Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
Friday 20th May 2016

Dear Members

There will be a public meeting of the Trust Board on Friday 20th May 2016 at 2:15pm in the Levinsky Room, Institute of Child Health, 30 Guilford Street. WC1N 1EH.

Company Secretary
Direct Line: 020 7813 8230
Fax: 020 7813 8218

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment
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 1st April 2016**	Chairman	**N**
3.	**Matters Arising/ Action Checklist**	Chairman	**O**
4.	**Chief Executive Report**	Chief Executive	**Verbal**
	ANNUAL ACCOUNTS		
5.	**GOSH Foundation Trust annual financial accounts and annual report 2015/16**	Audit Committee Chair/ Chief Finance Officer/ Company Secretary	**P**
6.	**Quality Report 2015-16**	Medical Director	**Q**
7.	**Audit Committee Annual Report 2015-16**	Chief Finance Officer	R
	STRATEGIC ISSUES		
8.	**Overview of performance against strategic objectives 2015/16**	Interim Director of Strategy and Planning	**S**
9.	**Update on access improvement programme**	Deputy Chief Executive	**Presentation**
	PERFORMANCE		
10.	**Quality and Safety Report**	Medical Director	**9**
11.	**Performance Targets & Indicators: April 2016**	Deputy Chief Executive	**U**
12.	**Workforce Update** **PDR Appraisal Rate Update**	Director of Human Resources &OD	**V** **W**

13.	**Finance Update** • **March 2016** • **April 2016**	Chief Finance Officer	**X** **11**
	ASSURANCE		
14.	**PALS Annual Report 2015/16**	Chief Nurse	**Y**
15.	**Friends & Family Test Q4 2015/16 Report - experience of children, young people and their families at GOSH**	Chief Nurse	**Z**
16.	**Staff Friends and Family Test results – Quarter 4 2015/16**	Director of HR and OD	**1**
17.	**Annual Complaints Report 2015-16**	Chief Nurse	**2**
18.	**Annual Safeguarding report 2015/16**	Chief Nurse	**3**
19.	**Safe Nurse Staffing Report (March and April 2016)**	Chief Nurse	**4**
	GOVERNANCE		
20.	**Annual Risk Report 2015-16**	Medical Director	**5**
	REPORTS FROM COMMITTEES		
21.	**Audit Committee update – April 2016 meeting and revised Audit Committee Terms of Reference and workplan**	Chair of the Audit Committee	**7**
22.	**Clinical Governance Committee update – May 2016 meeting including revised terms of reference**	Chair of the Clinical Governance Committee	**8**
23.	**Finance and Investment Committee Update – May 2016**	Chair of the Finance and Investment Committee	**Verbal**
24.	**Members' Council Update – April 2016**	Chairman of the Members' Council	**10**

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 20th July 2016 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT N

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 1st April 2016

Present

Baroness Tessa Blackstone	Chairman
Dr Peter Steer	Chief Executive
Ms Mary MacLeod	Non-Executive Director
Mr Akhter Mateen	Non-Executive Director
Mr David Lomas	Non-Executive Director
Professor Stephen Smith	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Mr Charles Tilley	Non-Executive Director
Ms Nicola Grinstead	Deputy Chief Executive
Mr Ali Mohammed	Director of Human Resources and OD
Ms Juliette Greenwood	Chief Nurse
Ms Loretta Seamer	Chief Finance Officer
Mr Bill Boa	Interim Chief Finance Officer

In attendance

Mr Matthew Tulley	Director of Redevelopment
Ms Cymbeline Moore	Director of Communications
Dr John Harley	Director of Infection Prevention and Control
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
2 members of the Members' Council	
1 member of the public	

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

243	**Apologies for absence**
243.1	Apologies for absence were received from Dr Vinod Diwakar, Medical Director and Mrs Claire Newton, Interim Director of Strategy and Planning
244	**Declarations of Interest**
244.1	No declarations of interest were received.
245	**Infection Control Report**
245.1	Dr John Hartley, Director of Infection Prevention and control highlighted some on-going issues with arrangements for the management of IPC data due to out-dated systems and the vacancy of the administration/data manager post.
245.2	Dr Hartley said that the increase in healthcare associated infections was due in part to a seasonal increase however this had been greater than anticipated and was likely to be due to additional factors. An audit had been undertaken on compliance with baseline audits taking place throughout the Trust which had demonstrated that compliance was below the anticipated level.

245.3	**Action:** Dr Peter Steer, Chief Executive noted the disappointing results of the hand hygiene audit and agreed that an improvement plan would be brought to the next Trust Board meeting. Baroness Blackstone, Chairman agreed that were results were disappointing and said that the Board would be looking for increased compliance in the next report.
246	**Minutes of previous meeting**
246.1	The minutes of the meeting held on 27th January 2016 were **approved**.
247	**Matters Arising/ Action Checklist**
247.1	The actions taken were noted.
248	**Chief Executive Report**
248.1	<u>CQC Quality Summit</u>
248.2	Dr Peter Steer, Chief Executive said that the CQC Quality Summit had been held on 23rd February following the publication of the Trust's CQC report. Dr Steer said that an action plan had been submitted based on the recommendations and other comments from the report and a number of actions had already been closed.
248.3	<u>Organisational Restructure</u>
248.4	Dr Steer said that the Trust's clinical operations had been restructured from five divisions to two following extensive consultation which had received approximately 100 comments. In internal application process had taken place for the new roles and appointments had been made. A Divisional Assistant Chief Nurse in each division would ensure that the nursing profile was raised and finance and HR leads would be part of each division to ensure that corporate functions were given priority alongside clinical excellence.
248.5	Dr Steer said that each division would have a divisional chair who would be direct reports of the Deputy Chief Executive and finance and HR leads would be business partners offering senior advice. They would be accountable to the divisions but have professional lines back to finance and HR. It was confirmed that three development sessions would be run with divisions to ensure there was clarity about how these functions would operate.
248.6	Ms Mary MacLeod, Non-Executive Director emphasised the importance of ensuring that clinicians were engaged in the discussions about which division they would be in. Dr Steer said that it had been made clear that the specialty mix would be evaluated after six months.
248.7	<u>Productivity and Efficiency</u>
248.8	It was reported that a three year financial view was being taken to bring the Trust to a surplus position and GOSH had been working with PwC to develop a three year productivity and efficiency programme. The three main streams from which schemes would be drawn had been identified as: procurement including pharmacy, patient flow and workforce.

249	**Annual Plan 2016/17**
249.1	Mr Bill Boa, Interim Financial Advisor presented the annual plan that would be submitted to Monitor on 11th April and uploaded to the Trust's website. He confirmed that it had been review on three occasions by the Finance and Investment Committee and considered by the Executive Management Team and Senior Management Team.
249.2	The Board **approved** the annual plan 2016/17.
250	**Update on access improvement programme**
250.1	Dr Peter Steer, Chief Executive said that over 90,000 clinical pathways had now been validated, the majority of which were closed. He said that around 8,000 patients had been added to the patient tracking list and long waiters would be reviewed further to look for any harm caused. Dr Steer said that two patients currently required further investigation.
250.2	Work was being undertaken to look at the demand and capacity for each specialty and engage with NHS England on the issue.
250.3	Dr Steer said that the Intensive Support Team had conducted a follow up review on the actions that had been taken and information feedback had been very positive. The Trust was awaiting the written report.
250.4	Ms Mary MacLeod, Non-Executive Director asked for assurance that clinical priority was the main driver of remedial actions.
250.5	Dr Steer confirmed that this was the case and said that Monitor and NHS England had noted the excellent clinical engagement.
250.6	**Action:** It was agreed that an update would be brought to the next meeting setting out the proportion of work that had taken place and what was still to be done.
251	**Quality and Safety Report**
251.1	Ms Juliette Greenwood, Chief Nurse said that the rate of central venous line (CVL) infections had been reviewed by the Quality Improvement team and although there had been an increase, this was not statistically significant.
251.2	Discussion took place about the use of lines which had been impregnated with antibiotics which newly published research conducted at GOSH had shown significantly reduced the rate of CVL infections. Professor Rosalind Smyth, Non-Executive Director stressed that the cost of treating a patient in whom infection had developed was substantial. She suggested that a large review which demonstrated the benefits that GOSH had found put the onus on GOSH to lead the change.
252	**Targets and Activity Report**
252.1	Dr Peter Steer, Chief Executive presented the report and said that there had been a significant reduction in bed closures and congratulated the staff involved. He added that the reduction in theatre utilisation which was primarily due to industrial action which was currently on-going.

252.2	Mr David Lomas, Non-Executive Director noted the increase in refusals in PICU, NICU and CATS and asked for a steer on the drivers of this.
252.3	Dr Steer confirmed that this was a seasonal issue in general however there had been additional funding in 2015 to run an additional CATS ambulance that was not available in 2016.
252.4	The Board discussed staff turnover and Mr Ali Mohammed, Director of HR and OD reported that a dedicated nursing workforce group had been established to look specifically at retention. He said that there were areas in the Trust with high turnover but these were much smaller.
252.5	Mr Akhter Mateen, Non-Executive Director said that level of turnover was continuously above target he said that consideration must be given to whether it was possible for the Trust to meet the target or whether it should be amended. Mr Mateen added that it was important to look at the trend in turnover.
252.6	Dr Steer said that the target in place was a stretch target and it should be acknowledged that it would take time for the Trust to reach this level however he agreed that it was important to work towards a level of turnover that was comparable with other London Trusts.
253	**Workforce Summary Report**
253.1	Mr Ali Mohammed, Director of HR and OD said that Monitor had introduced a cap on agency staff pay which would require some changes to be made in the short term.
253.2	It was reported that the first in the most recent series of industrial action strikes by junior doctors had taken place and approximately 75% of rostered doctors had been present at work.
253.3	Dr Peter Steer, Chief Executive said that junior doctors at GOSH had been professional and collaborative and added that it was disappointing that the situation had not been resolved through discussion.
253.4	Mr David Lomas, Non-Executive Director expressed concern at the results of the staff survey which indicated that approximately 10% of staff had been subject to a physical attack in the workplace. He said that it was vital that the Board had sight of this information which was not corroborated by the number of incidents that had been reported.
253.5	Mr Mohammed said that it was clear from the staff survey that there had been an increase in difficult and high pressure situations. He said that there had been some serious individual incidents and agreed that it was important to concentrate on this.
253.6	**Action:** The Board noted that there had been a reduction in the PDR completion rate and it was agreed that a full report would be received on how this was being managed at the next meeting.
253.7	Mr Charles Tilley, Non-Executive Director emphasised the importance of PDRs for staff and the link between PDRs and wellbeing.

254	**Finance Summary Report**
254.1	Mr Bill Boa, Interim Financial Advisor said that the Trust was reporting an underlying deficit of £8.9million for the 11 month period to 29 February 2016 and the Trust was still on plan to achieve the predicted outturn at year end despite the formal notification that had been received of NHS England's intention to levy a fine of £1.3million for an information breach and non-reporting of targets.
254.2	Mr Akhter Mateen, Non-Executive Director expressed concern at the increase in IPP debtor days for the significant outstanding funds.
254.3	Mr Boa confirmed that a full report would be considered by the Audit Committee. He said that the rise in debt was in line with the increase in IPP income but acknowledged that the number of debtor days was rising.
254.4	Baroness Blackstone, Chairman welcomed the additional scrutiny of this issue by the Audit Committee and said the current situation was not acceptable.
255	**Safe Nurse Staffing Report January 2016 and February 2016**
255.1	Ms Juliette Greenwood, Chief Nurse said that an increase in establishment had been approved at the February Board Strategy day in line with business cases. She added that fill rates continued to be strong, however there were a number of vacancies for Healthcare Assistants and this was apparent in the fill rates.
255.2	It was confirmed that no unsafe shifts were reported in January or February and Clinical Site Practitioners were moving nurses around the Trust appropriately in response to any areas with reduced numbers of staff. Ms Greenwood said that there had been two reports by staff during January that a shift felt unsafe, however this had been reviewed and confirmed that they were safe. Ms Greenwood said that this was indicative of the pressure that was being felt.
255.3	Mr Ali Mohammed, Director of HR and OD noted the significant variation between wards in fill rates for Healthcare Assistants and asked if this continued to be safe.
255.4	Ms Greenwood said that the proportion of HCAs to registered nurses was still very small at GOSH so a shift for a vacant HCA post would be filled by a registered nurse and would be reflected in the fill rates. She said that it was important to move forward with increasing the number of HCAs although there were no concerns from a safety perspective.
256	**2015 Annual Staff Survey Results**
256.1	Mr Ali Mohammed, Director of HR and OD said that despite receiving a lower response rate to the survey than in previous years, GOSH has the second highest response rate of the 44 teaching Trusts.
256.2	The Board discussed the health and wellbeing scores and noted that GOSH was in the top three Trusts for staff feeling that the Trust was interested in taking action on health and wellbeing. There was work to be done to look at issues of increasing conflict from parents and visitors towards staff and staff feeling they were suffering work related stress. Professor Rosalind Smyth, Non-Executive Director suggested that resilience training could be appropriate in this situation.

257	**Risk Management Strategy**
257.1	Dr Anna Ferrant, Company Secretary said that the strategy had been widely consulted on and the main updates were around definitions and responsibilities.
257.2	The Risk Management Strategy was **approved.**
258	**Register of Interests and Register of Gifts and Hospitality**
258.1	**Action:** The Board discussed the number of staff who declared interests and gifts and agreed that it was unlikely that all relevant interests and gifts were being declared. It was agreed that work would take place to look at making declarations of interest and receipt of hospitality part of the appraisal process.
259	**Members' Council Update – January 2016**
259.1	Dr Anna Ferrant, Company Secretary said that an Annual Plan survey had been undertaken and Councillors had conducted the survey in the Lagoon with patients and families. Work was on-going to analyse the responses and an update would be provided at the Members' Council meeting.
260	**Update from the Audit Committee in January 2016**
260.1	Mr Charles Tilley, Chair of the Audit Committee provided the update. He said following the emergence of issues with RTT data, KPMG had undertaken a data review. Mr Tilley said that the Audit Committee had reviewed the final report and noted that processes could be improved, however the data itself was not considered a significant risk to the Trust.
260.2	Ms Mary MacLeod, Chair of the Clinical Governance Committee (CGC) welcomed the report and confirmed that the CGC would also review the report at its next meeting.
261	**Update from the Clinical Governance Committee in February 2016**
261.1	**Action:** Ms Mary MacLeod, Chair of the Clinical Governance Committee said that the Committee had received a presentation from the mortality review group. She suggested that this presentation should be given at the Members' Council.
261.2	**Action:** Ms MacLeod said that it was vital that the outcomes of Clinical Audit were reported to the Board and it was agreed that this would take place annually.
262	**Update from the Finance & Investment Committee**
262.1	**Action:** Mr David Lomas, Chair of the Finance and Investment Committee said that discussion had taken place about the future financial environment and potentially taking on debt to fund phase 4 of the redevelopment programme. It was agreed that further discussion on this would take place at the Trust Board seminar in April 2016.
263	**Any Other Business**
263.1	There were no items of other business.

ATTACHMENT O

Attachment O

TRUST BOARD – PUBLIC ACTION CHECKLIST
May 2016

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
213.2	27/01/16	It was agreed that consideration would be given to having a visible metric for the number of cancelled appointments.	CN/ NG	March 2016	Work is on-going to review the integrated performance report for the Board and this metric will be considered as part of this review. In the short term it is being explored what appropriate metric can be included for the new financial year. An update on the integrated report was provided at the April 2016 Seminar meeting and work continues.
213.4	27/01/16	It was agreed that further discussion would take place outside the meeting about writing to NHS England about a patient being eligible at each visit to complete the Friends and Family Test.	JG	May 2016	On agenda on the Patient and Carer FFT agenda item
245.3	01/04/16	Dr Peter Steer, Chief Executive noted the disappointing results of the hand hygiene audit and agreed that an improvement plan would be brought to the next Trust Board meeting. Baroness Blackstone, Chairman agreed that were results were disappointing and said that the Board would be looking for increased compliance in the next report.	JG	May 2016	To be raised under the CEO verbal update
250.6	01/04/16	It was agreed that an update would be brought to the next meeting setting out the proportion of RTT work that had taken place and what was still to be done.	NG	April 2016	On agenda

Attachment O

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
253.6	01/04/16	The Board noted that there had been a reduction in the PDR completion rate and it was agreed that a full report would be received on how this was being managed at the next meeting.	AM	May 2016	On agenda
258.1	01/04/16	The Board discussed the number of staff who declared interests and gifts and agreed that it was unlikely that all relevant interests and gifts were being declared. It was agreed that work would take place to look at making declarations of interest and receipt of hospitality part of the appraisal process.	AF&AM	October 2016	Not yet due
261.1	01/04/16	Ms Mary MacLeod, Chair of the Clinical Governance Committee said that the Committee had received a presentation from the mortality review group. She suggested that this presentation should be given at the Members' Council.	AF/ Deirdre Leyden	June 2016	To be presented at the June Members' Council meeting
261.2	01/04/16	Ms MacLeod said that it was vital that the outcomes of Clinical Audit were reported to the Board and it was agreed that this would take place annually.	AF	May and ongoing	Added to the Board workplan
262.1	01/04/16	It was agreed that further discussion on potentially taking on debt to fund phase 4 of the redevelopment programme would take place at the Trust Board seminar in April 2016.	MT	April 2016	Actioned

Attachment P

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
20th May 2016

GOSH Foundation Trust Annual Financial Accounts 2015/16 and Annual Report 2015/16 **Submitted by:** Anna Ferrant, Company Secretary	**Paper No:** Attachment P

Aims / summary

The Trust is required to publish a Foundation Trust annual report and accounts for 2015/16. Board members will find attached the following documents:

- A copy of the annual accounts 2015/16
- A copy of the annual report 2015/16 incorporating
  - an overview of the Trust's compliance with the Code of Governance, where it is reported that the Trust was compliant with the provisions of the NHS Foundation Trust Code of Governance throughout 2015/16
  - the Head of Internal Audit Opinion
  - the Annual Governance Statement

The annual report and accounts will be submitted to Monitor by 27 May 2016 and then submitted to the Department of Health at the end of June, for presenting to Parliament.

The Audit Committee will consider the annual accounts and report at its meeting on 20th May 2016 and will provide comments at the Trust Board that day.

Action required from the meeting

To consider and approve the annual accounts and report 2015/16.

Contribution to the delivery of NHS / Trust strategies and plans

The Annual Report publically reports on the Trust's performance against its strategic priorities and objectives.

Financial implications

There are no direct financial implications.

Legal issues

There are no direct legal implications.

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?

A number of staff have contributed to the draft Annual Report. All Executive members have been asked to review the draft and their comments have been incorporated into this draft.

Who needs to be told about any decision

The Company Secretary will feed back any actions required to relevant staff.

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

The Company Secretary is leading the coordination of the Annual Report.

Who is accountable for the implementation of the proposal / project

The Chief Executive Officer is ultimately accountable for production and publication of the Annual Report.

Trust name:	Great Ormond Street Hospital for Children NHS Foundation Trust
This year	2015/16
Last year	2014/15
This year ended	31 March 2016
Last year ended	31 March 2015
This year beginning	1 April 2015

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: 20 May 2016

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 2016 have been prepared by Great Ormond Street Hospital for Children NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form which Monitor, with the approval of the Treasury, has directed.

Signed

Dr Peter Steer
Chief Executive
Date: 20 May 2016

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2016

	NOTE	**Year ended 31 March 2016 £000**	Year ended 31 March 2015 £000
Total revenue from patient care activities	2	**349,574**	345,198
Total other operating income	3	**94,863**	67,411
Operating expenses	4	**(403,547)**	(401,449)
Operating surplus		**40,890**	11,160
Finance costs:			
Finance income	8	**282**	240
Finance expenses - unwinding of discount on provisions	9	**(13)**	(15)
Surplus for the financial year		**41,159**	11,385
Public dividend capital dividends payable		**(6,985)**	(6,820)
Retained surplus for the year		**34,174**	4,565
Other comprehensive income			
- Impairments		**0**	(536)
- Revaluations - property, plant and equipment		**28,510**	6,830
Total comprehensive income for the year		**62,684**	10,859

Financial performance for the year - additional reporting measures			
Retained surplus for the year		**34,174**	4,565
Adjustments in respect of capital donations	3	**(31,493)**	**(15,351)**
Adjustments in respect of impairments/(reversal of impairments)	3 & 4	**(13,771)**	**13,665**
Adjusted retained (deficit)/surplus		**(11,090)**	**2,879**

The notes on pages 5 to 32 form part of these accounts.

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

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2016

		31 March 2016	2014/15
	NOTE	£000	£000
Non-current assets			
Intangible assets	10	**6,372**	6,427
Property, plant and equipment	11	**427,292**	358,862
Trade and other receivables	14	**7,139**	7,616
Total non-current assets		**440,803**	372,905
Current assets			
Inventories	13	**7,858**	7,599
Trade and other receivables	14	**51,326**	47,336
Cash and cash equivalents	15	**63,732**	58,932
Total current assets		**122,916**	113,867
Total assets		**563,719**	486,772
Current liabilities			
Trade and other payables	16	**(55,629)**	(42,075)
Provisions	19	**(513)**	(473)
Other liabilities	17	**(4,413)**	(4,007)
Net current assets		**62,361**	67,312
Total assets less current liabilities		**503,164**	440,217
Non-current liabilities			
Provisions	19	**(964)**	(1,002)
Other liabilities	17	**(5,357)**	(5,764)
Total assets employed		**496,843**	433,451
Financed by taxpayers' equity:			
Public dividend capital		**126,065**	125,357
Income and expenditure reserve		**260,983**	226,809
Other reserves		**3,114**	3,114
Revaluation reserve		**106,681**	78,171
Total taxpayers' equity		**496,843**	433,451

The financial statements on pages 1 to 32 were approved by the Board and authorised for issue on 20 May 2016 and signed on its behalf by:

Dr Peter Steer
Chief Executive

Signed:……..
Date: 20 May 2016

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2016

	Public Dividend Capital (PDC)	Revaluation reserve	Income and expenditure reserve	Other reserves	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2015	125,357	78,171	226,809	3,114	**433,451**
Changes in taxpayers' equity for the year ended 31 March 2016					
-Surplus for the year	0	0	34,174	0	**34,174**
- Revaluations - property, plant and equipment	0	28,510	0	0	**28,510**
- Public Dividend Capital received	1,115	0	0	0	**1,115**
- Public Dividend Capital repaid	(407)	0	0	0	**(407)**
Balance at 31 March 2016	**126,065**	**106,681**	**260,983**	**3,114**	**496,843**

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

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

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2016

	NOTE	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000
Cash flows from operating activities			
Operating surplus		**40,890**	11,160
Non-cash income and expense:			
Depreciation and amortisation		**18,013**	17,800
Impairments		**4,797**	17,780
Reversal of impairments		**(18,568)**	(4,115)
Profit on disposal of tangible fixed assets		**(16)**	(83)
Income recognised in respect of capital donations (cash and non-cash)		**(31,493)**	(15,351)
(Increase)/decrease in trade and other receivables		**(111)**	4,227
Increase in inventories		**(259)**	(462)
Increase/(decrease) in trade and other payables		**9,453**	(1,985)
Decrease in other liabilities		**(1)**	(1,785)
Increase/(decrease) in provisions		**(11)**	(195)
NET CASH GENERATED FROM OPERATIONS		**22,694**	26,991
Cash flows from investing activities			
Interest received		**282**	240
Purchase of property, plant and equipment		**(38,788)**	(30,447)
Payments for intangible assets		**(1,331)**	(4,079)
Sales of property, plant and equipment		**16**	142
Receipt of cash donations to purchase capital assets		**28,091**	15,351
Net cash outflow from investing activities		**(11,730)**	(18,793)
NET CASH INFLOW BEFORE FINANCING		**10,964**	8,198
Cash flows from financing			
Public Dividend Capital received		**1,115**	468
Public Dividend Capital repaid		**(407)**	0
PDC dividend paid		**(6,872)**	(6,744)
Net cash outflow from financing		**(6,164)**	(6,276)
NET INCREASE IN CASH AND CASH EQUIVALENTS		**4,800**	1,922
Cash and cash equivalents at start of the year		**58,932**	57,010
Cash and cash equivalents at end of the year	15	**63,732**	58,932

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 2015/16 *NHS Foundation Trust Annual Reporting Manual* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and certain financial assets and financial liabilities.

1.2 Going concern

International Accounting Standard (IAS)1 requires management to assess, as part of the accounts preparation process, the Foundation Trust's ability to continue as a going concern for the foreseeable future. IAS 1 deems the foreseeable future to be a period of not less than twelve months from the entity's reporting date. After making enquiries, (these are described in the Strategic Report section of the Annual Report on page xx), the directors can reasonably expect that the Foundation Trust has adequate resources to continue in operational existence for the next twelve months. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.3 Segmental reporting

Under IFRS 8 Operating Segments, the standard allows aggregation of segments that have similar economic characteristics and types and class of customer.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker, which is the overall Foundation Trust Board and which includes senior professional non-executive directors. The Trust Board review the financial position of the Foundation Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process implies a single operating segment under IFRS 8.

In addition, the large majority of the Foundation Trust's revenue originates with the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust, together with the related supplies and overheads needed to establish this service. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of "provision of acute care" is deemed appropriate.

Therefore, all the Foundation Trust's activities relate to a single operating segment in respect of the provision of acute care.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Foundation Trust's accounting policies, management is required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5 Critical 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 1.37% in real terms.
- When arriving at the valuation for property, Trust management engages a qualified surveyor to assist them in forming estimates.
- The Trust leases a number of buildings that are owned by Great Ormond Street Hospital Children's Charity. The Trust has assessed how the risks and rewards of ownership are distributed between itself and the charity in categorising these leases as either operating or finance leases.

- The Trust has incurred expenditure relating to payments to a third party power supplier in order to increase the amount of power supplied to the Trust's main site. This expenditure is included in prepayments and is being amortised over the estimated period of use.

- a provision is recognised when The Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle The obligation. In addition to widely used estimation techniques, judgment is required when determining The probable outflow of economic benefits.

1.7 Income

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

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

1.8 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. 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 2016, is based on the valuation data as 31 March 2014, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

1.9 Expenditure on other goods and services

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

1.10 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust;
• it is expected to be used for more than one financial year; and
• the cost of the item can be measured reliably.

Property, Plant and Equipment is also only capitalised where:
• it individually has a cost of at least £5,000; or
• it forms a group of assets that individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
• form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Measurement

Valuation

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

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

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

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

1.10 Property, Plant and Equipment (cont)

The Trust revalued its equipment as at 31 March 2016 using relevant indices published by the Office of National Statistics as a proxy for fair value.

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

Subsequent expenditure

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

Depreciation

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

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

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

Revaluation gains and losses

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

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

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

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'; and
-the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

Donated assets

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

Government grants

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

1.11 Intangible assets

Recognition

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

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

Internally generated intangible assets

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

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

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

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

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

Software

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

Measurement

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

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

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

Amortisation

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

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

1.12 Inventories

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

1.13 Financial instruments and financial liabilities

Recognition

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

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

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

De-recognition

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

Classification and measurement

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

Loans and receivables

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

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

Other financial liabilities

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

1.14 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.
The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance 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 1.37% in real terms.

Clinical Negligence Costs

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

Non-clinical risk pooling

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

1.16 Contingencies

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

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

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

1.17 Public Dividend Capital

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

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

1.18 Value Added Tax

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

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

1.19 Corporation Tax

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

1.20 Foreign exchange

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

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

1.21 Cash, bank and overdrafts

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

1.22 Heritage Assets

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

1.23 Losses and special payments

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

1.24 Charitable Funds

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

1.25 Recently issued IFRS Accounting Standards

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

IAS 1 (amendment) Disclosure Initiative
IAS 16 (amendment) Depreciation and Amortisation
IAS 16 (amendment) and IAS 41 (amendment) Bearer Plants
IAS 27 (amendment) Equity Method in Separate Financial Statements
IFRS 9 Financial Instruments
IFRS 10 (amendment) and IAS 28 (amendment) Investment Entities applying the Consolidation Exception
IFRS 10 (amendment) and IAS 28 (amendment) Sale or Contribution of Assets
IFRS 11 (amendment) Acquisition of an Interest in a Joint Operation
IFRS 15 Revenue from Contracts with Customers
Annual Improvements to IFRS; 2012-15 cycle

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

2. Revenue from patient care activities

2.1 Analysis of revenue from patient care activities	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000
Elective income	**83,061**	81,806
Non elective income	**16,153**	15,248
Outpatient income	**38,197**	38,724
Other NHS clinical income	**158,776**	163,305
Revenue from protected patient care activities	**296,187**	299,083
Private patient income	**47,886**	40,925
Other non-protected clinical income	**5,501**	5,190
	53,387	46,115
Total revenue from patient care activities	**349,574**	345,198

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

2.2 Analysis of revenue from patient care activities by source	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000
NHS Foundation Trusts	**552**	474
NHS Trusts	**535**	541
CCGs and NHS England	**295,100**	292,068
Local Authorities	**0**	0
Department of Health	**0**	6,000
Non-NHS:		
Private patients	**47,886**	40,925
Overseas patients (non-reciprocal)	**1,051**	390
Injury costs recovery (was RTA)	**25**	92
Other	**4,425**	4,708
Total revenue from patient care activities	**349,574**	345,198

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

2.3 Overseas visitors	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000
Income recognised in-year	**1,051**	390
Cash payments received in-year	**25**	401
Amounts added to provision for impairment of receivables	**425**	136

3. Other operating revenue	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000
Research and development	**17,448**	16,685
Charitable contributions to expenditure	**7,369**	10,206
Charitable contributions in respect of capital expenditure	**31,493**	15,351
Education and training	**7,853**	8,325
Profit on disposal of other tangible fixed assets	**16**	83
Reversal of impairments	**18,568**	4,115
Non-patient care services to other bodies	**1,072**	758
Clinical tests	**3,851**	3,491
Clinical excellence awards	**3,071**	3,365
Catering	**1,176**	1,072
Creche services	**484**	503
Staff accommodation rentals	**44**	56
Other revenue	**2,418**	3,401
	94,863	67,411

4. Operating expenses	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000
Services from other NHS bodies	**6,519**	6,633
Purchase of healthcare from non-NHS bodies	**2,619**	4,059
Executive directors' costs*	**1,899**	1,462
Non-executive directors' costs*	**162**	151
Staff costs	**206,394**	199,380
Supplies and services - clinical - drugs	**41,680**	40,610
Supplies and services - clinical - other	**54,167**	50,561
Supplies and services - general	**4,333**	2,975
Establishment	**3,096**	2,934
Research and development	**16,030**	14,823
Transport - business travel	**493**	609
Transport - other	**2,763**	2,730
Premises - business rates payable to local authorities	**2,136**	2,210
Premises - other	**22,133**	24,215
Operating lease rentals	**1,478**	1,611
Provision for impairment of receivables	**4,445**	1,936
Change in provisions discount rate	**4**	19
Inventories write down	**198**	240
Depreciation	**16,627**	16,452
Amortisation of intangible assets	**1,386**	1,348
Impairments and reversals of property, plant and equipment	**4,797**	17,780
Fees payable to the Trust's auditor for the financial statement audit	**102**	100
Other audit regulatory services - quality account	**18**	16
Clinical negligence insurance	**4,810**	3,103
Redundancy costs	**414**	358
Consultancy costs	**1,200**	920
Legal fees	**226**	444
Increase in other provisions	**257**	0
Internal audit costs	**135**	78
Losses and special payments	**0**	1
Other	**3,026**	3,691
	403,547	401,449

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

Research and development expenditure includes £11,870k of staff costs (£11,415k in 2014/15).

5. Operating leases

5.1 As lessee

Payments recognised as an expense	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000
Minimum lease payments	**1,478**	1,611
	1,478	1,611

Total future minimum lease payments	As at 31 March 2016 £000	As at 31 March 2015 £000
Payable:		
Not later than one year	**1,544**	1,530
Between one and five years	**6,004**	5,954
After 5 years	**4,566**	5,888
Total	**12,114**	13,372

6. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial year ended 31 March 2016.

7. Employee costs and numbers

7.1 Employee costs	Year to 31 March 2016 Total	Permanently Employed	Other	Year to 31 March 2015 Total
	£000	**£000**	**£000**	£000
Salaries and wages	181,307	180,422	885	174,387
Social security costs	15,000	15,000	0	14,741
Employer contributions to NHS Pension scheme	19,926	19,926	0	19,293
Agency / contract staff	7,574	0	7,574	6,684
Termination benefits	414	414	0	358
Employee benefits expense	**224,221**	**215,762**	**8,459**	215,463
Employee costs capitalised	(1,874)	(933)	(941)	(1,478)
Recoveries from other bodies in respect of staff costs netted off expenditure	(1,770)	(1,770)	0	(1,370)
Net employee benefits excluding capitalised costs and recoveries from other bodies	**220,577**	**213,059**	**7,518**	212,615

7.2 Average number of people employed*	Year to 31 March 2016 Total	Permanently Employed	Other	Year to 31 March 2015 Total
	Number	**Number**	**Number**	Number
Medical and dental	587	582	5	582
Administration and estates	1,020	886	134	1005
Healthcare assistants and other support staff	291	290	1	298
Nursing, midwifery and health visiting staff	1,421	1,414	7	1,338
Scientific, therapeutic and technical staff	743	724	19	754
Other staff	6	6	0	7
Total	**4,068**	**3,902**	**166**	3,984

*Whole Time Equivalent

7.3 Retirements due to ill-health

During the year there were no early retirements from the Trust on the grounds of ill-health. (There were two early retirements in 2014/15, £130k).

7.4 Staff exit packages

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

	Year to 31 March 2016					
Exit packages number and cost	**Number of Compulsory redundancies**	**Cost of compulsory redundancies**	**Number of other departures agreed**	**Cost of other departures agreed**	**Total number of exit packages**	**Total cost of exit packages**
	Number	**£000**	**Number**	**£000**	**Number**	**£000**
<£10,000	**1**	**3**	**0**	**0**	**1**	**1**
£10,00 - £25,000	**5**	**106**	**0**	**0**	**5**	**5**
£25,001 - £50,000	**2**	**63**	**0**	**0**	**2**	**2**
£50,001 - £100,000	**1**	**70**	**0**	**0**	**1**	**1**
Total	**8**	**172**	**0**	**0**	**8**	**8**

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

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

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

8 Finance Income	**Year ended 31 March 2016** £000	Year ended 31 March 2015 £000
Bank interest	**282**	240
Total finance income	**282**	240

9 Finance Expenses	**Year ended 31 March 2016** £000	Year ended 31 March 2015 £000
Provisions - unwinding of discount	13	15
Total finance expenses	**13**	**15**

10. Intangible assets

10.1 Intangible assets

	Software licences	Licences and trademarks	Development expenditure (internally generated)	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Gross cost at 1 April 2015	3,092	496	4,550	3,442	**11,580**
Additions - purchased	78	0	0	1,191	**1,269**
Additions - donated	0	0	0	62	**62**
Reclassifications	621	0	240	(861)	**0**
Disposals	0	0	0	0	**0**
Valuation/Gross cost at 31 March 2016	**3,791**	**496**	**4,790**	**3,834**	**12,911**
Amortisation at 1 April 2015	2,193	259	2,701	0	**5,153**
Provided during the year	490	55	841	0	**1,386**
Disposals	0	0	0	0	**0**
Amortisation at 31 March 2016	**2,683**	**314**	**3,542**	**0**	**6,539**
Net book value					
NBV total at 31 March 2016	**1,108**	**182**	**1,248**	**3,834**	**6,372**

All intangible assets are held at cost less accumulated 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 2014	2,807	496	3,591	3,192	**10,086**
Additions - purchased	287	39	192	2,619	**3,137**
Additions - donated	79	0	0	43	**122**
Reclassifications	151	1	767	(2,412)	**(1,493)**
Disposals	(232)	(40)	0	0	**(272)**
Valuation/Gross cost at 31 March 2015	**3,092**	**496**	**4,550**	**3,442**	**11,580**
Amortisation at 1 April 2014	1,742	222	2,054	0	**4,018**
Provided during the year	624	77	647	0	**1,348**
Disposals	(173)	(40)	0	0	**(213)**
Amortisation at 31 March 2015	**2,193**	**259**	**2,701**	**0**	**5,153**
Net book value					
NBV total at 31 March 2015	**899**	**237**	**1,849**	**3,442**	**6,427**

10.2 Economic life of intangible assets

	Min Life Years	Max Life Years
Intangible assets		
Software	1	8
Development expenditure	1	8
Licences and trademarks	1	8

11. Property, plant and equipment

11.1 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2015	78,057	212,853	7,903	15,271	72,149	22,432	12,716	**421,381**
Additions - purchased	0	2,585	0	7,702	603	415	40	**11,345**
Additions - donated	0	1,096	0	28,148	2,003	127	57	**31,431**
Impairments charged to the revaluation reserve	0	0	0	0	0	0	0	**0**
Reclassifications	0	1,837	0	(5,413)	879	2,398	299	**0**
Revaluations	18	34,631	56	0	0	0	0	**34,705**
Disposals	0	0	0	0	(286)	0	0	**(286)**
Cost or valuation at 31 March 2016	**78,075**	**253,002**	**7,959**	**45,708**	**75,348**	**25,372**	**13,112**	**498,576**
Accumulated depreciation at 1 April 2015	0	938	0	0	39,114	16,689	5,778	**62,519**
Provided during the period	0	6,265	170	0	6,146	2,975	1,071	**16,627**
Impairments charged to operating expenses	0	4,797	0	0	0	0	0	**4,797**
Reversal of impairments credited to operating income	0	(17,105)	(1,463)	0	0	0	0	**(18,568)**
Revaluations	0	6,195	0	0	0	0	0	**6,195**
Disposals	0	0	0	0	(286)	0	0	**(286)**
Accumulated depreciation at 31 March 2016	**0**	**1,090**	**(1,293)**	**0**	**44,974**	**19,664**	**6,849**	**71,284**
Net book value at 31 March 2016								
NBV - Owned at 31 March 2016	75,028	107,040	1,162	45,708	8,707	4,632	1,802	**244,079**
NBV - Finance leased at 31 March 2016	0	3,232	0	0	0	0	0	**3,232**
NBV - Government granted at 31 March 2016	0	142	0	0	85	0	0	**227**
NBV - Donated at 31 March 2016	3,047	141,498	8,090	0	21,582	1,076	4,461	**179,754**
NBV total at 31 March 2016	**78,075**	**251,912**	**9,252**	**45,708**	**30,374**	**5,708**	**6,263**	**427,292**

	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 2014	76,469	214,291	7,661	28,585	63,910	19,100	10,700	**420,716**
Additions - purchased	0	2,540	0	3,642	1,906	473	551	**9,112**
Additions - donated	0	2,130	0	5,716	6,211	46	1,126	**15,229**
Impairments charged to the revaluation reserve	0	(536)	0	0	0	0	0	**(536)**
Reclassifications	0	18,213	0	(22,672)	2,687	2,813	452	**1,493**
Revaluations	1,588	(23,785)	242	0	0	0	0	**(21,955)**
Disposals	0	0	0	0	(2,565)	0	(113)	**(2,678)**
Cost or valuation at 31 March 2015	**78,057**	**212,853**	**7,903**	**15,271**	**72,149**	**22,432**	**12,716**	**421,381**
Accumulated depreciation at 1 April 2014	0	8,403	(72)	0	36,522	14,120	4,892	**63,865**
Provided during the period	0	7,560	167	0	5,157	2,569	999	**16,452**
Impairments charged to operating expenses	0	17,780	0	0	0	0	0	**17,780**
Reversal of impairments credited to operating income	0	(3,830)	(285)	0	0	0	0	**(4,115)**
Revaluations	0	(28,975)	190	0	0	0	0	**(28,785)**
Disposals	0	0	0	0	(2,565)	0	(113)	**(2,678)**
Accumulated depreciation at 31 March 2015	**0**	**938**	**0**	**0**	**39,114**	**16,689**	**5,778**	**62,519**
Net book value at 31 March 2015								
NBV - Owned at 31 March 2015	75,010	88,457	1,130	5,072	9,440	4,482	1,886	**185,477**
NBV - Finance leased at 31 March 2015	0	2,749	0	0	0	0	0	**2,749**
NBV - Government granted at 31 March 2015	0	118	0	0	96	0	0	**214**
NBV - Donated at 31 March 2015	3,047	120,591	6,773	10,199	23,499	1,261	5,052	**170,422**
NBV total at 31 March 2015	**78,057**	**211,915**	**7,903**	**15,271**	**33,035**	**5,743**	**6,938**	**358,862**

11.2 Economic life of property plant and equipment

	Min Life Years	Max Life Years
Buildings excluding dwellings	8	48
Dwellings	45	46
Plant and machinery	1	14
Information technology	1	9
Furniture and fittings	1	14

Freehold land is considered to have an infinite life and is not depreciated.
The majority of Information Technology assets are depreciated over five years.
Assets under course of construction are not depreciated until the asset is brought into use.

Great Ormond Street Hospital Children's Charity donated £30,473k 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 2016
* the valuation of land, buildings and dwellings was undertaken by Peter Ashby, Member of the Royal Institution of Chartered Surveyors, Senior Surveyor, District Valuers Office
* the valuations were undertaken using a modern equivalent asset methodology.

12. Commitments

12.1 Capital commitments

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

	31 March 2016	31 March 2015
	£000	£000
Property, plant and equipment	**29,041**	42,941
Intangible assets	**967**	1,910
Total	**30,008**	**44,851**

12.2 Other financial commitments

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

	31 March 2016	31 March 2015
	£000	£000
Not later than one year	**7,461**	10,311
Later than one year and not later than five year	**4,774**	4,038
Total	**12,235**	14,349

13. Inventories

13.1 Inventories	**31 March 2016**	31 March 2015
	£000	£000
Drugs	**1,359**	1,436
Consumables	**6,472**	6,135
Energy	**27**	28
Total	**7,858**	7,599

The cost of inventories recognised as expenses during the year in respect of continuing operations was £82,157k (2014/15: £80,165k)

14. Trade and other receivables

14.1 Trade and other receivables	**Current**		**Non-current**	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000	£000	**£000**	£000
NHS receivables - revenue	**11,654**	21,972	**0**	0
Other receivables- revenue	**33,017**	19,085	**0**	0
Provision for impaired receivables	**(7,448)**	(4,574)	**0**	0
Receivables due from NHS charities – Capital	**7,118**	3,716	**0**	0
Prepayments	**2,089**	1,410	**7,139**	7,616
Accrued income	**4,450**	5,107	**0**	0
Interest receivable	**2**	2	**0**	0
VAT receivable	**444**	618	**0**	0
Total	**51,326**	47,336	**7,139**	7,616

14.2 Provision for impairment of receivables	**31 March 2016**	31 March 2015
	£000	£000
Opening balance	**4,574**	2,718
Increase in provision	**4,445**	1,936
Amounts utilised	**(1,571)**	(80)
Closing balance	**7,448**	4,574

14.3 Analysis of impaired receivables	**31 March 2016**	31 March 2015
	£000	£000
Ageing of impaired receivables		
0 - 30 days	**1,209**	370
30-60 days	**30**	92
60-90 days	**5**	320
90- 180 days	**990**	952
over 180 days	**5,214**	2,840
	7,448	4,574
Ageing of non-impaired receivables past their due date		
0 - 30 days	**5,309**	3,707
30-60 days	**4,066**	2,469
60-90 days	**2,346**	3,163
90- 180 days	**2,225**	2,955
over 180 days	**1,161**	911
	15,107	13,205

15. Cash and cash equivalents	**31 March 2016**	31 March 2015
	£000	£000
Balance at beginning of the year	**58,932**	57,010
Net change in year	**4,800**	1,922
Balance at the end of the year	**63,732**	58,932
Made up of		
Commercial banks and cash in hand	**13**	11
Cash with the Government Banking Service	**6,219**	921
Deposits with the National Loan Fund	**57,500**	58,000
Cash and cash equivalents as in statement of financial position	**63,732**	58,932
Cash and cash equivalents	**63,732**	58,932

16. Trade and other payables

16.1 Trade and other payables

	Current	
	31 March 2016	31 March 2015
	£000	£000
NHS payables - revenue	**5,728**	5,319
Other trade payables - capital	**8,972**	4,984
Other trade payables - revenue	**4,342**	4,705
Social Security costs	**2,104**	2,086
Other taxes payable	**2,201**	2,187
Other payables	**10,742**	8,615
Accruals	**21,288**	14,040
PDC dividend payable	**252**	139
Total	**55,629**	42,075

'Other payables' includes £2,931k outstanding pensions contributions at 31 March 2016 (£2,856k at 31 March 2015)

17. Other Liabilities

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000	£000	**£000**	£000
Deferred income	**4,006**	3,600	**0**	0
Lease incentives	**407**	407	**5,357**	5,764
Total	**4,413**	4,007	**5,357**	5,764

18. Prudential Borrowing Limit

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

19. Provisions

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000	£000	**£000**	£000
Pensions relating to other staff	**115**	115	**964**	1,002
Other legal claims	**14**	36	**0**	0
Redundancy	**170**	0	**0**	0
Other	**214**	322	**0**	0
Total	**513**	473	**964**	1,002

	Pensions relating to other staff	**Legal claims**	**Redundancy**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2015	1,117	36	0	322	**1,475**
Change in the discount rate	4	0	0	0	**4**
Arising during the year	108	9	170	22	**309**
Utilised during the year	(116)	(26)	0	(130)	**(272)**
Reversed unused	(47)	(5)	0	0	**(52)**
Unwinding of discount	13	0	0	0	**13**
At 31 March 2016	1,079	14	170	214	**1,477**
Expected timing of cash flows:					
- not later than one year	115	14	170	214	**513**
- later than one year and not later than five years	460	0	0	0	**460**
- later than five years	504	0	0	0	**504**
	1,079	14	170	214	**1,477**

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

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

The NHS Litigation Authority records provisions in respect of clinical negligence liabilities of the Trust. The amount recorded as at 31 March 2016 was £101,453k (£55,767k at 31 March 2015).

20. Revaluation reserve

	31 March 2016	31 March 2015
	£000	£000
Opening balance at 1 April	**78,171**	72,488
Impairments	**0**	(536)
Revaluations	**28,510**	6,830
Transfers to other reserves	**0**	(611)
Closing balance at 31 March	**106,681**	78,171

21. Contingencies

	31 March 2016	31 March 2015
Contingent liabilities	**£000**	£000
NHS Litigation Authority legal claims	**(10)**	(20)
Gross value of contingent liabilities	**(10)**	(20)
Net value of contingent liabilities	**(10)**	(20)

A contingent liability exists for potential third party claims in respect of employer's / occupier's liabilities and property expenses £10k at 31 March 2016 (£20k at 31 March 2015). The value of provisions for the expected value of probable cases is shown in Note 19.

22. Financial instruments

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

22.1 Financial assets by category

	31 March 2016	31 March 2015
	Loans and receivables	Loans and receivables
	£000	£000
Trade and other receivables excluding non financial assets	**43,767**	40,817
Cash and cash equivalents (at bank and in hand)	**63,732**	58,932
	107,499	99,749

22.2 Financial liabilities by category

	31 March 2016	31 March 2015
	Other financial liabilities	Other financial liabilities
	£000	£000
Trade and other payables excluding non financial assets	**33,069**	27,896
	33,069	27,896

22.3 Financial Instruments
22.3.1 Financial Risk Management

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

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

Currency risk

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

Interest rate risk

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

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, it has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

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

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

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

23. Related Party Transactions

Great Ormond Street Hospital for Children NHS Foundation Trust is a body corporate established under the National Health Service Act 2006.
Dr Cale's husband is a corporate account manager for Thermo Fisher Scientific with whom the Trust recorded expenditure of £43k in the financial year. No other Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Great Ormond Street Hospital for Children NHS Foundation Trust.
Remuneration of senior managers is disclosed in the audited part of the director's remuneration report on page 33.

The Trust holds a 20% interest in UCLPartners Limited (UCLP), a company limited by guarantee, acquired by a guarantee of £1. The company's costs are funded by its partners who contribute to its running costs on an annual basis. The contributions paid by the Trust are included within operating expenditure. The most recent available signed financial statements for UCLP have been prepared for the year ended 31 March 2015; the reported assets, liabilities, revenues and profit/loss are not material to the Trust.

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

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

2015/16

Organisation Category	Organisation	Income £000	Expenditure £000	Receivables £000	Payables £000
Clinical Commissioning Groups	NHS Barking And Dagenham CCG	353	0	0	129
	NHS Barnet CCG	899	0	0	0
	NHS Basildon And Brentwood CCG	466	0	0	0
	NHS Bedfordshire CCG	573	0	0	0
	NHS Bexley CCG	186	0	0	0
	NHS Brent CCG	580	0	0	0
	NHS Brighton & Hove CCG	142	0	0	0
	NHS Bromley CCG	227	0	0	0
	NHS Cambridgeshire And Peterborough CCG	370	0	0	0
	NHS Camden CCG	2,610	0	961	0
	NHS Canterbury & Coastal CCG	158	0	0	0
	NHS Castle Point & Rochford CCG	321	0	0	0
	NHS Central London (Westminster) CCG	159	0	0	0
	NHS City And Hackney CCG	629	0	0	0
	NHS Coastal West Sussex CCG	164	0	0	0
	NHS Croydon CCG	209	0	0	0
	NHS Crawley CCG	133	0	0	0
	NHS Dartford, Gravesham And Swanley CCG	239	0	0	0
	NHS Ealing CCG	569	0	0	0
	NHS East And North Hertfordshire CCG	907	0	0	0
	NHS Eastbourne, Hailsham and Seaford CCG	112	0	0	0
	NHS East Surrey CCG	218	0	142	0
	NHS Enfield CCG	846	0	0	0
	NHS Gloucestershire CCG	106	0	0	0
	NHS Great Yarmouth & Waveney CCG	145	0	0	0
	NHS Greenwich CCG	129	0	0	0
	NHS Guildford & Waverley CCG	287	0	0	0
	NHS Hammersmith & Fulham CCG	245	0	0	0
	NHS Haringey CCG	833	0	0	0
	NHS Harrow CCG	501	0	0	0
	NHS Hastings & Rother CCG	174	0	0	0
	NHS Havering CCG	510	0	0	0
	NHS Herts Valleys CCG	971	0	0	241
	NHS Hillingdon CCG	588	0	0	0
	NHS Horsham & Mid Sussex CCG	100	0	0	0
	NHS Hounslow CCG	410	0	0	0
	NHS Ipswich & East Suffolk CCG	152	0	0	0
	NHS Islington CCG	650	0	0	0
	NHS Kingston CCG	231	0	0	0
	NHS Lambeth CCG	160	0	0	0
	NHS Lewisham CCG	183	0	0	0
	NHS Luton CCG	517	0	0	0
	NHS Medway CCG	207	0	0	0
	NHS Mid Essex CCG	517	0	0	0
	NHS Milton Keynes CCG	171	0	0	0
	NHS Nene CCG	223	0	0	0
	NHS Newham CCG	502	0	0	120
	NHS North East Essex CCG	557	0	0	0
	NHS North West Surrey CCG	246	0	0	0
	NHS Redbridge CCG	692	0	159	0
	NHS Richmond CCG	272	0	0	0
	NHS Slough CCG	1,815	0	510	0
	NHS Southend CCG	326	0	0	0
	NHS South Kent Coast CCG	175	0	0	0
	NHS Southwark CCG	135	0	0	0
	NHS Surrey Downs	321	0	0	0
	NHS Thurrock CCG	366	0	0	0
	NHS Tower Hamlets CCG	356	0	0	0
	NHS Waltham Forest CCG	614	0	107	0
	NHS Wandsworth CCG	262	0	0	0
	NHS West Essex CCG	541	0	0	0
	NHS West Kent CCG	315	0	0	0
	NHS West London (K&C & Qpp)	265	0	0	0
	Cambridge University Hospitals NHS Foundation Trust	103	0	0	0
	Central Manchester University Hospitals NHS Foundation Trust	0	127	0	0
	Guys And St Thomas NHS Foundation Trust	106	1,721	0	648
	Luton & Dunstable NHS Foundatio Trust	121	114	0	0
	Moorfields Eye Hospital NHS Foundation Trust	0	124	0	0
	Oxford University Hospitals NHS Foundation	112	0	0	0
	Royal Brompton & Harefield NHS Foundation Trust	0	164	0	0
	Royal Free London NHS Foundation Trust	152	122	313	157
	Sheffield Children's NHS Foundation Trust	0	0	0	151
	St Georges University Hospital NHS Foundation Trust	102	0	0	0
	University Hospitals Birmingham NHS Foundation Trust	0	139	0	0
	University College London NHS Foundation Trust	642	1,537	5,886	1,243
NHS Trusts	Barts Health NHS Trust	2,876	858	498	614
	Imperial College Healthcare NHS Trust	143	132	145	105
	Mid Essex Hospital Services NHS Trust	0	914	101	147
	Portsmouth Hospitals NHS Trust	0	114	0	0
	Whittington Hospital NHS Trust	126	960	0	245
	NHS England - London Commissioning Hub	260,051	0	0	0
	NHS England - Central Specialised Commissioning Hub	320	0	0	0
	London Regional Office	7,337	0	0	0
	NHS England - Core	267,807	0	0	0
Other NHS Bodies	NHS Litigation Authority	0	4,810	0	0
	Health Education England	7,726	0	0	0
	Department of Health : Core trading & NHS Supply Chain (excluding PDC dividend)	9,902	0	0	150
Other Government Bodies	Camden London Borough Council	0	2,808	0	0
	Care Quality Commission	0	112	0	0
	Department of Health - PDC dividend only	0	6,985	0	252
	HM Revenue & Customs - VAT	0	0	444	0
	HM Revenue & Customs - Other taxes and duties	0	0	0	4,305
	National Insurance Fund (Employer contributions - Revenue Expenditure)	0	15,000	0	0
	National Loans Fund	0	0	57,500	0
	NHS Blood and Transplant (excluding Bio Products Laboratory)	0	2,076	0	128
	NHS Pension Scheme (Own staff employers contributions only plus other invoiced charges)	0	19,926	0	0
	Northern Health & Social Care Trust - Northern Ireland	1,415	0	0	0
	Welsh Assembly Government (incl all other Welsh Health Bodies)	2,226	0	0	0
	Scottish Government	522	0	341	0
Other Related Parties	Great Ormond Street Hospital Children's Charity	37,842	1,660	7,501	43

24. Events after the reporting period

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

25. Losses and special payments

	Number	£000
Stores losses	3	198
Other losses		
Total losses	**3**	**198**
Ex-gratia payments	10	3
Total special payments	**10**	**3**
Total losses and special payments	**13**	**201**

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

26. Expenses

Expenses totalling £17,400 were claimed by four directors of 17 (2014/15: £18,500 claimed by six directors of 22).
Expenses totalling £400 were claimed by six of 27 councillors of the Members' Council (2014/15: £1,300 claimed by six councillors of 22).

27. Off-Payroll engagements

As at 31 March 2016, the Trust had five off-payroll engagements for more than £220 per day lasting for longer than six months.
Of these, two have existed for less than 1 year at the time of reporting and four have existed for more than four years.

Great Ormond Street Hospital for Children NHS Foundation Trust

Annual Report and Accounts

2015-16

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

Contents

Performance Report

Introduction from the Chief Executive

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

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

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

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

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

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

The financial environment we have and which we continue to operate in remains very challenging. This year we recorded a deficit of £11.1 million for the first time in several years. This end of year position is after achieving £12 million of efficiencies and the consequence of achieving significant income from our private patient activities. The coming year promises to be equally challenging. As costs of provision of care continue to rise faster than income we receive for our services, we will continue to focus on transforming pathways of care to drive efficiency. We will also engage with our commissioners to ensure we are providing those specialist services that should be delivered at a specialist hospital and at

a rate that is fair and affordable. This approach is part of our three year financial plan which aims to restore the organisation to financial balance by the end of 2017/18.

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

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

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

Over the last year we have restructured our clinical divisions to better align our services around the patient pathways and facilitate better planning and delivery of complex care packages. This has resulted in two, rather than five, NHS clinical divisions. The new divisions are named after our founder Charles West and one of most significant benefactors J. M. Barrie. We have also restructured our executive team to better ensure a line of sight from the wards to the Board and better align portfolios and accountabilities.

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

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

Introduction from the Chair

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

In our 164-year-old history our purpose has been constant but the environment in which we work changes. The landscape is which we have operated in continues to evolve. As a specialist provider within the National Health Service, GOSH, in common with many others, continues to faces uncertainty around commissioning strategies and faces increasing costs. Taken together they have caused financial insecurity and difficulties in planning future sustainable models of care particularly around for our cardiac and oncology services.

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

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

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

Underpinning this strategy are Our Always Values which define the behaviours what our patients, their families and our partners expect of us and that what we should expect of each other. They were developed in collaboration with the families we care for and are a powerful statement of intent of our collective personality. I am very pleased that in the coming year a programme of work will be undertaken to further embed the values in our systems, processes and structures everything we do.

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

In the first CQC national inpatient survey our children and young people scored their overall experience as 8.5 out ten of 10 while their parents rated their experience 8.7 out of 10. This year for the

first time our Friends and Family Test was undertaken across all inpatient, outpatient and day case areas. While we recognise we have to strive to ensure that every parent and child is given the opportunity and encouraged to complete the test, the results from more than 17,000 responses were very encouraging. They showed that on a consistent basis more than 95 per cent of our patients and their families would recommend GOSH as a place to be treated.

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

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

Our programme of redevelopment would not be possible without the many thousands of donors who support us through our dedicated charity. Their immense generosity is not only enabling us to rebuild and build extraordinary facilities but also to buy new equipment, power vital research and improve the experience of our patients and their families through funding the support welfare projects including our parent accommodation.

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

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

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

Our staff are our most precious resource. Every time I enter the hospital I am struck by their dedication, hard work and compassion. I would like to end by thanking them for everything they continue to do to

help give the children and young people we see the best possible chance of fulfilling their potential having health and happy lives.

Who we are and what we do

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

Our clinical services

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

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

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

Leading research and development

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

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

Education and training for staff working in children's healthcare

GOSH offers a wide prospectus of learning to all staff groups. Together with London South Bank University, we train the largest number of 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 business model

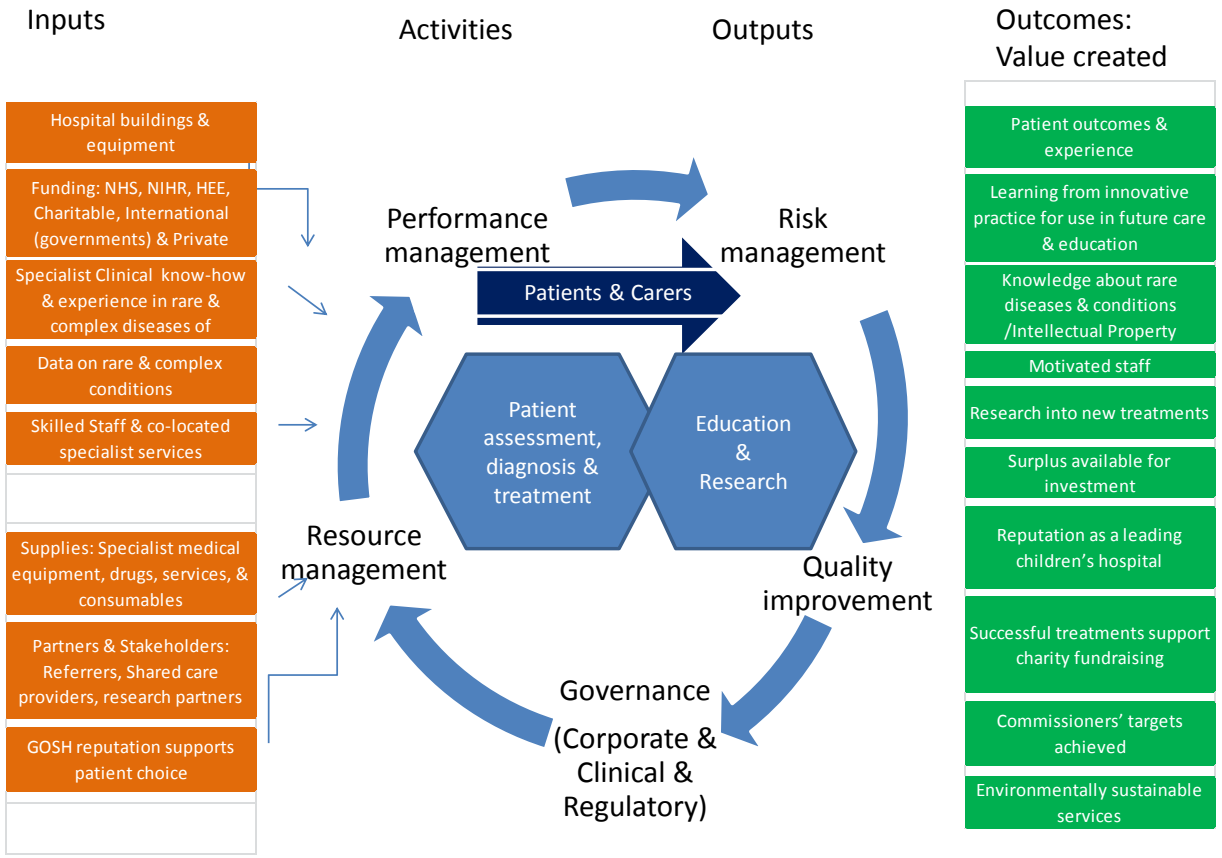
The Trust's business model demonstrates how GOSH creates value for its stakeholders through its activities. The model shows the critical inputs and the immediate outputs for its NHS services, education and research, and international and private patient activity and how these create value. The model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

The key outcomes we aim to deliver from our business model are as follows:

- Clinical outcomes – world class clinical outcomes for our specialised services
- Patient and Family Satisfaction – high levels of patient satisfaction with our services
- Research translated into clinical practice – new and innovative specialist treatments for children with complex or rare diseases
- Education – the largest programme of specialist paediatric training and education in Europe
- Financial – financially sustainable activities with the contribution from our private patient business supporting investment in developing our services
- Reputation – a hospital for the NHS to be proud of with a worldwide reputation for excellence in providing specialist healthcare for children.

Attachment P

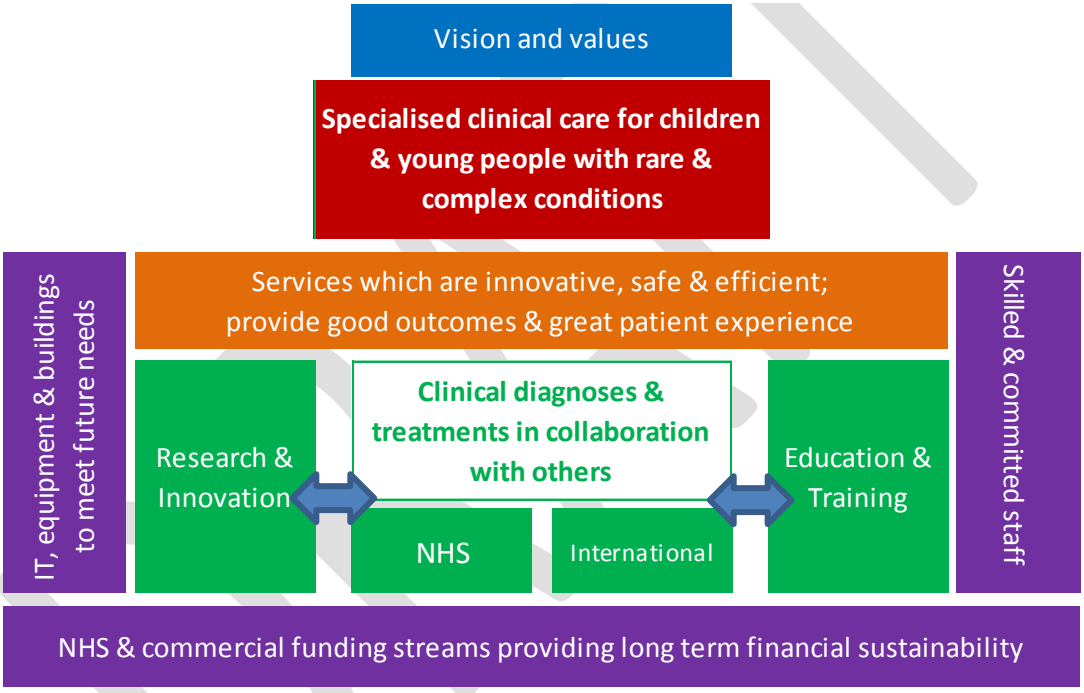
Our business model



Our strategic priorities in 2015-16

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

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



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

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

- To provide the best patient experience and outcomes
- To deliver world-leading paediatric research

- To be an excellent place to work and learn
- To be sustainable and efficient.

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

Management of risk in 2015-16

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

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

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

Risk	Potential impact	Mitigating actions implemented and underway
Reduction in funding available to NHS organisations coupled with the high costs of maintaining delivery of specialised services	A reduction in funding and/or increasing costs will lead to a need to reduce activity. This could potentially impact on our ability to deliver our vision, despite efforts to ensure excellent patient experience and outcomes.	- Robust financial planning including downside contingency planning and regular performance reviews - Development of commercial strategies. - Monthly monitoring of capital expenditure. - Working with Commissioners to support the Trust's service and growth strategy - Continued involvement in forums influencing paediatric tariff discussions. - On-going cost benchmarking
Recruitment and retention of sufficient highly skilled staff with specific experience	The inability to recruit and retain enough skilled staff could lead to a reduction in services that can be safely provided. This potential reduction could lead to GOSH being unable to accommodate all referrals to the Trust and/or result in longer wait times	- Specific action plans are in place for key service areas and professions. - Tactical use of temporary staff to fill vacancies. - Education commissioning plans to increase numbers of potential staff. - Monitoring workforce performance indicators to identify and address issues.

Risk	Potential impact	Mitigating actions implemented and underway
Management of Referral to Treatment (RTT) waiting time processes (Inconsistent application of the Trust Access Policy and unreliable data)	Failure to treat all patients within clinically appropriate timeframes and Inability to analyse data and subsequently make business decisions conducive to timely service provision.	- Implementation of a change programme across the Trust to review and implement the Trust's Access Policy (working in collaboration with the National Intensive Support Team (IST)). - Conducting training for all appropriate staff (non-clinical and clinical) on the application of the Trust Access Policy and national waiting list guidance. - Weekly monitoring of waiting lists, supported by on-going validation of patient lists and processes - Detailed analysis of current systems and processes with regard to the underlying datasets and reporting. - Additional resource and leadership identified to support the Information Services Team. - Validation of the underlying data. - Weekly Clinical Review Group and Access meetings with clinical teams. - Development and implementation of interim reporting solutions.

Financial control and management and going concern

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

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

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

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

The Trust maintains a strong liquidity position based upon historic surpluses and careful management of capital spend. The deficit in 2015/16 and any risk of not reversing this underlying deficit position will impact the levels of cash we are able to sustain but performance remains strong in this area.

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

Performance against Trust priorities 2015/16

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

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

Progress was also monitored by relevant Committees which include:

- Patient and Family Experience and Engagement Committee;
- Patient Safety and Outcomes Committee and the Quality Improvement Committee;
- Board Committees (Audit Committee, Clinical Governance Committee, Finance andInvestment Committee);

  and monitored at divisional level at the monthly operational performance reviews.

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

Strategic Objective	2015/16 Priorities	Evaluation:
Provides the best patient experience and outcomes	Deliver the actions identified to improve quality based on the Trust's 12 quality standards.	Achieved: Reported regularly in the Trust Board quality report. Progress maintained or improving in relation to mortality, detecting serious illness, healthcare associated infections
	All specialties to have published a minimum of two clinical outcome measures on the Trust website or intranet	Partially achieved: 300 outcome measures have been identified and 128 reported on the Trust website (>two per specialty). However a number of these need to be updated (with work progressing to address these).
	At least three benchmarking initiatives active in year	Achieved: Benchmarking outcomes in the craniofacial service is being progressed. The Trust joined the US Solutions for Patient Safety peer review system. Other benchmarking occurs at service level through the submission of quality dashboards to NHS England.
	To achieve a 60% Friends and Family Test response rate	Not achieved: The trust set this target for 15/16, based on the previous year's delivery, when the response rate was 33-35%. The measure was changed at the beginning of 15/16 to include day case areas which resulted in a decline to 14-17%. Targeted work is underway in day case areas and is being taken forward by the senior nursing leadership.
	95% of respondents would be likely to	Achieved:

	recommend GOSH to friends and family	The Trust is consistently achieving 98–99% likelihood to recommend for inpatients and 95-97% likelihood to recommend for outpatients
	Respond to 100% of complaints on time. The objective has been increased from 75% to 100%	Not achieved (60% of complaints responded to on time): A change to the complaints process in year (for very valid reasons) has temporarily extended the timeframe for responding. The process, policy and timescales are being reviewed, with training being given to relevant staff which should enable the Trust to achieve the target in 16/17
	Achieve all national (Referral to Treatment, diagnostic and cancer) waiting times targets	Not achieved: See additional section on Access / RTT (refer to page X)
	Ensure that all areas are staffed safely and efficiently with an initial priority on out of core hours provision	Partially achieved: On-going work includes: delivering the objectives set in the Quality Improvement programme which include: alignment to the Keogh 7 day standards, assessing workloads out of hours ("OOH") and revising standard operating procedures for reporting sickness, escalation and responsibilities OOH. The new Deputy Medical Director for Medical Education has been appointed and is current leading on work to ensure we have the appropriate staff with the right skill-set to fulfil the tasks required OOH. The sensitivity of the Children's Early Warning Score(CEWS) has been reviewed for the prediction of clinical deterioration. The Paediatrc Early Warning Score (PEWS) was identified as a more sensitive and validated scoring tool - work is underway to scope the process for change including the implementation of the Sepsis 6 recommendations.
Is an excellent place to work and learn	Achieve results in the upper quartile staff survey for staff recommending GOSH as a place to work / be treated	Achieved (based on quarter 1 2015/16 only): *Recommend as place to work, Upper quartile = 70.9%. GOSH = 71.1% *Recommend as place to be treated, Upper quartile = 87%, GOSH = 94%.
	Compliance with student nurse mentorship annual update	Partially Achieved: The Trust continues to promote mentoring and provide support to staff to achieve the update. Delivery at present is 90% compliance against a target of 100%
	All healthcare assistants starting employment from April 2015 will undertake the Care Certificate within 12 weeks	Achieved: 100% compliance
	Ensure the medical education provision supports the professional development of all levels of the medical workforce and effective service delivery for the Trust	Achieved: This has been delivered with improvements in feedback from national trainees and trainers surveys. There is an agreement in principle to re-establish national training grid posts in oncology. An additional rota has been established with extended working

		hours for consultants and medical specialties
Delivering world leading paediatric research	Recruit 3,100 or more patients to National Insttiture of Health Research (NIHR) portfolio research studies and achieve national agreed metrics	Achieved: In 2015/16 3,164 patients were recruited to NIHR portfolio studies.
	Commence patient recruitment to the national 100,000 Genomes project and roll out recruitment in all partners of the North Thames Genomics Medicine Centre	Achieved
	Continue to compete on international scale and remain in top three in terms of research outputs	Achieved: A recent Thomas Reuters analysis for publications 2010-2014 placed GOSH first for citation impact compared to five international comparators. GOSH was fifth in terms of actual numbers of publications.
	To provide research training opportunities, at least four training posts in clinical – academia and four nurse / Allied Health Professional (AHP) posts	Achieved
	Implement Research Accelerator program to improve access to research studies/trials and enable more research	Achieved: New Research Accelerator launched in September 2015
	Embed research in the fabric of the Trust (research and communications strategy and scope generic consent)	Achieved: This was achieved and continues to be developed and worked upon with regards to a research communications plan, continued focus on generic consent and working with the GOSH Charity on a Research Capacity Fund
Is the partner of choice	Provide patient discharge summaries to other clinicians in 24 hours	Partially Achieved: The proportion of summaries sent out within 24 hours of discharge has improved but it has proved difficult to sustain the improvement.
	Deliver more care closer to home by exploring partnership and network opportunities	Partially Achieved: The Trust continues to be actively engaged with commissioners and other providers responding to future models for collaborative working, e.g. for congenital cardiac surgery and neurosurgery.
Is sustainable	Achieve £12 million efficiency target	Achieved: £8-9million delivery of cost improvements augmented by non-recurrent cost under spends and contribution growth
	Develop the Strategic Outline Case for Phase 4 of the Redevelopment Programme	Partially Achieved: Good progress has been made.
	Reduce CO2 emissions to 152.78 CO2 / m2	Achieved: The Trust is seeing CO2 emissions falling 8% compared to 2014/15. We are on target to hit 138.59 kgCO2/m2.
	Work with NHS England and Monitor to develop a sustainable NHS funding	Partially Achieved:

	model for GOSH	Agreement reached with NHS England for a joint programme of work to review GOSH cost structure and address where services are demonstrably underfunded
	Deliver Outline Business Case for Electronic Patient Record system andData Warehouse and Analytics tools	Achieved: The OBC for the EPR was approved by the Board. The Data Warehouse OBC was deferred pending EPR supplier selection
	Fully implement Electronic Document Management	Partially Achieved: Following external delays to the project, pilots have progressed well and specialty engagement very good.

Finance and Activity

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

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

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

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

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

£ million		
For the period ended:	31-Mar-16	31-Mar-15
Operating income	394.3	389.6
Operating expenses	-380.7	-362.3
EBITDA	13.6	27.3
Depreciation, interest and dividend	-24.7	-24.4
Net surplus	-11.1	2.9

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

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

International and Private Patients

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

Highlights for the division include:

- improved patient access and referral turnaround time;
- established senior clinical presence in our primary referral region to aid patient experience and improve flow;
- enhanced relationship management with key referrers, and agreed a plan to further enhance in 16/17;
- increased income by 20 per cent in comparison to 14/15 and delivered against the divisional savings plan;
- progressed redevelopment work to provide additional private beds opening in 16/17.

Referral to Treatment (RTT) at GOSH

2015-16 was a challenging year for the Trust with respect to delivery of the RTT waiting time standards. Issues were identified in relation to the data and information processes required to robustly track patients through their elective pathway, as well as a number of operational processes in place to support these. No concerns with the clinical care received by patients have been identified. Further information can be found on page XX.

Productivity and Efficiency

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

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

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

Research

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

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

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

Care Quality Commission (CQC) inspection 2015

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

GOSH that the inspectors were particularly impressed with:

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

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

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

Quality Improvements

As part of the Trust's aims to continue to improve the quality of its services and ensure that this can be demonstrated through robust measurement, we defined and met our targets in relation to

mortality, detecting serious illness, and healthcare associated infections. In addition, we formerly started collecting Friends and Family surveys and although the results returned score us highly, we have been unable to achieve our targeted response rate. More information can be found in the Trust Quality Report on page XX

Development of specialised services

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

Organisational development

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

Annual Plan Priorities for 2016-17

Strategic priorities

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

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

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

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

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

Service and Operational Priorities

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

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

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

Research Priorities

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

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

Patient experience and involvement priorities

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

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

Redevelopment priorities

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

- Planning to occupy the Premier Inn Clinical Building (the second part of the Mittal Children's Medical Centre), opening in Summer 2017. The new building connects floor-by-floor with the Morgan Stanley Clinical Building and includes a new surgery centre, high-specification respiratory ward and specialist unit for children waiting for a heart transplant.
- Overseeing construction of the Zayed Centre for Research into Rare Disease in Children in collaboration with the GOSH Charity. Opening in 2018, it will provide a new outpatient department and laboratories to develop treatments and cures for children with rare conditions.
- Procuring a design team for a new clinical building on Great Ormond Street.

Corporate social responsibility

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

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

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

Sustainability

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

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

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

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

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

Emergency planning

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

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

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

Go Create!

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

In 2015/16 we:

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

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

Listening and learning from our patients, families and stakeholders

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

Patient Surveys

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

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

GOSH was recognised to be among the best hospitals on four scores out of 52; these were parents feeling involved in decision making about their child's care; children and young people feeling their pain was well managed; parents assessment of staff playing with their child whilst in hospital; and staff explaining operations or procedures. The Trust also performed well on measures related to Our Always Values in relation to being welcoming, friendly and expert.

The Trust had no red scores (the rating given to the worst performing hospitals). However, there were areas for improvement identified including patients' satisfaction with food; patients discussing their fears and anxieties with staff; changes to admission dates; and staff not working well together. A plan has been developed and is being implemented to deliver improvements in these areas. The Trust will be participating in a repeat of the survey in the autumn of 2016.

Friends and Family Test

The Trust has now implemented the Friends and Family Test across all inpatient, outpatient and day care areas with over 17,000 responses collected to date. Unfortunately, our response rate is only 22 per cent, which is well below our 60% target which was determined on a different basis (see page XX). We are delighted that the likelihood of family and friends to recommend GOSH's services has remained consistently above our 95 per cent target for both inpatients and outpatients.

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

Patient Advisory and Liaison Service (Pals)

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

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

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

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

Volunteering

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

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

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

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

Family equality and diversity

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

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

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

Complaints

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

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

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

The Trust received notification that four complaints had been escalated to the Ombudsman. The Ombudsman reached their final decision on six complaints. Six of these were not upheld and one was partly upheld.

Patient information

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

Working with our partners

The UCL Institute of Child Health (ICH)

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

Great Ormond Street Hospital Children's Charity

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

Working with our stakeholders

University College London Partners (UCL Partners)

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

Our commissioners

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

Referrers and clinical networks

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

Healthwatch

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

Accountability report

Directors' Report

How we are governed

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

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

- Trust objectives and supporting workstreams
- Care Quality Commission (CQC) requirements
- NHS Improvement requirements
- National priority and existing commitment performance indicators
- Commissioning and contract agreements
- Key internal measures.

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

As outlined on page XX, the Trust Board has identified four strategic objectives, supported by a number of more detailed actions to deliver them. The Board receives a monthly key performance indicator (KPI) report, which is used to monitor progress against priority objectives, as outlined in our Annual Plan, 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.
The key elements of the Trust's quality governance arrangements are:

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

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

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

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

Through these methods, all the data available on the quality of care in each specialty and service is considered as part of our internal and external management and assurance process. During the year, the Trust became aware of problems with the quality of its waiting list data (Referral to Treatment

data). The Trust decided to suspend reporting against its waiting list targets in September 2015 (see page xx for an explanation of the impact of this on Monitor's governance rating). This was reflected in the Trust's quarterly Board statements. Further information on the data quality and access issues is provided in the Annual Governance Statement on page xx and on page xx about the strategic risks facing the organisation.

The Royal College of Paediatrics and Child Health (RCPCH) was invited by the Trust in 2015 to conduct a review of the Gastroenterology service following a number of concerns expressed from within and outside the hospital about waiting times, communication and clinical governance of the service. It was recommended that a review be undertaken of the diagnosis and management of children currently being treated for Eosinophilic Colitis to determine whether the overall best interests of the child are being met, and if not, to devise a strategy for resolution. A turnaround programme has been implemented to improve the service.

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

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

Regulatory monitoring

Monitor publishes two ratings for each NHS foundation trust:

- The continuity of services rating is Monitor's view of the risk that 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.

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

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

2015/16	Q1	Q2	Q3	Q4
Financial sustainability risk rating	3	4	4	Yet to be received from Monitor
Governance rating	**Green**	Under review	Under review	

Registration with the Care Quality Commission (CQC)

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

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

Compliance with the Code of Governance

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

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

Members of the Trust Board in 2015/16

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

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

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

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

- The departure of Professor Martin Elliott, Co Medical Director and Dr Catherine Cale, Interim Co-Medical Director on 31 May 2016.

- 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 departure of Rachel Williams as Chief Operating Officer on 31 March 2016
- The departure of Robert Burns as Director of Planning and Information on 31 March 2016
- Claire Newton was Chief Finance Officer until 6 December 2015 and then became Interim Director of Strategy and Planning
- The appointment of Bill Boa as Interim Chief Finance officer from 7 December 2015 to 31 March 2016
- The appointment of Professor Stephen Smith as Non-Executive Director on 1 March 2016 following the departure of Yvonne Brown on 29th February 2016
- The appointment of Nicola Grinstead as Deputy Chief Executive on 1 April 2016
- The appointment of Loretta Seamer as Chief Finance Officer on 1 April 2016

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

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

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

Non-executive Directors

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

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

Current term of office expires: 28 February 2018

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

Experience

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

Current term of office expires: 31 August 2016

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

Experience

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

Current term of office expired: 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 Hospital NHS Foundation Trust
- Deputy Chair of the Child and Family Court Advisory and Support Service (CAFCASS)
- Chair of the ethics committee of the Internet Watch Foundation
- Trustee of Columbia 1400
- Non-Executive Director of the Video Standards Council
- Chief Executive of the Family and Parenting Institute (1999–2009)
- Director of Policy, Research and Development and Deputy CEO of Childline (1995–99)
- Independent consultancy on child and family policy
- Non-Executive Director of Video Standards Council

Current term of office expires: 31 August 2017

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

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

Current term of office expires: 28 February 2018

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

- Director of the Institute of Child Health 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

Current term of office expires: 31 December 2018

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

- Independent Member of the Advisory Board of FMCG company SuperMax
- Director of The British Pakistan Foundation
- Group Chief Auditor of Unilever (2011–2012)
- Senior Global and Regional Finance roles Unilever, leading finance teams in Latin America, South East Asia and Australasia. (1984-2011)

Current term of office expires: 27 March 2018

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

- Professor of Obstetrics and Gynaecology
- Chief Executive, Imperial Healthcare NHS Trust (October 2007 – December 2010)

- Dean, Faculty of Medicine Dentistry and Health Sciences, University of Melbourne (September 2013 – October 2015)
- Chairman of the Melbourne Academic Centre for Health (July 2014 – October 2015)

Executive Directors

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

- Chief Executive – Children's Health Queensland Hospital and Health Services (2009 – 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)

Mrs Claire Newton MA (Cantab) ACA
Chief Finance Officer until 6 December 2015 then Interim Director of Strategy and Planning
Claire Newton is responsible for the Trust's strategic planning. She is the named Senior Information Risk Owner.

Experience

- Qualified accountant and member of the Association of Corporate Treasurers
- Trained and worked at Senior Management level in Ernst and Young
- Finance Director and Financial Controller at Marie Curie Cancer Care (1998–2007)
- Chief Finance Officer at Great Ormond Street Hospital NHS Foundation Trust (2007 – 2015)

Mr Bill Boa
Interim Chief Finance Officer (from 7 December 2015)
Bill Boa is responsible for the financial management of the Trust and leads on contracting and information technology.
Experience

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

Ms Juliette Greenwood
Chief Nurse (from 1 April 2015)
Juliette Greenwood is responsible for the professional standards, education and development of nursing. She was also the Lead Executive responsible for patient and public involvement and engagement, safeguarding and infection prevention and control.
Experience

- Registered Sick Children's Nurse
- Held Chief Nurse roles in the NHS since 2005 most recently at Bradford Teaching Hospitals NHS Foundation Trust (2013 – 2015)

Professor Martin Elliott MB BS MD FRCS
Co-Medical Director (until 31 May 2015)
Martin Elliott was responsible for performance and standards (including patient safety) and 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)

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

- Practicing Consultant Paediatrician
- Medical Director at Birmingham Children's Hospital NHS Foundation Trust (2010 – 2015)
- Appointed member of the London Clinical Senate
- Appointed member of the London Children and Young People's Healthy Partnership Clinical Reference Group
- Chair of the Clinical Reference Group for Paediatric Medicine in NHS Specialised Commissioning

---

Mr Ali Mohammed
Director of Human Resources and Organisational Development
Ali Mohammed is responsible for the development and delivery of a human resources strategy and organisational development programmes.
Experience

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

Ms Rachel Williams
Chief Operating Officer (until 31st March 2016)
Rachel Williams was responsible for the operational management of the clinical services within the Trust.
Experience

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

Ms Dena Marshall
Interim Chief Operating Officer
Experience

- Joined the NHS as a graduate management trainee in 2003
- Thirteen years' experience as a Board Level Director, seven of them as Deputy Chief Executive
- Deputy Chief Executive and Director of Commissioning and Performance of NHS Heywood, Middlewood and Rochdale from 2007 to 2010 and Acting Chief Executive from August 2009 - March 2010.

Dr Catherine Cale MB ChB PhD MRCP FRCPath MRCPCH
Interim Co-Medical Director (until 31 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 (until 31 March 2016)

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

Experience

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

Mr Matthew Tulley

Director of Redevelopment

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

Professor David Goldblatt MB ChB PhD MRCP FRPCH

Director of Clinical Research and Development

David Goldblatt leads the strategic development of clinical research and development across the Trust. He is Honorary Consultant Immunologist and Director of the NIHR funded 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 International Private Patients (IPP) division.

Register of Interests

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

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

Trust Board meetings

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

During the year:

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

Directors' attendance at meetings

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

Evaluation of Board Performance

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

Board Committees

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

Audit Committee

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

Clinical Governance Committee

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

Finance and Investment Committee

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

Trust Board Remuneration Committee

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

Trust Board Nominations Committee

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

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

The Council

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

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

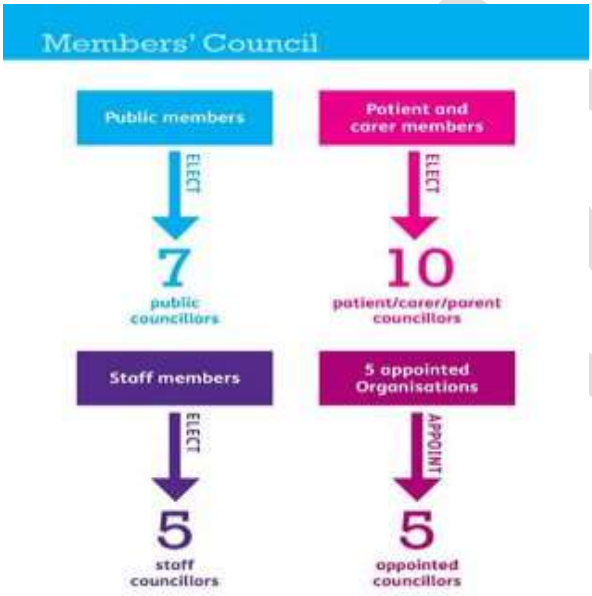
The GOSH Members' Council is made up of 27 councillors. Of these, 22 are elected representatives for patients, parents, carers, staff and the public and five representatives for appointed organisations. The duration of appointment for all elected and appointed councillors is three years.

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

For more information on the Members' Council visit - http://www.gosh.nhs.uk/about-us/foundation-trust/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.

Constituencies of the Members' Council

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



Name	Areas	Councillors
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 and Fulham; Haringey; Harrow; Havering; Hillingdon; Hounslow; Islington; Kensington and Chelsea; Newham; Redbridge; Tower Hamlets; Waltham Forest; Westminster. Comprising the following electoral areas in Bedfordshire: Bedford; Central Bedfordshire; Luton; Hertfordshire: Broxbourne; Dacorum; East Hertfordshire; Hertfordshire; Hertsmere; North Hertfordshire; St Albans; Stevenage; Three Rivers; Watford; Welwyn Hatfield; Buckinghamshire: Aylesbury Vale; Buckinghamshire; Chiltern; Milton Keynes;	4

	South Bucks; Wycombe; Essex: Basildon; Braintree; Brentwood; Castle Point; Chelmsford; Colchester; Epping Forest; Essex: Harlow; Maldon; Rochford; Southend on Sea; Tendring; Thurrock; Uttlesford.	
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; Wandsworth. Comprising the following electoral areas in: Surrey: Elmbridge; Epsom and Ewell; Guildford; Mole Valley; Reigate and Banstead; Runnymede; Spelthorne; Surrey Heath; Tandridge; Waverley; Woking; Kent: Ashford; Canterbury; Dartford; Dover; Gravesham; Maidstone; Medway; Sevenoaks; Shepway; Swale; Thanet; Tonbridge and Malling; Tunbridge Wells; Sussex: Brighton and Hove; East Sussex; Eastbourne; Hastings; Lewes; Rother; Wealden; Adur; Arun; Chichester; Crawley; Horsham; Mid Sussex; West Sussex; Worthing.	1
Rest of England and Wales	All electoral areas in England and Wales not falling within one of the areas referred to above.	2
Statutory		
UCL Institute of Child Health		1
London Borough of Camden		1
Partnership Organisations		
National Commissioning Group		1
Self management UK		1
The Hospital School at GOSH and UCL		1

Lead Councillor

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

Councillors' attendance at meetings

The Members' Council met five times during the 2015/16 reporting period. The Members' Council Nominations and Remuneration Committee (a subcommittee of the Members' Council) met three times during 2015/2016 and the Membership and Engagement Committee (a subcommittee of the Members' Council) met five times during that period.

The table below details attendance at these meetings. Details related to the Members' Council and committee meetings, and councillor attendance is provided in the table below.

Name	Constituency	Date of appointment	Attendance at Members' Council Meetings (out of 5 unless otherwise stated)	Member of Members' Council Nominations and Remuneration Committee Attendance (out of 3 meetings unless otherwise stated)	Member of Membership and Engagement Committee Attendance at meetings (out of 4 meetings unless otherwise stated)
*Edward Green	Patients outside London	1 March 2012-19 February 2015	4	Not a member	Not a member
*George Howell	Patients outside London	1 March 2012-19 February 2015	3	Not a member	4
**Sophie Talib	Patients from London	1 March 2012-19 February 2015	3	Not a member	1
***Susanna Fantoni	Patients from London	20 February 2015	3	Not a member	0
**Matthew Norris	Parents or carers from London	1 March 2012-19 February 2015	5	(3) Re-elected in March 2015	Not a member
**Lisa Chin-A-Young	Parents or carers from London	1 March 2012-19 February 2015	4	(3) Elected in March 2015	4
***Mariam Ali	Parents or carers from London	20 February 2015	5	Not a member	Not a member
**Claudia Fisher	Parents or carers from outside London	1 March 2012-19 February 2015	5	Not a member	1(1)
**Camilla Pease	Parents or carers from outside London	1 March 2012-19 February 2015	5	Not a member	0
***Carley Bowman	Parents or carers from outside London	20 February 2015	5	Not a member	3
**Trevor Fulcher	North London and surrounding area	1 March 2012-19 February 2015	3	Not a member	Not a member
**Rebecca Miller	North London and surrounding area	1 March 2012-19 February 2015	4	(2) Elected in March 2015	Not a member
***Mary De Souza	North London and surrounding area	20 February 2015	5	Not a member	Not a member
***Simon Hawtrey-Woore	North London and surrounding area	20 February 2015	2	Not a member	1
***Gillian Smith	South London and surrounding area	20 February 2015	5	Not a member	2
**Stuart Player	The rest of England and Wales	1 March 2012-19 February 2015	3	Not a member	Not a member
*** David Rose	The rest of England and Wales	20 February 2015	1	Not a member	Not a member
**Jilly Hale	Staff	1 March 2012-19	4	(2)	Not a member

Name	Constituency	Date of appointment	Attendance at Members' Council Meetings (out of 5 unless otherwise stated)	Member of Members' Council Nominations and Remuneration Committee Attendance (out of 3 meetings unless otherwise stated)	Member of Membership and Engagement Committee Attendance at meetings (out of 4 meetings unless otherwise stated)
		February 2015		Elected in March 2015	
**Clare McLaren	Staff	1 March 2012-19 February 2015	5	Not a member	Not a member
**James Linthicum	Staff	September 2013-19 February 2015	4	Not a member	Not a member
***Rory Mannion	Staff	20 February 2015	5	Not a member	Not a member
***Prab Prabhakar	Staff	20 February 2015	3	Not a member	Not a member
**Jenny Headlam-Wells	London Borough of Camden	1 March 2012	3	Not a member	Not a member
**Christine Kinnon	University College London, Institute of Child Health	1 March 2012	4	Not a member	Not a member
Olivia Frame	Expert Patient Programme Community Interest CIC	1 November 2013	2	Not a member	1
**Muhammad Miah	Great Ormond Street Hospital School	1 March 2012	2	Not a member	Not a member
Hazel Fisher	NHS England	31 March 2015	2	Not a member	Not a member

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

What Membership means at GOSH

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

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

Membership constituencies and membership numbers

Our membership database is held and managed by Great Ormond Street Hospital Children's Charity. At year end (31 March 2016) our membership numbers stood at 9,205 excluding staff and (13,019 including staff). We have met and exceeded our estimated annual membership target of 3,800 and our membership numbers have increased by 524 members during the financial year.

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

Constituency	Minimum number of members	Actual (as of 31/03/16)
Patient and carer	900	**6,205**
Parents or carers	600	5,267
Patients	300	938
Public (includes North London and the surrounding area, South London and the surrounding area and the rest of England and Wales)	900	**3,000**
Staff	2,000	**3,814**
Total	3,800	**13,019**

Membership Engagement

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

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

Last year's achievements included an updated Membership Strategy (see page X) and taking an active role in the design and carrying out of the Annual Plan Survey. The Survey was designed jointly by the Members Engagement Committee and the planning and patient experience staff within the

Trust. There were 375 responses of which 49 per cent were from patients or carers, 33 per cent from staff members. The findings were as follows:

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

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

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

Trust Board and Members' Council working together

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

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

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

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

- Councillors' contribution to the Redevelopment Project Group
- Councillors' participation in a CQC focus group

- Councillors' participation in the International Private Patients (IPP) Strategy group
- Annual Plan membership consultation

During the year, councillors and the Board Chairman discussed how the Board and Council can work effectively together. Actions were agreed on how the Council hold the Non-Executive Directors to account, gain dedicated access to the Chairman and the Senior Independent Director throughout the year, restructure the Council agenda to focus on strategic and membership engagement and representative issues, and review the role of the Membership Engagement Committee and management of Council meetings.

Members' Council Nominations and Remuneration Committee

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

- Reviewing the balance of skills, knowledge, experience and diversity of the Non- Executive Directors.
- Succession planning for the Chairman and Non-Executive Directors in the course of its work.
- Identifying and nominating for appointment candidates to fill Non-Executive posts.
- Considering any matter relating to the continuation of any Non-Executive Director.
- Reviewing the results of the performance evaluation process for the Chairman and Non-Executive Directors
- Reviewing the Board Evaluation process

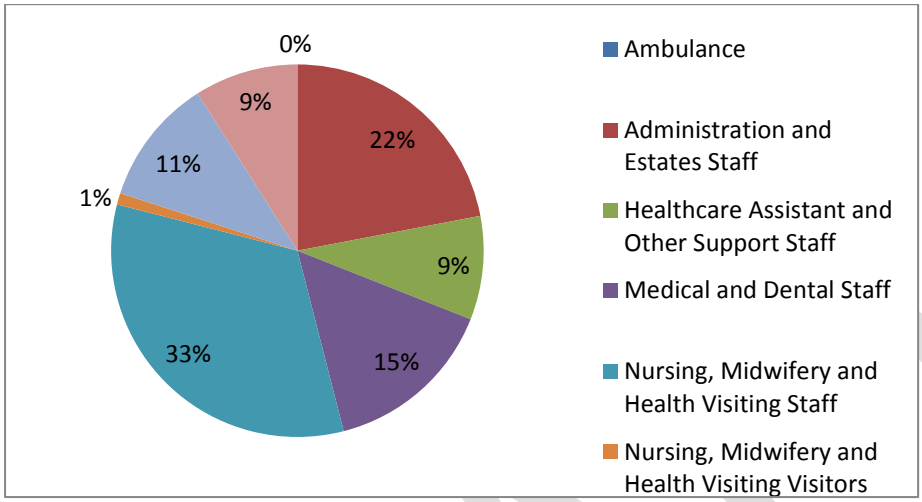
The committee is chaired by the Chairman of the Board and Members' Council. The Deputy Chairman is also a member. Membership and attendance of councillors at the meeting is detailed on page X. In 2015-16 the committee recommended to the Members' Council the following:

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

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

Staff Report

As at 31 March 2016, the Trust employed 3246 full-time equivalent (FTE) permanent staff, in addition to this we contractually employed 605 FTE staff on fixed-term contracts. Of our 3,851 contracted FTE staff, our staff group profile is as follows:

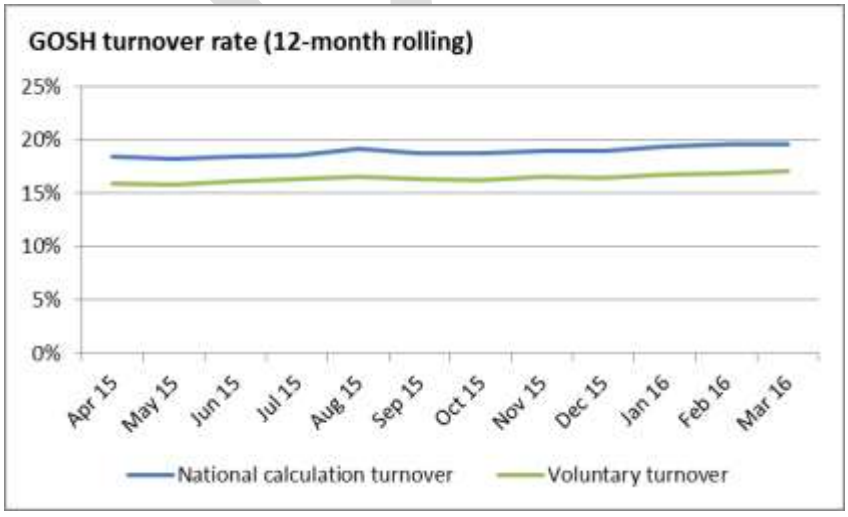


Recruitment and retention

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

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

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



Keeping our staff fit and healthy

We recognise the pressures our staff face and offer a range of measures including a free and on site dedicated staff physiotherapy service; a 24/7 staff counselling and advice service; a wide range of sports and social activities from netball teams to Pilates classes, as well as a full Occupational Health service. In 2015, we introduced online health clearance for our new recruits, which has resulted in a significant improvement in the time it takes to clear staff.

The Trust is committed to effectively controlling risks and preventing harm to all patients, visitors and staff through our health and safety work. 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 redevelopment programme underway which brings with it inherent risks especially given the proximity of clinical environments. There are measures in place which put additional controls on the construction work and ensures this work fits around the delivery of the clinical care.

Equality and diversity

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

- Training in dealing with concerns about bullying and harassment
- Managing the recruitment and selection process
- Ensuring our leaders are visibly demonstrating their commitment to equality and diversity

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

Support for disabled staff

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

The Trust's Equal Opportunities Policy and a Recruitment and Selection Policy and Procedure outlines the various mechanisms in place to ensure applications from disabled candidates receive full and fair consideration. We also provide training on fair recruitment and advice to managers. The Trust is accredited as a "2 Ticks" employer; a status awarded by Job Centre Plus to employers that have demonstrated commitment to employing and developing the abilities of disabled staff.

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

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

Policies for training, career development and promotion of disabled staff

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

Gender reporting

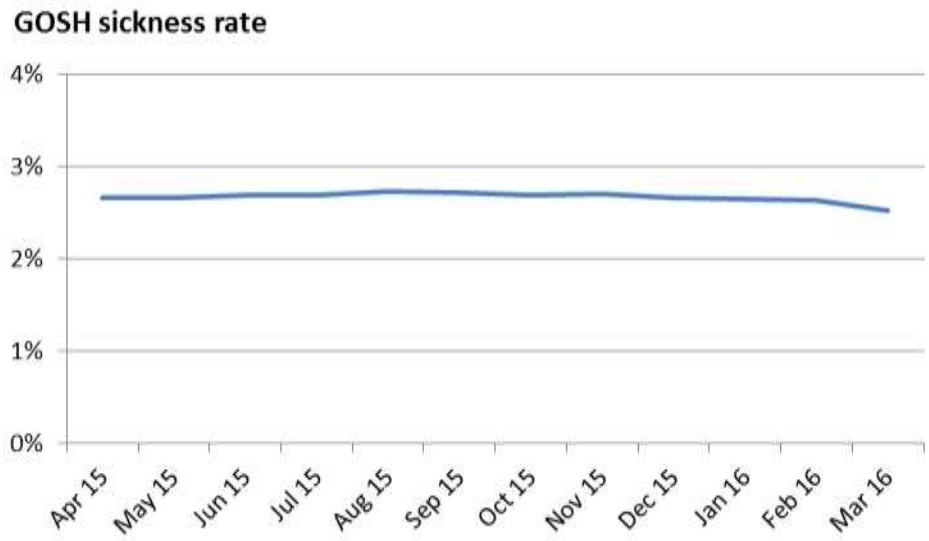
Detailed below is a summary of the gender of the directors, senior managers and staff employed at GOSH:

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

Sickness absenteeism

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

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



Engaging and listening to staff

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

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

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

Our quarterly staff friends and family test and annual staff survey provide us with regular opportunities to measure the experience of our employees.

Staff survey

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

	2014		2015		Trust improvement/deterioration
Staff Survey response rate	GOSH	National average	GOSH	National average	
	60%	Above average	53%	Above average	7% deterioration

	2014		2015		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	92	See note 1.
Percentage of staff experiencing physical violence from staff in last 12 months	1	1	1	1%	No significant change
Percentage of staff appraised in last 12 months	88	84	89	88	No significant change
Organisation and management interest in and action on health and wellbeing			3.79	3.72	See note 1 and 2
Percentage of staff able to contribute towards improvements at work	75	71	78	73	No significant change
	2014		**2015**		**Trust Improvement/ Deterioration/ No Change**
Bottom 5 Ranking Scores	**GOSH**	**National Average**	**GOSH**	**National Average**	
Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell *Need response from co-ordination centre as 2014 and 2015 scores are significantly different*	Not available		65	59	See note 3.
Percentage of staff working extra hours	76	72	80	75	No significant change
Percentage of staff suffering work related stress in last 12 months	35	35	37	34	No significant change
Percentage of staff witnessing potentially harmful errors, near misses, or incidents in last month	40	29	39	29	No significant change
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	6	6	10	6	Deterioration

1 The national survey states for this Key Finding: "Because of changes to the format of the survey questions this year, comparisons with the 2014 score are not possible."

2 This is measured on a scale of 1 to 5 (the higher the score the better).

3 The way this score was calculated in 2015 changed and the the national average for 2014 was not re-calculated using the new methodology.

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

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

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

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

Recognising and rewarding performance

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

Our monthly and annual staff awards have continued to be an extremely popular way for staff, patients and families to recognise outstanding individuals and teams, and for the hospital to celebrate them as role models. We received over 650 nominations from patients, families and staff in 2015/16.In our annual awards ceremony, we saw how all our staff - from finance managers to recovery nurses, porters to surgeons – all had to work together as One Team to help us deliver care to just one patient and his family. Our Child and Family award winner, nominated by almost 50 patients and families, was Dr Veronica Kinsler, a specialist in rare dermatological conditions in children, who combines outstanding care with ground breaking research.

Whistleblowing

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

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

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

Learning and Development

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

- In response to the Cavendish Review, a paediatric-specific national care certificate for Healthcare Assistants was developed to Healthcare Assistants (HCAs) have the skills and knowledge to deliver care to children and young people. In conjunction with London South Bank University, GOSH has also designed a course to provide a transition qualification for HCAs to move into a degree in nursing.

- Increased opportunities for different clinical and non-clinical professionals to learn with, from and about each other, through the introduction of Schwartz rounds. We have also launched an inter-professional education network which offers a range of workshops and seminars to staff.

- GOSH co-designed and delivered a training module to improve communication between healthcare professionals and children and young people across north central and east London.

- A Postgraduate Medical Education (PGME) app was launched, providing easily accessible information on all the learning opportunities available to doctors in training. The PGME design team continued to offer a range of innovative programmes including Clinical Leadership in Action to prepare junior medical staff for the step into leadership and management roles.

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

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

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

Remuneration Report

Directors' remuneration

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

Remuneration policy

The structure of pay for senior managers is designed to reflect the long-term nature of the Trust's business and the significance of the challenges we face. The remuneration should therefore ensure 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.

Future policy

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

How the component supports the strategic objective of the Trust	How the component operates (including provisions for recovery of sums paid; how changes are made).	Maximum potential value of the component	Description of framework used to assess performance
Salary and fees			
Set at an internationally competitive level to attract high quality Directors to a central London base; benchmarked across other NHS Trusts in order to deliver the Trust's strategic objectives.	Salaries are reviewed annually and any changes are normally effective from 01 April each year. Such proposed changes are made via the Remuneration Committee chaired by a Non-Executive Director. In exceptional circumstances, reviews of salary may be made outside of this cycle, but are made by Remuneration committee and ratified by the Board. Any sums paid in error, malus or recovered due to breach of contract are followed up with the individual.	Change to basic salary is usually enacted as a percentage increase in line with national Agenda for Change pay arrangements to ensure parity across the Trust (Directors are proportionally not treated more favourably than the rest of the Trust).	Trust Performance and development review (PDR)/annual appraisal to set objectives linked to the Trust's strategic objectives. Failure to meet objectives is managed via the Trust's performance frameworks.
Taxable benefits			
Not applicable			
Annual performance-related bonuses			
Not applicable			
Long term-related bonuses			
Not applicable			
Pension-related benefits			
Pension benefits (which may be opted out of) are part of the total remuneration of	Pension is available as a benefit to Directors and follows national NHS Pension Scheme	Pension is available as a benefit to Directors and follows national NHS Pension Scheme	Not applicable.

Directors to attract high calibre staff to enable the Trust to meet its strategic objectives.	contribution rules (or alternative pension provider).	contribution rules (or alternative pension provider). Pension entitlements determined in accordance with the HMRC method.

Directors with remuneration (total) greater than £142,500

The Trust balances the market forces factors for recruiting top Director talent with social responsibility in relation to executive pay. Remuneration is regularly benchmarked across peer UK NHS organisations.

Service contract obligations

The Trust does not stipulate any special terms in relation to severance arrangements for Directors. In any occasion of termination of a contract, Directors would not be treated differently from any other member of staff.

Policy on payment for loss of office

Directors' contracts primarily stipulate a minimum notice period of six-months. Payment in lieu of notice, as a lump sum payment, may be made at the discretion of the Trust and with the approval of the Trust's Remuneration Committee in line with government limits.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

Any changes to Directors' remuneration is usually enacted as a percentage increase in line with national Agenda for Change pay arrangements to ensure parity across the trust. Directors' remuneration is set at the Remuneration Committee and formally ratified by the Trust Board. Initial salary setting and review is undertaken by benchmarking ourselves with peer Trusts.

Remuneration for executive directors

The remuneration and conditions of service of the Chief Executive and Executive Directors are determined by the Board 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 2015/16 can be found on page xx

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

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

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

During 2015/16, the Committee:

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

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 reviewed the salaries of the executive directors when considering the pay for the Chief Finance Officer and Deputy Chief Executive. In 2016/17 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 XX) considered the remuneration of the Chairman and Non-Executive Directors in April 2015. It reviewed the data from

previous benchmarking exercises and updated information including benchmark data from a Foundation Trust peer group. Following consideration of the structure of the current remuneration packages, the committee recommended that the remuneration for the Chairman and Non-Executive Directors would not be uplifted for a two year period. This recommendation was unanimously approved by the Members' Council.

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

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

Salary entitlements of senior managers

Information about the salary and pension entitlements for senior managers can be found on page XX below**.**

Expenses

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

Salary entitlements of senior managers

		2015/16						2014/15					
Name	**Title**	**Salary and Fees** £000	**Taxable Benefits** £000	**Annual Performance-related Bonuses** £000	**Long-term Performance-related Bonuses** £000	**Pension-related Benefits** £000	**Total** £000	**Salary and Fees** £000	**Taxable Benefits** £000	**Annual Performance-related Bonuses** £000	**Long-term Performance-related Bonuses** £000	**Pension-related Benefits** £000	**Total** £000
Non-executive Directors													
Baroness Tessa Blackstone	Chairman of Trust Board	50-55	0	0	0	0	50-55	50-55	0	0	0	0	50-55
Ms Yvonne Brown	Non-Executive Director (until 29 February 2016)	10-15	0	0	0	0	10-15	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	10-15	0	0	0	0	10-15	0-5	0	0	0	0	0-5
Professor Stephen Smith	Non-Executive Director (from 1 March 2016)	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a
Ms Ros Smyth	Non-Executive Director	0-5	0	0	0	0	0-5	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 Bill Boa	Interim Chief Finance Officer (from 7 December 2015)	65-70	0	0	0	0	65-70	n/a	n/a	n/a	n/a	n/a	n/a
Mr	Interim Director of	135-	0	0	0	0	135-140	165-170	0	0	0	0	165-170

Michael Bone	Information and Communication Technology (until 31 December 2015)	140											
Mr Robert Burns	Director of Planning and Information	95-100	0	0	0	15-20	115-120	100-105	0	0	0	25-30	130-135
Dr Cathy Cale	Interim Co-Medical Director (until 31 May 2015)	15-20	0	0	0	0	15-20	15-20	0	0	0	25-30	45-50
Mr Trevor Clarke	Director of the International and Private Patients Division	80-85	0	0	0	15-20	95-100	80-85	0	0	0	10-15	95-100
Dr Vinod Diwakar	Medical Director (from 1 June 2015)	90-95	0	0	0	0	90-95	n/a	n/a	n/a	n/a	n/a	n/a
Mr Martin Elliott	Co-Medical Director (until 31 May 2015)	10-15	0	0	0	0	10-15	80-85	0	0	0	0	80-85
Professor David Goldblatt	Director of Clinical Research and Development	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Mrs Juliette Greenwood	Chief Nurse (from 1 May 2015)	110-115	0	0	0	65-70	180-185	n/a	n/a	n/a	n/a	n/a	n/a
Mr Paul Labiche	Director of Estates and Facilities	85-90	0	0	0	20-25	110-115	90-95	0	0	0	15-20	105-110
Mrs Dena Marshall	Interim Chief Operating Officer (from 20 April 2015)	115-120	0	0	0	20-25	135-140	n/a	n/a	n/a	n/a	n/a	n/a
Mr Niamat (Ali) Mohammed	Director of Human Resources	120-125	0	0	0	15-20	140-145	120-125	0	0	0	15-20	140-145
Mrs Claire Newton	Chief Finance Officer (to 6 December 2015) and Interim Director of Strategy and	125-130	0	0	0	15-20	145-150	125-130	0	0	0	15-20	145-150

	Planning (from 7 December 2015)												
Mr Ward Priestman	Interim Director of Information and Communication Technology (from 1 January 2016)	70-75	0	0	0	0	70-75	n/a	n/a	n/a	n/a	n/a	n/a
Dr Peter Steer	Chief Executive	205-210	0	0	0	45-50	255-260	50-55	0	0	0	5-10	60-65
Mr Matthew Tulley	Director of Development	125-130	0	0	0	25-30	150-155	125-130	0	0	0	15-20	140-145
Ms Rachel Williams	Chief Operating Officer	75-80	0	0	0	35-40	115-120	120-125	0	0	0	40-45	165-170

Pension entitlements of senior managers

Name	Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (bands of £2,500)	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)	Cash equivalent transfer value at 1 April 2015	Cash equivalent transfer value at 31 March 2016	Real increase/(decrease) in cash equivalent transfer value at 31 March 2015
		£000	£000	£000	£000	£000	£000	£000
Mr Robert Burns	Director of Planning and Information	0-2.5	(2.5)-0	35-40	60-65	384	402	18
Dr Cathy Cale	Interim Co-Medical Director (until 31 May 2015)	(2.5)-0	2.5-5	30-35	100-105	577	620	43
Mr Trevor Clarke	Director of the International and Private Patients Division	0-2.5	2.5-5	40-45	120-125	812	846	34
Dr Vinod Diwakar	Medical Director (from 1 June 2015)	0-2.5	0-2.5	35-40	110-115	627	638	11
Mrs Juliette	Chief Nurse (from	2.5-5	10-12.5	50-55	155-160	930	1,006	76

Greenwood	1 May 2015)							
Mr Paul Labiche	Director of Estates and Facilities	0-2.5	0	Oct-15	20-25	187	216	29
Mrs Dena Marshall	Interim Chief Operating Officer (from 20 April 2015)	0-2.5	(2.5)-0	30-35	80-85	436	468	32
Mr Niamat (Ali) Mohammed	Director of Human Resources	0-2.5	2.5-5	35-40	115-120	690	722	32
Mrs Claire Newton	Chief Finance Officer (to 6 December 2015) and Interim Director of Strategy and Planning (from 7 December 2015)	0-2.5	2.5-5	Oct-15	40-45	262	300	38
Dr Peter Steer	Chief Executive	2.5-5	0	0-5	0	12	65	53
Mr Matthew Tulley	Director of Development	0-2.5	(2.5)-0	25-30	75-80	397	419	22
Ms Rachel Williams	Chief Operating Officer	0-2.5	0-2.5	15-20	40-45	198	220	22

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

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

Median Pay

The highest paid director in 2015/16 was the Chief Executive whose remuneration was in the band £205,000-£210,000k. This was 4.9 times the median remuneration for all members of the Trust. The calculation is based upon full-time equivalent Trust staff for the year ended 31 March 2016 on an annualised basis.

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

Disclosures

Principal activities of the Trust

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

Expenditure on consultancy

Information about expenditure on consultancy can be found on page ??

Off-payroll arrangements

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

Exit packages

Information about exit packages can be found on page ??

Going concern

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

Directors' responsibilities

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

Safeguarding external auditor independence

While recognising 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.

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

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 x85.2 per cent of non-NHS invoices measured in terms of number and 87.8 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 2015/16.

Statement of compliance with cost allocation and charging

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

Countering fraud and corruption

The Trust has a countering fraud and corruption 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 (IG)

Summary of Serious Incident Requiring Investigation involving personal data as reported to the Information Commissioner's Office in 2015/16

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

Summary of other personal data related incidents in 2015-16

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

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

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

Audit Committee Report

Introduction from the Chairman of the Audit Committee

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

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

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

The attached report sets out, in detail, the responsibilities of the Audit Committee and how we have discharged those duties. The report also highlights the key areas considered by the Committee in 2015/16 but I will draw particular attention to a small number of these items here.

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

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

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

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

In keeping with last year, the Trust has undertaken a serious review of the appropriateness of the adoption of the going concern basis for the preparation of the accounts. This effectively reflects the confidence of the Trust that the organisation remains financially viable. As described below, we are confident that this is the case for the ensuing planning period of 2016/17 and that the Trust

management has therefore clearly adopted the appropriate accounting basis. The longer term challenges facing the Trust, like the wider NHS, are significant.

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

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

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

Charles Tilley

Audit Committee Chairman

20 May 2016

Audit Committee responsibilities

The Committee's responsibilities and the key areas discussed during 2015/16, whilst fulfilling these responsibilities, are described in the table below:

	Principal responsibilities of the audit committee	**Key areas formally discussed and reviewed by the Committee during 2015/16**
Review of the Trust's risk management processes and internal controls	• Reviewing the Trust's internal financial controls, its compliance with Monitor's guidance for Foundation Trusts, including the Code of Governance, and the effectiveness of its internal control and risk management systems. • Reviewing the principal non-clinical risks and uncertainties	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

	of the business and associated Annual Report risk management disclosures. (Clinical risks are reviewed by the Clinical Governance Committee).	effectiveness of internal control systems taking account of the findings from internal and external audit reports. • 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
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 and 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
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 and Charter defining its role and responsibilities. • Internal Audit programme of reviews of the Trust's processes and controls to be undertaken, and an assurance map showing the coverage of audit work over three years against the

		risks. • Status reports on audit recommendations and any trends and themes emerging. • The Internal Audit reports discussed by the Committee, included – key financial controls - Procurement and Contract Management - Risk Management - Education Strategy and Governance
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 and any waivers of those regulations during the financial year. • 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 the management of information governance and data quality risks • Updates on staff raising concerns policy • reporting to the Board and Members' Council where actions are required and outlining recommendations.

Effectiveness of the committee

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

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

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

External audit

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

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

Internal audit and counter fraud services

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

- KPMG LLP. The internal audit service covers both financial and non-financial audits according to a risk-based plan agreed with the Audit Committee. The Trust also has a 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 and Efficiency Target. In addition the risk of delivery of the Productivity and Efficiency targets, the contribution of International Private Patients and the risk that operational capacity is not sufficient to deliver future demands have also been assessed as part of this programme of review. For each risk the Committee reviews the risk assessment (including risk definition, risk appetite, and likelihood and impact scores); the robustness of the controls and evidence available that the controls are operating.

Data Quality reviews

The Committee agreed to additional audit scrutiny of the Trust's data quality. Following the suspension of reporting of waiting time data, the Committee sought assurance that the systems and processes for assuring data completeness, timeliness, relevance, accuracy and appropriateness were operating effectively. The Committee commissioned a significant review by the Internal Audit team and the subsequent report confirmed a number of system issues requiring remedial action. As noted in my introduction, the validation of open referral pathways continues and will continue into 2016/17. In addition the Data Quality Review identified a small number of metrics reported to the

Trust Board where the data extracted for reporting was incomplete or inaccurate due to the rules applied to the data in generating those reports. The Trust is undertaking a comprehensive review of the rules within its reporting systems, starting with the waiting time reports, and is validating not only the underlying data but data reporting systems.

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

Care Quality Commission Review

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

Board Assurance Framework

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

Productivity and Efficiency

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

Internal controls

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

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

Fraud detection processes and whistle-blowing arrangements

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

Financial reporting

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

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

Going concern

The Trust management has carefully considered the appropriateness of reporting on the going concern basis. The Trust financial position includes substantial charitable donations that must be reported as income and this can result in significant surpluses being reported by the Trust. Please note that the Trust presents an additional note to remove the impact of charitable donations and thus show an underlying position for the Trust. The Trust has suffered two years of underlying deficits and so a careful consideration of financial sustainability is required. Trust management has submitted a financial plan to NHS Improvement for 2016/17 that once again shows a significant surplus due to charitable donations. The Trust is planning another year of underlying deficit, however, this deficit is reducing over the 12 month period and the Trust continues to enjoy comparatively healthy, although diminishing, cash balances. The future planning assumptions and current operating environment of the NHS is probably the most challenging period the Trust has ever endured and this raises deep concerns about long term financial sustainability but for the purposes of determining the appropriateness of the going concern accounting approach the 2016/17 plan, the cash balances and the financial sustainability risk rating of the Trust provide absolute confidence that the accounting approach adopted by management is correct.

Significant financial judgements and reporting for 2015/16

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

We identified through discussion with both management and the external auditor the key risks of misstatement within the Trust's financial statements. We discussed these risks with management during the year, and with the auditor at the time we reviewed and agreed the external auditors' audit plan during the year and also at the conclusion of the audit. We set out in the table below how we satisfied ourselves that these risks of misstatement had been appropriately addressed.

Level of debt provisions

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

Valuation of property assets

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

Other areas of financial statement risk

Other areas where an inappropriate decision could lead to significant error include:

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

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

Conclusion

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

- It is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.

- It is consistent with the Annual Governance Statement, Head of Internal Audit Opinion and feedback received from the external auditors and there are no matters that the committee is aware of at this time that have not been disclosed appropriately.

- It is appropriate to prepare accounts on a going concern basis.

Clinical Governance Committee Report

Introduction from the Chair of the Clinical Governance Committee

I am pleased to present the Clinical Governance Committee's report on its activities during the year ended 31 March 2016.

As outlined in the report below, the Clinical Governance Committee (CGC) is a sub-committee of the Trust Board with delegated authority to ensure that the correct structure, systems and processes are in place within the Trust to appropriately manage and monitor clinical governance and quality related matters.

It has been a busy year for the CGC with a Care Quality Commission (CQC) scheduled inspection in April 2015, as well as some new clinical and quality challenges to consider and seek assurance on, including management of the Trust's elective surgery data and processes, a review of the Trust's gastroenterology service and progress with recommendations arising from the Health Education North Central and East London (HENCEL)report about medical trainee support and out of hours cover.

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

In July 2015, the Committee reviewed its effectiveness and found it had adequately discharged its duties in accordance with its terms of reference. The committee will review its effectiveness again in July 2016.

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

The members of the CGC are listed on page XXX and during 2015/16 included three Non-Executive Directors and a new independent member of the committee, James Hatchley. The Foundation Trust was authorised on 1 March 2012 and I have been Chairman of the committee since then. I would like to thank both John Ripley and Yvonne Brown, who retired from the committee during 2015, and welcome Stephen Smith as a new Non-Executive Director member from 28 March 2016.

The committee is in the process of updating its terms of reference and broadening its remit to seek assurance of the quality of care and treatment in all services provided by the Trust. To reflect this, the committee has been renamed the Quality and Safety Assurance Committee (QSAC).

Mary MacLeod

Clinical Governance Committee Chairman

20 May 2016

Clinical Governance Committee responsibilities

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 Committee requests assurance on scheduled matters as well as quality and safety issues arising during the year, for example, assurance of the appropriate management of the Trust's referral to treatment issues and the review of the Gastroenterology service.

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

Principal responsibilities of the committee	Key areas formally reviewed during 2015/16
Review of the framework to support an environment in which excellent clinical care will flourish	• Implementation of the Trust's Quality Strategy and review of the Annual Quality Report • Reports from the Clinical Ethics Committee • Regular review of performance reports • Learning from patient stories • Updates from service areas (social work, play service) • Assurance framework updates • Regular updates from the Risk, Assurance and Compliance Group • Involvement in the establishment of the Trust's Patient Safety and Outcomes Committee
Review when an issue occurs which threatens the Trust's ability to enable excellent clinical care to flourish, that this is managed and escalated appropriately and actions are taken and followed through	A range of specific, emergent issued were considered in 2015/16 including: • Review of the Gastroenterology service • Review of medical cover out of hours • IT issues impacting clinical work • Quality and safety impact of the productivity and efficiency programme • Access Improvement Programme workplan
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 • Reports received on specific and/or high risk areas: ○ Health and Safety

Principal responsibilities of the committee	Key areas formally reviewed during 2015/16
	○ Child Protection and Safeguarding ○ Research Governance ○ Summary from the Learning, Improvement and Monitoring Board (now disbanded) and the new Patient Safety and Outcomes Committee (covering complaints, patient advice liaison service, incidents and claims) ○ Staffing information Report ○ CQC compliance ○ Medical Revalidation and appraisal ○ Head of Nursing report
Review of findings and recommendations from internal audit, clinical audit and learning from external investigations and reports	• The internal audit annual plan and strategy was presented to the Committee in April with an 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 audits were discussed this year: - Health and Safety - Information Governance - Whistleblowing - Risk Management - Education strategy and education governance - SCA: Self-certifications (second level) - Discharge arrangements - Divisional level governance - Transformation and Improvement Programme (Productivity and Efficiency Plans) • Quarterly reports from the Trust's Clinical Audit Manager
Other	• Reviewed committee effectiveness • Reviewed Freedom of Information Annual Report

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

Risk reviews

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

In 2015/16, the committee also considered risks associated with other significant operational and strategic risks, including IT issues and challenges and the productivity and efficiency programme, in particular the impact on quality and safety.

Access Improvement Programme

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

Quality Impact of the Productivity and Efficiency Programme

The CGC has played an important role in monitoring the quality and safety implications of the Trust's Productivity and Efficiency Programme throughout 2015/16. The committee has reviewed a number specific services' productivity plans to ensure they are implemented within a robust quality governance framework and that the Trust's 'Zero Harm and No Waits' objectives are not compromised.

CQC compliance

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

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

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

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

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

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

- make judgements and estimates on a reasonable basis

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

- 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/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed……..

Chief Executive

Date: xx May 2016

Head of Internal Audit Opinion

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

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

Roles and responsibilities

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

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Board Assurance Framework process; 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 Board Assurance Framework should bring together all of the evidence required to support the AGS.

The Head of Internal Audit (HoIA) is required to provide an annual opinion in accordance with PSIAS, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (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 2015 to 31 March 2016 is that:

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

Commentary

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

Our opinion covers the period 1 April 2015 to 31 March 2016 inclusive, and is based on the eight audits that we completed in this period.

The design and operation of the Assurance Framework and associated processes

The Trust's Assurance Framework does reflect the organisation's key objectives and risks and is regularly reviewed by the Board.

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

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

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

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

enhanced the scope of its Project Management Office with external support as well as consolidating its savings to focus on key, strategic projects.

- Education strategy and governance – the Trust did not have in place a formally defined governance mechanism to ensure there was sufficient consideration of multi-disciplinary education across the organisation and ensure that all staff groups had fully reviewed their training needs. The Trust is implementing an Education Committee to provide strategic oversight and direction to education requirements moving forwards.

- IT infrastructure – we identified issues with the Trust's processes for approving system changes, ensuring there was appropriate prioritisation of resource and monitoring performance.

- Contract management – we found that the Trust did not have access to a single and complete record of contracts it has entered into and the officers responsible for their management.

- Discharge arrangements – we identified discrepancies between the information reported from the Trust's Patient Administration System and that there was no formal guidance in place to support staff identify when discharge summaries were required to be produced.

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

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

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

KPMG LLP
Chartered Accountants
London
18 April 2016

Annual Governance Statement

1 Scope of responsibility

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

2 The purpose of the system of internal control

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

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

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

3 Capacity to handle risk

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

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

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

- prosecution, defence or settlement of material incidents and claims.

The Board has a comprehensive work programme which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information which enables it to scrutinise the effectiveness of the Trust's operations and deliver focused strategic leadership through its decisions and actions. Whilst pursuing this work plan, the Board maintains its commitment that discussion of patient safety will always be high on its agenda. The Board has carried out an internal review of its effectiveness during the year and agreed actions to strengthen its oversight of risk.

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

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

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

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

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

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

4 The risk and control framework

The risk management strategy

In early 2016, the Trust's risk management strategy was reviewed and updated and 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 four it has concluded that it fully complies with the requirements and that there are processes in place to identify risks to compliance. No significant risks have been identified.

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

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

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

The risk management process

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

The Trust's Board Assurance Framework 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

strategic 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. 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 and monitor actions to reduce or remove control or assurance gaps.

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

Each division and department is required to identify, manage and control local risks whether clinical, non-clinical or financial in order to provide a safe environment for patients and staff and 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:

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

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

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

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 audits and health and safety reports. 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 and external audit action recommendation tracking system is in place which records progress in closing down the recommendations. The committees also seek other forms of assurance, which include the results of regulatory and other independent reviews of compliance with standards, relevant performance information, and management self-assessments coupled with the associated evidence base.

Key elements of the Trust's Quality Governance arrangements

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

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

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

- There is clear accountability at Board level for safety and clinical quality objectives and structured reporting of performance against these objectives.

- Internal processes to check that we meet both our own internal quality standards and those set nationally and in conjunction with our commissioners (CQUINS).

- Key performance indicators are presented, on a monthly basis, to the Trust Board. This includes progress against external targets (such as how we keep our hospital clean), internal safety measures (such as the effectiveness of actions to reduce infection) and process measures (such as waiting lists) and other clinical quality measures including CQUINS. It also includes the external indicators assessed and reported monthly by the CQC.

- The 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 recently reviewed Patient and Family Experience and Engagement Committee and through a range of other patient/ parent engagement activities.

- Risks to quality are managed through the Trust risk management process which includes a process for escalating issues.

- There is a clear structure for following up and investigating incidents and complaints and disseminating learning from the results of investigations.

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

<u>Compliance with the Foundation Trust License Conditions</u>

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 four (governance). The conclusion of the review was that the Trust's governance processes and structures are effective.

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

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

Compliance with CQC registration

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

Involvement of stakeholders

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

Data security

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

Other regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure 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.

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

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

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

The Trust did not declare any governance targets "at risk" in its plans for 2015/16. The Trust has subsequently reported that it is unable to declare compliance through the routine Governance statements to the Regulator because the Trust is unable to report on performance against the Referral to Treatment Times for the 18-week waiting time standard.

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

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

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

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

In light of the problems identified with RTT data, the Trust requested that a comprehensive review of data quality across the organisation was conducted by the internal audit team. This was completed in February 2016 and found for the majority of the indicators sampled, reported numbers

could be reconciled to data sources. The review concluded the need for establishment of a robust data quality framework at the Trust.

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

As a specialist tertiary hospital, the majority of our patients are referred to us from other hospitals and often commence treatment at that hospital 8-12 weeks into the 18-week treatment pathway. The Trust relies on referring hospitals to record the start date of the patient treatment and if this is not secured the Trust must record the patient treatment with an 'unknown clock start'. The number of referrals with no known clock start received by the Trust is unacceptable and requires significant intervention by the Trust to pursue incomplete records. The Trust is held to account and faces sanctions for any patient exceeding the 18-week treatment pathway irrespective of the point of referral to this organisation.

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

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

The Board has also agreed a series of performance metrics which provide information about the efficiency of processes within the Trust and the use of critical capacity such as theatre utilisation. The agenda of the Finance and Investment Committee includes reviews of financial performance, productivity and use of resources both at Trust and divisional level. More details of the Trust's performance and some specific Trust projects aimed at increasing efficiency are included in the 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. Monitor has issued guidance to NHS Foundation Trust boards on the form and contents of annual Quality Reports, which incorporate the legal requirements in the Foundation Trust Annual Reporting Manual.

There are a number of controls in place to ensure that the Quality 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 Safety Outcomes 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.

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

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

The report includes a description of the never event which occurred in the Trust during the year.

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.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Clinical Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- the reviews of compliance with CQC standards;
- consideration of performance against national targets,
- the assessment against the information governance toolkit;

- Health and safety reviews;
- the PLACE assessment
- and, relevant reviews by the Royal Colleges.

In addition, the Head of Internal Audit provides an opinion on the overall arrangements for gaining assurance through the 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:

<u>Control weaknesses</u>

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

Assurance weaknesses:

- Data Quality - A wider review of Data Quality identified a number of operational and strategic issues as points for development in order to improve and enhance the overall quality of performance information collected and reported at Board level and across the wider Trust. An action plan has been developed to address these development points.

- It is difficult to obtain assurance on the adequacy of the long term funding of the Trust due to the longer term proposals for reductions in tariff and adjustment of contract terms for specialist services by NHS England. Please see reference in the Trust's going concern on page XX

Assurance of core systems and controls

The Trust audit programme has identified significant assurances for Financial Controls and Risk Management and has found that the Trust Board Assurance Framework does reflect the organisation's key objectives and risks and is regularly reviewed by the Board.

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

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

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

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

Signed……

DR PETER STEER

Chief Executive

Date: XX XXX 2016

Independent Auditor's Report

To be added

Quality Report

Text to be added

Accounts

Accounts to be added

Glossary

To draft using last year's and checking with proof reading

Add:

Referral to Treatment Waiting Time Processes - monitor the length of time from referral through to elective treatment.

Friends and Family Test: The Friends and Family Test (FFT) is a feedback tool that asks people using NHS services if they would recommend the services they have used

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th May 2016**	
Quality Report 2015/16 **Submitted by:** Dr Vin Diwakar, Medical Director	**Paper No:** Attachment Q
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. The Audit Committee will review this report at its meeting on 20th May, prior to the Trust Board meeting.	
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 2016/17.	
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? Dr Vin Diwakar, Medical Director	

Great Ormond Street Hospital for Children
NHS Foundation Trust

Quality Report 2015/16

Contents

Cover: Tyler, age four, whilst on Badger ward.
This page: Essa, age 15, during one of his stays at the hospital.

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."

On the cover: GOSH patient Tyler, age four, whilst on Badger ward.
This page: Ava, age six, during one of her visits to the hospital.

What is the *Quality Report*?

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

What does it include?

The content of the *Quality Report* includes:

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

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

What is NHS Choices?

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

What is a Foundation Trust?

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


GREAT ORMOND STREET
HOSPITAL FOR CHILDREN

99%

of parents and patients
would recommend
the hospital

67,377

patient visits

4,122

permanent and fixed-term staff

58

specialties

1,581

outpatient clinics

838

active research studies

19

highly specialised national services

Part 1:
A statement on quality from the Chief Executive

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

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

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

Priority one - safety

To reduce all harm to zero

Priority two - clinical effectiveness

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

Priority three - experience

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

Safety

Many of our initiatives to improve quality have been clinically led and co-designed with our patients and their families. One such project was the roll-out of electronic 'Patient Status at a Glance' (ePSAG) boards.

These are large, easy to read electronic whiteboards that display a range of real time patient information. They primary aim is to improve patient safety by reducing avoidable harm through improving the identification, escalation and care planning of patients at risk of deterioration.

They were developed by clinical teams and a parent representative who facilitated the involvement of more than 30 patients and three families. This was important as our families views' helped inform the level of information on display and identify the features that would be meaningful to parents and therefore also improve their experience. Instrumentally their involvement also led to the creation of 'watcher 'status which is applied to patients that do not trigger the more formal Children's Early Warning Scores (CEWS) but indicate where a family member or clinical staff member has a concern.

We set ourselves the ambitious target of rolling out the boards across all our wards by the end of the financial year with effectiveness measured by a number of pre and post rollout audits.

A delay to the ambulatory version of ePSAG meant the Trust wide-rollout has been slightly delayed and we are now on track to achieve roll out by May 31. Where the Boards have been installed they have had a significant impact. They have contributed to an increased awareness of CEWs and of the term 'watcher' patient. Data has also shown that they have reduced interruptions and improved the patient experience. They have also facilitated better communication between staff particularly at safety huddles - which is an element we will be focusing on in the next year along with work to further improve the monitoring and communication of the deteriorating child.

Improving flow is theme woven through this report. It was an outcome that was supported by the roll out of the of the ePSAG initiative and is the focus of our second safety priority. Here we set out to reduce delays in the journeys of patients leaving the intensive care unit and avoid the number of refusals and cancellations. The work aimed to improve the patient experience and also inform a wider programme of work to create more capacity across the Trust.

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

Clinical effectiveness

In my introduction to this Annual Report I spoke about the important work we are undertaking to ensure that all our patients receive treatment within a time appropriate to their clinical conditions and the challenges we face ascertaining exactly when their pathway of care began. Our work to resolve the issue of incomplete pathways features in the clinical effectiveness s section of the Quality Report. It gives some detail how we have worked with NHS experts to address the issues identified. This work to improve access is extensive and ongoing and is the reason why we are unable to report performance against some of our quality indicators linked to waiting times. It is an essential programme of work and remains a quality priority for 16/17.

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

Patient experience

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

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

The second quality priority aimed at improving the care experience of patients with learning disabilities. This programme of work continued the commitment we set out last year to do better for our many patients with learning disabilities.

It comprised continuing to: embed training and support to staff, use clinical alerts and promote the hospital passport. There was also an additional focus on improving partnership working.

Many elements of this work were praised in our CQC Report and last year it resulted in us doubling the number of patients with learning difficulties that we were able to identify before they came to hospital and therefore better plan their care at GOSH. Within this report we hear directly from a patent of a patient with a learning disability. Her words are extremely moving and serve as an important reminder of how we must tailor the care and experience we provide to each of our chidren's needs.

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

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

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

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

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

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

Peter Steer
Chief Executive

Part 2a:
Priorities for improvement

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

Safety

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

Clinical effectiveness

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

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

Experience

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

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

Reporting our quality priorities for 2015/16

The six quality priorities for 2015/16 were:

Safety

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

Clinical effectiveness

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

Experience

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

In this section, we report on our performance against each quality priority by outlining:

- what we said we'd do
- what we did
- what the data shows
- what's going to happen next
- how this benefits patients

Safety

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

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

What we said we'd do

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

What we did

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

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

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

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

What the data shows

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

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

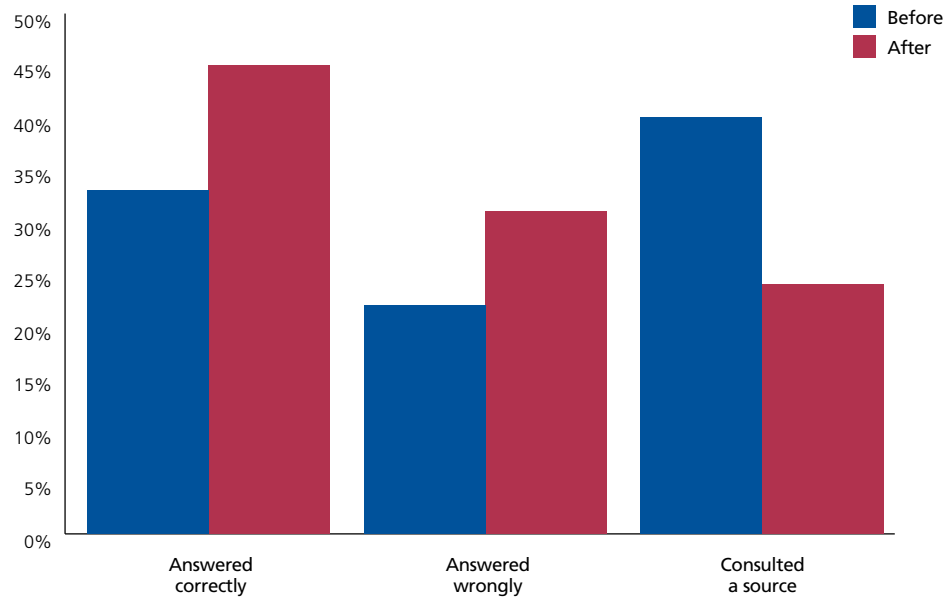
Situational awareness pre-project and post-project audit results (wave one)

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

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

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

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



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

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

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

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

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

R Recommendation
What do I want to happen now?

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

What is CEWS?

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

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

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

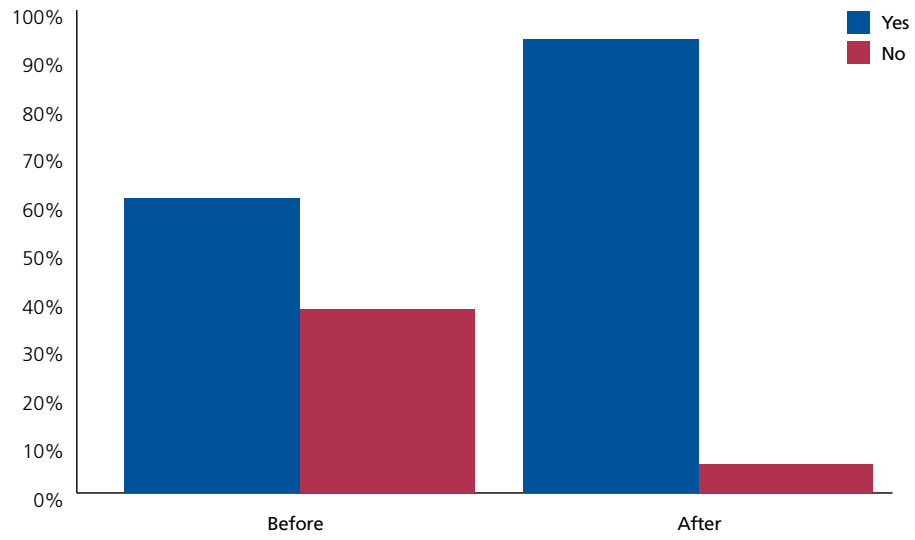
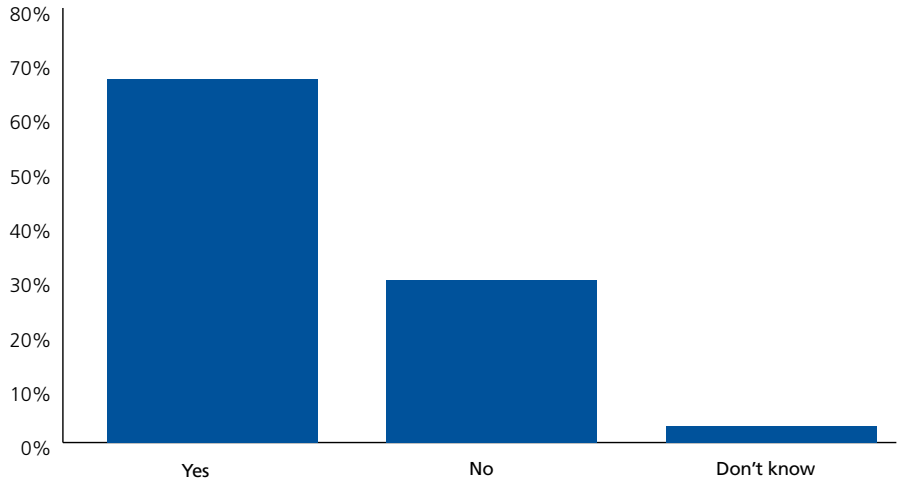


*Chart three – Percentage of parents and young people who felt ePSAG was helpful to them as a parent/patient**



*sample size: 27 individuals

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

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

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

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

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

What is a 'watcher' patient?

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

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

What is a Clinical Site Practitioner?

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

What is a safety huddle?

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

What's going to happen next?

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

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

How this benefits patients

The use of ePSAG boards:

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

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

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

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

Improving flow through our intensive care units

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

What we said we'd do

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

What we did

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

Time of transfer to the wards

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

Electronic Patient Status at a Glance (ePSAG)

The development of the ePSAG board, an electronic version of the patient whiteboard, has improved both communication and situational awareness of staff members. The inclusion of real time information about the location and status of ventilators and other essential equipment on the board has also reduced time lost by clinicians to non-clinical issues. See page 12 for more information about ePSAG.

Intensive care units e-referral process

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

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

Identifying reasons for delayed discharges

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

Increasing the spread of elective work across the working week

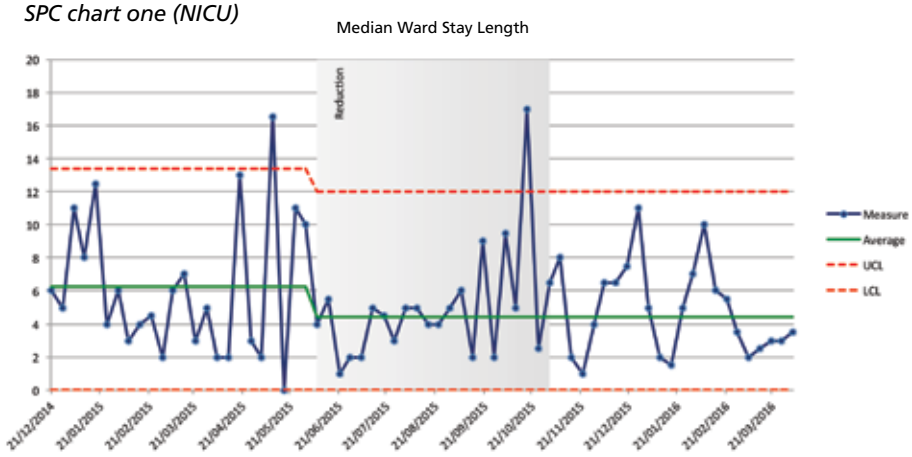
The PICU and NICU teams and the main surgical specialties that refer children into ICU have changed work practices to spread demand across the week. Previously, both of the two main specialties operated every Wednesday, with both teams trying to admit their patients for post-surgical intensive care at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

What the data shows

1. Length of stay in PICU and NICU

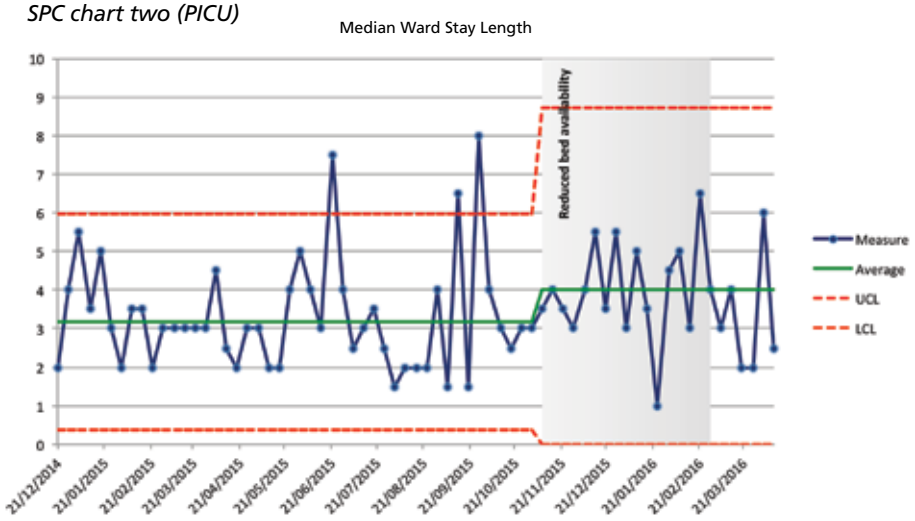
With improved flow, we expect to see reduced length of stay. The data shows a reduction in the median length of stay on NICU (SPC chart one) as compared with the 2015 baseline period. However, there has also been an increase in the median length of stay on PICU, as compared with the previous baseline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

SPC chart one (NICU)



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

SPC chart two (PICU)



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

What is a Statistical Process Control chart?

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

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

What is a baseline period?

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

What is the median?

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

2. Number of cancelled elective admissions for PICU

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

Chart three – PICU electronic referrals

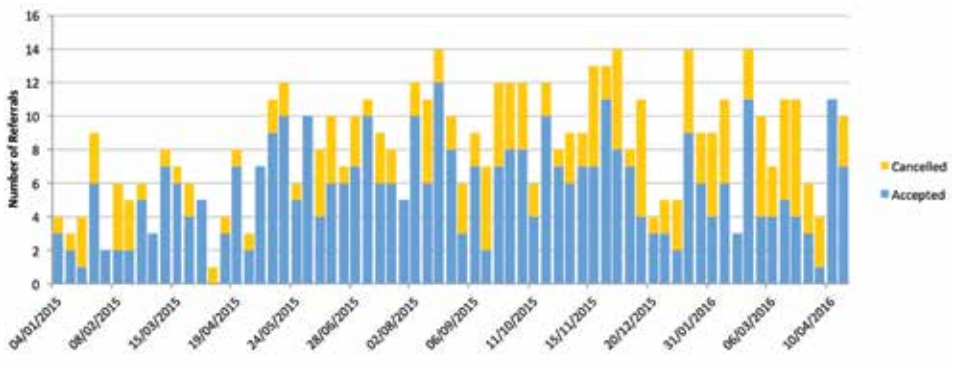
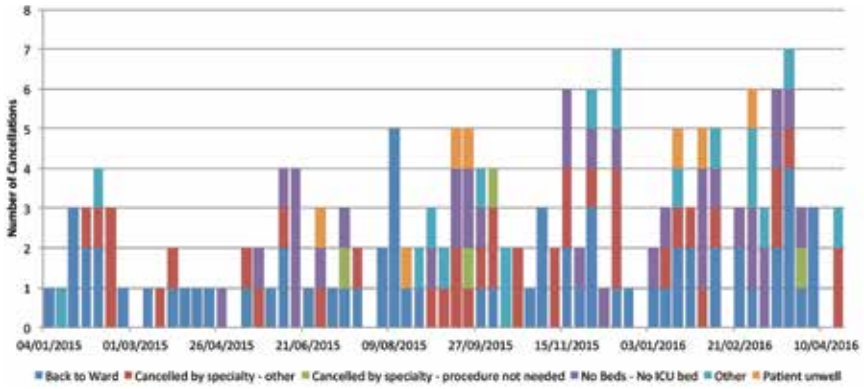


Chart four – PICU electronic cancellations



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

Mother, PICU patient

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

Mr. Joe Curry, Specialist Neonatal and Paediatric Surgery Consultant

What's going to happen next?

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

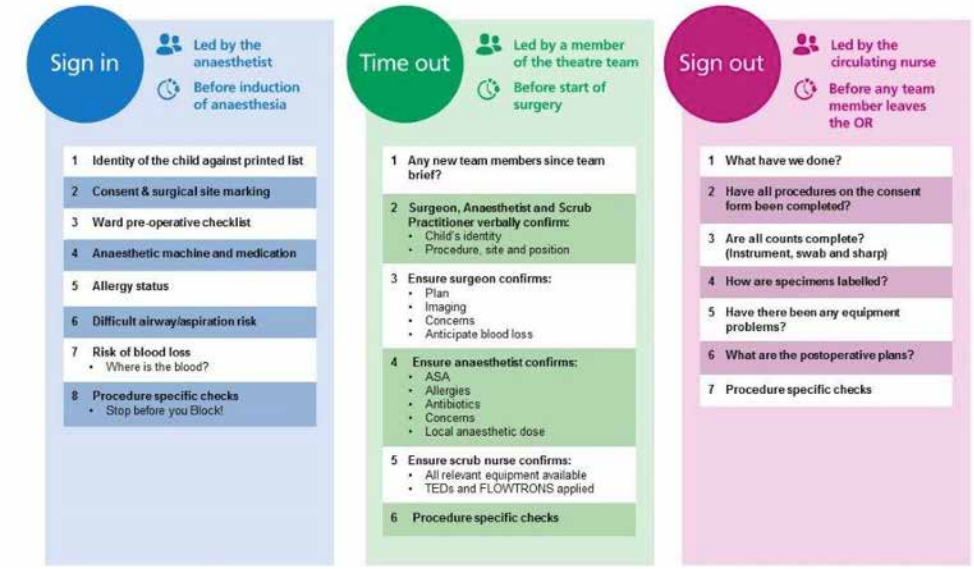
- Developing a robust and reliable method for capturing the multifaceted reasons patients may be delayed from intensive care.
- Developing reliable processes to ensure that patients can be discharged, without delay, to a ward bed.
- Working collaboratively with each surgical speciality team to identify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

How this benefits patients

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

Organisational engagement with the WHO Surgical Safety Checklist

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



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

97%

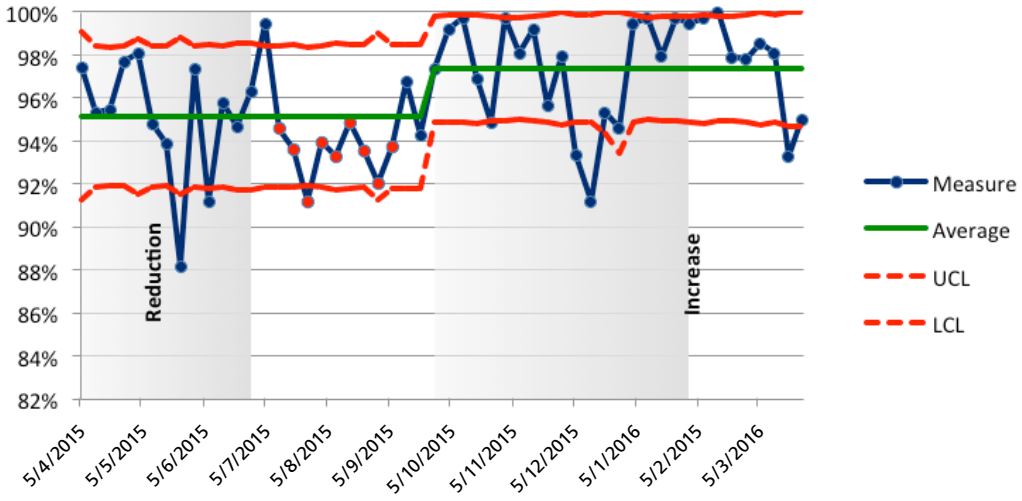
of procedures are reported as having all three parts of the Checklist completed

What is the WHO Surgical Safety Checklist?

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

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

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



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

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

What are the NatSSIPs?

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

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

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

Clinical effectiveness

Referral to treatment (RTT): incomplete pathways

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

What we said we'd do

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

What we did

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

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

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

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

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

What the data shows

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

What's going to happen next?

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

How this benefits patients

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

What is a care pathway?

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

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

Dr Vinod Diwakar, Medical Director

Working smarter to reduce blood component wastage

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

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

What we said we'd do

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

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

What we did

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

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

What the data shows

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

What's going to happen next?

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

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

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

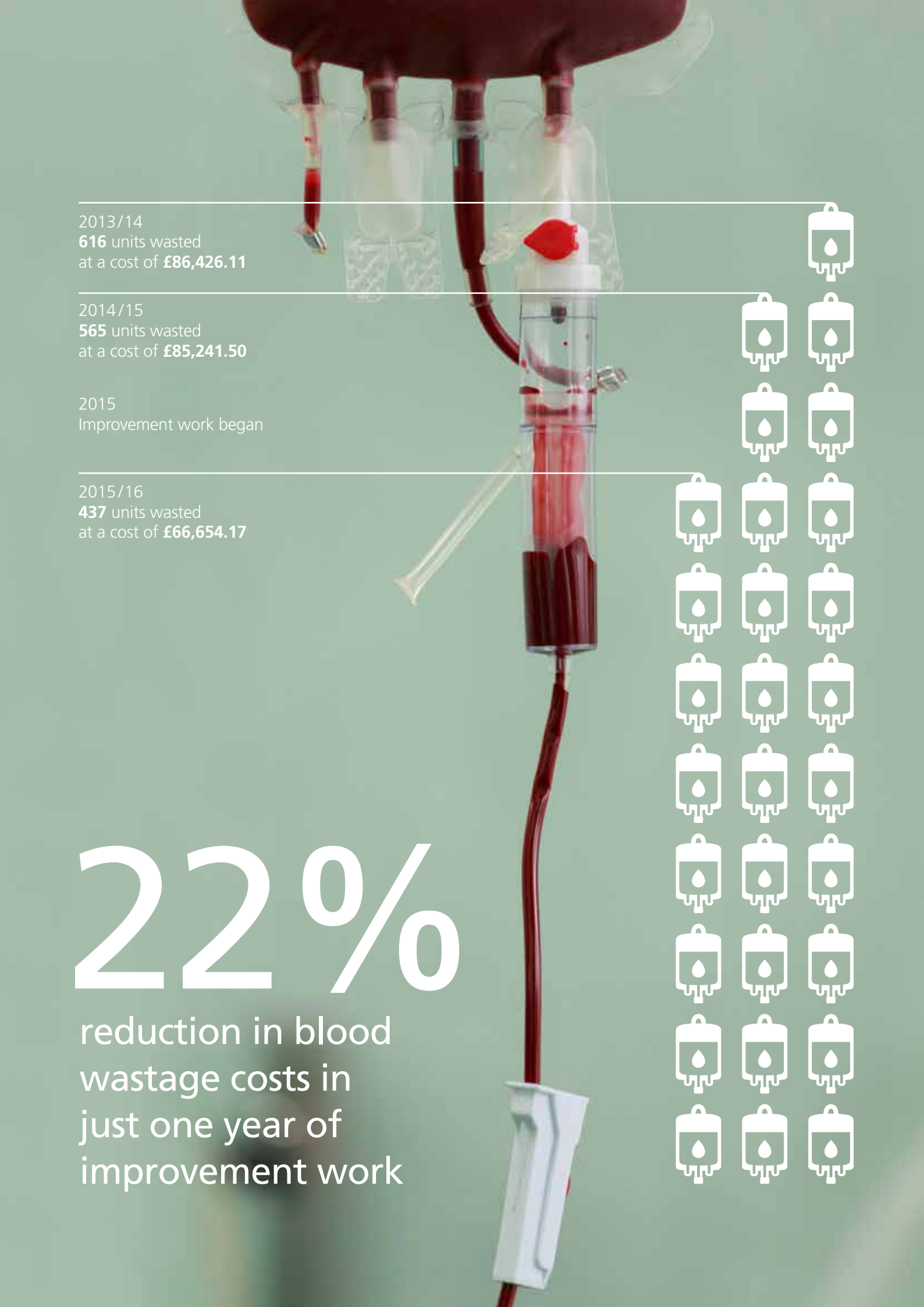
- minimise the volume of blood samples taken
- develop an anaemia pathway for investigating and treating patients undergoing elective surgery
- explore and educate our staff on alternatives to transfusion where appropriate

How this benefits patients

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

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

Deborah & Maria, Practice Educators, PICU


2013/14
616 units wasted
at a cost of **£86,426.11**
2014/15
565 units wasted
at a cost of **£85,241.50**
2015
Improvement work began
2015/16
437 units wasted
at a cost of **£66,654.17**
22%
reduction in blood wastage costs in just one year of improvement work

Experience

Improving discharge summary completion times

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

What we said we'd do

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

What we did

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

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

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

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

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

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

What the data shows

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

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

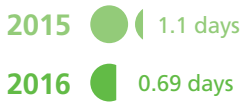
What is a discharge summary?

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

There have also been improvements across the following clinical divisions:

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

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



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

What's going to happen next?

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

How this benefits patients

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

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

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

Improving the care experiences of our patients with learning disabilities

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

What we said we'd do

For 2015/16, we said we would:

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

What we did

Training and support

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

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

Learning disability clinical alerts

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

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

Hospital passport

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

x2

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

Partnership working

Our partnership working has continued within the hospital and externally:

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

The Learning Disability Protocol for Preparation for Theatre and Recovery

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

Wake up patients with learning disabilities slower than those without

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

If the patient is disturbed or distressed in Recovery:

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

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

"The hospital had 'flagged' 459 of its patients as living with learning disabilities in the 12 months before our inspection. The hospital has a learning disability consultant nurse who is the lead for providing training, advice and support to other staff in the hospital. To support them, they had given enhanced training to 37 link learning disability staff."

"Approximately 40 per cent of children coming through Puffin Ward had a learning disability and Puffin had worked to improve meeting the needs of these children. All families were phoned the day before for confirmation of appointment and fasting times. If children had a learning disability, parents were asked what reasonable adjustments could be made such as the lighting being lowered in cubicles, not liking the surgical gowns and having a photo ID instead of wristbands. Preferences were also noted such as how close to stand to the child. 'Sing SIGN days' with Makaton took place (Makaton uses signs and symbols to help people communicate) and all staff had learned Makaton. The ward manager was due to present the Puffin Ward initiatives to a Royal College of Nurses conference later that month."

"On a recent visit to GOSH the staff had obviously read my daughter's personal passport and were aware of her complex needs and the best way in which to approach her. She is deafblind, has multi-sensory impairment and Down's syndrome amongst other things.

"The staff were aware of her sensory issues and were mindful of not overcrowding her and offered her a quiet space if that would make the whole experience both more accessible and more tolerable for her. The Consultant actually asked how close he needed to get so that she could see him talking to her! The first time her needs had been considered and addressed in such a pro-active way for many years. He also took time to listen to her questions and answered her rather than talk directly to me. This made her feel totally included and a valued part of the whole process, that she could make a decision about what was happening to her rather than simply being the person to whom things were done."

Parent of a patient with a learning disability

1 Where possible, staff are also applying these adaptations, such as lower levels of noise and light, for patients who do not have a learning disability.

What the data shows

Learning disability clinical alerts

Having an alert enables staff to know which patients with learning disabilities are in the hospital, where they are, and how they use the service, so that reasonable adjustments can be made to meet their individual needs.

Growth in the percentage of inpatients (Chart one) and outpatients (Chart two) for whom there was a learning disability alert has increased significantly in the past year. This demonstrates that as an organisation, we are increasingly able to identify children and young people with a learning disability in order to better support their care.

Chart one – Percentage of Inpatients with LD Alert - All Specialties

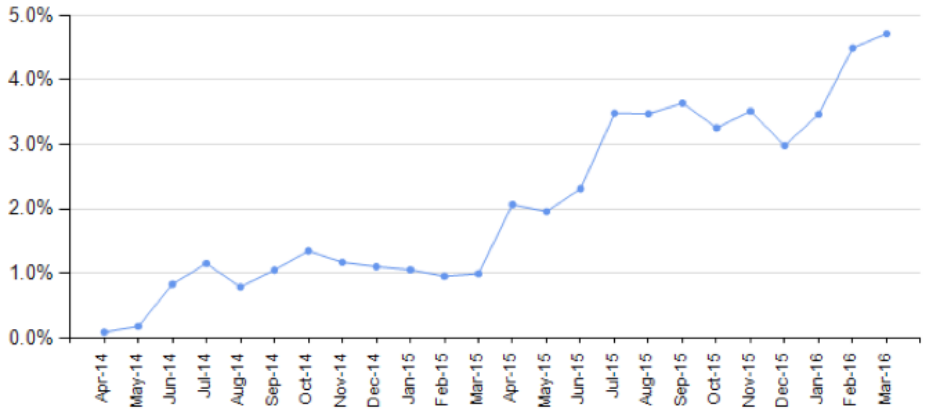
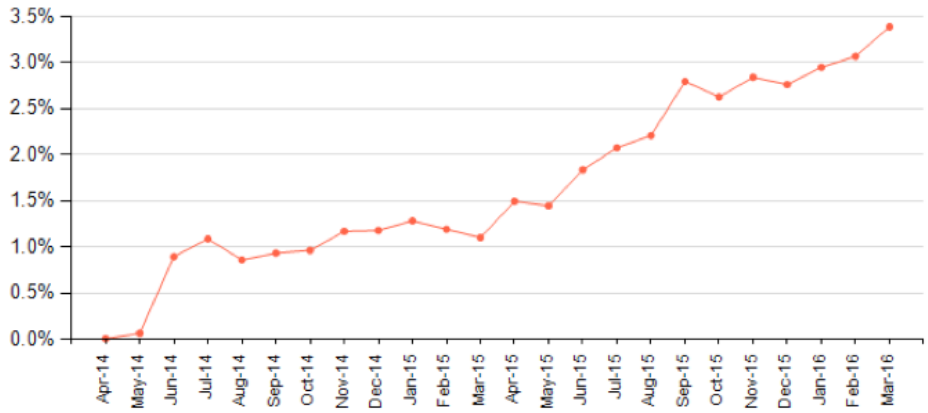


Chart two – Percentage of Outpatients with LD Alert - All Specialties

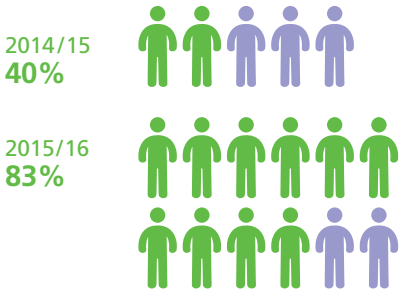


Reasonable adjustments

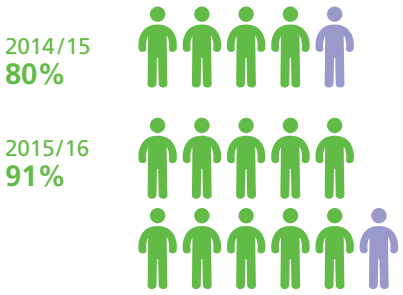
Reasonable adjustments are required to be made within services for people who have disabilities or impairments that fall within the Equality Act (2010).

In quarter three, we carried out an audit to find out how many of our patients had reasonable adjustments identified and documented in their patient record, and how many of the identified reasonable adjustments were met. Below are our figures for 2014/15 and 2015/16:

Reasonable adjustments that were identified and documented in patient notes:



Identified reasonable adjustments that were documented as having been met:



patient where this standard was met

patient where this standard was not met

What's going to happen next?

A steering group called 'Our Health, Our Hospital', made up of people with learning disabilities, families and staff has been set up. Under the group's guidance we will, in 2016/17:

1. Develop a more user-friendly clinic letter for patients with learning disabilities.
2. Establish Parent Support Volunteers so that parents of children and young people with learning disabilities (CYPLD) can be supported in clinics by other parents of CYPLD.
3. Engage in service evaluation and further teaching of staff across the hospital via Postgraduate Medical Education and other training opportunities.
4. Present at conferences and participate in research advisory groups to spread good practice.

How this benefits patients

- Reduced anxiety associated with hospital for patients with learning disabilities and their families.
- Improved experience of hospital.
- Genuine engagement with people who use the hospital to help us improve.

2016/17 Quality Priorities

The following table provides details of three of the quality improvement projects that the Trust will undertake on its services in 2016/17. These priorities were determined with input from staff, patients and their families, and commissioners. This input was sought through a range of mechanisms including survey, consultation, and use of established meetings such as our Members' Council, Young People's Forum, and Public and Patient Involvement and Experience Committee. All of our quality priorities are aligned with our strategic quality objectives, which in turn relate to the Trust vision of 'No waits, No waste, Zero harm'.

Safety

To reduce all harm to zero.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improve monitoring and communication of the deteriorating child	Ward teams alert the clinical outreach team about clinically deteriorating patients. We want to ensure that ward staff are effectively monitoring patients so they can identify early if a child's health is deteriorating and seek support when required to provide intervention to stabilise the child.	We will collect and analyse data on referrals to Clinical Site Practitioners and Intensive Care Outreach Network. The data will be published to our intranet dashboards, and reported to Trust Board.

Clinical effectiveness

To consistently deliver excellent clinical outcomes, with the vision to be the leading children's hospital in the world

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Referral to treatment (RTT): Reducing the number of patients with incomplete pathways at 18 weeks	Incomplete pathways are the RTT waiting times for patients whose RTT clock is still ticking at the end of the month. The national standard is 92 per cent of incomplete pathways are <18 weeks. This measure is a good indicator to ensure that patients on a RTT pathway are seen and treated within 18 weeks. Limited assurance work in 2015 confirmed that we had challenges with our 18 week pathway data, operational processes and capacity. This resulted in us taking a break from reporting 18 week data. In 2016/17 we will resume reporting, will launch new operational processes to ensure our waiting list management complies with national best practice, and will continue to work with commissioners to ensure sufficient capacity for the referrals received into the Trust.	In 2015, the Trust established an Access Improvement programme of work to define, scope and oversee the necessary improvements required across the elective care pathway, led by the Chief Operating Officer. This work programme is governed internally through a fortnightly Access Improvement Board and externally through a fortnightly tripartite meeting, which includes input from Monitor, NHS England and the CQC.

Experience

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

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improve young people's experience of transition to adult services	Good transition experiences are associated with improved levels of independence and engagement with adult services, with consequently improved health in adulthood. NICE Transition Guidelines (NICE, 2016) recommend that every specialty should have a designated Transition Lead with responsibility for overseeing transition, the improvement of transition practices and compliance with national guidelines. The guidelines also recommend that a data set of young people who will transition to adult services is established by age and specialty to support better transition planning.	The following measures will be reported: 1. Number and percentage of Specialty Transition Leads established 2. Numbers of young people treated at GOSH, be specialty, in age bands: 15yrs, 16yrs, 17yrs, and 17+yrs.

GOSH patient Louie (R) and his twin brother Aiden, age nine.

Part 2b:
Statements of assurance from the board

This section comprises the following:

- Review of our services
- Participation in clinical audit
- Participation in clinical research
- Use of the CQUIN payment framework
- CQC registration
- Data quality
- Service review
- Implementation of the duty of candour

Review of our services

GOSH is commissioned by NHS England to provide 58 specialised, or highly specialised, paediatric services. These services account for approximately 90 per cent of the Trust's healthcare activity. The remaining 10 per cent of our activity is typically care which, although not specialist, is provided to patients with complex conditions and is commissioned by Clinical Commissioning Groups.

In order to ensure that we maintain excellent service provision, we have internal processes to check that we meet our own internal quality standards and those set nationally. Key measures relating to the Trust's core business are presented to the Trust Board. These include measures of quality and safety, patient and referrer experience, and patient access to services.

The Trust's governance frameworks enable divisions to review regularly their progress, to identify improvements, and to provide the Trust Board with appropriate assurance.

The Trust's status during 2015/16 against Monitor's Governance Risk Assessment remains under review, as a consequence of the Trust's decision to commence non-reporting of referral to treatment (RTT) (Incomplete) target and the findings of a third party report, before deciding next steps.

The Trust is undertaking considerable work to rectify the identified data and systems issues in relation to RTT reporting, which have been a large focus during 2015/16 and will continue to be so during 2016/17. The Trust remains committed to the delivery of high quality, safe and effective specialist care for children.

What is Monitor?

Monitor is the independent regulator responsible for authorising, monitoring and regulating NHS Foundation Trusts.

Participation in clinical audit

During 2015/16, 11 national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. The Trust has participated in them all and data submissions are outlined below.

Name of audit/clinical outcome review programme	Cases submitted as a percentage of the number of registered cases required
Cardiac arrhythmia (National Institute for Cardiovascular Outcomes Research [NICOR])	154 / 154 (100%)
Congenital heart disease including paediatric cardiac surgery [NICOR]	1212 / 1212 (100%)
Diabetes (paediatric) (National Paediatric Diabetes Association)	25 / 25 (100%)
Maternal, Newborn and Infant Clinical Outcome Review Programme (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK [MBRRACE-UK])	13 / 15 (87%)
National Cardiac Arrest Audit (Intensive Care National Audit & Research Centre [ICNARC])	22 / 22 (100%)
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	We have reviewed all cases provided by NCISH to assess whether clinical case note reviews are required. No cases met the inclusion criteria.
Inflammatory bowel disease (Royal College of Physicians)	112 / 146 (77%)
Paediatric Intensive Care Audit Network (PICANet)	1,847 / 1,847 (100%)
Pulmonary hypertension (Health and Social Care Information Centre)	343 / 343 (100%)
Renal replacement therapy (UK Renal Registry)	192 / 192 (100%)
UK Cystic Fibrosis Registry (Cystic Fibrosis Trust)	179 / 179 (100%)

What is clinical audit?

'A cinical audit is a quality improvement cycle that involves measurement of effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.'

Healthcare Quality Improvement Partnership (HQIP) Principles of Best Practice in Clinical Audit 2011

Learning from National Audit reports

The following National Audit reports relevant to GOSH practice were published during 2015/16:

- Congenital Heart Disease (CHD) Audit Annual Report 2011–2014
- Inflammatory Bowel Disease (IBD) Paediatric Report
- Maternal Newborn and Infant Clinical Outcome Review Programme – Perinatal Mortality Surveillance Report 2013 data
- National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) Annual Report July 2015
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Just Say Sepsis Report
- Neonatal Intensive and Special Care (National Neonatal Audit Programme)
- Paediatric Intensive Care Audit Network Annual Report (PICANet)
- UK Cystic Fibrosis Registry Annual data report 2014

The reports have been reviewed by appropriate professionals within the organisation. Summaries of the learning from these audits and any actions required have been reported to the Patient Safety and Outcomes Committee (PSOC).

Key learning from clinical audit in 2015/16

The Clinical Audit team sits within the Clinical Governance and Safety department to ensure that there is integrated clinical governance. A central clinical audit plan is used to prioritise work to support learning from serious incidents, risk, patient complaints, and to investigate areas for improvement.

A selection of key findings is listed below:

Learning disabilities

Audit has taken place to support the improvement work on awareness and management of patients with learning disabilities (see page 26). The audit shows progress with documenting and meeting reasonable adjustments of care for children and young people with learning disabilities.

Surgical site marking

This audit took place to determine if patients were being appropriately 'site marked' before arrival in the operating theatre. Site marking helps to minimise the risk of surgery taking place in the wrong part of the patient. Wrong site surgery is classified as an NHS Never Event, an error that should never happen. 119 out of 121 cases (98 per cent) reviewed had appropriate site marking arrangements.

98%

of cases reviewed had appropriate site marketing arrangements in place

The audit shows we have a very high level of performance with safety precautions to prevent wrong site surgery. To help us get to 100 per cent, we are reviewing our guidance to make it even clearer.

Learning from incidents

Clinical Audit plays an important part in the effective implementation of recommendations from Serious Incidents (SIs). Some examples of work completed in 2015/16 are outlined below.

- An incident in January 2013 occurred when a patient's sutures were removed earlier than planned, which resulted in an additional general anaesthetic. The learning from the SI identified the need for clarity of post-operative instructions and communication at ward rounds. Completion of a re-audit this year showed that the recommended changes have been sustained.
- An SI occurred in May 2014 where a needle was retained in the patient. Audit showed that practice had changed in line with the recommendations of the investigation, but that further work is required to ensure that specific types of syringes are always used for closed cavity injections. As a result of this audit, a stock review of the specific syringes was undertaken and the location of the syringes was highlighted at relevant theatre handover. The audit results have been shared at a learning forum for all theatres staff, and changes made to the theatres care plan based around staff suggestions. This will be re-audited in 2016/17.
- In July 2014, an SI occurred where a child in a specialist chair slipped down and suffered positional asphyxiation. The findings of the audit this year showed good progress with the implementation of recommendations. As a result of the audit, staff have been offered additional training to ensure they are aware of the need for patients to be supervised in a specialist chair. We have also modified the instruction sheets that are kept at the patient's bedside when such chairs are used, to make the requirement for supervision clearer. This is currently being re-audited.
- Audit was prioritised to assess the implementation of learning following the unexpected death of a child who had been admitted for the insertion of a gastrostomy. The audit found that the recommendations made in the SI were implemented and no further actions were required.

Responding to national and local safety alerts

National patient safety alert

Here at GOSH, we audit patient safety alerts issued by NHS England, to support their implementation. An NHS England patient safety alert was issued in February 2015 following an incident where an adult patient in a nursing home choked after accessing a tub of thickening powder. In response to the alert, we devised an action plan here at GOSH to minimise the risk to our patients with dysphagia, who have thickened feeds. Practices to minimise the risk of accidental ingestion were evident in all cases audited.

Developing an internal alert in response to a 'near miss' incident

An internal safety alert was generated as a result of learning from a 'near miss' due to a false blood glucose reading. This was prepared by the Clinical Governance and Safety Team in April 2015 in order to proactively minimise the risk of a further incident. Audit showed:

84%

of cases in May 2015 met the safety alert requirements

To improve, an action plan was implemented, followed by re-audit to assess the effectiveness of implementation of the requirements:

95%

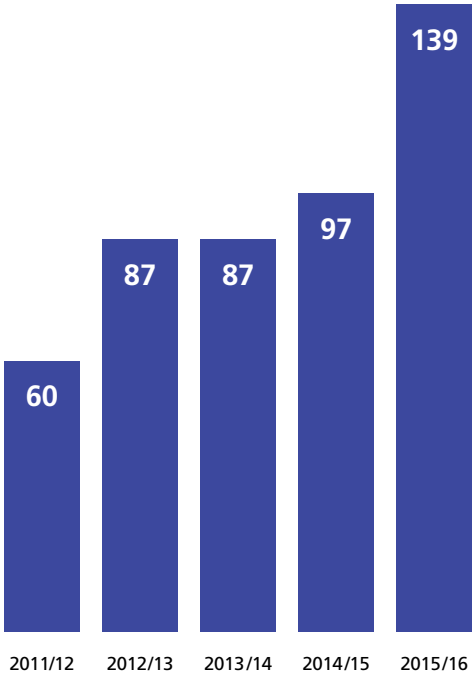
of cases in August 2015 met the safety alert requirements

This will be re-audited again in 2016/17 following additional practice changes agreed in one area of the hospital.

Local clinical audits

The summary reports of 139 completed local clinical audits were reviewed by clinical staff at GOSH during 2015/16. Our data shows we are improving our completion and sharing of local clinical audits over time.

Completed local clinical audits reported



To promote the sharing of information and learning, a summary of completed projects is published on the Trust's intranet and shared with the Patient Safety and Outcomes Committee.

The Clinical Audit team supports staff with their clinical audits so they can assess and improve the quality of their care. The audit team also recognises and promotes the Model For Improvement, which is taught by our Quality Improvement team and used in the Trust for improvement projects.

Examples of actions intended to improve the quality of healthcare, or work that has made a difference as a result of local clinical audit are listed below.

Congenital hyperinsulinism feeding audit

The Endocrinology service has completed their audit to look at feeding difficulties in children admitted with congenital hyperinsulinism. Compared with the previous audit in 2012, there have been no delayed discharges as a result of feeding issues, and an improvement in patients being able to feed orally on discharge. Parental anxiety about their child's feeding was also shown to have reduced since 2012.

"The safety alert and audit of blood glucose monitoring has improved the safety of our patients"

Clare Gilbert, Clinical Nurse Specialist, Hypoglycaemia

What is Model For Improvement?

Model For Improvement, shown by the diagram below, is a practical and systematic approach to change.

Learning from a complaint – Neurology team

Learning from a complaint in December 2015 highlighted the importance of rescue medication being written on a paper prescription for patients admitted for telemetry. An audit of the recommendations took place in February 2016, which showed that the recommendations have been met and are effective. This will be re-audited to ensure sustained change.

Visual Infusion Phlebitis (VIP) scores on Koala Ward

Injury from extravasation (the leakage of fluid from its intended vascular pathway) is a potential risk to any patient admitted to hospital. An audit was undertaken to review the number of staff recording VIP scores to prevent extravasation. The results showed that 66 per cent of patients had a VIP score documented appropriately. A different type of bandage is now being implemented to ensure all patients have a VIP score documented.

Holding bay trial – Ocean Theatres

Members of the Theatres Team used an audit to evaluate an intervention designed to reduce delayed start times for theatre lists in two operating theatres. A new sending system was implemented, initiated by the anaesthetist, which involves allocated recovery staff members collecting patients and 'holding' them in the Ocean recovery area until the lists are ready to start. A trial of the intervention showed a statistically significant reduction in mean delay time (from 26 to 11 minutes). The team now plan to roll out this intervention further in theatres.

Use of the fronto-facial protocol to reduce post-operative infections

The Craniofacial Team implemented the protocol in 2014, following four consecutive cases of mid-face infection. There have been no mid-face infections since the implementation of the protocol.

Participation in clinical research

At GOSH, we understand the immense importance to patients and their families of pushing the edges of medical understanding to make advancements in the diagnosis and treatment of childhood diseases. As a specialist hospital with strong academic links, many of our doctors are clinician-scientists who specialise in research and we are dedicated to harnessing opportunities for collaboration between clinicians and scientists, to deliver more research findings from 'bench to bedside' and 'bedside to bench'. In other words, medical research is a two-way process that allows us to offer the very latest treatments for our patients. Much of what we do is at the forefront of research in diseases of children and young people and we are also working to implement new evidence-based practice beyond GOSH, so that more patients can benefit in the UK and abroad.

GOSH's strategic aim is to be one of the top six leading children's research hospitals.

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

- The joint GOSH/ICH Research and Development Office.
- The Somers Clinical Research Facility (CRF), which is a state-of-the-art ward within GOSH for children taking part in clinical trials.
- Hosting research delivery staff funded through the Clinical Research Network: North Thames.

Our research activity is conducted with a range of national and international academic partners, and we work very closely with industry to support the development and introduction of new therapeutics, devices and diagnostics for the NHS.

Currently, we have 838 active research projects at GOSH/ICH. Of these, 212 have been adopted onto the NIHR Clinical Research Network (CRN) Portfolio, which is a grouping of high-quality clinical research studies. In total, 3164 of our patients were recruited in the past 12 months to participate in research.

838

research projects currently active at GOSH/ICH

Of these,

212

have been adopted onto the NIHR Clinical Research Network Portfolio

Some of our key research highlights in 2015/16 are described below.

- Our pioneering research teams, supported by the GOSH BRC, have developed a new treatment that uses 'molecular scissors' to edit genes and create designer immune cells programmed to hunt out and kill drug-resistant leukaemia. This form of gene therapy is promising for patients with particularly aggressive forms of leukaemia, where the cancer cells remain hidden or resistant to drug therapy. In addition to leukaemia, the teams continue to work together to develop gene therapy treatments for rare diseases, including Netherton syndrome, Fanconi anaemia and Wiskott Aldrich syndrome. The Gene and Cell Therapy Facility, which manufactures the modified cells, is funded through our BRC.
- GOSH has been successful in diagnosing the first patients through the 100,000 Genomes Pilot Study. These diagnoses have had a significant impact on the patients and their families. For the first patient, the genetic diagnosis resulted in a reduction of the patient's medication. In the second case, the diagnostic results indicated that the patient's condition was not inherited, but had arisen for the first time in the patient. Knowing that the chance of having a child with similar problems is very low, the parents now feel able to extend their family and have another child.

  The aims of the pilot were two-fold: to find out whether Whole Genome Sequencing would be a feasible diagnostic tool for patients in the NHS, and to test the pipelines and processes for patient recruitment and sample collection in anticipation of the main 100,000 Genomes Programme. Over 1,000 patient samples were provided by GOSH and our UCL partners, contributing to 22 per cent of the total samples included in the national pilot study.
- Children with a kidney cancer known as Wilms' tumour, who are at low risk of relapsing, can have their chemotherapy reduced. This finding, published in The Lancet, comes from a European-wide trial that studied a drug called doxorubicin. The 10-year study, led by BRC-funded Professor Kathy Pritchard-Jones, followed 583 children with stage II or stage III Wilms' tumour of intermediate risk type, which is the most common. The results showed that 96.5 per cent of children whose treatment included doxorubicin – which has been linked to irreversible heart problems later in life – survived for five years or more, compared with 95.8 per cent of children who did not receive the drug. Even though there was a slight increase in the risk of patients relapsing if they did not receive doxorubicin, such patients were successfully treated subsequently, meaning that overall survival rates were the same. The standard treatment for this type of Wilms' tumour has now been changed to no longer give doxorubicin. This means that the majority of these children now avoid the risk of long-term heart problems.
- The Dubowitz Neuromuscular Centre (DNC) at GOSH and ICH has been confirmed as a Centre of Paediatric Clinical and Research Excellence by Muscular Dystrophy UK. This is one of ten Centres of Excellence and the only paediatric centre selected. This award recognises centres with outstanding levels of specialist care for people living with muscle-wasting conditions. The status was awarded following a national audit carried out by Muscular Dystrophy UK, aimed at ensuring that high-quality care is provided to patients with muscle-wasting conditions. The DNC provides clinical assessments, diagnostic services and advice on treatment and rehabilitation alongside clinical trials. It also provides basic research focusing on causes of neuromuscular diseases in childhood and identifying novel therapeutic interventions. Professor Francesco Muntoni is Head of the DNC, and is the BRC Lead for the 'Novel Therapies for Translation in Childhood Diseases' theme.
- Promising findings from a trial for a new stem-cell based therapy for a rare skin condition have been published in the Journal of Investigative Dermatology. The clinical trial recruited 10 patients with recessive dystrophic epidermolysis bullosa, and was led by Professor John McGrath at King's College London and BRC-supported Principal Investigator Dr Anna Martinez at GOSH. The study involved intravenous injections of stem cells, and has led to an improvement in the quality of life for the subjects and their carers, including reports of improvement in skin healing, reduced pain, better sleep and reduced caring needs.

In addition, we are delighted to list recognitions and awards received:

- Professor Helen Cross received an OBE in the Queen's Birthday Honours for her services to children with epilepsy.
- Professor Waseem Qasim has been awarded a prestigious NIHR Research Professorship, one of only four awarded nationally this year. The posts are designed to support the country's most outstanding research leaders during the early part of their careers to lead research, to promote effective translation of research and to strengthen research leadership at the highest academic levels.
- Three academics associated with GOSH – Professor Helen Cross, Professor Francesco Muntoni and Professor Jane Sowden – were awarded NIHR Senior Investigator status. Professor David Goldblatt was successful in renewing his NIHR Senior Investigator status for a second term. These awards are made by the NIHR to outstanding research leaders.
- Two of our investigators – Dr Ri Liesner and Dr Anna Martinez – received awards from the NIHR CRN for their contribution to clinical research. Dr Liesner was recognised for recruiting the first global patient into a haemophilia study designed to evaluate the safety and efficacy of a recombinant fusion protein. Dr Martinez was recognised for recruiting the first European patient into a phase 3 epidermolysis bullosa trial.
- GOSH also hosts one of the few centres that brings together nurses and allied health professionals (AHPs) in a research setting, led by Faith Gibson, Professor of Child Health and Cancer Care, who holds a joint appointment between GOSH and the University of Surrey. Drs Kate Oulton, Debbie Sell and Jo Wray lead their own programmes of research from the centre, with success in NIHR funding, as well as funding from well-established charities. This team of researchers prioritise understanding the patient and family experience, helping to describe the care that families receive, and exploring both processes and outcome. Dr Kate Oulton is also the NIHR GOSH BRC Clinical Academic Programme Lead for Nursing and AHP research, and is leading the strategy to support and encourage nurses and AHPs to increase their research activity. Recent success includes an NIHR Clinical Doctoral Research Fellowship for Ms Lesley Katchburian, Clinical Specialist Physiotherapist and an NIHR Clinical Lectureship for Dr Elaine Cloutman-Green, Infection Prevention and Control Practitioner.

Use of the CQUIN payment framework

The Commissioning Quality and Innovation (CQUIN) payment framework makes up a proportion of NHS healthcare providers' income, conditional upon improvement. The framework aims to support a cultural shift by embedding quality and innovation as part of the discussion between service commissioners and providers, and constitutes 2.5 per cent of the Actual Contract Value between commissioner and provider.

In 2015/16 providers were given an option in relation to what tariff arrangement to implement (due to changes that were being made to how the tariff had been set nationally). The Trust (along with a number of other specialist tertiary service providers) chose to operate under the Default Tariff Rollover (DTR). By choosing the DTR (as opposed to the Enhanced Tariff Option), the Trust was ineligible to access CQUIN funding. As such, dedicated CQUIN schemes were not applicable during 2015/16

This arrangement was for one year only, and the Trust is now engaged with NHS England (its main commissioner) on CQUIN schemes for 2016/17.

CQC registration

The Care Quality Commission (CQC) is the independent healthcare regulator for England and is responsible for inspecting services to ensure they meet fundamental standards of quality and safety.

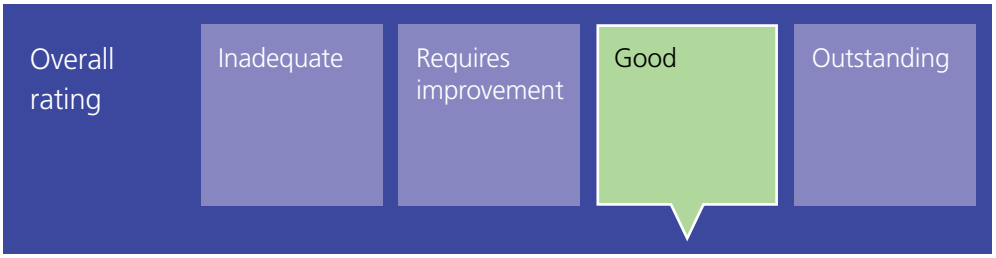
GOSH is required to register with the CQC and is currently registered, without conditions, as a provider of acute healthcare services. GOSH has not participated in any special reviews or investigations by the CQC in 2015/16.

In April and May 2015, as part of their announced rolling schedule of inspections, the CQC conducted a comprehensive inspection at GOSH. The ratings grid opposite demonstrates that the Trust was rated as "good" overall. As part of the assessment, it was rated 'outstanding' for being caring, mostly 'outstanding' for end-of-life care, and consistently 'good' for providing safe care.

What is CQUIN?

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

Ratings grid



	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care	Good	Outstanding ☆	Outstanding ☆	Good	Good	Outstanding ☆
Neonatal services	Good	Good	Outstanding ☆	Good	Good	Good
Transitional services	Good	Good	Outstanding ☆	Good	Requires improvement	Good
Surgery	Good	Good	Outstanding ☆	Requires improvement	Requires improvement	Requires improvement
Intensive/critical care	Good	Good	Outstanding ☆	Good	Requires improvement	Good
Services for children & young people	Good	Good	Outstanding ☆	Good	Good	Good
End of life care	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆
Outpatients	Good	Not rated	Outstanding ☆	Requires improvement	Requires improvement	Requires improvement

We were most concerned to be informed by the CQC that they sought to take enforcement action against GOSH during 2015/16. This was issued in relation to the Trust's management of referral to treatment (RTT) and associated data. This is reflected in the 'requires improvement' ratings for the responsive and well-led criteria in the surgery and outpatient services.

The Trust and its Board are committed to making the improvements to fully address the issues identified. An extensive transformation programme in the delivery of elective care is underway (see page 21), which will ensure that all patients will be treated in a more timely way in future, and that the systems and processes in place are robust. The Trust is aware of the effect these issues have had on patients' experience, and is working as quickly as possible to make the necessary improvements

Data quality

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

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

GOSH submitted records during 2015/16 to SUS for inclusion in the Hospital Episode Statistics, which are included in the latest published data. Performance is measured by examining the accuracy and completeness of data within the submissions to SUS and reported against local area and national averages.

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

Indicator	Patient group	Trust Score	Average national score
Inclusion of patient's valid NHS number	Inpatients	98.2%	99.2%
	Outpatients	98.8%	99.3%
Inclusion of patient's valid General Practitioner Registration Code	Inpatients	99.9%	99.9%
	Outpatients	99.9%	99.8%

Notes:

- The table reflects the most recent data available as of 23 March 2016 (April 2015–January 2016 at month 10 SUS inclusion date).
- Percentages for NHS number compliance have been adjusted locally to exclude international private patients, who are not assigned an NHS number.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

Clinical coding and data quality

GOSH was not subject to the Payment by Results clinical coding audit during the 2015/16 reporting period.

The Trust continues to carry out an internal clinical coding audit programme to ensure standards of accuracy and quality are maintained. As a result, for the second year in succession, the Trust has been shortlisted for the Data Quality Award (Specialist), one of only five specialist acute trusts across the UK to have excelled in a range of data quality indicators.

The award recognises the importance of clinical coding and data quality, and the essential role they play in ensuring appropriate patient care and financial reimbursement from commissioners.

The Trust has been shortlisted for this award based on performance against a range of data quality indicators including:

- depth of coding (not case mix adjusted)
- percentage of coded episodes with signs and symptoms as a primary diagnosis
- percentage of uncoded spells

The Trust has been shortlisted for the Data Quality Award

for the second year in a row

What is data quality?

Data quality refers to the tools and processes that result in the creation of correct, complete and valid data that is required to support sound decision making.

What is an NHS Number?

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

What is the NHS Health and Social Care Information Centre?

The NHS HSCIC is England's central, authoritative source of health and social care information.

Acting as a 'hub' for high-quality, national, comparative data for all secondary uses, they deliver information for local decision makers to improve the quality and efficiency of frontline care.

hscic.gov.uk

Information Governance Toolkit

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Information Governance Toolkit provides NHS organisations with a set of 45 standards, against which we declare compliance annually.

The Information Governance Toolkit overall score for GOSH in 2015/16 was 74 per cent. This represents a small decrease in performance against the score of 77 per cent reported in 2014/15.

For three of the 45 standards, our self-assessment was below a satisfactory level (level 2):

- Ensuring that all staff receive information governance training every year – only 84 per cent of staff completed the training in year.
- The use of NHS number in all outgoing correspondence – some areas of the Trust have not yet adopted this practice consistently.
- Conducting a recent audit of our corporate record practices.

To address these items, we have remedial action plans aimed at reaching the satisfactory level by June 2016. This includes:

- Communicating with all staff who have not completed their training.
- Introducing a new learning management system to support staff with their mandatory training.
- A project to ensure that all teams sending out correspondence include the NHS number.
- Carrying out a corporate records audit scheduled for completion by May 2016.

Improving data quality

GOSH will be taking the following actions to further improve data quality in the coming year:

- Ensuring that policies and processes regarding capturing of data on core IT systems are concise, complete and in a standard format.
- Development of online e-learning material available via the Trust intranet, giving staff immediate access to guidance when most needed.
- Assigning ownership at operational level of non-core data collection systems.
- Enhancing the data quality reporting suite, highlighting to service users missing or inconsistent data.

Part 2c:
Reporting against core indicators

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

What is the Department of Health?

The Department of Health is a department of the UK government with responsibility for government policy for England alone on health, social care and the NHS.

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2015/16	2014/15	2013/14	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Domain 3: Helping people recover from episodes of ill health or following injury									
				Source: Health & Social Care Information Centre Time period: 2013/14 financial year					
Emergency readmissions to hospital within 28 days of discharge:									
– % of patients aged 0–15 readmitted within 28 days	1.78%	0.74%	2.5%	Not available from the HSCIC at the time of publication of this report.				The results are from the Hospital Episode Statistics (HES) and the Office of National Statistics (ONS).	Ensuring divisions and directorates develop and implement local action plans, which respond to areas of weakness.
– % of patients aged 16+ readmitted within 28 days	1.62%	0.6%	0.9%						
Domain 4: Ensuring that people have a positive experience of care									
				Source: NHS Staff Survey Time period: 2015 calendar year					
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	88% (2015)	87% (2014)	87% (2013)	88%	93%	80%	91% (median score)	The survey is carried out under the auspices of the DH, using their analytical processes. GOSH is compared to other acute specialist trusts in England.	Ensuring divisions and directorates develop and implement local action plans, which respond to areas of weakness.
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	25% (2015)	24% (2014)	23% (2013)	25%	9%	49%	37% (median score)		
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	87% (2015)	89% (2014)	89% (2013)	87%	95%	81%	88% (median score)		

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its service, by:
	2015/16	2014/15	2013/14	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm									
				Source: Department of Health (acute providers) Time period: 2014/15 financial year					
Number of clostridium difficile (C. difficile) in patients aged two and over‡	7	14	13	14	0	121	34		Continuing to test stool samples for the presence of C.difficile, investigate all positive cases, implement isolation precautions and monitor appropriateness of antimicrobial use across the organisation.
Rate of C. difficile in patients aged two and over (number of hospital acquired infections/100,000 bed days)*	8.3	12.2	11.9	12.2	0	62.2	15.1	The rates are from Public Health England†	
C.difficile is endemic in children and rarely pathogenic. At GOSH, we test for C.difficile toxin in all diarrhoeal stool that 'conforms to the shape of the pot' (minimal national standard), as well as other stool where diarrhoea, fever or blood in stool was reported, where a request is made for enteric viruses and as part of the surveillance programme in children with congenital immunodeficiency and undergoing bone marrow transplants. On agreement with our commissioners, we investigate all positive detections and report to Public Health England those aged 2 and above with diarrhoea (or a history of diarrhoea) where no other cause is present or, if another possible cause is present, clinical opinion led to treatment as a possible case. We report on the Health Care Acquired Infection database according to a locally agreed paediatric modification of the national definition, to enable year-on-year comparison in our specialist trust. Our approach means we find more positive samples compared with the number of cases that we report. ‡ Of the 7 cases of C.difficile attributed to GOSH for 2015/16, two were attributed to a lapse of care in line with guidance published by Monitor. Of the 14 cases of C.difficile attributed to GOSH for 2014/15, one was attributed to a lapse of care in line with guidance published by Monitor. Information on lapses of care was not determined in 2013/14. * Previously published rates for 2014/15 (12.7) and 2013/14 (14.8) were based on a different calculation. These have been recalculated in line with Department of Health methodology and re-published here. † https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis									
				From National Reporting and Learning Service (NRLS) Time Period: 01/04/2015 to 31/03/2016					
Patient safety incidents reported to the NRLS: Number of patient safety incidents	5,338	5,231	4,922	5,330	-	-	-	GOSH introduced electronic incident reporting (DatixWeb) in April 2011 to promote easier access to and robust reporting of incidents. It is expected that organisations with a good safety culture will see higher rates of incident reporting year-on-year, with the severity of incidents decreasing.	Initiatives to improve the sharing of learning to reduce the risk of higher graded incidents from recurring include learning events and a Learning, Implementation and Monitoring Board.
Rate of patient safety incidents (number/100 admissions)	15.32	12.82	10.28	-	-	-	-		
Number and percentage of patient safety incidents resulting in severe harm or death	11 (0.2%)	26 (0.5%)	27 (0.5%)	6	-	-	-		
There is a time lag between NHS Trusts uploading data to the NRLS (performed twice a month at GOSH) and the trend analysis reports issued by the NRLS.									

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

It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission (CQC) as part of the CQC registration process. GOSH also reports its patient safety incidents to the National Reporting and Learning Service (NRLS), which runs a national database designed to promote learning.

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

Part 3:
Other information

Monitor uses a limited set of national mandated performance measures, sourced from the NHS Operating Framework, to assess the quality of governance at NHS foundation trusts.

Performance is measured on an aggregate (rather than specialty) basis and Trusts are required to meet the appropriate threshold each month. Consequently, any failure in one month is considered to be a quarterly failure. The table below sets out the relevant national performance measures used to assess the Trust's quality governance rating.

Performance against key healthcare targets 2015/16

Domain	Indicator	Threshold/target	GOSH performance for 2015/16 by quarter				2015/16 total	Indicator met?
			Q1	Q2	Q3	Q4		
Safety	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia – meeting the MRSA objective	Monitor no longer includes MRSA in its governance indicators	N/A	N/A	N/A	N/A	N/A	N/A
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment	96%	95.7%	100%	97.8%	100%	98.8%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:							
	· surgery	94%	94.4%	100%	92.3%	100%	96.1%	Yes
	· anti-cancer drug treatments	98%	100%	100%	100%	100%	100%	Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	2015/16 was a challenging year for the Trust related to delivery of the referral to treatment (RTT) standards, with a number of significant issues identified following an Elective Care Intensive Support team review in May 2015. As a result, GOSH has agreed with NHS England a pause in the reporting of its RTT figures until confidence in the data has been returned. The improvement work (see page 21) required to address the identified issues and return to compliance against the RTT Incomplete standard is ongoing, and we expect to resume reporting from the end of September 2016.					
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

* Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008)

Performance against key healthcare targets 2014/15

Domain	Indicator	Threshold/target	GOSH performance for 2014/15 by quarter				2014/15 total	Indicator met?
			Q1	Q2	Q3	Q4		
Safety	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia – meeting the MRSA objective	Monitor no longer includes MRSA in its governance indicators	N/A	N/A	N/A	N/A	N/A	N/A
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment	96%	100%	100%	100%	100%	100%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:							
	· surgery	94%	100%	100%	100%	100%	100%	Yes
	· anti-cancer drug treatments	98%	100%	100%	100%	100%	100%	Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%*	92.5%	92.2%	92.2%	94.4%	92.8%	Yes*
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements‡	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

* Work completed since last year has identified that the data quality of the Trust's RTT performance reporting was not of an appropriate standard. Therefore, we now know that the figures published last year (and included here) were not reflective of the Trust's position. A Trust Board decision was made to suspend RTT reporting while work is being completed to ensure that our processes are robust to report data that is an accurate reflection of the Trust's position.

‡ Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008)

Performance against local improvement aims 2015/16

In addition to the national mandated measures identified in the above tables, the Trust has implemented a range of local improvement programmes that focus on the quality priorities as described in Part 2a. The table below sets out the range of quality and safety measures that are reviewed at each Trust board meeting. Statistical Process Control (SPC) charts are used to measure improvements in projects over time and to identify areas that require further investigation (see definition on page 17). All measures remain within expected statistical tolerance.

2015/16

Domain	Indicator	Total 15/16 performance	2015									2016			Performance within statistical tolerance
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Safety	Number of serious patient safety incidents	18	3	4	1	1	2	1	1	1	1	3	0	0	Yes
Safety	CVL related bloodstream infections (per 1,000 line days)	1.4	0.3	1.5	0.9	1.7	1	1.2	1.9	0.9	2.5	1.6	2.3	1.3	Yes
Effectiveness	Hospitality mortality rate (per 1,000 discharges)	2.58	4.0	2.47	2.23	1.86	2.71	1.96	4.13	2.14	3.53	1.14	2.14	2.70	Yes
Patient Experience	RTT - Incomplete *	2015-16 was a challenging year for the Trust related to delivery of the RTT standards, with a number of significant issues identified following an Elective Care Intensive Support team review in May 2015. As a result, GOSH has agreed with NHS England a pause in the reporting of its RTT figures until confidence in the data has been returned. The improvement work (see page 21) required to address the identified issues and return to compliance against the RTT Incomplete standard is ongoing, and we expect to resume reporting from the end of September 2016.													
Patient Experience	Discharge summary completion time (within 24 hours)	81.8	78.7	81.0	83.4	80.2	79.4	82.9	82.6	82.3	73.0	74.5	76.6	79.4	N/A

2014/15

Domain	Indicator	Total 14/15 performance	2014									2015			Performance within statistical tolerance
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Safety	Number of serious patient safety incidents	23	1	2	2	3	2	1	2	2	3	0	1	4	Yes
Safety	CVL related bloodstream infections (per 1,000 line days)	-	1.1	2.3	0.5	1.3	1.5	1.8	1.5	1.2	1	1.2	1.4	1.3	Yes
Effectiveness	Hospitality mortality rate (per 1,000 discharges)	-	3.4	3.3	2.3	2	2.8	2.4	2.2	2.1	2.8	3.6	3.4	1.4	Yes
Patient Experience	RTT - Incomplete *	92.8%	92.8	92.2	92.6	92.0	92.2	92.2	92.0	92.1	92.7	94.6	93.9	94.7	Yes
Patient Experience	Discharge summary completion time (within 24 hours)	81.2%	82.2	81.1	85.1	84.9	77.7	80.6	83.4	81.2	78.8	80.3	79.0	80.2	N/A

Service review

To address issues with the Gastroenterology Service that had been reported via patient and parent complaints, PALS, and other internal rout es, the Trust commissioned an independent review and immediately took action upon receipt of early findings of the review.

Actions included:

- A review of all gastroenterology referrals by a multi-disciplinary team (MDT) chaired by the Medical Director.
- A revised approval process of procedure lists.
- A revised case review, diagnostic and treatment guidelines.
- Complex case review and management at MDT at which attendance was compulsory.

Implementation of these action plans is ongoing and is monitored closely by the executive team.

Implementation of the duty of candour

The Trust formalised its approach to openness and transparency in 2009 with the introduction of its Being Open Policy. This policy informed staff of the expectations of the Trust, that open and honest communication would take place with patients, parents and their families throughout all aspects of their care, including when patient safety events may have occurred.

The policy was updated to encompass the legal requirements that came into force on 1 April 2015, which described a legal responsibility to be open with patients and/or their families when a patient safety event caused harm graded as moderate, severe or death.

The Trust continues to engage in transparent communication with patients, parents and families and has robust processes to manage patient safety events that are reported at the Trust.

"The culture was very open and transparent. Parents and children were kept fully involved in their treatment. There was an evident commitment to continually improve the quality of care provided. Children and young people were involved in decision making as far as possible."

Quote from GOSH's CQC report, published January 2016

Annex 1: Statements from external stakeholders

Statement from NHS England (London), Specialised Commissioning Team

NHS England would like to thank Great Ormond Street Hospital for Sick Children for the opportunity to review and provide a response to the 2015/16 Quality Account.

NHS England is the Lead Commissioner and has a very positive relationship with the Trust. We continue to work together to consider improvements in the quality of care, taken up through contractual mechanisms, feedback from families and other stakeholders, clinical quality review meetings and through regular dialogue for example with Monitor and the Care Quality Commission which published its inspection report in January 2016.

We commend the Trust for the very positive feedback received and documented in the CQC report published in January 2016. The Trust received an overall rating of Good with a number of areas of outstanding practice. Two areas for improvement were identified in relation to Responsiveness and Well-led. A Requirement Notice was issued reflecting some necessary changes in the management of Referral to Treatment Targets (RTT) that were identified as a priority in the 2015/16 *Quality Report*. The Trust has undertaken extensive work in response to the issues raised, good progress has been made to date and work is planned to continue into 2016/17.

In 2015/16, NHS England established a Joint Strategic Change Programme and appointed a Project Manager to lead a programme of work that aims to improve paediatric care in London. GOSH clearly has a leadership role here. The *Quality Report* priority relating to "flow" particularly through paediatric intensive care and some service / pathway redesign which should have consequential benefits on RTT are key components of our joint work.

We acknowledge the areas of achievement reported this year. NHS England welcomes the ongoing focus of the following measures to address patient safety, clinical effectiveness and patient experience:

- To embed RTT processes (to include a better understanding of relative demand and capacity).
- To progress work to improve the care experiences of children and young people with learning disabilities.
- To focus on improving transition to adult services.
- To improve patient safety through better monitoring and communication of a child's deteriorating health.

More broadly, the new Executive team continues to review the governance processes in place across the Trust and has already made recommendations in relation to:

- Performance and turnaround of Serious Incident reports.
- Development of Ward to Board reporting.
- Prompt investigation of feedback from families point to concerns about clinical management warranting investigation.
- A wider review of data quality management processes.

We look forward to supporting the findings from these key pieces of work and building on the Trust's Always values to ensure continuous improvement for patients is delivered in 2016/17.

Response from Healthwatch Camden and Camden Health and Adult Social Care Scrutiny Committee

This report clearly sets out the continuing improvements at GOSH over the year. The results of the CQC inspection report were well deserved. We would like to congratulate the new leadership team on the way they have tackled the challenges they have faced. We are particularly pleased to see the excellent progress on supporting patients with learning disability.

GOSH has a demonstrable commitment to patient and family engagement. The caring ethos (rated as 'outstanding' by CQC) is evident in our contacts with GOSH staff.

We are concerned that data on referral to treatment (RTT) times is unreliable and hope that the trust is able to resolve the underlying issues, with a clear plan of action to share publicly, including with Camden's Health and Adult Social Care Scrutiny Committee in early autumn 2016.

Feedback from Members' Council councillors

Comments from patient councillor:

Overall, I am thoroughly impressed by the work performed at GOSH. It is always at the forefront and pioneering new medical treatments and practices, without compromising NHS care. The care I have received here and many others is world-class; it is extremely difficult to fault them.

GOSH is great at identifying problems early and responding to them rapidly, seen by their numerous audits and their reaction to improving flow through ICU. Getting clinicians, related staff members and families involved in the trials and development is essential to make the new system work. The implementation of ePSAG is wonderful and will provide real time information for everyone to access to enhance communication, which is always a concern and identify those at risk. The development of IT systems will really improve the workings of the hospital, especially the new EPRS in development. My only worry is that personal details are available to anyone that walks onto the wards and whether this is a breach of confidentiality.

I am pleased that GOSH responded to the RTT issue very promptly and have plans to resolve the current system and training. It is irritating to be waiting so long to receive treatment but in true GOSH spirit, they have not let significant harm come to anyone. GOSH have been open about this issue, adhering to their duty of candour.

Delayed discharges are inevitable at times, but are very frustrating as a patient and interfere with individual plans. I am glad work is being put into this to identify the reasons so this can be rectified, to free up beds and personal time. The use of ePSAG will really benefit this. No one likes to be on a ward unnecessarily.

Many patients at GOSH have chronic illnesses, and communication to their local services is fundamental for their care. The delay in discharge summary completion has been a concern for a while but I am pleased that work is being done to improve the completion time, as it will also free up time for clinicians. The development of a summary template will make it easier to complete and a system that is capable of connecting with other hospitals will revolutionise communication between GOSH and local teams. As a patient, duplicate copies are annoying but the communication once leaving hospital has always been difficult, tedious and can lead to delays in medical care. Looking at the outcomes of the intervention I am really impressed since they have notoriously been slow.

I am completely in agreement that there should be more support for those with learning difficulties. Hospital is a daunting place for anyone and everyone should be supported to meet their needs so they can get the best out of their treatment. The introduction of the hospital passport will make sure all departments are aware so they can improve the effectiveness of communication and the care they receive, making them feel as a valued individual.

What can be seen from the report is that staff engagement and support is vital to enhance the care they provide. This should be paramount to ensure they feel respected and valued in the work environment. The report shows staff likely to recommend the service to families and friends is lower than the national average, and those experiencing harassment (although both very high scores) could be improved. Whether they are provided equal opportunities for promotion is hard to say, as GOSH is a pioneering institution, so most people would be at the peak of their career.

I am particularly interested in Transition to Adult Services as this is something I have recently been through, however it is not executed particularly well and young people express very different experiences. It is an extremely difficult time to deal with in our lives and we have many questions and concerns. Preparation and support is key to this as is learning from other departments. By having a designated Transition lead in each department I hope that no-one will be missed. It means that young people know who to contact should they have any worries. Since transition in other departments is different we need a designated person in each department who understand the processes and knows when is an appropriate time to transition medically. It will hopefully mean that those under several specialities feel more relaxed as their transition leads can communicate with each other.

When I was treated at GOSH I was under the care of the gastroenterology team. I cannot fault them clinically however the service has been slow and communication was not always up to scratch. When waiting in outpatients, I never knew how long I would have to wait before being seen, and it would take me out of school for the whole day at times. Looking at PALS, they complain of a lack of care at times. I believe there is definitely room for improvement here, and I understand they are a large department with many patients to care for in an older part of the building. I think it is probably down to operational errors than anything else, however I am very satisfied that they are researching into this.

Comments from lead councillor:

GOSH is a world class tertiary paediatric hospital with an extraordinary reputation. This report highlights ongoing work to improve services and protocols as well as the incredible achievements of the hospital. Over the past 11 years GOSH care and expertise has saved my son's life on more than one occasion. I will always be grateful for this, so continue to work to improve services from the patient and parent perspective in the hope of improving the GOSH journey for others and in order to repay this debt.

I was pleased to read about the successful work to improve flow through intensive care, an important initiative. ePSAG is a welcome innovation that will help clinical treatment, save time, improve patient experience both trust wide and especially in relation to ICU. I am delighted that 'transparency and choice' are key concepts here; they are the way forward and will certainly improve patient and family experience and outcomes. It is refreshing to learn that a simple change in routine can make such a difference - it is so much more sensible to spread the load on ICU by simply changing operating days.

The 'watcher' facility now available through ePSAG is a fantastic new tool that will improve outcomes, reduce deteriorating child incidences and increase hugely patient safety and patient and family experience. I particularly applaud the ePSAG facility which allow parents' and staffs' concerns about a child's wellbeing to be recognised by flagging as 'watchers' whose CEWS don't trigger an alert. The benefits of ePSAG are clearly multifold and it is wonderful that the system can be built on and adapted according to specialist needs.

RTT issues are clearly very worry but it is reassuring to see that the situation is being dealt with carefully, thoroughly and efficiently. It is very good news that no patient harm has been discovered, I am confident that the 18 week window will be adhered to in the near future and that lessons learned will be beneficial to all areas of data management at GOSH.

It is good to read that there have been successful efforts to reduce the wastage of blood products as this is an expensive and valuable resource; it is clearly an area that needs continued monitoring.

Discharge summaries are a key local quality indicator that the Members' Council have selected as an item to include in this report annually since FT status was achieved in March 2012. This is because, as a Council, we recognise the importance role that discharge summaries play in the timely and safe discharge of patients. Not only does this improve patient and family experience, a timely and accurate discharge summary will also ensure a speedy return home and ensure that appropriate care is given by that patient's GP or local hospital on arrival. The Members' Council have been frustrated by the lack of improvement in discharge summary rates, so, while we applaud the work that has been done thus far, it clearly isn't enough as the job is not done. It is encouraging that the work that has been undertaken so far has resulted in significant improvement, but disheartening that the discharge summary times slipped so quickly after the end of the project. The Council hope to see a significant and sustained improvement in discharge summary rates for the 2016-17 Quality Report and are prepared to do whatever is necessary in supporting this.

The work around improving awareness and experience of patients with learning difficulties is wonderful, long may this continue. I do have concerns around the children and young people that do not fall into this category though, as this support is exclusive to patients with a significantly low IQ. This means that patients with a diagnosis of autism or Asperger Syndrome but with a higher IQ are not able to take advantage of the benefits offered through this facility. It is clearly a gap which needs closing as this group's needs are great too. Their experience and care would be vastly improved if they were able to access this service also.

I am pleased to see that 'Improving young people's experience of transition to adult services' is one of the three Quality Priorities for 2016/17, although I am concerned that the slant of this priority is on improving young people's experience rather than on significantly improving the transition provision. An experience is tenuous to measure, whereas a provision isn't. The transition provision at Great Ormond Street Hospital is sadly lacking, and this has been the case for many years. Often planned transition doesn't even happen. Young people become adults and they are moved on to adult hospitals with little support. There is certainly currently no standard protocol, so it is left to the specialities to work it out for themselves, resulting in a lack of consistency. The Members' Council have expressed concerns over this issue numerous times and we feel strongly that it needs tackling urgently. It isn't clear from this report whether the NICE guidelines for the provision of a Transition Lead for each specialty is going to be implemented trust wide.

Thorough auditing and learning from SI is clearly demonstrated by this report and is hugely reassuring and the extraordinary levels of medical innovation and excellence are heart warming to read. This is GOSH at its best. The 'molecular scissors' to edit genes and create designer immune cells is an example of this, as is the progress in diagnosis through the 100,000

Genomes Pilot Study. The list of extraordinary and groundbreaking new research and development in child health conducted at GOSH far too long to comment on individually but it is clearly something to be immensely proud of and to celebrate!

The CQC rating of 'Good' was very well deserved, the outstanding rating for caring and end of life care is a wonderful achievement and down to a set of people who do extraordinary things - every day. Clearly there is work still to be done in some areas, and the difficulties around RTT caused lower ratings that GOSH otherwise would have expected. But this is being dealt with and overall I am sure GOSH is very proud and deserving of its rating. GOSH is aware of, and proactive around, the issues in surgery and outpatients that need improvement. I am confident these will be tackled urgently. Data quality is a risk that the Trust is fully aware of and is working hard to improve. This is key to the delivery of a safe and effective service.

Issues with the Gastroenterology Service continue. I am pleased and reassured to hear that these complex issues are being monitored at Board level. It is an area where the Members' Council have expressed concern on several occasions in the past.

I am concerned by the minimal degree of reference to GOSH's 'Our Always Values' given in this report. These values were developed from the views of thousands of patients, parents and staff; they specify that GOSH aspires to be Always Welcoming, Always Helpful, Always Expert and Always One Team. I could find only one mention of these Values at any point through the document. It states that Our Always Values 'has been a visible commitment to our patients, families and staff' - while this is correct in that there are visible representations in the form of several posters and banners around the hospital and I know it is part of the recruitment policy, this minimal reference reflects my observation of many different GOSH departments and projects which either omit or keep to a minimum the utilisation of Our Always Values as a way of measuring and/or improving patient and family experience. The wholehearted adoption of Our Always Values by putting these values at the core of everything that GOSH offers and undertakes will inevitably lead to an improvement in all services, including clinical, and therefore will dramatically improve outcomes as well as patient and family experience. I trust this will improved in the 2016-17 Quality Report - because there will have been a significantly greater take up and awareness of the benefits of embracing 'Our Always Values' at the core of everything that GOSH does.

Nevertheless, overall I found this report interesting and enlightening. It has been carefully prepared and shows significant and heartening improvement in many areas. There are many achievements to celebrate and these are a testament to the extraordinarily hard, caring and dedicated work of thousands of people at GOSH who daily work together to make a positive difference to the sickest of children.

GOSH response to statements:

Confidentiality of ePSAG boards

We welcome the query about the confidentiality of the ePSAG boards. Throughout the implementation of ePSAG, which is installed only in swipe card access-controlled areas, all information that is added to the boards has been put through a formal information governance process. We have also consulted directly with patients and parents on the content of the boards. The feedback we have received is that the level of detail on the boards is appropriate and in fact, we found that parents welcomed the display of more information if it would increase the coordination and safety of care for their child. We continue to consult on and assess appropriateness of information as we make developments.

Discharge summaries

Discharge summaries are an important method of communication when a child or young person is discharged from hospital. We remain committed to improving timeliness by monitoring completion times, understanding why slips in performance happen, and targeting our improvement work accordingly. In 2016/17, we will focus on the remaining clinical areas that struggle to get their discharge summaries out in a timely fashion. Performance will be managed through our heads of clinical service, and we will undertake work in each poorly performing specialty to understand the reasons and learn from best practice in other areas.

Learning disabilities

Where appropriate and feasible, the principles underpinning aspects of the learning disabilities work stream are being modelled and mirrored for other children that would benefit from them.

Transition

The Trust is committed to achieving and consistently delivering all the required processes that underpin high quality transition for young people. In support of this, the Trust will be working to deliver the national CQUIN for Transition, the requirements outlined within the quality specification of the contract with commissioners, and the post-CQC GOSH Inspection Report (April 2015 inspection) action plan that focuses on improving the internal reporting of transition activity to the Board of Directors. Each specialty will provide a Transition Lead who, with their multi-disciplinary team, will be responsible for delivering the required process improvements such that every young person who requires transitioning from GOSH to a specialist adult service will receive this in a timely manner and as a positive experience. The delivery of this work across all of the pertinent specialties and consultants will be throughout 2016/17 and 2017/18.

Our Always Values – Always Welcoming, Always Helpful, Always Expert, Always One Team.

The contribution of our patients and families to the development of Our Always Values has been vital to them being embraced by staff (in our last Staff Friends and Family test, 97% of staff said they recognise Our Always Values). We welcome the continuing engagement of families in our work to embed the values, including the feedback provided here.

Having achieved high visibility of Our Always Values amongst staff, the next phase of work has been and continues to be the embedding of the values in our systems, processes and structures as well as in individual behaviours. Examples of this work in the last year include organisational redesign that has reduced the number of clinical divisions in part to reduce boundaries between specialist teams, supporting our 'One Team' value, and the commencement of a large piece of work to review the letters that we send to patients and families to ensure they are always clear and comprehensible, an example of our 'Helpful' value.

Major programmes of work are also underway, from building new patient care areas to delivering a new electronic patient record, which will allow us to further embed Our Always Values as 'business as usual'.

Jodie Irwin, Staff Nurse on Badger Ward at GOSH.

Annex 2: Statements of assurance

External assurance statement

Independent auditor's report to the Members' Council of Great Ormond Street Hospital for Children NHS Foundation Trust on the *Quality Report*

Text TBC 20 May 2016

Statement of directors' responsibilities in respect of the *Quality Report*

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the *Quality Report*.

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

- The content of the *Quality Report* meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance.
- The content of the *Quality Report* is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2015 to May 2016
  - papers relating to Quality reported to the board over the period April 2015 to May 2016
  - feedback from commissioners dated 27/04/2016
  - feedback from governors dated 20/04/2016 and 03/05/2016
  - feedback from local Healthwatch organisations dated 05/05/2016
  - feedback from Overview and Scrutiny Committee dated 05/05/2016
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xx/05/2016
  - the first CQC commissioned National Children's inpatient survey 2014 (conducted for GOSH by Picker Institute Europe) – the second version of this survey is under development and is expected to be available to conduct in 2016
  - the independently commissioned Ipsos MORI outpatient experience survey 2014 (this survey is conducted every two years)
  - the national NHS Staff Survey 2015
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 20/05/2016
  - CQC Intelligent Monitoring Report dated May 2015 and CQC *Quality Report* dated 8 January 2016
- The *Quality Report* presents a balanced picture of the NHS foundation Trust's performance over the period covered.
- The performance information reported in the *Quality Report* is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the *Quality Report*, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the *Quality Report* is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The *Quality Report* has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the *Quality Report* (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

20 May 2016

Chairman

20 May 2016

Chief Executive

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street
London WC1N 3JH
020 7405 9200
www.gosh.nhs.uk

Designed and produced by Great Ormond Street Hospital Marketing and Communications.

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

Design Manager
Great Ormond Street Hospital
Fourth floor
40 Bernard Street
London WC1N 1LE
E design.work@gosh.org

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th May 2016**	
Audit Committee Annual Report to the Trust Board for the financial year 2015/16 **Submitted by:** Loretta Seamer, Chief Financial Officer	**Paper No:** Attachment R
Aims / summary The purpose of the Audit Committee Annual Report is to describe the key activities of the Committee during the financial year, demonstrate how it has fulfilled its responsibilities; comment on key risks to the Trust and explain how it obtained assurance in relation to the key judgements made by management in preparing the financial statements. The attached draft is consistent with the report presented in the 2015/16 Trust Annual Report.	
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 has a crucial role in the Governance of the Trust by reporting on the relevance and rigour of underlying structures and processes and on the assurances the Board receives. The Audit Committee reviews and continually reassesses the system of Governance, risk management and internal control to ensure that it remains effective and 'fit for purpose' in providing those assurances.	
Financial implications No direct financial implications	
Legal issues No identified legal issues.	
Who is responsible for implementing the proposals / project and anticipated timescales The report is a retrospective review of delivery and effectiveness.	
Who is accountable for the implementation of the proposal / project Audit Committee Chair	

Attachment R

Audit Committee Report

Introduction from the Chairman of the Audit Committee

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

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

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

The attached report sets out, in detail, the responsibilities of the Audit Committee and how we have discharged those duties. The report also highlights the key areas considered by the Committee in 2015/16 but I will draw particular attention to a small number of these items here.

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

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

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

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

In keeping with last year, the Trust has undertaken a serious review of the appropriateness of the adoption of the going concern basis for the preparation of the accounts. This effectively reflects the confidence of the Trust that the organisation remains financially viable. As described below, we are confident that this is the case for the ensuing planning period of 2016/17 and that the Trust management has therefore clearly adopted the

appropriate accounting basis. The longer term challenges facing the Trust, like the wider NHS, are significant.

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

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

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

Charles Tilley

Audit Committee Chairman

20 May 2016

Audit Committee responsibilities

The Committee's responsibilities and the key areas discussed during 2015/16, whilst fulfilling these responsibilities, are described in the table below:

	Principal responsibilities of the audit committee	Key areas formally discussed and reviewed by the Committee during 2015/16
Review of the Trust's risk management processes and internal controls	• Reviewing the Trust's internal financial controls, its compliance with Monitor's guidance for Foundation Trusts, including the Code of Governance, and the effectiveness of its internal control and risk management systems. • Reviewing the principal non-clinical risks and uncertainties of the business and associated Annual Report risk management disclosures. (Clinical risks are reviewed by	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

	the Clinical Governance Committee).	reports. • 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
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 and 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
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 and Charter defining its role and responsibilities. • Internal Audit programme of reviews of the Trust's processes and controls to be undertaken, and an assurance map showing the coverage of audit work over three years against the risks. • Status reports on audit recommendations and any trends and

		themes emerging. • The Internal Audit reports discussed by the Committee, included – key financial controls - Procurement and Contract Management - Risk Management - Education Strategy and Governance
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 and any waivers of those regulations during the financial year. • 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 the management of information governance and data quality risks • Updates on staff raising concerns policy • reporting to the Board and Members' Council where actions are required and outlining recommendations.

Effectiveness of the committee

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

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

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

Attachment R

External Audit

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

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

Internal audit and counter fraud services

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

- KPMG LLP. The internal audit service covers both financial and non-financial audits according to a risk-based plan agreed with the Audit Committee. The Trust also has a 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 and Efficiency Target. In addition the risk of delivery of the Productivity and Efficiency targets, the contribution of International Private Patients and the risk that operational capacity is not sufficient to deliver future demands have also been assessed as part of this programme of review. For each risk the Committee reviews the risk assessment (including risk definition, risk appetite, and likelihood and impact scores); the robustness of the controls and evidence available that the controls are operating.

Data Quality reviews

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

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

Care Quality Commission Review

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

Board Assurance Framework

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

Productivity and Efficiency

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

Internal controls

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

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

Fraud detection processes and whistle-blowing arrangements

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

Financial reporting

We reviewed the Trust's financial statements and how these are positioned within the wider Annual Report. To assist this review we considered reports from management and from the

internal and external auditors to assist our consideration of: the quality and acceptability of accounting policies, including their compliance with accounting standards;

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

Going concern

The Trust management has carefully considered the appropriateness of reporting on the going concern basis. The Trust financial position includes substantial charitable donations that must be reported as income and this can result in significant surpluses being reported by the Trust. Please note that the Trust presents an additional note to remove the impact of charitable donations and thus show an underlying position for the Trust. The Trust has suffered two years of underlying deficits and so a careful consideration of financial sustainability is required. Trust management has submitted a financial plan to NHS Improvement for 2016/17 that once again shows a significant surplus due to charitable donations. The Trust is planning another year of underlying deficit, however, this deficit is reducing over the 12 month period and the Trust continues to enjoy comparatively healthy, although diminishing, cash balances. The future planning assumptions and current operating environment of the NHS is probably the most challenging period the Trust has ever endured and this raises deep concerns about long term financial sustainability but for the purposes of determining the appropriateness of the going concern accounting approach the 2016/17 plan, the cash balances and the financial sustainability risk rating of the Trust provide absolute confidence that the accounting approach adopted by management is correct.

Significant financial judgements and reporting for 2015/16

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

We identified through discussion with both management and the external auditor the key risks of misstatement within the Trust's financial statements. We discussed these risks with management during the year, and with the auditor at the time we reviewed and agreed the external auditors' audit plan during the year and also at the conclusion of the audit. We set out in the table below how we satisfied ourselves that these risks of misstatement had been appropriately addressed.

Level of debt provisions

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

in respect of the provisions and associated disclosures in the accounts. We concluded that we were satisfied with the level of provisions carried and the disclosure in respect of those provisions.

Valuation of property assets

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

Other areas of financial statement risk

Other areas where an inappropriate decision could lead to significant error include:

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

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

Conclusion

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

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
20th May 2016

Overview of Performance in 2015/16 measured against the objectives agreed by the Trust Board	**Paper No: Attachment S**
Submitted by: Claire Newton Interim Director of Strategy & Planning	For Discussion

Aims

To report the assessment of achievements against the key objectives within the 2015/16 Operating Plan.

Summary

The Trust's performance against the key external measures for Acute Trusts was as follows:

- The Trust achieved an overall CQC rating of Good, with the caring element receiving an Outstanding rating. Regrettably the Trust's NHSI governance rating is under review due to the issues with reporting against referral to treatment targets.
- The Trust delivered a net financial operating deficit at the planned levels although the NHSI (formerly Monitor) financial sustainability rating dropped to 2 because it also took into account the impact of delayed capital expenditure and therefore delayed funding of this expenditure.
- Our final score for the Friends & Family Test for March 2016 was 98.7% (Nat ave. 95.4%) of inpatients/families would be highly likely or likely to recommend GOSH and 97.3% (Nat ave. 92.3%) of outpatients.
- Our most recent scores for FFT Staff were that 71% (Nat ave. 62%) of staff would recommend GOSH as a place to work and 96% (Nat ave. 79%) would recommend its care.
- There were also some remarkable research achievements announced by teams drawn from GOSH and our research partners; we achieved a first for citation impact compared to international peers and and we exceeded our target for recruitment to research studies.

The attached report details progress against the objectives set at the beginning of the financial year. Progress is measured, wherever possible, against measurable targets;

- The Board is aware that reporting against waiting list targets was suspended during the year. A significant commitment of time and resource has been made by staff in all parts of the organisation to remedy the issues.
- There are a number of areas where targets were not met. These include: PDR & Mandatory training completion.
- There are a number of other objectives which have been affected in the short term by the recent changes in executive directors. These include the delays in taking action to improve the timeliness of responses to complaints and in updating our externally reported Clinical Outcomes.

We did however make good progress on some of our longer term targets; developing arrangements for benchmarking some our clinical services; reaching the procurement stage for an Electronic Patient Record System; progressing the construction of the new Premier Inn Clinical Building and improving the experience of trainees in medical education.

Action required from the meeting For discussion
Contribution to the delivery of NHS Foundation Trust strategies and plans Assessing performance against pre determined objectives which are in line with our strategy is an importance governance process.
Financial implications - No direct implications as a result of this paper
Legal issues N/A
Who needs to be told about any decision? All staff
Who is responsible for implementing the proposals ? All Executive Directors
Who is accountable for the implementation of the proposal / project? CEO

Introduction to detailed assessment of achievements against objectives

1 Basis of RAG rating

Each objective has been assessed with a RAG rating. The RAG rating has been set relative to the original target although the targets vary in their level of precision and therefore how readily they can be assessed:

Green = Objective achieved

Amber = Partially achieved or in some cases Not achieved but reasonable explanation for variance and clear mitigating actions taken

Red = Not achieved

2 Overview

There are 9 targets which have been Red RAG rated and 14 Amber rated (representing 50% of the targets when combined).

- 4 of the Red RAG rated targets can be seen with hindsight, and looking at comparable evidence, to have been over ambitious. These were all numerical targets. This is being addressed in how we set targets for 1617.
- Achievement of the mandatory training targets was impacted by the late implementation of the new Training system which will provide more timely and accurate reports on training completed.
- 2 of the Red rated targets were not achieved due to the RTT and data quality issues
- The remaining two targets; improving the timeliness of responses to complaints and developing the bed model to incorporate the new building which will be commissioned next year are both now being actively addressed.

Not all targets were as critical as others in terms of contributing to our strategic objectives. Achievement of a number of the targets were affected by the conflicting priorities of addressing the data recording issues which have affected the Trust's ability to report against the referral to treatment targets and also due to the number of changes in executive directors.

The underachievement against some of the critical operating KPIs, most notably the targets for Appraisal completion, mandatory training, complaints response times, discharge summary and clinical letter issue will all be addressed as high priorities in 2016/17.

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

1. Provides the best patient experience and outcomes

2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
1.1 All specialties to have published a minimum of 2 outcomes each to the Trust website or intranet	Med Dir	A	300 outcome measures identified 128 outcome measures reported on website which is at least 2 out comes per specialty But 55% of outcome measures out of date	· New specialist in outcome design appointed in QI team · Joining the US Solutions for Patient Safety peer review system · Out of date measures to be addressed progressively · Charity bid to develop outcomes in craniofacial submitted	A	The majority of outcomes require updating. New controls and resources now in place who will ensure all published outcome measures are updated and monitored by the QI committee.
1.2 At least 3 benchmarking initiatives active in year (Medical Director)	Med Dir	G	Charity bid to develop outcomes in craniofacial submitted (ICHOM) Joining the US Solutions for Patient Safety peer review system	Appointment of clinical design lead in the QI team	G	ICHOM bids funding now approved and include more services Benchmarking already active through clinical registries, PICANET & NHSE specialist service scorecards US Solutions for Patient Safety approved by executive but implementation at early stages
1.3 To achieve a 60% FFT response rate	Chief N	R	The Trust set a target of 60% based on the 2014 basis of calculating this ratio. We have been reporting a response rate for inpatients of 33-35% in recent months. However the basis of calculation was changed to include daycases resulting in a reduction to 14% (national acute ave. 25%; independent childrens ave 20.8%).	FFT survey volunteers are being recruited to help with the response rate in day care areas and outpatients. Increased ownership of FFT and response rate also to be taken by Heads of Nursing	R	IP Feb 16 23.7% response; NHS Average 24.1%. The target response rate was set prior to the expansion of the survey to include Daycase patients. Corrective actions were taken, obut due to the high number of frequent recurring daycase attendees (eg haemodialysis 3 times weekly) the target was not achievable as families do not wish to repeatedly respond Ward areas are receiving all of the narrative comments made on their FFT 's & acting upon the areas for improvement as reported to PFEEC
1.4 95% of respondents would be likely to recommend GOSH to friends and family	Chief N	G	The Trust is consistently achieving 98–99% likelihood to recommend for inpatients (nat ave. 96%, ind childrens 87%) and 95-97% likelihood to recommend for outpatients. (nat ave 92%; childrens 94%)	The Trust remains confident that it will continue to achieve or exceed the target of 95% likely to recommend	G	Inpatients: GOSH score 98.3% based on 23.7% response rate; national average 95.4% on 24.1% response rate Outpatients: GOSH score 97%, average 92%, although both scores based on very low response rates

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

1. Provides the best patient experience and outcomes

2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
1.5 Respond to 100% of complaints on time. The objective has been increased from 75% to 100%	Chief N	R	The Complaints Team received 73% of the draft responses on time from the divisions. 48% of complaint responses were completed within the timescale originally agreed. All families were advised of the reasons for the delay and new timescales were discussed and agreed. A change to the complaints process took place just prior to quarter 2. All responses are now reviewed by the Chief N or Med Dir before the CEO; temporarily extending the timeframe for responding.	The complaints process, policy and timescales are currently being reviewed. Training is also going to be provided to the Divisional Managers to improve the complaints investigations and responses provided which should enable the Trust to achieve the target.	R	The Trust has not achieved this target and further work will be undertaken with the new Divisional senior management teams to identify areas of best practice . The divisional teams have been significantly challenged to comply with response times with the increasing pressures and work associated with both the RTT requirements and specifically the increase in complex complaints associated with the Gastro service. Parents are always onformed in the event that a response may be delayed through the work of the Complaints Team.
1.6 Achieve all national (RTT, diagnostic & cancer) waiting times targets		R	SEPARATELY REPORTED		R	Separate report
1.7 Deliver on the priorities agreed in relation to the 12 standards in the quality strategy.	Med Dir	G	Reported regularly in the Trust Board quality report. Progress maintained or improving in relation to mortality, detecting serious illness, healthcare associated infections, discharge summaries	Review of reports to Trust Board in quality report Actions recommended from annual reviews of mortality and resuscitation being developed	G	(1) Annual report on mortality and resuscitation presented to Trust Board (2) New Patient Safety and Outcomes Committee implemented with emphasis on risk management as well as learning
1.8 Review our Patient and Family Engagement Strategy and update as appropriate	Chief N	G	A new patient engagement and experience strategy is currently in the process of being developed and written with the aim of being completed by the end of quarter 3.	The new strategy will be consulted on with parents, young people and members' councillors. Aim to have Board approval of strategy before year end.	G	A revised Patient & Family Experience & Engagement framework has been developed & presented to both SMT & the PFEEC - to complement & inform the Trust's new overarching strategy. A work plan will be developed to ensure delivery & demonstrate improvements.
1.9 Ensure that all areas are staffed safely and efficiently with an initial priority on out of core hours provision			• HENCEL revisit overall positive with improved GMC Trainees' Survey • Agreement in principle to re-establish national training posts in Oncology • Additional rota for oncology established	• Deliver objectives to be set by QI programme • Deliver Keogh 7 standards for seven-day services as they apply to GOSH • Appoint new Deputy MD for Medical Education		On-going work includes: delivering the objectives set in the Quality Improvement programme which include: alignment to the Keogh 7 day standards, assessing workloads out of hours ("OOH") and revising SOPs for reporting sickness, escalation and responsibilities OOH. The new Deputy MD for Medical Education has been appointed and is current leading on work to ensure we

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
	Med Dir	A	• Additional SHO rota for surgery established • Steering group and objectives set for Out of Hours Quality Improvement programme • Website established with links to current guidelines	• Re-assess workload out of hours once new surgery and oncology rosters established • Review sensitivity of CEWS score • Review and revise SOPs for OOH	**A**	have the appropriate staff with the right skill-set to fulfil the tasks required OOH CEWS (Childrens Early Warning Socre) score reviewed and it was concluded that the alternative Paediatric EWS was more sensitive - work underway to change over including implementation of Sepsis 6 recommendations

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

2. Is an excellent place to work and learn

2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
2.1 95% compliance with statutory & mandatory training	DirHR& OD	A	80% in September 2015 for compliance of core subjects which include safeguarding, fire and Information Governance.	• Preparation for new Learning Management System (LMS) has meant freezing old training compliance reports. • The new LMS will include dashboards which will enable individuals & Managers to view compliance with all statutory and mandatory topics. • The system will send automated reminders when any given element is due to expire, which will include an automated link to facilitate booking onto an appropriate update course. • Pilot in 1516; Roll out in 1617	R	This target was not achieved. The recording system was temporarily taken out of use pending implementation of a new LMS recording system which prevented effective monitoring by line managers. The implementation of the LMS was later than planned
2.2 95% compliance with PDR completion	DirHR& OD	A	Apr 2015 = 84%; Oct 2015 = 70%.	The new PDR policy was launched in April 2015 and has been supplemented by training. An automated system to send email reminders when an individual's PDR is due will go live in January 2016. Nurse revalidation, due for launch from April 2016, will provide further impetus for timely PDRs. Weekly reminders to managers and league tables showing response rate.	R	This target was not achieved. A new policy was launched in April 15 and supported by training but the completion percentage has falled from 84% to 73% due to reduction in active escalation with line managers although compliance reports available on intranet at all times. However staff survey results indicated that 89% of staff believed they had received appraisals
2.3 60% staff survey response rate	DirHR& OD	G	2015 Annual staff survey is currently underway so figures are not complete.	Weekly reminders to managers and league tables showing response rate. Proactive chasing and promotion.	A	Response rate 53% which is still above the national average of 41%. Forms received two weeks late and we believe target might have been achieved if this had not occurred
2.4 Upper quartile across all Trusts for staff recommending GOSH as place to work / be treated (staff survey)	DirHR& OD	G	*Recommend as place to work, Upper quartile boundary = 70.9%, GOSH = 71.1%; * Recommend as place to be treated, Upper quartile boundary = 87%, GOSH = 94%. Stable	Further quarterly data will be published and reviewed	G	Only Q2 results available to date. 71% of staff recommended GOSH as a place to work v average of 62% and upper quartile starts at 70%

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

Is an excellent place to work and learn.

2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
2.5 Sickness below 3%	DirHR& OD	G	2.63% (as at October) Stable	New sickness and attendance policy launched Sep 15. Major changes include introduction of new trigger tools and streamlined management process.	G	Good feedback following introduction of new policy
2.6 Compliance with student nurse mentorship annual update	DirHR& OD	A	90% compliance v target of 100%	Continuing to promote mentoring and provide support to staff to achieve update.	A	91% compliant - Mentors are now emailed directly if they are due to expire within 3 months, the PE's receive monthly reports on their mentorship compliance for their staff and the student practice facilitators liaise with their link area to undertake updates. A significant number of mentors have expired in the last month, the team are in the process of updating these mentors.
2.7 All healthcare assistants commencing employment from April 2015 will undertake the Care Certificate within 12 weeks	DirHR& OD	G	100% compliance. The Trust would be in breach of HEE requirements if this is not achieved	Continue to run 4 cohorts each year, in line with recruitment of HCA cohorts.	A	Over the year the compliance with the 12 week completion recommendation stated by HEE is 66% compliant. This was a new initiative that was introduced in April 2015 and the first large cohort can be viewed as a pilot. Compliance in the later 6 months of the year is 84%. We have agreed to run 5 cohorts a year to facilitate HCA recruitment, with divisional support.
2.8 Ensure medical education provision supports the professional development of all levels of the medical workforce and effective service delivery for the Trust	Med Dir	G	· Feedback in national trainees and trainers survey improved · Agreement in principle to re-establish national training grid posts in oncology	· Assessment of new arrangements · Review of supervision and workload in cardiology	G	Workstreams in place as planned

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
			· Additional rota established with extended working hours for consultants and medical specialties	· Agree plans for general trainees · QI programme to improve out of hours provision		
2.9 Set out an OD programme which clarifies roles, responsibilities and accountabilities of senior divisional managers and with an appropriate programme of development	DirHR& OD	G	Initial target (re Heads of Clinical Service and Divisional Director role definition) achieved. Further work on divisional structures has been launched.	Leadership development work (for example, all HOCS will be matched with an external mentor by end November) is still ongoing. Engagement on new divisional structure taking place. New Head of Leadership post being recruited to lead development which will prioritise divisional leaders.	G	All Heads of Clinical Service have a mentor in place via Morgan Stanley

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

3. Delivering world leading paediatric research

2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
3.1 Remain competitive recruitment site - recruit 3,100 or more patients to NIHR portfolio studies and achieve national agreed metrics	Dir R&I	G	Recruitment to date to NIHR portfolio studies is 1649. Our projected 15/16 recruitment based on M1-6 recruitment is 3656 NIHR Metrics • Ensure that all clinical studies being undertaken GOSH / ICH adhere to the NIHR 70-day • benchmark for governance approval and first patient recruitment – Q1 15/16 79.2% (national average for comparable Trust 78.7%) • Ensure that all industry sponsored clinical studies being undertaken at GOSH / ICH reach • their patient recruitment targets within the agreed timeframe – Q1 15/16 68.4% (national average for comparable Trust 45.7%)	Ensure any vacant posts are filled in a timely manner in order not to impact negatively on recruitment	G	3164 patients recruited to NIHR Portfolio studies
3.2 Continue to compete on international scale – remain in top 3 in terms of research outputs	Dir R&I	G	Recent Thomas Reuters analysis for publications 2010-2014: GOSH first for citation impact compared to 5 international comparators. 5th in terms of actual numbers		G	
3.3 To provide research training opportunities, at least 4 training posts in clinical – academia and 4 nurse / AHP posts	Dir R&I	G	One BRC-Francis Crick 1-year Clinical Training Fellowship 10 PhD students awarded Doctoral Training Support Funding for consumable costs 8 AHP/nurse Internships awarded (6 mths, I day per week BRC funded) 1 AHP/nurse Internship awarded (12 mths, I day per week BRC funded)		G	
3.4 Implement Research Accelerator program to facilities access to and enable more research	Dir R&I		New Research Accelerator launched in September 15	Further promotion of Research Accelerator, funding agreed through GOSH Research Capacity Fund to fund additional support such as statistics		

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

	2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
3. Delivering world leading paediatric research	3.5 Embed research in fabric of Trust (research & comms strategy and scope generic consent)	Dir R&I	G	<u>Communications</u> Research communications plan on track: -New research posters, banners and screen savers -Research Communications Group bringing together R&I, GOSH CC and Communications staff, -Research Awareness Day in May 2015, BRC Open Day Oct 15 -New Parent Group now running	<u>Communications</u> Research leaflet will be launched Nov 15 New research video to be launched Research section to be launched on MY GOSH APP	**G** **G**	First cut of video available however some further refinements required before it can be made available There has been an overall delay with the MY GOSH APP
				<u>Generic Consent</u> Vision scoped, engaged with parent advisory group, 3 work streams now moving forward	<u>Generic Consent</u> Three work streams to move forward – Regulatory, Information, Process	**G**	Our HTA licence application will be submitted in April 16 and a pilot will start with the Metabolic Team in May 16. There are a number of complexities with the project which are being worked through however the team now has a clear project plan.
				<u>Research Capacity Fund</u> 3rd Research Capacity Fund, £600k matched funding awarded by GOSH CC	<u>Research Capacity Fund</u> Appoint to posts funded, all posts to start by 1 April 16		

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

	2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
4. Is the partner of choice	*4.1* Provide clinical communication in a timely manner – 85% discharge summaries in 24 hours	*Med Dir*		Discharge summaries – 81.49% Overall the meantime from writing to sending a discharge summary has fallen from 1.1 days to 0.8 days. Learning is being shared between divisions to improve those still below 1.	There are some specialties where there are complex shared care arrangements which have needed to be addressed before targeting the 1. Also, in some medical specialties, investigation results are not available until after discharge and so in order to meet the target, two letters will need to be sent.	**A**	79.8% achieved for M1-10 which is a significant improvement on last year. Review of sustainability taking place as performance deteriorated once project transferred to BAU and QI resource removed. Lower performance in divisions where admin resource prioritising RTT validation
	- 50% clinic letters in 5 days	*Med Dir*	*R*	Clinic letters in 5 days - 33.64% (as of September)	Improvement in timescales continue to be addressed.	**R**	Target reviewed and to be reset to a more clinically relevant standard
	4.2 We will review opportunities arising from the 5YFV and Dalton Review	DirS&P	A	Joint strategic review change programme agreed in principle with NHSE Specialised Commissioning	Review of all major shared care arrangements will take place as part of the change programme Likely to upgrade service levels with some key relationships to effect change	**G**	A number of proposals have been made to commissioners involving greater collaborative working.
	4.3 Identify, prioritise and engage with major external stakeholders relevant to GOSHs strategic position	CEO	G	Meeting with a number of major stakeholders have taken place including various key staff within NHSE, UCLP and visits to referring hospitals + overseas	Further progressing and formalisation of stakeholder comms strategy	**G**	
	4.4 Deliver more care closer to home by exploring partnership and network opportunities	Med Dir	A	Response made to NHSE in relation to future network for congenital cardiac surgery. Otherwise limited work has been carried out in this area due to other priorities and NHSE delaying in issuing key reports	Further workstreams will be identified as part of the joint strategic work programme with NHSE Spec Comm	**A**	(1) Good progress in setting up shared care clinics in cardiac (2) Partnership and network opportunities discussed with commissioners but limited action

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

5 Is sustainable

2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
5.1 Achieve £12m P & E target	COO	R	£8-9m delivery is forecast for 2015/16, short of the target for cost reductions of £12m	Delivery is monitored by the Steering Group	A	Targeted benefits achievedf through the combination of cost improvement and non recurring cost savings and contribution gains
5.2 Achieve NHS and IPP income targets	COO Dir of IPP	A	The NHSE contract for 2015/16 was completed in August. NHS income was broadly in line with plan if phasing differences with the budget are taken into account but this reflects some non recurring income IPP activity has been ahead of plan	Both NHS and IPP activity are being closely monitored in the context of ensuring NHS patients are treated in order of the waiting lists	G	Targets achieved. IPP target over achieved
5.3 Agree a bed model post opening of PICB (COO)	COO	A	Evidence has emerged that bed modelling to date not sufficiently robust	Interim Director of Information & Planning appointed who is working on implementing a demand and capacity model	R	Priority given to Demand & Capacity model to identify new capacity required sooner to reduce long waiting lists
5.4 Develop the Strategic Outline Case for Phase 4 of the Redevelopment Program (Dir of Redevelopment)	D Dev	A	The Masterplan Project Board oversees the development of the SOC. The first draft will be delivered by the end of November. Decant strategy for P4 has been agreed by the MPB.	Take the SOC to Trust Board for approval (target January 2016). Progress design brief and commence the design competition process. Appoint cost and technical advisors.	A	Draft SOC submitted to Dec ETM and Jan F&I but further work required on clinical strategy and financial impact of the P4 investment. Design brief is developing to plan. Revised SOC planned for June Trust Board.
5.5 Reduce CO2 emissions to 152.78 CO2 / m2	D Dev	G	We are currently seeing CO2 emissions falling 8% compared to 2014/15. We are on target to hit 138.59 kgCO2/m2.	Continuing to invest last £70,000 CAPEX on LED lighting and Solar PV array.	G	The Trust is seeing CO2 emissions falling 8% compared to 2014/15. On target to hit 138.59 kgCO2/m2
5.6 Work with NHSE and Monitor to develop a sustainable NHS funding model for GOSH	CFO	A	Agreement reached with NHSE for a joint programme of work to review GOSH cost structure and address where services are demonstrably underfunded	Scope agreed; tender for independent consultant's for costing to be issued December	A	Independent consultants have commenced work and are due to complete in May
5.7 Develop a commercial strategy and internal capability	Dir S&P	R		New time limited group of execs & NExecs to be formed to assess & re state non NHS income growth strategy	A	Several meetings have been held to discuss options and a template agreed for an option appraisal

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
5.8 Deliver service portfolio changes	Dir S&P	A	Chronic fatigue service transferred	Further service portfolio changes will be proposed to commissioners following assessment of access criteria after investigation of corrected waiting list data for each specialty	G	The Cfatigue service was successfully transferred. No other transfers were confirmed following discussion with Commissioners
5.9 Deliver OBC for Electronic Patient Record system & Data Warehouse and Analytics tools	COO	G	The OBC for the EPR was approved by the Board. The Data Warehouse OBC was deferred pending EPR supplier selection	N/A	G	
5.10 Initiate Enterprise Transformation Program	CEO	G	Restructuring of the executive management team was commenced and the initial stage completed	Engagement of staff to agree a new organisation structure for divisional management which better fits with the Trust's strategic objectives	G	
5.11 Fully implement EDM	Med Dir	A	Following delays to the project due to issues with supplier delivery, pilots have progressed well and specialty engagement very good. Space for scanning bureau expansion identified as a limiting factor but solutions is now being progressed	Implementation <u>Phase 1:</u> *Go-live Urology 07 December to test end to end process if outstanding technical issues resolved with file transfer *Go-live General Surgery February if no issues from Urology *Go-live rest of Surgery March if no new issues <u>Phase 2</u> *Go-live Neurosciences April if new premises ready	A	Progress has been made but the phases are 3-5 months behind schedule Urology went live April 16 General surgery now targeted for June and rest of surgery August Phase 2 now targeted October 2016

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

	2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
6 Resources	We will make the best use of public resources to deliver world class care, research and people	CEO	G	**Board Structure** Consultation took place in September and October 2015 to alter the Board reporting structure; now implemented with vacant posts now being advertised.	Vacant posts will be recruited to with then full implementation of Board structure In recognition of improved robustness and rigour, authorisation to approve posts will be devolved to Divisional Directors (equivalent for corporate areas), General Managers and Heads of Nursing with effect from November 2015 Further local change programmes will commence throughout the remainder of 2015/16	G	
		DirHR& OD		**Divisional Change Programmes** Numerous change programmes have taken place across all divisional and corporate teams in order to better utilise our workforce, bring consistency across divisions, and manage budgets appropriately.	Workshop planned for November 2015, with further dialogue and discussion with the aim of agreeing a final divisional model in readiness for the start of 2016/17	G	
		DirHR& OD		**Making Choices Scheme** The scheme was launched in April 2015; total of 41 applications received, with 10 of these approved. The majority of those approved for option 3 (agreed resignation) left between August and December 2015)		G	
		ChN		**Nursing Workforce Recruitment & Retention Group** Summary paper presented to Execs in August 2015 with proposed membership and terms of reference circulated in September 2015.		A	
		DirHR& OD		**Recruitment & retention initiatives** particularly in hard to recruit areas		A	Commentary Outstanding

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

7 Information Technology:.

2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
7 Information Technology: Our information and technology systems will be "best in class"	COO COO	G	Priority has been given to progressing EPR with OBC approved by Board in June & PM joining in October. Some other key projects are still being progressed, EG: • In this period: Nervecentre roll out to all wards was successfully completed (patient observations & alerting system) • Patient status at a glance pilot completed & approved roll out	Procurement process for EPR will be started leading to FBC at Trust Board in October Major workstreams forming part of the procurement are the development of the Specifications for all key clinical & operational processes	G G G	Although the oberall objective will take several years to achieve, the specific project objectives were achieved in year
	Dir S&P		Data recording and reporting issues have been identified as part of Access Improvement work	Independent data quality review Further work on expanding internal data quality work programme		Data Quality remedial action plan agreed but will not be implemented until 1617

OBJECTIVES FOR EXECUTIVE BOARD 2015/16 - TRACKER of ACHIEVEMENT AGAINST OBJECTIVES APRIL 2016

8 Estate.

2015/16 Objectives	Respon-sible	RAG at Half Yr	Progress against target specific measures where available	What are the actions being taken in the second half year towards this target?	RAG at end of year	Reason for not achieving objectives/ target OR exceeding it where relevant
Our buildings will meet the needs of our children and young people and our staff	DirDev		**Redevelopment:** • The Trusts revised Master plan is being progressed.	Redevelopment projects continue to be monitored against the agreed programme timescales	G	
			• Demolition of the old Cardiac building to level 3 has been completed and construction of the new PICB has commenced.		G	PICB on target to open summer 2017
			• Phase 3a Rare Diseases Centre is progressing on programme		G	Procurement with main contractor stopped Dec 15. New main contractor appointed Mar16.
			• Phase 4 enabling (decant of Frontage building and POG) has started to be developed	The phase 4 decant programme has been developed and is continuing to adjusted following confirmation of the final moves to PICB	G	Decant plan agreed. Likely to be subject to change as clinical services stratgey evolves.
	DirDev		**Estates :** The review of Estates Compliance has been completed and an action plan to address identified weaknesses has been developed	The Estates compliance action plan is being progressed and audited by the Director of Estates and Facilities to ensure actions are completed by end of this financial year	A	A compliance structure is still in progress and being developed from the out-comes of the Capitec report 2015. To support the completion of the out standing actions, the estates PPM calendar is being revised and up-dated to capture testing and inspections, also a staff training matrix to ensure relevant competence for Authorising Engineers, Authorising Persons and Competent persons. This work will be finalised and implemented during 2016/2017.
			The 2015 PLACE inspection has been undertaken and the Trust has maintained its improvement against the 2013 scores 2013 2015 Cleanliness 89.75% 96.75% Food & Hydration 61.24% 88.40% Privacy & Dignity 73.68% 94.85% Condition 81.48% 91.07%	A revised specification for cleaning has been produced in line with NHS core standards. This is currently being tendered. Food User Group has been established and changes to the catering service continues to be monitored to ensure the improvements implemented are consistently being delivered to meet the needs of our patients	G	2016 Place Inspection 15th April 2016. Action plan in place to continue improvement.

ATTACHMENT T to follow

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 20th May 2016	
Performance Targets & Indicators: April 2016 **Submitted by:** Nicola Grinstead, Deputy Chief Executive Officer	**Paper No: Attachment U**

Aims / summary

This report provides an overview of April 2016's reported position across a number of key indicators

At present the Trust is undertaking a review of its Performance Management Framework, and the reporting that supports this. It is expected that the way this is presented and content will change over the next few months.

Hospital Acquired Infections

For 15/16 the Trust reported a total of 7 cases of C.Difficile, assigned to patients aged two and over, tested on third day or later. With two identified as lapses of care outlined in the assessment criteria from Monitor and agreed with NHS England. In April 2016 there is 1 Trust attributable case.

One case of MRSA was recorded in 15/16 attributed to an International Private Patient. For April 2016 zero cases were recorded. All episodes of positive blood cultures are reported to the DH via the HCAI submission site as bacteraemias and each case is discussed in detail with NHS England.

10 cases of E. Coli were reported in 15/16 following 48 hours of admission; one case of E. Coli has been reported for April 2016. The 15/16 position for MSSA was 8. One case of MSSA was reported in April 2016 following 48 hours of admission.

Activity & Patient Access

Overall for the month of April 2016 the Trust is reporting an increase in spells of 134 (3.91%) compared to April 2015, which is approximately an additional working day of activity. During April 2015 there were 20 working days, whilst April 2016 had 21. The total number of NHS patient spells in April 2016 has exceeded those of last year by 167 (5.16%). IPP spells is below April 2015 by 33 spells (-17.18%), the reduction in IPP activity has been a trend for the last 6 months.

The Number of ITU Bed Days (excluding IPP & HSS) as at April 2016 has seen a significant increase from March 16 of an additional 109 bed days.

The Total Number of Outpatient Attendances for April 2016 is below April 2015 by 313 (-1.74%) with both NHS and IPP activity being down from the previous April. The data provided is prior to final SUS inclusion date, and as such it is expected this is an under representation.

Last-minute non-clinical hospital cancelled operations are now included within the report for the last quarter of 2015/16. The Trust as part of the Data Quality Review has revised some of the supporting business rules, and is reviewing operational procedures. The national

standard for rebooking within 28 days was breached for the quarter.

DNA Rates for April has seen a further marginal increase of 0.4% to 7% compared to the previous month.

Cancer standards are now broken into the relevant reporting categories and the monthly year to date positions is reflected in the report. All 3 standards were achieved for the last quarter of 2015/16 in line with the quarterly national reporting timetable...

Patient / Referrer Experience

Number of complaints in period
The Trust received 4 formal complaints in April 2016, a reduction from March. There were no complaints graded as red (in line with the Trusts complaints policy). Themes reported by families within their complaints include poor communication within teams, delays in care and treatment due to cancelled admissions, surgery and outpatient appointments.

The Complaints team monitor all open complaints in order to ensure responses are sent in a timely manner. When actions are identified as a result of complaints the Complaints team also monitor these to ensure they are completed and learning is shared across the Trust.

Friends and Family Test
As at April the FFT percentage of patients who would recommend the Trust for both those surveyed within Inpatients 98.6% and Outpatients is at 95.5%, Outpatients has seen a decrease of 4.3% in the percentage recommending the Trust against March 2016. The level of respondents' remains low (23.6% and 2.5% respectively).

For Quarter 4 2015/16 the percentage of staff that would recommend the Trust to work at is 74.0% and 95% would recommend for care. Both are in line with previous reported quarters.

Discharge Summary Turnaround
April 2016 has seen a further slight increase in the percentage of discharge summaries being issues within 24 hours at 80.9%. To enable improvements within this area the project plan devised with each of the service lines has been undertaken with the majority of the actions being completed by 24th April, however embedding of the SOPs and clinical and administrative processes will be progressed during May. Where focused project support has been initiated significant progress has been seen, this needs to be rolled out across all service lines.

Clinic Letter Turnaround
This measure is now being reported as the percentage of letters CDD sent within seven working days (as agreed by the Board, with it previously having been five working days). The position for April is that over 51.9% of letters are being sent within this timeframe. The average time for clinic letter turnaround in March was 7.8 days. Both these measures have improved from March

Workforce
The Trust's sickness rate remained at 2.5% in April. Similarly the Trust's turnover and voluntary turnover rates remained at 19.7% and 17.2% respectively in the same month.

Action required from the meeting
Trust Board to note performance for the period.

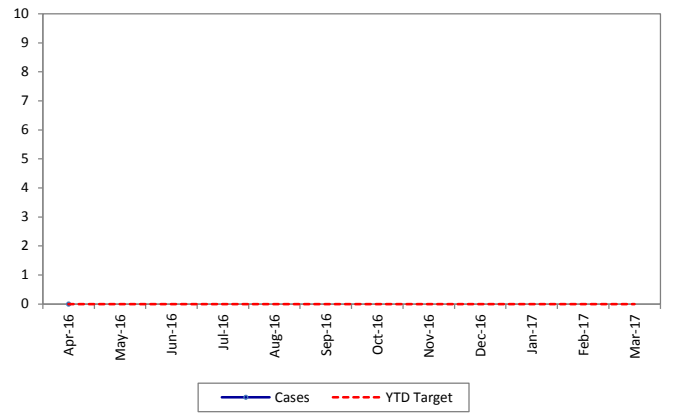
Contribution to the delivery of NHS Foundation Trust strategies and plans
To assist in monitoring performance across external and internal objectives.

Financial implications Failure to achieve contractual performance measures may result in financial penalties
Who needs to be told about any decision?
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.

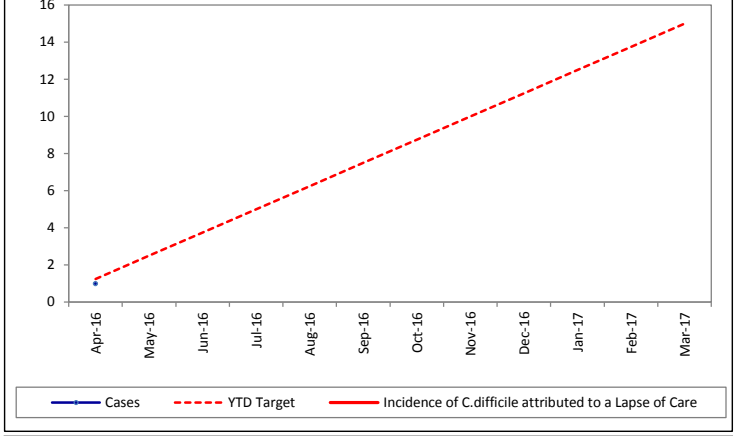
Targets & Indicators Report

		Target	YTD Performance	Monthly Trend												Source
				Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	
Activity & Use of Resources	Number of NHS patient spells (exc. CATS & IPP)	39,674	**39,674**	3,236	3,031	3,321	3,481	3,086	3,345	3,360	3,477	3,120	3,262	3,483	3,472	3403	PiMS Spell data. Indicative Target of 15/16 Outturn used until confirmation.
	Number of IPP patient spells	2,209	**2,209**	192	156	194	223	188	167	207	195	179	181	169	158	159	PiMS Spell data. Indicative Target of 15/16 Outturn used until confirmation.
	Total Number of Spells	41,883	**41,883**	3,428	3,187	3,515	3,704	3,274	3,512	3,567	3,672	3,299	3,443	3,652	3,630	3562	PiMS Spell data. Indicative Target of 15/16 Outturn used until confirmation.
	Last-minute Non-Clinical Hospital Cancelled Operations	-	**TBC**	Data not yet availble									311				Quarterly Monitoring of Cancelled Operations return
	Last-minute Non-Clinical Hospital Cancelled Ops that Breach the 28 Day Standard	-	**TBC**	Data not yet availble									52				Quarterly Monitoring of Cancelled Operations return
	Number of ITU bed days (excluding IPP & HSS)	10,338	**10,338**	915	899	909	886	834	754	903	768	879	895	890	806	915	Contract Team Bed Utilisation Report. Indicative Target of 15/16 Outturn used until confirmation
	IPP & HSS Bed Days	2,798	**2798**	121	254	208	230	259	289	241	282	197	206	214	297	312	Contract Team Bed Utilisation Report. Indicative Target of 15/16 Outturn used until confirmation
	Number of NHS outpatient attendances (New/Follow Up and Ward Attenders)	204,637	**204,637**	16,489	15,745	18,173	17,613	14,697	18,017	18,704	18,079	15,692	17,411	17,310	16,707	16,202	PiMS Outpatient Data. Indicative Target of 15/16 Outturn used until confirmation
	Number of IPP outpatient attendances (New/Follow Up and Ward Attenders)	18,881	**18,881**	1,483	1,382	1,720	1,915	1,631	1,610	1,613	1,592	1,627	1,459	1,455	1,394	1457	PiMS Outpatient Data. Indicative Target of 15/16 Outturn used until confirmation
	Total Number of outpatient attendances (New/Follow Up and Ward Attenders)	223,518	**223,518**	17,972	17,127	19,893	19,528	16,328	19,627	20,317	19,671	17,319	18,870	18,765	18,101	17,659	PiMS Outpatient Data. Indicative Target of 15/16 Outturn used until confirmation
	DNA rate (new & f/up) (%)	<10	**7.9**	7.7	8.3	9.0	9.9	8.8	8.3	7.3	7.3	7.9	6.9	6.7	6.6	7.0	Managers Dashboard. PiMS Outpatient Data.
Patient Access	Cancer - Decision To Treat to first treatment	96	**98.5**	100.0	92.3	100.0	100.0	100.0	100.0	100.0	94.4	100.0	100.0	100.0	100.0		National Cancer Submission. Target Nationally Set.
	Cancer - Decision To Treat to subsequent treatment - surgery	94	**95.9**	100.0	100.0	87.5	100.0	100.0	100.0	100.0	75.0	100.0	100.0	100.0	100.0		National Cancer Submission. Target Nationally Set.
	Cancer - Decision To Treat to subsequent treat - drugs	98	**100.0**	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0		National Cancer Submission. Target Nationally Set.
Patient / Referrer Experience	Number of complaints	40	**139**	10	8	14	20	12	13	10	13	8	15	16	7	4	Complaints Dashboard via Report Manager. Source Datix. Internal Target of less than previous year
	Number of complaints - Red Grade	4	**11**	2	0	0	4	1	0	0	0	1	1	2	0	0	Complaints Dashboard via Report Manager. Source Datix. Internal Target of less than previous year
	Inpatient Friends & Family Test (% of those Likely & Extremely Likely to recommend)	>95	**98.4**	98.1	96.9	98.9	98.1	98.5	99.0	98.5	98.0	98.5	99.5	98.3	99.0	98.6	Patient Experience Return/HSCIC Publication. Data collated interally on FTT database
	Inpatient Friends & Family Test (% Response Rate)	-	**22.5**	27.8	28.3	28.1	29.7	16.6	13.3	18.1	21.0	18.6	22.8	23.7	26.1	23.6	Patient Experience Return/HSCIC Publication. Data collated interally on FTT database
	Outpatient Friends & Family Test (% of those Likely & Extremely Likely to recommend)	>95	**96.4**	95.6	94.1	94.5	95.2	99.7	96.2	96.7	97.8	95.9	97.5	97.2	99.8	95.5	Patient Experience Return/HSCIC Publication. Data collated interally on FTT database
	Outpatient Friends & Family Test (% Response Rate)	-	**2.8**	1.5	1.0	2.5	2.7	2.2	3.6	3.8	3.9	2.8	3.4	3.6	3.2	2.5	Patient Experience Return/HSCIC Publication. Data collated interally on FTT database
	Staff Friends & Family Test Recommend to Work (% of those Likely & Extremely Likely to recommend)	-	**72.0**			71.0			71.0			74.0			74.0		Staff Experience Return from Picker Europe Submission.
	Staff Friends & Family Test Recommend for Care (% of those Likely & Extremely Likely to recommend)	>95	**94.8**			93.6			95.9			95.0			95.0		Staff Experience Return from Picker Europe Submission.
	Discharge Summary Turnaround, % sent within 24 hours	100%	**80.4**	78.9	81.1	83.4	80.8	79.7	82.5	83.4	83.0	74.2	77.8	78.9	79.5	80.9	Discharge Summary Dashboard. Using PiMS and Discharge Summary Web Portal Data
	Clinic Letter Turnaround, % letters on CDD - sent within 7 working days	-	**46.1**	43.5	40.7	49.3	43.6	47.2	45.0	48.0	45.4	38.4	50.8	55.3	47.0	51.9	Target set Internally. All OPD Attendances
	Clinic Letter Turnaround, Average Days Letter Sent	-	**10.3**	11.0	10.9	10.6	10.5	11.3	10.7	10.3	9.9	11.7	8.6	7.7	8.7	7.8	Target set Internally. All OPD Attendances
Workforce	Sickness Rate (%)	3	**2.6**	2.5	2.6	2.6	2.7	2.6	2.6	2.6	2.6	2.5	2.5	2.5	2.5	2.5	ESR Reporting
	Voluntary Turnover Rate (%)	14	**16.4**	16.4	16.1	15.8	15.9	15.9	16.1	16.3	16.4	16.5	17.4	17.2	tbc	17.2	ESR Reporting
	Trust Turnover (%)	18	**18.8**	18.3	18.1	18.3	18.6	19.1	18.7	18.7	19.0	19.0	19.4	19.6	19.7	19.7	ESR Reporting

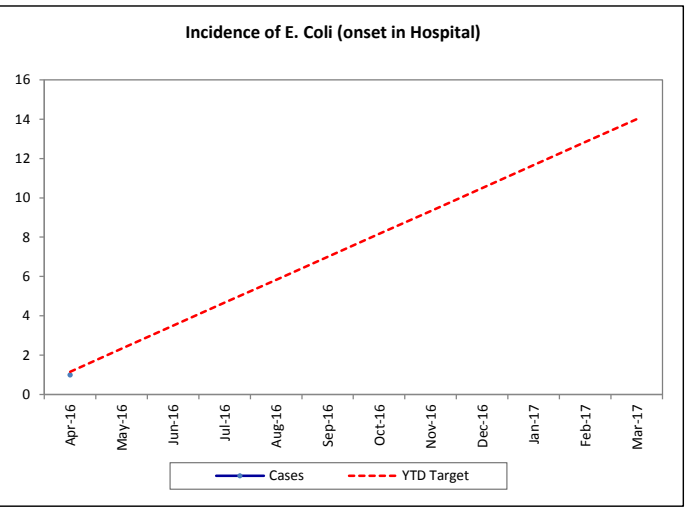
Health Care Associated Infection Indicators



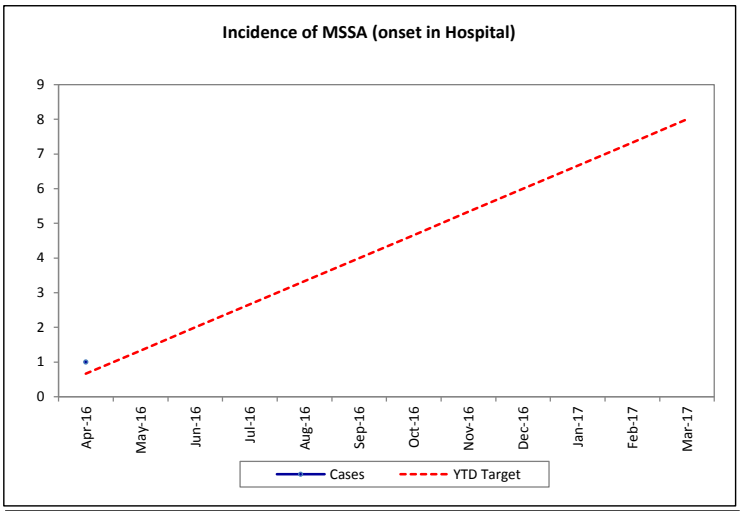
Description: MRSA bacteraemias
Target: Zero cases
Trend: 1 case reported to date
Comment: All episodes of positive blood cultures are reported to DH on HCAI site as bacteraemias



Description: **Cumulative Cases detected after 3 days (admission day = day 1) are assigned against trust trajectory**
Target: No more than seven cases per year
Trend: Trend remains below trajectory
Comment: The Trust has attributed two cases to a laspe of care for the YTD



Description: **Cumulative incidence of E. coli bacteraemia**
Target: Internal Target no more than fourteen cases
Trend: Performance below trajectory
Comment: Performance being monitored closely



Description: Cumulative incidence of MSSA bacteraemia episodes (Methicillin sensitive S. aureus)
Target: Internal Target no more than eight cases for the year
Trend: Performance has n't yet returned below trajectory
Comment: Performance being monitored closely

Monitor Governance Risk Rating

Targets - weighted (national requirements)		Threshold	Score Weighting	Reporting Frequency	Score Weighting Q1			
					M1	M2	M3	Q1
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0	0	0	0
2	Clostridium difficile year on year reduction (Against Monitors defined Lapse of Care categorisation)	0	1	Quarterly	0	0	0	0
3	All cancers: 31-day wait for second or subsequent treatment comprising either:	100%	1	Quarterly	0	0	0	0
	Surgery	94%			0	0	0	0
	Anti cancer drug treatments	98%			0	0	0	0
					0	0	0	0
4	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0	0	0	0
5	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	0.5	Annual	0	0	0	0
6	Data completeness, MH: identifiers	97%	1	Quarterly	-	-	-	
				Total	**0**	**0**	**0**	**0**
				Overall governance risk rating	**Green**	**Green**	**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

**Note that at the time of reporting the cancer standards performance is yet to be finalised

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th May 2016**	
Quality and Safety Report **Submitted by: Vin Diwakar, Medical Director**	**Paper No: Attachment 9**
Aims / summary The Quality and Safety report has been re-designed to provide information on whether patient care has been safe in the past, safe at the present time and what the organisation is doing to ensure that we are implementing and monitoring identified learning from our data sources (pals, complaints, incidents, SIs). The report also highlights areas of good practice identified through Clinical Audit and assurance that our systems and processes are reliable in the areas identified.	
Action required from the meeting To support the style of the report, providing any feedback or requested changes to the Medical Director. To note the on-going work and support any suggested changes to work streams.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The work presented in this report contributes to the Trust's objectives of No waste, Now Waits and Zero Harm.	
Financial implications N/A	
Who needs to be told about any decision? Divisional management teams, Quality Improvement team, Clinical Governance and Safety team	
Who is responsible for implementing the proposals / project and anticipated timescales? Divisional Management teams with support, where needed, from QI or CGST	
Who is accountable for the implementation of the proposal / project? Medical Director	

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

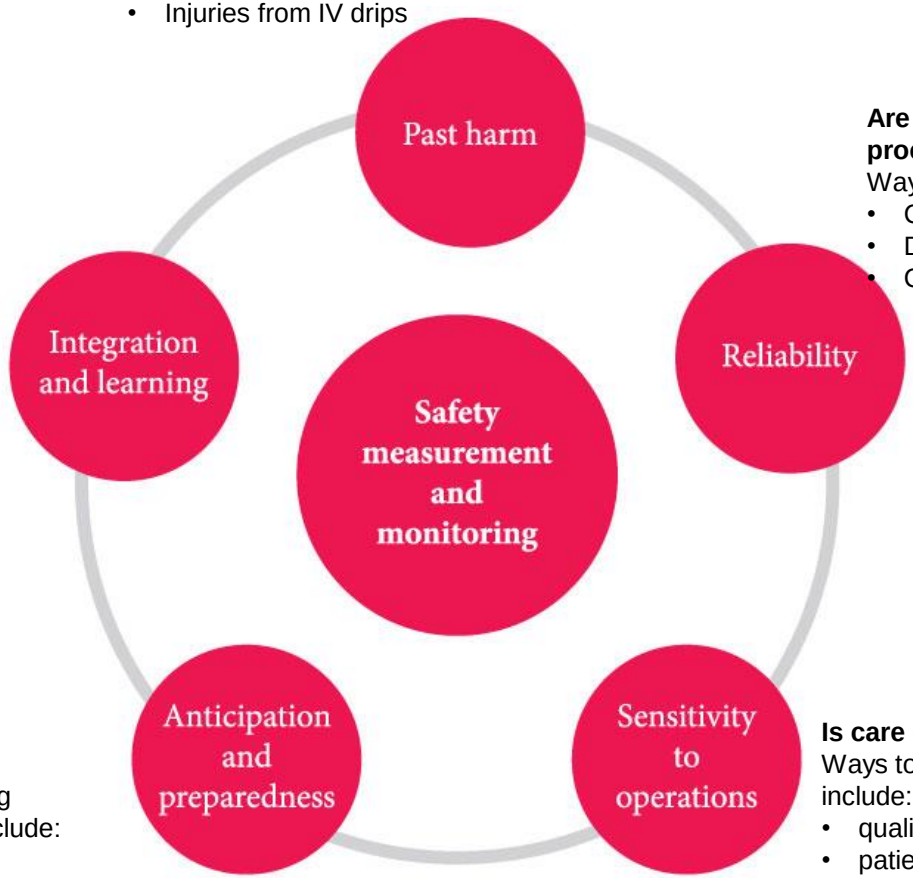
Quality & Safety Report

Dr Vin Diwakar, Medical Director
Juliette Greenwood, Chief Nurse
May 2016

The GOSH Quality Framework

Has patient care been safe in the past?
Ways to monitor harm :
- Death rates, cardiac and respiratory arrests
- Incident reporting & Never events
- Central line infections
- Pressure ulcers
- Injuries from IV drips

Are we responding and improving?
Sources of information to learn from include:
- Learning from SIs and complaints
- Audit to check that learning is embedded



Are our clinical systems and processes reliable?
Ways to monitor reliability include:
- Central line bundle compliance
- Discharge summary completion
- Clinical audit

Will care be safe in the future?
Possible approaches for achieving anticipation and preparedness include:
- risk registers

Is care good today?
Ways to monitor sensitivity to operations include:
- quality walk-rounds
- patient feedback
- Complaints and PALS

Source: Vincent C, Burnett S, Carthey J.
The measurement and monitoring of safety.
The Health Foundation, 2013

Has patient care been safe in the past?

Measures where we have no concerns

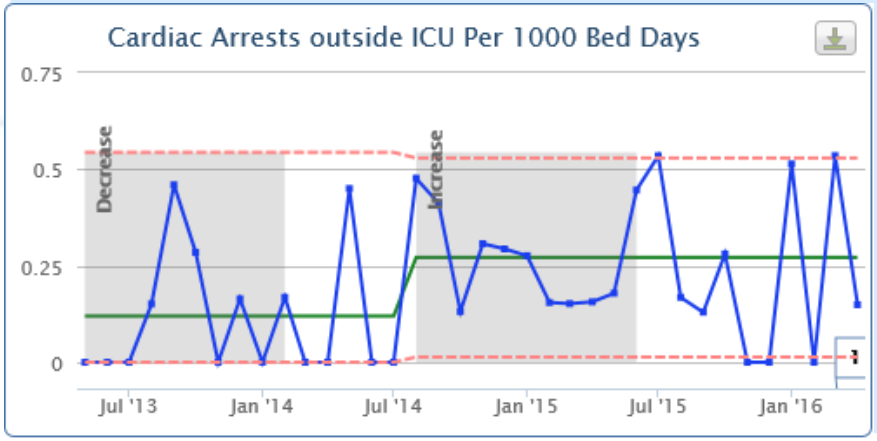
Great Ormond Street Hospital for Children NHS Foundation Trust

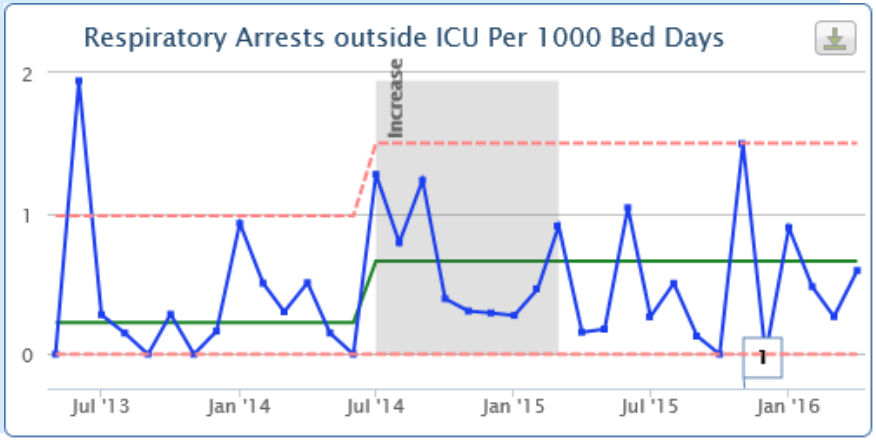
Measure	Comment
Patient safety incidents causing harm	No worrying trends this month
Medication Incidents reported via Datix causing harm	No worrying trends this month
Never Events	378 days since the last never event was reported.
Hospital acquired pressure ulcers reported (grades 2+) per 1000 bed days	No worrying trends this month
Non-2222 patients transferred to ICU by CSPs	No worrying trends this month
Serious Patient Safety Incidents	No worrying trends this month
GOSH acquired CVL infections	The CVL line infections data tells us that a number of line infections still occur each month therefore we have not yet reached our aim of zero. The rate remains steady with an average of 1.14/1000 line days.

Has patient care been safe in the past?

Important measures of interest

Great Ormond Street Hospital for Children NHS Foundation Trust





Cardiac and Respiratory Arrests

Do you have concerns about safety in this area?	**No**

What the data tells us:

We had 4 cardiac arrests in March which is higher than expected.

Three events due to difficult airway management and required chest compressions in order to maintain life whilst emergency airway management was instigated.

One patient is being reviewed in more detail as the child had a life limiting condition with no treatment plan in place.

Actions to improve:

We are focusing on

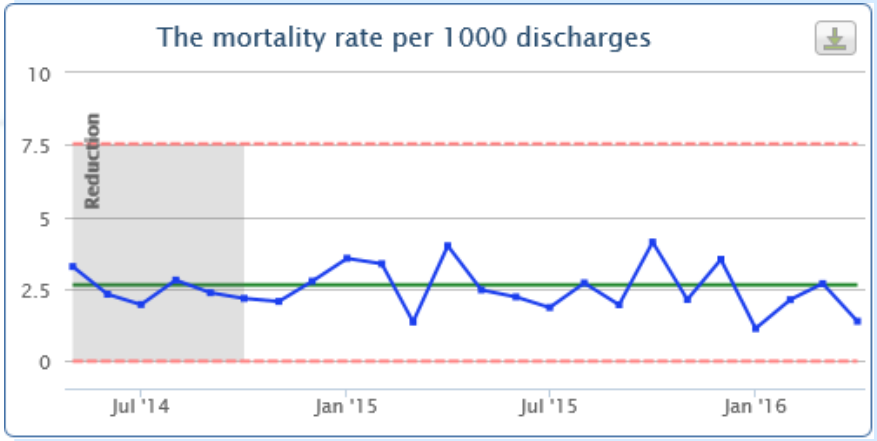
- tracheostomy training
- continuing to encourage teams to have management plans in place for complex children.

A good example of this is the child with central apnoeas has had no 2222 calls since January 30th. (Discharged home in May) The main reason was a management plan in place and increased confidence in those caring for her.

Has patient care been safe in the past?

Important measures of interest

Great Ormond Street Hospital for Children NHS Foundation Trust



Commentary:

Trend: The mortality rate remains unchanged at 2.65 deaths per 1000 discharges, with all data points within the control limits.

What are we doing to understand this:

- All deaths occurring in the trust are reviewed by a multidisciplinary team. 34 deaths were reviewed between January and April 2016, There was adequate, good or excellent documentation in 33 cases.
- The cohort included 6 deaths on the wards as part of planned end of life care and one on the roof garden (planned withdrawal of care).
- Potentially modifiable factors were identified in 4 cases that could have contributed to vulnerability, ill health or death;
- In 3 cases the modifiable factors were outside GOSH, in one case the modifiable factors related to transfer of a critically ill child to GOSH.

Mortality

Do you have concerns about safety in this area?	**No**

What are we doing to understand this (cont):

- Learning points from the reviews included:
  - When complex GOSH patients present to a local hospital, it is important to involve GOSH early in the discussions.
  - It is important to consider the rationale for transferring patients long distances where it is not possible to offer any treatment at GOSH
  - Training in completion of the *'Medical Certification of Cause of Death'* is required (mainly for ICU doctors)
  - Management of conflict with families can be very difficult, particularly when the families use social media. Trust wide training and advice would be beneficial
  - It can be difficult to make a diagnosis of an acute surgical abdomen in a child with learning difficulties

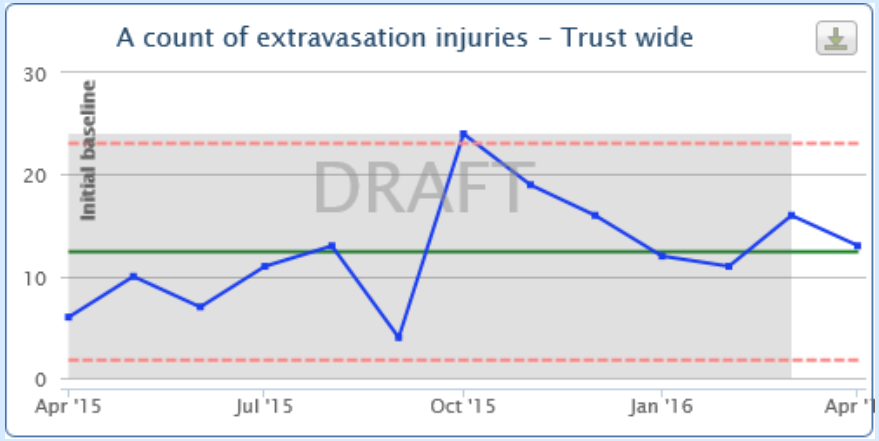
What actions are we taking to improve:

- Deliberations from the reviews are discussed with the local speciality teams
- There is currently no forum to discuss learning points from these reviews on a trust wide basis – plans are on-going to resolve this.

Has patient care been safe in the past?

Extravasation injuries are a new quality measure

Great Ormond Street Hospital for Children NHS Foundation Trust



Note: This data is from the department of Plastic Surgery and only includes patients referred to them. This does not include extravasation injuries reported via Datix.

Extravasation injuries

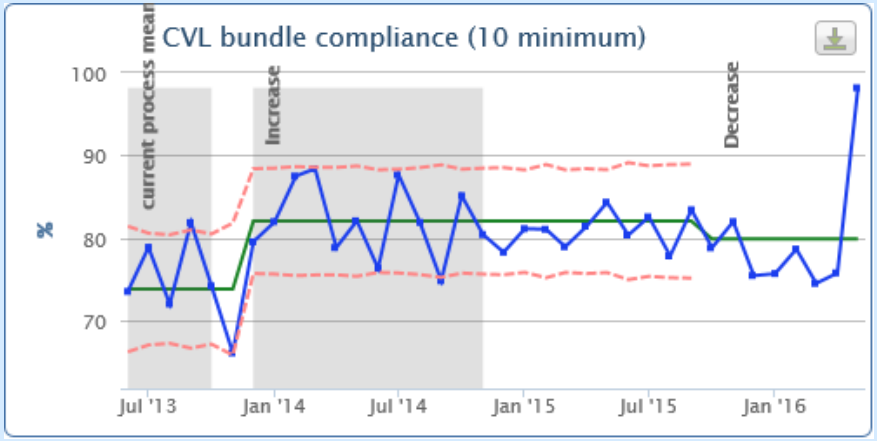
Do you have concerns about quality in this area?	**Yes**

Extravasation injuries occur when a IV drip becomes misplaced or where IV fluid leaks into the surrounding tissues
The degree of injury ranges from mild skin reaction to severe tissue damage. In severe cases extravasation injury may lead to skin grafts.
The Plastic Surgery team monitor cases that are referred to them. Some extravasations can be treated by surgically flushing out the tissues if referred promptly enough.
The aim of monitoring theses cases is to actively reduce the number of extravasations in the first place by dealing with the root causes.

This chart shows numbers of referrals over time (12.4 per month) but does not currently differentiate by severity or avoidability. Initially we would expect an increase in cases by better reporting across the Trust, but would then aim to see a gradual reduction particularly of more severe or more avoidable cases. This data was presented at the Patient Safety and Outcomes Cttee in April 2016 and we agreed to adopt this as a trust wide quality measure

Are our clinical systems and processes reliable? Central line bundle compliance

Great Ormond Street Hospital for Children NHS Foundation Trust



CVL bundle compliance

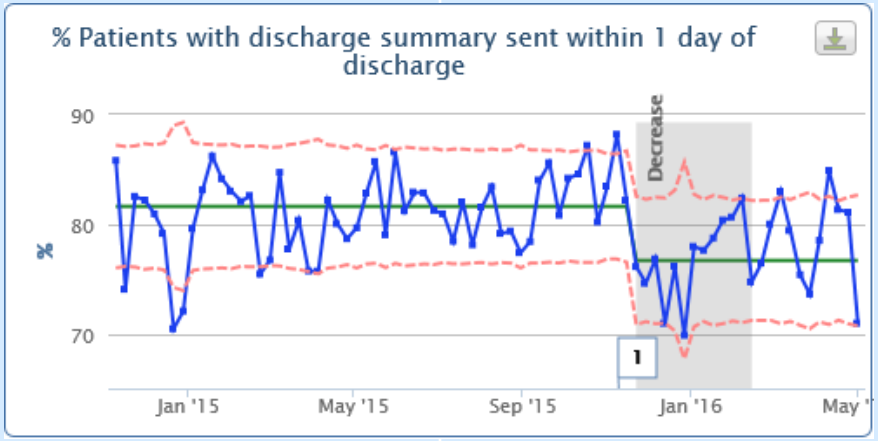
Do you have concerns about quality in this area?	**Maybe**

Commentary:

We have detected a fall in compliance (a run of 7 points below the mean) However, the data collected so far for May (incomplete as we're only part way through the month) indicates this may not be sustained. We will wait to see how the data changes through May as audit data is collected.

Are our clinical systems and processes reliable? Discharge summary completion

Great Ormond Street Hospital for Children NHS Foundation Trust



Discharge Summaries

Do you have concerns about quality in this area?	**Yes**

Commentary:

The work to improve the discharge summary position has involved several steps that have been actioned:

- Relevant support is in place to improve the current position reviewed and put in place April 2016.
- Meeting with the clinical teams , Service Managers and Admin Teams to go through the SOP and ensure all contact groups are set-up for circulation and escalation by ICT.

- Clinical teams and managers now know how to access a compliance report, interpret the data held within it and ensure this becomes a daily task for all teams.
- Process to be embedded into Business as Usual by end of May 2016.
- Circulate on a weekly basis the performance position by specialty to Service Managers (cc'ing Divisional Directors) highlighting both improved and poor performance requesting where appropriate .

Are our clinical systems and processes reliable? Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

Measure	Comment
Pressure ulcer risk assessments	No special cause variation detected this month. The current process mean remains at 94%

Are our clinical systems and processes reliable? Recent clinical audits

Great Ormond Street Hospital for Children NHS Foundation Trust

Quality of WHO checklist audit

Aim of the work

- Establish the quality of engagement in the WHO checklist
- Learn from staff about how well the checklist and team brief is being done

(i.e are checks are taking place in a structured way with staff are interested and participating in the checklist process

- Understand if we have a strong theatres checklist safety culture
- Identify any meaningful areas for improvement.

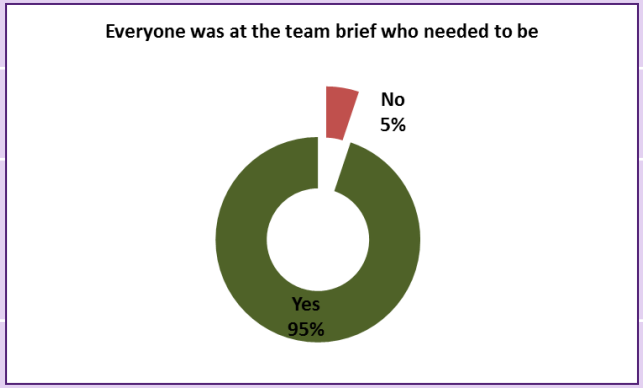
Background

The Trust collects continual process data on whether the three stages of the WHO checklist have been indicated as completed in the theatres PIM records of patients. This shows completion of checks but not quality of engagement in the process and safety checklist culture-and doesn't answer the question – 'how well do we really do it?'

The 2015 Care Quality Commission Inspection report for the Trust highlighted as a must do' that the Trust "resume WHO checklist audits in surgery"

Results

129 responses- positive response rate and good engagement from staff in the audit



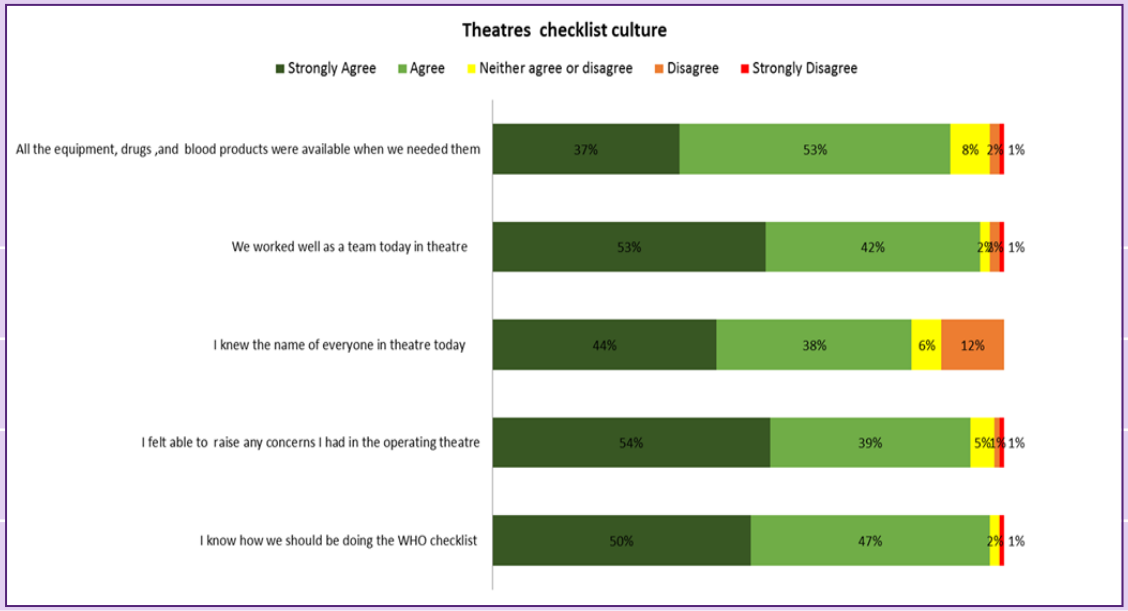
High levels of engagement and participation were reported in the team brief sign in, and time out

35% of staff 'agreed' or 'strongly agreed' that an aide memoir/checklist is used to guide practice (5 point likert scale used)

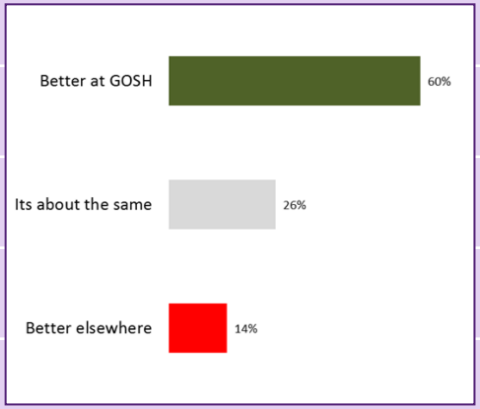
Are our clinical systems and processes reliable? Recent clinical audits

Great Ormond Street Hospital for Children NHS Foundation Trust

Quality of WHO checklist audit



How well are the team briefs and the WHO checklist observed at Great Ormond Street compared with where else you currently practice, or have practiced in the last three months?



Conclusion

The audit shows good engagement in the Team Brief and WHO checklist, and a positive safety checklist culture.

The areas for quality improvement are

- the involvement of surgeons in one speciality in the team brief.
- the use of an aide memoir of checklist rather than doing checks from memory
- spread of the debrief

Are our clinical systems and processes reliable? Recent clinical audits

Great Ormond Street Hospital for Children NHS Foundation Trust

Quality of WHO checklist audit

Actions and tests of change in response to this audit:

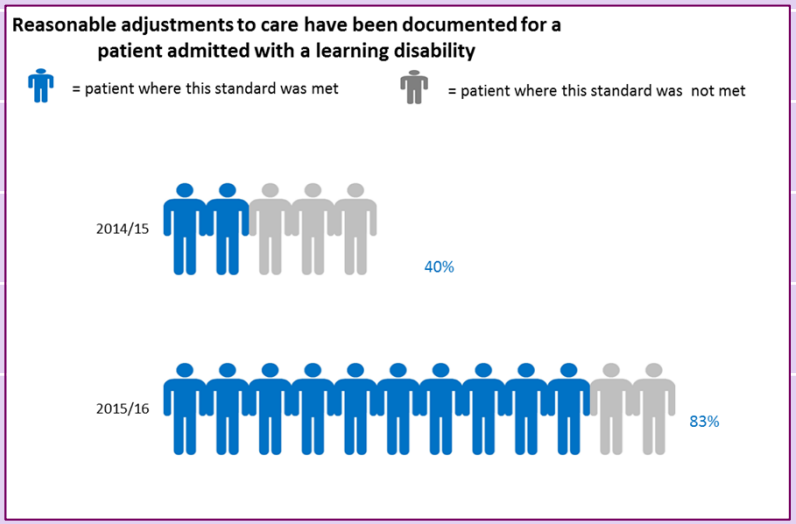
- Area of improvement in one speciality is to be escalated to the Divisional Director
- Results and learning to be shared at open theatres teaching session
- Availability of checklists and process for ensuring they are present in each case to be reviewed with team leaders.
- Theatres staff are to be asked to identify solutions as to how the aide memoir can be better used for each case. This will take the form of an electronic suggestion box to engage staffs energy and ideas for improvement. The most popular suggestions or those which staff have said work really well, will be reviewed to establish if they can be replicated to improve this element
- Despatch team 'to review ' practice and any learning from theatres checklist practice at UCLH and Luton and Dunstable

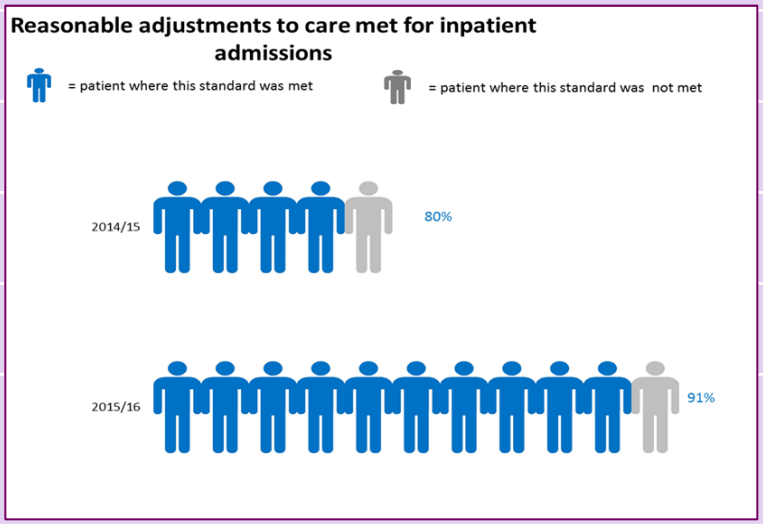
Are our clinical systems and processes reliable? Recent clinical audits

Great Ormond Street Hospital for Children NHS Foundation Trust

Clinical Audit to support the Learning Disabilities Action Plan

Background: Audits have taken place to support the work to improve awareness and management of learning disabilities.
Key learning: The audit shows progress with documenting and meeting reasonable care adjustments of care for children and young people admitted with learning disabilities.





These audit results were reported to the Learning Disabilities Steering Group (LDSG), we will continue to audit progress with core standards in 2016/17 and aim to complete the audit more frequently. In addition the department has supported the Nurse Consultant for Learning Disabilities by working on interventions to improve and monitor the implementation of a flagging system.
An audit also was completed to monitor and evaluate NICE guidance issued in June 2015 on managing challenging behaviour in children and young people with learning disabilities. The audit showed good overall awareness amongst all staff of those with a learning disability and the challenges this poses. The only issue was that that staff felt less confident with challenging behaviour with some of our older patients.
Actions identified: The recommendations of the audit were accepted by and will be monitored by the LDSG.

- An optional session on managing challenging behaviour will be made available for staff.
- Share existing supportive resources to manage challenging behaviour in older and larger children with a learning disability with frontline staff

Are our clinical systems and processes reliable? Recent clinical audits

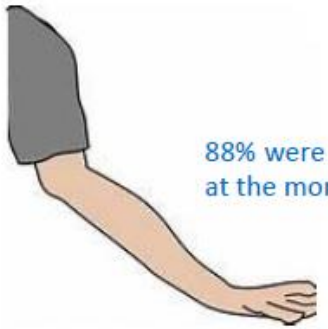
Great Ormond Street Hospital for Children NHS Foundation Trust

Infection Control Quality Audit

Background: An audit took place to review if Infection Control Standards are being met. These are in addition to the key performance indicators which are routinely collected on the ward, and were audits led by the infection control team

Key learning: Divisional Action plans were created by the Heads of Nursing in response to the audit. The audit will continue as a quarterly quality measure of the appropriateness of hand hygiene performance. The evidence base for similar independent observational audits typically finds a performance level of around 60% (Measuring Hand Hygiene Adherence, The Joint Commission, 2009

Hand Hygiene Performed for 51 % of opportunities.



88% were bare below the elbows at the moment of observation.

Are our clinical systems and processes reliable? Recent clinical audits

Great Ormond Street Hospital for Children NHS Foundation Trust

Clinical Audit– completion of agreed actions for patients reviewed at the RTT Clinical Harm Review Group (CRG)

Background:
An audit was requested to provide assurance as whether agreed actions for individual patients who have been waiting longer than 30 weeks have taken place. 148 patients had actions agreed following review at the CRG between September 2015 and February 2016, 50 of these cases were reviewed, with a stratified sample selected to ensure that the cases audit reflected the volume of each specialities involvement in the CRG.

Key learning:
The audit results:

- 96% the agreed actions for patients reviewed at CRG have taken place.
- 4% the agreed actions were not possible to be completed because of the circumstances of the patient. That is where the patient no longer wanted treatment or it was not safe to bring the patient into the Trust. Suitable plans and outcomes had been recorded for these cases.
- 0% There were no cases where the actions agreed had not been completed where they were needed

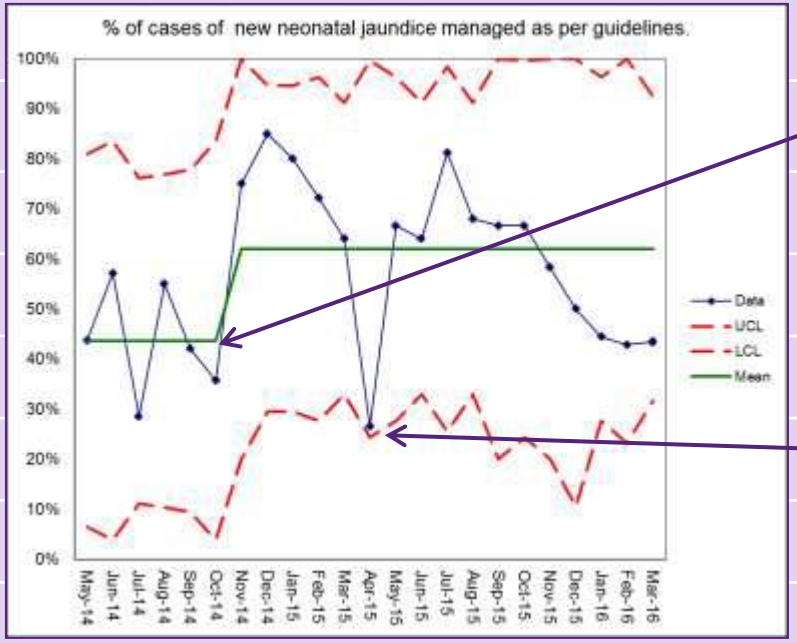
This audit will be undertaken every quarter as part of the, Clinical Audit Plan for 2016-17.

Are our clinical systems and processes reliable? Recent clinical audits

Great Ormond Street Hospital for Children NHS Foundation Trust

Neonatal jaundice

Key learning:
The audit data shows a negative trend in our performance in the management of neonatal jaundice.



Statistically significant improvement following interventions

Outlier show reliance on Neonatal Nurse Advisor to Chase and guide practice. Neonatal Nurse Advisor not in Trust for two weeks here

Without some focussed and resourced work it is unlikely that improvement can be made or sustained over time.
A paper was presented at PSOC (and accepted) with recommendations for working group with executive sponsorship to improve performance with the management of neonatal jaundice and bloodspot screening. In the short term – to support practice- each neonate will have a laminate placed on the front of their nursing case notes to sign post staff to existing supportive management resource and to clarify the essential neonatal care 'must dos'. This test of change is being implemented by the Clinical Audit Manager and Neonatal Nurse Advisor.

Are our clinical systems and processes reliable? Recent clinical audits

Great Ormond Street Hospital for Children NHS Foundation Trust

NHS England Seven Day Service Review

Background:
This is a review of NHS England standards around timeliness of consultant review and on-going review for emergency admissions

The standards are directed at situations where a patient will require emergency care at an Accident and Emergency unit in a local hospital. They have been interpreted as relevant to the way in which patients are seen in an emergency at Great Ormond Street (ICU unplanned and bed management ward admissions classified as emergencies). It is not appropriate for the Trust to submit data to NHS England for comparison and public reporting as the measures are not directly comparable with centres with an Accident and Emergency Department, and this has been agreed with NHS England. Twice yearly audits will be conducted as an internal quality assurance exercise and results will be shared with the Out of Hours Steering Group.

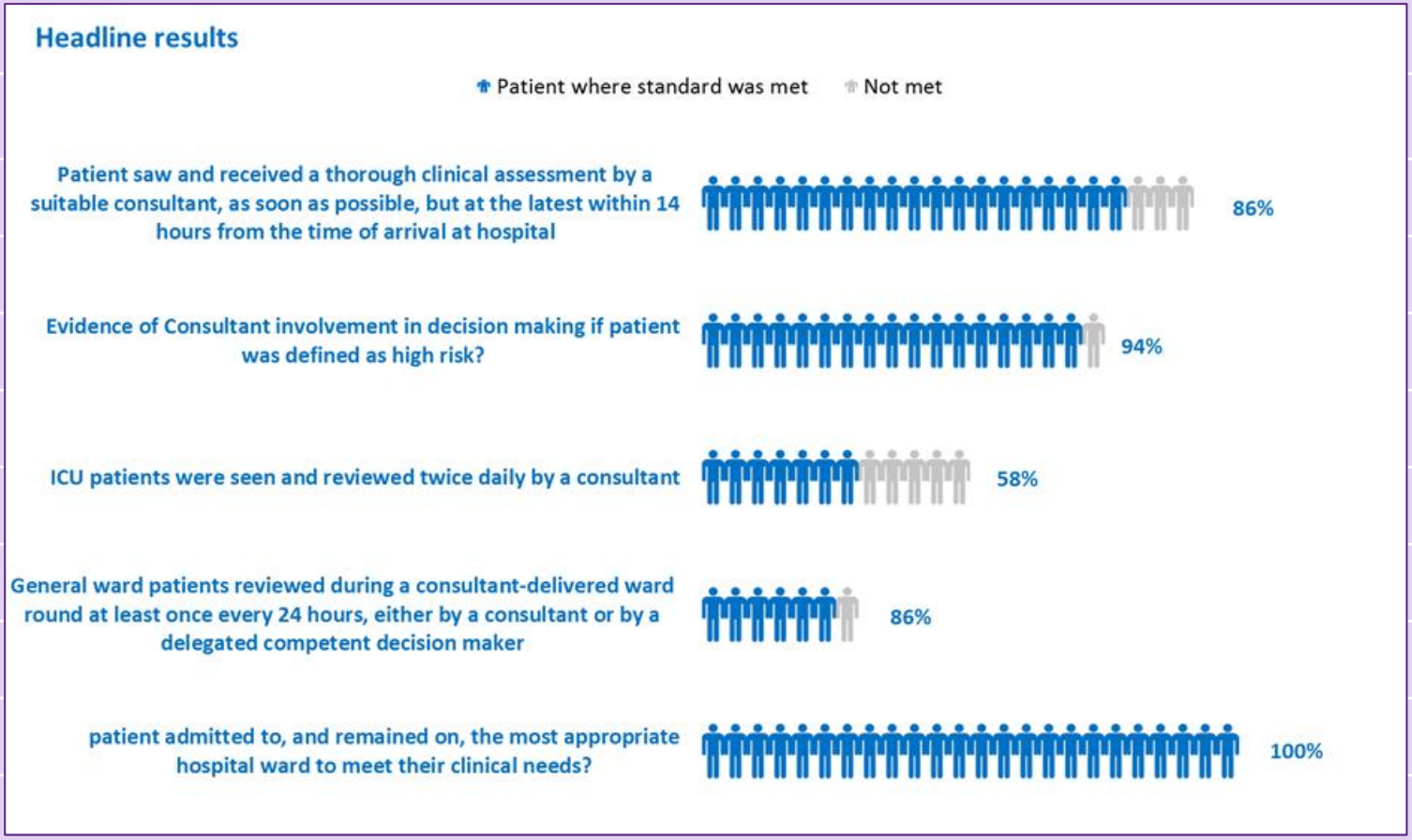
The chart (see over) shows the performance with our standards

The audit has highlighted a need to improve the documentation of consultant presence on ICU Ward Rounds, rather than a change in practice. Options for doing this are to taken through the Out of Hours Project Group.

Are our clinical systems and processes reliable? Recent clinical audits

Great Ormond Street Hospital for Children NHS Foundation Trust

NHS England Seven Day Service Review



Are we delivering high quality care today? Measures where we have no concerns

Great Ormond Street NHS Hospital for Children
NHS Foundation Trust

Measure	Comment
Admission on day of surgery rate	No special cause variation detected this month. The current process mean remains at 86% However it should be noted that we close to an increase
Delayed discharges	No change this month – the process mean remains at nearly 10 patients per month being delayed
All complaints	The process mean remains at about 11 complaints per month
Red complaints	The process mean remains at about 1 red complaint per month
Amber complaints	The process mean remains at about 2 complaints per month
Yellow complaints	The process mean remains at about 7 complaints per month
PALS contacts per 1000 adjusted patient days	No change – this is a very stable process at 18 contacts per 100 adjusted patient days
Friends and Families test – extremely likely/likely to recommend	The process mean remains at about 98%
Friends and Families test – extremely unlikely/unlikely to recommend	The process mean remains at about 1%

Are we responding and improving?

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from a complaint

Learning from a complaint – Neurology team
Learning from a complaint in December 2015 highlighted the importance of rescue medication being written on a paper prescription for patients admitted for telemetry. Audit of the recommendations took place in February 2016, and showed that the recommendations have been met and are effective. This will be re-audited to ensure sustained change.

Learning from a complaint – miscommunication around discharge in IPP
This audit took place to review implementation of actions identified following a complaint. Some actions around documentation of consultant agreement and parental agreement of discharge were evidenced in the audit. Improvement is required around the use of a discharge checklist (used in 60% of cases – standard was 100%). Discharge labels have been implemented in response to the audit and will be evaluated through a re-audit.

Learning from a complaint - Lack of communication with parents after child colonised with GRAM negative organisms
Following this complaint a change was committed to whereby GRAM negative status patients would receive a letter to inform them of their results and required precautions. An audit of the Infection Prevention and Control database showed that all patients who were eligible to receive letters had them sent.

Are we responding and improving?

Great Ormond Street Hospital for Children NHS Foundation Trust

A summary of learning from an SI

Purpose of audit
To assess the implementation and effectiveness of recommendations from a serious incident.

Summary of incident
Following a surgical procedure on 23rd October 2014 the patient's indwelling tracheostomy was damaged to gain access to the surgical site. It was not realised by the surgeon at this time that there was no appropriate tracheostomy tube available to replace the damaged one. A delay in ordering and delivery for a new tracheostomy occurred and a correct tracheostomy was not available until the 10th November 2014.

Key findings from the audit
The evidence collected and feedback from staff indicate that there is still a risk of the issues around equipment procurement which were noted in the SI. These are around the system in place to ensure urgently ordered equipment arrives when it is ordered.

The Head of Security Services & Portering has responded to the audit and advised that there are changes to the service which may mitigate the risks found in the audit.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th May 2016**	
Workforce Metrics & Exception Reporting – April 2016 **Submitted by:** Ali Mohammed, Director of HR & OD	**Paper No: Attachment V**
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.	
Action required from the meeting To note the content of the report.	
Contribution to the delivery of NHS Foundation Trust strategies and plans	
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.	
Who needs to be told about any decision? Not applicable.	
Who is responsible for implementing the proposals / project and anticipated timescales? Divisional management teams; supported by members of the HR & OD team.	
Who is accountable for the implementation of the proposal / project? Divisional management teams.	

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.

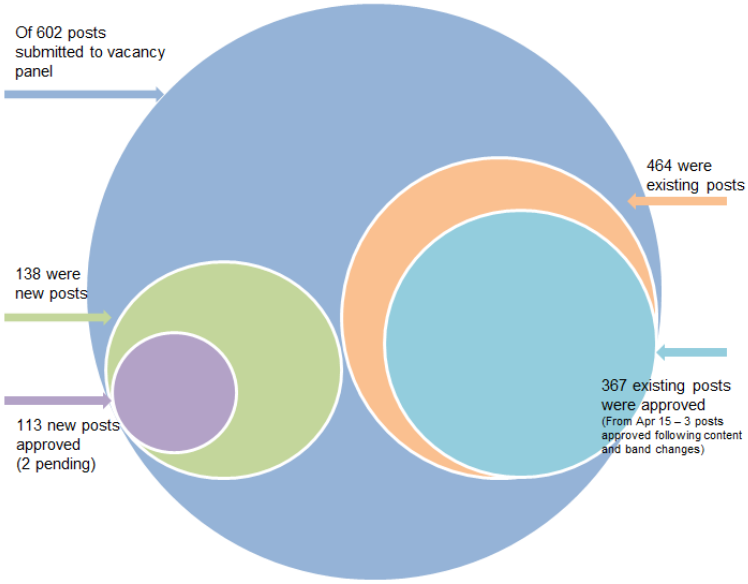
Statutory and mandatory training compliance rates are reported below against a number of key mandatory training subjects. The required training compliance for any of the courses is 95%; currently the Trust is compliant with one (safeguarding children level 1) of the reported seven topic areas. Two topics 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 2016 REPORT

Division	**Contractual Staff in Post (FTE)**	**Voluntary Turnover Rate (%, FTE)** (voluntary leavers in 12-months in brackets, <14% green)	**Total Turnover Rate (%, FTE)** (number of leavers in 12-months in brackets, <18% green)	**Sickness Rate (%)** (0-3% green)	**PDR Completion (%)** (target 95%)	**Statutory & Mandatory Training Compliance (%)** (target 95%)	**Agency (as % of total paybill, £)** (Max 0.5% Corporate, 2% Clinical)
West Division	1578	17.6% (248.9)	20.0% (283.7)	2.5	70.0%	84.0%	0.4%
Barrie Division	1570	15.8% (218.4)	18.6% (256.7)	2.2	74.0%	80.0%	1.1%
International Division	174	18.5% (29.0)	19.8% (31.0)	4.1	86.0%	86.0%	0.0%
Corporate Affairs	9	23.2% (2.0)	23.2% (2.0)	1.8	88.0%	73.0%	0.0%
Clinical & Medical Operations	54	29.6% (17.2)	29.6% (17.2)	1.8	45.0%	77.0%	51.2%
Human Resources & OD	83	33.4% (27.6)	38.7% (32.0)	4.0	98.0%	95.0%	0.0%
Nursing & Patient Experience	74	14.4% (9.0)	15.4% (9.6)	1.3	65.0%	84.0%	0.0%
Finance & ICT	111	19.9% (20.0)	18.9% (19.0)	3.2	51.0%	84.0%	22.1%
Development & Property Services	131	9.2% (11.2)	13.5% (16.4)	4.0	76.0%	72.0%	0.0%
Research & Innovation	85	15.4% (12.6)	16.7% (13.6)	2.0	83.0%	87.0%	0.0%
Trust	3870	**17.2%▲ (597.8)**	**19.7%▼ (683.2)**	**2.5%▼**	**73.0%►**	**79.3% NEW**	**2.9%▼**

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2016 REPORT

Highlights & Actions

Vacancy Rate	
Comments	Actions
Awaiting in month data.	

Sickness Rate	
Comments	Actions
• **IPP** continue to have the highest sickness percentage in the Trust at 4.1% • Three other divisions have sickness percentages over the threshold – **Finance & ICT, Development & Property Services** and **HR&OD** • **HR&OD** has a high percentage due to a high level of long term sickness over the last twelve months, the majority of which have returned to work	• **IPP** - Drop in sessions ran for managers in IPP to discuss employees with sickness concerns. This is predominantly made up of short term sickness as they have a very low long sickness rate. • **Development & Property Services –** a dedicated HR lead is working with the estates and facilities team to support their intermittent cases which is predominantly what drives the higher percentage. • **HR&OD** – OH advice is being provided to the manager of the remaining long term sickness case to support the employees return to work. Health and wellbeing agenda being created by OH.

Agency Spend	
Comments	Actions
• Finance & ICT have high agency spend at 22.11% due to senior interims covering post/project. • Clinical & Medical Operations has continued high agency spend mainly due to RTT Project resourcing and the Gastro review. (The ledger shows that 70% of M1 agency spend relates to RTT & Gastro review) • CBO agency 61% of total bill due to RTT work.	• On-going recruitment in to the senior posts within ICT. • Due to NHS Improvement adjusting the published April agency price cap on 23 March 2016 the Trust reported 502 breaches in April (shifts). This related to 46 individual workers in week 1 of M1. By the end of M1 the number of individual agency workers breaching was 13 • CBO converting 8 agency workers to substantive.

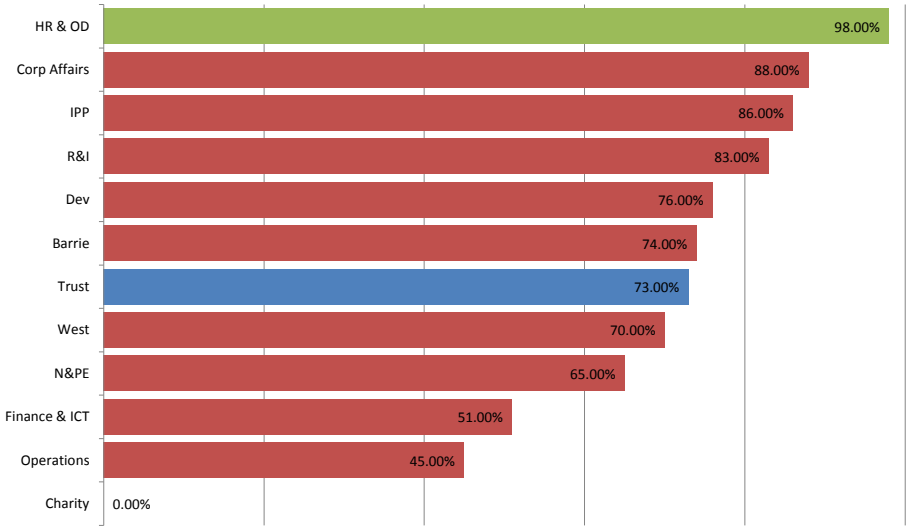
Voluntary Turnover Rate	
Comments	Actions
• Across the Trust there is high turnover with **many corporate areas** over 20%	• Overall retention plan being devised to be ready by end of May; • All leavers are offered a face to face exit interview with a member of the ER team, with personal emails sent to leavers from the team to those within **corporate areas**. • A new exit survey will be launched from the start of June utilising survey monkey and monthly/quarterly (dependent on the number of responses) reports will be produced for the divisions on the information collated.

PDR Completion	
Comments	Actions
• Completion rates range from 45% to 98%. Only one division is compliant with the rest of the Trust below 90%.	• Emails sent to employees from ER team monthly • League table to be created for divisions • Managers emailed monthly their employees outstanding

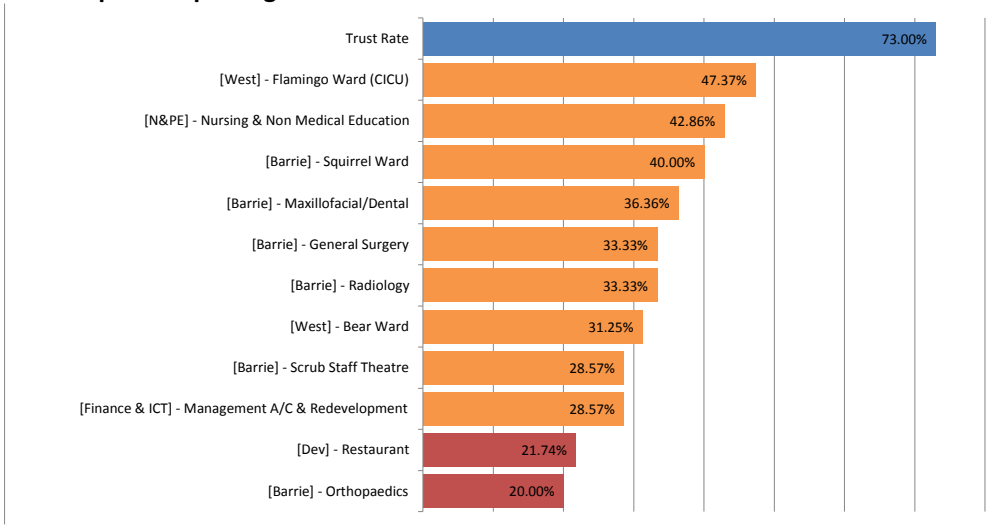
Statutory & Mandatory Training Compliance	
Comments	Actions
• Compliance rates range from 72% to 95%. Only one directorate is currently meeting target compliance HR&OD.	• More visibility through LMS • Learning and Development & ER team will work with managers to identify those who are non-compliant • Further developments to LMS to support employees ensure compliance

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2016 REPORT

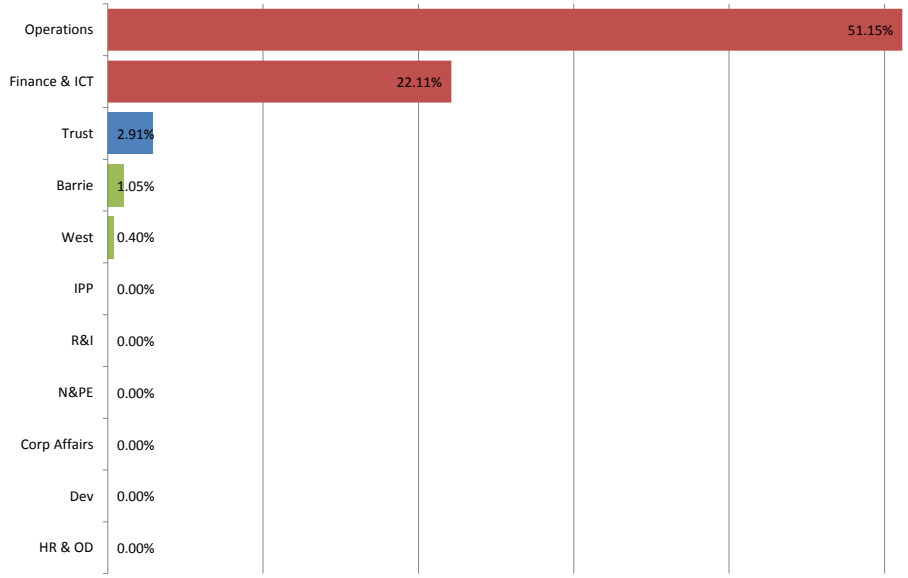
Divisional PDR (Target 95%)



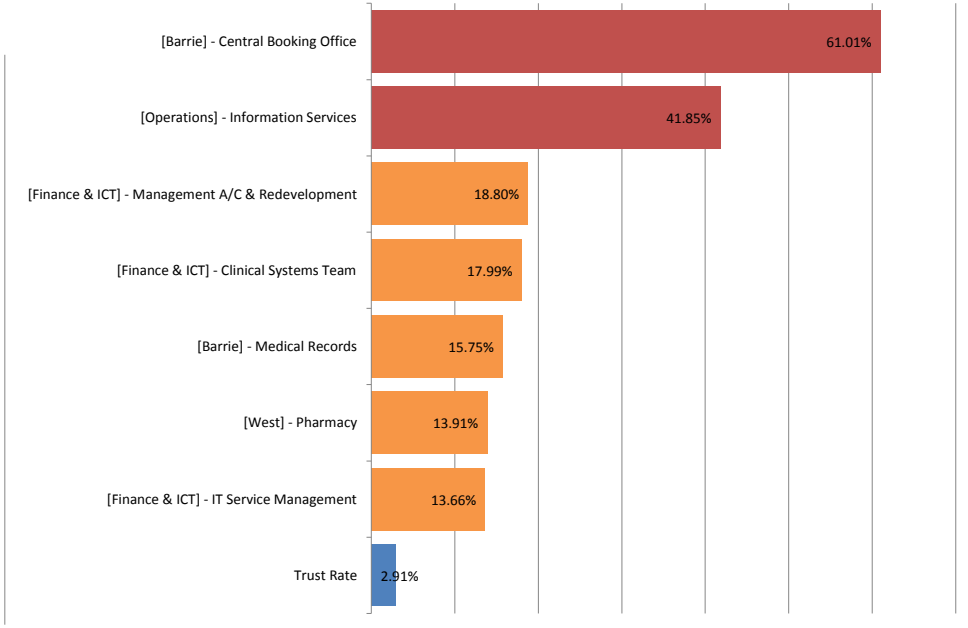
Exception Reporting PDR



Divisional Agency as % of paybill

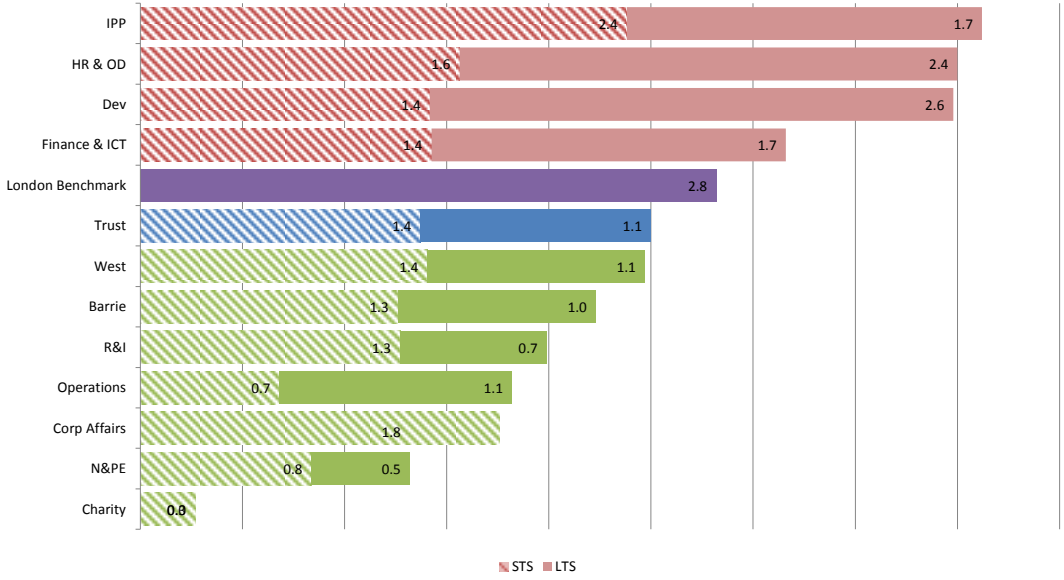


Exception Reporting Agency as % of Paybill

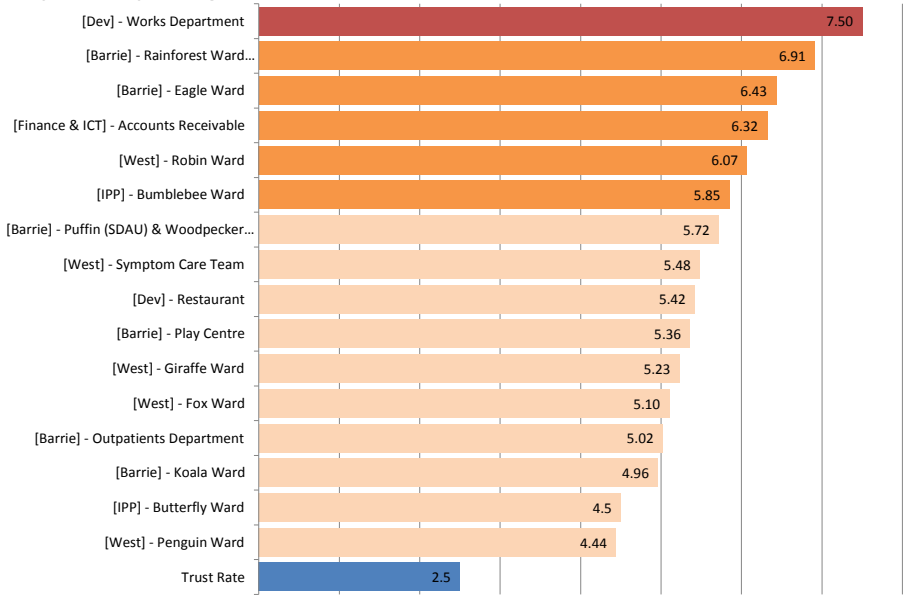


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2016 REPORT

Divisional Sickness

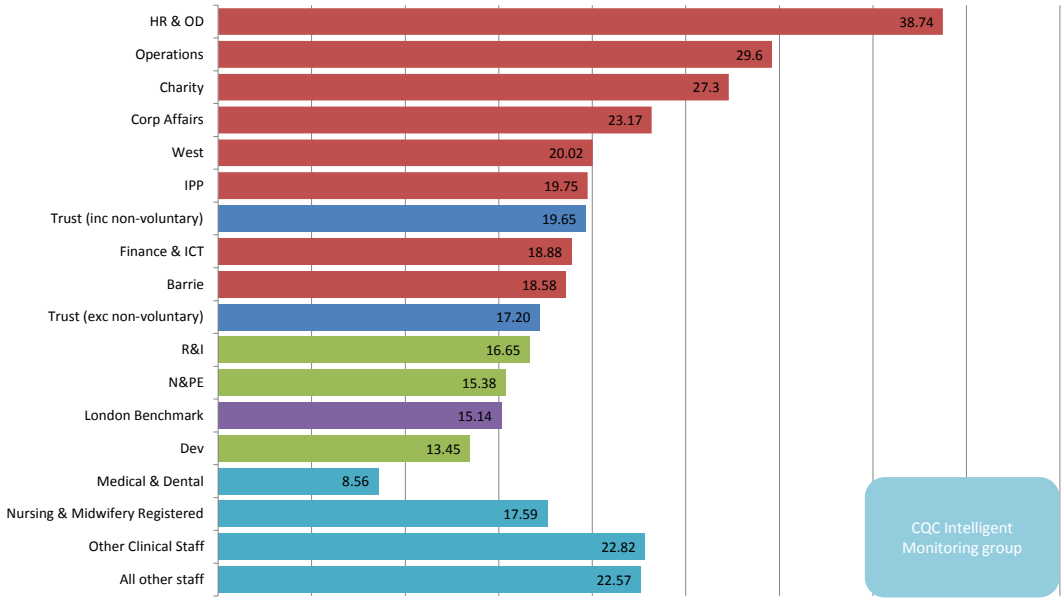


Exception Reporting Sickness

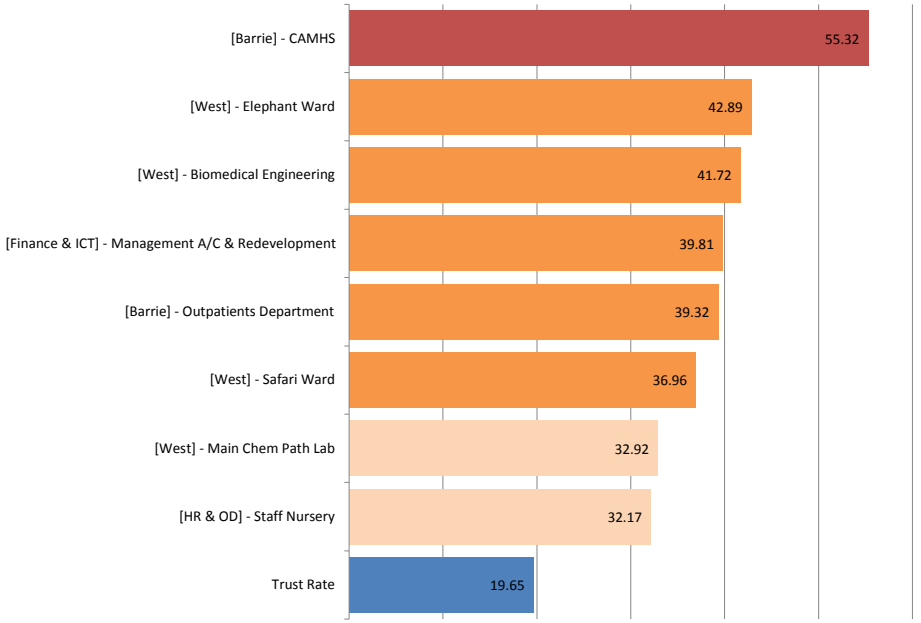


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2016 REPORT

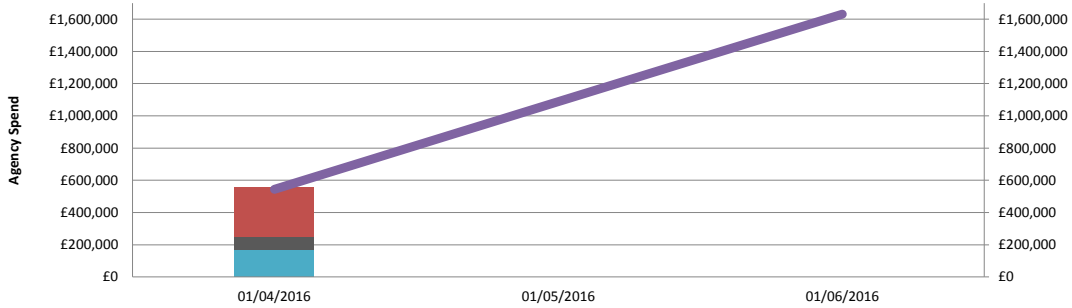
Divisional Turnover (Voluntary & Non-Voluntary)



Exception Reporting Turnover

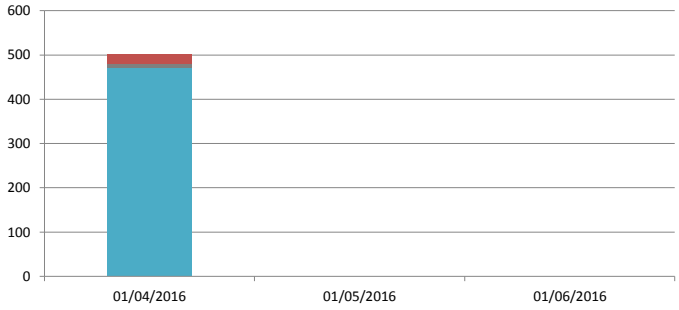


Agency Spend Ceiling (NHS Improvement Directive, Cumulative)



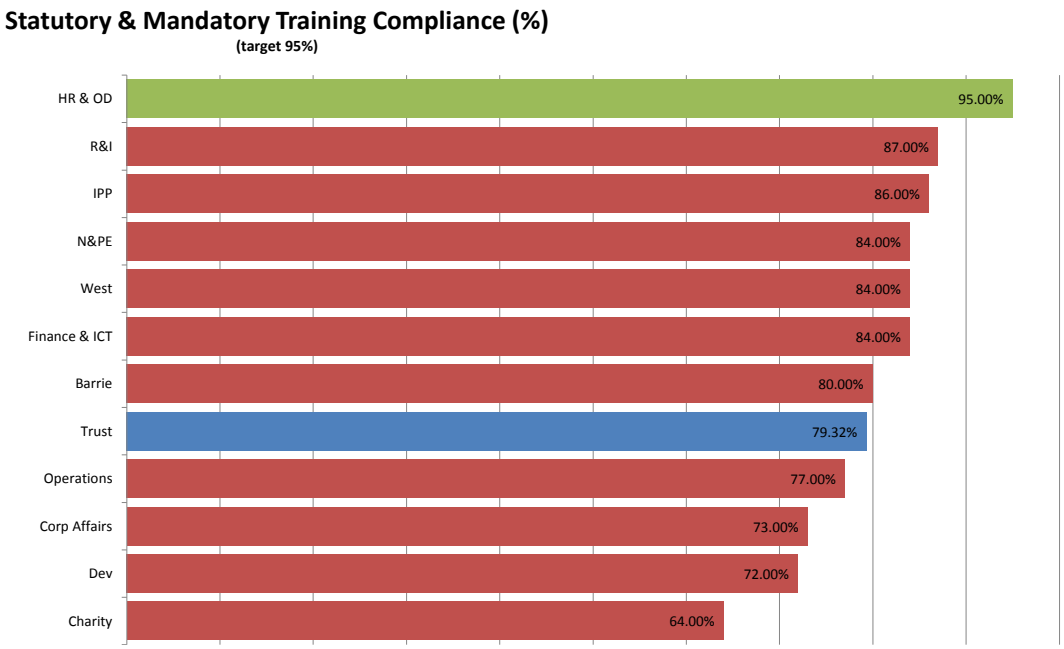
	30/04/2016	31/05/2016	30/06/2016
RTT	£308,004		
Gastro Review	£83,245		
Agency BAU	£168,006		
Agency Ceiling	£543,750	£1,087,500	£1,631,250

NHS Improvement Agency Rule Breaches (shifts per month, target zero)

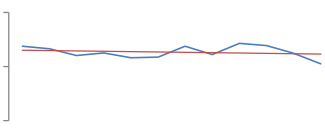
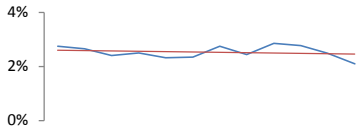
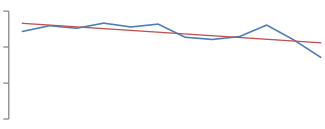
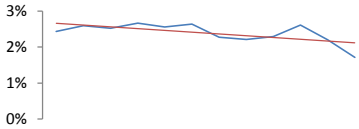
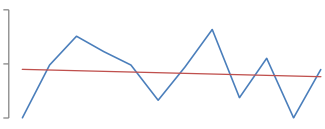
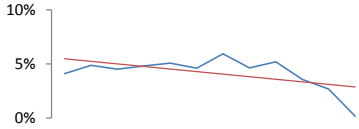
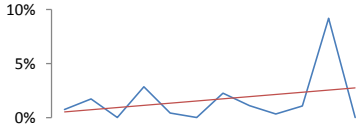
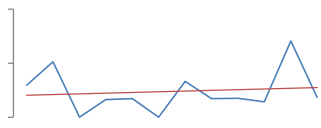
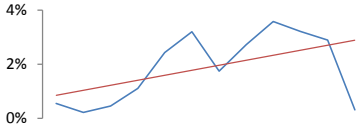
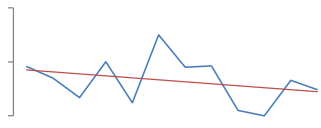
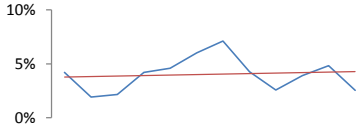
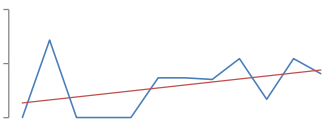
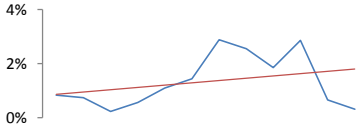
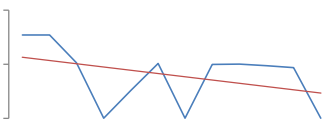
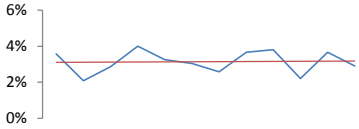
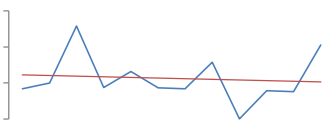
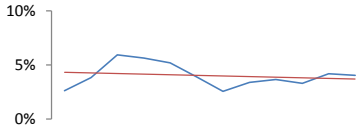
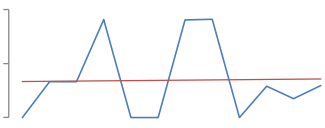
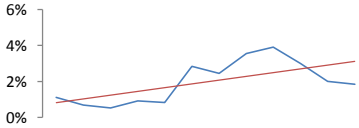
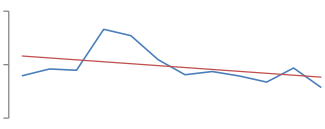
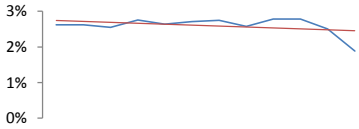


	30/04/2016	31/05/2016	30/06/2016
Shifts breached per month RTT	21		
Shifts breached per month Gastro Review	9		
Shifts breached per month BAU	472		

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2016 REPORT



HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2016 REPORT

Division	Total Turnover Rate (%, FTE) (number of leavers in 12-months in brackets, <18% green)	Total Turnover Rate (%, FTE) Monthly variation trend over 12 months	Sickness Rate (%) (0-3% green)	Sickness Rate (%, FTE) Monthly variation trend over 12 months
West Division	20.0% (283.7)		2.5	
Barrie Division	18.6% (256.7)		2.2	
International Division	19.8% (31.0)		4.1	
Corporate Affairs	23.2% (2.0)		1.8	
Clinical & Medical Operations	29.6% (17.2)		1.8	
Human Resources & OD	38.7% (32.0)		4.0	
Nursing & Patient Experience	15.4% (9.6)		1.3	
Finance & ICT	18.9% (19.0)		3.2	
Development & Property Services	13.5% (16.4)		4.0	
Research & Innovation	16.7% (13.6)		2.0	
Trust	**19.7%▼ (683.2)**		**2.5%▼**	

The scale varies per division to enable a trend view for 12-month with sufficient detail (blue line). The red 'direction of travel' indicates the overall direction of travel across each of the 12-months. The 'total turnover rate' approximates to the total of each individual's months' turnover rate.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 20th May 2016	
PDR (appraisal) rates Update **Submitted by:** Director of HR&OD	**Paper No: Attachment W**
Aims / summary To provide a statement for the Trust Board of current PDR rates with narrative, and actions to improve the position	
Action required from the meeting To note the actions	
Contribution to the delivery of NHS Foundation Trust strategies and plans Appraisals are an important mechanism in delivering the strategic objective "To be an excellent place to work and learn."	
Financial implications None	
Who needs to be told about any decision? The importance of appraisals and any changes to the process are communicated to all staff.	
Who is responsible for implementing the proposals / project and anticipated timescales? Assistant Director of Organisational Development	
Who is accountable for the implementation of the proposal / project? Director of HR&OD	

Great Ormond Street Hospital for Children NHS Foundation Trust

Paper for the Trust Board from the Director of HR&OD

May 2016

PDR (appraisal) rates

Introduction and background

This paper is in response to queries raised by the Trust Board at their April meeting, which related to PDR (appraisal) rates in the Trust. It should be noted that the data below excludes medical staff.

The Trust has set a target of 95% compliance for annual appraisals. An appraisal is an opportunity for a qualitative discussion between a member of staff and their line manager about their performance, achievements, challenges, development and objectives for the coming period.

Future of appraisals

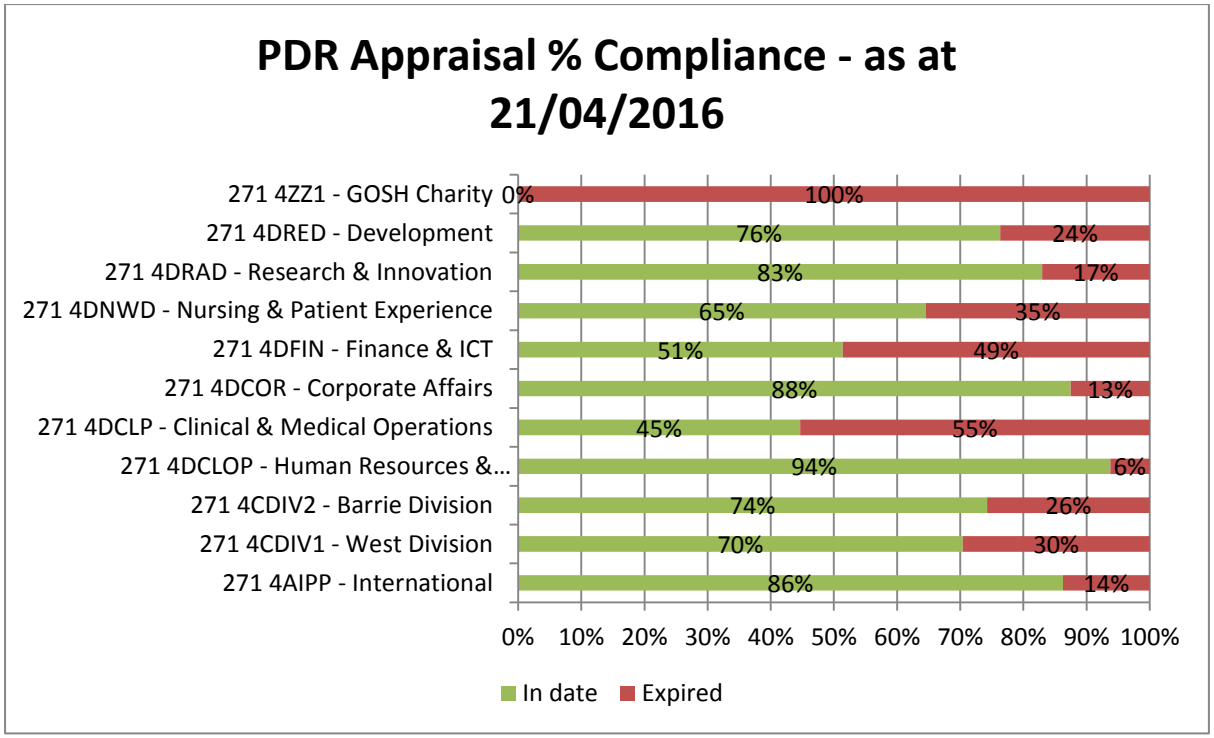
There has recently been press coverage of some organisations abandoning the annual appraisal. This is principally because the quality of the annual appraisal conversation is felt to be poor, and instead these companies are attempting to introduce more regular and less formal discussions between managers and staff. This approach is contingent upon the ability of staff and managers to meet regularly to discuss performance, which is challenging particularly in busy front line clinical environments. In these cases, a formal annual appraisal may be the *only* substantive opportunity for a member of staff and line manager to consider a range of issues including career development.

In addition, the revalidation process (introduced for nurses from April 2016) requires a formal review every three years which will build on the annual appraisal cycle. Considerable research also indicates a statistically significant link between well structured appraisals and patient mortality, patient satisfaction, staff absenteeism and turnover. (West, M. and Dawson, J. (2012) *Employee Engagement and NHS Performance)*

For these reasons, the Trust is maintaining its commitment to annual appraisals for all staff and is actively taking steps to improve the current rate.

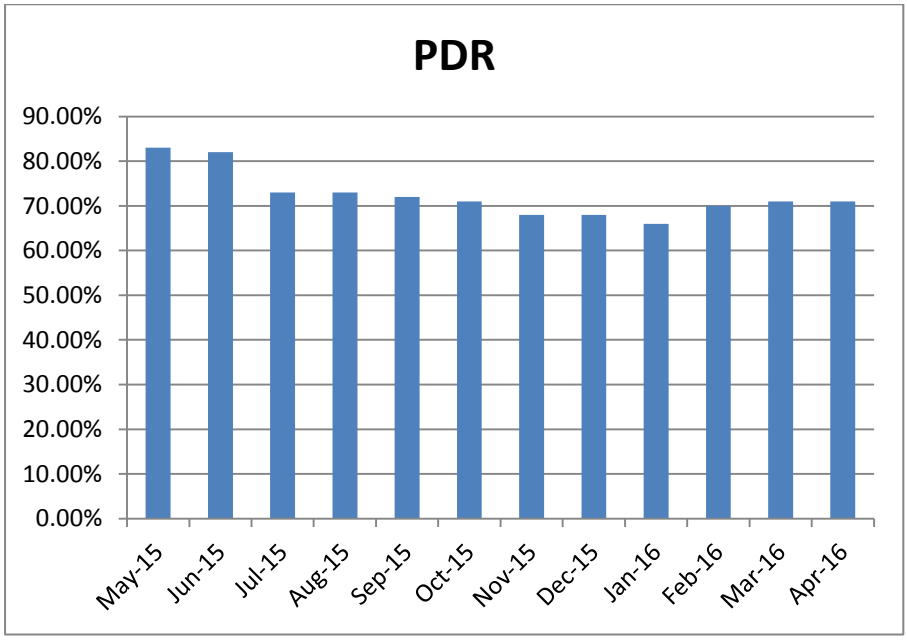
Current situation

The current Trust PDR rate is 73%. Rates across divisions and directorates vary significantly from 45% to 94%, with the two clinical divisions standing at 70% and 74%.



(Charity n=1)

12 month data



In **April 2015**, a new appraisal timetable was launched. This set a "window" for staff at bands 7 and above with the intention that they should have objectives set that reflect Trust business plan priorities between April and June, and then cascade these down to their teams (bands 2-6) in their appraisals during the remainder of the year. These staff had their own "window" set which was in line with their annual increment date. This new timetable initially inflated the compliance rate as it extended the existing deadline by which these staff needed to undertake their appraisal by three

months, to June 2015. However, the rate then fell in **July** as managers did not complete their appraisal within the required period.

In **February 2016**, the HR Team started to routinely notify line managers and staff that their appraisal was due. This has led to a small but sustained increase in the number of appraisals being undertaken.

Actions to improve appraisal rates

Further actions to improve compliance with the requirement to undertake an annual appraisal are taking place as follows:

- **Simplifying the process** Whilst the model of requiring managers and staff to undertake their appraisals within a window is valid, in practice this imposes an artificial timetable which has militated against the Trust's ability to achieve its target of an appraisal within 12 months for at least 95% of staff. This requirement will therefore be suspended although teams can continue with the model if they find it useful.
- The paperwork supporting the PDR process was reviewed and streamlined in April 2015. However, considerable guidance exists which, whilst intended to be helpful, risks adding an unnecessary layer of perceived complexity to the process. This will be reviewed and simplified.
- **Improved data and automated reminders** The Trust is in the process of launching the new GOLD Learning Management System (GOLD LMS) which will have a significantly improved reporting capability. The initial roll out is targeting reports on statutory and mandatory training, but rapidly post-roll out appraisals will be added to the system so that all staff will be able to see the date of their last appraisal; managers will be able to see the dates of appraisals for all their staff; and the system will send out automated reminders to staff and managers in advance of appraisals falling due and continue to prompt after they are due.
- **Targeted training** The existing training for managers who wish to develop their knowledge and skills in performing appraisals is currently one day and is often heavily subscribed. There is the risk that new managers in particular will delay performing appraisals until they have undertaken this training. With the simplifications of process outlined above, the existing training will be amended to reduce the time currently spent on process and focus on skills (for example, how to give difficult feedback; how to use the appraisal to motivate staff).
- **Communication** Executive-led all staff briefings in April 2016 have been used to promote the importance of appraisals. Communications about the simplified appraisals process will coincide with the launch of the new appraisals section in GOLD LMS (programmed for late June).
- **Performance Management** Appraisal rates will continue to be monitored under the Trust's performance management process. Discussions will be held with the Divisional management teams on the introduction of levers for driving compliance.

Action required

The Trust Board is asked to note the contents of this paper and support the actions outlined above.

Attachment X

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 20 May 2016	
2015/16 Finance Report – Month 12 (Subject to Audit) **Submitted by:** Loretta Seamer, Chief Finance Officer	**Paper No: Attachment X**

Aims / summary

To provide an update on the Month 12 Financial Outturn position (Subject to Audit) for the Trust Board

The Trust has reported an outturn deficit of £11.1m (excluding capital donations and impairments) at the end of 2015/16, in line with previous forecasts and subject to audit. The final outturn after the reversal of Impairments and Capital Donations was £33.2m, £1.9m better than plan.

The Trust contained its capital expenditure within available resources during 2015/16. The Trust underspent its Capital plan of £62.2m by £19.2m; largely due to slippage on the Phase 2b redevelopment, Mortuary redevelopment, Boiler house and Theatre 10 projects. The most significant area of slippage was against capital schemes funded through donations.

The slippage on capital schemes resulted in capital donations being £3m less than plan, offset by less expenditure which reduced the variance of I&E Margin as % of Income financial sustainability metric from a planned 3 to 1. This movement reduced the overall KPI from 3 to 2.

All other three financial metrics remain at a 3 or above.

Action required from the meeting
The Committee is asked to note the Month 12 Outturn position (Subject to Audit)

Contribution to the delivery of NHS / Trust strategies and plans
This paper details the Trusts delivery against its agreed Financial Plan for 2015/16.

Financial implications
None

Legal issues
None

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

Who is accountable for the implementation of the proposal / project
Chief Finance Officer

Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Month 12 2015/16
Contents

Subject to Final Audit Adjustments

Great Ormond Street Hospital for Children NHS FT - Activity & Income Summary. 12 Months to 31 March 2016

ACTIVITY AND INCOME

Clinical Income Categories	Income from NHS & Other Clinical Activity £M year to date				
	YTD Actual (£m)	Variance to plan (£m)	Variance to plan (%)	Variance to Prior Year (£m)	Variance to Prior Year (%)
Daycases	**26.6**	1.5	5.7%	2.9	12.1%
Elective Inpatients	**52.7**	(2.2)	-4.3%	(1.4)	-2.5%
Non-Elective Inpatients	**14.1**	0.2	1.7%	0.4	3.2%
Bed days	**45.9**	1.0	2.2%	1.2	2.7%
Outpatients	**38.2**	(1.5)	-3.9%	(0.5)	-1.4%
Other eg. Highly Specialised	**68.8**	(1.2)	-1.8%	(3.1)	-4.3%
Total	**246.2**	2.2	0.9%	(0.5)	-0.2%

Activity				
YTD Actual	Variance to plan	Variance to plan (%)	Variance to Prior Year	Variance to Prior Year (%)
20,589	815	4.0%	1,384	7.2%
12,560	(297)	-2.4%	(2)	0.0%
1,708	(128)	-7.5%	(79)	-4.4%
36,360	(225)	-0.6%	(113)	-0.3%
150,285	(9,083)	-6.0%	(5,826)	-3.7%

Elective

- Surgery Division activity is below plan particular in Spinal and Orthopaedics
- Activity within SNAPS and Cochlear has fallen below the 2014/15 levels.
- The Gastroenterology review in Q4 has seen reduced activity

The reduction in activity has been in areas of high price causing a larger financial reduction than an average price assessment would assume.

Day case

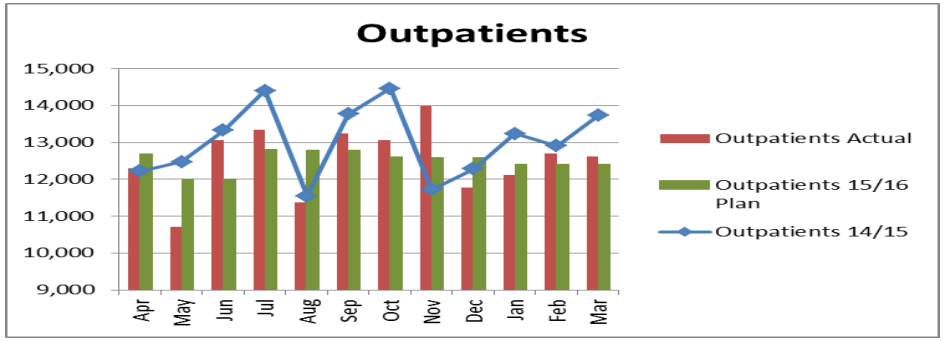
- Increased Urology due to RTT catch-up
- Rheumatology increase in infusion/injections following clinical commissioning policies
- Haematology/oncology increase linked to increased Chemotherapy and cancer referrals

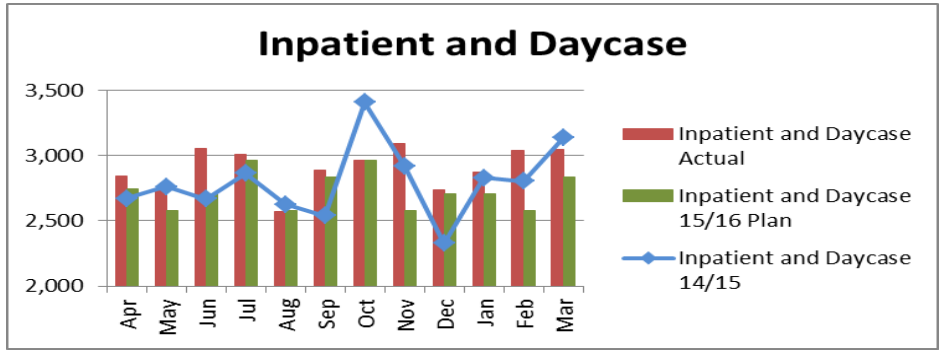
Outpatients

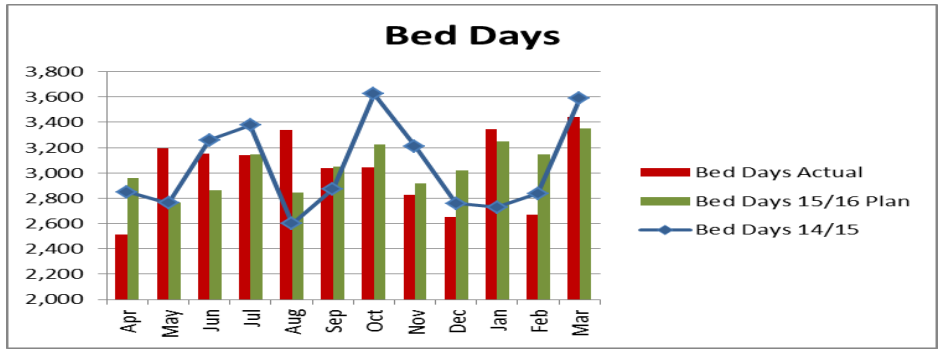
- Improvement in data quality relating to both billing against attendance criteria and haemotology/oncology
- Growth not being achieved in Cardiac, neurodisability and audiology due to staff shortages and Space constraints

Excess Beddays

- Fluctuates due to a small number of atypical very sick patients staying beyond their trim points







Great Ormond Street Hospital for Children NHS FT - I&E Financial Performance Summary. 12 Months to 31 March 2016

I&E	Current Month			Current Year to Date			YTD Prior Year to Date		RAG Rating Current Year Variance	Note
	Budget (£m)	Actual (£m)	Variance (£m)	Budget (£m)	Actual (£m)	Variance (£m)	Actual 2014/15 (£m)	Variance CY vs PY (£m)		
NHS & Other Clinical Revenue	20.4	23.9	3.5	244.0	246.2	2.2	252.7	(6.5)	G	1
Pass Through	4.8	4.6	(0.2)	56.7	54.7	(1.9)	51.2	3.5		
Private Patient Revenue	4.2	4.0	(0.2)	43.1	48.9	5.8	41.3	7.6	G	2
Non-Clinical Revenue	3.8	4.3	0.5	44.1	44.5	0.4	47.9	(3.3)	G	
Total Operating Revenue	**33.2**	**36.8**	**3.5**	**387.9**	**394.4**	**6.5**	**393.1**	**1.3**		
Permanent Staff	(17.7)	(16.5)	1.3	(212.9)	(197.8)	15.1	(192.5)	(5.3)		
Agency Staff	(0.0)	(1.4)	(1.4)	(0.2)	(7.6)	(7.4)	(5.5)	(2.1)		
Bank Staff	(0.2)	(1.7)	(1.5)	(1.9)	(15.3)	(13.5)	(14.8)	(0.6)		
Total Employee Expenses	**(17.9)**	**(19.6)**	**(1.7)**	**(214.9)**	**(220.7)**	**(5.8)**	**(212.8)**	**(8.0)**	R	3
Drugs and Blood	(0.9)	(0.8)	0.1	(11.4)	(10.6)	0.8	(11.4)	0.8	G	
Other Clinical Supplies	(3.2)	(3.5)	(0.3)	(38.3)	(39.8)	(1.4)	(39.3)	(0.5)	R	
Other Expenses	(4.4)	(8.2)	(3.8)	(52.5)	(54.9)	(2.4)	(51.1)	(3.8)	R	
Pass Through	(4.8)	(4.6)	0.2	(56.7)	(54.7)	1.9	(51.2)	(3.5)		
Total Non-Pay Expenses	**(13.3)**	**(17.1)**	**(3.8)**	**(158.9)**	**(160.0)**	**(1.1)**	**(153.1)**	**(6.9)**	R	4
EBITDA (exc Capital Donations)	**2.0**	**0.1**	**(1.9)**	**14.0**	**13.6**	**(0.4)**	**27.2**	**(13.6)**	A	
Depreciation, Interest and PDC	(2.3)	(2.3)	0.0	(25.3)	(24.7)	0.5	(24.3)	(0.4)		
Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	**(0.2)**	**(2.2)**	**(1.9)**	**(11.2)**	**(11.1)**	**0.2**	**2.9**	**(14.0)**	G	
EBITDA %	**6.1%**	**0.2%**		**3.6%**	**3.5%**		**7.9%**	**6.9%**		
Impairments	0.0	13.8	13.8	0.0	13.8	13.8	0.0	(13.7)		
Capital Donations	5.1	3.7	(1.4)	42.5	30.5	(12.0)	33.8	15.4		
Net Result	**4.9**	**15.3**	**10.4**	**31.3**	**33.2**	**1.9**	**36.7**	**(12.3)**		

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%

NHSI Key Performance Indicators

KPI	Annual	Q4 Plan	YTD Actual	Forecast	Rating	
Liquidity	4	4	4	4	G	
Capital Service Coverage	3	3	3	4	G	
I&E Margin	4	4	4	4	G	
Variance in I&E Margin as % of income	1	1	1	3	R	
Overall	3	3	3	4	G	
Overall after Triggers	2	2	2	4	R	5

Comments Key Areas:

- For the financial year 2015/16 the Trust incurred a deficit of £11.1m, excluding capital donations and Impairments, which is £0.1m favourable to plan.
- Included in the result was a fine of £0.648 million.
- P&E delivered £9.5m in 2015/16 in line with the trust forecast. Non-recurrent underspends provided some mitigation for the PE performance contributing towards the favourable variance against plan.
- For 2015/16 EBITDA was a £13.6m surplus and for Month 12 a surplus of £0.1m. The year to date EBITDA is £0.4m less than plan and represents 3.5% of income. EBITDA in Month 12 was £1.9m less than plan.

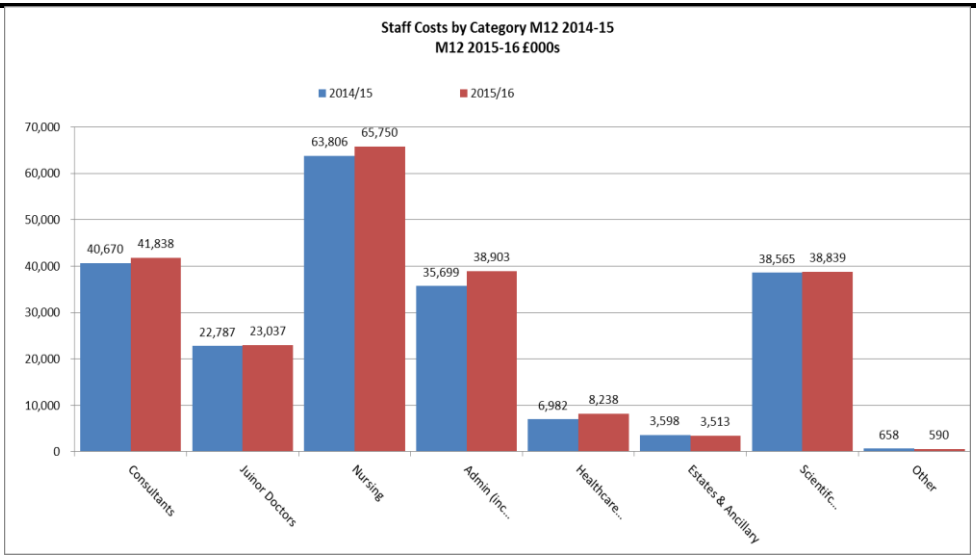
Notes:

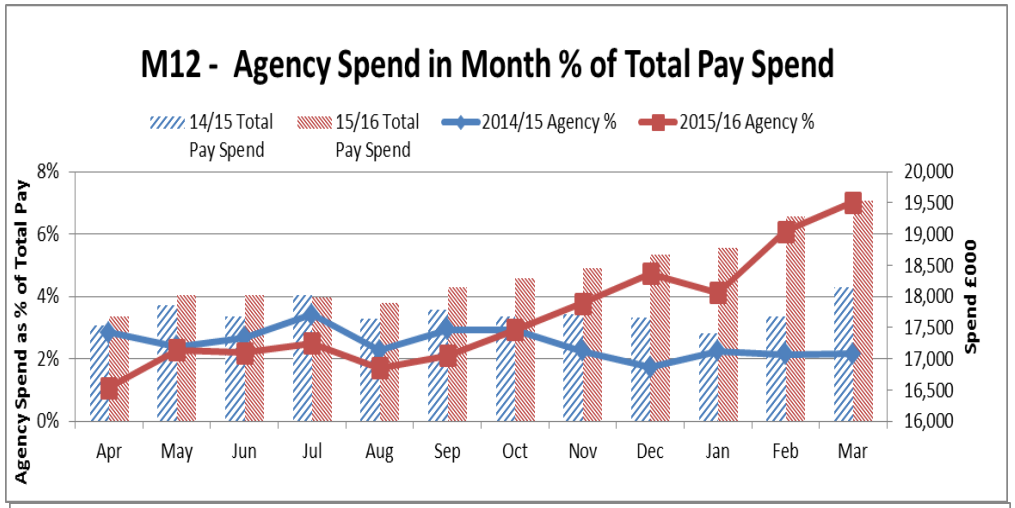
1) NHS income (excluding pass through) is above plan by £2.2m, which is due to the net effect of underperformance in surgery; additional income from the prior years contract settlement and improved tariffs.
2) Private patient income is £5.8m above for 2015/16, and was under plan by £0.2m in Month 12.
3) Pay was £5.8 worse than plan, of which £1.7m was attributable to month 12. £7.6m was year to date agency spend which was higher than the prior year due to the cost of RTT validation.
4) Non pay excluding pass through is £3.0m adverse to plan. This is due to increased activity against plan.
5) Although the overall weighted rating was a 3 for 2015/16, the impact of the rating of 1 for the Variance I&E Margin to plan reduced the overall rating to 2. This was as a result of the capital donations being £3m less than plan offset by less expenditure for the Phase 2B redevelopment project caused by delay in the building project.

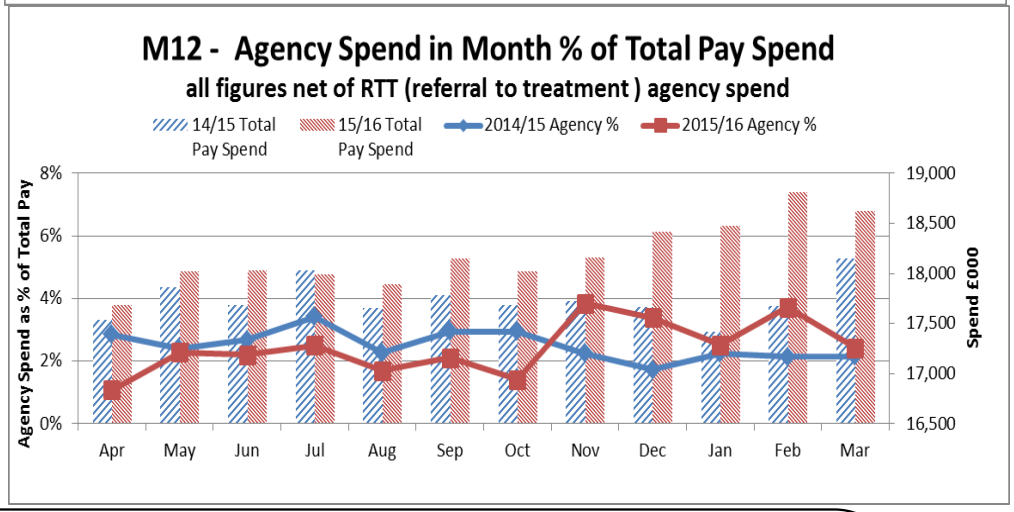
Great Ormond Street Hospital for Children NHS FT - Workforce Summary. 12 Months to 31 March 2016

PAY COSTS AND WTE					
Year to Date £m	Total - Perm, Agency + Bank	Agency	Agency % of Total	Bank	Bank of % of Total
2015/16	220.7	7.6	3.4%	15.3	7.0%
2014/15	212.8	5.5	2.6%	14.8	6.9%
Movement	8.0	2.1	0.9%	0.6	0.0%

M12 WTE	Total - Perm, Agency + Bank	Agency	Agency % of Total	Bank	Bank % of Total
2015/16	4,112	179	4.4%	276	6.7%
2014/15	4,110	54	1.3%	219	5.3%
Movement	2	125	3.1%	57	1.4%

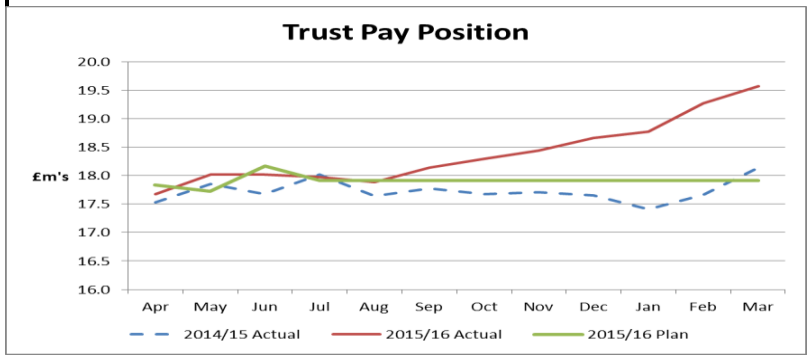


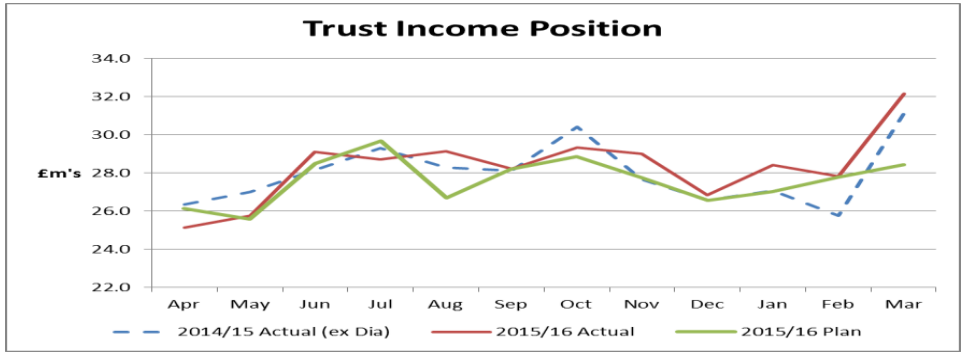


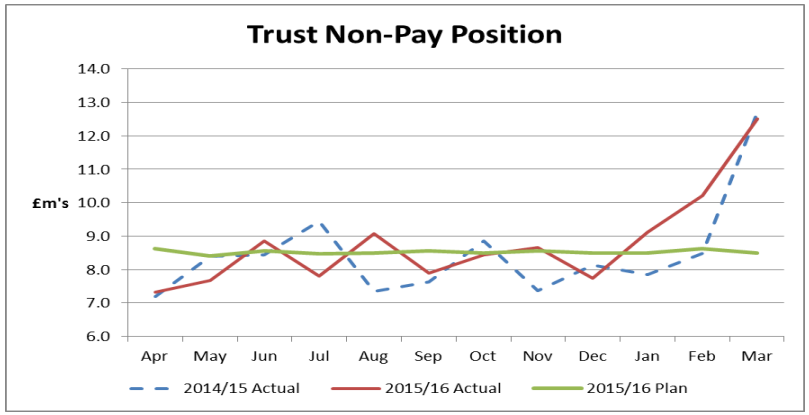


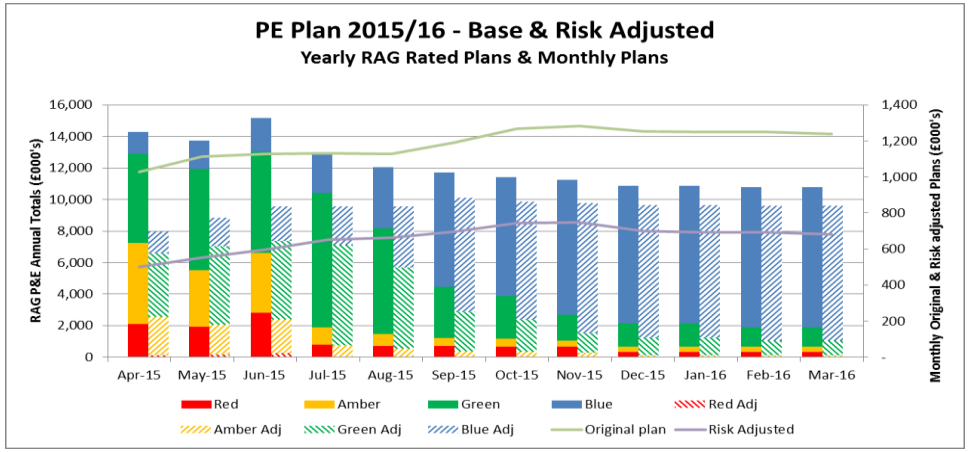
- The agency spend graphs show agency spend as a proportion of total pay spend,
  - Top Graph shows this at gross
  - Bottom Graph shows this net of £2.5m referral to treatment (RTT) agency staff working on validation. RTT agency staff within divisions will still be included and partly explains the increase seen in November.
- Agency spend was below the 14/15 level for the first seven months following a drive to convert agency staff to bank or permanent especially within the corporate areas.
- The significant increase in agency spend from October represents the increasing numbers of RTT validation staff within the organisation.
- The increase in pay costs are associated with inflationary increase, increase in pension contributions, increase in temporary staffing costs and research costs (offset by income).

Run Rate and Productivity and Efficiency Performance









Trust Non-pay and Income graphs Exclude Pass Through

Income

- Private patient income overachieved by £6.7m in year
- Other NHS income was £5.8m overachieved.

Pay

- The trust's pay expenditure has risen every month since September due to the increase in the number of staff working on RTT.

Non Pay

- £1m increase in clinical supplies and services at the end of the year, due to the expense of medical equipment purchased les s than £5,000 during the year, which was mostly offset by charitable donations.
- MDTS non pay drugs expenditure was 700k above the three month trend, due to year end pharmacy system consolidation of home delivery pass through drugs. This is offset by additional income, and mirrored the 14/15 trend.

Great Ormond Street Hospital for Children NHS FT - Cash, Capital and Statement of Financial Performance Summary. 12 Months to 31 March 2016

Cash

The closing cash balance was £63.7m, £9.9m higher than plan. This was due to lower than planned trust funded capital expenditure (£7.3m), higher than planned current liabilities (£2.4m) and lower than planned deficit (£0.2m).

Non-Current Assets

The closing balance was £439.8m, £23.6m higher than plan. This was the impact of the land and building revaluation carried out by the District Valuer which resulted in an increase in the value of the estate of £47m (a combination of Building and Locality indices) (of this; £18.5m was credited to income and £28.5m credited to the Revaluation Reserve). This was reduced by a £4.7m impairment in year due to additions adding no value and £19.2m underspend on the capital programme (details on the capital report).

NHS Debtor Days

Increased in month due to the billing of M11 and M12 estimates. Last March included debts for Project Diamond and high value NHSE overperformance.

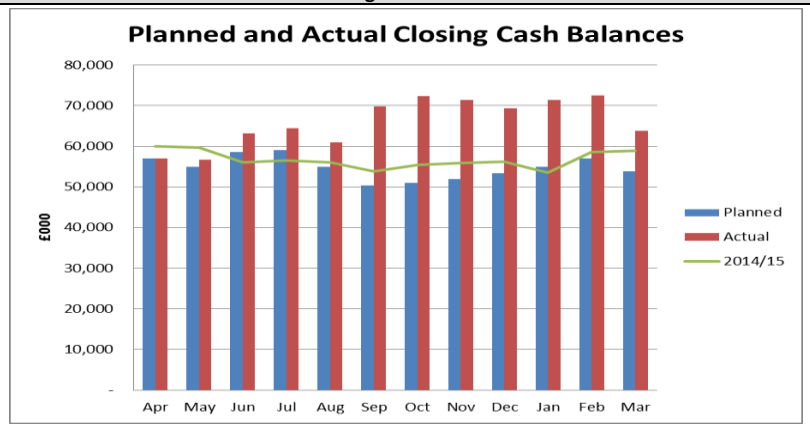
Creditor Days

The underlying systems used for calculating creditor days are being validated this will lead to a reduction in creditor days. The calculation currently includes all invoices whether or not they have been validated and approved. Invoice validation is an on-going process.

RAG Criteria:

NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)

BPPC Number and £: Green (over 90%); Amber (85-90%); Red (under 85%)



Statement of Financial Position	31 March 2015 Actual £m	31 Mar 2016 Planned £m	31 Mar 2016 Actual £m
Non-Current Assets	372.9	416.2	439.8
Current Assets (exc Cash)	56.3	57.9	57.9
Cash & Cash Equivalents	58.9	53.8	63.7
Current Liabilities	(47.9)	(57.1)	(59.3)
Non-Current Liabilities	(6.7)	(6.2)	(6.3)
Total Assets Employed	**433.5**	**464.6**	**495.8**

Capital Expenditure	Annual Plan £m	31 Mar 2016 Actual £m	Variance £m
Redevelopment - Donated	37.6	28.7	8.9
Medical Equipment - Donated	2.9	1.8	1.1
Estates - Donated	0.0	0.0	0.0
ICT - Donated	2.0	0.0	2.0
Total Donated	**42.5**	**30.5**	**12.0**
Redevelop& equip - Trust Funded	9.9	8.5	1.4
Estates & Facilities - Trust Funded	4.9	0.8	4.1
ICT - Trust Funded	5.0	3.3	1.7
Total Trust Funded	**19.8**	**12.6**	**7.2**
Total Expenditure	**62.3**	**43.1**	**19.2**

	31-Mar-15	29-Feb-16	31-Mar-16	RAG
NHS Debtor Days (YTD)	25.53	6.90	11.78	G
IPP Debtor Days	130.73	182.30	197.06	R
IPP Overdue Debt (£m)	6.36	11.40	13.00	R
Creditor Days	33.00	36.20	35.00	A
BPPC - Non-NHS (YTD) (number)	88.3%	85.4%	85.2%	A
BPPC - Non-NHS (YTD) (£)	91.8%	87.2%	87.8%	A

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 20 May 2016	
2016/17 Finance Report – Month 1 **Submitted by:** Loretta Seamer, Chief Finance Officer	**Paper No: Attachment 11**

Aims / summary

To provide an update on the Month 1 Financial position for the Trust Board.

The Trust has reported a deficit of £0.8m (excluding capital donations and impairments) at the end of April, £0.4m favourable to plan. The surplus after the Capital Donations was £2.5m, £3.0m lower than planned due to lower than expected capital donations caused by slippage on the Phase 2b development.

Under performance on planned NHS income £1.0m was offset by a higher than planned level of Private Patient Income £1.0m. The underspend was due to lower than planned non pay costs excluding pass through costs £0.6m.

The impact of lower than planned capital donations reduced the Variance in I&E Margin as a % of Income key performance indicator to 1, reducing the overall risk rating from a planned 3 to a 2.

Following discussions with NHS Improvement the Trust is awaiting confirmation that rating will be adjusted to a 2* to reflect the fact that the variance on I&E Margin is being impacted by Capital Donations and not underlying financial performance.

Action required from the meeting
The Committee is asked to note the Month 1 financial position

Contribution to the delivery of NHS / Trust strategies and plans
This paper details the Trusts delivery against its agreed Financial Plan for 2016/17.

Financial implications
None

Legal issues
None

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

Who is accountable for the implementation of the proposal / project
Chief Finance Officer

Great Ormond Street Hospital for Children NHS Foundation Trust
Finance and Activity Performance Report Month 1 2016/17
Contents

Great Ormond Street Hospital for Children NHS FT - Activity & Income Summary. 1 Month to 30 April 2016

ACTIVITY AND INCOME

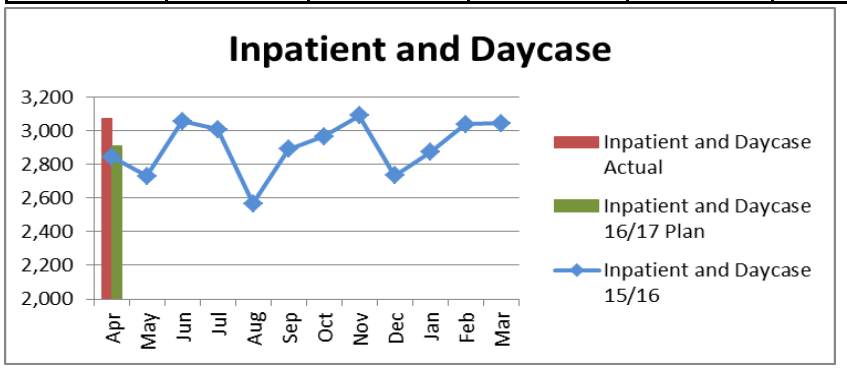
Clinical Income Categories	Income from NHS & Other Clinical Activity £M year to date				
	YTD Actual (£m)	Variance to plan (£m)	Variance to plan (%)	Variance to Prior Year (£m)	Variance to Prior Year (%)
Daycases	**2.1**	0.2	8.3%	0.2	7.6%
Elective Inpatients	**4.6**	(0.4)	-8.2%	0.2	5.2%
Non-Elective Inpatients	**0.9**	(0.3)	-36.0%	(0.2)	-22.1%
Bed days	**3.9**	(0.2)	-4.8%	0.2	5.5%
Outpatients	**3.1**	(0.1)	-2.3%	(0.1)	-3.4%
Other eg. Highly Specialised	**5.3**	0.4	7.1%	0.1	1.2%
Total	**19.8**	(0.4)	-2.0%	0.3	1.5%

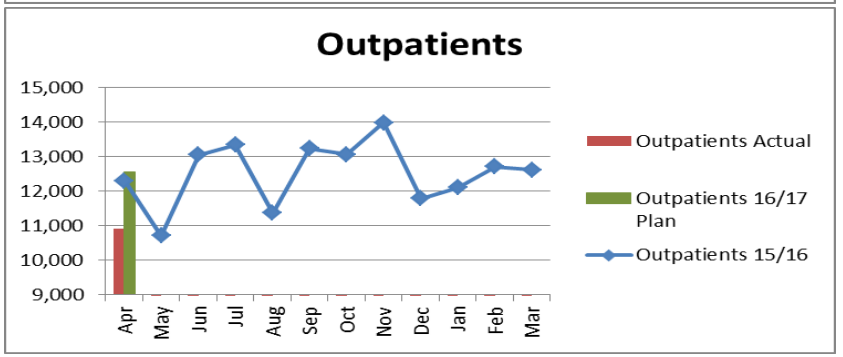
Activity					
YTD Actual	Variance to plan	Variance to plan (%)	Variance to Prior Year	Variance to Prior Year (%)	Prior Year FY Actual
1,629	(91)	-5.6%	(109)	-6.3%	20,589
1,327	278	20.9%	368	38.4%	12,560
118	(25)	-20.9%	(32)	-21.3%	1,708
3,129	92	2.9%	834	36.3%	36,360
10,923	(1,630)	-14.9%	(1,384)	-11.2%	150,285

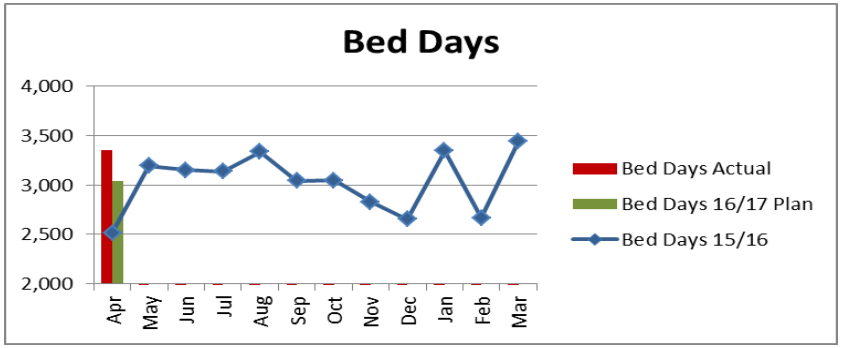
Activity

Following Contract negotiations with NHS England the original growth assumption within the trusts plans have been reduced to align with the growth agreed with the trusts main Commissioner.

The activity numbers in this report are provisional awaiting the finalisation of the contract negotiations. Once this has been finalised the activity plan will be realign with the new contract.







Great Ormond Street Hospital for Children NHS FT - I&E Financial Performance Summary. 1 Month to 30 April 2016

I&E	Current Month			Current Year Year to Date			Prior Year Comparator Year to Date		RAG Rating Current Year Variance	Note
	Budget (£m)	Actual (£m)	Variance (£m)	Budget (£m)	Actual (£m)	Variance (£m)	Actual 2015/16 (£m)	Variance CY vs PY (£m)		
NHS & Other Clinical Revenue	20.9	19.8	(1.0)	20.9	19.8	(1.0)	18.8	1.0	R	1
Pass Through	4.7	4.7	(0.0)	4.7	4.7	(0.0)	4.2	0.5		
Private Patient Revenue	4.0	5.0	1.0	4.0	5.0	1.0	2.9	2.1	G	2
Non-Clinical Revenue	3.5	3.4	(0.1)	3.5	3.4	(0.1)	3.4	0.0	A	
Total Operating Revenue	**33.1**	**32.9**	**(0.2)**	**33.1**	**32.9**	**(0.2)**	**29.3**	**3.6**		
Permanent Staff	(18.8)	(17.1)	1.7	(18.8)	(17.1)	1.7	(16.4)	(0.7)		
Agency Staff	(0.2)	(0.6)	(0.3)	(0.2)	(0.6)	(0.3)	(0.2)	(0.4)		
Bank Staff	(0.1)	(1.5)	(1.4)	(0.1)	(1.5)	(1.4)	(1.1)	(0.4)		
Total Employee Expenses	**(19.2)**	**(19.2)**	**(0.0)**	**(19.2)**	**(19.2)**	**(0.0)**	**(17.7)**	**(1.6)**	G	3
Drugs and Blood	(1.0)	(0.7)	0.3	(1.0)	(0.7)	0.3	(0.7)	(0.0)	G	
Other Clinical Supplies	(2.2)	(3.0)	(0.8)	(2.2)	(3.0)	(0.8)	(2.4)	(0.6)	R	
Other Expenses	(5.1)	(4.1)	1.0	(5.1)	(4.1)	1.0	(4.3)	0.1	G	
Pass Through	(4.7)	(4.7)	0.0	(4.7)	(4.7)	0.0	(4.2)	(0.5)		
Total Non-Pay Expenses	**(13.0)**	**(12.5)**	**0.6**	**(13.0)**	**(12.5)**	**0.6**	**(11.5)**	**(0.9)**	G	4
EBITDA (exc Capital Donations)	**0.9**	**1.2**	**0.3**	**0.9**	**1.2**	**0.3**	**0.1**	**1.1**	G	
Depreciation, Interest and PDC	(2.1)	(2.0)	0.1	(2.1)	(2.0)	0.1	(1.9)	(0.1)		
Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	**(1.2)**	**(0.8)**	**0.4**	**(1.2)**	**(0.8)**	**0.4**	**(1.8)**	**1.0**	G	
EBITDA %	**2.7%**	**3.7%**		**2.7%**	**3.7%**		**0.4%**			
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Capital Donations	6.8	3.3	(3.5)	6.8	3.3	(3.5)	1.1	2.3		
Net Result	**5.5**	**2.5**	**(3.0)**	**5.5**	**2.5**	**(3.0)**	**(0.7)**	**3.3**		

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%

NHSI Key Performance Indicators

KPI	Annual	Q1 Plan	YTD	Forecast	Rating	
Liquidity	4	4	4	4	G	
Capital Service Coverage	3	2	3	3	G	
I&E Margin	4	4	4	4	G	
Variance in I&E Margin as % of income	2	2	1	2	R	
Overall	3	3	3	3	G	
Overall after Triggers	3	3	2	3	R	5/6

Comments Key Areas:

- For Month 1 of the financial year 2016/17 the Trust has incurred a deficit of £0.8m, excluding capital donations. The month 1 position is £0.4 favourable to plan.
- Included in the result are costs associated with the RTT validation exercise.
- The plan includes a PE target of £12m
- The Month 1 EBITDA was a £1.2m surplus which is £0.3m favourable to plan and represents 3.7% of Income.

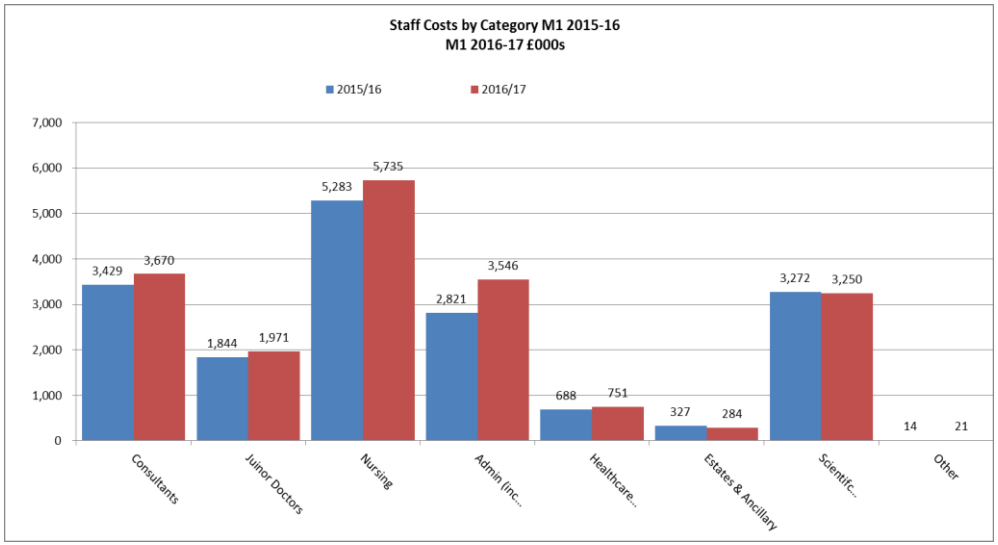
Notes:

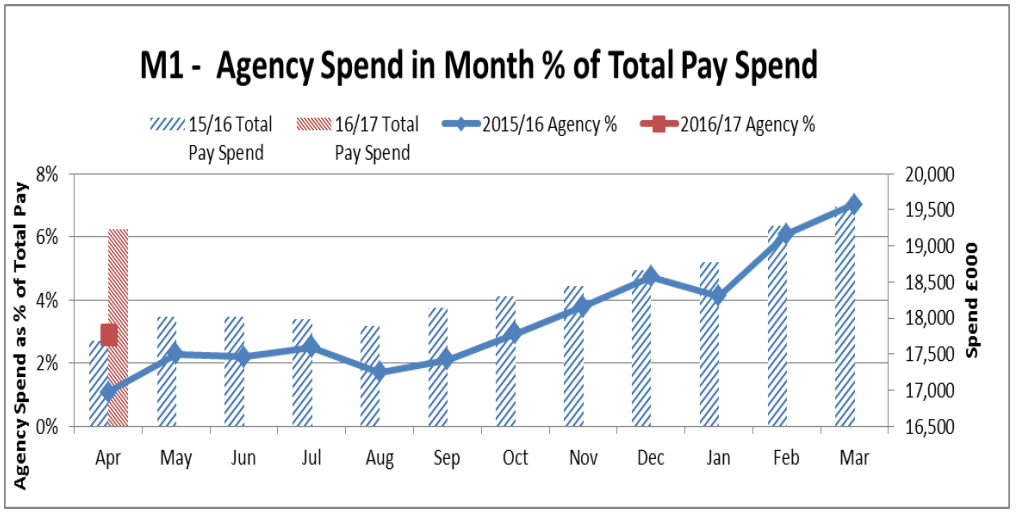
1) NHS income (excluding pass through) is below plan by £1.0m, which has been offset by over performance in Private Patient income of £1.0m.
2) Private patient income was £1.0m above plan for Month 1 in 2016/17. This was delivered through increased activity predominantly within the Cardiac. and Respiratory specialities.
3) Pay was breakeven in month, with agency spend £0.3m above plan. The agency spend was higher than the prior year due to the cost of RTT validation and the Gastro review.
4) Non pay excluding pass through is £0.6m favourable to plan.
5) Although the overall weighted rating was a 3 for Month 1, the impact of the rating of 1 for the Variance I&E Margin to plan reduced the overall rating to 2. This was as a result of the capital donations being £3.5m less than plan offset by less expenditure for the Phase 2B redevelopment project caused by delay in the building project.
6) The Variance in I&E margin NHSI KPI plan is set using the plan submitted to NHSI. The plan for this KPI will be set from our Monitor return (Risk Rating of 2) or from our actual outturn (Risk rating of 1). We are awaiting confirmation

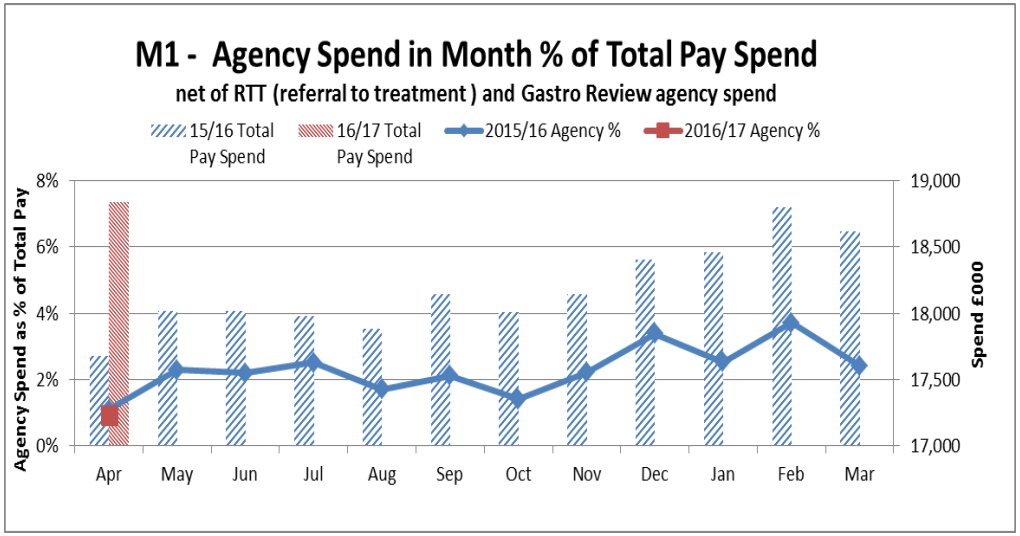
Great Ormond Street Hospital for Children NHS FT - Workforce Summary. 1 Month to 30 April 2016

PAY COSTS AND WTE					
Year to Date £m	Total - Perm, Agency + Bank	Agency	Agency % of Total	Bank	Bank of % of Total
2016/17	19.2	0.6	2.9%	1.5	8.0%
2015/16	17.7	0.2	1.1%	1.1	6.2%
Movement	1.6	0.4	1.8%	0.4	1.8%

M12 WTE	Total - Perm, Agency + Bank	Agency	Agency % of Total	Bank	Bank % of Total
2016/17	4,180	136	3.3%	207	5.0%
2015/16	4,094	56	1.4%	280	6.8%
Movement	86	80	1.9%	(73)	-1.9%

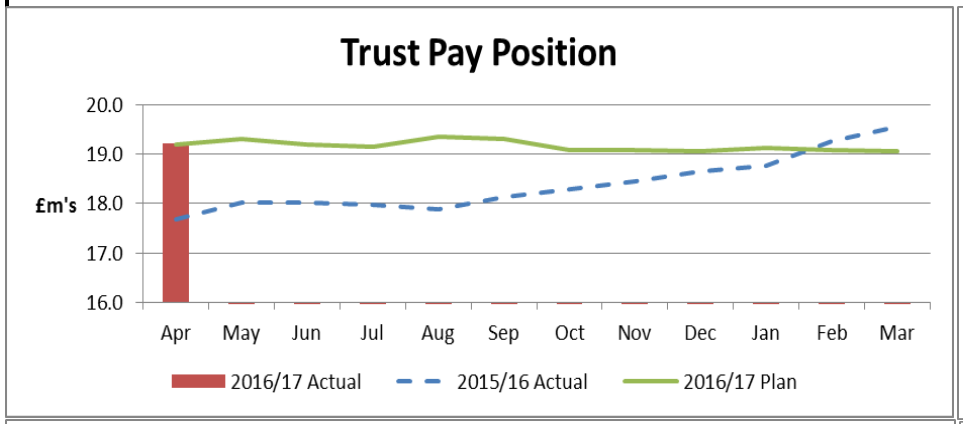


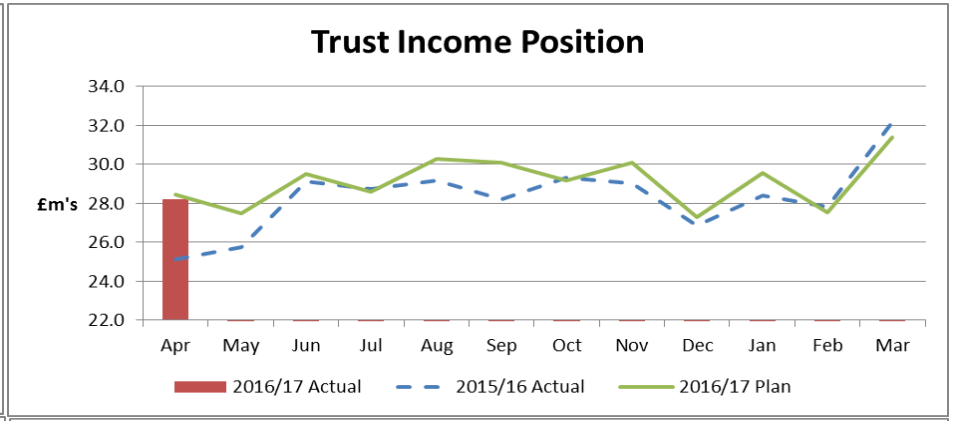


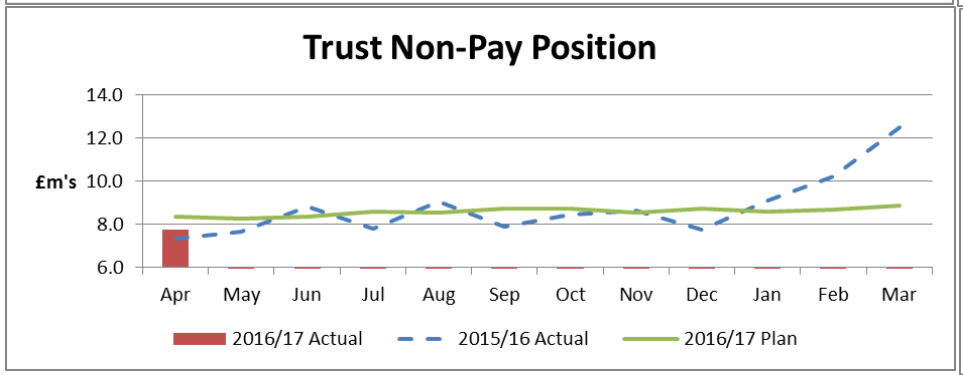


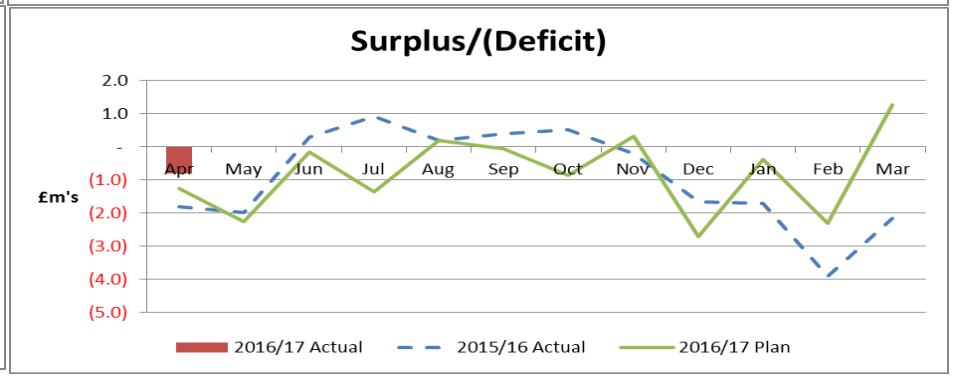
- The agency spend graphs show agency spend as a proportion of total pay spend,
  - Top Graph shows this gross of referral to treatment (RTT) and Gastro spend.
  - Bottom Graph shows this net of £0.4m RTT validation agency staff and Gastro review agency staff. RTT agency staff within divisions will still be included
- Agency spend has decreased between M12 2015/16 and M1 2016/17 due to a reduction in temporary staff within ICT.
- The RTT agency staff are the main reason for the increase in pay costs throughout the last 6 months of 2015/16 and into 2016/17. They are the key reason behind the change in M1 pay spend between 2015/16 and 2016/17.
- A change in National Pay rules removing discounted employer National Insurance rates has seen an increase in the Month1 pay bill of £0.3m
- Other reasons for an increase in pay costs are associated with inflationary increase, pay increments and research costs (offset by income) partly offset through the introduction of NHS agency Caps.

Run Rate & Performance









Trust Non-pay and Income graphs Exclude Pass Through

Income

- Private patient income overachieved by £1.0m in Month 1 across both OBW and outliers. This was predominantly in the Cardiac and Respiratory specialties.
- Other NHS income underachieved in month 1 by £0.8m

Pay

- The trust's pay expenditure has risen every month since September 2015, due to staff working on RTT, until April 2016 when spend fell due to a reduction in ICT temporary staffing

Non Pay

- The trusts non-pay expenditure has fallen from M12 2015/16 following one off expenditure in M12 relating to medical equipment purchased less than £5,000 (which was offset by charitable donations).
- Month 1 spend is inline with 2015/16 Month 1 spend having seen expected inflationary price increases

Great Ormond Street Hospital for Children NHS FT - Cash, Capital and Statement of Financial Performance Summary. 1 Month to 30 April 2016

Cash

The closing cash balance was £61.3m, £2.3m higher than plan. This was due to lower than planned trust funded capital expenditure (£1.3m) and lower than planned deficit (£0.8m)

Non-Current Assets

Non-current assets increased by £2.7m in month, the effect of capital expenditure of £4.1m less depreciation of £1.4m. The closing balance is £4.3m lower than plan largely as a result of the M1 capital expenditure being less than plan by £4.7m. This variance is analysed on the capital expenditure schedule.

NHS Debtor Days

Decreased in month due to Month 1 SLA all paid on time which resulted in an improvement to debtor days.

Creditor Days

The underlying systems used for calculating creditor days are being validated this will lead to a reduction in creditor days. The calculation currently includes all invoices whether or not they have been validated and approved. Invoice validation is an on-going process.

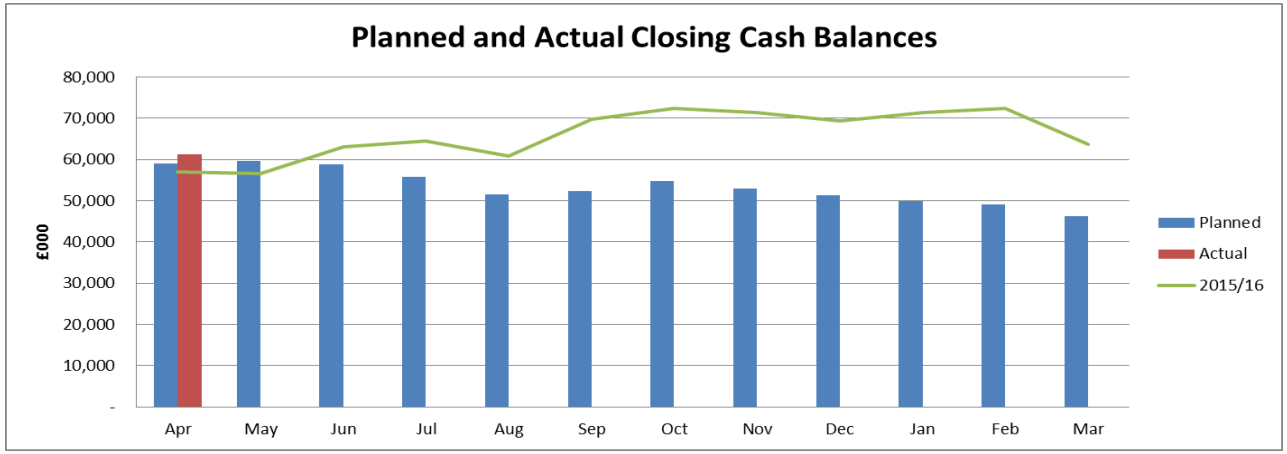
IPP

IPP receipts for April (net of deposits) were £1m lower that then average for the last 12 months.
Of the cash that was paid to the trust, a large amount was in relation to debt which was not yet due.

RAG Criteria:

NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
BPPC Number and £: Green (over 90%); Amber (85-90%); Red (under 85%)
IPP debtor days: Green (under 120 days); Amber (120-150 days); Red (Over 150 days)

Closing Cash Balance



Statement of Financial Position	31 Mar 2016 Actual £m	30 Apr 2016 Planned £m	30 Apr 2016 Actual £m
Non-Current Assets	440.8	447.8	443.5
Current Assets (exc Cash)	58.9	57.9	64.9
Cash & Cash Equivalents	63.7	59.0	61.3
Current Liabilities	(60.3)	(57.1)	(64.0)
Non-Current Liabilities	(6.3)	(6.2)	(6.3)
Total Assets Employed	**496.8**	**501.4**	**499.4**

Capital Expenditure	Annual Plan £m	30 Apr 2016 YTD plan £m	30 Apr 2016 Actual £m	YTD Variance £m
Redevelopment - Donated	34.9	6.5	3.2	3.3
Medical Equipment - Donated	3.3	0.3	0.1	0.2
Estates - Donated	0.0	0.0	0.0	0.0
ICT - Donated	0.0	0.0	0.0	0.0
Total Donated	**38.2**	**6.8**	**3.3**	**3.5**
Redevelop& equip - Trust Funded	10.0	1.3	0.6	0.7
Estates & Facilities - Trust Funded	2.4	0.1	0.1	0.0
ICT - Trust Funded	10.3	0.5	0.1	0.4
Contingency	1.7	0.1	0.0	0.1
Total Trust Funded	**24.4**	**2.0**	**0.8**	**1.2**
Total Expenditure	**62.6**	**8.8**	**4.1**	**4.7**

Working Capital	29-Feb-16	31-Mar-16	30-Apr-16	RAG Rating
NHS Debtor Days (YTD)	6.9	11.8	9.2	G
IPP Debtor Days	182.3	197.1	203.1	R
IPP Overdue Debt (£m)	11.4	13.0	16.3	R
Creditor Days	36.2	35.0	38.1	A
BPPC - Non-NHS (YTD) (number)	85.4%	85.2%	84.0%	A
BPPC - Non-NHS (YTD) (£)	87.2%	87.8%	83.0%	A

Attachment Y

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th May 2016**	
PALS Annual Report 2015/16 **Submitted by:** Juliette Greenwood-Chief Nurse	**Paper No: Attachment Y**
Aims / summary: To share with the Trust Board the aggregated themes of the previous quarter reports and to summarise the key themes of the year that have been raised by families to the Pals team.	
Action required from the meeting To support the Divisions in their work to implement the changes needed to reduce communication problems, cancelations of appointments and admissions and to support the efforts in supporting the children, families and staff involved with the Gastroenterology Service.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Pals Annual Report helps highlight the areas we need to improve, especially the Always Values of Always being Helpful and Always being Expert**.**	
Financial implications Costs incurred by families due to Trust errors or late cancelations of admissions or appointments has had a small cost to families. Departments across the Trust have helped with limited and reasonable travel costs. This is a significant factor in addressing concerns promptly and avoiding the need of a Formal Complaint.	
Who needs to be told about any decision? The Divisions to share the Annual Report through their management structure.	
Who is responsible for implementing the proposals / project and anticipated timescales? The Annual Report includes the Divisional responses to the experiences of patients and their families and the Divisions will take those actions forward.	
Who is accountable for the implementation of the proposal / project? Juliette Greenwood	

Attachment Z

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
20th May 2016

Friends & Family Test Q4 2015/16 Report - experience of children, young people and their families at GOSH **Submitted by:** Juliette Greenwood, Chief Nurse	**Paper No: Attachment Z**

Aims / summary

The purpose of this report is to summarise the Friends and Family Test information which captures the experience of children, young people and their families at GOSH.

The report includes Quarter 4 Friends and Family test results.

The Inpatient FFT response rate has been between 23% and 26% for this quarter, ending the year at 26%. This is below the Trust target of 60% due to the previously reported issues and the inclusion of day case discharge data. When benchmarked against 12 other Trusts, GOSH had the eighth highest response rate.

The overall percentage of inpatients 'likely to recommend' for Quarter 4 2015/16 has been 98% - 99.5% throughout the quarter which is 3-4.5% above the Trust target of 95%.

The overall percentage of outpatients 'likely to recommend' has remained consistently above 97% for Quarter 4 2015/2016, 2% above the Trust target of 95%.

Negative comments related to the following themes:

- Access / Admission & Discharge
- Catering
- Communication
- Environment and Infrastructure

Positive comments related to the following themes:

- Care
- Staff behaviours
- Welcoming

Action required from the meeting
Review and Comment.

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
Not applicable

Who needs to be told about any decision?
Herdip Sidhu-Bevan, Assistant Chief Nurse Quality & Patient Experience.

Attachment Z

Who is responsible for implementing the proposals / project and anticipated timescales? Herdip Sidhu-Bevan, Assistant Chief Nurse Quality & Patient Experience. Suzanne Collin, Patient Feedback Manager.
Who is accountable for the implementation of the proposal / project? Juliette Greenwood, Chief Nurse.

Attachment Y

Great Ormond Street Hospital for Children NHS Foundation Trust

Pals Annual Report
April 2015- March 2016

Highlights of this report

- Overall Pals activity for the year
- Key themes for the year
- Thematic analysis of cases by Division
- Thematic analysis of cases by top 5 specialities
- Cases formally escalated to Complaints or Risk teams
- Compliments for the teams across the Trust

1. Pals overall activity in 2014/15

- 3768 contacts and cases (decrease on previous 4074 in 2014/15)
- 2096 Information enquiries (decrease on previous 2536 in 2014/15)
- 1270 Promptly resolved cases (increase on previous 1186 in 2014/15)
- 283 Complex cases (decrease on previous 311 in 2014/15)
- 52 Escalated cases to Complaints (increase on previous 41 cases in 2014/15)
- 37 compliments for services across GOSH (increase on previous 30 cases in 2014/15)

In summary 77.3% of cases were resolved promptly, 17.1% were Complex and 3.2% were escalated to Formal Complaint. There has been a decline in information queries, however, there is a 7% increase in the number of promptly resolved cases from the preceding year, and the majority of Pals cases are resolved within a 5 day period. There is variation which can be explained by school holidays- this mirrors the Trust activity with a reduction in patients seen over the summer holidays and Christmas/ New Year period.

The key subjects were Outpatient Experience (32.1%); Admission and Discharge (16.1%) and Communication and Information (12.1%) and the main contributing reasons for these were lack of communication following outpatient appointments with families and lack of information about appointments and admissions being cancelled with no prior warning.

2.0 Key Themes for the year

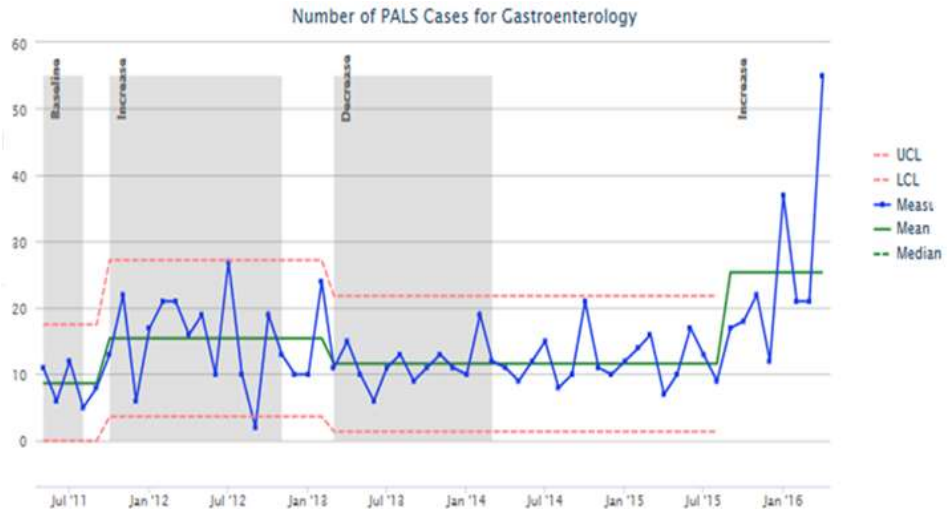
2.1 Cancellations

The case work in Pals relating to Cancellations has increased during the financial year 2015/2016 by 29% (152 cases about cancellations in 2014/15 increasing to 214 cases about cancellations in 2015-16). In the previous financial year it was not in the top 3 subjects for any directorates, but 2015/16 it has been in the top 3 for Surgery, MDTS, CCCR, Neurosciences and ICI. The top 5 specialities for 2015/16 for this subject are Cardiac Surgery (10.7%), Gastroenterology (10.7%), Neuroscience Medicine (8.9%), Cardiology (7.9%) and Ophthalmology (7.5%). Other changes that have occurred in Pals case work is compared to 2014/15 Dermatology has had reduction in cancellations. For admission/discharge and cancellations some of the reasons that were discussed were cancellations with no prior warning.

Pals works with colleagues in Outpatients and the admitting wards to provide support to those families arriving at GOSH without having been informed about their child's cancelled or rescheduled appointment or admission. In these cases Pals are able to work with the clinical team to arrange for support of their out of pocket expenses such as reasonable travel costs. Pals then work with the clinical teams to identify how the cancellation occurred and to offer the family a replacement appointment or admission. In some cases, infrequently, the teams are able to make alternative arrangements and enable to child and family to be seen by an alternative clinician on the day of arrival. This is however not always possible or appropriate.

2.2 Gastroenterology

During 2015/16- 68.2% of Gastro cases were promptly resolved, 24.2% were complex cases and 3.3% of Pals cases were escalated to Formal Complaints.

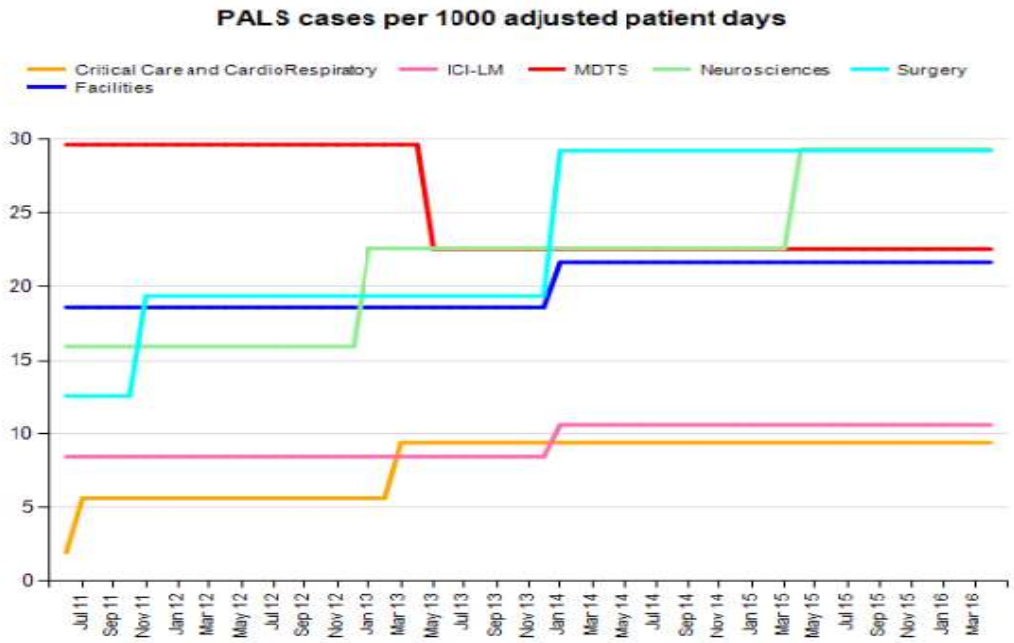


The above graph indicates that since August of 2015/16 the number of gastro cases for Pals have been increasing. This is not mirroring the previous financial years where there was variation around the mean and has resulted in an increase in the mean for gastroenterology. The reasons behind Pals attendances were: Outpatient experiences (28.9%); Communication/Information (20.4%) and Admission/Discharge (16.1%). Almost 50% of families coming to Pals have queries around communication issues and about 20% of the issues are around cancellations of outpatient appointments.

Team Explanation: The Trust is dedicated to listening to and learning from complaints and taking appropriate actions when gaps in our processes or themes have been identified. It is good practice to invite a review of services by other specialists in the same clinical area from other parts of the UK or internationally to help drive forward improvements and ensure best care. The Trust invited a review from the Royal College of Paediatric and Child Health of our Gastroenterology service.

Following the findings of the Royal College of Paediatric and Child Health, and taking the learning from the themes of the complaints received, a gastroenterology review group has been created which is led by a Programme Manager. This includes a review of how care is being managed and the themes detailed above will be reviewed as part of this work. In addition a new complaints co-ordinator has been recruited to support the service in fully investigating all complaints and in turn ensuring that families questions are answered and concerns addressed.

3.0 Thematic analysis of cases by Division



3.1: Surgery- There were 401 surgery cases for Pals making up 24.4% of the Pals Case-work during 15/16. This was a decrease from the preceding year where Surgery made up 28.3% of Pals case-work.

The specialities with the highest Pals contacts were: Orthopaedics/Spinal (19.7%); Urology (19.7%) and General surgery (16.7%). These specialities were also the main reasons behind surgery referrals during 2014/15.

We carried out a thematic analysis of the above specialities and the themes attributed to the cases were: Outpatient Experiences (32.7%); Admission/Discharge (25.7%) and Communication / Information (9.2%).

Evaluation of the above themes elicited detailed insight about the most common subjects behind the above themes for Surgery. A lack of communication with families regarding appointments and admissions remains the most frequent reason for Pals case-work in Surgery. This is followed by a recent increase in families experiencing cancelations of appointments and admissions with little or no notice given.

3.2: Neurosciences- There were 336 Neurosciences cases for Pals making up 20.5% of Pals case work. This is an increase from 2014/15 when Neurosciences was 14.4% of all Pals work.

The specialities that contributed to the highest case load for Pals were: Neuroscience Medicine (25.3%); Ophthalmology (20.5%); and Reception fares and reimbursements (9.2%).

The key themes attributing towards this increase were: Outpatient Experience (40.2%); Communication and Information (13.7%) and Admission/Discharge (7.7%). From detailed analysis of these themes the following reasons emerged as being the most common subjects for attendance: support with liaising the team to book outpatient appointments, or arrange tests or admissions, support when customers experienced cancelled outpatient appointments and admissions especially with little noticed provided to the families, and advice regarding fare imbursement policy.

3.3: MDTS- There were 369 MDTS cases for Pals making up 22.5% of Pals case work. This is an increase from the preceding year when it contributed 19.5% of Pals case work.

The specialities with the highest Pals contacts were Gastroenterology (57.2%); Endocrinology (14.1%) and Nephrology (5.4%).

The key themes for Pals cases in MDTS were: Outpatient Experiences (24.7%); Communication and Information (17.3%) and Admission/Discharge (12.5%). A analysis of these themes highlighted the following common subjects; a lack of communication with families about their appointments/providing information relating to admission; customers feeling their speciality are not liaising with other teams, families requiring assistance with rebooking cancelled appointments and helping families get new admission dates after their attempts have not resulted in the desired outcome.

3.4: CCCR- There were 188 CCCR cases for Pals during the financial year making up 11.4% of Pals case work. In 2014/15 CCCR contributed 12.9% of Pals cased, therefore there has been a decrease in this financial year.

The top three specialities Pals case work related to were: Cardiology (38.3%); Cardiac surgery (21.8%); Critical care (20.2%).

A thematic analysis of the cases for the above specialities showed the principal reasons for CCCR customers coming to Pals were: Admission / Discharge (28.2%); Outpatient Experience (20.2%) and Inpatient Experience (14.4%). Analysis highlighted the following: customers found a lack of information relating to their admission/discharge arrangements was a concern. Another reason was related to the cancellation of outpatient and inpatient admissions, and more support was required for managing bereavement compared to the previous financial year.

3.5: ICI- There were 176 ICI cases making up 10.7% of all Pals case work. This is a decrease from the previous year where ICI had 12% of all Pals case load.

The top specialities are Rheumatology (41.5%); Immunology (10.8%) and joint third Dermatology and Oncology (10.2%).

Following a thematic analysis to obtain the main subjects for ICI Pals cases the findings showed: Outpatient experience (35.2%); Communication and Information (15.3%) and Admission/Discharge (13.1%). The analysis showed the most common themes families sought Pals support were related to assistance to communicate with the teams to ascertain information about their outpatient appointments or admissions,

concerns relating to transport arrangements for outpatient appointments and discharges following a procedure and customers requiring support following cancellation of either outpatient appointments or and admissions.

3.6: Estates & Facilities- There were 92 cases for Estates and Facilities which attributes for 5.6% of Pals case load. This is a decrease from the previous year when 7.7% of Pals case load was for this division. The main departments are Accommodation and Patient transport (39%); Catering Kitchen (17.1%) and Catering Lagoon (12.2%). The themes for customers attending Pals about Estates and Facilities were: Inpatient experience (41.3%); Outpatient Experience (22.8%) and Admission/Discharge (12%). Thematic analysis showed the most frequent reason for customers attending Pals about the environment and facilities in inpatient accommodation and a need for support to receive information and communicate about accommodation.

3.7: IPP There were 20 IPP cases contributing to (1.2 %) for Pals during the financial year. 2014/15 there were 21 (1.1%).The top three reasons for Pals cases are Outpatient Experience (25%), Inpatient Experience (15%) and Referrals (15%). The main sub-subjects are Communication/Information; Medical records and Care advice.

4.0 Thematic analysis of cases by top 5 specialities

4.1 Gastroenterology (see above 2.2)

4.2 Neuroscience Medicine Themes

During 2015/16- 80% of cases were promptly resolved, 16.5% complex and 1.2% escalated to Formal Complaints. Thematic analysis revealed the main reasons customers attended Pals were:

- **Outpatient experience (36.5%)**- Analysis showed that Communication 38.7%; Cancellations 32.3% and Care advice 12.9% were the main subjects.
- **Communication/Information (16.5%)-** The main themes for why families attended Pals were: Lack of communication with families 64.3%; Telephone calls not returned 14.3% and lack of information between staff and teams 7.1%: and
- **Admission/Discharge (12.9%)**- the main contributing factors are: Communication 37.5%; Cancellations 25% and Care advice 18.8%. When comparing the information to 2014/15 it is noticeable that there is an increase in an almost 50% increase in queries across all subjects for this specialty.

Team Explanation: Centralisation of all referrals made to Neuroscience medicine across a small team of referral coordinators that we are looking to recruit/train existing staff. We are more strictly adhering to published referral criteria for a streamlined patient pathway to avoid unnecessary delays due to inadequate workup. Also, better acknowledgement of referrals received and their outcome of acceptance or rejection to both referrers and patients.

EDMD is under review with instruction to organise documents into folders according to date (week beginning) so older documents are more easily tracked and prioritised accordingly. KPIs for letters are being set between individual admin staff and consultant letter turnaround time reviewed on a monthly basis at review meetings.

Admin staff instructed that any amendment to appointments must be communicated with a telephone call, followed up with a clinic letter that is carefully selected from the various templates. Templates are being reviewed to include the correct clinic location and the text message service reviewed quarterly to ensure clinic are codes.

4.3 Orthopaedic/Spinal Themes

During 2015/16- 79.7% of cases were promptly resolved, 16.5% complex and 2.5% escalated to Formal Complaints. Thematic analysis revealed the main reasons for referral to Pals were:

- **Outpatient experience** (32.9%) and the main sub-subjects contributing to this were: (Communication 38.5%; Transport 23.1% and Cancellations 15.4%);
- **Admission/Discharge** (24.1%) and the main sub-subjects contributing to this were Communication 36.8%; Cancellations 31.6% and Care advice 26.3%)
- **Communication / Information** (10.1%) and the main subjects contributing to this were: Lack of communication with parents 75%; lack of communication between staff and teams 12.5% and Incorrect information 12.5%.

Overall there is an improvement in the types of queries that have come to Pals and in each subject there was an over decrease compared to 2014/415 by as much as 1/3 for outpatients.

Team Explanation: We are looking at tighter referral criteria. We are looking to recruit specialist physiotherapist and to support pre and post op discharge and rehab. We are looking to recruit an additional spinal consultant and orthopaedic consultant that specialises in CF.

4.4 Urology Themes

During 2015/16- 74% of cases were promptly resolved, 20.5% were complex and 4.1% were escalated to Formal Complaints. Thematic analysis showed the top three subjects for referral were:

- **Admission/Discharge** (31.6%) Reasons for this are: Cancellations 28%; Communication and letters 28% and Care advice 20%
- **Outpatient experience** (30.4%) Reasons for these are: Communication/letters (58.3%; cancellations 12.5% and seeking care advice 12.5%
- **Communication/Information** (7.6%) Reasons for this are: the lack of communication with parents (50%) lack of information 33.3% and lack of correspondence being sent out 16.7%.

Comparing to the preceding year admission related communication has increased but the communication regarding outpatient appointments, such as clinic letters, have remained the same.

Team Explanation: We are reviewing urodymanics service model. We are looking to recruit and additional urology consultant. We are looking to locate urology inpatient to a ward location with specialist nurses to assist with co-ordination and communication.

4.5 Rheumatology Themes

During 2015/16- 72.2% of cases were promptly resolved, 22.8% were complex cases and 2.5% were escalated to Formal Complaints.

- **Outpatient experience (43.8%)** contributing reasons for this subject are lack of communication and letters about outpatients 53.1%; seeking care advice 15.6%; cancellations 12.5% and transport 12.5%
- **Admission/Discharge (19.2%)** Reasons contributing to this subject are: Lack of communication about admission (35.7%); Transport 21.4% and Accommodation 14.3%.
- **Communication/Information (9.6%)** contributing to this subject is a lack of communication with parents 42.9%; and Breach of confidentiality 28.6% and Lack of communication between staff 14.3%.

Comparing the subjects to 2014/15 there has been an over 50% increase in the number of Pals cases about admission/discharge. The number of cases around outpatient experiences has remained the same.

Team Response: We are working to address recurrent issues in Rheumatology around telecommunications within the administrative team. We are also working to strengthen and build our shared care arrangements with local Trusts to streamline patient care. We have a strong multi-disciplinary team, and continue to work towards ensuring that patient pathways are communicated clearly to set appropriate expectations with patients and families from the outset.

5.0 Thematic analysis of February's data

During February all cases were also analysed thematically as well as the standard assigning a primary subject and assisting with all supporting queries. It was noted that out of 155 cases in February, 87 cases had multiple subjects and that the majority of the cases related to lack of information with families/other teams. Cases were around the need for regular calls to be returned, additional support if there was a cancellation either to an outpatient appointment or admission. Failure to arrange new admissions following a cancellation was a key theme, and for families who attended PALS following a cancellation of their appointment or admission part of the action plan back to the team was to ensure that a new appointment / admission would be arranged.

6.0 Social Media

There has been 46 contacts via various social media outlets. This includes a mixture of positive and negative reviews. All those who contact us via social media receive a response. During Q4 there was a campaign led by family and friends for a patient waiting for a BMT- this resulted in over 70 separate social media contacts about this case alone. All were responded to and the family were supported both by Pals and the clinical team.

7.0 Trust values

As part of the implementation of 'Our Always Values' Pals now log each subject raised within referrals against one of the Trust's Values. One aim of this is to provide data about how the Trust is performing in relation to 'Our Always Values' and to help identify more specific issues in relation to the communication issues that arise. This data is provided in the table below and relates to the absence of the values described.

Value	Number	%
Helpful - Reliable	230	21.6
One Team - Communication	165	15.5
Helpful - Understanding	127	11.9
Expert - Professional	121	11.4
Helpful - Helps others	104	9.8
Expert - Safe	61	5.7
Expert - Improving	55	5.2
One Team - Open	42	3.9
Helpful - Patient	37	3.5
Welcoming - Reduce waiting	34	3.2
One Team - Listening	25	2.3
Expert - Excellence	22	2.1
One Team - Involve	17	1.6
Welcoming - Friendly	16	1.5
Welcoming - Respect	5	0.5
Welcoming - Smiles	3	0.3
Totals:	1064	100.0

8.0 Same Sex Accommodation:
There was one incidence of same sex accommodation when a 12 year old female a patient was put on a mixed ward. This was addressed by the staff who arranged for the young person who has a cubicle.

9.0 Cases formally escalated to Complaints
52 cases were escalated to Formal Complaints. The top five specialties referred to formal complaints are: Gastroenterology (13.5%); Ophthalmology (7.7%); Cardiology (5.85); Endocrinology (5.8%) and Rheumatology (5.8%). The top reasons for escalation to complaints are: Outpatient experiences (30.8%); Staff attitude (17.35) and Clinical care (13.5%). This is an increase in the previous year

10.0 Compliments top three specialties: 37 compliments were made to Pals about a range of services at GOSH. We have included these in the quarter reports but the “top five” by frequency are below.

	%
Cardiology	10.8
Gastroenterology	10.8
Cardiac Surgery	5.4
Ear Nose and Throat	5.4
Neurosciences - Medicine	5.4

The top subjects that the compliments are based up are Clinical care (56.8%), Inpatient experiences (18.9%) and outpatient experiences (13.5%). Some of the themes for the compliments were old patients complimenting staff who cared for them whilst they were children and appreciation of consultants/surgeons.

11.0 Pals Evaluation
Each family who contacts the Pals department receives a questionnaire with a stamp-addressed envelope asking them for feedback and/or concerns yet to be resolved. Pals do this for each family we open a Promptly Resolved Case, Complex Case or a case that needed to be escalated to Complaints.

Pals receives about 5% back in response. The majority are positive and those that are negative are asking for further assistance.

Pals has looked at the Trust ethnicity data and Pals cases, against the designations on PIMs show the service to broadly mirror the range of communities the Trust serves.

Pals continues to be committed to providing a good service to all communities and this year has worked with the Learning Disabilities Lead Nurse to improve our service to be more welcoming and accommodating to children and to family members with learning disabilities as well as hosting the weekly “drop in” for those with learning difficulty concerns.

Great Ormond Street Hospital for Children NHS Foundation Trust

Friends and Family Test: Results for Q4 2015/2016

We received more than 20,000 comments via the Friends and Family test since it was established in April 2014. The response rate dropped significantly in August 2015 when day case patients were first included in FFT, however the response rate has recovered steadily since.

During Quarter 4, we have received 2,165 inpatient comments and 1,494 outpatient comments.

Friends & Family (FFT) implementation

Day cases are now included in FFT trust wide, including International Private Patients.

- The Information Services team are in the process of updating the internal reports to support improved timescales for FFT reporting to all wards and outpatient areas and to minimize error.
- The QI team have taken over the development of the new FFT database and have made excellent progress thus far. The system is currently being assessed on a number of wards for their initial comments, an official trial will commenced with roll out across the trust by June / July 2016.
- Database successfully tested on Patient Bed Entertainment System.
- Database successfully tested on internal iPads.
- Monthly FFT reports now available via the intranet.
- Live FFT response rate reports are available via the intranet.
- FFT stations are now available in all areas of the hospital, including the Activity Centre, Lagoon, Parent Accommodation, Patient Hotel, Physiotherapy and Radiology.
- Facilities team are testing the database on the Transport provider's iPads.
- Reports amended to reflect new divisional structure.

Actions to improve FFT data

- The new database will allow us to increase response rates to FFT by providing a variety of means for families to leave feedback.
- The new database will allow us to collect demographic information, including disability information in line with the demographics that will be used for Electronic Patient Records System.
- Work on-going with the Web Team to enable access to FFT database via the GOSH web page.
- Work on-going with the Digital Team to enable 'You said, we did' actions to be publicised on the website and social media. This will demonstrate to a wider audience the feedback we have received and the actions that have been taken as a result of FFT and encourage further feedback.

Real Time Feedback

The charity bid for the Real Time Feedback System has not been supported at this stage. Further information has been sent to GOSHCC highlighting the need for a real time system which will allow us to meet the Trusts strategic objectives. The Grants Committee will reconvene on 8th June 2016 a revised Trust bid will be submitted.

FFT Response Rate for Inpatient Areas

Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016
27.80%	28.30%	28.10%	29.70%	16.60%	13.30%	18.10%	21.00%	18.60%	22.80%	23.70%	26.10%

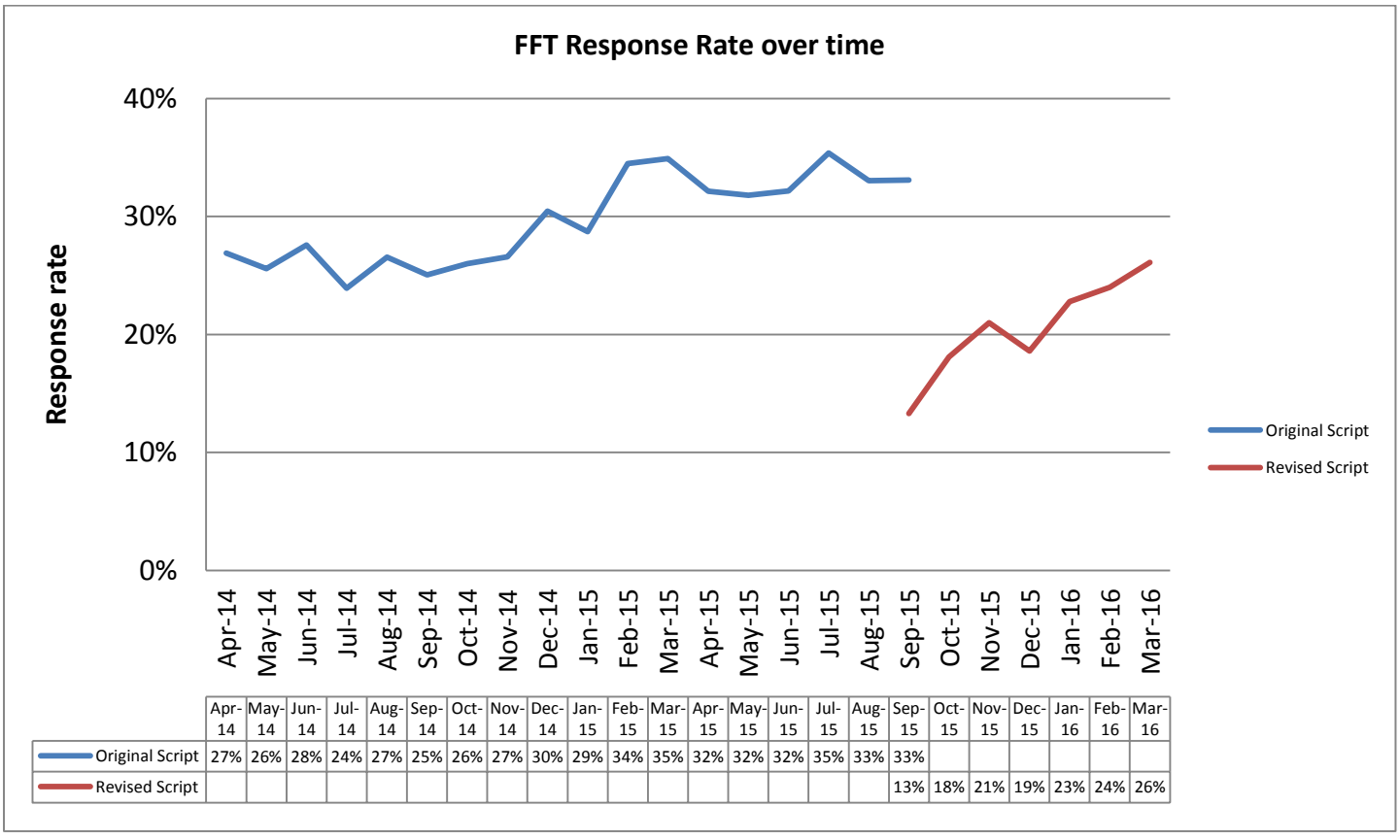
*Denominator derived from inpatient and day cases.

FFT Percentage to Recommend for Inpatient Areas

Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016
99.30%	97.96%	98.98%	98.82%	99.10%	98.20%	98.40%	97.86%	98.50%	99.50%	98.30%	98.74%

The following graph outlines the FFT response rate over time since April 2014:

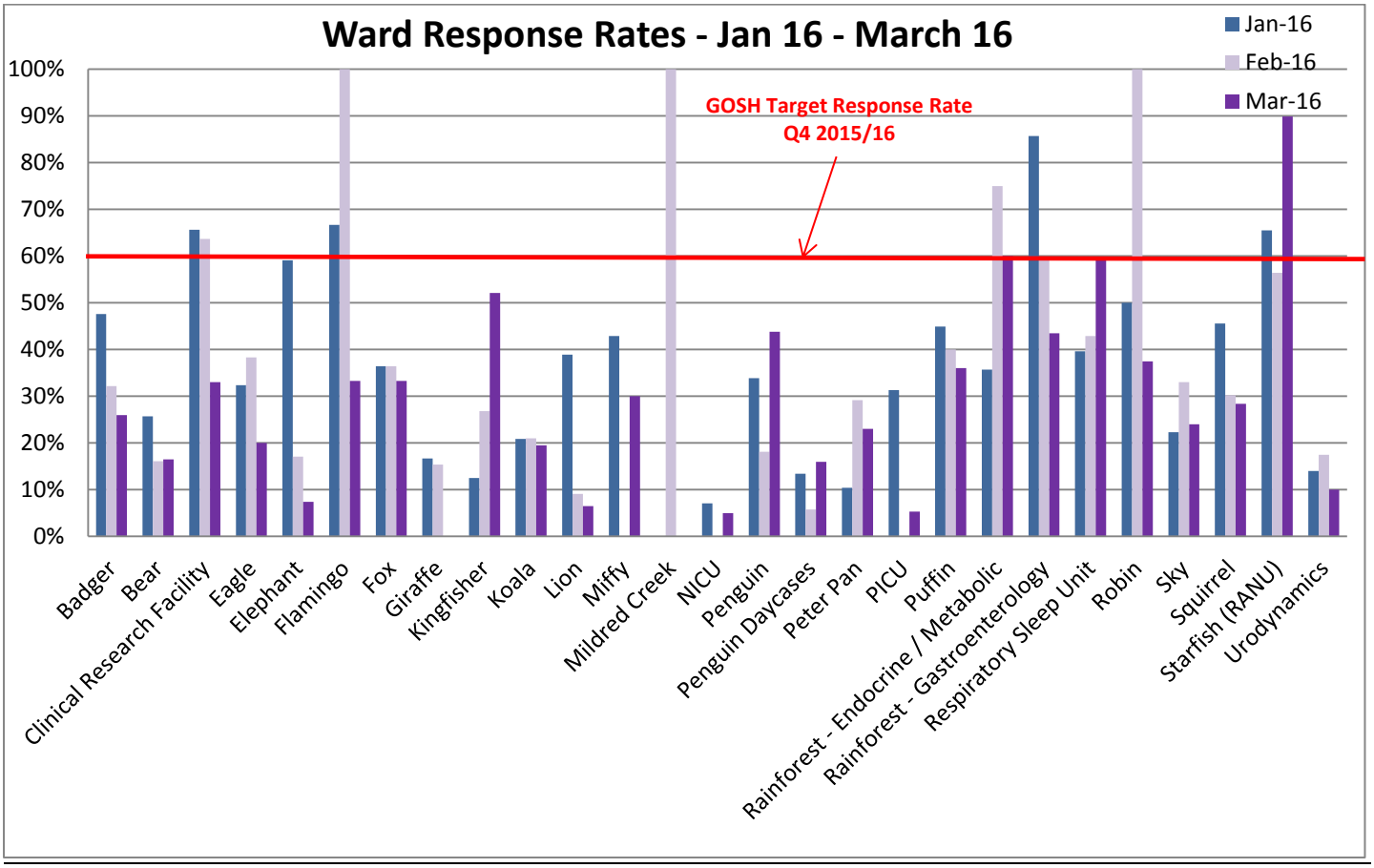
FFT Response Rate by Ward



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Original Script	27%	26%	28%	24%	27%	25%	26%	27%	30%	29%	34%	35%	32%	32%	32%	35%	33%	33%						
Revised Script																		13%	18%	21%	19%	23%	24%	26%

*****The revised script (technical coding) includes day case patients.

The following graph outlines response rate by ward in Q4 2015/16



Attachment Z

FFT in Outpatient Areas and Day Case Areas

	January 2016		February 2016		March 2016	
	No. of returns	% to recommend	No. of returns	% to recommend	No. of returns	% to recommend
Audiology	1	100%	7	100%	6	100%
CAHMS/ PANDA	36	96%	17	100%	28	96%
Cheetah	7	100%	33	94%	21	90%
Dental	42	100%	31	100%	43	100%
Haemophilia Centre	5	100%	3	67%	1	0%
Magpie	1	100%	6	100%	4	100%
Manta Ray	1	100%	0	-	2	50%
Radiology	16	100%	1	-	4	100%
Renal Outpatients	5	100%	3	100%	0	0
Rhino	17	94%	39	87%	34	100%
RLHIM Level 1	28	85%	38	97%	21	100%
RLHIM Level 2	297	99%	301	99%	157	99%
RLHIM Level 4	27	96%	16	81%	23	96%
Safari Outpatients	9	100%	6	83%	2	100%
Walrus	9	78%	6	100%	6	100%
Activity Centre	New stations have been installed in these areas				1	100%
Lagoon					6	83%
Patient Hotel						

FFT Percentage to recommend Outpatients Areas

Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016
95.6%	93%	94.5%	95.1%	97.1%	96.2%	97%	97.8%	95.8%	97.3%	97.1%	97.5%

Narrative from the FFT

Negative comments related to the following themes:

- Access / Admission & Discharge
- Catering
- Communication
- Environment and Infrastructure

"Things to improve: There is always a wait on arrival before somebody tells you the plan and shows you a bed. It would be great to know what you are waiting for when you arrive"

"Some lack of communication - told to reduce dosage of medication when it had already been reduced etc."

"Window broken, so there was a draft all night which makes the door rattle (we did get moved). Laundry Room could do with new machine"

"Beds are too small for my son, who is 15 and 5ft 10"

"On a general note, I think GOSH need to care for children seen by numerous departments on more MDT basis. I sometime feel my child is not seen as a child as a whole"

Positive Comments related to the following themes:

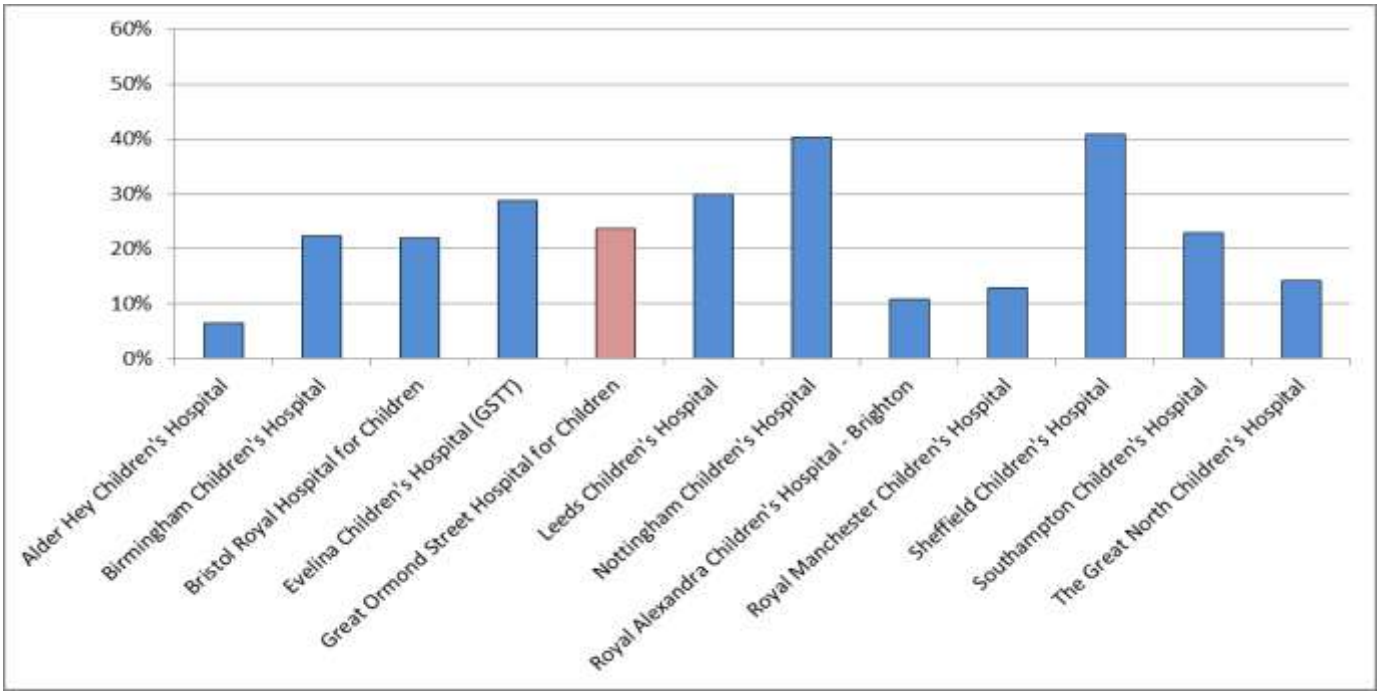
- Care
- Staff behaviours
- Welcoming

"Staff was brilliant with my daughter. We could not have asked for better care. Staff knew what they were doing, were very knowledgeable. Supported myself and my daughter 100% - Cannot praise them enough"

"We just cannot fault the care and attention our daughter has received on this (and every visit) to GOSH. You are all truly remarkable people, and everyone at GOSH contributes to helping us, as parents, and our daughter, deal with a situation that is at times both distressing and emotional. Thank you!"

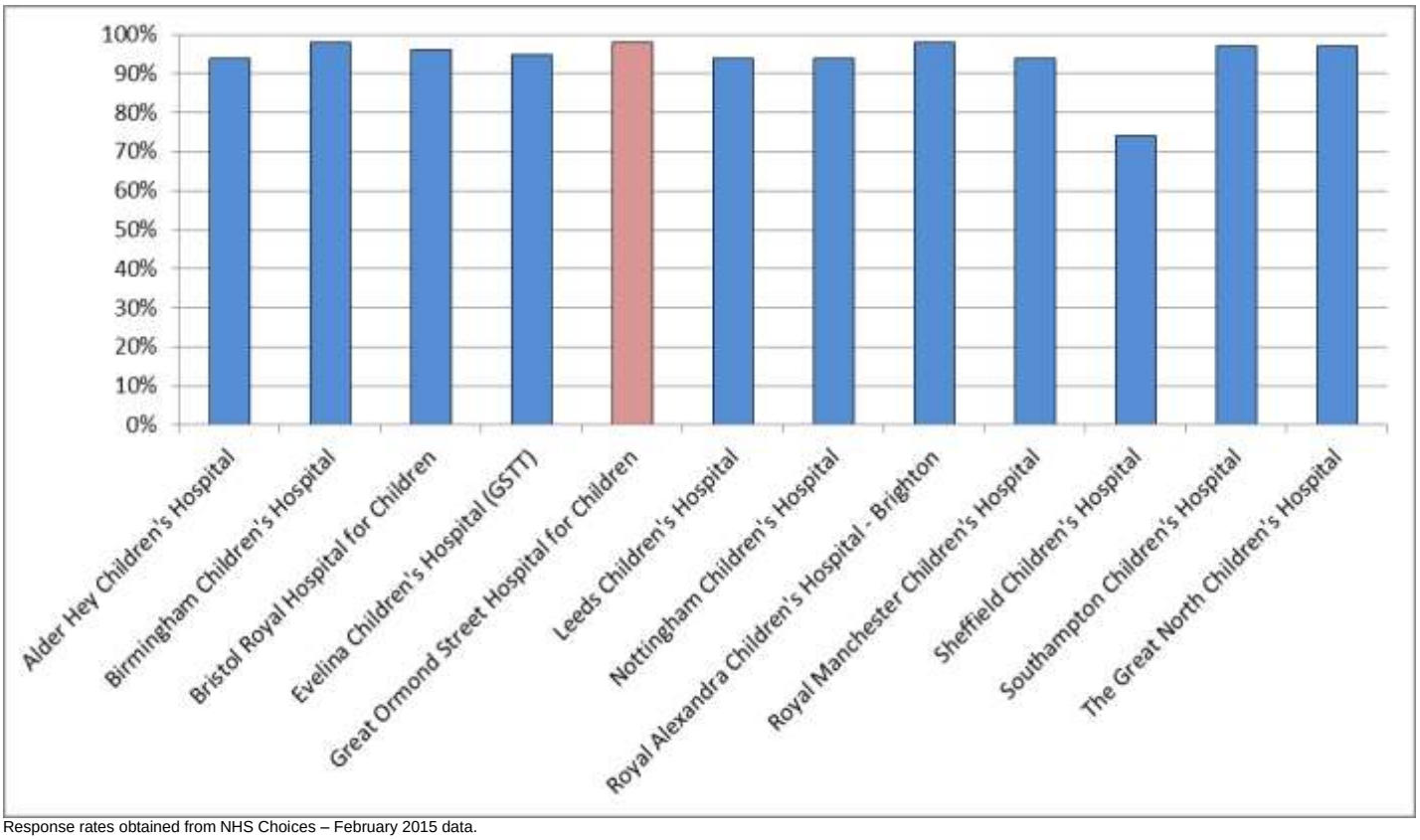
"Staff were very friendly and helpful and made us feel welcome and at ease"

FFT Response Rates Other Trusts



Attachment Z

FFT Percentage to Recommend Rates Other Trusts



Response rates obtained from NHS Choices – February 2015 data.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 20th May 2016	
Staff Friends and Family Test results – Quarter 4 2015/16 **Submitted by:** Director of HR&OD	**Paper No: Attachment 1**
Aims / summary To provide a report of latest Staff Friends and Family test results and actions	
Action required from the meeting To note the actions	
Contribution to the delivery of NHS Foundation Trust strategies and plans Staff FFT is an NHS England requirement and allows the Trust to monitor staff satisfaction and awareness of Values and Vision in-year.	
Financial implications None	
Who needs to be told about any decision? Feedback is communicated to staff	
Who is responsible for implementing the proposals / project and anticipated timescales? Assistant Director of Organisational Development	
Who is accountable for the implementation of the proposal / project? Director of HR&OD	

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street Hospital for Children NHS Foundation Trust

Paper to the Trust Board from the Director of HR&OD
May 2016
Staff Friends and Family Test results – Quarter 4 2015/16

Introduction and background

GOSH surveys a third of its staff each quarter for the Staff Friends and Family Test. In quarter 3, the annual staff survey replaces Staff FFT.

The national survey is made up of two questions which ask staff if they would be likely to recommend GOSH as a place to be treated, or as a place to work. In addition, GOSH has added specific questions relating to Our Always Values and the GOSH vision.

Results

Over 600 staff completed the survey in quarter 4 2015/16.

Recommending GOSH as a place to be treated and as a place to work

	Q1 2014 GOSH	Q2 2014 GOSH	Q4 2015 GOSH	Q1 2015 GOSH	*Q2 2015 UPPER QUARTILE FOR NHS TRUSTS*	Q2 2015 GOSH	Q4 2016 GOSH
Recommend for care	95%	94%	94%	94%	***86%***	96%	95%
Recommend as a place to work	70%	74%	73%	71%	***70%***	71%	74%

The data indicates a consistency of scoring across the two questions. GOSH is within the upper quartile of all NHS trusts for scores in both questions, but staff score the Trust particularly highly as a place to receive treatment.

Narrative from staff

Staff are invited to give reasons for their responses. The survey provider is currently developing a tool to provide basic sentiment analysis so that themes can be identified, but currently all comments are reviewed by the Assistant Director of OD. Representative comments for each question in Q4 are:

Would you recommend GOSH as a place to be treated?

- Very knowledgeable and professional team of staff. Want the very best for our patients and families. Very caring.
- On the whole I think the care and treatment is excellent, though the communication between departments (when children are being treated by different teams) could be better

Would you recommend GOSH as a place to work?

- Very good colleagues, extremely supportive work environment, very interesting work - I learn something new every day.

- Interesting place to work, but poor systems and processes and large turnover of staff make for a stressful work environment

Awareness of Our Always Values and Trust Vision

Question	Base	% score	Target	Target met	Change vs. last quarter	Lowest (to date)	Highest (to date)
I am aware of Our Always Values - Always Welcoming, Always Helpful, Always Expert, Always One Team	637	97%	N/A	N/A	0%	93%	97%
I see staff at GOSH demonstrating Our Always Values in how they behave	635	81%	N/A	N/A	6%	75%	81%
I know what the GOSH vision for 2020 is	627	42%	N/A	N/A	-5%	42%	47%
I understand how my work contributes to acheiving the GOSH vision	632	65%	N/A	N/A	-2%	63%	67%

- The questions relating to Our Always Values continue to show a very high level of awareness of Our Always Values, which were launched in March 2015.
- Comments relating to this question suggest that staff are largely very supportive of Our Always Values and recognise their importance in both how we deliver care and how we work with each other. However, there is a clear theme that the behaviours which underpin the values are not always displayed by all staff.
- There has been much less communication with staff on the GOSH vision, which is reflected in the lower awareness levels. Staff often express a desire to know more and be involved in developing and delivering the vision.

In both cases, a consistent theme in feedback is the importance of leaders at all levels of the organisation acting as visible role models and communicating with staff.

Next steps

- The results of the survey have been publicised in the Executive-led all staff briefings, and will appear in Roundabout. Messaging makes the connection between the feedback given by staff and major improvement work such as divisional reviews (reducing silo working); and EPR (improving systems and processes).
- Divisional and Directorate-level feedback (which includes staff comments) is being sent to the respective management teams to allow them to develop local responses or inform existing workstreams
- At a corporate level, the results and comments inform ongoing work on Our Always Values; leadership development programmes; and a review of internal communications.

Action required

The Trust Board are asked to note the results of the Staff Friends and Family test and the actions outlined above.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 20th May 2016	
Annual Complaints Report 2015-16 **Submitted by:** Juliette Greenwood, Chief Nurse	**Paper No: Attachment 2**
Aims / summary This report provides an overview of the complaint activity over the year, including information regarding: • Trends in the complaint numbers and grading's • Complaint themes • Learning from Complaints • Re-open complaints • Parliamentary & Health Service Ombudsman • Monitoring of the complaints process	
Action required from the meeting This report is for information only, however if further information is required Board Members can contact Donna Robinson, Patient Safety and Complaints Manager, donna.robinson@gosh.nhs.uk or 0207 813 8402	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Trust has processes in places to ensure that patients and their families know how to access the complaints team and to ensure they are listened to and responded to effectively and efficiently.	
Financial implications	
Who needs to be told about any decision? Donna Robinson, Patient Safety and Complaints Manger	
Who is responsible for implementing the proposals / project and anticipated timescales? Donna Robinson, Patient Safety and Complaints Manger	
Who is accountable for the implementation of the proposal / project? Juliette Greenwood- Chief Nurse	

Great Ormond Street Hospital for Children NHS Foundation Trust

Annual Complaints Report
April 2015- March 2016

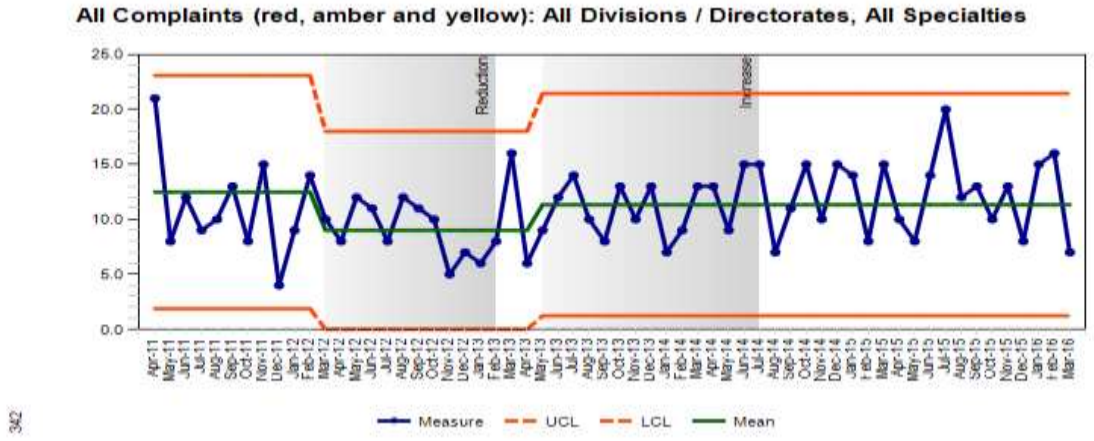
1.0 Summary of key points

The key points identified from this report are:

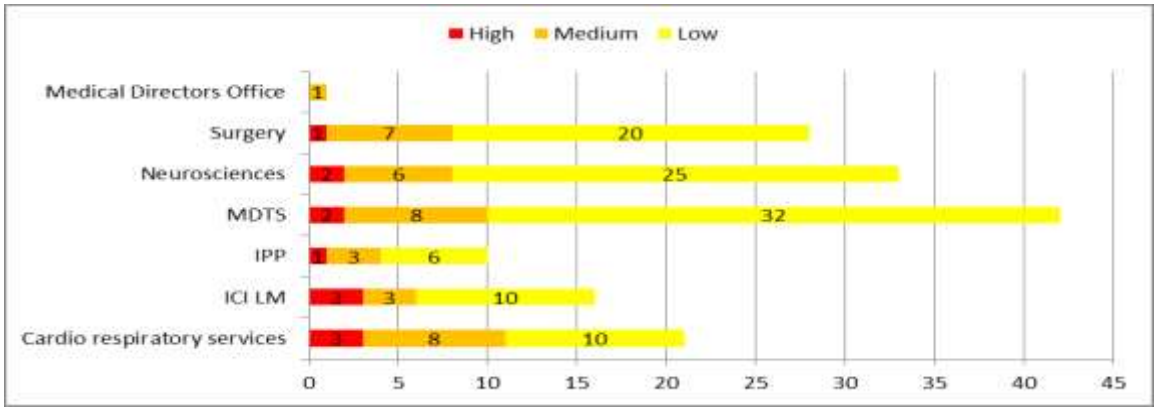
- 151 formal complaints were investigated in 2015-2016 in line with the NHS complaints regulations. This is a 5% increase from the previous year.
- Twelve complaints were graded as red, this is a 25% decrease compared to the number of red complaints in 2014-2015.
- 60% of complaint responses closed between 1 April 2015 and 31 March 2016 were sent out within agreed timescales. 48% of draft reports were received by the complaints team on time from the lead investigator.
- The themes raised within complaints include a lack of communication with parents, the gastroenterology service and outpatient experience.
- Six investigations were completed by the Parliamentary and Health Service Ombudsman during the year, five were not upheld and one was partially upheld.

2.0 Formal complaints investigated by the Trust

The Trust investigated 151 new complaints in 2015-2016 in line with the NHS complaint regulations, compared to 144 in 2014-2015. There was an overall 5% increase in formal complaints this year compared to last year. The chart below demonstrates the trends for the number of formal complaints received by the Trust since April 2009.



3.0 Number of complaints received by division and grading



The complaints were graded using the Trust risk grading protocol as detailed within the complaints policy.

Of the 151 complaints received:

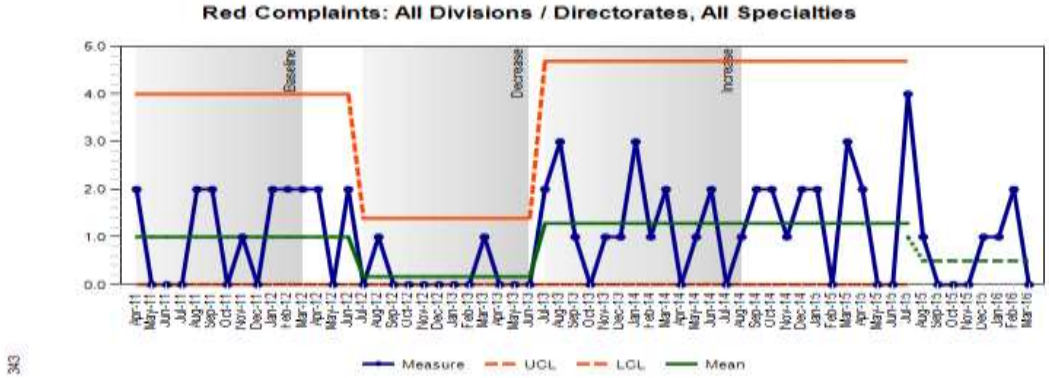
- 12 were graded as red (high)
- 36 were graded as amber (medium)
- 103 were graded as yellow (low)

The overall number of complaints increased this year however the number of complaints graded as red decreased 25%. The increase of complaints was reflected in the complaints graded as yellow (13% increase on last year's complaints graded yellow).

3.1 Red complaints

There were no reoccurring themes from the 12 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.

3.2 Trends for the number of red complaints received



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	42	128918.98	0.33	29.5%
Surgery	28	182875.12	0.15	13.8%
Neurosciences	33	111946.76	0.30	26.6%
ICI-LM	16	148024.32	0.11	9.8%
Cardio-respiratory	21	286511.56	0.07	6.6%
IPP	10	65902.30	0.15	13.7%

***During 2015-16, there was one complaint (logged under the Medical Directors Office) which is not in this table as there are no comparable bed days.**

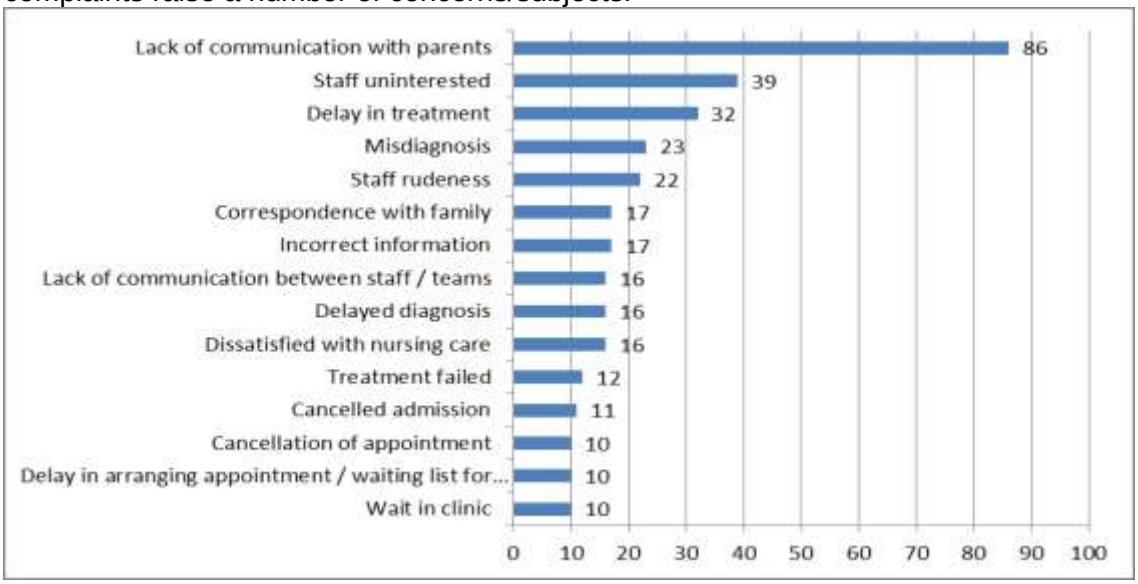
Adjusted Patient Activity is a measure which weights outpatients, inpatients and critical care bed days into a combined figure representative of overall healthcare resource activity. For example on average an inpatient requires more input than an outpatient and thus several outpatients will be the equivalent 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

60% of complaint responses closed between 1 April 2015 and 31 March 2016 were sent out within the timescale agreed with the family which is a decrease from last year. (48% of draft reports were received from the investigating staff on time). All complainants were kept informed and advised of the reasons for the delay in being sent the completed investigation response; new timescales were discussed and agreed with the complainant. The Complaints Manager and the Head of CGST are currently reviewing the capacity within the Complaints team to ensure the level of support offered to the Divisions is adequate.

6.0 Trends and Themes

Subjects most commonly raised in complaints in 2015-2016, please note some complaints raise a number of concerns/subjects.



Lack of communication with parents

This concern remains as the top issue in complaints and was raised in 86 of the 151 complaints received this year. This represented 57% of all complaints received which remains similar to last year (55%).

This subject covers a range of communication issues, some examples of the concerns raised included telephone calls not being responded to promptly, families not informed of cancelled appointments and delays in being sent clinic letters. Concerns relating to a lack of communication concerning waits in clinics and cancelled appointments were also raised as a theme in complaints – this is expanded upon below.

Since quarter 2 this year the Trust has started to log subjects raised within complaints against one of the Trust values. One aim of this is to provide more meaningful data and to try and identify more specific communication issues – please see the complaints quarterly reports for this data.

Although a number of actions have been taken within teams, specialities and divisions (please see section 8 for examples) this data would suggest there is more work needed.

Gastroenterology

Analysis of the 2015/16 complaint data at speciality level identified a theme in the number of gastroenterology complaints being raised. Throughout the year 22 complaints were raised which represented 15% of all the Trust complaints.

The concerns raised within these complaints included: poor and a lack of communication with parents, misdiagnosis, delayed diagnosis, staff uninterested and cancelled outpatient appointments.

The Trust is dedicated to listening to and learning from complaints and taking appropriate actions when gaps in our processes or themes have been identified. It is good practice to invite a review of services by other specialists in the same clinical area from other parts of the UK or internationally to help drive forward improvements and ensure best care. The Trust invited a review from the Royal College of Paediatric and Child Health of our Gastroenterology service.

Following the findings of the Royal College of Paediatric and Child Health, and taking the learning from the themes of the complaints received, a gastroenterology review group has been created which is led by a Programme Manager. This includes a review of how care is being managed and the themes detailed above will be reviewed as part of this work. In addition a new complaints co-ordinator has been recruited to support the service in fully investigating all complaints and in turn ensuring that family's questions are answered and concerns addressed.

Outpatient Experience
Concerns regarding outpatient experiences were raised throughout complaints this year. These were identified in a number of themes as follows:

Delays in arranging appointments
A theme has been identified within complaints this year concerning delays in arranging appointments. Families reported long waiting lists which have resulted in follow up appointments taking place months after they should be and a lack of cross covering for staff which has resulted in delays (weeks) in arranging appointments. A link was also established between families reporting de*lays in treatments* as detailed below.

Delays in treatment
32 of the 151 complaints received (21%) raised concerns relating to delays with treatment. There was a link to families who reported that their child's treatment was delayed as a result of cancelled appointments and delays in arranging appointments.

Lack of communication regarding waits in clinic and cancelled appointments
A lack of communication with parents was raised in 57% of all complaints received this year. The data also shows themes with regards to a lack of communication regarding both cancelled appointments and waits in clinic (13.5% of all complaints).

This includes concerns raised from families who have arrived for appointments which have been cancelled without the family being informed, families being informed of the cancelation by post after the appointment date and cancellations of the same appointments many times. Families also raised concerns that outpatient clinics have long delays, clinics are very over-crowded and the reasons for these delays are not communicated by staff.

Improving Access to Outpatient Pan Trust Project
This project is currently in place and aims to improve the outpatient experience for families**.** Key areas of focus:

- Communication of appointments which includes a review of all outpatient clinic letters
- Booking of new and follow up appointments:
    - streamlining processes across the hospital

  - paperless system to request follow ups which enables services to have better oversight of appointments needing to be booked and reduces the risk of not following up these appointments
  - Assessment and prioritisation of referrals (including having data which allows monitoring of the patient pathway
- Maximising space allocation of outpatient clinics and reducing over crowding

7.0 Learning from complaints

The Trust is committed to listening to 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 where actions are identified from complaints there is assurance that they are completed and are effective. Examples of learning are:

Details of Complaint: Following bladder augmentation surgery, the right uretic stent became clamped, leaving the patient in pain for some hours
Outcome/Actions: Following this incident, it was decided by the Urology team to change the bags used in stent drainage to a type of bag which does not contain a valve between the stent and the drainage bag, which will prevent this reoccurring in future. Nursing staff have been provided with guidelines and photographs to show the correct way to place the new bags.

Details of Complaint: Patient had two incidents of air in the line during BMT transfusions. On the second occasion the line was damaged, leading to loss of cells.
Outcome/Actions: Following this incident, the Trust has changed its use of transfusion lines so that a Y-Connector will be placed at the end of the transfusion line, between the line and the patient's Central Venous Catheter (CVC) or Hickman Line. This will allow any trapped air in the line to be withdrawn without disconnecting the line. All staff have been instructed in the use of Y-Connectors, which do not carry the same risk as the discontinued three-way taps, but do allow air to be withdrawn safely. The Trust was unable to identify a reason for these incidents but continues to monitor this which includes a regular meeting with senior nursing staff and the Chief Pharmacist. This issue was raised at the Patient Safety and Outcomes committee and an internal patient safety alert was devised and shared with ward teams.

Details of complaint: Patient suffered a prolonged seizure during telemetry testing as there was a delay in obtaining rescue medication

Actions taken

- Prior to the Telemetry tests commencing, nursing staff will ensure that the required seizure rescue medications are prescribed on the paper and electronic systems to ensure that staff are clear regarding the management plan for the patient
- If the rescue medication/intervention is not working, this will be promptly escalated to senior staff and the plan will be revised
- Staff have been reminded to record parental concerns regarding medication and to ensure that this is taken in to consideration
- All staff on the Ward will undergo further training on emergency seizure management and escalation

Audit of the recommendations took place in February 2016, and showed that the recommendations have been met and are effective. This will be re-audited to ensure sustained change.

Details of complaint:
Parent raised concerns that she was not informed for over a year that her child had an antibiotic resistant gram negative organism and that the family were very shocked when the patient was then isolated in an outpatient appointment with no prior explanation given.

Outcome/actions
Prior to the complaint the Trust Infection Control team only sent letters out to inform parents of MRSA positive results after they are discharged and they copy in the GP if they are resident in the UK.

Since receiving the complaint the Infection Control Team met to undertaken a review of the current process for communicating positive results. It was agreed during this review that the Infection Control Team will be implementing the same process we have for MRSA results by 30 September 2015. This process means that positive results will be called through to the ward and the nurse in charge or looking after the patient is informed of the result. They are asked to communicate this to the clinical team and patient/family and provide them with the patient leaflet. For outpatients the Infection Control Team will write a letter informing the family of the result and explaining what they mean. As well as providing them with an information sheet and sending an update to the GP and to the consultant.

An audit of the Infection Prevention and Control database showed that all patients who were eligible to receive letters had them sent.

8.0 Re-opened complaints

Of the complaints closed this year, 17 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.

9.0 Parliamentary and Health Service Ombudsman

The Parliamentary and 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. Six investigations were completed by the Health Service Ombudsman this year and one additional complaint has been referred to the Ombudsman and is still under investigation. These are detailed below.

Ref	Brief Description	Current Status

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 and queried if this impacted on their child's treatment.	This case was originally closed by the Ombudsman as the family had an alternative legal remedy. However the family then returned to the Ombudsman requesting a different outcome. Ombudsman concluded that the Trust had fully investigated and there were no concerns. Case closed and not upheld.
13/012	Family raised concerns that delays to treatment could have contributed to their child's death.	Ombudsman concluded that the Trust had fully investigated and there were no concerns. Case closed and not upheld.
13/025	Complaint about care and treatment during admission, including concerns about consent and staff attitude.	Ombudsman concluded that the Trust had fully investigated and there were no concerns. Case closed and not upheld.
13/078	Family raised concerns that their child's health became worse under the care of GOSH.	Ombudsman concluded that the Trust had fully investigated and there were no concerns. Case closed and not upheld.
14/103	Concerns were raised by the parents regarding the number of attempts to insert a butterfly needle.	Ombudsman concluded that the Trust had fully investigated and there were no concerns. Case closed and not upheld.
12/041	Family raised concerns about the decision to proceed with treatment and a procedure under GA.	The complaint was partly upheld due to concerns regarding limited documentation in the records. Appropriate actions took place. The PHSO asked the Trust to reconsider the decision not to pay financial compensation however the Trust has been notified that the family are seeking alternative legal remedy.
14/110	Family raised concerns regarding the treatment that the patient received on NICU and queried if/how this impacted on their child's death.	The Trust received notification that the Ombudsman would be investigating the complaint papers have been provided to the Ombudsman.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th May 2016**	
Safeguarding Annual Report 2015-16 **Submitted by:** **Juliette Greenwood-Chief Nurse**	**Paper No: Attachment 3**
Aims / summary Provide a summary report of Trust progress, activity and achievements 2015-2016 and the identify challenges and priorities for 2016-2017.	
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), Camden Safeguarding Children Board and Camden Clinical Commissioning Group for Trusts to provide a Child Protection Annual Report.	
Financial implications None	
Who needs to be told about any decision? Juliette Greenwood – Chief Nurse and Executive Lead for Safeguarding	
Who is responsible for implementing the proposals / project and anticipated timescales? Juliette Greenwood- Chief Nurse and Executive Lead for Safeguarding	
Who is accountable for the implementation of the proposal / project? Juliette Greenwood-Chief Nurse - Executive Lead for Safeguarding	

Great Ormond Street Hospital for Children NHS Foundation Trust

SAFEGUARDING OUR CHILDREN and YOUNG PEOPLE

ANNUAL REPORT 2015-2016

By

Juliette Greenwood - Chief Nurse & Executive Lead for Safeguarding

EXECUTIVE SUMMARY:

Collaborative working between Social Work and Safeguarding Teams has led to improved management of cases.

Numbers of staff receiving Safeguarding supervision from The Safeguarding and Social Work teams has increased by 43%.

Child Protection Conference contributions by staff have increased by 37%.

GOSH Social Work Service has seen an increase in Occasions of Service by 12%.

PREVENT training is well established with an increase in staff trained to facilitate Level 3 sessions.

CONTENTS

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 01/04/2015 – 31/03/2016.

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 (whole time equivalent)
- Named Doctor: Interim post 8 hours or 2 programmed activities (PAs); (establishment 4 PAs).
- Band 7 Specialist Safeguarding Nurses (2 part time posts) 1.1 WTE of which 0.1 WTE is part of a 6 month secondment.
- Senior Safeguarding Team Administrator 1 WTE
- Junior Administrator 0.7 WTE

The resources of the team have remained under considerable pressure throughout the year, largely due to the additional training sessions required to ensure the workforce remains competent in Safeguarding Children and The Prevent Strategy, the reduction in hours provided by the on-going interim arrangement for the Named Doctor role and contribution to Serious Case Reviews (SCRs).

As a tertiary specialist centre providing care for children across the country, the organisation can have an apparent disproportionate involvement in SCRs due to the nature and high numbers of children that we see.

In line with the Lampard recommendations (R5) an internal review of the safeguarding resource to meet the increased complexity of the case load has been undertaken, of the Safeguarding Team and the recommendations are currently under consideration by the Executive Team prior to presentation to the Trust Board.

The Trust recognises the difficulties experienced by the on-going interim arrangements for the Named Doctor for Safeguarding and as such has included the issue on the trust-wide risk register.

In addition to the provision of data to our external regulators and mandatory reporting to NHS England on Female Genital Mutilation (FGM) and The Prevent Strategy, the team have been reporting on their activities since 01/07/2015, to assure the Trust's internal governance structure.

The team have been involved in 491 cases during this period.

GOSH Social Work Service:

The service consists of a new Head of Profession / Service post, 5 senior Social Work(SW) practitioner (clinical / management posts), 14 .5 SW WTEs, 1 Family Support Worker, 2 Family Support Officers and 1 Psycho-Social Liaison worker. A successful recruitment of 4 new social work posts has completed a full establishment of staff.

The service is funded largely from the GOSH charity with a dedicated CLIC (Cancer and Leukaemia in Childhood) Sargent Service that works as part of the social work service but with a particular remit. Of the total composition of the social work service 4.5 FTE posts are funded by CLIC and this includes a dedicated senior practitioner. There is a service level agreement which requires this service to be overseen by the GOSH Head of Social Work.

The social work service is ensuring it maintains links with the local authority to ensure that GOSH takes account of developments within the social work profession. Consideration is currently being given to on-going training of the GOSH social work service in line with the new model of practice that is being developed within Camden to introduce systemic practice.

The service is also relooking at the current recording practice to ensure that we are compliant with social work professional standards and as part of this we are undertaking an audit to identify any areas requiring improvement. We are also ensuring that all staff within the service have updated their Camden local authority Child Protection (CP) training.

The Social Work service at GOSH provides support to all wards and units within the hospital, operating a 9-5 duty service which ensures that there is always a social worker and a senior practitioner available. When any member of staff identifies child protection concerns, they make an electronic referral to the Social Work Service.

The Social Work and Safeguarding teams have worked closely together to ensure that there is an integrated response to referrals identifying safeguarding /child protection concerns with information being shared routinely across both teams.

There were 2,139 referrals made to the Social Work service in 2015/16, a 15% decrease compared with 2014/15 (perhaps explicable in part because of a high level of staff vacancy during the period). However, there was an increase of Occasions of Service of 12% to 15,625. (Occasions of Service are any significant instance of professional social work activity relating to a particular patient – examples would include telephone calls, emails, report writing, assessment interviews and so forth). Additionally, 361 cases, or 17%, raise concerns about Child Protection, suggesting a 6% rise in the number of CP cases referred.

Work is being undertaken to improve the efficiency and reliability of data collection across the department – in common with other areas in the trust. There are several different software systems deployed into which data is inputted by, or gleaned from, which future data management solutions are seeking to simplify.

Internal Safeguarding Governance Structure

The Safeguarding Children Group (SCG) meets six weekly and is chaired by the Chief Nurse or her deputy. 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.

Within the past year the group has focussed on

- further increasing electronic and written referrals to social work
- an improvement project regarding reports for child protection conferences
- the development of a Safeguarding Multi-Disciplinary Team template to ensure consistency across the divisions
- expanding supervision
- developing care bundles for medical management pathways

The Clinical Governance Committee (CGC) receives quarterly reports from the Safeguarding and Social Work Teams, outlining the breadth of safeguarding activity delivered within the Trust and providing assurance of compliance against required standards and statutory framework.

Patient Safety Outcomes Committee (PSOC) receives reports quarterly from the Safeguarding Children Group in relation to identified areas of learning for the Trust. A presentation was delivered on learning from recent SCRs that GOSH have been involved with.

3.0 ACHIEVEMENTS AND ACTIVITIES:

Performance against key priorities for 2015 / 16 - Action Plan update

Action last report	Report
Achievement of external regulatory and contractual standards required by CQC; Camden CCG;NHS England.	*The Trust provides assurance to the commissioners for safeguarding in both NHS England (London region) and Camden Clinical Commissioning Group*. **CQC** The Trust participated in an inspection in April 2015. The report noted that staff demonstrated good knowledge of safeguarding procedures and were aware of their role and responsibilities at all levels, providing excellent examples of recognising and reporting abuse across the divisions. **Camden Clinical Commissioning Group. (CCG).** The Trust reports quarterly on monthly activity in relation to standards required by Camden CCG in each of the required areas, training, supervision, CP Conferences and audit.

	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. The team have been working with our Learning and Development Department and external contractors to develop a bespoke e learning modular programme. This will help to alleviate some of the demand created by the high numbers of staff who require updating in the next year. The training figures as at 31.03.2016 were: Level 1 – 82.3% Level 2 – 69.7% Level 3 – 80.4% (Data for levels 1 and 2 can only be provided up until 11/03/2016 having been frozen due to implementation of the new reporting system and can only provide a partial picture). GOSH has now identified all staff who holds an honorary contract with the organisation, facilitating the monitoring of their mandatory Level 3 training compliance. The current figures for Level 3 at 31.03.2016 are ; 73 % for ICH Consultants 39% for non ICH Consultants The way in which training figures are now being reported has led to an apparent drop in numbers. To ensure that the Trust maintains a high level of compliance above that of the 80% NHS England requirement, an increase in the number of training sessions is being offered at all levels, which will be achieved by increasing the external trainer input as well as utilising the broader pool of trainers to deliver the PREVENT component of the session. **Prevent training** Awareness of the PREVENT agenda is incorporated into all levels of safeguarding training, and the Trust has currently trained 31 members of staff to facilitate the training. The numbers of staff who have received training to in the past year are; Basic Awareness: 718 (17%) Workshops to raise Awareness of Prevent: 619 (28%). In addition a Prevent Policy has been ratified which clarifies staff roles and responsibilities. The Safeguarding Newsletter and webpages ensure that staff is updated regularly. **Safeguarding Adults** As of 11.03.2016 compliance at Level 1 is 84.7%. (Data can only be provided up until this date having been frozen due to implementation of the new reporting system and can only provide a partial picture). Following the introduction of the Care Act 2014, and the

	forthcoming publication of the Adult Safeguarding Intercollegiate Training Competencies document for Healthcare Staff, appropriate professionals will be required to complete an additional enhanced level of training, which will be achieved through e-learning or face to face sessions. **Themed Study Days** Key topics are explored in greater detail with subject matter experts on study days and are predominantly influenced by factors identified within serious case reviews as well as national issues. Training days have been held on Child Sexual Exploitation, Perplexing Presentations, Fabricated and Induced Illness and Neglect. Cultural Awareness sessions are delivered externally. A Domestic Violence and Abuse themed day has been planned for the latter part of this year. **Supervision to ensure identified health practitioners receive regular structured safeguarding supervision.** The Safeguarding Team works with Social Work and Psychology and provided 120 sessions (involving 810 staff) of Supervision activity in 2015/16. The team have offered drop in sessions for staff but these have a disappointing attendance and organised group or ad hoc sessions appear to better meet the needs of the workforce. Despite only a small increase in the number of sessions, the numbers receiving supervision has increased by 43%. **Monitor and evaluation of Professional input to CP Case Conferences** The prediction of the number of invitations to Child Protection Conferences is difficult. The Trust received 74 invitations to Initial or Review Conferences. Of these, 11 were attended by staff and 63 had reports submitted. Attendance is limited by geographical constraints and demand on available resources. An improvement project has been undertaken to develop a more user friendly conference template to facilitate the sharing of relevant information with external professionals. There has been an increase in notifications of conferences of 37% within the past year, most likely due to the increased awareness of staff through training and the oversight from the Safeguarding Team. **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. **Camden Safeguarding Children Board (CSCB)** GOSH completed a Section 11 audit in compliance with CSCB request. There was provider participation incorporated into Board

	scrutiny panels to which the Trust responded and provided a satisfactory response. **CSCB meetings 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 2015/16. **Mandatory reporting:** **Female Genital Mutilation (FGM)** Quarterly data has been provided to NHS England. The Trust has had 4 concerns raised about the possibility of FGM, 2 of which have been confirmed. **Prevent** The mandatory reporting of concerns and training compliance commenced in July 2015 to NHS England who in turn report to the Home Office. There were 9 enquiries to the Safeguarding Prevent Operational Lead, of which 2 were referred to the Channel Coordinator. There was no further action undertaken in either case.
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. The quarterly audit considers the care and experience of our patient's for which Child Protection concerns have been identified. During the year the audit has demonstrated an increased compliance from 78% - 92% with all standards pertaining to child protection referrals made. Additional checking processes were introduced successfully from August 2015 to the process of reviewing CP referrals requiring an alert for professionals to be added. Subsequently all alerts have been actioned in a timely manner. 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. An audit is underway in April 2016 to evaluate understanding of professional awareness of key learning points. GOSH have no relevant cases from which to contribute in the past year to the Camden LSCB Multi Agency Audit Process.
Effective multi agency working.	The Safeguarding and Social Work Teams have met daily to achieve and maintain the safety of children through a high level of collaborative working and information sharing to promote better

	outcomes.
Managing complex cases	The complex cases seen at GOSH are not infrequently known to multiple medical teams. The team have been working proactively with consultants, to review the process of specialities' closure of cases when they no longer need to be seen at GOSH, to ensure that families and local services know about the discharge from this speciality. This has arisen in response to enquiries from professionals external to GOSH.
Care Bundles	The Interim Named Doctor has worked with the Safeguarding Team to develop pathways in order to ensure medical professionals are consistent with best practice in managing safeguarding concerns for children on key areas of child abuse and neglect, to promote the best possible outcome for children, promote documentation use of body maps and medical illustration with a medical plan depending on the type abuse. The Pathways have been written in conjunction with RCPCH Child Protection Companion 2013. They will be appendixed to the Safeguarding Children and Young People Policy.
Establish involvement in CP Information Sharing Project CP-IS	The Trust has agreed the need to participate in the project. GOSH is working with the IT department to resolve some issues which have led to delay.

Case Reviews and Serious Case Reviews

The Trust has contributed to 10 Serious Case Reviews (SCR) over the past year, involving 12 children and one young adult.

Staff who are involved in the reviews are offered optional support, by the Trust, due to the stressful nature of the process.

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 these are 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.
- Raising awareness of staff to manage and escalate any child protection concerns appropriately.
- Managing cases with primary and secondary care providers where there is parental non engagement and compliance.
- Accessibility for staff to receive supervision by varying methods of delivery from the Safeguarding and Social Work teams.
- Themed training days provided on perplexing presentations, neglect, sexual abuse identified from SCRs.

Reviews not meeting SCR threshold

There has been one review that did not meet the threshold for a Serious Case Review, to which GOSH was represented at a multi-agency event.

Chronologies

The Trust has received 19 external requests to contribute to comprehensive chronologies for children, which have been completed, representing an increase of 27%.

Risk

The Clinical Governance and Safety Team were consulted about 47 families in relation to safeguarding concerns; and for 16 of these families a meeting took place to consider appropriate management of the risk posed.

Expanding safeguarding resources for staff

There were two further editions of the Safeguarding Newsletter which was circulated to all staff within the organisation. The newsletter (published six monthly) aims to keep staff updated about recent developments in policy practice and research, learning from SCRs and acts as a stimulus to good practice.

The webpages have been further developed and updated.

4.0 CHALLENGES AND PRIORITIES FOR 2016-2017

Challenges

- Meeting the increased training requirement for staff to remain competent at Level 3 Safeguarding and Prevent.
- Measuring the effectiveness of the safeguarding training programmes in delivering the required changes in practice.
- Implement Adult Safeguarding Training at enhanced levels for appropriate staff to complete, either through e learning or face to face sessions.
- Effective supervision of cases and activity to ensure reliability is subject to the pressures associated with the workload.
- Safeguarding supervision for staff will need further development and this may be challenging within the current constraints.

Priorities

- Meet external regulatory/contractual standards and metrics.
- Ensure the Trust is compliant with the checklist developed by the independent investigators; Verita in the course of the Myles Bradbury Inquiry (an investigation into the inappropriate sexual behaviours of the paediatric consultant at Addenbrookes Hospital), in preparation for The Goddard Inquiry which will consider the extent to which institutions have protected children from sexual abuse and exploitation.

- Implement the findings from the report on arrangements for safeguarding training, which would identify a more sustainable model for staff including honorary consultants.
- Further increase the uptake of supervision for staff through various methodologies.
- Incorporate future learning from Serious Case Reviews into the mandatory safeguarding training programme and disseminate messages to staff in a variety of educational modes.
- 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

Trust Board
30th May 2016

Safe Nurse Staffing Report for March 2016 **Submitted by: Juliette Greenwood Chief Nurse**	**Paper No: Attachment 4**

Aims / summary
This paper provides the required assurance that Great Ormond Street Hospital has identified and delivers safe nurse staffing levels across all in- patient ward areas with 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, nurse recruitment and this month contains specific information on nurse retention plans and initiatives.

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
Workforce Planning-Human Resources

Who is responsible for implementing the proposals / project and anticipated timescales?
Chief Nurse; Assistant Chief Nurse's

Who is accountable for the implementation of the proposal / project?
Chief Nurse; Assistant Chief Nurse

GOSH NURSE SAFE STAFFING REPORT

March 2016

1. Introduction

1.1 This report on GOSH Safe Nurse Staffing contains information from the month of March 2016. The report provides information on staff in post, safe staffing incidents, nurse vacancies and includes quality measures which are reported by exception.

1.2 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'.

1.3 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 identified impact on key quality and safety measures.

2. GOSH Ward Nurse Staffing Information for Trust Board

2.1 Safe Staffing

2.1.1 The UNIFY Fill Rate Indicator for March is attached as Appendix 1. The spreadsheet 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. A short term change in acuity and dependency requiring more or fewer staff is not reflected in planned hours but in the actual hours.
- Total monthly actual staff hours worked; this information is taken from the electronic rostering system (RosterPro), and includes supervisory roles, staff working additional hours, CNS shifts, and extra staff booked to cope with changes in patient dependency and acuity from the Nurse Bank. Supernumerary shifts are excluded. In order to meet the fluctuations in acuity and dependency the number may exceed or be below 100%.
- 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.

2.1.2 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 actions taken at the time to rectify and make the situation safe.
- The overall Trust fill rate % for March (February) is:

RN Day	RN Night	HCA Day	HCA Night	Total Fill Rate
96.7% (105.9%)	87.7% (91.1%)	94.5% (95.3%)	66.7% (63.3%)	86.4% (91.7%)

ICI – No unsafe shifts reported in March

- The higher fill rate on Penguin reflects their co-location with ambulatory care and the combined staffing and also the rise in patient dependency on both Penguin & Lion ward.
- The lower fill rates are due to staff sickness, staff moved to support this and lower patient dependency.

Surgery - No unsafe shifts reported in March

- The variance is due to vacancies, maternity leave and sickness and Care staff – (HCA's) were utilised on nights to fill gaps.
- Beds closed on Sky ward, owing to nurse vacancies (see Appendix 2).

CCCR – No unsafe shifts reported in March

- Miffy – The variance is due to HCA vacancies of more registered nurses used due to lack of availability of bank tracheostomy ventilory competent HCA staff
- Bear – The variance is due to patient dependency and acuity.
- Badger continues to have 2 x HCA's on maternity and one on short term medical redeployment.
- The variance across all intensive care areas in care staff (CICU, PICU & NICU) is HCA's vacancies. NICU opened 2 additional beds as interim to support an increase in patient activity, registered staff numbers reflect this.

MDTS - No unsafe shifts reported in March

- Eagle's increased requirement for registered nurses on day shifts was due to high patient acuity and dependency.
- Kingfisher, Rainforest Gastro and Endo/Met variances are due to HCA vacancies and nurse vacancy on Rainforest Endo/Met.

Neurosciences - No unsafe shifts reported in March

- The difference is due to short notice sickness or vacancies which were covered by either swapped shifts, ward sister/CNS working clinically or bank staff and 2 non-registered staff working days as a HCA & a Patient Pathway co-ordinator.
- MCU had a reduction in staffing requirements due to bed occupancy; patients were either discharged, on home leave or moved to a day case patient model during Easter.

IPP - No unsafe shifts reported in March

- Bumblebee continues to utilise HCAs appropriately to care for infants without resident parents and tracheostomy patients requiring 1:1 care.
- Beds were temporary closed as a result of increased level of patient dependency/complexity, short term sickness and unfilled banks shifts.
- The variance in Butterfly Ward registered nurse staff numbers on days and nights reflects the patient cohort which was predominately day case surgery and ambulatory care haematology/oncology/BMT patients and the moving of nursing staff to support patient dependency on Bumblebee.
- The increase in HCA's number is due the provision of additional support to long term patients and newly appointed staff working in a supernumerary capacity.

2.1.3 The Clinical Site Practitioners (CSPs) report that no wards were declared unsafe during March; however 2 shifts are noted where wards reported being short of staff but safety was not compromised.

3.0 General Staffing Information

3.0.1 Appendix 2 – Ward Nurse Staffing overview for March. The table provides information on ward based staff in post, vacancies and staff in the recruitment pipeline and includes bed closure information.

3.0.2 5 (9 in February) out of 23 inpatient wards closed beds at various points during March. An average of 7.4 beds, were closed each day which is an increase from February 2016 which had an average of 2.2 beds closed each day.

3.0.3 For the inpatient wards at March 1st registered and non-registered vacancies total 108 Whole Time Equivalents (WTE) decrease from 116 in February. This breaks down to 74 (88 in February) registered nurse (RN) vacancies (9% of RN total) and HCA vacancies number 33 (28 in February), (20% of HCA total). Temporary nurses, mainly from GOSH Nurse Bank, employed on wards totalled 118 WTE, the March position was therefore a -10 net vacancy rate (1 in January and 3 in February).

3.1 Vacancies and Recruitment

3.1.1 There has been a slight increase to 33 HCA vacancies and there remain a significant number of unregistered (HCA) vacancies (18) across the ICU areas (15) and Neurosciences (3) where recruitment is still on hold pending local work on the education pathway and recruitment plans.

3.1.2 Of 52 Registered Nurses recruited through the January and February Assessment Centres, 35 newly qualified and 5 experienced nurses commenced employment in March. There are a further 25 nurses due to start between April and July. Also 14 recently appointed HCA's started at the beginning of March, 9 for the inpatients wards with a further 5 for others areas across the Trust which include Theatres, Day care areas and the Clinical Research Facility.

3.1.3 10 nurses have started the Rotation Programme this month, 7 of these were new recruits and 3 were from the September 2015 1 year programme who showed an interest in the 2 year programme and therefore these transferred to the 2 year programme in March 2016.

3.1.4 GOSH staff attended a further 2 University Graduate Career fairs in March and is due to host the usual GOSH Recruitment Fair on 21st April. There are currently approximately 190 registered to attend the event, the majority are students from across the UK who qualify in September 2016, previously the feedback for this event has been very positive. Five assessment Centres have been organised in June and one for July for students seeking employment at GOSH from September onwards.

3.1.5 The next cohort recruitment for HCA Band 3 is planned for 25th April, there were 182 applicants and 33 were shortlisted and invited to the Assessment centre. Work is in progress to further develop a HealthCare Support Worker training pathway, it is anticipated that if the Nursing Workforce Programme board approve the proposal, the first cohort of Paediatric Healthcare Support worker trainees could start in September 2016.

3.1.6 49% (37) of RN vacancies in March remain at band 6.

4. Key Challenges

- Recruitment and retention of HCAs.
- Recruitment of Band 6 Nurses.
- Retention of Band 5 and 6 Nurses.
- Recruitment of staff to meet plans for growth.

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 March 2016.

5.2 The following quality measures provide a base line report for the Board. A number are Key Performance Indicators (KPIs) that are regularly monitored, any poor results are reviewed, challenged and investigated through the Head of Nursing and their review processes.

5.3 Infection control

Numbers of C diff's	1 (1 Community Acquired Infection)
Number of MRSA bacteraemias	0
Number of MSSA bacteraemias	2
Number of E.coli bacteraemias	0
Number of outbreaks and whether any beds closed	1 outbreak (Sky - no beds closed)
Carbapenemase-producing Entero-bacteriaceae	1 confirmed (Healthcare Associated Infection)
Hospital acquired enteric virus infec-tions	14
Hospital acquired viral respiratory in-fections	20

5.4 Pressure ulcers

Grade 3	**0**	
Grade 2	**7**	CICU x 5 (2 x ETT- avoidable, 1 x splint – avoidable, 1 x Rt Foot – avoidable, 1 x Rt Ear – avoidable) NICU x 1 (1 x ETT - avoidable) Koala x 1 (Occipital - Unavoidable acquired in PICU whilst on Neuro protection)

There was a slight reduction in the number of nasal endotracheal tubes (NEET) pressure ulcers (3 this month; 4 in February). Work continues to review all NEET pressure ulcers using a new root cause analysis process, these children are managed in intensive care and are acutely ill, making their management really challenging. New processes are being trialled to try to reduce these incidents.

5.5 **Deteriorating patient**

There were 6 2222 calls in March 2016, a slight reduction from the 7 in February. There were 3 cardiac arrests (considered not preventable) on Flamingo ward and one where sadly the child passed away. There were 2 respiratory arrests, which may have been preventable. In addition there were 6 unplanned admissions to intensive care (8 in February). From the reviews completed the evidence suggests these cases were well managed, with good observations and escalation of concerns about the patient's conditions.

5.6 **Numbers of safety incidents reported about inadequate nurse staffing levels**

There were 2 incidents reported by nursing staff regarding shortages of nurses or inadequate skill mix on shifts, these incidents occurred on Robin and Bumblebee, the latter resulted in temporary bed closures for 16 days in March. The staffing was not felt to be unsafe and there was no adverse impact on patient care and experience.

5.7 **Pals concerns raised by families regarding nurse staffing – 0**

There were 3 referrals to Pals, 2 where operations/procedures were cancelled and 1 where treatment was delayed due to lack of bed availability. The Trust has been operating at maximum capacity with increased pressures from RTT and it is unclear from these referrals whether nursing staff numbers contributed to the concerns reported

5.8 **Complaints received regarding nurse safe staffing – 0**

The Trust did not receive any complaints with regards to safe nurse staffing during March 2016.

5.9 All issues noted in 5.6 are under investigation by the respective Head of Nursing.

5.10 **Friends and family test (FFT) data**

Overall response rate for March 2016 increased to 26.1% (data extracted 12/04/2016) compared to 23.6% in February 2016. The target response was increased to 60%.

- The overall percentage to recommend score is 99% (data extracted 12/04/2016).
- 90% (708) of families indicated that they were extremely likely to recommend GOSH to their friends and family and 9% (73) indicated that they were likely to recommend (87% (624) and 11% in February 2016).

6.0 Conclusion

6.1 This paper seeks to provide the Board of Directors with the required overview and assurance that all wards were safely staffed against the Trust's determined safe staffing

levels during March, 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. Work is currently underway on a 5 year Recruitment and Retention strategy.

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.

7.4 The on-going challenges in retaining and recruiting nurses and HCA's.

Attachment 4
Appendix 1: UNIFY Safe Staffing Submission – March 2016

Only complete sites your organisation is accountable for					Day				Night				Day		Night	
Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - 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				
RP401	Great Ormond Street Hospital Central London Site - RI	Badger Ward	340 - RESPIRATORY MEDICINE		2403	2186.25	356	366.5	2139	1952.8	356	216.7	91.0%	102.9%	91.3%	60.9%
RP401	Great Ormond Street Hospital Central London Site - RI	Bear Ward	170 - CARDIOTHORACIC SURGERY	321 - PAEDIATRIC CARDIOLOGY	2852	3445	621	524	2852	3194.2	356	292.3	120.8%	84.4%	112.0%	82.1%
RP401	Great Ormond Street Hospital Central London Site - RI	Flamingo Ward	192 - CRITICAL CARE MEDICINE		7038	7040.82	356	379.5	6635	6367.85	218	108	100.0%	106.6%	96.0%	49.5%
RP401	Great Ormond Street Hospital Central London Site - RI	Miffy Ward (TCU)	340 - RESPIRATORY MEDICINE		713	807.2	1069	738.5	713	641.1	713	553.7	113.2%	69.1%	89.9%	77.7%
RP401	Great Ormond Street Hospital Central London Site - RI	Neonatal Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3208	3254.55	356	23	3208	2797.15	0	43.2	101.5%	6.5%	87.2%	-
RP401	Great Ormond Street Hospital Central London Site - RI	Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE		6060	6588.78	356	141	6060	5307.93	356	43.2	108.7%	39.6%	87.6%	12.1%
RP401	Great Ormond Street Hospital Central London Site - RI	Elephant Ward	370 - MEDICAL ONCOLOGY	823 - HAEMATOLOGY	1690	1584	356	310.5	1426	1286.18	356	380.1	93.7%	87.2%	90.2%	106.8%
RP401	Great Ormond Street Hospital Central London Site - RI	Fox Ward	303 - CLINICAL HAEMATOLOGY	313 - CLINICAL IMMUNOLOGY and ALLERGY	2139	1804.5	356	270.7	2001	1484.1	356	177	84.4%	76.0%	74.2%	49.7%
RP401	Great Ormond Street Hospital Central London Site - RI	Giraffe Ward	313 - CLINICAL IMMUNOLOGY and ALLERGY	350 - INFECTIOUS DISEASES	1069	1043.77	356	241.5	1069	852.2	356	221.6	97.6%	67.8%	79.7%	62.2%
RP401	Great Ormond Street Hospital Central London Site - RI	Lion Ward	370 - MEDICAL ONCOLOGY	303 - CLINICAL HAEMATOLOGY	1690	1497.3	356	401.5	1426	1195.5	356	203.5	88.6%	112.8%	83.8%	57.2%
RP401	Great Ormond Street Hospital Central London Site - RI	Penguin Ward	330 - DERMATOLOGY	410 - RHEUMATOLOGY	977	1077.05	356	518.05	713	673.5	356	99.3	110.2%	145.5%	94.5%	27.9%
RP401	Great Ormond Street Hospital Central London Site - RI	Robin Ward	350 - INFECTIOUS DISEASES	313 - CLINICAL IMMUNOLOGY and ALLERGY	2037	1479.45	354	276	1774	1284.9	354	268.3	72.6%	78.0%	72.4%	75.8%
RP401	Great Ormond Street Hospital Central London Site - RI	Bumblebee Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2223	2334.5	317	841.25	1906	2308.2	635	810.9	105.0%	265.4%	121.1%	127.7%
RP401	Great Ormond Street Hospital Central London Site - RI	Butterfly Ward	370 - MEDICAL ONCOLOGY	420 - PAEDIATRICS	2852	2055.5	356	749	2139	1375.6	356	379.1	72.1%	210.4%	64.3%	106.5%
RP401	Great Ormond Street Hospital Central London Site - RI	Eagle Ward	361 - NEPHROLOGY		2311	2796.05	713	714.85	1426	1343.8	356	277.7	121.0%	100.3%	94.2%	78.0%
RP401	Great Ormond Street Hospital Central London Site - RI	Kingfisher Ward	420 - PAEDIATRICS		1806	1642.45	925	528.2	347	367.9	0	76.3	90.9%	57.1%	106.0%	-
RP401	Great Ormond Street Hospital Central London Site - RI	Rainforest Ward (Gastro)	301 - GASTROENTEROLOGY		977	1118	713	262.35	713	728.5	713	213.6	114.4%	36.8%	102.2%	30.0%
RP401	Great Ormond Street Hospital Central London Site - RI	Rainforest Ward (Endo/Met)	302 - ENDOCRINOLOGY		1063	1092.55	708	253	1063	718.6	354	273.5	102.8%	35.7%	67.6%	77.3%
RP401	Great Ormond Street Hospital Central London Site - RI	Mildred Creak	711- CHILD and ADOLESCENT PSYCHIATRY		1126	875.5	632	675.2	511	405	465	336.2	77.8%	106.8%	79.3%	72.3%
RP401	Great Ormond Street Hospital Central London Site - RI	Koala Ward	150 - NEUROSURGERY	421 - PAEDIATRIC NEUROLOGY	3062	2987.87	322	403.5	2979	2703.7	322	151.2	97.6%	125.3%	90.8%	47.0%
RP401	Great Ormond Street Hospital Central London Site - RI	Peter Pan Ward	120 - ENT	160 - PLASTIC SURGERY	1598	1419.55	621	598	1506	1172.7	0	21.6	88.8%	96.3%	77.9%	-
RP401	Great Ormond Street Hospital Central London Site - RI	Sky Ward	110 - TRAUMA & ORTHOPAEDICS	171 - PAEDIATRIC SURGERY	1776	1173	618	484	1736	1099.3	0	57.5	66.0%	78.3%	63.3%	-
RP401	Great Ormond Street Hospital Central London Site - RI	Squirrel Ward	171 - PAEDIATRIC SURGERY	101 - UROLOGY	2981	3138.6	702	587	2675	2479.2	0	131	105.3%	83.6%	92.7%	-

Appendix 2: Overview of Ward Nurse Staffing – March 2016

			Registered Nursing staff			Non Registered							Recruitment Pipeline			
Division	Ward	Established Bed Numbers	Proposed Funded Establishment	Staff in Post	Vacancies	Proposed Funded establishment	Staff in Post	Vacancies	Total Establishment	Total Vacancies	Bank Used	Net Vacant	Registered Starters	Non-registered Starters	Number of unsafe shifts	Average Bed Closures
CCCR	Badger	15	39.5	37.0	2.5	7.5	7.0	0.5	47.0	3.0	1.8	1.2	5.0		0	0.0
	Bear	24	53.5	52.1	1.4	9.0	8.4	0.6	62.5	2.0	9.3	-7.3			0	0.0
	Flamingo	17	121.0	109.9	11.1	10.8	4.0	6.8	131.8	17.9	18.9	-1.0	10.0		0	0.0
	Miffy (TCU)	5	14.1	11.9	2.2	10.4	7.0	3.4	24.5	5.6	6.9	-1.3		3	0	0.0
	NICU	8	51.5	46.1	5.4	5.2	2.0	3.2	56.7	8.6	10.9	-2.3			0	0.0
	PICU	13	83.1	85.8	-2.7	8.9	3.0	5.9	92.0	3.2	8.6	-5.4	5.6		0	0.0
ICI-LM	Elephant	13	25.0	19.0	6.0	5.0	3.9	1.1	30.0	7.1	2.8	4.3			0	0.0
	Fox	10	31.0	26.1	4.9	5.0	3.9	1.1	36.0	6.0	3.7	2.3			0	0.0
	Giraffe	7	19.0	17.0	2.0	3.1	3.1	0.0	22.1	2.0	2.2	-0.2			0	0.0
	Lion	11	22.0	22.0	0.0	4.0	3.0	1.0	26.0	1.0	4.6	-3.6		1	0	0.0
	Penguin	9	15.5	13.5	2.0	5.8	5.8	0.0	21.3	2.0	2.5	-0.5			0	0.0
	Robin	10	27.2	22.7	4.5	4.5	2.2	2.3	31.7	6.8	3.6	3.2		2	0	0.0
IPP	Bumblebee	21	38.3	33.2	5.1	9.7	9.0	0.7	48.0	5.8	12.0	-6.2	1.0		0	2.3
	Butterfly	18	37.2	27.4	9.8	10.5	9.9	0.6	47.7	10.4	6.9	3.6		1	0	0.0
MDTS	Eagle	21	39.5	35.0	4.5	10.5	10.0	0.5	50.0	5.0	4.7	0.3	1.0		0	0.0
	Kingfisher	16	17.1	14.2	2.9	6.2	4.9	1.3	23.3	4.2	1.3	2.9			0	0.1
	Rainforest Gastro	8	17.0	14.9	2.1	4.0	3.5	0.5	21.0	2.6	1.6	1.0			0	0.0
	Rainforest Endo/Met	8	15.6	15.6	0.0	5.2	3.5	1.7	20.8	1.7	2.4	-0.7			0	0.0
Neuro-sciences	Mildred Creak	10	11.8	13.9	-2.1	7.8	8.3	-0.5	19.6	-2.6	0.7	-3.3			0	0.0
	Koala	24	48.2	44.0	4.2	7.8	6.0	1.8	56.0	6.0	6.7	-0.7			0	2.3
Surgery	Peter Pan	16	24.5	23.1	1.4	5.0	4.0	1.0	29.5	2.4	1.0	1.4	1.0		0	0.0
	Sky	18	31.0	24.0	7.0	5.2	5.0	0.2	36.2	7.2	3.2	4.0	2.0	0.9	0	2.4
	Squirrel	22	43.6	42.9	0.7	7.0	7.0	0.0	50.6	0.7	2.3	-1.6	2.0		0	0.3
	TRUST TOTAL:	**324**	**826.2**	**751.3**	**74.9**	**158.1**	**124.4**	**33.7**	**984.3**	**108.6**	**118.6**	**-10.0**	**27.6**	**7.9**	**0.0**	**7.4**

Great Ormond Street Hospital for Children NHS Foundation Trust

GOSH NURSE SAFE STAFFING REPORT

April 2016

1. Introduction

1.1 This report on GOSH Safe Nurse Staffing contains information from the month of April 2016. The report provides information on staff in post, safe staffing incidents, nurse vacancies and includes quality measures which are reported by exception.

1.2 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'.

1.3 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.

2. GOSH Ward Nurse Staffing Information for Trust Board

2.1 Safe Staffing

2.1.1 The UNIFY Fill Rate Indicator for April is attached as Appendix 1. The spreadsheet contains:

- Total monthly planned staff hours; the Divisional Assistant Chief Nurses and Head 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. A short term change in acuity and dependency requiring more or fewer staff is not reflected in planned hours but in the actual hours.
- Total monthly actual staff hours worked; this information is taken from the electronic rostering system (RosterPro), and includes supervisory roles, staff working additional hours, CNS shifts, and extra staff booked to cope with changes in patient dependency and acuity from the Nurse Bank. Supernumerary shifts are excluded. In order to meet the fluctuations in acuity and dependency the number may exceed or be below 100%.
- 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.

2.1.2 Commentary:

- Divisional Assistant Chief Nurses and IPP Head 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 actions taken at the time to rectify and make the situation safe.
- The overall Trust fill rate % for April (March) is:

RN Day	RN Night	HCA Day	HCA Night	Total Fill Rate
106% (96.7%)	99% (87.7%)	107% (94.5%)	74% (66.7%)	95% (86.4%)

Barrie – (MDTS/Neuro/Surgery) - No unsafe shifts reported in April

- 2 beds have been closed on Sky due to registered staff vacancies (see Appendix 2) and an increase in patient acuity. Beds were also temporarily closed on Squirrel due to an infection control outbreak and Peter Pan as a result of blocked drains.
- Staff were moved across the Division to maintain safe staffing levels and to maximise activity.

IPP – No unsafe shifts reported in April

- Bumblebee continues to utilise HCAs to care for infants without resident parents and trache-ostomy patients requiring 1:1 care and the variance with registered staff and bank staff is in a response to patient dependency.
- Beds on Bumblebee that were temporary closed were reopened in a staged process at the beginning of the month; the closure was due to patient dependency/complexity, short term sickness and skill mix.
- The variance in Butterfly Ward registered staff numbers on days and nights reflects the patient cohort which was predominately Day Case Surgery and ambulatory care Haematolo-gy/Oncology/BMT patients and the moving of nursing staff to support patient dependency on Bumblebee.
- The increase in HCA's number is due to the provision of additional support for long term pa-tients and recruitment of staff in preparation of the opening of the new ward – Hedgehog.
- Capacity planning is underway as it has been noted there is an increase in referrals of com-plex, highly dependent patients.

West – (CCCR/ICI) - No unsafe shifts reported in April

- Higher fill rates were due to an increase in dependency of patients and lower as a result of HCA vacancies, staff sickness and staff being across the division to support patient activity.
- Beds were temporarily closed on Badger due to an infection control issue and Bear due to ei-ther an increase in patient acuity and unfilled banks shifts.

2.1.3 The Clinical Site Practitioners (CSPs) report that no wards were declared unsafe during April; however 12 shifts are noted where wards reported being short of staff but safety was not compromised.

3.0 General Staffing Information

3.0.1 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.

3.0.2 9 (5 in March) out of 23 inpatient wards closed beds at various points during April. An average of 6.7 beds, were closed each day which is a decrease from March 2016 which had an average of 7.8 beds closed each day. The main reasons for this were problems with the estate in the Southwood Building; Peter Pan experienced severe disruption for several days following incidents with blocked drains. Infection control; Squirrel had bed closures due to a Diarrhoea & Vomiting outbreak and Badger due to an undiagnosed infectious patient being placed in the bay. Patient dependency and unfilled bank shifts on Bear, Koala and Bumblebee and registered staff vacancies on Sky.

3.0.3 For the inpatient wards at April 1st registered and non-registered vacancies total 96 Whole Time Equivalents (WTE) decrease from 108 in March. This breaks down to 72 (74 in March registered nurse (RN) vacancies (8.7% of RN total) and HCA vacancies number 23

(33 in March), (15% of HCA total). Temporary nurses, mainly from GOSH Nurse Bank, employed on wards totalled 99.5 WTE, the April position was therefore minus 3.1 net vacancy rate (-10 in March and 3 in February).

3.1 Vacancies and Recruitment

3.1.1 Staff attended both a University (Bournemouth) and a Health Expo (Dublin) Careers fair this month, both reviewed well by those attending. As with all the current and planned nurses' recruitment events, the candidate's expressions of interest will be followed up, tracked and analysed against job applications received and successful appointment.

3.1.2 GOSH hosted a Recruitment Fair and approximately 235 visitors attended the event which is over 50 more than last year, the majority were students from across the UK who qualify in September 2016, again the feedback from the event has been very positive. The subsequent advertisement has received 206 applications from both newly qualified and experienced nurses; these are currently in the shortlisting process. Assessment Centres have been organised in June and July for students seeking employment at GOSH from September onwards and experienced staff are being invited for interview over the coming month.

3.1.3 There has been a decrease this month in HCA vacancies to 23 wte, however there remains a significant number of unregistered (HCA) 14.9 wte vacancies in the ICU areas (64% of overall HCA vacancies), recruitment is still on hold pending local work on the education pathway and recruitment plans.

3.1.4 10 Band 3's, have been successfully recruited at April's Assessment centre and pending pre-employment checks are due to start in June 2016.

3.1.5 The Nursing Workforce Programme board have approved the Band 2 - 4 Clinical HealthCare Support Worker training and education pathway and the first cohort of these Paediatric Healthcare Support worker trainees is planned for September 2016.

3.1.6 18 either newly registered or experienced nurses are in the pipeline to start between May and July.

3.1.7 As a Trust we continue to sustain recruitment against a backdrop of well publicised national nurse shortages.

3.1.8 The 6 monthly nurse establishment reviews are planned to commence May/June 2016.

3.1.9 42% (41) of RN vacancies in April are at band 6.

4. Key Challenges

- Recruitment and retention of HCAs.
- Recruitment of Band 6 Nurses.
- Retention of Band 5 and 6 Nurses.
- Recruitment of staff to meet plans for growth.

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 2016.

5.2 The following quality measures provide a base line report for the Board. A number are Key Performance Indicators (KPIs) that are regularly monitored, any poor results are reviewed, challenged and investigated through the Divisional Chief Nurses and their review processes.

5.3 **Infection control**

Numbers of C diff's	?1 (to be reviewed by Dr Hartley)
Number of MRSA bacteraemias	0
Number of MSSA bacteraemias	4 (2 Healthcare Associated Infections, 2 Community Acquired Infections)
Number of E.coli bacteraemias	1
Number of outbreaks and whether any beds closed	2 outbreaks - Squirrel ward closed for 5 days
Carbapenemase-producing Entero-bacteriaceae	0
Hospital acquired enteric virus infec-tions	29
Hospital acquired viral respiratory in-fections	6

5.4 **Pressure ulcers**

Grade 3	**0**	
Grade 2	**5**	CICU x 2 (2 x ETT- avoidable) PICU x 2 (1 x Ear - avoidable) Squirrel x 1 (Heel – unavoidable)

There is again a slight reduction in the number of ETT pressure ulcers 2 (3 in March). The new root cause analysis process is being used at present to investigate and implement action plans for all the above pressure ulcers.

5.5 **Deteriorating patient**

There were 6 2222 calls in April 2016, which is the same as March. There was 2 cardiac arrest (1 considered potentially preventable) on Flamingo and Bear ward. There were 4 respiratory arrests, 3 of which may have been preventable. In addition there were 9 unplanned admissions to the Intensive care units; 4 x Barrie Division (2 Squirrel, 1 Koala & 1 Rainforest Endo/Met); 4 x West Division (2 Badger, 1 Bear & 1 Lion); IPP (1 Bumblebee).

5.6 **Numbers of safety incidents reported about inadequate nurse staffing levels**

There was 1 incident reported by staff regarding shortages of nurses, this occurred on a night shift on Squirrel ward, ward staff were unable to collect a patient from theatre when requested which resulted in the theatre staff having to return the patient to the ward. The staffing was not felt to be unsafe and there was no adverse impact on patient care.

5.7 **Pals concerns raised by families regarding nurse staffing – 0**

There was 1 referral to Pals where an operation was delayed due to lack of PICU bed availability. The Trust continues operate at maximum capacity with increased pressures from RTT and it is unclear from these referrals whether nursing staff numbers contributed to the concerns reported

5.8 **Complaints received regarding nurse safe staffing – 0**

The Trust did not receive any complaints in regards to nurse safe staffing during April 2016.

5.9 All issues noted in 5.6 are under investigation by the respective Divisional Assistant Chief Nurse.

5.10 **Friends and family test (FFT) data**

Overall response rate for April 2016 has decreased to 23.58% (data extracted 10/05/2016) compared to 26.1% in March 2016. The target response rate has increased to 60%.

- The overall percentage to recommend score is 98.6% (data extracted 10/05/2016).
- 89% (628) families were extremely likely to recommend GOSH to their friends and family and 9.6% (68) responded as likely to recommend compared with 90% (708) and 9% (73) in March 2016.
- For information, the following negative comments or suggestions regarding staffing issues/staff behaviour have been received for the following wards.
    - 2 families were extremely unlikely to recommend GOSH due to prolonged waiting time for a bed and staff attitude (Kingfisher) and lack of communication from staff (Penguin)
- The following positive comments regarding outstanding performance regarding staff behaviour have been received for the following wards
    - Kingfisher, Puffin, Koala and Starfish received comments about amazing care and treatment, knowledgeable and kind nurses, confidence in care received, overall quality of care and patient experience.

6.0 Conclusion

6.1 This paper seeks to provide the Board of Directors with the required overview and assurance that all wards were safely staffed against the Trust's determined 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. Work is currently underway on a 5 year Recruitment and Retention strategy.

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.

7.4 The on-going challenges in retaining and recruiting nurses and HCA's.

7.5 The impact of the reform to student nurse funding on nurse recruitment.

Attachment 4
Appendix 1: UNIFY Safe Staffing Submission – April 2016

Only complete sites your organisation is accountable for					Day				Night				Day		Night	
Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - 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				
RP401	GREAT ORMOND STREET HOSPITAL CEN	Badger Ward	340 - RESPIRATORY MEDICINE		2252	2424	336	358.5	2017	1911.3	336	228.2	107.6%	106.7%	94.8%	67.9%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Bear Ward	170 - CARDIOTHORACIC SURGERY	321 - PAEDIATRIC CARDIOLOGY	2679	3079.25	569	500	2679	2747.3	334	183.6	114.9%	87.9%	102.5%	55.0%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Flamingo Ward	192 - CRITICAL CARE MEDICINE		6796	7775.68	345	276	6394	6911.3	184	108	114.4%	80.0%	108.1%	58.7%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Miffy Ward (TCU)	340 - RESPIRATORY MEDICINE		690	932.75	1035	793	690	620.2	690	589.9	135.2%	76.6%	89.9%	85.5%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Neonatal Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3105	3409.6	345	0	3105	3060.25	0	0	109.8%	0.0%	98.6%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5865	6830.55	345	184	5865	5563.1	345	108	116.5%	53.3%	94.9%	31.3%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Elephant Ward	370 - MEDICAL ONCOLOGY	823 - HAEMATOLOGY	1621	1610.7	345	364	1380	1254.6	345	349.1	99.4%	105.5%	90.9%	101.2%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Fox Ward	303 - CLINICAL HAEMATOLOGY	313 - CLINICAL IMMUNOLOGY and ALLERGY	2055	1725	342	194.8	1895	1425.3	342	271.4	83.9%	57.0%	75.2%	79.4%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Giraffe Ward	313 - CLINICAL IMMUNOLOGY and ALLERGY	350 - INFECTIOUS DISEASES	1035	1169	345	264.5	1035	816.3	345	174.9	112.9%	76.7%	78.9%	50.7%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Lion Ward	370 - MEDICAL ONCOLOGY	303 - CLINICAL HAEMATOLOGY	1621	1551.1	345	379.5	1380	1165.6	345	278.85	95.7%	110.0%	84.5%	80.8%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Penguin Ward	330 - DERMATOLOGY	410 - RHEUMATOLOGY	931	1138.94	345	617.05	690	634.8	345	173.5	122.3%	178.9%	92.0%	50.3%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Robin Ward	350 - INFECTIOUS DISEASES	313 - CLINICAL IMMUNOLOGY and ALLERGY	1966	1473.9	345	426	1725	1274.8	345	470.4	75.0%	123.5%	73.9%	136.3%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Bumblebee Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2349	2724.5	335	816.5	2013	2264.9	671	817.4	116.0%	243.7%	112.5%	121.8%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Butterfly Ward	370 - MEDICAL ONCOLOGY	420 - PAEDIATRICS	2756	2302.5	344	1001	2067	1366.5	344	297.9	83.5%	291.0%	66.1%	86.6%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Eagle Ward	361 - NEPHROLOGY		2208	2944.25	690	803.53	1380	1315.2	345	295.1	133.3%	116.5%	95.3%	85.5%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Kingfisher Ward	420 - PAEDIATRICS		1707	1684.02	879	528.35	294	379.4	0	43.9	98.7%	60.1%	129.0%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Rainforest Ward (Gastro)	301 - GASTROENTEROLOGY		909	1266.65	673	239.5	673	694	673	206.95	139.3%	35.6%	103.1%	30.8%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Rainforest Ward (Endo/Met)	302 - ENDOCRINOLOGY		1035	1067.28	690	287.5	1035	720.75	345	266.9	103.1%	41.7%	69.6%	77.4%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Mildred Creak	711- CHILD and ADOLESCENT PSYCHIATRY		1077	1044.8	587	675	490	378.7	437	315.3	97.0%	115.0%	77.3%	72.2%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Koala Ward	150 - NEUROSURGERY	421 - PAEDIATRIC NEUROLOGY	3204	3169.47	340	568.5	3090	2649.6	340	205.9	98.9%	167.2%	85.7%	60.6%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Peter Pan Ward	120 - ENT	160 - PLASTIC SURGERY	1386	1066.75	535	391	1281	955.3	0	43.2	77.0%	73.1%	74.6%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Sky Ward	110 - TRAUMA & ORTHOPAEDICS	171 - PAEDIATRIC SURGERY	1789	1780.5	627	946	1737	1418.7	0	11.5	99.5%	150.9%	81.7%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Squirrel Ward	171 - PAEDIATRIC SURGERY	101 - UROLOGY	2700	3029.3	642	748	2421	2461.4	0	141.8	112.2%	116.5%	101.7%	-

Attachment 4

Appendix 2: Overview of Ward Nurse Staffing – April 2016

Speciality	Ward	Established Bed Numbers	Registered Nursing staff			Non Registered			Total Establishment	Total Vacancies	Bank Used	Net Vacant	Recruitment Pipeline		Number of unsafe shifts	Average Bed Closures
			Proposed Funded Establishment	Staff in Post	Vacancies	Proposed Funded establishment	Staff in Post	Vacancies					Registered Starters	Non-registered Starters		
CardioRespiratory	Badger	15	39.5	37.0	2.5	7.5	7.0	0.5	47.0	3.0	2.2	0.8	0.0	1	0	0.4
	Bear	24	53.5	50.4	3.1	9.0	8.4	0.6	62.5	3.7	4.4	-0.7	0.0	0	0	0.6
	Miffy (TCU)	5	14.1	11.4	2.7	10.4	7.5	2.9	24.5	5.6	5.5	0.1	0.0	3	0	0.0
Critical Care	Flamingo	17	121.0	107.0	14.0	10.8	5.0	5.8	131.8	19.8	19.0	0.8	6.0	0	0	0.0
	NICU	8	51.5	45.0	6.5	5.2	2.0	3.2	56.7	9.7	9.1	0.6	0.0	0	0	0.0
	PICU	13	83.1	85.8	-2.7	8.9	3.0	5.9	92.0	3.2	7.5	-4.3	4.0	0	0	0.0
Haematology/Oncology/Dertrmatology/Rheumatology	Elephant	13	25.0	20.9	4.1	5.0	5.1	-0.1	30.0	4.0	2.4	1.6	1.0		0	0.0
	Fox	10	31.0	25.2	5.8	5.0	5.0	0.0	36.0	5.8	2.1	3.7	1.0	2	0	0.1
	Giraffe	7	19.0	19.7	-0.7	3.1	3.0	0.1	22.1	-0.6	1.0	-1.6			0	0.0
	Lion	11	22.0	22.8	-0.8	4.0	4.0	0.0	26.0	-0.8	4.3	-5.1			0	0.0
	Penguin	9	15.5	17.8	-2.3	5.8	5.8	0.0	21.3	-2.3	1.3	-3.6			0	0.0
	Robin	10	27.2	23.7	3.5	4.5	4.4	0.1	31.7	3.6	4.9	-1.3			0	0.0
IPP	Bumblebee	21	38.3	34.3	4.0	9.7	12.0	-2.3	48.0	1.7	11.8	-10.1		2	0	0.6
	Butterfly	18	37.2	25.4	11.8	10.5	9.9	0.6	47.7	12.4	4.5	7.9			0	0.0
MDTS	Eagle	21	39.5	35.6	3.9	10.5	8.0	2.5	50.0	6.4	2.8	3.6	1.0		0	0.0
	Kingfisher	16	17.1	14.2	2.9	6.2	4.9	1.3	23.3	4.2	1.7	2.5		1	0	0.0
	Rainforest Gastro	8	17.0	15.9	1.1	4.0	3.5	0.5	21.0	1.6	0.3	1.3			0	0.2
	Rainforest Endo/Met	8	15.6	14.6	1.0	5.2	5.5	-0.3	20.8	0.7	1.8	-1.1			0	0.0
Neuro-sciences	Mildred Creak	10	11.8	14.2	-2.4	7.8	7.3	0.5	19.6	-1.9	0.3	-2.2			0	0.0
	Koala	24	48.2	44.0	4.2	7.8	6.0	1.8	56.0	6.0	7.0	-1.0			0	0.3
Surgery	Peter Pan	16	24.5	23.1	1.4	5.0	5.0	0.0	29.5	1.4	0.8	0.6	1.0		0	1.4
	Sky	18	31.0	24.8	6.2	5.2	5.0	0.2	36.2	6.4	2.7	3.7	4.0		0	1.6
	Squirrel	22	43.6	40.8	2.8	7.0	7.0	0.0	50.6	2.8	2.0	0.8			0	1.5
	TRUST TOTAL:	**324**	**826.2**	**753.6**	**72.6**	**158.1**	**134.3**	**23.8**	**984.3**	**96.4**	**99.5**	**-3.1**	**18.0**	**9.0**	**0.0**	**6.7**

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th May 2016**	
Annual Risk Management Report	**Paper No: Attachment 5**
Submitted by: Clinical Governance and Safety Team	

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 2015 – March 2016

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 declared to NHS England between 1 April 2015 and 31 March 2016.

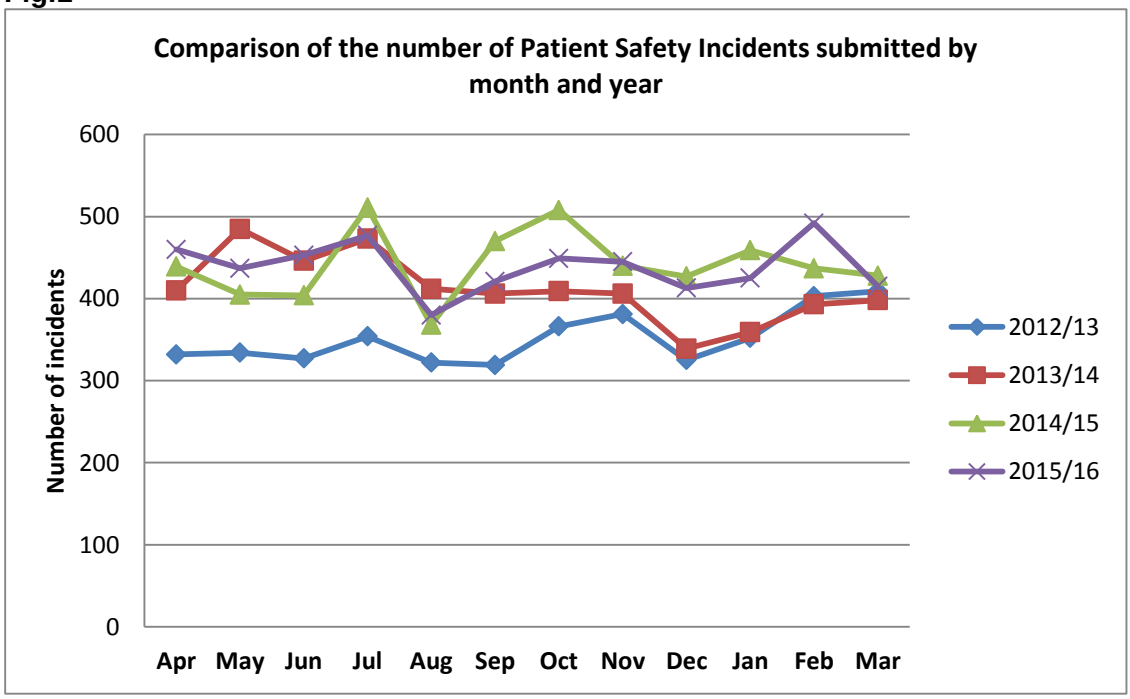
1. Incident Reporting Levels

1.1 Internal Analysis

There were 5266 patient safety incidents reported in the last year (01 April 15 – 31 March 16) via the Trust's incident reporting System. **Fig. 1** demonstrates the trends in the numbers of incidents reported year on year since 2012.

Reporting levels have been fairly consistent over the past five financial years initially increasing year on year until a plateau fo the past two years. There were 3639 patient safety incidents submitted 2011/12;4244 2012/3; 4936 2013/14; 5296 2014/5 and 5266 for 2015/16. This is illustrated on the graph below:

Fig.1



The web based electronic system (Datix Web) was first implemented in April 2011 to improve the timeliness of incident reporting to aid accurate analysis of trends. . Reporting activity data indicates that this is embedded in all areas across the Trust and the risk management team continue to work within the divisions to encourage incident reporting, review and proactively analyse trends linking closely with Local and Trustwide RIsk Registers. To ensure appropriate escalation, ownership and scrutiny of high risks and Trustwide risks there has been a change in the pathway to executive level with these risks currently reviewed at the fortnightly senior management team meeting.

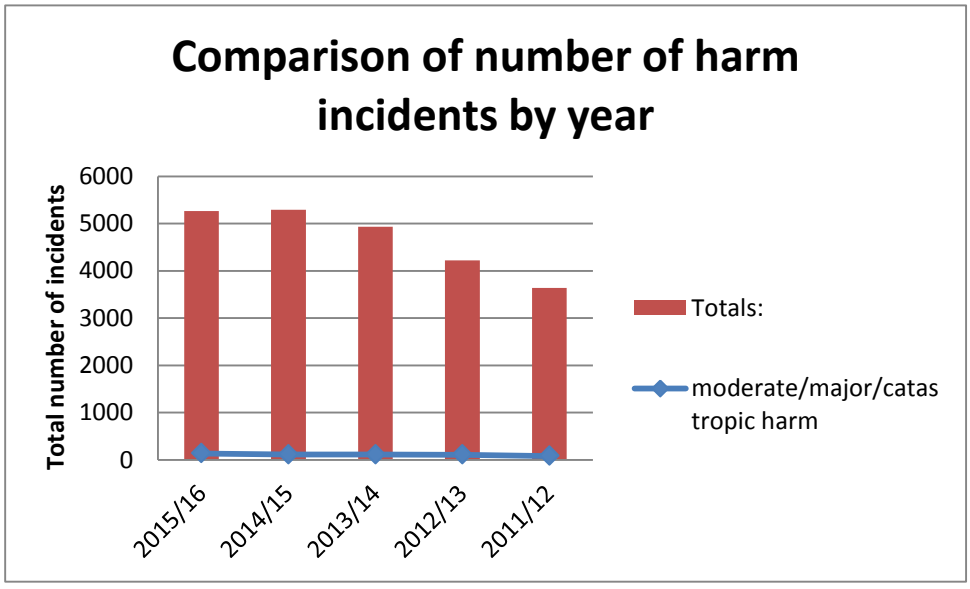
The datix web system was upgraded to the latest version (14.0) in November 2015 which both allowed improvements to the overall system to be implemented across the Trust in line with many other hospitals where datix is embedded and also expansion of datix capabilities Trustwide with the addition of further functions including the cas alert module (discussed laetr in the report). The upgraded system was relaunched with ongoing teaching and roll out and has been positively received across the divisions. Previously the risk management team had been aware that many staff felt that they would submit an incident and then not receive

any feedback. Whilst each specialty area has a regular risk action group where local incident, risks and other relevant information is presented and actively discussed and managed as well as inclusion as agenda items at most specialty and divisional board meetings it is evident that this is not always fully disseminated and the risk team is working with the divisions to address this. One noticeable improvement with the upgrade is that the reporter receives an email when the incident is closed with a summary of actions taken by the manager, recommendation and lessons learnt. Over time it is envisaged that this feedback loop will further promote an open reporting culture and proactive approach to risk management. Similarly the upgrade incorporates a new reporting layout which should be easier and quicker to complete and the incident categories heve been streamlined in an effort to reduce the number of possible categories that an incident could be reported under which should in the long term make it easier to identify trends and so again facilitate a proactive approach to risk management . To ensure timely investigation alongside this is the introduction of a search directory to allow the reporter to identify the appropriate manager and investigator for an incident.

2. Analysis of reported incidents (including level of harm)

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.

Generally overall the past five years the majority of incidents cause low or no harm as illustrated on the graph below:



Of the 5266 patient safety incidents reported between 01 April 2015 and 31 March 2016 the distribution of harm caused is illustrated in the table below..

Severity of Incident	Number of Incidents	Percentage of Incidents
Catastrophic	1	0.02
Major	13	0.25
Moderate	124	2.35

Low	1265	24.02
No harm	3863	73.36
Total	5266	100

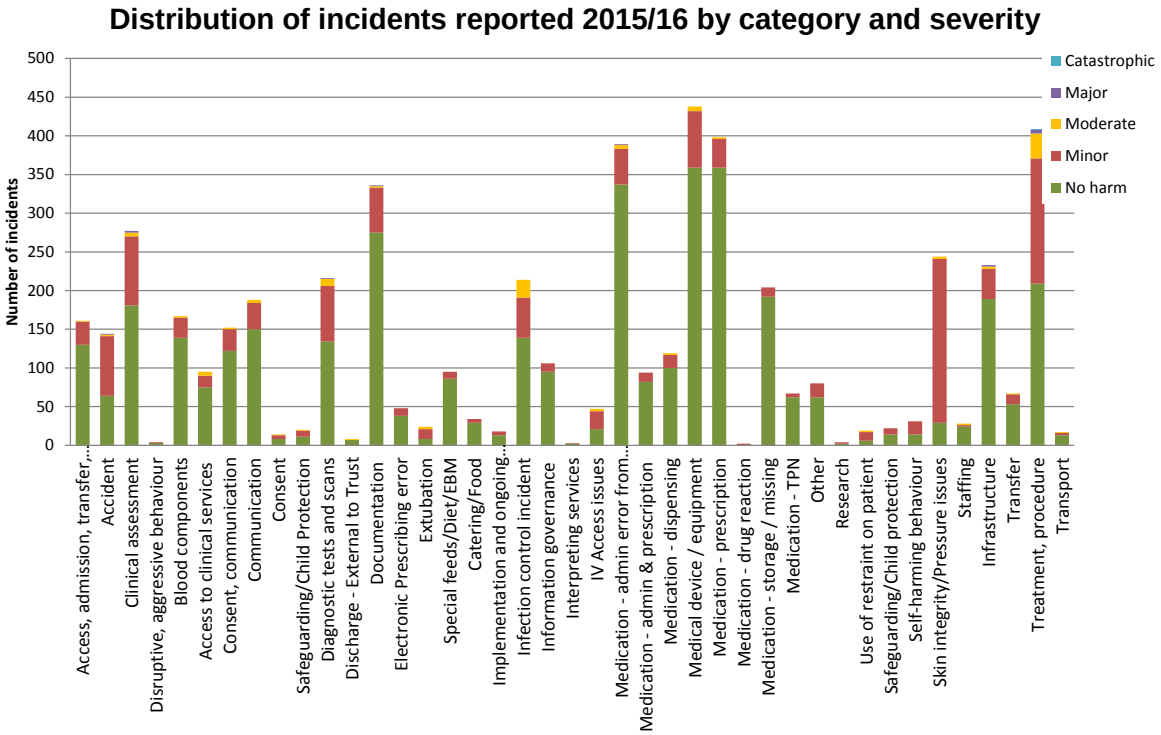
Being open with patients and their families at all times including when something goes wrong is a key component of developing a safety culture; a culture where all incidents are reported, discussed, investigated and learned from.

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).

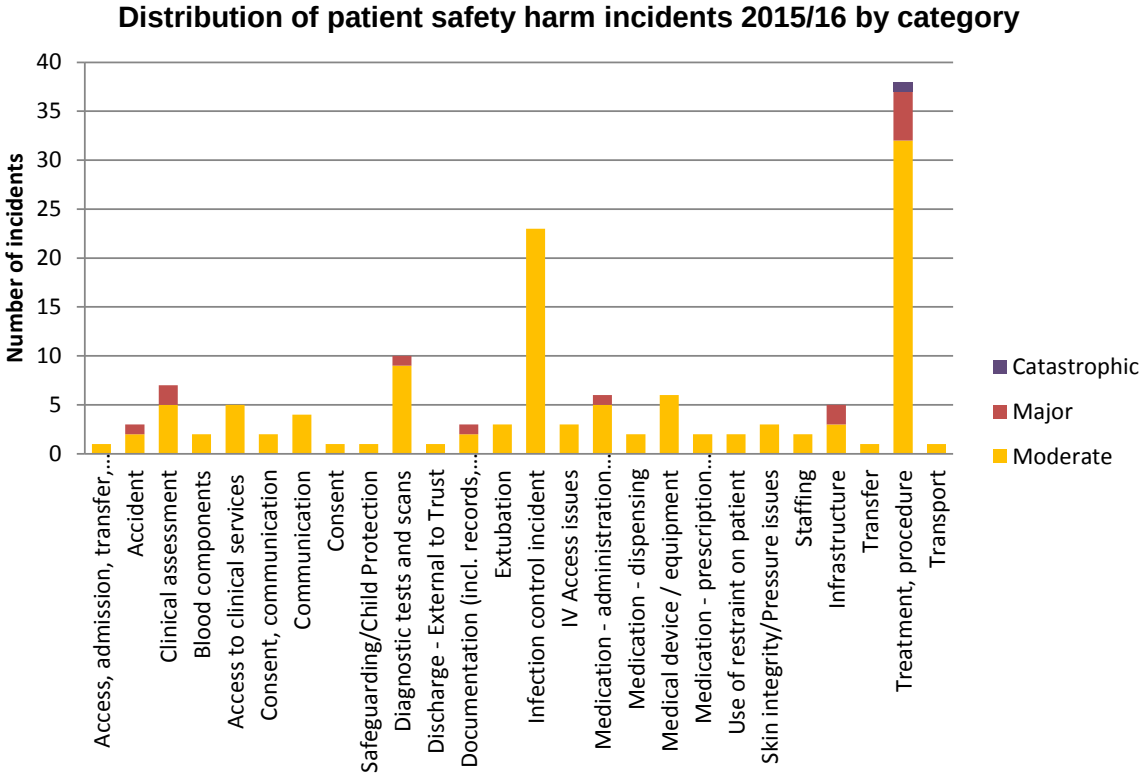
In the period specified 2015/16 where recorded the Trust informed 65% of families where a 'harm' incident occurred, 27% were not informed and 8% were marked as 'not appropriate'. Currently this data is captured from the incident data at the time and so the reasons families may not be informed may be dependent on how quickly the incident form is submitted after the event – if the family are not present at the time it is often the case that this is discussed in person as they arrive on a unit and this information is updated by the manager at a later date. There will be some incidents that are included in this report where investigation is ongoing and not yet closed so family involvement may not yet be reflected in the data.Since the updated datix has been introduced this has been easier to capture which will be reflected in reports from this point.

3. Type of harm caused

Between 01 April 2015 and 31 March 2016 the distribution of category and severity of incidents can be illustrated on the table below:



For those incidents where there was moderate harm and above the distribution of categories categories reported is illustrated below:

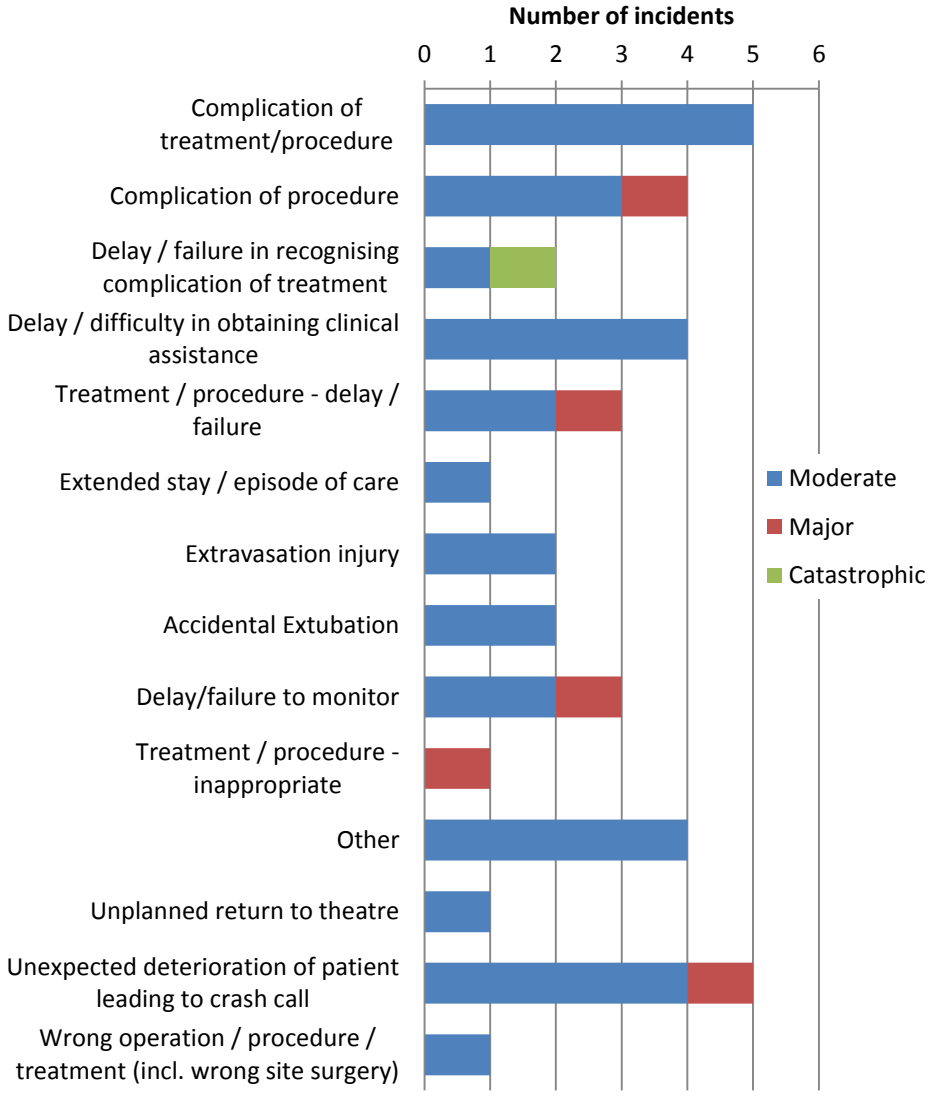


Treatment, procedure (38 incidents)

Treatment/Procedure incidents accounted for 38 of the incidents reported in the Trust.

7 of these were investigated as part of SI investigations. The learning from SIs closed for this period is included in **Appendix 1.**

A break down of treatment, procedure incidents is as follows:



There are currently 10 open Treatment, procedure risks on risk registers throughout the trust. These include:

- 4 Low risks
- 4 Medium risks
- 2 High risks

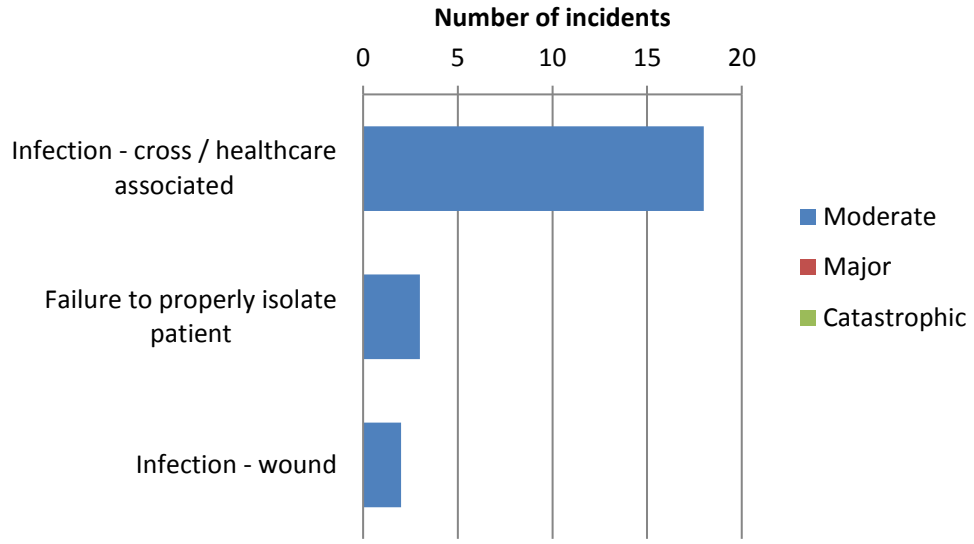
5 of these were opened between April 2015 and March 2016.

5 risks have been opened for over 12 months.

Infection control (23 incidents)

Infection control accounted for 23 of the incidents reported in the Trust during this period.

The breakdown for these is as follows:



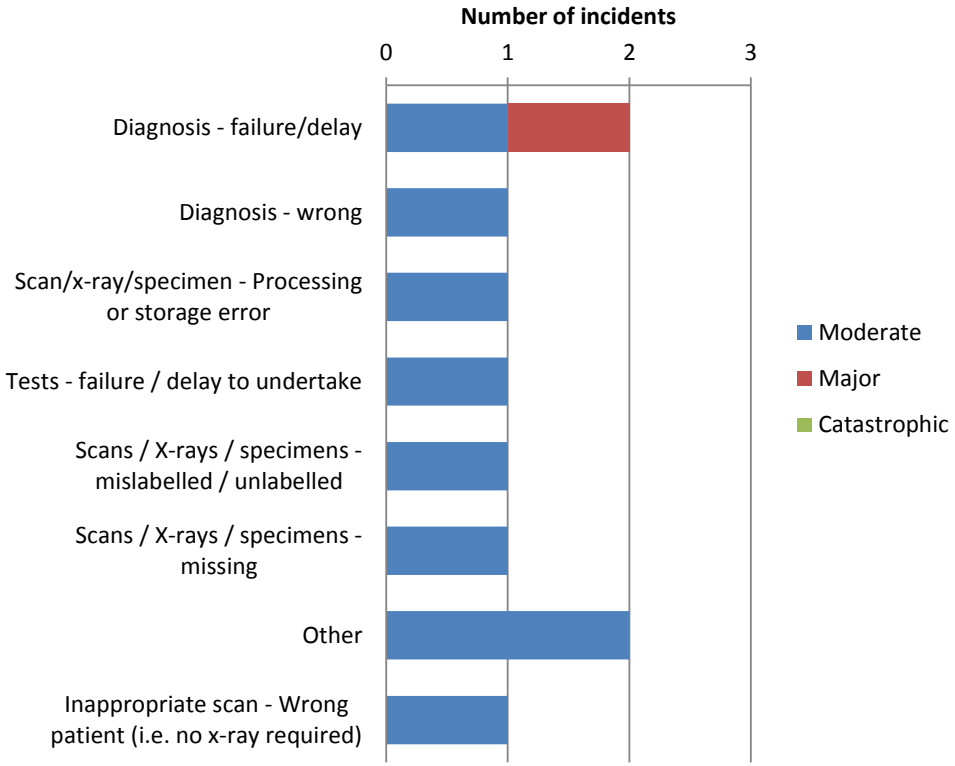
There are currently 14 infection control risks on risk registers across the trust which are being managed at a local level. These include:

- 5 Low risks
- 6 Medium risks
- 3 High risks

7 of these risks have been opened for over 12 months.

Diagnostic tests and scans (10 incidents)

There were 10 diagnostic tests and scans during this period. The breakdown for these is as follows:



1 incident is currently being investigated as part of a SI investigation.

There are currently 0 diagnostic tests and scans risks on any risk registers across the trust.

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 declared 22 Sis to NHS England in 2015-16. 20 of these incidents were directly related to patient care whilst 2 were related to infrastructure issues in the trust including a power failure and carevue failure for a prolonged period of time.

The 20 SI's relating to patient care concern:
1 a loss of sight for a patient following surgery in the prone position
1 retained surgical instrument (Never Event)
1 incorrect storage of stem cells
3 surgical errors requiring additional sugery for the patient
3 delays in diagnosing a patient
1 accidental burn to a patient during a procedure

1 equipment failure (balloon catheters) for more than one patient requiring further treatment
1 detection of a displaced femoral fracture
1 failure to detect a deteriorating patient
3 loss to follow up causing harm (spinal,cardiac, urodynamics)
1 unexpected complication following surgery
1 accidental medication overdose (morphine)
1 capacity issues leading to a failure to treat a patient urgently
1 regarding the process used to section a patient under the MHA
1 incorrect diagnosis.

The chart below indicates the occurrence of SIs in the Trust between April 2010 and March 2016.

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.

During 2015/16 there has been a decrease in the number of SI's reported by the trust. This may be due to new, redefined NHS England reporting criteria issued in April 2015. The new criteria places emphasis upon harm caused to a patient and has discontinued the previous SI list meaning that some types of incidents may no longer fall into the SI criteria for reporting. For example, acute trusts are now no longer required to blanket report all grade 3 and 4 pressure sores. Instead, only pressure sores which the clinical team feel were preventable are reportable.

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 2015 and March 2016 the Trust received 30 MHRA Alerts. 8 of the alerts received were relevant to the Trust. Actions have been completed for 7 of the alerts and there is one alert currently in progress.

The other alerts received include Patient Safety Alerts from NHS ENgland or Estates Notices from the Department of Health. 65 Alerts of this type were received by the Trust during 2015-16. 16 of these required action by the Trust and were completed. 3 are still under review.

The Trust recently upgraded to the latest version of DatixWeb. As part of this upgrade the Trust also purchased the Safety Alerts module on Datix. Currently, safety alerts issued by the Department of Health's Central Alerting System are received and acknowledged by a member of the Clinical Governance and Safety Team, CGST then disseminate the alert to the appropriate teams and departments to assess the relevance so that we are able to either close the alert if it is not relevant, or to implement any action which is required if it is relevant.

In line with the Trusts Risk Management Strategy, the plan is that going forward safety alerts issued via the Central Alerting System will be disseminated and responses recorded on Datix. This will mean that rather than receiving an email from a member of CGST, relevant staff will receive a notification email directly from Datix, the email will contain details of the alert and a web link which will take them directly to the response page, here they will find further information about the alert, any attachments and documents which have been provided by the Central Alerting System and fields to log their response status (relevant or not relevant etc) and a free text field allowing you to document why the alert is not relevant or what action will be taken if the alert is relevant.

Benefits

As a result of managing the Trusts Safety Alerts through Datix there will be various benefits to both staff directly involved in the dissemination and response of alerts as well as wider staff groups looking for information about previous or on-going alerts. Datix will allow the dissemination and response of Safety Alerts to be standardised and responding will be quick and simple. Benefits can be seen listed below:

- Compliance – By disseminating and recording all response and action on Datix evidence can be provided to demonstrate that there are systems in place to monitor overall compliance with the relevant policies which can be used to meet CQC and NHSLA requirements.

- Assurance – Reports can be generated from Datix quickly and easily. Action plans and progress notes will be available to ensure that those who need access to view the information have access to do so.

- Live data – up to date and live data will be available and can be published on the intranet allowing for further dissemination of alerts and their current relevance or action status.

Plans for the future – SIRS and consideration of whether the complaints module will be incorporated into Datix Web

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.

During 2015/16, the Risk Management team were contacted regarding 46 families, 19 resulted in a 'Persons who may pose a risk to Children' meeting.

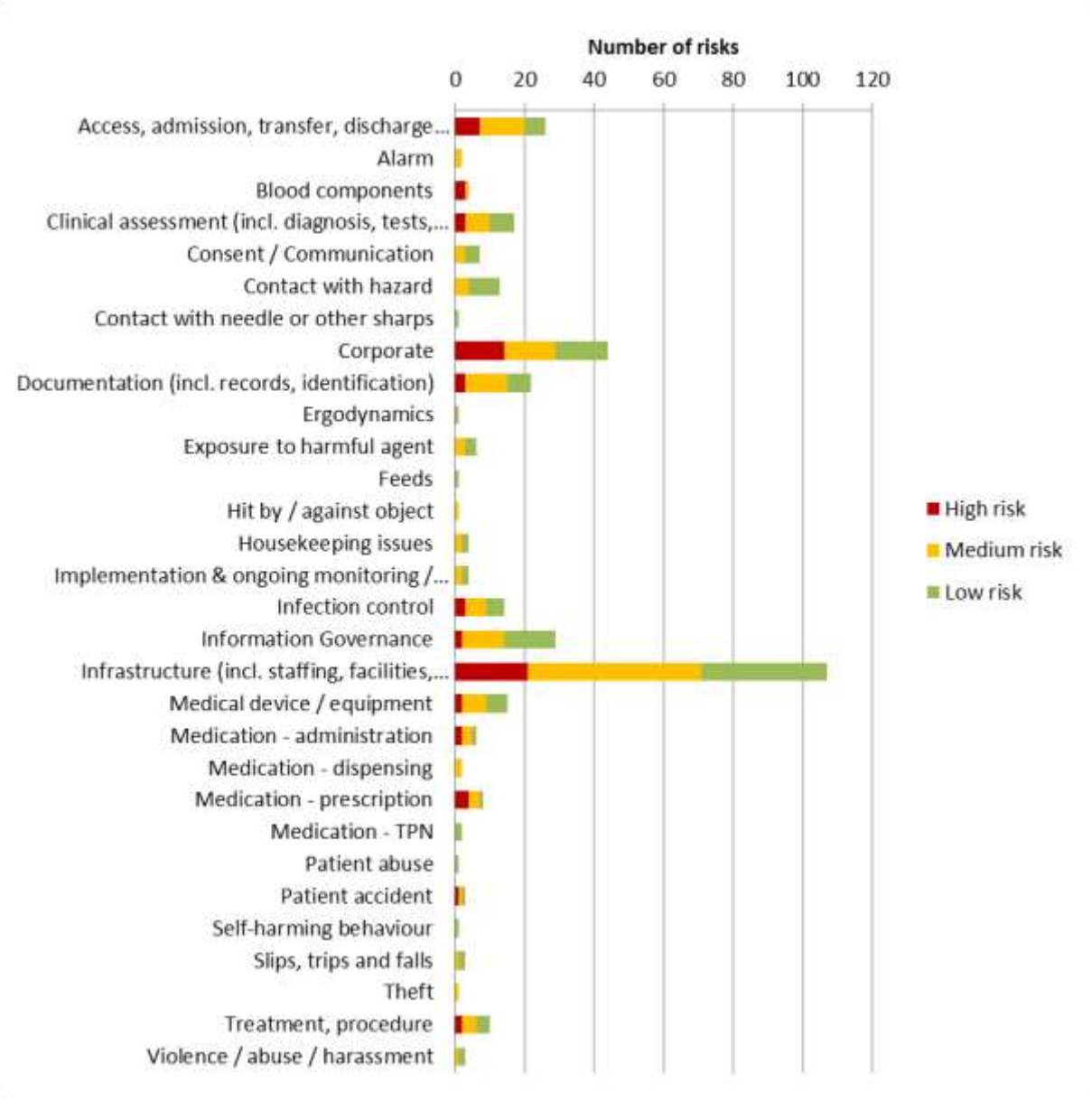
7. Risk Register Analysis

7.1 General

There are currently 359 open risks on the Datix Risk Management system. 139 of these were opened between April 2015 and March 2016.

7.2 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.



Risk trends 2015/16:

- Infrastructure (106)
  Risks catagorised as infrastructure are included on the risk registers of 47 specialities. 21 have a current risk rating as high, 50 are graded medium and 36 are low.

The majority of these risks are regarding lack of maintenance of equipment.
Other types of infrastructure risks are regarding:

- Management and reporting of Referral To Treatment (RTT) times (2)
- Staffing numbers / provision (26)
- Capacity to treat patients (e.g.demand for beds, clinic rooms, theatres) / ward environment (12)
- Environmental issues (e.g. cleans / infection control/ working environment) (10)
- Switchboard resilience / ICT issues (11)
- Other equipment / maintenance issues (14)
- Security concerns (5)
- Financial concerns (5)
- Meeting P&E targets / concerns regarding income (3)

- Ongoing building works (3)
- Concerns regarding fire safety (2)
- External changes affecting clinical equipment (2)
- Malfunctioning doors (2)
- Meeting clinic letter turn around times (1)
- Prescribing of medication in the community (1)
- Staff sickness levels (1)
- Estates handover (1)
- Accessing intelligent storage (1)
- Lone working (1)
- Mandatory training issues (1)
- Transport of a deceased child (1)
- Manual handling / movement of equipment (1)

56 of these have been opened for over 12 months.

Risk Manager
May 2016

Appendix 1: Serious Incidents declared to NHS England between 01/04/2015 and 31/03/2016.

Ref	Date declared to NHS England	Description	Type of Recommendations	Closed date
2015/12756	08/04/2015	A four year old patient with an underlying condition of Pfeiffers syndrome underwent a neurosurgical procedure (Foramen Magnum Decompression). Following this surgery the patient has experienced loss of vision in her left eye.	1) Loss of vision is a known but very rare complication of surgery that is undertaken when the patient is in the prone position. Great care is taken to protect the eyes from pressure during this type of surgery. the surgical team will investigate alternative products available. 2) In some cases a patient may be moved during a surgical procedure to relieve pressure on the optic nerve. However, moving patients during surgery brings with it additional risks. However, this option should be considered prior to surgery if it is felt the patient's optic nerves could potentially be at risk. 3) The patient's parents were not informed of the risk of Loss of vision whilst discussing the risks of surgery during the consent process. the risk of Loss of vision will now be consented for.	13/07/2015

2015/12734	08/04/2015	Deterioration and cardiorespiratory arrest in a cardiac patient with associated co-morbidities who received an inadvertent morphine overdose.	An acuity assessment of all the patients on the unit should be carried out in preparation for the start of all shifts for staffing levels relative to the number and acuity / severity of illness of the patients on the unit at that time.There should be an escalation policy to senior staff in the hospital when this balance crosses a critical threshold which might influence bringing in more staff where possible, shifting staff between units in the hospital or cancelling elective cases or refusing admissions. This should be a 24 hour Trustwide policy including appropriate escalation up to the clinical site practitioners (CSPs) and all managers if required out of hours. All bolus doses of opiates and benzodiazepines in patients on the ICU and HDU, who are NOT already on such infusions and not ventilated (and not being given for chest drain removal), should be discussed with the senior fellow / consultant if being administered semi-electively. Re-iterate importance of the medication administration policy to all current staff and all new staff at induction. Use this SI as part of a teaching case for all staff. Human factors training on situational awareness in complex cases should continue to be taught in local ICU training and ICU simulation training using this case as a teaching scenario. Continue to communicate to all new and current trainees, the importance of calling the consultant on call when unsure of a patients condition or when the situation is failing to improve as expected with time.	16/03/2016

2015/14749	23/04/2015	A patient with a diagnosis of Tuberous Sclerosis (TS) presented to her local ophthalmology team with swollen optic discs in May 2013. The patient was reviewed again by their local ophthalmology team in March 2014 and her optic discs were noted to still be swollen. She was referred and triaged routinely to the GOSH ophthalmology team for review and MRI scan. The patient was seen by the GOSH consultant ophthalmologist 2 in July 2014. She confirmed swollen optic discs and referred the patient for an MRI scan at GOSH. As the GOSH consultant ophthalmologist 2 was retiring she noted on the MRI request form that the results needed to be sent to her colleague, GOSH consultant ophthalmologist 3. However, the patient was not handed over to GOSH consultant ophthalmologist 3 so he was unaware of this patient or that the MRI results would be sent directly to him by email. The MRI scan was completed on 31 July 2014 confirming a Subependymal Giant Cell Astrocytoma (SEGA) and hydrocephalus. It was formally reported and authorised on 1st August 2014. The MRI report was emailed to GOSH consultant ophthalmologist 3 who did not review this email. The patient's parents attended a follow-up ophthalmology appointment in September 2014 where the MRI scan was reviewed and the diagnosis communicated to them. The patient was then urgently referred to the neurosurgical team for intervention and management. The patient's visual acuity has been noted to have deteriorated during this period of time.	In childhood, TS patient's (including patients who are not exhibiting symptoms) should have a brain scan approximately every two years as it is often difficult to elicit appropriate history and fundoscopy can be difficult. Consultants who request serious clinical investigations on behalf of a colleague should hand over to another consultant. Ensure all specialities trust wide are aware of the neurology internal referral processes for emergency and urgent referrals. A formal verbal/written communication process for urgent radiological results both in and out of hours must be implemented	18/09/2015

2015/14987	27/04/2015	The patient, born in 1998, has been a regular patient of the Trust throughout their life. She has undergone a number of major procedures, both at the Trust and in other hospitals. In 2012, the patient began to be transitioned to adult services. As part of the transition process, the adult centre undertook a routine series of images of the patient's abdomen. In this series of scans, a foreign object was identified, appearing to possibly be a surgical swab. However, It is not possible to determine with certainty if this object is indeed a retained swab, nor is it possible to tell with certainty when such retention may have occurred.	1)Take steps to ensure the current surgical swab policy reflects the use of swabs appropriately sized to the procedure being undertaken. This incident highlights that best practice would advise against the use of loose small swabs inside the abdominal cavity unless attached to a surgical instrument (e.g. the use of a swab on a rampley's sponge holder for mopping out the abdomen). 2)Reiterate to all staff the need to record any patient safety incident relating to a GOSH patient on Datix, regardless of how it was identified or any delay in becoming aware of such information. This must include a reminder of the Serious Incident and Never Event criteria established by NHS England. Similarly, the message must address how GOSH staff should address escalating incidents to other healthcare providers for incidents identified internally.	16/07/2015
2015/15280	28/04/2015	On Friday 10th April 2105, the patient underwent a cardiac catheter procedure in IR3, to stent her pulmonary artery. There were two stents used in this case. However, covered stents were used instead of a bare metal stent. The 1st stent was implanted with a good result. However, the the second stent that was implanted covered the origin of the pulmonary arteries. As the stents were covered and not bare, this meant there was no flow to the lungs, though there was some blood flow to the lungs overall from another blood supply.		Open
2015/16544	11/05/2015	Stem cells collected and frozen for storage for subsequent use for an autologous transplant were found to be defrosted, having been stored in a quarantine container over a bank holiday weekend. The cells were therefore not possible to use	To ensure all areas have a complete list of all equipment requiring validation and/or servicing and that these tasks are completed in a timely and robust way	04/08/2015

2015/17059	14/05/2015	The patient was undergoing emergency neurosurgery for closure of a myelomeningocele during which they suffered a cardiac arrest.The investigation panel consensus was that the patient suffered a hypovolaemic cardiac arrest caused by hypololaemia exacerbated by hypothermia. There were clear signs of deterioration prior to the cardiac arrest; if the signs of hypervolemia were acted on sooner it could have potentially prevented the cardiac arrest.	Anaesthetics team to review their temperature monitoring policies especially the indications for core temperature monitoring in neonates. Anaesthetics team to review their policies and procedures for monitoring glucose homeostasis Resuscitation team to ensure the resuscitation policy is clear with regards to reallocation of leadership of resuscitations which occur in theatres when necessary. It is essential that those involved in the team brief have the right information (regardless of job title/seniority.). It is acceptable for these plans to change on the basis of new/different information, however any subsequent changes to the plan discussed at the brief must then be communicated to all other team members	06/11/2015
2015/18436	27/05/2015	Over a period of 6 months three incidents occurred where the balloon part of three Covidien urinary Foley catheters size 8fr failed to deflate. All 3 patients required additional intervention and underwent a full general anaesthetic to remove the catheters by percutaneous puncture	Whilst the investigations are continuing with the manufactures regarding the fault with the urinary catheter balloon deflation, it was decided to switch catheter type to another type already in use in the Trust to prevent patients being harmed in the interim. Review of the training and competency assessment programmes in place in the Trust to ensure these are fit for purpose for both medical and nursing staff. Learning must be embedded regarding the importance of consulting the Urology team regarding issues with urinary catheter use.	29/10/2015

2015/19003	01/06/2015	A patient was referred to the ophthalmology team with a lesion in her eye. Clinically this looked like a benign vascular lesion but the local ophthalmology team wanted to confirm diagnosis and rule out anything more sinister such as rhabdomyosarcoma. The patient was seen by the GOSH ophthalmology team and referred for an MRI scan. This was reported by the neuroradiology team. The language used in the report was very technical but alluded to the presence of malignant cells by saying that there was a high nuclear to cytoplasm ratio. However, this report was interpreted as a vascular/lymphatic malformation by the ophthalmology and IR teams and the patient was started on sclerotherapy treatment. The lesion failed to respond to treatment and was excised. The patient has now been diagnosed with a possible neuro-endocrinology condition, possibly malignant.	Radiology scan reports should use plain English and a brief useful list of differential diagnosis should be offered where appropriate. Referral and management of patients undergoing orbital sclerotherapy should be a clearly defined pathway. This includes 1 - a lead, named consultant looking after the patient; 2 - all patient's undergoing treatment being discussed by a multi-disciplinary team including the ophthalmology and IR teams	08/09/2015
2015/19141	02/06/2015	The patient sustained a femoral fracture causing the patient pain and requiring admission to the local hospital and conservative management following a procedure	Manual handling risk assessment documentation must be completed for all patients Concerns raised by parents/carers/patients should be documented in the medical records and addressed appropriately	30/10/2015

2015/21530	22/06/2015	This incident involves a 9 month old patient who has been treated at GOSH since February 2015 under the Dermatology team for removal of pyogenic granulomas which appear primarily on the patient's face but also over their body. In June 2015 the patient attended GOSH for a third procedure to remove the lesions. Unfortunately during the procedure the patient experienced significant burns to the face.	a. The Trust is to robustly review the available national & international evidence and best practice to identify the feasibility or not of moving to the use of aqueous based skin cleaning fluids in theatres, the laser room & any other determined environments and not alcohol based especially in the presence of heat sources. The outcome of this review to be presented to the Chief Nurse, Medical Director & Divisional Director for Surgery b. With immediate effect a review of the current standard operating procedure (SOP) / policy for the application of skin cleaning fluid in theatres and associated environments that ensures there is no pooling of skin cleaning fluid & the appropriate time between application and commencement of surgery is documented and adhered to. The outcomes & assurance to be reported to the Division of Surgery's Clinical Governance Meeting & the Patient Safety & Outcomes Committee. c. All appropriate staff to be made aware of the actions required to minimise the risk of fire when using the Hyfrecator. - All swabs used next to heat sources should be soaked in saline.Alternative non-flammable products to be explored for use during laser procedures - All appropriate staff to be made aware prevention of fire when using the the Hyfrecator - Reiteration of the importance of retaining items which are subject to investigation. If staff are unsure about appropriateness of retention they should discuss this with a member of the Risk Management team. - Medical Illustration to be used to document harm caused to a patient. - Correspondence with other Trust's and families regarding incidents which have occurred should be approved with the patient's consultant.	25/02/2016

2015/25824	03-Aug-15	The patient was under the care of a Consultant Spinal Surgeon, since June 2012. After assessment in outpatient clinic on 17 October 2012 it was agreed that she would require a posterior spinal fusion operation within the next 6 month and to have a brace fitted by Orthotics in the meantime. The brace was fitted on the 20th November 2012 but the patient was not added to the waiting list for the posterior spinal fusion and no follow up was made. Due to not having the posterior spinal fusion in early 2013 the patient's curvature has progressed and she will now need an extra procedure of an anterior release prior to the spinal fusion. The clinical outcome is expected to be the same as it would have been if operated on in 2013 but there will be an additional procedure required.	The Trust must establish a reliable system to 'cash up' clinics to confirm that all follow up activity has been booked. There must be a Trust policy to describe the actions to be taken if it is not possible to contact a family if their treatment pathway is not complete	04/02/2016
2015/28165	25/08/2015	The patient underwent a second stage hypospadias repair with meatoplasty on the 29 July 2015. Following surgery the patient's parents noticed a change in appearance of his penis and brought him back to GOSH for review. The patient was reviewed by the urology consultant on the 13 August who noted that the patient's penis was very swollen in the area of the repair. The tip of the penis was a dark colour and beneath the suture line there was a white swelling. This was an unexpected complication of surgery.	Contact details must be provided to patients and their families in so that they may contact appropriate staff if they have any concerns regarding their child's clinical condition. The contact details provided must include telephone numbers that will be answered out of hours. The nurse discharging the patient must check that parents understand who to call if they have concerns. Consultant Urology Lead and Lead Nurse to review the removal of dressings after hypospadias surgery and training and support required	04/02/2016

2015/29954	15/09/2015	On insertion of an arterial line into the left radial artery the guidewire migrated and could not be secured at the time. The patient required an additional procedure under general anaesthetic to retrieve the guidewire. The patient did not suffer any harm nor neurovascular compromise but escalation of the ischaemic limb pathway was not successful. This is a newly commissioned venture		Open
2015/30579	22/09/2015	Capacity issues on Eagle ward resulting in a patient needing to be transferred to the Evalina for treatment		Open
2015/32273	08/10/2015	Child known to cardiac and general surgery. Last cardiac appointment May 2014. Six month follow up appointment not made. DNA surgical OPA in June 2015. Mum called department on 02 Oct 2015 as concerned child unwell. Advised to attend local ED. Follow up call to mum by cardiac nurse practitioner on 05/10/2015. Informed child had collapsed. Taken to local but resuscitation was unsuccessful and the child sadly died. Declared as an SI as a lost to follow up for cardiology services.		Open
2015/36824	26/11/2015	Patient not rebooked for urodymanics studies when cancelled in September 2014. Not seen at GOSH until November 2015 when attended for bladder function assesment. Several days later presented to local hospital and found to be in 'acute on chronic' renal failure, subsequently transferred to Eagle for management.		Open

2015/37127	01/12/2015	Generator test caused a power failure in one of the hospital buildings causing 4 wards and laboratories to be without power for the day		Open
2015/38180	11/12/2015	Process to section a patient under the mental health act.		Open
2016/2368	26/01/2016	Patient sample sent for genetic testing in 2002. Test failed a number of times and no result received. The patient was lost to follow up. The test was for lynch syndrome, a cancer predisposing condition. If Lynch syndrome had been confirmed the patient would have been screened 2 yearly. However, the patient was screened 5 yearly. In 2015 the patient has been found to be suffering from bowel cancer which may be been diagnosed earlier with more regular screening.		Open
2016/3144	03/02/2016	Extended Careview downtime.	SI investigation commenced	Open
2016/6069	03/03/2016	Assessment/ diagnosis and management of patient who underwent pyloric stenosis surgery		Open

ATTACHMENT 7

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Audit Committee meeting held on 18th April 2016

Board Assurance Framework

The Committee noted the position of the risks on the Board Assurance Framework (BAF) for 2015/16 and discussed the suggested BAF risks for 2016/17. It was agreed that any merging of risks should not divert focus from key areas which should continue to be specifically referenced within the risk description. The importance of being assured about the management of Trust Wide Risks was emphasised.

External Audit: Interim update report to the Audit Committee for the year ended 31 March 2016

Deloitte suggested that further work was required on the Trust's draft Annual Governance Statement which should include further information about the RTT issues in light of GOSH's reporting suspension. No risks had come to light as a result of Deloitte's substantive work and IPP debt would be considered again as large amounts of debt had been outstanding at month 9. The Committee discussed the disclosures that would be made around going concern in the annual report and Deloitte said that this should follow on from the disclosure made in 2014/15.

Risk Management Report

The Committee welcomed the Chief Executive taking the Chair of the Risk Assurance and Compliance Group to bring increased focus to the risk work within the divisions.

The Committee discussed the following high level risks:

- Risk 9: Research funding available to GOSH

It was noted that the process for applying for BRC and CRF funding was on-going and discussed the Trust's current level of commercial funding. The Committee welcomed the recent increase in levels of commercial funding and encouraged the continuation of this increase.

- Risk 10: Access Policy

The Committee noted that the Access Policy would be considered by the Policy Approval Group on 25th April and go live in the organisation from 1st May. The Intensive Support Team had confirmed that the policy was an example of best practice.

- Risk 12: Commissioners

The Committee discussed the two elements of the risk: a lack of commissioner strategy which would provide GOSH with the structure to prioritise services and future capacity, and the lack of differentiation in funding strategy between specialist paediatric services and others. It was noted that a gap remained between the funding offer made by NHS England and GOSH's proposal.

- Risk 15: Data Quality Risk and Data Quality Review Update

An action plan had been developed following the completion of the data quality review and the greatest challenges were around resources in operational teams and competing priorities within the organisation. Work was taking place to scope the additional resources required.

International and Private Patient (IPP) Debt Update 2015/16

The Committee discussed the levels of IPP debt which had risen along with the time taken to retrieve the debt. The Trust's external auditors confirmed that GOSH was not in an unusual position and the committee noted that the debt had been adequately provided for. Letters of guarantee were in place for over 90% of the debt.

Final report on generator test serious incident

The Committee received the report and noted that the learning would be shared with other Trusts.

Cyber activity at GOSH

It was reported that the priority was to complete the remediation and consolidation works to the network and servers and it was anticipated that this would take place within the next three months. As there were a large number of niche applications run by the Trust, these would take longer to consolidate. A significant work programme was underway which was being monitored by the IT Board.

Whistle blowing Update

It was reported that there was one open case being reviewed by the Trust's Counterfraud Manager. A lead GOSH investigator had been appointed as had two members of the finance team to support the investigation.

Losses and Comps (Debt Write off) and Aged Debtor/Creditors

Discussion took place around the write off of two key elements of debt, one of which had the possibility of being incorporated into a future contract. It was confirmed that this debt had been 100% provided for. Deloitte said it was vital that the revenue was not recognised twice, both in terms of having been written off and being recovered by a new contract. The Committee discussed the risk of treating self-paying patients following a clinician's estimate of the likely extent of the treatment.

Draft Head of Internal Audit Opinion for 2015-16

It was confirmed that the draft Head of Internal Audit Opinion had provided significant assurance with minor improvements required and that the core areas of the internal audit programme had provided green or amber green assurance throughout the year.

Internal Audit Strategic and Operational Plan: 2016-17

The Committee discussed the plan for 2016-17 and noted that a number of key areas would not be reviewed as part of the five year audit plan. It was agreed that the October meeting would review a robust internal control self-assessment programme that was being developed by the Chief Finance Officer.

Counter Fraud Workplan 2016/17

The Committee approved the Counter Fraud workplan for 2016/17.

Audit Committee Annual Effectiveness Survey Results

The Committee noted the results of the effectiveness survey and the key areas of concern which had been raised. The areas of improvement would be addressed during meetings.

Audit Committee Terms of Reference and workplan

The Audit Committee considered the proposed minor updates to the committee's terms of reference and approved the amendments. The terms of reference and workplan are attached at Appendix 1.

The Trust Board is asked to endorse the terms of reference.

Compliance with the NHS provider licence – self assessment

Areas of amber on the self-assessment showed where the Trust was in the process of addressing areas of non-compliance. KPMG confirmed that they were satisfied with this approach.

Procurement Waivers

The Committee requested that a deep dive be conducted into cases where it was not possible to issue procurement paperwork in the timescales available and to review the effectiveness of the process.

Great Ormond Street Hospital for Children NHS Foundation Trust

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Authority

1.1. The Audit Committee is a non-executive committee of the Board of Great Ormond Street Hospital for Children NHS Foundation Trust (the Board), established in accordance with paragraph 36 of the Trust's Constitution and section 27 of the Board of Director's Standing Orders.

2. Remit

2.1.The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial internal controls that supports the achievement of the organisation's objectives.

3. Authority

3.1. The Committee is authorised by the Board to:

a) investigate any activity arising within its terms of reference;

b) to seek any information it requires from any member of staff and all members of staff must co-operate with any request made by the Committee;

c) to request specific reports from individual functions within the Trust.

d) to obtain independent legal or professional advice; and

e) to request the attendance of individuals and authorities outside the Trust with relevant experience and expertise if it considers this necessary.

4. Membership

4.1. The Audit Committee shall be composed of at least three independent non-executive directors. The Chairman of the Trust shall not be a member of the Committee.

4.2. At least one of the committee members shall have recent and relevant financial experience. Two members shall constitute a quorum.

4.3. The Board may appoint an independent member of the committee in addition to the non-executive director members to bring in additional experience and expertise.

4.4. One of the non-executive members will be appointed as Chair of the Committee by the Board.

4.5. The independent member of the Audit Committee shall also sit as an independent member of the Clinical Governance Committee.

5. Attendance at meetings

5.1. The Chief Executive, Chief Finance Officer, Deputy Chief Executive, Head of Clinical Governance and Safety; representative of the external auditors; and the Head of Internal Audit shall normally be invited to attend meetings.

5.2. The external auditors and internal auditors shall meet annually with the Committee without executive directors present, or at the Auditor's or Committee's request.

5.3. The Company Secretary shall be the Secretary to the Committee.

5.4. The Committee may invite any member of GOSH staff or directors to attend a meeting of the Committee, should it be considered necessary.

6. **Frequency of meetings**

6.1. Meetings shall be held a minimum of four times a year at dates agreed to coincide with key stages in the accounting and audit cycle. The external auditors or Head of Internal Audit may request a meeting if they consider one is necessary.

6.2. Members are expected to attend a minimum of 3 meetings per year.

7. **Duties**

7.1. To discharge the Trust's duties for Audit, the Committee shall ensure that the business of the Trust is conducted fully in accordance with the principles of accountability and probity by undertaking the following duties:

8. **Governance, risk management and internal control**

8.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

8.2. In particular, the Committee shall review the adequacy and effectiveness of:

8.2.1. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to the endorsements by the Board.

8.2.2.The underlying processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of the principal risks and the appropriateness of the above disclosure statements.

8.2.3.The policies and strategies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

8.2.4.The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the Counter Fraud Service.

8.3. The Committee shall advise the chief executive on the effectiveness of the system of internal control.

8.4. The Assurance Framework will be used to guide the Committee's work and that of the audit and assurance functions that report to it.

8.5. The Committee shall review and make recommendations to the Board on the management of risk, and the resources required including the annual business plan.

9. **Internal Audit**

9.1.The Committee shall ensure that there is an effective internal audit function that meets mandatory Audit Standards in a Foundation Trust and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

9.1.1.consideration of the provision of the internal audit service, resourcing of the service, the cost of the audit and any questions of resignation and dismissal;

9.1.2.review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that it is consistent with the audit needs of the organisation as identified in the Assurance Framework;

9.1.3.consideration of the major findings of internal audit work (and management's response) and monitoring of the implementation of audit recommendations by management;

9.1.4.ensuring coordination between the internal and external auditors to optimise audit resources;

9.1.5.an annual review of the effectiveness of internal audit.

10. **External Audit**

10.1. The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work.

10.2. Consideration of the appointment and performance of the external auditors will be conducted as outlined below:

10.2.1.1. The Committee will assess the external auditor's quality and value of work and the timeliness and reporting and fees on an annual basis and, based on this assessment, make a recommendation to the Members' Council with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards. To the extent that that recommendation is not adopted by the Members' Council, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

10.2.1.2. The Committee will make recommendation to the Members' Council about the remuneration and terms of engagement of the external auditor.

10.2.1.3. The Committee will oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years. It will agree with the Members' Council, the criteria for appointing, re-appointing and removing external auditors. The committee shall make a recommendation to the Members' Council with respect to the appointment of the auditor.

10.2.1.4. The Committee will develop,implement and monitor the policy on the engagement of the external auditor to supply non-audit services.

10.2.1.5. The Committee will consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal. Where the Members' Council puts forward a proposal to consider removing the auditor, the Audit Committee will investigate the issue, including allegations made against the auditor and report the findings to the Council.

10.1.2 Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy

10.1.3 Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

10.1.4 Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses and progress on implementation of the recommendations.

11 Other assurance functions

11.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications for the governance of the Trust.

11.2 The Committee will review the work of other committees in the Trust whose work can provide relevant assurance to the Audit Committee's scope of work. In particular, this will include the Clinical Governance Committee but may also include the Patient, Safety and Outcomes Committee and specific Risk Action Groups (RAGs).

11.3 The Committee will receive a report on the appropriateness of the evidence compiled to demonstrate the Trust's eligibility to hold the Monitor licence and its fitness to register with the Care Quality Commission (CQC)

11.4 The Committee will review the framework in place for managing, governing and monitoring data quality and information governance.

12 Counter Fraud

12.1 The Committee shall satisfy itself that the Trust has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

13 Raising concerns

13.1 The Audit Committee should review arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.

13.2 The Audit Committee will monitor the arrangements in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. Through this work, the Audit Committee will ensure that:

13.2.2 safeguards for those who raise concerns are in place and operating effectively;
13.2.3 individuals or groups are enabled to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations
13.2.4 valid concerns are promptly addressed
13.2.5 processes reassure individuals raising concerns that they will be protected from potential negative repercussions

14 Financial reporting

14.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's performance.

14.2 The Committee shall ensure that the systems for reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

14.3 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

14.3.2 the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;

14.3.3 changes in, and compliance with, accounting policies, practices and estimation techniques;

14.3.4 unadjusted mis-statements in the financial statements;

14.3.5 significant adjustments in preparation of the financial statements;

14.3.6 significant adjustments resulting from the audit.

14.3.7 letter of representation

14.3.8 qualitative aspects of financial reporting.

15 Standing Orders, Standing Financial Instructions and Standards of Business Conduct

15.1 On behalf of the Board of Directors, the Committee shall:

15.1.2 review the operation of, and proposed changes to, the Board of Directors and Members' Council standing orders; the standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

15.1.3 review the scheme of delegation.

15.1.4 report to the Board of Directors on its findings and recommended amendments for approval.

16 Administration of the Committee

16.1 The Committee shall undertake an annual review of its effectiveness, which will be reported to the Board of Directors.

16.2 The Committee shall be supported administratively by the Company Secretary, whose duties shall include:

16.2.2 Agreement of the agendas with the Chair and collation of the papers;

16.2.3 Taking the minutes;

16.2.4 Keeping a record of matters arising and issues to be carried forward;

16.2.5 Advising the Committee on pertinent issues/ areas;

16.2.6 Enabling the development and training of Committee members.

16.3 The Committee shall review its terms of reference and work-plan on an annual basis and consult with the Members' Council on any revisions.

16.4 The Committee shall receive a summary of the minutes of the Risk, Assurance and Compliance Group and Clinical Governance Committee.

17 Reporting

17.1 A summary of the reports received by the Audit Committee is outlined in the work-plan attached at annex 1.

17.2 A summary of the minutes of the Audit Committee shall be submitted to a meeting of the Board of Directors.

17.3 The Chair of the Committee shall draw to the attention of the Board and the Member's Council any issue that requires disclosure to the full Board or requires action, making recommendations as to the steps to be taken.

17.4 The Committee will report to the Board at least annually on

17.4.2 its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework;

17.4.3 the completeness and extent to which the risk management framework is embedded across the Trust;

17.4.4 the completeness and extent to which the data quality framework is embedded;

17.4.5 the completeness and extent to which the information governance framework is embedded;

17.4.6 the integration of governance arrangements and the assurances sought of the robustness of the evidence demonstrating the Trust's eligibility to hold the Monitor licence and its fitness to register with the Care Quality Commission; and

17.4.7 the robustness of evidence demonstrating compliance with Monitor's Code of Governance, the Well Led Governance Framework and production of the Quality Report.

April 2016

Attachment 7

Great Ormond Street Hospital for Children NHS Foundation Trust

GOSH Audit Committee Annual Workplan 2016-17

Agenda Item/Issue	April 2016	May 2016	October 2016	January 2017
External Auditor Reporting				
Agreement of External Audit plan			✓	
Private discussions with External Audit (including the terms of engagement and fees; ensuring independence, objectivity and effectiveness of the process; an annual review of the effectiveness of external audit) and report to the Members' Council		✓ and report to MC		
Review of non-audit work carried out by external auditors (and reported in Annual Report)		✓		
Market testing exercise for appointment of external auditor	External auditor appointed from April 2014			
Recommendation to Members' Council on appointment of external auditor including remuneration and terms of engagement	✓ - remuneration			
Agreement of annual audit letter before submission to Board and Council		✓		
Internal Auditor Reporting				
Approve Internal Audit Strategy and Operational Plan	✓			
Review of Internal Audit Progress Reports and performance against the internal audit plan	✓	✓	✓	✓
Receipt of annual internal audit report and associated opinions		✓		
Private discussions with Internal Audit (annual review of effectiveness of internal audit)			✓	
Counter fraud annual report and annual plan	✓	issues by exception	issues by exception	issues by exception
Assessment of performance of internal audit (including the cost of internal audit; ensuring that the resource is adequately resourced; an annual review of the effectiveness of internal audit)			✓	
Financial matters				
Review of audited accounts and financial statements		✓		
Year-end plan for accounts	✓			

Attachment 7

Agenda Item/Issue	April 2016	May 2016	October 2016	January 2017
Review of working capital, losses and compensations and debtors and creditors over £5,000	✓		✓	
Annual report on waivers of Standing Financial Instructions over £5,000				✓
Reference costs	✓			
Risk management and controls assurance				
Joint Risk Management Meeting (with AC, CGC and F&I)	July 2015			
Update on CQC compliance and Quality Accounts from the Clinical Governance Committee	Issues as they arise	Issues as they arise	Issues as they arise	✓
NHS Litigation Authority assessment – annual update	Issues as they arise	Issues as they arise	✓	Issues as they arise
Board Assurance Framework (including programme of risk reviews)	✓	✓	✓	✓
High level risk register • Any accepted risks during the period – explanation in the risk report	✓		✓	
Top 3 risks for Divisional Chairs and corporate departments		✓ - to July risk meeting		✓
Annual overview of management of P&E (CIPs) for previous year and forthcoming year	✓			
Service Level Agreements progress	✓			
Local Security Manager Annual Report and workplan (for info)		✓		
Fire Safety Annual Report (for info)	Annual Report			
Raising concerns – items reported	Policy review	✓	✓	✓
Salary Overpayments	✓		✓	
Update on data quality	✓	✓	✓	✓
Value of claims and the drivers behind the increase	✓			
Governance Matters				
Audit recommendations exception report	✓	✓	✓	✓
Annual review of Audit Committee	Draft	With annual report		

Attachment 7

Agenda Item/Issue	April 2016	May 2016	October 2016	January 2017
Review of Annual Governance Statement	Draft	✓ with annual report		
Review of compliance with the Quality Governance Framework		To Board		
Review of compliance with the Code of Governance		✓		
Information Governance Annual Report				✓ including IT system and security risk
Review terms of reference for ratification at Board of Directors	✓ and report to Members' Council			
Review of annual work-plan	✓			
Review of Standing Financial Instructions and Scheme of Delegation		Scheme of Delegation	SFIs	
Review of Constitution, maintenance of registers and Conflict of Interest Policy, Counterfraud Policy	As issues arise	As issues arise	As issues arise Conflict of Interest Policy/ Counter-fraud Policy	As issues arise
Note business of specified committees and review inter-relationships (summary reports) - Risk, Assurance and Compliance Group - Finance and Investment Committee (including an update on the robustness of the P&E programme) - Clinical Governance Committee	 ✓ ✓ ✓	 ✓ ✓ ✓	 ✓ ✓ ✓	 ✓ ✓ ✓

April 2016

ATTACHMENT 8

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Clinical Governance Committee meeting held on 5th May 2016

Committee Terms of Reference

The Committee approved the revised terms of reference (see Appendix 1 for further information).

Internal Audit Progress Report

The Committee received the Internal Audit Reports for Education Strategy and Governance and IT Operations and Infrastructure which had both provided partial assurance with improvements required. Discussion took place around the importance of implementing an Education Strategy and it was noted that this was a complex area for many Trusts due to the number of funding streams and different staff groups.

Internal Audit Strategic and Operational Plan 2016-2019

The committee approved the internal audit plan and noted that the term 'aggregate risk' had been developed by KPMG to describe the level of priority given to an areas and the value that KPMG would be able to add.

Work of the Clinical Review Group (CRG)

The committee received an update on the work of the CRG and the programme of work to review patient notes. The Committee noted that the validation work would be completed at the end of August.

Risk 10: Access improvement programme

It was reported that the Access Policy had been developed with the Intensive Support Team and had been discussed with the relevant assurance committees and stakeholders. It was confirmed that it met the required standards and would be rolled out throughout the Trust. Reporting on cancer waits was planned to resume in May 2016 and RTT reporting in September 2016. Further work would be done on the demand and capacity mismatch.

Gastroenterology Review Update

It was reported that the key on-going risk was the capacity to review patients within the service rapidly with an independent gastroenterologist. It was confirmed that currently two clinicians external to the Trust were undertaking patient reviews. The Committee noted that so far no physical harm to patients had been identified. It was agreed that a process was required for the work that takes place in an organisation such as GOSH where clinicians are working at the forefront of knowledge in their specialty where there are limited standard protocols.

Update on out of hours medical cover

The Committee noted that Health Education North, Central and East London (HENCEL) had agreed to return trainees that had been removed and to return GOSH to routine quality assurance reporting.

Update on quality and safety impact of Productivity & Efficiency (P&E) programme and Revised Productivity and Efficiency QIA process

An update was received on two Productivity and Efficiency Schemes: Neurosciences Administrative Workforce Review and Pharmacy (initial) Review and it was noted that there had been no adverse quality or safety impact as a result of the schemes. Discussion took place about the Quality Impact Assessment (QIA) process and the importance of ensuring it was not burdensome. Work would take place to consider the schemes that would require QIAs in the future and those that could be taken forward on a basis of 'business as usual'.

Annual Freedom of Information Update

The Committee expressed some disappointment at the reduction in FOI responses which had been issued with 20 days and welcomed the proposed improvement plan.

Compliance Update

It was reported that much of the CQC action plan had been completed. The Committee welcomed the progress.

Safeguarding update

The increase in safeguarding activity and social work referrals was noted and the committee welcomed the good work around honorary consultant safeguarding training. An internal safeguarding review had been undertaken which was currently going through factual accuracy and would be reported to the Clinical Governance Committee in due course.

Clinical Audit

Discussion took place around the Audit on hand washing, the results of which had not been as high as anticipated. It was reported that this had been discussed with the Director of Infection Prevention and Control and the Executive Team were satisfied that this was being taken seriously. It was agreed that it was vital that data such as this was provided alongside an evidence based explanation. The committee expressed disappointment that there had been a negative trend in the management of neonatal jaundice and emphasised the importance of this work. The Committee asked for a further update at the next meeting.

Matters to be raised at Trust Board

It was agreed that the following items would be raised at the Trust Board:

- RTT
- Gastroenterology
- Medical cover out of hours
- Timely responses by estates to health and safety issues
- Fire training
- The internal audit on IT

Attachment 8

Great Ormond Street Hospital for Children NHS Foundation Trust

Appendix 1: Revised terms of reference of the Clinical Governance Committee

Following an effectiveness review of the Clinical Governance Committee in July 2015 it was agreed that the workload and remit of the committee would be considered in light of a broader review of Ward-to-Board reporting. Due to resourcing problems, this work is still to be conducted and will commence on receipt of the results of the external Board governance assessment (to be undertaken this calendar year).

The NED members of the CGC are keen to ensure that the CGC is fit for purpose and receiving appropriate information to provider assurance on clinical risk and quality. As such, the terms of reference of the committee have been revised and updated.

The previous ToR of the CGC stated that the purpose of the committee was 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.

The revised ToR are broader, reflecting not only a role in seeking assurance that clinical governance systems and processes are in place, but that high quality, safe, patient centred care is provided:

To seek assurance of the quality of care and treatment in all services provided by the Trust (The definition of 'Quality' includes clinical effectiveness and outcomes, safety, service user and carer experience, equality and inclusion).

This will include seeking assurance:

- *That the necessary structures and processes are in place to deliver safe, high quality, patient-centred care and an excellent patient experience.*
- *Of any issues identified by the Trust Board (as requiring more detailed review that fall within the remit of the committee) including on any quality, safety or patient experience matters or shortcomings arising from the Trust's operational and quality and safety performance*

As part of a redefining and focusing of the committee, the membership of the committee has been altered to mirror that of the other assurance committee reporting to the Board, the Audit Committee. This means that the membership will be made up of three NEDs plus the independent member, with executive directors as attendees.

A revised workplan will be produced and as outlined in the ToR, include reporting from the PSOC and PFEEC.

The CGC considered the revised terms of reference and approved them at the May 2016 meeting. The committee endorsed the proposal to change the title of the committee from the Clinical Governance Committee to the **Quality and Safety Assurance Committee**.

The Trust Board is asked to approve the amendments to the terms of reference and change of name of the committee.

Great Ormond Street Hospital for Children NHS Foundation Trust

Quality and Safety Assurance Committee
Terms of Reference

1.0 Authority & Scope

1.1 The Quality and Safety Assurance Committee is a sub-committee of the Trust Board and is chaired by a Non Executive Director.

1.2 It has delegated authority from Trust Board to seek assurance of the quality of care and treatment in all services provided by the Trust.

1.3 The definition of 'Quality' includes clinical effectiveness and outcomes, safety (patient, public and staff), service user and carer experience, equality and inclusion.

2.0 Purpose

The purpose of the Quality and Safety Assurance Committee is:

2.1 To provide assurance to the Board and that the necessary structures and processes are in place to deliver safe, high quality, patient-centred care and an excellent patient experience.

2.2 To review and seek assurance on any issues identified by the Trust Board (as requiring more detailed review that fall within the remit of the committee) including on any quality, safety or patient experience matters or shortcomings arising from the Trust's operational and quality and safety performance.

2.3 To be assured that when an issue occurs which threatens the Trust's ability to deliver safe, high quality, patient-centred care and an excellent patient experience that this is managed and escalated appropriately and actions are taken and followed through.

2.4 To assure the Trust Board that the controls to mitigate risk within the areas of responsibility of the committee are in place and working within a regulatory and legislative framework.

2.5 To assure the Board that appropriate action is taken to identify implications for the delivery of safe, high quality, patient-centred care and excellent patient experience arising out of recommendations from external investigations of other organisations/ systems and processes

2.6 To assure the Trust Board that the annual internal audit and annual clinical audit plans are aligned and focused on the appropriate quality focused risks

2.7 To be responsible for reviewing, on behalf of the Trust Board, progress with quality improvement priorities set in the Quality Strategy and Quality Report.

2.8 To work in partnership with the Audit Committee and ensure that implications for clinical care of non-clinical risks and incidents are identified and adequately controlled. This will include seeking assurance of health and safety across the Trust.

3.0 Duties

<u>Governance, internal control and risk management</u>

3.1 To review the establishment and maintenance of an effective system of governance, risk management and internal control in relation to clinical services, research and development, education and training and workforce, in order to ensure to ensure the delivery of safe, high quality, patient-centred care.

3.2 To receive and review at each meeting those entries on the Trust's Board Assurance Framework (BAF) which are to be overseen by the Committee.

3.3 To receive annual assurance reports in relation to both research and development and education and training governance issues.

Audit

3.4 To review the Internal Audit operational plan and more detailed work programme and make recommendations, on the clinical, research and development, and education and training aspects of the Internal Audit annual workplan.

3.5 To receive and review the findings of Internal and External Audit reports covering patient safety, quality and experience, research and development, and education and training, and to assure itself that the management of the Trust is implementing the agreed recommendations in a timely and effective way.

3.6 To review the annual Clinical Audit programme and receive and review findings of clinical audit reports. This will include (by exception) details of national clinical audits where the Trust is identified as an outlier or a potential outlier.

Quality and safety

3.7 To receive regular reporting on compliance with the Care Quality Commission's Standards, including any areas of current concern or focus.

3.8 To receive all reports on the Trust produced by the Care Quality Commission and to seek assurance on the actions being taken to address recommendations and other issues identified.

3.9 To ensure that the Trust learns from national and local reviews and inspections and implements all necessary recommendations to improve the safety and quality of care

3.10 To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and patient experience and seek assurance of the actions being taken by management to address these.

3.11 To review the Trust's Quality Report and make recommendations.

3.12 To receive regular exception reports covering quality outcomes, safety (including health and safety matters) and patient experience issues and themes escalated from the Patient Safety and Outcomes Committee and the Patient Family Experience and Engagement Committee.

3.13 To receive notice of any 'whistleblowing' concerns raised on quality or safety matters.

3.14 To request 'deep dive' reports on any matters arising from within its terms of reference.

3.15 To require internal audit:

- to initiate special projects or investigations on any matter arising from within its terms of reference;
- to monitor the implementation of audit recommendations by management and report progress at every meeting;
- to consider any other relevant matters, as determined by the Committee.

4.0 Reporting

4.1 The Committee will receive reports as outlined in the committee work-plan.

4.2 The Quality and Safety Assurance Committee Chairman will present a summary report to the Trust Board following every meeting.

4.3 A summary of the Quality and Safety Assurance Committee will be shared with the Audit Committee (and vice versa).

4.4 The Committee will provide an annual report to the Trust Board on the effectiveness of its work and its findings, including its review of relevant Board Assurance Framework entries and audit reports covering areas within its terms of reference. This will be presented in the Trust's Annual Report.

4.0 Membership

4.1 Three Non-Executive Directors, one of whom shall chair the meeting.

4.2 The Board may appoint an independent member in addition to the non-executive director members to bring further experience and expertise. The same independent member shall sit on both the Audit Committee and Quality and Safety Assurance Committee.

4.3 For a quorum, there must be at least two Non-Executive Directors.

4.4 The following shall be expected to attend meetings:

- Chief Executive
- Deputy Chief Executive
- Medical Director
- Chief Nurse
- Director of Human Resources and Organisational Development
- Internal Auditor
- Head of Clinical Governance and Safety

4.5 Additional members may be added or invited to attend as appropriate. In particular, where appropriate, the Committee will invite clinical teams to attend its meetings to provide assurance on key governance and risk issues.

4.6 The Company Secretary will ensure that the Executive Office provides appropriate administrative support to the committee, Chair and committee members.

5.0 Frequency of meetings

5.1 The Committee will meet 4 times a year and committee dates will be sent out at the beginning of the year

5.2 Members are expected to attend a minimum of 3 meetings per year.

5.3 Papers for the meeting will be sent out one week before the meeting.

6.0 Monitoring

6.1 The Committee shall review its terms of reference on an annual basis, including attendance at meetings, coverage of the terms of reference and workplan requirements during the year. The views of members of the committee, staff attending the meeting and receiving requests for reports will be sought as part of the review. Recommendations will be brought to the committee for consideration and approval.

6.2The Chair of the committee shall draw to the attention of the Board any issue that requires disclosure to the full Board or requires executive action.

6.3The Chair will give an account of the committee's work in the Trust's annual report.

6.4The Committee shall undertake an annual review of its effectiveness which will be reported to the Trust Board.

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council update

A Members' Council meeting was held on Wednesday, 27th April 2016

The Council approved, subject to minor amendments, the revised Members' Council Terms of Reference and approved the revised Terms of Reference for the Members' Council Nominations and Remuneration Committee.

A presentation on GOSH's International Private Patients service was received. The Council discussed potential new territories for the service to move into and the importance of the GOSH brand for achieving referrals. It was reported that GOSH's IPP case mix was very different to other London hospitals as a result of having agreed not to enter the secondary care market. The Council noted the importance of having capacity for GOSH consultants to undertake their private practice at GOSH rather than at an alternative provider.

The Council discussed the risk associated with IPP debtor days which had increased and noted that Deloitte had confirmed that GOSH were not unusual in this respect.

The Council confirmed that they were supportive of the Trust's IPP activity but continued to be concerned that there remained no adverse impact on NHS services. The Chairman confirmed that the Board's expectation is that IPP services do not impact on NHS services . It was reported that during periods of extremely high NHS demand it had been possible to allocate IPP space to NHS patients, providing greater flexibility for the Trust as a whole.

A presentation on the Electronic Patient Record Project was received and it was confirmed that the Members' Council was an important stakeholder who would be kept up to date and would be involved through work with the Young People's Forum. It was confirmed that each of the Board's subcommittees would monitor the relevant areas of the project. The Council discussed the ways in which the project would enable parents to access patient notes.

The Council received an update on the annual plan and the outcome of the survey of members on annual planning priorities. It was noted that good responses were received around recognition of the Always Values, however there was work to be done around ensuring that patients and families felt that staff operated as one team. Work was taking place to develop an annual listening event for both patients and staff to take place towards the end of 2016.

A presentation was received on the output of the Membership and Engagement Committee away day and the patient and family stories that had been received by Councillors during engagement sessions within the hospital. This information would be fed into the Patient and Family Engagement and Experience Committee (PFEEC).

An update was received from the Young People's Forum which had discussed planning a 'takeover day' for young people as a means to get involved with in hospital and gain insight into its day to day work.

The Chief Executive provided an update on the following matters:

- Divisional restructure – developed to provide new core clinical leadership and reduce silo working across the organisation making change more efficient.
- Junior Doctor strike action – The Trust's Junior Doctors had been communicating well with the Trust and other staff had been extremely supporting during the action.
- End of financial year – The Trust had achieved its planned outturn for 2015/16 which was a considerable achievement when taking into account the competing priorities.
- Referral to Treatment and an update on validation of data.

The Council discussed the financial and other costs of not meeting targets. The Chief Executive emphasised that the Trust's highest priority was to safely treat all patients within a clinically appropriate timeframe. Discharge summary completion rates were discussed and it was noted that despite on-going focus and significant work, performance had reduced.

Following an election amongst the Council it was confirmed that the following Councillors would take up seats on the Members' Council Nominations and Remuneration Committee:

- Rebecca Miller
- Edward Green
- Mariam Ali
- Jilly Hale

The Council endorsed the Lead Councillor with 19 endorsements received.

An update on compliance, including the action plans that had been submitted in response to the CQC report, was received. The Council noted that there was work to be done around transition however there were areas of good practice in the Trust.

It was noted that Ms Mary de Sousa had secured a permanent job at the Trust and therefore must step down as a public Councillor. The Council thanked Ms de Sousa for her input.