Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Meeting of the Trust Board
Friday 22nd May 2015

Dear Members

There will be a public meeting of the Trust Board on Friday 22nd May 2015 at 2:00pm in Barclay House Conference Room, Great Ormond Street, London, WC1N 3JH.

Company Secretary

Direct Line: 020 7813 8230

Fax: 020 7813 8218

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Author
1.	**Apologies for absence**	Chairman	**Verbal**
	Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.		
2.	**Minutes of Meeting held on 25th March 2015**	Chairman	**J**
3.	**Matters Arising/ Action Checklist**	Chairman	**K**
4.	**Chief Executive Report**	Chief Executive	**Verbal**
	ANNUAL ACCOUNTS		
5.	**Annual accounts and annual report 2014/15** **NHS Foundation Trust Final Accounts** **and** **Annual Report 2014-15 including:** • **Update on Code of Governance** • **Head of Internal Audit Opinion** • **Annual Governance Statement**	Audit Committee Chair/ Chief Finance Officer/ Company Secretary	**L** **Li** **Lii**
6.	**Quality Report 2014-15**	Co-Medical Director	**N**
7.	**Annual Report of the Audit Committee 2014-15**	Chief Finance Officer	**O**
	STRATEGIC ISSUES		
8.	**Progress against strategic objectives**	Director of Planning and Information	**P**
9.	**Lampard Report**	Chief Nurse	**Q**
	PERFORMANCE		
10.	**Performance Summary Report (Quality and Safety and Targets and Indicators)**	Co-Medical Director and Acting Chief Operating Officer	**R**

11.	**Workforce Update**	Director of Human Resources &OD	**S**
12.	**Finance Update**	Chief Finance Officer	**T to follow**
	ASSURANCE		
13.	**Patient Experience Update including** • **PALS Q4** • **Friends and Family Test**	Chief Nurse	**U**
14.	**Annual Complaints Report 2014-15**	Acting Chief Operating Officer	**V**
15.	**IPSOS Mori Outpatient survey results**	Chief Nurse	**W**
16.	**Safe Nurse Staffing Report**	Chief Nurse	**X**
17.	**Safeguarding Annual Report 2014-15**	Chief Nurse	**Y**
	GOVERNANCE		
18.	**Annual Risk Report 2014-15**	Co-Medical Director	**1**
19.	**Review of Quality Governance Framework**	Director of Information and Planning	**2**
20.	**Register of Seals**	Company Secretary	**3**
	REPORTS FROM COMMITTEES		
21.	**Audit Committee update – April 2015 meeting**	Chair of the Audit Committee	4
22.	**Clinical Governance Committee update – April 2015 meeting**	Chair of the Clinical Governance Committee	**5**
23.	**Finance and Investment Committee Update – April 2015**	Chair of the Finance and Investment Committee	**6**
24.	**Members' Council Update – April 2015**	Chairman of the Members' Council	**7**

Any Other Business
(Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)

Next meeting
The next Trust Board meeting will be held on Wednesday 22nd July 2015 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT J

Great Ormond Street Hospital for Children NHS Foundation Trust

Minutes of the meeting of Trust Board on 25th March 2015

Present

Baroness Tessa Blackstone	Chairman
Dr Peter Steer	Chief Executive
Ms Mary MacLeod	Non-Executive Director
Ms Yvonne Brown	Non-Executive Director
Mr John Ripley	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Mr David Lomas	Non-Executive Director
Mr Charles Tilley*	Non-Executive Director
Dr Catherine Cale	Interim Co-Medical Director
Professor Martin Elliott	Co-Medical Director
Mr Ali Mohammed	Director of Human Resources and OD
Mrs Liz Morgan	Chief Nurse and Families' Champion
Mrs Claire Newton	Chief Finance Officer
Ms Rachel Williams	Chief Operating Officer

In attendance

Mr Robert Burns	Director of Planning and Information
Mr Matthew Tulley	Director of Redevelopment
Ms Cymbeline Moore	Director of Communications
Dr John Hartley*	Director of Infection Prevention and Control
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
1 member of public	

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

205	**Apologies for absence**
205.1	No apologies for absence were received.
206	**Minutes of Meeting held on 28th January 2015**
206.1	The minutes of the meeting of 28th January 2015 were **approved.**
207	**Matters Arising/ Action Checklist**
207.1	The actions taken were **noted**.
208	**Chief Executive Report**
208.1	Dr Peter Steer, Chief Executive gave an update on the following items: • CQC inspection: Dr Steer said that a lot of work was being done in preparation for the CQC inspection in April, including responding to large data requests and conducting mock inspections in clinical areas. Dr Steer said that there had been positive feedback from staff involved. • Information Technology: Work is being led by the Chief Operating Officer and another iteration of the business plan will be considered by the Trust

	Board in June 2015. The importance of this work to the Trust was emphasised. • Centre for Research into Rare Diseases in Children (CRRDC): It was reported that representatives of the Donor had visited GOSH on 24th March. They had met with the Chief Executive and visited the site following planning approval which had been granted by Camden Council on 2nd March 2015. • Always Values launch: The well-attended launch of the Always Values took place on 24th March. Speakers included members of staff and Claudia Fisher, Lead Councillor. Dr Steer said that there had been significant investment from leadership in embedding the Always Values into operations and HR processes. • Staff open forums: Dr Steer told the Board that he had led open forum sessions which were open to all staff and had been well attended. Dr Steer had also attended a positive GMSC meeting at which all attendees had demonstrated good levels of engagement.
208.2	Ms Rachel Williams, Chief Operating Officer said that the digital strategy had been discussed at the Trust Board strategy day in February and it had been agreed that the next steps would test some current assumptions underlying the transformation project. Ms Williams said that the Board discussed whether the digital strategy should be implemented through a phased approach or at one time. It was noted that the proposed staffing structure would be brought to Board for approval prior to recruitment starting.
208.3	Baroness Blackstone, Chairman told the Board that she and Matthew Tulley would be meeting with Stanton Williams, the architects involved in the CRRDC project in the coming days following the approval of planning permission by Camden Council.
208.4	The Board **noted** the update.
209	**Board Assurance Framework Summary**
209.1	Mr Robert Burns, Director of Planning and Information presented the Board Assurance Framework summary and took the Board through the analysis of the risk of: "all patients at all times receive safe medical cover".
209.2	**Action:** The Board discussed whether a likelihood score of four was appropriate for this risk and agreed that the score should be reduced to three.
209.3	Mr Charles Tilley, Non-Executive Director expressed some concern that the acceptance score for the risk 'provide sufficient capacity to meet existing and future demands' was 12. Mr Burns said that this was as a result of the current excess demand across services. He said it was unlikely that a plan could be put in place to create capacity to meet this demand.
209.4	Mr John Ripley, Non-Executive Director emphasised that providing out of hours medical cover and having capacity to treat the patients who required GOSH input was key and said that it was important for the Trust to push itself in these areas.
209.5	Mr Tilley emphasised the importance of good project management to the success of the digital transformation programme.
209.6	The Board **noted** the update.

210	**Nurse Revalidation**
210.1	Mrs Liz Morgan, Chief Nurse said from 1st April 2015, the Nursing and Midwifery Council (NMC) would require nurses to undergo a revalidation process. She added that it was an individual's professional responsibility to ensure that they fulfilled the areas required however the Trust was required to have robust systems in place to monitor completion.
210.2	Ms Yvonne Brown, Non-Executive Director asked for assurance that the Trust had sufficiently robust systems in place. Mrs Morgan said the nurse re-registration dates were already monitored and the Trust was able to ensure that no one was able to work as a registered nurse with a lapsed registration. She said that the monitoring of revalidation would build on that system.
210.3	The Board **noted** the update.
211	**Quality and Safety and Targets and Activity Summary Report**
211.1	Professor Martin Elliott, Co-Medical Director said that GOSH continued to have no instances of MRSA and although there had been an increase in the number of cases of MSSA, it was noted that this did not become a problem unless it became resistant. Professor Elliott told the Board that this continued to be closely monitored.
211.2	Mr John Ripley, Non-Executive Director noted that a number of indicators continued to be persistently rated red and asked for a steer on the priorities and the ways in which the issues were being managed.
211.3	Ms Williams said that a lot of work had been done on the 18 weeks to referral target and there had been particular challenges in surgery related to historic waits and how those cases were managed taking into account the target.
211.4	It was reported that although discharge summary performance did not appear as red for the Trust as a whole, there were areas where performance had improved and was rated green. Ms Williams added that the average length of time taken to produce discharge summaries had significantly improved across the Trust and further measures were being introduced to continue that improvement.
211.5	Ms Williams told the Board that work on the central booking office and outpatients in 2015/16 would allow focus on clinic letter turnaround times. She said that work would aim to develop a consistent process for 'cashing up' clinics, ensuring that the actions which must be completed following each clinic were done.
211.6	Baroness Blackstone queried whether a five day target was achievable and whether or not a review was required in order to asses this.
211.7	Ms Williams said that further work should be done to improve performance before a review would be required however there were explanations in some specialties where a 5 day target for clinic letter turnaround was not appropriate.
211.8	**Action:** It was agreed that both a prevalence rate and an incidence rate for discharge summary and clinic letter turnaround times would be considered as part of the targets and activity report as it was recognised that activity and spells were increasing.

211.9	The Board **noted** the update.
212	**Workforce Summary Report**
212.1	Mr Ali Mohammed, Director of HR and OD presented the report and highlighted that the workforce had continued to grow in recent months. Discussion had taken place at the Senior Management Team meeting about the controls which should be put in place to constrain further growth where appropriate.
212.2	Mr Mohammed said that following comments at previous Trust Board meetings, the staff turnover resulting from the expiry of fixed term contracts had been separated from the turnover rate which could be benchmarked with other London Trusts. Mr Mohammed said that it was important that the Trust continued to focus on this. He added that additional focus was likely to reduce the disparity between turnover, which was relatively high in comparison to very low sick leave and engagement rates.
212.3	Professor Rosalind Smyth, Non-Executive Director acknowledged the complex issues in nursing turnover which stood at 12.3% but asked for assurance that exit interviews were conducted and the information gained from this was analysed to assess the drivers for turnover.
212.4	Mrs Liz Morgan, Chief Nurse said that all leavers were offered an exit interview however not all took this up.
212.5	The Board congratulated the estates team for the significant improvement in PDR completion rates.
212.6	The Board **noted** the update.
213	**Finance Summary Report**
213.1	Mrs Claire Newton, Chief Finance Officer said that following nine months of consistent financial performance, February's performance had been worse than trend. Mrs Newton said that this was due in part to lower Critical Care utilisation than in previous months, which had been significantly higher than previously. Mrs Newton said that February's performance had resulted in adverse variance to budget in revenue of £2.8m.
213.2	Mrs Newton told the Board that work was on-going to reduce agency usage which was at a peak predominantly in highly technical areas such as IT however it was added that GOSH did not experience the same significant issues with nursing agency usage as other Trusts.
213.3	Mr Ripley asked if the Trust would be in a better position in terms of debtors at year end. Mrs Newton said that this was likely and debt levels were being tracked daily. She said that the trend in debt was difficult to understand and following good progress earlier in the year when significant progress had been made, there had been some slippage. Mrs Newton added that a large proportion of the debt was from long term customers with no record of bad debt.
213.4	Mr Ripley suggested that IPP growth although vital had an attached burden because of the associated debt levels.

213.5	The Board **noted** the update.
214	**CQC Update**
214.1 214.2 214.3 214.4	Ms Rachel Williams, Chief Operating Officer presented a paper which provided an update on progress with the preparations for the forthcoming CQC inspection in April 2015 along with initial findings from mock inspections and a listening event. Ms Williams told the Board that following the inspection, GOSH would have the opportunity to comment on the factual accuracy of the report with the release of the final report anticipated to be around July 2015. It was reported that feedback from the mock inspections had provided a number of positive comments about care and leadership however some issues had been noted, primarily due to limitations of space in clinical areas. The Board **noted** the update.
215	**Infection Control Report**
215.1 215.2 215.3	Dr John Hartley, Director of Infection Prevention and Control told the Board that it had been twenty months since a case of MRSA was reported at the Trust and central venous line (CVL) infections had reached the lowest level that the Trust had experienced which was an excellent achievement. Dr Hartley said that the team continued to speak to staff about personal responsibility for IPC and continuing to always use standard IPC precautions. Dr Hartley said that there had been an outbreak of a Carbapenemase producing enterobacteriaceae including cross transmission to three other children however work to prevent further cross contamination had been successful. The Board **noted** the update and welcomed the reduction in CVL infections; they thanked the nursing staff.
216	**Safe Nurse Staffing Report**
216.1 216.2	Mrs Liz Morgan, Chief Nurse told the Board that there had been no reports of unsafely staffed shifts in the previous two months. She added that two issues related to staffing levels had been reported on Datix and both had been investigated with learning. The Board **noted** the update.
217	**Staff Survey Results 2014**
217.1 217.2	Mr Ali Mohammed, Director of HR and OD said that analysis of staff survey responses for 2014 had shown that GOSH was eighth in the ranking of teaching hospitals which was a good improvement on the scores for 2013. Mr David Lomas, Non-Executive Director noted that the Trust was not well ranked in staff reporting good communication between senior management and staff. He asked what the Trust's aspirations were in this area.

217.3	Mr Mohammed said that the Trust was aspiring to be in the top quartile which would require a score of 40% or above. He added that it would be important to ask staff what they would envisage as good communication.
217.4	Ms Yvonne Brown, Non-Executive Director expressed some concern that only 69% of staff who responded to the survey said that they had received health and safety training in the previous 12 months. She noted that the Trust's internal auditors had provided significant assurance with minor areas for improvement on a recent health and safety audit.
217.5	Mr Mohammed said that there were good levels of training within the Trust and it was possible that there were issues with staff perception.
217.6	The Board **noted** the update.
218	**Register of interests and gifts and hospitality**
218.1	Mr Lomas noted that several staff conducted private practice at the Portland Hospital rather than GOSH. He asked why this was and if the Trust had plans in place to capture this work.
218.2	Dr Catherine Cale, Co-Medical Director said that in many cases there was not sufficient capacity at to carry out all additional private practice work of GOSH consultants and it was important to manage consultants' expectations in this area.
218.3	Professor Rosalind Smyth, Non-Executive Director expressed some concern that the Trust was not capturing the declarations of all staff particularly those who held honorary contracts with GOSH.
218.4	Dr Anna Ferrant, Company Secretary said that communication was through the all staff newsletter and emails to individuals who had declared an interest in the previous year. She said that declaring interests was a requirement of staff as set out in the Declaration of Interest and Gifts and Hospitality Policy.
218.5	**Action:** It was agreed that an update would be received with thoughts about how registering a declaration of interest could be included in individuals' appraisals and how best to capture the interests of honorary contract holders.
218.6	The Board **noted** the update.
219	**Members' Council Update – January 2015**
219.1	Dr Anna Ferrant, Company Secretary reported that at the last meeting of the Members' Council in January 2015, the Council had approved the appointment of Mr Akhter Mateen to the post of Non-Executive Director and Claudia Fisher had been appointed Lead Councillor.
219.2	The update was **noted.**
220	**Update from the Audit Committee in January 2015**
220.1	Mr David Lomas, Member of the Audit Committee said that Committee had expressed concern about the Trust's business continuity plan which had not been tested since 2012. The Committee requested a table top exercise took place by

	April 2015.
220.2	Ms Rachel Williams, Chief Operating Officer said that plans were in place to conduct the table top exercise and staff training. She added that a new business continuity lead had been appointed and he was being proactive in this area.
220.3	The Board **noted** the update.
221	**Update from the Clinical Governance Committee in January 2015**
221.1	Mrs Mary MacLeod, Chair of the Clinical Governance Committee said that the committee had noted that two productivity and efficiency programmes which had been reviewed were found not to have adversely affected quality and safety. Mrs MacLeod added that she and the Chair of the Audit Committee had met with KPMG to discuss the internal audit plan for 2015/16.
221.2	The Board **noted** the update.
222	**Update from the Finance & Investment Committee**
222.1	Mr David Lomas, Chair of the Finance and Investment Committee provided an update which was **noted.**
223	**Register of Seals**
223.1	The Board **endorsed** the use of the company seal.
224	**Any Other Business**
224.1	Baroness Blackstone, Chairman told the Board that it would be Mrs Liz Morgan and Mr John Ripley's last Trust Board meeting as they would be retiring at the end of March 2015.
224.2	Baroness Blackstone thanked Mrs Morgan for her work with the Trust and noted that a farewell gathering had already taken place.
224.3	Baroness Blackstone thanked Mr Ripley for his excellent service to the Trust particularly in the areas of strategy and the finance and investment committee.

ATTACHMENT K

TRUST BOARD – PUBLIC ACTION CHECKLIST
May 2015

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
138.2	26/11/14	Baroness Blackstone agreed that play was a very important part of therapy for children and requested a paper to set out the costs of the service, the number of staff, the space involved and therefore opportunity costs. It was agreed that this would be brought to the Board following the completion of work which was being done with Manchester Children's Hospital at the March meeting.	LM	July 2015	A review of play services at GOSH will be brought back to the Board following the appointment of and discussion with the new Chief Nurse. Not yet due
175.6	28/01/15	It was agreed that an update on progress with goals towards the strategic objectives would be considered at the next meeting and that a list of acronyms would be provided with the paper.	RB	May 2015	Deferred from March and on May agenda
209.2	25/03/15	The Board discussed whether a likelihood score of four was appropriate for the risk "all patients at all times receive safe medical cover" and agreed that the score should be reduced to three.	CC	May 2015	Actioned
211.8	25/03/15	It was agreed that both a prevalence rate and an incidence rate for discharge summary and clinic letter turnaround times would be considered as part of the targets and activity report as it was recognised that activity and spells were increasing.	DM	July 2015	Not yet due

Attachment K

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
218.5	25/03/15	It was agreed that an update would be received with thoughts about how registering a declaration of interest could be included in individuals' appraisals and how best to capture the interests of honorary contract holders.	AF&AM	May 2015	Actioned. This is now included in the PDR paperwork

Attachment L

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board **22nd May 2013**	
GOSH Draft Annual Accounts 2014/15 and Annual Report 2014/15 **Submitted by:** Anna Ferrant, Company Secretary	**Paper No:** Attachment L

Aims / summary

The Trust is required to publish a Foundation Trust annual report and accounts for 2014-15. The draft annual report and annual accounts will be considered by the Audit Committee on 22nd May for recommendation to the Trust Board.

Board members will find attached the folklowing documents:

A copy of the annual accounts 2014/15
A copy of the annual report 2014/15 incorporating

- an overview of the trust's compliance with the Code of Governance (p.68) where it is reported that the Trist was compliant with the provisions of the NHS Foundation Trust Code of Governance throughout 2014/15
- the Head of Internal Audit Opinion (p.114)
- the Annual Governance Statement (p.117)

The annual report and accounts will be submitted to Monitor by end of May 2015 and then submitted to the Department of Health at the end of June, for presenting to Parliament.

Action required from the meeting

To consider and approve the annual report and accounts.

Contribution to the delivery of NHS / Trust strategies and plans

Covers all Trust objectives

Financial implications

None

Legal issues

None

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?

N/A

Who needs to be told about any decision

N/A

Who is responsible for implementing the proposals / project and anticipated timescales

Attachment L

No proposals included
Who is accountable for the implementation of the proposal / project No proposals included

Trust name:	Great Ormond Street Hospital for Children NHS Foundation Trust
This year	2014/15
Last year	2013/14
This year ended	31 March 2015
Last year ended	31 March 2014
This year beginning	1 April 2014

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

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

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

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

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

• observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

• make judgements and estimates on a reasonable basis;

• state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements;

• ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and

• prepare the financial statements on a going concern basis.

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

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

Signed

Dr Peter Steer
Chief Executive
Date: xx May 2015

FOREWORD TO THE ACCOUNTS

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street Hospital for Children was authorised as an NHS Foundation Trust on 1 March 2012. These accounts for the year ended 31 March 2015 have been prepared by Great Ormond Street Hospital for Children NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form which Monitor, with the approval of the Treasury, has directed.

Signed

Dr Peter Steer
Chief Executive
Date: xx May 2015

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2015

	NOTE	**Year ended 31 March 2015 £000**	Year ended 31 March 2014 £000
Total revenue from patient care activities	2	**345,198**	332,680
Total other operating income	3	**67,411**	81,230
Operating expenses	4	**(401,449)**	(374,052)
Operating surplus		**11,160**	39,858
Finance costs:			
Finance income	8	**240**	181
Finance expenses - unwinding of discount on provisions	9	**(15)**	(31)
Surplus for the financial year		**11,385**	40,008
Public dividend capital dividends payable		**(6,820)**	(6,214)
Retained surplus for the year		**4,565**	33,794
Other comprehensive income			
- Impairments		**(536)**	(944)
- Revaluations - property, plant and equipment		**6,830**	26,056
Total comprehensive income for the year		**10,859**	58,906

Financial performance for the year - additional reporting measures			
Retained surplus for the year		**4,565**	33,794
Adjustments in respect of capital donations	3	**(15,351)**	(23,758)
Adjustments in respect of impairments/(reversal of impairments)	3 & 4	**13,665**	(5,014)
Adjusted retained surplus		**2,879**	**5,022**

The notes on pages 5 to 33 form part of these accounts.

All income and expenditure is derived from continuing operations.
The Trust has no minority interest.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2015

	NOTE	31 March 2015 £000	31 March 2014 £000
Non-current assets			
Intangible assets	10	**6,366**	**6,068**
Property, plant and equipment	11	**358,923**	**356,851**
Trade and other receivables	14	**7,616**	**8,091**
Total non-current assets		**372,905**	**371,010**
Current assets			
Inventories	13	**7,599**	**7,137**
Trade and other receivables	14	**48,732**	**51,088**
Cash and cash equivalents	15	**58,932**	**57,010**
Total current assets		**115,263**	**115,235**
Total assets		**488,168**	**486,245**
Current liabilities			
Trade and other payables	16	**(42,075)**	**(50,910)**
Provisions	19	**(473)**	**(564)**
Other liabilities	17	**(5,403)**	**(5,385)**
Net current assets		**67,312**	**58,376**
Total assets less current liabilities		**440,217**	**429,386**
Non-current liabilities			
Provisions	19	**(1,002)**	**(1,091)**
Other liabilities	17	**(5,764)**	**(6,171)**
Total assets employed		**433,451**	**422,124**
Financed by taxpayers' equity:			
Public dividend capital		**125,357**	**124,889**
Income and expenditure reserve		**226,809**	**221,633**
Other reserves		**3,114**	**3,114**
Revaluation reserve		**78,171**	**72,488**
Total taxpayers' equity		**433,451**	**422,124**

The financial statements on pages 1 to 33 were approved by the Board and authorised for issue on xx May 2015 and signed on its behalf by:

Dr Peter Steer
Chief Executive

Signed:……………………………………………..
Date: xx May 2015

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2015

	Public Dividend Capital (PDC)	Revaluation reserve	Income and expenditure reserve	Other reserves	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2014	124,889	72,488	221,633	3,114	**422,124**
Changes in taxpayers' equity for the year ended 31 March 2015					
-Surplus for the year	0	0	4,565	0	**4,565**
-Transfers between reserves	0	(611)	611	0	**0**
- Impairments	0	(536)	0	0	**(536)**
- Revaluations - property, plant and equipment	0	6,830	0	0	**6,830**
- Public Dividend Capital received	468	0	0	0	**468**
Balance at 31 March 2015	**125,357**	**78,171**	**226,809**	**3,114**	**433,451**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2014

	Public Dividend Capital (PDC)	Revaluation reserve	Income and expenditure reserve	Other reserves	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2013	124,732	48,380	186,835	3,114	**363,061**
Changes in taxpayers' equity for the year ended 31 March 2014					
-Surplus for the year	0	0	33,794	0	**33,794**
-Transfers between reserves	0	(1,004)	1,004	0	**0**
-Impairments	0	(944)	0	0	**(944)**
-Revaluations - property, plant and equipment	0	26,056	0	0	**26,056**
- Public Dividend Capital received	157	0	0	0	**157**
Balance at 31 March 2014	**124,889**	**72,488**	**221,633**	**3,114**	**422,124**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2015

	NOTE	**Year ended 31 March 2015 £000**	Year ended 31 March 2014 £000
Cash flows from operating activities			
Operating surplus		**11,160**	39,858
Non-cash income and expense:			
Depreciation and amortisation		**17,800**	25,840
Impairments		**17,780**	2,292
Reversal of impairments		**(4,115)**	(7,306)
Profit on disposal of tangible fixed assets		**(83)**	0
Decrease/(increase) in trade and other receivables		**2,831**	(18,682)
Increase in inventories		**(462)**	(574)
(Decrease)/increase in trade and other payables		**(1,985)**	10,315
(Decrease)/increase in other liabilities		**(389)**	71
Decrease in provisions		**(195)**	(2,799)
NET CASH GENERATED FROM OPERATIONS		**42,342**	49,015
Cash flows from investing activities			
Interest received		**240**	184
Purchase of property, plant and equipment		**(32,185)**	(24,196)
Payments for intangible assets		**(2,341)**	(639)
Sales of property, plant and equipment		**142**	0
Net cash outflow from investing activities		**(34,144)**	(24,651)
NET CASH OUTFLOW BEFORE FINANCING		**8,198**	24,364
Cash flows from financing			
Public Dividend Capital received		**468**	157
PDC dividend paid		**(6,744)**	(5,915)
Net cash outflow from financing		**(6,276)**	(5,758)
NET INCREASE IN CASH AND CASH EQUIVALENTS		**1,922**	18,606
Cash and cash equivalents at start of the year		**57,010**	38,404
Cash and cash equivalents at end of the year	15	**58,932**	57,010

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 2014/15 *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 (these are outlined in the Strategic Report section of the Annual Report on page xx). 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 Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

a As described in note 1.10, the Trust's plant and equipment is valued at depreciated replacement cost; the valuation being assessed by the Trust taking into account the movement of indices that the Trust has deemed to be appropriate. The Trust is required to review property, plant and equipment for impairment. In between formal valuations by qualified surveyors, management make judgments about the condition of assets and review their estimated lives.

b Management use their judgment to decide when to write off revenue or to provide against the probability of not being able to collect debt especially in light of the changing healthcare commissioning environment. Judgment is also used to decide whether to write off or provide against International Private Patient and overseas debt.

1.6 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period not already included in note 1.5 above, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- the cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements as a provision. As the calculation involves a large number of staff, sampling techniques are used to collate the results for the entire Trust.
- the useful economic life of each category of fixed asset is assessed when acquired by the Trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets.
- For early retirements that took place before the NHS pension scheme was modified in 1995, a provision is made in the accounts incorporating inflation and the discount rate. Inflation is estimated at 2.5% and where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 1.8% in real terms.
- When arriving at the valuation for property, Trust management engages a qualified surveyor to assist them in forming estimates.
- The Trust leases a number of buildings that are owned by Great Ormond Street Hospital Children's Charity. The Trust has assessed how the risks and rewards of ownership are distributed between itself and the charity in categorising these leases as either operating or finance leases.
- The Trust has incurred expenditure relating to payments to a third party power supplier in order to increase the amount of power supplied to the Trust's main site. This expenditure is included in prepayments and is being amortised over the estimated period of use.
- a provision is recognised when The Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle The obligation. In addition to widely used estimation techniques, judgment is required when determining The probable outflow of economic benefits.

1.7 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Foundation Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. Income relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Other income received from commissioners may be in the form of an investment in quality. Any quality investment income surplus may be used in subsequent years to supplement any major projects / capital schemes.

1.8 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. The utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on the valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

1.9 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust;
• it is expected to be used for more than one financial year; and
• the cost of the item can be measured reliably.
Property, Plant and Equipment is also only capitalised where:
• it individually has a cost of at least £5,000; or
• it forms a group of assets that individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
• form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Measurement

Valuation

Under IAS 16, assets should be revalued when their fair value is materially different from their carrying value. Monitor requires revaluation at least once every 5 years.

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of the revaluation less any subsequent accumulated depreciation and impairment losses.

All land and buildings are revalued using professional valuations in accordance with IAS 16. Fair values are determined as follows:
• Land and non-specialised buildings – market value for existing use
• Surplus land – market value for existing use
• Specialised buildings – depreciated replacement cost

1.10 Property, Plant and Equipment (cont)

The Trust revalued its equipment as at 31 March 2015 using relevant indices published by the Office of National Statistics as a proxy for fair value.

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

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value and asset life. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed during the year, with the effect of any changes recognised on a prospective basis.

Freehold land is considered to have an infinite life and is not depreciated.
Property, plant and equipment that has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.10 Property, Plant and Equipment (cont)

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:
-management are committed to a plan to sell the asset;
-an active programme has begun to find a buyer and complete the sale;
-the asset is being actively marketed at a reasonable price;
-the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale';
-the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Following the accounting policy change outlined in the Treasury FREM for 2011/12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Government grants

Following the accounting policy change outlined in the Treasury FREM for 2011/12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights.

They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust and for at least a year and where the cost of the asset can be measured reliably and is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised and expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;

• the Trust intends to complete the asset and sell or use it;
• the Trust has the ability to sell or use the asset;
• how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;

• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and

• the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software that is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

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

The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.13 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

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

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables, whereas financial liabilities are classified as other financial liabilities.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

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

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

1.14 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.
The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

The following is the methodology used for the re-classification of operating leases as finance leases:

Finance leases in which the Trust acts as lessee
- the finance charge is allocated across the lease term on a straight line basis.
- the capital cost is capitalised using a straight line basis of depreciation.
- the lease rental expenditure that would otherwise have been charged to expenditure under an operating lease is removed from expenditure on a straight line basis.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.15 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 1.3% in real terms.

Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in note 19.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.16 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 21 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be
confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.17 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the unaudited version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.18 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Corporation Tax

Great Ormond Street Hospital for Children NHS Foundation Trust has determined that it has no corporation tax liability as the Trust has no private income from non-operational areas.

1.20 Foreign exchange

The functional and presentational currencies of the Trust are sterling.
A transaction that is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.
Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.21 Cash, bank and overdrafts

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

1.22 Heritage Assets

Heritage assets (under FRS30 and as required by the FT ARM) are tangible assets with historical, artistic, scientific, technological, geographical or environmental qualities, held principally for their contribution to knowledge or culture. The Trust holds no such assets as all assets are held for operational purposes - this includes a number of artworks on display in the hospital.

1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 Charitable Funds

From 2013/14, the divergence from the FReM that NHS Charitable Funds are not consolidated with bodies' own returns was removed. Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' returns. The funds of Great Ormond Street Hospital for Children's Charity are not under the control of the Foundation Trust and have not, therefore, been consolidated in these accounts.

1.25 Recently issued IFRS Accounting Standards

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) but have not yet been adopted in the Annual Reporting Manual. Monitor does not permit the early adoption of accounting standards, amendments and interpretations that are in issue at the reporting date but effective at a subsequent reporting period.

IFRS 9 Financial Instruments
IFRS 13 Fair Value Measurement
IFRS 15 Revenue from Contracts with Customers
IAS 1 (amendment) Disclosure Initiative
IAS 19 (amendment) Defined Benefit Plans: Employee Contributions
IAS 16 (amendment) and IAS 38 (amendment) Clarification of Acceptable Methods of Depreciation and Amortisation
IAS 36 (amendment) Recoverable Amount Disclosures for Non-Financial Assets
IFRIC 21 Levies
Annual Improvements to IFRSs: 2010-12 Cycle
Annual Improvements to IFRSs: 2011-13 Cycle
Annual Improvements to IFRSs: 2012-14 Cycle

The directors do not expect that the adoption of these standards and interpretations will have a material impact on the financial statements in future periods. All other revised and new standards have not been listed here as they are not considered to have an impact on the Foundation Trust.

2. Revenue from patient care activities

2.1 Analysis of revenue from patient care activities	**Year ended 31 March 2015 £000**	Year ended 31 March 2014 £000
Elective income	**81,806**	81,570
Non elective income	**15,248**	15,983
Outpatient income	**38,724**	37,957
Other NHS clinical income	**163,305**	151,677
Revenue from protected patient care activities	**299,083**	287,187
Private patient income	**40,925**	41,754
Other non-protected clinical income	**5,190**	3,739
	46,115	45,493
Total revenue from patient care activities	**345,198**	332,680

The Trust's Provider Licence sets out the Commissioner Requested Services that the Trust is required to provide. All of the income from activities before private patient income and other non-protected clinical income shown above is derived from the provision of Commissioner Requested Services.

2.2 Analysis of revenue from patient care activities by source	**Year ended 31 March 2015 £000**	Year ended 31 March 2014 £000
NHS Foundation Trusts	**474**	394
NHS Trusts	**541**	505
CCGs and NHS England	**292,068**	286,288
Department of Health	**6,000**	0
Non-NHS:		
Private patients	**40,925**	41,754
Overseas patients (non-reciprocal)	**390**	100
Injury costs recovery (was RTA)	**92**	50
Other	**4,708**	3,589
Total revenue from patient care activities	**345,198**	332,680

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

2.3 Overseas visitors	**Year ended 31 March 2015 £000**	Year ended 31 March 2014 £000
Income recognised in-year	390	100
Cash payments received in-year	401	129
Amounts added to provision for impairment of receivables	136	143
Amounts written off in-year	0	0

Due to the additional disclosure, prior year figures have been reclassified.

3. Other operating revenue	**Year ended 31 March 2015**	Year ended 31 March 2014
	£000	£000
Research and development	**16,113**	21,205
Charitable contributions to expenditure	**10,206**	6,007
Charitable contributions in respect of capital expenditure	**15,351**	23,758
Education and training	**8,325**	9,966
Profit on disposal of other tangible fixed assets	**83**	0
Reversal of impairments	**4,115**	7,306
Non-patient care services to other bodies	**758**	867
Clinical tests	**4,063**	3,517
Clinical excellence awards	**3,365**	3,186
Catering	**1,072**	920
Creche services	**503**	539
Staff accommodation rentals	**56**	127
Other revenue	**3,401**	3,832
	67,411	81,230

4. Operating expenses	**Year ended 31 March 2015 £000**	Year ended 31 March 2014 £000
Services from other NHS bodies	**6,633**	6,025
Purchase of healthcare from non-NHS bodies	**4,059**	3,815
Executive directors' costs*	**1,462**	1,419
Non-executive directors' costs*	**151**	133
Staff costs	**199,380**	192,268
Supplies and services - clinical - drugs	**40,610**	36,774
Supplies and services - clinical - other	**50,561**	50,733
Supplies and services - general	**2,975**	2,505
Establishment	**2,934**	2,691
Research and development	**14,823**	13,792
Transport - business travel	**609**	588
Transport - other	**2,730**	2,327
Premises - business rates payable to local authorities	**2,210**	1,574
Premises - other	**24,215**	22,039
Operating lease rentals	**1,611**	1,809
Provision for impairment of receivables	**1,936**	184
Change in provisions discount rate	**19**	17
Inventories write down	**240**	210
Depreciation	**16,452**	24,278
Amortisation of intangible assets	**1,348**	1,562
Impairments and reversals of property, plant and equipment	**17,780**	2,292
Fees payable to the Trust's auditor for the financial statement audit	**100**	116
Other audit regulatory services - quality account	**16**	18
Clinical negligence insurance	**3,103**	2,482
Redundancy costs	**358**	13
Consultancy costs	**920**	1,193
Legal fees	**444**	321
Losses and special payments	**1**	2
Other	**3,769**	2,872
	401,449	374,052

* Details of directors' remuneration can be found in the Remuneration Report on page 33.

Research and development expenditure includes £11,415k of staff costs (£12,204k in 2013/14).

5. Operating leases

5.1 As lessee

Payments recognised as an expense	Year ended 31 March 2015 £000	Year ended 31 March 2014 £000
Minimum lease payments	**1,611**	1,809
	1,611	1,809

Total future minimum lease payments	As at 31 March 2015 £000	As at 31 March 2014 £000
Payable:		
Not later than one year	**1,530**	1,391
Between one and five years	**5,954**	5,113
After 5 years	**5,888**	6,521
Total	**13,372**	13,025

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 2015.

7. Employee costs and numbers

7.1 Employee costs	**Year to 31 March 2015 Total**	**Permanently Employed**	**Other**	Year to 31 March 2014 Total
	£000	**£000**	**£000**	£000
Salaries and wages	174,387	173,191	1,196	171,307
Social security costs	14,741	14,741	0	13,236
Employer contributions to NHS Pension scheme	19,293	19,293	0	18,705
Agency / contract staff	6,684	0	6,684	5,178
Termination benefits	358	358	0	13
Employee benefits expense	**215,463**	**207,583**	**7,880**	208,439
Employee costs capitalised	(1,478)	(1,478)	0	(1,124)
Recoveries from other bodies in respect of staff costs netted off expenditure	(1,370)	0	(1,370)	(1,411)
Net employee benefits excluding capitalised costs and recoveries from other bodies	**212,615**	**206,105**	**6,510**	205,904

7.2 Average number of people employed*	**Year to 31 March 2015 Total**	**Permanently Employed**	**Other**	Year to 31 March 2014 Total
	Number	**Number**	**Number**	Number
Medical and dental	582	535	47	549
Administration and estates	1,005	891	114	956
Healthcare assistants and other support staff	298	282	16	272
Nursing, midwifery and health visiting staff	1,338	1,232	106	1,301
Scientific, therapeutic and technical staff	754	732	22	726
Other staff	7	7	0	7
Total	**3,984**	**3,679**	**305**	3,811

*Whole Time Equivalent

7.3 Retirements due to ill-health

During the year there were two early retirements from the Trust on the grounds of ill-health resulting in additional pension liabilities of £130k (There were two early retirements in 2013/14, £54k).

7.4 Staff exit packages

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

	Year to 31 March 2015					
Exit packages number and cost	**Number of Compulsory redundancies**	**Cost of compulsory redundancies**	**Number of other departures agreed**	**Cost of other departures agreed**	**Total number of exit packages**	**Total cost of exit packages**
	Number	**£000**	**Number**	**£000**	**Number**	**£000**
<£10,000	**9**	**45**	**5**	**21**	**14**	**66**
£10,00 - £25,000	**7**	**132**	**0**	**0**	**7**	**132**
£25,001 - £50,000	**4**	**181**	**0**	**0**	**4**	**181**
Total	**20**	**358**	**5**	**21**	**25**	**379**

	Year to 31 March 2014			
Exit packages number and cost	**Compulsory redundancies**	**Cost of compulsory redundancies**	**Total number of exit packages**	**Total cost of exit packages**
	Number	**£000**	**Number**	**£000**
<£10,000	**2**	**9**	**2**	**9**
£10,00 - £25,000	**3**	**50**	**3**	**50**
£25,001 - £50,000	**4**	**135**	**4**	**135**
£50,001 – £100,000	**5**	**370**	**5**	**370**
Total	**14**	**564**	**14**	**564**

Any exit packages in relation to senior managers (should they arise) are not included in this note as these would be disclosed in the remuneration report.

The cost of ill-health retirements falls on the relevant pension scheme, not the Trust, and is included in note 7.3.

8 Finance Income	**Year ended 31 March 2015**	Year ended 31 March 2014
	£000	£000
Bank interest	240	181
Total finance income	**240**	**181**

9 Finance Expenses	**Year ended 31 March 2015**	Year ended 31 March 2014
	£000	£000
Provisions - unwinding of discount	15	31
Total finance expenses	**15**	**31**

10. Intangible assets

10.1 Intangible assets

	Software licences	Licences and trademarks	Development expenditure (internally generated)	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Gross cost at 1 April 2014	2,807	496	3,591	3,192	**10,086**
Additions - purchased	277	39	192	934	**1,442**
Additions - donated	79	0	0	0	**79**
Reclassifications	152	2	715	(685)	**184**
Disposals	(232)	(40)	0	0	**(272)**
Valuation/Gross cost at 31 March 2015	**3,083**	**497**	**4,498**	**3,441**	**11,519**
Amortisation at 1 April 2014	1,742	222	2,054	0	**4,018**
Provided during the year	376	77	895	0	**1,348**
Disposals	(173)	(40)	0	0	**(213)**
Amortisation at 31 March 2015	**1,945**	**259**	**2,949**	**0**	**5,153**
Net book value					
NBV - Purchased at 31 March 2015	883	238	1,549	3,398	**6,068**
NBV - Donated at 31 March 2015	255	0	0	43	**298**
NBV total at 31 March 2015	**1,138**	**238**	**1,549**	**3,441**	**6,366**

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

	Software licences	Licences and trademarks	Development expenditure (internally generated)	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Gross cost at 1 April 2013	2,383	202	3,288	2,754	**8,627**
Additions - purchased	176	201	113	800	**1,290**
Additions - donated	35	0	0	134	**169**
Reclassifications	213	93	190	(496)	**0**
Valuation/Gross cost at 31 March 2014	**2,807**	**496**	**3,591**	**3,192**	**10,086**
Amortisation at 1 April 2013	1,293	127	1,036	0	**2,456**
Provided during the year	449	95	1,018	0	**1,562**
Amortisation at 31 March 2014	**1,742**	**222**	**2,054**	**0**	**4,018**
Net book value					
NBV - Purchased at 31 March 2014	994	274	1,537	3,058	**5,863**
NBV - Donated at 31 March 2014	71	0	0	134	**205**
NBV total at 31 March 2014	**1,065**	**274**	**1,537**	**3,192**	**6,068**

11. Property, plant and equipment

11.1 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2014	76,469	214,291	7,661	28,585	63,910	19,100	10,700	**420,716**
Additions - purchased	0	3,084	0	4,838	1,981	473	551	**10,927**
Additions - donated	0	1,586	0	6,248	6,146	46	1,126	**15,152**
Impairments charged to the revaluation reserve	0	(536)	0	0	0	0	0	**(536)**
Reclassifications	0	18,280	0	(24,399)	2,632	2,834	469	**(184)**
Revaluations	1,588	(23,785)	242	0	0	0	0	**(21,955)**
Disposals	0	0	0	0	(2,565)	0	(113)	**(2,678)**
Cost or valuation at 31 March 2015	**78,057**	**212,920**	**7,903**	**15,272**	**72,104**	**22,453**	**12,733**	**421,442**
Accumulated depreciation at 1 April 2014	0	8,403	(72)	0	36,522	14,120	4,892	**63,865**
Provided during the period	0	7,638	167	0	5,079	2,569	999	**16,452**
Impairments charged to operating expenses	0	17,780	0	0	0	0	0	**17,780**
Reversal of impairments credited to operating income	0	(3,830)	(285)	0	0	0	0	**(4,115)**
Revaluations	0	(28,975)	190	0	0	0	0	**(28,785)**
Disposals	0	0	0	0	(2,565)	0	(113)	**(2,678)**
Accumulated depreciation at 31 March 2015	**0**	**1,016**	**0**	**0**	**39,036**	**16,689**	**5,778**	**62,519**
Net book value at 31 March 2015								
NBV - Owned at 31 March 2015	75,010	90,327	1,130	5,073	11,200	4,503	1,891	**189,134**
NBV - Finance leased at 31 March 2015	0	2,749	0	0	0	0	0	**2,749**
NBV - Government granted at 31 March 2015	0	113	0	0	96	0	0	**209**
NBV - Donated at 31 March 2015	3,047	118,715	6,773	10,199	21,772	1,261	5,064	**166,831**
NBV total at 31 March 2015	**78,057**	**211,904**	**7,903**	**15,272**	**33,068**	**5,764**	**6,955**	**358,923**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	57,620	215,798	8,128	12,662	59,810	17,220	9,772	**381,010**
Additions - purchased	0	70	0	4,580	179	797	82	**5,708**
Additions - donated	0	3,030	0	17,743	2,347	60	357	**23,537**
Impairments charged to the revaluation reserve	(303)	(515)	(526)	0	0	0	0	**(1,344)**
Reversals of impairments credited to the revaluation reserve	0	400	0	0	0	0	0	**400**
Reclassifications	0	3,226	0	(6,400)	1,662	1,023	489	**0**
Revaluations	19,152	(7,718)	59	0	397	0	0	**11,890**
Disposals	0	0	0	0	(485)	0	0	**(485)**
Cost or valuation at 31 March 2014	**76,469**	**214,291**	**7,661**	**28,585**	**63,910**	**19,100**	**10,700**	**420,716**
Accumulated depreciation at 1 April 2013	0	12,588	309	0	31,522	10,869	3,964	**59,252**
Provided during the period	0	14,640	166	0	5,293	3,251	928	**24,278**
Impairments charged to operating expenses	0	2,292	0	0	0	0	0	**2,292**
Reversal of impairments credited to operating income	0	(6,700)	(606)	0	0	0	0	**(7,306)**
Revaluations	0	(14,417)	59	0	192	0	0	**(14,166)**
Disposals	0	0	0	0	(485)	0	0	**(485)**
Accumulated depreciation at 31 March 2014	**0**	**8,403**	**(72)**	**0**	**36,522**	**14,120**	**4,892**	**63,865**
Net book value at 31 March 2014								
NBV - Owned at 31 March 2014	73,177	86,170	1,130	6,314	9,257	3,472	1,529	**181,049**
NBV - Finance lease at 31 March 2014	0	2,725	0	0	0	0	0	**2,725**
NBV - Government granted at 31 March 2014	0	117	0	0	111	0	0	**228**
NBV - Donated at 31 March 2014	3,292	116,876	6,603	22,271	18,020	1,508	4,279	**172,849**
NBV total at 31 March 2014	**76,469**	**205,888**	**7,733**	**28,585**	**27,388**	**4,980**	**5,808**	**356,851**

11.2 Economic life of property plant and equipment

	Min Life Years	Max Life Years
Buildings excluding dwellings	0	42
Dwellings	45	45
Plant and machinery	0	15
Information technology	0	10
Furniture and fittings	0	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 Trust has demolished a part of the Cardiac Wing as part of its Redevelopment programme. The part of the wing that was demolished was fully depreciated at the point of demolition.

Great Ormond Street Hospital Children's Charity donated £15,351k towards property, plant and equipment expenditure during the year.

The Trust has completed a number of agreements with Great Ormond Street Hospital Children's Charity in connection with amounts donated to fund capital expenditure on building work in relation to buildings used by the Trust for its core activities. The agreements provide that, in the event that there is a material change in use of these buildings, the amounts donated would be repayable based on a formula which takes account of the total value of donations received and the period for which the new building work has been in use by the Trust. There are no past events or events foreseen by the directors which would require the recognition of an obligation to the Charity as a result of these agreements.

For assets held at revalued amounts:
* the effective date of revaluation was 31 March 2015
* 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 2015	31 March 2014
	£000	£000
Property, plant and equipment	**46,676**	5,449
Intangible assets	**1,910**	147
Total	**48,586**	**5,596**

12.2 Other financial commitments

The Trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements). The payments to which the Trust is committed are as follows:

	31 March 2015	31 March 2014
	£000	£000
Not later than one year	**10,311**	11,177
Later than one year and not later than five year	**4,038**	960
Total	**14,349**	12,137

13. Inventories

13.1 Inventories	**31 March 2015**	31 March 2014
	£000	£000
Drugs	**1,436**	1,246
Consumables	**6,135**	5,826
Energy	**28**	65
Total	**7,599**	7,137

14. Trade and other receivables

14.1 Trade and other receivables	**Current**		**Non-current**	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
NHS receivables - revenue	**23,569**	16,233	**0**	0
Other receivables- revenue	**19,085**	19,600	**0**	0
Provision for impaired receivables	**(4,574)**	(2,718)	**0**	0
Receivables due from NHS charities – Capital	**3,716**	11,597	**0**	0
Prepayments	**1,410**	1,988	**7,616**	8,091
Accrued income	**4,906**	4,021	**0**	0
Interest receivable	**2**	2	**0**	0
VAT receivable	**618**	365	**0**	0
Total	**48,732**	51,088	**7,616**	8,091

14.2 Provision for impairment of receivables	**31 March 2015**	31 March 2014
	£000	£000
Opening balance	**2,718**	2,692
Increase in provision	**1,936**	184
Amounts utilised	**(80)**	(158)
Closing balance	**4,574**	2,718

14.3 Analysis of impaired receivables	**31 March 2015**	31 March 2014
	£000	£000
Ageing of impaired receivables		
0 - 30 days	**370**	876
30-60 days	**92**	46
60-90 days	**320**	360
90- 180 days	**952**	225
over 180 days	**2,840**	1,241
	4,574	2,748
Ageing of non-impaired receivables past their due date		
0 - 30 days	**3,707**	6,799
30-60 days	**2,469**	2,883
60-90 days	**3,163**	1,678
90- 180 days	**2,955**	1,573
over 180 days	**911**	1,923
	13,205	14,856

15. Cash and cash equivalents	**31 March 2015**	31 March 2014
	£000	£000
Balance at beginning of the year	**57,010**	38,404
Net change in year	**1,922**	18,606
Balance at the end of the year	**58,932**	57,010
Made up of		
Commercial banks and cash in hand	**11**	9
Cash with the Government Banking Service	**921**	1,001
Deposits with the National Loan Fund	**58,000**	56,000
Cash and cash equivalents as in statement of financial position	**58,932**	57,010
Cash and cash equivalents	**58,932**	57,010

16. Trade and other payables

16.1 Trade and other payables

	Current	
	31 March 2015	31 March 2014
	£000	£000
NHS payables - revenue	**5,319**	7,299
Other trade payables - capital	**4,984**	11,910
Other trade payables - revenue	**4,705**	5,646
Social Security costs	**2,086**	2,013
Other taxes payable	**2,187**	2,208
Other payables	**8,615**	8,576
Accruals	**14,040**	13,195
PDC dividend payable	**139**	63
Total	**42,075**	50,910

'Other payables' includes £2,856k outstanding pensions contributions at 31 March 2015 (£2,725k at 31 March 2014)

17. Other Liabilities

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Deferred income	**4,996**	4,978	**0**	0
Lease incentives	**407**	407	**5,764**	6,171
Total	**5,403**	5,385	**5,764**	6,171

18. Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the National Health Service Act 2006 were repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statement disclosures that were provided previously are no longer required.

19. Provisions

	Current		**Non-current**	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Pensions relating to other staff	**115**	118	**1,002**	1,091
Other legal claims	**36**	61	**0**	0
Redundancy	**0**	13	**0**	0
Other	**322**	372	**0**	0
Total	**473**	564	**1,002**	1,091

	Pensions relating to other staff	**Legal claims**	**Redundancy**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2014	1,209	61	13	372	**1,655**
Change in the discount rate	19	0	0	0	**19**
Arising during the year	0	0	0	513	**513**
Utilised during the year	(115)	(25)	(13)	(563)	**(716)**
Reversed unused	(11)	0	0	0	**(11)**
Unwinding of discount	15	0	0	0	**15**
At 31 March 2015	1,117	36	0	322	**1,475**
Expected timing of cash flows:					
- not later than one year	115	36	0	322	**473**
- later than one year and not later than five years	460	0	0	0	**460**
- later than five years	542	0	0	0	**542**
	1,117	36	0	322	**1,475**

Provisions for capitalised pension benefits are based on tables provided by the NHS Pensions Agency reflecting years to normal retirement age and the additional pension costs associated with early retirement.

"Other Legal Claims" consists of amounts due as a result of third party and employer liability claims. The values are based on information provided by the Trust's insurer, in this case , the NHS Litigation Authority. The amount shown here is the gross expected value of the Trust's liability to pay minimum excesses for outstanding cases under the Scheme rules. Provision has also been made for cases which are ongoing with the Trust's solicitors.

The NHS Litigation Authority records provisions in respect of clinical negligence liabilities of the Trust. The amount recorded as at 31 March 2015 was £55,767k (£53,707k at 31 March 2014).

20. Revaluation reserve

	31 March 2015	31 March 2014
	£000	£000
Opening balance at 1 April	**72,488**	48,380
Impairments	**(536)**	(944)
Revaluations	**6,830**	26,056
Transfers to other reserves	**(611)**	(1,004)
Closing balance at 31 March	**78,171**	72,488

21. Contingencies

	31 March 2015	31 March 2014
Contingent liabilities	**£000**	£000
NHS Litigation Authority leagal claims	**(20)**	(25)
Gross value of contingent liabilities	**(20)**	(25)
Net value of contingent liabilities	**(20)**	(25)

A contingent liability exists for potential third party claims in respect of employer's / occupier's liabilities and property expenses £20k at 31 March 2015 (£25k at 31 March 2014). The value of provisions for the expected value of probable cases is shown in Note 19.

22. Financial instruments

The carrying value and the fair value are equivalent for the financial assets and financial liabilities shown below in notes 22.1 and 22.2. All financial assets and liabilities included below are receivable/payable within 12 months.

22.1 Financial assets by category

	31 March 2015	31 March 2014
	Loans and receivables	Loans and receivables
	£000	£000
Trade and other receivables excluding non financial assets	**42,414**	45,077
Cash and cash equivalents (at bank and in hand)	**58,932**	57,010
	101,346	102,087

22.2 Financial liabilities by category

	31 March 2015	31 March 2014
	Other financial liabilities	Other financial liabilities
	£000	£000
Trade and other payables excluding non financial assets	**27,896**	37,652
	27,896	37,652

22.3 Financial Instruments
22.3.1 Financial Risk Management

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

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

Currency risk

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

Interest rate risk

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

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, it has low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's net operating costs are incurred under agency purchase contracts with NHS England and local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust receives the majority of such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to a National / Local Tariff unit cost. The Trust receives cash each month based on an annually agreed level of contract activity and there are periodic corrections made to adjust for the actual income due under the contract.

A high proportion of private patient income is received from overseas government bodies. The Trust has a good record of collection of this income although there can be delays.

The Trust presently finances its capital expenditure mainly from donations and internally generated funds and is not, therefore, exposed to significant liquidity risks in this area.

These funding arrangements ensure that the Trust is not exposed to any material credit risk.

23. Related Party Transactions

Great Ormond Street Hospital for Children NHS Foundation Trust is a body corporate established under the National Health Service Act 2006.
Dr Cale's husband is a corporate account manager for Thermo Fisher Scientific with whom the Trust recorded expenditure of £42k in the financial year. No other Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Great Ormond Street Hospital for Children NHS Foundation Trust.
Remuneration of senior managers is disclosed in the audited part of the director's remuneration report on page 33.

The Trust holds a 20% interest in UCLPartners Limited (UCLP), a company limited by guarantee, acquired by a guarantee of £1. The company's costs are funded by its partners who contribute to its running costs on an annual basis. The contributions paid by the Trust are included within operating expenditure. The most recent available signed financial statements for UCLP have been prepared for the year ended 31 March 2014; the reported assets, liabilities, revenues and profit/loss are not material to the Trust.

During the year Great Ormond Street Hospital for Children NHS Foundation Trust has had a significant number of material transactions with NHS and other government bodies as well as Great Ormond Street Hospital Children's Charity.

Where the value of transactions is considered material, these entities are listed below. All of these bodies are under the common control of central government.

2014/15

Organisation Category	Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
Clinical Commissioning Groups	NHS Barking And Dagenham CCG	498			
	NHS Barnet CCG	1,018			
	NHS Basildon And Brentwood CCG	485			
	NHS Bedfordshire CCG	644			
	NHS Bexley CCG	202			
	NHS Brent CCG	661			116
	NHS Brighton & Hove CCG	144			
	NHS Bromley CCG	219			
	NHS Cambridgeshire And Peterborough CCG	300			
	NHS Camden CCG	3,014		1,807	
	NHS Canterbury & Coastal CCG	140			
	NHS Castle Point & Rochford CCG	321			
	NHS Central Lonson (Westminster) CCG	210			
	NHS City And Hackney CCG	589			
	NHS Coastal West Sussex CCG	149			
	NHS Croydon CCG	212			
	NHS Dartford, Gravesham And Swanley CCG	220			
	NHS Ealing CCG	509			
	NHS East And North Hertfordshire CCG	924			
	NHS East Surrey CCG	161			
	NHS Enfield CCG	755			
	NHS Great Yarmouth & Waveney CCG	110			
	NHS Greenwich CCG	132			
	NHS Guildford & Waverley CCG	190			
	NHA Hammersmith & Fulham CCG	170			
	NHS Haringey CCG	864		130	
	NHS Harrow CCG	475			
	NHS Hastings & Rother CCG	105			
	NHS Havering CCG	455			
	NHS Herts Valleys CCG	1,143			205
	NHS Hillingdon CCG	510			
	NHS Horsham CCG	147			
	NHS Hounslow CCG	321			
	NHS Ipswich & East Suffolk CCG	146			
	NHS Islington CCG	547			
	NHS Kingston CCG	164			
	NHS Lambeth CCG	114			
	NHS Lewisham CCG	262			
	NHS Luton CCG	469			
	NHS Medway CCG	280			
	NHS Mid Essex CCG	532			
	NHS Milton Keynes CCG	203			
	NHS Nene CCG	198			
	NHS Newham CCG	570			104
	NHS North East Essex CCG	509			
	NHS North West Surrey CCG	220			
	NHS Redbridge CCG	540			122
	NHS Richmond CCG	281			
	NHS Slough CCG	1,657		168	
	NHS Southend CCG	336			114
	NHS Surrey Downs	270			
	NHS Thurrock CCG	275			
	NHS Tower Hamlets CCG	325			
	NHS Waltham Forest CCG	489			
	NHS Wandsworth CCG	377			
	NHS West Essex CCG	492		103	
	NHS West Kent CCG	292			
	NHS West London (K&C & Qpp)	235			
NHS Foundation Trusts	Alder Hey Childrens NHS Foundation Trust	107			
	Frimley Health				114
	Guys And St Thomas NHS Foundation Trust		1,802		559
	Luton & Dunstable NHS Foundatio Trust	110			103
	Moorfields Eye Hospital NHS Foundation Trust	165			
	Royal Brompton & Harefield NHS Foundation Trust	119	147		
	Royal Free London NHS Foundation Trust	285	160	146	
	Royal Marsden NHS Foundation Trust	145			
	Sheffield Children's NHS Foundation Trust		127		105
	St Georges University Hospital NHS Foundation Trust	116	111		
	University College London NHS Foundation Trust	1,606	2,793	6,421	1,015
NHS Trusts	Barts Health NHS Trust	2,393	893	239	147
	Imperial College Healthcare NHS Trust	190	114	106	
	Ipswich Hospital NHS Trust		107		
	Mid Essex Hospital Services NHS Trust	638	1,722	885	1,020
	Portsmouth Hospitals NHS Trust		101		
	Whittington Hospital NHS Trust	122	1,007		
NHS England & Clinical Support Units	London Regional Office (including all London Area Teams: Q61, Q62, Q63, Q71)	267,726		11,012	
	NHS England - Core	195			
Other NHS Bodies	NHS Litigation Authority		3,357		
	Health Education England	8,113			
	Department of Health : Core trading & NHS Supply Chain (excluding PDC dividend)	15,721		6,179	145
Other Government Bodies	Department of Health - PDC dividend only		6,820		139
	HM Revenue & Customs - VAT			630	
	HM Revenue & Customs - Other taxes and duties				2,187
	National Insurance Fund (Employer contributions - Revenue Expenditure)		13,647		2,086
	NHS Pension Scheme (Own staff employers contributions only plus other invoiced charges)		19,265		2,856
	NHS Blood and Transplant (excluding Bio Products Laboratory)	135	1,982	295	113
	Welsh Assembly Government (incl all other Welsh Health Bodies)	1,760		139	
	Scottish Government	271		108	
Other Related Parties	Great Ormond Street Hospital Children's Charity	33,734	2,143	1,886	445

24. Events after the reporting period

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

25. Losses and special payments

	Number	£000
Stores losses	5	240
Total losses	**5**	**240**
Ex-gratia payments	11	1
Total special payments	**11**	**1**
Total losses and special payments	**16**	**241**

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

26.1 Salary entitlements of senior managers

Name	Title	2014/15 Salary and Fees	2014/15 Taxable Benefits	2014/15 Annual Performance-related Bonuses	2014/15 Long-term Performance-related Bonuses	2014/15 Pension-related Benefits	2014/15 Total	2013/14 Salary and Fees	2013/14 Taxable Benefits	2013/14 Annual Performance-related Bonuses	2013/14 Long-term Performance-related Bonuses	2013/14 Pension-related Benefits	2013/14 Total
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Non-executive Directors													
Baroness Tessa Blackstone	Chairman of Trust Board	50-55	0	0	0	0	50-55	45-50	0	0	0	0	45-50
Ms Yvonne Brown	Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Mr David Lomas	Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Ms Mary MacLeod OBE	Non-Executive Director	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20
Mr Akhter Mateen	Non-Executive Director (from 28 March 2015)	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a
Mr John Ripley	Non-Executive Director (until 27 March 2015)	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Ms Ros Smyth	Non-Executive Director	0-5	0	0	0	0	0-5	0-5	0	0	0	0	0-5
Mr Charles Tilley	Non-Executive Director	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20
Executive Directors													
Mr Michael Bone	Interim Director of Information and Communication Technology	165-170	0	0	0	0	165-170	80-85	0	0	0	0	80-85
Mr Robert Burns	Director of Planning and Information	100-105	0	0	0	25-30	130-135	100-105	0	0	0	55-60	160-165
Dr Cathy Cale	Interim Co-Medical Director	15-20	0	0	0	25-30	45-50	5-10	0	0	0	0-5	5-10
Mr Trevor Clarke	Director of the International and Private Patients Division	80-85	0	0	0	10-15	95-100	80-85	0	0	0	15-20	100-105
Mr Martin Elliott	Co-Medical Director	80-85	0	0	0	0	80-85	90-95	0	0	0	0	90-95
Professor David Goldblatt	Director of Clinical Research and Development	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Mr Paul Labiche	Director of Estates and Facilities	90-95	0	0	0	15-20	105-110	10-15	0	0	0	0-5	15-20
Mr Niamat (Ali) Mohammed	Director of Human Resources	120-125	0	0	0	15-20	140-145	120-125	0	0	0	80-85	200-205
Mrs Elizabeth Morgan	Chief Nurse and Director of Education	105-110	0	0	0	15-20	120-125	105-110	0	0	0	25-30	130-135
Mr Julian Nettel	Interim Chief Executive (until 31 December 2014)	90-95	0	0	0	0	90-95	25-30	0	0	0	0	25-30
Mrs Claire Newton	Chief Finance Officer	125-130	0	0	0	15-20	145-150	125-130	0	0	0	20-25	145-150
Dr Peter Steer	Chief Executive (from 1 January 2015)	50-55	0	0	0	5-10	60-65	n/a	n/a	n/a	n/a	n/a	n/a
Mr Matthew Tulley	Director of Redevelopment	125-130	0	0	0	15-20	140-145	125-130	0	0	0	20-25	145-150
Ms Rachel Williams	Chief Operating Officer	120-125	0	0	0	40-45	165-170	85-90	0	0	0	55-60	145-150

26.2 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 2015 (bands of £2,500) £000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2015 £000	Cash equivalent transfer value at 31 March 2014 £000	Real increase/(decrease) in cash equivalent transfer value at 31 March 2015 £000
Mr Robert Burns	Director of Planning and Information	0-2.5	0	32.5-35	60-65	384	352	32
Dr Cathy Cale	Interim Co-Medical Director	0-2.5	5-7.5	32.5-35	95-100	577	528	49
Mr Trevor Clarke	Director of the International and Private Patients Division	0-2.5	2.5-5	37.5-40	115-120	812	766	46
Mr Paul Labiche	Director of Estates and Facilities	0-2.5	0	7.5-10	20-25	187	163	24
Mr Niamat (Ali) Mohammed	Director of Human Resources	0-2.5	2.5-5	37.5-40	110-115	690	644	46
Mrs Elizabeth Morgan	Chief Nurse and Director of Education	0-2.5	2.5-5	52.5-55	155-160	n/a	n/a	n/a
Mrs Claire Newton	Chief Finance Officer	0-2.5	2.5-5	10-12.5	35-40	262	221	41
Dr Peter Steer	Chief Executive (from 1 January 2015)	0-2.5	n/a	0-2.5	n/a	12	0	12
Mr Matthew Tulley	Director of Redevelopment	0-2.5	2.5-5	25-27.5	75-80	397	363	34
Ms Rachel Williams	Chief Operating Officer	2.5-5	7.5-10	12.5-15	40-45	198	157	41

26.3 Expenses

Expenses totalling £18,500 were claimed by six directors of 22 (2013/14: £600 claimed by four directors of 24).
Expenses totalling £1,300 were claimed by six of 22 councillors of the Members' Council (2013/14: £1,300 claimed by four councillors of 24).

26.4 Off-Payroll engagements

As at 31 March 2015, the Trust had six off-payroll engagements for more than £220 per day lasting for longer than six months.
Of these, one has existed for between three and four years at the time of reporting and five have existed for more than four years.

Great Ormond Street Hospital for Children NHS Foundation Trust

Annual Report and Accounts

2014-15

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

Contents

[To be provided]

Highlights of 2014/15

Nine out of ten patients (94 per cent) say they are satisfied with the care they receive [With info graphic]	Consistently met the six-week diagnostic waiting time target in 15 key diagnostic tests. [With info graphic]
97 per cent of families responding to the Friends and Family Test were likely or extremely likely to recommend the Trust [With info graphic]	Staff sickness rate down from last year at 2.5% [With info graphic]
95 per cent of our non-admitted patients were seen within 18 weeks. [With info graphic]	Record levels of patients were seen at GOSH. [With info graphic]
100 per cent compliance against all relevant cancer waiting standards (Cancer patients waiting no more than 31 days for second of subsequent treatment (%)) [With info graphic]	Maintained a green governance rating and continuity of service rating score of four throughout the year. [With info graphic]
Announced development of the Centre for Research into Rare Diseases in Children [With info graphic]	

Introduction from the Chairman

Our focus and guiding principle since 1850s has been and will remain 'the child first and always'. The children and young people we care for have some of the most complex and rare conditions identified today. For many there is no known cure and we are one of the only institutions, if not the only institution in the country, and sometimes the world, that has the expertise to offer treatment. Due to the unique nature and concentration of these patients at GOSH we have been provided with the opportunity and responsibility to drive toward new treatments and cures for these rare and complex diseases.

Today, we continue our rich tradition of working in the continuum of discovery to cure. This is without forgetting that the focus of all our activity, from education, research and our clinical service is based on the care of the individual child and family in the context of their community.

While our principles remain, the landscape around us continues to change. Over the last year common with other acute trusts, the Trust continues to experience financial uncertainty due to changes in commissioning strategies, challenging productivity targets and increased costs to deliver new regulatory requirements. However, it has extensive plans in place to rise to this challenge.

This year we revised our strategy to respond to the changes in landscape and plan for how we can make the most positive impact on child health. This important work was developed in collaboration with a range of key stakeholders, including patients, carers, the Members' Council, our research partner the UCL Institute for Child Heath (ICH) and our charity. It resulted in an ambitious organisational vision: to be the leading children's hospital in the world.

In order for us to achieve this we have identified five key areas where we want to deliver and be seen to deliver excellence. These form our strategic objectives which are:

- To provide the best patient experience and outcomes
- To be an excellent place to work and learn
- To deliver world-class research
- To be the partner of choice
- To be sustainable

These will be in addition to our commitment to ensuring that quality and safety are a strong focus in everything we do.

The strategy which outlines our direction for the next 5 years and beyond is underpinned by another significant and important piece of work - defining our values. The values were shaped by more than 2500 staff, patients, children and young people, families and volunteers. Of particular note are representatives from our Member's Council in the parent and staff constituency who were instrumental

in the development process. The resulting Always Values, launched in March 2015, define the core of who we are, how we should behave and shape the expectations we have of each other and others have of us.

Feedback from our patients and their families is essential to ensure the highest of standards and drive improvements in care. We are pleased that 94 per cent of inpatients were satisfied with the care they receive, with confidence in our doctors and nursing staff remaining extremely high (97 and 96 per cent respectively).

Despite the increase in the number of patients treated at the hospital, we have continued to meet the majority of our waiting time targets including those in the areas of cancer and diagnostics.

It extremely difficult to deliver high quality care in cramped and out dated accommodation and we recognise that the standards of care we aspire to deliver are not always matched by the quality of accommodation we have. We are very fortunate to have many generous supporters, who through our wonderful charity, are enabling us to completely re-build two-thirds of the hospital over a 20-year period.

Last year we forged ahead with the construction of the Premier Inn Clinical Building ready for the completion of the Mittal Children's Medical Centre in 2017. The facility will provide much needed new in-patient wards, more operating theatres and a recovery unit as well as a new surgery centre, respiratory centre and specialist centre for children with severe forms of arthritis, skin conditions or infectious diseases. We are also moving forward with the creation of the Centre for Research into Rare Disease in Children which was granted planning permission in March 2014. This Centre, once opened in 2018, will enable hundreds of researchers and clinicians to work together under one roof supported by state-of-the-art facilities to advance our understanding of rare diseases and identify new and better treatments. The Centre is only possible thanks to charitable support, in particular Her Highness Sheikha Fatima bint Mubarak wife of the late founder of the United Arab Emirates whose incredibly generous gift will help fund the building of the new centre.

Much of the strategic work outlined above has involved input from our active Members' Council and Young People's Forum. Members have also been involved in a wide range of groups and committees looking at the patient experience. This includes being part of team that undertook the annual Patient Led Assessment of the Care Environment (PLACE) where I am very pleased to report our scores have improved dramatically. Of particular note the 2014 percentage score for food was 93 per cent, which in in sharp contrast to the previous year's score of 61 per cent.

We have held our Member's Council election this year and I would like to thank all those who took part in the election process. We are extremely fortunate to have individuals of such calibre on our Council and I would like to thank all our Members for their continued input and support.

This year there have also changes in the make-up of the Board. At the end of December Julian Nettel stepped down as interim chief executive and we were joined by Dr Peter Steer. I would like to thank Julian for his significant contribution in supporting the organisation prior to Peter's arrival.

Among the non-executive directors, John Ripley stepped down in March 2015 after 3 years with the Trust. John has been a much valued member of the Trust Board and Board committees. His vast experience in the commercial sector also helped shape our approach to the development of our

strategy. John has been extremely committed in his role and I would like to thank him for his guidance and support over the past few years. I would like to welcome Akhter Mateen, non-executive director which joined the Board in March 2015.

2015/16 promises to be another exciting and challenging year for the Trust. The landscape around us continues to change and without doubt there is renewed pressure on us to make the best use of our resources. However, I am confident that with can start to deliver on our bold new strategy. This will not be possible without our dedicated staff. They are what makes our organisation great and I would like to express thanks to all of them including our volunteers for their dedication and hard work over the past year.

Introduction from the Chief Executive

Prior to joining Great Ormond Street Hospital, I was aware of its reputation as a centre of excellence for specialist paediatric care. We are rightly proud of our world-leading research and excellent clinical outcomes and it is very clear to me that these are a result of the quality and commitment of our dedicated staff.

Over the last year the hospital has faced numerous challenges and these will continue for the foreseeable future. Demand for our services is increasing, with our recent trajectory showing an increase of 45 per cent in our inpatient activity and 75 per cent increase in outpatients' activity over the last five years. Such increases have taken place against a backdrop of heightened financial uncertainty and a complex and changing health landscape.

Striving for excellence should be at the heart of everything we do and underpins our ambitious vision to be the leading children's hospital in the world by 2020. As you will see in our Quality Report, included later in this document, we are performing well against key external and internal quality indicators. Our work to develop and publish internationally agreed outcome measures is particularly important. Many of our children have rare and very complex diseases and can only access treatment in a handful of centres nationally or internationally. I am very proud that we publish more clinical outcomes on our website than any other children's hospital in the world.

Feedback from our patients and staff is also instrumental in driving improvements. This year, as planned, we embraced the opportunity to expand the Friends and Family Test beyond inpatients to include responses from children and young people cared for in both day care and outpatients. Taking all areas of the hospital together the percentage of patients and their families being likely to or extremely likely to recommend the Trust remained high with the Trust achieving a staggering 98 per cent score in February 2015. The confidence in the quality of care provided at the hospital was also borne out in feedback from staff, with results of the staff Friends and Family Test and the staff survey being among the highest in the country.

At the beginning of April the Care Quality Commission carried out a scheduled inspection of the hospital. We will know the outcome of the inspection in summer 2015. However, the level of engagement by staff in the process was outstanding and a reflected their passion and commitment to providing the very highest standards of care.

The quality of our training has also been under scrutiny over the last year. The reviews carried out by bodies such as Health Education North Central and East London (HE NCEL) have identified areas of excellence in medical training at GOSH but also concerns in areas such as paediatric medical specialties. Working with our trainees, we have made a significant number of changes to address the issues raised and project plans have been developed to ensure that we better meet their training needs in the longer term.

Information technology offers hospitals an enormous opportunity to improve the quality of care that they provide. At GOSH, in part due to the specialist nature of the work we do which has led to the creation of multiple bespoke systems, we are behind many others in harnessing the potential of the latest technology to improve safety, efficiency and communication. Last year we took great strides to developing an Electronic Document Management System which will provide one single format for each patient record and in the coming year we expect to start the procurement of an Electronic Patient Record (EPR) system.

Over the last year our focus on continuous improvement of care has taken place against a backdrop of more stringent and uncertain financial circumstances. This is reflected in our accounts which show a smaller year-end surplus compared to previous years. Without doubt, along with all our colleagues in the NHS, we are expected to do more with less. Our response to such challenging financial circumstances is to not compromise quality because we believe high quality and efficient care are the mutually reinforcing elements of all that we do. One example of many is our work to drive down waiting times for patients across the Trust; another is the successful reduction in general anaesthetic use for CT scanning.

While we are confident that GOSH will remain financially viable despite the challenging financial and political environment, we are under no illusions that next year promises to be an even tougher year financially and we must redouble our efforts to deliver the highest quality care and be more efficient.

One way in which we hope to achieve both of these objectives is by ensuring that we have very clear lines of accountability internally, with clearly defined roles including an ability at all levels to suggest and make improvements in the way we work. Establishing this has included reviewing the roles of our clinical leaders. Work is now underway to explore how we can make our divisional structures work more effectively and efficiently.

We also know that we can only be truly effective if we work well with other providers. This year we are looking to develop more deliberate partnerships with providers outside the quaternary sector so that our patients are only with us when they need to be and they are confident they can access seamless transition support closer to home. We are also actively engaged in national discussions around consolidation of paediatric services ……

We provide some education and training to overseas patients as part of our International Private Patients activity too. This work, along with the overseas patients we see at Great Ormond Street, is extremely important as it enables us to help us treat children with rare diseases that cannot be treated in their home countries and provides revenue to support our highly specialised NHS services.

Our unique cohort of patients provides us with a particular opportunity and responsibility for pioneering research to improve treatments and find cures for life limiting and life threatening conditions. Our research partner, the UCL Institute of Child Health, is instrumental in this endeavour. One area where we are making great strides is in genetics. This year GOSH took a lead role coordinating a new North Thames network of hospitals involved in Genomic England's 100,000 Genome Project. By collecting and analysing these genetic samples and matching them with the symptoms and long-term outcome associated with these conditions, this project aims to position the UK as the first country in the world to sequence 100,000 whole genomes, which will help researchers and clinicians better understand, and ultimately treat, rare and inherited diseases and common cancers.

Over the next year we will be continuing this work and also examining our culture and infrastructure to ensure we become a 'research hospital' rather than a hospital that does research. This ambition, along with the continued growth in demand for our services and considerations about how we can best to support the increasing complexity of specialised paediatric care, has led us to consider the long-term future of our island site. Over the last year, working with staff, patients, families and carers and local stakeholders, we have developed a Masterplan, which is a roadmap for the next 15 years of redevelopment. We are now working with partners, particularly our fantastic and supportive charity which raises so much money to fund our redevelopment, to consider its implementation.

2015/16 promises to be exciting and challenging for GOSH. We must continue to provide the very highest quality of care to each and every one of our patients and their families despite the complex

landscape public healthcare in which we operate. I am very pleased that in meeting this challenge we have been joined by some exceptional new members of the executive team. At the beginning of the financial year Liz Morgan retired as chief nurse and has been succeeded by Juliette Greenwood, who has returned to GOSH after a few years in other hospitals. Simultaneously we were joined by Dena Marshall who will be our chief operating officer on an interim basis while Rachel Williams takes maternity leave. In June we will be joined by Dr Vin Diwaker who comes to us from Birmingham to be our medical director. He succeeds Professor Martin Elliot and Dr Catherine Cale. I am would like to thank Liz, Martin and Cathy for all their dedication and support to the organisation in their respective roles.

Finally, I would like to thank all our staff. Without their dedication and hard work over the past year, we would not have been able to provide the quality of services that we have. They remain our greatest strength and I am confident that by working together as one team, we can meet the challenges ahead and continue to provide the care that our patients deserve from us.

Who we are and what we do

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. GOSH 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 220,000 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 transplants.
- Children treated from overseas in our International and Private Patients' (IPP) wing.

Leading research and development

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

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. In partnership with UCL Partner NHS Trusts, University College London and Moorfields Eye Hospital, we are the prime provider for North Thames in the national 100,000 Genomes Project. Thanks to a transformative gift announced in July 2014 from Her Highness Sheikha Fatima bint Mubarak, wife of the late Sheikh Zayed bin Sultan Al Nahyan, founder of the United Arab Emirates, the Centre for Research into Rare Diseases in Children is being developed as a

partnership between Great Ormond Street Hospital (GOSH), University College London (UCL) and the GOSH Children's Charity.

Education and training for staff working in children's healthcare

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

Year at a glance

April 2014

- GOSH doctors developing technique to grow replacement ears and noses using stem cells taken from a patient's abdominal fat
- Pilot programme encouraging families on Eagle Ward to report safety concerns in order to make the hospital safer shortlisted for Innovation in Healthcare Award

May 2014

- Dr Peter Steer appointed as Chief Executive of Great Ormond Street Hospital
- Great Ormond Street Hospital opens new maritime themed reception designed by patients
- GOSH wins patient safety award for project that aims to increase levels of patient safety across the Trust

June 2014

- GOSH surgeons to play a key role in a new foetal surgery research project which will create better tools, imaging techniques and therapies for future operations on unborn babies.
- ITV1 documentary *The Secret Life of Babies* features GOSH patient whose severe epilepsy was cured following brain surgery as a newborn

July 2014

- Announcement of Transformative gift to create the world's first centre for research into rare diseases in children
- New treatment carroed out at GOSH for first time leads to successful kidney transplants in 'untransplantable' children

August 2014

- GOSH patient undergoes double ear construction made from his own ribs
- GOSH patient is offered place at prestigious ballet school following surgery for cerebral palsy

September 2014

- Marked improvement in Patient-led Assessments of the Care Environment (PLACE) scores for cleanliness, food and dignity and privacy

October 2014

- Construction work begins on the new Premier Inn Clinical Building, part of the Mittal Children's Medical Centre
- New genetic clues to autism discovered by team at GOSH and UCL Institute for Child Health

November 2014

- GOSH Co-Medical Director Professor Martin Elliott named one of Health Service Journal's top healthcare innovators of for his work looking at how technology can improve hospital information management
- Health Education England raise concerns about the quality of training in Haematology and Oncology – action plan is immediately put in place
- GOSH and UCL Institute of Child Health research team find epilepsy surgery in childhood can protect memory

December 2014

- GOSH named as key centre in Genomic England's 100,000 Genome Project to help understand and ultimately treat rare diseases and common cancers
- Celebrities attend GOSH Christmas parties for patients

January 2015

- CQC announces scheduled inspection of Hospital in April 2015
- A newly recognised virus discovered by GOSH may be the cause of a severe brain infection in children whose immune systems are low.
-

February 2015

- New Chief Nurse and Medical Director appointed to the executive team
- Her Royal Highness the Duchess of Cornwall visited The Arthritis Research UK Centre for Adolescent Rheumatology, the world's first centre dedicated to understanding how and why arthritis affects teenagers.

March 2015

- GOSH launches a new non-invasive prenatal test for Down's Syndrome offering greater accuracy and a reduced need for invasive tests
- Akhter Mateen appointed as a new non-executive director.
- Plans approved for the new Centre for Research into Rare Disease in Children

STRATEGIC REPORT

Introduction

Our vision is to the leading children's hospital in the world. During 2014/15 we worked with senior leaders from across the Trust, as well as the UCL Institute of Child Health, the GOSH Children's Charity and our Members' Council and set out to define where and what we want GOSH to be in 5 – 10 years' time, and what we will need to do to achieve that. We also considered factors such as the environment in which we operate; our areas of strength and weakness; and, how and where we can make the biggest positive impact on children's health.

To be the leading children's hospital in the world we want to deliver and be recognised the world over for excellence in five key areas. These form our strategic objectives going forward. They are:

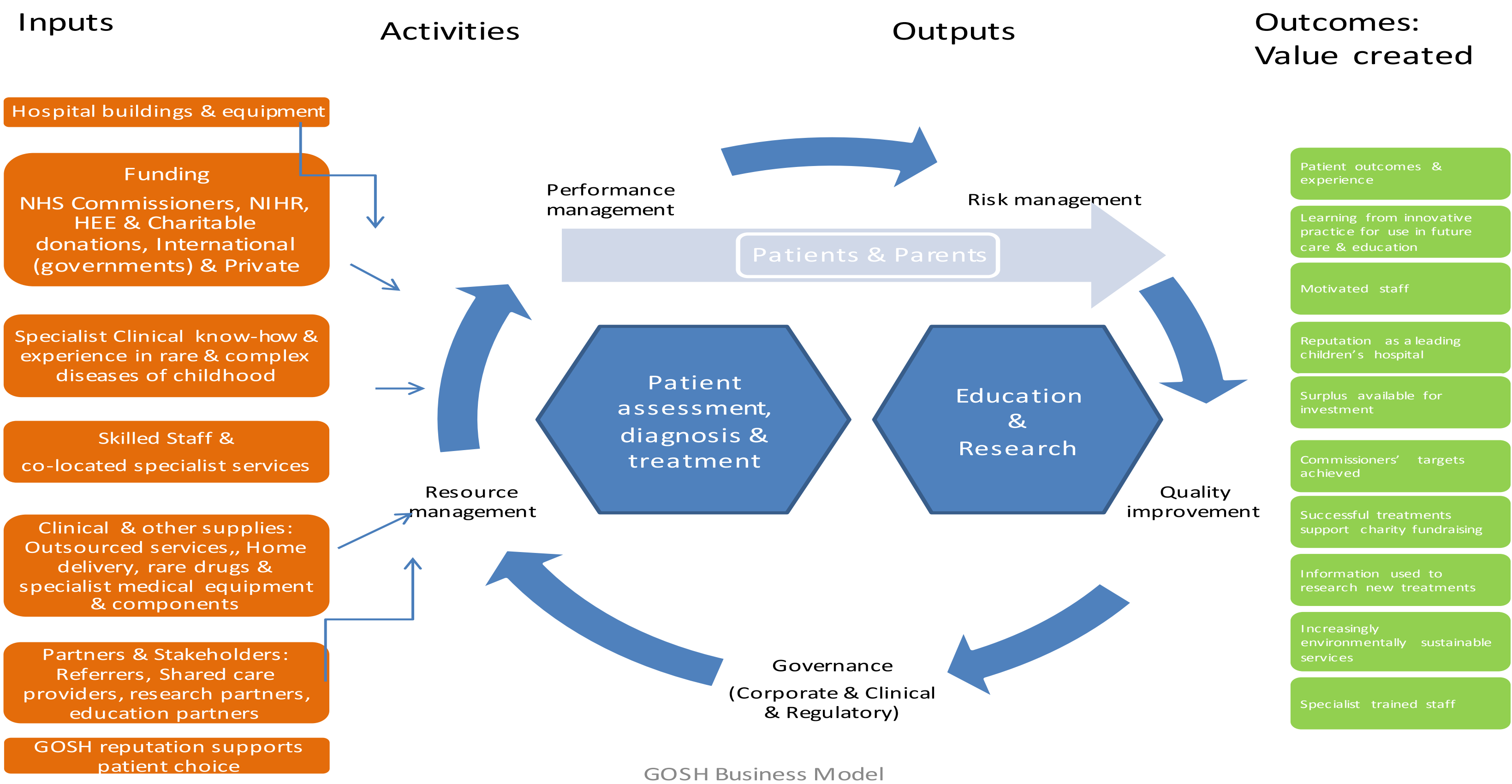
- To provide the best patient experience and outcomes
- To be an excellent place to work and learn
- To deliver world-class research
- To be the partner of choice
- To be sustainable

These will be in addition to our commitment to ensuring that quality and safety are a strong focus for all we do.

We are a hospital which specialises in children and young people with complex, rare or highly specialised illnesses or disabilities. We do not have an Accident and Emergency Department, and we accept mainly specialist referrals from other hospitals and community services.

Our business model

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



GOSH Business Model

The key outputs delivered from our business model are as follows:

- Clinical outcomes – world class clinical outcomes for numerous highly specialised children's treatments
- Patient & Family Satisfaction – high levels of patient / satisfaction with our services
- Research – one of the top few organisations in the world for developing new and innovative treatments in children
- Education – the largest provider of specialist paediatric training and education in Europe
- Financial – good value specialist paediatric healthcare for the NHS supported by surplus from our International and Private Patient business
- Reputation – a hospital with a worldwide reputation for excellence which the NHS can be proud of.

Our strategy and annual plan priorities for 2014/15

As set out in the introduction, the Trust's strategy has set a very clear vision for GOSH to be the leading Children's Hospital in the World. In doing so the organisation has outlined 5 strategic objectives for which the Trust wants to deliver against and be recognised for. In the Trust's Strategy for the next five years (2014-2019), we have looked at the key areas for the Trust to consider and have developed key pillars upon which the Trust vision and overarching strategy sits. The diagram below demonstrates the interdependencies and linkages across all these key aspect.

During 2014/15, in order for the Trust to be able to deliver these overarching strategic objectives and vision through the operational plan, a number of priorities were outlined. For ease of review and monitoring these fall under each of the headings below:

- **Service Developments / Operational Improvements**: Predominantly clinical and clinically lead, in-year strategic service developments and / or operational improvements to enhance the delivery and care provided by GOSH

- **Supporting Function Improvements**: Those areas often referred to as corporate departments, which have a vital role to play in supporting the overall running and delivery of the Hospital, additionally require constant review and improvement. Specific areas were identified in 2014/15.

- **Quality Improvements**: As part of the Trust's aims to provide: Zero Harm, No Waste and No Waits, key quality improvements were recognised as requiring improvement in 2014/15 in line with being the hospital offering the best patient experience and outcomes.

- **Finance & Activity**: For the Trust to be sustainable, specific activity (outpatient, inpatient, day case, ITU etc) requirements were set alongside financial deliverables for the organisation.

Management of risk in 2014/15

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

During 2014/15, we have further enhanced our BAF to ensure that at Trust Board level we are focusing on the key risks to delivering our plans and have a corporate view on an acceptable level of risk. All risks outlined in our BAF are reviewed by one of our Board Assurance committees (either the Audit Committee or Clinical Governance Committee).

A summary of the top 3 risks to our operational or strategic plans and the mitigations we have in place to manage them are outlined below.

Risk	Potential Impact	Mitigating Actions
NHS clinical activity funding available to GOSH. The national overspend in specialised services and their subsequent future commissioning arrangements will place extreme financial pressure on GOSH	A reduction in funding to the Trust will lead to a requirement to cut activity. This could potentially impinge on our ability to deliver our vision, although we would do everything possible to ensure excellent patient experience and outcomes are maintained.	Dedicated Productivity & Efficiency Program aimed at reducing costs Robust financial planning, budget setting and strict cost pressure approval Restrictions on capital expenditure with monthly

Risk	Potential Impact	Mitigating Actions
		monitoring Diversifying our income base with targeted increased IPP and commercial income Controls on recruitment of non-front line clinical staff
Medical cover out of core hours.	At all times, our patients receive safe medical cover. However, we believe that improving our senior medical cover beyond core hours would support the delivery of efficient patient pathways.	We have already put in place extended consultant presence in a number of specialties, including cardiac services, intensive care and cancer services. We have a dedicated project to review the out of hour's medical provision across all specialties with the aim to implement enhancements where they will deliver better patient care.
Delivery of Productivity and Efficiency (P&E) targets	Historically our cost improvement programs have been dominated by delivering a financial contribution from increased income rather than cost reduction. This balance will need to change in 2015/16 and beyond.	Increased focus and resources allocated to our P & E program Widespread engagement and involvement of staff at all levels in the P & E program Robust financial and performance management of Divisions / Departments

Financial Control, going concern and financial risk

In common with other acute trusts, the Trust continues to experience financial uncertainty due to continuing changes in commissioning strategies, limits in growth of specialised commissioning budgets, reductions in tariff prices, challenging productivity targets, increased costs to deliver new regulatory requirements and a demanding capital programme.

The Trust has prepared a financial plan for the next three years which forecasts that the Trust will move from a small surplus in 2014/15 to a significant deficit in 2015/16 and for the subsequent years of this

plan. Although the contract has yet to be concluded, the plan includes the funding offered by NHS England for 2015/16.

Beyond, 2015/16 , the risk of changes in the rules for determining paediatric specialist top up rates, expected to be implemented for 2016/17, are a particular concern as the Trust receives one of the highest values of paediatric specialist top up in the country. Another key risk is the continuing requirement to deliver productivity and efficiency savings whilst there are further delays in commissioner lead system wide restructuring. Together these matters create significant uncertainties.

IAS 1, Presentation of Financial Statements, requires Directors to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. IAS 1, deems the foreseeable future to be a period of not less than 12 months from the entity's reporting date.

The financial plan referred to above demonstrates that the Trust can remain financially viable for the next twelve months.

The Directors have also considered the risk of the Trust's services not being in demand in the future. The Trust is a tertiary provider of specialist paediatric services and has the largest concentration of paediatric tertiary and quaternary services of any Trust in the country. Demand for the Trust's services continues to increase. In addition the NHS England Five Year Forward View advocated greater concentration of specialised services and establishment of centres for rare diseases. The Directors believes that the Trust is uniquely placed to facilitate both of these objectives within specialist paediatrics.

After consideration of the financial plan and making reasonable enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue as a going concern for the next 12 months.

Currency and interest rate risk

The Trust is primarily a domestic organisation with the majority of its transactions, assets and liabilities being in the UK and denominated in sterling. The Trust does not undertake transactions in currencies other than sterling and is therefore not directly 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 there are no other significant overseas operations.

Credit risk

The majority of the Trust's income comes from contracts with other NHS bodies. Income received in relation to private patients residing outside the UK comes primarily from overseas government sources and, where this is not the case, deposits are taken prior to the admission of the patient.

Liquidity risk

The Trust has not used any external borrowings in the year. The Trust receives interest on surplus cash deposits, but due to the low value of this income source, interest rate risk is not a significant concern.

Our annual plan priorities for 2015/16

For 2015/16 the NHS will see significant changes as the impact of the Five Year Forward View, the Dalton Review and other key strands of NHS policy start to be enacted. As a consequence, GOSH needs to respond to these and guide (where appropriate) the direction of further rationalisation of specialist children's services. This will only be possible by working closely with our stakeholders and commissioners, along with partner provider organisations (both in London and as part of Clinical Networks across the country). GOSH is best placed to provide specialist paediatric care, with non-complex / non-specialist care being provided in the most appropriate alternate setting, closer to child and family's home.

Due to substantial changes in the commissioning landscape and the consequences of the national tariff on the funding of specialist services in 2015/16, GOSH has had to respond to the resulting unplanned increased financial pressures, as outlined below:

- Expediting the Clinical Services Strategy i.e. those services that may require rationalising and those that require growth;
- Increasing the emphasis on the Productivity & Efficiency (Cost Improvement) Program across the Trust
- Prioritising and expediting the expansion of International and Private Patients (IPP) facilities
- Exploiting the commercial opportunities currently available to the Trust, focusing on the Genetics clinical services (see below);
- Considering the impact and requirements on our current workforce.

Whilst 2015/16 is undoubtedly going to be a challenging time for GOSH, there are a number of opportunities and developments that will be key enablers for the Trust within the year. We are the prime provider for North Thames in the national 100,000 Genomes Project. The work on the 100,000 genome project will inform the Trust's approach to genetic testing as part of our diagnostic and treatment services and will be complimented by the research projects already established in this area. Additionally, in the field of Genetics and as a fundamental part of the Trust's clinical and commercial strategies we have developed implementation of non-invasive prenatal testing and diagnosis (NIPT / NIPD). GOSH has now commenced the first NHS NIPT service and is working to establish an NIPD service which is a world first.

The Trust continues to progress with plans for the Centre of Research into Rare Disease in Children (CRRDC), with the expectation of building works commencing in year. This will offer GOSH prime facilities to locate these essential research services.

Carrying on the excellent work we undertook in 2014/15, and as a catalyst from the Francis report, a priority for the Trust in 2015/16, is a programme of work focused on embedding the Trust's "Always Values". The intention is that the Trust and its staff are always: Welcoming, Helpful, Expert and One Team, in all that it does. This will ensure that as the Trust responds to the challenges it faces in 2015/16, patient safety and patient experience remains at the core of all that it does.

Research at GOSH

GOSH's strategic aim is to be one of the global leading children's research hospitals. We are in a unique position working in partnership with our academic partner UCL Institute of Child Health (ICH), to combine research strengths and capabilities with our diverse patient population and to embed research into the fabric of the organisation. In addition to the ICH, GOSH has the benefit of access to the wealth of the wider UCL research capabilities and platforms. 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. Together, GOSH and ICH form the largest paediatric research centre outside North America and we host the only Biomedical Research Centre (BRC) in the UK dedicated to children's health. Our BRC status, awarded by the National Institute for Health Research (NIHR), provides funding and support for experimental and translational biomedical research. In addition to the BRC, the Division of Research and Innovation includes:

- the joint GOSH/ICH Research and Development Office
- the Somers Clinical Research Facility, which is a state-of-the-art ward within GOSH for the day care accommodation of children taking part in clinical trials
- hosting research delivery staff funded through the Comprehensive Research Network: North Thames.

Currently, we have 875 active research projects at GOSH/ICH. Of these, 223 have been adopted onto the NIHR Clinical Research Network Portfolio, which is a grouping of high-quality clinical research studies. In total, 3021 patients receiving health services provided or sub-contracted by GOSH have been recruited in the last 12 months to participate in research ethics committee-approved research projects that have been accepted on the portfolio.

Key achievements in 2014/15 include:

- 106 active studies were supported by the Somers CRF in 2014/15. 549 patients, attending over 1200 appointments, took part in research studies in the Somers CRF in 2014/15. The Somers CRF is also a central point of contact for commercial partners looking to undertake clinical trials at GOSH; 55% of the studies supported by the CRF in 2014/15 were commercially sponsored.
- In partnership with UCL Partner NHS Trusts, University College London and Moorfields Eye Hospital, GOSH successfully participated in the Genomics England 100,000 pilot. The 100,000 Genomes Project has been established to deliver on the government's commitment to sequencing 100,000 genomes by the end of 2017. GOSH will now play a lead role in the main study through coordinating a network of hospitals that will form the North Thames Genomic Medicine Centre, and alongside other partnering London Trusts, will recruit participants to the project.
- Three of our clinical academics were awarded NIHR Senior Investigator status. NIHR made 16 awards in total to outstanding research leaders of clinical and applied health and social care research.

- Our investigators received awards from the NIHR Clinical Research Network for their contribution to clinical research: Dr Ri Liesner as a Leading Commercial Principal Investigator; Dr William van't Hoff for 'Delivering above and beyond'; and Professor Francesco Muntoni for 'Consistently delivering to time and target' and 'First global or European patient';
- We are committed to developing the next cadre of clinical academics and through our BRC have developed a comprehensive training programme including the appointment of our first Clinical Academic Programme Lead - Nurses and Allied Health Professionals. With this role, we aim to increase the number of nurses and AHPs who are engaged with and undertaking research. In addition, we hosted a residential National Paediatric Academic Training weekend, organised through our BRC. This was open to clinical academic trainees nationally and provided a unique opportunity to develop research skills and network with peers and senior academics.
- We have appointed our first Clinical Research Nurse Practice Educator who will play a key role in further integrating research with clinical care.
- Raising research awareness is a key priority, in May 2014 we held our first Research Awareness Week for staff, patients and families and in November 2014 we held an open day for the public in conjunction with the London Science Festival.

Redevelopment of the hospital

Our Redevelopment programme is replacing cramped, outdated buildings and creating new facilities appropriate for world-class paediatric care and research. We are also planning for the future to meet growing demand for our services and support the increasing complexity of specialised care.

[Picture of redevelopment plan]

Phase 2B: Premier Inn Clinical Building

In June 2014, Skanska commenced deconstruction of the Cardiac Wing to make way for the Premier Inn Clinical Building, opening in 2017. The new building will connect floor by floor with the Morgan Stanley Clinical Building, creating the Mittal Children's Medical Centre. It will house a new surgery centre and high-specification acute facilities, with space for a parent or carer to stay comfortably by their child's bedside.

In September 2014, GOSH charity patrons Tess Daly and Vernon Kay joined some of our young patients in a Breaking Ground ceremony to celebrate the start of building works. [photo]

Phase 3A: The Centre for Research into Rare Disease in Children

Plans to create a world-leading new Centre for Research into Rare Disease in Children are on track, principally thanks to a transformative gift to the GOSH Children's Charity, announced in July 2014. A donation of £60 million was received from Her Highness Sheikha Fatima bint Mubarak, wife of the late Sheikh Zayed bin Sultan Al Nahyan, founder of the United Arab Emirates, in recognition of GOSH's unique position to advance treatments and cures in this area.

The centre is being developed as a partnership between Great Ormond Street Hospital (GOSH), University College London (UCL) and the GOSH Children's Charity. Situated adjacent to the hospital, it will incorporate an outpatient department caring for children and young people with a range of rare and complex conditions. It will also house laboratories, specialist equipment and workspace for 350+

experts to develop diagnostic procedures, manufacture gene and cell therapies and create personalised medical devices.

The building has been carefully designed to be sensitive to its context within a conservation area, revitalise the streetscape and, give public expression to the important scientific endeavours within.

Town planning consent was achieved in March 2015. Demolition of the existing disused office block on the site of 20 Guilford Street will commence in the spring 2015. Construction of the new building starts in October 2015 and the building will open in 2018.

Masterplan 2015
During 2014 a masterplan review was undertaken to ensure the hospital is on track to maximise on-site opportunities and support clinical and research activity in the medium to long term. Masterplan 2015 has identified the Frontage Building site as the next phase for development (Phase 4), with the potential to provide 60 additional outpatient consulting rooms, 90 additional beds and significant teaching and education space.

Go Create!

This has been the best part of our day. My daughter will remember the hospital visit as a brilliant day of art rather than a day about her illness. –Parent

The GO Create! arts programme makes a vital contribution to the healing environment at GOSH, offering transformative experiences that spark the imagination of our patients, families and staff. Our pioneering, innovative and collaborative approach contributes to our status as one of the leading children's hospitals in the world.

During 2014/15 we focused on increasing our impact, developing research and building high-profile external cultural partnerships. Our curated participatory opportunities, performances, artist residencies, online activities and collaboration with patients in developing permanent artworks involved more than 4,160 children and young people.

Memorable GO Create! projects were recognised as two of Great Ormond Street Hospital Children's' Charity's 'Ten amazing moments in 2014'.

Find out more about GO Create! at: www.gosh.nhs.uk/go_create or follow us on Twitter: @gocreateGOSH

Our performance in 2014/15

The Trust has delivered or is on track to deliver for the vast majority of areas. There are a couple of notable areas which either will not deliver or are at risk of delivery, as set out in the plan. This is largely concentrated around the underlying financial position of the Trust, which will be reporting an underlying deficit in 2014/15.

Financial performance

The Trust has had a challenging financial year with EBITDA falling from £36.9 million (9.6% of operating income) to £27.3 million (7.0% of operating income). Although there was continued growth in delivery of care to NHS patients, the growth level at just under 1% was considerably lower than in previous years. Private patient activity levels were lower than in 2013/14 with income falling by 2%. The summary information below shows growth in total income of 1.8 per cent, a deterioration in the net surplus from £5.0 million to £2.9 million, and an increase in cash levels of just £1.9 million which will be used to fund future investment in buildings, IT and medical equipment.

Whilst income grew by only 1.8%, operating expenditure increased by 5.8%, this disparity reflecting the continuing challenge to delivery of high quality specialist services which require highly skilled staff, specialist equipment, better use of information technology and consume high cost drugs and consumables. Property and insurance costs are also increasing as newly refurbished space is commissioned. Our clinical negligence insurance premium increased by 25%.

In order to properly compare the financial performance resulting from the operations of the Trust, the following financial information excludes income from donations to fund capital expenditure, donations funding non-recurring revenue expenditure within the redevelopment programme and gains/losses arising from impairments of land and buildings included in the revenue account.

£m		
For the period ended:	**31 March 2015**	**31 March 2014**
Operating income	389.6	382.8
Operating expenses	(362.3)	(345.9)
EBITDA*	27.3	36.9
Depreciation, interest and dividend	(24.4)	(31.9)
Net surplus	**2.9**	**5.0**
Increase in cash	1.9	18.6
As at the end of the period:		
Assets employed	433.4	422.1

Key ratios:		
EBITDA* as a % of Income	6.9%	9.6%
Net surplus as a % of income	0.7%	1.3%
Income growth	2.7%	6.9%
Capital service cover	4.0	5.9
Liquidity - days	59.2	53.3

*EBITDA - Earnings before interest, taxes , depreciation and amortization

We continued to invest considerable sums to improve the hospital's facilities. In addition to the £15.4 million capital expenditure on the redevelopment programme & medical equipment funded by the charity, there was also capital expenditure from the Trust's resources amounting to £11.8 million.

The Trust continued to pursue productivity and efficiency improvements in order and delivered £11.5m of its efficiency target of £13.6 million. The programme included initiatives to increase the utilisation of the Trust's specialised facilities and resources through growth in patient care and reductions in costs.The shortfall can be attributed to delays in schemes for which benefits should be realisable in 2015/16.

Performance against objectives 2014/15

In 2014/15, the Trust made good progress against its objectives and priorities, which have been categorised under the following headings (as referenced in section X):

- Service Developments / Operational Improvements
- Supporting Function Improvements
- Quality Improvements
- Finance & Activity

The table below details delivery against these key areas:

	Trust priorities in 2014/15	Evaluation
Service Developments / Operational Improvements	Implement routine outpatient clinics across a number of specialities and MRI scanning service on a Saturday.	Achieved: • MRI Service running extra sessions in the evening and occasional weekends. • Additional Saturday clinics are running (although acknowledged uptake has been low and a revised approach being taken)
	Open additional ICU beds and Implement a new model of Neonatal ICU beds.	Achieved • New separate neonatal ICU is now operational and increased beds have been opened across all three ICUs
	Open Southwood imaging suite (which will see the addition of modern CT and 3-Tesla MRI scanners)	Achieved: • Successfully implemented
	New outpatient facilities	Achieved: • Successfully implemented in December 2014
	Open 3 new Angiography laboratories	Achieved: • Successfully implemented in May 2014
	Expand respiratory ward.	Achieved: • Successfully implemented expanded Badger (respiratory) ward opened May 2014
	Recruitment and retention of key health care professionals: Nursing workforce, particularly for our Intensive Care Units (ICUs).	Partially achieved: • Alternative approaches to recruitment have now been implement (including

	Trust priorities in 2014/15	Evaluation
		executive recruitment, difficult to fill posts and a strategy for nurse recruitment)
	Open a comprehensive and standardised pre-operative assessment (to include a clinic for planned patients who will require a general anaesthetic)	Achieved: • Being provided in the outpatient facilities above
Supporting Function Improvements	Values: Statement of values will be developed and a programme of work will be undertaken over the subsequent 2 years to embed revised values and behaviours across the organisation.	Achieved: • The Trust's "Always Values" have been agreed following a comprehensive engagement exercise.
	ICT: • The introduction of an Electronic Document Management System (EDRMS) • Electronic Patient Record (EPR). During 2014/15 develop the business case and commencing procurement	Achieved: • EDM being delivered in 3 phases • EPR business case being prepared
	Temporary Workforce • Over the next three years reduce overall spend by shifting bank: agency spend ratio from the current 74:26 to 82:18 and decrease total usage by 10.14% • Go live with an e-bank system in Q3 2014/15 to allow improved demand analysis and control; improved governance through electronic timesheets; improved detail and timeliness of data	Partially achieved: • Currently off projected target. Actions being put in place to resolve, targeting key areas Achieved

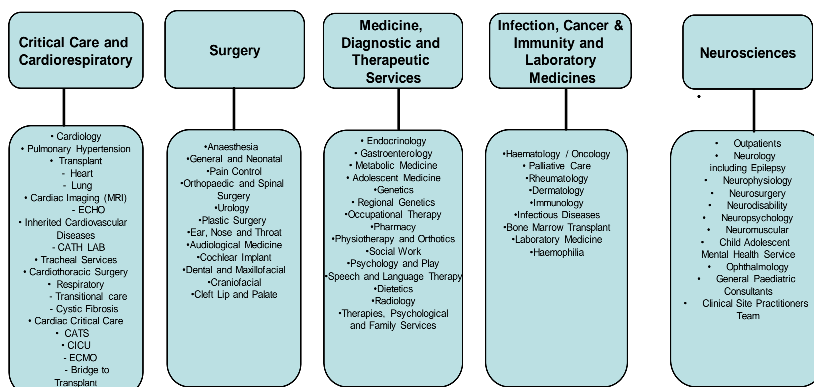
	Trust priorities in 2014/15	Evaluation
	Implement Workforce Friend and Family Test	Achieved
Quality Improvements	Zero Harm Standards: Decrease and eliminate hospital acquired infections	Partially achieved: • The Trust makes year on year progress and improvement in a number of areas for this standard (e.g. Central line infections).
	Zero Harm Standards: Eliminate all pressure injuries occurring in hospital	Achieved: • Year-on-year improvement is being seen based on YTD analysis
	Zero Harm Standards: Recognise and respond to unexpected deterioration of children	Partially achieved: • The Trust is delivering improvements with regard to accurately recording clinical observations, knowing when escalation is indicated and improving situation awareness through effective communication. Further work is due to start that will improve handovers.
	Outcome Measures: Each specialty to define five outcome measures for the five items of care most common and to identify five centres against which they should be compared in order to provide evidence of Top five status.	Achieved: • Good progress is being made in this area, and a wide range of outcome measures are available on the internet.
Finance & Activity	Productivity and Efficiency: Robust plans to deliver savings of £14.8m	Not Achieved: • The Trust is behind on its Productivity & Efficiency programme with a predicted year end under-delivery of

	Trust priorities in 2014/15	Evaluation
		circa £3m
	Activity Plan: • NHS Inpatient spells for 2014/15 = 32,094 • NHS Outpatient activity for 2014/15 = 149,908	Achieved: • Based on most recent month's reporting and forecasted for
	Financial Plan	Not Achieved: • The Trust is expecting to report a deficit for 2014/15

Division performance in 2014/15

The clinical divisions at GOSH are each led by a divisional director and supported by a divisional general manager, a head of nursing and a series of specialty leads, all of whom are responsible for performance delivery in their specific work areas. Each corporate department is led by a department manager. The clinical divisions are accountable to the Chief Operating Officer and the corporate departments to the relevant Executive Director. The diagram below provides a summary of the services provided by the following divisions:

- Critical care and cardio-respiratory
- Surgery
- Medicine, diagnostics and therapeutic services
- Infection, cancer and immunity and laboratory medicine
- Neurosciences.



In 2014/15 the clinical speciality structure was reviewed. Where different specialties regularly collaborate, we have brought them together into new Clinical Services so that we can more easily make improvements in patient care. A senior doctor or other healthcare professional will lead each Clinical Service, ensuring that clinicians remain at the heart of management and help to inform decisions right across the Trust.

The following areas are monitored during monthly performance reviews:

- clinical outcomes
- safety
- quality
- access times and timeliness of clinical communications
- efficiency
- productivity
- staff
- budgets

In these meetings, remedial actions that are required to achieve or maintain performance to targeted levels are agreed.

The text boxes below provide a summary of all of the divisions' performance during the year (including International and Private Patients and Research and Innovation), focusing on quality and safety, and effectiveness and activity.

Medicine, Diagnostic & Therapeutic Services	
The MDTS division encompasses some of the medical specialties (Endocrine, metabolic Medicine, Gastroenterology, Adolescent Medicine and Renal) and many of the supporting services (Pharmacy, Radiology, Dietetics, Social Work, Psychology, Physiotherapy, OT, SLT, Bereavement Services, Chaplaincy, Volunteer Services, BME, Orthotics and Play).	
2014/15 highlights – quality and safety	2014/15 highlights – effectiveness and activity
• Introduction of PGAU (Paediatric Gastro Ambulatory Unit) – where IBD patients requiring rapid access can come in quickly and be seen and assessed by a consultant and nurse, and start treatment as appropriate. This has been a great success and allowed the team to manage patients better and more quickly. • Review of the LSD (Lysosomal Storage Disorders) service model – to ensure the expertise is held across the Metabolic team and there is a robust model in place to sustain the expertise for this patient group. • Development of the Gastroenterology Complex MDT – to review perplexing presentations into the service – the service has been running for 18 months now and has presented its first audit to the team. • The Imaging services achieved the ISAS accreditation from the United Kingdom Assessment Services which is a mark of high quality paediatric imaging services – we are the only accredited paediatric service in the UK.	• Review of the psychology service has been completed looking at what is needed for psychology across the Trust and proposing a revised structure for the service – all psychology has now been moved under one division • Significant increase in Gastro day case activity associated with the ward reconfiguration business case and introduction of PGAU. • Development of research capacity in both Metabolic Medicine and Radiology. The Radiology service has directly employed two research radiographers to embed research skills within the service. The Metabolic service has built in 6 sessions of research time into the consultant rota to support research. • Introduction of extended working and service provision in radiology to accommodate the building works over phase 2B – this has provided evening MRI and Nuclear Medicine sessions every day. • Development of a trust imaging strategy to set the imaging agenda for the next 10 years for the Trust.

Infection, Cancer & Immunology & Laboratory Medicine
The division manages patients with cancer, infectious diseases, problems with fighting infections (immunology), rheumatology and dermatology. The hospital's main laboratory services (with the recent inclusion of genetics) are part of this division.

2014/15 highlights – quality and safety	2014/15 highlights – effectiveness and activity
• Reconfiguration of Haematology / Oncology wards into three wards, with Giraffe as a designated HDU for cancer • The apheresis service is now being run in house • Palliative Care foundation skills training course has been delivered to over 200 nurses within GOSH and externally • Significant progress towards the UKAS ISO15189 laboratory standards (inspection imminent) • Findings from a GOSH Serious Incident have been incorporated in Coroners PFD to improve governance of autologous stem cell transplant	• Haematology / Oncology has been open to 31 beds consistently for the last 8 months • The division has incorporated the genetics service (clinical genetics and laboratory) • Non-Invasive Pre-natal Testing and Non-Invasive Pre-natal Diagnostic service implemented • The trust is a lead partner in the successful Genomics England bid • Haemophilia team recipients of NIHR award for commercial trial activity

Neurosciences	
The division provides services to children with conditions of the brain or eyes. The division also includes the General Paediatric team, the Clinical Site Practitioners, corporate outpatients and Bed Managers who provide pan-hospital support. In 2015, the division expanded further with the centralisation of all psychology and play services into the Neurosciences division	
2014/15 highlights – quality and safety	2014/15 highlights – effectiveness and activity
• Child and Adolescent Psychiatry received an Excellent rating for a recent QNIC review • The psychology services won an NHS England bid to create patient centred outcomes • A consultant won the BMJ Patient Safety Award for 2014 for the project on: Junior Doctor Led and Owned Patient Safety– Medication Error Reduction in an acute tertiary neurosciences ward • Koala ward has achieved among some of the best scores for the Friends and Family test across England, regularly scoring above 90 and most families being extremely likely to recommend the service.	• The CESS service has commenced SEGS, with two procedures performed to date. • Home telemetry was implemented in Feb 2015. This has the advantage of releasing bed capacity, improved patient experience and more accurate recording of seizure patterns • March 2015 saw the introduction of a new Clinical Nurse Specialist post for Batten Disease, the first across the UK. The post is hosted by GOSH and funded by the Batten Disease Family Association for a three year period. • A VR service was commenced with the appointment of 2 paediatric vitreoretinal surgeons. GOSH is now one of only two centres in the world with expertise in

• The project work delivering nerve centre across the hospital has been clinically led by a CSP and will improve early warnings for deteriorating patients. • GOSH Visual Electrophysiology Unit's participated in a National Audit of International Standard Tests of Retinal function. This UK wide project was directed by BriSCEV the professional group for visual electrophysiology in the UK and ensures our young patients with retinal disease diagnosed at GOSH transition to adult services with transferable physiological information that can be replicated at major adult units in the UK.	novel endoscopic vitrectomy in complex paediatric retinal detachments • GOSH became a UK centre for surgery in retinopathy of prematurity, with new collaboration with Oxford University Hospitals NHS Trust (John Racliffe & Oxford Eye) • The ophthalmology department employed a dispensing optician that has improved the patient pathway for children requiring complex dispensed glasses. These include patients with craniofacial abnormalities and young infants with high prescriptions.

<table>
<tr><th colspan="2">Surgery</th></tr>
<tr><td colspan="2">The Division provides nine highly specialised surgical services: Cleft, Craniofacial, Maxillofacial, ENT, Plastic Surgery, Orthopaedics, Spines, Urology and SNAPS. It also provides specialist audiological and dental services on a mainly outpatient basis. It manages the anaesthetics department and runs 11 operating theatres and 12 procedures rooms for the Trust. In 2015 it opened a new anaesthetic pre-operative assessment service.</td></tr>
<tr><td>2014/15 highlights – quality and safety</td><td>2014/15 highlights – effectiveness and activity</td></tr>
<tr><td>• The division established a new Anaesthetic Pre-Operative Assessment service which opened in January 2015. All surgical patients will be screened through this service prior to general anaesthetic.
• Work was undertaken with the staff on Squirrel Ward to support and enhance leadership and team working so that it runs more effectively for the benefit of patients. The new leadership structure has been very effective in underpinning this work and making the ward a positive environment.
• Puffin Ward, the same day admission</td><td>• Woodpecker daycare ward was able to increase from 8 to 10 beds within existing staffing structure and so support an increase in daycase work.
• The Division has consolidated its inpatient beds and reduced the overall number to 56. We have maintained our activity levels with reduced staffing costs.
• Developed an electronic admission planner which standardised and streamlined the admission booking processes across the division and helps bed planning through SDAU and the wards.</td></tr>
</table>

unit, has had a very successful first year. Throughput has increase whilst maintaining a high quality patient experience. The team have introduced personalised fasting plans to reduce the length of time patients are without fluids. Puffin ward has been recognised for its outstanding work for patients with learning disabilities by Keele University • The General Surgery Team have adopted the new electronic discharge summary and have maintained an improvement in the timeliness of discharge summaries.	

Critical Care and Cardiorespiratory.	
Critical Care and Cardiorespiratory continue to grow with more beds open and more patients treated than ever before, making us one of the largest Units in Europe. Our aim is to achieve the best outcomes possible at lowest cost, to have satisfied families, training and work centre of choice and the leading research centre in our field of expertise.	
2014/15 highlights – quality and safety	2014/15 highlights – effectiveness and activity
• Implanted the first Heartware device on a child waiting for a heart transplant allowing the child to be discharged home on the device. • Established an early warning sign home monitoring service for babies born with single ventricles • Developed a programme called Future Search that involved all of Critical Care and their interface with the rest of the hospital. Four future workstreams were developed from the days – Culture and Values, Leadership, Patient Flow and Education • Transition of cardiology imaging on to a Vendor Neutral Archive (VNA) meaning images can be reviewed on any machine or anywhere in the hospital. • Introduced a Non-invasive ventilation (NIV)pathway to ensure the consistency	• The Sleep Unit opened an additional cubicle and started to run a seven day a week service. • Established rapid access clinics for cardiology - allowing urgent patients to be seen more quickly • Introduced Patient at a Glance (PSAG), which are electronic boards displaying patient information aimed at improving flow out of the ICUs • Junior Doctors have developed pathways to reduce unnecessary pathology ordering. • CATS introduced a third retrieval team over the winter months to ensure more children were transported during the winter surge period.

and safety of the 270 patients currently on home NIV.	

International and Private Patients	
The division provides the majority of GOSH clinical services on a private basis through its two inpatient wards and outpatient facilities. Patients come from over 80 countries.	
2014/15 highlights – quality and safety	2014/15 highlights – effectiveness and activity
• 'Nervecentre' was introduced to both IPP wards. The system enables staff to electronically record observations therefore removing the paper observation charts. The system allows improved escalation and aids communication of the deteriorating child or those with elevated CEWS in real time. • The division received recognition of staffing quality by being the proud recipients of GOSH annual staff awards "Team of the Year", "Medical Registrar of the Year" and "Consultant of the Year for Pastoral Care" • Additional late evening 'Safety huddles' were introduced to improve the communication between the doctors and nurses. This is a five-minute meeting to discuss patient progress and treatment and ensure the sickest patient is identified. IPPD featured as a beacon area for safety huddles relating to the SAFE project. • The division has worked in partnership with School of Oriental and African Studies (SOAS) to develop a one day Arabic cultural awareness programme. The trial received excellent staff feedback and future study days are now being rolled out Trust wide, as well as external to the Trust, through collaborative working between the Education and Training department and the division.	• The division continued to improve nurse recruitment. As a result the need for bank staff reduced by over a third. Nurse retention has also been a focus and the division has developed a staff satisfaction and wellbeing strategy. One element is all new nursing recruits are encouraged to complete a survey at three, six and twelve months post start date from which an action plan is developed and monitored. It will be rolled out to all staff groups in the division. • The division has received recognition for middle grade doctor posts from the Royal College of Paediatrics and Child Health. This also includes experienced Paediatricians from overseas who are on the Medical Training Initiative in Paediatrics programme. • Ward rounds have been reviewed and a standardised LEAN approach introduced which improves efficiency, safety and ultimately clinical outcomes and experience. • The Arabic interpreting service in the division is now delivering a 7 day service. There is greater clarity on role boundaries, standardised practices, line management and supervision and training.

Productivity and Efficiency

For 2014/15 the Trust successfully delivered £11.6 million against a productivity and efficiency target of £14.8m, which equates to 78%. Whilst not the delivering the full amount, the Trust is pleased with the progress made by staff during the year. A number of projects and schemes that took effect in 2014/15, have a beneficial recurrent impact for the Trust for the future. Examples include:

- **Increased productivity in PICU**
  Paediatric Intensive Care Unit (PICU) opened two extra beds on the unit in 2014/15. This has resulted in reducing the number of cancelled operations and refusals into the hospital, and as such resulting in treating more patients needing our services and providing a better patient experience.

- **Reduction in use of General Anaesthetic (GA) for Computed Tomography (CT)**
  Based on the implementation of new equipment and techniques for the delivery of CT without the need for GA has resulted in reducing risks associated with the use of GA, more convenient for the patient (as they no longer need to fast beforehand) and shorter recovery times enabling patients to leave on the same day.

  Additionally as a consequence of these changes this has enabled the service to be more flexible in the way it delivers its GA and non-GA sessions. These procedures have reduced the need demand for beds and family accommodation for overnight stays.

- **Review of key clinical products**
  This project focused on seeking expert advice in regard to the most clinically appropriate products to be using in certain settings (e.g. Haematology). In reviewing and implementing this change has represented significant quality improvement, in providing a more consistent and reliable product.

- **Unit wide Junior Doctor Workforce Planning, Surgery**
  This involved introducing better management and control of recruitment to reduce money spend on expensive agency doctors to cover gaps in service. In co-ordinating recruitment of junior doctors across the division (10 specialties), ensuring rotas were appropriately planned and managed, and monitor monthly spend on junior doctor agency, resulted in reduction in spend in this area during 2014/15. Additionally, there were benefits in terms of increasing the substantive members of junior doctors and therefore providing a higher level of continuity for patients.

2015/16 Summary

Building on this agenda into 20015/16, and in line with the Trust's Strategic Plan and Productivity & Efficiency (P&E) strategy, for 2015/16 there will be a £12m cost reduction requirement (which is 4.5% of influenceable spend).

The programme is being carried out under the following categories:

- Local projects - Individual departmental projects identified by clinical divisions and corporate departments

- Workstreams - These are organisational wide workstreams that ensure there is a consistent approach to large scale projects to P&E across the Trust. These include:
  - Outpatients

- Procurement / Non-Pay
- Workforce

Quality Assurance

In order to ensure that such cost reduction P&E schemes (over £10k), do not adversely impact on patient safety and quality, a Quality Impact Assessment (QIA) needs to be completed within the project mandate form by the Project Lead, and signed off by their respective Divisional Director and either the Chief Nurse or Medical Director.

Risks against various criteria (Clinical Effectiveness, Patient Safety, Patient Experience, Staff Experience, Targets/ Performance) can be indicated, as well as mitigation actions being identified within the QIA for such P&E cost-reduction schemes.

Additionally, on a quarterly basis, samples of P&E schemes(above £100k) are reviewed by the Clinical Governance Committee, ensuring such schemes have no adverse impact on quality and safety, and this is reported to the Trust 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 a Sustainability Action Plan to guide our activities in becoming a more sustainable organisation.

Our Sustainability Plan was created following a consultation process we held with our staff. Over 150 individuals and groups were engaged through a range of in-depth interviews, focus groups and surveys.

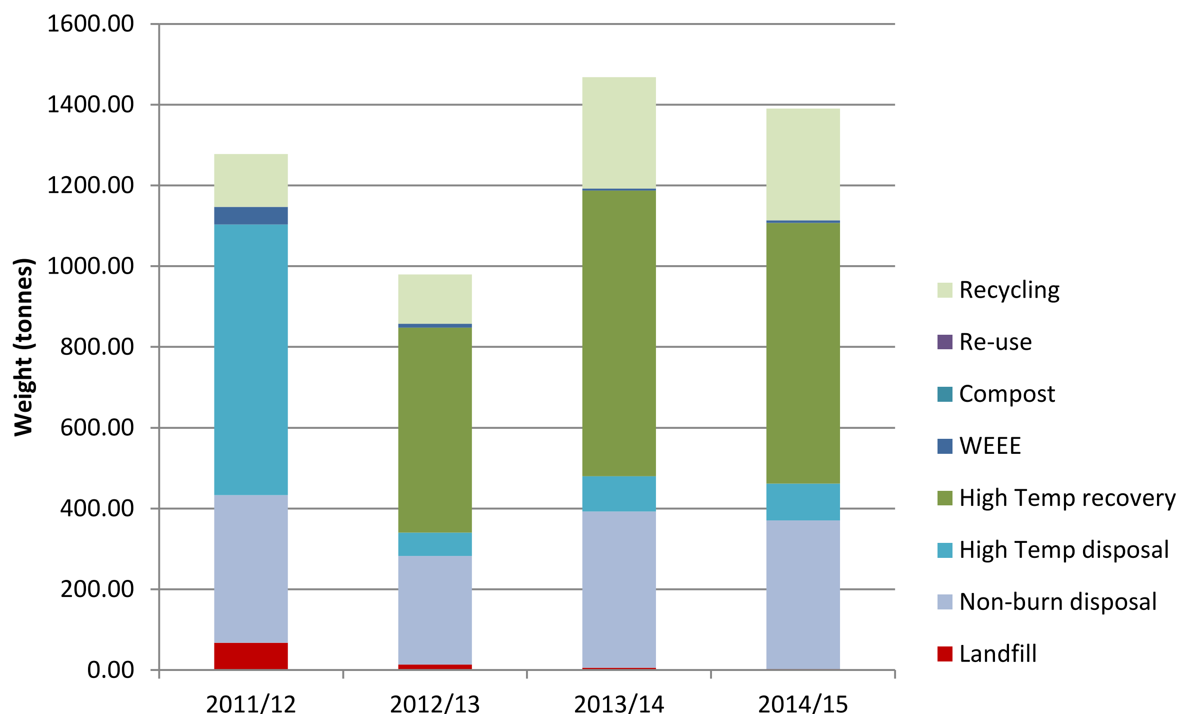
Following this consultation we have developed a much better idea about what sustainability means for our staff and visitors and this led us to develop three strands of activity to pursue:

1. Being more efficient with resources
2. Improving patient care through sustainable actions
3. Advocating on health and sustainability

Waste

Waste volumes across the trust have shown a slight decrease in comparison to the previous year. Recycling is increasing across the trust, although due to operational challenges this has not been facilitated as quickly as planned. Waste to landfill is continuing to decrease and the trust is on course to achieve its zero waste to landfill target. Through the management of the service and negotiation with suppliers there has been a reduction in the cost of some waste disposal services, and no additional increases in the cost per tonne of waste streams disposed during 2014.

In November 2014 Great Ormond Street Hospital commissioned a behaviour change organisation to undertake a comprehensive site audit of waste practices, compliance and segregation. The trust will focus on improving the correct segregation of waste; moving forward and to support this objective it is planned to introduce a behaviour change programme in 2015.



	2011/12	2012/13	2013/14	2014/15
High Temperature Disposal Waste with Energy Recovery	0	507	708	645
High Temperature Disposal Waste	670	58	87	91

Non Burn Treatment Disposal Waste	365	269	387	368
Landfill disposal waste	68	14	6	3
Waste Electrical and Electronic Equipment (WEEE)	44	10	5	6
Preparing for re-use	0	0	0	0
Composted	0	0	0	0
Waste Recycling	1,131	122	275	277

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.

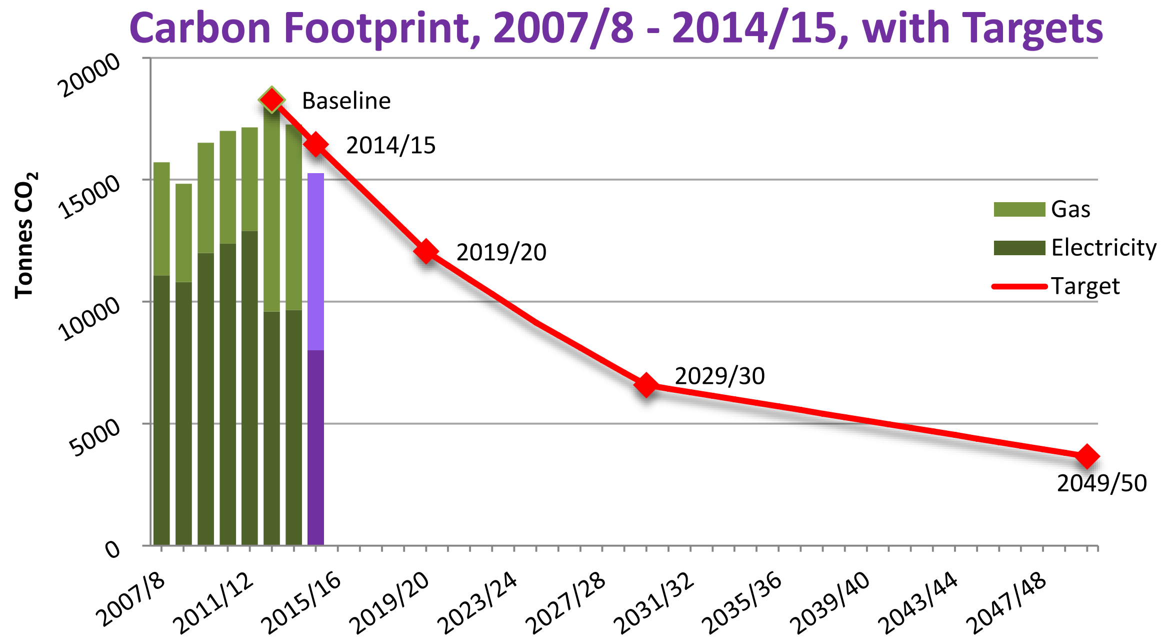
We have become one of the most open and transparent Trust's when it comes to showing how much energy we use, how much it costs and the associated carbon footprint. This information is now publicly available via the Trust's website or by going to www.carbonculture.net/gosh

GOSH employees Isobel and Brian collecting our awards at the NHS Sustainability Awards 2015

This year we have made great progress in making our systems work as efficiently as possible. This has been recognised as we won the **Energy & Carbon Management Award** at the NHS Sustainability Awards 2015.

Our success in the past year is best demonstrated by the amount of gas that we have used for our heating systems as we used 30% less gas than the previous year without compromising the comfort of our patients and staff. This has been achieved by working with our suppliers to improve the control system for our boilers. We have also focused on optimising our Energy Centre and have managed to improve our Combined Cooling, Heating and Power generator's annual electrical output by 15% and utilised heat output by over 100%. The CCHP has saved the Trust over half a million pounds this year.

As the table and graph below show, the Trust has reduced its total energy consumption by **18%** and our Carbon Footprint by **12%** compared to 2013/14. This means we have comfortably hit our first Carbon Reduction Target as shown in **Table X**.



Energy Indicators		2010/11	2011/12	2012/13	2013/14	2014/15	Target
Energy Consumption (million kWh)	Electricity	22808	23721	17739	17847	14700	-
	Gas	24972	22520	47443	41430	39443	-
	Fuel Oil			0.397	0.127	0	-
Energy Intensity (kWh/m^2)	Energy per m^2			703	687	595	562.4 by 2015/16
Emissions (tCO_2e)	Total gross emissions	17007	17141	18282	17262	15254	16454 by 2014/15
	Emissions per m^2	0.22	0.20	0.18	0.17	0.17	-
Expenditure (£)	Total Cost	2,640,000	2,788,570	3,106,049	3,360,678	2,952,472	-

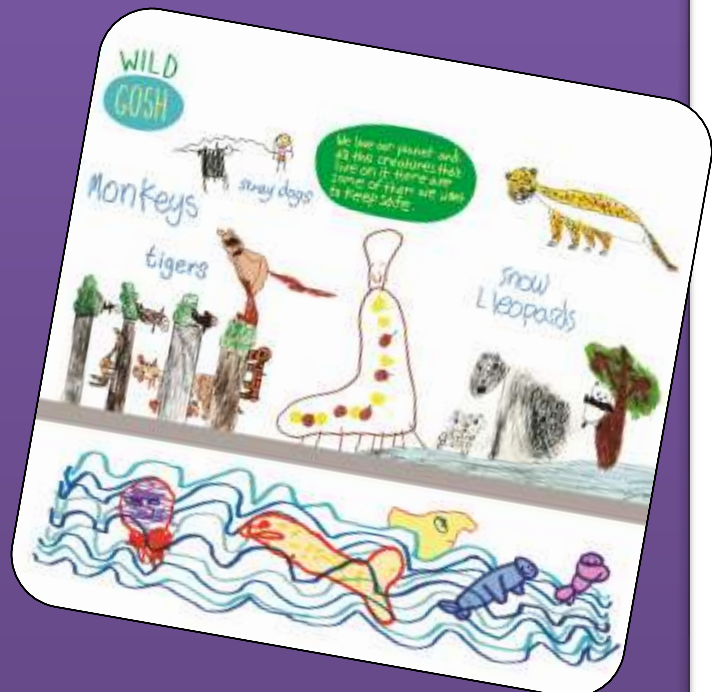
Case Study

Sustainability through the eyes of our patients

The sustainability team at Great Ormond Street Hospital teamed up with our arts programme, GO Create! and Camden's House of Illustration to create a sustainability-themed artwork by engaging with our patients and visitors.

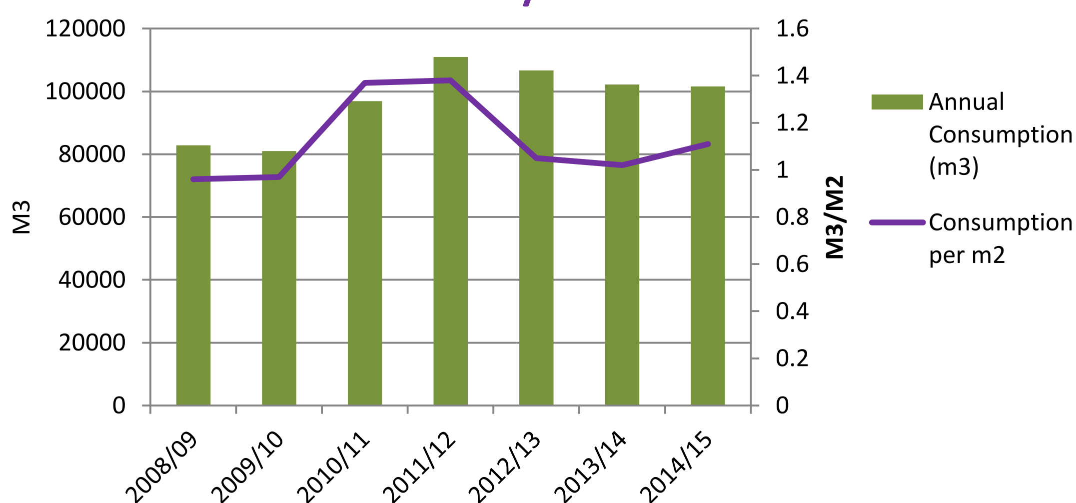
The theme of 'Building a Sustainable Hospital' was explored in workshops with patients throughout the hospital. These gave us an opportunity to educate young people about sustainability but also took a 'blue sky thinking' approach, firing their imaginations and inspiring them to get excited about what could be possible, now and in the future. Our patients were challenged to think creatively about topics including 'spaceship earth', 'one planet living' and telehealth technologies such as remote monitoring and creating a 'virtual GOSH'.

A montage of the children's ideas has been created that tells their story of 'Building a Sustainable Hospital'. The installation is positioned for maximum thoroughfare for both staff and visitors being directly outside the Trust's restaurant. The sustainability story will inspire all the staff and visitors who pass by it. This will bring to life the importance of sustainability and demonstrate the Trust's commitment to becoming a more sustainable organisation.



Water

We have continued with our partnership with ADSM and have benefited from their expertise in water management and bill verification services. This past year ADSM have moved GOSH onto cheaper tariffs and installed urinal sensors across the trust. As a result, water consumption has reduced for the third year running. Water consumption reduced slightly in 2014/15, which is a **8.5%** reduction from the peak in 2011/12. Our consumption per m2 has increased slightly from last year, though this has also been reduced by **20%** since 2011/12,



Indicators		2010/11	2011/12	2012/13	2013/14	2014/15	Target
Total Water Consumption	m^3	96,901	110,953	106,657	102,217	101,550	96,514 by 2015/16
Water Intensity (against estate size)	m^3/m^2	1.37	1.38	1.05	1.02	1.11	-
Expenditure	£	162,440	143,477	185,227	199,642	236,173	-

Plans for 2015/16

There is a lot of work planned for 2015/16 to build on the progress made this year. We have behaviour change campaigns being rolled out for energy use and waste disposal. For both of these projects we are using the expertise of Global Action Plan and Sust-N who are experts in energy and waste management respectively.

We have invested over £120,000 on new LED lights which will be installed in early 2105/16 and we are looking at the possibility of a Solar Photovoltaic system. Finally, the second CCHP generator planned for installation in the 3rd Quarter of 2015/16.

Governance and Monitoring

The Sustainable Development Management Plan is monitored and managed through the Trust's Sustainable Development Committee.

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

Emergency planning

The Civil Contingencies Act 2004 identifies the organisation as a Category One responder which compels the need for robust Emergency Preparedness and Business Continuity plans. All staff need to be aware of their role and responsibilities during a significant incident or emergency.

During December 2014 the Trust tested its procedures to a power failure. The aim of the exercise was to manage the transition from mains supply electricity to a generator back up system.

In February 2015, awareness training followed by a table-top exercise was organised to test the response to a prolonged Heatwave. A 'Live' exercise was completed in March to test the procedures for a full lockdown of the main site.

The membership of the Major Incident Planning Group was revised. The group continue to capture the learning from incidents and exercises and agree future steps. The action plan for 2015/16 focus on the revision of business continuity plans for all services and arrange additional 'Live' exercises to test emergency preparedness procedures.

The appointment of a full time Emergency Planning Officer has ensured the requirements for Emergency Preparedness are maintained.

Delivering value in 2014/15

All of 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. We strive to do this by delivering harm free care for every patient, every time, everywhere.

Quality and Safety at Great Ormond Street Hospital

Since 2013 GOSH has identified 12 standards against which the Trust will continually improve. In 2014 these standards were incorporated into our improvement plan for the Sign Up for Safety programme, a national initiative supported by NHS England which aims to reduce avoidable harm to patients by 50% and in doing so contribute to saving 6,000 lives nationally over the next three years. The programme champions openness and honesty and supports everyone to improve the safety of patients.

GOSH has explicitly committed to:

- Placing safety at the forefront of the strategic objectives
- Continually learning from the Trust's experience of what works well and when things go wrong
- Being transparent about safety outcomes
- Sharing experience locally and nationally
- Being open with patients and to support staff in cases where incidents occur

The Trust recognises that Quality and Safety are imperatives, even during times of financial constraint. At performance reviews, via trust wide dashboards and at divisional and executive meetings, quality and safety issues are under constant scrutiny and will remain so. Each Clinical Division is required to achieve the quality standards with improvement initiatives focusing on those areas identified as a priority by local needs assessments and responses to clinical incidents.

Transformation and improvement

Pan-Trust Quality Improvement initiatives are supported by a dedicated team of Quality Improvement experts and analysts whose priorities focus on removing waste, waits and achieving zero harm. This work is governed by a recently established Quality Improvement Committee who has delegated authority from the Executive Management Team to provide assurance that all quality improvement work;

i. aligns to the Trusts strategic direction and supports achievement of the Trusts Quality Strategy
ii. actively involves patients and families
iii. is appropriately prioritised and resourced
iv. drives, challenges and supports continuous improvement
v. is successfully implemented and spread
vi. supports achievement of the deliverables declared in the Quality Account

The Quality Improvement Team empower and enable frontline teams to continuously improve using a systematic approach: The Model for Improvement (Association of Process Improvement, 2012).

Over the past year the Quality Improvement Team has been supporting the following projects:

1. Improving Discharge Summaries

The aim of this project is to reduce the time between a patient leaving the hospital and a good quality discharge summary being sent. This project was reported in last year's Quality Report at which time huge improvements had been achieved in Rheumatology with the turnaround time for discharge summaries reducing from 1.6 to 0.8 days. The electronic system and improved processes have now been implemented across the entire ICI-LM Division and is now being spread to Cardio-Respiratory and Critical Care; Surgery; and Neurosciences Divisions. Currently, 25% of all discharge summaries are being generated using the new electronic system. We predict that the quality of discharge summaries and turnaround times will improve for all patients when the project is spread hospital wide by July 2015.

2. Improving flow through the Intensive Care Units

The development and implementation of an electronic Patient Status at a Glance whiteboard last year was just the beginning of the improvement journey on the intensive care units at GOSH. Since then there have been a number of changes to systems and processes which have helped to improve communication between clinical teams; to aid decision making; and to ensure the best allocation of resources to patients. Most recently, an electronic ITU bed booking form has been developed to help smooth the demand for elective admissions and reduce the number of beds reserved for patients who did not need them. This will help to ensure that intensive care beds are available for the right patients, at the right time.

3. Improving the patient pathway through Interventional Radiology

This project aims to reduce the number of patients who are booked to have a procedure under general anaesthetic in the interventional radiology department, but are cancelled on the day. Whilst some patients may become too clinically unwell to have their procedure, many more patients are being cancelled due to lack of preparation or poor communication. Our commitment is to reduce the number of occasions a patient is cancelled due to avoidable reasons and believe this can be reduced from twelve to 4 patients per week. We have discovered that the cause of most avoidable cancellations originates outside of the interventional radiology departments. The project teams are therefore working with the wards to help them to ensure patients are prepared and assessed well in advance of them coming for their procedure.

4. Reducing waiting times for medication dispensary in pharmacy outpatients

This project was introduced in last year's quality report at which time a project team was established to diagnose and understand pharmacy processes and to identify areas where improvement efforts should be focussed. This led to the development of a system which tracks the prescription through the dispensary and displays progress to the patient via an electronic

whiteboard. The system automatically generates a text message to let the patient know when their medication is ready for collection, thus improving the patient experience.

5. Situation awareness for everyone (SAFE)

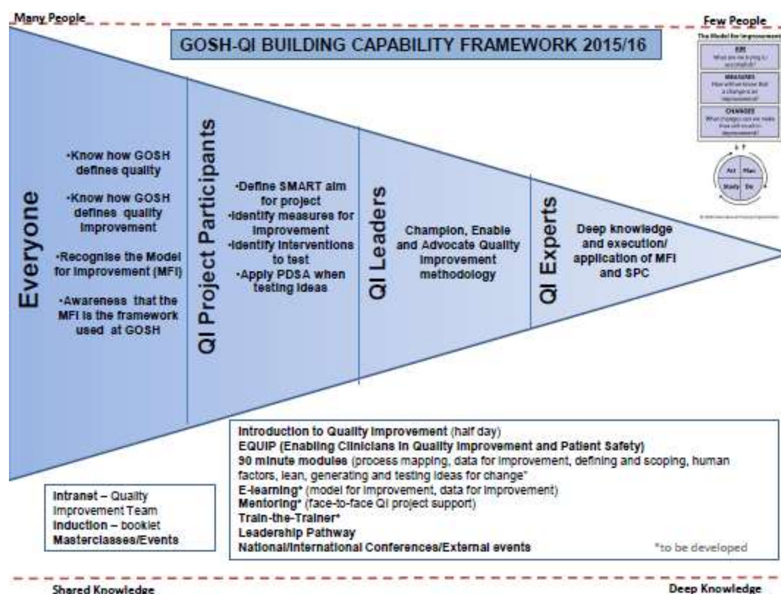
The aim of SAFE is to reduce avoidable harm to patients on inpatient wards by improving the identification, escalation and care planning of patients at risk of deterioration through the implementation of "huddles". Huddles are short briefings designed to give frontline staff and bedside caregivers opportunities to stay informed, review events, make and share plans for ensuring co-ordinated patient care.

Huddles have been successfully implemented in two of our inpatient areas and are due to be spread to other wards over the next year.

In addition to these projects, more improvement work is being done locally within the divisions, supported by staff trained in improvement methodology.

Sir Bruce Keogh acknowledged in his review of hospital trusts that leaders need "*to be confident and competent in using data for the forensic pursuit of quality improvement*". In August 2013, The Berwick Report highlighted the importance of leadership as well as training and capacity building as key areas of focus for NHS organisations. It emphasised the need for an "agenda of capability-building in order to deliver continuous improvement."

The following diagram shows the GOSH Quality Improvement Capability Framework for 2015/16. This demonstrates our commitment to training staff in quality improvement and also how we intend to execute the plan.



Going forward, the Quality Improvement Team will work with frontline staff across the organisation to achieve No Waste; No Waits; Zero Harm with new projects starting up in pursuit of standardising clinical care; removing waste from procurement processes and outpatients, improving surgical bed booking processes and helping the Trust to increasingly deliver Consultant led care 24/7.

Safeguarding Children

Safeguarding and promoting the welfare of our patients is everyone's responsibility and remains a priority for GOSH.

There were 2535 referrals made to the Social Work service in 2014/15. This is an increase of (24.6%) from 2013/14. Of these referrals 290 (11.4%) were related to child protection (CP) concerns. This is an increase on last year's CP referrals by (17.8%).

This growth can be accounted for by the recent improvements implemented in the data activity collection system, as well as an actual increase in referrals and complexity of cases (including child protection) being referred to the team.

GOSH provides assurance to our commissioners for safeguarding on training, supervision and staff participation in child protection conferences.

Staff are trained to the relevant competency level, which consistently exceeds the requirements of our external commissioners of 80% (see page ?? on mandatory training).In addition, themed days on national issues such as Child Sexual Exploitation and Female Genital Mutilation have been organised.

Safeguarding newsletters are distributed to the workforce twice per year and the web-based resources support staff to remain updated with current national policy research and guidance.

Supportive supervision in safeguarding is available to all staff in GOSH and is repeatedly highlighted as good practice in Serious Case Reviews.

A 'drop in' clinic for staff has been recently established by the Safeguarding Team to enable staff to discuss any concerns and promote good practice.

Increasingly GOSH uses video and tele-conferencing facilities to ensure that professionals can contribute effectively to child protection conferences across the country, minimising disruption to their clinical workload. Otherwise a written report is provided for the multi-agency network.

In 2014/15

The Trust has maintained external regulatory/contractual standards and contributed to eight Serious Case Reviews (SCR) and 3 non SCR reviews involving 14 children. These have been conducted in line with the statutory guidance, which requires proportionate reviews of cases where children have suffered serious injuries or died through maltreatment or neglect.

The Trust has a robust audit program in place to assure itself and its' commissioners that safeguarding systems and processes are working.

Priorities in 2015/16

The Trust will continue to develop an effective child-centred and coordinated approach to safeguarding our children and young people within the Trust. The Trust plans to further increase uptake of

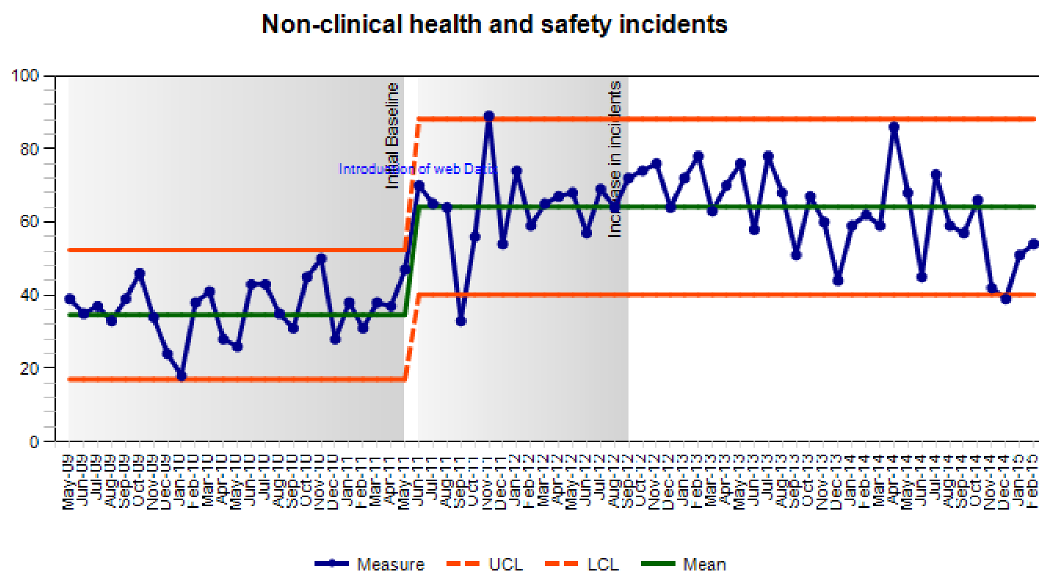
supervision for staff as well as increase professional awareness of the Government's Prevent Strategy to identify those vulnerable young people at risk of radicalisation.

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.

GOSH employees reported 826 health and safety incidents in 2014/15. These included 126 patient safety incidents. The number of health and safety incidents involving patients has risen slightly and increased as a proportion of the overall number of health and safety incidents

Non-clinical health and safety incidents



There was one serious health and safety incident reported during the year. In conjunction with the incident reporting system the Trust uses proactive means of identifying and subsequently mitigating risks. These include auditing the entire Trust using a tool which monitors compliance against statutory regulations and measures performance against any safety critical alerts or Trust/paediatric specific criteria. The governance structure ensures that any statutory compliance is undertaken within stated legislative guidelines.

The Trust has a multimillion pound building/redevelopment program underway which brings with it inherent problems especially when juxtaposed with the clinical environment. There are measures in place which put additional controls on the construction work and ensures this work fits around the delivery of the clinical care rather than vice versa.

Supporting and developing our staff

Staff who are trained, supported and valued are more likely to live Our Always Values and deliver the best possible care to patients and families.

Recruitment and retention (including recruitment of qualified nursing staff)

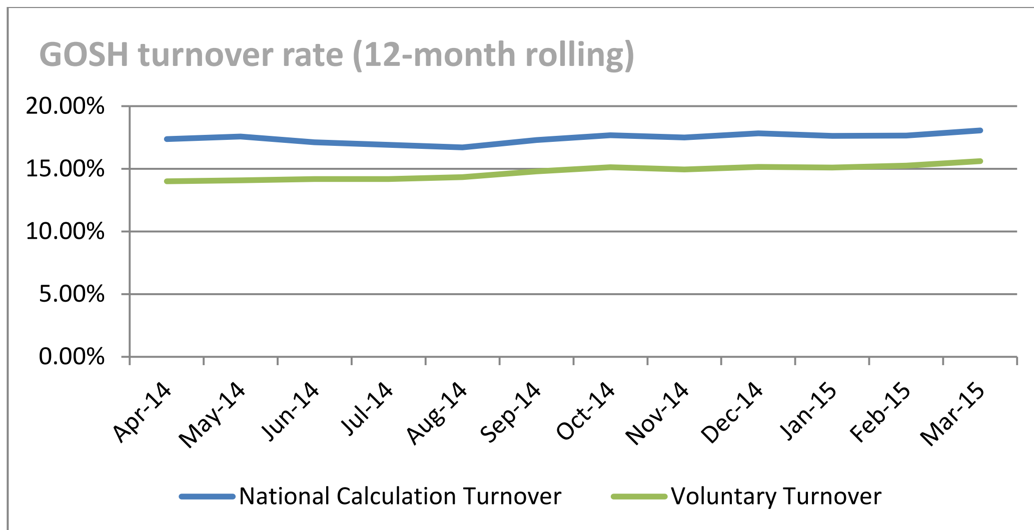
Recruiting and retaining high-calibre staff has continued to be an important feature of our work in 2014/15. We identified that Band 5 and 6 nurses are consistently among our hardest to recruit and retain posts. Therefore, we have recruited highly selectively from universities and overseas, as well as through our normal recruitment mechanisms.

The Trust has continued to closely monitor its turnover and vacancy rates. We recognise that GOSH has a large number of staff on fixed-term contracts, in particular but not only due to our extensive research activities and associated roles; however, we have worked hard to address this during 2014/15 to ensure that these are used in the right circumstances.

In 2014/15, we introduced a new report that indicates both the national calculation for turnover but also indicates the figure adjusted for non-voluntary leavers so that we can identify more accurately what is driving our turnover and take appropriate actions. This information is reported monthly to the Trust Board.

Newly qualified staff form a substantial core of the ward workforce and we continue to work with London South Bank University in this regard. We devised a clear plan for 2014/15 which included several promotional events and job fairs in the UK, and held a successful recruitment open day.

We continue to adopt an assessment centre approach to ensure high quality recruits for many roles and improve the reliability and validity of appointments made.



Temporary staffing

GOSH has continued to take concerted action in 2014/15 to manage its overall temporary staffing costs by displacing costly agency staff and replacing them with staff employed directly by the hospital on our in-house staff bank.

Bank spend, and consequently overall temporary spend has increased slightly in 2014/15 when compared to 2013/14. This has been driven by increase in demand for some services, and additional projects across the organisation such as the EDMS.

During 2014/15, the Trusts Executive approved a recommendation to slightly decrease the maximum number of hours a bank worker can work per week from 37.5 hrs to 35 hrs per week for admin, and from 39 to 37.5 for ancillary workers. This supported a planned cost reduction, but also provided an opportunity for our management teams to review the usage of bank workers generally.

The Trust implemented an e-bank system in Q4 of 2014/15 which allows improved analysis of demand; improved governance through electronic timesheets and improvements in the accuracy of the data.

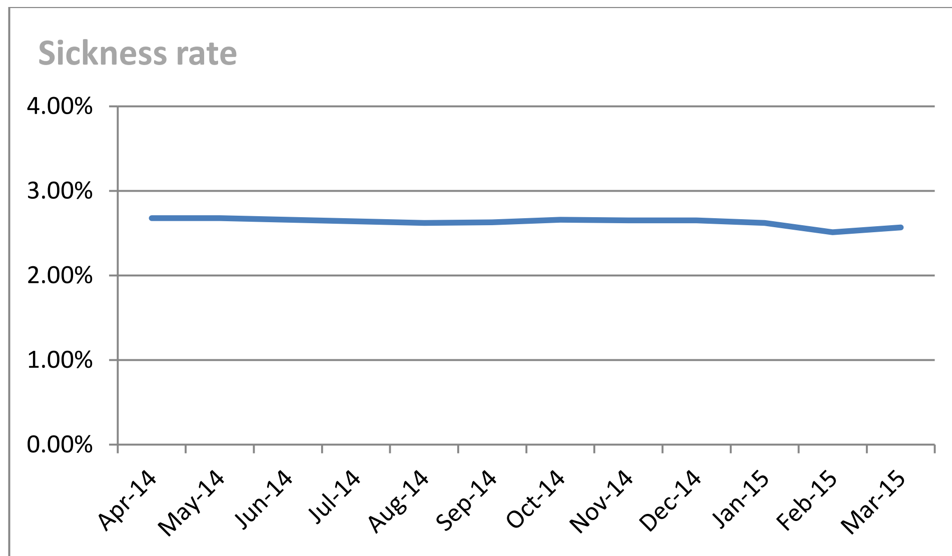
Within this overall picture, nursing shifts continue to be filled predominantly by bank staff (via our Nurse Bank Partners), allowing us greater control of cost and quality.

Sickness absenteeism

Our sickness absence rates continue to be among the lowest of all NHS organisations in the country.

In 2014/15, we reviewed our policy on this matter to ensure it remained both supportive, yet robust in the management of both short term and long term absence.

Our human resources team continue to provide training for managers on this subject (and others) to ensure that absence is managed well across the organisation.



Helping our staff keep fit and healthy

Helping our staff maintain their physical and mental health is critical in ensuring they can deliver the best care to children, families and carers. We promote a range of services to help them in different ways. During 2014/15:

- Our expert on site Occupational Health team held 6,136 appointments including vaccination screening and updates, health surveillance, and sickness absence advice. We undertook 2,546 pre-placement assessments to assess fitness for role, seeing an increase of 61% in this kind of work compared to the same period last year as we set the same standards of fitness for our growing temporary staffing bank as for our substantive workforce. Over the next 12 months we will modernise our OH systems and processes so that we can work more efficiently and spend more time helping managers and staff to recognise and address health problems early.

- Our award winning on site staff physiotherapy service saw over 300 staff. This service is free to our staff as we believe fast and pro-active interventions for musculoskeletal disorders significantly reduce the costs of staff taking time off work.

- Our free and confidential 24 hour staff counselling and advice service was contacted by 174 staff. Depending on their needs, they received telephone counselling, face-to-face counselling or help from CAB-trained advisors.

- Over 500 members of staff attended events organised by our sports and social committee. Activities ranged from dance classes to membership of our running club to guided walks to social events, in order to appeal to as many different staff as possible.

Equality and Diversity

One of the principles of Our Always Values is consistency –Welcoming, Helpful, Expert and One Team should apply to all of our people, all of the time. Our work on staff equality and diversity recognises that different groups may have a different experience of GOSH as an employer, and tries to address this. During 2014/15, our HR teams have run well received sessions for our GROW network (a group which supports black and ethnic minority staff in particular) on making successful job applications, interviews and what to do if you feel you are being treated unfairly at work.

Our comprehensive annual report on equality data, published in January 2015, supports us in meeting the requirements of the NHS's new Workforce Race Equality Standard. This report reflects our view that transparency and honesty are the starting points for making real and lasting change. We have maintained our commitment to engage on difficult subjects by running sessions for line managers on unconscious bias, and how it affects our actions and decisions. In 2015/16, we will consult on and agree new objectives to help us ensure the behaviours of Our Always Values are demonstrated and experienced by all our staff.

Control measures are in place to ensure that the Trust's obligations under equality, diversity and human rights legislation are complied with. Equality Impact Assessments are carried out on policies and procedures, and are audited on an annual basis. In addition, the Trust monitors key data on issues such as equality and diversity in recruitment and disciplinary activity. It conducts and annual review of all its activity on equality and diversity for patients, families and staff, which includes analysing data and reporting omits progress against objectives to the Trust Board. Making sure our patients, families and staff are safe and they are treated with dignity, respect and fairness is at the heart of Our Always Values and we will monitor our progress formally through surveys and other measures.

Policies in relation to disabled staff. Policies 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 Job Centre 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.

Gender reporting

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

	Female		**Male**	
Group	**Headcount**	**%**	**Headcount**	**%**
Director	**8**	**53.3%**	**7**	**46.7%**
Senior manager	**14**	**63.6%**	**8**	**36.4%**
Employees	**3113**	**77.9%**	**884**	**22.1%**
Grand total	**3135**	**77.7%**	**899**	**22.3%**

Engaging and listening to staff

We maintained our programme of Executive-led open briefings for staff, with the opportunity for staff to ask questions and share ideas and reflections on key issues for the hospital. We also launched a Trust brief, so that messages can be cascaded to all staff across the organisation. Our staff survey results tell us that although staff feel they can contribute very effectively to improvements in their work, they would like more opportunities for engaging with and influencing senior managers and this will be a feature of our work in embedding Our Always Values in the coming months.

Whistleblowing

The Trust is clear that it wishes to be transparent and open and, as such, actively encourages staff to raise concerns. While we would encourage staff to raise any concerns informally, we also have a clear policy (Raising Concerns in the Workplace) detailing how our staff can raise concerns under a formal framework, underpinned by the Protected Interest Disclosure Act 1998; this policy was both revised (to ensure it continued to meet statutory obligations) and audited (by our external auditors) in 2014 resulting in a favourable rating.

There are various other ways in which staff can raise concerns or issues in an open and supportive way, such as executive safety walkrounds; staff open meetings with the Chief Executive; senior staff meetings; Visible Nursing Leadership; an open door policy from the Executive team and periodic visits to clinical and non-clinical areas across the Trust; ad hoc visits by Non-Executive Directors to areas across the Trust and, via incident reporting.

Results of the 2014 staff survey revealed that 92 per cent of respondents stated that they would know how to report concerns; this is an increase of 5% from the 2013 survey (87%).

Additionally, quarterly reports are now provided to the Trusts audit committee which provide a summary of current cases.

Recognising and rewarding performance

Our GEMS awards – monthly awards for GOSH Exceptional Members of Staff – went from strength to strength in the last 12 months, with large numbers of nominations for individuals and teams across the hospital. As well as our clinical teams, we have seen winners who do vital work in less high profile areas such as biomedical engineering, ICT, blood bank. These staff demonstrate Our Always Values in practice.

Our annual staff awards ceremony in June has become a very popular fixture of the GOSH calendar, with hundreds of nominations from patients, families, carers and staff. Mr Neil Bulstrode, one of our plastic surgeons, won the Child and Family Award in 2014 and we heard very movingly from a number of patients that it is not simply what our staff do - from surgeon to receptionist - but *how* they do it that makes all the difference to them.

Photo

Annual Staff Survey

We maintained the significant improvement in our response rate to the annual survey in 2014, meaning we have firm foundation for actions. Our results showed little change compared to 2013, but identified two clear priorities for action:

	2013		2014		Trust improvement/deterioration
Response rate	GOSH	National average	GOSH	National average	
	62%	Above average	60%	Above average	2% deterioration

	2013		**2014**		**Trust Improvement/ Deterioration/No Change**
Top 5 Ranking Scores	**GOSH**	**National Average**	**GOSH**	**National Average**	
Percentage of staff agreeing that their role makes a difference to patients	93%	91%	95%	92%	No significant change *(highest score nationally)*
Percentage of staff receiving job-relevant training, learning	84%	80	85%	81%	No significant

or development in last 12 months					change
Staff motivation at work	3.88	3.91	3.97	3.90	No significant change
Percentage of staff reporting errors, near misses or incidents witnessed in last 12 months	93%	92	96%	92%	No significant change *(highest score nationally)*
Percentage of staff able to contribute towards improvements at work	74%	71%	75%	71%	No significant change

	2013		**2014**		**Trust Improvement/ Deterioration/ No Change**
Bottom 5 Ranking Scores	**GOSH**	**National Average**	**GOSH**	**National Average**	
Percentage of staff reporting good communication between senior management and staff	33%	35%	29%	37%	No significant change
Percentage of staff having equality and diversity training in last 12 months	64%	52%	54%	68%	Deterioration
Percentage of staff receiving health and safety training in last 12 months	69%	76%	63%	78%	No significant change
Percentage of staff witnessing potentially harmful errors, near misses, or incidents in last month	37%	29%	40%	29%	No significant change
Effective team working	3.76	3.80	3.76	3.83	No significant

	2013		2014		Trust Improvement/ Deterioration/ No Change
Bottom 5 Ranking Scores	**GOSH**	**National Average**	**GOSH**	**National Average**	
					change

We take seriously our commitment to statutory and mandatory training, which includes health and safety and equality and diversity. Our update training takes place every two years, in line with NHS guidance, and our data shows that, in February 2015, well over 80% of our staff had completed both these modules. Further information on mandatory training is detailed on page ??.

We believe our highly-skilled staff recognise errors and near misses when they witness them. Critically, the survey results consistently show that staff report these incidents, 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.

Our two critical areas for action in the coming months will be on improving good communication between senior management and staff, and team working. We will ask our staff what practical steps would make a difference to them, and work together to make improvements as part of our plans to embed Our Always Values right across the hospital.

Education and development

Education is critical to the work of the Trust. In 2014-15 more than 10,500 course places were filled across all centrally recorded learning. GOSH is the largest provider of pre-registration children's nursing education in the UK (offering 300-400 placements/year), and is a major provider of post-graduate medical education in paediatrics (250-300 trainees per year). The Trust supports trainees in healthcare science, therapies, dietetics and pharmacy. The organisation also has a track record of supporting non-clinical careers through the introduction of apprentices, competency frameworks and bespoke learning interventions.

Mandatory training

The Trust has continued to innovate to support staff maintain compliance – this year introducing an "Update Booklet" providing staff with a simple tool for confirming their understanding of mandatory topics. This - combined with Trust Induction, teaching and e-learning - provides a varied prospectus of training options.

In March 2015, compliance rates for core mandatory topics were:

- **Safeguarding Children** – consistently over 90% with level 1 at 96%; level 3 at 94%
- **Information Governance** – increase over year of 8% to 91%
- **Safeguarding Adults** – increase over year of 11% to 71%

- **Counter Fraud** – increase over year of 18% to 86%
- **Equality Diversity and Human Rights** – increase over year of 35% to 89%
- **Health Safety and Welfare** – increase over year of 17% to 87%
- **Infection Prevention and Control Level 1** – increase over year of 17% to 87%

Education Services work in partnership with all subject matter experts to formulate action plans for raising compliance. This work will be on-going throughout 2015-16.

Staff appraisal

The Trust launched its revised Performance Development Review (PDR) Appraisal paperwork in 2014/15 which was well received. This was underpinned by an updated PDR Appraisal policy, in line with the revised Agenda for Change terms and conditions. As at May 2015, PDR rates have increased to 84%, with 88% of staff survey respondents in 2014 stating they had been appraised in the last 12 months. More work is required on addressing concerns around the quality of the appraisal discussion with 45% of those respondents feeling they benefited from a well-structured appraisal. PDR Appraisal Training is being reviewed to address quality issues as part of the roll out of the new PDR process.

Medical education and nursing development

Post Graduate Medical Education continued to design and deliver innovative educational initiatives including “Clinical Leadership in Action”, “Courtroom Skills”, and Human Factors training. Funding was secured to develop “Crossing Boundaries” a simulation programme using serious gaming techniques addressing care fragmentation across the patient journey. The team also continued to support junior doctors in training and consultants to develop their educational supervision role.

External training reviews have identified areas of excellence in medical training at GOSH but also concerns in areas such as paediatric medical specialties. As a result, a large number of changes have been made to address some of these issues, and project plans developed for medium and longer term change.

Nursing development

In partnership with London South Bank University, we have implemented an accredited programme for Healthcare Assistants (HCAs) which provides the knowledge and skills to care for children and young people. The team were also commissioned by HENCEL to develop a pilot for the HCA Care Certificate, specific to staff caring for children and young people. This programme will commence in April 2015.

GOSH commissioned 468 modules on post-registration specialist nursing courses, in addition to supporting staff on a variety of Masters Programmes. A new work-based learning programme was introduced in 2014 to provide nursing staff across the Trust with specialist skills and knowledge to care for patients with high dependency needs. This supports the Trust’s improvement work regarding the deteriorating child.

Leadership development

The Trust’s “Leadership Pathway” offers a wide range of development opportunities supporting staff to access the right leadership support at every stage in their career. The Trust’s leadership development centre provides bespoke leadership support and helps identify leadership talent within Trust’.

Programmes are delivered using both traditional face-to-face sessions (including simulation and classroom based teaching) and online/blended learning solutions. We also support applications to attend courses run by the NHS Leadership Academy or other external partners.

Apprenticeships

Our apprenticeship scheme has continued to grow. Upon successful completion of their apprenticeship, apprentices are converted automatically into a substantive position in the Trust, enabling progression into full time employment. During the year, we have commissioned 27 apprenticeship places for existing staff and have had seven new apprentices start. Since the programme began in 2012, over 25 new apprentices have joined GOSH which is recognised as an exemplar Trust, having embedded the scheme across a variety of services.

Moving forward in 2015/16

The Trust's emerging education strategy sets out a clear vision of 'Education in All That We Do' supporting greater integration of education with the clinical, workforce and research strategies. The overarching goals for 15/16 are to ensure:

- GOSH is an excellent place to train and learn for students/trainees in all professions
- Education and development equips staff with the skills, knowledge, aptitudes and values they need to deliver world leading care
- GOSH is the provider of choice for specialist education programmes in paediatrics and child health, national & internationally
- GOSH's Education Service is financially sustainable.

Listening and learning from our patients, staff and stakeholders

GOSH seeks to provide the best possible services to patients and their families who come from diverse backgrounds and from all parts of the UK and abroad. Therefore, we need many ways to find out about and improve patient and family experience. We do this best by involving and engaging our patients, their families and members in shaping healthcare at GOSH that is appropriate to their needs and by making best use of the knowledge and skills of our staff.

Patient and Public involvement at GOSH

The Trust has continued to deliver year three of the patient experience plan continually improving the active involvement of patients and families in the development and improvement of GOSH care and services. We also focused on obtaining more real time patient experience feedback through the implementation of the friends and family test.

Over the summer and autumn of 2014 the Trust participated in the first Care Quality Commission (CQC) national inpatient postal survey for children's services facilitated by the Picker Institute. This survey will allow the Trust to compare patient and family satisfaction at GOSH with other children's services in England. A report of the results from the survey is awaited.

The Trust also commissioned leading Market Research Company, Ipsos Mori, to conduct a biannual independent t telephone survey of patients and their family's experience of our outpatient care. Top line results show that once again patient and family satisfaction remains very high at 95% (94% in 2012) with 95% likely to recommend the hospital to friends or family members (96% in 2012). Trust and confidence in staff in the outpatient department was very high at 97%. Cancellation and rearrangement of appointments remains a concern for patients, families and the hospital. However the Trust is pleased to note that there has been some improvement in this area with a 10% decrease in the number of patients/parents having to cancel their appointments (46% reduced from 56%) and a 6% improvement in GOSH staff having to cancel appointments (47% to 41%). The survey also showed that 61% of patients and families had to wait for their appointment with 20% of respondents waiting more than 30 minutes. An outpatient improvement group is already established and areas for improvement have been prioritised as part of the Trusts Quality Improvement programme.

Implementation of our values

In January 2014, we launched a major listening exercise to identify the values we should adopt. Over 1,400 staff and 1,200 patients, families and carers responded, giving us an overwhelming set of messages.

They told us the best things about their experience of GOSH…

And the worst

And similarly our children told us what they like…

And what they don’t

We also asked our staff for their experiences. This is how they would like to be described when they are at their best

From this feedback, we developed Our Always Values:

Always Welcoming

Always Helpful

Always Expert

Always One Team

A clear message from this exercise, and from much of the feedback we get from our patients, families and staff, is that we have fantastic staff and services, but we are not *all* excellent *all* of the time. Our Always Values sets us all the aspiration to live our values every day.

Because so many patients, families and staff contributed to the development of Our Always Values, and because it's their words that are reflected in the behaviours that underpin them, they have been embraced by staff. We formally launched the values in an event in March 2015, but wanted to make sure through a process of briefing and leadership sessions that they had already started to be incorporated into how we do things at GOSH before then.

Over the coming months, we will see all our staff regularly appraised against Our Always Values. Our recruitment processes will be redesigned so that we test applicants for their ability to live our values as well as for their technical skill and experience. We will continue to celebrate individuals and teams through our staff awards, and we have already identified that it is our people who make GOSH what we are by using pictures of our own staff to represent Our Always Values.

Patients, families and carers have worked with us at every stage of the development of Our Always Values, from identifying the need for values at our Listening Event in June 2013 to helping design the values themselves and now on embedding them in the hospital.

As we give our staff the tools and knowledge to live Our Always Values, we will be increasingly asking our patients, families and carers to help us see when we are doing well and when we are falling short. This will not always be an easy or a quick journey; living Our Always Values means we will have to look hard at our systems and processes to make sure we are genuinely being Welcoming, or that we are communicating with patients and families as equal members of One Team. But we believe the inclusive process to develop our values and the measures we are taking to make them an integral part of how we all work are essential first steps.

The Patient Advice and Liaison Service (Pals)

Pals is the Hospital's "Customer Services Department" helping to advise and support patients, parents and the public with queries or problems they might have with services provided by GOSH. In the year to date of 2014/15 the Pals service has received more than 3200 contacts. More than half of these have been information requests, most commonly about how to be referred to Great Ormond Street but also about eligibility for travel support and other support services such as parent accommodation.

From the 1416 cases so far, the most common theme is communication between GOSH and parents or local healthcare services. Pals have been able to support our patients, parents and carers to resolve their concerns and to then share those cases with the Trust to help learn from their experiences.

Patient surveys

In 2014/15 we consulted patients and families about our longer term strategic goals asking them in particular for their views about where (geographically) they would like receive GOSH services, which methods of communication they prefer and aspects of services they would like us to improve. Feedback identified that patients and their families prefer to attend the GOSH site for their outpatient and inpatient care but they would like access to more peripheral clinics if that were feasible. Traditional methods of communications such as post, telephone and email for communications were also

preferred. The main areas identified for improvement focused on reducing waiting times at outpatient appointments, waiting for diagnostic tests and improvement of communication with families when they are at home. These areas have been prioritised for improvement in 2015/16 and are in line with other feedback received.

The Staff Friends and Family Test

In 2014, the national Staff Friends and Family test (FFT) was introduced. Over the course of 12 months, all our staff will have the opportunity to respond to questions asking whether they would recommend GOSH as a place to work, or as a place to be treated. At the time of publication, we have run the test and had results back, as follows:

	June 2014		August 2014		March 2015	
	GOSH	National average	GOSH	National average	GOSH	National average
Recommend as a place to be treated	95%	76%	94%	77%	94%	Not available
Recommend as a place to work	70%	62%	74%	61%	73%	Not available

The Staff FFT is different to the annual staff survey in that it poses only two questions, and asks staff to give reasons for their answers. The comments we have received describe GOSH as a hospital with hardworking, expert staff who are committed to delivering excellent care. However, they also say that it can be a very intense place to work, and that we are not *consistently* excellent in all that we do. This reflects the themes in Our Always Values, so we will use the Staff Friends and Family test as a way of monitoring the impact of our programme of cultural change over coming months.

The Patient Friends and Family Test

The Trust has implemented the friends and family test to all inpatient areas and started rollout to outpatient and day care areas. In March 2015, the response rate was above plan at 34.9%, the highest achieved to date. The Friends and family test net promoter score has improved to 80 with the percentage of families likely or extremely likely to recommend the Trust, achieving 97% in March 2015.

New feedback stations have been implemented and positively received these are child friendly and contain information about the test, feedback cards and post box for returns. Posters have also been developed for wards to put up beside the stations to show patients and families what feedback has been received and what is being done to address areas identified for improvement.

Plans for 2015/16

The following three priorities have been identified as the most important for patient experience over the coming year:-

- Reduce the amount of time patients and families spend waiting for appointments, diagnostic tests or treatment and to improve the experience of waiting focusing on the redesign and standardisation of systems and processes for outpatient appointments, surgical and interventional radiology booking procedures, and patient pathways through the intensive care units.
- Improve the consistency of our communication and behaviours towards patients, families and each other to ensure that all staff uphold the GOSH 'Our Always values – always being welcoming, helpful, expert and one team'.
- Improve the comfort of our patients and families and the environment in which they are cared for focusing particularly on the provision of food to patients on the ward and in our restaurants facilities, improving the retail experience and improving the provision of play to children and young people.

Our success will be measured through feedback from the friends and family test and this year we plan to focus on gaining more feedback from children and young people. The Trust aims to have an FFT response rate of 35% by April 2016 and to consistently achieve 95% of our families recommending the Trust to friends or family members.

Family equality and diversity

One of the objectives for the Family Equality and Diversity (FED) group has been to improve the experience of families with additional needs, particularly those caring for children and young people with learning disabilities. A flagging system has been established to identify when a patient has a learning disability so that staff can be better prepared to meet their needs. A hospital passport has been introduced to give vital information about a patient to all involved in their care and the range of Easy Read information sheets has been extended. Training and education for all levels of staff has been devised and delivered with extremely positive feedback. Reasonable adjustments can now be made in various departments, including Outpatients, to help provide as positive experience as possible.

Volunteering at GOSH

GOSH recognises the value of engaging volunteers in many varied roles across the Trust. We have steadily increased the number of specially vetted and trained volunteers and currently have approximately 850 people who volunteer for a minimum of 4 hours per week. Volunteers provide services that enhance the patients and families experience, including emotional and practical support roles. They support staff carrying out their own duties, reducing pressure on staffing time and resources. Ensuring patients have a less stressful visit also has proven clinical and recovery benefits.

With over 50 different roles, volunteers are assisting the trust in meeting its objectives of providing best quality services for patients and families. The volunteer service now has one of the largest and most comprehensively trained/prepared teams of volunteers across any NHS trust, working on a regular basis within the hospital.

In the last calendar year (2014) volunteers contributed approximately 177,000 hours of support work, sometimes freeing up staff to undertake their necessary work. This equates to approximately £1,556,000 worth of time to the trust, based on the London Living wage.

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

Complaints Handling

The Trust is committed to responding to all complaints openly and honestly in a way that is fair to everyone concerned. Complaints can be made in writing (via letter or e-mail) or verbally either face to face or over the phone. The Complaints team agree a timescale for the investigation with the complainant, coordinate the investigation and keep the complainant updated of progress throughout the investigation. A final response is sent from the Chief Executive or member of the Executive Team and an offer to meet with relevant staff to discuss any further concerns will usually be made. If the complainant is unhappy following the Trust's response they can ask the Health Service Ombudsman to review their complaint. Complaints correspondence is kept separately to medical records and quarterly audits are carried out on a sample of records to ensure that no complaints correspondence has been misfiled. A log of all actions agreed as an outcome of complaints is kept by the complaint team and updates on progress are regularly sought from the responsible staff.

In 2014/15 the Trust received 144 formal complaints. All complaints are graded green, amber or red according to severity and in 2014/15 there were 16complaints graded red (the most severe grading). In 2014/15 the Trust received notification that 2 complaints had been escalated to the Ombudsman. The Ombudsman reached their final decision on 3 complaints. 1 of these was not upheld and 2 were partly upheld.

Patient information

GOSH continues to seek to improve the experience of children, young people and their families who use our services. Over the last year we have continued to actively involve and engage both our young members and parent members in helping to identify areas for improvement through surveys and feedback, as well as involving them in shaping how we provide care and services to best meet the needs of patients and families.

The Child and Family Information Group continues to write and design information sheets for children, young people and families, with over 200 new or revised information sheets published this year. Information sheets continue to be popular with users of our website with some about medical conditions being viewed over 7000 times a month. Our range of Easy Read information for people with learning disabilities has also expanded to a total of 28 in this format.

The project to develop Patient Information Pathways continues – several clinical specialties have produced pathway and are using them to ensure all information needed by children, young people and families is available at the right time in the patient journey. Ward bedside folders are also in development – the aim of the folders is to pull together all the information families might need during an inpatient stay, making it easily accessible at the bedside without requiring internet access. Seven wards now have the folders in situ with remaining wards developing them currently.

Working with our partners

The Institute of Child Health

The ICH, in partnership with GOSH, is the largest centre in Europe devoted to clinical and basic research and postgraduate teaching in children's health. Together, we host the only academic Specialist Biomedical Research Centre in the UK specialising in paediatrics, and we are the largest paediatric research partnership outside North America.

In partnership with GOSH, the aim of the ICH is to build on its position as one of the leading centres in the world for child health research and education.

GOSH Children's Charity

Great Ormond Street Hospital Children's Charity raises money to enable the hospital to redevelop its buildings, buy new equipment, fund paediatric research conducted at the hospital and its research partner, the UCL Institute of Child Health (ICH) and to support specific welfare projects such as family accommodation. In the year 2014/15, total fundraising income before expenses was just over £80 million – the highest amount the charity has ever raised in one year, and the fifth consecutive year of income growth.

During this time, the charity committed to grants of over £15 million for the hospital, funding priority research projects (£5.84 million), state-of-the-art medical equipment and infrastructure development (£3.75 million) and projects to support patients and staff welfare (£5.46 million).

Charity donations are used to help fund the redevelopment of the hospital site. As part of the redevelopment programme, which aims to rebuild two-thirds of the hospital site over a 20-year period, in September 2014, work began on the second part of the Mittal Children's Medical Centre – the Premier Inn Clinical building (see page ??). In January 2015, the hospital also received planning permission to build our Centre for Research into Rare Diseases in Children. This paves the way for construction of the Centre to start in October 2015 and for the building to open in 2018.The Centre is funded principally from charitable donations including a gift of £60million from Her Highness Sheikha Fatima bint Mubarak, wife of the late founder of the United Arab Emirates.

In supporting clinical innovation and research, the charity made grants to the Trust and its academic partner, the ICH, as well as partner organisations. Almost £1 million was committed through the charity's national call, which is open to researchers from across the UK. The theme of the 2014/15 call was rare diseases, which dovetails with the hospital's plans for the new Centre for Research into Rare Diseases in Children and further demonstrates the hospital's commitment to help those children with the most unusual and difficult to treat diseases. Seven new research projects were funded, looking at a wide range of different diseases, from an enzyme deficiency disease called Sanfilippo syndrome to a rare form of epilepsy. The grants also included three PhD studentships at the ICH, supporting young scientists starting their career in child health research.

Working with our stakeholders

University College London Partners (UCL Partners)

One of five accredited academic health science systems in the UK, UCL Partners (UCLP) is a partnership (known as an Academic Health Science Centre [AHSC]) between University College London, Queen Mary University of London and the London School of Hygiene and Tropical Medicine and four of London's most prestigious hospitals and research centres – Moorfields Eye Hospital NHS Foundation Trust, the Royal Free Hampstead NHS Foundation Trust, University College London Hospitals NHS Foundation Trust and Great Ormond Street Hospital for Children NHS Foundation Trust.

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

Great Ormond Street Hospital is involved on a number of programmes of work including the SAFE programme. The main objective of this programme is to reduce harm and drive cultural change through better communication in children's wards by encouraging information sharing and equiping staff with the skills to spot when a child's condition is deteriorating and to prevent missed diagnosis.

Our commissioners

Over 90 per cent of our clinical services are commissioned by one commissioner, NHS England, with the remaining 10 per cent of our services being delivered through arrangements with 205 clinical commissioning groups. The Trust has a proactive working relationship with NHS England, and holds regular contract meetings with commissioners to discuss service demand, quality indicators and finance.

Many of our clinicians are engaging with the clinical reference groups ("CRGs") established by NHS England to provide clinical input into standards and strategic planning of each specialised service.

Referrers and clinical networks

The Trust has an active programme of engagement with referrers, which this year has focussed on regular meetings to develop a shared agenda to improve patient pathways and care with some of our key referrers. Work continues to improve communication with referrers and others with whom we share care, including a Trust wide project involving administrative and clinical staff to improve timeliness of discharge summary communication and local initiatives to improve clinic letter sending times. These are regularly monitored and metrics reported at Board level.

In addition, many GOSH specialised services operate with other healthcare providers in local, regional and national clinical networks of care. They also play a broader role in working with other healthcare organisations, including through the provision of outreach clinics, as a source of specialist clinical advice and playing a role in clinical reference and formulary groups. Working closely with referrers and within networks of care to strengthen shared care arrangements is a key strategic aim over the coming year.

Healthwatch

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

In May 2014, Healthwatch Camden conducted enter and view visits following concerns that had been raised about patient/parent satisfaction with the quality and variety of hospital food. Visits by Health watch Camden volunteers were facilitated by GOSH staff to inpatient wards out of hours. Healthwatch Camden received a lot of positive feedback from patients and families about their care and treatment at GOSH, including comments about the hospital food. However, some concerns were identified in relation to the handover procedures of meal trolleys to ward staff, consistency of meal service delivery out of hours in the absence of housekeepers and, availability of snacks at ward level. An action plan has been put in place including a review of the snacks available and provision of information about this to ward staff, implementation of a signing sheet for handover of meal trolleys on the wards and development of a training video for ward staff on food service.

Statement from directors

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

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

Dr Peter Steer

Date: 22nd May 2015

DIRECTORS' REPORT

Governance at GOSH

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

This section introduces our governance arrangements and Board members, and provides an overview of the work of the Members' Council.

How we are governed

The Board of Directors is responsible for overseeing the Trust strategy, managing strategic risks, and providing managerial leadership and accountability. The Senior Management team has delegated authority from the Board of Directors for the operational and performance management of the clinical and non-clinical services of the Trust, including research and development, education and training. It is responsible for co-ordinating and prioritising all aspects of risk management issues that may affect the delivery of the services. The diagram below outlines where these committees report.

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

- Trust objectives and supporting workstreams
- Care Quality Commission requirements
- Monitor requirements
- national priority and existing commitment performance indicators
- commissioning and contract agreements
- key internal measures

As outlined on page ??, the Board of Directors has identified five key Trust-wide strategic objectives to be achieved, supported by a number of critical workstreams and actions to deliver them.

The Board receives a monthly key performance indicator (KPI) report, which is used to monitor progress against priority objectives, as outlined in our Annual Plan, and to ensure that the Trust continues to meet and remain compliant with the range of external reviews, targets and contractual standards.

Quality Governance

The Trust places the highest priority on quality, measured through its clinical outcomes, patient safety and patient experience indicators. Using the Monitor Quality Governance Framework, t he Trust has assessed and concluded that it has satisfactory quality governance arrangements in place. The Trust's quality strategy was reviewed during the year and demonstrates the Board's commitment 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.
- There are internal processes to check that we meet our own internal quality standards and those set nationally
- Key performance indicators are presented at every meeting to the Board of Directors. This includes:
    - Progress against external targets, such as how we minimise infection rates
    - Internal safety measures, such as the effectiveness of actions to reduce cardiac and respiratory arrests outside of the intensive care units.
    - Process measures, such as waiting times.

  It also includes the external indicators assessed and reported monthly by Monitor.

- The Board also regularly receives reports on the quality improvement initiatives and other quality information, such as incidents and reports from specific quality functions within the Trust, for example PALS. The Clinical Governance Committee receives reports 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 monthly performance reviews.
- Patient and parent feedback is received via a detailed survey at least once a year, the Friends and Family Test, through the work programme of the Patient, Public Involvement and Experience Committee, and through a range of other patient/parent engagement activities.
- Risks to quality are managed through the Trust risk management process, which includes a process for escalating issues.
- There is a clear structure for following up and investigating incidents and complaints and disseminating learning from the results of investigations.
- 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. The Audit Committee receives assurance on the quality of this data.

Regulatory monitoring

Monitor publishes two ratings for each NHS foundation trust:

- The continuity of services rating is Monitor's view of the risk that the trust will fail to carry on as a going concern. A rating of 1 indicates the most serious risk and 4 the least risk. A rating of 2* means the trust has a risk rating of 2 but its financial position is unlikely to get worse.
- The governance rating is Monitor's degree of concern about how the trust is run, any steps we are taking to investigate this and/or any action we are taking. We'll either indicate we have no

evident concerns, that we have begun enforcement action, or that the foundation trust's rating is 'under review', which means we have identified a concern but not yet taken action.

The role of these ratings is to indicate when there is a cause for concern at a trust. The ratings do not automatically trigger regulatory action. They simply prompt Monitor to consider whether a more detailed investigation is needed.

Monitor updates foundation trusts' ratings each quarter and also in 'real time' to reflect any regulatory action taken

As is evident from the tables below, the Trust has reported the least risk position for continuity of service rating and green for governance rating consistently over the last two years (2013/14 to 2014/15). Irrespective of the consistent position year on year, the Trust continually reviews and monitors all aspects of its regulatory requirements to ensure that this position can be sustained.

2014/15	Q1	Q2	Q3	Q4
Continuity of service rating	4	4	4	4
Governance rating	Green	Green	Green	Green

Registration with the Care Quality Commission

GOSH is registered with the CQC as a provider of acute healthcare services.

In April 2015 the CQC conducted a scheduled inspection of the Trust. The inspection report will be published later in 2015-16.

The CQC has not taken enforcement action against GOSH during 2014/15. GOSH has also not participated in any special reviews or investigations by the CQC during this period.

Compliance with the Code of Governance

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

Board of Directors

The Board of Directors is responsible for setting the Trust's strategic aims and objectives and for monitoring and managing key risks. It is also 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 has a number of subcommittees to which it delegates specific functions – the Audit Committee, Clinical Governance Committee and Finance and Investment Committee (see pages).

The Board is comprised of a Chairman, Deputy Chairman, Senior Independent Director (SID),four additional independent Non-Executive Directors, and seven Executive Directors including two Co-Medical Directors who share one vote (From 1st June 2015, there will be one Medical Director on the Board rather than two co-medical directors). One of the Non-Executive Directors is appointed by the ICH and the Board agrees that a good balance of skills is in place. The Executive Directors are responsible for managing the day-to-day operational and financial performance of the Trust while the Non-Executive Directors provide scrutiny based on Board level experience of private and public sector organisations. Among their skills are accountancy, audit, child protection, management consultancy, law and communications.

The Members' Council has responsibility for appointing and where necessary removing Non-Executive Directors.

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

- The departure of Julian Nettel, Interim Chief Executive in December 2014
- Dr Peter Steer joined the Trust as substantive Chief Executive in January 2015
- The retirement of Mrs Elizabeth Morgan, Chief Nurse in March 2015
- The departure of John Ripley, Non-Executive Director in March 2015
- The appointment of Juliette Greenwood as Chief Nurse, commencing employment on 1 May 2015
- The appointment Dr Vinod Diwakar as Medical Director, commencing employment on 1 June 2015
- The appointment of Akhter Mateen as Non-Executive Director in March 2015

The Trust Board carried out significant work on the Trust's strategies in 2014/15 and held additional meetings to focus on this area.

Following a positive internal audit on the risk management and assurance framework the Board has continued to review and strengthen the framework for monitoring the Trust's top strategic and operational risks. A special risk meeting was held in July 2014 to focus on the assurance framework and management of risk across the Trust. The Risk, Assurance and Compliance Group, attended by several members of the Executive Team, has maintained an overview of this area.

Members of the Board of Directors in 2014/15

Baroness Tessa Blackstone BSc (Soc) PhD

Chairman of the Trust Board and Members' Council

Appointed 1 March 2012

Experience

- Member, House of Lords
- Chair of the British Library Board
- Director of UCL Partners
- Chair of Orbit Group
- Co-Chair of the Franco-British Council

Membership of committees

- Chairman of the Board of Directors 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
- Board member of the Association of International Certified Professional Accountants
- Non-Executive Director and member of the Asset and Liability Committees and Chairman of the Audit Committee – Ipswich Building Society (until March 2015)

Membership of committees

- Chairman of the Audit Committee
- Board of Directors' Remuneration Committee member

- Board of Directors' Nominations Committee member
- Deputy chairman of the Members' Council Nominations and Remuneration Committee

Current term of office expires: 31 August 2015

Ms Yvonne Brown LLB Solicitor

Non-Executive Director

Appointed 1 March 2012

Experience

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

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

Ms Mary MacLeod OBE MA CQSW DUniv

Appointed 1 March 2012

Non-Executive Director and Senior Independent Director

Experience

- Non-executive Equality and Diversity lead at Great Ormond Street
- Trustee of Gingerbread
- Deputy Chair of the Child and Family Court Advisory and Support Service
- Chief Executive of the Family and Parenting Institute (–1999–2009)
- Director of Policy, Research and Development and Deputy CEO of Childline (1995–99)
- Independent consultancy on child and family policy
- Non-Executive Director of Video Standards Council
- Vice Chair of Internet Watch Foundation

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

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

Mr John Ripley

Non-Executive Director Appointed 28 March 2012 and retired on 27th March 2015

Experience

- Qualified accountant
- Director of CAB International
- Governor of Kingston University
- Director of The Howard Partnership Trust

- Governor of Eastwick Schools (Junior and Infants)
- Group Deputy Chief Finance Officer of Unilever (1973–2008)

Membership of committees

- Audit Committee member
- Finance and Investment Committee member
- Board of Directors’ Remuneration Committee member
- Board of Directors’ Nominations Committee member

Professor Rosalind Smyth CBE FMedSci

Non-Executive Director

Appointed 1 January 2013

Experience

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

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 2015

Mr Akhter Mateen

Non-Executive Director

Appointed 28 March 2015

Experience

- Financial consultant and advisor
- Independent Member of the Advisory Board of an unlisted FMCG business - SuperMax
- Director of British Pakistan Foundation
- Group Chief Auditor of Unilever (2011–2012)
- Senior Global and Regional Finance roles Unilever (1984-2011)

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 2018

Executive Directors

Dr Peter Steer

Chief Executive from 1st January 2015

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

Experience

- Chief Executive – Children's Health Queensland Hospital and Health Services (2009 – 2014)
- Professor of Medicine, University of Queensland (2009-2014)
- Adjunct Professor, School of Public Health, Queensland University of Technology (2003 – 2008)
- President – McMaster Children's Hospital, Hamilton, Ontario (2003 – 2008)
- Professor and Chair, Department of Paediatrics, McMaster University, Canada (2003-2008)

Membership of committees

- Clinical Governance Committee member
- Finance and Investment Committee member
- Audit Committee attendee
- Board of Directors' Remuneration Committee attendee
- Board of Directors' Nominations Committee attendee

Mr Julian Nettel

Interim Chief Executive until 31st December 2014

Experience

- Chief Executive of Ealing Hospital NHS Trust (1994–99)
- Chief Executive at St Mary's NHS Trust (1999–2007)
- Chief Executive of Barts and The London NHS Trust (2007–09)
- Managing Director of the NHS Institute for Innovation and Improvement (2011–12) Senior advisor to Leadership Development and Talent Management team at London Strategic Health Authority (2009–10)

Membership of committees

- Clinical Governance Committee member
- Finance and Investment Committee member
- Audit Committee attendee
- Board of Directors' Remuneration Committee attendee
- Board of Directors' Nominations Committee attendee

Mrs Claire Newton MA (Cantab) ACA MCT

Chief Finance Officer

Claire Newton is responsible for the financial management of the Trust and leads on contracting 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

- Audit Committee attendee
- Finance and Investment Committee member

Mrs Elizabeth Morgan MSc RN Adult RN Child RNT RCNT Dip N IHSM Diploma

Chief Nurse until 31st March 2015 and retired on 31st March 2015

Liz Morgan was responsible for the professional standards, education and development of nursing. She was also the Lead Executive responsible for patient and public involvement and engagement, safeguarding and infection prevention and control.

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 (2002–07)
- member of WellChild Research Strategy Advisory Panel

- Honorary Visiting Professor in Department of Child and Adolescent Health, Kings College London

Membership of committees

- Clinical Governance Committee member

Professor Martin Elliott MB BS MD FRCS

Co-Medical Director until 31st May 2015

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

Experience

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

Membership of committees

- Clinical Governance Committee member

Mr Ali Mohammed

Director of Human Resources and Organisational Development

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

Experience

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

Membership of committees

- Clinical Governance Committee member
- Board of Directors' Remuneration Committee attendee
- Board of Directors' Nominations Committee attendee

Ms Rachel Williams

Chief Operating Officer

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

Experience

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

Membership of committees

- Clinical Governance Committee member
- Audit Committee attendee
- Finance and Investment Committee member

Dr Catherine Cale MB ChB PhD MRCP FRCPath MRCPCH

Interim Co-Medical Director until 31st May 2015

Catherine Cale is responsible for postgraduate medical education and training for doctors; medical workforce development; and partnership services.

Experience

- Consultant in Paediatric Immunology and Immunopathology
- Divisional Director for Infection, Cancer, Immunity and Laboratory Medicine (2008–14)
- Clinical Lead for Immunology and Cell Therapy Laboratories

Other directors who attend the Board of Directors' meetings

Mr Robert Burns BSc (Hons) CPFA

Director of Planning and Information

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

Experience

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

Membership of committees

- Clinical Governance Committee member
- Audit Committee attendee
- Finance and Investment Committee member

Mr Matthew Tulley

Director of Redevelopment

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

Professor David Goldblatt MB ChB PhD MRCP FRPCH

Director of Clinical Research and Development

David Goldblatt leads the strategic development of clinical research and development across the Trust. He is Honorary Consultant Immunologist and Director of the NIHR funded GOSH UCL BRC.

Mr Trevor Clarke BSc MSc

Director of International Patients

Trevor Clarke is responsible for the strategic development and management of the Trust's IPP division.

Register of Interests

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

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.

Evaluation of Board performance

In light of the appointment of a new Chief Executive in January 2015, a new non-executive director in March 2015 and the appointment of a new Chief Nurse and Medical Director in quarter 1 f 2015/16, the agreed to undertake an independent assessment of the Well Led criteria in quarter 4 2015/16, in line with Monitor's requirements. In 2014/15 the Board conducted a self-assessment evaluation against specific areas of the four domains and ten questions outlined in the Monitor guidance. The results of this assessment are provided below:

Board of Directors' meetings

Board of Directors' meetings

The Board of Directors held a total of 11 meetings between 1st April 2014 – 31st March 2015. Six of these included sessions in public. In October 2014 and February 2015, the Board held strategy development sessions. The Board did not meet in August 2014, and a Board seminar meeting was held in April and June 2014. One extraordinary meeting was held in July 2014.

During the year:

- The Audit Committee met four times.
- The Clinical Governance Committee met five times, including one extraordinary meeting.
- The Finance and Investment Committee met eight times
- The Board of Directors' Nominations Committee and the Board of Directors' Remuneration Committee met twice during the year.

Directors' attendance at meetings

Name	Board	Audit	Clinical Governance	Finance & Investment	Nominations	Remuneration
Tessa Blackstone	11 meetings of 11 held	N/A	N/A	N/A	2 meetings of 2 held	2 meetings of 2 held
Charles Tilley	11 meetings of 11 held	4 meetings of 4 held	N/A	N/A	1 meeting of 1 held	2 meetings of 2 held
Mary MacLeod	11 meetings of 11 held	N/A	5 meetings of 5 held	N/A	1 meeting of 1 held	2 meetings of 2 held

Yvonne Brown	11 meetings of 11 held	4 meetings of 4 held	5 meetings of 5 held	N/A	1 meeting of 1 held	2 meetings of 2 held
David Lomas	11 meetings of 11 held	2 meetings of 4 held	N/A	8 meetings of 8 held	1 meeting of 1 held	2 meetings of 2 held
John Ripley	10 meetings of 11 held	4 meetings of 4 held	N/A	8 meetings of 8 held	1 meeting of 1 held	2 meetings of 2 held
Rosalind Smyth	10 meetings of 11 held	N/A	4 meetings of 5 held	N/A	0 meetings of 1 held	0 meetings of 2 held
Julian Nettel (until 31st December 2014)	8 meetings of 8 held	3 meetings of 3 held	3 meetings of 4 held	2 meetings of 5 held	1 meetings of 1 held	1 meetings of 1 held
Peter Steer (from 1st January 2015)	3 meetings of 3 held	1 meeting of 1 held	1 meeting of 1 held	3 meetings of 3 held	N/A	1 meetings of 1 held
Claire Newton	10 meetings of 11 held	4 meetings of 4 held	N/A	8 meetings of 8 held	N/A	N/A
Martin Elliott	10 meetings of 11 held	N/A	3 meetings of 5 held	N/A	N/A	N/A
Catherine Cale	10 meetings of 11 held	N/A	N/A	N/A	N/A	N/A
Elizabeth Morgan	11 meetings of 11 held	N/A	5 meetings of 5 held	N/A	N/A	N/A
Ali Mohammed	10 meetings of 11 held	N/A	5 meetings of 5 held	N/A	1 meeting of 1 held	2 meetings of 2 held
Rachel Williams	8 meetings of 11 held	4 meetings of 4 held	3 meetings of 5 held	6 meetings of 8 held	N/A	N/A
Robert Burns	11 meetings of 11 held	4 meetings of 4 held	4 meetings of 5 held	6 meetings of 8 held	N/A	N/A
Matthew Tulley	9 meetings of 11 held	N/A	N/A	N/A	N/A	N/A

Board Committees

The Board of Directors delegates certain functions to its subcommittees which meet regularly. The Board receives any amendments to the committee terms of reference, annual reports and committee self-assessments.

One Non-Executive Director sits on both the Audit Committee and Clinical Governance Committee to provide a link and ensure that information is effectively passed between committees.

Audit Committee

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

Clinical Governance Committee

The Clinical Governance Committee is chaired by a Non-Executive Director and has delegated authority from Trust Board to be assured that the correct structure, systems and processes are in place within the Trust to manage Clinical Governance and quality related matters and that these are monitored appropriately. A summary of the work of the committee can be found on page ?.

Finance and Investment Committee

The Finance and Investment Committee is chaired by a Non-Executive Director and has delegated authority from Trust Board to oversee financial strategy and planning, financial policy, investment and treasury matters and in reviewing and recommending for approval major financial transactions. The Committee also maintains an oversight of the Trust's financial position, and relevant activity data and workforce metrics.

Board of Directors' Remuneration Committee

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

Board of Directors' Nominations Committee

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

Members' Council

At the heart of the NHS foundation trust model is local accountability, in which our Members' Council play an essential role.

Our 27 elected and appointed councillors represent the interests and views of our patients and their families, the public, staff, and local stakeholders ensuring that the membership voice is heard and reflected in the strategy for the hospital.

Ultimately we see the Members' Council as our critical friend and guardian of our values.

The role of the Members' Council

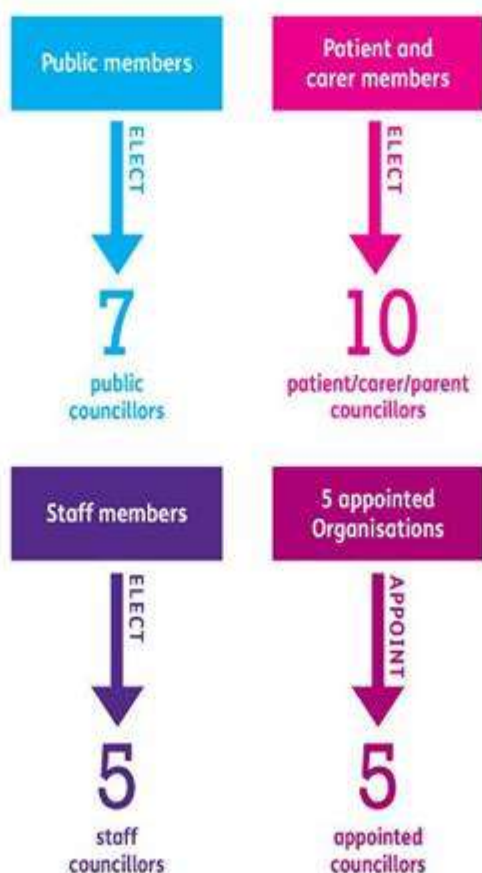
As the governors (councillors) of the hospital, the role of the Members' Council is to provide challenge to the Board of Directors and hold the Non-Executive Directors individually and collectively to account. They ensure that the views of the hospital's patients and wider communities are heard and reflected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

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

In February 2015 our Members' Council entered its second three year term of office.

Constituencies of the Members' Council

The council is led by the Chairman of the Trust. During the period, the Members' Council consisted of 27 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 five councillors appointed by partner organisations. The table below details the membership constituencies and organisations represented by councillors.



The table below provides the breakdown in more detail:

Constituency (2015-18)	No. of seats on Council
ELECTED COUNCILLORS	
Patient and carer constituency	
Patients from London	2
Patients from outside London	2
Parents or carers from London	3

Parents or carers from outside London	3
Public constituency	
North London and surrounding area Comprising the following electoral areas in North London: Barking & Dagenham; Barnet; Brent; Camden; City of London; Hackney; Ealing; Enfield; Hammersmith & Fulham; Haringey; Harrow; Havering; Hillingdon; Hounslow; Islington; Kensington & 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.	4
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; Southwark; Sutton; Wands worth. 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;	1

Wealden; Adur; Arun; Chichester; Crawley; Horsham; Mid Sussex; West Sussex; Worthing.	
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	
University College London, Institute of Child Health	1
London Borough of Camden	1
Partnership organisations	
National Commissioning Group	1
Expert Patients' Programme Community Interest Company (now known as self management UK)	1
Great Ormond Street Hospital School	1
Total	**27**

Councillor attendance at meetings

The duration of appointment for all elected and appointed councillors is three years.
The Members' Council met seven times during the 2014/15 reporting period. The Members' Council Nominations and Remuneration Committee (a subcommittee of the Members' Council) met three times during 2014/2015 and the Membership & Engagement Committee (a subcommittee of the Members' Council) met six times during that period.

The table below details attendance at these meetings.

Name	**Constituency**	**Date of appointment**	Attendance at **Members' Council Meetings** (out of 7 unless otherwise stated)	Member of **Members' Council Nominations & Remuneration Committee** Attendance (out of 3 meetings unless otherwise stated)	Member of **Membership & Engagement Committee** Attendance at meetings (out of 6 meetings unless otherwise stated)
*Edward Green	Patients outside London	1st March 2012-19 February 2015	7	2(2)	3
*George Howell	Patients outside London	1st March 2012-19 February 2015	7	Not a member	5
**Sophie Talib	Patients from London	1st March 2012-19 February 2015	4	Not a member	4
***Susanna Fantoni	Patients from London	20 February 2015	1(1)	Not a member	Not a member
**Matthew Norris	Parents or carers from London	1st March 2012-19 February 2015	7	3 Re-elected in March 2015	Not a member
Lynne Gothard	Parents or carers from London	1st March 2012-19 February 2015	4(6)	Not a member	Not a member
**Lisa Chin-A-Young	Parents or carers from London	1st March 2012-19 February 2015	7	(1) Elected in March 2015	6
***Mariam Ali	Parents or carers from London	20 February 2015	1(1)	Not a member	Not a member
John Charnock	Parents or carers from outside London	1st March 2012-19 February 2015	5(6)	Not a member	Not a member

Name	**Constituency**	**Date of appointment**	Attendance at **Members' Council Meetings** (out of 7 unless otherwise stated)	Member of **Members' Council Nominations & Remuneration Committee** Attendance (out of 3 meetings unless otherwise stated)	Member of **Membership & Engagement Committee** Attendance at meetings (out of 6 meetings unless otherwise stated)
**Claudia Fisher	Parents or carers from outside London	1st March 2012-19 February 2015	7	Not a member	3
**Camilla Pease	Parents or carers from outside London	1st March 2012-19 February 2015	6	Not a member	5
***Carley Bowman	Parents or carers from outside London	20 February 2015	1(1)	Not a member	Not a member
**Trevor Fulcher	North London and surrounding area	1st March 2012-19 February 2015	6	1	0
**Rebecca Miller	North London and surrounding area	1st March 2012-19 February 2015	7	(1) Elected in March 2015	Not a member
Ian Lush	North London and surrounding area	1st March 2012-19 February 2015	5(6)	Not a member	5
Lewis Spitz	North London and surrounding area	1st March 2012-19 February 2015	3(6)	Not a member	Not a member

Name	**Constituency**	**Date of appointment**	Attendance at **Members' Council Meetings** (out of 7 unless otherwise stated)	Member of **Members' Council Nominations & Remuneration Committee** Attendance (out of 3 meetings unless otherwise stated)	Member of **Membership & Engagement Committee** Attendance at meetings (out of 6 meetings unless otherwise stated)
***Mary De Souza	North London and surrounding area	20 February 2015	1(1)	Not a member	Not a member
***Simon Hawtrey-Woore	North London and surrounding area	20 February 2015	1(1)	Not a member	Not a member
Louise Clark	South London and surrounding area	1st March 2012-19 February 2015	3(6)	Not a member	Not a member
***Gillian Smith	South London and surrounding area	20 February 2015	1(1)	Not a member	Not a member
**Stuart Player	The rest of England and Wales	1st March 2012-19 February 2015	4	Not a member	4
*** David Rose	The rest of England and Wales	20 February 2015	1(1)	Not a member	Not a member
**Jilly Hale	Staff	1st March 2012-19 February 2015	7	(1) Elected in March 2015	Not a member

Name	**Constituency**	**Date of appointment**	Attendance at **Members' Council Meetings** (out of 7 unless otherwise stated)	Member of **Members' Council Nominations & Remuneration Committee** Attendance (out of 3 meetings unless otherwise stated)	Member of **Membership & Engagement Committee** Attendance at meetings (out of 6 meetings unless otherwise stated)
**Clare McLaren	Staff	1st March 2012-19 February 2015	4	2(2)	Not a member
Dhimple Patel	Staff	1st March 2012-19 February 2015	3(6)	Not a member	Not a member
**James Linthicum	Staff	September 2013- 19 February 2015	4	Not a member	3
***Rory Mannion	Staff	20 February 2015	1(1)	Not a member	Not a member
***Prab Prabhakar	Staff	20 February 2015	1(1)	Not a member	Not a member
**Jenny Headlam-Wells	London Borough of Camden	1st March 2012	4	Not a member	Not a member
**Christine Kinnon	University College London, Institute of Child Health	1st March 2012	6	Not a member	Not a member
Olivia Frame	Expert Patient Programme	1 November 2013	3	Not a member	Not a member

Name	Constituency	Date of appointment	Attendance at **Members' Council Meetings** (out of 7 unless otherwise stated)	Member of **Members' Council Nominations & Remuneration Committee** Attendance (out of 3 meetings unless otherwise stated)	Member of **Membership & Engagement Committee** Attendance at meetings (out of 6 meetings unless otherwise stated)
	Community Interest CIC				
**Muhammad Miah	Great Ormond Street Hospital School	1st March 2012	6	Not a member	Not a member
Alastair Whitington	NHS England	1st June 2013 - 31 March 2015	5	Not a member	Not a member

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

Lead Councillor

Mr Ian Lush, Public Councillor for North London and the surrounding area held this position from March 2012- February 2015. Following an election in March 2015, Ms Claudia Fisher, councillor representing parents or carers from outside London has been elected to serve for three years with endorsement of the Members' Council on an annual basis.

The Board of Directors and Members' Council working together

The Trust Chairman is responsible for the leadership of the Members' Council and the Board of Directors. The Chairman has overall responsibility for ensuring that the views of the Members' Council and Trust members are communicated to the Board as a whole and considered as part of the decision-making process, and that the two bodies work effectively together. The Board of Directors are responsible for the operational management of the Trust, but they must take into account the views of the Members' Council when developing strategy and forward plans. The Members' Council provide a steer on how the Trust should carry out its business in ways consistent with the needs of its members

and the wider population. Examples of how the Board of Directors and Members' Council have worked together during the year include:

- Executives and Non-Executive Directors attend every Council Meeting
- Summaries of the Board Assurance Committees (Audit Committee, Clinical Governance Committee and Finance and Investment Committee) are presented by the relevant Non-Executive Director Chairs of the committees at each Council meeting
- Summaries of Members' Council Meetings are reported to the Board of Directors
- The Members' Council has an open invitation to attend all Trust Board public Meetings
- Councillors are invited to observe at the Board of Directors' Audit Committee, Clinical Governance Committee and Finance and Investment Committee and attend strategy sessions with the Board of Directors.

The Trust Board has also worked in partnership with the Members' Council in the following areas during the year:

<u>Consultation, Involvement and Feedback</u>

Councillors have been involved in the work of the Board and Hospital in the following ways:

- Involvement in the appointment of the Chief Executive, Medical Director and Chief Nurse
- Consultation on the selection of an indicator for auditing for the Quality Report.
- Consultation on changes to the staff membership constituency.
- Consultation on the Centre for Research into Rare Disease in Children
- Participating in Members' Council seminars providing views and opinions about GOSH services.
- Undertaking the Annual Patient Led Assessments of the Care Environment (PLACE).
- Developing and launching the Always Values for the Trust.
- Attending and presenting at two pre-election sessions to meet their constituents.
- Taking part in Vox pops- membership videos for the Trust website membership area.
- Developing the membership strategy and ensuring the membership is representative.
- Giving presentations in local schools to raise the profile of membership.
- Members' Council sessions in the Lagoon area of the hospital.
- Attending events in the local community to recruit new members.
- Providing comments on and/or sharing experience of :

    - Centre for Research into Rare Disease in Children
    - The Trust's Quality Strategy Action Plan
    - Continual review of the retail space and retail proposals for GOSH Shop
    - New wayfinding services
    - Improving the website pages for election and teen membership

Councillors have sat on the following groups and committees

- Public and Patient Involvement and Experience Committee
- Hospital Food Group
- Membership and Engagement Committee

- Nominations and Remuneration Committee
- Editorial Committee for Member Matters
- Young People's Forum (a councillor, George Howell chairs the meeting)
- Trust's Annual Plan Development Group 2015/16.
- International Private Patient Working Group

Councillors have undertaken training and development as follows:

- Members' Council Seminars on :
  - Pharmacy Waiting Times
  - Discharge Summaries
  - Freedom of Information and Data Protection Act

- Membership recruitment and engagement training in order to maintain and increase engagement with membership constituencies
- Attendance at internal Trust events- exhibition for the Centre for Research into Rare Disease in Children, launch of Friends and Family Test and Trust Always Values
- Attendance at Foundation Trust Network events and Deloitte Governor Lunches

In May 2014, councillors voting at the Extraordinary Meeting of the Members' Council unanimously ratified the appointment of Dr Peter Steer as substantive Chief Executive following a process of open competition.

In January 2015, the Members' Council approved the appointment of Mr Akhter Mateen as a Non-Executive Director.

Members' Council Nominations 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 Chairman 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 Deputy Chairman is also a member (both attended all meetings). Membership and attendance of councillors at the meeting is detailed on page ?.

The committee carried out the following work during the year:

- reviewed the appraisals of the Chairman and Non-Executive Directors and was satisfied with the appraisal process conducted and the results. This was reported to the Members' Council in April 2015, where the council agreed with the committee's findings.
- Reviewed and recommended the results of a skills and experience audit of the Board of Directors. The findings of the audit were approved by the Council in November 2014.
- considered and approved the process for the appointment process for a Non-Executive Director (overseeing advertising of the post, shortlisting and interviewing of candidates) and the appointment of Mr. Akhter Mateen in January 2015. The Council approved this appointment in the same month.
- considered the remuneration for the Chairman and Non-Executive Directors in order to make a recommendation to the Members' Council in April 2015. In April 2015, the Council approved the recommendation for no uplift in remuneration or cost of living for the Chairman and Non-Executive Directors for two years until March 2017 (see page ?).

The term of office of the existing committee members ended in March 2015. The following councillors were elected to take up positions on the committee for one year:

1. Lisa Chin-A-Young - Patient and Carer Constituency (Parents or carers from London)
2. Matthew Norris - Patient and Carer Constituency (Parents or carers from London)
3. Rebecca Miller- Public Constituency (North London and Surrounding Area)
4. Jilly Hale- Staff Councillor (elected unopposed)

Membership and membership development

What is membership?

Membership is open to patients, their carers and families, members of the public, and staff. Our Foundation Trust membership is open to anyone living in England and Wales over the age of 10 and is free. We welcome our broad and diverse community to join, as well as those who share the GOSH vision of 'the child first and always'. All permanent staff and fixed term staff employed by the hospital for more than 12 months are automatically joined as members on an opt out basis.

Members provide valuable input that helps shape the future of the hospital. They can choose from a variety of involvement opportunities, ranging from participation in focus groups to more active roles in working groups or becoming a charity ambassador. Members also vote for and can stand for councillor elections. Members are kept in touch with what is going on at GOSH by receiving our twice-yearly *Member Matters* newsletters. A representative and active membership is one of the key strengths of GOSH as a Foundation Trust. We hope that members will feel a real sense of involvement as we work in partnership together. You can join as a member by visiting www.gosh.nhs.uk/FTmembership.

Membership Engagement Committee

The Membership and Engagement Committee (a sub-committee of the Members' Council), oversees the recruitment and retention of members and seeks to maximise on engagement opportunities. It monitors progress against the Trust's membership strategy. It is co-chaired by two councillors and meets 6 times a year and is supported by the Membership and Governance Manager and Company

Secretary. In 2014/15 it provided a valuable steer on membership engagement and communication around the 2014/15 Members' Council election.

Key priorities included:

1. Marginal growth of an engaged and representative membership base, with a particular focus on young people aged 10-16 years.
2. Maintaining face to face as the primary means of recruitment and engagement.
3. Building awareness, communication, and interaction between Councillors and their constituents (including pre-election and local events and use of social media)
4. Creating engagement opportunities between councillors and their constituents by converting the election website page to an engagement page.
5. Continued support of the Trust's Patient & Public Involvement work

2014/15 Highlights and looking forward to 2015/16

The 2014/15 Members' Council election enabled us to reach out to our membership community in a more targeted and tailored way:

Some of this year's highlights:

- Increasing the awareness and visibility of youth councillors with presence in Member Matters, with key messaging and cover letters having a more youth focus. Key councillors are now working alongside the Communications teams providing valuable input to member publications.

- A new "Take One" Teen leaflet was developed alongside the new Teen website pages in conjunction with the Young People's Forum to encourage new youth member sign-up. Leaflets are now distributed in hard copy across the hospital and in appointment letters and are available in electronic format.

- Connections made with local schools where membership presentations were made and invitation to follow up by attending Summer Fairs.

- Connections made with Coram Fields and attendance at their Christmas Fair resulting in 50 new members being recruited.

- "Meet your Councillor Sessions" where approximately 30 new members were recruited per session.

- Staff Surgeries are now run on a regular basis and increased visibility for FT staff membership in Roundabout magazine

- Membership data was reviewed and 'cleansed' to make it as accurate a record as possible in preparation for the 2014/15 Members' Council election.

Looking forward

We will continue to actively engage with the patient community within the hospital by holding regular face-to-face recruitment sessions in the Lagoon restaurant area as well as in the Outpatients area. We will offer our young councillors the opportunity to run membership awareness sessions in the GOSH school, Activity Centre and local schools.

We aim to continue to develop relationships with other FT Young People's networks and benchmark our progress against other Foundation Trusts. We have already established some connections with membership departments in three other Foundation Trusts but would like to develop this further.

We will focus on engagement with staff members also and hold staff surgery sessions facilitated by staff councillors.

We will support the developing and evolving role of councillors by equipping them with the skills and knowledge in order to fulfil their role as GOSH ambassadors and promote interaction between them and their constituents.

We will continue to progress against our key priorities in particular, identifying the most effective means of recruiting engaged members and how best to communicate and engage with our geographically dispersed membership base.

We plan to identify the best means of using social media in our communications as a means to consult our members on a more regular basis.

Membership numbers in 2014/15

Our membership database is held and managed by Great Ormond Street Children's Charity. At year end (31 March 2015) our membership numbers stood at 8,832 excluding staff (or 12,495 including staff). We have met and exceeded our estimated annual membership target of 8,449 and our membership numbers have increased by 808 members during the financial year.

In June 2014 the Trust Board and Members' Council agreed to change the make-up of the staff constituency and focus staff membership on all employees who hold a Great Ormond Street Hospital NHS Foundation Trust permanent contract or fixed term contract of 12 months or more.

Trust Agency and Bank staff, Trust volunteers and individuals working on an honorary contract, and those employed by GOSH Children's Charity were actively encouraged to join the Trust and assigned to the public constituency where they live.

The constituencies and our membership numbers

Constituency	Minimum number of members	Actual (as of 31/03/14)
Patient and carer		**6,133**
Parents or carers	600	5,217
Patients	300	916
Public (includes North London and surrounding area, South London and surrounding area and the rest of England and Wales)	900	**2,699**
Staff	2,000	**3,663**
Total	3,800	**12,495**

Register of Interests of councillors

All councillors are required to declare any interests that may compromise their objectivity in carrying out their duties. There is also a standing item at each Council meeting.

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.

Contacting the Members' Council

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 Great Ormond Street Hospital NHS Foundation Trust website.

Remuneration Report

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 ??). The only non-cash element of the most senior managers' remuneration packages is pension-related benefits accrued

during membership of the NHS Pension Scheme. Contributions into the scheme are made by both the employer and employee in accordance with the statutory regulations.

Remuneration Policy

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

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

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

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 remuneration for other staff is paid in accordance with national terms and conditions of service. The Remuneration Committee is chaired by a non-executive director and meets twice a year, in November and March. Attendance at meetings held in during 2014/15 can be found on page ??

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

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

For the financial year 2014/15, the committee recommended that there should be a one per cent non-consolidated payment and that there should be no uplift in basic pay for Executive Directors. This recommendation was is in line with the pay awards for other senior NHS staff on the Agenda for Change pay scales and was ratified by the Board of Directors.

During 2014/15, the committee:

- recommended an uplift to the salary for the Chief Operating Officer (see remuneration report on page ??).
- approved the salaries for the Chief Nurse (commencing 1 May 2015) and Medical Director (commencing 1 June 2015).

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 employment and are substantive employees of the Trust. Their contracts are open-ended employment contracts, which can be terminated by either party with six months' notice. The Trust redundancy policy is consistent with NHS redundancy terms for all staff. All new directors are now employed on probationary periods in line with all non-medical staff within the Trust.

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

In 2015/16 the Board of Directors' Remuneration Committee will refresh a benchmarking exercise to ensure that remuneration packages for executive directors are competitive and jobs are appropriately weighted.

Remuneration for non-executive directors

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

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

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

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

Expenses

Information on the expenses received by the directors and councillors can be found in the accounts on page??

Disclosures

Principal activities of the Trust

Information on the principle activities of the Trust, including performance management, financial management and risk, efficiency, employee information (including consultation and training) and the work of the research and development division and International and Private Patient division is outlined in the strategic report from page ??.

Going concern

As outlined on page ??, after consideration of the financial plan and making reasonable enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. As such, the Directors continue to prepare the Trust's accounts on a going concern basis.

Directors' responsibilities

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

Safeguarding external auditor independence

While recognising there may be occasions when the external auditor is best placed to undertake other accounting, advisory and consultancy work on behalf of the Trust, the Board seeks to ensure that the auditor is, and is seen to be, independent. The Trust 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.

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 material audit information of which the Trust's auditors are unaware; and each Director has taken all the steps that he/she ought to have taken as a Director to make himself/herself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

Income from the provision of goods and services

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

Off payroll engagements

Information about off payroll engagements can be found on page ??

Transactions with related parties

Transactions with third parties are presented in the accounts on page ??

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

Consultations in year

The Trust has conducted a consultation on the development of the Centre for Research into Rare Diseases in Children. It has also consulted patients and families about our longer term strategic goals asking them in particular for their views about where (geographically) they would like receive GOSH services, which methods of communication they prefer and aspects of services they would like us to improve.

Better Payment Practice Code

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

The Trust maintained its Better Payment Practice Code performance for non-NHS creditor payments and achieved payment within 30 days of 88 per cent of non-NHS invoices measured in terms of number, and 92 per cent by 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. From July 2013, staff who are not eligible for the NHS Pension Scheme are subject to the auto-enrolment scheme offered by the National Employment Savings Trust. The Trust contributes 1 per cent for all staff who remain opted in.

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

Remuneration of senior managers

Details of senior employees' remuneration can be found in page XX of the remuneration report.

Treasury Policy

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

Political and charitable donations

The Trust has not made any political or charitable donations during 2014/15.

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.

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

Information Governance

The Trust takes the confidentiality of its patient's data seriously. Staff are trained in information governance annually and this year the focus of the training has been confidentiality and information sharing as highlighted in Dame Fiona Caldicott's review 'to share or not to share'. As the trust prepares for electronic records management system and the first steps toward an electronic patient record, the importance of cataloguing information assets has been vital and this work will continue and strengthen in the year ahead.

Information Governance incidents

Incidents are categorised by means of a consistent methodology used across the NHS and issued by the Health and Social Care Information Centre. Staff are actively encouraged to report the incidents they witness.

Summary of serious incidents requiring investigations involving personal data as reported to the Information Commissioner's Office in 2014/15

There have been two serious incidents this year. The first in January 2015 involved an unencrypted laptop that was used by our partner organisation for research that was stolen and contained patient names and clinical details. While GOSH laptops are issued with encryption as standard, other organisations laptops may not be so this has prompted a review of laptops used to ensure that the minimum patient information is stored on them and that the security is sufficient to enforce encryption.

The second serious incident occurred in March 2015 and when 2 letters containing highly sensitive health information was sent to a member of public at the wrong address. Staff are reminded about the importance of checking postal addresses to avoid this type of incident occurring.

Date of incident	**Nature of incident**	**Nature of data involved**	**Number of data subjects potentially affected**	**Notification steps**
Jan 2015	Lost or stolen hardware	Name, Date of Birth, Clinical Information	260	Individuals notified by post with opportunity to raise concerns by phone.
Further action on information risk	Review of all research laptops to patient identifiable information on portable media is minimised and that where necessary the laptops and equipment are encrypted.			

Date of incident	**Nature of incident**	**Nature of data involved**	**Number of data subjects potentially affected**	**Notification steps**
Mar 2015	Disclosed in Error	Name, Address, Date of Birth, Clinical Information	1	Individual reported incident to us.
Further action on information risk	Additional communications to staff are planned to highlight this risk.			

Summary of other personal data related incidents in 2014-15

In addition to the 2 serious incidents, 64 Information Governance incidents with a lower severity were reported. The majority were category 'Disclosed in error' which includes patient information being disclosed to the wrong patient or to the wrong address. The 11 'Other' events were all misfiled notes patients notes have been filed in the wrong medical record.

Category	Breach Type	Total
A	Corruption or inability to recover electronic data	2
B	Disclosed in error	38
C	Lost in transit	0
D	Lost or stolen hardware	0

E	Lost or stolen paperwork	1
F	Non-secure disposal - hardware	0
G	Non-secure disposal - paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	5
J	Unauthorised access/disclosure	7
K	Other	11

Where incidents involving the loss of disclosure of patient information have taken place these are reported and actions monitored.

Sustainability

Management of our energy and utilities, and reduction of our carbon emissions can be found on page ??

Audit Committee report

Introduction from the Chairman of the Audit Committee

I am pleased to present the Audit Committee's report on its activities during the year ended 31st March 2015.

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

Clinical risks and their associated controls are considered by the Clinical Governance Committee. One member of that Committee is also a member of the Audit Committee to ensure that the work of each Committee is complementary.

The Committee reviews its effectiveness annually and no material matters of concern were raised in the 2014/15 review.

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

The members of the Audit Committee are listed on page XXX and during the financial year included four independent Non-Executive Directors and one independent member. The Foundation Trust was authorised on 1st March 2012 and I have been Chairman of the Committee since then. Four of the members of the committee were qualified accountants and at least three members of the committee have recent and relevant financial experience.

I would like to thank both John Ripley and Yvonne Brown who are retiring from the committee during 2015 after serving 3 years on the committee of the Foundation Trust and welcome Akhter Mateen as a new member from 28th March 2015. Akhter was appointed as a non-executive director of the Trust on the same day and has recent experience as a Group Chief Auditor of a multinational company. Michael Dallas, who served as an independent member of the Committee since March 2012 and for eight years as a member of the audit committee of the predecessor NHS Trust has also retired and I am pleased to report will be replaced by James Hatchley, a qualified accountant who will also become an independent member of the Clinical Governance Committee.

CHARLES TILLEY

Audit Committee Chairman

22nd May 2015

Committee Responsibilities

The Committee's responsibilities and the key areas discussed during 2014/15, whilst fulfilling these responsibilities, are described in the table below:

	Principal responsibilities of the audit committee	**Key areas formally discussed and reviewed by the Committee during 2014/15**
Review of the Trust's risk management processes and internal controls	• Reviewing the Trust's internal financial controls, its compliance with Monitor's guidance for Foundation Trusts, including the Code of Governance, and the effectiveness of its internal control and risk management systems. • Reviewing the principal non-clinical risks and uncertainties of the business (Clinical risks are reviewed by the Clinical Governance Committee) and associated Annual Report risk management disclosures.	The outputs of the Trust's risk management processes including reviews of: • the Board Assurance Framework • the principal risks and uncertainties identified by the Trust's management and movement in the impact and likelihood of these risks in the year. • further developments in the Trust's risk management processes and risk reporting • an annual assessment on the effectiveness of internal control systems taking account of the findings from internal and external audit reports which is documented in the Annual Governance Statement. • An annual report and fraud risk assessment prepared by the Trust's counterfraud officer. • An annual report from the Trust's Security Manager • The Trust's insurance arrangements. • The results of an internal review of compliance with the Code of Governance was reviewed
Financial reporting and external audit	• Monitoring the integrity of the Trust's financial statements and annual financial returns; reviewing significant financial reporting judgements contained within them. • making recommendations to the Board regarding the appointment of the External Auditor. • monitoring and reviewing the External Auditor's independence, objectivity and effectiveness. • developing and implementing policy on the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance.	• A commentary on the annual financial statements • Key accounting policy judgements, including valuations. • Impact of changes in financial reporting standards where relevant. • Basis for concluding that the Trust is a going concern. • External Auditor effectiveness & independence • External Auditor reports on planning, a risk assessment, internal control and value for money reviews • External Auditor recommendations for improving the financial systems or internal controls • The policy for engagement of the External auditor for non-audit work and an annual report of compliance with that policy has been reviewed • Developing and updating the Trust's policy in relation to non-audit work

Internal audit	• monitoring and reviewing the effectiveness of the Company's Internal Audit function, including its plans, level of resources and budget	• Internal Audit effectiveness &Charter defining its role and responsibilities.
		• Internal Audit programme of reviews and an assurance map showing the coverage of audit work over three years against identified risks.
		• Implementation status reports on audit recommendations & any trends and themes emerging
		• The Internal Audit reports discussed by the Committee, included
		  • Core financial systems
		  • Financial Reporting and Budgetary control
		  • Risk management & assurance framework
		  • Processes for monitoring compliance with the Provider License
		  • Incident reporting
		  • Whistle blowing
		  • HR arrangements & employment checks
		  • Governance arrangements
		  • Health & Safety
		  • Maintaining the Trust's estate
		  • Private patient management processes
		  • The Productivity & Efficiency programme

Other	• Reviewing the Committee's Terms of Reference and monitoring its execution. • Considering compliance with legal requirements, accounting standards. • Reviewing the Trust's Whistle-blowing Policy and operation.	• Updates to Audit Committee's Terms of Reference. • Updates to the Trust's Standing Financial Instructions and financial approval limits • Reviewing the assurance relating to the Trust's compliance with the Foundation Trust licensing conditions • Annual Report sections on governance. • The impact of new regulations • Updates on management of information governance and data quality risks • Updates on whistle blowing • reporting to the Board and Members' Council where actions are required and outlining recommendations.

Effectiveness of the committee

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

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

External audit

A competitive tendering process of the audit contract took place during 2013 involving members of the Audit Committee and two members of the Members' Council. Deloitte LLP were reappointed for a three-year term from 2014/15.

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

The non-audit services provided by Deloitte Consulting, pro bono, during the year were:

- Commercial Opportunities Review
- Further development of specific opportunities identified in the first review

Prior to appointing Deloitte Consulting for these assignments, the Committee considered whether the scope of the review might result in any impairment of the auditor objectivity and independence and concluded that it would not.

Internal audit and counter fraud services

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

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

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

Risk reviews

The Committee reviews all non-clinical strategic and high scoring operating risks at least annually. Current significant risks include the potential reduction in the Trust's funding arising from the challenging external environment and commissioning changes and delivery of the Trust's Productivity & Efficiency Target. Specific risks relating to the preparation of the financial statements were also reviewed and are detailed later in this report.

In addition the Committee considered risks associated with the Trust's evolving strategy and in particular the risks associated with:

- Implementation of the Trust's digital transformation strategy and the required change management processes;
- private patient services;
- the major building redevelopment programme.
- R and D funding

For each risk the Committee reviews the risk assessment (including risk definition, risk appetite, and likelihood and impact scores); the robustness of the controls and evidence available that the controls are operating.

In July 2014, members of the Audit Committee attended an extra meeting with other Board members to proactively review and improve the Trust's risk management processes

Internal controls

We focused in particular on controls relating to securing sustainable funding; control weaknesses identified in the Trust's procurement, contract management, credit control and business continuity management processes. Action plans were put in place to address issues arising from the areas considered .

Fraud detection processes and whistle-blowing arrangements

We reviewed the levels of fraud and theft reported and detected and the arrangements in place to prevent, minimise and detect fraud and bribery. Only one significant fraud was uncovered in the past year.

Serious incidents

The Committee has reviewed the results of the investigations into one serious fire incident and ensured the Trust has identified the changes required to reduce the risk of similar incidents occurring.

Financial reporting

We reviewed the Trust's accounts and Annual Governance Statement and how these are positioned within the wider Annual Report. To assist this review we considered reports from management and from the internal and external auditors to assist our consideration of: the quality and acceptability of accounting policies, including their compliance with accounting standards;

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

Significant financial judgements and reporting for 2014/15

We considered a number of areas where significant financial judgements were taken which have influenced the financial statements:

We identified through discussion with both management and the external auditor the key risks of misstatement within the Trust's financial statements. We discussed these risks with management during the year, and with the auditor at the time we reviewed and agreed the external auditors' audit

plan during the year and also at the conclusion of the audit. We set out in the table below how we satisfied ourselves that these risks of misstatement had been appropriately addressed.

Areas of accounting judgement and other issues

The following items were reviewed by the Audit Committee in relation to the preparation of the accounts:

Level of debt provisions The financial statements include provisions in relation to uncertainty. Judgments in this area are largely related to the timing of recognition of these provisions, the quantum recognised and the amount which has been utilised in previous years.	We reviewed and discussed the level of both NHS and private patient debt and associated provisions with management. This included consideration of the reasons for debt becoming overdue, difficulties in obtaining payment for over performance of the commissioning contracts, new debt provisions and any release and utilisation of existing provisions. Management confirmed to us that they have applied a consistent approach to the recognition and release of provisions. We also considered the views of the external auditors in respect of the provisions and associated disclosures in the accounts. We concluded that we were satisfied with the level of provisions carried and the disclosure in respect of those provisions.
Valuation of property assets The Trust has historically revalued its properties each year which combines properties held under freehold with those held under finance and operating leases. Judgements relate to the future life of these buildings, which can change the appropriate accounting treatment and affect the carrying value on the balance sheet.	We reviewed reports from management which explained the basis of valuation for the most significant buildings, including the future life and rationale for any impairments associated with structural refurbishment expenditure. We also considered the auditors' views on the accounting treatment for these buildings. We are satisfied that the valuation of these properties within the financial statements is consistent with management intention and is in line with accepted accounting standards.
Other areas of financial statement risk	We consider that the Trust's existing financial control systems should ensure that such items

Other areas where an inappropriate decision could lead to significant error include: • the treatment of capital expenditure • going concern	are properly treated in the accounts. We have discussed the external auditors' findings in these areas. There were no issues of concern reported to us in these areas and consequently we are satisfied that the systems are working as intended. We have reviewed the Trust's medium term financial plans and taking into account the requirements of IAS1 have concluded that it is appropriate to prepare the accounts on a going concern basis.

Conclusion

The Committee has reviewed the content of the annual report and accounts and advised the Board that, in its view, taken as a whole:

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

Clinical Governance Committee Report

The Clinical Governance Committee is a non-executive committee of the Trust Board with delegated authority to review the structure, systems and processes to manage Clinical Governance and quality related matters and seek assurance that these are monitored appropriately. Non-clinical and financial risks and their associated controls are considered by the Audit Committee.

The principal purpose of the Clinical Governance Committee is to assure the Board that work being undertaken by the clinical divisions, departments, standing committees and any sub groups in respect of clinical governance and improvement is co-ordinated and prioritised to meet the Trust's objectives.

The members of the Clinical Governance Committee are listed on page ?? including three non-executive directors . The committee's responsibilities and the key areas discussed during 2014/15 are outlined in the table below:

Principal responsibilities of the committee	Key areas formally reviewed during 2014/15
Review of the framework to support an environment in which excellent clinical care will flourish Review of implementation of Quality Strategy	• Implementation of the Trust's Quality Strategy • Learning arising from patient stories and sought assurance of actions taken • Reports from the Clinical Ethics Committee
Review of the controls to mitigate clinical risk within a regulatory and legislative framework	Summary reports on the relevant risks on the Board Assurance Framework - Senior managers were invited to report on the controls in place to manage the risks and the assurances available to determine the effectiveness of these controls. Patterns and themes arising from analysis of the high level risks reported across the Trust. Summary of actions take following reviews of clinical and support services Reports received on key risk areas: • Quality review of high cost efficiency savings • Health and Safety • Head of Nursing Report • Child Protection and Safeguarding • Research Governance • Summary from the Learning, Improvement and Monitoring Board (LIMB) covering complaints, PALS, incidents and claims • Workforce Information CQC compliance

Review of findings and recommendations from Internal audit, clinical audit and learning from external investigations and reports	The Internal Audit annual plan was presented to the committee in January 2014, with update on progress with the plan covered at subsequent meetings Findings and recommendations of clinical focused internal audit reports are presented to every committee meeting. The following internal audit reports were discussed during the year: Incident reporting Whistle blowing arrangements Health and Safety Governance arrangements HR arrangements – employment checks Implementation and status reports on audit recommendations Findings from clinical audits and recommendations and work programmes arising from these results
Other	Reviewed and updated the committee terms of reference and annual workplan Reviewed the Freedom of Information Act annual report

Effectiveness of the committee

The committee will conduct a review of its effectiveness and impact in July 2015. Aspects of the Board evaluation survey in 2014 focused on quality governance and the role of the committee. No significant concerns were raised, with the majority of respondents agreeing or strongly agreeing that there is clear accountability for quality of care throughout Great Ormond Street and that there are systems and processes in place for escalating and resolving quality issues.

Statement of accounting officer responsibilities

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 NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the National Health Service 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.
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance.
- Prepare the financial statements on a going concern basis.

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

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

Signed
Dr Peter Steer
Chief Executive Date: 22 May 2015

Head of Internal Audit Opinion

Basis of opinion for the period 1 April 2014 to 31 March 2015

Our internal audit service has been performed in accordance with KPMG's internal audit methodology which conforms to Public Sector Internal Audit Standards. As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) or International Standard on Assurance Engagements (ISAE) 3000. PSIAS require that we comply with applicable ethical requirements, including independence requirements, and that we plan and perform our work to obtain sufficient, appropriate evidence on which to base our conclusion.

Roles and responsibilities

The Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The Assurance Framework should bring together all of the evidence required to support the AGS.

The Head of Internal Audit (HoIA) is required to provide an annual opinion in accordance with Public Sector Internal Audit Standards, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the system of internal control). This is achieved through a risk-based programme of work, agreed with Management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below.

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

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

Opinion

Our opinion is set out as follows:

- Basis for the opinion;
- Overall opinion; and
- Commentary.

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas; and
- An assessment of the process by which the Trust has assurance over its registration requirements of its regulators.

Our overall opinion for the period 1 April 2014 to 31 March 2015 is that:

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

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

Our opinion covers the period 1 April 2014 to 31 March 2015 inclusive, and is based on the eight audits that we completed in this period.

The design and operation of the Assurance Framework and associated processes

The Trust's Assurance Framework does reflect the organisation's key objectives and risks and is reviewed on a regular basis by the Board and its sub-committees.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year

We issued one 'partial assurance with improvements required' and no 'no assurance' assurance opinions in respect of our 2014/15 assignments. This partial assurance conclusion related to our audit of the arrangements for the delivery of Productivity and Efficiency savings.

We raised one high risk recommendations in period within our audit of the arrangements for the delivery of Productivity and Efficiency savings. This will be addressed early in 2015/16. We note that the four high risk recommendations outstanding from previous financial years that were brought forward at the start of the period have now been fully addressed.

KPMG LLP
Chartered Accountants
London
22 May 2015

Annual Governance Statement

1 Scope of responsibility

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

2 The purpose of the system of internal control

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

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

The system of internal control has been in place in GOSH for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts 2014/15.

3 Capacity to handle risk

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

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

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

The Board has a comprehensive work programme which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information which enables it to scrutinise the effectiveness of the Trust's

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

There are two Board assurance committees, the Audit Committee and the Clinical Governance Committee 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. The roles and responsibilities of these Committees, a description of their work during the financial year and the attendance record of members is set out on pages [?**XX**] and [?] respectively. 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 receives 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.

The Learning and Implementation and Monitoring Board, was established to ensure that learning from incidents and complaints is effective, remedial actions taken and learning disseminated to staff not involved in the original incident. The Board is chaired by the Chief Operating Officer and reports to the Clinical Governance Committee.

There are a range of other processes to ensure that lessons 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 Trust has reviewed its compliance with the NHS Foundation Trust license conditions and in relation to condition 4, (the requirement that Trusts do not allow unfit persons to become or continue as governors or directors), it has concluded that it fully complies with the requirements and that there are processes in place to identify risks to compliance . No significant risks have been identified.

The strategy is integrated into the management, performance monitoring and assurance systems of the Trust to ensure that safety and improvement is embedded in all elements of the Trusts work, partnerships and collaborations and existing service developments. This enables early identification of factors whether internally or externally driven, which may prevent the Trust from achieving its strategic objectives of ensuring 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. Risks are divided between strategic and operational risks. The Framework includes cross references to assurance obtained from internal and external audits and self-assessments of compliance with other regulatory standards. It has been monitored and updated throughout the year.

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

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
- use of self-assessment tools.

Further risks are also identified through specific consideration of external factors, progress with strategic objectives and other internal and external requirements affecting the Trust.
Risks are evaluated using a “5x5” scoring system that enables the Trust to assess the impact and likelihood of the risk occurring and prioritise accordingly. Assessments are made as to whether the prioritised risks are acceptable or not.

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

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

- Difficulties in recruiting and retaining highly skilled staff with specific experience
- Maintaining patient safety in very high intensity and complex clinical services which includes ensuring that there are adequate staffing levels at all times including out of core hours
- The risk of a significant deterioration in the Trust’s financial position as a result of:
    - the significant reductions in tariff;
    - challenges in completing contracts with NHS Commissioners for 2015/16; and
    - difficulties in delivering the required levels of cost reduction without adversely impacting the quality of services;
    - delivery of funding targets for non NHS activities.
- Delivery of the Trust’s major redevelopment programme on time and without impacting patient access to clinical services ; and

- Failure to ensure that all assets, facilities and equipment on the site are maintained at the required safe and sustainable level
- Delivering the changes necessary to streamline patient pathways through the hospital in order to obtain the maximum benefits from investment in technology.

Each of these risks are broken down into a number of component parts covering the different drivers of these risks, and appropriate mitigating actions for each component identified.

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

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 in closing down the recommendations. The committees also seek other forms of assurance which include the results of regulatory and other independent reviews of compliance with standards, relevant performance information, and management self assessments coupled with the associated evidence base.

Key elements of the Trust's Quality Governance arrangements

The Trust places a high priority on quality, measured through its clinical outcomes, patient safety and patient experience indicators. The Trust has assessed and concluded satisfactorily on its Quality Governance arrangements using the Monitor Quality Governance Framework .

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 (CQUINS).
- Key performance indicators are presented, on a monthly basis, to the Trust Board. This includes progress against external targets (such as how we keep our hospital clean), internal safety measures (such as the effectiveness of actions to reduce infection) and process measures (such as waiting lists) and other clinical quality measures including CQUINS. It also includes the external indicators assessed and reported monthly by the CQC.
- The Boards regularly receives reports on the quality improvement initiatives and other quality information (such as complaints, incidents and reports from specific quality functions within the Trust such as the Patients Advice and Liaison Service). The 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 the Friends and Family surveys, a more 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. The data quality improvement plan is monitored by the Audit Committee to ensure that the Board receives assurance of the quality of this data.

Compliance with the Foundation Trust License Conditions

An assessment has been carried out of the Trust's processes to ensure that it complies with the License Conditions and in particular License condition 4 (governance). The conclusion of the review was that the Trust's governance processes and structures are effective.

A review was also carried out of the Trust's processes to provide assurance to the Board in relation to the Corporate Governance Statement. This included consideration of each element of the Corporate Governance Statement and identification of the assurance process for each element. This included a review of information and performance indicators provided to the Finance & Investment Committee and the Trust Board, the performance management processes applying to all divisions and departments within the Trust, and how risks relating to adverse performance variances are managed.

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 a scheduled inspection in April 2015 and their report will be issued in the first half of 2015/16. The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

Involvement of stakeholders

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

discussions of service issues and other pertinent risks with Commissioners. Staff from the Trust are also involved in strategic planning groups with commissioners and other healthcare providers.

Data security

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

There have been two serious information governance incidents during the year. Details of the incidents and the further action taken to reduce the risk of a similar incident happening again are described on pages [??]

Other regulations

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

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 UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Governance section within the Annual Report explains how the Trust is governed and provides details of its Board committee structure, the frequency of meetings of the Board and its Committees, attendance records at these meetings and the coverage of the work carried out by committees. The Board has assessed its compliance with the Monitor Corporate Governance code and not identified any areas of non-compliance.

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. In addition the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and where significant these are reviewed by the Trust Board.

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

performance and some specific Trust projects aimed at increasing efficiency are included in the director's report.

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

6 Annual Quality Report

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

There are a number of controls in place to ensure that the Quality 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 has a wide range of specific clinical policies in place to ensure the quality of care. These address all aspects of safety and quality. Policies are used to set required standards and ensure consistency of care.

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

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

During the year, a review of the Trust's waiting list data revealed two data quality issues; a relatively high proportion of patients within the incomplete pathways did not have clock starts; and the records of incomplete pathways included pathways for a particular specialty which are not within the scope of the national indicator. The Trust was asked by its Commissioners to carry out an audit of this data and support has been requested from the national response team. An action plan will be put in place to address these issues.

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

There was one never event (wrong site surgery) reported during the year which was subsequently remedied.

7 Review of effectiveness

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

the assurance obtained from the Assurance Committees and reports from internal and external auditors and self-certifications of compliance with various regulatory requirements.

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

My review of the effectiveness of the system of internal control has been informed by reports at the Board, the Audit Committee and the Clinical Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

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

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 with minor improvements required.

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:

Control weaknesses

- The Trust has identified weaknesses in the processes for managing contracts resulting in delays to procurement. A programme has been developed to address the outstanding issues.
- The Trust's business continuity plan had not been kept up to date in all areas and the programme of testing the plan had fallen behind. This has now been addressed.
- Data quality – as detailed in section 6 above, a review of the Trust's waiting list data highlighted two recording issues which affected the accuracy of the waiting list indicators reported during the year.

Assurance weaknesses:

- It is difficult to obtain assurance on the adequacy of the long term funding of the Trust due to the recent reductions in tariff and adjustment of contract terms for specialist services by NHSE
- An internal audit report on the management of the Trust's productivity and efficiency programme identified some assurance gaps which are actively being addressed. These included the absence of project documentation and quality impact assessments for some schemes within the programme and inconsistencies in the risk assessments of certain schemes.

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

In addition, monitoring of incidents and complaints has highlighted gaps in assurance in the Trust's processes for managing the impact of estates projects whilst maintaining services in the same area. These have now been addressed with more effective communication between the teams responsible.

The Board has reviewed the risks and assurance available in relation to both its redevelopment programme and its information 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.

I have considered the results of the assessment of compliance with the Monitor Code of Governance for NHS Foundation Trusts (which are set out in the Annual Report on page XX), the Trust's license conditions and a self-assessment using the Monitor Well Led Framework, and no issues in compliance were identified.

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 gaps are being actively addressed. There have been no significant control issues identified during the period.

Signed……………….....................

DR PETER STEER

Chief Executive
Date: 22 May 2015

Independent Auditor's report

[To be provided]

Accounts

[Attached separately]

Glossary

[To be provided]

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
22nd May 2015

Quality Report 2014/15 **Submitted by:** Prof Martin Elliott, Co-Medical Director	**Paper No:** Attachment N

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

The production of the document is in line with Department of Health and Monitor published requirements. One document has been produced, which meets the requirements of both.

Action required from the meeting
Sign off of Quality Report

Contribution to the delivery of NHS Foundation Trust strategies and plans
This document describes quality improvement work that has taken place in line with Trust strategic aims and in line with quality as defined in the Next Stage Review. The document also outlines the Trust's quality improvement work for 2015/16.

Financial implications
None

Who needs to be told about any decision?
Deloitte

Who is responsible for implementing the proposals / project and anticipated timescales?
The delivery of the report is the responsibility of the Clinical Outcomes Development Lead. The deliveries of the projects therein are the responsibility of the individual project teams.

Who is accountable for the implementation of the proposal / project?
Prof Martin Elliott, Co-Medical Director

Great Ormond Street
Hospital for Children
NHS Foundation Trust

Quality Report 2014/15

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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 is NHS Choices?

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

What does it include?

The content of the *Quality Report* includes:

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

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

What is a Foundation Trust?

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

Understanding the *Quality Report*

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

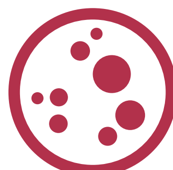
This is a "what is" box

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

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

Our hospital

51
specialties



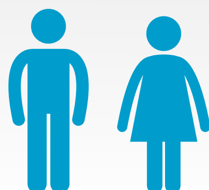
875
active research studies

66,095
patient visits

97%
of parents and patients would recommend the hospital

1,581
outpatient clinics

84,048
procedures performed



4,153
permanent and fixed-term staff

19
highly specialised national services

(tbc)
scientific papers contributed to by clinicians

Part 1
A statement on quality from the Chief Executive

Great Ormond Street Hospital is one of the world's leading children's hospitals, providing care and treatment for children with some of the world's rarest and most complex illnesses. Last year, over 240,000 patients visited GOSH, and were seen by our clinical teams, which span 51 specialties.

We believe that everyone who comes through our doors should have an excellent experience at GOSH. This means making sure that all our patients receive the highest quality and safest care in a friendly, nurturing environment; that we actively engage with the parents and carers of our patients so that they feel supported during what is often a very challenging time; and that our staff feel well-prepared and empowered to deliver excellence in all they do.

This Quality Report is one way we can provide information on how well we are meeting those expectations. While some standards are set externally and we strive always to find ways of meeting and bettering our performance against them, a primary driver for many of our quality improvement efforts arise from listening to our patients, their carers and families, our commissioners and other stakeholders. We also seek input from our staff as we identify and implement actions to improve the quality of the GOSH experience.

In part three of this report, you will find the results of our performance against key external quality indicators. This includes aspects such as whether we have met waiting time targets for our patients with cancer and are providing appropriate access to healthcare for people with a learning disability. I am very pleased to say that we have met or exceeded the majority of the key targets set for us. Of note, we narrowly missed our 18 week referral to treatment target for our admitted patients and we have an action plan in place to improve this going forward.

In this same section, we have also set out the results of quality improvement targets we have set ourselves locally. These cover areas such as reducing the number of serious patient safety incidents and CVL bloodstream infections; delivering lower hospital mortality rates and completing discharge summaries swiftly and efficiently.

The second part of this report provides information on how we have performed against the 2014/15 quality priorities we have set for ourselves. These fall into three categories:

Priority one – safety

To reduce all harm to zero.

Priority two – clinical effectiveness

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

Priority three – experience

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

Safety

We continually strive to reduce harm to zero. One example of this is the work that we continue to do to decrease the rate of infection, in particular, infections that result from Central Venous Lines (CVLs) or catheters (CVCs). Through sustained focus over recent years, we have made significant gains, and this has been shown in the reduction from four per 1,000 line days in 2007/8 to two per 1,000 line days in 2011/12. Having seen progress tail off in 2012 and 2013, we introduced some extra interventions that could help drive down infection rates even further. While these involved considerable additional staff time for each line, we needed to be sure that our increased vigilance would deliver the results we wanted so we also set up detailed monitoring of line infection rates for each ward, division and for the whole Trust. I am pleased to report that the considerable investment of clinical staff time and effort has paid off: throughout 2014/15 we have seen a sustained decrease in infections, with the rate now down to 1.4 per 1,000 line days.

Fewer CVL infections means less harm to patients, be that additional antibiotic treatment, additional operations to remove and replace lines, and disruption to treatment. Reducing these infection rates also means there are more resources available to help other children.

In addition, we continue our work to prevent pressure ulcers. We have done this through a range of approaches: from training to specific risk assessment, trialling and now agreeing to roll out new specialist air mattresses for our sickest neonates and appointing a nurse specialist with specific remit to review and advise nursing staff on how to prevent or care for patients with pressure ulcers. This work has resulted in zero grade three pressure ulcers in the past year and zero grade four pressure ulcers for three years now. Grade two pressure ulcers have also been reduced, further reducing harm. Our work has also been shared with other teams, both nationally and internationally.

Clinical effectiveness

Given the evidence from leading health centres on the adverse impact that variability of patient care pathways can have on cost, outcomes and patients, we have worked on two areas of variability over this past year. They are:

- The care of neonates with jaundice
- Anaesthetic pre-operative assessments

The work on jaundice in neonates incorporated efforts across the Trust to raise the profile of neonatal jaundice to support clinical staff in practicing care that is in line with best recommended care standards, including additional training and education, on-going clinical audit and display of results, and new information resources on jaundice for families. In the course of the year, we have seen good progress but will be continuing the work to ensure improved practice is maintained and awareness of neonatal jaundice remains high amongst our clinical staff.

To address the variability in pre-operative assessment, we introduced an anaesthetic pre-operative assessment clinic (APOA) across several surgical specialties. We began this clinic in January 2015 and initial impact of the clinics has been good. The monitoring period of this new approach will be completed in the summer after which, we anticipate being able to roll out the new APOA model across the Trust. We believe that by having a comprehensive and standardised pre-operative anaesthetic process for all patients needing a procedure under general anaesthetic, we will improve patient safety, reduce unnecessary cancellations and improve patient experience.

Other work that has been undertaken this year on clinical effectiveness includes making our clinical outcomes more accessible to the public. This year, we have added 47 outcomes across 17 clinical specialties to our website. We include in this report a selection of our world-class outcomes, of which we are proud. We have also done further work to find ways to measure our outcomes with our peers, both nationally and internationally. We believe that increasing visibility and use of our outcomes data will result in improved outcomes for our patients as well as increased choice of where they wish to receive care.

Experience

This year, we have begun the implementation of our new values and behaviours, which we created through active engagement with patients, families and staff. The adoption of these new behaviours will be a key driver to ensuring that we consistently provide an excellent experience for all those who interact with GOSH. We will embed these through a range of different approaches, from leadership development to implementing values-based recruitment. This is long term programme of events, but the enthusiasm of patient and parents who have helped us throughout the development of the values, and the active participation of all those who attended our launch event in March, provide us with a strong foundation on which to build for the future.

As part of our work on patient experience, we appointed a Nurse Consultant Intellectual (Learning) Disabilities in September 2013 to identify and then implement improvements in the service we provide for our patients with learning disabilities. We have also set up an alert system to enable staff to plan care more effectively, and we now have dedicated protocols governing the theatre and recovery experience so all staff can better meet individual needs, and we have enhanced both our information links and our staff training. We will continue this work, to further increase staff confidence in supporting patients with learning disabilities, and to reduce anxiety about hospital that may be experienced by patients and their carers.

We recognise that haven't achieved all that we've hope such outpatient pharmacy with time.

As this report shows, there are many areas where, over the past year, we have make great improvements to the quality of the GOSH experience. We are, however, equally cognisant of the continued work we need to do to provide the consistently excellent experience we want for everyone who comes into contact with GOSH. One such area where we have not made the strides forward that we have hoped to is in the reduction of waiting times in our outpatient pharmacy. This is an area where we will have a very deliberate focus over the next year to ensure progress is made.

Improving the quality of care and experience we provide is a continual process and one that we can only do by robust monitoring and listening to our patients, their families and carers, our key stakeholders and our staff. By working together I am confident that we can drive real improvements and take tangible steps to realise our vision.

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

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

The Trust and its executive team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to my knowledge, the information in the document is accurate. The only exception being the matters identified in respect of the 18 week referral to treatment incomplete pathway indicator as described on page 41.

Peter Steer
Chief Executive

Part 2a
Priorities for improvement

This part of the report sets out how we have performed against our 2014/15 quality priorities. These have been determined by a combination of national priorities as well as local priorities identified by staff, patients and their families, and wider stakeholders such as referrers and commissioners. The quality priorities fall into three categories: 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.

Safety

To reduce all harm to zero.

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 every patient receives the correct treatment or action the first time, every time.

Clinical effectiveness

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

Delivering effective care is, and always has been, a primary focus of GOSH. Since 2011, we have been demonstrating the effectiveness of our care through the identification of clinical measures and Patient-Reported Outcome Measures (PROMs), and by publishing this data on our website. Wherever possible, we 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

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

We recognise that the 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 wider public via our membership, patient and member surveys, listening events, focus groups, the use of social media, and asking patients and families about their experience within 48 hours of discharge.

Reporting our quality priorities for 2014/15

Safety section

Reducing central venous line infections

Central venous lines (CVLs) or catheters (CVCs) are very important for administration of care, but are also invasive devices associated with serious complications, such as infection. We undertake multiple interventions during insertion and care to reduce the incidence of infections.

What we said we'd do

For many years, we have worked hard to reduce the rate of infection. Very significant Trust-wide gains had been made, from a rate of four per 1,000 line days in 2007/8 to two per 1,000 line days in 2011/12, but this remained unchanged in 2012/13 and 2013/14. During 2014/15, we hoped to reduce further the rate of infection by promoting compliance with all the accepted components of the care bundles and the introduction of extra measures.

What is a care bundle?

A care bundle is a structured way of improving processes of care and patient outcomes. It is a small straightforward set of practices that, when performed collectively, reliably and continuously, have demonstrated improvement in patient outcomes.

What is a 'line day'?

One line day is counted for every day that a child has a single CVC in. If they have two different CVCs in at the same time, then we count two 'line days' for each calendar day.

What we did

We introduced extra interventions including the use of antiseptic-impregnated patches to protect the skin entry site, and the use of a protective Parafilm® wrap around the line connection points to help keep them clean. These extra interventions used a lot of staff time, so to help us know if it was effective we undertook continuous surveillance, which gave a measure of line infections per 1,000 line days for individual wards, divisions, and the whole Trust.

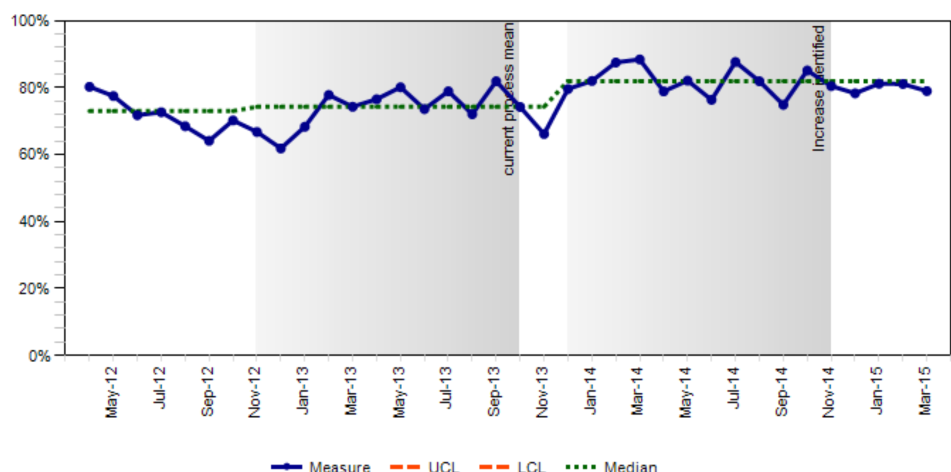
What the data shows

The ward and microbiology staff undertook detailed surveillance to determine the rate of infection. This involved counting and recording every line in every child every day, then analysing every positive blood culture using standard criteria to see if there was a possible line infection (defined as a GOSH-acquired CVC-related bacteraemia). The number of line days and infections each month were matched to give a rate, which was then charted. The ward staff also undertook monthly audits to see if they were complying with the standard care bundles.

Overall compliance with the standard care bundle improved towards the end of 2013, and then remained static into 2014. This was a composite indicator, incorporating compliance with completion of the audit (each ward is asked to undertake 10 audits a month) and compliance with the components of the care bundle. Incomplete audits were scored as non-compliant and as a result of time constraints not every ward was able to complete 10 audits every month. Therefore, some non-compliance figures may be for wards that were compliant, but did not complete the audit to confirm this.

The average monthly composite Trust-wide CVL care bundle audit is shown below.

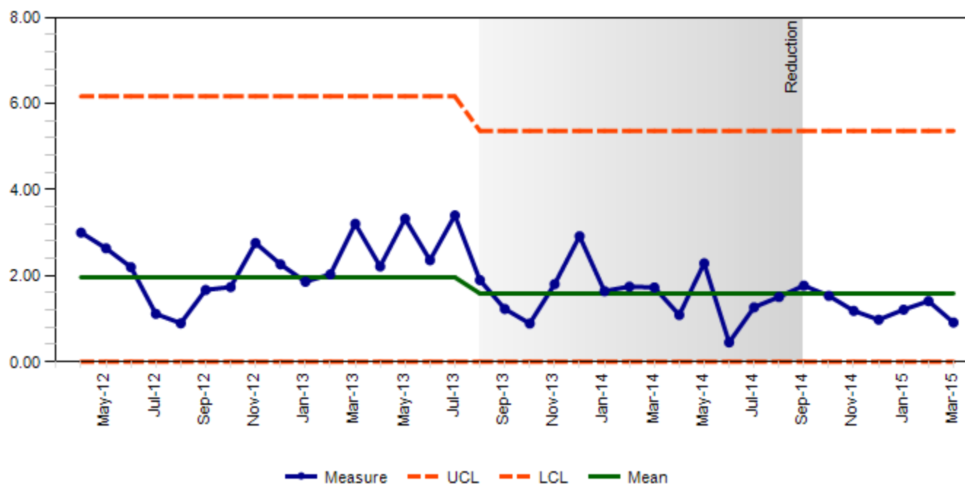
CVL bundle compliance: all wards



In real terms, during the first 11 months of the financial year 2014/5, there were 3,500 care bundle compliance audits. Compliance of completed audits was 87 per cent, although this improved to 91 per cent in the second half of the year. Compliance with the additional interventions was not measured.

These results represent an enormous investment of clinical staff time and effort. The good news is that the rate of infections has shown a sustained decrease throughout the year: for 2014/15 the rate is 1.4 per 1,000 line days, compared to 2.1 in 2013/14 and 2012/13, shown in the monthly process control chart below.

GOSH-acquired CVL infections for every 1,000 line days: all wards



What this meant for our patients is that there were approximately 35 fewer serious infections during the year, compared to each of the previous two years.

Statistical Process Control Charts

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

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

What's going to happen next?

Although the infection rate is quite low, this rate still represents around 80 children a year with a CVC infection. Next year, we would like to try to reduce this further by working even harder to approach 100 per cent compliance with the standard care bundle. We will also introduce the additional care measures (which were introduced in limited areas with the highest infection rate) to other areas of the Trust.

We will continue to undertake the surveillance to help every ward keep up the good work and allow us to see if we can make further improvements.

How this benefits patients

Fewer CVL infections at GOSH means less harm to patients, such as otherwise unnecessary antibiotic treatment, additional operations to remove and replace the lines, and disruption to treatment. Equally important, there are also more resources available to help other children.

Improving flow through our intensive care units

The smooth flow of patients through our Paediatric Intensive Care Unit (PICU) and Neonatal Intensive Care Units (NICU) is vital to the effective running of the hospital. We need to ensure patients can get into and out of these wards in a timely and safe way to reduce cancellations and refused referrals to the Trust.

What we said we'd do

We said we would improve the flow of patients through PICU and NICU. We agreed to do this by understanding the reasons why patients who had a confirmed bed on PICU or NICU were cancelled at short notice, resulting in the bed not being used and

thus potentially denying another patient use of that bed. Once this was understood, we could make appropriate improvements.

What we did

Six simultaneous work streams were initiated by a dedicated team with the overall aim 'to reduce the number of PICU and NICU bed hours lost to avoidable delays or cancellations, by 31st December 2015'. The specific areas identified for improvement were:

PICU and NICU admissions

- Review of the referral process into PICU and NICU for elective admissions:
  - The introduction of an electronic system for referring elective patients, allowing clinicians within the hospital to track the progress of their referral, ensuring an audit trail.
  - A shared electronic calendar within the referral system, displaying all booked referrals, which enabled the user to select an appropriate date for the request. Daily referral limits were set to ensure admissions were spread across the week.
  - An anaesthetic review was introduced into the referral process for all elective patients referred to PICU and NICU. Once approved, the referral progressed to the PICU and NICU consultant teams for review. This step was added to reduce the number of cases booked 'just in case'.
- Guidelines were developed to ensure that all patients admitted to PICU and NICU have a named consultant who agrees to accept them on discharge from PICU and NICU, as this had been identified as cause of transfer delays.
- Prioritisation criteria for admission into PICU and NICU were agreed. These criteria ensured that there was transparency and consistency for admission selection when demand for a PICU or NICU bed was high.

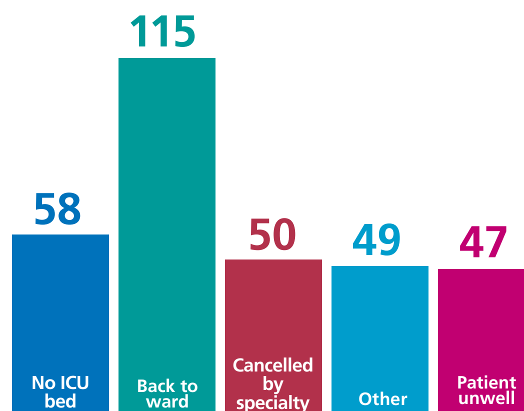
PICU and NICU discharges

- A discharge co-ordinator role was trialled. The co-ordinator looked specifically at all patients' discharge plans on a daily basis and co-ordinated with wards internally and other hospitals externally, to ensure smooth and timely discharges from the units.
- Review of ward capabilities for PICU and NICU discharges. To reduce the number of delayed discharges to the wards, an updated list of skills required by specific wards was created.
- Active discharge planning was introduced. PICU and NICU board 'huddles' occurred every morning with the PICU and NICU multidisciplinary teams, reviewing and escalating patient discharges.

What the data shows

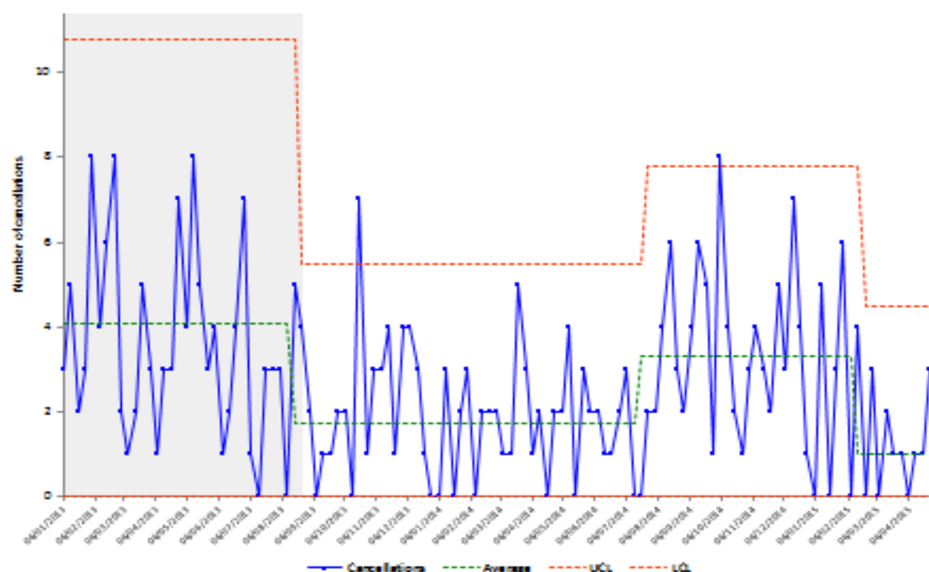
Throughout 2014, we collected specific data to identify the short-notice cancellation reasons for patients who had an ICU bed booked. The results are shown in the bar chart below.

Reasons for cancellations

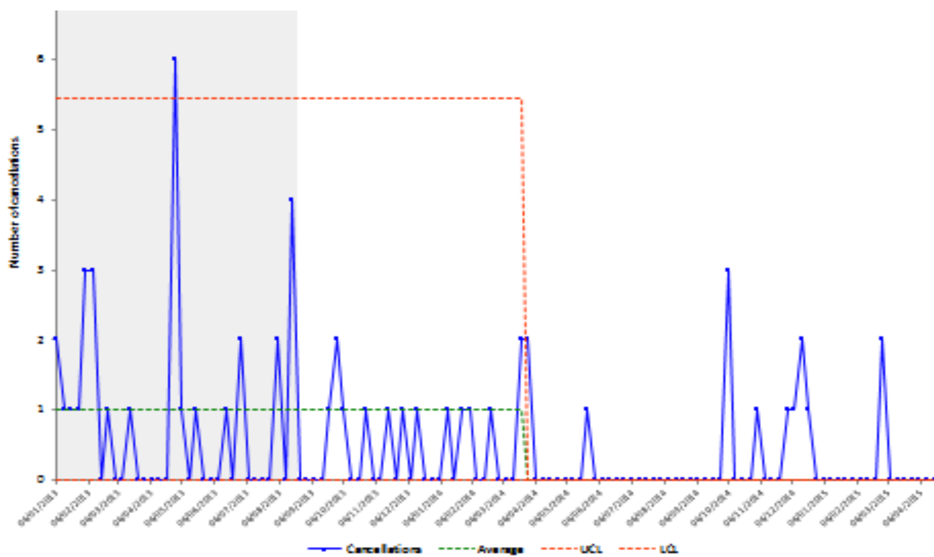


Overall, ICU has experienced a reduction in the number of elective cancellations, with a statistically significant reduction in February 2014.

Elective admissions cancellations: all cancellations



Elective admissions cancellations: ICU cancellations



What's going to happen next?

We continue to work with the Clinical Divisions to spread elective referrals across the working week and improve the quality of information gathered prior to agreeing an elective ICU admission. We also plan to improve the pre-operative assessment of the probability of an ICU bed being required. These interventions aim to reduce the peaks and troughs in demand and reduce the likelihood of patients having an ICU bed booked unnecessarily.

How this benefits patients

These improvements will ensure that our patients experience an admission process through PICU and NICU that is seamless. They will have their procedure or surgery booked, confident in the knowledge that cancellations caused by lack of PICU or NICU beds become a rarity.

> "The new electronic referral system has made it much easier to monitor current referrals and track progress. It allows us to quickly and easily keep all relevant individuals updated when a patient's condition changes, leading to a smoother patient journey."
>
> Rory, Patient Pathway Manager

Preventing pressure ulcers

What is a pressure ulcer?

A pressure ulcer is a sore that develops from sustained pressure on a particular part of the body. It affects areas of skin and underlying tissue. Pressure ulcers are graded from one to four depending on the degree of injury to the skin, with higher grades being more severe. Critically ill children are more at risk of getting pressure ulcers because the severity of their condition can make it difficult to reposition them.

Here at GOSH, we use the internationally recognised European Pressure Ulcer Advisory Panel grading system (EUPAP 2014). The definitions of those grades are as follows:

Grade 1 Intact skin with redness caused by pressure shear or friction.

Grade 2 Typically presenting as a blister or abrasion with surrounding redness.

Grade 3 Deeper ulcers involving full thickness skin loss extending to fascia involving tissue necrosis.

Grade 4 Deep ulcer exposing bone, tendon or muscle with tissue necrosis.

www.epuap.org/wp-content/uploads/2010/10/Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-16Oct2014.pdf

What we said we'd do

We said that, we would continue to reduce the number of GOSH-acquired pressure ulcers that were avoidable, particularly focusing on those that occur as a result of some of the medical devices we use to treat patients (for example, breathing and feeding tubes).

What we did

We have continued to develop and deliver teaching and training packages at GOSH that focus on both the prevention and management of pressure ulcers. A new specialist 'Maintaining Skin Integrity' course has been developed, delivered internally, and attended by ward-based tissue viability link nurses.

Training across the organisation has included the prevention of medical device-related pressure ulcers, and an acronym has been devised to support nurses (see below). This is now included within our induction training for new staff and an article was published in our staff magazine, *Roundabout*.

DEVICE – preventing medical device-related pressure ulcers

To support nurses to prevent device-related pressure ulcers we use this acronym in our teaching:

D.E.V.I.C.E – Preventing medical device related pressure ulcers
Document skin integrity on and throughout admission
Ensure equipment is correctly sized and fits the child to avoid excessive pressure
Visualize skin under the device regularly (if possible)
Inspect skin/device interface and use protective dressings
Correct tension, positioning and follow manufacturer's specifications
r**E**position device regularly (if it is clinically safe to do so)

We embedded the Glamorgan Pressure Ulcer Risk Assessment in 2012/2013, and we have achieved 98 per cent compliance, with patients receiving a daily risk assessment score. This demonstrates the ongoing commitment of our nurses in maintaining the skin integrity of our patients. Compliance with the risk assessment score is measured monthly as part of nursing key performance indicators.

98%

compliance with patients receiving a pressure ulcer risk assessment on admission

We trialled a new specialist air mattress to reduce pressure for our sickest neonates and, based on results, we have committed to purchase this equipment.

In January 2015, a new Tissue Viability Nurse Specialist joined the team. The Tissue Viability team review all pressure ulcers within the organisation, attend the wards to help advise nursing staff on different strategies for caring for patients who are at risk of developing a pressure ulcer, and also care for children who have severe and complicated nappy rash.

We have also shared our pressure ulcer work nationally and internationally. The Nurse Educator who works alongside the Tissue Viability team presented the work of the Trust at an international European Pressure Ulcer Advisory Panel conference in Sweden and also sat on the National Institute of Clinical Excellence Pressure Ulcer Quality Standards development committee.

What the data shows

As a hospital, we are proud that we have seen zero grade 3 pressure ulcers in the past year. This demonstrates our nurses' commitment to protecting patients' skin integrity, and it is a particular achievement for our PICU and NICU nurses caring for many of the sickest patients who are more susceptible to developing pressure ulcers.

2012/13

2013/14

2014/15 (0)

The number of hospital-acquired grade three pressure ulcers has reduced from seven in 2012/13, to three in 2013/14, to zero in 2014/2015, and no grade four pressure ulcers in all three years.

zero

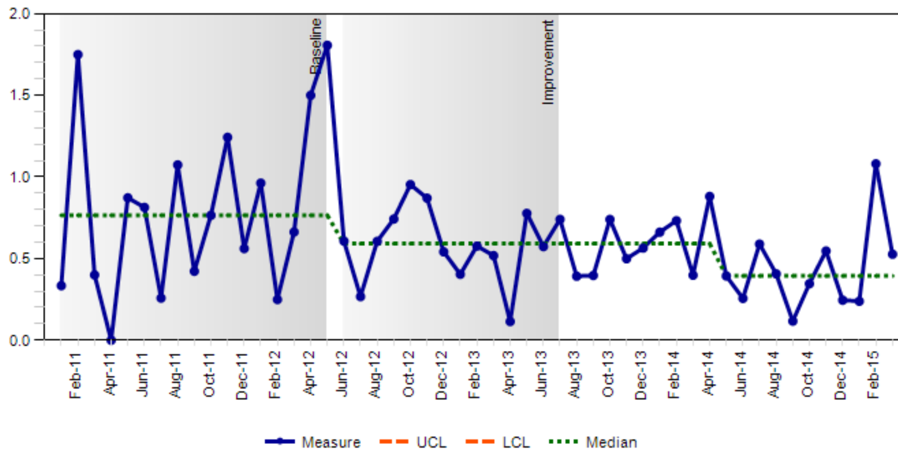
grade 4 pressure ulcers for three years

PICU has also seen an overall 48 per cent reduction in grades 2+ hospital-acquired pressure ulcers per 1,000 bed days, according to Statistical Process Control methodology. A statistically significant improvement was identified from February 2014 onwards.

48%

reduction in grades 2+ pressure ulcers

Hospital-acquired pressure ulcers reported (grades 2+) per 1,000 bed days: PICU



What's going to happen next?

In 2015/16, we will continue to review our pressure ulcer data regularly and seek to further reduce the number of hospital-acquired pressure ulcers that are avoidable.

We aim to develop our ward-based network of tissue viability link nurses on each inpatient ward, with regular training sessions and communication with the Tissue Viability team.

We will review the current nappy care guidelines. We are planning to work with staff from across the organisation to increase their knowledge of skin damage caused by urine, faeces, and perspiration that is in continuous contact with intact skin. In turn, this will help empower staff to educate parents on the best creams and strategies to use to help reduce pain caused by severe nappy rash.

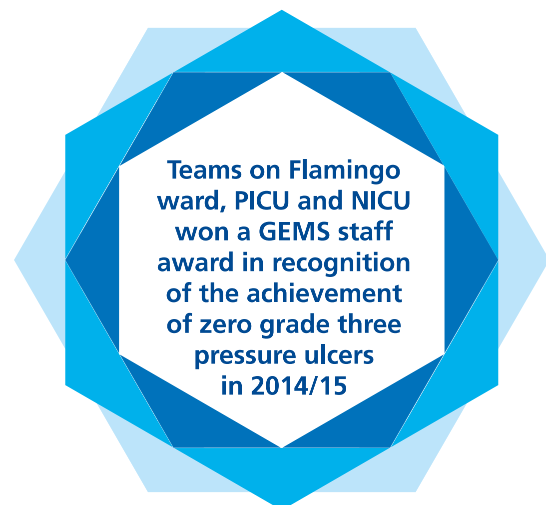
How this benefits patients

The reduction in pressure ulcers and increase in education about nappy care benefits our patients by:

- reducing pain
- preventing infections that can occur when skin is damaged as a result of a pressure ulcer
- reducing nappy rash occurrence for patients
- supporting parents to prevent nappy rash in their children

We are extremely proud to be celebrating our one-year anniversary with no grade 3 pressure ulcers. To mark this auspicious occasion, we hosted a party in the staff room for all members of the PICU and NICU teams, where staff were recognised for all their continued hard work in striving to increase pressure area awareness. In the past year, PICU has worked hard to educate staff on the importance of the early detection and reporting of pressure areas to the Tissue Viability team. From the start of the patient journey, pressure area care has become an integral part of our working day. 'Have a care, be pressure aware!'

Alison, sister on PICU



Effectiveness section

Standardising patient care pathways

Experience from leading centres indicates that variability of practice between physicians and teams can raise costs in healthcare, produce variable outcomes, and negatively affect patient experience. Two of the areas we focused on in the past year to tackle variability were:

- the care of neonates with jaundice
- anaesthetic pre-operative assessment

Care of neonates with jaundice

Our clinical incident reports highlighted the potential to improve the recognition and management of neonatal jaundice.

What we said we'd do

We said we would raise the profile of neonatal jaundice in order to support clinical staff so they are able to practice in line with best recommended care standards.

What we did

Throughout 2014/15, work took place to raise the profile of neonatal jaundice in the Trust. To support staff to practice effectively and to standardise practice in line with National Institute for Health and Care Excellence (NICE) recommendations, we undertook the following interventions:

- Purchased three additional phototherapy units to provide hospital-wide coverage for jaundice treatment.
- Circulated a threshold chart and a best practice flyer to raise awareness and increase early detection of jaundice in neonates.
- Provided additional training and education by the Neonatal Nurse Advisor to support ward teams.
- Developed e-training on how to plot a treatment threshold chart.
- Provided ongoing clinical audit and feedback of results to show progress.
- Developed a new information sheet on jaundice for families.

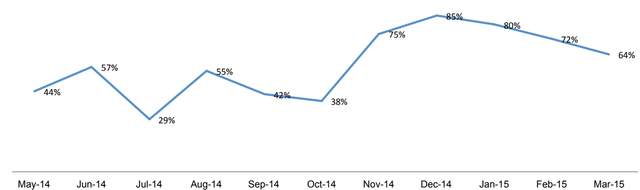
Four must-dos when caring for a neonate

1. Be mindful that every neonate you look after can develop jaundice.
2. Check for signs of jaundice at every opportunity.
3. Do not rely on visual inspection to confirm jaundice – check bilirubin levels.
4. Use the NICE threshold chart to plot bilirubin levels in order to determine whether the level requires treatment.

What the data shows

Data is collected each month for all new cases of jaundice. The chart below shows progress with more neonates receiving care in line with best evidence-based standards. However, the decline between December 2014 and March 2015 shows there is a need to ensure that progress is maintained.

Percentage of new cases of neonatal jaundice where management was as per guidelines



What's going to happen next?

The auditing of how neonatal jaundice is managed will continue as part of the Trust priority clinical audit plan, to ensure that improved practice is maintained and awareness of neonatal jaundice remains high.

How this benefits patients

This will help to ensure that patients are not seriously harmed due to poor management of high bilirubin levels in the newborn period.

Anaesthetic pre-operative assessment

Thorough pre-operative assessment is considered to be an effective method of reducing cancellations and patient non-attendance at appointments, through mechanisms of assessment and preparation of the patient (NHS Institute for Innovation and Improvement 2008).

What we said we'd do

We knew from complaints, incident reporting and coroners' reports that pre-operative assessment was variable across the Trust in occurrence, multidisciplinary input, timing, and purpose, and that it also varied by clinical division and specialty. This has at times been a factor in list changes, cancellations, and last-minute specialty reviews. These process problems can be an inconvenience to patients and their families, but they can also be a source of clinical risk.

To address the variability in pre-operative assessment we said that we would introduce anaesthetic pre-operative assessment (APOA) to augment the existing specialty surgical pre-operative assessment.

What we did

After planning and preparation, the APOA clinic opened at the beginning of January 2015. The plan is that all patients in the Surgery division will attend this clinic or be reviewed by the team. The standardised nursing process is supported by an anaesthetic consultant and input from specialist teams, such as Cardiology, Respiratory, Metabolic and Endocrinology, who advised on agreed referral criteria and the tests and assessments required. The clinic commenced with Dental, Maxillofacial, Plastic Surgery, Hand and Upper Limb Surgery and Ear, Nose, and Throat (ENT) departments in January, followed by the Specialist Neonatal and Paediatric Surgery and Audiology departments in February, and most recently Urology, Spinal (non-pathway), and Cleft Lip and Palate departments in March.

What the data shows

524 elective surgery patients have been referred to the anaesthetic pre-op assessment clinic

Up to 31 March, 524 patients have been referred to the clinic, of which:

- 69 per cent have been cleared from the process for surgery
- 22 per cent are booked to return due to the date of surgery or for reasons of patient choice
- 9 per cent are currently being assessed.

The impact of the improvements will be assessed over the next 12 months by comparing complaints and incident reporting before and after the introduction of the clinic and standardised nursing process.

What's going to happen next?

New systems are being monitored to ensure they are working well and meeting expectations. Implementation for the surgical division will be complete in summer 2015. The dashboard will be monitored for the impact of the service and an audit for patient experience is being designed. Once every detail is signed off, the new APOA model will be rolled out across the Trust.

How this benefits patients

A comprehensive and standardised pre-operative anaesthetic assessment process for all patients attending for a procedure under a general anaesthetic will:

- improve patient safety
- reduce unnecessary cancellations
- improve patient experience

> "Being able to refer a patient straight from clinic for pre-assessment review has saved many families unnecessary trips to hospital and reduced unexpected issues on the day of surgery which have in the past led to cancellations. It is a fantastic improvement in our pre-operative care of patients."
>
> Specialist Neonatal and Paediatric Surgeon

Evidence and publish our world-class outcomes

Clinical outcomes are broadly agreed and measurable changes in health or quality of life that result from our care. Routine measurement of outcomes is central to improving service quality and accountability. We are proud of our world-class outcomes, and yet we don't currently publish them all in one place.

What we said we'd do

We said we would demonstrate our outcomes in a way that is accessible and understandable to the public. We already publish outcomes to our website, and in 2014/15, we aimed to include our world-class outcomes in this number.

What we did

In 2014/15, we published to our Trust website[1] 47 outcomes across 17 clinical specialties. Eleven outcomes were updates of data previously published, and 36 were outcomes published for the first time.

To know how good we are compared with our peers, all centres must measure their outcomes in the same way. Comparing outcomes for specialist services is a challenge, and our peers are scattered across the globe. Such comparison has been established in some specialties, including paediatric cardiac surgery (international), kidney transplant (international), HIV (UK and Ireland), cleft lip and palate (national) and intensive care (national). However, the vast majority of outcome measures are decided at individual hospital level and do not necessarily match others' measures.

Where this is the case, we look to established standards or to research published in medical journals in order to get an understanding of expected outcomes for treatment. We have also begun work with international groups devoted to better outcome reporting, such as the International Consortium for Health Outcomes Measurement (ICHOM). We also work directly with 16 leading paediatric centres around the world, including Boston and Cincinnati Children's Hospitals to reach agreement on shared outcome measures for conditions.

1 www.gosh.nhs.uk/health-professionals/clinical-outcomes/

A selection of our published world-class outcomes can be found below.

What the data shows

World-class outcomes from the Cardiac Surgery department

30 day survival for paediatric cardiac surgery (overall, expected and prediction interval)

The 30-day survival rate for paediatric cardiac surgery is a nationally accepted benchmark that is used to judge outcomes. It has to be born in mind, however, that the outcomes should be considered in the context of case mix severity. Furthermore, that 30-day outcome is a relatively limited measure of outcome, with longer term survival and other measures of morbidity being important to consider. The GOSH cardiac team is completely committed to developing other means to monitor outcomes in children with heart disease (see http://www.gosh.nhs.uk/medical-conditions/clinical-specialties/cardiothoracic-surgery-information-for-parents-and-visitors/research/complications-after-heart-surgery/)

In the three years 2012 to 2015, there were 1900 cardiothoracic operations performed in our unit, of which 99.0% of patients survived to 30 days. When these outcomes are benchmarked using the Partial Risk Adjustment in Surgery (PRAiS) model, the **results are better than expected based on the confidence limits** selected by the National Congenital Heart Audit (NCHDA).*

* Please note that the validation process and the external validation visit for our paediatric cardiac surgery audit data will not take place until 25 June 2015 and these data will not be confirmed as accurate by NCHDA until early 2016.

The data are shown in more detail below. For those readers interested in the results for individual specific operations, these can be found at:

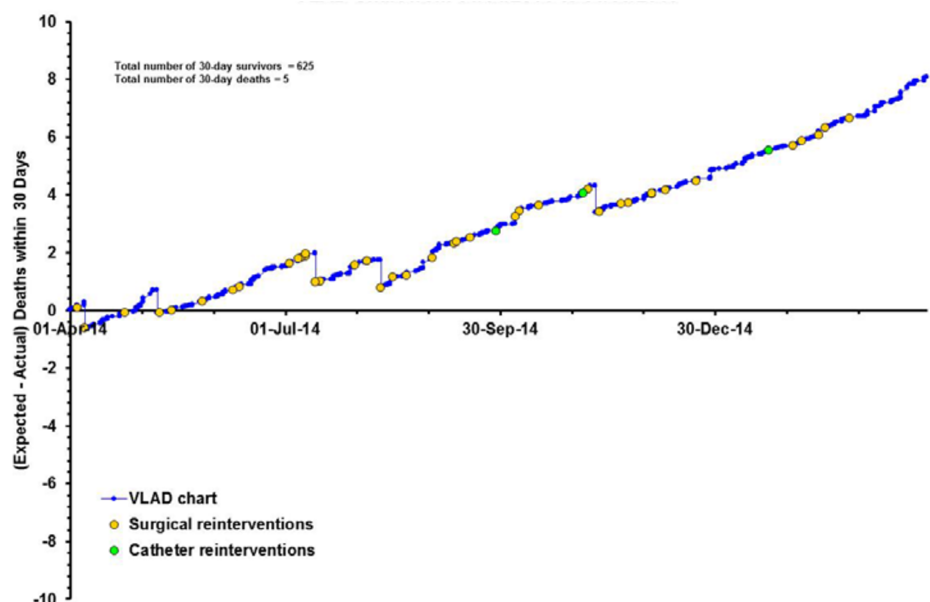
https://nicor4.nicor.org.uk/CHD/an_paeds.nsf/WBenchmarksYears?openview&RestrictToCategory=2012&start=1&count=500

Cardiorespiratory and Intensive Care Unit – Cardiac Surgery	April 2012 – March 2015	April 2011 – March 2014
Actual 30-day survival rate	99.0%	98.4%
Expected survival rate using PRAiS	97.8%	97.8%
95% prediction interval for observed survival rate	(97.2%, 98.5%)	(97.1%, 98.4%)
Ratio of survival rate to expected survival rate	1.012	1.006
95% prediction interval for ratio of observed survival to expected survival rate	(0.993, 1.007)	(0.993, 1.006)

Our annual Variable Life Adjusted Display (VLAD) plot for paediatric cardiac surgery outcomes

The following VLAD plot shows the trend in 30 day outcome of all cardiac surgery patients under 16 years old during 2014-15, benchmarked against expected based on the Partial Risk Adjustment in Surgery (PRAiS) model. The number of procedures carried out and the number of deaths within the year are written at the top of the plot. Using the national risk adjustment method for paediatric cardiac surgery, the VLAD plot displays how many fewer (or more) deaths there are over time compared to 'what would be expected'. As some readers may be less familiar with VLAD plots, which are now used in all children's cardiac programs in the UK for quality assurance, we have added some information overleaf to guide interpretation.

VLAD chart from 01/04/2014 to 31/03/2015



What would be expected?

We use a recently developed risk model (Crowe et al, JTCVS, 2012) to estimate the risk of death, m, for each patient, taking into account risk factors such as procedure, diagnosis, age and weight.

Interpreting the VLAD chart

Each point on the VLAD chart represents an episode of care (the first surgical procedure for a child in a 30-day care period). If the 30-day outcome is a survival then the VLAD plot goes up by m and if it is a death the VLAD plot goes down by (1-m). The vertical axis is the total number of (expected – actual) deaths: when this is positive (negative) there have been fewer (more) than expected deaths.

- 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. Ending close to zero is not a sign that things are not going well! The risk model essentially benchmarks the unit s outcomes against recent national outcomes in paediatric heart surgery. 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. So typically, m, the estimated risk of death for a patient is small (e.g. about 85% of GOSH patients have estimated risks of 0.1%-5%, and the highest risk is about 20% for the most complex procedures such as some Norwood pro). This means that the VLAD will rise much more slowly for a run of survivors than it will fall for a run of deaths (but of course there are many more survivors than deaths).

What is a VLAD most useful for?

- Spotting trends in outcomes (whether positive or negative) that might prompt discussion
- A visual aid to gain an overall perspective on how things are going. The VLAD plot 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.

World-class outcomes from the Tracheal Service

The Tracheal team at GOSH was established in 2001 and is a group of health professionals brought together to provide the full range of expertise needed to treat conditions associated with the trachea (windpipe) and bronchi (branches of the windpipe to each lung).

Long segment congenital tracheal stenosis (LSCTS) is the condition we see most often in the Tracheal Service. The team established the slide tracheoplasty surgical technique as the gold standard approach to treat LSCTS, and has the world's largest experience of this type of surgery. The technique involves dividing the narrowed part of the trachea, which can sometimes be only 1 or 2 millimetres wide, and sliding the two sections over each other until the part of the trachea that is normal width is reached.

We have the world's largest series, which means our team has seen the greatest number of patients, and thus we have had the opportunity to build our expertise in the treatment of this condition. We have produced the best outcomes internationally, with the lowest death rates for this serious condition, and our follow up, which extends to 235 months is also the longest available to judge the outcome of this treatment.

The table below references results from centres around the world, published in peer-reviewed medical journals since 2002.

Early and late mortality rate for long segment congenital tracheal stenosis

Author	Year	n	Early death	Late death	F/u month
grillo	2002	8	0	24%	
wright	2002	7	15%		24
rutter	2003	11	22%	44%	12
tsugawa	2003	17	24%	12%	36
koopman	2004	6	33%	33%	12
kim	2004	4	25%		12
chiu	2006	37	32%	24%	
anton-pacheco	2006	7	21%		60
le bret	2006	5	20	5%	70
manning	2010	80	5%	5%	70
GOSH	**2015**	**127**	**7 (5%)**	**6 (4%)**	**235**

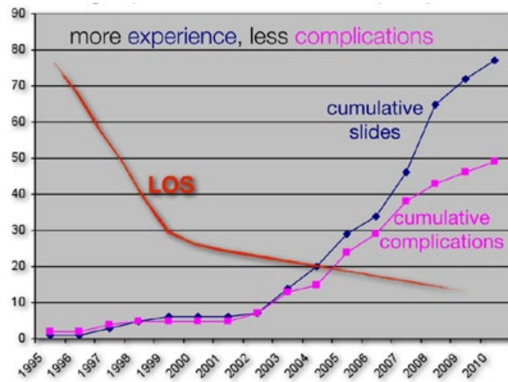
GOSH reference: Butler CR, Speggiorin S, Rijnberg FM, Roebuck DJ, Muthialu N, Hewitt RJ, Elliott MJ. Outcomes of slide tracheoplasty in 101 children: a 17-year single-center experience. The Journal of Thoracic and Cardiovascular Surgery 2014; 147(6): 1783–9.

Length of stay

Another focus of the team's commitment to delivering the best quality care is to reduce the patients' length of stay, with particular attention to the time spent on the intensive care units. The chart below shows our marked improvement over time in getting our patients well and fit for discharge after slide tracheoplasty.

Both our complication rate and our length of stay (LOS) can be seen over time in the chart below, in the context of the number of 'slides' we have performed.

Increasing experience of slide tracheoplasty

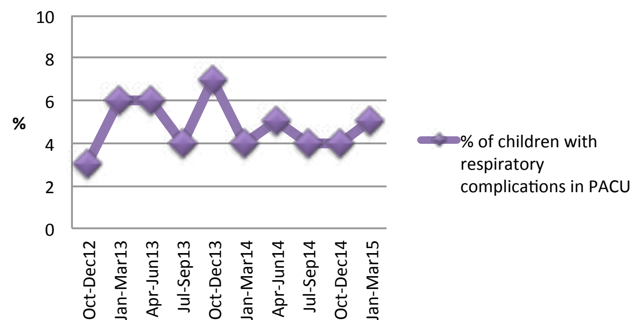


World-class outcomes for the Anaesthesia department

Anaesthesia outcome: percentage of patients that experience a respiratory complication in the Post-anaesthesia Care Unit (PACU)

Some children experience breathing problems shortly after waking up from an anaesthetic. The degree of risk will depend on the child's medical condition and the nature of surgery for which anaesthesia is being provided. Our aim is that less than 10 per cent of our patients experience respiratory complications in PACU, a target we share with Cincinnati Children's Hospital and Medical Center.

Respiratory complications in PACU



This graph shows that, on average, five per cent of our patients experience a respiratory complication in PACU, well within the shared aim of 10 per cent or less.

More anaesthesia outcomes are available here: www.gosh.nhs.uk/health-professionals/clinical-outcomes/anaesthesia-clinical-outcomes/

World-class outcomes from the Infectious Diseases Service

A major part of our Infectious Diseases Service is dedicated to the care of HIV-infected children. HIV is a blood-borne virus which attacks the body's immune system and weakens its ability to fight infections and diseases, such as cancer.

Undetectable viral load results

An important marker of the management of HIV is viral load, which is a test to determine the level of HIV in the body. The quantity of virus is measured in 'copies per ml' of blood. The lower the number, the less active virus is present.

The line chart below shows the percentage of GOSH patients and the percentage of total paediatric patients across UK and Ireland who have a viral load of equal to or less than 50 copies per ml, 12 months after starting combined Anti-Retroviral Therapy (ART). The figures show that we have consistently and rapidly improved our viral load results, surpassing the UK/Ireland average since 2007 and most recently achieving the viral load target range in 100 per cent of our patients.

We have provided the latest comparative data that we have access to from the paediatric HIV registry, the Collaborative HIV Paediatric Study. April 2014 to March 2015 data is not available until later in the year.

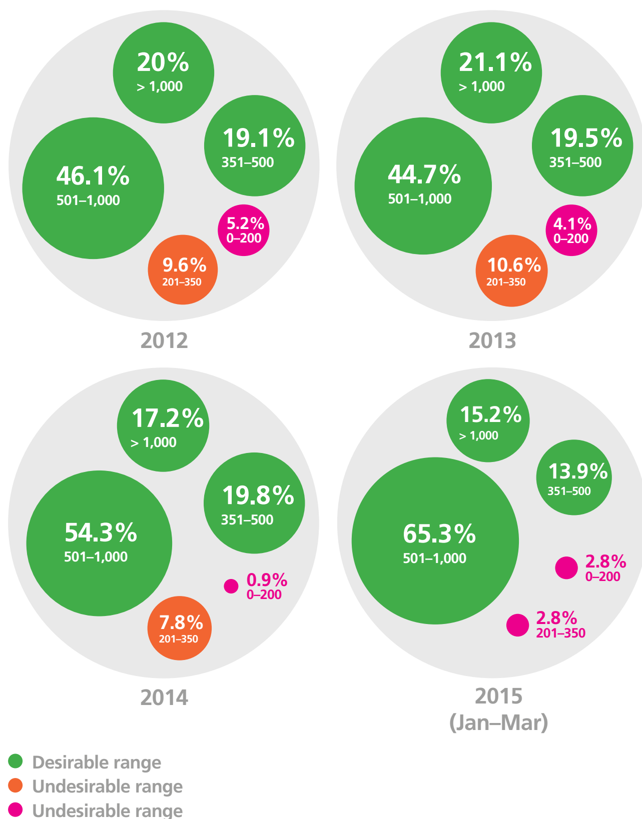
CD4 cell count results

Another important test in the treatment of HIV is called a CD4 cell count. HIV attacks CD4 cells in the immune system. A CD4 cell count measures the number of CD4 cells in a sample of blood to give a rough idea of the health of the patient's immune system. The higher the count, the better the immune system.

The CD4 cell count can vary from 0 to over a 1000 per cubic millimetre of blood. A lower CD4 count is a sign that HIV is progressing, and the immune system is becoming weaker. If CD4 cell count levels reduce to less than 350 per cubic millimetre, there is potential that without treatment there will be progression to AIDS.

Of patients treated at GOSH for HIV, 85 per cent of the 115 treated in 2012, 85 per cent of the 125 treated in 2013, and 91 per cent of the 116 treated in 2014 had a CD4 count within a desirable ranges, thus slowing the damage of the disease on the child's immune system.

The following diagram shows the proportion of GOSH patients within each range of CD4 cell count by calendar year (and Jan–Mar 2015):



We do not have these figures for other centres, so we compare our own results year-on-year. These results show that we consistently improve on our own outcomes.

More HIV outcomes are available here:
www.gosh.nhs.uk/health-professionals/clinical-outcomes/infectious-diseases-clinical-outcomes/

What's going to happen next?

Our vision is to be the best children's hospital in the world. However, regardless of our position compared to others, one thing remains fundamental – even in those areas of practice where we know that the care we provide is world-class; we must always be improving. We will *always seek to improve our outcomes*, year on year, for our patients.

To support our clinical teams, we will establish automatic reporting of outcomes on our intranet, so that they can be viewed by all staff at any time and more easily integrated in to existing clinical meetings to inform clinical practice and service improvement.

How this benefits patients

Demonstrating and publishing our world-class outcomes benefits patients by:

- Internal visibility of outcomes data drives better outcomes for patients.
- Public visibility of outcomes data gives the confidence that transparency brings, and can help families to decide at which hospital their child will receive care for their condition.

> "Anyone whose child is sick wants to be sure they get the best care for them. We believe it is our duty to provide the right information to patients and their families to help them to get that best care. The outcomes of the care we provide must form the basis of that; they are fundamental to our work. Good outcomes not only attract patients, but also the best staff, and if we want to be the best, and to continue to innovate, we need both."
>
> Professor Martin Elliott, Co-Medical Director and strategic lead for the GOSH outcomes programme

Non-invasive ventilation service development

Non-invasive ventilation (NIV) is a way to assist breathing without the use of a tracheostomy or endotracheal tube. Instead, a soft mask that sits over the nose or nose and mouth is used. Pressurised air flows through the mask and into the airways to help overcome any obstruction in the airway or to help reduce the work of breathing. This can be used when acutely unwell or for the long-term for those with a chronic condition.

The use of NIV has markedly increased over the past two decades, becoming an integral tool in the management of many acute and chronic respiratory conditions, both in hospital and home settings. At GOSH, we look after 270 children on NIV, the largest paediatric cohort under a single tertiary paediatric centre in the UK.

Previously, all children requiring NIV were cared for on the respiratory unit at GOSH regardless of the primary reason for their admission, for example, if a child on NIV was admitted for spinal surgery they would have to be admitted to the respiratory ward instead of the orthopaedic ward where spinal pre- and post-operative care was specialised. The reason for this was the lack of trained staff on non-respiratory wards, who were able to care for children on NIV.

What we said we would do

- Enable children on NIV to be safely cared for in the ward areas of their admitting specialities by providing NIV training for the non-respiratory nursing staff on other speciality wards in the hospital.
- Support local community teams, district general hospitals, patients and their families at home by ensuring that they could contact the NIV team at GOSH 24/7 for advice, and that every child on NIV had a community nurse.

What we did

We created training and competency packs, and focused on specific needs of the more prevalent patient cohorts. We set up weekly to monthly training sessions and bedside learning with these teams and found champions for NIV in each area to help

support the ongoing training and ensure staff keep up to date with their skills.

We have an in-house NIV study day that is available for all staff from each specialty area, which runs every six months.

All patients and community teams have access to the NIV nurse specialist (from Monday to Friday.) During evening and weekends, the sleep physiologists and the nursing staff on the respiratory unit, who are all fully NIV-trained, are available to provide support on all queries including equipment issues.

We also run a weekly NIV clinic and two acclimatisation clinics for children who are starting NIV or struggling to tolerate the mask and pressure. The involvement of our play specialist (and if required, a family therapist) is invaluable in improving compliance and reducing anxiety for the whole family.

What the data shows

1. Number of patients requiring NIV, cared by the admitting specialty on a non-respiratory ward

In the past year, 24 NIV patients requiring high-dependency nursing either post-surgery or because they were acutely unwell were able to be cared for in admitting specialty ward areas by non-respiratory nursing staff who had received NIV training from the NIV team. This is a significant move in improving patient flow and care quality in general for this group of children with complex needs.

2. Number of bed days used by NIV patients facilitated on non-respiratory wards

Over the past year, we have saved 235 bed days in the Respiratory department due to these patients being cared for in their admitting specialties' areas. As a result, the Respiratory department has been able to treat more respiratory patients and reduce waiting times.

What's going to happen next?

We will continue to roll out training across the Trust and ensure that update study days are held every six months to sustain and grow the NIV expertise of staff in non-respiratory specialties.

We are planning an NIV study day for community health workers and medical/nursing staff from district general hospitals to help to support the growing NIV population in the community. We hope to make it an annual event.

Since February 2015, our newly set-up weekly NIV clinic allows our NIV patients to access the NIV clinical nurse specialist (CNS) and consultant for advice and support in outpatients, thereby reducing the need for an overnight stay. We aim to extend our multidisciplinary and holistic approach further by setting up a joint neuro-respiratory clinic and NIV adult transition clinic.

We have just appointed our second NIV clinical nurse specialist, which will allow us to give more support to our staff and NIV inpatients at GOSH, as well as families, community nursing teams and local hospitals, to enable our NIV population to be cared for closer to home.

How this benefits patients

Providing NIV training for non-respiratory nursing staff on other specialty wards benefits patients by:

- Patients who require respiratory input but are admitted for other care are now looked after by the specialty that has the most relevance to their care.
- Clinical staff across the Trust have been empowered by new skills to improve the holistic care of their patients.
- Patients who require NIV and those who require specialist respiratory care have seen a reduction in waiting times and improved experience.
- Improved clinical efficiency in treating patients in a timely fashion.
- The training has meant that 235 respiratory bed days have been freed up for use by other patients.

A tracheostomy is a surgically made hole that goes through the front of the neck and into the windpipe. A tracheostomy tube is a plastic tube inserted into the windpipe via the tracheostomy.

An endotracheal tube is a long breathing tube that is inserted through the mouth /nose and into the windpipe.

Assisted breathing that is delivered via tracheostomy or endotracheal tube (in hospital only) is termed as invasive ventilation.

"The NIV CNS role was integral in getting all the staff trained and competent to care for children on NIV. The CNS was able arrange and deliver training to all of the staff as well as creating a competency book and training resources. Once patients began appearing on the wards, the CNS role was able to provide clinical support and further teaching at the bedside. If problems arise it is essential to have experienced experts like the CNS to support and assist staff."

GOSH staff member

"The CNS at GOSH is brilliant, and being able to link to a named nurse for these patients is truly invaluable. However, I know the community children's nursing service would benefit greatly from more training on the different machines used in the community, and it would be highly appreciated."

Community nurse

"The NIV Nurse Specialist plays a key role in everyday life for our family, ensuring critical advice and support for us. In our opinion the NIV nurse has an essential role in preventing my son's care becoming fragmented. Making this process more simplistic for the family saves us, as a minimum, time and stress. Whenever he has been required to be admitted into GOSH, the NIV nurse has always ensured we know where to go and what is happening, taking time to visit us no matter what ward we are on (respiratory or non-respiratory)."

Parent of a child who requires NIV

Experience section

Implementing and embedding Our Always Values

What we said we'd do

After a major consultation exercise in 2013/14 with staff, patients and families, we said we would implement the resulting values and behaviours framework at GOSH. We want our shared values to be integral to everything that happens at GOSH.

What the data showed

We consulted very widely with staff, patients and families to derive our values.

Over 2,500 people defined our values

1,444 members of staff

1,200 patients, families and carers

2,644 people in total

1,444 staff

264 patients

876 families

60 carers

Our families told us about the best things about their experience at GOSH, which we presented as word clouds.

Used expertise
Friendly
Helpful
Kind
Caring
Knowledgeable
Understanding
Professional
Supportive
Welcoming
Never kept us waiting
Made the time

They also told us the worst.

Long waits
Late appointments
Poor communication
Parking
The food
Clinics

We designed a version for children or people who might prefer to answer a shorter and simpler form. They similarly told us what they like about GOSH.

Happy to help
Friendly
Care for children
Care about you
Kind
Make me better
Lovely people
Play while you wait
Food and drink

In addition, they told us what they don't like.

Waiting
Nothing!
Travelling here
Getting lost
Far from home
Late appointments
Having to come here
Food
Communication

We asked our staff for their opinions, including how they would like to be described by their colleagues.

What we did

Using all this information, we derived Our Always Values. We wanted to tie the values to our motto – 'the child first and always' – because this is our founding principle and very widely recognised by our staff. We also wanted to respond to the theme in feedback from patients, families and staff that while we have many great people and services, we are not consistently excellent. Therefore, 'Our Always Values' – comprising Always Welcoming, Always Helpful, Always Expert and Always One Team – is a deliberately bold statement that is congruent with our vision to be the leading children's hospital in the world.

As well as developing the four values, we developed behaviours that underpin each of them. These behaviours drew directly from

the language of the patients, families, carers and staff who had participated in our engagement exercise and help us to have a shared understanding of what 'good' looks like.

Once we had derived our values and behaviours, we spent time talking about them to teams across the Trust. There was an overwhelmingly positive reception, with the comprehensive engagement process providing assurance that this was something that responded to the genuine concerns of our patients and families.

We felt very strongly that we needed to keep testing our ideas with patients, families and staff, so as well as recruiting parents onto our project groups we also established virtual user groups to help us develop the visual imagery for Our Always Values.

Between January and May 2015, we ran leadership sessions that were attended by over 220 of our key clinical and non-clinical leaders, including all of our Executive Directors. These sessions provided a clear explanation of how living Our Always Values will result in improved patient outcomes. They also gave leaders tools to promote positive behaviours and reflect back to colleagues the impact of behaviours that do not demonstrate our values.

On 24 March 2015, we formally launched Our Always Values to staff. We have fully incorporated Our Always Values into our annual staff appraisals, so that staff must demonstrate that they consistently live our values in order to achieve an overall excellent rating. We have also built Our Always Values into our popular annual and monthly staff recognition awards, and will use images of our award winners to keep our posters and other materials updated.

What's going to happen next?

We will continue to work on a range of embedding measures, including values-based recruitment and ensuring that Our Always Values are reflected throughout our policies and procedures.

As our staff become familiar with Our Always Values, we will increasingly be asking our patients, families and carers to help us recognise when we live our values, and when we could do better.

We will measure our progress in a range of ways:

- By embedding measures such as the number of staff who have attended leadership sessions
- By process alignment, for example, how many staff have been recruited using values-based recruitment
- By impact measures, using our staff and patient surveys. We will use the measures to ask if people know what our values are, and gauge whether they are having an impact on the experience of the people we treat and employ.

This is a long-term programme of work, but the enthusiasm of the patients and parents who have been closely involved throughout and the extremely well-attended launch event provides us with a very strong impetus to build on the foundations that have been laid.

How this benefits patients

The implementation and embedding of Our Always Values benefits patients by:

- Evidence shows that better patient experience scores are linked to lower readmission rates and shorter length of stay.[2]
- There is a clear relationship between the wellbeing of staff and patients' wellbeing[3]

Reducing outpatient waiting times for medication from the hospital pharmacy

What we said we'd do

The results of the Ipsos MORI Outpatient Experience Survey 2012 showed a need for improvement in waiting times while at the hospital and the pharmacy (according to 15 per cent of respondents). We began a project in 2013 to explore the causes of this feedback and determine the best way to achieve improvement. Our aim was:

To reduce the time taken from when an outpatient prescription arrives in pharmacy to when the patient receives their medication and improve patient satisfaction by 30 April 2015.

What we did

Targeted survey

We conducted a targeted follow-up survey to get more detail. Responses gave us helpful suggestions and included:

"If there was an automated display showing the prescription was either still being processed or ready. Waited a long time queuing just to find out if it's ready or not. Also waited 90 minutes to be told only had some of the medicine in stock and would have to return in a week's time. This was very frustrating, especially when you have a long journey home."

"Waiting area small and cramped, really hard with children with special needs to sit and wait, could do with a way of notifying

2 Manary MP et al (2013) The Patient Experience and Health Outcomes. New England Journal of Medicine 368(3) pp201–203

3 Boorman S (2009) NHS Health and Well-being – Final Report. Leeds: Department of Health (ref 299039)

patients when prescription is ready – such as an automated display so could keep coming back to check without having to sit and wait for long periods – or stand in a long queue to check."

We set up a working group with pharmacy dispensary staff to generate and agree small tests of change, based on the improvement methodology of Plan-Do-Study-Act.

What is Plan-Do-Study-Act?

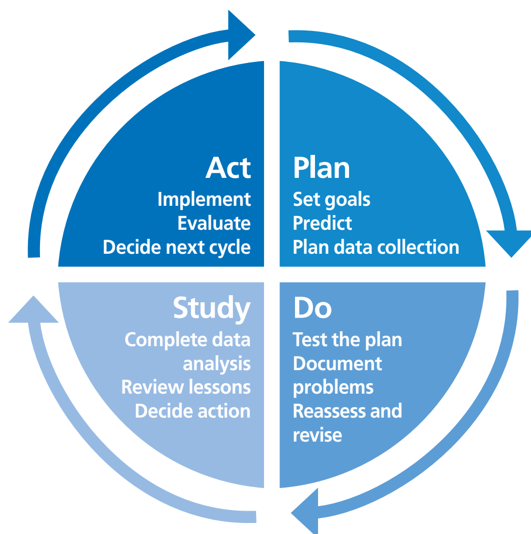
Plan-Do-Study-Act (PDSA) is a methodology to test an idea by trialling a change on a short-term basis and assessing its impact. The four stages of the PDSA cycle are:

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.



Communication

We knew we needed to improve communication and set clearer expectations for our patients and their families, particularly with regard to medications that take longer to prepare. The project team designed and created posters to answer some common questions that were frequently asked of them, such as: *"Why are we waiting for our prescriptions?"* and *"What can we do while we wait?"*.

The dispensary process was also filmed with a narrator describing each step in the journey to ensure the right medication was safely prepared and made available to the patient. This podcast is now displayed in the pharmacy reception and helps people to understand what is happening behind the scenes and why each step is important.

Identifying and tackling delays

We carried out various process analyses on the dispensary floor to identify areas where there were delays. To address these issues, we:

- installed additional IT equipment for dispensing
- put dedicated staff on the pharmacy hatch over the busier lunch time period
- tested separate streams for complex and simple prescriptions.

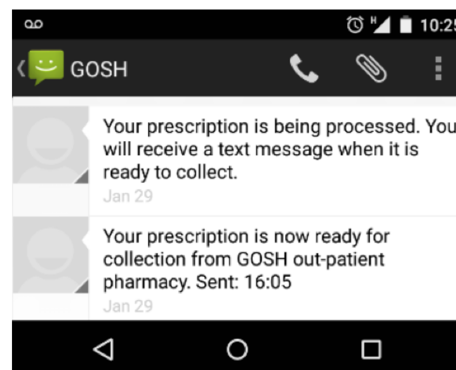
We spent time speaking with patients and their families as they waited for medication. One parent made the suggestion that we send a text message as soon as the medication is ready for collection. We worked with the dispensary team to design and develop an electronic system to track the prescription and provide real time information with visual alerts for prescriptions with long waits. If the wait time exceeded 30 minutes, the alert turned orange. If the wait exceeded an hour, the alert turned red.

Pharmacy

User guide | Last updated: 09/04/15 16:36 | Filter: Current day - not collected | Add patient | Search | Logs | Display settings

Patient	Type	Ticket	Location	Received	Screening	Dispensing	Final check	Collected	Authorised	Follow	Wait
MS	IPP	D67	SAFARI PIGEON HOLE	09:15	09:38	09:50					445
ID	OP	D82		11:46		14:31 15:01					293
AA	OP	D76		13:34							186
AA	OP	D76		13:34							186
ID	OP	D95		13:37	13:40						183
RA	OP	D99	BULK-A	13:52							167
RT	OP	E10		14:59	16:14 16:14	16:32 16:35					101
GN	OP	E11		15:00	15:13 15:13						100
AS	OP	E13		15:00	15:13 15:13						100
SS	OP	E12		15:01	15:13 15:13						99
OH	OP	E15		15:22	15:32 15:35	16:01 16:03					78
CH	OP	E16		15:22	15:35 15:40	16:05 16:16					78
EW	OP	E17		15:25	15:40 15:40	16:10 16:14					75
OC	OP	E19		15:35	16:04 16:07	16:23					65
DA	OP	E18		15:36	16:01 16:05	16:16 16:23					64
FA	IPP	E20		15:53	16:03 16:03	16:21					47

The new tracker system was also designed to send an automated text message to patients and families, notifying them when their prescription was ready for collection. We sent a registration message with the ticket number and a second message to alert when medications are ready for collection. Approximately 50 text messages were sent to patients each day.



What the data shows

We now have a means of identifying bottlenecks and delays in the dispensing process that need further exploration to understand if and how these can be overcome.

In order for this work to progress and for there to be sustained, continuous improvement further work is needed.

What's going to happen next?

Most improvement efforts have focussed on improving the patient and family experience by improving communication and providing information that helps to set expectations where this was not previously available.

The tracker system will soon be displayed in the patient waiting area in the main hospital reception and also on one of the existing television screens in The Lagoon restaurant. This will allow patients and their families to wait in a less cramped environment or get refreshments while they wait, confident in the knowledge that their prescription is progressing through the system.

Patients will be asked to score their satisfaction when both installations are complete.

How this benefits patients

The introduction of new systems in the Pharmacy department benefits patients by:

- The text message service allows patients and their families the flexibility to leave the pharmacy waiting area and, for example, visit a park or go to a café while waiting for their medication.
- Displaying prescription progress on an LCD screen will reduce unnecessary trips to the hatch to enquire about medication.
- Updated information will reduce the frustration of 'not knowing'.

Improving the experience of our patients with learning disabilities

Most people find it daunting to have to go to hospital. For people with a learning disability, this can be magnified by not knowing what to expect. In addition, staff may not know how best to interact and support, and how to adjust their practices and services to meet the needs of these patients.

What we said we'd do

We recognised we wanted to do better for our patients with learning disabilities. We appointed a Nurse Consultant Intellectual (Learning) Disabilities in September 2013 to identify how we could improve in partnership with our learning disabled patients and families, and undertake work to embed improvements and to train staff.

What we did

Learning disability clinical alert

A learning disability alert system has been established in the hospital, which enables staff to know which patients are in the hospital, where they are, and how they use the service so that reasonable adjustments can be made to help their care and treatment. Over 850 patients are already on the alert system.

In May 2014, an audit was conducted to ascertain how many patients on the ward had intellectual disabilities. Thirteen of the 15 wards randomly selected were able to answer this question. A total of 15 patients were identified across the 15 wards, 10 of whom had reasonable adjustments identified and implemented, with no information recorded for the remaining two wards.

Reasonable adjustments

Reasonable adjustments are required to be made within services for people who have disabilities or impairments that fall within the Equality Act (2010). The following core adjustments were developed to meet the needs of our patients:

- actively involve the child/young person and their families/carers
- offer double appointments
- offer first or last appointment
- act on information in the patient's hospital passport
- change the environment – for example, dim lights, provide quieter waiting areas
- make information easy to understand – for example, use signing and pictures

Bespoke adjustments are also made and audited to improve the service.

Hospital Passport

> "Nurses and doctors read the information (in the Hospital Passport) about our daughter and had an idea of how to approach her without being patronising."
>
> Parent of a patient with a learning disability

The Learning Disability Protocol for Preparation for Theatre and Recovery

A service gap was identified as a result of a complaint made about a theatre and recovery experience. The protocol we developed and disseminated in late 2014 has already greatly enhanced the care and treatment of surgical patients with learning disabilities. It ensures all staff are aware of a person's individual requirements and specific needs to enable the best possible care and treatment to take place in theatre and recovery.

The Learning Disability Protocol for Preparation for Theatre and Recovery

- Discuss the patient's needs with them and their family/carers.
- Use 'comforters' to relax the patient pre op and in recovery .
- Document and handover to colleagues.

Recover patients with learning disabilities slower than those without one

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

If the patient is disturbed or distressed in Recovery:
1. Call an anaesthetist to use sedation to induce a relaxed, sleepier state.
2. Increase levels of sedation as required.

For more information and advice www.gosh.nhs.uk/intellectual-learning-disability

Great Ormond Street Hospital for Children NHS

Links and information

We have provided links and information to support people with learning disabilities via the following:

- Establishing 36 learning disability 'Link Leads' in areas across the Trust from a range of roles and professions to aid dissemination of the work and action plan.
- Creating partnerships with the British Institute of Learning Disabilities (BILD), Books Beyond Words, Assist Advocacy, Keele University, and Hertfordshire Community Learning Disability Services. These partnerships involve collaboration on education and research, and implementation of best practice initiatives.
- Developing a learning disability section for staff on the Trust intranet.

Bespoke training

We have delivered training in the following ways:

- Carrying our bespoke teaching and training sessions have been carried out on wards, pre-operative services, and clinics to a variety of staff groups
- Delivering teaching in partnership with BILD and GOSH in outpatient services.
- 'Education in action' took place regularly during actual patient contact to enhance clinical practice in the 'real world', not just in a training room.

What the data shows

In 2013 and 2014, the Staff Awareness of Intellectual Disability Survey was conducted to ascertain the knowledge of clinical and non-clinical staff when working supportively and sensitively with learning disabled patients. The survey also asked staff about the initiatives implemented. Some of the key findings include:

- In 2013, 83 per cent of staff felt they effectively advocated for people with intellectual disabilities. In 2014 this rose to 97.5 per cent.
- In both 2013 and 2014, 40 per cent of staff felt that working in partnership with other organisations happens, but not all the time. However, staff who gave the lowest rating on our performance in partnership working dropped from 21 per cent in 2013 to 14 per cent in 2014, illustrating that we are making progress in embedding better partnership working with patients with learning disabilities.
- In 2013, 17 per cent of staff surveyed knew about the hospital passports, rising to 37 per cent in 2014 – a 20 per cent increase.
- In 2014, 69 per cent felt adequately trained and prepared to care for people with learning disabilities compared to 60 per cent in 2013.

While these figures are encouraging, we're continuing in our actions to improve our partnership working, promote our hospital passport, and roll out our training to provide a better experience for our patients with learning disabilities.

What's going to happen next?

Ongoing training and support will continue to be provided by senior learning disability nurses and the learning disability Link Leads to:

- increase staff confidence in supporting our patients with learning disabilities
- increase awareness and use of the hospital passport
- to support partnership working

How this benefits patients

We undertook work to improve the experience for our patients with learning disabilities, which benefits them by:

- Reduced anxiety associated with hospital for patients and their families.
- Collaborative working between families and staff means better support and a reduction in a 'them and us' feel to healthcare.

2015/16 quality priorities

Previously, we have presented our quality reporting under the domains of Safety, Clinical Effectiveness and Experience, as described by Lord Ara Darzi in his NHS review for the Department of Health in 2008. In future, we will publish all our improvement work as categorised by the standards we work towards from our Quality Strategy:

Standard 1	Develop a strong governance structure for Quality and Safety.
Standard 2	Maintain high levels of medication safety.
Standard 3	Decrease and eliminate hospital acquired infections.
Standard 4	Improve clinical handover and documentation.
Standard 5	Eliminate all pressure injuries.
Standard 6	Recognise and respond to deterioration.
Standard 7	Decrease unnecessary delay in all processes.
Standard 8	GOSH will deliver clear measures of our clinical outcomes.
Standard 9	Work closely with our patients and their families to have high levels of experience.
Standard 10	GOSH will provide equal access to all.

These standards are central to our quality improvement programme, and align with the Darzi domains, and the Trust vision of No waits, No waste, Zero harm.

The following table provides details of three of the quality improvement projects that the Trust will undertake on its services in 2015/16. These priorities were determined with input from staff, patients and their families, and commissioners. This input was sought through a range of mechanisms including survey, consultation, and use of established meetings such as our Members' Council, Young People's Forum, and Public and Patient Involvement and Experience Committee.

Safety / Standard 7

To reduce all harm to zero.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improving flow through our intensive care units	The smooth flow of patients through our Paediatric Intensive Care Unit and Neonatal Intensive Care Unit is vital to the effective running of the hospital. We need to ensure patients can get into and out of these wards in a timely and safe way to reduce cancellations and refused referrals to the Trust.	We will collect data on delays, refusals and cancellations of elective admissions. This will be monitored through the Intensive Care Units Flow Steering Group, which will report to the Senior Management team.

We chose this initiative to report on in 2015/16 because we know there is pressure on our ICUs and we sometimes have to refuse patient referrals or cancel patients due to a sicker patient being admitted. We want to reduce these occurrences so they only occur for clinical, rather than operational reasons.

Clinical effectiveness / Standard 10

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

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Referral to treatment (RTT): Incomplete pathways.	Incomplete pathways are the RTT waiting times for patients whose RTT clock is still ticking at the end of the month. The national standard is 92% of incomplete pathways are <18 weeks. This measure is a good indicator to ensure that patients on a RTT pathway are seen and treated within 18 weeks.	The national standard is that 92% of incomplete pathways are <18 weeks. This measure is a good indicator to ensure that patients on a RTT pathway are seen and treated within 18 weeks. This is reported to the Trust Board monthly, submitted nationally and reviewed internally at all Clinical Divisional Performance Reviews as well as reviewed frequently at an operational level.

We chose this initiative to report on in 2015/16 as an area the Trust wishes to see continuous improvement. Via work that the Trust has undertaken internally it is aware that due to its place in the patient pathway a number of referrals come to the Trust without all the necessary information (including the clock start of the pathway), this presents challenges for GOSH. As part of the external audit by Deloitte of our records in 2014/15, this substantiated the issue, for which the Trust is seeking advice and guidance on how best this is resolved.

Experience / Standard 9

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?
Improving discharge summary completion times.	To make sure there are no delays or problems with the child's post-discharge care, it is important that discharge summaries are written promptly and contain all of the information the child's local doctor needs to continue their care.	The following measures will be reported: 1. Percentage of discharge summaries sent within 24 hours of discharge. 2. Average days between patient discharge and a discharge summary being sent. 3. Percentage of discharge summaries completed using the Trust's new electronic system for producing discharge summaries. Measure 1 is reported at divisional performance reviews. Measures 2 and 3 are reported to the Quality Improvement Committee. All of the measures are reported on the Trust intranet in Statistical Process Control format.

We chose this initiative to report on in 2015/16 because we know from our referrers' survey and our Members' Council that it matters to patients and their families. We are improving, but we still have work to do to spread improvement across the Trust.

Part 2b
Statements of assurance from the board

Review of our services

During 2014/15, GOSH provided and/or sub-contracted 51 relevant health services. The income generated by these services reviewed in 2014/15 represents 100 per cent of the total income generated from the provision of relevant services by GOSH for 2014/15.

GOSH has reviewed all the data available to us on the quality of care in our 51 services. In order to ensure that we maintain excellent service provision, we have internal processes to check that we meet our own internal quality standards and those set nationally. Key performance indicators relating to the Trust's core business are presented to every Trust Board meeting. 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 review regularly their progress, to identify improvements, and to 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.

The Trust has remained 'green' against Monitor's Governance Risk Assessment during 2014/15, 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 Executive team actively promote the importance of incident reporting to all staff in the support of safety.

What is Monitor?

Monitor is the independent regulator responsible for authorising, monitoring and regulating NHS Foundation Trusts.

Participation in clinical audit

What is clinical audit?

'A clinical audit is a quality improvement cycle that involves measurement of effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.'

HQIP Principles of Best Practice in Clinical Audit 2011

During 2014/15, nine national clinical audits and one clinical outcome review programme covered the NHS services that GOSH provides. The Trust participated in eight of these national clinical audits and the clinical outcome review programme. Data collection was completed during 2014/15, and is outlined in the table below.

Name of audit/clinical outcome review programme	Cases submitted as a percentage of the number of registered cases required
Cardiac arrhythmia (National Institute for Cardiovascular Outcomes research [NICOR])	169/169 (100%)
Congenital heart disease including paediatric cardiac surgery (NICOR)	553/1100 (50.3%). Remaining cases to be submitted by the end of May 2015.
Diabetes (paediatric) (National Paediatric Diabetes Association)	25/25 cases (100%)
Maternal, Newborn and Infant Clinical Outcome Review Programme (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK [MBRRACE-UK])	24/24 (100%)
National Cardiac Arrest Audit (Intensive Care National Audit & Research Centre [ICNARC]).	26/26 (100%)
Inflammatory bowel disease (Royal College of Physicians)	44/44 (100%)
Paediatric Intensive Care Audit Network (PICANet)	1,771/1,771 (100%)
Pulmonary hypertension (Health and Social Care Information Centre)	350/350 (100%)
Renal replacement therapy (UK Renal Registry)	212/212 (100%)
Severe trauma (Trauma Audit & Research Network [TARN])	The Trust did not provide data for 2014/15

The clinical audit team monitors the publication of any reports from the above studies to ensure that any relevant recommendations made are reviewed appropriately through the Mortality Review Group.

Key learning from clinical audit in 2014/15

GOSH has a central clinical audit plan where work is prioritised to support learning from serious incidents, risk, patient complaints, and to investigate areas for improvement.

A selection of key findings is listed below.

Consent

In 2013/14 the need to improve the consent forms used for young people and patients aged over 18 was identified. Consent forms for specific age groups were rolled out across the Trust in February 2015. Audit showed that 93.5 per cent of patients in an audit had consent taken with the correct age appropriate consent form following the roll out.

Identification of patients

Clinical audit completed in 2012 highlighted the need to improve adherence to the policy to identify patients in an inpatient setting. The learning from the audit and feedback from staff led to wristbands being changed to ones that were noted to be more comfortable to wear. The audit was repeated in October and November 2014 to assess the effectiveness of the change. Eighty-seven per cent of patients reviewed in this audit had a patient identity wristband or alternative identification arrangements in place (compared with 63 per cent in the 2012 audit).

Learning from an incident

Changes were introduced to bed booking processes in International and Private Patients following a Serious Incident that occurred in 2012. Audit showed that changes made have been successful, with 99.6 per cent of patients included in audit having no discrepancy between the medical problems documented in booking and the ones they arrived with.

Local clinical audits

The summary reports of 87 clinical audits were reviewed by GOSH during 2014/15. To promote the sharing of information and learning these are published on the Trust's intranet and are shared with the Learning, Implementation, and Monitoring Board.

Examples of actions intended to improve the quality of healthcare, or work that has made a difference as a result of local clinical audit are listed below.

- The Dermatology team reviewed the use of propranolol for treating infantile haemangioma, which resulted in a protocol change that reduced the need for pre-treatment investigations.
- Audit work within the Neurodisability department looked at the protocol for the assessment of autism spectrum disorder within the Neurodevelopmental Assessment Clinic. The audit found that the protocol was being followed, with all essential measures being used for each child. As a result of the audit the team are reviewing an improved method of communicating with schools more efficiently, and considering adaptations to the protocol dependent on the age of the child. The team are also looking at age-appropriate feedback for children and young people to help them to understand more about the assessment and diagnosis of autism spectrum disorder.

- The inherited cardiovascular diseases team reviewed ECGs in children seen with long QT syndrome. As a result of this audit, practice has changed and ECGs are routinely performed lying and standing on any child presenting to the service with confirmed or possible long QT syndrome.
- The Haemophilia team undertook an audit looking at pain in children with inherited bleeding disorders. The audit highlighted the importance of analgesia as a treatment option in bleed management. As a result of this audit, pain management has been added into telephone triage/advice to help patients by ensuring better pain control before attending hospital.

Participation in clinical research

In summary

At GOSH, we understand the immense importance to patients and their families of pushing the edges of medical understanding and technologies to make advancements in the diagnosis and treatment of childhood diseases. As a specialist hospital with strong academic links, we are dedicated to harnessing opportunities for collaboration between clinicians and scientists to deliver more research findings from 'bench to bedside' – in other words, from the laboratory research setting into clinical practice where it can directly benefit patients. We are also working to implement new evidence-based practice beyond GOSH, so that more patients can benefit in the UK and abroad.

GOSH's strategic aim is to be one of the global leading children's research hospitals.

We are in a unique position of working in partnership with our academic partner, the UCL Institute of Child Health (ICH), to combine enviable research strengths and capabilities with our diverse patient population. This enables us to embed research in the fabric of the organisation. In addition to the ICH, GOSH has the benefit of access to the wealth of the wider University College London research capabilities and platforms. Scientists at the ICH and clinicians at the hospital work together to provide an integrated and multidisciplinary 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.

Together, GOSH and the ICH form the largest paediatric research centre outside North America and we host the only Biomedical Research Centre (BRC) in the UK dedicated to children's health. Our BRC status, awarded by the National Institute for Health Research (NIHR), provides funding and support for experimental and translational biomedical research. In addition to the BRC, the Division of Research and Innovation includes:

-
- the joint GOSH/ICH Research and Development Office
- the Somers Clinical Research Facility (CRF), which is a state-of-the-art ward within GOSH for the day care accommodation of children taking part in clinical trials
- hosting research delivery staff funded through the Comprehensive Research Network: North Thames

Our research activity is conducted with a range of national and international academic partners, and we work very closely with industry to support the development and introduction of new therapeutics, devices and diagnostics for the NHS.

Currently, we have 875 active research projects at GOSH/ICH. Of these, 223 have been adopted onto the NIHR Clinical Research Network (CRN) Portfolio, which is a grouping of high-quality clinical research studies. In total, 3021 patients receiving health services provided or sub-contracted by GOSH have been recruited in the past 12 months to participate in research ethics committee-approved research projects that have been accepted on the portfolio.

Some of our key research highlights in 2014/15 are described below.

- GOSH BRC theme lead Professor Adrian Thrasher and a team of local and international collaborators have developed improved gene therapy technology for treatment of children with X-linked severe combined immunodeficiency (X-SCID) who do not have matched bone marrow donors. X-SCID is an inherited disorder of the immune system that affects predominantly boys. Most children die before they are one year old from infections that their immune system is unable to fight. A clinical trial published in the New England Journal of Medicine used a modified Gamma Retrovirus Vector to treat the condition and restored immunity in most patients. The treatment showed high efficacy and better outcomes for most patients with fewer adverse effects. The new therapy was covered by the BBC news.
- The GOSH BRC funded gene discovery facility, GOSgene and its collaborator, the North East Thames Regional Genetics Service, are continuing to successfully develop screening tools for genetic diseases. In a recent publication in the *Journal of Medical Genetics*, the collaborative partners report results on their development of a gene panel to screen patients affected by very early onset inflammatory bowel disease (VEOIBD). The development of this panel is significant, because of its impact on patient management. It can identify in a short period of time which patients have certain VEOIBD genotypes and advise on the correct treatment pathway, such as haematopoietic stem cell transplantation. At the same time, whole exome sequencing was performed by GOSgene in the same VEOIBD patients and the results compared with the gene panel.
- A study led by NIHR GOSH BRC Director, Professor David Goldblatt, in collaboration with Public Health England, and published in the journal *The Lancet Infectious Diseases*, has shown that a new 13-valent pneumococcal conjugate vaccine (PCV), introduced into the infant immunisation programme in 2010, provides significant protection for most vaccine serotypes. This is the first report of this new vaccine's effectiveness

and incorporated an indirect cohort method to assess vaccine effectiveness in the three-and-a-half years following introduction. The paper also defined, for the first time, new correlates of protection for extended PCVs that will inform future vaccine licensing strategies and implementation of PCVs around the world.

- For the first time in the UK, a novel kidney transplantation method has been performed at GOSH. This method is used for patients who have previously had transplants. Patients who have had a previous transplant will face the problem that the body produces antibodies that can jeopardise future transplanting success by fighting an introduced organ. The new method removes a large proportion of the antibodies using a blood filtering process called plasmapheresis, before re-introducing the patient's blood in to their body.
- Molybdenum cofactor deficiency (MoCD) type A is an extremely rare metabolic disorder that, if untreated, results in neurological damage and eventual death within a few months of birth. Up to 40 centres across the world are participating in a natural history study of MoCD that will inform future therapeutic trials. Within only a few weeks of the study opening at GOSH, a team led by Dr Sophia Varadkar achieved the recruitment of two patients to the trial. Instrumental to the robust and swift feasibility, set up and successful recruitment was the support provided by the BRC-funded CRF and the NIHR CRN: North Thames (children's division).
- GOSH is playing a leading role in the co-ordination of a network of hospitals participating in the Genomics England 100,000 Genomes Project. GOSH has been named as the lead organisation responsible for co-ordinating the recruitment of patients through the new network that will form the North Thames Genomic Medicine Centre and, alongside other partnering London trusts, will recruit participants to the project.

In addition, we are delighted to list awards received for research.

- Three of our clinical academics, Professor Phil Beales, Professor Lyn Chitty, and Professor Neil Sebire, were awarded NIHR Senior Investigator status in 2014. This success is particularly significant: these three awards to academic staff at GOSH were out of a total of only 16 new awards in England to outstanding research leaders of clinical and applied health and social care research.
- A number of our investigators received awards from the NIHR CRN for their contribution to clinical research: Dr Ri Liesner as a Leading Commercial Principal Investigator, Dr William van't Hoff for 'Delivering above and beyond', and Professor Francesco Muntoni for 'Consistently delivering to time and target' and 'First global or European patient'.

We are also delighted to have made appointments that build capacity to support our vision to be a global leading research hospital:

- We are committed to developing the next cadre of clinical academics and through our BRC have developed a comprehensive training programme, including the appointment of Dr Kate Oulton, our first Clinical Academic Programme Lead – Nurses and Allied Health Professionals (AHPs). Kate is research active, spending half her time undertaking research through the Centre for Outcomes and Experience Research in Children's Health, Illness and Disability (ORCHID) and half of her time in her lead training role. With Kate's direction, we aim to increase the number of nurses and AHPs who are engaged with and undertaking research.
- We have appointed our first Clinical Research Nurse Practice Educator who will play a key role in further integrating research with clinical care.

Use of the CQUIN payment framework

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

The Trust's CQUIN schemes for 2014/15 were as follows:

1. Friends and Family Test
2. NHS Safety Thermometer
3. highly specialised audit workshops
4. retinopathy in prematurity
5. perinatal pathology - reporting time
6. antimicrobial stewardship
7. CVL maintenance
8. Quality dashboards:
    - bone marrow transplant
    - clinical genetics
    - cystic fibrosis
    - haemophilia
    - immunoglobulin
    - inherited metabolic disorders
    - spinal surgery
    - child and adolescent mental health
    - neurosurgery
    - paediatric intensive care
    - rheumatology
    - congenital heart
    - cleft lip palate
    - oncology
9. newborn screening – lean working
10. newborn screening – failsafe
11. newborn screening – chrd interface
12. nephrology – nephrotic syndrome care plan development
13. transition
14. non invasive ventilation
15. early implementation of nice spinal rod guidance
16. pathways – chronic pain relief

In 2014/15, 2.4 per cent of GOSH's income (activity only) was conditional upon achieving CQUIN goals agreed with NHS England. If the Trust achieves 100 per cent of its CQUIN payments for 2014/15, this will equate to £5,503,181. During Q1 to Q3 of the financial year, we reported high compliance against all our CQUIN indicator milestones. We expect to report over 95 per cent compliance at year end.

In 2013/14, 2.4 per cent of GOSH's income (activity) and 1.1 percent (drugs and devices) was conditional upon achieving CQUIN goals. The total figure we achieved was £5,345,784, which represented 97 per cent of the total offered.

Further details of the agreed goals for 2014/15 are available on request from:

Graham Terry, Head of Planning and Performance
graham.terry@gosh.nhs.uk
020 7405 9200

CQC registration

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

GOSH is registered with the CQC as a provider of acute healthcare services.

The CQC has not taken enforcement action against GOSH during 2014/15. GOSH has also not participated in any special reviews or investigations by the CQC during this period.

In April 2015, the CQC conducted a scheduled inspection of the Trust. The inspection report will be published later in 2015/16.

Monitor's Risk Assessment Framework shows when there is:

- A significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services (the continuity of services risk rating rated 1–4, where 1 represents the highest risk and 4 the lowest); and/or
- Poor governance at an NHS foundation trust (the governance risk rating rated red or green, where red rating is given if regulatory action is to be taken and a green rating is given if no governance concern is evident)

During 2014/15 Monitor had no concerns with the safety of health provision at GOSH, as shown below:

2014/15	**Q1**	**Q2**	**Q3**	**Q4**
Continuity of services risk rating	4	4	4	4
Governance risk rating	Green	Green	Green	Green

Data quality

What is data quality?

Data quality refers to the tools and processes that result in the creation of correct, complete and valid data that is required to support sound decision-making.

What is an NHS Number?

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.

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 Health & Social Care Information Centre (HSCIC) and its reporting is based on data submitted by all provider trusts.

What is the 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.

Please visit ic.nhs.uk for more information.

GOSH submitted records during 2014/15 to SUS for inclusion in the Hospital Episode Statistics, which are included in the latest published data. Performance is measured by examining the accuracy and completeness of data within the submissions to SUS and reported against local area and national averages.

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

Indicator	Patient group	Trust score	Average national score
Inclusion of patient's valid NHS Number	Inpatients	99.3%	99.2%
	Outpatients	99.3%	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 24 March 2015 (April 2014 – January 2015 at month 10 SUS inclusion date).
- Percentages for NHS Number compliance have been adjusted locally to exclude International Private Patients, who are not assigned an NHS Number.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

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 Toolkit overall score for 2014/15 was 77 per cent and we met the minimum standard of level 2 against all the requirements, which gave the Trust a grading of green (satisfactory). This represents an improvement on 2013/14 when the Trust score was 75 per cent and 2012/13, when the Trust score was 70 per cent. This improvement was achieved by meeting the highest level (level 3) on an additional three requirements.

Clinical coding and data quality

GOSH was not subject to the Payment by Results clinical coding audit by the Audit Commission during the 2014/15 reporting period.

The Trust continues to carry out an internal clinical coding audit programme to ensure standards of accuracy and quality are maintained. As a result, the Trust has been shortlisted for the Data Quality Award (Specialist), one of only five specialist acute trusts across the UK to have excelled in a range of data quality indicators.

The award recognises the importance of clinical coding and data quality, and the essential role they play in ensuring appropriate patient care and financial reimbursement from commissioners.

The Trust has been shortlisted for this award based on performance against a range of data quality indicators including:

- depth of coding (not case mix adjusted)
- percentage of coded episodes with signs and symptoms as a primary diagnosis
- percentage of uncoded spells

Improving data quality

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

- Ensuring policies and processes regarding capturing of data on core IT systems are concise, complete and in a standard format.
- Development of online e-learning material available via the Trust intranet, giving staff immediate access to guidance when it is most needed.
- Assigning ownership at operational level of non-core data collection systems.
- Enhancing the data quality reporting suite, highlighting missing or inconsistent data to service users.

Part 2c
Reporting against core indicators

What is the 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.

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 & Social Care Information Centre, unless stated otherwise. Where national data is available for comparison, it is included in the table.

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2014/15	2013/14	2012/13	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Domain 3: Helping people recover from episodes of ill health or following injury									
				From Health & Social Care Information Centre Time period: 2012/13 financial year					
Emergency readmissions to hospital within 28 days of discharge:									
– % of patients aged 0–15 readmitted within 28 days	0.74%	2.5%	2.4%	Not available from HSCIC until 2016				The results are from the Hospital Episode Statistics (HES) and the Office of National Statistics (ONS).	Ensuring divisions and directorates develop and implement local action plans, which respond to areas of weakness.
– % of patients aged 16+ readmitted within 28 days	0.6%	0.9%	1.5%						
Domain 4: Ensuring that people have a positive experience of care									
				From NHS Staff Survey Time period: 2014 calendar year					
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends (Source: NHS Staff Survey)	87% (2014)	87% (2013)	90% (2012)	87%	93%	73%	89%	The survey is carried out under the auspices of the DH, using their analytical processes. GOSH is compared to other acute specialist trusts in England.	Ensuring divisions and directorates develop and implement local action plans, which respond to areas of weakness.
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm									
				From the Department of Health (acute providers) Time period: 2013/14 financial year					
Number of clostridium difficile (C. difficile) in patients aged two and over	14‡	13	7	14	0	364	63	The rates are from the Department of Health	Continuing to test stool samples for the presence of C. difficile, investigate all positive cases, implement isolation precautions and monitor appropriateness of antimicrobial use across the organisation.
Rate of C. difficile in patients aged two and over (number of hospital acquired infections/ 100,000 bed days)*	12.7	14.8	9.1	12.7	0	85.5	37		

C. difficile is endemic in children and rarely pathogenic. At GOSH, we test for C. difficile toxin in all diarrhoeal stool that 'conforms to the shape of the pot' (minimal national standard), as well as other stool where diarrhoea, fever or blood in stool was reported, where a request is made for enteric viruses and as part of the surveillance programme in children with congenital immunodeficiency and undergoing bone marrow transplants. On agreement with our commissioners, we investigate all positive detections and report to Public Health England those aged two and above with diarrhoea (or a history of diarrhoea) where no other cause is present or, if another possible cause is present, clinical opinion led to treatment as a possible case. We report on the healthcare associated infections (HCAI) database according to a locally agreed paediatric modification of the national definition, to enable year-on-year comparison in our Specialist Trust. Our approach means we find more positive samples compared to the number of cases that we report.

‡ GOSH has reported 14 cases of C. difficile for 2014/15, one of which was attributed to a lapse of care in line with guidance published by Monitor.

*The rate reported in the Quality Report for 2012/13 differs to that of 2013/14 and 2014/15 due to the calculation of total bed days used. Elective surgery bed day numbers where used in 2012/13 and total bed days in 2013/14 and 2014/15.

				From National Reporting and Learning Service (NRLS) **Time Period: 01/04/2014 to 31/03/2015**					
Patient safety incidents reported to the NRLS:								GOSH introduced electronic incident reporting (DatixWeb) in April 2011 to promote easier access to and robust reporting of incidents. It is expected that organisations with a good safety culture will see higher rates of incident reporting year-on-year, with the severity of incidents decreasing.	Initiatives to improve the sharing of learning to reduce the risk of higher graded incidents from recurring include learning events and a Learning, Implementation and Monitoring Board.
Number of patient safety incidents	5,231	4,922	4,206	4,582	-	-	-		
Rate of patient safety incidents (number/100 admissions)	12.82	10.28	9.98	-	-	-	-		
Number and percentage of patient safety incidents resulting in severe harm or death	26 (0.5%)	27 (0.5%)	23 (0.5%)	16 (0.4%)	-	-	-		

There is a time lag between NHS Trusts uploading data to the NRLS (performed twice a month at GOSH) and the trend analysis reports issued by the NRLS. The last report issued was in 2013.

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

It is mandatory for NHS trusts in England to report all serious patient safety incidents to the CQC as part of the CQC registration process. On a voluntary basis, GOSH also reports its patient safety incidents to the National Reporting and Learning Service, which runs a national database designed to promote learning.

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

Part 3
Other information

Monitor uses a limited set of national mandated performance measures, sourced from the NHS Operating Framework, to assess the quality of governance at NHS foundation trusts.

Performance is measured on an aggregate (rather than specialty) basis and Trusts are required to meet the appropriate threshold each month. Consequently, any failure in one month is considered to be a quarterly failure. The table below sets out the relevant national performance measures used to assess the Trust's quality governance rating.

Performance against key healthcare targets 2014/15

Domain	Indicator	Threshold/target	GOSH performance for 2014/15 by quarter				2014/15 total	Indicator met?
			Q1	Q2	Q3	Q4		
Safety	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia – meeting the MRSA objective	N/A – Monitor no longer includes MRSA in its governance indicators	N/A	N/A	N/A	N/A	N/A	N/A
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment	98%	100%	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% 100% 100%	100% 100% 100%	100% 100% 100%	100% 100% 100%	Yes Yes Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90%	91.2%	89.3%	82.8%	91.3%	88.7%	No
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – non admitted	95%	96.0%	95.2%	93.3%	95.4%	95.0%	Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	92.5%	92.2%	92.2%	94.4%	92.8%	Yes
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

* Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008)

Performance against key healthcare targets 2013/14

Domain	Indicator	Threshold/target	GOSH performance for 2013/14 by quarter				2013/14 total	Indicator met?
			Q1	Q2	Q3	Q4		
Safety	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia – meeting the MRSA objective	0	1	0	N/A – Monitor no longer includes MRSA in its governance indicators	N/A – Monitor no longer includes MRSA in its governance indicators	1	Trust remains within Monitor de-minimis limit
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment**	96%	100%	100%	100%	100%	100%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising: • surgery • anti-cancer drug treatments • radiotherapy	94% 98% 94%	100% 100% 100%	100% 100% 100%	100% 100% 100%	100% 100% 100%	100% 100% 100%	Yes Yes Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90%	90.5%	90.4%	92.9%	90.4%	91.1%	Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – non admitted	95%	95.5%	95.8%	95.5%	95.8%	95.7%	Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	92.7%	92.9%	92.3%	93.6%	92.9%	Yes
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

**This indicator was incorrectly worded in the 2013/14 Quality Report as 'All cancers: 31-day wait from diagnosis to first treatment'.

Performance against local improvement aims 2014/15

In addition to the national mandated measures identified in the above tables, the Trust has implemented a range of local improvement programmes that focus on the quality priorities as described in section 2a. The table below sets out the range of quality and safety measures that are reviewed at each Trust board meeting. SPC charts (see page 10 for definition) are used to measure improvements in projects over time and to identify areas that require further investigation. All measures remain within expected statistical tolerance.

2014/15

Domain	Indicator	Total 14/15 performance	2014									2015			Performance within statistical tolerance
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Safety	Number of serious patient safety incidents	23	1	2	2	3	2	1	2	2	3	0	1	4	Yes
Safety	CVL related bloodstream infections (per 1,000 line days)	-	1.09	2.29	0.45	1.26	1.51	1.77	1.53	1.18	0.98	1.21	1.41	TBC	TBC
Effectiveness	Hospitality mortality rate (per 1,000 discharges)	-	3.35	3.28	2.33	1.96	2.82	2.38	2.18	2.07	2.70	3.57	3.38	1.36	Yes
Patient Experience	RTT - Admitted*	88.7%	92.0	91.2	90.3	87.8	90.3	89.8	81.8	86.4	80.3	90.4	90.6	93.1	No
Patient Experience	RTT - Non-Admitted*	95.0%	95.5	97.0	95.5	95.3	95.2	95.0	92.3	94.5	93.1	95.2	95.6	95.5	Yes
Patient Experience	RTT - Incomplete*	92.8%	92.8	92.2	92.6	92.0	92.2	92.2	92.0	92.1	92.7	94.6	93.9	94.7	Yes
Patient Experience	Discharge summary completion time (within 24 hours)	81.2%	82.2	81.1	85.1	84.9	77.7	80.6	83.4	81.2	78.8	80.3	79.0	80.2	N/A

* RTT, patient safety incidents and discharge summary indicators are standard definitions. The Trust has been undertaking reviews of its RTT delivery this year with the aim of building and improving on largely good wait times experienced by its patients. These findings are as follows (which are being addressed by the Trust):

- Often due to the complexity of the pathways and the reasons for referrals into the Trust, the reported data can include pathways which may not be RTT applicable and/or may on occasion potentially exclude RTT pathways.
- As additional data is obtained throughout the year, we are able to improve the quality and completeness of the data which can alter the position from that reported on page 40.
- As a consequence of the specialist / tertiary services GOSH delivers, patients are very often referred to the Trust towards the end of the patient pathway. This often results in a number of referrals received with missing information, such as exact details of the treatment prior to referral and the clock start date for the pathway. The latter particularly provides some limitations on the Trust's ability to report. Consequently the Trust applies a working rule of adding 3 weeks onto every referral received with a missing clock start and monitors these closely, to ensure patients are not disadvantaged. The Trust is aware that the prevalence of unknown clock start pathways is higher than most other Trusts (at circa 20%) and is taking action to better understand and put further mitigation and controls in place.

See page 29 for information about improvement work planned for 2015/16 for RTT data completeness and discharge summaries.

2013/14

Domain	Indicator	Total 13/14 performance	2013									2014			Performance within statistical tolerance
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Safety	Number of serious patient safety incidents	29	5	1	2	1	2	2	6	2	1	1	2	4	Yes
Safety	CVL related bloodstream infections (per 1,000 line days)	-	3.00	2.64	2.20	1.11	0.89	1.67	1.73	2.76	2.26	1.86	2.03	3.21	Yes
Effectiveness	Hospitality mortality rate (per 1,000 discharges)	-	3.09	2.90	2.76	1.70	1.83	2.51	2.49	2.85	3.81	1.74	4.61	1.77	Yes
Patient Experience	RTT - Admitted	91.0%	90.4	90.3	90.7	90.5	90.2	90.5	93.1	93.8	91.8	91.0	90.0	90.3	Yes
Patient Experience	RTT - Non-Admitted	95.6%	95.3	95.9	95.3	95.4	95.7	96.2	95.0	95.1	96.4	95.8	95.6	96.0	Yes
Patient Experience	RTT - Incomplete	92.9%	92.5	92.8	92.9	93.9	92.5	92.3	92.1	92.3	92.5	92.6	93.5	94.6	Yes
Patient Experience	Discharge summary completion time (within 24 hours)	83.0%	77.1	77.1	81.4	87.8	80.5	85.8	82.2	85.5	74.5	88.2	87.2	88.5	N/A

Safeguarding children and young people

Safeguarding and promoting the welfare of our patients is everyone's responsibility and is an ongoing priority for GOSH.

When staff identify child protection concerns, they make a referral to the Social Work service. This can be done through an electronic referral or verbally to their allocated or duty social worker. The Social Work service at GOSH provides social work support to all wards and units within the hospital.

There were 2535 referrals made to the Social Work service in 2014/15. This is an increase of 25 per cent from 2013/14. Of these referrals, 290 (11 per cent) were related to child protection (CP) concerns, compared with 246 CP-related referrals in 2013/14.

2014/15 has seen a growth in the total numbers of patients, occasions of service and hours spent on each child by the Social Work team. A similar growth occurred in work done with patients where child protection was an issue. This is in part due to improvements in the activity data collection system, as well as an actual increase in referrals and complexity of cases (including child protection) being referred to the Social Work team. Whilst there was an increase in the number of child protection cases in 2014/15, it remained a similar percentage of the overall work compared to the previous year.

GOSH provides assurance to our commissioners about safeguarding, which covers training, supervision and staff participation in child protection conferences.

Staff are trained to the relevant competency level, which consistently exceeds our commissioners' requirement of 80 per cent of staff trained. Training incorporates key government initiatives such as female genital mutilation awareness and the PREVENT strategy to identify vulnerable young people at risk of radicalisation. It also includes learning from serious case reviews. In addition, themed training days are run, safeguarding newsletters are distributed to the workforce twice per year, and web-based resources support staff to remain updated with current national policy, research and guidance.

Supportive supervision in safeguarding is available to all staff at GOSH and is repeatedly highlighted as good practice in Serious Case Reviews. A 'drop in' clinic for staff has been established in the past year by the Safeguarding Team to enable staff to discuss any concerns and to promote good practice.

Increasingly, GOSH uses teleconferencing facilities to ensure that professionals can contribute effectively to child protection conferences across the country, while minimising disruption to their clinical workload.

In 2014/15, the Trust has:

- Maintained external regulatory/contractual standards
- Contributed to 8 Serious Case Reviews (SCR) and 3 non-SCR reviews involving 14 children.
- A robust audit program in place to assure itself and its commissioners that safeguarding systems and processes are working.
- Acted upon learning from SCRs, including:
  - Management of bruising in babies and non-ambulant children.
  - Streamlining the training requirements of the various contracts provided to honorary professionals and those staff on placements and observational visits.
  - Monitoring mandatory training requirements for all staff through their personal development reviews.
  - Encouraging staff to escalate any child protection concerns appropriately.
  - Enhancing awareness through training, electronic updates and intranet and updating policy where applicable on a range of issues including:
  - Parental non-compliance
  - Management of shared care cases where there are safeguarding concerns

Priorities for 2015/16 include:

- Continue to evolve an effective child-centred and coordinated approach to safeguarding our children and young people.
- Further increase in uptake of supervision for staff.
- Three themed study days planned: child sexual exploitation; domestic abuse; neglect.
- Increase professional awareness of the Government's PREVENT Strategy.
- Review of transition protocol for young people from paediatric to adult services.

Annex 1: statements from external stakeholders

Statement from NHS England (London), Women and Children Programme of Care

Many thanks for the opportunity to comment on the draft iterations of the Great Ormond Street Quality Account Report. Please accept my apologies for the delay in responding with the feedback from colleagues across NHS England including from the Patient Safety, Infection Control, Patient Experience and Nursing Directorate.

The infection control and patient team had no specific comments to note but wished to relay that the report was well constructed, well developed and clear. Otherwise, specific comments in relation to the 2014/15 review are:

Effectiveness

We await the output of the paediatric and neonatal critical care project as appropriate utilisation of beds in both services and also in cardiac critical care remain high priorities for both the Trust and for NHS England. I would request that the improvement dashboard referenced be scheduled for wider discussion at an upcoming CQRG.

The positive feedback from patients and staff and in particular those relating to the CNS for non- invasive ventilation (incentivised via CQUIN for 2014/15) and presented to the CQRG are clear. I note that sustainability of this model is being discussed as part of the 2014/15 contractual negotiations.

Patient Safety

The report demonstrates good outcomes on Grade 3 and 4 pressure ulcers. Whilst no numbers are provided for Grade 1 and 2 we would like the measures being adopted to mitigate these to be referenced also.

Patient Experience

There has clearly been a significant amount of effort in developing "Our Always Values" and it is evident that these are founded on the clear relationship between good staff engagement and experience translating well through the patient experience. NHS England supports this approach absolutely.

Whilst staff FFT figures are not cited, for Q1 and Q2 these are suggestive of excellent care and Great Ormond Street is noted to rank in the top 10% here. The Trust however doesn't do so well on staff recommendation as a place to work and it would be useful to test this further.

We would hope to see some improvements in pharmacy waiting times in the 2014 survey when it is published.

As reported, further work is required in relation to children with learning difficulties and we note the importance of raising staff awareness of the patient passport. Regionally, the NHS England PE Team have undertaken work with CLCH on a project 'My Health, My Say', which enables those people with learning difficulties to provide feedback directly rather than through a mediator. The project has been publicised and recently won an award and whilst the Trust may be aware of it already we would be happy to share details about the principles applied if helpful.

There is no reference to the effectiveness of the Trust's transition programme in 2014/15 for any child and in particular those with learning difficulties which was a specific area for improvement noted in the CQUIN plan. This should remain a high priority given the Trust's current performance and the CQC report published last year.

For 2015/16, it is clear that there is further work required to improve in the areas listed that is discharge summary completion and turnaround, improving flow and referral to treatment pathways. We would however expect these to be core components of the work programme having been discussed extensively throughout 2014/16. We would anticipate that there are more ambitious priorities for 2015/16 reflecting Great Ormond Street's positions as a World Leader in paediatric care and perhaps reflecting some of the emerging themes from the Trust's Strategic Change Plan. We would encourage these be amended accordingly.

With apologies once again for the late circulation, we would of course be happy to discuss further or confirm any points of clarity as required.

Joint statement from Healthwatch Camden and the Camden Health and Adult Social Care Scrutiny Committee

Camden Healthwatch and the Camden Health and Adult Social Care Scrutiny Committee (HOSC) are pleased to be given the opportunity to comment on the Great Ormond Street Hospital (GOSH) NHS Foundation Trust's Quality Report for 2014/2015.

It is clear that GOSH has taken effective action to improve the quality of its services in 2014/15 as set out in the report. Indeed, all their identified priorities and improvements have been successful. They are to be congratulated for this. The report states that the Trust's priorities have been chosen as a result of a combination of national and local issues, the latter in part determined by patients and their families. The Trust measures patient experience across the hospital and uses that information to improve the services offered. The Trust also 'seek to create meaningful opportunities for engagement with our patients, their families, and the wider public via our membership, patient and member surveys, listening events, focus groups, the use of social media, and asking patients and families about their experience within 48 hours of discharge.' This is something that both Camden Healthwatch and Camden HOSC are very keen to support.

What is not clear from the report is how far understanding of the patient experience and engagement led to the setting of the Trust's priorities for 2014/2015 and what the patient view of those improvements actually is. The report sets out how the actions taken have improved patient experience but it would be helpful in future quality reports if the Trust could outline how patient views contributed to the chosen priorities and whether the improvements have made a difference to the patient experience. This is particularly the case in regard to the results of a consultation with patients and their families about what was good and not so good about GOSH. This was intended to help in developing 'Our Always Values' which are about identifying appropriate behaviours by staff, again, something we support. This work identified a number of problem areas however none of them appear to have been picked up as priorities for improvement by the Trust. We understand the importance of improving behaviours but there is no reason in principle why this information could not also inform work on improvement priorities.

Feedback from Members' Council councillors

Comments from patient councillor:

This is awesome! – what an incredible insight into the work the hospital does. The format and structure is super clear and very easy to understand and follow. The more data the better! At any chance I would always include more (perhaps around the neonates and the air mattresses, if available).

The quotes are also nicely balanced across a good range of staff, including Managers, Nurses, Community outreach and Medical Director – really powerful and a great addition. The only quote that is missing is one from a Patient or Parent, that could be a nice addition.

Benefits to patients are clear through the focused work but reinforcing them at the end works well.

Think it's great and look forward to seeing the published report. If there is anything else you need from me, just shout.

Comments from parent councillor:

Thanks for sending the draft report to me. I've spent some time reading through and have to say how impressed I am with the way it is set out and the information within it.

I found it very clear to read and liked the way the report was broken up into clearly definable sections: What we did; What the data shows; What's going to happen next and How this benefits patients.

A couple of questions/comments below:

- Most of the language was clear but some words could be less 'corporate', such as 'evidencing' (showing? proving?).
- The phrase 'care bundles' needs an explanation, though I think from the notes that this is being considered.
- The CVLs section could benefit from an explanation of what a 'line day' is.
- Were the 2014/15 quality priorities listed in any particular order? I was unclear whether there was any significance in the way they were set out.
- I would find some context or explanation of why GOSH has chosen the three 2015/2016 quality priorities useful. Also, there were six reported for 2014/15 so is there a reason why there are only three listed for the next year?
- Perhaps consider a couple of paragraphs of conclusion summing up GOSH's achievements against last year's priorities.

The addition of quotes gives some nice context to the data and I think the report does clearly state how the actions have benefited patients.

I do hope that's useful. If you would like any more detail from me, then please do let me know.

GOSH response to statements

We welcome this feedback from our external stakeholders, commissioners and councillors. We would like to respond on the following points:

Transition of our young people in to adult services remains a key Trust quality priority for the coming year and a new action plan is being developed for 2015/16 to build on the work over the last two years.

We have made progress on our outpatient pharmacy wait times project that has improved patient experience while waiting. However, we are disappointed not to have achieved a reduction in wait times – our primary aim. The development of the pharmacy tracker means that we now have good data to help us identify where the bottlenecks occur. A review of the data is currently underway and a new project will be launched in June, aimed specifically at removing waste from the system and improving processes so that they are more efficient.

We are currently reviewing the whole structure of our quality agenda, to clarify accountability and to streamline delivery and reporting. We intend to use information gleaned from the Our Always Values work to inform our quality priorities in the coming year, and we will continue to ensure priorities reflect feedback from patients and their families.

Annex 2: statements of assurance

External assurance statement

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the *Quality Report*.

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

- The content of the *Quality Report* meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance.
- The content of the *Quality Report* is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2014 to May 2015
  - papers relating to Quality reported to the board over the period April 2014 to May 2015
  - feedback from commissioners dated 05/05/2015
  - feedback from governors dated 20/04/2015 and 24/04/2015
  - feedback from local Healthwatch organisations dated 05/05/2015
  - feedback from Overview and Scrutiny Committee dated 05/05/2015
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 12/05/2015
  - the first CQC commissioned National Children's inpatient survey 2014 (conducted for GOSH by Picker Institute Europe)
  - the independently commissioned Ipsos MORI outpatient experience survey 2014 (this survey is conducted every two years)
  - the national NHS Staff Survey 2014
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 22/05/2015
  - CQC Intelligent Monitoring Report dated July 2014, October 2014 and December 2014
- The *Quality Report* presents a balanced picture of the NHS foundation Trust's performance over the period covered.
- The performance information reported in the *Quality Report* is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the *Quality Report*, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the *Quality Report* is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The *Quality Report* has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the *Quality Report* (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

<NB: sign and date in any colour ink except black>

22 May 2015
Chairman

22 May 2015
Chief Executive

Great Ormond Street
Hospital for Children
NHS Foundation Trust

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Thank you to everyone who was interviewed for, or gave permission for their picture to be used in, this report, as well as the many members of Great Ormond Street Hospital staff who helped during its production.

This *Quality Report* is available to view at www.gosh.nhs.uk

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Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **22nd May 2015**	
Audit Committee Report **Submitted by:** Claire Newton, Chief Finance Officer	**Paper No: Attachment O** *For approval*

Aims

To discuss the final draft of the Audit Committee's Report to the Board which will also be included in the 2014/15 Annual Report

Summary

The purpose of the Audit Committee Report is to describe the key activities of the Committee during the financial year and how the Committee discharged its responsibilities. The report should include:

- the significant issues that the Committee considered in relation to the financial statements, operations and compliance and how these were addressed
- an explanation of how the Committee has assessed the effectiveness of the external audit process, how auditor objectivity and independence are safeguarded; details regarding their appointment, tenure & when the service was last tendered
- the value of external audit services and value of non-audit services, if provided.
- Details of the internal audit function and what role it performance
- Names of Members of the Committee (if not elsewhere).

In past years the Committee has submitted an annual report detailing its work to the Trust Board and included a separate short report in the Annual Report. For 1415 the two reporting responsibilities have been combined into one report. Where relevant, the report reflects consistency with best practice guidance reflected in the NHS Audit Committee Handbook.

Action required from the meeting

To discuss the draft report and suggest refinements prior to finalisation of the report.

Contribution to the delivery of NHS / Trust strategies and plans

The Audit Committee is committed to achieving and demonstrating best practice in governance. Reviewing effectiveness is a key element of good governance.

Financial implications

No direct financial implications

Who needs to be / has been consulted about the proposals in the paper? N/A

Who needs to be told about any decision The Trust Board

Who is responsible for implementing the proposals / project and anticipated timescales? *CFO*

Who is accountable for the implementation of the proposal / project

Audit Committee Chair

Great Ormond Street NHS
Hospital for Children
NHS Foundation Trust

INTRODUCTION FROM THE CHAIR OF THE AUDIT COMMITTEE

I am pleased to present the Audit Committee's report on its activities during the year ended 31st March 2015.

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

Clinical risks and their associated controls are considered by the Clinical Governance Committee. One member of that Committee is also a member of the Audit Committee to ensure that the work of each Committee is complementary.

The Committee reviews its effectiveness annually and no material matters of concern were raised in the 2014/15 review.

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

The members of the Audit Committee are listed on page XXX and during the financial year included four independent Non-Executive Directors and one independent member. The Foundation Trust was authorised on 1st March 2012 and I have been Chairman of the Committee since then. Four of the members of the committee were qualified accountants and at least three members of the committee have recent and relevant financial experience.

I would like to thank both John Ripley and Yvonne Brown who are retiring from the committee during 2015 after serving [3] years on the committee of the Foundation Trust and welcome Akhter Mateen as a new member from 28th March 2015. Akhter was appointed as a non-executive director of the Trust on the same day and has recent experience as a Group Chief Auditor of a multinational company. Michael Dallas, who served as an independent member of the Committee since March 2012 and for X years as a member of the audit committee of the predecessor NHS Trust has also retired and I am pleased to report will be replaced by James Hatchley, a qualified accountant who will also become an independent member of the Clinical Governance Committee.

CHARLES TILLEY
Audit Committee Chairman
22nd May 2015

Attachment O

Report of the Audit Committee in relation to the year ended 31st March 2015

Committee Responsibilities

The Committee's responsibilities and the key areas discussed during 2014/15, whilst fulfilling these responsibilities, are described in the table below:

	Principal responsibilities of the audit committee	**Key areas formally discussed and reviewed by the Committee during 2014/15**
Review of the Trust's risk management processes and internal controls	• Reviewing the Trust's internal financial controls, its compliance with Monitor's guidance for Foundation Trusts, including the Code of Governance, and the effectiveness of its internal control and risk management systems. • Reviewing the principal non-clinical risks and uncertainties of the business (Clinical risks are reviewed by the Clinical Governance Committee) and associated Annual Report risk management disclosures.	The outputs of the Trust's risk management processes including reviews of: • the Board Assurance Framework • the principal risks and uncertainties identified by the Trust's management and movement in the impact and likelihood of these risks in the year. • further developments in the Trust's risk management processes and risk reporting • an annual assessment on the effectiveness of internal control systems taking account of the findings from internal and external audit reports which is documented in the Annual Governance Statement. • An annual report and fraud risk assessment prepared by the Trust's counterfraud officer. • An annual report from the Trust's Security Manager • The Trust's insurance arrangements. • The results of an internal review of compliance with the Code of Governance was reviewed
Financial reporting and external audit	• Monitoring the integrity of the Trust's financial statements and annual financial returns; reviewing significant financial reporting judgements contained within them. • making recommendations to the Board regarding the appointment of the External Auditor. • monitoring and reviewing the External Auditor's independence, objectivity and effectiveness. • developing and implementing policy on the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance.	• A commentary on the annual financial statements • Key accounting policy judgements, including valuations. • Impact of changes in financial reporting standards where relevant. • Basis for concluding that the Trust is a going concern. • External Auditor effectiveness & independence • External Auditor reports on planning, a risk assessment, internal control and value for money reviews • External Auditor recommendations for improving the financial systems or internal controls • The policy for engagement of the External auditor for non-audit work and an annual report of compliance with that policy has been reviewed • Developing and updating the Trust's policy in relation to non-audit work

Attachment O

Report of the Audit Committee in relation to the year ended 31st March 2015

	Principal responsibilities of the audit committee	Key areas formally discussed and reviewed by the Committee during 2014/15
Internal audit	• monitoring and reviewing the effectiveness of the Company's Internal Audit function, including its plans, level of resources and budget	• Internal Audit effectiveness &Charter defining its role and responsibilities. • Internal Audit programme of reviews and an assurance map showing the coverage of audit work over three years against identified risks. • Implementation status reports on audit recommendations & any trends and themes emerging • The Internal Audit reports discussed by the Committee, included ◦ Core financial systems ◦ Financial Reporting and Budgetary control ◦ Risk management & assurance framework ◦ Processes for monitoring compliance with the Provider License ◦ Incident reporting ◦ Whistle blowing ◦ HR arrangements & employment checks ◦ Governance arrangements ◦ Health & Safety ◦ Maintaining the Trust's estate ◦ Private patient management processes ◦ The Productivity & Efficiency programme
Other	• Reviewing the Committee's Terms of Reference and monitoring its execution. • Considering compliance with legal requirements, accounting standards. • Reviewing the Trust's Whistle-blowing Policy and operation.	• Updates to Audit Committee's Terms of Reference. • Updates to the Trust's Standing Financial Instructions and financial approval limits • Reviewing the assurance relating to the Trust's compliance with the Foundation Trust licensing conditions • Annual Report sections on governance. • The impact of new regulations • Updates on management of information governance and data quality risks • Updates on whistle blowing • reporting to the Board and Members' Council where actions are required and outlining recommendations.

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

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

Attachment O

Report of the Audit Committee in relation to the year ended 31st March 2015

External audit
A competitive tendering process of the audit contract took place during 2013 involving members of the Audit Committee and two members of the Members' Council. Deloitte LLP were reappointed for a three-year term from 2014/15.

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

The non-audit services provided by Deloitte Consulting, pro bono, during the year were:

- Commercial Opportunities Review
- Further development of specific opportunities identified in the first review

Prior to appointing Deloitte Consulting for these assignments, the Committee considered whether the scope of the review might result in any impairment of the auditor objectivity and independence and concluded that it would not.

Internal audit and counter fraud services

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

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

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

Risk reviews
The Committee reviews all non-clinical strategic and high scoring operating risks at least annually. Current significant risks include the potential reduction in the Trust's funding arising from the challenging external environment and commissioning changes and delivery of the Trust's Productivity & Efficiency Target. Specific risks relating to the preparation of the financial statements were also reviewed and are detailed later in this report.

In addition the Committee considered risks associated with the Trust's evolving strategy and in particular the risks associated with:

- Implementation of the Trust's digital transformation strategy and the required change management processes;
- private patient services;
- the major building redevelopment programme.
- R and D funding

For each risk the Committee reviews the risk assessment (including risk definition, risk appetite, and likelihood and impact scores); the robustness of the controls and evidence available that the controls are operating.

Attachment O

Report of the Audit Committee in relation to the year ended 31st March 2015

In July 2014, members of the Audit Committee attended an extra meeting with other Board members to proactively review and improve the Trust's risk management processes

Internal controls

We focused in particular on controls relating to securing sustainable funding; control weaknesses identified in the Trust's procurement, contract management, credit control and business continuity management processes. Action plans were put in place to address issues arising from the areas considered .

Fraud detection processes and whistle-blowing arrangements

We reviewed the levels of fraud and theft reported and detected and the arrangements in place to prevent, minimise and detect fraud and bribery. Only one significant fraud was uncovered in the past year.

Serious incidents

The Committee has reviewed the results of the investigations into one serious fire incident and ensured the Trust has identified the changes required to reduce the risk of similar incidents occurring.

Financial reporting

We reviewed the Trust's accounts and Annual Governance Statement and how these are positioned within the wider Annual Report. To assist this review we considered reports from management and from the internal and external auditors to assist our consideration of: the quality and acceptability of accounting policies, including their compliance with accounting standards;

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

Significant financial judgements and reporting for 2014/15

We considered a number of areas where significant financial judgements were taken which have influenced the financial statements:

We identified through discussion with both management and the external auditor the key risks of misstatement within the Trust's financial statements. We discussed these risks with management during the year, and with the auditor at the time we reviewed and agreed the external auditors' audit plan during the year and also at the conclusion of the audit. We set out in the table below how we satisfied ourselves that these risks of misstatement had been appropriately addressed.

Areas of accounting judgement and other issues

The following items were reviewed by the Audit Committee in relation to the preparation of the accounts:

Level of debt provisions The financial statements include provisions in relation to uncertainty. Judgements in this area are largely related to the timing of recognition of these provisions, the quantum recognised and the amount which has been utilised in previous years.	We reviewed and discussed the level of both NHS and private patient debt and associated provisions with management. This included consideration of the reasons for debt becoming overdue, difficulties in obtaining payment for over performance of the commissioning contracts, new debt provisions and any release and utilisation of existing provisions. Management confirmed to us that they have applied a consistent approach to the recognition and release of provisions. We also considered the views of the external auditors in respect of the provisions and associated disclosures in the accounts. We concluded that we were satisfied with the level of provisions carried and the disclosure in respect of those provisions.
Valuation of property assets The Trust has historically revalued its properties each year which combines properties held under freehold with those held under finance and operating leases. Judgements relate to the future life of these buildings, which can change the appropriate accounting treatment and affect the carrying value on the balance sheet.	We reviewed reports from management which explained the basis of valuation for the most significant buildings, including the future life and rationale for any impairments associated with structural refurbishment expenditure. We also considered the auditors' views on the accounting treatment for these buildings. We are satisfied that the valuation of these properties within the financial statements is consistent with management intention and is in line with accepted accounting standards.
Other areas of financial statement risk Other areas where an inappropriate decision could lead to significant error include: • the treatment of capital expenditure • going concern	We consider that the Trust's existing financial control systems should ensure that such items are properly treated in the accounts. We have discussed the external auditors' findings in these areas. There were no issues of concern reported to us in these areas and consequently we are satisfied that the systems are working as intended. We have reviewed the Trust's medium term financial plans and taking into account the requirements of IAS1 have concluded that it is appropriate to prepare the accounts on a going concern basis.

Attachment O

Report of the Audit Committee in relation to the year ended 31st March 2015

Conclusion

The Committee has reviewed the content of the annual report and accounts and advised the Board that, in its view, taken as a whole:

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

Attachment P

Great Ormond Street Hospital for Children NHS Foundation Trust

<table>
<tr><td colspan="2" align="center">Trust Board
22nd May 2015</td></tr>
<tr><td>Strategic Goals – update report

Submitted by:
Robert Burns, Director of Planning & Information</td><td>Paper No: Attachment P</td></tr>
<tr><td colspan="2">Aims / summary
The purpose of this paper is to provide Trust Board with an update on the Trust's delivery against its strategic goal of being the leading children's' hospital in the world.

This report builds upon previous versions submitted to the Board and incorporates feedback and suggestions.

As is evident from the report, the Trust is in a positive position across all strategic goals. Inevitably the Trust will want to strive for constant improvement and delivery, and this provides areas of focus to consider.

From previous iterations of the report it is important to note that in some instances there is not always comparable benchmarking data available (nationally or internationally). Therefore the most appropriate datasets / evidence have been used.</td></tr>
<tr><td colspan="2">Action required from the meeting

To note</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS Foundation Trust strategies and plans
This paper is an assessment of the Trust's strategic goals</td></tr>
<tr><td colspan="2">Financial implications
NA</td></tr>
<tr><td colspan="2">Who needs to be told about any decision?</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales?
Graham Terry, Head of Planning & Performance</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project?
Robert Burns, Director of Planning & Information</td></tr>
</table>

Attachment P

Strategic Goals - To be the leading Childrens Hospital in the World

	Strategic Goals	2014/15		
		Better than Average	High Performer	Exceptional Performer
Measures	Provides the best patient experience	✓	✓	
	Provides the best patient outcomes	✓	✓	✓
	Is an excellent place to work and learn	✓	✓	
	Delivers world-leading paediatric research	✓	✓	✓
	Is the partner of choice	✓	✓	
	Is sustainable	✓		

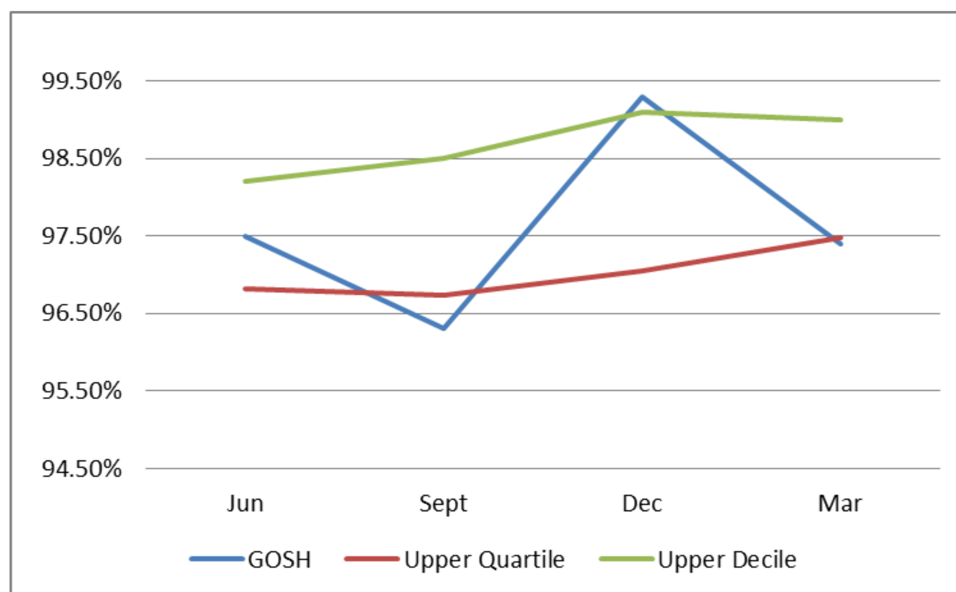
Strategic Goal: Provides the best patient experience and outcomes

Patient Experience

National Friends and Family Test (FFT) – 2014/15
Predicated on the NHS England calculation for the FFT, as a percentage of respondents who would/would not recommend the service to their friends and family, GOSH based on 2014/15 is between the upper quartile and upper decile nationally.

It is important to note that for Children's Hospitals it remains non-mandatory to report / submit FFT data. This analysis shows where GOSH would be positioned (based on 2014/15 submitted data) were the Trust to compare itself against other inpatient hospitals across the country.

The graph below shows GOSH's FFT results over 2014/15, of those patients who would be likely and extremely likely to recommend the service, compared to the national upper quartile and decile from a cohort of approximately 170 inpatient providers.



Clinical Outcomes

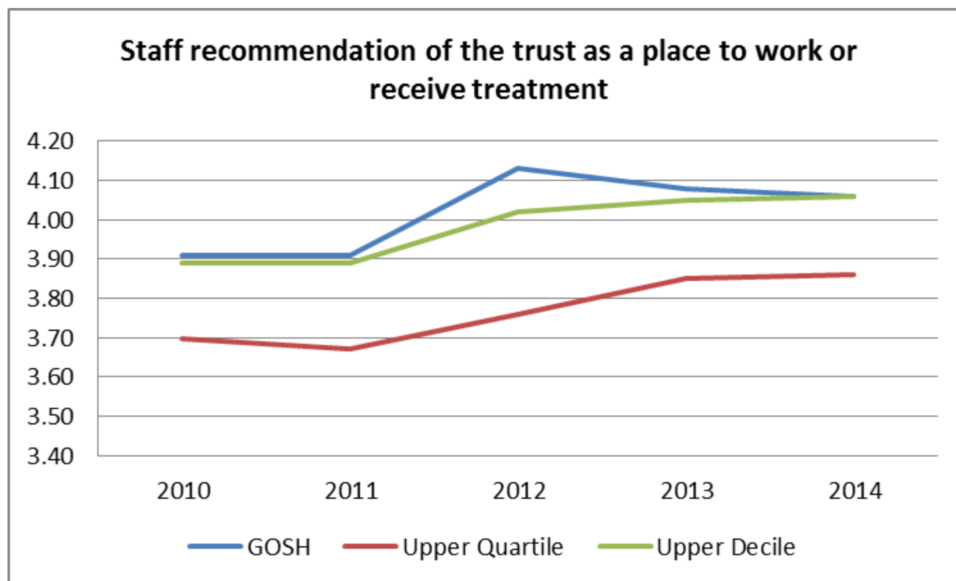
GOSH continues to be leading in the field of reporting and presenting on clinical outcomes. Other providers reporting on outcomes very much focus on process measures or have very finite evidence published publically which focuses on clinical outcomes. To date the Trust has 82 outcomes published over 31 specialties. This is far more than any other paediatric hospital in the world. Nationally in the UK, University Hospitals Birmingham comes closest (of which these mainly encompass process measures).

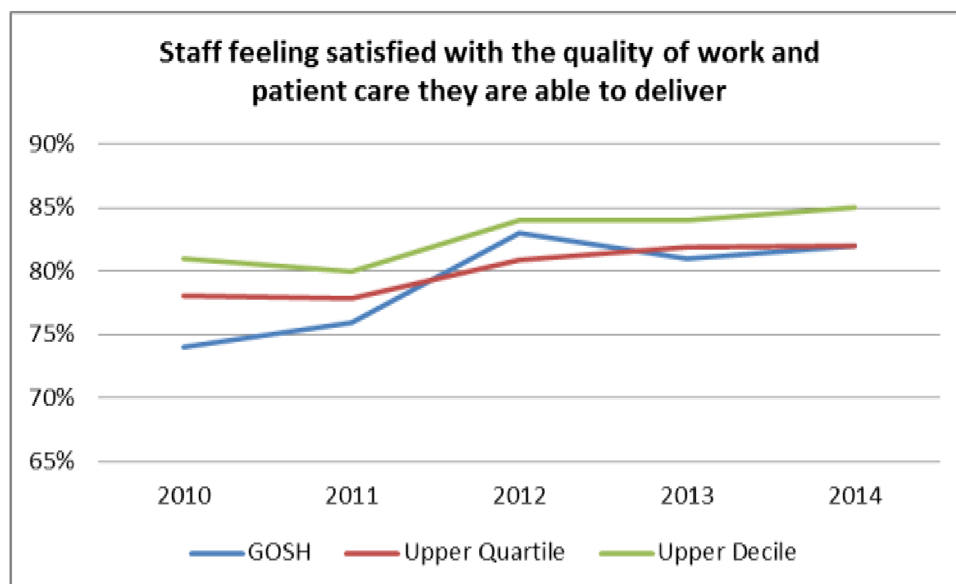
Consequently as a result of this absence of reporting, and/or capturing clinical outcomes makes benchmarking GOSH very difficult. However based on the reporting GOSH has undertaken, and in assessing what evidence there is to benchmark itself against others, the Trust is leading in many areas (e.g. HIV, tracheal surgery, metabolic).

Strategic Goal: Is an excellent place to work and learn

Looking at GOSH as a place to work and learn the most useful and appropriate data from which to assess this is the national NHS staff survey. This provides a rich body of evidence over a range of years, enabling the Trust to understand areas of improvement or areas requiring improvement. As yet there are not comparable datasets internationally.

Based on the most recent survey results across the previously reported indicators below, GOSH remains in a very strong position. Clearly the Trust will wish to improve and to be viewed as the leading Children's Hospital would wish to be in the upper decile. However to be between upper quartile and upper decile compared to all Acute Trust is an excellent achievement.





Strategic Goal: Delivers world-leading paediatric research

As reported in previous quarters, upon reviewing GOSH's standing as being the leading Children's Hospital internationally in paediatric research, a number of key studies (inclusive of analysis from Thomson Reuters) have already been undertaken, and the intention is for these to be carried out again in 2015/16.

From this analysis GOSH is joint 3rd on Citation impact, 5th for percentage of highly cited and 5th on numbers of publications. Previously discussed in reporting on this, in wanting to be the leading Children's Hospital, it is important that GOSH maintains this position.

Research activity within the Trust would suggest this continues to deliver at these levels and the analysis later in the year should support this.

Strategic Goal: Is the partner of choice

In reviewing this goal some of the most useful indicators are those associated with market share for key services, and assessing if GOSH is sustaining or growing in these areas. Based on recent analysis using Hospital Episode Statistics (HES) data from July 2010 to December 2014 most specialties are clear market leaders with a growing market share: Cardiac Surgery, Neurosurgery, Spinal Surgery and Gastroenterology. In General Surgery the Trust has seen a decline in market share; however there are actions to reverse this trend.

Appended to this paper are graphical representations of some key specialties at GOSH and the Trust’s place in the market.

Strategic Goal: Is sustainable

As stated previously, sustainability has been reviewed in the context of financial and environmental sustainability.

Financial Sustainability
For 2014/15 GOSH reported to Monitor (NHS Foundation Trusts' national regulator) service continuity score the best possible (which assesses the financial stability of the organisation) along with a green governance rating, which is very positive. It is important to acknowledge that for 2015/16 the environment within which GOSH will be operating will continue to be increasingly challenging.

Continuity of services rating	Governance rating
4 (out of 4)	Green

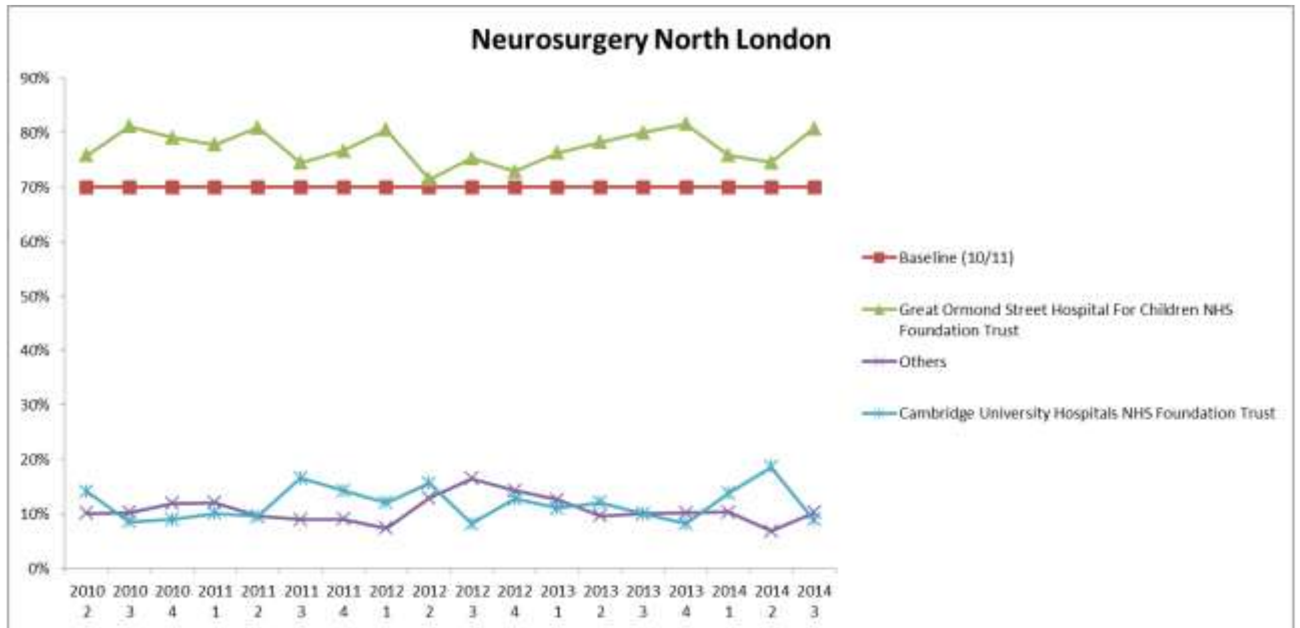
Environmental Sustainability
As update previously, in reviewing how sustainable an organisation is environmentally, there are a number of metrics and indicators for which Hospitals are measured and monitored. A key area is associated with the reduction in an organisation's carbon footprint. As indicated below, GOSH has set itself (via its Sustainable Development Management Committee) a target to see a reduction of 20% of CO2e/m2 by 2015/16.

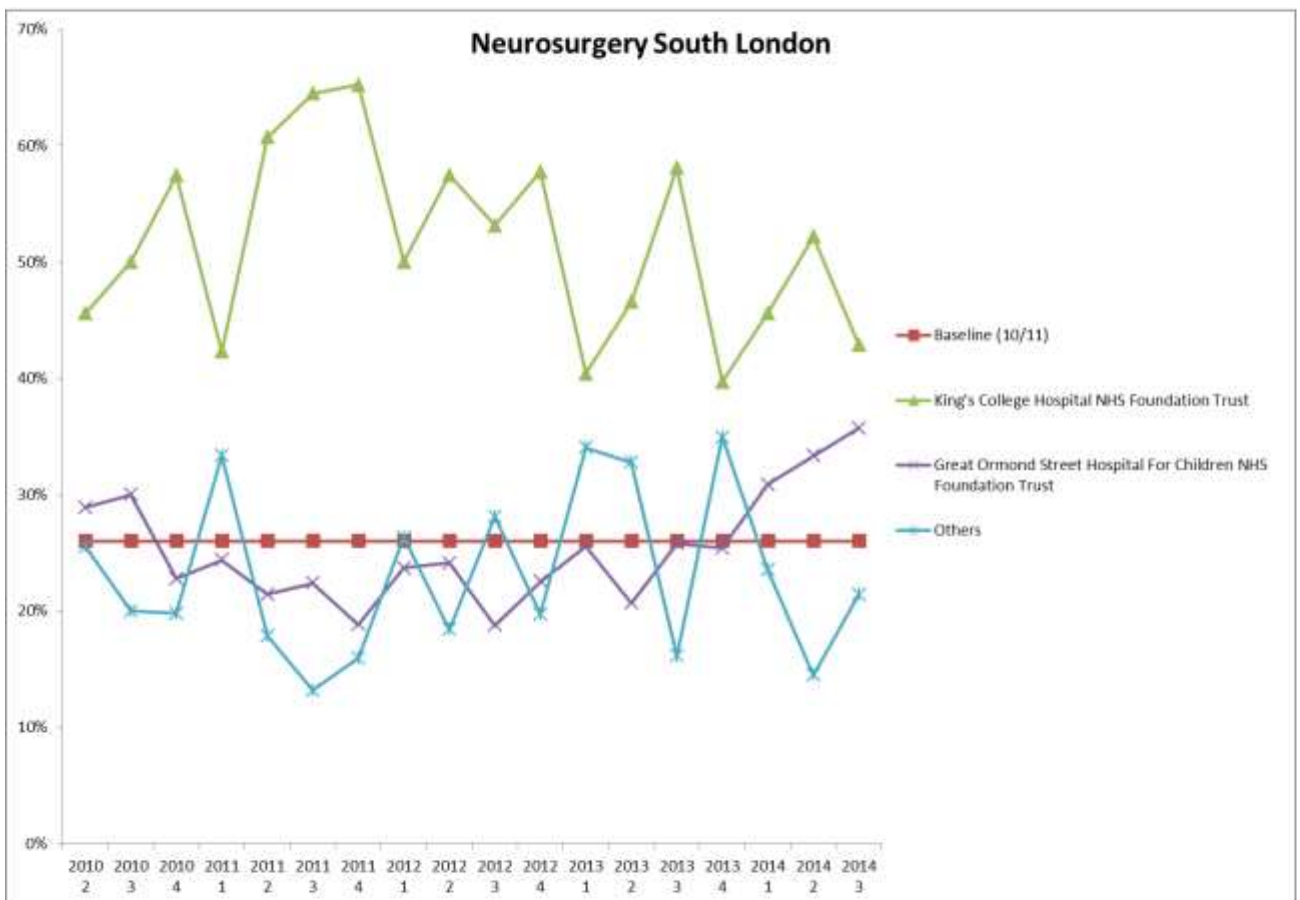
Goal	2011/12	2012/13	2013/14	2014/15	2015/16
Emissions: reduce CO2e emissions per m2 of occupied floor area by 20% from 2012/13 baseline by 2015/16 (CO2e/m2)	202.87	190.98	189.39	167.50	152.78
Target					152.78
					-20%
% reduction yr on yr	-	12%	2%	11.5%	8.8%

The Trust continues to do well in the reduction of emissions overall (across a number of indicators). This will incrementally become more challenging as the Trust reduces its square footage with the reduction of floors etc. Notwithstanding the increased challenges in this area, GOSH continues to demonstrate a great deal of focus in this important area, and will continue to do so.

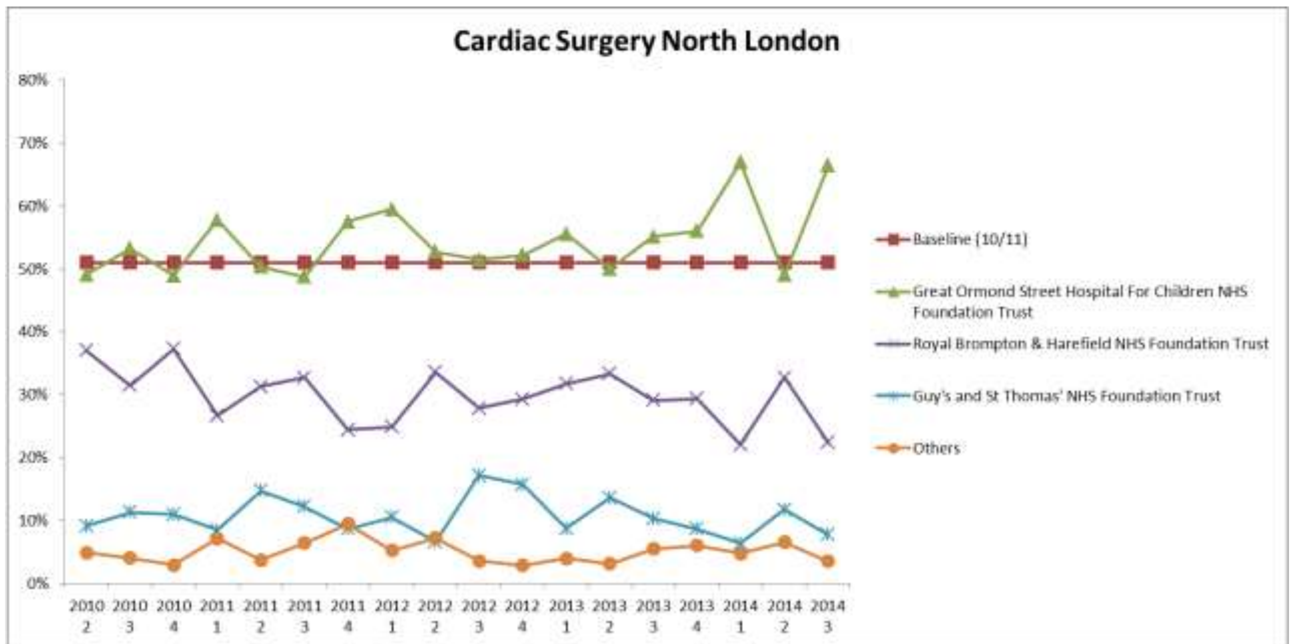
Appendix I - Strategic Goal: Is the partner of choice

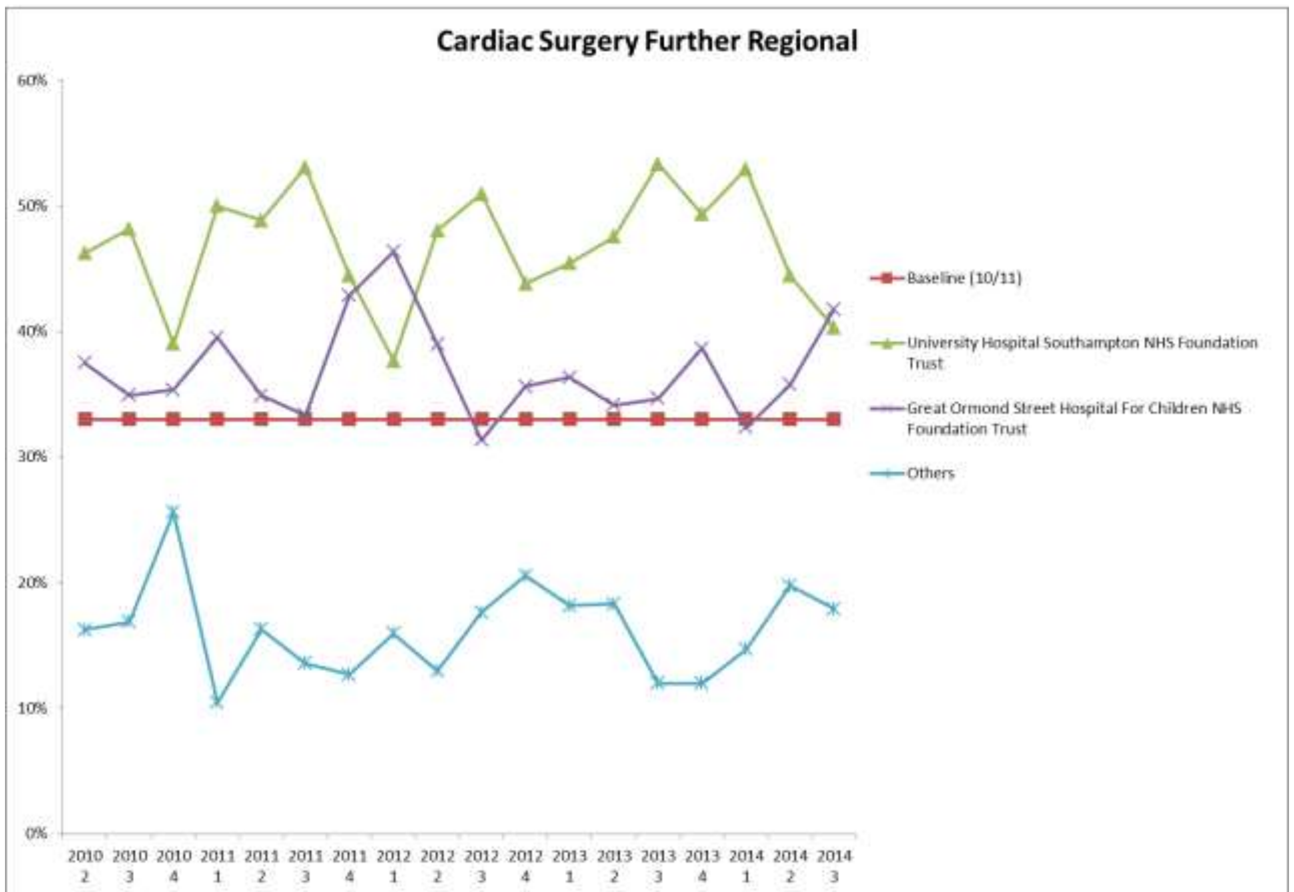
Market Share Analysis – inpatient spells for relevant HRGs





Attachment P





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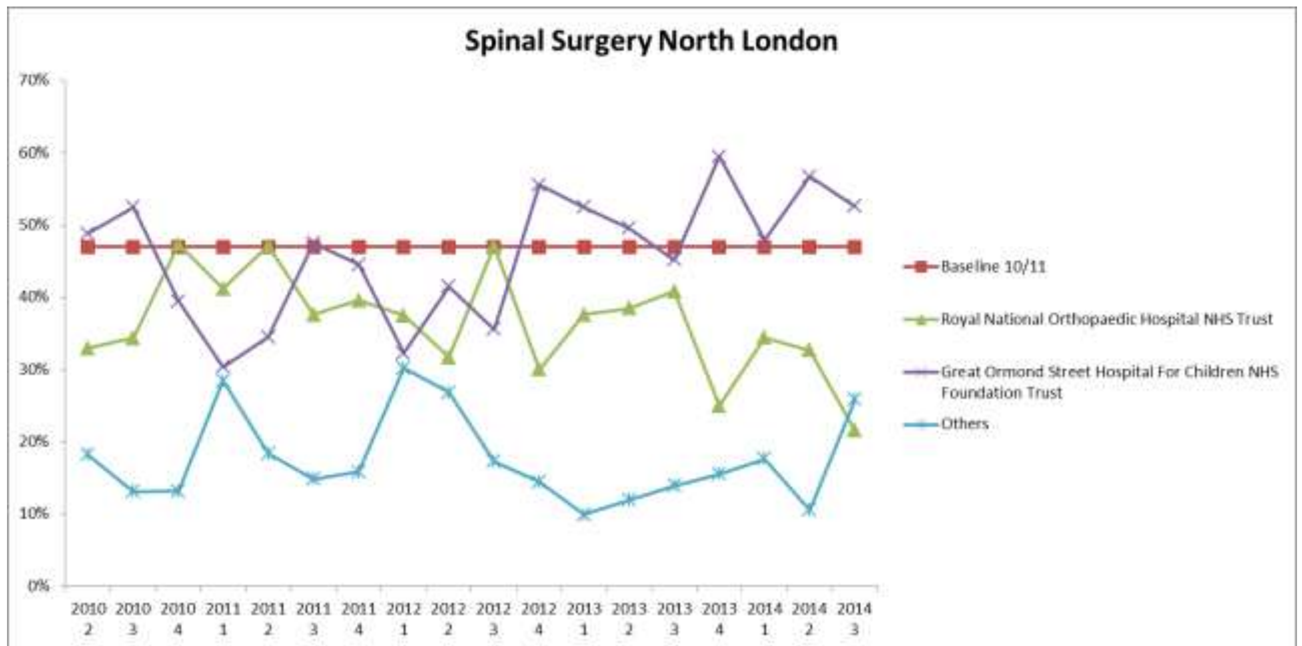

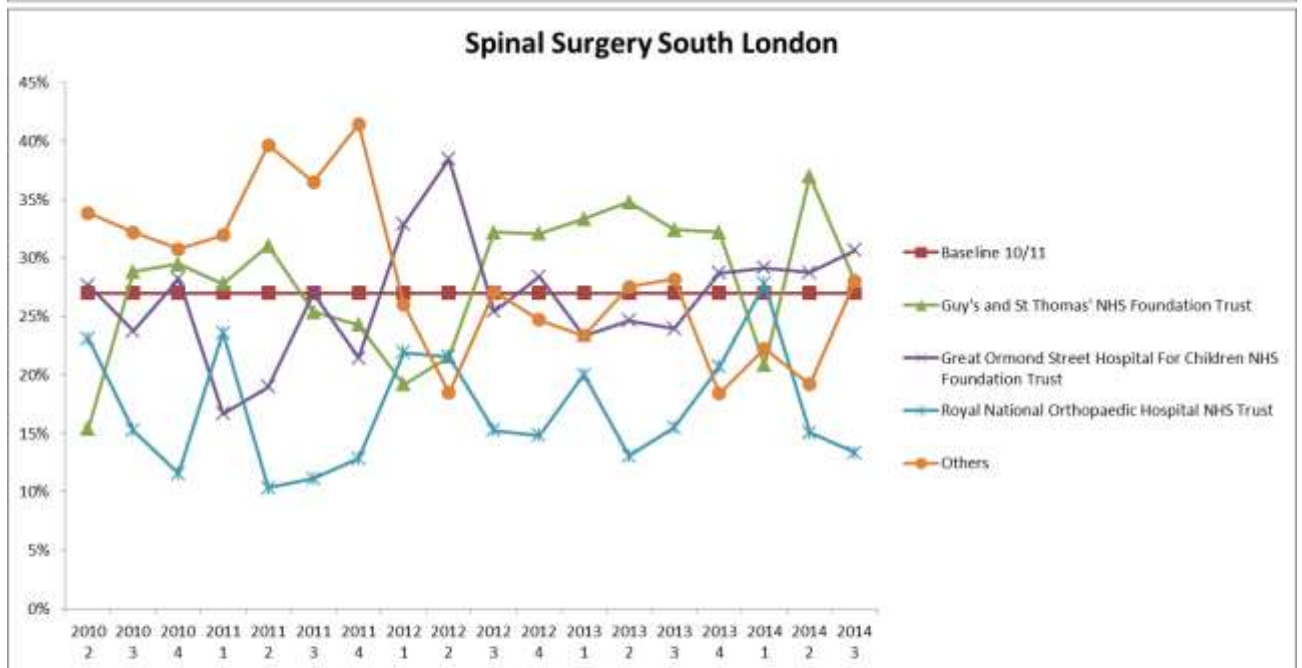

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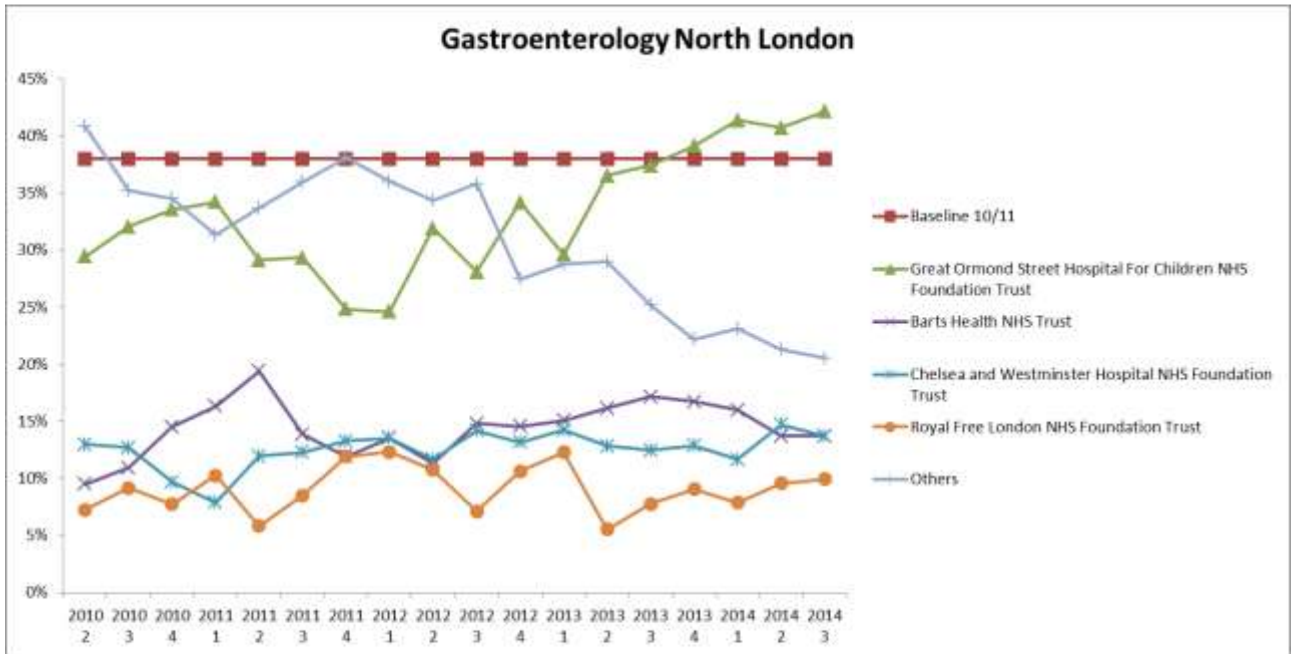
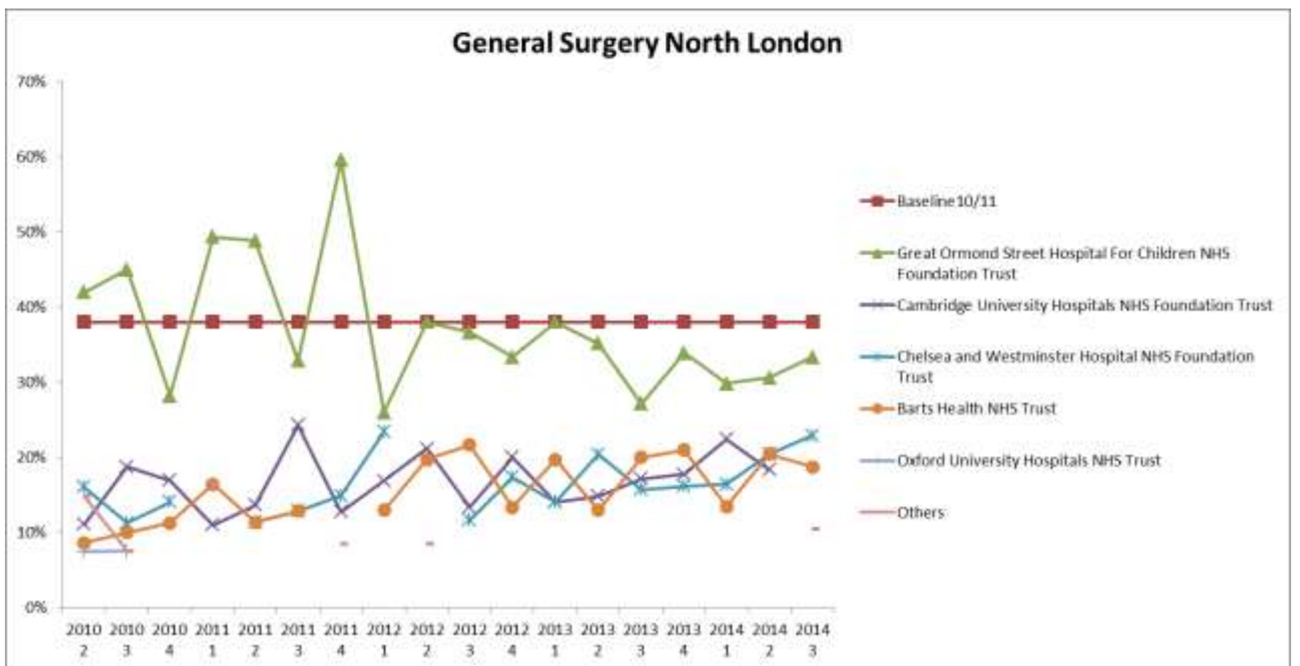




Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
22nd May 2015

Lampard Report **Submitted by:** Juliette Greenwood, Chief Nurse	**Paper No: Attachment Q**

Aims / summary
To present the 'Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'. (The Lampard report) (February 2015).
To assure the Board that the appropriate actions have been identified to enable the trust to demonstrate compliance against the appropriate recommendations in the report.

Action required from the meeting

The Board to discuss the requirements arising from the Lampard report and support the identified actions to ensure the Trust meets the recommendations within the report.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Financial implications

Who needs to be told about any decision?
The safeguarding team and appropriate heads of department who will be leading on the agreed actions

Who is responsible for implementing the proposals / project and anticipated timescales?
Chief Nurse

Who is accountable for the implementation of the proposal / project?
Chief Nurse

Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile

The Lampard report

May 2015

1.0 Background.

Following the death of Jimmy Savile and subsequent investigations of his wrongdoings at NHS organisations, the Department of Health launched an inquiry into his activities across the NHS. A total of 44 reports have been published. While many of these actions took place a long time ago, the Secretary of State for Health asked Kate Lampard to produce a 'lessons learnt' report. This was to draw on findings from previously or newly published investigations to identify areas of potential concern. This report was published in February 2015 and includes 14 recommendations. 13 of these have been accepted by the Secretary of State for Health.

Lampard report available at www.gov.uk/government/publications/jimmy-savile-nhs-investigations-lessons-learned.

One of the 44 reports was written by Great Ormond Street Hospital (GOSH). GOSH undertook a thorough investigation following an allegation raised through the NSPCC helpline and passed on to the Trust in November 2012. The conclusion of this investigation was that 'there is no documentary evidence to suggest that Jimmy Savile was at the Trust in the 1970's (when the alleged incident was said to have taken place).

Although no formal recommendations were identified through the investigation, the Trust had previously undertaken an assessment based on the letter from Sir David Nicholson in November 2012 and has completed the actions required following this assessment.

Monitor wrote to all foundation Trusts in March 2015 asking that they assess the relevance of the Lampard (2015) recommendations to the organisation and take any action necessary to protect patients, staff, visitors and volunteers. Monitor require that Trusts respond to this by 15th June 2015 with an overview of necessary actions taken or where actions are in progress the date by which they will be completed.

2.0 Lampard Report (February 2015).

Lampard was asked to

- Identify the common themes from all the NHS investigation reports into matters relating to Jimmy Savile.
- Look at the NHS-wide guidelines and procedures in the light of the findings and recommendations of all the NHS investigation reports
- Seek relevant expert advice
- Advise the Secretary of State for Health on whether and how any relevant guidelines of procedures need to be tightened or changed.

Lampard was also asked to consider whether any inappropriate access was given to Savile because of his celebrity or his fundraising role and whether current systems sufficiently safeguard patients.

In relation to organisational cultures, behaviours and governance arrangements, Lampard concluded that the findings of the separate NHS investigations into these organisations that had allowed Savile access, influence and the opportunities to carry out the abuses were strikingly consistent. She reported that while there has been improvement in these areas and that social attitudes and public policy has changed in relation to protecting children, there were a number of themes seen as still relevant to the wider NHS today. The themes identified were:

- Security and access arrangements, including celebrity and VIP access
- The role and management of volunteers
- Safeguarding
- Raising complaints and concerns (by staff and patients)
- Fundraising and charity governance; and
- Observance of due process and good governance.

Lampard made the following recommendations specifically for NHS trusts and NHS foundation trusts.

R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.

R2 All NHS trusts should review their voluntary services arrangements and ensure that:

- They are fit for purpose;
- Volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and
- All voluntary services managers have development opportunities and are properly supported.

R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.

R5 All NHS hospital trusts should undertake regular reviews of:

- their safeguarding resources, structures and processes (including their training programmes); and
- the behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.

R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.

R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.

R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.

R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.

R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.

3.0 GOSH self-assessment.

The Lampard recommendations have been sent to the appropriate heads of department for self-assessment and to identify the actions required to ensure full delivery of compliance.

The conclusion of this self-assessment is that the Trust is complaint against recommendations 1, 2, 4, 7, 9, 11 and 12, having robust arrangements in place against these recommendations. The GOSH Children's Charity is compliant against recommendation 12 .

For the remaining two recommendations (5 and 10), the Trust is partly complaint. An action plan (see appendix 1) has been developed in response to the gaps identified with a clear time frame to achieve completion of the actions. This will then provide full assurance of the Trusts safeguarding improvements. The delivery of the actions will be monitored through the safeguarding children's group, chaired by the Chief Nurse. This action plan will be forwarded on, as required, to Monitor by 15th June 2015.

Sharing the learning from the Lampard report.

The Lampard report will be shared for discussion at the Safeguarding Children's Group and at the Learning Implementation and Management Board.

4.0 Recommendation.

The Board to discuss the requirements arising from the Lampard report and support the identified actions to ensure the Trust meets the recommendations within the report.

Appendix 1

Report on actions in response to Kate Lampard's report into Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile				
NAME OF TRUST:	Great Ormond Street Hospital for Children NHS Foundation Trust			
Recommendation	**Issue identified**	**Planned Action**	**Progress to date**	**Due for completion**
R5 All NHS hospital trusts should undertake regular reviews of: •their safeguarding resources, structures and processes (including their training programmes); and •the behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible	A review of the safeguarding team resource is due.	To undertake a regular review of the safeguarding resources, structures and processes in line with the section 11 audit required by Camden SCB.	The safeguarding team is currently being reviewed by the Interim Named Doctor in Safeguarding to assess the resource and application	October 2015

R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	The majority, but not all contractor contracts include the normal checks that we insist upon. This includes DBS.	Finalising the process of adding the appropriate arrangements and processes for the recruitment, checking, general employment and training into the contracts that fall outside a framework agreement to all outstanding contracts.	In final stage of completion	May 15
I confirm that this NHS foundation trust Board reviewed the full recommendations in Kate Lampard's lessons learnt report SIGNED: DATE: CE NAME:				

Please return to MonitorJSlearnings@monitor.gov.uk by 5pm Monday 15 June 2015. If you have any questions or queries you may also use this email address to send them to us.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
22nd May 2015

Performance Summary Report (Quality and Safety and Targets and Indicators) **Submitted by:** Martin Elliot – Medical Director Dena Marshall – Chief Operating Officer	**Paper No: Attachment R**

Quality and Safety
In April, the Trust reported 1 case of C.Difficile, assigned in patients aged two and over, tested on third day or later.

This case was not attributed to a lapse of care outlined in the assessment criteria from Monitor and agreed with NHS England.

No cases of MRSA were reported in April.

Targets and Activity
Patient spells were reported above plan in month, however Intensive Care Unit bed days were below plan for April. This has been attributed to 46 PICU and CICU bed days in IPP and 40 other non NHS bed days in month. In addition, this years' activity is profiled according to working days whereas it is anticipated the ITU expansion business case will come on line on October

Discharge summary completion rates decreased to 78.6% in April. A Trust wide improvement project for Discharge Summary completion is currently underway and introduction across all Specialties within the Hospital will be completed by the end of July 2015. This is being led by the Quality Improvement team.

In relation to 18 week Referral to Treatment Time measures, the Trust achieved the Admitted, Non-Admitted and Incomplete performance standards in March. The April position is unavailable at the time of reporting. The April position of the Diagnostic Testing measure is also unavailable at the time of reporting.

The Trust maintained compliance against all other service performance measures including Cancer Wait times.

Action required from the meeting
Trust Board to note performance for the period.

Contribution to the delivery of NHS Foundation Trust strategies and plans
To assist in monitoring performance across external and internal objectives.

Financial implications
Failure to achieve contractual performance measures may result in financial penalties.

Legal issues - N/A

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?
The Members' Council receive a copy of the performance report and Commissioners receive a sub-section of the performance report monthly.

Who needs to be told about any decision?
Executive Directors.

Who is responsible for implementing the proposals / project and anticipated timescales?
Executive Directors.

Who is accountable for the implementation of the proposal / project?
Executive Directors.

Targets & Indicators Report

Section	Indicator	Target	YTD Performance	Jan-15	Feb-15	Mar-15	Apr-15
Activity & Use of Resources	Number of patient spells	2,746	**2,847**	2,829	2,802	3,137	2,847
	Number of outpatient attendances	12,699	**12,307**	13,234	12,911	13,733	12,307
	DNA rate (new & f/up) (%)	<10	**7.7**	7.3	7.4	6.9	7.7
	Number of ITU bed days	883	**710**	840	774	856	710
	Number of unused theatre sessions	17	**22**	12	5	13	22
	Average number of beds closed - Total Ward	-	**20.2**	14.1	10.5	13.7	20.2
	Average number of beds closed - Total ICU	-	**0.4**	0.0	0.5	0.4	0.4
Patient Access	18 week referral to treatment time performance - Admitted (%)	>90	**-**	90.4	90.6	93.1	
	18 week referral to treatment time performance - Non-Admitted (%)	>95	**-**	95.2	95.6	95.5	
	18 week referral to treatment time performance - Incomplete Pathways (%)	>92	**-**	94.6	93.9	94.7	
	Patient Refused Admissions - Trust Total Excluding PICU/NICU & CATS*	90	**1**	4	3	1	1
	PICU/NICU & CATS General refusals	<286	**0**	12	20	21	
	Cancer patients waiting no more than 31 days for second of subsequent treatment (%)	98	**100.00**	100	100	100	100
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	<=1	**-**	0.9	0.0	1.1	

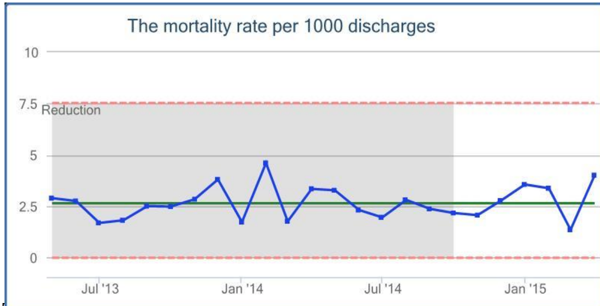
	Indicator	Target	YTD Performance	Monthly Trend			
				Jan-15	Feb-15	Mar-15	Apr-15
Patient / Referrer Experience	Number of complaints	12	**13**	11	9	13	13
	Number of complaints - high grade	1	**2**	1	1	3	2
	Friends & Family Test (% of those Likely & Extremely Likely to recommend)	>95	**93.7**	97.5	97.8	97.4	93.7
	Discharge summary completion (%)	85	**78.6**	80.3	79.0	80.2	78.6
	Clinic Letter Turnaround, % letters on CDD - sent within 5 working days	50	**-**	31.6	34.9	37.8	
	Clinic Letter Turnaround, Average Days Letter Sent	-	**-**	12.1	11.2	10.0	
Work - force	Sickness Rate (%)	2.99	**2.5**	2.6	2.5	2.6	2.5
	Trust Turnover (%)	14.13	**18.3**	17.6	17.7	18.9	18.3

Monitor	YTD Target	YTD Performance	Quarter 4			Quarter 1
Monitor governance risk rating 14/15	Green	0	0	0	Green	0

*Patient Refused Admissions figure is the total received at the time of reporting and may be subject to change as further data is collated

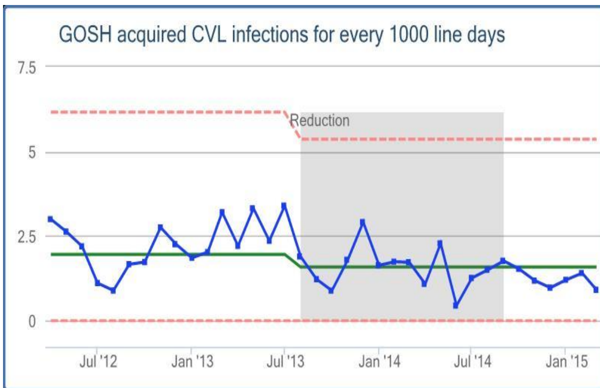
Quality and Safety report

Quality and Safety Indicators

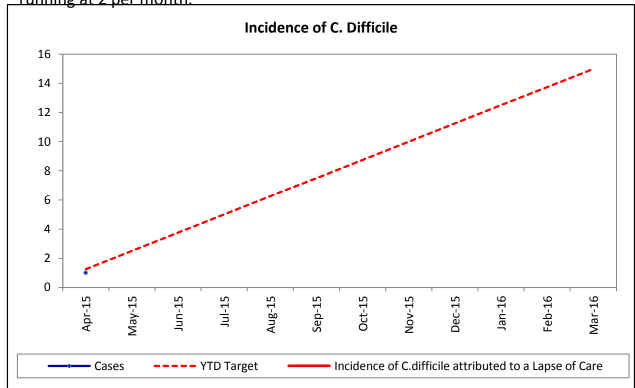


Description: The mortality rate per 1000 discharges
Target: Internal target: Year on year reduction
Trend: The current rate is 2.5 deaths per 1000 discharges.
Aim: To make statistically significant reductions in the mortality rate.
Comment: We will continue to measure, looking for a further reduction in the mortality rate.

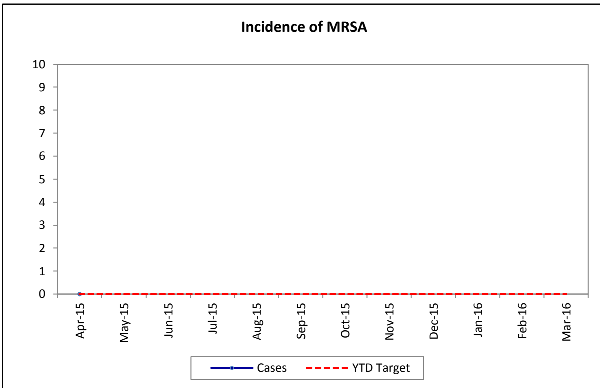
Description: Defined as either - Unexpected/avoidable death of patient(s), staff visitors or members of public. Serious harm to patient(s), staff, visitors or members of public. Allegations of abuse. One of the core sets of 'Never Events'
Target: Internal target: To remain within control limits
Trend: Performance sustained
Comment: There has been no statistical change in the number of SIs – we are still running at 2 per month.



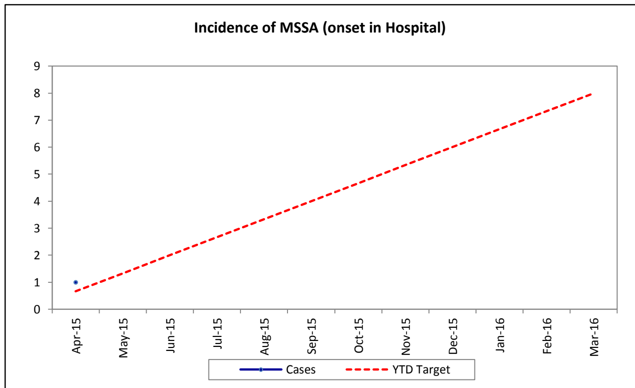
Description: The number of CVLInfections for every 1000 Bed Days acquired at the Trust
Target: Internal target: <=1.5
Trend: Performance sustained.
Comments: There has been no statistical change in the number of CVL infections – we are still running at 1.6 per 1000 line days



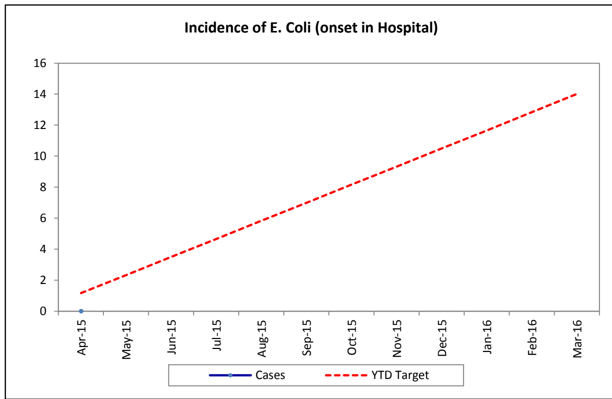
Description:	**Cases detected after 3 days (admission day = day 1) are assigned against trust trajectory**
Target:	No more than seven cases per year
Trend:	Trend below trajectory in month 1
Comment:	**The Trust has attributed no cases to a laspe of care for the YTD.**

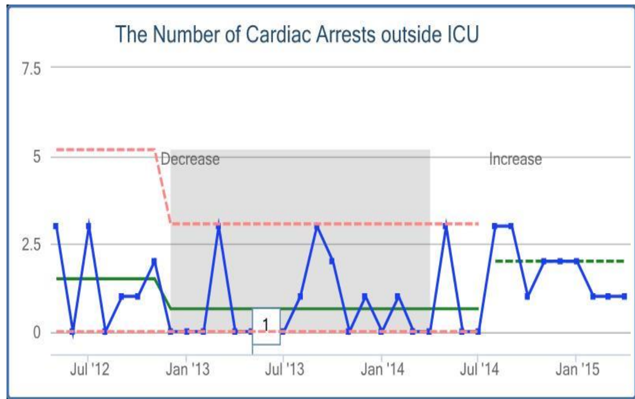


Description: MRSA bacteraemias
Target: Zero cases
Trend: 0 cases reported to date
Comment: Performance sustained at zero cases



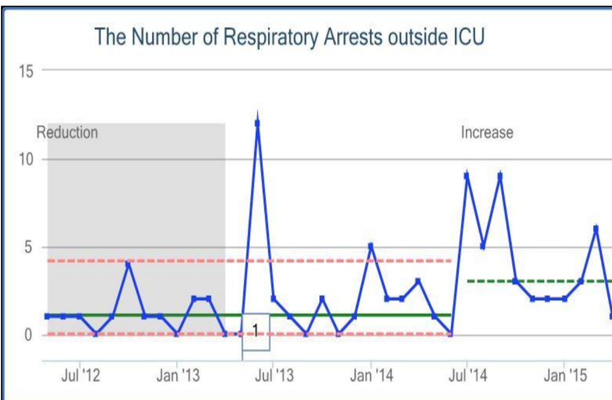
Description: Cumulative incidence of MSSA bacteraemia episodes (Methicillin sensitive S. aureus)
Target: Internal Target no more than eight cases
Trend: Performance above trajectory
Comment: Performance being monitored closely

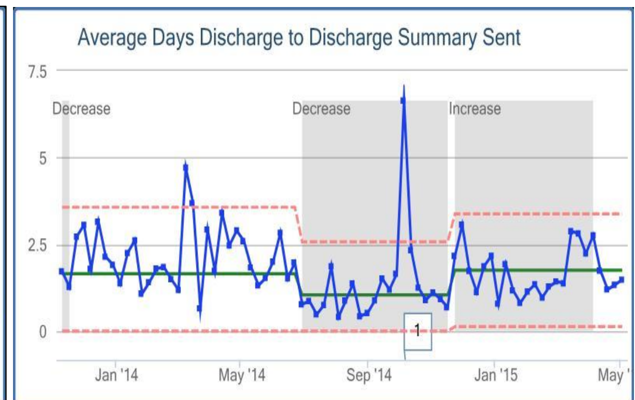




Description: **Cumulative incidence of E. coli bacteraemia**
Target: Internal Target no more than fourteen cases
Trend: Performance delivered below trajectory at M1
Comment: Performance being monitored closely

Description: The monthly number of arrests (cardiac) outside of ICU wards (recorded from calls made to the 2222 Clincal Emergency Team)
Target: Internal target: 50% reduction
Comment: See Respiratory Arrests





Description: The monthly number of arrests (respiratory) outside of ICU wards (recorded from calls made to the 2222 Clincal Emergency Team)
Target: Internal target: 50% reduction
Trend: Performance sustained
Comment: We have seen an increase in the number of respiratory and cardiac arrests since July 2014. The increases have been sustained and we are continuing to measure.

Description: Harm index comprised of hospital acquired infections (CVL, serious incidents, non-ICU arrests, medication errors, falls, and pressure ulcers
Trend: Performance sustained
Comment: For Rheumatology the time taken from discharge to completing the discharge summary was reduced back in September 2013 and remained steady at less than 2 days but has recently increased again.

More specialties have joined the project with plans to spread across the remaining specialties with project end 31st July 2015

Monitor Governance Risk Rating

Targets - weighted (national requirements)		Threshold	Score Weighting	Reporting Frequency	Score Weighting Q1			
					M1			
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0			
2	Clostridium difficile year on year reduction (Against Monitors defined Lapse of Care categorisation)	0	1	Quarterly	0			
3	All cancers: 31-day wait for second or subsequent treatment comprising either:	100%	1	Quarterly	0			
	Surgery	94%			0			
	Anti cancer drug treatments	98%			0			
	Radiotherapy (from 1 Jan 2011)	94%			0			
4	Admitted within 18 weeks	90%	1	Quarterly	0			
5	Non-Admitted within 18 weeks	95%	1	Quarterly	0			
6	Referral to treatment time Incomplete Pathways Performance	92%		Quarterly	0			
7	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0			
8	Certification against compliance with requirements regarding access to healthcare for peopl e with a learning disability	N/A	0.5	Annual	0			
				Total	**0**			
				Overall governance risk rating	**Green**			

*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

Great Ormond Street Hospital for Children NHS Foundation Trust

<table>
<tr><td colspan="2">Trust Board
22nd May 2015</td></tr>
<tr><td rowspan="2">Workforce Metrics & Exception Reporting – April 2015

Submitted by:
Ali Mohammed, Director of HR & OD</td><td>Paper No: Attachment S</td></tr>
<tr><td></td></tr>
<tr><td colspan="2">Aims / summary
This report provides an updated position of a number of workforce metrics, together with a summary of interventions for those areas of concern.</td></tr>
<tr><td colspan="2">Action required from the meeting
To note the content of the report.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS Foundation Trust strategies and plans</td></tr>
<tr><td colspan="2">Financial implications
The report details metrics on a number of areas which have a direct and indirect financial implication; these include absence (sickness) and the percentage of the total paybill spent on agency usage; the report shows that both of these areas have reduced from the previous month.</td></tr>
<tr><td colspan="2">Who needs to be told about any decision?
Not applicable.</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales?
Divisional management teams; supported by members of the HR & OD team.</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project?
Divisional management teams.</td></tr>
</table>

TRUST BOARD WORKFORCE METRICS & EXCEPTION REPORTING – APRIL 2015

Introduction

This suite of workforce reports includes:

- Voluntary turnover and total turnover;
- Sickness absence;
- Vacancy rates;
- PDR appraisal rates (based on new PDR framework);
- Agency usage as a percentage of paybill;
- Statutory and mandatory training compliance (at Trust level only).

Each report shows divisional and directorate performance, and an exception report that indicates the cost centres which are the most statistically significant outliers against average performance. Where data exists to provide an external comparator (London trusts) this is indicated on each graph.

Headlines

GOSH reduced its contractual FTE (full-time equivalent) figure by 17 in April to 3745. This change is within anticipated levels and is 103 FTE higher than the same point in 2014.

Sickness absence has decreased slightly to 2.51% (from 2.57%) and remains significantly below the London average figure of 3% (which has also decreased).

Turnover is now being reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands at 16.4% (increased from 15.7% March 15) and will be reported and compared on a monthly basis; this new reported value excludes non-voluntary forms of leavers (e.g. dismissals, TUPE, fixed-term and redundancies). Total (voluntary and non-voluntary) has increased slightly – currently at 18.3% (+0.1%) in April. The (unadjusted) London benchmark figure is 14.28% (which includes voluntary and non-voluntary leavers) which has also increased.

The reported **vacancy rate** has increased to 5.7% in April.

Agency usage for 2015/16 (year to date) stands at 1.14% of total paybill; this is significantly below 2014/15 (at 2.5%) outturn. Estates retains high spend on agency as percentage of paybill at 25%.

PDR completion rates The Trust overall appraisal rate stands at 84% - an increase of 3%. This has been calculated using the new PDR framework calculation (linking increments to performance outcomes). Three directorates are meeting the target of 95% (Nursing & Patient Experience, HR & OD and Redevelopment). Two divisions are within 4% of meeting target (Estates and International).

Inclusion of 'CQC Intelligent Monitoring' measures to the sickness, turnover and vacancy reports. These are consistent with the calculations used by the CQC as a measure of risk. Comparison of month-on-month changes to made from next report.

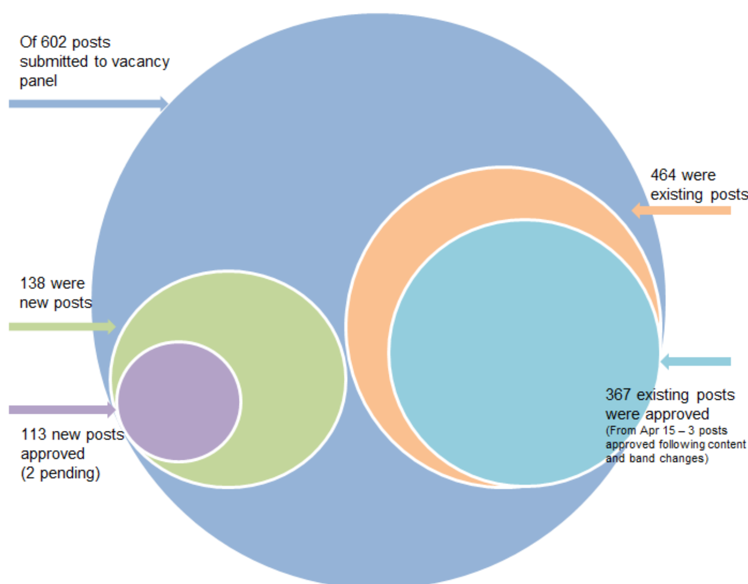
Statutory and mandatory training compliance rates are reported below against a number of key mandatory training subjects. The required training compliance for any of the courses is 95%; currently the Trust is compliant with one (safeguarding children level 1) of the reported seven topic areas. Two topics have increased compliance slightly (Information Governance and Fire Safety), no topics decreased in compliance. Further work continues around increasing compliance with the upward trend expected to continue over the forthcoming weeks/months.

Training Topic	Trust Training Compliance (%)
Information Governance – current	93
Safeguarding Children – level 1	96
Fire Safety Overall	73
Counter Fraud	87
Equality, Diversity and Human Rights	90
Health Safety and Welfare	88
Infection Prevention and Control Level 1	88

Key issues

Executive level scrutiny of all posts continues. The executive vacancy panel meets on a weekly basis to review jobs requesting to be recruited to (this excludes some key roles e.g. rostered roles). The new Workforce Control processes came into effect late March 2015.

The graphic (right) demonstrates the volume and outcomes of roles considered by the vacancy panel from 1 April 2014 to 30 April 2015.



A total of 120 roles were not approved from the 602 submitted (2 pending).

Vacancy control period	Approval rate
April 14 to October 14	92%
April 14 to December 14	81%
Year to date (Apr 14 to Apr 15)	80%

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2015 REPORT

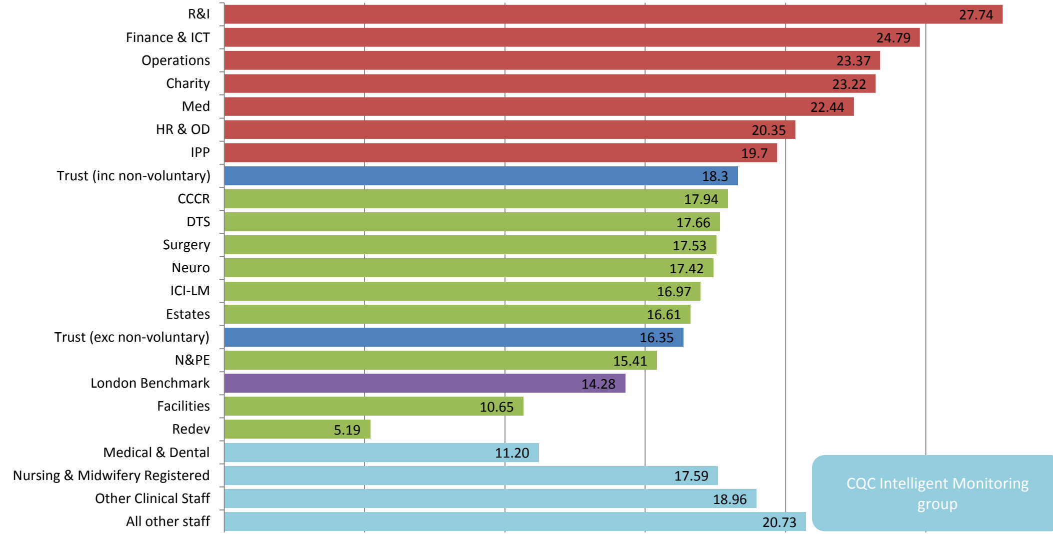
Division	Contractual Staff in Post (FTE)	Voluntary Turnover Rate (%) (voluntary leavers in 12-months in brackets, <14% green)	Total Turnover Rate (%) (number of leavers in 12-months in brackets, <18% green)	Sickness Rate (%) (0-3% green)	PDR Completion (%) (target 95%)	Vacancy Rate (%) (Unfilled vacancies, 0-10% green; overestablished white)	Agency (as % of total paybill) (Max 0.5% Corporate, 2% Clinical)
Critical Care & Cardio-Respiratory	709	17.9% (110.8)	17.9% (110.9)	2.6	89.0%	4.8%	1.4%
Diagnostic & Therapeutic Services	452	13.1% (58.9)	17.7% (79.4)	2.6	81.0%	7.5%	2.3%
Infection, Cancer & Immunity	682	15.7% (99.1)	17.0% (107.1)	2.4	88.0%	4.1%	0.1%
International	162	18.3% (26.9)	19.7% (28.9)	4.4	91.0%	12.7%	1.7%
Medicine	264	21.9% (50.0)	22.4% (51.2)	3.1	87.0%	9.0%	2.3%
Neurosciences	387	14.7% (51.5)	17.4% (60.9)	1.7	83.0%	3.9%	0.6%
Surgery	560	15.4% (74.3)	17.5% (84.6)	2.5	89.0%	3.2%	0.3%
Clinical & Medical Operations	61	18.3% (10.9)	23.4% (13.9)	0.7	77.0%	0.4%	0.4%
Corporate Affairs	9	12.2% (1.0)	28.1% (2.3)	0.1	88.0%	36.3%	0.0%
Corporate Facilities	86	9.5% (7.9)	10.7% (8.9)	3.0	38.0%	31.6%	1.6%
Estates	29	16.6% (5.0)	16.6% (5.0)	4.7	93.0%	28.6%	25.6%
Finance & ICT	98	24.8% (22.4)	24.8% (22.4)	2.2	52.0%	14.7%	
Human Resources & OD	110	17.0% (17.0)	20.4% (20.4)	2.6	95.0%	3.4%	
Nursing & Patient Experience	30	10.5% (3.0)	15.4% (4.4)	0.7	100.0%	11.2%	0.0%
Redevelopment	21	0.0% (0.0)	5.2% (1.0)	2.5	95.0%	0.0%	0.0%
Research & Innovation	73	23.3% (16.7)	27.7% (19.9)	1.6	74.0%		0.0%
Trust	3745	**16.4%▲ (557.1)**	**18.3%▲ (623.5)**	**2.5▼**	**84.0%►**	**5.7%▲**	**1.1%▼**

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2015 REPORT

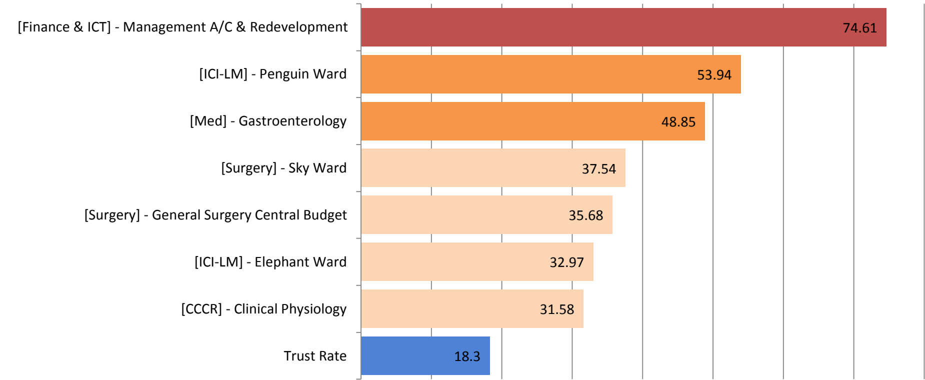
Division	Red Metrics / DoT	Metric	DoT	Actions & Comments
Estates	5 (previously 5)	Voluntary turnover improved from 19.7% to 16.6%		Work on-going with the department regarding the structure which should drive a more stable workforce.
		Sickness worsened from 4.5% to 4.7%		Ongoing work with managers regarding absent staff members to address intermittent absence
		PDR rate unchanged at 93%		On-going reminders to complete and submit PDRs
		Vacancy rate worsened from 21.9% to 28.6%		Recruitment has paused during the consultation period due to conclude mid-June
		Agency usage worsened from 19.7% to 25.6%		Recruitment has paused during the consultation period due to conclude mid-June
International	4 (previously 4)	Voluntary turnover improved from 19.8% to 18.3%		Following meeting with International last month, meeting to be set up to analyse the turnover report to create an improvement plan.
		Sickness improved from 4.5% to 4.4%		Monthly meetings occur with senior management. Absences are a combination of short and long-term.
		PDR rate improved from 90% to 91%		On-going reminders to complete and submit PDRs
		Vacancy rate worsened from 7.8% to 12.7%		Workforce control measures took effect from April 2015
Medicine	4 (previously 4)	Voluntary turnover worsened from 18.9% to 21.9%		Turnover report for Medicine to be analysed to identify why staff are leaving and where they are going to create an improvement plan.
		Sickness improved from 3.2% to 3.1%		On-going management with individual managers
		PDR rate improved from 83% to 87%		All meetings with managers PDR is to be raised as a reminder.
		Agency usage improved from 2.7% to 2.3%		Workforce control measures took effect from April 2015
Corporate Facilities	4 (previously 3)	Sickness improved from 3.3% to 3%		
		PDR rate worsened from 40% to 38%		Department are creating a timetable for all PDRs to take place by the end of May.
		Vacancy rate stands at 31.6%		Recruitment has paused during the consultation period due to conclude mid-June
		Agency usage improved from 6.3% to 1.6%		Workforce control measures took effect from April 2015
Finance & ICT	3 (previously 4)	Voluntary turnover worsened form 21.7% to 24.8%		Exit Interviews held with HR, themed feedback being provided to department.
		PDR rate improved from 50% to 52%		Improved compliance
		Vacancy rate worsened from 12.4% to 14.7%		

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2015 REPORT

Divisional Turnover (Voluntary & Non-Voluntary)

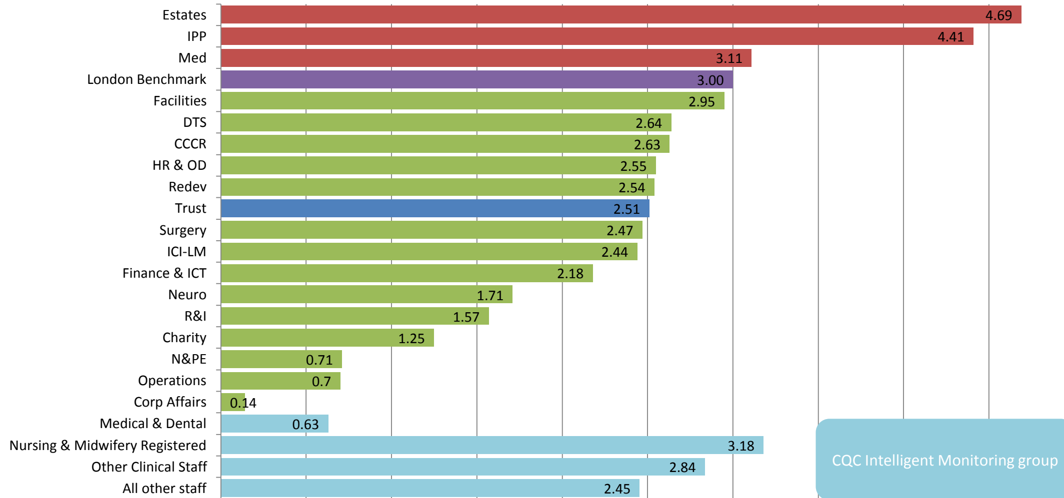


Exception Reporting Turnover

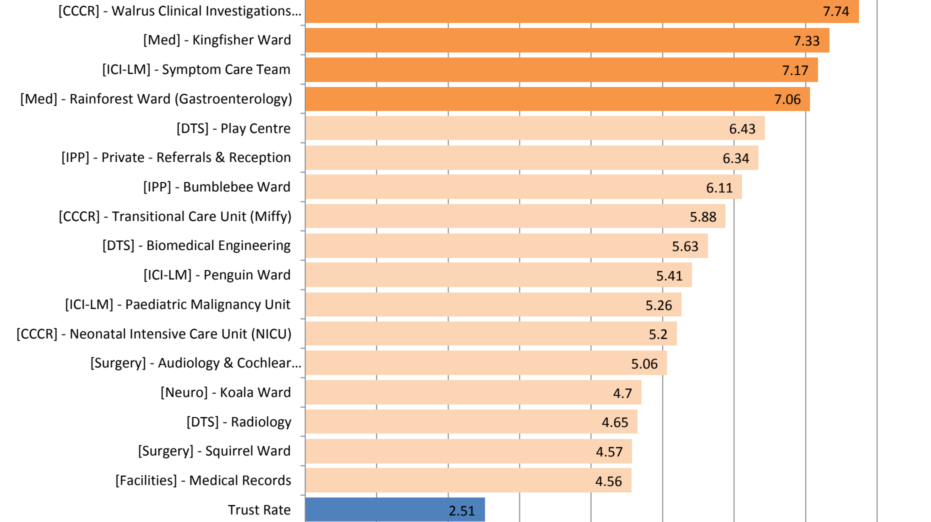


DTS (pharmacy) – pre reg pharmacists are on 12 month fixed term contracts around 20 staff on average; Surgery (Anaesthetic Staff Theatres) – majority of the staff are ODPs come and work at the Trust for 6 months to develop, the band 6 roles have low turnover so they are appointed to band 6 and 7 roles externally as there are limited opportunities elsewhere in the Trust. R&I (CRF) – research funding, majority of staff on fixed term contracts in line with funding

Divisional Sickness

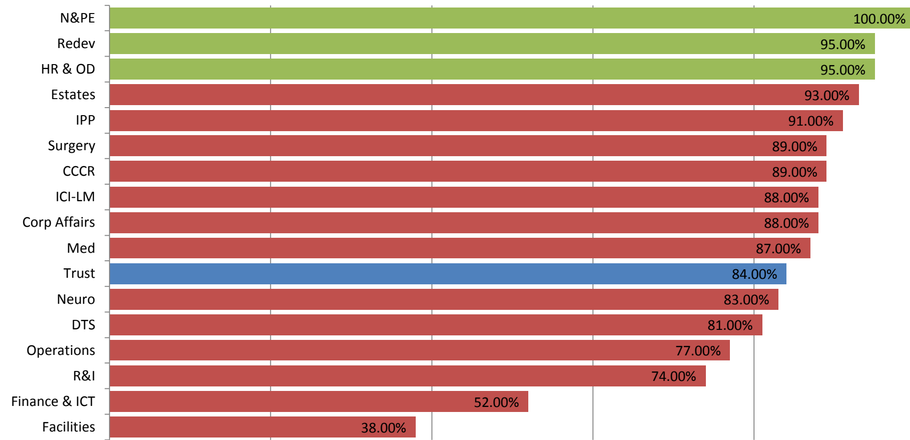


Exception Reporting Sickness

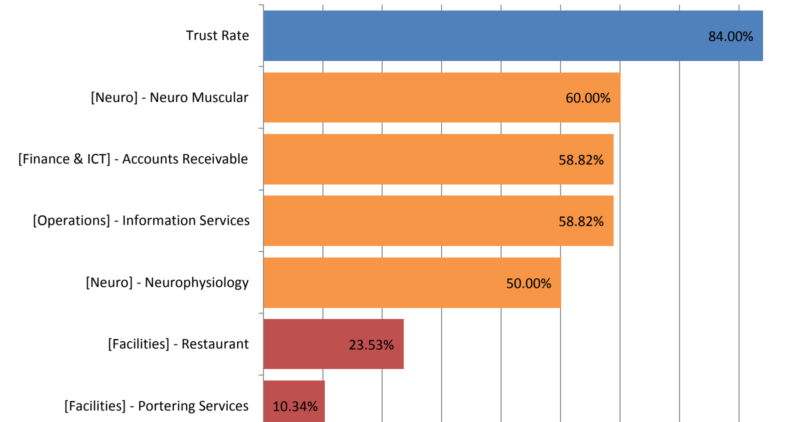


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2015 REPORT

Divisional PDR (Target 95%)



Exception Reporting PDR



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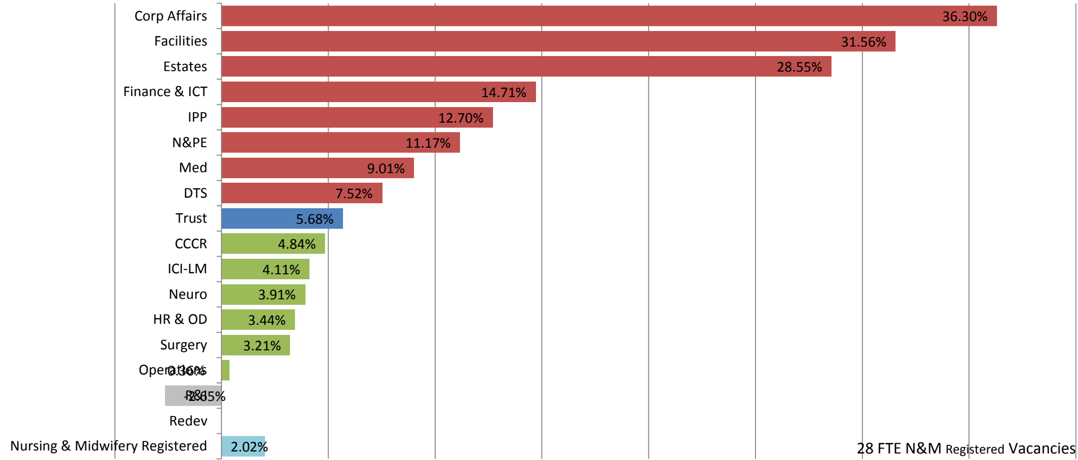
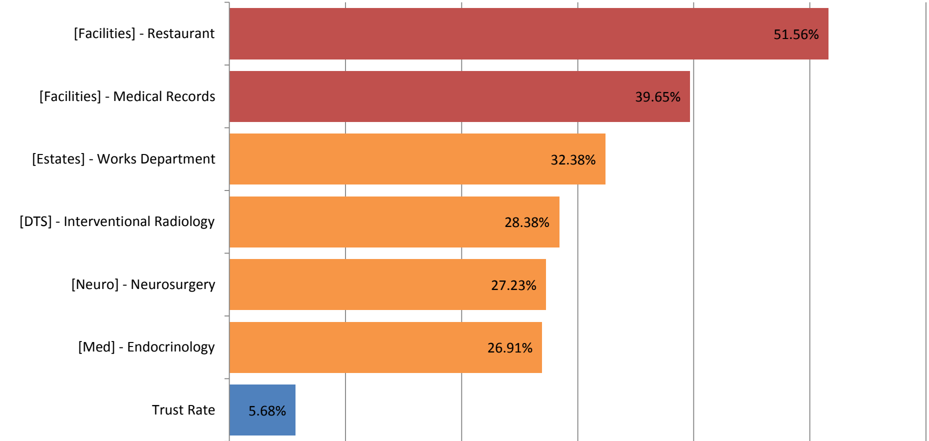
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2015 REPORT

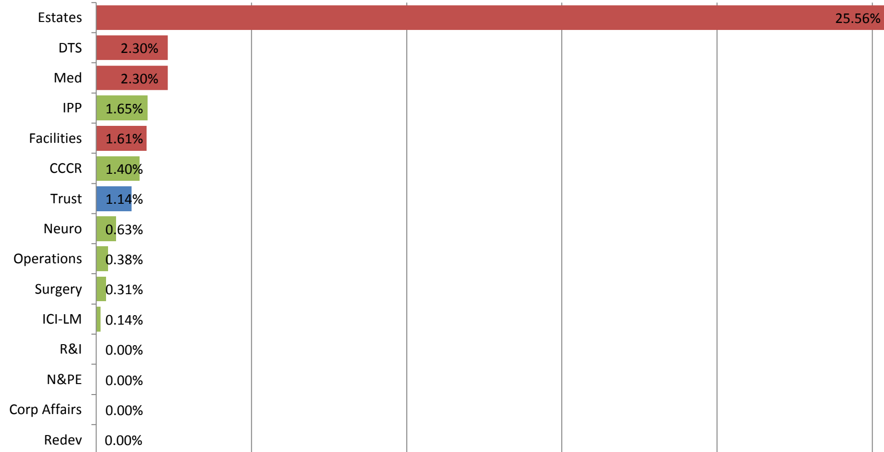
Divisional Vacancy Rate



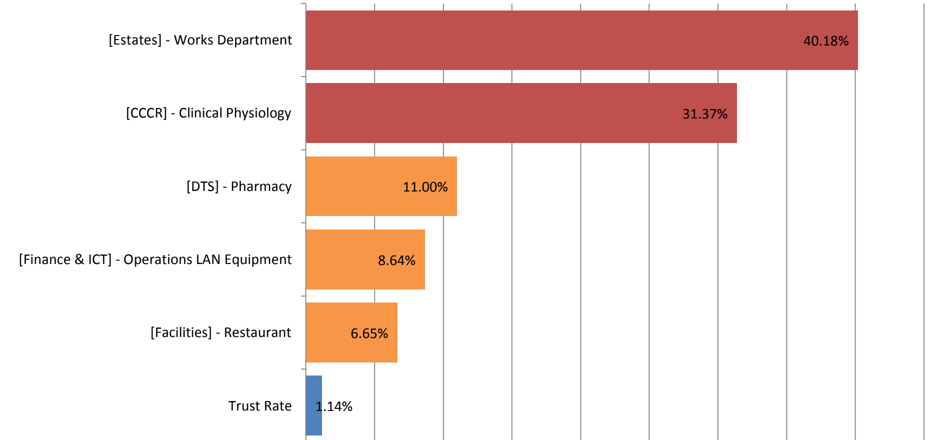
Exception Reporting Vacancy Rate



Divisional Agency as % of paybill



Exception Reporting Agency as % of Paybill



ATTACHMENT T to follow

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Trust Board
22nd May 2015

Patient Experience Report **Submitted by:** Juliette Greenwood, Chief Nurse	**Paper No: Attachment U**

Aims / summary

This report provides information on patient experience in quarter 4 in relation to the Friends and Family Test and Pals referrals, the annual complaints report is submitted as a separate item.

Highlights from the reports show that:

Friends & Family Test (FFT)

- The FFT response rate continues to improve achieving 34.92% in March 2015 almost 10% above the 25% CQUIN target.
- The percentage of families likely to recommend the hospital remains consistently very high at 97% above the Trust target of 95%.
- Analysis of narrative comments continue to highlight that staff behaviours in relation to being welcoming and caring are the most positive aspects of the care experience
- Environment/Infrastructure issues remain the issues causing dissatisfaction including temperature of rooms, noise of wards, Wi-Fi connection and chair beds remain the areas of concern.

Pals

- 949 Pals contacts to Pals were made this quarter
- 3.65% decrease in Pals contact when compared to quarter 3.
- 5 cases escalated to complaints
- 6 Compliments received regarding GOSH services

In Q4 Pals received a significant increase in parents unhappy about people smoking outside of the hospital entrance. In previous quarters this had been raised in small numbers but in this quarter Pals received over 40 contacts about parents smoking outside the hospital. Some parents have described having to take their child to a respiratory appointment through “a tunnel of smoke” and others tells Pals that they had been sworn at when they had asked other parents not to smoke. Pals have been working with Estates and Facilities to address this issue including reactivating the automated message of a child telling the smoker to stop.

Action required from the meeting

Trust board to note the positive experiences of patients and families and the areas that require improvement.

Contribution to the delivery of NHS Foundation Trust strategies and plans

This contributes to the Trusts strategic objective to be the number 1 children’s hospital in the world in relation to patient experience.

Financial implications

There was a 2014/2015 CQUIN attached to the FFT response rate and rollout of the FFT to outpatient and day care areas. Targets were met in quarter 4 in relation to all of the CQUIN requirements.

Who needs to be told about any decision?

Caroline Joyce Assistant, Assistant Chief Nurse Quality & Patient Experience.
Who is responsible for implementing the proposals / project and anticipated timescales? Caroline Joyce Assistant Chief Nurse Quality & Patient Experience.
Who is accountable for the implementation of the proposal / project? Juliette Greenwood Chief Nurse

Great Ormond Street Hospital for Children NHS Foundation Trust

Pals-Q4 Report
January-March 2015

1. Key themes of this report

- **949 contacts to were made this quarter**
- **3.65% decrease in contacts**
- **5 cases escalated to Complaints**
- **6 Compliments received regarding GOSH services**

2. Learning and Patient Experience from cases in Q4

2.1. Issue: In Q4 Pals received a significant increase in parents unhappy about people smoking outside of the hospital entrance. In previous quarters this had been raised in small numbers but in this quarter Pals received over forty contacts about smoking. Some parents have described having to take their child to a respiratory appointment through "a tunnel of smoke" and others tells Pals that they had been sworn at when they had asked other parents not to smoke.

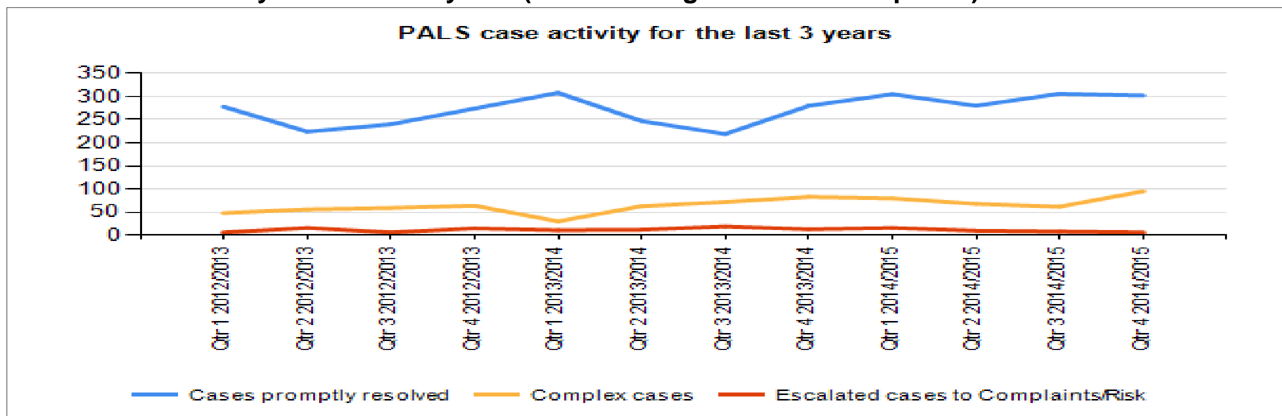
In order to prove a more welcoming hospital and reduce conflict between parents Pals shared this with the Estates and Facilities team who increased security supervision of the area, agreed to move anyone from GOSH premises who had been smoking. The Estates team also connected smoke detectors which then play an automated recording of a child telling the smoker to stop. The Estates team also agreed to update/replace the No Smoking sign.

Pals will report back in the next quarter on the impact of these interventions on the numbers of concerns raised regarding smoking outside the hospital.

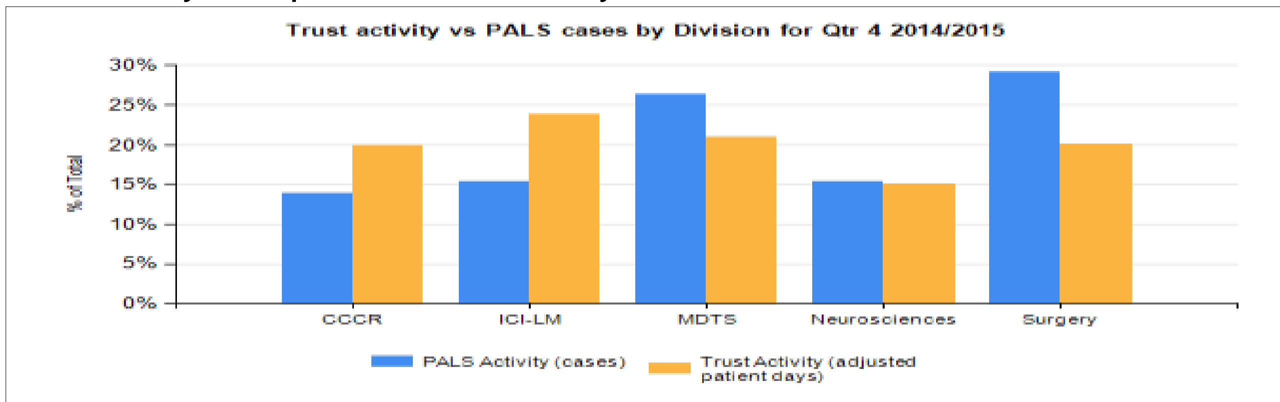
3. Pals Casework Activity in Q4

- 541 Information enquiries
- 302 Promptly resolved cases
- 95 Complex cases
- 6 Escalated cases to Complaints

4. Pals case activity for the last 3 years (not including Information inquiries)



5. Trust activity in comparison with case activity - for clinical divisions for Q4



6 Analysis of trends and themes by Division.

6.1 Surgery:

- Overall case numbers for surgery fell by 8 cases to 103 contacts in quarter four. Of these the top specialties were Orthopaedics/Spinal, Urology and Specialist Neonatal and Paediatric Surgery (SNAPS). The Orthopaedic cases have slightly reduced but both Urology and SNAPS have increased over the quarter.
- The key themes within Surgery for cases able to be promptly resolved were communication regarding outpatient appointments, difficulty in planning admissions and following up referrals. There has been a fall on the previous quarter where families were concerned about cancelations.
- Complex cases include cases where it has taken longer than a week to respond to concerns about challenges in organising outpatient appointments, delays in communication such as delays in receiving clinic letters and telephone messages not being returned.
- The more complex cases are where parents first present to Pals unhappy at the lack of communication but underlying issues are about allocation of appointments or admission dates. Families in this situation are often frustrated but sometimes angry.
- Communication has improved on the previous quarter but families continue to contact Pals about admission dates being later than they want or appointments being later than they want. Pals continues to work closely with Surgery staff to improve the response times to concerns being raised and regularly shares trends in data with the Operational Managers and General Manager.

6.2 MDTS:

- The case numbers have increased by 15 to 92 cases. Half of these cases are for Gastroenterology but this is a slight improvement on the previous quarter.
- Endocrinology had 14% and Radiology at 6% of cases work for Medicine/DTS.
- Promptly resolved cases were similar on the previous quarter where communication about admissions and appointments were the basis of the majority of contacts.
- The more complex cases were about communication and managing expectations. Some of these relate to patients where safeguarding concerns have been identified which required the Gastro team at GOSH to agree care plans with local services for on-going care and treatment. This is experienced as “delays” in communication by those families.
- Pals is conscious of the difficulties in the complex case work and collaborates with Social Work, Psychology and the Gastroenterology Lead to support patients, families and staff in reducing conflict and improving communication.

6.3 CCCR:

- There was an increase of 6 cases this quarter taking the numbers up to 49.
- The CCCR numbers remain similar to the preceding quarter except the numbers of Pals contacts regarding families in the Intensive Care Units (ITU’s) has fallen. This reduction relates to one very long term and complex family no longer on the unit.
- Promptly resolved cases were about communication about appointments/admission dates and referral follow up.

- This is a change on the last quarter where the key themes were concerns about care on the ward and cancelations. These have both fallen in this quarter.
- Pals work closely with the Liaison Nurses on ITUs and continue to support families who want to informally resolve concerns about their experiences.

6.4 ICI:

- Pals received 12 more cases this quarter. The 54 cases were spread similarly to the previous quarter where Rheumatology was half of the cases at 46%. Dermatology and Oncology followed both at 15% each.
- Communication regarding appointments and admissions remain the same as the previous quarter for the promptly resolved cases.
- The more complex cases for Rheumatology are similar to Gastroenterology and are managed in a similar way, with careful collaboration with Social Work, Psychology and the Clinical Lead.

6.5 Neurosciences:

- The numbers of cases coming to Pals from Neurosciences have fallen over the quarter to 54 cases from 61.
- The spread of specialties remains similar but with improvements for Ophthalmology.
- The common theme is communication regarding appointment dates or admissions but these are responded to very quickly and so the numbers of complex cases or delays in responding are limited.
- Pals have shared data with the Lead Nurse for Neurosciences and work very closely with the Outpatient Management team to arrange prompt responses for those families unhappy about cancelations.

6.6 Facilities:

- We had an increase in contacts regarding estates and Facilities. These were largely due to the smoking issues mentioned above.
- 33 cases were raised with Pals and these included parents unhappy at limited access to Family and/or Child Accommodation as they wanted more than one parent to stay overnight. The Head of Facilities is currently reviewing the accommodation capacity.
- Medical Records requests have also increased though these are usually complex and Pals works closely with the Legal Team, Medical Records, Social Work and Clinical Teams.

7 **Same Sex Accommodation**: There have been no breaches this quarter.

8. Update on key issues from Q3 2014

Issue	Update
Communication breakdown between clinical/nursing staff and administrators leading to delays in communication with families or inaccurate in communication to families. This was an issue for a range of services at GOSH and identified in 32 cases.	Pals have been monitoring this issue and have found a significant fall in cases. This fall is particularly marked in Surgery where such cases are now infrequent.
Difficulties in discharge from GOSH to local hospital/services or home	The Clinical Audit Team has recently been completed the audit of evidence of parent involvement in discharge planning. The key finding is that there is a discrepancy between practice and what we say we do in our policy, which is particularly important given that it has been noted that the policy has been referred to by families. Our policy states that "Each child must have a Discharge Plan in their medical record". A large number of cases have a discharge checklist. Pals are now working with the Assistant Chief Nurse to consider the revisions to the Discharge Policy in conjunction with the Head of Nursing for Surgery. This will be reported back Patient and Public Involvement and Experience Committee.

9. Cases formally escalated to Complaints or Risk teams

Pals escalated five cases to the Complaints Team in Q4. This is a reduction on the preceding quarter. These cases are managed and reported via the Complaints Q4 Report. These cases are either when

families specifically request a Formal Complaint or we have been unable to facilitate an informal resolution to a family or where the complexity of investigation warrants the timeframes of a Formal Complaint.

10. Compliments

We received six families sharing positive experiences and compliments. These included inpatient experiences from families on Koala Ward, Bear Ward and Squirrel as well as compliments for Nephrology and Outpatients regarding patient transport.

Attachment U

Great Ormond Street Hospital for Children NHS Foundation Trust

Friends and Family Test: Results for January – March 2015

The Q4 CQUIN requirements for the Friends and Family Test (FFT) were as follows:

- Achieve a minimum of 25% response rate for inpatient areas for Quarter 4 2014/15
- Roll out to outpatient and day case areas in Quarter 4 2014/15

FFT Response Rate for Inpatient Areas

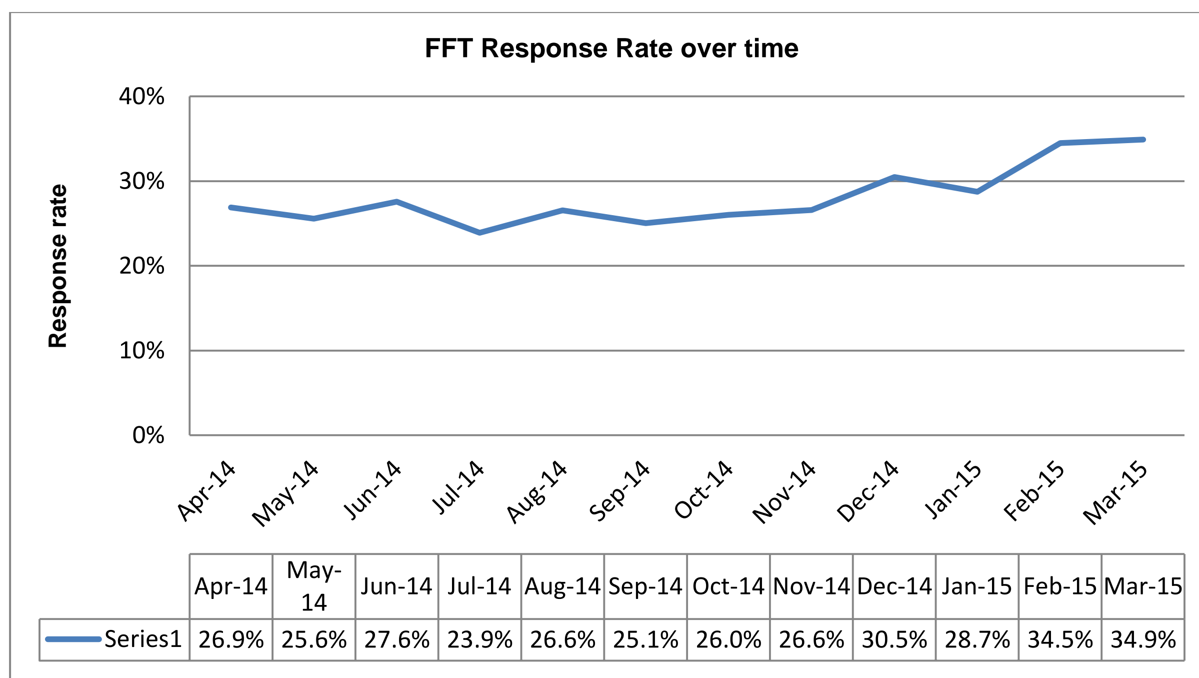
The Trust response rate to the FFT exceeds the end of year target of 25%. The aim is to increase the target to 40% by the end of March 2016.

The response rate for inpatient areas is as follows for Q4 2014/15.

	January	February	March
Number of discharges	964	960	985
Number of responses	277	331	344
Response rate	**28.73%**	**34.48%**	**34.92%**

The increased face to face presence of the Patient Experience and Systems Development (PESD) officer on the wards had a positive impact on the number of responses received over the course of 2014/2015.

The following graph outlines the FFT response rate over time since April 2014:

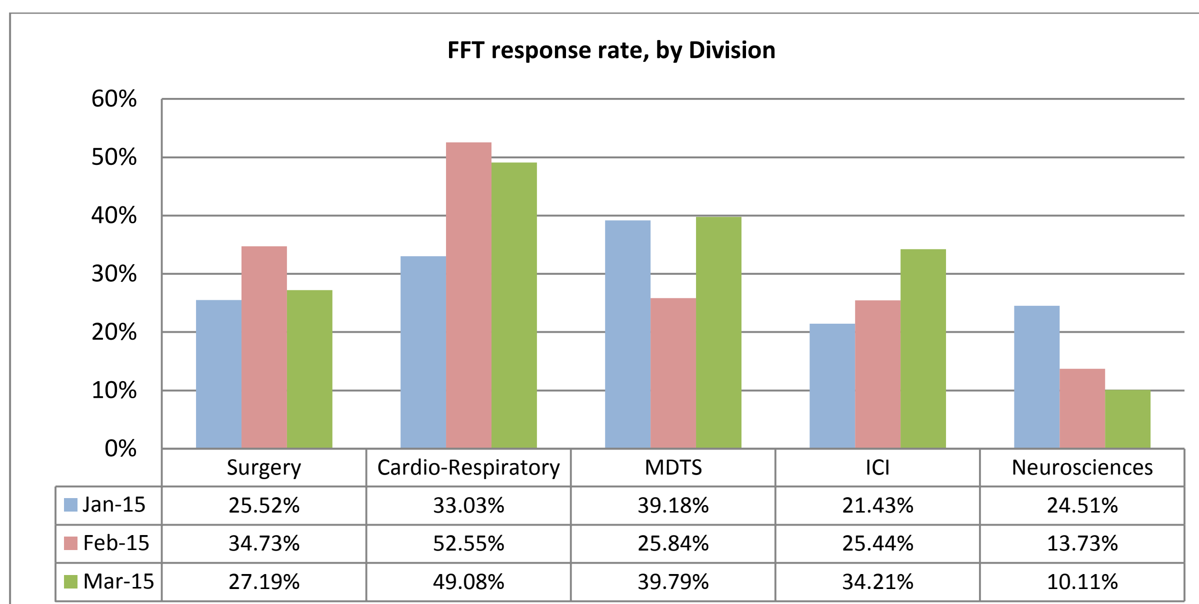


	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Series1	26.9%	25.6%	27.6%	23.9%	26.6%	25.1%	26.0%	26.6%	30.5%	28.7%	34.5%	34.9%

The new Patient Feedback Project Manager is now in post as of 12th May 2015 which will allow the PESD officer increased time to work closely with each of the wards.

Attachment U

The following graph outlines response rate by division in Q4 2014/15:



The reduction in responses within Neurosciences is directly related to the high turnover in Ward Administration staff. As a result of the PESD officer working closely with the wards, it is anticipated that this figure will increase. A chart displaying each ward by response rate will be available for the next quarter.

FFT Percentage to recommend

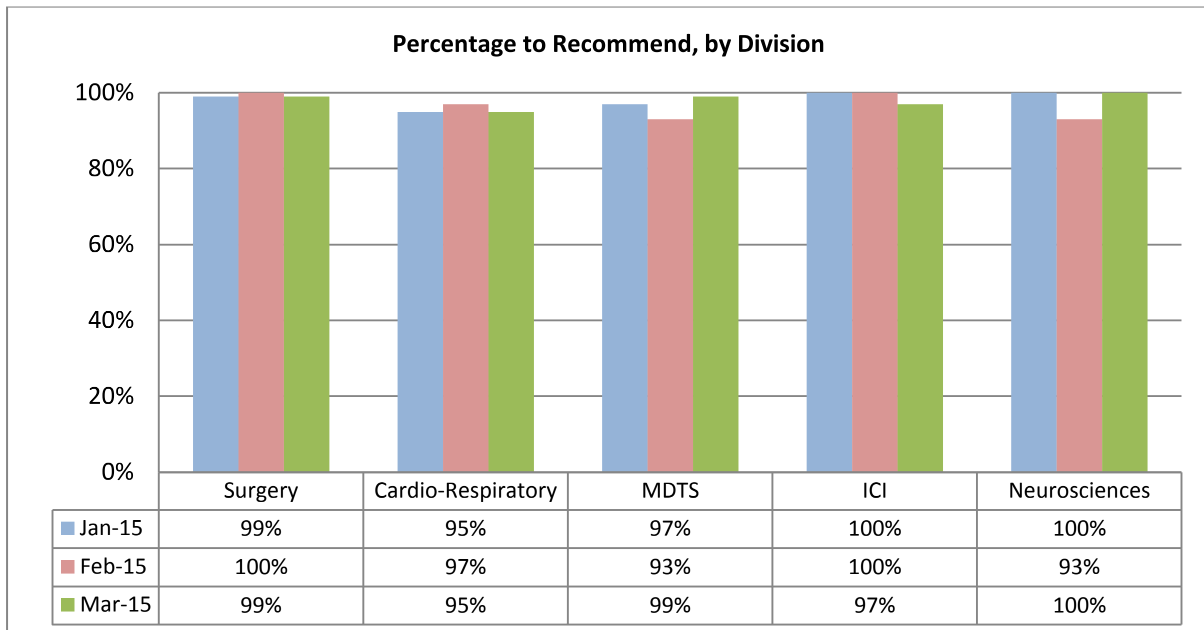
From October 2014, NHS England changed the calculation and presentation of FFT results from the FFT Net Promoter Score to a percentage of respondents who would/would not recommend the service to their friends and family.

The FFT Percentage to recommend for inpatient areas are as follows for Q4 2014/15:

		January	February	March
Promoter	Number of extremely likely	231	273	282
Passive	Number of likely	39	51	53
Detractor	Number of neither likely nor unlikely	4	3	1
	Number of unlikely	0	4	4
	Number of extremely unlikely	1	0	2
	Number of don't know	2	0	2
	Percentage to recommend	**97%**	**98%**	**97%**

Negative scores in March 2015 related to concerns raised by families on Badger Ward regarding insufficient nursing staff, staff behaviours and the environment. These concerns have been escalated to the Divisional Head of Nursing and an action plan is being put in place to address the issues raised.

The following graph outlines the percentage to recommend by division for Quarter 4, 2014/15:



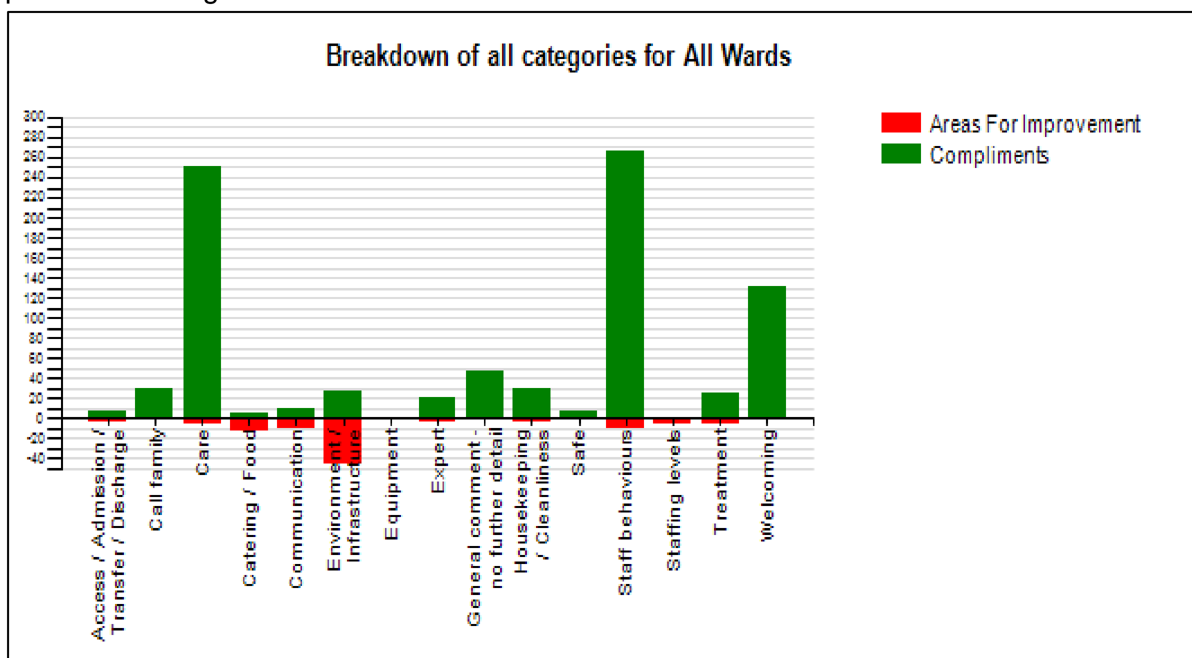
	Surgery	Cardio-Respiratory	MDTS	ICI	Neurosciences
Jan-15	99%	95%	97%	100%	100%
Feb-15	100%	97%	93%	100%	93%
Mar-15	99%	95%	99%	97%	100%

The reduction of 'percentage to recommend' within the Cardio-Respiratory Division is as a direct result of the issues on Badger Ward as outlined above.

Narrative from the FFT

All narrative feedback from inpatients areas is categorised to allow the organisation to review the information for areas of improvement to be identified. A report is sent to all inpatient areas on a monthly basis. Day case and outpatient areas will receive their reports once the new database is installed. The next phase of the FFT project is to better establish the "You said we did" boards within each inpatient area. These will display the common themes and trends observed from the FFT comments and the actions taken.

The following graph outlines the categorisation and trends of narrative comments both positive and negative:



- Staff behaviours, welcoming and care are the most positive areas experienced by parents/patients.
- Environment/infrastructure is the area where most improvement is required. Some of the themes within this category for improvement include: temperature of room, noise of wards, Wi-Fi connection and chair beds. Wi-Fi connection issues have been escalated to the Director of ICT and redevelopment have been testing a range of parent chair/beds in order that a recommendation can be made to wards as to which chair/bed is most comfortable to that new chair/beds can be purchased.

FFT in Outpatient Areas and Day Case Areas

In line with the CQUIN, the Trust rolled out FFT to outpatients and day case areas in Quarter 4 2014/15. Nationally, the guidance for outpatients is different to that of inpatients with the test only required to be offered. No guidance has been provided about the denominator from which to calculate a response rate and there is no agreed target for the response rate within outpatient areas. However day case areas will be expected to be in line with inpatient areas.

The following results are for FFT in outpatient areas:

	Jan-15		Feb-15		Mar-15	
	No. of returns	% to recommend.	No. of returns	% to recommend	No. of returns	% to recommend.
RLHIM Level 2	128	96.1	80	98.8	82	99
Dental	44	97.7	23	100	14	100
Safari Outpatients	46	93.5	16	100	23	87
RLHIM Level 4	83	97.6	62	95.2	93	91
RLHIM Level 1	46	97.8	10	100	65	97
Walrus	58	98.3	34	100	52	92

CAHMS/ PANDA	36	100	56	100	20	100
Cheetah	8	100	8	87.5	5	80
Rhino	14	100	46	95.7	32	91
Manta Ray	23	91.3	8	100	4	80
Clinical Research Facility	4	75	2	100	1	100
Totals	**490**	**96.7**	**345**	**98**	**392**	**94**

Current response rates for outpatients have decreased. IT system issues have limited the ability to provide timely information back to outpatient and daycare areas and have negatively impacted on staff morale and engagement with the FFT. It is anticipated that the response rates will rise once these systems issues have been resolved along with the support of the PESD Officer. The board are asked to note that during the CQC inspection the Inspectors of Outpatients asked to speak to the PESD Officer specifically as they were impressed with the level of engagement and positivity about the FFT amongst staff in outpatients and the support provided to enable this. "You said, We Did" boards have been provided for outpatient areas which will have an additional positive effect on the number of responses returned once more timely narrative feedback can be provided

The following results are for FFT in day case areas:

	Jan-15		**Feb-15**		**Mar-15**	
	No. of returns	**% to recommend.**	**No. of returns**	**% to recommend.**	**No. of returns**	**% to recommend**
Urodynamics	46	97.8	38	97.3	2	100
Penguin Ambulatory	50	98	62	100	42	98
Woodpecker	123	98.4	133	99	92	100
Walrus	30	100	26	100	14	100
Safari Day case	8	100	5	80	6	100
Clinical Research Facility	5	100	1	100	4	100
Totals	**262**	**99%**	**271**	**98.5%**	**164**	**99%**

Day case area responses are also impacted by the IT system issues and as with Outpatients it is anticipated that once these issues are resolved this will improve with the support of the PESD officer.

Annual Review of FFT

This has been a very positive first year for the Friends and family test at GOSH with the response rate increasing from 15% initially to 35% by the end of March 2015, exceeding our aspirations of 25%. The percentage likely to recommend has consistently achieved over our 95% target since June 2014. There have been good levels of engagement across the organisation and a welcome response to the narrative comments received.

As a result of comments received wards and departments have been able to make practical changes that positively improve patient experience. Examples include

- The lack of entry cards for parents to access wards was raised as an issue. Wards have worked with the facilities team to address this and set up better systems for ensuring cards are returned at the end of a patients stay.
- Minor changes required in the ward environment have been made E.g. Penguin ward have installed mirrors in all patient/family bathrooms and toilets in response to parents feedback.
- The FFT report is sent to the IT director who promptly acts on feedback re Wi-Fi connectivity where this has been identified as a concern.
- Following a negative comment related to patient safety the PESD Officer reviews all comments entered on a daily basis and immediately escalates anything of concern in relation to patient safety, experience or safeguarding to ensure prompt action is taken.

Caroline Joyce

Assistant Chief Nurse Quality & Patient Experience.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board

22nd May 2015

Annual Complaints Report 2014/15 **Submitted by:** Dena Marshall, Acting Chief Operating Officer	**Paper No: Attachment V**

Aims / summary

- 76% of complaint responses closed between 1 April 2014 and 31 March 2015 were sent out within agreed timescales, only 61% of draft reports were received by the complaints team, on time.
- Communication with parents, awareness of the needs of patients with learning difficulties and sharing information with other organisations were identified as reoccurring themes in complaints.
- Three investigations were completed by the Health Service Ombudsman during the year, two were partly upheld and the remaining complaint was not upheld.

Action required from the meeting

Board Members are encouraged to review the incident trends highlighted and learning from SI reports and disseminate these in their areas.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Through learning lessons and implementing risk mitigating actions to address incident trends the Trust is working towards achieving its goal of zero harm.

Financial implications

None

Who needs to be told about any decision?

N/A

Who is responsible for implementing the proposals / project and anticipated timescales?

Donna Robinson, Patient Safety and Complaints Manager

Who is accountable for the implementation of the proposal / project?

Salina Parkyn, Head of Clinical Governance and Safety

Annual Complaints Report
April 2014 – March 2015

This report aims to provide a summary and overview of complaint activity over the last year.

1.0 Summary of key points

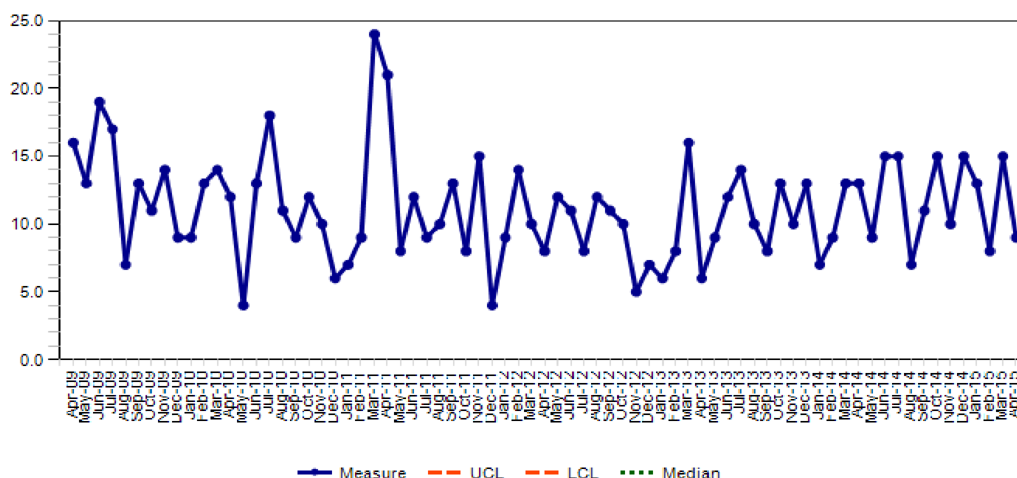
The key points identified from this report are:

- 144 formal complaints were investigated in 2014-2015, in line with the NHS complaints regulations. Sixteen of these complaints were graded as red.
- 76% of complaint responses closed between 1 April 2014 and 31 March 2015 were sent out within agreed timescales, only 61% of draft reports were received by the complaints team, on time.
- Communication with parents, awareness of the needs of patients with learning difficulties and sharing information with other organisations were identified as reoccurring themes in complaints.
- Three investigations were completed by the Health Service Ombudsman during the year, two were partly upheld and the remaining complaint was not upheld.

2.0 Formal complaints investigated by the Trust

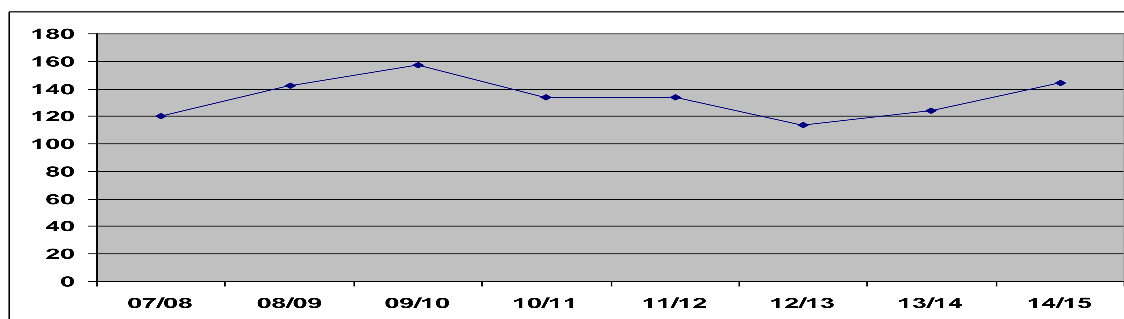
The Trust investigated 144 new complaints in 2014-2015 in line with the NHS complaint regulations, compared to 123 in 2013-2014. In addition, the Trust received 4 complaints where the complainant chose not to proceed with their complaint. There was an overall 17% increase in formal complaints this year compared to last year. A likely explanation is the increased promotion of the complaints service within GOSH and wider media coverage of NHS complaints. The chart below demonstrates the trends for the number of formal complaints received by the Trust since April 2009.

All Complaints (red, amber and yellow): All Clinical Units / Directorates, All Specialties

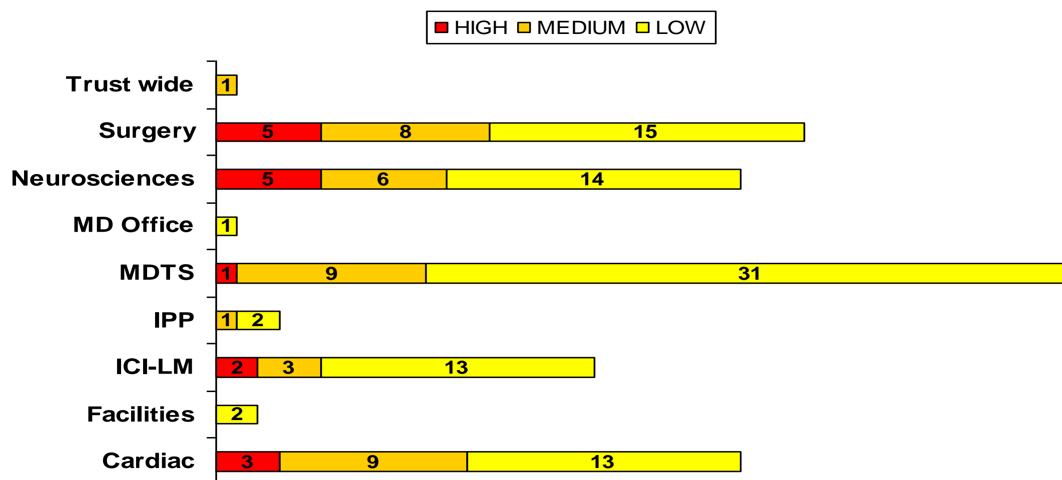


Attachment V

Total complaints received by year



3.0 Number of complaints received by division, speciality and grading



The complaints were graded using the Trust risk grading protocol

Of the 144 complaints received:

- 16 were graded as high, up from 13 in 2013/2014
- 37 were graded as medium, up from 36 in 2013/2014
- 91 were graded as low, up from 74 in 2013/2014

Although the numbers all increased, as a % of the overall complaints those graded as high remained consistent (11% in 2013/14 and 11% in 2014/15), medium decreased slightly (29% in 2013/14 and 26% in 2014/15) and low increased slightly (60% in 2013/14 and 63% in 2014/15).

3.1 Red complaints trends

There were no reoccurring themes from the 16 red complaints. Appropriate action plans have been devised and are being monitored (please see point 8 for examples). Any identified risks have been added to the Trust wide risk register and been appointed an executive lead.

4.0 Percentage of complaints received compared to patient activity for each division.

Directorate	Total # of Complaints	Adjusted patient activity	Amount of Complaints per 1000 Adjusted Patient Days	% of Complaints per 1000 Adjusted Patient Days

MDTS	41	124787.19	0.33	30.7%
Surgery	28	165784.89	0.17	15.8%
Neurosciences	25	100365.58	0.25	23.3%
ICI-LM	18	124521.37	0.14	13.5%
Cardio-respiratory Services	25	203112.89	0.12	11.5%
IPP	3	53393.24	0.06	5.2%
Totals:	140	771965.16	2.51	100.0%

***During 2014-15, there were four complaints which are not counted in this table as there are no comparable bed days as they concerned Facilities or the Medical Directors Office.**

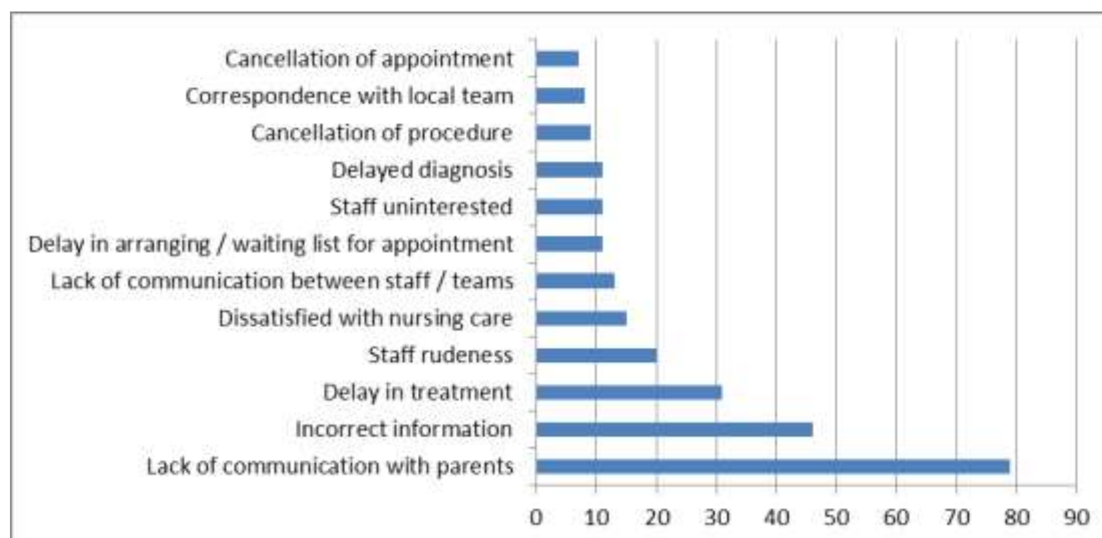
Adjusted Patient Activity is a measure which weights outpatients, inpatients and critical care bed days into a combined figure representative of overall healthcare resource activity. For example on average an inpatient requires more input than and an outpatient and thus several outpatients will be the equivalent of one inpatient. This combined APA enables different specialties to be compared with each other and over time and will account for the relative differences in patient complexity. It can be used as a denominator for comparable measures across the Trust sure as harm and workforce productivity

5.0 Complaints closed within the agreed timescale

In accordance with the NHS Complaint Regulations 2009, the Trust is required to agree a timescale for responding to a complaint with the complainant. 61% of draft reports were received from the investigating staff on time however 76% of complaint responses closed between 1 April 2014 and 31 March 2015 were sent out on time. In all cases where additional time was required, the complainant was kept informed.

7.0 Trends and Themes

Subjects most commonly raised in complaints in 2014-2015 (please note some complaints raise a number of concerns/subjects.



Themes in complaints

Lack of communication with parents
This concern remains as the top issue in complaints and was raised in 79 of the 144 complaints received this year. However, this represented 55% of all complaints received which is a decrease from 75% in 2013-2014 and an indication that improvements are being made in this area.

Lack of communication covers a range of issues where parents do not feel they have been communicated with appropriately or effectively and was raised across all divisions during the year.

Examples of the learning already being taken to address these concerns are:

- Increased administrative support, staff recruitment and improved administration processes
- Implementation of additional cross-department communications through regular newsletters and restructured meetings to ensure improved communication among staff which in turn will lead to improved communication with patients and families.
- Additional information added to pre-admission parent information packs to explain process for allocation of cubicles
- Development of a patient/parent information leaflet regarding antibiotic resistant organisms.
- Allocation of specific CNS staff to work with specific Consultants to facilitate communication with families and patients – details of this update on the Trust website.
- Feedback and training provided to staff

Lack of awareness of patient and family needs relating to learning difficulties or autism.
There have been several complaints received this year regarding the failure of the Trust to meet the needs of patients and/or families with learning difficulties or autism. This usually concerns incidents where parents have contacted the relevant team/ward in advance to talk about their needs and how to ensure the admission will run as smoothly as possible and have been assured that action will be taken. However on the day staff have then been unaware of the plans or these have not been followed resulting in distress to the patients and, often, the family making the decision to take patients home without completing planned tests or investigations.

Responses to these complaints have apologised to the families and explained the circumstances of each case and, where possible, the reasons why the plans made were not followed (for example if an emergency procedure meant the patient's position on a procedure list was changed). Different actions have been implemented in different areas. The IPP team now have allocated Link nurses to work with the Consultant Nurse for Intellectual (Learning) Disabilities and share information and learning with the ward staff and are making use of the Hospital Passport. Staff on Kingfisher ward have made changes to the daily schedule to ensure any relevant information is highlighted to the team prior to patients arriving and the Psychology team have agreed that when working with patients to prepare

for admissions they need to take into account the ward environment and work to set realistic expectations.

A recent complaint raising similar issues on Rainforest ward is currently under investigation and it is likely that this is a matted which will continue to be raised and which further work is required across the Trust.

Sharing of information with other services/organisations
A number of complaints were received this year in which concerns have been raised about clinical information about a child being shared with local social services and/or other organisations such as a local hospital or the patient's school. In some cases the parents were unaware that information was being shared and felt that this had breached patient confidentiality.

Responses to these complaints have all explained that the Trust has a legal obligation to share information as required and a duty of care to the child which includes sharing information with other organisations when this is in the best interests of the patient. It has been explained this does not constitute a breach of confidentiality but is in line with the duties staff have to the patient. In addition to this the issue has been discussed at the PRACTICAL meeting (a weekly meeting with PALS, Complaints, Risk, Legal and Audit staff) and work is being done to produce a short leaflet explaining the circumstances in which information may be shared which could be given to parents when appropriate. It is hoped that a leaflet such as this would help families feel better informed about the processes followed and the reasons why this is done as well as the Trust's obligations and be reassured that any information shared is done so in the best interests of the patient.

8.0 Learning from complaints

The Trust is committed to listening and involving patients and families in the improvement of our services. As part of the formal complaints investigation process, we identify areas in which the quality of the services could be improved, and devise an appropriate action plan. The complaints team monitor these recommendations to make sure action has been taken. They may also involve other teams, such as the audit team, to ensure that the actions have addressed the issues identified. As a result of the feedback and actions a number of changes have been made

Of the complaints closed over the year, 44 complaints were identified as requiring actions. Details of some of the actions implemented following red complaints are below:

8.1 Examples of learning from red complaints

Details of complaint: A family raised concerns about the diagnosis given to the patient and the lack of re-testing by the lab prior to releasing the results. The results of the test were given as confirming a diagnosis of a genetic condition which a year later was proved to be incorrect.
Outcome/actions: The investigation identified that the positive results were given as the genetic markers were very faint (non-existent markers would indicate a positive result,

strong markers a negative result) and a similar condition had been shown to exist when genetic markers were faint. As a result of this case revisions were made to the laboratory standard operating procedures as follows: a. Results indicating a diagnosis of specific conditions will be confirmed by an independent method prior to reporting b. Results that show a potentially inconclusive result (whether comparable to control or not) will be repeated using an alternative method prior to reporting. A training meeting was also held for all relevant staff in order to learn from this experience.

Details of complaint: A complaint was raised regarding a urology patient who was admitted for tests requiring insertion of a SP catheter. Following insertion of the catheter the patient became unwell and was discharged without completing the tests. After discharge it was identified at the local hospital that the patient was suffering an infection following urine leaking into the peritoneum which was a known complication of the SP insertion.
Outcome/actions: The investigation found that staff should have identified the infection prior to discharging the patient but did not do this as they had thought the patient's pain was due to the more common complication of bladder spasm. As a result of this incident the Clinical Lead and Clinical Nurse Specialist agreed to produce an integrated care pathway for the insertion of SP lines to explain to staff looking after these patients the potential complications and warning signs to look out for as well as the appropriate way in which to escalate any concerns regarding any patient.

Details of complaint: The complaint concerned delays in diagnosing a brain tumour for a patient. An SI investigation was carried out following which the family made a complaint about the failings identified and raised concerns that they did not believe that the actions identified would be carried out.
Actions: The complaint investigation identified that, largely due to changes in staff, actions agreed in the SI investigation had not progressed as far had been expected at the time the complaint was made. This was explained in the response along with an update on the progress to date and an amended timescale for taking actions forward. The actions concerned discussions taking place between different teams to agree patient pathways and process for sharing information. One additional action was also taken to ensure the e-mail inbox for monitoring images being shared with the team was regularly checked.

9.0 Re-opened complaints

Of the complaints closed this year, 24 families accepted the offer of further discussion/explanation and asked the complaints team to arrange this. Due to the complexity and clinical explanations required a number of these families were invited back to ensure the conclusions and explanations were fully understood.

10.0 Health Service Ombudsman

The Health Service Ombudsman is responsible for managing the second and final stage of the NHS complaints procedure, where the complainant is dissatisfied with the Trust's final response.

Attachment V

Three investigations were completed by the Health Service Ombudsman this year and the Trust received notification of two new complaints being referred to the Ombudsman. These are detailed in the table below. Additionally a draft report was received on one case for which the Trust have provided comments to the Ombudsman. All six of these complaints were investigated by the Trust in previous years.

Ref	Brief Description	Current Status
12/058	Complaint from family following death of patient regarding patients care and treatment.	Ombudsman concluded that the Trust had fully investigated and there were no concerns. Case closed and not upheld.
11/134	Complaint from family raising concerns regarding the removal of a tumour from the patient's eye	The case was partly upheld due to concerns regarding communication, delays in arranging a follow-up appointment and record keeping. A full action plan has been developed and implemented.
12/083	Complaint received from patient's family regarding the lack of communication from the patient's clinician after the patient's death and contradictory information from GOSH and another Trust involved.	The case was partly upheld due to poor communication with the family and a lack of clear management plan between GOSH and the other Trust. Actions had already been taken to address these issues and details of these were shared with the Ombudsman and family.
12/102	Complaint investigated alongside another Trust regarding an operation undertaken at GOSH. Parent raised concerns over the operation taking place in an unfamiliar environment.	This case was originally closed by the Ombudsman as the family had an alternative legal remedy. However the Ombudsman have now informed us that the family have returned to them requesting a different outcome and they are now investigating.
13/025	Complaint about care and treatment during admission including concerns about consent and staff attitude	The Trust received notification that the Ombudsman would be investigating the complaint in July 2014, papers have been provided to the Ombudsman.
13/007	Parent raised questions surrounding the patient's treatment whilst on the ward and the reasons for their cardiac arrest.	A draft report was received by the Ombudsman proposing to uphold the complaint. The Trust has provided substantial comments to the Ombudsman in disagreement with the conclusions and they are in the process of considering these.

Great Ormond Street Hospital for Children NHS Foundation Trust NHS

<table>
<tr><td colspan="2">Trust Board
22nd May 2015</td></tr>
<tr><td>Ipsos Mori Outpatient Survey Results

Submitted by:
Juliette Greenwood Chief Nurse</td><td>Paper No: Attachment W</td></tr>
<tr><td colspan="2">Aims / summary
To inform the Trust Board of the results of the biannual survey of patient experience in the Outpatient Department in 2014. This work also contributes to providing assurance to the Care Quality Commission (CQC) and Monitor about how the Trust is meeting its statutory obligations in relation to patient experience in the outpatient department.</td></tr>
<tr><td colspan="2">Action required from the meeting
To note the results.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS Foundation Trust strategies and plans
Collecting and acting upon patients experiences in the outpatient department contributes to the Trusts strategic objective to be the number 1 Children's hospital in the world in relation to patient experience.</td></tr>
<tr><td colspan="2">Financial implications

Nil</td></tr>
<tr><td colspan="2">Who needs to be told about any decision?
The Assistant Chief Nurse Quality & Patient Experience</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales?
The Neurosciences Divisional Management team are responsible for delivering the Outpatient Improvement project through the Outpatient Head of Nursing and Service Manager supported by the Quality Improvement team</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project?
Juliette Greenwood Chief Nurse</td></tr>
</table>

Attachment W

Great Ormond Street Hospital for Children NHS Foundation Trust

Report of IPSOS MORI Outpatient Experience Survey

2014

Aim of Survey:
The 2014 outpatient survey seeks to measure and track GOSH's performance in terms of the following:-

- Outpatients' overall perceptions of their visit to the hospital;
- Satisfaction levels with the appointments and booking in processes;
- The quality and effectiveness of staff communications;
- Aspects of doctors' and nurses' care;
- The process of leaving hospital;
- Potential improvements to patients' visits.

Specific areas of service and patient care are explored within each of these overarching themes

Methodology:
The 2014 survey was undertaken on the Trusts behalf by independent market research company Ipsos Mori. This was the third time that Ipsos Mori have undertaken this piece of work for the Trust. The 2014 survey:-

- Replicated the approach used in the previous 2010 & 2012 surveys to enable comparison of results.
- 750 telephone interviews were conducted with either outpatients (aged 10+), or parents of outpatients who attended the hospital during the period 1st July – 31st August 2014.
- Fieldwork took place between 3rd – 23rd November 2014
- A Computer Assisted Telephone Interviewing (CATI) approach was used.
- In total, 589 parent and 151 patient interviews were conducted.
- The average length of each interview was 10 minutes.

Overall Satisfaction and likelihood to recommend the hospital (see table 1 appendix 1)

- Patients and their parents again report very high satisfaction with the service provided by GOSH. Overall, 95% are satisfied 1% higher than in 2012 and consistent with the 2010 results.
- Whilst still very high the proportion who say they are likely to recommend the hospital to a friend or relative has fallen from 98% in 2010, to 96% in 2012 and a further 1% reduction in 2014 to 95%. (see table 1 appendix 1)
- The reduced likelihood to recommend experienced particularly in 2012 related to the 24% increase in outpatient activity over the preceding 3 years without commensurate investment in resources. This led to reduced satisfaction particularly around the booking and rearrangement of appointments.
- In 2014 there were some changed ways of working in the central booking office and investment in additional nursing and administrative staff which has started to positively impact on patients experience of the appointments process (outlined below).

Satisfaction with information and appointments (see table 2 appendix 1)

- There has been a significant decrease in the amount of parents stating that they had had to cancel or rearrange an appointment, reduced from 56% in 2012 to 46% in 2014.
- The proportion of parents reporting that GOSH had to cancel/rearrange their appointment also reduced from 47% to 41%. However, there has been a significant increase in parents reporting that when GOSH cancels appointments this happens 4+ times 12% in 2014 as opposed to 5% in 2010. This will be addressed through the Outpatient improvement project.
- Satisfaction with the ease of the process for changing appointments also increased from 76% in 2012 to 81% in 2014.
- 20% of patients reported waiting more than 30 minutes for their appointment. for these patients and families their level of overall satisfaction with their visit was reduced compared to those seen in less than 30 mins (88% satisfied compared to 97% for those who waited less than 30 mins)

Doctors & Nurses Care (see table 3 appendix 1)

- Satisfaction with doctors and nurses care remains high and in line with the results of the 2012 survey. This includes 97% satisfaction that staff were polite at all times and 95 % satisfaction with staff explaining tests and treatment.
- There was a 3% decrease in satisfaction with staff involving patients or their families in decisions about their care or treatments (91% in 2014 compared to 94% in 2012. This reflects initial results from the CQC commissioned Picker Inpatient survey. Further work will need to be undertaken to explore why this might be.
- The areas where parents and patients feel slightly less positive are dealing with the child’s fears and anxieties (82% good) and asking how the child and parent were feeling (88% good). Again, these results are in line with the 2012 findings.
- Satisfaction with knowing how to complain improved from 64% in 2012 to 66% in 2014 but remains lower than other aspects of the service.
- Satisfaction with feeling able to feedback or complain improved 1% from 74% to 75% in 2014.
- New posters have been implemented across the Trust which have had a positive impact on the number of Pals and complaints received suggesting that the posters have raised awareness. It is hoped that full implementation of the Friends and Family test will also help to improve this measure in the outpatient department.

General Experience in outpatients (see table 4 appendix 1)

- Satisfaction with the general environment in outpatients in relation to cleanliness, temperature and comfort remain good and consistent with the 2010 and 2012 surveys. This includes 93% satisfaction with cleanliness and 87% satisfaction with temperature in the department.
- The only measure which has decreased significantly in satisfaction with the availability of food and drink in outpatient which has reduced from 72% in 2012 to 67% in 2014. Parents of younger children and young people themselves are more dissatisfied with this aspect of the service. Since the 2012 survey the main reception has been redevelopment leading to the closure of the only café facility that was close to the main hospital outpatient department. Families now have to go to the Lagoon for refreshments. Concerns were also raised with Pals about difficulties for mothers of infants and toddlers in relation to heating bottles and baby food in the Lagoon this has now been addressed and concerns have decreased in this area.

Special Needs and Disabilities:

- Most parents (82%) agree that the hospital understands the needs of patients with special needs and/or disabilities, and that the hospital puts arrangements in place to meet them. This has stayed consistent with the previous survey in 2012.
- A third (34%) of parents whose child has a special need and/or disability were directed to disabled facilities when it was required, while 15% were not. Around half (49%) did not need to be directed or did not require the facilities

Leaving the hospital (Table 5 appendix 1)

- Satisfaction with arrangements for leaving the hospital were good and in line with the 2012 survey with the exception of two measures
- Parents knowing who to contact if they had a question when they got home reduced by 3% from 90% to 87%
- There was also a significant (7%) reduction in patients and parents being given enough information about any medications (79% in 2014 from 84% in 2012)

Suggested Improvements

3 main areas were identified by patients and families for improvement:-

1. Shorter waiting times
2. Improving the comfort of the waiting areas (play areas and seats)
3. Improving communication when waiting times are prolonged.

In addition a number of areas will be focused upon e.g. patients who have appointments cancelled more than once.

Next Steps:
The key areas identified for improvement within the survey are being taken forward by the Outpatient Improvement Project which is one of the key Quality Improvement initiatives for 2015/16. A significant project plan and actions are in place to address issues particularly around appointment bookings, reducing waiting and improving the waiting experience. This project reports to the Quality Improvement Committee. In addition refurbishment of the chairs in the outpatient areas in RLIM has taken place thanks to funding from GOSHCC.

Caroline Joyce
Assistant Chief Nurse Quality & Patient Experience 2014

Appendix 1.

Table 1 Overall satisfaction and likelihood to recommend

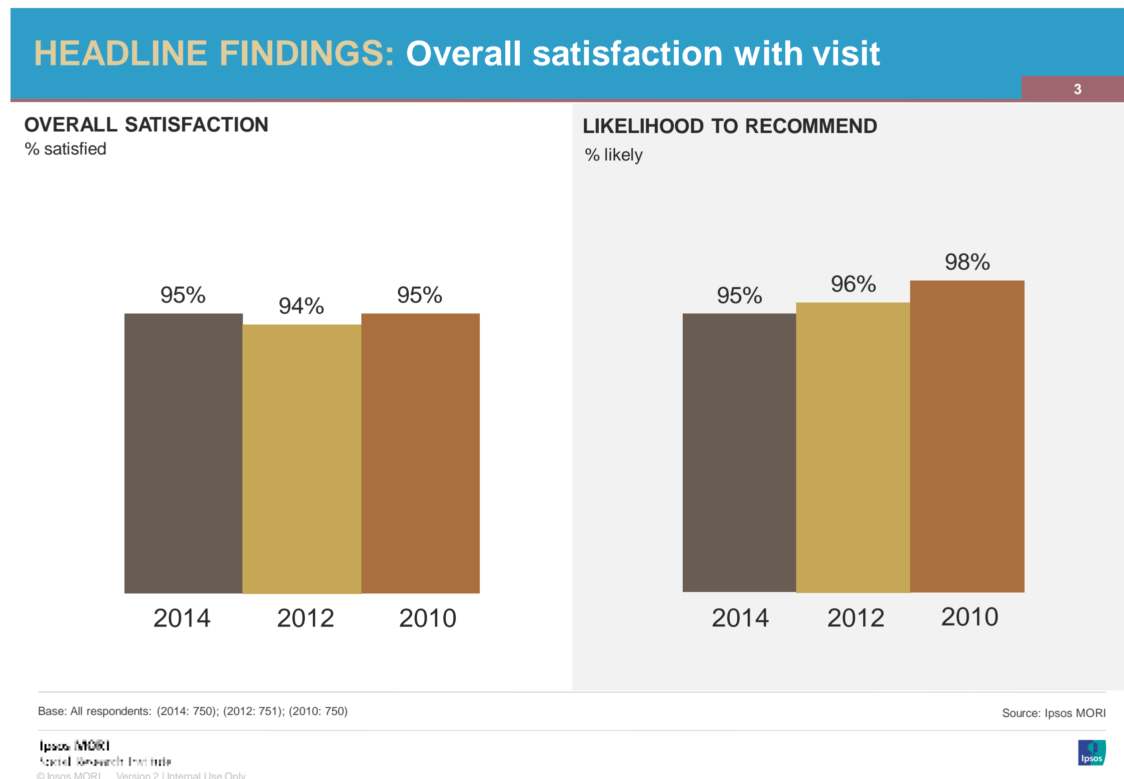


Table 2 Satisfaction with appointments and information

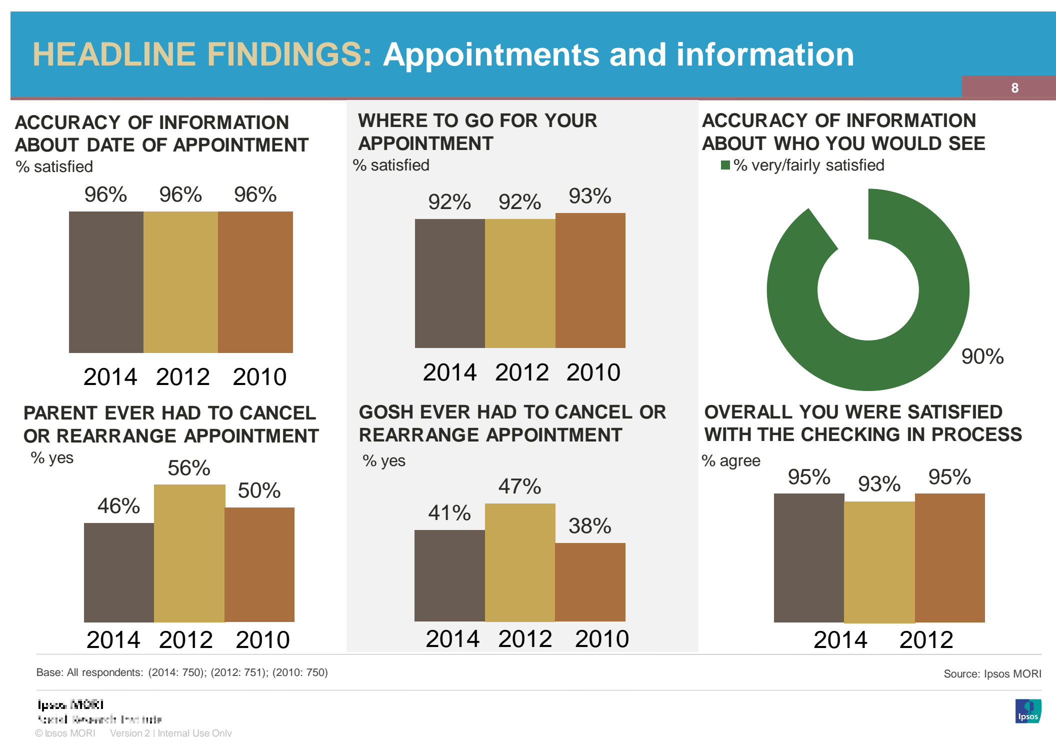


Table 3 Satisfaction with doctors and nurses care

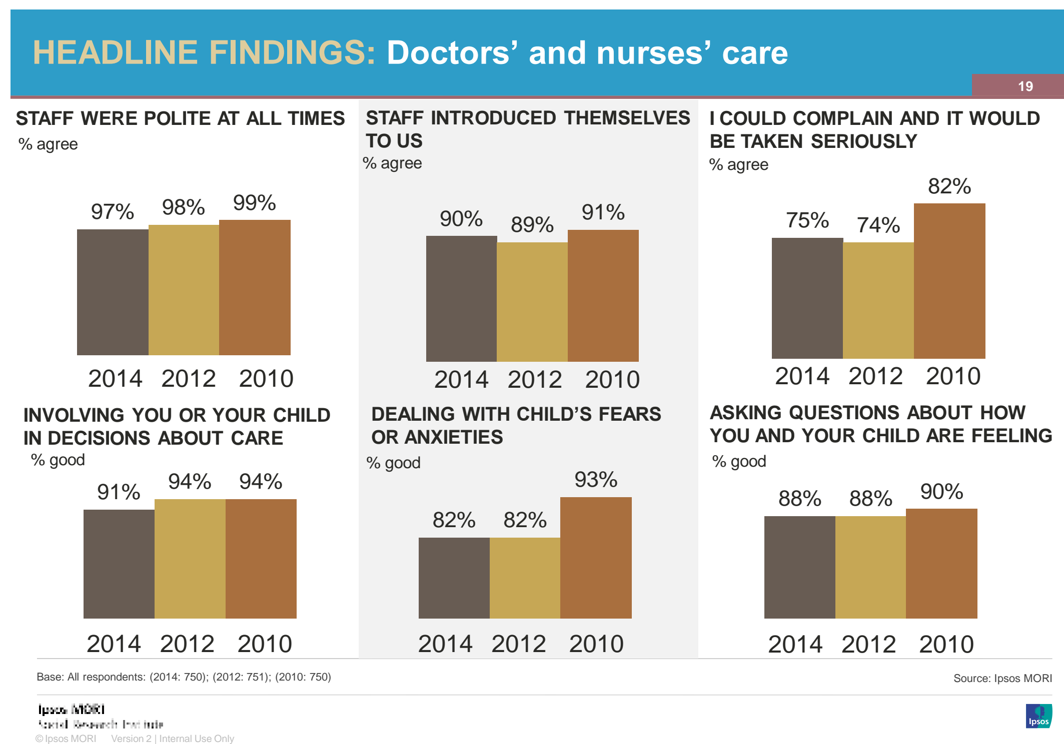


Table 4 General Experience in Outpatients.

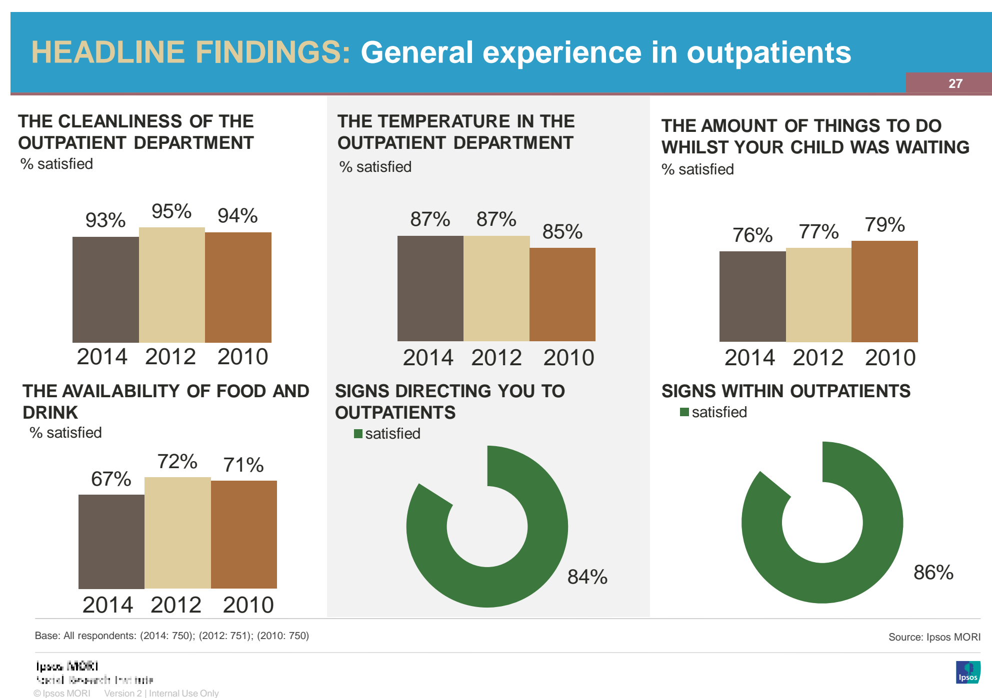
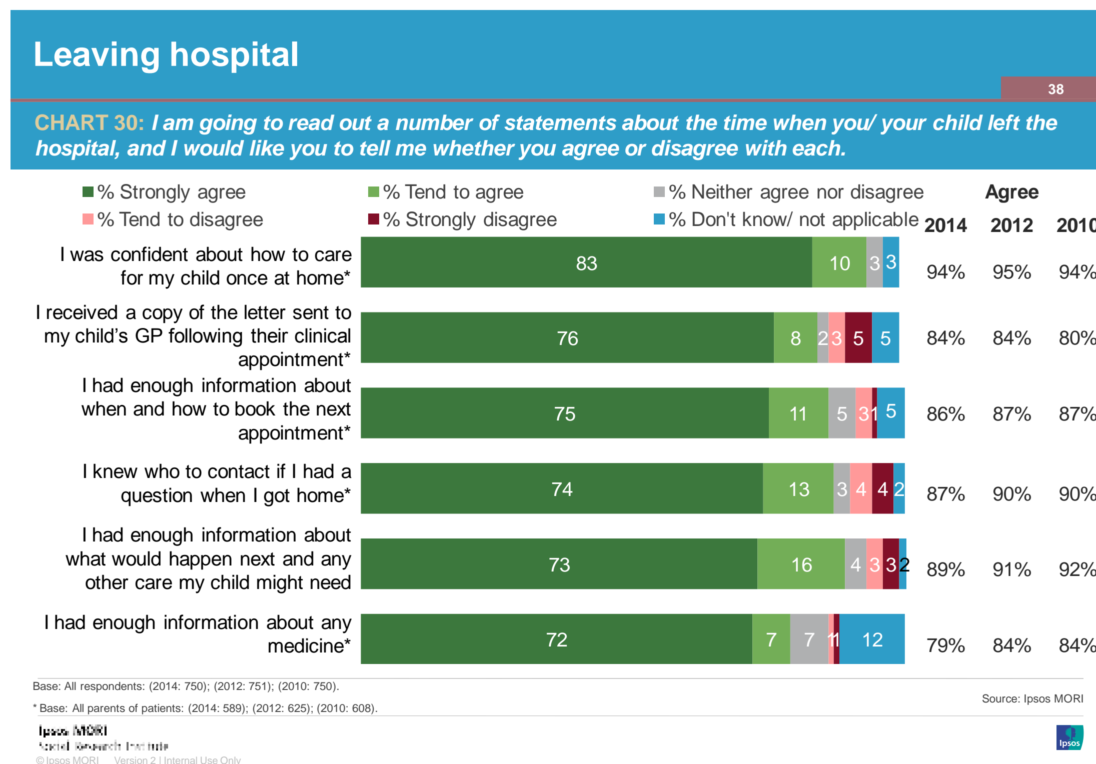


Table 5 Leaving the hospital



Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **22nd May 2015**	
Safe Nurse Staffing Report **Submitted by: Juliette Greenwood** **Chief Nurse**	**Paper No: Attachment X**

Aims / summary

This paper provides the required assurance that GOSH has safe nurse staffing levels across all in- patient ward areas and appropriate systems in place to manage the demand for nursing staff. In order to provide greater transparency the report also includes appropriate nurse quality measures and details of ward safe staffing reports. The paper includes a brief summary of nursing vacancies and nurse recruitment.

Action required from the meeting

The Board is asked to note:

- The content of the report and be assured that appropriate information is being provided to meet the national and local requirements.
- The information on safe staffing and the impact on quality of care.
- To note the key challenges around recruitment and the actions being taken.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.

Compliance with *How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing and capability'* (NHS England, Nov 2013) and the *'Hard Truths Commitments Regarding the Publishing of Staffing Data'* issued by the Care Quality Commission in March 2014.

Financial implications

Already incorporated into 15/16 Division budgets

Who needs to be told about any decision?

Divisional Management Teams
Finance Department

Who is responsible for implementing the proposals / project and anticipated timescales?

Chief Nurse; Assistant Chief Nurse, Heads of Nursing

Who is accountable for the implementation of the proposal / project?

Chief Nurse; Divisional Management Teams

GOSH NURSE SAFE STAFFING REPORT

April 2015

1. Introduction

1.1 This report on GOSH Safe Nurse Staffing contains information from the month of April 2015. The report provides information on staff in post, safe staffing incidents, nurse vacancies and includes quality measures which are reported by exception.

2. Context and Background

2.1 The expectation is the Board 'take full responsibility for the care provided to patients and, as a key determinant of quality, take full and collective responsibility for nursing care capacity and capability'.

2.2 Monthly nurse staffing updates are submitted to NHS England and the Trust Board with the following information:

1. The number of staff on duty the previous month compared to planned staffing levels.
2. The reasons for any gaps, highlighting those wards where this is a consistent feature and impacts on the quality of care, to include actions being taken to address issues.
3. The impact on key quality and safety measures.

3. GOSH Ward Nurse Staffing Information for Trust Board

3.1 Safe Staffing

3.1.1 The UNIFY Fill Rate Indicator for April is attached as Appendix 1. The spread sheet contains:

- Total monthly planned staff hours; the Heads of Nursing provide this figure based on the agreed average safe staffing level for each of their wards. These figures are fixed i.e. do not alter month on month. Bed closure information is used to adjust the planned staffing levels.
- Total monthly actual staff hours worked; this information is taken from RosterPro, and includes supervisory roles, staff working additional hours, CNS shifts, extra staff booked to cope with changes in patient dependency and acuity from the Nurse Bank. This may both exceed or be below 100% to meet the changing demands of patient activity, dependency and acuity.
- Average fill rate of planned shifts. It must be noted that the presentation of data in this way is open to misinterpretation as the non-registered pool is small in comparison to the registered pool, therefore one HCA vacancy or extra shifts worked will have a disproportionate effect on the % level.

3.1.2 Commentary:

- Heads of Nursing are asked to comment on percentage scores of less than 90% or greater than 110%, and declare any unsafe staffing situations that have occurred during the month in question including action taken to rectify and make the situation safe.

ICI – No unsafe shifts reported in April
Robin Ward and Fox Ward report high levels of sickness and several vacant posts. Several patients have been unable to commence treatment due to their clinical condition, this has resulted in some shifts with lower dependency and acuity, and reduced staffing. ICI staff are moved across

wards to meet the needs of the patient population. Penguin Ward, HCA requirement on night reduced due to patient numbers.
Surgery No unsafe shifts reported in April Sky Ward – reduced night staff due to bed closures. Peter Pan higher acuity on day shifts requiring increase in Registered Nurses.
CCCR – No unsafe shifts reported in April Badger report having increased numbers of Ward Intensive Care patients requiring 1:1 care. MIFFY have an extra nurse on days undergoing training. Two funded extra beds remain closed on Badger Ward. HCA numbers have increased and are being trained for their new posts hence the high numbers on days. Flamingo planned staffing for 17 beds, up to 3 additional beds (total 20) are opened when staff available through the Nurse Bank. NICU have increased sickness requiring extra staff on shifts and new staff on induction.
MDTS - No unsafe shifts reported in April Variations in staffing on Rainforest Gastro Ward and Rainforest Endocrine/Metabolic Ward reflect changes in acuity and dependency.
Neurosciences - No unsafe shifts reported in April Koala has reported high levels of acuity requiring extra staff. A new HCA working supernumerary accounts for the increase in the day numbers from 1 to 2 HCAs (reported on UNIFY as 147%). Mildred Creak Unit – Increased staffing to provide 1:1 care for several high risk patients.
IPP - No unsafe shifts reported in April Bumblebee - increase in HCAs on days based on clinical need. Butterfly has seen an increase in day case activity resulting in fewer Registered staff on night shift. Staff worked flexibly across the wards as needed.

3.1.4 The Clinical Site Practitioners (CSPs) report that no wards were declared unsafe during April, however there were 6 occasions in April where staff were moved between wards for part or a whole shift to maintain safe care. A further 4 occasions are noted where wards reported shifts being short of staff despite this safety was not compromised.

3.1.5 As part of the required six monthly establishment review process the monthly planned staff hours are currently being validated.

3.2 General Staffing Information

3.2.1 Appendix 2 – Ward Nurse Staffing overview for April. The table provides information on staff in post, vacancies and staff in the recruitment pipeline and includes bed closure information. 15 out of 23 inpatient wards closed beds at various points during April. An average of 17 beds were closed each day this has increased from 13.4 beds in March. The main reasons for this increase include maintenance and problems with the estate in Southwood Building. Peter Pan and Rainforest experienced severe disruption for several days following incidents with blocked drains. Badger Ward had 2 beds closed whilst staff were recruited and trained, Koala closed up to 4 beds due to increased patient acuity and dependency.

3.2.2 For the inpatient wards, registered and non-registered vacancies for April are 100 (10%) Whole Time Equivalents (WTE), this breaks down to 73 registered nurse (RN) vacancies (9% of RN total). HCA vacancies have increased slightly to 27 non registered vacancies

(20% of HCA total). Temporary nurses, mainly from GOSH Nurse Bank, employed on wards totalled 89 WTE, the April position was therefore minus 11 WTE.

3.2.3 A total of 61 Band 3 – 6 new starters commenced in March and April. The majority will now be on supernumerary practice for a period of 1 – 3 months depending on their experience and the environment in which they work.

3.2.4 New starters progressing through pre-employment checks total 13 registered nurses and 2 HCAs.

3.2.5 A further 14 Health Care Assistants were successful at the April Assessment Centre and have been offered posts to commence in June, these candidates will become the second cohort to participate of the Care Certificate programme. HCA recruitment to the ICUs is on currently on hold pending further work on the education pathway.

3.2.6 GOSH staff attended a further 2 University Graduate job fairs and hosted a GOSH Recruitment Fair. Approximately 180 visitors attended the event, the majority were students from across the UK who qualify in September 2015, feedback from the event has been very positive. The subsequent advertisement has received 195 applications which are going through the shortlisting process. Five assessment Centres have been organised in June for students seeking employment at GOSH from September onwards.

3.2.7 As a Trust we continue to sustain recruitment against a backdrop of well publicised national nurse shortages.

3.2.8 The 6 monthly nurse establishment reviews will complete in May 2015, Trust Board will receive the report in July.

4 Key Challenges

- Recruitment of HCAs in the Critical Care areas.
- Recruitment of Band 6 Nurses.
- Retention of Band 5 and 6 Nurses.

5. Key Quality and Safety Measures and Information

5.1 Hard Truths Commitments Regarding the Publishing of Staffing Data (Care Quality Commission, March 2014) states 'data alone cannot assure anyone that safe care is being delivered. However research demonstrates that staffing levels are linked to the safety of care and that fewer staff increases the risks of patient safety incidents occurring.' In order to assure the Board of safe staffing on wards the following nursing quality and patient experience information has been collated to demonstrate that the wards were safe during April 2015.

5.2 The following quality measures provide a base line report for the Board. A number are Key Performance Indicators (KPIs) are regularly monitored, any poor results are challenged and investigated through the Nursing quarterly performance reviews led by the Chief Nurse with each Divisional Nursing team.

5.3 **Infection control**

C Difficile		
MRSA Bacteraemias	0	
MSSA Bacteraemias	1	
E Coli Bacteraemia	0	

D & V and other outbreaks	0	
Carbopenamase resistance	1	

5.3.1 All incidents are investigated via a root cause analysis and additional support put in place by the Infection Prevention and Control team. In addition, those areas that experienced small outbreaks of infection are subject to comprehensive chlorine clean.

5.4 **Pressure ulcers**

	Number	**Ward**
Grade 3	**0**	
Grade 2	**3**	Bear, Badger, Flamingo

5.5 **Deteriorating patient**

5.5.1 For the month of April, 8 patient related emergency calls were received of which 2 were cardiac arrests (Flamingo and Robin Wards) there was 1 respiratory arrest. In addition 13 patients had unplanned admissions to Intensive Care.

5.6 **Numbers of safety incidents reported about inadequate nurse staffing levels**

1 description of a busy shift on PICU; Bank nurses were cancelled which compromised the ability to admit new patients, it became apparent as the night progressed that these staff were indeed needed.

5.7 **Pals concerns raised by families regarding nurse staffing - 0**

5.8 **Complaints re nurse safe staffing - 0**

5.9 **Friends and family test (FFT) data**

- Response rate for February was 33% decreasing slightly to 32% in March, with a further reduction to 30% in April (Target 25%).
- The FFT score 80 increased from 80 in March to 82 in April.
- No wards scored below a “0” FFT score for April.
- Families that were extremely likely to recommend their friends and family was 82% (236) with 15% (44) likely to recommend.
- 2 Families (0.7%) were extremely unlikely to recommend. Reasons cited relate to the environment and attitude of staff on Penguin Ward, the second the attitude of hospital reception staff.

6. Conclusion

6.1 This paper has provided The Board with the required overview and assurance that all wards were safely staffed against agreed safe staffing levels during April, and appropriate actions were taken when concerns were raised. All Trusts are required to ensure the validity of data by triangulating information from different sources prior to providing assurance reports to their Board of Directors, this has been key to compiling the report.

7. Recommendations - The Board of Directors are asked to note:

7.1 The content of the report and be assured that appropriate information is being provided to meet the national and local requirements.

7.2 The information on safe staffing and the impact on quality of care.

7.3 The bi annual establishment review process will be complete in May 2015, the Board will receive the outcome report in July 2015.

Attachment X

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RP4 Great Ormond Street Hospital For Children NHS Foundation Trust

Period: April_2015-16

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

Comments

Only complete sites your organisation is accountable for

Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night	
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	RP401	Great Ormond Street Hospital Central London Site - R	Badger Ward	340 - RESPIRATORY MEDICINE		2013	2605.9	299	425.5	1794	1980.1	299	152.6	129.5%	142.3%	110.4%	51.0%
	RP401	Great Ormond Street Hospital Central London Site - R	Bear Ward	170 - CARDIOTHORACIC SURGERY	321 - PAEDIATRIC CARDIOLOGY	2709	3011.6	587	539.08	2709	2620	338	304.5	111.2%	91.8%	96.7%	90.1%
	RP401	Great Ormond Street Hospital Central London Site - R	Flamingo Ward	192 - CRITICAL CARE MEDICINE		5428	6669.5	345	333.5	5175	6235.65	207	162	122.9%	96.7%	120.5%	78.3%
	RP401	Great Ormond Street Hospital Central London Site - R	Miffy Ward (TCU)	340 - RESPIRATORY MEDICINE		683	1007.2	1024	732.25	683	688.8	683	562.4	147.5%	71.5%	100.8%	82.3%
	RP401	Great Ormond Street Hospital Central London Site - R	Neonatal Intensive Care Unit	192 - CRITICAL CARE MEDICINE		2639	3169.5		207	2309	2605.3		151.2	120.1%		112.8%	
	RP401	Great Ormond Street Hospital Central London Site - R	Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5865	6451.9	345	299	5865	5277.23	345	237.6	110.0%	86.7%	90.0%	68.9%
	RP401	Great Ormond Street Hospital Central London Site - R	Elephant Ward	370 - MEDICAL ONCOLOGY	823 - HAEMATOLOGY	1633	1829.9	345	338.2	1380	1395	345	335.5	112.1%	98.0%	101.1%	97.2%
	RP401	Great Ormond Street Hospital Central London Site - R	Fox Ward	303 - CLINICAL HAEMATOLOGY	313 - CLINICAL IMMUNOLOGY and ALLERGY	2311	1629.5	343	325.85	1922	1293.3	343	328.9	70.5%	95.0%	67.3%	95.9%
	RP401	Great Ormond Street Hospital Central London Site - R	Giraffe Ward	313 - CLINICAL IMMUNOLOGY and ALLERGY	350 - INFECTIOUS DISEASES	1035	1069.5	345	195.5	1035	773.1	345	258.75	103.3%	56.7%	74.7%	75.0%
	RP401	Great Ormond Street Hospital Central London Site - R	Lion Ward	370 - MEDICAL ONCOLOGY	303 - CLINICAL HAEMATOLOGY	1633	1659.2	345	356.5	1380	1197.8	345	302.55	101.6%	103.3%	86.8%	87.7%
	RP401	Great Ormond Street Hospital Central London Site - R	Penguin Ward	330 - DERMATOLOGY	410 - RHEUMATOLOGY	943	943.5	345	619	690	655.1	345	112.2	100.1%	179.4%	94.9%	32.5%
	RP401	Great Ormond Street Hospital Central London Site - R	Robin Ward	350 - INFECTIOUS DISEASES	313 - CLINICAL IMMUNOLOGY and ALLERGY	1898	1678.39	331	294.55	1656	1253.6	331	318.8	88.4%	89.0%	75.7%	96.3%
	RP401	Great Ormond Street Hospital Central London Site - R	Bumblebee Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2369	2556.65	338	529	2030	1947	676	348.4	107.9%	156.5%	95.9%	51.5%
	RP401	Great Ormond Street Hospital Central London Site - R	Butterfly Ward	370 - MEDICAL ONCOLOGY	420 - PAEDIATRICS	2468	2065.25	308	671	1851	1040.85	617	226.8	83.7%	217.9%	56.2%	36.8%
	RP401	Great Ormond Street Hospital Central London Site - R	Eagle Ward	361 - NEPHROLOGY		2183	2158.45	675	443.7	1350	1386.85	337	271.65	98.9%	65.7%	102.7%	80.6%
	RP401	Great Ormond Street Hospital Central London Site - R	Kingfisher Ward	420 - PAEDIATRICS		1748	1685.6	897	609.5	331	412.5		21.6	96.4%	67.9%	124.6%	
	RP401	Great Ormond Street Hospital Central London Site - R	Rainforest Ward (Gastro)	301 - GASTROENTEROLOGY		730	829.28	534	402.18	534	611.92	534	239	113.6%	75.3%	114.6%	44.8%
	RP401	Great Ormond Street Hospital Central London Site - R	Rainforest Ward (Endo/Met)	302 - ENDOCRINOLOGY		1035	1147.8	690	149.5	1035	683.9	345	228.2	110.9%	21.7%	66.1%	66.1%
	RP401	Great Ormond Street Hospital Central London Site - R	Mildred Creak	711- CHILD and ADOLESCENT PSYCHIATRY		1022	1542.5	570	625	464	399.6	421	486	150.9%	109.6%	86.1%	115.4%
	RP401	Great Ormond Street Hospital Central London Site - R	Koala Ward	150 - NEUROSURGERY	421 - PAEDIATRIC NEUROLOGY	2458	2786.09	290	428.5	2787	2455.3		141.1	113.3%	147.8%	88.1%	
	RP401	Great Ormond Street Hospital Central London Site - R	Peter Pan Ward	120 - ENT	160 - PLASTIC SURGERY	1189	1710	461	327.5	1118	1190.8			143.8%	71.0%	106.5%	
	RP401	Great Ormond Street Hospital Central London Site - R	Sky Ward	110 - TRAUMA & ORTHOPAEDICS	171 - PAEDIATRIC SURGERY	1868	2130.75	651	618.5	1824	1416.7			114.1%	95.0%	77.7%	
	RP401	Great Ormond Street Hospital Central London Site - R	Squirrel Ward	171 - PAEDIATRIC SURGERY	101 - UROLOGY	2828	3143.05	668	741	2538	2389.2		23	111.1%	110.9%	94.1%	

Appendix 2: Overview of Ward Nurse Staffing – April 2015

Division	Ward	Established Bed Numbers	Registered Nursing staff: Proposed Funded Establishment	Registered Nursing staff: Staff in Post	Registered Nursing staff: Vacancies	Non Registered: Proposed Funded establishment	Non Registered: Staff in Post	Non Registered: Vacancies	Total Estabslishment	Total Vacancies	Bank Used	Net Vacant	Recruitment Pipeline: Registered Starters	Recruitment Pipeline: Non-registered Starters	Number of unsafe shifts	Average Bed Closures
CCCR	Badger	15	39.5	34.0	5.5	7.5	5.0	2.5	47.0	8.0	4.0	4.0	1.0	0	0	2.0
	Bear	22	47.8	42.0	5.8	9.0	6.0	3.0	56.8	8.8	4.7	4.1	1.0	0	0	0.4
	Flamingo	17	121.0	101.8	19.2	10.8	7.0	3.8	131.8	23.0	16.8	6.2	0.0	0	0	0.0
	Miffy (TCU)	5	14.0	12.5	1.5	7.8	6.0	1.8	21.8	3.3	4.5	-1.2	0.0	1	0	0.1
	NICU	8	51.5	41.8	9.7	5.2	1.0	4.2	56.7	13.9	7.8	6.1	2.0	0	0	0.4
	PICU	13	83.0	93.7	-10.7	8.9	5.0	3.9	91.9	-6.8	7.2	-14.0	2.0	0	0	0.0
ICI-LM	Elephant	13	25.7	23.0	2.7	4.9	5.1	-0.2	30.6	2.5	2.5	0.0	2.0	0	0	0.0
	Fox	10	31.0	23.0	8.0	5.2	5.0	0.2	36.2	8.2	4.1	4.1	2.0	0	0	0.1
	Giraffe	7	19.0	18.3	0.7	1.0	3.5	-2.5	20.0	-1.8	2.1	-3.9	0.0	0	0	0.0
	Lion	11	22.0	23.0	-1.0	5.2	4.0	1.2	27.2	0.2	2.8	-2.6	1.0	0	0	0.0
	Penguin	9	15.2	13.8	1.4	5.5	5.0	0.5	20.7	1.9	4.4	-2.5	0.0	0	0	0.0
	Robin	10	27.2	24.0	3.2	5.2	4.5	0.7	32.4	3.9	3.4	0.5	1.0	0	0	0.4
IPP	Bumblebee	21	38.3	34.4	3.9	9.7	8.6	1.1	48.0	5.0	6.4	-1.4	0.0	1	0	0.4
	Butterfly	18	37.2	29.4	7.8	10.5	10.0	0.5	47.7	8.3	1.2	7.1	1.0	0	0	2.1
MDTS	Eagle	21	39.5	34.5	5.0	10.5	10.0	0.5	50.0	5.5	1.3	4.2	0.0	0	0	0.2
	Kingfisher	16	18.2	17.2	1.0	6.2	4.8	1.4	24.4	2.4	0.8	1.6	0.0	0	0	0.0
	Rainforest Gastro	8	16.0	9.8	6.2	5.2	5.0	0.2	21.2	6.4	2.7	3.7	0.0	0	0	2.0
	Rainforest Endo/Met	8	15.7	16.1	-0.4	5.2	4.0	1.2	20.9	0.8	0.8	0.0	0.0	0	0	0.0
Neuro-sciences	Mildred Creak	10	11.8	15.2	-3.4	7.8	7.6	0.2	19.6	-3.2	0.0	-3.2	0.0	0	0	0.3
	Koala	24	44.7	45.2	-0.5	7.1	5.5	1.6	51.8	1.1	4.1	-3.0	0.0	0	0	3.8
Surgery	Peter Pan	16	24.5	23.0	1.5	5.0	4.0	1.0	29.5	2.5	0.4	2.1	0.0	0	0	4.1
	Sky	18	31.0	27.0	4.0	5.2	5.0	0.2	36.2	4.2	2.6	1.6	0.0	0	0	1.1
	Squirrel	22	43.6	41.6	2.0	7.0	7.0	0.0	50.6	2.0	4.3	-2.3	0.0	0	0	0.3
	TRUST TOTAL:	**322**	**817.4**	**744.3**	**73.1**	**155.6**	**128.6**	**27.0**	**973.0**	**100.1**	**88.9**	**11.2**	**13.0**	**2.0**	**0.0**	**17.7**

Great Ormond Street Hospital for Children NHS Foundation Trust NHS

Trust Board **22nd May 2015**	
Safeguarding Annual Report 2014-15 **Submitted by:** **Juliette Greenwood, Chief Nurse**	**Paper No: Attachment Y**
Aims / summary Provide a summary report of Trust progress, activity and achievements 2014-2015 and the identify challenges and priorities for 2015-2016.	
Action required from the meeting The Board of Directors are asked to note the priorities for the year ahead and continue to support the development of safeguarding children and young people arrangements.	
Contribution to the delivery of NHS Foundation Trust strategies and plans CQC Core Standard 2 Child Protection. Requirement also from NHS England (London) for Trusts to provide a Child Protection Annual Report.	
Financial implications None	
Who needs to be told about any decision? Juliette Greenwood - Executive Lead for Safeguarding	
Who is responsible for implementing the proposals / project and anticipated timescales? Juliette Greenwood	
Who is accountable for the implementation of the proposal / project? Juliette Greenwood	

Great Ormond Street NHS
Hospital for Children
NHS Foundation Trust

SAFEGUARDING OUR CHILDREN and YOUNG PEOPLE

ANNUAL REPORT 2014-2015

By

Juliette Greenwood - Chief Nurse & Executive Lead for Safeguarding

EXECUTIVE SUMMARY:

The Safeguarding Team have recruited up to full establishment enabling improved access for staff across the Trust.

Provision of training at all levels now meets or approaches the acknowledged standards of best practice.

Safeguarding supervision has been expanded further to clinical professionals and delivered in partnership with social workers.

New ways of working collaboratively with Social Care have been introduced.

Introduction of the Trust's safeguarding intranet to increase awareness and provide timely updates for all staff.

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1.0 INTRODUCTION:

The Children Act 1989 and 2004 (Section 11) places a duty upon all NHS Provider Services to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children. The Trust is expected to ensure that its' provider arrangements are robust and that safeguarding and promoting the welfare of children is integral to clinical governance and audit arrangements. The Care Quality Commission (CQC) and the Trust's commissioners NHS England (London) and Camden Commissioning Group (CCG) require assurance that good standards of care are met and maintained.

This annual report relates to the period from 01/04/2014 – 31/03/2015.

2.0 GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS:

Safeguarding Team:

The Safeguarding Team is accountable to the Chief Nurse who is the Executive Lead for Safeguarding, and comprises;

- Head of Safeguarding and Named Nurse 1 WTE
- Named Doctor 4 programmed activities
- Band 7 Specialist Safeguarding Nurses (2 part time posts) 1.1 WTE
- Senior Safeguarding Team Administrator 1 WTE
- Junior Administrator 0.7 WTE

Although now at full establishment the team continue to experience an increase in the number of requests for involvement within Serious Case Reviews (SCRs) and other types of reviews. The nature of Great Ormond Street Hospital's (GOSH) contribution to SCRs and the numbers that the hospital are consecutively involved with can appear disproportionate. This contributes significantly to the pressures experienced by the safeguarding team.

GOSH Social Work Service:

The service consists of a Team Manager, 4 senior practitioner (clinical / management posts), 17 Social Worker (SW) posts, 3 Family Support Workers / Officers and 1 Psycho-Social Liaison worker.

When any member of staff identifies child protection concerns, they make a referral to the Social Work service. This can be done through an electronic referral or verbally to their allocated or duty social worker. The Social Work service at GOSH provides social work support to all wards and units within the hospital.

There were 2,535 referrals made to the Social Work service in 2014/15. This is an increase of 25 per cent from 2013/14. Of these referrals, 290 (11 per cent) were related to child protection (CP) concerns, compared with 246 CP-related referrals in 2013/14.

2014/15 has seen a growth in the total numbers of patients, occasions of service and hours spent on each child by the Social Work team. A similar growth occurred in work done with patients where child protection was an issue. This is in part due to improvements in the activity data collection system, as well as an actual increase in referrals and complexity of cases (including child protection) being referred to the Social Work team. Whilst there was an increase in the number of child protection cases in 2014/15, it remained a similar percentage of the overall work compared to the previous year.

Within the Trust the Governance arrangements that support the delivery of safeguarding are the following two corporate groups:

Safeguarding Children Group (SCG)

The SCG meets six weekly and is chaired by the Chief Nurse. The Designated Safeguarding Professionals from Camden attend quarterly.

The priority of the SCG has been to ensure compliance with the requirements of the commissioners and the internal Trust reporting structure. A particular focus has been on increasing electronic and written referrals to social work, record keeping in child protection cases, supervision and the development of a chronology template for complex cases.

Clinical Governance Committee (CGC)

The Safeguarding Team provides quarterly reports to the Clinical Governance Committee outlining the breadth of safeguarding activity delivered within the Trust and providing assurance of compliance against required standards and statutory framework.

3.0 ACHIEVEMENTS AND ACTIVITIES:

Performance against key priorities for 2014 / 15 - Action Plan update

Action last report	Report
Achievement of external regulatory/contractual	*The Trust provides assurance to the commissioners for safeguarding in both NHS England (London region) and Camden*

| standards and metrics e.g. CQC; Camden CCG; DH. Commissioners' reports and external inspections demonstrate that GOSH are meeting the standards required. | *Clinical Commissioning Group*.

Training
To ensure progress with Levels 1-3 is maintained and the Trust moves towards the gold standard of 95%.

Members of staff are trained to the required competency level which exceeds the requirements (80%) of our commissioners. A bespoke e-learning has been developed, funded by the GOSH Charity, to meet the on-going training requirements. This will be introduced in 2015/16.
The training figures as at 31.03.2015 were:
Level 1 - 96%
Level 2 – 89%
Level 3 – 94%

Awareness of the PREVENT agenda is being incorporated into all levels of safeguarding training and more detailed training to appropriate staff will commence in 2015/16.

Themed study days are influenced by factors identified within serious case reviews as well as national issues. Training days have been held on subjects such as Child Sexual Exploitation and Fabricated and Induced Illness. For the forthcoming year themed sessions will provide staff with an opportunity to increase their knowledge of neglect, Domestic Abuse, Impact of Mental Health on the Child and Family and Cultural Awareness.

Supervision:
Ensuring identified health practitioners receive regular structured safeguarding supervision.

Ofsted's recommended that provider services across Camden's health economy, improve access to regular supervision for professionals. The Safeguarding Team works with Social Work and Psychology and provided 115 sessions (involving 565 staff) of Supervision activity in 2014/15.

Camden Safeguarding Children Board (CSCB) and sub groups.
The GOSH Executive Lead for Safeguarding Children attends CSCB. The Named or Specialist Professionals attend CSCB Sub groups for NHS, Quality Assurance and Learning & Development. Attendance at meetings was above 80% for 2014/15.

Respond to invitations to Case Conferences.
The prediction of the number of invitations to Child Protection Conferences is difficult.

The Trust received 54 invitations to Initial or Review Conferences. Of these, 31 were attended by staff and 23 had reports submitted. Attendance is limited by geographical constraints and demand on available resources.

The Safeguarding Team and Social Work Manager have developed a combined template for child protection conferences to facilitate the sharing of relevant information with external |

	professionals. **Ensure that GOSH organisational policy and procedures are compliant with Working Together, NHS Accountability Framework, and London CP Procedures** The Safeguarding Children Policy has been reviewed and updated as necessary in line with statutory guidance. A review of the Vulnerable Adults Policy is complete. **Disclosure and Barring Scheme (DBS)** There is a 100% compliance of substantive and bank staff who have a current status. HR re-check staff on a three yearly basis and also ensures that all honorary staff have up to date clearance. Their work has been audited independently by KPMG in 2014.
Extend Audit Activity	**Audit** *Completion of the Record Keeping Audit review in order to capture the recommendations from Munro, changes in Working Together and Ofsted/CQC Inspection standards.* The Trust has a robust audit programme to provide assurance that safeguarding systems and processes are working. Outcomes of the audit activity are reported to SCG and the CGC as an assurance perspective. The quarterly audit of '*Our Children's Journey'* considers the care and experience of our patient's from outpatient attendance, admission through to discharge. During the year the audit has demonstrated an increased compliance with all standards pertaining to child protection referrals made from 64% to 78% in the last audit in April 2015. Improvements have been achieved by the addition of electronic alerts. The Safeguarding and Social Work teams share information on children newly confirmed as having CP concerns This minimises the risk of an alert not being added in a timely way. GOSH participates in the Camden LSCB Multi Agency Audit Process. This has highlighted the need to improve notification to the Trust of children who are subject to CP Plans.
Improve systems for managing complex cases; chronologies and electronic flagging	**Complex cases to have an identified lead professional where multiple medical teams are involved and development of a management pathway. Develop a clinical database for outcome tracking.** The weekly complex gastro-enterology meetings have been established and are attended by multi-disciplinary professionals, the social work service, and chaired by an Honorary Consultant. The collaborative project is working well and ensures that the health needs of complex patients are identified in a more timely manner. A pathway for management of cases within the project has been devised and it is anticipated that this model will be tested furthering other areas. A database has been established to capture outcomes
Develop Safeguarding Intranet site	The Safeguarding webpage is now a resource to provide information to staff on key developments in Safeguarding Children and Young People.

Develop Safeguarding Link Groups / divisional meetings	**Safeguarding Children & Young People Link Networks for Nurses and Allied Health Professionals (AHP).** A trust-wide network meets quarterly to provide learning, dissemination of research and policy as well as information sharing. This is cascaded to each different clinical areas of the Trust. The meetings are jointly facilitated by the Named Nurse and Social Work Team Manager. The focus of the quarterly meetings has been to ensure awareness of the Safeguarding Children and Supervision Policies, learning from Serious Case Reviews and Female Genital Mutilation (FGM). A study day was held in December 2014 for Nursing and AHP professionals with a focus on Domestic Abuse and Accommodation Syndrome and skills for making robust referrals to Social Work. **Reviewing the Model of the Divisional Safeguarding Management Group meetings** Safeguarding Management Groups have been established in each Division to facilitate discussion on challenges as well as good practice identified within each locality. The Divisions have been consulted on the most appropriate format for dissemination of information. Future meetings will be flexible 3-6 monthly meetings with interim written reports where appropriate.
Establish involvement in CP Information Sharing Project CP-IS	In 2013, Ofsted recommended that health providers should have a robust system in place to identify children who are subject to a Child Protection Plan. There have been delays for Connecting for Health in the system 'going live'. The system will identify those children on a Child Protection (CP) plan and Looked after Children (LAC) in a timely manner if all local authorities have engaged. Recommendations by external inspectors, as well as findings from multi-agency audits within Camden, have highlighted the need to improve identification of this cohort of children.

Case Reviews and Serious Case Reviews

The Trust has contributed to 8 Serious Case Reviews (SCR), involving 14 children and one young adult who had recently transitioned into adult services.

The SCR process can be stressful for staff who are involved and support is provided by the Trust as individuals require it.

Action Plans from recommendations of reviews are monitored internally through the SCG and externally by the Local Safeguarding Children Boards.

Learning from SCRs

The identified learning is incorporated into the mandatory training programmes, themed study days, safeguarding newsletter and intranet pages as well as ensuring robust reflection in policies and guidance. These include:

- Management of bruising in babies and non-ambulant children,
- Stream lining the training requirements of the various contracts provided to honorary professionals and those staff on placements and observational visits.

- The Monitoring of mandatory training requirements for all staff through their personal development reviews.
- Raising awareness of staff to escalate any child protection concerns appropriately.
- The enhancement of awareness through training, electronic updates and intranet and updating policy where applicable on a range of issues including: addressing parental non-adherence to medical recommendations, management of shared care cases where there are safeguarding concerns, management of records and review of transition protocol for young people from paediatric to adult services.

Reviews not meeting SCR threshold

A peer learning review was held for safeguarding professionals, which has led to study day being arranged for GOSH staff on the issue of neglect.

There have been two reviews that did not meet the threshold for a Serious Case Review.

Chronologies

The Trust has received 15 external requests to contribute to comprehensive chronologies for children, which have been completed.

Risk

The Clinical Governance and Safety Team were consulted about 40 families in relation to safeguarding concerns; and for 22 of these families a meeting took place to consider appropriate management of the risk posed.

There were 42 incidents reported with a category of safeguarding/child protection on Datix.

Department of Health (DH) Investigation into Savile.

The DH published the report on 26th June 2014, along with the individual reports from 28 organisations in which there had been allegations of abuse by Jimmy Savile.
GOSH was one of those 28 trusts and was identified as having had completed a thorough investigation. There was no evidence found to substantiate the allegation made that Savile had abused a child in the Trust during the early 1970s.
In line with all other NHS providers the Trust will provide further assurance that both local learning and that identified nationally in the recently published report *Themes and Lessons Learnt from NHS investigations into matters relating to Jimmy Savile: The Lampard Report* (2015) will be submitted as required in June 2015 to Monitor.

Improving multi agency working between Safeguarding and Social Work Teams
At the end of 2014 a daily meeting to share information was introduced. The aim is to improve collaborative working. A shared data base for these cases has been established.

In addition senior managers from Social Work meet with the Named Professionals fortnightly to ensure the services are complementary.

Expanding safeguarding resources for staff
Newsletter to staff
The first edition of the Safeguarding Newsletter was circulated to staff in January 2015. The newsletter (published six monthly) aims to keep staff updated about recent developments in policy practice and research, and acts as a stimulus to good practice.

4.0 CHALLENGES AND PRIORITIES FOR 2015-2016

Challenges

- Effective supervision of cases and activity to ensure reliability is subject to the pressures associated with the workload.
- In line with the Lampard recommendations (R5) an internal review of the safeguarding resource to meet the increased complexity of the case load needs to be undertaken in line with the trust agreed time frame
- The effectiveness of the safeguarding training programmes in delivering the required changes in practice
- Safeguarding supervision of staff will need further development and this may be challenging within the current constraints.

Priorities

- Exceed external regulatory/contractual standards and metrics.
- To undertake the required internal review of the safeguarding resources required by the Trust.
- Increase the uptake of supervision for staff.
- Extend audit activity to incorporate recommendations from Serious Case Reviews and other types of case review and the effectiveness of staff training.
- Incorporate national initiatives such as the PREVENT agenda and learning from Serious Case Reviews into the mandatory safeguarding training programme.
- To progress as appropriate the involvement in the CP Information Sharing Project CP-IS.

RECOMMENDATION

The Board of Directors are asked to note the priorities for the year ahead and continue to support the development of safeguarding children and young people arrangements.

Great Ormond Street Hospital for Children NHS Foundation Trust NHS

Trust Board 22nd May 2015	
Annual Risk Management Report 2014/15 **Submitted by:** Dena Marshall, Acting Chief Operating Officer	**Paper No: Attachment 1**

Aims / summary

Summary and overview of patient safety incident activity over the last year.

This includes:

- Analysis of reporting levels
- Analysis of reported incidents
- Levels & types of harm reported
- Incidents reported externally
- Analysis of Trust wide themes and the management of identified risks

Action required from the meeting

Board Members are encouraged to review the incident trends highlighted and learning from SI reports and disseminate these in their areas.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Through learning lessons and implementing risk mitigating actions to address incident trends the Trust is working towards achieving its goal of zero harm.

Financial implications

None

Who needs to be told about any decision?

N/A

Who is responsible for implementing the proposals / project and anticipated timescales?

N/A

Who is accountable for the implementation of the proposal / project?

N/A

Annual Risk Management Report

April 2014 – March 2015

Executive Summary
This report provides a summary and overview of patient safety incident activity over the last year.

This includes:
- Analysis of reporting levels
- Analysis of reported incidents
- Levels & types of harm reported
- Incidents reported externally
- Analysis of Trust wide themes and the management of identified risks

Appendix 1 includes details of all SIs which have been opened since April 2014. Please click here for the full details, which are available on the Clinical Governance and Safety Intranet site:

Appendix 2 includes details of all current high risks which have been opened since April 2013. Please click here for the full details, which are available on the Clinical Governance and Safety Intranet site:

1. Incident Reporting Levels

1.1 Internal Analysis

There were 5250 patient safety incidents reported in the last year (April 14 – March 15) via the Trust's incident reporting System. **Fig. 1** demonstrates the trends in the numbers of incidents reported year on year since 2010.

The graph shows a 16% increase in incident reporting from year '13/'14 and year '14/'15.

Overall there has been a consistent rise in incident report since the web based electronic reporting system was first implemented in April 2011. This demonstrates the effective use of the on line system and that staff not only identify incidents but feel confident in reporting them. The risk management team will continue to work with the Divisional teams to ensure that incident reporting levels continue to rise.

Fig.1

1.2 Analysis of incident reporting Trends following implementation of web reporting

The Trust implemented an online incident reporting system (DATIXWeb) in April 2011. This was to improve on the timeliness of incident reporting to aid accurate analysis of trends.

Since the implementation of DATIXWeb the Risk Management team have been monitoring the effectiveness of the system. Between April 2010 and March 2011 the Trust received 3389 patient safety incident reports. After implementation of DATIXWeb in April 2011 there has been a consistent rise in the number of patient safety incidents reported. Between April '11 and March '12 the number rose by 5%, this was followed by a 14% rise and then 16% rise respectively.

There has been an decrease in the time taken to report incidents after they occur (from days in '13/'14 to an average of 3 days in '14/'15). However, there has been an increase in the time taken to process these incidents once they have been reported. This has an impact on the time taken to close the incident from the date of submission. The risk management team will continue to work with the Divisional management teams to understand the reasons for the delays and to reduce the risk of them occurring again.

2. Analysis of reported incidents (including level of harm)

Of the 5250 patient safety incidents reported in this period, 25 were reported as causing significant harm. 255 were reported as moderate harm. 1304 were reported as causing minor harm and 3665 were reported as causing no harm.

In 2013/14 97% of incidents that were reported resulted in no harm or low harm. This year there has been a slight decrease of 95% no or low harm to reported.

Severity of incident	Number of incidents	Percentage of incidents
No harm	3665	70%
Low	1304	25%
Moderate	255	5%
Major	21	0%
Catastrophic	4	0%

Being open with patients and their families at all times including when something goes wrong is a key component of developing a safety culture; a culture where all incidents are reported, discussed, investigated and learned from.

New and revised regulations that came into effect at the end of November 2014 decree for the first time that a failure to be candid on the part of NHS Bodies in certain circumstances is a criminal offence. Therefore, the Trust has legal and contractual requirements in addition to its moral and ethical requirements to ensure that patients and/or their families are told about patient safety incidents that affect them that result in moderate harm, severe harm or death (by NPSA definitions).

In the period specified the Trust informed 65% of families where a 'harm' incident occurred, 28% were not informed and 8% were marked as 'not appropriate'.

Incident reporting levels can be used as an indication of an organisation's safety culture. The sign of a safe reporting culture is one in which there continues to be high numbers of incidents reported, but that the level of harm caused by those incidents decreases. The overall Trust picture is shown in **Fig. 4** below.

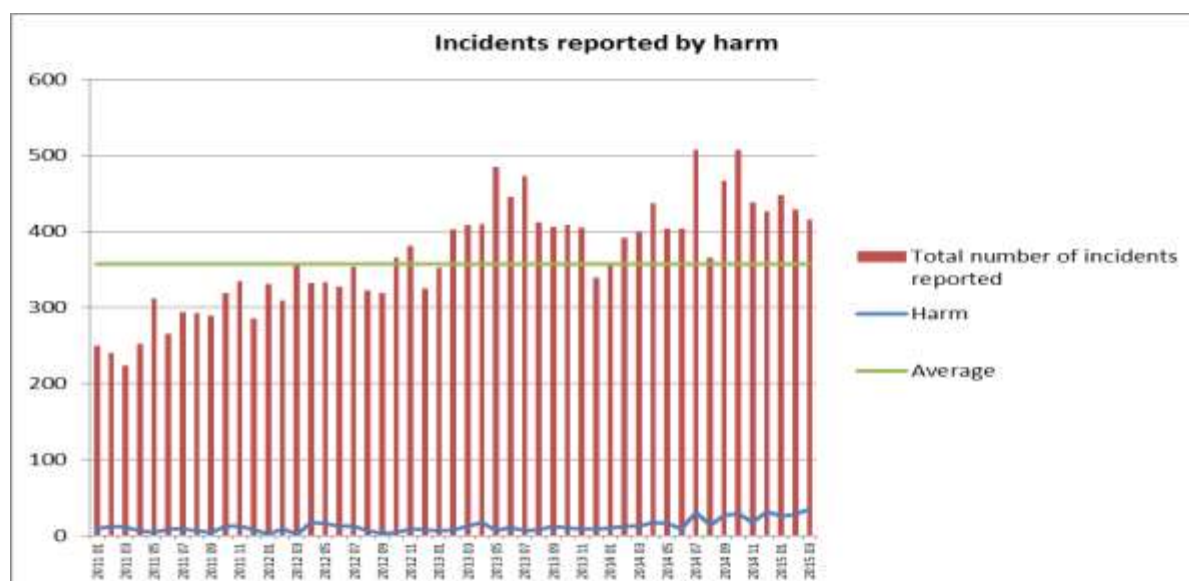
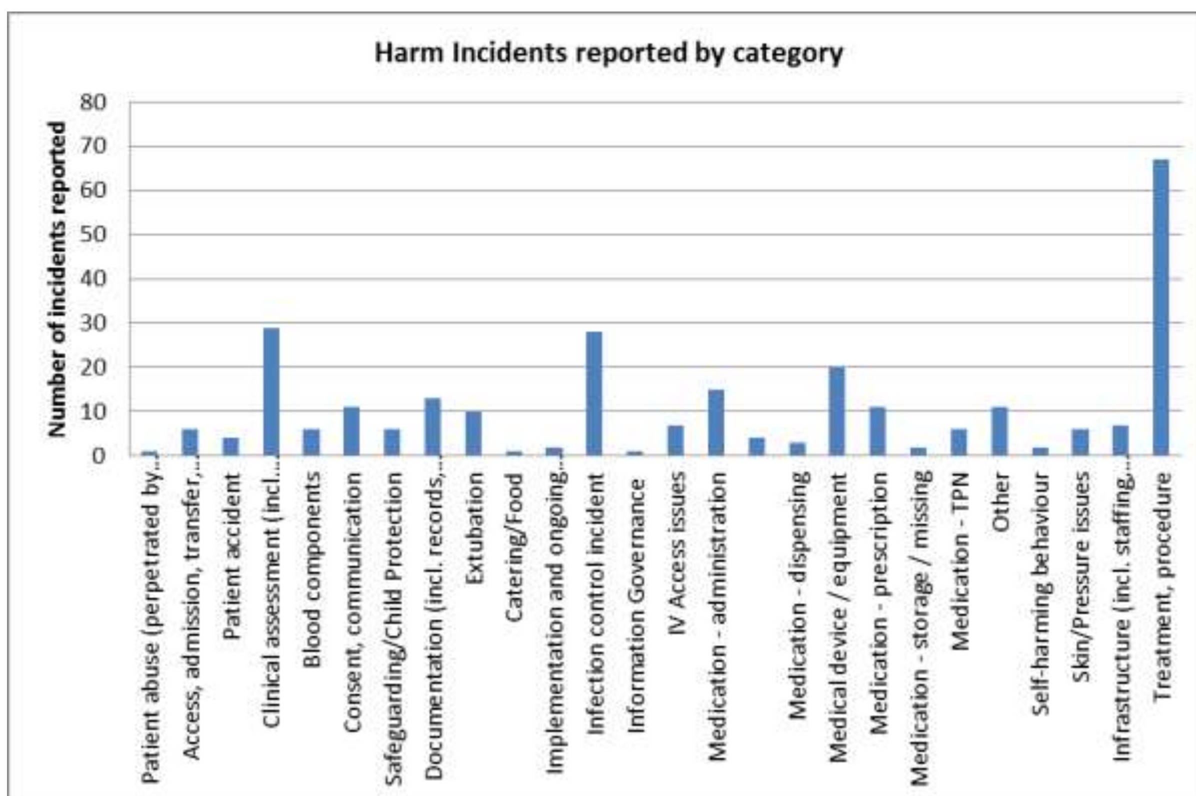


Fig. 4 above shows that the total number of harm incidents reported is variable

3. Type of harm caused
In 2014-15 the top 3 types of harm caused by reported incidents were:

- Treatment, procedure (67 incidents)
- Clinical assessment (incl. diagnosis, tests, assessments) (29 incidents)
- Infection control (28 incidents)



Treatment, procedure
Treatment/Procedure incidents accounted for 67 of the incidents reported in the Trust.

The types of incidents included in this category were:

- Unexpected deterioration leading to additional procedure/prolonged period of care (9)
- Complication of procedure (11)
- Delay / failure in recognising complication of treatment (2)
- Treatment / procedure – delay / failure (12)
- Extravasation injury (10)
- Failure to discontinue treatment (1)
- Treatment / procedure – inappropriate (2)
- Retained needle / swab / instrument (1)
- Transfer – delay / failure (1)
- Unexpected deterioration of patient leading to crash call (2)
- Other (7)

9 of these were investigated as part of SI investigations. The learning from SIs closed for this period is included in **Appendix 1.**

There are currently 9 Treatment, procedure risks open on risk registers throughout the trust. These include:

- 2 Low risks
- 5 Medium risks
- 1 High risks

5 of these were opened between April 2014 and March 2015.

4 of these risks have been opened for over 12 months.

	High risk	Medium risk	Low risk	Total
Cardio-respiratory Services	0	1	0	1
MDTS	1	0	0	1
Neurosciences	1	2	0	3
Surgery	1	2	1	4
Totals:	3	5	1	9

Clinical assessment (incl. diagnosis, tests, assessments)
Clinical assessment accounted for 29 of the incidents reported in the Trust during this period. The breakdown for these is as follows:

- Test results - failure / delay to interpret or act on (2)
- Tests - failure / delay to undertake (1)
- Delay / difficulty in obtaining clinical assistance (3)
- Diagnosis – delay / failure to (4)
- Diagnosis – wrong (2)
- Scan / x-ray / specimen – processing error (1)
- Failure to follow up missed appointment (1)
- Scan / x-ray / specimens – inadequate / incomplete (1)
- Assessment – lack of clinical or risk assessment (3)
- Failure to follow policy (1)
- Specimen damaged / lost / leaking during transport (1)
- Other (3)

3 of these were investigated as part of SI investigations. The learning from SIs closed for this period is included in **Appendix 1.**

There are currently 12 clinical assessment risks on the Trust wide risk register which are being managed at a local level. These include:

- 4 Low risks
- 4 Medium risks
- 4 High risks

6 of these were opened between April 2014 and March 2015.

6 of these risks have been opened for over 12 months.

	High risk	Medium risk	Low risk	Total
Cardio-respiratory Services	1	0	3	4
ICI-LM	0	1	0	1
MDTS	0	0	1	1
Neurosciences	1	1	0	2
Research & Innovation	1	0	0	1
Surgery	1	2	0	3
Totals:	4	4	4	12

Infection control

There were 28 infection control incidents during this period. The breakdown for these is as follows:

- Test results – failure / delay to interpret or act on (1)
- Hospital acquired infections patients (22)
- Other (4)

2 of these incidents was investigated as part of a SI investigation, as the infection was listed on the death certificate as contributing to her death. The learning from SIs closed for this period is included in **Appendix 1.**

There are currently 15 Infection Control risks on the Trusts wide risk register which are being managed at a local level. These include:

- 4 Low risks
- 9 Medium risks
- 2 High risks

4 of these were opened between April 2014 and March 2015.

6 of these risks have been opened for over 12 months.

	High risk	Medium risk	Low risk	Total
Cardio-respiratory Services	1	2	0	3
Facilities	0	2	0	2
ICI-LM	0	1	1	2
International & Private Patients	0	0	1	1
Medicine-Diagnostic & Therapeutic Services (DTS)	0	0	1	1
Trust wide	1	4	1	6
Totals:	2	9	4	15

4. External Reporting

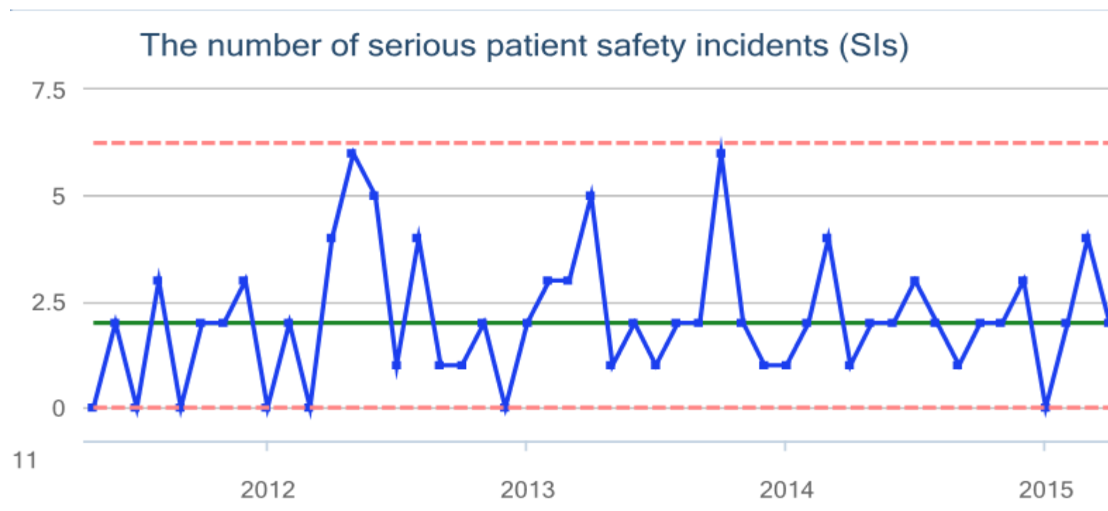
NHS London

To enable the Trust to achieve the goal of zero harm it is important that all staff are able to openly report and discuss incidents which result in, or may result in, harm to patients. By reporting incidents of all levels of severity it is possible to analyse and identify the systemic changes that the Trust needs to make in order to improve the safety of our patients and staff. It is important that the Trust Board is aware of all SIs.

The Trust has reported 23 SIs in 2014-15. 20 of these incidents were directly related to patient care.

The chart below indicates the occurrence of SIs in the Trust between April 2010 and March 2014. SIs are not just concerned with incidents that cause harm to patients; they include

incidents relating to the loss/misuse of confidential information, fires, child protection, ward closures and incidents likely to attract adverse media attention.



The data above is presented in Statistical Process Control (SPC) charts, which allow you to see the difference between common cause (normal) variation and special cause variation. The red lines are the upper and lower control limits and data which falls within these limits are within common cause variation. When using SPC charts, we are looking for special causes, which result from a significant change in the underlying process.
SPC is the tool that we use to determine where a change in practice has led to an improvement.

5. MHRA Alerts
The MHRA send frequent alerts to the Trust via the Central Alerting System (CAS). Each alert specifies a different timescale for action and completion depending on the severity of the alert and the actions required.

Between April 2014 and March 2015 the Trust received 129 MHRA Alerts. 17of the alerts received were relevant to the Trust and the actions have been completed.

The other alerts received may be Rapid Response Reports or Patient Safety Alerts from NPSA or Estates Notices from the Department of Health. 76 Alerts of this type were received by the Trust during 2014-15. 23 of these required action by the Trust and were completed. 2 are still under review.

6. Persons who may pose a risk to Children
In July 2014 a review of the 'Persons who may pose a risk to Children' process was undertaken. The responsibility for chairing the meetings under s.14 of the Child Protections Policy (Persons who may pose a risk to children) was changed from the Risk Management Team to the Heads of Nursing.

Under the new process, when the Heads of Nursing are informed by the social work team that a patient, parents, carer or relative who is planning to visit the Trust poses a risk to children a meeting is held. The Risk Management Team provide support and guidance on this process.

For this year, the Risk Management team were contacted regarding 40 families, 22 resulted in a 'Persons who may pose a risk to Children' meeting.

7. Risk Register Analysis

7.1 General

There are currently 289 open risks on the Datix Risk Management system. 107 of these were opened between April 2014 and March 2015. A full listing of the high risks opened during this period is in **Appendix 2.**

Of the 107 risks opened:

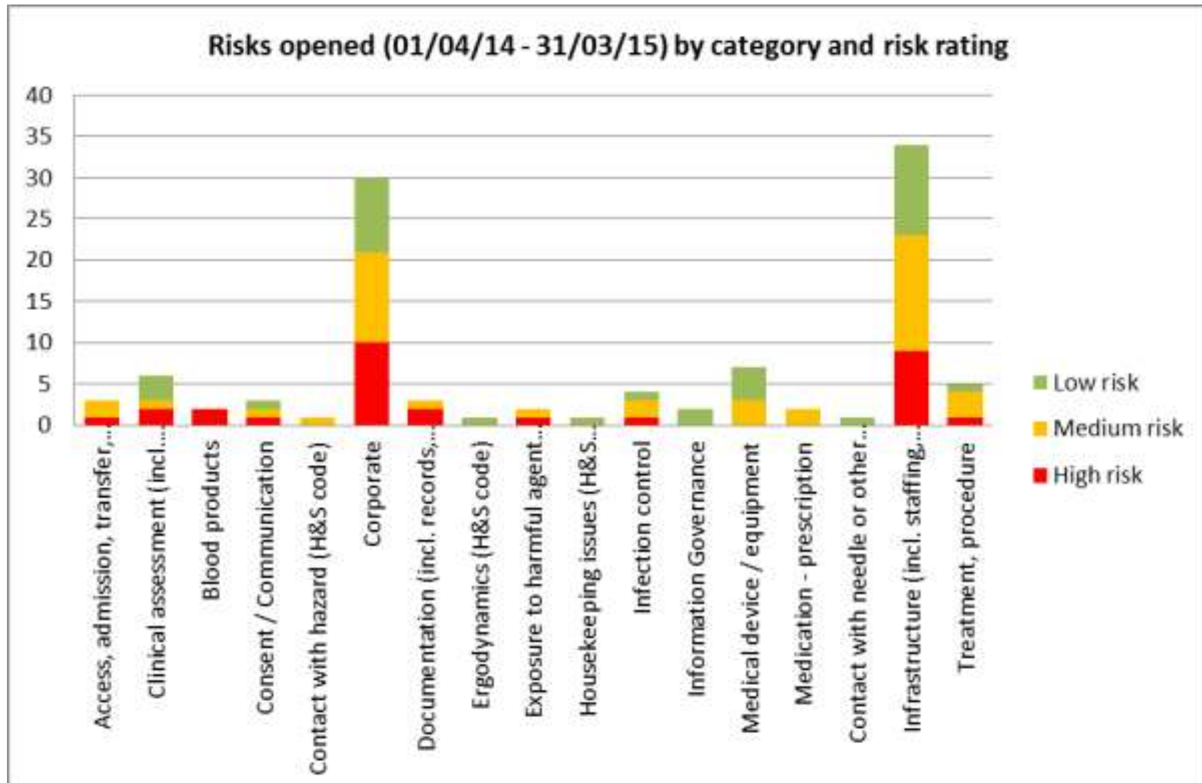
- 30 were graded as high
- 42 were graded as medium
- 35 were graded as low

There were 205 risks closed during this period. Of the 205 risks that were closed:

- 11 were graded as high
- 51 were graded as medium
- 143 were graded as low

5.2 Risk Types

Each risk is categorised upon entry to the Datix system to allow for analysis. Within each category the number of risks at each risk grade (High, Medium, and Low) can be seen in the chart below.



The top risk opened in 2014-15:

- Infrastructure (34)

The majority of these risks are regarding lack of maintenance of equipment.
Other types of infrastructure risks are regarding:

- Environmental issues (space for storage / working conditions (such as lack of air conditioning provision).
- Staffing (including recruitment, sickness)
- Meeting CRES/ financial targets)
- Risks related to ongoing building works.

In total there are 78 Infrastructure risks open.

	High risk	Medium risk	Low risk	Total
Cardio-respiratory Services	4	2	2	8
Estates	0	3	4	7
Facilities	1	4	3	8
Finance	1	3	3	7
ICI-LM	3	4	2	9
International & Private Patients	1	1	3	5
MDTS	3	6	11	20
Redevelopment	0	1	0	1
Research & Innovation	0	3	0	3
Surgery	0	3	0	3
Trust wide	0	1	2	3
Neurosciences	0	0	4	4
Totals:	13	31	34	78

39 of these have been opened for over 12 months.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board **22nd May 2015**	
Review of Quality Governance Framework **Submitted by:** Robbie Burns, Director of Planning & Information	**Paper No: Attachment 2**
Aims / summary Every year the Trust is required to assure the Board that it meets the requirements of the Quality Governance Framework. This is done by completing a self-assessment document (attached). Based on this assessment the Board are required to sign the Monitor statement. Our self-assessment has concluded a score of 0.5, the only amber / green score relating to data quality. Whilst there are many examples of good data quality management, e.g. coding, national SUS submissions, there are areas where the quality of data is less assured. An example would be the quality of our RTT reporting. This issue is being dealt with proactively and an action plan is being developed with support from national NHS specialists.	
Action required from the meeting The Board are required to review the self-assessment document it and sign the Monitor statement.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Required as part of the governance process for NHS Foundation Trusts	
Financial implications N/A	
Who needs to be told about any decision? The Board	
Who is responsible for implementing the proposals / project and anticipated timescales? N/A	
Who is accountable for the implementation of the proposal / project? Chief Executive Officer	

Attachment 2

Review of Quality Governance Framework 2014/15

A risk rating has been assigned to each of the ten components of quality governance on a red, amber/red, amber/green, green scale as detailed in the table below.

Risk rating	Scoring	Definition	Evidence
Green	0	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber/Green	0.5	Partially meets expectations but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, has no major omissions and robust action plans to address perceived shortfalls with proven track record of delivery
Amber/Red	1	Partially meets expectations but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in early stage of development with limited evidence of track record of delivery
Red	4	Does not meet expectations	Major omission in Quality Governance identified. Significant volume of action plans required and concerns on management capacity to deliver.

When Monitor assesses Trusts for authorisation, they expect Trusts to demonstrate:

- a Quality Governance score of less than 4 with an overriding rule that none of the four categories of the Quality Governance Framework (Strategy, Capabilities and Culture, Structures and Processes and Measurement) to be entirely Amber/Red rated; and
- for those applicants that have been assessed by an external auditor (experienced in quality governance reviews), a clean (unqualified) opinion on Quality Governance.

Quality Governance – Self assessment 2014-15 - overall summary

Strategy	Capabilities and Culture	Processes and Structures	Measurement
1A: Does Quality drive the Trusts' strategy? **Proposed RAG rating:** **Green**	2A: Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? **Proposed RAG rating:** **Green**	3A: Are there clear roles and accountabilities in relation to quality governance? **Proposed RAG rating:** **Green**	4A: Is appropriate quality information being analysed and challenged? **Proposed RAG rating:** **Green**
1B: Is the Board sufficiently aware of the potential risks to quality? **Proposed RAG rating:** **Green**	2B: Does the Board promote a quality focused culture throughout the Trust? **Proposed RAG rating:Green**	3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? **Proposed RAG rating:** **Green**	4B: Is the Board assured of the robustness of the quality information **Proposed RAG rating:** **Amber/ Green** **Issues:** Data quality assurance.
		3C: Does the Board actively engage patients, staff and stakeholders on quality? **Proposed RAG rating:** **Green**	4C: Is quality information used effectively? **Proposed RAG rating:** **Green**

Quality Governance – Self assessment May 2015 – Examples and evidence

1. Strategy	Rating	Lead	Example Good Practice	GOSH evidence
1a: Does quality drive the Trust's strategy?	GOSH Self-Assessment: Green	Lisa Kelly	Quality is embedded in the Trust's overall strategy	• Quality is inherent in the Trust's vision statement "to be the leading children's hospital in the world" • The Trust recently reviewed and agreed a revised set of strategic goals. The first of which relates specifically to clinical outcomes and patient & family experience. • The annual plan describes what will be done each year to deliver these strategic goals. • The Quality strategy outlines our overall approach to quality and is annually updated by Trust Board

		Meredith Mora / Caroline Joyce	The Trust's strategy comprises a small number of ambitious Trust-wide quality goals covering safety, clinical outcomes and patient experience which drive year on year improvement	○ Safety: our goal is "Zero Harm", and we strive for continuous improvement in the reduction of :
				    ○ Central venous line infections (CVLs)
				    ○ Cardiac and respiratory arrests outside ICU
				    ○ Medication errors
				○ Quality Improvement Committee established in March 2015 and chaired by the CEO
				○ Clinical Outcomes: our objective is to "Consistently deliver world class clinical outcomes". We have outcome measures for almost all specialties in the hospital, and those that can be benchmarked internationally include:
				    ○ Mortality rates in cardiology and cardiac surgery
				    ○ BMT outcomes benchmarked with European providers
				    ○ Renal transplant outcomes
				    ○ Gastroenterology inflammatory bowel disease
				    ○ HIV is benchmarked across Europe, and Cleft, Lip and Palate and Cystic Fibrosis across UK
				
				○ Patient experience: our objective is to "Consistently deliver an excellent and compassionate experience for all of our patients and families". We measure this through:
				
				○ Annual patient and family surveys
				○ Surveys of referrers
				○ Local Surveys in clinical areas
				○ The friends and family test for patients, families and staff.
				○ Staff Survey

		Meredith Mora /	Quality goals reflect local	• Examples of national priorities include: C diff, MRSA, MSSA, WHO surgical

1. Strategy	Rating	Lead	Example Good Practice	GOSH evidence
		Caroline Joyce	as well as national priorities, reflecting what is relevant to patient and staff	checklist • Examples of local priorities are: CVL Infections, medication errors, management of the deteriorating patient, surgical site infections and pressure ulcer reduction • Improvement projects are driven by direct patient feedback. • We have now implemented the friends and family test across inpatient wards, day care areas and outpatients. Our response rate has increased from 15% in April 2014 to 32% in March 2015 with 97% per cent of families likely to recommend the hospital to a friend or family member. • Patient experience is measured across the hospital and it is ensured 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 wider public via our membership, patient and member surveys, listening events, focus groups, the use of social media, and asking patients and families about their experience within 48 hours of discharge.
		Zoe Egerickx	Quality goals are selected to have the highest possible impact across the overall Trust	• Targets selected from issues identified through: o Learning from other healthcare organisations (e.g. Cincinnati, Boston) o Proactive identification of issues at GOSH e.g. through use of the Executive Safety Walkround o Reactive analysis of incidents and complaints o Learning from other non-healthcare organisations (e.g. through Risky Business)
			Wherever possible, quality goals are specific, measurable and time-bound	• Annual reduction target, overall target • Monitored using run charts, dashboards and analysis of special causes by Quality improvement team • Targets and indicators report has targets and benchmarks
			Overall Trust-wide quality goals link directly to goals in divisions/services (which will be tailored to the specific service)	• Annual planning process for clinical divisions, including quality goals • Clinical division plans • Quality improvement plans • Revival of quality improvement committee • Realigning performance dashboards
			There is a clear action plan for achieving the quality goals, with designated lead and timeframes	• Clear action plans with designated leads and timeframes are included within the: o Clinical outcomes development plan o Quality improvement work programme o Clinical Division improvement plans o Patient and public involvement strategy o Education and training strategy

1. Strategy	Rating	Lead	Example Good Practice	GOSH evidence
			Applicants are able to demonstrate that the quality goals are effectively communicated and well-understood across the Trust and the community it serves	• Quality improvement web pages, master classes and regular communication events • Schwarz rounds • Roundabout articles • Local projects • Quality and Safety Report to the Board (as part of the performance report) • Business case structure • Quarterly quality nursing reviews
		Anna Ferrant	The Board regularly tracks performance relative to quality goals	• Quantitative performance is tracked through monthly targets and indicators reviewed at divisional level on a monthly basis and at the Board at every public meeting • Examples of specific reports which are reviewed at Trust Board to track performance also include Safeguarding reports, staff survey, patient survey results, Serious Incident Report, Red complaints Report, complaints report, Care Quality Commission Registration Update, • The Clinical Governance Committee reviews the output from the Learning, Implementation and Monitoring Board at every meeting. • Trust Board formally reviews progress on the annual plan and strategic objectives on a six monthly basis • The annual formal review of quality is through the published Quality Report
1b: Is the Board sufficiently aware of potential risks to quality?	GOSH Self-Assessment: Green		The Board regularly assesses and understands current and future risks to quality and is taking steps to address them	**External sources (reported to the Board when published):** • National inquiries – e.g. Francis reports, Berwick and Keogh reviews • CQC reports such as the Alder Hey Inspection • Annual GOSH/ICH Safety Conference "Risky Business" which highlights safety issues and solutions from other risky businesses, attended by many TB members **Internal sources (reported to the Board routinely):** • Targets and Indicator reports • Patients and staff safety reports • Health and safety reports (Clinical Governance Committee) • Safeguarding • Serious Incident investigations • Legal cases and claims • Complaints (Trust Board) • Patient Experience Report • Incidents (Clinical Governance Committee) • Risk register (Clinical Governance Committee (CGC) and Audit Committee (AC))

1. Strategy	Rating	Lead	Example Good Practice	GOSH evidence
				• Board Assurance Framework • Specialty presentations • CQC update • Reviews of external risks to the organisation
			The Board regularly reviews quality risks in an up-to-date risk register	• Board assurance framework (BAF), which includes the Trust strategic risks. • BAF reviewed at Risk Assurance and Compliance Group (reports to CGC and AC), CGC, AC and Trust Board. • BAF risks are reviewed at the relevant assurance committee • Rolling programme of challenge at the CGC and AC on each risk, with attendance by each risk owner • NED led risk meeting held annually and reporting to the Board on the risk management framework at GOSH
			The Board risk register is supported and fed by quality issues captured in directorate/service risk registers	• The Board Risk Register (BAF) is built up from divisional risk registers and external intelligence. It is updated from incidents, complaints, audits and SIs
		Robert Burns	The risk register covers potential future external risks to quality (e.g. new techniques / technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks	• The Board Assurance Framework includes the following risks: • NHS Funding • Medical cover out of hours • IPP Income • Tracking of patient pathways • Recruitment & retention of staff
			There is clear evidence of action to mitigate risks to quality	• Clear actions are included for each risk on the BAF • Action plans on the Risk register • Actions for BAF risks are reviewed at the assurance committees (Clinical Governance and Audit Committees)
			Proposed initiatives are rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment)	• Business cases include quality & safety impact analysis • Risk registers also include identified risks from new initiatives
			Initiatives with significant potential to impact quality	• In order to ensure that cost reduction Productivity & Efficiency schemes do not adversely impact on patient safety and quality, a Quality Impact

1. Strategy	Rating	Lead	Example Good Practice	GOSH evidence
			are supported by a detailed assessment that could include:	Assessment (QIA) is completed and signed off by the respective Divisional Director and either the Chief Nurse or Medical Director. • On a quarterly basis, samples of P&E schemes(above £100k) are reviewed by the Clinical Governance Committee, ensuring such schemes have no adverse impact on quality and safety, and this is reported to the Trust Board.
			- 'Bottom-up' analysis of where waste exists in current processes and how it can be reduced without impacting quality (e.g. Lean)	• No waste week in May 2015 • The Trust is focusing efforts on reducing waste through service redesign. • Bed management processes continue to be reviewed and improved and work is been undertaken to improve flow through PICU/NICU. • A review is being conducted into how outpatient clinics can be used more efficiently.
			- Internal and external benchmarking of relevant operational efficiency metrics (of which nurse/bed ratio, average length of stay, bed occupancy, bed density and doctors/bed are examples which can be markers of quality)	• Benchmarking data available (Civil eyes) but limited applicability due to case mix • Benchmarked Key ALOS, excess bed days and re-admission rates • Benchmarked outcome measures • Longitudinal trends within GOSH • Dashboards, e.g. theatre utilisation (where our objective is the agreed national standard) • CuSum charts for on-going outcomes (e.g. mortality, surgical site infections) allow us to quickly identify a changing trend or cluster of incidents • PANDA system for monitoring patient acuity feeds into ward establishment and skill mix reviews • Benchmarked ward occupancy levels with other Children's Hospitals
			- Historical evidence illustrating prior experience in making operational changes without negatively impacting quality (e.g. impact of previous changes to nurse/bed ratio on patient complaints)	• Recent examples include: o Nursing skill mix review o In our Annual Report we evidence annual delivery o Weekly Productivity and Efficiency steering group chaired by Chief Operating Officer
			The Board is assured that initiatives have been assessed for quality	• Business cases include quality and risk assessment • Quality risks and risk management included in project initiation documents (PIDs) for major projects
			All initiatives are accepted and understood by clinicians	• Clinical leadership and representation of all specialties on division boards • Clinical representation on the Senior Management Team (SMT) and Trust Board • Clinical division leadership of Productivity and Efficiency, quality

1. Strategy	Rating	Lead	Example Good Practice	GOSH evidence
				improvement and workforce projects • Clinical representation on steering and/or project groups for quality improvement projects
			There is clear subsequent ownership (e.g. relevant clinical director)	• Clinical division leadership • All relevant projects have a clinical leader
		Salina Parkinson	There is an appropriate mechanism in place for capturing front-line staff concerns, including a defined whistle blowing policy	• Appropriate Trust policies ("Duty of Candour", "Incident Reporting and Management", "Raising Concerns in the Workplace") are in place • We have the 2nd highest reporting rate for acute specialist Trusts (NPSA data). • Weekly executive patient walkrounds give staff an opportunity to informally discuss any concerns or issues with a member of the Trust Board. • The Chief Executive holds regular update sessions at which staff can raise issues/ concerns/ ask questions. • The Audit Committee recently reviewed the mechanisms for staff to report concerns and incidents (April 2014) and were assured of the mechanisms in place. An internal audit of the whistle blowing process was conducted. • The staff survey for 2014 shows that 92% of staff know how to report concerns (average for acute specialist trusts = 94%). 70% stated that they would feel secure raising concerns (average = 70%); and, 64% stated that they would feel confident that Trust would address the concerns (average = 65%).
			Initiatives' impact on quality is monitored on an ongoing basis (post implementation)	• Post project implementation reports (for any large project such as development of the Morgan Stanley Clinical Building) • KPI monitoring of specific indicators linked to scheme and Clinical Division Safety reports (for on-going changes) • Quality Improvement Committee
			Key measures of quality and early warning indicators identified for each initiative	• CuSum charts for on-going outcomes (e.g. mortality, surgical site infections) allow us to quickly identify a changing trend or cluster of incidents • Monitoring of dashboards with analysis of all 'special causes'
			Quality measures monitored before and after implementation	• Targets and indicator reports • SPC charts for key safety indicators allow us to immediately identify when a statistically significant change has occurred.
			Mitigating action taken where necessary	• External review on gastroenterology 2015 by the Royal College • Projects reviewed and stopped if insufficient progress is being made

<table>
<tr><th>2. Capabilities and culture</th><th>Rating</th><th>Example Good Practice</th><th>GOSH examples</th></tr>
<tr><td rowspan="8">2a. Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?</td><td rowspan="8">GOSH Self-Assessment:

Green</td><td>The Board is assured that quality governance is subject to rigorous challenge, including full NED engagement and review (either through participation in Audit Committee or relevant quality-focused committees and sub-committees)</td><td>• There is regular rigorous challenge by the Trust Board of quality issues – for example, the review of medical cover OOH.
• The Clinical Governance Committee (chaired by a NED) specifically focuses on quality governance, whilst the Audit Committee (chaired by a NED) focuses on non-clinical risk and finance.</td></tr>
<tr><td>The capabilities required in relation to delivering good quality governance are reflected in the make-up of the Board</td><td>• The Board's skills and knowledge self-assessment (December 2014) has supported this</td></tr>
<tr><td>Board members are able to:</td><td></td></tr>
<tr><td>- Describe the Trust's top three quality-related priorities</td><td>• Delivering an excellent and compassionate experience for our patients and their families
• Delivering world class clinical outcomes
• Equipping all staff with the knowledge, skills and training to deliver high quality compassionate care.
• Each priority has an overall work programme, with a range of projects to achieve to specific objectives set by the Board.</td></tr>
<tr><td>- Identify well and poor performing services in relation to quality, and actions the Trust is taking to address them,</td><td>• Board members are enabled to do this through:
○ Triangulating information from patient safety reports and patient experience reports, including incidents, complaints and PALS cases.
○ Clinical audits and audits performed as part of quality improvement work.
○ Internal audit reports – reported at the CGC and AC includes an update on how the Trust responds to recommendations and progress with implementing action plans
○ Reviewing findings from the LIMB</td></tr>
<tr><td>- Explain how it uses external benchmarks to assess quality in the organisation (e.g. adherence to NICE guidelines, recognised Royal College or Faculty measures).</td><td>• Specialty specific accreditation; e.g. cancer, cardiac, intensive care, cystic fibrosis, BMT, radiology, CATS, Laboratories, Pharmacy
• Adherence to NICE guidelines
• External benchmarks where available for clinical outcomes
• Benchmark patient experience measures</td></tr>
<tr><td>- Understand the purpose of each metric they review, be able to interpret them and draw conclusions from them</td><td>• Feedback from board members on the development of the targets and indicators report</td></tr>
<tr><td>- Be clear about basic processes and structures of quality governance</td><td>• The processes and structures of quality governance, including the roles of the Learning, Implementation and Monitoring Board and Clinical Division Boards, and the assurance role of the Clinical Governance Committee are clear to the Trust Board.</td></tr>
</table>

2. Capabilities and culture	Rating	Example Good Practice	GOSH examples
		- Feel they have the information and confidence to challenge data	• Review of targets and indicators at Trust Board • Assurance reports on complaints, PALS, patient and staff survey results • The in-depth review of risks at the CGC and the AC enable Board members to develop a greater understanding of issues which in turn enables them to be able to challenge the data robustly.
		- Be clear about when it is necessary to seek external assurances on quality e.g. how and when it will access independent advice on clinical matters.	• The Trust Board has done this on some occasions recently, including: o Intensive care review o Gastroenterology review
		Applicants are able to give specific examples of when the Board has had a significant impact on improving quality performance (e.g. must provide evidence of the Board's role in leading on quality)	• The Trust Board very visibly leads the Quality strategy, in particular the focus on Zero Harm • The Board has also been clear in its expectations that each specialty must have specialty-specific outcome measures • Some specific examples of where the Trust Board (NEDs) has challenged current performance levels and demanded improvements include: o Communication (discharge summaries) o Quality of Food o Quality of care and patient experience provided by the Gastroenterology Team o Actions following the results of the referrers survey o 24/7 working arrangements o Medical cover OOH
		The Board conducts regular self-assessments to test its skills and capabilities; and has a succession plan to ensure they are maintained	• Undertook a board evaluation process in April 2015. The results will be reported at the May 2015 Board.
		Board members have attended training sessions covering the core elements of quality governance and continuous improvement	• Board development programme sessions o February 2014; June 2014; October 2014; February 2015 • External courses/ and seminars –e.g. King's Fund, FT Network • Annual GOSH/ICH Safety Conference "Risky Business" which highlights safety issues and solutions from other risky businesses
2b. Does the Board promote a quality-focused culture throughout the Trust?	GOSH Self-Assessment: Green	The Board takes an active leadership role on quality	• Executive patient safety Walkrounds • Targets and Indicators reporting to Trust Board • In depth consideration of risk areas at Board meetings, for example, update on achievement of C Diff target, child protection update, redevelopment update
		The Board takes a proactive approach to	• Care quality Commission reports

2. Capabilities and culture	Rating	Example Good Practice	GOSH examples
		improving quality (e.g. it actively seeks to apply lessons learnt in other Trusts and external organisations)	• Francis reports and Berwick and Keogh review • Trust supports a programme of Quality improvement which takes learning from across the globe and drives quality improvement on the front line

		The Board regularly commits resources (time and money) to delivering quality initiatives	• Committed investment in clinical governance and quality improvement teams
			• Committed to investment in data for improvement
			• Each QI project has an executive sponsor with clear roles and responsibilities
			• Committed investment in quality service developments:
			  o Interventional radiology
			  o ICU flow
			  o Additional doctors out of core hours

		The Board is actively engaged in the delivery of quality improvement initiatives (e.g. some initiatives led personally by Board members)	• Co-medical director and Chief Nurse jointly lead Deteriorating Child project • Co-medical director leads improving the patient journey for multi-specialty patients • Co-medical director leads improving discharge summaries • Co-medical director leads improving waits for outpatient pharmacy • COO leads Trust flow work. • COO leads Out-patient improvement • Non Exec chairs Ethics Committee • Non-Exec personally reads every Serious Case Review with GOSH involvement • ICU review
		The Board encourages staff empowerment on quality	• Quality improvement programme • Devolution of resources • Divisional development of priorities • Clinicians employed as Patient safety officers and Quality Improvement Leads in each division • Through executive patient safety walkrounds
		Staff are encouraged to participate in quality / continuous improvement training and development	• A key part of the Quality improvement Programme is to spread skills and knowledge • We have a monthly programme of Quality Improvement Master Classes with external speakers. • We have EQuIP (Enabling Doctors in Quality Improvement and Patient Safety Programme) • GOSH / ICH organises an annual conference 'Risky Business', focussing on safety issues • GOSH Staff have also participated in the following national and international courses o InterMountain collaboration for patient safety

2. Capabilities and culture	Rating	Example Good Practice	GOSH examples
			○ LIPS (Leading Innovation in Patient Safety) ○ Generation Q ○ IHI Fellowships ○ Other NHSII programmes ○ IHI International Forum on Quality & Safety in Healthcare
		Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment)	• High levels of incident reporting (NPSA – 2nd highest reporting rate for acute specialist Trusts) • The staff survey for 2014 shows that 92% of staff know how to report concerns (average for acute specialist trusts = 94%). 70% stated that they would feel secure raising concerns (average = 70%); and, 64% stated that they would feel confident that Trust would address the concerns (average = 65%).
		Staff are entrusted with delivering the quality improvement initiatives they have identified (and held to account for delivery)	• Quality improvement programme • Accountability through clinical divisions and corporate department review meetings • Quality Improvement Committee chaired by CEO
		Internal communications (e.g. monthly news letter, intranet, notice boards) regularly feature articles on quality	• Examples of internal communications which focus on quality exclusively or significantly include: ○ Roundabout (the in-house magazine) ○ Quality improvement intranet site ○ Quality improvement events, master classes and presentations ○ Notice boards with relevant safety performance data in every clinical area ○ Patient safety alerts / patient safety message of the month on Trust Brief ○ Learning from LIMB

3. Structures and Processes	Rating	Example Good Practice	GOSH examples
3a. Are there clear roles and accountabilities in relation to quality governance?	GOSH Self-Assessment: Green	Each and every board member understand their ultimate accountability for quality	• Every Trust Board member understands this and this has been confirmed through the results of the recent board evaluation process (April 2015) • Executives attend executive safety walkrounds. • NEDs attend ad hoc walkrounds
		There is a clear organisation structure that cascades responsibility for delivering quality performance from 'Board to ward to Board' (and there are specified owners in-post and actively fulfilling their responsibilities)	• The organisational structure is clear, with the key committees being Trust Board, Clinical Governance Committee, LIMB and the Clinical Division Boards. The Assurance and Escalation Framework explains how responsibility is devolved (currently under review) • Formal documents, in particular the risk management strategy and clinical division governance frameworks describe structures and responsibilities.

3. Structures and Processes	Rating	Example Good Practice	GOSH examples
			• Job descriptions for senior staff clearly describe personal responsibilities • Robust performance management and appraisal processes are in place to ensure post-holders actively fulfil their responsibilities.
		Quality is a core part of main Board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions	• The Trust Board receives a formal quality and safety report every month. • The Board receives a regular patient experience report
		Quality performance is discussed in more detail each month by a quality-focused board sub-committee with a stable, regularly attending membership	• The Clinical Governance Committee is a sub-committee of the Trust Board. It is chaired by a non-executive and solely focuses on clinical quality. It meets quarterly. • Safety reports to fortnightly Senior Management Team • Both meetings are well attended with a stable membership. • The Trust has established a Compliance Working Group which reports to the RACG and monitor compliance with CQC and Monitor requirements • LIMB meets monthly
3b: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	GOSH Self-Assessment: Green	Boards are clear about the processes for escalating quality performance issues to the Board	• Processes are defined within the Performance management strategy and the Risk Management Strategy and the Assurance and Escalation Framework • The Trust has an electronic system 'Datix' for the management of incidents and risks – this enables easy access by front-line staff to record concerns. • Risks are managed by local risk management groups and reported to Clinical Division Boards on a monthly basis and if necessary to Trust Board in their formal safety report. • The Clinical Governance Committee provides assurance • Clinical Divisions are formally performance managed through monthly reviews • Issues are regularly raised at Trust Board through the Targets and Indicators report, Quality and Safety reports Safeguarding reports, PALS Annual Report, , incidents, legal cases, , Serious Incident Report, Head of Nursing Report, Care Quality Commission Registration Update • The Board Assurance Framework contains all the Strategic Risks, plus controls and assurances • The Trust has a robust "whistle-blowing" policy • Board members chair the steering groups for quality improvement projects • Datix upgrade May 2015

		- Processes are documented	• Processes are described in the following documents:
			  ○ Risk management strategy
			  ○ Performance management strategy
			  ○ Clinical Division Governance Frameworks

3. Structures and Processes	Rating	Example Good Practice	GOSH examples
			o Assurance and Escalation Framework
		- There are agreed rules determining which issues should be escalated	• Risk management strategy sets out actions against the 5x5 risk assessment matrix
		Robust action plans are put in place to address quality performance issues. With actions having:	
		- Designated owners and time frames	• Action plans with owners and timeframes are agreed through the following mechanisms: o Risks logged on the Risk Register have logged actions and controls o Every Strategic Risk on the Assurance framework has a set of controls and assurances, with any gaps noted, with an action plan to resolve o Agreed actions arising from SI reports are logged on Datix
		- Regular follow-ups at subsequent Board meetings	• Each issues is linked with appropriate KPIs • Assurance framework • Progress on action plans reviewed at quality and safety committee follows up their own actions, for instance o Actions arising from audits are logged and followed up by the Audit Committee and Clinical Governance Committee o The Quality and Safety Committee reviews and follows up all actions arising from Serious Incidents o The Risk, Assurance and Compliance Committee follows up actions on the Assurance Framework which relate to gaps in controls or assurances o The Learning Implementation and Monitoring Board draws together all actions arising from incidents audits, complaints etc and is in the process of developing a system for analysing these actions, so as to recognise where there is duplication and ensure learning is spread across the Trust.
		Learning from quality performance issues is well-documented and shared across the Trust on a regular, timely basis, leading to rapid implementation at scale of good-practice	• The Trust's Learning, Implementation and Monitoring Board (LIMB) is the key committee where learning from incidents is discussed, and actions are agreed and shared across the Trust. All clinical divisions are represented at this meeting. • The Quality Improvement Programme is also a helpful mechanism to share improvements, through the clinical divisions (via the improvement managers and co-ordinators, through the intranet site, master classes, and events and through more informal discussion. For instance, quality improvement facilitators have spread learning between divisions e.g. reducing drug errors. • KPIs & any recent quality incidents and risks are reviewed pat the Divisional

3. Structures and Processes	Rating	Example Good Practice	GOSH examples
			Performance reviews and action agreed where appropriate • The Commissioners Quality Review Group reviews all serious incidents and the Trust's core quality reports on a regular basis and provides independent challenge • In terms of wider communication across the Trust, the Quality improvement web site is available to all staff, which includes data to drive improvement and we have started a trial within cardiac of putting more detailed information about learning points from incidents on the intranet site. • Further work is being conducted into how we can ensure the Trust effectively documents learning, analyses it and ensures that it is effectively disseminated across the Trust.
		There is a well-functioning, impactful clinical and internal audit process in relation to quality governance, with clear evidence of action to resolve audit concerns	• We undertake Clinical Audit (i.e. improving care through systematic review) through: o The Trust Clinical Audit Plan. An annual priority clinical audit plan is facilitated by the Clinical Audit Manager and approved at the Learning, Implementation, and Monitoring Board (LIMB). The drivers and items for this plan are: • Aggregated analysis from risk, incidents, claims, complaints, and PALS • Learning from patient complaints • Learning from Serious Incidents • Required National Audits and Clinical Outcome Reviews • Priorities where the need for clinical audit is identified in the Quality Strategy • Safeguarding • Additional work may be raised by the CQC Compliance Group, through other clinical governance sources Progress with the clinical audit plan is reported to the Clinical Governance Committee on a quarterly basis. Learning from the Clinical Audit Plan and any issues identified which require consideration and action are reviewed at the LIMB on a quarterly basis o Local clinical audits led by clinical teams (e.g. 'Clinical audit of compliance with GOSH investigation guidelines in children with CNS demyelinating conditions and autoimmune encephalitis'). There is a process of registration of local clinical audit and service evaluations which is outlined in the Clinical Audit Policy. Completion and learning from completed projects is shared on the Clinical Audit intranet page. A summary of learning points from completed local audits is reported to

3. Structures and Processes	Rating	Example Good Practice	GOSH examples
			the LIMB on a quarterly basis. o The Internal and External Auditors (e.g. Internal Audit of Medical Equipment, Deloitte's review of the Quality Account) o The Quality improvement team, with a dedicated facilitator in each Clinical Division and access to data analysts (e.g. on-going audits of hand-washing compliance on each ward, monthly audits of the quality of medical records) o Participation in relevant national audits and clinical outcome reviews is monitored by the Clinical Audit team and reported in the Quality Report. • The Clinical Governance Committee and the Audit Committee both receive the annual audit plans of the Clinical Audit team, the Internal Auditors and the External Auditors, and agree that these plans correspond appropriately to the Trust's Strategic Risks on the Board Assurance Framework. • The programme covers both national audits (e.g. high risk cancer treatments) and responses to local incidents (e.g. .Surgical Site Marking) • There is also a comprehensive audit programme that responds to Commissioners' concerns, for instance auditing emergency readmissions • Internal audit programme – both audit plans are shared and agreed at CGC and developed to prevent duplication and ensure that areas of risk/ gaps in assurance/ compliance requirements are the main focus
		- Continuous rolling programme that measures and improves quality	• The Quality improvement programme is key for measuring quality in terms of continuous improvement. • Through the Quality improvement programme dashboards are immediately available for all staff which shows quality improvement data for the key quality standards. • The annual clinical audit plan of pan Trust issues • Internal audit teams undertake audits of clinical and non-clinical practice.
		- Action plans completed from audit	• Actions required following specific audits are reviewed at the Clinical Governance and Audit Committees as appropriate re clinical and non-clinical and clinical matters • Actions are reviewed at the LIMB to ensure communication of cross Trust learning
		- Re-audits undertaken to assess improvement	• Our on-going metrics of quality and safety are continuously being expanded and adapted as required to assess improvement. • In addition where issues have been identified in audits the Clinical Governance or Audit committees request a re-audit – e.g. Rosterpro, medical records • Internal audit undertakes re-audits • Clinical audit undertakes re-audits
		A 'whistleblower'/error reporting process	• We have a "Raising Concerns in the Workplace" policy

<table>
<tr><th>3. Structures and Processes</th><th>Rating</th><th>Example Good Practice</th><th>GOSH examples</th></tr>
<tr><td></td><td></td><td>is defined and communicated to staff; and staff are prepared if necessary to blow the whistle</td><td>• Concerns can be registered with a designated officer (Non-Executive Director)
• Safety issues are raised and issues investigated as appropriate</td></tr>
<tr><td></td><td></td><td>There is a performance management system with clinical governance policies for addressing under-performance and recognising and incentivising good performance at individual, team and service line levels</td><td>• Staff appraisal process
• Consultant appraisal process
• Performance management process
• Sabbaticals and other development opportunities (e.g. Visits to Cincinnati) for staff
• Staff recognition awards focused on quality and safety, some individual and some team providing service
• Employer based excellence awards for consultants and specialist doctors
• Staff awards (monthly and annual)</td></tr>
<tr><td>3c: Does the Board actively engage patients, staff and other key stakeholders on quality?</td><td>GOSH Self-Assessment:

Green</td><td>Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance</td><td>• We seek to be an open organisation and put as much quality and safety information (good or bad) as possible into the public domain through the quality account and publication of an increasing number of clinical outcomes on our website www.gosh.nhs.uk.
• Many of our quality outcomes are also available through national organisations or publications, such as
    ○ Cardiac surgery outcomes data (CCAD)
    ○ Picanet data (intensive care)
    ○ Renal transplant register
• Within the Trust, we publish quality improvement information on the Quality improvement Website, so that it is freely available to all staff and able to be ‘drilled down’ by Clinical Division or ward.
• We have more clinical outcomes published than any other NHS Trust and any other children’s hospital in the world</td></tr>
<tr><td></td><td></td><td>The Board actively engages patients on quality, e.g.:</td><td>• The Trust has implemented the Government’s Friends and Family test to obtain information and feedback from patients and families at the point of discharge on their experiences of our services. This is extended to include responses from children and young people, and those cared for in day care areas and those who attend outpatients.
• The Trust has a Members’ Council who act as a critical friend to the organisation particularly in relation to involvement and engagement of patients and families
• A Young Members Forum has a key role in enabling the involvement of young members in the hospital’s quality and experience agenda.
• The Trust is fortunate to have a large pool of committed parent representatives who participate in a range of trust activities including sitting on committees, unit management boards, improvement projects, Executive safety walkrounds and inspections.</td></tr>
</table>

<table>
<tr><th>3. Structures and Processes</th><th>Rating</th><th>Example Good Practice</th><th>GOSH examples</th></tr>
<tr><td rowspan="3"></td><td rowspan="3"></td><td></td><td>A Members’ Council representative sits on the Patient and Public Involvement and Engagement Committee (PPIEC)
Members’ Council representatives have been actively involved in providing a patient/ carer perspective on the development of the Trust Commitment; the gastroenterology service; changes to ward locations; changes to the shop; way finding to the hospital.
Last year the Trust has consulted with patients and families on the Trust’s annual plan priorities, their views on extending the hours some of our services are provided, the merchandise that families would like to see in the hospital shop and how we can better use the Lagoon area.</td></tr>
<tr><td>- Patient feedback is actively solicited, made easy to give and based on validated tools</td><td>We proactively seek patient feedback on the outcomes of treatment (Patient Reported Outcome Measures). Some specific examples include:
School attendance and PE involvement for rheumatology patients
Improvement in understanding for parents of neurology patients
We also seek feedback on experience (PREMS) including:
Ipsos MORI in-patient and out-patient surveys
Service specific surveys, particularly focused on quality, safety and patient experience
Clinical divisions have implemented a range of local initiatives to gain real time feedback including feedback cards, informal complaint forms, parent teas and management walkrounds.
Wards and departments have ‘Listening to You boards’ where information about patient experience results and what is being done about them is shared.
All members of the Trust Board take the opportunity to speak personally to patients and their families during Executive Walkrounds
The Chief Nursing Officer, Deputy and Assistant Chief Nurses, and Heads of Nursing conduct a monthly Visible leadership morning where aspects of patient care or experience are observed, These exercises always include time to talk to patients, parents and staff about their experiences of the aspect of care being observed e.g. hand hygiene, environmental cleanliness.</td></tr>
<tr><td>- Patient views are proactively sought during the design of new pathways and processes</td><td>Parents and families are fundamentally involved in the Quality improvement Programme, for instance:
Individual parents are involved in of quality improvement projects
Parents are actively involved in recruitment
Parents are currently being recruited to sit on the Quality Improvement Board
Children and parents are also very involved in the Redevelopment, including the planning and design of new facilities</td></tr>
</table>

3. Structures and Processes	Rating	Example Good Practice	GOSH examples
		- All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly and intelligently by the Board	• A report on patient experience with summary of Pals activity is presented to Clinical Governance Committee on a quarterly basis and to the Board on an annual basis. • The Members' Council receives the quarterly PALS report at its meeting for discussion • PALS reports also provide information on issues raised by families more informally • Annual Ipsos Mori reports received by the Trust Board
		- The Board regularly reviews and interrogates complaints data	• The Clinical Governance Committee receives reports on complaints. The LIMB reviews the quality report on complaints and discusses for dissemination of learning.
		- The Board uses a range of approaches to 'bring patients into the Board room' (e.g. face-to-face discussions, video diaries, ward rounds, patient shadowing)	• Weekly Executive patient Walkrounds allow Executives the opportunity to families face to face • Every Serious Incident is reported in detail to the board, including the impact on the patient and family • The Trust collects and uses patient stories which are brought to the CGC and Trust Board, via written papers, video links and attendance by patients and carers at meetings • The Trust Board evaluation noted the importance of Board members being more visible across the Hospital
		The Board actively engages staff on quality, e.g.:	• Weekly Executive patient Walkrounds allow both Executives and Non-Executives the opportunity to talk to staff face to face as well as patients and families. • The Chief Nursing Officer, Deputy and Assistant Chief Nurses, and Heads of Nursing conduct a monthly Visible leadership morning where aspects of patient care or experience are observed, These exercises always include time to talk to staff about their experiences of the aspect of care being observed e.g. hand hygiene, environmental cleanliness. • Board members are responsible for chairing steering groups for quality improvement projects • The Board support the Quality improvement programme to actively engage staff in quality. • The Trust staff survey shows a better than average ranking for staff feeling able to contribute towards improvement at work
		- Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (e.g. monthly 'temperature gauge' plus annual staff survey)	• The Trust participates in the National staff survey • General Medical Staff Council meetings monthly • The Chief Executive holds regular open forums for staff

3. Structures and Processes	Rating	Example Good Practice	GOSH examples
		- All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the Board	• Staff survey results and action plans are published in Roundabout and discussed at relevant forums • Clinical division/ specialty presentations at board meetings
		The Board actively engages all other key stakeholders on quality, e.g.:	• Members of the Executive team engage with commissioners and other external stake holders regarding quality
		- Quality performance is clearly communicated to commissioners to enable them to make educated decisions	• Clinical quality sub-group with commissioners • Clinical audit report to commissioners • Quality Accounts, risk reports, SI information, complaint reports and patient experience information is regularly provided to the Clinical Quality review Group with Commissioners.
		- Feedback from PALS and LINKs is considered	• PALS feedback is pro-actively sought and taken seriously, for instance: o Quarterly PALS reports to Clinical Governance Committee as well as the LIMB and annually to the Trust Board. The PALS team work closely with the appropriate clinical team to resolve problematic issues (e.g. gastroenterology) o Both PALS and Healthwatch feedback is being sought for the Quality Account.
		- For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway	Children at GOSH frequently have a complex pathway involving many providers and we work hard to ensure overall quality. Specific projects include: • We work in a network model for many services – including for instance Haemophilia where we have recently been accredited as the lead centre, and Oncology where we have shared care cancer accreditation • Where we feel we can improve the pathway we are seeking to do so – at present we are developing standardisation and better patient pathways across the trust, led by the Co-medical Director. • We work closely with community services to enable complex discharge planning, in particular for instance through our Transitional Care Unit
		- The Board is clear about Governors' involvement in quality governance	• Members' council representatives have attended a range of training events to develop their understanding of quality governance and they are keen to participate more in the monitoring and improvement of quality and patient experience in the Trust.

4. Measurement	Rating	Example good practice	GOSH examples
4a: Is appropriate quality information being analysed and challenged?	GOSH Self-Assessment: Green	The Board reviews a monthly 'dashboard' of the most important metrics. Good practice dashboards include:	
		- Key relevant national priority indicators and regulatory requirements	• The targets and Indicators report received by the Trust Board every month includes: o Infection Control priority indicators: Incidence of C. difficile, MRSA o 18 week indicators: Admitted performance (%) Non-Admitted (%),Incomplete Pathways, Diagnostic waiting times o Discharge summary completion (%) o Cancer wait times o Clinic letter turnaround
		- Selection of other metrics covering safety, clinical effectiveness and patient experience (at least 3 each)	• The Targets and Indicators report is received by the Trust Board every month includes: • Metrics covering quality and safety (Mortality rate, Serious patient safety incidents, CV line infections and arrests outside ICU, metrics covering patient and referrer experience (2 relating to complaints, discharge summary completeness, clinic letter turnaround and patient refusals)
		- Selected 'advance warning' indicators	The Quality Improvement Team provides data for Trust Wide quality and safety, which can be used as advance warning indicators. Examples are: • Mortality rates per 1000 discharges • Number of respiratory and cardiac arrests outside ICU • Infection rates • Harm index, comprised of hospital acquired infections, serious incidents, non-ICU arrests, medication errors, falls and pressure ulcers
		- Adverse event reports	• The Targets and Indicators report includes Serious Incidents, Mortality figures and other adverse events as listed above • The Board receives a report on Serious Incidents at every meeting.
		- Measures of instances of harm (e.g. Global Trigger Tool)	• Many other more specific instances of harm are also reported as listed above
		- Monitor's risk ratings (with risks to future scores highlighted)	• These are included within the targets and indicator report and compliance framework report
		- Where possible/appropriate, percentage compliance to agreed best-	• This is done where appropriate, examples include: o WHO theatre checklist

4. Measurement	Rating	Example good practice	GOSH examples
		practice pathways	○ Hand washing audits ○ CVL infection reduction
		- Qualitative descriptions and commentary to back up quantitative information	• Numeric information is backed up with the following Trust Board papers: ○ The Targets and Indicators report cover sheet which gives more explanation and planned actions for indicators not on track ○ Integrated patient safety reports which highlight issues, trends and actions regarding incidents, complaints ○ PALS reports which focus on issues raised by patients and families go to the Clinical Governance Committee ○ Individual reports on each Serious Untoward Incident are presented to the Board
		The Board is able to justify the selected metrics as being:	
		- Linked to Trust's overall strategy and priorities	• The Targets and indicators report supports the key elements of the Trust's Strategic Objectives
		- Covering all of the Trust's major focus areas	• As above, the Targets and indicators report supports the key elements of the Trust's Strategic Objectives
		- The best available ones to use	• KPIs focus on issues that relate to national objectives and Trust issues of highest risk.
		- Useful to review	• KPIs for issues that can be addressed by Trust actions.
		The Board dashboard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines	• Reports reviewed by sub-committees of the Trust Board include: Each Clinical Division receives a Target and Indicators report, which is discussed every month at their performance reviews. Specialty level data is provided where poor performance is identified. More granular information is also available and used by local teams, including quality and safety data at a ward / departmental level.
		Quality information is analysed and challenged at the individual consultant level	• Quality and safety information is available at a consultant level and uses include: ○ As part of the Consultant appraisal process, where relevant information is compiled for each individual consultant ○ As part of appropriate quality improvement projects– e.g. Quality and timeliness of discharge summaries, theatre utilisation ○ Where there is specific reason to be concerned about individual performance
		The Board dashboard is frequently reviewed and updated to maximise effectiveness of decisions; and in areas lacking useful metrics, the Board commits time and resources to	• There is an annual process for reviewing and updating the metrics on the Targets and Indicators report • However there is a constant process of iteration, as demonstrated by the development of new metrics over the past year.

<table>
<tr><th>4. Measurement</th><th>Rating</th><th>Example good practice</th><th>GOSH examples</th></tr>
<tr><td></td><td></td><td>developing new metrics</td><td>• We have undertaken a full revision of our strategy.
• A Board level performance dashboard which directly links to the Trust's agreed strategic goals are presented to the Board quarterly.</td></tr>
<tr><td rowspan="3">4b: Is the Board assured of the robustness of the quality information?</td><td rowspan="3">GOSH Self-Assessment:

Amber/ Green</td><td>There are clearly documented, robust controls to assure on-going information accuracy, validity and comprehensiveness</td><td>• The Trust has an active Data Quality Group.
• We also have coding and billing quality meetings with each Clinical Division.
• Specific aspects of data quality are the subject of Internal audit
• The data quality work plan has concentrated upon making improvements to the accuracy and completeness of data recorded on the Trust Patient Administration System, in particular those items that make up the Commissioning Data Set (CDS) that is used to support reporting to commissioners. The review group are also undertaking a systematic review of all business procedures associated with the PAS system to ensure these meet Trust requirements. This work will be used to support local systems managers in devising their own data quality standards and procedures as outlined in the revised Data Quality Policy.
• A formal structure of Information Asset Administration and Ownership has been implemented. This includes a record of all information assets and their associated owners and administrators. An external assessment of a sample of these assets has been undertaken and a project plan is being developed to improve the robustness of the most business crucial information assets</td></tr>
<tr><td>- Each directorate/service has a well-documented, well-functioning process for clinical governance that assures the Board of the quality of its data</td><td>• Every Clinical Division has:
○ A governance framework which defines the role of the Clinical Division Board, the Risk Action Groups, Specialty Leads and the Clinical Division Management Team.
○ Monthly reports on Harm, Other Key Measures and Incidents / Complaints/quality and safety, other key measures and incidents / complaints, which are discussed at their Board Meeting.
○ Access to electronic information where data can be produced at a more granular level (e.g. by ward / consultant)
○ A representative at the Trust's 18 week delivery group, which focuses on the quality of this data.
• Regarding data quality, Clinical divisions have the following:
○ Monthly processes to validate activity and coding data
○ Database managers to manage data submission to external bodies e.g. cardiac, cancer, renal
○ The opportunity at Divisional Boards to triangulate data, for instance to correlate data on Trust systems with information from complaints
• Clinical divisions are formally held to account for the above through the Monthly Reviews process.</td></tr>
<tr><td>- Clinical audit programme is driven by</td><td>• We undertake Clinical Audit (i.e. improving care through systematic review)</td></tr>
</table>

4. Measurement	Rating	Example good practice	GOSH examples
		national audits, with processes for initiating additional audits as a result of identification of local risks (e.g. incidents)	through: o The Clinical Audit central team (e.g. Consent) o Local audits within local clinical teams o The Internal and External Auditors (e.g. Internal Audit of Medication Errors, Deloitte's review of the Quality Account) o Participating in national audits • The Clinical Governance Committee receives the annual audit plans of the Clinical Audit team, the Internal Auditors and the External Auditors, and agrees that these plans correspond appropriately to the Trust's Strategic Risks on the Board Assurance Framework. • The programme covers both national audits (e.g. high risk cancer treatments) and responses to local incidents (e.g. outward opening toilet doors, medical records) • There is also a comprehensive audit programme that responds to Commissioners' concerns, for instance auditing emergency readmissions
		- Electronic systems are used where possible, generating reliable reports with minimal ongoing effort	• The majority of the Trust's data is housed within the Data warehouse, from which automated reports are reported, in general via the o Information services portal o Quality improvement website • Most specialties also have individual databases which give additional clinical information about their patients. We are in the process of consolidating and supporting these databases. • We are also continuing to move further to electronic systems wherever possible • Complaints and Incidents are reported on Datix and computer generated reports can be produced • Development of Electronic Document Management System (EDMS)
		- Information can be traced to source and is signed-off by owners	• All CQC submissions have agreed source and sign-off • All data on the Targets and Indicators and Quality Improvement Reports (including Harm, quality and safety) has a defined source.
		There is clear evidence of action to resolve audit concerns	• Completion of Audit with recommendation reviewed at both CGC and Audit Committee.
		- Action plans are completed from audit (and subject to regular follow-up reviews)	• Action plans are agreed, documented and monitored through the, Clinical Governance Committee and local Risk Action Groups. • In addition all recommendations from internal and external audit are formally monitored by the Audit Committee
		- Re-audits are undertaken to assess performance improvement	• For those measures which are subject to one-off audits, a re-audit is undertaken by either the Clinical Audit team or Internal Audit where required (for instance, medical equipment, record management)
		There are no major concerns with coding accuracy performance	• The Trust has an internal audit programme for Clinical coding. Each quarter coding for a specific clinical specialty is recoded by the coding auditor and

4. Measurement	Rating	Example good practice	GOSH examples
			checked against the original coding. If notable discrepancies are detected these are communicated to the individual coder or the ream in general via training and general awareness sessions. • The Trust has been shortlisted for a national coding quality award

4c: Is quality information being used effectively?	GOSH Self-Assessment:
	
	Green
		Information in quality reports is displayed clearly and consistently	• Our range of quality reports (including Targets and Indicator reports, Dashboards, Integrated Patient Safety Reports, PALS Reports, Quality Account etc.) display information clearly and consistently:
			  ○ In absolute numeric form where small numbers mean that this is appropriate (e.g. C Diff)
			  ○ Through time series graphs (with summary dashboard indicating improvement or deterioration)
			  ○ With SPC or CuSum Graphs to show statistical change
			  ○ With benchmarked external comparators where possible
			  ○ Using % compliance to target when appropriate
			• A large proportion of our quality data is also available to every member of staff electronically on the intranet. This is a much more flexible way of presenting data and enables for instance 'drill-down' to individual ward / department for each indicator.

		Information is compared with target levels of performance (in conjunction with a R/A/G rating), historic own performance and external benchmarks (where available and helpful)	• As appropriate we use all three of these techniques:
			  ○ Comparisons with target levels of performance, with RAG rating: examples include C Diff and MRSA infections, WHO Safety Checklist
			  ○ Comparisons with historic own performance: examples include CVL Infections, Hospital Mortality Rate
			  ○ Comparisons with external benchmarks: examples include clinical outcomes (Renal transplant, PICU survival, Cardiac Surgery outcomes) and efficiency comparisons (Dr Foster productivity report)

		Information being reviewed must be the most recent available, and recent enough to be relevant	• The most recent data is reviewed within the Trust, and this is as recent as possible. For example:
			  ○ Weekly information – theatre utilisation
			  ○ Monthly information – CVL infections
			  ○ Annual information – external benchmarking through national registries e.g. renal
			• The KPI and Harm/quality and safety reports that go to the Trust Board generally use monthly information.

		'On demand' data is available for the highest priority metrics	• 'On demand' data is available through the intranet, via the
			  ○ Quality improvement website
			  ○ Information services portal

		Information is 'humanised'/personalised where possible (e.g. unexpected deaths shown as an absolute number, not	• We absolutely believe in this approach and have used it, for example, in the following cases: ○ Our CVL infection rate is frequently expressed in terms of the numbers

4. Measurement	Rating	Example good practice	GOSH examples
		embedded in a mortality rate)	of children who were infected in the last month ○ Our MRSA and C Diff rates are always expressed in absolute numbers of patients. The Trust Board have also received individualised information on each patient who tested positive for C Diff or had a MRSA bloodstream infection. ○ Individual children who were the subject of Serious Incidents are discussed by the Trust Board on a case by case basis
		Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance	• Numerous examples, including ○ We have maintained a reducing rate of CVL infection rates

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
22nd May 2015

Register of Seals **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment 3**

Aims / summary
Under paragraph 39 of the NHS Foundation Trust Standing Orders, the Trust is required to keep a register of the sealing of documents. The attached table details the seal affixed and authorised since end November 2013.

Date	Description	Signed by
27/03/15	Deed of Understanding GOSH/GOSH Children's Charity/GOSH Children's Charity Trustees	PS & CN

Action required from the meeting
To endorse the application of the common seal and executive signatures.

Contribution to the delivery of NHS / Trust strategies and plans
Compliance with Standing Orders and the Constitution

Financial implications
N/A

Legal issues
Compliance with Standing Orders and the Constitution

Who is responsible for implementing the proposals / project and anticipated timescales
N/A

Who is accountable for the implementation of the proposal / project
Anna Ferrant, Company Secretary oversees the register of seals

ATTACHMENT 4

Great Ormond Street Hospital for Children NHS Foundation Trust NHS

Update from the Audit Committee meeting held on 20th April 2015

Risk Management

The Committee discussed the Board Assurance Framework. Discussion focused on the number of risks with a significant gap between the net and accepted risk levels. The committee agreed that it was vital to mitigate these risks as far as possible. It was agreed that the committee would discuss two risks in depth per meeting and a brief would be provided on the drivers of the net risk score.

It was agreed that a risk management meeting would be scheduled for summer 2015 to include members of the Clinical Governance Committee.

The Committee reviewed the following high level risks:

Update on NHS clinical activity funding available to GOSH

It was reported that negotiations with NHS England (London Region) had recommenced following GOSH's rejection of the 2015/16 tariff offer from NHS England. The Committee noted difficulties with timeframes as a result of the delay as the Trust was required to indicate a need to go to arbitration before negotiations were likely to have ended. It was agreed that this would be further discussed at Trust Board.

The Trust's external auditors Deloitte told the Committee that throughout the country, approximately 30 Foundation Trust's had rejected the proposal however the proportion was far greater within London.

Research funding available to GOSH

It was reported that the Trust's priority for 2015/16 was to continue to improve the transparency of research funding and income generation to ensure that commercial research is incentivised for clinicians. It was noted that commercial research income at the Trust was the highest it had been.

Trust wide agreement and alignment on the changes required to transform our process using IT

It had been agreed by Trust Board that the Outline Business Case for a transformation programme using IT would be considered at the June Board meeting and the programme director from Cambridge University Hospitals had been engaged to work towards this. The Committee emphasised the importance of standardising processes across the Trust and noted that a large proportion of the benefits of an IT system would be achieved in this way.

Update on progress with the testing of business continuity plans (and assurance on the robustness of the processes)

It was reported that, following concerns raised by the Audit Committee around testing of business continuity plans, a live test had been undertaken in the form of a site lockdown and the learning from this was being collated. It was reported that the team worked with business continuity leads throughout the Trust to identify their particular highest areas of risk and provide training accordingly. The Committee requested to be updated with a high level plan including how it would be tested and congratulated the team on good progress since the last meeting.

Productivity and Efficiency Update

It was reported that focus was being placed on communication and transparency around the Productivity and Efficiency programme and the importance of clarity of accountability for performance. It was agreed that divisional directors should be required to sign off their schemes.

It was confirmed that work was on-going around procurement. Work in outpatients and central booking was focusing on the patient experience and quality improvement which would also drive efficiencies.

Whistleblowing

It was reported that three cases were currently being investigated and although they had all arisen in the same division it was confirmed that they were not linked.

External Audit Update

The Trust's external auditors, Deloitte told the committee that under Monitor's assurance requirements for the Quality Report, Deloitte would be required to review the Trust's referral to treatment time (RTT) incomplete pathway data and it was likely that they would be required to qualify their opinion in three areas:

- Unknown clock start time
- A number of genetics patients having been incorrectly included in the RTT data
- When the interpretation of the RTT target has been amended, the Trust had not reviewed previous months' data in line with the amended definition. Deloitte confirmed that this was similar to most Trusts and GOSH would not be unusual in qualification in this area. Deloitte reported that when calculations had been made using updated definitions, the Trust had breached the RTT target for the year. The Committee agreed that Monitor should be informed of this likely breach.

The Committee noted the requirement for the Chief Executive to sign the 'true and fair' statement. In light of the false and misleading legislation, Deloitte confirmed that they would be drafting some suggested wording for inclusion in the Trust's Quality Report.

Internal Audit Strategic and Operational Plan: 2015-16

The Committee agreed the following additional areas for internal audit throughout 2015/16 alongside areas which had previously been agreed:

- Transformation and improvement programme - to include the Productivity and Efficiency programme
- Procurement/contract management
- IT operations and infrastructure
- SCA: Self certification (second level)
- Discharge process – it was noted that this audit must have a clear definition and could be exchanged for asset utilisation, KPIs and benchmarking if necessary.

Draft Head of Internal Audit Opinion for 2014-15

KPMG confirmed that they would be providing a positive overall conclusion on the audits they had undertaken throughout 2014/15.

Counter Fraud Annual Report and Workplan 2015/16

The Committee approved the plan of work for 2015/16.

Year end 2014/15 - Annual Accounts financial reporting timetable and brief on non-routine accounting matters

The Committee discussed the building and land valuations which had been made as at 31st March 2015. It was confirmed that during the year, the majority of the Phase 2B enabling works had come online. This had been categorised as assets under construction in the 2013/14 annual accounts however having come online, the majority of the works had not added any value to the Trust's buildings and were therefore likely to result in a significant impairment.

Draft Audit Committee Report to be included in the Annual Report

The Committee reviewed the draft document and noted the need to ensure that risks and accounting judgements were consistent with the Annual Governance Statement.

Revised Terms of Reference

The Committee approved the revised Terms of Reference.

Eligibility to hold Monitor's Licence

It was confirmed that a self-assessment had concluded that the Trust was compliant with the Monitor licence.

Salary Overpayment Report

The Committee noted that the cost of salary overpayments was increasing and suggested that 2013/14 was an unusually low year for comparison.

Performance Report – Month 11 (2014-15)

The Committee discussed the number of complaints the Trust had received which was red rated. It was suggested that although the number of complaints did need to be monitored and increases should be investigated, it was important that the Trust did receive complaints where necessary and rating the number as red should be reviewed.

ATTACHMENT 5

Great Ormond Street Hospital for Children
NHS Foundation Trust

Update from the Clinical Governance Committee meeting held on 22nd April

The Committee requested that the Trust's media policy, which was currently in development, consider social media and in particular how GOSH should manage the challenges presented by social media. It was agreed that the chair should be consulted on this strategy prior to approval.

Patient Story

The Committee welcomed a patient story about the challenges of accessing care from a range of specialties within GOSH and in addition support services such as transport. The Chief Executive agreed to give feedback through divisions about the family's frustration at not being able to get through to relevant teams by telephone. The Committee noted the on-going work looking at 'lead consultant' but agreed that this would probably not have been sufficient to respond to all the family's needs.

Medical Cover Out of Hours

It was reported that it had not been possible to recruit to all posts left vacant when Haematology/Oncology trainees left the Trust at the end of February. The Committee noted that four locum consultants had been recruited and the process was underway to recruit seven registrars. It was emphasised that the service remained safe and had not had to close beds.

The committee received an update on the improvement work that had been done including around handover, a junior doctor listening event, increased phlebotomy provision and work to ensure that the intensive care outreach service (ICON) was always available.

Update on review of gastroenterology service

It was reported that discussions were under way with the visiting team which had been chosen to undertaken an external review and they would be meeting with each gastroenterology consultant individually over a two week period.

Update on recent IT issues (impacting on clinical work and issues with server capacity)

The Committee received an update from the interim Director of ICT on recent IT outages. It was noted that the majority of outages were planned as part of on-going IT projects and the committee was assured that there was a service desk available twenty four hours a day which would respond to out of hours areas by priority. It was agreed that further discussion would take place outside the meeting on IT incidents which occurred, but failed to reach the threshold of a serious incident and the way in which the learning from these events was being captured.

Assurance Framework

The Committee reviewed the following high level risks:

- Recruitment and retention of sufficient highly skilled staff with specific experience (operational risk)

It was agreed that turnover performance would be differentiated to allow additional focus to be given to the required areas. The Committee emphasised the importance of focusing on retention of staff in the current financial environment.

- Patient referrals and staff recruitment is affected by issues which attract considerable negative media coverage

It was reported that negative media coverage had implications for reduced staff morale and potential suboptimal care. It was reported that members of the communications team had expertise in negative media management and a robust media policy was in place.

Update on quality and safety impact of the Productivity and Efficiency programme

It was reported that the Trust was carrying out some work to test the PICS standards for the number of Paediatric ICU beds per consultant. The Committee noted that work was on-going along with other Trusts to look at the burnout rate of staff working in critical care.

The Committee noted that there had been no adverse effects on quality and safety as a result of the P&E schemes reviewed.

CQC Update

It was reported that the Trust had been inspected by the CQC. Inspectors worked in eight teams and provided very high level feedback at the end of the inspection process. A darft report is due Summer 2015.

Research Governance Annual Update

The Committee welcomed the implementation of guidance for transition to adult care for research purposes.

Internal Audit Operational Plan 2015-16

The Committee discussed the internal audit plan for 2015-16. It was noted that 15 days had been protected for potential additional work arising from the scheduled CQC inspection feedback.

Clinical Audit Report Q4 2014/15

The Committee noted that audits were agreed as a result of outcomes from serious incidents, learning from complaints and were a mixture of proactive and reactive audits. It was reported that that there was sufficient flexibility to audit additional areas which emerged throughout the year.

ATTACHMENT 6

Attachment 6

Great Ormond Street Hospital for Children
NHS Foundation Trust

Update from the Finance and Investment Committee meeting held on 27th April 2015

2014/15 Financial Performance

The Committee reviewed 2014/15 finance and activity and segmental reporting. The non-executive directors questioned the rise in WTE and pay costs in the year and the Trust's productivity for the year.

2015/16 Financial Plan

The Committee reviewed the assumptions that were feeding into the 2015/16 annual plan. The non-executive directors challenged the forecast levels of paycosts and questioned the achievability of productivity and efficiency targets.

2015/16 Operational Plan

The non-executive directors suggested that the narrative document should highlight the research work done in the hospital and the Trust's links to the Charity.

Productivity Report

The Committee discussed the productivity report and staff productivity.

2015/16 Productivity and Efficiency Programme Update

The Committee was given an update.

IPP Review of Activity, Capacity and Demand

The Committee review the paper provided. The non-executive directors questioned price increases and price elasticity.

Education Business Model

The Committee discussed the paper. The non-executive directors questioned standardisation of study leave for trainee doctors between funded and non-funded posts.

Cash Management Update

The Committee was given an update.

Results of Review of Effectiveness

The Committee discussed the results of the effectiveness review. The non-executive directors suggested that there should be an alignment to the Trust's strategy. The non-executive directors also suggested that the Committee spends more time reviewing productivity metrics, pay costs and headcount.

Review of Terms of Reference and 2015/16 Work Programme

Terms of reference and the workplan for 2015/16 were agreed.

ATTACHMENT 7

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council update

A Members' Council meeting was held on Wednesday, 29th April

The Chief Executive provided an update on the following areas:

- The CQC announced inspection which took place in the week of 13th April 2015
- Institute for Healthcare Improvement Experience Day which was hosted at GOSH on 21st April 2015
- NHS tariff negotiations
- The arrival of a new Interim Chief Operating Officer and imminent arrival of a new Chief Nurse and Medical Director
- The 'Our Always Values' launch which took place on 24th March

The Council received an update on the GOSH masterplan which had been developed by a firm of architects who looked how the use of space could be maximised on the GOSH site. The Council welcomed the additional 30,000m^2 space which was available under the masterplan and provided the opportunity for GOSH to remain on one site and continue to develop. The Council expressed some concern about the suitability of the space in the Southwood building and the Executive Team confirmed that they recognised the importance of accelerating the move of patients currently occupying the Southwood building to better space.

An update was provided on catering and it was reported that PLACE assessment was due to carried out in May 2015. The Council suggested that the standard of GOSH food was benchmarked against both the private and commercial sector and school meals.

The Council received a presentation on the Trust's digital strategy. It was reported that the Interim ICT Director and members of the Executive Team had visited an international partner in 2014 to look at the way in which electronic systems were being used. It was clear from the visit that it was vital to have a transformation programme in place. The Council noted that Cambridge University Hospitals NHS Foundation Trust was the only NHS organisation to have implemented the electronic system in the UK and the Trust had engaged their support to help with the work undertaken at GOSH. The Council noted that clinicians had been heavily involved in developing the digital strategy.

The Council was advised that in order to concentrate resources at GOSH, a review of current services had been undertaken and that it had been agreed that the small Chronic Fatigue service could be better provided by other providers in the NHS. Work was underway to explore where else the service could be provided, specifically with a provider that already provides inpatient services and would enable a smooth transition into adulthood.

A presentation was received on the Annual Plan and Finance Plan for 2015/16. It was reported that costs had increased at a greater rate than income and it was anticipated that this would also occur in 2015/16 meaning that the Trust was predicted to return a deficit. The

committee noted the assumptions underlying the finance plan including the assumed delivery of the Productivity and Efficiency programme which would be challenging.
It was reported that the Trust's risk ratio with Monitor remained at a good level and if a similar tariff was received this would continue for another few years. It was emphasised that NHS England had been clear that their aim was to consolidate services with fewer service providers so it was vital that GOSH continued to be flexible and able to take on additional activity.

It was reported that the Trust had been inspected by 52 CQC inspectors including 45 who were 'experts by experience'. Inspectors worked in eight teams and provided very high level feedback at the end of the inspection process. A draft report will be shared with the Trust in Summer 2015.

The Council approved the outcome of the appraisals of the Chairman and Non-Executive Directors and also the remuneration of the Chairman and Non-Executive Directors both of which had been recommended to the Council by the Members' Council Nominations and Remuneration Committee.

The Council received an update from the Young People's Forum and it was confirmed that transition would continue to be a focus in the coming year.

The Council received the results of the staff survey. They expressed concern about the results relating to communication and emphasised its importance, particularly in time of change. The importance of a visible leadership was stressed. The Council was informed that focus was being placed on internal communication.