Great Ormond Street Hospital for Children
NHS Trust

Annual Report 2009/10

The child first and always

Mission and values

Our mission is to provide world-class clinical care and training, pioneering new research and treatments in partnership with others for the benefit of children in the UK and worldwide.

In everything we do, we work hard to live up to our three core values: pioneering, world-class and collaborative.

Cover: Solomon was born with a problem with his oesophagus, which he had repaired at Great Ormond Street Hospital nine years ago. The surgery he had left his oesophagus narrower than normal, and today he is back to have a grape that has got stuck, removed. He shouldn't be in for long, and his mum is hoping that they can still go on holiday as planned.

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Chairman's foreword

Great Ormond Street Hospital for Children NHS Trust (GOSH) was founded in 1852 by Charles West, a forward-thinking doctor who recognised that children have very different medical needs to adults. His solution was to establish a hospital dedicated solely to caring for children and trying to find new and better ways to improve their health.

Since that time, clinicians and researchers at GOSH and our research partner, the UCL Institute of Child Health, have pioneered many treatments and cures that have benefited not just patients at the hospital, but also sick children across the world.

Professor Martin Elliott, for example, was part of an international team of experts who this year pioneered the transplant of a new trachea into a child using the child's own stem cells to rebuild it. This incredible new technique will greatly reduce the risk of rejection of the trachea, and also has far-reaching applications which will help children around the world.

Research and development continues to be central to what we do, and with Child Health as one of the initial themes of the UCL Academic Health Science Partnership (UCL Partners), we look forward to collaborating even more widely and finding even more ways of helping the children who need us.

The opening of the Somers Clinical Research Facility last year gave us a much better space in which to conduct important clinical trials. There are currently more than 700 research projects taking place across the hospital and the Institute, and I am proud that Charles West's original commitment to combating childhood illness is still so in evidence today.

While children's medicine has been transformed since Victorian times, we still maintain the view that children need their own specialist hospital, focusing on paediatric research, education and clinical care.

We would like to be able to help more children. We are planning for growth in some of our key services and await the results of various NHS reviews. To grow, we need to increase the capacity of our site, and the ongoing redevelopment is central to this. We are currently in the second phase of our plans – the construction of the Mittal Children's Medical Centre – which will enable us to help up to 20 per cent more children. Due to open in 2012, the first building, the Morgan Stanley Clinical Building, will provide new heart and lung, neurosciences and kidney centres. I would like to record our thanks to all the donors to Great Ormond Street Hospital Children's Charity, whose generosity and support are making this possible.

The Trust's achievements this year are considerable when measured against its strategic objectives, quality targets and financial plan. I would like to thank the Executive team and all the staff of the hospital, who have worked hard to help the Trust achieve these results. This leaves us well positioned to make our Foundation Trust application.

Becoming an NHS Foundation Trust is important because it will enable us to retain our independence and, therefore, our single-minded focus on children and their healthcare needs. Much work has been done during the past year to enable us to move forward with our application. Achieving this will give us more freedom to innovate and to grow within the NHS, so that we can improve our services, treat more children and provide a better experience for patients and families.

We recognise that we still have challenges to overcome, but I am confident that we are now better placed than ever to become an NHS Foundation Trust and ensure that we continue to be true to Dr Charles West's vision: to provide dedicated care for the children who need us.

Tessa Blackstone
Chairman

A message from the Chief Executive

In recent years, patient safety and quality improvement have quite rightly moved to the top of the health agenda both nationally and internationally. We all recognise that we need to do the very best we can for patients and their families.

During the year, we asked Ipsos MORI[1] to conduct a satisfaction survey among inpatients and their families. The results were very encouraging, with 94 per cent of respondents being satisfied with the care they received and 96 per cent of people saying that they would recommend the hospital. Confidence in doctors and nursing staff was also very high at 95 per cent.

While these results are positive, it's important not to be complacent, and to continue to find ways to improve quality and safety. The Transformation programme, introduced in 2007, has three clear aims – zero harm, no waits and no waste.

Around the hospital, there are many important safety projects, all of which will help us to meet our zero harm objective. We want the focus always to be on safety, which is why the Executive team regularly take part in Executive Patient Safety Walkrounds, which aim to increase awareness of safety issues, improve communication and relationships with frontline staff, and enable management to obtain and act upon information identifying areas for improvement. These have resulted in initiatives to reduce hospital-acquired infections, manage medicines more safely and transform the care we provide on wards.

The Transformation programme has continued to work across the Trust to find better ways of working. During 2009/10, the Variability and Flow Management (V&FM) programme was launched. This involved the Transformation team engaging with hospital staff in supporting the redevelopment of five patient pathways. The projects focused on reducing the variability in the provision of care, enabling us to treat more patients, as well as improving patient safety and increasing efficiency.

In 2009/10, we produced our first Quality Account (see page 30), which set out our performance measured against defined priorities. During the year, Great Ormond Street Hospital for Children NHS Trust (GOSH) made significant progress in being able to measure and benchmark the quality of the services provided, for example, measures have been developed in certain services that have enabled patients and families to access detailed information about the effectiveness of the care they receive.

We need to record what happens accurately and honestly, and we are delighted to be leading the way with the development of a paediatric trigger tool to record harm, which is defined as anything you wouldn't want to happen to your own child. By learning from what goes wrong, we can continue to find better ways to care for children safely.

Last year, we were able to treat more children than ever at the hospital. We had an 8.2 per cent increase in inpatient and a 6.8 per cent increase in outpatient episodes, with many more day cases and new outpatient appointments.

We have reduced our average length of stay for patients and increased the number of day cases, which has minimised the amount of time that our families have to spend in hospital and also enables us to safely help more patients.

As you will see, the Trust was able to report a net surplus of £3.6 million for the year, which is £3.6 million above our original plan to break even. This has been achieved due to our improved tariff position, higher than estimated research and development income, and the fact that we have been able to treat more NHS and international patients.

Our service at North Middlesex University Hospital NHS Trust (NMUH) has reverted to being run by NMUH. I'd like to thank the team for their commitment and hard work during the time they worked for us.

My thanks also go out to the entire GOSH workforce, all of whom are dedicated to helping the children and families who need them.

I know they share my commitment to always do the very best we can for children.

Jane Collins
Chief Executive

[1] Ipsos MORI is the second largest survey research organisation in the UK.

Directors' report

Great Ormond Street Hospital for Children NHS Trust (GOSH) aims to set world-class standards in every aspect of its service. We are guided and inspired by the hospital's motto, 'the child first and always'.

Our history

The focus of the hospital's work in its early days was on treating the children of the poor in London, where malnutrition and disease were such that infant mortality was almost 50 per cent. Since those early days, outcomes for children have improved immeasurably, and the hospital has developed over time to be recognised as one of the leading specialist children's hospitals in the world.

The hospital today

GOSH has a world-class reputation as a specialist children's hospital, which encompasses clinical care, research and the education of healthcare professionals. The hospital has more than 50 paediatric specialties – the widest range of any hospital in Europe – which uniquely enables us to diagnose and pioneer treatments for children with highly complex, rare or multiple conditions.

The hospital is constituted as an NHS trust and provides a tertiary service within the NHS. This means that most of the children we care for are referred from other hospitals throughout the UK; either district general hospitals, or in some cases, other UK teaching and children's hospitals.

In addition to the specialist services delivered from our main central London site on Great Ormond Street, the Trust has also delivered general paediatric services at the North Middlesex University Hospital Trust site and community health services to children in Haringey.

Working in partnership with the UCL Institute of Child Health, we are the UK's only Specialist Biomedical Research Centre in paediatrics, and its research capacity is strengthened by our membership of UCL Partners, an organisation with Academic Health Science Centre status. The number of children treated at the hospital, and the complexity of their conditions, provides a unique opportunity to carry out research into clinical practices and treatments, which can save lives and improve quality of life for children today and in the future.

The hospital is also at the forefront of paediatric training in the UK. We train more children's nurses than any other hospital in the UK and play a leading role in training paediatric doctors. Nursing practice is advancing rapidly, with many nurses also supporting clinical research activity and leading specific nursing care research programmes. The quality of training they receive here, at the leading-edge of paediatric healthcare, will benefit both them and the children they care for, wherever they work in the future.

'The child first and always' has been the hospital's motto for almost 100 years. That focus and commitment remains the same today, with an emphasis on looking at both the child's medical condition and their overall wellbeing, and that of their family. This characterises Great Ormond Street Hospital's approach today, and as we actively work towards Foundation Trust status in 2011 (see page 15), it will inform our vision for the future.

Clinical strategy and activity

The children we care for often have highly complex, life-limiting or life-threatening conditions, and for many, Great Ormond Street Hospital for Children NHS Trust is the only hospital capable of helping.

Although we are based in London and serve the populations within London and the south of England, more than 50 per cent of our children come from outside London, including from other countries in the UK and overseas. Many of our patients are very young, with 35 per cent currently under three years old. Advances in early diagnosis mean that the average age of our patients is likely to continue to fall. However, many of the conditions we treat require constant monitoring and, as a result, we often have relationships with our patients which span their entire childhood.

In order to ensure that we are able to provide leading-edge care for our patients, collaboration with other healthcare providers around the world is a key part of our working practice. Advancing technology, and our ability to share learning and breakthroughs with other leading paediatric hospitals, accelerates developments in clinical practice for everyone.

Also critical to advances in our paediatric clinical services is our commitment to research and development, and central to that is our academic partnership with the UCL Institute of Child Health and our membership of UCL Partners. Together, we can more effectively and efficiently research, trial and translate learning into advances in treatment and care. Our research and development plans are covered in detail later in this report.

Clinical activity during the financial year
Growth in activity levels for our specialist services continued this year, with increases in inpatient and day case episodes, operations and outpatient attendances.

	2007/08	2008/09	growth %	2009/10	growth %
Inpatient and day case patient episodes:					
NHS patients	29,984	32,144	+ 7.2%	34,654	+ 7.8%
Private patients	2,057	2,113	+ 2.7%	2,448	+ 15.9%
Total	32,041	34,257	+ 6.9%	37,102	+ 8.3%
Outpatient attendances	119,076	130,133	+ 9.3%	138,941	+ 6.8%
Inpatient and day case episodes comprised:					
Day cases	15,290	16,916	+ 10.6%	18,839	+ 11.4%
Other elective	27,829	30,268	+ 8.8%	33,355	+ 10.2%
Emergency	4,202	3,995	-4.9%	3,747	-6.2%
Activities within these episodes included:					
Occupied bed days	93,747	96,134	+ 2.5%	99,563	+ 3.6%
Number of operations	15,294	16,131	+ 5.5%	17,262	+ 7.0%

*Inpatient and day case episodes are measured in terms of 'Finished Consultant Episodes' (FCE), the period during which a consultant from a particular specialty is responsible for an inpatient or day case admission. However, within one patient's stay in the hospital there may be more than one FCE if the care of the child is transferred to a consultant of a different specialty during the admission, for example, if the child is transferred to intensive care.

Research activity

The referral pattern of patients to Great Ormond Street Hospital for Children NHS Trust (GOSH) results in relatively large numbers of patients with complex and rare disorders gathering under the care of a hospital team. Such experience with rare conditions not only provides the opportunity to optimise care, but also enables pioneering research to be undertaken.

During 2009, one important area of activity for research at GOSH and the UCL Institute of Child Health (ICH) was the consolidation of research for patient benefit.

The purpose-built Somers Clinical Research Facility (CRF), designed to provide both bespoke accommodation for ambulatory patients participating in research and a focus for research expertise for the joint organisation, celebrated its first birthday in December 2009. The facility has seen increasing numbers of patients pass through its doors – CRF staff have helped to establish 40 clinical studies, and more than 90 patients visit the facility each month for research studies.

Together, GOSH and the ICH host the only National Institute of Health Research Specialist Biomedical Research Centre focused solely on children. We are very aware of our responsibility to contribute to the training of the next generation of child health-focused scientists and clinical academics, and we therefore decided to award, in open competition, several training fellowships to support scientists at the pre and post-doctoral phases of their career, as well as clinician scientists.

GOSH and the ICH have enthusiastically embraced the first year of the UCL Academic Health Science Partnership, known as UCL Partners (UCLP). Child Health was adopted as one of the initial themes of the partnership. In September 2009, the inaugural symposium of the UCLP Child Health theme was held, providing an opportunity for Child Health academics from across the partnership to gather to hear presentations and review posters showcasing some of the research being undertaken in the wider north London child health community. Presentations focused on eye disease, obesity, epilepsy, stroke and service improvements, with a focus on respiratory disease, and several of these are being taken forward as UCLP initiatives. We hope, through these workstreams, to encourage research at the population level, ultimately bringing health gains and benefits to a much wider population than that represented on the wards in our hospital.

You can read more about our research partnerships on page 14.

Education

Great Ormond Street Hospital for Children NHS Trust (GOSH) trains more nurses than any other hospital in the UK and plays a leading role in training paediatric doctors. This year, the education and training prospectus continued to support safety, excellence, and innovation within the workforce.

Our key education and training priorities for 2009/10 were:

- Ensuring that all learning supported safety and a positive patient experience.
- Ensuring that we lead on the provision of education for child health professionals and exploit any business development opportunities.
- Ensuring that all staff have access to appropriate education and training which supports competence and service development.
- Continuing to develop the leadership, management and team-working capacity of the Trust.
- Supporting workforce redesign.
- Ensuring that all Trust statutory and mandatory training obligations were met.
- Ensuring that clinical staff function at the competence level required in their role, and that all learning can be seen to have a positive impact in the workplace, where good practice and success is celebrated and shared.

In 2009/10, more than 17,500 training places were accessed by 2,695 staff. Appraisal figures for the Trust ran at around 55 per cent for non-medical and non-clinical staff and 80 per cent for medical.

Postgraduate medical education activity continued to reflect the demands of the postgraduate medical education training board and the London Deanery contract.

The impact of training in the workplace was measured using existing tools (such as reduction in occupational health referrals for back complaints, infection control rates, positive feedback in staff and patient surveys, and electronic evaluation of courses), and through the increase in applications for places on programmes such as the Developing Leadership Potential and Coaching programme.

Significant investment was made to support leadership development and key performance indicators were developed for all units in relation to statutory training, local induction, appraisals and e-learning compliance. GOSH remains the largest commissioning organisation for paediatric nurse education.

We met the national safeguarding standards for training; all staff had access to level one or two programmes, with level three activity provided for those members of staff who required it. Seventy-three per cent of staff accessed some form of classroom-based or e-learning training, and all staff received electronic media updates and child protection contact cards.

The Trust's online campus (GOLD) continues to evolve and expand, offering 24 hours a day, seven days a week access to educational information and e-learning.

Operational and financial review

Trust objectives for 2009/10

In 2009/10, we reviewed the annual planning framework with a specific focus on developing a set of three-year strategic objectives, each with a series of executive-led critical workstreams and actions to ensure close monitoring and successful delivery. We already had a strong basis on which to build, with three well-established values that focus on zero harm, no waits and no waste. These values distinguish what we stand for as a Trust, and what we are collectively working to achieve.

We have considered the development of our objectives and supporting workstreams within the internal and external contexts in which we operate. We have undertaken market and competition analysis, identified key drivers for change, analysed regulatory requirements and policy, and reviewed our own organisational capacity and capability to manage these effectively.

In order to ensure that we achieved the strategic elements of our plans in the first year, the Trust Board additionally developed a number of key deliverable outcome measures – a series of 'must-dos' against which we would measure our success.

Strategic objective	Key deliverable measures	Achievements
1. Consistently deliver clinical outcomes that place us among the top five children's hospitals in the world	Ensure that appropriate support is available to the sickest children on our wards 24 hours a day through the development of an Intensive Care Outreach Network (ICON)	Achieved
	Achieve a 50 per cent reduction in drug errors and a 50 per cent reduction in healthcare-acquired infections	Good progress – on target to achieve
	Identify and develop two clinical outcome measures in all specialties	Achieved
	Ensure compliance with the HCAI/Care Quality Commission's (CQC) infections standards	Good progress made towards compliance with the new *Code of Practice for health and adult social care on the prevention and control of infections and related guidance* Achieved MRSA trajectory Underachieved against the Clostridium difficile trajectory

Strategic objective	Key deliverable measures	Achievements
2. Consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations	Roll out our Advanced Access Transformation project across all specialties. This project aims to reduce the time from referral to first appointment to no more than 10 working days	Six specialties have implemented the programme
	Roll out our Variability and Flow Management (V&FM) Transformation projects across the first five identified specialties. These projects apply operations management principles and practices to reduce the cost and improve the quality of hospital care	Achieved
	Achieve a rating of 'excellent' in the CQC's Annual Health Check	CQC will publish benchmarking data in autumn 2010
3. Successfully deliver our clinical growth strategy	Ensure delivery of the Trust activity plan for 2009/10 (NHS and international and private patients)	Achieved
	Develop a joint cardiac and respiratory service with the Royal Brompton and Harefield NHS Foundation Trust	Project on hold. We are working with the Safe and Sustainable Cardiac National Review Group to ensure that centres providing care within England are of the highest quality and are sustainable
4. Currently partnered with the UCL Institute of Child Health, and moving to UCL Partners with Academic Health Science Centre status, maintain and develop our position as the UK's top children's research organisation	Ensure our research and development (R&D) strategies are agreed and implemented	The R&D strategy was approved by the Board in June 2010
5. Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK	Contribute to the development of a North London Sector Health Innovation and Educational Cluster (HIEC). HIECs are formal partnerships between NHS organisations which promote innovation, quality and productivity in the NHS through the training and education of healthcare staff, and share best practice across the capital	Achieved
6. Deliver a financially stable organisation	Deliver a £5 million surplus	The Trust achieved a surplus of £8.7 million for the financial year before dividends
7. Develop and strengthen support processes in line with the changing needs of the organisation	Develop our integrated business plan (IBP) to support our Foundation Trust application	The development of our IBP is progressing well against the project plan
	Maintain NHS Litigation Authority Risk Assessment level two. This is a risk-based insurance scheme that assists the Trust in the management of claims and litigation	Achieved

Performance against Care Quality Commission (CQC) targets and standards

Each year, the CQC assigns an Annual Health Check to NHS organisations, rating them on their financial performance and quality of care. The quality of care rating is based on performance against a number of existing commitments and national priority indicators, and an assessment against standards monitored by the CQC.

Our internal assessment for the 2009/10 Annual Health Check shows that we have met all of the targets applicable to the Trust, with the exception of incidence of Clostridium difficile. The Trust had a very low trajectory of no more than 10 cases for the year, which we exceeded by two. We declared full compliance with all core standards at the year end.

Existing commitment indicators

Indicator	Target	Performance	
Cancelled operations: operations cancelled by the Trust for non-clinical reasons on the day of admission or later	<=0.8%	0.59%	Achieved
Cancelled operations not admitted within 28 days	<5%	0%	Achieved
Ethnic coding data quality: the number of finished consultant episodes (FCEs) for the Trust with valid 2001 census coding for ethnic category	85%	89%	Achieved
Inpatients waiting longer than the standard: the number of patients waiting 26 weeks or more for an elective inpatient (ordinary or day case) admission	<=0.03%	No breaches of the 26-week standard	Achieved
Outpatients waiting longer than the standard: the number of patients waiting 13 weeks or more for a first outpatient appointment following a GP's written referral	<=0.03%	No breaches of the 13-week standard	Achieved

National priority indicators

Indicator	Target	Performance	
18-week referral to treatment times data completeness and 18-week referral to treatment times performance	Not yet published	High data completeness and performance maintained	Achieved
Cancer diagnosis to treatment waiting times: the NHS Cancer Plan set the ultimate goal that no patient should wait longer than one month (31 days) from diagnosis of cancer to the beginning of treatment, except for good clinical reasons	Threshold not yet published	No breaches of 31-day standard	Achieved
Clostridium difficile infections: number of Clostridium difficile infections confirmed from samples obtained from admitted patients (aged two years and above, and where the sampling interval is greater than 28 days for the same patient) against the Trusts' agreed ceiling for incidence of Clostridium difficile	10	12	Underachieved
Engagement in clinical audit: professional engagement in clinical audit and enabling the local environment to participate in audit activity are necessary to ensure that organisations are embracing the full potential of these methods in informing service delivery	'Yes' to question one and four out of five 'yes' responses to questions two to six	Compliant with all six questions	Achieved
MRSA bacteraemias: the number of MRSA bacteraemia reports against the Trusts' agreed ceiling for MRSA bacteraemia reports	4	1	Achieved
Staff satisfaction: selected questions from the NHS staff survey are used to calculate a job satisfaction key score, which will be used to score this indicator overall	National average composite score = 3.55	3.55	Achieved

A full list of the existing commitment and national priority indicators for acute and specialist trusts, including the rationale and constructs, can be found at www.cqc.org.uk

Financial overview

The activity growth during 2009/10 set out on page four resulted in a further year of financial growth:

- Operating income from all our activities grew to £318.1 million. This was an increase of 9.2 per cent on the previous year, due to increases in activity levels and to increased resources employed in our research, education and community services.
- Operating expenses increased to £309.9 million, up 8.7 per cent on the previous year.
- Staff costs increased by 7.7 per cent in total, as a result of increased staff numbers to deliver the growth in services and as a result of pay increases.
- There were impairment charges totalling £3.8 million resulting from the Trust's quinquennial revaluation of its land and buildings.
- We continued to invest considerable sums to improve the hospital's facilities. In addition to the expenditure on the redevelopment programme, there was also expenditure on other hospital buildings, medical equipment and our IT infrastructure. In total, £43.2 million was invested across the site during the year, comprising £15 million of funding from the Department of Health (part of a total funding award for the programme of £75 million), £18.5 million from Great Ormond Street Hospital Children's Charity and the Friends of the Children of Great Ormond Street charity, £0.2 million in grants from governance bodies, and the balance from internal resources.

We delivered a financial surplus of £8.7 million (2008/09: £6.2 million). Of the £8.7 million, £5.2 million (2008/09: £5 million) goes back to the government as a public dividend, leaving £3.6 million (2008/09: £1.2 million) which can be retained for future investment and growth.

The value of fixed assets increased by a net £21 million to stand at £248.6 million at the year end. This change was the net result of the additional capital expenditure of £43.2 million, less the impact of the revised valuation of the Trust's land, and building depreciation and impairment charges of £22.2 million.

The revised valuation reflects the fall in value of land and buildings throughout the UK and does not reflect any change in the Trust's assets.

Net current assets (excluding receivables due in more than a year) stood at £12.6 million, up £4.9 million on the previous year. Both trade receivables and payables have increased as a result of the inclusion of amounts payable relating to the capital redevelopment programme.

During 2009/10, there was a further reduction of £13.5 million in the Culyer research and development (R&D) funding, but improved income from the payment by results tariff, increases in funding for some of our most specialist services funded through prices negotiated with commissioners, and continuing growth in new streams of R&D funding offset this reduction.

Productivity improvements and efficiency savings

The Trust achieved £10 million of productivity and efficiency savings in 2009/10 – approximately 4.5 per cent of influenceable expenditure. This was was achieved without any impact on our clinical services and was the result of continuing efforts from all staff. The efficiency programme is broken down into initiatives which will increase activity and the associated income with less, or no, increase in cost; and those which reduce costs with less, or no, reduction in income. This is most notable in the transformation of clinical service, reduction in drug costs, procurement, and workforce modernisation. To assist with this work, the Trust is progressing service line reporting, which enables us to identify services for which costs exceed the funding received.

Financing and investment

Before the beginning of the financial year, the Trust had to agree limits with the Department of Health (DH) for any public funding required and the amount of capital expenditure, other than that funded by Great Ormond Street Hospital Children's Charity ('the external financing limit' and 'the capital resource limit' respectively). Throughout 2009/10, the Trust maintained strong controls on working capital and cash levels, and kept within these limits.

Better Payment Practice Code (BPPC)

The Trust improved its BPPC performance and achieved payment within 30 days of 87 per cent of non-NHS invoices and 82 per cent of NHS invoices by value.

Pension funding

Former and current 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.

Treasury policy

Surplus funds are lodged with the Bank of England through the Government Banking Service.

Financial risks

The Trust has experienced several years of financial uncertainty due to the change in the R&D funding structure and successive changes in the way the national payment by results tariff applies to specialist paediatric trusts. The challenging economic environment will continue to put pressure on the Trust's finances, in terms of erosion of tariff, funding not keeping up with cost inflation and the increased costs of delivering regulatory requirements. The DH continues to set challenging productivity targets, and so the achievement of the Trust's cost reduction targets, while maintaining a high standard of patient care, is one of the principal objectives for 2010/11.

The Trust has a counter-fraud officer who proactively reviews our counter-fraud arrangements and follows up on any incidents reported. There is also a whistle-blowing procedure in place, which is available to all staff. All matters raised are dealt with in confidence.

Community services

From the outset, Great Ormond Street Hospital for Children NHS Trust (GOSH) has worked in partnership with children, young people and their families and carers, as well as local teams, to plan, provide and evaluate the care that our patients need and receive.

Our local services in north London

Since 2006/07, the Trust has been responsible for the provision of general paediatric services at the North Middlesex University Hospital NHS Trust (NMUH) site. Since April 2008, the Trust has also provided community health services for children, young people and families in Haringey.

NMUH

Paediatric services at NMUH have benefited from focused child-centric training, development, education and research opportunities. Children and families have benefited too. The Advanced Access programme has reduced the amount of time that families have to wait for an appointment, and a new Child Protection Unit has been developed at NMUH.

Issues concerning clarity of accountability for governance and risk between the two sites prompted both Trust Boards to agree to consult on a proposal to return the operational management of the paediatric services and direct employment of the staff providing these services to NMUH. Following a consultation process, the two Trust Boards confirmed that they wished to proceed with the proposed change of operational management and staff employment, with effect from 1 May 2010.

Aspects of the original arrangements have continued, with GOSH providing child health-focused education and training, professional child protection and nursing advice to the acute paediatric staff at NMUH. GOSH views this development as a positive one, enabling the Trust to continue to support the delivery of local children's healthcare services.

Haringey

Haringey poses unique challenges for service delivery, with a requirement to deliver universal, targeted and specialist health services to an economically, socially and culturally diverse population of 56,000 children and young people.

During the two years that GOSH has been providing the Children, Young People and Families Community Health Services for NHS Haringey, the focus of work has been managing the considerable safeguarding agenda. The focus on child protection has driven a significant range of key service developments and quality improvements. A revitalised and refocused relationship between all health partners in the sector (GOSH at NMUH, GOSH in Haringey, NMUH, The Whittington Hospital NHS Trust and general practice), along with the London Borough of Haringey and other key partners, such as the Metropolitan Police Service, resulted in the production of a three-year joint area review action plan for Haringey, which is now in its second year.

Year one of the plan, known as the Safeguarding Plan for Haringey, has driven a considerable agenda of quality improvements across all agencies, including improvements to the quality of services, the quality of practice, and the clarity and depth of partnership working. Substantial progress has been made in multi-agency collaboration and the development of more systematic multi-agency planning and service delivery. The plan impacts upon joint working arrangements and the development and delivery of services to vulnerable children and young people, in which health services for children and young people play a key role.

We have also celebrated some successes. Haringey underwent a third Ofsted/Care Quality Commission inspection in relation to safeguarding in January 2010, the outcome of which was a judgement of "extensive and consistent evidence of good progress overall".

Innovations such as the Health Safeguarding Scorecard have been very well received, and the development of a multi-agency First Response Service for Child Protection and Children in Need, where social workers, health visitors, police and legal colleagues work together in a single, co-located team, is already demonstrating added value. All five of Haringey's special schools for children with disabilities are supported by a multi-disciplinary team from GOSH in Haringey, and they have achieved either "outstanding" or "good with outstanding features" results in Ofsted inspections during the year. GOSH in Haringey has also been successful in securing funding from the Department of Health to provide the Family Nurse Partnership programme to 100 teenage first-time parents.

Recruitment to services which are key to child protection, such as community paediatrics and health visiting, has been very successful, with health visiting now fully recruited and only one community paediatrics post remaining to be filled.

Research and education partnerships

Our research and education partnerships are fundamental to our work. Together we work to find new and better treatments and cures for childhood illness, and ensure that future generations of paediatric healthcare professionals have the best possible education.

UCL Institute of Child Health (ICH)

The ICH, in partnership with Great Ormond Street Hospital for Children NHS Trust (GOSH), is the largest centre in Europe devoted to clinical and basic research, and postgraduate teaching in children's health. Together we host the UK's only academic Specialist Biomedical Research Centre specialising in paediatrics, and constitute the largest paediatric research partnership outside North America.

This year, a team at GOSH and the ICH, with partners across Europe, launched an important study aimed at developing new drug treatments that could treat seizures in neonates and therefore reduce incidences of brain damage and neurological difficulties in later life.

UCL Partners

Our ICH collaboration has been further enhanced by our involvement in UCL Partners, a partnership between UCL and four of London's most prestigious hospitals and research centres – Moorfields Eye Hospital NHS Foundation Trust, the Royal Free Hampstead NHS Trust, University College London Hospitals NHS Foundation Trust and GOSH. UCL Partners was awarded Academic Health Science Centre status in March 2009.

With Child Health as one of its leading themes, the partnership aims to use the expertise and skill of our clinicians, along with those of our partner hospitals and our UCL colleagues, to make further advances in treating sick children – including, of course, those we see at GOSH.

In November 2009, the partnership agreed its academic strategy, outlining the initial priorities across the programme themes where activities will be concentrated to deliver benefits for patients in the future. An alliance developed between UCL and Yale University in New Haven, USA, aims to bring together the expertise from UCL Partners to advance biomedical research and treatment of disease, and create new joint clinical programmes. In the current economic climate, the partnership is working to deliver services effectively and efficiently, recognising joint benefits where possible.

London South Bank University (LSBU)

All student nurses at GOSH are enrolled at London South Bank University (LSBU), which offers a wide range of academic courses and is affiliated with the Royal College of Nursing Institute.

GOSH works closely with LSBU to offer quality learning and teaching which covers both pre and post-registration education. The Department of Children's Nursing at LSBU is responsible for the design, development and delivery of a range of child-focused courses. These courses support life-long learning and professional development. The pathways offered provide flexible learning through various part-time modules and web-based support, and all courses have a strong clinical focus.

Foundation Trust application

We started work on our Foundation Trust application in October 2009. We want to become an NHS Foundation Trust so that we can retain our independence and be able to protect our exclusive focus on children's healthcare needs.

We want to become a Foundation Trust because we believe it will help us to deliver better care for children and their families, and to increase the number of children we can help at Great Ormond Street Hospital for Children NHS Trust, in the UK and across the world.

Becoming a membership organisation will help us to work even better with our key stakeholders and to actively seek their views in new ways. Our vision is for membership to be at the heart of everything we do. We want our members to:

- help us to understand better the needs of our children and families and comment on our proposals
- strengthen our advocacy role for the health of all children
- enable more formal involvement of patients, families and frontline staff in our strategic planning
- be guardians of the values of the organisation.

Greater financial flexibility will allow us to seek wider funding options for our work, and will support our mission to deliver world-class and pioneering clinical care and research while collaborating with others to share that knowledge. We are planning to continue the expansion of our services to meet the anticipated needs of a larger population of children under 14 years old, to take advantage of the availability of new and more effective treatments, and to accommodate centralisation of specialised health services on fewer sites.

The increased freedom that comes with Foundation Trust status will allow us to investigate how we can meet wider public health objectives, specifically concerning childhood illnesses and overall child health. We are developing new ways of improving the safety of our services by reducing complications and by improving communication and co-operation between teams.

We are planning to submit our application for Foundation Trust status later in 2010, and to be authorised in 2011.

Delivering excellence through our workforce

Supporting and developing our workforce remained a priority in 2009/10, so that we can constantly deliver high-quality care and meet the challenges that lie ahead.

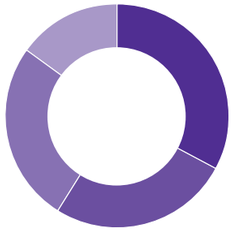
Our staff

In March 2010, we employed approximately 3,300 staff. We have seen our staff numbers increase in recent years as we treat more patients who are more seriously ill. Our challenge for the year ahead will be to see how we can continue to provide excellent care within tight financial constraints.

Staff turnover, often due to our central London location, can be a problem for us. This has fallen from 18 per cent in 2008/09 to 15 per cent in 2009/10.

Some turnover is good as it brings in new staff and new ideas, but we aim to manage this by providing attractive careers, support to achieve a work-life balance and excellent working practices. In 2009, our staff survey reported an increase in satisfaction across a range of scores, including support from immediate managers, and an increase in the numbers who plan to remain working in the Trust.

A breakdown of the main staff groups



- Nurses (registered) – 1,123 33%
- Other clinical and clinical support staff – 861 26%
- Administrative, managerial and facilities – 865 26%
- Doctors – 494 15%

Managing absence

One way in which we can avoid unnecessary costs is by reducing the amount of sickness leave our staff take. We have significantly improved the way in which we record and report absence, and this has allowed us to develop more accurate and complete data, which has also influenced some of our historic reporting. Our absence rate now stands at 3.65 per cent across the whole Trust, a figure we think is likely to have been increased by swine flu during 2009. We monitor absence closely and provide tailored support to line managers to address particular issues within their teams.

We launched a new in-house Occupational Health Service in autumn 2009 and aim to see improvements in the management of staff absence over the coming year. Our staff physiotherapy service continues to achieve excellent results in reducing and preventing absence, and is now working proactively with safety and training teams to educate staff in areas with high incidences of musculoskeletal problems.

Staff stress is also a significant cause of absence, and we have continued to develop our Stress Management Toolkit to help understand and address the causes of stress. In response to our staff survey, we launched our new approach to dealing with conflict between staff, which promotes the use of workplace mediation. This has already proved successful and is helping individuals and teams to work together more effectively.

Staff communication

We continue to benefit from excellent working relationships with our Staff Side (union) representatives. As part of our preparation to become a Foundation Trust, we also recruited 24 Foundation Trust ambassadors, who attended a large number of team meetings to explain the Trust's strategy. This provided an excellent opportunity for staff to understand how they contribute to the Trust's objectives and ask questions about our plans.

Staff absence 2009/10

Unit	March 2009	March 2010
Cardiac	2.48%	3.04%
Diagnostic and therapeutic services	4.72%	4.27%
Infection, cancer and immunity	3.21%	3.24%
International Division	4.13%	4.59%
Medicine	2.33%	2.70%
Neurosciences	1.82%	2.73%
Partnerships (North Middlesex University Hospital NHS Trust and NHS Haringey)	3.22%	4.71%
Surgery	2.73%	2.67%
Support functions	4.43%	4.74%
Trust average	**3.42%**	**3.65%**

Investing in equality and valuing diversity

The Family Equality and Diversity Group benefited considerably in 2009/10 from the involvement of parent and public representation. They have brought expertise and guidance that has helped us to ensure that our work makes a positive difference to patients and families.

Listening to families made us realise that we weren't providing sufficient disabled toilets and changing facilities for older children. We have now opened new facilities and feedback has been positive.

When we consulted on our Single Equality Scheme, our families told us that they would like more visual information about the Trust. We therefore created a *Welcome to GOSH* DVD and an *Essential Information* booklet, using more easily understood symbols. An Arabic version of the DVD is planned for 2010.

We also looked closely at the results of the Ipsos MORI patient survey to see if particular concerns were raised by children and families from black and ethnic minority backgrounds. There were no clear or consistent messages, but we will continue to influence the Trust's work on patient surveys to ensure that we identify any areas of concern for particular groups.

The Trust's Black, Asian and Minority Ethnic Network (BAMEN) for staff continued to attract new members in 2009/10. Black and ethnic minority staff have told us, via the staff survey, that they do not always feel they receive access to development opportunities, and BAMEN is currently delivering a range of learning opportunities tailored to these staff. Our wider aim is to see larger numbers of black and ethnic minority staff in more senior Trust roles.

We maintain our principle of always seeking to make adaptations to allow disabled people to be appointed or to continue working for us. Our recruitment data show that we have a good record in this area.

We have also continued our careful monitoring of employee relations activity – disciplinary, bullying and harassment, and grievance hearings. We ask our employment lawyer to review a sample of cases to ensure that we are following our procedures fairly at all times. They have endorsed our approach, but we always seek to implement learning wherever we can.

Information governance

The Trust is required to report information governance-related serious, untoward incidents. These involve the actual or potential loss of personal information, which could lead to identity fraud, or otherwise significantly impact upon individuals, and should be considered serious.

One serious untoward incident occurred during the 2009/10 financial year, and this was reported to the Information Commissioner's Office. An email containing a spreadsheet with the details of 4,143 staff members was sent to 79 members of staff and six external email addresses.

Action was taken to contact all recipients with requests that the data be destroyed, and staff were reminded of the Trust's procedures for communicating confidential data.

There were a number of further data security incidents, not categorised as 'serious', involving the accidental transmittal of emails containing personal data within the Trust, and in some cases, to external email addresses (see table below).

A summary of other personal data-related incidents in 2009/10

Category	Target	Total
I	Loss or theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	4
II	Loss or theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	2
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1
IV	Unauthorised disclosure	10
V	Other	34

Sustainability

We have been actively working to reduce our carbon footprint and to meet the challenging targets set by the Climate Change Act.

The NHS has a carbon footprint of 18 million tonnes of CO2 per year. This is composed of energy (22 per cent), travel (18 per cent) and procurement (60 per cent). Despite an increase in efficiency, the NHS has increased its carbon footprint by 40 per cent since 1990. This means that meeting the targets set by the Climate Change Act (2008) – 26 per cent reduction by 2020 and 80 per cent reduction by 2050 – will be a huge challenge. The carbon reduction strategy for England establishes a target of reduction equalling 10 per cent by 2015.

In response, Great Ormond Street Hospital for Children NHS Trust (GOSH) continued to develop its sustainability agenda over the past 12 months and completed all of its key objectives:

- Assessed the Trust against the key actions from the NHS Sustainable Development Unit.
- Produced a baseline for the Trust's carbon footprint.
- Signed up to the good corporate citizenship model.
- Committed to the Mayor of London's cycling strategy.
- Created partnerships with other local NHS Trusts.

In line with the requirements of the NHS Sustainable Development Unit, GOSH produced a sustainable development management plan which was endorsed by the Trust Board in March 2010. The plan delivers a framework for the Trust to work to and provides support in various forms to ensure success in reducing carbon consumption.

We will use this plan to expand on our previous carbon-reduction success through our work with the Carbon Trust. The focus of the plan is on the key priorities:

- environmental legislation
- governance
- organisational and workforce development
- partnerships
- finance
- energy and carbon management
- water and waste management
- travel and transport
- design and operation of buildings.

Development of the sustainable development management plan demonstrates the Trust's commitment to carbon reduction via a range of practical but ambitious measures, the sharing of good practice, and the active engagement and support of its staff. We are also committed to the good corporate citizenship model.

The Trust has established a Sustainable Development Committee, chaired by the director of redevelopment, who is also the Trust lead for sustainability. The group meets bi-monthly and monitors progress against both internal and external targets for carbon reduction and sustainability, and formally reports annually to the Trust Board.

Redevelopment

Great Ormond Street Hospital for Children NHS Trust (GOSH) is undertaking a major redevelopment programme to replace buildings which are nearing the end of their useful lives, and to provide new world-class facilities where parents can sleep alongside their child in comfort.

The conditions in some of the hospital's current buildings are cramped, inflexible and outdated – they were built at a time when healthcare needs were very different. New facilities designed for 21st-century healthcare will enable us to provide a better, more flexible, convenient and comfortable service for children and their families. We will be able to treat up to 20 per cent more children and give our researchers and clinical staff the resources they need to develop new treatments.

Bright, modern, spacious facilities also encourage healing, and make it easier for staff to do their very best for the children they treat. The redevelopment is largely funded through donations to Great Ormond Street Hospital Children's Charity. The NHS has backed the redevelopment programme by granting the hospital £75 million towards the costs, but there remains a huge job to do to fund the rest of the redevelopment in an increasingly difficult economic climate.

Phase 2

The first phase of the redevelopment was completed in 2006 and comprised the Octav Botnar Wing, Weston House (including the Paul O'Gorman Patient Hotel) and the Djanogly Outpatient Department. We are currently undertaking the second phase of the redevelopment programme to create the Mittal Children's Medical Centre. The centre is made up of two clinical buildings – the new Morgan Stanley Clinical Building and the redevelopment of the existing Cardiac Wing.

Redevelopment overview

There are four phases to our redevelopment plans:

Phase	Date	Nature of development
1	2004–2006	• Octav Botnar Wing • Weston House, including the Paul O'Gorman Patient Hotel • Djanogly Outpatient Department in the Royal London Homeopathic Hospital
2	2006–2016	• The Mittal Children's Medical Centre, comprising: – The Morgan Stanley Clinical Building – Phase 2B Building (redevelopment of the Cardiac Wing)
3 and 4	2016 onwards	• New ambulatory care centre • New central square and main entrance pavilion

During the year, we have made good progress in the development of the Morgan Stanley Clinical Building, with the builders' topping out ceremony held in July 2010. Opening in 2012, the Morgan Stanley Clinical Building will provide new clinical accommodation, including 92 inpatient beds, theatres and angiography facilities, together with a new restaurant and improved staff areas. We are continuing to work with children and young people, their families, staff and other stakeholders to finalise the interior design and equipping of this new building, along with policies and procedures for its use.

Environmental strategy

The Trust's redevelopment plans incorporate some major energy-reduction measures. Our strategy aims to achieve the lowest possible energy use for all of our buildings, including cost-effective heating and power for the site. Our Phase 2 redevelopment project will inspire future projects, and has set a target to provide a 120 per cent carbon reduction, along with a 60 per cent renewables contribution (these figures are based on the agreed plan to use biofuels, but the system is also able to use gas if necessary).

The sustainability programme is being independently monitored by the Building Research Establishment.

Improved facilities within the existing buildings

Alongside the redevelopment programme, we have continued to invest in our existing facilities to keep them as up to date and energy-efficient as possible. Work during the year has included ward refurbishments, providing new energy-efficient chillers, and updating public facilities and office accommodation for clinical and corporate teams. We were also able to complete the improvement of the Mildred Creak Unit, our inpatient facility for specialist child and adolescent mental health services (CAMHS).

Emergency preparedness

Like any other NHS organisation, we have to be prepared to manage out-of-the-ordinary events and major incidents.

Situations such as a fire or major utility failure may happen in the hospital at any time. They may also happen outside the Trust, when we may be required to provide support to a neighbouring hospital by receiving patients.

Planning for these events and managing the associated risks is extremely important, and documents such as the Major Incident Plan (MIP) provide guidance and help to structure our response. The MIP is scrutinised and updated regularly to ensure that our learnings from each event are incorporated, and that the plan complies with the Civil Contingencies Act (2004) and *NHS Emergency Planning Guidance (2005),* as well as other emerging policies and guidance.

Our planning covers business continuity, thus ensuring that whenever our services are under threat of disruption from an unexpected event, we can continue to work effectively and safely, and if necessary, rationalise our services to meet the requirements of those in greatest need. This sort of organisation was most recently evident in our plans for managing a flu pandemic.

All staff receive information on major incident planning when they start work in the hospital. In addition, key players are put through their paces during regular exercises to test the plans we have in place. We work closely with our neighbouring hospitals, host Primary Care Trust, NHS London and other agencies in order that, when a multi-agency response is required, we understand our role and contribution.

Ombudsman's Principles of Remedy

We aim to provide the best possible care for all of the children we treat. We do this in line with the Parliamentary and Health Service Ombudsman's *Principles of Good Complaints Handling*, *Principles of Good Administration* and *Principles of Remedy*.

Our aim is to always get it right. Our focus is on the needs of our children and their parents and carers, on being open and accountable, acting fairly and proportionately, putting things right and seeking continuous improvement. The Trust Board and Clinical Governance Committee receive regular reports to ensure that patients' views and complaints are dealt with in a timely manner and that appropriate lessons learned are acted upon.

Complaints

Between 1 April 2009 and 31 March 2010, the Trust received 152 complaints, which is comparable with the number received the year before. Four complaints were referred to the Health Service Ombudsman for review, but the ombudsman has not investigated any of these cases.

Number of complaints received by category 2009/10

Categories (please note that some complaints raise more than one issue)	
Treatment	58
Staff attitude	13
Outpatient appointments	10
Communication	46
Waiting times	20
Operations delayed	4
Standards of cleanliness	3
Admission/discharge procedures	10
Other	3

Patient and public involvement activity

Agreeing a patient and public engagement strategy for Great Ormond Street Hospital for Children NHS Trust (GOSH) opened up exciting possibilities for the Trust to involve members, many of whom are parents and patients, in service improvements, governance and helping us to keep a firm focus on the views of our patients and families.

There are now well over 60 members acting as parent representatives in the Trust who are making a unique and valuable contribution to our work. Many of them are giving a regular commitment to service planning and redesign, as well as to the Transformation Board and its many projects. Parents were active in the Food at GOSH Group, patient environment inspections, the Redevelopment Group, the patient and bedside information and entertainment project, and the Patient, Public Information and Experience Committee and its working groups, while a parent also co-chairs the Family Equality and Diversity Group.

Following a successful pilot, the Trust is proud to welcome parent representatives into recruitment interviews for all GOSH jobs – ranging from consultants to catering staff – that involve face-to-face dealings with the public.

A 'Learning from our parent representatives' event was held in March, when members came together to tell us what was working well and what could be improved. We are now putting their suggestions into practice and plan to design an online training and induction programme.

The Members' Forum continued to act as a critical friend pending the election of a Members' Council. Its work this year included advising the Trust on its strategic objectives, the appointments access policy and the Quality Account, and ensuring that the views represented in *GOSH Parents Say* (a list of parents' expectations) and the DVD *GOSH What a Hospital* (showing patients' views of what is important) were put into practice. Good relations were also established this year with Camden LINks. It is expected that this relationship will blossom in the future, and we continue to report to the Camden Health Scrutiny Committee.

The PALS (Patient Advice and Liaison Service) had another very busy year, helping more than 2,500 families. As a frontline drop-in service, open six days a week, PALS listens to the experiences of families and is well placed to give advice, tackle complaints, act on suggestions and help rebuild relationships where trust has broken down. Concerns raised by families with PALS enabled many positive changes to be made, including the relocation of the neuromuscular clinic, provision of better information for families on diagnosis of a life-limiting condition, and improved communication between patients, surgical wards and theatres.

Digital developments

This year has seen exciting developments on the digital front. The three web teams responsible for supporting the Trust, charity and Children First for Health websites have merged into one Digital team. This will create a more streamlined and consistent approach across all of our web-based services, including our substantial presence on other sites, such as Facebook.

Our vision is to deliver a website experience commensurate with the world-class care being delivered by the hospital.

Plans are underway to develop a single website which will showcase the work of the hospital and the charity's, and address the needs of all our online users.

Information for patients and the public

The Child and Family Information Group has worked hard to build on its successes in 2008. Around 160 new or updated information sheets were produced during the year, including award-winning sheets on glomuvenous malformations (a type of birthmark) and spiritual care at GOSH. A podcast about having a magnetic resonance imaging (MRI) scan was highly commended at the British Medical Association Patient Information Awards. All of our podcasts are now available on YouTube as well as the GOSH website, where they continue to prove very popular. Another new information resource developed this year is a DVD welcoming patients and families for their stay at GOSH.

Fundraising for our hospital

Great Ormond Street Hospital for Children NHS Trust (GOSH) has always relied on the support of the public. From its opening in 1852, through to the establishment of the NHS in 1948, the hospital was funded exclusively by gifts from philanthropists and large numbers of subscribers.

Although the basic level of provision is today covered by the NHS, the hospital is highly dependent on charitable giving, in order to ensure that world-class standards of care for children are maintained and that research into new and better treatment is properly funded.

The range of people and organisations that support the hospital is humbling, with all of them moved by the children, families and staff who are the heart of the hospital.

The hospital requires donations from the public to support four key areas:

1. Redevelopment of hospital buildings
Patients and staff struggle with cramped, outdated clinical buildings completely ill-suited to 21st-century medicine. Donations are helping us to fund the necessary redevelopment of two-thirds of the hospital site.

2. Equipment
In order to provide world-class care for patients, it is essential to have state-of-the-art equipment. Providing medical equipment which is suitable to be used for children and babies, is particularly expensive.

3. Research
Pioneering new ways to prevent, treat and cure complex, life-limiting and often life-threatening illnesses is critical to improving the lives of sick children.

4. Accommodation
The hospital knows that having a parent stay with their child improves recovery; consequently, the charity also fundraises to provide parent accommodation.

During the past year, the charity has been able to meet its annual targets thanks to some major gifts, corporate contributions and ongoing support from the general public.

The hospital's work and future plans are supported by a number of charities, all independent of the NHS Trust, most notably the Great Ormond Street Hospital Children's Charity and the Friends of the Children of Great Ormond Street.

Great Ormond Street Hospital Children's Charity needs to raise at least £50 million every year for the next 10 years to enable it to continue to meet the needs of the hospital and fund the vital redevelopment programme. This is a great challenge in the light of increasing competition in the charity sector and a pessimistic economic outlook.

The remarkable children and families we care for move us to do all we can to improve the health of children. The needs of sick children do not go away, and the hospital is aiming to be able to treat up to 20 per cent more children over the next few years. The charity's commitment to raising the necessary funds is absolute, and it is fortunate to have the engagement of existing and prospective supporters who have been inspired to support the hospital's work by our world-class care and the patients we treat.

Angela is in the cardiac daycare waiting room with her mum. Two weeks ago, she went home after a seven-month stay at Great Ormond Street Hospital for a heart condition, which is a long time when you are only nine months old. Today she is just here for a checkup.

Quality Account

Alanis is five days old. She was born prematurely at 33 weeks and has been through a lot. But she is now well enough to move to her local hospital and her mum is looking forward to being closer to home.

About the Quality Account

Why we are producing a Quality Account?
Great Ormond Street Hospital for Children NHS Trust (GOSH) has a long-standing reputation as one of the finest paediatric hospitals in the world. We are keen to share information about the quality of our services, and our plans to improve even further, with patients and families.

All NHS trusts are required to produce an annual Quality Account from 2010. The requirement was set out in the *Next Stage Review*[2] in 2008.

What are the required elements of a Quality Account?
The National Health Service (Quality Accounts) Regulations 2010 specify the requirements for all quality accounts[3]. We have used the requirements as a template around which our account has been built.

The key requirements are:

Part 1
A statement from the Chief Executive.

Part 2
- Priorities for improvement – these are commitments that an organisation makes to improve the level of quality within it.
- Statements about the organisation – these are expected to allow readers to compare different organisations.

Part 3
Review of quality performance – this demonstrates how the organisation has performed to date.

How did we produce our Quality Account?
- We have used the Department of Health's *Quality Accounts toolkit*[4] as the basic template for our Quality Account.
- In addition to ensuring that we have all the mandatory elements of the account, we have worked with patients, families, commissioners and staff to ensure that the account gives an insight into the organisation.

[2] Darzi. *Next Stage Review,* June 2008, Department of Health. This was a document that was published to coincide with the sixtieth anniversary of the NHS. The document developed a vision for how the NHS would continue to serve the needs of the public in the 21st century.

[3] *The National Health Service (Quality Accounts) Regulations 2010.*

[4] *Quality Accounts toolkit,* February 2010, Department of Health. This document was published by the Department of Health to assist with the production and publication of their Quality Accounts in 2010.

1. Priorities for improvement
Zero harm – reducing all avoidable harm to zero.

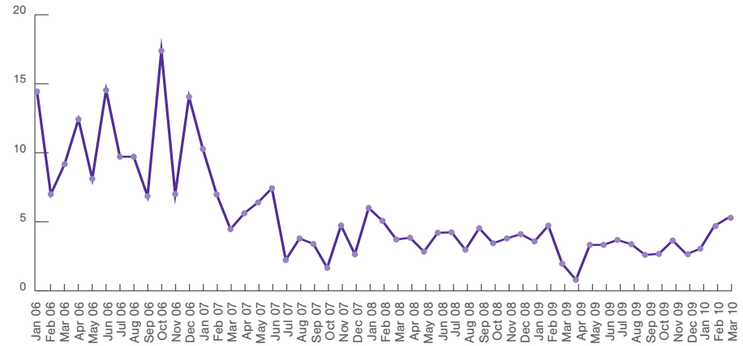
Why is this one of our priorities?
Reducing harm to patients is a national priority in the NHS, and a top one at Great Ormond Street Hospital for Children NHS Trust (GOSH). We want to be the leader in developing ways to decrease healthcare-acquired harm in children.

Where is performance reported?
Updates about these four initiatives are provided on a monthly basis to the Transformation, Management and Trust Board meetings. For all of these meetings 'safety' is the first agenda item.

Improvement initiative
Reducing GOSH-acquired central venous catheter (CVC) line infections (for every 1,000 line days)
CVC infections are avoidable infections if evidence-based practice is applied. Reducing the level will help reduce length of stay and increase the quality of the patient experience. The chart below shows infections were significantly reduced three years ago with a slower annual decline since.

How will we measure the performance?
The Transformation team collect data and monitor performance.

GOSH-acquired CVC infections for every 1,000 line days



Priorities for improvement
continued

Improvement initiative

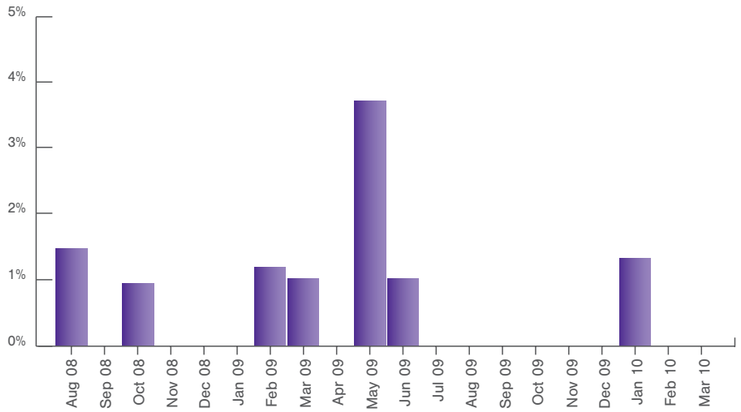
Reducing the percentage of operations resulting in surgical site infections (SSIs)

Reducing SSIs is a national priority and can be avoided if the correct model of care is followed. We are monitoring them through our Surgical Site Infection Prevention and Surveillance Team and through the clinical specialties, and will initially concentrate on urology, cardiothoracic and spinal surgery. The chart shows the percentage of operation sites becoming infected each month. An average of 82 operations are performed a month.

How will we measure the performance?

The Urology team collect data in their regular audit meetings, recording the number of infections detected and total number of procedures performed that month.

Percentage of SSIs for urology per operation



Improvement initiative

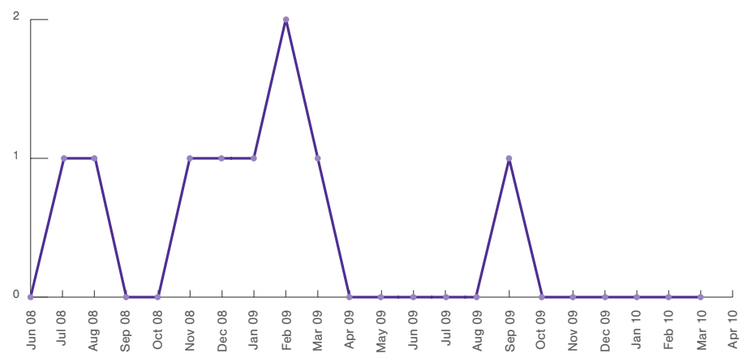
Reduce the incidence of MRSA bacteraemia

MRSA infections can have a long-standing effect on a child's ability to recover from an operation or illness. Therefore, reducing rates has become a national priority. In the last financial year we had one MRSA bacteraemia. Our national target for the current financial year is a maximum of two cases, although our overall aim is to strive to eliminate MRSA infections completely. Cases of MRSA bacteraemia are reported nationally and shown on the graph at the top of the following page.

How will we measure the performance?

When we have an occurrence of MRSA bacteraemia, the cause is investigated and the incident reported to the Health Protection Agency (HPA) and the Department of Health (DH).

MRSA bacteraemias reported to DH



Improvement initiative

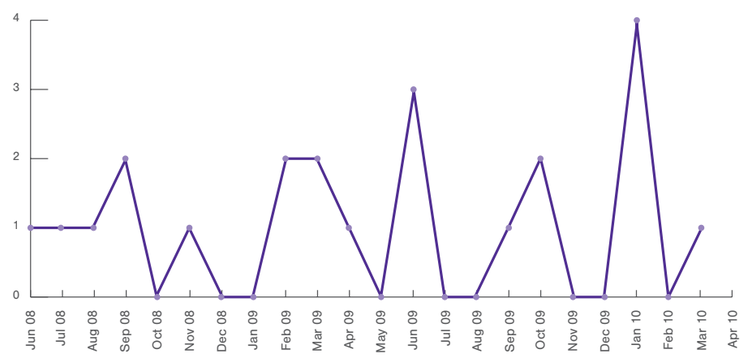
Reducing the annual incidence of Clostridium difficile-associated diarrhoea

Clostridium difficile infections are especially serious in adults, but may have a serious impact on the health of children, although this is difficult to assess as there are often other causes of loose stool in children. We monitor and implement control procedures for infection in all age groups, reporting infection in the over ones as required nationally.

How will we measure the performance?

When a case of Clostridium difficile occurs, it is always investigated by the Great Ormond Street Hospital Infection Prevention and Control team and any control measures implemented as necessary. Those children aged over one are notified to the HPA and DH. Cases where the test was performed on the third day or later of admission are monitored nationally and shown on the graph below.

Number of trajectory cases of probable Clostridium difficile-associated diarrhoea



2. Priorities for improvement

Consistently deliver clinical outcomes that place us among the top five children's hospitals in the world.

Why is this one of our priorities?

Delivering effective care is, and always has been, the primary focus of Great Ormond Street Hospital for Children NHS Trust (GOSH). However, one of the difficulties has been identifying measures that adequately show how effective the care that we provide is. The specialised nature of the care given sometimes means we lack centres with which we can compare ourselves. This year, we have worked to identify measures that allow us to benchmark our clinical performance both internally and externally, and to compare our effectiveness with previous periods. Over the next 12 months, we will work to identify measures that show how the Trust compares to our expected outcomes, and how we rate against other healthcare providers. Our objective is to consistently deliver clinical outcomes that place us among the top five children's hospitals in the world. We have ensured that the priorities we have identified in this Quality Account are closely aligned to our strategic objectives.

How will we measure the performance?

All clinical services in the hospital have been working to develop and highlight clinical effectiveness measures since December 2008. This additionally includes GOSH in Haringey services and the paediatric accident and emergency at the North Middlesex University Hospital, and it is intended that these will be published in the 2011 Quality Account. However, all clinical outcome measure developments will be available via the Trust website.

External assurance measures

Where possible, we are using pre-existing national or international measures that allow us to benchmark our performance against other services. This is particularly difficult at GOSH due to the unique nature of many of the conditions that we treat. For example, the widely-used, Dr Foster's Hospital Standardised Mortality Ratio (HSMR)[5] figure – which many local hospitals will use – is not a useful measure for children because the methodology is underpinned by an analysis of adult diseases. We will continue working with other children's hospitals to develop an alternative measure for risk-adjusted mortality and morbidity (complications). In addition, we are in discussions with Dr Foster about leading some international work that will aid the development of a paediatric HSMR figure.

Internal assurance measures

In some services, we have not yet been able to develop measures that allow us to compare ourselves with other providers. In some instances this is because the services we provide at GOSH are unique, and therefore it is impossible to compare our outcomes with how other providers perform. In other cases, measures have not been developed yet that allow comparisons to be drawn. Where this is the case, we have worked to develop measures that allow us to show how our current performance compares with our previous performance.

The tables opposite outline a number of outcome measures that have been identified to date. We have not included all the measures that have been identified so far, but we feel the lists show the extent to which the work has been embraced across the hospital. This list will be updated on the quality section of the GOSH website.

For more information, please contact enquiries@gosh.nhs.uk

[5] Dr Foster's HSMR figure. This figure is based on work that Professor Brian Jarman, an emeritus professor at London's Imperial College School of Medicine, and his colleagues undertook. They analysed over eight million discharges between 1991 and 1995 from English NHS hospitals when the primary diagnosis was one of the diagnoses accounting for 80 per cent of inpatient deaths. Based on this analysis, they identified a set of variables relating to patients that have an impact on their likely mortality. These included sex, age on admission (in five-year bands up to 90+), primary diagnosis and the number of previous emergency admissions a patient has experienced.

Below are some of the measures we have already developed or identified. To ensure that this Quality Account is not too long and unwieldy, we have not shown charts for these, but they will be accessible via our website during 2010/11.

Internal measures – only benchmarked against our previous performance

Patient group served	Measure
Dermatology patients who receive laser surgery	Laser surgery – level of change in affected area
Patients receiving chemotherapy through *Hickman®*[6] catheters	The interventional Radiology team's *Hickman®* catheter insertion success rate
Profoundly deaf or severely hard of hearing patients who receive cochlear implants	Speech intelligibility score of children post-operatively
Urology patients having pyeloplasties and hypospadias repairs	Complication rates for certain high-volume procedures
Paediatric laboratory medicine patients – those accessing the department that undertakes a large number of tests to diagnose patients	Error rate per 1,000 test requests

External measures – showing our performance compared to other providers

Patient group served	Measure
Patients undergoing cardiothoracic surgery	30-day and one-year mortality for surgical procedures
Patients who are inpatients on the Cardiac Intensive Care Unit	Standardised Mortality Ratio (SMR)[7] – the rate of mortality within the unit compared with other centres
Bone marrow transplants	Mortality status
Patients undergoing dental surgery	GOSLON[8] and five-year index for facial growth and dental arch relationship at five, 10, 15 and 20-year audits
Patients having kidney transplants	Number of kidneys functioning at the end of the year compared with those not functioning

We are aiming to have at least 20 measures available on our website by the end of 2010/11. These will form the basis for a suite of specialty-level Quality Accounts.

[6] *Hickman* is a registered trademark of CR Bard, Inc.

[7] Standardised Mortality Ratio. This is similar to the HSMR figure in that it shows the level of observed deaths compared to expected deaths. Different methods of working on SMR attach differing weights to various factors.

[8] The GOSLON (Great Ormond Street, London and Oslo) yardstick is a clinical measurement tool that allows for the categorisation of dental arch outcomes.

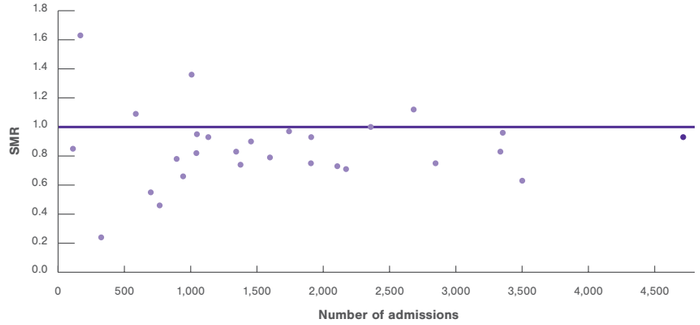
Priorities for improvement
continued

We have included examples of two of the external measures below – Paediatric Intensive Care Unit (PICU) and Cardiac Intensive Care Unit (CICU) – and one of the internal measures (*Hickman®*[9] catheter success rate).

Overview
The next two pages feature the Intensive Care team's effectiveness measures. These measures compare our team's performance with other centres around the country. The first chart relates to our overall intensive care service, the second shows the data for CICU. Patients who have had specialised surgery at Great Ormond Street Hospital for Children NHS Trust (GOSH) are admitted to PICU and the Neonatal Intensive Care Unit (NICU). In addition, the team aid colleagues in other specialties such as general surgery, oncology, neurology, metabolic medicine, renal, spinal surgery, ears, nose and throat, respiratory and endocrinology. CICU is for children under 16 years of age who need intensive care for conditions involving the heart, lungs or airways.

Overall intensive care service at GOSH

Standard Mortality Ratio figure for different NHS paediatric intensive care units (2006/08)



[9] *Hickman* is a registered trademark of CR Bard, Inc.

What is standardised mortality ratio (SMR)?
The SMR of a unit is a measure that shows how the 'observed deaths' related to the 'expected deaths'. The likelihood of death is based on a number of factors relating to the condition of the patient.

Why have we picked SMR?
The SMR rate for the unit is a nationally benchmarked figure – we can compare ourselves to other providers using it.

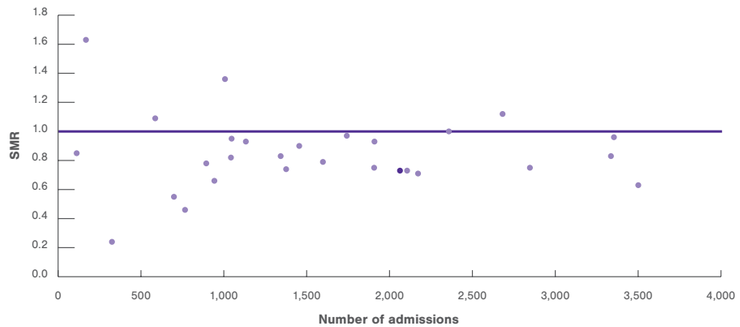
What is GOSH's SMR?
Our SMR for 2006/08 was below one – this indicates that we had better results than was reasonable to expect.

What is an 'expected' rate of SMR?
If a unit is performing exactly 'as expected', its SMR will be one. Below one is 'better than expected', and above one is 'worse than expected'.

Where can you find more information?
More information about the performance of different PICU units can be found at www.picanet.org.uk

Cardiac Intensive Care Unit at GOSH

SMR figure for different NHS Paediatric Intensive Care Units (2006/08)



For CICU, what is the SMR level?
For 2006/08, the CICU SMR level was 0.73 – significantly below 1.0.

In CICU, what can be done to reduce the SMR?
The fact that the SMR level for CICU is currently low is reflective of two practices that will be continued further:

- Enhanced sub-specialisation among the team, increasing the level of expertise in areas such as tracheal and complicated neo-natal surgery, interventional cardiology and the transplant service.
- Increasing use of evidence-based decision-making regarding the likelihood that patients will achieve a desired outcome.

What is a *Hickman®* catheter insertion in interventional radiology?
A *Hickman®*[10] catheter is inserted to allow administration of medication or the withdrawal of blood. It involves making two incisions, one to tunnel the catheter under the skin and the second at the site where the catheter is inserted into the vein. X-ray and ultrasound are used to perform the procedure.

What is a 'successful insertion'?
A successful insertion is defined as 'an episode in hospital during which it was possible to make the insertion – even if it was not at the first attempt'. This basically means that a patient who has had a successful insertion leaves the suite with the catheter inserted.

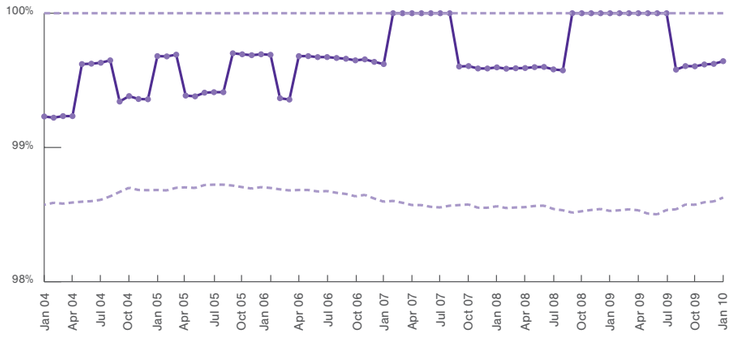
What is an 'expected' rate of success?
A published article[11] cited an expected rate of success as 95 per cent. We are currently successful in inserting between 99 and 100 per cent of *Hickman®* catheters.

What can be done to increase the success rate?
Use of ultrasound and x-ray guidance to insert *Hickman®* catheters reduces the likelihood of complications. It is important that complications are regularly audited to try and ensure that the risks associated with *Hickman®* catheter insertion are minimised.

Why use 12 months' data?
Despite the rate of failed insertion being so low, we were keen to still plot a trend. To have sufficient data to do this, we needed to use the previous 12 months of data. This means that when this chart is updated in July 2010, it will be showing data from July 2009 to June 2010.

What do the 'control limits' lines on the chart mean?
The dashed lines are the control limits. When the rate is outside of the control limits, it shows that something unusual has occurred. The dark purple line is the mean average. This shows the average rate of success during the time that this chart refers to.

Rate of successful insertion for patients having *Hickman®* catheters inserted in preceding 12 months



[10] *Hickman* is a registered trademark of CR Bard, Inc.

[11] *Quality Improvement Guidelines for Central Venous Access,* CA Lewis, J Vasc Interv Radiol. 2003 Sep; 14(9 Pt 2):S231-5.

3. Priorities for improvement

Consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations.

Why is this one of our priorities?
The memories and perceptions that families and patients have of Great Ormond Street Hospital for Children NHS Trust (GOSH) are heavily influenced by the quality of their experience. Most other NHS providers are included in the National NHS Inpatient Survey that the Department of Health commissions. GOSH does not participate in this survey as it is solely aimed at patients aged 16 and above. However, we are very keen to understand what patients and families think about us. In 2009, we commissioned Ipsos MORI to undertake a study of 750 patient and parent views. Overall, we achieved some excellent feedback scores. The report identified some key satisfaction measures, including overall satisfaction, cleanliness, confidence and trust in staff and food. We will continue to measure patient and family experience over the coming 12 months to ensure that we exceed expectations.

Improvement initiative
Improving elements of patient and family experience that were identified as needing improvement in our 2009 Ipsos MORI survey

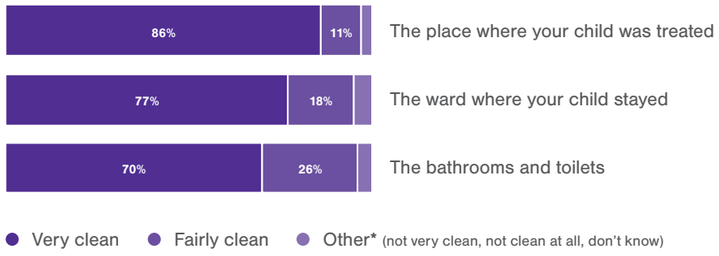
How will we measure the performance?
Overall, our 2009 Ipsos MORI survey showed some excellent results for GOSH.

Overall satisfaction

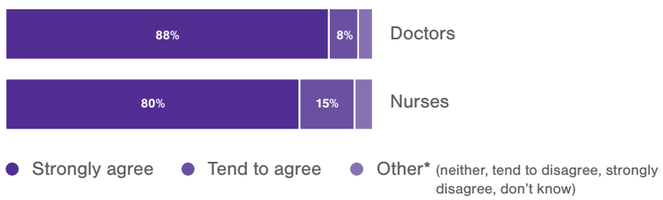
How well do you think staff dealt with fears?

Priorities for improvement
continued

How clean, if at all, did you feel the following areas were?



I had confidence and trust in the staff treating my child



We will commission a similar survey in 2010. The survey will involve at least 750 people being contacted via telephone. We will inform you about our progress, as demonstrated in the 2010 survey, in next year's Quality Account.

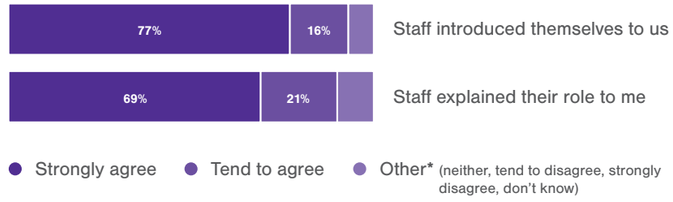
Issues to address

Were you able to stay overnight with your child?

We were concerned that these figures showed some parents not being aware of the facilities that we have for them to stay.

Action to address it
Improve the information for parents about the available accommodation options through the production of a new leaflet and poster by August 2010.

Do you agree/disagree with the following statement?



We were concerned that these figures showed some patients and families were unaware of who the member of staff they were dealing with was.

Action to address it
An audit will be undertaken of at least one ward per month for 2010/11, checking that all staff are wearing their name badges. The expectation is that this will highlight any areas where staff are not being clear about their names and roles.

Priorities for improvement
continued

Do you agree/disagree with the following statement?

Action to address it
Run a detailed survey regarding discharge for cardiac surgery and cardiology families, then report the findings back to the cardiac multi-disciplinary team clinical governance meeting in April 2010.

Was there anything that could have been improved about your child's hospital visit

The most common response to the question was *"nothing to improve"* – 29 per cent. However, when people did identify an issue to improve, the key focus was on waiting times: *shorter waiting times at hospital/shorter waiting times at pharmacy* – 10 per cent.

Action to address it
To offer magnetic resonance imaging (MRI) and outpatient appointments on the same day for neurology patients by October 2010.

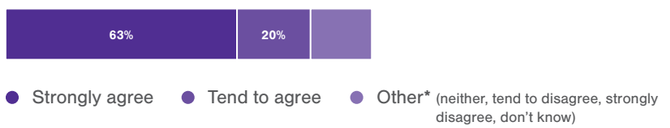
How satisfied or dissatisfied were you with the quality and amount of toys on the ward?

Action to address it
During 2010/11, more than 200 of our beds will be equipped with a bedside entertainment system. This will allow children to play computer games and watch DVDs and TV.

In addition to these improvements, we have worked closely with our commissioners to identify key areas where we have committed to increasing our performance levels as shown below. We have delivered a number of actions to ensure that we achieve these increases.

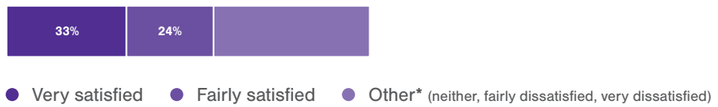
2009 performances

Did you feel you could complain and it would be taken seriously?



2010 target
Inrease the overall 'agree' from 83 per cent to at least 88 per cent.

How satisfied or dissatisfied were you with the quality and variety of hospital food?



2010 target
Inrease the overall 'satisfied' from 57 per cent to 65 per cent.

Priorities for improvement
continued

Improvement initiative
Collecting more information

How will we measure the performance?
While we are pleased with the overall results of the inpatient survey, we are still keen to learn more about the experiences of patients and families. We are currently exploring the best way of collecting real-time feedback, which will enable us to respond quickly to views that are expressed. We also participated in a pilot of a child-friendly electronic survey tool called Fabio the Frog that has been developed at Alder Hey Children's Hospital, and we are currently looking at various options to collect real-time patient experience feedback. We are also exploring the extent to which the bedside entertainment system will allow for immediate surveying of patients.

In addition to these measures, during 2010/11, Great Ormond Street Hospital for Children NHS Trust (GOSH):

- has commissioned an independent survey of 100 referring clinicians. We are currently developing an action plan based on the results to ensure that we are exceeding our referrers' expectations. We have identified this workstream as one of our key priorities for 2010/11.
- will commission an independent survey of users of our outpatient services. Following this, we will develop an action plan to ensure that the views of patients and parents are taken into consideration in the development of our services.

Improvement initiative
Continue to meet national waiting-time targets

How will we measure the performance?
All trusts which provide NHS services are required to do so within set timescales that are specified within the Department of Health's operating framework. Getting timely access to necessary care has an impact on the effectiveness and experience of services.

There are currently five waiting-time and access targets that apply to GOSH. We have met these in 2009/10, and will continue to do so during 2010/11:

At least 90 per cent of patients getting treated within 18 weeks (or less) after their initial referral	✔
Maximum 13-week wait for an outpatient appointment after a referral from a GP	✔
Maximum 26-week wait for inpatient treatment	✔
Cancer – maximum of 31 days between diagnosis and treatment	✔
Less than 28 days between the on-the-day cancellation of an operation and a rebooked operation taking place	✔

Quality Account mandatory statements approved by the Great Ormond Street Hospital for Children NHS Trust (GOSH) Board

The following statements were discussed and approved by the Trust Board on 26 May 2010.

Review of services
During 2009/10, GOSH provided NHS services within 49 specialties. The income generated by the NHS services reviewed in 2009/10 represents 100 per cent of the total income generated from the provision of NHS services by GOSH for the reporting period. These included medical and surgical services as well as those offering support, therapy, diagnosis and investigation. As a tertiary centre, we see patients from across the country, and the aim is to provide access for children with specific needs to a range of services within one site wherever possible. In addition to this, we provide community services in Haringey and the paediatric accident and emergency at the North Middlesex University Hospital.

In order to ensure that we maintain excellent service provision, we have internal processes to check that we meet both our own internal quality standards and those set nationally. Key performance indicators relating to each of the Trust's strategic objectives are presented, on a monthly basis, to the Trust Executive and Management Boards. This includes progress against external targets, such as how we keep our hospital clean, the effectiveness of actions to reduce infection and ensure patients have access to our services when they need them.

Each specialty and clinical unit has an internal monitoring structure so that teams can regularly review their progress and identify areas where improvements may be required. This information links into the wider Trust governance framework where the units report on the progress of the care they provide at least once a year. These updates are recorded through the quarterly operational performance reviews and the committee structure of the Trust to ensure the quality of service delivery and monitoring is discussed and acted upon at the appropriate level within the Trust. This will be further supported in the future by the integration of the Quality Account with specific, measurable targets.

Delivery of healthcare is not risk free and the Trust has a robust system for ensuring that the care delivered by our services is as safe and effective as possible. Our process has been externally assessed and we achieved level two in the National Health Service Litigation Risk Management Standards in November 2009.

Unless events are reported when the outcome of care is not as expected, the Trust cannot learn and make improvements. A good safety culture is one with high levels of reporting and where the severity of the event is low. The National Patient Safety Agency has consistently identified the Trust as meeting these criteria. Analysis of the types of risks identified by staff is incorporated into our assurance process to ensure management, performance and safety are closely aligned.

Through these methods, GOSH reviews all the data available on the quality of care in each of our 49 NHS services as part of our internal and external management and assurance process.

Participation in clinical audits
Clinical audit is an evaluation of the quality of care provided against agreed standards. The aim of clinical audit is to provide assurances about services provided and stimulate improvement to them where necessary.

There are two types of clinical audit:

1. International/national ones that we are asked to become involved in – these are listed below.
2. Local audits undertaken within GOSH. The information that is gathered from these is also used to ensure patients get the best possible care.

During 2009/10, 22 national clinical audits and national confidential enquiries covered NHS services that GOSH provides. In that period, GOSH participated in 91 per cent of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The reports of 133 local clinical audits were reviewed by the provider in 2009/10. During 2009/10, we were not able to log all the actions that stemmed from these audits because the guidance relating to Quality Account was only published in February 2010. However, we will be able to include information relating to the actions stemming from these local audits in next year's Quality Account.

We have identified the national audits we need to participate in. We have agreed as part of our clinical audit plan that we will be reporting progress with the national audits identified overleaf in November 2010 to ensure relevant actions are acted upon. Due to the timescales of the publication of the 2009/10 Quality Account, we were not able to give specific numbers for the number of cases submitted to each national clinical audit. However, we will be able to give these figures in the 2010/11 Quality Account.

Quality Account mandatory statements approved by the Great Ormond Street Hospital (GOSH) Board
continued

Eligible to participate in	Participating in
National Neonatal Audit Programme (NNAP)	✘
UK Renal Registry	✔
UK Cystic Fibrosis (CF) Registry	✔
Centre for Maternal and Child Enquiries (CMACE): perinatal mortality	✔
Trauma Audit and Research Network (TARN)	✔
Congenital heart disease, including paediatric surgery	✔
The Paediatric Intensive Care Audit Network (PICANet)	✔
Heart rhythm management	✔
Hepatitis C National Register	✔
The CRANE database	✔
Sudden Arrhythmic Death Syndrome Audit (SADS)	✔
Pulmonary Hypertension Audit	✔
Potential Donor Audit (PDA)	✔
Major Complications of Airway Management (NAP4)	✔
Patient Outcomes in Surgery (National PROMS Programme)	✔
Occupational Health Clinical Effectiveness Unit (OHCEU) national audits	✔
National Kidney Care Audit	✔
National Comparative Audit of Blood Transfusion	✔
National Cancer Registries	✔
UK and Ireland Liver Transplant Audit and the UK Intrathoracic Transplant Audit	✔
British Association of Endocrine and Thyroid Surgeons (BAETS) – second national audit	✘
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✔

The Trust has participated in two national confidential enquiries in 2009/10. Five studies were run by National Confidential Enquiry into Patient Outcome and Death (NCEPOD). Two of the five were studies that were appropriate for GOSH to participate in, three did not include paediatric cases.

The two NCEPOD studies which the Trust participated in were:

- Parenteral Nutrition (PN) study (19 per cent of 31 registered cases were completed).
- surgery in children (51 per cent of 56 registered cases were completed).

Participation in NCEPOD studies was formally reviewed by the Trust Quality and Safety Committee in March 2010.

Participation in clinical research

Clinical research ensures that treatments improve and that more patients are able to recover. GOSH works at the forefront of worldwide research into a variety of conditions. We feel that it is important that patients and families understand the level of research occurring at GOSH, to provide confidence that all that could be done, is being done.

- The number of patients receiving NHS services provided or sub-contracted by GOSH in 2009/10, that were recruited during that period to participate in research approved by a Research Ethics Committee, was 2,507. This number is based on the number of patients who were recorded as being added to Clinical Research Network-approved studies in 2009/10.
- The 2,507 patients for 2009/10 was up from a figure of 956 in 2008/09. This increasing level of participation in clinical research demonstrates GOSH's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.
- GOSH's commitment to clinical research is further evidenced by the fact that it is part of UCL Partners, one of the UK's first five Academic Health Science Partnerships. Through the partnership, we will be strengthening our links with other centres of excellence in clinical research.

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

The CQUIN Payment Framework is an arrangement between provider NHS trusts and their commissioner. The aim is to incentivise improvement work. This shows that we are working closely with the commissioners of our services.

- 0.5 per cent of GOSH's income in 2009/10 was conditional on achieving quality improvement and innovation goals.
- 1.5 per cent of our income for 2010/11 is conditional on achieving the quality improvements.

If you have any queries about the CQUIN arrangements relating to GOSH, please contact us at enquiries@gosh.nhs.uk

2009/10 CQUIN targets	2010/11 CQUIN targets
Establish a log of complaints	Undertake further inpatient and outpatient surveys, and achieve specific levels of satisfaction in certain areas
Develop a system for reporting delayed discharges	Implement the paediatric trigger tool – a method of assessing potential safety issues
Introduce an online patient-experience survey	Improve the quality and timeliness of discharge information
Audit the quality of discharge summaries	Improve percentage of children on total parenteral nutrition (TPN) who have blood-recorded measurements. Improve monitoring of patients on TPN for complications
	Reduce the number of surgical site infections in urology. Implementation of continuous surgical site infection surveillance for all inpatients, and 30 days post-discharge in urology and spinal surgery specialties
	Reduction in the rate of central venous catheter (CVC) related bloodstream infections. Achievement of target for ventilator-associated pneumonia (VAP) on the Paediatric Intensive Care Unit (PICU)

Quality Account mandatory statements approved by the Great Ormond Street Hospital (GOSH) Board
continued

What others say about GOSH

Statements from the Care Quality Commission (CQC)

The CQC is the organisation which regulates and inspects health and social care services in England.

GOSH is registered with the CQC without conditions, for the provision of the following regulated activities:

- treatment of disease, disorder and injury
- surgical procedures
- diagnostic and screening procedures
- transport, triage and medical advice provided remotely.

Part of the CQC's role is monitoring the quality of services provided across the NHS and taking corrective action where necessary. No such enforcement action has been taken by the CQC against GOSH during 2009/10.

Their assessment of quality is based on a range of external sources of information, some of which we are required to provide from our performance management systems, which are triangulated with information from other external monitoring sources. These are drawn together to create a Quality Risk Profile for the Trust. This data is frequently reviewed by the CQC and used to inform their decision as to when periodic reviews will take place. All newly registered trusts will be subject to a periodic review at any time within three months and two years of registration to assess how they demonstrate compliance with the registration quality and management standards. The Trust has not been subject to a periodic review during 2009/10, as registration only applied from 1 April 2010.

If any issue is raised as part of the data review process or based on other information received that might indicate that the quality of services has been compromised or is not meeting the required standard, a special review to look at the area of concern would be triggered. GOSH has not participated in any special reviews or investigations by the CQC during 2009/10.

Data quality

NHS managers and clinicians are dependent upon good-quality information derived from data from operational systems, to ensure that they are delivering appropriate services to patients. It is a strongly held view among NHS staff, including clinicians, administrators and managers – that they must have access to all of the data, whenever they need it, in a useable and accessible format, to support them in the delivery of high-quality care. It is crucial that the data that we capture about patients is accurate.

Secondary Uses Service (SUS) submissions

The SUS is the single source of comprehensive data to enable a range of reporting and analysis of healthcare in the UK. The SUS is run by the NHS Information Centre and based on data that is submitted by all provider trusts.

GOSH submitted records during 2009/10 to SUS, which are included in the latest published Hospital Episode Statistics (HES) data. Currently, we only have information from April 2009 to January 2010. The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - 90.4 per cent for admitted patient care
  - 90.1 per cent for outpatient care
- which included the patient's valid general medical practice code was:
  - 99.7 per cent for admitted patient care
  - 99.8 per cent for outpatient care.

Information Governance Toolkit attainment levels

The Information Governance Toolkit is a device that supports organisations in managing the data they have about patients. The score that organisations get reflects how well they have followed the guidance.

GOSH's score for 2009/10 for information quality and records management, assessed using the Information Governance Toolkit was 80 per cent. Eighty per cent puts GOSH in the highest level – the green section.

Clinical coding error rate

Clinical coding is the process by which the notes that clinical staff record are categorised to reflect the activity that happens to patients.

GOSH was subject to the Payment by Results clinical coding audit during 2009/10 by the Audit Commission. The Trust Healthcare Resource Group (HRG) error rate has reduced compared to the previous audits and it is implementing the recommendations from our 2008/09 review, indicating commitment to improving performance. This year, the Trust's HRG error rate is 4.5 per cent. The national average in 2008/09 was 8.1 per cent and the Strategic Health Authority (SHA) average error rate in 2008/09 was 12.1 per cent.

The most recent audit showed the following error rates:

- Primary diagnoses incorrect: 8 per cent
- Secondary diagnoses incorrect: 4.3 per cent
- Primary procedures incorrect: 6.3 per cent
- Secondary procedures incorrect: 7.8 per cent

Statement from our commissioners – The North Central London Commissioning Agency

The North Central London Commissioning Agency has reviewed this document and is pleased to assure this Quality Account for Great Ormond Street Hospital. We are responsible for the commissioning of services from all eight acute hospital trusts that are located in North Central London.

In this review, we have taken particular account of the identified priorities for improvement for the Trust during 2010/11 and how this work plan will enable real improvements for patients and their relatives for their care. We have also taken account of the views of the main Primary Care Trusts where their local residents access services from the Trust.

We have made the following specific comments about the Trust's plan and have discussed these directly with the Trust:

- Ensuring that detailed comments from NHS London have been incorporated and reflected as appropriate.
- Reflecting how the plan's quality of services shows a real commitment to improvement.
- Minor textual and diagrammatic changes to make it easier to read and understand.
- Consideration of how the Trust plans will be monitored and taken forward.

We look forward to continuing our partnership with the Trust in the agreement of how services are provided for its patients.

Statement from our Local Involvement Network (LINk) – Camden LINk

The Camden LINk had a few minor concerns regarding GOSH that were taken from NHS Choices, which had been addressed prior to the LINk's communication with the Trust. There is a high degree of patient/parent satisfaction with GOSH, which enjoys a worldwide reputation for high-quality services.

We are required to ask for input into our Quality Account from Camden Council's Overview and Scrutiny Committee. Due to the fact that the General Election campaign was ongoing, Camden's Overview and Scrutiny Committee was unable to provide us with a statement. However, they expect to be able to input into next year's Quality Account.

Review of quality performance
How we've done up to now.

Samuel and Tracy's story – and making it better for the next family
Samuel has been coming to Great Ormond Street Hospital for Children NHS Trust (GOSH) since he was five weeks old. He came because his local hospital was unable to identify why he kept having seizures.

Over the past four years, Samuel has been coming to the hospital on average once every three weeks. In this time, he has been accessed by lots of different specialties, including Neurology, Metabolic Medicine, Gastroenterology, Orthopaedics and Clinical Genetics.

Samuel's mother, Tracy, says that she loves GOSH, although not all of her experiences have been ideal. The frequent visits that her family have made to the hospital have given her insight into some ways that the service could improve for other families. She feels that parents need to be given more explanation about reasons why things happen. This feedback is reflected in our recent patient and family survey results. Although most parents felt they were told why treatment or tests were needed, three per cent felt this was explained poorly.

In an effort to improve aspects of GOSH, Tracy has become involved in the Managing Variability and Flow project in Neurosciences. The project is aiming to reduce waiting times and improve access to the neurology service by planning and communicating more effectively. Initially Tracy was concerned that the project was going to be too dry and focused on technical details. However, as time progressed she found working with the project group a positive experience.

She was keen to ensure that the views of other parents were included in the discussions the project group had. Therefore, she has worked with the Transformation team to adapt an experience-based design questionnaire that was developed by the Institute of Innovation and Improvement. The emotional mapping questionnaire is a way for parents and patients to map and record their experiences, and feelings, as they access different parts of GOSH. This information will allow us to plan to ensure that any processes we introduce are more centred around the needs of the families accessing GOSH. An example of this would be when staff don't explain 'why' certain things are happening. The tool that Tracy's been involved in developing, should help highlight to staff how this makes families feel.

The aim is to start using the tool in 2010, and Tracy will be asked to report on its progress in the 2011 Quality Account.

Variability and Flow Management (V&FM) – reducing variability in patient pathways
During 2009/10, the V&FM programme was launched. This involved the Transformation team facilitators and analysts engaging with hospital staff in supporting the redevelopment of five patient pathways. The projects are owned and driven by dedicated, multi-disciplinary teams of staff, who focus on reducing the variability in the provision of services to patients to increase flow, as well as improving patient safety and increasing efficiency.

The first five pathways have looked at:
- increasing the throughput of day case/short stay investigations for Endocrinology, Gastroenterology, Dermatology, Metabolic Medicine and Rheumatology.
- increasing the throughput of general surgical elective/emergency inpatients.
- increasing Neurology magnetic resonance imaging (MRI) utilisation and throughput for short stay/ day case patients requiring investigations/treatment.
- increasing the capacity of Cardiac Day Care.
- introducing an evidence-based system for theatre useage and bed booking, to increase neurosurgical throughput within the International Division.

The programme has 18 months left to run and is scheduled to look at 24 major patient pathways in total. We will report back on progress in the 2011 Quality Account.

Lisa and Sebastian's story
When Lisa and her husband, Mario, went in for their 20-week scan, they were excited to find out whether they were having a boy or girl. Instead, the sonographer had to share the news that one of their baby's hands did not appear to have developed as it should. Further scans led to the diagnosis of a cleft hand with four fingers rather than five. This was a rare condition that neither Lisa nor Mario had heard of and one where there was limited information even on the internet. It was difficult news to receive, especially as this was their first baby, and it raised so many questions and concerns for them as new-parents-to-be.

After some discussions at their original hospital, they were referred to GOSH. Once Lisa and her husband attended their appointment, they took great comfort in meeting the Plastics team who specialise in congenital hand deficiencies, and in learning more about the condition, as well as likely treatment routes to improve both functionality and cosmetics once their son was born. They finally felt that they could start to move from all their questions into the solution phase. Their son, whom they were to name Sebastian, was most likely going to need three operations, the first of which would be done at six months old. They were reassured to know that, while Sebastian's hand would always be different, the surgeries would help him to make the most of what he had.

About eight weeks after Sebastian was born, he came to an outpatient appointment and met the surgeon who would operate upon him for the first time. Lisa found this appointment particularly comforting, as it gave her confidence in the surgeon's expertise, and gave her a clearer understanding of what was going to happen.

Four months after this appointment, when Sebastian was six months old, he had his first operation. It was a difficult time for Lisa and Mario, and they were very grateful for the care that GOSH had provided. Six weeks later, Sebastian had his bandages removed and was happily playing with his new hand. When he was almost two, he had his second operation, which also, thankfully, went very well.

Today, despite not yet being three, Sebastian often says "Thank you for my operation" as he looks at his hand and massages cream in to help reduce the scars.

Lisa says that she felt really happy with the care that she received from GOSH, even though she still has some concerns for Sebastian's future, in terms of the development of his handwriting and the level of emotional support he might need.

However, Lisa says that there were some areas where it could have been better – like delays in receiving the results of a test that is still outstanding, and lack of clarity over the location of some outpatients appointments. These, as well as the gratitude that Lisa felt, have prompted her to become involved in two improvement projects. The first, Transforming Care on Your Ward, was a project designed to maximise the use of ward staff's time. The second project, Advanced Access, is aiming to work with clinical teams to reduce waiting times for appointments. She feels that GOSH is a very special organisation, and one that is eager to hear the 'parents' voice' in order to further improve the care already provided to so many children. She hopes that her involvement will make a little difference to an organisation that has made a big difference in her family's life.

Advanced Access – helping patients to see clinicians more quickly
The Advanced Access project aims to deliver an outcome whereby patients have to wait no longer than two weeks for an appointment at GOSH.

Twenty specialties began the Advanced Access programme in 2009/10, of which 11 are now delivering. A further eight specialties started at the beginning of 2010/11, and all 37 are planned to deliver by the end of 2010. Each of the delivering services is now able to offer first appointments to new patients within two weeks of referral acceptance.

The project looks at demand and capacity, acceptance and discharge criteria, administrative process and flow within clinics. 'Pooling' criteria within specialties are then agreed, and administrative process and clinic templates are modified to ensure that every patient is offered the right appointment as soon as is appropriate.

Whilst the Transformation team are working on a number of other initiatives that relate to the development of GOSH services – both at the main hospital site and in Haringey and the North Middlesex University Hospital – we wanted to highlight the Advanced Access and V&FM programmes. This is because they are improving the speed with which patients can get seen – and therefore directly improving patient care.

This is our first Quality Account, and we are keen to ensure that the account is a useful document that helps patients and families to understand GOSH. If you have any suggestions for next year's Quality Account, or any queries about this year's document, please contact us at enquiries@gosh.nhs.uk

Governance

Three-year-old Dominic has been in and out of hospital a lot for an undiagnosed gastro problem. This time he has been in for seven weeks and isn't sure when he will be able to go home, but his brother and sister are keeping him amused with pots of slime and lollipops.

Trust Board roles and responsibilities

The Trust Board has responsibility for setting the strategic direction of the Trust and for managing significant risks. The Board receives assurances that the Trust is fulfilling its responsibilities and complying with regulatory and legislative requirements.

The Board delegates specific functions to committees identified within terms of reference. The Trust is assured, by a review of its effectiveness in 2010, that it operates a balanced and unified Board, one which maintains an appropriate balance of skills and experience.

Details of the remaining terms of office of the chair and non-executive directors are as follows:

Name	First appointment	To	Extended to
Baroness Tessa Blackstone	01/01/09	31/12/13	
Ms Yvonne Brown	01/07/08	30/06/12	
Professor Andrew Copp	01/02/03	18/04/11	
Mr Andrew Fane	01/11/01	31/10/09	30/04/11
Ms Mary MacLeod	01/11/08	31/10/12	
Mr Charles Tilley	01/09/07	31/08/11	

Effectiveness review

In March 2010, in preparation for Foundation Trust status, the Trust Board commissioned the NHS Institute to undertake an independent assessment of the effectiveness of the Board and how it functions. The findings of this review have been used to inform the Board development programme.

The directors on the Board undergo an annual performance review against agreed objectives, skills and competencies, and agree personal development plans for the forthcoming year.

Trust Board
Non-Executive Directors

Baroness Tessa Blackstone BSc (Soc) PhD

Chairman of the Trust Board

Baroness Blackstone leads a team of five non-executive directors, who contribute to the development of strategy for the Trust, monitor its activity and represent Great Ormond Street Hospital for Children NHS Trust (GOSH) in the immediate and wider community.

Declared interests

- Member, House of Lords
- Vice Chancellor, University of Greenwich
- Chair, Royal Institute of British Architects Trust
- Member, Royal Opera House Board
- Director, UCL Partners.

Ms Yvonne Brown LLB Solicitor

Non-Executive Director

Yvonne Brown is a solicitor whose main areas of expertise are children, child protection, family law, and education. In September 2005, she was appointed to the Solicitors Regulation Authority, where she chairs the Scrutiny Committee. Yvonne sits on the Trust Audit Committee and is also the non-executive Patient Environment Action Team (PEAT) lead.

Declared interests

- Member, Solicitors Regulation Authority
- Consultant, Legal Management Consulting
- Peer reviewer, Legal Service Commissioner.

Professor Andrew Copp MBBS DPhil FRCPath FMed Sci

Non-Executive Director

Andrew Copp is the Director of the UCL Institute of Child Health (ICH). He is Professor of Developmental Neurobiology at the Institute, as well as an honorary consultant for the hospital.

Declared interests

- Director, ICH
- Honorary Director of Research, Children's Trust, Tadworth
- Associate Editor, *Birth Defects Research Part A*, USA
- Board Member, Bo Hjeldt Foundation, Amsterdam.

Mr Andrew Fane MA FCA

Non-Executive Director

Andrew Fane is a Non-Executive Director of the Trust and an associate special trustee of Great Ormond Street Hospital Children's Charity. Andrew is Chair of the Clinical Governance Committee and a member of the Audit Committee and Redevelopment Programme Steering Committee. He is a former Chairman of the special trustees of Great Ormond Street Hospital Children's Charity.

Declared interests

- Chairman, Friends of the Children of Great Ormond Street
- Chairman of Governors, The Children's Hospital School at Great Ormond Street and University College London Hospitals (UCLH)
- Chairman, General Charitable Trust, ICH
- Chairman, Child Health Research Appeal Trust, ICH
- Chairman, Bill Marshall Memorial Fund, ICH
- Director, Genex Biosystems Ltd, ICH
- Director, ICH Productions Ltd, ICH
- Trustee, The CP Charitable Trust (supporters of ICH)
- Trustee, The Coram Family
- Chairman, The Foundling Museum
- Chairman, Audit Committee, English Heritage
- Trustee, League of Remembrance
- Wife – Clare Lucy Marx CBE MB BS FRCS is a consultant orthopaedic surgeon at Ipswich Hospital NHS Trust, a former President of the British Orthopaedic Association and a member of the Council of the Royal College of Surgeons of England.

Ms Mary MacLeod OBE MA CQSW DUniv

Non-Executive Director

Mary MacLeod sits on the Trust Clinical Governance Committee and is the non-executive equality and diversity lead. She has a long and distinguished career in family policy, academia and social work. Until her retirement in 2009, Mary was Chief Executive of the Family and Parenting Institute.

Declared interests

- Member, Child and Family Court Advisory Service (Cafcass)
- Member, Internet Watch Foundation
- Member, Video Standards Council
- Member, Gingerbread
- Member, Executive Board, UK Council for Child Internet Safety
- Member, Thomas Coram Research Unit Advisory Board
- Chair, Department for Children, Schools and Families Advisory Group on Private Fostering
- Chair, Safenetwork Advisory Board
- Chair, Respect Research Advisory Group on domestic violence.

Mr Charles Tilley FCA

Non-Executive Director

Charles Tilley is the Chief Executive Officer at The Chartered Institute of Management Accountants (CIMA), and is a qualified accountant. He chairs the Trust's Audit Committee.

Declared interests

- Chief Executive, Chartered Institute of Management Accountants (CIMA) (including acting as a corporate representative for dormant companies)
- Non-Executive Director and member, Audit and Asset and Liability committees, Ipswich Building Society
- Director, Seaview Yacht Club Limited.

Trust Board
Executive Directors

Dr Jane Collins MSc FRCP FRCPCH
Chief Executive
Jane Collins is responsible for delivering the strategic and operational plans of the hospital through her Executive team. She leads the Transformation programme to improve the Trust's systems and processes and to increase efficiency and reduce costs. Jane sits on the UCL Partners Board.

Declared interests
- Member, Advisory Board, Judge Business School, University of Cambridge
- Chief Executive, Great Ormond Street Hospital Children's Charity
- Trustee, Child Health Research Appeal Trust and the General Charitable Trust of the UCL Institute of Child Health
- Director, UCL Partners
- Director, Great Ormond Street International Hospital Community Interest Company (dormant)
- Husband – Mr David Evans is a Trustee of Shooting Star Children's Hospice.

Dr Barbara Buckley MB BS FRCP FRCPCH
Co-Medical Director
Dr Buckley is responsible for postgraduate medical education and training for doctors, medical workforce development, partnership services, and public health within the Trust. In addition, she works clinically at the Children's Developmental Centre in Haringey. She has a long-standing interest in medical management.

Declared interests
- None

Ms Fiona Dalton MA (Hons) (Oxon)
Deputy Chief Executive/ Director of Operations
Fiona Dalton is responsible for the operational management of clinical services within the Trust, and also leads the strategic planning, performance management and operational HR functions.

Declared interests
- None

Professor Judith Ellis MBE PhD MSc BSc (Hons) RN Adult and Child PGCE
Outgoing Director of Nursing, Education and Workforce Development (until January 2010)
Judith Ellis was responsible for the professional development of nursing and all other non-medical clinical staff groups. She was also responsible for workforce development and for education and training for all staff in the Trust. She was lead director for child protection.

Declared interests
- Member, Nursing and Midwifery Council
- Member, General Nursing Council
- Trustee, League of Remembrance
- Trustee, Help for Hurting Children in Africa.

Mr Robert Evans BSc (Hons) BDS (Hons) MScD FDSRCS (Eng) MOrth RCS (Ed)
Co-Medical Director
Robert Evans is responsible for performance and standards (including patient safety). He is also the Trust's Caldicott Guardian. He leads on clinical governance and is co-ordinating the development of outcome measures. Mr Evans continues to practice as an orthodontist and has sub-specialised in the management of children and adolescents with complex congenital craniofacial deformities.

Declared interests
- Patron, Headlines (Craniofacial Support Group)
- Private practice
- Chair, London Dental Forum (London Deanery)
- Member, Patient Safety Counsel, Addenbrooke's Hospital, Cambridge.

Mrs Claire Newton MA (Cantab) ACA MCT
Chief Finance Officer
Claire Newton is responsible for the financial management of the Trust. Claire also leads on information governance and information technology. She is a qualified accountant and member of the Association of Corporate Treasurers.

Declared interests
- Director, Great Ormond Street International Hospital Community Interest Company (dormant).

Mrs Janet Williss RN Adult and Child BSc (Hons) MSc
Acting Director of Nursing, Education and Workforce Development (from January 2010)

Declared interests
- Member, Fitness to Practice Panel, Nursing and Midwifery Council.

Non-Trust Board
Other Directors

Professor David Goldblatt MB ChB PhD MRCP FRPCH (Non-Trust Board)
Director of Clinical Research and Development
David Goldblatt leads the strategic development of clinical research and development across the Trust and the UCL Institute of Child Health. He is an honorary consultant immunologist and leads a research team at the Institute.

Declared interests
- Programme Director for Child Health, UCL Partners
- Chairman, Wellcome Trust Immunology and Infectious Disease Funding Committee
- Occasional Member, expert panels/ advisory boards for Wyeth Lederle Vaccines, Sanofi Pasteur, Novartis and Intercell
- Member, Department of Health, Strategic Advisory Group on Pandemic Influenza.

Mr William McGill MSc (Non-Trust Board)
Director of Redevelopment
William McGill leads the work to redevelop the Trust's buildings. The redevelopment is being undertaken in stages, so that the hospital can continue to function while the work is being carried out. One of his key roles is to co-ordinate this complicated process.

Declared interests
- None

Mr Mark Large MBCS CITP MCMI (Non-Trust Board)
Director of Information Technology
Mark Large leads on IT for the Trust, with responsibility for updating the IT infrastructure, and for the creation and delivery of the IT Strategy, in turn supporting the achievement of Trust objectives.

Declared interests
- None

Mr Trevor Clarke (Non-Trust Board)
Director of the International and Private Patients Division
Trevor Clarke is responsible for the strategic development and management of the Trust's International and Private Patients Division.

Declared interests
- None

Ms Dorothea Hackman
Associate Non-Executive Director
Dorothea is the Chair of the Great Ormond Street Hospital Members' Forum. She serves as an Associate Non-Executive Director in an ex-officio capacity.

Declared interests
- Director of Education, Royal London Society for the Blind
- Principal, Dorton College of Further Education
- Headteacher, Dorton House School
- Chair, Great Ormond Street Hospital Members' Forum
- Governor, The Children's Hospital School at Great Ormond Street
- Volunteer, Child Death Helpline
- Trustee, St Pancras Lands Trust
- Lay Chair, South Camden Deanery Synod.

Attendance at Board of Directors and Board committee meetings

During 2009/10, the Trust Board held 10 Trust Board meetings – eight of these included sessions in public. In February and October, the Board held development sessions. The June meeting was called to approve the annual accounts. The Board did not meet in August or December.

	Trust Board	Audit Committee	Clinical Governance Committee
Number of meetings 2009/10	10	4	5
Baroness Tessa Blackstone (Chairman)	10	Not a member	Not a member
Ms Yvonne Brown (Non-Executive Director)	10	4	Not a member
Dr Barbara Buckley (Co-Medical Director)	10	Not a member	Not a member
Dr Jane Collins (Chief Executive)	10	Invitee – 3	4
Professor Andrew Copp (Non-Executive Director)	8	Not a member	0
Ms Fiona Dalton (Deputy Chief Executive/ Director of Operations)	9	Invitee – 3	4
Professor Judith Ellis (Director of Nursing, Education and Workforce Development)	5 (until January 2010)	Not a member	3
Mr Robert Evans (Co-Medical Director)	8	Not a member	5
Mr Andrew Fane (Non-Executive Director)	9	2	5
Ms Mary MacLeod (Non-Executive Director)	9	Not a member	5
Mrs Claire Newton (Chief Finance Officer)	9	Invitee – 4	Not a member
Mr Charles Tilley (Non-Executive Director)	10	4	Not a member
Mrs Janet Williss (Acting Director of Nursing, Education and Workforce Development)	3 (from January 2010)	Not a member	2

Trust Board committees – role and membership

The Board delegates functions to the following subcommittees:

Audit Committee
The committee considers the effectiveness of the Trust's systems of integrated governance and non-clinical risk management, and the financial and non-financial internal controls that support the achievement of the organisation's objectives. It works alongside the Trust's Clinical Governance Committee, which oversees clinical governance and risk management. The Audit Committee meets at least four times per year, which ensures coverage of its terms of reference and the Trust's governance and risk framework. This includes receiving reports from both external and internal auditors. Membership of the committee is as follows:

Ms Yvonne Brown
Mr Michael Dallas (independent external committee member)
Mr Andrew Fane
Mr Charles Tilley (Chair)

Clinical Governance Committee
The Clinical Governance Committee is a sub-committee of the Trust Board with delegated authority to review clinical governance and risk management matters. Its membership includes senior clinical and non-clinical managers as well as Executive and Non-Executive Directors. The committee meets at least four times per year, and receives reports from internal auditors and clinical audit.

Dr Jane Collins
Professor Andrew Copp
Ms Fiona Dalton
Mr Robert Evans
Mr Andrew Fane (Chair)
Ms Mary MacLeod
Ms Janet Williss

Remuneration Committee
See page 98 for an overview of the role and function of this committee.

Statement on audit information by each Director

The Directors have confirmed that, as far as they are aware, there is no relevant audit information of which the auditors are unaware. The Directors have each confirmed that they have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that it has been communicated to the auditor.

Jane Collins
Chief Executive
9 June 2010

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *Accountable Officers Memorandum* issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets, and to assist in the implementation of corporate governance.
- value for money is achieved from the resources available to the Trust.
- the expenditure and income of the Trust have been applied to the purposes intended by Parliament and conform to the authorities which govern them.
- effective and sound financial management systems are in place.
- annual statutory accounts are prepared in a format directed by the secretary of state with the approval of the Treasury, to give a true and fair view of the state of affairs as at the end of the financial year, and the income and expenditure, recognised gains and losses, and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Jane Collins
Chief Executive
9 June 2010

Statement of Directors' responsibilities in respect of the accounts

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The secretary of state, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust, and of the income and expenditure, recognised gains and losses, and cash flows for the year. In preparing these accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the secretary of state with the approval of the Treasury.
- make judgements and estimates which are reasonable and prudent.
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The Directors are responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Trust and enable them to ensure that the accounts comply with requirements outlined in the aforementioned direction of the secretary of state. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm that, to the best of their knowledge and belief, they have complied with the above requirements in preparing the accounts.

By order of the Board

Jane Collins
Chief Executive
9 June 2010

Claire Newton
Chief Finance Officer
9 June 2010

External audit

The Trust's external auditors, Deloitte LLP, are appointed by the Audit Commission.

Independent auditors' report to the Board of Great Ormond Street Hospital for Children NHS Trust

We have audited the financial statements of Great Ormond Street Hospital for Children NHS Trust for the year ended 31 March 2010 under the Audit Commission Act 1998. The financial statements comprise the statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers' equity, the statement of cash flows and the related notes one to 32. These financial statements have been prepared in accordance with the accounting policies directed by the secretary of state with the consent of the Treasury as relevant to the National Health Service set out within them. We have also audited the information in the remuneration report that is described as having been audited.

This report is made solely to the Board of Great Ormond Street Hospital for Children NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Board those matters we are required to state to them in an auditors' 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 Board as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditors

The Directors' responsibilities for preparing the financial statements in accordance with directions made by the secretary of state are set out in the statement of Directors' responsibilities.

Our responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view, in accordance with the accounting policies directed by the secretary of state as being relevant to the National Health Service in England. We report whether the financial statements and the part of the remuneration report to be audited have been properly prepared in accordance with the accounting policies directed by the secretary of state as being relevant to the National Health Service in England. We report to you whether, in our opinion, the information which comprises the commentary on the financial performance included within the Directors' report, included in the Annual Report, is consistent with the financial statements.

We review whether the Directors' statement on internal control reflects compliance with the Department of Health's requirements, set out in *Guidance on Completing the Statement on Internal Control 2009/10* issued in February 2010. We report if it does not meet the requirements specified by the Department of Health or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the Directors' statement on internal control covers all risks and controls. Neither are we required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

We read the other information contained in the Annual Report as described in the contents section, and consider whether it is consistent with the audited financial statements. This other information comprises the foreword, the unaudited part of the remuneration report, the Chairman's statement and the remaining elements of the Directors' report. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any further information.

Basis of audit opinion

We conducted our audit in accordance with the Audit Commission Act 1998, the Code of Audit Practice issued by the Audit Commission and International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the remuneration report to be audited. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and the financial statements and the part of the remuneration report to be audited have been properly prepared. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the remuneration report to be audited.

Opinion

In our opinion:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by the secretary of state as being relevant to the National Health Service in England, of the state of the Trust's affairs as at 31 March 2010 and of its income and expenditure for the year then ended.
- the financial statements and the part of the remuneration report to be audited have been properly prepared in accordance with the accounting policies directed by the secretary of state as being relevant to the National Health Service in England.
- information which comprises commentary on the financial performance included within the directors' report, included within the Annual Report, is consistent with the financial statements.

Conclusion on arrangements for securing economy, efficiency and effectiveness in the use of resources

Directors' responsibilities

The Directors are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and regularly to review the adequacy and effectiveness of these arrangements.

Auditor's responsibilities

We are required by the Audit Commission Act 1998 to be satisfied that proper arrangements have been made by the Trust for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion in relation to proper arrangements, having regard to the criteria for NHS bodies specified by the Audit Commission. We report if significant matters have come to our attention which prevent us from concluding that the Trust has made such proper arrangements. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Conclusion

We have undertaken our audit in accordance with the Code of Audit Practice and having regard to the criteria for NHS bodies specified by the Audit Commission and published in December 2006, we are satisfied that, in all significant respects, Great Ormond Street Hospital for Children NHS Trust made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2010.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Heather Bygrave FCA BA (Hons) (Engagement lead)
for and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom
9 June 2010

Statement on internal control

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets, for which I am personally responsible as set out in the Accountable Officer Memorandum.

As Chief Executive, I provide performance reports to the Chief Executive of the London Strategic Health Authority, who monitors progress and achievement, and I also engage regularly with Chief Executives of Primary Care Trusts and other acute trusts within the Strategic Health Authority, which include the lead commissioners of services from the Trust.

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 provide only reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the Trust for the year ended 31 March 2010 and up to the date of approval of the Annual Report and Accounts.

3. Capacity to handle risk

The Trust is committed to providing high-quality patient services in an environment that is safe and secure. As Chief Executive, I have overall responsibility for risk management and for ensuring that all risk management processes in the organisation are integrated. The risk management strategy sets out the specific roles and responsibilities of the Trust's committees in respect of risk management and defines the delegation of responsibility for specific aspects of risk through the Executive Directors.

The Trust believes that good risk management is an integral part of an efficient and effective organisation, and as such, training in risk management is provided for all staff relevant to their grade and situation to ensure that they have the necessary skills and knowledge and are competent to identify, control and manage risk within their work environment. This is delivered at induction, via mandatory updates and through the policies and procedures in place. To support staff during the risk assessment process, expert guidance and facilitation are available from members of the patient and staff safety team, who are responsible for the co-ordination of risk management, clinical governance, and health and safety. This team also disseminates good practice arising from both external sources and internal exemplars within the Trust.

Actions taken to reduce risk are regularly monitored and reported, and trends analysed at unit, department and Management Board level. Before submission to the Trust Board, these are then reported and reviewed by committees of the Board – the Clinical Governance Committee and the Audit Committee. Evaluation of their effectiveness promotes both individual and organisational learning.

4. The risk and control framework

The key elements of the risk management strategy are to identify, manage and control risks appropriately, whether clinical, non-clinical or financial. This is achieved by providing a rigorous organisational framework, which enables co-ordinated risk management activity and the early identification of risks. It provides a safe working environment for staff and for patients, and reduces unnecessary expenditure. In addition, it ensures that all staff are aware of their roles and responsibilities in managing risks, and describes the processes in place by which risk is assessed, controlled and monitored.

Risks are identified through diverse sources of information such as formal risk assessments, audit data, clinical and non-clinical incident reporting, complaints, claims, patient or user feedback, information from partnership arrangements, operational reviews and 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.

The Trust recognises the importance of the involvement of stakeholders. This underpins the process to ensure 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 of these stakeholder interests, whether they be those of patients, the public, staff or service users.

A fundamental principle of the framework is the devolution of responsibility for achieving Trust objectives and managing risk to staff at all levels of the organisation. The risk management operational procedure sets out guidance for the maintenance of risk registers for all departments within the Trust.

Risks are evaluated using a 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 are identified for accepted risks, with the risk assessment score informing the level of control required. 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.

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 Management Board. This group uses the Information Governance Toolkit assessment to inform its review.

The Trust's Assurance Framework is based on structured and ongoing assessment of the key risks to the Trust of not achieving its objectives. The Assurance Framework is mapped to the *Standards for Better Health,* and to other internal and external risk management processes such as the NHS Litigation Authority Standards, internal and external audit recommendations and the Information Governance Toolkit. It has been monitored and updated throughout the year.

The Assurance Framework is used to provide information concerning the controls in place to manage the key risks, and details the evidence provided to the Board indicating that the control is operating. Use of the Assurance Framework and investigations of incidents have identified control gaps in three areas: maintenance of estates equipment; fire prevention processes; and inefficiency in processes used to compile and send outpatient discharge letters, resulting in a failure to meet the government's target in this area.

In respect of the first point, the Trust declared non-compliance with core standard C21 of the *Standards for Better Health* (healthcare services are provided in environments which promote effective care and optimise health outcomes by being well-designed and well-maintained, with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises) following investigation of an incident in October 2009.

Detailed action plans have been put in place as a result of investigations of the two incidents to remedy the control weaknesses identified.

Additional systems have been put in place to increase the speed at which discharge letters are produced and despatched, and progress has been made.

Assurance gaps were also identified in respect of the first two points and have been remedied.

The Trust has progressively strengthened its controls on information governance, but our Information Governance Toolkit return to the Department of Health on 31 March 2010 identified areas for improvement, particularly in relation to information-sharing protocols with other organisations. An Information Governance Steering Group reporting to the Audit Committee will monitor the action plan to improve information governance procedures. However, the Trust has reported two information governance incidents as serious untoward incidents in the current financial year. These were the despatch of an email including details of a patient's complaint to a third party in error, and the despatch of an email containing confidential staff details using a Trust-wide email address which included six external email recipients.

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 of 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 UK Climate Projections (UKCIP09) weather projects, to ensure that this organisation's obligations under the Climate Change Act (2008) and the adaptation reporting requirements are complied with. Given that this is the first time that probabilistic projections have been produced, there will be a period of learning regarding how we, as decision makers, can best understand and make use of them. This will coincide with the first round of adaption reporting when it takes place.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways; by discussions held by the Trust Board, the Audit Committee, the Clinical Governance Committee, and by reports from internal and external auditors and the Assurance Framework Group.

Statement on internal control
continued

The Assurance Framework provides me with evidence that the effectiveness of controls that manage the risks to the organisation of not achieving its principal objectives has been reviewed. The Assurance Framework Group – which comprises executives and other staff responsible for risk management and internal audit – ensures that all such risks and actions are appropriately reflected in the Trust's Assurance Framework. Plans to address weaknesses and ensure continuous improvement of the system are in place, and are monitored by the Assurance Framework Group and the relevant committees of the Board, specifically the Audit Committee and the Clinical Governance Committee. Summary reports are considered periodically by the Board.

The head of internal audit provides me with an opinion of the overall arrangements for gaining assurance through the Assurance Framework and of the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

My review is also informed by the following:

- Core Standards for Better Health Self-Assessment Declaration and the registration requirements
- NHS Litigation Authority Clinical Negligence Scheme for Trusts (CNST) accreditation process
- internal and external audit reports
- Auditors' Local Evaluation (ALE) assessment.

Other sources of evidence include the Risk Pooling Scheme for Trusts Level 1 accreditation; the baseline assessment on the information governance framework; the Health and Safety Executive review; the Patient Environment Action Team assessment and relevant reviews by the Royal Colleges; and consideration of performance against national targets.

The Trust was reviewed for Level 2 compliance with the NHS Litigation Authority (Clinical Negligence Scheme for Trusts) Risk Management Standards during the year and was found to be compliant.

The effectiveness of the system of internal control is maintained through reviews and monitoring of:

1. high-level risk registers derived from self-assessment of compliance with the core standards, CNST standards, the ALE key lines of enquiry, external targets, and other standards applicable to the Trust.
2. internal and external audit recommendations, and the related action plans.

These reviews have not identified any significant control issues other than the following matters:

- The lapse on C21of core standards referred to in section four above, for which remedial action was put in place before the end of the year.
- The serious untoward incidents relating to information governance referred to in section four above.

The Trust 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.

Jane Collins
Chief Executive
9 June 2010

International Financial Reporting Standards (IFRS)

This is the first Annual Report including accounts prepared in accordance with IFRS, which was a requirement for all NHS trusts. This has resulted in a change in titles and format of the primary financial statements and some changes to accounting policies.

Statement of comprehensive income
For the year ended 31 March 2010

	Note	2009/10 £000	2008/09 £000
Revenue			
Revenue from patient care activities	4	**267,547**	230,510
Other operating revenue	5	**50,599**	60,940
Operating expenses	7	**(309,915)**	(285,190)
Operating surplus		**8,231**	6,260
Finance costs			
Investment revenue	13	**36**	476
Other gains (losses)	14	**487**	(512)
Finance costs	15	**(31)**	(29)
Surplus for the financial year		**8,723**	6,195
Public dividend capital dividends payable		**(5,172)**	(4,997)
Retained surplus for the year		**3,551**	1,198
Other comprehensive income			
Impairments and reversals		**(13,052)**	(76,211)
Gains on revaluations		**9,786**	15,988
Receipt of donated/government-granted assets		**18,681**	14,269
Transfers from donated and government grant reserves		**(7,365)**	(6,446)
Total comprehensive income for the year		**11,601**	(51,202)

The notes on pages 71 to 96 form part of these accounts.

Statement of financial position
As at 31 March 2010

	Note	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Non-current assets				
Property, plant and equipment	17	**248,606**	227,640	270,496
Intangible assets	16	**472**	552	507
Trade and other receivables	21	**9,039**	8,126	8,526
Total non-current assets		**258,117**	236,318	279,529
Current assets				
Inventories	20	**5,173**	2,949	2,771
Trade and other receivables	21	**36,555**	26,409	29,949
Cash and cash equivalents	22	**8,485**	5,875	9,843
Total current assets		**50,213**	35,233	42,563
Total assets		**308,330**	271,551	322,092
Current liabilities				
Trade and other payables	23	**(33,065)**	(23,130)	(30,518)
Other liabilities	24	**(3,008)**	(3,228)	(3,777)
Provisions	25	**(1,549)**	(1,147)	(994)
Net current assets		**12,591**	7,728	7,274
Total assets less current liabilities		**270,708**	244,046	286,803
Non-current liabilities				
Other liabilities	24	**(7,728)**	(8,126)	(8,526)
Provisions	25	**(1,304)**	(1,202)	(1,279)
Total assets employed		**261,676**	234,718	276,998
Financed by taxpayers' equity				
Public dividend capital		**109,732**	94,375	85,453
Retained earnings		**9,515**	5,951	3,327
Revaluation reserve		**41,996**	41,945	53,785
Donated asset reserve		**97,126**	89,296	131,267
Government grant reserve		**193**	37	52
Other reserves		**3,114**	3,114	3,114
Total taxpayers' equity		**261,676**	234,718	276,998

The financial statements on pages 67 to 96 were approved by the Board on 9 June 2010 and signed on its behalf by

Dr Jane Collins
Chief Executive
9 June 2010

Statement of changes in taxpayers' equity

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Government grant reserve £000	Other reserves £000	Total £000
Changes in taxpayers' equity for 2009/10							
Balance at 1 April 2009	94,375	5,951	41,945	89,296	37	3,114	234,718
Total comprehensive income for the year							
Retained surplus for the year	0	3,551	0	0	0	0	3,551
Transfers between reserves	0	13	0	(13)	0	0	0
Impairments and reversals	0	0	(8,123)	(4,929)	0	0	(13,052)
Net gain on revaluation of property, plant and equipment	0	0	8,174	1,612	0	0	9,786
Receipt of donated/government-granted assets	0	0	0	18,509	172	0	18,681
Transfers from donated asset/government grant reserves	0	0	0	(7,349)	(16)	0	(7,365)
New PDC received	15,357	0	0	0	0	0	15,357
Balance at 31 March 2010	**109,732**	**9,515**	**41,996**	**97,126**	**193**	**3,114**	**261,676**
Changes in taxpayers' equity for 2008/09							
Balance at 31 March 2008							
As previously stated	85,453	16,880	41,126	131,267	52	3,114	277,892
Prior period adjustment	0	(13,553)	12,659	0	0	0	(894)
Restated balance	85,453	3,327	53,785	131,267	52	3,114	276,998
Total comprehensive income for the year							
Retained surplus/(deficit) for the year	0	1,198	0	0	0	0	1,198
Transfers between reserves	0	1,426	(1,426)	0	0	0	0
Impairments and reversals	0	0	(20,561)	(55,650)	0	0	(76,211)
Net gain on revaluation of property, plant and equipment	0	0	10,147	5,840	1	0	15,988
Receipt of donated/government-granted assets	0	0	0	14,269	0	0	14,269
Transfers from donated asset/government grant reserves	0	0	0	(6,430)	(16)	0	(6,446)
New PDC received	11,199	0	0	0	0	0	11,199
PDC repaid in year	(2,277)	0	0	0	0	0	(2,277)
Balance at 31 March 2009	94,375	5,951	41,945	89,296	37	3,114	234,718

Statement of cash flows
For the year ended 31 March 2010

	Note	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Operating surplus		**8,231**	6,260
Depreciation and amortisation		**15,348**	11,757
Impairments and reversals		**3,817**	4,541
Transfer from donated asset reserve		**(7,349)**	(6,430)
Transfer from government grant reserve		**(16)**	(16)
Dividends paid		**(5,124)**	(4,997)
(Increase) in inventories		**(2,224)**	(178)
(Increase)/decrease in trade and other receivables		**(5,359)**	2,801
Increase/(decrease) in trade and other payables		**3,452**	(5,931)
(Decrease) in other current liabilities		**(618)**	(949)
Increase in provisions	25	**473**	47
Net cash inflow from operating activities		**10,631**	6,905
Cash flows from investing activities			
Interest received		**36**	476
(Payments) for property, plant and equipment	17	**(36,777)**	(35,493)
Proceeds from disposal of plant, property and equipment		**500**	0
(Payments) for intangible assets	16	**(118)**	(186)
Net cash (outflow) from investing activities		**(36,359)**	(35,203)
Net cash (outflow) before financing		**(25,728)**	(28,298)
Cash flows from financing activities			
Public dividend capital received		**15,357**	11,199
Public dividend capital repaid		**0**	(2,277)
Other capital receipts		**12,981**	15,408
Net cash inflow from financing		**28,338**	24,330
Net increase/(decrease) in cash and cash equivalents		**2,610**	(3,968)
Cash and cash equivalents at the beginning of the financial year		**5,875**	9,843
Cash and cash equivalents at the end of the financial year	22	**8,485**	5,875

Notes to the accounts

1. Accounting policies

The secretary of state for health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the *NHS Trusts Manual for Accounts,* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/10 *NHS Trusts Manual for Accounts* issued by the Department of Health. The accounting policies contained in that manual follow international financial reporting standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *NHS Trusts Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They 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, inventories, and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions regarding 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.

1.3.1 Critical judgements 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 which have the most significant effect on the amounts recognised in the financial statements.

a As described in note 1.7, 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 which the Trust has decided are appropriate.

b The Trust leases a number of buildings which 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.

c 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.

1.3.2 Key sources of estimation uncertainty

There are no areas subject to estimation that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.4 Revenue

Revenue 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 revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end is 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.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid – for example, by an insurer. The Trust recognises the income when it receives the money from the Department of Work and Pensions' Compensation Recovery Unit. The income is measured at the agreed tariff for the treatments provided to the injured individual.

1.5 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

Former and current employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general 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.

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 expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the pensions reserve and reported as an item of other comprehensive income.

1.6 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, 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
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment is measured initially at cost, representing the cost 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 revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost.

Until 31 March 2008, the depreciated replacement cost of specialised buildings was estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets, and where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury has agreed that NHS trusts must apply these new valuation requirements by 1 April 2010 at the latest.

The Trust engaged the services of the district valuer to revalue all of its buildings to a modern equivalent value as part of the International Financial Reporting Standards (IFRS) exercise, and to meet the new standard approach adopted by HM Treasury. These new values have been recognised in these accounts. During the period of the hospital redevelopment programme, the Trust will be conducting more frequent valuations as and when projects are completed and buildings are brought into use.

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

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008, indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives, and new fixtures and equipment are carried at depreciated historic cost, as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve, except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the statement of comprehensive income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised, and any existing carrying value of the item replaced is written out and charged to operating expenses.

1.8 Intangible assets

Recognition and measurement

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at cost and amortised to determine fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.9 Depreciation, amortisation and impairments

Freehold land, properties under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. 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. Assets held under finance leases are depreciated over their estimated useful lives.

Periodically, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss, and if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there, and thereafter, to the revaluation reserve.

1.10 Donated assets
Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to the donated asset reserve. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the donated asset reserve, and each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to offset the expenditure. On sale of donated assets, the net book value is transferred from the donated asset reserve to retained earnings.

1.11 Government grants
Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate. Capital grants are credited to the government grant reserve and released to operating revenue over the life of the asset in a manner consistent with the depreciation and impairment charges for that asset. Assets purchased using government grants are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the government grant reserve, and each year, an amount equal to the depreciation charge on the asset is released from the government grant reserve to offset the expenditure.

1.12 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value, or if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Where a lease is for land and buildings, the land and building components are separated. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

The Trust also has peppercorn lease arrangements in place. In these cases, if the lease is assessed to be a finance lease, the lease is valued at fair value on inception of the lease agreement and then amortised over the life of the lease agreement.

The Trust revalues property finance leases on the same basis and with the same regularity as owned property assets.

1.13 Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation of fair value due to the high turnover of stocks.

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

1.15 Provisions
Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2 per cent in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or by announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.16 Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 25.

1.17 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 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 as and when they become due.

1.18 Financial assets
Financial assets are recognised when the Trust becomes party to the financial instrument contract, or in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified in the following categories: financial assets at fair value through profit and loss, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss', are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed.

1.19 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument, or in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.20 Value Added Tax (VAT)
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.

1.21 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.22 Public Dividend Capital (PDC) and PDC dividend
The PDC represents taxpayers' equity in the NHS trust. At any time, the secretary of state can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as PDC dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5 per cent) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. Prior to 2009/10, the PDC dividend was determined using forecast average relevant net assets, and a note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

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

The Trust does not have the power to influence or control the financial and operating policies of Great Ormond Street Hospital Children's Charity.

1.25 Accounting standards that have been issued but have not yet been adopted

The following standards and interpretations have been adopted by the European Union but are not required to be followed until 2010/11. None of them is expected to impact upon the Trust's financial statements.

- International Accounting Standards (IAS) 27 (revised) *Consolidated and Separate Financial Statements.*
- Amendment to IAS 32 *Financial Instruments: Presentation on classification or rights issues.*
- Amendment to IAS 39 *Eligible Hedged Items.*
- International Financial Reporting Standards (IFRS) 3 (revised) *Business Combinations.*
- International Financial Reporting Issue Council (IFRIC) 17 *Distributions of Non-cash Assets to Owners.*
- IFRIC 18 *Transfer of Assets from Customers.*

1.26 Accounting standards issued that have been adopted early

The amendment to IFRS 8 *Operating Segments* that was included in the April 2009 *Improvements to IFRSs* has been adopted early. As a result, total assets are not reported by operating segment.

1.27 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured.

2. Operating segments

The Trust has one operating segment – healthcare. This is consistent with the current internal reporting arrangements to the chief operating decision maker – the Management Board. The segment, therefore, includes all of the assets, liabilities and taxpayers' equity as reported in the statement of financial position and for which there is a summary of key numbers in the table below. Further detail is available on other statements in these accounts, as well as in the disclosures and notes, and can be read as pertaining entirely to the healthcare segment.

	2009/10 £000	2008/09 £000
Healthcare		
Income	**318,146**	291,450
Surplus		
Segment surplus	**3,551**	1,198
Interest received	**(36)**	(476)
Surplus before interest	**3,515**	722
Net assets		
Segment net assets	**261,676**	234,718

3. Income generation activities

The Trust has no income generation activities which exceed £1 million or are otherwise material.

4. Revenue from patient care activities

	2009/10 £000	2008/09 £000
Strategic Health Authorities	**38,703**	37,169
NHS trusts	**7,508**	7,215
Primary Care Trusts	**181,850**	156,053
Foundation Trusts	**304**	0
Local authorities	**1,009**	1,009
Department of Health	**1,046**	0
NHS other	**12,133**	6,508
Non-NHS		
Private patients	**20,963**	19,737
Overseas patients (non-reciprocal)	**28**	0
Injury costs recovery	**64**	81
Other	**3,939**	2,738
	267,547	230,510

5. Other operating revenue

	2009/10 £000	2008/09 £000
Patient transport services	**877**	632
Education and training	**11,220**	11,126
Research and development	**13,817**	24,287
Charitable and other contributions to expenditure	**5,179**	4,059
Transfers from donated asset reserve	**7,349**	6,430
Transfers from government grant reserve	**16**	16
Non-patient care services to other bodies	**3,764**	4,209
Income generation	**1,317**	2,396
Other revenue	**7,060**	7,785
	50,599	60,940

6. Revenue

	2009/10 £000	2008/09 £000
From rendering of services	**318,146**	291,450

Revenue is almost totally from the supply of clinical services and includes reimbursement for clinically-related expenses such as drugs, blood and prosthesis, as well as funding for research activities. Revenue from the sale of goods is immaterial.

7. Operating expenses

	2009/10 £000	2008/09 £000
Services from other NHS trusts	**2,500**	2,554
Services from Primary Care Trusts	**252**	654
Services from other NHS bodies	**310**	0
Services from Foundation Trusts	**897**	772
Purchase of healthcare from non-NHS bodies	**1,645**	1,663
Directors' costs	**1,037**	886
Other employee benefits	**183,747**	170,800
Supplies and services – clinical	**64,828**	62,312
Supplies and services – general	**2,447**	2,301
Consultancy services	**1,587**	1,745
Establishment	**2,809**	3,063
Transport	**2,172**	2,826
Premises	**18,707**	15,413
Provision for impairment of receivables	**271**	(683)
Depreciation	**15,177**	11,616
Amortisation	**171**	141
Impairments and reversals of property, plant and equipment	**3,817**	4,541
Audit fees	**150**	163
Other auditor's remuneration	**174**	189
Clinical negligence	**1,463**	888
Education and training	**2,365**	1,486
Other	**3,389**	1,860
	309,915	285,190

Other auditors' remuneration comprises amounts paid to London Audit Consortium for internal audit services.

8. Operating leases

	2009/10 £000	2008/09 £000
Payments recognised as an expense		
Minimum lease payments	**1,293**	1,227
Total future minimum lease payments		
Payable		
Not later than one year	**1,293**	1,251
Between one and five years	**5,016**	4,962
After five years	**11,709**	12,918
Total	**18,018**	19,131

9. Employee costs and numbers

9.1 Employee costs

	2009/10			2008/09		
	Total £000	Permanently employed £000	Other £000	Total £000	Permanently employed £000	Other £000
Salaries and wages	**157,682**	**139,084**	**18,598**	144,291	127,962	16,329
Social security costs	**11,248**	**11,248**	**0**	11,227	11,227	0
Employer contributions to NHS Pension Scheme	**15,944**	**15,847**	**97**	14,857	14,857	0
Termination benefits	**(90)**	**(90)**	**0**	1,247	1,247	0
Employee benefits expense	**184,784**	**166,089**	**18,695**	171,622	155,293	16,329

9.2 Average number of people employed

	2009/10			2008/09		
	Total number	Permanently employed number	Other number	Total number	Permanently employed number	Other number
Medical and dental	**520**	**483**	**37**	507	472	35
Administration and estates	**887**	**776**	**111**	813	686	127
Healthcare assistants and other support staff	**240**	**229**	**11**	346	340	6
Nursing, midwifery and health-visiting staff	**1,292**	**1,155**	**137**	1,209	1,108	101
Scientific, therapeutic and technical staff	**676**	**621**	**55**	517	484	33
Other	**4**	**4**	**0**	0	0	0
Total	**3,619**	**3,268**	**351**	3,392	3,090	302

9.3 Staff sickness absence

	2009/10 number	2008/09 number
Days lost (long term)	**9,289**	8,077
Days lost (short term)	**24,875**	20,347
Total days lost	**34,164**	28,424
Total staff years	**3,236**	2,976
Average working days lost	**10.56**	9.55
Total staff employed in period (headcount)	**4,300**	3,959
Total staff employed in period with no absence (headcount)	**1,939**	1,944
Percentage of staff with no sick leave	**45.1%**	49.1%

9.4 Management costs

	2009/10 £000	2008/09 £000
Management costs	**13,888**	13,631
Income	**318,146**	292,139

10. Pension costs

Former and current employees are covered by the provisions of the NHS Pension 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, general 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.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a 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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates, was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion of the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14 per cent of pensionable pay, and most employees had, up to April 2008, paid six per cent, with manual staff paying five per cent.

Following the full actuarial review by the government actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his valuation report recommended that employer contributions could continue at the existing rate of 14 per cent of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale of five per cent to 8.5 per cent of their pensionable pay, depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations, at a two-year midpoint, a full and detailed member dataset is provided to the scheme actuary. At this point, the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2010 is based on detailed membership data as at 31 March 2008 (the latest midpoint), updated to 31 March 2010 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c Scheme provisions

In 2008/09, 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:

Annual pensions

The scheme is a final salary scheme. Annual pensions are normally based on 1/80th for the 1995 section and on 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 HM Revenue & Customs rules. This new provision is known as 'pension commutation'.

Pensions indexation

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 12 months ending 30 September in the previous calendar year.

Lump sum allowance
A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-health retirement
Early payment of a pension, with enhancement in certain circumstances, is available to members of the scheme who are permanently incapable of fulfilling their duties or of carrying out regular employment effectively through illness or infirmity.

Death benefits
A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement, is payable.

Additional Voluntary Contributions (AVCs)
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.

Transfer between funds
Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved benefits
Where a scheme member ceases NHS employment with more than two years' service, they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for early retirement
Where a member of the scheme is made redundant, they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

11. Retirements due to ill health
This note discloses the number of, and additional pension costs for, individuals who retired early on grounds of ill health during the year. There were two retirements, at an additional cost of £68,056 (2008/09: 0). This information has been supplied by NHS Pensions. These retirements represented 0.59 per 1,000 active scheme members.

The costs of these ill-health retirements will be borne by the NHS Business Services Authority – Pension Division.

12. Better Payment Practice Code

	2009/10		2008/09	
	Number	**£000**	Number	£000
Total non-NHS trade invoices paid in the year	**70,589**	**136,063**	73,512	131,835
Total non-NHS trade invoices paid within target	**62,084**	**118,446**	58,157	113,514
Percentage of non-NHS trade invoices paid within target	**88%**	**87%**	79%	86%
Total NHS trade invoices paid in the year	**3,100**	**16,949**	3,094	14,991
Total NHS trade invoices paid within target	**1,962**	**13,872**	1,745	11,621
Percentage of NHS trade invoices paid within target	**63%**	**82%**	56%	78%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

13. Investment revenue

	2009/10 £000	2008/09 £000
Bank accounts	**36**	476

14. Other gains and losses

	2009/10 £000	2008/09 £000
Gain/(loss) on disposal of property, plant and equipment	**487**	(512)

15. Finance costs

	2009/10 £000	2008/09 £000
Unwinding of discount on provisions	**31**	29

16. Intangible assets

	Computer software (internally generated) £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Total £000
Current year 2009/10				
Gross cost at 1 April 2009	316	76	463	855
Additions purchased	71	9	10	90
Additions donated	1	0	0	1
Gross cost at 31 March 2010	**388**	**85**	**473**	**946**
Amortisation at 1 April 2009	47	49	207	303
Charged during the year	61	14	96	171
Amortisation at 31 March 2010	**108**	**63**	**303**	**474**
Net book value				
Purchased	261	21	142	424
Donated	19	1	28	48
Total at 31 March 2010	**280**	**22**	**170**	**472**
Prior year 2008/09				
Gross cost at 1 April 2008	130	76	463	669
Additions purchased	186	0	0	186
Gross cost at 31 March 2009	**316**	**76**	**463**	**855**
Amortisation at 1 April 2008	16	34	112	162
Charged during the year	31	15	95	141
Amortisation at 31 March 2009	**47**	**49**	**207**	**303**
Net book value				
Purchased	242	26	203	471
Donated	27	1	53	81
Total at 31 March 2009	**269**	**27**	**256**	**552**

17. Property, plant and equipment

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construct £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	Total £000
Current year 2009/10								
Cost or valuation at 1 April 2009	41,855	107,643	2,810	34,610	53,758	10,931	2,918	254,525
Additions purchased	0	3,145	0	14,677	1,809	3,799	1,129	24,559
Additions donated	0	1,932	0	10,970	3,560	1,731	315	18,508
Additions government granted	0	0	0	0	172	0	0	172
Reclassifications	0	16,929	0	(16,929)	0	0	0	0
Disposals	0	(3,206)	0	0	(3,473)	(626)	(12)	(7,317)
Revaluation/indexation gains	0	9,363	423	0	0	0	0	9,786
Impairments	(3,300)	(9,680)	0	(72)	0	0	0	(13,052)
At 31 March 2010	**38,555**	**126,126**	**3,233**	**43,256**	**55,826**	**15,835**	**4,350**	**287,181**
Depreciation at 1 April 2009	0	0	0	0	19,989	5,536	1,360	26,885
Disposals	0	(3,206)	0	0	(3,473)	(613)	(12)	(7,304)
Impairments	0	3,817	0	0	0	0	0	3,817
Charged during the year	0	6,541	73	0	5,953	1,969	641	15,177
Depreciation at 31 March 2010	**0**	**7,152**	**73**	**0**	**22,469**	**6,892**	**1,989**	**38,575**
Net book value								
Purchased	36,808	57,679	3,160	24,435	21,126	6,812	1,315	151,335
Donated	1,747	61,295	0	18,821	12,038	2,131	1,046	97,078
Government granted	0	0	0	0	193	0	0	193
Total at 31 March 2010	**38,555**	**118,974**	**3,160**	**43,256**	**33,357**	**8,943**	**2,361**	**248,606**
Asset financing								
Owned	38,555	114,942	3,160	43,256	33,357	8,943	2,361	244,574
Finance leased	0	4,032	0	0	0	0	0	4,032
Total 31 March 2010	**38,555**	**118,974**	**3,160**	**43,256**	**33,357**	**8,943**	**2,361**	**248,606**

17. Property, plant and equipment (continued)

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construct £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	Total £000
Prior year 2008/09								
Cost or valuation at 1 April 2008	49,257	160,509	4,783	21,057	45,098	7,540	2,541	290,785
Additions purchased	0	4,132	0	9,226	3,118	3,178	113	19,767
Additions donated	0	4,598	0	4,499	4,695	213	264	14,269
Disposals	0	(2,853)	0	(172)	0	0	0	(3,025)
Revaluation/indexation gains	7,568	7,593	0	0	847	0	0	16,008
Impairments	(14,970)	(59,374)	(1,867)	0	0	0	0	(76,211)
At 31 March 2009	**41,855**	**114,605**	**2,916**	**34,610**	**53,758**	**10,931**	**2,918**	**261,593**
Depreciation at 1 April 2008	0	0	0	0	14,870	4,565	854	20,289
Disposals	0	(2,513)	0	0	0	0	0	(2,513)
Revaluation/indexation gains	0	0	0	0	20	0	0	20
Impairments	0	4,541	0	0	0	0	0	4,541
Charged during the year	0	4,934	106	0	5,099	971	506	11,616
Depreciation at 31 March 2009	**0**	**6,962**	**106**	**0**	**19,989**	**5,536**	**1,360**	**33,953**
Net book value								
Purchased	40,075	49,287	2,810	20,225	21,491	4,144	358	138,390
Donated	1,780	58,356	0	14,385	12,241	1,251	1,200	89,213
Government granted	0	0	0	0	37	0	0	37
Total at 31 March 2009	**41,855**	**107,643**	**2,810**	**34,610**	**33,769**	**5,395**	**1,558**	**227,640**
Asset financing								
Owned	41,855	107,643	2,810	34,610	33,769	5,395	1,558	227,640

Great Ormond Street Hospital Children's Charity donated £18.5 million (2008/09: £14.3 million) towards property plant and equipment expenditure.

For assets held at revalued amounts:

- The effective date of revaluation was 31 March 2010.
- The valuation of land, buildings and dwellings was undertaken by Peter Ashby, Member of the Royal Institution of Chartered Surveyors (MRICS), Senior Surveyor, District Valuers Office.
- The valuations were undertaken using a modern equivalent asset methodology.

17. Property, plant and equipment (continued)

Useful economic lives

	Minimum life (years)	Maximum life (years)
Asset type		
Buildings excluding dwellings	27	58
Dwellings	35	43
Plant and machinery	5	30
Information technology	5	5
Furniture and fittings	5	10

18. Impairments

An impairment of £3.8 million is reflected in the accounts. This is a result of a full valuation of the Trust's land and buildings, carried out by the district valuer using the modern equivalent assets valuation methodology. This was carried out as of 1 April 2010 to comply with the Department of Health's requirement for a full valuation every five years.

19. Capital commitments

Contracted capital commitments at 31 March 2010 not otherwise included in these financial statements:

	31 March 2010 £000	31 March 2009 £000
Property, plant and equipment	**88,039**	10,842

20. Inventories

	31 March 2010 £000	31 March 2009 £000
Drugs	**3,261**	2,917
Consumables	**1,912**	32
Total	**5,173**	2,949

21. Trade and other receivables

21.1 Trade and other receivables

	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	**31 March 2010 £000**	31 March 2009 £000
NHS receivables – revenue	**16,962**	16,105	**0**	0
Non-NHS receivables – revenue	**9,467**	8,168	**0**	0
Non-NHS receivables – capital	**5,851**	151	**0**	0
Provision for the impairment of receivables	**(1,435)**	(1,258)	**0**	0
Prepayments and accrued income	**3,171**	1,124	**9,039**	8,126
Value Added Tax (VAT)	**1,630**	1,110	**0**	0
Other receivables	**909**	1,009	**0**	0
Total	**36,555**	26,409	**9,039**	8,126

The great majority of trade is with Primary Care Trusts (PCTs), as commissioners for NHS patient care services. As PCTs are funded by the government to buy NHS patient care services, no credit scoring of them is considered necessary.

21.2 Receivables past their due date but not impaired

	31 March 2010 £000	31 March 2009 £000
By up to three months	**6,251**	6,166
By three to six months	**762**	444
By more than six months	**915**	278
Total	**7,928**	**6,888**

21.3 Provision for impairment of receivables

	31 March 2010 £000	31 March 2009 £000
Balance at 1 April	**(1,258)**	(1,966)
Amount written off during the year	**94**	25
Amount recovered during the year	**176**	0
(Increase)/decrease in receivables impaired	**(447)**	683
Balance at 31 March	**(1,435)**	(1,258)

A provision is made for impairment of receivables based on the length of time after the due date for payment.

22. Cash and cash equivalents

	31 March 2010 £000	31 March 2009 £000
Balance at 1 April	**5,875**	9,843
Net change in year	**2,610**	(3,968)
Balance at 31 March	**8,485**	5,875
Made up of		
Cash with Office of HM Paymaster General	**8,440**	5,819
Commercial banks and cash in hand	**45**	56
Cash and cash equivalents as in statement of financial position	**8,485**	5,875

23. Trade and other payables

	Current	
	31 March 2010 £000	31 March 2009 £000
NHS payables – revenue	**4,102**	3,963
Non-NHS trade payables – revenue	**3,716**	799
Non-NHS trade payables – capital	**7,084**	649
Accruals and deferred revenue	**14,300**	14,172
Social security costs	**1,666**	1,544
Tax	**2,149**	2,003
Other	**48**	0
Total	**33,065**	23,130

24. Other liabilities

	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	**31 March 2010 £000**	31 March 2009 £000
Lease incentives	**400**	400	**7,728**	8,126
Other payables	**2,608**	2,828	**0**	0
Total	**3,008**	3,228	**7,728**	8,126

Other payables include:
£2.2 million outstanding pensions contributions at 31 March 2010 (31 March 2009: £2 million).

25. Provisions

	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	**31 March 2010 £000**	31 March 2009 £000
Pensions relating to other staff	109	103	1,304	1,202
Staff benefits (annual leave)	1,440	1,044	0	0
Total	**1,549**	1,147	**1,304**	1,202

	Pensions relating to staff £000	Other £000	**Total £000**
At 1 April 2008	1,379	894	**2,273**
Arising during the year	0	150	**150**
Used during the year	(103)	0	**(103)**
Unwinding of discount	29	0	**29**
At 1 April 2009	1,305	1,044	**2,349**
Arising during the year	211	256	**467**
Used during the year	(134)	(585)	**(719)**
Reversed unused	0	(310)	**(310)**
Unwinding of discount	31	0	**31**
Transfers in year	0	1,035	**1,035**
At 31 March 2010	1,413	1,440	**2,853**

Expected timing of cash flows

In the remainder of the spending review period to 31 March 2011	109	1,440	**1,549**
Between 1 April 2011 and 31 March 2016	545	0	**545**
Between 1 April 2016 and 31 March 2021	545	0	**545**
Thereafter	214	0	**214**

£25.6 million is included in the provisions of the NHS Litigation Authority at 31 March 2010 in respect of clinical negligence liabilities of the Trust (31 March 2009: £17.7 million).

26. Financial instruments

26.1 Financial assets

	2009/10 £000	2008/09 £000
Receivables	**30,845**	23,166
Cash at bank and in hand	**8,485**	5,875
Total	**39,330**	29,041

26.2 Financial liabilities

	2009/10 £000	2008/09 £000
Payables	**19,898**	11,652

26.3 Financial risk management

Financial reporting standard International Financial Reporting Standards (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 NHS trust has with Primary Care Trusts (PCTs), and the way in which those PCTs are financed, the NHS 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 is typical of listed companies, to which the financial reporting standards mainly apply. The NHS 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. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2010 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with PCTs, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

27. Events after the reporting period

The Trust has agreed to transfer responsibility for the acute paediatric services based at the North Middlesex University Hospital NHS Trust (NMUH) back to NMUH on 1 May 2010. The annual cost of these services in 2009/10 was £7.4 million. The cost of the service during 2010/11 up to the date of transfer will be approximately £0.65 million.

28. Financial performance targets

The figures given for periods prior to 2009/10 are on a UK Generally Accepted Accounting Principles (GAAP) basis, as that is the basis on which the targets were set for those years.

28.1 Breakeven performance

	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000
Turnover	221,449	247,048	270,693	291,450	318,146
Retained surplus/(deficit) for the year	1,902	2,117	6,956	1,348	3,551
Adjustments for impairments				4,541	3,817
Breakeven in-year position	1,902	2,117	6,956	5,889	7,368
Breakeven cumulative position	3,673	5,790	12,746	18,635	26,003

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10, NHS trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury on measuring departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include private finance initiative schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring breakeven performance.

	2005/06 %	2006/07 %	2007/08 %	2008/09 %	2009/10 %
Materiality test (ie is it equal to or less than 0.5 per cent?)					
Breakeven in-year position as a percentage of turnover	1	1	3	2	2
Breakeven cumulative position as a percentage of turnover	2	2	5	6	8

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

28.2 Capital cost absorption rate

For 2008/09, the Trust was required to absorb the cost of capital at a rate of 3.5 per cent of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital (PDC), totalling £5 million, bears to the actual average relevant net assets of £138.7 million, that is 3.6 per cent.

From 2009/10, the dividend payable on PDC is based on the actual (rather than forecast) average relevant net assets, and therefore the actual capital cost absorption rate is automatically 3.5 per cent.

28.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2009/10 £000	2008/09 £000
External financing limit	**19,905**	15,188
Cash flow financing	**25,728**	28,298
Other capital receipts	**(12,981)**	(15,408)
External financing requirement	**12,747**	12,890
Undershoot against the external financing limit	**7,158**	2,298

28.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2009/10 £000	2008/09 £000
Gross capital expenditure	**43,330**	34,222
Less: book value of assets disposed of	**(13)**	(512)
Less: donations towards the acquisition of non-current assets	**(18,681)**	(14,269)
Charge against the capital resource limit	**24,636**	19,441
Capital resource limit	**25,207**	19,885
Underspend against the capital resource limit	**571**	444

29. Related party transactions

Great Ormond Street Hospital for Children NHS Trust (GOSH) is a body corporate established by order of the secretary of state for health.

During the year, none of the Board members or members of the key management staff, or parties related to them, has undertaken any material transactions with the Trust.

The Department of Health is regarded as a related party. During the year, GOSH has had a significant number of material transactions with the department, and with other entities for which the department is regarded as the parent department. These entities are listed below:

	Receipts from related party 2009/10 £000	Receipts from related party 2008/09 £000	Due from related party 2009/10 £000	Due from related party 2008/09 £000
Revenue receipts from				
London Strategic Health Authority	46,596	45,419	2,271	4,343
South East Essex Primary Care Trust (PCT)	36,053	23,790	1,592	453
Hillingdon PCT	19,639	21,195	99	1,839
Tower Hamlets PCT	19,392	11,771	739	272
Haringey Teaching PCT	16,733	21,115	2,798	1,050
Bexley Care PCT	14,928	13,256	0	0
Croydon PCT	14,777	15,270	0	39
Camden PCT	13,688	6,916	672	76
Department of Health	13,516	44,197	62	483
Hampshire PCT	10,438	2,103	1,242	0
North Middlesex University Hospital NHS Trust	7,685	6,879	461	787
West Kent PCT	5,465	4,321	84	207
Barnet PCT	4,236	5	521	45
Enfield PCT	4,178	2	610	1
Bristol PCT	4,153	3,874	0	192
Surrey PCT	3,938	2,450	590	145
Leicestershire County and Rutland PCT	3,088	1,879	44	2
Islington PCT	2,526	135	152	41
Ealing PCT	2,526	2,375	226	107
Barts and the London NHS Trust	2,143	502	307	295
Brent Teaching PCT	2,113	1,781	0	59
Eastern and Coastal Kent PCT	2,081	1,407	137	0
Harrow PCT	1,843	1,163	407	112
Hounslow PCT	1,731	1,026	436	235
Birmingham East and North PCT	1,544	750	39	1
Bromley PCT	1,361	748	112	0
Westminster PCT	1,359	904	187	78
East of England Strategic Health Authority	1,310	24	8	8
Hammersmith and Fulham PCT	1,049	277	321	0

	Payments to related party 2009/10 £000	Payments to related party 2008/09 £000	Owed to related party 2009/10 £000	Owed to related party 2008/09 £000
Expenditure payments to				
NHS Business Services Authority	5,136	3,666	286	211
NHS Blood and Transplant	2,082	1,543	273	66
NHS Litigation Authority	1,745	1,055	0	130
University College London NHS Foundation Trust	1,718	2,554	509	170
Mid Essex Hospital Services NHS Trust	1,508	1,366	0	114
NHS Purchasing and Supply Agency	361	1,395	0	504

The de minimis limit is £1 million.

The Trust has also had the following transactions with the special trustees of Great Ormond Street Hospital Children's Charity:
Donations for capital expenditure: £18.5 million (2008/09: £14.3 million)
Contributions towards revenue expenditure: £2.8 million (2008/09: £2.4 million)

Notes to the accounts
continued

30. Intra-government and other balances

	Current receivables £000	Non-current receivables £000	Current payables £000
Balances with other central government bodies	21	0	6,042
Balances with local authorities	137	0	1
Balances with NHS trusts and Foundation Trusts	16,962	0	4,102
Intra-government balances	17,120	0	10,145
Balances with bodies external to government	19,435	9,039	22,920
At 31 March 2010	**36,555**	**9,039**	**33,065**
Balances with NHS trusts and Foundation Trusts	16,105	0	3,963
Balances with bodies external to government	10,304	8,126	19,167
At 31 March 2009	26,409	8,126	23,130

31. Losses and special payments

There were 37 cases of losses and special payments (2008/09: 10 cases) totalling £143,036 (2008/09: £25,261) accrued during 2009/10.

32. Transition to International Financial Reporting Standards (IFRS)

	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Government grant reserve £000
Taxpayers' equity at 31 March 2009 under UK Generally Accepted Accounting Principles (GAAP)	**19,654**	**29,286**	**89,296**	**37**
Adjustments for IFRS changes:				
Removal of positive reserves balances	(12,659)	12,659	0	0
Employee benefits (annual leave accrual)	(1,044)	0	0	0
Taxpayers' equity at 1 April 2009 under IFRS	**5,951**	**41,945**	**89,296**	**37**
Surplus for 2008/09 under UK GAAP	**1,348**			
Adjustments for:				
Employee benefits (annual leave accrual)	(150)			
Surplus for 2008/09 under IFRS	**1,198**			

The UK GAAP 2008/09 cash flow statement included net movements in liquid resources of £4 million. This net movement is included in the bottom line cash and cash equivalents figure in the 2009/10 statement of cash flows under IFRS.

Remuneration report

The remuneration and conditions of service of the Chief Executive and Executive Directors are determined by the Remuneration Committee. The committee meets twice a year, in March and November.

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 Hay job evaluation and weightings. There is some scope for adjusting remuneration on the basis of performance.

The remuneration of the Chairman and Non-Executive Directors is determined by the Department of Health. Pension arrangements for the Chief Executive and Executive Directors are in accordance with the NHS Pension Scheme. The accounting policies for pensions and other relevant benefits are set out in the notes to the accounts. Non-Executive Directors do not receive pensionable remuneration.

Mr Andrew Fane (Chairman)
Baroness Tessa Blackstone (Chairman from January 2009)
Ms Yvonne Brown
Professor Andrew Copp
Ms Mary MacLeod
Mr Charles Tilley

Salary entitlement of senior managers

Name	Title	**2009/10 Salary (bands of £5,000) £000**	2008/09 Salary (bands of £5,000) £000
Baroness Tessa Blackstone	Chairman of Trust Board*†	**20-25**	5-10
Ms Yvonne Brown	Non-Executive Director*†	**5-10**	0-5
Dr Barbara Buckley	Co-Medical Director*	**170-175**	160-165
Mr Trevor Clarke	Director of the International and Private Patients Division	**65-70**	5-10
Dr Jane Collins	Chief Executive*	**180-185**	175-180
Professor Andrew Copp	Non-Executive Director*†	**5-10**	5-10
Ms Fiona Dalton	Deputy Chief Executive/Director of Operations*	**130-135**	70-75
Professor Judith Ellis	Director of Nursing, Education and Workforce Development (left 31 January 2010)	**80-85**	95-100
Mr Robert Evans	Co-Medical Director*	**165-170**	165-170
Mr Andrew Fane	Non-Executive Director*†	**5-10**	5-10
Professor David Goldblatt	Director of Clinical Research and Development	**60-65**	65-70
Mr Mark Large	Director of Information Technology	**90-95**	45-50
Ms Mary MacLeod OBE	Non-Executive Director*†	**5-10**	0-5
Mr William (Bill) McGill	Director of Redevelopment	**125-130**	125-30
Mrs Claire Newton	Chief Finance Officer*	**120-125**	115-120
Mr Mike Ralph	Director of Estates and Facilities (left 7 April 2009)	**0-5**	80-85
Mr Charles Tilley	Non-Executive Director*†	**5-10**	5-10
Mrs Janet Williss	Acting Director of Nursing, Education and Workforce Development* (from 1 February 2010)	**15-20**	Nil

* denotes Board member
† denotes member of Remuneration Committee
No senior manager at the Trust received any other benefits from the Trust.

Remuneration report
continued

Pension entitlements of senior managers

Name	Title	Real increase in pension and related lump sum at age 60 (bands of £2,500) £000	**Total accrued pension and related lump sum at age 60 at 31 March 2010 (bands of £5,000) £000**	**Cash equivalent transfer value at 31 March 2010 £000**	Cash equivalent transfer value at 31 March 2009 £000	**Real increase in cash equivalent transfer value at 31 March 2010 £000**
Dr Barbara Buckley	Co-Medical Director	0-2.5	**175-180**	**829**	740	**52**
Dr Jane Collins	Chief Executive	0-2.5	**300-305**	**1,705**	1,544	**84**
Mr Trevor Clarke	Director of the International and Private Patients Division	12.5-15	**130-135**	**651**	532	**92**
Ms Fiona Dalton	Deputy Chief Executive/ Director of Operations	7.5-10	**95-100**	**303**	249	**42**
Professor Judith Ellis	Director of Nursing, Education and Workforce Development	0-2.5	**135-140**	**671**	604	**31**
Mr Robert Evans	Co-Medical Director	0-2.5	**180-185**	**1,062**	929	**86**
Mr Mark Large	Director of Information Technology	7.5-10	**60-65**	**286**	226	**49**
Mr William (Bill) McGill	Director of Redevelopment	0-2.5	**200-205**	**1,261**	1,136	**69**
Mrs Claire Newton	Chief Finance Officer	5-7.5	**15-20**	**81**	45	**34**
Mr Mike Ralph (left 7 April 2009)	Director of Estates and Facilities	0-2.5	**0-5**	**n/a**	528	**n/a**
Mrs Janet Williss	Acting Director of Nursing, Education and Workforce Development	0-2.5	**115-120**	**576**	470	**13**

There were no employer contributions to stakeholder pensions for any of the senior managers.

Salaries payable to Non-Executive Directors are non-pensionable.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures – and from 2004/05, the other pension details – include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV
This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement), and uses common market valuation factors for the start and end of the period.

Financial glossary

Capital expenditure
Expenditure to renew the fixed assets used by the Trust.

Capital resource limit
The limit on the amount that the Trust was permitted to invest in capital expenditure, other than expenditure funded by charitable sources.

Depreciation
The process of charging the cost of a fixed asset to the income and expenditure account over its useful life to the Trust, as opposed to recording the cost in a single year.

External financing limit
The limit on the funding which could be drawn down from the Department of Health during the year.

Fixed assets
Land, buildings or equipment that are expected to be used to generate income for the Trust for a period exceeding one year.

Indexation
The process of adjusting the value of a fixed asset to account for inflation. Indexation is calculated using indices published by the Department of Health.

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.

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 exact timing and amount.

General glossary

BRE
Building Research Establishment

CATS
Children's Acute Transport Service

CBI
Confederation of British Industry

CICU
Cardiac Intensive Care Unit

CNST
Clinical Negligence Scheme for Trusts

Commissioners
The organisations that purchase services from GOSH

CQC
Care Quality Commission – the organisation that regulates and inspects health and social care services in England

CQUIN
Commissioning for Quality and Innovation

CVC
Central venous catheter

DH
Department of Health

ECMO
Extracorporeal membrane oxygenation

ENT
Ears, nose and throat

FCE
Finished consultant episode

GP
General practitioner

GOSH
Great Ormond Street Hospital for Children NHS Trust

HCAI
Health-care acquired infection

HES
Hospital episode statistics

HPA
Health Protection Agency

HRG
Healthcare Resource Group – activity relating to hospitals is illustrated by codes that are based on these groups

HSMR
Hospital Standardised Mortality Ratio – a measure of quality that indicates whether the death rate at a hospital is higher or lower than one would expect based on a number of factors relating to patients and their conditions

ICH
UCL Institute of Child Health

MDT
Multi-disciplinary team – a group of different types of clinicians who work together

MRI
Magnetic resonance imaging

MRSA
Methicillin-resistant *Staphylococcus aureus*

NCEPOD
National Confidential Enquiry into Patient Outcome and Death

NHS
National Health Service

NICU
Neonatal Intensive Care Unit

NIHR
National Institute of Health Research

NMUH
North Middlesex University Hospital NHS Trust

PALS
Patient Advice and Liaison Service

PEAT
Patient Environment Action Team

PICANET
Paediatric Intensive Care Audit Network (PICANet) – a national audit co-ordinated by the Universities of Leeds and Leicester which collects data on all children admitted to Paediatric Intensive Care Units (PICUs) across the UK

PICU
Paediatric Intensive Care Unit

R&D
Research and Development

RPST
Risk Pool Scheme for Trusts

SCID
Severe combined immunodeficiency

SHA
Strategic Health Authority – regional organisations responsible for ensuring that all NHS trusts adhere to Department of Health rules and regulations.

SMR
Standardised Mortality Ratio – this is similar to the HSMR figure in that it shows the level of observed deaths compared to expected deaths. Different methods of working on SMR attach differing weights to various factors

SSI
Surgical site infection – an infection in a wound that is identified after surgery

SUS
Secondary Uses Service – a central dataset about all NHS provision in England

TPN
Total parenteral nutrition

UCL
University College London

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Bengali
অনুরোধ করলে নিম্নলিখিত ঠিকানায় থেকে এই লেখার অনুবাদ, বড় অক্ষর, ব্রেল বা অডিও বিবরন পাওয়া যাবে|

English
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French
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Polish
Tłumaczenia są do uzyskania na żądanie pod podanym powyżej adresem. Dokumenty w formacie dużym drukiem, brajlem lub audio są także do uzyskania na żądanie.

Punjabi
ਇਸ ਰਿਪੋਰਟ ਦੇ ਤਰਜਮੇ, ਅਤੇ ਇਹ ਰਿਪੋਰਟ ਵੱਡੇ ਅੱਖਰਾਂ ਜਾਂ ਬ੍ਰੇਲ ਵਿਚ, ਜਾਂ ਸੁਣਨ ਵਾਲੇ ਰੂਪ ਵਿਚ ਹੇਠ ਲਿਖੇ ਪਤੇ ਤੋਂ ਮੰਗ ਕੇ ਲਏ ਜਾ ਸਕਦੇ ਹਨ।

Somali
Turjubaan ayaa cinwaanka kor ku qoran laga heli karaa markii la soo codsado. Daabacad far waa-wayn, farta indhoolaha Braille ama hab la dhegaysto ayaa xittaa la heli karaa markii la soo codsado.

Tamil
பெரிய அச்சில், இந்த அறிக்கையின் மொழிபெயர்ப்புகள்,பெரய்லி அல்லது ஒலி பதிப்புகள் விண்ணப்பித்தால் கீழ்கண்ட விலாசத்தில் கிடைக்கும்

Turkish
Talep edilirse yukarıdaki adresten çevirileri tedarik edilebilir. Talep edilirse, iri harflerle, Braille (görme engelliler için) veya sesli şekilde de tedarik edilebilir.

Urdu
گزارش کرنے پر یہ رپورٹ ترجمے، بڑے حروف کی چھپائی، بریل یا آڈیوپردرج ذیل پتے سے حاصل کی جا سکتی ہے۔

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