Great Ormond Street Hospital for Children
NHS Trust

Annual Report for 1 April 2011–29 February 2012

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.

This report covers the period 1 April 2011 to 29 February 2012. A separate report is available on the Trust website covering 1 March 2012 to 31 March 2012.

In some instances, and where highlighted, commentary in this report covers 1 April 2011 to 31 March 2012.

Cover: Four-year-old Milan is an oncology patient on Elephant Ward.

Contents

Message from the Chairman and Chief Executive

In February 2012, we celebrated 160 years as a hospital dedicated to the care of children. It is really important to reflect on the history of Great Ormond Street Hospital (GOSH) and to think about all the wonderful staff who have worked here to do the best they can for children in their care. We are very proud that so many advances in children's medicine have originated from some of the work carried out here and that the ambition of our staff to find better ways to treat children continues today.

In February, we learned that the hospital had been authorised to become an NHS Foundation Trust from 1 March 2012. It has been a long and difficult journey to achieve this new status but it was something we were determined to attain because it secures the hospital's independence and thereby enables us to maintain our single-minded focus on children's health. The hospital's founder, Dr Charles West, recognised that children need special care and we all share that belief today.

Of course, the hospital has changed beyond recognition since it was founded in a single house on Great Ormond Street all that time ago. Today, we continue our plans to upgrade our facilities and to increase our capacity so that we can help more children who need the specialist expertise that we offer.

In December 2011, the builders 'handed over' the new Morgan Stanley Clinical Building to the hospital so that we could get it ready for occupation by our patients and families from 31 March 2012. We were delighted that the new building was completed on time and on budget. The whole process has been a huge undertaking. There are so many people who have made this possible, including the clinical teams who have done so much planning, the redevelopment team and their contractors who have delivered the building and of course our charity and supporters who've raised the money to pay for it. We are so grateful to all of you.

The hospital is treating more patients than ever and demand for our services continues; that is why we need more space. With that in mind, the next phase of our redevelopment is starting, which focuses on the Cardiac Wing. Together with the Morgan Stanley Clinical Building, this will form the Mittal Children's Medical Centre. It is at this stage that the hospital will really start to benefit from additional capacity and we anticipate that we will be able to treat up to 20 per cent more children as a result.

We were delighted that our joint application with the UCL Institute of Child Health to renew our Biomedical Research Centre status was accepted. This means that we continue to be the only academic biomedical research centre in the UK dedicated to paediatrics and, more importantly, receive additional funding to support our research work.

Rare diseases are an important part of this application, and indeed earlier in the year, we announced plans to develop a new Centre for Children's Rare Disease Research. GOSH probably sees more children with rare conditions than most other hospitals in the world and, this fact combined with our research expertise, makes us one of the few places where this type of research could be conducted.

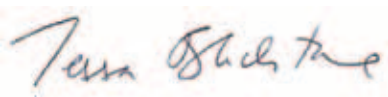
Some of our clinicians and their academic counterparts are already working together to take advantage of new advances in medicine – including regenerative medicine and gene therapy. As new technologies develop and people gain more understanding of our genetic make-up, we believe it will be possible to diagnose and then treat many more children. This is an important and exciting prospect and we must all work together to help make this happen.

While we must look to the future, we want to take this opportunity to recognise all the hard work that has been achieved this year by so many of our staff. Our latest patient and parent satisfaction study shows that 97 per cent of people would recommend the hospital to their friends. This truly reflects the outstanding care that our staff provide day in and day out. We are grateful to them for their commitment.

Of course, we do not get everything right, particularly where we are carrying out complex procedures for very sick patients. And when we do not, the results can be devastating for families and the members of staff involved. We must strive to achieve the highest standards of quality and safety at all times and to learn from any mistakes that are made. In this report, you will read about some of the quality and safety initiatives that teams in the hospital have undertaken to improve what they do. You will also see that we are reporting on more and more clinical outcomes, and we will continue to expand the number and range of outcomes which we publish and compare, where possible, with other specialist providers.

As a new Foundation Trust, we look forward to working with our Members' Council and consulting with our wider membership as we implement our plans for the future. It will be important to seek their opinions as we continue to operate in difficult times for the NHS. All parts of the NHS, including acute hospitals such as ours, will have to find ways to reduce costs, yet provide the same high standards of care. We know that we will be asked to find better ways to do things and to work more efficiently. We look forward to working with our members to help us find the right solutions for the children in our care.

Dr Jane Collins
Chief Executive



Baroness Blackstone
Chairman

Who we are and what we do

Great Ormond Street Hospital for Children (GOSH) is an acute specialist Trust for children, providing a full range of specialist and sub-specialist paediatric health services as well as carrying out clinical research and providing education and training for staff working in children's healthcare.

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

We have more than 200,000 patient visits a year (outpatient appointments and inpatient admissions). More than half of our patients come from outside London. We are the largest paediatric centre in the UK for:

- cardiac surgery – we are one of the largest heart transplant centres for children in the world
- neurosurgery – we carry out about 60 per cent of all UK operations for children with epilepsy
- craniofacial surgery
- nephrology and renal transplant
- intensive care.

With University College London Hospitals, we are also one of the largest centres in Europe for children with cancer.

Leading research and development

- We are the UK's only academic Biomedical Research Centre specialising in paediatrics
- We are a leading member of UCL Partners, an alliance for world-class research benefiting patients, joining UCL with four hospitals
- Through carrying out research with international partners, GOSH has developed a number of new clinical treatments and techniques used around the world.

Education and training for staff working in children's healthcare

- Great Ormond Street Hospital, together with London South Bank University, trains the largest number of children's nurses in the UK
- We also play a leading role in training paediatric doctors and other health professionals.

The commissioning of our services
The Trust has a contractual relationship with every English Primary Care Trust (PCT). However, rather than entering into a contract with each individual organisation, GOSH has contracts set at a strategic health authority level, with a lead commissioning PCT or commissioning body representing all of the PCTs within that geographic area.

In addition, a significant level of work is with patients with rare or complex diseases and, in many cases, these services are commissioned by a regional consortia of PCTs or, if extremely rare on a national basis, by the National Commissioning Group; meaning that GOSH is either the only or one of very few providers nationally.

Our vision, aims and strategic objectives

Our vision is that through the work undertaken at Great Ormond Street Hospital and with our partner, the UCL Institute of Child Health, more sick children across the world get better and others are able to have a higher quality of life than is possible today.

Our well-established guiding principle, 'the child first and always', and goals that focus on 'zero harm, no waste and no waits', continue to underpin our objectives which run like a thread through every part of the organisation and inform everything we do.

Our mission is to:

- deliver world-class clinical care to the children we treat
- undertake original research which will lead to new and improved treatments for children everywhere
- share our expertise through the education and training of children's healthcare professionals so that more children benefit from our work
- learn from the paediatric breakthroughs achieved by other institutions.

To achieve this, we have very specific aims, which are to:

- keep safety and quality at the top of our agenda – measuring the outcomes of all our work and benchmarking ourselves against the best in the world
- listen to patients and families so that we constantly improve the child and parent experience
- recruit, train and retain the very best clinical staff and paediatric researchers
- manage our finances and to operate efficiently so that we are able to continue to invest in clinical care, research and training
- update our existing estate so that we have the buildings and equipment we need, and increased capacity to be able to treat more children
- maintain the support of the public so that they continue to donate to our charity
- remain firmly within the NHS so that we can deliver care to children who need us.

Our current strategic objectives developed to achieve these aims and deliver our mission are:

- To consistently deliver clinical outcomes that place us among the top five children's hospitals in the world
- To consistently provide an excellent experience that exceeds the expectations of patients, families and referrers
- To successfully grow our clinical services to meet the needs of our patients and commissioners
- In partnership with UCL Institute of Child Health and UCL Partners, maintain and develop our position as the UK's top children's research organisation
- To work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK
- To deliver a financially stable organisation
- To ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation.

Accomplishing these objectives ensures a major focus on quality improvement initiatives that enhance patient safety, which will improve the experience and clinical outcomes for patients. Details of our performance for the year are set out in the Directors' Report on page 06.

Directors' report

Operational and financial review

Samaviya was diagnosed with cystinosis – a hereditary disease which also affects her aunts. She is one of the first patients to stay on Eagle Ward in the Morgan Stanley Clinical Building, and is very much enjoying having her mum stay by her bedside. The en suite is proving to be entertaining for Samaviya, as she loves playing with water!

Performance

2011/12 has been a successful year for Great Ormond Street Hospital (GOSH).

The Trust's services, within the NHS Trust and then from 1 March 2012 within the NHS Foundation Trust have continued to grow in all types of activity. Year-on-year growth is shown in the table below.

In December 2011, Morgan Stanley Clinical Building (MSCB), the first part of the Mittal Children's Medical Centre, was 'handed over' by the builders to the Trust and work commenced to get it ready for occupation. The project was completed on time and on budget. The official opening will be in the summer of 2012.

In 2011/12, we retained full Care Quality Commission registration, demonstrating that we have continued to meet essential standards of quality and care across all our services. This has been supported by our safety programme that aims to minimise incidents and risks through both reflective organisational learning and a proactive programme focusing on areas of harm that can occur in children. This includes, for example, understanding the nature of harm through the use of a systematic review of a sample of patient records; improving medication administration; and decreasing hospital-acquired infection rates such as Methicillin-resistant Staphylococcus aureus (MRSA) and central line and surgical site infections.

Our drive to deliver the highest quality of services is also demonstrated in the significant progress we have made in the identification and publication of our clinical outcome measures. All our specialties have now identified at least two clinical outcome measures, many of which have already been published on our internet site. A plan to measure, analyse and publish all identified outcome measures over the next year is firmly in place.

Key external factors that will have an impact on our services include the National Safe and Sustainable Paediatric Cardiac Surgery and Neurosurgery reviews. The reviews aim to rationalise the numbers of centres undertaking paediatric surgery across the country. All the options consulted on in relation to cardiac surgery include a reduction of centres in London to two, with GOSH as one of the remaining centres. For neurosurgery, there would be a rationalisation of centres – particularly those undertaking highly specialised procedures such as for epilepsy or tumours. The first wave of this has been through the tendering process for epilepsy surgery with GOSH appointed as one of only four centres in the country.

The NHS London publication, *Children's and Young People's Project – London's Specialised Children's Services: Guide for Commissioners,* strongly supports the rationalisation of the number of providers of specialist children's services across London.

In 2011/12, we set an ambitious savings target of £10.4 million across the organisation, of which we realised £8.2 million. By making good progress against our efficiency savings and by increasing our income through treating more patients, we were able to deliver our planned financial surplus. We will continue to strengthen our efficiency savings programme and develop schemes on a Trust-wide basis in order to achieve the stretching targets we have set ourselves in the coming years. We are also working closely with UCL Partners to ensure that we are able to leverage maximum efficiency benefits, working together where possible.

The new Morgan Stanley Clinical Building, the first part of the Mittal Children's Medical Centre, contains new kidney, neurosciences and heart and lung centres; seven floors of modern inpatient wards for children with acute conditions and chronic illnesses; state-of-the-art operating theatres enabling us to carry out more operations on children with complex conditions; and enhanced diagnostic and treatment facilities offering faster and more accurate services for patients. Tele-medicine and tele-education facilities have been installed, enabling peer practitioners around the world to observe surgical interventions and other treatments via a video link-up.

Following completion of the MSCB, we are now planning the next phase of the Mittal Children's Medical Centre, which will involve the partial demolition and rebuilding of the Cardiac Wing. This will enable all patient care currently sited in the ageing Southwood building to be transferred to new facilities.

Great Ormond Street Hospital Children's Charity has also recently announced our appeal to build a new Centre for Children's Rare Disease Research. The hospital sees many more children with rare diseases than any other in the country. Taken together, rare diseases are a significant health issue and this new centre will serve as a facility to support the hospital and University College London in translating new research techniques into helping more children.

These announcements represent an important step forward for the hospital in our 160th year. Although there are challenges, we plan to grow our work so we can help more children, both directly and through our training and research.

Performance against national targets and standards

The Trust continues to monitor closely performance against key targets as set out in the NHS Operating Framework, as well as key commissioning requirements and internally defined standards.

Infection control

In 2011/12, we reported a total of eight cases of Clostridium difficile against an agreed trajectory of nine. The Trust was set a very challenging target of zero cases of MRSA for the year against which we reported four. While there was an absolute increase in the overall number from last year, our root cause analysis of each case showed only one of these to be truly avoidable. We remained within Monitor's de minimis threshold of six MRSA cases for the year, which is applied to organisations that have a low trajectory.

Access targets

The Trust continued to meet the Department of Health's targets for referral to treatment waiting time standards, with a consistent month-on-month achievement above the targets of 90 per cent of admitted patients and 95 per cent of non-admitted patients receiving treatment within 18 weeks (see diagram below).

In addition to achieving our access targets, we delivered against all applicable national cancer waiting-time standards, reporting 100 per cent compliance against:

- maximum waiting time of one month, from diagnosis to treatment for all cancers
- cancer patients waiting no more than 31 days for second or subsequent treatment for surgery, drug treatments and radiotherapy.

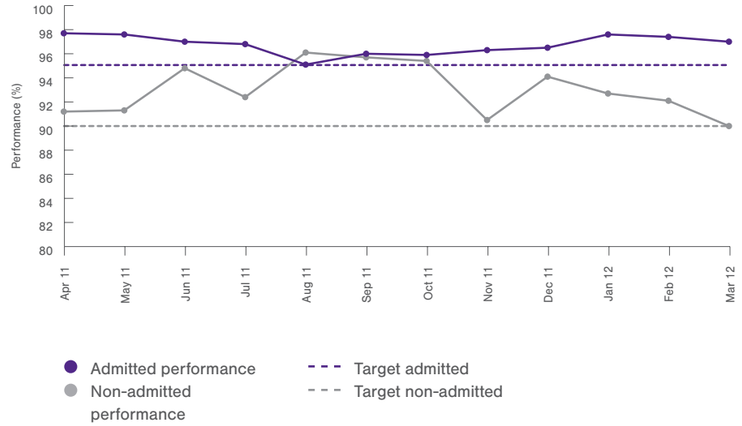
Table one: activity for full year (1 April 2011–31 March 2012)

Activity for full year
(activity up to 29 February 2011 is the activity of the NHS Trust)

	2009/10	growth %	2010/11	growth %	2011/12	growth %
Inpatient and day case patient episodes:						
NHS patients	34,645	7.8%	35,688	3.0%	37,620	5.4%
Private patients	2,450	15.9%	2,572	5.0%	2,702	5.1%
Total	37,102	8.3%	38,260	3.1%	40,322	5.4%
Outpatient attendances	138,941	6.8%	154,662	11.3%	170,982	10.6%
Inpatient and day case episodes comprised:						
Day cases	18,842	11.4%	19,036	1.0%	20,272	6.5%
Other elective	14,519	8.7%	14,892	2.6%	15,592	4.7%
Emergency	3,742	-6.3%	4,332	15.8%	4,458	2.9%
Activities within these episodes included:						
Occupied bed days	101,067	5.0%	109,681	8.5%	111,886	2.0%
Operations	17,262	7.0%	18,027	4.4%	18,774	4.1%

Inpatient and day case activity is measured in terms of Finished Consultant Episodes: the period during which a consultant from a particular specialty is responsible for the patient during the period of the patient's stay in hospital

Referral to treatment waiting time performance



Risk management

The Trust has identified several key risks that may have an impact on the overall delivery of the Trust's Integrated Business Plan (a five-year plan approved by Monitor). These risks have been reviewed and mitigating actions, both proactive and reactive, developed to ensure that, should they arise, plans are in place to address the identified risks.

Key risk	Mitigating action
Children may be harmed through medication errors	• Electronic prescribing system implemented • Medicines management programme in place • Analysis of reported medication errors by type, location and frequency, and feedback to clinical teams to share learning
Children may not be appropriately identified as being at risk of abuse and subsequent actions not taken	• Child protection (CP) policies in place • All staff receive CP training, and attendance is centrally monitored • Clear structure implemented with funded, named, professional input • CP supervision in place for appropriate staff • Strategic partnership working, engagement in Camden Local Safeguarding Children Board Quality and Learning Development Group • Attendance at relevant case conferences
Children may be at risk from hospital-acquired infection (includes decontamination and cleanliness)	• Cleaning contracts for external contractors identify what, when and how areas should be cleaned • Antibiotic prescribing guidelines, policies and procedures relating to Healthcare Associated Infections (HCAI) • Infection Control team and local assurance framework in place for the management of HCAI • Training programme for staff in place regarding all aspects of infection control management
The organisation, administration and practice of clinical services may not always optimally deliver the best outcomes	• Employment of professionally competent staff • Clear role and direction for the Clinical Unit Management team, which includes the responsibility for clinical service organisation • Policies and procedures where required • Cash Releasing Efficiency Savings (CRES) challenge meetings (to ensure the impact of CRES on clinical service delivery is understood) • Formal quarterly reviews with each clinical unit covering clinical outcomes, as well as patient experience and financial performance
Lack of appropriate clinical response to the deterioration in children	• Clinical site practitioners act as a nursing rapid response team; monitoring of internal collapses and deterioration • Use of SBARD (situation, background, assessment, recommendation, decision) to improve communication of clinical status • Intensive Care Outreach Service established to provide medical support • Children's Early Warning Scores pilot
We may fail to maintain compliance with regulatory and legislative requirements	• Identification of leads for managing regulatory requirements • Risk, Assurance and Compliance Group responsible for monitoring compliance with standards/regulatory requirements • Programme of review and audit (internal audit annual plan and clinical audit annual plan reviewed together to avoid duplication) • Where external assessments result in qualifications or recommendations, action plans are developed to bring the Trust into line with the regulatory/ legislative requirements
We may not deliver the information technology and information strategies	• Investment to strengthen infrastructure • Maintenance agreements for all key systems • Business continuity plan
We may not be able to recruit and retain key staff	• Human resources, recruitment and workforce planning strategies, plans and policies in place • Specific recruitment strategies and plans in place for key hard-to-recruit areas • Monthly monitoring of vacancies and impact on bed numbers • Access policy and bed planning meetings organised to manage workload despite staff shortages • Patients turned away/delayed by the hospital are reported by clinical units monthly to Management Board
We may fail to get commissioner support for the Trust's growth plans and service developments	• The growth assumptions are linked to a London tertiary paediatric strategy and national cardiac and neurosurgery reviews • Regular meetings with commissioners and discussions of drivers of growth and unmet demand • Letters of support for the Trust's strategy were received from a majority of commissioners
Sustainable funding solution for each activity within the Trust strategy may not be secured	• Monitoring of developments on Payment by Results tariff • Development of service-line reporting and Patient-Level Information and Costing Systems to provide analysis of under-funded services • Regular assessments of the adequacy of local prices • Improve understanding of future drivers of research and development funding • Monitor developments in changes in the Medical Education tariff in 2013/14

Quality improvement

We place quality at the top of our agenda and set our standards high, aiming to be within the top five children's hospitals in the world in terms of service delivery, research and patient experience.

To achieve and maintain excellent service provision, we have internal processes to check that we meet both our own internal quality standards and those set nationally. The range of internationally benchmarked outcome measures we are developing will help us to achieve our aim to provide care that is in the top five for children's hospitals worldwide.

Key performance indicators relating to each of the Trust's strategic objectives are presented, on a monthly basis, to the Trust Board and Management Board. This includes progress against external targets, such as how we keep our hospital clean and 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 strategic 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 is further supported by the use of specific, measurable targets.

Great Ormond Street Hospital (GOSH) patient survey

Every year, the Trust commissions Ipsos MORI to conduct an independent telephone survey of patients' and families' experiences of their inpatient care.

Once again this year, the results were very positive, with 96 per cent of young people and parents reporting that they were satisfied or very satisfied with their care at GOSH. Ninety-seven per cent also said that they would recommend the Trust to a friend or family member.

Over the past year, the Trust has focused on sustaining and improving its performance on the five aspects of patient experience that have been identified as most important to patients nationally, the results of which are shown below.

The Trust was required by commissioners to sustain an average of 90 per cent for the five questions and achieve a one per cent improvement on the 2010/11 results. This was achieved with an average score of 92 per cent, increased from 91 per cent the previous year.

The following two local patient experience questions (right) were also identified for improvement.

The Trust sustained performance on 'knowing how to feedback or complain' at 74 per cent. Clinical units are reviewing mechanisms for feedback and provision of information about the Patient Advice and Liaison Service (PALS) and complaints. Since the survey, results show there has been an increasing uptake of feedback cards and boxes, and requests for PALS advice leaflets.

However, satisfaction with the quality and variety of food decreased by six per cent, from 60 per cent to 54 per cent. The Trust has an ongoing project to improve satisfaction with food as part of this year's patient experience Commissioning for Quality and Innovation. In April 2012, the Trust launched a new patient menu and meal trolley delivery timetable in response to feedback from patients, families and staff.

These aspects of patient experience remain a priority for the coming year.

This year, an additional question was asked to ascertain the experience of families with a child with special needs or disability. Of the 44 per cent of families who identified that their child had a special need or disability, 85 per cent agreed that plans were put in place to meet their child's needs.

Last time you saw a doctor or nurse at the hospital, how good were they at:

Involving you in decisions about your child's care (% good)

Asking you questions about how you and your child were feeling (% good)

I would like you to tell me whether you agree or disagree with each:

My child had enough privacy when the doctors/nurses talked about his/her treatment (% agree)

Great Ormond Street Hospital (GOSH) patient survey continued

I had enough information about any medicine (% agree)

I knew who to contact if I had a question when I got home (% agree)

During your stay at GOSH, how satisfied or dissatisfied were you with:

The quality and variety of hospital food (% satisfied)

I would like you to tell me whether you agree or disagree with:

I knew how to complain or offer feedback (% agree)

Great Ormond Street Hospital (GOSH) staff survey

Our annual staff survey helps us understand what our staff feel we do well, and where we need to improve. Detailed below are the findings from the 2011 survey, benchmarked against the 2010 survey.

Table two: top and bottom ranking scores

	2010		2011		Trust improvement/ deterioration/ no change
Top four ranking scores	**GOSH**	**National average**	**GOSH**	**National average**	
Percentage of staff agreeing that their role makes a difference to patients	93%	90%	91%	90%	No significant change*
Percentage of staff appraised in the past 12 months	85%	79%	82%	81%	No significant change*
Support from immediate managers	3.78%	3.66%	3.64%	3.64%	No significant change*
Percentage of staff appraised with personal development plans in the past 12 months	77%	68%	75%*	70%	No significant change*
Percentage of staff receiving job-relevant training, learning and development in the past 12 months	N/A	N/A	84%*	77%	
Percentage of staff able to contribute towards improvements at work	N/A	N/A	68%*	66%	
Percentage of staff feeling valued by their work colleagues	N/A	N/A	79%*	76%	

*As determined by the Department of Health

Great Ormond Street Hospital (GOSH) staff survey continued

	2010		2011		Trust improvement/ deterioration/ no change
Bottom four ranking scores	**GOSH**	**National average**	**GOSH**	**National average**	
Percentage of staff saying hand washing materials are always available	48%	68%	47%*	67%	No change
Percentage of staff working extra hours	76%	65%	76%*	67%	No change
Percentage of staff suffering work-related stress in past 12 months	31%	26%	29%	27%	No change
Percentage of staff witnessing potentially harmful errors, near misses, or incidents in past month	42%	33%	45%*	31%	No change
Percentage of staff experiencing physical violence from staff in the past 12 months	N/A	N/A	2%*	1%	No change

Indicates top scores and bottom scores in 2011

Above average in 2011

Below average in 2011

The 2011 results reflect our emphasis on education and training, and the importance we place on staff being able to contribute towards improvements in their own areas of work.

The key areas of work we will be focusing on for improvement are:

- **Availability of hand washing facilities:** results of a more detailed survey indicated that staff in non-clinical roles and non-frontline departments were most likely to feel that hand washing materials were not always available. Work includes continuing monthly audits of hand washing on wards; improved monitoring and reporting of empty soap/sanitiser dispensers across the Trust; and improved hand washing facilities in the new Morgan Stanley Clinical Building.

- **Understanding and tackling stress:** we launched our new employee assistance programme in December 2011, providing a free and confidential counselling and support service to staff. We will also increase practical training to help staff and managers better recognise and manage stress at work.

- **Witnessing errors and near misses:** we encourage staff to report all incidents. We believe that the high numbers of staff reporting errors reflects the expertise of our clinicians to recognise problems when they occur, and then to use our reporting processes to learn from them openly and constructively. The survey tells us that overwhelmingly, our staff report errors when they see them, and have high levels of confidence in our systems to manage this process. Our objective is to maintain the high level of reporting of incidents but see the severity of each incident reduce.

- **Bullying and harassment:** we have worked with our union colleagues and managers to understand this result from the survey and will be sending out a very clear message as part of our ongoing work that any form of bullying and harassment is totally unacceptable. We will continue to promote early interventions, mediation and high-quality line management in order to tackle concerns over bullying and harassment.

In addition to our annual staff survey, we have used exit questionnaires, intelligence from our Human Resources, Occupational Health and staff counselling services, and targeted surveys to test staff views over the past year. We surveyed line managers on the support they need to deal with stress and workplace conflict, and undertook a major exercise to help us identify our objectives under the 2011 Equality Act (see page 36). The results emphasise the critical influence of line managers in the experience of staff at work, and we have revised some of our key training courses and are improving our selection processes to ensure that staff in these key posts are competent and confident to carry out these roles.

We remain very committed to close working with our partners in unions and professional bodies. Our monthly Staff Involvement Forum allows senior managers and staff-side representatives to discuss a wide range of issues including the Trust's financial position and any change processes affecting staff.

As a dynamic organisation, we continue to implement changes to clinical and support services – and staffing structures – in order to achieve the highest quality of service provision in the most cost-effective manner. We have long-standing Human Resources (HR) policies, agreed with our staff-side colleagues, to implement these changes quickly and effectively while minimising as far as possible any adverse impact on our staff. Given this, great emphasis is placed on consulting with staff and explaining the anticipated benefits of service changes. Every effort is also made to protect job security (and minimise any redundancies) through redeployment and retraining. As such, during the course of the past 12 months, significant changes have occurred (among other areas) within the Trust's laboratories, Finance Department, and Genetics Unit. These changes have occurred after full consultation with staff and their representatives, and have been implemented in a way that upholds the best HR practice in the management of change.

Our new intranet site, launched in January 2012, has provided a foundation for improved information-sharing across the organisation, and our targeted use of corporate emails allows us to disseminate important messages quickly to all staff. We ran elections for the staff constituency of our Foundation Trust Members' Council which concluded in November 2011. Three of our elected staff councillors helped us to establish our equality and diversity objectives, and we will be working with all of them to help them engage with their membership and provide a further, important means of two-way communication across the hospital.

In 2011/12, the Chief Executive and directors hosted two open meetings for all senior members of the clinical and non-clinical workforce to discuss issues such as safety and communications.

Commissioning for Quality and Innovation (CQUIN) 2011/12

The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation. The framework aims to support a cultural shift by embedding quality improvement and innovation as part of the commissioner/provider discussion. In 2011/12, each provider on a national standard contract was entitled to earn 1.5 per cent of the contract value, subject to achieving goals in a CQUIN scheme. The Trust made excellent progress across all indicators, achieving an overall compliance rate of 96 per cent against the standards set. Table six summarises our performance against both Primary Care Trust and London Specialist Commissioning indicators.

Table three: performance against 2011/12 CQUIN indicators

Indicator		£ available	£ achieved	% achieved
1a	Patient experience – personal needs (national patient survey questions)	101,040	101,040	100
1b	Patient experience –composite score on Ipsos MORI survey (local survey questions)*	20,208	0	0
1c	Patient experience – strategy and action plan	60,624	60,624	100
1d	Patient experience – undertake qualitative benchmarking	20,208	20,208	100
2a	Surgical site infections – reduction (or maintenance) of current infection rate in four surgical specialties**	181,871	136,403	75
2b	Surgical site infections – implementation of surveillance plans in five further specialties	181,871	181,871	100
3a	Central venous line infections – maintenance in rate	181,871	181,871	100
3b	Central venous line infections – reduction in rate	181,871	181,871	100
4a	Nutrition screening – implementation of tool to meet requirements of Care Quality Commission (CQC)	145,497	145,496	100
4b	Nutrition screening – weight audit	72,749	72,749	100
4c	Nutrition screening – height audit	145,496	145,496	100
5a	Safeguarding – record keeping***	72,749	36,240	50
5b	Safeguarding – supervision	218,244	218,244	100
5c	Safeguarding – training	72,749	72,748	100
6	Paediatric Trigger Tool process review	363,742	363,742	100
7a	Unplanned readmission rate (Paediatric Intensive Care Unit/ Neonatal Intensive Care Unit/Cardiac Intensive Care Unit)	179,696	179,696	100
7b	Accidental extubation rate	19,966	19,966	100
8	Paediatric haemophilia – progress towards optimum individualised prophylactic dosage of clotting factor	199,662	199,662	100
9a	Paediatric oncology – prescribing improvements	199,662	199,662	100
9b	Paediatric bone marrow transplant – antifungals usage			
	Total	**2,619,776**	**2,517,589**	**96**

***1b. Patient experience – composite score on Ipsos MORI survey (local survey questions)**

For this target, 50 per cent of the payment was based on an improved composite score (against the previous year) of responses to the two local questions within the Ipsos MORI survey:

1. Knowing how to feedback or complain
2. Quality and variety of food.

The Trust sustained performance against 'knowing how to feedback or complain', achieving 74 per cent satisfaction, which was the same as the 2010/11 survey. However, the Trust did not sustain performance on the quality and variety of food, which deteriorated by six per cent, from 60 per cent to 54 per cent against 2010/11. The overall composite score was therefore lower than that reported in 2010/11.

Fifty per cent of the payment was also based on an improvement of one per cent in either of the local questions.

****2a. Surgical site infections – reduction (or maintenance) of current infection rate in four surgical specialties**

The Trust was awarded 75 per cent of the payment based on the spinal implant specialty, reporting a year-end surgical site infection rate outside the 95 per cent confidence limit set. Cardiac, neurosurgery and urology all remained within the confidence limits at year-end.

*****5a. Safeguarding – record keeping**

The Trust reported a 50 per cent achievement of the payment based on:

- The quarter one record-keeping audit did not take place due to revisions to the audit tool
- Quarter two compliance against the record-keeping audit was reported at 66 per cent against a target of 75 per cent
- The Trust achieved compliance against the audit standards in quarters three and four.

For 2012/13, the CQUIN contract value has increased from 1.5 per cent to two per cent. Key measures have been agreed with commissioners and include:

- mortality review of all deaths
- reducing the number of pressure ulcers within the hospital
- reducing surgical site infection and blood stream infections
- improving patient experience
- introducing smoking cessation for parents
- improving the discharge planning process.

Service review

The hospital's clinical services are divided into five clinical units. The clinical units contain diagnostic or therapeutic services for similar conditions or types of treatments. Within each clinical unit, we have outlined below the key developments or changes to services that will occur over the forthcoming year.

Cardio-respiratory Clinical Unit

This unit provides services to children with conditions of the heart or lungs.

The cardiac wards (intensive care, high-dependency care/ward care, and day cases) have recently moved into a new purpose-built facility. This has increased the number of beds in each area and will allow us to treat more patients. As a result, this will also enable us to treat the proposed increased number of patients that will be referred to Great Ormond Street Hospital (GOSH) following the rationalisation of children's cardiac surgery in the National Safe and Sustainable Review.

Infection, Cancer, Immunology and Laboratory Medicine Clinical Unit

This unit manages patients with cancer, blood or infectious diseases and the hospital's pathology services. Often patients are managed in partnership with another hospital closer to the patient's home.

We will increase the number of beds on the wards that provide services to these patients, to enable more patients to be treated, and patient transfers from a partner provider to occur rapidly. The growing range of indications for bone marrow transplants is increasing the demand for them and our expansion will also enable us to complete more each year.

Medicine, Diagnostic and Therapy Services Clinical Unit

This unit provides services to children with medical conditions and manages many of the hospital's clinical support services such as Radiology, Physiotherapy and Pharmacy.

We have several new and advanced technologies planned for our Imaging (Radiology) Department over the coming year. Firstly, we will be replacing one of our magnetic resonance imaging (MRI) scanners with a 3 Tesla MRI scanner, which will increase picture clarity and be especially useful for complex brain imaging. We will also be opening three new angiography laboratories, one of which will also be a theatre and, as such, joint angiography/theatre procedures can be undertaken. These projects follow implementation of the Trust's Picture Archiving and Communication System which stores radiology images and allows clinicians to view them anywhere in the Trust.

The Renal Unit has just transferred to a new, combined Inpatient and Dialysis Unit in the Morgan Stanley Clinical Building (MSCB).

Neurosciences Clinical Unit

This unit provides services to children with conditions of the brain or eyes.

We have recently been selected as one of only four centres in the country that will provide specialist assessment and surgery for children with uncontrolled epilepsy. In this role, we will co-ordinate all the services throughout London, the South East and East of England, and undertake all complex surgical procedures. We will also provide a leadership role for the development of services in the other three centres in the country. Neuroscience ward facilities have just been transferred to the MSCB.

Surgery Clinical Unit

This unit provides services to children who require surgical treatments and also manages all the theatres within the hospital, as well as the Paediatric and Neonatal Intensive Care Units.

In early summer 2012, we will be opening an additional, eleventh theatre. This will enable us to increase the number of surgical cases we undertake in several different specialties, particularly neurosurgery, urology, general and neonatal surgery, ear nose and throat, and cardiac surgery.

Additionally, we will be converting two of our existing theatres with new, integrated technologies that will enable us to undertake a greater number and complexity of endoscopic (keyhole) procedures which reduce scarring and enable faster recovery.

We are also opening a new, eight-bed, short-stay surgical unit for patients who require a hospital stay of approximately two to three days.

The Trust has two divisions which work closely with the clinical units.

Research and Innovation Division

The aim of the division is to provide an effective infrastructure to support our mission to provide world-class, pioneering research and treatments, in partnership with others, for the benefit of children in the UK and worldwide.

Two significant achievements in 2011 included the successful application to the National Institute for Health Research (NIHR) to host a Biomedical Research Centre at Great Ormond Street Hospital and the Institute of Child Health, University College London (GOSH BRC) for a second five-year term; and a positive outcome to a Medicines and Healthcare Regulatory Authority (MHRA) routine inspection.

The NIHR confirmed a further five years' funding for GOSH BRC. The award is for a total of £36 million and supports the only BRC in the UK solely focused on paediatric experimental medicine; research that brings basic laboratory scientific advances into the clinical setting to maximise patient benefit. This programme of research includes initiating new studies, accelerating the discovery of the molecular basis for childhood diseases, developing novel diagnostics and imaging modalities, and developing new and novel treatments including stem-cell and gene therapies. The main focus of our BRC during its second term will be on rare diseases, recognising the collective burden they represent and the way their study informs generic/more common disease mechanisms.

With regards to the MHRA inspection, a number of GOSH-sponsored studies were selected for detailed routine analysis, along with the examination of research and development (R&D) procedures and governance arrangements. The Division is delighted to report that there were no critical findings.

The Division of Research and Innovation has continued to grow over the last year, with the development of specialist teams in R&D in the areas of research facilitation, research governance, industrial collaboration, clinical trials, and costings and contracts, as well as increased collaborative working between the R&D Office, Somers Clinical Research Facility and Medicines for Children Research Network (MCRN). Areas of particular focus have been in the development of key performance indicators for research reporting and streamlining R&D processes. The NIHR has set a target for study set-up arrangements to be completed within 70 days, which comes into effect from 2013, and preparations to meet this are well underway.

The following figures outline current research activity within GOSH during 2011/12:

- One hundred and forty-two active research projects are currently taking place within GOSH, of which 34 are commercially funded, two are EU funded and six are NIHR funded.
- Sixty-four research projects have been set up (an increase of 73 per cent from 2010/11), including 19 commercially funded projects.
- One thousand, three hundred and sixty-two GOSH participants have been recruited to projects on the UK Clinical Research Network Portfolio database (high-quality clinical research studies that are eligible for support from the NIHR).
- Thirty-six projects have been internally peer-reviewed by the Clinical Research Adoptions Committee.
- More than 75 studies have been conducted in the Somers Clinical Research Facility. These have involved 1,326 participant appointments. Nine hundred and eighty-eight participants have been seen over the two years 2010–12.
- There were 102 GOSH studies on the MCRN portfolio, of which 40 were open to recruitment and over 60 per cent are GOSH patients. Four hundred and fifty-two participants have been recruited for these projects.

Areas of growth for 2012/13 include the number of phase one and two clinical trials of investigative medicinal products, increased industrial collaborations, and a target to recruit 10 per cent more patients to clinical research studies.

International Private Patients (IPP) Division

The IPP Division provides almost the full range of specialist services offered by GOSH to private and international patients. In addition, there is a developing programme of education and training for clinical professionals working in other countries.

The activity undertaken by the IPP Division has increased by almost 10 per cent over the past year; total income increased by almost 14 per cent. International referrals from Kuwait and other Middle Eastern countries have increased over the period. The unit has successfully re-established a related donor kidney transplant service for children and new outpatient services in travel medicine and allergy. Quaternary cases are increasing; for example, craniofacial complex cases including the separation of conjoined twins.
The removal of the cap on income earned from non-NHS activities means that in the coming year, IPP will recruit staff to open a total of eight additional beds and two dedicated intensive care beds. This will provide greater capacity for specialist work in London and increase the ability to accept urgent referrals. The unit will also access additional MRI capacity to improve access to this diagnostic service. Marketing in the Gulf region will be enhanced to raise the profile of GOSH as a world-class, specialist children's hospital and encourage referrals to GOSH rather than to Germany, the US and Canada.
It is likely that activity from Greece and Cyprus will reduce as those countries seek to retain patients rather than refer abroad. Libya has expressed an interest in establishing a referral relationship with GOSH, and the first patients have already been treated in London. Work will continue to explore the potential for the Trust to undertake the direct provision of clinical services in Kuwait.

IPP will also further develop overseas education and training services. The unit is actively pursuing opportunities to extend training and attachment programmes to territories outside the Middle East.

Quality, Safety and Transformation team

In October 2011, the Transformation team and Clinical Governance and Safety team amalgamated to form the Quality, Safety and Transformation (QST) team.

The QST team is responsible for facilitating the delivery of the Trust's quality strategy. Working with teams throughout the hospital, it provides a comprehensive and integrated system of effective project support and incident response as well as education and training. The QST team strengthens and enables the energy and innovation within the Trust for safety and quality improvement.

The QST team's work feeds into a far-reaching and responsive network of improvement champions across the Trust that includes the unit-devolved improvement co-ordinators/managers, risk managers, patient safety officers and clinical improvement leads. A central team also provides resources throughout the hospital to support the safety agenda; maintaining the complaints- and incident-reporting mechanisms, supporting audits, and providing analyst support to provide the data required to drive improvement. The clinical outcomes programme continues to support specialties in the development, measurement and publication of benchmarked clinical outcomes.

Education is key to ensuring those on the front line have the training in improvement quality methodology they need to deliver projects. This training aims to develop skills in continual improvement and leadership, with individuals working on projects in their department. This training is supported by a development programme and mentoring. Monthly masterclasses from national and international experts in patient safety and quality improvement are open to all Trust staff to attend.

Members of the QST team are now able to report as a joint team and produce monthly reports and data to the Trust Board which show how the Trust is progressing towards the 'no waits, no waste, zero harm' objectives. Further information about the outcome of the work of the QST team can be found in the Quality Account on page 42.

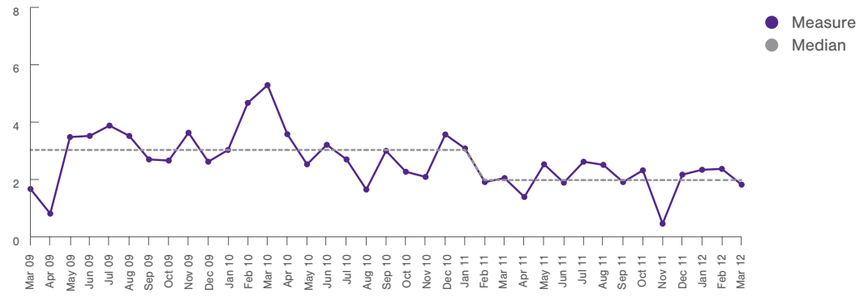
Each clinical unit developed an improvement plan in the first half of 2011. These plans are made up of core projects to help them reach the Trust's strategic objectives (below) and more local projects which also link to the 'no waits, no waste, zero harm' objectives.

Examples of transformation projects include:

Reducing hospital-acquired central venous catheter line (CVL) infections
The combination of training and education and improvement methodology to change behaviour and culture is making a real difference to the number of infections. The chart below shows a reduction from 3.02 to 1.97 CVL for every 1,000 line days. This has been sustained since February 2011.

The clinical units themselves have come up with a range of innovative ways to address the problems. Every ward is working on a project to reduce infection. One clinical unit is currently focusing on the impact of parents and families on improving infection control and using transformation and human-factors techniques to achieve this, including monthly infection prevention and control walk-arounds to understand the barriers to good infection control from a parent's point of view. Another initiative is to improve hand hygiene for visitors, whereby infection-control link nurses are auditing a minimum of 10 parents and families to assess the impact of training and educating parents and families, and of changes to the ward environment.

GOSH-acquired central venous catheter line infections for every 1,000 line days



As can be seen on the chart above, the number of infections fell in November 2011. This was due to a focus at clinical unit level on improving compliance with the central venous care bundle. The bundle is a set of practices that, when performed collectively, reliably and continuously, have demonstrated improvement in patient outcomes. The bundle includes, among other things, hand washing, daily inspection of the site and ensuring the dressing is dry. This project has concentrated its efforts in making sure that staff are complying with the bundle through education and training.

Improving reliability of record keeping
Each clinical unit has a project designed to improve the quality of medical records. The Cardio-respiratory Unit embraced this project and appointed clinical and project leaders to work towards improving reliability of inpatient records. The team used small cycles of change to help make sure they were going in the right direction. They held education and awareness sessions, had weekly feedback and included an induction training passport. The project has now maintained 92 per cent compliance which has been sustained since May 2011. Each clinical unit is continuing to work to improve the quality of medical records in 2012/13.

Education and training

Education underpins the delivery of world-class clinical care and innovative clinical research, as reflected in the Trust's strategic aim to 'recruit, train and retain the very best staff', and be one of the top five children's hospitals globally.

Learning Education and Development (LEaD) co-ordinates and monitors learning activities to ensure that every single student and member of staff is supported to achieve their potential.

2011/12 has been an exciting year as we have embarked on delivering the first full year of our five-year education strategy. This year, 2,938 staff and students accessed some form of in-house learning, and 12,006 course places were filled. In addition, staff also attended a wide range of learning experiences outside the Trust, including university-based courses, conferences and one-off training courses.

The provision of high-quality systems for mandatory training of staff is essential. This year, we completed our bi-annual review of the staff induction and updated it in collaboration with managers and users. We have adopted learning innovations such as enhancing the Trust's online campus (known as GOLD), video and simulated learning to improve learner satisfaction and significantly reduce the amount of staff time out of the workplace.

We also provide role-development preparation, including advanced clinical skills and management and leadership courses, launching two new improvement programmes: the Transformation Improvement Methodology Programme and EQiP, innovative improvement training for doctors.

Learning occurs in all parts of the hospital and our strategy aims to ensure that there is an equitable, integrated, multidisciplinary approach Trust-wide. This year we have restructured the department to integrate nursing with medical education and the wider education department and have made stronger links with clinical units and departments.

We have further strengthened the governance and outcomes framework for education. We attend quarterly unit/department performance reviews and a Strategic Education Committee now reports to the Trust Management Board through a monthly *Zero Harm* report indicating performance against key performance indicators for statutory training and appraisal.

Priorities for 2012/13 include a continued focus on simulated learning, strengthening our commercial business model and ensuring that Great Ormond Street Hospital is a lead player in the new education commissioning framework for London.

Redevelopment

Great Ormond Street Hospital 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 out-dated – they were built at a time when healthcare needs were very different. New facilities 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

Phase 1 of the redevelopment was completed in 2006 and comprised the Octav Botnar Wing, Weston House (including 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 (MSCB) and the redevelopment of the existing Cardiac Wing.

During the year, we continued to make good progress on the development of the MSCB, with the contractor handing the completed building to us in December 2011. We continued our work with staff and other stakeholders – including children and young people and their families – to finalise the detailed plans for moving into the new building.

Formally opening in June 2012, the Morgan Stanley Clinical Building provides new clinical accommodation, including 84 inpatient beds, 16 day case beds for use by haemodialysis and cardiac services, theatres and angiography facilities, together with a new restaurant and improved staff areas.

We continue work on the design implementation of Phase 2B (redevelopment of the Cardiac Wing) which is due for completion in 2016. We have also started work with Great Ormond Street Hospital Children's Charity and the UCL Institute of Child Health on Phase 3A of the redevelopment programme, the creation of the Centre for Rare Diseases on the old University of London Computing Centre site.

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 renewable contribution.

Improving facilities within the existing buildings

During the year, alongside the redevelopment programme, we have undertaken further ward refurbishments as part of our continuing investment in our existing facilities to keep them as up-to-date and energy-efficient as possible.

Information management and technology

Investment in information technology (IT) continued in 2011/12, building on the infrastructure established in the previous year. The Trust's investment plan includes both the replacement of ageing clinical systems and the implementation of new applications aimed at improving the patient experience and increasing the efficiency of the Trust's processes.

During the year, two major clinical systems were replaced: the Trust's Picture Archiving and Communication System (PACS), which stores radiology images and allows clinicians to view them anywhere in the Trust; and the Trust's intensive care monitoring system. A new intranet and email system was also installed in order to improve communications within the Trust. In addition, the Trust is partway through implementing a new diagnostic test ordering and results reporting system which will go live during 2012.

The Trust also invested in a number of new systems, the most notable being:

- an image exchange portal (allowing images to be exchanged between trusts electronically)
- state-of-the-art audio visual and video conferencing equipment which allows clinicians to communicate effectively with other clinicians anywhere in the world
- asset tracking using the wireless network, enabling mobile clinical equipment to be located at any time.

The Trust will continue to progress its IT strategy during 2012 with an overall target of implementing fully electronic, integrated patient records within three years.

Financial review

This section provides a review of the financial performance for the 11-month period ending 29 March 2012, but also shows full twelve months information combined for the NHS trust and the Foundation Trust to allow better understanding of year-on-year trends.

The Trust attained NHS Foundation Trust status on the 1 March 2012 and as a result is required to prepare two sets of accounts covering the financial year to 31 March 2012. The Trust's accounts for the period 1 April 2011 to 29 February 2012 have been prepared in accordance with Department of Health guidance. The accounts are also prepared in accordance with International Financial Reporting Standards as adopted by the European Union and are designed to present a true and fair view of the Trust's financial activities. There are no substantive differences between the way in which these accounts and the accounts for the NHS Foundation Trust have been prepared.

NHS organisations were required to fully comply with IAS 20 in relation to the treatment of donated assets with effect from 1st April 2011. As a result, the Trust's revenue statement includes charitable donations received to fund capital expenditure which are currently very significant relative to other income streams in the Trust due to the redevelopment programme detailed on page 22.

In order to fully understand the trends in income and expenditure, the information included in the following table includes the financial information for the NHS Trust and the NHS Foundation Trust combined for the year to 31 March 2012. In addition, the financial information has been adjusted to exclude discontinued activities (the children and young people's community services based in Haringey which transferred to a community health provider in May 2012) and the impairment charge to the revenue account arising from the annual revaluation of buildings.

Donations for capital are reported separately due to the variability between years.

	Growth %	Year ended 31 March 2011 £'m	Growth %	Year ended 31 March 2012 £'m	11 months ended 29 February 2012 £'m
For the period ended					
Operating income excluding donations for capital	8.5	318.9	5.3	335.9	303.1
Donations for capital		49.2		28.2	23.9
Total income		368.1		364.1	327.0
Operating expenses	8.4	296.7	5.5	313.1	282.4
Earnings before interest, tax and depreciation					
• Including donations for capital		71.4		51.0	44.6
• Excluding donations for capital	9.5	22.2	3.2	22.7	20.7
Net surplus					
• Including donations for capital and impairments		50.1		18.4	13.5
• Excluding donations for capital and impairments arising on revaluation of buildings		2.4		2.5	1.8
As at the end of the period					
Assets employed		335.3		351.1	346.0
Key ratios					
Earnings before interest, taxes, depreciation, and amortisation		6.9%		6.8%	6.8%
Operating margin as a percentage of income		0.7%		0.7%	0.6%

The following trends relate to the annual growth combining the results of the NHS Foundation Trust and the NHS trust and adjusted as in the table:

- Operating income increased by 5.3 per cent as a result of growth in patient care and increased funding for the resources employed in our research and education activities.
- Strong growth in patient activity was achieved in both the NHS and international private patient services
- Operating expenses excluding. depreciation and impairment charges increased by 5.5 per cent on the previous year.
- Staff costs increased by 5.8 per cent as a result of the increased staff numbers to deliver the growth in services and research and development activity, and as a result of pay increases.
- There were impairment charges totalling £12.3 million (2010/11: £1.4 million) resulting from the Trust's revaluation of its land and buildings including the revaluation of the recently completed Morgan Stanley Clinical Building.

We continued to invest considerable sums to improve the hospital's facilities. In addition to the expenditure on the new redevelopment programme, there was also expenditure on other hospital buildings, medical equipment and our information technology infrastructure. In total, £34.3 million was invested across the site during the eleven months ended 31 March 2012 and £40.9 million for the year ended on the same date, of which £23.9 million and £28.2 million respectively were funded by Great Ormond Street Hospital Children's Charity and the balance funded from internal resources.

We delivered a financial surplus of £18.8 million in the eleven months to 31 March 2012 including £23.9 million of donations funding capital expenditure and after charging £12.3 million for asset impairments arising on the revaluation of the Trust's estate including the newly completed Morgan Stanley Clinical Building. If these donations and the revaluation impairments and loss on asset disposals are excluded the Trust made a net operating surplus of £7.2 million from which a dividend of £5.3 million is paid to the government.

Net assets employed

The value of property, plant and equipment and intangible assets increased by a net £34.3 million during the 11-month period to stand at £325.8 million at 29 February 2012. This change was the net result of the additional capital expenditure less the impact of depreciation.

Net current assets (excluding receivables due in more than a year) stood at £19.4 million, increasing by £5.1 million in the eleven month period. The cash position reduced by £13.3 million to £19.1 million as a result of a reduction in levels of creditors and some outstanding debt positions which cleared significantly in March.

Productivity improvements and efficiency savings

The Trust continued to pursue productivity and efficiency savings in the month-long period, without any impact on our clinical services. The efficiency programme includes both initiatives that will increase activity and the associated income with less or no increase in cost, and those that reduce costs with less or no reduction in income. This is most notable in the transformation of clinical services, reduction in drug costs, procurement, and increasing the efficiency of administrative support processes.

Financing and investment

Throughout the period the Trust maintained strong controls on capital expenditure and working capital.

Better Payment Practice Code (BPPC)

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

The Trust maintained its BPPC performance for non-NHS creditor payments and achieved payment within 30 days of 87 per cent non-NHS invoices measured in terms of number and value.

Pension funding

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme which covers all NHS employers. The Trust makes contributions of 14 per cent to the scheme.

Treasury policy

Surplus funds are lodged with counterparty banks through the Government Banking Service.

Political and charitable donations

The Trust has not made any political or charitable donations during the 11-month period or in the previous year.

Financial risks

The Trust continues to experience financial uncertainty due to further changes in the Payment by Results tariff, both generally and also due to specific changes affecting specialist paediatric trusts, and the annually determined R&D funding.
The challenging economic environment puts considerable pressure on the Trust's finances, both in terms of erosion of tariff and funding not keeping up with cost inflation and the increased costs to deliver regulatory requirements.

The Department of Health 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 2012/13.

The Trust's financial instruments, other than those used for treasury risk management purposes, comprise cash and liquid resources, borrowings and various items such as trade debtors and creditors that arise directly from its operations.

Currency risk and interest rate risk
The Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. As such, the Trust does not undertake transactions in currencies other than sterling and is therefore not exposed to movements in exchange rates over time. The Trust has a representative office in one Middle East country but otherwise has no significant overseas operations.

Credit risk
Due to the fact that the majority of the Trust's NHS income comes from contracts with other government departments and other NHS Bodies, the Trust is not exposed to major concentrations of credit risk. A large proportion of the income received on private patient activity comes from overseas government sources.

Liquidity risk
The Trust is subject to limits on its borrowings imposed by way of its Prudential Borrowing Limit. The Trust has not utilised any external borrowings in year.The Trust may receive interest on surplus cash deposits. Interest rate risk is also a concern due to the historically low rates of interest obtainable on surplus cash deposits.

Public interest disclosures

Safeguarding
Safeguarding remains a priority for the Trust. Our achievements for 2011/2012 were:
- Achievement of year-end Safeguarding Commissioning for Quality and Innovation (CQUIN) target for Level 3 training
- Design and implementation of the Great Ormond Street Hospital (GOSH) Safeguarding Scorecard
- Positive Care Quality Commission (CQC) Inspection for Safeguarding June 2011
- The establishment of a GOSH seat on the Camden Safeguarding Children Board
- Development and implementation of an electronic system for referrals to GOSH social work.

The Trust is the first NHS Foundation Trust in London to be given a Safeguarding CQUIN with attached financial incentives. The Trust is also now in a stronger position to integrate the latest Safeguarding monitoring tool, the North Central London 1 Safeguarding Matrix, which began in April 2012.

Progress against key priorities for safeguarding 2011/12
Level 3 child protection training
Eighty-eight per cent of staff have already attained the minimum Level 1 child protection training standard. We have also significantly increased our provision to ensure all clinical staff achieve Level 3 over the next two years. In 2011/12, we exceeded the CQUIN target of 40 per cent for Level 3 training.

Child protection supervision
The Trust showed an overall increase in child protection supervision from 20 per cent in 2010 rising to 90.4 per cent in quarter four of 2011/12, well above our target of 50 per cent.

Case conferences
During this reporting period, the Trust was advised of 30 invitations to attend case conferences. Of these, 14 were attended and for 16, reports were submitted. GOSH is therefore compliant with the required standard for reporting to case conferences, where invited. The majority of invitations were from London boroughs (approximately 70 per cent).

Inspections
Safeguarding (outcome seven) was included in an unannounced CQC inspection of standards at GOSH in July 2011. The inspection found the Trust was meeting the safeguarding standard. In addition, the London Borough of Camden completed a two-week inspection by Ofsted/CQC of its children's services. One of the cases chosen to map the child's journey through Camden was a GOSH case known to our neurology service. Feedback was largely positive.

Social care referral activity
For this financial year, the GOSH social work service was involved with 1,333 children. Of these, 185 children required some child protection intervention. (This includes direct/non-direct involvement by GOSH social work, as well as children who may have been re-referred following a re-admission/subsequent attendance to outpatients, for example.)

Looking forward to 2012/13
Our priorities for safeguarding in 2012/13 are:
- To develop safeguarding metrics in line with the requirements of the North Central London Health cluster. This will build on the GOSH scorecard and will continue to reflect GOSH progress against national safeguarding standards
- To achieve North Central London safeguarding metrics on record-keeping, child protection supervision, Level 3 training, attendance at case conferences
- Review the new requirements for serious case review systems in relation to the Munro review and revise *Working Together* (2010) to ensure compliance.

[1] The North Central London cluster consists of Camden, Islington, Enfield and Haringey health economies.

Health and safety

Health and safety at Great Ormond Street Hospital (GOSH) is treated with the same importance and degree of expertise as other core activities to effectively control risks and prevent harm to all patients, visitors and staff.

There has been a marked increase in the number of reported non-clinical incidents affecting staff, contractors and visitors over the past 12 months (70 per cent) following the introduction of the new online reporting system.

GOSH employees reported 811 health and safety incidents from 1 of April 2011 to 31 March 2012, including 99 patient-safety incidents.

Health and safety audit

The Trust has an annual, rolling programme of assessments, checklists and audits designed, in part, to monitor whether the Trust is meeting its statutory obligations and to ensure that a process of continual improvement is in place. The governance structure within safety ensures that any statutory compliance is undertaken within stated legislative guidelines.

Ongoing work

The Health and Safety team continues to work closely with all areas of the Trust. Work that has been undertaken this year includes:

- The Trust Health and Safety Policy and Lone Worker Policy have been revised
- Each ward/area has a bespoke intranet page that contains their local risk assessments/control of substances hazardous to health assessments/ safety data sheets/policies/guidance and procedures
- The health and safety audit tool and cycle have been revised to ensure the Trust meets its statutory duties
- Additional audits have been devised which include new contractors based on site
- Quarterly workshop audits have been introduced with Unison.

The Health and Safety Department continues to work closely with the Estates Directorate, helping to bolster safety culture. The Directorate continues to have monthly Health and Safety Committee meetings which oversee safety management/statutory compliance and quality initiatives.

Sustainability report

The Trust is committed to its sustainability agenda and has developed an annual Sustainable Development Management Plan (SDMP) in response to the NHS Sustainable Development Unit's Carbon Reduction Strategy.

This strategy delivers a framework for the Trust to work to, which will build on the work already carried out in our Carbon Management Strategy and Implementation Plan, which was produced in partnership with the Carbon Trust. The development of the plan demonstrates the Trust's commitment to carbon reduction through a range of practical but ambitious measures, sharing of good practice and active engagement and support of its staff.

Summary of performance

The SDMP for 2011 focused on the following key priorities: environmental legislation, governance, organisational and workforce development, partnerships, finance, energy and carbon management, water and waste management, travel and transport, procurement and design and operation of buildings. The resultant action plans which supported the SDMP included the following measures:

- To produce a comprehensive carbon baseline (footprint) to measure progress towards objectives, identify milestones, and guide action. **Completed**
- The incorporation of sustainability within the Trust's policies and procedures and reinforcement of Board-level commitment and responsibility. **Approved annual plan at Trust Board**
- Enhanced data management relating to energy, waste and water and the robust measurement of our carbon footprint. **Completed March 2012**
- The development of a communication strategy to ensure the effective implementation of the plan throughout the Trust. **Completed**
- The development and establishment of partnerships with key stakeholders through local strategic partnerships and others. **Completed through the role of the Joint Environmental Committee**
- The development of a sustainable procurement strategy, incorporating supply chain activity, with the Trust's head of procurement and supply chain manager. **Completed**
- Identify opportunities to reduce the Trust's carbon emissions, particularly through the active management of energy, transport and procurement. **Completed as part of Travel Plan 2012**
- Establish clear targets following the final assessment of the Trust's carbon baseline (footprint).
- Annual assessment of action plans. **Completed**
- Establish the Trust's commitment to the Good Corporate Citizenship Model.

The following tables summarise Trust performance in 2011/12.

Table four: gross scope one to three carbon emissions

		2007/08	2008/09	2009/10	2010/11	2011/12
Emissions as a result of electricity consumption	Electricity	11,866	10,453	11,507	11,965	12,905
Emissions as a result of gas consumption	Gas	3,161	4,037	4,162	4,584	4,178
Emissions as a result of business travel – air	Air	0	0	62,284	113,554	96,532
Emissions as a result of business travel – road	Road	0	0	0	0	0
Emissions as a result of business travel – rail	Rail	0	0	12,376	12,643	12,636
Emissions as a result of other activities	Other					
	All CO2e tonnes		Change in emissions scope (Level 3)			**1,179**

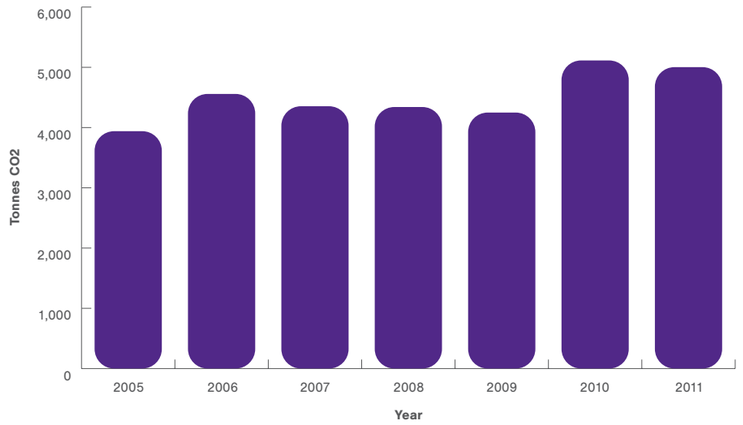
Table five: waste expenditure – total expenditure on waste

	2010/11	2011/12
Total waste arising	384,504	345,079
Waste sent to landfill	32,452.10	21,750.24
Waste recycled/reused	52,726.30	67,693.36
Waste incinerated/energy from waste	299,325.70	255,635.40

Table six: energy usage

	Phase 2 only	Whole site
Carbon reduction	124%	77%
Renewable contribution	62%	26%

EU Emissions Trading System emissions between 2005 and 2011



Summary of future strategy

Energy management

The Trust is committed to responsibly managing the use of energy and utilities; particularly those that have non-renewable sources so that consumption and pollution are minimised and scarce, non-renewable resources are protected.

2012 is a significant year for energy management at GOSH. The opening of the Morgan Stanley Clinical Building (MSCB) brings with it the new Energy Centre. The main difference will be the Combined Cooling, Heating, Power generator that sits on the roof of MSCB and allows GOSH to produce its own electricity for the first time. The generation of electricity on site is a more efficient process than electricity being produced at a power station and delivered to the hospital. Furthermore, we can use the by-product of the electricity generation – heat – to provide part of our heating and cooling needs.

Improved sustainability reporting

This year is the first in which the Trust is required to report on its sustainability performance in a wide range of areas, including carbon, waste and water usage and financial information covering the Trust's emissions, waste and finite resource consumption.

The Trust has also produced a revised Active Travel Plan (2012) which has reviewed progress over the last eight years on our travel planning targets and aims to further deliver improvements in terms of workplace and business travel, and the implementation of a sustainable service and delivery plan that will significantly contribute to the reduction of carbon emissions and the impact of our carbon footprint.

Corporate social responsibility

The Trust has a responsibility to address social, economic and environmental challenges and encourage other organisations to do the same. The Trust is committed and will continue to:

- be aware of the impact of our buildings and ensure that we manage them effectively to avoid any detrimental environmental impact
- maximise the benefits of being a large employer and the significant social and economic impact that has on our local community, including our own workforce
- understand the impact our suppliers have and consider how we can engage and involve them in order to benefit local communities
- work in partnership on many different levels to enable the most effective use of resources and share best practice
- engage our stakeholders to work with us to deliver our Sustainable Development Management Plan.

Waste

A review of the Trust's electrical equipment waste (WEEE, or Waste Electrical and Electronic Equipment) contract has resulted in an annual cost saving of £10,000.

A monthly saving of approximately £2,400 in landfill tax has been achieved by sending all domestic waste to the energy-for-waste route.

As shown in the figures on the previous page, the Trust has increased the amount of waste it has recycled this year.

Use of resources

The guiding principles of energy management are to reduce overall demand for energy, supply this demand for energy through renewable resources and to supply remaining energy as efficiently as possible. Following these principles, the Trust has achieved the following:

- Installing meters across the site so that we can see where energy is being used and an target wasteful energy use
- Fitting energy-efficient LED light bulbs in areas being refurbished
- Updating all lifts in the hospital to more efficient ones
- Installed bio-fuel tanks in the MSCB so that we are ready to use this renewable resource if it becomes available to us within the central London area
- Installed a new form of water treatment that uses copper/silver ionisation to kill legionella bacteria. This allows us to run our water at a much lower temperature.

Climate change adaptation

GOSH has a Climate Change Adaptation Strategy that has helped the Trust to develop an understanding of the risks we face and will lead to the consideration of climate change in future design. A number of responses to mitigate the risks associated with climate change have been reviewed and design features presented. Water conservation and flood management form a central pillar in our adaptation to climate change in the future.

Biodiversity and the natural environment

The newly opened MSCB has a sedum roof which will promote sustainable biodiversity.

Procurement including food

This is an ongoing process that is being addressed through supplier rationalisation, consolidation of delivery schedules with neighbouring trusts, order consolidation to minimise unnecessary delivery/handling charges, and the use of specialised distributors to minimise the number of vehicles entering the Trust and associated costs.

Sustainable construction

Going forward, the Redevelopment Energy Strategy sets a carbon-reduction target of 120 per cent and a renewable-contribution target of 60 per cent from its new developments, while site-wide it sets a carbon reduction of over 70 per cent and a renewable-contribution target of 25 per cent.

The stated objectives from the strategy are as follows:

- Achieving the lowest energy use for the new hospital buildings while meeting patient and staff comfort issues, clinical needs and best value
- Delivering a cost-effective heating and power strategy for the site
- Provide an integrated, overarching site strategy with buy-in from all parties
- Delivering a development to inspire future projects.

Governance

The SDMP is monitored and managed through the Trust's Sustainable Development Committee (SDC) which produces an annual report to the Trust Board.

Monitoring

The SDC leads produce regular monthly reports which are validated by the Trust's Finance team. An external audit on the data produced was carried out in January 2012, which showed that the Trust understands its requirements on sustainability and has governance arrangements in place to support this.

Countering fraud

The Trust has a counter fraud policy which is scheduled for review in October 2012. Counter fraud arrangements are reviewed annually by the Local Counter Fraud Service (LCFS).

The most recent report recorded the counter fraud arrangements for the Trust at level two, which is defined as an "organisation partially meeting the standards set by NHS Protect in relation to counter fraud processes". The Trust was assessed as only partially meeting the standards, as certain policies and procedures had not been kept up-to-date. The review in the current year has been suspended but we aim to address those areas where policies had not been updated during the course of 2012.

LCFS undertakes an ongoing programme of work to raise the profile of counter fraud measures. This includes the use of fraud awareness presentations and fraud awareness surveys. The Audit Committee receives and approves the Counter Fraud Annual Report and monitors the adequacy of counter fraud arrangements at the Trust and reports on progress to the Board.

Statement of compliance with cost allocation and charging

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

Patient and public involvement

The Patient Advice and Liaison Service (PALS) service helped more than 2,500 families, handling a 26 per cent increase in complex cases. 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 with PALS by families enabled many positive changes to be made, including improved bed facilities for older children and parents, better café facilities and improved transport service for patients on dialysis.

Involving patients, their families and the wider public through our membership scheme in areas of service improvement and governance continues to ensure we focus on what really matters to our patients and families. Many members give a regular commitment to service planning and redesign, as well as to the Transformation Board and its improvement projects. New involvement opportunities opened up in 2011/12 with the recruitment of members as volunteer researchers, undertaking over 1,000 interviews with families using reception and outpatients, and visiting wards to interview patients as part of a 'real time' patient experience pilot.

Listening to patients and their families is key to improving services. We have started on a programme of consultations with faith and disability groups, focusing initially on the Jewish Orthodox community, and children on the autism spectrum and their families. In 2012/13, the priorities will be to put insight gained into practice, and to consult with other groups who may have special needs.

Working with our stakeholders

Health Watch
As part of Camden Council's work with the local Local Involvement Networks to create a new patient voice locally, called Health Watch, a representative attended the Trust's Patient, Public Involvement and Experience Committee to update and discuss ways of working together.

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

UCL Partners
Our ICH collaboration has been further enhanced through our involvement in UCL Partners (UCLP), a partnership between University College London and four of London's most prestigious hospitals and research centres – Moorfields Eye Hospital NHS Foundation Trust, the Royal Free Hampstead NHS Foundation Trust, University College London Hospitals NHS Foundation Trust and Great Ormond Street Hospital for Children NHS Foundation Trust. By linking experts from different specialist institutions to share their knowledge and expertise, UCLP will advance scientific knowledge and ensure its healthcare benefits are passed to patients as quickly as possible.

UCLP works to advance medical research, quality patient care and education. The aim is to improve the health of Londoners, share scientific knowledge, and train an internationally renowned, caring workforce focused on academic, clinical and educational excellence.

London South Bank University (LSBU)
All student nurses within GOSH are enrolled with LSBU.

GOSH works closely with LSBU to design quality learning and teaching programmes encompassing both pre- and post-registration education. The new degree level pre-registration programme commenced in September 2011 using the new standards set by the Nursing and Midwifery Council, and a further development will see a shortened, two-year children's nursing programme commencing in September 2012 for people who already have a related degree. In addition to the same clinical mentorship at ward level, students on this programme will be allocated to a senior clinical nurse at GOSH who will act as an organisational coach to ensure that these students achieve their full potential and are supported to become the clinical nurse leaders of the future at GOSH.

GOSH is also part of a UCLP initiative, to launch in September 2012, an accelerated development programme to take newly registered nurses and prepare them to be the future UCLP ward sister/ team leader over a four-year period.

Consultation with local groups and organisations

The Trust has not been required to carry out any statutory consultations throughout 2011/12.

Volunteer Services at Great Ormond Street Hospital (GOSH)
The Trust is committed to engaging volunteers in meaningful volunteer roles that enhance services and add value to the patient and family experience.

Volunteers are engaged in a variety of roles that either directly or indirectly impact on patients, families and staff. Activities include: befriending patients, easing anxiety and boredom; sitting with parents, chatting and being a listening ear; guiding people around the hospital site, signposting to other Trust services and departments; supporting important services such as pharmacy, laboratories, portering and catering; and supporting reception and administration staff.

Volunteering continues to grow, with the department recruiting, training and placing an additional 246 people over the past year. We currently have just over 470 people volunteering on a regular basis (once a week). We estimate that volunteers donate more than 2,000 hours of their time per week.

Alongside the current roles, we have developed nine new roles across the Trust to support staff in their work, including:

- ward host – welcoming patients and families to wards, assisting with finding services in GOSH and giving emotional and practical support where needed
- patient experience and survey support – assisting various departments with important patient and parent information gathering
- GOSH guide – welcoming and guiding people around the Trust.

Volunteer Services also manage the relationships with external organisations that have a stake in GOSH by providing a negotiated service. Some of these organisations include the Scouts and Guides, Radio Lollipop, Epilepsy Society, Citizens Advice Bureau and Child Death Helpline. Volunteer Services works closely with the organisations to ensure suitable services are provided in line with GOSH objectives, volunteer good practice and appropriate standards.

Information for patients and parents
The Child and Family Information Group continued to build on previous successes with another 120 leaflets completed in the past year. The *Essential Information Booklet* has been updated and a new set of information about the wards in the Morgan Stanley Clinical Building has also been completed. Additional supporting information highlighting activities and attractions in the local area has been produced for both children and teenagers.

GOSH website
The GOSH website was relaunched in November 2011. Bringing the Trust and charity websites into one online space, the site provides a springboard for GOSH's digital future, as the hospital increasingly looks to online solutions to meet the needs of patients, families and health professionals. Over 400 patients, families, doctors, nurses and donors took part in the research that led to the design of the new site which has separate sections for teenagers, parents, children and health professionals – including a dedicated section for referrers.

A new site for international and private patients with content in English and Arabic went live in April 2012 and a laboratory medicine website showcasing our range of accredited clinical laboratory services went live in September 2011.

Future plans for the hospital website include the addition of more video content for children and families including video diaries, podcasts and a virtual tour of the hospital. We are also working with clinical teams to enable departments to share relevant information with other healthcare professionals around the country via protected areas of the website. A mobile-friendly version of the site is also being built.

Valuing staff at Great Ormond Street Hospital (GOSH)

We report key performance indicators to our Trust and Management Boards regularly to help us monitor our performance in staffing issues.

We have seen a considerable reduction in our vacancy levels as we implement our planned growth strategy, benefit from improved recruitment processes, and replace higher cost temporary staff with substantive appointments. Our turnover rates remain stable, although we continue to focus on recruiting and retaining a highly skilled workforce and using role redesign and innovation to reduce the need for transactional roles.

Supporting our staff to stay fit and healthy remains a priority. Our health and safety teams supported staff moving into the Morgan Stanley Clinical Building to use new equipment safely and minimise the risk of injury. In December we launched a new staff counselling service which provides high-quality counselling and advice and workplace mediation. We have also added to our suite of reports to more pro-actively identify and manage absence at departmental and Trust level.

Our Occupational Health team continues to support the Trust in ensuring all staff are able to enjoy a healthy work environment. Particular emphasis has been placed in the past 12 months on providing mechanisms for supporting and rehabilitating staff absent from work due to physical or mental health difficulties.

In 2011, our staff awards attracted more nominations from children and families than ever before, and the event in May allowed us to publically celebrate the commitment and team working of our staff.

Table seven

	GOSH 2010/11	London benchmark 2011/12	GOSH 2011/12
Turnover	18%	12%	15%
Absence	3.29%	3.02%	3.24%*
Vacancies	7%	No data available	4%

*Annual Reporting Manual calculation shows average working days lost as 6.615.

Equality and diversity

Our policies, procedures and practices aim to balance the needs of our diverse workforce against the demands of providing high quality care. Our Staff Equality and Diversity Group monitors a range of indicators and develops actions to ensure that Great Ormond Street Hospital is a supportive and fair employer for all staff. Over the past 12 months, we have implemented the reporting arrangements set out in the Public Sector Equality Duty and have strengthened our arrangements to ensure that no one from a protected group suffers a disadvantage under our policies.

At the start of 2012, we ran an engagement process which identified two objectives to support us in our work in improving equality and diversity in the Trust. These are:

- By 2013, the appraisal rates for all protected groups will match the appraisal rates of all other staff
- There will be a year-on-year increase in the percentage of tests used in recruitment selection processes. This will help ensure objectivity in decision-making processes.

Progress against these objectives will be monitored by our Board.

Policies in relation to disabled staff
Policies for giving full and fair consideration to applications for employment by disabled people
The Trust has an Equal Opportunities Policy and Recruitment and Selection Policy and Procedure which supports applications from disabled candidates to receive full and fair consideration. Specific support for Trust staff is provided through recruitment training for recruiting managers, as well as advice to managers in individual cases.

The Trust is recognised as a '2 Ticks' employer. This status is awarded by Jobcentre Plus to employers that have made commitments to employ and develop the abilities of disabled staff.

Policies for continuing the employment of, and arranging appropriate training for, staff who have become disabled
Our Occupational Health department (with input from specialist agencies as necessary), advise on adjustments to support disabled staff, including adjustments to job roles, working hours, environment and any training they may require in order to continue working safely and effectively. Our Managing Attendance Policy has specific provisions to support staff with disabilities.

Policies for training, career development and promotion of disabled staff
We have a policy of regular appraisals for all our staff, which provides an opportunity for the training needs and personal development of all employees to be discussed on an individual basis, taking into account their particular needs.

Complaints handling and reporting to the Ombudsman

We aim to provide the best possible care to all 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 for 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.

Between 1 April 2011 and 31 March 2012, the Trust received 133 complaints, which is comparable with the number received the year before.

Categories by number of complaints (please note some complaints raise more than one issue and therefore maybe counted twice).

The Trust is always looking at improving its services. Following feedback from families, a patient experience project on the Trust's complaints process is being carried out to ensure that the views of our families and patients are listened to and all services provided by Great Ormond Street Hospital are appropriate to their needs.

Ombudsman's Principles of Remedy

There were three complaints referred to the Health Service Ombudsman for a review this year, which included one complaint dealt with by the Trust in previous years.

One case from 2009, regarding failings in clinical care, was upheld by the Ombudsman. An action plan has been developed and agreed with the family and is in the process of being implemented.

As a result of the findings and recommendations from this report, the Trust has reviewed its complaints handling process and made changes to ensure the process is easy for patients and families to understand, is effective in resolving complaints promptly, and enables the complaints to be risk assessed and an appropriate investigation technique to be implemented.

Table eight

Categories	1 April 2011 to 31 March 2012	1 April 2011 to 29 February 2012	1 March 2012 to 31 March 2012
Lack of communication with parents	65	61	4
Staff rudeness	22	21	1
Dissatisfied with nursing care	19	19	0
Delay in treatment	19	17	2
Lack of communication between staff/teams	17	17	0
Inappropriate treatment	16	16	0
Staff uninterested	16	15	1
Incorrect information	11	14	2

Information governance

Information governance incident reporting

The Trust is required to report information governance-related serious incidents. These are incidents involving the actual or potential loss of personal information that could lead to identity fraud or otherwise significantly impact on individuals and should be considered as serious. Two incidents occurred during the 2011/12 financial year which were reported to the Information Commissioner's Office (see Annual Governance Statement on page 123).

All recorded incidents for the period 1 April 2011 to 31 March 2012 are categorised in the table below.

Freedom of information

The Trust's Freedom of Information team is responsible for ensuring that the Trust is complying with its obligations under the Freedom of Information Act 2000 (FOI).

The 2011/12 year saw a marked increase in the number of requests received (49 per cent) compared to 2010/11. Most of the requests were received through the dedicated FOI email address and a marginal number of requests were received by post.

The Trust has 20 working days to respond to a request. This means that responses will usually be due in the month following receipt.

In 2011/12, there were 335 responses due, an increase of 57 per cent compared to 2010/11 (213 responses due). The number of responses sent within 20 working days has increased to 84 per cent compared to 59 per cent in 2010/11.

Subject access requests

Under the Data Protection Act 1998, a patient or person with parental responsibility can apply for a copy of part or all of a patient's medical notes. A fee is applied to such requests.

In the year 2011/12, 983 subject access requests were received. Of these requests, 952 were processed to completion. The remaining 33 were not actioned since the requester did not respond to the payment letter.

Table nine: a summary of information governance incidents in 2011/12

Category	Nature of incident	Total
I	Breach of patient confidentiality	22
II	Loss or theft of encrypted confidential information	2
III	Loss or theft of unencrypted confidential information	2
IV	Patient incorrectly or not identified	2
V	Other	21

Emergency preparedness

We recognise the statutory obligations placed upon us as a Category 1 responder and the requirement to respond to disruptive challenges. These situations may be either within the hospital, such as a fire, or be external where we are required to provide support to neighbouring hospitals.

Planning for these events and managing the associated risks is extremely important. Our plans provide us with guidance and a framework to manage our response. The Major Incident Plan is reviewed and updated annually to incorporate learning from previous incidents not only within the Trust, but also to take note of the experience of others. Our plans comply with the Civil Contingencies Act 2004, NHS Emergency Planning Guidance (2005) and other emerging policies and guidance.

The importance of the Olympic Games in London and its potential impact upon the Trust has been recognised. Significant work has been conducted to ensure that we can continue to conduct 'business as usual' throughout the Olympic period. The Games' legacy within the Trust will be the development of more flexible and resilient working practices.

New staff continue to receive major incidents information on their induction. Specialised training is provided to key staff to ensure they are familiar with their roles and they have the opportunity to utilise these skills in regular scenario based exercises.

We work closely with local partners through the Camden Resilience Forum, the North Central London cluster and NHS London in order that when a multi-agency response is required we understand our role and contribution.

Fundraising

In 2011/12, we are delighted to announce that Great Ormond Street Hospital Children's Charity has had its best ever fundraising year, generating income of around £66.3 million.

This is particularly welcome given the demands of the hospital for support for four major parts of the hospital's work – redevelopment, research, medical equipment and patient and family welfare.

Charity funding is enabling the largest redevelopment in the hospital's history – involving two thirds of the hospital estate. In the coming year, we will see the opening of the Morgan Stanley Clinical Building. This is the first part of the Mittal Children's Medical Centre with the second building planned to open in 2016. Together they will transform inpatient facilities at the hospital and allow us to treat up to 20 per cent more children.

The charity also funds research programmes in the hospital and the UCL Institute of Child Health. The charity's particular focus is to support new research projects which might otherwise be hard to fund, and projects that translate the work undertaken in laboratories into clinical practice at the hospital so that we can see real patient benefit as quickly as possible. In the last year, the charity made over £10 million of research grants across the hospital and the Institute.

Medicine continues to evolve and new technologies and equipment become available which can make a significant difference to what we are able to do to help children. In the past year, the charity agreed to fund a range of medical equipment including two state-of-the-art integrated laparoscopic theatres.

We'd like to thank everyone who has donated so generously.

Quality Account 2011/12

Joseph, age 10, is having tests on Kingfisher Ward to find out the cause of his dizziness.

Image caption

Contents

Part one

A statement on quality from the Chief Executive

Great Ormond Street Hospital (GOSH) is an international centre of excellence in children's healthcare. Every year, GOSH treats thousands of children and young people from many different parts of the UK and abroad. Our staff are dedicated to making sure that the service we give children and their families is the best it can be.

This is the third annual Quality Account produced by GOSH. This account details the areas in which we want to focus on quality improvement in 2012/13 and provides information on the progress we have made in improving the quality of our services since our last Quality Account.

In the first Quality Account, we introduced the following three broad priorities, which we felt were important to improving the quality of care for patients treated at GOSH:

Priority one – safety
To reduce all harm to zero.

Priority two – clinical effectiveness
To consistently deliver clinical outcomes that place us among the top five children's hospitals in the world.

Priority three – experience
To consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations.

These priorities are embodied in our hospital's core objectives. This ensures that our commitment to delivering high-quality patient care is at the very heart of all we do.

Great Ormond Street Hospital believes completely in its motto, 'the child first and always'. Everything the Trust does is devoted to improving the health of children and to the support of their families during what we know are difficult times. GOSH has always been at the forefront of developments in children's healthcare, and the Trust has engaged actively in developing new ways to deliver both higher quality and greater safety. We emphasise the importance the Trust places on quality and safety, embedding it deeply in our culture and making it top of our agenda.

This year we became a Foundation Trust, which was really important to keep our independence. This will help in our ambition to strive to be in the top five children's hospitals in the world and to keep quality and safety at the centre of all we do. To support this, we have developed roles in teams across the hospital to provide clinical leadership for quality and safety improvement. We have also developed a quality training programme for junior doctors.

We have made good progress in our zero harm programme over the past year and have seen some statistically significant improvements in reducing infection rates, such as central venous catheter line infection rates. We have also improved the use of the World Health Organisation surgical checklist across the hospital. Ward staff are routinely using the Children's Early Warning Score to monitor patients' health and are communicating effectively using a standardised technique. I am really proud of these improvements, but our priority must be to continue to improve care, focusing on quality and safety. We have set ambitious targets to achieve zero harm and not all of these have been achieved in the past year. However, I am confident that we will continue to aim for improvement over the next year. We know we need to focus on reducing medication errors across the hospital, and a new specialist improvement role will help to focus attention on where it is required to make the biggest impact and share learning across the organisation.

We have continued to use measures and publish information that evidences clinical outcomes on our website and worked with parents to make this information meaningful to them. We know we need to develop further measures to show the results of all the services we provide and, in particular, to show how we compare with others. I am excited at the prospect of working with other leading children's hospitals around the world to do this and to learn from national campaigns in the next year.

I am delighted that our most recent annual independent survey results show that we have maintained a 96 per cent overall satisfaction rate from our inpatients and their parents in the past year. We have also trialled other methodologies to get valuable feedback from patients and parents on where we need to make improvements. I know there is more work to be done to make improvements in the quality and variety of food to ensure equal access and experience for all of our patients. We really value all of the parent representatives that are supporting our improvement projects and providing helpful advice. Our new Members' Council will help to focus on what matters most to our key stakeholders and I am keen to hear more from our adolescent patients on where we need to improve.

This year, we also held a referrers' open day which ended with a really helpful discussion and feedback session on areas where we need to make improvements – for example, making it easier to transfer a patient to GOSH.

In 2012/13, we will continue to focus improvement across our key priority areas and have identified specific improvement initiatives in each area which are set out in this Quality Account. I hope that you will find this information helpful and that it gives you the confidence that we are dedicated to ensuring the highest quality of care for all of our patients.

I, Jane Collins, confirm that, to the best of my knowledge, the information in this document is accurate.

Dr Jane Collins
Chief Executive

About the Quality Account

Why are we producing a Quality Account?

All NHS trusts have been required to produce an annual Quality Account since 2010. This requirement was set out in the *Next Stage Review* in 2008[1].

A Quality Account is a report about the quality of services provided and is available to the public. Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

Great Ormond Street Hospital 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 service, and our plans to improve even further, with patients and families.

What are the required elements of a Quality Account?

The National Health Service (Quality Accounts) Regulations 2010 specify the requirements for all Quality Accounts. We have used the requirements as a template around which our account has been built.

The Quality Account is laid out as follows:

Part one

- A statement from the Chief Executive (see page 43)
- About the Quality Account
- Brief summary of how we have done since our last Quality Account and the new improvement initiatives we have identified for 2012/13.

Part two

- Priorities for improvement in 2012/13 – this section identifies our three priority areas for improving the quality of our services and the new improvement initiatives for 2012/13
- Mandatory statements, as set out in the National Health Service (Quality Accounts) Regulations 2010.

Part three

- Review of our quality priorities and performance in 2011/12, and case studies to illustrate improvement
- Statements from our Commissioners, Camden Council and Local Improvement Network (LINks).

How did we produce our Quality Account?

We have used the Department of Health's Quality Account toolkit as the basic template for our Quality Account and included all the mandatory elements of the account.

We have engaged with staff, patients, parents, volunteers and commissioners to ensure that the account gives an insight into the organisation and reflects the priorities that are important to us all. Following feedback on our Quality Account last year, we have identified specific and measurable improvement initiatives in each of our priority areas. These initiatives will support improvement in our three priority areas.

We consulted a parent on the design and content of the Quality Account last year and we received feedback from Camden Council and LINks. This stated that our Quality Account would benefit from a brief summary at the beginning, detailing briefly and simply what we plan to do to improve quality and how we have done since the last Quality Account.

Feedback from parents also told us that they preferred to see quotes from patients, families or staff to explain or illustrate projects and performance.

We are also trying to use patient stories more frequently to aid the understanding and impact of improvement across the organisation. While there is not a specific patient story in this year's Quality Account, we will aim to include at least one next year. In the past couple of months, we have been writing specific guidance on the development of patient stories which ensures that we have consent from the families before using stories in the hospital.

We have also reduced the number of new improvement initiatives that are detailed, going further to make the content easier to understand. We still continue to focus on the improvement work detailed last year and there is lots of quality improvement work going on in the organisation, but we selected a few initiatives that represent projects that are meaningful to our stakeholders.

We appreciate that some of the language used may be difficult to understand if you don't work in healthcare. This year we have spent more time on providing explanation and understanding around issues, and more detail on how and who we report progress too. We continue to include a glossary at the end of our Quality Account to explain some of the words that we use within this document.

We are keen to ensure that the account is a useful document which helps patients, families and the public to understand the priorities we have for delivering quality care to our patients. If you have any suggestions for next year's Quality Account, or any queries regarding this year's document, please contact us at enquiries@gosh.nhs.uk

[1] Darzi. *Next Stage Review*, June 2008, Department of Health. This document was published to coincide with the 60th anniversary of the NHS. It developed a vision of how the NHS would continue to serve the needs of the public in the 21st century.

Summary of our Quality Account

What are our quality priorities?

At Great Ormond Street Hospital (GOSH), we are committed to providing the highest quality of care to the patients that we treat. We have identified three main priorities which will help us to continuously improve the quality of services we provide. These priorities reflect the core dimensions that define quality: safety; clinical effectiveness; and experience.

Our three priorities for improving quality at GOSH are detailed as follows:

We have developed improvement initiatives with specific focus and aims that can be measured each year to ensure that we make progress in achieving these priority areas.

Safety
To reduce all harm to zero

Clinical effectiveness
To consistently deliver clinical outcomes that place us among the top five children's hospitals in the world

Experience
To consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations

How have we improved on these priorities in the last year?
The following table shows the improvement areas and aims that we stated in our Quality Account last year, and an indicator of the progress we have made so far.

Safety

Zero harm – reducing all harm to zero

Improvement area and aim in 2011/12	What does this mean and why is it important?	How did we do?
Reduce infections by reducing central venous catheter (CVC) line infection days by 50 per cent	A central venous catheter is a line that is inserted into a patient's vein to give them fluid or medication. Because the skin is broken, it can allow infection to enter the blood stream. Infection can be controlled by applying best-practice principles such as ensuring that staff and visitors wash their hands. An infection may cause harm to a patient by making them sicker and may increase the length of time they need to stay in hospital	We have made a 24 per cent reduction in the number of CVC line infection days, which is an improvement, but not met our target
Reduce infections by reducing surgical site infections by 50 per cent for: • cardiac surgery • spinal surgery • urology surgery	A surgical site infection is an infection at the place where a patient's skin has been cut to carry out a surgical procedure. Infection can be controlled by applying best-practice principles such as ensuring that staff and visitors wash their hands. An infection may cause harm to a patient by making them sicker and may increase the length of time they need to stay in hospital. We want to be able to reduce infections across all surgical specialties. Therefore, we need to set up systems that can identify and record infections	We have reduced the rate of surgical site infections for cardiac surgery and urology surgery. The rate of surgical site infections has increased slightly for spinal surgery
Establish surveillance of surgical site infections in further surgical specialties		We have established surgical site infection surveillance in thoracic and tracheal; cochlear implant; plastic surgery; general and neonatal surgery and orthopaedics
Reduce infections by reducing or maintaining the number of Methicillin-resistant Staphylococcus aureus (MRSA) infections	MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections. An infection may cause harm to patients by making them sicker and may increase the length of time they need to stay in hospital	We had four MRSA infections this year, although review of these shows that only one was avoidable. While this is an increase from last year, we are still within our contractual target level
Reduce infections by reducing or maintaining the number of Clostridium difficile-associated (C. difficile) diarrhoea infections	C. difficile are bacteria that are present naturally in the gut of around two-thirds of children and three per cent of adults. C. difficile does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. difficile bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. Infection can be controlled by applying best-practice principles such as ensuring that staff and visitors wash their hands. We want to be able to reduce infections across all surgical specialties. An infection may cause harm to patients by making them sicker and may increase the length of time they need to stay in hospital	We reported eight C. difficile infections this year, which is lower than the 10 we reported last year

Improvement area and aim in 2011/12	What does this mean and why is it important?	How did we do?
Ensuring that all ward staff use the Children's Early Warning Score (CEWS) and SBARD (situation, background, action, result and decision) when monitoring and communicating concerns about a deteriorating child	CEWS are used to identify, record and report signs of deterioration in patients when they are in hospital, by using a simple scoring system based on clinical observations. A score above a certain level means that the patient must be referred to senior staff to ensure intervention where required. SBARD is a universal communication tool that was implemented to improve the safety, efficiency and effectiveness of patient care. It ensures that important information is communicated in a standardised and consistent way	We have improved the percentage of cases where CEWS were reported from 83 per cent to 94 per cent, and increased the use of SBARD from 71 per cent to 84 per cent
All relevant teams to use and record the World Health Organisation (WHO) surgical safety checklist in every procedure	A Surgical Safety Checklist was developed by the WHO to help to prevent deaths in surgery. A checklist co-ordinator must confirm that the surgery team has completed the listed tasks before it proceeds with an operation. It is estimated that at least half a million deaths per year would be preventable with effective implementation of the WHO Surgical Safety Checklist worldwide	We have increased the number of completed checklists from 60 per cent to 92 per cent
Reduce the number of medication errors by reducing the clinical prescribing errors per bed day in the Paediatric Intensive Care Unit and Cardiac Intensive Care Unit by 25 per cent	Medication errors are patient safety incidents in which there has been an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred. This is a broad definition and the majority of medication errors do not result in harm. However, some do have the potential to do harm and are often termed 'near misses'. A medication error may cause harm to a patient by making them sicker, which could increase the length of time they need to stay in hospital	We have made a 30 per cent reduction in prescribing errors in the Cardiac Intensive Care Unit, but we have not made a reduction in prescribing errors in the Paediatric Intensive Care Unit
Staff to record incidents when they happen, to maintain high levels of incident reporting and implement the National Patient Safety Agency's national framework for serious incidents	Patient safety involves the identification, analysis and management of patient-related risks and incidents, to make patient care safer and minimise harm to patients. Within the NHS, a patient safety incident is defined as any unintended or unexpected incident, which could have or did lead to harm for one or more patients receiving NHS-funded healthcare	We have increased the number of incidents reported by five per cent this year, but the level of actual harm has been reduced to two per cent
Improve safeguarding by: • improving the quality of record-keeping • implementing group child protection supervision and ensure that at least 50 per cent of referrals receive supervision • ensuring that 40 per cent of the relevant staff have Level 3 training	Safeguarding and promoting the welfare of children is defined as: • protecting children from abuse and neglect • preventing impairment of their health or development and • ensuring that they receive safe and effective care... so as to enable them to have optimum life chances. We are responsible for having the sound processes and structures to support any child where there are safeguarding concerns	We have improved the quality of record-keeping and, in the latest audit, the records were scored as excellent. Ninety per cent of child protection referrals received supervision. Fifty per cent of the relevant staff have undergone Level 3 safeguarding

Clinical effectiveness

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

Improvement area and aim in 2011/12	What does this mean and why is it important?	How did we do?
Publish clinical outcome information on the Great Ormond Street Hospital (GOSH) website in a further nine specialties	We have developed measures to reflect some of the results of the treatments provided at GOSH. Parents have told us that they would like to see this information on our GOSH website for each of our specialties	We have published result information on the GOSH website for a further nine specialties
Use and develop patient-reported outcome measures in cystic fibrosis; epilepsy surgery; neurodisability; dermatology; adolescent medicine and orthopaedics	We want to use measures that reflect results of treatment from the patient's or parent's perspective. These are often referred to as patient-reported outcome measures (PROMs). This ensures that we understand and can measure if treatment is successful from the point of view of the patient and the results help to inform clinical care and further treatment	We have implemented PROMs in these specialties and also identified PROMs in other services
Benchmark outcomes against other comparable organisations in cardiology and cardiothoracic surgery; cardiac and paediatric intensive care; cystic fibrosis; renal; adolescent medicine; gastroenterology; haemophilia; infectious diseases and ophthalmology	We want to use measures that show our results compared with other organisations. Parents have told us this helps them to understand if our results are good and what to expect when coming to Great Ormond Street Hospital	We have submitted outcome information to the relevant networks and registries, and identified further specialties where we can benchmark

Experience

To consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations

Improvement area and aim in 2011/12	What does this mean and why is it important?	How did we do?
Maintain at least 90 per cent overall patient and parent satisfaction with our service in our annual inpatient telephone survey	Patient and parent feedback on their experience of Great Ormond Street Hospital (GOSH) is really important to us. Each year, an independent telephone survey takes place on a sample of patients who need to stay in hospital. The survey asks a number of questions regarding experience of GOSH and, in particular, we compare the overall satisfaction results to determine how well we are doing	We achieved a 96 per cent overall satisfaction rate in this year's survey
Improve overall agreement for 'I knew how to complain or offer feedback' in our annual inpatient telephone survey	In our previous annual survey, 74 per cent of families agreed they knew how to complain or offer feedback. We want to ensure that we listen to all families to understand what matters most to them and make improvements where necessary. It is important that all families know how to give us feedback or complain	We maintained a 74 per cent agreement from families responding to this question
Improve overall satisfaction with the quality and variety of hospital food in our annual inpatient telephone survey	In our previous annual survey, 60 per cent of families were satisfied with the quality and variety of our hospital food. Nutrition is an important part of a patient's care when in hospital and we want to ensure that we improve the quality and variety of hospital food	Satisfaction in the quality and variety of food dropped to 54 per cent this year
Capture and record regular local feedback through trialling electronic systems	While our annual survey gives us valuable feedback for the whole of the hospital, we wanted to explore using surveys on the wards and in outpatients to capture feedback when families are still in our hospital. We wanted to trial this using an electronic hand-held device such as an iPad. This would allow us to understand issues when they happen and allow ward staff to have more local information regarding their patients' experience in the hospital	We trialled three different ways of capturing local feedback through using both electronic and paper systems
Reduce the number of complaints regarding our communication with parents	Feedback from parents last year told us that at times, we are not good at communicating with them. The main theme of the complaints we receive is about our communication. Communication covers a broad remit but is important for the safety, effectiveness and experience of a patient's care. We are keen to improve this and act on parents' feedback	The number of complaints relating to communication with parents increased this year from 51 to 65
Improve the timeliness and quality of our discharge summaries	After a patient stays in hospital, a summary of the treatment they received, medication given and the recommendations for future management is sent to the patient's local doctor (this could be a general practitioner or a doctor at a local hospital to the patient). This is important to ensure that the doctors involved in the patient's care know what happened to the patient and if additional treatment or support is needed. Feedback from these local doctors has told us that we need to improve the time it takes us to send these discharge summaries to them	Seventy-nine per cent of discharge summaries were sent within 24 hours of a patient's discharge
Identify patients with a learning disability and ensure that reasonable adjustments are made to enable them to access our services	Last year, an external independent review told us that we needed to review our services and put in place actions to improve these for patients with learning disabilities. One of the initial key actions required was the ability to develop a system that can identify if patients have a learning disability so that staff can provide the relevant information and access to our services. We wanted to develop a process to ensure that if a patient has a learning disability, this is recorded in the patient's notes	We have developed a system to identify if patients have a learning disability and aim to implement this in 2012/13. We have also developed information in the right format
Maintain timely access to services by ensuring that our waiting times are within the national standards	We understand that when a child is ill and needs medical attention, the waiting time to be seen by a doctor is really important and families want to be seen as quickly as possible. The government has set national standards to ensure that patients are treated in any hospital in England within a maximum waiting time from referral. There are different waiting time targets set, but the main one that is referenced is 18 weeks from referral to treatment	We have met all of the national waiting time standards

What additional improvement initiatives are we planning to focus on in 2012/13?
The following section briefly summarises the new improvement initiatives and aims we have identified to focus on in 2012/13 in each of the priority areas.

Safety
Zero harm – reducing all harm to zero

What additional things are we going to improve and what do we aim to do in 2012/13?	What does this mean and why is it important?
Improve the effective monitoring and communication of the deteriorating child by making a 50 per cent reduction in the number of cardiac and respiratory arrests for patients outside of intensive care units and theatres	A crash call is a call made to alert emergency staff when a child goes into cardiac arrest. We want to ensure that ward staff are effectively monitoring children so they can identify if a child's health is deteriorating and provide intervention before an onset of a cardiac arrest. This will improve the outcome and experience of a child's care
Improve skin viability of our patients by reducing the number of pressure ulcers that are developed within the hospital, which are graded from two to four, by 20 per cent	A pressure ulcer is sometimes known as a bedsore and is a type of injury that affects areas of skin and underlying tissue. Critically ill children are more at risk of getting pressure ulcers because their condition makes it difficult to move their body. Pressure ulcers are graded from one to four depending on degree of injury to the skin, with higher grades being more severe. Pressure ulcers can cause pain and discomfort to a patient, and increase the time needed to stay in hospital while it heals

Clinical effectiveness
To consistently deliver clinical outcomes that place us among the top five children's hospitals in the world

What additional things are we going to improve and what do we aim to do in 2012/13?	What does this mean and why is it important?
Learn from why children die by reviewing mortality cases and sharing the learning across the organisation	Death in childhood remains a rare event, but recent national research and confidential enquiries have highlighted and given evidence that some deaths could be avoidable and hospitals can learn from reviewing events. While individual teams at Great Ormond Street Hospital review their own cases, a hospital-wide review will help to share learning across all teams and put in place best clinical practice
Develop clinical outcome measures to evidence our effectiveness by identifying a third clinical outcome measure for each specialty	A clinical outcome measure is a way to assess the results of clinical treatment. We have worked hard to identify clinical outcome measures in each of our specialties, but feedback from parents this year has told us that we need to ensure that measures are reflective of the main conditions treated

Experience
To consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations

What additional things are we going to improve and what do we aim to do in 2012/13?	What does this mean and why is it important?
Improve the way we manage and use our hospital beds by reducing the number of patients that we can't admit for unplanned treatment	While we don't have an emergency department, patients that are in local hospitals sometimes need to be admitted to Great Ormond Street Hospital for unplanned treatment. To do this, we need to have a spare bed. We want to ensure that patients get the care that they need when they need it, and improve the use of our beds so that we can admit patients when required
Improve the experience of our adolescent patients by reviewing our services against the Department of Health's You're Welcome quality criteria and identifying priorities for improvement	We treat children and young people of all ages up to 18. Feedback from our adolescent patients tell us that they should be treated as individuals. The You're Welcome quality criteria was developed by the government to help ensure that hospitals such as Great Ormond Street Hospital provide the best standards of care for adolescent patients. We want to ensure the services we provide reflect the needs of our adolescent patients and put in place improvements where needed

Part two

Priorities for improvement in 2012/13
This section details each of the priority areas for improvement and information on how we identify improvement work. It then details the new improvement initiatives that we will be focusing on in 2012/13.

Safety priority
Zero harm – reducing all harm to zero

Over the past few years, Great Ormond Street Hospital (GOSH) has been committed to reducing avoidable harm for patients treated at the hospital. We have a responsibility to ensure the safety of the patients we treat and also to learn from times when treatment doesn't go as initially planned. To achieve this, we developed a zero harm programme with the aim of ensuring that every patient receives the correct treatment or action the first time, every time, and to reduce harm to patients. Avoidable harm can include, for example, the development of infections while a patient is in hospital; complications after a patient has had surgery or errors when providing medications.

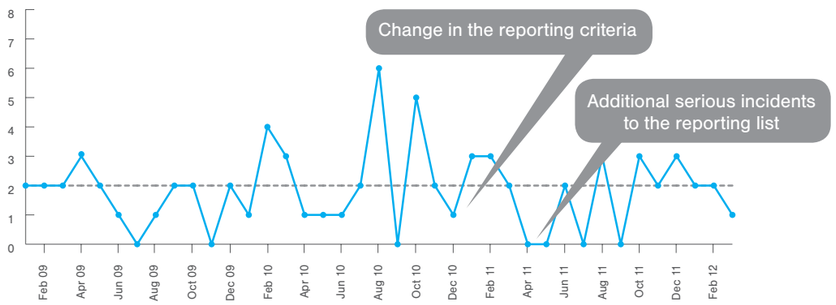
At GOSH, we have a team that is responsible for facilitating and implementing transformation change in the organisation. Transformation means thinking differently and implementing solutions in areas which need improving. The transformation programme is focused around three goals of improvement, 'zero harm, no waste and no waits'. Zero harm focuses on making improvement to the safety of the services we provide at GOSH. The progress on this priority is therefore monitored by the Transformation Board. Board meetings are established to hold teams to account and monitor objectives and aims. The Transformation Board is led by the Chief Executive, and the members include not only transformation and clinical staff, but also parent representatives.

In order to reduce harm, we need to understand what types of harm happen and when these happen to patients. Within the NHS, a patient safety incident is defined as any unintended or unexpected incident which could have, or did lead to harm for one or more patients receiving NHS-funded healthcare. This is also sometimes referred to as an adverse event/incident, mistake or clinical error, and includes near misses.

At GOSH, we have an established system in the hospital to encourage staff to report and record every incident. All incidents are reported into a central database in the organisation and are reviewed by a central patient safety team and graded on the level of severity and cause of harm. This allows us to monitor the number of incidents and types of incidents. Every three months, a formal report is taken to a quality and safety committee where senior clinical and management representatives from all teams across the hospital review the themes and actions required. The number of the most serious incidents is also reported on a monthly basis to the Trust Board. The following graph shows the number of serious incidents reported on a monthly basis; the grey dotted line represents the average. We aim to reduce the number of serious incidents.

Priorities for improvement in 2012/13
Safety priority

The number of reported serious incidents that take place each month at Great Ormond Street Hospital (GOSH)



Data source: Incident Reporting Datix Database

Definition: A serious patient safety incident is defined as an incident that occurred in relation to care, resulting in one of the following:
- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public
- Serious harm to one or more patients, staff, visitors or members of the public, or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
- Allegations of abuse
- One of the core sets of 'never events'.

We also report the more serious incidents externally to our commissioners who are responsible for providing external scrutiny. All serious incidents are reviewed using a root cause methodology, which means that the whole case of the patient is reviewed to identify what factors contributed to the harm in an attempt to learn lessons to stop the incident happening again. Together with our reporting database, we can identify themes and areas for improvement, informing our zero harm programme.

We have introduced the Paediatric Trigger Tool (PTT) which helps staff to measure and understand the nature of any harm that takes place in the hospital. We use this tool to review the medical records of a sample of 20 patients each month to identify any events that resulted in harm or had the potential to cause harm. This is a structured review and focuses on a number of treatment events including medication. A rate of harm is then calculated and the themes of harm identified help to inform the zero harm programme.

The co-medical director from Sheffield Children's Hospital visited GOSH in February 2012 and reviewed how the PTT integrated with our governance and safety work, interviewed key staff and observed the PTT review. He concluded that the GOSH PTT system is a robust process for objectively quantifying the degree of harm resulting to patients. In addition, it was stated that the governance structure around the process ensures that findings are acted on rapidly where appropriate.

The zero harm programme is also informed by national and international safety reports. For example we aim to implement the principles of the Patient Safety First Campaign. We also work closely with Cincinnati Children's Hospital Medical Center in the United States, which is a recognised leader in ensuring patient safety, and compare ourselves against it to indicate how we currently perform and identify new measures of quality or areas for improvement. We reflect on feedback from staff, patients, parents and commissioners to inform the zero harm programme.

The summary of the review stated:

There is clear evidence that the introduction of the Paediatric Trigger Tool has been associated with a reduction in harm, and that the findings from the reviews influence the Trust's workstreams and policy-making process.

Last year, we identified a number of improvement projects and aims that would help us to reduce harm to our patients and achieve zero harm. These included:

We have made improvement in all of these improvement initiatives over the past year and part three shows the details of this improvement. Our zero harm programme is built on the principles of continuous improvement. We will aim for year-on-year improvement on all of our initiatives and continue to improve our systems of measurement, monitoring and change. Therefore we will continue to seek improvement in all of these areas in the following years.

In addition, one of the improvement initiatives we described last year was on improving how ward staff communicate when a child's health is deteriorating so that they receive the right intervention at the right time. This year, we are extending this improvement work with an additional indicator on the number of crash calls outside an intensive care unit and this is detailed below.

GOSH is committed to expanding the list of safety improvement initiatives which are identified from analysis of incidents and complaints; clinical audit; national and international safety reports; and feedback from staff, patients, parents and commissioners to ensure that we focus improvement on areas that can help to achieve zero harm. This year, we have identified a further improvement initiative with our commissioners to reduce the number of patients that develop pressure ulcers while in hospital.

Both of these improvement initiatives are detailed in this section.

Priorities for improvement in 2012/13
Safety priority
continued

Safety improvement initiative one

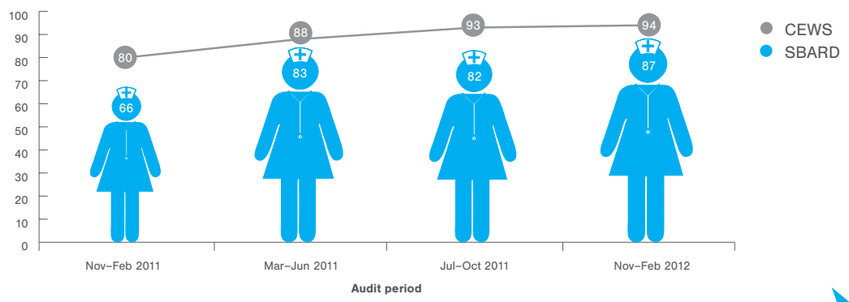
Effective monitoring and communication of the deteriorating child
Last year, we identified that we wanted to improve the way our ward staff communicate information about a patient when their health is deteriorating and urgent clinical support is required. Effective communication is fundamental to managing the safety of these patients by helping to make informed clinical decisions.

To monitor improvement in this area, we have been recording the number of calls that have been made to our senior nursing team, the clinical site practitioners (CSPs) using the technique of SBARD. SBARD stands for situation, background, action, result and decision. It is a universal communication tool that is intended to improve safety, efficiency and effectiveness of patient care by ensuring that information is structured and standardised.

We have also been monitoring the use and reporting of the Children's Early Warning Score (CEWS) in calls to the CSPs. CEWS are used to identify, record and report signs of deterioration in patients by using a simple scoring system based on vital sign observations; for example, pulse and blood pressure.

Last year, our aim was to ensure that 100 per cent of calls to the CSPs used SBARD and reported the most recent CEWS for the patient. The following graph shows the improvement we have achieved so far:

Percentage of calls to CSPs where CEWS were given and information was communicated using SBARD



Data source: CSPs callsheets

CEWS and SBARD are an important part of our work on improving the care of the deteriorating child, but we recognised that we needed a more effective way to monitor our progress and spread good practice. We have therefore developed a new improvement initiative to continue to concentrate on improving the care of the deteriorating ward patient. For instance, it is important that when a child's condition deteriorates, this is communicated and managed appropriately. This usually involves assessment of the child, emergency treatment and possible transfer to a ward such as intensive care to ensure that the right level of support is provided to reduce the likelihood of further deterioration. In the past, cardiac and respiratory arrests were considered to be unexpected emergency events that we could do little to prevent. Nowadays, it is recognised that many of these events are preceded by clinical signs that are either not recognised or not acted upon by staff. We are keen to review cardiac and respiratory arrests that happen outside intensive care units and theatres to learn lessons and reduce the likelihood of them happening in the future.

Preventing arrests is important because even if a child received prompt resuscitation, many children die either immediately or later in intensive care. Cardiac and respiratory arrests also cause considerable distress, not only to the child's family and friends, but also to the staff caring for them.

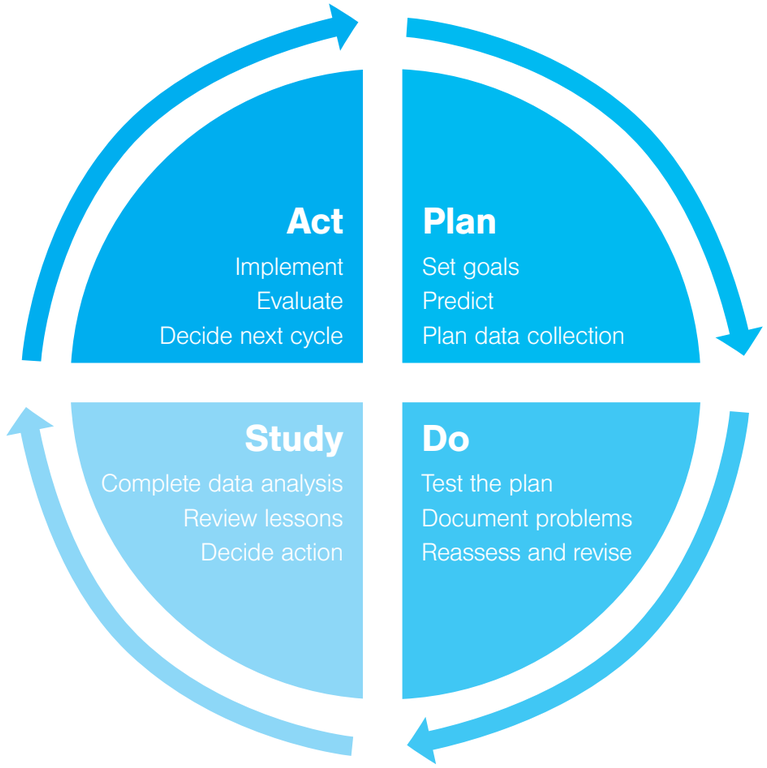
Sue Chapman, Nurse Consultant

What do we aim to improve in 2012/13?
We aim to reduce cardiac and respiratory patient arrests outside intensive care and theatres by 50 per cent.

How do we plan to improve in 2012/13?
A multi-professional group has been developed with representation from all clinical units and key services such as resuscitation and transformation. This group will review data on clinical emergency team calls, cardiac and respiratory arrests, and unplanned transfers from the ward to intensive care.

They also identify areas where improvements might be made and advise on data that would allow us to track our progress and monitor our success.

The focus in 2012/13 is on improving the quality of vital sign observations, and we will continue to monitor and review the use and accuracy of CEWS scores. We are also exploring innovative ways of capturing and recording vital sign observations, such as electronic hand-held devices which allow vital signs recorded at the bedside to be simultaneously viewed by other professionals. Change will be implemented using the plan-do-study-act (PDSA) improvement methodology. This approach is recommended by the Institute for Healthcare Improvement and the NHS Institute for Innovation and Improvement. Each PDSA cycle 'tests out' an idea on a small scale to identify quickly what works and what doesn't. It also engages front-line staff in the change process and promotes innovation to focus improvement in this area.



The group will follow the cycle:

Plan – the group plan to review the data on the number of cardiac and respiratory arrests outside intensive care and identify the three wards which are at the highest risk owing to the complexity and severity of the child's illness.

Do – the group will undertake a review of patients' medical records and the CEWS scoring to understand what caused the cardiac and respiratory arrest or what, if anything, could have been done to prevent it happening.

Study – the group will study the results taken from the 'do' phase and compare to see if there are common themes or indicators that can be used with future patients or other causes for the cardiac and respiratory arrests.

Act – the group will then implement recommendations from the study phase which may include training and education to try to improve performance.

The concept of the PDSA cycle will continue throughout this work and after the initial actions are implemented, the situation will be reviewed again and action identified accordingly. This will also enable the approach and solutions to be rolled out across other wards.

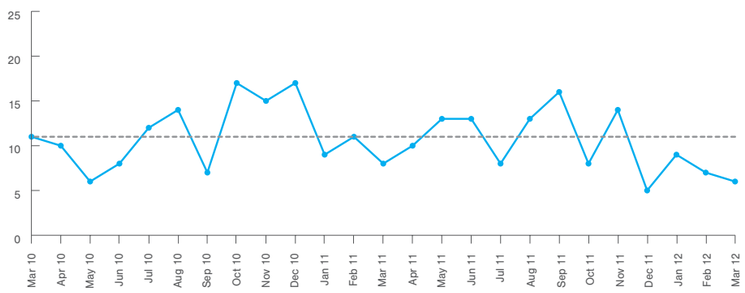
The clinical unit teams have recently developed specific roles within their teams to support with improving safety and quality in practice. Every clinical unit now has a patient safety officer (PSO) and a clinical improvement lead (CIL). PSOs and CILs are clinical staff who have expertise in improvement and patient safety and can support local improvement initiatives. We plan to develop a quality collaborative with their support to engage front-line staff in identifying innovative ways to protect children against cardiac and respiratory arrests.

How will we measure and monitor performance in 2012/13?

We will use the number of cardiac and/or respiratory arrests outside intensive care and theatres to measure improvement in this area. The data will be broken down at ward level to focus on the areas where action is put in place.

The data is collected by the resuscitation team and entered into a database. As well as being submitted to a national database, this data is also reviewed and monitored internally through our online dashboards. The following graph shows the monthly number of crash calls outside intensive care and theatres; the grey line represents the average. Our aim is to reduce the number of crash calls.

The monthly number of crash calls outside intensive care and theatres



Data source: Clinical Emergency Team 2222 Database

This improvement initiative is also monitored by our Transformation Board. Board meetings are established to hold teams to account and monitor objectives and aims. The Board is led by the Chief Executive, and the members include not only transformation and clinical staff but also parent representatives.

The findings of this work will be shared with our commissioners, as this improvement initiative is part of our contract with them to ensure that we focus on areas to improve quality. They will monitor our progress and, if we do not fulfil the agreed requirements, there will be a financial penalty for the organisation.

Who is responsible for this improvement initiative?

The nurse consultant for acute and high dependency care is responsible for overseeing and directing the actions required to deliver this improvement. This improvement initiative is overseen by the co-medical director, who is the executive lead for quality and safety at Great Ormond Street Hospital.

Safety improvement initiative two

Improving patients' skin viability

Pressure ulcers, sometimes known as bedsores or pressure sores, are a type of injury that affect areas of the skin and the underlying tissue. They are caused when the affected area of skin is placed under too much pressure. The extra pressure disrupts the flow of blood through the skin. Without a blood supply, the affected area of skin becomes starved of oxygen and nutrients. It begins to break down, leading to the formation of an ulcer.

Infants, children and young people in hospital who have restricted mobility are at higher risk of pressure ulcers because their condition makes it difficult for them to move their body. If children are continually able to adjust their posture and position so that no part of their body is subjected to excessive pressure, a pressure ulcer is less likely to occur. There is evidence that critically ill children are more at risk of pressure ulcers than other children in hospital. Pressure ulcers can develop in different places from those common in adults such as on the back of the head, ears and nose.

Pressure ulcers can cause considerable harm to patients and may lead to increased hospital costs and length of stay. Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. When a child or young person is admitted to hospital, nurses check his or her skin, and staff on the ward ensure that a patient who is at risk of developing a pressure ulcer is moved regularly with the correct equipment. All beds in the hospital have special mattresses to try to prevent the development of a pressure ulcer.

If a pressure ulcer is noted, it is graded by the degree of injury to the skin. There are four grades of pressure ulcers, ranging from grade one (skin discolouration) to grade four (deep tissue damage with bone involvement).

Patients have told us that pressure ulcers can be very painful and parents have observed that pressure ulcers cause a lot of discomfort to their child. We are therefore committed to ensuring that as far as possible, we provide the right support to prevent our patients getting pressure ulcers.

Unfortunately, over the past two years, the number of pressure ulcers developed in the hospital has increased, causing harm to our patients. We have discussed this issue with our commissioners and developed aims to reduce the number of pressure ulcers for our patients.

Priorities for improvement in 2012/13
Safety priority
continued

What do we aim to improve in 2012/13?
We aim to reduce the number of pressure ulcers per 1,000 bed days that are developed within the hospital, which are graded from two to four, by 20 per cent by March 2013. This means a reduction from 0.71 pressure ulcers per 1,000 bed days, to 0.57 per 1,000 bed days.

How do we plan to improve in 2012/13?
Preventing pressure ulcers involves firstly identifying patients that are more at risk of getting pressure ulcers and, secondly, implementing prevention strategies for those patients who are identified as being at risk. The focus of this improvement will be to identify areas of good practice to spread across the hospital.

The hospital plans to implement a new pressure ulcer risk assessment which will be completed for all patients who require a hospital stay at Great Ormond Street Hospital. A risk assessment helps staff to determine the likelihood that the patient could develop a pressure ulcer by using a standard set of questions and a grading score for every patient.

Where patients are deemed to be at medium or high risk of developing pressure ulcers, the ward staff will monitor them frequently using a full skin assessment document and preventative measures will be used; for example, ensuring that the patient is frequently moved as far as feasible.

In the event that a patient develops a pressure ulcer, a specialist plastic surgery nursing team can also provide support, management and advice to the patient and the ward to minimise the impact of the ulcer.

The specialist plastic surgery nursing team will be supported by a new nursing quality practice educator who will provide education, training and support to clinical teams on the wards. This will involve training in practice on the ward to ensure that ward staff are capable and comfortable in identifying and monitoring patients at risk of pressure ulcers.

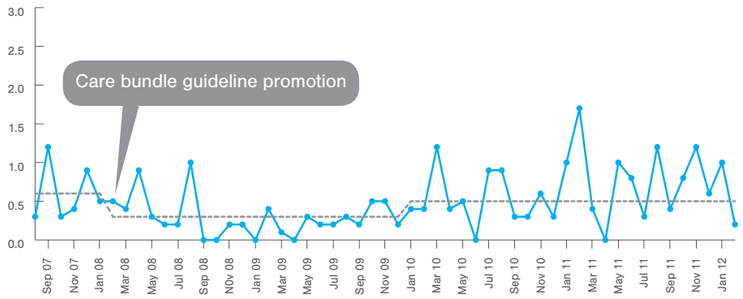
In addition, training is provided for new members of clinical and allied health staff on our corporate induction days. This training content will be built upon and new interactive teaching models have been purchased for teaching purposes.

It is important to involve families where possible in the prevention of pressure ulcers. There is a leaflet explaining what pressure ulcers are and how best to prevent them while in hospital. This will be made widely available, and tools such as charts for parents to tick when they have picked up their child or moved them to make them more comfortable, will help the nurse and carer to work together.

How will we measure and monitor performance in 2012/13?
We will use the number of pressure ulcers by 1,000 bed days recorded each month to measure the performance of this improvement work.

Ward staff notify the specialist plastic surgery nursing team when a patient develops a pressure ulcer, who then confirms the grading. The number and grading of pressure ulcers is then reported into a central database. The number of pressure ulcers is divided by the number of bed days to identify the number of pressure ulcers per 1,000 bed days. This rate is recorded and monitored internally using the graph illustrated (right). The dotted grey line represents the average, and our aim is to reduce the number of pressure ulcers per 1,000 bed days.

The number of reported hospital-acquired pressure ulcers per 1,000 bed days graded two to four



Data source: Tissue Viability Database

The number of pressure ulcers developed in the hospital has increased over the past year. The hospital aims to reduce the number of pressure ulcers with a new team structure over the next year. The new team will also be reviewing the case notes of patients who had pressure ulcers during the past year to try to identify any patterns and areas to focus improvement on first.

Pressure ulcers that are graded three and four are also reported to our commissioners as a serious incident. A root cause analysis is undertaken to explore the principle cause and enables lessons to be learnt and implemented.

A working group with representation of nursing, doctors and practice educators will be established to oversee and support the improvement work. This group will meet monthly and monitor the agreed steps and actions for improvement. The progress of this improvement work will then be fed back to the nursing senior management team via a nursing quality forum.

The findings of this work will be shared with our commissioners every three months, as this improvement initiative is part of our contract with them to ensure that we focus on areas to improve quality. They will monitor us and, if we do not fulfil the agreed requirements, there will be a financial penalty for the organisation.

Who is responsible for this improvement initiative?
The nursing quality practice educator is responsible for the education, advice and teaching on the prevention of pressure ulcers, and the plastic surgery clinical nurse specialists are responsible for pressure ulcer management, grading and advice. This improvement initiative is overseen by the chief nurse and director of education.

Clinical effectiveness priority

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

Delivering effective care is, and always has been, the primary focus of Great Ormond Street Hospital (GOSH). Over the past couple of years, we have been trying to evidence the effectiveness of our care and all specialties have been identifying measures that demonstrate the results of the treatment they provide. This means understanding success rates from different treatments for different conditions. This could include clinical measures such as survival rates, complication rates or measures that demonstrate clinical improvement. Just as important is measuring the effectiveness of care from the patient's own perspective through the use of patient-reported outcome measures (PROMs).

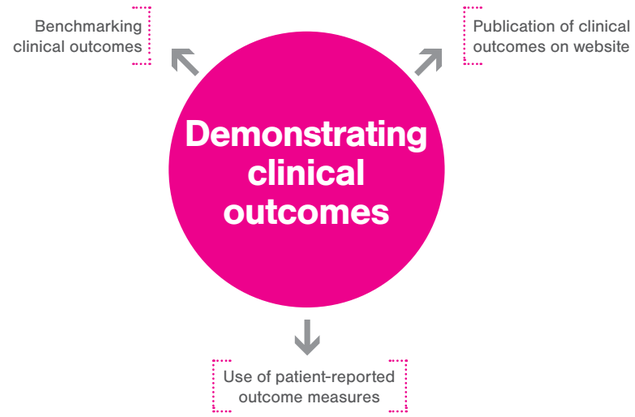
Alongside our internal work to demonstrate effectiveness, there is also a national drive from the government to use clinical outcome measures to demonstrate the results and quality of treatment. The difficulty for us is that a lot of the new initial clinical outcome measures that are proposed are focused more on general hospitals and involve the measurement of the outcome of adult care, and are not applicable or suitable for use at GOSH.

Wherever possible, we are using established national or international measures that allow us to benchmark our results with other services. However, some specialties find this difficult owing to the unique nature of many of the conditions we treat and at times are the only service in the UK providing treatment for rare conditions. Where it is more difficult, we have encouraged specialties to develop local measures to demonstrate their results and aim to compare these measures over time.

To ensure that we make progress in demonstrating clinical outcomes that place us among the top five children's hospitals in the world, we have established a clinical outcome programme. This programme supports specialties in the development of clinical outcome measures and identifying comparable organisations and measures to benchmark against. It also monitors the development of measures across specialties and reviews the information that is produced. Every three months, clinical teams are required to give updates on progress and provide examples of clinical outcomes to the senior management team in performance reviews.

Feedback from parents, patients and referrers over the past couple of years has told us that they want more information on the results of treatment to make more informed choices and have better understanding of treatment options. We recognise that there are many forms of information currently available on the worldwide web, but not all of this is accurate or reflective of our current medical practice and could be misleading. We therefore feel that we need to take responsibility for providing our own information to inform our families and be open and transparent about our results.

Last year, we identified three improvement initiatives that would help us to achieve our priority of consistently delivering clinical outcomes that place us among the top five children's hospitals. These included:



We have made improvement in all of these areas and more detail is provided in part three of this account.

We are keen to continue to improve in these areas and, in particular, are keen to use our experience and knowledge from the clinical outcomes programme in the past couple of years and reflect some of the new initiatives that are developing nationally. We have written to leading children's hospitals around the world to seek their interest in a collaborative study with regard to sharing clinical outcome measures and considering services that we provide to see if they are comparable.

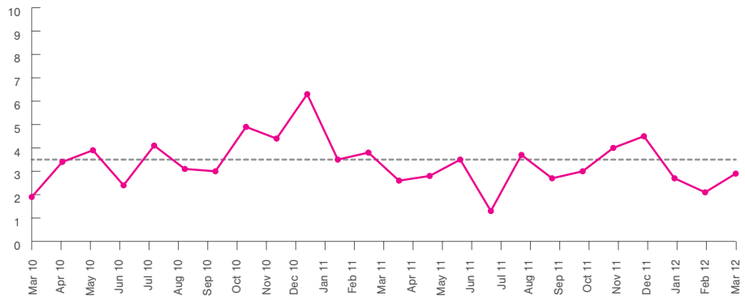
Therefore from feedback from parents, staff and commissioners, we have developed two new improvement projects to help us to continue to make progress in this priority. The first is in relation to reviewing the survival outcomes of patients that are treated at GOSH, and the second will focus on extending the current number of clinical outcomes identified for specialties to three.

Clinical effectiveness improvement initiative one

Monitoring and learning from why children die

In previous Quality Accounts, we have identified that the hospital's Standardised Mortality Ratio, used previously by many hospitals in the UK to demonstrate outcomes, is not applicable to paediatric care. Similarly, the new summary hospital-level mortality indicator is not calculated for children's hospitals either. These tools are useful for providing an indicator of where mortality outcomes may need further attention and understanding by comparing performance against expected outcomes. At Great Ormond Street Hospital (GOSH), while we don't have the same ability to compare expected outcomes to actual outcomes, we do monitor the number of deaths each month. This is monitored by reviewing the mortality rate of patients per 1,000 discharges and is shown in the graph below. The dotted grey line represents the average mortality rate per 1,000 discharges. We aim to reduce the mortality rate.

The mortality rate per 1,000 discharges



Data source: GOSH Patient Information Management System

Death in childhood remains a rare event, but evidence shows us that the care children and their families receive leading up to and around the time of death, warrants particular attention. Recent national research and confidential enquiries have highlighted and given evidence that some deaths could be avoidable and hospitals can learn from reviewing the Confidential Enquiry into Maternal and Child Health report, *Why Children Die,* 2008, and the 2011 National Confidential Enquiry into Patient Outcome and Death report, *Are We There Yet?*

This research and evidence suggests that establishing a system to review the medical records of patients who die is an effective way of identifying if any areas need improvement across the hospital. Within GOSH, clinical teams hold frequent meetings to discuss cases when children die or complications arise in their care, to discuss the reasons and to learn lessons for future management. An example of where this happens is in the Cardiorespiratory Unit. This unit compromises clinical teams that treat and operate on children with cardiac and respiratory conditions. For example, cardiac surgery or providing treatment for cystic fibrosis patients. The unit holds weekly Friday morning meetings which review patient outcomes of recent operations and enables a forum to discuss unexpected outcomes and learning. Performance is compared against previous time periods. All staff in the unit, both clinical and non-clinical, are invited and attendance is strong.

At GOSH, we also have extensive experience of using a structured review of harm by using the Paediatric Trigger Tool. This tool helps staff to measure and understand the nature of any harm that takes place in the hospital, by reviewing the medical records of patients after they have been discharged. The team that are involved represent different areas across the organisations and the medical records are selected to represent all areas of the Trust to provide a system-wide approach to monitoring harm. This approach could also be applied to reviewing the medical records of patients who die. It offers the opportunity to identify organisation learning and implement good practice across the Trust to help improve to the outcomes for other patients. By taking this approach, the ultimate aim would be to reduce the number of avoidable deaths across the hospital.

What do we aim to improve in 2012/13?

In the first three months, we will establish a mortality review group and, in the following nine months, the group will review the medical records of 60 per cent of patients that have died and share the learning with staff across the organisation.

How do we plan to improve in 2012/13?

We will identify clinicians to form a mortality review group who will be representative of staff and teams across the hospital. This group will agree a process for undertaking reviews and establish a tool to use to ensure that the reviews are carried out in a standardised and consistent way. This tool will reflect the best practice process learnt from the use of the Paediatric Trigger Tool and examples of tools used to review mortality at other hospitals.

The group will make use of the NHS Institute 2x2 matrix to provide an initial analysis of the patient's death. The NHS Institute 2x2 matrix is a way to categorise for each patient who died, whether there was an intensive care admission and whether the patient was receiving palliative care. It is demonstrated as follows:

		Intensive Care Unit admission	
		Yes	No
Receiving palliative care	Yes	1	2
	No	3	4

The matrix was established by the NHS Institute as a tool for hospitals to review the death of patients and to focus on identifying health and care system problems with the intention of improving the quality of care for patients. By using the NHS institute 2x2 matrix, those patients who are in category four will be a particular focus of the review.

It should be noted that a number of children who die in the Trust do so as part of planned end-of-life care. The Palliative Care team, who support these patients, have developed an end-of-life care pathway tool, and the case notes will also be assessed with reference to how this tool has been used.

Every three months, between July 2012 and April 2013, the mortality review group will review the medical records of 60 per cent of patients who have died and conclude with a report of any services issues.

How will we measure and monitor performance in 2012/13?
We will measure the performance of this improvement initiative by monitoring the number of case note reviews that have been completed every three months and identifying what actions are needed to make improvements in the future.

The findings of the mortality review group will be fed back across all levels of the organisation. For example, each clinical unit team has identified specific individuals who can lead on patient safety and provide clinical leadership within their local teams. The findings of this mortality review work will be shared with these individuals to ensure that learning is disseminated and actions can be implemented at local level to help to improve the quality of care for patients.

To monitor quality and safety for patients at GOSH, we have an organisation-wide committee meeting called the Quality and Safety Committee. This committee is responsible for all matters that affect quality and safety for patients and is attended by a representative of all clinical units and corporate teams. It is chaired by the most senior medical post in the organisation, the co-medical director. The findings of the mortality review group will be reported to this Quality and Safety Committee. It enables a system-wide response to learning, and the committee is able to ensure that actions are implemented where required.

The Quality and Safety Committee reports to the Trust Board, which will monitor that the actions are being implemented and challenge performance if required.

To ensure that learning is disseminated across the whole hospital, it is proposed that an annual meeting is held to report the findings to clinical staff.

The findings of this work will be shared with our commissioners, as this improvement initiative is part of our contract with them to ensure that we focus on areas to improve quality. They will monitor us and, if we do not fulfil the agreed requirements, there will be a financial penalty for the organisation.

Who is responsible for this improvement initiative?
A consultant in the anaesthetic department is responsible for overseeing and directing the actions required to deliver this improvement. The improvement initiative is overseen by the co-medical director, who is the executive lead for quality and safety at GOSH.

Clinical effectiveness improvement initiative two

Development and use of clinical outcome measures for each specialty
Over the past few years, each of our clinical specialties has been identifying at least two clinical outcome measures to demonstrate the effectiveness of the care that they provide. A clinical outcome is defined as 'the change in the health of an individual, group of people or population, which is attributable to an intervention or series of interventions'. For example, we use clinical outcome measures such as survival rates, complication rates or measures that demonstrate clinical improvement. We also try to measure the effectiveness of care from the patient's own perspective through the use of patient-reported outcome measures (PROMs).

Specialties have been working to collect the information to measure their results and, over the past year, we have developed a section of the Great Ormond Street Hospital (GOSH) website to detail the results from 18 of our specialties. We have worked with parents to make this information available and found their input and recommendations really valuable to informing our priority to demonstrate clinical outcomes. In particular parents recognised that some of our specialties treat a number of conditions and use different procedures. Therefore, some of the results currently on the website reflect only one part of a specialty and other condition or treatment results are not currently available. For example, Infectious Diseases has provided information on the results of treatment for patients with human immunodeficiency virus, but the specialty also treats other conditions and these results are not currently available.

The parent group recommended that we continue to develop clinical outcome information and to ensure that these demonstrate the results from the more common conditions treated. The group also proposed that we should clearly state the targets and timeframes we have set for making more information available on the website.

Feedback from these parents also told us that the information would be more powerful and aid understanding if there was some form of comparator to understand the performance.

Since starting this programme, we have gained experience and knowledge about developing clinical outcome measures, and we also have a better understanding of how to produce information that can be understood by parents. We are therefore keen to develop further clinical PROMs for each specialty.

What do we aim to improve in 2012/13?
We aim to increase the number of clinical outcomes that we have for each specialty to three in 2012/13 and ensure that the outcome measures used are reflective of a specialty's main work.

How do we plan to improve in 2012/13?
From the experience of identifying clinical and parent-reported outcome measures over the past two years, we have more knowledge to identify a measure that is representative of the result of treatment.

To support the identification of the third clinical outcome measure, we will use criteria to guide and inform decision-making and agreement from our specialties.

I'm pleased that GOSH has asked for parents' views when revamping their website. It is really important that parents are able to easily access and understand information which affects their children, particularly in a hospital. Well done GOSH for listening to parents and providing some excellent information.

Graham Manfield,
Parent Representative

This criteria is reflective of best-practice guidance that is available on developing outcome measures and includes assessment of the following:

- Proxy power – whether the measure describes something which is reflective of the specialty's treatment objective
- Data power – whether the data required to measure outcomes is of interest to the service and available and reliable
- Good communication power – whether the measure clearly communicates to others what you are trying to achieve.

We are also currently writing to other leading national and international children's hospitals to scope a collaborative piece of work to share clinical outcome measures which are used. This will help us to understand if the services we provide are comparable elsewhere in the longer term and could give us an opportunity to consider sharing data for comparison. We hope the response to this proposal is positive and would give us valuable information on how other similar organisations are measuring the results of treatment and potential other measures to consider.

Since the introduction of the NHS Outcomes Framework, there has also been a lot of work in the development of quality dashboards, which include clinical outcome measures that demonstrate effectiveness. Over the next year, more specific specialty dashboards that are relevant to GOSH are being proposed and considered for implementation. We will implement the dashboards which are relevant to our specialties to ensure that we can start reporting on these measures in 2013/14.

The clinical outcomes development lead will meet with specialties across the hospital to discuss new measures together with feedback from the benchmarking work and the quality dashboards. We will also take the opportunity to get feedback from specialties of their views on effectively benchmarking with other organisations.

How will we measure and monitor performance in 2012/13?
We have a central list of specialties and clinical outcome measures agreed to date. This list will be updated by the clinical outcomes development lead when specialties have confirmed a third clinical outcome measure.

We will measure the number of specialties and associated clinical outcomes that are identified. The development of the third clinical outcome measure will be monitored by the clinical unit action plans which identify the next steps for measuring and publishing clinical outcomes.

Progress in the development, measurement and publication of these clinical outcomes is reviewed and monitored on a monthly basis by the Clinical Outcomes Board. This board oversees and directs the clinical outcome programme and is led by the most senior medical position in the organisation, the co-medical director.

Each clinical unit is required to present information on its progress and provide examples of clinical outcomes to the senior management team every three months at performance reviews.

Who is responsible for delivering this improvement initiative?
The clinical outcomes development lead is responsible for overseeing and directing the actions required to deliver this improvement. This improvement initiative is overseen by the co-medical director, who is the executive lead for quality and safety at GOSH.

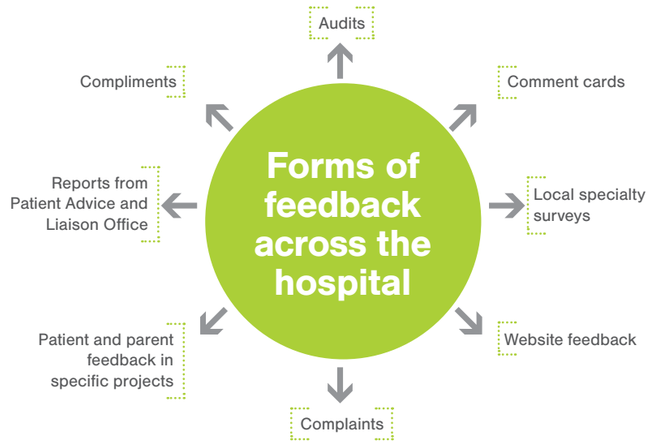
Experience priority

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

We recognise that the memories and perceptions that patients and families have of Great Ormond Street Hospital (GOSH) are heavily influenced by the quality of their experience. GOSH seeks to provide the best possible services to patients and their families who come from diverse backgrounds and from all parts of the UK and abroad. We therefore need many ways to find out about and improve patient and family experience. We do this best by involving and engaging our patients, their families and members in shaping healthcare at GOSH so it is appropriate to their needs and by making the best use of the knowledge and skills of our staff.

We have identified in our previous Quality Account that we use a variety of ways to get feedback from patients and parents about their experience at GOSH, including an annual telephone survey, as well as more local surveys at specialty or ward level. While the results of these surveys offer valuable information and responses to set questions, we have also invested time this year in getting more detailed feedback from parents in the form of focus groups. These events help to illuminate the main themes of information we gather from surveys and give us more depth to areas that need improvement. For example, we had a focus group of parents to review the spinal surgery pathway for patients. We have also gained valuable feedback from having parent representatives on specific project groups; for example, on the clinical outcomes on the website parent reference group. Their input has been very valuable and has often helped to make decisions and focus staff on the matters that mean the most to patients and families. By gaining Foundation Trust status this year, we have also newly elected a Members' Council. This gives us a great opportunity to work in closer partnership with patient, parent, public and staff representatives, and members as well as local community agencies and representatives of patient groups over the next year.

To ensure that we continue to focus on the priority of exceeding the experience of our patients and their families, we have established a committee called the Patient and Public Involvement and Engagement Committee. This committee reviews the various forms of feedback that we get from patients' and families as illustrated below:



Priorities for improvement in 2012/13
Experience priority continued

The committee is led by the assistant director of nursing for quality and safety and has representatives from across the hospital from clinical teams, as well as representatives from groups that provide services across the hospital; for example, accommodation and food. It also has five parent representatives. The purpose of this committee is to set a plan of work to ensure that we focus on the needs of our patients and their families and to ensure that the responsible teams deliver on the relevant actions to improve experience.

Last year, we identified the following improvement initiatives that would help us to achieve our priority of delivering an excellent experience. These included:

We have made improvements in all of these areas and more detail is provided in part three of this Quality Account. We are keen to continue to improve in these areas. We recognise that we need to work more on gaining feedback from patients and making improvements that matter most to them and, this year, we are keen to involve our adolescent patients in reviewing our hospital and helping to inform recommendations for improvement.

We also keen to ensure that doctors who refer their patients to us for further treatment also have the best experience of GOSH. This is important for a number of reasons but, most importantly, to ensure that the patients' care is as seamless and effective as possible.

Over the past couple of years, we have developed an improvement programme informed by a telephone survey undertaken with our referrers. We have a specific project group that is focused on making improvement work following this feedback from our referrers. This is led by the most senior medical post in the hospital, the co-medical director, and involves representation from teams across the hospital. In last year's Quality Account, we focused on the work that we were doing to improve the timeliness and quality of our correspondence with the doctors who refer patients. The progress of this work is detailed in part three. This year, we held a referrers' open day which was well attended and we received some valuable feedback during a question and answer session at the end of the day.

Experience improvement initiative one

Exceeding the experiences of our adolescent patients

Great Ormond Street Hospital (GOSH) is committed to improving the patient journey for children, young people and their families. However, we recognise that, like other hospitals, catering for the needs of all age groups can be difficult. For example, 70 per cent of our patients that required a hospital stay in 2010/11 were under the age of 10. There is a tendency to communicate with the parents of patients, rather than directly with the young people, especially when patients have been under our care for a number of years.

Engagement work in recent years with our adolescent patients told us that they, quite rightly, want to be treated as individuals. To support this work, a group of our adolescent patients developed a video about how they would like to be treated when in hospital. This video now forms part of the GOSH induction programme and is shown to every new member of staff. This video outlines the standards that the young people expect. These include:

- To be listened to and taken seriously
- To be given information by doctors in a way which makes it understandable
- To be involved in decisions regarding treatment
- To be given somewhere private when treated or examined
- To have access to enough toys, games and things to do on the ward.

Teenagers have strong views on what 'to be listened to, and taken seriously' means to them – they want to be talked to as individual patients and not via their parents; they want to feel they are a person and not a disease; and they want 'to be believed'. Two additional satisfaction features are of particular note – the ability to maintain contact with school, and a plea to staff 'to smile and be positive'.

Over the past couple of years, we have carried out an annual telephone survey with the families of patients that have needed to stay in hospital here. Patients over the age of 10 are asked to take part in this survey. These responses show us that patients compared with their parents are more likely to say that:

- they knew how to complain or offer feedback
- they could complain or offer feedback, and that this feedback would be taken seriously
- doctors or nurses asked questions about how they were feeling
- they were scared in the hospital, but also that staff helped to deal with these fears
- they had enough privacy when doctors/nurses talked about their treatment
- they were kept awake at night by noise
- they were satisfied with the quality and variety of food
- the process of leaving hospital was easy.

Patient satisfaction was high across a number of key areas, including involving them with decisions about their care and giving an explanation about treatment or tests and answering questions. Two areas where satisfaction was lower, was in response to 'what extent do you agree or disagree that the ward was well designed for children of your age and you were kept awake at night by noise'.

More local surveys have also been used and together have highlighted some of the issues for young people, including communication with professionals, privacy and dignity, and transition to adult care.

The Department of Health developed the You're Welcome quality criteria to improve service delivery for adolescents. These criteria aim to give young people a voice in the NHS to ensure that their experience and contribution to the overall health of the nation is valued. They were developed following recognition that patterns of health-related behaviour laid down in adolescence impact on long-term health behaviours. The first set of criteria was developed in 2005 and has been updated in 2011. They are based on examples of effective local practice with young people aged under 20. The updated version sets out established principles that enable healthcare professionals working in hospitals such as GOSH, to improve services by making them more accessible to young people.

What do we aim to improve in 2012/13?
We aim to review the services at GOSH to see if they meet the You're Welcome quality criteria, and identify and prioritise five areas for improvement in 2013/2014.

How do we plan to improve in 2012/13?
At GOSH, we have an adolescent medicine service led by a consultant nurse working with a clinical nurse specialist. This team leads on the review of the quality criteria in services offered at GOSH. The quality criteria covers 10 topic areas which are detailed as follows:

- Accessibility
- Publicity
- Confidentiality and consent
- Environment
- Staff training, skills, attitudes and values
- Joined-up working
- Young people's involvement in monitoring and evaluation of patient experience
- Health issues and transition for young people
- Sexual and reproductive health services
- Specialist child and adolescent mental health services.

The Adolescent team has adapted the You're Welcome assessment tool for reviewing services at GOSH. They are working to develop a programme for roll-out of the tool across the hospital and its services.

The team have started to recruit adolescent patients to help with the assessment of services and get feedback on how to improve services to better meet the needs of young people.

The results of the assessment will be reviewed with young people and analysed to identify the areas that most need improvement. They will be prioritised by reviewing the evidence and continuing to work closely with young people throughout the process.

The team will also be comparing the process and results obtained with other hospitals to see if lessons and actions can be shared. This will also help with the prioritising of what improvements need to be made first.

How will we measure and monitor performance in 2012/13?
The number of assessments and the results of the assessments will be used to measure performance in 2012/13.

To ensure that we continue to focus on the priority of exceeding the experience of our patients and their families, we have a committee called the Patient Involvement and Engagement Committee. This committee has representatives from across the hospital in clinical teams, as well as representatives from groups that provide services across the hospital; for example, accommodation and food. It also has five parent representatives. The purpose of this committee is to set a plan of work to ensure that we focus on the needs of our patients and their families, and to ensure that the responsible teams deliver on the relevant actions to improve experience. You're Welcome forms part of this improvement work, and progress and performance will be reported back to this committee every three months to ensure that the results are shared across the organisation.

We will also consider the best way to feed back to our adolescent patients on what we are doing and what improvements we are going to make.

The findings of this work will be shared with our commissioners as this improvement initiative is part of our contract with them to ensure that we focus on areas to improve quality. They will monitor us and if we do not fulfil the requirements agreed, there is a financial penalty for the organisation.

Who is responsible for this improvement initiative?
The clinical nurse specialist and consultant nurse in adolescent medicine are responsible for overseeing and directing the actions required to deliver this improvement. This improvement initiative is overseen by the chief nurse and director of education.

Experience improvement initiative two

Ensuring timely access to our services

In last year's Quality Account, we described the work we had started to gain feedback from our referrers, who are mainly consultant doctors in other hospitals. We are keen to understand what these doctors thought of the service we provided to them and their patients, and where they felt we needed to improve. One of the areas that they highlighted for improvement was our communication to them. A number of the patients we treat at Great Ormond Street Hospital (GOSH) are also cared for at other hospitals, and when patients get ill, they may first go to their local hospital for treatment before being transferred to GOSH if further specialist support is required. The patients may also be routinely seen at local hospitals in outpatient clinics. Therefore, it is important that our communication is effective so that local hospitals are made aware when the patient was last at GOSH, what care the patient received and what their future treatment plans are. Over the past year, we have focused on improving the time it takes to send discharge summaries to local hospital teams following the discharge of a patient. Importantly, we have also been reviewing the content of these summaries to ensure that all the relevant information is included. Our performance in this is detailed in part three of this Quality Account.

In the past year, we have also held a referrers' open day. This involved presentations from teams at GOSH and some focused work with specific services. This included reviewing how patients access services and proposed guidelines for referral to GOSH for specific treatments. The day was well attended and ended with a question and answer session with a panel of GOSH staff, including our Chief Executive. Feedback from our referrers was really helpful and one area noted was that referrers found it very difficult to transfer a patient under their care at a local hospital to GOSH because of limited availability of beds and access to clinical teams. We obviously want to ensure that, as far as possible, we can provide a bed for a child who needs our specialist care.

What do we aim to improve in 2012/13?
We aim to reduce the number of times we are unable to admit a patient needing to be transferred from another hospital to GOSH because of insufficient bed availability, by 25 per cent.

How do we plan to improve in 2012/13?
For patients who do not require an intensive care bed, there are two routes which a local hospital could use to discuss the transfer of a patient to GOSH. We have a Bed Management team made up of two full-time staff who explore all possible routes of admission for patients during normal working hours. This responsibility is handed over to the clinical site practitioner team out of hours. Local hospitals can also contact specific known wards and speak to staff on duty to see if there are beds available and enable the transfer of the patient and their care.

Our first task to improve this patient pathway was to agree the criteria for admitting a patient for each of our specialties. This is important to ensure that beds are utilised by patients who genuinely require support from these specialist services. It was important to be clear and consistent with this information so that local hospitals knew when they could transfer a patient if required. This guidance is now available on the GOSH website under the 'Health professionals refer a patient' section. This information will help to guide local doctors to the different services provided and conditions treated at GOSH, as well as the timeframe that patients should be admitted in. It is hoped that this will help local doctors to manage their own and their patients' and families' expectations. It will also help GOSH clinicians and the Bed Management team by informing them of the agreed criteria and aid in the decision-making of when to admit a patient that needs care.

We have also updated our Admission and Bed Management Policy which governs the systems and processes in the hospital to manage the number of beds we have in the most effective way. This states that no patient should be refused admission to GOSH unless agreed with the bed manager. This team will endeavour to find a suitable bed for the patient when the preferred specialty ward is full. From reviewing and updating this policy, we have achieved full engagement and collaboration of all teams involved, and put in place actions to learn from best practice.

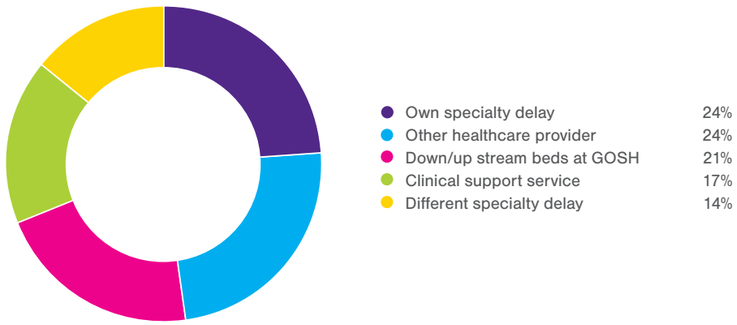
To support the effective use of our beds, we will be introducing an electronic real-time bed management system which will present accurate and transparent information about bed availability across the hospital. It will also display information about patients who are ready to leave the intensive care units and waiting for a bed on the ward. This will help the Bed Management team to facilitate moving patients into the environment that best meets their clinical needs and accept requests from local hospitals for patients who need to be transferred.

Engagement sessions with key staff are underway to ensure that the required cultural and process changes are identified and embedded across the organisation when the new system is implemented.

During 2012/13, we will be increasing the number of beds in our hospital across many specialties and this should also assist in decreasing the number of patient transfers that we are unable to admit. Like all organisations, we have an absolute number of beds in the hospital and if these are all full, we won't be in a position to exceed capacity. However, it is also recognised that at times, patients who are in hospital are waiting for internally provided services; for example, waiting for scans, which places extra demand for beds and increases patients' length of stay. Over the past year, we have established a Health Care Delay Audit Group which, on a fortnightly basis, reviews a ward to understand if there are any internal delays experienced by ward patients. A delay is defined as healthcare action not occurring in a timely manner which has the potential either to cause harm or increase the patient's length of stay in hospital by at least one night.

The group consists of a core team of staff and is led by the deputy chief operating officer. The results from this work have been collated and themed. They reveal that in this sample of 205 patients, 20 per cent of patients are delayed waiting for services. The reason for these delays is as follows:

Reasons for delay in healthcare



However, the analysis shows that there isn't a common theme or team that we can easily approach to improve this situation. A real-time bed management system would be crucial for improving the delays for patients and identifying where action is needed.

How will we measure and monitor performance in 2012/13?
We will measure the number of times we refuse to admit a clinically appropriate patient needing to transfer to a bed at GOSH.

To ensure that we capture all patients referred for a transfer to a bed at GOSH, an electronic referral form has been developed which is completed for each patient and identifies the outcome of the referral accordingly.

The following graph shows the number of patient transfers that we have been unable to admit by each month.

The number of patients we have been unable to admit to a bed in GOSH by month

Data source: Monthly Management Board Report

Priorities for improvement in 2012/13
Experience priority continued

This information is currently locally discussed and reviewed by the relevant clinical teams. It is reported to their central management teams and these teams then provide a report on a monthly basis to the senior management team.

At GOSH, we have a team that is responsible for facilitating and implementing transformation change in the organisation. Transformation means thinking differently and implementing solutions in areas which need improving. The transformation programme is focused around three goals of improvement called zero harm, no waste and no waits. This bed management project and improvement work reflects the goal of no waits. The progress on this improvement initiative is therefore monitored by the Transformation Board. Board meetings are established to hold teams to account and monitor objectives and aims. The Transformation Board is led by the Chief Executive and the members include not only transformation and clinical staff, but also parent representatives.

Who is responsible for this improvement initiative?
A project manager has been appointed who is responsible for operationally improving the bed management system, and this is overseen by the chief operating officer.

Statements relating to the quality of NHS services
The following section details the mandatory statements as set out in the National Health Service (Quality Accounts) Regulations 2010.

Review of services
During 2011/12, Great Ormond Street Hospital (GOSH) provided and/or sub-contracted 38 NHS services. The income generated by the NHS services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by GOSH for 2011/12. The data reviewed should aim to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience.

Our services incorporate medical and surgical services as well as offering support, therapy, diagnosis and investigation. As a tertiary quaternary centre, we see patients from across the country, and our aim is to enable children with specific needs to access a range of services within one site whenever possible.

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. These include progress against external targets such as the ways in which we keep our hospital clean, and the effectiveness of actions to reduce infections and ensure that 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 in which improvement may be required. This information links into a wider Trust governance framework, where the units report at least once a year on progress in the care they provide.

These updates are recorded via quarterly operational performance reviews and the committee structure of the Trust to ensure that the quality of service delivery and monitoring is discussed and acted upon at the appropriate level within the Trust.

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 2 in the National Health Service Litigation Authority (NHSLA) Risk Management Standards in November 2009.

The NHSLA provides GOSH with indemnity cover and assists NHS organisations in improving their risk management arrangements through assessment against a set of 50 standards and criteria. These standards cover a wide range of topics including record keeping and blood transfusion management. Assessments are carried out at three levels. GOSH will be assessed again at the end of 2012.

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 events is low. The National Patient Safety Agency (NPSA) has consistently identified the Trust as meeting this criteria. Analysis of the types of risks identified by staff is incorporated into our assurance process to ensure that management, performance and safety are closely aligned.

GOSH has reviewed all the data available to them on the quality of care in 38 of these NHS services.

Participation in clinical audit

Clinical audit is an evaluation of the quality of care provided against agreed standards, with actions taken to improve quality where needed.

The Clinical Audit team is part of the Quality Safety and Transformation team and works closely with the improvement managers and co-ordinators, the information analysts, risk managers and Complaints team.

The Clinical Audit team provides additional support and expertise to ensure that clinicians are supported in undertaking good-quality clinical audit which leads to improved practice.

We have identified three types of clinical audit at Great Ormond Street Hospital (GOSH):
1. International/national audits in which we are asked to take part.
2. Local audits undertaken within GOSH, identified by clinical teams to ensure that patients get the best possible care.
3. Clinical audits directed and managed by the Clinical Audit Department, which address controls associated with known risks and best clinical practice.

1. Participation in national audits

Engagement with national audits is essential in ensuring that improvements are made to clinical care and to encourage delivery of better outcomes as a result of the quality of care that is provided.

The Department of Health and the Health Care Quality Improvement Partnership recommended that trusts participate in 51 national audits.

During 2011/12, 17 national clinical audits and no national confidential enquiries covered the NHS services that GOSH provides.

During 2011/12, GOSH participated in 88 per cent of the national clinical audits which it was eligible to participate in.

The national clinical audits and national confidential enquiries that GOSH participated in during 2011/12 are as detailed in the following table. The national clinical audits and national confidential enquiries that GOSH participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

> Clinical audit is a quality improvement cycle that involves measurement of effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.
>
> **HQUIP Best Practice for Clinical Audit 2011**

Audit title	Cases requested from national body	Cases submitted by Great Ormond Street Hospital
Peri- and neonatal		
Centre for Maternal and Child Enquiries: perinatal mortality	Applicable to the death of any baby from 24 weeks' gestation to 28 days	100 per cent of applicable cases
Children		
Paediatric Intensive Care Audit Network: paediatric intensive care	Approximately 1,700 cases	100 per cent of applicable cases
Congenital Heart Disease: paediatric cardiac surgery	100 per cent of applicable cases	Confirmation: 100 per cent of applicable cases will be submitted by May 2012, meeting deadline for submissions
British Thoracic Society: paediatric asthma	100 per cent of applicable cases	100 per cent of applicable cases (n = four)
British Thoracic Society: paediatric pneumonia	100 per cent of applicable cases	100 per cent of applicable cases (n = nine)
Acute care		
NHS Blood and Transplant: potential donor audit	100 per cent of applicable cases	100 per cent of applicable cases (n = 85)
National Cardiac Arrest Audit: cardiac arrest audit	100 per cent of applicable cases	100 per cent of applicable cases (n = 43)
Long-term conditions		
National Inflammatory Bowel Disease: ulcerative colitis and Crohn's disease	Round 3 Clinical Audit: 100 per cent of applicable cases Round 3 Biologics Audit: 100 per cent of applicable cases	Round 3 Clinical Audit: (n = three Crohn's disease cases, three ulcerative colitis cases) Round 3 Biologics Audit: submission will occur once registration to the system has been completed
British Thoracic Society: bronchiectasis	100 per cent of applicable cases	100 per cent of applicable cases (n = 12)
National Pain Audit: chronic pain	No minimum	n = 17 *comment from national body 'represents a very good return for the three-month collection period'
Elective procedures		
NHS Blood and Transplant UK Transplant Registry: intrathoracic	100 per cent of applicable cases	100 per cent of applicable cases
Cardiovascular disease		
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	100 per cent of applicable cases	100 per cent of applicable cases
Renal disease		
Renal Registry: renal replacement therapy	100 per cent of applicable cases (December 2011 submission)	Data to be submitted July 2012
NHS Blood and Transplant UK Transplant Registry: renal transplantation	100 per cent of applicable cases	100 per cent of applicable cases (n = 31)
Blood transfusion		
National Comparative Audit of Blood Transfusion: bedside transfusion	100 per cent of applicable cases	100 per cent of applicable cases (n = 50)

We did not participate in the following audits
- Patient-reported outcome measures for the four elective procedures
- Trauma Audit and Research Network: severe trauma

Participation in national confidential enquiries
Three National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies collected data in 2011/12 and did not require GOSH participation as they did not cover the care of children:
- Cardiac arrest procedures
- Bariatric surgery
- Alcohol related liver disease.

The reports of national clinical audits were reviewed by GOSH in 2011/12. The relevant specialties intend to take the relevant actions to improve the quality of healthcare provided. In 2012/13 we continue to develop a central system to record all the actions associated with national clinical audits.

NCEPOD published a report and recommendations on 27 October 2011 following the Deaths in Surgery Study in which the Trust participated (2010/11).

This has been reviewed and an organisational gap analysis was reported to the Quality and Safety Committee in January 2012. The actions identified are being monitored by the clinical audit manager and will be reported to the Quality and Safety Committee to ensure that the learning from the report is acted upon.

Local clinical audits
The reports of 42 local clinical audits were reviewed by the provider in 2011/12 and GOSH intends to take the following actions to improve the quality of healthcare provided.

Specialty	Audit title	Project description	Actions intended
Anaesthesia	Audit of optical laryngoscope in neonates	Review of outcomes of licensed optical laryngoscope to establish effectiveness	Confirmed technique is effective
Anaesthesia	Association paediatric anaesthetists (APA) sponsored multi-centre peri-operative paediatric aspiration project	Eleven centre national paediatric audit co-ordinated by the APA to identify the incidents of the rare but serious complications in both elective and emergency procedures. Also to help to identify any specific risk factors and outcome	All relevant information forwarded to Manchester Children's Hospital. National report will be released
Anaesthesia	Respiratory complications in recovery post-operatively	Identification of problems with airways picked up in recovery based on time of procedure, in order that can be explored further to increase patient safety	Not applicable – audit showed compliance
Anaesthesia	Peri-operative temperature maintenance	Assess prevalence of peri-operative hypothermia and measures used to prevent it	Met standards for audit
Anaesthesia	Audit of peri-operative fluid prescription and monitoring in children	Adherence with the Great Ormond Street Hospital surgical unit guidelines	Update and disseminate guidelines. Re-audit
Cardiac Intensive Care Unit	Teaching of Berlin heart dressings for families	To ensure that parents feel comfortable/competent in changing the dressing on their child's Berlin heart. To reduce surgical site infections and to minimise risk. To improve training/ teaching where necessary	To develop a video to demonstrate to parents and staff the correct way to change a Berlin heart dressing. To be available on the intranet
Cardiology	Outpatients' experience of the cardiac magnetic resonance imaging (MRI) unit at Great Ormond Street Hospital	The aim of the audit is to assess the experience of outpatients	To consider improvement of adult literature or entertainment in the waiting area, alternative strategies for minimising crowding in the waiting area, further audit of scheduling time and waiting times for cardiac MRI scans
Cardiology	Non-medical prescribing audit	This is a relatively new practice for the Trust to see how medicines are being prescribed across the Trust by people other than doctors	To review options regarding medication currently unable to prescribe (April 2012)
Cardiothoracic	Arterial blood gas (ABG) sampling	Aim is to reduce inappropriate ABG samples	Teaching pack in place for ABG indications
Cleft	Evaluating incidents of complications related to cleft palate repair	Aim is to evaluate the incidents of complications	To continue to practise in the same way
Clinical genetics	Audit of follow-up for all families who are known to carry a balanced chromosome rearrangement, with a view to improving service provision	The aim of this project is to identify those individuals who are at a significant risk of having a child with an unbalanced chromosome rearrangement. To then arrange tests to minimise harm for families	Diagnostic codes changed and increase awareness of the need to test at 16
Craniofacial	Functional outcomes in patients with craniofacial dysostosis – five to seven-year follow-up review	The aim is to determine if improvements are maintained at five years or more post-operatively	Results showed compliance to standards
Dental	An audit of dental anomalies affecting five-year-old children with bilateral cleft lip and palate	An audit to look at patient experience and satisfaction after visiting the dental department. Re-audit of initial audit ref. 567	To extend to multi-regional audit and include 10-year-old review patients
Ear, nose and throat	Surgical site infection audit	To assess if the antibiotic protocol is being adhered to	Department antibiotic protocol to be followed
Ear, nose and throat	Discharge summary re-audit	Recommendations were implemented from the initial audit (ref: 899). The re-audit will look at if these recommendations have been implemented successfully	Compliance has improved from previous audit. No further work needed
Endocrinology	Parental survey to assess the demand for a telephone clinic service in the congenital hypothyroid service	Assess whether families would benefit from a telephone clinic	Telephone clinic set up in August 2011 for endocrinology, which has been positive for the families and means one less hospital visit

Statements relating to quality of NHS services
continued

Specialty	Audit title	Project description	Actions intended
Gastro-enterology	Nutritional status of allergic children in the United Kingdom	To determine the nutritional status of children with a confirmed food allergy in the UK. There is no previous information so this will help to determine the severity of poor growth and malnutrition, which will help to improve dietetic management	None required. All cases submitted showed the children were well nourished
General surgery	Clinical outcomes in neonates undergoing abdominal operations on the Neonatal Intensive Care Unit	To determine the clinical outcomes in neonates requiring abdominal operations in intensive care unit from 2002 to 2010	Further audit in 2013
General surgery	Effectiveness of a Meckel's scan	To compare the relevance of the scan	This audit reassures the quality of practice of a Meckel's scan at these centres
Histopathology	Audit of reporting turnaround times	To compare Great Ormond Street Hospital turnaround times against two key performance indicators, as recommended by the Royal College of Pathology	To discuss with Information and Communication Technology the possibility of generating turnaround time data automatically
Infectious diseases	Audit of investigation and management of patients with Kawasaki disease in Great Ormond Street Hospital's Infectious Diseases Department	The aim of the project is to determine whether current treatment and management of patients with Kawasaki disease follows the guidelines set out in Brogan et al (2002) for recognition and treatment of patients in the United Kingdom	No action needed. Audit showed the guidelines were being followed
Nephrology	Audit of Epstein-Barr (EBV) virus and posttransplantation lymphoproliferative disorders post renal transplantation	Evaluate the change from a qualitative to a quantitative test. In particular, the audit will identify the risk factors and prevalence of EBV disease post transplantation	Met standards for audit
Neurodisability	Family satisfaction audit of the movement disorder clinic and botulinum toxin clinic	Feedback from families who use the service about the whole clinic process	Review information provided before clinic
Neurology	Outcome in children with medically unexplained neurological symptoms	To study if the recommendations that have been implemented for the children were correct and outcomes	No actions
Neurology	Audit of external review in a single-handed neuropathology department	Great Ormond Street Hospital is a centre with a single consultant neuropathologist, therefore it is important that its practice is in line with that of colleagues. This can be ensured by a proportion of cases reviewed by a consultant neuropathologist at another centre	Reports should state whether the second pathologist has seen the slides for a case
Neurology	Paediatric multiple sclerosis (MS): under-reported, under-diagnosed disease	To audit the implementation of guidance which should have resulted in an increase of the timescales of diagnosis and treatment of MS	To increase awareness of MS across healthcare professionals
Neurology	Use of low molecular weight heparin in neurology inpatients	To clarify whether current guidelines are being used	No need to change protocol
Neurology	Safeguarding guidelines for serious head injuries in children younger than two years old	Retrospective audit against the non-accidental injury hospital protocol (2003). Data collected retrospectively over a one-year period (from January 2010)	Checklist introduced
Neurology	Clinical queries	To assess calls logged on to the clinical queries database over a one-month period	To improve documentation of the local consultant. To document the time spent on dealing with queries. To fax completed forms to local hospital. To extend system to include neurosurgery
Paediatric Intensive Care Unit (PICU)	Bronchograms on the Neonatal Intensive Care Unit/PICU	To see if changes made in 2007 to ensure bronchograms are not undertaken on children who cannot breath spontaneously have been sustained	Re-introduction of bronchogram checklist
Radiology	Annual review of 'did not attend' (DNA) in the Radiology Department	To review archived records to find out current DNA rate for radiology	To review having letters in a variety of languages to reduce the number of DNAs in the department
Radiology	Staff dosimetry audit	Personal dosimeter badges are required by local and national rules (local radiation protection rules and Royal College of Radiologists) in order to assess the level of radiation exposure	To include information on the importance of dosimeter badges prior to arrival at Great Ormond Street Hospital. Refresher meeting on staff exposure during induction. Re-audit in 2013
Respiratory	Sweat tests on infants referred for further investigation of cystic fibrosis (CF) on the newborn screening programme	Compare with national guidance	To review the education and training of lab technicians who perform the sweat tests. To compare sweat test failure rates in NBS infants with other tertiary UK CF centres
Rheumatology	Biologics in Rheumatology: funding issues	To assess the amount of time spent waiting for approval of medication – owing to funding criteria, many children have delays in receiving their medication	To get the tuberculosis screening done in clinic, once it has been decided to start biological agent
Rheumatology	Clinical nurse specialist education survey	To identify whether local health professionals' education needs are being met	To plan study day. Nurse helpline now in place
Rheumatology	Follow-up of patients who receive intra-articular injections	Compliance with three-month follow-ups	Extra general anaesthetic lists for rheumatology
Urology	Results and long-term follow-up for feminising genitoplasty	To assess the indications and outcomes for feminising genitoplasty in patients with congenital adrenal hyperplasia	None
Urology	Portable extracorporeal shock wave lithotripsy in paediatric urolithiasis under general anaesthetic	Effectiveness of the use of a portable extracorporeal shock wave lithotripsy (ESWL)	To re-establish the ESWL service

Specialty	Audit title	Project description	Actions intended
Urology	Outcome for horseshoe kidneys	Data collection on outcomes of hydronephrosis screening and minimise investigations for the future	None
Urology	Treatment of bladder exstrophy in children at Great Ormond Street Hospital: a cost-effectiveness analysis	Review of a long-term follow-up of the effectiveness of two approaches used to treat bladder exstrophy and their related costs to decipher which of the interventions is more effective, offers less post-operative complications and is more cost-effective	Current protocol is most effective
Urology	Outcomes of pyeloplasties at Great Ormond Street Hospital over a two-year period	An analysis of the outcomes of the pyeloplasties	Success and complication rates compare favourably with, and often better than, peer rates around the world. At present, there is no need to change or alter the method of management
Urology	Adrenocortical tumours in children: a 25-year experience from Great Ormond Street Hospital	To assess outcomes. This will lead to the further improvement of treatment of such patients	Confirmed technique

Participation in clinical research

With our dedicated research partner, the UCL Institute of Child Health (ICH), Great Ormond Street Hospital (GOSH) now forms the largest paediatric centre in Europe dedicated to both clinical and basic scientific research. We are committed to carrying out pioneering research in order to find treatments and cures for some of the most complex illnesses, for the benefit of children in the UK and worldwide. Commitment to research is a key aspect of improving the quality of care and patient experience.

This year, GOSH was awarded its second National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) status from April 2012, which recognises the quality and importance of the research conducted within the organisation; GOSH is the only paediatric BRC in the UK. In addition to the BRC, the Division includes the joint GOSH/ICH Research and Development Office, the Somers Clinical Research Facility, and hosts the Medicines for Children's Research Network (MCRN) for London and the South East. Our research activity is conducted with a range of national and international academic partners, and we work very closely with industry to support the development and introduction of new therapeutics, devices and diagnostics for the NHS.

Our recent research activity is described below:

- Sixty-two active commercially-funded projects (clinical trials of investigative medicinal products and non-clinical trials of investigative medicinal products), 19 of which have been approved in the past 12 months.
- Of the 62 active commercially funded projects, 29 are commercially sponsored clinical trials of investigative medicinal products. Twenty-one of these have been approved in the past 12 months, seven of which are GOSH-sponsored trials and 31 are hosted non-commercial trials.
- Ninety-three UK Clinical Research Network Portfolio studies are currently recruiting patients at GOSH.
- We have more than 80 active research awards administered via GOSH Finance, excluding five active NIHR-funded research projects, and five active European Union-funded research projects.
- Forty-five research projects have been internally peer-reviewed through the Clinical Research Adoptions Committee.
- Over the past year, 65 research studies have been conducted in the Somers Clinical Research Facility, with more than 550 patients attending 1,326 research appointments. This represents a 34 per cent increase in appointments from the previous year.
- Four hundred and thirty-nine patients have been recruited to GOSH through the MCRN, of which 45 are for studies within the Clinical Research Facility. Forty-nine per cent of MCRN studies led by the London and South East team are GOSH-led.
- GOSH BRC has provided ongoing support for 47 studies, which includes output of major clinical impact of international and clinical significance.
- UCL Business PLC has now been contracted to support GOSH activity. In the last year, four technology disclosures have been reviewed.

The number of patients receiving NHS services provided or sub-contracted by GOSH that were recruited during that period to participate in a NIHR Portfolio Research Study approved by a Research Ethics Committee, was 1,210.

GOSH's commitment to clinical research is further evidenced by our membership of UCL Partners, which is the first of the UK's five Academic Health Science Partnerships. Through the partnership, we continue to strengthen 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 commissioners. The aim is to incentivise improvement work. This shows that we are working closely with the commissioners of our services.

A proportion (1.5 per cent) of Great Ormond Street Hospital's (GOSH) NHS clinical income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between GOSH and any person or body with whom they entered into a contract, agreement or arrangement for the provision of NHS services through the CQUIN payment framework.

Further details of the agreed goals for 2011/12 and for the following 12-month period are available on request from the assistant director of nursing or the head of contracts.

The following table summarises our CQUIN targets for 2011/12 and 2012/13:

2011/12 CQUIN targets	2012/13 CQUIN targets
To implement the patient experience strategy and action plan; maintain and improve satisfaction on nationally prioritised questions, on knowing how to feed back, and with the quality and variety of food in the annual independent inpatient satisfaction survey	Development and application of SSI prevention plans and reduction or maintenance of SSI rates
To continue to review 20 sets of case notes per month using the Paediatric Trigger Tool; undertake a peer review of the implementation of the tool	Reduction or maintenance of CVC line infection rates, and establish an audit process to give an understanding of how to avoid infections
To improve compliance with child protection record-keeping; achieve improvement in levels of group supervision of staff; increase the number of staff achieving Level 3 training	To retrospectively review 60 per cent of patient deaths using an internally developed mortality review toolkit and to identify system level issues
To implement and evaluate Great Ormond Street Hospital's (GOSH) nutrition screening flowchart; monitor patient nutrition outcomes using weight scores; complete a full audit of height measurement and set a target for improvement	To implement a new pressure ulcer risk assessment and reduce the number of pressure ulcers by 20 per cent
To reduce the current rate of surgical site infections (SSI) in four specialties; establish surveillance in five new specialties	To focus on the patient journey as they move through the organisation to identify themes for improvement on flow, process and communication, and to undertake an assessment of the hospital against the You're Welcome quality criteria
To further reduce the rate of central venous catheter (CVC) infections	To improve patients' and families' experience of food in the hospital
	To focus on parental smoking cessation by improving general information and awareness of smoking for patients and parents, and developing a strategy for training and awareness across the hospital
	To develop systems and processes which enable timely internal and external escalation of patients with delayed discharges to facilitate the reduction in the length of stay at GOSH

Statements from the Care Quality Commission (CQC)

The CQC is the organisation which regulates and inspects health and social care services in England. Great Ormond Street Hospital (GOSH) is registered with the CQC with no conditions attached to its registration. The CQC has not taken enforcement action against GOSH during 2011/12.

Part of the CQC's role is monitoring the quality of services provided across the NHS and taking corrective action where necessary. Its 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 considered with information from other external monitoring sources. These data items are drawn together to create a quality risk profile for the Trust, which provides an estimate of the risk of non-compliance with registration requirements

GOSH has participated in special reviews or investigations by the CQC relating to the following areas during 2010/11:

- Meeting all the essential standards of quality and safety.

GOSH intends to take the following action to address the conclusions or requirements reported by the CQC:

- Improve the tagging of clinical equipment for purposes of maintenance and cleaning. GOSH has made the following progress by 31 March 2012 in taking such action by developing an action plan and implementing it.

Information on the quality of data and information governance

NHS managers and clinicians are dependent upon good-quality information, using data derived from operational systems to ensure that appropriate services are delivered 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 usable and accessible format, to support them in the delivery of high-quality care.
It is crucial that all data captured about patients is accurate, timely, and of good quality.

Secondary Uses Service (SUS)

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 is based on data submitted by all provider trusts.

GOSH submitted records during 2011/12 to the SUS for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - 97.4 per cent for admitted patient care
  - 98 per cent for outpatient care
  - not applicable for accident and emergency care
- which included the patient's valid general medical practice code was:
  - 100 per cent for admitted patient care
  - 100 per cent for outpatient care
  - not applicable for accident and emergency care.

Note: the percentages for NHS number compliance have been adjusted locally to exclude international private patients who do not require an NHS number.

Information Governance Toolkit

The Information Governance Toolkit is a device that supports organisations in managing the data they hold about patients. The score achieved by an organisation reflects how well it has followed the guidance.

GOSH's Information Governance Assessment Report overall score for 2011/12 was 69 per cent and was graded green.

GOSH will be taking the following actions to improve data quality:

- The introduction of a data quality strategy
- The review and update of the data quality policy.

Clinical coding

Clinical coding is the process by which the notes that clinical staff record are categorised to reflect the activity that occurs regarding each patient.

GOSH was subject to the Payment by Results Clinical Coding Audit during the reporting period by the Audit Commission, and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was five per cent. This is better than the national average of 9.1 per cent. The data used for audit included a randomly selected sample of activity across the whole range of specialties and an equivalent sample volume selected randomly from the paediatric neurosciences specialty.

GOSH was not subject to the Payment by Results Outpatient Audit in 2011/12.

Please note the following points regarding the results of clinical coding audit:

- That the results should not be extrapolated further than the actual sample audited
- Which services were reviewed within the sample.

Review of quality performance in 2011/12

The following section reviews the priorities that were included in last year's Quality Account and the associated performance over the past year. It assesses whether we met our targets and illustrates some examples of initiatives intended to improve the quality of the services provided by Great Ormond Street Hospital (GOSH).

Safety priority

Zero harm – reducing all harm to zero

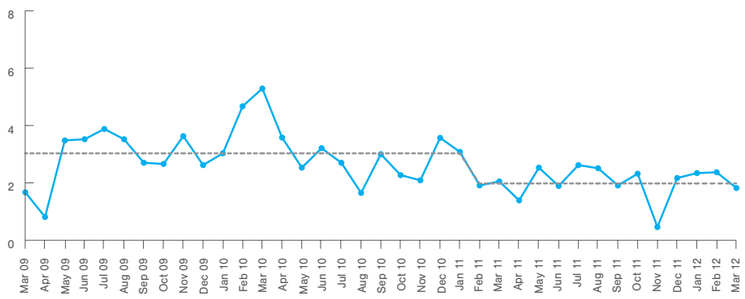
This section reviews the improvement initiatives we detailed last year to support the achievement of the priority of zero harm and our performance compared with previous years.

1. Reducing healthcare-acquired infections rates

What did we say we would do?	Performance 2009/10	2010/11	2011/12	How did we do and what are we going to do next?
Reduce the number of central venous catheter (CVC) line infections developed at Great Ormond Street Hospital	3.26 per 1,000 line days	2.61 per 1,000 line days	2.0 per 1,000 line days	We have improved, although not achieved the specific target of a 50 per cent reduction. We are committed to reducing CVC lines and set ourselves a target of a 10 per cent reduction for the next year. We have also appointed an infection control practice educator to support training and education

The following graph shows the number of central venous catheter (CVC) line infections on a monthly basis and demonstrates our sustained improvement over the past year. The grey dotted line presents the average, and our aim is to reduce the average towards zero.

GOSH-acquired central venous catheter line infections for every 1,000 line days



Data source: Infection Prevention and Control Database

What really made a difference for us was taking on an infection link nurse who is really keen to make a difference. She is working with her colleagues on education and making sure they get feedback.

Elizabeth Ball, Improvement Manager for Surgery

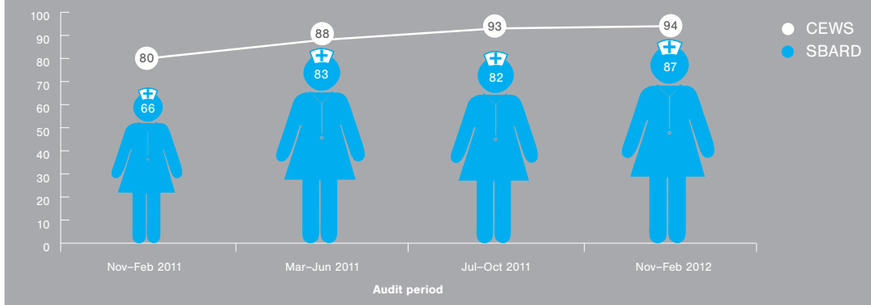
What did we say we would do?	Performance 2009/10	2010/11	2011/12	How did we do and what are we going to do next?
Reduce the number of surgical site infections against the identified baseline for each specialty				The number of infections has reduced this year but we have not met our specific target. We have established surveillance in some of the other specialties, and in 2012/13, we plan to establish baseline surveillance data in all surgical specialties and continue development of care bundles. Care bundles help to minimise the likelihood of infections by giving staff best practice steps to look after a patient following surgery
• **Urology**	Eight infections	Six infections*	Four infections	
• **Spinal implant**		Five infections from 180 operations	11 infections from 108 operations	
• **Cardiac surgery**		48 infections from 592 operations	40 infections from 568 operations	
Surveillance established in further specialties				
Reduce or maintain low levels of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia	One case	One case	Four cases	We did not reach our target this year on reducing MRSA and the numbers have increased slightly. However, the number is still within our contractual target. A full examination of these four cases were reviewed and lessons were shared in the organisation. We aim to reduce the numbers for 2012/13
Reducing the annual number of cases of Clostridium difficile-associated (C. difficile) diarrhoea	12 cases	10 cases	Eight cases	We have maintained the annual number of cases of C. difficile and will continue to strive to reduce the number of patients who get C. difficile each year

*We reported eight infections in last year's Quality Account for surgical site infections.
These infections were checked by the clinical lead and revised to six after the Quality Account was prepared

2. Effective monitoring and communication of the deteriorating child

What did we say we would do?	Performance 2010/11	Performance 2011/12	How did we do and what are we going to do next?
All ward staff to use Children's Early Warning Score (CEWS) for monitoring patients and SBARD (situation, background, assessment, recommendation, decision) for communicating concerns	**CEWS –** average 83 per cent **SBARD –** average 71 per cent	**CEWS –** average 94 per cent **SBARD –** average 84 per cent	We have consistently improved but not achieved our absolute target of 100 per cent yet. We will continue to monitor calls and provide education and feedback to staff

Percentage of calls to clinical site practitioners where CEWS were given and information was communicated using SBARD

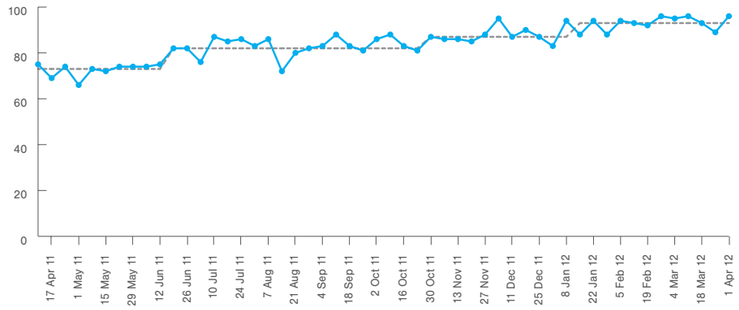


3. Use of the World Health Organisation surgical and procedural safety checklist

What did we say we would do?	Performance 2010/11	Performance 2011/12	How did we do and what are we going to do next?
All relevant teams to use and record the World Health Organisation Surgical Safety Checklist in every procedure	Average 60 per cent	Average 92 per cent	We have continued to improve over the past year and have nearly reached our target of 100 per cent compliance. To aid this work, we have arranged to have teams filmed using the checklist and focused on the quality of completion

The following graph shows the percentage of total World Health Organisation's Surgical Safety Checklist completion on a bi-weekly basis and our sustained improvement over the past year. The grey dotted line represents the average, and our aim is to increase the average to 100 per cent.

Percentage of total checklist completion



Data source: Great Ormond Street Hospital Patient Information and Management System

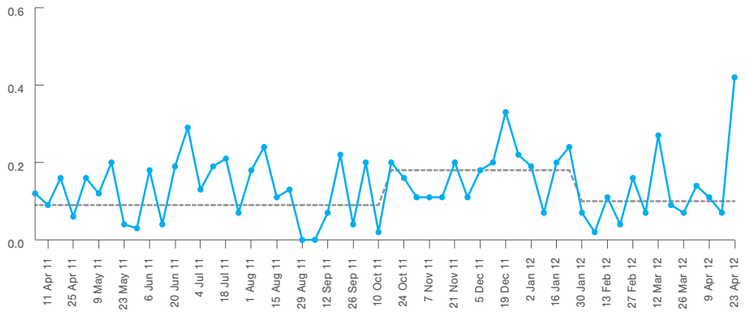
In recognition of the improvement, the Project team won an award at the Association for Perioperative Practice Annual Conference. The surgical specialties are completing the checklist 95 per cent of the time, and we are now focusing on particular areas where this has proved harder to implement than others.

4. Reducing the number of medication errors

What did we say we would do?	Performance 2010/11	Performance 2011/12	How did we do and what are we going to do next?
Reduce the established baseline of medication errors in the Paediatric Intensive Care Unit (PICU) and Cardiac Intensive Care Unit (CICU) by 25 per cent	**PICU –** average 0.09 per bed day **CICU –** average 0.13 per bed day	**PICU –** average 0.10 per bed day **CICU –** average 0.09 per bed day	**PICU** We have not reduced the average medication error rate for patients in the PICU. We have reduced the median medication error rate for patients in the CICU but not met our target. To focus improvement in this area, we employed a medicines management improvement specialist to work on a project to tackle cross-cutting issues relating to medicines management. The postholder will also work at clinical unit and specialty level to support improvement initiatives and spread good practice

The following graph shows the performance of prescribing errors for the Paediatric Intensive Care Unit (PICU):

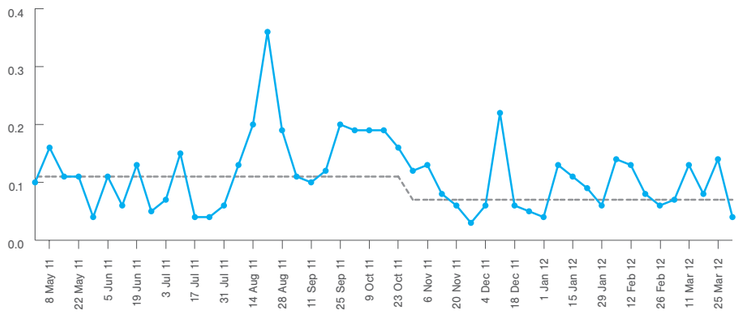
Clinical prescribing errors per bed day



Data source: PICU pharmacists

The following graph shows the performance of prescribing errors for the Cardiac Intensive Care Unit (CICU):

Clinical prescribing errors per bed day



Data source: CICU pharmacists

Case study

Cardiac Intensive Care Unit (CICU) Medicine Safety Week

A drug safety week was held in the Cardiorespiratory Unit at the end of January. There was a programme of daily events, centred on medicines management issues.

Clare Paley, Practice Educator, Barbara Childs, Lead Nurse CICU, and Lynne Cochrane, CICU Pharmacist, shared their thoughts about it. Lynne explains the background: "The main aim of the week was to highlight the importance of getting prescriptions right and to raise awareness of the fact that it's a collective responsibility. We aimed to encourage ownership of tackling medication errors and sought out suggestions from nursing and medical staff on how to safely prescribe and administer patients' medicines."

The week started on Monday by looking at the top 10 prescribing errors, with short presentations at nursing and doctors' handovers. That was just the start, as Practice Educator Clare Paley explains: "Tuesday covered the human factors of prescribing errors with Dr Jane Carthy. Staff spoke to Jane about prescribing errors, and this is ongoing. Wednesday saw a talk from Dr Barry Sullman about medication risk and all the nurses from the unit attended. It was a powerful exploration of a fatal error from a personal perspective. The advance nurse practitioners came and looked after the patients so that the nurses could go, which was quite a feat. A big thanks to everyone involved with that."

"Reflecting on someone else's experience is very sobering," said Clare. "It highlights the importance of teamwork, following the procedures for checking prescriptions so that errors are noticed before the drug is administered."

CICU Lead Nurse, Barbara Childs, remarked on nurses' feedback to the week: "They recognise how human factors are involved in drug errors instead of looking at it in isolation; there is a sequence of events sometimes. There's not one person involved in a drug error. We had recognition of that and staff fed back to say they got a lot from the session."

The effect of the Drug Safety Week has been noticeable, according to Pharmacist, Lynne Cochrane: "The data collected in the weeks since it took place has been really encouraging."

Teamwork was crucial, says Clare: "We all worked together to make sure it happened and it was rolled out. The days went according to plan; it was a multidisciplinary effort that was nurse-led."

5. Reporting and learning from incidents

What did we say we would do?	What did we do?	How did we do and what are we going to do next?
Staff to record incidents when they happen and implement the National Patient Safety Agency's national framework for serious incidents	We implemented a new electronic incident reporting system to help make it easier for staff to report incidents and improve feedback on the lessons learnt from the incident. We have implemented the National Patient Safety Agency's national framework for serious incidents	Between April 2010 and March 2011, the Trust received 3,389 patient safety incident reports. After implementation of web reporting in April 2011, the number of patient safety incidents being reported has risen to 3,559 (April 2011–March 2012); this is an increase of five per cent. We will continue to monitor the number of incidents reported and aim to reduce the severity of harm that is reported

Last year, we showed the number of incidents that we reported compared to other similar hospitals from the National Reporting and Learning System (NRLS). This demonstrated that we have high reporting levels, which is important to ensure that we learn from incidents. We have encouraged staff to report incidents and the National Patient Safety Agency advises that high reporting is a sign of a good safety culture. It shows that the hospital has an open and positive approach to discussing things that go wrong, and proactively dealing with them. We grade incidents by the severity of the incident from no harm; low harm; moderate harm; major harm and catastrophic harm. The sign of a safe reporting culture is one in which there continues to be high numbers of incidents reported, but that the level of harm caused by those incidents decreases.

In 2010/11, 96 per cent of incidents were reported as resulted in no harm or low harm. In 2011/12, 98 per cent of incidents were reported as resulted in no harm or low harm.

We have not used the more recent NRLS information report as we did last year because the number of incidents reported is inconsistent with our local system reports.

Next year, we will report on the severity of incidents compared to the overall number of incidents reported.

6. Improve safeguarding

What did we say we would do?	How did we do?	What are we going to do next?
Improve safeguarding and implement a balanced scorecard to improve our performance by: • **improving record-keeping** • **implementing group child protection supervision** • **ensuring that 40 per cent of staff have Level 3 training**	We undertook regular audits of case notes to monitor the quality of record keeping and rated each case note against established quality criteria. At the end-of-year audit, the case notes reviewed scored on average 88 per cent which relates to 'excellent'. This is higher than the aim of 80 per cent We developed a new supervision model to support with child protection cases. In the last three months of the year, we reported that of the 21 referrals received, 19 received supervision, which is higher than the aim of 50 per cent We increased the number of staff that had the relevant Level 3 safeguarding supervision and, at the end of the year, 53 per cent of the relevant staff had training, which is higher than our aim of 40 per cent	We continue to set targets to aim to improve these three aspects of safeguarding

We have not reported this year on ventilator-associated pneumonia in the Paediatric Intensive Care Unit because we have not undertaken any formal audits or data collection. However, we will be introducing a new care bundle next year.

Clinical effectiveness priority

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

This section reviews the improvement initiatives we detailed last year to support the achievement of our effectiveness priority and our progress over this year.

1. Publication of clinical outcomes on the website

What did we say we would do?	Performance 2009/10	Performance 2010/11	How did we do and what are we going to do next?
We said we would publish information on clinical outcomes on the Great Ormond Street Hospital (GOSH) website in a further nine specialties	Nine specialties with measures available on the website	18 specialties with measures available on the website	We achieved our target and published information on clinical outcomes on the GOSH website for: Children's Acute Transport Service; clinical genetics; dermatology; immunology; infectious diseases; interventional radiology; occupational therapy; orthopaedics and specialist neonatal and paediatric surgery

We wanted to make more information about clinical outcomes available and to ensure that this information could be understood and be meaningful to the parents of children treated at Great Ormond Street Hospital (GOSH).

We sent an advert to all the parents who were members of GOSH, stating that we were looking for volunteers to provide feedback and guidance on making information on clinical outcomes available on the website. We had a fantastic response from five parents that had experience and interest in making information available on the website. We recruited all five parents to ensure that we got feedback and advice from parents on the clinical outcome information that was planned next for publication on the GOSH website.

The parent group met four times between December 2011 and March 2012 and reviewed the current information on clinical outcomes that is on the GOSH website. They provided valuable feedback and guidance on what areas worked well and what areas did not work so well. The parents also provided fantastic suggestions of what additional information is needed to understand the results of clinical outcomes and proposed a template to guide how the information should be developed. In particular, they felt that the use of parent, patient or staff quotes on the outcome of the service would be really good to illuminate the message of the graphs and data that is presented.

This group of parents reviewed information on a further nine clinical outcomes and provided recommendations and advice if areas needed more information or better explanation. All the recommendations were taken on board and this information is now available on the website. We will be using the principles of this work to help inform further information that is developed.

GOSH would like to say a big thank you to the parents who helped us with this work:
Graham Manfield
Antonia Wade
Sophie Huang
Jacqueline Steward
Myriam Lantrade

> It has been a privilege to be able to contribute to this valuable work and a great learning experience. Many thanks for this opportunity.
>
> **Sophie Huang**

2. Using and developing patient-reported outcome measures (PROMs)

What did we say we would do?	How did we do?	What are we going to do next?
Continue to use patient-reported outcome measures (PROMS) in specialties and aim to develop and implement further PROMs across the hospital	We have been monitoring the use of PROMs in the six specialties used last year (listed below) and have implemented collecting PROMS in the following specialties: • Clinical genetics • Children and Adolescent Medicine Mental Health Service • Cleft • Speech and language therapy • Orthopaedics Research for a specific quality of life validated patient-reported outcome questionnaire is currently ongoing within the Ophthalmology team	Continue to monitor the number of responses across all PROMs ongoing in the organisation In addition we plan to host a collaborative workshop with clinicians interested in using PROMs to share learning and best practice. This will be informed by feedback from patients and parents about the best ways to engage them with completing questionnaires

The following table shows the number of questionnaires that have been completed to date and the next steps:

Specialty and patient-reported outcome measure (PROM)	Number of initial questionnaires completed	Number of follow-up questionnaires completed	Next steps
Cystic fibrosis Cystic fibrosis questionnaire	12	12	Consider the use of the PROM in further frequent flier programme
Epilepsy surgery Quality of life in childhood epilepsy	52	3	Continue to capture responses and focus on follow-up responses
Dermatology Laser surgery patient-reported outcome measure	6	6	Continue to capture responses
Chronic fatigue service A variety of PROMs are used including EQ-5D	74	26	Initial analysis of responses to some of the questions asked was published on the Great Ormond Street Hospital website in March 2011. This information will be refreshed and updated by July 2012
Orthopaedics Oakland hospital hip evaluation study	22	0	Continue to capture responses
Neurodisability Parental understanding questionnaire	Not applicable	Not applicable	Research into formalising the measure for use in clinic

Case study

The Cystic Fibrosis (CF) Frequent Flyer Programme (FFP) Patient-Reported Outcome Measure

The Frequent Flyer Programme was started in September 2010, starting with the 16 sickest children with CF. Physiotherapy included weekly-supervised exercise sessions, regular review of airway clearance and inhaled mucolytic techniques. Dietetic management included monitoring of growth, absorption, appetite and intake, and nutritional education.

To evaluate the impact of the programme, the main measures used were IV antibiotics, hospital stays and courses of IV antibiotics completed at home. Exercise capacity, lung function, growth and body composition data were also evaluated.

In addition, the Cystic Fibrosis Questionnaire (CFQ) UK version (Bryon et al., 2009) was completed before and after intervention to evaluate changes in quality of life. Satisfaction questionnaires were also completed post-intervention.

The questions were designed into age-appropriate versions:
- Age six to 11 (interview schedule)
- Age 12 and 13 (self report)
- Fourteen years and older (self report).

Questions were arranged into nine subcomponents relating to: physical functioning; energy/wellbeing; emotions; social limitations; role; embarrassment; body image; eating disturbances; and treatment burden. The questionnaire for adolescents aged 14 and older has a further four subcomponents: role functioning; vitality; health perception; and weight. Each subcomponent is calculated out of a score of 100 (100 is the best) and the overall score is the average of these subcomponents.

Twelve out of the 16 children completed the questionnaire. We recognise that analysis is limited due to a small sample size. In addition, the responses to each component for each child varied from zero to 100 out of 100.

Six out of the 12 children reported an overall improvement score in their quality of life; two reported no improvement; and four reported a reduction. Children that reported an improvement in their quality of life completed the CFQ for children aged six to 11. Improvement was on average an increase of 11 out of 100. This group reported significant improvement in physical functioning; body image; social improvement; and respiratory. However, this group also reported a significant reduction in energy burden, which may reflect the ongoing burden those children with moderate to severe CF experience to maintain regular, multiple home treatment regimens.

Children aged 14 and older reported an overall reduction in quality of life. This is consistent with other research showing that quality of life scales (such as emotional functioning, physical and psychological wellbeing and self-perception) decrease from childhood into adolescence (Michel et al, 2009). The reduction was particularly in relation to body image and eating disturbances, which may reflect the challenges in the management of enzyme dosing and pancreatic exocrine insufficiency.

We also reviewed the changes to quality of life for each patient and noted in the physical subcomponent, 10 out of the 12 children reported an average increase of 10 out of 100.

While the changes in the scores are limited, it is acknowledged that this is the first time we have attempted to capture outcomes that demonstrate quality of life from the point of view of the patient. Therefore, any improvement in the quality of life is important and it will take some time to become accustomed to using such measures to understand the results of treatment.

The CFQ will continue to be used in the programme and in further trials of treatment.

3. Benchmarking outcomes against other organisations

What did we say we would do?	How did we do?	What are we going to do next?
To encourage specialties at Great Ormond Street Hospital to use outcome measures that can be benchmarked against those of other providers and/or to lead on the development of outcome measures that can be used by other centres	The following specialties that were identified last year continue to submit clinical information to registries or networks which enables benchmarking of outcomes: • Cardiology and cardiothoracic surgery through the central Cardiac Audit Database • Cardiac and paediatric intensive care – through the Paediatric Intensive Care Audit Network • Cystic fibrosis – through the Cystic Fibrosis Registry • Renal – through the National Health Service Blood and Transplant Organisation • Chronic Fatigue Service (CFS) – through the CFS National Outcomes Database • Gastroenterology inflammatory bowel disease – through the ImproveCareNow Registry • Haemophilia – through the specialist commissioning forum • Infectious diseases – through the collaborative Human Immunodeficiency Virus (HIV) Paediatric Study • Ophthalmology – through the Royal College of Ophthalmologist quality standards quality indicators Other specialties which have also submitted clinical outcome information to registries or studies in 2011/12 are: • Oncology and haematology • Bone marrow transplant • Interventional radiology • Dental and maxillofacial	We have written to leading children's hospitals around the world to seek their interest in a collaborative study with regard to sharing clinical outcome measures and considering services that we provide to see if they are comparable. To support this work, we are also meeting with the leads for our specialties to determine how data, definitions and outcome results are currently shared with others and what resource is needed to facilitate this work. We hope this work will give us more understanding of what work needs to be done to facilitate benchmarking and a clear idea of how we can start to compare ourselves with other leading children's hospitals There is also a national development of specialist quality dashboards that encourage all hospitals that provide specialist services to report against defined measures. This also gives us an opportunity to compare our performance with others

Case study

Gastroenterology Inflammatory Bowel Disease (IBD) ImproveCareNow

Our hospital is committed to providing the best possible care to all of our patients. To accomplish this mission, the Gastroenterology Inflammatory Bowel Disease team at Great Ormond Street Hospital (GOSH) has joined up with several other hospitals in the USA in the ImproveCareNow collaborative for Crohn's disease and ulcerative colitis (ImproveCareNow for short).

The primary goal of ImproveCareNow is to help children and adolescents with Crohn's disease and ulcerative colitis to overcome their conditions and to lead happy, healthy lives. It is a quality improvement project that focuses on measuring and improving the care we provide for our patients with ulcerative colitis, indeterminate colitis and Crohn's disease. There are many benefits of participating in this collaborative for patients treated at GOSH. For instance, the collaborative ensures that data is collected at each visit for a number of measures, which helps to document nutrition, growth, disease severity and actions for patients. Advanced tools and management reports have been developed to make sense of these results over time to enable the team to monitor health and disease status, medications, medication doses, serious side-effects, regular visits, and to identify and provide extra care for patients needing more help. It also helps to identify where our performance meets the collaborative target. Our team benefits from working with other teams that also regularly see and treat patients with the same condition to build a more reliable, effective and safe way to provide care. This allows the network to send targets for measures to ensure that we learn and improve the care that patients receive.

For example, in our GOSH centre report in February 2012:

- Ninety-one per cent of the patients with IBD have satisfactory growth status which is above the network target of 90 per cent
- Fifty-four per cent of the patients with IBD have had a sustained remission rate which is above the network target of 45 per cent
- Eighty-nine per cent of patients with IBD have satisfactory nutritional status which is just below the network target of 90 per cent
- Sixty-seven per cent of patients with IBD have had a steroid-free remission rate which is below the network target of 76 per cent; when we first started in the collaborative, this rate was 50 per cent
- Since working in this collaborative, we have increased the number of patients who no longer need prednisolone from 75 per cent to 86 per cent.

We also have access to the results of other centres to see how we compare and where we need to improve.

Case study

Ophthalmology Quality Standards

The Royal College of Ophthalmologists has developed quality standards to help to inform how well a clinical service is working across the quality domains of safety; effectiveness and experience. The Royal College of Ophthalmologists has developed quality standards with the aim of helping to improve the structure, processes and health outcomes of ophthalmic care and services for children and young people. The Royal College also developed quality indicators and metrics to assess the degree to which the quality standards are being achieved, to identify areas for quality improvement and to measure the impact of quality improvement initiatives. This included the Royal College of Ophthalmologists' Quality Indicators Tool for Paediatric Ophthalmology, which focuses on key aspects of service provision and can be used as a quality improvement tool, an audit tool, and to support professional appraisal and revalidation processes. It is a simple self-assessment questionnaire which asks 23 questions across the dimensions of patient experience, clinical effectiveness and safety, which represented best practice standards. The questions could be answered with either a 'yes', 'no' or 'don't know', and additional comments could also be provided if required. At the end of the self-assessment, a question was asked to the extent that there was evidence to support each question and the types of information that could provide evidence.

The Great Ormond Street Hospital Ophthalmology Department is an early implementer of these quality standards. In December 2011, an electronic form with the self-assessment questions was sent out to the 26 clinicians in the department. A total of 17 responses were received, representing junior doctors, vision scientists, optometrists and consultants.

The responses were collated and each question was colour coded depending on whether the standard was met:

- Green represented questions which were mostly answered with a 'yes' and the standard being met
- Amber represented questions where there was a balance between 'yes' and 'no' and 'don't know'
- Red represented questions where there was a greater proportion of responses of either 'no' or 'don't know'.

The results were as follows:

The red responses were for the following questions:

- Child and/or family ('patient') experience is measured, using validated tools where possible (eg assessment of satisfaction with services, quality of communications, family-centredness of services).
- All visually impaired children and young people are referred to their local consultant paediatrician (community or neurodisability) for multidisciplinary assessment by a child development and/or a visual impairment team.
- Clinical audits assessing healthcare outcomes are undertaken regularly to inform clinical practices, and staff and service development.
- There is an agreed process for transition of care to adolescent or adult services.

The results of the self-assessment were discussed in a department-wide meeting and proposed actions for improvement were debated. Importantly, it was recognised that work needed to take place on evidencing each of the questions. The results and action plan will also be shared with the Royal College of Ophthalmologists in May 2012.

Alongside this work, a telephone survey is underway with families that have attended clinics in 2011. This asks questions that can be related back to some of the quality of standards and will help the department to assess whether families have the same views as the clinicians on the standards of the service. The results will be collated by the end of May and used in conjunction with the results of the self-assessment to inform actions.

The self-assessment questionnaire will be repeated next year to assess if there has been improvement and compare against other providers to see how we perform.

Experience priority

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

This section reviews the improvement initiatives we detailed last year to support the achievement of our experience priority and our progress over this year.

1. Maintaining high satisfaction of parents and patients through results of the survey

What did we say we would do?	Performance 2009/10	2010/11	2011/12	How did we do and what are we going to do next?
Maintain at least 90 per cent overall satisfaction in our annual inpatient parent and patient survey	94 per cent	96 per cent	96 per cent	We maintained a very high rate of satisfaction and continue to monitor satisfaction rates
Maintain the high level of positive results for the following:				We maintained or improved in all of the questions; we aim to continue with best practice and monitor satisfaction rates
• **Involving you in decisions about your child's care**	93 per cent	94 per cent	94 per cent	
• **Asking you questions about how you and your child were feeling**	88 per cent	88 per cent	91 per cent	
• **My child had enough privacy when the doctors/nurses talked about his/her treatment**	93 per cent	92 per cent	94 per cent	
• **I had enough information about any medicine**	88 per cent	91 per cent	89 per cent	
• **I knew who to contact if I had a question when I got home**	89 per cent	91 per cent	92 per cent	
Improve responses to "I knew how to complain or offer feedback" in our annual inpatient parent and patient survey	Not asked	74 per cent*	74 per cent	Maintained the rate but we would like to improve focusing on improving awareness of how to complain or offer feedback
Improve satisfaction with the quality and variety of hospital food in our annual inpatient parent and patient survey	57 per cent	60 per cent	54 per cent	Disappointingly, while we have tried to improve the quality and variety of food this year, this is not reflected in the survey results. We have established a Food at Great Ormond Street Hospital Group which has parent representatives on it and are implementing an action plan to improve the quality of food in the next year

*Last year, we reported our performance in this area as 75 per cent when it was actually 74 per cent

Case study

Nutrition

In January 2011, Great Ormond Street Hospital (GOSH) undertook a self-assessment across the organisation on standards set by the Care Quality Commission (CQC). This demonstrated that we needed to make improvement in our outcomes which related to our patients' nutrition. For example, the results of the self-assessment identified that we needed to implement a formal nutrition policy that set out the requirements and processes for staff to support the nutrition needs of patients treated at GOSH. It also identified that staff would benefit from a nutrition screening tool to support with the appropriate actions required. Importantly, staff should be documenting growth measurement of children in their medical records at each appointment or admission to hospital. We also recognised that at this time, there is no protected mealtime for children and young people.

In particular, we aimed to implement a formal nutrition policy and implement and evaluate a nutrition screening flowchart that could help staff with monitoring children's nutrition and putting in actions where necessary. We also aimed to ensure that staff documented growth measurement of height and weight.

To improve the outcomes for patients in relation to nutrition, we employed a specialist nurse for general nutrition with the objective of improving the issues that were identified.

A nutrition policy was developed and implemented which sets out the standards for assessing and managing patients' nutritional needs. A nutrition screening flowchart for use by ward staff was developed and introduced. This is completed for all patients who need to stay in hospital for more than three days. This helps to identify the nutritional needs of the patient and ensures that staff put in place support where required.

Nutrition ambassadors have been established on the wards, who are promoting improvement in nutrition screening and support of patients at mealtimes.

A mealtime feedback card was trialled on a few wards to get feedback from patients about the support, equipment and quality and experience of the food service.

Weekly nutrition rounds have commenced on the Cardiac Intensive Care Unit and Neonatal Intensive Care Unit. These enable staff to focus on the nutritional needs of their patients and ensure that actions are implemented where required.

To ensure that staff are documenting growth measurement, routine audits of weight and height documentation in patients' notes also took place.

We have improved against the outcome standards set by the CQC, which related to our patients' nutrition.

There is a 100 per cent compliance with weighting children and documenting this. Compliance with height measurement has improved from 55 per cent in March 2011 to 79 per cent in March 2012.

There are still low levels of satisfaction with the quality and variety of food. A shared food vision project is being established with the Evelina Children's Hospital and the ward food improvement group has a project plan in place to improve the experience and satisfaction with food. A new menu will be created which responds to patient feedback and automation of ward meal ordering to allow patients to order on need rather than mealtime.

2. Establishing frequent feedback systems

What did we say we would do?	What did we do?	What are we going to do next?
Capture and record regular local feedback through trailing electronic systems	We have trialled a pilot using volunteers and hand-held devices to capture parent survey results while patients are on the wards. We have trialled using volunteers to capture patient survey results while parents are in outpatient clinics. We have also trialled using volunteers to capture telephone surveys with parents	Consider the evaluation of these initial pilots and consider the options for roll-out across the organisation, including the potential of using the bedside entertainment system that is available on some of our wards

Patient experience surveys using hand-held devices with support from volunteers

We have been keen to trial using electronic hand-held devices to capture responses from patients and parents. This would enable us to capture the responses of local surveys that take place on a ward in a more sustainable way. It would also ensure that the responses from local surveys could be recorded in a central place, and themes across areas could be identified. To test this, we purchased a couple of hand-held devices and used local software development to enable the device to host a survey. We recruited two young volunteers and identified four wards across the hospital to trial capturing responses in December 2011. Feedback from parents, patients, staff and volunteers was positive regarding the concept of using hand-held devices and volunteers to capture 'real-time' responses. In total, 28 out of the 32 families approached were happy to take part in the survey. The hand-held devices and the software to host the survey seemed fit for purpose. The responses to the questions asked were very positive. However, feedback suggested that the questions needed to be more specific for parents to answer and for wards to be able to act on improvement. It was also recognised that some work needed to take place on how the wards should use and display the information from surveys and implement any actions that are needed.

Patient experience surveys in Outpatients with support from volunteers

Through anecdotal feedback, we understand that the experience of patients and families using Great Ormond Street Hospital's (GOSH) main reception and the Outpatients receptions based in the Royal London Hospital for Integrated Medicine could be improved.

A group of enthusiastic volunteers were therefore recruited to carry out a patient and family satisfaction survey.

One volunteer, Mimi, said: "The GOSH team were absolutely amazing. They helped me build my confidence in communication skills. Parents and patients were lovely to speak to. They were very open in sharing their experience. I felt a real sense of achievement and fulfilment. I certainly recommend anyone to volunteer at GOSH."

The volunteers did a fantastic job, gathering more than 1,000 completed surveys. We are now in the process of analysing the responses and will feedback the results in a future edition of *Member Matters.*

3. Improving communication with patients, parents and referrers

What did we say we would do?	Performance 2009/10	2010/11	2011/12	How did we do and what are we going to do next?
Reduce number of complaints regarding our communication with parents	Not applicable	51	65	Complaints regarding communication with parents still continue to be a problem and cover a range of issues and departments. A central piece of work is being developed to look at the pathway of the complex patient and the communication involved
Improve the timeliness and quality of our discharge summaries by sending 80 per cent of discharge summaries within 24 hours from discharge*	51 per cent	82 per cent	79 per cent	Our performance has fluctuated over the past year and we are just under our target of sending out discharge summaries within 24 hours. Performance reports at a local level are now available so that action can take place where required. We reviewed the completeness and quality of discharge summaries and developed templates. In 2012/13, we will pilot a system of completing discharge summaries by voice recognition software to see if it speeds up the process

*We were subject to an independent audit of our discharge summaries performance which identified that we do not always have the paper records to support our performance. We will be working to improve this in 2012/13

Great Ormond Street Hospital continues to move towards increased consultant-delivered services, both within and outside routine working hours. In February 2011, we appointed a team of general paediatricians who provide extended general paediatric cover for the hospital. The team provides paediatric support for the surgical patients and some medical patients during the daytime, and has developed the Hospital at Night team by supporting handovers and working with clinical units to improve safe, efficient out-of-hours care. This new consultant team provides a variety of general hospital-wide services in addition to each team member developing a special interest and area of responsibility.

In summary, the new consultant-delivered service provides a variety of general hospital-wide services and:

- supports the paediatric care of patients admitted under the surgical specialties
- supports the pre-admission and discharge planning of children on the surgical wards, in particular those who are accessing multiple specialist services
- provides medical leadership for the Hospital at Night team
- conducts general paediatric outpatient clinics for the cleft service
- works with the clinical site practitioners and Intensive Care Outreach Network in managing acutely unwell children on the surgical wards
- supports the paediatric training across the hospital
- supports the safeguarding service for the Trust.

4. Ensuring equal access for all patients

What did we say we would do?	How did we do?	What are we going to do next?
Identify patients with a learning disability and ensure that reasonable adjustments are made to enable them to access our services	We have reviewed our current service provision for people with learning disabilities and employed a learning disabilities co-ordinator to review what support, training or resource departments need to provide suitable care for patients with learning disabilities. A core set of information has also been produced in the right easy-read format The family form that is used with families when a patient first attends Great Ormond Street Hospital (GOSH) is being updated to include information that reflects the content of national learning disabilities passports. To support the completion of this information, a sentence will be added to our standard admission and appointment letters, requesting information on specific needs in advance of attendance at GOSH	The learning disabilities group will review the recommendations from the learning disability co-ordinator and consider how to implement action and improvement in this area for 2012/13 The hospital also aims to raise awareness of learning disabilities during National Learning Disability Week on 18–24 June

We know that how well and how quickly children recover depends not only on their clinical treatment, but also on whether they and their families feel comfortable, safe, understood, respected and listened to during their time with us. This is why we believe that promoting equality and diversity at Great Ormond Street Hospital (GOSH) is not only right, but also makes clinical and business sense.

Results from our most recent independent inpatient survey

Our recent annual independent inpatient survey asked an additional question on the specific needs of patients with a disability. The results show that 44 per cent of the parents surveyed said that their child had special needs or disabilities. Eighty-five per cent of these agreed that the hospital understands their needs and puts arrangements in place to meet them. The findings suggest that satisfaction levels are high across all areas questioned and, in particular, parents of patients with disabilities are more likely to be able to stay overnight with their child if they wanted to (84 per cent versus 74 per cent of parents and patients without disabilities). However, it is identified that overall, the positive experiences of patients and parents of patients with a disability or special needs, are generally fewer compared with those without a disability.

Equality Act 2010

To meet the requirements of the Equality Act 2010, we have published information about our patient population and how we are meeting their needs. This report is available on the GOSH website. One of our key improvement objectives for the next year is to improve the data we collect about our patients and families to ensure that reasonable adjustments are made when necessary and to increase their satisfaction with our services.

Autism and Jewish Focus groups

At GOSH, we're committed to providing a world-class service for all our patients and families. To do this, we must consider faith and cultural requirements, as well as special needs such as autism and learning disabilities, when we plan and deliver services.

To gain a deeper insight into the issues faced by some of these groups, we conducted a number of parent focus groups; one focusing specifically on Jewish families and another on children with an autistic spectrum disorder.

Topics covered included communication and information, the time and attention received, how involved patients and families were in decisions about care and treatment, how well personal and spiritual needs were met, food, and general comments on staying with us. The groups were interactive and a number of suggestions and recommendations were developed for how GOSH can improve its services for these groups of patients.

The responses and themes will be presented to the Patient and Public Involvement and Engagement Committee, and an action plan will be developed and agreed to ensure that improvement takes place.

Emma, whose seven-year-old daughter has been attending the GOSH Outpatients Department since birth, took part in a focus group for Jewish families. "I felt that the feedback we gave was listened to with interest and genuine sensitivity, and the suggestions made for improving how needs can be met will be acted upon over the next few months."

5. Maintaining timely access to services

What did we say we would do?	Performance			How did we do and what are we going to do next?
	2009/10	2010/11	2011/12	
Ensure that our waiting times are within the national standards	Achieved	Achieved	Achieved	We achieved our waiting time targets across all the areas that are monitored by the government. We will continue to aim to meet these waiting times

Our performance in each of our waiting times is demonstrated overleaf in the Monitor key performance indicators.

Performance against key national priorities

The following table details our performance against the Department of Health's operating framework.

National requirements	Performance
Methicillin-resistant Staphylococcus (MRSA) – meeting the MRSA objective	Achieved
Clostridium difficile year-on-year reduction (to fit with trajectory for the year as agreed with the Primary Care Trust)	Achieved
All cancers: 31-day wait for second or subsequent treatment comprising either: • surgery • anti cancer drug treatments • radiotherapy (from 1 Jan 2011)	Achieved
Admitted 95th centile performance	Achieved
Non-admitted 95th centile performance	Achieved
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	Achieved
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Achieved

Mandatory statements

Any statements provided from our commissioning PCT, LINks or OSCs
The regulations require us to send copies of the Quality Account to our relevant Local Involvement Network (LINk), Overview and Scrutiny Committee (OSC) and lead commissioning Primary Care Trust (PCT) for comment prior to publication, and we should include these comments in the published Quality Account. The following are the statements received from the Camden LINk and NHS North Central London. Camden Council OSC chose not to comment on our Quality Account this year.

Statement from Camden LINk
Prior to writing this response in regard to these Quality Accounts, we discussed the Trust with Great Ormond Street Hospital's (GOSH) Care Quality Commission (CQC) compliance manager. Our comments focus on the parent/patient experience since we are not competent to comment on health treatments.

The fact that the Trust has continued to reduce and maintain the level of infections for patients across the hospital in the past year is reassuring and we assume that the levels are acceptable to the CQC.

It is disappointing that we have not made a reduction in the number of medication errors that are reported in our Paediatric Intensive Care Unit (which treats severely ill patients) and it would have been useful to see what the main reasons for medication errors are. The Trust must have looked into this since they made a 30 per cent reduction in the number of medication errors reported in our Cardiac Intensive Care Unit (which treats severely ill patients with heart conditions).

We would have liked to have been informed of the protocol for the new child protection supervision.

Having two parent representatives on the priority and improvement work group ensures that initiatives have patient-focused outcomes and the views of patients or their parents on the success of treatment and impact on quality of life are used when developing and using measures. This is something we may choose to take up with adult secondary care trusts.

The number of complaints has not reduced in the past year and there seem to be problems regarding communications with both parents and referring doctors. Unfortunately, this problem seems to be endemic throughout the NHS.

Our quality priorities and improvement aims for 2012/13 – we would like to suggest that the QA next year includes something regarding the pathway when patients become too old for GOSH and are referred on to adult trusts, and how much the patient/parents are involved in the referral, especially in regard to choice of hospital.

As part of our research into the parent/patient experience, we placed requests on national social networking sites for feedback regarding parents' satisfaction with GOSH. Below are some of the comments:

"Can you get to Great Ormond Street Hospital? If so, ask for a referral to Dr xxxxxx xxxxxx. He is the guru on this type of thing and is fab."

"When you get your appointment at Great Ormond Street Hospital, book to see the social workers there after your appointment. They're really good at getting things going in your own area."

"I haven't had any personal experience of Great Ormond Street Hospital, but I have been there multiple times with work (I'm a paramedic) and I cannot speak highly enough of what I've seen. Every member of staff has been attentive to the child we were with, knowledgeable and enthusiastic. Patients I have spoken to have always felt well looked after and what always stands out is how supported the parents feel. A very close friend of mine lost her little brother a few years back and he was treated there; they seemed to take excellent care of him and the family while he was there."

"Only had good experience. What is worrying you?"

"Only good."

"Have no experience of inpatients, but my seven-year-old is an outpatient and goes to a day assessment unit a few times a year. We have been treated superbly there by everyone, and especially the day unit nurses who are just lovely. Have you got specific concerns?"

"Fantastic care, very overwhelming as it's such a big place but amazing. Everyone talked through the whole thing with us and the anaesthetist was a specialist from New Zealand who couldn't have been kinder. There are kitchens there where you can make food, tea and just chat to other parents."

"Great Ormond Street Hospital has a teenage room which is great."

While there were no adverse comments received in connection with GOSH, there was considerable dissatisfaction on the websites about parents' visits to general practitioners regarding their child's health. So it was not just a matter of parents tending to only make favourable comments.

Statement from our commissioners
NHS North Central London are responsible for the commissioning of health services from eight acute/specialist trusts, two mental health trusts and a range of community and primary health services located in Barnet, Camden, Enfield, Haringey and Islington.

NHS North Central London has reviewed this document and is pleased to assure this Quality Account for Great Ormond Street Hospital (GOSH).

In this review, we have taken particular account of the identified priorities for improvement for GOSH during 2012/13, and how this work will enable real focus on improving the quality and safety of health services for children and their families. We continue to support the overarching focus on zero harm, improving outcomes and excellent experiences for patients and families. I am particularly pleased to see that GOSH is striving for excellence in terms of improving the experience of adolescent patients. We are also pleased to see that there is a focus on improving outcomes for the deteriorating ward patient. During the next 12 months, we look forward to discussing all the identified priorities at the monthly clinical quality review meetings, attended by GOSH and its commissioners.

We have made comments about the Trust's Quality Account and have discussed these directly with the Trust. These comments focus on:
- changes to make the account easier to read and understand
- clarification on some of the measurements for improvement to make the data more meaningful.

We look forward to continuing our partnership with the Trust to improve both the quality and safety of health services provided to children and their families.

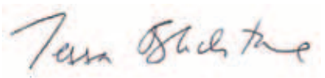
Statement of directors' responsibilities in respect of the Quality Account
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Account.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:
- the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to June 2012
  - papers relating to quality reported to the Board over the period April 2011 to June 2012
  - feedback from the commissioners dated 11 May 2012
  - feedback from governors dated 28 March 2012
  - feedback from LINks dated 11 May 2012
  - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13 April 2012
  - the [latest] national patient survey 25 April 2012
- the Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; the Quality Account has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account's regulations, published at www.monitor-nhsft.gov.uk/annualreportingmanual), as well as the standards to support data quality for the preparation of the Quality Account (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board



Chairman
30 May 2012

Chief Executive
30 May 2012

Independent Auditor's Assurance Report to the Council of Governors of Great Ormond Street Hospital for Children NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Great Ormond Street Hospital for Children NHS Foundation Trust to perform an independent assurance engagement in respect of Great Ormond Street Hospital for Children NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Great Ormond Street Hospital for Children NHS Foundation Trust as a body, to assist the Council of Governors in reporting Great Ormond Street Hospital for Children NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Ormond Street Hospital for Children NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- MRSA bacteraemia
- maximum 31-day wait from diagnosis to treatment (this was chosen by the Trust as the 62-day cancer target is not applicable to the Trust).

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of the Detailed Guidance for External Assurance
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – *Assurance Engagements other than Audits or Reviews of Historical Financial Information* issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- testing key management controls
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* with the categories reported in the Quality Report
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The nature, form and content required of Quality Reports are determined by DH/Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Great Ormond Street Hospital for Children NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*
- the Quality Report is not consistent in all material respects with the sources specified in the detailed guidance
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

Deloitte LLP
Chartered Accountants
St Albans, United Kingdom
30 May 2012

Governance

Jade, 13, had a heart transplant at Great Ormond Street Hospital at the start of last year and shortly afterwards, developed symptoms of diabetes. She is now a member of the Young People's Forum, which has been created to give young people the oppprtunity to develop and improve the hospital services they use.

The Trust Board

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.

The Board is made up of the Chair, five non-executive directors and six executive directors (including two co-medical directors). It also has three other directors who regularly attend meetings in an advisory capacity. All Trust directors have joint responsibility for decisions. The executive directors manage the day-to-day running of the Trust, while the Chair and non-executive directors provide operational and Board level experience gained from other public and private sector bodies. Among their skills are accountancy, audit, child protection, management consultancy, law and communications.

Evaluation of performance

A Board development and evaluation programme is under review which will continue to include half yearly development reviews and annual board evaluation.

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

The Trust continually seeks to review its governance framework including its committee structures, reporting requirements and effectiveness of its standing committees against their terms for reference.

Composition of the Trust Board

Non-executive directors

The composition of the Trust Board in 2011/12 was as follows:

Baroness Tessa Blackstone
BSc (Soc) PhD
Chairman of the Trust Board

Experience
- Member, House of Lords
- Chair of the British Library Board
- Member, Royal Opera House Board and Chair of the Education, Engagement and Access Committee
- Director of UCL Partners
- Vice-Chancellor of the University of Greenwich (2004–2011).

Membership of committees
- Chairman of the Board of Directors' Nominations Committee
- Board of Directors' Remuneration Committee member.

Mr Andrew Fane
Non-Executive Director
(until October 2011)

Experience
- Chartered Accountant
- Chair Trustees, UCL Institute of Child Health
- Chair of the Friends of the Children of Great Ormond Street
- Chairman of Governors of the Children's Hospital School at Great Ormond Street and University College London Hospitals
- Deputy Chair English Heritage (2001–2004)
- Chair of Audit Committee, English Heritage (2003–2011).

Membership of committees
- Chairman of the Clinical Governance Committee
- Audit Committee member
- Board of Directors' Remuneration Committee member.

Mr Charles Tilley FCA, FCMA, CGMA
Non-Executive Director

Experience
- Qualified accountant
- Chief Executive Officer at The Chartered Institute of Management Accountants (CIMA)
- Director (Corporate representative) CIMA China Ltd
- Director (Corporate representative) CIMA Enterprises Limited (CEL)
- Board member of the Association of International Certified Professional Accountants
- Non-Executive Director and Member of Audit, and Asset and Liability Committees – Ipswich Building Society.

Membership of committees
- Chairman of the Audit Committee
- Board of Directors' Remuneration Committee member
- Board of Directors' Nominations Committee member.

Ms Yvonne Brown LLB Solicitor
Non-Executive Director

Experience
- Qualified solicitor – areas of expertise in children, child protection, family law, and education
- Independent Member of the Royal Institute of Chartered Surveyors UK Regulatory Board
- Panel Chair of the Nursing and Midwifery Council Conduct and Competence Committee
- Former Chair of the Compliance and Scrutiny Committees, Solicitors Regulation Authority
- Non-Executive Patient Environment Action Team lead until February 2012.

Membership of committees
- Chair of the Board of Directors' Remuneration Committee
- Audit Committee member
- Clinical Governance Committee member
- Board of Directors' Nominations Committee member.

Professor Andrew Copp MBBS
DPhil FRCPath FMed Sci
Non-Executive Director

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

Experience
- Director of the ICH
- Professor of Developmental Neurobiology at the ICH
- Honorary consultant at Great Ormond Street Hospital
- Honorary Director of Research, Children's Trust, Tadworth.

Membership of committees
- Clinical Governance Committee member
- Board of Directors' Remuneration Committee member
- Board of Directors' Nominations Committee member.

Ms Mary MacLeod OBE MA
CQSW DUniv
Non-Executive Director

Experience
- Non-Executive Equality and Diversity Lead at Great Ormond Street Hospital
- Chief Executive of the Family and Parenting Institute (1999–2009)
- Director of Policy, Research and Development and Deputy Chief Executive Officer of Childline (1995–1999).

Membership of committees
- Chair of the Clinical Governance Committee
- Board of Directors' Remuneration Committee member
- Board of Directors' Nominations Committee member.

Mr David Lomas
Designate Non-Executive Director
(from July 2011)
Non-Executive Director
(from November 2011)

Experience
- Qualified accountant
- Chief Financial Officer of Elsevier and Vice Chairman of Elsevier's Management Committee
- Chief Executive of British Telecom Multi Media Services (2004–2005) (previously Chief Operating Officer)
- Vice President Operational Effectiveness of British Telecom Global Services (2003–2004)
- Chief Commercial and Operations Officer, ESAT British Telecom, Dublin (April 2002–May 2003).

Membership of committees
- Audit Committee member
- Board of Directors' Remuneration Committee member
- Board of Directors' Nominations Committee member.

Executive directors

Mr John Ripley
Non-Executive Director
(from July 2011)

Experience
- Qualified accountant
- Director of CAB International
- Governor of Kingston University
- Director/Governor of The Howard of Effingham School, The Howard Partnership Education Trust and The Howard Partnership Trust
- Governor of Eastwick Junior School
- Unilever 1973–2008 (Group Deputy Chief Finance Officer).

Membership of committees
- Audit Committee member
- Board of Directors' Remuneration Committee member
- Board of Directors' Nominations Committee member.

Ms Dorothea Hackman
Associate Non-Executive Director

Dorothea Hackman served as an Associate Non-Executive Director in an ex-officio capacity on the Trust Board until June 2011. She was the Chair of the Great Ormond Street Hospital (GOSH) Members' Forum.

Experience
- Chair of GOSH Members' Forum
- Governor, The Children's Hospital School at Great Ormond Street
- Volunteer, Child Death Helpline
- Trustee, St Pancras Lands Trust
- Churchwarden, St Pancras Parish Church.

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.

Experience
- Chief Executive of Great Ormond Street Hospital Children's Charity
- Director of UCL Partners
- Advisory Board Member Judge of University of Cambridge Business School
- Director of Clinical Services at Great Ormond Street Hospital (1999–2001).

Membership of committees
- Chair of Management Board
- Clinical Governance Committee member
- Attends Audit Committee
- Attends Board of Directors' Remuneration Committee
- Attends Board of Directors' Nominations Committee.

Dr Barbara Buckley MB BS FRCP FRCPCH
Co-Medical Director

Experience
- Medical Director at the Hertfordshire Partnership Foundation Trust (2003–08)
- Consultant in Community Paediatric Medicine
- Certificate in Company Direction from the Institute of Directors.

Membership of committees
- Management Board member.

Ms Fiona Dalton MA (Hons) (Oxon)
Chief Operating Officer/ Deputy Chief Executive

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 for the Trust.

Experience
- Executive Director of Strategy and Business Development, Southampton University Hospitals (2005–2008)
- Divisional Director, Oxford Radcliffe Hospitals (2000–2004).

Membership of committees
- Management Board member
- Clinical Governance Committee member
- Attends Audit Committee.

Mrs Claire Newton MA (Cantab) ACA MCT
Chief Finance Officer

Claire Newton is responsible for the financial management of the Trust and leads on information governance and information technology.

Experience
- Qualified accountant and member of the Association of Corporate Treasurers.
- Finance Director and Financial Controller at Marie Curie Cancer Care (1998–2007).

Membership of committees
- Management Board member
- Attends Audit Committee.

Other directors

Mrs Elizabeth Morgan MSc RN Adult RN Child RNT RCNT Dip N IHSM Diploma
Chief Nurse and Director of Education

Liz Morgan is responsible for the professional standards and development of nursing, and all other non-medical clinical staff groups. She is also responsible for patient and public involvement and engagement, and education and training for all staff in the Trust. She is Lead Director for Child Protection.

Experience
- Registered general and children's nurse
- Professional Adviser for Children and Young People (Nursing) with the Department of Health (2007–2010)
- Director of Nursing at Birmingham Children's Hospital NHS Foundation Trust (2002–2007).

Membership of committees
- Management Board member
- Clinical Governance Committee member.

Professor Martin Elliott MB BS MD FRCS
Co-Medical Director

Martin Elliott is responsible for performance and standards (including patient safety), and leads on clinical governance.

Experience
- Professor of Paediatric Cardiothoracic Surgery, University College London
- Director of the National Service for Severe Tracheal Disease in Children (at Great Ormond Street Hospital (GOSH))
- Chairman of Cardiorespiratory Services (2001–2010) and led the Cardiothoracic Transplant Service, both at GOSH
- Founded the European Congenital Heart Defects Database and the European Congenital Heart Surgeons Association
- President of the International Society for the Nomenclature of Congenital Heart Disease (2000–2010).

Membership of committees
- Management Board member
- Clinical Governance Committee member.

Other directors who attend the Board of Directors' meetings in an advisory capacity:

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

- Leads the strategic development of clinical research and development across the Trust
- Honorary consultant immunologist
- Director of the NIHR-funded Great Ormond Street Hospital Biomedical Research Centre
- Programme Director for Child Health, UCL Partners (until 31 March 2012).

Mr William McGill MSc
Director of Redevelopment

- Leads the work to redevelop the Trust's buildings.

Mr Mark Large FBCS CITP FCMI FIoD FIMIS
Director of Information Technology (IT)

- Leads on IT for the Trust, encompassing the updating of the IT Infrastructure, creation and delivery of the IT strategy, in turn supporting the achievement of Trust objectives.

Mr Trevor Clarke BSc MSc
Director of International Services

- Responsible for the strategic development and management of the Trust's International and Private Patients Division.

Register of interests

The Board of Directors has approved and signed up to the Board of Directors' Code of Conduct, which sets out a requirement for all Board members to declare any interests which may compromise their role.

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

Board of Directors' meetings

During the period 1 April 2011 to 31 March 2012, the Trust Board held 14 meetings. Nine of these included sessions in public. In October and March, the Board held development sessions. The Board did not meet in August. Two extraordinary meetings were held in June 2011 and one in February 2012.

The table below covers the full year (1 April 2011–31 March 2012).

Name	Position	Attendance (out of 14 meetings)
Baroness Blackstone	Chairman	14
Andrew Fane	Non-Executive Director until 31 October 2011	7
Andrew Copp	Non-Executive Director	12
Charles Tilley	Non-Executive Director	12
Mary MacLeod	Non-Executive Director	12
Yvonne Brown	Non-Executive Director	11
David Lomas	Designate Non-Executive Director from July 2011 and full Non-Executive Director from November 2011	9
John Ripley	Designate Non-Executive Director from November 2011 and full Non-Executive Director from end of March 2012	5
Dr Jane Collins	Chief Executive	13
Fiona Dalton	Chief Operating Officer	12
Claire Newton	Chief Finance Officer	13
Professor Martin Elliott	Co-medical Director	8
Dr Barbara Buckley	Co-Medical Director	11
Elizabeth Morgan	Chief Nurse and Director of Education	13

Audit Committee

The Audit Committee is a committee of the Trust Board with delegated authority to review the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial internal controls that supports the achievement of the organisation's objectives.

The Audit Committee comprises four non-executive directors (including the Chairman). Mr Michael Dallas, an independent external committee member, also attends the meeting to provide independent scrutiny. Membership of the committee and attendance is detailed below (table 15) for the full year (1 April 2011 to 31 March 2012).

The Board is satisfied that at least one member of the committee has recent and relevant financial experience. The Chief Executive and other senior staff attend throughout the year. The Audit Committee responsibilities include:

- monitoring the integrity of financial statements
- reviewing financial reporting judgements
- reviewing internal controls and risk management systems (in conjunction with the Clinical Governance Committee)
- monitoring the effectiveness of the internal audit function
- monitoring the external auditor's independence and effectiveness of the audit process
- developing a policy on working with the external auditor to supply non-audit services
- reporting to the Members' Council where actions are required and outlining recommendations.

Safeguarding external auditor independence

While recognising there may be occasions when the external auditor is best placed to undertake other accounting, advisory and consultancy work on behalf of the Trust, the Board seeks to ensure that the auditor is, and is seen to be, independent. The Trust is in the process of developing a policy for any non-statutory audit work undertaken on behalf of the Trust to ensure compliance with the above objective.

Name	Position	Attendance (out of four meetings)
Mr Charles Tilley FCA (Chair)	Non-Executive Director	4
Mr Andrew Fane (until 31 October 2011)	Non-Executive Director	3
Mr David Lomas	Designate Non-Executive Director from July 2011 and full Non-Executive Director from November 2011	2
Ms Yvonne Brown LLB	Non-Executive Director	3
Mr John Ripley	Designate Non-Executive Director from November 2011 and full Non-Executive Director from end March 2012	1
Dr Jane Collins*	Chief Executive	3
Mrs Claire Newton*	Chief Finance Officer	4
Ms Fiona Dalton*	Chief Operating Officer	4

*In attendance

Other Board committees

Some of the work of the Board of Directors is delegated to other committees, which also meet regularly. There is a standing item at every Board of Directors' meeting to receive reports and minutes of meetings from Board committees. Committee annual reports, including a self-assessment and review of the terms of reference, are also received.

In addition to the Audit Committee, the following committees report to the Board.

Clinical Governance Committee

The Clinical Governance Committee is a committee of the Trust Board with delegated authority to review clinical governance and risk management matters. It is chaired by a non-executive director. Its membership includes senior clinical and non-clinical managers, as well as executive and non-executive directors. The Committee usually meets at least four times a year. However, for 2011/12, it only met three times, with clinical governance matters being regularly reviewed as part of the Trust's development sessions in preparation for authorisation as a Foundation Trust. The committee receives reports from internal auditors and clinical audit. Attendance at meetings for the period 1 April 2011 to 31 March 2012 is detailed below.

Name	Position	Attendance (out of three meetings)
Mr Andrew Fane (Chair until 31 October 2011)	Non-Executive Director	2
Ms Mary MacLeod (Chair from 1 November 2011)	Non-Executive Director	3
Professor Andrew Copp	Non-Executive Director	3
Ms Yvonne Brown (from 1 November 2011)	Non-Executive Director	1
Dr Jane Collins	Chief Executive	2
Ms Fiona Dalton	Chief Operating Officer	3
Professor Martin Elliott	Co-Medical Director	2
Mrs Elizabeth Morgan	Chief Nurse and Director of Education	3

Remuneration Committee

See Remuneration Report on pages 122 and 157.

Members' Council

As part of its preparation as an NHS Foundation Trust, the organisation established a Shadow Member's Council (our equivalent of the Board of Governors described in NHS Foundation Trust legislation).

The Members' Council consists of 28 Councillors and is led by the Chairman of the Trust.

In November 2011, seven councillors were elected by the Trust Public membership, 10 by the Trust Patient and Carer membership, five by the Trust Staff Membership and the remaining six councillors were appointed by partner organisations.

Engaging with our members

During the period of our application to become a Foundation Trust, we have gained insight into how to harness the enthusiasm, skills and willingness of our membership to contribute in all areas of Trust decision-making. The membership scheme has provided a basis for recruiting parent representatives to key committees and decision-making bodies throughout the Trust, and active lay members are now involved in a range of the Trust's Transformation programme work streams, bringing their experience of being the parents of sick children at Great Ormond Street Hospital (GOSH) into the heart of service quality improvement.

Members have also been involved in recruitment interview panels for consultants, senior managers and ward sisters, and on the Food at Great Ormond Street Hospital working party, Redevelopment Group, Family Equality and Diversity Committee, and on Patient Environment Action Team visits.

On recruitment, members are asked about the extent of their willingness to contribute, be consulted and to get involved. This means that we are able to target our membership on specific consultations and to contact the entire membership on key strategic issues for the Trust.

Engaging with children and young people

As a children's hospital, it is important that children and young people remain central to our vision and are able to participate in the planning and development of the organisation's services. While children have to be at least 10 to become a member, we are committed to developing mechanisms to receive the views of younger children.

The Trust has developed a children and young people's participation strategy based on Article 12 of the UN Convention on the Rights of the Child, which emphasises that children and young people have a right to be listened to and to influence matters that affect them. The strategy seeks to ensure that the needs of children and young people are considered holistically and distinctly, and that they are consulted and engaged with in their own right.

Engaging with staff

GOSH staff are committed to the organisation and its values, and staff membership offers a mechanism for more formal involvement of frontline staff in the decision-making processes, alongside existing arrangements. The Trust seeks to value, involve and develop its staff, and we believe that offering greater involvement in its strategic direction and purpose will reinforce this sense of staff ownership. The Trust plans to use an active staff membership and the role of staff councillors to transform more of the ideas and concerns of staff into valuable contributions to the Trust's development and improvement of services.

The Trust also views staff as an effective means of engaging with parents, carers, children and young people.

We plan to use our membership to help us to improve and develop our services, and to act as advocates for the interests of children who need specialist health services.

Remuneration report

Remuneration for executive directors
The remuneration and conditions of service of the Chief Executive and executive directors are determined by the Board of Directors' Remuneration Committee. The Committee meets twice a year, in March and November. Attendance at meetings held in during the period 1 April 2011 to 31 March 2012 is detailed below:

Name	Position	Attendance (out of two meetings)
Ms Yvonne Brown (Chair)	Non-Executive Director	2
Baroness Blackstone	Chairman of the Board	2
Ms Mary MacLeod	Non-Executive Director	2
Professor Andrew Copp	Non-Executive Director	2
Mr Charles Tilley	Non-Executive Director	2
Mr David Lomas	Designate Non-Executive Director from July 2011 and full Non-Executive Director from November 2011	2
Mr John Ripley	Designate Non-Executive Director from November 2011 and full Non-Executive Director from end of March 2012	2
Dr Jane Collins (by invitation)	Chief Executive	2

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 after appointment as directors take on the full set of responsibilities in their role.

Affordability is also taken into account in determining pay uplifts for directors. Where it is appropriate, terms and conditions of service are consistent with NHS pay arrangements, such as the Agenda for Change. For the financial year 2011/12, there was no uplift in basic pay for executive directors.

Performance is closely monitored and discussed through both an annual and ongoing appraisal process. All executive directors' remuneration is subject to performance and they are employed on contracts of service and are substantive employees of the Trust. Their contracts are open-ended employment contracts which can be terminated by either party with six months' notice. The Trust redundancy policy is consistent with NHS redundancy terms for all staff.

The executive co-medical directors are appointed on a three-year contract, with the option of extending the engagement for a further fixed-term period.

Details of remuneration, including the salaries and pension entitlements of the Board of Directors, are published in the annual accounts on page 157. The only noncash element of the most senior managers' remuneration packages is pension related benefits accrued during membership of the NHS Pension Scheme. Contributions into the scheme are made by both the employer and employee in accordance with the statutory regulations.

Dr Jane Collins
Chief Executive
30 May 2012

Annual Governance Statement

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

I am also responsible for keeping proper accounting records and ensuring the accounts are properly prepared on a going concern basis in accordance with the Manual for Accounts issued by the Department of Health. This also includes using suitable accounting policies on a consistent basis and consistent with applicable accounting standards; and ensuring that any judgements and estimates required to prepare the accounts are made on a reasonable basis

This also includes taking steps for the prevention and detection of fraud and other irregularities, for which I am personally responsible as set out in the Accountable Officer Memorandum.

2. The governance framework of the organisation
The Board of Directors is ultimately and collectively responsible as a Board for all aspects of the performance of the Trust and is committed to providing high-quality patient services in an environment that is safe and secure and has an integrated governance framework with clear accountability for risk.

The Board determines the overall strategy; creation, acquisition or disposal of material assets; matters of public interest that could affect the Trust's reputation; operating plans and key performance indicators; prosecution, defence or settlement of material incidents and claims. The Board has a formal schedule of matters reserved for its decision and delegates certain matters to Committees as set out below.

There is a comprehensive Board work programme which includes all matters required to consider by statutory, regulatory and other forms of guidance as well as a range of strategic and operational performance information which enables it to scrutinise the effectiveness of the Trust's operations and deliver focused strategic leadership through its decisions and actions. Whilst pursuing this workplan, the Board maintains its commitment that discussion of patient safety will always be high on its agenda and will comprise at least 25 per cent of the time of meetings.

The Board has two committees, the Clinical Governance Committee and Audit Committee. The chair of each committee reports to the Board at the board meeting following the committee's last meeting. Each committee is charged with reviewing its effectiveness annually.

The Trust Board meets eight times a year in formal session and has two further meetings each year to discuss the Trust's strategy and redevelopment plans.

Attendance by board members is included on page 118 of the annual report.

In addition to the Board's assurance committees, the Trust's Management Board (comprising senior managers from all clinical units and corporate departments), the Risk Assurance and Compliance Group (comprising executives, quality, safety and compliance leads and internal audit) and the Quality and Safety Committee (comprising senior clinical staff from all staff categories and clinical support staff) are the key senior management forums for consideration of risks. Each of these groups receive reports of risks, incidents and risk mitigating actions from unit and department groups and specialist sub- committees. In addition each Clinical Unit Board considers risks, quality and safety indicators, incidents and complaints on a regular basis.

The Board commissioned an independent review of its effectiveness in 2010 and intends to carry out further independent reviews every three years. In the interim years, a programme of internal updates is maintained and an internal assessment against its Terms of Reference is carried out.

As part of the process for applying to be authorised as a Foundation Trust, the Board has reviewed all aspects of governance and also assess compliance with the Corporate Governance code.

3. The risk and control framework
The Trust's Assurance Framework is based on structured and on-going assessment of the key risks to the Trust of not achieving its objectives. The Framework is used to provide information of the controls in place to manage the key risks and details the evidence provided to the Board indicating that the control is operating. It is mapped to the CQC essential standards for quality and safety 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.

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

4. Risk assessment
The top risks for the Trust during the year and in the immediate future are:
- maintaining patient safety
- recruiting and retaining staff with the skills required in specialist services
- financial sustainability.

Each of these risks are broken down into a number of component parts, and appropriate mitigating actions for each component identified. Outcomes will be monitored by the Management and Trust Boards through the monthly financial, quality and safety and KPI performance reports and at clinical unit and corporate department level through the Trust's quarterly strategic reviews.

The risk management strategy sets out guidance for the maintenance of risk registers for all departments within the Trust to manage operational risks. 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.

Each unit and department is required to identify, manage and control local risks whether clinical, non-clinical or financial

in order to provide a safe environment for patients and staff and reduce unnecessary expenditure. This ensures the early identification of risks and the devolution of responsibility for management of risks to staff at all levels of the organisation. In practice this is achieved through the involvement of staff in risk action groups, risk training and occasional surveys.

Risks are identified through diverse sources of information such as formal risk assessments, audit data, clinical and non-clinical incident reporting, complaints, claims, patient/user feedback, information from external sources in relation to issues which have adversely affected other organisations, operational reviews 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.

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.

A summary of the key risks for the Trust in the period covered by this report is set out on page 08 of the report.

The Trust recognises the importance of the involvement of stakeholders in ensuring that risks and accidents are minimised and that patients, visitors, employees, contractors and other members of the public are not exposed to any unnecessary risks or hazards. Risks are assessed and managed to ensure that the Trust's systems reflect consideration of all these stakeholder interests.

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 and the Audit Committee. This Group uses the Information Governance Toolkit assessment to inform its review.

There have been two serious incidents relating to data security during the year which were reported to the Information Commissioner. The first occurred when patient information in respect of seven patients was sent in error to a relation of one of the patients. The second occurred when private information relating to certain staff was faxed in error to general fax numbers within the Trust.

Both incidents were investigated and lessons identified which resulted in changes to address the weaknesses in the Trust's systems

5. Review of the effectiveness of risk management and internal control

The Board has responsibility for conducting a review of the effectiveness of its governance framework including the system of internal control. This review of effectiveness is informed by the work of Internal Audit who review all of the risks on the Assurance Framework and seek evidence that the controls are in place and effective in mitigating the risk. In some instances the audit work has found that the controls believed to be in place are not working as planned or that there is insufficient evidence that the control is working effectively. The instances where the assurance was not sufficient, or controls were not adequate when subject to routine audits during the year were:

- Providing assurance of the Trust's processes to meet the needs of individuals with learning disabilities.
- Providing assurance of compliance with requirements in relation to taking consent to treat children.
- Adequacy of documentation of IT business continuity and disaster recovery plans and procedures.
- Effectiveness of processes to prevent salary overpayments.
- Adequacy of the documentation in respect of the review of the Cabinet Office guidance on data handling.

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

In addition, the Head of Internal Audit provides an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work and this opinion has provided reasonable assurance.

The review is further informed in a number of ways.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

The Risk, Assurance and Compliance Group – which comprises executives and other staff responsible for risk management and internal audit -ensures that for each risk the mitigating actions are appropriate and that there is assurance as to the effectiveness of these actions. Plans to address weaknesses and ensure continuous improvement of the controls are also monitored.

My review is also informed by discussions at the assurance committees of the Board whose agendas include reports from internal auditors and external auditors and the executives responsible for the mitigating actions related to each risk. It is also supplemented by the reviews of compliance with CQC safety and quality standards; consideration of performance against national targets, the RPST Level 2 accreditation; the baseline assessment on the information governance framework; Health and Safety Executive reviews; the PEAT assessment and relevant reviews by the Royal Colleges.

The Trust was reviewed for Level 2 compliance with the NHS Litigation Authority (Clinical Negligence Scheme for Trusts) Risk Management Standards during 2009/10 and was found to be compliant.

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.

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

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

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

6. Significant issues

The review, as detailed above, provides good assurance of the effectiveness of the Trust's system of internal control. With the exception of the minor gaps in internal controls and assurances referred to above, my review confirms that GOSH has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and I am confident that all minor gaps are being actively addressed. There have been no other governance issues identified during the year that are considered significant in relation to the Trust's overall governance framework.

Dr Jane Collins
Chief Executive
30 May 2012

Statement of comprehensive income
For the 11 months ended 29 February 2012

	Note	11 months to 29 February 2012 £000	12 months to 31 March 2011 £000
Employee benefits	8.1	**(177,607)**	(192,216)
Other costs	6	**(132,000)**	(130,775)
Revenue from patient care activities	3	**265,635**	283,881
Other operating revenue	4	**63,053**	94,663
Operating surplus		**19,081**	55,553
Investment revenue	10	**63**	68
Other losses	11	**(309)**	(633)
Finance costs	12	**(36)**	(31)
Surplus for the period		**18,799**	54,957
Public dividend capital dividends payable		**(5,285)**	(5,551)
Retained surplus for the period		**13,514**	49,406
Other comprehensive income			
Impairments and reversals		**(11,450)**	4,139
Net gain on revaluation of property, plant and equipment		**8,721**	5,030
Total comprehensive income for the period		**10,785**	58,575
Financial performance for the period		**13,514**	
Retained surplus for the period Impairments		**12,304**	
Adjustments in respect of donated asset and government grant reserve elimination		**23,949**	
Adjusted retained surplus		**1,869**	

The Trust's reported NHS financial performance is derived from its retained surplus, but adjusted for impairments since these charges are not considered to be part of the organisation's operating position. In 2011/12, the NHS Manual for Accounts was brought into line with International Financial Reporting Standards in respect of donated asset and government grant reserves. This led to an elimination of the reserves. The impact of these changes in not considered to be part of the organisation's operating position. Prior year performance is not re-assessed following accounting restatements.

Public dividend capital dividends are payable in September and March.

Public dividend capital dividend: balance payable at 29 February 2012	**(2,400)**

The notes on pages 130 to 158 form part of these accounts.

Statement of financial position
As at 29 February 2012

	Note	29 February 2012 £000	31 March 2011 (restated) £000	1 April 2010 (restated) £000
Non-current assets				
Property, plant and equipment	13	**323,630**	319,127	248,606
Intangible assets	14	**2,173**	997	472
Trade and other receivables	19.1	**9,082**	9,505	9,039
Total non-current assets		**334,885**	329,629	258,117
Current assets				
Inventories	18	**6,432**	5,156	5,173
Trade and other receivables	19.1	**37,319**	30,509	36,555
Cash and cash equivalents	20	**19,063**	32,371	8,485
Total current assets		**62,814**	68,036	50,213
Total assets		**397,699**	397,665	308,330
Current liabilities				
Trade and other payables	21	**(35,481)**	(47,588)	(33,065)
Other liabilities	22	**(4,834)**	(3,382)	(3,008)
Provisions	24	**(3,120)**	(2,867)	(1,549)
Total current liabilities		**(43,435)**	(53,837)	(37,622)
Non-current assets plus/less net current assets/liabilities		**354,264**	343,828	270,708
Non-current liabilities				
Other liabilities	22	**(6,987)**	(7,327)	(7,728)
Provisions	24	**(1,241)**	(1,250)	(1,304)
Total non-current liabilities		**(8,228)**	(8,577)	(9,032)
Total assets employed		**346,036**	335,251	261,676
Financed by taxpayers' equity				
Public dividend capital		124,732	124,732	109,732
Retained earnings		169,529	155,621	106,031
Revaluation reserve		48,661	51,784	42,799
Other reserves		3,114	3,114	3,114
Total taxpayers' equity		**346,036**	335,251	261,676

The notes on pages 130 to 158 form part of these accounts. The financial statements on pages 126 to 158 were approved by the Board on 30 May 2012 and signed on its behalf by

Dr Jane Collins
Chief Executive
30 May 2012

Statement of changes in taxpayers' equity
For the 11 months ended 29 February 2012

	Public dividend capital £000	Retained earnings £000	Revaluation reserve £000	Other reserves £000	**Total reserves £000**
Balance at 1 April 2011 (restated)	124,732	155,621	51,784	3,114	**335,251**
Changes in taxpayers' equity for 2011/12					
Retained surplus for the period	0	13,514	0	0	**13,514**
Net gain on revaluation of property, plant and equipment	0	0	8,721	0	**8,721**
Impairments and reversals	0	0	(11,450)	0	**(11,450)**
Transfers between reserves	0	394	(394)	0	**0**
Net recognised revenue/(expense) for the period	0	13,908	(3,123)	0	**10,785**
Balance at 29 February 2012	**124,732**	**169,529**	**48,661**	**3,114**	**346,036**
Changes in taxpayers' equity for 2010/11					
Balance at 1 April 2010 (restated)	109,732	106,031	42,799	3,114	**261,676**
Retained surplus for the year	0	49,406	0	0	**49,406**
Net gain on revaluation of property, plant and equipment	0	0	5,030	0	**5,030**
Impairments and reversals	0	0	4,139	0	**4,139**
Transfers between reserves	0	184	(184)	0	**0**
New PDC received	15,000	0	0	0	**15,000**
Net recognised revenue for the year	15,000	49,590	8,985	0	**73,575**
Balance at 31 March 2011 (restated)	**124,732**	**155,621**	**51,784**	**3,114**	**335,251**

Statement of cash flows
For the 11 months ended 29 February 2012

	Note	**11 months to 29 February 2012 £000**	12 months to 31 March 2011 (restated) £000
Cash flows from operating activities			
Operating surplus		**19,081**	55,553
Depreciation and amortisation		**13,259**	13,641
Impairments and reversals		**12,304**	1,448
Dividend paid		**(2,817)**	(5,664)
(Increase)/decrease in inventories		**(1,276)**	17
(Increase)/decrease in trade and other receivables		**(8,433)**	5,585
(Decrease)/increase in trade and other payables		**(6,371)**	9,541
Increase/(decrease) in other current liabilities		**1,112**	(27)
Provisions utilised		**(947)**	(564)
Increase in provisions		**1,155**	1,797
Net cash inflow from operating activities		**27,067**	**81,327**
Cash flows from investing activities			
Interest received		**63**	63
Payments for property, plant and equipment		**(39,766)**	(71,857)
Payments for intangible assets		**(705)**	(647)
Proceeds of disposal of assets held for sale (PPE)		**33**	0
Net cash outflow from investing activities		**(40,375)**	(72,441)
Net cash (outflow)/inflow before financing		**(13,308)**	8,886
Cash flows from financing activities			
Public dividend capital received		0	15,000
Net cash inflow from financing activities		**0**	**15,000**
Net (decrease)/increase in cash and cash equivalents		**(13,308)**	**23,886**
Cash and cash equivalents at beginning of the period		32,371	8,485
Cash and cash equivalents at end of the period	20	19,063	32,371

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 2011/12 *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 about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors

that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.3.1 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 that 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 deemed to be 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.

d A provision is recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgment is required when determining the probable outflow of economic benefits.

e Management use their judgement to decide when to write off revenue or to provide against the probability of not being able to collect debt.

f The Trust is required to review property, plant and equipment for impairment. In between formal valuations by qualified surveyors, management make judgments about the condition of assets and review their estimated lives.

1.3.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements as a provision. As the calculation involves a large number of staff, sampling techniques are used to collate the results for the entire Foundation Trust.
- The useful economic life of each category of fixed asset is assessed when acquired by the Foundation Trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets.
- For early retirements that took place before the NHS pension scheme was modified in 1995, a provision is made in the accounts incorporating inflation and the discount rate. Inflation is estimated at 2.5 per cent and where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.9 per cent in real terms.

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 are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

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 eg by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. 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

Past and present employees are covered by the provisions of the NHS Pensions 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.

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
- the item has cost of at least £5,000
- 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, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control
- 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 are 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 impairment.

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 has been 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.

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

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 that does not result from a loss of economic value or service potential 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. Impairment losses that arise from a clear consumption of economic benefit should be taken 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

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 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.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

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.

At each reporting period end, 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.

A revaluation decrease that does not result from a loss of economic value or service potential 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. Impairment losses that arise from a clear consumption of economic benefit should be taken 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.

Impairments are analysed between departmental expenditure limits (DEL) and annually managed expenditure (AME) from 2011/12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the spending review and departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.10 Donated assets

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

This accounting policy change has been applied retrospectively and consequently the 2010/11 results have been restated.

1.11 Government grants

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

This accounting policy change has been applied retrospectively and consequently the 2010/11 results have been restated.

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 on 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.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually 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 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 to 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 in 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.

In the statement of cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

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 (2.8 per cent for employee early departure obligations).

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.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

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 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 24.

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 NHS litigation authority 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 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.19 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 into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, 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 does not exceed what the amortised cost would have been had the impairment not been recognised.

1.20 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 de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.21 Value added tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 29 February (2010/11: 31 March). Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.23 Public dividend capital (PDC) and PDC dividend
Public dividend capital 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 public dividend capital 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.

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

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

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

1.26 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. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

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

IFRS 7 Financial Instruments: Disclosures (amendment for transfers of financial assets)

IFRS 9 Financial Instruments

IFRS 10 Consolidated Financial Statements

IFRS 11 Joint Arrangements

IFRS 12 Disclosure of Interests in Other Entities

IFRS 13 Fair Value Measurement

IAS 1 Presentation of Financial Statements (amendments to other comprehensive income (OCI))

IAS 12 Income Taxes (amendment)

IAS 27 Separate Financial Statements

IAS 28 Associates and Joint Ventures

The directors do not expect that the adoption of these standards and interpretations will have a material impact on the financial statements in future periods. All other revised and new standards have not been listed here as they are not considered to have an impact on the Trust.

2. Operating segments

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

3. Revenue from patient care activities

	11 months to 29 February 2012 £000	12 months to 31 March 2011 £000
Strategic health authorities	**42,911**	42,791
NHS Trusts	**693**	1,733
Primary Care Trusts – tariff	**59,366**	61,149
Primary Care Trusts – non-tariff	**110,741**	119,899
Primary Care Trusts – market forces factor	**17,367**	19,333
Local authorities	**151**	1,059
Department of Health	**635**	951
NHS other	**5,715**	8,267
Non-NHS		
Private patients	**25,502**	24,989
Overseas patients (non-reciprocal)	**0**	112
Injury costs recovery	**5**	29
Other	**2,549**	3,569
	265,635	283,881

4. Other operating revenue

	11 months to 29 February 2012 £000	12 months to 31 March 2011 £000
Patient transport services	**1,066**	1,267
Education, training and research	**24,712**	27,136
Charitable and other contributions to expenditure	**4,425**	5,054
Receipt of donations for capital acquisitions	**23,948**	49,033
Receipt of government grants for capital acquisitions	**0**	200
Non-patient care services to other bodies	**3,791**	3,789
Income generation	**976**	1,873
Other revenue	**4,135**	6,311
	63,053	94,663
Total operating revenue	**328,688**	378,544

5. Revenue

	11 months to 29 February 2012 £000	12 months to 31 March 2011 £000
From rendering of services	**304,740**	329,311

Revenue is almost totally from the supply of clinical services and includes clinical related expenses including drugs, blood and prosteheses, as well as research activities. Revenue from the sale of goods is immaterial.

6. Operating expenses (excluding employee benefits)

	11 months to 29 February 2012 £000	12 months to 31 March 2011 £000
Services from other NHS trusts	**2,209**	2,422
Services from Primary Care Trusts	**22**	270
Services from other NHS bodies	**138**	152
Services from Foundation Trusts	**1,202**	1,800
Purchase of healthcare from non NHS bodies	**2,697**	2,165
Trust chair and non executive directors	**55**	56
Supplies and services – clinical	**69,133**	72,081
Supplies and services – general	**1,885**	3,092
Consultancy services	**1,193**	1,101
Establishment	**2,473**	2,779
Transport	**2,550**	2,787
Premises	**17,526**	18,985
Impairments and reversals of receivables	**(47)**	92
Inventories write down	**44**	0
Depreciation	**12,723**	13,519
Amortisation	**536**	122
Impairments and reversals of property, plant and equipment	**12,304**	1,448
Audit fees	**120**	215
Other auditors' remuneration*	**183**	174
Clinical negligence	**1,788**	1,714
Research and development (excluding staff costs)	**68**	0
Education and training	**1,156**	2,744
Other	**2,042**	3,057
	132,000	130,775
Employee benefits		
Employee benefits excluding board members	**176,583**	191,230
Board members	**1,024**	986
Total employee benefits	**177,607**	192,216
Total operating expenses	**309,607**	322,991

*'Other auditors' remuneration' relates to the cost of internal audit services provided by London Audit Consortium as well as other audit regulatory services.

7. Operating leases

	11 months to 29 February 2012 £000	12 months to 31 March 2011 £000
Payments recognised as an expense		
Minimum lease payments	**1,162**	1,422
Total	**1,162**	1,422

	Buildings £000	Other £000	As at 29 February 2012 Total £000	As at 31 March 2011 Total £000
Payable				
No later than one year	**1,306**	**81**	**1,387**	1,383
Between one and five years	**5,088**	**56**	**5,144**	5,198
After five years	**8,956**	**0**	**8,956**	10,404
Total	**15,350**	**137**	**15,487**	16,985

8 Employee benefits and staff numbers

8.1 Employee benefits

	Other £000	Permanently employed £000	Other £000
Employee benefits 11 months to 29 February 2012 – net expenditure			
Salaries and wages	150,545	134,596	15,949
Social security costs	11,155	11,155	0
Employer contributions to NHS pensions scheme	15,558	15,497	61
Termination benefits	995	995	0
Total employee benefits	178,253	162,243	16,010
Employee costs capitalised	(646)	(646)	0
Net employee benefits excluding capitalised costs	177,607	161,597	16,010
Net expenditure 12 months to 31 March 2011			
Salaries and wages	163,746	145,714	18,032
Social security costs	11,541	11,541	0
Employer contributions to NHS pensions scheme	16,556	16,481	75
Termination benefits	1,089	1,089	0
Total employee benefits	192,932	174,825	18,107
Employee costs capitalised	(716)	(716)	0
Net employee benefits excluding capitalised costs	192,216	174,109	18,107

8.2. Staff numbers

	11 months to 29 February 2012 Total number	Permanently employed number	Other number	12 months to 31 March 2011 Total number
Average staff numbers				
Medical and dental	530	492	38	516
Administration and estates	904	814	90	919
Healthcare assistants and other support staff	66	60	6	269
Nursing, midwifery and health visiting staff	1,264	1,134	130	1,278
Scientific, therapeutic and technical staff	672	645	27	692
Other	199	199	0	4
Total	3,635	3,344	291	3,678
Of the above – staff engaged on capital projects	19	19	0	14

8.3 Staff sickness absence and ill health retirements

	11 months to 29 February 2012 number	12 months to 31 March 2011 number
Total days lost	**21,491**	**22,155**
Total staff years	**3,358**	**3,305**
Average working days lost	6.40	7.00
Number of persons retired early on ill health grounds	**3**	0

	11 months to 29 February 2012 £000s	12 months to 31 March 2011 £000s
Total additional pensions liabilities accrued in the year	**230**	0

8.4 Exit packages agreed in 11 months to 29 February 2012

	11 months to 29 February 2012			12 months to 31 March 2011		
	Number of compulsory redundancies number	Number of other departures agreed number	**Total number of exit packages by cost band number**	Number of compulsory redundancies number	Number of other departures agreed number	**Total number of exit packages by cost band number**
Less than £10,000	**7**	0	**7**	7	0	**7**
£10,001–£25,000	**3**	0	**3**	7	3	**10**
£25,001–£50,000	**0**	0	**0**	6	2	**8**
£50,001–£100,000	**1**	0	**1**	3	1	**4**
£100,001–£150,000	**2**	0	**2**	0	1	**1**
£150,001–£200,000	0	0	**0**	2	0	**2**
>£200,000	**0**	0	**0**	0	0	**0**
Total number of exit packages by type (total cost	**13**	**0**	**13**	**25**	**7**	**32**
Total resource cost (£000s)	359	0	359	944	285	1,229

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme.

Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

8.5 Pension costs

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

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

a) Full actuarial (funding) valuation

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

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

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. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS pension scheme (England and Wales) pension accounts, published annually. These accounts can be viewed on the NHS pensions website. Copies can also be obtained from the stationery office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:

The scheme is a 'final salary' scheme. annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the scheme regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008, members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as 'pension commutation'.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the 12 months ending 30 September in the previous calendar year. From 2011/12, the consumer price index will be used to replace the retail prices index.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS scheme and contribute to money purchase AVCs run by the scheme's approved providers or by other free standing additional voluntary contributions providers.

9. Better payment practice code

	11 months to 29 February 2012 number	11 months to 29 February 2012 £000	12 months to 31 March 2011 number	12 months to 31 March 2011 £000
9.1 Measure of compliance				
Non-NHS payables				
Total Non-NHS trade invoices paid in the year	**73,450**	**168,802**	76,386	196,153
Total Non-NHS trade invoices paid within target	**63,676**	**147,255**	66,727	169,758
Percentage of NHS trade invoices paid within target	86.69%	87.24%	87.36%	86.54%
NHS Payables				
Total NHS trade invoices paid in the year	**3,158**	17,977	3,267	18,334
Total NHS trade invoices paid within target	**1,703**	10,407	1,681	10,365
Percentage of NHS trade invoices paid within target	53.93%	57.89%	51.45%	56.53%

The better payment practice code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

10. Investment income

	11 months to 29 February 2012 £000	12 months to 31 March 2011 £000
Interest income		
Bank interest	**63**	68

11. Other losses

	11 months to 29 February 2012 £000	12 months to 31 March 2011 £000
Loss on disposal of property, plant and equipment	**(309)**	(633)

12. Finance costs

	11 months to 29 February 2012 £000	12 months to 31 March 2011 £000
Interest		
Provisions – unwinding of discount	**36**	31

13. Property, plant and equipment

13.1 Property, plant and equipment

2011/12	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and POA £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	**Total £000**
Cost or valuation								
at 31 March 2011	45,055	137,574	3,379	105,647	56,862	19,667	4,382	**372,566**
Opening adjustments	0	(8,601)	(72)	0	0	0	0	**(8,673)**
At 1 April 2011 restated	45,055	128,973	3,307	105,647	56,862	19,667	4,382	**363,893**
Additions purchased	0	0	0	9,450	0	0	0	**9,450**
Additions donated	0	0	0	23,942	0	0	0	**23,942**
Reclassifications	0	130,203	0	(129,479)	313)	(1,371)	(226)	**(1,186)**
Disposals other than for sale	0	0	0	0	(5,638)	(3,164)	(62)	**(8,864)**
Upward revaluation/positive indexation	8,120	601	0	0	0	0	0	**8,721**
Impairments/negative indexation	0	(10,336)	(1,114)	0	0	0	0	**(11,450)**
At 29 February 2012	**53,175**	**249,441**	**2,193**	**9,560**	**50,911**	**15,132**	**4,094**	**384,506**
Depreciation at 31 March 2011	0	12,181	186	0	29,141	9,194	2,737	**53,439**
Opening adjustments	0	(8,601)	(72)	0	0	0	0	**(8,673)**
At 1 April 2011 restated	0	3,580	114	0	29,141	9,194	2,737	**44,766**
Reclassifications	0	2,572	0	0	(2,797)	(207)	41	**(391)**
Disposals other than for sale	0	0	0	0	(5,319)	(3,148)	(59)	**(8,526)**
Impairments	0	12,744	0	0	0	0	0	**12,744**
Reversal of impairments	0	(440)	0	0	0	0	0	**(440)**
Charged during the year	0	5,348	105	0	4,632	2,195	443	**12,723**
At 29 February 2012	**0**	**23,804**	**219**	**0**	**25,657**	**8,034**	**3,162**	**60,876**
Net book value at 29 February 2012	53,175	225,637	1,974	9,560	25,254	7,098	932	**323,630**
Purchased	50,908	96,588	1,974	3,263	11,254	6,164	542	**170,693**
Donated	2,267	128,743	0	6,297	14,000	934	390	**152,631**
Government granted	0	306	0	0	0	0	0	**306**
Total at 29 February 2012	**53,175**	**225,637**	**1,974**	**9,560**	**25,254**	**7,098**	**932**	**323,630**
Asset financing								
Owned	53,175	221,189	1,974	9,560	25,254	7,098	932	**319,182**
Held on finance lease	0	4,448	0	0	0	0	0	**4,448**
Total	53,175	225,637	1,974	9,560	25,254	7,098	932	**323,630**

Revaluation reserve balance for property, plant and equipment

	Land £000	Buildings £000	Dwellings £000	Plant and machinery £000	Furniture and fittings £000	**Total £000**
At 31 March 2011	27,564	17,378	2,642	1,024	15	**48,623**
Prior period adjustments	295	2,766	2	98	0	**3,161**
At 1 April 2011 restated	27,859	20,144	2,644	1,122	15	**51,784**
Movements*	8,120	(10,046)	(1,111)	(73)	(13)	**(3,123)**
At 29 February 2012	35,979	10,098	1,533	1,049	2	**48,661**

*Movements in the revaluation reserve have been caused by revaluations.
'Reclassifications' includes £1.2 million of infomation technology assets reclassified from tangible to intangible assets.
'Opening adjustments' relate to the netting down of accumulated depreciation following revaulation at 31 March 2011.

13.2 Property, plant and equipment

2010/11	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and POA £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	**Total £000**
Cost or valuation at 1 April 2010	38,555	126,126	3,233	43,256	55,826	15,835	4,350	**287,181**
Additions – purchased	0	8,506	0	15,000	381	3,832	0	**27,719**
Additions – donated	0	285	0	47,391	1,325	0	32	**49,033**
Additions – government granted	0	200	0	0	0	0	0	**200**
Reclassifications	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	(1,041)	0	0	**(1,041)**
Revaluation and indexation gains	3,200	1,390	146	0	599	0	0	**5,335**
Impairments	0	(788)	0	0	(228)	0	0	**(1,016)**
Reversals of impairments	3,300	1,855	0	0	0	0	0	**5,155**
At 31 March 2011	**45,055**	**137,574**	**3,379**	**105,647**	**56,862**	**19,667**	**4,382**	**372,566**
Depreciation at 1 April 2010	0	7,152	73	0	22,469	6,892	1,989	**38,575**
Disposals other than for sale	0	0	0	0	(408)	0	0	**(408)**
Upward revaluation/positive indexation	0	0	0	0	305	0	0	**305**
Impairments	0	2,723	0	0	0	0	0	**2,723**
Reversal of Impairments	0	(1,275)	0	0	0	0	0	**(1,275)**
Charged during the period	0	3,581	113	0	6,775	2,302	748	**13,519**
At 31 March 2011	0	12,181	186	0	29,141	9,194	2,737	**53,439**
Net book value	**45,055**	**125,393**	**3,193**	**105,647**	**27,721**	**10,473**	**1,645**	**319,127**
Purchased	43,013	63,132	3,193	39,435	18,353	9,061	1,051	**177,238**
Donated	2,042	62,061	0	66,212	9,205	1,412	594	**141,526**
Government granted	0	200	0	0	163	0	0	**363**
Total at 31 March 2011	45,055	125,393	3,193	105,647	27,721	10,473	1,645	**319,127**
Asset financing								
Owned	45,055	120,608	3,193	105,647	27,721	10,473	1,645	**314,342**
Held on finance lease	0	4,785	0	0	0	0	0	**4,785**
	45,055	125,393	3,193	105,647	27,721	10,473	1,645	**319,127**

Revaluation reserve balance for property, plant and equipment

2010/11	Land £000	Buildings £000	Dwellings £000	Plant and machinery £000	Furniture and fittings £000	**Total £000**
At 1 April 2010 restated	21,359	17,068	2,498	1,056	15	**41,996**
Movements*	6,205	310	144	(32)	0	**6,627**
At 31 March 2011	27,564	17,378	2,642	1,024	15	**48,623**

*Movements in the revaluation reserve have been caused by revaluations.

13.3 Property, plant and equipment

Great Ormond Street Hospital Children's Charity donated £23.9 million (2010/11: £49 million) towards property, plant and equipment expenditure.

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

For assets held at revalued amounts:
- the effective date of revaluation was 29 February 2012
- the independent valuation of land, buildings and dwellings was undertaken by Peter Ashby, Member of the Royal Institution of Chartered Surveyors, Senior Surveyor, District Valuers Office
- the valuations were undertaken using a modern equivalent asset methodology.

Useful economic lives

Asset type	Minimum life years	Maximum life years
Buildings excluding dwellings	1	52
Dwellings	23	27
Plant and machinery	1	15
Information technology	1	5
Furniture and fittings	1	4
Infomation Technology development expenditure	1	5
Software	1	5
Licences and trademarks	1	3

14. Intangible assets

14.1 Intangible non-current assets

	Software purchased £000	Licences and trademarks £000	Development expenditure £000	**Total £000**
Cost or valuation at				
31 March 2011	932	188	473	**1,593**
Additions – purchased	284	56	579	**919**
Reclassifications	769	35	382	**1,186**
Disposals other than by sale	(20)	(77)	(56)	**(153)**
At 29 February 2012	1,965	202	1,378	**3,545**
Amortisation at				
31 March 2011	184	76	336	**596**
Reclassifications	372	19	0	**391**
Disposals other than by sale	(19)	(77)	(55)	**(151)**
Charged during the period	315	41	180	**536**
At 29 February 2012	852	59	461	1,372
NBV at 29 February 2012	1,113	143	917	2,173
Net book value at 29 February 2012 comprises				
Purchased	1,036	133	916	**2,085**
Donated	77	10	1	**88**
Total at 29 February 2012	1,113	143	917	**2,173**

'Reclassifications' includes £1.2 million of Information Technology assets reclassified from tangible to intangible assets.

14.2 Intangible non-current assets

	Software purchased £000	Licences and trademarks £000	Development expenditure £000	**Total £000**
Cost or valuation at				
1 April 2010	388	85	473	**946**
Additions – purchased	544	103	0	**647**
At 31 March 2011	932	188	473	**1,593**
Amortisation				
At 1 April 2010	108	63	303	**474**
Charged during the year	76	13	33	**122**
At 31 March 2011	184	76	336	**596**
Net book value at 31 March 2010	748	112	137	**997**
Net book value at 31 March 2010 comprises				
Purchased	738	111	123	**972**
Donated	10	1	14	**25**
Total at 31 March 2011	748	112	137	**997**

15. Analysis of impairments and reversals recognised in 2011/12

	Total £000
Property, plant and equipment impairments and reversals taken to SoCI	
Over-specification of assets	12,304
Total charged to departmental expenditure limit	12,304
Property, plant and equipment impairments and reversals charged to the revaluation reserve	
Over specification of assets	11,450
Total impairments for PPE charged to reserves	11,450
Total impairments of property, plant and equipment	23,754
Total impairments charged to revaluation reserve	11,450
Total impairments charged to SoCI – DEL	12,304
Overall total impairments	23,754

16. Commitments

16.1 Capital commitments

Contracted capital commitments at 29 February not otherwise included in these financial statements:

	29 February 2012 £000	31 March 2012 £000
Property, plant and equipment	**11,318**	30,388
Intangible assets	**851**	145
Total	**12,169**	30,533

16.2 Other financial commitments

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

	29 February 2012 £000	31 March 2012 £000
Not later than one year	**23,328**	24,849
Later than one year and not later than five year	**2,562**	3,954
Total	**25,890**	28,803

17. Intra Government and other balances

	Current recieveables £000	Non-current receiveables £000	Current payables £000
Balances with other central government bodies	14,959	0	8,657
Balances with local authorities	2	0	16
Balances with NHS trusts and Foundation Trusts	2,290	0	2,377
Balances with bodies external to government	20,068	9,082	24,431
At 29 February 2012	**37,319**	**9,082**	**35,481**
Prior period (restated)			
Balances with other central government bodies	6,906	0	8,241
Balances with local authorities	83	0	1,684
Balances with NHS trusts and Foundation Trusts	2,265	0	3,307
Balances with bodies external to government	21,255	9,505	34,356
At 31 March 2011	**30,509**	**9,505**	**47,588**

18. Inventories

	Drugs £000	Consumables £000	Energy £000	**Total £000**
Balance at 1 April 2011	1,294	3,862	0	**5,156**
Additions	258	995	67	**1,320**
Write-down of inventories (including losses)	(44)	0	0	**(44)**
Balance at 29 February 2012	1,508	4,857	67	**6,432**

19. Trade and other receivables

19.1 Trade and other receivables

	Current		Non-current	
	29 February 2012 £000	31 March 2011 £000	**29 February 2012 £000**	31 March 2011 £000
NHS receivables – revenue	**16,601**	7,455	**0**	0
NHS receivables – capital	**0**	0	**0**	0
NHS prepayments and accrued income	**481**	22	**0**	0
Non-NHS receivables – revenue	**9,690**	10,360	**0**	0
Non-NHS receivables – capital	**4,598**	6,571	**0**	0
Non-NHS prepayments and accrued income	**5,236**	4,897	**0**	0
Provision for the impairment of receivables	**(1,108)**	(1,498)	**0**	0
VAT	**705**	1,895	**0**	0
Other receivables	**1,116**	807	**9,082**	9,505
Total	**37,319**	30,509	**9,082**	9,505
Total current and non current	**46,401**	40,014		

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

19.2 Receivables past their due date but not impaired

	29 February 2012 £000	31 March 2012 £000
By up to three months	**2,119**	2,130
By three to six months	**598**	500
By more than six months	**88**	28
Total	**2,805**	2,658

19.3 Provision for impairment of receivables

	11 months ended 29 February 2012 £000	12 months ended 31 March 2012 £000
Balance at 1 April 2011	**(1,498)**	(1,435)
Amount written off during the period	343	29
Amount recovered during the period	0	34
Decrease/(increase) in receivables impaired	47	(126)
Balance at the end of the period	**(1,108)**	**(1,498)**

20. Cash and cash equivalents

	29 February 2012 £000	31 March 2012 £000
Opening balance at	**32,371**	8,485
Net change in year	**(13,308)**	23,886
Closing balance	**19,063**	32,371
Made up of		
Cash with Government Banking Service	**19,042**	32,349
Commercial banks	**21**	22
Cash and cash equivalents as in statement of financial position	**19,063**	32,371
Cash and cash equivalents as in statement of cash flows	**19,063**	32,371

21. Trade and other payables

	Current	
	29 February 2012 £000	31 March 2012 £000 (restated)
NHS payables – revenue	**4,035**	7,722
NHS accruals and deferred income	**6,997**	4,997
Non-NHS payables – revenue	**3,277**	2,519
Non-NHS payables – capital	**4,043**	12,179
Non-NHS accruals and deferred income	**10,643**	16,149
Social security costs	**1,884**	1,737
Tax	**2,198**	2,285
Other	**2,404**	0
Total	**35,481**	47,588
Total payables (current and non-current)	**35,481**	47,588
Included above		
Outstanding pension contributions at the period end	2,202	2,208

22. Other liabilities

	Current		Non-current	
	29 February 2012 £000	31 March 2011 £000	**29 February 2012 £000**	31 March 2011 £000
Lease incentives	**444**	400	**6,987**	7,327
Other payables	**4,390**	2,982	**0**	0
Total	**4,834**	3,382	**6,987**	7,327
Total other liabilities (current and non-current)	**11,821**	**10,709**		

23. Deferred income

	Current	
	29 February 2012 £000	31 March 2012 £000
Opening balance at 1 April	**6,281**	3,326
Deferred income addition	**5,884**	2,955
Transfer of deferred income	**(4,620)**	0
Current deferred Income at 29 February/31 March	**7,545**	6,281
Total other liabilities (current and non-current)	**7,545**	**6,281**

Deferred income is included in note 21 both within 'NHS accruals and deferred income' and 'Non-NHS accruals and deferred income'.

24. Provisions

	Total £000	Pensions relating to other staff £000	Legal claims £000	Other £000	Redundancy £000
Balance at 1 April 2011	4,117	1,359	78	2,100	580
Arising during the period	1,407	40	48	164	1,155
Utilised during the period	(947)	(83)	(59)	(76)	(729)
Reversed unused	(252)	0	0	(143)	(109)
Unwinding of discount	36	36	0	0	0
Balance as at 29 February 2012	**4,361**	**1,352**	**67**	**2,045**	**897**
Expected timing of cash flows					
No later than one year	**3,120**	**111**	**67**	**2,045**	**897**
Later than one year and not later than five years	**444**	**444**	**0**	**0**	**0**
Later than five years	**797**	**797**	**0**	**0**	**0**

Amount included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities	£000
As at 29 February 2012	30,565
As at 31 March 2011	25,408

25. Contingencies

	29 February 2012 £000	31 March 2012 £000
Contingent liabilities		
Pending legal cases	**(29)**	(31)
Net value of contingent liabilities	**(29)**	(31)

26 Financial instruments

26.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Primary Care Trusts and the way those Primary Care Trusts 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 would be 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.

Interest rate risk

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

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 29 February 2012 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

26.2 Financial assets

	29 February 2012 £000	31 March 2011 £000
Receivables – NHS	16,601	7,455
Receivables – non-NHS	15,001	18,135
Cash at bank and in hand	19,063	32,371
Total at the end of the period	50,665	57,961

26.3 Financial liabilities

	29 February 2012 £000	31 March 2011 £000
NHS payables	4,035	7,722
Non-NHS payables	9,200	18,720
Total at the end of the period	13,235	26,442

27. Events after the end of the reporting period

The Trust was licensed as a Foundation Trust from 1 March 2012. The new name of the Trust is Great Ormond Street Hospital for Children NHS Foundation Trust. The Trust's core business remains unchanged.

28. Related party transactions

Great Ormond Street Hospital for Children NHS Trust 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, Great Ormond Street Hospital for Children NHS Trust 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		Due from related party	
	11 months ended 29 February 2012 £000	12 months ended 31 March 2011 £000	29 February 2012 £000	31 March 2011 £000
Revenue receipts from				
Croydon PCT	51,891	55,441	1,027	0
London Strategic Health Authority	50,333	51,128	1,796	0
South East Essex PCT	39,724	40,418	1,099	309
West Kent PCT	11,471	14,407	313	617
Department of Health	11,811	12,133	35	57
Haringey Teaching PCT	4,682	12,062	0	592
Hampshire PCT	10,175	11,255	0	6
Camden PCT	13,069	10,367	7,201	152
Tower Hamlets PCT	4,077	9,523	34	0
Barnet PCT	5,194	6,053	0	478
Leicestershire County and Rutland PCT	4,098	4,470	0	385
Enfield PCT	3,829	3,958	43	0
Redbridge PCT	3,137	3,492	0	138
Waltham Forest PCT	2,995	3,282	46	0
Bristol PCT	3,202	3,144	37	0
Islington PCT	3,217	3,062	0	20
Hillingdon PCT	2,730	2,880	107	353
Newham PCT	3,001	635	0	37
City and Hackney Teaching PCT	2,112	627	19	38
Ealing PCT	2,577	2,707	0	0
Brent Teaching PCT	2,333	2,466	240	76
Barking and Dagenham PCT	1,990	2,396	28	0
Harrow PCT	2,055	2,228	64	225
Havering PCT	2,076	2,182	54	0
East of England Strategic Health Authority	0	2,080	0	16
Hounslow PCT	1,956	1,929	242	408
Birmingham East and North PCT	1,765	1,927	0	19
Barts and the London NHS Trust	1,403	1,859	703	383
Bromley PCT	1,098	1,182	0	0
Western Cheshire PCT	1,116	1,134	1	44
Sutton and Merton PCT	922	1,115	0	111
Bexley Care PCT	1,113	1,108	46	54
Greenwich Teaching PCT	988	1,095	0	153
Westminster PCT	1,224	1,060	53	0
Barnsley PCT	1,080	1,015	151	25
HMRC – VAT Recovery	5,907	6,636	705	1,895

28. Related party transactions (continued)

	Payments to related party		Owed to related party	
	11 months ended 29 February 2012 £000	12 months ended 31 March 2011 £000	29 February 2012 £000	31 March 2011 £000
Expenditure payments to				
NHS Business Services Authority	0	243	1	306
NHS Blood and Transplant	1,905	4	257	435
NHS Litigation Authority	1,947	1,886	0	0
University College London NHS Foundation Trust	1,360	4	689	1,599
Mid Essex Hospital Services NHS Trust	1,279	1,395	0	0
NHS Pensions Agency	15,559	16,481	2,202	2,208
HMRC (Tax and National Insurance)	35,624	38,898	4,169	4,143
Department of Health (PDC Dividend)	5,285	5,551	2,400	0

The de minimis limit is £1,000,000.

The Trust has also had the following transactions with the Special Trustees for Great Ormond Street Hospital Children's Charity:

- Donations for Capital Expenditure £23,939k (2010/11 £49,033k)
- Contributions towards Revenue Expenditure £5,828k (2010/11 £10,302k).

29. Losses and special payments

	Total value of cases £s	Total number of cases
The total number of losses cases in 2011/12		
Losses	343,032	167
Special payments	176	2
Total losses and special payments	**343,208**	**169**
The total number of losses cases in 2010/11		
Losses	119,657	16
payments	440	2
Total losses and special payments	**343,208**	**169**

30. Financial performance targets

The figures given for periods prior to 2009/10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

30.1 Breakeven performance

	12 months ended 31 March 2006 £000	12 months ended 31 March 2007 £000	12 months ended 31 March 2008 £000	12 months ended 31 March 2009 £000	12 months ended 31 March 2010 £000	12 months ended 31 March 2011 £000	11 months ended 29 February 2012 £000
Turnover	221,449	247,048	270,693	291,450	318,146	336,307	328,688
Retained surplus for the period	1,902	2,117	6,956	1,348	3,551	7,169	13,514
Adjustments for							
Impairments	0	0	0	4,541	3,817	1,448	12,304
Impact of policy change regarding donated/government grants assets	0	0	0	0	0	0	(23,949)
Break-even in-year position	1,902	2,117	6,956	5,889	7,368	8,617	1,869
Break-even cumulative position	3,673	5,790	12,746	18,635	26,003	34,620	36,489

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10, NHS trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

Prior year figures have not been updated in respect of the change in accounting policy for donated assets.

	12 months ended 31 March 2006 %	12 months ended 31 March 2007 %	12 months ended 31 March 2008 %	12 months ended 31 March 2009 %	12 months ended 31 March 2010 %	12 months ended 31 March 2011 %	11 months ended 29 February 2012 %
Materiality test (ie is it equal to or less than 0.5 per cent)							
Break-even in-year position as a percentage of turnover	0.86	0.86	2.57	2.02	2.32	2.56	0.57
Break-even cumulative position as a percentage of turnover	1.66	2.34	4.71	6.39	8.17	10.29	11.10

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.

30.2 Capital cost absorption rate

Until 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 bears to the actual average relevant net assets.

Where accounts are being prepared for a part-year, the dividend is calculated based on the average relevant net assets over a 12-month period and then pro-rated for the part-year accounts. The dividend shown in these accounts of £5,285k is 11/12 of the dividend calculated in respect of the average relevant net assets for the 12 months ended 31 March 2012.

	11 months to 29 February 2012 £000	12 months to 31 March 2011 £000
External financing limit	13,308	15,417
Cash flow financing	13,308	39,627
Other capital receipts	0	(48,513)
External financing requirement	13,308	(8,886)
Undershoot	0	24,303

2010/11 figures above have not been restated in respect of the change in accounting policy for donated assets.

30.4 Capital resource limit

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

	11 months to 29 February 2012 £000	12 months to 31 March 2011 £000
Gross capital expenditure	**34,311**	77,599
Less: book value of assets disposed of	**(340)**	(633)
Less: capital grants	**0**	(200)
Less: donations towards the acquisition of non-current assets	**(23,948)**	(49,033)
Charge against the capital resource limit	**10,023**	27,733
Capital resource limit	**10,023**	28,250
Underspend against the capital resource limit	**0**	**517**

31. Restatement of prior year figures

31.1 Statement of comprehensive income

The accounting policy change described in note 1.10 has the following impact on the primary statements:

	2010/2011 as previously reported £000	Adjustment for change in accounting policy for donated assets £000	2010/2011 restated £000
Income from activities	283,881	0	283,881
Other income			
Donations towards capital expenditure	0	49,233	49,233
Transfers from the donated asset reserve	6,996	(6,996)	0
All other income	45,430	0	45,430
Total other income	52,426	42,237	94,663
Total income	**336,307**	**42,237**	**378,544**
Expenditure			
Depreciation on donated assets	(6,996)	0	(6,996)
All other expenditure	(315,995)	0	(315,995)
Total expenditure	(322,991)	0	(322,991)
Operating surplus	**13,316**	**42,237**	**55,553**
Financing costs and other adjustments	(6,147)	0	(6,147)
Surplus for the period	**7,169**	**42,237**	**49,406**
Other comprehensive income adjustments	9,169	0	9,169
Transfers from the donated asset reserve	(6,996)	6,996	0
Donations received	49,233	(49,233)	0
Total comprehensive income for the period	**58,575**	**0**	**58,575**

31.2 Statement of financial position

	Revaluation reserve £000	Donated asset reserve £000	Government grant reserve £000	Retained earnings reserve £000
As stated at 1 April 2010	**41,996**	**97,126**	**193**	**9,515**
Restatement of donated asset reserve, analysed as:				
Donations recognised	**0**	**(97,126)**	**(193)**	**96,516**
Revaluation recognised	**803**	**0**	**0**	**0**
As restated at 1 April 2010	**42,799**	**0**	**0**	**106,031**
Change	**803**	**(97,126)**	**(193)**	**96,516**

31.3 Statement of cash flows

	2010/11 As previously reported £000	Adjustment for change in accounting policy for donated assets £000	2010/11 restated £000
Cash flows from operating activities			
Operating surplus from continuing operations	13,316	42,237	55,553
Non-cash income and expenses			
Transfer from the donated asset reserve	(6,996)	6,996	0
Decrease in trade and other receivables	6,305	(720)	5,585

32. 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.

32.1 Salary entitlements of senior managers

Name	Title	11 month's salary to 29 February 2012 (bands of £5,000) £000	Proforma 12 month's salary to 31 March 2012 (bands of £5,000) £000	12 month's salary to 31 March 2011 (bands of £5,000) £000
Non-Executive				
Baroness Tessa Blackstone	Chair*^	20–25	20–25	20–25
Ms Yvonne Brown	Non-Executive Director*^	5–10	5–10	5–10
Professor Andrew Copp	Non-Executive Director*^	5–10	5–10	5–10
Mr Andrew Fane	Non-Executive Director (until 31 October 2011)*^	0–5	0–5	5–10
Mr D A Lomas	Non-Executive Director (from 1 November 2011)*^	0–5	0–5	n/a
Ms Mary MacLeod OBE	Non-Executive Director*^	5–10	5–10	5–10
Mr J K Ripley	Non-Executive Director (from 1 November 2011)*^	0–5	0–5	N/A
Mr Charles Tilley	Non-Executive Director*^	5–10	6–10	5–10
Executive				
Dr Barbara Buckley	Co-Medical Director*	155–160	170–175	170–175
Mr Trevor Clarke	Director of the International and Private Patients Division*	70–75	75–80	65–70
Dr Jane Collins	Chief Executive*	165–170	180–185	180–185
Ms Fiona Dalton	DeputyChief Executive/Director of Operations*	115–120	125–130	125–130
Mr Martin Elliott	Co-Medical Director *	215–220	235–240	135–140
Professor David Goldblatt	Director of Clinical Research and Development	60–65	65–70	65–70
Mr Mark Large	Director of Information Technology	85–90	90–95	90–95
Mr William (Bill) McGill	Director of Redevelopment (part time from 3 May 2011)	70–75	80–85	125–130
Mrs Elizabeth Morgan	Director of Nursing, Education and Workforce Development*	100–105	110–115	85–90
Mrs Claire Newton	Chief Finance Officer*	110–115	125–130	125–130

Annualised proforma information for the 12 months to 31 March 2012 has also been included.
* denotes Board Member
^ denotes Member of Remuneration Committee
No Senior Manager at the Trust Received any other benefits from the Trust.

	£000
Band of Chief Executive's total remuneration	180–185
Median total remuneration	37,192
Ratio	**4.9**

Notes to the accounts
continued

32.2 Pension entitlements of senior managers

Name	Title	Real increase in pension at age 60 bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension age 60 at 31 March 2012 (bands of £2,500) £000	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of 5,000) £000	Cash equivalent transfer value at 31 march 2012 £000	Cash equivalent transfer value at 31 March 2011 £000	Real increase/ (decrease) in cash equivalent transfer value at 31 March 2012 £000
Dr Barbara Buckley	Co-Medical Director	0–2.5	7–7.5	45–50	140–145	884	776	108
Mr Trevor Clarke	Director of the International and Private Patients Division	0–2.5	2.5–5	35–40	105–110	677	607	70
Dr Jane Collins	Chief Executive	2–2.5	7.5–10	80–85	245–250	n/a	n/a	n/a
Ms Fiona Dalton	Deputy Chief Executive/ Director of Operations	2–2.5	7.5–10	25–30	80–85	373	270	103
Mr Martin Elliott*	Co-Medical Director	2–2.5	7.5–10	90–95	275–280	n/a	n/a	n/a
Mr Mark Large	Director of Information Technology	0–2.5	2.5–5	15–20	50–55	322	275	47
Mrs Liz Morgan	Director of Nursing, Education and Workforce Development	2.5–5	10–12.5	45–50	140–145	1,108	1,011	97
Mrs Claire Newton	Chief Finance Officer	0–2.5	5–7.5	5–10	20–25	143	105	38

* Where employees turn 60 in the reporting year, no CETV will be shown

The table above shows information for the 12–month period 1 April 2011 to 31 March 2012; information is not separately available at 29 February 2012.

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. he 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.

This reflects the increase/decrease in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, 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 and in the current year reflects revised actuarial assumptions.

Going concern

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Statement of the 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 those 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 to enable them to ensure that the accounts comply with requirements outlined in the above mentioned 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 to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Dr Jane Collins
Chief Executive
30 May 2012

Claire Newton
Finance Director
30 May 2012

Disclosure of information to auditors

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

Statement of the Chief Executive's responsibilities as the Accounting Officer of Great Ormond Street Hospital for Children NHS Trust

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer to 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 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 has 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.

Dr Jane Collins
Chief Executive
30 May 2012

Head of Internal Audit Opinion

Head of Internal Audit Opinion on the effectiveness of the system of internal control for the 11 months ended 29 February 2012

Roles and responsibilities

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process
- the conduct and results of the review of the effectiveness of the system of internal control, including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the AGS requirements.

In accordance with NHS Internal Audit Standards and Department of Health requirements, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (ie the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Board takes into account in making its AGS.

The Trust became a Foundation Trust with effect from 1 March 2012, consequently this opinion covers the 11 month period to that date. I will issue a separate opinion on the one month period to 31 March 2012 covering the one month the Trust operated as a Foundation Trust. The internal audit plan, upon which my opinion is based, was drawn up on the assumption the Trust would exist for a full year and both opinions are therefore based on the results of that full year's plan.

The Head of Internal Audit Opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This opinion will in turn assist the Board in the completion of its AGS.

My opinion is set out as follows:

1. Overall opinion
2. Basis for the opinion
3. Commentary.

My overall opinion is that:
Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. We have issued a number of limited overall assurance opinions during the period. These covered the taking of consent, management and prevention of salary overpayments Information Governance Assurance, IT business continuity and disaster recovery and learning disabilities. However, we whilst we have provided limited assurance on these and a small number of other individual control objectives we consider that there are unlikely to be any material or significant errors or losses as a result of the weaknesses identified although improvements are required for which recommendations have been made and accepted by management.

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes.
2. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

The commentary below provides the context for my opinion and together with the opinion should be read in its entirety.

A review was undertaken of the Board Assurance Framework and its associated processes. This confirmed that there was a process in place for identifying key risks to the Trust, meeting its key objectives and for mapping out the key controls in place to manage those risks. The process also enables the Trust Board to gain assurance about the effectiveness of these key controls. Where any gaps in either control or assurance were identified appropriate action plans were in place to address them. We have attended the regular Risk, Assurance and Compliance group meetings. We have made a number of observations and recommendations designed to aid and improve the process.

The process by which the Trust ensures its continued compliance in respect of its Care Quality Commission registration was reviewed. We found the Trust's processes were generally adequate but required more outcome based evidence to be documented in a number of instances.

We have carried out a wide range of audits during the period, most of which enabled us to provide reasonable or significant assurance that the controls and systems were operating effectively. We identified throughout the audit work a number of weaknesses in either design or application of the controls for which we have proposed recommendations and for which management has developed action plans for improvement. We have issued a number of limited assurance overall opinions – consent, management and prevention

Head of Internal Audit Opinion
continued

of overpayments of salary, information governance assurance, information technology business continuity and disaster recovery and learning disabilities and we have been able to provide only limited assurance on certain individual control objectives. However, we consider that the risk of material error or loss to the Trust arising from such weaknesses to be low.

We have made recommendations which Foundation Trust management have accepted, to enable improvements to be effected.

There have been no limitations of scope or coverage placed upon any internal audit work although certain planned work has not been undertaken as circumstances had rendered the timing of the work to be unsuitable. In these cases the planned work has been deferred to the 2012/13 internal audit plan.

Roger Brealey
Director of Operations
London Audit Consortium

Independent auditor's report

Independent auditor's report to the governers of NHS Foundation Trust in respect 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 11–month period ended 29 February 2012 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 1 to 32. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. 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 Governors of Great Ormond Street Hospital for Children NHS Foundation Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. Our audit work has been undertaken so that we might state to the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditor

As explained more fully in the Statement of Directors' Responsibilities, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Great Ormond Street Hospital for Children NHS Trust as at 29 February 2012 and of its expenditure and income for the 11 month period then ended
- have been prepared properly 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 in England.

Opinion on other matters

In our opinion:

- the information given in the Annual Report for the period for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of Great Ormond Street Hospital for Children NHS Trust 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
30 May 2012

Glossary of terms

Financial glossary

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

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

EBITDA
Earnings before interest, taxes, depreciation and amortization

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 to the Trust for a period exceeding one year

Impairment
A charge to the revenue account resulting from a reduction in the value of assets

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 the exact timing and amount

Public dividend capital
The NHS equivalent of a company's share capital

General glossary

Balanced scorecard
A performance-management tool

BRE
Building Research Establishment

Care bundles
A small set of clinical practices which, when performed collectively, reliably and continuously, have been shown to improve patient outcomes

CATS
Children's Acute Transport Service

CBI
Confederation of British Industry

CEMACH
The Confidential Enquiry into Maternal and Child Health

CEWS
Children's Early Warning Score

CICU
Cardiac Intensive Care Unit

Clinical Unit Chair
Lead clinician for a unit

CNST
Clinical Negligence Scheme for Trusts

Commissioners
The organisations which purchase services from Great Ormond Street Hospital

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

CQUIN
Commissioning for Quality and Innovation

CSP
Clinical site practitioner – an experienced intensive-care nurse who has expertise in assessing and caring for seriously ill children and works across the hospital

CVC
Central venous catheter

DH
Department of Health

ECMO
Extracorporeal membrane oxygenation

ENT
Ears, nose and throat

FCE
Finished consultant episode

General Manager
Lead manager for a unit

GP
General practitioner

GOSH
Great Ormond Street Hospital for Children NHS Foundation Trust

HCAI
Healthcare-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

ICON
Intensive Care Outreach Network

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

NHS Institute for Innovation and Improvement
The NHS' own improvement agency, which facilitates change management to improve care or patients

NICU
Neonatal Intensive Care Unit

NIHR
National Institute for Health Research

NPSA
National Patient Safety Agency

Paediatric Trigger Tool
A tool that measures harm caused by healthcare. By using the tool, it is possible to calculate the adverse event rate and identify the areas of care in which most incidents of harm are occurring

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 that collects data on all children admitted to paediatric intensive care units across the UK

PICU
Paediatric Intensive Care Unit

PROM
Patient-reported outcome measure – measures of a patient's health status or health-related quality of life

R&D
Research and development

RPST
Risk Pool Scheme for Trusts

Safeguarding
Keeping children safe from harm, such as illness, abuse or injury (Commissioner for Social Care Inspection et al, 2005:5)

SBARD
Situation, background, assessment, recommendation and decision

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 – 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

Transformation
A service redesign programme that aims to improve the quality of care we provide to children and enhance the working experience of staff

TPN
Total parenteral nutrition

UCL
University College London

Unit
How we group and manage our clinical services

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

English
Translations, large print, Braille or audio versions of this report are available upon request from the address above.

French
Traductions disponibles sur demande à l'adresse ci-dessus. Des versions en gros caractères, en braille ou audio sont également disponibles sur demande.

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 آڈیو پر درج ذیل پتے سے حاصل کی جا سکتی ہے۔

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This Annual Report is available to view at www.gosh.nhs.uk