Great Ormond Street Hospital for Children
NHS Foundation Trust

# Annual Report and Accounts 2015/16

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

# Contents



Cover: GOSH patient six-year-old Michael, Giraffe ward


GOSH Nurses Reshma Kaur (left) and Hanna Thomas, Sky ward

# Performance Report

# Introduction from the Chairman

Our mission remains to provide world-class care to children and young people with rare, complex and difficult-to-treat conditions. Due to the concentration of these patients at this hospital, we must also strive to learn from treating these conditions. We need to harness the latest developments in medical science to discover new treatments and cures that that will benefit children across the world. This mission can only be achieved through working in partnership with our children and their families, other healthcare providers, leading research institutions and our wonderful charity.

In our 164-year history, our purpose has been constant but the environment in which we work changes. As a specialist provider within the National Health Service, Great Ormond Street Hospital (GOSH), in common with many others, faces uncertainty around commissioning strategies and increasing costs. Taken together, they cause financial insecurity and difficulties in planning future sustainable models of care, particularly for our cardiac and oncology services.

In response to such challenges, we worked with staff and the Members' Council to refresh our strategy during 2015/16. During its development there was a particular focus on how we could deliver the highest quality safe care while ensuring timely access for all the children and young people who need to be treated at GOSH. This reflects our renewed efforts to ensure that all our patients do not need to wait long before they are treated.

In order to meet our vision of being the leading children's hospital in the world, our new three-year strategy has four strategic objectives. These are:

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

Underpinning this strategy are Our Always Values which define what our patients, their families and our partners expect of us and what we should expect of each other. They were developed in collaboration with the families we care for. I am pleased that in the coming year, work will be undertaken to further embed these values in everything we do.

Working with and listening to our patients and their families is essential to achieving our vision. In the *Quality Report* on page 73 you will read how they have been instrumental in shaping some of our new initiatives to improve safety and experience. Their voices – through regular surveys, the Members' Council and the Patient Advice and Liaison Service (Pals) – enable us to see how we are performing, and areas that need attention. I am pleased that overall our patients and their families are satisfied with the care they have received.

In the first Care Quality Commission (CQC) national inpatient survey, our children and young people scored their overall experience as 8.5 out of 10, while their parents rated their experience 8.7 out of 10. This year for the first time, our Friends and Family Test was undertaken across all inpatient, outpatient and day case areas. While we recognise we have to strive to ensure that every parent and child is given the opportunity and encouraged to complete the test, the results from more than 17,000 responses were very encouraging. They showed that on a consistent basis more than 95 per cent of our patients and their families would recommend GOSH as a place to be treated.

Many of our patients have complex conditions needing rare and specific care. There are few, if any, alternative places for them to receive treatment. In order to improve access, we must create greater capacity, both by being as efficient as possible in how we use our existing resources, and by carving out more physical space.

Last year the organisation was able to meet its challenging productivity and efficiency targets and forge ahead with its redevelopment programme. In September we celebrated two important milestones: the 'topping out' of the Premier Inn Clinical Building, the second part of the Mittal Children's Medical Centre due to open in 2017; and the naming of the new Zayed Centre for Research into Rare Diseases in Children, scheduled to open in 2018. Together, they will provide much needed extra space which will include five new inpatient wards, additional theatres, an extensive surgery centre and a large outpatient facility dedicated to rare diseases. The Zayed Centre for Research – a partnership with University College London – will also dramatically enhance our research capabilities by providing additional space for collaboration and the most complex Good Manufacturing Practice (GMP) facility in the world dedicated to paediatric research and treatments.

Our programme of redevelopment would not be possible without the many thousands of donors who support us through our dedicated charity, Great Ormond Street Hospital Children's Charity.

> "In uncertain times we must focus on bringing everything we do up to the standard that we expect of ourselves and would want for our own children."

Their immense generosity is not only enabling us to rebuild and build extraordinary facilities but also to buy new equipment, power vital research and improve the experience of our patients and their families through funding the support projects, including our parent accommodation.

Throughout the year we have also been supported by the Members' Council. This group of patients, parents, staff and local stakeholders give their time and energy to ensure that the views of the wider hospital community are heard and reflected in the Trust's strategy. I would like to thank the Council for its input over the last year.

Our ambitions to be a research hospital are set out in this report and I am delighted that at the beginning of the financial year Professor Stephen Smith joined the Board. Professor Smith, a leading academic and clinician, was the driving force behind the country's first Academic Health Science Centre. His contribution over the coming years will be invaluable.

The year ahead promises to be exciting and challenging. Our vision is ambitious. We are world class in many aspects of what we do but not all. In uncertain times we must focus on bringing everything we do up to the standard that we expect of ourselves and would want for our own children. The only way we can achieve this is collectively.

Our staff are our most precious resource. Every time I enter the hospital I am struck by their dedication, hard work and compassion. I would like to end by thanking them for everything they do to help give the children and young people we see the best possible chance of having healthy and happy lives.

**Baroness Tessa Blackstone**
**BSc (Soc) PhD**
Chairman


GOSH patient Joshua, age five, Badger ward

# Introduction from the Chief Executive

## The children and young people we see at Great Ormond Street Hospital (GOSH) deserve the highest standards of paediatric care possible. This can only be achieved by striving for excellence in everything we do, continually pushing the boundaries of science, harnessing new technologies, and fostering a culture of learning and accountability.

Over the last year we have continued to see a high and increasing demand for many of our services with us seeing more patient visits than ever before. Thanks to our dedicated and expert staff the quality of care remains high as evidenced in the inspection report we received this year from the Care Quality Commission (CQC). The CQC rated the Trust as 'good' overall and 'outstanding' for being effective and caring.

The position that GOSH occupies in the wider NHS system is unique among paediatric providers. We offer the widest range of specialist care available in the country, with patients coming to us from local and more general hospitals rather than from general practitioners. This can mean that patients have been on a pathway of care for some time before they reach Great Ormond Street.

We have an obligation to know when this journey began so we can ensure that all our patients receive treatment within a time appropriate to their clinical condition. However, patients often come to us without information about when their pathway started which means our data on how long they have been waiting for their treatment is often inaccurate. This year we have carried out extensive work to understand how we can better improve our systems and processes to ensure the data we have is accurate, so we can assure ourselves that patients are not waiting longer than they should be for treatment. This work and the progress made was highlighted in our CQC Report.

In order to undertake this work, we have had to do a root-and-branch review of how we receive information from other providers and our own operational and data capture processes. While this work has taken place we have been unable to report performance data for some of our waiting times.

This work is on-going and will continue into next year with reporting expecting to resume in September 2016. Throughout this programme of work we have investigated whether the way we have managed data has had an impact on the quality of care we have delivered. I am very pleased to say that to date no concerns with clinical care have been identified.

The financial environment we continue to operate in remains very challenging. This year we recorded a deficit of £11.1 million (adjusted to remove capital donations) for the first time in several years. This end of year position is after achieving £12 million of efficiencies (£11.6m in 2014/15) and the consequence of achieving significant income from our private patient activities. The coming year promises to be equally challenging. As costs of provision of care continue to rise faster than the income we receive for our services, we will continue to focus on transforming pathways of care to drive efficiency. We will also engage with our commissioners to ensure that we are providing those specialist services that should be delivered at a specialist hospital and at a rate that is fair and affordable. This approach is part of our three-year financial plan which aims to restore the organisation to financial balance by the end of 2017/18.

We see a unique cohort of patients with rare and complex diseases. Due to the critical mass of these patients and the life-limiting and life-threatening nature of their conditions we have a responsibility, if not an obligation, to carry out research to improve treatments and discover cures. Our academic partner University College London, and in particular its Institute of Child Heath, is central to this endeavour. A notable success over the last year was the use of a new gene therapy using modified T-cells to successfully treat drug-resistant leukaemia in a little girl with no other options left. This was a world first and received global attention. We have now treated a second child using the same approach and are starting the first-in-man trial this coming year.

We cannot hope to achieve all that we have set out to do without recruiting, retaining and investing in the right staff. The high cost of living in London, a national shortage of nurses and a highly mobile workforce means that attracting and keeping the staff we need remains a challenge. This recruitment and retention challenge is now named as one of our top three organisational risks. To help ensure that we retain our newly qualified nurses, we have introduced an extensive professional development programme. We are also investing in the development of our clinical leaders, through an innovative mentoring programme with one of our supporters.

Due to the complexity of their conditions, the majority of our patients are seen by many specialties across the organisation. In order to provide the best possible care and experience, our patients' needs and the co-ordination of their care must remain at the centre of our thinking and inform how we are structured.

Over the last year we have restructured our clinical divisions to better align our services around the patient pathways and to facilitate better planning and delivery of complex care packages. This has resulted in two, rather than five, NHS clinical

"The high cost of living in London, a national shortage of nurses and a highly mobile workforce means that attracting and keeping the staff we need remains a challenge."

divisions. The new divisions are named after our founder, Charles West, and one of most significant benefactors, JM Barrie. We have also restructured our executive team to better ensure a line of sight from the wards to the Board and align portfolios and accountabilities.

This restructure resulted in the creation of a Deputy Chief Executive position which I am delighted has been filled by Nicola Grinstead, who joined us at the start of the new financial year from Imperial College Healthcare. We have also appointed Loretta Seamer as Chief Finance Officer, who joins us from Children's Health Queensland Hospital and Health Service. Loretta replaced Claire Newton, who has led our financial strategy for a number of years and has made a huge contribution. Claire's expertise remains within the organisation as she has been appointed our interim Director of Strategy and Planning. I would like to thank her for her continued support.

I would like to end by thanking our talented and dedicated teams. As highlighted, in 2016/17 we will continue to face a number of strategic and operational challenges. I am confident that their passion, hard work and unrelenting search for new and better ways of delivering care will ensure that we deliver even higher standards of care, in a timely fashion, to the children and young people that deserve them.

**Dr Peter Steer**
Chief Executive

GOSH patient Mina, age eight, Squirrel ward

# Who we are and what we do

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) is an acute specialist hospital for children, providing a full range of specialist and sub-specialist paediatric healthcare services. We also carry out clinical research and provide education and training for staff working in children's healthcare. GOSH was authorised as a Foundation Trust on 1 March 2012.

## Our clinical services

GOSH has the UK's widest range of specialist health services for children on one site: a total of 50 different specialties and sub-specialties.

We have more than 239,800 patient visits a year (outpatient attendances and inpatient admissions). More than half of our patients come from outside London. We are the largest paediatric centre in the UK for:

- paediatric intensive care
- cardiac surgery – we are one of the largest heart transplant centres for children in the world
- neurosurgery – we carry out about 60 per cent of all UK operations for children with epilepsy
- paediatric cancer services including bone marrow transplants– with University College London Hospitals (UCLH), we are one of the largest centres in Europe for children with cancer
- nephrology and renal transplants
- children treated from overseas in our International and Private Patients' (IPP) wing

## Leading research and development

Through carrying out research with the Institute of Child Health, University of London and international partners, GOSH has developed a number of new clinical treatments and techniques that are used around the world.

The UK's only academic Biomedical Research Centre (BRC) specialising in paediatrics is a collaboration between GOSH and UCL Institute of Child Health. We are a member of University College London (UCL) Partners, joining UCL with a number of other hospitals – an alliance for world-class research benefitting patients. In partnership with six other NHS trusts, we are the lead provider for North Thames Genomics Medicine Centre, part of the national 100,000 Genomes Project.

## Education and training for staff working in children's healthcare

GOSH offers a wide prospectus of learning to all staff groups. Together with London South Bank University, we train the largest number of paediatric nurses in the UK. We also play a leading role in training paediatric doctors and other health professionals, which includes training on non-technical skills (human factors).

## Our business model

The Trust's business model demonstrates how GOSH creates value for its stakeholders through its activities. The model shows the critical inputs and the immediate outputs for its NHS services, education and research, and international and private patient activity and how these create value. The model provides a key focus for strategy development and for 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.

# Our strategic priorities

## Strategic priorities in 2015/16

Our vision is to be the leading children's hospital in the world. At the core of who we are and how we deliver our strategy are 'Our Always Values'– Always welcoming; Always helpful; Always expert; and Always one team. Delivery of this vision will only be possible with the continued commitment of our highly skilled staff and the close relationships with our key partners, the UCL Institute of Child Health and the GOSH Children's Charity.

The following diagram shows our key activities; how these activities contribute to the delivery of our vision; and how they are supported by staff, funding, information technology and physical assets.

### Key activities


## Strategic priorities in 2016/17

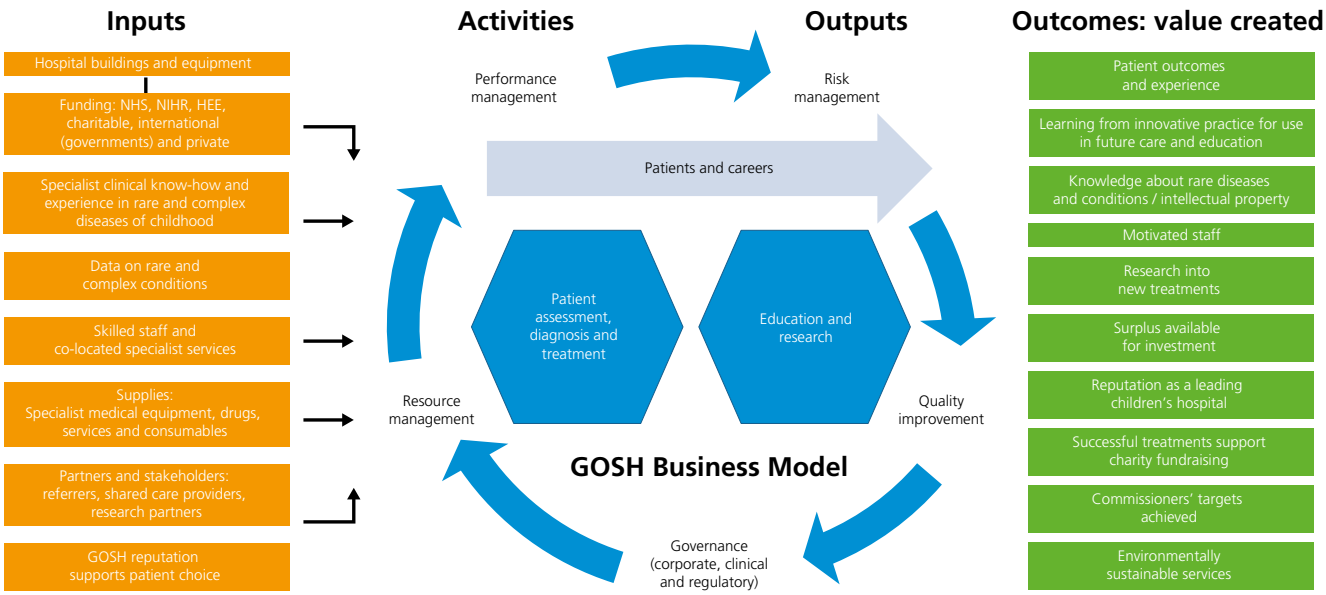
During 2015/16 we refreshed our strategy, to take account of the changes in the external environment and the NHS Shared Planning Guidance 2016/17 – 2020/21. As part of the strategic review, we sought fresh input from staff and our Members' Council. We re-evaluated our areas of strength and weakness, and how and where we can make the biggest positive impact on children's health through care, research and education.

Our strategic plan articulates how we will work to ensure access to high-quality, safe and timely care for all the children and young people that need to be treated at GOSH, and how we will continue to develop new treatments and innovative practices to improve child health. To achieve these priorities, we have agreed on the following four strategic objectives:

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

Most of our patients will be cared for by more than one organisation or team. When providing care and carrying out research, we seek to establish strong relationships and effective communications with all partners and stakeholders, to optimise patient experience and outcomes.

### The Trust's business model



## Management of risk in 2015/16

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

During 2015/16, we further improved our BAF to ensure that, at Trust Board level, we are focusing on the key risks to delivering our plans and the mitigating actions taken to enhance controls. The Board also agreed the level of risk we are prepared to accept across all business segments (the Trust's risk appetite). All risks in our BAF are reviewed by one of the Board Assurance committees (either the Audit Committee or Clinical Governance Committee).

A summary of the top three risks to our operational or strategic plans in 2015/16, and the mitigations in place to manage them, is outlined below.

| Risk | Potential impact | Mitigating actions implemented and underway |
|---|---|---|
| **Reduction in funding available to NHS organisations coupled with the high costs of maintaining delivery of specialised services** | A reduction in funding and/or increasing costs will lead to a need to reduce activity. This could potentially impact on our ability to deliver our vision, despite efforts to ensure excellent patient experience and outcomes. | • Robust financial planning including downside contingency planning and regular performance reviews<br>• Development of commercial strategies<br>• Monthly monitoring of capital expenditure<br>• Working with Commissioners to support the Trust's service and growth strategy<br>• Continued involvement in forums influencing paediatric tariff discussions<br>• Ongoing cost benchmarking |
| **Recruitment and retention of sufficient highly skilled staff with specific experience** | The inability to recruit and retain enough skilled staff could lead to a reduction in services that can be safely provided. This potential reduction could lead to GOSH being unable to accommodate all referrals to the Trust and/or result in longer waiting times. | • Specific action plans are in place for key service areas and professions<br>• Tactical use of temporary staff to fill vacancies<br>• Education commissioning plans to increase numbers of potential staff<br>• Monitoring workforce performance indicators to identify and address issues |
| **Management of Referral to Treatment (RTT) waiting time processes (Inconsistent application of the Trust Access Policy and unreliable data) (see page 67 in the Annual Governance Statement for further information)** | Failure to treat all patients within clinically appropriate timeframes<br>Inability to analyse data and subsequently make business decisions conducive to timely service provision. | • Implementation of a change programme across the Trust to review and implement the Trust's Access Policy (working in collaboration with the National Intensive Support Team (IST))<br>• Conducting training for all appropriate staff (non-clinical and clinical) on the application of the Trust Access Policy and national waiting list guidance<br>• Weekly monitoring of waiting lists, supported by on-going validation of patient lists and processes<br>• Detailed analysis of current systems and processes with regard to the underlying datasets and reporting<br>• Additional resource and leadership identified to support the Information Services Team<br>• Validation of the underlying data<br>• Weekly Clinical Review Group and access meetings with clinical teams<br>• Development and implementation of interim reporting solutions |

## Financial control and management and going concern

2015/16 saw the Trust report an underlying deficit for the first time in several years. In 2016/17 national intervention to reverse the deterioration in the finances of provider trusts may provide some relief. However, the financial risks facing GOSH will continue unabated from 2017/18.

The Trust is preparing a three year financial plan aimed at restoring the organisation to financial balance by the end of 2017/18. This will require us to deliver efficiencies at an unprecedented level.

The increasing demand for specialist services alongside inflation growth in costs for specialist health care delivery place a significant pressure on the Trust. In order to meet this pressure, the Trust will have to continue to transform pathways of care and be very clear about the activity that can only be done by us. The Trust continues to engage nationally on the subject of paediatric specialist top-up rates but these remain a significant concern to the Trust, with changes likely to occur for prices in 2017/18.

The Trust has deliberately increased services provided to international partners, particularly in the Middle East. Work in this region carries a degree of geo-political risk which the Trust does provide for but we are also actively seeking to diversify to reduce exposure to one key market.

The Trust maintains a strong liquidity position based upon historic surpluses and careful management of capital spend. The deficit in 2015/16 and any risk of not reversing this underlying deficit position will impact the levels of cash we are able to sustain, but performance remains strong in this area (please see page 57 for the Trust's going concern statement)

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


GOSH patient Cecilia, age one, Elephant ward

# Performance against Trust priorities in 2015/16

In setting the annual operating plan for 2015/16, the Trust agreed a number of key priorities to align with the Trust's overarching strategic objectives. Good progress was made during the year although not all prioritised targets were fully delivered.

The Board is regularly updated on specific performance measures on financial and non-financial performance. In addition, a mid-year and end of year assessment of the overall delivery of the Trust's priority objectives (aligned to the strategic objectives) is provided.

Progress was also monitored by relevant Committees which include:

- Patient and Family Experience and Engagement Committee;
- Patient Safety and Outcomes Committee;
- Quality Improvement Committee;
- Board Committees (Audit Committee, Clinical Governance Committee, Finance and Investment Committee) and monitored at divisional level at the monthly operational performance reviews.

The table below provides an evaluation of the Trust's achievements during 2015/16 against pre-determined targets linked to the strategic objectives.

| Strategic Objective | 2015/16 Priorities | Evaluation: |
|---|---|---|
| **Provides the best patient experience and outcomes** | Deliver the actions identified to improve quality based on the Trust's 12 quality standards | Achieved:<br>Reported regularly in the Board *Quality Report*. Progress maintained or improving in relation to mortality, detecting serious illness, healthcare associated infections. |
| | All specialties to have published a minimum of two clinical outcome measures on the Trust website or intranet | Partially achieved:<br>300 outcome measures have been identified and 128 reported on the Trust website (>two per specialty). However a number of these need to be updated (with work progressing to address these). |
| | At least three benchmarking initiatives active in year | Achieved:<br>Benchmarking outcomes in the craniofacial service is being progressed. The Trust joined the US Solutions for Patient Safety peer review system. Other benchmarking occurs at service level through the submission of quality dashboards to NHS England. |
| | 95 per cent of respondents would be likely to recommend GOSH to friends and family | Achieved:<br>The Trust is consistently achieving 98–99 per cent likelihood to recommend for inpatients and 95-97 per cent likelihood to recommend for outpatients. |
| | Respond to 100 per cent of complaints on time. The objective has been increased from 75 per cent to 100 per cent | Not achieved (60 per cent of complaints responded to on time):<br>A change to the complaints process in year (for very valid reasons) has temporarily extended the timeframe for responding. The process, policy and timescales are being reviewed, with training being given to relevant staff which should enable the Trust to achieve the target in 2016/17. |
| | Achieve all national (Referral to Treatment (RTT), diagnostic and cancer) waiting times targets | Not achieved:<br>See additional section on RTT (refer to page 19) |

| Strategic Objective | 2015/16 Priorities | Evaluation: |
|---|---|---|
| **Provides the best patient experience and outcomes** | Ensure that all areas are staffed safely and efficiently with an initial priority on out of core hours provision | Partially achieved:<br>Ongoing work includes: delivering the objectives set in the Quality Improvement programme which include: alignment to the Keogh seven day standards, assessing workloads out of hours (OOH) and revising standard operating procedures for reporting sickness, escalation and responsibilities OOH.<br><br>The new Deputy Medical Director for Medical Education has been appointed and is currently leading on work to ensure that we have the appropriate staff with the right skill-set to fulfil the tasks required OOH.<br><br>The sensitivity of the Children's Early Warning Score (CEWS) has been reviewed for the prediction of clinical deterioration. The Paediatric Early Warning Score (PEWS) was identified as a more sensitive and validated scoring tool. Work is underway to scope the process for change including the implementation of the Sepsis 6 recommendations. |
| **Is an excellent place to work and learn** | Achieve results in the upper quartile staff survey for staff recommending GOSH as a place to work / be treated | Achieved (based on first quarter 2015/16 only):<br>• Recommend as place to work,<br>Upper quartile = 70.9 per cent. GOSH = 71.1 per cent<br>• Recommend as place to be treated,<br>Upper quartile = 87 per cent, GOSH = 94 per cent. |
| | Compliance with student nurse mentorship annual update | Partially achieved:<br>The Trust continues to promote mentoring and provide support to staff to achieve the update. Delivery at present is 90 per cent compliance against a target of 100 per cent. |
| | All healthcare assistants starting employment from April 2015 will undertake the Care Certificate within 12 weeks | Achieved:<br>100 per cent compliance |
| | Ensure that the medical education provision supports the professional development of all levels of the medical workforce and effective service delivery for the Trust | Achieved:<br>This has been delivered with improvements in feedback from national trainees and trainers surveys. There is an agreement in principle to re-establish national training grid posts in oncology. An additional rota has been established with extended working hours for consultants and medical specialties. |
| **Delivering world leading paediatric** | Recruit 3,100 or more patients to National Institute of Health Research (NIHR) portfolio research studies and achieve national agreed metrics | Achieved:<br>In 2015/16, 3,164 patients were recruited to NIHR portfolio studies. |
| | Commence patient recruitment to the national 100,000 Genomes Project and roll out recruitment in all partners of the North Thames Genomics Medicine Centre | Achieved |

| Strategic Objective | 2015/16 Priorities | Evaluation: |
|---|---|---|
| | Continue to compete on an international scale and remain in top three in terms of research outputs | Achieved:<br>A recent Thomas Reuters analysis for publications 2010-2014 placed GOSH first for citation impact, compared to five international comparators. GOSH was fifth in terms of actual numbers of publications. |
| | To provide research training opportunities, at least four training posts in clinical academia and four nurse / Allied Health Professional (AHP) posts | Achieved |
| | Implement Research Accelerator program to improve access to research studies/trials and enable more research | Achieved:<br>New Research Accelerator launched in September 2015. |
| | Embed research in the fabric of the Trust (research and communications strategy and scope generic consent) | Achieved:<br>This was achieved and continues to be developed and worked upon with regards to a research communications plan, continued focus on generic consent and working with the GOSH Charity on a Research Capacity Fund. |
| **Is the partner of choice** | Provide patient discharge summaries to other clinicians within 24 hours | Partially achieved:<br>The proportion of summaries sent out within 24 hours of discharge has improved but it has proved difficult to sustain the improvement. |
| | Deliver more care closer to home by exploring partnership and network opportunities | Partially achieved:<br>The Trust continues to be actively engaged with commissioners and other providers responding to future models for collaborative working, eg for congenital cardiac surgery and neurosurgery. |
| **Is sustainable** | Achieve £12 million efficiency target | Achieved:<br>£9.5 million delivery of cost improvements augmented by non-recurrent cost under spends and contribution growth. |
| | Develop the Strategic Outline Case for Phase 4 of the Redevelopment Programme | Partially achieved:<br>Good progress has been made. |
| | Reduce CO2 emissions to 152.78 CO2 / m2 | Achieved:<br>The Trust is seeing CO2 emissions falling 8 per cent compared to 2014/15. We are on target to hit 138.59 kgCO2/m2. |
| | Work with NHS England and Monitor to develop a sustainable NHS funding model for GOSH | Partially achieved:<br>Agreement reached with NHS England for a joint programme of work to review GOSH cost structure and address where services are demonstrably underfunded. |
| | Deliver Outline Business Case (OBC) for Electronic Patient Record (EPR) system andData Warehouse and Analytics tools | Achieved:<br>The OBC for the EPR was approved by the Board. The Data Warehouse OBC was deferred pending EPR supplier selection. |
| | Fully implement Electronic Document Management | Partially achieved:<br>Following external delays to the project, pilots have progressed well and specialty engagement very good. |

## Finance and activity

The Trust has had a challenging financial year with earnings before interest, taxes, depreciation and amortisation (EBITDA) falling from £27.3 million (7 per cent of operating income) to £13.6 million (3.4 per cent of operating income).

NHS clinical activity has increased overall but the Trust has seen increasing demand for intensive care and highly specialised services which has reduced our capacity to deliver planned elective care.

The Trust business case to develop international private patient (IPP) activity has succeeded. Significant growth in IPP has made an important contribution to the Trust's financial position and has helped to offset significant non-recurrent costs incurred this year.

The Trust has incurred a number of significant non-recurrent costs to remedy issues with reporting of the referral to treatment (RTT) operating standards. The Trust has been validating historic data and the cost of this validation has been £2.5 million in 2015/16. Other operating costs have increased by 5.1 per cent, this year compared to the increase in operating income of 1.2 per cent.

The following table shows the Trust financial performance excluding income from donations. This table shows the underlying deficit of £11.1 million incurred by the Trust in 2015/16.

| For the period ended: | 31 March 2016 £ million | 31 March 2015 £ million |
|---|---|---|
| Operating income | 394.3 | 389.6 |
| Operating expenses | -380.7 | -362.3 |
| EBITDA | 13.6 | 27.3 |
| Depreciation, interest and dividend | -24.7 | -24.4 |
| Net surplus | -11.1 | 2.9 |

We have continued to invest considerable sums to improve the hospital's facilities in line with our published Masterplan 2015. The Trust resources are generously supplemented by charitable donations and together this enabled the Trust to spend £31.5 million on buildings and equipment this year.

The Trust set itself an ambitious savings target of £12 million in 2015/16 and delivered this target through recurrent and non-recurrent means. The target included an extensive programme of work on non-pay spending, clinical pathway improvement, careful reviews of staffing mix and skills and work to ensure that we run our buildings and facilities as efficiently as we possibly can.

## International and Private Patients (IPP)

The IPP division provides clinical services through two dedicated inpatients wards, through funded beds on NHS wards and a dedicated outpatient facility on the GOSH site in London. During the financial year 2015/16, the IPP division delivered against the agreed business objectives which contributed towards the Trust's strategic objectives.

Highlights for the division include:

- improved patient access and referral turnaround time
- established senior clinical presence in our primary referral region to aid patient experience and improve flow
- enhanced relationship management with key referrers, and agreed a plan to further enhancement in 2016/17
- increased income by 20 per cent in comparison to 2014/15 and delivered against the divisional savings plan
- progressed redevelopment work to provide additional private beds opening in 2016/17.

## Referral to Treatment (RTT) at GOSH

2015/16 was a challenging year for the Trust with respect to delivery of the RTT waiting time standards. The national standard for RTT requires 92 per cent of all patients to be seen within 18 weeks. Issues were identified in relation to the data and information processes required to robustly track patients through their elective pathway, as well as a number of operational processes in place to support these. No concerns with the clinical care received by patients have been identified. Further information can be found on page 67.

## Productivity and Efficiency (P&E)

The Trust's P&E programme for 2015/16 identified a £12 million cost reduction requirement. By the end of month 12 we successfully delivered £9.5 million of cost savings. This represents a significant improvement on our performance for 2014/15 and when combined with a non-recurrent recognition of income over performance and other non-recurrent underspends we have reported an overall achievement of our £12 million 2015/16 P&E target to NHS Improvement.

PricewaterhouseCoopers (PwC) has been working with us to develop a broader programme of work over the next three years, concentrating on a smaller number of Trust-wide initiatives that are then supplemented by schemes being developed by clinical divisions and corporate departments. The focus of this work is "no waits, no waste, zero harm".

To support this work we have been reviewing our Project Management Office function to assess how it can better support the delivery of the programme. We have also revised the Quality Impact Assessment process with the Medical Director, Chief Nurse and Head of Clinical Governance and Safety, to ensure that all P&E schemes have taken the potential quality impacts into account and to evidence that any identified risks have been mitigated accordingly.

## Research

We are committed to carrying out pioneering research to find treatments and cures for some of the most complex illnesses, for the benefit of children here in the UK and worldwide. With over 800 active research projects, key achievements in 2015/16 include:

- An analysis of publications from GOSH/ICH demonstrates the quality and impact of our research and reinforces our position as one of the leading children's research hospitals, with the citation impact of our publications (the number of times others cite our research publications) being twice the world average.
- Our commitment to supporting clinical research has been acknowledged by the National Institute for Health Research (NIHR), with two of our investigators receiving awards from the NIHR Clinical Research Network for their contribution to clinical research.

For more information please visit gosh.nhs.uk/research-and-innovation

## Care Quality Commission (CQC) inspection 2015

The CQC, the independent regulator of health and social care in England, visited the Trust in April and May 2015 as part of its rolling schedule of inspections. Services were rated as 'good' overall and 'outstanding' for being caring and for being effective.

The CQC inspectors were particularly impressed with:

- The degree of compassion and respect demonstrated by staff: examples of staff being compassionate and treating patients and their families with the highest levels of dignity and respect were seen throughout the inspection.
- Patient and parent involvement: the Trust was praised for keeping parents and children fully involved in their treatment, including decision making wherever possible.
- Commitment to continually improve the quality of care and to innovate: the inspectors noted many incidences of staff working together in the pursuit of excellent care and developing innovative treatments.
- An open and transparent culture: good examples of duty of candour were noted, with praise for staff being very open when things had gone wrong. This approach was seen with parents and patients, when apologies and support were offered. It was also seen corporately through the reporting and investigation of incidents.

In addition to highlighting areas of 'outstanding' practice, the CQC's report also details areas for improvement in order for GOSH to meet the highest standards, including a need for better data management, record keeping and administration processes, and ensuring there are clearer arrangements for reporting transitional care service performance.

The Trust is committed to making the improvements to fully address the issues identified. Further information can be found in the *Quality Report* on page 73.

## Quality improvements

As part of the Trust's aim to continue to improve the quality of its services and ensure that this can be demonstrated through robust measurement, we successfully delivered quality improvement projects in relation to patient flow, detecting deterioration and improving efficiency. More information on these projects can be found in the Trust *Quality Report* on page 73 In addition, we formally started collecting Friends and Family surveys which returned very positive results (refer to page 23).

## Development of specialised services

In addition to continuing to develop strategically important services such as paediatric critical care, genetics, haematology, oncology and epilepsy/ neurosurgery, we also acted as the lead for the newly formed North Thames Genomic Medicine Centre, providing DNA samples to the 100,000 Genome Project.

## Organisational development

Continuing the excellent work we undertook in 2014/15, and as a catalyst from the Francis Report, we delivered a programme of work focused on embedding the Trust's 'Our Always Values'. We also appointed a new tier of clinical leaders for each group of clinical specialties.

# Annual plan priorities for 2016/17

## Strategic priorities

Due to the continuing impact of funding constraints, organisations are required to collaborate more extensively to deliver sustainable services through transformation or streamlining care pathways across regional groups. As a result of the wide geographic spread of our patients and the specialist nature of our services, GOSH is in the unusual position of not fitting within any one of the regional Sustainability and Transformation (STP) footprints.

We are committed to working with NHS England and to influence the regional STP groups to ensure that appropriate priority is given to specialist children's services. We recognise that this will mean closer collaboration with other organisations to ensure that patients receive the right care, in the right location. GOSH is best placed to provide specialist paediatric care, while non-specialist care is best provided closer to the child's home.

Financial sustainability remains a key challenge in the context of decreasing real term funding for specialised services. We are committed to finding new ways of delivering our efficiency targets, but at the same time managing new cost pressures arising from routine cost increases (e.g. clinical negligence insurance and National Insurance contributions) and developments required to maintain high clinical standards. We are currently working with NHS England on a review of the prices received for our most specialist services, where a price is not set through the national tariff, and we expect to agree changes early in 2016/17.

Focussing on the longer term, in 2016/17 we want to set up processes to ensure that every patient has the opportunity to participate in a research study or trial. We also wish to optimise the integration between research and the development of new clinical diagnostics and treatments which is particularly relevant in developing our ability to identify and treat rare diseases.

We also expect to play an active role in the care pathways for delivering congenital cardiac surgery nationally and paediatric cancer services in London (this is to be determined).

## Service and operational priorities

Our most immediate priority is to complete the work to improve our processes and patient records so that we will be able to recommence reporting our performance against national waiting list targets and also to ensure that patients are treated within the established maximum waiting times. We are fast-tracking the procurement and implementation of an Electronic Patient Record (EPR) system which will further strengthen our processes and facilitate the sharing of patient information with other providers across care pathways.

A further urgent priority is to optimise recruitment and retention practices to ensure that we can maintain the number of skilled staff required to meet the demands of our services.

Ensuring that we listen and act on the feedback we receive from our patients and their carers is critical. As such, we wish to build on existing feedback systems and develop the capability for receiving and acting on real-time feedback. We also intend to develop clinical outcome measurement and reporting, through benchmarking with appropriate peers.

## Research priorities

Our key research priority for 2016/17 is to continue to realise the vision of the GOSH Research Hospital. For the prospective year, this will include:

- introducing a model for generic consent, allowing us to learn from each and every patient we see and using the knowledge gained to improve our patients' health and the health of future patients
- working with our partners to continue to grow a sustainable research infrastructure
- successfully applying for funding for a third NIHR Biomedical Research Centre and for independent funding for our Somers Clinical Research Facility

## Patient experience and involvement priorities

One of the Trust's key priorities in 2016/17 is to implement a real-time patient feedback system, to enable more timely and relevant responses to feedback. We will also continue to improve our patients' and families' experience by:

- hosting more events to listen to patients, families and staff
- reducing the time that patients and families spend waiting for appointments, diagnostic tests or treatment, and improve the experience of waiting
- improving the comfort of the hospital environment, focusing on the provision of food, satisfaction with overnight accommodation and improving the provision of play to children and young people
- improving the consistency of our communication and behaviours towards patients, families and each other, to ensure that all staff uphold the GOSH Our Always Values

## Redevelopment priorities

The redevelopment programme continues to replace outdated buildings and create new facilities. Our priorities for 2016/17 include:

- planning to occupy the Premier Inn Clinical Building (the second part of the Mittal Children's Medical Centre), opening in Summer 2017. The new building connects floor-by-floor with the Morgan Stanley Clinical Building and includes a new surgery centre, a high-specification respiratory ward and a specialist unit for children waiting for a heart transplant

- overseeing construction of the Zayed Centre for Research into Rare Disease in Children in collaboration with the GOSH Charity. Opening in 2018, it will provide a new outpatient department and laboratories to develop treatments and cures for children with rare conditions
- procuring a design team for a new clinical building on Great Ormond Street

## Corporate social responsibility

From encouraging all our staff to contribute to making GOSH a sustainable workplace, to helping employees stay fit and healthy, good corporate citizenship is a critical and increasing element of the way we work.

A tangible example of this is in the continuing development of apprentices at GOSH. In 2015/16, 40 apprentices started work at GOSH, with the promise that they will be employed on a full contract when they successfully complete their apprenticeship. GOSH was recognised for our apprenticeships work by being recognised with highly commended runner-up status in the 2015 Camden Business Awards.

Further information about how we support and develop our staff can be found on page 39.

## Sustainability

GOSH is committed to being a sustainable organisation and to protecting the environment in which our patients will grow up.

Our scope one and two carbon emissions have reduced by 8 per cent from 2014/15, which brings the total reduction since 2012/13 to 24 per cent. This reduction can, amongst others, be attributed to installing energy efficient LED lights and a behaviour change campaign.

Water consumption has increased by 10 per cent from 2014/15. We will therefore review water use and work with our partners and staff to ensure that our water consumption is minimised in 2016/17 and beyond.

Overall, waste volumes continue to steadily increase in line with an increase in patient activity. The focus of the sustainable waste management programme for the current year is the implementation of centrally located dual recycling bins. The project has proved successful in areas such as Barclay House, showing a 17 per cent increase in its recycling rate.

We have focused our sustainability initiatives on those that have a positive patient impact such as our behaviour change campaign, Operation TLC, and our advocacy work on air quality along Great Ormond Street. More information can be found at carbonculture.net/gosh

## Emergency planning

The Trust takes a proactive approach to emergency preparedness, resilience and response (EPRR). Following an NHS England audit in October 2015, the Trust improved its overall compliance against the core standards from 'partially' to 'substantially' compliant. To date, no London Trust has achieved full compliance. NHS England recognised the achievements in our planning and shared areas of our work as good practice.

In November 2015, the Trust declared an internal major incident following a significant power failure affecting a number of buildings on the main site. A post-incident report highlighted that, overall, the major incident team responded well in dealing with the immediate incident. The lessons learned have been integrated into the 2015/16 work plan.

The priority for the major incident planning group is to complete the work plan and continue the training and exercise programme for all staff.

## GO Create!

GO Create! is the Trust's Arts Programme and seeks to improve the hospital environment and experience through imaginative commissioning and creative experiences for patients, families and staff.

In 2015/16 we:

- significantly increased our regular workshop programme from one day to four days each week
- focused the Arts Programme on sustainability themes, to support the Trust's strategic objective
- won two national awards for our creative projects
- introduced the Arts Observational Scale to measure the impact of our activities
- created downloadable resources
- became an Arts Award centre to deliver accreditation for creative participation

For further information on the programme and recent projects, please see gosh.nhs.uk/gocreate

# Listening to and learning from our patients, families and stakeholders

GOSH seeks to provide the best possible services and experience to patients and their families, who come from diverse backgrounds and from all over the UK and the world. We have continued to do this through the active involvement of our Members' Council, parent representatives, Young Peoples' Forums as well as undertaking patient surveys and focus groups. Our commitment to excellent patient experience was recognised by the Care Quality Commission's 2015 inspection which rated every core service across the Trust as 'outstanding'.

## Patient surveys

Over the summer and autumn of 2014, the Trust participated in the first Care Quality Commission (CQC) national inpatient postal survey for children's services, along with 137 other trusts. The results of the survey were published by the CQC on 1 July 2015.

GOSH achieved an overall response rate of 30 per cent (3 per cent above the national average) with 31 per cent of respondents from a black and ethnic minority (BME) background, which was 10 per cent above the national average for BME responses. Our children and young people scored their overall experience 8.5 out of 10 while parents rated their experience 8.7 out of 10. This was comparable to other children's hospitals, but lower than the best performing trusts that achieved up to 9.4 out of 10.

GOSH was recognised to be among the best hospitals on four scores out of 52; these were:

- parents feeling involved in decision making about their child's care
- children and young people feeling their pain was well managed
- parents assessment of staff playing with their child whilst in hospital
- staff explaining operations or procedures

The Trust also performed well on measures related to Our Always Values in relation to being welcoming, friendly and expert.

The Trust had no red scores (the rating given to the worst performing hospitals). However, areas for improvement were identified including:

- patients' satisfaction with food
- patients discussing their fears and anxieties with staff
- changes to admission dates
- staff not working well together

A plan has been developed and is being implemented to deliver improvements in these areas. The Trust will be participating in a repeat of the survey in the autumn of 2016.

## Friends and Family Test

The Trust has now implemented the Friends and Family Test across all inpatient, outpatient and day care areas, with over 17,000 responses collected to date. While our response rate of 22 per cent is comparable to like trusts, the target GOSH sets itself will be reviewed in 2016/17 to ensure it is ambitious, but still achievable when compared with like trusts. In terms of the survey results, we are delighted that the likelihood of family and friends to recommend GOSH's services has remained consistently above our 95 per cent target for both inpatients and outpatients.

As part of our work to revise performance frameworks within clinical teams, responsibility for ensuring every parent, child and young person has had the ability to participate in the Friends and Family Test will be strengthened.

## Patient Advisory and Liaison Service

The Patient Advice and Liaison Services (Pals) is the hospital's customer services department, helping to advise and support patients, parents and the public with queries or problems they might have with services provided by GOSH.

During 2015/16 we helped 1,624 families. Of these, 1260 cases were resolved within a working week. Only 52 cases were escalated to formal complaints in this period.

Pals has received 2,096 information contacts, more than half of which were requests about being referred to GOSH. Many other contacts were about eligibility for travel support, parent accommodation and other support services.

The most common theme in Pals' casework remains communication between GOSH, parents or local healthcare services. Pals has been able to support our patients, parents and carers to resolve their concerns and to then share those cases with the Trust to help learn from their experiences.

## Volunteering

GOSH continues to recognise the value of engaging specially trained volunteers in meaningful and appropriate roles across the Trust. Reflecting the core values of the Trust, volunteers embody Always Welcoming, Always Helpful, Always Expert and Always One Team through all of their work supporting staff, families and patients.

Our volunteer numbers have remained steady at about 850 in 2015. With over 70 different roles, volunteers play a critical role in providing the best quality services for patients and families. In the last calendar year, volunteers contributed approximately 177,000 hours of support work, which sometimes enabled staff to undertake other necessary work. This equates to approximately £1,700,000 worth of time to the Trust, based on the London living wage.

Volunteer Services also oversees and manages 25 partner organisations delivering support services including Radio Lollipop, Scouts and Guides, Spread a Smile Entertainers, Epilepsy Society, Ezra U'Marpeh and Camp Simcha.

For more information on volunteering at GOSH, visit gosh.nhs.uk/working-here/volunteering-us

## Family equality and diversity

The Family Equality and Diversity Group continues to monitor whether our services meet the needs of our children, young people and families, many of whom have additional needs in terms of disability or language.

Last year, two focus groups were held to understand the experience of Muslim families and families of children with mobility problems. These prompted tangible improvements in patient experience, for example, in response to feedback that Muslim families were not always clear on whether food served in the Lagoon was halal, we now have copies of the halal certification available.

A key priority for 2016/17 is to achieve the Accessible Information Standard. This will ensure that we can communicate effectively with people with hearing and/or visual impairment. Our existing information will be produced in other accessible formats, such as signed video with a written transcript, which will further expand our audience.

## Complaints

The Trust fully investigates and responds to all complaints openly and honestly, in a way that is fair to everyone concerned. The Complaints team agree a timescale for the investigation with the complainant, co-ordinate the investigation and keep the complainant updated of progress throughout the investigation. A final response is sent from the Chief Executive or member of the Executive team and an offer to meet with relevant staff to discuss any further concerns will usually be made. If the complainant is unhappy following the Trust's response, they can ask the Health Service Ombudsman to review their complaint.

As part of the investigation process, areas for service improvement are identified and actions plans are devised. A log of all actions agreed as an outcome of complaints is kept by the Complaints team and updates on progress are regularly sought from the responsible staff.

In 2015/16, the Trust received 151 formal complaints. All complaints are graded green, amber or red according to severity. There were 12 complaints graded red (the most severe grading).

In 2015/16, the Trust received notification that four complaints had been escalated to the Ombudsman. The Ombudsman reached their final decision on six complaints, including compliants from previous years. Five of these were not upheld and one was partly upheld.

## Patient information

Information for children, young people and families continues to be produced, with around 200 new or revised information sheets published in the last year. These are popular with visitors to our website, with many viewed between 5,000 and 10,000 times a month.

## Working with our partners

### The UCL Institute of Child Health (ICH)

The UCL Institute of Child Health (ICH), in partnership with GOSH, is the largest centre in Europe devoted to clinical and basic research and postgraduate teaching in children's health. Together, we host the only academic specialist Biomedical Research Centre in the UK specialising in paediatrics, and we are the largest paediatric research partnership outside North America. Working with GOSH, the aim of the ICH is to build on its position as one of the leading centres in the world for child health research and education.

### Great Ormond Street Hospital Children's Charity

Great Ormond Street Hospital Children's Charity raises money to enable the hospital to redevelop its buildings, buy new equipment, fund paediatric research conducted at the hospital (and by its research partner, the ICH), and to support specific welfare projects, such as family accommodation. In the year 2015/16, total income before expenses was just over £93 million –the sixth consecutive year of income growth. Further information about the work of the Charity can be found at goshcc.uk

## Working with our stakeholders

### University College London Partners

One of five accredited academic health science systems in the UK, University College London Partners (UCLP) is a partnership – known as an Academic Health Science Centre – between UCL, Queen Mary University of London, the London School of Hygiene and Tropical Medicine, and four of London's most prestigious hospitals and research centres, including GOSH. By linking with experts and sharing knowledge and expertise between different specialist institutions through UCLP, GOSH can better support the advancement in scientific knowledge and ensure healthcare benefits are passed to patients as quickly as possible. Further information about UCLP can be found at: uclpartners.com.

### Our commissioners

More than 90 per cent of our clinical services are commissioned by one commissioner, NHS England, with the remaining 10 per cent of our services being delivered through arrangements with 205 Clinical Commissioning Groups (CCGs). The Trust has a proactive working relationship with NHS England, and holds regular contract meetings with commissioners to discuss service demand, quality indicators and finance. Many of our clinicians are engaging with the clinical reference groups established by NHS England to provide clinical input into standards and strategic planning of each specialised service.

### Referrers and clinical networks

Many GOSH specialised services operate with other healthcare providers in local, regional and national clinical networks of care. GOSH teams also play a role in working with other healthcare organisations, such as through the provision of outreach clinics, as a source of specialist clinical advice and as members of clinical reference and formulary groups. Working closely with referrers and within networks of care to strengthen shared care arrangements is a key strategic aim for the Trust.

### Healthwatch

Healthwatch is an independent organisation that has an important role in monitoring and shaping health and social care services locally, ensuring that staff listen to patients and families and respond to their needs.

### Statement from Directors

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

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

**Dr Peter Steer**
Chief Executive
20 May 2016

GOSH patient eight-year-old Kaylin, Squirrel Ward

# Accountability Report

## How we are governed

The Trust Board is responsible for overseeing the Trust strategy, managing strategic risks, and providing managerial leadership and accountability. The Executive Team has delegated authority from the Trust Board for the operational and performance management of clinical and non-clinical services of the Trust, including research and development, education and training. It is responsible for co-ordinating and prioritising all aspects of risk management issues that may affect the delivery of services. The Senior Management Team reports to the Executive Team and provides a regular forum for discussing and making decisions on a range of issues relevant to the day to day operational management, including efficiency, effectiveness and quality.

A performance management system is in place to monitor progress against:

- Trust objectives and supporting work streams
- Care Quality Commission (CQC) requirements
- NHS Improvement requirements
- national priority and existing commitment performance indicators
- commissioning and contract agreements
- key internal measures

The Trust's divisional structure has been consulted on and was redesigned in 2015/16. The divisions have been streamlined, from five divisions (for NHS activity) down to two. The revised structure is intended to avoid siloed work processes and unnecessary variation, and to facilitate more integrated and efficient pathways for the children we treat. The new structure should improve the speed and effectiveness of decision making with, and strengthen the involvement of, the clinical leadership in the management of the hospital. Corporate functions will be increasingly integrated with the operational teams as business partners. In addition, a Deputy Chief Executive position has been established to oversee the new structure, which will provide a breadth of oversight not previously provided.

As outlined on page 13, the Board has identified four strategic objectives, supported by a number of more detailed actions to deliver them. The Board receives a monthly key performance indicator (KPI) report, which is used to monitor progress against priority objectives, as outlined in our Annual Plan. This ensures that the Trust continues to meet and remain compliant with the range of external reviews, targets and contractual standards.

## Quality governance

The Trust places the highest priority on quality, measured through its clinical outcomes, patient safety and patient experience indicators.

The key elements of the Trust's quality governance arrangements are:

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

Further information can be found in the *Quality Report*.

The Board regularly receives reports on the quality improvement initiatives and other quality information, such as incidents and reports from specific quality functions within the Trust, for example Pals. The Clinical Governance Committee receives reports on clinical audits and health and safety audits. Each specialty and clinical division has an internal monitoring structure so that teams can regularly review their progress and identify areas where improvements may be required. Each specialty has to measure and report a minimum of two clinical outcomes. Each division's performance is considered at monthly performance reviews.

Patient and parent feedback is received via a detailed survey at least once a year (the Patient Friends and Family Test) through the work programme of the Patient and Family Experience and Engagement Committee, and a range of other patient and parent engagement activities. Further information can be found on page 23.

Risks to quality are managed via the Trust risk-management process, which includes a process for escalating issues. There is a clear structure via the Patient Safety and Outcomes Committee and the Patient and Family Experience and Engagement Committee, for following up and investigating incidents and complaints and disseminating learning from the results of investigations. There are well-developed child protection policies and practice.

Through these methods, all of the data available on the quality of care in each specialty and service is considered as part of our internal and external management and assurance process. During the year, the Trust became aware of problems with the quality of its waiting list data (Referral to Treatment data). The Trust decided to suspend reporting against its waiting list targets in September 2015 (see below for an explanation of the impact of this on Monitor's governance rating). This was reflected in the Trust's quarterly Board statements. Further information on the data quality and access issues is provided in the Annual Governance Statement on page 64.

More details about the strategic risks facing the organisation can be found on page 14.

The Royal College of Paediatrics and Child Health (RCPCH) was invited by the Trust in 2015 to conduct a review of the gastroenterology service, following a number of concerns expressed from within and outside the hospital about waiting times, communication and clinical governance of the service. It was recommended that a review be undertaken into some of the packages of care for our patients with rare and complex conditions that are hard to diagnose and treat. We are now working with international and national experts to undertake this work.

The CQC undertook a scheduled inspection of the Trust in April 2015. The Trust received an overall rating of 'good'. The recommendations and actions are outlined in the *Quality Report* on page 112.

The Trust is in the process of planning an external assessment against the Monitor Well Led Governance Framework (the quality governance framework is now incorporated within this framework). The results are due to be presented to the Board in the second quarter of 2016/17.

## Regulatory monitoring

Monitor publishes two ratings for each NHS foundation trust:

- The continuity of services rating is Monitor's view of the risk that a trust will fail to carry on as a going concern. A rating of 1 indicates the most serious risk and 4 the least risk. A rating of 2* means that a trust has a risk rating of 2 but its financial position is unlikely to get worse.
- The governance rating is Monitor's degree of concern about how a trust is run, any steps being taken to investigate this and/or any action being taken.

These ratings indicate where there is a cause for concern, but do not automatically trigger regulatory action. They simply prompt Monitor to consider whether a more detailed investigation is needed. Monitor updates foundation trusts' ratings each quarter and also in 'real time' to reflect any regulatory action taken.

The Trust's status during 2015/16 against Monitor's Governance Risk Assessment remains under review, following the Trust's decision to suspend reporting of performance against the referral to treatment (RTT) (incomplete) target (see page 67).

| 2015/16 | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Financial sustainability risk rating | 3 | 4 | 4 | 2 |
| Governance rating | Green | Under review | Under review | Under review |

### Registration with the Care Quality Commission (CQC)

GOSH is registered with the CQC as a provider of acute healthcare services. In January 2016, the CQC issued its report on the April 2015 comprehensive inspection, rating the Trust as 'good' overall. While many areas were identified as 'outstanding' the CQC issued one formal requirement notice and a number of actions for improvement. GOSH has submitted final plans to the CQC, outlining the progress and plans to implement both the formal and informal actions. Implementation continues in consultation with the CQC and other external regulators and stakeholders.

The Trust is committed to making the improvements required to fully address the issues identified by the CQC. An extensive transformation programme in the delivery of elective care is under way. This will ensure that all patients will be treated in a more timely way going forward, and that the systems and processes in place to support this are robust (for more detailed information on this work please refer to page 67). The Trust is aware of the effect these issues have had on patients' experience, and is working as quickly as possible to make the necessary improvements.

### Compliance with the Code of Governance

GOSH has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code, issued in 2012. The Trust Board considers that from 1 April 2015 to 31 March 2016 it was compliant with the provisions of the NHS Foundation Trust Code of Governance.

The schedule of matters for the Trust Board and Members' Council will be reviewed again in July 2016. The directors' and councillors' induction and development programme is under review. The directors' development programme will be considered in light of the findings of the Board Well Led Assessment, which is being conducted in June 2016.

## Members of the Trust Board in 2015/16

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

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

The Chief Executive has led a review and restructure of the Executive team to ensure that individual accountabilities are clear and 'fit for purpose' to deliver world class services.

During the year, changes to the Board of Directors were as follows:

- The departure of Professor Martin Elliott, Co-Medical Director and Dr Catherine Cale, Interim Co-Medical Director on 31 May 2015
- The appointment of Juliette Greenwood as Chief Nurse, commencing employment on 1 May 2015
- The appointment of Dr Vinod Diwakar as Medical Director, commencing employment on 1 June 2015
- The departure of Rachel Williams as Chief Operating Officer on 31 March 2016
- The departure of Robert Burns as Director of Planning and Information on 31 March 2016
- Claire Newton was Chief Finance Officer until 6 December 2015 and then became Interim Director of Strategy and Planning
- The appointment of Bill Boa as Interim Chief Finance Officer from 7 December 2015 to 31 March 2016
- The appointment of Professor Stephen Smith as Non-Executive Director on 1 March 2016 following the departure of Yvonne Brown on 29 February 2016

- The appointment of Nicola Grinstead as Deputy Chief Executive on 1 April 2016
- The appointment of Loretta Seamer as Chief Finance Officer on 1 April 2016.
- The reappointment of the Chairman, Baroness Blackstone until 28 February 2018
- The reappointment of Charles Tilley for one year (until 31 August 2016) as Non-Executive Director and Deputy Chairman, after which he will stand down from the Board
- The reappointment of Mary MacLeod as Non-Executive Director until 31 August 2017
- The reappointment of David Lomas for 2 years and 4 months (until 28 February 2018)

The Board and Council agrees that there is a good balance of skills in place, including the provision of patient services, quality improvement systems, education, research, accountancy, audit and change management. All Board members have been assessed against the requirements of the Fit and Proper Person Test.

The Board carried out significant work on the Trust's strategies in 2015/16 and held additional meetings to focus on this area.

The Board has continued to review and strengthen the Board Assurance Framework for monitoring the Trust's top strategic and operational risks. A special risk meeting was held in July 2015 to focus on the Board Assurance Framework and management of risk across the Trust.

## Non-Executive Directors

**Baroness Tessa Blackstone BSc (Soc) PhD**
**Chairman of the Trust Board and Members' Council**
**Appointed 1 March 2012**

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

Current term of office expires: 28 February 2018

**Mr Charles Tilley OBE FCA FCMA CGMA**
**Non-Executive Director and Deputy Chairman**
**Appointed 1 March 2012**

Experience:
- Qualified accountant
- Chief Executive Officer at The Chartered Institute of Management Accountants (CIMA)
- Director (corporate representative) CIMA China Ltd
- Director (corporate representative) CIMA Enterprises Limited
- Board member of the Association of International Certified Professional Accountants
- Chairman of the International Federation of Accountants' professional accountants in business committee
- Accounting for Sustainability Council member

Current term of office expires: 31 August 2016

**Ms Yvonne Brown LLB Solicitor**
**Non-Executive Director**
**Appointed 1 March 2012**

Experience
- Qualified solicitor – expertise in children, child protection, family law, and education
- Independent Board member of the Royal Institute of Chartered Surveyors UK Regulatory Board and member of the Scrutiny Committee
- Member of the Architects Registration Board Investigation Panel
- Panel Chair of the Nursing and Midwifery Council Fitness to Practice Committee and Registration Appeals Panel
- Trustee of the Law Society of England and Wales Charity

Term of office expired: 29 February 2016

**Ms Mary MacLeod OBE MA CQSW DUniv**
**Non-Executive Director and Senior Independent Director**
**Appointed 1 March 2012**

Experience:
- Non-Executive Equality and Diversity lead at Great Ormond Street Hospital NHS Foundation Trust
- Deputy Chair of the Child and Family Court Advisory and Support Service (CAFCASS)
- Chair of the ethics committee of the Internet Watch Foundation
- Trustee of Columba 1400
- Non-Executive Director of the Video Standards Council
- Chief Executive of the Family and Parenting Institute (1999–2009)
- Director of Policy, Research and Development and Deputy CEO of Childline (1995–99)
- Independent consultancy on child and family policy

Current term of office expires: 31 August 2017

**Mr David Lomas**
**Non-Executive Director and Chairman of the Finance and Investment Committee**
**Appointed 1 March 2012**

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

Current term of office expires: 28 February 2018

**Professor Rosalind Smyth CBE FMedSci**
**Non-Executive Director**
**Appointed 1 January 2013**

Experience:
- Director of the Institute of Child Health
- Honorary Consultant Respiratory Paediatrician at Great Ormond Street Hospital.
- Director of the Public Library of Science
- Honorary Professor of Paediatric Medicine at the University of Liverpool

Current term of office expires: 31 December 2018

**Mr Akhter Mateen**
**Non-Executive Director**
**Appointed 28 March 2015**

Experience:
- Independent Member of the Advisory Board of SuperMax
- Director of The British Pakistan Foundation
- Non-Executive Director CABI (Centre for Agriculture and Biosciences International) – an international not-for-profit organisation
- Group Chief Auditor of Unilever (2011–12)
- Senior global and regional finance roles at Unilever, leading finance teams in Latin America, South East Asia and Australasia. (1984–2011)

Current term of office expires: 27 March 2018

**Professor Stephen Smith DSc FMedSci FRCOG**
**Non-Executive Director**
**Appointed 1 March 2016**

Experience:
- Professor of obstetrics and gynaecology
- Chief Executive, Imperial Healthcare NHS Trust (2007–10)
- Dean, Faculty of Medicine Dentistry and Health Sciences, University of Melbourne (2013–15)
- Chairman of the Melbourne Academic Centre for Health (2014–15)

Current term of office expires: 28 February 2019

## Executive Directors

**Dr Peter Steer MBBS FRACP FRCP FAAP GAICD**
**Chief Executive**

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

Experience:
- Chief Executive, Children's Health Queensland Hospital and Health Services (2009–14)
- Professor of Medicine, University of Queensland (2009-14)
- Adjunct Professor, School of Public Health, Queensland University of Technology (2003–08)
- President, McMaster Children's Hospital, Hamilton, Ontario (2003–08)
- Professor and Chair, Department of Paediatrics, McMaster University, Canada (2003–08)

**Mrs Claire Newton MA (Cantab) ACA**
**Chief Finance Officer until 6 December 2015 then Interim Director of Strategy and Planning**

Claire Newton is responsible for the Trust's strategic planning. She is the named Senior Information Risk Owner.

Experience:
- Qualified accountant and member of the Association of Corporate Treasurers
- Trained and worked at Senior Management level at Ernst and Young (now EY)
- Finance Director and Financial Controller at Marie Curie Cancer Care (1998–2007)
- Chief Finance Officer at Great Ormond Street Hospital NHS Foundation Trust (2007–15)

**Mr Bill Boa**
**Interim Chief Finance Officer**
**(from 7 December 2015)**

Bill Boa is responsible for the financial management of the Trust and leads on contracting and information technology.

Experience:
- Qualified accountant, trained with Ernst & Whinney (now EY)
- Held Director of Finance positions in a number of NHS Trusts and NHS Foundation Trusts between 1995 and 2012
- Undertaken interim positions in a number of NHS organisations since 2012 including most recently as Interim Director of Financial Recovery at Royal Cornwall Hospitals NHS Trust.

**Ms Juliette Greenwood**
**Chief Nurse (from 1 April 2015)**

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

Experience:
- Registered Sick Children's Nurse
- Held Chief Nurse roles in the NHS since 2005 most recently at Bradford Teaching Hospitals NHS Foundation Trust (2013–15)

**Professor Martin Elliott MB BS MD FRCS**
**Co-Medical Director (until 31 May 2015)**

Martin Elliott was responsible for performance and standards (including patient safety) and led on clinical governance.

Experience:
- Gresham Professor of Physic, Gresham College London (2014–17)
- Professor of Paediatric Cardiothoracic Surgery, UCL
- Director of the National Service for Severe Tracheal Disease in Children (at GOSH)
- Chairman of Cardiorespiratory Services (2001–10) and led the Cardiothoracic Transplant Service, both at GOSH
- President of the International Society for the Nomenclature of Congenital Heart Disease (2000–10)

**Dr Vinod Diwakar MBBS FRCPCH MMedEd**
**Medical Director (from 1 June 2015)**

Vinod Diwakar is responsible for patient and staff safety and clinical quality and governance. He also provides professional leadership to the medical body and is responsible for postgraduate medical education and training for doctors, medical workforce development and clinical network development.

Experience:
- Practicing consultant paediatrician
- Medical Director at Birmingham Children's Hospital NHS Foundation Trust (2010–2015)
- Appointed member of the London Clinical Senate
- Appointed member of the London Children and Young People's Healthy Partnership Clinical Reference Group
- Chair of the Clinical Reference Group for Paediatric Medicine in NHS Specialised Commissioning
- Medical Advisor to the Noonan Syndrome Society

### Mr Ali Mohammed
### Director of Human Resources and Organisational Development

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

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

### Ms Rachel Williams
### Chief Operating Officer (until 31 March 2016)

Rachel Williams was responsible for the operational management of the clinical services within the Trust.

Experience:
- Divisional Manager at University College London Hospitals (2011–13)
- Divisional Manager at Great Ormond Street Hospital NHS Foundation Trust (2008–11)
- Service Manager at Imperial College Healthcare NHS Trust (2007–08)
- Site Manager at the Western Eye Hospital at Imperial College Healthcare NHS Trust (2007)

### Ms Dena Marshall
### Interim Chief Operating Officer (until 31 March 2016)

Experience:
- Joined the NHS as a graduate management trainee in 2003
- Thirteen years' experience as a Board Level Director, seven of them as Deputy Chief Executive
- Deputy Chief Executive and Director of Commissioning and Performance of NHS Heywood, Middlewood and Rochdale (2007–10) and Acting Chief Executive (2009–10)

### Dr Catherine Cale MB ChB PhD MRCP FRCPath MRCPCH
### Interim Co-Medical Director (until 31 May 2015)

Catherine Cale was responsible for postgraduate medical education and training for doctors, medical workforce development, and partnership services.

Experience:
- Consultant in paediatric immunology and immunopathology
- Divisional Director for Infection, Cancer, Immunity and Laboratory Medicine (2008–14)
- Clinical Lead for Immunology and Cell Therapy Laboratories

## Other directors who attend the Board of Directors' meetings

### Mr Robert Burns BSc (Hons) CPFA
### Director of Planning and Information (until 31 March 2016)

Robert Burns was responsible for the Trust's strategic planning, performance management and provision of information. He was also the named Senior Information Risk Owner and Executive Lead for risk management until October 2015.

Experience:
- Full member of the Chartered Institute of Public Finance and Accountancy
- Deputy Chief Operating Officer for Great Ormond Street Hospital NHS Foundation Trust (2009–12)
- Head of Partnerships, Southampton University Hospitals NHS Trust (2007–09)

### Mr Matthew Tulley
### Director of Redevelopment

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

### Professor David Goldblatt MB ChB PhD MRCP FRPCH
### Director of Clinical Research and Development

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

### Mr Trevor Clarke BSc MSc
### Director of International Patients

Trevor Clarke is responsible for the strategic development and management of the Trust's International Private Patients (IPP) division.

### Register of Interests

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

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

### Trust Board meetings

The Board of Directors held a total of 13 meetings between 1 April 2015 and 31 March 2016 of which six included a session held in public. In October 2015 and February 2016 the Board held strategy development sessions. The Board did not meet in August 2015. Extraordinary Board meetings were held in June, September and December 2015. Board seminar meetings were held in April and June 2015.

During the year:
- the Audit Committee met five times, including one extraordinary meeting
- the Clinical Governance Committee met four times
- the Finance and Investment Committee met seven times
- the Board of Directors' Nominations Committee met three times
- the Board of Directors' Remuneration Committee met twice

### Directors' attendance at meetings

| Name | Board | Audit | Clinical Governance | Finance and Investment | Nominations | Remuneration |
|---|---|---|---|---|---|---|
| **Tessa Blackstone** | Chair – 13 meetings of 13 held | N/A | N/A | N/A | Chair – 2 meetings of 2 held | 2 meetings of 2 held |
| **Charles Tilley** | 13 meetings of 13 held | Chair – 5 meetings of 5 held | N/A | N/A | 2 meetings of 2 held | 2 meetings of 2 held |
| **Mary MacLeod** | 13 meetings of 13 held | N/A | Chair – 4 meetings of 4 held | N/A | 2 meetings of 2 held | 2 meetings of 2 held |
| **Yvonne Brown** | 10 meetings of 10 held | 3 meetings of 3 held | 4 meetings of 4 held | N/A | 1 meeting of 1 held | Chair – (until 29 February 2016) 1 meeting of 1 held |
| **David Lomas** | 12 meetings of 13 held | 4 meetings of 5 held | N/A | Chair – 7 meetings of 7 held | 2 meetings of 2 held | Chair – (from 1 March 2016) 2 meetings of 2 held |
| **Rosalind Smyth** | 11 meetings of 13 held | N/A | 4 meetings of 4 held | N/A | 2 meetings of 2 held | 2 meetings of 2 held |
| **Akhter Mateen** | 12 meetings of 13 held | 5 meetings of 5 held | N/A | 7 meetings of 7 held | 2 meetings of 2 held | 2 meetings of 2 held |
| **Peter Steer** | 13 meetings of 13 held | 5 meetings of 5 held | 3 meetings of 4 held | 6 meetings of 7 held | 2 meetings of 2 held | 2 meetings of 2 held |
| **Claire Newton** | 12 meetings of 13 held | 5 meetings of 5 held | N/A | 7 meetings of 7 held | N/A | N/A |
| **Dena Marshall** | 10 meetings of 11 held | 4 meetings of 4 held | 3 meetings of 3 held | 4 meetings of 7 held | N/A | N/A |
| **Bill Boa** | 4 meetings of 4 held | 2 meetings of 2 held | N/A | 3 meetings of 3 held in tenure | N/A | N/A |
| **Vinod Diwakar** | 10 meetings of 11 held | N/A | 3 meetings of 3 held | N/A | N/A | N/A |
| **Juliette Greenwood** | 12 meetings of 12 held | N/A | 3 meetings of 3 held | N/A | N/A | N/A |
| **Martin Elliott** | 0 meetings of 2 held | N/A | 0 meetings of 1 held | N/A | N/A | N/A |
| **Catherine Cale** | 1 meeting of 2 held | N/A | N/A | N/A | N/A | N/A |
| **Ali Mohammed** | 13 meetings of 13 held | N/A | 3 meetings of 4 held | N/A | 2 meetings of 2 held | 2 meetings of 2 held |
| **Rachel Williams** | 3 meetings of 3 held | 1 meeting of 1 held | 1 meeting of 1 held | 1 meeting of 1 held | N/A | N/A |
| **Robert Burns** | 4 meetings of 12 held | 2 meetings of 5 held | 2 meetings of 4 held | 2 meetings of 7 held | N/A | N/A |
| **Matthew Tulley** | 10 meetings of 13 held | N/A | N/A | N/A | N/A | N/A |

## Evaluation of Board Performance

The Trust is in the process of planning an external assessment against the Monitor Well Led Governance Framework. The results are due to be presented to the Board in the second quarter of 2016/17.

## Board Committees

The Board delegates certain functions to its subcommittees which meet regularly. The Board receives any amendments to the committee terms of reference, annual reports and committee self-assessments. An independent member (non-voting) sits on both the Audit Committee and Clinical Governance Committee to provide a link and to ensure that information is effectively passed between committees. Members of both assurance committees meet annually to discuss strategic risk and consider how the committees effectively share responsibility for monitoring strategic risk on behalf of the Board.

### Audit Committee

The Audit Committee is chaired by a non-executive director and has delegated authority to review the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes to support the organisation's objectives. A summary of the work of the committee can be found on page 54.

### Clinical Governance Committee

The Clinical Governance Committee (CGC) is chaired by a non-executive director and has delegated authority from the Board to be assured that the correct structure, systems and processes are in place within the Trust to manage clinical governance and quality and safety related matters and that these are monitored appropriately. A summary of the work of the committee can be found on page 58. The committee receives regular internal audit and clinical audit reports.

### Finance and Investment Committee

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

### Trust Board Remuneration Committee

The Remuneration Committee is chaired by a non-executive director and is responsible for reviewing the terms and conditions of office of the Board's Executive Directors, including salary, pensions, termination and/or severance payments and allowances. A summary of the work of the committee can be found on page 45.

### Trust Board Nominations Committee

The Trust Board Nominations Committee is chaired by the Chairman of the Board. It has responsibility for reviewing the size, structure and composition of the Board and making recommendations with regard to any changes – giving full consideration to succession planning and evaluating the balance of skills, knowledge and experience in relation to the appointment of both executive and non-executive directors. A summary of the changes to the structure of the executive teams, including appointments can be found on page 27.

GOSH patient one-year-old Freya, Badger ward

## Members' Council

At the heart of the NHS Foundation Trust model is local accountability, in which our Members' Council plays an essential role.

Our 27 elected and appointed governors (councillors) represent the interests and views of our patients and their families, the public, staff and local stakeholders ensuring that the membership voice is heard and reflected in the strategy for the hospital. We see the Members' Council as our critical friend and guardian of our values.

### The role of the Members' Council

The role of the Members' Council is to challenge the Board of Directors and hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. They ensure that the views of the hospital's patients and wider communities are heard and reflected in the strategy for the hospital. Councillors represent specific constituencies and are elected or appointed to do so. Key responsibilities of the Members' Council include:

- appointing and removing the Non-Executive Directors, including the Chairman of the Trust
- Setting the pay levels of the Chairman and Non-Executive Directors
- approving the appointment of the Chief Executive
- appointing the Trust's financial auditors
- receiving and approving the Trust annual accounts, auditor's report and annual reports, including the *Quality Report*
- deciding whether the Trust's private patient work would significantly interfere with the Trust's principal purpose
- approving any proposed increases in non-NHS income of five per cent or more in any financial year
- actively representing the interests of members
- acting as a source of ideas about how the Trust can provide its services, and working with the Board of Directors to help influence strategic direction
- acting as an advocate for children who need specialised healthcare
- being an essential link between the Trust and various partner organisations

The GOSH Members' Council is made up of 27 councillors. Of these, 22 are elected representatives for patients, parents, carers, staff and the public and five are representatives for appointed organisations. The duration of appointment for all elected and appointed councillors is three years.

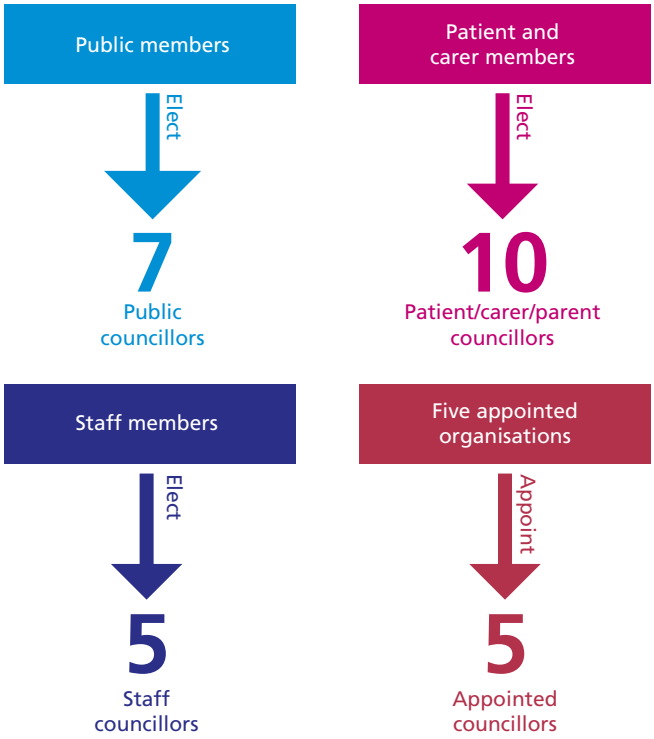
Councillors attend five official Members' Council meetings a year, provide input on Trust work through various committees and working groups, and get involved in specific projects where their expertise or perspective is valuable. They are active in the hospital, and attend events in the community, key Trust and other engagement events. The Members' Council is a critical guardian of Our Always Values.

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

### Constituencies of the Members' Council

As a specialist trust with a broad geographical catchment area, we do not have a defined 'local community'. We treat patients from across England and internationally, although most come from London, Eastern Counties and South East England. Therefore, it is important that our geographically diverse patient and carer population is reflected in our membership base.

**Members' Council**



The table below provides the breakdown in more detail.

| Constituency (2015–18) | Number of seats on council |
|---|---|
| **Elected councillors** | |
| Patient and carer constituency | |
| • Patients from London | 2 |
| • Patients from outside London | 2 |
| • Parents or carers from London | 3 |
| • Parents or carers from outside London | 3 |
| Public constituency | |

| Name | Areas | Councillors |
|---|---|---|
| North London and surrounding area | Comprising the following electoral areas in North London:<br>Barking & 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.<br><br>Comprising the following electoral areas in:<br>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; Harlow; Maldon; Rochford; Southend on Sea; Tendring; Thurrock; Uttlesford. | 4 |
| South London and surrounding area | Comprising the following electoral areas in South London:<br>Bexley; Bromley; Croydon; Greenwich; Royal Borough of Kingston upon Thames; Lambeth; Lewisham; Merton; Richmond upon Thames; Southwark; Sutton; Wandsworth.<br><br>Comprising the following electoral areas in:<br>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; Kent: Ashford; Canterbury; Dartford; Dover; Gravesham; Maidstone; Medway; Sevenoaks; Shepway; Swale; Thanet; Tonbridge and Malling; Tunbridge Wells; | 1 |
| Rest of England and Wales | All electoral areas in England and Wales not falling within one of the areas referred to above. | 2 |
| **Statutory** | | |
| UCL Institute of Child Health | | 1 |
| London Borough of Camden | | 1 |
| **Partnership Organisations** | | |
| National Commissioning Group | | 1 |
| Self management UK | | 1 |
| The Hospital School at GOSH and UCL | | 1 |

### Lead Councillor

Ms Claudia Fisher, the councillor representing parents and carers from outside London, was elected in March 2015 to serve as Lead Councillor for three years, with endorsement of the Members' Council on an annual basis.

### Councillors' attendance at meetings

The Members' Council met five times during the 2015/16 reporting period. The Members' Council Nominations and Remuneration Committee (a subcommittee of the Members' Council) met three times, and the Membership and Engagement Committee (a subcommittee of the Members' Council) met five times during that period. The table below details councillors' attendance at these meetings.

| Name | Constituency | Date of appointment | Attendance at Members' Council Meetings (out of 5 unless otherwise stated) | Nominations and Remuneration Committee attendance (out of 3 meetings unless otherwise stated) | Membership and Engagement Committee attendance at meetings (out of 4 meetings unless otherwise stated) |
|---|---|---|---|---|---|
| Edward Green* | Patients outside London | 1 March 2015 | 4 | Not a member | Not a member |
| George Howell* | Patients outside London | 1 March 2015 | 3 | Not a member | 4 |
| Sophie Talib** | Patients from London | 1 March 2015 | 3 | Not a member | 1 |
| Susanna Fantoni*** | Patients from London | 1 March 2015 | 3 | Not a member | 0 |
| Matthew Norris** | Parents or carers from London | 1 March 2015 | 5 | (3)<br>Re-elected in March 2015 | Not a member |
| Lisa Chin-A-Young** | Parents or carers from London | 1 March 2015 | 4 | (3)<br>Elected in March 2015 | 4 |
| Mariam Ali*** | Parents or carers from London | 1 March 2015 | 5 | Not a member | Not a member |
| Claudia Fisher** | Parents or carers from outside London | 1 March 2015 | 5 | Not a member | 1(1) |
| Camilla Pease** | Parents or carers from outside London | 1 March 2015 | 5 | Not a member | 0 |
| Carley Bowman*** | Parents or carers from outside London | 1 March 2015 | 5 | Not a member | 3 |
| Trevor Fulcher** | North London and surrounding area | 1 March 2015 | 3 | Not a member | Not a member |
| Rebecca Miller** | North London and surrounding area | 1 March 2015 | 4 | Elected in March 2015 | Not a member |
| Mary De Souza*** | North London and surrounding area | 1 March 2015 | 5 | Not a member | Not a member |
| Simon Hawtrey-Woore*** | North London and surrounding area | 1 March 2015 | 2 | Not a member | 1 |

| Name | Constituency | Date of appointment | Attendance at Members' Council Meetings (out of 5 unless otherwise stated) | Nominations and Remuneration Committee attendance (out of 3 meetings unless otherwise stated) | Membership and Engagement Committee attendance at meetings (out of 4 meetings unless otherwise stated) |
|---|---|---|---|---|---|
| Gillian Smith*** | South London and surrounding area | 1 March 2015 | 5 | Not a member | 2 |
| Stuart Player** | The rest of England and Wales | 1 March 2015 | 3 | Not a member | Not a member |
| David Rose*** | The rest of England and Wales | 1 March 2015 | 1 | Not a member | Not a member |
| Jilly Hale** | Staff | 1 March 2015 | 4 | (2)<br>Elected in March 2015 | Not a member |
| Clare McLaren** | Staff | 1 March 2015 | 5 | Not a member | Not a member |
| James Linthicum** | Staff | 1 March 2015 | 4 | Not a member | Not a member |
| Rory Mannion*** | Staff | 1 March 2015 | 5 | Not a member | Not a member |
| Prab Prabhakar*** | Staff | 1 March 2015 | 3 | Not a member | Not a member |
| Jenny Headlam-Wells** | London Borough of Camden | 1 March 2015 | 3 | Not a member | Not a member |
| Christine Kinnon** | University College London, Institute of Child Health | 1 March 2015 | 4 | Not a member | Not a member |
| Olivia Frame | Expert Patient Programme Community Interest Company | 1 March 2015 | 2 | Not a member | 1 |
| Muhammad Miah** | Great Ormond Street Hospital School | 1 March 2015 | 2 | Not a member | Not a member |
| Hazel Fisher | NHS England | 31 March 2015 | 2 | Not a member | Not a member |

*Elected unopposed in February 2015; **Re-elected or re-appointed for a second three year term; ***Newly elected in March 2015

### What membership means at GOSH

Membership at GOSH is open to anyone living in England and Wales over the age of 10. Employees who hold a GOSH permanent contract or fixed term contract of 12 months or more are eligible for staff membership.

Membership enables formal involvement for our patients, their families and carers, the public and staff to engage with and shape the strategic direction of the Trust. Our members help us better understand the views of our hospital community so that we can improve the quality, responsiveness and development of services and ensure that patients' and carers' needs are met.

### Membership constituencies and membership numbers

Our membership database is held and managed by Great Ormond Street Hospital Children's Charity. In 2016/17, Membership Engagement Services (MES) will hold and manage this data on behalf of the Trust. At year end (31 March 2016) our membership numbers stood at 9,205 excluding staff (13,014 including staff). We have met and exceeded our estimated annual membership target of 9,097 (excluding staff members) and our membership numbers have increased by 524 members during the financial year.

The revised membership strategy sets out the plans for membership over the next three years. The strategy is based around three key themes of Recruit, Communicate and Engage, with a number of more detailed objectives falling under each theme. These themes will be used to build on the Trust's established systems and processes to develop, maintain and engage its members; to guide our annual membership recruitment, engagement and communication calendars; and to evaluate the effectiveness of the Trust's membership performance.

| Constituency | Minimum number of members | Actual (as of 31/03/16) |
|---|---|---|
| Patient and carer | 900 | 6,205 |
| • Parents or carers | 600 | 5,267 |
| • Patients | 300 | 938 |
| **Public** (includes North London and the surrounding area, South London and the surrounding area and the rest of England and Wales) | 900 | 3,000 |
| Staff | 2,000 | 3,809 |
| **Total (excluding staff)** | **9,205** | **13,014**[1] |

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

### Membership engagement

Members receive the Trust's newsletter *Member Matters* and the monthly 'Get Involved' email which provide updates on hospital news and ways to get involved. Members have the opportunity to vote in elections and stand for election to the Members' Council. There are dedicated pages to membership on the Trust website at gosh.nhs.uk/about-us/foundation-trust

The Membership and Engagement Committee, a subcommittee of the Members' Council, oversees the recruitment and retention of members and seeks to maximise engagement opportunities for them for the benefit of the Trust. The committee is co-chaired by two Councillors, and meets at least four times a year.

Last year's achievements included an updated Membership Strategy and taking an active role in the design and carrying out of the Annual Plan Survey. The survey was designed jointly by the Membership and Engagement Committee and the planning and patient experience staff within the Trust. There were 375 responses of which 49 per cent were from patients or carers and 33 per cent from staff members. The findings were as follows:

- There was good support for the questions aimed at finding out interest in specific developments in our *Annual Plan*, specifically the website, the Research Hospital and virtual patient consultations
- The survey showed some extremely positive responses for the Trust's Our Always Values but flagged some specific issues with the Always Values – One Team
- The survey included free text suggestions of some matters for Members' Council to discuss with the Board. These fell under the following major themes: improving patient care and experience; staff behaviours; and administrative processes
- The survey also invited members to suggest their top priority for improvement in 2016/17 under the following major themes: improving communication, improving administrative processes and catering, along with some specific comments on certain services

The survey results have informed the *Annual Plan 2016/17* and ideas for improvements and concerns have been referred to the relevant committee/ group in the hospital.

Following an away day in February 2016, the Committee proposed a new reporting system to capture and process feedback received during member engagement activities to the Patient and Family Engagement and Experience Committee (PFEEC). Ensuring the membership voice is heard is key to our status as a Foundation Trust.

## Trust Board and Members' Council working together

The Trust's Chairman is responsible for the leadership of both the Members' Council and the Board of Directors. The Chairman has overall responsibility for ensuring that councillors' views are appropriately considered. The Chairman is also responsible for effective relationship building between the Board and councillors to ensure that councillors effectively perform their statutory duties and contribute to the forward planning of the organisation.

The respective powers and roles of the Board of Directors and the Members' Council are set out in their standing orders. Some of the key features between the two bodies are:

- Executive and Non-Executive Directors attend each Members' Council meeting
- Summaries of the Board Assurance Committees (Audit Committee, Clinical Governance Committee and Finance and Investment Committee) are presented at each Council meeting
- Summaries of Members' Council meetings are reported to the Board of Directors
- The Members' Council has an open invitation to attend all Trust Board meetings
- An open invitation is extended to all councillors to observe at Board Assurance Committee meetings

In 2015/16 the Members' Council and Board have worked together on:

- Councillors' contribution to the Redevelopment Project Group
- Councillors' participation in a CQC focus group
- Councillors' participation in the International Private Patients (IPP) Strategy group
- *Annual Plan* membership consultation

During the year, councillors and the Board Chairman discussed how the Board and Members' Council can work effectively together. Actions were agreed on:

- how the Council hold the Non-Executive Directors to account
- dedicated access to the Chairman and the Senior Independent Director throughout the year
- a restructure of the Council agenda to focus on strategic and membership engagement and representative issues
- a review of the role of the Membership Engagement Committee
- the management of Council meetings

### Members' Council Nominations and Remuneration Committee

The Members' Council Nominations and Remuneration Committee has delegated responsibility for assisting the Members' Council in:

- reviewing the balance of skills, knowledge, experience and diversity of the Non- Executive Directors
- succession planning for the Chairman and Non-Executive Directors in the course of its work
- identifying and nominating candidates to fill Non-Executive posts
- considering any matter relating to the continuation of any Non-Executive Director
- reviewing the results of the performance evaluation process for the Chairman and Non-Executive Directors

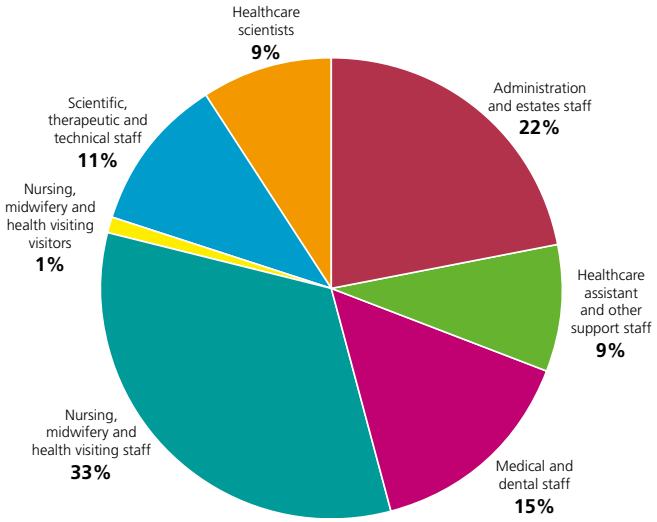
The committee is chaired by the Chairman of the Board and Members' Council. The Deputy Chairman is also a member. Membership and attendance of councillors at the meeting is detailed on page 35. In 2015/16 the committee recommended to the Members' Council the following:

- reappointment of Mr Charles Tilley for one year (until 31 August 2016) as Non-Executive Director and Deputy Chairman, after which he will stand down from the Board
- reappointment of Mr David Lomas for 2 years and 4 months (until 28 February 2018)
- acceptance of the findings of a Board experience and knowledge audit
- recommendation of the appraisals of the Chairman and Non-Executive Directors (conducted in December 2015)
- reappointment of Baroness Blackstone, Chairman (until 28 February 2018
- reappointment of Mary MacLeod, Senior Non-Executive Director (until 31 August 2017)
- appointment of Professor Stephen Smith as a Non-Executive Director from 1 March 2016 for three years (using open advertising).

All of these recommendations were approved by the Members' Council.

# Staff Report

As at 31 March 2016, the Trust employed 3,246[1] full-time equivalent (FTE) permanent staff, in addition to this we contractually employed 605 FTE staff on fixed-term contracts. Of our 3,851 contracted FTE staff, our staff group profile is as follows:




1. Based on staff in post as at 31 March 2016. Substantive contract holders only (excludes temporary staff).

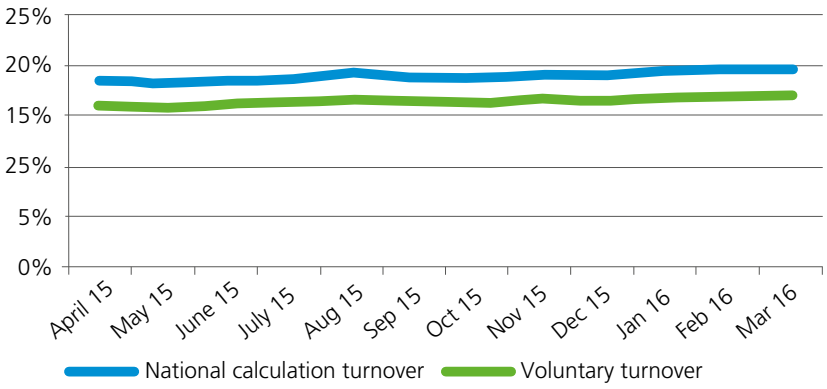
## Recruitment and retention

Our ability to deliver outstanding care to our patients and families depends on recruiting, retaining and supporting outstanding staff.

The high cost of living in London and a highly mobile workforce means that recruitment and retention continue to be challenges for GOSH. In June 2015, we ran assessment centres for newly qualified nurses that resulted in us appointing 106 newly qualified nurses. We also recruited 44 nurse graduates from the Republic of Ireland.

To help ensure that we retain our newly qualified nurses we have introduced a professional development programme which provides additional support as part of the preceptorship programme.

**GOSH turnover rate (12-month rolling)**




## Keeping our staff fit and healthy

We recognise the pressures our staff face and offer a range of benefits including:

- a free and on site dedicated staff physiotherapy service
- a 24/7 staff counselling and advice service
- a wide range of sports and social activities, from netball teams to Pilates classes
- a full Occupational Health service

## Health and safety at GOSH

In 2015, we introduced online health clearance for our new recruits, which has resulted in a significant improvement in the time it takes to clear staff.

The Trust is committed to effectively controlling risks and preventing harm to all patients, visitors and staff through our health and safety work. In conjunction with the incident reporting system, the Trust uses proactive means of identifying and subsequently mitigating risks. These include auditing the entire Trust using a tool which monitors compliance against statutory regulations and measures performance against any safety critical alerts or Trust/paediatric specific criteria. The governance structure ensures that any statutory compliance is undertaken within stated legislative guidelines.

The Trust has a multimillion-pound redevelopment programme underway which brings with it inherent risks – especially given the proximity of clinical environments. There are measures in place which put additional controls on the construction work and ensures that this work fits around the safe delivery of the clinical care.

## Equality and diversity

Treating all our staff fairly, equitably and with respect is a core component of our 'One Team' Always Value. In 2015 we welcomed the launch of the new NHS Equality Delivery System as an opportunity to engage staff in conversations about the priorities in our equality and diversity work. We believe that open and honest conversations are vital in making real and lasting change and this led to feedback that informed our new objectives on:

- training in dealing with concerns about bullying and harassment
- managing the recruitment and selection process
- ensuring our leaders are visibly demonstrating their commitment to equality and diversity

In July 2015, we published our extensive annual review of data relating to equality and diversity, which put us in a strong position to meet the reporting requirements of the new Workforce Race Equality Scheme.

## Support for disabled staff

**Policies for giving full and fair consideration to applications for employment by disabled people.**

The Trust's Equal Opportunities Policy and a Recruitment and Selection Policy and Procedure outline the various mechanisms in place to ensure that applications from disabled candidates receive full and fair consideration. We also provide training on fair recruitment and advice to managers.

The Trust is accredited as a '2 Ticks' employer; a status awarded by Job Centre Plus to employers that have demonstrated a commitment to employing and developing the abilities of disabled staff.

**Policies for continuing the employment of, and arranging appropriate training for staff who have become disabled.**

Our Occupational Health department, with input from specialist agencies as necessary, provides advice on modifications required to support disabled staff, including adjustments to job roles, working hours, environment and training that may be required to enable staff to continue working safely and effectively. Our Sickness and Attendance Management Policy has specific provision to support staff with disabilities.

**Policies for training, career development and promotion of disabled staff**

We have a policy of regular performance and development appraisal reviews (PDRs) for all our staff, which provides an opportunity for the training needs and personal development of all employees to be discussed on an individual basis, taking into account their particular needs.

## Gender reporting

Detailed below is a summary of the gender of the directors, senior managers and staff contractually employed at GOSH[1]:

| | Female | | Male | |
|---|---|---|---|---|
| **Group** | **Headcount** | **%** | **Headcount** | **%** |
| **Director** | 7 | 41.2 | 10 | 58.8 |
| **Senior manager** | 12 | 60.0 | 8 | 40.0 |
| **Employees** | 3190 | 78.1 | 896 | 21.9 |
| **Grand total** | 3209 | 77.8 | 914 | 22.2 |

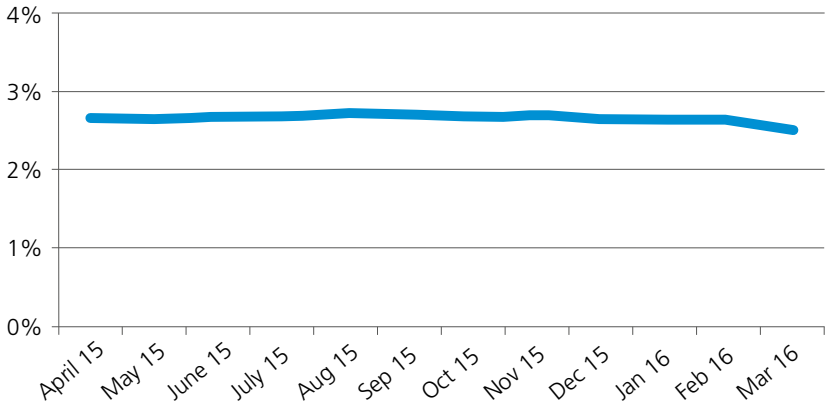
1. Based on headcount of staff in post as at 31 March 2016 (not FTE). Substantive contract holders only (excludes temporary staff).

## Sickness absenteeism

We believe the support we offer to keep staff healthy is an important component in this, but we also know that our staff are highly committed to delivering the best possible care to patients, families and each other at all times.

We have also enhanced the Sickness and Attendance Management Policy to review the trigger systems following feedback from line managers. The policy also now provides a structure for employees managing long-term conditions.

**GOSH sickness rate**



## Engaging and listening to staff

Our programme of Executive-led briefings has been well received, with staff regularly taking up the opportunity to hear from the Chief Executive and Executive Directors, ask questions and provide feedback on a very wide range of subjects. We recognise that many staff may be busy treating patients, so a summary of each briefing, including the Q&A, is published on our intranet pages.

We have also continued regular sessions that bring together a large number of our most senior clinical leaders together with the hospital's management team to share thoughts and ideas on the Trust's activities and performance.

These forums are in addition to regular committees, such as our Staff Partnership Forum, which allow us to discuss issues with our formal staff side representatives, and the Members' Council which includes staff councillors. We consult staff on changes that may affect their roles, such as organisational restructures, as well as asking our staff for their views in ad hoc events on issues such as creating a sustainable hospital.

Our quarterly Staff Friends and Family Test and annual staff survey provide us with regular opportunities to measure the experience of our employees.

### Staff survey

We have continued to work hard to promote the importance of the staff survey, and have maintained an above average response rate.

| | 2014 | | 2015 | | Trust improvement/ deterioration |
|---|---|---|---|---|---|
| **Staff survey response rate** | **GOSH** | **National average** | **GOSH** | **National average** | |
| | 60% | Above average (49%) | 53% | Above average (49%) | 7% deterioration |
| **Top 5 Ranking Scores** | **GOSH** | **National Average** | **GOSH** | **National Average** | |
| Percentage of staff agreeing that their role makes a difference to patients | | | 93 | 92 | See note 1. |
| Percentage of staff experiencing physical violence from staff in last 12 months | 1 | 1 | 1 | 1 | No significant change |
| Percentage of staff appraised in last 12 months | 88 | 84 | 89 | 88 | No significant change |
| Organisation and management interest in and action on health and wellbeing | | | 3.79 | 3.72 | See notes 1 and 2 |
| Percentage of staff able to contribute towards improvements at work | 75 | 71 | 78 | 73 | No significant change |
| **Bottom 5 Ranking Scores** | **GOSH** | **National Average** | **GOSH** | **National Average** | |
| Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell | Not available | | 65 | 59 | See note 3 |
| Percentage of staff working extra hours | 76 | 72 | 80 | 75 | No significant change |
| Percentage of staff suffering work-related stress in the last 12 months | 35 | 35 | 37 | 34 | No significant change |
| Percentage of staff witnessing potentially harmful errors, near misses, or incidents in the last month | 40 | 29 | 39 | 29 | No significant change |
| Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months | 6 | 6 | 10 | 6 | Deterioration |

NOTES:
1. The national survey states for this key finding: "Because of changes to the format of the survey questions this year, comparisons with the 2014 score are not possible."
2 This is measured on a scale of 1 to 5 (the higher the score the better).
3 The way this score was calculated in 2015 changed and the national average for 2014 was not re-calculated using the new methodology.

The reports are reviewed by the Trust Board and divisional senior management teams, and the quarterly Staff Friends and Family Test scores are also monitored at divisional level on a quarterly basis. Our results for 2015/16 consistently show that over 90 per cent of staff would recommend GOSH as a place to be treated; over 70 per cent as a place to work; and over 90 per cent are familiar with Our Always Values.

We believe that our staff recognise errors and near misses when they witness them, and as these survey results show, that staff consistently report these incidents and have high levels of confidence in incident reporting systems and processes. We carefully monitor all reported incidents, and take steps to learn from them and avoid them in future, as recognised in the CQC's most recent inspection report.

We know that our staff can only do their jobs if they are fit and healthy, and we have a range of measures to help them stay well, both physically and psychologically. The detailed survey results show that staff feel their managers are supportive but that staff themselves are highly committed to not letting their patients or their colleagues down. The Trust is working hard to ensure that staff know about and are accessing all the support available to them, and that managers are equipped to provide a supportive working environment. The Trust is also improving systems and processes across the hospital to help us work more efficiently, to alleviate pressure on staff.

Our staff see families who may be experiencing significant life stress, and very occasionally this can lead to physical or verbal aggression. We are committed to keeping our staff safe without compromising the care of the child. To do this, in 2016/17 we will be improving the training offered in recognising and managing conflict, and ensuring senior that staff are trained to deal with serious situations when they arise.

### Recognising and rewarding performance

In 2015 we updated our approach to annual staff appraisals. We now place equal value on the extent to which our staff behave in line with Our Always Values as well at their achievement of objectives – we know that it is not just what our staff do but how they do it that makes a difference to patients and families. In the coming year, we will be building on this work to help us develop our talent management strategy.

Our monthly and annual staff awards have continued to be an extremely popular way for staff, patients and families to recognise outstanding individuals and teams, and for the hospital to celebrate them as role models. We received over 650 nominations from patients, families and staff in 2015/16. In our annual awards ceremony, we saw how all our staff – from finance managers to recovery nurses, porters to surgeons – all had to work together as One Team to help us deliver care to just one patient and his family.

### Whistleblowing

GOSH encourages staff to always raise their concerns in accordance with GOSH policy. The policy was reviewed by our external auditor and another high performing NHS Trust and subsequently the policy has been simplified to provide staff with a one page 'route map' outlining the avenues available to them should they wish to raise a concern. This is included in staff induction training. The Audit Committee receives assurance of compliance with the GOSH policy and receives reports on any whistleblowing cases.

The 2015 annual staff survey found that 96 per cent of staff said they knew how to report any unsafe clinical practice and 70 per cent stated that they would feel secure raising their concerns. These results are at least as good as those of other acute specialist trusts.

In 2016/17 we will consider how we might further strengthen current policies and practices, including introducing the role of a 'Speak up Guardian'.

## Learning and Development

To deliver the best care to children and their families, our staff need the best learning and development opportunities. In 2015/16, a range of innovative learning opportunities have been provided to GOSH staff, as well as clinicians at other paediatric facilities. These include:

- In response to the Cavendish Review, a paediatric-specific national care certificate for Healthcare Assistants (HCAs) was developed so that HCAs can gain the skills and knowledge to deliver care to children and young people. In conjunction with London South Bank University, GOSH has also designed a course to provide a transition qualification for HCAs to move into a degree in nursing.
- Increased opportunities for different clinical and non-clinical professionals to learn with, from, and about each other, through the introduction of Schwartz rounds. We have also launched an inter-professional education network which offers a range of workshops and seminars to staff.
- GOSH co-designed and delivered a training module to improve communication between healthcare professionals and children and young people across north central and east London.
- A Postgraduate Medical Education (PGME) app was launched, providing easily accessible information on all the learning opportunities available to doctors in training. The PGME design team continued to offer a range of innovative programmes, including Clinical Leadership in Action, to prepare junior medical staff for the step into leadership and management roles.

The Trust is due to launch its new Learning Management System in May 2016, with a personalised learner and manager dashboard which will give at-a-glance updates on compliance with mandatory training. This is a critical step forward for the use of technological innovation to facilitate learning and development in the future, and in 2015/16 our e-learning team created 14 new modules across a wide range of clinical and non-clinical subjects.

In the coming year we will review our statutory and mandatory training to ensure it is always high quality, outcome focused and supports our staff to deliver safe and effective care. We will also continue to roll out bespoke training to all our staff who are involved in managing waiting lists so that none of our patients wait longer than they should for treatment.

We know that high quality leadership at all levels of the organisation is imperative, and in the last twelve months we have developed new Heads of Clinical Service roles, which puts clinicians at the heart of management across the hospital. We used a leadership assessment centre to select candidates and provide them with individual feedback to support their development in these roles. Building teams and leaders will be a focus of our organisational development work as we introduce new structures, and new systems and processes, in the coming months.

# Remuneration Report

## Directors' remuneration

Details of remuneration, including the salaries and pension entitlements of the Board of Directors, are provided on pages 46-49. The only non-cash element of the most senior managers' remuneration packages is pension-related benefits accrued during membership of the NHS Pension Scheme. Contributions into the scheme are made by both the employer and employee in accordance with the statutory regulations.

## Remuneration policy

The structure of pay for senior managers is designed to reflect the long-term nature of the Trust's business and the significance of the challenges we face. The remuneration should therefore ensure that it acts as a legitimate and effective method to attract, recruit and retain high performing individuals to lead the organisation. That said, the financial and economic climate across the health sector position must also be considered.

NHS Trusts, including Foundation Trusts, are free to determine the pay for senior managers, in collaboration with the Board of Directors' Remuneration Committee. Historically, reference has been made to benchmarking information available from other comparable teaching hospitals, and any recommendations made on pay across the broader NHS, when looking to recommend any potential changes to the remuneration for senior managers. This includes those under the Agenda for Change terms and conditions, and those senior managers in the NHS covered by national pay frameworks.

Our commitment to senior managers' pay is clear. Whilst consideration is given to all internal and external factors, it is important that GOSH remains competitive if we are to achieve our vision of being the world's leading children's hospital. The same principles of rating performance and behaviour will be applied to senior managers, in line with the Trust's appraisal system. This in turn may result in senior managers having potential increases withheld, and even reduced, as is the case with senior managers under the Agenda for Change principles, should performance fall below the required standard.

## Future policy

The future policy table below highlights the components of Directors' pay, how we determine the level of pay, how change is enacted and how Directors' performance is managed.

GOSH patient Rifah, age 16, Eagle ward

| How the component supports the strategic objective of the Trust | How the component operates (including provisions for recovery of sums paid; how changes are made). | Maximum potential value of the component | Description of framework used to assess performance |
|---|---|---|---|
| **Salary and fees** | | | |
| Set at an internationally competitive level to attract high quality Directors to a central London base; benchmarked across other NHS Trusts in order to deliver the Trust's strategic objectives. | Salaries are reviewed annually and any changes are normally effective from 1 April each year. Such changes are proposed and made via the Board's Remuneration Committee, chaired by a Non-Executive Director. In exceptional circumstances, reviews of salary may be made outside of this cycle, but are made by the Remuneration Committee and ratified by the Board.<br>Any sums paid in error, malus or recovered due to breach of contract are followed up with the individual. | Change to basic salary is usually enacted as a percentage increase in line with national Agenda for Change pay arrangements, to ensure parity across the Trust (Directors are proportionally not treated more favourably than the rest of the Trust). | Trust Performance and development review (PDR)/annual appraisal to set objectives linked to the Trust's strategic objectives. Failure to meet objectives is managed via the Trust's performance frameworks. |
| **Taxable benefits** | | | |
| Not applicable | | | |
| **Annual performance-related bonuses** | | | |
| Not applicable | | | |
| **Long term-related bonuses** | | | |
| Not applicable | | | |
| **Pension-related benefits** | | | |
| Pension benefits (which may be opted out of) are part of the total remuneration of Directors to attract high calibre staff to enable the Trust to meet its strategic objectives. | Pension is available as a benefit to Directors and follows national NHS Pension Scheme contribution rules (or alternative pension provider). | Pension is available as a benefit to Directors and follows national NHS Pension Scheme contribution rules (or alternative pension provider). Pension entitlements are determined in accordance with the HMRC method. | Not applicable |
| **Directors with remuneration (total) greater than £142,500** | | | |
| The Trust balances the market forces factors for recruiting top Director talent with social responsibility in relation to executive pay. Remuneration is regularly benchmarked across peer UK NHS organisations. | | | |
| **Service contract obligations** | | | |
| The Trust does not stipulate any special terms in relation to severance arrangements for Directors. In any occasion of termination of a contract, Directors would not be treated differently from any other member of staff. | | | |
| **Policy on payment for loss of office** | | | |
| Directors' contracts primarily stipulate a minimum notice period of six-months. Payment in lieu of notice, as a lump sum payment, may be made at the discretion of the Trust and with the approval of the Trust's Remuneration Committee, in line with government limits. | | | |
| **Statement of consideration of employment conditions elsewhere in the Foundation Trust** | | | |
| Any changes to Directors' remuneration is usually enacted as a percentage increase in line with national Agenda for Change pay arrangements to ensure parity across the Trust. Directors' remuneration is set at the Remuneration Committee and formally ratified by the Trust Board. Initial salary setting and review is undertaken by benchmarking ourselves with peer Trusts. | | | |

## Remuneration for Executive Directors

The remuneration and conditions of service of the Chief Executive and Executive Directors are determined by the Board's Remuneration Committee. The remuneration for other staff is paid in accordance with national terms and conditions of service. The Remuneration Committee is chaired by a non-executive director and meets twice a year, in November and March. Attendance at meetings held in during 2015/16 can be found on page 31.

The committee determines the remuneration of the Chief Executive and Executive Directors after taking into account uplifts recommended for other NHS staff, any variation in or changes to the responsibilities of the Executive Directors, market comparisons, and job evaluation and weightings. There is some scope for adjusting remuneration after appointment as directors take on the full set of responsibilities in their role.

Affordability is also taken into account in determining pay uplifts for directors. Where it is appropriate, terms and conditions of service are consistent with NHS pay arrangements, such as Agenda for Change.

For the financial year 2015/16, the committee recommended that there should be a one per cent non-consolidated payment and that there should be no uplift in basic pay for Executive Directors. This recommendation is in line with the pay awards for other senior NHS staff on the Agenda for Change pay scales and was ratified by the Board of Directors. The 2016/17 Agenda for Change pay award granted a 1 per cent pay award to all Agenda for Change staff to basic and high cost area supplements. On consideration of this, the committee agreed to consolidate the previous years' local percentage allowance into basic pay to mirror the national pay award.

During 2015/16, the Committee:

- approved the salaries for the Chief Nurse (commencing 1 May 2015) and Medical Director (commencing 1 June 2015)
- approved the salaries of the Chief Finance Officer and Deputy Chief Executive (both commencing 1 April 2016)
- a correction to the Medical Director's salary (from 1 April 2016)

Performance is closely monitored and discussed through both annual and on-going appraisal processes. All Executive Directors' remuneration is subject to performance – they are employed on contracts of employment and are substantive employees of the Trust. Their contracts are open-ended employment contracts, which can be terminated by either party with six months' notice. The Trust redundancy policy is consistent with NHS redundancy terms for all staff. All new directors are now employed on probationary periods in line with all non-medical staff within the Trust.

In the event of loss of office (e.g. through poor performance or misconduct), the Trust will apply the principles and policies set out in this area within its relevant employment policies. Any such termination of employment would be a matter for consideration by the Board's Remuneration Committee and subject to audit by its Audit Committee.

In 2015/16, the Board's Remuneration Committee reviewed the salaries of the Executive Directors when considering the pay for the Chief Finance Officer and Deputy Chief Executive. In 2016/17 the Remuneration Committee will refresh a benchmarking exercise to ensure that remuneration packages for executive directors are competitive and jobs are appropriately weighted.

## Remuneration for Non-Executive Directors

The remuneration of the Chairman and Non-Executive Directors is determined by the Members' Council, taking account of relevant market data. Non-Executive Directors do not receive pensionable remuneration.

The Members' Council Nominations and Remuneration Committee (see page 38) considered the remuneration of the Chairman and Non-Executive Directors in April 2015. It reviewed the data from previous benchmarking exercises and updated information including benchmark data from a Foundation Trust peer group. Following consideration of the structure of the current remuneration packages, the committee recommended that the remuneration for the Chairman and Non-Executive Directors would not be uplifted for a two year period. This recommendation was unanimously approved by the Members' Council.

Remuneration levels for the Chairman and Non-Executive Directors will remain fixed at the following rates until March 2017:

- Chairman's remuneration: £55,000pa
- Non-Executive Directors' remuneration: £14,000pa
- Deputy Chairman/Chairman of Audit Committee and Senior Independent Director's remuneration: £19,000pa

### Salary entitlements of senior managers

Information about the salary and pension entitlements for senior managers can be found from page 46.

### Expenses

Information on the expenses received by Directors and Councillors can be found in the Accounts on page 162.

**Dr Peter Steer**
Chief Executive

### Non-executive Directors 2015/16 (£000)

| Name | Title | Salary and fees | Taxable benefits | Annual performance related bonuses | Long-term performance related bonuses | Pension related benefits | Total |
|---|---|---|---|---|---|---|---|
| Baroness Tessa Blackstone | Chairman of Trust Board | 50—55 | 0 | 0 | 0 | 0 | 50–55 |
| Ms Yvonne Brown | Non-Executive Director (until 29 February 2016) | 10–15 | 0 | 0 | 0 | 0 | 10–15 |
| Mr David Lomas | Non-Executive Director | 10–15 | 0 | 0 | 0 | 0 | 10–15 |
| Ms Mary MacLeod OBE | Non-Executive Director | 15–20 | 0 | 0 | 0 | 0 | 15–20 |
| Mr Akhter Mateen | Non-Executive Director (from 28 March 2015) | 10–15 | 0 | 0 | 0 | 0 | 10–15 |
| Professor Stephen Smith | Non-Executive Director (from 1 March 2016) | 0–5 | 0 | 0 | 0 | 0 | 0–5 |
| Ms Ros Smyth | Non-Executive Director | 0–5 | 0 | 0 | 0 | 0 | 0–5 |
| Mr Charles Tilley | Non-Executive Director | 15–20 | 0 | 0 | 0 | 0 | 15–20 |

### Non-executive Directors 2014/15 (£000)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Baroness Tessa Blackstone | Chairman of Trust Board | 50–55 | 0 | 0 | 0 | 0 | 50–55 |
| Ms Yvonne Brown | Non-Executive Director (until 29 February 2016) | 10–15 | 0 | 0 | 0 | 0 | 10–15 |
| Mr David Lomas | Non-Executive Director | 10–15 | 0 | 0 | 0 | 0 | 10–15 |
| Ms Mary MacLeod OBE | Non-Executive Director | 15–20 | 0 | 0 | 0 | 0 | 15–20 |
| Mr Akhter Mateen | Non-Executive Director (from 28 March 2015) | 0–5 | 0 | 0 | 0 | 0 | 0–5 |
| Professor Stephen Smith | Non-Executive Director (from 1 March 2016) | n/a | n/a | n/a | n/a | n/a | n/a |
| Ms Ros Smyth | Non-Executive Director | 0–5 | 0 | 0 | 0 | 0 | 0–5 |
| Mr Charles Tilley | Non-Executive Director | 15–20 | 0 | 0 | 0 | 0 | 15–20 |

**Executive Directors 2015/16 (£000)**

| Name | Title | Salary and fees | Taxable benefits | Annual performance related bonuses | Long-term performance related bonuses | Pension related benefits | Total |
|---|---|---|---|---|---|---|---|
| Mr Bill Boa | Interim Chief Finance Officer (from 7 December 2015) | 65–70 | 0 | 0 | 0 | 0 | 65–70 |
| Mr Michael Bone | Interim Director of Information and Communication Technology (until 31 December 2015) | 135–140 | 0 | 0 | 0 | 0 | 135–140 |
| Mr Robert Burns | Director of Planning and Information | 95–100 | 0 | 0 | 0 | 15–20 | 115–120 |
| Dr Cathy Cale | Interim Co-Medical Director (until 31 May 2015) | 15–20 | 0 | 0 | 0 | 0 | 15–20 |
| Mr Trevor Clarke | Director of the International and Private Patients Division | 80–85 | 0 | 0 | 0 | 15–20 | 95–100 |
| Dr Vinod Diwakar | Medical Director (from 1 June 2015) | 90–95 | 0 | 0 | 0 | 0 | 90–95 |
| Mr Martin Elliott | Co-Medical Director (until 31 May 2015) | 10–15 | 0 | 0 | 0 | 0 | 10–15 |
| Professor David Goldblatt | Director of Clinical Research and Development | 5–10 | 0 | 0 | 0 | 0 | 5–10 |
| Mrs Juliette Greenwood | Chief Nurse (from 1 May 2015) | 110–115 | 0 | 0 | 0 | 65–70 | 180–185 |
| Mr Paul Labiche | Director of Estates and Facilities | 85–90 | 0 | 0 | 0 | 20–25 | 110–115 |
| Mrs Dena Marshall | Interim Chief Operating Officer (from 20 April 2015) | 115–120 | 0 | 0 | 0 | 20–25 | 135–140 |
| Mr Niamat (Ali) Mohammed | Director of Human Resources | 120–125 | 0 | 0 | 0 | 15–20 | 140–145 |
| Mrs Claire Newton | Chief Finance Officer (to 6 December 2015) and Interim Director of Strategy and Planning (from 7 December 2015) | 125–130 | 0 | 0 | 0 | 15–20 | 145–150 |
| Mr Ward Priestman | Interim Director of Information and Communication Technology (from 1 January 2016) | 70–75 | 0 | 0 | 0 | 0 | 70–75 |
| Dr Peter Steer | Chief Executive | 205–210 | 0 | 0 | 0 | 45–50 | 255–260 |
| Mr Matthew Tulley | Director of Development | 125–130 | 0 | 0 | 0 | 25–30 | 150–155 |
| Ms Rachel Williams | Chief Operating Officer | 75–80 | 0 | 0 | 0 | 35–40 | 115–120 |

**Executive Directors 2014/15 (£000)**

| Name | Title | Salary and fees | Taxable benefits | Annual performance related bonuses | Long-term performance related bonuses | Pension related benefits | Total |
|---|---|---|---|---|---|---|---|
| Mr Bill Boa | Interim Chief Finance Officer (from 7 December 2015) | n/a | n/a | n/a | n/a | n/a | n/a |
| Mr Michael Bone | Interim Director of Information and Communication Technology (until 31 December 2015) | 165–170 | 0 | 0 | 0 | 0 | 165–170 |
| Mr Robert Burns | Director of Planning and Information | 100–105 | 0 | 0 | 0 | 25–30 | 130–135 |
| Dr Cathy Cale | Interim Co-Medical Director (until 31 May 2015) | 15–20 | 0 | 0 | 0 | 25–30 | 45–50 |
| Mr Trevor Clarke | Director of the International and Private Patients Division | 80–85 | 0 | 0 | 0 | 10–15 | 95–100 |
| Dr Vinod Diwakar | Medical Director (from 1 June 2015) | n/a | n/a | n/a | n/a | n/a | n/a |
| Mr Martin Elliott | Co-Medical Director (until 31 May 2015) | 80–85 | 0 | 0 | 0 | 0 | 80–85 |
| Professor David Goldblatt | Director of Clinical Research and Development | 5–10 | 0 | 0 | 0 | 0 | 5–10 |
| Mrs Juliette Greenwood | Chief Nurse (from 1 May 2015) | n/a | n/a | n/a | n/a | n/a | n/a |
| Mr Paul Labiche | Director of Estates and Facilities | 90–95 | 0 | 0 | 0 | 15–20 | 105–110 |
| Mrs Dena Marshall | Interim Chief Operating Officer (from 20 April 2015) | n/a | n/a | n/a | n/a | n/a | n/a |
| Mr Niamat (Ali) Mohammed | Director of Human Resources | 120–125 | 0 | 0 | 0 | 15–20 | 140–145 |
| Mrs Claire Newton | Chief Finance Officer (to 6 December 2015) and Interim Director of Strategy and Planning (from 7 December 2015) | 125–130 | 0 | 0 | 0 | 15–20 | 145–150 |
| Mr Ward Priestman | Interim Director of Information and Communication Technology (from 1 January 2016) | n/a | n/a | n/a | n/a | n/a | n/a |
| Dr Peter Steer | Chief Executive | 50–55 | 0 | 0 | 0 | 5–10 | 60–65 |
| Mr Matthew Tulley | Director of Development | 125–130 | 0 | 0 | 0 | 15–20 | 140–145 |
| Ms Rachel Williams | Chief Operating Officer | 120–125 | 0 | 0 | 0 | 40–45 | 165–170 |

### Pension entitlements of senior managers (£000)

| Name | Title | Real increase in pension at age 60 (bands of £2,500) | Real increase in pension lump sum at age 60 (bands of £2,500) | Total accrued pension at pension age at 31 March 2016 (bands of £2,500) | Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000) | Cash equivalent transfer value at 1 April 2015 | Cash equivalent transfer value at 31 March 2016 | Real increase/ (decrease) in cash equivalent transfer value at 31 March 2015 |
|---|---|---|---|---|---|---|---|---|
| Mr Robert Burns | Director of Planning and Information | 0–2.5 | (2.5)–0 | 35–40 | 60–65 | 384 | 402 | 18 |
| Dr Cathy Cale | Interim Co-Medical Director (until 31 May 2015) | (2.5)–0 | 2.5–5 | 30–35 | 100–105 | 577 | 620 | 43 |
| Mr Trevor Clarke | Director of the International and Private Patients Division | 0–2.5 | 2.5–5 | 40–45 | 120–125 | 812 | 846 | 34 |
| Dr Vinod Diwakar | Medical Director (from 1 June 2015) | 0–2.5 | 0–2.5 | 35–40 | 110–115 | 627 | 638 | 11 |
| Mrs Juliette Greenwood | Chief Nurse (from 1 May 2015) | 2.5–5 | 10–12.5 | 50–55 | 155–160 | 930 | 1,006 | 76 |
| Mr Paul Labiche | Director of Estates and Facilities | 0–2.5 | 0 | 10–15 | 20–25 | 187 | 216 | 29 |
| Mrs Dena Marshall | Interim Chief Operating Officer (from 20 April 2015) | 0–2.5 | 0–2.5 | 30–35 | 80–85 | 436 | 468 | 32 |
| Mr Niamat (Ali) Mohammed | Director of Human Resources | 0–2.5 | 2.5–5 | 35–40 | 115–120 | 690 | 722 | 32 |
| Mrs Claire Newton | Chief Finance Officer (to 6 December 2015) and Interim Director of Strategy and Planning (from 7 December 2015) | 0–2.5 | 2.5–5 | 10–15 | 40–45 | 262 | 300 | 38 |
| Dr Peter Steer | Chief Executive | 2.5–5 | 0 | 0–5 | 0 | 12 | 65 | 53 |
| Mr Matthew Tulley | Director of Development | 0–2.5 | (2.5)–0 | 25–30 | 75–80 | 397 | 419 | 22 |
| Ms Rachel Williams | Chief Operating Officer | 0–2.5 | 0–2.5 | 15–20 | 40–45 | 198 | 220 | 22 |

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0 per cent to 2.8 per cent. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

| | 2015/16 | 2014/15 |
|---|---|---|
| Band of the highest paid director's total remuneration (£000) | 205–210 | 165–170 |
| Median total remuneration | 42,106 | 36,800 |
| Ratio | 4.9 | 4.6 |

### Median Pay

The highest paid Director in 2015/16 was the Chief Executive whose remuneration was in the band £205,000–£210,000. This was 4.9 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 2016 on an annualised basis.

GOSH patient six-year-old Emily, Badger ward

# Disclosures

### Principal activities of the Trust

Information on the principal activities of the Trust, including performance management, financial management and risk, efficiency, employee information (including consultation and training) and the work of the research and development division and International and Private Patient division is outlined in the Performance Report on page 12.

### Expenditure on consultancy

Information about expenditure on consultancy can be found on page 146.

### Off-payroll arrangements

Information about off-payroll engagements can be found on page 162.

### Exit packages

Information about exit packages can be found on page 148.

### Going concern

Although we are operating in a particularly constrained financial environment, the Directors have a reasonable expectation that the Foundation Trust has adequate resources to continue in operational existence 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.

### Directors' responsibilities

The Directors acknowledge their responsibilities for the preparation of the financial statements.

### Safeguarding external auditor independence

While recognising that there may be occasions when the external auditor is best placed to undertake other accounting, advisory and consultancy work on behalf of the Trust, the Board seeks to ensure that the auditor is, and is seen to be, independent. The Trust has developed a policy for any non-statutory audit work undertaken on behalf of the Trust to ensure compliance with the above objective. This policy has been approved by the Members' Council. In Q1 2016/17, Deloitte LLP was appointed to conduct a Well Led Governance Review at GOSH, following an open competition. An independent engagement partner and team will conduct the review and the Trust has been given assurances that there will be no consultation between the review team and the external audit team.

### Disclosure of information to auditors

The Board of Directors who held office at the date of approval of this Annual Report confirm that, so far as they are each aware, there is no material audit information of which the Trust's auditors are unaware; and each Director has taken all the steps that he/she ought to have taken as a Director to make himself/herself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

### 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.

### Transactions with related parties

Transactions with third parties are presented in the accounts on page 158.

For the other Board Members, the Foundation Trust's Councillors, or parties related to them, none of them have undertaken material transactions with the Trust.

### Consultations in year

In 2015/16, the Trust has consulted patients, families, the public and staff members about the 2016/17 annual plan, asking them which methods of communication they prefer, their feedback on their experience of the hospital and their views on the extent to which the hospital is a research hospital. Views were also gathered on the implementation of the Trust's Always Values.

### 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 per cent of non-NHS invoices measured in terms of number (88 per cent in 2014/15) and 88 per cent by value (92 per cent in 2014/15).

### Pension funding

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme, which covers all NHS employers. The Trust makes contributions of 14 per cent to the scheme. From July 2013, staff who are not eligible for the NHS Pension Scheme are subject to the auto-enrolment scheme offered by the National Employment Savings Trust. The Trust contributes 1 per cent for all staff who remain opted in.

Accounting policies for pensions and other retirement benefits are set out in note 138 to the accounts.

### Remuneration of senior managers

Details of senior employees' remuneration can be found in page 43 of the Remuneration Report.

### Treasury policy

Surplus funds are lodged with the National Loan Fund through the Government Banking Service.

### Political and charitable donations

The Trust has not made any political or charitable donations during 2015/16.

### Statement of compliance with cost allocation and charging

The Trust has complied, to the extent relevant, with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

### Countering fraud and corruption

The Trust has a countering fraud and corruption policy.

Counter fraud arrangements are reviewed during the year by the Local Counter Fraud Service (LCFS). The LCFS undertakes an on-going programme of work to raise the profile of counter fraud measures and carries out ad hoc audits and specific investigations of any reported alleged frauds. This includes the use of fraud awareness presentations and fraud awareness surveys. The Audit Committee receives and approves the Counter Fraud Annual Report, monitors the adequacy of counter fraud arrangements at the Trust and reports on progress to the Board.

## Information governance

**Summary of serious incident requiring investigation involving personal data as reported to the Information Commissioner's Office in 2015/16**

There were no serious incidents involving personal data in 2015/16.

**Summary of other personal data related incidents in 2015/16**

| Category | Breach Type | Total |
|---|---|---|
| A | Corruption or inability to recover electronic data | 1 |
| B | Disclosed in error | 49 |
| C | Lost in transit | 2 |
| D | Lost or stolen hardware | 1 |
| E | Lost or stolen paperwork | 5 |
| F | Non-secure disposal - hardware | 0 |
| G | Non-secure disposal - paperwork | 2 |
| H | Uploaded to website in error | 0 |
| I | Technical security failing (including hacking) | 5 |
| J | Unauthorised access/disclosure | 3 |
| K | Other | 12 |

There were 80 incidents in 2015/16 that are classified as an information governance incident requiring investigation. The majority of these were category 'Disclosed in Error' which includes patient information being disclosed to the wrong patient or to the wrong address. The 12 'Other' events include misfiled patients' notes and data quality issues relating to inaccurate data about patients.

We are always seeking to improve our Information Governance practices. In addition to the learning gathered from incidents we also had a voluntary audit from the Information Commissioner's Office into our records management and information sharing practices, which we are using to make improvements. In addition, there has been much focus on data quality and we are looking to refresh our data quality strategy and improve the governance arrangements in this area.

# Audit Committee Report

## Introduction from the Chairman of the Audit Committee

I am pleased to present the Audit Committee's report on its activities during the year ending 31 March 2016.

The Audit Committee is a non-executive committee of the Trust Board with delegated authority to review the establishment and maintenance of an effective system of integrated governance, risk management and financial, non-financial and non-clinical internal controls, which support the achievement of the Trust's objectives. Key responsibilities include monitoring the integrity of the Trust's accounts, and the effectiveness, performance and objectivity of the Trust's external and internal auditors. In addition, the committee is required to satisfy itself that the Trust has adequate arrangements for countering fraud, managing security and ensuring that there are arrangements by which staff of the Trust may raise concerns.

The Clinical Governance Committee (CGC) considers clinical risks and their associated controls. The independent member of that committee is also an independent member of the Audit Committee to ensure that the work of each committee is complimentary.

The table below 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 2015/16, but I will draw particular attention to a small number of these items here.

During 2015/16, issues were identified in relation to the data and information processes required to robustly track patients through their elective pathway, as well as a number of operational processes in place to support these. Further information can be found in the Annual Governance Statement on page 64.

An action plan was agreed with Commissioners and is routinely monitored through a four party meeting of the Trust, Monitor (now NHS Improvement), CQC and Commissioner. The Audit Committee receives regular reports on progress in implementation of this action plan.

The Committee commissioned a detailed review of data quality in response to this matter. The report of our internal auditors noted a number of data quality issues and data management and reporting issues. The report recommended a number of actions and Trust management has responded. The Audit Committee is routinely monitoring the implementation of the agreed actions as detailed further in this report.

The Trust received a report from the Care Quality Commission (CQC) this year. The report highlighted the outstanding delivery of care within the hospital but also reflected the difficulties the Trust has faced in reporting, as noted above. The report contained a number of recommendations and the Audit Committee, Clinical Governance Committee and Trust Board routinely monitor the delivery of the action plan the Trust has put in place to respond to these recommendations.

In keeping with last year, the Trust has undertaken a serious review of the appropriateness of the adoption of the going concern basis for the preparation of the accounts. This effectively reflects the confidence of the Trust that the organisation remains financially viable. As described below, we are confident that this is the case for the ensuing planning period up until 31 May 2017 and that the Trust management has therefore clearly adopted the appropriate accounting basis. The longer term challenges facing the Trust, like the wider NHS, are significant.

I am satisfied that the Committee was presented with papers of good quality during the year, and that they were provided in a timely fashion to allow due consideration of the subjects under review. I am also satisfied that meetings were scheduled to allow sufficient time to enable a full and informed debate. Each meeting is fully minuted and summaries of the matters discussed at each meeting are reported to the Trust Board and Members' Council.

The Committee reviews its effectiveness annually and no material matters of concern were raised in the 2015/16 review.

The members of the Audit Committee are listed on page 31 and during 2015/16 included three independent Non-Executive members and one independent member. The Foundation Trust was authorised on 1 March 2012 and I have been Chairman of the Audit Committee since then. Two of the Non-Executive members of the committee are qualified accountants and at least three members of the audit committee have recent and relevant financial experience.

**Charles Tilley**
Audit Committee Chairman

20 May 2016

### Audit Committee responsibilities

The Committee's responsibilities and the key areas discussed during 2015/16, 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 2015/16 |
|---|---|---|
| Review of the Trust's risk management processes and internal controls | • Reviewing the Trust's internal financial controls, its compliance with Monitor's guidance for Foundation Trusts, including the Code of Governance, and the effectiveness of its internal control and risk management systems<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 CGC) | The outputs of the Trust's risk management processes including reviews of:<br>• The Board Assurance Framework<br>• 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>• Further developments in the Trust's risk management processes and risk reporting<br>• An annual assessment on the effectiveness of internal control systems taking account of the findings from internal and external audit reports<br>• An annual report and fraud risk assessment prepared by the Trust's counterfraud officer<br>• An annual report from the Trust's Security Manager<br>• The Trust's insurance arrangements |
| 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>• Key accounting policy judgements, including valuations<br>• Impact of changes in financial reporting standards where relevant<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 |
| Internal audit | • Monitoring and reviewing the effectiveness of the Trust's internal audit function, including its plans, level of resources and budget | • Internal audit effectiveness and Charter defining its role and responsibilities<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, include:<br>- key financial controls<br>- procurement and contract management<br>- risk management<br>- education strategy and governance |
| 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 | • Updates to Audit Committee's Terms of Reference<br>• Updates to the Trust's Standing Financial Instructions and financial approval limits and any waivers of those regulations during the financial year<br>• Reviewing the assurance relating to the Trust's compliance with the Foundation Trust licensing conditions<br>• Annual Report sections on governance<br>• The impact of new regulations<br>• Updates on the management of information governance and data quality risks<br>• Updates on staff raising concerns policy<br>• Reporting to the Board and Members' Council where actions are required, and outlining recommendations |

### Effectiveness of the committee

The Committee reviews its effectiveness and impact annually, using criteria from the NHS Audit Committee Handbook and other best practice guidance, and ensures that any matters arising from this review are addressed.

The self-assessment for 2015/16 continues to show progress and the minor procedural issues identified by the survey respondents are addressed on an on-going basis to ensure that the effectiveness of the Committee is optimised.

The Committee also reviews the performance of its internal and external auditor's service against best practice criteria as detailed in the Healthcare Financial Management Association, Audit Commission and NHS Audit Committee Handbook.

### External audit

A competitive tendering process of the audit contract took place during 2013, involving members of the Audit Committee and two members of the Members' Council. Deloitte LLP was appointed for a three-year term from 2014/15, with an option to extend for a further 2 years.

Their audit and non-audit fees are set, monitored and reviewed throughout the year and are included in note 4 of the accounts.

### Internal audit and counter fraud services

The Board uses independent firms to deliver the internal audit and counter-fraud services:

- KPMG LLP. The internal audit service covers both financial and non-financial audits according to a risk-based plan agreed with the Audit Committee. The Trust also has a team of staff carrying out clinical and health and safety audits.
- The Trust's separate counter fraud service is provided by TIAA Ltd who provide fraud awareness training, carry out reviews of areas at risk of fraud and investigate any reported frauds.

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

**Risk reviews**
The Committee reviews all non-clinical strategic and high scoring operating risks at least annually. Current significant risks include the potential reduction in the Trust's funding arising from the challenging external environment and commissioning changes and delivery of the Trust's Productivity and Efficiency (P&E) Target. In addition, the risk of delivery of the P&E targets, the contribution of the International Private Patients (IPP) Division and the risk that operational capacity is not sufficient to deliver future demands have also been assessed as part of this programme of review. For each risk, the Committee reviews the risk assessment (including risk definition, risk appetite, and likelihood and impact scores), the robustness of the controls and evidence available that the controls are operating.

**Data quality reviews**
The Committee agreed to additional audit scrutiny of the Trust's data quality. Following the suspension of reporting of waiting time data, the Committee sought assurance that the systems and processes for assuring data completeness, timeliness, relevance, accuracy and appropriateness were operating effectively. The Committee commissioned a significant review by the Internal Audit team and the subsequent report confirmed a number of system issues requiring remedial action. As noted in my introduction, the validation of open referral pathways continues and will continue into 2016/17. In addition the Data Quality Review identified a small number of metrics reported to the Trust Board where the data extracted for reporting was incomplete or inaccurate, due to the rules applied to the data in generating those reports. The Trust is undertaking a comprehensive review of the rules within its reporting systems, starting with the waiting time reports, and is validating not only the underlying data but data reporting systems.

The Audit Committee now monitors the implementation of the action plan agreed by management and the internal auditors, to gain assurance that system weaknesses are being addressed in a timely manner.

**Care Quality Commission Review**
The Clinical Governance Committee (CGC) is the key source of assurance to the Trust Board on the implementation of the action plan arising from the Care Quality Commission review received in 2015. The Audit Committee triangulates assurances received from reviews undertaken by the internal and external auditors to support the work of the CGC on this key action plan. The Audit Committee commissions audit work to externally validate the delivery of the action plan agreed with the regulator.

**Board Assurance Framework**
The Audit Committee reviewed the Board Assurance Framework (BAF) in detail this year. The Risk Assurance and Compliance Group review each strategic risk on the BAF along with the related mitigation controls and assurances. The Audit Committee reviewed the consistency and presentation of the BAF and receives routine presentations on strategic risks at each committee meeting.

**Productivity and efficiency**
The Finance and Investment Committee monitors the identification, planning, monitoring, delivery and post implementation review of Trust savings schemes. The CGC receives assurances from the Quality Impact Assessment Group that those schemes do not adversely or unacceptably affect the quality of services delivered. The Audit Committee seeks independent assurance that the systems and processes supporting those assurances are operating effectively. The Committee links closely with the Finance and Investment Committee and receives a summary of the minutes of the CGC.

**Internal controls**
We focused in particular on controls relating to securing sustainable funding; contract management and credit control management; delays in debt collection. Action plans were put in place to address issues in operating processes.

The Audit Plan of the internal auditors is risk based and the Executive team work with the auditors to identify key risks to inform the Audit Plan. The Audit Committee considers the links between the Audit Plan and the Board Assurance Framework. The Audit Committee approves the Internal Audit Plan and monitors the resources required for delivery. During the course of the year the Committee considers any proposed changes to the Audit Plan and monitors delivery against the plan approved at the start of the financial year.

**Fraud detection processes and whistle blowing arrangements**
We reviewed the levels of fraud and theft reported and detected and the arrangements in place to prevent, minimise and detect fraud and bribery. Five significant fraud cases were investigated in the past year resulting in five dismissals, one criminal sanction and recovery of £21,817 through sanctions and redress.

**Financial reporting**
We reviewed the Trust's financial statements and how these are positioned within the wider Annual Report. To assist this review we considered reports from management and from the internal and external auditors to assist our consideration of:

- the quality and acceptability of accounting policies, including their compliance with accounting standards
- their compliance with accounting standards
- key judgements made in preparation of the financial statements
- compliance with legal and regulatory requirements
- the clarity of disclosures and their compliance with relevant reporting requirements
- whether the Annual Report as a whole is fair, balanced and understandable and provides the information necessary to assess the Trust's performance and strategy

## Going concern

The Trust management has carefully considered the appropriateness of reporting on the 'going concern' basis.

The Trust's financial position includes substantial charitable donations that must be reported as income and this can result in significant surpluses being reported by the Trust. Please note that the Trust presents an additional note to remove the impact of charitable donations and thus show an underlying position for the Trust. The Trust has suffered a year of underlying deficits, adjusted for capital donations, and so a careful consideration of financial sustainability is required. Trust management has submitted a financial plan to NHS Improvement for 2016/17 that, once again, shows a significant surplus due to charitable donations. The Trust is planning another year of underlying deficit; however, this deficit is reducing over the 12 month period and the Trust continues to enjoy comparatively healthy, although diminishing, cash balances.

The future planning assumptions and current operating environment of the NHS is probably the most challenging period the Trust has ever endured. This raises deep concerns about long term financial sustainability, but for the purposes of determining the appropriateness of the going concern accounting approach, the 2016/17 plan, the cash balances and the financial sustainability risk rating of the Trust provide absolute confidence that the accounting approach adopted by management is correct.

## Significant financial judgements and reporting for 2015/16

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 following three paragraphs how we satisfied ourselves that these risks of misstatement had been appropriately addressed.

**Level of debt provisions**
The financial statements include provisions in relation to uncertainty. Judgements in this area are largely related to the timing of recognition of these provisions, the quantum recognised and the amount which has been utilised in previous years. We reviewed and discussed the level of debt and debt provisions with management. This included consideration of new provisions and any release and utilisation of existing provisions. Management confirmed to us that they have applied a consistent approach to the recognition and release of provisions. We also considered the views of the external auditors in respect of the provisions and associated disclosures in the accounts. We concluded that we were satisfied with the level of provisions carried and the disclosure in respect of those provisions.

**Valuation of property assets**
The Trust has historically revalued its properties each year, which combines properties held under freehold with those held under finance and operating leases. Judgements relate to the future life of these buildings, which can change the appropriate accounting treatment and affect the carrying value on the balance sheet. We reviewed reports from management which explained the basis of valuation for the most significant buildings, including the future life and rationale for any impairments associated with structural refurbishment expenditure. We also considered the auditors' views on the accounting treatment for these buildings. We are satisfied that the valuation of these properties within the financial statements is consistent with management intention and is in line with accepted accounting standards.

**Other areas of financial statement risk**
Other areas where an inappropriate decision could lead to significant error include:

- the recognition of commercial revenue on new contracts
- the treatment of expenditure related to capital contracts

We consider that the Trust's existing financial control systems should ensure that such items are properly treated in the financial statements. We have discussed the external auditors' findings in these areas. There were no issues of concern reported to us in these areas and consequently we are satisfied that the systems are working as intended.

## Conclusion

The Committee has reviewed the content of the Annual Report and Accounts and advised the Board that, in its view, taken as a whole:

- It is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.
- It is consistent with the Annual Governance Statement, Head of Internal Audit Opinion and feedback received from the external auditors, and there are no matters that the committee is aware of at this time that have not been disclosed appropriately.
- It is appropriate to prepare accounts on a going concern basis.

# Clinical Governance Committee Report

## Introduction from the Chair of the Clinical Governance Committee

I am pleased to present the Clinical Governance Committee's report on its activities during the year ended 31 March 2016. As outlined in the report below, the Clinical Governance Committee (CGC) is a sub-committee of the Trust Board, with delegated authority to ensure that the correct structure, systems and processes are in place within the Trust to appropriately manage and monitor clinical governance and quality related matters and strategic and operational risks.

It has been a busy year for the CGC with a Care Quality Commission (CQC) scheduled inspection in April 2015, as well as some new clinical and quality challenges to consider and seek assurance on, including:

- management of the Trust's elective surgery data and processes
- a review of the Trust's gastroenterology service
- progress with recommendations arising from the Health Education North Central and East London (HENCEL) report about medical trainee support and out of hours cover.

The Committee reviewed the CQC report and the Committee Chair attended the Quality Summit to make sure that we have identified all the messages on quality, safety and patient care contained in the inspection report. While pleased with the overall rating of 'good' and in particular the 'outstanding' rating for 'are services caring and effective?', we will be including in our forward work plan any aspects of quality that merit attention.

As Chair, I am satisfied that the committee was presented with the appropriate level of information and in a timely fashion. Each meeting is fully minuted and summaries of the matters discussed at each meeting are reported to the Trust Board and Members' Council.

The members of the CGC are listed on page 31 and during 2015/16 included three Non-Executive Directors and a new independent member of the committee, James Hatchley. The Foundation Trust was authorised on 1 March 2012 and I have been Chair of the committee since then. I would like to thank Yvonne Brown, who retired from the committee during 2015, and welcome Stephen Smith as a new Non-Executive Director member from 1 March 2016.

In July 2015, the Committee reviewed its effectiveness and found it had adequately discharged its duties in accordance with its terms of reference. To ensure the committee continues to fulfil its responsibility to assure the Board of the quality of care provided by the Trust, the committee is in the process of updating its terms of reference and broadening its remit to seek assurance of the quality, clinical effectiveness and patient and family experience of care and treatment in all services provided by the Trust. To reflect this, the committee has been renamed the Quality and Safety Assurance Committee (QSAC), effective from May 2016.

**Mary MacLeod**
Clinical Governance Committee Chair

20 May 2016

### Clinical Governance Committee responsibilities

The principal purpose of the CGC is to assure the Board that work being undertaken by the clinical divisions, departments, standing committees and any sub groups in respect of clinical governance and improvement is co-ordinated and prioritised to meet the Trust's objectives. The Committee requests assurance on scheduled matters as well as quality and safety issues arising during the year, for example, assurance of the appropriate management of the Trust's RTT issues and the review of the gastroenterology service.

The Committee's responsibilities and the key areas discussed during 2015/16 are outlined in the table below.

| Principal responsibilities of the committee | Key areas formally reviewed during 2015/16 |
|---|---|
| Review of the framework to support an environment in which excellent clinical care will flourish | • Implementation of the Trust's Quality Strategy and review of the annual *Quality Report*<br>• Reports from the Clinical Ethics Committee<br>• Regular review of performance reports<br>• Learning from patient stories<br>• Updates from service areas (social work, play service)<br>• Assurance framework updates<br>• Regular updates from the Risk, Assurance and Compliance Group<br>• Involvement in the establishment of the Trust's Patient Safety and Outcomes Committee |
| 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 | A range of specific, emergent issues were considered in 2015/16 including:<br>• Review of the gastroenterology service<br>• Review of medical cover out of hours<br>• IT issues impacting clinical work<br>• Quality and safety impact of the productivity and efficiency programme<br>• Access Improvement Programme workplan<br>• Recruitment and retention |
| Review of the controls to mitigate clinical risk within a regulatory and legislative framework | • Summary reports on the relevant risks on the Board Assurance Framework<br>• Reports received on specific and/or high risk areas:<br>- Health and Safety<br>- Child Protection and Safeguarding<br>- Research Governance<br>- Summary from the Learning, Improvement and Monitoring Board (now disbanded) and the new Patient Safety and Outcomes Committee (covering complaints, patient advice liaison service, incidents and claims)<br>- Staffing information report<br>- CQC compliance<br>- Medical revalidation and appraisal<br>- Head of Nursing report |
| Review of findings and recommendations from internal audit, clinical audit and learning from external investigations and reports | • The internal audit annual plan and strategy was presented to the Committee in April 2015 with an update on progress with the plan covered at subsequent meetings<br>• Findings and recommendations of clinical focused internal audit reports are presented to every committee meeting. The following audits were discussed this year:<br>- Health and Safety<br>- Information governance<br>- Whistleblowing<br>- Risk management<br>- Education strategy and education governance<br>- SCA: Self-certifications (second level)<br>- Discharge arrangements<br>- Divisional level governance<br>- Transformation and Improvement Programme (Productivity and Efficiency Plans)<br>• Quarterly reports from the Trust's Clinical Audit Manager |
| Other | • Reviewed committee effectiveness<br>• Reviewed Freedom of Information Annual Report |

### Key areas of focus for the Clinical Governance Committee in the past year

**Risk reviews**
The committee reviews all clinical strategic and high scoring operating risks at least annually. As at 31 March 2016, the Trust's most significant risks relating to clinical delivery include ensuring sufficient capacity to respond to activity demands; ensuring safe medical cover to all patients at all times; recruiting and retaining sufficient highly skilled staff; and consistent application of the Trust's access policy.

In 2015/16, the committee also considered risks associated with other significant operational and strategic risks, including IT issues and challenges, and the Productivity and Efficiency (P&E) programme, in particular the impact on quality and safety.

**Access Improvement Programme**
In conjunction with the Trust Board and Audit Committee, the CGC has sought assurance of the implementation of the Access Improvement Programme and its impact on the safety of care provided to patients.

**Quality impact of the Productivity and Efficiency Programme**
The CGC has played an important role in monitoring the quality and safety implications of the Trust's Productivity and Efficiency Programme throughout 2015/16. The committee has reviewed a number specific services' productivity plans to ensure they have a robust quality governance framework and that the Trust's 'no waits, no waste, zero harm' objectives are not compromised.

**CQC compliance**
Following the release of the CQC's inspection report in January 2016, the CGC has received, and will continue to receive, regular update reports on the implementation of the (nine) formal inspection recommendations. In addition, a log of informal actions for improvement has been created based on the detailed feedback included in the CQC's full report, which the CGC will also continue to monitor. At the end of financial year many of the actions have already been closed and most are on track to be completed within agreed due dates. The CGC will continue to monitor and support the Trust's efforts to deliver all opportunities for improvement highlighted during the CQC's 2015 inspection.

### Conclusion

As Chair, I am satisfied that the committee adequately discharged its duties in accordance with its terms of reference throughout 2015/16.

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

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

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

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

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

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

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

**Signed**

Chief Executive

Date: 20 May 2016

# Head of Internal Audit Opinion

## Basis of opinion for the period 1 April 2015 to 31 March 2016

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 Board Assurance Framework process
- 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 Board 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 organisation's risk management, control and governance processes (that is, the system of internal control). This is achieved through a risk-based programme of work, agreed with management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below.

The purpose of our HoIA opinion is to contribute to the assurances available to the accountable officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. This opinion will in turn assist the Board in the completion of its AGS, and may also be taken into account by other regulators to inform their own conclusions.

The opinion does not imply that the HoIA has covered all risks and assurances relating to the Trust. The opinion is derived from the conduct of risk-based plans generated from a robust and management-led Assurance Framework. As such, it is one component that the Board takes into account in making its AGS.

### Opinion

Our opinion is set out as follows:

- basis for the opinion
- overall opinion
- commentary

The basis for forming our opinion is as follows:

- an assessment of the design and operation of the underpinning Assurance Framework and supporting processes
- 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
- an assessment of the process by which the Trust has assurance over its registration requirements of its regulators

Our overall opinion for the period 1 April 2015 to 31 March 2016 is that:

'Significant assurance with minor improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

### 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 2015 to 31 March 2016 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 Assurance Framework does reflect the organisation's key objectives and risks and is regularly reviewed by the Board.

**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 have not issued any NO ASSURANCE (RED) assurance opinions for the reviews in our 2015/16 internal audit programme.

We have issued five PARTIAL ASSURANCE WITH IMPROVEMENTS REQUIRED (AMBER-RED) assurance reports during 2015/16. Our partial assurance reviews related to the following areas:

1. Productivity and Efficiency programme: we identified that compliance with the Trust's defined processes for planning savings projects and ensuring that there will not be an unacceptable impact on quality had not been consistently followed in planning savings for the year. The Trust has subsequently implemented a revised governance approach and has enhanced the scope of its Project Management Office with

external support, as well as consolidating its savings to focus on key, strategic projects.

2. Education strategy and governance: the Trust did not have in place a formally defined governance mechanism to ensure that there was sufficient consideration of multi-disciplinary education across the organisation, and to ensure that all staff groups had fully reviewed their training needs. The Trust is implementing an Education Committee to provide strategic oversight and direction to future education requirements.
3. IT infrastructure: we identified issues with the Trust's processes for approving system changes, ensuring there was appropriate prioritisation of resource and monitoring performance.
4. Contract management: we found that the Trust did not have access to a single and complete record of contracts it has entered into and the officers responsible for their management.
5. Discharge arrangements: we identified discrepancies in the information reported from the Trust's Patient Administration System, and that there was no formal guidance in place to support staff identify when discharge summaries were required to be produced.

We raised three high priority recommendations from these reports, relating to completion of quality impact assessments for productivity and efficiency schemes, ensuring that the Trust has visibility of the contracts it has entered into, and ensuring that there are contract managers assigned to them.

We have provided significant assurance from our reviews of the Trust's core assurance processes relating to financial controls and risk management, and raised no high priority recommendations from these reviews.

We are satisfied that sufficient action has been taken by Management to address the issues identified from our partial assurance reports and that the controls established for the Trust's core systems reviewed operated effectively during the period under review.

**KPMG LLP**
Chartered Accountants
London

18 April 2016

GOSH patient James, age three, Lion ward

# Annual Governance Statement

## 1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

## 2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable, and not absolute, assurance of effectiveness. The system of internal control is based on an on-going 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 (GOSH)
- evaluate the likelihood of those risks being realised and the impact should they be realised
- manage risks efficiently, effectively and economically

The system of internal control has been in place in GOSH for the year ended 31 March 2016 and up to the date of approval of the Annual Report and Accounts 2015/16.

## 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 Monitor and the Care Quality Commission. Further accountability and responsibility for elements of risk management are set out in the Trust's Risk Management Strategy.

The Board has a formal schedule of matters reserved for its decision, and delegates certain matters to Committees as set out below. Matters reserved for the Board are:

- determining the overall strategy
- creation, acquisition or disposal of material assets
- matters of public interest that could affect the Trust's reputation
- ratifying the Trust's policies and procedures for the management of risk
- determining the risk capacity of the Trust in relation to strategic risks
- reviewing and monitoring operating plans and key performance indicators
- prosecution, defence or settlement of material incidents and claims

The Board has a comprehensive 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. Whilst pursuing this work plan, the Board maintains its commitment that discussion of patient safety will always be high on its agenda. The Board has carried out an internal review of its effectiveness during the year and agreed actions to strengthen its oversight of risk.

There are two Board assurance committees, the Audit Committee and the Clinical Governance Committee (CGC), which assess the assurance available to the Board in relation to risk management, review the Trust-wide non-clinical and clinical risk management processes respectively and raise issues requiring attention by the Board. In addition to the two assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The Chair of each Committee reports to the Board at the meeting following the committee's last meeting. Each Committee is charged with reviewing its effectiveness annually.

The Risk Assurance and Compliance Group (comprising executives, quality, safety and compliance leads) reports to the Audit Committee and the CGC. This group monitors the effectiveness of risk management systems and the control and assurance processes and monitors the Board Assurance Framework.

The Trust has established the Patient Safety and Outcomes Committee (PSOC), chaired by the Medical Director (comprising executives, and senior managers and clinicians from the clinical divisions and corporate teams). This committee monitors the implementation of clinical risk management processes throughout the Trust, ensuring that risks are identified, registered and managed at appropriate levels of responsibility in the clinical divisions and corporate departments. It receives reports of risks, incidents and risk-mitigating actions from division and department groups and specialist subcommittees. In addition, each clinical division's Board considers risks, quality and safety indicators, incidents and complaints on a regular basis. These are the key senior management forums for consideration of risks.

The Trust has a central Risk Management team who administer its risk management processes. Within each clinical division, safety is championed by a clinical lead for patient safety supported by an individual within the Risk Management team. The Risk Management team also meet regularly with their peers at other Trusts to share learning.

All staff receive relevant training to enable them to manage risk in their division or department. At a Trust level, emphasis is placed on the importance of preparing risk assessments where required, on reporting, investigating and learning from incidents.

There are a range of other processes to ensure that lessons are learned from specific incidents, complaints and other reported issues. These include reports to risk action groups, divisional boards and articles within internal newsletters.

There are also periodic seminars open to all staff where learning from an event is presented and discussed.

## 4 The risk and control framework

### The risk management strategy

In early 2016, the Trust's risk management strategy, which sets out how risk is systematically managed, was reviewed and updated. This extends across the organisation, from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research, and to ensure the business continuity of the Trust.

The strategy identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk, and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process to provide assurance for the Trust Board review of the strategic organisational risks, and the local structures to manage risk in support of this policy.

The Trust has reviewed its compliance with the NHS Foundation Trust license conditions and in relation to condition four, it has concluded that it fully complies with the requirements and that there are processes in place to identify risks to compliance. No significant risks have been identified.

The strategy is integrated into the management, performance monitoring and assurance systems of the Trust, to ensure that safety and improvement is embedded in all elements of the Trusts work, partnerships and collaborations and existing service developments. This enables early identification of factors, whether internally or externally driven, which may prevent the Trust from achieving its strategic objectives of ensuring that care is provided in a cost effective way without compromising safety.

It provides the framework in which the Trust Board can determine the risk appetite for individual risks and how risks can be managed, reduced and monitored. The Board has recently reviewed and revised its risk appetite statement.

The Board recognises that the Trust's clinical services and research activity are delivered within a high risk environment. The delivery of GOSH's strategic objectives and its relationships with its patients, the public, its funders and other strategic partners determines the Trust's long term sustainability. As such, the Board has agreed that the Trust has an overall low appetite for risks relating to its clinical service and research delivery. The lowest risk appetite applies to all safety and compliance objectives, including preventable patient harm, public and employee health and safety. The Trust has a marginally higher risk appetite for the pursuit of innovation and its strategic and operations objectives. This means that the risks originating from clinical and research processes as well as meeting legal and other regulatory obligations will take priority over other business objectives.

### The risk management process

The Trust's Assurance and Escalation Framework sets out how the organisation identifies, monitors, escalates and manages concerns and risks in a timely fashion and at an appropriate level.

The Trust's Board Assurance Framework (BAF) is used to provide the Board with assurance that there is in place a sound system of internal control in place to manage the key risks to the Trust of not achieving its strategic objectives. The BAF is used to provide information about the controls in place to manage the key risks, and details the evidence provided to the Board indicating that the control is operating. The BAF includes cross references to assurance obtained from internal and external audits, and self-assessments of compliance with other regulatory standards. It has been monitored and updated throughout the year.

Each strategic risk on the Assurance Framework, the related mitigation controls and assurance available as to the effectiveness of the controls, is reviewed by the Risk Assurance and Compliance Group and by either of the Clinical Governance Committee or the Audit Committee at least annually. The Committees look for evidence that the controls are appropriate to manage the risk and for independent assurance that the controls are effective and monitor actions to reduce or remove control or assurance gaps.

In addition, the Trust Board recognises the need to 'horizon scan' for emerging risks and review low probability / high impact risks to ensure that contingency plans are in place, and has included such matters in Board discussions of risks.

Each division and department is required to identify, manage and control local risks whether clinical, non-clinical or financial in order to provide a safe environment for patients and staff, and to reduce unnecessary expenditure. This ensures that the early identification of risks and the devolution of responsibility for management of risks to staff at all levels of the organisation. In practice, this is achieved through the involvement of staff in risk action groups, risk training and occasional surveys.

Risks are identified through diverse sources of information such as:

- formal risk assessments
- audit data
- clinical and non-clinical incident reporting
- complaints
- claims
- patient/user feedback
- information from external sources in relation to issues which have adversely affected other organisations
- operational reviews
- use of self-assessment tools

Further risks are also identified through specific consideration of external factors, progress with strategic objectives, and other internal and external requirements affecting the Trust.

Risks are evaluated using a '5x5' scoring system that enables the Trust to assess the impact and likelihood of the risk occurring and prioritise accordingly. Assessments are made as to whether the prioritised risks are acceptable or not.

Control measures, aimed at both prevention and detection, are identified for accepted risks, in order to either reduce the impact or likelihood of the risk. An assessment is then made of the effectiveness of the control on reducing the risk score, and what assurance is available to the Board that the control is both in place

and operating effectively to reduce risk. A designated person becomes responsible for monitoring, reviewing and reporting on the effectiveness of the control in place. Risks and controls are evaluated periodically and when new or changed risks are identified, or if the degree of acceptable risk changes.

The principal risks for the Trust during the year and in the immediate future are:

- reduction in funding available to NHS organisations coupled with the high costs of maintaining delivery of specialised services
- recruitment and retention of sufficient highly skilled staff with specific experience
- management of Referral to Treatment (RTT) processes (inconsistent application of the Trust Access Policy and unreliable data)

Each of these risks are broken down into a number of component parts covering the different drivers of these risks, and appropriate mitigating actions for each component identified. Further information is provided on page 14.

Emerging risks with medium or high scores are reported through the quality and safety and KPI performance reports and at clinical division and corporate department level through the Trust's quarterly strategic reviews. A more detailed statement of the Trust's risks and mitigating actions is set out on page 14.

Assurance is obtained by the Board from the results of Internal Audit reviews which are reported to the Audit Committee and CGC. The CGC also receives the results of clinical audits and health and safety reports. The counterfraud and security management programmes are also monitored by the Audit Committee.

Both Committees take a close interest in ensuring that system weaknesses and assurance gaps are addressed. An internal and external audit action recommendation tracking system is in place, which records progress in closing down the recommendations. The committees also seek other forms of assurance, which include the results of regulatory and other independent reviews of compliance with standards, relevant performance information, and management self-assessments coupled with the associated evidence base.

### Key elements of the Trust's quality governance arrangements

The Trust places a high priority on quality, measured through its clinical outcomes, patient safety and patient experience indicators.

The Board is committed to placing quality and safety at the top of its own agenda, to encourage continuous improvement in safety and quality indicators, and to establish mechanisms for recording and benchmarking clinical outcomes.

The key elements of the Trust's quality governance arrangements are:

- There is clear accountability at Board level for safety and clinical quality objectives and structured reporting of performance against these objectives.
- Internal processes to check that we meet both our own internal quality standards and those set nationally and in conjunction with our commissioners (CQUINS).
- Key performance indicators are presented, on a monthly basis, to the Trust Board. This includes progress against external targets (such as how we keep our hospital clean), internal safety measures (such as the effectiveness of actions to reduce infection) and process measures (such as waiting lists) and other clinical quality measures including CQUINS. It also includes the external indicators assessed and reported monthly by the CQC.
- The Board regularly receives reports on the quality improvement initiatives and other quality information (such as complaints, incidents and reports from specific quality functions within the Trust such as the Patients Advice and Liaison Service). The CGC receives reports from clinical and health and safety audits.
- Each specialty and clinical division has an internal monitoring structure so that teams can regularly review their progress and identify areas where improvements may be required. Each specialty has to measure and report a minimum of two clinical outcomes. Each division's performance is considered at quarterly strategic performance reviews.
- Patient and parent feedback is received through the Friends and Family surveys, a more detailed survey at least once a year, through the work programme of the recently reviewed Patient and Family Experience and Engagement Committee and through a range of other patient/ parent engagement activities.
- Risks to quality are managed through the Trust risk management process which includes a process for escalating issues.
- There is a clear structure for following up and investigating incidents and complaints, and disseminating learning from the results of investigations.

Through these methods, all the data available on the quality of care in each specialty and service is considered as part of our internal and external management and assurance process. The data quality improvement plan is monitored by the Audit Committee to ensure that the Board receives assurance of the quality of this data. Further information about the management and monitoring of data quality is presented below.

### Compliance with the Foundation Trust Licence Conditions

An assessment has been carried out of the Trust's processes to ensure that it complies with the Licence Conditions, and, in particular, Licence condition four (governance). The conclusion of the review was that the Trust's governance processes and structures are effective.

A review was also carried out of the Trust's processes to provide assurance to the Board in relation to the Corporate Governance Statement. This included consideration of each element of the Corporate Governance Statement and identification of the assurance process for each element.

A review of information and performance indicators provided to the Finance and Investment Committee and the Trust Board was commissioned from our internal audit service, following the decision of the Trust to suspend reporting of referral to treatment (RTT) waiting times. This report identified a number of weaknesses in reporting processes and systems that means that I can only report partial assurance as to the accuracy of reporting to the Trust Board. In response, the Trust has developed a detailed action plan including a significant programme of data quality reviews and the Trust Board is closely monitoring delivery against this action plan.

### Compliance with CQC registration

The Trust has identified an executive director and a manager who are respectively accountable and responsible for ensuring compliance with each element of the CQC registration standards. It is the responsibility of these staff to provide evidence of compliance with the standards. The evidence is reviewed periodically by compliance staff. The CQC carried out an inspection in April 2015 and the Trust is fully compliant with the registration requirements of the CQC. Further information can be found on page 112.

### Involvement of stakeholders

The Trust recognises the importance of the involvement of stakeholders in ensuring that risks and accidents are minimised, and that patients, visitors, employees, contractors and other members of the public are not exposed to any unnecessary risks or hazards. Risks are assessed and managed to ensure that the Trust's systems reflect consideration of all these stakeholder interests. Stakeholders are also involved in the Trust's risk management process where appropriate. For example, patient views on issues are obtained through the Patient Advice and Liaison Service and patient representatives are involved in Patient-Led Assessments of the Care Environment (PLACE) inspections. There are regular discussions of service issues and other pertinent risks with commissioners. Staff from the Trust are also involved in strategic planning groups with commissioners and other healthcare providers.

### Data security

Risks to data security are managed in the same way as other Trust risks but are subject to separate evaluation and scrutiny by the Information Governance Steering Group which reports to the Trust's Audit Committee. This Group uses the Information Governance Toolkit assessment to inform its review.

### Other regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure that all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the Scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust management has carefully considered the appropriateness of reporting on the going concern basis. Trust management has submitted a financial plan to NHS Improvement for 2016/17 that shows a significant surplus due to charitable donations. The underlying plan is another year of underlying deficit. However, this deficit is reducing over the 12 month period, and the Trust continues to enjoy comparatively healthy, although diminishing, cash balances. For the purposes of determining the appropriateness of the going concern accounting approach for the 2016/17 plan, the cash balances and the financial sustainability risk rating of the Trust provide absolute confidence that the accounting approach adopted by the Trust is correct.

## 5 Review of economy, efficiency and effectiveness of the use of resources

The governance section within the Annual Report explains how the Trust is governed and provides details of its Board committee structure, the frequency of meetings of the Board and its committees, attendance records at these meetings and the coverage of the work carried out by committees. The Board has assessed its compliance with the Monitor Corporate Governance code.

The Trust did not declare any governance targets 'at risk' in its plans for 2015/16. The Trust has subsequently reported that it is unable to declare compliance through the routine governance statements to the Regulator because the Trust is unable to report on performance against the national standard for Referral to Treatment Times (RTT); that is, the requirement that 92 per cent of all patients are seen within 18 weeks of their referral. In addition, the Trust suspended reporting against the national diagnostic standard, which requires Trusts to carry out a defined list of diagnostic tests within six weeks for at least 99 per cent of patients.

In May 2015, the Trust asked the Intensive Support Team (IST) to carry out a review of its RTT systems and processes. This was prompted by the Executive Team's concern about the quantity of unknown clock starts reported on the monthly submission (see below) and the external auditors' qualification in the *Quality Report* 2014/15 following an audit of waiting list data.

The IST identified issues with the management and processing of RTT data, the operational management of some RTT pathways and some capacity challenges. The Board considered the findings and in September 2015 agreed to suspend RTT and diagnostics reporting.

As a result, the Trust swiftly developed an improvement plan (agreed with external parties including NHS Improvement and NHS England) and determined the resources necessary to deliver the plan. The plan involved the Trust validating all planned and other patients on waiting lists to ensure that they comply with the RTT guidance, and that treatment is prioritised where required. Policies and processes were reviewed and revised, and clinical and non-clinical staff trained in the management of RTT pathways.

A clinical review panel was set up with the primary role of overseeing the review of patients who have waited longer than the nationally required wait times, to provide assurance and rigor that the length of time any patient has waited has not been clinically disadvantageous.

In light of the problems identified with RTT data, the Trust requested that a comprehensive review of data quality across the organisation was conducted by the internal audit team. This was completed in February 2016 and found for the majority of the indicators sampled, reported numbers could be reconciled to data sources. The review concluded the need for establishment of a robust data quality framework at the Trust.

As a specialist tertiary hospital, the majority of our patients are referred to us from other hospitals and often commence treatment at that hospital 8–12 weeks into the 18-week treatment pathway.

The Trust relies on referring hospitals to record the start date of the patient treatment and if this is not secured, the Trust must record the patient treatment with an 'unknown clock start'. The number of referrals with no known clock start received by the Trust is unacceptable and requires significant intervention by the Trust to pursue incomplete patient records. The Trust is held to account and faces sanctions for any patient exceeding the 18-week treatment pathway, irrespective of the point of referral to this organisation.

The Trust plans to recommence external RTT reporting for the month of September 2016.

The Board has agreed Standing Orders and Standing Financial Instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust.

The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. In addition, the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and, where significant, these are reviewed by the Trust Board.

The Board has also agreed a series of performance metrics which provide information about the efficiency of processes within the Trust and the use of critical capacity such as theatre utilisation. The agenda of the Finance and Investment Committee includes reviews of financial performance, productivity and use of resources both at Trust and divisional level. More details of the Trust's performance and some specific Trust projects aimed at increasing efficiency are included in the Performance Report.

The Trust's external auditors are required to consider whether the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They report the results of their work to the Audit Committee. Their report is on page 70.

## 6 Annual Quality Report

The directors are required under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010 (as amended) to prepare a *Quality Report* for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and contents of annual *Quality Reports*, which incorporate the legal requirements in the Foundation Trust Annual Reporting Manual.

There are a number of controls in place to ensure that the *Quality Report* presents a balanced view of the Trust's Quality agenda. Many of the measures in the *Quality Report* are monitored throughout the year either at the Board or the Patient and Safety Outcomes Committee which reports in to the CGC. The Trust has a wide range of specific clinical policies in place to ensure the quality of care. These address all aspects of safety and quality. Policies are used to set required standards and ensure consistency of care.

The Trust's annual corporate objectives include targets for quality and safety measures and performance relative to these targets is monitored by the Trust Board and also measures specific to Clinical Divisions are monitored at the quarterly strategic reviews of performance.

The Audit Committee is responsible for monitoring progress on data quality. Objectives for data quality are defined and data quality priorities are monitored. Particular focus has been directed at key measures of quality and safety, which are relied upon by the Board and are collected from locally maintained systems. These measures are reported regularly through the Trust's quality performance management processes and reviews of deterioration in any such measure are fully investigated.

As noted already, during last year, a review of the Trust's waiting list data revealed a very high level of patients on waiting lists with unknown clock starts. The Trust was asked by its commissioners to carry out an audit of this data, and support was requested from the national response team. An action plan was agreed with commissioners and is routinely monitored through a four party meeting of the Trust, Monitor, CQC and commissioner. A review of progress by the national response team in March 2016 noted the good progress the Trust has made against this action plan. The Trust anticipates that the remedial action plan will continue for a further six months, with certain specialties requiring on-going action by the Trust and assistance from commissioners for all of the next financial year.

External assurance statements on the *Quality Report* are provided by our local commissioners and our local LINKs as required by Quality Account Regulations.

## 7 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work and reports of the external and internal auditors, clinical audit, and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. The Board has conducted a review of the effectiveness of the Trust's system of internal controls by consideration of the assurance obtained from the assurance committees, reports from internal and external auditors, and self-certifications of compliance with various regulatory requirements.

I have drawn on the content of the *Quality Report* attached to this Annual Report and Accounts 2015/16 and other performance information available to me.

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 the Clinical Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- the reviews of compliance with CQC standards
- consideration of performance against national targets
- the assessment against the information governance toolkit
- Health and safety reviews
- the PLACE assessment
- relevant reviews by the Royal Colleges.

In addition, the Head of Internal Audit provides an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of internal audit's work, and this opinion has provided significant assurance with minor improvements required.

I have also considered the reviews of the BAF risks by the assurance committees, the Risk, Assurance and Compliance Group and internal audit who seek evidence that the controls are in place and effective in mitigating the risk and by the work of clinical audit. In some instances, the audit work has found that the controls

believed to be in place are not working as planned or that there is insufficient evidence that the control is working effectively.

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

### Control weaknesses

- Data quality: a review of the Trust's waiting list data has indicated an unusually high level of unknown clock starts (as detailed above).
- The Trust has identified weaknesses in the processes for managing contracts resulting in delays to procurement. A programme has been developed to address the outstanding issues.
- A review of the Trust's arrangements for providing training to staff (both clinical and non-clinical), and the adequacy of governance arrangements in place to ensure delivery of the education strategy, identified some areas for improvement. An action plan has been developed to address these areas.
- A review of the design of controls relating to IT operations and infrastructure was undertaken. The review identified a number of processes and systems where improvements can be made and these are now being addressed through a formal action plan.
- Discharge arrangements: a review has identified weaknesses in the Trust's processes for managing discharges and the information provided at discharge. An action plan has been agreed and is monitored through the audit implementation tracker, Audit Committee and Clinical Governance Committee.
- Productivity and Efficiency Programme: a review of the programme for identifying savings and efficiencies identified weaknesses in the processes and risks against delivery. The Trust commissioned assistance with the programme and has reviewed and strengthened systems and processes considerably.

### Assurance weaknesses:

- Data Quality: A wider review of data quality identified a number of operational and strategic issues as points for development, in order to improve and enhance the overall quality of performance information collected and reported, both at Board level and across the wider Trust. An action plan has been developed to address these development points.
- It is difficult to obtain assurance on the adequacy of the long term funding of the Trust due to the longer term proposals for reductions in tariff and adjustment of contract terms for specialist services by NHS England. Please see reference in the Trust's going concern on page 15.

### Assurance of core systems and controls

The Trust audit programme has identified significant assurances for financial controls and risk management, and has found that the Trust Board Assurance Framework does reflect the organisation's key objectives and risks, and is regularly reviewed by the Board.

In all cases, action plans have been put in place to remedy any controls or assurance gaps, and the remedial action is being monitored by the assurance committees of the Board.

In addition, the Board has reviewed the risks and assurance available in relation to both its redevelopment programme and its information technology strategy, which is focussing on the introduction of electronic patient records and moving towards a fully digital hospital. It has been agreed that due to the challenges inherent within these projects and their importance to the on-going strategy, further actions are required to ensure that both programmes can be carried out within the required timescales and achieve their objectives.

I have also considered the results of the assessment of compliance with the Monitor Code of Governance for NHS Foundation Trusts (which are set out in the Annual Report on page 27).

The Board is committed to continuous improvement and, through its agenda, ensures that there are regular reviews of the Trust's performance in relation to its key objectives and that processes for managing the risks are progressively developed and strengthened.

## 8 Conclusion

With the exception of the gaps in internal controls and matters where assurances can be improved, as set out in Section 7, 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. There have been no significant control issues identified during the period.

**Signed**

**Dr Peter Steer**
Chief Executive

Date: 20 May 2016

# Independent Auditor's Report to the Board of Governors and Board of Directors of Great Ormond Street Hospital for Children NHS Foundation Trust

## Opinion on financial statements of Great Ormond Street Hospital for Children NHS Foundation Trust

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2016 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and have been prepared in accordance with the requirements of the National Health Service Act 2006.

The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Cash Flow Statement, the Statement of Changes in Taxpayers' Equity and the related notes 1 to 27. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

### Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and Code of Audit Practice.

### Going concern

We have reviewed the Accounting Officer's statement contained on page 15 of the Accountability Report that the Trust is a going concern. We confirm that:

- we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

### Independence

We are required to comply with the Financial Reporting Council's Ethical Standards for Auditors and we confirm that we are independent of the group and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.

### Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team:

| Risk | How the scope of our audit responded to the risk |
|---|---|
| **NHS revenue and provisions**<br><br>There are significant judgments in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to: the complexity of the Payment by Results regime and other locally set tariffs for specialised services, in particular in determining the level of overperformance; and the judgemental nature of provisions for non-payment, including in respect of outstanding overperformance income for quarters 3 and 4; and the risk of revenue not being recognised at fair value due to adjustments agreed in settling current year disputes and the status of agreement of future year contracts and tariff arrangements.<br><br>The majority of the Trust's income from patient care activities of £349.6m is commissioned by NHS England, increasing the significance of associated judgements. The Trust also works with numerous disparate Clinical Commissioning Groups ('CCGs') on a smaller scale which increases the complexity of agreeing a final year-end position.<br><br>The settlement of income with NHS England and Clinical Commissioning Groups continues to present challenges, leading to delays in the agreement of year end positions. The year end NHS debtors balance per Note 14.1 of the accounts is £9.8m. | We evaluated the design and implementation of controls over recognition of Payment by Results income, with the assistance of our internal IT specialists.<br><br>Where contracts were signed with commissioners we confirmed revenue to contractual terms. We performed detailed substantive testing of the recoverability of overperformance income and evaluated the results of the agreement of balances exercise.<br><br>We challenged key judgements around specific areas of non-payment of outstanding balances and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for outstanding balances and reviewed correspondence with commissioners. |

| Risk | How the scope of our audit responded to the risk |
|---|---|
| **Recoverability of receivables for overseas, private patient and non-NHS revenue**<br><br>The Trust has significant non-NHS revenues including private patient income of £47.9m (Note 2.1). Due to the nature of the debt (predominantly embassy or privately funded) amounts typically take longer to recover than NHS amounts and can be individually large and hence judgement is required to determine the level of provision required. The year end debtor in relation to international private payment debt is contained within the £33.0m of non-NHS receivables disclosed in Note 14.1. | We evaluated the design and implementation of controls over recognition and collection of overseas, private patient and non-NHS revenue.<br><br>We traced a sample of debtors at an interim date to subsequent cash receipts and performed roll forward procedures to year end balance. We tested a sample of patients to confirm the validity of the revenue. We also tested new debt arising since the interim date on a sample basis. We tested the mechanical accuracy of the bad debt provision and challenged assumptions made to assess the adequacy of the provision.<br><br>Where there was no evidence of cash receipts, the prior payment history was assessed relevant correspondence reviewed and we challenged management in relation to their judgement around recoverability to assess whether payments will be made.<br><br>We agreed a sample of debtors to letters of guarantee to support recoverability.<br><br>The provisions were also assessed to determine whether individual balances were overstated by considering the historical accuracy of the provision. |
| **Property valuations**<br><br>The Trust holds property assets within Property, Plant and Equipment at a modern equivalent use valuation. The valuations are by nature significant estimates which are based on specialist and management assumptions and which can be subject to material changes in value. The valuation of land, buildings and dwellings of £339.3m is disclosed in Note 11.1. | We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer.<br><br>We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties, including through benchmarking against relevant building indices 31 March 2016.<br><br>We assessed whether the valuation and the accounting treatment of the impairment was compliant with the relevant accounting standards, and in particular whether impairments should be recognised in operating expenditure or other comprehensive income. Additionally we reviewed the floor plan assumptions in the model.<br><br>We tested fixed asset additions to supporting invoices and whether they were appropriately capitalised. |

See also note 1.5 to the financial statements, critical accounting judgements and key sources of estimation uncertainty and the Audit Committee's Report on page 57.

The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on page 57.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

## Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

We determined materiality for the Trust to be £4.0m (2014/15: £3.8m), which is below 1% of revenue and below 1% of equity. Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements. This is an increase on 2015/16 due to the increased revenue for the year.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £198,000 in 2015/16 (2014/15: £187,000), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

## An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's head offices directly by the audit engagement team, led by the audit partner.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems.

Data analytic techniques were used as part of audit testing, in particular to support profiling of populations to identify items of audit interest.

### Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

### Matters on which we are required to report by exception

**Use of Resources**
The Trust has described, in its Annual Governance Statement, on page 67, weaknesses in its arrangements to ensure the quality of reported data around the 18 weeks Referral to Treatment indicator, and is currently on a reporting break in relation to this indicator.

This matter is evidence of weaknesses in proper arrangements to ensure that the Foundation Trust can take properly informed decisions to achieve planned and sustainable outcomes.

Except for the matter referred to above in relation to the data reporting around the 18 weeks Referral to Treatment indicator, no matters have come to our attention that indicate that the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters

**Annual Governance Statement and compilation of financial statements**
We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

**Our duty to read other information in the Annual Report**
Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements;
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

### Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and International Standards on Auditing (UK and Ireland). We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Great Ormond Street Hospital for Children NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

### Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

**Heather Bygrave FCA BA Hons**
(Senior statutory auditor) for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
St Albans, United Kingdom

20 May 2016

GOSH patient Tyler, age four, whilst on Badger ward

# Quality Report 2015/16

# Contents

# Understanding the *Quality Report*

We recognise that some of the information provided may not be easily understood by people who do not work in healthcare. So, for clarity, we have provided explanation boxes alongside the text.

**This is a "what is" box**

It explains or describes a term or abbreviation found in the report.

"Quotes from staff, patients and their families can be found in speech bubbles."

GOSH patient Ava, age six, during one of her visits to the hospital.

# What is the *Quality Report*?

The *Quality Report* is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. Its aim is to enhance accountability and engage leaders of NHS organisations in their quality improvement agendas. The *Quality Report* is a mandated document, which is laid before Parliament before being made available to patients, their families, and the public on the NHS Choices website.

## What does it include?

The content of the *Quality Report* includes:

- Local quality improvement information, which allows trusts to:
  - demonstrate their service improvement work, and
  - declare their quality priorities for the coming year and how they intend to address them.
- Mandatory statements and quality indicators, which allow comparison between trusts.
- Stakeholder and external assurance statements.

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) has a long-standing reputation as one of the finest paediatric hospitals in the world. We are keen to share information publicly about the quality of our services and about our continuous improvement work.

**What is NHS Choices?**

NHS Choices is the UK's biggest health website. It provides a comprehensive health information service to patients and the public.

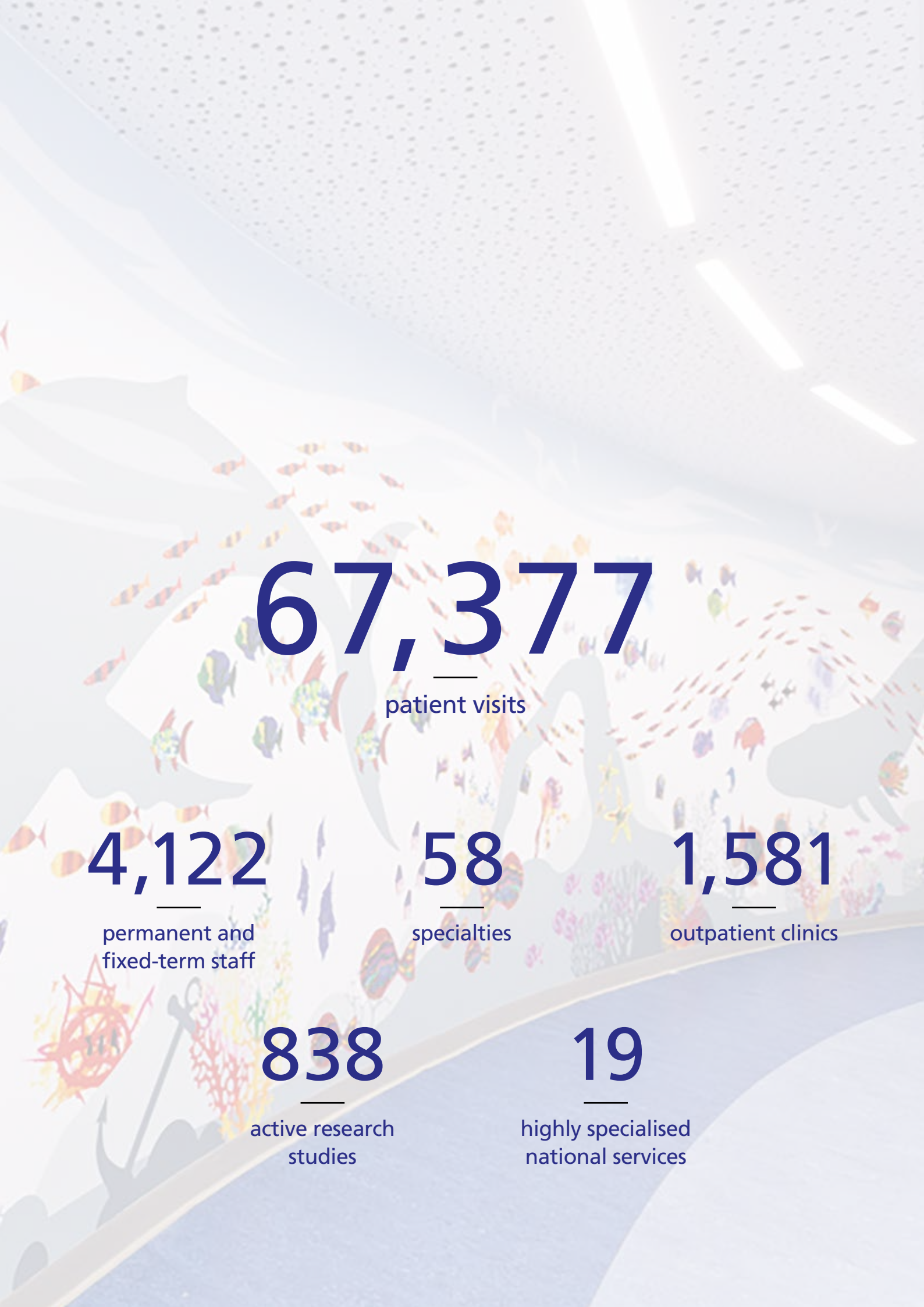
**What is a Foundation Trust?**

A foundation trust is a type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities. NHS Foundation Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public, and staff, and are governed by a board of governors comprising people elected from and by the membership base.


GREAT ORMOND STREET
HOSPITAL FOR CHILDREN

# 99%

of parents and patients would recommend the hospital



67,377

patient visits

4,122

permanent and fixed-term staff

58

specialties

1,581

outpatient clinics

838

active research studies

19

highly specialised national services

# Part 1:
# A statement on quality from the Chief Executive

We strive to ensure that every patient and family that comes through the doors of Great Ormond Street Hospital receives care commensurate with the best in the world. This can only be delivered by a deliberate strategy to continually challenge, refine and improve the quality of care we provide. Our annual Quality Report sets out our current strategy by detailing our performance against our 2015/16 quality priorities and outlining the priorities we have set ourselves for the coming year.

They have not been developed in isolation. Our priorities for improvement have been determined by listening and responding to priority areas identified by patients and their families, staff, and local stakeholders including our commissioners. They are also informed by international best practice.

Our quality priorities fall into three categories: safety, clinical effectiveness and experience.

## Priority one – safety

To reduce all harm to zero

## Priority two – clinical effectiveness

To consistently deliver excellent clinical outcomes, with the vision of being the leading children's hospital in the world.

## Priority three – experience

To consistently deliver an excellent experience that exceeds our patents' families' and referrers' expectations.

## Safety

Many of our initiatives to improve quality have been clinically led and co-designed with our patients and their families. One such project was the roll-out of electronic 'Patient Status at a Glance' (ePSAG) boards. These are large, easy-to-read electronic whiteboards that display a range of real-time patient information. The primary aim is to improve patient safety by reducing avoidable harm through the early identification, escalation and necessary care planning of patients at risk of deterioration.

These ePSAG Boards were developed by clinical teams and a parent representative who facilitated the involvement of more than 30 patients and three families. Our families' views informed the level of information on display and identified the features that would be meaningful to parents to improve their experience. Instrumentally, their involvement also led to the creation of 'watcher' status, which is applied to patients that do not trigger the more formal Children's Early Warning Scores (CEWS) highlighting those children at risk of deterioration, but indicate where a family member or clinical staff member has a concern.

Our ambitious target was to roll out the boards across all our wards by the end of the financial year with effectiveness measured by a number of pre- and post-roll out audits. An unexpected delay to the ambulatory version of ePSAG meant the Trust-wide roll out has been slightly delayed and we are now on track to complete roll out by 31 May. Where the boards have been installed they have had a significant impact. They have contributed to an increased awareness of CEWS and of the term 'watcher' patient. Data has also demonstrated that the introduction of the boards has reduced unnecessary interruptions for our patients and families and improved the overall patient experience. They have also facilitated improved communication between staff, particularly at safety huddles. This element of communication will remain a focus in the next year along with work to further improve the monitoring and care of the deteriorating child.

Improving access and patient flow has been a key theme woven through this report. Improved access was supported by the roll out of the ePSAG initiative and is the focus of our second safety priority. We aimed to reduce delayed discharges from our intensive care unit and reduce the number of refusals and cancellations. This work aimed to improve the patient experience and also inform a wider programme of work to create increased capacity across the Trust.

Following the introduction of a number of initiatives to improve flow and an in-depth analysis of our data, we saw some lengths of stay reduced and were able to identify that delays in discharge were, in part, a result of limited beds being available in other parts of the hospital or locally. We also found that the vast majority of patients booked by GOSH consultants to be transferred to ICU did not end up requiring intensive support. Over the coming year we will work to model the risk for all theatres cases to better judge and manage the need for ICU beds post-surgery. We will also work with teams across the Trust to enable swifter discharges.

## Clinical effectiveness

We are undertaking important work to ensure that all our patients receive treatment within a time appropriate to their clinical conditions and to understand the challenges we face ascertaining exactly when an individual patient's pathway of care began. Our work to resolve this issue of Referral-To-Treatment (RTT) 'incomplete pathways' features in the clinical effectiveness section of this Quality Report and gives some detail how we have worked with NHS experts to address these issues. This work to improve access is extensive and ongoing and is why we are unable to report performance against some of our waiting time quality indicators. It is an essential programme of work and remains a quality priority for 2016/17.

Blood is an extremely precious resource and plays a vital role in saving lives at GOSH. We have a responsibility to use blood only when clinically necessary and therefore ensure it is available to those children that need it wherever they are being treated. This year, as part of our 'no waste' strategy, we set out to reduce any avoidable blood wastage. Through a number of work streams covering surgical ordering, education and training and improved inventory management we were able to dramatically cut blood wastage by 30 per cent compared to 2013/14.

## Experience

As a specialist provider, our patients come to us from other hospitals, often returning to these local hospitals before returning home. Ensuring the receiving hospitals have accurate and comprehensive information about the treatment received at GOSH is essential for a smooth transfer of care and is facilitated by the production of a discharge summary. In 2015/16 we undertook to improve the quality and timeliness of our discharge summaries using national guidance and local expertise. A key component of this work was moving to an electronic system that could pull information from other systems including those capturing prescribed medicines.

This project has had success in clinical areas such as rheumatology and specialist neonatal and paediatric surgery, dramatically cutting the time between discharge and the production of a discharge summary. Significant Trust-wide improvements were made in the first part of the year and there is an ongoing programme of work to ensure that the improvements made are sustained.

The second quality priority aimed at improving the care experience of patients with learning disabilities. This programme of work continued the commitment we set out last year to do better for our many patients with learning disabilities. This involved further embedding training, supporting staff on the use of clinical alerts and promoting the hospital passport.

Many elements of this work were praised in our CQC Report and last year it resulted in us doubling the number of patients with learning difficulties that we were able to identify prior to admission or being seen in Outpatients, enabling better planning for their care at GOSH. Within this report, we hear directly from a parent of a patient with a learning disability. Her words are moving and serve as an important reminder of how we must tailor the care and experience we provide to each of our children's needs.

Many of our young people tell us that the transition from being treated at GOSH, where they have often been seen for many years, into adult services is not always smooth. This year we have decided to focus on improving young people's experience of transition to adult services by working with young people and the adult centres they will be treated at to deliver an improved experience. We will, in the short term, measure progress by the number and percentage of Specialty Transition Leads established across our many subspecialty areas.

As this report shows, there are many areas over the last year where we have made significant improvements to the quality of the care and experience we provide. There are some areas where further improvement work is necessary and which require a renewed and deliberate focus. There are also some new areas of work that we have identified as requiring attention. Many of these challenges cannot simply be solved within the walls of Great Ormond Street Hospital. It is imperative that we work with other healthcare providers and partners to achieve across the patient journey, the standards of care and experience our patients and their families deserve.

We are very mindful that much of the information we have provided in this report is dependent on the quality of the data we can obtain. In preparing the Quality Accounts, there are a number of inherent limitations which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data is collected by a large number of teams across the trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.
- Where we have been unable to provide accurate data in relation to key healthcare targets it is clearly stated.

The Trust and its executive team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.

Following these steps, to my knowledge, the information in the document is accurate.

Peter Steer
Chief Executive

# Part 2a:
# Priorities for improvement

This part of the report sets out how we have performed against our 2015/16 quality priorities. These have been determined by a combination of national priorities as well as local priorities identified by staff, patients and their families, and wider stakeholders such as referrers and commissioners. The quality priorities fall into three categories: safety, clinical effectiveness and experience. These categories were defined by Lord Ara Darzi in his NHS review for the Department of Health, in which he emphasised that quality should be a central principle in healthcare.


## Safety

We are committed to reducing avoidable harm and improving patient safety, year on year, and as rapidly as possible. Our Zero Harm initiatives aim to ensure that each patient receives the correct treatment or action the first time, every time.

## Clinical effectiveness

At Great Ormond Street Hospital we seek to provide care for our patients commensurate with the best in the world. Furthermore, as a major academic centre we work with our patients to improve the effectiveness of this care. Wherever possible we use international and national benchmarks to measure our effectiveness and we publish this data on our website and in major international and national journals. To measure our effectiveness from the patient's perspective, we use Patient-Reported Outcome Measures (PROMS).

Our extensive research and innovation work is evidence of our dedication to delivering the most clinically effective care.

## Experience

We wish our patients and their families to have the best possible experience of our care and treatment. Therefore, we measure patient experience across the hospital and we seek feedback from our patients, their families, and the wider public via our membership, patient and member surveys, focus groups, the use of social media, and asking patients and families about their experience within 48 hours of discharge. All of these sources of information we use to improve the services we offer.

After an extensive consultation and development period, we formally launched *Our Always Values* in March 2015. Since then, *Our Always Values* has been a visible representation of our commitment to our patients, families and staff.

# Reporting our quality priorities for 2015/16

The six quality priorities for 2015/16 were:

## Safety

- Roll-out of electronic 'Patient Status at a Glance' on the ward
- Improving flow through our intensive care units

## Clinical effectiveness

- Referral to treatment (RTT): incomplete pathways
- Working smarter to reduce blood component wastage

## Experience

- Improving discharge summary completion times
- Improving the care experiences of our patients with learning disabilities

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

# Safety

## Roll-out of electronic 'Patient Status at a Glance' on the ward

The traditional ward whiteboard provides clinical staff and families with an overview of the patients on the ward. The electronic Patient Status at a Glance (ePSAG) board is an in-house GOSH software development to deliver an electronic whiteboard system. Information is pulled from clinical hospital systems to ensure that what is displayed is up-to-date and relevant. Large touch screens and intuitive software design mean that the effort required to update the data is kept to a minimum.

### What we said we'd do

In September 2015, we said we would install the electronic Patient Status at a Glance (ePSAG) boards in all of our wards by 30 April 2016 to make the updating and accessibility of patient overview information more efficient, and thereby improve safety.

### What we did

A clinical user group was set up on each ward to look at the particular workflow in that area and design a template for ePSAG to support the ward's current working practices. The groups also looked for opportunities to improve their workflow as part of the project. Division-wide clinical user groups were set up to address the need for standardised elements of the board across the hospital and to manage individual requests for new alerts and functions to be added to the boards.

With the support of a dedicated parent representative, we consulted with over 30 patients and parents to gather their opinions on the purpose of ePSAG, the ideal level of information to display, and to learn about other features that were meaningful to them. A parent focus group was held to review this feedback and compile key themes to be carried forward and addressed by the steering group.

By 31 March, we had successfully rolled out the ePSAG board to all inpatient wards, and were on schedule to roll out to day-care units by 30 April.*

We approached the roll-out of ePSAG in four 'waves', beginning with wards that were already implementing safety huddles. On completion of these areas, we grouped long-stay wards into similar specialties and rolled ePSAG out to these areas in two phases before finally approaching the Day-care and Ambulatory units.

### What the data shows

A delay to the development of the ambulatory version of ePSAG meant that we did not complete roll out to all day-care units by 30 April. We are now working to a 31 May deadline, and are on schedule to achieve this. In order to know whether an improvement had been made by the use of ePSAG, we carried out situational awareness audits in the weeks prior to installing the boards on each ward. We then returned to the wards two months after installation to assess staff awareness as a result of having the board and access to real-time data.

*A delay to the development of the ambulatory version of ePSAG meant that we did not complete roll out to all day-care units by 30 April. We are now working to a 31 May deadline, and are on schedule to achieve this.

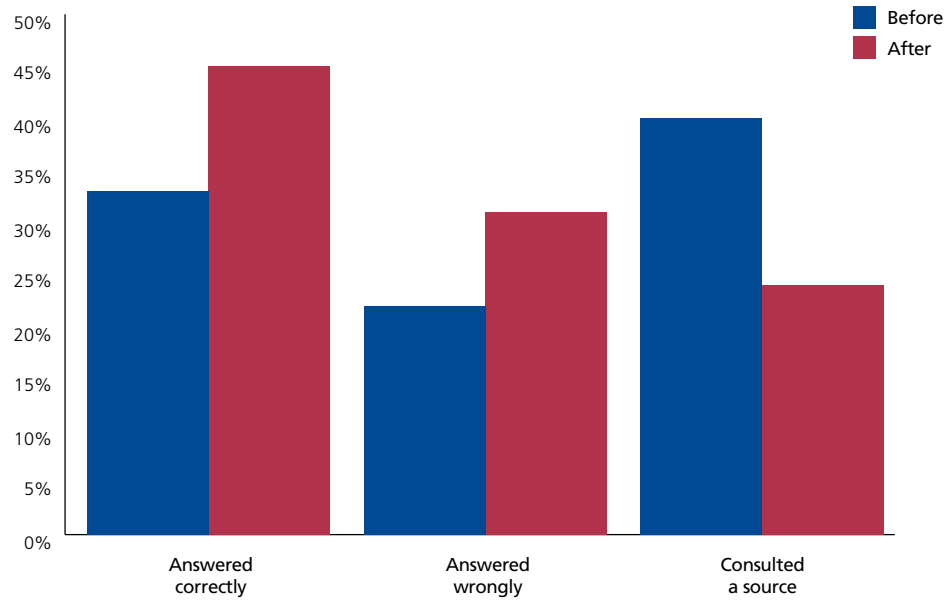
*Situational awareness pre-project and post-project audit results (wave one)*

Before the project, the range of sources checked when a staff member could not answer included: the handover document, electronic observation system, whiteboard, patient notes, or asking the nurse in charge.

After the project, the range of sources checked had reduced to one: ePSAG.

The results show the intended increase in staff awareness of the patients on their ward with CEWs of 3 or above. They also show a reduction in the number of sources consulted by staff when they need to find the answer. This increases efficiency, reduces the risk of error, and increases our confidence that staff know where to access information about patients' CEWs scores when needed

*Chart one – Percentage of staff aware of patients with a CEWS of 3 or above currently on the ward*




| Children's Early Warning Score (CEWS) Action to be taken when a patient scores: | |
|---|---|
| 0 – 2 | No action needed<br>Nurse/parental concern inform nurse-in-charge (NIC) |
| 3 – 4 | Report CEWS to nurse-in-charge (NIC)<br>Repeat observations within 30 minutes, agree monitoring plan, consider adjusting parameters<br>If no improvement after 30 minutes, inform the NIC and Registrar for review<br>Follow escalation algorithm |
| 5+ | Inform nurse-in-charge (NIC), Registrar and CSP with recommendation (SBARD) to attend |

If there is concern about the clinical condition of the patient at any time consider placing a 222 call regardless of the CEWs score

**S** Situation
I am *(your name and role)* in *(ward x or department x)*. What is the problem?

**B** Background
What is the background or context?
What has led up to this event?

**A** Assessment
What do I think is wrong?
How worried am I about this situation?

**R** Recommendation
What do I want to happen now?

**D** Decision
The receiver reads back the SBARD
What plan do we agree on?
Is there anything that I need to do now?

**What is CEWS?**

CEWS (Children's Early Warning Score) is a tool to support staff to recognise and respond to children who may be deteriorating (see left).

Early warning scores are generated by combining the scores from a selection of routine observations of patients including pulse, respiratory rate, blood pressure, oxygen saturation and consciousness level.

*Chart two – Percentage of staff who understood the term 'watcher' patient*

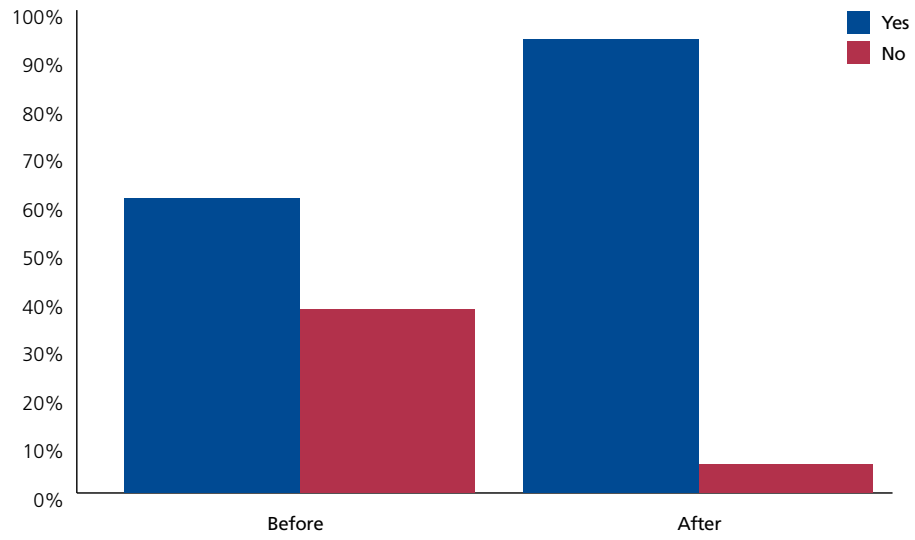
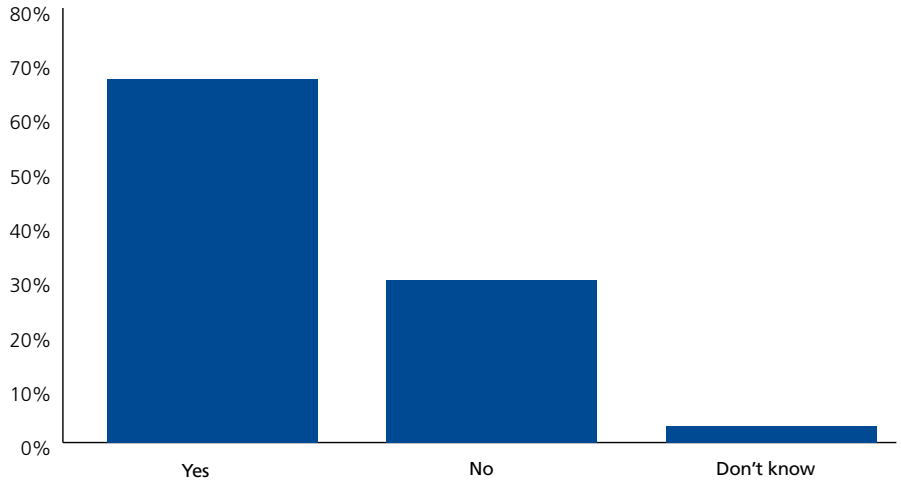



*Chart three – Percentage of parents and young people who felt ePSAG was helpful to them as a parent/patient**




*sample size: 27 individuals

The data shows us that ePSAG reduces interruptions, increasing time to care. It facilitates communication at daily safety huddles, handover and ward rounds, ensuring clinicians are always expert in their knowledge of and care for their patients and are always working as one team. ePSAG also helps with planning for discharge, bed management, and communication between staff and families.

The ePSAG boards have supported improvements in patient flow – on Puffin Ward, the board requires all essential fields to be completed before a child/young person goes to theatre, including: clerking, consent, and marking of the site for surgery. Getting the process right first time avoids delay and ensures that patients are consistently prepared for their operations.

In support of the Trust's Situation Awareness for Everyone (SAFE) project, ePSAG also improves situational awareness on wards by:

- clearly displaying Child Early Warning Scores (CEWS)
- flagging 'watchers'
- displaying other information relevant to identifying patients at risk of deterioration

Pre-project audits have also been completed for waves 2 and 3. We are currently undertaking the post-project audits for waves 2 and 3 to measure change from the implementation of ePSAG.

**What is a 'watcher' patient?**

The 'watcher' patient initiative at GOSH is a formalising of previously informal action. 'Watchers' are the patients whose CEWS do not trigger an alert, but where the patient's family/carer or a clinical member of staff has a concern.

These patients are formally monitored and reviewed on the basis of this concern.

**What is a Clinical Site Practitioner?**

A Clinical Site Practitioner (CSP) is a senior nurse in charge of the day-to-day operational management of the hospital

**What is a safety huddle?**

'Patient safety team huddles' are daily, focused, group discussions by frontline staff to support identification and management of patients at risk of deterioration. The safety huddles not only ensure that refined escalation plans are in place for these patients, but that all staff are aware of the severity of patients under their care.

### What's going to happen next?

The next steps for the ePSAG roll-out project will be:

1. Complete the design and roll-out of ePSAG to all day-care units by 31 May 2016.
2. Return to all recently installed areas and undertake situational awareness audits to measure change.
3. Integrate this work with the roll-out of safety huddles in order to fully realise the combined benefits of both interventions in improving the situational awareness of the whole team.

### How this benefits patients

The use of ePSAG boards:

- Improves patient and family experience by making relevant information visible at all times, including estimated discharge date and the named nurse and doctor for each patient.
- Can reduce avoidable harm to patients on inpatient wards by improving the identification, escalation and care planning of patients at risk of deterioration.
- The introduction of the 'watcher' status empowers individuals to speak up and provides visual validation of parental concerns. It also enables clinicians to highlight patients for whom they have a concern or clinical 'gut feel', despite the observations remaining within normal parameters.
- Improves flow for theatre patients, which reduces avoidable delays and cancellations.
- Encourages earlier and better discharge planning, reducing delayed discharges for non-clinical reasons.

"I have been privileged to be part of the ePSAG group since last year. It has been wonderful to see that the foundation values the input of parents and allows them to contribute to how the hospital is constantly developing and evolving.

"ePSAG has given the parents a source of information which was never available with the traditional whiteboards and most importantly they can access details quickly and without having to disturb members of staff. The clarity and frequently updated information on the boards is also incredibly helpful and also reassuring to parents."

*Parent, and Outpatients and Family Liaison Volunteer (Bear Ward)*

## Improving flow through our intensive care units

The smooth flow of patients through the Paediatric Intensive Care Unit (PICU) and Neonatal Intensive Care Unit (NICU) is vital to the effective running of the hospital.

### What we said we'd do

We said we would collect data on delays, refusals and cancellations of elective admissions to understand the impact of our improvement work and further target our interventions.

### What we did

The Intensive Care Units Flow project continued throughout 2015/16, focusing on five key areas of improvement:

#### Time of transfer to the wards

A new process was trialled, then introduced, at the daily Trust-wide bed management meeting, whereby all patients transferred from an intensive care area must be given a 'receiving time' by the accepting ward. This has improved the discharge planning process and reduced the risk of afternoon cancellations. Consultants within each specialty actively prioritise accepting children from intensive care to avoid delayed discharges from the intensive care units.

#### Electronic Patient Status at a Glance (ePSAG)

The development of the ePSAG board, an electronic version of the patient whiteboard, has improved both communication and situational awareness of staff members. The inclusion of real time information about the location and status of ventilators and other essential equipment on the board has also reduced time lost by clinicians to non-clinical issues. See page 84 for more information about ePSAG.

#### Intensive care units e-referral process

Though the earlier implementation of an electronic referral tool was very successful, a number of clinician-led changes have now been made to deliver further improvements. A new interface was created on ePSAG to display the status of all imminent PICU and NICU referrals in real time. The referral review process is incorporated into the ICU morning ward round, reducing delays and improving data quality. The PICU and NICU teams use the system dynamically to flex capacity within the context of current bed availability and external constraints. The ability to pre-empt potential cancellations and flex beds proactively improves patient experience and reduces unnecessary cancellations.

Trust-wide, the specialty teams have appreciated the new referral process, as they now have access to all current PICU and NICU referrals in the system. This offers greater transparency and choice to them when making their own referrals.

#### Identifying reasons for delayed discharges

A number of different methods were tested to determine why patients were delayed when being discharged from the intensive care units. While we know that the reasons for delays are variable and complex, we consider it worthwhile to test a coded analysis approach to aid understanding of flow.

#### Increasing the spread of elective work across the working week

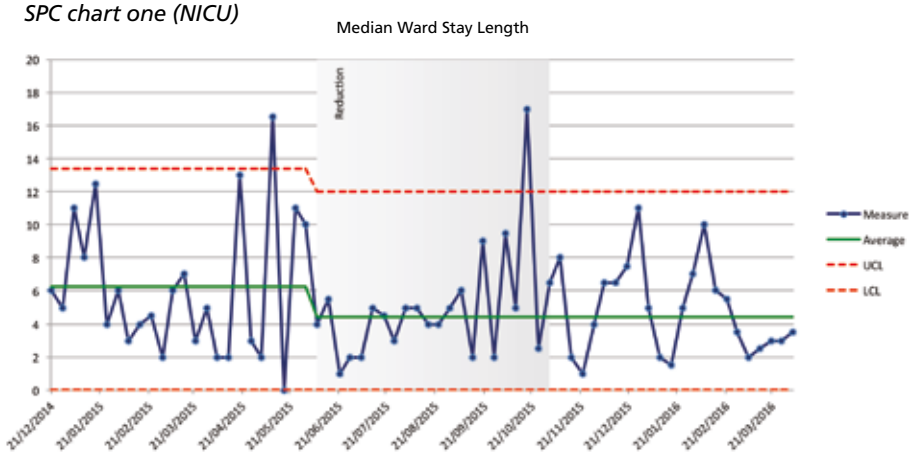
The PICU and NICU teams and the main surgical specialties that refer children into ICU have changed work practices to spread demand across the week. Previously, both of the two main specialties operated every Wednesday, with both teams trying to admit their patients for post-surgical intensive care at the same time. These lists are now spread over three days, thus increasing access to intensive care beds and reducing cancellations.

## What the data shows

### 1. Length of stay in PICU and NICU

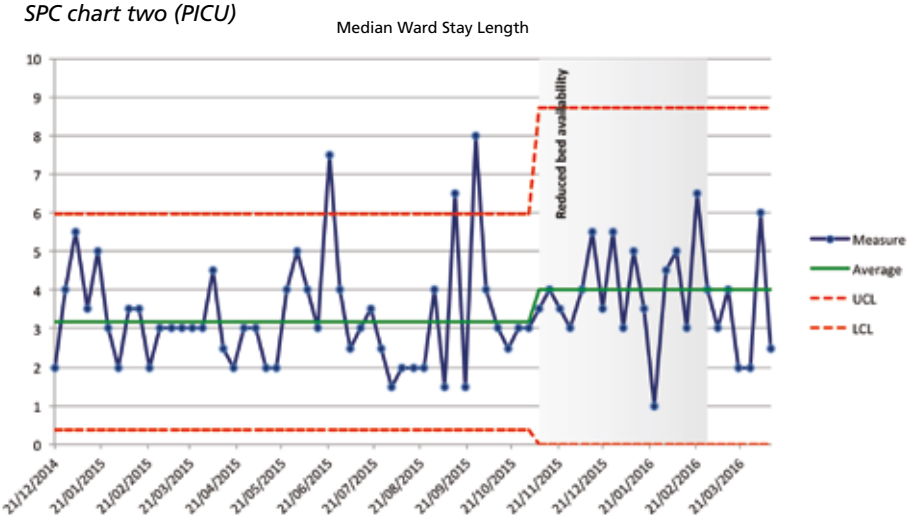
With improved flow, we expect to see reduced length of stay. The data shows a reduction in the median length of stay on NICU (SPC chart one) as compared with the 2015 baseline period. However, there has also been an increase in the median length of stay on PICU, as compared with the previous baseline period from 2014 (SPC chart two). We believe that the increased length of stay in PICU is related to a lack of ward beds internally and at local hospitals.

*SPC chart one (NICU)*




This chart uses SPC methodology and shows a sustained reduction in median length of stay on NICU.

*SPC chart two (PICU)*




Using SPC methodology, the dots highlight a reduction in median length of stay on PICU. However, this reduction was not sustained, and there has subsequently been a statistically significant increase. Work is ongoing in this area.

**What is a Statistical Process Control chart?**

Statistical Process Control (SPC) charts are used to measure variation and improvement over time.

SPC methodology takes into account the phenomenon of natural variation, which, if acted upon without analysis, is an inefficient approach to improvement work. Upper control limits (UCL) and lower control limits (LCL) are calculated to help with data analysis. SPC methodology enables focus on the 'special causes' of variation, thus identifying areas that require further investigation and action.

**What is a baseline period?**

A baseline is the period of measurement to establish 'how things are' before changes are made to a process, to enable comparison 'before' and 'after'. An average (mean) of the data making up that baseline period would be used for that comparison.

**What is the median?**

The median is an average that is derived by finding the middle point in a sorted range of values. Unlike the mean average, which is the total divided by the number of values, the median provides an average that is not skewed by 'outlier' or extreme data points.

2. Number of cancelled elective admissions for PICU

While patients continue to be successfully admitted to our intensive care units from other specialties within the Trust via our electronic referral process tested on PICU (chart three), approximately 80 per cent of the accepted cases do not go to ICU despite being booked, because they are well enough to return to the surgical ward from theatre, or are cancelled for other patient-related reasons (chart four). Future work is planned on modelling the risk for all theatres cases to better judge the need for an ICU bed post-surgery.

*Chart three – PICU electronic referrals*

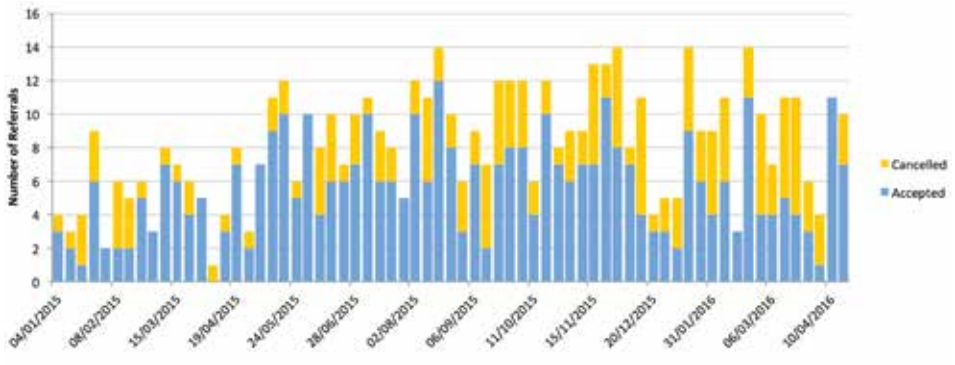
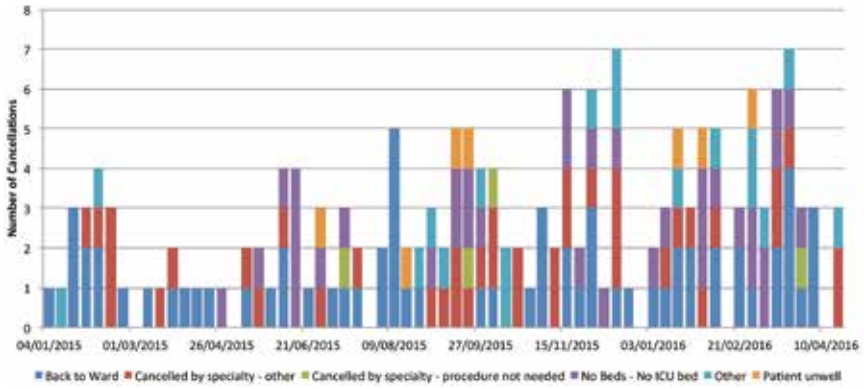



*Chart four – PICU electronic cancellations*




"When my daughter was medically fit to be discharged from PICU, there was no bed available for her on the ward. It was a battle to get her discharged several days later. The PICU staff were very helpful and in the end we were delighted to be discharged, but the process was very frustrating for us."

*Mother, PICU patient*

"I think we can now more clearly see the flow of elective patient bookings through PICU and NICU, which gives us greater flexibility to plan the timing of surgery, and reduce the likelihood of cancellation because of lack of capacity."

*Mr. Joe Curry, Specialist Neonatal and Paediatric Surgery Consultant*

## What's going to happen next?

In 2016/17, the Intensive Care Units Flow project team will continue to work on improving flow through the intensive care areas, focusing on:

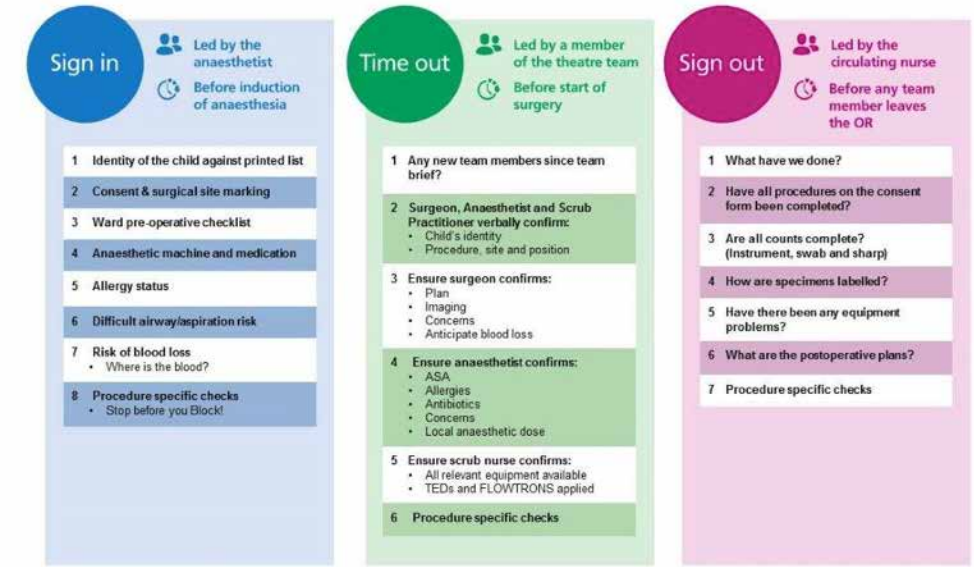
- Developing a robust and reliable method for capturing the multifaceted reasons patients may be delayed from intensive care.
- Developing reliable processes to ensure that patients can be discharged, without delay, to a ward bed.
- Working collaboratively with each surgical speciality team to identify areas for improvement in their current patient pathways.

## How this benefits patients

Reducing delays in the patient journey and reducing the risk of cancellation improves patient care and experience.

## Organisational engagement with the WHO Surgical Safety Checklist

The World Health Organisation (WHO) Surgical Safety Checklist is an intervention to improve safety culture in theatres.




Teams at GOSH had begun using the Checklist in 2008, and it was rolled out across the Trust in 2009. The National Patient Safety Agency mandated use of the WHO Checklist in a patient safety alert in 2009. The Trust has since collected data continually to monitor compliance with the three stages of the WHO Checklist. Our data indicates high levels of performance with recording that the WHO Checklist takes place. The mean average for completion of all three stages of the Checklist is 97 per cent. This means that 97 per cent of procedures are reported as having all three parts of the Checklist completed.

**97%**

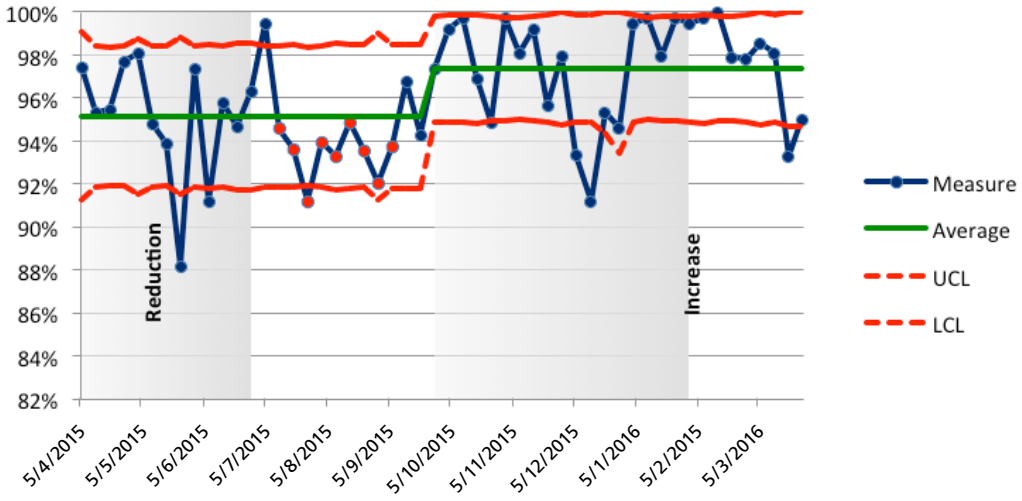
of procedures are reported as having all three parts of the Checklist completed

**What is the WHO Surgical Safety Checklist?**

"The Checklist is intended to give teams a simple, efficient set of priority checks for improving effective teamwork and communication and to encourage active consideration of the safety of patients in every operation performed. Many of the steps on the Checklist are already followed in operating rooms around the world; few, however, follow all of them reliably. The Checklist has two purposes: ensuring consistency in patient safety and introducing (or maintaining) a culture that values achieving it."

*Safe Surgery Saves Lives, Implementation Manual WHO Surgical Safety Checklist 2008, World Health Organisation*

*Percentage Total WHO Checklist Completion (Sign In, Time Out & Sign Out)*




In addition to monitoring the use of the WHO Checklist, it is important to know how well our teams are engaged in and participating in the Checklist process. This is part of our Clinical Audit work plan and we will report the outcome of this work at our Patient Safety and Outcomes Committee in quarter one of 2016/17.

GOSH will be reviewing how it intends to prevent Never Events in the operating theatre as part of its work for National Safety Standards for Invasive Procedures (NatSSIPs). An NHS Never Event is an error that should never happen, such as wrong site surgery.

**What are the NatSSIPs?**

The NatSSIPs bring together national and local learning from the analysis of Never Events, Serious Incidents and near misses through a set of recommendations that will help provide safer care for patients undergoing invasive procedures. This does not in any way replace the existing WHO Surgical Checklist, but rather enhances it by looking at additional factors such as the need for education and training.

The principle behind the NatSSIPs is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with the new national standards. This will be done by organisations working in collaboration with staff to develop their own set of 'Local Safety Standards for Invasive Procedures' (LocSSIPs).

*Source: https://www.england.nhs.uk/patientsafety/never-events/natssips/*

# Clinical effectiveness

## Referral to treatment (RTT): incomplete pathways

Incomplete pathways are the care pathways of those patients who are still awaiting treatment for their condition. This is measured against the national 'Incomplete' standard, which states that 92 per cent of patients waiting at any point in time should be waiting less than 18 weeks from referral (the length of time defined as a patient's constitutional right). This measure ensures that patients on an RTT pathway are seen and treated within 18 weeks and thus receive timely care.

### What we said we'd do

We chose to report on our RTT work in 2015/16 because we recognised that we needed to improve our processes and data management to ensure that we see all patients in a timely manner. As a tertiary and quaternary provider, we do not know when the 'clock' has been started for nearly 70 per cent of the referrals we receive. This is a considerable challenge for us, and other specialist providers, in meeting the 18 week RTT timescale. However, despite this challenge, we knew we needed to do better at determining exactly how long our patients on these pathways have been waiting to ensure that they are seen within 18 weeks. Limited assurance work by Deloitte in 2014/15 highlighted the problem.

### What we did

Since May 2015, we have been working with the national Intensive Support Team (IST) for Elective Care, who are the national experts in supporting trusts in the management and reporting of waiting times and RTT.

A number of significant issues were identified by the IST, in addition to the challenges mentioned above. These mainly related to the data and information processes in place to manage and track patients robustly through their elective pathway. A number of problems with operational processes were also identified.

The Trust established an Access Improvement Programme, led by the Chief Operating Officer, to define, scope, and oversee the necessary improvements required across the elective care pathway. This work programme has been governed internally through a fortnightly Access Improvement Board and externally through a fortnightly tripartite meeting, which includes input from Monitor, NHS England and the Care Quality Commission (CQC).

Significant progress has been made over the course of the year to address the issues identified, including the establishment of robust processes for the management and tracking of RTT patients across the organisation and the training of staff in RTT rules and GOSH processes related to elective care.

While the review has not to date flagged any significant concerns with the clinical care received by patients, we are clinically reviewing our very long-waiting patients to make absolutely sure that they have been managed appropriately and are treated without further delay.

### What the data shows

The prime measure for improvement for RTT is the national 'incomplete' standard of 92 per cent, as outlined above. While the Trust is presently unable to report against this standard, we expect to resume reporting from the end of September 2016.

### What's going to happen next?

The work programme will continue into 2016/17 in line with the approach set out above until the problems are fully resolved.

### How this benefits patients

The Access Improvement Programme aims to provide greater assurance and improved processes for patients accessing elective care at GOSH, ensuring they are treated within the most clinically appropriate timescales.

**What is a care pathway?**

A care pathway is an outline of anticipated care in an appropriate timeframe to treat a patient's condition or symptoms.

"Delivering high-quality and safe care in a timely fashion has to be our guiding principle. Good progress has been made this year to improve our systems and processes for tracking patients across their pathways and therefore reassuring them and us that they are being seen and treated within the most appropriate timescales. Over the next year, we are committed to further improving our systems and processes to ensure our data is robust and to maximise access for the children and young people who need our care."

*Dr Vinod Diwakar, Medical Director*

## Working smarter to reduce blood component wastage

Blood and blood components are used at GOSH every day to save lives. The availability of blood components is due to the generosity of voluntary blood donors, so it is a precious resource that we should manage well, minimising wastage as well as unnecessary cost.

There will always be some discards of blood components, particularly fresh components with short expiry dates, which must be available immediately for clinical emergencies. This is inevitable and appropriate. However, there is a proportion of discards of blood components that can be avoided by better management of the system of blood availability.

### What we said we'd do

In 2015, the Transfusion Team, supported by the Quality Improvement Team, undertook a project to eliminate avoidable blood component wastage as part of the 'No Waste' strategy. Our workstreams included:

- improved inventory management
- reduction in surgical ordering, despite a background of growing surgical activity
- education and training of staff handling blood components

### What we did

We began by mapping blood management processes, to help us to understand where in the system improvements could be made, to enable reductions in issued and wasted components. The reasons and cost of blood component wastage were highlighted to staff involved in the transfusion process and it was noted that this varied between clinical divisions. We undertook the following actions:

- Review of the maximum surgical blood ordering schedule requirements for all surgical specialties, with a particular focus on cardiorespiratory care.
- Re-development of the blood components usage and wastage dashboard, with the addition of more measures to enable us to better use the data to inform the project.
- The reservation period for all blood was reduced to 24 hours.
- Review of availability and use of emergency O RhD negative blood (this is the blood group that is compatible with all other blood groups, so can be given to any patient).
- Education of staff to include the lifespan of components and storage requirements.
- Publication of a focus topic about the project for 'Blood Drops', the blood transfusion newsletter, which is available throughout the Trust.
- Support and empowerment of biomedical scientists to challenge orders that don't seem appropriate or necessary.
- Review of the age of red cell requirements to reduce overuse of the freshest components.

### What the data shows

Data is collected monthly and shows that relatively inexpensive interventions have had a dramatic impact on blood component wastage, improving patient outcomes and offering savings to the Trust.

### What's going to happen next?

The national picture from clinical audits consistently shows that blood components are sometimes used inappropriately. So, the next steps for the project to reduce blood component wastage are:

1. We will undertake an audit of appropriate use of blood to monitor and continue to improve practice.
2. We will maintain awareness of blood component wastage issues through ongoing education.

In addition, we will undertake the following blood management initiatives:

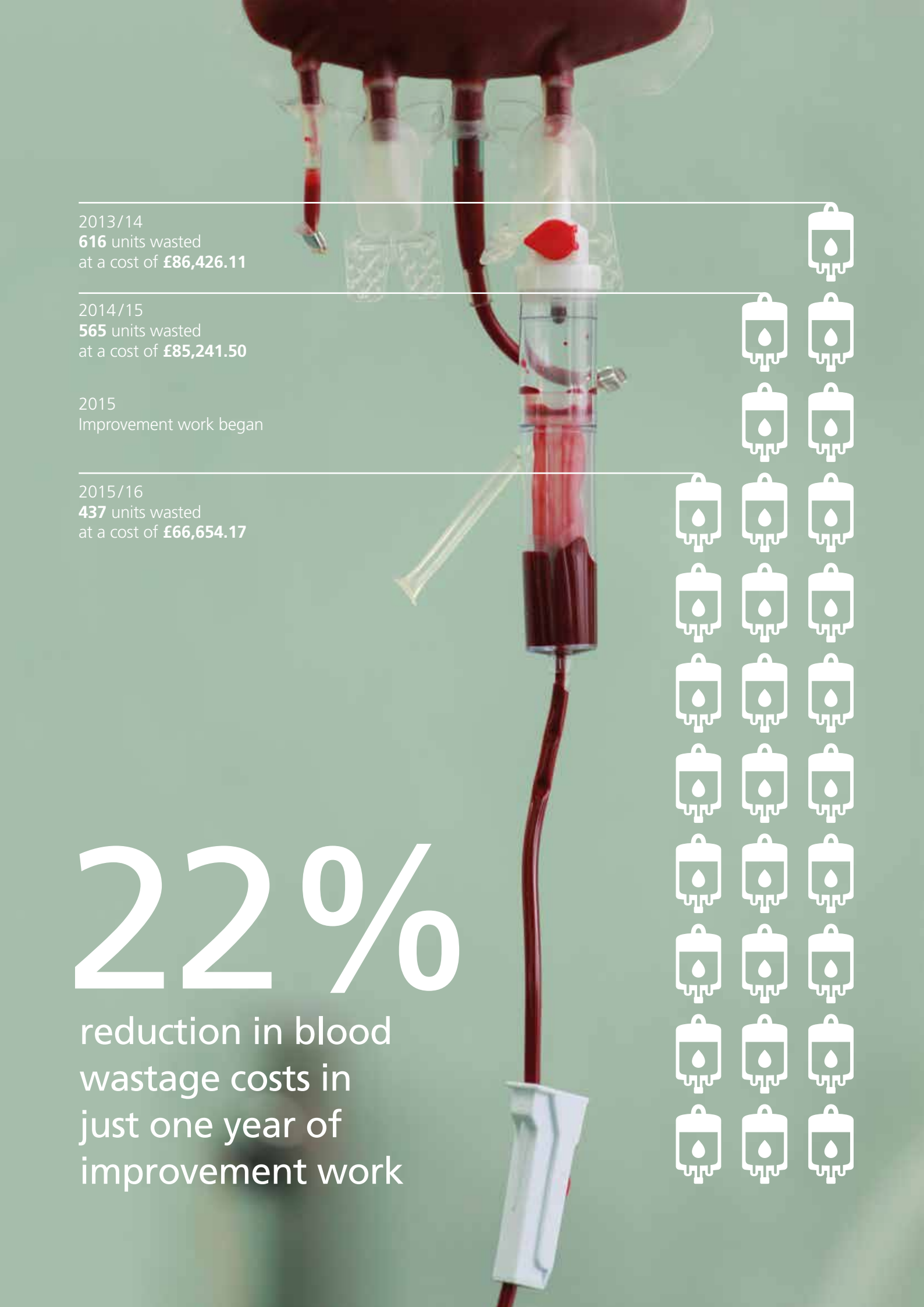
- minimise the volume of blood samples taken
- develop an anaemia pathway for investigating and treating patients undergoing elective surgery
- explore and educate our staff on alternatives to transfusion where appropriate

### How this benefits patients

Reduction in wastage of blood components helps to ensure they are available where and when they are clinically needed. All blood management improvements by healthcare providers also contribute to the sustainability of the national blood supply in the future.

"Addressing blood wastage issues at our team days and knowing how we are performing as a team by reviewing timely data, has helped us to identify opportunities to improve. This could benefit all patients if blood that may have been wasted is available for another patient in clinical need and money saved can be diverted to other uses in the Trust."

*Deborah & Maria, Practice Educators, PICU*



2013/14
**616** units wasted
at a cost of **£86,426.11**

2014/15
**565** units wasted
at a cost of **£85,241.50**

2015
Improvement work began

2015/16
**437** units wasted
at a cost of **£66,654.17**

# 22%

reduction in blood wastage costs in just one year of improvement work

## Improving discharge summary completion times

When doctors refer children and young people to GOSH for inpatient care, they rely on us to provide them with information about that care once the child is discharged from hospital. This information is sent in a discharge summary.

### What we said we'd do

We said we would improve the quality and timeliness of our discharge summaries, by rolling out an electronic system that we piloted from June 2013 to January 2015. We said we would introduce a standardised discharge summary template, using guidance from the Royal College of Physicians to inform the core content required in every summary. We also committed to develop the electronic system further, so it could pull in patient information from other hospital systems in order to reduce duplication and make the process of writing summaries more efficient for clinicians.

### What we did

A package of implementation tools was developed, based on our work in the departments that piloted the system (Rheumatology, Dermatology and Specialist Neonatal and Paediatric Surgery). The tools included: the web system itself, a future state process map, dashboards, user guides, posters, and exclusion lists. All clinical specialties were approached via their general managers, who were asked to promote the project within their divisions, identify and engage clinical champions for each specialty, and provide management support for the work.

Uptake of the web system and use of the core content of the standardised discharge summary template was mandatory, but customisation of templates was also available. Requests for adjustments were prioritised and added to an ongoing development plan. At the same time, development of additional features for all users continued. Integration of completed documents into the electronic document management system and a near-live feed of medications from the Trust's e-prescribing system were made available to all clinical specialties in April 2015, after smaller-scale tests had been completed.

Twenty-five specialties across five clinical divisions were identified for roll-out. We established the project in each division through formal spread to one specialty, targeting either those with the greatest need or those who were most eager to be involved. By building our 'early majority' of adopters across the Trust, we were then able to create momentum as well as the spread of good practice through informal interactions between staff.

Our success in 'selling' the project to clinical teams relied on two key messages:

- Our interventions could reduce the overall time spent on discharge summaries as well as improving timeliness and quality.
- As development of our web system had been driven by the clinical team in Rheumatology, the end product had a greater degree of credibility with clinical teams in other areas. This was true even for teams whose clinical practice had little in common with Rheumatology.

By September 2015, all 25 specialties, except Intensive Care, had adopted the electronic system to produce their discharge summaries. In March 2016, the International and Private Patients division also adopted the system to begin writing discharge summaries for their patients.

### What the data shows

Rheumatology achieved a statistically significant improvement in their discharge summary completion rate. Their average number of days from discharge of patient to discharge summary completion decreased from 6.1 days (March 2013) to 1.3 days (March 2016).


Specialist Neonatal and Paediatric Surgery has also achieved a reduction in average days from discharge of patient to discharge summary completion, from 4.2 days (May 2014) to 0.4 days (March 2016).

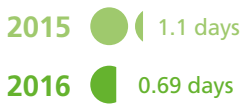

**What is a discharge summary?**

A discharge summary is a short clinical review of a patient's hospital stay. It lists any tests, procedures and medications the child received and gives instructions for follow-up care once they return home. To make sure there are no delays or problems with the patient's post-discharge care, it is important that discharge summaries are written promptly and contain all of the information the child's local doctor needs to continue their care.

There have also been improvements across the following clinical divisions:

- Neurosciences division has reduced their discharge summary completion time from 1.7 days (January 2015) to 0.4 days (March 2016).


- Surgery division has reduced their time from 1.1 days (January 2015) to 0.69 days (March 2016).




In September 2015, our overall discharge summary completion time was 0.8 days after patient discharge. This was sustained until December 2015 when delays began to reoccur across some clinical specialties.

### What's going to happen next?

1. We will continue to smooth administration processes to improve the quality and timeliness of our discharge summaries.
2. We will update the Trust's policy on managing discharges, to include clear guidance on which patients require discharge summaries, and also to agree a clear process of roles and responsibilities in managing patients that are on a ward that is different from their admitting specialty.
3. We will also roll out the electronic system to the Intensive Care Units to complete its implementation across the organisation. This will allow the benefits of a Trust-wide standardised process to be fully realised.
4. We will continue to monitor completion times.

### How this benefits patients

High-quality and prompt discharge summaries ensure a smooth and safe transfer of care of GOSH patients to other healthcare providers. This means that our patients receive the care they need when they need it because the right information is exchanged between care-givers at the right time.

"The teams have found the electronic system very helpful in terms of reducing unnecessary admin tasks (such as populating templates) and allowing better tracking of the progress on summaries. However, it was not simply the system that made the difference. Also key was the flexibility and engagement of the Quality Improvement Team to adapt the template for each specialty and work closely to support the administrative and clinical staff who actually compile these summaries."

*Bryony, Service Manager (Immunology, Cancer and Infectious Diseases)*

## Improving the care experiences of our patients with learning disabilities

In last year's GOSH *Quality Report*, we explained our commitment to do better for our patients with learning disabilities. We described the work that had been undertaken across the Trust under the leadership of our Nurse Consultant for Intellectual (Learning) Disabilities and outlined the work we would be undertaking in the coming year.

### What we said we'd do

For 2015/16, we said we would:

- Continue to deliver and embed training and support to staff, provided by senior learning disability nurses and the learning disability Link Leads.
- Continue to grow the use of clinical alerts.
- Promote our hospital passport.
- Improve our partnership working.

### What we did

#### Training and support

We ran six educational programmes for all staff via our Post Graduate Medical Education department. The training was delivered in partnership with people with learning disabilities and their parents. The training we deliver is ever-evolving and expanding, based on the training needs identified from an ongoing programme of audits.

In addition, we respond to direct requests from staff for expert clinical advice and guidance in caring for our learning disabled patients. This support is provided by our nurse consultant and 45 staff trained to act as Learning Disability Link Leads.

#### Learning disability clinical alerts

In December 2014, we set up clinical alerts on our patient administration system to identify 780 of our patients with learning disabilities. By December 2015, this had grown to over 1,450, doubling the number of patients with learning disabilities that we were able to identify before they came in to hospital.

These alerts enable us to better plan for their attendance, to more pro-actively act to support their care and their experience of GOSH.

#### Hospital passport

Ongoing promotion of the hospital passport has meant that we know how to individually support more of our learning disabled patients when they come in to hospital, whether for an outpatient appointment, a ward attendance or an inpatient admission. The addition of 'Better Care – Healthier Lives', an information pack for staff, has maximised the effectiveness of the hospital passport.

x2

We were able to identify double the number of patients with learning difficulties before they came in to hospital

### Partnership working

Our partnership working has continued within the hospital and externally:

- Within the hospital, we have worked in partnership with the complaints team to identify themes for complaints related to care of our patients with learning disabilities. In 2014, nine operations were cancelled on one day due to inadequate support of a patient with a learning disability who was due for surgery. Since implementation of the Learning Disability Protocol for Preparation for Theatre and Recovery in late 2014, there have been zero cancellations of operations related to a patient's learning disability. This has enhanced patient experience and outcomes as well as ensuring more efficient delivery of care. Our theatre protocol[1] has been implemented in Jersey General Hospital
- Externally, we have developed partnership working with Swiss Cottage School, Westminster College, British Institute of Learning Disabilities, Mencap, Bookts Beyond Words, Kingston University, St George's University, Jersey General Hospital and University College London Hospitals. These partnerships have enhanced patient care and experiences by sharing knowledge and expertise across organisations.

#### The Learning Disability Protocol for Preparation for Theatre and Recovery

- Discuss the patient's needs with them and their family/carer(s).
- Use 'comforters' to relax the patient pre op and recovery.
- Document and hand over to colleagues.

**Wake up patients with learning disabilities slower than those without**

a. Lower levels of noise and light
b. Place the patient in a quiet area within recovery
c. Ensure patient/carers are present and involved
d. Gradually recover observing how the patient is progressing.

**If the patient is disturbed or distressed in Recovery:**

1. Call an anaesthetist to use sedation to induce a relaxed, sleepier state
2. Increase levels of sedation as required.

The Care Quality Commission inspected GOSH in 2015 and in their 2016 report said the following about learning disability provision:

*"The hospital had 'flagged' 459 of its patients as living with learning disabilities in the 12 months before our inspection. The hospital has a learning disability consultant nurse who is the lead for providing training, advice and support to other staff in the hospital. To support them, they had given enhanced training to 37 link learning disability staff."*

*"Approximately 40 per cent of children coming through Puffin Ward had a learning disability and Puffin had worked to improve meeting the needs of these children. All families were phoned the day before for confirmation of appointment and fasting times. If children had a learning disability, parents were asked what reasonable adjustments could be made such as the lighting being lowered in cubicles, not liking the surgical gowns and having a photo ID instead of wristbands. Preferences were also noted such as how close to stand to the child. 'Sing SIGN days' with Makaton took place (Makaton uses signs and symbols to help people communicate) and all staff had learned Makaton. The ward manager was due to present the Puffin Ward initiatives to a Royal College of Nurses conference later that month."*

"On a recent visit to GOSH the staff had obviously read my daughter's personal passport and were aware of her complex needs and the best way in which to approach her. She is deafblind, has multi-sensory impairment and Down's syndrome amongst other things.

"The staff were aware of her sensory issues and were mindful of not overcrowding her and offered her a quiet space if that would make the whole experience both more accessible and more tolerable for her. The Consultant actually asked how close he needed to get so that she could see him talking to her! The first time her needs had been considered and addressed in such a pro-active way for many years. He also took time to listen to her questions and answered her rather than talk directly to me. This made her feel totally included and a valued part of the whole process, that she could make a decision about what was happening to her rather than simply being the person to whom things were done."

*Parent of a patient with a learning disability*

1 Where possible, staff are also applying these adaptations, such as lower levels of noise and light, for patients who do not have a learning disability.

## What the data shows

### Learning disability clinical alerts

Having an alert enables staff to know which patients with learning disabilities are in the hospital, where they are, and how they use the service, so that reasonable adjustments can be made to meet their individual needs.

Growth in the percentage of inpatients (Chart one) and outpatients (Chart two) for whom there was a learning disability alert has increased significantly in the past year. This demonstrates that as an organisation, we are increasingly able to identify children and young people with a learning disability in order to better support their care.

*Chart one – Percentage of Inpatients with LD Alert - All Specialties*

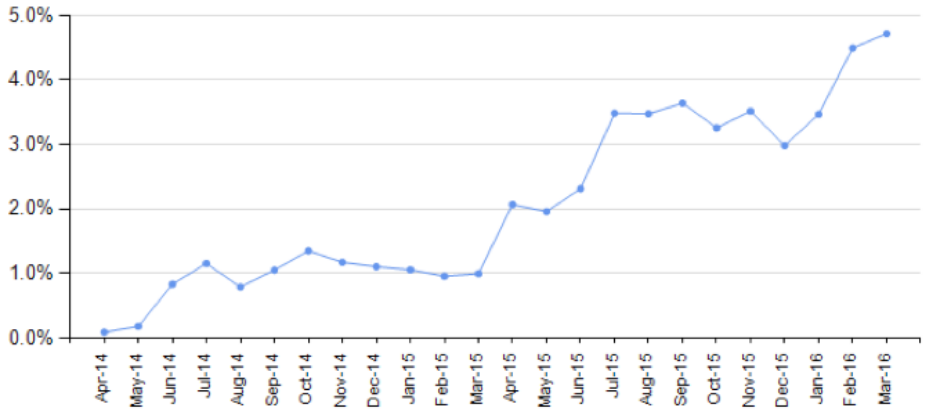
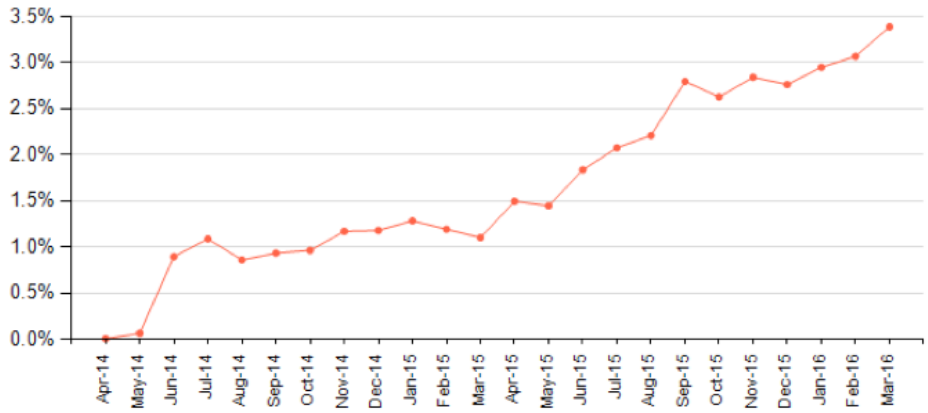



*Chart two – Percentage of Outpatients with LD Alert - All Specialties*

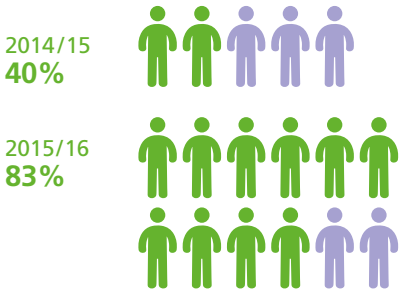



### Reasonable adjustments

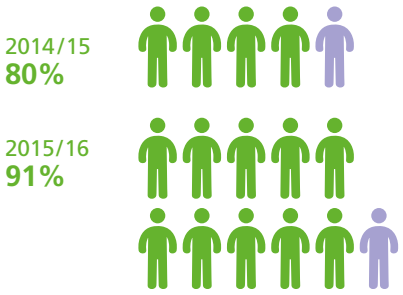
Reasonable adjustments are required to be made within services for people who have disabilities or impairments that fall within the Equality Act (2010).

In quarter three, we carried out an audit to find out how many of our patients had reasonable adjustments identified and documented in their patient record, and how many of the identified reasonable adjustments were met. Below are our figures for 2014/15 and 2015/16:

*Reasonable adjustments that were identified and documented in patient notes:*




*Identified reasonable adjustments that were documented as having been met:*




patient where this standard was met

patient where this standard was not met

## What's going to happen next?

A steering group called 'Our Health, Our Hospital', made up of people with learning disabilities, families and staff has been set up. Under the group's guidance we will, in 2016/17:

1. Develop a more user-friendly clinic letter for patients with learning disabilities.
2. Establish Parent Support Volunteers so that parents of children and young people with learning disabilities (CYPLD) can be supported in clinics by other parents of CYPLD.
3. Engage in service evaluation and further teaching of staff across the hospital via Postgraduate Medical Education and other training opportunities.
4. Present at conferences and participate in research advisory groups to spread good practice.

## How this benefits patients

- Reduced anxiety associated with hospital for patients with learning disabilities and their families.
- Improved experience of hospital.
- Genuine engagement with people who use the hospital to help us improve.

# 2016/17 Quality Priorities

The following table provides details of three of the quality improvement projects that the Trust will undertake on its services in 2016/17. These priorities were determined with input from staff, patients and their families, and commissioners. This input was sought through a range of mechanisms including survey, consultation, and use of established meetings such as our Members' Council, Young People's Forum, and Public and Patient Involvement and Experience Committee. All of our quality priorities are aligned with our strategic quality objectives, which in turn relate to the Trust vision of 'No waits, No waste, Zero harm'.

## Safety

To reduce all harm to zero.

| Improvement initiative | What does this mean and why is it important? | How will progress be monitored, measured and reported? |
|---|---|---|
| Improve monitoring and communication of the deteriorating child | Ward teams alert the clinical outreach team about clinically deteriorating patients.<br><br>We want to ensure that ward staff are effectively monitoring patients so they can identify early if a child's health is deteriorating and seek support when required to provide intervention to stabilise the child. | We will collect and analyse data on referrals to Clinical Site Practitioners and Intensive Care Outreach Network.<br><br>The data will be published to our intranet dashboards, and reported to Trust Board. |

## Clinical effectiveness

To consistently deliver excellent clinical outcomes, with the vision to be the leading children's hospital in the world

| Improvement initiative | What does this mean and why is it important? | How will progress be monitored, measured and reported? |
|---|---|---|
| Referral to treatment (RTT): Reducing the number of patients with incomplete pathways at 18 weeks | Incomplete pathways are the RTT waiting times for patients whose RTT clock is still ticking at the end of the month. The national standard is 92 per cent of incomplete pathways are <18 weeks. This measure is a good indicator to ensure that patients on a RTT pathway are seen and treated within 18 weeks.<br><br>Limited assurance work in 2015 confirmed that we had challenges with our 18 week pathway data, operational processes and capacity. This resulted in us taking a break from reporting 18 week data. In 2016/17 we will resume reporting, will launch new operational processes to ensure our waiting list management complies with national best practice, and will continue to work with commissioners to ensure sufficient capacity for the referrals received into the Trust. | In 2015, the Trust established an Access Improvement programme of work to define, scope and oversee the necessary improvements required across the elective care pathway, led by the Chief Operating Officer.<br><br>This work programme is governed internally through a fortnightly Access Improvement Board and externally through a fortnightly tripartite meeting, which includes input from Monitor, NHS England and the CQC. |

## Experience

To consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations.

| Improvement initiative | What does this mean and why is it important? | How will progress be monitored, measured and reported? |
|---|---|---|
| Improve young people's experience of transition to adult services | Good transition experiences are associated with improved levels of independence and engagement with adult services, with consequently improved health in adulthood.<br><br>NICE Transition Guidelines (NICE, 2016) recommend that every specialty should have a designated Transition Lead with responsibility for overseeing transition, the improvement of transition practices and compliance with national guidelines. The guidelines also recommend that a data set of young people who will transition to adult services is established by age and specialty to support better transition planning. | The following measures will be reported:<br><br>1. Number and percentage of Specialty Transition Leads established<br><br>2. Numbers of young people treated at GOSH, be specialty, in age bands: 15yrs, 16yrs, 17yrs, and 17+yrs. |


GOSH patient Louie (R) and his twin brother Aiden, age nine.

# Part 2b:
# Statements of assurance from the board

This section comprises the following:

- Review of our services
- Participation in clinical audit
- Participation in clinical research
- Use of the CQUIN payment framework
- CQC registration
- Data quality
- Service review
- Implementation of the duty of candour

## Review of our services

GOSH is commissioned by NHS England to provide 58 specialised, or highly specialised, paediatric services. These services account for approximately 90 per cent of the Trust's healthcare activity. The remaining 10 per cent of our activity is typically care which, although not specialist, is provided to patients with complex conditions and is commissioned by Clinical Commissioning Groups.

In order to ensure that we maintain excellent service provision, we have internal processes to check that we meet our own internal quality standards and those set nationally. 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 governance frameworks enable divisions to review regularly their progress, to identify improvements, and to provide the Trust Board with appropriate assurance.

The Trust's status during 2015/16 against Monitor's Governance Risk Assessment remains under review, as a consequence of the Trust's decision to commence non-reporting of referral to treatment (RTT) (Incomplete) target and the findings of a third party report, before deciding next steps.

The Trust is undertaking considerable work to rectify the identified data and systems issues in relation to RTT reporting, which have been a large focus during 2015/16 and will continue to be so during 2016/17. The Trust remains committed to the delivery of high quality, safe and effective specialist care for children.

**What is Monitor?**

Monitor is the independent regulator responsible for authorising, monitoring and regulating NHS Foundation Trusts.

## Participation in clinical audit

During 2015/16, 11 national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. The Trust has participated in them all and data submissions are outlined below.

| Name of audit/clinical outcome review programme | Cases submitted as a percentage of the number of registered cases required |
|---|---|
| Cardiac arrhythmia (National Institute for Cardiovascular Outcomes Research [NICOR]) | 154 / 154 (100%) |
| Congenital heart disease including paediatric cardiac surgery [NICOR] | 1212 / 1212 (100%) |
| Diabetes (paediatric) (National Paediatric Diabetes Association) | 25 / 25 (100%) |
| Maternal, Newborn and Infant Clinical Outcome Review Programme (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK [MBRRACE-UK]) | 13 / 15 (87%) |
| National Cardiac Arrest Audit (Intensive Care National Audit & Research Centre [ICNARC]) | 22 / 22 (100%) |
| National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) | We have reviewed all cases provided by NCISH to assess whether clinical case note reviews are required. No cases met the inclusion criteria. |
| Inflammatory bowel disease (Royal College of Physicians) | 112 / 146 (77%) |
| Paediatric Intensive Care Audit Network (PICANet) | 1,847 / 1,847 (100%) |
| Pulmonary hypertension (Health and Social Care Information Centre) | 343 / 343 (100%) |
| Renal replacement therapy (UK Renal Registry) | 192 / 192 (100%) |
| UK Cystic Fibrosis Registry (Cystic Fibrosis Trust) | 179 / 179 (100%) |

### Learning from National Audit reports

The following National Audit reports relevant to GOSH practice were published during 2015/16:

- Congenital Heart Disease (CHD) Audit Annual Report 2011–2014
- Inflammatory Bowel Disease (IBD) Paediatric Report
- Maternal Newborn and Infant Clinical Outcome Review Programme – Perinatal Mortality Surveillance Report 2013 data
- National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) Annual Report July 2015
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Just Say Sepsis Report
- Neonatal Intensive and Special Care (National Neonatal Audit Programme)
- Paediatric Intensive Care Audit Network Annual Report (PICANet)
- UK Cystic Fibrosis Registry Annual data report 2014

The reports have been reviewed by appropriate professionals within the organisation. Summaries of the learning from these audits and any actions required have been reported to the Patient Safety and Outcomes Committee (PSOC).

**What is clinical audit?**

'A clinical audit is a quality improvement cycle that involves measurement of effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.'

*Healthcare Quality Improvement Partnership (HQIP) Principles of Best Practice in Clinical Audit 2011*

## Key learning from clinical audit in 2015/16

The Clinical Audit team sits within the Clinical Governance and Safety department to ensure that there is integrated clinical governance. A central clinical audit plan is used to prioritise work to support learning from serious incidents, risk, patient complaints, and to investigate areas for improvement.

A selection of key findings is listed below:

### Learning disabilities

Audit has taken place to support the improvement work on awareness and management of patients with learning disabilities (see page 98). The audit shows progress with documenting and meeting reasonable adjustments of care for children and young people with learning disabilities.

### Surgical site marking

This audit took place to determine if patients were being appropriately 'site marked' before arrival in the operating theatre. Site marking helps to minimise the risk of surgery taking place in the wrong part of the patient. Wrong site surgery is classified as an NHS Never Event, an error that should never happen. 119 out of 121 cases (98 per cent) reviewed had appropriate site marking arrangements.

**98%**

of cases reviewed has appropriate site marking arrangements in place

The audit shows we have a very high level of performance with safety precautions to prevent wrong site surgery. To help us get to 100 per cent, we are reviewing our guidance to make it even clearer.

## Learning from incidents

Clinical Audit plays an important part in the effective implementation of recommendations from Serious Incidents (SIs). Some examples of work completed in 2015/16 are outlined below.

- An incident in January 2013 occurred when a patient's sutures were removed earlier than planned, which resulted in an additional general anaesthetic. The learning from the SI identified the need for clarity of post-operative instructions and communication at ward rounds. Completion of a re-audit this year showed that the recommended changes have been sustained.
- An SI occurred in May 2014 where a needle was retained in the patient. Audit showed that practice had changed in line with the recommendations of the investigation, but that further work is required to ensure that specific types of syringes are always used for closed cavity injections. As a result of this audit, a stock review of the specific syringes was undertaken and the location of the syringes was highlighted at relevant theatre handover. The audit results have been shared at a learning forum for all theatres staff, and changes made to the theatres care plan based around staff suggestions. This will be re-audited in 2016/17.
- In July 2014, an SI occurred where a child in a specialist chair slipped down and suffered positional asphyxiation. The findings of the audit this year showed good progress with the implementation of recommendations. As a result of the audit, staff have been offered additional training to ensure they are aware of the need for patients to be supervised in a specialist chair. We have also modified the instruction sheets that are kept at the patient's bedside when such chairs are used, to make the requirement for supervision clearer. This is currently being re-audited.
- Audit was prioritised to assess the implementation of learning following the unexpected death of a child who had been admitted for the insertion of a gastrostomy. The audit found that the recommendations made in the SI were implemented and no further actions were required.

## Responding to national and local safety alerts

### National patient safety alert

Here at GOSH, we audit patient safety alerts issued by NHS England, to support their implementation. An NHS England patient safety alert was issued in February 2015 following an incident where an adult patient in a nursing home choked after accessing a tub of thickening powder. In response to the alert, we devised an action plan here at GOSH to minimise the risk to our patients with dysphagia, who have thickened feeds. Practices to minimise the risk of accidental ingestion were evident in all cases audited.

### Developing an internal alert in response to a 'near miss' incident

An internal safety alert was generated as a result of learning from a 'near miss' due to a false blood glucose reading. This was prepared by the Clinical Governance and Safety Team in April 2015 in order to proactively minimise the risk of a further incident. Audit showed:

**84%**

of cases in May 2015 met the safety alert requirements

To improve, an action plan was implemented, followed by re-audit to assess the effectiveness of implementation of the requirements:

**95%**

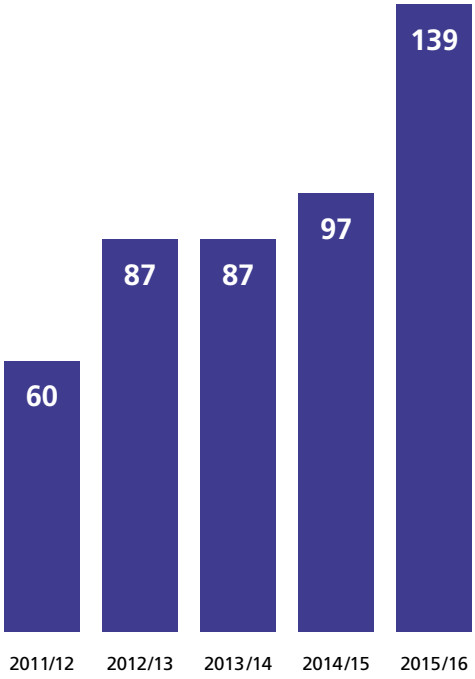
of cases in August 2015 met the safety alert requirements

This will be re-audited again in 2016/17 following additional practice changes agreed in one area of the hospital.

## Local clinical audits

The summary reports of 139 completed local clinical audits were reviewed by clinical staff at GOSH during 2015/16. Our data shows we are improving our completion and sharing of local clinical audits over time.

*Completed local clinical audits reported*




To promote the sharing of information and learning, a summary of completed projects is published on the Trust's intranet and shared with the Patient Safety and Outcomes Committee.

The Clinical Audit team supports staff with their clinical audits so they can assess and improve the quality of their care. The audit team also recognises and promotes the Model For Improvement, which is taught by our Quality Improvement team and used in the Trust for improvement projects.

Examples of actions intended to improve the quality of healthcare, or work that has made a difference as a result of local clinical audit are listed below.

### Congenital hyperinsulinism feeding audit

The Endocrinology service has completed their audit to look at feeding difficulties in children admitted with congenital hyperinsulinism. Compared with the previous audit in 2012, there have been no delayed discharges as a result of feeding issues, and an improvement in patients being able to feed orally on discharge. Parental anxiety about their child's feeding was also shown to have reduced since 2012.

"The safety alert and audit of blood glucose monitoring has improved the safety of our patients"

*Clare Gilbert, Clinical Nurse Specialist, Hypoglycaemia*

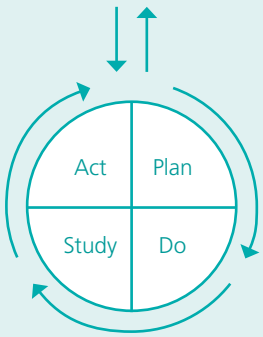
### What is the Model For Improvement?

Model For Improvement, shown by the diagram below, is a practical and systematic approach to change.

**AIM**
What are we trying to accomplish?

**MEASURES**
How will we know that a change is an improvement?

**CHANGES**
What changes can we make that will result in improvement?



### Learning from a complaint – Neurology team

Learning from a complaint in December 2015 highlighted the importance of rescue medication being written on a paper prescription for patients admitted for telemetry. An audit of the recommendations took place in February 2016, which showed that the recommendations have been met and are effective. This will be re-audited to ensure sustained change.

### Visual Infusion Phlebitis (VIP) scores on Koala Ward

Injury from extravasation (the leakage of fluid from its intended vascular pathway) is a potential risk to any patient admitted to hospital. An audit was undertaken to review the number of staff recording VIP scores to prevent extravasation. The results showed that 66 per cent of patients had a VIP score documented appropriately. A different type of bandage is now being implemented to ensure all patients have a VIP score documented.

### Holding bay trial – Ocean Theatres

Members of the Theatres Team used an audit to evaluate an intervention designed to reduce delayed start times for theatre lists in two operating theatres. A new sending system was implemented, initiated by the anaesthetist, which involves allocated recovery staff members collecting patients and 'holding' them in the Ocean recovery area until the lists are ready to start. A trial of the intervention showed a statistically significant reduction in mean delay time (from 26 to 11 minutes). The team now plan to roll out this intervention further in theatres.

### Use of the fronto-facial protocol to reduce post-operative infections

The Craniofacial Team were able to show through audit that their protocol had reduced variations in treatment, which led to significantly reduced infection rates and improvement in quality of care.

The protocol was implemented in 2014 following four consecutive cases of mid-face infection. There have been no mid-face infections since the implementation of the protocol.

## Participation in clinical research

At GOSH, we understand the immense importance to patients and their families of pushing the edges of medical understanding to make advancements in the diagnosis and treatment of childhood diseases. As a specialist hospital with strong academic links, many of our doctors are clinician-scientists who specialise in research and we are dedicated to harnessing opportunities for collaboration between clinicians and scientists, to deliver more research findings from 'bench to bedside' and 'bedside to bench'. In other words, medical research is a two-way process that allows us to offer the very latest treatments for our patients. Much of what we do is at the forefront of research in diseases of children and young people and we are also working to implement new evidence-based practice beyond GOSH, so that more patients can benefit in the UK and abroad.

GOSH's strategic aim is to be one of the top six leading children's research hospitals.

We are in the unique position of working with our academic partner, the University College London (UCL) Institute of Child Health (ICH), to combine enviable research strengths and capabilities with our diverse patient population. This enables us to embed research in the fabric of the organisation. In addition to ICH, GOSH has the benefit of access to the wealth of the wider UCL research capabilities and platforms. Together, GOSH and ICH form the largest paediatric research centre outside North America, and we host the only Biomedical Research Centre (BRC) in the UK dedicated to children's health. Our BRC status, awarded by the National Institute for Health Research (NIHR), provides funding and support for experimental and translational biomedical research. In addition to the BRC, the Division of Research and Innovation includes:

- The joint GOSH/ICH Research and Development Office.
- The Somers Clinical Research Facility (CRF), which is a state-of-the-art ward within GOSH for children taking part in clinical trials.
- Hosting research delivery staff funded through the Clinical Research Network: North Thames.

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

Currently, we have 838 active research projects at GOSH/ICH. Of these, 212 have been adopted onto the NIHR Clinical Research Network (CRN) Portfolio, which is a grouping of high-quality clinical research studies. In total, 3164 of our patients were recruited in the past 12 months to participate in research.

**838**

**research projects currently active at GOSH/ICH**

Of these,

**212**

**have been adopted onto the NIHR Clinical Research Network Portfolio**

Some of our key research highlights in 2015/16 are described below.

- Our pioneering research teams, supported by the GOSH BRC, have developed a new treatment that uses 'molecular scissors' to edit genes and create designer immune cells programmed to hunt out and kill drug-resistant leukaemia. This form of gene therapy is promising for patients with particularly aggressive forms of leukaemia, where the cancer cells remain hidden or resistant to drug therapy. In addition to leukaemia, the teams continue to work together to develop gene therapy treatments for rare diseases, including Netherton syndrome, Fanconi anaemia and Wiskott Aldrich syndrome. The Gene and Cell Therapy Facility, which manufactures the modified cells, is funded through our BRC.
- GOSH has been successful in diagnosing the first patients through the 100,000 Genomes Pilot Study. These diagnoses have had a significant impact on the patients and their families. For the first patient, the genetic diagnosis resulted in a reduction of the patient's medication. In the second case, the diagnostic results indicated that the patient's condition was not inherited, but had arisen for the first time in the patient. Knowing that the chance of having a child with similar problems is very low, the parents now feel able to extend their family and have another child.

  The aims of the pilot were two-fold: to find out whether Whole Genome Sequencing would be a feasible diagnostic tool for patients in the NHS, and to test the pipelines and processes for patient recruitment and sample collection in anticipation of the main 100,000 Genomes Programme. Over 1,000 patient samples were provided by GOSH and our UCL partners, contributing to 22 per cent of the total samples included in the national pilot study.
- Children with a kidney cancer known as Wilms' tumour, who are at low risk of relapsing, can have their chemotherapy reduced. This finding, published in The Lancet, comes from a European-wide trial that studied a drug called doxorubicin. The 10-year study, led by BRC-funded Professor Kathy Pritchard-Jones, followed 583 children with stage II or stage III Wilms' tumour of intermediate risk type, which is the most common. The results showed that 96.5 per cent of children whose treatment included doxorubicin – which has been linked to irreversible heart problems later in life – survived for five years or more, compared with 95.8 per cent of children who did not receive the drug. Even though there was a slight increase in the risk of patients relapsing if they did not receive doxorubicin, such patients were successfully treated subsequently, meaning that overall survival rates were the same. The standard treatment for this type of Wilms' tumour has now been changed to no longer give doxorubicin. This means that the majority of these children now avoid the risk of long-term heart problems.
- The Dubowitz Neuromuscular Centre (DNC) at GOSH and ICH has been confirmed as a Centre of Paediatric Clinical and Research Excellence by Muscular Dystrophy UK. This is one of ten Centres of Excellence and the only paediatric centre selected. This award recognises centres with outstanding levels of specialist care for people living with muscle-wasting conditions. The status was awarded following a national audit carried out by Muscular Dystrophy UK, aimed at ensuring that high-quality care is provided to patients with muscle-wasting conditions. The DNC provides clinical assessments, diagnostic services and advice on treatment and rehabilitation alongside clinical trials. It also provides basic research focusing on causes of neuromuscular diseases in childhood and identifying novel therapeutic interventions. Professor Francesco Muntoni is Head of the DNC, and is the BRC Lead for the 'Novel Therapies for Translation in Childhood Diseases' theme.
- Promising findings from a trial for a new stem-cell based therapy for a rare skin condition have been published in the Journal of Investigative Dermatology. The clinical trial recruited 10 patients with recessive dystrophic epidermolysis bullosa, and was led by Professor John McGrath at King's College London and BRC-supported Principal Investigator Dr Anna Martinez at GOSH. The study involved intravenous injections of stem cells, and has led to an improvement in the quality of life for the subjects and their carers, including reports of improvement in skin healing, reduced pain, better sleep and reduced caring needs.

In addition, we are delighted to list recognitions and awards received:

- Professor Helen Cross received an OBE in the Queen's Birthday Honours for her services to children with epilepsy.
- Professor Waseem Qasim has been awarded a prestigious NIHR Research Professorship, one of only four awarded nationally this year. The posts are designed to support the country's most outstanding research leaders during the early part of their careers to lead research, to promote effective translation of research and to strengthen research leadership at the highest academic levels.
- Three academics associated with GOSH – Professor Helen Cross, Professor Francesco Muntoni and Professor Jane Sowden – were awarded NIHR Senior Investigator status. Professor David Goldblatt was successful in renewing his NIHR Senior Investigator status for a second term. These awards are made by the NIHR to outstanding research leaders.
- Two of our investigators – Dr Ri Liesner and Dr Anna Martinez – received awards from the NIHR CRN for their contribution to clinical research. Dr Liesner was recognised for recruiting the first global patient into a haemophilia study designed to evaluate the safety and efficacy of a recombinant fusion protein. Dr Martinez was recognised for recruiting the first European patient into a phase 3 epidermolysis bullosa trial.
- GOSH also hosts one of the few centres that brings together nurses and allied health professionals (AHPs) in a research setting, led by Faith Gibson, Professor of Child Health and Cancer Care, who holds a joint appointment between GOSH and the University of Surrey. Drs Kate Oulton, Debbie Sell and Jo Wray lead their own programmes of research from the centre, with success in NIHR funding, as well as funding from well-established charities. This team of researchers prioritise understanding the patient and family experience, helping to describe the care that families receive, and exploring both processes and outcome. Dr Kate Oulton is also the NIHR GOSH BRC Clinical Academic Programme Lead for Nursing and AHP research, and is leading the strategy to support and encourage nurses and AHPs to increase their research activity. Recent success includes an NIHR Clinical Doctoral Research Fellowship for Ms Lesley Katchburian, Clinical Specialist Physiotherapist and an NIHR Clinical Lectureship for Dr Elaine Cloutman-Green, Infection Prevention and Control Practitioner.

## Use of the CQUIN payment framework

The Commissioning Quality and Innovation (CQUIN) payment framework makes up 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 per cent of the Actual Contract Value between commissioner and provider.

In 2015/16 providers were given an option in relation to what tariff arrangement to implement (due to changes that were being made to how the tariff had been set nationally). The Trust (along with a number of other specialist tertiary service providers) chose to operate under the Default Tariff Rollover (DTR). By choosing the DTR (as opposed to the Enhanced Tariff Option), the Trust was ineligible to access CQUIN funding. As such, dedicated CQUIN schemes were not applicable during 2015/16

This arrangement was for one year only, and the Trust is now engaged with NHS England (its main commissioner) on CQUIN schemes for 2016/17.

## CQC registration

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.

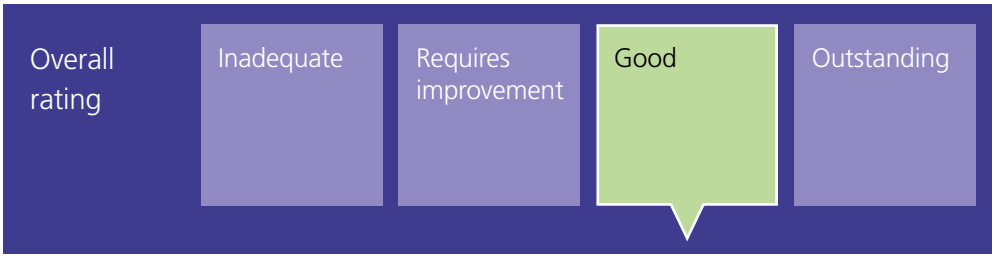
GOSH is required to register with the CQC and is currently registered, without conditions, as a provider of acute healthcare services. GOSH has not participated in any special reviews or investigations by the CQC in 2015/16.

In April and May 2015, as part of their announced rolling schedule of inspections, the CQC conducted a comprehensive inspection at GOSH. The ratings grid opposite demonstrates that the Trust was rated as "good" overall. As part of the assessment, it was rated 'outstanding' for being caring, mostly 'outstanding' for end-of-life care, and consistently 'good' for providing safe care.

**What is CQUIN?**

The Commissioning 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.

*Ratings grid*




| | Safe | Effective | Caring | Responsive | Well led | Overall |
|---|---|---|---|---|---|---|
| Medical care | Good | Outstanding ☆ | Outstanding ☆ | Good | Good | Outstanding ☆ |
| Neonatal services | Good | Good | Outstanding ☆ | Good | Good | Good |
| Transitional services | Good | Good | Outstanding ☆ | Good | Requires improvement | Good |
| Surgery | Good | Good | Outstanding ☆ | Requires improvement | Requires improvement | Requires improvement |
| Intensive/critical care | Good | Good | Outstanding ☆ | Good | Requires improvement | Good |
| Services for children & young people | Good | Good | Outstanding ☆ | Good | Good | Good |
| End of life care | Good | Outstanding ☆ | Outstanding ☆ | Outstanding ☆ | Outstanding ☆ | Outstanding ☆ |
| Outpatients | Good | Not rated | Outstanding ☆ | Requires improvement | Requires improvement | Requires improvement |

We were most concerned to be informed by the CQC that they sought to take enforcement action against GOSH during 2015/16. This was issued in relation to the Trust's management of referral to treatment (RTT) and associated data. This is reflected in the 'requires improvement' ratings for the responsive and well-led criteria in the surgery and outpatient services.

The Trust and its Board are committed to making the improvements to fully address the issues identified. An extensive transformation programme in the delivery of elective care is underway (see page 93), which will ensure that all patients will be treated in a more timely way in future, and that the systems and processes in place are robust. The Trust is aware of the effect these issues have had on patients' experience, and is working as quickly as possible to make the necessary improvements

## Data quality

NHS managers and clinicians are reliant on information to support and improve the quality of services they deliver to patients. This information, or data, should be accurate, reliable, and timely. Some of this data is used to inform local decisions about clinical care and service provision. Some data is reported nationally, and enables comparison between healthcare providers.

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 the NHS Health and Social Care Information Centre (HSCIC) and its reporting is based on data submitted by all provider trusts.

GOSH submitted records during 2015/16 to SUS for inclusion in the Hospital Episode Statistics, which are included in the latest published data. Performance is measured by examining the accuracy and completeness of data within the submissions to SUS and reported against local area and national averages.

The table below shows the percentage of records in the published data against specified indicators:

| Indicator | Patient group | Trust Score | Average national score |
|---|---|---|---|
| Inclusion of patient's valid NHS number | Inpatients | 98.2% | 99.2% |
| | Outpatients | 98.8% | 99.3% |
| Inclusion of patient's valid General Practitioner Registration Code | Inpatients | 99.9% | 99.9% |
| | Outpatients | 99.9% | 99.8% |

Notes:

- The table reflects the most recent data available as of 23 March 2016 (April 2015–January 2016 at month 10 SUS inclusion date).
- Percentages for NHS number compliance have been adjusted locally to exclude international private patients, who are not assigned an NHS number.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

### Clinical coding and data quality

GOSH was not subject to the Payment by Results clinical coding audit during the 2015/16 reporting period.

The Trust continues to carry out an internal clinical coding audit programme to ensure standards of accuracy and quality are maintained. As a result, for the second year in succession, the Trust has been shortlisted for the Data Quality Award (Specialist), one of only five specialist acute trusts across the UK to have excelled in a range of data quality indicators.

The award recognises the importance of clinical coding and data quality, and the essential role they play in ensuring appropriate patient care and financial reimbursement from commissioners.

The Trust has been shortlisted for this award based on performance against a range of data quality indicators including:

- depth of coding (not case mix adjusted)
- percentage of coded episodes with signs and symptoms as a primary diagnosis
- percentage of uncoded spells

**The Trust has been shortlisted for the Data Quality Award**

for the second year in a row

**What is data quality?**

Data quality refers to the tools and processes that result in the creation of correct, complete and valid data that is required to support sound decision making.

**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.

**What is the NHS Health and Social Care Information Centre?**

The NHS HSCIC is England's central, authoritative source of health and social care information.

Acting as a 'hub' for high-quality, national, comparative data for all secondary uses, they deliver information for local decision makers to improve the quality and efficiency of frontline care.

*hscic.gov.uk*

### Information Governance Toolkit

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Information Governance Toolkit provides NHS organisations with a set of 45 standards, against which we declare compliance annually.

The Information Governance Toolkit overall score for GOSH in 2015/16 was 74 per cent. This represents a small decrease in performance against the score of 77 per cent reported in 2014/15.

For three of the 45 standards, our self-assessment was below a satisfactory level (level 2):

- Ensuring that all staff receive information governance training every year – only 84 per cent of staff completed the training in year.
- The use of NHS number in all outgoing correspondence – some areas of the Trust have not yet adopted this practice consistently.
- Conducting a recent audit of our corporate record practices.

To address these items, we have remedial action plans aimed at reaching the satisfactory level by June 2016. This includes:

- Communicating with all staff who have not completed their training.
- Introducing a new learning management system to support staff with their mandatory training.
- A project to ensure that all teams sending out correspondence include the NHS number.
- Carrying out a corporate records audit scheduled for completion by May 2016.

### Improving data quality

GOSH will be taking the following actions to further improve data quality in the coming year:

- Ensuring that policies and processes regarding capturing of data on core IT systems are concise, complete and in a standard format.
- Development of online e-learning material available via the Trust intranet, giving staff immediate access to guidance when most needed.
- Assigning ownership at operational level of non-core data collection systems.
- Enhancing the data quality reporting suite, highlighting to service users missing or inconsistent data.

# Part 2c:
# Reporting against core indicators

NHS trusts are subject to national indicators that enable the Department of Health (DH) and other institutions to compare and benchmark trusts against each other. Trusts are required to report against the indicators that are relevant to them. The table below shows the indicators that GOSH reports against on a quarterly basis to our Trust Board and also externally. The data is sourced from the Health and Social Care Information Centre, unless stated otherwise. Where national data is available for comparison, it is included in the table.

**What is the Department of Health?**

The Department of Health 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: |
|---|---|---|---|---|---|---|---|---|---|
| | 2015/16 | 2014/15 | 2013/14 | Most recent results for Trust | Best results nationally | Worst results nationally | National average | | |
| **Domain 3: Helping people recover from episodes of ill health or following injury** | | | | | | | | | |
| | | | | **Source: Health & Social Care Information Centre Time period: 2013/14 financial year** | | | | | |
| Emergency readmissions to hospital within 28 days of discharge: | | | | | | | | | |
| – % of patients aged 0–15 readmitted within 28 days | 1.78% | 0.74% | 2.5% | Not available from the HSCIC at the time of publication of this report. | | | | The results are from the Hospital Episode Statistics (HES) and the Office of National Statistics (ONS). | Ensuring divisions and directorates develop and implement local action plans, which respond to areas of weakness. |
| – % of patients aged 16+ readmitted within 28 days | 1.62% | 0.6% | 0.9% | | | | | | |
| **Domain 4: Ensuring that people have a positive experience of care** | | | | | | | | | |
| | | | | **Source: NHS Staff Survey Time period: 2015 calendar year** | | | | | |
| The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends | 88% (2015) | 87% (2014) | 87% (2013) | 88% | 93% | 80% | 91% (median score) | The survey is carried out under the auspices of the DH, using their analytical processes. GOSH is compared to other acute specialist trusts in England. | Ensuring divisions and directorates develop and implement local action plans, which respond to areas of weakness. |
| Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | 25% (2015) | 24% (2014) | 23% (2013) | 25% | 9% | 49% | 37% (median score) | | |
| Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion | 87% (2015) | 89% (2014) | 89% (2013) | 87% | 95% | 81% | 88% (median score) | | |

| Indicator | From local trust data | | | From national sources | | | | GOSH considers that this data is as described for the following reasons: | GOSH intends to take the following actions to improve this score, and so the quality of its service, by: |
|---|---|---|---|---|---|---|---|---|---|
| | 2015/16 | 2014/15 | 2013/14 | Most recent results for Trust | Best results nationally | Worst results nationally | National average | | |
| **Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm** | | | | | | | | | |
| | | | | **Source: Department of Health (acute providers) Time period: 2014/15 financial year** | | | | | |
| Number of clostridium difficile (C. difficile) in patients aged two and over‡ | 7 | 14 | 13 | 14 | 0 | 121 | 34 | | 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 two and over (number of hospital acquired infections/100,000 bed days)* | 8.3 | 12.2 | 11.9 | 12.2 | 0 | 62.2 | 15.1 | The rates are from Public Health England† | |
| C.difficile is endemic in children and rarely pathogenic. 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 Health Care 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>‡ Of the 7 cases of C.difficile attributed to GOSH for 2015/16, two were attributed to a lapse of care in line with guidance published by Monitor. Of the 14 cases of C.difficile attributed to GOSH for 2014/15, one was attributed to a lapse of care in line with guidance published by Monitor. Information on lapses of care was not determined in 2013/14.<br>* Previously published rates for 2014/15 (12.7) and 2013/14 (14.8) were based on a different calculation. These have been recalculated in line with Department of Health methodology and re-published here.<br>† https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis | | | | | | | | | |
| | | | | **From National Reporting and Learning Service (NRLS)**<br>**Time Period: 01/04/2015 to 31/03/2016** | | | | | |
| **Patient safety incidents reported to the NRLS:**<br>Number of patient safety incidents | 5,338 | 5,231 | 4,922 | 5,330 | - | - | - | GOSH introduced electronic incident reporting (DatixWeb) in April 2011 to promote easier access to and robust reporting of incidents. It is expected that organisations with a good safety culture will see higher rates of incident reporting year-on-year, with the severity of incidents decreasing. | Initiatives to improve the sharing of learning to reduce the risk of higher graded incidents from recurring include learning events and a Learning, Implementation and Monitoring Board. |
| Rate of patient safety incidents (number/100 admissions) | 15.32 | 12.82 | 10.28 | - | - | - | - | | |
| Number and percentage of patient safety incidents resulting in severe harm or death | 11 (0.2%) | 26 (0.5%) | 27 (0.5%) | 6 | - | - | - | | |
| There is a time lag between NHS Trusts uploading data to the NRLS (performed twice a month at GOSH) and the trend analysis reports issued by the NRLS. | | | | | | | | | |

## 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 Care Quality Commission (CQC) as part of the CQC registration process. GOSH also reports its patient safety incidents to the National Reporting and Learning Service (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

Monitor uses a limited set of national mandated performance measures, sourced from the NHS Operating 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.

## Performance against key healthcare targets 2015/16

| Domain | Indicator | Threshold/target | GOSH performance for 2015/16 by quarter | | | | 2015/16 total | Indicator met? |
|---|---|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 | | |
| Safety | Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia – meeting the MRSA objective | Monitor no longer includes MRSA in its governance indicators | N/A | N/A | N/A | N/A | N/A | N/A |
| Effectiveness | All cancers: 31-day wait from decision to treat to first treatment | 96% | 97.4% | 100% | 98% | 100% | 98.9% | Yes |
| Effectiveness | All cancers: 31-day wait for second or subsequent treatment, comprising: | | | | | | | |
| | · surgery | 94% | 94.4% | 100% | 92.3% | 100% | 96.1% | 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% | 2015/16 was a challenging year for the Trust related to delivery of the referral to treatment (RTT) standards, with a number of significant issues identified following an Elective Care Intensive Support team review in May 2015. As a result, GOSH has agreed with NHS England a pause in the reporting of its RTT figures until confidence in the data has been returned. The improvement work (see page 93) required to address the identified issues and return to compliance against the RTT Incomplete standard is ongoing, and we expect to resume reporting from the end of September 2016. | | | | | |
| 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)

## Performance against key healthcare targets 2014/15

| Domain | Indicator | Threshold/target | GOSH performance for 2014/15 by quarter | | | | 2014/15 total | Indicator met? |
|---|---|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 | | |
| Safety | Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia – meeting the MRSA objective | Monitor no longer includes MRSA in its governance indicators | N/A | N/A | N/A | N/A | N/A | N/A |
| Effectiveness | All cancers: 31-day wait from decision to treat to first treatment | 96% | 100% | 100% | 100% | 100% | 100% | Yes |
| Effectiveness | All cancers: 31-day wait for second or subsequent treatment, comprising: | | | | | | | |
| | · surgery | 94% | 100% | 100% | 100% | 100% | 100% | Yes |
| | · anti-cancer drug treatments | 98% | 100% | 100% | 100% | 100% | 100% | Yes |
| Experience | Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway | 92%* | 92.5% | 92.2% | 92.2% | 94.4% | 92.8% | Yes* |
| 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 |

* Work completed since last year has identified that the data quality of the Trust's RTT performance reporting was not of an appropriate standard. Therefore, we now know that the figures published last year (and included here) were not reflective of the Trust's position. A Trust Board decision was made to suspend RTT reporting while work is being completed to ensure that our processes are robust to report data that is an accurate reflection of the Trust's position.

‡ Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008)

## Performance against local improvement aims 2015/16

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 89). All measures remain within expected statistical tolerance.

**2015/16**

| Domain | Indicator | Total 15/16 performance | 2015 | | | | | | | | | 2016 | | | Performance within statistical tolerance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | |
| Safety | Number of serious patient safety incidents | 18 | 3 | 4 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 3 | 0 | 0 | Yes |
| Safety | CVL related bloodstream infections (per 1,000 line days) | 1.4 | 0.3 | 1.5 | 0.9 | 1.7 | 1 | 1.2 | 1.9 | 0.9 | 2.5 | 1.6 | 2.3 | 1.3 | Yes |
| Effectiveness | Hospitality mortality rate (per 1,000 discharges) | 2.58 | 4.0 | 2.47 | 2.23 | 1.86 | 2.71 | 1.96 | 4.13 | 2.14 | 3.53 | 1.14 | 2.14 | 2.70 | Yes |
| Patient Experience | RTT - Incomplete * | 2015/16 was a challenging year for the Trust related to delivery of the RTT standards, with a number of significant issues identified following an Elective Care Intensive Support team review in May 2015. As a result, GOSH has agreed with NHS England a pause in the reporting of its RTT figures until confidence in the data has been returned. The improvement work (see page 93) required to address the identified issues and return to compliance against the RTT Incomplete standard is ongoing, and we expect to resume reporting from the end of September 2016. | | | | | | | | | | | | | |
| Patient Experience | Discharge summary completion time (within 24 hours) | 81.8 | 78.7 | 81.0 | 83.4 | 80.2 | 79.4 | 82.9 | 82.6 | 82.3 | 73.0 | 74.5 | 76.6 | 79.4 | N/A |

**2014/15**

| Domain | Indicator | Total 14/15 performance | 2014 | | | | | | | | | 2015 | | | Performance within statistical tolerance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | |
| Safety | Number of serious patient safety incidents | 23 | 1 | 2 | 2 | 3 | 2 | 1 | 2 | 2 | 3 | 0 | 1 | 4 | Yes |
| Safety | CVL related bloodstream infections (per 1,000 line days) | - | 1.1 | 2.3 | 0.5 | 1.3 | 1.5 | 1.8 | 1.5 | 1.2 | 1 | 1.2 | 1.4 | 1.3 | Yes |
| Effectiveness | Hospitality mortality rate (per 1,000 discharges) | - | 3.4 | 3.3 | 2.3 | 2 | 2.8 | 2.4 | 2.2 | 2.1 | 2.8 | 3.6 | 3.4 | 1.4 | Yes |
| Patient Experience | RTT - Incomplete * | 92.8% | 92.8 | 92.2 | 92.6 | 92.0 | 92.2 | 92.2 | 92.0 | 92.1 | 92.7 | 94.6 | 93.9 | 94.7 | Yes |
| Patient Experience | Discharge summary completion time (within 24 hours) | 81.2% | 82.2 | 81.1 | 85.1 | 84.9 | 77.7 | 80.6 | 83.4 | 81.2 | 78.8 | 80.3 | 79.0 | 80.2 | N/A |

## Service review

The Royal College of Paediatrics and Child Health (RCPCH) was invited by the Trust in 2015 to conduct a review of the gastroenterology service, following a number of concerns expressed from within and outside the hospital about waiting times, communication and clinical governance of the service. It was recommended that a review be undertaken into some of the packages of care for our patients with rare and complex conditions that are hard to diagnose and treat. We are now working with international and national experts to undertake this work.

## Implementation of the duty of candour

The Trust formalised its approach to openness and transparency in 2009 with the introduction of its Being Open Policy. This policy informed staff of the expectations of the Trust, that open and honest communication would take place with patients, parents and their families throughout all aspects of their care, including when patient safety events may have occurred.

The policy was updated to encompass the legal requirements that came into force on 1 April 2015, which described a legal responsibility to be open with patients and/or their families when a patient safety event caused harm graded as moderate, severe or death.

The Trust continues to engage in transparent communication with patients, parents and families and has robust processes to manage patient safety events that are reported at the Trust.

"The culture was very open and transparent. Parents and children were kept fully involved in their treatment. There was an evident commitment to continually improve the quality of care provided. Children and young people were involved in decision making as far as possible."

*Quote from GOSH's CQC report, published January 2016*

# Annex 1: Statements from external stakeholders

## Statement from NHS England (London), Specialised Commissioning Team

NHS England would like to thank Great Ormond Street Hospital for Sick Children for the opportunity to review and provide a response to the 2015/16 Quality Account.

NHS England is the Lead Commissioner and has a very positive relationship with the Trust. We continue to work together to consider improvements in the quality of care, taken up through contractual mechanisms, feedback from families and other stakeholders, clinical quality review meetings and through regular dialogue for example with Monitor and the Care Quality Commission which published its inspection report in January 2016.

We commend the Trust for the very positive feedback received and documented in the CQC report published in January 2016. The Trust received an overall rating of Good with a number of areas of outstanding practice. Two areas for improvement were identified in relation to Responsiveness and Well-led. A Requirement Notice was issued reflecting some necessary changes in the management of Referral to Treatment Targets (RTT) that were identified as a priority in the 2015/16 *Quality Report*. The Trust has undertaken extensive work in response to the issues raised, good progress has been made to date and work is planned to continue into 2016/17.

In 2015/16, NHS England established a Joint Strategic Change Programme and appointed a Project Manager to lead a programme of work that aims to improve paediatric care in London. GOSH clearly has a leadership role here. The *Quality Report* priority relating to "flow" particularly through paediatric intensive care and some service / pathway redesign which should have consequential benefits on RTT are key components of our joint work.

We acknowledge the areas of achievement reported this year. NHS England welcomes the ongoing focus of the following measures to address patient safety, clinical effectiveness and patient experience:

- To embed RTT processes (to include a better understanding of relative demand and capacity).
- To progress work to improve the care experiences of children and young people with learning disabilities.
- To focus on improving transition to adult services.
- To improve patient safety through better monitoring and communication of a child's deteriorating health.

More broadly, the new Executive team continues to review the governance processes in place across the Trust and has already made recommendations in relation to:

- Performance and turnaround of Serious Incident reports.
- Development of Ward to Board reporting.
- Prompt investigation of feedback from families point to concerns about clinical management warranting investigation.
- A wider review of data quality management processes.

We look forward to supporting the findings from these key pieces of work and building on the Trust's Always values to ensure continuous improvement for patients is delivered in 2016/17.

## Response from Healthwatch Camden and Camden Health and Adult Social Care Scrutiny Committee

This report clearly sets out the continuing improvements at GOSH over the year. The results of the CQC inspection report were well deserved. We would like to congratulate the new leadership team on the way they have tackled the challenges they have faced. We are particularly pleased to see the excellent progress on supporting patients with learning disability.

GOSH has a demonstrable commitment to patient and family engagement. The caring ethos (rated as 'outstanding' by CQC) is evident in our contacts with GOSH staff.

We are concerned that data on referral to treatment (RTT) times is unreliable and hope that the trust is able to resolve the underlying issues, with a clear plan of action to share publicly, including with Camden's Health and Adult Social Care Scrutiny Committee in early autumn 2016.

## Feedback from Members' Council councillors

### Comments from patient councillor:

Overall, I am thoroughly impressed by the work performed at GOSH. It is always at the forefront and pioneering new medical treatments and practices, without compromising NHS care. The care I have received here and many others is world-class; it is extremely difficult to fault them.

GOSH is great at identifying problems early and responding to them rapidly, seen by their numerous audits and their reaction to improving flow through ICU. Getting clinicians, related staff members and families involved in the trials and development is essential to make the new system work. The implementation of ePSAG is wonderful and will provide real time information for everyone to access to enhance communication, which is always a concern and identify those at risk. The development of IT systems will really improve the workings of the hospital, especially the new EPRS in development. My only worry is that personal details are available to anyone that walks onto the wards and whether this is a breach of confidentiality.

I am pleased that GOSH responded to the RTT issue very promptly and have plans to resolve the current system and training. It is irritating to be waiting so long to receive treatment but in true GOSH spirit, they have not let significant harm come to anyone. GOSH have been open about this issue, adhering to their duty of candour.

Delayed discharges are inevitable at times, but are very frustrating as a patient and interfere with individual plans. I am glad work is being put into this to identify the reasons so this can be rectified, to free up beds and personal time. The use of ePSAG will really benefit this. No one likes to be on a ward unnecessarily.

Many patients at GOSH have chronic illnesses, and communication to their local services is fundamental for their care. The delay in discharge summary completion has been a concern for a while but I am pleased that work is being done to improve the completion time, as it will also free up time for clinicians. The development of a summary template will make it easier to complete and a system that is capable of connecting with other hospitals will revolutionise communication between GOSH and local teams. As a patient, duplicate copies are annoying but the communication once leaving hospital has always been difficult, tedious and can lead to delays in medical care. Looking at the outcomes of the intervention I am really impressed since they have notoriously been slow.

I am completely in agreement that there should be more support for those with learning difficulties. Hospital is a daunting place for anyone and everyone should be supported to meet their needs so they can get the best out of their treatment. The introduction of the hospital passport will make sure all departments are aware so they can improve the effectiveness of communication and the care they receive, making them feel as a valued individual.

What can be seen from the report is that staff engagement and support is vital to enhance the care they provide. This should be paramount to ensure they feel respected and valued in the work environment. The report shows staff likely to recommend the service to families and friends is lower than the national average, and those experiencing harassment (although both very high scores) could be improved. Whether they are provided equal opportunities for promotion is hard to say, as GOSH is a pioneering institution, so most people would be at the peak of their career.

I am particularly interested in Transition to Adult Services as this is something I have recently been through, however it is not executed particularly well and young people express very different experiences. It is an extremely difficult time to deal with in our lives and we have many questions and concerns. Preparation and support is key to this as is learning from other departments. By having a designated Transition lead in each department I hope that no-one will be missed. It means that young people know who to contact should they have any worries. Since transition in other departments is different we need a designated person in each department who understand the processes and knows when is an appropriate time to transition medically. It will hopefully mean that those under several specialities feel more relaxed as their transition leads can communicate with each other.

When I was treated at GOSH I was under the care of the gastroenterology team. I cannot fault them clinically however the service has been slow and communication was not always up to scratch. When waiting in outpatients, I never knew how long I would have to wait before being seen, and it would take me out of school for the whole day at times. Looking at Pals, they complain of a lack of care at times. I believe there is definitely room for improvement here, and I understand they are a large department with many patients to care for in an older part of the building. I think it is probably down to operational errors than anything else, however I am very satisfied that they are researching into this.

### Comments from lead councillor:

GOSH is a world class tertiary paediatric hospital with an extraordinary reputation. This report highlights ongoing work to improve services and protocols as well as the incredible achievements of the hospital. Over the past 11 years GOSH care and expertise has saved my son's life on more than one occasion. I will always be grateful for this, so continue to work to improve services from the patient and parent perspective in the hope of improving the GOSH journey for others and in order to repay this debt.

I was pleased to read about the successful work to improve flow through intensive care, an important initiative. ePSAG is a welcome innovation that will help clinical treatment, save time, improve patient experience both trust wide and especially in relation to ICU. I am delighted that 'transparency and choice' are key concepts here; they are the way forward and will certainly improve patient and family experience and outcomes. It is refreshing to learn that a simple change in routine can make such a difference - it is so much more sensible to spread the load on ICU by simply changing operating days.

The 'watcher' facility now available through ePSAG is a fantastic new tool that will improve outcomes, reduce deteriorating child incidences and increase hugely patient safety and patient and family experience. I particularly applaud the ePSAG facility which allow parents' and staffs' concerns about a child's wellbeing to be recognised by flagging as 'watchers' whose CEWS don't trigger an alert. The benefits of ePSAG are clearly multifold and it is wonderful that the system can be built on and adapted according to specialist needs.

RTT issues are clearly very worry but it is reassuring to see that the situation is being dealt with carefully, thoroughly and efficiently. It is very good news that no patient harm has been discovered, I am confident that the 18 week window will be adhered to in the near future and that lessons learned will be beneficial to all areas of data management at GOSH.

It is good to read that there have been successful efforts to reduce the wastage of blood products as this is an expensive and valuable resource; it is clearly an area that needs continued monitoring.

Discharge summaries are a key local quality indicator that the Members' Council have selected as an item to include in this report annually since FT status was achieved in March 2012. This is because, as a Council, we recognise the importance role that discharge summaries play in the timely and safe discharge of patients. Not only does this improve patient and family experience, a timely and accurate discharge summary will also ensure a speedy return home and ensure that appropriate care is given by that patient's GP or local hospital on arrival. The Members' Council have been frustrated by the lack of improvement in discharge summary rates, so, while we applaud the work that has been done thus far, it clearly isn't enough as the job is not done. It is encouraging that the work that has been undertaken so far has resulted in significant improvement, but disheartening that the discharge summary times slipped so quickly after the end of the project. The Council hope to see a significant and sustained improvement in discharge summary rates for the 2016-17 Quality Report and are prepared to do whatever is necessary in supporting this.

The work around improving awareness and experience of patients with learning difficulties is wonderful, long may this continue. I do have concerns around the children and young people that do not fall into this category though, as this support is exclusive to patients with a significantly low IQ. This means that patients with a diagnosis of autism or Asperger Syndrome but with a higher IQ are not able to take advantage of the benefits offered through this facility. It is clearly a gap which needs closing as this group's needs are great too. Their experience and care would be vastly improved if they were able to access this service also.

I am pleased to see that 'Improving young people's experience of transition to adult services' is one of the three Quality Priorities for 2016/17, although I am concerned that the slant of this priority is on improving young people's experience rather than on significantly improving the transition provision. An experience is tenuous to measure, whereas a provision isn't. The transition provision at Great Ormond Street Hospital is sadly lacking, and this has been the case for many years. Often planned transition doesn't even happen. Young people become adults and they are moved on to adult hospitals with little support. There is certainly currently no standard protocol, so it is left to the specialities to work it out for themselves, resulting in a lack of consistency. The Members' Council have expressed concerns over this issue numerous times and we feel strongly that it needs tackling urgently. It isn't clear from this report whether the NICE guidelines for the provision of a Transition Lead for each specialty is going to be implemented trust wide.

Thorough auditing and learning from SI is clearly demonstrated by this report and is hugely reassuring and the extraordinary levels of medical innovation and excellence are heart warming to read. This is GOSH at its best. The 'molecular scissors' to edit genes and create designer immune cells is an example of this, as is the progress in diagnosis through the 100,000

Genomes Pilot Study. The list of extraordinary and groundbreaking new research and development in child health conducted at GOSH far too long to comment on individually but it is clearly something to be immensely proud of and to celebrate!

The CQC rating of 'Good' was very well deserved, the outstanding rating for caring and end of life care is a wonderful achievement and down to a set of people who do extraordinary things - every day. Clearly there is work still to be done in some areas, and the difficulties around RTT caused lower ratings that GOSH otherwise would have expected. But this is being dealt with and overall I am sure GOSH is very proud and deserving of its rating. GOSH is aware of, and proactive around, the issues in surgery and outpatients that need improvement. I am confident these will be tackled urgently. Data quality is a risk that the Trust is fully aware of and is working hard to improve. This is key to the delivery of a safe and effective service.

Issues with the Gastroenterology Service continue. I am pleased and reassured to hear that these complex issues are being monitored at Board level. It is an area where the Members' Council have expressed concern on several occasions in the past.

I am concerned by the minimal degree of reference to GOSH's 'Our Always Values' given in this report. These values were developed from the views of thousands of patients, parents and staff; they specify that GOSH aspires to be Always Welcoming, Always Helpful, Always Expert and Always One Team. I could find only one mention of these Values at any point through the document. It states that Our Always Values 'has been a visible commitment to our patients, families and staff' - while this is correct in that there are visible representations in the form of several posters and banners around the hospital and I know it is part of the recruitment policy, this minimal reference reflects my observation of many different GOSH departments and projects which either omit or keep to a minimum the utilisation of Our Always Values as a way of measuring and/or improving patient and family experience. The wholehearted adoption of Our Always Values by putting these values at the core of everything that GOSH offers and undertakes will inevitably lead to an improvement in all services, including clinical, and therefore will dramatically improve outcomes as well as patient and family experience. I trust this will improved in the 2016-17 Quality Report - because there will have been a significantly greater take up and awareness of the benefits of embracing 'Our Always Values' at the core of everything that GOSH does.

Nevertheless, overall I found this report interesting and enlightening. It has been carefully prepared and shows significant and heartening improvement in many areas. There are many achievements to celebrate and these are a testament to the extraordinarily hard, caring and dedicated work of thousands of people at GOSH who daily work together to make a positive difference to the sickest of children.

GOSH response to statements:

**Confidentiality of ePSAG boards**

We welcome the query about the confidentiality of the ePSAG boards. Throughout the implementation of ePSAG, which is installed only in swipe card access-controlled areas, all information that is added to the boards has been put through a formal information governance process. We have also consulted directly with patients and parents on the content of the boards. The feedback we have received is that the level of detail on the boards is appropriate and in fact, we found that parents welcomed the display of more information if it would increase the coordination and safety of care for their child. We continue to consult on and assess appropriateness of information as we make developments.

**Discharge summaries**

Discharge summaries are an important method of communication when a child or young person is discharged from hospital. We remain committed to improving timeliness by monitoring completion times, understanding why slips in performance happen, and targeting our improvement work accordingly. In 2016/17, we will focus on the remaining clinical areas that struggle to get their discharge summaries out in a timely fashion. Performance will be managed through our heads of clinical service, and we will undertake work in each poorly performing specialty to understand the reasons and learn from best practice in other areas.

**Learning disabilities**

Where appropriate and feasible, the principles underpinning aspects of the learning disabilities work stream are being modelled and mirrored for other children that would benefit from them.

**Transition**

The Trust is committed to achieving and consistently delivering all the required processes that underpin high quality transition for young people. In support of this, the Trust will be working to deliver the national CQUIN for Transition, the requirements outlined within the quality specification of the contract with commissioners, and the post-CQC GOSH Inspection Report (April 2015 inspection) action plan that focuses on improving the internal reporting of transition activity to the Board of Directors. Each specialty will provide a Transition Lead who, with their multi-disciplinary team, will be responsible for delivering the required process improvements such that every young person who requires transitioning from GOSH to a specialist adult service will receive this in a timely manner and as a positive experience. The delivery of this work across all of the pertinent specialties and consultants will be throughout 2016/17 and 2017/18.

**Our Always Values – Always Welcoming, Always Helpful, Always Expert, Always One Team.**

The contribution of our patients and families to the development of Our Always Values has been vital to them being embraced by staff (in our last Staff Friends and Family test, 97% of staff said they recognise Our Always Values). We welcome the continuing engagement of families in our work to embed the values, including the feedback provided here.

Having achieved high visibility of Our Always Values amongst staff, the next phase of work has been and continues to be the embedding of the values in our systems, processes and structures as well as in individual behaviours. Examples of this work in the last year include organisational redesign that has reduced the number of clinical divisions in part to reduce boundaries between specialist teams, supporting our 'One Team' value, and the commencement of a large piece of work to review the letters that we send to patients and families to ensure they are always clear and comprehensible, an example of our 'Helpful' value.

Major programmes of work are also underway, from building new patient care areas to delivering a new electronic patient record, which will allow us to further embed Our Always Values as 'business as usual'.


NHS

# Annex 2: Statements of assurance

## External assurance statement

### Independent auditor's report to the council of governors of Great Ormond Street Hospital NHS Foundation Trust on the *Quality Report.*

We have been engaged by the council of governors of Great Ormond Street Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Great Ormond Street Hospital NHS Foundation Trust's quality report for the year ended 31 March 2016 (the '*Quality Report*') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Great Ormond Street Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting Great Ormond Street Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Ormond Street Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

### Scope and subject matter

The national priority indicators as mandated by Monitor for limited assurance testing for the year ended 31 March 2016 relevant to the Trust are:

- Percentage of incomplete pathways within 18 weeks for patients for patients on incomplete pathways at the end of the reporting period
- Maximum waiting time of 31 days from urgent GP referral to first treatment for all cancers

However, as detailed on page 118 of this document and page 64 of the Annual Governance Statement, the Trust has been unable to report upon the following indicator for the year:

- Percentage of incomplete pathways within 18 weeks for patients for patients on incomplete pathways at the end of the reporting period

As the *Quality Report* does not include a figure for this indicator, Monitor guidance mandates an alternative national indicator for testing:

- Emergency re-admissions within 28 days of discharge from hospital.

This is in addition to testing Maximum waiting time of 31 days from urgent GP referral to first treatment for all cancers. We refer to these national priority indicators collectively as the 'indicators'.

### Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the Monitor 2015/16 'Detailed guidance for external assurance on quality reports'; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual', and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with

- board minutes for the period April 2015 to March 2016;
- papers relating to quality reported to the board over the period April 2015 to March 2016;

- feedback from the Commissioners dated May 2016;
- feedback from the governors dated May 2016;
- feedback from local Healthwatch organisations, dated May 2016;
- feedback from Overview and Scrutiny Committee, dated May 2016;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2016;
- the national patient survey July 2015;
- the national staff survey dated May 2015;
- Care Quality Commission Intelligent Monitoring Report dated May 2015;
- Care Quality Commission reports; and
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2016.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

### Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

### Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

### Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the Monitor 2015/16 'Detailed guidance for external assurance on quality reports'; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.

20 May 2016

Deloitte LLP
Chartered Accountants
St Albans

## Statement of directors' responsibilities in respect of the *Quality Report*

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor 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 2015/16 and supporting guidance.
- The content of the *Quality Report* is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2015 to May 2016
  - papers relating to Quality reported to the board over the period April 2015 to May 2016
  - feedback from commissioners dated 27/04/2016
  - feedback from governors dated 20/04/2016 and 03/05/2016
  - feedback from local Healthwatch organisations dated 05/05/2016
  - feedback from Overview and Scrutiny Committee dated 05/05/2016
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17/05/2016
  - the first CQC commissioned National Children's inpatient survey 2014 (conducted for GOSH by Picker Institute Europe) – the second version of this survey is under development and is expected to be available to conduct in 2016
  - the independently commissioned Ipsos MORI outpatient experience survey 2014 (this survey is conducted every two years)
  - the national NHS Staff Survey 2015
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 20/05/2016
  - CQC Intelligent Monitoring Report dated May 2015 and CQC *Quality Report* dated 8 January 2016
- The *Quality Report* presents a balanced picture of the NHS foundation Trust's performance over the period covered.
- The performance information reported in the *Quality Report* is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the *Quality Report*, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the *Quality Report* is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The *Quality Report* has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the *Quality Report* (available at www.monitor.gov.uk/annualreportingmanual).

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

20 May 2016

Chairman

20 May 2016

Chief Executive

GOSH patient Charlie, age eight, Squirrel ward

# Accounts

# 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 Monitor.

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

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

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

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

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

Signed

**Dr Peter Steer**
Chief Executive
Date: 20 May 2016

# Foreword to the accounts

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 2016 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 Monitor, with the approval of the Treasury, has directed.

Signed

**Dr Peter Steer**
Chief Executive
Date: 20 May 2016

# Statement of Comprehensive Income for the year ended 31 March 2016

| | NOTE | **Year ended 31 March 2016 £000** | Year ended 31 March 2015 £000 |
|---|---|---|---|
| Total revenue from patient care activities | 2 | **349,574** | 345,198 |
| Total other operating revenue | 3 | **94,863** | 67,411 |
| Operating expenses | 4 | **(403,547)** | (401,449) |
| **Operating surplus** | | **40,890** | 11,160 |
| | | | |
| **Finance costs:** | | | |
| Finance income | 8 | **282** | 240 |
| Finance expenses - unwinding of discount on provisions | 9 | **(13)** | (15) |
| **Surplus for the financial year** | | **41,159** | 11,385 |
| Public dividend capital dividends payable | | **(6,985)** | (6,820) |
| **Retained surplus for the year** | | **34,174** | 4,565 |
| | | | |
| **Other comprehensive income** | | | |
| **Will not be reclassified to income and expenditure:** | | | |
| - Impairments | | **0** | (536) |
| - Revaluations - property, plant and equipment | | **28,510** | 6,830 |
| **Total comprehensive income for the year** | | **62,684** | 10,859 |
| | | | |
| **Financial performance for the year - additional reporting measures** | | | |
| Retained surplus for the year | | **34,174** | 4,565 |
| Adjustments in respect of capital donations | 3 | **(31,493)** | (15,351) |
| Adjustments in respect of (reversal of impairments)/impairments | 3 & 4 | **(13,771)** | 13,665 |
| **Adjusted retained (deficit)/surplus** | | **(11,090)** | 2,879 |

The notes on pages 137 to 162 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 2016

| | NOTE | **Year ended 31 March 2016 £000** | Year ended 31 March 2015 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 10 | **6,372** | 6,427 |
| Property, plant and equipment | 11 | **427,292** | 358,862 |
| Trade and other receivables | 14 | **7,139** | 7,616 |
| **Total non-current assets** | | **440,803** | 372,905 |
| **Current assets** | | | |
| Inventories | 13 | **7,858** | 7,599 |
| Trade and other receivables | 14 | **51,326** | 47,336 |
| Cash and cash equivalents | 15 | **63,732** | 58,932 |
| **Total current assets** | | **122,916** | 113,867 |
| **Total assets** | | **563,719** | 486,772 |
| **Current liabilities** | | | |
| Trade and other payables | 16 | **(55,629)** | (42,075) |
| Provisions | 19 | **(513)** | (473) |
| Other liabilities | 17 | **(4,413)** | (4,007) |
| **Net current assets** | | **62,361** | 67,312 |
| **Total assets less current liabilities** | | **503,164** | 440,217 |
| **Non-current liabilities** | | | |
| Provisions | 19 | **(964)** | (1,002) |
| Other liabilities | 17 | **(5,357)** | (5,764) |
| **Total assets employed** | | **496,843** | 433,451 |
| | | | |
| **Financed by taxpayers' equity:** | | | |
| Public dividend capital | | **126,065** | 125,357 |
| Income and expenditure reserve | | **260,983** | 226,809 |
| Other reserves | | **3,114** | 3,114 |
| Revaluation reserve | | **106,681** | 78,171 |
| **Total taxpayers' equity** | | **496,843** | 433,451 |

The financial statements on pages 133 to 162 were approved by the Board and authorised for issue on 20 May 2016 and signed on its behalf by:

Signed

**Dr Peter Steer**
Chief Executive
Date: 20 May 2016

# Statement of changes in taxpayers' equity for the year ended 31 March 2016

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

# Statement of changes in taxpayers' equity for the year ended 31 March 2015

| | Public Dividend Capital (PDC) | Revaluation reserve | Income and expenditure reserve | Other reserves | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Balance at 1 April 2014** | 124,889 | 72,488 | 221,633 | 3,114 | **422,124** |
| **Changes in taxpayers' equity for the year ended 31 March 2015** | | | | | |
| - Surplus for the year | 0 | 0 | 4,565 | 0 | **4,565** |
| - Transfers between reserves | 0 | (611) | 611 | 0 | **0** |
| - Impairments | 0 | (536) | 0 | 0 | **(536)** |
| - Revaluations - property, plant and equipment | 0 | 6,830 | 0 | 0 | **6,830** |
| - Public Dividend Capital received | 468 | 0 | 0 | 0 | **468** |
| **Balance at 31 March 2015** | 125,357 | 78,171 | 226,809 | 3,114 | **433,451** |

# Statement of cash flows for the year ended 31 March 2016

| | NOTE | Year ended 31 March 2016 £000 | Year ended 31 March 2015 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| **Operating surplus** | | **40,890** | 11,160 |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | | **18,013** | 17,800 |
| Impairments | | **4,797** | 17,780 |
| Reversal of impairments | | **(18,568)** | (4,115) |
| Profit on disposal of property, plant and equipment | | **(16)** | (83) |
| Income recognised in respect of capital donations (cash and non-cash) | | **(31,493)** | (15,351) |
| (Increase)/decrease in trade and other receivables | | **(111)** | 4,227 |
| Increase in inventories | | **(259)** | (462) |
| Increase/(decrease) in trade and other payables | | **9,453** | (1,985) |
| Decrease in other liabilities | | **(1)** | (1,785) |
| Decrease in provisions | | **(11)** | (195) |
| **NET CASH GENERATED FROM OPERATIONS** | | **22,694** | 26,991 |
| | | | |
| **Cash flows from investing activities** | | | |
| Interest received | | **282** | 240 |
| Purchase of property, plant and equipment | | **(38,788)** | (30,447) |
| Payments for intangible assets | | **(1,331)** | (4,079) |
| Sales of property, plant and equipment | | **16** | 142 |
| Receipt of cash donations to purchase capital assets | | **28,091** | 15,351 |
| **Net cash outflow from investing activities** | | **(11,730)** | (18,793) |
| | | | |
| **NET CASH INFLOW BEFORE FINANCING** | | **10,964** | 8,198 |
| | | | |
| **Cash flows from financing** | | | |
| Public Dividend Capital received | | **1,115** | 468 |
| Public Dividend Capital repaid | | **(407)** | 0 |
| PDC dividend paid | | **(6,872)** | (6,744) |
| **Net cash outflow from financing** | | **(6,164)** | (6,276) |
| | | | |
| **NET INCREASE IN CASH AND CASH EQUIVALENTS** | | **4,800** | 1,922 |
| | | | |
| **Cash and cash equivalents at start of the year** | | **58,932** | 57,010 |
| **Cash and cash equivalents at end of the year** | 15 | **63,732** | 58,932 |

## 1. Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2015/16 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

### 1.1 Accounting convention

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

### 1.2 Going concern

International Accounting Standard (IAS)1 requires management to assess, as part of the accounts preparation process, the Foundation Trust's ability to continue as a going concern for the foreseeable future. IAS 1 deems the foreseeable future to be a period of not less than twelve months from the entity's reporting date. After making enquiries, (these are described in the Annual Report on page 57), 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 judgements 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. Management use their judgment to decide when to write off revenue or to provide against the probability of not being able to collect debt especially in light of the changing healthcare commissioning environment. Judgment is also used to decide whether to write off or provide against International Private Patient and overseas debt.

### 1.6 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period not already included in note 1.5 above,

that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- the cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements as a provision. As the calculation involves a large number of staff, sampling techniques are used to collate the results for the entire Trust.
- the useful economic life of each category of fixed asset is assessed when acquired by the Trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets.
- For early retirements that took place before the NHS pension scheme was modified in 1995, a provision is made in the accounts incorporating inflation and the discount rate. Inflation is estimated at 2.5% and where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 1.37% in real terms.
- When arriving at the valuation for property, Trust management engages a qualified surveyor to assist them in forming estimates.
- The Trust leases a number of buildings that are owned by Great Ormond Street Hospital Children's Charity. The Trust has assessed how the risks and rewards of ownership are distributed between itself and the charity in categorising these leases as either operating or finance leases.
- The Trust has incurred expenditure relating to payments to a third party power supplier in order to increase the amount of power supplied to the Trust's main site. This expenditure is included in prepayments and is being amortised over the estimated period of use.
- a provision is recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgment is required when determining the probable outflow of economic benefits.

## 1.7 Income

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

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

## 1.8 Expenditure on employee benefits

**Short-term employee benefits**

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

**Pension costs**

**NHS Pension Scheme**

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016, is based on the valuation data as 31 March 2014, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

## 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 IAS 16, assets should be revalued when their fair value is materially different from their carrying value. Monitor 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. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of the revaluation less any subsequent accumulated depreciation and impairment losses.

All land and buildings are revalued using professional valuations in accordance with IAS 16. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Surplus land – market value for existing use
- Specialised buildings – depreciated replacement cost

The Trust revalued its equipment as at 31 March 2016 using relevant indices published by the Office of National Statistics as a proxy for fair value.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 1.11 Intangible assets

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

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

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

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

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

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

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

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

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

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

### 1.12 Inventories

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

### 1.13 Financial instruments and financial liabilities

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

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

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

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

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

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

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

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

### 1.14 Leases

**Finance leases**
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest

rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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

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

Finance leases in which the Trust acts as lessee

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

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

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

### 1.15 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 1.37% in real terms.

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

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

### 1.16 Contingencies

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

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

### 1.17 Public Dividend Capital

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

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

### 1.18 Value Added Tax

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

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

### 1.19 Corporation Tax

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

### 1.20 Foreign exchange

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

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

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

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

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

### 1.21 Cash, bank and overdrafts

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

### 1.22 Heritage Assets

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

### 1.23 Losses and special payments

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

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

### 1.24 Charitable Funds

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

### 1.25 Recently issued IFRS Accounting Standards

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

IAS 1 (amendment) Disclosure Initiative
IAS 16 (amendment) Depreciation and Amortisation
IAS 16 (amendment) and IAS 41 (amendment) Bearer Plants
IAS 27 (amendment) Equity Method in Separate Financial Statements
IFRS 9 Financial Instruments
IFRS 10 (amendment) and IAS 28 (amendment) Investment Entities applying the Consolidation Exception
IFRS 10 (amendment) and IAS 28 (amendment) Sale or Contribution of Assets
IFRS 11 (amendment) Acquisition of an Interest in a Joint Operation
IFRS 15 Revenue from Contracts with Customers
Annual Improvements to IFRS; 2012-15 cycle

The directors do not expect that the adoption of these standards and interpretations will have a material impact on the financial statements in future periods. All other revised and new standards have not been listed here as they are not considered to have an impact on the Foundation Trust.

## 2. Revenue from patient care activities

### 2.1 Analysis of revenue from patient care activities

| | Year ended 31 March 2016 | Year ended 31 March 2015 |
|---|---|---|
| | £000 | £000 |
| Elective income | **83,061** | 81,806 |
| Non elective income | **16,153** | 15,248 |
| Outpatient income | **38,197** | 38,724 |
| Other NHS clinical income | **158,776** | 163,305 |
| Revenue from protected patient care activities | **296,187** | 299,083 |
| Private patient income | **47,886** | 40,925 |
| Other non-protected clinical income | **5,501** | 5,190 |
| | **53,387** | 46,115 |
| Total revenue from patient care activities | **349,574** | 345,198 |

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 2016 | Year ended 31 March 2015 |
|---|---|---|
| | £000 | £000 |
| NHS Foundation Trusts | **552** | 474 |
| NHS Trusts | **535** | 541 |
| CCGs and NHS England | **295,100** | 292,068 |
| Department of Health | **0** | 6,000 |
| Non-NHS: | | |
| - Private patients | **47,886** | 40,925 |
| - Overseas patients (non-reciprocal) | **1,051** | 390 |
| - Injury costs recovery (was RTA) | **25** | 92 |
| - Other | **4,425** | 4,708 |
| Total revenue from patient care activities | **349,574** | 345,198 |

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 2016 | Year ended 31 March 2015 |
|---|---|---|
| | £000 | £000 |
| Income recognised in-year | **1,051** | 390 |
| Cash payments received in-year | **25** | 401 |
| Amounts added to provision for impairment of receivables | **425** | 136 |

## 3. Other operating revenue

| | **Year ended 31 March 2016** | Year ended 31 March 2015 |
|---|---|---|
| | **£000** | £000 |
| Research and development | **17,448** | 16,685 |
| Charitable contributions to expenditure | **7,369** | 10,206 |
| Charitable contributions in respect of capital expenditure | **31,493** | 15,351 |
| Education and training | **7,853** | 8,325 |
| Profit on disposal of other property, plant and equipment | **16** | 83 |
| Reversal of impairments | **18,568** | 4,115 |
| Non-patient care services to other bodies | **1,072** | 758 |
| Clinical tests | **3,851** | 3,491 |
| Clinical excellence awards | **3,071** | 3,365 |
| Catering | **1,176** | 1,072 |
| Creche services | **484** | 503 |
| Staff accommodation rentals | **44** | 56 |
| Other revenue | **2,418** | 3,401 |
| | **94,863** | 67,411 |

## 4. Operating expenses

| | **Year ended 31 March 2016** | Year ended 31 March 2015 |
|---|---|---|
| | **£000** | £000 |
| Services from other NHS bodies | **6,519** | 6,633 |
| Purchase of healthcare from non-NHS bodies | **2,619** | 4,059 |
| Executive directors' costs* | **1,899** | 1,462 |
| Non-executive directors' costs* | **162** | 151 |
| Staff costs | **206,394** | 199,380 |
| Supplies and services - clinical - drugs | **41,680** | 40,610 |
| Supplies and services - clinical - other | **54,167** | 50,561 |
| Supplies and services - general | **4,333** | 2,975 |
| Establishment | **3,096** | 2,934 |
| Research and development | **16,030** | 14,823 |
| Transport - business travel | **493** | 609 |
| Transport - other | **2,763** | 2,730 |
| Premises - business rates payable to local authorities | **2,136** | 2,210 |
| Premises - other | **22,133** | 24,215 |
| Operating lease rentals | **1,478** | 1,611 |
| Provision for impairment of receivables | **4,445** | 1,936 |
| Change in provisions discount rate | **4** | 19 |
| Inventories write down | **198** | 240 |
| Depreciation | **16,627** | 16,452 |
| Amortisation of intangible assets | **1,386** | 1,348 |
| Impairments and reversals of property, plant and equipment | **4,797** | 17,780 |
| Fees payable to the Trust's auditor for the financial statement audit | **102** | 100 |
| Other audit regulatory services - quality account | **18** | 16 |
| Clinical negligence insurance | **4,810** | 3,103 |
| Redundancy costs | **414** | 358 |
| Consultancy costs | **1,200** | 920 |
| Legal fees | **226** | 444 |
| Increase in other provisions | **257** | 0 |
| Internal audit costs | **135** | 78 |
| Losses and special payments | **0** | 1 |
| Other | **3,026** | 3,691 |
| | **403,547** | 401,449 |

* Details of directors' remuneration can be found in the Remuneration Report on pages 46-47.
Research and development expenditure includes £11,870k of staff costs (£11,415k in 2014/15).

## 5. Operating leases

### 5.1 As lessee

| Payments recognised as an expense | Year ended 31 March 2016 | Year ended 31 March 2015 |
|---|---|---|
| | **£000** | £000 |
| Minimum lease payments | **1,478** | 1,611 |
| | **1,478** | 1,611 |

| Total future minimum lease payments | As at 31 March 2016 | As at 31 March 2015 |
|---|---|---|
| | **£000** | £000 |
| Payable: | | |
| Not later than one year | **1,544** | 1,530 |
| Between one and five years | **6,004** | 5,954 |
| After 5 years | **4,566** | 5,888 |
| Total | **12,114** | 13,372 |

## 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 2016.

## 7. Employee costs and number

### 7.1 Employee costs

| | Year to 31 March 2016 Total | Permanently Employed | Other | Year to 31 March 2015 Total |
|---|---|---|---|---|
| | **£000** | **£000** | **£000** | £000 |
| Salaries and wages | 181,307 | 180,422 | 885 | 174,387 |
| Social security costs | 15,000 | 15,000 | 0 | 14,741 |
| Employer contributions to NHS Pension scheme | 19,926 | 19,926 | 0 | 19,293 |
| Agency / contract staff | 7,574 | 0 | 7,574 | 6,684 |
| Termination benefits | 414 | 414 | 0 | 358 |
| **Employee benefits expense** | **224,221** | **215,762** | **8,459** | 215,463 |
| Employee costs capitalised | (1,874) | (933) | (941) | (1,478) |
| Recoveries from other bodies in respect of staff costs netted off expenditure | (1,770) | (1,770) | 0 | (1,370) |
| **Net employee benefits excluding capitalised costs and recoveries from other bodies** | **220,577** | **213,059** | **7,518** | 212,615 |

## 7.2 Average number of people employed*

| | Year to 31 March 2016 Total | Permanently Employed | Other | Year to 31 March 2015 Total |
|---|---|---|---|---|
| | Number | Number | Number | Number |
| Medical and dental | 587 | 582 | 5 | 582 |
| Administration and estates | 1,020 | 886 | 134 | 1005 |
| Healthcare assistants and other support staff | 291 | 290 | 1 | 298 |
| Nursing, midwifery and health visiting staff | 1,421 | 1,414 | 7 | 1,338 |
| Scientific, therapeutic and technical staff | 743 | 724 | 19 | 754 |
| Other staff | 6 | 6 | 0 | 7 |
| Total | **4,068** | **3,902** | **166** | 3,984 |

*Whole Time Equivalent

## 7.3 Retirements due to ill-health

During the year there were no early retirements from the Trust on the grounds of ill-health. (There were two early retirements in 2014/15, £130k).

## 7.4 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 2016 | | | | | |
|---|---|---|---|---|---|---|
| **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 | **1** | **3** | **0** | **0** | **1** | **3** |
| £10,00 - £25,000 | **5** | **106** | **0** | **0** | **5** | **106** |
| £25,001 - £50,000 | **2** | **63** | **0** | **0** | **2** | **63** |
| £50,001 - £100,000 | **1** | **70** | **0** | **0** | **1** | **70** |
| **Total** | **9** | **242** | **0** | **0** | **9** | **242** |

| | Year to 31 March 2015 | | | | | |
|---|---|---|---|---|---|---|
| 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 | 9 | 45 | 5 | 21 | 14 | 66 |
| £10,00 - £25,000 | 7 | 132 | 0 | 0 | 7 | 132 |
| £25,001 - £50,000 | 4 | 181 | 0 | 0 | 4 | 181 |
| Total | 20 | 358 | 5 | 21 | 25 | 379 |

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

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

## 8 Finance Income

| | Year ended 31 March 2016 | Year ended 31 March 2015 |
|---|---|---|
| | **£000** | £000 |
| Bank interest | **282** | 240 |
| Total finance income | **282** | 240 |

## 9 Finance Expenses

| | Year ended 31 March 2016 | Year ended 31 March 2015 |
|---|---|---|
| | **£000** | £000 |
| Provisions – unwinding of discount | **13** | 15 |
| Total finance expenses | **13** | 15 |

## 10. Intangible assets

### 10.1 Intangible assets

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

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

| | Software licences | Licences and trademarks | Development expenditure (internally generated) | Intangible assets under construction | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Gross cost at 1 April 2014** | 2,807 | 496 | 3,591 | 3,192 | 10,086 |
| Additions - purchased | 287 | 39 | 192 | 2,619 | 3,137 |
| Additions - donated | 79 | 0 | 0 | 43 | 122 |
| Reclassifications | 151 | 1 | 767 | (2,412) | (1,493) |
| Disposals | (232) | (40) | 0 | 0 | (272) |
| **Valuation/Gross cost at 31 March 2015** | **3,092** | **496** | **4,550** | **3,442** | **11,580** |
| **Amortisation at 1 April 2014** | 1,742 | 222 | 2,054 | 0 | 4,018 |
| Provided during the year | 624 | 77 | 647 | 0 | 1,348 |
| Disposals | (173) | (40) | 0 | 0 | (213) |
| **Amortisation at 31 March 2015** | **2,193** | **259** | **2,701** | **0** | **5,153** |
| **Net book value** | | | | | |
| **NBV total at 31 March 2015** | **899** | **237** | **1,849** | **3,442** | **6,427** |

## 10.2 Economic life of intangible assets

| | Min Life Years | Max Life Years |
|---|---|---|
| **Intangible assets** | | |
| Software | 1 | 8 |
| Development expenditure | 1 | 8 |
| Licences and trademarks | 1 | 8 |

## 11. Property, plant and equipment

### 11.1 Property, plant and equipment

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

### 11.1 Property, plant and equipment (cont'd)

| | Land £000 | Buildings excluding dwellings £000 | Dwellings £000 | Assets under construction and payments on account £000 | Plant and machinery £000 | Information technology £000 | Furniture and fittings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|
| **Cost or valuation at 1 April 2014** | 76,469 | 214,291 | 7,661 | 28,585 | 63,910 | 19,100 | 10,700 | **420,716** |
| Additions - purchased | 0 | 2,540 | 0 | 3,642 | 1,906 | 473 | 551 | **9,112** |
| Additions - donated | 0 | 2,130 | 0 | 5,716 | 6,211 | 46 | 1,126 | **15,229** |
| Impairments charged to the revaluation reserve | 0 | (536) | 0 | 0 | 0 | 0 | 0 | **(536)** |
| Reclassifications | 0 | 18,213 | 0 | (22,672) | 2,687 | 2,813 | 452 | **1,493** |
| Revaluations | 1,588 | (23,785) | 242 | 0 | 0 | 0 | 0 | **(21,955)** |
| Disposals | 0 | 0 | 0 | 0 | (2,565) | 0 | (113) | **(2,678)** |
| **Cost or valuation at 31 March 2015** | **78,057** | **212,853** | **7,903** | **15,271** | **72,149** | **22,432** | **12,716** | **421,381** |
| **Accumulated depreciation at 1 April 2014** | 0 | 8,403 | (72) | 0 | 36,522 | 14,120 | 4,892 | **63,865** |
| Provided during the period | 0 | 7,560 | 167 | 0 | 5,157 | 2,569 | 999 | **16,452** |
| Impairments charged to operating expenses | 0 | 17,780 | 0 | 0 | 0 | 0 | 0 | **17,780** |
| Reversal of impairments credited to operating income | 0 | (3,830) | (285) | 0 | 0 | 0 | 0 | **(4,115)** |
| Revaluations | 0 | (28,975) | 190 | 0 | 0 | 0 | 0 | **(28,785)** |
| Disposals | 0 | 0 | 0 | 0 | (2,565) | 0 | (113) | **(2,678)** |
| **Accumulated depreciation at 31 March 2015** | **0** | **938** | **0** | **0** | **39,114** | **16,689** | **5,778** | **62,519** |
| **Net book value at 31 March 2015** | | | | | | | | |
| NBV - Owned at 31 March 2015 | 75,010 | 88,457 | 1,130 | 5,072 | 9,440 | 4,482 | 1,886 | **185,477** |
| NBV - Finance leased at 31 March 2015 | 0 | 2,749 | 0 | 0 | 0 | 0 | 0 | **2,749** |
| NBV - Government granted at 31 March 2015 | 0 | 118 | 0 | 0 | 96 | 0 | 0 | **214** |
| NBV - Donated at 31 March 2015 | 3,047 | 120,591 | 6,773 | 10,199 | 23,499 | 1,261 | 5,052 | **170,422** |
| **NBV total at 31 March 2015** | **78,057** | **211,915** | **7,903** | **15,271** | **33,035** | **5,743** | **6,938** | **358,862** |

### 11.2 Economic life of property plant and equipment

| | Min Life Years | Max Life Years |
|---|---|---|
| Buildings excluding dwellings | 8 | 48 |
| Dwellings | 45 | 46 |
| Plant and machinery | 1 | 14 |
| Information technology | 1 | 9 |
| Furniture and fittings | 1 | 14 |

Freehold land is considered to have an infinite life and is not depreciated.
The majority of Information Technology assets are depreciated over five years.
Assets under course of construction are not depreciated until the asset is brought into use.

Great Ormond Street Hospital Children's Charity donated £31,493k towards property, plant, equipment and intangibles expenditure during the year.

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

For assets held at revalued amounts:

- the effective date of revaluation was 31 March 2016
- the valuation of land, buildings and dwellings was undertaken by Peter Ashby, Member of the Royal Institution of Chartered Surveyors, Senior Surveyor, District Valuers Office
- the valuations were undertaken using a modern equivalent asset methodology.

## 12. Commitments

### 12.1 Capital commitments

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

| | **31 March 2016** | 31 March 2015 |
|---|---|---|
| | **£000** | £000 |
| Property, plant and equipment | **29,041** | 42,941 |
| Intangible assets | **967** | 1,910 |
| **Total** | **30,008** | **44,851** |

### 12.2 Other financial commitments

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

| | **31 March 2016** | 31 March 2015 |
|---|---|---|
| | **£000** | £000 |
| Not later than one year | **7,461** | 10,311 |
| Later than one year and not later than five year | **4,774** | 4,038 |
| **Total** | **12,235** | **14,349** |

## 13. Inventories

### 13.1 Inventories

| | **31 March 2016** | 31 March 2015 |
|---|---|---|
| | **£000** | £000 |
| Drugs | **1,359** | 1,436 |
| Consumables | **6,472** | 6,135 |
| Energy | **27** | 28 |
| **Total** | **7,858** | **7,599** |

The cost of inventories recognised as expenses during the year in respect of continuing operations was £82,157k (2014/15: £80,165k)

## 14. Trade and other receivables

### 14.1 Trade and other receivables

| | Current | | Non-current | |
|---|---|---|---|---|
| | **31 March 2016** | 31 March 2015 | **31 March 2016** | 31 March 2015 |
| | **£000** | £000 | **£000** | £000 |
| NHS receivables - revenue | **9,782** | 21,972 | **0** | 0 |
| Other receivables- revenue | **31,564** | 18,152 | **0** | 0 |
| Provision for impaired receivables | **(7,448)** | (4,574) | **0** | 0 |
| Receivables due from NHS charities – capital | **7,118** | 3,716 | **0** | 0 |
| Receivables due from NHS charities – revenue | **1,453** | 933 | **0** | 0 |
| Prepayments | **2,089** | 1,410 | **7,139** | 7,616 |
| Accrued income | **6,322** | 5,107 | **0** | 0 |
| Interest receivable | **2** | 2 | **0** | 0 |
| VAT receivable | **444** | 618 | **0** | 0 |
| **Total** | **51,326** | 47,336 | **7,139** | 7,616 |

'Receivables due from NHS Charities – revenue' was previously included within 'Other Receivables – revenue'; this is now shown separately.

### 14.2 Provision for impairment of receivables

| | **31 March 2016** | 31 March 2015 |
|---|---|---|
| | **£000** | £000 |
| **Opening balance** | **4,574** | 2,718 |
| Increase in provision | **4,445** | 1,936 |
| Amounts utilised | **(1,571)** | (80) |
| **Closing balance** | **7,448** | 4,574 |

### 14.3 Analysis of impaired receivables

| | **31 March 2016** | 31 March 2015 |
|---|---|---|
| | **£000** | £000 |
| **Ageing of impaired receivables** | | |
| 0 - 30 days | **1,209** | 370 |
| 30-60 days | **30** | 92 |
| 60-90 days | **5** | 320 |
| 90- 180 days | **990** | 952 |
| over 180 days | **5,214** | 2,840 |
| | **7,448** | 4,574 |
| **Ageing of non-impaired receivables past their due date** | | |
| 0 - 30 days | **5,309** | 3,707 |
| 30-60 days | **4,066** | 2,469 |
| 60-90 days | **2,346** | 3,163 |
| 90- 180 days | **2,225** | 2,955 |
| over 180 days | **1,161** | 911 |
| | **15,107** | 13,205 |

## 15. Cash and cash equivalents

| | 31 March 2016 | 31 March 2015 |
|---|---|---|
| | £000 | £000 |
| Balance at beginning of the year | **58,932** | 57,010 |
| Net change in year | **4,800** | 1,922 |
| **Balance at the end of the year** | **63,732** | 58,932 |
| | | |
| **Made up of** | | |
| Commercial banks and cash in hand | **13** | 11 |
| Cash with the Government Banking Service | **6,219** | 921 |
| Deposits with the National Loan Fund | **57,500** | 58,000 |
| **Cash and cash equivalents as in statement of financial position** | **63,732** | 58,932 |
| **Cash and cash equivalents** | **63,732** | 58,932 |

## 16. Trade and other payables

### 16.1 Trade and other payables

| | Current | |
|---|---|---|
| | 31 March 2016 | 31 March 2015 |
| | £000 | £000 |
| NHS payables – revenue | **5,728** | 5,319 |
| Other trade payables – capital | **8,972** | 4,984 |
| Other trade payables – revenue | **4,342** | 4,705 |
| Social Security costs | **2,104** | 2,086 |
| Other taxes payable | **2,201** | 2,187 |
| Other payables | **10,742** | 8,615 |
| Accruals | **21,288** | 14,040 |
| PDC dividend payable | **252** | 139 |
| **Total** | **55,629** | 42,075 |

'Other payables' includes £2,931k outstanding pensions contributions at 31 March 2016 (£2,856k at 31 March 2015)

## 17. Other Liabilities

| | Current | | Non-current | |
|---|---|---|---|---|
| | 31 March 2016 | 31 March 2015 | 31 March 2016 | 31 March 2015 |
| | £000 | £000 | £000 | £000 |
| Deferred income | **4,006** | 3,600 | **0** | 0 |
| Lease incentives | **407** | 407 | **5,357** | 5,764 |
| **Total** | **4,413** | 4,007 | **5,357** | 5,764 |

## 18 Prudential Borrowing Limit

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

## 19. Provisions

| | Current | | Non-current | |
|---|---|---|---|---|
| | **31 March 2016** | 31 March 2015 | **31 March 2016** | 31 March 2015 |
| | **£000** | £000 | **£000** | £000 |
| Pensions relating to other staff | **115** | 115 | **964** | 1,002 |
| Other legal claims | **14** | 36 | **0** | 0 |
| Redundancy | **170** | 0 | **0** | 0 |
| Other | **214** | 322 | **0** | 0 |
| **Total** | **513** | 473 | **964** | 1,002 |

| | **Pensions relating to other staff** | **Legal claims** | **Redundancy** | **Other** | **Total** |
|---|---|---|---|---|---|
| | **£000** | **£000** | **£000** | **£000** | **£000** |
| At 1 April 2015 | 1,117 | 36 | 0 | 322 | **1,475** |
| Change in the discount rate | 4 | 0 | 0 | 0 | **4** |
| Arising during the year | 108 | 9 | 170 | 22 | **309** |
| Utilised during the year | (116) | (26) | 0 | (130) | **(272)** |
| Reversed unused | (47) | (5) | 0 | 0 | **(52)** |
| Unwinding of discount | 13 | 0 | 0 | 0 | **13** |
| At 31 March 2016 | 1,079 | 14 | 170 | 214 | **1,477** |
| **Expected timing of cash flows:** | | | | | |
| – not later than one year | 115 | 14 | 170 | 214 | **513** |
| – later than one year and not later than five years | 460 | 0 | 0 | 0 | **460** |
| – later than five years | 504 | 0 | 0 | 0 | **504** |
| | 1,079 | 14 | 170 | 214 | **1,477** |

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

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

The NHS Litigation Authority records provisions in respect of clinical negligence liabilities of the Trust. The amount recorded as at 31 March 2016 was £101,453k (£55,767k at 31 March 2015).

## 20. Revaluation reserve

| | 31 March 2016 | 31 March 2015 |
|---|---|---|
| | £000 | £000 |
| Opening balance at 1 April | **78,171** | 72,488 |
| Impairments | **0** | (536) |
| Revaluations | **28,510** | 6,830 |
| Transfers to other reserves | **0** | (611) |
| Closing balance at 31 March | **106,681** | 78,171 |

## 21. Contingencies

| | 31 March 2016 | 31 March 2015 |
|---|---|---|
| **Contingent liabilities** | £000 | £000 |
| NHS Litigation Authority legal claims | **(10)** | (20) |
| Gross value of contingent liabilities | **(10)** | (20) |
| Net value of contingent liabilities | **(10)** | (20) |

A contingent liability exists for potential third party claims in respect of employer's / occupier's liabilities and property expenses £10k at 31 March 2016 (£20k at 31 March 2015). The value of provisions for the expected value of probable cases is shown in Note 19.

## 22. Financial instruments

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

### 22.1 Financial assets by category

| | 31 March 2016 | 31 March 2015 |
|---|---|---|
| | Loans and receivables | Loans and receivables |
| | £000 | £000 |
| Trade and other receivables excluding non financial assets | **42,915** | 40,817 |
| Cash and cash equivalents (at bank and in hand) | **63,732** | 58,932 |
| | **106,647** | 99,749 |

### 22.2 Financial liabilities by category

| | 31 March 2016 | 31 March 2015 |
|---|---|---|
| | Other financial liabilities | Other financial liabilities |
| | £000 | £000 |
| Trade and other payables excluding non financial assets | **34,089** | 27,896 |
| | **34,089** | 27,896 |

### 22.3 Financial Instruments

#### 22.3.1 Financial Risk Management

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

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

**Currency risk**

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

**Interest rate risk**

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

**Credit risk**

Because the majority of the Trust's income comes from contracts with other public sector bodies, it has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

**Liquidity risk**

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

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

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

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

## 23. Related Party Transactions

Great Ormond Street Hospital for Children NHS Foundation Trust is a body corporate established under the National Health Service Act 2006.

Dr Cale's husband is a corporate account manager for Thermo Fisher Scientific with whom the Trust recorded expenditure of £43k in the financial year. No other Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Great Ormond Street Hospital for Children NHS Foundation Trust. Remuneration of senior managers is disclosed in the audited part of the director's remuneration report on page 33.

The Trust holds a 20% interest in UCLPartners Limited (UCLP), a company limited by guarantee, acquired by a guarantee of £1. The company's costs are funded by its partners who contribute to its running costs on an annual basis. The contributions paid by the Trust are included within operating expenditure. The most recent available signed financial statements for UCLP have been prepared for the year ended 31 March 2015; the reported assets, liabilities, revenues and profit/loss are not material to the Trust.

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

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

| | | 2015/16 | | | |
|---|---|---|---|---|---|
| **Organisation Category** | **Organisation** | **Income £000** | **Expenditure £000** | **Receivables £000** | **Payables £000** |
| **Clinical Commissioning Groups** | NHS Barking And Dagenham CCG | 353 | 0 | 0 | 129 |
| | NHS Barnet CCG | 899 | 0 | 0 | 0 |
| | NHS Basildon And Brentwood CCG | 466 | 0 | 0 | 0 |
| | NHS Bedfordshire CCG | 573 | 0 | 0 | 0 |
| | NHS Bexley CCG | 186 | 0 | 0 | 0 |
| | NHS Bracknell and Ascot CCG | 167 | 0 | 0 | 0 |
| | NHS Brent CCG | 580 | 0 | 0 | 0 |
| | NHS Brighton & Hove CCG | 142 | 0 | 0 | 0 |
| | NHS Bromley CCG | 227 | 0 | 0 | 0 |
| | NHS Cambridgeshire And Peterborough CCG | 370 | 0 | 0 | 0 |
| | NHS Camden CCG | 2,610 | 0 | 961 | 0 |
| | NHS Canterbury & Coastal CCG | 158 | 0 | 0 | 0 |
| | NHS Castle Point & Rochford CCG | 321 | 0 | 0 | 0 |
| | NHS Central London (Westminster) CCG | 159 | 0 | 0 | 0 |
| | NHS Chiltern CCG | 333 | 0 | 0 | 0 |
| | NHS City And Hackney CCG | 629 | 0 | 0 | 0 |
| | NHS Coastal West Sussex CCG | 164 | 0 | 0 | 0 |
| | NHS Croydon CCG | 209 | 0 | 0 | 0 |
| | NHS Crawley CCG | 133 | 0 | 0 | 0 |
| | NHS Dartford, Gravesham And Swanley CCG | 239 | 0 | 0 | 0 |
| | NHS Dorset CCG | 133 | 0 | 0 | 0 |
| | NHS Ealing CCG | 569 | 0 | 0 | 0 |
| | NHS East And North Hertfordshire CCG | 907 | 0 | 0 | 0 |
| | NHS Eastbourne, Hailsham and Seaford CCG | 112 | 0 | 0 | 0 |
| | NHS East Surrey CCG | 218 | 0 | 142 | 0 |
| | NHS Enfield CCG | 846 | 0 | 0 | 0 |
| | NHS Gloucestershire CCG | 106 | 0 | 0 | 0 |
| | NHS Great Yarmouth & Waveney CCG | 145 | 0 | 0 | 0 |
| | NHS Greenwich CCG | 129 | 0 | 0 | 0 |
| | NHS Guildford & Waverley CCG | 287 | 0 | 0 | 0 |
| | NHS Hammersmith & Fulham CCG | 245 | 0 | 0 | 0 |
| | NHS Haringey CCG | 833 | 0 | 0 | 0 |
| | NHS Harrow CCG | 501 | 0 | 0 | 0 |
| | NHS Hastings & Rother CCG | 174 | 0 | 0 | 0 |
| | NHS Havering CCG | 510 | 0 | 0 | 0 |
| | NHS Herts Valleys CCG | 971 | 0 | 0 | 241 |
| | NHS Hillingdon CCG | 588 | 0 | 0 | 0 |
| | NHS Horsham & Mid Sussex CCG | 100 | 0 | 0 | 0 |
| | NHS Hounslow CCG | 410 | 0 | 0 | 0 |
| | NHS Ipswich & East Suffolk CCG | 152 | 0 | 0 | 0 |
| | NHS Islington CCG | 650 | 0 | 0 | 0 |
| | NHS Kingston CCG | 231 | 0 | 0 | 0 |
| | NHS Lambeth CCG | 160 | 0 | 0 | 0 |
| | NHS Lewisham CCG | 183 | 0 | 0 | 0 |
| | NHS Luton CCG | 517 | 0 | 0 | 0 |
| | NHS Medway CCG | 207 | 0 | 0 | 0 |

| | | 2015/16 | | | |
|---|---|---|---|---|---|
| **Organisation Category** | **Organisation** | **Income £000** | **Expenditure £000** | **Receivables £000** | **Payables £000** |
| **Clinical Commissioning Groups** | NHS Mid Essex CCG | 517 | 0 | 0 | 0 |
| | NHS Milton Keynes CCG | 171 | 0 | 0 | 0 |
| | NHS Nene CCG | 223 | 0 | 0 | 0 |
| | NHS Newham CCG | 502 | 0 | 0 | 120 |
| | NHS North East Essex CCG | 557 | 0 | 0 | 0 |
| | NHS North East Hampshire & Farnham CCG | 157 | 0 | 0 | 0 |
| | NHS North Hampshire CCG | 102 | 0 | 0 | 0 |
| | NHS North West Surrey CCG | 246 | 0 | 0 | 0 |
| | NHS Oxfordshire CCG | 141 | 0 | 0 | 0 |
| | NHS Redbridge CCG | 692 | 0 | 159 | 0 |
| | NHS Richmond CCG | 272 | 0 | 0 | 0 |
| | NHS Slough CCG | 0 | 0 | 487 | 0 |
| | NHS Southampton CCG | 114 | 0 | 0 | 0 |
| | NHS Southend CCG | 326 | 0 | 0 | 0 |
| | NHS South Kent Coast CCG | 175 | 0 | 0 | 0 |
| | NHS Southwark CCG | 135 | 0 | 0 | 0 |
| | NHS Surrey Downs | 321 | 0 | 0 | 0 |
| | NHS Thurrock CCG | 366 | 0 | 0 | 0 |
| | NHS Tower Hamlets CCG | 356 | 0 | 0 | 0 |
| | NHS Waltham Forest CCG | 614 | 0 | 107 | 0 |
| | NHS Wandsworth CCG | 262 | 0 | 0 | 0 |
| | NHS West Essex CCG | 541 | 0 | 0 | 0 |
| | NHS West Kent CCG | 315 | 0 | 0 | 0 |
| | NHS West London (K&C & Qpp) | 265 | 0 | 0 | 0 |
| | Cambridge University Hospitals NHS Foundation Trust | 103 | 0 | 0 | 0 |
| | Central Manchester University Hospitals NHS Foundation Trust | 0 | 127 | 0 | 0 |
| | Guys And St Thomas NHS Foundation Trust | 106 | 1,721 | 0 | 648 |
| | Luton & Dunstable NHS Foundation Trust | 121 | 114 | 0 | 0 |
| | Moorfields Eye Hospital NHS Foundation Trust | 0 | 124 | 0 | 0 |
| | Oxford University Hospitals NHS Foundation | 112 | 0 | 0 | 0 |
| | Royal Brompton & Harefield NHS Foundation Trust | 0 | 164 | 0 | 0 |
| | Royal Free London NHS Foundation Trust | 152 | 129 | 313 | 157 |
| | Sheffield Children's NHS Foundation Trust | 0 | 0 | 0 | 151 |
| | St Georges University Hospital NHS Foundation Trust | 102 | 0 | 0 | 0 |
| | University Hospitals Birmingham NHS Foundation Trust | 0 | 139 | 0 | 0 |
| | University College London NHS Foundation Trust | 642 | 1,537 | 5,886 | 1,243 |

| | | 2015/16 | | | |
|---|---|---|---|---|---|
| **Organisation Category** | **Organisation** | **Income £000** | **Expenditure £000** | **Receivables £000** | **Payables £000** |
| **NHS Trusts** | Barts Health NHS Trust | 2,876 | 858 | 498 | 614 |
| | Imperial College Healthcare NHS Trust | 143 | 190 | 145 | 105 |
| | Mid Essex Hospital Services NHS Trust | 0 | 914 | 101 | 147 |
| | Portsmouth Hospitals NHS Trust | 0 | 114 | 0 | 0 |
| | Whittington Hospital NHS Trust | 126 | 960 | 0 | 245 |
| | NHS England - London Commissioning Hub | 262,332 | 649 | 4,537 | 0 |
| | NHS England - Central Specialised Commissioning Hub | 845 | 0 | 0 | 0 |
| | London Regional Office | 5,127 | 0 | 1,559 | 0 |
| | NHS England - Core | 66 | 0 | 0 | 106 |
| **Other NHS Bodies** | NHS Litigation Authority | 0 | 5,025 | 0 | 0 |
| | Health Education England | 7,726 | 0 | 0 | 0 |
| | Department of Health: Core trading & NHS Supply Chain (excluding PDC dividend) | 9,902 | 0 | 0 | 150 |
| | Department of Health: PDC Dividend | 0 | 0 | 0 | 252 |
| **Other Government Bodies** | Camden London Borough Council | 0 | 672 | 0 | 0 |
| | Care Quality Commission | 0 | 112 | 0 | 0 |
| | Department of Health – PDC dividend only | 0 | 6,985 | 0 | 252 |
| | HM Revenue & Customs – VAT | 0 | 0 | 444 | 0 |
| | HM Revenue & Customs – Other taxes and duties | 0 | 15,000 | 0 | 4,305 |
| | National Loans Fund | 0 | 0 | 57,500 | 0 |
| | NHS Blood and Transplant (excluding Bio Products Laboratory) | 0 | 2,076 | 0 | 128 |
| | NHS Pension Scheme (Own staff employers contributions only plus other invoiced charges) | 0 | 19,926 | 0 | 2,931 |
| | Belfast Health & Social Care Trust – Northern Ireland | 1,415 | 0 | 0 | 0 |
| | Welsh Assembly Government (incl all other Welsh Health Bodies) | 2,226 | 0 | 0 | 0 |
| | Scottish Government | 522 | 0 | 341 | 0 |
| **Other Related Parties** | Great Ormond Street Hospital Children's Charity | 38,862 | 1,660 | 8,521 | 43 |

## 24. Events after the reporting period

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

## 25. Losses and special payments

| | Number | £000 |
|---|---|---|
| Stores losses | 3 | 198 |
| Total losses | **3** | **198** |
| Ex-gratia payments | 10 | 3 |
| Total special payments | **10** | **3** |
| **Total losses and special payments** | **13** | **201** |

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

## 26. Expenses

Expenses totalling £17,400 were claimed by four directors of 17 (2014/15: £18,500 claimed by six directors of 22).

Expenses totalling £400 were claimed by six of 27 councillors of the Members' Council (2014/15: £1,300 claimed by six councillors of 22).

## 27. Off-Payroll engagements

As at 31 March 2016, the Trust had five off-payroll engagements for more than £220 per day lasting for longer than six months.

Of these, two have existed for less than 1 year at the time of reporting and four have existed for more than four years.

# Glossary

**BAF**
Board Assurance Framework.

**Benchmarking**
Benchmarking is a process by which an organisation compares its performance and practices against other organisations. These comparisons are structured and are typically undertaken against similar organisations and against top performers. Benchmarking helps to define best practice and can support improvement by identifying specific areas that require attention.

**BRC**
The Biomedical Research Centre is funded by the National Institute for Health Research and supports paediatric experimental medicine research at Great Ormond Street Hospital and the UCL Institute of Health.

**Capital expenditure**
Expenditure to renew the fixed assets used by the Foundation Trust.

**Cardiac/respiratory arrest**
Cardiac arrest is the cessation of normal circulation of the blood due to failure of the heart to contract effectively. A cardiac arrest is different from (but may be caused by) a heart attack, where blood flow to the muscle of the heart is impaired. Cardiac arrest prevents delivery of oxygen to the body. Lack of oxygen to the brain causes loss of consciousness, which then results in abnormal or absent breathing. Brain injury is likely if cardiac arrest goes untreated for more than five minutes. For the best chance of survival and neurological recovery, immediate and decisive treatment is imperative.

**CEWS**
Children's Early Warning Score.

**CGC**
Clinical Governance Committee

**CICU**
Cardiac Intensive Care Unit.

**Clinical audit**
A quality improvement cycle that involves measurement of effectiveness of healthcare against agreed and proven standards for high quality. The audit takes action to bring practice in line with these standards so as to improve the quality of care and health outcomes. (HQUIP Best Practice for Clinical Audit 2011).

**Clinical outcome measures**
A clinical outcome is a change in health that is attributable to a healthcare intervention. Routine outcomes measurement is central to improving service quality and accountability.

**Commissioners**
Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Primary Care Trusts were the key organisations responsible for commissioning healthcare services for their area. However, on 1 April 2013, commissioning structures changed. GP-run Clinical Commissioning Groups, responsible to NHS England, now commission services (including acute care, primary care and mental healthcare). Commissioning of specialist services is provided directly by NHS England. From 1 April 2013, around 90 per cent of the Foundation Trust's activity is commissioned by NHS England.

**CQC**
The Care Quality Commission replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit ww.cqc.org.uk for more information.

**CQUIN**
Commissioning for Quality and Innovation.

**Dashboards**
Information dashboards present the most important information from large amounts of data in a way that is easy for users to read and understand. Dashboards summarise information and focus on changes and exceptions in the data.

**Data quality**
Data quality refers to the tools and processes that result in the creation of correct, complete and valid data that is required to support sound decision-making.

**Department of Health**
The Department of Health is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS.

**Depreciation**
The process of charging the cost of a fixed asset to the Statement of Comprehensive Income over its useful life to the Trust, as opposed to recording the cost in a single year.

**Division**
How we group and manage our clinical services.

**EBITDA**
Earnings before interest, taxes, depreciation and amortisation.

**ePSAG**
Electronic Patient Status on a Glance definition.

**Fixed assets**
Land, buildings or equipment that are expected to be used to generate income to the Trust for a period exceeding one year.

**FMCG**
Fast moving consumer goods.

**Foundation trust**
A foundation trust is a type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities. NHS foundation

trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS foundation trusts have members drawn from patients, the public, and staff, and are governed by a board of governors comprising people elected from and by the membership base.

**Friends and Family Test**
The Friends and Family Test (FFT) is a feedback tool that asks people using NHS services if they would recommend the services they have used

**GOSH**
Great Ormond Street Hospital for Children NHS Foundation Trust.

**GP**
General practitioner.

**Healthwatch**
Healthwatch is the new consumer champion for both health and social care from 1 April 2013. It exists in two distinct forms – local Healthwatch, at local level, and Healthwatch England, at national level. The aim of local Healthwatch will be to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

**HCA**
Health care assistant.

**HCAI**
Healthcare-acquired infection.

**ICH**
UCL Institute of Child Health.

**Impairment**
A charge to the Statement of Comprehensive Income resulting from a reduction in the value of assets.

**Indexation**
The process of adjusting the value of a fixed asset to account for inflation.

**IPP**
International and Private Patients.

**KPI**
Key performance indicator.

**MDT**
Multidisciplinary team – a group of different types of clinicians who work together.

**Medical Director**
The Medical Director is a physician who is usually employed by a hospital to serve in a medical and administrative capacity as head of the organised medical staff. A medical director provides guidance, leadership, oversight and quality assurance.

**Members' Council**
GOSH's Members' Council was established when the Trust became a Foundation Trust. The council is vital for the direct involvement of members in our long-term vision and planning, as a critical friend, and as a guardian of our values. It supervises public involvement, membership recruitment, and activation. The council has specific powers, including involvement in picking the Non-Executive Directors, ratifying the appointment of the Chief Executive, receiving the accounts, and appointing the auditors.

**Monitor**
Now known as NHS Improvement, Monitor is the independent regulator responsible for authorising, monitoring and regulating NHS Foundation Trusts.

**Multidisciplinary team meeting**
A meeting of the group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

**Net current assets**
Items that can be converted into cash within the next 12 months (eg debtors, stock or cash minus creditors). Also known as working capital.

**NHS**
National Health Service.

**NHS Choices**
NHS Choices is the UK's biggest health website. It provides a comprehensive health information service to patients and the public. The website helps users make choices about their health, from decisions about lifestyle, such as smoking, drinking and exercise, to finding and using NHS services in England.

**NHS England**
NHS England is an executive non-departmental public body of the Department of Health. It oversees the planning, delivery and day-to-day operation of the NHS in England as set out in the Health and Social Care Act 2012.

**NICU**
Neonatal Intensive Care Unit.

**NIHR**
National Institute for Health Research.

**Overview and scrutiny committees**
Since January 2003, every local authority with responsibilities for social services (150 in all) has had the power to scrutinise local health services. Overview and scrutiny committees take on the role of scrutiny of the NHS – not just major changes but the ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

**Pals**
Patient Advice and Liaison Service.

**Patient pathway**
The patient pathway is the route that a patient will take from their first contact with an NHS member of staff (usually their family doctor), through referral, to the completion of their treatment. It also covers the period from entry into a hospital or a treatment centre, until the patient leaves. Events such as consultations, diagnosis, treatment, medication, assessment, and teaching and preparing for discharge from the hospital are all

part of the pathway. The mapping of pathways can aid service design and improvement.

**PGME**
Postgraduate Medical Education.

**PICU**
Paediatric Intensive Care Unit.

**PLACE**
Patient Led Assessments of the Care Environment.

**Providers**
Providers are the organisations that provide NHS services, for example NHS trusts and their private or voluntary sector equivalents.

**Provisions**
Costs treated as expenditure in the current or previous periods but where cash will actually be paid in future periods. Amounts are estimated because it is not possible to be certain about the exact timing and amount.

**Public dividend capital**
The NHS equivalent of a company's share capital.

**QSAC**
Quality and Safety Assurance Committee, the new name for the Clinical Governance Committeee (effective May 2016)

**R&D**
Research and development.

**Referral to Treatment (RTT) Waiting Time Processes**
The length of time from referral through to treatment. The RTT 'clock' often starts weeks before a patient arrives at GOSH. The national standard is that 92 per cent of all patients are seen and treated within 18 weeks of their referral.

**Research**
Clinical research and clinical trials are an everyday part of the NHS. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

**Safe and Sustainable**
Safe and Sustainable is the name of the national paediatric surgery reviews of children's congenital heart services and children's neurosurgical services. The purpose of Safe and Sustainable is to canvas the opinions of all stakeholders, including professional bodies, clinicians, patients and their families, to weigh the evidence for and against different views of service delivery and to develop proposals that will deliver high-quality and sustainable services into the future.

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

**Special review**
A special review is a review carried out by the Care Quality Commission (CQC). Special reviews and studies are projects that look at themes in health and social care. They focus on services, pathways of care or groups of people. A review will usually result in assessments by the CQC of local health and social care organisations. A study will usually result in national level findings based on the CQC's research.

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

**Trust Board**
The role of the Trust Board is to take corporate responsibility for the organisation's strategies and actions. The Chair and Non-Executive Directors are lay people drawn from the local community and are accountable to the Secretary of State. The Chief Executive is responsible for ensuring that the Board is empowered to govern the organisation and to deliver its objectives.

**UCL**
University College London.

**UCLP**
University College London Partners.

# Great Ormond Street Hospital for Children NHS Foundation Trust

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