latest research.

This building will demonstrate a physical Research Hospital in action, with the creation of flexible spaces that can respond to the rapidly changing nature of cancer care and research landscape, facilitating accelerated adoption of innovations. The centre will also include an upgraded pharmacy and internationally leading research programme to develop and test new formulations and methods of drug delivery.

The value of art in this therapeutic environment will be realised by the involvement of experts from GOSH Arts throughout the process.

Construction is expected to begin in 2022. In readiness, a significant programme of work will be undertaken to relocate teams and functions from the proposed site.

Our aspiration is that the proposed works will also provide the opportunity to significantly improve the public realm aspects of Great Ormond Street in order to benefit the local community not just our patients, staff and visitors. To this end, we will continue to undertake close dialogue with the London Borough of Camden as well as with the local community.

## NEW MILESTONE: Make GOSH a great place to work by investing in the wellbeing and development of our people

By the end of year one of the strategy we plan to have:

- Developed a new employee brand to support recruitment and retention of a diverse, talented and engaged workforce, and delivered high profile recruitment campaigns to fill key vacancies
- Built a trust-wide workforce plan, using an updated model and tools to better support business planning and budget setting.

- Published a leadership and management framework to develop organisational capacity and set standards and expectations, and launched a development programme for aspiring, developing and established leaders.
- Rolled out a training module for all line managers to increase capability and confidence.
- Established an employee relations support service with coaching, mentoring and mediation services.
- Established an efficient and effective corporate infrastructure to support managers and staff in doing better on the basics, and in preparing for transformational change.
- Delivered an internal communications strategy and infrastructure to promote engagement ensure the employee voice is heard, and created a staff engagement network and channels.
- Developed a staff health and wellbeing strategy and a reward and recognition framework.
- Published a diversity and inclusion strategy and work programme, including cultural awareness and unconscious bias training.

### NEW MILESTONE: Develop a GOSH Learning Academy and become the first-choice provider for paediatric training

By the end of year one of the strategy we plan to have:

- Aligned the GOSH Learning Academy offer with the GOSH People Strategy, Transformation portfolio and the NHS Long Term Plan and NHSI Developing People–Improving Care Framework.
- Formalised and aligned partnerships between the GOSH Learning Academy team and GOSH DRIVE and academic partners.
- Established a digital learning team, who are developing a virtual learning platform in collaboration with DRIVE.

### NEW MILESTONE Accelerate translational research and innovation

Embedding research in every aspect of hospital activity has never been more important. We will further realise our Research Hospital vision in 2020/21 by enabling wards at GOSH to take on more clinical research studies. With the support of our expert NIHR Clinical Research Facility (CRF), we'll develop infrastructure across all clinical departments to support research alongside clinical practice.

Collecting data centrally through our EPR system Epic, used alongside our research and innovation platform (Digital Research Environment or DRE), opens up untold opportunities to advance understanding of child health. Next year, our Digital Health and Research Informatics team will continue to expand its specialised workforce, initiate new research studies, and work towards goals such as systems that instantly identify children eligible for clinical trials.

The coming year will see GOSH launch its London North Genomics Laboratory Hub (GLH), one of seven national hubs commissioned by NHSE to service the nation's genome sequencing requirements. The approach - 'reading' the entire sequence of more than 3 billion letters in a person's DNA - will focus first on patients with rare diseases, cancer and infectious diseases. From 2019, all children at GOSH with cancer will have their genome sequenced. In 2020/21, we expect to see this service begin to increase our capacity and ability to take part in cutting-edge genomics research to improve the diagnosis and treatment of rare childhood diseases.

Our Centre for Outcomes and Experience Research in Children's Health Illness and Disability (ORCHID) will continue to conduct and support research. The team leads research to inform the development of interventions that impact on the care and experience of children, young people and families, at GOSH and worldwide. They also provide support to nurses and allied health professionals to start or develop their research careers, plan and deliver research projects, and apply for research funding.

## NEW MILESTONE Deliver a Future Hospital Programme to transform outdated pathways and processes

In year one of the strategy we plan to have:

- Developed a transformation portfolio with a governance framework, resources and KPIs.
- Developed an Operational Hub; a centre to co-ordinate patient flow by improving operational visibility of key data relating to demand and capacity, current activity and staffing.
- Reviewed and redesigned key clinical pathways to identify any opportunities for increased efficiency.
- Reviewed our outpatient process, put service specifications in place for video visits, and optimised the MyGOSH app.
- Engaged with partners and policy-makers on the case for change, challenges and next steps to developing a data-driven, virtual children's hospital for London–a learning health system to seamlessly connect all children's health services and empower patients and families in taking control of their care.
- Scoped and developed a system and international partnerships for data sharing and benchmarking to advance Quality Improvement in paediatric specialised services.

## 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.

**Mr Matthew Shaw**

**Chief Executive**

**XX May 2020**

# 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 new directorate leadership structure is now embedded (see page xx). Our Operational Board, comprising members of the senior clinical and corporate leadership teams, reports to our Executive Team and provides a regular forum for discussing and making decisions on a range of issues relevant to day-to-day operational management, including quality, efficiency and effectiveness.

## The Trust Board–who we are and what we do

The Board is normally comprised of a Chair, Deputy Chair, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by University College London.

Professor Rosalind Smyth (UCL appointment) stepped down from the Board on 31 December 2019. From 1 January 2020 until 30 April 2020, the Board comprised a chair and five non-–executive directors.

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

## Trust Board members 2019/20

### Non–executive directors

| | |
|---|---|
| **Sir Michael Rake FCA FCGI**<br>Term: 1 November 2017–31 October 2020<br>Chair of the Trust Board and Council of Governors<br>Attended 8 out of 8 Board meetings in 2019/20<br>Attended 4 out of 4 Council of Governors' meetings 2019/20<br>Chair of:<br>• Trust Board Nominations Committee (1 meeting of 1 in 2019/20)<br>• Council of Governors' Nominations and Remuneration Committee (3 meetings of 3 in 2019/20)<br>Experience:<br>• Chairman of Newday Ltd<br>• Chairman, Phoenix Global Resources<br>• Vice President, Royal National Institute of Blind People<br>• Senior Advisor, Chatham House<br>• Director of Open Britain<br>• Chairman of BT Group Plc until 2017<br>• Chairman (both UK and international), KPMG (2002–2007)<br>• Chairman, Easyjet (2009–2013)<br>• Director, Worldpay Group plc (Chairman 2015–2018)<br>• Qualified accountant | Insert image |
| **Mr Akhter Mateen**<br>Deputy Chair and Chair of the Audit Committee<br>Term: 28 March 2015–27 March 2021<br>Attended 8 out of 8 Board meetings in 2019/20<br>Attended 4 out of 4 Council of Governors' meetings 2019/20<br>Chair of:<br>• Audit Committee (attended 4 meetings of 4 in 2019/20)<br>Member of:<br>• Finance and Investment Committee (attended 6 meetings of 6 in 2019/20)<br>• Trust Board Remuneration Committee (attended 3 meetings of 3 in 2019/20)<br>• Trust Board Nominations Committee (1 meeting of 1 in 2019/20)<br>Experience<br>• Trustee, Malala Fund UK<br>• Non-executive director, Centre for Agriculture and Biosciences | Insert image |

| | |
|---|---|
| International<br>• Trustee, Developments in Literacy (DIL) UK<br>• Non-executive director and Audit Committee Chair, Centre for Agriculture and Biosciences International<br>• Group Chief Auditor of Unilever (2011–2012)<br>• Senior Global and Regional Finance roles Unilever, leading finance teams in Latin America, South East Asia and Australasia. (1984–2011) | |
| **Mr James Hatchley**<br>Senior Independent Director<br><br>Term: 1 September 2016–31 August 2022<br><br>Attended 8 of 8 Board meetings in 2019/20<br><br>Attended 3 out of 4 Council of Governors' meetings 2019/20<br><br>Chair of:<br>• Finance and Investment Committee (attended 6 meetings of 6 in 2019/20)<br>• Trust Board Remuneration Committee (attended 3 meetings of 3 in 2019/20)<br>Member of:<br>• Audit Committee (attended 4 meetings of 4 in 2019/20)<br>• People and Education Assurance Committee (attended 3 meetings of 4 in 2019/20)<br>• Trust Board Nominations Committee (0 meetings held in 2019/20)<br>Experience:<br>• Qualified accountant<br>• Group Strategy Director 3i Group PLC and member of the 3i Investment Committee<br>• Chief Operating Officer KKR Europe (2014 to 2016)<br>• Former independent member of the GOSH Audit Committee and GOSH Quality and Safety Assurance Committee | Insert image |
| **Lady Amanda Ellingworth**<br>Non-executive director<br><br>Term: 1 January 2018–31 December 2020<br><br>Attended 8 of 8 Board meetings in 2019/20<br><br>Attended 4 out of 4 Council of Governors' meetings 2019/20<br><br>Chair of:<br>• Quality, Safety and Experience Assurance Committee (attended 4 meetings of 4 in 2019/20) | Insert image |

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|---|---|
| Member of:<br><br>• People and Education Assurance Committee (attended 4 meetings of 4 in 2019/20)<br>• Trust Board Remuneration Committee (attended 3 meetings of 3 in 2019/20)<br>• Trust Board Nominations Committee (0 meetings held in 2019/20)<br><br>Experience:<br><br>• Background as a senior social worker focusing on children and families<br>• Director, Plan International UK<br>• Deputy Chair, Sir Ernest Cassel Education Trust<br>• Lay Adviser Royal College of Medicine (2015–2019)<br>• Deputy Chair, Barnardo's (2010–2019)<br>• Chair The Guinness Partnership (2005 – 2016)<br>• Chair, The Caldecott Foundation (2001 - 2010 | |
| **Mr Chris Kennedy**<br><br>Non-executive director<br><br>Term: 1 April 2018–31 March 2021<br><br>Attended: 5 of 8 Board meetings in 2019/20<br><br>Attended 2 out of 4 Council of Governors' meetings 2019/20<br><br>Member of:<br><br>• Audit Committee (attended 4 meetings of 4 in 2019/20)<br>• Finance and Investment Committee (attended 4 out of 6 meetings in 2019/20)<br>• Trust Board Remuneration Committee (attended 3 meetings of 3 in 2019/20)<br>• Trust Board Nominations Committee (0 meetings held in 2019/20)<br><br>Experience:<br><br>• Qualified accountant<br>• Non-executive director and Chair of Audit Committee, Whitbread PLC<br>• Non-executive director, The EMI Archive Trust<br>• Group Chief Financial Officer, ITV PLC<br>• Chief Financial Officer, Micro Focus (2018–2019)<br>• Chief Financial Officer, ARM Holdings (2015–April 2017)<br>• Chief Financial Officer, easyJet (2010–2015) | Insert image |
| **Ms Kathryn Ludlow**<br><br>Non-executive director<br><br>Term: 1 September 2018–31 August 2021 | Insert image |

| | |
|---|---|
| Attended: 4 of 4 Board meetings in 2019/20<br><br>Attended 4 out of 4 Council of Governors' meetings 2019/20<br><br>Chair of:<br><br>• People and Education Assurance Committee (attended 4 meetings of 4 in 2019/20)<br><br>Member of:<br><br>• Quality, Safety and Experience Assurance Committee (attended 3 meetings of 4 in 2019/20)<br>• Trust Board Remuneration Committee (attended 3 meeting of 3 in 2019/20)<br>• Trust Board Nominations Committee (0 meetings held in 2019/20)<br><br>Experience:<br><br>• General Counsel, Centreview Partners UK LLP<br>• Partner, Linklaters (1997–2017)<br>• Special Advisor to G3, the Good Governance Group<br>• Trustee of the International Rescue Committee, UK | |
| **Professor Rosalind Smyth CBE FMedSci**<br><br>Non-executive director<br><br>Term: 1 January 2013–31 December 2019<br><br>Attended 5 out of 7 Board meetings in 2019/20<br><br>Attended 2 out of 4 Council of Governors' meetings 2019/20<br><br>Member of:<br><br>• Quality, Safety and Experience Assurance Committee (attended 4 meetings of 4 in 2019/20)<br>• Board of Directors' Remuneration Committee (attended 3 meetings of 3 in 2019/20)<br>• Board of Directors' Nominations Committee (0 meetings held in 2019/20)<br><br>Experience:<br><br>• Director of the UCL Great Ormond Street Institute of Child Health<br>• Honorary Consultant Respiratory Paediatrician at GOSH<br>• Chair of the MRC Clinical Training and Careers Panel<br>• Chair of the Paediatric Expert Advisory Group of the Commission on Human Medicines (2002–2013)<br>• Previously the Director of the UK Medicines for Children Research Network<br>• Trustee, Cystic Fibrosis Trust | Insert image |
| **Professor Russell Viner**<br><br>Non-executive director | |

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|---|---|
| Term: 1 May 2020–30 April 2023<br><br>**Member of:**<br>• Quality, Safety and Experience Assurance Committee<br>• Trust Board Remuneration Committee<br>• Trust Board Nominations Committee<br>**Experience:**<br>• President of the Royal College of Paediatrics and Child Health<br>• Professor of Adolescent Health at the UCL Great Ormond Street Institute of Child Health (UK's first professor of Adolescent Health)<br>• Vice Chair of NHS England Children and Young People's Transformation Board<br>• Member, NHS Assembly<br>• Member of Scientific Advisory Group for Emergencies (SAGE) and sub-committees<br>• Executive Committee member for the International Paediatric Association<br>• Patron, Association of Young People's Health, UK. | |

## Executive directors

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| **Mr Matthew Shaw**<br>Chief Executive<br>Matthew is responsible for delivering the strategic and operational plans of the hospital through the Executive Team.<br>Attended 8 out of 8 Board meetings in 2019/20<br>Attendee of:<br>• Quality, Safety and Experience Assurance Committee (3 meetings of 4 in 2019/20)<br>• Audit Committee (3 meetings of 4 in 2019/20)<br>• Finance and Investment Committee (3 meetings of 6 in 2019/20)<br>• People and Education Assurance Committee (3 meetings of 4 in 2019/20)<br>• Trust Board Remuneration Committee (attended 3 meetings of 3 in 2019/20)<br>• Trust Board Nominations Committee (0 meetings held in 2019/20)<br>Experience<br>• Orthopaedic surgeon<br>• GOSH Medical Director (March 2018–December 2018)<br>• Clinical Director of the spinal unit at the Royal National Orthopaedic Hospital (2011–2018)<br>• Medical Director for Health Provision, BUPA UK until April 2018. | Insert image |
| **Mr Phillip Walmsley**<br>Interim Chief Operating Officer<br>Phillip is responsible for the operational management of the clinical services within the Trust. He is the named Senior Information Risk Owner. | Insert image |

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|---|---|
| Attended 3 out of 3 Board meetings in 2019/20<br>Attendee of:<br>• Quality, Safety and Experience Assurance Committee (1 meeting of 2 in 2019/20)<br>• Audit Committee (1 meeting of 2 in 2019/20)<br>• Finance and Investment Committee (2 meetings of 3 in 2019/20)<br>• People and Education Assurance Committee (3 meetings of 4 in 2019/20)<br>Experience<br>• Seconded to GOSH from role as Director of Operations at Weston Area Health NHS Trust<br>• Fifteen years of operational management experience | |
| **Dr Sanjiv Sharma**<br>Medical Director from May 2019 (interim post holder from December 2018). Sanjiv is responsible for performance and standards (including patient safety) and leads on clinical governance.<br>Attended 7 out of 8 Board meetings in 2019/20<br>Attendee of:<br>• Quality, Safety and Experience Assurance Committee (attended 4 meetings of 4 in 2019/20)<br>• People and Education Assurance Committee (attended 3 meetings of 4 in 2019/20)<br>Experience<br>• Consultant in Paediatric and Neonatal Intensive Care<br>• Deputy Medical Director for Medical and Dental Education (2016–2018) | Insert image |
| **Ms Alison Robertson**<br>Chief Nurse<br>Alison is responsible for the 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.<br>Attended 8 out of 8 Board meetings in 2019/20<br>Attendee of:<br>• Quality, Safety and Experience Assurance Committee (attended 2 meetings of 4 in 2019/20)<br>• People and Education Assurance Committee (attended 4 meetings of 4 in 2019/20)<br>Experience<br>• Qualified adult and children's nurse<br>• Executive Director of Nursing, Al Wakra Hospital, Hamad Medical Corporation, Qatar until 2018<br>• Led nursing and midwifery in five different organisations over the last 16 years | Insert image |

| | |
|---|---|
| • Former visiting Professor at the Florence Nightingale School of Nursing and Midwifery, King's College | |
| **Ms Caroline Anderson**<br>**Director of Human Resources and Organisational Development**<br>Caroline is responsible for the development and delivery of a human resources strategy and organisational development programmes.<br>Attended 8 out of 8 Board meetings in 2019/20<br>Attendee of:<br>• Quality, Safety and Experience Assurance Committee (attended 4 meetings of 4 in 2019/20)<br>• People and Education Assurance Committee (attended 4 meetings of 4 in 2019/20)<br>• Trust Board Remuneration Committee (attended 3 meetings of 3 in 2019/20)<br>• Trust Board Nominations Committee (0 meetings held in 2019/20)<br>Experience<br>• Director of HR, OD and Corporate Communications, HM Land Registry (2013–2019)<br>• Assistant Director, HR and OD, London Borough of Hackney (2007–2013) | Insert image |
| **Ms Helen Jameson**<br>Chief Finance Officer<br>Helen is responsible for the financial management of the Trust, as well as leading on contracting, estates and facilities and the North London Genomic Laboratory Hub.<br>Attended 8 out of 8 Board meetings in 2019/20<br>Attendee of:<br>• Finance and Investment Committee (attended 6 meetings of 6 in 2019/20)<br>• Audit Committee (attended 4 meetings of 4 in 2019/20)<br>Experience:<br>• Director, UCL Partners<br>• Established the North Central and East London office of Health Education England<br>• Lead on finance and governance of the London wide education commissioning system<br>• Strategic Health Authority (London Region).<br>• Former Deputy Director of Finance and Joint Divisional Manager for Surgery and Critical Care at Kingston Hospital NHS Trust<br>• Former Assistant Director of Financial Planning and Reporting for South East Coast Ambulance Service NHS Trust | Insert image |
| **Professor Andrew Taylor**<br>**Acting Chief Operating Officer (17 December 2018–30 September 2019)**<br>Andrew was responsible for the operational management of the clinical services within the Trust. He is the named Senior Information Risk Owner. | Insert image |

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|---|---|
| Attended 0 out of 1 Board meetings in 2019-120<br>Attendee of:<br>• Quality and Safety Assurance Committee (attended 0 meetings of 1 in 2019/20<br>• Finance and Investment Committee (attended 3 meetings of 3 in 2019/20)<br>• Audit Committee (attended 1 meeting of 1 in 2019/20<br>Experience<br>• GOSH Clinical Director of Operations (until 16th December 2018)<br>• Head of Department, Children's Cardiovascular Diseases, UCL Institute of Cardiovascular Science<br>• Acting Medical Director, GOSH (2016)<br>• North London Representative, NHSE National Clinical Reference Group for Paediatric Cardiology | |

## Other directors

**Ms Cymbeline Moore - Director of Communications**

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

**Ms Stephanie Williamson from 1 January 2020 - Acting Director of Built Environment**

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

**Professor David Goldblatt - Director of Research and Innovation**

David 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.

**Richard Collins, Director of Transformation**

Richard has been appointed on a 12-month secondment from July 2019 to drive innovation and deliver projects that strengthen and refine the Trust.

**Mr Matthew Tulley, Director of Development**

Matthew led the work to redevelop the Trust's buildings until 31 December 2019

## Register of Interests

The Trust Board has signed up to the revised Trust Board 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 assurance committee meeting.

A Register of Directors' Interests is published on the Trust website, https://gosh.mydeclarations.co.uk/home and can also be obtained by request from the Company Secretary, Great Ormond Street Hospital for Children NHS Foundation Trust, Executive Offices, Barclay House, 37 Queen Square, Great Ormond Street, London, WC1N 3BH.

## Trust Board meetings

In 2019/20, the Board held a total of eight meetings of which six included a session held in public. In May 2019 the Board held a joint meeting with GOSH Children's Charity Board of Trustees and in October 2019 the Board held a strategy meeting. The Board did not meet in June 2019, January 2020 or March 2020.

## Evaluation of Board performance

As part of their routine scheduled inspection programme, the CQC conducted an independent well–led inspection of the Trust in October 2019 and during 2019/20 the Board and its committees monitored progress with the action plan. Further information can be found on page xx. The Board is planning on conducting an externally-led Board evaluation by end Q1 2021/22.

## Trust 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. 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. Assurance committee chairs meet to discuss the remit of their committees and avoid duplication.

### 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, Safety and Experience Assurance Committee

The Quality, Safety and Experience 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 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.

### People and Education Assurance Committee

The People and Education Assurance Committee is chaired by a non-executive director and has delegated authority from the Board to ensure a supported and innovative workforce, an excellent learning environment for clinic and non-clinical staff and a culture that aligns with the Trust's strategy and Our Always Values. A summary of the work of the committee can be found on page XX.

### 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. A summary of the work of the committee can be found on page XX.

### 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 Chair of the Board. It has responsibility for reviewing the size, structure and composition of the Board and making recommendations 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 Mr Phillip Walmsley as Interim Chief Operating Officer on 1 October 2019. Professor Andrew Taylor stepped down as Acting Chief Operating Officer.
- The appointment of Ms Stephanie Williamson, Acting Director of Development from 1 January 2020 following the departure of Mr Matthew Tulley, Director of Development on 31 December 2019.
- The appointment of Ms Zoe Asensio-Sanchez as Director of Estates, Facilities and Built Environment from 1 August 2020 following the departure of Ms Stephanie Williamson, Acting Director of Development.

## Council of Governors

As a foundation trust we are accountable to our members through our Council of Governors.

The Council of Governors is made up of 26 elected and appointed Governors. They support and influence the strategic direction of the Trust by representing the views and interests of our members.

The Council of Governors act as a link to the hospital's patients, their families, staff and the wider community ensuring that their views are heard and reflected in the strategy for the hospital. Although the Council of Governors 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 of Governors can be found at https://www.gosh.nhs.uk/about-us/foundation-trust/council-governors.

### Constituencies of the Council of Governors

Governors 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 Council of Governors.

There were no elections in 2019/20.

In 2019/20 two vacancies arose from Governors standing down earlier than the end of their term. The vacancies were offered to next highest polling candidates in the previous February 2018 election, to serve a term of office expiring on 1 March 2021 (the remaining term for the seats). In May 2019 the Council welcomed the two new Governors, they were:

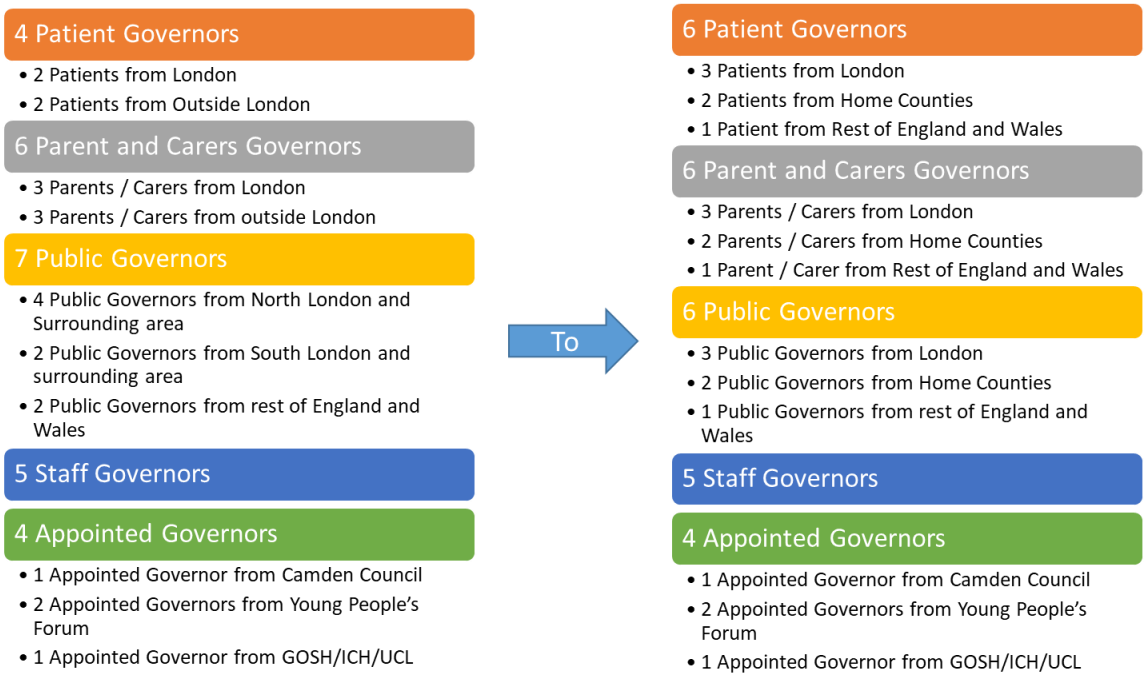
- Margaret Bugyei-Kyei – Staff constituency
- Carly Bowman – Parents and Carers from outside London constituency.

## Elections in 2020/21

Between November 2020 and January 2021, the trust will hold elections for all elected Governors whose terms expire on 1 March 2021. This election will see the implementation of two areas of constitutional change previously agreed by the Council in July 2018.

### The implementation of changes to member constituency classes

The current way public and patient/carer members are allocated to classes was found to be inconsistent and confusing. The classes were updated to ensure the electoral areas covered by the patient, carer and public constituencies align with current electoral boundaries and provided consistency in how many Governors each constituency could vote for. Following these changes, the Council will look like this from the 2021 term onwards:



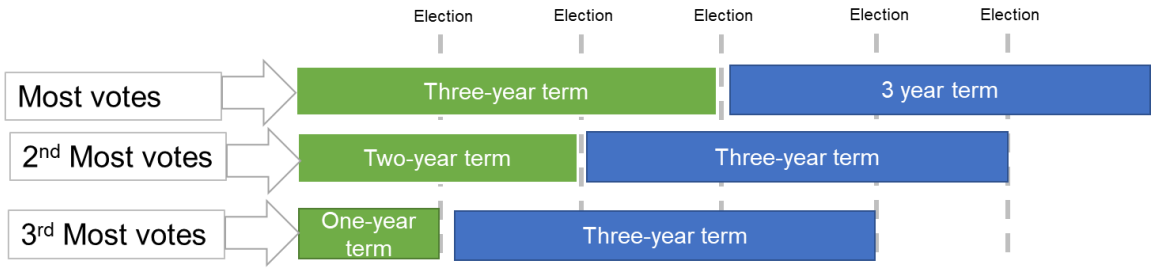

Following these boundary changes in January 2021, there will be 27 Governors on the Council – an increase of one.

### The introduction of phased elections for Governors.

Currently, all elected Governors serve a three-year term, and they all stand down at the same time. To ensure that we have a gradual turnover, retain experience and provide for succession planning going forward, the Council agreed to stagger elections.

At the next election only, Governors' terms will be amended to one, two or three years based on the number of votes received during that election (for the next election only). Subsequent elections will then be for full three-year terms. Appointed Governors' positions will not be subject to staggering of terms.

Once we have set the staggering in motion, we will hold elections annually. In each election, approximately one third of elected Governor seats will be available to be filled. Each elected Governor will be elected for a three-year term.




Implementing the changes at the same time reduces impact and ensures economies of scale in planning and communicating any changes to members. Members will receive updates on what these changes means for them throughout 2020/21 ahead of the election.

## Governors' attendance at meetings

The Council of Governors met four times in 2019/20. Governors attended these meetings as follows:

| Name | Constituency | Date role began | Council of Governors' meeting (out of 4 unless otherwise stated) | Nominations and Remuneration Committee (out of 2 unless otherwise stated) | Membership Engagement Recruitment and Representation Committee (out of 3 unless otherwise stated) |
|---|---|---|---|---|---|
| Mariam Ali | Parents and Carers: London | February 2015 | 4 | Not a member | Not a member |
| Stephanie Nash | Parents and Carers: London | February 2018 | 3 | Not a member | Not a member |
| Emily Shaw | Parents and Carers: London | February 2018 | 3 | Not a member | Not a member |
| Lisa Allera | Parents and Carers: Outside London | February 2018 | 4 | 2 | Not a member |

| | | | | | |
|---|---|---|---|---|---|
| Carley Bowman | Parents and Carers: Outside London | May 2019 | 3 (3) | Not a member | Not a member |
| Claire Cooper-Jones **Lead Governor** | Parents and Carers: Outside London | February 2018 | 4 | 2 | Not a member |
| Faiza Yasin | Patients: Outside London | February 2018 | 3 | Not a member | 1 |
| Alice Rath | Patients: Outside London | February 2018 | 3 | Not a member | Not a member |
| Elena - May Reading | Patients: London | February 2018 | 2 | Not a member | 2 |
| Zoe Bacon | Patients: London | February 2018 | 2 | Not a member | 3 |
| Fran Stewart | Public: South London and surrounding area** | October 2016 | 4 | 1 | Not a member |
| Simon Hawtrey-Woore | Public: North London and surrounding area* | February 2015 | 3 | Not a member | 1 |
| Teskeen Gilani[1] | Public: North London and surrounding area* | December 2016 | 1 | Not a member | Not a member |
| Theo Kayode-Osiyemi | Public: North London and surrounding area* | February 2018 | 1 | Not a member | 1 |
| Simon Yu Tan | Public: North London and surrounding area* | February 2018 | 2 (3) | Not a member | Not a member |
| Colin Sincock | Public: Rest of England and Wales | February 2018 | 4 | 1 | 3 |
| Julian Evans | Public: Rest of England and Wales | February 2018 | 2 | Not a member | Not a member |
| Sarah Aylett | Staff | February 2018 | 3 | Not a member | 1 |

| | | | | | |
|---|---|---|---|---|---|
| Margaret Bugyei-Kyei | Staff | May 2019 | 3 (3) | Not a member | Not a member |
| Nigel Mills | Staff | February 2018 | 3 | Not a member | 1 |
| Paul Gough **Deputy Lead Governor**[3] | Staff | February 2018 | 4 | Not a member | Not a member |
| Quen Mok | Staff | February 2018 | 3 | 2 | Not a member |
| Lazzaro Pietragnoli | London Borough of Camden | February 2018 | 1 | Not a member | Not a member |
| Emma Beeden[1, 4] | Young People's Forum | February 2019 | 3 | Not a member | Not a member |
| Joshua Hardy[1] | Young People's Forum | February 2019 | 4 | Not a member | 1 (1) |
| Jugnoo Rahi | UCL GOS Institute of Child Health | February 2018 | 2 | Not a member | Not a member |

[1] Appointed to represent a new constituency following the July 2018 review of the Constitution

[2] Joined the Council as the next highest polling candidate following the previous seat holder stepping down

[3] Stood down as Deputy Lead Governor in February 2020

[4] Stood from the Council in February 2020

*The 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.

**The 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.

## Elected Governor Vacancies

On 19 February 2020, an elected Governor from the staff constituency resigned. As permitted by the Trust's Constitution, the trust will leave the seat vacant until the next elections in November 2020, as the unexpired period of the term of office is less than 12 months.

## Review of Council effectiveness

In late 2019, the Council conducted a self–assessment of effectiveness. This was led by the Chair and informed by questionnaires sent to both the Council of Governors, the Non-Executive Directors, Chief Executive and Chief Finance Officer. The positive results of the evaluation showed:

- That all Governors were able to contribute to the meetings.
- The Council meeting papers provided sufficient information for Governors to make decisions at meetings.
- The conduct of Governors was consistent with the Trust's 'Always Values'.

The results also highlighted areas for the Council to improve on over the following 18 months, these included:

- Improved engagement and communication between Governors and their constituencies
- A refresh of the Governors' training needs analysis and development program.
- Increased collaboration with the Lead Governor on the Council's forward plan.

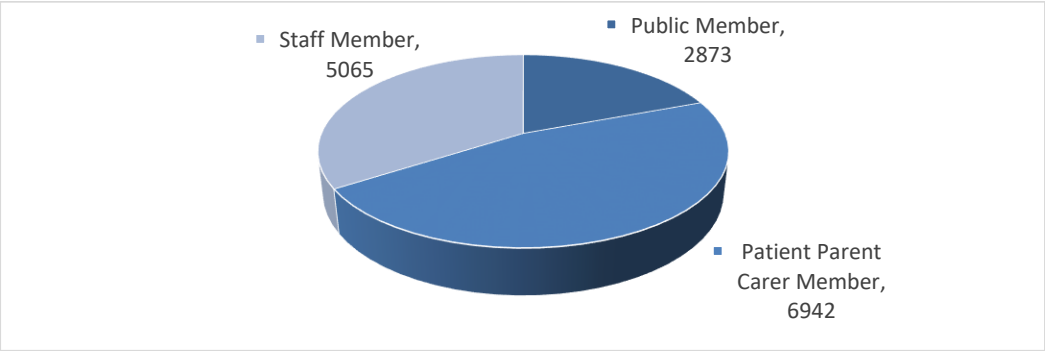
## Membership at GOSH

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 www.gosh.nhs.uk/about–us/foundation–trust/foundation–trust–membership.

## Membership constituencies and membership numbers 2019/20

On 31 March 2020, our membership totalled 14,880 (9,815 plus 5,065 staff).

Membership Engagement Services (MES) is our membership database provider and holds and manages our public and patient and carer data.




We managed to increase our public membership by 48 to 2,873. This was 28 members short of our estimated public membership target of 2,901. The membership of patient/parent/carer constituency decreased by five to 6,942. This was 183 short of our target of 7,125. Overall, we increased our membership by 43.

The Trust remains committed to recruiting a membership reflective of the population it serves, in particular the underrepresented stakeholder groups. In 2020/21, the Trust, supported by ideas from the Young People's Forum and the Membership Engagement, Recruitment and Representation Committee will adopt a refreshed approach to membership engagement. To lead on this work the Trust has recruited a Stakeholder Engagement Manager who plans to:

- Improve the content of the Monthly 'Get Involved' to ensure members are kept engaged

- Designing engagement opportunities across the Trust for both Internal (Patients, Parents, Carers, Staff, Volunteers, etc) and External Stakeholders (Colleagues at other FT's, Health & Social Care organisations, Local Councils, etc)

- Collaborating with the digital engagement team to ensure there is better use of the Trust's digital channels (social media, website, digital screens) in order to reach out to current and prospective members as well as keeping all platforms up to date

- Supporting the Young People's Forum and Play team to promote the benefits of membership to current patients and partnering with them to seek out and implement methods of engagement / recruitment of members

- Working with the MERRC to create marketing content / resources for engagement (leaflets, agendas, magazine, FAQs etc)

## Council of Governors' expenses

Governors can claim reasonable expenses for carrying out their duties. For the year 2019/20, the total amount claimed by six governors was £1,712.00

## Register of interests

A Register of Governors' Interests is published on the Trust website, https://gosh.mydeclarations.co.uk/home and can also be obtained by request from the Company Secretary, Great Ormond Street Hospital for Children NHS Foundation Trust, Executive Offices, Barclay House, 37 Queen Square ,Great Ormond Street, London, WC1N 3BH.

## Contacting a Governor

Anyone wanting to get in touch with a Governor 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 'contact us' section of the GOSH website, gosh.nhs.uk.

## Trust Board and Council of Governors working together

The Trust's Chair is responsible for the leadership of both the Council of Governors and the Trust Board. The Chair is also responsible for effective relationship building between the Trust Board and Governors to ensure that Governors effectively perform their statutory duties and contribute to the forward planning of the organisation. There has been a continued focus on developing relationships between the Council of Governors and non-executive directors in this reporting period, with the delivery of several programmes of work to facilitate engagement. The key programmes are covered below. Additional examples of how the Council of Governors and Board worked together in 2019/20 included:

- Governors have an open invitation to attend all Trust Board meetings.
- Governors observe at Trust Board assurance committee meetings.
- Governors and Board members worked together on the Constitution Working Group.
- Executive and non-executive directors attend each Council of Governors' meeting.
- Summaries of the Board assurance committees (Audit Committee, Quality and Safety Experience and Assurance Committee, People, Education and Assurance Committee and Finance and Investment Committee) are presented by the relevant non-executive director chairs of the committees at each meeting of the Council of Governors.
- Summaries of Council of Governors' meetings are reported to the Trust Board.

In 2019/20 the Council of Governors has:

- Contributed to the GOSH strategy, our vision and objectives for 2025, and the People Strategy.
- Approved role descriptions for the Lead Governor and Deputy Lead Governor.
- Received regular updates from the Young People's Forum.
- Received updates on our redevelopment plans including the plans for the Children's Cancer Centre.
- Contributed to the appraisal of the non-executive directors.
- Contributed to the actions in response to the CQC report and recommendations.
- Reviewed the Trusts preparations for Brexit.
- Received updates from the Membership Engagement Recruitment and Representation Committee (MERRC).

## Governor induction and development

From November 2018, Governor induction sessions transitioned into Governor development sessions. These sessions were developed in partnership with Governors to provide them with the skills and knowledge needed to deliver their key duties over their tenure.

From the November 2019 meeting onwards, the format of the development sessions changed from two one hour slots, to three different 45-minute slots to allow more topics to be covered.

In February 2020, the Council approved a revised development plan informed by a Council led training needs analysis. This plan will inform the content of Council development sessions in 2020/21.

In collaboration with the Learning and Development team, a tailored set of mandatory training courses were selected for Governors to complete. To access the courses, Governors were provided with access to GOSH Online Learning and Development. Governor compliance was monitored throughout the year by the Corporate Affairs Team.

## Governor education events

Several Governors attended external training and events throughout the year and provided reports back to the Trust. These included:

- Governor Focus conference, to help Governors explore how they can be best equipped to support their Trusts in delivering quality healthcare.
- GOVSEC's Government IT Security Conference, which explored how public sector organisations and professionals could make sense of securing their IT functions in a rapidly changing environment.
- GovernWell: Member and public engagement, which aimed to help Governors explore what 'representation' means.

## Governors' and Chair meeting

Prior to each Council of Governors' meeting, the Chair meets with all Governors in a private session. This gives the Governors an opportunity to discuss any issues directly with the Chair.

## Governors private meeting with Lead Governor and Deputy Lead Governor

In July, the Council requested the introduction of a private governor session with Lead Governor/Deputy Lead Governor. The session allows Governors an opportunity to discuss the key issues, network, prepare for the private session with the Chair and the Council of Governors' meeting.

## 'Buddying' with non-executive directors

The Trust established a buddying programme between non-executive directors and Governors to support the Governor's role and share information on matters of interest or concern. A review of the programme took place in July 2019 and it was agreed that buddying would continue with a revised structure: Governors would be paired with two non-executive directors and rotate every six months following objectives set by each buddying group.

## Governors' online library

Governors have access to an online library of resources designed by the corporate affairs team that provides them with 24/7 access to key documents and information.

## Governors' newsletter

From March 2019 Governors have received a monthly newsletter from the Corporate Affairs team containing actions required, key meeting dates, Trust developments and training and development opportunities.

## 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 Council of Governors.

The Council fed their comments into development of the GOSH operational plan 2020/21 and revised Trust strategy, which will be launched once the risk of COVID-19 has abated.

The Membership Engagement, Recruitment and Representation Committee (MERRC), a subcommittee of the Council of Governors, oversees the recruitment and retention of members and seeks to maximise engagement opportunities with members for the benefit of the Trust. In 2019/20, the committee was chaired by a Patient and Carer Governor. Last year's achievements included: a revision of the membership engagement methods and planning and delivery of a successful annual general meeting and annual members' meeting.

Member Matters was the bi-annual (Spring and Autumn) 16-page publication sent to all members. At the April 2019 meeting of MERRC, members voiced concerns around how well Member Matters served the needs of the Trust, provided value for money, its impact on the environment and its usefulness in including the most recent information for members.

To maximise engagement with the membership, while allocating appropriate time and resources, the Council agreed to consolidate the news, updates and involvement opportunities into one regular, monthly email. Get Involved will enable the sharing of timely and relevant news, features and opportunities.

## The Membership Strategy 2019–2022

The Trust's Membership Strategy and its objectives of recruiting, communicating and engaging with our members guided our membership engagement in 2019/20. It aims to strengthen the link between the hospital and its members by maximising involvement and engagement opportunities and focusing on better representing our younger membership community.

## Council of Governors' Nominations and Remuneration Committee

The Council of Governors' 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 Chair 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 Chair and non-executive directors.

The committee is chaired by the Chair of the Trust Board and Council of Governors. Governors nominate themselves each year to sit on the committee.

Membership and attendance of governors 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 Council of Governors).

In 2019/20 the Council of Governors approved the reappointment of Mr James Hatchley as a non-executive director for a further three years from 1 September 2019.

An external search company and open advertising are used for all new non-executive director appointments. The recruitment process includes inviting candidates to attend stakeholder events where they get the chance to meet staff, parents and patients and to take part in a tour of the hospital.

The chair's other significant commitments are disclosed to the Council of Governors before appointment and when they change. Information about Sir Michael Rake's significant commitments in 2019/20 can be found in the Board's declarations of interest here: https://gosh.mydeclarations.co.uk/

The Trust constitution (revised in July 2018) 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 chair and non-executive directors, which requires the approval of three-quarters of the members of the Council of Governors. If any proposal to remove a non-executive director is not approved at a meeting of the Council of Governors, 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

## Annual statement of remuneration

The Trust Board's 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, with extraordinary meetings as required. Attendance at meetings held in during 2019/20 can be found on pages XX–XX.

Under the terms of reference of the committee and for the report below, voting 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 and Director of HR and OD. The Chief Executive keeps the Remuneration Committee informed of any changes to remuneration for these staff.

Remuneration of non-executive directors is considered and approved by the Council of Governors' Nominations and Remuneration Committee and approved by the Council of Governors. Further information is provided on pages XX–XX.

## Senior manager remuneration

The committee determines the remuneration of senior managers after taking into account NHSI guidance (see below), any variation in or changes to the responsibilities of the senior managers, market comparisons, job evaluation, and weightings and uplifts recommended for other NHS staff. 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. Where appropriate, 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 and those for very senior managers.

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 four months' notice. The committee considers on a case by case basis whether an element of performance related pay or earn-back pay will be included within senior manager contracts. This is consistent with NHSI guidance.

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.

## 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 Trust Board's Remuneration Committee. Reference is made to:

- benchmarking information available from:
    - NHSI on senior manager remuneration
    - other comparable hospitals
    - NHS Providers' Remuneration Survey results
- any recommendations made on pay across the broader NHS for example, changes applied under the Agenda for Change terms and conditions.

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 principle of rating both performance and behaviour is applied to senior managers, in line with the Trust's appraisal system. This in turn may result in senior managers having potential increases withheld, 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 and 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 | 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 | 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 | Trust performance and development review (PDR)/annual appraisal to set objectives linked to our strategic objectives. Failure to meet objectives is managed via our |

| | | | |
|---|---|---|---|
| deliver the Trust's strategic objectives. | exceptional circumstances, reviews of salary may be made outside of this cycle, but are made by the Remuneration Committee.<br><br>Any sums paid in error, malus, recovered due to breach of contract or to be withheld are considered and agreed by the Remuneration Committee and then followed up with the individual. | are proportionally not treated more favourably than other staff). | performance frameworks. |
| Taxable benefits | | | |
| Not applicable | | | |
| Annual performance-related bonuses | | | |
| Provides the flexibility and capability to reward high performers adequately for their outcomes. Helps to retain highly specialised senior managers and supports innovation. | The committee reviews application of performance-related pay (PRP) on appointment to a senior manager role where relevant. The decision to apply PRP will be subject to the measurability of the outputs in relation to delivery of the strategy. | The committee will apply PRP as a maximum of 10% of total salary (excluding pension entitlements). | Trust PDR/annual appraisal process. |
| Long-term-related bonuses | | | |
| Not applicable. | | | |
| Pension-related benefits (see below) | | | |
| Pension benefits (which may be opted out of) are part of the total | Pension is available as a benefit to directors and follows national NHS Pension Scheme | Pension is available as a benefit to directors and follows national NHS | Not applicable. |

| | | |
|---|---|---|
| remuneration of directors to attract high-calibre staff to enable the Trust to meet its strategic objectives. | contribution rules. | Pension Scheme contribution rules. Pension entitlements are determined in accordance with the HMRC method. |

## Directors with remuneration (total) greater than £150,000

The Committee takes steps to satisfy itself that remuneration is reasonable for those senior managers paid more than £150,000 (and £142,500 pro rata for part-time senior managers), taking account of NHSI's *Guidance on pay for very senior managers in NHS trusts and foundation trusts.*

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.

## Policy on payment for loss of office

Senior managers' contracts primarily stipulate a minimum notice period of four months and are determined by the Remuneration Committee.

In the event of loss of office (eg through poor performance or misconduct), the Trust will apply the principles and policies set out in this area within its relevant employment policies (disciplinary and performance management policy) and any compensation for loss of office will be in line with the contract of employment. The Trust does have the right to use its discretion about compensation payments for loss of office. Any such payments over and above a contractual entitlement will be in line with appropriate guidance from NHSI/NHSE.

Notice periods for senior managers are determined by the Remuneration Committee.

Payment in lieu of notice, as a lump sum payment, may be made with the approval of the Trust's Remuneration Committee, in line with NHSI/NHSE guidance.

## Remuneration for senior managers in 2019/20

Details of remuneration, including the salaries and pension entitlements of the Board directors, are provided on pages XX–XX.

For the financial year 2019/20 the committee:

- Approved remuneration of the incoming Interim Chief Operating Officer based on data from NHSI.
- Approved remuneration of the incoming Director of Estates, Development and Built Environment.
- Conducted benchmarking exercises on existing senior managers' remuneration packages to ensure they were competitive in terms of total remuneration. To inform the benchmarking exercise, data from NHSI was used.
- Agreed that most of the voting executive directors were new in role and so had only recently had their salaries negotiated and approved. On this basis, it was **agreed** that those directors who had joined the Trust within the last 12 months would not receive a cost of living pay increase. It was agreed that on the basis of a strong performance, one director would be awarded a cost of living payment for 2019/20. The Committee **agreed** that none of the voting executives would receive a non-consolidated payment. The payment made was in line with NHSI/NHSE guidance.
- Received information about an agreed cost of living award for relevant senior managers on Trust contracts who do not fall under the remit of the Remuneration Committee, taking into account the cost of living award made to staff on Agenda for Change contracts and the guidance issued by NHSI/E in March 2020. The Chief Executive considered the financial position of the trust, length of tenure in post, performance assessment via appraisals, staff survey results and statutory and mandatory team performance.

## NHS Pension Annual Tax Allowance Threshold

In 2019/20, the Remuneration Committee discussed the impact on GOSH staff of the implementation of changes to pension tax. For the 2019/20 tax year the annual tax allowance threshold was £40,000 tapering down to £10,000 depending on an employee's income. The taper was based on levels of pensionable and non-pensionable pay from all sources. If an individual's pension savings were more than the annual allowance (in one scheme year), they receive a tax charge on the additional amount. It is possible to carry forward any unused annual allowance, provided the employee was a member of a qualifying pension scheme at some time during all of the three previous tax years. An employee can carry forward unused annual allowances for a maximum of three years.

The committee became aware that for those employees particularly affected (doctors), they were requesting to reduce activity, withdraw from additional programmed activities and refuse additional income including Clinical Excellence Awards. Some staff were considering leaving the pension scheme altogether however the over-riding advice was to remain in the scheme and to access independent financial advice. The committee agreed that it was important for the Trust to work in partnership with other NHS trusts within the North Central London STP via the HR Directors Forum.

The committee considered the impact of the tax allowance threshold on staff throughout the year. The committee agreed that any support provided should be available to all clinical and non-clinical staff and not just doctors. In November 2019, the committee approved a policy for all staff to address operational risks created by the changes introduced to the pension tax regime and through consultation with interested staff in the Trust and their representatives. At the same time, NHS England published an interim solution for 2019/20 for clinical staff only. Clinicians who are members of the NHS Pension Scheme who, as a result of reaching

their annual allowance, receive a tax charge for 2019/20 will be able to choose 'Scheme Pays' to pay their tax charge.

The March 2020 Budget announced that the tapered allowance threshold for pensions' tax relief would increase to £200,000 and that the majority of staff would no longer be affected by the new threshold.

## Ensuring diversity and inclusion

One of the key outputs of the GOSH People Strategy in year one, is the creation of an integrated Diversity and Inclusion (D&I) Strategy. The D&I Strategy will present objectives for the Trust to meet and these will include consideration of and actions to take in response to the inequalities in remuneration for example in relation to gender, profession etc.

The Trust annually publishes a Gender Pay Gap Report and the Remuneration Committee review this prior to publication and make recommendations for further action. In 2019, the GOSH gender pay gap was reduced but further work is required in this area.

GOSH uses the following pay systems to ensure pay is equal and consistent regardless of gender:

- Agenda for Change: a national pay system which covers all job roles excepting those given below.
- Trust contracts - for senior managers and directors.
- National Junior Doctors' contract.
- National Consultants' contract.
- Clinical Excellence Awards.
- Consistent application of national policy where applicable – for example the Remuneration Committee were firm in their decision that any local solution to the pension tax issue would be made available to all staff regardless of profession.

NHS foundation trusts can, if they wish, negotiate local terms and conditions. In common with all other NHS foundation trusts GOSH has chosen to remain with Agenda for Change rather than move to locally created pay systems due to the protection it affords in terms of ensuring work of equal value is paid equally. Agenda for Change was designed to evaluate the job rather than the person in it and by doing so, ensuring equity between similar jobs in different areas.

## Evaluation and remuneration of non-executive directors

The Council of Governors considered and approved a refreshed performance evaluation framework for non-executive directors in 2019. All non-executive directors were appraised throughout the year.

In early 2020, NHSE and NHSI published guidance on a standard framework for chair annual appraisals. The Council of Governors considered the guidance and approved a refreshed evaluation framework for the chair and also agreed to apply the framework where applicable to non-executive directors. The new framework will be implemented from April 2020.

The Council's Nominations and Remuneration Committee is responsible for recommending remuneration levels for non-executive directors to the Council of Governors. The policy for benchmarking salaries for the Chair and non-executive directors is reviewed on a three-yearly basis with a review due to take place in March 2020. In 2019, guidance was published by NHSE and NHSI on the remuneration of Chairs and non-executive directors in the NHS in order to address a longstanding issue of disparity between the remuneration in NHS Trusts and NHS Foundation Trusts.

Previously GOSH has conducted a benchmarking exercise of similar sized trusts and there had been no increases in remuneration, including cost of living, in recent years. The guidance provided a limit of £13,000 salary for non-executive directors or £15,000 for specific non-executive director roles. In November 2019, The Council of Governors agreed that the new guidance would be implemented as new Board members joined or were reappointed for second terms. In April 2020, the Chair and non-executive directors agreed that the remuneration guidance should be applied from 1 April 2020 for all existing Chair and non-executive director positions on the Board and any new positions going forward. This proposal was endorsed by the Council in April 2020.

The table below shows the salaries for the Chair and non-executive directors for 2019/20 and changes to remuneration following application of the NHSI/NHSE guidance from 1 April 2020.

| **Role** | **2019/20** | **2020/21 (application of NHSI guidance for a large trust) – from 1 April 2020** |
|---|---|---|
| Chair | **£55k** | **£50k** |
| Deputy Chair | **£19k** | **£15k** |
| Senior independent director | **£19k** | **£15k** |
| Non-executive director | **£14k** | **£13k** |

Details of remuneration for the executive and non-executive directors are provided in the tables on pages XX–XX.

**Mr Mathew Shaw**

**Chief Executive**

**Date: XX May 2020**

| Great Ormond Street Hospital for Children NHS Foundation Trust | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance Department | | | | | | | | | | | | | |
| Remuneration Report 2019/20 | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| Salary entitlements of senior managers | | 2019/20 | | | | | | 2018/19 | | | | | |
| Name | Title | Salary and Fees | Taxable Benefits | Annual Performance-related Bonuses | Long-term Performance-related Bonuses | Pension-related Benefits | Total | Salary and Fees | Taxable Benefits | Annual Performance-related Bonuses | Long-term Performance-related Bonuses | Pension-related Benefits | Total |
| | | | | | | | | | | | | | |
| **Non-executive Directors** | | | | | | | | | | | | | |
| Sir Michael Rake | Chairman of Trust Board | 50-55 | 0 | 0 | 0 | 0 | 50-55 | 50-55 | 0 | 0 | 0 | 0 | 50-55 |
| Lady Amanda Ellingworth | Non-Executive Director | 10-15 | 0 | 0 | 0 | 0 | 10-15 | 10-15 | 0 | 0 | 0 | 0 | 10-15 |
| Mr James Hatchley | Non-Executive Director | 15-20 | 0 | 0 | 0 | 0 | 15-20 | 15-20 | 0 | 0 | 0 | 0 | 15-20 |
| Mr Chris Kennedy | Non-Executive Director | 5-10 | 0 | 0 | 0 | 0 | 15-20 | 15-20 | 0 | 0 | 0 | 0 | 15-20 |
| Miss Kathryn Ludlow | Non-Executive Director | 10-15 | 0 | 0 | 0 | 0 | 5-10 | 5-10 | 0 | 0 | 0 | 0 | 5-10 |
| Mr Akhter Mateen | Non-Executive Director | 15-20 | 0 | 0 | 0 | 0 | 15-20 | 15-20 | 0 | 0 | 0 | 0 | 15-20 |
| Professor Ros Smyth | Non-Executive Director (until 31 December 2019) | 10-15 | 0 | 0 | 0 | 0 | 10-15 | 10-15 | 0 | 0 | 0 | 0 | 10-15 |
| | | | | | | | | | | | | | |
| **Executive Directors** | | | | | | | | | | | | | |
| Ms Caroline Anderson | Director of Human Resources and Organisational Development | 130-135 | 0 | 0 | 0 | 0 | 130-135 | 0-5 | 0 | 0 | 0 | 0 | 0-5 |
| Miss Helen Jameson | Chief Finance Officer | 140-145 | 0 | 0 | 0 | 37.5-40 | 180-185 | 140-145 | 0 | 0 | 0 | 122.5-125 | 265-270 |
| Professor Alison Robertson | Chief Nurse | 135-140 | 0 | 0 | 0 | 0 | 135-140 | 130-135 | 0 | 0 | 0 | 0 | 130-135 |
| Dr Sanjiv Sharma | Medical Director, Acting Medical Director (until 30 April 2019) | 105-110 | 0 | 0 | 0 | 30-32.5 | 135-140 | 135-140 | 0 | 0 | 0 | 2.5-5 | 140-145 |
| Mr Matthew Shaw | Chief Executive Officer | 210-215 | 0 | 0 | 0 | 67.5-70 | 280-285 | 195-200 | 0 | 0 | 0 | 340-342.5 | 535-540 |
| Andrew Taylor | Acting Chief Operating Officer (until 30 September 2019) | 90-95 | 0 | 0 | 0 | 0 | 90-95 | 140-145 | 0 | 0 | 0 | 0 | 140-145 |
| Phillip Walmsley | Interim Chief Operating Officer (from 1 October 2019) | 65-70 | 0 | 0 | 0 | 0 | 65-70 | n/a | n/a | n/a | n/a | n/a | n/a |
| | | | | | | | | | | | | | |

| Great Ormond Street Hospital for Children NHS Foundation Trust | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Finance Department | | | | | | | | |
| Remuneration Report 2019/20 | | | | | | | | |
| | | | | | | | | |
| Pension entitlements of senior managers | | | | | | | | |
| Name | Title | Real increase in pension at pension age (bands of £2,500) | Real increase in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31 March 2020 (bands of £5,000) | Lump sum at age 60 related to accrued pension at 31 March 2020 (bands of £5,000) | Cash equivalent transfer value at 1 April 2019 | Real increase/(decrease) in cash equivalent transfer value | Cash equivalent transfer value at 31 March 2020 |
| | | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Miss Helen Jameson | Chief Finance Officer | 2.5-5 | 0-2.5 | 35-40 | 90-95 | 570 | 52 | 636 |
| Dr Sanjiv Sharma | Acting Medical Director (until 30 April 2019), Medical Director (from 1 May 2019) | 0-2.5 | 0-2.5 | 25-30 | 55-60 | 442 | 41 | 494 |
| Mr Matthew Shaw | Chief Executive Officer | 5-7.5 | 2.5-5 | 40-45 | 85-90 | 591 | 77 | 682 |
| | | | | | | | | |
| | | | | | | | | |

## Median pay

The highest paid Director in 2019/20 was the Chief Executive Officer whose remuneration was in the band £210,000 – £215,000. This was 5.2 times the median remuneration for all members of the Trust. The calculation is based upon full-time equivalent Trust staff for the year ended 31 March 2020 on an annualised basis.

| | **2019/20** | **2018/19** |
|---|---|---|
| Band of the highest paid director's total remuneration (£000) | 210-215 | 195-200 |
| Median total remuneration | 41,439 | 39,244 |
| Ratio | 5.2 | 5.0 |

### Statement on better payment practice code

The Trust aims to pay its non–NHS trade creditors in accordance with the Prompt Payment Code and government accounting rules. The Trust has registered its commitment to following the Prompt Payment Code.

The Trust maintained its Better Payment Practice Code performance for non–NHS creditor payments and achieved payment within 30 days of 85% of non–NHS invoices measured in terms of number (86% in 2018/19) and 89% by value (91% in 2018/19).

| Better payment practice code | | 2019/20 |
|---|---|---|
| | Number | £000 |
| **Non NHS** | | |
| Total bills paid in the year | 69,153 | 300,525 |
| Total bills paid within target | 58,770 | 267,956 |
| Percentage of bills paid within target | 85% | 89% |
| | | |
| **NHS** | | |
| Total bills paid in the year | 2,487 | 27,271 |
| Total bills paid within target | 1,017 | 19,173 |
| Percentage of bills paid within target | 41% | 70% |
| | | |

| **Total** | | |
|---|---|---|
| Total bills paid in the year | 71,640 | 327,796 |
| Total bills paid within target | 59,787 | 287,129 |
| Percentage of bills paid within target | 83% | 88% |

**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.

## Staff report

## 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.

## Our People Strategy

During this year, we published our first integrated GOSH People Strategy. It was developed within the context of the changing NHS and local STP landscape, and what was then our current organisational context.

The People Strategy is built around four key themes:

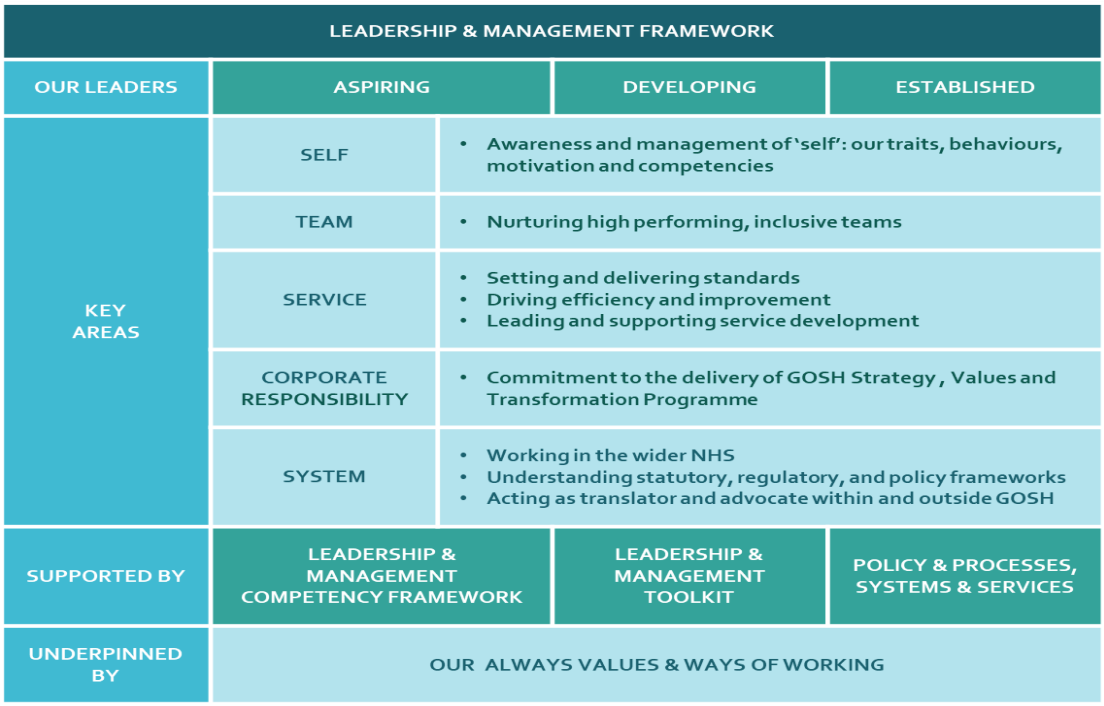
1. Capacity and workforce planning – resourcing, retention, and strategic workforce planning.
2. Developing skills and capability – ensuring that the Trust continues to meet its responsibilities as a teaching, training and research hospital, as well as building skills and capability to meet new challenges and changing priorities.
3. Modernising and reshaping the corporate and HR infrastructure – including HR policies, processes, systems, and supporting structures.
4. Culture, engagement, health and wellbeing – ensuring all our staff feel well led and well managed, but also valued, developed, supported and empowered to be and do their best.

The People Strategy covers the period from December 2019 to December 2022 and the annual work programmes and projects which support its delivery are overseen by the People and Education Assurance Committee.

### Leadership

Our leadership strategy *Accelerating journeys towards exemplary leadership* has been taken forward through the creation of a GOSH-wide leadership and management framework. This

is focused on building and maintaining whole organisational capability, supported by a competency framework which sets out standards, knowledge and skills required at each level of leadership.



| LEADERSHIP & MANAGEMENT FRAMEWORK | | | |
|---|---|---|---|
| OUR LEADERS | ASPIRING | DEVELOPING | ESTABLISHED |
| KEY AREAS | SELF | • Awareness and management of 'self': our traits, behaviours, motivation and competencies | |
| | TEAM | • Nurturing high performing, inclusive teams | |
| | SERVICE | • Setting and delivering standards<br>• Driving efficiency and improvement<br>• Leading and supporting service development | |
| | CORPORATE RESPONSIBILITY | • Commitment to the delivery of GOSH Strategy , Values and Transformation Programme | |
| | SYSTEM | • Working in the wider NHS<br>• Understanding statutory, regulatory, and policy frameworks<br>• Acting as translator and advocate within and outside GOSH | |
| SUPPORTED BY | LEADERSHIP & MANAGEMENT COMPETENCY FRAMEWORK | LEADERSHIP & MANAGEMENT TOOLKIT | POLICY & PROCESSES, SYSTEMS & SERVICES |
| UNDERPINNED BY | OUR ALWAYS VALUES & WAYS OF WORKING | | |

We have also designed a line management development programme, supported by an online library, for all existing and newly promoted line managers. This will be delivered over the next 12/18 months, prior to it being mainstreamed into induction and promotion processes going forward. Its purpose is to build capability and to support decision making to be more compassionate, resolution focused and appropriate, with the aim of shifting formal processes to informal. The collaborative approach of GISH leaders both within the Trust and with external partners was recognised by CQC inspectors in October 2019.

## Volunteers at GOSH

Volunteers continue to play an important part of patient and family experience at GOSH. In the last year, we maintained the number of volunteers working regularly in the Trust from the previous year – with the total number of regular volunteers recorded as 1,087 on 31 March 2020. This is made up of 482 people who volunteer directly with GOSH and 605 who volunteer through external charities and organisations.

We attract skilled, motivated and enthusiastic people to the GOSH volunteer programme and offer extensive, valuable training and support to individual volunteers. There is a wide variety of volunteering roles, ranging from those working directly with patients and families, to those supporting back office staff and departments. These opportunities make volunteering at GOSH interesting and worthwhile.

We estimate that our volunteers donated approximately 226,100 hours of their time over the year to supporting the hospital, providing services for patients and families. This volunteer effort equates to £2,500,000 of donated time, based on the London Living Wage.

Volunteer Services also manages the partnerships with external charities, who provide a variety of services for patients and families. There are currently 27 external charity partner groups registered with GOSH. Volunteer Services provide training for all people who volunteer through external charities and organisations.

## Our staff

In 2019/20, the Trust employed an average of 5,065 full-time equivalent (FTE) staff.

On 31 March 2020, the gender mix of GOSH directors, senior managers and staff was:

| | **Female** | **Male** |
|---|---|---|
| Director | 46% (6) | 54% (7) |
| Senior managers | 59% (13) | 41% (9) |
| Staff | 77% (3937) | 23% (1166) |

The table below provides analysis of the cost of staff for the year 2019/20:

| Average number of people employed* | Year ended 31 March 2020 Total | Permanently Employed ** | Other | Year ended 31 March 2019 Total |
|---|---|---|---|---|
| | **Number** | **Number** | **Number** | Number |
| Medical and dental | **700** | **677** | **23** | 681 |
| Administration and estates | **1,346** | **1,309** | **37** | 1,335 |
| Healthcare assistants and other support staff | **284** | **282** | **2** | 283 |
| Nursing, midwifery and health visiting staff | **1,526** | **1,521** | **5** | 1,552 |
| Scientific, therapeutic and technical staff | **960** | **873** | **87** | 920 |
| Other staff | **9** | **9** | **0** | 5 |
| **Total average numbers** | **4,825** | **4,671** | **154** | 4,776 |

* Whole Time Equivalent

** Includes Bank Staff

| Employee costs | Year ended 31 March 2020 Total | Permanently Employed | Other | Year ended 31 March 2019 Total |
|---|---|---|---|---|
| | **£000** | **£000** | **£000** | £000 |
| Salaries and wages | **238,072** | **229,743** | **8,329** | 224,600 |
| Social security costs | **24,334** | **24,334** | **0** | 22,957 |
| Apprenticeship levy | **1,090** | **1,090** | **0** | 1,032 |
| Pension cost - defined contribution plans employer's contributions to NHS pensions | **26,421** | **26,421** | **0** | 25,288 |
| Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%) | **11,556** | **11,556** | **0** | 0 |
| Pension costs - other | **46** | **46** | **0** | 64 |
| Temporary staff - agency/contract staff | **2,356** | **0** | **2,356** | 3,436 |
| Termination benefits | **30** | **30** | **0** | 471 |
| **Total gross staff costs** | **303,905** | **293,220** | **10,685** | 277,848 |
| Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure | **(2,090)** | **(2,090)** | **0** | (1,706) |
| Recoveries from other bodies in respect of staff costs netted off expenditure | **(413)** | **(413)** | **0** | (804) |
| **Total staff costs** | **301,402** | **290,717** | **10,685** | 275,338 |
| **Included within:** | | | | |
| Costs capitalised as part of assets | **5,752** | **5,379** | **373** | 6,881 |
| Analysed into operating expenditure | | | | |
| Employee expenses - staff and executive directors | **273,689** | **268,230** | **5,459** | 247,115 |
| Research and development | **18,805** | **13,985** | **4,820** | 18,000 |
| Education and training | **3,126** | **3,093** | **33** | 2,871 |
| Redundancy | **30** | **30** | **0** | 471 |
| **Total employee benefits excluding capital costs** | **295,650** | **285,338** | **10,312** | 268,457 |

## Speak Up for Safety

At GOSH we understand that safety can be impacted by the organisational culture. Our aim for 2019/20 was to implement the Speak Up programme. The Speak Up programme is a multi-year transformation programme of work to build and sustain an outstanding culture of safety, reliability and openness. Our objectives for the past year were to encourage and support our staff to feel safe in speaking up for safety and to implement processes to manage behaviours that had the potential to undermine the safety of our patients, families and colleagues.

The programme is Trust-wide with the goal of building a culture of safety and quality by empowering staff to support each other and raise concerns. This will be achieved through focused training and the promotion of professional accountability. In June 2019 we launched Speak Up for Safety workshops. The workshops were well attended with 80% of staff and volunteers having attended workshops in the six months to December 2019. Culture change is a long-term commitment for GOSH and we have ensured that Speak Up workshops are included in the staff induction process, promoted at Trust briefings and highlighted at Trust Open Days, Schwartz rounds and conferences.

Following implementation of Speak Up for Safety we have been working on the next stage of the programme, Speak Up for Our Values. The aim was to align the launch of this work with the launch of the Trust's People Strategy. However, much of the work was placed on hold in March 2020 due to changing priorities in relation to the COVID-19 outbreak.

## Recognising reward and performance

We continue to emphasise the importance of appraisals as an opportunity for line managers to recognise the achievements of individuals. During 2019/20 PDR (appraisal) rates averaged 87%, which was a 4% increase on the previous year. Consultant appraisals in 2019/20 averaged 88% which was a 5% increase on the previous year. The 2019staff survey results showed the Trust performance for the theme 'quality of appraisals' had improved from the year before from 5.7 to 5.8 We are currently reviewing our Appraisal Policy and associated processes to drive their ability to recognise and reward excellent performance.

Our GOSH Exceptional Members of Staff (GEMS) awards attract high quality nominations from staff as well as patients and families. In 2019/20, we were delighted to receive nominations for exceptional teams and individuals, with awards being given throughout the year. In 2020 we will review our overall approach to recognising the unique contributions of our staff and will engage with our colleagues to design a new reward and recognition strategy.

We have taken the opportunity to thank our teams and individuals through our Senior Leadership Team meetings, our Big Brief events, and local initiatives, including 'Praise'.

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 12 years, recognise the very best of GOSH people; those who epitomise our Always Values. Staff can be nominated for an award by staff and patients and families, across 10 categories. In 2019 we received

339 nominations across all professions and directorates. We also celebrated long service awards to staff who had worked at GOSH for 10, 20, 25, 30, 35 years and we recognised exceptional long service: 40, 45 and 50 years of service.

## Raising concerns at GOSH

Implementation of the Trust's Raising Concerns in the Workplace Policy is monitored by the Audit Committee. In the 2019 staff survey we have seen improvements in two key questions: 'I would feel secure raining concerns about unsafe clinical practice' increased from 70.6% to 74.2%, and 'I am confident my organisation would address my concerns' increased from 57.9% to 61.3%.

We continue to embed the role of GOSH Freedom to Speak Up (FTSU) Ambassador service for staff to discuss any concerns they may have. This service is provided by a multi-professional group of GOSH staff and led by the Freedom to Speak UP Guardian. It allows representation and accessibility to be achieved across the Trust.

### Health and wellbeing

We continue to support health and wellbeing initiatives for our employees. Our wellbeing benefits include:

- a free onsite staff physiotherapy service
- counselling and advice service available 24/7
- an onsite occupational health service
- free flu vaccinations for staff - in 2019/20 we vaccinated 59% of our healthcare workers plus additional support staff
- a subsidised massage service
- a free weekly yoga class
- access to Mental Health first aiders
- Mental Health First Aider Courses – two delivered in 2019/20
- access to a free Mindfulness app

We ran three health and wellbeing challenges and activities for Mental Wellbeing Week in May 2019.

## Disability

During 2019, our third cohort of nine young people with learning disabilities graduated from their DFN Project Search internships at GOSH, and a fourth intake of seven interns began. We are pleased that two of our previous interns have been employed at the Trust. DFN Project Search provides young people with both valuable work and life experiences in order to prepare them for employment.

We have a Recruitment and Selection Policy and an Equality at Work Policy and which supports the employment, training and development of all our staff, including those who have disabilities. We also include unconscious bias into both our recruitment and selection and appraisal training for managers.

In 2019 GOSH was awarded Level 2 Disability Confident Employer status. This is a government scheme, replacing the two tick scheme, to help people with disabilities secure and remain within employment. For the first time in 2019 the Trust published its Workforce Disability Equality Standard data and accompanying action plan.

The Trust launched its Staff Disability and Long Term Health Conditions Forum in December 2019. In the coming year we will be working with our staff with disabilities and long-term health conditions to ensure they are supported, connected and heard.

## 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. Recognising, respecting and valuing diversity are important in order to underpin these expectations.

In 2019 we celebrated Black History, LGBT History Month and International Women's Day, working with our newly established BAME, LGBT+ and Women's forums to run a series of events celebrating and recognising the contribution of all our staff. Each of the forums has an executive sponsor working alongside the forum teams.

We were delighted that our LGBT+ forum members again marched at Pride 2019.

We published our extensive annual staff data report, our Workforce Race Equality Scheme report and action plan, and our Gender Pay Gap report in March. We will be working with our staff in the coming year to understand the data and implement required actions to ensure GOSH is a welcoming, supportive and inclusive environment for all our service users and staff.

During 2019 the Trust undertook to review ourselves against the Workforce Disability Equality Standard Trust data for the first time. This was published with the action plan, following the Trust Board meeting in September.

Our CQC report during the year reported that *'staff felt respected, supported and valued. The services promoted equality and diversity in daily work and provided opportunities for career development'.*

## Staff engagement

We take engagement with our staff very seriously. We provide frequent opportunities for staff across the hospital to ask questions and share ideas, particularly with senior colleagues. This is important in helping us to live Our Always Values of Always One Team and Always Expert.

Every month, our Chief Executive Matthew Shaw holds 'Mat's Big Briefing'; informal sessions, open to all staff and volunteers, to communicate updates and give an opportunity to ask questions on the big things going on at GOSH. Our weekly senior leadership meetings include a wider audience of clinical leaders as well as managers.

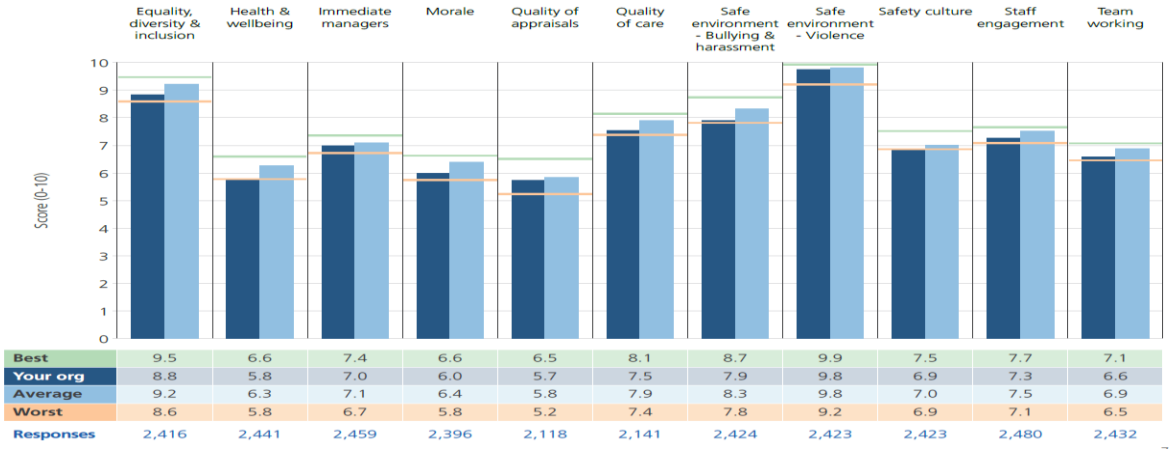
We continue to hold regular discussions with formal staff representatives through our Staff Partnership Forum, Local Negotiating Committee and Members Council.

Formal feedback data is collected via the annual NHS staff survey, quarterly Staff Friends and Family Test, and exit questionnaires.

## NHS staff survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in 10 indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2019 survey among trust staff was 53% (2018: 50%). Scores for each indicator together with that of the survey benchmarking group (Acute Specialist Trusts) are presented below.




| | Equality, diversity & inclusion | Health & wellbeing | Immediate managers | Morale | Quality of appraisals | Quality of care | Safe environment - Bullying & harassment | Safe environment - Violence | Safety culture | Staff engagement | Team working |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Best | 9.5 | 6.6 | 7.4 | 6.6 | 6.5 | 8.1 | 8.7 | 9.9 | 7.5 | 7.7 | 7.1 |
| Your org | 8.8 | 5.8 | 7.0 | 6.0 | 5.7 | 7.5 | 7.9 | 9.8 | 6.9 | 7.3 | 6.6 |
| Average | 9.2 | 6.3 | 7.1 | 6.4 | 5.8 | 7.9 | 8.3 | 9.8 | 7.0 | 7.5 | 6.9 |
| Worst | 8.6 | 5.8 | 6.7 | 5.8 | 5.2 | 7.4 | 7.8 | 9.2 | 6.9 | 7.1 | 6.5 |
| Responses | 2,416 | 2,441 | 2,459 | 2,396 | 2,118 | 2,141 | 2,424 | 2,423 | 2,423 | 2,480 | 2,432 |

The survey received 2,489 responses, representing 53% of the workforce, and is above the national average. Compared to 2018, the Trust improved in eight themes, was stable in two and deteriorated in one.

The Trust was lowest in two themes: health & wellbeing, and safety culture. All of the actions and plans outlined above as part of our People Strategy are designed to listen to and address the issues raised by our staff with the aim of improving these results going forward.

Our survey results indicate the need to prioritise the 'culture & engagement' work stream of the People Strategy. The purpose of this is to ensure our people feel that they are well led and well managed, but also supported and empowered to be and do their best.

## COVID-19

The latter part of the year was affected by the global pandemic and specific measures were taken to respond to the changing needs of our organisation and the people working at GOSH.

Since February 2020 we have:

- Led the workforce input into silver and gold command – developed adaptations and situation-specific interpretations to existing HR policies, responding to emerging needs.
- Maintained and strengthened links with staff partnership and trade union colleagues to ensure feedback was sought and consultation took place in the moment.
- Provided input and shaped STP level workforce policy decisions.
- Reorganised nursing and medical rosters.
- Onboarded more volunteers and returners to work at GOSH.
- Provided a framework for deployment of 80 clinical staff across STP trusts.

- Processed the transfer of 325 colleagues from other Trusts and organisations.
- Moved to remote working and provided advice for others.
- Reshaped the function to meet the following priorities: reporting staff sickness and absence, pastoral care and health and wellbeing, occupational health (testing), on-boarding and recruitment, redeployment, rostering and workforce intelligence.

## Sickness absence data

Sickness absence data for 2019/20 will be published by NHS Digital on the following website: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates,

## GOSH Learning Academy

Education and training remains fundamental to the quality and safety of patient care and is recognised as one of the four priorities of our new Trust strategy: *Above and Beyond*. To deliver on this, we launched the GOSH Learning Academy in September 2019 with the release of £14.5 million of funding support from the GOSH Charity. The Learning Academy strategy aims to make GOSH's journey to 2025 a success. It should become the first choice for multi-professional paediatric healthcare education, training, and development for the whole workforce, utilising state-of-the-art technology in contemporary learning environments.

In 2019/20 we expanded learning across all six priorities of the Learning Academy: apprenticeships, academic education, clinical simulation, digital learning, leadership, and specialty training. Highlights included:

- Our first digital Learning Academy Prospectus became available. It had a wide multi-professional offer, both clinical and non-clinical, for any professional interested in the skills and knowledge to provide paediatric healthcare.
- We launched new clinical apprenticeships for valuable staff groups, ensuring our workforce for the future, including nursing associates, healthcare scientists, and advanced clinical practitioners.
- The Learning Academy is now recognised as one of the UK's largest providers of postgraduate academia for paediatric healthcare, with eight new modules commencing this year and a total of 19 modules currently running. An additional four new modules are now accredited for September 2020.
- We appointed leads in specialty areas to deliver a portfolio of education to support GOSH's priorities as well the *NHS Long Term Plan*, including mental health, learning disabilities, clinical ethics, and digital learning.

In 2019/20 a wide-range of educational initiatives were developed or are in development and soon to launch:

- A new Virtual Learning Environment – a state-of-the-art digital platform to change the way we educate and learn, opening up our reach to clinical and non-clinical professionals worldwide. Work continues for an anticipated launch in Autumn 2020.
- A suite of leadership development opportunities to enhance the competencies of our aspiring and established clinical and non-clinical leaders and make GOSH a great place to work and learn – a key priority of our *People Strategy*.
- We have developed some of the first allied health and undergraduate nursing apprenticeships, with over 20 placements due to commence in September 2020.
- The *GOSH Children's Charity Scholarship Awards*, launching April 2020 and ensuring continued professional development access for the entire workforce. All

staff will be able to apply for funding to explore opportunities for their development, including study, conferences, and sabbaticals. These will continue to develop our internal competency and disseminate our highly-specialist knowledge nationally and internationally to improve paediatric care across the globe.

Though joined together under the Learning Academy strategy, our corporate and clinical directorate education teams continue to deliver a large portfolio of activity and achievements within their areas, detailed below.

## Organisational and Employee Development

Organisational and Employee Development (OED) increased its activity over the past year and facilitated a total of 248 courses, which involved 1,761 hours of sessions, where 5,762 delegates attended.

On top of increased activity, the team has expanded many programmes and embarked on new projects. Some main achievements include:

- We saw a large growth in apprenticeships, with 110 starters, exceeding the annual public sector target. Newly introduced programmes include healthcare scientist, network engineer, and data analyst.
- Created a range of learning and development offers in a new Management Development Suite.
- Developed and delivered leadership programmes for aspiring and developing leaders.
- Implemented coaching conversations workshops for over 60 staff.
- Reviewed and refreshed our approach to conflict resolution through 'Safe and Respectful Behaviour' Programme.
- Maintained statutory and mandatory training compliance at high levels throughout the year and currently at 93%.
- The induction programme was redesigned integrating the EPR, Speak Up initiatives and engagement activities.
- As part of embedding compassionate leadership at GOSH, new coaching workshops were implemented.
- A new staff resource, *Developing your career at GOSH,* was published to support staff retention.
- A succession planning and talent management workstream programme was created to identify opportunities to build career pathways for high-potential administrative workers, graduates, and apprentices.

## Clinical Simulation Centre

The Clinical Simulation Centre continued its growth as one of the most expansive elements of the Learning Academy strategy. It plays a vital role as one of the fundamental methods of knowledge delivery for contemporary, evidence-based rehearsal of clinical practice.

In 2019/20, some achievements include:

- 12,113 learner hours logged, a 15% increase from 2018/19.
- 3,338 multi-professional candidates – an 18% increase – were taught on internal and external programmes.

- Our in-situ training programme, facilitating clinical simulation scenarios within clinical areas, saw significant development with total sessions increasing by 57%. We have now reached 44 clinical areas, and embedded satellite simulation spaces within four key areas across the Trust.
- Launch of our first Critical Care Boot Camp for Advanced Clinical Practitioners, delivered in partnership with the ICR across sites at GOSH and St Mary's Hospital.

## Nursing and Non-Medical Education

The Nursing and Non-Medical Education team facilitated 483 education and training sessions in 2019/20, delivering a total of 38,074 learner hours for both internal and external candidates.

Some of our main achievements include:

- Supported 1,520 events of continued professional development, including postgraduate academia, conferences, and study days.
- Facilitated 19 postgraduate academic modules, including eight new modules in ground-breaking areas, such as Orthopaedic and Spinal Conditions, Haematopoietic Stem Cell Transplantation, and Preceptorship in Practice. We have continued expanding our partnerships across the STP which now include Barts Health, the Royal Marsden, and the Royal National Orthopaedic Trust. In 2019/20 alone, 360 learners from across the UK enrolled on our academic portfolio.
- The Clinical Apprenticeship team launched the new Nursing Associate Apprenticeship as well as continuing to facilitate successful placements of apprentice healthcare support workers, with 42 apprentices currently on programme and 37 new commencements.
- Our Undergraduate team facilitated 4,625 pre-registration nursing placement weeks across 37 clinical areas and rolled-out the newly implemented NMC standards for student supervision and assessment.
- The Operational Practice Educator team facilitated foundation courses for all clinical specialties and launched new development programmes such as Stepping Up to Band 6 and Stepping Up to Band 7 as part of our education pathways for the nursing workforce.
- Operational practice educators have also been fundamental to the success of the Laboratory Testing and Catheter Quality Improvement projects as well as leading twice yearly Core Care projects to ensure our care provided is the highest standard for patients and families.
- Our Graduate team facilitated our newly accredited Preceptorship in Practice module for 95 newly registered practitioners entering the Trust as part of our Graduate Programme: Year 1. 145 newly registered practitioners completed the first year of their programme and continued onto year two.

## Postgraduate Medical Education

The Postgraduate Medical Education (PGME) department saw sustained growth in activity over the last year, with an 18% increase in educational events and 2,287 multi-professional candidates.

A successful year yielded productive areas of collaboration in education and training development. Some main achievements include:

- The second annual *GOSH Conference 'Continuous Care'* was held in November 2019 with 200 attendees and 160 abstract submissions, showcasing the amazing

work taking place across GOSH. All accepted abstracts were published in *Archives of Disease in Childhood*.

- The team successfully facilitated the formal RCPCH Membership exams for a third year running with excellent feedback from examiners. This would not be possible without the help of our wonderful patients and their families.

## 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 staff report incidents. In 2019/20 GOSH employees reported 730 health and safety incidents including 98 patient safety accidents. This has decreased from 849 incidents in 2018/19. This included one serious incident. Eight incidents were reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.

The Trust's governance structure ensures statutory compliance is undertaken within legislative requirements. Assurance via the Health and Safety Committee has been provided on a range of subjects such as violence against staff, sharps compliance, Control of Substances Hazardous to Health and fire safety. Maintaining compliance in a complex and diverse environment can present challenges. We are continuously assessing and auditing to allow us to review and develop our systems to manage risk more effectively.

## Trade union facility time

The Trust has 13 trade union representatives across the organisation. The representatives spent an average of 3% of their work time on union activities (65 hours per month in total).

The total cost of union activities was less than 1% of the total pay bill for the year.

## 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 X of the annual accounts on page xx.

## Exit packages

Information about exit packages can be found on page xx.

## Modern Slavery statement for 2019/20

GOSH supports the Government's objectives to eradicate modern slavery and human trafficking, and recognises the significant role the NHS has to play in both combatting it and supporting victims. In particular, we are committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to date include:

### People

The Trust makes appropriate pre-employment checks on all directly employed staff. Only agencies on approved frameworks are used and they are audited to provide assurance that pre-employment clearance has been obtained for all agency staff.

There is a range of policies and procedures designed to protect staff from poor treatment and/or exploitation, which comply with all relevant employment law and the Advisory, Conciliation and Arbitration Service code of practice. These include the provision of fair pay rates based on nationally negotiated terms and conditions of employment. There is also a range of benefits, including health and wellbeing support, and access to training and development opportunities

Where changes to employment, work, organisation and policies and procedures are proposed, there is communication, consultation and negotiation with trade unions.

Efforts to engage and involve staff in matters which affect them include regular staff briefings and consultation with a range of staff forums.

### Procurement and our supply chain

Most of our products are purchased from UK or EU based firms, who may also be required to comply with the requirements of the UK Modern Slavery Act (2015) or similar legislation in other EU states.

A significant number of products are purchased through NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour.

Where possible and consistent with the Public Contracts Regulations, the Trust builds long-standing relationships with suppliers.

### Training

Advice and training about modern slavery and human trafficking is available to staff through our Safeguarding Children and Adults training, our safeguarding policies and procedures and our Safeguarding team.

### Responding

Any concerns about modern slavery are taken seriously and managed sensitively, and support is provided. This includes referring to external agencies, where appropriate.

### Approval

This statement has been approved by the Chief Nurse who chairs the Strategic Safeguarding Committee, which will review and update it on an annual basis

**Off payroll engagements**

Information about off payroll engagements can be found on page xx.

# 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 directorate and International and Private Patients 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 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.

Throughout our annual report we describe how we meet the Code. A summary of where detail can be found on the issues we are required to disclose is given in the following table.

| Code reference | Section of annual report |
|---|---|
| A.1.1 | Accountability Report:<br>• Council of Governors (role of Council)<br>• Trust Board (role of Trust Board)<br>• Annual Governance Statement (role of Trust Board) |
| A.1.2 | Accountability Report - Trust Board members 2019-20 |

| Code reference | Section of annual report |
|---|---|
| A.5.3 | Accountability Report - Governors' attendance at meetings |
| Additional requirement- FT Annual Reporting Manual | A statement about the number of meetings of the council of governors and individual attendance by governors and directors.<br>Accountability Report - Trust Board members 2019-20<br>Accountability Report - Governors' attendance at meetings |
| B.1.1 | Accountability Report - Trust Board members 2019-20 |
| B.1.4 | Accountability Report - Trust Board members 2019-20 |
| Additional requirement- FT Annual Reporting Manual | Brief description of the length of appointments of the non-executive directors, and how they may be terminated<br>Accountability Report - Trust Board members 2019-20 |
| B.2.10 | Accountability Report:<br>Trust Board Nominations Committee<br>Council of Governors' Nominations and Remuneration Committee |
| Additional requirement - FT Annual Reporting Manual | Explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.<br>Not applicable |
| B.3.1 | Accountability Report - Trust Board members 2019-20 |
| B.5.6 | Accountability Report – Membership Engagement |
| Additional requirement- FT Annual Reporting Manual | Governors having exercised their powers to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions<br>Not applicable |
| B.6.1 | Accountability Report – Evaluation of Board performance |
| B.6.2 | Accountability Report – Evaluation of Board performance |

| Code reference | Section of annual report |
|---|---|
| | |
| C.1.1 | Disclosures -Statement of the chief executive's responsibilities as the accounting officer of Great Ormond Street Hospital for Children NHS Foundation Trust |
| C.2.2 | Accountability Report – Audit Committee Report and Annual Governance Statement |
| C.3.5 | Not applicable for 2019-20 |
| C.3.9 | Accountability Report – Audit Committee Report |
| D.1.3 | Not applicable for 2019-20 |
| E.1.4 | Accountability Report – Council of Governors |
| E.1.5 | Accountability Report - Trust Board and Council of Governors working together |
| E.1.6 | Accountability Report - Membership constituencies and membership numbers 2019-20 and Membership Engagement |
| Additional requirement- FT Annual Reporting Manual | Eligibility for being a member, membership statistics and membership strategy<br><br>Accountability Report – Council of Governors |
| Additional requirement- FT Annual Reporting Manual | Details of company directorships or other material interests in companies held by governors and/or directors<br><br>Accountability Report – Council of Governors<br><br>Accountability Report – Register of Interest (Directors) and Register of Interests (Governors) |
| B.1.2 | The Board is normally comprised of a Chair, Deputy Chair, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by University College London.<br><br>Professor Rosalind Smyth (UCL appointment) stepped down from the Board on 31 December 2019. From 1 January 2020 until 30 April 2020, the Board comprised a chair and five non-–executive directors. |

## Transactions with related parties

Transactions with third parties are presented in the accounts on page xx. None of the other Board members, the Foundation Trust's Governors, or parties related to them have undertaken material transactions with the Trust.

## Consultations in year

We received nearly 140 written responses from patients, families and staff who we engaged with at the strategy roving stand in September, having to spoken to at least four or five times that number.

In 2019/20, we consulted patients, families, members, the public and staff on a variety of issues:

- The Trust consulted patients, families, staff and stakeholders on refreshing its strategy for the next five years. Key consultations included:
    - Exploratory workshops with staff, Governors, the Young People's Forum and our academic partners to develop vision and priorities for the ideal version of GOSH in 2025 and high-impact ideas to achieve the vision.
    - A space-themed open day that welcomed around 130 patients and their families to explore options for developing virtual hospital services, hub and spoke models and urgent care.
    - Roving exhibition stands at events like Play Street (see page XX), and face-to-face sessions with key staff (including the leadership team, nurses, porters, healthcare scientists and others).
    - Meetings with our key partners, questionnaires, and a feature in Get Involved.
- We consulted with our young patients through the Young People's Forum on:
    - The Clean Air Hospital Framework – considering ways GOSH could improve air quality
    - How young people were heard via the PALS and Complaints services.
    - The plans for the Children's Cancer Centre.

## 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. Employer contributions for 2019/20 were 20.68% of which the Trust makes contributions of 14.38% and the remaining 6.3% is paid by NHSE. 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 2019/20, the Trust contributed 3% 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 XX to the accounts. Information about application of the NHS Pension Annual Tax Allowance Threshold can be found on page xx.

## 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.

## Trust Board member expenses

Directors can claim reasonable expenses for carrying out their duties. For the year 2019/20, the total amount claimed by four Board members was £18,200.

## Information governance

The implementation of the Information Governance Framework at GOSH is monitored by the Information Governance Steering Group (IGSG). Chaired by the Trust Caldicott Guardian, this group manages risks to data governance security and provides assurance to the Trust's Audit Committee. IGSG meets monthly and reviews areas affecting data quality, records management and information security. Key considerations for its work plan are outlined by the new Data Security and Protection (DSP) Toolkit. This submission is how the Trust demonstrates it is practising good data security and that personal information is handled correctly. Compliance is required for access to NHS patient data and NHS digital systems but also for many of the Information Sharing Agreements the Trust will enter in.

The implementation of the General Data Protection (GDPR) Legislation in May 2018 drove the information governance work programme over the last year. While a lot of the changes were already requirements for NHS organisations, improvements were still required. This included a focus on reviewing all personal data processing, how individuals access the data GOSH holds on them, and how patients are informed of their options with regards to data sharing.

On 23 March 2020 the Trust appointed a new Caldicott Guardian, Sarah Aylett, who is a Consultant Paediatric Neurologist.

Over the coming year the Trust will continue to ensure the requirements under GDPR are embedded and that specific areas of improvement identified via the DSP Toolkit have action

plans agreed. Training and staff awareness are a key focus to help prevent information breaches. Incidents, near misses and their subsequent lessons learnt are used to inform the training and communication programme, ensuring it remains dynamic and reflects current and meaningful issues to facilitate greater staff engagement and ownership of information governance processes.

With the launch of the new Epic EPR system, and the tools and benefits it brings, GOSH has an opportunity to further develop its commitment to confidentiality. Patients and families will now be able to use the secure online portal, MyGOSH, to access their appointment and medical details. We will have better controls to secure patient records and monitor access to records, combining several different systems ensures one clear, accurate and up-to-date patient record.

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.

## Registration with the CQC

GOSH is registered with the CQC as a provider of acute healthcare services. The CQC visited the Trust in October 2019 as part of its rolling schedule of inspections. The report was published in 22 January 2020 and services were rated as ‘good’ overall and ‘outstanding’ for being caring and for being effective. The CQC also conducted a well-led inspection and the Trust was rated ‘good’ – further information can be found on page XX. The Trust has developed an action plan in response to the recommendations. Further information on progress with the plan can be found on page xx.

## Complaints and how we handle them

The Trust takes all complaints seriously and is committed to being fair, open and transparent when dealing with any complaint. All complaints are acknowledged within three days and the complaints team try to speak with all complainants to understand their complaint and the outcome they are seeking. Complaints are always shared with members of the executive team and are managed sensitively. Timescales are agreed with the complainant while taking into consideration individual circumstances.

A final response is sent from a member of the Executive Team, which aims to provide appropriate and proportionate remedies. As part of complaint investigations, lessons are identified and action plans are devised to improve the service and experience for our patients and families. The Trust uses the Datix system to record, analyse and report on the learning from complaints. Complaint trends and the actions taken in response to these are reported to the Trust Board. Compliance of these actions is monitoring by the Complaints Team and at the Patient and Family Experience and Engagement Committee.

If a complainant is dissatisfied with the response to their complaint the Trust aims to work with them to try and resolve their concerns. This includes offering a meeting with the staff members or teams involved where appropriate. 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.

In 2019/20, the Trust received 90 formal complaints (three were later withdrawn at the request of the complainant and two could not be investigated in line with the NHS Complaint Regulations due to the significant lapse in time since the events being complained about). During the year, there were no new complaints investigated by the PHSO.

## Detail of political and charitable donations

The Trust made a charitable donation of £4,250 to The United Nations Children's Fund (UNICEF) in respect of the 'Get a Jab, Give a Jab' initiative.

The Trust did not make any political donations during 2019/20.

## NHS Oversight Framework

NHSE and NHSI's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. It incorporates 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 one to four, where four reflects providers receiving the most support, and one reflects providers with maximum autonomy. A foundation trust will only be in segments three or four where it has been found to be in breach or suspected breach of its licence.

## Segmentation

For 2019/20, the Trust continued to be placed in Segment two by NHSI. Current segmentation information for NHS trusts and foundation trusts is published on the NHSI website.

## Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from one to four, where one 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 | 2019/20 scores | | | |
|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 |
| Financial sustainability | Capital service capacity | 4 | 2 | 2 | 1 |
| | Liquidity | 1 | 1 | 1 | 1 |
| Financial efficiency | Income and expenditure margin | 4 | 4 | 3 | 2 |
| Financial controls | Distance from financial plan | 1 | 1 | 1 | 1 |
| | Agency spend | 1 | 1 | 1 | 1 |
| Overall scoring | | 3 | 3 | 1 | 1 |

## NHSI well-led framework

As part of their routine scheduled inspection programme, the CQC conducted a well-led inspection of the Trust in October 2019. The Trust was rated as 'good'; an improvement since the last inspection.

The Trust developed an action plan in response to the recommendations raised in the report and the plan is monitored by the Executive Team and reported to the Trust Board and Council of Governors (see page xx).

## Working with partner and stakeholder organisations

During 2019/20, 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

The Trust has a close and unique partnership with the UCL Great Ormond Street Institute of Child Health (ICH), working together to develop 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.

At a strategy workshop with ICH colleagues in July 2019, we identified potential areas of focus for our strategy refresh including:

- An increased research focus on health, not just on disease, noting that discoveries can have a greater impact on population health if they are applied early on in the patient pathway.
- A world-class model for operational integration of research and education into hospital care.

- A focus on research and funding to explore transition issues and consenting to ensure data for young people moving on to adult services is not lost and their long term outcomes can inform research.

## GOSH Children's Charity

The GOSH 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 the ICH, and to make the patient experience as good as it can be. In 2019/20, the charity's total income was just over £87million. Whilst this was another strong year for the charity, it is anticipated that 2020/21 will see a significant drop in income due to the economic impact of COVID-19. Further information about the work of the charity can be found at www.gosh.org.

## Our commissioners

More than 90% of our clinical services are commissioned by NHSE, with the remaining 10% being delivered through arrangements with over 204 clinical commissioning groups. We have a proactive working relationship with NHSE, 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 NHSE to provide clinical input into the standards and strategic planning of each specialised service.

## North Central London Sustainability and Transformation Partnership

The *NHS Long Term Plan*, published in January 2019, set out an ambitious ten-year vision for the health system in England that consolidates previous calls for a greater focus on out-of-hospital care and services to be designed around patient needs rather than institutional boundaries. The intention is that regional partnerships of NHS organisations and local councils (known as Sustainability and Transformation Partnerships, or STPs) will develop into Integrated Care Systems that will have more control over how the care for their local population is delivered and how NHS resources are distributed.

Although just 4% of GOSH patients come from within the North Central London STP, national policy direction means that our contribution to this local network is very important. GOSH participates in several of its committees, looking at issues including procurement, leadership of transformation, nurse leadership and workforce. The STP has provided an essential platform for planning and delivering paediatric services during the COVID-19 pandemic. Further information on how GOSH worked with its STP partners can be found on page xx.

## Children's Hospitals Alliance

GOSH is part of the UK Children's Hospitals Alliance – a group of children's hospitals across the UK that includes Alder Hey, Birmingham, Southampton, Manchester, Evelina London, Leeds, Sheffield, the Great North Children's Hospital and Bristol Royal Hospital for Children. The group acts as a unified voice advocating for children and young people's services and runs a variety of projects to share learning, innovation and best practice. The Alliance has formalised a set of objectives and focus areas and GOSH CEO Mat Shaw is chairing the Alliance working group to create a National Paediatric Pathology Network.

GOSH has led the Alliance effort to establish a Specialised Services Quality Dashboard to allow these hospitals to benchmark their data. We continue to support collaborative efforts to promote the use of and refine the tool, so that it can ultimately be used for quality improvement and research.

A group of finance experts from the Alliance hospitals has been working with the pricing team at NHSE and NHSI on a review of tariffs and payments. Their aim is to work towards budgeting that better reflects the complexities and high cost of care for children with complex health needs to safeguard services and improve the financial sustainability and viability of specialised children's hospitals.

### UCL Partners

GOSH is a member of UCL Partners, an academic health science centre, which works to tackle the greatest health challenges affecting our population, by accelerating the translation of discoveries in areas of unmet need.

UCL Partners brings together expertise from five NHS trusts (GOSH, Barts Health, Moorfields, the Royal Free and University College Hospitals), four NIHR BRCs and three Universities (UCL, the London School of Hygiene and Tropical Medicine and Queen Mary University of London).

In April 2020, UCL Partners announced it has been re-designated as an Academic Health Science Centre by the NIHR for a further five years, following a competitive process. Over the next five years, it aims to continue driving collaborative work to identify transformational innovations in healthcare, support them with specialist expertise, training and seed funds, speed-up development and maximise benefit for patients and NHS partners.

### North Thames Paediatric Network

GOSH is a member of the North Thames Paediatric Network. The network brings together 24 providers of paediatric services across the North London region; 18 acute care and six specialist providers with inpatient facilities. It also provides a forum for these providers and commissioners of paediatric services to work closely together to ensure that services are configured around children and young people. The Network aims to improve the efficiency and effectiveness of service provision through a reduction in the variation of treatment, develop sustainable pathways of care for specialist paediatric services; and support sustainability of services through training and the development of new models of care.

### European Children's Hospital Organisation (ECHO)

GOSH is a founding member of European Children's Hospital Organisation (ECHO), a partnership of specialist paediatric hospitals across Europe. GOSH has supported ECHO by establishing a Quality, Safety, Outcomes and Value working group to share best practice for shared benchmarking of clinical outcomes. We collaborate with member organisations to disseminate learning, information and research calls. The organisation has developed its role in advocacy, responding to an EU consultation on cancer care and publishing a joint declaration calling for early and sustained investment in child health together with children's hospitals organisations in Australasia, Canada, and the United States, marking 30 years since the signing of the United Nations Convention on the Rights of the Child. GOSH is now working with ECHO colleagues to develop a Green Promise for European Children's

Hospitals and further position statements to influence public policy on the role of children's hospitals.

GOSH clinicians participate in a number of the European Reference Networks (ERN), which are European Commission-funded partnerships seeking to improve access, diagnosis and outcomes for rare disease patients across Europe. Professor Helen Cross is the coordinator for EpiCARE, the ERN which brings together 28 highly specialised centres in 13 European countries, which are collaborating on care, research, education and training to benefit patients with rare and complex epilepsies.

## 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. 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.

**Signed……..**

**Mr Matthew Shaw**

**Chief Executive**

**Date: XX May 2020**

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

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 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, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care 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 and Social Care 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.
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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 them 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.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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……..**

**Mr Matthew Shaw**

**Chief Executive**

**Date: XX May 2020**

# Audit Committee report

## Introduction from the Chair of the Audit Committee

I am pleased to present the Audit Committee's report on its activities during the year ending 31 March 2020.

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 consideration of non-clinical risks and their associated controls; 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, business continuity, managing security and ensuring that there are arrangements by which staff of the Trust may raise concerns.

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 2019/20, but I would like to draw particular attention to the following items

Electronic Patient Record: The Trust's new EPR system went live on 19 April 2019. The Audit Committee and the Board received regular reports on progress with the plans for implementation of the stabilisation phase and the associated impact on patient care, activity and reporting. The Audit Committee continues to retain an overview of the strategic risk on the Board Assurance Framework of the benefits of the system not being realised and has sought assurance of the capitalisation of the EPR in the accounts.

Planning for a no deal Brexit: The committee sought assurance of the controls in place to manage the risk of a 'no deal Brexit'. Regular updates were presented to the committee on the Brexit risk in the Board Assurance Framework including the impact on the supply of medicines, funding of research and assurance of the readiness and testing of the business continuity plans. Positive assurances given around business continuity plans were key and timely when considering the readiness for management and planning for COVID-19 (see page xx).

CQC inspection report: In October 2019, the CQC conducted a scheduled unannounced inspection of three services (critical care, surgery and CAMHS) and an announced inspection against the well-led criteria. More detail can be found on pages XX but I wanted to draw to attention the improvement in ratings for Well Led and the findings in the report about how staff demonstrated to the CQC how they identified and escalated relevant risks and issues and identified actions to reduce their impact. This provided another level of assurance of the implementation of the Trust risk management strategy.

Financial report requirements: The Audit Committee has received regular updates on the impact of IFRS 9 (including analysis of overdue debt levels by classes of debtor) and IFRS 16 (leases). The Committee will continue to monitor these areas in 2020/21.

The Trust has undertaken a review of the appropriateness of the adoption of the going concern basis for the preparation of the accounts. We are confident that Trust management has adopted the appropriate accounting basis and recognise that the financial challenges faced by the wider NHS during COVID-19 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 2019/20 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**

**Chair of the Audit Committee**

**XX May 2020**

## Audit Committee responsibilities

The committee's responsibilities and the key areas discussed during 2019/20, 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 2019/20 |
|---|---|---|
| **Review of the Trust's risk management processes and internal controls** | • Reviewing the Trust's internal financial controls, its compliance with NHSI's guidance for foundation trusts, including the Code of Governance, and the effectiveness of its internal control and risk management systems.<br><br>• 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.) | • The outputs of the Trust's risk management processes including reviews of:<br><br>• 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.<br><br>• An annual assessment on the effectiveness of internal control systems taking account of the findings from internal and external audit reports.<br><br>• An annual report and fraud risk assessment prepared by the Trust's counter fraud officer.<br><br>• An annual report from the Trust's security manager.<br><br>• Assurance of controls in place for emergency planning and business continuity and with particular focus on Brexit and latterly COVID-19 planning.<br><br>• Assurance of plans to manage debt provisioning.<br><br>• Assurance of the stabilisation of the EPR and impact on delivery of care, activity and finances. |

| | Principal responsibilities of the Audit Committee | Key areas formally discussed and reviewed by the committee during 2019/20 |
|---|---|---|
| **Financial reporting and external audit** | • Monitoring the integrity of the Trust's financial statements and annual financial returns; reviewing significant financial reporting judgements contained within them.<br>• Making recommendations to the Board regarding the appointment of the external auditor.<br>• Monitoring and reviewing the external auditor's independence, objectivity and effectiveness.<br>• Developing and implementing policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance. | • A commentary on the annual financial statements.<br>• Assurance on the framework in place to deliver required Better Value schemes.<br>• Key accounting policy judgements, including valuations.<br>• Impact of changes in financial reporting standards where relevant (IFRS 9 and IFRS 16).<br>• Assurance of strategy and plans to deliver IPP contribution targets.<br>• Basis for concluding that the Trust is a going concern.<br>• External auditor effectiveness and independence.<br>• External auditor reports on planning, risk assessment, internal control and value for money reviews.<br>• External auditor recommendations for improving the financial systems or internal controls.<br>• Review of non-audit work conducted by the external auditors. |

| | Principal responsibilities of the Audit Committee | Key areas formally discussed and reviewed by the committee during 2019/20 |
|---|---|---|
| **Internal audit** | • Monitoring and reviewing the effectiveness of the company's internal audit function, including its plans, level of resources and budget. | • Internal audit effectiveness.<br>• 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.<br>• Status reports on audit recommendations and any trends and themes emerging.<br>• The internal audit reports discussed by the committee included:<br>- Key financial controls (significant assurance with minor improvement potential).<br>- Better Value (significant assurance with minor improvement potential).<br>- Directorate Governance (significant assurance with minor improvement potential).<br>- Incident Reporting (partial assurance with improvements required).<br>- GDPR (partial assurance with improvements required).<br>- Patient discharge (partial assurance with improvements required).<br>- Estates and Health and Safety (partial assurance with improvements required).<br>- Access and activity data (partial assurance with improvements required). |

| | Principal responsibilities of the Audit Committee | Key areas formally discussed and reviewed by the committee during 2019/20 |
|---|---|---|
| **Other** | • Reviewing the committee's terms of reference and monitoring its execution.<br>• Considering compliance with legal requirements, accounting standards.<br>• Reviewing the Trust's whistle-blowing policy and operation. | • Review of SFIs and Scheme of Delegation.<br>• Review of Audit Committee's terms of reference and workplan in light of external guidance.<br>• Updates on compliance with GDPR and data quality.<br>• Assurance of the delivery of the Trust cyber security strategy.<br>• Updates on staff raising concerns policy (whistleblowing) and issues raised with Freedom to Speak Up Ambassadors.<br>• Monitoring of the process for and approval of procurement waivers.<br>• Reporting to the Board and Council of Governors where actions are required and outlining recommendations.<br>• Assurance of compliance with the Bribery Act 2011.<br>• Assurance on the management of claims and associated cost. |

## 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 2019/20 was used to review the committee's terms of reference 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

The 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 were provided by KPMG LLP during 2019/20 covering both financial and non-financial audits according to a risk-based plan agreed with the Audit Committee.

The Trust's counter-fraud service was provided by Grant Thornton UK LLP during 2019/20, who provided fraud awareness training, carried out reviews of areas at risk of fraud and investigated any reported frauds.

## Key areas of focus for the Audit Committee in the past year

## Cyber security

The committee received regular updates on work undertaken to categorise and assess GOSH Strategic Cyber Security risk profile in line with regulatory and compliance requirements as well as tracking and countering the evolving threat landscape. With the changes to working practices in response to COVID-19, the committee continues to seek assurance of the robustness of the Trust's cyber security risk assessments and remediation plans. There were no significant cyber security breaches during the year.

## Compliance with GDPR

During the year, the committee was assured that progress continued to be made to maintain compliance with the Data Protection Act 2018. Following the internal audit results into GDPR, the committee received assurance that a plan was in place to review and update the Trust information asset register. Work had been conducted on updating training resources and key policies, reviewing and publishing privacy notices and rolling out an updated data privacy impact assessment template and information sharing templates.

## Board Assurance Framework (BAF)

The Risk Assurance and Compliance Group reviewed each strategic risk on the BAF along with the related mitigation controls and assurances and made recommendations to the assurance committees about changes to controls, assurances and residual risk scores.

For each risk relevant to the Audit Committee, the committee reviewed the risk statement, the robustness of the controls cited and the evidence available that the controls were operating, the associated risk appetite, and likelihood and impact scores. The committee received presentations on strategic risks at each committee meeting based upon focused questions posed to risk owners by Audit Committee members prior to each meeting.

## 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, Safety

and Experience 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, Safety and Experience Assurance Committee.

## International and Private Patient (IPP) debtors

The Audit Committee monitored and reviewed the IPP debt levels for each major customer and discussed with the Executive Team, strategies to minimise the level of exposure. Although the debt exposure for the organisation has increased over the year, the committee has confirmed it is satisfied that management are actively working to reduce this and will continue to monitor this key risk. The committee also reviewed the implications of IFRS 9 and approved the Trust's provisioning methodology.

## Internal controls

We focused in particular on controls relating to cyber-security, information governance, contract management and delays in IPP 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

We reviewed the levels of fraud and theft reported and detected, and the arrangements in place to prevent, minimise and detect fraud and bribery. We continue to see assurance of the actions being taken to fully meet the standards under the NHS Counter Fraud Authority Self-Review Tool.

## 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 Executive Team has carefully considered the appropriateness of reporting on the 'going concern' basis.

## Significant financial judgements and reporting for 2019/20

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, calculated following an evidence-based approach under IFRS 9, 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 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.

Due to the value of the intangible asset under construction related to the EPR and Digital Research Platform systems, the Trust carried out an impairment review in line with the requirements of International Accounting Standard 36 (IAS 36) and the DH Group Accounting Manual to determine whether the assets carrying value exceed the service potential value. We reviewed reports from management which explained the basis of valuation of these assets including the future life and rationale for any impairment. We also

considered the auditors' views on the accounting treatment for these assets. We are satisfied that the valuation of these intangible assets under construction within the financial statements is consistent with management intention and is in line with accepted accounting standards.

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**

**Chair of the Audit Committee**

**XX May 2020**

# Quality, Safety and Experience Assurance Committee report

## Introduction from the Chair of the Quality, Safety and Experience Assurance Committee

Key responsibilities of the committee include consideration of clinical risks and the effectiveness of their associated controls; seeking assurance of learning from incidents, complaints, horizon scanning and external reviews and investigations as well as the work in place to improve the experience of our patients and their families.

The table on page XX sets out, in detail, the responsibilities of the committee and how we have discharged those duties. The report also highlights the key areas considered by the committee in 2019/20.

In its first year as the Quality, Safety and Experience Assurance Committee (QSEAC), it has sought to refine the breadth and coverage of the information presented at its meetings. It has reviewed its workplan to ensure that appropriate focus is given to those significant areas of clinical risk facing the Trust and that benchmarking data is available where relevant. This approach has been supported by the work of the People and Education Assurance Committee which now seeks assurance of matters related to staff in the delivery of safe and effective services.

During the year, the QSEAC has sought to identify possible systemic weaknesses and gain an understanding of why certain services have been challenged by team working issues and gaps in quality assurance processes. The committee has been assured by the appetite of the senior management team to continually learn, to bring in external experts when necessary. The committee welcomes that senior management reflect openly on how working practices can be improved and better supported and systems and processes fortified to ensure consistent high quality outcomes.

## Quality, Safety and Experience Assurance Committee responsibilities

The principal purpose of the QSEAC 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 also works in partnership with the Audit Committee and the People and Education Assurance Committee to ensure that implications for clinical care of non-clinical risks and incidents and risks and incidents related to staff are identified and adequately controlled.

The committee requests assurance on scheduled matters as well as quality and safety issues arising during the year. Where weaknesses are identified, the committee agrees and tracks the strengthening actions. The committee's responsibilities and the key areas discussed during 2019/20 are outlined below.

| Principal responsibilities of the committee | Key areas formally reviewed during 2019/20 |
|---|---|
| Review the establishment and maintenance of an effective system of governance, risk management and internal control in relation to clinical services, research and development. | • The committee received updates at every meeting from the Risk Assurance and Compliance group about the management of strategic clinical risks. This includes a new Board Assurance Framework (BAF) risk on safety management and a separate BAF risk on establishment of a research hospital.<br>• The committee reviewed the patient and family experience and engagement framework.<br>• A quality and safety report was presented at every committee meeting. This included a focus on the experience of our patients and families and tracking the improvements resulting from complaints, Friends and Family Test results and, PALs feedback. An update on the results of the CQC inpatient survey was also presented.<br>• A quarterly safeguarding report was presented at every meeting. This provides assurance of processes and structures in place to provide a comprehensive safeguarding service covering an overview of referrals and working with partners, staff training, supervision, updates on policies and guidance and audit results. |
| Assure the Board that appropriate action is taken to identify implications for the delivery of safe, high quality, patient-centred care and excellent patient experience arising out of recommendations from external investigations of other organisations/systems and processes. | • As Chair, I reported to the Board following every meeting of the committee, on the key matters requiring escalation or assurance. The committee is charged with seeking assurance around the significant clinical/quality related issues facing the Trust – this includes understanding the findings from external reviews such as the Urology review and how learning from complaints, incidents and external reports are cascaded across the Trust to improve outcomes.<br>• Matters pertinent to other assurance committees (Audit Committee and People and Education Assurance Committee) are also reported to those committees as appropriate. |
| Be responsible for reviewing, on behalf of the Trust Board, progress with quality improvement priorities set in the Quality Strategy and Quality | • The committee selected options for improvement projects reported in the annual Quality Report. Non-executive director committee members annually review the Quality Report on behalf of the Board.<br>• In January 2020, the committee received a |

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| Report. | presentation and live display of the Specialist Services Quality Dashboard (SSQD) benchmarking project – these are a list of measures against which NHS organisations collate and share data to understand the quality and outcomes of services. |
| Review and seek assurance on any issues identified by the Trust Board (as requiring more detailed review that falls 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. | • The Board delegated the committee with an action to scrutinise the Trust's progress with its response to the Medicines and Healthcare Regulatory Authority (MHRA) findings in pharmacy. The committee requested senior members of the pharmacy team to attend on a few occasions to discuss progress with the actions and also provide an update on the mitigations in place to control the medicines management risk on the BAF (see below).<br>• The committee reviewed a report on Paediatric Intensive Care Audit Network (PICANEet) data around mortality rates. |
| 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. | • Every six months, the committee receives an update on recent reports and guidance issued by a range of external stakeholders. This horizon scanning report provides a summary of documents which could/should shape the Trust's approach to quality and governance within the organisation.<br>• At every meeting, the Medical Director reported on emerging significant risks. This is based on the aggregation and integration of information from a broad range of sources in the Trust including: serious incidents, complaints, inquests, clinical negligence claims, harm reviews, and the feedback from our recent CQC inspection, and other external inspections or reviews. The report outlines how the risks are currently being managed, providing updates on progress where appropriate.<br>• Where GOSH reviews have been instigated, these have highlighted the importance of managing performance and behaviours effectively in order to deliver high quality care. The committee found that there were comprehensive action plans in place and findings were shared with the People and Education Assurance Committee<br>• The committee received quarterly updates on |

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| | actions taken in response to patient stories reported at Board meetings. |
| 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. | • The committee is regularly appraised of progress in the response to the routine CQC report of October 2019 via the newly formed Always Improving Group. The committee also received updates on other compliance matters including readiness for regulatory inspections and assessments. |
| Assure the Trust Board that the annual internal audit and annual clinical audit plans are aligned and focused on the appropriate quality focused risks<br><br>Review of findings and recommendations from internal audit, clinical audit and learning from external investigations and reports | • The Trust's internal auditors report to the committee at every meeting and provide an update on any clinical related internal audit reports as well as progress with closing relevant internal audit actions<br>• The clinical audit team reports to the committee every six months and provides an overview of monitoring of specialty-led clinical audits as well as progress with implementation of relevant NICE guidance.<br>• The committee members are annually provided with an opportunity to review the draft Internal Audit Plan for the following year and make suggestions on areas of risk to be audited. |

## Review of effectiveness of the committee

The QSEAC conducted a self-assessment effectiveness survey in January 2020. Overall, the results of the survey were positive and respondents provided some helpful and supportive feedback on how the committee can function more efficiently and effectively.

Respondents were positive about the how the committee fulfils its role in relation to obtaining assurance of quality and safety structures, process, shortcomings and operational performance. Comments were made about how the recent changes to reporting and focus had been a significant improvement.

Respondents were positive about the information that is submitted to the committee being sufficiently honest and not misleading, and that it comes from a wide range of sources and draws the committee's attention to the areas that require focus. The committee recommended that further work be conducted with authors on presentation of triangulated information that provided assurance with updates on actions taken to mitigate risks. The committee agreed that this approach would support the work underway to ensure sufficient time for the committee to focus on the key quality issues affecting the Trust.

The information from the committee self-assessment survey 2019/20 was used to review the committee's terms of reference with no major changes being made. The committee workplan is in the process of being updated.

## Key areas of focus for QSEAC in 2019/20

### CQC compliance

Following a routine CQC inspection in October 2019, the Board welcomed the report and the committee was charged with seeking assurance of progress with the actions in place to respond to the recommendations. The committee noted the rating provided by CQC on the question 'Are services safe?'. A new risk related to this has been added to the BAF and the committee will monitor delivery of the necessary actions and implementation of the necessary controls to mitigate the risk around the relevant governance and safety systems.

### Follow up following the MHRA Pharmacy inspection

An MHRA inspection of Pharmacy in May 2019 found weaknesses, especially in manufacturing. An internal review was undertaken to provide insight into the management of the department and to understand whether there was sufficient organisational understanding and oversight of the problems and challenges faced by the department. The Pharmacy Transformation Programme updated its action plan in response to the inspection and review. The committee received assurance of the implementation of a refreshed Pharmacy quality improvement framework and changes to the estate to support delivery of the service. It was informed that a Medicines Safety Committee had been established, chaired by the Deputy Medical Director. The committee will continue to seek assurance of progress with the plan, noting that (pre COVID-19) the MHRA were expected to return to inspect the Trust in 2020.

### Transition

The committee sought assurance on the implementation of the GOSH Transition Improvement Programme with the aim to improve the experiences of young people moving from paediatric to adult services, and their families. It was assured that plans were in place to monitor the impact of GOSH's *Growing Up Gaining Independence* (GUGI) framework. The committee was informed that the framework places a general emphasis for all patients and families on preparation for adulthood and removes the need for clinicians to identify who will need to transfer by the age of 14 or to discuss transition unnecessarily. GUGI makes the individual needs of each young person the focus of transition and initiates transition for those who need it.

### Royal College Review of Urology

In March 2019 the GOSH Medical Director commissioned a Urology Service Review from the Royal College of Surgeons (RCS), asking for a review of team dynamics, quality and performance data, departmental leadership, and future opportunities for sub-specialisation. The review report was presented at Board in November 2019 and published on the GOSH website. QSEAC monitored progress with the action plan and has received assurance on the provision of coaching and mentorship for the team, changes to team dynamics, and agreement on the management of sub-specialisation. The committee continues to monitor progress.

## Conclusion

As Chair of the Quality, Safety and Experience Assurance Committee, I am satisfied that the committee adequately discharged its duties in accordance with its terms of reference throughout 2019/20.

**Lady Amanda Ellingworth**

**Chair of the Quality, Safety and Experience Assurance Committee**

**XX May 2020**

# Finance and Investment Committee report

### Introduction from the Chair of the Finance and Investment Committee

I am pleased to present the Finance and Investment Committee's report on its activities during the financial year ending 31 March 2020.

The Finance and Investment Committee Chair is 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 metrics.

The Finance and Investment Committee's membership consists of three independent non-executive directors, the Chief Executive, Chief Operating Officer and Chief Finance Officer. 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.

### Key responsibilities of the committee

Key responsibilities include:

- Review the annual and medium term financial plans.
- Review progress against key financial and operational targets, financial performance ratings, trends, capacity utilisation, productivity and efficiency measures.
- Oversee the Trust's treasury management strategy and borrowings arrangements.
- Review changes in the trust's corporate structures, investments or acquisitions including significant transactions
- Retain oversight on the financial implications of all major investments and business developments.
- Advise the Board on all proposals/business cases for major capital expenditure over £1 million, including the Estates and IT strategies.
- Review of the Trust's procurement policies, processes and performance.

### Key areas of work

Throughout the financial year, the committee undertook a range of work in addition to the regular reports it received to satisfy its terms of reference, and contributed to the achievement of the Trust's strategy in 2019/20. This included the review and endorsement of

several business cases for major Trust projects and contributing to the Trust's response to unplanned events such as COVID-19.

The key areas I would particularly like to draw attention to are listed below.

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| Review and approval of financial plans | The committee reviewed and approved:<br>• the budgeting approach for 2019/20 and reviewed the Trust's Long Term Financial Model and the variables within the model.<br>• The approach to annual business planning and budget setting process. |
| Children's Cancer Centre | The committee reviewed, in close co-operation with Trustees at GOSH Charity, the business case for the Children's Cancer Centre, ensuring affordability and consistency with the Trust's strategy and risk tolerances, requesting detail on the various options for the phasing of the development. |
| Major project updates | The committee received progress updates, details of issues and remedial actions on the Trust's other major redevelopment projects including: Sight and Sound Centre, work on the Southwood Courtyard Building to enable the installation of new iMRI facilities and a new physiotherapy space. |
| Electronic Patient Record | The committee scrutinised the financial aspects of the implementation of the EPR project and through its membership played an important role in the overall assurance of this project during its implementation and ongoing optimisation. |
| Learning Academy | The committee endorsed the business case for the Learning Academy to the GOSH Charity Grants Committee. |
| DRIVE (Digital, Research, Informatics and Virtual Environments) | The committee received updates on DRIVE's key priorities for 2019/20 and its plans to provide increased revenue for the Trust. |
| Commercialisation | At the start of the year, the committee decided to consider potential commercialisation as a theme in all agenda items.<br>The committee received a focused report outlining the main areas of focus that the Trust would use seek to prioritise the delivery of additional commercial value. |
| Post project reviews | The committee reviewed a review of a completed major Estates project to identify lessons learned that could be applied to future projects. |
| Treasury management strategy | The committee reviewed and endorsed the Trust's Treasury Management Policy. |

**Emerging**

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| COVID-19 | The committee took steps to focus on key priorities and the changing financial processes implemented during the early stages of the COVID-19 pandemic whilst maintaining discipline |

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| | and the financial control environment. It specifically reviewed financial contingencies and other measures and processes put in place relevant to the system response to this national issue. It also considered the short-term impact on major projects at GOSH and ensured actions had been taken to manage the Trust's risk profile and ensure that the committee's agenda was focused on understanding and preparing for the medium term impacts on the Trust's future operating model as it returns to business as usual. |

**Standing updates**

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| Finance report | The committee received a finance report at each meeting and discussed performance against the NHSE NHSI control total and Trust income targets as well as an overview of outstanding debt and cash levels.<br><br>The format of the report was further refined over the course of the year to improve committee focus on the most pertinent areas of Trust finances. |
| Productivity and efficiency (Better Value) monthly update | The committee received a report at each meeting covering both directorate and Trust-wide efficiency schemes and challenged Executives to consider a variety of approaches to identify additional schemes. This agenda item will continues to be a key area of focus as the requirement for additional savings remains critical. |
| Integrated performance report | The committee received the integrated performance report at every meeting and challenged Executives on a range of specific performance measures. |
| Directorate reviews | The committee undertook selective reviews of the Trust's directorates throughout the year. A revised template will be used in 2020/21 to continue the challenge of management. The output can be shared across the appropriate Assurance Committees. |
| International and Private Patients | The committee received regular updates on IPP directorate business activity with a focus on its development of new business markets and the sustainability of the important contribution made to GOSH's financial position. |
| Governance arrangements between the Trust and charity major projects | The committee received regular reports on milestones, key performance indicators and benefits for the non-recurrent projects supported by the GOSH Charity. |
| Optimising the electronic patient record project | The committee received regular reports on the Trust's implementation and optimisation of its new EPR, probed the robustness of action plans to address risk and issues and proactively sought assurance that all reasonably practicable considerations had been taken. |
| Procurement services | The committee received a report from its procurement provider on the procurement efficiencies that had been found. |
| Patient-Level Information and Costing Systems (PLICS) | The committee endorsed the approach for approving the PLICS submission. |

## 2019/20 review of effectiveness

Following the committee's review of effectiveness in 2018/19 a number of actions were implemented to improve the effectiveness of the committee. The results of the 2019/20 survey showed that these actions had a positive impact on the quality of papers received and the quality of discussion at the committee. Additionally, no material matters of concern were raised in the 2019/20 review.

The committee met six times over the financial year and I am satisfied that it was presented with papers of good quality and 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 was fully minuted and summaries of the matters discussed at each meeting reported to the Trust Board, Council of Governors and Audit Committee. Members of the Council of Governors also observed committee meetings throughout the year.

The committee reviewed its terms of reference during the year and approved minor changes.

## 2020/21

Looking ahead to 2020/21, the Finance and Investment Committee will continue its focus on supporting the work necessary to ensure the Trust can play its critical role in the national effort to combat the challenges of COVID-19 and thereafter ensure a robust and effective return to a focus on the financial governance and deliverability of the Trust's new strategy.

**Mr James Hatchley**

**Chair of the Finance and Investment Committee**

**XX May 2020**

# People and Education Assurance Committee report

## Introduction from the Chair of the People and Education Assurance Committee

I am pleased to present the first People and Education Assurance Committee's report on its activities during the year ending 31 March 2020.

The committee was established in July 2019 with a remit to obtain assurance on behalf of the Board regarding the wellbeing, training, education and management of all the people who work for GOSH.

During its first eight months, the committee has reflected on is function and focussed on methods of supporting an open and collaborative culture, recognising the complexities, within a specialist NHS trust like GOSH. Committee members are determined to seek assurance direct from staff and external stakeholders on the effect of the application of GOSH's processes on staff. We wish to discover the extent to which those processes foster a culture in which staff feel able to speak, that they are being heard and supported, and have an opportunity to grow.

In 2019 the Board approved a new People Strategy. Further information can be found on page xxx. The committee's role is to scrutinise delivery of the People Strategy via the associated action plan, seeking assurance of investment in the development and welfare of the whole workforce at GOSH and establishment of the Trust as an open and inclusive employer of choice, able to attract, retain and grow talent. The committee is monitoring its progress across its four pillars: capacity and workforce planning, developing skills and capability, modernising and reshaping the corporate and HR infrastructure, and culture, engagement, health and wellbeing

## People and Education Assurance Committee responsibilities

The principal purpose of the People and Education Assurance Committee is to assure the Board that the necessary structures and processes are in place to meet our responsibilities as an employer and training and research hospital. That by focussing on those which promote and value teamwork and collaboration, we create an organisation at which all staff are well led and well managed and where everybody, irrespective of their role, feels valued, heard, supported, safe and connected. The committee also works in partnership with the Audit Committee and the Quality, Safety and Experience Assurance Committee to ensure that any staff-related matters that have an impact on the management of clinical or non-clinical risk are shared and considered by the appropriate assurance committee.

The table below sets out the responsibilities of the committee and how they have been discharged. The report also highlights the key areas considered by the committee in 2019/20.

| Principal responsibilities of the committee | Key areas formally reviewed during 2019/20 |
|---|---|
| Delivery of the People Strategy via its associated action plan, | • The committee received the findings of the 2018 |

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| seeking assurance of investment in the development and welfare of the whole workforce at GOSH and establishment of the Trust as an open and inclusive employer of choice, to attract and retain talent. | and 2019 staff surveys as well as assurance that, at a Trust-wide level, the results were used in the preparation of the GOSH People Strategy and in identifying the key priorities within the strategy and associated HR&OD Service Plan. The committee reflected on the changes in the survey results between years to help understand the prioritisation within the strategy workplan. |
| Alignment of the deliverables within the People Strategy to ensure that appropriate people resources are allocated to deliver the Trust-wide strategic objectives and successfully innovate GOSH services.<br><br>Seek assurance of development in the competence and skills of GOSH staff to deliver existing and future innovative services | • The committee was assured of the plan's focus on the work and structure of the HR Directorate in order to meet the changing requirements of the organisation and to provide a foundation for future investment in capability building and career development. The new HR&OD service will be built around four key functions: organisational and employee development HR strategy, policy and pay, business partnering and advice, operations and systems.<br>• The committee scrutinised the BAF risks on recruitment and retention and service innovation to seek assurance that the necessary controls were working effectively to recruit and retain the right staff and ensure that their development needs and the business needs of the organisation were met. |
| Assurance of delivery of the strategic priorities relating to education and training and the plans for the GOSH Learning Academy. | • The committee received an update on the development of the GOSH Learning Academy, its structure, funding and recruitment plans to support the establishment of work programmes: academic education, clinical simulation, apprenticeships, clinical specialty training, leadership and technology enhanced learning. |
| Seek assurance of creation of opportunities for career development and advancement across all disciplines and professions | • The NHS Workforce Race Equality Standard (WRES) data was shared with the committee including an action plan to address the issues raised. It was noted that GOSH performs poorly across the indicators of the WRES and among other actions, the committee was assured of the creation of an integrated Diversity & Inclusion (D&I) strategy to address the issues raised.<br>• The committee listened to experiences direct from staff in relation to the support, development and opportunities available to them and the functioning of their teams. |
| Seek assurance of enhancing | • Progress with development of the leadership and |

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| leadership and line management capability, developing compassionate and inclusive leaders. | management competency framework has been outlined to the committee including development of a suite of resources to support managers and a pilot of the line management development programme run with members for the senior leadership team. A programme for aspiring and developing leaders is also under development. |
| Seek assurance of improvements in Trust internal communication with staff, embedding GOSH values across the Trust. | • The committee was updated with progress of the culture, engagement and health and wellbeing priority under the People Strategy. This included: the launch of the Disability & Long Term Health Conditions Staff Forum (December 19), recruitment and training of Peer Messengers for the Speak Up for Values programme, the consultation and engagement exercise on diversity and inclusion priority themes during Open House week (350 participants), and the establishment of the Diversity & Inclusion working group.<br>• A communication and engagement programme is under development and recruitment will be made to support the work. |
| Review those entries on the Trust's Board Assurance Framework (BAF) which are to be overseen by the committee.<br><br>Seek assurance that the Trust is compliant with relevant legislation and regulations relating to workforce and education matters.<br><br>Receive and review the findings of relevant internal and external audit reports covering workforce, education and training and staff engagement and to assure itself that recommendations are appropriately responded to and implemented in a timely and effective way. | • The committee receives updates at every meeting from the Risk Assurance and Compliance group about the management of relevant strategic risks. These include a BAF risk on the establishment of a positive culture across the hospital and a separate BAF risk on recruitment and retention and service innovation.<br><br>• The Trust's internal auditors report to the committee and provide an update on any staff related internal audit reports as well as progress with closing relevant internal audit actions.<br><br>• Committee members were provided with an opportunity to review the draft Internal Audit Plan for the following year and to make suggestions on areas of risk to be audited.<br><br>• As Chair, I report to the Board following every committee meeting, on the key matters requiring escalation or assurance. Matters pertinent to other assurance committees (Audit Committee and Quality, Safety and Experience Assurance Committee) are reported to them. |

## Review of effectiveness of the committee

The committee will conduct a self-assessment effectiveness survey in Q2 2020/21 following its first full year of meetings. The findings will be used to review the committee's terms of reference and workplan.

## Conclusion

As Chair of the new People and Education Assurance Committee, I am satisfied that the committee adequately discharged its duties in accordance with its terms of reference in the first months of its operation on 2019/2020.

**Ms Kathryn Ludlow**

**Chair of the People Education Assurance Committee**

**XX May 2020**

# Head of Internal Audit opinion

***Included in Audit Committee Papers May 2020***

## Basis of opinion for the period 1 April 2019 to 31 March 2020

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, in particular we have not updated work performed earlier in the year to take

account of the Trust's response to the COVID19 pandemic, nor have we considered the operation of controls in the specific final three week of the year while the Trust mobilised to respond to these events. The opinion is derived from the conduct of risk-based plans generated from a robust and Management-led Assurance Framework. As such it is one component that the Board takes into account in making its AGS.

## Opinion

Our opinion is set out as follows:

- Basis for the opinion;
- Overall opinion; and
- Commentary.

### Basis for the opinion

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning aspects of the risk and assurance framework and supporting processes; and
- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas.

### Overall opinion

Our overall opinion for the period 1 April 2019 to 31 March 2020 is that:

***'partial assurance with improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The rating has been driven the level of assurance over data controls within the Trust following new systems implementation.'***

### 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 2019 to 31 March 2020 inclusive, and is based on the eight audits that we completed in this period.

## The design and operation of the Assurance Framework and associated processes

The Trust's Board Assurance Framework does reflect the Trust's key objectives and risks and is regularly reviewed by the Board. The Executive reviews the Board Assurance Framework on a monthly basis and the Audit and Risk 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 three substantial assurance and five partial assurance reports and zero no assurance opinions in respect of our 2019/20 assignments. Our partial assurance reports related to the following areas:

- *Incident reporting* – we identified that there was a significant backlog of aged incidents that had been raised and the investigation not yet completed, which could lead to actions required to help prevent future similar incidents not being taken on a timely basis;
- *GDPR* – while progress had been made in implementing the systems required to help ensure compliance with the requirements of GDPR, there were gaps in the recording of data flows within the Information Asset Register, physical security controls in the Trust's IT environment and allocation of clear responsibilities for handling patient data for International and Private Patient patients;
- *Patient discharge planning* – our review identified that there were significant opportunities for efficiencies in the way in which planning for discharge is undertaken to help these be undertaken as soon as patients are medically fit for discharge;
- *Access and activity data* – we identified gaps in the understanding of clinicians responsible for the recording of referral to treatment data leading to patients being incorrectly recorded as entering into treatment when appointments did not qualify as treatment. We also identified inconsistencies in the recording of when referrals were received; and
- *Estates health and safety* – we identified that for five of a sample of five wards that had their ventilation inspected they had been assessed as not meeting minimum standards. While the standards assessed against are voluntary a risk assessment had not been undertaken to consider further actions required in response to common areas of noncompliance.

We raised one high risk recommendations in the period which related to the development of a plan for the implementation of recommended initiative in order to help improve the efficiency of patient discharge planning processes.

We assessed whether these findings, individually or in aggregate, required modification to our Head of Internal Audit opinion. The findings from our access and activity data review included sufficiently high rates of exceptions that there is a risk of referral to treatment data being significantly misstated. Due to the importance of reliable data quality for the reporting of performance against core NHS constitutional standards we considered that only partial assurance could be

KPMG LLP
Chartered Accountants
London
26 May 2020

# 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 2020 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 which was updated in 2019.

During Q4 2019/20 and planning for the COVID-19 pandemic, the Trust implemented its emergency management processes with clear accountability at an executive (Gold), senior operational (Silver) and local operational (Bronze) team level and a clear cascade system implemented on a daily basis. All decisions reached were risk assessed at the appropriate level or passed to the relevant accountable planning level for discussion and risk assessment. Further information can be found on page xx.

Capacity for the routine management of risk was reviewed, with the quality and safety teams cross-covering colleagues to maintain resilience and key meetings being held virtually. The Executive Team conducted risk assessments of key areas of delivery: safety of patients, quality of care, patient experience, workforce, activity, performance and finances. These assessments were reported at Board and monitored at relevant Gold, Silver and Bronze levels. As a result of these risk assessments, planned work was re-prioritised based on the impact on safety and effectiveness of delivery of care and the wellbeing and availability of

the workforce. In April 2020, the Board was appraised of the impact of the pandemic on the controls in place to mitigate existing BAF risks and the Risk Assurance and Compliance Group maintained scrutiny of these risks during the period, taking account of guidance and direction from NHSI or NHSE as required.

## Trust Board and assurance committees

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 include:

- 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.

In 2019/20 there were three Board assurance committees in place: the Audit Committee, the Quality, Safety and Experience Assurance Committee (QSEAC) and the People and Education Assurance Committee (PEAC). These committees scrutinise the controls in place to mitigate the strategic risks to the organization and assurances that these risks are working effectively. They review the Trust's non-clinical risks (Audit Committee), clinical and quality risk management processes (QSEAC) and seek assurance that the necessary structures and processes are in place to deliver the Trust's vision for a supported and innovative workforce and an excellent learning environment (PEAC). All three committees raise issues that require the attention of the Board. In addition to the three assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The chairs of these committees report to the Board following every committee meeting. Each committee is charged with reviewing its effectiveness annually and making improvements to the way it works and is administered.

## Risk Assurance and Compliance Group

The Risk Assurance and Compliance Group (RACG) comprises executives, quality, safety and also compliance leads. The Group is chaired by the Chief Executive and reports to the Audit Committee, the Quality, Safety and Experience Assurance Committee and the People and Education Assurance Committee. The RACG monitors the effectiveness of risk management systems and the control and assurance processes across the Trust. It also monitors the effectiveness of the controls cited to mitigate the strategic risks on the Board Assurance Framework (BAF) and the timeliness of the closure of gaps in controls and assurances of these risks.

## Operational Board

The Operational Board comprises senior managers from the directorates and corporate departments and has oversight and delivery of Trust-wide operational performance. It holds responsibility for reviewing high-rated risks and Trust-wide risks (risks that have been identified as affecting more than one directorate) and considering whether these should be escalated to the RACG for consideration for inclusion on the BAF.

## Standing committees

Standing committees are responsible for managing the cross-Trust issues relevant to their area of expertise and, as such, have delegated authority within their terms of reference for a specific remit. This includes assessing the effectiveness of the control systems in place to reduce the risks relevant to their areas of expertise. Standing committees with responsibility for risk management include, but are not limited to:

- Patient Safety and Outcomes Committee
- Patient, Family Experience and Engagement Committee
- Health and Safety Committee
- Information Governance Steering Group.

## Risk Action Groups

Local Risk Action Groups (RAGs) are multidisciplinary meetings which discuss the principal risks to patient safety and service delivery within a directorate or department. The RAGs review low, medium and high risks, approve scores, monitor actions to mitigate the risks and accept low and medium risks where appropriate. The RAGs 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 RAGs report into the Directorate Boards and equivalent in corporate areas.

## Risk Management Team and staff training

The Trust has a central Risk Management team that administers the risk management processes. Each clinical operational directorate has a Deputy Chief of Service who is responsible for championing safety and is 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 directorate, specialty or department. At a Trust level, we emphasise the importance of preparing risk assessments where required and the importance of reporting, investigating and learning from incidents. Support is available to staff from various corporate areas of the Trust to discuss and document risks including the Quality and Safety team, Health and Safety team, Emergency Planning Officer and Information Governance team.

## Learning from good practice

The following frameworks are in place to support learning from auditing of current practice and best practice:

- Closing the Loop: Closing the Loop is a new organisational sub-committee (reporting to the Patient Safety and Outcomes Committee) which has taken responsibility for overseeing the implementation of key actions required in response to learning from errors and learning from excellence. The group aims to deliver on the organisational Quality Priority of embedding a learning culture which supports our people to learn and thrive, by:
    - Monitoring action plans from Serious Incidents, Red Complaints and Learning from Deaths.
    - Taking referrals from other groups or committees at GOSH to support the delivery of actions associated with systemic or Trust-wide quality issues.
    - Identifying opportunities for spreading learning from error and learning from excellence through communication, education and quality improvement techniques.
- Clinical audit: clinical audit is undertaken at GOSH to ensure that the quality of care and services are reviewed against best practice standards, and improvement actions taken where those standards are not met.
- Clinical outcomes: the GOSH Clinical Outcomes Programme was established in 2010 and is run by a dedicated team that supports clinical staff to collect, analyse and publish their clinical outcomes. GOSH has published more outcomes data to its hospital website than any other paediatric hospital in the world. In the last two years, GOSH proposed and has successfully led on benchmarking of the Specialised Services Quality Dashboards, in partnership with the Children's Alliance and NHSE. In the last six months, the initiative has gone live on the NHSE portal and we are now able to compare our results - in detail - online with other member hospitals. The project is for improvement, not ranking.
- Horizon Scanning: lessons learned in other organisations can often be transferred into wider learning for NHS Trusts. A quarterly horizon-scanning review is conducted and presented at the Quality, Safety and Experience Assurance Committee, providing a short overview of recent reports and guidance issued by a range of external stakeholders that could shape the approach to quality and governance within the organisation. The report identifies any learning and provides the Trust with an opportunity to review and implement change where appropriate.
- Risky Business: The Risky Business conference in June 2019 was supported by GOSH. It focused on crisis management and brought together speakers with experience from the Manchester Arena bombing, the rescue of the Thai boys from a cave, and the Grenfell fire among many. The learning from the conference was considered at the Trust Board's annual Risk Management meeting in October 2019.

## Cascading risk and embedding learning

There are a range of ways in which information on risk is embedded across the Trust. Lessons are learnt from specific incidents, complaints and other reported issues. These include:

- Quality impact assessments, for example of the Better Value schemes.
- Equality impact assessments of our policies and strategies.
- Risk management training.
- Incident reporting.
- Reports to and cascaded from risk action groups, directorate boards and the Operations Board (Trust meeting of senior managers) where high risks and Trust-wide risks are discussed.
- Cascading from key risk meetings such as the Patient and Safety Outcomes Committee.
- Articles within internal newsletters and screen-savers.

- ‘Learning from’ events where serious incidents are presented including any learning, for the purposes of cascade through the hospital.

## 4 The risk and control framework

### The risk management strategy and process

The Trust’s risk management strategy sets out how risk is systematically managed. This extends across the organisation, from the frontline service through to the Board, to promote the mitigation of clinical and non-clinical risks associated with healthcare and research and to ensure the continuous review of business continuity plans across 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 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 Trust’s 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.

### Risk appetite

The Trust defines its risk appetite as the amount of risk it is prepared to accept, tolerate, or be exposed to at any particular time, in the context of the highly specialised services the Trust offers. The Board is committed to doing everything possible to reduce risk for children and to deliver high-quality, efficient and effective care. The Board recently reviewed and approved its revised 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 operations and commercial 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.

### Identification, evaluation and control of risk

The Trust’s Assurance and Escalation Framework presents a single, comprehensive overview of the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance. The Trust routinely reviews and reports this assurance through the following key governance processes and frameworks including:

- Performance management: the Trust has a range of frameworks and policies in place that outline how the Trust's performance objectives and standards will be met, reviewed and managed. The Performance Management Framework is the most significant.
- The Trust's risk management strategy (see above) sets out how the organisation identifies, monitors, escalates and manages risks in a timely fashion and at an appropriate level. In 2019, the CQC inspection report stated that leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Further detail on the identification and evaluation of strategic and local risks is provided below.
- The Trust has in place a comprehensive and integrated Compliance Framework that seeks to ensure ongoing compliance with statutory and regulatory requirements through integrated, rigorous and proactive structures, policies and practices. It ensures appropriate controls are in place to maintain compliance with statutory and regulatory requirements and that external guidance and alerts are considered in a fulsome and responsive way.
- Policy framework: this provides for clear and accessible policies, procedures and guidelines which support staff in undertaking their duties in a safe and effective way that takes account of all relevant legislation, regulation and guidance. The Trust's policy framework is administered by the Policy Approval Group (PAG).
- Committee structure: the Trust's committee structure, developed from the Trust Board down, is currently under review to ensure each committee or group has a clear purpose, scope and authority. Some committees have statutory functions, others have authority to make decisions and direct actions, and others provide advice, support and oversee specific functions.

## Identification and monitoring of strategic risks

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.

Each strategic (BAF) 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. The Quality, Safety and Experience Assurance Committee, the People and Education Assurance Committee and the Audit Committee scrutinise the BAF risks relevant to their remits on a rotational basis and at least annually. The assurance committees look for evidence that the controls are appropriate to manage the risk and independent assurance that the controls are effective. The assurance committees monitor progress with actions to reduce or remove control or assurance gaps.

In addition, the Trust Board recognises the importance of scanning the horizon for emerging risks and reviewing 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. In 2019, the Board received presentations from external and internal speakers on the key risks facing the NHS in the next 5–10 years.

In April 2020, the Board approved a revised BAF which had been reviewed in light of the refreshed Trust strategy, new principles and objectives, and other assurance information (audits, external reviews, monitoring of performance). The revised BAF includes new risk statements on clinical safety and cyber security. It also contains revised risk statements around business continuity and COVID-19, redevelopment and the estate, operational performance, data quality and data management. The Board noted that a cohort of the existing BAF risks would be significantly affected by the COVID-19 pandemic with implications for the effectiveness of the controls cited to mitigate the risks. As at April 2020, it was unclear the extent to which risks around failure to achieve IPP income or failure to retain financial sustainability would be affected. It was agreed that the RACG would scrutinise the impact and report back to the Board in May 2020.

## Identification and monitoring of local risks

Each directorate 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 the 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 also when new or changed risks are identified, or if the degree of acceptable risk changes.

In 2019, the Internal Auditors conducted an audit into Incident Reporting at GOSH with an assurance rating provided of ‘Partial Assurance with Improvements Required’. Actions were

recommended around management of incidents reported about the EPR, management of Datix users in line with leavers report from HR, and a process for escalating overdue open incidents. Actions have been taken in response to all of these recommendations.

## Principal risks in 2019/20

The principal risks for the Trust during the year and in the immediate future are:

- Business Continuity, planning and management of COVID-19.
- Management and monitoring of medicines.
- Financial sustainability (being able to meet the control total target set by NHSI, in an environment where 1) the NHS is fighting the COVID-19 pandemic. 2) Core services are underfunded and money available to NHS organisations is reduced. 3) The cost of delivering specialised services is high. 4) There is increasing need to rely on international and private patients to support financial viability, but COVID-19 has suspended air travel and there is a focus on essential NHS treatments).
- Move to stabilisation of the EPR and the impact on changes to working practices and finances, and the work underway to improve and monitor data quality.
- Robustness of systems to retain compliance with Referral to Treatment standards.
- Management of personal and sensitive personal data.
- The culture across the hospital in relation to levels of staff engagement and motivation in alignment with the Trust strategy and values.
- The political instability caused by Brexit and the ongoing reconfiguration of the health economy and its impact on delivery of services.

These risks are broken down into a number of component parts covering their different drivers, and appropriate mitigating actions for each component identified. A summary of these eight risks to our operational and/or strategic plans in 2019/20 and the mitigations in place to manage them are outlined below:

| Risk | Explanation | Mitigating actions implemented and underway |
|---|---|---|
| **Business Continuity** | The trust is unable to deliver normal services and critical functions during periods of significant disruption. | Major Incident Planning Group meets regularly and reviews implementation and testing of plans.<br>Business continuity plans across all directorates/ departments in the Trust.<br>Trust Business Continuity Plan was assessed at the annual NHS England Assurance meeting in October 2019 and rated fully compliant across all core standards for Emergency Preparedness, Resilience & Response.<br>A number of 'Live' and 'table top' exercises have been held and are planned.<br>Gold, Silver and Bronze command stepped up for managing COVID-19 pandemic and responding to central returns. Cascade communication system implemented.<br>Restoration Group established to plan post COVID-19 and Clinical Prioritisation Group in place to make decisions on the delivery of clinical services including programmes of work and actions required to return the Trust to a new steady state. This includes agreeing guiding principles for priorities in clinical decision making which will be delivered by the operational teams |
| **Medicines management** | Medicines are not managed in line | Drugs and Therapeutics Committee (DTC) in place.<br>Medicines are dispensed by competent pharmacy staff |

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| | with statutory and regulatory guidance (procuring, storing, prescribing, manufacturing and giving of medicines (including self-administration)) and that processes are not appropriately documented or monitored. | and there is a program of training and competence assessment now in the dispensary.<br>Work programmes in place to continue to ensure that pharmacy systems align/link up with the EPR system.<br>Following an MHRA inspection of pharmacy manufacturing facilities in 2019, a hospital pharmacy transformation programme has been established. Quality assurance process for manufacturing of medicines under review and update. Review of policies and pharmacy facilities underway.<br>Controlled Drugs are securely stored with auditable paperwork. |
| **Financial sustainability** | Failure to be financially sustainable and deliver productivity and efficiency targets and IPP income plans. | Robust financial planning (revenue and capital) to produce budgets for approval by the Trust Board at the start of the financial year with monthly reporting against in year performance and continuously updating the forecast outturn position to ensure delivery of the financial position.<br>Financial governance and reporting processes updated in line with Standing Financial Instructions and Scheme of Delegation to ensure appropriate oversight of spend during the COVID-19 crisis.<br>Programme management office in place to support the Trust in identifying and delivering productivity and efficiency schemes.<br>Utilised the Trust's long-term financial model to ensure affordability of the proposed Children's Cancer Centre as part of the outline business case (approved by the Trust Board in September 2019) and impacts of different scenarios on financial sustainability to support future planning and the development of the full business case for the major build.<br>Developed a 'GOSH Narrative' through ongoing cost benchmarking with other specialist children's hospitals and STP partner organizations.<br>Appointment of a Commercial Director and drafting of a commercial strategy with a plan for increasing non-NHS income.<br>Working with commissioners to support the implementation of newly approved treatments and care pathways.<br>Continued involvement in forums to influence the funding mechanisms for complex paediatric care and approach to developing tariffs.<br>Continued to expanding IPP referral partnerships in UK and Overseas and work to minimise IPP debt. |
| **Stabilisation of the Electronic Patient Record and failure to establish an effective data management framework** | The risk that the EPR system is not successfully optimised; does not align with other key programmes of work for the purposes of implementing service innovation and is not supported by an effective data quality framework | Robust programme governance led by the EPR Programme Board, including engagement with clinical experts, patients and families, finance, IT, research and operational management and key suppliers.<br>EPR Programme forms part of a portfolio of programmes (including Better Value, Flow, Clinical Pathway Redesign and eQUIP) with executive oversight to ensure that transformation objectives and benefits are aligned across change programmes being delivered across different teams.<br>Work underway to develop a revised data quality framework and approach to support optimisation of the EPR. This includes a new data strategy to support delivery of the Trust strategy, working with partners to |

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| | | optimise the potential of Trust data for purposes of innovation, benchmarking and advancing Quality Improvement in paediatric specialised services |
| **Robustness of systems to retain compliance with Referral to Treatment standards** | | Ongoing and escalated monitoring of revised and agreed delivery trajectories to achieve the incomplete RTT standard<br>• Ongoing focus on the Trust 52 week position to ensure the volume of breaches are minimised and treatment plans are in place for all patients. Trajectories agreed with NHSE pre COVID-19. Delivery of these targets under review as part of clinical prioritisation plans once elective work recommences.<br>• Continued monitoring of compliance against the Diagnostic and Cancer standards and delivery under review as part of clinical prioritisation plans once elective work recommences.<br>• Individual directorate meetings with the those clinical areas of the trust who are not achieving trajectory.<br>• Demand and capacity modelling to support individual recovery plans for each relevant clinical area. These models are under review following impact of COVID-19. |
| **Management of personal and sensitive personal data** | Personal and sensitive personal data is not effectively collected, stored, appropriately shared or made accessible in line with statutory and regulatory requirements. | Data Protection Privacy Impact Assessments (DPIA) undertaken for new projects and policies. All new systems require an appropriate security review by ICT with a focus with any data held offsite.<br>A patient and carer privacy notice and research privacy notice is published on the website outlining how the Trust gathers, uses, discloses and manages patient data.<br>Mandatory training on Information Governance and reminding staff of their requirements with regards to confidentiality and the processing of personal data.<br>Collection of evidence for the Data Security and Protection Toolkit and establishment of actions plans to close identified gaps.<br>Information Asset Register under review following findings from an internal audit report on GDPR. Trust wide request for information assets and where data is processed, documenting of legal basis for this processing. |
| **Culture and staff engagement** | GOSH fails to develop its culture and levels of staff engagement and motivation in alignment with its strategy and values | Trust People Strategy approved by Board and plan under development. PEAC seeks assurance of delivery of the plan and impact on culture across the hospital.<br>Recruitment policies in place and diversity groups established (LGBTQ+, BAME, Disability) and sponsored by an executive director.<br>GOSH Learning Academy Programme Board monitors delivery of the GLA plan. Includes oversight of delivery of the leadership and line management framework and training and development of all staff groups and professions.<br>HR Business Partners embedded across clinical and corporate directorates and supporting managers with consistent implementation of policies and expectations of staff.<br>Staff engagement strategy and health and wellbeing |

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| | | strategy under development. Plans underway to enhance communication channels across the Trust–some improvements implemented during Q4 2019/20 as part of COVID-19 response. |
| **Political instability** | The recent political instability caused by Brexit, the ongoing reconfiguration of the health economy, the COVID-19 pandemic and national incidents will have an adverse impact on the ability of Trust to ensure continuity of effective patient care. | Brexit Steering Working Group established, monitoring impact of Brexit on delivery of services, supply of medicines, equipment and consumables, staff recruitment and retention, finance and research. Communications cascaded to staff, and information posted on Trust website and around key patient areas. CEO and GOLD Command linked up with NHSI/NHSE on scenario planning and supporting wider NHS to manage the COVID-19 pandemic across North Central London. |

## Involvement of stakeholders in risk management

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).
- 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 the STP, commissioners and other healthcare providers.
- The Board receives patient stories at every Board meeting and tracks learning and actions agreed from these stories via the Quality, Safety and Experience Assurance Committee.
- The People and Education Assurance Committee receives staff stories at every meeting and tracks learning and agreed actions.
- Governors observe Board assurance committees to seek assurance of how risk is scrutinised and mitigated.
- Non-executive directors undertake walkrounds of clinical and non-clinical areas of the Trust prior to board meetings and feedback their findings at the meeting.
- The CQC scheduled inspection report has been used to reflect on how the Trust manages relevant risks.
- The Board holds a risk management meeting annually to horizon scan potential risks and invites external speakers to present.

## Internal audit function

The Trust contracts with KPMG LLP for its internal audit function. Internal audit reports to the Audit Committee and the Quality, Safety and Experience Assurance Committee. Further information about the work of internal audit can be found on page XX.

## Workforce safeguards

During 2019/20, the Trust's strategy was built around its vision of 'Helping Children with Complex Health Needs Fulfil Their Potential'. Within that strategy were four priorities, including the people priority with an aspiration to attract and retain the right people through creating a culture that enables us to thrive and learn. Workforce strategies and plans have been built around the people priority and in particular around the themes of culture, leadership, talent and education.

In 2019 the Trust launched a consultation to build on the principle of Fulfilling Our Potential, resulting in a refreshed five-year strategy to 2025. *Above and Beyond* will guide GOSH as we advance care for children and young people with complex health needs. It is based on six principles, one of them being 'Above and beyond in our culture'. By 2025, the aim is that GOSH will be a tolerant, inclusive, open and respectful place where staff are valued for who they are as well as what they do. Our people will enjoy coming to work and will live the GOSH Always Values: Always Kind and Welcoming, Always Helpful, Always Expert and Always One Team. We will form strong, supportive multi-disciplinary teams in which everyone has the freedom to learn and contribute and no one is afraid to speak up. While the strategy has been approved, the formal launch was postponed due to COVID-19 emergency planning. The programmes of work will be reprioritised over 2020/21.

The People Strategy has been launched to deliver this culture principle and is aligned with the National Interim People Plan. The purpose is to bring together all of the people-related issues and activities in order to provide visibility and ensure that they are aligned and coordinated. The Strategy is built around 4 key themes:

- Capacity and workforce planning
- Skills and capability
- Modernising and reshaping the corporate and HR infrastructure
- Culture, engagement, health and wellbeing

A plan has been developed to deliver the strategy based upon 10 workstreams. These include:

- repositioning our employee brand
- establishing a recruitment and retention programme for non-medical staff
- investing in the role and capability of our leaders
- improving line management capability
- providing a holistic approach to health and wellbeing
- delivering a Diversity and Inclusion strategy
- reviewing our approach to reward and recognition.

As a result of COVID-19 emergency planning, the programmes of work will be reprioritised during 2020/21 and onwards.

Assurance against our workforce strategies is provided by the following groups and committees:

- GOSH Learning Academy Programme Board
- Nursing Board
- Nursing Workforce Advisory Group – all aspects of workforce, planning, establishment reviews, rostering etc. Report into Nursing board
- Modernising Medical Workforce Board

The People and Education Assurance Committee seeks assurance that the necessary structures and processes are in place to deliver the Trust's vision for a supported and innovative workforce and an excellent learning environment.

Our workforce plan is derived from the business planning process and is aligned to operational activity and finance, together with local, national and international drivers.

The Medical Director and Chief Nurse are engaged throughout the workforce planning process, including in plans for new roles such as physicians' assistants and nursing associates. Reviews have been conducted into advanced nurse practitioners and Practice Education Facilitators in the Trust, with a plan to review the role of clinical nurse specialists. Any savings schemes, business cases and service changes undergo a quality impact assessment. A vacancy control panel has been established to risk-assess vacancies across the Trust and challenge new appointments.

Ward establishments are reviewed on an annual basis as per National Quality Board Guidance and reported on by the Chief Nurse to the Nursing Board and Executive Management Team, and then presented to the Trust Board. Removing or making changes to any nursing posts has to be signed off by the Chief Nurse.

The Trust Board regularly receives workforce analysis and key performance indicators, benchmarked metrics including staffing profile, voluntary and non-voluntary turnover, sickness, agency usage (as a percentage of the paybill) and vacancies. Monthly directorate performance reviews are executive-led and consider this workforce data at a drill-down level in conjunction with finance, activity and quality data in order to identify themes or impact on service delivery. In addition, other quality metrics such as staff survey results are reported to the Board, Executive Management Team and at directorate performance meetings to provide an overall picture of workforce issues within each directorate, including cultural and leadership issues. Nurse recruitment and retention workstreams are overseen by the Nursing Workforce Advisory Board which reports to the Executive Management Team and the Trust continues to participate in the NHSI retention work with a retention plan for nursing.

Our workforce plans are included in the Trust operational plan, which is signed off by the Board and monitored by the Workforce and Education Committee. As part of the workforce planning processes and safe staffing assessments, the Trust uses the paediatric acuity and nurse dependency assessment tool (PANDA), which the Trust co-designed, as an acuity tool for inpatient paediatric services. We have now implemented the SafeCare system which will integrate the existing PANDA acuity information with information from the rostering system. The Trust uses Allocate E Rostering system for all staff (currently in roll out for non-clinical staff) and Doctors Job Planning.

Assurance of safe staffing is provided to the People and Education Assurance Committee via workforce numbers, data and metrics including:

- statutory and mandatory training compliance.
- appraisal rates.
- temporary staffing spend.
- annual staff survey results.
- quality metrics such as patient feedback, serious incidents etc.

Other means of assurance include:

- Nurse Safe staffing – Care Hours Per Patient Day (CHPPD) information is reported at every formal Board meeting and the Guardian of Safe Working also reports to every Board meeting.
- The Modernising Medical Workforce Board reviews current and future workforce challenges while the Nursing Workforce Advisory Group ensures that there is a bottom up approach which supports the development of our trust-wide plans for nursing.
- A bed management meeting is held twice a day. Any issues of safety relating to staffing are notified to the Executive Management Team via the weekly safety report.

## Trust quality governance arrangements

The Trust places a high priority on quality, measured through clinical outcomes, clinical audit, and patient safety 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 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 and assurance at the Trust is part of the work of the Quality and Safety team which incorporates quality improvement, clinical audit, patient safety, clinical outcomes and compliance. Supported by the Associate Medical Director for Safety and the Associate Medical Director for Innovation and Wellbeing, the team work together to support the clinical directorates and ensure an organisational approach to maintaining and improving our quality governance processes.
- A five-year strategy has been developed for both Quality and Safety which outlines how the Trust will be an organisation that Always Learns, Always Improves and Always Involves. These three areas of focus will ensure that the Trust further develops its commitment to be an organisation that is committed to improving, learning when things go well and not so well, and involving the people who use our service - the patients and their families. As a result of COVID-19 emergency planning, the programmes of work will be reprioritised during 2020/21 and onwards.
- Executive oversight of patient experience and engagement is provided by 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 Head of Quality and Safety, Head of Patient Experience and Engagement and the Associate Medical Directors. Patient and parent feedback is monitored and acted on via the Friends and Family Test, patient surveys and feedback events supported by the patient experience team, and through a survey carried out at least once a year by the CQC .The work programme is monitored at the Patient and Family Experience and

Engagement Committee and through a range of other patient/parent engagement activities.

- The delivery of high quality care and highly specialised services in a complex healthcare environment requires good processes for the early identification of potential risks, early intervention and robust arrangements for ongoing review with accountability at the correct level in the organisation to ensure effective and timely resolution. The Board receives a regular update on current and ongoing concerns which the organisation is managing. This covers cases where the Trust has caused harm to our patients; impacts on our ability to deliver services to the patients who need them when they need them, creates a difficult working culture for our staff, can worry patients and their families, threaten the delivery of our strategy, or result in regulatory action. Examples include:
    - Royal College reviews into gastroenterology and urology
    - updates on the roll out of Duty of Candour regulations
    - updates on progress with actions arising from externally led inspections such as the MHRA inspection into manufacturing the pharmacy department
    - learning from individual patient and staff cases

- Each specialty and clinical directorate has an internal monitoring structure so teams regularly review their progress and identify areas where improvements may be required.
- Clinical specialties are encouraged and supported to report clinical outcomes. Participation and engagement in clinical audit is monitored and reported across the Trust.
- Each directorate's performance is considered at monthly performance review meetings. Working with the directorate management teams, the aim is to support 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 Improvement team work collaboratively with the Trust's Project Management Office and Transformation directorate to ensure the right approach is used to support the delivery of work streams to improve patient care and experience. Each of the priority quality improvement projects have an allocated executive director, operational lead and allocated specialist from the Quality Improvement 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 or the Patient Safety and Outcomes Committee. These committees provide assurance to the Trust Board on the quality and safety programme.
- Using the Institute for Health Improvement model, the Quality and Safety Team use data to encourage improvement activity and to demonstrate and evidence the impact of the improvement programme.
- Key quality and 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 such as complaints, incidents and reports from specific quality functions within the Trust, such as PALS. It also includes the external indicators assessed and reported monthly by the CQC. The report is aligned to the CQC key lines of enquiry: Safe, Effective, Caring, Responsive and Well Led. It asks the question: are our patients receiving high-quality care?
- 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. This has been strengthened in 2019/20 with the

implementation of Closing the Loop, a group which monitors and oversees the completion of actions and learning identified through patient safety investigations, complaints, harm, legal cases, and learning from deaths.

- The Trust has developed a 'Managing External Review' standard operating procedure providing a clear process for approving the need for a review (internal or external). It also sets out the scope of the review to ensure that it is fair and proportionate, that staff are supported during the review, robust governance arrangements are in place, and recommended actions are implemented in a timely and appropriate way.

## Never Events

The Trust reported one Never Event in April 2019. A patient with a rare type of tumour was admitted for a resection and exploration of the major arteries of the heart. The procedure was long and complex with unexpected bleeding. During the procedure a Kelly's forceps was left inside the patient. The consolidation count continued but the surgical team assessed that the patient was at higher risk by remaining in theatre and made the decision to return the patient to CICU. The missing forceps was identified on X-ray. The patient had been left open (due to the bleed) and so the forceps were removed during closure. The patient experienced no harm as a result of this incident.

## Data quality

The Trust has established a Data Quality Review Group to monitor implementation of the Trust Data Quality Plan. The plan has been reviewed and updated in light of implementation of the new Electronic Patient Record system, Epic. The purpose of the plan is to ensure the data and information which underpins our organisational decisions is robust and of a high quality, and where this is not the case there is an active plan in place to make the necessary improvements to embed the changes needed to support business decision making. Kitemarking forms part of the data quality programme of work over the next 18 months. The plan covers the following areas for implementation over the next 18 months (although these plans will be reprioritised during 2020/21 and onwards as a result of COVID-19 emergency planning):

1. Performance Management Framework and Kitemarking Performance and Information: to reinvigorate the framework where it relates to the delivery of the data quality agenda, ensuring a close coordination with the optimisation work being completed in Epic.

2. Operational engagement and ownership: ensure operational ownership of the ongoing data quality work across the organisation.

3. Training: focused roll out of training across the organisation.

4. Data Quality Dashboard: roll out and embedding of the new data quality dashboard into the organisation now that it is integrated within the Epic system.

5. Refresh of the Trust Data Quality Policy to support the overarching approach across the organisation.

6. Outpatient consultation with missing outcomes: ongoing review and validation of this key workstream for the organisation around patients who attend an appointment but no outcome is recorded for the patient's activity.

7. Referrals and schedule order work queues: ensuring that a robust and defined process is in place for the management of elective referrals into the organisation.

8. Internal audit programme: enhancement of the current audit programme to ensure that a suitable sample of patients' pathways are audited across a selection of standards to ensure the data supporting delivery of care is of a high quality.

9. Data Assurance team: training and development for our Data Assurance team to ensure they are up to speed on the wide range of work they are required to complete, across a large selection of datasets, and are well placed to ensure onward individual development.

Progress with the plan is monitored by the Information Governance Steering Group and assurance is sought by the Audit Committee of the impact of the plan on overall data quality.

The programme defined provides the basis of the mechanisms in place monitor and improve the quality and robustness of Trust data and information across the organisation. In terms of assurance, the Trust continues to use the NHSI Kitemarking approach for assurance. A review of all Trust Board Indicators was completed in March 2020 (including those tracking elective waiting time data) and is currently being signed off by the relevant Executive Directors. In addition progress against a large number of data quality indicators is tracked and managed through the Data Quality Review Group and other associated forums. The Data Assurance team, together with our interim Data Validation team are supporting targeted improvement of known data quality issues with our data, while awaiting changes to the configuration of the Epic system.

## Cyber security

The cyber security strategy will be subject to review in 2020. The current strategy includes a number of risk mitigations and controls applied to increase the protection of the organisation, build operational resilience and reduce the impact of any cyber security attack. These cyber security risk mitigations and controls are designed to counter the evolving threats facing both the Trust and NHS today, and ensure an integrated approach to cyber security across all aspects of operations including people, process, real estate and technology.

Risks to information security and operational systems are managed in the same way as other Trust risks but are subject to separate evaluation and scrutiny by the Information Governance Steering Group with oversight provided by the Audit Committee. In April 2020, the Board agreed that a new cyber security risk should be added to the BAF for scrutiny by the Audit Committee.

## Compliance with CQC registration

The Foundation Trust is fully compliant with the registration requirements of the CQC.

The Trust has identified an executive director and a manager who are respectively accountable and responsible for ensuring compliance with 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.

In October 2019, the CQC conducted a scheduled unannounced inspection of three services (critical care, surgery and CAMHS) and an announced inspection against the well-led

criteria. The report was published in January 2020. The Trust retained a rating of 'Good' overall.

The CQC issued two enforcement notices:

- Regulation 12: Safe Care and Treatment. This recommendation relates to the robustness of access control measures in PICU medication room, the safe storage of IV fluids in theatres, interventional radiology and on one of the surgical wards, the process for denaturing controlled drugs on wards, and the temperature monitoring arrangements for medication rooms.

- Regulation 17: Good Governance. This recommendation relates to the articulation of the breadth of the medicines risk on the BAF, and the need to ensure that the EPR system fully meets the needs of the staff in the CAMHS service to deliver safe care.

In total the hospital was advised of four 'Must Do' actions which were required to bring services in line with legal requirements. The Trust was also been advised of 18 'Should Do' actions (10 Trust wide, two Critical Care, three Surgery and three Mental Health) which were required to comply with minor breaches that did not justify regulatory action and to prevent the service from failing to comply with legal requirements in future, or to improve services.

A CQC action plan has been developed to address all actions. An executive led committee, Always Improving, has been established and meets monthly to review progress against this action plan, whilst supporting the ongoing work with the Trust's CQC compliance. This committee reports into the Risk, Assurance and Compliance meeting with regular reports to Board and the Council of Governors. The Trust will continue to conduct mock inspection framework (CQC Quality Rounds) in clinical directorates and review potential areas/sources of learning for example reviews of themes from other CQC reports and evaluation of CQC Insight reports.

### NHS Improvement Well Led framework

The CQC rated the Trust as 'Good' for Well Led, an improvement from the previous inspection report in 2018. The report highlighted:

- Leaders had the skills and abilities to run the service. Most services had a vision and strategy for what they wanted to achieve, developed with all relevant stakeholders. The culture of the services provided were centred on the needs and experiences of children, young people and their families who used services.
- Leaders operated effective governance processes, throughout the service. However, the planning and implementation of the EPR did not meet the individual needs of all services. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- Leaders and staff actively and openly engaged with children, young people and their families, staff, equality groups, the public and local and national organisations to plan

and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services.

The CQC identified an action that the Trust must take about how the risk around medicines management was accurately documented on the BAF in relation to the inclusion of the storing, administration and destroying of medicines in line with legislation and the trust medicines management policies

The Trust CQC action plan addresses this recommendation. A plan is being developed to support and monitor ongoing compliance with the NHSI Well Led Framework. This will take into account any recommendations from the external effectiveness review of the Board in 2020.

## Compliance with the foundation trust license conditions

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 and mitigate risks to compliance. No significant risks have been identified. Mitigations include:

- Governance structures including clarity of role of directors as outlined below and under the Accountability Report.
- Reporting lines and accountabilities – assurance was provided by the Internal Audit report into Directorate Governance in 2020.
- The Trust's assurance and escalation framework details the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance. It includes the range of forums and processes available to staff, patients, families and other stakeholders to raise and escalate concerns or risks.
- Submission of timely and accurate information to assess risks to compliance with the Trust's license.
- The board's oversight of the trust's performance – as outlined below.

## Governance structure, responsibilities and reporting

The Trust's committee structure has been developed from the Trust Board down, to ensure each committee or group has a clear purpose, scope and authority. Some committees have statutory functions (for example the Trust Board, Health and Safety Committee, Infection Prevention and Control Committee), others have authority to make decisions and direct actions (for example Executive Management Team and Operational Board) and others provide advice, support and oversee specific functions.

The Trust has terms of reference and work plans in place for the Board, Council and relevant committees. The Board committees conduct annual effectiveness reviews (surveys) on the delivery of their terms of reference and running of the committees. Findings are reviewed and where appropriate, changes to the terms of reference and workplans of the committees are made.

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.

There are eight clinical directorates, each with a Chief of Service, Deputy Chief of Service, Head of Nursing and General Manager. The Senior Leadership Team meets weekly (around 100 senior managers from across the clinical and corporate areas of the Trust). An Operational Board meets fortnightly. The purpose of the Operational Board is to bring together clinical and corporate senior leadership members to ensure the robust, effective and efficient operational management of the Trust. The internal auditors provided a rating of 'Significant assurance with minor improvement potential' for the audit into directorate governance.

The Trust's risk management 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.

## Oversight of performance by the Board

The Board receives an integrated performance and quality report at every meeting. Further information on how the Board retains oversight can be found under *Review of economy, efficiency and effectiveness of the use of resources*, below.

## Declarations of interest

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the Managing Conflicts of Interest in the NHS guidance.

## NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Information about the Trust's approach to management of the implications of the NHS Pension Annual Tax Allowance Threshold in 2019/20 can be found on page XX.

## Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

## Carbon reduction

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

## 5 Review of economy, efficiency and effectiveness of the use of resources

The Board has agreed standing orders and standing financial instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. 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 directorate management structure. The Finance and Investment Committee reviews the operational, productivity and financial performance and use of resources both at Trust and directorate level (see pages XX). 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 pages XX.

## 6 Information governance

Over the last few months the Trust has been compiling its submission for the Data Security and Protection Toolkit (DSPT). This annual submission demonstrates GOSH's position against the legal requirements providing assurance that we are practicing good data security and our personal information is handled correctly. This was due for submission 31 March 2020. However, NHSX has recognised that it will be difficult for many organisations to fully complete the Toolkit without impacting on their COVID-19 response. Therefore the final deadline for submissions has been pushed back to 30 September 2020.

While GOSH is already compliant with the majority of mandatory requirements, some areas of improvement have been identified for which action plans have been produced. These include fully implementing the compliance with the national data opt-out and achieving a 95% staff compliance rate with information governance training. Given the extra time for submission, GOSH should be in a position to fully achieve the Toolkit for the September deadline.

This year there have been three serious information governance incidents (classified at a reportable level using the Incident Reporting Tool within the DSPT) involving sensitive information. Details are as follows:

- Over 60 cases were identified of staff having sent emails containing patient data non-securely to personal emails (sent between 2015 and 2017).
- Monitoring information of 10 new members of staff was erroneously sent to their new managers.
- A letter containing sensitive safeguarding information was sent to an incorrect address local to a patient.

Each of these cases have been reported to the Information Commissioner's Office (ICO) and NHSE as Serious Reportable Incidents with an internal root cause analysis completed and

shared. The learning from these has been implemented back into Trust practice to ensure similar incidents do not occur. The ICO considered the information we provided in reporting and investigating in each case decided that no further action was necessary given our response and approach.

Risks to data security are managed in the same way as other Trust risks, but subject to separate evaluation and scrutiny by the Information Governance Steering Group, in turn providing assurance to the Trust's Audit Committee. Specific controls are in place to risk assess changes and new ways of processing personal data using the Trust Data Protection Impact Assessment to asses any privacy risks and ensure all processing is legal and fair. GOSH further considers the controls in place when sharing data with partner organisations by asking for information sharing agreements to be completed and approved before access is authorised.

This year the Trust requested a KPMG internal audit on GDPR and the processing and management of personal information held by the Trust. While there were areas GOSH was praised for with regards good information governance practice, the audit provided an assurance rating of 'partial assurance with improvements required' due, in the main, to concerns raised about the certain aspects of recording of data assets. An action plan was developed in response to the audit and will further support the Trust in developing an effective foundation for managing its data privacy responsibilities. One of the key ongoing tasks for the Information Governance team is to update and refresh the Trust Information Asset Register, the record of all personal data processed and held by GOSH and one of the first steps to ensuring all data collected is done so in line with legal requirements.

## 7 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 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 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, Safety and Experience Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- Reviews of the strategic risks facing the Trust by the Board assurance committees. This includes deep dives into each BAF risk on a rotational basis every year, with committee members scrutinising the effectiveness of controls and seeking assurances that any gaps in controls will be closed in a timely manner.
- Internal audit reports providing evidence that the controls are in place and effective in mitigating the risk.
- The Trust clinical audit programme.
- Reviews of compliance with CQC standards and other regulatory bodies (see above for explanation of the work programme in place).

- Consideration of performance against national targets (see above on waiting list data as an example).
- The assessment against the Data Security and Protection Toolkit (see above for further information).
- Health and safety reviews.
- Relevant reviews by external bodies.
- Horizon scanning for risks and learning from reviews in the wider NHS.
- Reviews conducted by the new group, Closing the Loop.
- 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 instances where the assurance was not sufficient or controls were not adequate when subject to routine audits during 2019/20 are outlined below. Plans are in place to implement necessary actions. The Risk Assurance and Compliance Group monitors progress with these actions at every meeting and reports this to the relevant Board assurance committee:

- Incident reporting. The internal auditors identified a backlog of open incident reports, exceeding the Trust's 45 day target where an investigation had not been completed. Recommendations were made related to the management of incident reporting and a plan is in place to implement the necessary actions.

- GDPR. While progress had been made in implementing the systems required to help ensure compliance with the requirements of GDPR, there were gaps in the recording of data flows within the Information Asset Register, physical security controls in the Trust's IT environment and allocation of clear responsibilities for handling patient data for IPP patients.

- Patient discharge planning. The internal audit review identified that there were significant opportunities for efficiencies in the way in which planning for discharge is undertaken to help these be undertaken as soon as patients are medically fit for discharge.

- Access and activity data. The internal auditors identified gaps in the understanding of clinicians responsible for the recording of Referral to Treatment data leading to patients being incorrectly recorded as entering into treatment when appointments did not qualify as treatment. They also identified inconsistencies in the recording of when referrals were received.

- Estates health and safety. Audit identified that for five of a sample of five wards that had their ventilation inspected, they had been assessed as not meeting minimum standards. While it was recognized that the standards assessed against are voluntary, a risk assessment had not been undertaken to consider further actions required in response to common areas of non-compliance.

**Assurance of core systems and controls**

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 reflected on the number of internal audits that received partial assurance were the controls were not deemed fully effective. 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 relevant assurance committees of the Board. The Board accepts that during the year, the senior management team has sought to expose areas where the effectiveness of existing controls have previously been limited. In these instances, Internal Auditor scrutiny has provided an opportunity to establish a baseline for the required controls and has led to an enhanced level of scrutiny and more significantly, improvement and learning in these areas.

There has been specific scrutiny of implementation of the plans for stabilisation of the Electronic Patient Record, particularly in relation to the significance of the accuracy of data entered into the system and the quality of data provided by Epic to support effective quality and financial performance management across the hospital. The Audit Committee and Trust Board have received regular reports on the mitigations in place to manage the risk.

In addition, the Board and its assurance committees have reviewed the risks and assurance available in relation to the following key operational risks:

- Business continuity in relation to COVID-19. In response to COVID-19, the Trust put in place a system of Gold, Silver and Bronze emergency planning meetings to manage the incident and scenario plan. Regular updates were provided to Board members at meetings and between meetings. The Audit Committee retains responsibility for seeking assurance of the robustness of the emergency planning framework at GOSH throughout the year.

- Escalation of key clinical risks from management committees through to Board. The Quality, Safety and Experience Assurance Committee has sought assurance around emerging risks that impact on patient safety and experience and how these are escalated promptly. The committee also receives regular assurance about how the Trust is scrutinising the quality of services and learning from these reviews. A new safety risk has been added to the BAF.

- Brexit. The executives established a Brexit Steering Group attended by key senior managers from across the Trust representing emergency planning, pharmacy, research, procurement, and workforce. The Board received updates on mitigations in place to manage the risk of leaving the EU without a deal.

- Data Protection, Data Quality and Cyber Security. The Audit Committee has scrutinised these areas of risk throughout the year, reporting assurances and gaps to the Board (see above on data quality). A separate cyber security risk has been added to the BAF, and the data quality BAF risk has been extended to reflect the risk of not having the appropriate framework in place to oversee and manage data and data quality.

- Redevelopment of the site. During the year, the Board and the Finance and Investment Committee have actively considered and balanced the risks involved in redeveloping the frontage buildings of the hospital into a Children's Cancer Centre. This risk has been revised to incorporate the risk of not getting the basics right in relation to management of the estate.

- Level of international and private practice debt. Throughout the year the Audit Committee has scrutinised the mitigations in place to secure payment from authorities for outstanding debt.

- Response to CQC Report. The CQC issued two enforcement notices, four 'Must Do' actions and 18 'Should Do' actions. An action plan has been developed and is monitored at the Always Improving Group (see page xx). The Trust was rated 'Requires Improvement' for 'Are services Safe' and in response to this, the Board agreed that a new risk should be added to the BAF as follows: *Patients are not consistently cared for within a comprehensive safety system which ensures they are protected from avoidable harm and focuses on openness, transparency and learning when things go wrong*.
- Cyber security. With the increase in the level of threat faced by NHS organisations to the security of their data, the Audit Committee has sought assurance throughout the year of the controls in place to secure GOSH systems and enhance the cyber maturity of the organisation. A separate cyber security risk has been added to the BAF.

## 8 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.

**Mr Matthew Shaw**

**Chief Executive**

**xx May 2020**

# Independent auditor's report

INDEPENDENT AUDITOR’S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF THE GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

# Accounts

See Board papers

# Glossary

| | |
|---|---|
| ACAS | Advisory, Conciliation and Arbitration Service |
| BAF | Board Assurance Framework |
| BAME | Black Asian and Minority Ethnic |
| BRC | Biomedical Research Centre |
| CAHF | Clean Air Hospital Framework |
| CHESS | Children's Hospital Education Specialist Symposium |
| CORONA VIRUS | An infectious disease caused by severe acute respiratory syndrome first identified in December 2019 and resulted in a pandemic. |
| COVID-19 | An infectious disease caused by severe acute respiratory syndrome first identified in December 2019 and resulted in a pandemic. |
| CHP | Combined Heat and Power |
| CRF | Clinical Research Facility |
| CQC | Care Quality Commission |
| DRIVE | Digital Research Informatics & Virtual Environment |
| DSP | Data Security and Protection |
| DSPT | Data Security and Protection Toolkit |
| ECHO | European Children's Hospital Organisation |
| EEA | European Economic Area |
| EMT | Executive Management Team |
| Epic | The service provider of the EPR |
| EpiCARE | The European Reference Network for rare and complex epilepsies |
| EPR | Electronic Patient Record |
| ERN | European Research Networks |
| EU | European Union |
| FTE | Full-time equivalent |
| FTSU | Freedom to Speak Up |
| GDPR | General Data Protection Regulations |

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|---|---|
| GEMS | GOSH Exceptional Member of Staff |
| GOSH | Great Ormond Street Hospital |
| HEE | Health Education England |
| ICH | UCL Great Ormond Street Institute of Child Health |
| I&E | Income and Expenditure |
| IGSG | Information Governance Steering Group |
| IP | Intellectual Property |
| LCFS | Local Counter Fraud Service |
| LITT | Laser interstitial thermal therapy |
| MES | Membership Engagement Services |
| NED | Non-executive directors |
| NHS | National Health Service |
| NHSE | National Health Service England |
| NHSI | NHS Improvement (Monitor) |
| NIHR | National Institute for Health Research |
| NIHR BRC | National Institute for Health Research Great Ormond Street Biomedical Research Centre |
| PALS | Patient Advice and Liaison Service |
| PDR | Performance and development review |
| PHSO | Parliamentary and Health Service Ombudsman |
| PICB | Premier Inn Clinical Building |
| PLACE | Patient-led Assessments of the Care Environment |
| QIA | Quality impact assessment |
| QSEAC | Quality, Safety and Experience Assurance Committee |
| RACG | Risk Assurance and Compliance Group |
| SDMP | Sustainable Development Management Plan |
| SID | Senior independent director |
| STP | Sustainability and Transformation Partnerships |
| UCL | University College London |

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|---|---|
| UCLH | University College London Hospitals |
| UCLP | UCL Partners |
| WHO | World Health Organisation |
| YPF | Young People’s Forum |

Great Ormond Street Hospital for Children
NHS Foundation Trust

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

26 May 2020

Our Ref: CAW/RLG/2020

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 2020 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 2020 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 2020.

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 engagement letter.

2. Significant assumptions used by us in making accounting estimates, including those measured at fair value and assessing the impact of Covid-19 on the Trust, are reasonable. In particular, when assessing the impact of Covid-19 on the Trust we have considered the following:

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(i) The disclosures made regarding key sources of estimation uncertainty within note 1.6, particularly the material uncertainty issued by the external valuers in relation to property valuation.

3. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of *IAS24 "Related party disclosures"*.

   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 uncorrected misstatements and disclosure deficiencies, if any, is detailed in the appendix to this letter.

6. We confirm that the financial statements have been prepared on the going concern basis and disclose in accordance with IAS 1 all matters of which we are aware that are relevant to the Trusts' ability to continue as a going concern, including principal conditions or events and our plans. We do not intend to liquidate the Trust or cease trading as we consider we have realistic alternatives to doing so. We are not aware of any material uncertainties related to events or conditions that may cast significant doubt upon the Trust's ability to continue as a going concern. We 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 plans for future actions. We are satisfied as to the status of negotiations with commissioners being in support of this.

7. We acknowledge our responsibility for ensuring the Trust has put in place arrangements for securing economy, efficiency and effectiveness in its use of resources.

8. We are not aware of any deficiencies in the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources.

9. 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.

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10. 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.

11. We do not currently have the power to govern, nor do we have control over any of the charities involved with Great Ormond Street Hospital for Children NHS Foundation Trust and as a result have not consolidated any of these charities in our financial statements.

12. With respect to revaluation of the properties in accordance with the Group Accounting Manual:

    a) Notwithstanding the material uncertainty issued by the external valuer over the valuation of property assets, 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.

13. 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.

*Information provided*

14. 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.

15. All transactions have been recorded and are reflected in the financial statements and the underlying accounting records.

16. We acknowledge our responsibilities for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

17. 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.

18. 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:

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(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.

19. 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.

20. 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.

21. 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.

22. All minutes of board and management meetings during the year and since the financial year have been made available to you.

23. 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.

24. We have no plans or intentions that may materially affect the carrying value or classification of assets and liabilities reflected in the financial statements.

25. We confirm that:

(i) we consider that the Trust has appropriate processes to prevent and identify any cyber breaches other than those that are clearly inconsequential; and

(ii) we have disclosed to you all cyber breaches of which we are aware that have resulted in more than inconsequential unauthorised access of data, applications, services, networks and/or devices.

26. We have reconsidered the estimated remaining useful lives of the fixed assets and confirm that the present rates of depreciation are appropriate to amortise the revalued amount less residual value over the remaining useful lives.

27. We confirm that no significant fixed assets have been sold or scrapped during the financial year other than those listed in the fixed asset register.

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28. We have recorded or disclosed, as appropriate, all liabilities, both actual and contingent.

29. Except as disclosed in Note 13.1 to the financial statements, as at 31 March 2020 there were no significant capital commitments contracted by the Trust.

30. We confirm that we consider all debtors recognised under IFRS 15 to be "contract receivables" and that there are no "contract assets" as at the year-end, as there are no debtors for which the Trust's right to consideration is conditional on something other than the passage of time (including future performance).

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

Matthew Shaw, Chief Executive Officer
Signed as Accounting Officer, and on behalf of the Board of Directors

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# Appendix 1

## Schedule of Uncorrected Misstatements

| Description | Assets DR / (CR) £ | Liabilities DR / (CR) £ | Equity DR / (CR) £ | Income Statement DR / (CR) £ |
|---|---|---|---|---|
| NONE NOTED | | | | |

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# Appendix 2

## Disclosure deficiencies

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

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**Trust Board**
**26 May 2020**

| **Compliance with the Code of Governance 2019/20**<br><br>**Submitted by:** Anna Ferrant, Company Secretary | **Paper No: Attachment M** |
|---|---|

***Aims / summary***

Monitor, 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.

Foundation trusts are required to report against Monitor's (now referred to as NHS Improvement) 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.

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 at Appendix 1 (for information). The text in red highlights those criteria against which the Trust is required to explain any areas of non-compliance.

The review has found that the Board has applied the principles and met the requirements of Code of Governance during 2019/20 with the exception of one provision where alternative arrangements are explained. It is proposed that the text provided below is published in the annual report 2019/20 explaining the Trust's compliance with the Code.

- The first section (highlighted in yellow) outlines where in the annual report reference to the provisions of the Code that must be explained are located.
- The second section (highlighted in blue) provides an explanation against those provisions where there is a "comply or explain" requirement. These disclose where the Trust has departed from the Code and the plans/ alternative arrangements in place to reflect the principles of the Code.

***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.*

*Throughout our annual report we describe how we meet the Code. A summary of where detail can be found on the issues we are required to disclose is given in the following table.*

| *Code reference* | *Section of annual report* |
|---|---|
| *A.1.1* | *Accountability Report:*<br>• *Council of Governors (role of Council)*<br>• *Trust Board (role of Trust Board)*<br>• *Annual Governance Statement (role of Trust Board)* |
| *A.1.2* | *Accountability Report - Trust Board members 2019-20* |
| *A.5.3* | *Accountability Report - Governors' attendance at meetings* |
| *Additional requirement- FT Annual Reporting Manual* | *A statement about the number of meetings of the council of governors and individual attendance by governors and directors.*<br>*Accountability Report - Trust Board members 2019-20*<br>*Accountability Report - Governors' attendance at meetings* |
| *B.1.1* | *Accountability Report - Trust Board members 2019-20* |
| *B.1.4* | *Accountability Report - Trust Board members 2019-20* |
| *Additional requirement- FT Annual Reporting Manual* | *Brief description of the length of appointments of the non-executive directors, and how they may be terminated*<br><br>*Accountability Report - Trust Board members 2019-20* |
| *B.2.10* | *Accountability Report:*<br>*Trust Board Nominations Committee*<br>*Council of Governors' Nominations and Remuneration Committee* |
| *Additional requirement - FT Annual Reporting Manual* | *Explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.*<br><br>*Not applicable* |
| *B.3.1* | *Accountability Report - Trust Board members 2019-20* |
| *B.5.6* | *Accountability Report – Membership Engagement* |
| *Additional requirement- FT Annual Reporting Manual* | *Governors having exercised their powers to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions*<br><br>*Not applicable* |
| *B.6.1* | *Accountability Report – Evaluation of Board performance* |
| *B.6.2* | *Accountability Report – Evaluation of Board performance* |

| | |
|---|---|
| *C.1.1* | *Disclosures -Statement of the chief executive's responsibilities as the accounting officer of Great Ormond Street Hospital for Children NHS Foundation Trust* |
| *C.2.2* | *Accountability Report – Audit Committee Report and Annual Governance Statement* |
| *C.3.5* | *Not applicable for 2019-20* |
| *C.3.9* | *Accountability Report – Audit Committee Report* |
| *D.1.3* | *Not applicable for 2019-20* |
| *E.1.4* | *Accountability Report – Council of Governors* |
| *E.1.5* | *Accountability Report - Trust Board and Council of Governors working together* |
| *E.1.6* | *Accountability Report - Membership constituencies and membership numbers 2019-20 and Membership Engagement* |
| *Additional requirement- FT Annual Reporting Manual* | *Eligibility for being a member, membership statistics and membership strategy*<br><br>*Accountability Report – Council of Governors* |
| *Additional requirement- FT Annual Reporting Manual* | *Details of company directorships or other material interests in companies held by governors and/or directors*<br><br>*Accountability Report – Council of Governors*<br><br>*Accountability Report – Register of Interest (Directors) and Register of Interests (Governors)* |
| *B.1.2* | *The Board is normally comprised of a Chair, Deputy Chair, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by University College London. Professor Rosalind Smyth (UCL appointment) stepped down from the Board on 31 December 2019. From 1 January 2020 until 30 April 2020, the Board comprised a chair and five non-–executive directors.* |

**Action required from the meeting**
Note the review and approve the statement to be included in the 2019/20 annual report.

**Contribution to the delivery of NHS Foundation Trust strategies and plans**
Good corporate governance

**Financial implications**
None

| |
|---|
| **Legal issues**<br>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?**<br>N/A |
| **Who needs to be told about any decision?**<br>N/A |
| **Who is responsible for implementing the proposals / project and anticipated timescales?**<br>Company Secretary |
| **Who is accountable for the implementation of the proposal / project?**<br>Chair of Board and Council |

# Compliance with the Code of Governance 2019-2020

| 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. | • A schedule of matters is in place and was updated in September 2019 and approved by the Board.<br><br>The Constitution was revised in July 2018 in consultation with the Board and Council. It includes:<br>• A statement about resolving disagreements is detailed in the Constitution.<br>• 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 and has been part of the Trust Strategy for 2019/20. |
| A.1.4 | The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual obligations, and approved plans and objectives. | The Board receives regular reports on quality, safety, patient experience and workforce and these are presented in an integrated report. A seperate report is presented on finance and activity. These reports monitor the Trust's plans and strategies. Corporate risks are reviewed at the Risk, Assurance and Compliance Group (an executive led group chaired by the CEO) and the actions shared with the Audit Committee, Quality, Safety and Experience Assurance Committee (QSEAC) and the People and Education Assurance Committee.. Assurance of the robustness of the controls in place to mitigate these risks is sought by the Audit Committee and QSEAC. The annual report provides a summary of the adequacy of these systems.<br><br>External sources of assurance are sought on high risk/ complex areas . |
| 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. | The Board receives regular reports on quality, safety, finance, patient experience and workforce. These include relevant metrics, milestones and measures.<br><br>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 audit and clinical audit plan every year. |
| 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. | The Board receives an integrated quality and performance report at each Board meeting.<br><br>The Quality, Safety and Experience Assurance Committee, a committee of the Board, seeks assurance of the adequacy of controls in place to manager quality risks and provides a summary report of matters considered at its last meeting to the next available Board meeting.<br><br>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.<br><br>The Quality Report is published annually. Progress with the Quality Strategy is reviewed by the QSAEAC on an annual basis.<br><br>Compliance with CQC standards and other regulatory and statutory requirements are monitored by the Always Improving Group and reported to the Risk Assurance and Compliance Group. An Assurance and Escalation Framework is in place. Learning from incidents, audits, reviews etc. is captured and cascaded by the Closing the Loop Group. |
| 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). | Standards of conduct are included in staff job decsriptions.<br><br>The Board of Directors' Code of Conduct was refreshed in 2019 and reflects these values (including the Trust's Always Values) and accepted standards of behaviour in public life. All directors have signed this code which includes reference to the fit and proper person test. |
| 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. | See above on the Code of Conduct for directors and governors.<br><br>The directors and governors are asked to submit an annual, now mandatory declaration of interests using the new web portal reporting system 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. |

| 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).<br>The Trust has also arranged top up insurance to provide additional indemnity for risks not covered by the NHSLA e.g.:<br>• Claims made against the Entity itself<br>• Past Directors, Governors, Employees. |
| A.2.1 | The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the board of directors. | The responsibilities of the Chair 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 Chair 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 Chair 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 Mr James Hatchley appointed by the Board in consultation with the Council in April 2017. The deputy chair is Akhter Mateen, appointed in April 2017.<br><br>The SID attends Council meetings, is available to speak with governors individually and invites comments from governors on the appraisal of the Chair 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 Chair held meetings with the NEDs during the year without the executives present. The Senior Independent Director (SID) lead the performance evaluation of the Chair and consulted with the other NEDs, executives and the governors on his performance. |
| 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. |
| 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 (including opportunities to observe Board andf assurance committees) via the monthly Governor bulletin. |
| 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 26 governors. When revising the Constitution in July 2018, the Board and Council agreed that this was of a sufficient, representative size.<br><br>The Council of Governors has a terms of reference which will be subject to review in 2020 as part of an annual update. The Constitution includes key procedures of the Council. |
| A.5.3 | The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request. | This information is recorded in the annual report which is published on the website. The Constitution includes an expectation of the number of meetings that governors should attend. A record of attendance for governors is maintained and is available on request throughout the year. |
| 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.<br><br>The schedule of matters highlights the Council's responsibilities. This document was upated in September 2019. |
| 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 provides a written report at each Council 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 relevent reports.<br><br>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.Governors have contact details of their 'Buddy' NED to ask questions inbetween meetings. Governors hold a private meeting with the Chair prior to every Council meeting to discuss matters raised in the Council papers and ask questions. |
| 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.<br><br>The SID is available to discuss concerns about the performance of the board of directors and/or compliance with licence requirements.<br><br>All of the Non-Executive directors attend each Council meeting and are available to answer questions about performance matters.<br><br>The Chair holds a private meeting with Governors prior to each Council meeting and provides the opportunity to ask any question and receive updates on key matters. |
| 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 observe the assurance committees.<br><br>A bulletin is sent regularly to governors, updating them on development opportunities, requests for information, media news stories and the key meeting dates for diaries.<br><br>The Trust seeks to spell out all acronyms in Council papers. A glossary of terms has also been circulated to governors.<br><br>Governors are paired up with Non-Executive Director 'Buddies' who they can contact for |

| Para | Code of Governance Requirement | Disclosure |
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| 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 governor and Senior Independnet Director. |
| 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 key news and developments as well as finance and performance targets and quality indicators (covreing safety and patient experience) and workforce.<br><br>Governors receive feedback from the non-executive chairs of the Board assurance committees. Governors are invited to attend to observe these assurance committee meetings. Governors who attended the Assurance meetings share their feedback with other Governors.<br><br>Emails are sent to governors on significant performance matters between meetings.<br><br>A bulletin is sent out regularly to governors, updating them on development opportunities, requests for information, media news stories and dates for diaries.<br><br>The Chair of the Council holds a private meeting with governors prior to each Council meeting to answer any questions. |
| 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:<br>- raising matters with non-executive directors in Council meetings (NEDs attend every Council meeting)<br>- Attending assurance committees chaired by NEDs and observing how they hold the executive team to account;<br>-Holding a private meeting between Governors and the Lead Governor to discuss their observations sincce the last Council meeting, prior to each Council meeting<br>- Holding a private meeting with the Chair prior to each Council meeting<br>-Attending public Board meetings;<br>- Attending the AGM. |
| 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 *NHS Foundation Trust Annual Reporting Manual*:<br>(a) the annual accounts;<br>(b) any report of the auditor on them; and<br>(c) the annual report. | These documents were presented to the Council at the Annual Member's meeting in October 2019. |
| 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 and minutes of confidential meetings of the Board are uploaded to the Governor Portal where Governors have access to these documents at all times and can be easily found in one place.<br><br>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, Safety and Experience Assurance Committee, People and Education 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:<br>• 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.<br>• More than half of governors who vote to approve a significant transaction.<br>• More than half of all governors to approve an application by a trust for a merger, acquisition, separation or dissolution.<br>• 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.<br>• 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.<br>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 2018.. |

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| B.1.1 | 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:<br><br>• has been an employee of the NHS foundation trust within the last five years;<br><br>• 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;<br><br>• 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;<br><br>• has close family ties with any of the NHS foundation trust's advisers, directors or senior employees;<br><br>• holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;<br><br>• has served on the board of the NHS foundation trust for more than six years from the date of their first appointment; or<br><br>• is an appointed representative of the NHS foundation trust's university medical or dental school. | The annual report details the independence of all of the non-executive directors. It notes that one NED is nominated by University College London.<br>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 |
| B.1.2 | At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent. | The Board is normally comprised of a Chair, Deputy Chair, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by University College London. Professor Rosalind Smyth (UCL appointment) stepped down from the Board on 31 December 2019. From 1 January 2020 until 30 April 2020, the Board comprised a chair and five non-–executive directors. |
| B.1.3 | No individual should hold, at the same time, positions of director and governor of any NHS foundation trust. | None of the directors on the GOSH Board are governors on the GOSH Council of Governors, nor a governor on another Trust's Council of Governors. |
| B.1.4 | The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website. | This information is included in the annual report (accountabiility report) and on the Trust website. |
| B.2.1 | The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board of directors to meet them. | There are two nomination committees: one for the appointment of the Chair 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. The executives produced a succession plan for executive positions and other VSM posts in 2019.The Board will undertake a full skills assessment in 2020/21. |
| 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'.<br><br>Governors are asked to make a declaration about their fitness to hold the role of Governor and are subject to a DBS check every three years (and on appointment/ election). Further checks are conducted with regards director disqualifications and bankruptcy and on an annual basis. |
| B.2.3 | There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairperson). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson. | There are two nominations committees - the Board of Directors' Nominations Committee and the Council Nominations and Remuneration Committee. A Board skills anaylsis is undertaken every 18 months - 2 years to enable the Board and Council to review the structure and composition of the Board.The next analysis will be undertaken in 2020/21. |
| B.2.4 | The chairperson or an independent non-executive director should chair the nominations committee(s).At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chairman. | The Council Nominations and Remuneration Committee is chaired by the chair of the Board and Council. The terms of reference state that when the chair is being appointed or reappointed, the deputy chair 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).<br><br>The Board of Directors' Nominations Committee is chaired by Sir Michael Rake, Chair. |
| B.2.5 | The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors. Once suitable candidates have been identified the nominations committee should make recommendations to the council of governors. | Following a recommendation from the CoG Nominations and Remuneration Committee, the Council of Governors approved the reappointment of one NEDs in 2019/20. There were no new NED appointments to the Board during the year. |
| 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 chair of the Trust, the deputy chair, 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).<br>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 Council takes into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for the a new NED position. For the reappointment of the NED, it considered the results of the NED's appraisal, attendance, input and engagement with stakeholders including the Council. |
| 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 new NEDs. |

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| 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. Independent external advisers were invited to attend the interview panel for the appointment of the Chief Executive and Director of HR and OD but in both cases 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.<br><br>The Board of Directors' Nominations Committee and the Council of Governors' Nominations and remuneration Committee Terms of Reference are published on the Trust website. The Board Nominations Committee ToR are currently under review |
| 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. The Council approved the appointment of the current Chief Executive in November 2018. |
| 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. |
| 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 Chair JD and terms and conditions define the role and capabilities required including an assessment of the time commitment expected. The Chair's significant commitments are documented in the annual report and declared in the register of interests. The Chair is not a chair 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 February 2020.The non-executive directors' significant commitments are reported in the Trust annual report. |
| B.3.3 | The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairperson of such an organisation. | None of the executives or the Chair have taken on a non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity. |
| 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.<br><br>Directors have access to development programmes organised and run by NHS Providers, the Kings Fund, Deloitte etc.Governors are invited to attend similar external events and report back to the Council. |
| 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 Chair held appraisal meetings with the NEDs during the year and discussed their training and development as they relate to the Board. |
| 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 includes 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 have been consulted on agreeing their development programme.<br><br>Governors attend meetings with other governors run by external organisations such as Deloitte and NHS Providers and report back to meetings. |
| 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. | 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.<br><br>The Board receives an integrated quality and performance report at every public meeting.<br><br>The communication team regularly send around press updates to the Board and the Council.<br><br>The Board work calendar has been updated to mirror reporting around the refreshed Trust strategy.<br><br>Any significant matters are communicated to the Board as soon as possible by email, rather than wait for the next board meeting.<br><br>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.<br><br>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. |
| 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. | The non-executive directors do request deeper analysis of high risk areas during board and assurance Committee meetings.<br><br>Access to external assurance/ advice is made available on request, for example legal advice around agreements regarding large scale development contracts or commercial matters. |
| 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. The People and Education Assurance Committee is supported by the HR team with input from the Company Secretary. |

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| 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/ professional and legal advice is sought. Video-conferences are set up where required between meetings. |
| 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. | The Council fed comments into development of the GOSH operational plan 2019/20 and were also consulted on the revision of the Trust Strategy in April 2019. Further work will be conducted in 2020/21 on engagement with stakeholders such as members with the publication of the Stakeholder Engagement Strategy |
| 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 fed comments into development of the GOSH operational plan 2019/20 and were consulted on the revision of the Trust Strategy in April 2019. |
| 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. | As part of their routine scheduled inspection programme, the CQC conducted an independent well-led inspection of the Trust in October 2019 and during 2019/20, the Board monitored progress with the action plan.<br><br>The Board took part in an externally-led Board development programme in 2019.<br><br>Planning for the next externally lead evaluation of the Board will be start in Q3 2020/21 for the evaluation to take place in Q4 2020/21.<br><br>The Board assurance committees conduct annual self assessments and use the findings to review the terms of reference and workplans where relevant. |
| 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 leads the performance evaluation of the Chair and discusses the Chair's performance with the executive directors, NEDs and governors (via the Lead Governor). |
| 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.<br><br>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:<br><br>• holding the non-executive directors individually and collectively to account for the performance of the board of directors.<br><br>• communicating with their member constituencies and the public and transmitting their views to the board of directors; and<br><br>• contributing to the development of forward plans of NHS foundation trusts.<br><br>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 governor) This information is also presented in the annual report. Governors have been involved in drafting the letters accompanying the Member Matters publication.<br><br>An evaluation of the Council was conducted in 2019 with regular updates to the Council on progress with the agreed actions. The structure and composition of the Council was reviewed in 2018 at the time of the reviiew of the Constitituion. |
| 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 revised Constitution (July 2018) details the process for removal of a governor including the requirements to attend a certain number of council meetings and management of potential conflicts of interest.<br><br>. |
| 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 chair confirms to the governors the performance of the individual proposed for re-appointment continues to be effective and demonstrates commitment to the role.<br><br>In 2019, the Council of Governors extended the appointment of Professor Rosalind Smyth as a Non-Executive Director for one further year on the Board on the basis of a positive appraisal and recommendation from Professor Smyth's appointing body, University College London highlighting her role as Director of the UCL GOSH Institute of Child Health and the alignment between the two organisations. It was not felt that the reappointment affected Professor Smyth's independence on the Board. Professor Smyth stepped down on 31 December 2019 and Professor Viner has been appointed as the UCL nominated appointment from 1 May 2020. |
| 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.<br>The next Foundation Trust election is scheduled for November 2020 to January 2021. |
| 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.<br><br>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. The last Trust election was conducted in January 2018. The next election is scheduled for November to January 2021 and seats will be staggered to prevent the turnover of the entire Council at the end of a 2x 3 year tenure. |

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| 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 the their post during the year (Director of Development). |
| 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.<br><br>The Council of Governors receives performance and financial information at each meeting and all directors attend Council meetings to answer any questions where required.<br><br>The annual plan is consulted on with the Council.<br><br>Public Board meetings and Council of Governors meetings are advertised and the papers are available on the GOSH website. |
| C.1.4 | 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.<br><br>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:<br><br>• the NHS foundation trust's financial condition;<br><br>• the performance of its business; and/or<br><br>• 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 England/Improvement and CQC), reporting any significant matters and ensuring that these are also flagged with the Council both between meetings and at the next relevant Council meeting. |
| 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. | The Trust is compliant with preparing and reviewing the assurance framework and the annual governance statement.<br><br>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.<br><br>The assurance committees conduct deep dives into BAF risks at every meetng, with NEDs posing questions to seek assruance about the robustness of the controls cited and timeliness of the actions in place to close gaps. |
| C.2.2 | A trust should disclose in the annual report:<br>(a) if it has an internal audit function, how the function is structured and what role it performs; or<br>(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 | 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:<br><br>• 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;<br><br>• 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;<br><br>• Monitor and review the effectiveness of the NHS foundation trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements;<br><br>• 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;<br><br>• 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<br><br>• 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 May 2018. They will be reviewed by the Audit Committee in October 2019. |
| 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 Council was involved in the appointment of Deloitte LLP for a 3 year term from 2018/19. |

| Para | Code of Governance Requirement | Disclosure |
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| 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 update from the Audti Committee Chair on the performance of the external auditors.<br>The external auditors were appointed by the Council in 2018 (for 2019/20) via an open tender process and a working group inclusing governors and Audit Committee members |
| 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 2019/20. |
| 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 2018/19, following a competitive tender process. |
| C.3.7 | When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision. | The Trust will be compliant with this requirement, should the situation arise. Deloitte were re-appointed as the Trust's external auditors following a competitive tender process. |
| C.3.8 | The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions. | This matter is the responsibility of the Audit Committee and documented in its terms of reference. The Committee receives a quarterly report on an whistle blowing and Freedom to Speak up cases and actions taken to address issues raised. The QSEAC considers any reports that are related to the quality of care and teh PEAC receives an update on any reports reated to staff issues. |
| 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:<br>• the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;<br>• 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<br>• 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 and reports this to the Council of Governors. |
| 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:<br><br>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.<br><br>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.<br><br>iii) Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed.<br><br>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. | Executive directors are not awarded annual bonuses.The Remuneration Committee remineration policy has the flexibility to consider whether an element of performance related pay will be included within senior manager contracts. This is consistent with NHSI guidance. |

| Para | Code of Governance Requirement | Disclosure |
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| 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 Chair and the NEDs were updated in February 2020 and approved by the CoG.<br><br>The Council of Governors' Nominations and Remuneration Committee is responsible for recommending remuneration levels for non-executive directors to the Council of Governors. In April 2020, the Council approved tha proposal from the Char and NEDs to adopt (from 1 April 2020) the remineration levels cited in guidance from NHSE/I on Chair and NED remuneration. This required a reduction in salary for the Chair and NEDs. |
| 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.<br><br>The 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 authorisation of the Remuneration Committee and taking into account guudance from external bodies NHSI 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. A remuneration consultant was not employed during the period. |
| D.2.2 | The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose should be determined by the board, but should normally include the first layer of management below board level. | The terms of reference of the Board of Directors Remuneration Committee cover these areas. The Chief Executive determines the remuneration for non Board senior managers (first layer below Board) and reports this to the Remuneration Committee for monitoirng purposes. |
| 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 Council of Governors' Nominations and Remuneration Committee is responsible for recommending remuneration levels for non-executive directors to the Council of Governors. In April 2020, the Council approved tha proposal from the Char and NEDs to adopt (from 1 April 2020) the remineration levels cited in guidance from NHSE/I on Chair and NED remuneration. This required a reduction in salary for the Chair and NEDs. Chair and NED remuneration levels will be market tested in the next 2 years. |
| D.2.4 | The council of governors is responsible for setting the remuneration of non-executive directors and the chairperson. | This is the case - see above. |
| E.1.1 | The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on. | The Patient and Family Experience and Engagement Committee is responsible for overseeing involvement of members, patients and the local community at large. Information from the committee is reported to the Board (via the integrated quality and performance report) and the Council. The Board has approved a Patient Experience Framework. |
| 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. The Trust hs also approved a Stakeholder Management Strategy. |
| 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. | The Chair presents a summary report of the previous Council meeting to the Trust Board.<br><br>The Chair holds a private meeting with governors prior to every Council meeting. NEDs (and executive directors) regularly attend Council meetings (including the SID).<br><br>The SID has met with individual governors during the year.<br><br>The NEDs provided opportunities for governors to meet with them via the buddying system throughout the year in addition to the normal general meetings)<br><br>Emails from governors raising any concerns are shared with the executive and non-executive directors.<br><br>All governors are provided with gosh emails. |
| 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. | 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.<br><br>Governors have been involved in drafting content for the Get Involved monhtly newsletter to Members.<br><br>See B.5.6 for information about consultation held during the year with members. |
| 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. The Council of Governors and the Board have reviewed how they work together via an effectiveness survey and made recommendations for enhanced communication including continuing the NED buddying program initiated in 2018/19 and circulating a monthly news bulletin to governors. 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 was reviewed and approved in 2018/19. |

| Para | Code of Governance Requirement | Disclosure |
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| 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. The annual meeting is also held in public.Due to COVID-19 and the need for social distancing, public Board meetings have been held virtually. Whilst members of the public are unable to attend, governors can dial in and agendas and papers are published on the GOSH website prior to the meeting. |
| 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 2019 and being planned for September 2020) and the directors present the annual report and accounts and the report from the auditors. All governors, 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 and other directors regularly discuss attendance at key stakeholder meetings at the EMT. A Stakeholder Engagement Stratgey ishas been approved by the Board and the CQC stated in its report in January 2020: "T*he trust had taken a range of approaches to actively engage with patients, staff and stakeholders to plan, develop and manage services and collaborated with partner organisations effectively. There was evidence the trust had changed its attitude and approach to stakeholder working with an increased emphasis on commitment to partnership working with others* ." |

Attachment N

**Trust Board**
**26 May 2020**

| **Compliance with the NHS provider licence – self assessment**<br><br>**Submitted by:** Anna Ferrant, Company Secretary | **Paper No: Attachment N** |
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**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 one requirement under the Health and Social Care Act. Due to COVID-19, no guidance has been released by NHSI this year. However, it is good governance to assure the Board that these key conditions under the licence have been met.

| **Licence condition** |
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| **Condition G6(3):** Providers must certify that their board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution. |
| **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. |
| **Condition FT4(8)**: Providers must certify compliance with required governance standards and objectives |
| 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. |

. **Appendix 1** documents evidence against the four conditions stating the executive directors' recommendations for each condition.

In previous years, NHSI have required an FT Board to take into account the views of governors when considering whether the Trust confirms compliance with the above declarations. In April 2020, the Council of Governors were asked for their views on the attached conditions and evidence cited. Governors requested further information about the work underway to close the recommendations

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| arising from the CQC report and also about how the Trust was working to implement its cyber strategy. The Council agreed with the recommendations proposed by the GOSH executive team for all conditions. |
| **Action required from the meeting**<br>The Board is asked to **consider and agree** the Trust's response to the four conditions, taking into account the views of the governors. |
| **Contribution to the delivery of NHS / Trust strategies and plans**<br>Providers are normally required to complete an annual self-certification that confirms their continued eligibility to hold an NHS provider licence. |
| **Financial implications**<br>None |
| **Legal issues**<br>None |
| **Who is responsible for monitoring the license conditions?**<br>Company Secretary and Chief Finance Officer |
| **Who is accountable for the implementation of the proposal / project**<br>The Board is responsible for ensuring continued eligibility to hold an NHS provider licence. |

Attachment N

**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 |
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| **G6 – Systems for compliance with licence conditions and related obligations (scope = past financial year 2019/20)** | 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.<br><br>The steps that the Licensee must take ….shall include:<br>(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and<br>(b) regular review of whether those processes and systems have been implemented and of their effectiveness.<br><br>A statement shall be provided for Monitor to certify compliance with this condition no later than 2 months from the end of the | The Executive Team have considered the evidence cited and recommend 'Confirmed'.<br><br>Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors | The Trust has systems and processes to monitor risks of failure through lack of compliance or adverse variances in performance:<br><br>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)<br><br>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. This covers the following key areas:<br>• Risk Management<br>• Compliance<br>• Performance<br>• Information Governance<br>• Safeguarding<br>• Health and Safety<br><br><u>Risk Management</u><br>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 |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | financial year. | | of the strategic organisational risks, and the local structures to manage risk in support of this policy.<br><br>**Assurance**: The GOSH CQC report (2020) stated: *Staff at all levels were clear about their roles, areas of responsibility and accountability. This included delegation of responsibility to committees. The trust had an assurance and escalation framework with groups and committees providing the board with assurance or escalating concerns and/or risks relating to the quality of services, performance, targets, service delivery and achievement of strategic objectives.*<br><br>*The GOSH Board Assurance Framework includes a strategic risk of failing to maintain compliance with the Trust Licence (BAF Risk 5). This is monitored by the Risk Assurance and Compliance Group and assurance sought of the robustness of the controls cited at the Audit Committee (see below).*<br><br>On managing and learning from incidents, the CQC report stated: "*There was a clear system for categorising, reporting, investigating and learning from serious incidents, supported by the incident reporting and learning policy and duty of candour policy. Themes from serious incidents were used to inform targeted improvement work or organisational learning, for example the changes to handover and provision of revised duty of candour training*."<br><br>The Board receives a regular, high level summary of significant quality related issues currently being managed by the executive team at GOSH. It includes summaries and learning from internal and external reviews of services as well as concerns identified through concerns raised by our staff and our patients and their families; and through the aggregation of data regarding quality performance.<br><br>**Assurance**: The GOSH CQC report (2020) stated:<br>*"The trust had systems and processes for identifying risks, planning to eliminate or reduce these, and coping with both the expected and unexpected. The risks recorded on the corporate risks register reflected those that leaders stated were the top risks and there was evidence that these* |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | *were regularly reviewed."*<br><br>*"Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care."*<br><br>The CQC stated (Surgery service): *Staff recognised and reported incidents and near misses.* Critical care service: *The last four governance committee minutes included discussions about complaints, incidents, key performance indicators (KPIs), training, risk register, learning, issues from other health and safety committees, and other clinical issues and audits. Actions to address concerns or outstanding issues were identified and monitored through the monthly critical care governance meetings. The meetings were minuted for dissemination to other staff who were not able to attend.*<br><br>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 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 Board assurance committees and updated throughout the year. In April 2020 the Board is reviewing an updated BAF which has been aligned with the refreshed 5 year Trust strategy.<br><br>The Risk Assurance and Compliance Group monitors progress with the BAF. This includes a 'stress test' of BAF risks to check (using key performance indicators and external assurance information) whether the controls and assurances cited are working and appropriate.<br><br>**Assurance:** The GOSH CQC report recommended (must do): "*Ensure the board assurance framework reflects all known medicine risks, including the storing, administration and destroying* |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | *of medicines in line with legislation and the trust medicines management policies."* This recommendation has been acted upon and the relevant BAF updated to reflect the different stages of managing medicines safely.<br><br><u>Compliance</u><br>The foundation trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust has identified an executive director and a manager who are respectively accountable and responsible for ensuring compliance with 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.<br><br>In December 2019, the CQC conducted a scheduled unannounced inspection of three services (critical care, surgery and CAMHS) and an announced inspection against the well-led criteria. The report was published in January 2020. The Trust retained a rating of 'Good' overall.<br>The CQC issued 2 enforcement notices:<br>• Regulation 12: Safe Care and Treatment: This recommendation relates to the robustness of access control measures in PICU medication room; the safe storage of IV fluids in theatres, interventional radiology and on one of the surgical wards; the process for denaturing controlled drugs on wards; and the temperature monitoring arrangements for medication rooms.<br><br>**Assurance**: Work has been conducted to review and secure storage of IV fluids across theatres and radiology and update access control in PICU. Progress with denaturing of controlled drugs and temperature monitoring arrangements are underway.<br><br>• Regulation 17: Good Governance: This recommendation relates to the articulation of the breadth of the medicines risk on the board assurance framework; and the need to ensure that the EPR system fully meets the needs of the staff in the CAMHS service to deliver safe care.<br><br>**Assurance**: Medicines risk: The medicines BAF has been updated and is subject to regular review by the Risk Assurance and Compliance Group. |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | **Assurance**: EPR and CAMHS service: Following the inspection in October 2019, work began immediately between the EPR and CAMHS team to identify and address problems. This included instigating a formal Speciality Level Optimisation process. There is an associated action log which tracks progress, and all actions which had been classified as high risk were completed in March 2020.<br><br>In total the hospital was advised of 4 'Must Do' actions which were required to bring services in line with legal requirements. The Trust was also been advised of 18 'Should Do' actions (10 Trust wide, 2 Critical Care, 3 Surgery and 3 Mental Health) which were required to comply with minor breaches that did not justify regulatory action and to prevent the service from failing to comply with legal requirements in future, or to improve services.<br><br>**Assurance**: The Trust ran a programme of work to ensure CQC readiness and to maintain compliance for the Trust with a view to ensuring that compliance and governance are interlinked with quality, safety and experience and embedded in day to day working within the Trust.<br><br>A CQC action plan has been developed to address all actions. An executive led committee, Always Improving, has been established and meets monthly to review progress against this action plan, whilst supporting the ongoing work with the Trust's CQC compliance. This committee reports into the Risk, Assurance and Compliance meeting with regular reports to Board and the Council of Governors. The Trust will continue to conduct mock inspection framework (CQC Quality Rounds) in clinical directorates and review potential areas/sources of learning for example reviews of themes from other CQC reports and evaluation of CQC Insight reports.<br><br>The Quality, Safety and Experience Assurance Committee receives updates on CQC compliance and all other compliance areas on a regular basis. A database supports monitoring of ongoing inspections, audits and self -assessments. |

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| | | | <u>Information Governance</u><br>The Information Governance Steering Group monitors information governance risks and compliance with GDPR. The Trust has been compiling its submission for the Data Security and Protection Toolkit (DSPT). This annual submission demonstrates GOSH's position against the legal requirements providing assurance that we are practicing good data security and our personal information is handled correctly. While GOSH is already compliant with the majority of mandatory requirements, some areas of improvement have been identified for which action plans have been produced. These include fully implementing the compliance with the national data opt-out and training levels for staff.<br><br>This year there have been three serious information governance incidents (classified at a reportable level using the Incident Reporting Tool within the DSPT) involving sensitive information. Details are as follows:<br>• Over 60 cases were identified of staff having sent emails containing patient data non-securely to personal emails.<br>• Monitoring information of 10 new members of staff was erroneously sent to their new managers.<br>• A letter containing sensitive safeguarding information was sent to an incorrect address local to a patient.<br><br>Each of these cases have been reported to the Information Commissioner's Office (ICO) and NHS England as Serious Reportable Incidents with an internal root cause analysis completed and shared. The learning from these has been implemented back into Trust practice to ensure similar incidents do not occur. The ICO considered the information provided via reporting and investigating and in each case decided that no further action was necessary given the Trust's response and approach.<br><br>The Trust's internal auditors conducted an audit of compliance with elements for GDPR and provided a rating of 'partial assurance with improvements required'. Whilst the report found that *"Effective governance structures have been established to oversee the delivery of the Trust's* |

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| | | | *information governance and data privacy requirements", the Trust's information asset register did not document all requirements and additional physical controls for limiting access to the Trust IT systems were recommended.* The CQC also stated that the Trust should *"Improve the accuracy of the trust's information asset register".* An action plan is in place – the port control programme has been rolled out and the information asset register is in the process of being completed across the Trust.<br><br>*The CQC report stated: "The board were sighted on information governance issues including some issues with data quality which could impact on its ability to accurately report performance internal and externally. While data quality was improving, and action was taken when specific data issues were identified, more work was required to ensure accurate data was available to inform discussions and provide assurance."*<br><br>In the CQC evidence base document: *"Information breaches were taken seriously, and action taken to mitigate the risks associated with the breach and reduce the risk of re-occurrence. It was recorded on the BAF that personal and sensitive data was not always effectively collected, stored, shared or made accessible in line with statutory and regulatory requirements. There had been several breaches of regulatory requirements in the last 12 months which could be attributed to staff not following trust policies or human error. All these breaches had been investigated and none to date had been 'upheld' by the ICO. To facilitate learning the trust had held a learning event which considered internal breaches. To widen this learning the trust was collating learning from external breaches and issues which would be shared with staff."*<br><br><u>Infection Control</u><br>The Infection Prevention and Control Committee (IPCC) meets monthly and reports to Patient Safety and Outcome Committee. A continuous advice service is provided by IPC Team / Consultant Microbiologists. The Director of Infection Prevention and Control meets bi-weekly with the Chief Nurse.<br><br>*The CQC reported that "Some services did not always control infection risk well. Staff used* |

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| | | | *equipment and control measures inconsistently, they did not always use hand sanitisers when entering or leaving the wards, or when moving between patient bays". In other services, the CQC stated (surgery): "controlled infection risk well. Staff used equipment and control measures to protect patients, their families and themselves from infection. They kept equipment and the premises visibly clean".* An action plan is in place to respond to these matters and ensure a consistent approach to infection control across the Trust.<br><br><u>Health and Safety</u><br>The Trust is 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 staff report incidents. The Trust's governance structure ensures statutory compliance is undertaken within legislative requirements. Assurance via the Health and Safety Committee has been provided on a range of subjects such as violence against staff, sharps compliance, Control of Substances Hazardous to Health and fire safety.<br><br>The Trust's internal auditors conducted an audit into estates health and safety and provided a rating of 'partial assurance with improvements required'. The audit recommended improvements to planning of quarterly visual inspections and annual inspections of ventilation equipment and monitoring of findings/ actions to close gaps; development of an action plan to respond to the self-assessment against estates health and safety requirements; and, development and management of derogations for the Trust's sites where ventilation is not fully compliant with recommended practice, such as Health Technical Memoranda. A plan is in place to implement the necessary actions.<br><br><u>Safeguarding</u><br>The Strategic Safeguarding Committee, chaired by the Chief Nurse, oversees all safeguarding matters across the Trust and reports into the Patient Safety and Outcomes Committee (PSOC).<br><br>The CQC stated (CAMHS): *"Staff understood how to protect patients from abuse and the service* |

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| | | | *worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the unit had a safeguarding lead."*<br><br>In the CQC evidence base document*: "We saw safeguarding information displayed in waiting areas, offering advice and guidance to staff and patients on how to recognise and report abuse. Staff knew how to access safeguarding policies and procedures on the trust intranet. The trust had recently updated its safe and respectful behaviour policy, which provided the steps for staff to follow when faced with an aggressive parent. The update to the policy protected staff as they could now escalate the incident quickly, using a warning card system."*<br><br>*"Staff used an electronic flagging system, held on the patient's electronic record, to identify children at risk or on a child protection plan. Staff could also see if a safeguarding referral had been made. A safeguarding referral is a request made to the local authority or police to intervene, support or protect a child or vulnerable adult from abuse. From June 2018 to May 2019, there were 107 child safeguarding referrals made by staff within surgery."*<br>The CQC report cited a number of areas that the Trust should focus on following the inspection and a plan is in place to act upon these matters, monitored at the Always Improving Group:<br><br>*Raise staff awareness of the safe and respectful behaviour policy and improve access to conflict resolution training.* A survey has been conducted with staff and feedback used to raise awareness of the policy.<br><br><u>Performance monitoring</u><br>Directorate performance reviews take place on a monthly basis, attended by directorate 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 information presented at the performance reviews include an integrated dashboard which provides a one page summary of key metrics across the domains, allowing rapid identification of linked risks and |

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| | | | issues. An integrated performance report is then scrutinised at each Trust 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 directorate integrated dashboard reviewed in the monthly performance reviews.<br><br>**Assurance**: The internal auditors conducted an audit into the Trust's directorate governance framework and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019).<br><br>**Assurance**: The CQC report stated: *"There were clear reporting lines from ward to board and from board to wards, to manage performance and identify, potential issues or failure to meet local and national standards. These were informed by the integrated quality and performance report which included both safety and financial information and discussed at the monthly directorate performance review meetings, attended by the directorate management team and representatives from the trust executives".*<br><br>However, the CQC stated that the Trust should: "*Improve the oversight of delivery of services by the pharmacy department, including identifying and reporting key performance indicators via the directorate performance process to the board*." A number of actions have been delivered in response to improve reporting through to the Trust Board.<br><br><u>Escalation</u><br>The Trust has systems and processes in place to support staff and patients in escalating concerns in provision of care or management of systems. These include the complaints process, PALS, Freedom to Speak Up Guardian, Guardian of Safe Working, Raising Concerns Policy, Counterfraud service etc. The Trust is one of the first UK hospitals 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. Safety Champions from across the hospital have been appointed. |

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| | | | **Assurance**: CQC stated (2020): "*Staff at all levels were clear about their roles, areas of responsibility and accountability. This included delegation of responsibility to committees. The trust had an assurance and escalation framework with groups and committees providing the board with assurance or escalating concerns and/or risks relating to the quality of services, performance, targets, service delivery and achievement of strategic objectives.*"<br><br>*Managers at all levels in the trust had the skills, knowledge and experience to run a service providing high-quality sustainable care. Leadership had been strengthened since the last inspection with several changes of both executives and non-executives. The executives were described as an inclusive, dynamic team who were open and transparent.*<br><br>*Leaders were knowledgeable about the challenges to quality and sustainability the trust faced including those arising from the current NHS financing model for specialised services; and its dependence on continuing to be able to attract international private patients. Leaders were proactive in addressing these through a range of initiatives including exploring alternative international markets and research activity.*<br><br>*The trust had a vision and strategy that was currently being refreshed in consultation with staff, children, families and stakeholders. Staff understood the trust's vision, values and strategy and were supportive of these. Several strategies to support the trust strategy were either in place or currently being developed. These aligned and supported the trust's vision.*<br><br>*The hospital had a culture in which staff could speak openly about safety concerns allowing these to be effectively managed and safe high-quality care delivered. Leaders at all levels across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.*<br><br>*Leaders did not tolerate behaviour that was not in line with the trust's values, regardless of seniority. In some directorates staff continued to report issues with bullying and harassment, low morale and lack of staff engagement. Several initiatives had been implemented to address these* |

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| | | | *including a 'stand up for our values', program to tackle those behaviours that were not in line with the trust's values and promoting the Dignity at work policy. At the time of our inspection the impact of these initiatives had not yet been measured but will be measured through the next NHS staff survey and staff engagement.*<br><br>"*Children, young people and their families were aware of how to raise a complaint. Complaints and concerns were taken seriously and responded to in a timely manner. Improvements were made to the quality of care as a result of complaints and concerns being raised*."<br><br>The CQC report cited a number of areas that the Trust should focus on following the inspection and a plan is in place to act upon these matters, monitored at the Always Improving Group:<br><br>• *Continue to promote the role of the Freedom to Speak Up Guardian (FTSUG), taking proactive action to identify and address themes from staff contacts with the FTSUG.* Work is underway but delayed due to Covid-19 planning.<br>• *Raise staff awareness of the role of the accredited safety champions.* Work is underway and due for delivery in June 2020.<br>• *Take action to improve the number of incidents closed within the trust's 45 working day target.* Some actions have been delivered and some remain underway and delayed due to Covid-19 planning.<br><br>The internal auditors conducted an Incident Reporting audit looking at the processes in place for the recording and management of operational risks. The report allocated a rating of 'Partial assurance with improvement required'. The audit report identified a large number of open incident reports, exceeding the Trust 45 day target. Recommendations were made related to the management of incident reporting and a plan is in place to implement the necessary actions.<br><br>In 2019, the NAO public sector award for excellence in public sector reporting was won by Great Ormond Street Hospital. The award recognises good corporate reporting that builds trust and transparency. |

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| | | | The Trust assesses compliance with the FT licence annually. |
| **CoS7 – Availability of resources (scope = next financial year 2020/21)** | The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.<br><br>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.<br><br>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:<br><br>(a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after | The Executive Team have considered the evidence cited and recommend "Confirmed" for (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."<br><br>Response to be considered by the | 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. The Executive Team actively monitors the finance position at every meeting to ensure that the mitigations in place are effective and appropriate.<br><br>As the national NHS operational planning process has been suspended for 2020/21 the Trust has still approved a budget for the year based on the planning process prior to COVID19. To date, it has received confirmation from DHSC that all expenditure would be funded until at least the end July 2020 after which time the system is expected to return to a block contracting system. Discussions remain ongoing with NHSE/I about how any loss of commercial income will be rectified after exiting from the COVID19 crisis recognising there will be a lead time to build the business back up.<br><br>No material agreements which might create a material risk have been entered into.<br><br>The Trust Audit Committee and Board will review for approval the 2019/20 annual report and accounts (26 May 2020), on a going concern basis, confirming that the Directors have a reasonable expectation that the organisation has the required resources available for the next 12 month licence (a).<br><br>The Trust is implementing a robust savings plan for 2020/21. The Trust is holding discussions with other NHS trusts on managing implications of tariff changes.<br><br>Assurance: Both External and Internal Audit services provide assurance that reporting is accurate and there is no material mis-statement.<br><br>The CQC stated: "The trust had developed a long-term financial model that was subject to |

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| | taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."<br>OR<br><br>(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".<br><br>OR<br>(c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources | board in light of assurance provided here and taking into account the views of the governors | regular in-depth scrutiny by the board through its finance and investment committee. The trust had concluded that, under current NHS financial assumptions, it was likely to face significant financial challenge over the next two years." …The Trust should: "Take action to develop and assure itself about financial sustainability going forward .".<br><br>"Leaders were knowledgeable about the challenges to quality and sustainability the trust faced including those arising from the current NHS financing model for specialised services; and its dependence on continuing to be able to attract international private patients. Leaders were proactive in addressing these through a range of initiatives including exploring alternative international markets and research activity."<br><br>The internal auditors conducted an audit into the Better Value programme and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019).<br><br>The internal auditors conducted an audit into the Trust's financial controls and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019). |

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| | available to it for the period of 12 months referred to in this certificate". | | |
| **FT4- NHS foundation trust governance arrangements (scope = next financial year 2020/21)**<br><br>**PLEASE NOTE – all four parts need to be confirmed for an overall 'confirmation'** | The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | The Executive Team have considered the evidence cited and recommend "Confirmed".<br><br>Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors | The Trust has a range of governance and assurance structures and systems in place including a Trust wide strategy, scheme of delegation, risk management framework, accountability framework, compliance framework, escalation framework, policy framework and assurance framework and a financial management framework (see controls and assurances above).<br><br>Directors and governors are asked to sign a code of conduct (both documents were refreshed in 2018) and declare any interest for publication on a Register of Interests.<br><br>**Assurance**: A new Declarations of Interest and Gifts and Hospitality Policy has been launched, updated in line with NHS England's policy and identifying key decision makers. The Trust has also implemented a new electronic declaration portal for staff to update declarations immediately and to ensure timely reporting publicly.<br><br>The Trust's Local Counter Fraud Service is in the process of collating evidence toward the Trust's NHS Counter Fraud Authority Self-Review Tool and informed the Trust Audit Committee in April 2020 that they are proposing an overall green (compliant) return.<br><br>Directors complete a self-assessment for the Fit and Proper Person Test (and are reviewed against the criteria annually) and are required to declare any interests annually. Governors sign an eligibility form which includes reference to the Fit and Proper Person's Process.<br><br>**Assurance**: The CQC stated: "*The trust had a process and a recently updated and approved fit and proper persons (FPP) policy to assess that staff with director level responsibilities, including the NEDs, were compliant with FPP in accordance with Regulation 5 of the Health and Social Care Act (2014). Overall responsibility for FPP was held by the chairperson, who delegated this responsibility to the company secretary.* |

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FPP checks were completed on appointment and annual reviews were the responsibility of a member of the human resources team, supported by the company secretary. We saw evidence that checks were carried out and that an electronic spreadsheet of compliance was maintained. This spreadsheet was a live document and used as a tool to identify any checks i.e. Disclosure and Barring Service (DBS) checks which were due for renewal. The trust also required all directors, NEDs, budget holders and councillors to complete an electronic annual conflict of interest and hospitality declaration. This approach facilitated on-going compliance with Regulation 5 of the Health and Social Care Act (2014).”<br><br>
A self-assessment is prepared annually against the Monitor code of Governance and will be reported to the Board in May 2020. The Trust Board considers that from 1 April 2019 to 31 March 2020 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 :<br><br>
<table>
<tr><td>B.1.2</td><td>The Board is normally comprised of a Chair, Deputy Chair, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by University College London. Professor Rosalind Smyth (UCL appointment) stepped down from the Board on 31 December 2019. From 1 January 2020 until 30 April 2020, the Board comprised a chair and five non-–executive directors.</td></tr>
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Further information about corporate governance systems and standards at GOSH is detailed below.
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| | The Licensee shall:<br>(a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time;<br>(b) comply with the following paragraphs of this Condition. | The Executive Team have considered the evidence cited and recommend 'Confirmed'.<br><br>Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors | The Trust has regard to guidance on good corporate governance as issued by NHS Improvement. |
| | The Licensee shall establish and implement:<br>(a) effective board and committee structures;<br>(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) clear reporting lines and accountabilities throughout its organisation. | The Executive Team have considered the evidence cited and recommend 'Confirmed'.<br><br>Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors | The Board has a formal schedule of matters reserved for its decision, and delegates certain matters to committees.<br><br>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.<br><br>There are three Board assurance committees - the Audit Committee, the Quality, Safety and Experience Assurance Committee and the People and Education Assurance Committee. These committees assess the assurance available to the Board in relation to risk management, review the Trust's non-clinical and clinical and quality risk management processes and review the structures and processes in place to deliver the Trust's vision for a supported and innovative |

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| | | | workforce, an excellent learning environment and a culture that aligns with the Trust's strategy and always values. All three committees raise issues that require the attention of the Board at every Board meeting.<br><br>In addition to the three assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The chairs of these committees report to the Board following every committee meeting. Each committee is charged with reviewing its effectiveness annually.<br><br>The Trust has terms of reference and work plans in place for the Board, Council and assurance committees. The Board committees conduct annual effectiveness reviews (surveys) on the delivery of their terms of reference and running of the committees. Findings are reviewed and where appropriate, changes to the terms of reference and workplans of the committees are made.<br><br>The assurance committees receive minutes from other assurance committees to prevent matters falling between them. Summaries of assurance committee meetings are reported at the Board and the Council. At the Council, the chairs of the assurance committees present the summary reports and are held directly to account by the governors at the Council meeting. Governors are also invited to attend assurance committees and Board meetings throughout the year.<br>The Trust's Assurance and Escalation Framework presents a single, comprehensive picture of the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance. The Trust routinely reviews and reports this assurance through the following key governance processes and frameworks including:<br>• Performance Management: The Trust has a range of frameworks and policies in place that outline how the Trust's performance objectives and standards will be met, reviewed and managed.<br>• The Trust's Risk Management Strategy (see above) sets out how the organisation identifies, monitors, escalates and manages risks in a timely fashion and at an appropriate level. |

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| | | | • The Trust has in place a comprehensive and integrated Compliance Framework that seeks to ensure on-going compliance with statutory and regulatory requirements through integrated, rigorous and proactive structures, policies and practices. It ensures appropriate controls are in place to maintain compliance with statutory and regulatory requirements and that external guidance and alerts are considered in a fulsome and responsive way.<br>• Policy Framework: This provides for clear and accessible policies, procedures and guidelines which support staff in undertaking their duties in a safe and effective way that takes account of all relevant legislation, regulation and guidance. The Trust's policy framework is administered by the Policy Approval Group (PAG) and reported through to the Risk Assurance and Compliance Group.<br>• Committee structure: The Trust's committee structure, developed from the Trust Board down, is currently under review to ensure each committee or group has a clear purpose, scope and authority. Some committees have statutory functions, others have authority to make decisions and direct actions, and others provide advice, support and oversee specific functions. The review is being conducted via the Risk Assurance and Compliance Group.<br>• The Risk Assurance and Compliance Group monitors progress with the strategic risks on the Board Assurance Framework (see above).<br><br>There are eight directorates, each with a Chief of Service, Deputy Chief of Service, Head of Nursing and General Manager. The Senior Leadership Team meets weekly (around 100 senior managers from across the clinical and corporate areas of the Trust). An Operations Board made up of senior operational managers from across the Trust meets fortnightly. The purpose of the Operational Board is to bring together clinical and corporate senior leadership members to ensure the robust, effective and efficient operational management of the Trust.<br><br>The Trust's risk management strategy sets out how risk is systematically managed. 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 |

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| | | | the business continuity of the Trust.<br><br>**Assurance**: The CQC reported stated: "*Staff at all levels were clear about their roles, areas of responsibility and accountability. This included delegation of responsibility to committees. The trust had an assurance and escalation framework with groups and committees providing the board with assurance or escalating concerns and/or risks relating to the quality of services, performance, targets, service delivery and achievement of strategic objectives*."<br><br>The CQC evidence base document stated: "*The trust board had the appropriate range of skills, knowledge and experience to perform its role. Executives and non-executive directors (NEDs) had a mix of skills and attributes which were complimentary to each other and their backgrounds ensured there was cover across clinical and operational activity."*<br><br>*"All those we spoke with said leadership had been strengthened since the last inspection and that the CEO was very visible and open. Some staff reported that the CEO had visited their departments and explored how staff were feeling. This made them feel he was genuinely interested in the work they were doing and their wellbeing. The executives were described as an inclusive, dynamic team who were open and transparent.*<br><br>*We observed that the board worked effectively together. At the board meeting we attended, all board members were prepared for the meeting, constructively challenged each other. Those NEDs not present had sent in comments on papers which were shared at the meeting by the chair. Board members were knowledgeable not only about their own portfolios but also about those of other board members, this provided support if the portfolio lead was not available."*<br>The internal auditors conducted an audit into the Trust's directorate governance framework and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019).<br><br>See assurances cited on risk management above. |

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| | The Licensee shall establish and effectively implement systems and/or processes:<br>(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(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 Commissioning Board and statutory regulators of health care professions; | The Executive Team have considered the evidence cited and recommend 'Confirmed'.<br><br>Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors | 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.<br><br>Each specialty and clinical directorate has an internal monitoring structure so teams regularly review their progress and identify areas where improvements may be required. Each directorate's performance is considered at monthly performance review meetings (see above). The Finance and Investment committee reviews the operational, productivity and financial performance and use of resources both at Trust and divisional level.<br><br>The Board has a work programme (aligned with the Well Led Assessment Key Lines of Enquiry), 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. A Board development programme is under review.<br><br>The Board assurance committees scrutinise the strategic risks facing the trust on a rotational basis every year, with committee members reviewing the effectiveness of controls and seeking assurances that any gaps in controls will be closed in a timely manner.<br>Key performance indicators are presented on a monthly basis to the Trust Board. The report, which has recently been refreshed and integrates quality and performance data includes progress against external targets, internal safety measures, operational efficiency/process measures, well-led and other clinical quality measures such as complaints, incidents and reports from specific quality functions within the Trust such as the Patient Advice and Liaison Service |

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| | | | (PALS). It also includes the external indicators assessed and reported monthly by the CQC. The report is aligned to the CQC key lines of enquiry: Safe, Effective, Caring, Responsive and Well Led. It asks the question: are our patients receiving high quality care?<br><br>In December 2019, the Trust was inspected by the CQC and achieved an overall rating of GOOD for its clinical services and GOOD for the assessment of Well Led. An action plan was developed and rolled out across the Trust (see above for monitoring framework).<br>**Assurance**: See statements from the CQC above on senior management, performance management and internal audit reports. |

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| **s.151(5) of the Health and Social Care Act (not a licence condition)** **(scope = past financial year 2019/20)** | 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. | The Executive Team have considered the evidence cited and recommend 'Confirmed'.<br><br>Response to be considered by the board in light of assurance provided here and taking into account the views of the governors | **Governor Induction and training and development:**<br>During 2019/20, governors 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. This is actively monitored by the Deputy Company Secretary and governors reminded and supported to complete the training during the year.<br><br>Prior to each Council of Governors' meeting, the Chair meets with all governors in a private session. This gives the Governors an opportunity to discuss any issues directly with the Chair and to gather information about the Trust and its activities and processes.<br><br>The Trust has established a buddying programme between Non-Executive Directors (NEDs) and governors. The buddying programme provides governors with direct contact with a NED to support their role and share information on matters of interest or concern. The programme has been evaluated and revised during the year.<br><br>Governor Development sessions have been developed in partnership with Governors to provide them with the skills and knowledge needed to deliver their key duties over their tenure.<br><br>Several Governors attended external training and events throughout the year and provided reports back to the Trust. These included:<br>• Governor Focus conference, to help Governors explore how they can be best equipped to support their Trusts in delivering quality healthcare.<br>• GOVSEC's Government IT Security Conference, which explored how public sector organisations and professionals could make sense of securing their IT functions in a rapidly changing environment.<br>• GovernWell: Member and public engagement, which aimed to help Governors explore what 'Representation' meant.<br><br>Governors have access to an online library of resources. This provides governors with 24/7 access to key documents and information.<br><br>Governors receive a monthly newsletter from the Corporate Affairs team containing key dates, developments and training and development opportunities. |

Attachment O

Great Ormond Street Hospital for Children NHS Foundation Trust

**Trust Board**
**26 May 2020**

| **2019/20 Quality Report**<br><br>**Submitted by:**<br>Dr Sanjiv Sharma, Medical Director<br>Salina Parkyn, Head of Quality and Safety | **Paper No: Attachment O** |
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**Aims / summary**

The Quality Report is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. Its aim is to enhance accountability and engage leaders of NHS organisations in their quality improvement agendas. The Quality Report is a mandated document, which is laid before Parliament before being made available to patients, their families, and the public on the NHS Choices website.

In light of the COVID-19 pandemic NHSE/I have made the following changes in Regulation:

- There will no longer be a requirement to include a quality report in the annual report.
- Auditor assurance work on quality accounts and quality reports should cease for 2019/20 with no limited assurance opinions expected to be issued in 2019/20.
- For NHS foundation trusts, there is no formal requirement for a limited assurance opinion or governors' report.
- Providers will not be subject to the 30 June deadline – the new deadline is 15th December 2020.
- Provider organisations will no longer be required to submit any hard copy documents to NHS Improvement for the annual report and accounts.

The Trust remained committed to producing the Quality Report albeit with an extended timeframe to ensure all efforts are re-allocated to the COVID-19 management. Attached is the draft report for review and comment.

Feedback is awaited from the following colleagues which will be received and incorporated by the end of May 2020:

- Non-Executive Director comments from Lady Amanda Ellingworth and Kathryn Ludlow.
- Two representatives of the Council of Governors
- Healthwatch

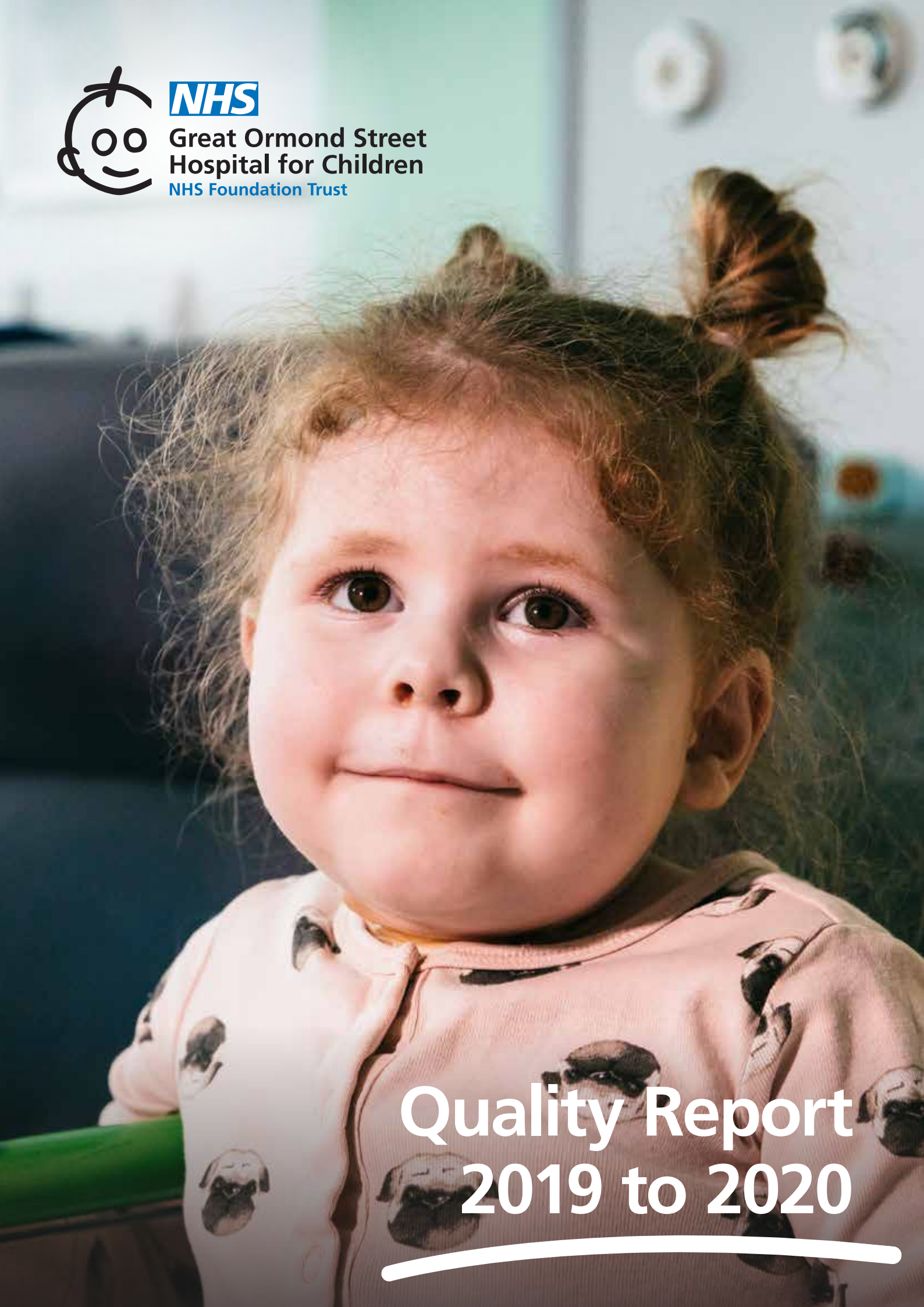
**Action required from the meeting**

To provide feedback for inclusion prior to final draft.

**Contribution to the delivery of NHS / Trust strategies and plans**

The document describes quality improvement work that has taken place in line with the Trust's strategic aims of Fulfilling Our Potential, and in line with quality as defined in the

| |
|---|
| Next Stage Review. The document will also declare and outline some of the Trust's quality improvement work for 2020/21. |
| **Financial implications**<br>None |
| **Legal issues**<br>None, there is usually a legal requirement to produce the Quality Report annually which has been removed for the 19/20 report. |
| **Who is responsible for implementing the proposals / project and anticipated timescales**<br>The delivery of the report is the responsibility of the Head of Quality and Safety. The deliveries of the projects therein are the responsibility of the individual project teams. |
| **Who is accountable for the implementation of the proposal / project**<br>The identified leads of the projects therein are accountable for delivery. |



NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

# Quality Report 2019 to 2020

# Contents



**TO BE CONFIRMED**

**ONCE ALL CONTENT IN PLACE**

**Cover:** Four-year-old **Lillie-Anne**, is being treated at GOSH for a brain tumour. She also has a tracheostomy to help her breathe. While at the hospital, Lillie-Anne likes watching her favourite film *Frozen*.

# 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 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.

## 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 boxes."**

**What is the NHS website?**

The NHS website 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.

**Enzo** is seven years old and is currently receiving treatment as part of a clinical research trial at GOSH. He loves superheroes and playing on his games console.



# Our hospital

GOSH had
**40,273**
inpatients and
**193,766**
outpatient appointments
in 2019/20.

**100%**
of our clinical specialities
collect data on outcomes
of treatment

GOSH has
**19**
highly
specialised
services.

**GOSH has 61 specialties.**

Over
**1290**
research studies
active in 2019/20.

GOSH employs
**5065**
hospital staff including doctors
nurses, allied health professionals
and administrative staff

**96.9%**
of inpatients would
recommend the hospital.

# Our strategy – fulfilling our potential

Following a refresh and launch of Fulfilling Our Potential in 2017, our activities in 2019 continued to focus on creating a structure and engaging staff to embed our strategy as a plan for the Trust.

Alongside celebration of the work at GOSH to help children and young people with the most complex needs to fulfil their potential, this year's Open House was our third successful event that celebrated the amazing things we achieve as an organisation. This year's focus was on how we are using technology, providing care, developing and supporting our workforce and continue to help advance important research.

We also used 2019/20 as an opportunity to review Fulfilling Our Potential and in consultation with GOSH patients and families, staff and partners, develop a new five year strategy that will be launched in 2020/21.

We also launched a revised and improved business planning process that saw our clinical and corporate teams work even more collaboratively on their 2020/21 plans to ensure we continue to deliver our priorities.

**Other key achievements include:**

- Successfully separating conjoined twins, care of whom demanded a close collaboration between more than 100 experts at GOSH – one of the few places in the world with the skills and facilities for this procedure.
- Closing Great Ormond Street and turning it into a Play Street for Clean Air Day and Traffic Free Day.
- Completion of construction of the Zayed Centre for Research into Rare Disease in Children and the transfer of some outpatient services to the Centre.
- Roll out the Safety and Reliability Improvement Programme across the Trust.
- Launch of the GOSH Learning Academy providing first-choice, multi-professional paediatric education and training, available through state-of-the-art technologies and in contemporary evidence-based designed learning environments.
- Go Live of the Electronic Patient Records system, Epic and the beginning of the optimisation phase.

We continue to engage actively in a range of national and international collaborations to learn together and to share good practice across paediatric healthcare settings. For example, research is a key area where GOSH can promote clinical collaboration and benefits across clinical networks.

GOSH hosts 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). Within education and training, partnership programmes across the STP will include lead employer for CYP Nursing Associate pilot, and a Darzi Fellow working with lead educator for local CCG to improve the communication and care for children with rare diseases.

During 2020/21 we will collaborate with other inpatient mental health providers in North London. Internally, we will also ensure collaboration across service areas. CAMHS and Psychology will merge into one mental health team and will work to make the liaison service at GOSH multi-professional.

**What is Open House?**

Open House is the annual celebration of all things GOSH. It's a time to come together, celebrate our hospital strategy and showcase our work to our colleagues.

**What is a Darzi Fellow?**

The Darzi Fellow is a London-wide programme run by NHS London Leadership Academy. It was started in 2009 in response to Lord Darzi's review *High quality care for all: NHS Next Stage Review (2009)*, which called for stronger clinical leadership and management roles.



# Electronic Patient Records system

GOSH went live with the Epic Electronic Patient Record (EPR) system on the 19 April 2019. The Programme was delivered on time and under budget and saw the entire organisation come together to ensure the biggest transformation programme the Trust has ever seen was a huge success.

The Easter weekend was chosen for go-live so that inpatient areas would have four days to stabilise prior to outpatients and other services coming online the following Tuesday. A total of 800 GOSH super users and 150 clinicians from hospitals in the US, Australia, Canada and Lebanon came together to form a network of support for GOSH staff as they become accustomed to the new ways of working. GOSH ran the go-live using a bronze, silver, gold command structure, using clinical and operational management structures to communicate between staff on the frontline into the programme team and to the executive.

A 3-month Stabilisation period followed go-live which was designed to embed the system and highlight any key issues prior to the commencement of Optimisation. During this time some key areas were identified as in need of intensive support. In Pharmacy, the Willow Inventory module caused medication stock and cost discrepancies which had a significant impact on pharmacy purchasing, dispensing workflows and financial reporting. GOSH EPR, Epic and Pharmacy teams worked closely for eight months to refine the system, the workflows and the processes, which included some developments to the Epic system itself. In Radiology, some workflows were suboptimal and issues exacerbated by some poor user process further up the patient workflow. The key issues in Radiology have been resolved and we continue to optimise the workflows and the Radiant application for the Radiology teams. Documentation and data quality needed additional support and training so that discharge summaries and clinic letters were completed and sent in a timely fashion

The Optimisation phase commenced in July 2019. The 15-month phase is, broken into five 3-month tranches of work to further develop the system. The scope of each tranche is a mix of issue/process resolution, development of new speciality content and implementation of new functionality. Key projects have been established such as: Thrive with Epic, which uses data and follow up training sessions to improve users efficiency and therefore data quality; Integrating Infusion Pumps with Epic to reduce medication errors and wastage, and; the extension of external facing tools such as the MyGOSH patient portal and the EpicCare Link and Care Everywhere portals for clinicians with whom we carry out shared care.

The Trust has commenced Benefits Realisation work and is beginning to meet financial benefits as outlined in the Full Business Case. Patient safety and staff efficiency benefits have also started to be realised and case studies documented. Of particular note are Therapeutic dose monitoring in Paediatric Oncology Shared Care Units (POSCUs) via EpicCare Link; Patient access to records, documentation, blood results and the communication with the clinician via MyGOSH patient portal; reduction in the turnaround of clinic letters, and in the environmental impact of paper, printing and postage. It has also given some teams such as Laboratories and Radiology the space to review their skills mix and workload. The EPR team will continue to work with the organisation to realise and document these benefits.

As with many areas of GOSH, much of the optimisation work was placed on hold in March 2020 due to changing priorities in relation to the Coronavirus (COVID-19) outbreak. The team has turned its attentions to making changes to existing system configuration to support ward layout and referral pathways/admission processes for general paediatric work coming from other local hospitals and establishment of increased ITU capacity, and to add key data items for recording COVID activity. There is a focus on new functionality to support remote working such as integrated video visits (through Zoom) and extension of interoperability features such as EpicCare link and CareEverywhere. The technical team are involved in supporting the establishment and configuration of hardware to support the planned increase in beds.

## Part 1:
## A statement on quality from the Chief Executive

**TO BE SUPPLIED**

**TO BE SUPPLIED**

# Part 2a:
# Priorities for improvement

This part of the report sets out how we have performed against our 2019/20 quality priorities. These are made up of 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



## Reporting our quality priorities for 2019/20

**The six quality priorities reported for 2019/20 were:**

**Safety**

- Implementing the Speak Up Programme to eliminate avoidable harm.
- Urethral catheterisation: Improving practice for safer care.

**Clinical effectiveness**

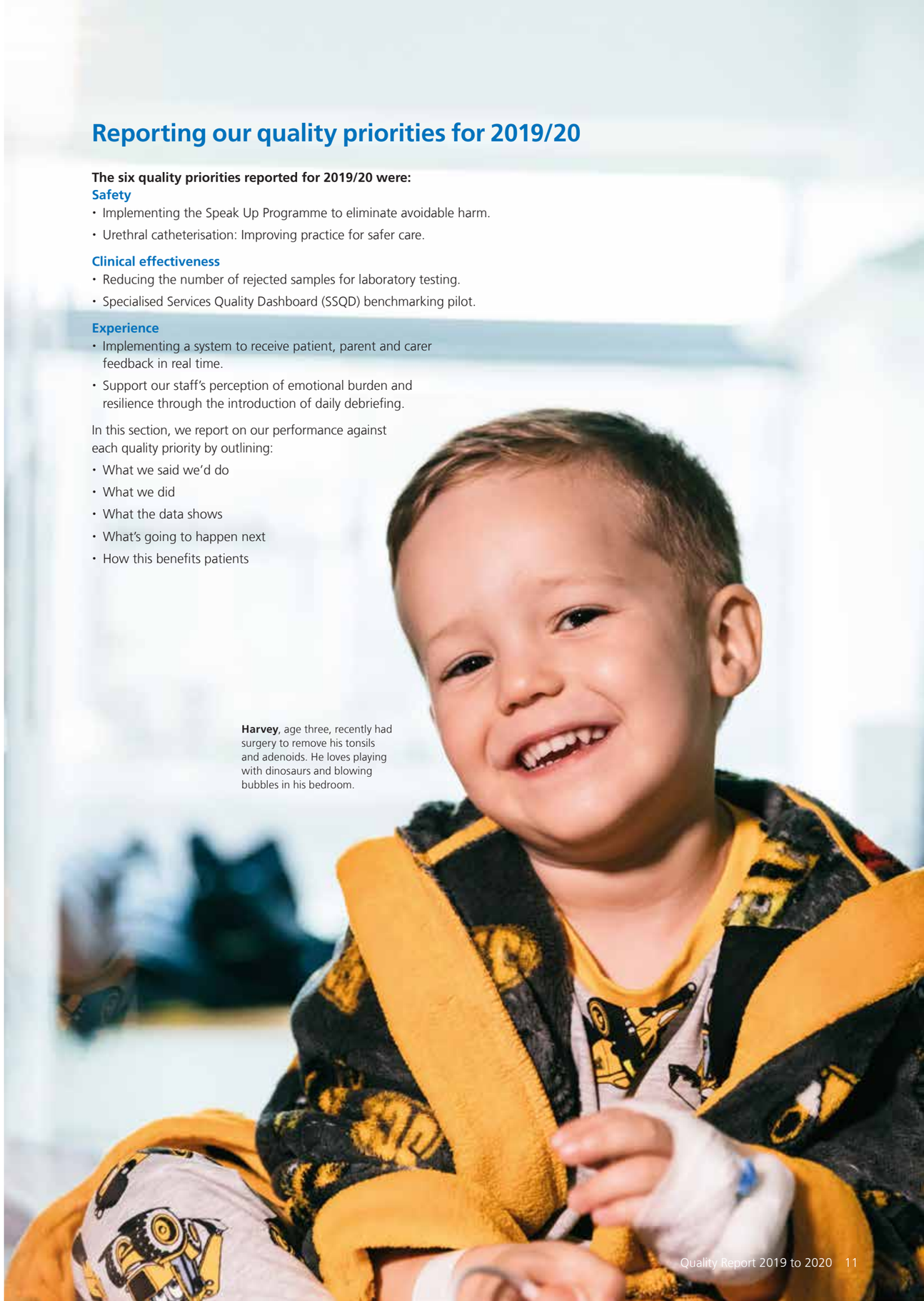
- Reducing the number of rejected samples for laboratory testing.
- Specialised Services Quality Dashboard (SSQD) benchmarking pilot.

**Experience**

- Implementing a system to receive patient, parent and carer feedback in real time.
- Support our staff's perception of emotional burden and resilience through the introduction of daily debriefing.

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



**Harvey**, age three, recently had surgery to remove his tonsils and adenoids. He loves playing with dinosaurs and blowing bubbles in his bedroom.

# Safety

## Implementing the Speak Up Programme

At GOSH we strive for zero preventable harm and it was therefore recognised that it was a priority for the organisation to identify what within the culture at GOSH had the potential to undermine this.

### What we said we would do

During the past decade, Great Ormond Street Hospital (GOSH) has aspired to zero preventable harm. It was recognised that cultural change was required to achieve this goal. In order to understand the root cause of the specific problems at GOSH we scrutinised our staff survey results and specifically those questions and responses relating to our Safety Culture.

Our aim for 2019/20 was to implement the Speak Up Programme. The Speak Up programme is a multi-year transformation programme of work to build and sustain an outstanding culture of safety, reliability and openness. Our objectives for the past year were to encourage and support our staff to feel safe in speaking up for safety and to implement processes to manage behaviours that had the potential to undermine the safety of our patients, families and colleagues.

Building on this feedback we held leadership workshops attended by 240 senior staff from across all workforce teams within the Trust aimed at increasing understanding of the environment in which we work and to gain support from our senior staff to undertake a programme to achieve cultural change at GOSH.

The aim of the Speak Up programme is to help overcome entrenched behaviours that can lead to poor patient outcomes by achieving culture change from within through supporting the right safety culture, focussed clinical leadership development and support two-way communication to prevent unintended patient harm.

The programme is Trust-wide with the goal of building a culture of safety and quality by empowering staff to support each other, raise concerns and addressing behaviours that have the ability to undermine a culture of safety and respect. This will be achieved through focused training, promoting professional accountability and addressing staff behaviours that do not align to the values of our organisation.

Speak UP
for safety in the moment



### What we did

Speaking Up for Safety is delivered in house by 26 trained and accredited Safety Champions; volunteers from across all staff groups, with the aim of normalising respectful two-way communication that helps to prevent unintended patient harm. The programme teaches the Safety C.O.D.E., a graded model for standardising language when communicating concern. This model balances patient safety with respect, resulting in a culture where GOSH staff feel comfortable to 'check' each other and welcome being 'checked' by others. All staff will develop the skills and insights to respectfully raise issues with colleagues when they are concerned about a patient's safety.

Initially, we piloted Speaking Up for Safety workshops within one directorate. We invited 360 staff to undertake training and had a 93% uptake on the workshops. The directorate were highly engaged and this sparked interest from a number of other directorates keen to commence training. Through learning from the pilot we adapted our workshops, developed new materials and launched Trust-wide workshops in June 2019. The workshops were well attended with 80% of staff and volunteers having attended workshops in the six months to December 2019.

Culture change is a long-term commitment for GOSH and we have ensured that Speak Up workshops are included in the staff induction process to ensure speaking up is embedded into normal practice and that it becomes part of our culture. Speaking Up is promoted at all Trust briefings, is included in training across the Trust and is promoted as part of the Trust Open Days, Schwartz rounds and conferences. We used members of our executive team to highlight the importance of Speaking Up and provide assurance that staff choosing to Speak Up would be support at the highest possible level to do so. We also worked with the Freedom to Speak Up (FSU) Guardian and Ambassadors at the Trust Open Day, GOSH Conference and various road shows throughout the period to promote the Speak Up message and show a united front.

### What's going to happen next

Following implementation of Speak Up for Safety we have been working on the next stage of the Programme, Speak Up for Our Values. The aim was to align the launch of this work with the launch of the Trust's People Strategy however as with many areas of GOSH, much of the work was placed on hold in March 2020 due to changing priorities in relation to the Coronavirus outbreak.

### How this benefits patients

The programme is aligned to the hospital strategy 'Fulfilling Our Potential' and highly sponsored by the Trust Board and Board of Governors (both of which have patient/family representation).

**The overarching goals of the Programme are:**

- Improved Patient Outcomes: The project will improve patient outcomes by empowering staff to respond promptly and effectively to any behaviour that may undermine patient safety.
- Better Patient Experience/Enhanced Experience for Families: This project improves patient experience by improving reliability and consistency around procedures. The project ultimately aims to improve patient safety by achieving zero preventable harm.

Staff across all professions come together for Speak Up for Safety workshops.

## Urethral catheterisation: Improving practice for safer care

Across GOSH a variation in practice in urethral catheter related issues was identified in 2019, relating to the correct insertion and care of urinary catheterisation across the Trust. This lack of standardised care had unfortunately contributed to 28 patient safety incidents since January 2018.

### What this means

Analysis of these incidents identified common themes, including the incorrect device/size being inserted, insufficient care of pressure areas, issues when flushing a urethral catheter and adherence to infection control standards. This project was initiated with the aim to eliminate avoidable harm to urethral catheterised patients at GOSH by 31st March 2020.

### Why it is important

At GOSH the ethos of patient first and always makes this work so important in its response to where aspects of care have been suboptimal and a good patient experience compromised. The intention of this project was to reduce catheter related incidents which can lead to harm and lengthen hospital admission.

### What we said we would do

The progress of this project has been measured through a number of incidents on Datix, urinary catheter audit compliance, reduction in queries directed to Urology CNS, training compliance via the staff learning and management system, and a staff skills confidence survey.

**The following data definitions align with the main work streams of the project:**

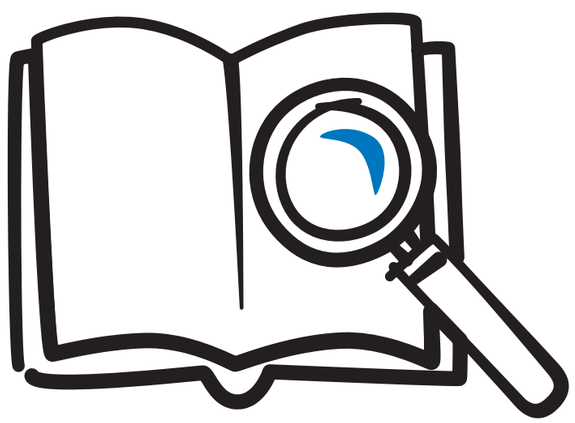
- Training: The number of staff trained as a result of the project (increased Trust wide competency).
- Devices: The number of catheter devices were reviewed within this project and the decision was made to reduce the number of devices used. We had 4 brands from 3 different suppliers of urethral catheters before we reduced to 2 main devices. Rationalising our equipment in this way improves quality by standardising practice and ensuring that staff are familiar and appropriately trained to insert and manage catheters across different wards. There is also a positive cost implication of rationalising stock and savings can be realised through bulk procurement.
- Contact: The calls received have been monitored by Urology Clinical Nurse Specialist (CNS) throughout this project. The analysis and evaluation of the impact that the project has had on the levels of catheter related contact to the Urology team will take place in September 2020, following the roll out of the education programs. This is an amended deadline due to the postponed training schedule which was created prior to COVID -19.
- Confidence: Survey from the PE to assess the increase in competence on the wards.

### What we did

The project has been delivered through three main work streams. To standardise catheter devices, a review of current devices has been conducted and an agreement made to consolidate to two preferred devices for the Trust.

This has led to streamlining the devices used between the neonatal ward and other specialty wards. In order to review and update the existing catheter pathway, a new guideline, FAQ guide and escalation pathway has been published and been made available to all staff via the Trust intranet. The new developed guidance has also been embedded into Trust Electronic Patient Record system to prompt and assist staff in their daily responsibilities with regards to catheter care.

To establish and facilitate multi-professional training, a competency booklet, training guide and resource-based intranet page has been created. Train the trainer sessions have been completed with the clinical education team who will cascade the education to their teams accordingly.



### What the data shows

We used the key metrics  of staff reported incidents via Datix, Staff Confidence Surveys pre and post the project interventions and the availability of standardised equipment to relevant staff to measure the impact of this quality improvement initiative. Unfortunately, the COVID 19 Pandemic has had a significant impact on the data collection of this project and timeframes have had to be adjusted for analysis of any improvement. A core intervention of this project was to develop robust 'Catheter Care and Insertion' education programmes on relevant wards and make broader resources and training material available Trust-wide. Once this enhanced education was embedded, a post-intervention staff confidence survey was planned to measure any change in capability and confidence amongst staff that are required to catheterise patients as part of their role. Whilst the education programmes have been developed and are now widely accessible to staff via an online resources hub, the face-to-face prong of the education strategy has had to be postponed until August 2020 to allow those on the frontline to focus on the COVID-19 related pressures.

**Datix incidents**

Comparing the Datix incidents from January 2018 to April 2020, there was been a 0.3.% increase each month in incidents (from 1.5 to 1.8 per month) and a change in the prominent incident themes from poor documentation and wrong device selection to process errors. We believe that the increase in Datix reporting could be a result of increased staff awareness of best practice surrounding catheter management however further analysis will be undertaken over the next 3 months to establish how to address these ongoing challenges.

**Staff Confidence Surveys – Post Implementation**

These surveys will be conducted in September 2020 as per the adjusted timeframes explained above.

**Standardised Devices**

The number of catheter devices were reviewed within this project and the decision was made to reduce the number of devices used.

We had 4 brands from 3 different suppliers of urethral catheters before we reduced to 2 main devices. Rationalising our equipment in this way improves quality by standardising practice and ensuring that staff are familiar and appropriately trained to insert and manage catheters across different wards. There is also a positive cost implication of rationalising stock and savings can be realised through bulk procurement.

### What's going to happen next

The final stage of this project is to increase competency through training sessions and medical education bootcamp events. This will be monitored annually.

### How this benefits patients

A range of benefits have been identified resulting in improved quality of care for our patients, not least the standardisation of best practice catheter care across all wards.

**The project provides the following benefits:**

- Reduced unwarranted variation in care and device related incidents.
- Improved identification and treatment of catheter related issues, ensuring they are addressed in a timely way with appropriate expertise.
- Standardised working practices, increased staff knowledge and expertise, and appropriate escalation will ensure children and young people requiring urethral catheterisation receive appropriate care from an appropriately trained clinician.
- Reduced patient harm and distress and the possible need for further interventions caused by catheter related incidents.
- Efficiency savings in sourcing and procuring the appropriate device.
- Improved efficiency of the Urology Team in signposting to teaching and resources, enabling expertise to be directed to appropriate queries.
- Timely and appropriate escalation of catheter related issues.
- Care delivered by appropriately trained practitioners.
- Trust-wide standardisation to improve care and outcomes for all children and young people requiring catheterisation at GOSH.

# Clinical effectiveness

## Reducing the number of rejected samples for laboratory testing

When a laboratory sample is rejected, it usually means that the test needs to be repeated and we know this could lead to delayed diagnosis and treatment which can have an impact on discharge and outcomes for our patients. Patient experience can also be significantly affected. This Quality Improvement project was set up to understand what leads to these rejections and introduce measures to stop them from happening.

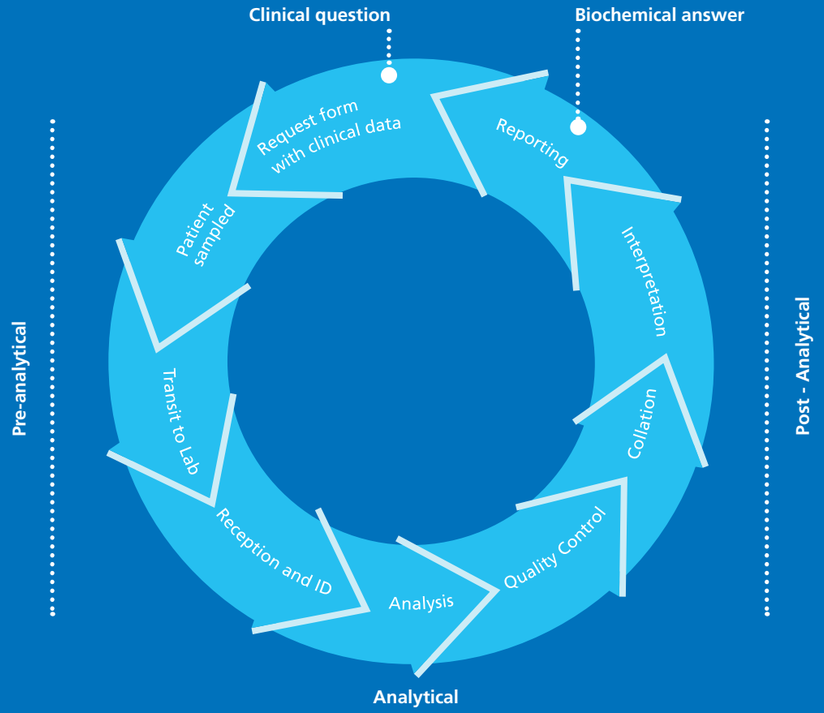
### What we said we would do

Approximately 70%[1] of clinical decisions are based on information derived from laboratory test results. In 2017, GOSH received more than 400,000 samples and performed more than 1 million tests.

Through manually recorded data, GOSH laboratory identified 4900 patient samples were rejected in 2017 due to pre-analytical errors. A Quality Improvement project was set up in late 2018 with the aim of reducing laboratory sample rejections due to pre-analytical errors.

**What is the pre-analytical phase?**

The pre-analytical phase starts at the point of test requesting by the medical team and ends when the sample arrives in the laboratory and is evaluated for errors. The phase includes collection of the sample from the patient and transportation of the sample to the lab.




[1] Datta P (2004) Resolving discordant specimens in clinical laboratory practice. [online] https://www.mlo-online.com/articles/200411/1104LabManagement.pdf



### What we did

A multi-disciplinary approach in engaging stakeholders from across the hospital was key in taking this project forward, as often rejection reasons occur as a result of process/system issues before the sample arrives in the labs and needs investigation by the clinical teams.

We created a project steering group comprising of medical, nursing, education, portering, phlebotomy, facilities and laboratory representation. Input from patients and parents were obtained where necessary.

The project was structured into four key work streams, each with focus on an integral part of achieving a quality sample:

1. **Sample Collection Resources –** focusing on the equipment and resources we use to collect patient samples to certify that they are adequate, compatible and do not hinder a quality sample being obtained.
2. **Sample Transport –** looking at the different ways in which patient samples get to the laboratory and the time it takes for samples to be transported from a patient to the lab.
3. **Training and Education –** assessing the current availability and content of education and training opportunities related to sample collection and comparing it with best practice.
4. **Policy and Guidelines –** reviewing our policies and guidelines to ensure they are evidence based and support staff to obtain adequate samples.

We developed real-time reporting on the intranet using data from the laboratory information system. The report displays statistical process control (SPC) charts including trends of rejections for specific reasons where improvement efforts are focussed. Data is available to view at Trust and ward level and is accessible by all staff.

When the Trust moved to an Electronic Patient Recording (EPR) system in April 2019, the project faced new opportunities and challenges. The availability of automated data, and therefore complete rejection numbers, will increase in its accuracy however in the short-term requires significant data quality checks. We are still working on identifying true sample rejections from all these which appear as rejections on the system. Many process errors and categorisation errors also increased at this time as a result of staff members (both wards and labs) getting used to a new EPR system.

One of the prominent successes achieved so far is the reduction of the blood culture transport time. The maximum recommended blood culture transport time (needle to incubator) is 4 hours[2]. At GOSH we set an aim to deliver these samples (needle to receipt in lab) in 120 minutes, leaving room for any other pre-analytical steps before a sample goes in to the incubator. We used different interventions including (both in wards and labs) myth busting, education, process changes at different stages to bring down the transport time.

**Other key project interventions have included:**

- Staff education package to avoid unnecessary clotting of blood samples.
- Improved blood collection resource and staff education in NICU.
- A study to optimise the sample transport methods available in the Trust.

**What are blood cultures?**

Blood cultures are blood samples performed to detect infections in the blood. If a blood culture test is positive, the bacteria causing the infection will be identified and testing will be done to find out which antibiotics would effectively treat the infection.

**"The project has dedicated staff in all areas of expertise! This was evident when new blood bottle was recently introduced for coagulation screens. This intervention will vastly benefit our laboratory with superior plasma quality and aid improved sample quantity allowing fewer sample rejections which means less patients will need re-bleeding and consequently will help overall patient experience"**
Haemostasis Lead Scientist, Coagulation Laboratory (Camellia Botnar Laboratories)

[2] L. S. Garcia (ed.), *2007 Update: Clinical Microbiology Procedures Handbook*, 2nd ed., 2007.

## What the data shows

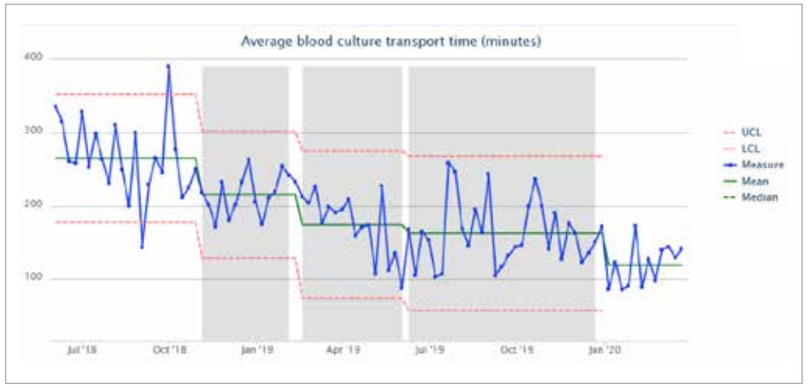
**1. Number of samples with at least one test rejection**

The weekly average number of samples where at least one test was rejected (a single sample can be used to do one or many tests depending on test types).


The EPR system has provided the opportunity to see all rejected samples in one graph, which was not possible previously. In part, the reduction of rejections shown in the above graph demonstrates an improvement of data quality as the project team identify and overcome various process and categorisation issues on the electronic system. The data cleaning process is ongoing to ultimately provide a true picture of real patient samples which were rejected for pre-analytical reasons.

**2. Average blood culture transport time**

The time between collection of a blood culture sample from a patient and the time of receipt in the laboratory, calculated as an average of all blood culture samples sent in a week.




Starting with an average time of 265 minutes at the beginning of the project, the various step changes reflect the various interventions introduced and tested at different stages. After a focussed trial in two wards, education (importance of sending samples immediately) and process change (encouraging the use of the chute system to send samples) was rolled out to the rest of the wards. This was done at various levels to capture as many staff members as possible. The final drop in the average transport time, which has allowed us to reach our aim, currently stands at 119 minutes. This reflects an extensive drive to bring down the time in the lab to receive a sample which was delivered to them. Focussing mostly on out of hours samples received to the lab, improvement in communication between main sample receiving reception and Microbiology labs and awareness of the lab staff on the urgency, supported this significant drop in time. There is still room for improvement in reducing those individual samples taking longer than 120 minutes.



## What's going to happen next

- We will continue with the data cleansing efforts so that overall better visibility is available for all stakeholders.
- Lessons learnt through this project will be incorporated in to the Trust routine training programmes under the topics relevant. These will include the correct order of blood draw to collection tubes, the best practices in the techniques used to collect samples using the available resources (especially focussed on paediatric veins/ difficult access), and tips to avoid under/over filled samples to name a few.
- Relevant policies and guidelines will be updated as per the project learning and outcomes.

## How this benefits patients

A reduction in rejection of samples will help avoid multiple sampling and support efficient diagnosis process. This will lead to better treatment outcomes for patients as well as have a significant impact on patient experience.

**"The project has built an amazing relationship between labs and the wards across the Trust. The strong link has created baseline platform for pre analytics to embed sustainable improvements. We'll persevere to strengthen education, training, and awareness amongst staff to ascertain positive change in sample rejection rates."** Quality Improvement Lead (Preanalytical), Camelia Botnar Labs


Seven-year old **Yasir** receives regular treatment at GOSH. He loves doing arts and crafts with the Play Specialists.

## Benchmarking with our specialist paediatric healthcare peers

Comparing our results with other specialist paediatric hospitals is an important way that we can understand how we're doing. However, developing measures that work for everyone requires detailed work and can take a long time. Working with our fellow paediatric hospitals and NHS England, we found a way to utilise existing national measures to see how we're all doing and what we can learn from each other to improve patient care together.

### What we said we'd do

After successfully proposing a benchmarking pilot to the UK Children's Hospitals Alliance (CHA), of which GOSH is a member, we said we would lead the agreed project to access and compare our results within the membership group of hospitals, to build benchmarking experience together and drive improvement.

### What we did

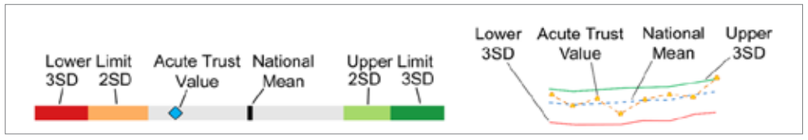
GOSH obtained agreement from the CHA executive members that as a group we would share our Specialised Services Quality Dashboard (SSQD) reports with each other. Using the nationally established SSQDs meant that we could build this initiative using existing metrics that we all reported on, thereby saving time and additional effort. We coordinated medical director sign-off from each member organisation and approached NHS England (NHSE) to explore electronic options for our benchmarking plans.

Over 2018/19, we worked with NHSE to achieve agreement for a pilot project in which they would allow three managers per CHA member organisation to access the SSQD reports[3] of the 11 member trusts. This access was provided by NHSE in May 2019.

Over the next six months, GOSH and the Evelina Children's Hospital at Guy's and St Thomas' NHS Foundation Trust each hosted a national working group to move the project forward at pace, involving clinicians and hospital managers from across the CHA member trusts, and NHSE representatives. As well as confirming practical aspects, the meetings were used to discuss and advance the commitment to an ideal benchmarking framework, which includes shared vision, clear terms of engagement, and consensus on measures.

The working group agreed to initially focus on three dashboards: Paediatric Rheumatology, Paediatric Neurosurgery and PICU. Each hospital provided input from its clinical leads to:

- Identify the measures in their SSQD that they find most meaningful.
- Confirm how they interpret each metric and how they and collect data, to understand any differences in reporting.
- Share this information within the group.
- Share this information with NHSE colleagues to provide the added value of provider feedback that could be useful in further development of operational definitions of measures.
- Each hospital continues to report its data to NHSE, review its own dashboards, and compare results across the CHA member hospitals.




NHSE's presentation of data on charts showing standard deviations (SD) allows trusts to see when they have a result that's an outlier compared to other hospitals for that reporting period.

### What is the UK Children's Hospitals Alliance?

The UK Children's Hospitals Alliance (CHA) is a group of 11 hospitals[4] in England that provide specialist paediatric care. This executive member group is self-organising, with a range of evolving work streams, including paediatric healthcare tariffs, models of care, and benchmarking.

### What are Specialised Services Quality Dashboards?

The Specialised Services Quality Dashboards (SSQDs) are NHS England (NHSE)-run dashboards of metrics agreed by Clinical Reference Groups. Specialist trusts are required to submit data for the SSQDs through an online portal, usually quarterly, to enable commissioners to monitor performance across process, safety, outcome and experience. Currently, the reports are not publicly available. Each trust receives its reports back via the portal, and each shows the specialty averages across centres for the reporting period, as well as outer limits to three standard deviations.[5]

[3] Of the Women's and Children's Programme of Care: https://www.england.nhs.uk/commissioning/spec-services/npc-crg/spec-dashboards/

[4] Alder Hey; Birmingham; Manchester; GOSH; GSTT Evelina; Leeds; Sheffield; Newcastle; Bristol; Southampton; Oxford John Radcliffe

[5] Learn more about standard deviation at: https://en.wikipedia.org/wiki/68–95–99.7_rule



### What the data shows

Number of paediatric hospitals involved: **11**

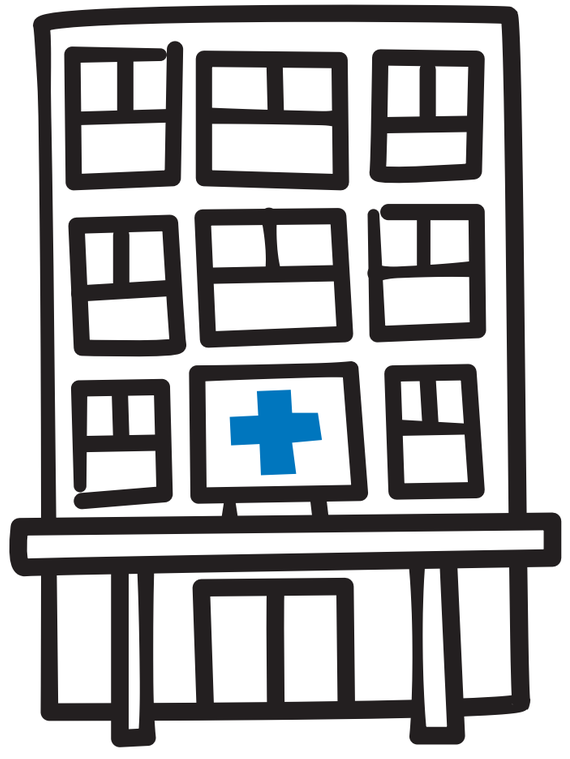
Number of metrics in the pilot: **126**

### What's going to happen next?

- The next national working group is planned for July 2020, hosted by Birmingham Children's Hospital.
- Two doctors from the Evelina Children's Hospital, who are members of the working group, are preparing raw data and discussion points about what we have learned from five years of SSQD data through the lens of the benchmarking pilot. This will be presented and discussed at the next working group and will lead to a full report.
- Ongoing collaboration with NHSE.

### How this benefits patients

- Collaboration with other specialist trusts opens up opportunities to share best practice in paediatric care.
- Cross-organisational comparison of relevant data helps us to identify areas of excellence and areas for improvement.



### What is benchmarking?

Benchmarking is the act by organisations of comparing their business processes and outputs, and learning from the successful practices of others. In specialist healthcare, the systematic measurement and peer comparison of our processes and outcomes can provide a powerful driver for continuous improvement in care.

**"While GOSH is leading on this benchmarking pilot, the strength of this project is in the peer collaboration and combined expertise. Together we are capable of using data for improvement in ways that would not be possible individually."**
Clinical Outcomes Development Lead, Haemostasis Lead Scientist, Coagulation Laboratory (Camellia Botnar Laboratories)

**"Benchmarking against other equivalent intensive care units at quarterly intervals allows us to see regularly how we are performing relative to our peers. Being able to see the detail of that at hospital level for the first time has been vital in better understanding our position and where we can make improvements."**
Consultant Neonatalogist

# Experience

## Implementing a system to receive patient, parent and carer feedback in real time

We wish our patients and their families to have the best possible experience of our treatment and care, it is therefore vital we use their feedback to continually improve our services.

### What we said we'd do

Patients and families told us that they would like to a choice in how they provide feedback to the Trust. In response to this, the Patient Experience Team launched new feedback software in 2018 which allowed patients and families to submit feedback online at a time that was suitable for them. During the early stages of this project, we further understood that children and young people in particular would like a more interactive way of providing their views to the Trust.

### What we did

There were no existing feedback systems on the market at that time which met the Trust requirements. Our current supplier offered to work in collaboration with the Trust and our Young People's Forum (YPF) to develop the existing software to make it more interactive, thus enabling and encouraging young people to provide their feedback.

It was vital that the surveys could utilise emojis and child and young person friendly attitude scales. This would allow our younger patients, who form a large part of our patient demographic and those patients and families with learning disabilities to also be able to provide feedback.

In early 2020 the new survey module had been finalised. This allows the Patient Experience Team to use pictures and emojis rather than producing text only surveys. The original plan was to also include audio to accompany the survey, however this has not yet been possible, but we hope this will be rolled out at a later stage.

In addition, the YPF were keen that the surveys could advise patients and their families which improvement initiatives were being carried out at the Trust as a result of feedback already received at Great Ormond Street Hospital. The new module allows us to add improvement updates to each survey, so this is communicated directly to the person completing the feedback.

It was essential that the data received from these surveys could be stored alongside the other data collected by the Patient Experience Team, including the Friends and Family Test data. This allows for easier interrogation of the data, structured follow up of the negative comments, thematic analysis of all the feedback received across the Trust and comprehensive action plans as a result of the feedback. This has been successfully implemented and the full survey module went live at Great Ormond Street Hospital in April 2020.

### What the data shows

Due to the current situation with Coronavirus (COVID-19), we have not yet been able to test the surveys with patients and families, however this will be carried out as soon as soon as possible.

### What's going to happen next

The next phase of the project will enable the Patient Experience Team to send the surveys external to the Trust environment. This is planned for late 2020, early 2021. Furthermore, we will continue to work with the software designers to continually improve the survey module as a result of further input from the patients and families at the hospital.

**"Knowing that GOSH is listening to my feedback and doing something with it will make me want to feedback more."**
YPF Member

**"It is really important to know my views are making a difference to the hospital."**
YPF Member

**"One size will not fit all, we need to create a tool that is engaging and for multiple age groups, audiences and needs."**
Software designer after meeting with the YPF.



## Support our staff's perception of emotional burden and resilience through the introduction of daily debriefing.

At GOSH, we are committed to improving the access and types of support available to staff recognising the emotional demands of working in an environment with complex patients.

Recognising the emotional burden being described by nurses on our long term gastroenterology ward (Squirrel Ward), combined with increasing sickness levels and voluntary turnover rates there was a clear need to offer a differing method of staff support to the monthly sessions already on offer to the team.

The Royal College of Nursing (RCN) recognise that debriefing can reduce the possibility of psychological harm by talking about what has happened; facts can be shared, misconceptions corrected, as well as fair and valid observations taken on board. It provides a valuable opportunity to share thoughts, feelings and experiences.

### What we said we'd do

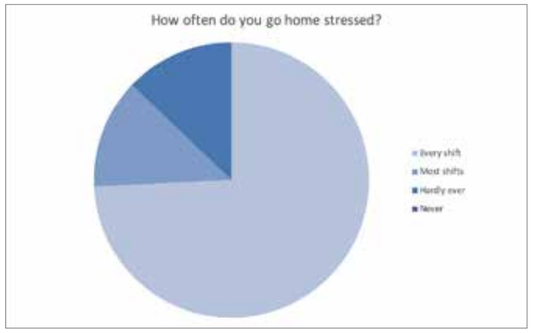
We said that we would be committed to supporting the staff caring for these complex patients and that we would focus on methods that could allow a separation of/and better work life balance. Recognising that daily debriefing is a well-established tool in psychiatric nursing and in GOSH on our inpatient psychiatric ward it was felt this was a potential project that we could adapt and spread to gain the known benefits across physical health wards.

### What we did

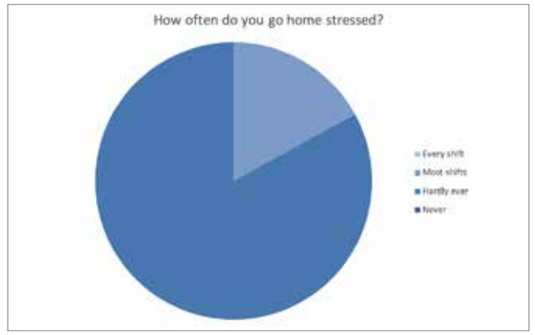
We surveyed our staff across Squirrel, this was anonymised and demonstrated a clear need for debriefing. We then utilised our mental health colleagues, firstly to promote the benefits and then to support the roll out. We attended staff team days to promote our intended project and worked up an audit plan with the QI team to monitor the effects. We paused after one month to take on board suggested adjustments such as timing, location and structure. After two months we re-surveyed the team to monitor the effects.

During the project we safeguarded the staff in the recognition of when would more support be required and how to escalate this. We recognised that there were many good shifts but that even on these the momentum needed to be maintained and that missing days led to risk of returning to old practices, therefore prompts were developed for reflection and sharing of praise and gratitude.

### What the data shows




**Pre-survey**
75% went home after every shift stressed, 13% most shifts and 13% hardly ever.




**Post-survey**
83% hardly ever went home stressed and 17% went home stressed after most shifts.

**What is debriefing**

Debriefing was developed as an approach for people working in environments that expose them to stressful incidents. The aims are to help in the processing of thoughts and emotions arising from their work. Debriefing is a simple yet effective tool for a team to bond, self-correct and enhance their performance.

**"A great way of strengthening the team and enhancing working relationships."**
Staff feedback

**"My favourite thing about debriefs is it allows me to keep my work and personal life separate."**
Staff feedback

**Observations during the project by project team**

- In general, ward staff seemed to value the opportunity to talk with their team in a private space.
- Ward staff seemed more willing to gather for a debrief when it was initiated by the Ward Sister or Nurse in Charge.
- On two occasions, ward staff gathered for a debrief but once in the room one staff member said they had nothing to discuss and the others agreed.
- Gathering for debriefs in the IV/drug room meant that it was difficult to avoid being disturbed, as doctors, pharmacists etc. could walk in.
- When concerns or issues were raised, questions asked by the NIC or Ward Sister such as; 'what could have been done differently', 'could allocation have been better', etc. appeared to prompt further discussion and appeared to be received positively by the other staff.
- Action plans initiated by the staff member leading the debrief e.g. 'I will discuss the concerns you have raised with X and will get back to you' seemed to be received positively by staff.

**Suggestions occurring through the project**

- Debrief 'champions' to prompt and promote gathering of the team at 4pm each day.
- Introduction of a debriefs prompt card to provide structure to the debriefs on occasions where discussion does not start naturally.
- Debriefs to be held in a room where staff can sit down and where they are less likely to be interrupted.
- Timing altered to 4pm from original 6pm.

**"I find these useful. Encourages honesty about what could have been better. Able to speak openly."**
Staff feedback

**"A good way of reflecting on the days events."**
Staff feedback

**"I would say that debriefs is one of the most important spaces on MCU. The best thing I would say is that you can share the difficulties, worries and the positive things of you day with the rest of the team and feel understood and supported."**
Staff feedback

## What's going to happen next

Commitment to continue to share the simplicity yet positivity of this tool. Recognising that we debrief after major events is common place yet we have failed previously to acknowledge the day to day pressures contribute to stress, emotional fatigue and burnout in nursing and to provide support accordingly.

Rolled out across other medical and surgical areas in the Body, Bones and Mind group with similar results seen or expected. Provision of longer monthly support to be provided and facilitated by psychology teams who in our areas have always demonstrated dedication to allowing reflective space for the MDT. Adaptation of the MIND going home checklist as a further provision to aid separation of work and home life.

## How this benefits patients

Patient care at GOSH is becoming increasing complex, the recognition of the technological and physical aspects of care are easier to quantify, more challenging is the social and emotional complexities and its impacts on teams.

Debriefing helps staff to engage in true reflective practice, to scrutinise, self-correct and seek practical solutions. It strengthens team working and supports frontline staff experiencing difficult situations. Debriefing is key to improving both patient safety and care, in creating a non-judgemental reflective workforce that are dedicated to enhancing future performance. Resilience of teams is enhanced, sickness and turnover are potentially improved although not formally measured in this project ensuring patients access to expert practitioners at the point of care.

**Gabriel** is eight years old and has been coming to GOSH every week since he was diagnosed with acute lymphoblastic leukaemia – a rare type of childhood cancer. He loves singing and tickles from his Mum.

# Quality priorities for 2020/21

The following tables provide details of three of the quality improvement projects that the Trust will undertake in 2020/21.

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 Council of Governors, 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? |
|---|---|---|
| Improving medicines safety | Through thematic analysis of Datix, listening to our staff, and through the most recent CQC report, we are clear on the need for improvement in the safety, patient experience and efficiency of our medicines management.<br><br>A multi-stranded programme of improvement is currently being finalised and initiated that will include:<br>• Safer medicines administration.<br>• Strengthened processes and teaching on storage, administration and disposal of controlled drugs.<br>• Safer stock management of medication, including storage and destruction.<br>• Reduction in the number of uncollected medications in the Pharmacy Dispensary, aiming to improve the dispense time to within 1 hour of patient 'checking in' at Pharmacy outpatients.<br>• Optimisation of Pharmacy modules in Epic for ease of use and alignment with workflows. | • Reduced severity rating of medicine Datix reports.<br>• An online program development covering all the specifics of the medicines policy.<br>• Regular audit cycles of the specifics of the medicines policy.<br>• A completed QI programme for outpatient prescribing and dispensing.<br>• Out-patients waiting times of <1hr.<br><br>Completed QI programme for ward pharmacy process in EPIC assessed against: staff satisfaction, Lean workflow modelling and reduced re-dispensing.<br><br>This programme is supported by the Deputy Medical Director for direct executive team engagement and oversight. |

## Clinical effectiveness

**To consistently deliver excellent clinical outcomes, to help children with complex health needs fulfil their potential.**

| Improvement initiative | What does this mean and why is it important? | How will progress be monitored, measured and reported? |
|---|---|---|
| Improvement of patient documentation in Child and Adolescent Mental Health Services (CAMHS). | Through staff feedback and the most recent CQC report, we are aware of the need for improvement of patient documentation in our EPR system so that staff can record, update and find patient records promptly.<br><br>In recent months, there have been changes to nursing documentation and flowsheets in Epic to improve fit, and the EPR link analyst for CAMHS is working with the team to arrange additional training around clinic letters.<br><br>This refining work is ongoing and will have benefit not only to the Mildred Creak Unit but also across CAMHS services.<br><br>We plan to:<br>• Improve recording of consent and competence and ensure that these are accessible on the electronic record.<br>• Improve the layout of the electronic record to make it easier to navigate e.g. a drop down tab for 'Core team minutes'<br>• Add suitable templates for meetings eg Ward round, Review meetings, and correspondence e.g. Short and Long Discharge Summaries<br>• Improve the recording of Risk Assessments with a suitable template, including adequate free space for documentation/comments. | Progress will be reviewed regularly over the next 12 months.<br><br>Measures missing |

## Experience

**To deliver kind and compassionate care, and communicate clearly to build confidence and ease.**

| Improvement initiative | What does this mean and why is it important? | How will progress be monitored, measured and reported? |
|---|---|---|
| Improving the hospital care and experiences of children and young people with learning disabilities (LD), Autism and/or additional needs through four interconnected workstreams.<br><br>Unless stated otherwise, progress of each of the four LD initiatives will be monitored through Patient and Family Experience and Engagement Committee (PFEEC) and the Family, Equality and Diversity (FED) Group as well as a Disability Forum including staff and parents that will be established as part of this work. | **Workstream 1**<br>Improve staff competence and confidence to deliver individualised care to patients with LD/Autism through a comprehensive and targeted programme of staff training. The programme will, a) Expand our existing Simulation Training, b) Co-produce with patients and/or their parents Mandatory LD Awareness Training ready for delivery from April 21, c) Source external Positive Behaviour Support Training and, d) deliver bespoke training for particular specialties, wards, and professional groups. Accompanying the training will be a programme of awareness about raising the needs of our patients with LD/Autism with the aim of developing and sustaining culture in which issues related to LD/Autism are embedded in everything that we do.<br><br>**Workstream 2**<br>Increase focus on safety of patients with LD/Autism through, a) improved processes for flagging and tracking these patients on EPIC, b) developing a risk assessment tool, c) reviewing hospital space and, d) fostering a culture of openness and honesty about their care, working with our Patient Advice and Liaison Service, Complaints Team and Patient Safety Team to ensure our recording and monitoring processes are accessible and designed to capture both incidents and near misses and facilitate shared learning and feedback to staff and families.<br><br>**Workstream 3**<br>Increase involvement of patients with LD/Autism in making decisions about their care and planning services through, a) increased availability and use of communication resources throughout the hospital and, b) increased engagement through a coordinated plan of activities and feedback sessions developed in conjunction with the Patient Experience Team. | **Workstream 1**<br>• Numbers/range of staff completing LD Simulation Training.<br>• Co-production of LD Mandatory Awareness Training.<br>• Procurement of external training in Positive Behaviour Support.<br>• Perception of staff competence and confidence captured informally through discussions with a range of staff, and formally through training evaluation forms, staff LD question box, staff survey.<br>• Evaluate feedback from staff, parents and CYP with LD through multiple forums and mechanisms about 'our values'.<br><br>**Workstream 2**<br>• An audit of, a) the number and accuracy of LD flags applied on patient records, complaints and Datix and, b) the issues raised and the process of learning from these and reporting back to staff/parents.<br>• An audit of staff awareness and knowledge regarding the use, documentation and reporting of restraint<br>• Risk assessment tool development will be monitored through regular research team meetings, a study steering committee, and reports to the funders.<br>• An audit of the number of quiet, safe spaces within the hospital and their use, including feedback from families.<br><br>**Workstream 3**<br>• Number and accessibility/ appropriateness of communication resources available.<br>• Evaluation of staff awareness, knowledge of and confidence to use communication resources in practice.<br>• Feedback from families about the accessibility and suitability of engagement activities in place (Year 1), with examples of changes in practice (Year 2). |
| | **Workstream 4:** Improve the hospital experience for patients with LD/Autism and their families through the use of an accessible patient reported experience measure (PREM) purposefully designed for CYP with LD to ensure their views are captured ready for Trust-Wide use in 2021. We will evaluate qualitatively whether input from the LD team, in conjunction with music therapy, can reduce pre-op anxiety and improve hospital experience for patients seen in the anaesthetic pre-op clinic.<br><br>We will introduce a sensory toy library to ensure increased accessibility to sensory equipment and equitable provision to patients with LD across the Trust within and outside of 'normal working hours'.<br><br>**Our training programme is responsive to:**<br>**1. Latest Research Evidence**<br>Data from a 3-year national study of the equality of hospital care for CYP with LD led by GOSH (Oulton et al. 2018) revealed that hospital staff a) feel less confident and capable to identify and meet the needs of CYP with LD compared to CYP without LD, b) feel that children with LD are less safe in hospital than children without LD, including in relation to the environment being safe for meeting their needs, c) feel that children with LD are significantly less involved than children without LD in decisions about their care and in planning services and, d) feel that children with LD are valued less and treated with less dignity and respect that children without LD.<br><br>**2. Direct parent feedback**<br>That the Trust could and should be doing more to ensure that staff value CYP with LD and their families equally and that their particular needs are being identified and met in a timely manner.<br><br>**3. Current NHS LD Standards**<br>- Staff having to be trained and then routinely updated in how to deliver care to people with LD/Autism.<br>- Trusts must have mechanisms to identify and flag patients with LD/Autism from the point of admission through to discharge; and where appropriate, share this information as people move through departments and between services.<br>- Trusts must demonstrate that they learn from complaints, investigations and mortality reviews, and that they engage with and involve people, families/carers throughout these processes.<br>- Trusts must demonstrate that they co-design relevant services with people LD/Autism.<br>- Trusts must have measures to promote anti-discriminatory practice in relation to people with LD/Autism.<br>- Trusts must compare outcomes and experiences of people with LD/Autism with those of non-disabled peers.<br><br>This is a Trust wide programme focused on developing and sustaining a healthcare culture that enhances safety, reduces risk and promotes equality for CYP with LD/Autism. | **Workstream 4**<br>• a) The successful introduction of sensory toy library (Year 1) b) Evaluation of how, where, when and by whom the sensory toy library is used, as well as costs and issues (Year 2).<br>• Development and piloting of PREM in at least one inpatient and outpatient setting, including analysis of process to identify what is working well and what improvements are needed.<br>• Use PREM with CYP with LD attending anaesthetic pre-op clinic to assess impact of music therapy and LD Nurse input (Year 2). |

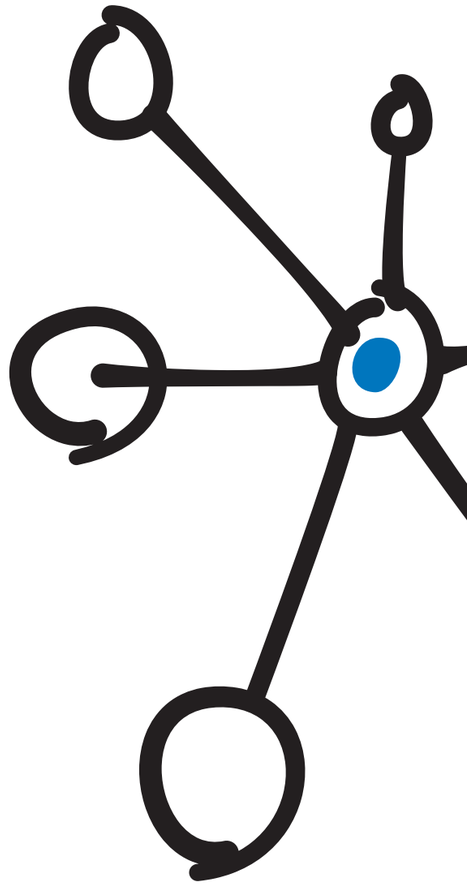
**Tulsi** had delicate spinal surgery at GOSH within hours of being born. Her mum Laxmi says: "Tulsi is doing really great. She's crawling, standing up, and she loves going to play group."



# Part 2b:
# Statements of assurance from the Board

This section comprises the following:

- 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
- Priority clinical standards for seven-day hospital services
- Promoting safety by giving voice to concerns
- Reducing rota gaps for NHS doctors and dentists in training



## Review of our services

During 2019/20, GOSH provided and/or sub-contracted 61 relevant health services. The income generated by these services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant services by GOSH for 2019/20. GOSH has reviewed all the data available to us on the quality of care in our 61 services.

In order to ensure that we maintain excellent service provision, we have internal processes to check that we meet our own quality standards and those set nationally. These processes include scrutiny by committee. One example is our Quality, Safety and Experience 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. Our structure can respond to our improvement needs. For example, our recent NHS Staff Survey results have prompted the development of a comprehensive People Strategy and a new committee, the People and Education Assurance Committee to monitor its delivery.

## Participation in clinical audit

**Participation in National Clinical Audit**
During 2019/20 12 national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. The Trust has participated in them all and data submissions have been outlined below.

| Name of national audit / clinical outcome review programme | Cases submitted, as a percentage of the number of registered cases required |
|---|---|
| Cardiac arrhythmia (NICOR: National Institute for Cardiovascular Outcomes Research) | 220/220 (100%) |
| Congenital heart disease including paediatric cardiac surgery (NICOR: National Institute for Cardiovascular Outcomes Research) | 1290/1290 (100%) |
| Diabetes (Paediatric) (National Paediatric Diabetes Association) | 53/53 (100%) |
| Inflammatory Bowel Disease (IBD) Registry (British Society of Gastroenterology, The Royal College of Physicians, and Crohn's and Colitis UK via IBD Registry Ltd) | 156/156 (100%) |
| Learning Disability Mortality Review Programme (LeDeR) | 10/10 (100%) |
| Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) | 16/16 (100%) |
| National Cardiac Arrest Audit (ICNARC: Intensive Care National Audit and Research Centre) | 11/11 (100%) |
| National Neurosurgical Audit Programme | Data is collected from mandatory Hospital Episode Statistics rather than submitted. |
| National Confidential Enquiry into Patient Outcome and Death NCEPOD (Long Term Ventillation) | 13/17 (76%) |
| Paediatric Intensive Care Audit Network (PICANet) | 1760/1760 (100%) |
| Serious Hazards of Transfusion (SHOT) (UK National Haemovigilance Scheme) | 16/16 (100%) |
| UK Cystic Fibrosis Registry (Cystic Fibrosis Trust) | 190/190 (100%) |

**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.'[6]

[6] https://www.england.nhs.uk/ourwork/qual-clin-lead/clinaudit/

**National clinical audit reports**
The following national clinical audit reports and data were published from mandatory national audits in 2019/20:

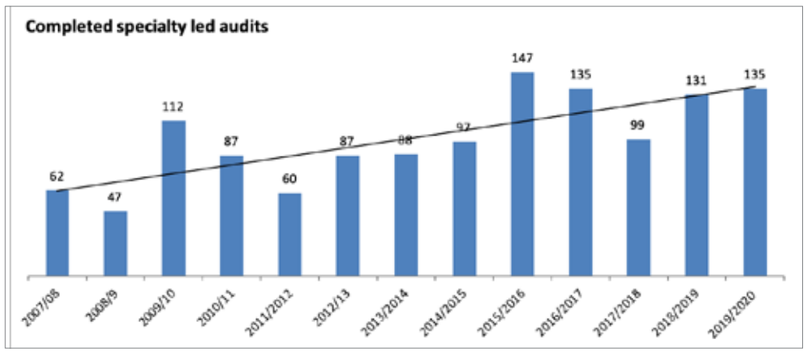
| Name of national audit/clinical outcome review programme | Relevance to GOSH practice |
|---|---|
| Congenital heart disease including paediatric cardiac surgery (NICOR: National Institute for Cardiovascular Outcomes Research) | The 30-day survival rate for paediatric cardiac surgery is a nationally accepted benchmark that is used to judge outcomes. Predicted patient survival is determined for all centres using a calculation called PRAiS2, which adjusts for procedure, age, weight, diagnosis, and co-occurring conditions (co-morbidities).<br><br>GOSH perform the highest number of surgical episodes in the UK and Ireland. In the three years 2015/16 to 2017/18, there were 1,812 cardiac operations performed in our unit, of which 99.3% of patients survived to 30 days. Based on the confidence limits selected by the National Congenital Heart Audit (NCHDA), our risk-adjusted survival rates for paediatric cardiac surgery are defined as 'much higher than predicted'. More information about this can be found on the Cardiothoracic clinical outcomes page on the Great Ormond Street Hospital website.[7] |
| Diabetes (Paediatric)<br><br>(National Paediatric Diabetes Association) | The 2018/19 NPDA national audit report was published in March 2020. It focuses on the measurement of care for type 1 diabetes. GOSH submitted data for 53 children and young people with diabetes in comparison to 48 in the previous year. GOSH does not have sufficient numbers of typical type 1 diabetes to allow comparison of data in the report. 17% of GOSH cases included in the audit have complex forms of Type 1 diabetes, this is in comparison to 97.4% of standard Type 1 and Type 2 diabetes in other centres. 83% of GOSH cases included have rare forms of diabetes. |
| Inflammatory Bowel Disease Registry | The IBD registry report quarterly data, the most recent report was received at the end of January 2020. There is not significant paediatric data included in the report to allow measurement of GOSH practice against the national data.<br><br>The Gastroenterology Service GOSH participates in Improve Care Now, an international collaboration between Paediatric Gastroenterology centres. The collaboration benchmarks improvement in quality and monitors clinical outcomes for children with inflammatory bowel disease. As part of the Improve Care Now initiative, GOSH monitors specific IBD outcome measures and have routinely collected data since 2011. These data include outcomes relating to disease remission rates, nutrition and growth for the children we treat. More information about this can be found on the Gastroenterology clinical outcomes page on the Great Ormond Street Hospital website.[8] |
| Learning Disabilities Mortality Review (LeDeR) Programme report | The third LeDeR annual report was published on 21 May 2019. It gave 12 recommendations based on the evidence from deaths notified to the programme between July 2016 and December 2018. The report has been reviewed by the Consultant Nurse for Learning Disabilities. The following actions are in place which address the report recommendations<br><br>**LeDeR process**<br>1. Continue process of identifying children/young people with LD at child mortality review meetings and reporting to LeDer.<br>2. Review process of flagging children with LD on EPIC to ensure it is comprehensive and accurate.<br><br>**Staff training**<br>1. Develop and deliver Learning Disability Awareness Training for all staff and engage with NHS England regarding forthcoming mandatory LD training.<br>2. In conjunction with the Lead for Mental Capacity, review training about mental capacity and audit mental capacity assessments and best interest decisions.<br>3. In conjunction with the Pain team, review information for staff about pain assessment for children/young people with LD.<br><br>**Provision of reasonable adjustments**<br>1. Identify children, young people and parents with LD who require reasonable adjustments.<br>2. Record adjustments required.<br>3. Audit provision of adjustments.<br><br>**Palliative care**<br>1. In conjunction with the Palliative Care Team Review provision of end of life care plans for children/young people with LD.<br><br>The LD programme at GOSH is monitored via the Patient and Family Experience and Engagement Committee. A Disability Forum, comprising parents and professionals is also in the process of being established, which will provided a further level of oversight. |

[7] https://www.gosh.nhs.uk/health-professionals/clinical-outcomes/cardiothoracic-clinical-outcomes
[8] https://www.gosh.nhs.uk/health-professionals/clinical-outcomes/gastroenterology-clinical-outcomes

| Name of national audit/clinical outcome review programme | Relevance to GOSH practice |
|---|---|
| National Cardiac Arrest Audit (NCAA)<br><br>(ICNARC (Intensive Care National Audit & Research Centre)). | The NCCA publish quarterly reports at organisational level to support benchmarking and to identify trends to inform practice and policy on both a local, and national level. GOSH has not had sufficient cardiac arrests in the 2019/20 to allow benchmarking in the reports. The Annual Report should be published in 2020/2021. Once published this will be reviewed via the Resuscitation Committee to identity any trends and to determine any actions required in response to the report |
| Paediatric Intensive Care Audit Network<br><br>(PICANet) | The primary outcome measure used in Intensive Care Units (ICU) is the survival rate for patients, measured at the time when they are discharged. 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.<br><br>The most recent PICANET report compares Trusts Standardised Mortality Ratio[9] for the calendar years of 2016–18.The data in this report shows GOSH mortality as within what would be expected based around the case mix. More information about this can be found on the Intensive Care Unit clinical outcomes page on the Great Ormond Street Hospital Website.[10] |
| National Confidential Enquiry into Patient Outcome and Death (NCEPOD)<br><br>*Balancing the Pressures A review of the quality of care provided to children and young people aged 0-24 years who were receiving long-term ventilation.* | The report was published in March 2020 and highlights remediable factors in the care provided to people who were receiving, or had received, long-term ventilation (LTV) up to their 25th birthday.<br><br>The report highlights five key areas of focus at a national level<br>• Service Planning And Commissioning Of Integrated Care<br>• Multidisciplinary Care<br>• Emergency Healthcare Plans<br>• Discharge Planning<br>• Transition From Child To Adult Services<br><br>The report has been reviewed by the Respiratory team at GOSH, and any specific actions required at GOSH will be confirmed by the team in the next six months. |
| UK Cystic Fibrosis Registry (Cystic Fibrosis Trust) | The 2018 Cystic Fibrosis report was published in 2019/20 and includes data about individual cystic fibrosis centres, to help the centres benchmark themselves against their peers.<br><br>The data shows that GOSH results for key clinical outcomes are within expected variation. More information about this can be found on the Cystic Fibrosis clinical outcomes page on the Great Ormond Street Hospital Website.[11] |

**Specialty led Clinical Audit**

A total of 135 clinical audits led by clinical staff were completed at GOSH during 2019/20. To promote the sharing of information summaries of completed projects are published on the Trust's intranet, and reports of clinical audit activity are shared with the Patient Safety and Outcomes Committee. Our long-term data suggests we are encouraging a culture of sharing our specialty led clinical audit activity.




In this report it is not possible to list every clinical audit completed in 2019/20 that has had a positive impact on quality and safety. A summary of completed clinical audits in 2010/20 can be obtained on request by contacting the Clinical Audit Manager on 0207 405 9200 ext 5892 or at **clinical.audit@gosh.nhs.uk**.

[9] Standardised Mortality Ratio (SMR). The SMR is the ratio of observed deaths in the ICU compared to the expected number of deaths based upon the PIM3r score: the SMR is calculated periodically and is used as a method of benchmarking the outcomes between ICUs nationally via PICANET.

[10] https://www.gosh.nhs.uk/health-professionals/clinical-outcomes/intensive-care-unit-clinical-outcomes

[11] https://www.gosh.nhs.uk/health-professionals/clinical-outcomes/cystic-fibrosis-clinical-outcomes



**Clinical Audit and Quality Improvement prize**

This event was run to celebrating the excellent clinical audits and QI projects led by GOSH staff. This year we had 20 entries – double the amount we had last year when we first ran the prize.

| Winner | Runners up | |
|---|---|---|
| **Implementing Thromboprophylaxis**<br>Hannah Lewis, Sarah Heikal, Victoria Buswell, Helen Hume-Smith | **Can we reduce the isolation time and testing for children following acute respiratory viral infection?**<br>Zainab Golwala, Tim Best, John Hartley | **Pelican Ward Improvements Throughout 2019**<br>Carole Campbell/team |
| Date collection started in May 2019. 68% of cases reviewed had mechanical thromboprophylaxis applied when indicated. Changes made:<br><br>"Guidance was simplified. Education sessions were provided for staff. A visual prompt was built into the electronic patient theatre checklist to appear when TED stockings are indicated. TED stocking length was standardised throughout the trust."<br><br>Re-measurement showed 96% and 92% correct application of TED stockings. | Identified a large number of children are maintained in isolation unnecessarily.<br><br>A new risk stratified policy will be written based on the learning from the audit. | Improvements in nursing handover and the ambulatory pathway.<br><br>"Sepsis and PEWS escalation on the ward required improvement. We implemented a consistent programme of SIMS sessions on Pelican ward and have utilised having BMT sharing the ward to upskill the nursing team with more acute patients. Our datix numbers regarding escalation of care have significantly reduced during 2019." |

The winner and runners up were announced at the Senior Leadership Team meeting in March 2020.

Andrew Pearson, Clinical Audit Manager presenting the Clinical Audit Prize to Dr Hannah Lewis at the GOSH Senior Leadership Team meeting on the 5th March 2020.

## 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.

**Implementation of the Child Death Review Statutory Guidance**
The guidance outlines the statutory NHS requirements for child death reviews for all child deaths occurring after 29 September 2019. This requires a Child Death Review Meeting (CDRM) that is a multi-professional meeting where all matters relating to a child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death. To support this GOSH a Medical Lead for Child Death Reviews has been appointed and a Child Death Review Coordinator has been recruited within the Bereavement Services Team.

Case record reviews take place through two processes at GOSH:

1. **Mortality Review Group (MRG):** This was established in 2012 to provide a Trust level overview of all deaths to identify 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 inpatient deaths in the Trust. This group continues to review deaths to ensure a thorough level of review and challenge can be provided before reviews are finalised at a Child Death Review Meeting (CDRM), as well as identifying learning points and making referrals to other safety investigation processes at the earliest opportunity.
2. **Child Death Review Meetings (CDRM):** These are now in place at GOSH.

**Deaths in 2019 and case record reviews**
Between 1 January 2019 and 31 December 2019, 114 children died at GOSH. 112 of these those deaths have been subject to a case record review .

1. One death has not been reviewed by the MRG/CDRM as a Serious Incident Investigation and Coroner's case is in process. This in line with the Child Death Review Statutory Guidance which indicates that CDRMS should take place following the completion of necessary investigations and reviews.
2. One death from December 2019 will be reviewed in April 2020, the review was delayed due to logistical difficulties in arranging the meeting.

Of the 114 deaths, four had modifiable factors in the care provided at GOSH that may have contributed to vulnerability, ill health or death.

| 2019 | Jan–Mar | Apr–Jun | Jul–Sep | Oct–Dec | Total |
|---|---|---|---|---|---|
| **Number of deaths** | 29 | 31 | 27 | 27 | **114** |
| **Deaths where modifiable factors around GOSH care were identified** | 2 | 0 | 2 | 0 | **4** |

### What are modifiable factors?

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.

An influence score offers an interpretation of the extent to which a factor may have contributed to the death of the patient.

### What is the Child Death Overview Panel (CDOP)?

The CDOPs are statutory bodies that review the deaths of all children who die in the UK. The death is reviewed by the CDOP where the child is resident, so GOSH liaises with multiple CDOPs.

**Learning from clinical case reviews**
The learning points from case record reviews and actions taken are shared via quarterly Learning from Deaths reports at the Patient Safety and Outcomes Committee, and at Trust Board. The Learning from Deaths reports highlight specific learning points and actions taken and are included in the public Trust board meeting papers that can be found online.[12]

| Learning from deaths in | Trust Board meeting discussed at |
|---|---|
| **Oct to December 2019** | Due to be reported 26th May 2020 |
| **June to Sep 2019** | Wednesday 1st April 2020 |
| **April to June 2019** | Wednesday 27 November 2019 |
| **Jan to March 2019** | Thursday 18th July 2019 |

Any Trustwide learning points and actions that require implementation are monitored via the Trust Closing the Loop Group.

**Actions taken following a Prevention of Future Deaths (PFD) Report.**
An inquest into the death of Amy Allan was heard in September 2019. The coroner determined that Amy had died as a result of multi-organ failure and that an elective operation in September 2018 set in train a sequence of events which led to her death. During the inquest evidence was presented which gave rise to concerns for the coroner and he issued a Prevention of Future Deaths Report.

- Lack of awareness and sharing of information between departments. In particular the PICU had not been given any advance warning of Amy's complex medical background.
- There was no clear plan or instruction for the management of Amy post operation in relation to extubation and ECMO support on the PICU.
- The handover between clinicians involved in Amy's operation and those taking over her care in the PICU was poorly executed with vital information either not properly conveyed or recorded or simply missed.
- Delay in commencing ECMO support.
- No single properly informed clinician appeared to be coordinating Amy's post operative care in such a complex and high risk case.

Following the inquest an action plan has been updated and expanded to include the learning from the inquest and the issues identified in the PFD. The actions are being followed up through Closing the Loop and the Quality Safety Experience and Assurance Committee

[12] https://www.gosh.nhs.uk/about-us/who-we-are/our-organisational-structure/trust-board/trust-board-meetings

## GOSH Bereavement Survey

The purpose of the survey is to learn from the experience of bereaved parents and carers whose children died at GOSH .This is to highlight what we do well, and also to identify areas where we can improve.

Eighty six children and young people died at GOSH in 2018. Eighty one families were contacted and responses were received from the families of 27 children who died at GOSH.

**Key findings**

The overall findings are positive and highlight:

- Families reported being able to approach the clinical team with questions about treatment, and being given regular updates about the treatment plan.
- All respondents recall being contacted by their child's medical team and offered a bereavement follow up meeting following the death of their child.
- Responses highlight the level of emotional and spiritual support offered by the whole GOSH team, including housekeepers, volunteers, palliative care, the chaplaincy and the family liaison nurses.
- The report outlines the bereavement support provided to families and children who needed bereavement support.
- Families who identified that they had faith and spiritual needs indicated that those needs were met.
- Families were asked; "What was helpful for you during your experience at GOSH?"
  The top themes identified were:
  - Overall experience of care and expression of gratitude for all that was done (11)
  - Nursing care and compassion (5)
  - Family Liaison Nurse support (4)
  - Chaplaincy (4)

**Areas for improvement**

- 18/28 (64%) of families advised that there was a discussion with them about the fact that the child was dying. Five cases where this didn't happen were unexpected deaths, and five were expected. This feedback highlights the need to ensure that discussions about the fact that a child is dying take place where it is possible.
- Families were not always aware of all internal and external mortality review processes when a child dies. It should be noted that The Child Death Review: Statutory and Operational Guidance became statutory in September 2019. Families are given the NHS England information 'When a child dies' in their bereavement packs, this explains the process and their key worker's contact details.
- Families were asked "What we could have done better to improve your experience?" There were two responses that indicated they felt less secure at weekends due to fewer staff being around. Two responses expressed regret that there was no Family Liaison Nurse in place at the weekend.

The survey findings were shared at the Patient and Family Experience and Engagement Committee. A specific action plan in response to this survey will be developed by the End of Life Care Group.



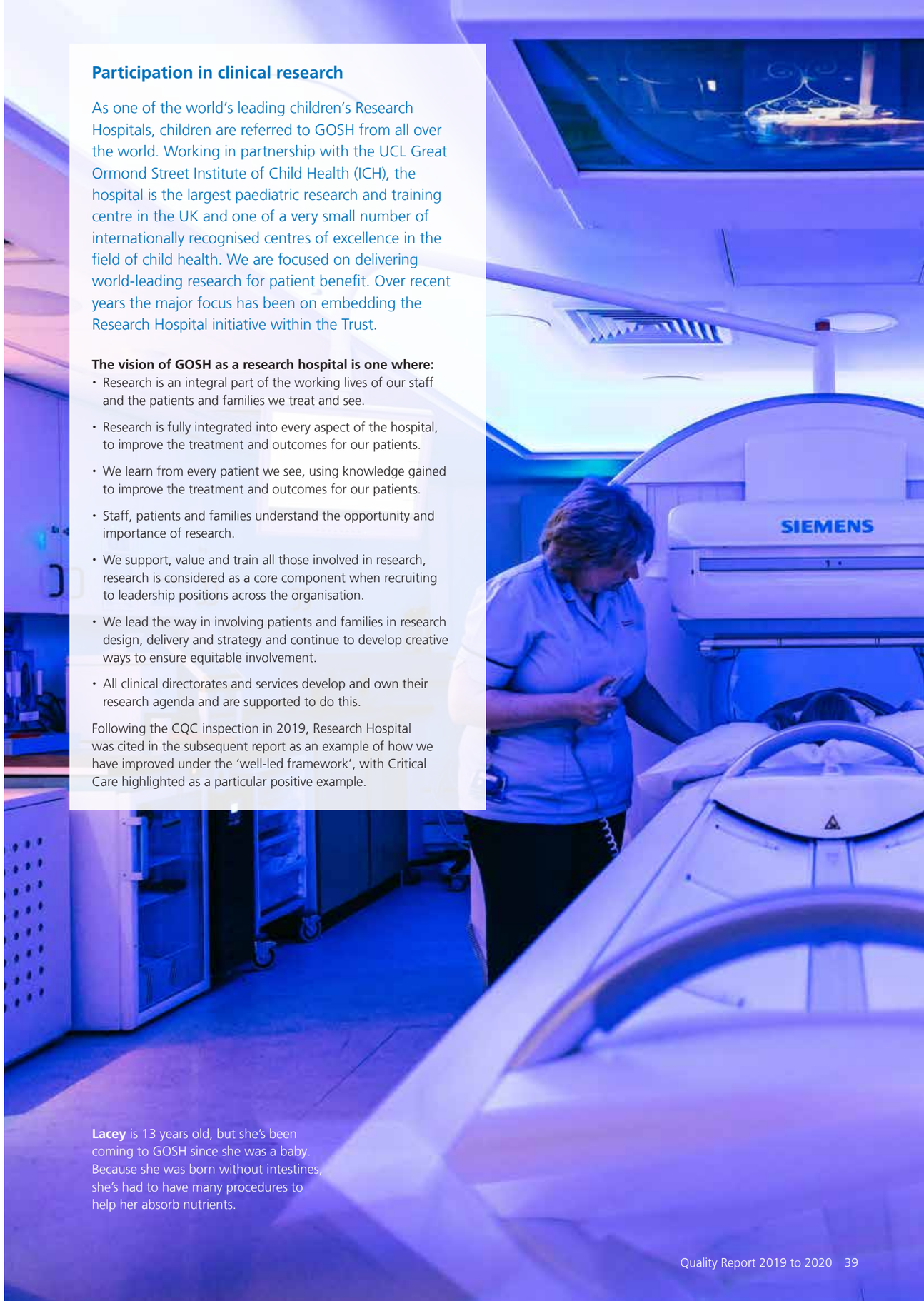
## Participation in clinical research

As one of the world's leading children's Research Hospitals, children are referred to GOSH from all over the world. Working in partnership with the UCL Great Ormond Street Institute of Child Health (ICH), the hospital is the largest paediatric research and training centre in the UK and one of a very small number of internationally recognised centres of excellence in the field of child health. We are focused on delivering world-leading research for patient benefit. Over recent years the major focus has been on embedding the Research Hospital initiative within the Trust.

**The vision of GOSH as a research hospital is one where:**

- Research is an integral part of the working lives of our staff and the patients and families we treat and see.
- Research is fully integrated into every aspect of the hospital, to improve the treatment and outcomes for our patients.
- We learn from every patient we see, using knowledge gained to improve the treatment and outcomes for our patients.
- Staff, patients and families understand the opportunity and importance of research.
- We support, value and train all those involved in research, research is considered as a core component when recruiting to leadership positions across the organisation.
- We lead the way in involving patients and families in research design, delivery and strategy and continue to develop creative ways to ensure equitable involvement.
- All clinical directorates and services develop and own their research agenda and are supported to do this.

Following the CQC inspection in 2019, Research Hospital was cited in the subsequent report as an example of how we have improved under the 'well-led framework', with Critical Care highlighted as a particular positive example.




**Lacey** is 13 years old, but she's been coming to GOSH since she was a baby. Because she was born without intestines, she's had to have many procedures to help her absorb nutrients.

## Research activity

During 2019/20, we have run 1,290 research projects at GOSH/ICH. Of these, 377 were adopted onto the National Institute for Health Research Clinical Research Network (NIHR CRN)[13] Portfolio, a prestigious network that facilitates research delivery across the NHS.

Our already extensive research activity has grown year-on-year with the support of our most recent NIHR Clinical Research Facility (CRF) and Biomedical Research Centre (BRC) awards, which began in April 2017. The overall trend for the CRF in 2019/20 is for fewer studies to be hosted, but these are of higher intensity with a higher proportion of trials being early-phase. The occupancy of the CRF remains high, though the number of overnight visits has decreased slightly due to studies transitioning out of the CRF and onto the wards.

In 2019/20, over 2,300 patients and family members took part in research at GOSH, approved by the Health Research Authority (HRA), including Research Ethics Committee and Medicines and Healthcare products Relatory Agency (MHRA) approval as appropriate. Recruitment for 2019/20 is substantially lower than the previous year due to both the end of recruitment to the 100,000 genomes project and the overall trend for fewer studies being hosted by the CRF, but these are of higher intensity which tend to have fewer participants. In addition, this year we transitioned to recording recruitment in the Trust's electronic patient record (EPR) Epic rather than in EDGE (a cloud-based clinical trials management programme). As a result, we are investigating reporting mechanisms to ensure that recruitment is being recorded correctly and that data is not being accidently overlooked.

GOSH leads the London North Genomic Laboratory Hub (GLH)[14], one of seven regional centres that are responsible for coordinating genomic testing in the NHS, consolidating and enhancing the existing laboratory provision. This will create a world class resource for the NHS and underpin the future Genomic Medicine Service. It will also support the delivery of the Government's Life Sciences Strategy and the broader research and innovation agenda, building upon the NHS contribution to the 100,000 Genomes Project[15]. The London North GLH will deliver genomic testing for 34 Trusts and CCGs across North Thames and parts of Hertfordshire and Essex, as well as 11 specialty services. It will host the rare and inherited disease laboratory, with somatic cancer testing being largely consolidated at the Royal Marsden. The new hub gives GOSH the opportunity to continue to lead in genomics, offering an excellent service to our patients, enabling further genomic research and embedding genomics in mainstream medicine.

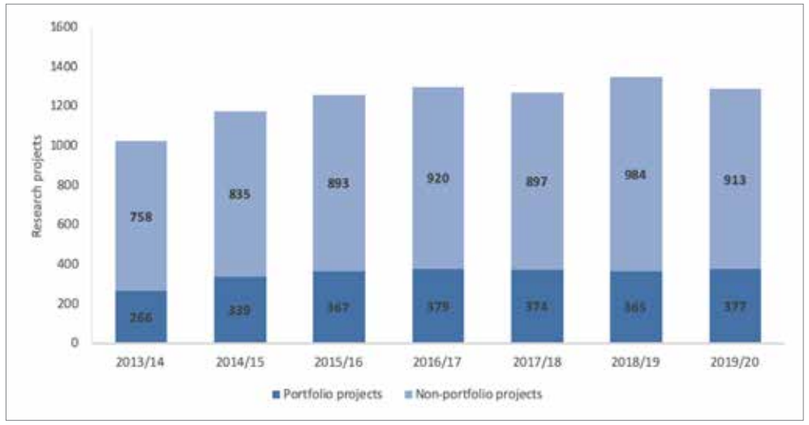



Figure 1: Number of research projects taking place at GOSH/ICH, highlighting the high-quality NIHR CRN Portfolio projects.

[13] https://www.nihr.ac.uk/explore-nihr/support/clinical-research-network

[14] https://www.england.nhs.uk/genomics/genomic-laboratory-hubs

[15] https://www.england.nhs.uk/genomics/100000-genomes-project



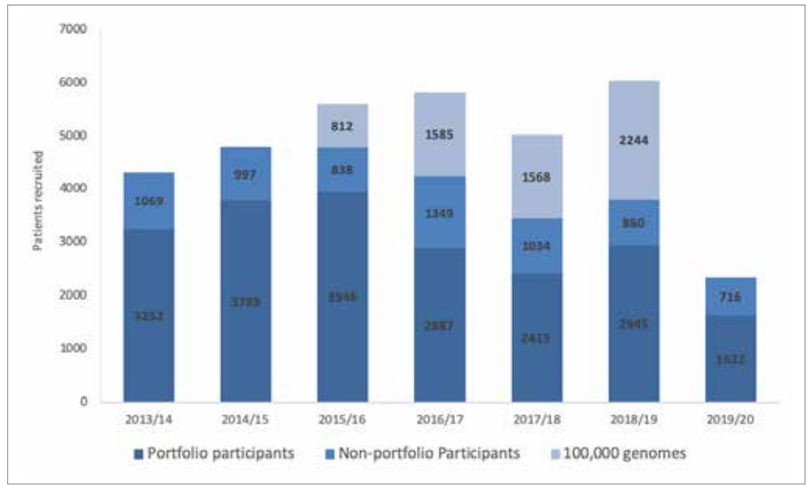



Figure 2: Number of research participants recruited at GOSH/ICH, highlighting the high-quality NIHR CRN Portfolio projects and those recruited to the 100,000 genomes project in previous years.

The Trust has made considerable progress against its objective to establish GOSH Sample Bank, a key project for achieving our Research Hospital vision. Launched to staff and patients/familes in October 2019, we are asking for consent to us retaining and storing surplus tissue, instead of these being discarded. We can then potentially use these samples, alongside associated clinical data, for future research.

The pilot completed its initial outpatient phase in September 2017, moving to the next phase (inpatients) in July 2018, with further areas beginning to consent in 2019. The pilot phase indicated that the principle for consenting to GOSH Sample Bank was generally accepted by patients and families but indicated the need for face to face discussion about the scheme.

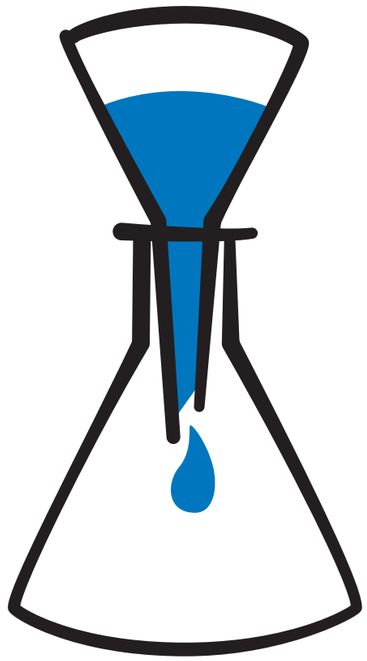
To assist our teams with this communication, our Digital team produced a short animation[16] to explain to patients what happens to their samples. We got invaluable input on this from both our Young Persons Advisory Group (YPAG) and Parent and Carers Advisory Group (PCAG), and the voiceover was provided by Sandra, a GOSH patient and member of YPAG.

## Funding

This year we saw an overall 12% growth in our research income to £28 million, which supports research infrastructure and projects across the Trust. This has been in part due to a higher than anticipated growth in commercial income of 25%, through attracting an increased number and value of commercial studies to the Trust as well as extensive work to improve the effectiveness of commercial income recovery.

We have also increasingly focused on improving relationships with industry and maximising potential benefits of those relationships via commercialisation of intellectual property. We are also ensuring that we have the infrastructure to support a pipeline of new studies as existing trials transition into clinical care. 2019/20 was the third (out of five) year of our third funding term of the NIHR GOSH Biomedical Research Centre (BRC) and of our newly designated NIHR Clinical Research Facility.

In the coming year we will begin work to prepare for the BRC renewal process, a vital undertaking to ensure we can continue to maintain and progress key areas of translational research.



[16] https://www.gosh.nhs.uk/our-research/taking-part-research/gosh-sample-bank

## Innovation

The Trust regularly reviews our IP portfolio and makes strategic recommendations to R&I Board for support of innovation with commercial potential. The Trust has a robust IP policy which supports the it's objective to encourage the creation and successful exploitation of innovation, ensuring that GOSH effectively manages its IP and that revenue share arrangements to incentivise employees are transparent and well managed. We have a contract with Health Enterprise East (who provide innovation management services to NHS organisations across London, South East and South West regions) for managing the Trust's IP.

The Trust also engages regularly with the BRC Translational Research and Enterprise Accelerator (TREAC) cross-cutting theme through their dedicated Business Development Manager based within the Division of R&I. This enables more regular, on-site access to our university partner and facilitates shared learning in the translational research space.

The Trust launched the Digital Research Informatics & Virtual Environment (DRIVE)[17] in October 2018; a partnership with University College London (UCL) and leading industry experts in technology, artificial intelligence and digital innovation. DRIVE aims to become a world leading clinical informatics unit focused on data analysis, accelerating research and the deployment of cutting-edge technology. With the implementation of the Trust's electronic patient record (EPR) Epic and the Digital Research Environment (DRE – which provides the technological infrastructure to facilitate research undertaken at GOSH), DRIVE will harness the powerful combination of rich health data with data science and digital innovation and develop scalable solutions to enhance health services not only for GOSH patients but across the wider NHS.

The recent appointment to the newly created Trust post of Commercial Director offers the opportunity to review current commercial processes in research, creating strategic partnerships with the commercial sector to fully maximize the benefit to the Trust.

## Zayed Centre for Research into Rare Disease in Children

The Zayed Centre opened in October 2019. The facility brings together pioneering research and clinical care; patients will benefit from the latest developments in the laboratory, accelerating the progress of new diagnoses, treatments and cures for rare and complex diseases. It houses the latest technologies[18] in a flexible space that acts as a vibrant and collaborative hub.

Over the coming months, research teams will continue moving into the new centre and vital steps will progress to ready a six-room laboratory suite on the top floor. This suite adheres to the strict requirements required to manufacture therapeutic, gene-edited cells that can then be returned to patients. Facilities with this capability are extremely rare, with no comparable labs in the UK at present. One of the first patients to be treated at the Centre was Kai (pictured below). Kai has hypertrophic cardiomyopathy (HCM), a rare genetic condition, where the muscle wall of the heart becomes thickened. He is taking part in a research project aiming to discover new biological markers of inherited heart conditions, with the hope that it will result in better ways to diagnose patients and to predict how the disease will develop over time.

**Below: Kai**, age 10 has hypertrophic cardiomyopathy, a rare cardiac condition, and he experienced multiple cardiac arrests before receiving a donor heart earlier in 2019. Kai attends the outpatient clinic in the Zayed Centre for Research and is taking part in a research project aiming to discover new biological markers of inherited cardiac conditions.

## Journal publications

In 2019/20 we pulished 660 papers, 399 of these were with our academic partner. In the five year period between 2012 and 2016, GOSH and ICH research papers together had the second highest citation impact (1.997) of comparable international paediatric organisations.

## Research highlights

Successful clinical trials at GOSH and other centres resulted in NHS approval of Brineura, a novel treatment for Batten Disease. Patients given the treatment had 80% less decline in motor and language skills and reduced loss of brain tissue. The drug is administered directly into the brain via a novel intraventricular device. Since Brineura approval, GOSH has been given a leading role by NHSE in training other UK centres in managing Batten Disease patients receiving regular intracerebroventricular enzyme replacement therapy infusions.

A pioneering new stem cell gene therapy treatment, manufactured at GOSH and ICH (after being developed at the University of Manchester with funding from GOSH Charity), was used to treat the world's first patient with the severe life-limiting genetic condition MPSIIIA (Sanfilippo syndrome). The transplant was performed on a two-year old patient at the Royal Manchester Children's Hospital (RMCH).

A promising new cancer treatment (CAR-T therapy), is being offered to children with acute lymphoblastic leukaemia (ALL) through a GOSH clinical trial. GOSH also treated the first NHS patient for relapsed ALL with a similar CAR-T therapy, known as Kymriah.

GOSH researchers developed the first ever tool to identify children at risk of sudden death from a rare heart condition called hypertrophic cardiomyopathy (HCM). Children identified at high risk have the option of being fitted with an implantable cardioverter defibrillator (ICD) – a small device that can shock the heart back into a normal rhythm if they experience a life-threatening abnormal heart rhythm and could potentially save their lives.

## Centre for Outcomes and Experience Research in Children's Health Illness and Disability (ORCHID)

As a Research Hospital, research is an integral part of the working lives of our staff and the patients and families we treat and see. Research is considered a core component of the work of all healthcare professionals at GOSH. Integral to maintaining that component of work is The Centre for Outcomes and Experiences Research in Children's Health, Illness and Disability (ORCHID). ORCHID is a centre for research at GOSH, bringing together non-medical professionals, to undertake their own research, as well as collaborate on multi-professional studies, within the field of child health. Professor Faith Gibson, Director of Research – Nursing and Allied Health, leads this centre, and along with Dr Paula Kelly, Dr Kate Oulton, Dr Debbie Sell and Associate Professor Jo Wray, provides leadership to the Research and Clinical Academic Faculties within ORCHID. They represent the professions of nursing and allied health with researchers undertaking time limited studies, funded through grant income, and PhD students, funded by NIHR Fellowships and NIHR GOSH Biomedical Research Centre (BRC) funds.

Our aim, within the centre, is to contribute significantly to innovation and excellence in care, to influence and help embed a research culture into the fabric of GOSH, and to foster a culture of inquiry amongst nurses and the allied health professions. One of the strategic aims of GOSH is to function as a research hospital. We contribute to this vision through firstly building nursing and allied health professions research capacity and capability and secondly through our research on experiences and outcomes of children/young people and their families: our academic and research achievements are captured in the infographic below.

### The numbers 2019/20

| | |
|---|---|
| **63** Peer reviewed publications | **70** Conference presentations |
| **37** Published abstracts | **33** Invited presentations |
| **6** Book chapters | **1** Edited book |
| **12** New research grants | **23** Ongoing studies |
| **1** New PCAF award | **4** New doctoral fellowships |
| **15** PhD students | **1** Resource |
| **£1,116,912** Fellowship income | **£3,358,334** Research income |

Our success in mentoring and supporting others was demonstrated by the recent award of a further three prestigious non-medical fellowships by the NIHR, a direct result of the internship funding we are able to offer nurses and AHPs though support from our NIHR GOSH BRC Education theme. Polly Livermore was appointed as Clinical Academic Programme Lead GOSH BRC, to support and plan for initiatives such as the internship programme. Dietitian James Evans, children's nurse, Tara Kerr-Elliott, and an optometrist Sian Handley were awarded Clinical Doctoral Research Fellowships. We have expanded our clinical academic faculty, there are now 11 NIHR Nurses and AHPs undertaking PhDs, and four further PhD students who received other grant awards.

[17] https://www.goshdrive.com
[18] https://www.gosh.nhs.uk/our-research/our-research-infrastructure/zayed-centre-research-rare-disease-children/about-zayed-centre-research

## 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 2019/20.

As of March 2020, and in response to the NHSE/I request for the Trust to support the wider NHS during the COVID 19 pandemic, the Trust has expanded its registration to:

- Treat patients up to the age of 65.
- Treat patients who have been detained under the Mental Health Act.

In December 2019, the CQC conducted a scheduled unannounced inspection of three services (critical care, surgery and CAMHS) and an announced inspection against the well-led criteria. The report was published in January 2020. The Trust retains its overall rating of *Good*. All services provided by the hospital are now rated as either *Outstanding* or *Good*.

The effectiveness of our care, and the caring attitude of our staff have been rated as *Outstanding* again. Our Well Led rating has improved to *Good*, which is a welcome reflection on the work at all levels in the organisation to improve. The safety of the care we provide has reduced to *Requires Improvement*. This is linked primarily to medicines management within the hospital specifically the storage and disposal of medicines.

**The CQC issued 2 enforcement notices:**

- Regulation 12: Safe Care and Treatment – This recommendation relates to the robustness of access control measures in PICU medication room; the safe storage of IV fluids in theatres, interventional radiology and on one of the surgical wards; the process for denaturing controlled drugs on wards; and the temperature monitoring arrangements for medication rooms.
- Regulation 17: Good Governance – This recommendation relates to the articulation of the breadth of the medicines risk on the board assurance framework; and the need to ensure that the EPR system fully meets the needs of the staff in the CAMHS service to deliver safe care.

A CQC action plan has been developed to address all actions. An executive led committee, Always Improving, has been established and meets monthly to review progress against this action plan, whilst supporting the ongoing work with the Trust's CQC compliance. This committee reports into the Risk, Assurance and Compliance meeting with regular reports to Board and the Council of Governors. The Trust will continue to conduct mock inspection framework (CQC Quality Rounds) in clinical directorates and review potential areas/sources of learning for example reviews of themes from other CQC reports and evaluation of CQC Insight reports.

**What is the Care Quality Commission?**

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.

## Use of the CQUIN payment framework

A variety of CQUINs have been undertaken by the Trust in 2019/20. 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 2019/20 | |
|---|---|
| **CQUIN title** | **Overview** |
| Promoting Transplantation | The aim is to increase the Organ transplantation rate by addressing barriers to organ uptake and optimising the pathway and to reduce the work up time for the live donor pathway to promote transplant rates. |
| Medicines Optimisation | This CQUIN scheme aims to support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services.<br><br>A number of priority areas for implementation have been identified nationally by clinical leaders, commissioners, Trusts, the Carter Review and the National Audit Office. |
| Paediatric Movement Therapies | The scheme aims to ensure equity of access to the pathway for all children with cerebral palsy and avoid geographical variation.<br><br>There are several thousand children in England who would benefit from specialist MDT review.<br><br>It also increases the focus on improving children's lives by ensuring that professionals work together across organisational boundaries. |
| Paediatric Movement Therapies | The aim of this local scheme is to reduce pre-analytical sample rejections and to improve pre-analytical sample transit time.<br><br>For our patients there are significant consequences including delays in diagnosis and treatment, inconvenience and discomfort for the patient, and increased hospital and laboratory costs.<br><br>For some of our children and neonates, it is very difficult for staff to obtain good samples, and it is not acceptable to repeat this process. |

In 19/20 the total financial allocation for CQUINs was set at 1.25% for clinical commissioning groups and 0.75% for NHS England of GOSH's NHS income (activity only). This equates to circa £1.8m for the 19/20 financial year.

The value of the individual CQUINs for the Trust ranged from £14,000 for CAMHS Training to £625k for Medicines Optimisation. We have achieved 100% compliance for 2019/20 however the value for the year will be finalised by the end of June 2020 when final activity values are reported.

**What is the Commissioning for Quality and Innovation framework?**

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.

## Data quality

Good quality data is crucial to the delivery of effective and safe patient care. 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.

Highlights of the work completed in 2019/20 across Information Services, Data Assurance, Information Governance, and Clinical Coding include:

**Information Services**

- Statutory & Mandatory Returns datasets built in the new EPR data warehouse with both internal (for validation) and external (for submission) reporting mechanisms.
- Statutory & Mandatory Returns datasets updated throughout the year as new versions and requirements released, including in-house XML translation to meet new requirements for submission in that format.
- Multiple datasets built in the new EPR data warehouse and QlikView to provide the Trust with oversight of various operational areas, from Theatre Utilisation to Patient Management, including any specific data quality issues.
- Standards for both data warehousing and reporting development consistently followed by the team and shared with other data teams across the Trust.
- Knowledge sharing with data teams across the Trust delivered via several means, including an Epic data warehouse user group established and run by the team.
- New processes developed for managing maintenance of data warehousing and reporting during system upgrades.
- Managed shutdown of warehouse data feeds from legacy systems and development of reporting on data from those systems not migrated to the new EPR, according to the requirements of diverse user groups.

**Data Assurance**

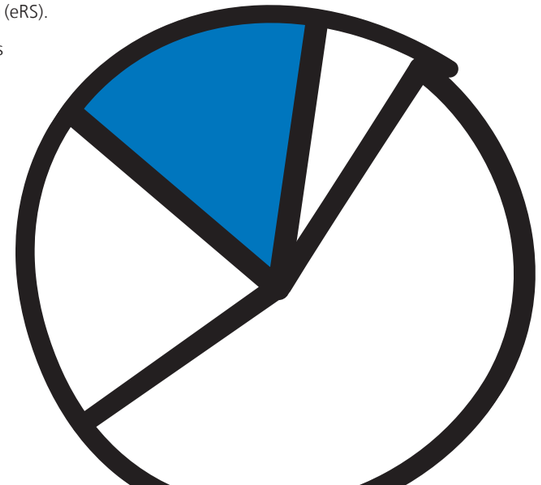
- Members of Data Assurance team were accredited Epic Credential trainers.
- Data assurance team supported the Epic go-live period and continue to provide training delivery, development of training content, standard operating procedures and data entry support to front end users.
- With successful implementation of our new Epic EPR System in April 2019 we completed a full review of our data quality governance structure. Also, reviewed Terms of Reference for weekly Data Quality Focus Groups and monthly Data Quality Review Group to ensure our work continues to be relevant and fit for purpose.
- Refreshed Data Quality Policy which also covers the Digital Research Environment Data Lake.
- Agreed programme of work for our Data Quality Plan .
- Data quality dashboards and work queues are fully integrated within the Epic and forms part of the data assurance team daily checks and Epic build review.
- Extensive validation of migrated and new epic data to ensure all dimensions of data quality criteria is met which includes full validation of all unknown RTT clock start, Statutory reporting month end submission errors (RTT, DM01, DID and SUS).
- Continuous  training and user support for the Electronic Referrals System (eRS).
- Managed the transition of IPTMDS process from Central booking Services to Data Assurance Team.

### What is data quality?

Data quality refers to the tools and processes that result in the creation of accurate, complete and valid data that is required to support sound decision making.

### What is NHS Digital?

NHS Digital is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.





**Secondary Uses Service**

As required by NHS Digital, GOSH submitted records during 2019/20 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 | 91.3% | 99.4% |
| | Outpatients | 91.9% | 99.7% |
| Inclusion of patient's valid General Practitioner Registration Code | Inpatients | 99.6% | 99.7% |
| | Outpatients | 99.6% | 99.6% |

**Notes:**

- The table reflects data from February 2020 at month 11 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 91.3% for inpatients and 91.9% for outpatients.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

**Information governance**

The Trust is in the process of finalising its submission against the Data Security and Protection Toolkit (DSPT). This system allows us to demonstrate our position against the General Data Protection Regulations (GDPR) 2018 and other data protection legislation.  The outlining of the key requirements allows GOSH to maintain status as a `Trusted Organisation' with regards to sharing NHS data with NHS bodies and other Trusted partners.

While compliant with the mandatory requirements, some areas of improvement have been identified and an action plan is underway.

Actions include:

- Ensuring the Trust is compliant with the national data opt-out so that patient wishes are respected with regard to the secondary use of data.
- The development of a continual ongoing programme to ensure an accurate and up to date list of all personal data held by GOSH.

**Clinical coding**

GOSH has a dedicated and highly skilled clinical coding team, which continues to maintain high standards of inpatient coding. The depth of coding continues to sit above the national average due to the complexity of our patients.

GOSH has implemented a new audit process and now carries out a continuous individual internal audit programme to ensure that accuracy and quality are maintained, that national standards are adhered to, and any training needs are identified. As a result of the audit programme, training sessions are now undertaken more regularly on either a team or individual basis, and we continue to standardise coding across the Trust.

The recent 2019/20 audit for the Data Security and Protection Toolkit showed results of over 97.5% accuracy for primary diagnostic coding, and 94.29% for primary procedure coding.

GOSH was subject to a national Payment by Results clinical coding audit during the 2019/20 reporting period.

## 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.

For these unplanned critical care admissions, we participate in the NHS England seven-day service audit and self-assessment framework. The audit measures whether patients admitted as an emergency are seen by a consultant within 14 hours of arrival, and whether patients are subsequently seen twice daily by a consultant. Our audit data for 2019/20 shows that we meet all required clinical standards.

### What is the Secondary Uses Service?

The Secondary Uses Service (SUS) is a single source of specified data sets to enable analysis and reporting of healthcare in the UK. SUS is run by NHS Digital and its reporting is based on data submitted by all provider trusts.

### What is an NHS Number?

Everyone registered with the NHS in England and Wales has their own NHS number, a unique 10-digit number that helps healthcare staff to find a patient's health records. The NHS number increasingly helps to identify the same patient between organisations and different areas of the country.

## Promoting safety by giving voice to concerns

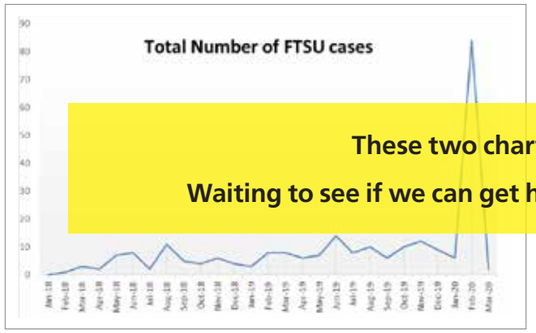
### Freedom to Speak Up Guardian

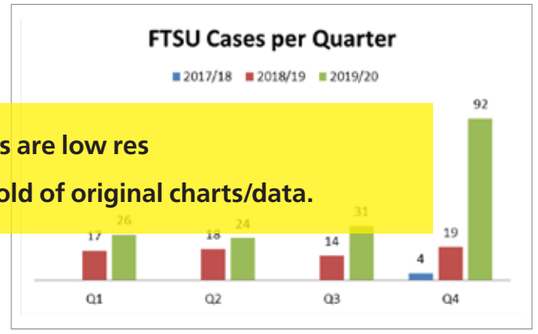
The Freedom To Speak Up service has seen a marked increase in contacts between 2018/19 and 2019/20. Nine months of the financial year saw FTSU cases increases compared to the same month the preceding year.

February 2020 saw a significant increase due to the presentation of two petitions from OCS cleaning staff. One petition was about OCS not allowing sufficient time for Muslim staff to pray but the larger petition was about poor relations between OCS managers and OCS cleaners. No safety concerns related to GOSH staff or patients were identified. OCS staff guided to their HR teams and Trade Union for support however these concerns were raised with GOSH Director of Facilities also.

Although the number of FTSU cases has increased, the proportion of staff raising concerns about bullying and about safety remain the same with bullying and harassment the most significant feature of FTSU contacts. Staff contacting the FTSU service receives advice and support to use the Trust policies and processes to raise concerns. The FTSU also aggregates the cases and anonymously reports the numbers and themes to the Quality, Safety and Assurance Committee and to the Audit Committee to alert senior Executives and Non-Executives to the experiences of staff.

| Month of the financial year | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2019/20** | 6 | 7 | 14 | 8 | 10 | 6 | 10 | 12 | 9 | 6 | 82 | 2 | **174** |
| **2018/19** | 2 | 7 | 8 | 2 | 11 | 5 | 4 | 6 | 4 | 3 | 8 | 8 | **68** |




**These two charts are low res**

**Waiting to see if we can get hold of original charts/data.**

### Whistleblowing protection

Most issues raised by employees are easily resolved. However, there are times when concerns are of a more serious nature. The Trust has a policy, which has recently been updated in line with national guidance, which provides a clear and easily accessible route for raising these types of concerns which are known as qualifying disclosures (also known as whistleblowing concerns).

The policy also outlines a range of people who employees can raise concerns with even if they don't fall under the definition of a whistleblowing concern, including the Freedom to Speak Up Guardians and Speaking Up for Safety™.

The overarching aim of the policy is to demonstrate the Trust's commitment to openness and accountability through:

- The provision of a safe environment to raise concerns at work.
- Reassurance of employees that it's safe and acceptable to speak up.
- Reassurance of employees that they can raise a concern at an early stage and with clarity about the process.



### Speaking Up for Safety

June 2019 saw the implementation of the Speak Up Programme.

All NHS organisations have to show they are encouraging staff to speak up with patient safety concerns. Failing to do this can harm patients and in extreme cases, may contribute to loss of life. GOSH was determined to go beyond the minimum requirement – we want to use the Speaking Up for Safety programme to create the right safety culture for our colleagues, patients and their families. The programme empowers our staff to support each other and raise concerns. Between June and December 2019 we ran in-house workshops, led by trained and accredited volunteers from across all staff groups. The purpose of the workshops were to enable staff to develop the skills and insights to respectfully raise concerns with colleagues through the use of the Safety C.O.D.E.

### Reducing rota gaps for NHS doctors and dentists in training

AWAITING SUBMISSION – RENEE MCCULLOH

**Reagan** is 15 years old and as she's grown, she's developed scoliosis. She recently had surgery at GOSH to straighten her spine.

# Part 2c:
# Reporting against core indicators

## Performance against Department of Health and Social Care quality indicators

NHS trusts are subject to national indicators that enable the DHSC and other institutions to compare and benchmark trusts. 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. Where national data is available for comparison, it is included in the table.

**What is the Department of Health and Social Care?**

The Department of Health and Social Care (DHSC) is a department of the UK government with responsibility for government policy for England alone on health, social care and the NHS.

| 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: |
|---|---|---|---|---|---|---|---|---|---|
| | 2019 | 2018 | 2017 | Most recent results for Trust | Best results nationally | Worst results nationally | National average | | |
| | | | | **Source: NHS Staff Survey<br>Time period: 2019 calendar year** | | | | | |
| The percentage of staff who would be happy with the standard of care provided by the organisation if a friend or relative needed treatment. | 88.7% | 88.2% | 86.1% | 88.7% | 94.8% | 80.9% | 90.0% | 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 key actions associated with addressing staff survey findings will be incorporated into the Integrated People Strategy – with its four pillars; Capacity, Infrastructure, Skills and Culture & Engagement.<br>The survey results indicate the need to prioritise the Culture & Engagement pillar. This workstream's purpose is to ensure all our people feel well led and managed, but also supported and empowered to do and be their best.<br>The key components of this pillar are: Visible Leadership, Corporate Strategy & Narrative, Creating an Employee Voice, Living Our Values, Creating Transparency & Promoting Dialogue, and Integrating Support Services & Networks. These are underpinned by Training & Development and Internal Communications. |
| Percentage of staff who agreed that care of patients is the organisation's top priority. | 86.5% | 84.2% | 82% | 86.5% | 91.9% | 82.9% | 87.3% | | |
| Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from managers in last 12 months. | 16.3% | 17.2% | 17.1% | 16.3% | 7.2% | 16.3% | 11.6% | | |
| Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from other colleagues in last 12 months. | 24.4% | 22.1% | 20.8% | 24.4% | 13.9% | 24.4% | 18.7% | | |
| Percentage of staff who consider the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. | 75.9% | 78.8% | 81.3% | 75.9% | 91.4% | 75.9% | 86.2% | | |

| 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: |
|---|---|---|---|---|---|---|---|---|---|
| | 2019/20 | 2018/19 | 2017/18 | Most recent results for Trust | Best results nationally | Worst results nationally | National average | | |
| Friends and Family Test (FFT) - % of responses (inpatient). | 24% | 18.9% | 24.6% | 26% | 41% | 6% | 25% | The rates are from NHS England<br>Time period:2019/20 financial year<br>Comparing: paediatric trusts* | We are promoting FFT at ward level, so every family is aware they can provide feedback and how. We advertise the online feedback on our weekly Feedback Friday slot on the @GreatOrmondSt Twitter feed, along with the feedback page link. Interactive feedback functions are being developed to encourage our children and young people to complete the FFT. |
| FFT - % of respondents who recommend the Trust (inpatient). | 97% | 96.7% | 97.1% | 96% | 99% | 48% | 26% | | |
| *Children's hospitals: Alder Hey, Birmingham, Bristol Royal, Evelina, Leeds, Nottingham, The Alex Brighto, Royal Manchester, Sheffield, Southampton and the Great North. | | | | | | | | | |
| Number of clostridium difficile (C.difficile) in patients aged two and over. | xx | 6 | 11 | xx | xx | xx | xx | The rates are from Public Health England.<br>Time period: 2017/18 financial year<br>Comparing: Stand-alone paediatric trusts† | 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). | xx | 10.3 | 18.8 | xx | xx | xx | xx | | |
| 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.<br>* National report used estimated bed days at time of reporting. † www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data. | | | | | | | | | |

| 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: |
|---|---|---|---|---|---|
| | 2019/20 | 2018/19 | 2017/18 | | |
| **Patient safety incidents reported to the National Reporting and Learning System (NRLS):** | | | | | |
| Number of patient safety incidents | 5,069 | 6,751 | 6,345 | 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 in root cause analysis, 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) | 12.6 | 14.9 | 14.2 | | |
| Number and percentage of patient safety incidents resulting in severe harm or death | 4 (0.1%) | 6 (0.1%) | 12 (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.

# 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 2019/20

| Domain | Indicator | National threshold | GOSH performance for 2019/20 by quarter | | | | 2019/20 mean | Indicator met? |
|---|---|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 | | |
| Effectiveness | All cancers: 31-day wait from decision to treat to first treatment*** | 96% | 100% | 100% | 100% | Jan and Feb only: 100% | 100% | Yes |
| Effectiveness | All cancers: 31-day wait for second or subsequent treatment, comprising:*** | | | | | | | |
| | · surgery | 94% | 100% | 100% | 100% | 89.47% | 95.65% | 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: 90.08%<br>May: 88.26%<br>June: 86% | Jul: 84.47%<br>Aug: 82.45%<br>Sep: 83.72% | Oct: 85.02%<br>Nov: 85.71%<br>Dec: 84.98% | Jan: 86.14%<br>Feb: 85.95%<br>Mar: 82.88% | Can't have a mean as this is a snapshot. | No |
| Experience | Maximum 6-week wait for diagnostic procedures*** | 99% | Apr: 90.79%<br>May: 90.52%<br>June: 92.08% | Jul: 94.93%<br>Aug: 96.04%<br>Sep: 96.92% | Oct: 95.19%<br>Nov: 96.79%<br>Dec: 91.02% | Jan: 87.94%<br>Feb: 91.57%<br>Mar: 74.77% | Can't have a mean as this is a snapshot. | 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 | Yes |

*Target based on meeting the needs of people with a learning disability, from recommendations set out in Healthcare for All (Department of Health, 2008)

Capacity has also been an issue. The Trust is currently working through a recovery plan to improve performance against this standard in 2019/20. ***Source: NHS Digital

**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 xx). All measures remain within expected statistical tolerance.

| Domain | Indicator | GOSH performance for 2019/20 by quarter | | | | 2019/20 mean |
|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | |
| Effectiveness | Inpatient mortality rate (per1,000 discharges)‡‡† | 8.97 | 8.20 | 8.38 | 6.26 | 7.99 |
| Experience | Discharge summary completion time (within 24 hours) | 47.40% | 60.36% | 70.07% | 74.25% | 62.71% |
| Effectiveness | PICU discharges delayed by 8–24 hours | 9 | 6 | 11 | 14 | 10 |
| Effectiveness | PICU discharges delayed by more than 24 hours | 21 | 9 | 3 | 9 | 10.5 |
| Effectiveness | Last minute* non-clinical hospital cancelled operations‡ and breaches of 28-day standard: | | | | | |
| | · cancellations | 157 | 142 | 104 | 83 | 122 |
| | · breaches | 34 | 6 | 9 | 9 | 15 |
| Experience | Formal complaints investigated in line with the NHS complaints regulations*** | 21 | 24 | 24 | 21 | 90 (total) |
| Effectiveness | % of patients aged 0–15 readmitted to hospital within 28 days of discharge‡‡ | 2.55% | 2.32% | 2.21% | 2.34% | 2.36% |
| Effectiveness | % of patients aged 16+ readmitted to hospital within 28 days of discharge‡‡ | 0% | 0% | 3.87% | 4.76% | 3.02% |



## Performance against key healthcare targets 2018/19

| Domain | Indicator | National threshold | GOSH performance for 2018/19 by quarter | | | | 2018/19 mean | Indicator met? |
|---|---|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 | | |
| Effectiveness | All cancers: 31-day wait from decision to treat to first treatment*** | 96% | 97.87% | 100% | 100% | 100% | 99.45% | Yes |
| Effectiveness | All cancers: 31-day wait for second or subsequent treatment, comprising:*** | | | | | | | |
| | · surgery | 94% | 100% | 93.33% | 90.91% | 100% | Indicative position: 95.65% | Yes for Q1&4. No for Q2&3 |
| | · 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: 93.62%<br>May: 93.64%<br>June: 92.59% | Jul: 92.76%<br>Aug: 92.85%<br>Sep: 92.24% | Oct: 92.19%<br>Nov: 92.15%<br>Dec: 92.09% | Jan: 92.59%<br>Feb: 92.18%<br>Mar: 92.24% | 92.60% | Yes |
| Experience | Maximum 6-week wait for diagnostic procedures*** | 99% | Apr: 97.87%<br>May: 97.45%<br>June: 98.43% | Jul: 97.43%<br>Aug: 94.44%<br>Sep: 94.53% | Oct: 94.07%<br>Nov: 96.98%<br>Dec: 93.14% | Jan: 95.19%<br>Feb: 97.54%<br>Mar: 97.48% | 96.21%†† | 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 |

*Target based on meeting the needs of people with a learning disability, from recommendations set out in Healthcare for All (Department of Health, 2008)

**Additional indicators – performance against local improvement aims**

| Domain | Indicator | GOSH performance for 2018/19 by quarter | | | | 2018/19 mean |
|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | |
| Safety | Central Venous Line (CVL) related bloodstream infections (per 1,000 line days) | 1.7 | 1.2 | 1.3 | 2.6 | 1.7† |
| Effectiveness | Inpatient mortality rate (per 1,000 discharges)‡‡† | 4.74 | 5.00 | 7.62 | 8.95 | 6.49 |
| Effectiveness | PICU discharges delayed by 8–24 hours | 19 | 13 | 16 | 17 | 16 |
| Effectiveness | PICU discharges delayed by more than 24 hours | 36 | 25 | 57 | 56 | 43 |
| Experience | Discharge summary completion time (within 24 hours) | 89.24% | 87.18% | 80.75% | 77.32% | 83.30% |
| Effectiveness | Last minute* non-clinical hospital cancelled operations‡ and breaches of 28-day standard: | | | | | |
| | · cancellations | 112 | 135 | 155 | 150 | 137 |
| | · breaches | 13 | 17 | 21 | 13 | 16 |
| Experience | Formal complaints investigated in line with the NHS complaints regulations*** | 18 | 30 | 27 | 20 | 95 (total) |
| Effectiveness | % of patients aged 0–15 readmitted to hospital within 28 days of discharge‡‡ | 1.63% | 2.72% | 2.24% | 1.58% | 2.04% |
| Effectiveness | % of patients aged 16+ readmitted to hospital within 28 days of discharge‡‡ | 0 | 0 | 1.53% | 0 | 0.38% |

† Does not include day cases †† Reported to Board from October 2017 *** Source: NHS Digital ‡‡ Source: Hospital Episode Statistics

* 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.

‡ Thirteen episodes come from one child with a serious gastrointestinal issue who had recurrent bacteraemias likely to have arisen from the gut but seeded the line. Removing these unavoidable 13 episodes (and the line days) gives an annual rate of 1.4.

†††Throughout the last year, the Trust continued work to improve the quality and robustness of our waiting list data, building on the work that had been completed over previous years. The principle focus for 2018/19 was maintaining compliance against the RTT standard as an organisation and focusing on speciality level compliance. In addition a significant focus has been placed on the build of the EPIC system to ensure we are able to robustly track and manage patients who are awaiting treatment, both within the EPIC system, as well as utilising Qlikview reporting to provide a patient targeting list (PTL) and booking reports for the operational teams. Throughout 2018/19, the Trust successfully delivered the 92% incomplete standard every month. This was a testament to the work completed by the clinical and operational teams. Following the completion of our audit of the Quality Accounts for 2018/19, a number of data quality issues were identified related to the small sample undertaken, although the significance of errors have reduced since last year's audit. While disappointing, the majority of the errors related to documentation management and late receipt / processing of referral information and thus were not material to the Trust's reported RTT position and as such this has led to a modified opinion by our auditor, Deloitte. This year's audit was completed using a cross section of waits on the PTL in addition to focusing on those waiting between 17 and 18 weeks. As such, the review highlighted a reduced quality of data across those pathways below 18 weeks, compared to those who have waited over 18 weeks as all of these pathways are validated as part of our RTT reporting processes in-line with processes completed. Those pathways under 18 weeks are randomly sample audited as part of our waiting times and data assurance processes on a weekly basis. Our previous patient administration system was not capable of tracking patients against an RTT pathway, so this had to be constructed and calculated outside of the system in a data warehouse environment. While much work has been completed to compensate for this, it allowed the user to enter pathway data and an outcome code regardless of the status of the pathway. The functionality provided by Epic will go some way to mitigate this, although this is unlikely to address all the issues identified as part of the audit. In addition, the initial concept of RTT was developed around the clinical model of simple surgical care, rather the complex tertiary and quaternary care that we offer at GOSH. As such, it remains a challenge to our clinicians and operational teams to apply the rules to the clinical pathways we have at GOSH. This is further compounded by the fact that 93% of the patients we receive at GOSH have been referred from another hospital setting and hence will have already waited for care at another organisation. This means that for each we have to source a minimum dataset, informing us of the current status of the patient together with their current waiting time. This vital information is often hard to source. However the Trust has completed a significant amount of work to reduce the volume of unknown clock starts from 894 in April 2018 to 231 in March 2019. Finally, although the number of errors was higher 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.

# Annex 1:
# Statements from external stakeholders

**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 of the Council of Governors**

**Comments from Public governor, north London and surrounding area:**

**Comments from Staff governor**

## 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 2019/20* and supporting guidance *Detailed Requirements for Quality Reports 2019/20*.
- 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 2019 to May 2020
  - papers relating to Quality reported to the board over the period April 2019 to May 2020
  - feedback from commissioners dated xxx
  - feedback from governors dated xxx
  - feedback from Camden Healthwatch organisation dated xxx
  - feedback from Camden Health and Adult Social Care Scrutiny Committee dated xxx
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xxx
  - National Paediatric Outpatient Survey 2016
  - Children and Young People's Inpatient and Day Case Survey 2016
  - the national NHS Staff Survey 2018
  - the Head of Internal Audit's annual opinion of the trust's control environment dated xxx
  - CQC inspection report dated xxx
- 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 manual and supporting 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

DATE

Chair

DATE

Chief Executive



# Great Ormond Street Hospital for Children NHS Foundation Trust

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**REMINDER: ONCE ALL CONTENT HAS BEEN SUPPLIED CHECK FOOTNOTES/REFERENCES as copy is being supplied in batches the running order of the footnotes will be inconsistent at the mo.**

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The *Annual Report and Accounts* is available to view at www.gosh.nhs.uk.

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