Great Ormond Street Hospital for Children
NHS Foundation Trust

Annual Report and Accounts 2012/13

The child first and always

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

A message from the Chairman

Whatever decisions we make, we must put children and families at the centre of them. Last year it was our first full year as an NHS Foundation Trust, which secured our independence as an NHS hospital and enables us to focus exclusively on the needs of sick children and their families. We treated more patients than ever before and we anticipate that demand for our services will continue to grow with an increasing movement in the NHS towards fewer, larger centres. To enable us to support this growth and to provide better facilities for families and staff, the hospital is currently redeveloping its site. In the summer we were delighted to open the new Morgan Stanley Clinical Building which is the first of two buildings within the Mittal Children's Medical Centre, with the second building due to open in 2017. I am enormously grateful to everyone who contributed to this wonderful achievement.

The hospital aims to provide high quality and safe care and an excellent experience for all our patients and their families. One of the ways to find out how the Trust is performing against this aim is to ask our staff and our families whether they would recommend the organisation to others: 90% of staff and 96% of families said they would. These results compare very favourably with other hospitals. However, in the aftermath of the review into Mid Staffordshire by Robert Francis QC, no Trust can afford to be complacent and we have set up a working group to establish what we should be doing better.

We want to find new and better ways to treat the patients we care for. To do this, the hospital works in partnership with the UCL Institute of Child Health. Our joint aim is to translate the work undertaken in laboratories into clinical care for children as quickly as possible. The Board looks forward to working with Professor Rosalind Smyth, the new director of the Institute.

This year was the first of a new five year award for the hospital and the institute as a National Institute for Health Research (NIHR) Biomedical Research Centre specialising in paediatrics. The hospital is one of the leading specialist paediatric trusts in the country for undertaking clinical research studies and specifically providing opportunities to take part in clinical trials.

Our Members' Council has now been in place for just over a year. We value the feedback they have given us on our plans and their involvement in various projects within the hospital. They play a key role in helping us develop ways of working with our members to find the right solutions for the children in our care.

We are fortunate to benefit from the generosity of the thousands of people who support the Great Ormond Street Hospital Children's Charity. This enables us to fund our redevelopment programme, support research and buy medical equipment.

I would also like to thank Dr Jane Collins who left the Trust earlier this year after more than ten years as our Chief Executive and to wish her continuing success in her new role as the Chief Executive of Marie Curie Cancer Care.

In November we welcomed our new Chief Executive, Jan Filochowski. Jan is one of the most respected and experienced NHS chief executives in the UK, and I am looking forward to working with him as we develop our future plans for the hospital.

I want to finish by thanking our staff for their dedication. If you saw the documentary series, *Great Ormond Street*, which was shown on the BBC last summer, you will have seen some of the incredible work that goes on here. None of this is possible without the contribution of everyone who works here, both clinical and non-clinical.

Baroness Blackstone
Chairman

A message from the Chief Executive

I'm really proud to have joined Great Ormond Street Hospital for Children Foundation Trust as its new Chief Executive. It's a unique hospital with unique interests and I am looking forward to working with the talented people here to help guide the hospital into its next phase.

The NHS is constantly changing and the hospital must adapt to meet these changes. What that means is being led by the hospital's motto, 'The child first and always', and then asking ourselves what it means in today's context. We need to retain what we're doing very well and then identify what could be done better.

The hospital has always been at the forefront of innovation and research and that is something we all want to continue. Some of the work I've seen and the ideas I've discussed with our staff, offer new hope for better treatments and care for our patients. This includes taking advantage of advances in medical science such as gene therapy and regenerative medicine. It also means looking at how technology can be used to improve models of care.

This comes with challenges as we look to improve the infrastructure and processes which support new ideas and also underpin the day-to-day challenges faced by the organisation. These include the increased demand for our services and a need to provide better facilities for many of our patients, parents and staff.

However, we also need to be a high-performing and efficient organisation within the NHS and we face the same financial challenges as all NHS organisations. It is our responsibility to use money wisely so that we make the right decisions in the interests of children and young people. One aspect of this is the treatment and provision of advice for private patients from overseas. We have increased our earnings in this area and used the money to benefit our NHS patients.

We must make sure that we listen to what people are telling us, including patients, families and staff. This is a big theme in the Francis Report and is something that we must take very seriously. I know that the Board and Members' Council want us to ensure we do all we can to respond to the feedback we receive and to use that information to inform our decisions.

The hospital has a rich and proud history. I'm delighted to be leading this next stage as we develop a clear strategy and vision for its future.

Jan Filochowski
Chief Executive

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.

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This report includes, as additional comparative information, proforma unaudited financial information for the year ended 31 March 2012 to allow a better understanding of the annual trends in revenue and expenditure for the operations. The proforma unaudited information for the year ended 31 March 2012 has been derived by combining the financial results for the NHS Trust (1 April 2011 to 29 February 2012) and the Foundation Trust (1 March to 31 March 2012).

The Trust has met the requirement in section 43(2A) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

Cover: one-year-old Caroline, on Rainforest Ward, with nurse Nicola. Caroline has a metabolic condition called Maple syrup urine disease.

Directors' report

Operational and financial review

Two-year-old Dwayne has a Wilms' tumour and is at the hospital for chemotherapy. He has lots of energy and loves playing football with his big brother.


REBEL GOODS
QUALITY
VINTAGE GAS
MONTANA

Introduction

Who we are and what we do

Great Ormond Street Hospital (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. The Trust was authorised as a Foundation Trust on 1 March 2012.

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:

- Paediatric intensive care.
- Cardiac surgery – we are one of the largest heart transplant centres for children in the world.
- Neurosurgery – we carry out about 60 per cent of all UK operations for children with epilepsy.
- Paediatric cancer services – with University College London Hospitals (UCLH) we are one of the largest centres in Europe for children with cancer.
- Nephrology and renal transplant.
- Children treated from overseas in our International and Private Patients wing.

Leading research and development

We are the UK's only academic Biomedical Research Centre (BRC) specialising in paediatrics. We are a member of University College London (UCL) Partners, an alliance for world-class research benefitting patients, joining UCL with a number of other 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

GOSH offers a wide prospectus of learning to all staff groups. Together with London South Bank University (LSBU), we train the largest number of children's nurses in the UK. We also play a leading role in training paediatric doctors and other health professionals. We have embedded learning on non-technical skills (human factors) and improvement methodology across our prospectus. Our aim is to work in partnership across all areas of the Trust to ensure the prospectus supports staff to be the best that they can be.

Health policy and the economy

2013/14 is said to be the first year of the 'new NHS' following the structural changes put in place by the Health and Social Care Act 2012. For Great Ormond Street Hospital (GOSH) this means moving from many Primary Care Trust (PCT) commissioners to one commissioner for 90 per cent of our clinical services, with the remaining 10 per cent of our services commissioned by over 70 of the new Clinical Commissioning Groups.

Many of our clinicians are engaging with the Clinical Reference Groups established by NHS England to standardise the specifications of specialised service patient pathways and develop targeted outcomes.

The reduced number of commissioners for our specialist services is anticipated to assist in joint strategic planning. It may enable further clarity regarding designation of specialist centres, greater consistency in service provision for patients and in funding for specialised services nationally.

The healthcare system is also facing the challenge of significant and enduring financial pressures and GOSH is not excluded from these pressures. The types of services we are able to offer and the need for our services will continue to grow faster than the funding available to acute trusts. Specialist services delivered to complex patients are costly and we have continued to work closely with other paediatric providers to demonstrate the reasons why there is an ongoing need for the 'specialist top-ups' to be added to the national tariff. We look forward to working with our commissioners and other paediatric service providers to transform the way that specialist paediatric services are provided for patients, while ensuring that safety and outcomes are not compromised due to the reduced level of funding. The recurring annual NHS efficiency targets remain a continuing challenge but we will seek to achieve these targets through better use of our resources and our facilities.

The Commissioning for Quality and Innovation (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 2012/13 each provider on a national standard contract was entitled to earn 2.5% of the contract value subject to achieving goals in a CQUIN scheme. Further information on our performance against these targets can be found on page 09.

Progress with the new paediatric congenital heart networks, to be established in line with the recommendations of the Safe and Sustainable review of paediatric cardiac services, has been delayed following a judicial review. We hope that in 2013/14 work can continue, with the result of concentrating the care of children needing these services into fewer, larger specialist centres as an integral part of children's heart networks. We are committed to working with NHS England to deliver the changes required as quickly as possible on behalf of children and their families.

We are delighted to have been designated as one of the four paediatric epilepsy surgical centres in England in November 2012 following a review as part of the Safe and Sustainable review of paediatric neurosurgery.

The NHS information strategy was published in May 2012. It sets a ten-year framework for transforming information for the NHS, public health and social care. This was followed by a target set by the Secretary of State for Health in January for the NHS to become paperless by 2018 and aims to establish the most modern digital health service in the world with patients at the heart of this change. At GOSH, we see many opportunities to improve the services provided to our patients and their parents and carers, through increased use of IT, telecare and telemedicine. During 2013 we will be reviewing our IT strategy in order to identify the path by which we can become a truly digital hospital well before 2018, but it will require significant investment.

Quality at Great Ormond Street Hospital

All the children and young people we treat at the hospital deserve high quality, safe care and, together with their families, to receive an excellent experience while they are here. Our staff are dedicated to providing a high-quality service but we know that there are things that we can do better.

The Trust has set three core priorities:

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.

There are a range of general external measures which are used to assess how well the Trust is performing. In each of these the Trust has performed well this year. The Quality Report (page 64) documents how well we are doing to improve our services and the progress we are making.

The Trust has developed a Quality Strategy which highlights the 10 quality standards that will govern future quality improvement work:

Standard one: Develop a strong governance structure for quality and safety with a systems approach to quality and safety.
Standard two: Maintain high levels of medication safety.
Standard three: Decrease and eliminate hospital acquired infections.
Standard four: Improve reliability in clinical handover and patient documentation.
Standard five: Eliminate all pressure injuries occurring in hospital.
Standard six: Recognise and respond to unexpected deterioration of children.
Standard seven: Decrease unnecessary delay in all processes.
Standard eight: Develop clear measures of clinical outcomes to provide evidence of Top Five Children's hospitals status.
Standard nine: Measure and continually improve the experience of children and families.
Standard 10: Provide equal access to all children who need our care.

GOSH is recognised nationally and internationally as an organisation that shares learning. The team have developed collaborations with other hospitals and individuals with a passion for sharing knowledge on improving healthcare for children.

Great Ormond Street Hospital response to the *Francis Report*

The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, known as the *Francis Report*, was published in February 2013. GOSH has responded by establishing a working group, chaired by the Co-medical Director, Professor Martin Elliott.

At GOSH it is our intention to ensure that in everything we do, across every department, for every patient, we provide the quality of care that we would want for our own family. This is implied in our Trust motto 'The child first and always', and the Francis working group aims to build upon the passionate commitment of our staff to ensure that we consistently deliver this aim.

As the *Francis Report* and recommendations are very detailed, the working group has organised the recommendations by theme. This has enabled us to communicate coherently with staff, patients, families and the public about our response to the report and our planned actions. The themes identified are:

1. values
2. candour
3. listening
4. compassion
5. quality and excellence
6. monitoring and measuring

The working group is developing an action plan to address the themes and ensure that patients receive the highest quality care. The plan will be reported to the Trust Board and the Clinical Governance Committee will seek assurance that the plans are being implemented during the year.

Redevelopment of the hospital site at Great Ormond Street Hospital

Great Ormond Street Hospital (GOSH) is undertaking a major redevelopment programme to replace buildings which are nearing the end of their useful lives, and to provide new world-class facilities.

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

Phase 2

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.

The MSCB was formally opened in June 2012. We continued work on the design implementation of Phase 2B of the Mittal Children's Medical Centre (redevelopment of the Cardiac Wing) in preparation for seeking tenders for construction which is due for completion in 2017.

Phase 3

We continue to work with GOSH Children's Charity and the UCL Institute of Child Health on Phase 3A of the redevelopment programme. This will see the development of new clinical and research facilities on the old University of London Computing Centre site in 2017.

Introduction

Key Indicators	2011/12 (Proforma)*	2012/13	Increase / Decrease
NHS Clinical Income on continuing operations	£253.9m	£ 261.7m	+3.1%
Total Income**	£336.0m	£358.3m	+6.6%
Earnings before interest, tax, depreciation and amortisation (EBITDA)**	£22.8m	£27.0m	+18.0%
EBITDA margin	6.8%	7.5%	
Inpatient Episodes	40,377	42,123	+4.3%
Theatre episodes	9,891	10,274	+3.9%
Staff survey – relative job satisfaction score***	99%	102%	+3.6%
Patient and family satisfaction rates (national average 60%)	96%	93%	-3.1%

* Financial information for 2011/12 includes the results of the Great Ormond Street Hospital for Children NHS Foundation Trust for 11 months to 29.02.12 and for the GOSH Foundation Trust for one month to 31.03.12
** Excludes capital donations and in 2011/12 excludes discontinued operations
*** Relative to national average

This year has been a challenging but successful year for Great Ormond Street Hospital (GOSH). Our well established 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 income and clinical activity has grown. The staff survey job satisfaction score improved in relative terms and our patient and family satisfaction rates, though lower than last year, remained well above the national average.

In 2012 we retained full Care Quality Commission (CQC) 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, harm and risks. Some of our key achievements include reducing prescribing errors by up to 60 per cent in a number of high risk areas and maintaining a reduced rate of 2.0 line infections per 1,000 bed days, down from 2.8 in 2011.

In October 2012, we were assessed by the National Health Service Litigation Authority[1] against the Level 3 Risk Management Standards for Acute Trusts. Each Level results in a 10 per cent discount on Trust contributions to claims, with Level 3 (30%) being the highest. The Trust is currently 1 of 37 NHS organisations to achieve NHSLA Level 3.

Last year we were appointed as one of only four centres in the country for the provision of specialist epilepsy services following the first phase of the National Safe and Sustainable Paediatric Surgery reviews. The reviews aim to rationalise the number of specialist centres to ensure the best outcomes for children who need congenital cardiac surgery and neurosurgery.

We have continued to meet the national waiting time standards with over 90 per cent of our admitted patients and over 95 per cent of our non-admitted patients being seen within 18 weeks. With the exception of one month, April 2012, the percentage of patients who are yet to be seen but have not waited longer than 18 weeks (ie incomplete pathways) has also remained above the 92 per cent standard for the year. We have also continued to achieve 100 per cent compliance against all relevant cancer waiting standards and have consistently met the six week diagnostic waiting time target over the last seven months.

Over the first three-quarters of the financial year we have reported 100 per cent compliance against all our Commissioning for Quality and Innovation (CQUIN) indicator milestones against a number of measures relating to reducing harm and infection and improving patient experience, public health and patient flow. At year end we reported over 99 per cent compliance against our CQUIN indicators.

We have realised much of our growth plans, with significant increases across Cardiac Surgery and Cardiology, Neurosurgery and Spinal Surgery.

1. The NHS Litigation Authority (NHSLA) is a Special Health Authority, which was established in 1995. The NHSLA administers the Clinical Negligence Scheme for Trusts (CNST) and the Liabilities to Third Parties Scheme (LTPS) and the Property Expenses Scheme (PES), together known as the Risk Pooling Schemes for Trusts (RPST).

Performance against objectives in 2012/13

In 2012/13 we developed 19 key workstreams, each with a series of supporting actions that would move us towards achievement of our seven strategic objectives. We have made good progress against the milestones that we set with 26 of the 36 actions assessed as being 'achieved' and 10 assessed as 'partially achieved' at year end.

The table below outlines our progress against our objectives and supporting workstreams and actions.

Table one: progress against Trust objectives, 2012/13

Objective / Work-stream	Action to deliver workstream	Year end evaluation
Objective 1. Consistently deliver clinical outcomes that place us amongst the top five Children's Hospitals in the world		
1.1 Maintain our focus on zero harm	Continue our work to reduce drug errors.	Partially achieved
	Continue our work on reducing infection rates.	Achieved
	Maintain child protection and broader safeguarding structures and processes to ensure effective safeguarding of all children and young people.	Achieved
	Ensure effective provision of nutritional care for all patients.	Achieved
	Ensure provision of safe services for the deteriorating and critically ill child, including the development of a work plan in response to the critical care review.	Achieved
	Ensure consenting processes for treatment meet necessary standards and exceed patient and family expectations.	Partially achieved
1.2 Improve our measurement of clinical outcomes and demonstrable continued improvement in outcomes	Continue developing outcome measures and benchmarking.	Achieved
	Ensure accountability for delivery of Commissioning for Quality & Innovation (CQUIN) targets are fully devolved operationally and monitored regularly.	Achieved
Objective 2. Consistently deliver an excellent experience that exceeds our patient, family and referrer expectations		
2.1 Continue to reduce waiting times further through our 'no waits' programme	Continue to meet national and commissioning standards for waiting times and improve the utilisation and efficiency of our resources.	Achieved
2.2 Continually improve the standard of customer service that we offer patients and families	Implement year one of the Patient and Public Involvement and Experience (PPIE) strategic plan including the agreement of a method to measuring patient experience.	Achieved
2.3 Continue to improve our relationships with referrers in order to achieve our market share objective.	Continue to implement the actions for improvement following the results of the Referrer Survey including producing a directory, improving clinical letter turnaround times along with implementing an electronic bed management solution.	Achieved
2.4 Continue to improve the patient environment through major upgrades, working closely with our charitable partners	Invest within our 10 year capital programme to improve the patient environment within our existing buildings and continue progress on redevelopment of new buildings within agreed timescale and budget. This includes the agreement of the full business case for 2B and the continuing progress of the case for 3A.	Partially achieved
	Ensure that we maximise the advantages of our new clinical building.	Achieved

Table one: progress against Trust objectives, 2012/13 (continued)

Objective / Workstream	Action to deliver workstream	Year end evaluation
Objective 3. Successfully deliver our clinical growth strategy		
3.1 Deliver our planned in year growth	Deliver our planned growth in line with population changes and specific growth across specialties as defined in our Integrated Business Plan (IBP).	Achieved
3.2 Maintain International Private Patient (IPP) service growth	Improve patient access and staff recruitment and retention to ensure IPP income target growth is achieved (assuming income cap is lifted).	Achieved
3.3 Position ourselves as a pan-London leader of networked paediatric services, providing co-ordination, training and education and setting standards	Achieve accreditation as a national paediatric centre for cardiac surgery and neuro surgery through the new national processes, and plan to accommodate any further growth that arises from this process.	Achieved
	Be intrinsically involved with the establishment of a North Thames paediatric network ensuring that we obtain the expected market share gains.	Achieved
Objective 4. With partners, maintain and develop our position as the UK's top children's research organisation		
4.1 Deliver the Research Strategy	Deliver the UCL GOSH Biomedical Research Centre (BRC) meeting milestones for year 1.	Achieved
	Continue to develop academic and commercial partnerships for research.	Achieved
	Increase research activity and income for the Trust, and measure and report impact.	Partially achieved
4.2 Continue to improve the mechanisms for the management of research within the Trust	Continue to improve the mechanisms for the management of research within the Trust in line with the National Institute for Health Research (NIHR) requirements.	Partially achieved
Objective 5. Be the provider of choice for specialist paediatric education and ensure our staff have the skills they need		
5.1 Deliver the Education and Training Strategy	Deliver education, training and organisational development to support service transformation at GOSH.	Partially achieved
	To work with our partners to market our education and training programmes locally, nationally and globally.	Achieved
Objective 6. Deliver a financially stable organisation		
6.1 Agree achievable Cash Releasing Efficiency Scheme (CRES) plan and ensure delivery through robust project and performance management	Agree robust plans for the delivery of the CRES programme and ensure that these plans are delivered.	Achieved
	Deliver surplus to plan.	Achieved
6.2 Improve efficiency and productivity through our Transformation Programme	Deliver operational efficiencies through the devolved Transformation team and engine-room projects including theatres, beds and Magnetic Resonance Imaging (MRI) usage.	Achieved
	Develop workforce to improve productivity and enhance patient experience.	Achieved

Performance against objectives in 2012/13
continued

Table one: progress against Trust objectives, 2012/13 (continued)

Objective / Workstream	Action to deliver workstream	Year end evaluation
Objective 6. Deliver a financially stable organisation		
6.3 Ensure appropriate funding for our clinical services from commissioners	Work with other specialist paediatric providers to develop rationale for changes in specialist tariffs.	Achieved
	Ensure risks of changes to commissioning structures are managed and minimised and new commissioning support processes are established in collaboration with the specialist commissioner.	Achieved
6.4 Support the charity to raise targeted funds	Maintain good communication between GOSH and GOSH Children's Charity at all levels to ensure fundraising targets are met.	Achieved
Objective 7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation		
7.1 Develop as a Foundation Trust	Develop the function of the Members' Council and maintain the membership.	Achieved
7.2 Ensure that the Trust is compliant with regulatory requirements	Ensure that the Trust retains registered status as a Foundation Trust, with Care Quality Commission (CQC) along with attaining NHSLA level three.	Achieved
7.3 Improve efficiency of business processes	Improve the quality and access to critical information relating to the Trust's strategic and operational objectives.	Partially achieved
	Develop a robust Information Strategy including appropriate SMART objectives and a clear delivery plan.	Partially achieved
	Deliver the Trust's Information Technology plan – including successful implementation of CareVue, Picture Archiving and Communications (PACs) and Order Comms systems.	Partially achieved
	Continue to develop management and leadership across the Trust including specific plan to target Specialty Leads.	Partially achieved

We will continue to ensure all outstanding workstreams are progressed. These broadly include:

- Rolling out and embedding our revised consent policy across all clinical divisions to ensure high quality consenting for treatment at the Trust and to make consent a better experience for patients and their families and carers.
- Reducing our drug error rates through a phased pan-Trust roll out of a Centralised Intravenous Additive Service (CIVAS) for the preparation of drugs.
- Identifying Research and Innovation (R&I) funding opportunities to ensure that we can continue to provide world-class research.
- Continuing our extensive capital programme, ensuring all planned phases of development are realised.
- Embedding our revised Information Strategy to support the improvement of patient experience, increased efficiency, and improved safety across all services and departments and continuing to improve our IT systems through the implementation of an electronic document record management system to replace our existing paper records.
- We will also continue to develop our managers across the organisation through new leadership programmes and a new Learning Management System, to ensure that we are able to better deliver education, training and organisational development to support service transformation.

Performance of services in 2012/13

As an acute specialist trust, the hospital has divided healthcare services into seven divisions including the International and Private Patients (IPP) division and research and innovation division. Within each division, we have outlined below the key developments to services over the last year.

Critical Care and Cardio-respiratory

This division provides intensive care support and management of children from both within the hospital and direct transfers from other hospitals. Intensive care is provided in Paediatric Intensive Care (PICU), Neonatal Intensive Care (NICU) and Cardiac Intensive Care (CICU).

Cardio-respiratory services provide management of children with congenital and acquired heart and lung disease. Following a best practice review of the Trust's intensive care services, PICU/NICU merged with Cardio-respiratory. As part of a move to new facilities within the recently completed Morgan Stanley Clinical Building (MSCB) and in order to meet demand we additionally increased our capacity within CICU and our high dependency ward. A key feature of our growth last year included cardiac surgery bypass procedures. We undertook more of these over the year than ever before and the service remains the largest of its kind in Europe.

The service continues to focus on improving quality and safety. For example, in the last year we reported reductions in prescribing errors, particularly within CICU, which reduced by 33 per cent. A programme trialling new drugs and treatment regimes for pulmonary hypertension was also introduced and the service commenced its cystic fibrosis INSPIRE programme, which aims to reduce the number of hospital admissions and the use of antibiotics by increasing patient activity through local physiotherapy services.

Infection, Cancer, Immunology and Laboratory Medicine

The division manages patients with cancer, infectious diseases, problems with fighting infections (immunology) and rheumatology and dermatology. The hospital's main laboratory services (with the exception of genetics) are part of this division. In the last year the division has worked on strengthening its research infrastructure and links in haematology and oncology, so that even more children can be offered innovative treatments within the context of clinical trials.

Successful patient care extends beyond the doors of the hospital and the Great Ormond Street Hospital (GOSH) team is working hard on improving links and communication with clinical teams in other hospitals who share the care of our patients. The number of patients offered specialist care has continued to increase, in particular due to the increase in demand for the dermatology laser and non-inflammatory rheumatology services. The laboratories continue to increase the number of specialist diagnostic tests they provide, and with funding from the British Research Council, have been able to transfer the latest research findings into diagnostic and monitoring tests that will help all the Trust's patients.

Medicine, Diagnostic and Therapy services

The division provides services to children with medical conditions and manages many of the hospital's clinical support services such as Radiology, Physiotherapy and Pharmacy. Over the last financial year we have successfully implemented an Interventional Radiology (IR) on-call service which went live in April 2013. The Imaging Services have also been successfully reassessed and accredited by the UK Accreditation Service as a nationally accredited paediatric imaging service.

In the last year we purchased a high throughput, high-capacity next-generation DNA Sequencer. The new system can sequence many millions of chemical bases in a single experiment. This means we can effectively look at all of the genes contained in the human genome (more than 20,000) in one experiment. Previously, we would have had to analyse one gene at a time. This offers many new and exciting opportunities for the service in the diagnosis of genetic disease.

Neurosciences Clinical division

The division provides services to children with conditions of the brain or eyes. The division also contains the General Paediatric team. The Ophthalmology department has undertaken a review of medical workforce, which has enabled them to establish a new joint-consultant post with Moorfields Eye Hospital.

Surgery Clinical division

This division provides services to children who require surgical treatments and also manages theatres and the anaesthetic department. During 2012 we opened an additional, eleventh theatre, enabling expansion in neurosurgery, urology, general and neonatal surgery, ear nose and throat, and cardiac surgery. We also opened a new, eight-bed, short-stay unit to support this. We continued our work to improve the pathway for complex patients undergoing spinal surgery, launching a combined investigation day at which patients get all the tests and assessments needed prior to surgery.

International and Private Patients (IPP)

In 2012/13 IPP clinical income delivered a growth of over 40 per cent from the previous financial year. This was achieved through the planned opening of all of the beds in the International division to a maximum of 43. The majority of IPP patients continue to be referred from the Middle East, mainly Kuwait, United Arab Emirates and Saudi Arabia. There has also been an increase in patients referred from Bahrain and Libya. These have compensated for the reducing patient flows from Greece and Cyprus due to the economic constraints in these countries.

The provision of an education and training programme to Kuwait is in the third year of the current contract and discussions regarding renewal and expansion are underway.

The division has completed a workforce review of clinical and non-clinical staff and a restructure has been implemented to improve the clinical leadership and quality of the patient experience. An annual plan of patient surveys has also been developed for 2013/14.

Research and Innovation division

The Research and Innovation division comprises the GOSH-UCL Biomedical Research Centre (BRC), the Clinical Research Facility (CRF) and the Joint Research and Development Office. The division attracts around £14m in research funding per annum to the Trust, of which £1 million is received by the Medicines for Children Local Research Network which is hosted by the Trust.

The division keeps track of the progress of funding applications and active projects. These projects contribute to more than 1,000 peer reviewed publications produced by GOSH and the Institute of Child Health each year. At the end of March 2013 there were almost 600 active research projects ongoing.

Financial review for 2012/13

The Trust attained NHS Foundation Trust status on 1 March 2012 and as a result was required to prepare its first set of accounts for the one month to 31 March 2012. Prior to this, the operations of the Trust were carried out by the Great Ormond Street Hospital for Children NHS Trust.

The Trust's financial statements have been prepared in accordance with Monitor guidance, the independent regulator for Foundation Trusts. They are also prepared to comply with International Financial Reporting Standards (IFRS) as adopted by the European Union and are designed to present a true and fair view of the Trust's financial activities.

This section provides a review of the financial performance for the year ended 31 March 2013, and provides comparative information based on proforma unaudited financial information for the year ended 31 March 2012 derived from combining the financial results for the NHS Trust and the NHS Foundation Trust. The proforma information has been provided to allow a better understanding of year-on-year trends.

NHS organisations were required to fully comply with IAS 20 (accounting for government grants and disclosure of government assistance) in relation to the treatment of donated assets with effect from 1 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 08. In order to better understand the trends in income, the earnings before tax, interest, depreciation and amortisation (EBITDA) and net surplus financial information has been shown in the table below both exclusive and inclusive of donations for capital. In addition, to improve comparability, the proforma 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 2011) and the impairment charges to the revenue account arising from the annual revaluation of buildings.

	One month ended 31.03.12	Proforma unaudited year ended 31.03.12	Growth in 2011/12 %	Year ended **31.03.13**	Growth in 2012/13 %
For the period ended					
Operating income excluding donations for capital	32.8	336.0	5.3%	**358.3**	6.6%
Donations for capital	4.3	28.2		**13.6**	
Total income	37.1	364.2		**371.9**	
Operating expenses	(30.7)	(313.1)	5.5%	**(331.3)**	5.8%
Earnings before interest, tax and depreciation					
• Including donations for capital	6.4	51.0		**40.6**	
• **Excluding donations for capital**	**2.1**	**22.8**	**2.3%**	**27.0**	**18.2%**
Net surplus					
• Including donations for capital and impairments	4.9	18.4		**12.2**	
• **Excluding donations for capital and impairments**	**0.6**	**2.5**		**2.4**	
As at the end of the period					
Assets employed	351.1	351.1		**363.1**	
Key ratios					
Earnings before interest, taxes, depreciation and amortisation as a percentage of gross income excluding donations for capital	6.6%	6.8%		7.5%	
Operating margin as a percentage of gross income excluding donations for capital and impairment charges	1.9%	0.7%		0.7%	

The following trends relate to the annual growth relative to the combined results of the NHS Foundation Trust and the NHS Trust and adjusted as in the table above:

- Operating income increased by 6.6 per cent as a result of growth in patient care both in NHS services and growth in International and Private Patient (IPP)activity following the removal of the private patient cap.
- Operating expenses excluding depreciation and impairment charges increased by 5.8 per cent on the previous year.
- Staff costs increased by 3.7 per cent as a result of an increase in average staff numbers to deliver the growth in services and research and development activity by 2.3 per cent, and as a result of pay increases.
- There were impairment charges totalling £3.7 million (2011/12 proforma: £12.3 million) resulting from the Trust's revaluation of its land and buildings.
- We continued to invest considerable sums to improve the hospital's facilities. In addition to the expenditure on the new redevelopment programme, there was also expenditure on other hospital buildings, medical equipment and our IT systems. In total, £19.2 million was invested across the site during 2012/13, of which £13.6 million was funded by Great Ormond Street Hospital Children's Charity and the balance funded from internal resources.

We delivered a financial surplus of £8.2 million for the year (excluding £13.6 million of donations funding capital expenditure), out of which a dividend of £5.8 million goes back to the government, leaving £2.4 million retained for future investment in services.

Net assets employed

The value of property, plant, equipment and intangible assets was £327.9 million at 31 March 2013. This was the net result of the additional capital expenditure of £19.2 million less the impact of depreciation of £18.8 million and the impact of revaluations of £4.0 million.

Net current assets (excluding receivables due in more than a year) stood at £34.4 million, the increase of £15.7 million being due to the increase in cash of £11.8 million to £38.4 million, a reduction in trade payables of £4.9 million less other movements netting to £1.0 million.

Productivity improvements and efficiency savings

The Trust continued to pursue productivity and efficiency savings, the target for the year being £13.1 million, approximately 5.0 per cent of influenceable expenditure. Approximately 99.1 per cent of the target was achieved and without any adverse impact on the quality of our clinical services. The efficiency programme includes both initiatives that will increase activity and the associated income with lower increases in cost, and those that reduce costs with no reduction in income. This is most notable in the changes in models of delivery 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's BPPC performance for non-NHS creditor payments fell slightly: it achieved payment of supplier invoices within 30 days of 85.5 per cent (2012 figure: 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 period.

Statement of compliance with cost allocation and charging

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

Countering fraud

The Trust has a countering fraud and corruption strategy which was approved during the year.

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

Corporate social responsibility

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

- 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.
- Be aware of the impact of our buildings and ensure that we manage them effectively to avoid any detrimental environmental impact.
- Engage our stakeholders to work with us to deliver our Sustainable Development Management Plan.
- Work in partnership on many different levels to enable the most effective use of resource but also to share best practice.

Sustainability

The Trust is committed to its sustainability agenda and has developed an annual Sustainable Development Management Plan (SDMP).

The SDMP for 2013 focussed on the following key priorities: finance, energy and carbon management, water and waste management review, travel and transport, procurement and design and operation of buildings.

Table one summarises Trust performance in 2012/13 for measured carbon emissions.

Waste

The Trust has reviewed its arrangements for waste and has introduced a total waste management provision for all waste streams including chemical waste. Revised waste segregation facilities and procedures have been implemented along with waste and recycling awareness campaigns.

The Trust has invested in a food waste composter that returns food waste to grey water. It is planned to develop this waste stream for patient food.

An additional compactor has been installed in the Trust waste compound which has enabled greater segregation and an increase in the amount of mixed recycling generated. The Trust recovers and recycles 220 tonnes of waste which is 16 per cent of total waste produced.

Table two summarises the total expenditure on waste in 2012/13.

Table one: gross scope 1-3 carbon emissions

	Unit		2011/12	2012/13
Emissions as a result of electricity consumption	kWH	Electricity	13,991	10,463
Emissions as a result of gas consumption	kWh	Gas	4,602	9,695*
Emissions as a result of business travel – air	km	Air	182	196
Emissions as a result of business travel – road	miles	Road	–	–
Emissions as a result of business travel – rail	miles	Rail	9	10
Emissions as a result of other activities	tonnes	Other	–	–

* The past year has seen Great Ormond Street Hospital change its energy profile significantly as a result of the installation of a combined cooling heat and power generator. This technology is accepted as being a more efficient form of electricity generation rather than the conventional form of grid-sourced electricity. The generator runs on gas 24/7 and it is therefore expected that the Trust's gas consumption and emissions from gas combustion have increased in 2012/13. However, this is off-set by the reduction in emissions from electricity consumption. These measures have resulted in our relative energy consumption from the grid being reduced by 15 per cent.

Table two: total expenditure on waste

	2011/12 £	2012/13 £
Total waste arising	345,079	**340,919**
Waste sent to landfill	21,750	**29,955**
Waste recycled/ reused	67,693	**32,096**
Waste incinerated/ energy from waste	255,653	**278,868**

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 was a significant year for improving energy management at Great Ormond Street Hospital (GOSH). The Morgan Stanley Clinical Building (MSCB) and the new Energy Centre opened, which significantly changed the Trust's energy profile. The Trust now generates around half its electricity base load on-site through a combined cooling, heat and power generator. The generation of electricity on-site is a more efficient process than electricity being produced at a power station and being delivered to the hospital. Furthermore, the by-product of the electricity generation, heat, has been used to provide part of our heating and cooling needs.

However, the first year performance of the Energy Centre has not proven to be as efficient as expected and investigative work has been carried out to assess this. Improvements that need to be made to the design will be carried out in this year. The Trust's actual CO_2 footprint has risen by 7 per cent to 18,300 tonnes – this is in part due to the increase in the Trust's estate with the addition of the MSCB. However, our carbon intensity has reduced by 12.5 per cent, meaning we heat and power our estate more efficiently.

There are currently 11 energy efficiency related projects being looked at by the Trust which are at different stages of completion.

We are investigating the possibility of the Trust providing our excess spare heat to residents in the local community housing estate. This project, if viable, would enable the Trust to increase its energy efficiency by utilising its waste heat, with the aim to assist the local residents.

Figure one: CRC emissions in tonnes between 2010/11 and 2012/13

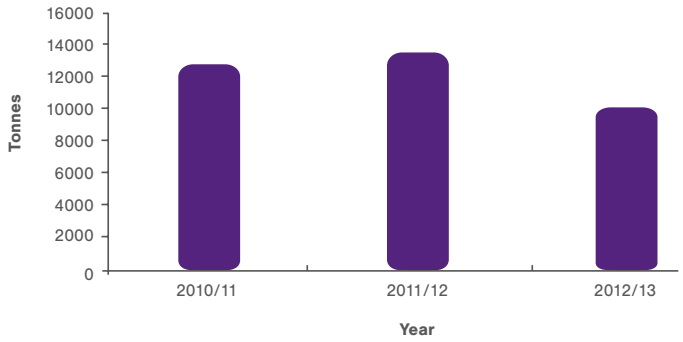
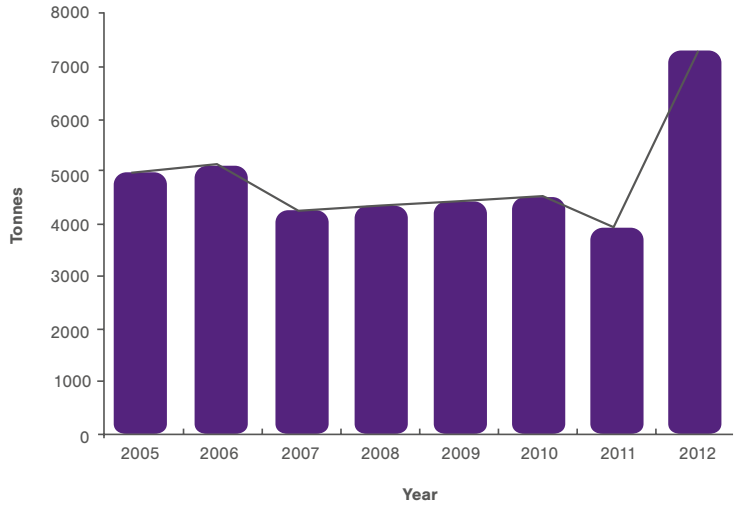


Figure two: EU Emissions Trading System emissions in tonnes between 2005 and 2012



Corporate social responsibility
continued

Engagement
In 2012 the sustainability leads ran three successful engagement events, Climate Week, NHS Change Day and NHS Sustainability Day of Action. These events focused on promoting sustainability initiatives such as meat-free low-carbon menus, waste management and recycling, reduction in use of resources and energy and water conservation.

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

Procurement including food
Work is underway to procure food more efficiently and 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
The redevelopment energy strategy set a target of 120 per cent carbon reduction and 60 per cent renewable contribution from its new developments with over 70 per cent carbon reduction and 25 per cent renewable contribution site wide.

The stated objectives from the strategy are as follows:

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

Governance and monitoring
The Sustainable Development Management Plan is monitored and managed through the Trust's Sustainable Development Committee which produces an annual report to the Trust Board.

The Trust reports on several mandatory measures and requirements on sustainability and has governance arrangements in place to support this.

Regulatory ratings

Each quarter, Monitor evaluates the Trust's risk of failure to comply with its Terms of Authorisation. Monitor publishes two risk ratings: a financial risk rating (rated 1–5, where 1 represents the highest risk and 5 the lowest); and a governance risk rating (rated red, amber-red, amber-green or green where red represents a likely or actual significant breach of terms of authorisation and green reflects no material concerns).

Governance risk rating

The governance risk rating reflects the quality of governance at the Trust and is made up of a number of elements including:

- Performance against a range of national measures.
- Third party reports including the Trust's compliance with the Care Quality Commission (CQC) essential standards of care.
- Declared risk of failure to deliver mandatory services.

Overall, and as outlined below, we have continued to meet the CQC essential standards of care for all periods in the year. We performed well against all national performance targets including cancer waiting time standards. We achieved the 18 week referral to treatment waiting time standards for all months (with the exception of April 2012) and our MRSA and Clostridium difficile infection rates were reported within tolerance for each quarter of the year. On this basis we achieved a governance risk rating of 'amber-green' for the first quarter of the year and 'green' for the following three quarters.

Finance risk rating

This rating is a weighted average of specific ratings determined from a range of measures derived from the Trust's overall earnings and operating margins, return on assets and liquidity and the extent to which the Trust achieved the targeted earnings within its financial plan. A rating of 4 was achieved in each quarter which was in line with the Trust's plan.

2012/13	Q1	Q2	Q3	Q4
Governance risk rating	Amber-green	Green	Green	Green
Financial risk rating	4	4	4	4

Management of risks to achievement of the Trust strategic objectives

The Trust Board Assurance Framework (BAF) details the risk to the achievement of our strategic objectives. It is informed by local clinical division risk registers and external intelligence and is continuously updated from incidents, complaints and audit. The table below presents the principle risks from the assurance framework and the controls in place to reduce the risk.

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. • Designated area on Infection, Cancer, Immunity & Laboratory Medicine for prescriptions to be written. • Separate drug preparation rooms.
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. • Root cause analysis investigation performed for all hospital acquired infections.
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 Division 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 division covering clinical outcomes.
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. • Weekly review of 2222 (in-patient emergency calls) outside ICU • Use of Situation, Background, Assessment, Recommendation, Decision (SBARD) to improve communication of clinical status. • Children's Early Warning System (CEWS) helps clinical staff recognise patients at risk of deterioration. • All staff receive training on CEWS and SBARD on induction.
Appropriately qualified and trained staff may not always obtain fully informed consent or not obtain consent from the correct person	• Consent policy and forms in place. • Training in consent provided at corporate induction and on update basis by the legal team. • Commenced pan-Trust consent project to improve ability to take full informed consent for all appropriate procedures. • Local induction training provided where consent is delegated. • Monitoring of incidents where consent process fails.

Key risk	Mitigating action
We may not work effectively across multiple teams or with parents to manage complex patients	• Multi-disciplinary tram meetings in place to discuss patients. • General Paediatricians and Clinical Site Practitioners work across all teams. • Patient Advice and Liaison Service (PALS) and complaints teams available to support families where they do not feel that the hospital is working with them appropriately. • Monitoring of the production and turnaround times of clinical correspondence (discharge summaries and clinic letters) and waiting times.
We may fail to maintain compliance with regulatory and legislative requirements	• Identification of leads for managing regulatory requirements. • Risk, Assurance and Compliance Group (RACG) 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.
The redevelopment of the site may not meet delivery timescales or financial or operational expectations	• Robust project management processes. • Use of external advisers on design and project management. • Effective project specific risk identification and contingency planning for any service risks.
We may not deliver the IT and Information strategies	• Investment to strengthen infrastructure and progressively upgrade or replace clinical systems. • Maintenance agreements for all key systems. • Business continuity plan. • IT investment plan to be reviewed and updated during 2013/14.
We may not be able to recruit and retain key staff	• HR, 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.
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 (PLICS) 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. • Monitoring and responding to developments in changes in the Medical Education tariff in 2013/14.
We may not meet financial and operational expectations or timescales to achieve process efficiencies and deliver electronic patient record systems through investment in IT/ Information systems	• Targeted investment plan and effective project management of each investment project. • IT Investment Plan regularly updated and monitored by the Technical Delivery Board. • Information work plan agreed and information strategy vision developed. • IT elements of business continuity plan in place.

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; changes to the annually determined research and development funding and changes in the commissioning environment. The challenging economic environment will continue to put 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 principle objectives for 2013/14.

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 receivables and payables 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 and provides education services in another 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 not a significant concern due to the low rates of interest obtainable on readily accessible cash deposits.

Emergency planning

Planning for major incidents and business continuity events, together with managing the associated risks, is extremely important. These plans provide us with guidance and the framework to manage our response. All preparedness plans are reviewed annually to incorporate learning from previous incidents and events. Our plans are developed and maintained in conjunction with the other responders and are compliant with the Civil Contingencies Act 2004 and other relevant guidance.

During 2012, significant planning was conducted around the need to ensure 'business as usual' during the Olympic Games. This has resulted in more resilient working practices in some areas of the Trust.

Specialised resilience 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.

The Trust continues to work closely with local partners through the Camden Resilience Forum and other key stakeholders to ensure that when a disruptive challenge is encountered we understand our role in the multi-agency response.

Information governance

Information governance risks are monitored by the Trust's Information Governance Steering Group. The Trust takes information governance related incidents very seriously. Any incidents involving the actual loss of personal information that could lead to harm or otherwise significantly impact individuals are considered serious. Three such serious information governance incidents were reported to the Information Commissioner's Office during the 2012/13 financial year. All of these incidents involved clinical letters intended for patient's families being posted to an out-of-date address. Actions are being taken to prevent such incidents occurring.

A summary of all information governance incidents is provided below.

A summary of information governance incidents in 2012/13

Category	Nature of incident	Total
I	Breach of patient confidentiality	32
II	Loss or theft of encrypted confidential information	1
III	Loss or theft of unencrypted confidential information	17
IV	Patient incorrectly or not identified	2
V	Other	31*

* includes patient information transferred/stored insecurely and IT system issues.

Safeguarding at Great Ormond Street Hospital

Great Ormond Street Hospital (GOSH) is committed to fulfilling our statutory responsibility to safeguard and promote the welfare of children and young people. Our Safeguarding Service has been restructured following extensive consultation in 2012, to ensure that the needs of our workforce are best met in the Trust to Safeguard Children and Young People effectively.

- Training has remained a priority throughout the past year. Staff are trained to a level appropriate to their role with the Trust meeting its target of over 80 per cent of staff trained against Level 1, 2 or 3 of the intercollegiate standards for safeguarding.
- Two inspections by the Care Quality Commission (CQC)/Ofsted were completed successfully in 2012/13.

The Social Work Service recorded contacts with 1601 children during 2012/13 which 216 (13.5 per cent) were relating to child protection.

The Safeguarding Team has set a number of priorities for 2013/14, including a commitment to continue to evolve effective systems to safeguard children within the Trust, to focus on supervision for wider staff groups and review child protection and safeguarding policies in line with national guidance.

External developments during 2012/13

National paediatric surgery reviews

There are currently two national 'Safe and Sustainable' reviews of specialist paediatric services being undertaken: a review of children's congenital heart services and a review of children's neurosurgical services. The reviews aim to transform services, providing better care and improved outcomes through concentrating care into fewer, larger specialist centres, as an integral part of clinical networks.

For congenital heart services networks are planned to be formally structured around Specialist Surgical Centres in Bristol, Birmingham, Liverpool, Newcastle and Southampton. Great Ormond Street Hospital (GOSH) and Evelina Children's Hospital are planned to lead the networks in London and the South East.

However, further to a High Court ruling and review by an independent reconfiguration panel, the final outcome of the process is currently unclear. Despite this, cardiac services at GOSH continue to grow and we are planning capacity expansions in theatres, intensive care and ward areas to meet current and expected demand across our services.

For Neurosurgery, a rationalisation of centres, particularly those undertaking highly specialised procedures, and more formal networks are also proposed.

London paediatric networks

Within London, the development of two tertiary paediatric networks is underway in order to deliver services in line with the NHS London publication 'Children's and Young People's Project – London's Specialised Children's Services: Guide for Commissioners', which recommended a rationalisation of the number of providers of specialist children's services whilst enabling as much care as possible to be provided closer to home. We see these changes as a positive development for children and families and will remain engaged in this process as it develops.

London 2012 honour

As estimated audience of over a billion people worldwide watched as GOSH took its place in the colourful spectacle of the London 2012 Opening Ceremony in July. Part way through the event, directed by film-maker Danny Boyle and titled 'Isles of Wonder', a tribute was made to the NHS, with a particular section focusing on GOSH. Hundreds of dancers formed the charity's logo with illuminated beds, before the stadium filled with characters from children's literature. *Harry Potter* author, JK Rowling, appeared, reading from JM Barrie's *Peter Pan*, a story with its own special connection to the hospital.

It was a wonderful honour for the hospital and a very special moment for the patients and staff at the hospital who were lucky enough to be involved. For the children who attended and their families, it was a moment they will treasure for a very long time.

Charitable income

Great Ormond Street Hospital Children's Charity raises money to enable the hospital to redevelop its estate, buy new equipment, fund paediatric research conducted at the hospital and its research partner, the UCL Institute of Child Health (ICH) and to support specific welfare projects such as family accommodation. In the year 2012/13, total fundraising income before expenses was £70.1 million, the highest amount the charity has ever raised in one year.

The charity has increased its fundraising activities over recent years, primarily to fund the major redevelopment of the hospital. In the year, the charity made commitments on grants to the hospital of £49.9 million: much of this was towards the redevelopment programme. The charity also made grants to the ICH and other organisations.

As well as upgrading old facilities, the hospital needs to increase its capacity so that it can treat more children who need its specialist expertise. In June 2012, the hospital formally opened the new Morgan Stanley Clinical Building, which is the first of two buildings within the Mittal Children's Medical Centre, with the second building scheduled to open in 2017.

In addition, the charity funded around £5.5 million's worth of equipment, which included a mass spectrometer for new born screening, a cardiac 3D echocardiogram and some beds and equipment for the paediatric intensive care unit.

The charity made research grants of £12.9 million, including funding for research into harder to treat leukaemia and for new surgery research to help children born with a rare facial condition known as craniosynostosis. The research aims to develop a number of distraction devices that will allow for both accurate planning and delivery of surgery. This year also saw the establishment of the Livingstone Skin Research Centre for Children, which is the first children's skin research centre in the world. It brings together leading scientists and clinicians in skin biology from the hospital and the ICH to find new and better treatments for children with rare skin conditions.

It also funded welfare projects for families and for staff amounting to £4 million. This includes the patient hotel, which means that children coming from all over the country for day cases can stay next to the hospital and not have to be admitted to an inpatient ward.

The hospital is so grateful to all our supporters who have fundraised or donated to the charity. The impact of the donations is clear to see to everyone who visits the hospital. Thank you to all of you.

Health and Social Care Act

The Health and Social Care Bill received Royal Assent on 27 March 2012. The Act restructured the NHS, including:

- Establishment of the NHS Commissioning Board.
- Introduction of the requirement for NHS trusts to operate under licence provided by Monitor
- Additional duties for governors (councillors) to hold the non-executive directors, individually and collectively, to account for the performance of the board of directors and to represent the interests of the members of the trust as a whole and the interests of the public.

Over the past year, the Trust has sought to develop systems to align with these changes and ensure compliance with the Act.

Looking to the future

Our objectives for 2013/14

Our overarching aim is summarised in our mission statement, 'The Child First and Always', and our vision is that through the work undertaken at Great Ormond Street Hospital (GOSH), more sick children across the world get better and have a higher quality of life than is possible today. We wish to be seen by all our stakeholders as absolutely committed to delivering this, in partnership with families, other healthcare providers and other agencies.

In developing our priority objectives for the year ahead, we have considered our purpose and values and the internal and external contexts in which we will be operating during 2013/14 and beyond. Together with a review of our past year performance we identified drivers, opportunities and threats and reviewed our own organisational capacity and capability to manage these effectively.

Following this process we have slightly revised our strategic objectives, notably to reflect a greater appreciation of the importance of our workforce and clinical interfaces with healthcare partners.

Our objectives for 2013/14 are to:

1. Consistently deliver an excellent and compassionate experience for our patients and their families.
2. Consistently deliver world class clinical outcomes.
3. Work with clinical networks, partner providers and referrers to deliver streamlined patient pathways.
4. With partners maintain and develop our position as the UK's top children's research and innovation organisation.
5. Continue to deliver high-quality specialist paediatric multi-professional healthcare education.
6. Equip all staff with the knowledge, skills and training to deliver high quality compassionate care.
7. Continue to redevelop and improve the hospital's estate to provide high quality accommodation for current and future patients.
8. Be a financially stable organisation and promote the sustainable use of resources.

Review of Trust strategy

We are in the process of reviewing the Trust-wide strategy by developing and aligning the current multiple strategic strands into a cohesive strategy. It is anticipated that the review will be completed within 2013, with ongoing work to ensure that this is fully owned and embedded within the Trust and the Trust's risk management objectives.

As an acute specialist Trust, the hospital has divided its services into seven divisions including the International and Private Patient's division and Research and Innovation division. Within each division, we have outlined below the key developments to services over the last year.

Service priorities for 2013/14

Outlined below are the key priorities for the divisions in 2013/14.

Critical Care and Cardiorespiratory

During the year the team plan to move the Neonatal Intensive Care Unit (NICU) to a dedicated area and to expand all intensive care services to allow more children to be treated.

The Cardiorespiratory service plans to continue to expand and to strengthen outreach for the cardiology, fetal and respiratory network. Badger Ward, for children and young people with long-term breathing problems, will move to a larger unit on Victoria Ward as part of the next phase of the Trust's redevelopment project. We also plan to integrate all measures that reflect the overall quality of care we deliver to our patients and effectively communicate these to all areas of the division. These include clinical outcome measures and patient experience measures.

Infection, Cancer, Immunology and Laboratory Medicine

A particular focus this year is on oncology shared care hospitals and rheumatology networks with the aim to improve the education provided to their staff. New models of care are being adopted which include training a number of nurse practitioners across the division and the appointment of a nurse consultant role in palliative care.

Medicine, Diagnostic and Therapy services

In the coming year, the division is implementing a new medical ward reconfiguration which will have significant positive impacts for patient care on the wards. The Adolescent Team are leading on a Trust-wide Commissioning for Quality and Innovation (CQUIN) to ensure that planning arrangements are firmly in place for the transfer of care of young people from paediatric to adult services.

All specialties are developing networks in line with tertiary commissioning guidelines. We are leading on an Imaging Strategy (Trust-wide) for the coming 10 years, and this will inform the purchase of a new MRI. Our Pharmacy department is developing a strategy for medicines production across London. The Therapies and Psychosocial services continue to develop Service Level Agreements (SLAs) with clinical divisions.

Neurosciences clinical division

In 2013/14 the division will take on responsibility for the Clinical Site Practitioners and bed managers. In November 2012, the Trust was officially commissioned as a Children's Epilepsy Surgery Service (CESS), which will allow us to further develop our assessment and treatment for children with complex epilepsy.

Surgery clinical division

In 2013/14 the division plans to launch global standardised pre operative assessment for all patients having a general anaesthetic, further reducing risk and improving the quality of experience for patients and families. The new procedure floor, combining a new same-day admissions unit, theatres and post-anaesthetic care unit, will also be opened.

Research and Innovation division

Key components of our research programmes for the year ahead include supporting research infrastructure and research training programmes and developing a patient and public involvement strategy for research.
The division will continue to work closely with our local comprehensive research network to maximise research support funding and to streamline processes and procedures in order to facilitate research.
We will further develop links with our commercial partners and develop a strategy for identifying and supporting innovation within the Trust.

International and Private Patients (IPP) at Great Ormond Street Hospital

The division has completed a workforce review of clinical and non-clinical staff and a restructure has been implemented to improve the clinical leadership and quality of the patient experience. An annual plan of patient surveys has also been developed for next year.

The relaxation of the private patient income cap as part of the Health and Social Care Act 2012 enabled the IPP strategy to be revised for 2013/2014. A group was configured consisting of executives, non-executives, Members' Council representatives and IPP staff. Recommendations were made and accepted at the Trust Board and Members' Council. The strategy for next year has three main streams:

1. **Treatment in London:** In 2013/2014 there will be an increase in the numbers of cardiac and nephrology patients by using currently unresourced beds with additional staffing.
2. **Education and training and consultancy:** The plan is to continue in Kuwait and other opportunities will be assessed as they arise.
3. **Treatment overseas:** Opportunities are being explored to provide treatment overseas and, if any proceed, a scoping exercise will need to be completed.

Transformation at Great Ormond Street Hospital

Our safety programme aims to minimise incidents, harm and risks through reflective organisational learning and which includes, for example, understanding the nature of harm through the continuous use of the paediatric trigger tool (PTT), improving prescribing and administration of medications and decreasing hospital acquired infection rates such as Methicillin-resistant Staphylococcus aureus (MRSA), central line and surgical site infections.

The Trust's transformation programme supports the delivery of the Trust vision of 'no waits, no waste, zero harm'. There is a dedicated improvement team to support this work and each clinical division has their own improvement plan, to demonstrate how they aim to deliver cross-Trust priorities and other local improvement projects.

Crucial to the success of the programme is motivation of staff and building the will to change. Teams and individuals are provided with education and training to enable them to become change agents at the front line. The transformation team runs a number of courses aimed at building sustainable capacity.

Work has also been undertaken across the organisation to improve the use of the Children's Early Warning Scores (CEWS) and the use of Situation, Background, Assessment, Recommendation, Decision (SBARD) communication tool to identify the deteriorating child. Arrests are reviewed and learning shared. There has been a reduction in variation of crash calls and although this has not yet been sustained, there is much work being undertaken to understand this.

Other achievements for the year, and further plans to improve the quality of our services next year, are detailed in the Quality Report.

The Trust has prioritised projects that aim to deliver improved performance and efficiency through rapid cycles of improvement without impacting the quality of care. These include:

- Improving theatre productivity – continuing our focus on increasing the total number of procedures being undertaken through our theatre capacity.
- A new pre-assessment model is in development for implementation in the coming year in order to better assess the fitness of patients for procedures and reduce short notice cancellations. New theatre and procedure areas and a Same Day Admissions unit and Post Anaesthesia Care unit will additionally be operational in January 2014, further facilitating better use of resources.
- Improving admissions and discharge – to continue to improve and standardise our admission and discharge processes both within and outside intensive care for both elective and non-elective patients.
- Improving flow through Intensive Care – by reducing non-clinical delays we aim to be able to make most efficient use of our intensive care bed capacity and maximise the number of children we can accommodate.
- Improving outpatient flow – to improve the use of outpatient space and patient and family experience by analysing clinic utilisation and processes.
- Improving timeliness of discharge summaries – to improve communication with families and referrers and thereby co-ordination of care.
- Improving complex patient pathways – to improve the patient journey for patients who are under the care of several specialties.
- Reducing waits for Pharmacy in outpatients – to respond to results from the outpatient survey which identifies this as a key issue, we will undertake work to reduce the waiting time for medications.

Patient and public involvement at Great Ormond Street Hospital

Great Ormond Street Hospital's (GOSH) updated three-year Patient and Public Involvement and Experience strategic plan was approved in January 2012. Since then, substantial progress has been made in the following areas:

Young People's Forum

GOSH now has an active Young People's Forum, chaired by a Young People's Members' Councillor. The Forum has decided to focus on improving support for young people with their transition to adult services. A Facebook and web page will soon be up and running. Feedback from the group has told us that:

- "Teens want to be heard and noticed more."
- "I want to be able to make Radio Lollipop more for different types of people with different music tastes."
- "I want it to make it a brilliant place for adolescents."

The young people told us what most interested them about the Forum was:

- "The ability to make a change, to be heard as a patient and a young person."
- "That I get to use my own experience to help others in the hospital."
- "Having a voice, an opportunity to make a difference."

Patient-led inspections

Patients and parents have welcomed being trained to participate in ward inspections focussing on environment, cleanliness and food.

Patient experience standards for receptions

Work has started with the training department to plan the roll out of experience standards (positive behaviours and attitudes required from reception staff) agreed between patients, families and staff for receptionists. This includes the feasibility of promoting the standards during staff induction and extending training to key staff groups such as healthcare assistants.

The needs of Jewish patients and families

The report from the focus group held with Jewish patients and their families was presented to the Family Equality and Diversity Group (FED) in December 2012. A task and finish group for one year (2013/14) will prioritise issues and work on implementation including the creation of a Sabbath room.

The needs of patients and families living with autism

Findings and recommendations have been reflected in and will be actioned through the Trust's Learning Disabilities Action Plan. The group is developing tools to improve communication around learning disabilities so that staff can make reasonable adjustments to the care we provide.

Survey of Nationally Commissioned Services (NCS) by Picker Institute

The Trust took part in a national patient and parent experience survey, commissioned by the Department of Health from the Picker Institute, of five specialist services in order to benchmark performance against other providers.

Overall the results were positive regarding clinical care although families need better information and support on social care. Action plans for each service has been put in place.

Real-time patient experience

The Trust is in the process of reviewing its approach to the collection of real-time patient and carer views, using roaming technology and volunteers.

The Patient Advice and Liaison Service (PALS)

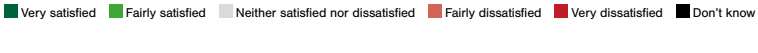
PALS helped more than 2,800 families in 2012/13 – a modest increase on the previous year. As a frontline drop-in service, open six days a week, the PALS team listen to the experiences of families and give advice, help to resolve issues, act on suggestions and help rebuild relationships where trust has broken down between families and staff. Concerns raised by families with PALS has enabled many practical changes to be made, including improved wayfinding and access to family support services during the redevelopment of reception.

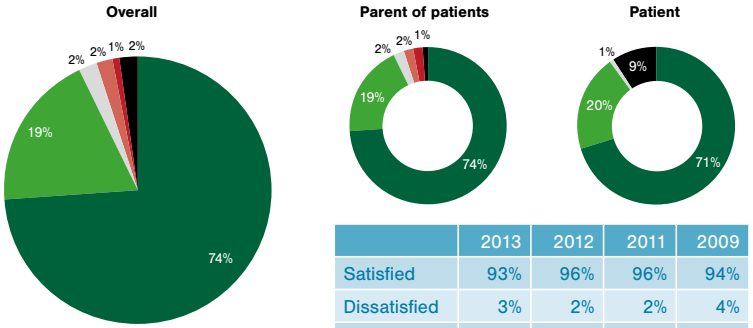
Great Ormond Street Hospital patient survey

The Trust commissions Ipsos MORI, a leading market research company in the UK, to conduct an annual independent telephone survey of patients' and families' experiences of their inpatient care. Once again, patient and family satisfaction rates remain very strong, despite a small decrease in satisfaction compared to last year (93 per cent in 2013 versus 96 per cent in 2012). Our results are very positive when compared to the context of an average 60 per cent NHS satisfaction rate nationally (Kings Fund 2013).

Satisfaction with visit

Q2 Overall, how satisfied or dissatisfied were you with your last visit to Great Ormond Street Hospital?





	2013	2012	2011	2009
Satisfied	93%	96%	96%	94%
Dissatisfied	3%	2%	2%	4%
Net satisfied	+90	+94	+94	+90

Base: All respondents (751) 28th January – 16th February 2013; 2012 base (760); 2011 base (750); 2009 base (750).
Base: All parents of patients (615) 28th January – 16th February 2013. Base: All child patients (136); 28th January – 16th February 2013.

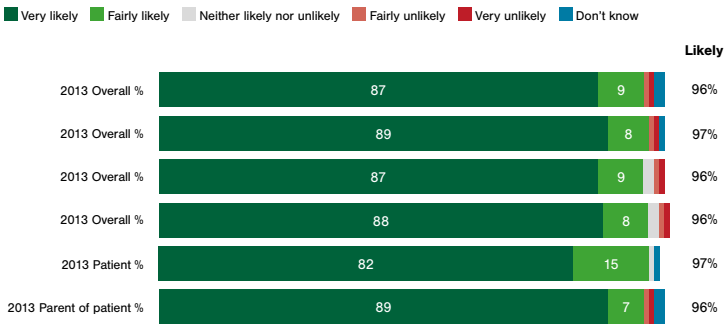
Source: Ipsos MORI

Patient and family advocacy rates (known as the friends' and family test) are very high at 96 per cent. This is complemented by a 90 per cent score from Trust staff in the staff survey.

Advocacy

Q4 PARENT WORDING: How likely or unlikely would you be to recommend Great Ormond Street Hospital to a friend or relative if their child needed treatment?

COMBINED CHILD WORDING: If a friend or relative of yours needed treatment, how likely or unlikely would you be to recommend Great Ormond Street Hospital (say Great Ormond Street Hospital is a good place to receive care)?



Base: All respondents (751) 28th January – 16th February 2013; 2012 base (760); 2011 base (750); 2009 base (750).
Base: All parents of patients (615) 28th January – 16th February 2013. Base: All child patients (136); 28th January – 16th February 2013.

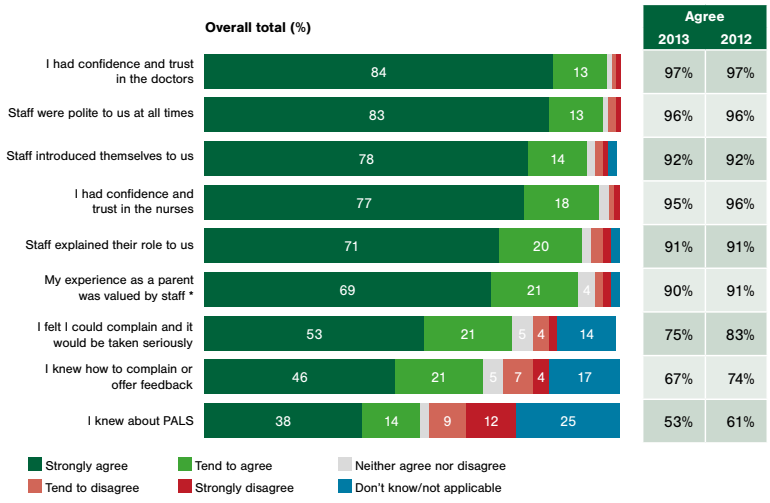
Source: Ipsos MORI

Great Ormond Street Hospital patient survey
continued

Confidence in doctors (97 per cent) and nurses (94 per cent) remains extremely high – in previous work to identify the most important criteria for parents and young people, this has been identified as the most important driver of satisfaction.

Treatment and service

Q6 I would like you to tell me whether you agree or disagree with each



Base: All respondents (751) 28th January – 16th February 2013; 2012 base (760)
* Base: All parents of patients (615) 28th January – 16th February 2013.

Source: Ipsos MORI

Despite a significant focus on patient experience over the last year, satisfaction has dropped across some measures, though the overall scores remain high. In some questions there has been a reduction in the very highest scores. The Trust is considering why this has happened and putting plans in place for improvement.

Over the past year, the Trust has focused on sustaining and improving its performance on the five aspects of patient experience, covering:

- The patient's views about involvement in decisions.
- Doctors and nurses asking questions about how the patient is feeling.
- The degree of privacy when talking to the doctor or nurse.
- Sufficiency of information provided about medicines and whether they were advised about who to contact when they returned home.

The Trust achieved an average score of 89 per cent across these areas, meeting the requirements of our commissioners.

Volunteering at Great Ormond Street Hospital

Volunteers (including patient and parent representatives) are a valuable source of additional support for the Trust, bringing different and varied perspectives, skills and experience.

In 2012/13, the Trust saw a further increase in numbers of volunteers recruited, trained and placed in volunteer roles across the Trust. Volunteers are engaged in a variety of roles that either directly or indirectly impact on patients, families and staff. Developing volunteering roles within the Trust assists us in meeting our objectives of providing best quality services for patients and families.

Feedback from families and patients regarding support from volunteers has been 100 per cent positive. Families are very grateful for opportunities to chat to a friendly (non-staff) person, or to be given time to have a break away from caring for their sick child. In the last year, 668 volunteers contributed approximately 138,900 hours of support work, freeing up staff to undertake their necessary work.

Alongside the large volunteer programme, Volunteer Services also manages a number of partner organisations delivering support services – including Radio Lollipop, Scouts & Guides, British Heart Foundation, Spread a Smile Entertainers, Epilepsy Society, CAB and Rainbow Trust.

Complaints handling and reporting to the Ombudsman at Great Ormond Street Hospital

We try to achieve the highest standards in our clinical care and also in the services we provide for children, young people and families. We regard any comments, compliments, concerns and complaints about our services as an opportunity to learn and make improvements. 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.

Between 1 April 2012 and 31 March 2013, the Trust investigated 117 complaints, which is a 12 per cent decrease in the number investigated the year before.

The Trust is always looking at improving its services. A patient experience project on the Trust's complaints process was 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.

Two focus groups, an online survey and a telephone survey, were carried out. In general, feedback from those who have used the process was positive. Areas and actions identified for potential improvements have been put in place.

Categories by number of complaints
(Please note some complaints raise more than one issue.)

Categories	1 April 2012 to 31 March 2012
Lack of communication with parents	64
Incorrect information	29
Delay in treatment	25
Staff rudeness	18
Delay in arranging appointment	13
Staff uninterested	13
Lack of communication between staff / teams	13
Treatment failed	12

Ombudsman's Principles of Remedy
There were six complaints referred to the Health Service Ombudsman for a review during this year. All complaints were fully investigated by the Trust in previous years.

Patient information at Great Ormond Street Hospital

The Trust has written, designed and published over 200 new or revised information sheets for children, young people and families this year. Many of these are developed in collaboration with children, young people and parents.

Following an audit of services for children and young people with learning disabilities, Easy Read versions of core information sheets are also being produced. These are symbol based with minimal text and designed using industry standard software.

Non-paper versions of information, such as podcasts, continue to be produced in collaboration with clinicians on topics such as central venous access and preparation for surgery.

Supportive non-medical information, such as suggestions for activities while staying at GOSH, and information identifying support services for specific groups, such as our Jewish families, are also in production.

Information management and technology

Investment in information technology continued in 2012/13, addressing 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.

There was further work to develop two major clinical systems: 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. In addition, the Trust continued to progress implementation of a new diagnostic test ordering and results reporting system which will go live during 2013.

The Trust also commenced work on a project to implement an electronic document record management system with a targeted go-live date in early 2014. This project has involved a significant amount of preparatory work in scanning existing paper records.

There have been a number of very successful innovative projects testing the use of portable devices in clinical areas to access systems and information, display images and input data. Investments have also been made in specialist clinical data bases to improve the quality and consistency of specialty specific clinical information for use in treatment, research and measurement of outcomes.

The Trust's IT infrastructure which underpins all the clinical applications is required to support a wide range of clinical systems and enable rapid access from both desk based PCs and portable devices. Recurring issues experienced by clinical staff with the speed of log-ins and printing resulted in the commissioning of an in-depth review by external consultants of the infrastructure components and resolve these issues. An improvement programme is now underway to renew or upgrade elements of the existing infrastructure and some of the core applications.

In October 2012 the Trust Board agreed a vision for its longer term Information Strategy which anticipates a move to integrated and accessible patient information systems and records, fully automated support systems and increased use of telemedicine. This poses significant challenges in terms of design, funding and implementation. The Trust will be reviewing its IT strategy during 2013/14 with an overall target of implementing fully electronic, integrated patient records within two to three years and prioritising further steps towards the overall goals of the Information Strategy.

Our people

Introduction

The people who work at Great Ormond Street Hospital are the key to our success. Our annual awards process sees hundreds of nominations for individuals and teams from across the hospital. Nominations from children and families describe our staff as “dedicated” and “exceptional”. Our challenge is to provide the environment and tools for everyone who works here to be exceptional, and for that quality to be demonstrated within every service.

We are committed to getting the basics right – to recruit and retain, manage and motivate our staff, and to do so whilst retaining high standards and within a financially challenging environment. We believe there is a significant opportunity to improve the Trust’s approach to managing its staff for the benefit of children and families and we aim to do this more consistently in 2013/14 and beyond.

Key Performance Indicators

	GOSH 2011/12	GOSH 2012/13
Turnover	15.00%	16.63%
Absence	3.24%	2.91%
Vacancies	4.00%	8.69%

In 2012 we developed our reporting capability to benchmark principal workforce Key Performance Indicators (KPIs) against a group of London trusts on a quarterly basis. There is an action plan in place to address specific areas within the Trust that are performing less well on these indicators.

Turnover

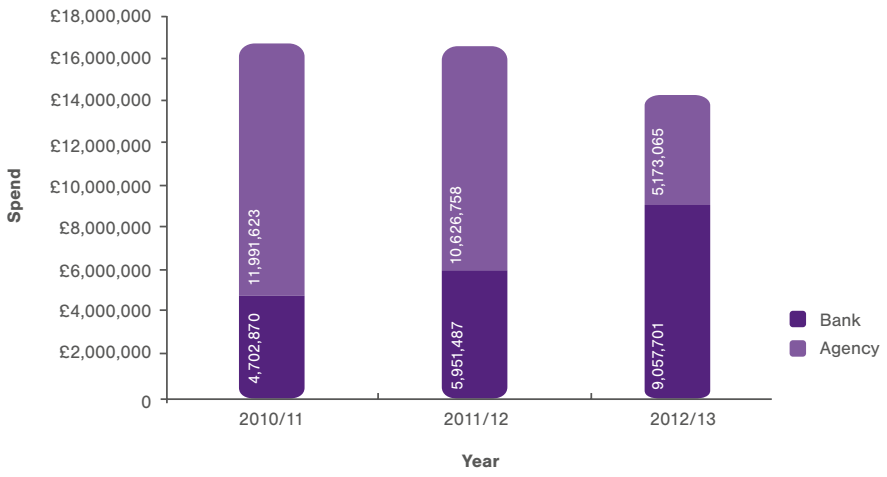
We are seeing a gradual year-on-year increase in our turnover. As a result, we have undertaken an exercise to identify ‘hard to recruit’ posts across the organisation, and are implementing bespoke plans to deal with particular challenges. In 2012/13 we focussed our work on recruiting and retaining nursing staff in our expanding intensive care areas, recognising the need to build for the future as well as meet existing demand.

Recruitment and vacancy rates

Great Ormond Street Hospital has seen a fall in temporary staffing costs by 15 per cent over the past two years, after the Trust targeted this as a key area for cost saving. In 2012/13 we rolled out our in-house bank to all non-nursing staff groups and took steps to reduce temporary nursing costs, including a comprehensive retendering exercise for the nurse bank. We anticipate further savings can be made by addressing remaining agency spend, and managing demand for temporary staff more effectively.

Our vacancy rate includes posts that are filled with temporary staff. The success of our in-house bank has meant that an increased number of posts are now being filled successfully with high quality bank staff for tactical reasons, such as pending organisational change or to meet short term demand. We will continue to prioritise work in departments with high vacancy and turnover rates.

Bank and agency trend



Sickness and absenteeism

Between 2011/12 and 2012/13, our absence rate fell from 3.24 per cent to 2.91 per cent. In 2012 we launched our Health and Wellbeing Strategy, which was recognised by the Chartered Institute of Physiotherapists as a model of good practice. This strategy formally sets out our commitment to the health of our staff and the steps we take to achieve it. These initiatives include:

- The staff counselling and advice service, which continues to be extremely well utilised with staff able to access expert counsellors 24 hours a day.
- A pilot training programme for managers run by Occupational Health to recognise and manage stress and anxiety amongst staff, which will be further developed in 2013/14.
- An on-site physiotherapy service, which conducted over 1,000 appointments in 2012/13, and in the majority of cases supported staff to manage their musculoskeletal problems safely while continuing to work.
- Classes and events such as yoga, pilates, walking and sports events, which contribute to both physical and mental fitness.

Education and medical education

Most elements of our annual plan for learning education and development were achieved during 2012/13. Over 3,600 staff accessed some form of in-house learning with more than 12,500 course places filled across all centrally recorded learning.

Mandatory Training

In 2013/13 we introduced a suite of live data reports providing information against a number of training topics alongside a more localised monitoring framework. As a result we have seen some improvements in compliance with training, as outlined below (as of 31 March 2013):

Induction and update compliance improved slightly from 73.9 per cent to 78.8 per cent.
Information Governance training is maintained at over 95 per cent.
Resuscitation training has increased from 70 per cent at 78.7 per cent.
Safeguarding Level 1 Child Protection training is maintained at over 95 per cent.
Safeguarding Level 2 Child Protection training improved from 50 per cent to 88.2 per cent.
Safeguarding Level 3 Child Protection training improved from 43 per cent to 83.2 per cent.

Appraisal of Great Ormond Street Hospital staff

The Trust's appraisal processes underpins all developmental activity. It acts as a prompt to remind staff of their mandatory requirements but also offers an opportunity to reflect on an individual's development needs and to plan accordingly so that objectives are met.

At the end of 2011/12 69 per cent of clinical and 60 per cent of non-clinical staff had a current appraisal. By April 2013 that figure had increased to 84 per cent for clinical and 75 per cent for non-clinical – an overall rate of 81.5 per cent. This is an area of real improvement.

Post Graduate Medical Education (PGME)

PGME designed and delivered two major educational initiatives this year: 'Clinical Leadership in Action' (CLiA) and 'Defining moments.....when things go wrong', both designed for multi-professional groups. These included the development of complex simulation scenarios and a serious multi player computer game.

The team also continued to support junior doctors in training and consultants to develop their educational supervision role.

Nurse education

Great Ormond Street Hospital hosts more students in paediatric nursing than any other NHS organisation. All student nurses within GOSH are enrolled with the London South Bank University (LSBU). GOSH works in partnership with LSBU to design quality learning and teaching programmes encompassing both pre and post-registration education.

This year saw a rise in the number of training places and resulted in the greatest number of students on placement at GOSH ever, including, for the first time, mature students on a pre registration postgraduate programme. We continue to work hard to ensure these students are supported by well-qualified and prepared nurses in the workplace who adopt the role of clinical mentors.

Our ongoing commitment to academic and professional support saw over 40 nurses graduate with undergraduate or postgraduate degree awards this year – our best year ever.

Supporting Quality Improvement

We continued to blend improvement methodology learning into leadership and team events. The transformation and Improvement Methodology Programme (TIMP) and Enabling Doctors in Quality Improvement and Patient Safety (EQuIP) programme supported the delivery of improvement and service quality projects across all areas of the Trust.

Leadership

Over 200 staff went through some level of leadership training during the year. We modified our leadership prospectus into a new focussed strategy commencing with an assessment centre designed to identify specific leadership needs of the delegates. A further 65 staff attended the 'Gateway' assessment centre – all of whom will go on to access leadership development opportunities throughout 2013.

Online Learning

The Trust's online campus (GOLD) continued to evolve and expand offering 24/7 access to educational information and online learning. This campus will be further developed in 2013/14 to reflect user feedback on accessibility and module effectiveness.

Keeping staff informed

Great Ormond Street Hospital has been through a significant period of change in the last 12 months, with achievement of NHS Foundation Trust status, a new chief executive and changes to the senior management team. Throughout this time we have used our existing communications platforms, such as our staff newsletter, email updates and open meetings, as well as making use of new means of reaching staff, with the Chief Executive delivering podcasts, providing all staff the opportunity to hear from him directly.

The NHS Litigation Authority assessment provided an opportunity to review and refresh a large number of our policies and procedures, which we did so in conjunction with our staff side bodies. We continue to work closely with our unions and professional bodies in achieving structural change within the organisation, maintaining our commitment to open communication and fairness in all our joint working. This includes sharing financial and other information at our monthly Staff Involvement Forum meetings as well as discussing all structural and procedural changes that affect staff.

We continue to explore more efficient models for delivering support services, and in 2012/13 we agreed a shared service arrangement for the provision of Procurement and Supply Chain services with other local NHS trusts. Other changes affecting staff included the arrangements for provision of ICT services, and a new structure for clinical and non-clinical services in the International and Private Patients (IPP) division to support its growth and to deliver a customer-focussed service.

Staff survey

The 2012 staff survey results showed an increase in satisfaction across a wide range of areas.

Table one: staff survey response rate

	2011		2012		
Response rate	GOSH	National average	GOSH	National average	**Trust improvement/ deterioration**
	46%	Above average	42%	Below average	4% decrease

Table two: top and bottom ranking scores

	2011		2012		
Top five ranking scores	GOSH	National average	GOSH	National average	**Trust improvement/ deterioration/ no change**
Fairness and effectiveness of incident reporting procedures*	3.60	3.53	3.69	3.60	Improvement
Percentage of staff appraised in last 12 months	82%	81%	89%	83%	Improvement
Staff motivation at work*	3.81	3.83	3.99	3.88	Improvement
Staff job satisfaction*	3.51	3.55	3.75	3.66	Improvement
Percentage of staff able to contribute towards improvements at work	68%	66%	74%	71%	Improvement

	2011		2012		
Bottom five ranking scores	GOSH	National average	GOSH	National average	**Trust improvement/ deterioration/ no change**
Percentage of staff saying hand-washing materials are always available	47%	67%	51%	61%	Improvement
Percentage of staff working extra hours	76%	67%	76%	72%	No change
Percentage of staff receiving health and safety training in last 12 months	71%	83%	60%	76%	Deterioration
Percentage of staff witnessing potentially harmful errors, near misses, or incidents in last month	45%	31%	38%	30%	Deterioration
Percentage of staff agreeing that their role makes a difference to patients	91%	90%	88%	91%	Deterioration

*Out of a total of five.

In addition to those highlighted in the table above, our staff reported improvements in team working and their levels of satisfaction with the quality of work and patient care they are able to deliver.

The key areas of work arising from the 2012 results are:

- **Improving our response rate in the 2013 survey**
  Increasing the numbers of staff who complete the survey will increase the validity and usefulness of the results, forming a stronger basis for the action plans we devise.

- **Availability of hand-washing materials**
  We are undertaking a detailed survey to understand the concerns staff have, including our administrative staff who report greater dissatisfaction than their clinical colleagues. We will use this feedback to ensure we maintain high-quality facilities and review and refresh our approach to hand hygiene so all staff and visitors are aware of the importance we attach to this issue as part of our continuing drive to reduce the risk of harm to patients.

- **Health and safety training**
  We run a two-year mandatory update programme, in line with the NHS national training framework, which delivers refresher training and assessment on a number of health and safety-related topics, including fire safety and moving and handling. In addition, staff in patient-facing areas receive annual training refreshers in handwashing and local fire procedures.

  We have prioritised attendance at mandatory training in the last six months, and in April 2013, 77.6 per cent of staff were up to date with this training – an increase from October 2012 of 9 per cent. We will remain focussed on further improvement.

- **Witnessing errors and near misses**
  The survey results consistently show that staff report errors and near misses, and that they also have very high levels of confidence in the systems and processes that help us recognise and address issues. We carefully monitor all the incidents that are reported and where we see patterns or themes we take action to resolve them. We will review our work in light of the *Francis Report* recommendations and identify any areas for improvement.

- **Local plans**
  In addition to Trust-wide actions in response to the survey, all of our clinical and corporate departments are drawing up local action plans to respond to the issues that are most significant for staff in their areas. These include ensuring all staff receive appraisals, promoting regular team meetings, and encouraging staff to raise concerns about challenging behaviours. These action plans will be monitored at executive level.

Equality and diversity at Great Ormond Street Hospital

Our Staff Equality and Diversity Group has monitored delivery against two objectives to support us in our work to improve equality and diversity in the Trust, on appraisal rates and the use of testing as a routine part of the selection process. We have made good progress against these objectives in the first year, and will continue to monitor their impact annually. We publish large amounts of data and analysis on equality and diversity issues on our website each year. In addition, we have made an e-learning component on equality and diversity part of our two yearly mandatory update, and produced a video to be shown at induction in which staff representatives set out the Trust's commitment to equality and diversity, and how this works in practice.

Policies in relation to disabled staff and for giving full and fair consideration to applications for employment by disabled people

The Trust has both an Equal Opportunities policy and a Recruitment and Selection Policy and Procedure which supports applications from disabled candidates to receive full and fair consideration. We also provide training on fair recruitment and advice to managers and staff to help support individual cases.

The Trust is accredited 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 provision 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.

The Trust has published detailed equality and diversity data about our staff and patients on our website at www.gosh.nhs.uk

Off-payroll engagements

There were five off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012. Of these, all have given the Trust assurance as to their tax obligations.

There were two new off-payroll engagements between 23 August 2012 and 31 March 2013 for more than £220 per day and for more than six months. Of these, one has given assurance to the Trust of their tax obligations and one is switching to bank employment with the Trust.

Health and safety

The Trust is committed to effectively controlling risks and preventing harm to all patients, visitors and staff through our health and safety work.

There has been an 8.8 per cent increase in the number of reported non-clinical incidents affecting staff, contractors, visitors and patients over the past year. Over 900 health and safety incidents were reported from the 1 April 2012 to the 31 March 2013 including 100 patient safety incidents. The number of health and safety incidents involving patients has remained steady but reduced as a proportion of the overall number of health and safety incidents.

The Trust has an annual rolling programme of assessments, checklists, online surveys 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 ensures that any statutory compliance is undertaken within stated legislative guidelines.

The team has developed the Great Ormond Street Hospital safety website providing bespoke information for clinical and non-clinical areas covering local risk assessments, control of substances hazardous to health assessments, safety data sheets, policies, guidance and procedures. Greater co-operation and benchmarking with other paediatric healthcare establishments on health and safety has also been conducted.

Working with stakeholders

The UCL Institute of Child Health (ICH)

The 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 (UCLP)

One of five accredited academic health science systems in the UK, UCLP is a partnership between University College London and other hospitals and research centres including Moorfields Eye Hospital NHS Foundation Trust, the Royal Free Hampstead NHS Foundation Trust, University College London Hospitals NHS Foundation Trust and GOSH.

By linking with experts from different specialist institutions through UCLP to share knowledge and expertise, GOSH can better support advancement in scientific knowledge and ensure healthcare benefits are passed to patients as quickly as possible.

GOSH has been particularly actively engaged in UCLP workstreams around education and service improvement over the last year. Work in these areas has included:

- Design and launch of a 'Nursing Excel' programme – a fast-track development programme to prepare newly registered nurses to be the ward sisters of the future.
- Leadership of the UCLP programme aimed at improving the care of the deteriorating hospitalised child.
- Plan to enable mandatory training to be transferred between different Trusts – rather than repeated by new staff.

In the coming year GOSH will continue to engage within the partnership including:

- Taking a lead in the contracting process for providing specialist paediatric education.
- Bids for research funding.
- Supporting child health elements of the 'Life Course' programme to improve experience and outcomes in healthcare for women, children and young people.
- Developing a shared procurement service to ensure cost effective purchasing across the partner organisations.

Referrers and clinical networks

The Trust has an active programme of engagement with referrers and ran a successful open day this year to support continued building of links with referring clinicians. A referrers group is in place to take forward improvements from referrers' feedback – such as turnaround time of clinic letters and improving the process for referrals and bed management.

In addition, many GOSH specialised services operate with other healthcare providers in local, regional and national clinical networks of care and play a broader role in working with other healthcare organisations including, through provision of outreach clinics, as a source of specialist clinical advice and playing a role in clinical reference and formulary groups.

A key strategic aim over the forthcoming year is to work closely with referrers and within networks of care to strengthen shared care arrangements and improve transition pathways for patients onwards from the paediatric services at GOSH to adolescent and adult services.

Healthwatch

GOSH is looking forward to working with the newly created Camden Healthwatch, the successor body to Camden Links. Once fully established as an independent organisation, it will have an important role in monitoring and shaping health and social care services locally, ensuring that clinicians and managers listen to patients and families and respond to their needs. We have invited representatives to join our Patient and Public Involvement and Experience Committee and will continue to seek their advice, share our plans and work co-operatively with them in the future.

Corporate reporting

Charlotte, 12, is waiting for the results of a video capsule endoscopy. This involves swallowing a capsule containing a tiny light and camera, which transmits pictures of the digestive system to a data recorder worn on a belt around the waist. Charlotte is excited to see what she looks like inside!

Corporate reporting

The Trust was authorised as an NHS Foundation Trust on 1 March 2012 under the National Health Service Act 2006.

The Board of Directors

The Board of Directors has responsibility for setting the strategic direction of the Trust and for managing significant risks. It is responsible for ensuring compliance with the terms of authorisation, including the constitution, with mandatory guidance issued by Monitor, and with relevant statutory requirements and contractual obligations. The Board delegates specific functions to committees.

The Board is made up of a chairman, six non-executive directors and seven executive directors (including two co-medical directors as a joint appointment). It also has four 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 chairman 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.

The Board of Directors has a Deputy Chairman, and has also appointed a Senior Independent Director. All non-executive directors are considered by the Board of Directors to be independent. The Board of Directors considers that there is a good balance of skills represented by both non-executive and executive Board members.

Non-executive directors' terms of office are three years. They are appointed by the Members' Council who may also terminate their appointment.

Evaluation of performance

The Trust Board Development Programme details the issues to be considered at the half-yearly development reviews. In December 2012, the Board undertook a self-assessment evaluation of its performance. A plan was developed and is being used to update the Board development programme.

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 the effectiveness of its standing committees against their terms for reference.

Composition of the Trust Board

The composition of the Trust Board in 2012/13 was as follows:

Non-executive directors

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

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

Membership of committees
- Chairman of the Trust Board and Members' Council
- Board of Directors' Remuneration Committee member
- Chairman of the Board of Directors' Nominations Committee
- Chairman of the Members' Council Nominations and Remuneration Committee.

Current term of office expires:
29 February 2016

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

Experience
- Qualified accountant
- Chief Executive Officer at The Chartered Institute of Management Accountants (CIMA)
- Director (Corporate representative) CIMA China Ltd
- Director (Corporate representative) CIMA Enterprises Limited (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
- Members' Council Nominations and Remuneration Committee member.

Current term of office expires:
31 August 2015

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

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
- Council member of the Law Society of England and Wales
- Panel Chair of the Nursing and Midwifery Council Conduct and Competence Committee
- Former Chair of the Compliance and Scrutiny Committees, Solicitors Regulation Authority.

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

Current term of office expires:
29 February 2016

Professor Andrew Copp MBBS DPhil FRCPath FMed Sci
Non-Executive Director
Appointed 1 March 2012

Experience
- Director of the UCL Institute of Child Health (ICH)
- Professor of developmental neurobiology at the ICH
- Honorary consultant at Great Ormond Street Hospital (GOSH)
- 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.

Term of office expired on:
31 December 2012

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

Experience
- Non-Executive Equality and Diversity lead at GOSH
- Chair of Gingerbread and Safe network Advisory Board
- Deputy chair of the Child and Family Court Advisory and Supoort Service (CAFCASS)
- Chief Executive of the Family and Parenting Institute (1999–2009)
- Director of Policy, Research and Development and deputy CEO 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.

Current term of office expires:
29 February 2016

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

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 & Operations Officer, ESAT British Telecom, Dublin (04/02–05/03).

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

Current term of office expires:
31 October 2015

Trust Board executive directors

Mr John Ripley
Non-Executive Director
Appointed 28 March 2012

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 and Infants Schools
- Unilever 1973–2008 (Group Deputy Chief Finance Officer).

Membership of committees
- Audit Committee member
- Finance and Investment Committee member
- Board of Directors' Remuneration Committee member
- Board of Directors' Nominations Committee member

Current term of office expires:
27 March 2015

Professor Rosalind Smyth
Appointed 1 January 2013

Experience
- Director of the ICH
- Honorary Consultant Respiratory Paediatrician at GOSH
- Director of the Public Library of Science
- Professor of Paediatric Medicine at the University of Liverpool and honorary consultant paediatrician at Alder Hey Children's NHS Foundation Trust (until September 2012).

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

Current term of office expires:
31 December 2016

Mr Jan Filochowski
Chief Executive
From 8 November 2012

Jan Filochowski is responsible for delivering the strategic and operational plans of the hospital, through the Executive team.

Experience
- Chief Executive at West Hertfordshire Hospitals NHS Trust (2007–2012)
- Senior Management Adviser at South East Health Authorities (2003–2007)
- Associate of the Prime Minister's Delivery Unit (2004–2007)
- Chief Executive of Royal United Hospital, Bath NHS Trust (2002–2003)
- Chief Executive of the Medway NHS Trust (1999–2002).

Membership of committees
- Clinical Governance Committee member
- Finance and Investment Committee member
- Attends Audit Committee
- Attends Board of Directors' Remuneration Committee
- Attends Board of Directors' Nominations Committee.

Jane Collins MD MSc FRCP FRCPCH
Chief Executive
Until 31 August 2012

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

Membership of committees
- Clinical Governance Committee member
- Finance and Investment Committee member
- Attended Audit Committee
- Attended Board of Directors' Remuneration Committee
- Attends Board of Directors' Nominations Committee.

Dr Barbara Buckley MB BS FRCP FRCPCH
Co-Medical Director

Barbara Buckley is responsible for postgraduate medical education and training for doctors, medical workforce development and partnership services.

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.

Ms Fiona Dalton MA (Hons) (Oxon)
Chief Operating Officer/ Deputy Chief Executive
Deputy Chief Executive (1 April – 31 August 2012 and 8 November 2012 – 14 March 2013)/ Interim Chief Executive (1 September – 7 November 2012)

Fiona Dalton was responsible for the operational management of clinical services within the Trust, and also led 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
- Clinical Governance Committee member
- Attends Audit Committee
- Finance and Investment Committee member.

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
- Attends Audit Committee
- Finance and Investment Committee member.

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;, for patient and public involvement and engagement, and education and training for all staff in the Trust and 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 NHS Foundation Trust (2002–2007).

Membership of committees
- 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, UCL
- Director of the National Service for Severe Tracheal Disease in Children (at 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
- Clinical Governance Committee member.

Mr Robert Burns
Deputy Chief Operating Officer/ Interim Chief Operating Officer
Deputy Chief Operating Officer (1 April – 31 August 2012 and 8 November 2012 – 3 March 2013)/ Interim Chief Operating Officer (1 September – 7 November 2012 and from 4 March – 31 March 2013)

Robert Burns is responsible for the operational management of clinical services within the Trust, and also leads on strategic planning and performance management.

Experience
- Full member of the Chartered Institute of Public Finance and Accountancy
- Deputy Chief Operating Officer, GOSH (2009–2012)
- Head of Partnerships, Southampton University Hospitals NHS Trust (2007–2009).

Membership of committees
- Clinical Governance Committee member
- Attends Audit Committee
- Finance and Investment Committee member.

Other directors who attended the Board of Directors' meetings:

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 GOSH Biomedical Research Centre.

Mr William McGill MSc
Director of Redevelopment
Until 31 July 2012

- Lead 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 and creation and delivery of the IT Strategy, in turn supporting the achievement of Trust objectives.

Mr Trevor Clarke BSc MSc
Director of International and Private Patients (IPP)

- Responsible for the strategic development and management of the Trust's IPP division.

Mr Matthew Tulley
Director of Redevelopment
From 3 December 2012

- Leads the work to redevelop the Trust's buildings and ensure that it is suitable to support the capacity and quality ambitions of the Trust's clinical strategy.

Mr Ali Mohammed
Interim Director of Human Resources and Organisational Development
From 21 January 2013

- Responsible for leading on the development and delivery of a human resources strategy and delivering the Trust's organisational development programmes.

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 2012 – 31 March 2013, the Trust Board held a total of 11 meetings. Eight of these included sessions in public. In October and February the Board held development sessions. The Board did not meet in August or December 2012. One extraordinary meeting was held in May 2012. The table below summarises the attendance of the directors at these meetings.

Name	Position	Attendance (out of 11 meetings)
Baroness Blackstone	Chairman	11
Andrew Copp	Non-Executive Director (until 31 December 2012)	7
Charles Tilley	Non-Executive Director	10
Mary MacLeod	Non-Executive Director	10
Yvonne Brown	Non-Executive Director	8
David Lomas	Non-Executive Director	10
John Ripley	Non-Executive Director	10
Rosalind Smyth	Non-Executive Director (from 1 January 2013)	3
Jane Collins	Chief Executive until 31 August 2012	5
Jan Filochowski	Chief Executive from 8 November 2012	4
Fiona Dalton	Deputy Chief Executive (1 April – 31 August 2012 and 8 November 2012 – 14 March 2013)/Interim Chief Executive (1 September – 7 November 2012)	9
Claire Newton	Chief Finance Officer	11
Martin Elliott	Co-Medical Director	8
Barbara Buckley	Co-Medical Director	11
Elizabeth Morgan	Chief Nurse and Director of Education	11
Robert Burns	Deputy Chief Operating Officer (1 April – 31 August 2012 and 8 November 2012 – 3 March 2013)/Interim Chief Operating Officer (1 September – 7 November 2012 and from 4 March – 31 March 2013)	4

Board Committees at Great Ormond Street Hospital

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 external committee member, also attends the meeting to provide independent scrutiny. The committee met four times during the period. Membership of the committee and attendance is detailed below for the full year (1 April 2012 – 31 March 2013).

Name	Position	Attendance (out of four meetings)
Charles Tilley (Chair)	Non-Executive Director	4
Yvonne Brown LLB	Non-Executive Director	3
David Lomas	Non-Executive Director	4
John Ripley	Non-Executive Director	3
Michael Dallas	Independent external committee member	3
Jane Collins*	Chief Executive until 31 August 2012	2
Claire Newton*	Chief Finance Officer	4
Fiona Dalton*	Deputy Chief Executive (1 April – 31 August 2012 and 8 November 2012 – 14 March 2013)/Interim Chief Executive (1 September – 7 November 2012)	4
Robert Burns*	Deputy Chief Operating Officer (1 April – 31 August 2012 and 8 November 2012 – 3 March 2013)/Interim Chief Operating Officer (1 September – 7 November 2012 and from 4 March – 31 March 2013)	1
Jan Filochowski*	Chief Executive from 8 November 2012	0

*In attendance.

The Board is satisfied that at least three members of the committee have recent and relevant financial experience. The Chief Executive and other senior staff attend throughout the year.

The Audit Committee's 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.

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 receives reports from internal auditors and clinical audit.

The committee met four times during 2012/13. Attendance at meetings for the period 1 April 2012 – 31 March 2013 is detailed below.

Name	Position	Attendance (out of four meetings)
Mary MacLeod (Chair)	Non-Executive Director	4
Andrew Copp	Non-Executive Director (until 31 December 2012)	3
Yvonne Brown	Non-Executive Director	4
Rosalind Smyth	Non-Executive Director (from 1 January 2013)	0
Jane Collins	Chief Executive until 31 August 2012	1
Fiona Dalton	Deputy Chief Executive (1 April – 31 August 2012 and 8 November 2012 – 14 March 2013)/Interim Chief Executive (1 September – 7 November 2012)	2
Martin Elliott	Co-Medical Director	2
Elizabeth Morgan	Chief Nurse and Director of Education	2
Robert Burns	Deputy Chief Operating Officer (1 April – 31 August 2012 and 8 November 2012 – 3 March 2013)/Interim Chief Operating Officer (1 September – 7 November 2012 and from 4 March – 31 March 2013)	3
Jan Filochowski	Chief Executive from 8 November 2012	1

Remuneration Committee

See page 56.

Finance and Investment Committee

The Finance and Investment Committee is a committee of the Trust Board with delegated authority for assisting the Board in overseeing financial strategy and planning, financial policy, investment and treasury matters and in reviewing and recommending for approval major financial transactions to the Trust Board. The committee also maintains an oversight of the Trust's financial position, relevant activity data and workforce metrics. It is chaired by a non-executive director. Its membership includes the Chief Executive and other executive and non-executive directors. The committee met on six occasions during the period. Attendance at meetings is detailed below.

Name	Position	Attendance (out of six meetings)
David Lomas (Chairman)	Non-executive Director	6
John Ripley	Non-Executive Director	6
Jane Collins	Chief Executive until 31 August 2012	2
Jan Filochowski	Chief Executive from 8 November 2012	3
Claire Newton	Chief Finance Officer	6
Fiona Dalton	Deputy Chief Executive (1 April – 31 August 2012 and 8 November 2012 – 14 March 2013)/Interim Chief Executive (1 September – 7 November 2012)	5
Robert Burns	Deputy Chief Operating Officer (1 April – 31 August 2012 and 8 November 2012 – 3 March 2013)/Interim Chief Operating Officer (1 September – 7 November 2012 and from 4 March – 31 March 2013)	1

Board of Directors' Nominations Committee

The Board of Directors' Nomination Committee is a committee of the Trust Board with delegated authority for:

- Assisting the Board in reviewing the structure, size and composition (including the skills, knowledge and experience) of the Board.
- Identifying and nominating for appointment candidates to fill executive posts.
- Considering any matter relating to the continuation in office of any executive board director.

It is chaired by the Chairman of the Board of Directors and attended by all non-executive directors, the Chief Executive and the Interim Director of Human Resources and Organisational Development. During the year, the committee considered and approved the appointment of the Chief Executive, Chief Operating Officer and Interim Director of Human Resources and Organisational Development. Attendance is detailed below.

Name	Position	Attendance (out of two meetings)
Tessa Blackstone (Chair)	Chairman	2
David Lomas	Non-Executive Director	2
John Ripley	Non-Executive Director	2
Charles Tilley	Non-Executive Director	2
Mary MacLeod	Non-Executive Director	2
Yvonne Brown	Non-Executive Director	2
Rosalind Smyth	Non-Executive Director (from 1 January 2013)	2
Andrew Copp	Non-Executive Director (until 31 December 2012)	1
Jan Filochowski*	Chief Executive from 8 November 2012	2
Ali Mohammed*	Interim Director of Human Resources and Organisational Development from 21 January 2013	1

*In attendance.

Members' Council (governors of the Trust)

The role of the Members' Council, as the governors of the hospital, is to work with and hold to account the Board of Directors and to ensure that the views of the hospital's patients and wider communities are heard and reflected in the strategy for the hospital. Councillors represent specific constituencies and are elected or appointed to do so. Key responsibilities of the Members' Council include:

- Appointing and removing the non-executive directors, including the Chairman of the Trust.
- Setting the pay levels of the Chairman and non-executive directors.
- Approving the appointment of the Chief Executive.
- Appointing the Trust's financial auditors.
- Receiving and approving the Trust annual accounts, auditor's report and annual reports, including the Quality Accounts.
- Deciding whether the Trust's private patient work would significantly interfere with the trust's principal purpose (as of 1 October 2012).
- Approving any proposed increases in non-NHS income of 5 per cent or more in any financial year (as of 1 October 2012).
- Actively representing the interests of members.
- Acting as a source of ideas about how the Trust can provide its services and working with the Board of Directors to help influence strategic direction.
- Acting as an advocate for children who need specialised healthcare.
- Being an essential link between the Trust and various partner organisations.

The council is led by the Chairman of the Trust. During the period, the Members' Council consisted of 28 councillor positions. 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 appointed by partner organisations. The table below details the membership constituencies and organisations represented by appointed councillors. Following changes in NHS commissioning arrangements from 31 March 2013, the council has approved that the appointed councillor positions from Camden Primary Care Trust and the National Commissioning Group will be replaced by an appointed councillor from NHS England, bringing the total number of councillors to 27.

Constituency	Number of seats on council
Elected councillors	
Patient and carer constituency	
Patients from London	2
Patients from outside London	2
Parents or carers from London	3
Parents and carers from outside London	3
Public constituency	
North London and surrounding area	4
Comprising the following electoral areas in: • **North London:** Barking and Dagenham, Barnet, Brent, Camden, City of London, Hackney, Ealing, Enfield, Hammersmith and Fulham, Haringey, Harrow, Havering, Hillingdon, Hounslow, Islington, Kensington and Chelsea, Newham, Redbridge, Tower Hamlets, Waltham Forest, Westminster.	
Comprising the following electoral areas in: • **Bedfordshire:** Bedford, Central Bedfordshire, Luton. • **Hertfordshire:** Broxbourne, Dacorum, East Hertfordshire, Hertfordshire, Hertsmere, North Hertfordshire, St Albans, Stevenage, Three Rivers, Watford, Welwyn Hatfield. • **Buckinghamshire:** Aylesbury Vale, Buckinghamshire, Chiltern, Milton Keynes, South Bucks, Wycombe. • **Essex:** Basildon, Braintree, Brentwood, Castle Point, Chelmsford, Colchester, Epping Forest, Essex, Harlow, Maldon, Rochford, Southend-on-Sea, Tendring, Thurrock, Uttlesford.	

Constituency	Number of seats on council
South London and surrounding area Comprising the following electoral areas in: • **South London:** Bexley, Bromley, Croydon, Greenwich, Royal Borough of Kingston-upon-Thames, Lambeth, Lewisham, Merton, Richmond-upon-Thames. Comprising the following electoral areas in: • **Surrey:** Elmbridge, Epsom and Ewell, Guildford, Mole Valley, Reigate and Banstead, Runnymeade, Spelthorne, Surrey Heath, Tandridge, Waverley, Woking. • **Kent:** Ashford, Canterbury, Dartford, Dover, Gravesham, Maidstone, Medway, Sevenoaks, Shepway, Swale, Thanet, Tonbridge and Malling, Tunbridge Wells. • **Sussex:** Brighton and Hove, East Sussex, Eastbourne, Hastings, Lewes, Rother, Wealden, Adur, Arun, Chichester, Crawley, Horsham, Mid Sussex, West Sussex, Worthing.	1
The rest of England and Wales All electoral areas in England and Wales not falling within one of the areas referred to above	2
Staff constituency	5
Appointed councillors	
Statutory	
UCL Institute of Child Health	1
London Borough of Camden	1
Camden Primary Care Trust	1
Partnership organisations	
National Commissioning Group	1
Expert Patients' Programme Community Interest Company	1
Great Ormond Street Hospital School	1
Total	**28**

Councillors on the Members' Council and attendance at meetings

The term of office for all elected and appointed councillors is three years. The Members' Council met 5 times during 2012/13. The table below details attendance at these meetings.

Name	Constituency	Date of appointment	Attendance (out of five meetings)
Edward Green	Patients outside London	1 March 2012	3
George Howell	Patients outside London	1 March 2012	3
Mason Moore	Patients from London	1 March 2012, Resigned 30 January 2013	0
Sophie Talib	Patients from London	1 March 2012	4
Matthew Norris	Parents and carers from London	1 March 2012	5
Lynne Gothard	Parents and carers from London	1 March 2012	4
Lisa Chin-A-Young	Parents and carers from London	1 March 2012	5
Claudia Fisher	Parents and carers outside London	1 March 2012	4
Camilla Pease	Parents and carers outside London	1 March 2012	5
John Charnock	Parents and carers outside London	1 March 2012	4
Lewis Spitz	North London and surrounding area	1 March 2012	4
Trevor Fulcher	North London and surrounding area	1 March 2012	4
Rebecca Miller	North London and surrounding area	1 March 2012	5
Ian Lush	North London and surrounding area	1 March 2012	5
Louise Clark	South London and surrounding area	1 March 2012	3
Stuart Player	The rest of England and Wales	1 March 2012	3
Julia Olszewska	The rest of England and Wales	1 March 2012	4
Daniel Dacre	Staff	1 March 2012	5
Mary De Sousa	Staff	1 March 2012	4
Jilly Hale	Staff	1 March 2012	3
Clare McLaren	Staff	1 March 2012	5
Dhimple Patel	Staff	1 March 2012	2
John Carrier	NHS North Central London (Camden Primary Care Trust)	1 March 2012, Resigned 31 October 2012	3
Jenny Headlam-Wells	London Borough of Camden	1 March 2012	4
Christine Kinnon	UCL Institute of Child Health	1 March 2012	4
Jo Sheehan	National Specialised Commissioning Team	1 March 2012, Resigned 22 February 2013	2
Fiona Price-Kuehne	Expert Patient Programme Community Interest Co.	1 March 2012, Resigned 17 February 2013	4
Muhammad Miah	Great Ormond Street Hospital School	1 March 2012	2

Lead councillor

Mr Ian Lush, Public Councillor for North London and the surrounding area, was elected as lead councillor in March 2012. This position will be held for three years.

Register of interests of councillors

All councillors have signed the Trust's Code of Conduct and are required to declare any interests which may compromise their objectivity in carrying out their duties.

A Register of the Interests for all members of the Members' Council is published on the Trust's website, www.gosh.nhs.uk, and may also be obtained from the Company Secretary, Executive Offices, Paul O'Gorman Building, Great Ormond Street, London WC1N 3JH.

Board of Directors and Members' Council working together

The Chairman of the Trust chairs both the Board of Directors and the Members' Council and plays a significant role in ensuring effective and sound working relationships. Members of the Board are invited to meetings of the Members' Council and councillors attend the Trust Board meetings and Board strategy days.

The Trust has sought the views of the Members' Council on the following areas during the year:

- Consultation on the Trust's annual plan for 2013/14.
- Consultation on the selection of indicator for auditing for the Quality Report.
- Participating in Members' Council seminars providing views and opinions about Great Ormond Street Hospital (GOSH) services.
- Participation in safety walkrounds.
- 121 meetings with Chief Executive to share views and experiences on GOSH services.
- Undertaking the annual Patient Environment Action Team (PEAT) inspections.
- Membership of the Patient and Public Involvement and Engagement Committee, developing plans for a GOSH event for patients, families, members and staff.
- Chairing and attending Members' Council committees on membership recruitment, communication and engagement.
- Attending meetings on the appointment and remuneration of non-executive directors.
- Reviewing changes to the Trust Constitution.

In July 2012, the Members' Council approved the appointment of the Chief Executive, Mr Jan Filochowski, following a process of open competition. Councillors were advised of the process for appointment to the post and invited to attend pre-interview meetings with all candidates.

Members' Council Nomination and Remuneration Committee

The Members' Council Nomination and Remuneration Committee has delegated responsibility for:

- Assisting the Members' Council in reviewing the balance of skills, knowledge, experience and diversity of the non-executive directors on the board.
- Giving consideration to succession planning for the Chair and non-executive directors in the course of its work.
- Identifying and nominating for appointment candidates to fill non-executive posts.
- Considering any matter relating to the continuation in office of any non-executive board director.
- Reviewing the results of the performance evaluation process for the Chairman and non-executive directors.

The committee is chaired by the Chairman of the Board of Directors and Members' Council.

The committee met on three occasions during the year and membership and attendance at the meetings is detailed below.

Name	Position	Attendance (out of three meetings)
Baroness Blackstone	Chairman of the Board	3
Charles Tilley	Deputy Chairman	3
Ian Lush	Public Councillor: North London and surrounding area	3
Edward Green	Patient and Carer Councillor: Patients outside London	3
Daniel Dacre	Staff Councillor	3
John Carrier (until 31st October 2012)	Appointed Councillor: NHS North Central London	1
Christine Kinnon	Appointed Councillor: UCL Institute of Child Health	1

Appointment of non-executive directors

The committee recommended the appointment of Professor Rosalind Smyth as the Non-Executive Director, representing the UCL Institute for Child Health. This appointment was approved by the council in November 2012.

The committee reviewed the composition of the non-executive directors on the Board and agreed that there are no significant gaps in knowledge or experience for the non-executive members of the Great Ormond Street Hospital Foundation Trust Board of Directors.

The committee considered applications for reappointment from Baroness Blackstone, Chairman, Ms Mary MacLeod, Non-Executive Director and Ms Yvonne Brown, Non-Executive Director. The committee reviewed these applicants' attendance at meetings, experience, skills and recent appraisal reports. A recommendation was made to the January 2013 council meeting that all three should be reappointed for a further three years. The council unanimously approved reappointment of these individuals for a further three years until 29 February 2016.

Membership and membership development

Eligibility to be a member

Our Foundation Trust membership is open to anyone who lives in England and Wales and is over the age of 10. Patient members need to have been seen in the hospital within the last six years. Parents or carers of patients seen in the last six years can be members. Where a patient or parent or carer member was last seen more than six years ago, we transfer them to be a public member. This is because we want patient and public members to be those with more recent experience of our service. All eligible staff will be members unless they choose to opt out.

Staff membership is open to all employees who hold a Great Ormond Street Hospital (GOSH) permanent contract. Staff on fixed-term contracts of 12 months or more, and those staff that work with the hospital (such as the fundraising charity Great Ormond Street Hospital Children's Charity), the staff at our school and the social workers on our site, contractors such as cleaners and security, and our volunteers working on site, may also become members if they have been working with the Trust for 12 months or more.

Membership is open to patients, their carers and families, members of the public and staff. Apart from staff, all other categories of members have to proactively sign up to join. The Trust actively encourages those working with children, policy and advocacy groups for children, and others interested in the life and well-being of children to become members. We set a minimum age of 10 for membership.

Recruitment of membership

Our membership strategy sets out how we, as a Trust, intend to attract, retain, engage and develop a representative and diverse membership and to support and encourage the development of the role of councillors as representatives of this membership community.

The council has established a Membership Engagement Committee, chaired by a councillor. The role of this committee is to review the Membership Strategy and consider actions for growing a representative membership. The committee is in the process of developing a work programme and action plan to review and monitor progress. The committee has reviewed membership data and identified under-represented groups. The Trust is planning to undertake face-to-face recruitment in the hospital and aims to target parents and carers from these groups. Work is also underway to improve communication with constituencies.

The council established a short-life Membership Communications Group chaired by a councillor. The role of this group was to consider methods of communicating with members across all constituencies including publications and use of social media. The group's functions have now been incorporated into the Membership Engagement Committee.

Engaging with our members

Involving patients, their families and the wider public – through our Membership scheme, in service improvements and governance – continues to ensure we focus on 'what really matters' to our patients and families. Many members gave a regular commitment to service planning and redesign, as well as to the transformation programme and its improvement projects. Significant work has been conducted, drawing on members[1] involvement to improve the service for spinal surgery patients and to improve pre-assessment clinics prior to surgery.

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.

The Members' Council is planning a listening event in June 2013 for patients, families, members and staff.

Contacting councillors

If members would like to get in touch with a councillor and or directors they are asked to email foundation@gosh.nhs.uk. The message is forwarded on to the relevant person so that they can respond to them directly. These details are included within the Foundation Trust 'contact us' section of the GOSH website.

The constituencies and our membership numbers

Constituency	Minimum number of members	Actual (as of 31 June 2013)
Patient and carer		
Parents or carers	600	6,422
Patients	300	1,175
Public (includes North London and surrounding area, South London and surrounding area and the rest of England and Wales)	900	2,683
Staff	2,000	4,205
Total	**3,800**	**10,280 (excluding staff)**

Directors' remuneration

Details of remuneration, including the salaries and pension entitlements of the Board of Directors, are published in the annual accounts (within the Remuneration Report on page 156). The only non-cash element of the most senior managers' remuneration packages is pension related benefits accrued during membership of the NHS Pension Scheme. Contributions into the scheme are made by both the employer and employee in accordance with the statutory regulations.

This part of the report concerns the process for considering payments to the Chairman, Chief Executive, non-executive directors and executive directors of the Trust. The salaries and allowances cover pensionable amounts, where applicable. The Board of Directors does not receive performance-related pay.

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 November and March. Attendance at meetings held in during the period 1 April 2012 – 31 March 2013 is detailed below.

Name	Position	Attendance (out of two meetings)
Yvonne Brown (Chair)	Non-Executive Director	2
Tessa Blackstone	Chairman of the Board	2
Mary MacLeod	Non-Executive Director	2
Andrew Copp	Non-executive Director until 31 December 2012	1
Charles Tilley	Non-Executive Director	2
David Lomas	Non-Executive Director	2
John Ripley	Non-Executive Director	2
Rosalind Smyth	Non-Executive Director (from 1 January 2013)	1
Jan Filochowski*	Chief Executive (from 8 November 2012)	2
Ali Mohammed*	Interim Director of Human Resources and Organisational Development (from 21 January 2013)	1

*In attendance.

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 2012/13, the committee recommended an uplift in basic pay for executive directors of 1 per cent in line with other NHS staff. This was ratified by the Trust Board.

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.

Remuneration for non-executive directors

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

The Members' Council Nominations and Remuneration Committee considered the remuneration of the Chairman and non-executive directors in July 2012, using benchmark data from a Foundation Trust peer group. Following consideration of the structure of the revised remuneration packages, the committee recommended that the remuneration for the Chairman and non-executive directors were set out as outlined below. This recommendation was approved by a majority of the Members' Council.

Chairman's remuneration:
- 1 April 2012 – £40,000pa
- 1 April 2013 – £47,500pa
- 1 April 2014 – £55,000pa

Non-executive directors' remuneration:
- 1 April 2012 – £11,000pa
- 1 April 2013 – £12,500pa
- 1 April 2014 – £14,000pa

Deputy Chairman/Chairman of Audit Committee and Senior Independent Director's remuneration;
- 1 April 2012 – £16,000pa
- 1 April 2013 – £17,500pa
- 1 April 2014 – £19,000pa

It was agreed that these levels of remuneration would remain fixed until 31 March 2015.

Compliance with the Code of Governance

The Board of Directors considers that from 1 April 2012 to 31 March 2013 it was compliant with the provisions of the NHS Foundation Trust Code of Governance with the following exceptions:

Requirement in Code	Explanation and action to be taken
A.1.1 There should be a formal schedule of matters specifically reserved for decision by the board of directors.	A Schedule of Matters was in place following a review in May 2012. This is subject to further review following restructuring of the Trust's governance framework.

Safeguarding external auditor independence

Whilst 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 has developed a policy for any non-statutory audit work undertaken on behalf of the Trust to ensure compliance with the above objective. This policy has been approved by the Members' Council. The Trust appointed the external auditor for a review of progress against the recommendations arising from an assessment of the Quality Governance Framework during the period.

Transactions with related parties

During the year, none of the Board Members, the Foundation Trust's Councillors, or parties related to them has undertaken any material transactions with the Trust, either themselves or through other roles held with the Trust's related parties

Annual Governance Statement

1. Scope of responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH).
- Evaluate the likelihood of those risks being realised and the impact should they be realised.
- Manage risks efficiently, effectively and economically.

The system of internal control has been in place in GOSH for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

As Chief Executive I have overall responsibility for ensuring there is an effective risk management system in place within the Trust, for meeting all relevant statutory requirements and for ensuring adherence to guidance issued by regulators which include Monitor and the Care Quality Commission (CQC). Further accountability and responsibility for elements of risk management are set out in the Trust's Risk Management Strategy.

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

- Determining the overall strategy.
- Creation, acquisition or disposal of material assets.
- Matters of public interest that could affect the Group's reputation.
- Ratifying the Trust's policies and procedures for the management of risk, determining the risk capacity of the Trust in relation to strategic risks.
- Reviewing and monitoring operating plans and key performance indicators.
- Prosecution, defence or settlement of material incidents and claims.

The Board has a comprehensive work programme which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance 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 focussed 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 carried out an internal review of its effectiveness during the year and agreed actions to strengthen its oversight of risk.

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

Reporting to the Trust Board and its committees are 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). Each of these groups receive reports of risks, incidents and risk mitigating actions from division and department groups and specialist sub-committees. In addition, each clinical division's Board considers risks, quality and safety indicators, incidents and complaints on a regular basis. These are the key senior management forums for consideration of risks.

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

All staff receive relevant training to enable them to manage risk in their division or department. At a Trust level, emphasis is placed on the importance of preparing risk assessments where required, on reporting, investigating and learning from incidents. There are a range of processes to ensure that lessons are learned from specific incidents, complaints and other reported issues. These include reports to risk action groups, divisional boards and articles within internal newsletters.

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

4. The risk and control framework

The risk management strategy

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

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

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

It provides the framework in which the Trust Board can determine the risk appetite for individual risks and how risks can be managed, reduced and monitored.

The Trust defines its risk appetite as the amount of risk it is prepared to accept, tolerate, or be exposed to at any particular time. This will vary for different risks reflecting how they might impact the Trust's strategic objectives and differences in risk management capability. Controlled risk taking within defined parameters (policies, procedures, objectives, risk assessment, review and control processes) agreed by the Trust Board, encourages the creativity and innovation necessary to improve service or financial performance in order to produce benefits for patients and other stakeholders. The level of risk deemed acceptable (affected by both internal and external drivers) is kept under review by the Trust Board. The aim is not to remove all risk but by identifying and assessing the risk drivers enable risk-taking to occur in an appropriate, balanced and sustainable way.

The risk management process

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

The Trust's Board Assurance Framework is used to provide the Board with assurance that there is in place a sound system of internal control to manage 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 appropriate to manage the risk and for independent assurance that the controls are effective.

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

Each division and department is required to identify, manage and control local risks whether clinical, non-clinical or financial, in order to provide a safe environment for patients and staff and 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 '5x5' scoring system that enables the Trust to assess the impact and likelihood of the risk occurring and prioritise accordingly. Assessments are made as to whether the prioritised risks are acceptable or not.

Control measures, aimed at both prevention and detection, are identified for accepted risks, in order to either reduce the impact or likelihood of the risk. An assessment is then made of the effectiveness of the control on reducing the risk score and what assurance is available to the Board that the control is both in place and operating effectively to reduce risk. A designated person becomes responsible for monitoring, reviewing and reporting on the effectiveness of the control in place. Risks and controls are evaluated periodically and when new or changed risks are identified or if the degree of acceptable risk changes.

The principal risks for the Trust during the year, and in the immediate future, result from potential failures in the following critical processes:

- Recruiting and retaining highly skilled staff with specific experience.
- Maintaining patient safety in very high-intensity and complex clinical services and minimising the risk of infections.
- Continuing to deliver high quality care in a challenging economic environment and consequential year on year reduction in funds allocated to NHS organisations.
- Ensuring that our buildings and equipment are adequately maintained.
- Delivery of the Trust's major redevelopment programme on time and without impacting clinical services.

Each of these risks are broken down into a number of component parts covering the different elements of these risks and appropriate mitigating actions for each component identified. Emerging risks with medium or high scores are reported to through the quality and safety and Key Performance Indicators (KPI) reports and at clinical division and corporate department level through the Trust's quarterly strategic reviews. Specific emerging risks which have been identified include the impact on the Trust of the changes in the NHS commissioning processes and the funding and delivery challenge of achieving the targets set by the NHS Information Strategy of a paperless and fully digital hospital. A more detailed statement of the Trust's risks and mitigating actions are set out on page 19.

Assurance is obtained by the Board from the results of Internal Audit reviews which are reported to the Audit Committee and Clinical Governance Committee. The Clinical Governance Committee also receives the results of clinical and health and safety audits. The counter-fraud programme and security management programme are also monitored by the Audit Committee.

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

The Board has conducted a review of the effectiveness of the trust's system on internal controls and not found anything which impacts on the financial results.

Key elements of the Trust's Quality Governance arrangements

The Trust places a high priority on quality, measured through its clinical outcomes, patient safety and patient experience indicators. The Trust has assessed and concluded satisfactorily on its Quality Governance arrangements using the Monitor Quality Governance Framework and also received a report of an independent assessment from Deloitte LLP indicating that progress had been made on recommendations for further improvements included in their report.

The Trust's Quality Strategy was reviewed during the year and demonstrates the Board's commitment to place quality and safety at the top of its own agenda, to encourage continuous improvement in safety and quality indicators and establish mechanisms for recording and benchmarking clinical outcomes.

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

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

Through these methods, all the data available on the quality of care in each specialty and service is considered as part of our internal and external management and assurance process. A data quality action plan has been approved by the Board to ensure that the Board receives assurance of the quality of this data.

Compliance with CQC registration

The Trust has identified an Executive Director and a Manager who are respectively accountable and responsible for ensuring compliance with each element of the CQC registration standards and it is the responsibility of these staff to provide evidence of compliance with the standards. The evidence is reviewed periodically by compliance staff. The CQC carried out an inspection during the year and concluded that the Trust met the required level in all standards checked. The Foundation Trust is fully compliant with the registration requirements of the CQC.

Involvement of stakeholders

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

Data security

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

There have been three serious incidents relating to data security reported to the Information Commissioner during the year. The first and second both involved sending personal data of one patient inappropriately to another patient and those involved in this second patient's care. The third arose due the Trust sending a number of letters for over a year for a patient to the wrong address, in spite of being notified that the patient was not at the address where they were being sent.

All incidents have been investigated and lessons identified which resulted in changes to address the weaknesses in the Trust's systems.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that members' 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 Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UK Climate Impacts Programme (UKCIP) 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Annual Governance Statement
continued

5. Review of economy, efficiency and effectiveness of the use of resources
The Board has agreed Standing Orders and Standing Financial Instructions which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust.

The Board's processes for managing its resources include approval of annual budgets for both revenue and capital in the context of a long term financial plan, reviewing financial performance against these budgets and assessing the results of the Trust's cost improvement programme on a monthly basis. Reviews of cost improvements plans include an assessment of the risk of the plan adversely impacting the quality and safety of patient services and an identification of relevant indicators which, when monitored, might indicate heightened risk. In addition, the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and where significant these are reviewed by the Trust Board.

The Board has also agreed a series of performance metrics which provide information about the efficiency of processes within the Trust and the use of critical capacity such as theatre utilisation. The agenda of the Finance and Investment Committee includes reviews of financial performance, productivity and use of resources both at Trust and divisional level.

The Trust's external auditors are required to consider whether the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and they report the results of their work to the Audit Committee. Their report is on page 127. In addition, within the Trust's internal audit plan, there are a number of audits which consider whether processes are efficient or there is a risk of loss resulting from weaknesses in controls.

6. Annual Quality Report
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 in the NHS Foundation Trust Annual Reporting Manual.

There are a number of controls in place to ensure that the Quality Account presents a balanced view of the Trust's Quality Agenda. Many of the measures in the Quality Account are monitored throughout the year either at the Board or the Patient and Staff Safety Committee which reports into the Clinical Governance Committee.

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

The Audit Committee is responsible for monitoring progress on a data quality improvement plan. Objectives for data quality are defined and data quality priorities are monitored.

External assurance statements on the Quality Report are provided by our local commissioners and our Local Involvement Networks (LINKs) as required by Quality Account Regulations.

7. Review of effectiveness
As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work and reports of the external and internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee (and risk/clinical governance/quality committee, if appropriate) and a plan to address weaknesses and ensure continuous improvement of the system is in place. My review is also informed by:

- The reviews of compliance with CQC safety and quality standards.
- consideration of performance against national targets, the assessment on the information governance framework.
- Health and Safety Executive reviews.
- The PEAT assessment and relevant reviews by the Royal Colleges.
- The results of the review by the NHS Litigation Authority (Clinical Negligence Scheme for Trusts) Risk Management Standards during 2012/13 when the Trust achieved Level 3 compliance.

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 significant assurance. I have also taken note of the comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of effectiveness of the system of internal control by the Board, the Audit Committee, the Clinical Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have also considered the reviews of the Assurance Framework risks by the Assurance Committees, the Risk Assurance and Compliance Group and Internal Audit who seek evidence that the controls are in place and effective in mitigating the risk and by the work of clinical audit. In some instances, the audit work has found that the controls believed to be in place are not working as planned or that there is insufficient evidence that the control is working effectively. The instances where the assurance was not sufficient, or controls were not adequate when subject to routine audits during the year were:

- Providing evidence of compliance with requirements to train staff in the use of medical equipment.
- Repeated incidents of salary overpayments resulting from late processing of leavers or other changes in staff pay.
- Lack of a secure link between the staff's rostering system and the payroll.

In all cases, action plans have been put in place to remedy the weaknesses in controls or assurance gaps described above, and the remedial actions are being monitored by the Assurance Committees of the Board.

In addition, the Board has reviewed the risks and assurance available in relation to both its redevelopment programme and its information technology strategy which is focussing on the introduction of electronic patient records and moving towards a fully digital hospital. It has been agreed that due to the challenges inherent within these projects and their importance to the ongoing strategy, further actions are required to ensure that both programmes can be carried out within the required timescales and achieve their objectives. This will include seeking advice from experts and ensuring there are sufficient dedicated and expert resources in place to deliver and monitor progress on these vital programmes.

I have considered the results of the assessment of compliance with the Monitor Code of Governance for NHS Foundation Trusts (which are set out on page 58).

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.

8. Conclusion

With the exception of the minor gaps in internal controls and matters where assurances can be improved set out in Section 7 and the data security incidents referred to in Section 4, my review confirms that GOSH has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and I am confident that all minor gaps are being actively addressed. There have been no significant control issues identified during the period.

Jan Filochowski
24 May 2013

Quality Report

Cover: Toby is 12 and has a rare genetic condition called Hurler's syndrome. He has been coming to the hospital for 11 years and has recently had a spinal fusion and hip reconstruction.

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Cover: Toby is 12 and has a rare genetic condition called Hurler's syndrome. He has been coming to the hospital for 11 years and has recently had a spinal fusion and hip reconstruction.

What is the Quality Report?

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

What does it include?

The content of the *Quality Report* includes:

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

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

Understanding the Quality Report

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

This is a "what is" box.
It explains or describes a term or abbreviation found in the report.

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

These speech bubbles are for quotes from patients and their families

A glossary at the back of the report provides a brief description of abbreviations used in more than one section, and provides definition of some terms.

Arsenal fans Ronni, four, and Fredi, six, are brothers and both have cystic fibrosis. They are staying for two weeks to receive IV antibiotics, in between playing Skylanders!

A statement on quality from the Chief Executive

Great Ormond Street Hospital is one of the world's leading children's hospitals. The children we treat often have rare, complex or life-limiting conditions and need the breadth of specialist expertise that we have at the hospital. In the last year, there were more than 200,000 patient visits to the hospital. These are a mix of inpatients, day cases and outpatient appointments.

All the children and young people we treat at the hospital deserve high quality, safe care and together with their families, to receive an excellent experience while they are here. Our staff are dedicated to providing a high quality service but we know that there are things that we can do better.

The *Quality Report* is one way in which we report how well we are doing to improve our services and the progress we are making to achieve our three core priorities:

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.

There are a range of general external measures which are used to assess how well the Trust is performing. In each of these the Trust has performed well this year. The Trust achieved compliance with Level 3 of the NHS Litigation Authority Risk Management Standards for NHS Trusts providing acute services. In the latest *Care Quality Commission Report*, the Trust met all the required standards. At the time of writing the Trust had achieved 100 per cent of its quality and innovation local improvement goals.

Against each of the above priorities, the Trust has established individual improvement plans.

There are a number of initiatives aimed at further reducing all harm to zero. This includes improving how we effectively monitor and communicate with other teams when a child's condition deteriorates. There has also been work to reduce the number of pressure ulcers developed by our patients, a risk among very sick children. In both these areas, we have made progress but there is more work to be done.

The Trust has made it a clear ambition to publish as many clinical outcomes as possible and each specialty has been looking at this. It is not always easy to compare outcomes when you are dealing with very sick and complex patients and many teams have been working with international partners to establish meaningful benchmarks. Parents have told us that they would like to see more outcomes for the main conditions treated and we will continue to work on this. We are, however, pleased to continue to publish an increased number of outcomes on our website because we believe it will help clinical colleagues and families to access vital information for them.

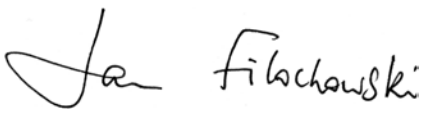
One of the programmes we are most proud of this year is the change we have made to part of our cystic fibrosis service. We wanted to reduce the need for children to keep coming into hospital for their intensive intravenous antibiotic treatment and we have achieved this with significant benefits to patients, both for their health and quality of life.

We are also pleased to have improved access to the hospital by some changes to our systems. This means that we have reduced the number of patients that we have been unable to admit due to lack of available beds. We do need to do more work on this but I'd like to thank all the teams for the progress they have made – we have been able to treat more children as a result.

Following feedback from families and our referrers, the Gastroenterology team commissioned a global advisory panel to suggest ways in which we could improve the service and the overall family experience. This has resulted in a number of improvement measures which the team are continuing to work on.

It is important that we continue to listen to the feedback from patients, families and our healthcare partners. This will help us to identify where we need to focus our efforts so that we deliver the high quality experience to our patients that we would want for ourselves and our families.

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



Jan Filochowski
Chief Executive

Fourteen-year-old Millie is having some tests on Kingfisher Ward. She has a floppy larynx (laryngomalasia), gastro oesophageal reflux and unstable blood sugars. Millie is listening to her brother's iPod but is not impressed with his choice of music!

Part 2a: Priorities for improvement

This part of the report sets out how we have performed against our quality priorities in 2012/13. The quality priorities fall in to three categories: patient safety, clinical effectiveness and experience. These categories were defined by Lord Ara Darzi in his NHS review for the Department of Health, in which he emphasised that quality should be a central principle in healthcare. Our quality priorities are aligned with these categories:

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

Safety

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

Clinical effectiveness

Delivering effective care is, and always has been, a primary focus of Great Ormond Street Hospital (GOSH). Over the last couple of years we have been evidencing the effectiveness of our care through the identification of clinical measures and Patient-Reported Outcome Measures (PROMs). Wherever possible we will use established national or international measures that allow us to benchmark our results with other services.

Our commitment to research and innovation also demonstrates our dedication to delivering the most clinically effective care.

Experience

We recognise that the memories and perceptions that patients and families have of GOSH are heavily influenced by the quality of their experience. Therefore, we measure patient experience across the hospital and ensure that we use that information to improve the services we offer. We also seek to create meaningful opportunities for engagement with our patients, their families, and the public.

When asked what 'experience' means for her as someone whose child is treated by several of our services, one parent said only three words:

Transparency.
Respect.
Information.

For us, these are powerful and important words, and we take them seriously. We seek to meet these terms of engagement in our day-to-day provision of services to our patients and their families and carers, and in the improvement projects we undertake.

Reporting our quality priorities for 2012/13

In addition to reporting our progress with the 2012/13 quality priorities that we declared in last year's *Quality Report*, in this section we also report on:

- an additional project under the safety category
- two additional projects under the clinical effectiveness category
- an additional project under the experience category

This is to provide readers with information on other areas of service improvement work during the reporting year that we expect to be of interest.

Safety
Zero harm – reducing all harm to zero

Improvement initiative	What does this mean and why is it important?
Improve the effective monitoring and communication of the deteriorating child, measured by making a 50 per cent reduction in the number of cardiac and/or 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 and/or respiratory arrest. We want to ensure that ward staff are effectively monitoring patients so they can identify if a child's health is deteriorating and provide intervention *before* onset of an 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 can make it difficult to re-position them. Pressure ulcers are graded from one to four depending on degree of injury to the skin, with higher grades being more severe.
ADDITIONAL PROJECT REPORTED To implement a 'gold standard' efficient and safe patient pathway from consideration for spinal surgery through to discharge post surgery (or removal from the pathway) for all patients referred to the spinal surgery service.	The pathway for major surgery combined with the percentage of patients with complex medical needs means that we must ensure that key elements are in place for safety and efficiency. Mapping and improving our process enables better communication across specialties and with families and the child.

Clinical effectiveness

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

Improvement initiative	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 that some deaths could be avoidable and hospitals can learn from reviewing events. While individual teams at Great Ormond Street Hospital (GOSH) 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 last year has told us that we need to ensure that measures are reflective of the main conditions treated.
ADDITIONAL PROJECT REPORTED Reduce the need for children and young people with cystic fibrosis (CF) to be admitted to hospital for intensive intravenous (IV) antibiotic treatment and to improve clinical status.	Reducing the requirement for hospital admissions and IV antibiotic therapy enables children with CF to spend more time at home, at school, and socialising with their friends. With more physiotherapy support, fitness levels can also increase, improving overall health. In addition to delivering better outcomes for the patient, this approach is cost effective for the hospital.
ADDITIONAL PROJECT REPORTED To develop risk-adjusted outcomes in real time in cardiac surgery.	Risk-adjusted outcomes are reported nationally so they can be monitored externally. However, if these data are available in real time, they can be used by services to quickly spot positive or negative outcomes that might prompt discussion. The Variable Life Adjusted Display (VLAD) charts were devised to achieve real time information in cardiac surgery.

Experience

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

Improvement initiative	What does this mean and why is it important?
Improve the way we manage and use our hospital beds, to increase the number of unplanned patients we can admit.	While we don't have an emergency department, patients in local hospitals sometimes need to be urgently transferred to GOSH for specialist treatment. To provide this care, we need to have sufficient beds available. We want to improve the use of our beds so that we can admit more of these unplanned patients when they need our care.
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. The You're Welcome quality criteria were developed by the government to help ensure that hospitals such as GOSH provide the best standards of care for adolescent patients. We want to ensure the services we provide reflect the needs of our young people and put in place improvements where needed.
ADDITIONAL PROJECT REPORTED Improve the experience of patients treated by our Gastroenterology service by reviewing the process and the different strands of the service, and identifying priorities for improvement.	Feedback from patients and families using the Gastroenterology service and from clinicians referring into the service demonstrated that experience was not always good: patients/ referrers struggled with communication with the Gastroenterology team and with accessing services. Improvement work was, and is, essential to put in place system, process and culture changes to ensure the service functioned more effectively.

Safety

Effective monitoring and communication of the deteriorating child

What we said we'd do

Through effective monitoring and communication of the deteriorating child, this improvement initiative aimed to reduce the number of cardiac and respiratory patient arrests outside intensive care by 50 per cent each year.

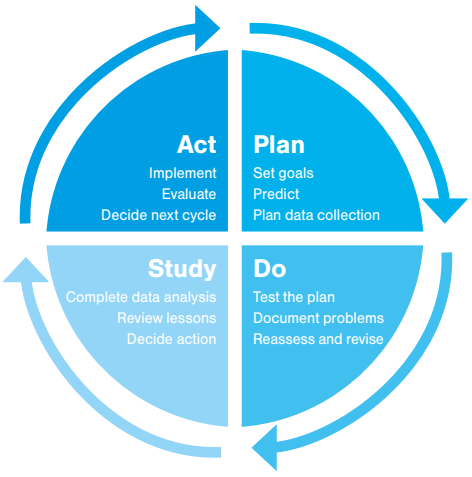
In the 12-month period, we said we would review data on clinical emergency team calls, cardiac and respiratory arrests and unplanned transfers from the ward to intensive care (ICU). By doing this we could identify areas where improvements might be made and advise on data that would allow us to track our progress and monitor our success.

An important aspect of the work was improving the quality of vital sign observations and the use of Children's Early Warning Scores (CEWS), which are used to identify, record, and report signs of deterioration in patients. This is done by using a simple scoring system based on vital sign observations, for example, pulse and blood pressure. We wanted to explore innovative ways of capturing and recording the observations.

Learning more about why patients arrest, and evaluating our processes, will help us to reduce arrests.

What we actually did

During the year, we looked at different ways of collecting the information we need when a child arrests. We started with a weekly meeting to give us an overview of arrest incidents, but we realised we needed to disseminate learning more quickly than this. No suitable tools were found in the literature, so a group of experienced clinicians, safety experts, and risk managers used the Plan-Do-Study-Act (PDSA) approach to develop a tool for "Rapid Evaluation of Cardio-respiratory Arrests with Lessons for Learning" (RECALL). The RECALL tool gave a framework to do this and a traffic light approach was applied to each category to communicate findings: green (no areas identified from the notes that could be improved), amber (areas for improvement identified but unlikely to have predicted or prevented the arrest) or red (areas for improvement identified which was likely to have prevented the arrest).



RECALL is now used to review all arrests. Using it has facilitated a culture of learning so that clinical teams can understand how to improve their recognition and escalation of seriously ill children. Although this project is relatively new, common themes are already emerging such as completeness of observations and timeliness of interventions.

The CEWS score aims to keep children safe by identifying children who are deteriorating quickly and aid decision-making to ensure that they get the right help at the right time. The central project team has been working with several wards across Great Ormond Street Hospital identifying what works and what we could do better, with a pilot in our International and Private Patient (IPP) Clinical Unit.

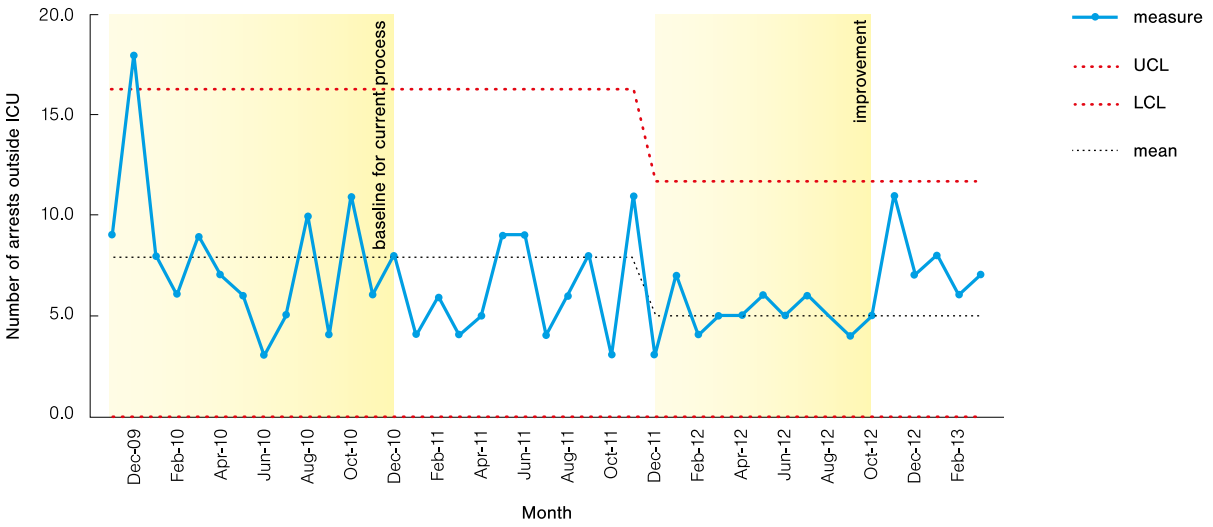
A project team was formed to review the current practice of recognising and escalating a deteriorating child on the ward. Over a two week period all clinical staff on the pilot ward were observed completing a vital sign assessment. The assessment highlighted variability of nurses' knowledge of normal observation values and ability to interpret signs of deterioration in a child's condition. The team used the PDSA approach to drive the improved use of CEWS. Each week a minimum of five sets of observations were observed and audited using an online tool. Direct feedback was given to nursing staff on the results and a ward 'huddle' was introduced to increase awareness of CEWS and escalation of CEWS.

What the data shows

Statistical Process Control (SPC) charts are used to measure improvements in projects over time. SPC methodology aids the identification of statistically significant changes and identifies areas that require further investigation. Upper control limits (UCL) and lower control limits (LCL) are calculated to help with data analysis. Although we did not achieve the 50 per cent reduction in cardiac and/or respiratory arrests outside of ICU, we have sustained the improvement achieved in the previous year 2011/12, which was a 37 per cent reduction in cardiac and/or respiratory arrests outside of ICU. The work being undertaken at the front line is crucial to ensure we are able to maintain and improve in 2013/14.

The graph below shows the monthly number of arrests (cardiac and/or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team).

The number of arrests outside ICU: all locations



What's going to happen next?

The learning from RECALL will be implemented locally with trust-wide learning incorporated into system-wide improvement projects in 2013/14.

The CEWS project has now completed the first phase of this improvement programme and in April 2013 the learning from the IPP work will be rolled out to other wards.

Our priority for the near future is not only to sustain the established processes, but to expand the scoring system to include two further components. We aim to quantify the nurses' 'gut' feeling about a patient's condition when the CEWS identifies that there is no need for intervention, yet the nurse's intuition suggests otherwise. The second component is to recognise and acknowledge the concern of a patient or parent. We are developing a number of options to capture that concern and raise it in a timely way.

Improving skin viability

What we said we'd do

In last year's *Quality Report*, we said we would aim to reduce the number of pressure ulcers per 1,000 bed days that develop 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.

What we actually did

A team of experts from different specialties and professions developed an action plan, and met on a monthly basis to oversee the improvement work. A working group reviewed every incidence of pressure ulcer, and spoke with clinical staff, parents and carers, and young people about their experiences. The team identified areas of good practice and areas for improvement.

A key finding was the need to improve the sensitivity of the risk assessment tool used by staff to determine the likelihood of a pressure ulcer developing. We changed from the Braden Q system to the Glamorgan Pressure Ulcer Risk Score, which requires nurses to use a standard set of questions and a grading score for every patient. The new risk assessment tool was implemented on all wards by the end of March 2013.

To support nurses in the actions taken when a risk is identified, we also introduced the GOSH SSKIN Care Bundle, which includes the following five components:

- Appropriate support **S**urface
- Comprehensive **S**kin assessment
- Assisting patients to **K**eep moving
- Optimal **I**ncontinence management
- Maintenance of good **N**utrition

Both the Glamorgan and the SSKIN Care Bundle were incorporated into a new, quicker and easier-to-use Combined Mandatory Risk Assessment booklet, which also includes nutrition and manual handling/falls risk assessments.

The pressure ulcer prevention and management team (comprised of specialist plastic surgery nurses and a practice educator) have developed a training programme and provided support to ensure that ward staff are fully capable of identifying and monitoring patients at risk of pressure ulcers using these new tools.

The Combined Mandatory Risk Assessments should be completed on all inpatients within six hours of admission. A monthly audit of pressure ulcer risk assessments completed on admission shows completion rates of, on average, 88 per cent over the past three years. However, once a patient has been identified as being at risk, the use of correct prevention measures is key to avoiding the development of a pressure ulcer. Over the last year we have improved the provision of pressure relieving mattresses for infants, children and young people, and have introduced other new pressure-relieving products to help reduce the incidents of pressure ulcers.

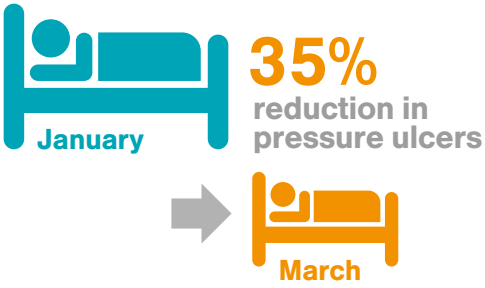
It should be noted that many of the pressure ulcers that do occur happen to patients who are very sick in intensive care. This happens because their blood circulation and oxygen levels may be low, or they are too poorly to be moved as often as they require. This can cause the skin to break down more quickly and easily.

What is a pressure ulcer?

Pressure ulcers, sometimes known as bedsores, are a type of injury that affects the skin and underlying tissue. They are caused when an area of skin is placed under too much pressure, if sensitive skin is subject to friction, or through shearing injuries. Pressure ulcers are graded from one to four, with four being the most severe. They can be very painful, and can increase a patient's risk of infection. Every hospital wants to reduce this type of harm.

What the data shows

The project commenced in April 2012. Improvements were implemented and rolled out to the majority of wards by December 2012. The rate of pressure ulcers per 1,000 bed days dropped to 0.46 from January 2013 to March 2013. Therefore, a reduction of 35 per cent was achieved against a target of 20 per cent. Variability since June 2012 has reduced due to the implementation of sustainable processes.



What's going to happen next?

We have exceeded our target, and in doing so, improved the way we assess the skin integrity of infants, children and young people, and implemented better prevention measures to protect vulnerable skin.

In 2013/14, we aim to go further in our pressure ulcer prevention work through the following:

- Complete the roll out of the specialist training programme to nursing staff.
- Ensure that every patient admitted to GOSH receives a pressure ulcer risk assessment score assigned on their admission.
- Ensure appropriate action is taken in response to this score.
- Extend to grade 2 pressure ulcer occurrences the detailed 'Root Cause Analysis' process that we currently undertake for all grade 3 pressure ulcers that have developed within the hospital. This will enable us to determine whether the pressure ulcer was 'avoidable' or 'unavoidable' and whether appropriate actions were employed and documented.

As we continue to improve our prevention measures, and monitor prevalence of pressure ulcers in our children, we hope to publish more papers and contribute to the wider evidence base.

"Maisie has hypoventilation syndrome, which means she can't breathe for herself. She has been in hospital for two years now. She has a tracheostomy and a ventilator tube in her neck – and tapes around her neck to hold it in place. When she got a bit older and started to move more and play, the tapes would pull and rub. It must have been uncomfortable – I can't imagine having that around your neck all the time. She has a damaged neck now. It was red at first but gradually it got worse. The pressure ulcer was like a deep wound. The nurses put a special brown tape on it to help clear it up, but it didn't really help. Then Jo, the tracheostomy nurse, helped design padded tapes and it has made all the difference. The wound is healing and Maisie stopped itching her neck. There's a dent still, but it's only red now. She used to cry getting her tapes done, but now she gets all excited or will just let you change them without needing to be distracted."

Parents of Maisie, aged two, on Miffy Ward

Spinal patient pathway improvement

In early 2011 an external review of the spinal surgical service was commissioned at the request of the surgical team to investigate a small number of deaths among complex patients having major spinal surgery. In August 2011 the Medical Director, General Manager and Clinical Unit Chair for Surgery initiated a project charged with delivering recommendations of that review. In particular, the project's key deliverable was to implement an efficient and safe pathway from consideration for spinal surgery to discharge post-surgery (or removal from the pathway) by February 2012, and to implement a 'gold standard pathway' by December 2012.

What we did

A monthly multi-disciplinary team (MDT) meeting was set up to review risk and benefit for all patients on the pathway and agree the best approach for each child. At the same time, the project lead met with the specialties involved in the pathway. A process mapping session with all involved was arranged to map the complex multi-factorial process. Rather than map what *was* happening, they mapped in depth how the process should work to minimise risk, disruption, and cancellation. This exercise enabled the MDT to discuss and debate what constituted 'gold standard' care and why, identifying how patients' journeys flowed. As part of the exercise, the clinical staff put resource limitations to one side, and in doing so they generated innovative ideas and produced a skeleton 'gold standard' pathway.

That session enabled the project to evolve into a dynamic process of improvement. The whole team engaged fully with the development of the pathway to 'make it right because it's not quite there', with smaller, focused, meetings occurring to make further changes for approval by the wider group. By version eight, the team were ready to use the pathway as a basis for a business case and the improvement to quality, safety and activity was outlined to ensure the pathway was correctly resourced.

A database was developed by the project analyst to record the key points of the pathway agreed as essential for each patient. Here, the team recorded each patient referred into the pathway, thus ensuring that the agreed new pathway was completed for all patients.

During 2012, the outpatient clinics were changed to include a Clinical Nurse Specialist review, to collect key patient information earlier in the process for improved planning. A co-ordinated investigation day commenced, the MDT meeting improved in focus and structure, and completion of consent moved into a clinic setting. All of these changes required the team to engage in new methods of working, and to be open and honest about the positives and the areas for further work using tools such as After Action Review (AAR) to inform PDSA cycles of improvement. In early 2013, the ward opened a High Dependency Unit (HDU) delivering care for children on non-invasive ventilation, previously only available outside of the specialty.

Components of the 'gold standard' pathway

Consultant level assessments and core agreed tests completed within three months of surgery.

⇩

Assessments and test results reviewed at multi-disciplinary team meeting. Risk/benefit discussion and decision.

⇩

If decision is to proceed, individualised care plan agreed.

⇩

Clinic for consent, with consultant.

⇩

Surgery.

What is an After Action Review (AAR)?

An After Action Review is a structured discussion of an event that enables the individuals involved to learn for themselves what happened, why it happened and what can be improved. It asks four questions:

- What was expected?
- What actually happened?
- Why was it different?
- What have we learned?

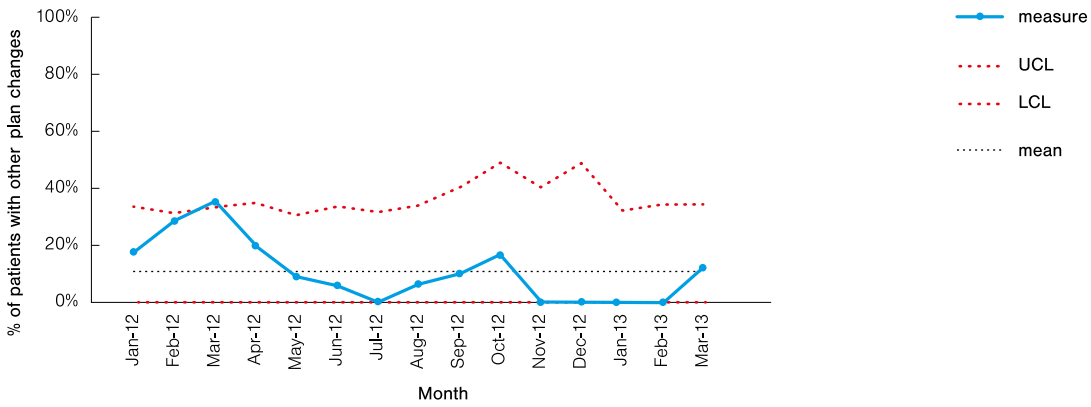
An AAR can generate insight, promote understanding, and change behaviours through bringing differing expectations and perspectives to light. The key objective of an AAR is to learn in order to improve.

After the completion of the work to assure safety, the project focused on achieving the 'gold standard' pathway for spinal patients (see box opposite). Now that components of the gold standard pathway are agreed, efforts are focused on embedding and measuring each element in the process so that they are consistently achieved.

What the data shows

An additional data set has since been added, recording what was *planned* in the MDT meeting for the patient's admission, and then noting any *deviation* from this plan. This allows for any variance to be easily identified and reviewed for continuous improvement of the pathway.

Percentage of patients with other plan changes: spinal surgery



The monthly percentage of spinal patients for whom there was one or more differences between what was planned and their actual care. Lower percentages indicate better planning. Differences may include: Non-invasive ventilation, planned / actual procedure, consultant, admission date, admitting ward, or post-operative ward.

The project data is readily accessible to staff via project 'dashboards' on the Trust intranet.

The outputs of this work mean that patients will have a better understanding of the procedure and its risks and benefits at an individual level, which will also enhance informed consent. The improvement in efficiency and multi-disciplinary team working provides a robust assessment and a shorter pathway to surgery.

What's going to happen next?

Further refinements to the pathway will follow now that key components are in place, and our patient information leaflets will be finalised. The project has broken down many barriers, with practices challenged and changed along the way. The group has successfully delivered all but one of the recommendations of the external review allocated to the project and are now working towards exceeding them, providing truly gold standard services for the patients under the care of the Spinal team.

Clinical Effectiveness

Monitoring and learning from why children die

Death of children in hospital is a rare event, but evidence shows that the care children and their families receive leading up to and around the time of death, warrants particular attention. The Confidential Enquiry into Maternal and Child Health (CEMACH) *Why Children Die* and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) *Are we there yet*? highlighted important areas for improvement, such as recognition of the sick child, escalation of care, the need to keep parents informed at all times, and in some cases, the need to provide appropriate end-of-life care.

What we said we'd do

In last year's *Quality Report*, we said that we would review the medical records of 60 per cent of patients who died in the Trust in 2012/13 to look at appropriateness of care, to share examples of good practice and, where opportunities for improvement are identified, to share learning across the organisation.

What we actually did

We formed a monthly Mortality Review Group in the first quarter of 2012/13, which included consultants from Intensive Care, Anaesthesia, Palliative Care, General Paediatrics, Surgery, Nephrology and Pathology. For each patient, the consultants:

- Completed the 2x2 Mortality Matrix and supplementary questions.
- Looked for evidence in the medical records of the involvement of the Palliative Care team.
- Looked for evidence in the medical records of discussion at Morbidity and Mortality (M and M) meetings (M and Ms are regular meetings where clinical cases are discussed to consider what happened and what could be done differently in future. They are recognised to improve the quality of clinical care.).

Action points arising from each review were agreed. While the findings will be published in a final report, some action points were able to be addressed with clinical teams directly, enabling immediate improvement as a result of this process.

What is palliative care?

Palliative care for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family. The aim of palliative care is to achieve quality of life and a dignified death, preferably in a place of the child and family's choosing. All children with palliative care needs require an individual package of care including variable components of generic and, where necessary, specialist palliative care, provided in a planned, co-ordinated, timely and flexible manner as directed by their individual need.

What is a 2x2 Mortality Matrix?

Originally developed by the NHS Institute for Innovation and Improvement, the 2x2 Mortality Matrix tool enables review of deaths in hospital to determine appropriateness of the location and level of care being received at the time of death. This tool can be used as a measure of safety and quality of care, and can highlight areas where improvements can be made.

		ICU Admission	
		Yes	No
Active Resuscitation	No	**1** Suggests over use of ICU or HDU beds.	**2** Focuses attention on end-of-life care plans.
	Yes	**3** Identifies system issues in intensive care where known improvement techniques can be applied.	**4** Highlights areas for improvement on the ward such as infection prevention, and identifying the deteriorating child.

What the data shows

The infographic opposite shows the percentage of deaths in the Trust in 2012/13 that were reviewed as part of the mortality review work. With a review rate of 86 per cent (91 of 106 deaths), we exceeded our target of 60 per cent.

As expected, most patients died in the intensive care unit (ICU) (92 of 106 deaths), where acutely sick children are treated. There were no deaths on the ward with the child receiving active resuscitation, indicating that good systems are in place to identify the deteriorating child. However, there was one case where the review team felt that the ward had been slow to recognise how sick the child was before transferring to ICU. Targeted training has been undertaken on this ward to address concerns relating to escalation of care.

93 per cent of deaths occurring outside of ICU were reviewed by the Mortality Review Group (13 out of 14). The remaining case will be reviewed by the Mortality Review Group at their meeting in early June.

Many of the patients reviewed were receiving palliative care, but this was often not reflected with documented evidence of an end-of-life care plan at the time of death. While some medical records demonstrated how well end-of-life care had been managed, documentation in others could be improved.

The infographic opposite shows the percentage of reviews that had an action or learning point identified as a result of the review.

Another early finding was the inconsistent documentation of M and M meetings in medical records, which prompted a Trust-wide survey of M and M meetings. Of the 19 clinical units surveyed, 13 had regular M and M meetings, eight had an identified clinical lead, six meetings were minuted, five were multidisciplinary, and three units routinely recorded the conclusions of the M and M meeting in the medical record. Work is already underway to improve the structure of M and M meetings, and the quality of the documentation.

The group also found that Serious Incident reviews and coroners' reports were not always noted in the medical records. Interim findings from the first six months of reviews were presented to the Quality and Safety Committee in January 2013 for dissemination to individual clinical units, with recommendations for improvement work to address the identified issues.

86%

of deaths in the Trust were reviewed by the Mortality Review Group

35%

of reviews had an action or learning point

What's going to happen next?

Review findings for the year will be presented to the clinical staff at a Trust-wide mortality review meeting and will be cascaded to safety and improvement officers for sharing. It will also be reported to our commissioners with an action plan to address service issues identified. In 2013/14, the work to strengthen the structure of the M&M meetings will continue, and the Trust will highlight the importance of consistent documentation in the medical record, including:

- End-of-life care plans.
- Documentation of discussions (including M&Ms).
- Inclusion of copies of relevant reviews and external reports.

GOSH is also working with Dr Foster, an organisation that provides comparative information and performance data on health and social care services in England. Together, GOSH and Dr Foster are investigating the potential for developing a Standardised Mortality Ratio (SMR) specifically for paediatrics. The current Hospital SMR measures whether the death rate in a hospital is higher or lower than expected, by comparing actual mortality against expected mortality for that group. However, it is oriented towards acquired (adult) illnesses. By the end of 2013, it is hoped that this piece of work will yield agreed principles for a measure that is more relevant and appropriate to paediatrics.

Development and use of clinical outcome measures

What we said we'd do

In last year's *Quality Report*, we said we would aim to increase the number of clinical outcomes that we have for each specialty from two to three, and ensure that the outcome measures used are reflective of a specialty's main work.

What we actually did

Over the course of the year, the Clinical Outcomes Development Lead supported clinical units and specialties to:

- Identify applicable outcome measures that already exist and are used nationally or internationally.
- Adopt applicable measures and begin to gather data.
- Analyse the data.
- Begin to publish the data on our website, with contextual information to help readers to understand what the data means for our patients.

Given the specialised work that we do, some existing measures may not fit the services we provide. Where this is the case, specialties have worked on devising and validating their own measures, which capture relevant data on our clinical outcomes – and provide us with information that is meaningful to our services and our patients. Outcome measures should not just measure a Trust's clinical outcomes; at their best, outcome measures should inform service improvement.

Forty-five of our specialties are developing outcome measures. Of that number, 43 have identified at least three such measures. The two specialties that did not were Laboratory Medicine and Clinical Neurophysiology. Both of these departments perform tests to provide diagnostic information for patients. In both cases, the process of identifying suitable measures has raised an important issue about the applicability of 'stand alone' outcome measures for diagnostic services. Measures that could be identified tended to resemble performance indicators (such as turnaround times) rather than measures of the treatment outcome. Therefore, in 2013/14 we will explore how we might better measure the contributions of the diagnostic departments to patient outcomes.

Another element of meaningful measurement is the collection of data on our routine work. While outcomes data pertaining to treatment of rare conditions are important, we also recognise that we must anchor our outcomes programme in the work we do most often. This represents our core service delivery and, importantly, such measures can more readily be benchmarked against similar services. In 2012/13 we focused on developing more measures. While we are comfortable that many do represent our main work, we did not comprehensively evaluate this. We will undertake this work in 2013/14 to ensure that we move forward with a demonstrably solid foundation.

Robust, benchmarked clinical outcome measures generate information that can lead to improvements in treatment and in services provided to patients. This data also brings more transparency of hospitals' performance relative to others.

What's going to happen next?

In 2013/14, we will progress our clinical outcome measures by:

- Exploring alternative measurement options for diagnostic services' contributions to outcomes.
- Evaluating whether identified measures represent a specialty's main work, and where they do not, developing measures that do.
- Reviewing our Patient-Reported Outcome Measures and standardising the approaches where possible.
- Progressing our benchmarking project, which has already successfully identified international partners with whom we can benchmark specialist paediatric outcomes.

What is benchmarking?

Benchmarking is a process by which an organisation compares its performance and practices against other organisations. These comparisons are structured and are typically undertaken against similar organisations and against top performers. Benchmarking helps to define best practice and can support improvement by identifying specific areas that require attention.

"The era of measurement in medicine holds the promise of promoting the most effective clinical strategies and rewarding excellence, not just reputation. But this will work well for everyone only if we maintain our focus on ensuring that the measures are worthy of the task, that they undergo continual scrutiny, and that they are used in appropriate ways."

KRUMHOLZ, H.M., LIN, Z., and NORMAND S-L.T. (2013) Measuring Hospital Clinical Outcomes: Methods Matter. *BMJ*, 346 (f620)

Cystic Fibrosis Frequent Flyer Programme

The Frequent Flyer Programme (FFP) was undertaken as a quality improvement initiative within the GOSH Cystic Fibrosis (CF) Unit between September 2010 and April 2012. The pilot programme, so named because children with moderate to severe CF spend so much time in hospital, aimed to reduce the need for children and young people with CF to be admitted to hospital for intensive intravenous (IV) antibiotic treatment and to improve clinical status.

Each child was provided with a 12-month, weekly supervised, intensive outreach physiotherapy and nutrition programme. The primary outcome measure was the total number of IV antibiotic days required during the 12-month intervention period, compared to the 12 months pre-intervention. A comprehensive cost analysis was also undertaken. Participants were monitored over the course of the year for changes in their exercise capacity, lung function, growth and quality of life.

What we did

Sixteen of the sickest children (four male; 12 female) aged four to 15 years that had required more than 40 days of IV antibiotic treatment in the previous 12 months, were invited to participate. Physiotherapy included weekly-supervised exercise sessions and regular review of airway clearance and mucolytic inhalation therapy. Exercise sessions included aerobic, strength, core-conditioning and stretching components. In addition, children were encouraged to exercise independently and to actively participate in school sports for an extra two hours each week. Dietetic management included more regular monitoring of growth, absorption, appetite and intake and nutritional education sessions.

What the data shows

There was a 21 per cent reduction in the requirement for GOSH inpatient IV antibiotic treatment, from 619 days in the pre-intervention year to 478 in the intervention year; a 24 per cent decrease in shared-care inpatient IV antibiotic requirement from 249 to 189 days; and a 20 per cent reduction in home IV antibiotic treatment from 304 to 243 days. This meant that children were able to spend more time at home and school, and experienced less of a dip in their general quality of health. Full cost analyses determined there was an estimated saving of £170,610 in GOSH inpatient costs; £39,480 in shared-care hospital bed costs; and £10,248 in home IV costs. After factoring in the £100,000 set up costs for the programme, plus estimated annual gym memberships costs of £6,768, the average cost per patient during the intervention year was £53,146 suggesting a cost saving of £7,098 per child or £113,570 overall.

What is CF shared care?

The majority of people with CF receive all or some of their care from a Specialist CF Centre. In some circumstances, a shared care network arrangement between a specialist centre and a local hospital has been developed as a means of improving local expertise and community support and minimising travel for children and their parents, thus offering quality care irrespective of the distance from the CF Centre.

21%
reduction in the requirement for inpatient IV antibiotic treatment

£7,098
cost saving per child

£113,570
overall cost saving

Feedback from both children and parents was very encouraging, with families reporting that their children had an improved quality of life. Subtle changes in clinical status identified by more frequent contact with the children enabled early intervention and initiation of appropriate treatment. Fitness levels increased significantly, with children saying they are now able to exercise at the same level or sometimes even higher than their peers. The majority of children on the programme maintained their lung function and growth outcomes.

2a: Priorities for improvement
Clinical effectiveness priority
continued

What's going to happen next?
The FFP showed a reduction in IV antibiotic requirement with a cost benefit, and significant increases in exercise capacity, in a small group of sicker children with moderate to severe CF. If the positive results realised in this pilot programme were replicated in other CF units across the UK, the implications for cost saving, improvement in clinical status and quality of life are potentially extensive.

Developing a new model of care to improve the quality of clinical practice has the potential to significantly improve clinical outcomes for all Great Ormond Street Hospital Children's Charity CF patients. A fully powered randomised controlled trial, INSPIRE-CF, has now been funded by the GOSH Children's Charity. This research will enable us to rigorously quantify the clinical and economic benefits of a similar, individualised regimen to the FFP, compared with current standard clinical care, in a larger group of children with a wider range of disease severity.

Case study

Tom's story

Tom, 15, from St Albans, was one of the first patients to enrol on the Frequent Flyer Programme.

Struggling to gain weight, and with a bad cough, Tom was diagnosed with CF at six weeks old. He began visiting GOSH bi-monthly and was an outpatient until he was four. Tom then developed an infection and was admitted for two weeks to receive IV antibiotics. By the time Tom was nine, he was spending two to three weeks in hospital every few months for antibiotic treatment.

Currently, in order to protect his lungs, Tom uses a chest physiotherapy technique twice a day to clear his chest of mucous. In addition, he must adhere to a strict regime of oral and nebulised antibiotics. A nebulised mucous-thinning drug is taken daily to help clear his airways. Enzyme medication is taken to aid food digestion, as CF also affects the digestive system.

Tom's mum Karen says:

"Having a child with CF has a huge impact on the whole family. When it became clear that Tom needed more frequent inpatient stays, the effect on family life was quite considerable. It became a struggle to maintain my career and most importantly, to divide my time between Tom and my elder daughter of school age. Tom's schooling was also affected, as more and more time was spent away from school while in hospital."

"However, since Tom joined the Frequent Flyer Programme, the difference to his health and to family life has been enormous. Hospital admissions have been reduced considerably and Tom has realised the importance of staying fit and healthy to help manage his CF. Tom is an active member of a football team and is a regular visitor to his local gym. There is no better reward for Tom's efforts than to see him as active as his friends."

"Overall, we have been delighted with the Frequent Flyer Programme and very much hope that other children will be able to benefit from such schemes."

Data definitions

About cystic fibrosis

- CF is a genetic disease that affects the internal organs, especially the lungs and digestive system.
- It is characterised by chronic lung infection and inflammation, and digestive problems.
- It is the most common, life-shortening, genetically inherited disease affecting multiple organs in the body.
- It affects over 9,000 individuals in the UK.
- Two million people (one in 25) carry the faulty gene.
- 85 per cent of CF-related deaths result from lung disease.
- Each week five babies are born with CF.
- Each week three young lives are lost to the disease.

CF Trust estimated cost of CF healthcare in the UK

- £400,000–£500,000 per patient over the course of a lifetime.
- £25,000 direct costs per patient per year.
- £20,000 for a 14-day admission to hospital for IV antibiotics treatment.
- £2,300 for a 14-day course of IV antibiotic treatment at home.

Objectives of the programme

- Reduce inpatient admissions to hospital and IV antibiotic requirement by 20–30 per cent.
- Reduce hospital costs.
- Increase exercise capacity.
- Improve clinical status and quality of life of sickest group of children.

Results

- 23 per cent reduction in inpatient IV antibiotic requirement.
- 20 per cent reduction in home IV antibiotic requirement during the intervention year.
- Cost saving of £7,098 per patient.
- Cost- benefit of £113,570 for the programme.
- Exercise capacity increased by 13 per cent.
- Majority of group maintain lung function and growth outcomes.
- Improved quality of life.

Plan

- Randomised controlled trial, INSPIRE-CF has been funded and is in progress.

Cardiac Surgery Variable Life Adjusted Display (VLAD) pilot

When we are monitoring the short term results of a hospital treatment such as an operation or an admission to the intensive care unit, we frequently look at mortality rates in order to assess our clinical outcomes. One important issue to consider when reviewing the short term mortality rates of patients undergoing hospital treatment is the complexity of the case mix. It is recognised that a team of healthcare professionals who take on more complex or severe cases may have fewer survivors. Therefore, attempts need to be made to adjust for the severity of the case mix in order to ensure that outcomes are judged fairly. This involves a process called 'risk adjustment', whereby information about a group of patients is gathered together and analysed in order to judge complexity.

What we did

GOSH teamed up with the Clinical Operational Research Unit (CORU) at University College London and the National Institute for Cardiovascular Outcomes Research (NICOR) to develop and validate a method of risk adjustment specific to a high-risk area of healthcare – paediatric cardiac surgery. Having completed this piece of work, which has been peer reviewed, the new risk adjustment method will now be used by NICOR to benchmark paediatric cardiac surgery outcomes nationally.

A further development of this work stream is the monitoring of risk-adjusted outcomes in real time, using Variable Life Adjusted Display Charts or VLAD charts. These charts:

- Quickly spot trends in outcomes (whether positive or negative) that might prompt discussion.
- Provide a visual aid to gain an overall perspective on how things are going.

The VLAD essentially benchmarks a unit's outcomes against recent national outcomes in paediatric heart surgery based on the risk adjustment model.[1]

Despite this being one of the most complex areas of surgery, and lifesaving for the children involved, the UK programme has excellent outcomes with very low mortality rates (for example, about 85 per cent of GOSH patients have estimated risks of 0.1 per cent to five per cent.)

Interpreting the VLAD chart

Each point on the VLAD chart represents the first surgical procedure for a child in a 30-day care period. If the 30-day outcome is a survival the VLAD plot goes up and if it is a death the VLAD plot goes down. A run of survivors will cause the VLAD plot to go up and a run of deaths will cause it to go down. Over time, if outcomes are as expected by the risk model, the end of the VLAD plot will tend to be close to zero – that is, neither more nor less deaths than expected.

1 The VLAD chart is not intended to judge outcomes, nor does it provide statistical control limits. Any risk model can only partially adjust for risks associated with any individual child.

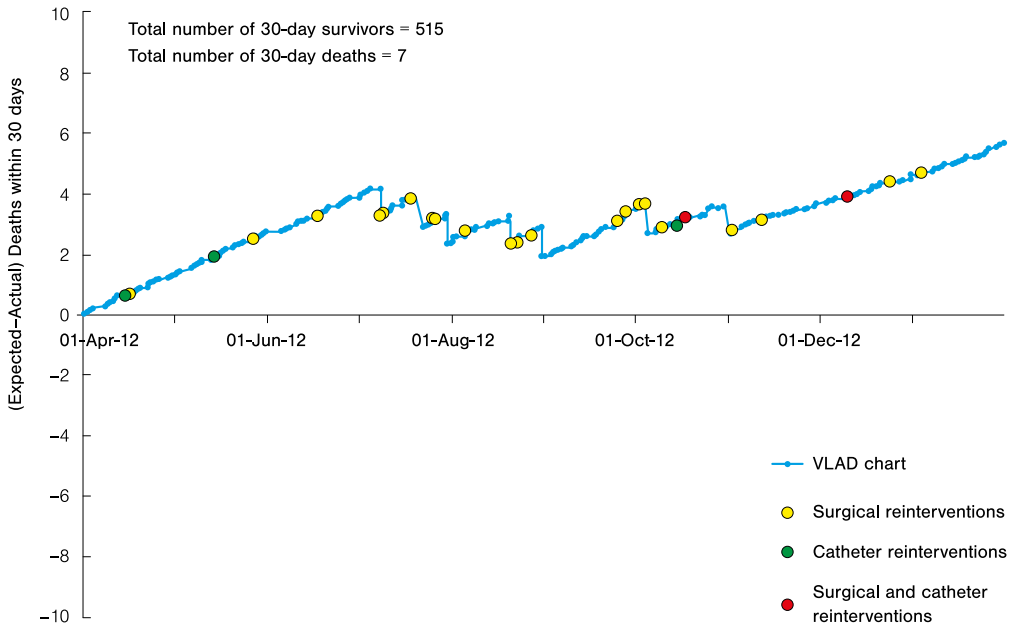
What the data shows

The following VLAD chart shows GOSH's 30-day outcomes for all cardiac surgery patients under 16 years old from April 2012 to January 2013. The number of procedures carried out and the number of deaths for that period are written at the top of the chart. It displays how many fewer (or more) deaths there are over time compared to what would be expected. This data shows better than expected outcomes, with more survivors compared against national outcomes.

The VLAD chart is not intended to judge outcomes, nor does it provide statistical control limits. Any risk model can only partially adjust for risks associated with any individual child.

After a two-year period of data collection and analysis (2010–2011), the methodology for generating paediatric cardiac surgery VLAD charts has been peer-reviewed, and is now used as standard for every paediatric cardiac surgery patient at GOSH.

VLAD chart from 02/04/2012 to 31/01/2013



What's going to happen next?

The VLAD kit will be rolled out nationally in 2013/14 to all paediatric cardiac surgery units in the UK. This will be done under licence with University College London and is funded by the Safe and Sustainable Review of Children's Congenital Heart Services in England. This spread of timely and routine monitoring of mortality following paediatric cardiac surgery will enable all units to be more immediately aware of their outcomes, and will ultimately lead to benefit for patients.

Experience

Ensuring timely access to our services

What we said we'd do

In last year's *Quality Report*, we said we would improve the way we manage and use our hospital beds to increase the number of unplanned patients we can admit. We said our aim was to reduce by 25 per cent the number of times we are unable to admit a patient, who needs to be transferred from another hospital for specialist care, because of insufficient bed availability.

We explained that an electronic referral form would be developed, which would enable us to capture and standardise all referrals and monitor the outcomes (eg admission, including which ward and by whom, refusal, or cancellation because the patient went to another hospital).

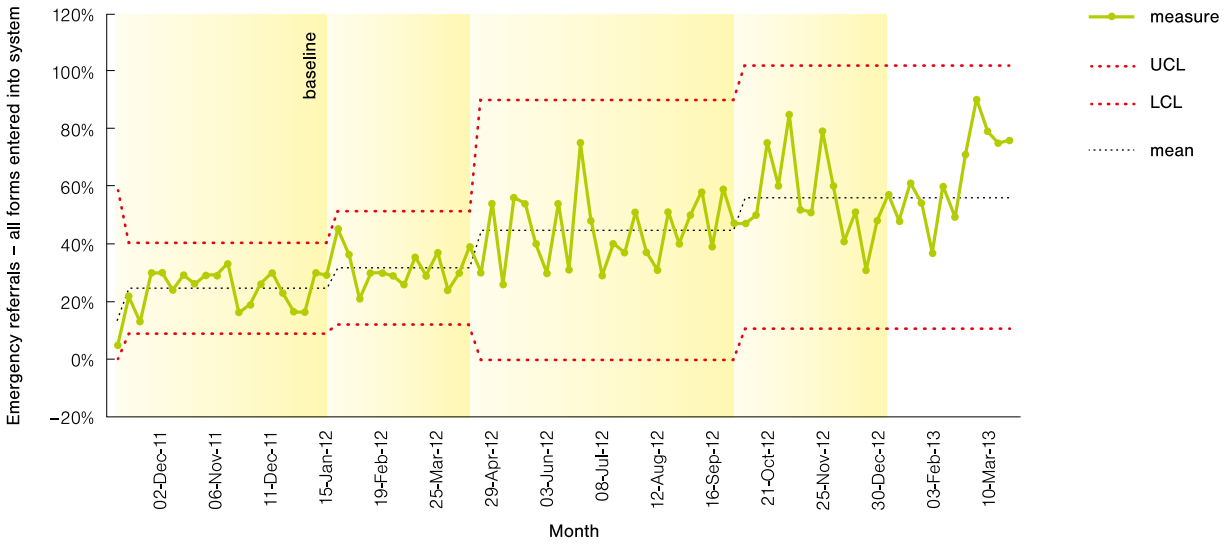
What we actually did

The form was originally designed in collaboration with the bed managers and General Surgery Team, who receive the highest number of emergency referrals from other organisations (approximately 90 referrals per month). Essential information is entered onto the form by the doctor receiving the call. The Bed Managers are then alerted to the referral and endeavour to find a suitable bed for the patient without delay.

As a specialist centre, GOSH's clinical staff frequently provide advice to colleagues in other hospitals. At the beginning of a call, it may not be clear whether advice or patient transfer is required. As use of the electronic form increased, it became apparent that full details of advice given should also be captured. This additional functionality has been developed and proves to be an excellent way to record and track communication between GOSH and our referrers. Follow-up calls can be logged against pre-existing entries and accessed by relevant members of the team as and when required.

The quality of information shared, in what can be a complex chain of communication, is now more thorough and consistent. In addition to improving the emergency referral process, this also improves patient safety. News of the form soon spread to other specialties, and it is being trialled and adopted. The chart below shows the increase in the number of referrals entered onto the electronic referral form since it was introduced.

Emergency referrals – all forms entered into system

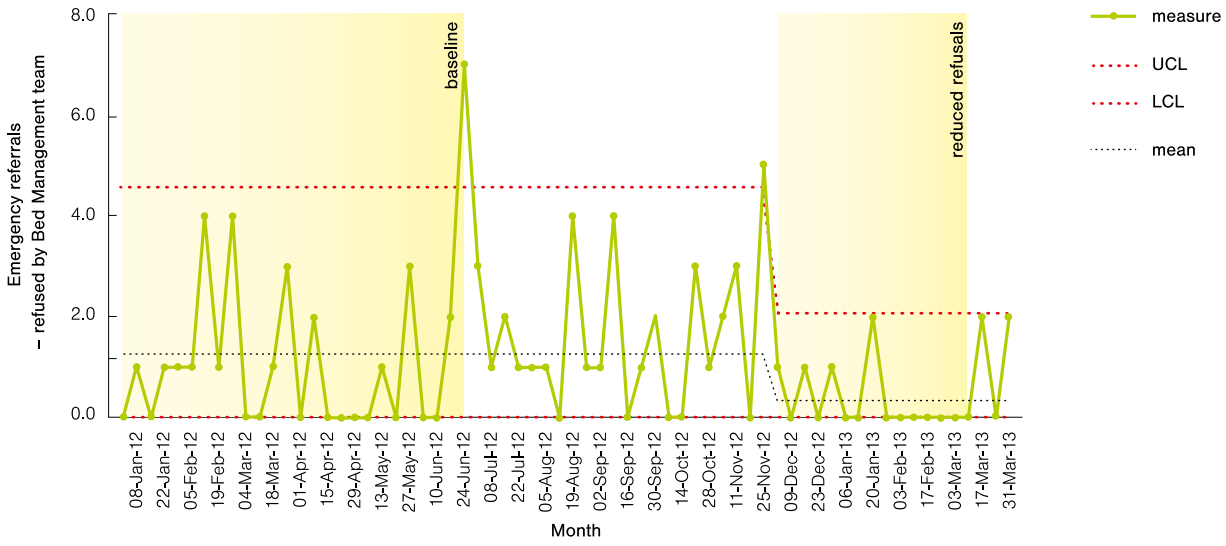


Bed meetings are now held at an earlier time each day, therefore ensuring bed shortages are identified and resolved more proactively. When the Trust experiences pressures on bed availability, a clear escalation procedure has been designed to ensure a consistent approach to resolution.

Over the past year, we have also been working with our commissioners to reduce the number of patients staying longer than clinically necessary. A web-based system has been developed to track these patients and alert staff when escalation is required. This system has improved communication about delayed discharges – both internally and externally.

These improvements have contributed to a reduction in the number of patients refused admission to the Trust due to lack of beds, as demonstrated on the graph below.[2] However, until the electronic referral form is used by every specialty to capture all referrals to the Trust, we will not know exactly how many referrals we are receiving in total, nor therefore the exact number of refused admissions. What we are able to demonstrate is that we are recording more referrals and refusing fewer patients – and this is certainly a trend of improvement.

Emergency referrals – refused by bed management team



This demonstrates that fewer patients are being refused admission, which means that those who require specialist care at GOSH are being seen.

2 This excludes referrals that are not alerted to the Bed Managers, or to ITU via the Children's Acute Transfer Team (CATs).

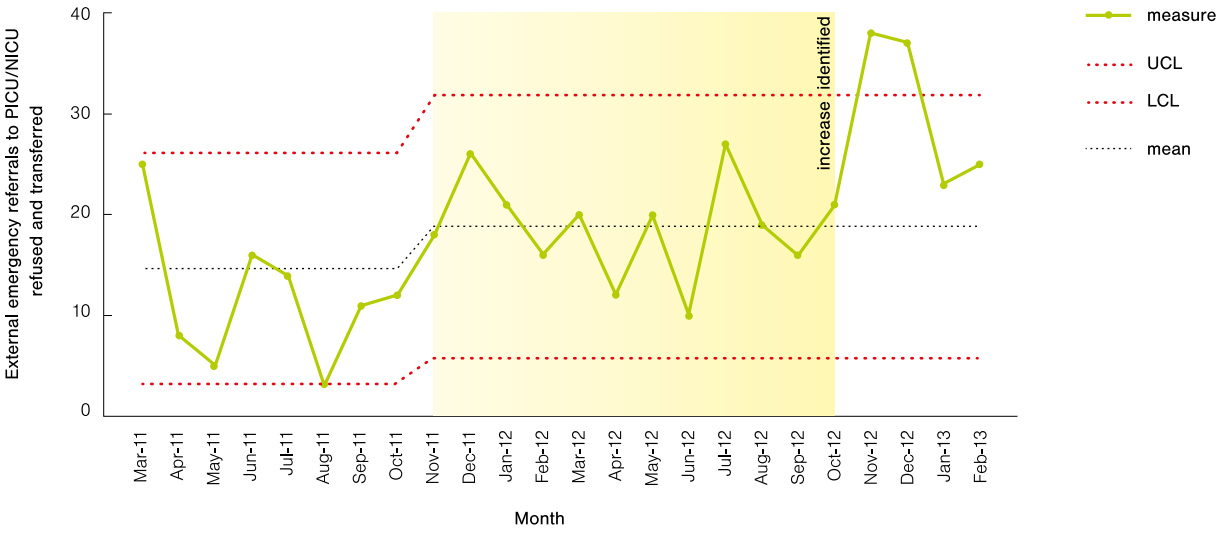
2a: Priorities for improvement
Experience priority
continued

What's going to happen next?
The next version of the form will enable an automated email to be sent to the GOSH on-call consultant to alert them that a new referral has been received. The email will include a summary of the advice given, or decision to admit. It will also be possible to copy this notification to the person making the referral, which will further improve communication between the referring organisation and GOSH. We aim to have the form fully rolled out across the organisation by the end of July 2013.

At a recent event attended by clinical, administrative and support staff, it was identified that easier access to information and resources related to bed management was needed. So, another priority for 2013/14 is to design and publish an intranet page dedicated to bed management.

While we have seen a reduction in the number of patients being refused admission to our wards, we are aware that the number of refusals to the Paediatric Intensive Care Unit (PICU) and Neonatal Intensive Care Unit (NICU) continue to increase, as the graph below demonstrates.

External emergency referrals to PICU/NICU refused and transferred to external ICUs



This is reflective of a national shortage of paediatric intensive care beds. However, there are things we are doing locally to optimise our intensive care provision. A rapid improvement project is underway to improve access to Paediatric and Neonatal Intensive Care and to reduce obstructions to patient flow through the organisation. Effective discharge planning will be key in achieving this. The Trust is also committed to expanding its critical care and high dependency capacity to meet increasing demand.

You're Welcome at GOSH

What we said we'd do

In last year's *Quality Report*, we said we would aim to review the services at GOSH to see if they meet the You're Welcome quality criteria for young people, and identify and prioritise five areas for improvement in 2013/14.

What we actually did

In order to improve the experiences of young people coming to GOSH, the Adolescent Medicine team, comprising a Nurse Consultant and Clinical Nurse Specialist, initiated a project to benchmark GOSH against the Department of Health (DH) You're Welcome Quality Criteria Self-Assessment Tool (DH 2007). These criteria were developed so that services can see how 'young person-friendly' they are.

The criteria were originally written with GP surgeries and sexual health clinics in mind. However, the need for a similar tool for tertiary centres was recognised by the DH. The adapted tool became available in late 2011 and GOSH was one of the first specialist paediatric hospitals to use it. As other paediatric trusts apply the self-assessment tool, we will be able to benchmark ourselves against them.

The self-assessment tool comprises 36 criteria grouped in eight key themes:

- accessibility
- publicity
- environment
- staff training, skills, attitudes and values
- joined-up working
- young people's involvement and evaluation of patient experience
- health issues and transition to adult services

There are two additional specialist themes that were not relevant to the whole Trust:

- Sexual and reproductive health
- Specialist child and adolescent mental health services

Thirty-six wards and departments were identified for assessment against the criteria, and we originally intended to ask young people to perform the necessary interviews and assessments. We decided against this as it would have meant asking young people to miss education or employment to complete the assessments of wards that only operate Monday to Friday. Instead, a core team consisting of the Adolescent Nurse Consultant, the Adolescent Nurse Specialist and the Trust Audit Assistant completed the interviews. To ensure consistency in how wards were marked against the criteria, two people performed each assessment independently. They each rated areas according to the assessment tool guidelines:

- Meets You're Welcome
- Getting There
- Not Yet Started
- Not Applicable

Answers were collated, and any discrepancies were adjudicated by the third person. Assessments were completed in December 2012.

2a: Priorities for improvement
Experience priority continued

Each ward has now received an individual report with the results of their assessment, allowing them to see how 'young person-friendly' they are in relation to the Trust as a whole, and helping them to identify their own areas for improvement.

A Trust report was produced with aggregate scores for each of the criteria. This was presented to the GOSH Young People's Forum (YPF) in February. Specifically, the 23 criteria assessed as 'Getting There' or 'Not Yet Started' were presented to forum members for discussion. Members concluded that the following five areas for improvement were most important to young people attending the hospital, and should be prioritised by GOSH for improvement work in 2013/14:

1. Transition to adult services.
2. Provision of age-appropriate information, including in languages other than English and for young people with disabilities.
3. Providing an age-appropriate environment.
4. Ensuring that staff who have contact with young people receive appropriate training so that they can discuss health issues, confidentiality.
5. Increased involvement of young people in service evaluation, monitoring and improvements.

These were not ranked in order of importance by the YPF.

What's going to happen next?
Improvement work will be undertaken on each of the five priorities selected by the YPF. At the time of going to print, project options are being discussed. Forum members have been asked for their continued input in identifying how they would like these aspects to be improved, and how they regard any proposals for improvement the Trust makes.

This exercise has also helped to highlight a number of areas of good practice where GOSH meets and sometimes exceeds the quality criteria, including:

- Our written policies on confidentiality and consent.
- Accessibility by public transport.
- Provision of services for marginalised or socially excluded young people.
- Training in assessing pain and providing pain relief for young people.

Individual areas have also demonstrated good practice that can be shared across the Trust, including:

- How to work with young women who present with an unplanned pregnancy.
- Area-specific facilities for young people.
- Encouraging young people to feedback their experiences.

Six-year-old Charlie likes drawing and street dancing. He has a rare respiratory disease and is at the hospital for an operation on his larynx.

Gastroenterology service improvement work

The Gastroenterology service at GOSH sees a large number of patients every year, many of whom have been through multiple services before reaching GOSH. The team perform a wide range of investigations, working with patients with chronic conditions.

Over time, issues have emerged in the service that the Trust is aware of through a number of channels. The issues identified are:

- Delays or failures in communication with referrers and families.
- Inadequate pre-admission and administrative support services.
- Demand increasingly out-stripping capacity.
- Inability to recruit junior doctors within Medicine.

What we did

In seeking to address these issues, the Gastroenterology team commissioned a review by a Global Advisory Panel (which consisted of international membership, parent representation, and a UK expert). This panel interviewed staff and proposed areas for improvement. A project manager was appointed to support the Specialty Lead in delivering service improvements based on the Panel's findings.

The team have worked hard to deliver the aims of the project and by February 2013, completed actions included:

- Tighter referral criteria implemented, which means that resources are focused on the patients who need the service most.
- Increased administrative support.
- Daily consultant ward rounds.
- All 'outliers' seen by a dedicated registrar.
- Successful bid to work with the Kings Fund and the Health Foundation on a programme to review and improve the endoscopy patient pathway.
- Weekly audit meeting introduced – to discuss results of tests, finalise discharge summaries and confirm follow-up arrangements with the whole clinical team present.
- Video-conferencing introduced to improve discussion of patients with local hospitals and to improve discharge planning.
- One email contact for each sub-specialty, to improve communication.

Some improvements have been achieved, including:

- Improved admissions process.
- Improved multi-disciplinary team work on complex cases.
- Quicker turnaround times for discharge summaries.
- Improvement in the process for answering patient/parent concerns in conjunction with the Patient Advice and Liaison Service (Pals).

However, while efforts have yielded some improvements, there is more to be done:

Number and rating of Pals contacts regarding the Gastroenterology service

Grading of case	2011/12 total	2012/13 total
Cases escalated to formal complaints or risk teams due to their severity	9	2
Complex cases to resolve	52	39
Less complex cases to resolve	100	121
TOTAL	**161**	**162**

Number and rating of formal complaints regarding the Gastroenterology service

Grading of case	2011/12 total	2012/13 total
High	1	0
Medium	6	7*
Low	13	12
TOTAL	**20**	**19***

* There was one re-opened complaint which is not counted as a new complaint

COMPLAINTS LEGEND:

High - severe harm to patient or family or reputation threat to the Trust.
Medium - less than severe but still poor service, communication or quality evident.
Low - minor issues or difference of opinion rather than deficient service.

What's going to happen next?

The Trust acknowledges that the need for focused improvement work in the Gastroenterology service remains. The following work is underway and will continue in 2013/14:

- Communicate with existing patients and their families that the department recognises a problem and are working towards improvement.
- Production of a 'clinical portfolio' to support referrers to make appropriate referrals.
- Care pathways published for all services.
- Further work to improve communication with parents (both on and off the wards).
- Work more effectively with General Surgery and the general paediatricians.
- Ensure the Kings Fund project work has parent representation and delivers benefits for patients.
- Produce clinical outcome data to assess effectiveness of treatments and underpin research.
- Complete a new model of care for a dedicated gastroenterology ward in July 2013.

Discharge summaries

In last year's *Quality Report*, we explained that an independent audit of our discharge summary figures identified that we do not always have the paper records to support our performance. We said that we would work to improve this in 2012/13.

In 2012/13, we revised our Discharge of Patients policy to ensure staff are aware that:

- Discharge summaries must include the discharge date.
- Discharge summaries must be dated on the day they are sent to the GP.
- Copies of completed discharge summaries must be placed in the patient's healthcare record.

Ongoing discharge summary improvement work is also being undertaken by one of our Clinical Improvement Leads, to improve the timeliness of discharge summary completion.

2013/14 Quality priorities

The following table provides details of the quality improvement work that the Trust intends to undertake on its services in 2013/14, which have been approved by the Board. A number of these priorities were selected to represent the views of patients, families and staff, through the use of surveys and discussion. Others link to specific Trust strategic objectives, and all contribute to the achievement of the Trust vision of No waits, No waste, Zero harm.

Safety

Zero harm – reducing all harm to zero

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
A patient and family feedback system will be piloted for 12 months on our renal ward from March 2013. The project aims to actively engage families in reporting safety concerns in order to identify adverse events and near misses. This is a SHINE innovation project, funded by independent UK charity, The Health Foundation.	Safety issues in hospitals are usually reported by staff through an established process. However, patients, families and carers can be an important source of information about safety. The SHINE project will pilot a system by which families can give their views on patient safety and report any concerns. This information will then feed in to Trust processes to improve patient safety.	This is the first project of its kind in a UK paediatric trust. Therefore, the project will establish a baseline of data on the contribution of family incident reporting to safety. The project will be measured by: • Effective family reporting of adverse events and near misses. • Volume of reporting. The project will be monitored by an operational group and a steering group.
We aim to further reduce the overall incidence and grade of pressure ulcers that occur within the Trust, by: • Completing the roll out of the specialist training programme to nursing staff. • Ensuring that every patient admitted to GOSH receives a pressure ulcer risk assessment score assigned on their admission and appropriate action is taken in response to this score. • Extending to grade 2 pressure ulcer occurrences the detailed 'Root Cause Analysis' process that we currently undertake for all grade 3 pressure ulcers that have developed within the hospital.	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 can make it difficult to re-position them. Pressure ulcers are graded from one to four depending on degree of injury to the skin, with higher grades being more severe. The risk assessment tool aids nurses to implement appropriate prevention strategies and/or to seek specialist help from the Pressure Ulcer Prevention and Management team.	This project will be monitored by auditing compliance with the mandatory risk assessment process. A new Pressure Ulcer Prevention Ward Round will aid compliance with the risk assessment process and will support nurses in practice.

Clinical effectiveness

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

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Achieve international agreement on three clinical outcome measures and commence data collection against these aligned measures to enable benchmarking with participating international centres of excellence.	Benchmarking enables us to systematically compare our treatment outcomes with other paediatric healthcare providers. Specialist hospitals such as GOSH can benefit most from comparing with our colleagues across the world. To do this accurately, we must ensure that we measure the same things in the same ways.	Progress is monitored by the medical director and the project board. The measure of progress is against the project plan and is reported to the project board and the Trust Board.
Establish an out-of-hours and weekend service for the diagnosis and monitoring of children with inherited metabolic disorders. The service is a joint venture between GOSH and Guy's and St Thomas' NHS Foundation Trust. It will be the first service of its kind in the UK.	Metabolic disorders are inherited diseases that occur as a result of an enzyme deficiency. Clinical outcomes are related to early diagnosis and implementation of treatment. Currently, there is no out-of-hours service other than an ad hoc analytical service. This means that there can be delays to treatment for patients seen out-of-hours, which can be particularly problematic for acutely unwell patients. This service will enable earlier treatment, which can improve clinical outcomes.	The number of patients/samples analysed, the time taken for results to be available to the clinicians, and laboratory staff time spent on analysis will all be monitored and compared to the current system. Clinical impact will be assessed via feedback from the metabolic team. Progress will be reported to the Pathology Board and at clinical metabolic meetings.

Experience

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

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improve the experience of our young people in the following areas: 1. Transition to adult services. 2. Provision of age-appropriate information, including in languages other than English and for young people with disabilities. 3. Providing an age-appropriate environment. 4. Ensuring that staff who have contact with young people receive appropriate training so that they can discuss health issues, confidentiality. 5. Increased involvement of young people in service evaluation, monitoring and improvements.	We treat children and young people of all ages up to 18. The 2012/13 project to measure our performance against the Department of Health's You're Welcome criteria (see page 91) showed us that we have some areas for improvement to make our services and facilities more 'young people-friendly'. Our Young People's Forum members selected their top five from that list, and these are the areas we will focus our improvement efforts on in 2013/14.	Five core working groups are being established to monitor and support these work streams. Action plans will be agreed to ensure GOSH achieves 'Meets You're Welcome' status for each of the five areas selected by Young People's Forum by March 2014. Each core group will provide a quarterly progress report to the Adolescent Medicine team and Young People's Forum.
Reduce outpatient waits for 'To take away' medication from the hospital pharmacy.	The results of the Ipsos MORI Outpatient Experience Survey 2012 were overwhelmingly positive. However, some areas for improvement were identified. The most common improvement suggestion was the waiting times at the hospital and the pharmacy (15 per cent of respondents).	An improvement facilitator will be appointed and the first step will be to establish a baseline of data using quantitative and qualitative measures to determine the extent and scope of the improvement required. The results will be used to formulate and target the improvement work. The project will be monitored through the Trust transformation programme and will be reported to Trust Board.

Florence is at the hospital with her bear, Violet, for a week. She is having tests for low blood sugar levels.

Part 2b: Statements of assurance from the board

Review of our services

During 2012/13, GOSH provided and/or sub-contracted 51 relevant health services. The income generated by these services reviewed in 2012/13 represents 100 per cent of the total income generated from the provision of relevant services by GOSH for 2012/13.

GOSH has reviewed all the data available to them on the quality of care in 51 of these services, covering the domains of clinical effectiveness, safety, and patient experience.

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 the Trust's core business are presented to the Trust Board on a monthly basis. These include measures of quality and safety, patient and referrer experience, and patient access to services.

The Trust has a clear governance framework that enables Divisions to regularly review their progress, identify improvements, and provide the Trust Board with appropriate assurance. Delivery of healthcare is not risk-free, but the Trust has a robust system for ensuring that the care delivered by our services is as safe and effective as possible.

In 2012 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 paediatric patients.

In October 2012, the hospital was assessed by the National Health Service Litigation Authority (NHSLA) against the Level 3 Risk Management Standards for Acute Trusts. The assessment provides an external, independent benchmark for the processes in place to manage risk. Five key areas were assessed including governance, the competence and capability of our workforce, the safety of the environment in which care is delivered, the management of clinical care including infection control, and the ways that we ensure we learn from experience. The Trust was successful in achieving level 3 – the highest level of compliance.

Additionally, the Trust has remained 'green' against Monitor's Governance Risk Assessment, which uses a number of healthcare targets to assess service performance, clinical quality and patient safety.

The Trust recognises that a good safety culture is one with high levels of reporting, where the severity of events is low. The National Patient Safety Agency (NPSA) has consistently identified GOSH as an organisation with such a culture. The executive team actively promote the importance of incident reporting to all staff in the support of safety.

What is NHSLA?

The NHSLA provides indemnity cover to the NHS, and assists organisations to improve their management of risk through assessment against 50 criteria relating to governance, training, and safety. The assessment takes place every three years.

Participation in national clinical audits and national confidential enquiries

During 2012/13, 11 national clinical audits and two national confidential enquiries covered the relevant health services that GOSH provides. The Trust participated in all of these national clinical audits and national confidential enquiries.

The national clinical audits and national confidential enquiries that GOSH participated in, and for which data was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of registered cases required by the terms of that audit or enquiry.

National Audits

Title and provider	Cases submitted for 2012/13
Cardiac arrhythmia (NICOR: National Institute for Cardiovascular Outcomes Research)	53/55 cases (96%) 53/55 cases for Q1–Q3 have been submitted. The two remaining cases will be sent with data for Q4, which is due to be sent on 31 May 2013.
Congenital heart disease including paediatric cardiac surgery (NICOR: National Institute for Cardiovascular outcomes research)	761/767 (99%) 761/767 cases for Q1–Q3 have been submitted. The six remaining cases will be sent with data for Q4, which is due to be sent on 31 May 2013.
Diabetes (Paediatric) (National Paediatric Diabetes Association)	From April 2012 to April 2013, data was collected on 13 patients (all patients for whom GOSH is the main provider of diabetes care in this time period.) The NPDA will request this data to be submitted in May/June 2013.
Intra-thoracic transplantation (NHS Blood and Transplant)	13/13 (100%)
National cardiac arrest audit (Resuscitation Council / Intensive Care National Audit & Research Centre)	18/18 (100%)
National Comparative Audit of Blood Transfusion (NHS Blood and Transplant)	26/26 (100%)
Paediatric Intensive Care Audit Network (PICANet)	1781/1781 (100%)
Potential donor audit (NHS Blood and Transplant)	57/57 (100%)
Renal replacement therapy (UK Renal Registry)	194/194 (100%)
Renal transplantation (NHS Blood and Transplant)	22/22 (100%)
Severe trauma (Trauma Audit & Research Network)	The Trust is currently identifying cases from January 2012 onwards and we plan to submit those by September 2013.

National Confidential Enquiries

Title and provider	Cases submitted
Child Health Clinical Outcome Review Programme (Royal College of Child Health and Paediatrics)	3/5 cases (60%)*
Confidential Enquiry into Maternal and Infant Deaths (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK)	18/18 (100%)

* Patient notes for two cases could not be located by the submission deadline. This was reported as a clinical incident.

The Clinical Audit department will monitor the publication of any reports from the above studies to ensure that any recommendations made are reviewed appropriately within the Trust.

Local clinical audits

The summary reports of 54 clinical audits were reviewed by GOSH at the Quality and Safety Committee in 2012/13. Examples of actions intended to improve the quality of healthcare as a result of local clinical audit are listed below:

Speciality	Audit Title	Summary of actions to be taken
Anaesthesia	Throat pack audit	Circulate new guideline.
Cardiac Intensive Care	Teaching of Berlin Heart dressings for families	To develop a video to demonstrate to parents and staff the correct way to change a Berlin Heart dressing.
Children's Acute Transport Service (CATS)	Audit of management of paediatric diabetes ketoacidosis prior to referral to the CATS	Feedback to individual hospitals during outreach meetings and re-audit within five years.
Endocrinology	Cortisol response in children undergoing Glucagon stimulation test	Recommendations agreed regarding cortisol levels required to maximise effectiveness of simulation test.
Haematology	Completion of tissue banking consent forms	• Write policy detailing process of consent for research bloods. • Tissue bank coordinator to be appointed.
Neuromuscular	Education pack questionnaire	Seek funding to develop pack folders to support school knowledge of the condition.
Neurology	Evaluation of cerebellar hypoplasia in children	To establish diagnostic decision tree.
Neurosurgery	Hydrocephalus information	Information packs to be provided and wound care information to be updated.
Ophthalmology	Screening for cytomegalovirus retinitis in immuno-compromised patients	• Written screening protocol to be devised. • Re-audit to take place in November 2014.
Ophthalmology	Audit of the results of sclerotherapy in paediatric orbital lymphangiomas	Extra slots created in clinic to ensure all patients are being reviewed post-operatively.
Tracheal Team	Improving community-based care for tracheal patients	Developing the tracheal information available to community teams.

Clinical audit plan

The Clinical Audit team facilitate audit in a number of key areas. Highlights from the 2012/13 clinical audit plan include:

- Prevention of retained throat packs in the operating theatre. Clinical audit was used to:
  - evaluate the implementation of recommendations which were made following a serious incident
  - stimulate further actions
- Ensuring the safety of emergency trolleys to support the deteriorating patient. Work was undertaken following audit in January 2012 to improve the safety of emergency trolleys. Following a number of interventions audit data showed an improvement in the safety of trolleys.
- Clinical audit identified that it was not always possible for every patient to wear a patient identification wristband. Work is being undertaken as a result of the audit to look at ways to make it easier for patients to wear wristbands.

Participation in clinical research

Commitment to research is a key aspect of improving quality of care and stretching the boundaries of what treatment can provide. Together, GOSH and the UCL Institute of Child Health (ICH) form the largest paediatric research centre outside North America and host the only Biomedical Research Centre (BRC) in the UK dedicated to children's health.

Research is a core focus for us because GOSH is in a unique position with its broad range of clinical specialties and as a tertiary referral centre for children with complex and rare conditions. Scientists at the ICH and clinicians at the hospital work together to provide an integrated and multi-disciplinary approach to the diagnosis, treatment, prevention, and understanding of childhood disease. This allows us to translate research undertaken in laboratories into clinical trials in the hospital and really benefit children in the UK and worldwide.

Our BRC status, awarded by the National Institute for Health Research, provides funding and support for experimental and translational biomedical research. In addition to the BRC, the division includes:

- the joint GOSH/ICH Research and Development Office
- the Somers Clinical Research Facility, which is a state-of-the-art ward within GOSH for the day care accommodation of children taking part in clinical trials
- hosting of the Medicines for Children's Research Network (MCRN) for London and the South East

Research activity is also undertaken through the Centre for Nursing and Allied Health Research, which hosts a team of experienced researchers who promote, support, evaluate and disseminate research focusing on patient and family experience, with a particular emphasis on translational benefits and implementation in clinical practice.

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 Centres. Through the partnership, we continue to strengthen our links with other centres of excellence in clinical research.

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.

We are currently running 559 research projects in GOSH/ICH, 152 of which have been adopted onto the NIHR Clinical Research Network Portfolio, a grouping of high-quality clinical research studies. 2072 patients receiving health services provided or sub-contracted by GOSH have been recruited to participate in the studies on this Portfolio in 2012/13. This is an increase of 20 per cent on 2011/12 activity.[3]

3 In last year's *Quality Report*, we said the figure for the total number of research participants in 2011/12 was 1,210. This figure was provisional; the final figure was 1,720.

2b: Statements of assurance from the board
Participation in clinical research
continued

Some of our key research activity in 2012/13 is described below:

- With support from GOSH BRC and Sarepta Therapeutics, researchers led by Professor Francesco Muntoni have developed an early clinical study to obtain critical proof-of-concept data for a novel gene therapy method for Duchenne Muscular Dystrophy (DMD), a disease that causes progressive muscle loss due to a mutation in the dystrophin gene. GOSH, Newcastle University's Institute of Genetic Medicine, and the Royal Victoria Infirmary carried out a clinical trial of this novel therapy in 19 patients, aged between five and fifteen. The gene therapy restored missing dystrophin protein in seven of the 19 children with DMD and indicates that this therapy could restore muscle function in these children.
- Improvements in the development of retinal stem cell therapies for visually impaired children are currently being made by Professor Jane Sowden and colleagues. New data suggests using transplantation of retinal stem cells shows that eye function could be restored in children born without light perception.
- Researchers led by Professor Nigel Klein have been developing ways of using existing data from HIV studies in the UK, Europe and Africa and applying novel statistical methods to gain important insights into the HIV disease and its effect on the immune system. It is now possible to make accurate predictions of immune cell counts in HIV-infected children from these countries, which will help inform the next European and WHO guidelines for treatment of children with HIV infection. Researchers within GOSH BRC have also been identifying which patients may be amenable to gene therapy for the treatment of HIV infection.
- Research by Dr Chris Clark has focused on developing scanning and imaging techniques for studying brain tumours. This has led to new mathematical models to allow monitoring of brain tumours in children without the need for biopsies or surgery.
- Work by Dr Garth Dixon and Professor Judy Breuer on tissue samples from GOSH patients, has led to the development of a test to identify fungal pathogens that cause disease in humans. This has aided patient diagnosis and management of serious fungal disease in children being treated at GOSH and across the NHS.

Use of the CQUIN payment framework

In 2012/13, two and a half per cent of GOSH income was conditional upon achieving CQUIN goals agreed between GOSH and:

- NHS North Central London
- London Specialist Commissioning Group

The Trust's CQUIN schemes for 2012/13 were as follows:

1. Improve infection control
   - surgical site infections
   - central venous line infections
   - S. aureus blood stream infection
   - other blood stream infections
2. Review of patient deaths
3. Prevention of grade 2+ pressure ulcers
4. Patient experience
   - responsiveness to patient needs
   - patient journey
   - hospital food
   - responsiveness to the needs of young people
5. Parental smoking cessation
   - information and awareness
   - strategy and training
6. Discharge planning
7. Out-of-hours prescribing errors – Haematology/Oncology
8. Report bone marrow transplant outcomes
9. Paediatric Intensive Care and High Dependency Unit capacity

If the Trust achieves 100 per cent of its CQUIN payments for 2012/13, this will equate to £4,360,640. The Trust has achieved 100 per cent of its CQUIN goals for quarters 1, 2 and 3, and has submitted a year-end position of 99% achievement. Quarter 4 figures have not yet been ratified by our commissioners.

In 2011/12, one and a half per cent of GOSH income was conditional upon achieving CQUIN goals. The figure we achieved was £2,689,540, which represented 94.9 per cent of the total offered.

Further details of the agreed goals for 2012/13 and for the following 12-month period are available on request from:

Alex Faulkes, Head of Planning and Performance
Email: Alexander.Faulkes@gosh.nhs.uk
Tel: 020 7405 9200

What is CQUIN?

The Commissioning Quality and Innovation (CQUIN) payment framework makes a proportion of NHS healthcare providers' income conditional upon improvement. The framework aims to support a cultural shift by embedding quality and innovation as part of the discussion between service commissioners and providers.

CQC registration

The Care Quality Commission (CQC) is the organisation that regulates and inspects health and social care services in England.

GOSH is required to register with the CQC and its current registration status is *registered without conditions*.

The CQC has not taken enforcement action against GOSH during 2012/13.

GOSH has not participated in any special reviews or investigations by the CQC during the reporting period.

GOSH was inspected by the CQC in September 2012 as part of its routine inspection programme. The CQC declared GOSH compliant on all outcomes inspected.

Monitor's Compliance Framework also scores the level of concern regarding the safety of healthcare provision. In 2012/13, Monitor had no concerns with the safety of health provision in the trust as shown below:

	Trust score 2012/2013	Indicator met
Moderate CQC concerns regarding the safety of healthcare provision	0	Yes
Major CQC concerns regarding the safety of healthcare provision	0	Yes
Failure to rectify a compliance or restrictive condition(s) by the date set by the CQC within the condition(s) or as subsequently amended with the CQC's agreement	0	Yes

Data quality

NHS managers and clinicians are reliant upon information to support and improve the quality of services they deliver to patients. This information, or data, should be accurate, reliable, and timely. Some of this data is used to inform local decisions about clinical care and service provision. Some data is reported nationally, and enables comparison between healthcare providers.

The Secondary Uses Service (SUS) is a single source of specified data sets to enable analysis and reporting of healthcare in the UK. SUS is run by the NHS Information Centre and its reporting is based on data submitted by all provider trusts.

GOSH submitted records during 2012/13 to SUS for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The table below shows the percentage of records in the published data against specified indicators:

Indicator	Patient group	Trust score	Average national score
Inclusion of patient's valid NHS Number	Inpatients	99.3%	99.1%
	Outpatients	99.2%	99.3%
Inclusion of patient's valid General Practitioner Registration Code	Inpatients	99.9%	99.9%
	Outpatients	99.9%	99.9%

Notes:
- The table reflects the most recent data available as of 8 April 2013 (April 2012 – February 2013).
- Percentages for NHS number compliance have been adjusted locally to exclude international private patients, who are not assigned an NHS number.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

What is an NHS Number?

The NHS number is a unique 10-digit number that helps healthcare staff to find a patient's health records. The NHS number increasingly helps to identify the same patient between organisations and different areas of the country. Everyone registered with the NHS in England and Wales has their own NHS number.

Information Governance Toolkit

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Information Governance Toolkit provides NHS organisations with a set of standards against which we declare compliance annually.

GOSH's Information Governance Assessment Report overall score for 2012/13 was 70 per cent and was graded green (satisfactory).

Clinical coding audit

GOSH was not subject to the Payment by Results clinical coding audit by the Audit Commission during the 2012/13 reporting period.

Improving data quality

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

- Standardise polices and processes regarding capturing of data on core IT systems.
- Identify alternative training methods that could improve the impact of training.
- Develop a reporting suite to support the improvement of key data quality issues / requirements.

2b: Statements of assurance from the board
continued

Performance against Department of Health quality indicators

NHS trusts are subject to national indicators that enable the Department of Health (DH) and other institutions to compare and benchmark trusts against each other. Trusts are required to report against the indicators that are relevant to them. The table below shows the indicators that GOSH reports on a quarterly basis to our Trust Board and also externally. The data is sourced from the Health and Social Care Information Centre, unless stated otherwise.

Indicator	From local Trust data		From Health and Social Care Information Centre			
	2011/12	2012/13	Most recent results for Trust	Best result nationally	Worst result nationally	National average
Domain 4: Ensuring that people have a positive experience of care						
			Time period: 2011			
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. (Source: NHS Staff survey)	88% (2011)	90%[1] (2012)	88%	96%	21%	87%
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm						
			Time period: 2011/12			
Number of hospital-acquired *clostridium difficile* infections	9	7	9			
Rate of *clostridium difficile* (number of hospital-acquired infections/100,000 bed days)	21.5	17.2[2]	21.5	0.0	51.6	21.8
			Time period: 1/4/2012 to 30/9/2012			
Patient safety incidents reported to the National Reporting & Learning System						
• Number of patient safety incidents reported within the trust	3,780	4,206	907[3]	-	-	-
• Rate of patient safety incidents (number/100 admissions)	9.36	9.98	5.56[3]	-	-	-
• Number of patient safety incidents resulting in severe harm or death	14	23	6[3]	-	-	-
• Percentage of patient safety incidents resulting in severe harm or death	0.4%	0.5%	0.7%[3]	0%	1.8%	0.4%

1 This result of 90% puts GOSH in the top eight trusts in the country
2 2012/13 data not yet publicly published. Rate based on average bed days published in 2009/10 and 2010/11
3 An issue with uploading to NRLS in quarters 1 & 2 has resulted in NRLS figures that do not reflect the Trust's position for that period. The issue was resolved and complete figures will be available to NRLS for 2012/13 after the year-end upload at the end of May.

Explanatory note on patient safety incidents resulting in severe harm or death

This year is the first time that this indicator has been required to be included within the Quality Report alongside comparative data provided, where possible, from the Health and Social Care Information Centre. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission (CQC) as part of the CQC registration process. On a voluntary basis, GOSH also reports its patient safety incidents to the National Reporting and Learning Service (NRLS), which runs a national database designed to promote learning.

There is no nationally established and regulated approach to reporting and categorising patient safety incidents; different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a lengthy investigation, which could result in the classification being changed. This complexity makes it difficult to do formal comparison.

	GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	The survey is carried out under the auspices of the DH, using their analytical processes. GOSH is compared to other acute specialist trusts in England (n=19).	Ensuring divisions and directorates develop and implement local action plans, which respond to areas of weakness.
	These data were obtained from the Health Protection Agency (HPA) summary points on *Clostridium difficile*, published in July 2012. The remaining data published by the HPA prior to 31 March 2013 does not list specific trusts. The HPA became part of Public Health England on 1 April 2013.	Continuing to test stool samples for the presence of Clostridium difficile, investigate all positive cases, implement isolation precautions, and monitor appropriateness of antimicrobial use across the organisation.
	GOSH introduced electronic incident reporting (DatixWeb) in April 2011 to promote easier access to and robust reporting of incidents. It is expected that organisations with a good safety culture will see higher rates of incident reporting year-on-year, with the severity of incidents decreasing.	Initiatives to improve the sharing of learning to reduce the risk of higher graded incidents from reoccuring. These initiatives include learning events and a newly established 'Learning from Experience' working group.

Two-year-old Isla enjoys playing doctors. Isla has stomach dysmotility and is unable to feed. The doctors are working hard to try and get Isla to tolerate some sort of milk feed, but at present she is is having vitamins, minerals and lipids delivered directly to her blood.

Performance against Monitor quality indicators

Monitor use a limited set of national mandated performance measures, sourced from the NHS Operating Framework, to assess the quality of governance at NHS foundation trusts. Performance is measured on an aggregate (rather than specialty) basis and Trusts are required to meet the appropriate threshold each month. Consequently, any failure in one month is considered to be a quarterly failure. The table below sets out the relevant national performance measures used to assess the Trust's quality governance rating.

Domain	Indicator	Threshold / Target	GOSH performance for 2012/13 by quarter				Indicator met?
			Q1	Q2	Q3	Q4	
Safety	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia – meeting the MRSA objective	0	0	2	1	1	Trust remains within Monitor de-minimis level*
Effectiveness	All cancers: 31-day wait from diagnosis to first treatment	96%	100%	100%	100%	100%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising: • surgery • anti-cancer drug treatments • radiotherapy	 94% 98% 94%	100%	100%	100%	100%	Yes
Patient experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90%	90.3%	91.2%	92.4%	91.1%	Yes
Patient experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95%	96.7%	95.2%	95.7%	96.1%	Yes
Patient experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	92%	92.3%	93.9%	93.1%	Not met for one month in Quarter 1
Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements	Achieved	Achieved	Achieved	Achieved	Yes

* Where an NHS foundation trust has an annual MRSA objective of six cases or fewer (the de minimis limit) and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of Monitor's Compliance Framework.

3: Performance against Monitor Quality Indicators
continued

In addition to the national mandated measures identified in the above table, the Trust has implemented a range of local improvement programmes that focus on the quality priorities as described in section 2. The table below sets out the range of quality and safety measures that are reviewed at each Trust board meeting. Statistical Process Control (SPC) charts are used to measure improvements in projects over time and to identify areas that require further investigation. All measures remain within expected statistical tolerance.

Domain	Indicator	YTD performance	2012									2013		Performance within statistical tolerance?
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
Safety	Paediatric Trigger Tool (adverse events per 1,000 bed days)*	159	157	122	115	91	73	28	159	31	0	Data not available		Yes
Safety	Number of serious patient safety incidents	30	4	6	5	1	4	1	1	2	0	3	3	Yes
Safety	CV Line related blood-stream infections (per 1,000 line days)	2.0	3.1	2.8	2.1	1.2	0.7	1.8	2.1	2.3	2.3	1.9	2.0	Yes
Safety / Effectiveness	Number of arrests outside ICU (cardiac or respiratory)	68	5	6	5	6	5	4	5	11	7	8	6	Yes
Effectiveness	Hospital mortality rate (per 1,000 discharges)	3.3	1.8	2.9	4.5	3.4	4.4	2.9	2.3	3	5.1	2.2	3.4	Yes

* A random sample of 20–40 notes are pulled each week and analysed for adverse events using a methodology developed by the NHS Institute for Healthcare Improvement (IHI).

Statements from London Specialised Commissioning Group, Healthwatch Camden, and Camden Health Scrutiny Committee

Statement from London Specialised Commissioning Group

London Specialised Commissioning Group (LSCG) was the responsible commissioner for the specialised activity that took place at Great Ormond Street Hospital (GOSH) through 2012/13. The LSCG worked closely with NHS NC London. As a key member of the commissioning team we were directly involved in receiving progress reports, feedback and action plans both through direct contact and through the monthly Clinical Quality Review meetings at the Trust. We continue to support the Trust in their achievements in their key priority areas for 2012/13 as well as focussing on local innovation and improvements.

There has been a keen investment in time and action, with the tissue viability team successfully developing and implementing a risk assessment tool regarding skin viability and the Trust exceeded the target of 20% reduction in pressure ulcers grade 2 and 3 by achieving a 35% reduction.

The Trust has maintained their previous years improvement in reduction in cardiac and/or respiratory arrests outside of the ICU but were unable to achieve the 50% target and we welcome the planned continuation during 2013/14 of achieving the 50% target.

The Trust has made satisfactory progress in improving communications with patients and families and has strived to include children and their experiences to improve both service delivery and outcomes. Further challenges to build upon this work are ahead for 2013/14.

The work completed to understand and proactively respond to the mortality reviews within the Trust has resulted in further review meeting within the services. Working with Dr Foster the planned development of a children's focussed standardised mortality ratio will allow children's services to compare mortality against specific childhood diseases.

The work undertaken to show clinical outcomes for children under 16 years of age, after cardiac surgery, will continue to be monitored during 2013/14. The national roll out of monitoring of outcomes for cardiac patients develops this work further and will continue to be reported and monitored through 2013/14.

We are encouraged to see the progress that has been made during 2012/13 and where targets have not been achieved these are being carried forward and addressed during the 2013/14 commissioning cycle.

We take particular account of the identified priorities for 2013/14 as the responsible commissioner. We will continue to work with the Trust to ensure the best quality outcomes, safety and experiences are realised for the children and families who use the services of Great Ormond Street Hospital.

Statement from Healthwatch Camden

The following statement was received:
Frances Hasler, Director of Healthwatch Camden, said she has read the Quality Accounts for GOSH and has no comments to add.

Statement from Camden Health Scrutiny Committee

The following statement was received:
There is no Quality Account item on the HSC agenda this year so no formal comment will be provided by the committee.

External assurance statement

Independent Assurance Report

Independent Auditor's Report to the Council of Governors of Great Ormond Street Hospital for Children NHS Foundation Trust on the 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 2013 (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 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Ormond Street Hospital 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 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium Difficile;
- Maximum 31 day waiting time from Decision to Treat a Cancer diagnosed patient to the beginning of treatment (first day definitive treatment).

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

Respective responsibilities of the Directors and auditors

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

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

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

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with 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* to the categories reported in the Quality Report.
- Reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact 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 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 2013:

- 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 Monitor's 2012/13 Detailed Guidance for External Assurance on Quality Reports; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual.*

Deloitte LLP
Chartered Accountants
St Albans
24 May 2013

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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 Report*.

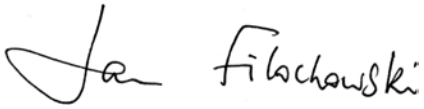
In preparing the *Quality Report*, directors are required to take steps to satisfy themselves that:

- The content of the *Quality Report* meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2012/13*.
- The content of the *Quality Report* is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2012 to May 2013
  - papers relating to quality reported to the board over the period April 2012 to May 2013
  - feedback from the commissioners dated 13/05/2013
  - feedback from Healthwatch Camden dated 29/04/2013
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/04/2013
  - the independently commissioned Ipsos MORI patient survey 2012
  - the national staff survey 2012
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 24/05/2013
  - Care Quality Commission quality and risk profiles dated 31/03/2013
- The *Quality Report* presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the *Quality Report* is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the *Quality Report*, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the *Quality Report* is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the *Quality Report* has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the *Quality Report* (available at www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

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

By order of the Board

Chairman
24 May 2013



Chief Executive
24 May 2013

Annual Accounts

Four-month-old Flora is on Butterfly Ward with her mum, following surgery to remove a cystic hygroma from the side of her neck.

Statement of accounting officer's responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Great Ormond Street Hospital for Children NHS Foundation Trust.

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

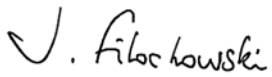
Under the NHS Act 2006, Monitor has directed Great Ormond Street Hospital for Children NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and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

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

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements.
- Prepare the financial statements on a going concern basis.

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

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



Jan Filochowski
Chief Executive
24 May 2013

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.

Directors' responsibilities

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

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.

Head of Internal Audit Opinion

Head of Internal Audit Opinion on the effectiveness of the system of internal control for the year ended 31 March 2013.

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 date of assessment is 10 April 2013 and is based upon work performed up to that date.

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 Annual Governance Statement.

My Opinion is set out as follows:

1. overall opinion
2. basis for the opinion
3. commentary.

My **overall opinion** is that:
Significant assurance can be given that controls are well-designed and are applied consistently. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. While an overall limited assurance opinion has been provided for a review on Rosterpro and also on a small number of 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 and 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 of the Trust's Board Assurance Framework (BAF) and its associated processes was undertaken as part of the planned audit coverage for 2012/13. This confirmed that a BAF was in place throughout 2012/13 and provided a mechanism for identifying the principal risks to the Trust meeting its corporate objectives and for mapping out the key controls and assurances to manage these risks. 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 and can confirm that the BAF, together with the Trust's performance management arrangements and other forms of reporting to the Board and its sub-committees, provides assurance that there was an effective system of internal control for monitoring the effectiveness of the management of the principal risks to the achievement of the Trust's objectives.

We reviewed the process by which the Trust ensures its continued compliance in respect of its Care Quality Commission (CQC) registration and found that they were operating effectively.

We have carried out a wide range of audits during the period, most of which enabled us to provide significant or reasonable assurance that the controls and systems were operating effectively. We identified through 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 – Rosterpro, prevention and management of salary overpayments and training on the use of new medical devices – 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 the 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.

Director of Operations
London Audit Consortium
14 May 2013

Independent auditor's report

Independent auditor's report to the Board of Governors and Board of Directors of Great Ormond Street Hospital For Children NHS Foundation Trust.

We have audited the financial statements of Great Ormond Street Hospital for Children NHS Foundation Trust for the year ended 31 March 2013, which 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 26. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

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

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts 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 Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements (and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit). If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- Give a true and fair view of the state of the trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended.
- Have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.
- Have been prepared in accordance with the requirements of the National Health Service Act 2006.

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

In our opinion:

- The information given in the directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements.

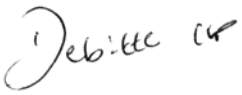
Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- The Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- Proper practices have not been observed in the compilation of the financial statements.
- The NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

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



Heather Bygrave, FCA, BA Hons
(Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants
and Statutory Auditor
St Albans, United Kingdom
24 May 2013

Statement of the Chief Executive's responsibilities as the Accounting Officer of Great Ormond Street Hospital for Children NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

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

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

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements.
- Prepare the financial statements on a going concern basis.

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

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

Jan Filochowski
Chief Executive
24 May 2013

Foreword to the accounts

Great Ormond Street Hospital for Children was authorised as an NHS Foundation Trust on 1 March 2012. These accounts for the year ended 31 March 2013 have been prepared by Great Ormond Street Hospital for Children NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form which Monitor, with the approval of the Treasury, has directed.

Jan Filochowski
Chief Executive
24 May 2013

Statement of comprehensive income
For the year ended 31 March 2013

	Note	12 months ended 31 March 2013 £000	One month ended 31 March 2012 £000	Proforma unaudited 12 months ended 31 March 2012 £000
Total revenue from patient care activities	2	**308,222**	27,366	288,301
Total other operating income	3	**63,612**	9,725	77,478
Operating expenses	4	**(353,871)**	(31,725)	(341,641)
Operating surplus		**17,963**	5,366	24,138
Finance costs				
Finance income	8	**85**	5	68
Finance expenses – financial liabilities	9	**(1)**	0	0
Finance expenses – unwinding of discount on provisions	9	**(34)**	(3)	(39)
Surplus for the financial period		**18,013**	5,368	24,167
Public dividend capital dividends payable		**(5,800)**	(480)	(5,765)
Retained surplus for the period		**12,213**	4,888	18,402
Other comprehensive income				
Impairments		**(4,823)**	0	(11,450)
Revaluations – property, plant and equipment		**4,547**	200	8,921
Total comprehensive income for the period		**11,937**	5,088	15,873
Financial performance for the period – additional reporting measures				
Retained surplus for the period		**12,213**	4,888	18,402
Adjustments in respect of capital donations		**(13,561)**	(4,256)	(28,205)
Adjustments in respect of impairments	4	**3,709**	0	12,304
Adjusted retained surplus		**2,361**	632	2,501

The notes on pages 130 to 157 form part of these accounts.

The Foundation Trust has no minority interest.

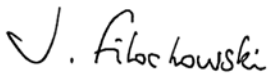
Proforma unaudited information for the year ended 31 March 2012 has been derived by combining the financial results for the NHS Trust (1 April 2011 to 29 February 2012) and the Foundation Trust (1 March to 31 March 2012). The proforma unaudited information has been provided throughout these accounts to allow a better understanding of the year-on-year results.

The proforma unaudited figures for the 12 months ended 31 March 2012 include income and expenditure of £1,556k relating to children and young people's community services based in Haringey which transferred to a community health provider in May 2012. All other income and expenditure is derived from continuing operations.

Statement of financial position
As at 31 March 2013

	Note	31 March 2013 £000	31 March 2012 £000
Non-current assets			
Intangible assets	10	**6,171**	4,931
Property, plant and equipment	11	**321,758**	326,639
Trade and other receivables	14	**8,566**	9,042
Total non-current assets		**336,495**	340,612
Current assets			
Inventories	13	**6,563**	6,209
Trade and other receivables	14	**32,170**	33,261
Cash and cash equivalents	15	**38,404**	26,628
Total current assets		**77,137**	66,098
Total assets		**413,632**	406,710
Current liabilities			
Trade and other payables	16	**(34,663)**	(39,545)
Provisions	20	**(3,201)**	(3,123)
Other liabilities	17	**(4,907)**	(4,727)
Net current assets		**34,366**	18,703
Total assets less current liabilities		**370,861**	359,315
Non-current liabilities			
Provisions	20	**(1,222)**	(1,234)
Other liabilities	17	**(6,578)**	(6,957)
Total assets employed		**363,061**	351,124
Financed by taxpayers' equity			
Public dividend capital		**124,732**	124,732
Income and expenditure reserve		**186,835**	174,430
Other reserves		**3,114**	3,114
Revaluation reserve		**48,380**	48,848
Total taxpayers' equity		**363,061**	351,124

The financial statements on pages 126 to 157 were approved by the Board on 24 May 2013 and signed on its behalf by:



Jan Filochowski
Chief Executive
24 May 2013

Statement of changes in taxpayers' equity
For the year ended 31 March 2013

	Public dividend capital (PDC) £000	Revaluation reserve £000	Income and expenditure reserve £000	Other reserves £000	**Total £000**
Balance at 1 April 2012	124,732	48,848	174,430	3,114	**351,124**
Changes in taxpayers' equity for the 12 months ended 31 March 2013					
Surplus for the year	0	0	12,213	0	**12,213**
Transfers between reserves	0	(169)	169	0	**0**
Impairments	0	(4,823)	0	0	**(4,823)**
Revaluations – property, plant and equipment	0	4,547	0	0	**4,547**
Transfer to retained earnings on disposal of assets	0	(23)	23	0	**0**
Balance at 31 March 2013	**124,732**	**48,380**	**186,835**	**3,114**	**363,061**

	Public dividend capital (PDC) £000	Revaluation reserve £000	Income and expenditure reserve £000	Other reserves £000	**Total £000**
Balance at 1 March 2012	124,732	48,661	169,529	3,114	**346,036**
Changes in taxpayers' equity for the one month ended 31 March 2012					
Surplus for the period	0	0	4,888	0	**4,888**
Transfers between reserves	0	(13)	13	0	**0**
Impairments	0	0	0	0	**0**
Revaluations – property, plant and equipment	0	200	0	0	**200**
Transfer to retained earnings on disposal of assets	0	0	0	0	**0**
Balance at 31 March 2012	**124,732**	**48,848**	**174,430**	**3,114**	**351,124**

Statement of cash flows
For the year ended 31 March 2013

	Note	12 months ended 31 March 2013 £000	One month ended 31 March 2012 £000	Proforma unaudited 12 months ended 31 March 2012 £000
Cash flows from operating activities				
Operating surplus		**17,963**	5,366	24,447
Non-cash income and expense				
Depreciation and amortisation		**18,827**	1,057	14,316
Impairments		**3,709**	0	12,304
Loss on disposal		**39**	0	0
Decrease in trade and other receivables		**1,808**	4,098	(4,335)
Increase/(decrease) in inventories		**(354)**	223	(1,053)
Increase/(decrease) in trade and other payables		**(3,478)**	3,064	(3,307)
Decrease in other liabilities		**(199)**	(137)	975
Increase/(decrease) in provisions		**32**	(7)	201
Net cash generated from operations		**38,347**	13,664	43,548
Cash flows from investing activities				
Interest received		**80**	5	68
Purchase of property, plant and equipment		**(19,435)**	(3,222)	(42,988)
Payments for intangible assets		**(1,204)**	0	(705)
Sales of property, plant and equipment		**24**	0	33
Net cash outflow from investing activities		**(20,535)**	(3,217)	(43,592)
Net cash outflow before financing		**17,812**	10,447	(44)
Cash flows from financing activities				
Public dividend capital (PDC) dividend paid		**(6,036)**	(2,882)	(5,699)
Net cash outflow from financing		**(6,036)**	(2,882)	(5,699)
Net increase in cash and cash equivalents		**11,776**	7,565	(5,743)
Cash and cash equivalents at start of period		**26,628**	19,063	32,371
Cash and cash equivalents at end of period	15	**38,404**	26,628	26,628

Proforma unaudited information for the year ended 31 March 2012 has been derived by combining the financial results for the NHS Trust (1 April 2011 to 29 February 2012) and the Foundation Trust (1 March to 31 March 2012). The proforma unaudited information has been provided throughout these accounts to allow a better understanding of the year-on-year results.

Notes to the accounts

1. Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012/13 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Going concern

International Accounting Standard (IAS)1 requires management to assess, as part of the accounts preparation process, the Foundation Trust's ability to continue as a going concern. After making enquiries, the directors can reasonably expect that the 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.

1.3 Segmental reporting

Under IFRS 8 Operating Segments, the standard allows aggregation of segments that have similar economic characteristics and types and class of customer.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker, which is the overall Foundation Trust Board and which includes senior professional non-executive directors. The Trust Board review the financial position of the Foundation Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process implies a single operating segment under IFRS 8.

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

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

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

1.5 Critical 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 Foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

a. As described in note 1.10, the Foundation Trust's plant and equipment is valued at depreciated replacement cost, the valuation being assessed by the Foundation Trust taking into account the movement of indices that the Foundation Trust has deemed to be appropriate.

b. The Trust leases a number of buildings that are owned by Great Ormond Street Hospital Children's Charity. The Trust has assessed how the risks and rewards of ownership are distributed between itself and the charity in categorising these leases as either operating or finance leases.

c. The Foundation 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 Foundation 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 judgment to decide when to write off revenue or to provide against the probability of not being able to collect debt, especially in light of the changing healthcare commissioning environment.

f. The Foundation 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.

1.6 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period not already included in note 1.5 above, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements as a provision. As the calculation involves a large number of staff, sampling techniques are used to collate the results for the entire 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 2.35 per cent in real terms.

1.7 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Foundation Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. Income relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Other income received from commissioners may be in the form of an investment in quality. Any quality investment income surplus may be used in subsequent years to supplement any major projects/capital schemes.

1.8 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, 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 Financial Reporting Manual (FReM) requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a. Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013 is based on the valuation data as at 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b. Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience) and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 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 were 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 due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at 31 March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c. Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

- The Scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

- With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax-free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as 'pension commutation'.

- Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011/12 the Consumer Price Index (CPI) was used to replace the Retail Prices Index (RPI).

- Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

- For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

- Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

1.9 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that, they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes.
- It is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust.
- It is expected to be used for more than one financial year.
- The cost of the item can be measured reliably.

Property, plant and equipment is also only capitalised where:

- It individually has a cost of at least £5,000.
- It forms a group of assets that individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.
- Form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Measurement

Valuation

Under IAS16 assets should be revalued when their fair value is materially different from their carrying value. Monitor requires revaluation at least once every five years. All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Foundation Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of the revaluation less any subsequent accumulated depreciation and impairment losses.

All land and buildings are revalued using professional valuations in accordance with IAS16. Fair values are determined as follows:

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

The Foundation Trust revalued its equipment in the 2012/13 accounts using relevant indices published by the Office of National Statistics as a proxy for fair value.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS23 for assets held at fair vale. Assets are revalued and depreciation commences when they are brought into use.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value and asset life. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The estimated useful life of an asset is the period over which the Foundation Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Foundation Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed during the year, with the effect of any changes recognised on a prospective basis.

Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment that has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the Foundation Trust Annual Reporting Manual (FT ARM), impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses, and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Derecognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales.
- The sale must be highly probable ie:
  - Management are committed to a plan to sell the asset.
  - An active programme has begun to find a buyer and complete the sale.
  - The asset is being actively marketed at a reasonable price.
  - The sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'.
  - The actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are derecognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Following the accounting policy change outlined in the Treasury FReM for 2011/12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Government grants

Following the accounting policy change outlined in the Treasury FReM for 2011/12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights.

They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust and for at least a year and where the cost of the asset can be measured reliably and is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised and expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use.
- The Foundation Trust intends to complete the asset and sell or use it.
- The Foundation Trust has the ability to sell or use the asset.
- How the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset.
- Adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset.
- The Foundation Trust can measure reliably the expenses attributable to the asset during development.

Software
Software that is integral to the operation of hardware eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware eg application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

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

The estimated useful life of an asset is the period over which the Foundation Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Foundation Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

1.12 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.13 Financial instruments and financial liabilities
Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs ie when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

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

Derecognition
All financial assets are derecognised when the rights to receive cashflows from the assets have expired or the Foundation Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are derecognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as loans and receivables, whereas financial liabilities are classified as other financial liabilities.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Foundation Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

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

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

1.14 Leases
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are derecognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

The following is the methodology used for the reclassification of operating leases as finance leases in which the Foundation Trust acts as lessee:

- The finance charge is allocated across the lease term on a straight-line basis.
- The capital cost is capitalised using a straight-line basis of depreciation.
- The lease rental expenditure that would otherwise have been charged to expenditure under an operating lease is removed from expenditure on a straight-line basis.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.15 Provisions

The Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2 per cent in real terms, except for early retirement provisions, and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.35 per cent in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Foundation Trust is disclosed at note 20.

Non-clinical risk pooling

The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.16 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 22 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control.
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.17 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the preceding NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5 per cent) on the average relevant net assets of the Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General.

1.18 Value added tax (VAT)

Most of the activities of the Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Corporation tax

Great Ormond Street Hospital for Children NHS Foundation Trust has determined that it has no corporation tax liability as the Trust has no private income from non-operational areas.

1.20 Foreign exchange

The functional and presentational currencies of the Foundation Trust are sterling.

A transaction that is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Foundation Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- Monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March.
- Non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction.
- Non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.21 Cash, bank and overdrafts

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

1.22 Heritage assets

Heritage assets (under FRS30 and as required by the FT ARM) are tangible assets with historical, artistic, scientific, technological, geographical or environmental qualities, held principally for their contribution to knowledge or culture. The Foundation Trust holds no such assets as all assets are held for operational purposes – this includes a number of artworks on display in the hospital.

1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 Recently issued International Financial Reporting Standards (IFRS) accounting standards

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) but have not yet been adopted in the Annual Reporting Manual. Monitor does not permit the early adoption of accounting standards, amendments and interpretations that are in issue at the reporting date but effective at a subsequent reporting period.

IAS 27 Separate Financial Statements

IAS 28 Associates and Joint Ventures

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

International Public Sector Accounting Standards (IPSAS) 32 Service Concession Arrangements

The directors do not expect that the adoption of these standards and interpretations will have a material impact on the financial statements in future periods. All other revised and new standards have not been listed here as they are not considered to have an impact on the Foundation Trust.

2. Total revenue from patient care activities

2.1 Analysis of revenue from patient care activities

	12 months ended 31 March 2013 £000	One month ended 31 March 2012 £000	Proforma unaudited 12 months ended 31 March 2012 £000
Elective income	**69,980**	5,610	64,404
Non-elective income	**15,108**	1,061	12,344
Outpatient income	**33,722**	2,940	33,964
Other NHS clinical income	**142,877**	14,722	144,731
Revenue from protected patient care activities	**261,687**	24,333	255,443
Private patient income	**41,294**	2,655	28,157
Other non-protected clinical income	**5,241**	378	4,701
	46,535	3,033	32,858
Total revenue from patient care activities	**308,222**	27,366	288,301

The Foundation Trust's Terms of Authorisation set out the mandatory services that the Trust is required to provide (protected services). All of the income from activities before private patients and other clinical income shown above is derived from the provision of protected services.

2.2 Analysis of revenue from patient care activities by source

	12 months ended 31 March 2013 £000	One month ended 31 March 2012 £000	Proforma unaudited 12 months ended 31 March 2012 £000
NHS trusts	**1,077**	110	803
Strategic Health Authorities	**45,742**	4,591	47,502
Primary Care Trusts	**214,868**	19,806	206,347
Local Authorities	**0**	0	151
Department of Health	**0**	0	635
Non-NHS			
Private patients	**41,294**	2,655	28,157
Overseas patients (non-reciprocal)	**2,697**	0	1,948
Injury costs recovery (was RTA)	**7**	0	5
Other	**2,537**	204	2,753
Total revenue from patient care activities	**308,222**	27,366	288,301

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

2.3 Private patient cap

Section 44 of the National Health Services Act 2006 required that the proportion of private patient income to the total patient related income of NHS Foundation Trusts should not exceed its propoprtion while the body was an NHS Trust in 2002/03 (Private Patient Cap). This statutory limitation on private patient income was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. As a result, the disclosures that were provided previously are no longer reported.

3. Total other operating revenue

	12 months ended 31 March 2013 £000	One month ended 31 March 2012 £000	Proforma unaudited 12 months ended 31 March 2012 £000
Research and development	**19,682**	1,972	19,803
Charitable contributions to expenditure	**5,841**	1,167	4,712
Charitable contributions in respect of capital expenditure	**13,561**	4,257	28,205
Education and training	**9,802**	690	10,238
Non-patient care services to other bodies	**949**	97	858
Clinical tests	**3,255**	496	3,097
Clinical excellence awards	**3,215**	222	3,122
Catering	**683**	50	712
Crèche services	**506**	41	470
Staff accommodation rentals	**81**	36	182
Other revenue	**6,037**	697	6,079
	63,612	9,725	77,478

4. Operating expenses

	12 months ended 31 March 2013 £000	One month ended 31 March 2012 (restated) £000	Proforma unaudited 12 months ended 31 March 2012 £000
Services from other NHS bodies	**4,737**	527	4,098
Purchase of healthcare from non-NHS bodies	**3,371**	1,734	4,431
Executive directors' costs*	**1,459**	106	1,303
Non-executive directors' costs*	**119**	5	60
Staff costs	**188,514**	16,152	187,101
Supplies and services – clinical – drugs	**36,367**	4,700	36,537
Supplies and services – clinical – other	**45,086**	3,144	40,440
Supplies and services – general	**2,559**	289	2,174
Establishment	**2,664**	311	2,784
Research and development	**8,285**	452	4,986
Transport	**2,802**	273	2,823
Premises	**23,571**	2,020	19,546
Operating lease rentals	**1,553**	185	1,347
Provision for impairment of receivables	**1,604**	18	(29)
Inventories write down	**71**	18	62
Depreciation	**17,798**	1,002	13,725
Amortisation of intangible assets	**1,029**	55	591
Impairments and reversals of property, plant and equipment	**3,709**	0	12,304
Fees payable to the Trust's auditor for the financial statement audit	**116**	59	215
Other audit regulatory services – quality account	**18**	18	22
Fees payable to the Trust's auditor and their associates for non-audit services	**10**	0	24
Loss on disposal of equipment	**39**	0	309
Clinical negligence	**2,142**	162	1,950
Redundancy costs	**1,207**	23	1,018
Consultancy costs	**1,163**	135	1,328
Legal fees	**293**	12	179
Losses and special payments	**3**	0	62
Other	**3,582**	325	2,251
	353,871	31,725	341,641

*Details of directors' remuneration can be found in the Remuneration Report on page 156.

'Operating lease rentals', 'Legal fees' and 'Losses and special payments' are now shown separately from 'Other' expenditure. Redundancy costs are now shown separately from 'Staff costs' and 'Internal audit fees' are now shown within 'Other' expenditure – prior year figures have been restated as a result.

Research and development expenditure includes £6.923 million of staff costs.

Notes to the accounts
continued

5. Operating leases

5.1 As lessee

	12 months ended 31 March 2013 £000	One month ended 31 March 2012 £000	Proforma unaudited 12 months ended 31 March 2012 £000
Payments recognised as an expense			
Minimum lease payments	**1,553**	185	1,347
	1,553	185	1,347

	As at 31 March 2013 £000	As at 31 March 2012 £000
Total future minimum lease payments		
Payable		
Not later than one year	**1,424**	1,388
Between one and five years	**5,178**	5,146
After five years	**7,775**	8,855
Total	**14,377**	15,389

6. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial year ended 31 March 2013.

7. Employee costs and numbers

7.1 Employee costs

	12 months to 31 March 2013 Total £000	Permanently employed £000	Other £000	One month to 31 March 2012 Total £000	Proforma unaudited 12 months to 31 March 2012 Total £000
Salaries and wages	**153,498**	**153,498**	**0**	12,266	146,862
Social security costs	**12,964**	**12,964**	**0**	1,048	12,203
Employer contributions to NHS Pension Scheme	**17,782**	**17,782**	**0**	1,460	17,018
Agency/contract staff	**14,737**	**0**	**14,737**	1,570	17,519
Termination benefits	**1,207**	**1,207**	**0**	23	1,018
Employee benefits expense	**200,188**	**185,451**	**14,737**	16,367	194,620
Employee costs capitalised	**(641)**	**(641)**	**0**	(86)	(732)
Net employee benefits excluding capitalised costs	**199,547**	**184,810**	**14,737**	16,281	193,888

7.2 Average number of people employed*

	12 months to 31 March 2013 Total number	Permanently employed number	Other number	One month to 31 March 2012 Total number	Proforma unaudited 12 months to 31 March 2012 Total number
Medical and dental	**539**	**517**	**22**	548	532
Administration and estates	**915**	**823**	**92**	887	903
Healthcare assistants and other support staff	**59**	**56**	**3**	66	66
Nursing, midwifery and health visiting staff	**1,295**	**1,187**	**108**	1,282	1,266
Scientific, therapeutic and technical staff	**698**	**682**	**16**	723	676
Other staff	**222**	**222**	**0**	226	201
Total	**3,728**	**3,487**	**241**	3,732	3,644

*Whole time equivalent.

7.3 Retirements due to ill health

During the year there were four early retirements from the Foundation Trust on the grounds of ill health resulting in additional pension liabilities of £0.232 million (There were no early retirements in the one-month period to 31 March 2012).

7.4 Staff exit packages

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

Exit packages number and cost	12 months to 31 March 2013 compulsory redundancies number	Compulsory redundancies £000	Voluntary severance scheme departures agreed number	Voluntary severance scheme departures agreed £000	Proforma unaudited 12 months to 31 March 2012 One month to 31 March 2012 compulsory redundancies number	Compulsory redundancies £000	Total number of exit packages number	Total number of exit packages £000
<£10,000	**2**	**16**	**1**	**1**	1	5	8	30
£10,00–£25,000	**4**	**73**	**1**	**17**	1	15	4	69
£25,001–£50,000	**7**	**228**	**0**	**0**	0	0	0	0
£50,001–£100,000	**5**	**408**	**0**	**0**	0	0	1	50
£100,001–£150,000	**1**	**124**	**0**	**0**	0	0	2	230
Total	**19**	**849**	**2**	**18**	2	20	15	379

Any exit packages in relation to senior managers (should they arise) are not included in this note as these would be disclosed in the remuneration report.

The cost of ill health retirements falls on the relevant pension scheme, not the Foundation Trust, and is included in note 7.3.

8. Finance income

	12 months ended 31 March 2013 £000	One month ended 31 March 2012 £000	Proforma unaudited 12 months ended 31 March 2012 £000
Bank interest	**85**	5	68
Total finance income	**85**	5	68

9. Finance expenses

	12 months ended 31 March 2013 £000	One month ended 31 March 2012 £000	Proforma unaudited 12 months ended 31 March 2012 £000
Provisions – unwinding of discount	**34**	3	39
Interest expenses	**1**	0	0
Total finance expenses	**35**	3	39

10. Intangible assets

10.1 Intangible assets

	Software licences £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Intangible assets under construction £000	**Total £000**
Gross cost at 1 April 2012	1,965	202	1,378	2,813	**6,358**
Additions – purchased	0	0	0	2,202	**2,202**
Additions – donated	0	0	0	34	**34**
Reclassifications	418	0	1,910	(2,295)	**33**
Valuation/gross cost at 31 March 2013	**2,383**	**202**	**3,288**	**2,754**	**8,627**
Amortisation at 1 April 2012	884	64	479	0	**1,427**
Provided during the period	409	63	557	0	**1,029**
Amortisation at 31 March 2013	**1,293**	**127**	**1,036**	**0**	**2,456**
Net book value					
Purchased at 31 March 2013	1,040	73	2,252	2,754	**6,119**
Donated at 31 March 2013	50	2	0	0	**52**
Total at 31 March 2013	**1,090**	**75**	**2,252**	**2,754**	**6,171**

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

The Trust reclassified £0.033 million of assets from ‘tangible’ to ‘intangible’ assets.

	Software licences £000	Licences and trademarks £000	Development expenditure (internally generated) £000	Intangible assets under construction £000	**Total £000**
Gross cost at 1 March 2012	1,965	202	1,378	0	**3,545**
Additions – purchased	0	0	0	874	**874**
Reclassifications	0	0	0	1,939	**1,939**
Valuation/gross cost at 31 March 2012	**1,965**	**202**	**1,378**	**2,813**	**6,358**
Amortisation at 1 March 2012	852	59	461	0	**1,372**
Provided during the period	32	5	18	0	**55**
Amortisation at 31 March 2012	**884**	**64**	**479**	**0**	**1,427**
Net book value					
Purchased at 31 March 2012	1,048	129	857	0	**2,034**
Donated at 31 March 2012	33	9	42	2,813	**2,897**
Total at 31 March 2012	**1,081**	**138**	**899**	**2,813**	**4,931**

10.2 Economic life of intangible assets

	Minimum life years	Maximum life years
Intangible assets		
Software	1	5
Development expenditure	1	5
Licences and trademarks	1	3

11. Property, plant and equipment

11.1 Property, plant and equipment

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and pre-owned asset (POA) £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	**Total £000**
Cost or valuation at 1 April 2012	53,175	225,943	1,982	13,371	51,407	15,132	4,094	**365,104**
Additions – purchased	0	0	0	3,471	0	0	0	**3,471**
Additions – donated	0	0	0	13,527	0	0	0	**13,527**
Impairments	0	(4,823)	0	0	0	0	0	**(4,823)**
Reclassifications	0	(5,322)	6,044	(17,707)	9,186	2,088	5,678	**(33)**
Revaluations	4,445	0	102	0	0	0	0	**4,547**
Transferred to disposal group as asset held for sale	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(783)	0	0	**(783)**
Cost or valuation at 31 March 2013	**57,620**	**215,798**	**8,128**	**12,662**	**59,810**	**17,220**	**9,772**	**381,010**
Accumulated depreciation at 1 April 2012	0	648	14	0	26,365	8,238	3,200	**38,465**
Provided during the period	0	8,453	73	0	5,877	2,631	764	**17,798**
Impairments	0	3,585	124	0	0	0	0	**3,709**
Reclassifications	0	(98)	98	0	0	0	0	**0**
Disposals	0	0	0	0	(720)	0	0	**(720)**
Accumulated depreciation at 31 March 2013	**0**	**12,588**	**309**	**0**	**31,522**	**10,869**	**3,964**	59,252
Net book value at 31 March 2013								
Owned at 31 March 2013	55,163	86,853	1,690	3,411	10,060	4,253	1,467	**162,897**
Finance leased at 31 March 2013	0	4,185	0	0	0	0	0	**4,185**
Government granted at 31 March 2013	0	155	0	0	127	0	0	**282**
Donated at 31 March 2013	2,457	112,017	6,129	9,251	18,101	2,098	4,341	**154,394**
Total at 31 March 2013	**57,620**	**203,210**	**7,819**	**12,662**	**28,288**	**6,351**	**5,808**	321,758

The Trust reclassified £5.537 million from Buildings to Dwellings and £0.033 million of assets from 'tangible' to 'intangible' assets.

	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 March 2012	53,175	249,441	2,193	9,560	50,911	15,132	4,094	**384,506**
Additions – purchased	0	0	0	1,488	0	0	0	**1,488**
Additions – donated	0	0	0	4,262	0	0	0	**4,262**
Reclassifications	0	0	0	(1,939)	0	0	0	**(1,939)**
Revaluations	0	(23,498)	(211)	0	496	0	0	**(23,213)**
Cost or valuation at 31 March 2012	**53,175**	**225,943**	**1,982**	**13,371**	**51,407**	**15,132**	**4,094**	**365,104**
Accumulated depreciation at 1 March 2012	0	23,804	219	0	25,657	8,034	3,162	**60,876**
Provided during the period	0	342	6	0	412	204	38	**1,002**
Revaluation surpluses	0	(23,498)	(211)	0	296	0	0	**(23,413)**
Accumulated depreciation at 31 March 2012	**0**	**648**	**14**	**0**	**26,365**	**8,238**	**3,200**	**38,465**
Net book value at 31 March 2012								
Owned at 31 March 2012	50,908	90,663	1,968	4,750	11,396	5,993	520	**166,198**
Finance lease at 31 March 2012	0	4,434	0	0	0	0	0	**4,434**
Government granted at 31 March 2012	0	301	0	0	0	0	0	**301**
Donated at 31 March 2012	2,267	129,897	0	8,621	13,646	901	374	**155,706**
Total at 31 March 2012	**53,175**	**225,295**	**1,968**	**13,371**	**25,042**	**6,894**	**894**	**326,639**

The figures above have been restated from the 2011/12 published accounts to reflect the correct balance carried forward of gross cost and accumulated depreciation on buidlings and dwellings following a full valuation of the Trust's estate as at 29 February 2012. Gross cost and accumulated depreciation were reduced by £23.498 million for buildings and £0.211 million for dwellings, there was no impact on net book value.

11.2 Analysis of property, plant and equipment

	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**
Net book value at 31 March 2013								
Protected assets	57,620	173,003	122	0	0	0	0	**230,745**
Unprotected assets	0	30,207	7,697	12,662	28,288	6,351	5,808	**91,013**
Total at 31 March 2013	**57,620**	**203,210**	**7,819**	**12,662**	**28,288**	**6,351**	**5,808**	**321,758**

	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**
Net book value at 31 March 2012								
Protected assets	53,175	186,507	0	0	0	0	0	**239,682**
Unprotected assets	0	38,788	1,968	13,371	25,042	6,894	894	**86,957**
Total at 31 March 2012	**53,175**	**225,295**	**1,968**	**13,371**	**25,042**	**6,894**	**894**	**326,639**

11.3 Economic life of property plant and equipment

	Minimum life years	Maximum life years
Buildings excluding dwellings	1	48
Dwellings	46	47
Plant and machinery	1	14
Information technology	1	5
Furniture and fittings	1	10

Freehold land is considered to have an infinite life and is not depreciated.

Assets under course of construction are not depreciated until the asset is brought into use.

The Foundation Trust is planning to demolish a part of the Cardiac Wing as part of its Redevelopment programme. As a result, the useful economic life of that part of the building has been reduced accordingly.

Great Ormond Street Hospital Children's Charity donated £13.561 million towards property, plant and equipment expenditure during the year.

The Foundation Trust has completed a number of agreements with Great Ormond Street Hospital Children's Charity in connection with amounts donated to fund capital expenditure on building work in relation to buildings used by the Trust for its core activities. The agreements provide that, in the event that there is a material change in use of these buildings, the amounts donated would be repayable based on a formula which takes account of the total value of donations received and the period for which the new building work has been in use by the Trust. There are no past events or events foreseen by the directors which would require the recognition of an obligation to the charity as a result of these agreements.

For assets held at revalued amounts:
- The effective date of revaluation was 31 March 2013.
- The valuation of land, buildings and dwellings was undertaken by Peter Ashby, Member of the Royal Institution of Chartered Surveyors, Senior Surveyor, District Valuers Office.
- The valuations were undertaken using a modern equivalent asset methodology.

12. Commitments

12.1 Capital commitments

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

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	**11,666**	10,558
Intangible assets	**108**	857
Total	**11,774**	**11,415**

12.2 Other financial commitments

The Trust has entered into non-cancellable contracts (which are not leases or Private Finance Initiative (PFI) contracts or other service concession arrangements). The payments to which the Foundation Trust is committed are as follows:

	31 March 2013 £000	31 March 2012 £000
Not later than one year	**13,050**	18,215
Later than one year and not later than five years	**2,699**	1,686
Total	**15,749**	**19,901**

13. Inventories

13.1 Inventories

	31 March 2013 £000	31 March 2012 £000
Drugs	**1,137**	1,286
Consumables	**5,361**	4,856
Energy	**65**	67
Total	**6,563**	**6,209**

14. Trade and other receivables

14.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables – revenue	**9,566**	9,694	**0**	0
Other receivables – revenue	**16,143**	12,869	**0**	0
Provision for impaired receivables	**(2,692)**	(1,126)	**0**	0
Receivables due from NHS charities – capital	**3,690**	6,690	**0**	0
Other receivables with related parties – revenue	**0**	112	**0**	0
Prepayments (non-PFI)	**1,753**	1,965	**8,566**	9,042
Accrued income	**3,169**	2,020	**0**	0
Interest receivable	**5**	0	**0**	0
PDC dividend receivable	**236**	0	**0**	0
VAT receivable	**300**	1,037	**0**	0
Total	**32,170**	33,261	**8,566**	9,042

The 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.

14.2 Provision for impairment of receivables

	31 March 2013 £000	31 March 2012 £000
Opening balance	**1,126**	1,108
Increase in provision	**1,604**	18
Amounts utilised	**(38)**	0
Closing balance	**2,692**	1,126

14.3 Analysis of impaired receivables

	31 March 2013 £000	31 March 2012 (restated) £000
Ageing of impaired receivables		
0–30 days	**412**	178
30–60 days	**18**	7
60–90 days	**21**	11
90–180 days	**310**	119
over 180 days	**1,931**	811
	2,692	1,126
Ageing of non-impaired receivables past their due date		
0–30 days	**3,102**	2,082
30–60 days	**809**	593
60–90 days	**893**	302
90–180 days	**1,197**	88
Over 180 days	**226**	47
	6,227	3,112

15. Cash and cash equivalents

	31 March 2013 £000	31 March 2012 £000
Balance at beginning of the period	**26,628**	19,063
Net change in year	**11,776**	7,565
Balance at the end of the period	**38,404**	26,628
Made up of		
Commercial banks and cash in hand	**53**	22
Cash with the Government Banking Service	**38,351**	26,606
Cash and cash equivalents	**38,404**	26,628

16. Trade and other payables

16.1 Trade and other payables

	Current 31 March 2013 £000	Current 31 March 2012 £000 (restated)
NHS payables – revenue	**4,753**	3,922
Other trade payables – capital	**6,041**	7,445
Other trade payables – revenue	**4,603**	8,553
Social Security costs	**1,939**	1,892
Other taxes payable	**2,207**	2,244
Amounts due to other related parties – revenue	**0**	122
Other payables	**3,723**	3,413
Accruals	**11,397**	11,954
Total	**34,663**	39,545

'Other payables' includes £2.438 million outstanding pension contributions at 31 March 2013 (£2.216 million at 31 March 2012).

17. Other liabilities

	Current 31 March 2013 £000	31 March 2012 £000	Non-current 31 March 2013 £000	31 March 2012 £000
Deferred income	**4,500**	4,290	**0**	0
Lease incentives	**407**	437	**6,578**	6,957
Total	**4,907**	4,727	**6,578**	6,957

Notes to the accounts
continued

18. Prudential Borrowing Limit

	31 March 2013 £000	31 March 2012 £000
Total long-term borrowing limit set by Monitor	**76,000**	76,000
Working capital facility agreed by Monitor	**15,000**	15,000
Total Prudential Borrowing Limit	**91,000**	91,000
Long term borrowing at beginning of period (1 March 2012 for prior year)	**0**	0
Net actual borrowing/(repayment) in year – long-term	**0**	0
Long term borrowing at end of period	**0**	0
Working capital borrowing at beginning of period (1 March 2012 for prior year)	**0**	0
Net actual borrowing/(repayment) in year – working capital	**0**	0
Working capital borrowing at end of period	**0**	0

The NHS Foundation Trust is required to comply and remain within a Prudential Borrowing Limit.

This is made up of two elements:
- The maximum cumulative amount of long term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.
- The amount of any working capital facility approved by Monitor.

19. Financial ratios

	12 months ended 31 March 2013 Approved	Actual	one month ended 31 March 2012 Approved	Actual	Proforma unaudited 12 months ended 31 March 2012 Approved	Actual
Minimum dividend cover	> 1	7	> 1	14.3	> 1	8.8
Minimum interest cover	> 3	n/a	> 3	n/a	> 3	n/a
Minimum debt service cover	> 2	n/a	> 2	n/a	> 2	n/a
Maximum debt service to revenue	2.5%	n/a	2.5%	n/a	2.5%	n/a

The Trust has £15 million of approved working capital facility which was put in place on 1 March 2012.

The Trust did not draw down any amounts under its working capital facility in the year.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts at: http://www.monitor-nhsft.gov.uk/index.php

20. Provisions

	Current 31 March 2013 £000	Current 31 March 2012 £000	Non-current 31 March 2013 £000	Non-current 31 March 2012 £000
Pensions relating to other staff	**116**	113	**1,222**	1,234
Other legal claims	**70**	64	**0**	0
Redundancy	**1,077**	901	**0**	0
Other	**1,938**	2,045	**0**	0
Total	**3,201**	3,123	**1,222**	1,234

	Pensions relating to other staff £000	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2012	1,347	64	901	2,045	**4,357**
Arising during the period	70	6	1,501	226	**1,803**
Utilised during the period	(113)	0	(1,031)	(26)	**(1,170)**
Reversed unused	0	0	(294)	(307)	**(601)**
Unwinding of discount	34	0	0	0	**34**
At 31 March 2013	1,338	70	1,077	1,938	**4,423**
Expected timing of cash flows					
Not later than one year	116	70	1,077	1,938	**3,201**
Later than one year and not later than five years	466	0	0	0	**466**
Later than five years	756	0	0	0	**756**
	1,338	70	1,077	1,938	**4,423**

Provisions for capitalised pension benefits are based on tables provided by the NHS Pensions Agency reflecting years to normal retirement age and the additional pension costs associated with early retirement.

'Other legal claims' consists of amounts due as a result of third party and employer liability claims. The values are based on information provided by the Trust's insurer, in this case, the NHS Litigation Authority. The amount shown here is the gross expected value of the Trust's liability to pay minimum excesses for outstanding cases under the scheme rules. Provision has also been made for cases which are ongoing with the Trust's solicitors.

The 'Other' Provision includes the Foundation Trust's annual leave accrual.

The NHS Litigation Authority records provisions in respect of clinical negligence liabilities of the Foundation Trust. The amount recorded as at 31 March 2013 was £36.218 million (£33.152 million at 31 March 2012).

21. Revaluation reserve

	31 March 2013 £000	31 March 2012 £000
Opening balance (1 March 2012 for prior year)	**48,848**	48,661
Impairments	**(4,823)**	0
Revaluations	**4,547**	200
Transfers to other reserves	**(169)**	(13)
Asset disposals	**(23)**	0
Closing balance	**48,380**	48,848

22. Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Other	**(25)**	(29)
Gross value of contingent liabilities	**(25)**	(29)
Net value of contingent liabilities	**(25)**	(29)

A contingent liability exists for potential third party claims in respect of employer's/occupier's liabilities and property expenses £0.025 million at 31 March 2013 (£0.029 million at 31 March 2012). The value of provisions for the expected value of probable cases is shown in Note 20.

23. Financial instruments

The carrying value and the fair value are equivalent for the financial assets and financial liabilities shown below in notes 23.1 and 23.2. All financial assets and liabilities included below are receivable/payable within 12 months.

23.1 Financial assets by category

	31 March 2013 loans and receivables £000	31 March 2012 loans and receivables £000
NHS trade and other receivables excluding non-financial assets	**9,566**	9,694
Non-NHS trade and other receivables excluding non-financial assets	**17,677**	19,470
Cash and cash equivalents (at bank and in hand)	**38,404**	26,628
	65,647	55,792

23.2 Financial liabilities by category

	31 March 2013 other financial liabilities £000	31 March 2012 other financial liabilities £000
NHS trade and other payables excluding non-financial assets	**4,753**	3,922
Non-NHS trade and other payables excluding non-financial assets	**18,513**	21,331
	23,266	25,253

23.3 Financial instruments

23.3.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the Foundation 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 Foundation 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 Foundation 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 Foundation Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Foundation Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

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

Credit risk

As the majority of the Foundation Trust's income comes from contracts with other public sector bodies, it has low exposure to credit risk. The maximum exposures as at 31 March 2013 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Foundation 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 Foundation Trust receives cash each month based on an annually agreed level of contract activity and there are periodic corrections made to adjust for the actual income due under the contract.

The Foundation Trust has put in place a £15 million working capital facility, which to date, due to careful cash management, it has yet to draw on.

The Foundation Trust presently finances its capital expenditure mainly from donations and internally generated funds and is not, therefore, exposed to significant liquidity risks in this area.

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

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continued

24. Related party transactions

Great Ormond Street Hospital for Children NHS Foundation Trust is a body corporate established under the National Health Service Act 2006.

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 Great Ormond Street Hospital for Children NHS Foundation Trust.

During the year Great Ormond Street Hospital for Children NHS Foundation Trust has had a significant number of material transactions with other NHS bodies.

Where the value of transactions is considered material, these entities are listed below:

Organisation category	Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
Primary Care Trusts (PCTs)	Barking and Dagenham PCT	2,433	0	179	0
	Barnet PCT	5,058	0	0	283
	Barnsley PCT	1,249	0	56	0
	Bexley NHS Care Trust PCT	1,128	0	32	0
	Birmingham East and North PCT	2,030	0	0	33
	Brent Teaching PCT	3,538	0	289	0
	Bristol PCT	3,907	0	128	0
	Bromley PCT	1,058	0	0	70
	Camden PCT	14,232	0	215	91
	City and Hackney Teaching PCT	3,406	0	127	0
	Croydon PCT	63,466	0	250	55
	Ealing PCT	3,109	0	281	0
	Enfield PCT	4,537	0	222	0
	Greenwich Teaching PCT	950	0	7	0
	Hampshire PCT	10,218	0	208	0
	Hammersmith and Fulham PCT	879	0	46	0
	Haringey Teaching PCT	4,563	0	247	130
	Harrow PCT	2,280	0	0	8
	Havering PCT	2,458	0	141	0
	Hillingdon PCT	2,996	0	85	0
	Hounslow PCT	2,231	0	158	0
	Islington PCT	3,246	0	0	211
	Kensington and Chelsea PCT	728	0	0	66
	Lambeth PCT	909	0	128	0
	Leicestershire County and Rutland PCT	6,121	0	197	0
	Lewisham PCT	607	0	31	0
	Newham PCT	4,625	0	234	0
	Redbridge PCT	3,779	0	261	0
	Richmond and Twickenham PCT	964	0	0	44
	South East Essex PCT	43,887	0	267	28
	Southwark PCT	786	0	67	0
	Sutton and Merton PCT	911	0	0	59
	Tower Hamlets PCT	2,635	0	71	0
	Waltham Forest PCT	3,317	0	0	43
	Wandsworth PCT	1,041	0	86	0
	West Kent PCT	14,280	0	838	0
	Western Cheshire PCT	952	0	6	15
	Westminster PCT	1,525	0	0	43

Organisation category	Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Foundation Trusts	Guys And St Thomas NHS Foundation Trust	46	927	16	726
	University College London NHS Foundation Trust	1,260	2,115	7,769	1,255
NHS Trusts	Barts Health NHS Trust	2,582	941	719	459
	Mid Essex Hospital Services NHS Trust	490	1,394	7	166
Strategic Health Authorities	London Strategic Health Authority	54,708	26	2,332	52
Other NHS bodies	NHS Blood and Transplant (excluding Bio Products Laboratory)	0	2,427	8	16
	NHS Business Services Authority	0	0	0	32
	NHS Litigation Authority	0	2,328	0	0
Other Government Bodies	Department of Health	11,162	0	287	0
	Department of Health (PDC dividend only)	0	6,036	236	0
	HM Revenue & Customs – VAT	0	0	300	0
	HM Revenue & Customs – other taxes and duties	0	0	0	2,207
	National Insurance Fund (Employer contributions – Revenue Expenditure)	0	14,094	0	2,039
	NHS Pension Scheme (Own staff employers contributions)	0	17,760	0	2,438
Other related parties	Great Ormond Street Hospital Children's Charity	20,636	1,757	5,428	58

25. Events after the reporting period

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

26. Losses and special payments

During the year there were 67 cases, on an accruals not cash basis, of losses and special payments totalling £0.229 million (March 2012: 14 cases totalling £0.019 million, proforma unaudited 2011/12: 183 cases totalling £0.362million).

Notes to the accounts
continued

27. Remuneration report

27.1 Salary entitlements of senior managers

Title		2012/13 £000	2011/12 Salary M1–M11 £000	2011/12 M12 £000	2011/12 Full year £000
Non-executive directors					
Baroness Tessa Blackstone	Chairman of Trust Board	35–40	20–25	0–5	20–25
Ms Yvonne Brown	Non-Executive Director	10–15	5–10	0–5	5–10
Professor Andrew Copp	Non-Executive Director (until 31 December 2012)	0–5	5–10	0–5	5–10
Mr David Lomas	Non-Executive Director	10–15	0–5	0–5	0–5
Ms Mary MacLeod OBE	Non-Executive Director	15–20	5–10	0–5	5–10
Mr John Ripley	Non-Executive Director	10–15	0–5	0–5	0–5
Ms Ros Smyth	Non-Executive Director (from 1 January 2013)	0–5	n/a	n/a	n/a
Mr Charles Tilley	Non-Executive Director	15–20	5–10	0–5	5–10
Executive directors					
Dr Barbara Buckley	Co-Medical Director	170–175	155–160	10–15	170–175
Mr Robert Burns	Deputy Chief Operating Officer (1 April until 31 August 2012 and 8 November 2012 until 3 March 2013)/ Interim Chief Operating Officer (1 September until 7 November 2012 and from 4 March to 31 March 2013)	85–90	n/a	n/a	n/a
Mr Trevor Clarke	Director of the International and Private Patients Division	80–85	70–75	5–10	75–80
Dr Jane Collins	Chief Executive (until 31 August 2012)	65–70	165–170	15–20	180–185
Ms Fiona Dalton	Deputy Chief Executive (1 April until 31 August 2012 and 8 November 2012 until 14 March 2013)/Interim Chief Executive (1 September until 7 November 2012)	130–135	115–120	10–15	125–130
Mr Martin Elliott	Co-Medical Director	85–90	130–135	10–15	140–145
Mr Edward (Jan) Filochowski	Chief Executive (from 8 November 2012)	70–75	n/a	n/a	n/a
Professor David Goldblatt*	Director of Clinical Research and Development	75–80	60–65	5–10	65–70
Mr Charles Handford	Interim Director of Estates (from 20 September 2012 until 25 January 2013)	60–65	n/a	n/a	n/a
Mr Mark Large	Director of Information Technology	90–95	85–90	5–10	90–95
Mr William (Bill) McGill	Director of Redevelopment (until 31 July 2012)	30–35	70–75	5–10	80–85
Mr Ali Mohammed	Interim Director of Human Resources (from 21 January 2013)	20–25	n/a	n/a	n/a
Mrs Elizabeth Morgan	Chief Nurse and Director of Education	100–105	100–105	5–10	110–115
Mr Graham Mills	Director of Estates and Projects (from 1 September until 19 September 2012)	0–5	n/a	n/a	n/a
Mrs Claire Newton	Chief Finance Officer	125–130	110–115	10–15	125–130
Ms Natalie Robinson	Interim Director of Redevelopment (from 1 August until 30 November 2012)	30–35	n/a	n/a	n/a
Mr Matthew Tulley	Director of Redevelopment (from 3 December 2012)	40–45	n/a	n/a	n/a

* Professor Goldblatt's salary is paid by the Insititute of Child Health (ICH). The portion of his salary that relates to his work at the Foundation Trust is recharged to the Trust by ICH.

	2012/13 £000	2011/12 £000
Band of highest-paid director's total remuneration	170–175	180–185
Median total remuneration	36,628	37,192
Ratio	4.7	4.9

27.2 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 at age 60 at 31 March 2012 (bands of £2,500) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2013 £000	Cash equivalent transfer value at 31 March 2012 £000	Real increase/ (decrease) in cash equivalent transfer value at 31 March 2013 £000
Dr Barbara Buckley	Co-Medical Director	0–2.5	5–7.5	50–52.5	150–155	946	884	62
Mr Robert Burns	Deputy Chief Operating Officer (1 April until 31 August 2012 and 8 November 2012 until 3 March 2013)/ Interim Chief Operating Officer (1 September until 7 November 2012 and from 4 March to 31 March 2013)	5–7.5	0	27.5–30	55–60	308	245	63
Mr Trevor Clarke	Director of the International and Private Patients Division	0–2.5	2.5–5	35–37.5	110–115	719	677	42
Ms Fiona Dalton	Deputy Chief Executive (1 April until 31 August 2012 and 8 November 2012 until 14 March 2013)/Interim Chief Executive (1 September until 7 November 2012)	2.5–5	7.5–10	30–32.5	90–95	427	373	54
Mr Mark Large	Director of Information Technology	0–2.5	2.5–5	17.5–20	55–60	353	322	31
Mr Ali Mohammed	Interim Director of Human Resources (from 21 January 2013)	0–2.5	2.5–5	30–32.5	95–100	553	514	39
Mrs Elizabeth Morgan	Chief Nurse and Director of Education	0–2.5	2.5–5	47.5–50	145–150	n/a	n/a	n/a
Mr Graham Mills	Director of Estates and Projects (from 1 September until 19 September 2012)	0–2.5	0–2.5	35–37.5	105–110	n/a	n/a	n/a
Mrs Claire Newton	Chief Finance Officer	0–2.5	2.5–5	7.5–10	25–30	180	143	37
Mr Matthew Tulley	Director of Redevelopment (from 3 December 2012)	0–2.5	2.5–5	22.5–25	65–70	330	298	32

Glossary of terms

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

Depreciation
The process of charging the cost of a fixed asset to the Statement of Comprehensive Income over its useful life to the Trust, as opposed to recording the cost in a single year.

EBITDA
Earnings before interest, taxes, depreciation and amortisation.

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 Statement of Comprehensive Income resulting from a reduction in the value of assets.

Indexation
The process of adjusting the value of a fixed asset to account for inflation. 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.

Acute trust
A trust is an NHS organisation responsible for providing a group of healthcare services. An acute trust provides hospital services (but not mental health hospital services, which are provided by a mental health trust).

Balanced scorecard
A performance-management tool.

Bed Manager
Bed managers are a team of clinical and non-clinical staff who hold an up-to-date overview of current bed status. They are responsible for finding beds for incoming patients.

Benchmarking
Benchmarking is a process by which an organisation compares its performance and practices against other organisations. These comparisons are structured and are typically undertaken against similar organisations and against top performers. Benchmarking helps to define best practice and can support improvement by identifying specific areas that require attention.

BRE
Building Research Establishment.

Cardiac/respiratory arrest
Cardiac arrest is the cessation of normal circulation of the blood due to failure of the heart to contract effectively. A cardiac arrest is different from (but may be caused by) a heart attack, where blood flow to the muscle of the heart is impaired. Cardiac arrest prevents delivery of oxygen to the body. Lack of oxygen to the brain causes loss of consciousness, which then results in abnormal or absent breathing. Brain injury is likely if cardiac arrest goes untreated for more than five minutes. For the best chance of survival and neurological recovery, immediate and decisive treatment is imperative.

Care bundles
A small set of clinical practices which, when performed collectively, reliably and continuously, have been shown to improve patient outcomes.

Care Quality Commission
The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: www.cqc.org.uk

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 audit
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).

Clinical Nurse Specialist
A Clinical Nurse Specialist (CNS) is a specialist in one disease or disease group who is often responsible for coordinating, delivering and monitoring treatment.

Clinical outcome measures
A clinical outcome is a change in health that is attributable to a healthcare intervention. Routine outcomes measurement is central to improving service quality and accountability.

Clinical Unit Chair
Lead clinician for a unit.

CNST
Clinical Negligence Scheme for Trusts.

Commissioners
Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Primary Care Trusts were the key organisations responsible for commissioning healthcare services for their area. However, on 1 April 2013, commissioning structures changed. GP-run Clinical Commissioning Groups, responsible to NHS England, now commission services (including acute care, primary care and mental healthcare). Commissioning of specialist services is provided directly by NHS England. From 1 April 2013, around 90 per cent of the Foundation Trust's activity is commissioned by NHS England.

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.

Dashboards
Information dashboards present the most important information from large amounts of data in a way that is easy for users to read and understand. Dashboards summarise information and focus on changes and exceptions in the data.

Data quality
Data quality refers to the tools and processes that result in the creation of correct, complete and valid data that is required to support sound decision-making.

Department of Health
The Department of Health is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS.

ECMO
Extracorporeal membrane oxygenation.

ENT
Ears, nose and throat.

FCE
Finished consultant episode.

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

General Manager
Lead manager for a unit.

GP
General practitioner.

GOSH
Great Ormond Street Hospital for Children NHS Foundation Trust.

Healthwatch
Healthwatch is the new consumer champion for both health and social care, from 1 April 2013. It exists in two distinct forms – local Healthwatch, at local level, and Healthwatch England, at national level. The aim of local Healthwatch will be to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

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.

Medical Director
The Medical Director is a physician who is usually employed by a hospital to serve in a medical and administrative capacity as head of the organised medical staff. A medical director provides guidance, leadership, oversight and quality assurance.

Members' Council
GOSH's Members' Council was established when the Trust became a Foundation Trust. The council is vital for the direct involvement of members in our long term vision and planning, as a critical friend, and as a guardian of our values. It supervises public involvement, membership recruitment, and activation.

The council has specific powers, including involvement in picking the non-executive directors, ratifying the appointment of the Chief Executive, receiving the accounts, and appointing the auditors.

Monitor
Monitor is the independent regulator responsible for authorising, monitoring and regulating NHS Foundation Trusts.

MRI
Magnetic resonance imaging.

MRSA
Methicillin-resistant *Staphylococcus aureus.*

Multi-disciplinary team meeting
A multi-disciplinary team meeting is a meeting of the group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

NCEPOD
National Confidential Enquiry into Patient Outcome and Death.

NHS
National Health Service.

NHS Choices
NHS Choices is the UK's biggest health website. It provides a comprehensive health information service to patients and the public. The website helps users make choices about their health, from decisions about lifestyle, such as smoking, drinking and exercise, to finding and using NHS services in England.

NHS England
NHS England is an executive non-departmental public body of the Department of Health. It oversees the planning, delivery and day-to-day operation of the NHS in England as set out in the Health and Social Care Act 2012.

NHS Information Centre
The NHS Information Centre is England's central, authoritative source of health and social care information. Acting as a 'hub' for high quality, national, comparative data for all secondary uses, they deliver information for local decision makers to improve the quality and efficiency of frontline care. Visit: www.ic.nhs.uk

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.

Overview and scrutiny committees
Since January 2003, every local authority with responsibilities for social services (150 in all) has had the power to scrutinise local health services. Overview and scrutiny committees take on the role of scrutiny of the NHS – not just major changes but the ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

Paediatric Trigger Tool
The Paediatric Trigger Tool (PTT) measures harm caused by healthcare and is applied in routine monthly case note review. Through use of the tool, it is possible to calculate the adverse event rate and identify areas of care where most harm is occurring. It informs priorities for action and tracks improvements over time. GOSH was one of the nine hospitals involved in the development of the PTT.

PALS
Patient Advice and Liaison Service.

Patient pathway
The patient pathway is the route that a patient will take from their first contact with an NHS member of staff (usually their family doctor), through referral, to the completion of their treatment. It also covers the period from entry into a hospital or a treatment centre, until the patient leaves. Events such as consultations, diagnosis, treatment, medication, assessment, and teaching and preparing for discharge from the hospital are all part of the pathway. The mapping of pathways can aid service design and improvement.

PDSA
Plan-Do-Study-Act is a methodology to test an idea by trialling a change on a short term basis and assessing its impact. The four stages of the PDSA cycle are:
Plan – the change to be tested or implemented
Do – carry out the test of change
Study – examine data before and after the change and reflect on what was learned
Act – plan the next change cycle or full implementation.

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

PROMs
Patient-Reported Outcome Measures are outcome measures that seek the patient's perspective on their health and quality of life after a medical or surgical intervention. In conjunction with clinical outcome measures, PROMs can help to improve the quality of healthcare.

Providers
Providers are the organisations that provide NHS services, for example NHS trusts and their private or voluntary sector equivalents.

R&D
Research and development.

Research
Clinical research and clinical trials are an everyday part of the NHS. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

RPST
Risk Pool Scheme for Trusts.

Safe and Sustainable
Safe and Sustainable is the name of the national paediatric surgery reviews of children's congenital heart services and children's neurosurgical services. The purpose of Safe and Sustainable is to canvas the opinions of all stakeholders, including professional bodies, clinicians, patients, and their families, to weigh the evidence for and against different views of service delivery and to develop proposals that will deliver high quality and sustainable services into the future.

Safeguarding
Keeping children safe from harm, such as illness, abuse or injury (Commissioner for Social Care Inspection et al, 2005:5).

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.

Special review
A special review is a review carried out by the Care Quality Commission (CQC). Special reviews and studies are projects that look at themes in health and social care. They focus on services, pathways of care or groups of people. A review will usually result in assessments by the CQC of local health and social care organisations. A study will usually result in national level findings based on the CQC's research.

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

Statistical Process Control Charts
Statistical Process Control (SPC) charts are used to measure improvements over time. SPC methodology aids the identification of statistically significant changes and identifies areas that require further investigation.

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.

Trust Board
The role of the Trust Board is to take corporate responsibility for the organisation's strategies and actions. The Chair and Non-Executive Directors are lay people drawn from the local community and are accountable to the Secretary of State. The Chief Executive is responsible for ensuring that the Board is empowered to govern the organisation and to deliver its objectives.

TPN
Total parenteral nutrition.

UCL
University College London.

Unit
How we group and manage our clinical services.

Great Ormond Street Hospital for Children NHS Foundation Trust
Great Ormond Street
London WC1N 3JH
020 7405 9200
www.gosh.nhs.uk

Design Manager
Great Ormond Street Hospital
Fourth floor
40 Bernard Street
London WC1N 1LE
E design.work@gosh.org

Bengali
অনুরোধ করলে নিম্নলিখিত ঠিকানায় থেকে এই লেখার অনুবাদ, বড় অক্ষর, ব্রেল বা অডিও বিবরন 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 آڈیوپردرج ذیل پتے سے حاصل کی جا سکتی ہے۔

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This Annual Report is available to view at www.gosh.nhs.uk