



**Great Ormond Street
Hospital for Children**
NHS Foundation Trust

Meeting of the Trust Board Thursday 18 June 2026

Dear Members

There will be a public meeting of the Trust Board on Thursday 18 June 2026 at 1:00pm held in the Charles West Room, Barclay House, Great Ormond Street.

AGENDA

	Agenda Item <u>STANDARD ITEMS</u>	Presented by	Attachment	Timing
1.	Apologies for absence	Chair	Verbal	1:00pm
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 13 May 2026	Chair	A	
3.	Matters Arising/ Action Checklist	Chair	B	1:05pm
	<u>ANNUAL REPORT AND ACCOUNTS</u>			
4.	Quality Report 2025/26	Chief Medical Officer	C	1:10pm
5.	GOSH Foundation Trust Annual Financial Accounts 2025/26 and Annual Report 2025/26 including: ○ the Annual Governance Statement ○ the assurance committee annual reports ○ Compliance with the NHS Code of Governance ○ Draft Internal Audit Annual Report 2025/26 Draft Representation Letter	Audit Committee Chair Including Chief Finance Officer Company Secretary	D E F	1:20pm
	<u>CULTURE</u>			
6.	Final Trust Values	Acting Director of HR and OD	G	1:40pm
	<u>GOVERNANCE</u>			
7.	National Cost Collection 2025/26	Chief Finance Officer	H	1:50pm
8.	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.)			2:00pm
9.	Next meeting The next confidential Trust Board meeting will be held on Thursday 16 July 2026 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.			



**Great Ormond Street
Hospital for Children**
NHS Foundation Trust

**DRAFT Minutes of the meeting of Trust Board on
13 May 2026**

Present

Ellen Schroder
Prof Helen Cross
Gautam Dalal
Suzanne Ellis
Camilla Kingdon
Amanda Rajkumar
Adam White
Tacy Lockett
Sarah Ottaway
Kate Pye
Dena Marshall
Margaret Monckton
Dr Sophia Varadkar

Chair
Non-Executive Director
Non-Executive Director
Non-Executive Director
Non-Executive Director
Non-Executive Director
Non-Executive Director
Acting Chief Executive
Acting Director of HR and OD
Acting Chief Nurse
Chief Operating Officer
Chief Finance Officer
Acting Chief Medical Officer

In attendance

Jason Dawson
Cymbeline Moore
Dr Kiki Syrad
Karl Munslow-Ong
Anna Ferrant
Victoria Goddard
Kiera Parkes*
Dr Edward Gaynor*
Dr Simon Hannam*
Dr Finella Craig*
2 Governors (observers)
2 members of the public
(observers)

Interim Director of Space and Place
Director of Engagement
Director of Research and Innovation
Chief Executive Designate
Company Secretary
Trust Board Administrator (minutes)
Freedom to Speak Up Guardian
Guardian of Safe Working
Joint Medical Lead for Child Death Reviews
Joint Medical Lead for Child Death Reviews

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

16	Apologies for absence
16.1	No apologies for absence were received.
17	Declarations of Interest
17.1	No declarations of interest were received.
18	Minutes of Meeting held on 29 January 2026 and 18 March 2026
18.1	The Board approved the minutes of the previous meetings.
19	Matters Arising/ Action Checklist
19.1	The actions taken since the previous meeting were noted.

20	Chief Executive Update
20.1	Tracy Lockett, Acting Chief Executive reported that, during her time as Acting Chief Executive, she had placed a strong focus on listening to staff in order to navigate what remained a challenging period for the organisation. She noted that conversations, including those relating to Better Value work, had been open and constructive, reflecting a good level of engagement across teams.
20.2	The Trust had closed the financial year with a £5 million deficit and the organisation continued to work to reduce costs while maintaining high standards of quality and safety and supporting staff. Work was ongoing to review workforce models as part of the broader organisational reset and right-sizing programme.
20.3	Operational performance had improved, with Referral to Treatment (RTT) performance reaching 74% in March, representing a 6% improvement compared with April of the previous year. Diagnostic performance had also improved significantly, with a 10% increase over the same period. Tracy Lockett congratulated all staff involved in delivering these improvements.
20.4	Tracy Lockett thanked colleagues across the organisation for their support during recent Resident Doctor industrial action. She noted that the Trust had maintained approximately 90% of activity during strike days, demonstrating strong resilience and teamwork.
20.5	Work continued in relation to organisational behaviours and values, with a focus on embedding these across the Trust. Tracy Lockett noted that close working was underway with colleagues and the incoming Chief Executive to ensure alignment ahead of the launch.
21	Integrated Quality and Performance Report (Month 12 2025/26) March 2026 data
21.1	Dena Marshall, Chief Operating Officer confirmed that the Trust remained within Segment 3 of the National Oversight Framework based on Quarter 3 data, with Quarter 4 results expected shortly. Ellen Schroder, Chair queried whether an improvement in segment position was anticipated and Dena Marshall said that, while financial performance remained a significant factor, there had been notable improvements in access performance. She highlighted that Referral to Treatment (RTT) performance had reached 74% at year end, achieving the Trust's operational plan and representing a significant improvement year on year. This performance had received positive feedback from NHS England and had been shared with teams. She further noted that the number of patients waiting more than 52 weeks had reduced to below 200 for the first time, and that waits over 65 weeks had reduced by over 80%, reflecting sustained improvement in long-wait performance.
21.2	Challenges continued within audiology and dental services. Recruitment was underway in both areas, alongside additional lists and exploration of mutual aid to support recovery.

21.3	All five cancer standards had been met and overall activity remained marginally below plan, primarily driven by lower elective and day-case activity. Looking ahead to April, RTT performance had continued to meet plan, although overall activity had been impacted by Easter and industrial action.
21.4	Ellen Schroder welcomed the improvement in diagnostic performance which had exceeded 90% in some areas and noted that sustaining this would have a positive effect on RTT performance.
21.5	Sophia Varadkar, Acting Chief Medical Officer confirmed that compliance with statutory patient safety metrics remained within required thresholds. Progress on Patient Safety Incident Investigation (PSII) actions continued, with outstanding actions relating to work with other organisations which was being actively managed. She noted that incident reporting volumes had reduced, with no significant change in harm profile. The Patient Safety team were monitoring this and working with senior leaders to reinforce the importance of maintaining a positive reporting culture.
21.6	Kate Pye, Acting Chief Nurse reported a marginal increase in central line infections, primarily associated with skin infections. Work continued to review cases of <i>Clostridioides difficile</i> , including auditing hospital-acquired cases. She noted that Friends and Family Test response rates had reduced to 24%, although overall patient experience remained strong at 98%. Complaints remained elevated, with 15 received in March and the annual complaints report was being written which would be presented to the Patient and Family Engagement and Experience Committee and QSEAC. Staff turnover in the nursing workforce remained stable at 9%, and sickness absence had reduced to 4.5%.
21.7	Ellen Schroder asked whether workforce establishment would be recalculated following the closure of beds in International and Private Care. Kate Pye confirmed that affected nursing staff would be redeployed and that a period of stabilisation would be required to ensure staff were aligned to appropriate roles and skills. It was anticipated that vacancy levels would reduce in a stepwise manner following this work.
21.8	Sarah Ottaway, Acting Director of HR and OD confirmed that core workforce metrics remained within target overall, with some exceptions including sickness and appraisal completion. She noted that sickness rates remained below the national average and that vacancy rates would reduce significantly in April and May as a result of organisational restructuring, with vacancies being removed from establishment. She further reported that the overall workforce had reduced by approximately 5% over the year, with a corresponding reduction in pay expenditure of £2 million per month. Ongoing cost control measures included the introduction of a new risk-stratified recruitment process to support decision-making at local level.
21.9	Action: Suzanne Ellis, Non-Executive Director raised a query regarding bed closure metrics, noting that while reported closures had reduced, this needed to be understood in the context of permanent bed reductions. She highlighted the importance of clarity in

	how key performance indicators were defined and measured. Dena Marshall confirmed that from 1 June bed numbers would be updated to reflect the revised bed base.
21.10	Action: Suzanne Ellis also requested greater clarity on how theatre utilisation was measured. It was agreed that this would be explored further through the Finance and Performance Committee.
21.11	Ellen Schrdoer emphasised the need to focus on a smaller number of critical KPIs and Dena Marshall confirmed that the data provided to performance review meetings had been refreshed and that this would support a review of the IQPR dataset.
22	Finance Report (Month 12 2025/26) March 2026 data
22.1	Margaret Monckton, Chief Finance Officer presented the Month 12 financial position, highlighting that the Trust had closed the year with a deficit of £5 million, in line with the agreed position. She noted that the position had deteriorated early in the year, which led to the development of a recovery plan. Delivery against this plan had remained on track until Month 10, when performance worsened due to a downturn in International and Private Care income.
22.2	The Trust's underlying deficit stood at £38 million at year end, which would present a significant challenge for the forthcoming financial year. Margaret Monckton also highlighted that headcount had been reduced by 299 staff over the course of the year, with a corresponding and significant reduction in monthly pay costs, representing a positive shift in the Trust's cost base.
22.3	Corporate departments had delivered in line with plan and that the Trust had received £32 million from GOSH Charity compared to £20 million originally planned. The Trust closed the year with £49.8 million in cash, and the importance of maintaining a strong focus on cash management in the new year was emphasised.
22.4	Discussion took place around deficit support funding which had been made available at year end, subject to specific conditions, including the requirement for organisations to deliver in line with plan in order to incentivise delivery against financial plans. Margaret Monckton said that GOSH had not received this funding. Karl Munslow-Ong, Chief Executive Designate reiterated that achieving the agreed financial plan would be critical in securing any available incentives.
22.5	Action: Suzanne Ellis reflected that, across functions, there had been a significant amount of Better Value activity undertaken during the year and asked whether an after-action review had been completed. Margaret Monckton agreed that it would be beneficial to formally review learning from the year, and this was agreed that this would be considered.
22.6	Gautam Dalal asked whether sufficiently robust plans were in place to deliver for the current financial year, noting that the organisation was already into May. Ellen Schroder said that it would be important for the Finance and Performance Committee to undertake further detailed work in relation to Better Value.

22.7	The Board congratulated the team on the year end outturn.
23	Nursing Workforce Assurance Report Q4
23.1	Kate Pye said that the nursing workforce team had supported the review of recruitment and advertising strategies and approximately 120 posts had been reviewed in quarter 4. A decision had been taken not to recruit Newly Qualified Nurses (NQNs) for the coming period. Two NQNs had joined in April, and communication had been issued to host students to provide early notice of this position. A programme of webinars had been delivered to support students and explain the situation, and ongoing support was being provided to those affected.
23.2	Voluntary turnover had reduced, resulting in a more stable workforce with a greater proportion of staff having between 18 months and two years' experience. This stability was enabling a focus on retention and development activity.
23.3	Progress was being made with staff engagement through the Shared Governance Council, including the launch of a dedicated webpage. This was supporting nurses to feel empowered to have discussions about their professional development and contribute to service improvement.
23.4	Sickness absence had reduced and the primary drivers of sickness continued to be anxiety and depression. This was being closely monitored. A significant programme of work was taking place to support the uplift of band 5 nurses to band 6 roles, affecting over 700 staff. It was noted that this would require substantial capacity and focus over the coming period.
23.5	Ellen Schroder commented that, while the overall position was positive, it was regrettable that the organisation was unable to take on students who were training at GOSH, particularly given wider market conditions. Tracy Luckett confirmed that engagement with universities was ongoing to manage this position.
24	Health and Safety Annual Report 2025/26
24.1	Jason Dawson, Chief Infrastructure and Redevelopment Officer presented the Annual Fire, Health and Safety Report, noting that it had previously been reviewed at QSEAC. He advised that controls across fire, health and safety remained strong, with good levels of compliance in mandatory training,
24.2	Reporting through Datix remained robust, supporting effective monitoring and oversight of incidents across the Trust. Following the visit by the Health and Safety Executive (HSE), all associated actions had now been completed and closed.
24.3	Ellen Schroder asked about the environment in the Sight and Sound building and Jason Dawson confirmed that work was ongoing and that the building effectively required recommissioning. He clarified that this did not represent a health and safety issue but was instead an environmental matter, with specific challenges identified in audiology relating to noise generated by the ventilation system.

25	Freedom to Speak Up Annual Report 2025/26
25.1	The Board received the Freedom to Speak Up Guardian Annual Report, noting that it had been prepared in line with the standard reporting template required by NHS England. Kiera Parkes, Freedom to Speak Up guardian reported that the number of cases had increased compared to previous years, reflecting both a higher number of contracts and increased resource and visibility of the service, as well as wider organisational pressures.
25.2	Benchmarking against Model Hospital data indicated that, for an organisation of this size, activity levels were typically within the mid to higher range which was considered a positive indicator of staff engagement in speaking up.
25.3	The Board discussed recurring themes, recognising that similar types of issues continued to arise. In particular, there had been an increase in concerns relating to speaking up culture, and it was noted that further consideration was required to understand why some staff may not be using alternative routes to raise concerns.
25.4	It was noted that demographic data continued to be requested from staff using the service however, response rates remained low, limiting the ability to draw firm conclusions. The available data suggested a higher proportion of staff with protected characteristics accessing the service compared to the wider workforce, although this was subject to the caveat of a small sample size.
25.5	The Board noted that similar staff groups continued to utilise the service more frequently than others, and that work had taken place with the Guardian of Safe Working to raise awareness of the Freedom to Speak Up service, recognising that alternative routes also existed for some staff groups. It was also noted that there were ongoing challenges associated with temporary staff accessing speaking up routes, and that this remained an important area for consideration, notwithstanding the reduced reliance on temporary staffing in the Trust.
25.6	An increase in anonymous contacts was reported, with reasons for anonymity varying. While the majority of staff continued to share their identity, the increase in anonymous contacts was recognised as an important indicator in understanding speaking up culture.
25.7	The Board considered staff survey findings relating to raising concerns, with the main issue identified as staff confidence in taking concerns forward. It was noted that this had also been discussed at the Operations Board, and that confidence in escalation remained a key theme.
25.8	Amanda Rajkumar, Non-Executive Director said that she met with the FTSUG in her role as Speak Up Champion and reported that there was a perceived tension in some cases, whereby individuals wished to escalate concerns but not beyond a certain point. This was understood to reflect concerns that issues may not be addressed, or fear of negative consequences, and this needed to be recognised as part of the wider cultural context.
25.9	Camilla Kingdon, Non-Executive Director noted the upcoming closure of the National Guardian's Office and asked about the implications for networking between Guardians. It was confirmed that NHS England Guardians were currently assuming many of the

	responsibilities and that networks between Guardians would be maintained, although there was some anxiety amongst colleagues about the future of the Freedom to Speak Up function.
25.10	Sarah Ottaway, Acting Director of HR and OD noted that some responsibilities previously held by the National Guardian's Office would transfer to providers, and that the Trust was well positioned to support this. The importance of ensuring that Freedom to Speak Up contact details were publicly available and that appropriate psychological support was accessible was also highlighted.
25.11	The Board noted that there had been the introduction of Ambassadors over the past year to support speaking up culture. It was suggested that further expansion of this approach across different staff groups could have a positive impact, and it was reported that there was increasing interest from more senior staff, with a focus now shifting towards greater engagement with more junior staff groups.
26	Compliance with the NHS Provider Licence – self assessment 2025/26
26.1	Anna Ferrant, Company Secretary said that within two months of year end, Trusts were required to self-certify against one condition of the provider licence, confirming that the Trust had a reasonable expectation that it would have the required resources to provide commissioned services for the coming year. An evidence base had been developed which had been reviewed by the Executive Management Team which had agreed to self-certify against this condition.
26.2	The Board approved the Trust's response to condition CoS7.
27	Register of Seals
27.1	The Board endorsed the use of the company seal.
28	Board Assurance Committee reports:
28.1	<u>Audit Committee – March 2026</u>
28.2	Gautam Dalal, Chair of the Audit Committee reported on recent Internal Audit activity, noting that a number of reports had been received by the Committee. He advised that, in developing the audit plan for the year, there had been improved focus in directing Internal Audit activity towards areas of identified risk and it was recognised that recommendations were an inevitable outcome of this work and that these would be reflected within the Annual Report.
28.3	An in-flight review had been undertaken on the Children's Cancer Centre (CCC) programme and Gautam Dalal advised that such reviews would be conducted on a six-monthly basis to provide assurance that governance arrangements for the programme remained appropriate and that delivery continued to align with budget expectations. Recommendations arising from this review had been made and were being taken forward.
28.4	The Board noted that a review of the Better Value programme had also been undertaken, which confirmed the scale of the challenge associated with delivery,

	particularly given that this type of programme had not historically been undertaken at this level within the organisation.
28.5	Regular updates continued to be received from the Risk Assurance and Compliance Group (RACG), being the executive forum responsible for oversight of risk. Internal Audit recommendations had now been formally incorporated into performance review processes to support timely completion.
28.6	It was reported that the Counter Fraud function was progressing well, enabling issues to be addressed more quickly and effectively.
28.7	Discussion took place around the CCC in flight review and Jason Dawson said that the recommendations made within the reports were sensible however the way the report was presented would be revised. Suzanne Ellis reflected that the initial report lacked sufficient context and clarity and would be reframed. Gautam Dalal said the committee had recognised that these reports were read by multiple stakeholders but emphasised that they remained a valuable tool for the executive team.
29	Guardian of Safe Working Updates
29.1	<u>Q4 Report and Annual Report (2025/26)</u>
29.2	Edward Gaynor, Guardian of Safe Working outlined the profile of the resident doctor workforce, highlighting the significant proportion of locally employed doctors alongside NHS England trainees, and noting that many UK graduates were now entering non-traditional training pathways.
29.3	In relation to Quarter 4 performance, it was reported that exception reporting remained low, with only eight reports received during the period. However, three of these resulted in work schedule reviews, demonstrating that the process was being used where required. All rotas remained compliant and supporting processes were in place to reduce the need for exception reporting.
29.4	Vacancy rates were highlighted as a key issue, with rota gaps and exception reporting largely driven by vacancies. In Quarter 4, vacancy rates ranged between 6.7% and 10.4%, which had contributed to increased pressure on the workforce.
29.5	It was reported that five fines had been applied during the year, all relating to inadequate rest between shifts for non-resident on-call doctors. It was noted that reporting levels were influenced by the seniority of the workforce, with more senior trainees less likely to submit exception reports, and therefore alternative mechanisms were required to ensure appropriate oversight.
29.6	Edward Gaynor confirmed that there was strong engagement with the Resident Doctor Forum, with regular attendance at local faculty groups where exception reporting and the ten-point plan were standing agenda items.

29.7	The Board noted that vacancies remained a significant concern, with gaps in rotas primarily attributable to vacancies and sickness. It was reported that vacancy rates were increasing and discussion took place about the timeliness of recruitment. Sarah Ottaway confirmed that whilst local sign-off was required for all posts, those contributing to 24/7 on-call rotas did not require Executive Management Team approval. Edward Gaynor emphasised that, given the highly specialised nature of the workforce, recruitment timelines of six to nine months were required to ensure posts were filled effectively.
29.8	The Board discussed challenges associated with recruitment pathways, including the closure of the Medical Training Initiative (MTI) route, which was identified as adding further complexity to recruitment processes.
29.9	Action: Sophia Varadkar said that additional vigilance was being requested from Care Groups in relation to recruitment processes, and that although posts were being approved in a timely manner, this did not fully meet the timelines required by specialties. She confirmed that this would be reviewed further and an update provided to the Board.
29.10	Good progress was being made in delivering the ten-point plan, particularly in relation to facilities for rest and training, and that engagement from resident doctors remained strong.
29.11	<u>Resident Doctor (RD) Update (May 2026)</u>
29.12	An update was provided on the alignment of terms and conditions, noting that locally employed doctors were currently on contracts over 20 years old, whereas NHS England trainees were on the 2016 contract. This created challenges around equity, particularly in relation to pay and conditions. Work was underway to harmonise contracts, with a plan to implement a phased approach from August.
29.13	Camilla Kingdon said that she was supportive of the work to harmonise contracts which was important if GOSH was ambitious about recruiting top performing colleagues. Sarah Ottaway said that a plan was in place to move forward with contracts for Resident Doctor roles being advertised from May 2026 but emphasised that not all locally employed RDs would receive a higher salary under these changes.
29.14	Action: It was noted that the Resident Doctor ball and award ceremony would be taking place soon and dates for those events and the Resident Doctor forum would be circulated to the Board through the Chief Medical Officer's office.
30	Learning from deaths report – learning from GOSH Child Death Review Meetings. Q3 2025/26
30.1	Simon Hannam, Joint Medical Lead for Child Death Reviews presented the Learning from Deaths report, explaining that Child Death Review Meetings (CDRMs) focused on identifying modifiable factors and learning points, including seeking feedback from families through bereavement key workers.

30.2	The Board noted that there were no cases where modifiable factors had been identified in the care provided at GOSH. However, in two cases, modifiable factors were identified outside of GOSH, specifically relating to co-sleeping and missed vaccinations. Additional learning was identified in ten cases, and examples of excellent care were highlighted in twenty-three cases.
30.3	Progress had been made in addressing the backlog of cases, with all cases up to July of the previous year now reviewed. It was noted that the backlog had arisen due to both service gaps and cases requiring coroner involvement. Additional support had been provided to help address this backlog, and it was confirmed that while this support had enabled clearance of historic cases, ongoing work continued to manage more recent cases progressing through the process.
30.4	It was highlighted that for children who died outside of intensive care, identifying a named bereavement key worker could present challenges, and this remained an area under review.
30.5	The Board noted that once the backlog work was complete, the additional resource would no longer be required, with confirmation that the existing team capacity was sufficient to manage the ongoing workload.
30.6	The Board discussed the extent to which learning points identified through the CDRM process were embedded in practice. It was acknowledged that that further audit and a structured mechanism for tracking actions would be required and that responsibility for confirming actions often sat with external organisations where issues had occurred prior to transfer to GOSH, although follow-up was undertaken where possible.
30.7	It was noted that themes relating to communication with families continued to arise frequently, and that this had been incorporated into Trust teaching and palliative care education. However, it was acknowledged that, outside of mandatory training, attendance could not be enforced and that communication training was not universally required for all colleagues. Ellen Schroder emphasised the importance of reinforcing good communication practice.
30.8	Simon Hannam highlighted examples of excellence identified through the reviews, including the extent to which clinical teams sought second and third opinions to provide reassurance to families that all possible options had been explored.
31	Board Assurance Committee reports:
31.1	<u>Quality, Safety and Experience Assurance Committee – April 2026</u>
31.2	Camilla Kingdon, QSEAC chair said that a large number of items from the QSEAC agenda had been discussed at the Board meeting. Good levels of mandatory training compliance were being achieved, particularly in terms of safeguarding training. The

	Committee had discussed the importance of safeguarding at GOSH given the level of complexity of the Trust's patients.
31.3	
31.4	<u>Finance and Performance Committee Update – February, March, April 2026</u>
31.5	Suzanne Ellis, Chair of FPC provided an update on recent Finance and Performance Committee (FPC) activity, noting that a further meeting had taken place on 7 May to review the security tender, in addition to the regular reporting cycle.
31.6	The Committee had focused extensively on the prior and forthcoming financial year, including the financial plan and Medium-Term Financial Plan (MTFP). It was acknowledged that the plan remained high risk and stretching, and the Committee had emphasised the importance of clearly documenting underlying assumptions and maintaining transparency in reporting.
31.7	The Committee had welcomed improvements in RTT performance and sustained recovery in diagnostic waiting times, although it was noted that long waits remained a risk in certain specialties.
31.8	International and Private Care activity had been reviewed. While recognising a recent downturn, it was noted that an external review had been commissioned. Although the review had not identified any fundamentally new issues, it had provided a comprehensive evidence base to support the development of short, medium and long-term improvement plans.
31.9	The Children's Cancer Centre (CCC) programme had been considered, alongside the Internal Audit review and Suzanne Ellis commended the team for the complexity of stakeholder management involved and the challenges associated with delivering a major construction programme in close proximity to operational clinical areas. The Committee had welcomed the reset of the cancer transformation programme.
31.10	There had been increased focus on working capital over the past 18 months, particularly in relation to cash flow. It was noted that improved visibility of cash forecasts and actuals had strengthened oversight and enabled improved monitoring, however, it was noted that performance against Better Payment Practice Code (BPPC) metrics remained below expected levels. This had previously been highlighted by the CQC, and further work would be required to improve the timeliness of supplier payments. Ellen Schroder emphasised the importance of maintaining a strong understanding of the Trust's cost base and reiterated that paying suppliers on time was a key priority.
31.11	<u>People and Education Assurance Committee – February 2026 and April 2026</u>
	Amanda Rajkumar, Chair of PEAC said that good progress was being made against the People Strategy and the Committee had reviewed the refreshed values and discussed

	their roll out to the organisation. Two staff stories had been reviewed which provided an opportunity for learning for the Trust.
32	Update from the Council of Governors: February 2026 and April 2026
32.1	Ellen Schroder said that the Council had requested an update on infection prevention and control and wellbeing services for staff. A deep dive had also taken place into GOSH's staff survey results. The process was beginning to elect a lead and deputy lead governor.
33	Any other business
33.1	There were no other items of business.

TRUST BOARD – PUBLIC ACTION CHECKLIST
June 2026

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
189.5	18/03/26	Caroline Anderson reported that the actions being taken around workforce were impacting the organisation and close oversight was being maintained. She confirmed that sixteen organisational restructures had been completed and that the second MARS scheme had concluded, with staff due to leave the organisation at the end of March 2026. Very limited employee relations activity had been recorded as a result, reflecting the work undertaken to manage change processes effectively. Discussion took place around headcount reduction and Caroline Anderson said that this had been approximately 5%. Matthew Shaw confirmed that a workforce dashboard was available and it was agreed that this would be uploaded to Diligent.	SO, VG	May 2026	In progress
191.9	18/03/26	Ellen Schroder referred to staff survey benchmarking and it was agreed that work would take place to understand how the continuously top performing organisations were able to maintain this performance.	SO	July 2026	Passed to PEAC
193.2	18/03/26	Camilla Kingdon, Non-Executive Director said that in her organisation, declaration of interest was linked to job planning which could not be signed off without declarations being made. It was agreed that this would be explored.	AF, CK	July 2026	In progress
21.9	13/05/26	Suzanne Ellis, Non-Executive Director raised a query regarding bed closure metrics, noting that while reported closures had reduced, this needed to be understood in the context of permanent bed reductions. She highlighted the importance of clarity in how key performance indicators were defined and measured. Dena Marshall confirmed that from 1 June bed numbers would be updated to reflect the revised bed base.	DM	July 2026	On July 2026 Trust Board agenda
21.10	13/05/26	Suzanne Ellis also requested greater clarity on how theatre utilisation was measured. It was agreed that this would be explored further through the Finance and Performance	DM	July 2026	Passed to FPC.

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		Committee.			
22.5	13/05/26	Suzanne Ellis reflected that, across functions, there had been a significant amount of Better Value activity undertaken during the year and asked whether an after-action review had been completed. Margaret Monkton agreed that it would be beneficial to formally review learning from the year, and this was agreed that this would be considered.	DM, MM	July 2026	Passed to FPC.
29.9	13/05/26	Sophia Varadkar said that additional vigilance was being requested from Care Groups in relation to recruitment processes, and that although posts were being approved in a timely manner, this did not fully meet the timelines required by specialties. She confirmed that this would be reviewed further and an update provided to the Board.	SV, SO	TBC	Passed to PEAC
29.14	13/05/26	It was noted that the Resident Doctor ball and award ceremony would be taking place soon and dates for those events and the Resident Doctor forum would be circulated to the Board through the Chief Medical Officer's office.	Ed Gaynor, SV		Complete

Trust Board 18 June 2026	
GOSH Quality Report 2024/25 Submitted by: Sophia Varadkar, Chief Medical Director	Paper No: Attachment C ☐ For information and noting
Purpose of report To present the annual Quality Report 2025/26 for Great Ormond St Children's Hospital.	
Summary of report The Quality Account 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 website. The content of this Quality Account includes: • Local quality improvement information, which allows trusts to: • Demonstrate their service improvement work • 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	
Patient Safety Implications None	
Strategy Pillar • Together We Shape How We Care • Together We Advance Discovery, Innovation and Impact • Together We Embrace the Whole	
Equality impact implications None	
Financial implications None	
Strategic Risk BAF Risk 10: Inconsistent Delivery of Safe Care	
Action required from the meeting Update – Quality Accounts published to Trust website 30 th June 2025	
Consultation carried out with individuals/ groups/ committees Key stakeholder and Subject Matter Experts	

Attachment C

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

Jit Olk Director of Quality

Who is accountable for the implementation of the proposal / project?

Dr Sophia Varadkar Acting Chief Medical Director



Great Ormond Street Hospital for Children NHS Foundation Trust

Quality Report

2025-2026

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What is the Quality Report?

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

What does it include?

The content of the Quality Report includes:

- Local quality improvement information, which allows trusts to:
 - reflect on the standard of care they have provided over the past year
 - demonstrate their service improvement work
 - 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

Since its inception in 1852, Great Ormond Street Hospital NHS Foundation Trust (GOSH) has had a clear purpose: to focus on children who rely on specialist care - those who are seriously ill, those who have complex needs and those with rare or undiagnosed conditions. What has allowed GOSH to set it apart from other specialist paediatric trusts is its co-location of multiple specialties and the clinical expertise of its multidisciplinary staff. These have helped the Trust drive forward world-leading care, clinical research, education and innovation to secure its position as one of the best paediatric hospitals in the world.

GOSH has a long-standing reputation for providing high quality care but we know we should always seek to learn from what we do and from others to make our care even better. It is important to us that we share information publicly about the quality of our services and about our continuous improvement work.

1. Part 1: A statement on quality from the Chief Executive

This is my first Quality Report as Chief Executive of Great Ormond Street Hospital. It covers the work before I joined on the 1st June 2026 and the ambition it sets out is now mine to lead with the multiple teams of dedicated staff across the hospital and beyond. I want to start by thanking all those that have contributed to improving the quality of care at GOSH, including my predecessors.

A challenging year

It has been a tough year. Our staff have carried on delivering world-leading care for some of the most seriously ill children in the country, while the NHS has been under sustained financial and workforce pressure. Our patients are more complex than ever, and through it all our teams have remained dedicated to providing safer and kinder care. In my first weeks in the organisation, I have visited many clinical and non-clinical teams, and I have been left in no doubt about their skill and dedication to providing high quality compassionate care.

We continually review the quality of our specialist services. This year improvement work continued in our orthopaedic service, and we published a review into the care provided by a former surgeon. This concluded that a number of patients had come to harm under our care. On behalf of the Trust, I would like to state how deeply sorry we are that this has happened. We cannot fully understand the impact the experience has had on the children, young people and families that are affected but I have heard about the Trust's unwavering commitment to learn and improve. One programme of work arising from the review is strengthening multidisciplinary team (MDT) governance. Quite rightly it is one of our quality priorities for 2026/27.

Progress against our 2025/26 priorities

Despite some challenges, I am pleased to say the Trust has made real progress against the three priorities it set itself a year ago, in safety, clinical effectiveness and experience.

In the area of safety, we have refreshed our Patient Safety Incident Response Framework (PSIRF) priorities, drawing on what staff across the hospital, our Patient Safety Partners and our incident data have all been telling us. The six priority areas we have agreed for 2026 to 2028 are: admission, discharge and transfer; medication; communication; access to clinical services; recognising and responding to deterioration; and treatment and procedural issues.

Our Electronic Patient Record, EPIC, is a powerful tool which allows us to provide safer and more efficient care. Over the last year our work with teams to maximise their use of EPIC has been a real success. The Epic Thrive sprints have reached 21 specialties so far, with over 550 clinicians taking part in personalisation sessions where they tailor their own EPIC workspace to match the way they work. This allows them to navigate EPIC more quickly and intuitively and spend more time with patients and families which in turn improves the safety and continuity of care. Across the Trust EPIC personalisation, has gone from 32 per cent to 46 per cent and we have identified more than 850 ways the system could work better for the people using it. The teams have been incredibly positive about the support and how it is improving the quality of interactions with patients and their families.

In the area of patient experience, our new programme, GOSH Voice, has begun to change how we hear from parents, siblings, carers and families. In its first six months, 118 members have given 527 hours of co-production time on everything from the new main entrance to the Children's Cancer Centre to sensory environments, food and teenage healthcare. We are also being honest about who is currently not part of our conversations and co-production work. The membership data tells us we have more work to do to make sure GOSH Voice reflects the diversity of the families we look after.

A wider story of quality

There is much more in this report than three priorities. Our research community supported 849 active projects this year and more breakthrough treatments moved from clinical trial to regulatory approval, including for children with rare epilepsies, immunodeficiencies and inherited conditions. The Health Inequalities Programme has moved from idea to embedded practice, with 30 wards and teams now using a self-assessment tool to drive change. The Quality Improvement (QI) team has helped colleagues redesign clinic flow, cut waste and make care more sustainable. The Care Quality Commission's (CQC) rating of 'Good' across the Trust, our surgical services and the well-led domain reflect the compassionate, child-centred culture our staff carry into work every day.

I want to thank our Freedom to Speak Up Guardians, our Patient Safety Partners, the families who give their time to GOSH Voice, and to our Young People's and Parent Carer Advisory Groups and our Council of Governors. They are a vital part of our community and provide rich insights which inform how the Trust continues to improve and provide even better care.

Looking ahead

In October 2025 the Trust launched its new five-year strategy, Together We Power Care. The 2026/27 quality priorities are: strengthening MDT governance; applying improvement science more rigorously to our safety actions; and providing free meals for parents and carers of inpatients. They reflect what staff, patients and families have told us, what our data says will make the biggest difference, and support our new strategy.

Before I took up this post at Great Ormond Street Hospital, I had had the opportunity to work closely with the institution through our shared EPR programme and genomics initiatives. This showed me the exceptional care that was being provided by our teams every day. My focus over the months ahead is to spend time in our clinical areas listening to patients and staff and to lead the organisation with the same focus on safety, effectiveness and experience that is so well articulated in this report.

On behalf of the Board, I confirm that to the best of my knowledge the information in this Quality Report is accurate and that it presents a balanced picture of the quality of care provided by Great Ormond Street Hospital in 2025/26.

To everyone who works at GOSH, thank you for your continued commitment and dedication to providing the best possible care to our children and young people and their families. To our patients and their families, thank you for trusting us with your children, and for telling us, honestly, when we get it right and when we don't. We will keep listening and keep learning so we provide the safe high-quality care you expect of us and so rightly deserve.

Karl Munslow Ong

Chief Executive

Great Ormond Street Hospital for Children NHS Foundation Trust

2. Our Strategy Refresh

Our previous strategy, Above and Beyond, was due for a refresh in 2025. We are very pleased to announce that in October 2025 we launched our new strategy, Together We Power Care. Our launch event was a huge success, with hundreds of staff attending, and some of our patients presenting. We also had an external speaker, Gary Lewin (Head of Performance with Arsenal Women's Team), who spoke to the importance of teamwork.



Our strategy sets a shared direction of travel and priority areas for the next five years. It is our roadmap to deliver care that is safer, faster, smarter and more connected - both within GOSH and across the wider system. By working together, we make sure that advances in science, technology and practice reach the children and families who rely on us for their care.

The strategy is built around three pillars, each representing a key way we will transform care. Each pillar include a 'big move', our vision for delivery, and is supported by flagship programmes that ensure these ideas become a reality for the children and families who rely on us. The three pillars are outlined below:



Together We Shape How We Care

Together We Advance Discovery, Innovation and Impact

Together We Embrace the Whole

We're now working hard to develop delivery architecture, including these flagship programmes, to ensure that our strategy delivers what we set out to do.

3. Part 2a: Priorities for improvement

This part of the report sets out how we have performed against our 2025/26 quality priorities. These are made up of 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 2008 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 as rapidly as possible. Our aim is to ensure that each patient receives the correct treatment or action the first time, every time. However, when this does not happen, we are committed to learning from mistakes, errors and incidents to ensure the safety of patients and their families, visitors to GOSH and our staff.

Effectiveness

At GOSH, we seek to provide patient care that is amongst the best in the world. As a major academic centre, we work with our patients to improve the effectiveness of our care through research and innovation. We use national and international benchmarks to measure our effectiveness whenever possible, and we publish this outcomes data on our website and in renowned academic journals. To measure our effectiveness from the patient's perspective, we use Patient-Reported Outcome Measures (PROMS).

Experience

We wish our patients and their families to have the best possible experience of our treatment and care. Therefore, we measure patient experience across the hospital and seek feedback from our patients, their families, and the wider public to improve the services we offer. We do this via:

- Membership, patient and member surveys
- Focus groups and events
- Asking patients and families about their experience following an appointment or admission

4. Reporting our quality priorities for 2025/26

Three quality priorities for 2025/26 were selected with input from membership of the Quality Review Group.

These are outlined below:

Safety

- Ensure that our Patient Safety Incident Response Framework (PSIRF) priorities accurately and appropriately reflect the safety trends and signals that are emerging and evident in our patient safety (and other) data and intelligence.

Effectiveness

- Epic Thrive Proficiency and Optimisation Specialty Sprints - The EPR Team will work with 46 clinical specialties over 18 months to offer dedicated support to make configuration updates helpful to them, deliver 1-2-1 personalisation training and Epic refresher sessions.

Experience

- GOSH Voice - enhancing and strengthening the voice of parents, siblings, carers and families at GOSH through the creation of an effective, meaningful and inclusive co-production and engagement community

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

1. What we said we'd do
2. What we did
3. What's going to happen next

Safety

To eliminate avoidable harm

Ensure that our PSIRF priorities accurately and appropriately reflect the safety trends and signals that are emerging and evident in our patient safety (and other) data and intelligence.

What does this mean and why is it important?

In 2025/26 the patient safety community of the hospital have a) reflected on their lived experience of working and receiving care at GOSH and b) analysed and assessed our datasets to understand the signals emerging from them. This stakeholder-driven, iterative process allows us to adjust and tailor our priorities accordingly. This is important so that our learning response and investigatory efforts as an organisation are directed correctly, to maximise the learning and improvement opportunities available to us within our resources. This also matters as we need to be sure we design and target improvement work where it can be most effective and of benefit to patients.

What we said we'd do

1. Monitor, measure and report progress through our safety governance systems and processes which include our weekly Safety Event Review Group, Organisational Learning Forum and Clinical Governance Committee.
2. Continue to work closely across our corporate and directorate teams in partnership with their Quality and Safety leads to identify emerging safety signals which may benefit from any focused quality improvement interventions.
3. Work closely with our Patient Safety Education team to ensure we engage learners with the outputs from activity under the PSIRF, for the benefit of patient care.

What we did

We embarked upon a series of facilitated round table meetings with members from a wide range of areas across the hospital to discuss and reflect upon the safety issues that they see as part of their daily work. We also gathered their insights as to what they feel the priorities for patient safety efforts at GOSH should be over the coming year. This qualitative data was then collated and analysed by the Patient Safety team and cross referenced with the quantitative data gathered over the year from the Datix local risk management system. This process was supported by our Patient Safety Partners – colleagues with lived experience of GOSH, either as past patients or carers/parents.

This process ran over two months and resulted in the identification of six defined areas of priority that were shared at the Organisational Learning Forum. After further refinement, they were agreed and will now form the focus for reactive and proactive patient safety work over the next two years.

These priorities are detailed here:

GOSH PSIRF Priorities 2026-2028

1 Admission, Discharge and Transfer

Admission or transfer of patients detained under the Mental Health Act 1983 (MHA) or otherwise assessed as high risk, where system or process failures are identified in:

- completion or sharing of structured risk assessments
- communication of known risks, vulnerabilities, or supervision requirements
- planning or implementation of appropriate safeguards in the receiving environment/Mildred Creek Unit (MCU).

System or process factors leading to delays or failures in admission or transfer for time critical transfers, timely escalation, acceptance and/or coordination of care across organisations.

- Delayed or unsafe transfer between specialty teams where system or process factors have been identified as contributory factors.

Transfers between referring and receiving organisations where there is evidence of inadequate senior clinical (consultant to consultant) communication resulting in unclear clinical responsibility, delayed decision making or risks to patient safety.

2 Medication

- Tenfold medication errors where system or process factors have been identified.
- These could include prescribing tools, verification steps, handover and environmental factors.
- Events involving high-risk medications (e.g. parenteral nutrition, continuous infusions, route dependent administration) where the incident reveals vulnerability in systemic factors relating to prescribing, checking, preparation or administration.

3 Communication

- Failures in communication between teams, services or organisations where system weaknesses have been identified. These could be in escalation, handover, shared decision-making processes or relate to the reputation of the Trust.
- Failures to recognise, respond to or act upon patient, family or carer-initiated escalation including the use of Martha's Rule.
- When communication or response systems have been unreliable, poorly understood or inconsistently applied.
- Recurrent communication failures across similar contexts indicating unreliable processes rather than isolated lapses or one-off misunderstandings.

4 Access to Clinical Services

Issues with clinical pathway design leading to delays in treatment due to lengthy or delayed referral, treatment or follow-up.

Systemic factors leading to or related to inaccurate or delayed interpretation of imaging.

Systemic factors leading to failure in linking a patient to the appropriate pathway.

- Systemic factors leading to errors in the management of patient appointments, for example:
 - missed follow-up leading to adverse events correspondence being sent to the wrong address - this has a safeguarding element to consider
- Systemic factors leading to inequalities in access to services and care outcomes including digital exclusion.
- Systemic factors leading to failures in recognition of additional needs and/or the provision of adequate support including the application of reasonable adjustments for patients with Autism and/or a Learning Disability.

5 Responding to Deteriorating Patients

Events in which deterioration was not recognised despite existing safety processes or where pathway design, human factors, communication or decision making contributed to harm.

Specific system related failures or delays in:

- recognition of physiological deterioration
- appropriate escalation of concerns, including senior clinician review
- appropriate response to parental concerns including Martha's Rule escalations transfer to higher levels of care

6 Treatment and/or Procedural Issues

Systemic factors identified as contributing to treatment or procedure related events, including unexpected complications or unintended outcomes.

7 Areas of Emerging Risk

Based on trends or analysis identified by the Patient Safety Team, a PSII will be conducted on the specific systemic factors that have been identified.

What we will do next

We will work to ensure that the daily output of the Patient Safety Team is tailored to support these priorities – these are the things our people and our data have told us need our focus. We will use our meeting, governance and learning structures to ensure that we work in service of these priorities and act as advocates for our patients, their family/carers and our teams when patient safety events happen.

Effectiveness

To consistently deliver excellent clinical outcomes, to help children with complex health needs fulfil their potential

Epic Thrive Proficiency and Optimisation Specialty Sprints

The EPR Team will work with 46 clinical specialties over 18 months to offer dedicated support to streamline configuration updates, deliver 1-2-1 personalisation training and Epic refresher sessions.

What does this mean and why is it important?

GOSH went live with the Epic electronic patient record (EPR) system over six years ago. The EPR was the biggest clinical transformation programme that the Trust had ever undertaken and from day one it has given us a new way for managing and improving care, experience and outcomes.

Epic allows our staff to access the right information, at the right time, in the right location, when and where it is needed to enhance the quality of care we give to our children and their families. However, since Epic was introduced, we have seen variable efficiency and satisfaction amongst staff, leading to workarounds, low levels of personalisation and quality of data. Requests for refresher training is also low. In addition to this Epic has had several upgrades and new functionality added over the years, which means that it is not always easy for existing staff to keep up to date and realise the maximum benefit from new functions.

In March 2025 we launched the Epic Thrive Proficiency and Optimisation Specialty Sprints to further improve the use of the system. This aims to free up clinical time to enable more direct patient care and increase staff awareness in the use of new functionality to allow staff to more efficiently support our patients. This has been made possible by funding from GOSH Charity.

This will be achieved through working with specialties to identify the different ways in which staff are utilising the EPR software, and the opportunities to implement configuration updates which would support increased quality and productivity. It's anticipated that through participation in the programme clinicians will achieve a higher level of competency and EPR personalisation

What we said we'd do

The Thrive Steering Group are tracking and monitoring the delivery through a number of metrics including;

- the numbers of tasks completed during the sprints,
- attendance to the 1-2-1 personalisation sessions as well as feedback from the session.

We will also be tracking the level of personalisation and the amount of time clinicians spend working in the Epic on unscheduled days, during "pyjama time," i.e. outside the hours of 7:00am to 7:00pm as this is linked to reports of burnout.

The Thrive Programme is monitored through the EPR Clinical and Operational Adoption Group (COAG). The evaluation reports will be shared across the Trust and Charity at key stages of the project.

Attachment C

What we did

Having Epic has ensured that all relevant staff are able to see the full clinical narrative for the patients they are looking after. This enables us as a hospital to provide safer, smarter, kinder care.

We are tracking the following metrics to monitor the progress and impact of the Speciality Sprints.

- **Number of specialties supported:** The EPR Team are offering clinical departments 6 -12 weeks of support depending on the size of the team. For 2025/26, we have supported 21(46%) specialties against a plan of 28(63%). Seven specialties were only offered 1-2-1 personalisation sessions and didn't get the full sprint experience due to recruitment challenges. Plans to support the remaining specialties are on track.
- **Number of 1-2-1 personalisation sessions attended:** So far over 550 clinicians have had a 1-2-1 session. During the sessions EPR Trainers support clinicians to personalise their favourites, shortcuts and preferences in Epic.
- **Levels of Epic personalisation across the Trust** – This has increased from 32% - 46% across since the sprints started with some specialties personalising at higher rates than others. We are aiming to get to 80% personalisation across the Trust. Epic users who update their settings are nearly twice as likely to be highly satisfied with their Electronic Health Record (HER) as it makes their use of Epic smoother and more intuitive. Additionally, the more settings they update, the more satisfied they are.
Number of tasks collected from observations: So far we have identified over 850 support needs most of which have been training on how to use the existing functions in the current system. This includes changes to Epic and training.

The team is spending 2 – 3 weeks in each speciality to understand what support is needed. We observe clinical teams in their own workspaces and agree a plan of work for the duration of the Sprint. Observations are carried out by trainers, analysts and clinical information officers. We are collecting common themes so that we can create improved induction and training in these areas.

- **Number of tasks completed during the sprint:** On average 40% of tasks identified from each speciality are completed during the sprint period. Other requests that need more specialist input from the wider EPR team are progressed after the sprint.
- **Epic refresher sessions:** Slicer Dicer continues to be the most frequently requested refresher session.

What we will do next

We will be delivering sprints to the remainder of the specialties on the schedule and working with service leads to increase uptake of the 1-2-1s and personalisation. This will include understanding any actual and perceived barriers to clinicians booking on to sessions.

The wider EPR team are continuing to work on configuration changes that were too large to complete during the sprints.

Experience:

To deliver kind and compassionate care and communicate clearly to build confidence and ease

GOSH Voice - enhancing and strengthening the voice of parents, siblings, carers and families at GOSH through the creation of an effective, meaningful and inclusive co-production and engagement community

What does this mean and why is it important?

GOSH Voice is a new community of voice championing parents, siblings, carers and families. Co-production will be at the core of the community optimising their role in service co-design, working in partnership, and driving improvements in patient and family experience.

Co-production is key to the NHS 10 Year Plan. We know that listening to patients about what's important to them is key to helping the NHS (including GOSH) deliver tangible improvements to people's experience (Darzi 2024, p112). Building on the success of the GOSH Young People's Forum and utilising the Lundy Model of Participation, GOSH Voice enables us to go further in embedding authentic engagement and co-production at the heart of what we do, placing children, young people and their families in the driving seat as active co-pilots of change and improvement (Chambers et al. 2021).

Plans include a GOSH Voice Café (a weekly drop in for parents and carers at GOSH which aims to provide a space both for peer-to-peer support, a chance to step away from the ward, and an opportunity to engage in creative coproduction activities) and GOSH Voice Mail (an 'audio guest book' telephone box which will give patients and families an opportunity to anonymously 'leave a message' in response to our question of the week).

What we said we'd do

In assessing the impact of GOSH Voice, we will:

- Build and track our network
- Track hours of co-production contributed
- Manage our membership
- Collect better data on the demographic makeup of our membership
- Review if GOSH Voice is reflective of GOSH

What we did

We have built and actively maintained a growing network of patients, siblings, parents and carers through a managed membership platform (Better Impact). This allows us to understand who is involved, how people engage, and how our community is developing over time.

We are now able to track the hours of co-production contributed across projects, giving visibility to the time, expertise and lived experience families are sharing with GOSH. As the attached document shows, we have to date 118 members, who have contributed 527 hours in our first six months.

We have also strengthened our data collection on the demographic makeup of our membership, allowing us to assess who is represented, identify gaps, and review whether GOSH Voice is genuinely

Attachment C

reflective of the diversity of the GOSH population. Together, this approach enables GOSH Voice to move beyond anecdotal impact and systematically assess reach, equity, and contribution across all our work. You can see how our data compares to the GOSH population below/ in the attached presentation.

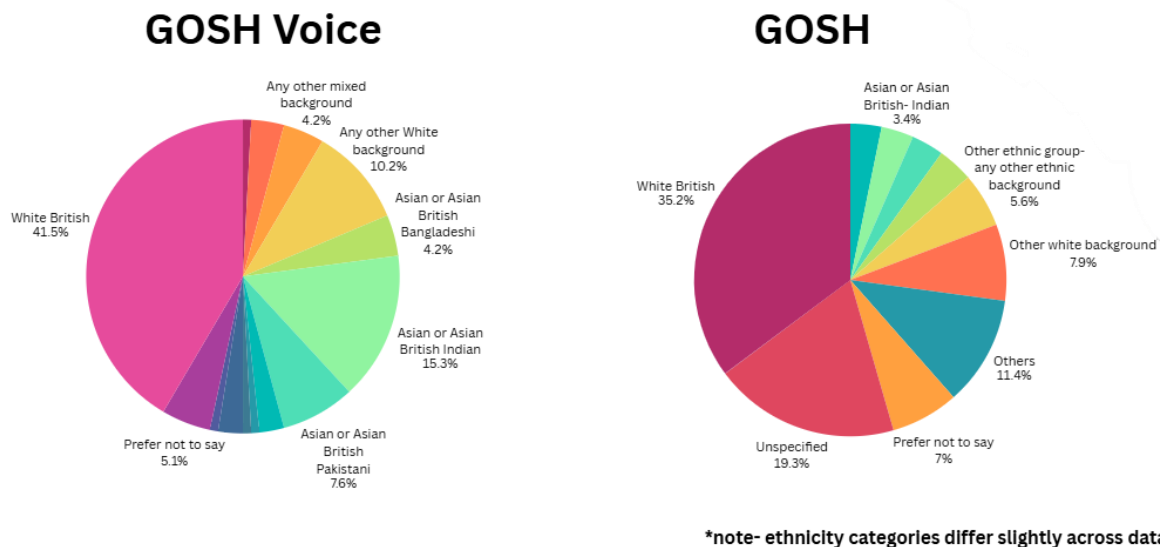


Figure 1 Ethnicity- GOSH Voice membership vs GOSH population

Over the last six months, GOSH Voice has been actively delivering and developing co-production activity across the Trust, alongside strengthening our systems and partnerships. We have coordinated and facilitated multiple co-production projects across key Trust priorities. This includes work linked to patient experience, health inequalities, the Children's Cancer Centre, radiology design, sensory environments, Trust values, sustainability, food, and teenage healthcare. These projects include both one-off engagement activities and ongoing groups, including participants as young as five years old.

One such example is our co-production workshop at the Science Museum, to creatively explore the new GOSH main entrance design. The workshop brought together patients, siblings, parents and carers of all ages to explore lived experiences of arriving at the hospital and to inform future thinking about the space. The workshop provided an opportunity for participants to share reflections on the proposed design, capture inspiration on how the space should look and feel and share how the space can be made welcoming, accessible and inclusive. This session formed part of the wider GOSH Voice main entrance workstream and ensures that patient and family perspectives are fed directly into the design of the new building.

In our first six months we have also worked closely with colleagues, as we look ahead to our development. We held structured discussions with research, learning disability and neurodisability colleagues to clarify how GOSH Voice can appropriately support internal projects, avoid duplication, and strengthen inclusive engagement pathways. These conversations have focused on accessibility, scope, and governance.

We have also continued to build and formalise our operating model, including maintaining a staff hub, developing guidance for facilitating co-production, and developing our membership platform to support network growth and session accessibility.

Attachment C

Overall, the last six months have focused on active delivery of co-production projects, expansion of engagement methods, and strengthening the systems needed to evidence impact, equity, and sustainability, positioning GOSH Voice to move into a more evaluative and outcomes-focused phase in 2026–27.

What we will do next

Our next phase of GOSH Voice will focus on strengthening delivery, impact, and learning. In April 2026, we will launch our first GOSH Voice Café, creating a regular, visible space for parents and carers to connect, share experiences, and influence improvement work in real time. Our first session will focus on catering, and the potential roll out of parent meals as part of Sophie's Legacy. We will be inviting parents and carers to 'drop in' to sample potential menus.

Alongside this, we will move to a more robust and consistent approach to measuring outcomes, ensuring that each GOSH Voice project is assessed against agreed GOSH Charity outcomes and GOSH priorities, rather than judged solely on whether activities were delivered as planned. We will also increase our evaluation and learning, using clearer outcome measures, feedback, and reflection to understand what difference our co-production work is making for patients, families, and services, and to continuously improve how GOSH Voice operates and demonstrates its value.

6. Quality priorities for 2026/27

The following tables provide details of three of the quality improvement projects that GOSH will undertake in 2026/27. As seen with previous quality reports these quality improvement projects are in line with our strategic priority to provide the safest, most effective and efficient care, with the best possible outcomes.

Quality Priorities for 2026/27 have selected with input from membership formed Quality Review Group to agree an Effectiveness priority. Priorities for Patient Safety and Patient Experience are identified with alignment to plan priorities for patient safety and patient experience.

Safety:

To eliminate avoidable harm

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
We will work to align our learning responses more closely with quality improvement science and techniques, as well as applying a rigorous lens to the quality of our safety actions arising from safety response activity. Now that PSIRF has been effectively embedded as part of business as usual, we will work to hone the path our safety actions take from conception to completion and seek stakeholder input to a process of consolidation of the range and breadth of learning responses we employ.	This means increasing the technical skill and rigour that we bring to safety actions and learning responses. This matters because Patient Safety is both an art and a science – we have made strong progress with the empathy, communication and human judgement that skilled practitioners develop over time and now seek to bring equal rigour to the scientific side, ensuring our safety actions and learning response are evidence based and methodologically sound.	Staff training – increasing the number of the team who have attained the status NHS England Patient Safety Specialist to all two thirds of the team with a plan in place for the remaining third to receive training in 2027. Audit of the of impact of our learning responses across the hospital – how far a safety message reaches incrementally reduces the chances of a safety event recurring and improves the sense of patient safety being something that every single staff member has responsibility for.

Experience:

To deliver kind and compassionate care and communicate clearly to build confidence and ease

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improved family support through the provision of free meals for parents and carers of inpatients at GOSH. Reducing the burden on families: reliable, equitable food provision for parents and carers of inpatients at GOSH. With funding from GOSH Charity, we will simplify current food provision and ensure all parents and carers of inpatients can access nutritious meals from the hospital restaurant alongside items from parent kitchens. This will reduce financial pressure and supporting families to remain at their child's bedside throughout their child's admission.	Feedback confirms that parents/ carers incur significant additional costs (including but not limited to food, travel and childcare costs) when their children are in hospital. Provision of food for inpatient families is inconsistent and information about what to expect is inadequate causing inequity and additional stress at an already unimaginably difficult time. A national survey of children's services showed estimated spending on food for parents/ carers was around £12-15 per day. In March 2023, a survey of Trusts with 121 responses, showed 63% of parents/carers do not have access to any free or subsidised food options while their child is in hospital. Between 2021–2025, Sophie's Legacy (a charity founded to improve dignity, comfort and basic care to parents and carers of hospitalised children) has delivered a multi-phase national programme in partnership with NHSE, ensuring that no parent or carer goes hungry. This includes the introduction of free hot meals for resident parents across multiple Trusts, including GOSH, with a strategy of trying to improve the provision of food for inpatient families.	Progress will be tracked against three measurable outcomes: Equity: consistency of provision across all inpatient wards, evidenced through regular audit of access and uptake. Awareness: proportion of families reporting they understood what food support was available to them, measured via regular surveys. Experience: reduction in food and cost-related themes in parent feedback, FFT comments and complaints. Performance will be reviewed by Space and Place (Catering) and the Patient Experience Team, with progress reported to QRG and onward to the Clinical Governance Committee through the quarterly Quality Report. An end-of-year evaluation will be published as part of the 2026/27 Quality Account.

Effectiveness:

To consistently deliver excellent clinical outcomes, to help children with complex health needs fulfil their potential

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Meeting Governance Multidisciplinary team (MDT) working underpins the majority of care at GOSH, with complex clinical decisions routinely reached through MDT discussion across surgical, medical and highly specialised services. Strong, consistent MDT governance is therefore central to ensuring that care is safe, effective and based on the right expertise, the right information and the right standards.	Learning from recent service reviews, alongside internal audit and external benchmarking, has highlighted variation in how MDTs operate across the Trust, including inconsistencies in membership and quoracy, documentation of decisions, escalation of contested cases and assurance against national standards. In 2026/27 we will strengthen MDT governance Trust-wide. The programme is led by the Medical Directors Office (MDO) and will: - Provide a Trust-wide MDT template with local adaptation defining membership, quoracy, frequency and chairing standards. - Ensure MDT discussion for defined complex case categories prior to definitive intervention, with the development of auditable documentation in EPR. - Develop a standardised MDT outcome proforma capturing relevant clinical information, supported by appropriate EPR build. - Establish an MDT chair training programme. - Introduce a process for peer review of MDT decisions and outcomes against national standards. - Embed shared decision-making with patients and families.	Monitored by the MDT Governance Working Group, chaired by the Deputy Chief Medical Officer. Measured against: - Trust-wide MDT template ratified Q1 2026/27. - ≥ 90% of mandated complex cases discussed at MDT pre-intervention. - To develop EPIC outcome proforma by year-end. - First Trust peer review pilot complete by Q4, with the year-end position included in the Annual Quality Report 2026/27.

7. Part 2b: Statements of assurance from the Board

This section comprises the following:

- Review of our services
- Participation in clinical audit
- Learning from deaths
- Participation in clinical research
- Use of the CQUIN payment framework
- CQC registration
- Data quality
- Promoting safety by giving voice to concerns
- Reducing rota gaps for NHS doctors and dentists in training
- Participation in GIRFT (Getting it Right First Time)

8. Review of our services

During 2025/26, GOSH provided and/or sub-contracted over 60 relevant health services. The income generated by these services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant services by GOSH for 2025/26. GOSH has reviewed all the data available to us on the quality of care in our services.

9. Participation in Clinical Audit

What is clinical audit?

“Clinical audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients.”

NHS England

Participation in National Clinical Audit

During 2025/26 sixteen national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides that are listed as eligible for reporting in quality accounts. The data submissions have been outlined below for those audits.

Name of audit / clinical outcome review programme	Cases submitted in 2025/26
British Spine Registry	GOSH has not been routinely providing submissions to this mandatory national outcome registry. This has been highlighted to the Spinal team and their Specialty Lead, who are actively implementing measures to improve this to meet national targets.
Cleft Registry and Audit Network (CRANE)	The North Thames Cleft Unit (GOSH and Broomfield) provided 94 cases
Epilepsy12 audit	GOSH doesn't meet the inclusion criteria for providing patient data (as do not see patients for their first paediatric assessment) GOSH does provide an annual organisational survey.
Maternal, Newborn, and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	19 notifications were made
National Audit of Pulmonary Hypertension (NAPH)	For 2025/26 data was provided on • 101 patients • 86 referrals • 706 consultations • 183 exercise tests • 15: pulmonary vascular resistance studies (Diagnostic Catheters)
National Cardiac Arrest Audit (NCAA)	16 reported events for 2025-2026
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit	GOSH provided data on 11 cases of activation of the major haemorrhage protocol for this audit, which was all eligible cases.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD). Stabilisation of the critically ill child	Organisational questionnaire completed. 12/19 critical care reviews completed. 3/5 stabilisation reviews completed.
National Confidential Inquiry into Suicide and Safety in Mental Health	Quarterly extracts of data are sent to the Clinical Audit Manager to review whether eligible case reviews are required

Attachment C

Suicide (& homicide) by people under mental health care	No cases have been identified that are relevant for GOSH to review.
National Audit of Cardiac Rhythm Management (CRM)	For 2025/26 data was provided on 178 CRM procedures: I. Devices: 98 • 60 pacemakers/implantable cardioverter defibrillator (ICD) procedures • 38 loop recorders II. CRM Electrophysiology: 80 • 73 ablations • 7 electrophysiology study only
National Congenital Heart Disease Audit	For 2025/26 data was provided on 1017 cases • 547 bypass & non bypass • 26 electrophysiology surgery • 175 catheter Interventions • 119 electrophysiology catheters • 118 diagnostic catheters • 32 support procedures
National Paediatric Diabetes Audit (NPDA)	A total of 36 children and young people with diabetes who received treatment at GOSH were included in the 2024/25 audit, with 3 diagnosed within the audit year.
Paediatric Intensive Care Audit Network (PICANet)	For the 2025 calendar year submission, data was provided on • 710 CICU admissions • 107 ECMO Referrals • 880 PICU admissions • 284 NICU admissions
UK Cystic Fibrosis Registry	185/185 submitted which could be, with 5 not submitted for appropriate reasons
UK Renal Registry Chronic Kidney Disease Audit	104 chronic kidney disease patients 21 transplant patients
National Acute Kidney Injury Audit	19 patients

National Clinical Audit reports published in 2025/26

This section outlines published mandatory national clinical audits in 2025/26 relevant to GOSH.

UK Cystic Fibrosis Registry 2024 Annual Report

The report was published in October 2025 and includes data about individual cystic fibrosis centres, to help the centres benchmark themselves against their peers.

The data shows that GOSH clinical outcomes all lie within expected variation for key measures including:

- Lung function
- Nutritional status
- Pseudomonas aeruginosa infection rate

Further information about GOSH Cystic Fibrosis clinical outcomes, which includes reference to the report is published on the [Cystic Fibrosis Clinical Outcomes page](#) on the GOSH website.

[<https://www.gosh.nhs.uk/conditions-and-treatments/clinical-outcomes/cystic-fibrosis-clinical-outcomes/>]

2025 National Congenital Heart Disease Audit Annual report

The survival rate for paediatric cardiac surgery is a nationally accepted benchmark to judge outcomes. To compare mortality outcomes across centres, it is necessary to adjust for the relative complexity of the cases that are being undertaken. This is done using the PRAiS v4.2 model, which reports the actual survival of patients relative to the predicted survival.

For the 3-year period 2022/23 to 2024/25:

- 7 hospitals performed as predicted
- 3 hospitals, including GOSH, achieved survival results that were higher than expected.

The clinical outcomes for the Cardiothoracic service at GOSH which include this data are published on the [Cardiothoracic Clinical Outcomes page](https://www.gosh.nhs.uk/conditions-and-treatments/clinical-outcomes/cardiothoracic-clinical-outcomes) on the GOSH website [https://www.gosh.nhs.uk/conditions-and-treatments/clinical-outcomes/cardiothoracic-clinical-outcomes].

Cleft Registry and Audit Network (CRANE) 2025 Annual Report (published in December 2025)

The audit reports cleft-related 5-year outcomes for consented children who were born 2016 to 2018. These outcomes are benchmarked across 11 regional cleft centres in the UK. GOSH hosts the North Thames Cleft Lip and Palate Service jointly with the Broomfield Hospital in Essex.

For the North Thames Service, ten measures were within benchmark control limits and four were negative outliers. The status of each measure for the North Thames Service is shown below – the number in brackets shows the number of services also in this category where there are negative outliers.

Type of measure	<u>Within control limit</u>	<u>Negative outlier</u>
Outcome	Healthy Body Mass Index (BMI) at 5 years of age. Dental • Dental decay at 5 years of age • Extensive dental decay at 5 years of age • No untreated disease, as measured by the dental treatment index at 5 years of age Facial Growth • Children with Five-Year-Old Index scores reflecting 'good' dental arch relationships. Speech National Speech Standard 3 Psychology All eligible children seen by a psychologist before the age of 6 years.	Speech National Speech Standard 1 (2) National Speech Standard 2a (2)
Data completeness	Facial growth at 5 years recorded for all eligible children. Speech at 5 years assessed and reported Psychology - Tiers of Involvement score recorded	Child growth at 5 years recorded for all eligible children (6) DMFT (Decayed, Missing, and Filled Teeth) at 5 years recorded for all eligible children (4)

Attachment C

Having had negative outlier status for Speech standards 1 and 2a for two years consecutively, the service undertook an internal review of nasal turbulence. It then commissioned a review of all cases from 2018 by specialist speech and language therapists from other centres, which took place in December 2025. Results of the review indicated multiple factors at play including case complexity, environmental factors influencing speech recording quality, and differences of application of ratings. While reassuring for GOSH in terms of its speech outcomes after cleft surgery, it has raised the need for national discussion about the extent to which consistency of rating is a challenge across a heterogeneous patient population. The service continues to engage with the Cleft Development Group (CDG) regarding next steps. The CDG has overall responsibility for steering the work of CRANE.

2025 Audit of Compliance with Major Haemorrhage Protocols (NHS Blood and Transfusion)

Major haemorrhage is a time-critical medical emergency that requires the rapid delivery of blood and blood components and coordinated responses from both clinical and laboratory teams. The national audit was published in February 2026 and reviewed Major Haemorrhage Protocol (MHP) governance, activation of the MHP protocol, and blood component provision.

GOSH provided data on 11 cases of activation of the MHP protocol. Overall GOSH followed the correct activation process in 10/11 cases. The one case where the process was not followed was a ward-based patient who was bleeding. The MHP was activated to expediate the blood and blood components from the lab. However, the patient required specialised matched platelets (known as HLA matched platelets due to platelet antibodies) that are issued on a named patient basis from NHSBT (NHS Blood & Transplant). In addition, the patient had red cell antibodies which also required specific named patient blood to be issued from NHSBT. The ward were concerned that these components were not available quickly enough, but they are specialised units. This is an example of where communication can be improved so that the ward are aware of what the lab are doing to provide the components but the lab are aware that the patient is becoming unwell and a conversation is required to make an alternative plan. In these cases, the Laboratory Haematology SpR becomes involved as they understand both areas (clinical and laboratory). There was no patient impact and the MHP wasn't stood down.

Delays/issues were identified when retrospectively reviewing the MHP process in 2/11 cases. The MHP was stood down in 6/11 cases. This means the Transfusion Laboratory were not made aware that the MHP had finished and no longer had to prioritise this patient, and/or continue to issue blood & blood components urgently. The message to inform the Transfusion Laboratory and stand them down needs to be reinforced.

The report and recommendations have been reviewed by the Advanced Transfusion Practitioner.

For these standards no actions are required at GOSH

- Major haemorrhage protocols (MHPs) – availability and activation
- Emergency red cells
- Policies for rapid release of other components/ products
- Tranexamic Acid (TxA)

The following actions have been identified in response to the report

Standard <i>Recommendations</i>	Actions to be taken at GOSH
Training and education of staff <i>Major Haemorrhage training should include the activation and stand down procedures</i>	• MHP simulation sessions are actively encouraged in both the clinical areas and the Transfusion Laboratory but are not done routinely • A new national MHP SIM toolkit was launched in February 2026 which the Transfusion Practitioner promoted to the Practice Educators to encourage local ward-based SIMS
Component Ratios <i>Training/ drills should cover appropriate plasma component ratios and the rationale for these</i>	• Recent GOSH MHP reviews have shown inconsistency with ratios of red cells and plasma in an MHP This is being addressed by the Transfusion Team by: - Reinforcing ratios on the next 2026 review of the MHP protocol - Developing prompts for the BMS in the Transfusion Laboratory to help when managing the MHP. This will include weight of the child and appropriate ratios
Haemostatic testing <i>Training/drill feedback should include review of haemostatic testing mentioned, and whether this aligns with local policy/ test availability.</i> <i>Viscoelastic Haemostatic Assays devices should interface with EPR/LIMS [Laboratory Information Management System] for governance, documentation and to reduce transcription errors. Where this is not possible, the clinical risk should be assessed and documented</i>	• Most MHP activated at GOSH are in the Theatre/ICU setting where haemostatic testing (rotational thromboelastometry by Werfen) is available (not situated in ICU but it is possible to use the one in Theatre). • This is not interfaced with the EPR or the LIMS. This has been escalated to both EPIC & Werfen but this isn't in place. One issue is the funding required for the interface. • Governance is overseen by the GOSH Point of Care Testing Team

National Paediatric Diabetes Audit (NPDA) 2024/25 Report (published in March 2026).

The report focuses on the completion of key health checks for Type 1 diabetes. GOSH does not have sufficient numbers of typical type 1 diabetes to allow significant comparison of data which reflect core clinical outcomes of the GOSH diabetes service. (GOSH data is included for twelve patients who completed a full year or care, with nine patients over the age of 12).

For GOSH the completion rate of key health checks is 84.1% compared with the national average of 93.5%. There have been improvements in some checks at GOSH over the last few years. For example, foot checks are now reported as 100% which was a challenge prior to 2022/23.

The lowest element completed from the six key health checks is urinary albuminuria screening (55.6%). The reason for this is that it is not always clinically appropriate or possible, as many patients have co-existent renal disease including renal failure and anuria (inability to pass urine).

Attachment C

91.7% of GOSH patients had HbA1c (glycated haemoglobin) checked. The team offer virtual appointments, and HbA1c needs to be taken by a home kit that is sent to families. The team are working to resolve an issue with a shortage of kits.

The audit also measures HbA1c as an outcome measure, which is recommended as the best indicator of long-term diabetes control. The mean HbA1c for GOSH for children and young people with Type 1 diabetes is within benchmarked control limits.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) : Right Place, Right Time, Right Team -A review of the quality of the care provided to children and young people needing emergency surgery.

The national report was published in December 2025. Recommendations have been reviewed by the Clinical Audit Manager with The Chief of Service for Core Clinical Services. The principal relevant recommendation from the NCEPOD which relates to GOSH is around the provision of an emergency theatres coordinator. GOSH is in line with the recommendation as it has a surgical consultant, anaesthetist, and nursing team which includes a co-ordinator that cover theatres, including the emergency list.

PICANet State of the Nations Report 2025

The gold standard for measuring paediatric intensive care mortality is through benchmarking by the Paediatric Intensive Care Audit Network (PICANet). The PICANet State of the Nations Report 2025 was published in December 2025 and covers the calendar years 2022-24.

The primary outcome measure used in Intensive Care Units (ICU) is the survival rate for patients, measured at the time when they are discharged. Raw survival/mortality rates may be challenging to interpret as patients that are admitted in a sicker condition are at greater risk, and therefore the outcomes need to be 'adjusted' to consider the level of severity of the patients in respect of case mix. The report shows GOSH PICU, NICU and CICU risk adjusted mortality as within expected range.

Further information about the PICANet measures for GOSH can be found on the [Intensive Care Clinical Outcomes page](https://www.gosh.nhs.uk/conditions-and-treatments/clinical-outcomes/intensive-care-unit-clinical-outcomes/) on the GOSH website [https://www.gosh.nhs.uk/conditions-and-treatments/clinical-outcomes/intensive-care-unit-clinical-outcomes/].

National Cardiac Arrest Audit

The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests attended by resuscitation teams (team visits) in the UK. Centres are provided with reports to benchmark risk adjusted outcomes. The most recent reported data available for GOSH covers 1st April 2024 to 31st March 2025.

For GOSH the rate of in hospital cardiac arrests was 0.31 per 1000 admissions for 2024-2025, slightly lower than the rate for 23-24, which was 0.4 per 1000 admissions. Rates are not reported as comparators or performance measures.

Risk adjusted outcomes are reported for

- Return of Spontaneous Circulation within 20 minutes.
- Survival to discharge

For GOSH these measures are indicated as within expected range. The GOSH Resuscitation Service monitor in real time monthly cardiac arrests.

UK Renal Registry 27th Annual Report

The report was published in July 2025 and includes an analysis for young people on kidney replacement therapy (KRT) for end-stage kidney disease (ESKD) in the UK in 2023. GOSH has the largest population of children on KRT in the UK, caring for 19.6% of all children requiring KRT in the UK. The report includes a paediatric chapter where there are a number of audit measures.

Measure	Data
Height and weight to be monitored at each clinic visit and plotted on the growth charts of healthy children and adolescents	This is not directly reported as a measure. The height and weight of children receiving KRT are compared to the age- and sex-matched general childhood population. For GOSH the median height z-and weight scores prevalent to dialysis on 31/12/2023 are lower than the UK median for paediatric centres
Blood pressure during PD or after HD to be maintained at <90th percentile for age, sex and height. Blood pressure in Tx patients to be maintained at <90th percentile for age, sex and height	There is insufficient national data to report these as outcome measures for UK paediatric centres.
Data is benchmarked across paediatric centres to report obtainment of targets prevalent to dialysis on 31/12/2023 for the below:	
Serum phosphate and calcium should be kept within the normal range.	For GOSH serum phosphate within target range is 50%, compared with 46.8% for UK paediatric data. No GOSH data is provided on calcium within normal range, due to low data completion.
Parathyroid hormone (PTH) levels should be maintained within twice the upper limit of the normal range but, contrary to adult standards, may be kept within the normal range if growth is normal	For GOSH PTH within target range is 60.7%, compared with 33.1% for UK paediatric data.
Serum bicarbonate concentrations should be 20–26 mmol/L	No data is reported for GOSH due to low GOSH data completion
Typically maintain the aspirational haemoglobin range 100–120 g/L for young people and children aged ≥2 years and 95–115 g/L for children <2 years, reflecting the lower normal range in that age group	For GOSH haemoglobin within target range is 39.3% compared with 45.4% for UK paediatric data.

The GOSH data suggests satisfactory or good outcomes for several parameters, when benchmarked against other centres.

This report highlights that data completeness is lower for GOSH than many other paediatric centres contributing to the UK Renal Registry, and this is an area of improvement for the service. The Specialty Lead for Nephrology is raising this issue with the informatics and data team that support registry submissions.

UK Renal Registry Acute kidney injury (AKI) A report on the nationwide collection of AKI warning test scores from 2024 (Published December 2025)

The report highlights the impact of acute kidney injury (AKI) in England. It reports variation in AKI rates across geographic area and highlights increased risk for patients with AKI in hospital.

“The primary aim of the report is to describe, benchmark and compare AKI alerts and episodes in England, without interpreting the results” – UK Renal Registry Acute Kidney report Dec 2025.

The data is descriptive and describes incidence of AKI. For GOSH the following are reported, these data describe prevalence of AKI and are not outcome or reflections of clinical quality.

Data	GOSH elective admissions	GOSH emergency admissions
AKI rates per 1000 admissions are reported by hospital for 2024	Community acquired AKI- 3.3 Hospital acquired -5.8	Community acquired AKI-21.8 Hospital acquired -112.7
Length of stay by hospital for elective, emergency and other type hospitalisations associated with AKI in 2024	495 admissions. Median length of stay – 10 days	348 admissions. Median length of stay-19 days

Mortality

The report does measure adjusted mortality per hospital. Adjusted means that mortality is adjusted for age and sex, and by clinical setting. For paediatric hospitals, adjusted mortality is not presented, due to poor prediction in this population by the adjustment model.

Data	GOSH
Mortality rate following an episode of hospital acquired AKI in emergency hospitalisation	Total 10.9% Community acquired AKI- 13.5% Hospital acquired AKI- 10.4%
30-day mortality rate following an episode of hospital acquired AKI in emergency hospitalisation	Total 8.6% Community acquired AKI- 13.5% Hospital acquired AKI- 7.7%

Inpatients requiring dialysis and ITU admission

Data	GOSH
% hospitalisations with AKI peak stage 2 or 3 requiring dialysis in 2024	6.8%
% hospitalisations with AKI peak stage 2 or 3 requiring ITU admission in 2024	49.9%

The National Audit of Pulmonary Hypertension

The audit's 16th Annual Report was published in December 2025. The National Audit of Pulmonary Hypertension is an audit of processes and outcomes, and all eight designated centres participate. This report includes data of patients referred to pulmonary Hypertension (PH) services up to 31st March 2025.

GOSH performance with national standards that are relevant for children for 2024-25 is outlined below.

Standard	Standard achieved at GOSH?
PH centres should participate in the audit	Standard met
PH centres should see a sufficient number of patients: 300 managed patients	Standard met
PH centres should see a sufficient number of patients: 100 managed patients with PAH (Pulmonary Arterial Hypertension) or CTEPH (Chronic Thromboembolic Pulmonary Hypertension)	Standard met

Standard	National target	GOSH %
New patients with a diagnosis recorded within six months	98%	92% This has improved from 80% in 2023-2024. Omissions are related to data capture fed into the national audit.
New patients with CTEPH/PAH/no diagnosis should be seen or discharged within 30 days.	50%	39% This reflects capacity in the cardiac unit to see new patients.
New patients should begin drug therapy within 12 weeks of referral.	80%	91%
New patients should begin drug therapy within 10 weeks of referral.	80%	91%
Patients receiving a PH drug should have an annual consultation	95%	94%
Patients receiving a PH drug should have had a face-to-face consultation	80%	90%

National Audit of Cardiac Rhythm Management (NACRM) 2025 Report

Cardiac rhythm management (CRM) is the treatment of arrhythmias (heart rhythm disorders). The National Audit of Cardiac Rhythm Management audit report was published in 2025 and reports on data relating to CRM procedures at implanting hospitals and ablating hospitals from across the UK.

The data highlights that for the under 16-year age group, GOSH carry out more catheter ablations and implantable cardioverter defibrillator (ICD) implantation than any other centre.

Attachment C

- For GOSH the proportion of ablation cases in 2023/24 using general anaesthesia is 100%, compared with the national paediatric data of 99.7%.
- The report reports reinterventions rates within one year, the data is not benchmarked for paediatrics and these are challenging to interpret as outcomes measures. This is because the report states that 0% reintervention rates may *“likely represent differences in waiting time or data reporting, rather than a true absence of reoccurrence”*
 - The % of standard ablations requiring reintervention within one year for 2023/24 is 5.2%, compared with the national data of 2%. The team plan to audit redo cases from 2023/24.
 - The % of complex atrial ablations requiring reintervention within one year (2023/24) is 0% for GOSH.
 - The % of complex ventricular ablations requiring reintervention within one year (2023/24) is 0% for GOSH.

Specialty led Clinical Audit

187 clinical audits and service evaluations led by clinical staff were completed at GOSH during 2025/26. The outcomes of these are summarised in our quarterly Quality at GOSH reports, which are reviewed at the Quality Review Group. The outcomes of all completed projects are also shared on our Quality Hub. The Quality Hub is an internal resource for staff, bringing together core information about quality at GOSH. This integrated area allows staff to view clinical outcomes, clinical audit activity, and Quality Improvement work across the Trust.

We have a “Clinical Audit excellence recognition” intranet page to promote best practice and spotlight the work that teams do to undertake good audit at GOSH. This forms part of the wider work of the Quality team to support and enable team-led audit and QI. This features in our quarterly “Our QI” news bulletin and web portal which gives space to show the excellent work our clinical teams do to review and improve quality.

Some examples of clinical audit completed in 2025/26 that have been highlighted as excellent projects

Service Evaluation - Piggybacking to Minimise the Number of General Anaesthesia Procedures

The Paediatric Dental team have collaborated with other specialties, to “piggyback” dental procedures onto another surgical procedure. General anaesthesia (GA) is an expensive treatment modality and presents significant risks for children with multiple co-morbidities such as those seen at Great Ormond Street Hospital. Piggybacking for joint procedures under GA for medically complex patients offers, not only health and social benefits to families, but reduces costs for Trusts and eases pressures on waiting lists. In 2024, 33 cases were completed in this way. This increased to 67 in 2025 which approximates to the Paediatric Dental team gaining 17 full days operating in 2025 without an increase in the dental GA list provision.

Credit – lead – Dr Rosheen Fatima, Dr Kunal Patel & Dr Rosie Whatling

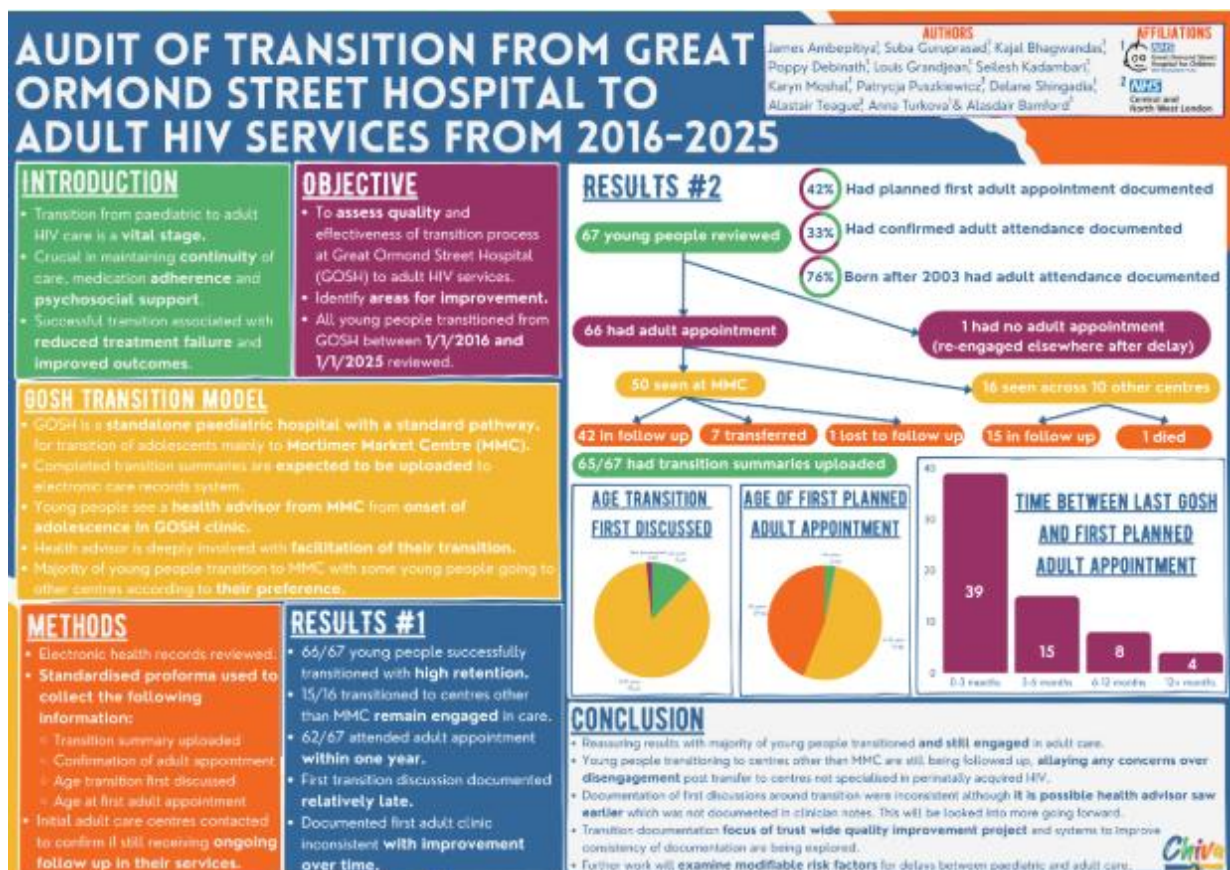
Evaluating The Effectiveness of The Transition of Adolescents with HIV To Adult Services

The Infectious Diseases team have completed effective audit work to evaluate transition processes.

The audit found that most young people successfully transferred from GOSH to adult HIV care and remained engaged in follow-up. However, documentation around transition planning, first appointments, and confirmed attendance was often incomplete, especially in earlier years. Documentation of transition discussions also tended to start late in adolescence. The results emphasise the need for earlier planning, clearer communication between paediatric and adult teams, and consistent record-keeping to support smooth, safe transitions and reduce the risk of disengagement from care at a critical time in a young person's healthcare.

This audit has helped the team recognise the need for consistent and timely documentation of all stages of the transition process. It re-enforces the importance that key steps such as transition meetings, confirmation of first adult appointments and uploading of transition summaries are now routinely completed. Incorporating these processes into Epic will make it easier to monitor progress, maintain oversight and ensure that young people continue to receive seamless care as they move to adult services.

A poster presentation was shared at the Annual Children's HIV Association (CHIVA) Conference.



Credit: Dr James Ambepitiya, Dr Alasdair Bamford on behalf of the GOSH paediatric HIV MDT

The quality of orthodontic clinical photographs in cleft patients

The gold standard for the quality of orthodontic clinical photographs has now been met with over 90% of photographs taken at a grade 1 standard.

Significant improvement has been seen from previous audit cycles due to:

- Meeting with the Medical Illustration Team
- Alternative retractors sizes purchased to help with circumoral soft tissues
- Photography training session
- Creation of a patient information video about the dental photography process currently in video-editing stage with medical illustration team. A patient information leaflet also under review.

"This audit work has supported the GOSH Trust values in term of providing an expert service and working as one team. This audit has demonstrated how excellent teamwork with the dental and maxillofacial department and medical illustration team can result in significant improvements to the photography service provided to our patients. "

We are now meeting the gold standard set in terms of the quality of intra- and extra-oral photographs taken for orthodontic patients under the care of the North Thames Cleft Network. A high standard of photography is essential not only for patient learning and education but also for medico-legal reasons to support the documented clinical notes.

Audit lead - Dr Olivia Johnson King

Examples of clinical audits and service evaluations completed in 2025/26:

Team	Audit	Value
Anaesthetics	Evaluation of complications following scoliosis surgery over a 5-year period.	The multidisciplinary traffic-light system used at GOSH effectively identifies high-risk patients undergoing scoliosis surgery. This audit revealed the usefulness of the Spinal MDT process. It helps identify at risk children and can help with resource allocation going forward as well as better informing our patients in the consent process.
Cardiac Surgery	ECMO evaluation	It has given the team an understanding of the spectrum of time required for cannulation in various scenarios. It has also demonstrated that mortality is not associated with the surgeon or time to cannulation.
Cardiology	Clinical Necessity for routine echocardiogram after epicardial Pacing Wire removal	Based on the findings of this audit, routine transthoracic echocardiography following epicardial pacing wire removal should not be performed routinely in asymptomatic patients. Instead, a selective, clinically driven approach is recommended. Transthoracic echocardiography would be reserved for patients who develop concerning clinical signs (unexplained tachycardia or hypotension, significant post-operative bleeding or high-risk surgical profile).

Attachment C

Team	Audit	Value
CICU	A clinical audit to evaluate the incidence and patient pathway of patients who were diagnosed with necrotising enterocolitis (NEC) while admitted to CICU	Current processes for monitoring cardiac babies for NEC are working. This reinforces patient pathways for assessment and management of NEC in cardiac babies
ENT	Post-op grommets and major ear surgeries instructions and advice	Variation in post-operative information had led to inconsistent advice for families. Introduction of a standardised EPIC smartphrase significantly improved the completeness and consistency of information provided. This intervention supports safer care at home, reduces avoidable post-operative queries, and improves workflow efficiency.
Gastroenterology	Trace elements and vitamin levels in long-term home parenteral nutrition paediatric patients.	This audit confirmed the effectiveness of the current monitoring practices; however, it also highlighted that despite adherence to guidelines, some micronutrient deficiencies, such as zinc, copper, vitamin D, and iron, remain common in certain patients. This suggests a need for more individualized supplementation strategies, especially for children with high intestinal losses. The audit has therefore reinforced the importance of guideline-based monitoring while promoting closer attention to personalized patient needs to improve nutritional management and patient outcome.
Haemophilia	Prevalence of hip bleeds in children with haemophilia	Improved awareness of hip bleeds in patients with mild haemophilia and a new finding of hip bleeds in those with severe haemophilia requiring closer monitoring
Pain	A Service Evaluation of the Pain Education Sessions (PES).	The evaluation provided insight into patient and parent experiences of online pain education sessions. Findings will inform service redesign, including clearer expectations, age-appropriate grouping, shorter session formats, and increased opportunities for engagement.
PAMHS	To evaluate the usefulness, effectiveness, and accessibility of a parent intervention program for parents of children feeding difficulties and avoidant restrictive food intake disorder (ARFID)	The parent group program was an effective intervention in increasing parents knowledge and confidence in ARFID and feeding difficulties.
SNAPS	Prospective audit of gastrostomy service	The following improvements were noted - Improved standardised documentation on EPIC - Updated patient/parent information leaflet in coordination with the gastrostomy CNS team. - More work needed towards standardisation of care (minimising complications, optimising patient/parent experience, reducing cost for the NHS). --Optimisation of patient/parents information and involvement due to the updated leaflets.

10. Orthopaedic Services Review

During the year, the Trust concluded its review of care provided within the Lower Limb Lengthening and Reconstruction Service between 2017 and 2022 and published the findings in January 2026.

We are deeply sorry to the children, young people and families that are affected. We cannot fully understand the impact the experience has had on the children, young people and families that are affected. We hope that the changes we have made and continue to make as a result of their experience will help prevent future patients and families going through what happened to them.

Following concerns raised in 2022 and an invited review by the Royal College of Surgeons of England, we undertook a comprehensive patient recall. Independent external paediatric orthopaedic surgeons reviewed 789 patient cases; reviews were completed by October 2025 and shared with families, with additional support introduced in response to feedback.

The independent review found that most children were not harmed; 98 patients (12.4%) experienced some level of harm, with 94 cases (11.9%) attributable to the surgeon's care. Alongside completing the recall, the Orthopaedic Service implemented strengthened oversight and more consistent pathways, including clearer referral and follow-up processes and routine multidisciplinary discussion before and after surgery.

We are grateful to staff who raised concerns and to families who contributed feedback. The Trust has reinforced the importance of speaking up and continues to strengthen governance and leadership to ensure concerns are identified and acted upon promptly across all services.

We again apologise to those affected and will continue to support families and deliver the improvements arising from this work, so that we provide consistently safe, high-quality care for every child and young person.

11. Quality Improvement (QI)

“Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement.” (The Health Foundation, 2021)

At GOSH, the QI team delivers three core functions to support the organisation in continuously improving care:

Supporting improvement projects: The team facilitates and mentors front-line staff and services to help them identify, design, implement, and sustain local quality improvement initiatives. They also provide advice and coaching to teams leading larger, Trust-wide projects.

Capacity and capability building: An education strategy is delivered to strengthen quality improvement knowledge and skills across all staff groups, with a focus on enabling and supporting the implementation of improvement initiatives.

Culture building: The team works with colleagues across the organisation to foster and maintain a culture of quality through the use of improvement tools and methodologies.

The **Quality Review Group** is a multidisciplinary, cross-directorate forum that identifies, shapes, and monitors quality improvement priorities for GOSH. It has developed over time to support consultation and co-development of priorities with clinical directorates, while also making decisions on the prioritisation of quality-related activities across the Trust.

The Quality Team offers a **Quality Hub** for colleagues, which brings together key information on quality at GOSH in one integrated platform. This hub enables colleagues to access clinical outcomes, audit activity, and ongoing QI work across the organisation, as well as guidance on initiating new projects and accessing support. It also includes dashboards and reports on key safety and quality metrics, supporting Trust-wide quality improvement efforts.

Quality Improvement project example:

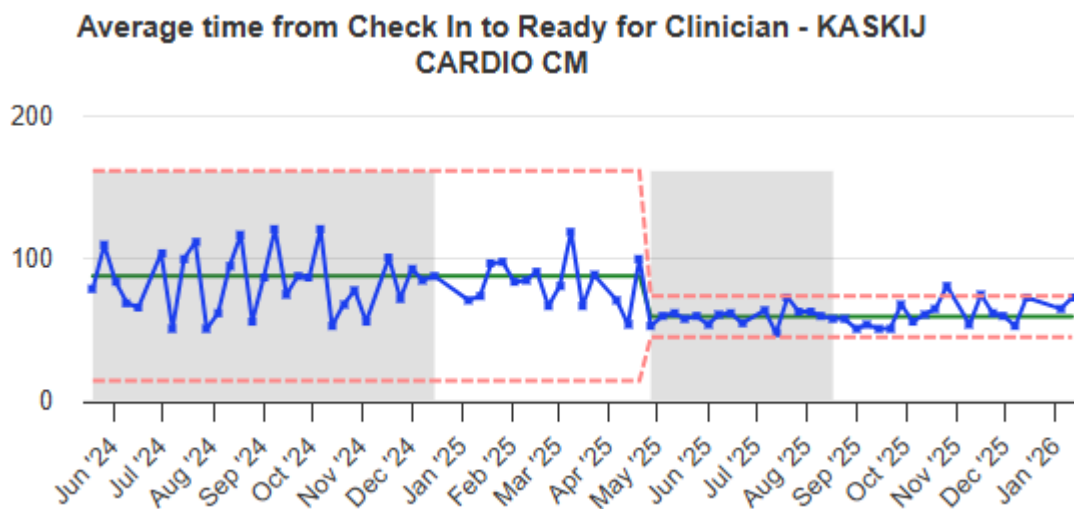
Improving Flow in Falcon Cardiac Outpatients

Across Falcon cardiac outpatients, busy clinics and appointment scheduling were contributing to long patient waits for ECG and Echocardiograms and increasing pressure on staff. With up to 100 patients attending daily, many requiring both ECGs and echocardiograms, cardiac physiology colleagues were experiencing frequent interruptions, rising fatigue and concerns about burnout, while patients reported delays and limited communication about waiting times.

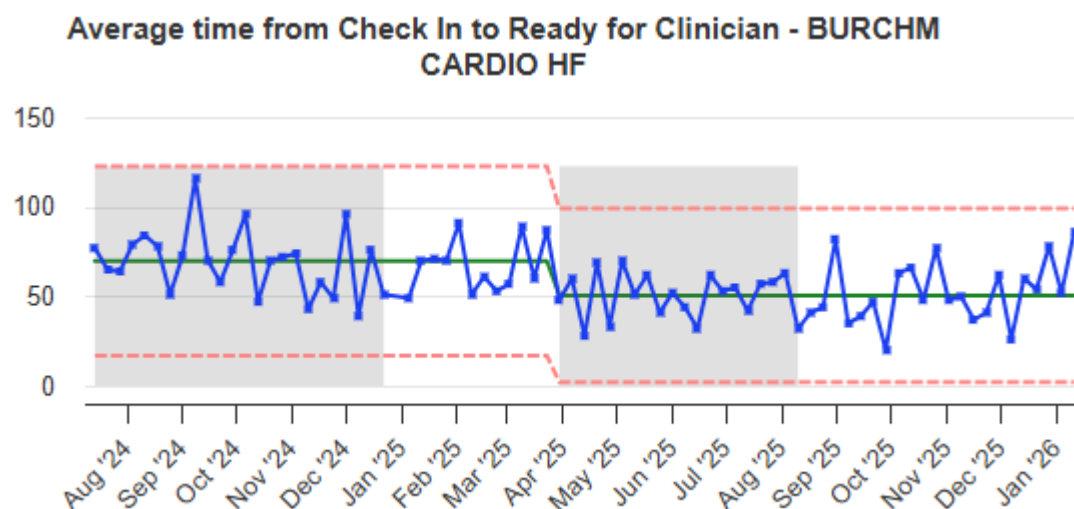
In response, Emma Carter and Elizabeth Aley (Cardiac Physiology) submitted an idea to the ‘Ideas Platform’ and subsequently led a multidisciplinary improvement effort to redesign the clinic template. They worked closely with the Heart Failure (HF) and Inherited Cardiovascular Disease (ICVD) clinical teams, the Central Booking Office, and were supported by the QI Team, QI Analyst and DRIVE. The aim was simple: improve patient experience and staff wellbeing in Falcon cardiac outpatients by removing bottlenecks and creating better flow.

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From 15th July to 30th September 2025, a new template was tested within Tuesday Falcon clinics (HF and ICVD). Instead of clustering face-to-face appointments mid-morning, appointments were spread more evenly throughout the day, with protected space over lunchtime and greater use of front-loaded telephone appointments.



Average waiting times from check-in to being ready for a clinician reduced (see SPC charts, showing sustained reduction), clinics felt calmer, and staff reported improved workflow.



One colleague reflected: “The new workflow is a significant improvement.” HF teams are now triaging more consistently, reducing unnecessary face-to-face appointments and diagnostic demand.

Capacity and capability building examples:

In our **Quality Improvement Expert** programme the following projects were completed in 2025:

- “Implementing the Pathway to Excellence Accreditation Framework: Challenges, Learnings, and Next Steps”
- “Understanding what Psychological Safety is and how to achieve it”
- “A Neuromuscular QI Project - Drawing up IT Nusinersen at the patient bedside”
- “GOSH Check-In Tools: Empowering Young People and Families in Healthcare Transition”

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- “Post Clinic Admin process improvement”
- “Improving psychological support for parents of children born with complex urological anomalies immediately post-diagnosis and during the first year of life”
- “Blood gas reduction project”

Examples of course feedback from participants:

“This was an incredible way of opening up discussion, considering perspective and underpinning the fundamentals of QI in a practical sense.”

“Content was so helpful. I've gone from feeling anxious and overwhelmed about how to make change to feeling that the next steps are much clearer.”

Culture building example:

The Quality Team has been supporting the **GOSH Goes Green Competition** in 2025 with the following projects:

“Reducing Single-Use Theatre Caps in Urology Theatres”

“Choose to Reuse” – Reusable Saturation Probe Project”

“Eliminating single use of surgical wraps for frequently used dental surgical instrument sets and replacement with reusable containers”

“Air Quality & Goods Yard Deliveries”

“Evaluating the percentage of wasted reusable bottles that are not returned to the Special Feed Unit (SFU)”

“Re-use of Hamilton T1 Ventilator Circuits”

An example project summary:

“Reducing Single-Use Theatre Caps in Urology Theatres”

Operating theatres are one of the highest waste-generating areas in healthcare. Disposable caps contribute to clinical waste, carbon emissions, and ongoing procurement costs. The project aligned with the NHS Green Plan and GOSH sustainability priorities, aiming to reduce waste while enhancing staff and patient experience.

Using a structured quality-improvement approach, the team introduced fabric, personalised theatre caps with the staff members' name and role. The project was seed funded initially by the GOSH Charity Everyday Impact fund and has now been adopted throughout the theatre environment.

There was strong staff engagement and sustained adoption, with clear substitution away from single-use caps. Qualitative feedback showed a positive response from both staff and patients post-implementation. In addition to supporting reduced waste, theatre staff reported significantly improved communication, knowledge of team name and roles, and a perception of looking more approachable and corporate. Patients and Families were also positive reporting improved recall of staff names and a more approachable, child friendly, appearance.

Examples of staff feedback:

“The hats ease introductions and lower barriers making us more One Team, aiding communication and increasing safety. I imagine it's also nice for children who can read and parents, making us more approachable and levelling the inherent power imbalance.”

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“As a rotating resident, it was very welcoming to receive this hat. As a new member of staff, it helped to settle in quickly, as consultants knew my name just by looking at my hat. The provision of the hat made me feel part of the team and therefore improved my wellbeing which is in line with the new NHS 10 point plan to improve resident doctor's working lives.”

“Made me feel really valued when I received one soon after starting at the hospital”

“Parents and patients found them useful and less intimidating and gave a more friendly appearance.”

“I love them, makes me feel part of the team, helps with my terrible memory when it comes to names, it helps delegate tasks, especially in an emergency. Also helped visitors and students identify team members”

Environmental impact analysis showed meaningful benefits, including reduced plastic waste, lower carbon emissions, and decreased reliance on non-recyclable consumables. Financially, the project demonstrated cost avoidance with potential year-on-year savings.

Beyond measurable outcomes, the project fostered a culture of sustainability, strengthened multidisciplinary collaboration, and generated strong interest from other clinical areas. It provides a replicable, low-risk and high-impact model that supports the triple bottom line of people, planet and profit, and positions the organisation to lead on practical, staff-led sustainability innovation.

12. Health Inequalities Programme at GOSH

Introduction

GOSH has established a comprehensive Health Inequalities Programme to identify and address barriers to health equity. The programme includes a Health Inequalities Steering Committee, a Programme Development Group, and working groups focusing on Access to Care, Clinical Outcomes, Digital Exclusion, Patient Experience and Raising Awareness of Health Inequalities, and developing/maintaining the Health Inequalities Data Dashboard. This provides the related data to the programme so that we have a full understanding of how social determinants of health are impacting our patient's ability to access our services. The programme aligns with the NHS Long Term Plan (2019), the Equality Act 2010, the Health Care Act 2022, and the 10-year Health Plan for England 2025, while supporting initiatives like Start Well and contributing to the work of the Children's Hospital Alliance.

Strategic Aims

The programme adopts a data-driven approach through health inequalities dashboards, integrates quality improvement methodologies, implements targeted initiatives, encourages collaborative efforts with local authorities and community organisations, fosters leadership commitment and ensures continuous evaluation. These approaches help GOSH systematically understand and address barriers to accessing care, supporting clinical teams to promote health equity and enhance care quality for children and young people.

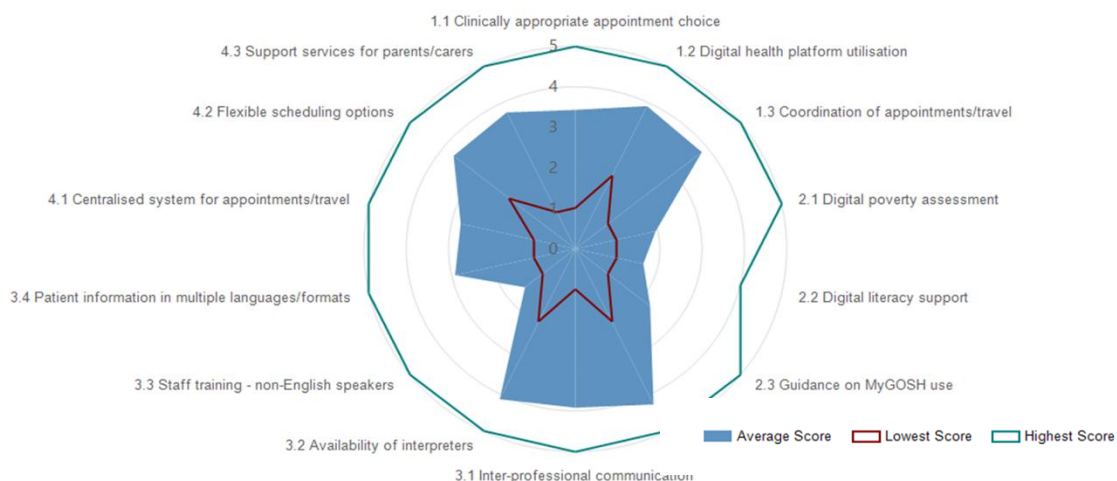
Programme Highlights (2025-2026)

Health Inequalities Quality Improvement Project

- Pan-trust Health Inequalities self-assessment: completed by 30 wards, teams and departments assessing themselves on the four key standards:
1. Equitable Access to Healthcare Services
 2. Digital Inclusion and Digital Literacy
 3. Communication and Language
 4. Logistical Coordination and Support

Aggregated results identify gaps in service provision across the four key standards (Figure 1).

Figure 1: Aggregated self-assessment results $n=30$ departments



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Embedding the Health Inequalities Self-Assessment into Business as Usual

From April 2025, the Health Inequalities Self-Assessment has been incorporated into the ward accreditation scheme, whereby wards are able to gain credit towards their accreditation if they have completed key milestones. These include:

- Completing the self-assessment, including all relevant team members in the assessment process.
- Completing the improvement plan and working towards bridging identified gaps.
- Registering improvements on the Quality Hub.

Additional mentoring is available to provide support for improvement work, upon request.

Co-Production Approach

Since the inception of and throughout this programme of work, a collaborative co-design approach has been central, involving:

- Members of the Young People's Forum and Parents from the Patient Safety Partners
- Staff from different departments
- Members of the Health Inequalities Steering Committee and Programme Development Group
- "Raising awareness of health inequalities" working group
- GOSH Volunteers
- Project lead and QI team
- Members from the Patient and Family Experience Team

Patient Voices

Patient testimony highlights the importance of equitable healthcare that doesn't make patients feel different or excluded. We are working on more patient stories to highlight the impact of this work.

Partnerships

The programme collaborates with the Children's Hospital Alliance, the Federation of Children's Hospitals, NHS England, the Office for Health and Improvement and Disparities, and charities including Good Things Foundation, Sophie's Legacy, the Ellis Lake Foundation and GOSH Charity.

Future Plans

- Ongoing support for clinical teams during self- assessment and improvement plan implementation.
- Reassessment every six months to demonstrate change and impact.
- Iterative development of standards, portal and approaches to respond to changing healthcare inequalities priorities.
- Integration of quality improvement and clinical service planning.
- Continuation of health inequalities working groups and their priorities.
- Ongoing collaborations and advocacy locally, nationally and internationally for children and young people with long-term, rare and/or life-limiting conditions.
- Expansion of the programme further through charity grant funding to conduct world-leading research on health inequalities, and to establish a Health Inequalities Academy, to facilitate hosting PhD and Master's students who would conduct research and projects identified as a priority within the programme.

13. Learning from Deaths

Death in childhood is a rare event. Whenever a child dies, it is important to learn if anything could be done differently in the future. We have systems and processes in place, to monitor mortality, highlight positive practice, and areas where improvements could be made to improve quality, the co-ordination of care, or patient and family experience

Implementation of the Child Death Review Statutory Guidance

The guidance outlines the statutory NHS requirements for child death reviews for all child deaths occurring after 29th September 2019. This requires a Child Death Review Meeting (CDRM) that is a multi-professional meeting where all matters relating to a child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death. To support this process at GOSH there are two Co Medical Leads for Child Death Reviews in post supported by a Child Death Review Coordinator and the Bereavement Services Manager.

Mortality reviews take place through two processes at GOSH:

1. Mortality Review Group (MRG). This was established in 2012 to provide a Trust level overview of all deaths to identify learning points, themes and risks and take action as appropriate to address any risks. This process is linked with local case reviews (Morbidity and Mortality Meetings) undertaken by specialty teams and provides an additional oversight of inpatient deaths in the Trust. This group continues to review deaths to ensure a thorough level of case note review and challenge can be provided before reviews are finalised at a Child Death Review Meeting (CDRM), as well as identifying learning points and making referrals to other safety investigation processes at the earliest opportunity.

2. Child Death Review Meetings (CDRM). Child Death Review Meetings are "a multi-professional meeting where all matters relating to a child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death." They include clinicians or professionals from external providers. CDRM meeting should be held within 12 weeks of the child's death, following the completion of all necessary investigations and reviews. Child Death Review Meetings (CDRMs) are the final meeting to confirm actions and learning in the mortality review process following the completion of all necessary investigations and reviews. It should be noted that this timeframe is guidance and not a statutory requirement. The Child Death Review Statutory and Operational Guidance states "*The meeting should take place as soon as is practically possible, ideally within three months, although serious incident investigations and the length of time it takes to receive the final post-mortem report will often cause delay*"

Deaths in 2025 and child death review meetings

Between 1st January 2025 and 31st December 2025, ninety-one children died at GOSH.

- Thirty-eight of those deaths have been reviewed at a CDRM at GOSH
- Five CDRMs cannot take place until the completion of necessary coroner/external investigations. Reviews can be delayed until completion of necessary coroner investigations. This in line with the Child Death Review Statutory Guidance.
- Twenty-nine CDRMs are being scheduled at the time of writing due to challenges in clinical staffs' capacity, chair availability and work required to arrange and attend the meetings.
- Nineteen are to take place /have taken place via a local child death review in the borough where the child lived

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Additional resource has been agreed with the Medical Directors Office – with an additional Consultant, familiar with the CDRM process, to chair CDRMs on an ad hoc basis to help reduce the backlog of outstanding CDRMs. There are also plans to increase the frequency of the Mortality Review Group.

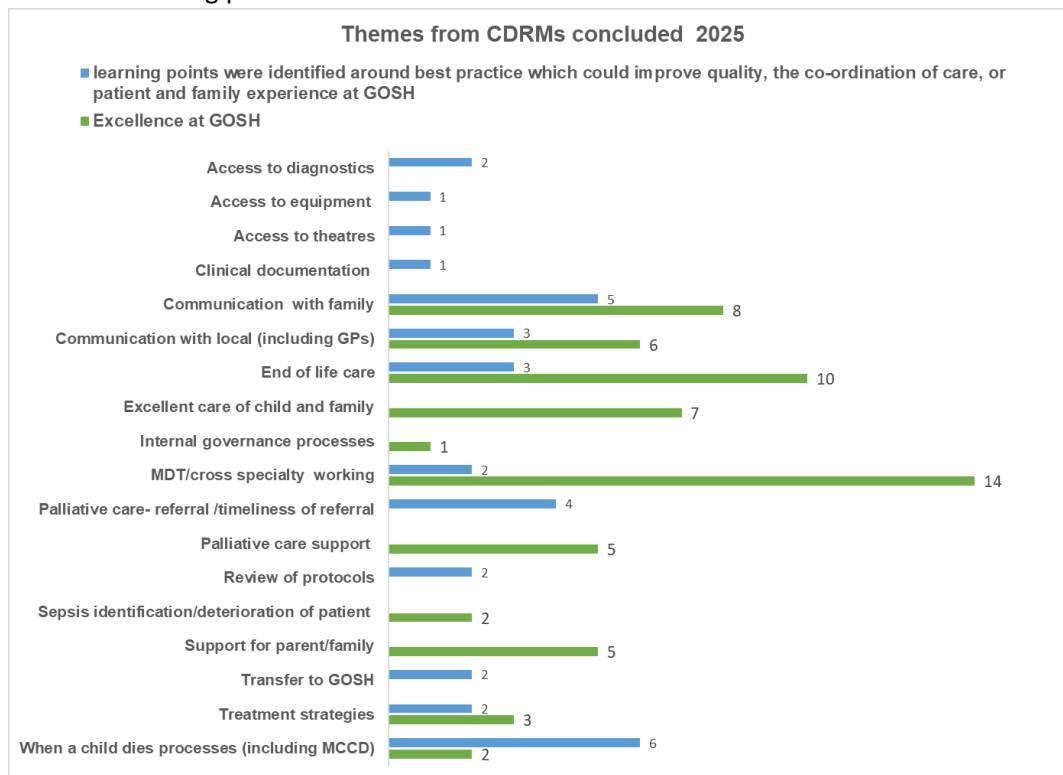
Learning from Child death review meetings concluded in 2025

Child Death Review Meetings are the final review meeting in the mortality review process following the completion of all necessary investigations and reviews, and the point at which learning from deaths can be fully and conclusively reported. Therefore, we report below the learning points from concluded Child Death Review Meetings held by GOSH.

GOSH Child death review meetings concluded in 2025.

Number of deaths reviewed at a GOSH Child Death Review Meeting	61
Number where modifiable factors ¹ around GOSH care were identified following the conclusion of a CDRM	0
Number of deaths where there were learning points around best practice which could improve quality, the co-ordination of care, or patient and family experience at GOSH	25
Number where excellent practice at GOSH was highlighted in the review	44

The learning points from reviews are shared via quarterly Learning from Deaths reports at Trust Board. Learning themes from these reviews are summarised below. Please note that each case may have more than one learning point



¹ Modifiable factors are defined as those, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths.

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A theme was highlighted with challenges with familiarity with aspects of the processes to follow when a child dies- where deaths have occurred on wards, and outside of intensive care.

An action plan to support awareness of the Bereavement Key Worker (BKW) for wards has been led by the Bereavement Services Manager.

The following actions have taken place:

- Contacted ward Practice Facilitators around When a Child Dies guidance including BKW training.
- Eagle ward –online training for Advanced Nurse Practitioner and Family Therapist.
- Ongoing training in the Palliative Care Foundation Course session includes BKW.
- ICU Family Liaison Nurses now assist with process and identifying BKW with ward staff on outlying ward deaths during Monday -Friday.
- Options required to support Oncology Wards discussed with the Blood Cells and Cancer, Associate Chief Nurse.
- Launch of updated *When a Child Dies Guidance* and toolkit on the intranet in Q3 2025/26, both include the role of the Bereavement Key Worker.
- BKW Support Group meets per quarter for learning, sharing experience, and peer support.

14. Participation in clinical research

Great Ormond Street Hospital (GOSH) and UCL Institute of Child Health (UCL GOS ICH) together form the largest paediatric research centre in Europe. GOSH’s research and innovation is achieved through leadership and an ecosystem of local, national, and international partners, funders, and infrastructure that is bold and collaborative. Most notable is its National Institute for Health and Care Research (NIHR) infrastructure, formed of the NIHR GOSH Clinical Research Facility (CRF), and the only paediatric Biomedical Research Centre (BRC) in the country, which since 2017 has helped to translate 20 novel treatments from clinical trials to regulatory approval. As a digitally mature hospital (HIMSS Level 7), GOSH is a leader in paediatric innovation, with our dedicated Data Research, Innovation and Virtual Environments (DRIVE) Unit for data and technology advancements. Our ambition is to grow further, to allow us to become the world’s first health life-sciences park for severe childhood disease. To achieve this, we need to continue our development towards becoming an Intelligent Research Hospital – one that offers the best research-led care, driven by curiosity and innovation.

Research activity

In 2025/26, we had 849 active research projects at GOSH and UCL GOS ICH (Figure 1). Of these, 367 were adopted onto the National Institute for Health and Care Research Delivery Network (NIHR RDN) Portfolio, a prestigious network that facilitates research delivery across the NHS. Our extensive research activity continues with the support of our NIHR CRF and NIHR BRC awards, which currently run to March 2029 and March 2028 respectively. The NIHR GOSH BRC and NIHR GOSH CRF underpin our clinical research infrastructure at GOSH and UCL GOS ICH.

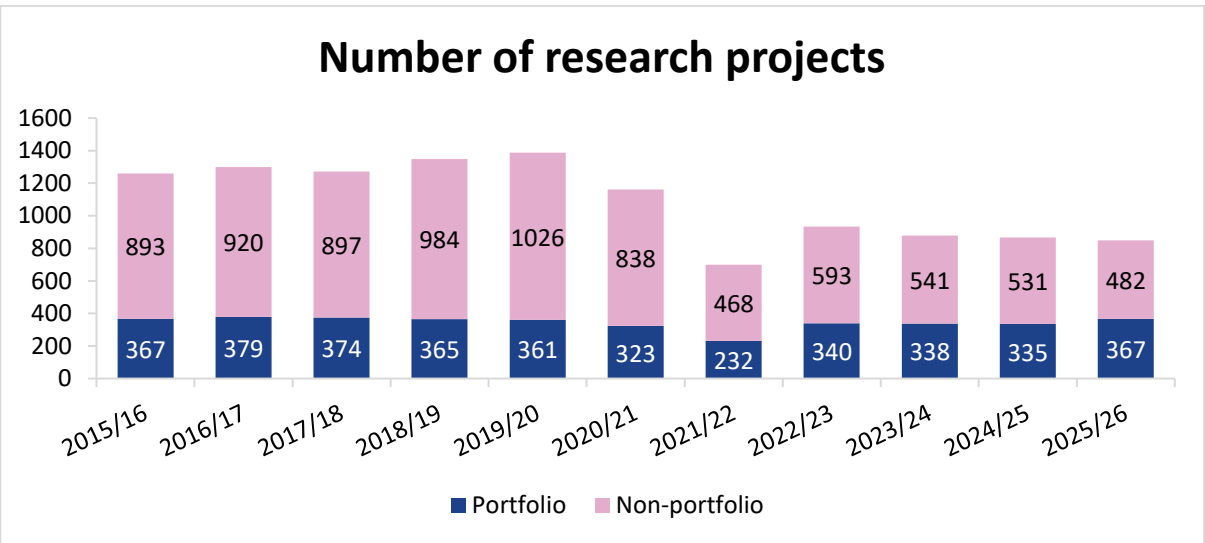


Figure 1: Number of active research projects taking place at GOSH and UCL GOS ICH, highlighting the NIHR RDN Portfolio projects.

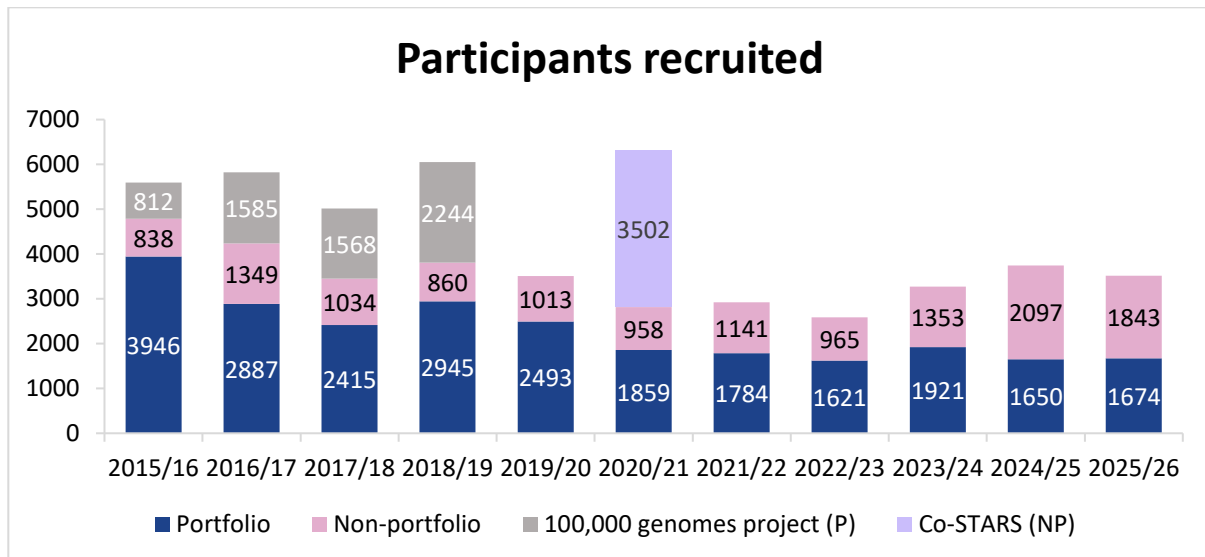


Figure 2: Recruitment to research projects

NIHR GOSH CRF

Our purpose-built NIHR GOSH CRF, which recently celebrated two years in its larger, upgraded location, has supported continued growth in research activity, with 1963 visits and 104 studies in 2025/26 (see Figure 3). The NIHR GOSH CRF has 10 clinical rooms, all with en-suite facilities which allow the unit to host studies requiring inpatient and overnight stays, something that was challenging in the previous unit. This inpatient and overnight capacity supports the growth in our gene therapy portfolio and facilitates extended inpatient research admissions, providing 24/7 research care. We continue efforts to develop our research capabilities in the rest of the hospital, and in 2025/26 the CRF supported 198 studies across the Trust.

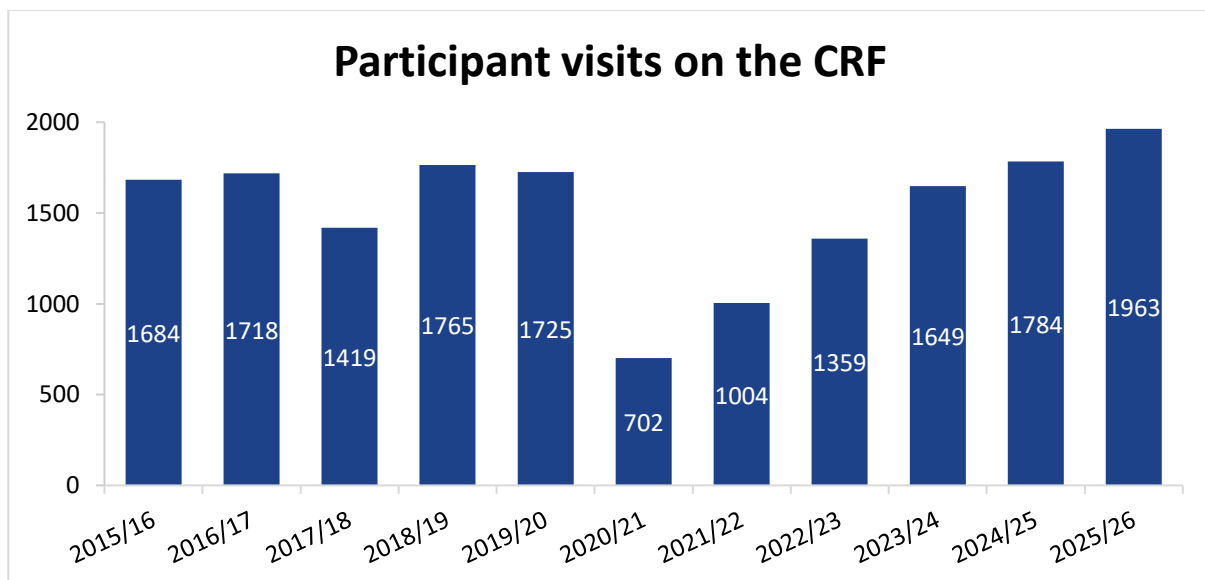


Figure 3: Participant visits on the NIHR GOSH CRF

Research Income

Research income enables us to deliver high-quality research at GOSH. Research income in 2025/26 was £27.7m, slightly higher than last year (see Figure 4). We ended the year with a £0.2m contribution to the Trust over and above our core costs, compared to £0.7m last year. In addition, the clinical directorates received £2.7m commercial research income. R&I is currently reviewing directorate research finances to increase transparency and incentivise research in the Trust.

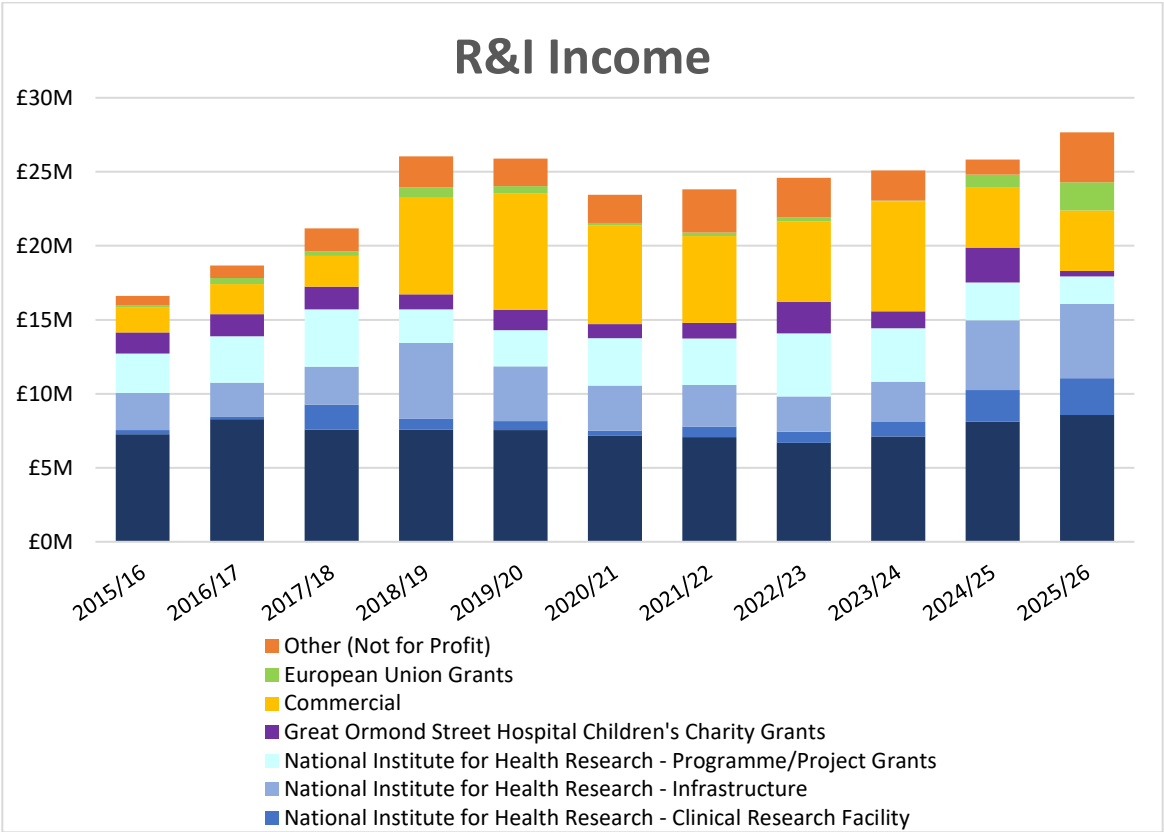


Figure 4: Research income (£m). NB final year-end figures for 2025/26 not yet validated.

Research highlights

In 2025, GOSH saw further success in novel treatments that have gone from a trial intervention through to regulatory approval:

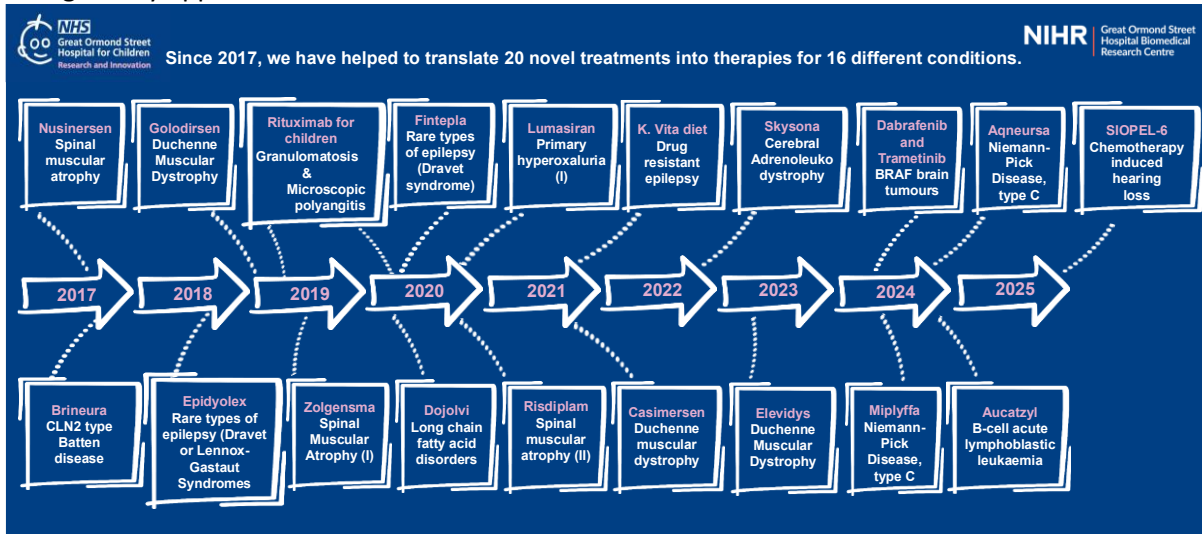


Figure 5: Timeline of novel treatments studied at GOSH that have gained regulatory approval.

In 2025/26 we published 1119 papers, 414 of these were with our academic partners. Highlights from our breakthrough studies that were published this year include:

Life-changing drug identified for children with rare epilepsy

A [GOSH and UCL-led trial](#) has shown that a new experimental treatment, Zorevunersen, can reduce seizures dramatically for children with Dravet Syndrome, a hard-to-treat form of epilepsy. The condition also causes feeding difficulties, movement problems and has a high risk of premature death. Current treatments fail to control seizures in most patients and there are no approved medicines that address the condition's devastating cognitive and behavioural impacts. The trial demonstrated that the treatment is safe and helps children lead much healthier and happier lives, reducing seizures by between 59% and 91%. The children's quality of life improved over a three-year period and most of the treatment's side effects were mild. A Phase III study is currently underway to further evaluate the treatment.

Engineered tissue offers hope for children born with oesophageal atresia

Scientists from GOSH and UCL have created the first lab-grown oesophagus shown to safely replace a full section of the organ and restore normal function, including swallowing, in a growing animal without the need for immunosuppression. The research published in [Nature Biotechnology](#) is a major leap towards personalised regenerative treatments for children born with life-threatening oesophageal conditions and could pave the way for translation to other disease areas. Professor Paolo De Coppi, NIHR and Nuffield Professor of Paediatric Surgery at UCL GOS ICH and Consultant Paediatric Surgeon at GOSH led the research team. He said: "The oesophagus is a really complex organ, without a blood supply from its own vessels, so it cannot be 'transplanted' in the way you might expect. To develop alternatives, it is essential to work with animal models that closely reflect human anatomy and function. In this respect, the pig oesophagus closely resembles the human one. With the success of this research, we hope that we can be successfully offering an engineered tissue alternative to children who desperately need it, within five years."

Achievements in Gene Therapies

There were several gene therapy successes at GOSH this year. Results from the largest group of children who received a gene therapy for a rare immunodeficiency condition, ADA-SCID were published in the [New England Journal of Medicine](#). Prior to the gene therapy, the standard treatment would be once or twice weekly enzyme-replacement therapy, monthly infusions of immunoglobulin (antibodies) and preventative antibiotics until a matched bone marrow donor can be found. The study showed the long-term safety and efficacy of the curative treatment for this life-threatening condition.

A toddler with a life-limiting and life-threatening rare disease was the youngest to be treated with the newest gene therapy available on the NHS at GOSH. Gunreet has the rare condition aromatic L-amino acid decarboxylase (AADC) deficiency and has been treated at GOSH for most of her life. Thanks to a life-changing gene therapy commissioned by NHS England, she has gained skills previously out of reach for her, like vocalising and movement. As she grows, the specialist teams that care for her are hopeful she will make further strides to a life like her peers. GOSH treats nearly all the children diagnosed with AADC deficiency in the UK and is the only site for the potentially lifesaving and life-changing gene replacement therapy, eladocogene exuparvec.

Children with severe leukocyte adhesion deficiency (LAD-I) do not have a functioning immune system; constantly struggling to fight infections. As a result, they are frequently hospitalised. Without treatment, they rarely live past two years old. All nine children in a [gene therapy trial for LAD-I](#) have responded well to treatment and, after one to two years of treatment, are all surviving with fewer symptoms. Their skin and dental lesions, infections and inflammatory symptoms have resolved, and the children have been able to resume everyday activities alongside their peers. Professor Claire Booth, Mahboubian Professor in Gene Therapy and Paediatric Immunology (UCL) and Consultant Paediatric Immunologist at GOSH said: "As this process has been shown to be successful for such a complex disease, we could move towards a blueprint to treat many other diseases. Gene therapy is being explored by teams at GOSH and our partners for blinding conditions, muscular dystrophies, cancer and others – the possibilities are really far reaching."

Major GOSH-Sponsored Clinical Trial: PKAN Trial

This trial opened in July 2025 and investigates a potential new treatment for pantothenate kinase-associated neurodegeneration (PKAN), a rare but devastating condition that affects the brain. Children are born normally but progressively lose the ability to walk or talk and develop painful twisting movements called dystonia. Children with PKAN cannot convert vitamin B5 into an essential molecule called co-enzyme A. The investigational product 4'-phosphopantetheine (UK-PKAN-B5D) aims to correct the underlying metabolic deficiency. Participants receive treatment or a placebo for 24 weeks, followed by a 24-week open-label extension. Key outcomes include safety assessments, biomarker analyses, ophthalmic monitoring, and quality-of-life measures.

Biobanking

GOSH Sample Bank enables patients to donate their residual samples, which would otherwise be discarded, for vital child health research. Following Research Ethics Committee (REC) approval of GOSH Sample Bank as a Research Tissue Bank (RTB), the Tissue Access Committee (TAC) has reviewed three applications from researchers seeking access to samples. Awareness of the resource is increasing, and interest from the research community continues to grow.

GOSH continues to be a recruiting site for the [NIHR BioResource](#), a national recallable resource of over 350,000 volunteers that support public participation in research, recruiting healthy volunteers and making it easier to find patients with specific conditions. In 2025, GOSH recruited 90 patients to the [D-](#)

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[CYPHR](#) cohort (the DNA, Children + Young People's Health Resource), a childhood DNA health resource for research from birth through adolescence, bringing us to a total of 205 since we received the greenlight in 2024. Nationally, D-CYPHR has now reached over 12,000 young volunteers. The BioResource at GOSH has recruited 16 patients, parents and staff for the [IBHO](#) (Improving Black Health Outcomes) since June 2025. The GOSH BioResource has now been integrated into the GOSH NIHR CRF and continues to receive £100k per year to support its activity.

Quality Assurance, Auditing, Monitoring & Risk

Quality Assurance and Regulatory Readiness

The GOSH R&I Quality Assurance (QA) team continues to collaborate closely with the UKCRF QA Group to strengthen research governance and elevate working practices in line with the newly published ICH GCP E6(R3) guidelines. Together, the group is updating the Joint Research Induction programme to ensure the research community has a clear and consistent understanding of the regulatory changes and the expectations for clinical trial conduct.

In parallel, the Clinical Trials Team within the R&D Office has delivered training to raise awareness of the new regulations. Standard Operating Procedures (SOPs) will also be updated to reflect these requirements for GOSH-sponsored clinical trials and preparation for the next Medicines and Healthcare products Regulatory Agency (MHRA) Inspection.

Trust-wide Quality Engagement

The R&I QA team remains an active contributor to the Policy Review Group and Trust-wide Quality Review Group (QRG). This enables research-specific quality priorities to be embedded across broader organisational quality improvement workstreams.

Audit Activity and Monitoring

In 2025, the R&I QA team completed five internal audits and supported study teams with preparations for five external sponsor audits. All clinical trials taking place at GOSH, whether hosted or sponsored, continue to be monitored for GCP compliance, with oversight provided jointly by the QA and Clinical Trials Teams.

The MHRA completed a two-day routine inspection of our Cell and Gene Therapy manufacturing activities under the MIA(IMP) 17328 and MS 17328 licences in February 2026. The inspector noted significant improvements to the operations since the previous inspections in 2022 and 2023. There were no critical findings, one major finding (related to contamination control) and no other findings or recommendations. We will be taking measures to address the gaps identified.

In 2025 we had our first HTA inspection for our R&D licence, receiving just one minor shortfall. There were many positive comments on our processes and teamwork and training on HTA and consent, as well as the generic consent process and management of MTAs, in particular the overarching MTA between GOSH and UCL. The minor shortfall relates to out-of-date SOPs/policies, which have been updated and the inspection closed.

In January 2026, an on-site audit of a study looking at the safety, pharmacokinetics, pharmacodynamics, and efficacy of Leniolisib in patients with APDS (Activated phosphoinositide 3-kinase delta syndrome) was undertaken. There was one critical finding, two major and one minor and one observation/recommendation and one request for a business continuity plan. The QA Team are working with PI and study team to ensure that all medical notes, questionnaires and patient diaries are checked for missed

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AEs and discrepancies. All findings and PI review will be documented correctly and reported to the sponsor (if applicable). The delegation and training logs will be updated, and all current training certificates will be added to the ISF. The ISF will be reviewed for missing documents, alongside storage of study documentation and laboratory kits. The team will work with ICT to obtain documents for a business continuity plan.

To strengthen internal governance, the R&I QA team is rolling out a structured internal audit programme focused on ensuring effective processes such as training, SOP management, and work instructions are in place to support the foundations of clinical trial delivery.

Additionally, a Trust-wide KPMG internal audit identified R&I specific recommendations which have been completed. These were around the monitoring, tracking and reporting of royalty payments for IP.

Digital Innovation: Electronic Site Files (eISFs)

The R&I QA team has also explored the adoption of electronic site file (eISF) systems to streamline documentation processes and enhance compliance. Engagement activities have included meetings with system providers; collaboration with Trusts already using eISFs; review of sponsor-hosted digital platforms; and consultation with GOSH staff using eISFs for hosted studies. A business case submission to GOSH Charity is in progress as part of a wider research infrastructure bid.

Quality Culture

The QA function continues to embed a culture focused on building and maintaining an effective quality system that adds value to the R&I strategy. The team works proactively with research groups to drive continuous improvement and uphold high standards of quality and safety in clinical research delivery.

Risk

Risk associated with research undertaken at GOSH is proactively identified, assessed, and managed through established clinical and research governance frameworks to ensure the safety, rights, and wellbeing of patients and participants. All research activity undergoes robust review through sponsorship processes, regulatory approvals, and local feasibility assessments prior to commencement, with risks documented and mitigated in accordance with Trust policies and national guidance. Ongoing oversight is maintained through study monitoring, incident reporting systems, audit, and regular review by relevant governance committees, ensuring that emerging risks are escalated appropriately and addressed in a timely manner. Learning from research-related incidents and near misses is embedded into wider clinical governance structures, enabling shared organisational learning and continuous improvement. This integrated approach ensures that research delivery at GOSH remains safe, ethically sound, and aligned with both clinical priorities and regulatory requirements, supporting high quality innovation while maintaining strong accountability and transparency.

R&I Staff Survey Results

Results from the 2025 staff survey provide clear assurance of a positive and open quality culture within R&I. 95% of respondents within the directorate agreed or strongly agreed that the organisation encourages staff to report errors, near misses and incidents, exceeding the Trust average (88%) and the previous year's figure for R&I (85%). Importantly, this culture is supported by action: 79% agreed or strongly agreed that action is taken in response to reported incidents to prevent recurrence (Trust average 71%), an improvement on the previous year's figure of 72%. Together, these results demonstrate a culture focused not only on transparency and learning, but also on continuous improvement and the effective use of incident reporting to strengthen quality and safety across R&I.

R&I Clinical Quality

GOSH Ward Accreditation

The GOSH Ward Accreditation programme provides a framework of clear expectations in relation to the quality and safety of care delivered to patients every day. It supports clinical teams in identifying excellence in practice and areas on which to focus our continuous quality improvement work. In 2025, the NIHR GOSH CRF was assessed for the first time and achieved Gold status and is only the second area in the hospital to achieve this. The areas of notable excellence in practice that were recognised were:

- Consistent compliance with admission KPIs
- Commitment to maintaining study integrity
- Commitment to maintaining high standards of patient care
- Focus on leadership
- Understanding of directorate risks and incidents
- Positive patient feedback.

The team is now focusing on recommendations around monthly quality and safety audit datasets, and appraisal and mandatory training compliance.

Clinical Holding

The NIHR GOSH CRF is leading work to ensure the safe and ethical use of clinical holding at GOSH. Clinical holding is the planned, proportionate restriction of a patient's movement—using limited force and/or supportive immobilisation—to enable essential care or treatment to be delivered safely and as quickly as possible, ideally with the patient's consent and always as a last resort (distinct from restraint by the degree of force used and the intention). R&I have strengthened GOSH's Clinical Holding and Safety Intervention Policy by explicitly embedding a research governance perspective:

- recognising GOSH's duty to uphold Good Clinical Practice
- clarifying that participation in trials and studies is voluntary
- requiring that any decision to use clinical holding for research-related procedures is discussed with the Principal Investigator (or delegated Sub-Investigator)
- ensuring that such episodes are documented, incident-reported, and monitored through R&I risk oversight processes to assure ethical, safe conduct of research activity

This makes our research more inclusive, as previously those who required clinical holding were not eligible to participate in clinical trials.

Research Governance and Compliance Infrastructure

Data Sharing and Material Transfer Agreements

To support the efficient setup of research studies at both GOSH and UCL, the R&D Office has established overarching data-sharing agreements for anonymised and pseudonymised data, as well as an overarching material transfer agreement (MTA). These frameworks reduce delays and facilitate smoother contract negotiation processes for new studies.

GOSH Intellectual Property (IP) Policy

The updated GOSH IP Policy has now been approved. This policy is aligned with NIHR guidance on managing intellectual property within the NHS, ensuring research-derived innovations are protected, exploited appropriately, and managed in a way that maximises public benefit while ensuring compliance with national expectations.

GOSH and UCL Revenue Share Agreement

The GOSH–UCL Revenue Share Agreement, signed in July 2025, provides a clear, fair, and transparent framework for managing revenue arising from jointly developed IP. This agreement strengthens collaborative research activity between the organisations, helps incentivise innovation, and ensures returns are reinvested to support further translational research, capacity building, and early-career researcher development.

Marketing Authorisation Licence

GOSH is piloting a new approach to make gene therapies for rare diseases available to more children. Such therapies are often not commercially viable for companies to invest in and keep on the market, even if they have been proven to work, because the cohort of patients is so small. GOSH, LifeArc and GOSH Charity hope to address this through a market authorisation plan, which would be the first of its kind in the UK and the first time an NHS Trust would hold the market authorisation for a gene therapy.

This approach will be piloted with a gene therapy for ADA-Severe Compromised Immuno-deficiency (ADA-SCID). The project is currently in the initial planning phase which involves GOSH undertaking various gap analyses to clarify the scope of work required to take the project forward.

The initial stages of the project have involved significant engagement with the MHRA, NHS England and NICE to clarify regulatory requirements, highlight the challenges the project is facing and the barriers that impact on the ability of not-for-profit entities to pursue market authorisation for ATMPs for rare diseases. This engagement has been effective in contributing to regulatory reforms with the MHRA announcing the development of a new licensing pathway (the Investigative Marketing Authorisation pathway (IMA)) for rare disease therapies). This is a major achievement and significant progress for the rare disease community. The draft framework is due to be published for industry consultation in May 2026.

Process Optimisation

R&I has continued work on more than 50 recommendations arising from our Process Optimisation project, with the aim of optimising the efficiency of our service by streamlining our grant application, clinical trial setup and costings processes, and to enhance collaboration between researchers and R&I staff. We have established a bi-monthly multi-team sprint workshop series, with the first three identifying several quick wins across areas such as governance and finance to streamline our processes, reduce workload, and enhance efficiency.

This year we strengthened our learning culture by continuing to optimise processes within R&I; uncovering causes of delays across governance, registration and finance and using evidence from staff-led workshops and sprints to reshape how our research processes operate. We learnt that duplication, unclear ownership, inconsistent information and unnecessary reviews were driving inefficiency.

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We simplified registration for low-value and two-stage grants, introduced a 15-day minimum registration deadline, and empowered governance teams to approve low-risk and unchanged post-award studies without finance review. We also redesigned amendment processes, so Category C changes are implemented immediately, helping improve compliance with the 35-day HRA target.

Sprint learning showed us that costings processes needed clearer flows and better transparency, prompting standardised checklists, annual tariff lists and improvements in task allocation, tracking and early moves toward automation. Financial review of aged debt signalled systemic issues, leading to strengthened debt-recovery processes and closer collaboration with Accounts Receivable.

These insights allowed us to build learning directly into how we improve, building simpler, faster and more consistent processes, helping teams focus on value-adding work. All of the process improvements directly support our ambition to consistently meet the NIHR target of setting up clinical trials in under 150 days by reducing avoidable delays and accelerating every stage of the approval pathway.

The process optimisation project is part of R&I's move toward a performance-based culture. Our operational effectiveness and efficiency are monitored by the R&I Operational Board, which receives quarterly reports from the key components of the Directorate and its committees.

Department of Health and Social Care 150-day Clinical Trial Set-up metric

In the coming year, R&I will deliver a structured improvement programme in response to the Department of Health and Social Care (DHSC) ambition for eligible clinical trials in the NHS to be set up and recruiting within 150 days. The programme focuses on strengthening the end-to-end pathway from early study identification and feasibility through to opening to recruitment and enrolling the first participant, reducing avoidable delays while maintaining robust governance, safety oversight and scientific rigour for complex paediatric and rare disease studies.

The 150-day metric is divided into 3 stages.

1. **60 days:** time taken for the MHRA and REC to deliver a combined review decision.
2. **60 days:** time from combined review decision to study opening.
3. **30 days:** time from study opening to first participant recruited.

This work is also important because the NIHR RDN includes set-up metrics in its performance framework, which contributes to confidence in delivery and may influence future infrastructure funding allocations. In the short to medium term, the programme is prioritising improvements against key interim indicators linked to this framework: >50% of studies opening to recruitment within 60 days of regulatory approval, and >40% of studies recruiting a first participant within 30 days of opening.

The programme will therefore prioritise practical, evidence-based improvements that strengthen early study planning, improve operational coordination, and enable more effective monitoring of study timelines across the research portfolio.

By improving predictability and speed of trial activation and early recruitment, the programme will support timely patient access to research opportunities and strengthen confidence in GOSH's research delivery capability within the national performance framework.

Innovation, Business Development and Data

Cell and Gene Therapy Service

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The Cell & Gene Therapy Service manufactured and released 26 Advanced Therapeutic Medicinal Products (ATMPs) in 2025/26 that were used in clinical trials to treat patients with Acute Lymphoblastic Leukemia (ALL), Hunter's Syndrome and Severe Combined Immunodeficiencies. This is the highest number of ATMPs manufactured in the last 20 years by the service, enabled by its new GMP facility based in the Zayed Centre for Research.

Virocell Holdings

GOSH maintains its strategic partnership with Virocell Holdings who continue to address the global bottleneck for viral vector which is the crucial starting material in manufacturing gene therapies for clinical trials. This partnership has enabled research studies conducted by principal investigators at UCL GOS ICH to treat patients earlier through increased access to viral vector.

Leucid Bio

GOSH works with [Leucid Bio](#), a biotechnology company, and provides quality assurance services required for the manufacture of their gene therapy product, called LEU011. LEU011 is a type of CAR T-cell therapy which reprogrammes immune cells to recognise and destroy cancer cells. It is the first CAR T candidate for solid tumours to be manufactured at ZCR. The company's therapy has a particular structure on the cell surface that has been shown through early-stage research to work more effectively at targeting cancers than other types of CAR T-cell therapies. The safety and clinical activity of this product is now being evaluated through a multi-centre trial called AERIAL where Leucid Bio have treated eight patients over the last year.

Ambient Voice Technology rollout at GOSH

The multi-site evaluation of Ambient Voice Technology across eight sites and over 17,000 patients in all areas of London, including adult and community care outpatient clinics, general practice, mental health, A&E, and the London Ambulance Service was highly successful. GOSH is now six months into its operational rollout of an AI scribe tool in outpatient clinics, which began in October 2025. Over 350 clinicians from 53 teams have been trained and the AI scribe has been used with 20,000 patients.

National Paediatric SDE

Over the last eight years, the Innovation team in partnership with Aridhia Informatics Ltd, has built one of the UK's leading secure data environments (SDE) – known as the Digital Research Environment (DRE) at GOSH. This environment has enabled GOSH to use data not only for research, but to share data externally with other organisations (including industry partners), use operational data to drive clinical decisions and efficiencies, and build new AI solutions, whilst also creating commercial opportunities, all to benefit patients and staff. Utilising the secure Aridhia platform (technical infrastructure), combined with GOSH's expertise in building data pipelines from Electronic Health Records, and experience with data governance and partnership building, to support the creation of a National Paediatric SDE to support and accelerate research, operational efficiencies & treatment discovery nationally. This will be created in partnership with the GOSH Charity and LifeArc and led by the Children's Hospital Alliance. This would create a unique asset for all children with rare and complex diseases in the UK

Roche UK

In 2023, GOSH announced a 5-year partnership with Roche UK to bring together capabilities and develop AI and data science solutions for more personalised care for children with rare or complex diseases. The partnership continues to build a comprehensive cancer dataset to deepen our understanding of the outcomes for children with cancer and facilitate access to innovative cancer treatments. It is also

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establishing a robust pipeline to demonstrate how data can be used to drive clinical decision making in a seamless way, using our GOSH PICTURE tool to gain data insights of patients previously treated at GOSH to understand how best to treat new patients through personalised medicine. The Innovation team has published over 40 academic papers through its DRIVE unit and Clinical Informatics Research Programme.

Education and Training

Clinical Research Delivery Education Team

During 2025, the R&I education team delivered a comprehensive programme of education and training that supported safe, effective and high-quality research delivery across the CRF and satellite research services, including highly specialised and rare disease pathways ranging from over 20 different clinical specialities.

In partnership with UCL affiliated NIHR CRFs, the team continued to deliver and refine the Joint Research Induction Programme, supporting consistent onboarding, reducing duplication of training and enabling efficient use of shared expertise, with ongoing learner feedback informing quality improvement. Throughout the year, the education team maintained a strong focus on clinical competence and governance, delivering clinical skills training, competency assessments, portfolio specific teaching, education shadow shifts and regular *in situ* simulations; enabling staff to safely rehearse paediatric emergency scenarios and reflect through structured debriefing. High levels of clinical competency compliance were sustained, supporting patient safety, research governance and workforce assurance.

The team also contributed extensively to Trust-wide nursing development and leadership pathways, including preceptorship, Band 6 and Band 7 programmes, experienced nurse IV study days and wider leadership education, reinforcing the role of research within clinical practice and supporting nurses at different career stages to work confidently in research active environments.

Facilitating research placements for students and staff interested in research is an important aspect of developing our future researchers and increasing opportunities for nurses to become involved in and engage in research alongside growing a research-positive culture. In 2025/26, the CRF hosted research placements for six student nurses and one medical student. Feedback highlighted a positive learning environment, family-centred care, strong professionalism and a welcoming team culture aligned with the Trust's values. *"I had a great experience at this placement staff were all lovely and helpful and I was able to meet my needs."*

The senior nursing team also deliver an annual session at Southbank University to around 180 first-year student nurses on the importance of evidence-based decision making and how clinical research is implemented in practice. This session ensures that nurses are exposed to research early in their training and supports the pipeline of student placements.

Alongside this, multidisciplinary research team development days were delivered across Bands 3–7, both clinical and non-clinical teams, focusing on wellbeing, staff voice, quality improvement and inclusive leadership, with consistently high levels of engagement and positive feedback. Together, this programme of work supports a skilled, research active and compassionate nursing workforce and contributes to a culture of continuous learning, safety and innovation across the organisation.

NIHR GOSH BRC Career Development Academy (CDA)

The NIHR GOSH BRC Career Development Academy (CDA) continues to deliver a diverse programme of training and education opportunities for researchers at GOSH, UCL GOS ICH and our partner sites (Birmingham, Alder Hey and Sheffield). This programme of career development schemes contributes to a network of research capacity-building infrastructure at GOSH including the Centre for Outcomes and Experience Research in Children's Health, Illness and Disability (ORCHID) and GOSH Learning Academy (GLA).

In 2025/26 this programme provided salaries for 51 researchers from a range of professions to develop their research careers. Awards included two Intermediate Fellowships (a Nurse and a Social Scientist), seven Catalyst Fellowships across clinical and non-clinical disciplines (with four previous awardees progressing to ICH Emerging Leaders Fellowships), six Research Hospital Internships, three Knowledge Transfer awards, five Doctoral Training Support Fund awards, 26 Conference and Training grants, and the Early Career Researcher Excellence in Impact Award, presented to Ben Jevans (ICH).

The Pre-Application Support Fund (PASF) supported four candidates (two clinicians, one dietitian and one non-clinical researcher) applying to NIHR Academic Clinical Lectureship, Advanced Fellowship and Doctoral schemes, with an additional successful NIHR PhD award to a BRC-supported candidate from Alder Hey Children's Hospital. The CDA also continues to support a growing PhD community, including 15 non-clinical PhDs, five clinical PhDs and four surgical trainees, with first completions expected in 2026.

Looking ahead, the CDA will continue to align its schemes with NIHR career pathways, expand support for under-represented groups, strengthen leadership and mentorship provision, and embed patient and public involvement across career development activity—ensuring a sustainable, inclusive research workforce equipped to deliver high-impact translational research for children and young people.

Beyond research, our education team plays a vital role in the wider clinical workforce. In January 2026, in collaboration with GOSH Charity, Orchard Therapeutics, Citrin Foundation, MLD Support Association UK and Action for BPAN, the GOSH BRC hosted its second Gene Therapy in Paediatrics event. This brought together 90 clinicians from 33 institutions across the UK, Ireland, Portugal, France, India and Australia. The hybrid event provided a comprehensive overview of gene therapy technologies and latest advances in the field, aimed at those who do not currently deliver care to patients who have received gene therapies.

Each session included a panel discussion featuring either a patient or a parent of a child who has received gene therapy, offering invaluable real-life perspectives. Feedback was overwhelmingly positive, with participants expressing a newfound awareness of gene therapy applications, appreciation of the patient and family's perspectives, a commitment to further learning, and a desire for future events to stay updated on rapid advances.

Examples of participant feedback

"Hearing from the patients themselves helped to emphasise that this work is helping real people and changing real lives and hearing how far the science and professionals in the field have come from when they started."

"A good mix of clinical, bioscience and patient perspectives. Keep this going."

"The patient advocates were very insightful and important."

"It has lit a spark within me!"

"This event has broadened my knowledge and understanding of various factors relating to genetic therapies"

"This exposure... has greatly impacted me and had a huge impact on my outlook and aspirations..."

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Other national and specialist events delivered by the CDA in 2025/26 included the [CRISPR Showcase](#), [Allied Healthcare Professionals in Clinical Academia Event](#), and the Junior Faculty Lead [seminar](#) on involving patients and the public. The Junior Faculty Bitesize Seminar Series remains a core feature of the training calendar. To date, 13 hybrid seminars have been delivered, featuring 37 expert speakers, engaging more than 400 attendees and attracting over 500 views via the GOSH BRC YouTube channel, demonstrating sustained engagement and reach across the research community.

Patient Experience

GOSH Charity Everyday Impact Funding

Staff in R&I were successful in obtaining funding through the first round of the new GOSH Charity Everyday Impact Fund. This scheme is open to GOSH staff to fund little things that make a big difference, to transform the experiences of patients and their families. Two projects were funded: one to develop a clinical trials animation to support families through the research journey and another to establish a parent & carer support group for families taking part in clinical trials.

The animation was developed in response to several formal complaints from parents received after trial termination, which described the uncertainty, distress, physical harm, and worry this has caused. The animation is intended to provide guidance on managing expectations at the conclusion of a trial, including details on follow-up procedures and resources available for support. Feedback from families and healthcare professionals indicates a lack of accessible educational resources related to clinical trials, particularly concerning their conclusion and associated implications. It is anticipated that the animation will help ensure families are well-informed, supported, and confident throughout their participation in clinical trials.

Feedback collected from both the Friends & Family Test (FFT) and the CRF Parent Carer Advisory Group recognises the immense pressure and emotional strain that many parents and carers experience whilst their child participates in a clinical trial. This highlights the lack of adequate support systems available to our GOSH families participating in research. The funding received from the Everyday Impact Fund will provide dedicated time from an independent experienced psychologist to design, establish and facilitate a pilot initiative for parent/carers support group sessions to meet with peers and share their experience of their child taking part in a clinical trial. The intention is that this future work will lead to structured peer support networks, signposting to professional counselling where needed, and wellbeing workshops tailored to address the emotional and psychological challenges our families face through clinical trial participation.

Friends and Family Test

The Research Participant Experience and Engagement Oversight Group oversees work to ensure that our patients receive outstanding high quality research care. The group includes representatives from R&I and Patient Advice and Liaison Service, Play and Trust Patient Experience leads. This ensures that our research is inclusive, our patient and families have a voice, and their feedback is acted on and responded to appropriately. This group feeds directly to the Patient and Family Experience and Engagement Committee, chaired by the Chief Nurse. Initiatives born out of the oversight group include the CRF Parent and Carer Advisory Group and Managing Patient Expectations Working Group.

Results of FFT within the GOSH NIHR CRF are gathered and reviewed monthly, recently achieving a 30% response rate alongside a 99% positive experience measure, which is the same as the previous year.

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To ensure continuous improvement, Patient Experience meetings are held every month to review these FFT responses. The meetings include the lead nurse, matron, service manager, reception staff, and play team. Direct actions from these questionnaires have led to tangible improvements in patient care; for example, pharmacy delays have been successfully addressed by coordinating with pharmacy to prepare drugs a day in advance for certain clinical trials. Additionally, following feedback that the toys in reception only catered to young children, the selection has now been updated to include suitable options for older patients as well. Feedback and actions are displayed on both our quality boards as you enter the CRF and in the parents and carers lounge via 'You said, we did' boards, allowing all users to see the feedback and understand the actions we have taken to address any concerns raised.

Ultimately these targeted improvements highlight our ongoing commitment to ensuring that every patient and family have a meaningful voice in their care.

Inpatient Discharges 2,284	Number of FFT Entries 669	Inpatient Response Rate 29.3% Target: 25%	FFT Experience Score 99.0% Target: 95%
% Would Recommend 99.0%	% Would Not Recommend 1.0%	Positive FFT Comment Count 187	Negative FFT Comment Count 4

FFT CRF data for 2025/26 as of 07/04/26.

Patient and Public Involvement & Engagement (PPIE) and Equality, Diversity & Inclusion (EDI)

NIHR GOSH CRF Parent and Carer Advisory Group

The NIHR GOSH CRF Parent and Carer Advisory Group continues to grow and is now in its second year. Six meetings have been held, and we have eight parents/carers, two of whom are international. This diverse group contributes directly to research design, review and dissemination. Their involvement has shaped patient-facing materials, informed national conference outputs and supported co-development of psychological support resources, ensuring family perspectives meaningfully improve research quality, accessibility and experience.

Now that the group are firmly established, we will be inviting members to contribute to the CRF Board as lay representatives. Other ongoing work includes:

- Coffee mornings for parent/carers, offering an opportunity to share their experiences of research to date and discuss PPIE opportunities.
- Presentation to Chief Nurse Fellows
- Taking part in the joint induction training for new starters at GOSH, UCL, Moorfields and the Royal Free about PPIE.

GOSH Parent and Carer Advisory Group for Research (PCAG)

Part of our growing patient and public involvement community, the PCAG meets with researchers across GOSH, GOSH BRC and UCL GOS ICH to provide their lived experience perspective and offer advice, guidance and constructive feedback on how to improve the quality of their research. The PCAG complements and at times works with, our GOSH Young Persons' Advisory Group (YPAG) for research. Meetings are held four times a year and the advice our members includes:

- Giving feedback on research proposals and funding applications, study design and dissemination.

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- Helping with revision of participant information literature and consent forms for studies and developing accessible information sheets.

In 2025/26:

- Eight research projects were prepared for presenting to GOSH PCAG for research over **4** evening meetings for support and input in their projects.
- Two new members joined the group.
- Five sets of Patient Information Sheets (PIS) and Plain English Summaries were reviewed by GOSH YPAG and PCAG.

Following meetings, researchers provide members with updates on their projects and the impact of PPIE.

Young Persons' Advisory Group for Research (YPAG)

The GOSH Young Person's Advisory Group (YPAG) represents a cornerstone of our commitment to meaningful PPIE across all research activities, ensuring that children, young people and families shape research priorities, study design and delivery. Our PPIE work extends beyond traditional consultation, embedding co-production principles throughout the research lifecycle and reaching diverse communities through innovative hybrid and digital approaches.



Members of GOSH YPAG attending Hybrid meeting

GOSH YPAG current metrics:

- 60 active members
- Nine Young Facilitators supporting GOSH YPAG at meetings
- 15 visitors; Early Career Researchers, visiting external groups, researchers due to attend a GOSH YPAG meeting to hone their engagement skills
- 31 research projects prepared for presenting to GOSH YPAG for example:
 - Children's Adaptive Deep Brain Stimulation for Epilepsy (CADET) Trial – input into the patient & carer device manual videos.
 - 3D Eye Scanning: Optical Coherence Tomography (OCT) to help Children with Brain Conditions.
- Six daylong meeting events

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- Two of six meetings delivered in hybrid format with 12 spaces to attend onsite whilst maintaining geographical reach and inclusivity (July 2025 and January 2026)
- 25-30 members attending each meeting
- Four organisations supported to set up their own YPAGs using the GOSH YPAG model, both in the UK and in Europe.

Two GOSH YPAG members attended the [Rare Disease Day Event 2026](#) to support activities, enabling a former patient to engage with school pupils and write an [article](#) for the GOSH website.



NIHR GOSH CRF nurse running 'chocolate trial' with North London Year 4 pupils at annual Rare Disease Day engagement event

GOSH YPAG launched an innovative pilot programme (GOSH YPAG Medical School Meet-Ups) to support current medical students and aspiring medics, bringing together young people with lived experience of healthcare alongside those pursuing medical careers. The initiative attracted attendees from across the GenerationR Alliance, including groups from Kent Surrey & Sussex, Bristol, Moorfields Eye and YPAG northeast. The planning committee co-produced educational presentations and resource materials to share widely, ensuring that learning from this initiative extends beyond GOSH to benefit the wider paediatric research community.

A new partnership was established with the North Thames Genomics Hub, with YPAG members participating in Website Design Group Workshops to ensure patient and public perspectives shaped digital engagement strategies from the outset. GOSH YPAG representatives also played a leadership role at the National AI Youth Council Event in Birmingham, with four GOSH YPAG representatives in attendance and three GOSH YPAG Young Facilitators co-producing and co-led activities and panels.

GOSH YPAG members have also presented and delivered sessions at the UCL GOS ICH Work Experience Programme and the INSPIRE Work Experience Programme. This participation and activity demonstrate the maturity and expertise of GOSH YPAG members, who are increasingly recognised as leaders in youth engagement nationally and are committed to inspiring the next generation of healthcare professionals and researchers while sharing their expertise in meaningful patient involvement.

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Quotes:

"We have now received regulatory body approval for study. The REC were very complimentary about our PPIE efforts, so a huge thank you to the members of the GOSH PCAG and YPAG for all the help." ATT-Heart Research project Team

"I enjoyed every part of the review process, and the meeting yesterday was excellent; I really appreciated just how open and respectful the dialogue was and coming away knowing the feedback to the applicants will be so supportive and helpful in reflecting what and why the decisions were reached." GOSH PPIE Panels on GOSH BRC Funding Calls

Research Hospital Without Walls: PPIE Implementation 2025/26

The "research hospital without walls" concept has moved from aspiration to reality through practical implementation of hybrid and digital engagement approaches. GOSH YPAG meeting event days are delivered in hybrid format twice a year, enabling members to access 'behind the scenes' tours of the NIHR GOSH Clinical Research Facility (CRF) and Zayed Centre for Research while simultaneously maintaining geographical reach for those unable to attend in person. All PPIE Funding Panel meetings are held online to enable geographical reach and involvement from families and patient representatives across the UK, removing barriers related to travel, time and accessibility. These approaches demonstrate a commitment to ensuring that location, mobility or other practical constraints do not prevent meaningful involvement in research governance and decision-making.

Equality, Diversity and Inclusion (EDI) in Research

Our Commitment

GOSH is committed to advancing EDI across all aspects of research, both in its workforce and participant communities. This means embedding diverse perspectives, ensuring equitable access, and taking an inclusive approach from study design through to delivery. A key example is integrating Learning Disability and autism considerations into early research processes, enabling timely identification of participants' reasonable adjustment needs. We have also strengthened inclusion by incorporating the Trust's Mental Capacity Act policy into research guidance, providing a clear, person-centred ethical framework for researchers working with participants aged 16 and over where capacity may be in question.

Building the Evidence Base

A major 2025/26 achievement was establishing baseline data for both the research workforce and research participants, building on 2024/25 data completeness efforts. This baseline ensures EDI actions over the next three years are:

- Targeted to areas of greatest need
- Measurable against clear indicators
- Meaningful in their impact on lived experiences

More Inclusive Internal Funding

Significant progress was made in ensuring internal funding calls and assessment panels are more inclusive, equitable and representative, improving transparency within internal decision-making structures. The work included:

- Review of funding call accessibility and language
- Diversification of panel membership
- Implementation of inclusive assessment criteria
- Training for panel members on unconscious bias and equitable decision-making

Workforce EDI Focus Areas

Work continues to identify and implement actions that make tangible difference to EDI in the research workforce. Areas of focus include:

- Recruitment practices that attract diverse candidates
- Progression pathways that support career development for under-represented groups
- Flexible working arrangements that enable participation from those with caring responsibilities or other commitments
- Inclusive leadership development
- Systems for preventing harm and supporting those who experience discrimination or exclusion

Evidence and stories demonstrating the impact of these actions are being gathered systematically to inform future priorities.

Increasing Opportunities for Under-Represented Groups in Research

Initiatives implemented in 2025/26 aimed to increase opportunities for under-represented groups to participate in research at GOSH (such as those with learning disabilities, autism, possible mental incapacity and patients that require clinical holding). Feedback and data from these groups is being systematically collected to understand:

- Who is now being reached through new approaches
- What barriers remain
- How participation experiences can be improved
- What additional support or adjustments would increase accessibility

This feedback will directly inform the design of future studies and engagement approaches.

15. CQUIN Payment Framework

What is CQUIN?

The Commissioning for 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.

2025/26

For the Financial year 2025/26, the nationally mandated Commissioning for Quality and Innovation (CQUIN) programme remains paused by NHS England and therefore does not operate as a compulsory, performance-linked element of the NHS Standard Contract. As a result, there are no national financial incentives or clawback arrangements linked to CQUIN performance, with the historic CQUIN funding element continuing to be incorporated into fixed contract payments. Despite this change, the Trust remains strongly committed to delivering high-quality, safe and effective care and to achieving measurable improvements in outcomes and patient experience. Our quality priorities for 2025/26 are aligned to national, regional and system objectives, and we will continue to use locally agreed quality indicators and improvement goals to support continuous improvement and provide robust assurance.

16. CQC Registration

The CQC undertook a two-day unannounced inspection of surgical services in January 2025, followed by an announced inspection of the Well-led domain in March 2025. The CQC's final summary report was published on 23 July 2025, rating the Trust as 'Good' overall. Surgical services were also rated 'Good', and the Well-led domain received a 'Good' rating.

The published findings highlighted strong, compassionate, child-centred care, effective multidisciplinary working, and a positive safety culture. Leadership was described as visible, values-driven, and fostering openness, learning, and improvement. No enforcement actions were issued.

Following the publication of the CQC's report, the Trust developed a comprehensive action plan to address all identified areas for improvement. Each action was assigned a clearly defined operational lead, ensuring accountability, ownership and timely progress. The action plan sets out measurable milestones, expected outcomes, and supporting evidence requirements, enabling consistent monitoring across all clinical and corporate services.

Progress against the action plan is actively monitored through the Risk Assurance and Compliance Group (RACG), chaired by the Chief Executive. This provides the governance framework for the management of improvement actions, including prioritisation, resource allocation and progress review. Through this structured approach, the Trust is ensuring that all CQC actions are embedded into sustainable organisational change, supporting continuous improvement and strengthening our commitment to delivering safe, high-quality, patient-centred care.

Regular engagement meetings between the Trust and the CQC have continued throughout 2025-26, these are valuable opportunities for the Trust to share information proactively, fostering an open and transparent relationship with the regulator.

17. Data quality

Good quality data is crucial to the delivery of effective and safe patient care. Data is vital to enable us to run our services efficiently as well as to identify any care quality issues and predict trends to take early action.

Data underpins all that we do at GOSH, from each patient's journey through the hospital to the running of our theatres and wards and ultimately feeding the research that helps inform new medical developments. We see it as imperative that we do all we can to ensure the best quality of that data, as mistakes, errors or omissions can impact every aspect of this work. Our vision is that we should strive to ensure data is correct and complete at the time of entry, that we check the quality of data through our processes, and we enhance it where appropriate. We aim to ensure that data, wherever it is needed by our staff, partners, or patients, is as accurate as possible.

The Epic electronic patient record system is the core "system of record" for patient data in the Trust. As an integrated system available and updated live throughout the hospital, it drives a data quality agenda.

The Trust Board receives the latest data on operational performance and quality/safety matters at every Trust Board meeting via the Integrated Quality and Performance Report (IQPR). This is part of an integrated framework of metrics that are used to run the hospital and include key national and statutory metrics.

We continue to develop improvements and highlights of the work completed in 2025/26 across Data Assurance, Clinical Coding, Data & Analytics, Performance and Data Insights Unit.

Data Assurance

We have careful monitoring of data quality in place by our Data Assurance Team and Data Quality Manager, who carry out daily checks and regular data quality audits. This process feeds back to adjust processes in the hospital, adapt Epic configuration and provide training for staff to continually improve data quality. Other data quality initiatives include:

- Legacy system replacement, where practical incorporating the functionality into the Epic system.
- Removal of manual off-system records, which helps drive all users to ensure data is correct in Epic.
- Enhanced interactive reporting to help users across the hospital engage and better understand their data. This feeds back to improved data entry.

At GOSH, we have designed and continue to implement effective controls to minimise risks around data quality. We have a Data Quality Policy which outlines what data quality is, why it is important, and the responsibilities of staff for maintaining high data quality. The policy outlines definitions and clarifies requirements for all staff in their roles. The key principles are:

- All staff are personally responsible for the quality of any data they enter onto Trust systems.
- All staff are responsible for reporting any data quality errors that they identify.

To support on-going management and assurance of data quality, there are some key groups and committees designed to routinely review data and audit our data and make recommendations to correct where necessary and highlight trends.

- Data quality governance is managed through the Data Quality Improvement Committee and the Data Quality, Finance & Reporting Group, which sits monthly and reports to the Information Governance Steering Group.

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- The Data Partnerships Committee is established to develop a consistent ethical and legally compliant framework for accessing, sharing and use of personal and special category data with our partners.

Clinical coding

GOSH has a dedicated and highly skilled clinical coding team, which continues to maintain high standards of inpatient coding. The depth of coding continues to sit above the national average due to the complexity of our patients who have, on average, 13.7 diagnoses.

GOSH's income is directly dependent on timely, complete, and accurate clinical coding. All of the coding team completed their mandatory training in March 2026 which is a national requirement. Another key objective for the team is to ensure month-end deadlines continue to be met and latest data shows that this was 100% coded for freeze date and 99.8% coded at Flex date for February 2026. When comparing in the region, this achievement is the fourth best performance in London.

Data & Analytics

The Data and Analytics team are responsible for all the Data management and analytics activities for the operational reporting for the Trust. There is a strategic group that brings together all activities relating to Data & Analytics (D&A) across various departments within the Trust. This governance takes place in the Data Analytics Council (DAC) and acts to provide co-ordination and strategic direction to D&A activities and practices and ensure implementation of the Trust D&A Strategy and oversee key priorities and deliverables.

- Continuing migration of QlikView reports to QlikSense to future proof our data platform and further development in QlikSense
 - New projects/datasets/dashboards completed for Referrals, PIFU/EROC, Pharmacy, and in progress for Outpatient, Theatres, PICANet, and Operational Optimisation
 - Process Improvements and improved Data Quality achieved for submission datasets for Performance & Planning team, including but not limited to Kh03, FFT, Daily Diagnostics, PIFU/EROC
 - Replaced Coeus with Qlik Native portal
- Reviewing future BI and Analytics tool strategy
- Data warehouse development of statutory return changes and error corrections - including but not limited to – Faster Data Flows (HODF), MhsDs, OPCS v4.11, DID v2.0, SACT v4, CQUIN, WL MDS, RTT, End of Year processes, and Reference Data.

Performance

The Performance Team collaborates closely with clinical and operational staff, delivering insights drawn from key data and emerging trends. Their responsibilities include monitoring, analysing, and reporting on critical performance indicators (KPIs) such as referral-to-treatment and diagnostic waiting times, cancer treatment outcomes, and tracking elective care backlogs to ensure alignment with national standards. By gathering and validating complex datasets, the team provides robust reports to Trust Boards, commissioners, and regulatory bodies.

Using their expertise, the team offers strategic guidance, identifies best practices, and supports the resolution of operational challenges, driving continuous improvement in patient care and safety. Timely, accurate reporting remains essential for upholding high-quality service delivery.

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- Updating the Integrated Quality and Performance Report (IQPR), which delivers the Board of Directors an integrated perspective across strategic domains including Patient Safety, Quality, Operational Performance, and People. The IQPR ensures oversight of Trust performance measures and data triangulation for a comprehensive evaluation, with regular reviews to maintain alignment with Trust ambitions and both national and local reporting requirements.
- Coordinating and facilitating Patient Tracking List (PTL) meetings to optimise patient flow and waiting times, preparing information packs, guiding discussions, and ensuring follow-through on agreed actions to improve patient outcomes and minimise delays.
- Drawing upon comprehensive knowledge of NHS standards and regulations to provide guidance and support that is consistent with current policies, enabling teams to maintain compliance and deliver exemplary patient care and safety.
- Assisting with the implementation of Information Standards Notices by working collaboratively with Data and Analytics teams, supplying testing feedback and recommending modifications to outputs.
- Conducting demand and capacity (D&C) modelling across multiple services. This includes analysing demand, calculating capacity, and performing gap analysis to identify discrepancies and inform actionable plans.

Insights Unit

Aligning with the GOSH overall strategy and the GOSH AI Strategy, anticipating the continued and increasing value of predictive analytics to drive efficiency, productivity, patient outcomes & experience and staff experience, the Clinical Insights Unit has been incorporated into the Data & Analytics Department from its previous home in DRIVE (Innovation).

Over the last year the team has engaged with clinical and operational teams to extract and curate useful data, present it in easily digestible ways and provide insights into potential future trends, as well as developing predictive tools to help with service planning.

- Capacity and demand analysis of cardiac surgical beds to understand the interplay between elective and non-elective patient groups – and to evidence expected waiting list trajectory in support of ongoing NHSE investment in Cardiac Surgery
- Ongoing analytical support for Day Cases and ENT to provide useful, timely reporting on day case KPIs, and investigation of opportunities to leverage simulation to assess further moves from overnight to day case activity
- GOSH-first moving an in-house clinical AI product into production – ongoing work to define and work through our governance for evaluation, approval and monitoring of AI products within the Trust
- Team Health work providing systematic, comprehensive views on services within the Trust to assess early indicators of service stress (from multiple weak signals) – prototype complete, now assessing fit in new organisation structure
- Providing data, analytics and research advice for programmes of work outside traditional operational analytics and research areas – such as AHPs and Anaesthetics,
- Providing data science expertise to support AI policy and AI strategy implementation in the wider Trust

18. Information Governance

Information Governance (IG) provides the framework for the handling of information in a confidential and secure manner. This includes the collection, storage and sharing of information, supported by appropriate policies and procedures, providing assurance that personal and sensitive data is being managed legally, securely, efficiently and effectively to deliver the best possible care and service.

Our Information Governance Framework ensures compliance with principles relating to the processing of personal data.

Risks to the management of information are monitored by the Information Management Steering Group meeting every month, chaired by the Chief Digital Information Officer and accountable to the Executive Management Team.

Our Information Governance Framework ensures compliance with principles relating to the processing of personal data. We continue to work to enhance the framework and our approach to IG by:

- Ensuring we have a “data protection by design and default” approach embedded throughout the Trust.
- Maintaining the documentation of processing activities, including the lawful basis for processing personal data.
- Ensuring the appropriate security measures, such as our commitment to meeting the standards of the Data Security and Protection Toolkit (DSPT).

The framework supports our future strategy to protect data as an asset and provide a balanced and proportionate approach to risk, placing the child first and always.

Risks to data processing are managed in the same way as other Trust risks but are subject to separate evaluation and scrutiny by the Information Governance Steering Group, in turn providing assurance to the Trust’s Audit Committee.

In June 2025 the Trust completed its submission for the Data Security and Protection Toolkit. This annual submission demonstrates GOSH’s position against the legal requirements, providing assurance that we are practicing good data security and personal information is handled correctly. The Trust was fully compliant upon submission. This is a strong indicator of the improved IT controls and Information Governance processes in place in the Trust. In April 2026, KPMG, the Trust’s Internal Auditors, provided an assurance rating of “significant assurance with minor improvement opportunities” after an audit into preparedness for the Data Security Protection Toolkit submission in June 2026.

In January 2026, the Trust consented to a voluntary audit conducted by the Information Commissioner’s Office (ICO). The purpose of this audit was to evaluate and report on the governance of child data and the cyber security measures adopted within the Trust. Following completion, the ICO issued an assurance rating of “High” for Cyber and Information Security, and “Reasonable” for the governance of children’s data. The ICO also identified areas of good and best practice, including our programme to promote information security awareness, a strong approach to supplier and privileged access controls, threat intelligence monitoring, a ‘segmentation first’ network design, and robust risk management, training and compliance monitoring for the processing of children’s personal data. The audit made 14 recommendations to further strengthen our arrangements; there were no critical non-conformities.

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In 2025/26 there were three information governance incidents classified at a reportable level using the Incident Reporting Tool in the DSPT, including three personal data breaches that met the threshold for reporting to the Information Commissioner's Office (ICO):

- The first incident involved a patient's sensitive data being sent to an incorrect postal address on several occasions. There were some missed opportunities identified where the address could have been updated but did not happen. The ICO was satisfied that the Trust had identified process errors and that the appropriate measures had been put in place to prevent this happening in the future.
- The second and third incidents involved access being granted to incorrect recipients for patients' MyGosh proxy accounts. Although these were separate occurrences affecting different patients, a recurring issue was identified: staff did not exercise sufficient diligence when granting proxy access. The ICO has not yet released its final outcome or recommendations. Meanwhile, the Trust has enhanced the proxy granting process by implementing an additional verification step, which ensures access cannot be processed unless the correct recipient information is provided.

19. Promoting safety by giving voice to concerns

Freedom to Speak Up Guardian

Overview of service

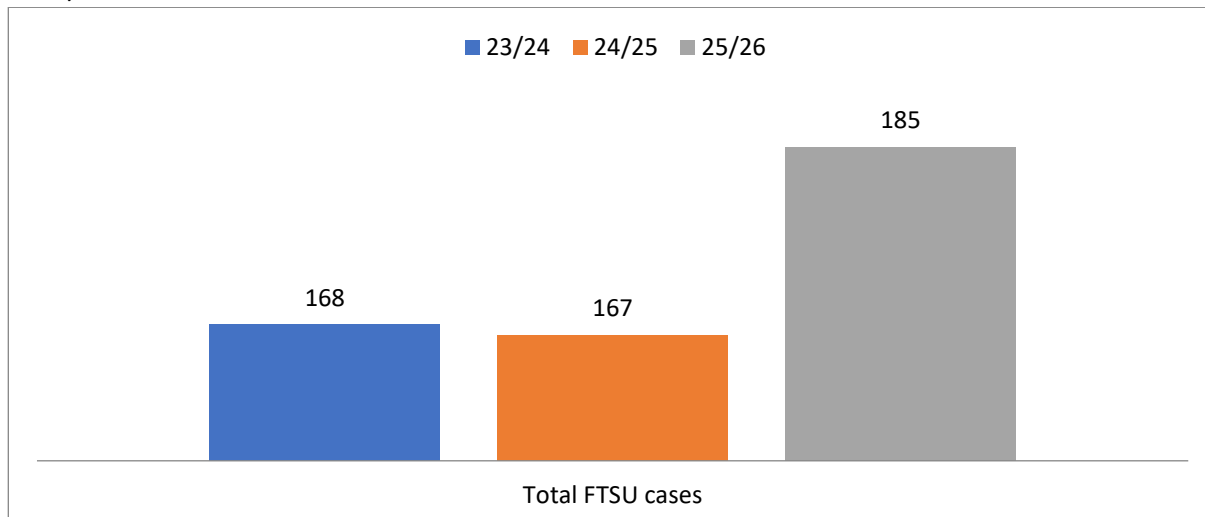
The Freedom to Speak Up Guardian (FtSUG) service provides staff with confidential and impartial support to raise concerns about patient care and safety, as well as issues that may impact their working lives. At GOSH, staff are encouraged to speak up through a range of channels. Where possible, this includes raising concerns with line managers or senior colleagues or seeking advice from specialist teams such as Patient Safety or Human Resources. The Trust's *Freedom to Speak Up* policy clearly outlines both internal and external routes available for raising concerns.

The FtSUG service does not replace these pathways but offers an additional layer of support. The service currently comprises a full-time Lead FtSUG and a full-time Deputy FtSUG, alongside a growing network of Freedom to Speak Up Ambassadors. Ambassadors play an important role in promoting a positive speaking up culture at GOSH and signposting colleagues to the appropriate routes for raising concerns but do not manage case work directly.

The following data relates to substantive cases reported to the FtSU Guardians.

Total number of contacts made to the FtSUGs.

In 2025/26 the FtSUG service received an increase of substantive cases compared to the previous reporting years, a trend that is being seen nationally. This is the highest number of cases recorded since 2021/22.

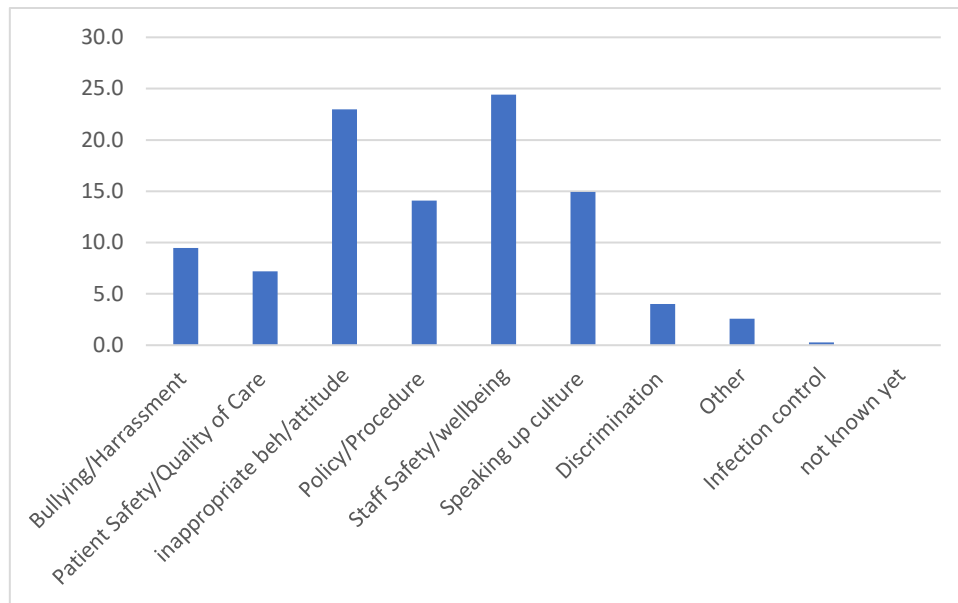


Total number of contacts made to the FtSUGs

Themes of concerns raised.

When staff speak up to the FtSUGs, common themes may be identified that support the reporting of emerging themes and learning, in line with the National Guardian's Office guidance. There is often more than one theme raised, with many cases involving multiple complex issues, and the graph shows these as overall percentages:

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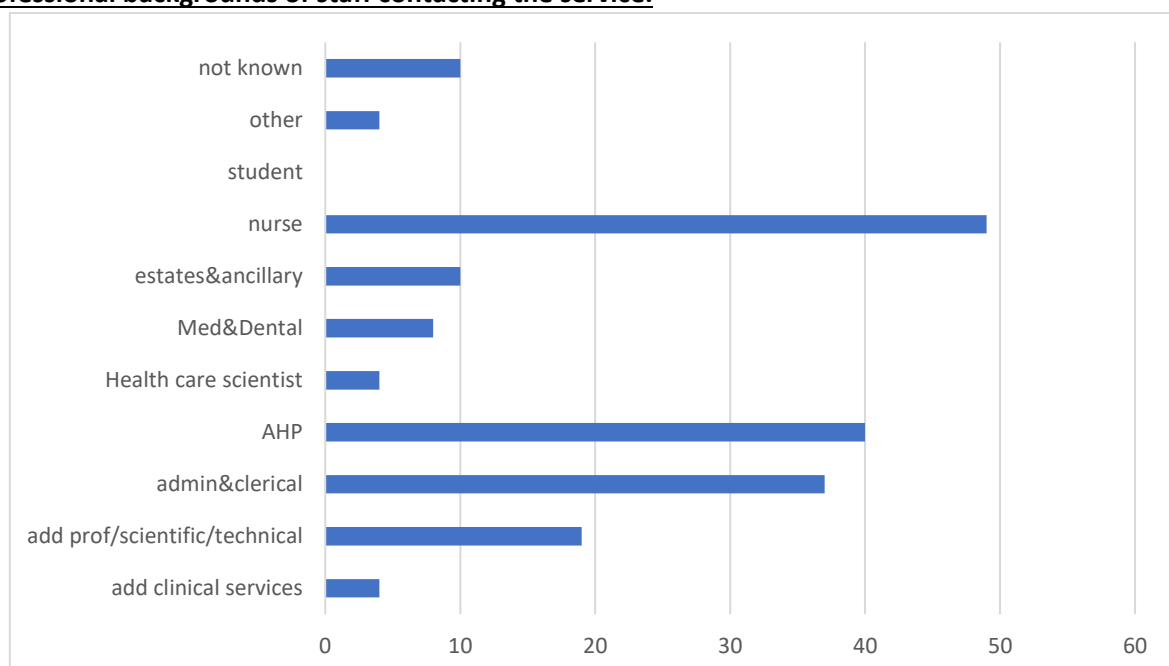


Themes of concerns raised

The highest themes raised over the year related to staff safety/ wellbeing, inappropriate behaviours (for example incivility) and speaking up culture.

The FtSUG service supports staff to feel heard in a variety of ways. This includes offering a confidential and safe space to raise concerns, supporting individuals to prepare for conversations with their line managers or signposting to other services. Where appropriate, the FtSUGs escalates concerns directly to senior leaders on a staff member's behalf. The service also provides ongoing support to ensure assurance is gained that concerns are reviewed and addressed appropriately.

Professional backgrounds of staff contacting the service.



Professional backgrounds of staff contacting the service

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As with the previous year, staff from all recorded professional groups other than students contacted the FTSUGs in 2025/26.

Ongoing work to support the Trust's speak up culture.

To promote awareness of the Freedom to Speak Up service and reinforce the principles of speak up, listen up, and follow up, a wide range of teaching and engagement activity was delivered throughout the year. Sessions varied from brief introductions to the FtSUG role and available speaking up routes, to more detailed and bespoke sessions tailored to specific groups. These included Allied Health Professionals (AHPs), nursing staff (including Band 6 development programmes), students (nursing and AHPs), senior leaders, internationally trained staff, and members of the Trust Board.

Since taking up post, the Deputy FtSUG has led the development of a structured programme of walk rounds. These involve regular visits to different clinical and non-clinical areas of the hospital, providing opportunities to meet staff, raise awareness of the FtSUG role, and signpost colleagues to the appropriate speaking up routes.

The FtSUGs actively contribute to, and work in partnership with, a range of Trust-wide initiatives and forums. These include Quality Support Visits, the Health and Wellbeing Steering Group and wellbeing events, Sexual Safety charter work, the Diversity & Inclusion Steering Group, and the Values & Behaviours Steering Group. Engagement in these forums ensures that the voice of staff is represented widely across the organisation and supports the sharing of learning arising from speaking up.

During 2025/26, GOSH introduced the National Guardian's Office / Health Education England *Listen Up* module as a role-specific mandatory training requirement, alongside the initial *Speak Up* module. This reflects a commitment to strengthening the listening aspect of speaking up and reinforces the Trust's aspiration to be a strong listening organisation. The Lead FtSUG also facilitated a session relating to the *Follow Up* module to the Trust Board.

The FtSUG service reports quarterly to the People & Education Assurance Committee, with updates also shared with the Executive Team and Operational Board. In addition, data is submitted externally to the National Guardian's Office, and an annual report is presented to the Trust Board. Short quarterly summaries are also published on Our GOSH, enabling all staff to view headline data on the volume and nature of contacts supported by the FtSUG service.

Due to the confidential nature of most Freedom to Speak Up cases, it is not always possible to share detailed case studies or learning outcomes widely. However, sharing themes through established governance routes helps highlight staff experiences across a broad range of issues and encourages managers to reflect on whether similar challenges may exist within their own areas.

Following the Dash Review, the National Guardian's Office (NGO) is being disestablished and a number of its functions with transfer to GOSH. We are currently working to understand the implications of this and will implement any required changes as needed.

20. Creating a Safe Working Environment for Doctors & Dentists in training

Reducing rota gaps for NHS doctors and dentists in training 2025-2026

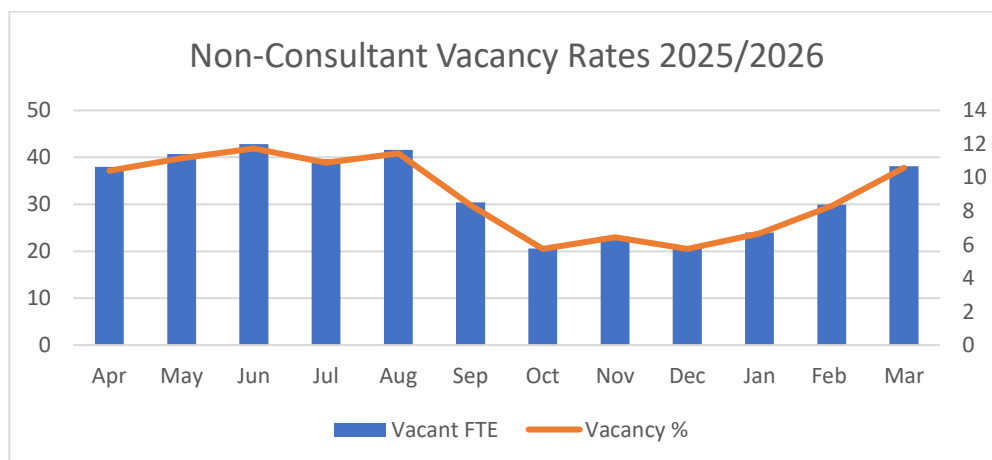
The GOSH response to the 10-Point Plan for Improving Resident Doctors' Working Lives

Great Ormond Street Hospital currently employs 413 doctors and dentists, including both those in training and locally employed doctors. The promotion of a safe working environment is crucial for delivering high-quality patient care, and this depends on maintaining an appropriately established medical workforce.

Despite these efforts, rota gaps persist within the hospital, due to its unique workforce requirements as a specialist paediatric centre. Over the past year, these rota gaps have been influenced by workforce challenges encountered at both national and local levels, such as:

- Vacancies due to challenging recruitment into specialist roles, with prolonged recruitment pathways (50%*)
- Short term unplanned absence and sickness (21%*)
- Sustained increase in less than full time working (60-80% whole time equivalent) with fewer opportunities to share high-specialised posts (8%*)
- Industrial Action (5%*)

**Percentage of bank spend for non-consultant doctors*



Non-Consultant Vacancy rates 2025/26

Vacancy rates contribute directly to rota gaps across the organisation. While GOSH vacancy rates have remained below the national average (7–12% over the past two years), they continue to represent an organisational pressure. The impact on safe working is monitored by the Guardian of Safe Working Hours and reported quarterly to the Trust Board.

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10-Point Plan for Improving Resident Doctors' Working Lives

There is recognition that improving the working environment for doctors and dentist, improves workplace wellbeing and patient safety. In August 2025, NHS England (NHSE) issued the 10-Point Plan on Getting Back to Basics for Resident Doctors, setting out national standards for improving working conditions, payroll accuracy, rest facilities, mandatory training recognition, and rota transparency.

Prompted by this plan, GOSH has undertaken an improvement programme - led jointly by the Deputy Medical Director and the Guardian of Safe Working Hours, to ensure that our resident doctor workforce is supported to deliver safe, sustainable, high-quality care.

Figure: 10 Point Plan Domains to Improve Resident Doctors' Working Lives



Every doctor rota is compliant with the 2016 Terms and conditions of service supported by band 5 rota coordinators to oversee rota management, ensure study and annual leave requirements, and to assist anticipating potential rota gaps in advance. Exception Reporting processes are available to all non-consultant doctors at GOSH including compensation (remuneration or time off in lieu) and review of work scheduling.

In addition to the full adoption of enhanced exception reporting mechanisms in February 2026, the GOSH 10-point plan has made meaningful progress improving doctors' working environment through initiatives to reduce contract and payroll errors, improve rest facilities, and support key course-related expenses reimbursement. There is now visible board-level leadership proactively collaborating with our monthly Resident Doctors' Forum to ensure that we continue as an organisation promote a safe working environment for this key staff group.

21. Part 2c: Reporting against core indicators

“As defined by NHSE’s mandated indicator set for Quality Reports”

Indicator	From local trust data (Trust assigned)				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:
	2025-26	2024-25	2023-24	2022-23	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Number of clostridium difficile (C.difficile) in patients aged two and over.	11	10	7	11	‡	‡	‡	‡	The rates are from UKHSA Time period: 2025/26	Implement a process which improves the documentation around decision to treat. Review the appropriateness of samples tested for C.Diff within the laboratory.
Rate of C.difficile in patients aged 2 and over (number of hospital acquired infections/ 100,000 bed days).	14.0	13.0	9.6	15.3	‡	‡	‡	‡		
Note: C.difficile colonisation is common in children and, while severe disease may occur at any age, it is rare. 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 UK Health Security Agency (UKHSA) 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 Healthcare 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. To note the number of hospital acquire infections /100,000 bed days refers to the number of cases notified by GOSH , and is not a measure of GOSH hospital acquired clostridium difficile † Data is released by NHSE and was not available at the time of publishing this report. ‡ Data is released by PHE and was not available at the time of publishing this report.										

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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:
	2025-26	2024-25	2023-24	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Friends and Family Test (FFT) - % of responses (inpatients only).	27%	32%	29%	NHSE FFT reporting resumed in January 2021 after the pandemic, however, the report no longer publishes response rates, only a comparison of the experience rating for inpatients and outpatients. GOSH has an internal target response rate of 25%. National results are only available up to February 2026 so the National results below include data from 11 months.				The Patient Experience Team and the GOSH BI Team work closely together to validate the FFT Information on a monthly basis.	
FFT Experience Score- % of respondents who score the Trust as 'Very Good' or 'Good' (inpatient).	98%	98%	99%	98% (March 2026)	99% (Apr – Feb)	79% (Apr – Feb)	94% (Apr – Feb)		All FFT KPIs are monitored via the GOSH Patient Family Experience and Engagement Committees with action plans required for directorates who consistently fail to meet Trust targets.
FFT Experience Score- % of respondents who score the Trust as 'Very Good' or 'Good' (outpatient)	95%	93%	95%	94% (March 2026)	99% (Apr – Feb)	86% (Apr – Feb)	94% (Apr – Feb)		All FFT KPIs are monitored via the GOSH Patient Family Experience and Engagement Committees with action plans required for directorates who consistently fail to meet Trust targets.

Core indicators 2c

Indicator	From local trust data Patient safety events reported to the National Reporting and Learning System (NRLS) up to 11 03 2024 and to the Learning From Patient Safety Events (LFPSE) system from 11 03 2024.					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:
	2025-26	2024-25	2023-24	2022-23	2021-22		
Number of patient safety events	6342	6136	5736 Consisting of: 5418 to NRLS 318 to LFPSE	5968	6081	GOSH uses electronic event reporting to promote robust reporting and analysis of events. A good reporting profile is reflected in high reporting numbers with low levels of harm. Around 20% of events reported in 2025/26 were reported as causing some level of harm. Benchmarking of reporting between providers is not recommended as a methodology or as an evaluative measure.	Driving system change through learning Learning focuses on understanding and addressing system weaknesses in care delivery, prioritising changes that improve pathways, communication, safeguards and reduce reliance on individual vigilance. Learning from multiple sources is combined to identify recurring themes and systemic risks, enabling improvement to be targeted beyond individual cases. Aggregated learning is reviewed through the Organisational Learning Forum (OLF), the Patient Safety Incident Response Plan (PSIRP) and Quality Review Group (QRG) to shape Trust-wide safety and improvement priorities and ensure coordinated organisational
Rate of patient safety events (number/100 admissions)	12.9	12.4	12.2	13.2	14.4		
Number and percentage of patient safety events resulting in severe harm or death	5 (0.08%)	6 (0.10%)	3 (0.05%)	4 (0.07%)	7 (0.12%)		

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							action rather than localised responses. Where sustained change is needed, improvement is delivered through Quality Improvement methods and the Hierarchy of Controls to achieve effective and lasting risk reduction. Actions from learning responses are owned, tracked, and reviewed through governance arrangements, with assurance focused on impact as well as completion. Learning is shared across GOSH through governance, safety forums, and Trust-wide communications to support shared understanding, psychological safety and wider patient benefit.
	There were five incidents graded severe or fatal physical harm in 2025/2026: – A 16 year old patient experienced an out-of-hospital cardiac arrest following a day case procedure at GOSH for a change of jejunostomy tube under general anaesthetic. – A young person who was cared for under the Inherited Cardiovascular Disease team presented at Newham University Hospital and died following a suspected overdose – Vancomycin administered on the ward, following which patient developed severe AKI and has required CVVH. His vancomycin level was toxic. – Known complication of arterial line insertion. However, the local investigation has highlighted that there may be a safety system component that contributed to the event and it is being escalated for further information/discussion at SERG.						

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	– Seen on AVM clinic in audiology in Feb 2025 and April 2025. An ABR was requested under GA by the AVM. Did not have an ABR until 06/02/2026 and 20/02/2026. This is a significant delay and significant harm to the patient. There were no cases of severe psychological harm.
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Explanatory note on patient safety incidents resulting in severe harm or death

GOSH reports all patient safety incidents to the Learning From Patient Safety Events (LFPSE) system since 11th March 2024. LFPSE is a national system which replaced National Reporting & Learning System (NRLS) and is designed to promote system-wide learning and improvement at the national level.

Since February 2024, GOSH has implemented the Patient Safety Incident Response Framework (PSIRF). GOSH has six priority areas within its PSIRF plan to guide its learning response/investigation activity. PSII investigations continue to be reported on the Strategic Executive Information System (StEIS) at the direction of our Integrated Care Board, with notification to commissioners and Integrated Care Boards. As with all providers there is no longer a requirement for GOSH to report in line with the Serious Incident Framework (NHS England, 2015).

GOSH may deploy alternative and proportionate learning responses, such as After-Action Reviews (AARs) to support the understanding of events collectively as a team, allowing for identification of safety actions and implementation of learning to happen sooner, to bring about rapid improvements in care.

Guidance on reporting the harm received by a patient, such as “Severe physical harm” or “Fatal” is offered through the LFPSE system, in an attempt to standardise reporting across the NHS. The harm recorded should be a result of the incident not a natural progression of disease or condition. Harm is not a determinant on its own for an investigatory response but may form part of the overall picture in reaching a decision.

22. Part 3: Other information

NHS Improvement uses a limited set of national mandated performance measures, described in its Single Oversight 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 2025-2026

Domain	Indicator	National threshold	GOSH performance for 2025/26 by quarter				2025/26 mean	Indicator met?
			Q1	Q2	Q3	Q4		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment	96%	100%	100%	100%	100%	100%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising: • surgery • anti-cancer drug treatments	94% 98%	100%	100%	100%	100%	100%	Yes
			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%	Apr-25 68.35% May-25 69.85% Jun-25 69.81%	Jul-25 70.59% Aug-25 69.18% Sep-25 70.10%	Oct-25 69.18% Nov-25 69.53% Dec-25 69.97%	Jan-26 72.29% Feb-26 73.19% Mar-26 73.97%	Can't have a mean as this is a snapshot	No
Experience	Maximum 6-week wait for diagnostic procedures	99%	Apr-25 72.83% May-25 77.47% Jun-25 79.97%	Jul-25 80.69% Aug-25 77.64% Sep-25 76.42%	Oct-25 80.51% Nov-25 81.74% Dec-25 79.18%	Jan-26 78.03% Feb-26 81.59% Mar-26 82.77%	Can't have a mean as this is a snapshot	No
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)

ADDITIONAL INDICATORS - PERFORMANCE AGAINST LOCAL IMPROVEMENT AIMS

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. All measures remain within expected statistical tolerance.

Effectiveness	Inpatient mortality rate (per		8.33	7.21	8.61	7.34	7.87	
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	1,000 discharges)+ (From data submitted to Hospital Episode Statistics (HES))							
Experience	Discharge summary completion time (within 24 hours)		78.14%	80.15%	77.74%	78.32%	78.59%	
Effectiveness	PICU discharges delayed by 8-24 hours		20	17	35	42	28.5	
Effectiveness	PICU discharges delayed by more than 24 hours		32	34	40	48	38.5	
Effectiveness	Last minute non-clinical hospital cancelled operations and breaches of 28-day standard* - Cancellations - breaches		69 15	76 14	82 8	53 11	70 12	
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge		3.06%	3.06%	3.55%	2.63%	3.08%	
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge		0%	0%	4.82%	4.08%	3.99%	

PERFORMANCE AGAINST KEY HEALTHCARE TARGETS 2025/26

+Does not include day cases

*'Last minute' is defined as: on the day the patient was due to arrive, after the patient has arrived in hospital, or on the day of the operation or surgery

23. Participation in GIRFT (Getting It Right First Time)

What is GIRFT?

Getting It Right First Time (GIRFT) is a national programme that is led by clinicians and uses a data-driven approach to identify differences in how services are delivered across the NHS. It aims to share best practice between NHS Trusts and to suggest changes to help improve patient care and outcomes, as well as to support Trusts with finding more efficient and cost-effective ways of working.

GIRFT started as a programme that focused on reviews of individual specialities with the aim of reducing unwanted variation (so called 'deep dives'). However, it has since expanded to additional cross-cutting workstreams, particularly around supporting NHS trusts to deliver routine care and planned operations as efficiently as possible and reduce patient waiting lists ('elective recovery').

GIRFT also provides important supporting intelligence within the wider NHS oversight and improvement frameworks such as the NHS Oversight Framework, Care Quality Commission (CQC) inspections, and Model Health System metrics.

GIRFT is closely integrated with the [NHS 10-year plan](#) and the GIRFT Programme at GOSH will support the Trust strategy [TOGETHER We Power Care](#).

Participation in GIRFT at GOSH

GIRFT governance strategy

The **GIRFT programme** came under the Quality Team in November 2024 with the appointment of a GIRFT Project Manager on secondment. Part of the role was to establish a governance structure to provide appropriate oversight, assurance and accountability for the delivery of the GIRFT programme at GOSH. The GIRFT Programme is now reported quarterly to RACG (the Risk, Assurance and Compliance Group) as well as in the quarterly and annual Quality reports. In November 2025, a permanent GIRFT role was created at GOSH and this GIRFT Programme Manager will continue to develop a robust governance structure that will ensure programme risks are effectively managed.

Overview of GIRFT projects

A summary of the projects supported at by the GIRFT Programme Manager at GOSH over the past year are outlined below.

Specialty/Area	Dates	Summary
Chronic Pain	Mar 2026 - ongoing	Specialty review for Chronic Pain within the Integrated Care System (ICS).
Paediatric Rheumatology	Feb 2026 - ongoing	Further Faster programme for Paediatric Rheumatology started following the specialty review and National Report. Further Faster programmes focus on reducing waiting lists.
Ear, Nose and Throat (ENT)	Jan 2026 - Feb 2026	Data collection for short notice or on the day cancellation of (adeno)tonsillectomy procedures due to current/recent history of tonsillitis or respiratory infection.
Paediatric Critical Care	Jan 2026 - ongoing	Data collection for a Paediatric Critical Care dashboard.

Attachment C

Specialty/Area	Dates	Summary
GIRFT Connect Member Survey	Oct 2025 - ongoing	GOSH collaborated with the GIRFT Connect lead (GIRFT Connect is a national forum for GIRFT leads and champions) and Lewisham & Greenwich NHS Trust to develop a survey to send to GIRFT Connect members to better understand how GIRFT is managed in Trusts.
Primary Secondary Interface	Jul 2025 - ongoing	Guidance and recommendations issued to support the improvement of the interface between primary and secondary care.
Acute Kidney Injury	Jul 2025 - ongoing	Guidance and recommendations issued to help standardise the detection and alerting of acute kidney injury (AKI).
Productivity Data Pack	May 2025 - ongoing	Data release with opportunities for improvement for Outpatients, Theatres, Children and Young people (CYP), Cancer, and Urgent and Emergency Care (UEC). These packs are intended for release every 3 months.
Elective Recovery /High Volume Low Complexity (HVLC)	May 2025	Review for Elective Recovery and High-Volume Low Complexity (HVLC) within the Integrated Care System (ICS) – looking at waiting list reduction and elective recovery in outpatients, as well as theatre productivity, utilisation, and elective hubs.
Anaesthetics and Pre-Operative Medicine	Mar 2025 - ongoing	Start of GIRFT Children and Young People (CYP) Pre-Operative Network.
Neonatology	Feb-2025 - ongoing	Data pack refresh for speciality review of Neonatology services within the North Central and East Neonatal Operational Delivery Network (ODN) (original review Sep 2020).
Litigation	Feb 2025 - May 2025	Data release for litigation workstream for the Trust – data are shared on litigation costs to encourage trusts to triangulate learning from claims, incidents, complaints, and inquests. The aim is to improve clinical practice, reduce future litigation costs, and enhance patient experience.
Interventional Radiology (IR)	Dec 2024 - ongoing	Specialty review for Interventional Radiology within the Trust.
Children and Young People (CYP) Diabetes	Nov 2024 - ongoing	Specialty review for Diabetes services for children and young people within the Integrated Care System (ICS).
Paediatric Rheumatology	Nov 2024 - ongoing	Specialty review for paediatric rheumatology within the care network (GOSH is a 'hub' site with care shared with a wide range of Trusts acting as 'spoke' sites).

GIRFT National Reports

The following National Reports relevant to GOSH have been published over the past year:

- Paediatric Rheumatology (Dec 2025)

24. Annex 1: Comments from the Chair of Camden Health and Adult Social Care Scrutiny Committee

Great Ormond Street Quality Accounts Response 2025/26

Comments from the Chair of the LB Camden Health and Adult Social Care Scrutiny Committee

Disclaimer: The Health and Adult Social Care (HASC) Scrutiny Committee did not sit between the receipt of the draft quality report and the due date for comments. They could not therefore provide comments on the named quality report. The following statement was provided solely by the Chair of the HASC Scrutiny Committee, Cllr Lorraine Revah, and they should not be understood as a response on behalf of the Committee.

I would like to commend the Trust for its continued dedication to delivering specialist, compassionate care for children and their families. The 2025/26 Quality Accounts present a clear and transparent reflection of the Trust's priorities and progress, highlighting where GOSH is performing well and where challenges remain.

The following observations were made in accordance with a set of core governance principles, which guide the scrutiny of health and social care in Camden.

1) Putting patients at the centre of all you do.

GOSH's quality accounts clearly reflect a commitment to child and family-centred care. From the Noise at Night initiative to the co-design of outpatient pathways, the Trust has shown it values patient and family voices in service improvement. The introduction of GOSH Voice, a new co-production community for parents, carers, and siblings, is a particularly welcome development. By building on the success of the Young People's Forum and using inclusive frameworks like the Lundy Model of Participation, GOSH is taking steps to embed lived experience at the heart of care planning and service delivery.

2) Focusing on a common purpose, setting objectives, planning.

The Quality Accounts present a clear and structured overview of GOSH's priorities in safety, effectiveness, and patient experience. Each priority is linked to measurable goals. The implementation of the Patient Safety Incident Response Framework (PSIRF), the Epic Thrive programme, and the redesign of outpatient pathways demonstrate a shared strategic direction, grounded in clinical insight and quality improvement.

Using real-time dashboards, steering groups, and focused working groups reflects a well-coordinated planning framework. The pilot approach to outpatient triage, for instance, enables learning based on early findings. These approaches are promising, success will rely on maintaining momentum and ensuring that learnings from pilots are implemented Trust-wide.

3) Working collaboratively.

The Trust have undertaken an impressive range of collaborative efforts across clinical, operational, and quality improvement teams. The work on PSIRF exemplifies this, with input from patient safety leads, clinicians, families, and NHS England.

The design and rollout of outpatient care models, informed by clinical teams, digital experts, and patient representatives, illustrate what can be achieved through collaborative effort. Similarly, the Trust's work with advisory groups, such as the Young People's Advisory Group and the Parent and Carer Advisory Group, demonstrates the value of sustained partnerships between staff and families.

There is also an encouraging focus on reducing inequalities, with hybrid participation models helping to widen access to engagement activities.

4) Acting in an open, transparent and accountable way - using inclusive language, understandable to all - in everything it does

GOSH demonstrates openness, not only in publishing clear data and reflections in its Quality Accounts but also in how it listens to both staff and families. The Freedom to Speak Up Guardian service plays a vital role in creating a safe environment for staff to raise concerns about patient safety and workplace wellbeing. The fact that most staff reported positive experiences of using the service, and that GOSH is addressing gaps in how senior leaders respond to concerns, is a sign of a healthy and reflective culture.

Attachment C

Regarding inclusion and equity, the Equality, Diversity and Inclusion Steering Group and targeted engagement with underrepresented communities show that inclusion is a live and ongoing process. GOSH's work to ensure that feedback leads to action, whether it be in the design of clinical trials, communication practices, or facilities improvements, is particularly welcome.

Going forward, it will be important to ensure that inclusive, person-centred communication is embedded across all levels of the organisation

Kind regards

Cllr Lorraine Revah, Chair of the LB Camden Health and Adult Social Care Scrutiny Committee

25. Annex 1: Feedback from Members of the Council of Governors

This quality report has demonstrated active engagement to drive quality improvement and increased transparency. It successfully displays accountability by showcasing improvement actions rather than just reporting data. There are also clear links between data shown, action taken and governance which is welcome. The document also prioritises the themes of safety, clinical effectiveness and patient and family experience, with these collectively underpinning the reporting and priorities discussed throughout the report.

A De Souza
Trust Governor
26th May 2026

26. Annex 2: Statements from NHS North Central London Integrated Care Board Statement



West and North London

22 May 2026
West and North London ICB
15 Marylebone Road
London
NW1 5JD
0203 198 9743

NHS West and North London Integrated Care Board Statement Great Ormond Street Hospital for Children NHS Foundation Trust

North Central London Integrated Care Board (NCL ICB) has worked closely with Great Ormond Street Hospital for Children (GOSH) throughout 2025/26 and welcome the opportunity to review and comment on the Trusts 2025/26 Quality Account, provided to the newly formed West and North London ICB in May 2026. The document received complies with the required content, as set out by the Department of Health and Social Care. Where the information is not yet available a place holder has been inserted.

The report highlights the Trust's achievements, priorities, and performance in delivering safe, effective, equitable and compassionate care.

The Care Quality Commission inspected Surgical services the Trust last summer rating GOSH as 'Good' overall, and 'Good' in the Well-led' domain.

Improving experience of care has been a key priority for the Trust, the ICB have been supportive of 'Community Voice' initiative supporting parents, siblings, carers and families to drive improvements through co-production and partnership working.

The ICB acknowledge the publication of the Orthopaedic Services Review in January 2026, which investigated the care provided within the Lower Limb Lengthening and Reconstruction Service between 2017 and 2022, providing key findings and recommendations to improve the service and patient safety.

The ICB supports the quality priorities for 2026/27 especially the priority to improve family support the provision of free meals for parents and carers of in-patients. This priority is based on feedback from parents regarding the additional cost of food while their child is in hospital.

We look forward to working with GOSH through the coming year.

Yours sincerely,

Jennifer Roye
Chief Nurse Officer
NHS West and North London ICS

27. Annex 2: Statements of Assurance

The directors are required under the Health Act 2009 and the National Health Service (Quality Reports) Regulations to prepare Quality Reports for each financial year.

NHS Improvement 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 2025/26 and supporting guidance Detailed Requirements for Quality Reports 2025/26.
- 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 2025 to March 2026
 - papers relating to Quality reported to the board over the period April 2025 to March 2026
 - feedback from NCL ICB dated 22nd May 2026
 - feedback from governors dated 26th May 2026
 - feedback from Non-Executive Directors dated 05th June 2026
 - feedback from Chair of Camden Health and Adult Social Care Scrutiny Committee dated 19th May 2026.
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, report will be published following review at the June '26 Quality, Safety and Experience Assurance Committee (QSEAC) meeting
 - 2024 Children and Young People's Patient Experience Survey: publication 22nd March 2025.
 - the national NHS Staff Survey 2025
 - the Head of Internal Audit's annual opinion of the trust's control environment dated 18th June 2026
 - CQC Well Led inspection report dated 23 July 2025.
- 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Reports regulations) as well as the standards to support data quality for the preparation of the *Quality Report*.

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

XX XXX 2026
Chief Executive

XX XXX 2026
Chair



Trust Board 18 June 2026	
GOSH Foundation Trust Annual Financial Accounts and Annual Report 2025/26 Submitted by: Maragret Monckton, Chief Finance officer and Anna Ferrant, Company Secretary	Paper No: Attachment D • Appendix 1: Annual financial accounts 2025/26 • Appendix 2: Annual report 2025/26 For approval
Purpose of report The Trust is required to publish a Foundation Trust annual report and accounts for 2025/26. Board members will find attached the following documents: • A copy of the annual accounts 2025/26 • A copy of the annual report 2025/26 incorporating: ○ Annual Governance Statement ○ Assurance committee annual reports ○ Compliance with the Code of Governance (see separate agenda item) ○ Draft Head of Internal Audit Opinion	
Annual Accounts 2025/26 (see Appendix 1). To note: In the reading room on Diligent, a copy of the month 12 financial report is also provided for information. Annual Report 2025/26 (see Appendix 2) We published our Patient Safety Statement in February 2023, based on the three elements of Listen, Learn and Lead, and have committed to focusing our annual report on each theme over the next three years; 2025/26's theme is 'Learn.' There are many examples of how we have learnt from our patients, families and staff, ensuring this is a golden thread throughout the report. The annual accounts and annual report are subject to external audit. The Audit Committee is meeting on the morning of 18 June 2026 and will report on the findings of the audit. A desktop-published version of the report is planned to be made available to view only in the Diligent Reading Room before the Board meeting. This is not a complete version of the report but is available to view from a design perspective. <u>Compliance with the Code of Governance</u> Following presentation of compliance to the Trust Board in March 2025, we have identified two areas (B2.7 and C4.7) that require explanation in the disclosure tables within the Annual Report. <i>B2.7: (At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.) The Trust was not compliant with this Code requirement for the whole of 2025-26. In summary:</i> In summary: Until 31 December 2025, the Trust Board was comprised of a Chair, five independent Non-Executive Directors, one Non-Executive Director appointed by University College London (UCL) (who was not considered independent due to the nature of their role at the University), and six Executive Directors.	

One of the independent NEDs resigned from the Trust Board and from 1 January 2026 until 11 February 2026, the Trust Board was comprised of a Chair, four independent Non-Executive Directors and one Non-Executive Director appointed by University College London (UCL), and six Executive Directors. Following NED recruitment and routine turnover, since 12 February 2026, the Trust Board has comprised five independent Non-Executive Directors, one Non-Executive Director appointed by University College London (UCL) and six Executive Directors. A routine succession planning exercise will be undertaken in Quarter 2, which will consider how to ensure compliance with this Code requirement. <i>C4.7 (All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.)</i> A Well-Led inspection was conducted by the CQC and published in July 2025, and the Trust was rated Good. The date of the next externally facilitated developmental review is to be confirmed. Letter of Representation (see Appendix 3) A copy of the representation letter to Deloitte, the external auditor, will be submitted to the Trust Board. The Board is required to declare in writing that the financial statements and other related documents have been properly prepared and without omission of material facts to the best of management's knowledge and belief. The letter is also used by the auditor to obtain the Board's confirmation that all necessary information has been provided to them and to confirm judgements made by management where there is no other means of obtaining definitive evidence.
Once approved by the Trust Board, the annual report and accounts will be submitted to NHS England by 26 June 2026 and then to the Department of Health and Social Care and Parliament in July 2026.
Patient Safety Implications • None identified
Strategy Pillar • Together We Shape How We Care
Equality impact implications • None identified
Financial implications None
Strategic Risk The annual accounts and annual report publicly report on the Trust's performance against its strategic priorities and objectives.
Action required from the meeting The Audit Committee will consider the annual accounts, annual report and representation letter at its meeting on the morning of 18 June 2026. At the time of writing, the annual accounts and annual report are being audited, and the Audit Committee Chair will provide an update on progress with the audit.

Attachment D

The Board is asked to approve the annual accounts and annual report 2025/26. If the Board determines that any significant changes are required to the report, or there are minor matters for the auditor to follow up, it is proposed that approval be delegated to Audit Committee members and the Chair.
Consultation carried out with individuals/ groups/ committees A number of staff have contributed to the draft Annual Report. All Executive members have been asked to review the draft, and any comments received have been incorporated into this draft.
Who is responsible for implementing the proposals / project and anticipated timescales? The Chief Finance Officer leads the coordination of the Annual Accounts. The Company Secretary leads the coordination of the Annual Report.
Who is accountable for the implementation of the proposal / project? The Chief Executive is ultimately accountable for production and publication of the Annual Accounts and Annual Report.

Trust Board 18 June 2026	
Compliance with the Code of Governance 2025/26 Submitted by: Anna Ferrant, Company Secretary	Paper No: Attachment E For approval
Purpose of report To present the annual review and supporting evidence against the provisions of the current Code of Governance for inclusion in the 2025/26 Trust Annual Report.	
Summary of report NHS England last revised the NHS Foundation Trust Code of Governance in 2023. The Code consists of a set of Principles and Provisions. Foundation trusts are required to report against the Code of Governance in their Annual Report on a comply-or-explain basis, confirming compliance with the Code or providing an explanation where there is a gap in compliance.	
Patient Safety Implications Not applicable	
Equality impact implications Not applicable	
Financial implications Not applicable	
Strategic Risk Not applicable	
Action required from the meeting The Board is asked to note the review and approve the disclosures to be included in the 2025/26 Annual Report.	
Consultation carried out with individuals/ groups/ committees Not applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary	
Who is accountable for the implementation of the proposal / project? The Board is responsible for ensuring continued compliance with the Code to retain authorisation as a Foundation Trust.	

Compliance with the Code of Governance 2025/26

1.0 Introduction

NHS England reviewed and updated the Code of Governance, with the revised Code taking effect from April 2024. The Code sets out a series of Principles and Provisions, and foundation trusts are required to report in their Annual Report on a comply-or-explain basis, confirming either compliance with the Code or explaining any areas where full compliance has not been achieved.

A review has been undertaken against all provisions of the Code during 2025/26, and an outline of the evidence supporting compliance against each criterion is provided at **Appendix 1** for information on Diligent. Text shown in **red** identifies those criteria for which the Trust is required to explain any areas of non-compliance, while text shown in **green** identifies those criteria that must be disclosed in the Annual Report. The relevant **green** disclosure requirements are set out below.

The review found that the Board applied the principles and met the requirements of the Code of Governance during 2025/26.

There are two provisions to draw to the Board's attention where the Trust was not compliant with two requirements (see amber highlighted sections in the table below):

- Non-executive director independence (provision B.2.7):

Up to 31 December 2025, the Trust Board comprised the Chair, five independent Non-Executive Directors, one Non-Executive Director appointed by University College London (UCL), who was not regarded as independent by virtue of their role at the University, and six Executive Directors.

Following the resignation of an independent Non-Executive Director, between 1 January 2026 and 11 February 2026 the Trust Board comprised the Chair, four independent Non-Executive Directors, one Non-Executive Director appointed by UCL, and six Executive Directors.

Following the appointment of a further independent Non-Executive Director and routine Board turnover, from 12 February 2026 the Trust Board has comprised the Chair, five independent Non-Executive Directors, one Non-Executive Director appointed by UCL, and six Executive Directors.

A routine succession planning exercise will be undertaken during Quarter 2 of 2026/27 to inform arrangements for maintaining compliance with this Code requirement.

- External developmental reviews of Trust leadership and governance using the Well-led framework (provision C.4.7). The Trust has just undergone a Well-Led inspection by CQC, and the Trust was rated Good. The next the next externally facilitated developmental review is to be confirmed.

Recommendation for Trust Board: It is proposed that the text set out below is published in the 2025/26 Annual Report to explain the Trust's compliance with the relevant disclosures in the Code.

Code of Governance Disclosures

Great Ormond Street Hospital for Children NHS Foundation Trust has applied the principles of The NHS foundation trust Code of Governance on a 'comply or explain' basis. The NHS foundation trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Throughout our annual report we describe how we meet the Code. A summary of where detail can be found on the issues we are required to disclose is given in the following table:

Code reference	Section of annual report
A.2.1	Performance Report - Operational performance, financial performance and working with our partners
A.2.3	Staff Report – GOSH People Strategy and Freedom to Speak Up at GOSH
A.2.8	Performance Report - Operational performance, financial performance and working with our partners
B.2.6	Accountability Report – Our Trust Board
B.2.7	Accountability Report – Our Trust Board The Trust was not compliant with this Code requirement for the whole of 2025-26. In summary: Until 31 December 2025, the Trust Board was comprised of a Chair, five independent Non-Executive Directors, one Non-Executive Director appointed by University College London (UCL) (who was not considered independent due to the nature of their role at the University), and six Executive Directors. One of the independent NEDs resigned from the Trust Board and from 1 January 2026 until 11 February 2026, the Trust Board was comprised of a Chair, four independent Non-Executive Directors and one Non-Executive Director appointed by University College London (UCL), and six Executive Directors. Following NED recruitment and routine turnover, since 12 February 2026, the Trust Board has comprised five independent Non-Executive Directors, one Non-Executive Director appointed by University College London (UCL) and six Executive Directors. A routine succession planning exercise will be undertaken in Q2 2026/27, which will consider how to ensure compliance with this Code requirement.
B.2.13	Accountability Report – Board Composition and Committee Meeting Attendance
B.2.17	Accountability Report – Leadership and Oversight describe decisions made by the Trust Board, Board Assurance Committee and Management.
C.2.5	Accountability Report – Council of Governors - Appointments in year
C.2.8	Accountability Report – Council of Governors - Chair and Non-Executive Director Recruitment
C.4.2	Accountability Report – Our Trust Board
C.4.7	The Trust has just undergone a Well-Led inspection by CQC, and the Trust was rated Good. The next the next externally facilitated developmental review is to be confirmed.
C.4.13	Accountability Report – Trust Board Nominations Committee

Code reference	Section of annual report
C.5.15	Accountability Report – Membership engagement.
D.2.3	
D.2.4	Accountability Report – Audit Committee Report
D.2.6	Accountability Report – Disclosure of information to auditors
D.2.7	Performance Report – Principal Risks Annual Governance Statement
D.2.8	Annual Governance Statement – review of the effectiveness of its system of internal controls
D.2.9	Disclosures -Statement of the chief executive’s responsibilities as the accounting officer of Great Ormond Street Hospital for Children NHS Foundation Trust.
E.2.3	Accountability Report – Remuneration Report
Appendix B, para 2.3	Accountability Report – Council of Governors – council of governors meetings
Appendix B, para 2.14	Accountability Report – Membership engagement Accountability Report – Contacting a governor
Appendix B, para 2.15	Accountability Report – Council of Governors - Trust Board and Council of Governors working together Accountability Report – Membership engagement
Additional requirement of FT ARM resulting in legislation	Governors having exercised their powers to require one or more of the directors to attend a governors’ meeting for the purpose of obtaining information about the foundation trust’s performance of its functions. This has not been required in 2025-26

3.0 Action required from the meeting

The Board is asked to:

- Note the review of compliance with the Code of Governance and **approve** the statement to be included in the 2025/26 Annual Report.

Compliance with the Code of Governance 2025-26		
Key		
	Fully compliant with the requirement	
	Partially compliant with the requirement	
Red text	Criteria against which NHSE expects the Trust to explain any areas of non-compliance.	
Green text	Criteria against which NHSE require disclosure in the annual report	
Blue text	Criteria against which NHSE require information to be made available to governors, even in the case that the trust is compliant with the provision.	
Purple text	Criteria against which NHSI require supporting information to be made available to members, even in the case that the trust is compliant with the provision.	
Orange text	Criteria against which NHSE require information to be made publicly available (or on request), even in the case that the trust is compliant with the provision.	
Para	Code of Governance Requirement	Disclosure 2025/26
A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Information in this area is routinely considered through reports on operational performance, financial performance and partnership working. The board receives assurance on how these matters support the Trust's long term sustainability, strategic objectives and contribution to the priorities of the ICP, ICB and place based partnerships. Examples include collaborative arrangements with other providers to address shared challenges, such as the RNOH/GOSH Partnership Agreement, the NCL Start Well Programme, the NHS Children and Young People's Gender Service, Martha's Rule, the Children's Health Alliance and the UCL Health Alliance. The annual governance statement in the annual report provides further detail on how the board's governance framework, assurance processes and decision-making contribute to strategic objectives and long-term value for patients, partners and the wider system.
A.2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.	The Trust new Strategy, Together We Power Care, officially launched on 22 October 2025 explicitly sets out the outcomes the Trust seeks to achieve for children and families. The Trust has a set of vlues that outlies the behaviours expected of leaders and staff in delivering safe, effective and holistic paediatric care. These values are in the process of being updated this year.
A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	During 2025-26, culture remained a key priority for the Trust Board. Culture was the focus for GOSH Board Development Sessions held in April 2025 and October 2025. The new Trust Strategy, 'Together We Power Care', which was launched on 22 October 2025, places a strong emphasis on culture. In support of this, the Trust has reviewed its values and behaviours framework and launched its anti racism statement, reinforcing the behaviours and standards expected across the Trust. Ongoing assurance on culture, workforce wellbeing and staff experience is provided through regular Board and committee oversight. This includes standing agenda items on raising concerns at the People and Education Assurance Committee, consideration of staff survey outcomes, oversight of a dedicated culture risk on the Board Assurance Framework, and the use of staff stories.
A.2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	The Board receives a regular integrated performance report on quality, safety, patient experience workforce and patient access. There is then a seperate report presented on finance. These reports monitor the Trust's plans and strategies. Corporate risks are reviewed at the Risk, Assurance and Compliance Group (an executive led group chaired by the CEO) and the actions shared with the Audit Committee, Quality, Safety and Experience Assurance Committee (QSEAC) and the People and Education Assurance Committee. Assurance of the robustness of the controls in place to mitigate these risks is sought by these assurance committees. The annual report provides a summary of the adequacy of these systems. External sources of assurance are sought on high risk/ complex areas . GOSH is an active member of the NCL Health Alliance, examples of working together include Start Well Programme and the involvement in creating a single innovation partnership for NCL, UCL Health Alliance, to maximise the collective impact on health outcomes. GOSH has a strategic BAF risk covering wider system working (the integrated care system) , and a health inequalities BAF risk. Both of these are regularly reviewed and presented to the Risk, Assurance and Compliance Group, taken through Board Assurance Committees and reported to the Trust Board. An annual Health Inequalities report is presented to the Trust Board and a there is a dedicated section in the annual report.
A.2.5	In line with principle 1.3 above, the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.	The Board receives regular reports on quality, safety, finance, patient experience. workforce and patient access. These include relevant metrics, milestones and measures. The assurance committees seek assurance of the robustness of the controls in place to mitigate risk and direct the internal audit function to provide assurance that these controls are robust. The assurance committees approve the internal audit and clinical audit plan every year. The Trust has a Lead Practice Educator and its Health Inequalities programme has an active Health Inequalities Steering Committee, with nine functional work-streams covering crucial pillars of health inequalities, including- Raising Awareness of Health Inequalities, Access to Care, Clinical Outcomes, Health Inequalities Data Dashboard, Digital Health Inequalities, Patient Experience. The health inequalities data dashboard has enabled us to be compliant with NHS England's statement under section 13SA(1) of the NHS Act 2006 on how NHS bodies should exercise their powers to collect, analyse and publish information related to health inequalities.
A.2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered	The Board receives an integrated quality and performance report at each Board meeting . This has been subject to a review and has been updated with streamlining of reporting to the Board and operational teams to support their performance management. The Quality, Safety and Experience Assurance Committee, a committee of the Board, seeks assurance of the adequacy of controls in place to manager quality risks and provides a summary report of matters considered at its last meeting to the next available Board meeting. The Quality, Safety, Outcomes and Compliance Committee (QSOCC) monitors the development and implementation of clinical risk management processes and evidence based standards and ensures that learning is disseminated and embedded across the Trust. QSOCC items of significance are reported through to the QSEAC and Risk Assurance and Compliance Group (RACG). The Trust has approved a Safety Transformation Plan (brought together both the Safety and Quality strategies).The Quality Report is published annually. Progress with the safety Transformation Plan is reviewed by the QSEAC. Compliance with CQC standards and other regulatory and statutory requirements are reported to the RACG. An Assurance and Escalation Framework is in place. Learning from incidents, audits, reviews etc. is captured and cascaded by QSOCC.

A.2.7	The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	The Trust Chair's job description includes partnership working and responsibility for building strong relationships internally and externally. This includes promoting collaborative, whole-system working through engagement with patients and the public, members and governors, staff, and key partners across the public, private and voluntary sectors, as well as regulators and other system chairs. The Chair's engagement supports productive relationships with NCL ICS, GOSH Charity, GOSH ICH and the Academic Health Science Partnership, and ensures that stakeholder perspectives inform governance and performance discussions. Ellen Schroder's engagement with key stakeholders includes: - Regular meetings with the Chief Executive - Monthly meetings with Non-Executive Directors - At least quarterly meetings with the Lead Governor - Attendance at walkrounds with Non-Executive Director colleagues and Executives, including Sight and Sound Directorate, Core Clinical Services and Body, Bones and Mind Directorate - Attendance at Directorate Board meetings and Chief of Service meetings - Attendance at the London Wide Chairs' Meeting - Meetings with the Chair of GOSH Charity - Attendance at Board Assurance Committees (excluding the Audit Committee) The Trust holds an Annual General Meeting in September each year, which all foundation trust members are invited to attend, meeting statutory requirements. Trust Governors are also invited to attend additional activities to support engagement with foundation trust members, including events such as the Royal Bank Canada Race for Kids in Hyde Park, membership engagement stands within the hospital and external events.
A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Information in this area is covered in the operational performance, financial performance and working with our partners. Updates are also included in the CEO report to the Board at every meeting. Examples include, RNOH/ GOSH Partnership, NCL Start well Programme, NHS Children and Young People's Gender Service, Martha's Rule, Children's Health Alliance, UCL Health Alliance. The annual governance statement sets out how the Trust's governance processes oversee its collaboration with other organisations.
A.2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	The Trust has established clear and accessible arrangements that enable the workforce to raise concerns in confidence and, where they wish, anonymously, through the Freedom to Speak Up (FTSU) Guardian, supported by two deputies. There is a dedicated page on the GOSH intranet providing information on how to raise a concern, who to contact and the benefits of speaking up. The Board receives regular updates FTSU for their respective areas, such as staff and culture related concerns are presented to PEAC and concerns about quality and safety are reported into QSEAC. Staff and culture related concerns are reported to the People and Education Assurance Committee, while quality and safety concerns are reported to the Quality, Safety and Experience Assurance Committee. The Trust Board also receives an annual Freedom to Speak Up report. The Freedom to Speak Up Policy was reviewed during 2023 and updated in January 2024 to ensure compliance with the NHS England Framework. The policy is due for its next review in 2027. A separate document outlining the different ways of raising concerns is available alongside the policy on the Trust's website.
A.2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).	The directors and governors are asked to submit an annual, mandatory declaration of interests using the externally supported web portal reporting system and are prompted to declare any interests at the start of every Board meeting. The live register of interests for directors and governors is published on the GOSH website. The Trust Board ToR states: "Encourage and promote openness, honesty and transparency about performance with patients and their representatives, the public, staff, governors, members and other stakeholders;" The Council of Governors' Code of Conduct and Trust Board Code of Conduct includes sections on values and principles, and governor interests.
A.2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	Any matters raised by directors regarding the operation of the Board or the management of the Trust are formally recorded in the minutes of the relevant Board meeting. Where such concerns cannot be resolved, this is explicitly noted. All minutes are reviewed and formally approved at the subsequent Board meeting. The Board operates in accordance with approved standing orders, standing financial instructions, and a scheme of delegation.
B.2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	The Chair is responsible for the Board agenda setting, supported by the Company Secretary and informed by the Executives. For the Council of Governors, the Lead Governor is also involved in the agenda setting. Time is allocated to each agenda item. The Trust Chair will ensure additional time is allocated for discussions during meetings as required.
B.2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	Papers for meetings are circulated, where possible, 5 clear days before the meeting. When this is not possible, members are informed that certain papers within a combined pack will follow and indicate an approximate timing. Trust governors receive a comprehensive induction programme, lunch and learn sessions and access to externally facilitated training. Governors are sent a month newsletter with the latest information and also have access to the Corporate Affairs Team for support and advice at any time.
B.2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	Feedback on the performance of the Chair as part of the annual appraisal process in 2025/26 indicates that directors and governors felt the chair substantially meets this requirement, with some identified opportunities to strengthen inclusivity of contribution and Board discussion further.
B.2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	Feedback on the performance of the Chair as part of the annual appraisal process in 2025/26 indicates that directors and governors consider the Chair to be effective in supporting constructive working relationships between the Board and the Council of Governors.
B.2.5	The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	The Trust Chair meets the independent criteria set out in provision 2.6. The roles of Chair and Chief Executive are held by separate individuals, and the Chair has not previously served as Chief Executive of the Trust. The Trust Board has appointed a Deputy Chair and Senior Independent Director, with Kathryn Ludlow holding the role up to the end of November 2025 and Camilla Kingdon appointed from 1 December 2025. The Trust Chair is not a member of the Audit Committee, and the Chair of the Audit Committee is neither the Deputy Chair nor the Senior Independent Director.
B.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: - has been an employee of the trust within the last two years - has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the trust - has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme - has close family ties with any of the trust's advisers, directors or senior employees - holds cross-directorships or has significant links with other directors through involvement with other companies or bodies - has served on the trust board for more than six years from the date of their first appointment (but note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval). - is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	The annual report details the independence of the non-executive directors. It notes that Professor Helen Cross was nominated by University College London and is the Director of the UCL GOS Institute of Child Health. In view of the seniority of this role and the associated oversight responsibilities within an organisation that has a close relationship with the Trust, the Board does not consider Professor Cross to be independent. During the year, the Board determined that, with the exception set out above, all other Non Executive Directors were independent. Kathryn Ludlow's term as Non Executive Director was extended beyond six years, from 5 September 2025 to 30 November 2025. This extension was subject to a rigorous review process and was approved by the Council of Governors and NHS England, in line with the requirements of the NHS Code of Governance. The extension was agreed to support continuity on the Board while recruitment was undertaken to appoint new Non Executive Directors. The Board did not consider that this extension impaired the NED's independence. The Trust appointed Amanda Rajkumar, initially as an Associate Non Executive Director from 18 September 2025 to 30 November 2025 and subsequently as a substantive Non Executive Director from 1 December 2025 for a three year term, and Adam White as a Non Executive Director from 12 February 2026 for a three year term. The Board considers both appointments to be independent.

B.2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	The Trust was not compliant with this Code requirement for the whole of 2025-26. In summary: Until 31 December 2025, the Trust Board was comprised of a Chair, five independent Non Executive Directors, one Non Executive Director appointed by University College London (UCL) (who was not considered independent due to the nature of their role at the University), and six Executive Directors. One of the independent NEDs resigned from the Trust Board and from 1 January 2026 until 11 February 2026, the Trust Board was comprised of a Chair, four independent Non Executive Directors and one Non Executive Director appointed by University College London (UCL), and six Executive Directors. Following NED recruitment and routine turnover, since 12 February 2026, the Trust Board has comprised five independent Non Executive Directors, one Non Executive Director appointed by University College London (UCL) and six Executive Directors. A routine succession planning exercise will be undertaken in Q2 2026/27, which will consider how to ensure compliance with this Code requirement.
B.2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	None of the directors on the GOSH Board are governors on the GOSH Council of Governors, nor a governor on another Trust's Council of Governors.
B.2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	The Chair considered committee chairship and membership during both the Non Executive Director recruitment process and the annual appraisal process, supporting appropriate refreshment of committee membership. The Board has two non-executive directors with clinical backgrounds. During 2025/26, when considering the skills, experience and expertise required for two Non Executive Director appointments during the year, the Council of Governors agreed that one role should have workforce, transformation and culture background and the other a finance and property background. Recruitment processes were focused on attracting candidates from diverse backgrounds. Kathryn Ludlow chaired the People and Education Assurance Committee until 30 November 2025. Amanda Rajkumar was appointed initially as an Associate Non Executive Director from September 2025 and subsequently as a substantive Non Executive Director from 1 December 2025, bringing extensive people and culture expertise. Amanda Rajkumar, chaired the People and Education Assurance Committee from 1 December 2025. Adam White was appointed as a substantive Non Executive Director from February 2026, bringing finance and property expertise.
B.2.10	Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Only the Trust Chair and Committee members are present at the Nominations and Remuneration Committee and Audit Committee with the terms of reference enabling others to attend by invitation.
B.2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director; to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.	In line with the NHS Code of Governance, and following consultation with the Council of Governors, the Board has appointed an independent non-executive director to the role of Senior Independent Director (SID). Kathryn Ludlow served as SID until 30 November 2025. With effect from 1 December 2025, Camilla Kingdon was appointed Senior Independent Director by the Board, with the appointment approved by the Council of Governors in November 2025. During the year, the Chair met with the non executive directors without executive directors present. The Senior Independent Director, leads the performance evaluation of the Chair, and consults with other non executive directors, executive directors, governors and key stakeholders, in accordance with the NHS Code of Governance.
B.2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	Non Executive Directors play a central role in the appointment and, where necessary, the removal of Executive Directors. The Chair holds regular meetings with the Non Executive Directors without Executive Directors present, enabling open and constructive challenge. The NEDs played a significant role in the recruitment and appointment of the new Chief Executive, who will joining the Trust on 01 June 2026.
B.2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.	The annual report outlines these roles, identifies the individuals in the roles and outlines the number of meetings attended by Board members.
B.2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	The job description and terms and conditions define the role and capabilities required including an assessment of the time commitment expected in accordance with NHSE Framework. Directors' significant commitments are documented in the annual report and declared in the register of interests as well as presented to the Board. None of the Executive Directors have taken on more than one non-executive directorship or Chairship of another trust or organisation of comparable size and complexity
B.2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	All directors have access to the advice of the Company Secretary. There has been no requirement to remove the Company Secretary.
B.2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	Trust Board meetings provide opportunity for scrutiny, challenge and indepth discussions; these are recorded in the minutes of the meeting.
B.2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.	The Trust operates as a unitary board, with all directors sharing collective responsibility for the leadership and oversight of the organisation.
B.2.17	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the board of directors.	The respective roles and responsibilities of the Trust Board and the Council of Governors are clearly defined in the Trust's Constitution, including matters reserved to each body and the arrangements for resolving any disagreements between the Council of Governors and the Board. A schedule of matters for the Trust Board is in place. The annual report explains how the Board and its Assurance Committees operate, and summarises the key types of decisions taken by the Board, those delegated to its committees, and those further delegated to executive management through the Trust's Scheme of Delegation. The Trust maintains up-to-date Standing Orders, Standing Financial Instructions and committee Terms of Reference, which together set out the framework for effective decision-making, accountability and oversight.
C.2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.	GOSH has two nominations committees: one responsible for the appointment of the Chair and Non Executive Directors, and one responsible for the appointment of Executive Directors. The Council Nomination and Remuneration Committee approved the recruitment process for two Non Executive Directors and Governors were involved in longlisting, shortlisting, and the formal interview panel members during 2025/26. Succession planning for executive roles is in place and is discussed at the Executive Management Board. A Board skills audit was completed and reported to the Trust Board in October 2024, followed by the Council of Governors. The recruitment process for the new Chief Executive, who will join the Trust in June 2026, was conducted in line with the approach agreed by the Board's Nominations Committee on 20 November 2025. The Council of Governors approved the succession plan for Non Executive Directors in November 2024, for NEDs whose terms came to an end in 2025 and an additional Non Executive Director role. This process was followed when recruiting two Non Executive Directors (Amanda Rajkumar and Adam White) in 2025/26. Another routine succession planning exercise will be undertaken in Q2 2026/27.

C.2.2	There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	There are two nominations committees - the Trust Board Nominations Committee and the Council Nominations and Remuneration Committee. A Trust Board skills knowledge and experience audit was undertaken in 2024, and this was used to form a succession plan that supported the development of a diverse board during recruitment campaigns in 2025 and 2026. A routine succession planning exercise will be undertaken in Q2 2026/27.
C.2.3	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	The Council Nominations and Remuneration Committee is chaired by the Chair of the Board and Council. The terms of reference of the Council Nominations and Remuneration Committee states that when the chair is being appointed or reappointed, the deputy chair shall take their place, unless they are standing for appointment, in which case another non-executive director shall be identified and agreed prior to the meeting to take their place. A majority of the committee is made up of governors (at meetings and at Chair/NED appointment panels). The Board Nominations and Remuneration Committee is chaired by the Chair of the Board.
C.2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	The Governors, through the Nominations Committee, agreed and implemented a clear and transparent process for the recruitment of two Non Executive Directors during 2025 and 2026. In accordance with this process, the Nominations Committee identified and assessed suitable candidates and made formal recommendations to the Council of Governors. The Council of Governors approved the appointment of Amanda Rajkumar at its meeting in September 2025, initially as an Associate Non Executive Director from 18 September to 30 November 2025, and as a substantive Non Executive Director from 1 December 2025 for a three year term. At its meeting in February 2026, the Council of Governors approved the appointment of Adam White as a substantive Non Executive Director with effect from 12 February 2026 for a three year term.
C.2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	During 2025/26 GOSH undertook a recruitment process for two non-executive directors (see above). The Trust used an external consultancy agency, Odgers Berndtson who have no other connection with the Trust or individual directors.
C.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	The Council of Governors' Nominations and Remuneration Committee comprise the chair of the trust, another independent non-executive director (to be deputy chair of the Committee), the lead governor, two governors from the public constituency and/or the patient and carer constituency, one staff governor and one governor from any constituency (patient and carer, public, staff or appointed).
C.2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	The Council takes into account the views of the Board on the qualifications, skills and experience required for the a new NED position which was also supported by a skills and experience audit in 2024. For the reappointment of the NED, the committee considers the results of the NED's appraisal, attendance, input and engagement with stakeholders including the Council.
C.2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	The annual report includes an overview of the process followed for appointment of a new Chair and NEDs. The terms of reference of the Council Nominations and Remuneration Committee are available on the GOSH web.
C.2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	The Foundation Trust conducted a Council election in November 2025 for new Governors to be elected and commence from 1 March 2026. The names of governors submitted for election or re-election was accompanied by sufficient biographical details and prior attendance and performance of those governors submitted for re-election is available to members in the Trust's annual report.
C.2.10	A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	The Trust Board Nominations and Remuneration Committee terms of reference details these requirements.
C.2.11	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	The Trust Board Nominations and Remuneration Committee terms of reference details these requirements. In February 2026, the Council approved the appointment of the new Chief Executive, who wis joining the Trust in June 2026.
C.2.12	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.	This process is documented in the Trust Constitution.
C.2.13	Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	This process is documented in the Trust Constitution.
C.2.14	The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.	The terms and conditions of the NEDs were revised and approved by the Council in November 2024. The T&Cs for the Chair were considered by the Council of Governors in November 2022. The letter of appointment clearly sets out the time commitment as does the job description. Significant commitments and experience are presented to the Council when considering approval of the appointment. The non-executive directors' significant commitments are reported in the Trust annual report.
C.4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	Directors on the Trust Board are subject to the Fit and Proper Person Test in accordance with NHSE's framework. The Trust has a Fit and Proper Person's Policy to support the process and adherence to the NHSE Framework. The FPPT does not apply to governors of a foundation trust but governors have a Code of Conduct which includes, values, behaviours, and interests.
C.4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	This information is included in the annual report (accountability report) and on the Trust website.
C.4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.	Neither the Chair nor any Non-Executive Director has served more than nine years from the date of their first appointment. All Non-Executive Director terms and extensions are managed in line with the NHS Code of Governance. Kathryn Ludlow's term was extended beyond six years and was subject to rigorous review, with approval from the Council of Governors and agreement with NHS England. The extension, initially from 5 September 2024 to 4 September 2025 and subsequently to 30 November 2025, was granted exceptionally to support continuity while recruitment to two Non-Executive Director vacancies was underway.
C.4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	The Foundation Trust conducted a Council election in November 2025 for terms to commence from 1 March 2026. The names of governors submitted for election or re-election was accompanied by sufficient biographical details. Prior attendance and performance of those governors submitted for re-election is available to members in the Trust's annual report. In accordance with the GOSH Constitution, governors do not serve more than two consecutive terms (one term is three years, so a maximum of six years) to ensure they retain objectivity and independency required to fulfil their roles and this position was observed during the election process in November 2025.
C.4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	The CQC conducted an independent well-led inspection of the Trust in March 2025, and the Trust was rated Good overall. Following July 2025 assessment, the CQC also rated the Trust Good for well-led. The CQC found that leaders were inclusive and fostered a strong culture of safety, where staff felt valued, and confident to raise concerns. The Trust operates a formal annual process to evaluate the performance of the Board Committees, the Chair and individual Directors, in line with the NHS Code of Governance Each year, the Council of Governors agrees the process for evaluating the Chair and Non Executive Directors, most recently in February 2026, in accordance with the NHS England Framework. The Senior Independent Director leads the evaluation of the Chair.

C.4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	All directors are subject to performance evaluation, identifying any personal professional development requirements. Non-executive directors individually attend professional development events and the Trust Board invites external speakers to Board meetings.
C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.	A Well-Led inspection was conducted by CQC (published July 2025), and the Trust was rated Good. The next the next externally facilitated developmental review is to be confirmed.
C.4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: - holding the non-executive directors individually and collectively to account for the performance of the board of directors - communicating with their member constituencies and the public and transmitting their views to the board of directors - contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.	An evaluation of the Council was conducted in April 2025 and the analysis of the results presented to the Council in July 2025 along with an action plan. The Council was kept updated on progress made against the recommendations which they approved.
C.4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.	The Constitution details the process for removal of a governor including the requirements to attend a certain number of Council meetings and management of potential conflicts of interest. A Standard Operating Procedure outlining the process for managing governor attendance is in place.
C.4.10	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.	The Trust's Consitution already includes a process for governor removal in line with NHS England's model core constitution.
C.4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	A Trust Board skills analysis was undertaken in 2024. The results informed the Board Succession Plan which was reviewed and approved by the Trust Board in October 2024 and the Council of Governors in November 2024. Another skills analysis exercise will be conducted in Q2 2026/27.
C.4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	The Trust Board is aware of this requirement.
C.4.13	The annual report should describe the work of the nominations committee(s), including: - the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline - how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition - the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives - the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served - the gender balance of senior management and their direct reports.	This information is presented in the annual report. The Trust Board Nominations and Remuneration Committee and the Council of Governors' Nominations and Remuneration Committee have current Terms of Reference. A Trust Board skills knowledge and experience audit was undertaken in 2024 and used to form a succession plan to support the development of a diverse board. Another skills analysis exercise will be conducted in Q2 2026/27. The job description for the chair recruitment clearly states: The best boards are those that reflect the workforce and communities they serve. We particularly welcome applications from all protected characteristics including women, people from local black, Asian and minority ethnic communities, and people with disabilities, who we know are all under-represented in these important roles.
C.5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	All director and governors receive a full induction when joining. For directors, they attend the GOSH Induction Day and additional 121's are arranged to meet other memebers of the Trust Board, their teams (as relevent) and external stakeholders. In addition NEDs are offered external training, such as the NHSP NED induction course. Governors, recieve a dedicated Induction session with the Corporate Affairs Team, and an externally led training session on effective questioning/holding to account. Governors also have lunch and learn session. Both directors and governors receive an Induction Handbook and multiple resources.
C.5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	The Chair ensures that the directors and governors continually update their skills throught the board development programme and Governor lunch and learn sessions.Regular Trust Board Development Sessions are held throughoui the year. The Council of Governors have lunch and learn session. De-biasing recruitment training available on GOSH Gold; the online GOSH training platform and members of the Board and Council are asked to complete the training before sitting on interview panels.The Board attended an antiracism tranning session in Q4 2024/25. The Trust Anti-Racism Statement was launched on 03 November 2025 setting out the Trust commitment to become an anti-racist organisation.
C.5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	Upon appointment, all directors and governors are provided with a robust induction and handbook including the values, policies and procedures adopted by the trust.
C.5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	New directors and governors receive information as part of their induction and are required to attend a tailored Trust corporate induction programme. Induction programmes for the Chair, NEDs and Executive Directors include initial induction meetings with system partners. An example is the Chairs induction which included the GOSH Charity, NCL ICS, NHSE, UCL Medical School, UCL Partners and GOSH/UCL Institute of Child Health. The Director induction programme includes a series of induction meetings, including other NEDs and Directors, the Lead Governor and access to external facilitated training such as NHSP NED induction courses. The Board invites external speakers to present at Board development and strategy sessions. The Governor induction process includes external speakers attending and training on roles and responsibilities. Governors receive information on an on-going basis via presentations to meetings and separate lunch and learn session.
C.5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	The Chair discussed training and development with NEDs during their appraisal meetings, as they relate to their role on the Board.
C.5.6	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	Governors are offered a through induction programme and regular lunch and learn sessions, of which the topics are agreed via discussions at council meetings or are requested by governors.
C.5.7	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients.	The Trust Board and Council of Governors are provided with relevent information on quality, performance, finance and partnership working in a timely manner as described. The Trust Board met six times a year and have additional strategy and Board development sessions inbetween. The Council of Governors meet quarterly, updated on ICS plans and activity when required via the CEO report or seperate reports.
C.5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	Directors and governors receive accurate, timely and clear information ahead of Trust Board and Council of Governor meetings. The Chair holds private meetings with NEDs each month to enable clarification to be sought. The Chair also meets with the governors privately before each Council of Governors meeting to answer any questions or clarifications.

C.5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	With support from the Company Secretary, the Chair ensures good information flow between meetings, assurance committees, Trust Board and the Council of Governors. Each board assurance committee produces a summary following each meeting that is presented by the NED Committee Chair to both the Trust Board and the Council of Governors. Governors are also given the opportunity to observe board assurance committees to both enable them to observe NEDs performance and to best understand the business of the Trust and improve there overall knowledge and understanding. A robust induction process is in place for directors and governors as well as professional development opportunities as required.
C.5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	The Board receives an integrated quality and performance report at every public meeting, providing concise and timely assurance on key issues. Any significant matters are escalated to the Board promptly by email where necessary, rather than waiting for the next scheduled meeting. The Chair /Company Secretary communicate directly with governors between meetings on significant issues to ensure timely information sharing. The communications team provides regular press and media updates to the Board and Council of Governors to support wider awareness and context. The Council of Governors receives a monthly newsletter highlighting key developments, training opportunities, and engagement events with members. Feedback from the 2025 governors' effectiveness survey confirmed that meetings are well chaired, information is clear and appropriately pitched, and governors are given sufficient opportunity for discussion and to raise matters outside the formal agenda. It was recommended that a rolling calendar of meetings be published on GovernorHub to support forward planning.
C.5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	The non-executive directors request deeper analysis of high risk areas during Board and assurance Committee meetings. Access to external assurance/ advice is made available on request, for example legal advice around agreements regarding large scale development contracts or commercial matters.
C.5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	Where requested, external advice is sought, for example legal advice or HR advice.
C.5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	The Company Secretary, Deputy Company Secretary, Head of Corporate Governance and Trust Board Administrator supports the duties of the Board, Council and their respective committees.
C.5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	Non-executive directors provide feedback on information received at Board meetings. As a result and where necessary, additional information is provided/ professional and legal advice is sought. Non-executive directors conduct an Annual Effectiveness review for each Board Assurance Committee they are a member of and this includes questions on timeliness of information and appropriate challenge.
C.5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	During 2025/26 Governors were regularly updated on the annual plan which was adopted by the Trust at its Board in March 2025. At its April 2025 meeting, the Governors were provided with an update on the planning process leading to the Annual Planning Statement which was required to be submitted to NHS England by 27 March 2025. Governors were given the opportunity to comment on the Trust Integrated Plan for 2026/27 – 2030/31. The Plan was developed in response to initial national guidance issued in September 2025. Throughout the year, Governors and the Corporate Affairs team hosted in person sessions, including #MissionGOSH workshops and the RBC Race for the Kids event, to gather views and recruit members. The Trust has also continued to consult with the local community, patients, and governors on the design of the Children's Cancer Centre. During 2025-26 we have canvassed the opinion of members by inviting them to: •Participate in the development and launch of the new Trust Strategy 'Together We Power Care' •Participate in the refreshing Trust Values.
C.5.16	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.	The Trust Board engaged with the Council of Governors in a timely manner on the development of the 2026/27 Annual Plan. At its meeting in November 2025, the Council was updated on the planned approach and timetable for preparation of the Annual Plan, in line with NHS England expectations. The Council of Governors received and considered the Organisational Integrated Plan, including the national planning framework and its implications for the Trust. The Board considered the views expressed by the Council of Governors as part of the planning process and subsequently informed the Council how those views were taken into account in the Trust's plans, including explanations where specific suggestions could not be incorporated.
C.5.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	This cover is provided under the LTPS (NHSR). The Trust has also arranged top up insurance to provide additional indemnity for risks not covered by the NHSLA e.g.: • Claims made against the Entity itself • Past Directors, Governors, Employees.
D.2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	The Audit Committee presents an annual report within the Trust Annual Report. Three NEDs are members of the Audit Committee. The Chair of the Board is not a member and the deputy chair/ senior independent director do not chair the audit committee. At least one member has recent and relevant financial experience and the committee as a whole has competence relevant to the sector in which the trust operates.
D.2.2	The main roles and responsibilities of the audit committee should include: - monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them - providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy - reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself - monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors - reviewing and monitoring the external auditor's independence and objectivity - reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements - reporting to the board of directors on how it has discharged its responsibilities.	The Audit Committee presents an annual report within the Trust Annual Report. The Audit Committee's terms of reference outlines its role and responsibilities.
D.2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.	A procurement exercise was completed in 2024/25, resulting in the appointment of Ernst & Young as the Trust's external auditor with effect from 1 April 2025, and is compliant with this Code provision from this date.
D.2.4	The annual report should include: - the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed - an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans - an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	The Trust Annual Report includes an Audit Committee annual report and covers the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed and the effectiveness of the external audit process. The Audit Committee's terms of reference outline its role and responsibilities.

D.2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.	The Trust Annual Report includes an Audit Committee annual report and covers the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed and the effectiveness of the external audit process. The Audit Committee considers application of the non audit services policy and reports this to the Council of Governors.
D.2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	These statements are presented in the annual report.
D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	The Trust Board regularly discussed the trust's emerging and principal risks through the Board Assurance Framework. These risks are also discussed with the Risk, Assurance and Compliance Group who make recommendations to the Board Assurance Committees and Trust Board on any changes, additions to the Board Assurance Framework. The Annual report discloses the trust's emerging and principal risks within the 'our purpose' section and the Annual Governance Statement. The Chief Executive report to each Board meeting also horizon scans for risks to delivery of the strategy.
D.2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	The Trust is compliant with preparing and reviewing the annual governance statement. The Risk Assurance and Compliance Group (RACG) comprises executives, quality, safety and also compliance leads. The Group is chaired by the Chief Executive and reports to the Audit Committee, the Quality, Safety and Experience Assurance Committee and the People and Education Assurance Committee. The RACG monitors the effectiveness of risk management systems and the control and assurance processes across the Trust, including the effectiveness of the controls cited to mitigate the strategic risks on the Board Assurance Framework (BAF) and the timeliness of the closure of gaps in controls and assurances of these risks. It considers the breadth of compliance requirements applied to the Trust and monitors responses to external and internal reviews of services and implementation of the policy governance framework. The assurance committees (NED led) conduct deep dives into BAF risks at every meeting, with NEDs posing questions to seek assurance about the robustness of the controls cited and timeliness of the actions in place to close gaps.
D.2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.	This statement is presented in the annual report and states that the Trust is a going concern.
E.2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. - Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. - Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. - Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary. - For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors. - The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	Executive directors are not awarded annual bonuses. The Nominations and Remuneration Committee remuneration policy has the flexibility to consider whether an element of performance related pay will be included within senior manager contracts. This is consistent with NHSE guidance.
E.2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure	The Chair and Non-Executive Director remuneration is compliant with NHS England's guidance.
E.2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	The current Chief Finance Officer serves as a non- executive director on University Hospitals North Midlands NHS Trust and retains earnings from this role. This is disclosed in the Remuneration Report within the Annual Report.
E.2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.	All executive director contracts require 6 months' notice period. The Chief Executive and executive director terms and conditions of employment are set by the Board Nominations and Remuneration Committee (except for pension entitlements which are managed in accordance with the provisions of the NHS Pension Scheme). Contracts issued to directors allow the Trust to terminate employment in accordance with employment legislation (for instance, for unsatisfactory performance, capability, ill health). On termination due to poor performance, directors receive their right to notice of dismissal (except in cases of gross misconduct where dismissal without payment of notice can occur) and any other relevant contractual entitlement (such as payment of outstanding annual leave). Non-contractual payments on dismissal cannot occur without the authorisation of the Remuneration Committee and taking into account guidance from external bodies NHSE and the Treasury); the Committee, therefore, can ensure Directors are not financially rewarded (beyond their contractual entitlements) if their employment is terminated on the grounds of poor performance.
E.2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).	Not applicable in this reporting period.
E.2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	The Trust Board has established a Nominations and Remuneration Committee, chaired by a NED and including all non- executive directors as members (therefore complying with the requirement for at least three independent NEDs) and the Chief Executive plus the Director of HR and OD who sits as an advisor when required. Terms of reference are in place. A remuneration consultant was not employed during the period.
E.2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	The terms of reference of the Trust Board Nominations and Remuneration Committee covers these areas and follows NHS England guidance.
E.2.8	The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.	The Council of Governors' Nominations and Remuneration Committee is responsible for recommending remuneration levels for non-executive directors to the Council of Governors. The remuneration for the Chair and NEDs was last considered in November 2023 and is due for consideration in November 2026.
Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	The annual report lists members of the council of governors, including their constituency or organisation, whether they were elected or appointed and their tenure. The report also identifies the nominated lead governor which is decided by the council annually.
Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	All governors are promoted on the Trust website and members can communicate with them via the foundation trust GOSH email address. This information is also presented in the annual report. Governors are invited to produce an article for members in the monthly Get Involved members newsletter and to get involved in membership engagement events.
Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	All NEDs are invited to attend Council of Governors meetings and executives attend where required by the agenda, with the CEO , CFO and Company Secretary as regular attendees. The annual report outlines how the Board and the Council of Governors have worked together during the year.

Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	This has not be required in the reporting period.
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Letter of representations: Audit of NHS single entity financial statements

[To be prepared on the entity's letterhead]

[Date]

Mark Hodgson
Audit Partner
Ernst & Young LLP
One Cambridge Square
Cambridge North
Cambridge
CB4 0AE

This letter of representations is provided in connection with your audit of the financial statements of Great Ormond Street Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2026. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to form an opinion as to whether the financial statements give a true and fair view of (or 'present fairly, in all material respects,') the financial position of *Great Ormond Street Hospital NHS Foundation Trust* as of 31 March 2026 and of its financial performance (or operations) and its cash flows for the year then ended in accordance with UK adopted International Financial Reporting Standards as interpreted and adapted by the 2025/26 HM Treasury's Financial Reporting Manual (the 2025/26 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.

We understand that the purpose of your audit of our financial statements is to express an opinion thereon and that your audit was conducted in accordance with International Standards on Auditing (UK), which involves an examination of the accounting system, internal control and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor necessarily be expected to disclose - all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

A. Financial Statements and Financial Records

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated 09 December 2025, for the preparation of the financial statements in accordance with UK adopted International Financial Reporting Standards as interpreted and adapted by the 2025/26 HM Treasury's Financial Reporting Manual (the 2025/26 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.

Letter of representations: Audit of NHS single entity financial statements

2. We acknowledge, as members of management of the Trust, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position, financial performance (or results of operations) and cash flows of the Trust in accordance with UK adopted International Financial Reporting Standards as interpreted and adapted by the 2025/26 HM Treasury's Financial Reporting Manual (the 2025/26 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England, and are free of material misstatements, including omissions. We have approved the financial statements.
3. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.
4. As members of management of the Trust, we believe that the Trust has a system of internal controls adequate to enable the preparation of accurate financial statements in accordance with UK adopted International Financial Reporting Standards as interpreted and adapted by the 2025/26 HM Treasury's Financial Reporting Manual (the 2025/26 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England that are free from material misstatement, whether due to fraud or error.
5. We believe that the effects of any unadjusted audit differences, summarised in the accompanying schedule, accumulated by you during the current audit and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

We have not corrected these differences because [specify reasons for not correcting misstatement].

Or

There are no unadjusted audit differences identified during the current audit and pertaining to the latest period presented.

B. Non-compliance with laws and regulations, including fraud

1. We acknowledge that we are responsible to determine that the Trust's business activities are conducted in accordance with laws and regulations and that we are responsible to identify and address any non-compliance with applicable laws and regulations, including fraud.
2. We acknowledge that we are responsible for the design, implementation and maintenance of a system of internal control to prevent and detect fraud and that we believe we have appropriately fulfilled those responsibilities.
3. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

Letter of representations: Audit of NHS single entity financial statements

4. We have no knowledge of any identified or suspected non-compliance with laws or regulations, including fraud that may have affected the Trust (regardless of the source or form and including without limitation, any allegations by “whistleblowers”), including non-compliance matters:
 - Involving financial improprieties
 - Related to laws or regulations that have a direct effect on the determination of material amounts and disclosures in the Trust’s financial statements
 - Related to laws and regulations that have an indirect effect on amounts and disclosures in the financial statements, but compliance with which may be fundamental to the operations of the Trust’s business, its ability to continue in business, or to avoid material penalties
 - Involving management, or employees who have significant roles in internal control, or others
 - In relation to any allegations of fraud, suspected fraud or other non-compliance with laws and regulations communicated by employees, former employees, analysts, regulators or others.

C. Information Provided and Completeness of Information and Transactions

1. We have provided you with:
 - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
 - Additional information that you have requested from us for the purpose of the audit; and
 - Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.
2. All material transactions have been recorded in the accounting records and are reflected in the financial statements
3. We have disclosed to you the use of all applications or tools using artificial intelligence, including generative artificial intelligence, that are reasonably likely to have a direct or indirect material effect on the financial statements.
4. We have made available to you all minutes of the meetings of the Board/Governing Body and committees (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the year to the most recent meeting on the following date 18 June 2026.
5. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Trust’s related parties and all related party relationships and transactions of which we are

Letter of representations: Audit of NHS single entity financial statements

aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the year end. These transactions have been appropriately accounted for and disclosed in the financial statements.

6. We believe that the methods, significant assumptions and the data we used in making accounting estimates and related disclosures are appropriate and consistently applied to achieve recognition, measurement and disclosure that is in accordance with UK adopted International Financial Reporting Standards as interpreted and adapted by the 2025/26 HM Treasury's Financial Reporting Manual (the 2025/26 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.
7. We have disclosed to you, and the Trust has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.
8. From 01 April 2025 through the date of this letter we have disclosed to you, to the extent that we are aware, any (1) unauthorized access to our information technology systems that either occurred or is reasonably likely to have occurred, including of reports submitted to us by third parties (including regulatory agencies, law enforcement agencies and security consultants), to the extent that such unauthorized access to our information technology systems is reasonably likely to have a material effect on the financial statements, in each case or in the aggregate, and (2) ransomware attacks when we paid or are contemplating paying a ransom, regardless of the amount.

D. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.
2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal counsel.
3. We have recorded and/or disclosed, as appropriate, all liabilities related to litigation and claims, both actual and contingent, and have disclosed in Note **IX** to the financial statements all guarantees that we have given to third parties.

E. Going Concern

1. Note 1.2 to the financial statements discloses all the matters of which we are aware that are relevant to the Trust's ability to continue as a going concern, including significant conditions and events, our plans for future action, and the feasibility of those plans.

Letter of representations: Audit of NHS single entity financial statements

F. Subsequent Events

1. Other than described in Note 28 to the financial statements, there have been no events subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

G. Other information

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises the elements of the Remuneration and Staff Report to be audited and other information published together with the audited financial statements in the Annual Report and Accounts.
2. We confirm that the content contained within the other information is consistent with the financial statements.

H. Climate-related matters

1. We confirm that to the best of our knowledge all information that is relevant to the recognition, measurement, presentation and disclosure of climate-related matters has been considered, including the impact resulting from the commitments made by the Trust, and reflected in the financial statements.
2. The key assumptions used in preparing the financial statements are, to the extent allowable under the requirements of UK adopted International Financial Reporting Standards as interpreted and adapted by the 2025/26 HM Treasury's Financial Reporting Manual (the 2025/26 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England, aligned with the statements we have made in the other information or other public communications made by us.

I. Agreement of Balances and key judgments

1. We have disclosed to you details of all transactions and judgments we have made on income and expenditure, payable and receivable balances with counterparties irrespective of whether or not they have been included in the 2025/26 Agreement of Balances Exercise
2. We have agreed balances, disputes and claims with all NHS bodies via the Agreement of Balances process and where not agreed, we have reported the matter to you.
3. We have disclosed to you all of the risks and judgments we have made in arriving at the Trust/ICB's reported financial outturn for financial year ended 31 March 2026.

J. Segmental reporting

1. We have reviewed the operating segments reported internally to the Board and We are satisfied that it is appropriate to aggregate these as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:

Letter of representations: Audit of NHS single entity financial statements

- The nature of the products and services
- The nature of the production processes
- The type or class of customer for their products and services
- The methods used to distribute their products

K. Ownership of Assets

1. Except for assets recognised as right-of use assets in accordance with IFRS 16 *Leases*, the Group and Trust has satisfactory title to all assets appearing in the balance sheet(s), and there are no liens or encumbrances on the Group and Trust's assets, nor has any asset been pledged as collateral. All assets to which the Group and Trust has satisfactory title appear in the balance sheets.
2. All agreements and options to buy back assets previously sold have been properly recorded and adequately disclosed in the consolidated and Trust financial statements.
3. We have no plans to abandon lines of product or other plans or intentions that will result in any excess or obsolete inventory, and no inventory is stated at an amount in excess of net realisable value.
4. There are no formal or informal compensating balance arrangements with any of our cash and investment accounts. We have no other line of credit arrangements.

L. Use of the Work of a Specialist

1. We agree with the findings of the specialists that we engaged to evaluate the Property, Plant & Equipment valuation, and have adequately considered the qualifications of the specialists in determining the amounts and disclosures included in the financial statements and the underlying accounting records. We did not give or cause any instructions to be given to the specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an effect on the independence or objectivity of the specialists.

M. Estimates

Property Valuation Estimate

1. We confirm that the significant judgments made in making the Property Valuation (including land and buildings) have taken into account all relevant information of which we are aware.
2. We believe that the selection or application of the methods, assumptions and data used by us have been consistently and appropriately applied or used in making the Property Valuation.

Letter of representations: Audit of NHS single entity financial statements

3. We confirm that the significant assumptions used in making the Property Valuation appropriately reflect our intent and ability to carry out materially correct valuations on behalf of the entity.
4. We confirm that the disclosures made in the consolidated and Trust financial statements with respect to the accounting estimate(s), including those describing estimation uncertainty are complete and are reasonable in the context of UK adopted International Financial Reporting Standards as interpreted and adapted by the 2025/26 HM Treasury's Financial Reporting Manual (the 2025/26 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.
5. We confirm that appropriate specialized skills or expertise has been applied in making the Property Valuation.
6. We confirm that no adjustments are required to the accounting estimate(s) and disclosures in the consolidated and Trust financial statements.

Allowances for Credit Losses (Contract Receivables) Estimate

1. We confirm that the significant judgments made in making the Allowances for Credit Losses (Contract Receivables) have taken into account all relevant information of which we are aware.
2. We believe that the selection or application of the methods, assumptions and data used by us have been consistently and appropriately applied or used in making the Allowances for Credit Losses (Contract Receivables).
3. We confirm that the significant assumptions used in making the Allowances for Credit Losses (Contract Receivables) appropriately reflect our intent and ability to calculate a materially correct allowance for credit loss on behalf of the entity.
4. We confirm that the disclosures made in the consolidated and Trust financial statements with respect to the accounting estimate(s), including those describing estimation uncertainty are complete and are reasonable in the context of UK adopted International Financial Reporting Standards as interpreted and adapted by the 2025/26 HM Treasury's Financial Reporting Manual (the 2025/26 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.
5. We confirm that appropriate specialized skills or expertise has been applied in making the Allowances for Credit Losses (Contract Receivables).
6. We confirm that no adjustments are required to the accounting estimate(s) and disclosures in the consolidated and Trust financial statements.

Letter of representations: Audit of NHS single entity financial statements

Provisions Estimate

1. We confirm that the significant judgments made in making the Provisions have taken into account all relevant information of which we are aware.
2. We believe that the selection or application of the methods, assumptions and data used by us have been consistently and appropriately applied or used in making the Provisions.
3. We confirm that the significant assumptions used in making the Provisions appropriately reflect our intent and ability to calculate a materially correct provision on behalf of the entity.
4. We confirm that the disclosures made in the consolidated and Trust financial statements with respect to the accounting estimate(s), including those describing estimation uncertainty are complete and are reasonable in the context of UK adopted International Financial Reporting Standards as interpreted and adapted by the 2025/26 HM Treasury's Financial Reporting Manual (the 2025/26 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.
5. We confirm that appropriate specialized skills or expertise has been applied in making the Provisions.
6. We confirm that no adjustments are required to the accounting estimate(s) and disclosures in the consolidated and Trust financial statements.

N. Comparative information – corresponding financial information

1. A review of our treatment in relation to contracts held with NHS England has highlighted an adjustment to prior year Income and Expenditure figures of £53.912 million. A prior period adjustment has been made to show the correct position. The restatement impacts gross Income and Expenditure only and does not impact the net surplus for the year.
2. The comparative amounts have been correctly restated to reflect the above matter and appropriate note disclosure of this restatement has also been included in the current year's financial statements.

Yours faithfully,

Margaret Monckton (Chief Financial Officer)

Gautam Dalal (Chairman of the Audit Committee)



**Great Ormond Street
Hospital for Children**
NHS Foundation Trust

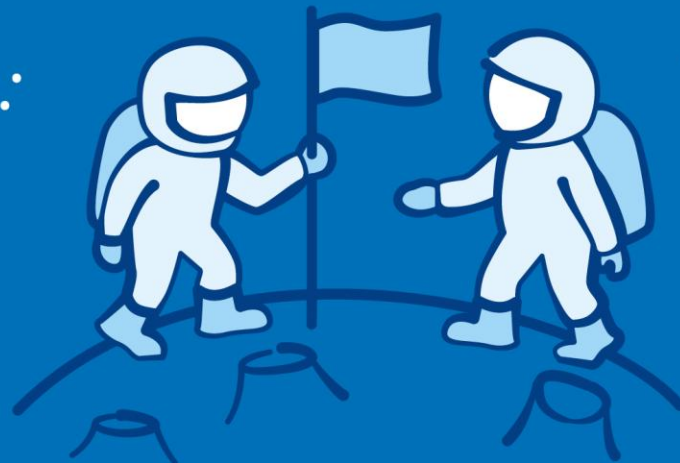
Trust Board 18 June 2026	
GOSH Trust Values Submitted by: Sarah Ottaway, Acting Director of HR&OD	Paper No: Attachment G ☐ For approval
Purpose of report To present the final output of co-creation exercise undertaken to refresh the Trust's values and behaviours.	
Summary of report The attached reports set out the rationale, development and planned implementation of GOSH's refreshed Values and Behaviours, aligned to the "Together We Power Care" strategy. The work responds to a challenging and changing context, recognising that clear, lived values are critical to providing direction, building trust and supporting consistent decision-making. The programme has been extensively co-created with over 2,700 staff, patients, families and partners through surveys, focus groups and engagement activity, ensuring strong ownership and authenticity. Three core values have been defined (Collaboration, Respect and Curiosity) underpinned by a value statement and explicit behaviours to guide how staff work together, deliver patient-centred care and drive innovation. A phased implementation and embedding plan has been developed, including a Trust-wide launch (planned for 20 th July pending Board approval of the values), leadership toolkits, and integration into key processes such as appraisal, staff recognition and professional development. Overall, the framework establishes a cultural foundation to enable safer, more connected and consistently excellent care.	
Patient Safety Implications A strong organisational culture and clearly embedded values are critical to patient safety, as they shape staff behaviours, decision-making, and willingness to speak up about risks or errors. A positive, open culture encourages learning, transparency, and continuous improvement, reducing the likelihood of harm.	
Strategy Pillar Together We Shape How We Care	
Equality impact implications An inclusive organisational culture and strong equality-focused values helps ensure fair, equitable access to care and reduce disparities in patient outcomes across different groups. When staff feel respected and supported, they are more likely to deliver compassionate, culturally competent care that meets the needs of our patients.	
Financial implications None	

Strategic Risk BAF risk 12: Culture
Action required from the meeting Trust Board is asked to approve the Values statements and associated behaviours included in this report, prior to the launch, adoption and embedding programme.
Consultation carried out with individuals/ groups/ committees The values and behaviours have been co-created with staff and key stakeholders. Wide staff engagement took place throughout late 2025/26 via focus groups, surveys, interviews and roadshows across the Trust as well as specific leadership engagement through targeted sessions such as the Senior Leaders Forum.
Who is responsible for implementing the proposals / project and anticipated timescales? Deputy Director of HR&OD, Associate Directors of HR&OD
Who is accountable for the implementation of the proposal / project? Director of HR&OD



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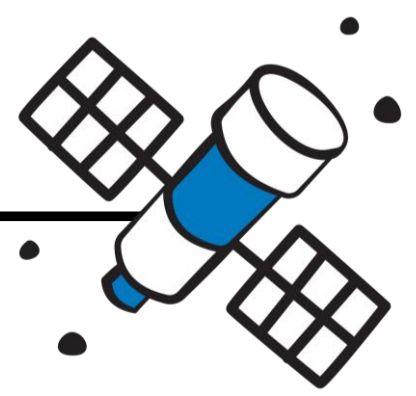
**TOGETHER WE
POWER CARE**

Our Values & Behaviours

Trust Board - 18 June 2026



Together We Shape How We Care



Big Move

Together we will build a culture of connection and collaboration to deliver brilliant, safer care in our hospital, in partnership, and out into the world.



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**TOGETHER WE
POWER CARE**

Our Values

For over 170 years, GOSH has advanced care for children and young people with rare and complex conditions, so they can fulfil their potential.

Our purpose hasn't changed, but the world around us has.

You told us what GOSH looks like at its best.

A place where every voice matters.

Where we work together.

Where asking questions leads to new possibilities.

And where speaking up leads to action.

In these conversations, we built our new values, shaped by you for you.

Collaboration - We work together to deliver safe, consistent, patient centred care.

Respect - We treat everyone with respect, kindness and equity.

Curiosity - We stay curious to drive innovation that delivers exceptional patient outcomes.

Our values are the foundation for our future, they define who we are, and how we work.

This is how we show up.

For each other, and for every child and young person we are here for.

Now it's time to build on everything that has brought us here, and work Together to Power Care.

Values and Behaviours

COLLABORATION

We work together to deliver, safe, consistent, patient-centred care.

I do this by:

- Listening to patients, families, caregivers and colleagues and acting on what I hear when making decisions.
- Working across teams and services, not in isolation.
- Actively working with patients, families, caregivers, partners, communities and other healthcare providers beyond the hospital to treat the whole child.

RESPECT

We treat everyone with respect, kindness and equity.

I do this by:

- Communicating clearly, openly and truthfully.
- Seeking and valuing all voices and contributions equally, even under pressure.
- Creating safe spaces where everyone feels able to speak up and know action will follow.
- Treating everyone with equity and fairness, regardless of role, level or background.

CURIOSITY

We stay curious to drive innovation that delivers exceptional patient outcomes.

I do this by:

- Recognising when things have gone well and building on that success.
- Being open about what is and isn't working and taking responsibility for fixing problems.
- Asking questions and trying new ideas safely and sharing what I learn.
- Embracing opportunities to learn and striving for excellence in everything I do.

Visual Identity



Our values

Collaboration • Respect • Curiosity

Our values



Collaboration



Respect



Curiosity

Visual Identity

Corridor poster



Pull-up banner



Visual Identity

Desktop screen saver



PowerPoint slide



Launch and embedding

Foundations & Awareness (Mar - May)

Getting clear and aligned

- Leadership alignment on values and future direction
- Clear, shared values narrative
- Early communications and manager preparation

Pre-launch socialisation (May - July)

Creating connection and ownership

- Showing how staff shaped the values
- Collating staff voices and shared stories about hopes for the future
- Preview of what will change and when

Trustwide Launch (20th July)

Making values and behaviours visible and real

- CEO & Exec – led launch and visible leadership commitment
- Values in action through staff and patient stories
- Clear tools and systems available from day one

Knowledge & Capability Building (Jul – Nov)

Helping people know what good looks like

- Values and behaviours published
- Manager toolkits and conversations
- Learning sessions and refreshed leadership development

Reinforcement & System Integration

(June –Apr 27)

Embedding Values into how we work

- Values built into recognition, appraisals and development
- Recognition of positive behaviours
- Ongoing governance, communication and role modelling

Measuring Success & Long-Term Impact

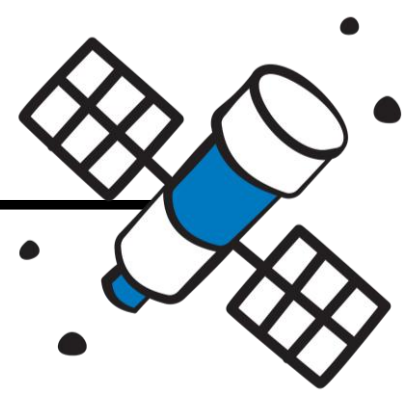
(from Nov onwards)

Knowing what's making a difference

- Use of existing staff, inclusion and engagement measures
- Stories and feedback alongside data
- Regular review through governance and leadership forums

A clear, phased approach helping leaders and teams build confidence, consistency and shared expectations over time

Launch Plan



Launch event – 20th July 2026

Assets ready for launch:

- Visual identity

- Animation video

- Leaders launch kit (inc. tools for team discussions, prompts for values-based conversations)

- GEMS

- Appraisal

Assets ready for August:

- Trust induction

- Updated Disciplinary Policy and Process

Followed by a programme of adoption and embedding



Measuring Impact

Adoption Dashboard

Awareness & Understanding (Are people clear on the values?)

% of staff who can recall values (pulse survey)
% of teams completing “values into action” activity
Leader self-assessment of confidence in role modelling

Behaviour in Practice (Are values being lived?)

Staff survey questions:
 “We collaborate effectively”
 “I feel respected and treated fairly”
 “I feel safe to speak up”
Freedom to Speak Up metrics (volume + resolution)
Recognition nominations linked to values
Themes from patient feedback referencing behaviours

Workforce Experience (Is culture improving?)

Staff engagement scores
Inclusion data
Staff turnover and retention
Sickness absence (stress-related)

Embedding and Impact

Organisational Impact (Is it affecting care & outcomes?)

Patient experience scores (FFT / qualitative themes)
Complaints relating to communication/respect
Safety culture indicators (incident reporting openness)
Cross-team working indicators

Embedding and Integration

Track whether values are becoming “how we work”:
% of appraisals referencing values
Leadership 360 feedback aligned to behaviours
Audit of decisions/papers referencing values

Qualitative Insight

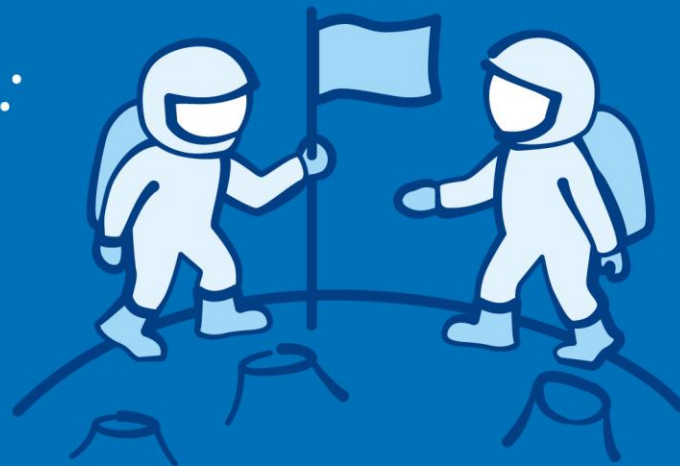
Include stories alongside data:

- staff stories
- patient/family examples
- examples of behaviour-driven improvement



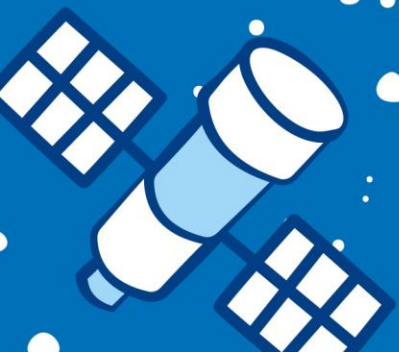
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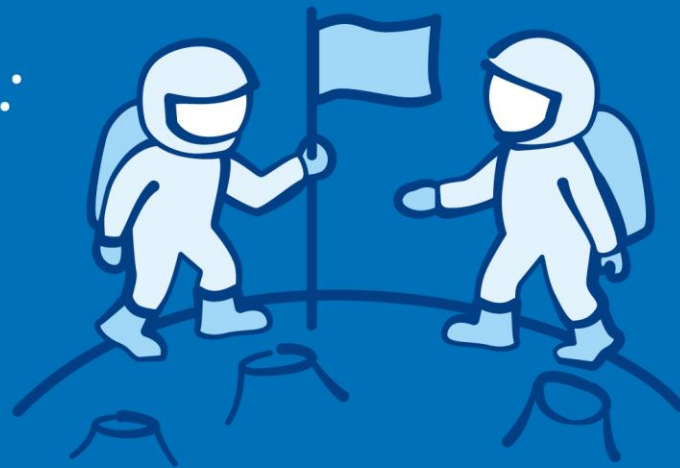
**Thank you
Any questions?**





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**TOGETHER WE
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GOSH Values & Behaviours

Background reading

Trust Board - 18 June 2026



Why now?

- The challenging context we operate in, coupled with our new strategy has given us a moment **to strengthen our culture deliberately**
- In uncertain times, clear values and behaviours provide:
 - **Direction** for decisions
 - **Trust** between leaders and teams
 - **Stability** for the workforce

But values alone aren't enough.

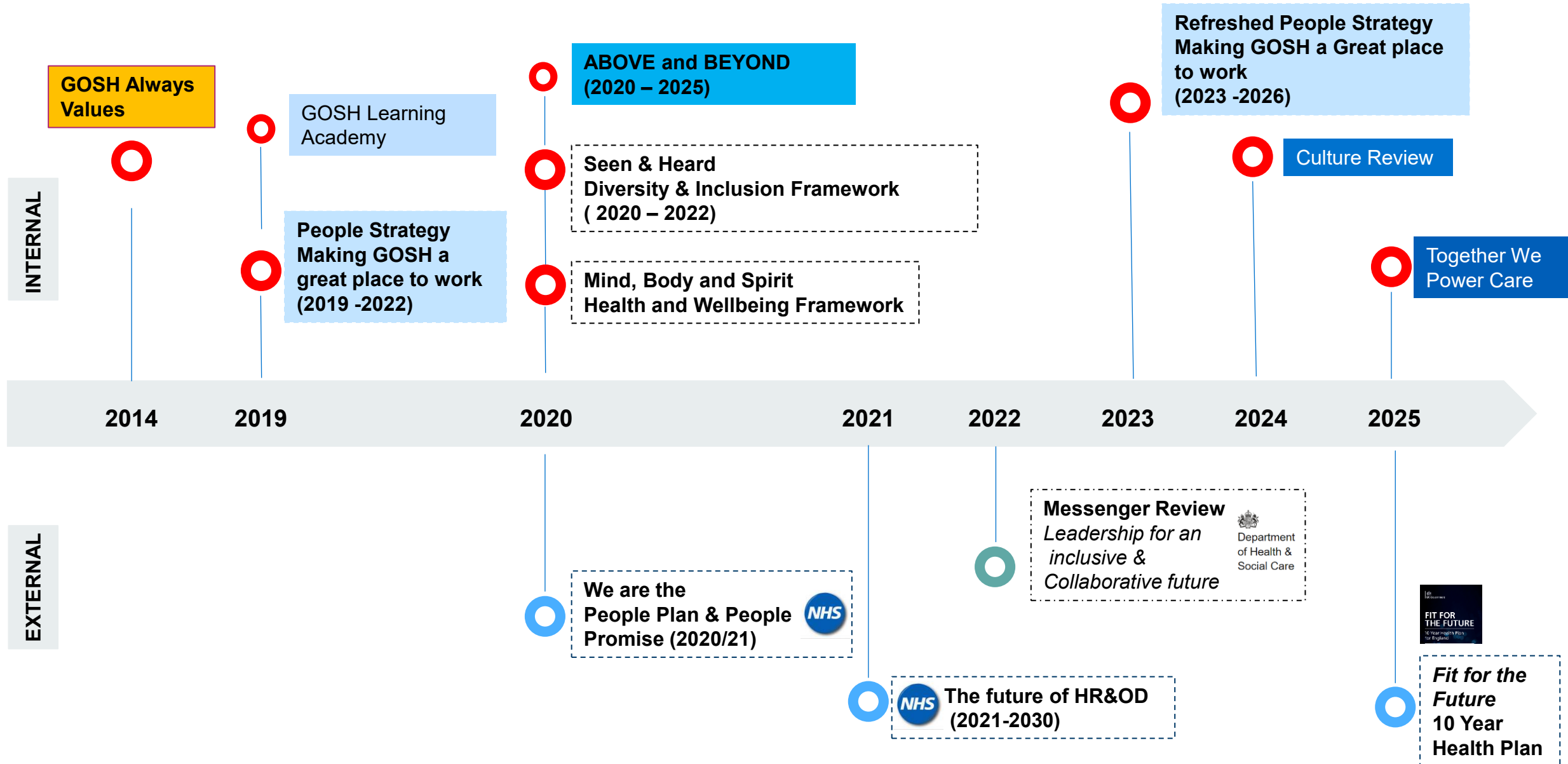
- **Values only matter when they are lived** – through consistent behaviours, especially under pressure

Connecting with the strategy

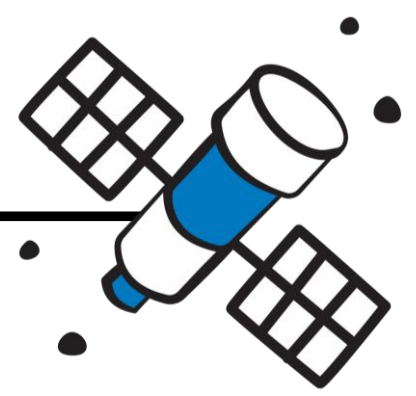
- The launch of our strategy was the catalyst for the values creation process
- By launching the process alongside our strategy, this re-enforces connection and demonstrates the role our values play as enablers of our strategic priorities.

A strong, Values-led culture will us to lead through change consistently and effectively

The journey so far – strategic context



Together We Shape How We Care



Big Move

Together we will build a culture of connection and collaboration to deliver brilliant, safer care in our hospital, in partnership, and out into the world.



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**TOGETHER WE
POWER CARE**

Values and Behaviours Programme

Phase 1 Preparation	Phase 2 Co-creation	Phase 3 Validation & Design	Phase 4 Launch & Early Adoption	Phase 5 Embedding – sustaining
Aug – Oct 2025	Nov 2025 – Jan 2026	Feb – Apr 2026	May – July 2026	July 2026 onwards
• Programme governance in place • Programme socialisation • Facilitator Selection • Launch Comms Campaign • Launch Staff Survey Values questions	• Programme socialisation • Change Impact assessment • Focus Group Facilitator Training • Focus Groups • Lagoon co-creation activity • Patient activity • Senior Leadership Forum Session • Change Readiness Assessment	• Co-creation session with YPF • Parents, family, carer Café • Analyse outputs • Steering group validation sessions • EMT & Board Sign-off	• Launch and implementation plan • Trust-wide campaign assets and launch activity (including films) • Senior leader engagement • Leader / manager toolkits • An executive engagement strategy • Scoping and embedding priorities	Integrating the values and behaviours into leadership practice, people processes and decision-making. The detailed work programme for phase 5 will be developed following completion of the phase 4 scoping activity.

A genuinely co-created approach

Co-creation with staff & stakeholders

- **Ownership and authenticity:** People support what they help create. The more inclusive the process, the more the values will be seen as real and relevant.
- **Resilience during change:** When people feel heard and valued, they are better able to navigate uncertainty and remain committed to shared goals.
- **Sustainable impact:** Values that emerge from within are more likely to be embedded in daily practice, becoming lived behaviours and not just words on a page.

• **Wide staff engagement**

Focus groups, surveys, interviews and roadshows across the Trust

• **Leadership involvement**

Senior leaders engaged through SLF and targeted sessions

• **Patient, family and carer voices**

Bedside activity, YPF forum and 1:1 conversations

• **Strong participation**

Higher- than – planned engagement with staff and leaders

Focus Groups

12% of our staff (**754** individuals) contributed to a focus group

Hour long face to face sessions with trained facilitators, using structured questions to explore themes:

- What’s it like to work at GOSH today?
- Innovation, discovery and impact
- Belonging, collaboration and learning
- Embracing the whole body, mind and family

Staff Type	Attendees
Nursing & ODPs	208
AHPs	130
Medical & Dental	88
Healthcare Scientists	23
Pharmacy staff	39
Estates & Ancillary	44
Senior Leaders	110
Research & Innovation staff	22
Admin & Clerical	80
Staff Side and Networks	4
Governors	6
TOTAL	754

Staff Survey

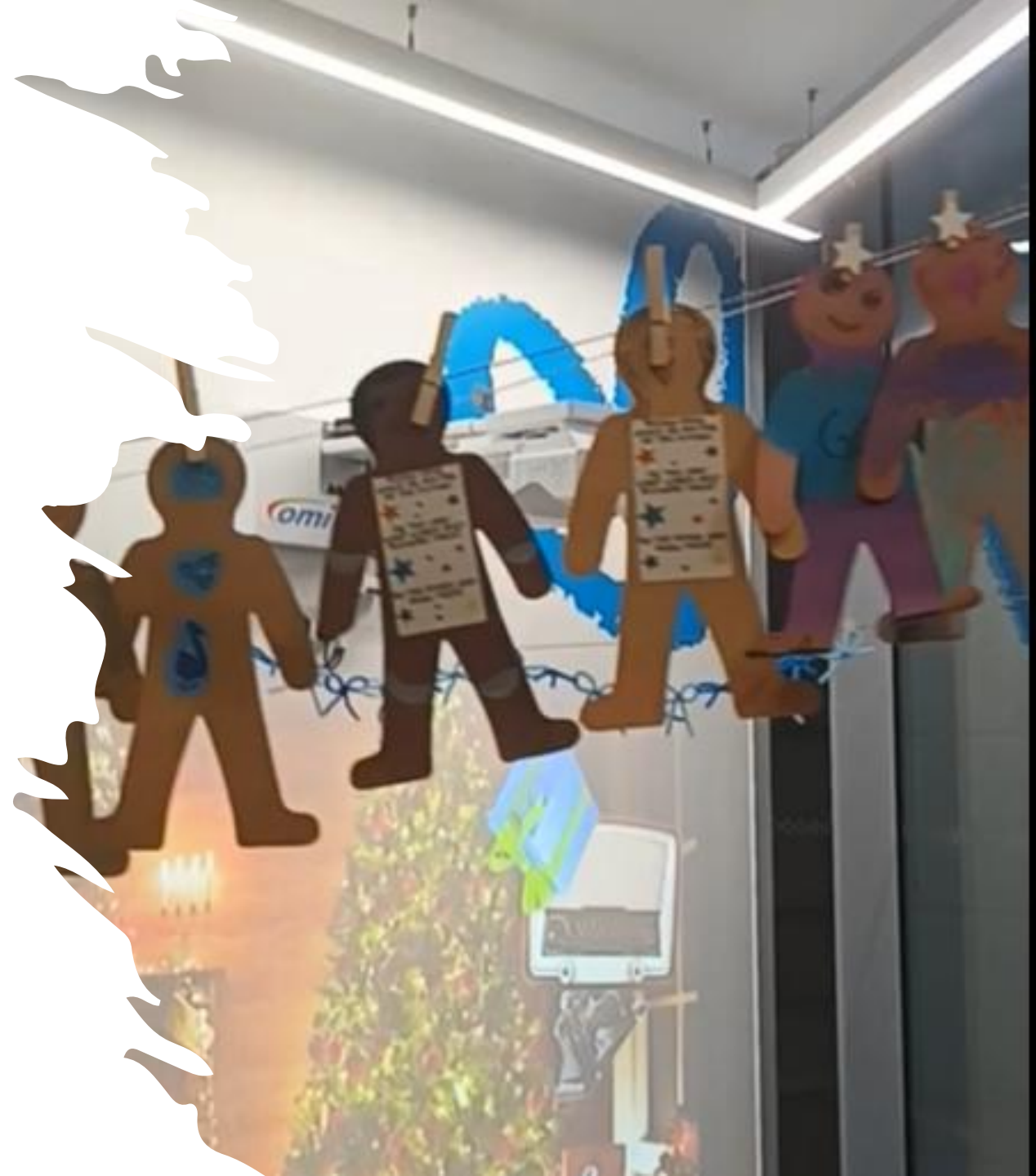
30% of our staff (**1,883** individuals) gave their input via bespoke questions in the annual staff survey

1. What three words would you use to describe GOSH at it’s best?
2. What behaviours do you see colleagues demonstrating that will help us start to build a better GOSH?
3. In tough and trying times, what characteristic would you like to see demonstrated at GOSH?
4. We collaborate effectively to deliver more for patients and families (Strongly Agree – Strongly Disagree)
5. GOSH takes meaningful action to make this the best place to work (Strongly Agree – Strongly Disagree)

Staff Group	Number of responses
Administrative and Clerical	528
Nursing Registered	501
Additional Clinical Services	169
Medical and Dental	162
Add Prof Scientific & Technic	151
Allied Health Professionals	149
Healthcare Scientists	128
Estates and Ancillary	95
TOTAL	1883

Patients, Families, Carers and Young People

- Fifty patients, supported by their families, participated in a creative engagement activity. In addition
- ward-based and outpatient engagement with parents and carers captured a further **46 voices** through one-to-one conversations
- An interactive session was also held with the Young People's Forum
- Trust's Governors participated in a dedicated focus group.



What did co-creation tell us?

A shared picture of GOSH at its best

- Deep pride in our mission and impact on children
- World-class care driven by innovation and learning
- Strong commitment to collaboration and professionalism in patient care
- Team connection brings people together, combining strengths to achieve our shared purpose

Consistent themes from staff, patients and families

People told us what they need most in tough and uncertain times is..

- **Kindness and compassion**, especially under pressure
- **Respect and fairness**, regardless of role or band
- **Feeling valued and listened to**, not just counted
- **Honest communication**, even when decisions are hard

What gets in the way of GOSH being at its best - consistently

- Working as **one team** isn't always the lived experience
- We don't always have the **courage to challenge and improve**
- We speak up, but don't always **listen or act**
- **Respect** isn't felt consistently
- **Transparency and trust** aren't always there

These issues shape our people's everyday experience

Testing and Validation

In March, the programme moved from co-creation into structured validation to test the emerging Values and Behaviours and ensure they are credible, inclusive, clearly articulated and supportive of the Trust's ambitions. Two options were presented :

Option1: Statement of Intent

Option 2: Value and Qualification Statement

Six validation sessions were delivered:

- **Four sessions with staff,**
- **One with the Senior Leaders Forum and,**
- **One session with young people and their families.**

All colleagues who participated in focus groups were invited to take part in conversations to validate the proposed values and behaviours they helped to co-create.

In addition, a dedicated session was held with **pan-network** representatives to ensure a cross-section of perspectives was reflected

Questions posed:

- If these values and behaviours were lived, would they support delivery of the strategy?
- Does this feel authentic and focused on the right things?
- If these behaviours were lived consistently, would you feel valued as an employee?
- Is the central role the patient in our organisation clear enough?
- What does 'curiosity' as a word mean to you?
- Do they feel aspirational?
- Does the language resonate?
- Does the tone feel accessible?
- Is there anything missing?

Our Values Statements

COLLABORATION

We work together to deliver, safe, consistent, patient-centred care.

RESPECT

We treat everyone with respect, kindness and equity.

CURIOSITY

We stay curious to drive innovation that delivers exceptional patient outcomes.

Values and Behaviours

COLLABORATION

We work together to deliver, safe, consistent, patient-centred care.

I do this by:

- Listening to patients, families, caregivers and colleagues and acting on what I hear when making decisions.
- Working across teams and services, not in isolation.
- Actively working with patients, families, caregivers, partners, communities and other healthcare providers beyond the hospital to treat the whole child.

RESPECT

We treat everyone with respect, kindness and equity.

I do this by:

- Communicating clearly, openly and truthfully.
- Seeking and valuing all voices and contributions equally, even under pressure.
- Creating safe spaces where everyone feels able to speak up and know action will follow.
- Treating everyone with equity and fairness, regardless of role, level or background.

CURIOSITY

We stay curious to drive innovation that delivers exceptional patient outcomes.

I do this by:

- Recognising when things have gone well and building on that success.
- Being open about what is and isn't working and taking responsibility for fixing problems.
- Asking questions and trying new ideas safely and sharing what I learn.
- Embracing opportunities to learn and striving for excellence in everything I do.

Visual Identity



Our values

Collaboration • Respect • Curiosity

Our values



Collaboration



Respect



Curiosity

Visual Identity

Corridor poster



Pull-up banner



Visual Identity

Desktop screen saver



PowerPoint slide



Visual Identity

Trifold leaflet



'Table talker'



Narrative

For over 170 years, GOSH has advanced care for children and young people with the rarest and most complex conditions in the world. Our core purpose, and the dedication of our people who live it every day, has not changed.

But the world around us has. The evolving NHS structures, financial pressure and new models of care have created significant change for us. We have responded to this by restructuring, changing what we do and how we do it and by developing Together We Power Care - an ambitious five-year strategy launched in October 2025 to shape care in the hospital and beyond.

Our current values and behaviours were created over 10 years ago and now need to evolve to reflect the world we live in, and to reflect the new strategy.

Our strategy sets out **what** we need to do. Our values and behaviours shape **how** we do it. From October 2025 , we launched a Trust-wide programme to refresh our values and supporting behaviours.

2,733 colleagues from clinical and non-clinical teams, patients, families and carers, networks, Senior Leaders and The Young People's Forum helped co-create the values – sharing their views on who GOSH is and who we need to be. Their input helped build the values and behaviours. We then went back to these groups to validate what we had created.

Narrative cont.

Our new values and behaviours are an opportunity for us to reset as an organisation and reimagine what makes GOSH great now and in the future. In the focus groups colleagues across the Trust told us that GOSH works at its best when these new behaviours are demonstrated.

Three new values statements were developed:

Collaboration - We work together to deliver safe, consistent, patient-centred care.

Respect - We treat everyone with respect, kindness and equity.

Curiosity - We stay curious to drive innovation that delivers exceptional patient outcomes.

Underpinned by the behaviours that will enable them to be lived every day.

Our values and behaviours set the foundations for the culture we want to build, and how GOSH works when it is at its best. They will shape how our hospital operates, how our teams work together, how individuals show up, and how we care for our patients and families.

They reflect what is already great about GOSH, and they clearly set out the things we need to do differently.

We built these values together. Now every one of us has a part in living them and bringing them to life every day. Over the coming months we will be looking at our ways of working and updating them to ensure they reflect the new values and behaviours. This will cover everything from recruitment, recognition and appraisals right through to leadership development.

Key messages

Connection to the strategy

This work is a key enabler of the “*Together We Shape How We Care*” pillar of the strategy, supporting the development of a culture grounded in connection, collaboration and accountability to deliver brilliant, safer care for children and families.

While our strategy helps clarify *what* we need to do, it is our values and behaviours that will shape *how* we do it.

Our Always Values were not working as hard for us as they could, they were developed for a different era of work.

Our values and new behavioural framework have been designed to reflect who we are today and who we aspire to be tomorrow.

Why are values and behaviours so important now?

Our values and behaviours set the foundations for the culture we want as an organisation. They are in equal measure reflective of who we are and who we want to become as an organisation.

They will play a significant role in how our hospital operates, how our teams interact with each other, caregivers, system partners and our patients.

Values and behaviours will set the tone of the organisation, how we treat one another, how we make decisions and how we lead change.

When an organisation is going through change, clearly defined values act as an anchor. They give people confidence in their actions and decisions, even when situations are complex or changing.

We are entering one of the most challenging periods in our history. The financial pressures facing the Trust are intensifying, and despite major efforts over the past year, the gap between what it costs to deliver our services and the funding we receive continues to widen. These changes will require all of us to work differently, flexibly, creatively and with a shared commitment to using our time, our spaces and our resources wisely. Our values will help us to do this consistently and effectively.

Key messages cont.

How did we decide what the new values and behaviours should be?

We used thematic analysis to help understand what we heard and how it could help us understand both the lived experience of our people but also where they felt we could do things differently or consistently to drive our strategy forward.

All of your amazing insight helped us produce three new values statements, and a set of behaviours that will support their delivery.

What our values will enable

Strengthen connection and trust between leaders and staff.

Guide our day-to-day actions, help us make decisions and prioritise what truly matters, in line with our strategic goals.

Help us to embed the strategy more effectively and consistently across GOSH.

Provide us with an opportunity to reset as an organisation and team.

Make it easier for our leaders and managers to set expectations, measure performance, and hold each other accountable.

Provide a consistent framework for us to rethink our processes and ways of working so that we operate consistently and effectively irrespective of our role.

How will we embed the values across the Trust?

We will change processes and ways of working to ensure they reflect our new values and behaviours, will use them to help make decisions and resolve problems. In addition, we will also look at key moments like recruitment, recognition, reward, development and performance management.



Trust Board 18 th June 2026	
2025-26 National Cost Collection Pre-submission report Submitted by: Petra Black, Deputy Chief Finance Officer & Costing Team	Paper No: Attachment H ☐ For approval
Purpose of report The purpose of this report is to provide assurance on the robustness of the processes underpinning the mandated National Patient Level Cost Collection, and to outline how PLICS data will be used to support improvements in care pathways, efficiency, and value. This is the first of two reports to the Committee, with a further report to follow post final submission.	
Summary of report Nationally, all Trusts are required to submit the mandated annual National Cost Collection as a condition of the NHS Provider Licence. The Trust is required to submit its final return to NHS England on, or before, 3 July 2026, in line with national guidance. The collection includes the costs and activity of services provided to NHS patients at Great Ormond Street Hospital (GOSH) and has been prepared in accordance with NHS England Approved Costing Guidance. The effective use and harnessing of PLICS data provides a powerful strategic tool to support evidence-based decision-making, enabling the Trust to better understand cost drivers, improve care pathways, maximise value, and ultimately enhance patient outcomes. • The national cost collection is being prepared in line with Approved Costing Guidance, with submission planned from the week commencing 8 June 2026 and final sign-off by <u>25 June 2026</u>. • All service costs and activity will be submitted at patient level using PLICS, with the cost quantum reconciled to the Trust's audited financial accounts and supported by robust validation and assurance processes. • Costs and activity are being benchmarked against the Trust's prior year submission, national averages, and Specialist Children's Alliance Trusts to support validation, identify variation, and inform understanding of relative efficiency. The Trust remains compliant with costing standards and continues to develop PLICS as a strategic tool to support evidence-based decision-making. NHS England is expected to transition from NCC to a Local Cost Collection (LCC) model from 2027/28, aligning national requirements more closely with locally produced PLICS data and improving timeliness and usability of costing information.	
Patient Safety Implications None	

Strategy Pillar Together We Advance Discovery, Innovation and Impact by improved insight into patient level costing data.
Equality impact implications None
Financial implications The costs collected are used as the basis for tariff setting in future years and therefore have an impact on future income recognition for GOSH. In addition, it provides a measure of efficiency against other Trusts and provides data to benchmark GOSH services against other providers, such as other Specialist Children's Hospitals.
Strategic Risk BAF Risk 1: Financial Sustainability
Action required from the meeting • Board to note the changes to the National cost collection process for the 2025-26 return. • Board is asked to endorse and approve the following: ○ the plan (shown above) is sufficient to meet the requirements to produce the costing submission by the deadline date. Submit our first internally reviewed submission into the national portal on <i>10th June</i>. ○ senior review and sign off to ensure the return have been prepared in accordance with the Approved Costing Guidance ○ processes to validate the activity and costing data with services and ○ the information gap analysis and costing standards gap analysis have both completed and any issues addressed as part of the planning process.
Consultation carried out with individuals/ groups/ committees External engagement with NHS England costing responsible for NCC collection and internally review by the costing team and finance as well as regular review with services.
Who is responsible for implementing the proposals / project and anticipated timescales? Petra Black, Deputy Chief Finance Officer
Who is accountable for the implementation of the proposal / project? Margaret Mockton, Chief Finance Officer

2025-26 National Cost Collection Pre-Submission

1. Introduction

All Trusts are required to submit their costed data as patient level to NHS England (NHSE) as a condition of their provider license. The collection contains costs and activity of services provided to NHS patients at Great Ormond Street Hospital (GOSH) using patient level costing information data (PLICS) and this has been prepared in accordance with the NHSE Costing Guidance and the Costing Transformation Programme (CTP).

Previously this collection was known as the Reference Cost collection and providers' costed data at a treatment level, call HRGs (Healthcare Resource Group) and submitting the average unit cost for services.

In recent years, the costing transformation programme has required costs to be collected for each patient and each episode of care across all NHS sectors, including Acute care. This allows us to see the true cost of provide care to patients across the whole treatment pathway across sectors.

PLICS provides a highly detailed and robust source of information on the patients cost of care. This information is used extensively at a national level to inform tariff development, benchmarking through Model Hospital, and wider funding policy decisions. Given the importance of this data, the Board assurance process reflects the significance of the annual cost collection and seeks to ensure strong governance while continuing to raise the profile and understanding of costing across the organisation, particularly at a senior level.

By presenting cost information at individual patient level, PLICS enables more meaningful engagement with clinicians and operational teams. As a specialist organisation, this is particularly important given the complexity and variability of GOSH's patient pathways. The data supports informed discussions on the cost effectiveness of delivering care, helping to shape decisions around resource allocation, service sustainability, and the strategic development of highly and specialised services.

NHS England has increasingly emphasised the expectation that providers actively use patient-level costing information as a core tool to support collaboration between finance and clinical teams. At GOSH, this supports a shared focus on improving quality of care, enhancing value for patients, and ensuring that limited resources are utilised effectively to deliver the best possible outcomes for children and young people.

This year's submission window begins from **8th June to 3rd July 2026**. GOSH's cost collection will aim to be submitted and signed off by the **25th June 2026**.

2. Harnessing the power of patient – level costing information

The NHS continues to operate within a financially constrained environment, with increasing demand for care and limited resources. Improving the Trust's understanding of the cost of care is therefore a key enabler for effective decision-making, financial sustainability, and the delivery of high-quality care.

For GOSH, this is particularly important given the complexity of its patient case mix and the specialised nature of services delivered. A clear understanding of costs across patient pathways supports benchmarking, informs tariff development, and ensures resources are used effectively.

Enhanced insight into patient level costing data enables the identifies variation, inefficiencies, and key cost drivers for services we deliver. It also supports the evaluation of service developments and new models of care, ensuring that decisions on investment and service configuration are evidence-based.

Historically, the use of PLICS data has been limited due to its complexity and the time required to produce outputs. The Trust has therefore strengthened its analytical capability to provide more timely and accessible information, supporting engagement with clinical and operational teams.

PLICS data is increasingly being used to support service redesign, cost improvement programmes, and assessments of service sustainability. The Trust has also expanded its use of costing data to include analysis of patient complexity and integration with operational data to support a broader understanding of service performance. Examples of how PLICS data has been applied are included in the Appendix 1.

3. Costing Assurance on PLICS Data

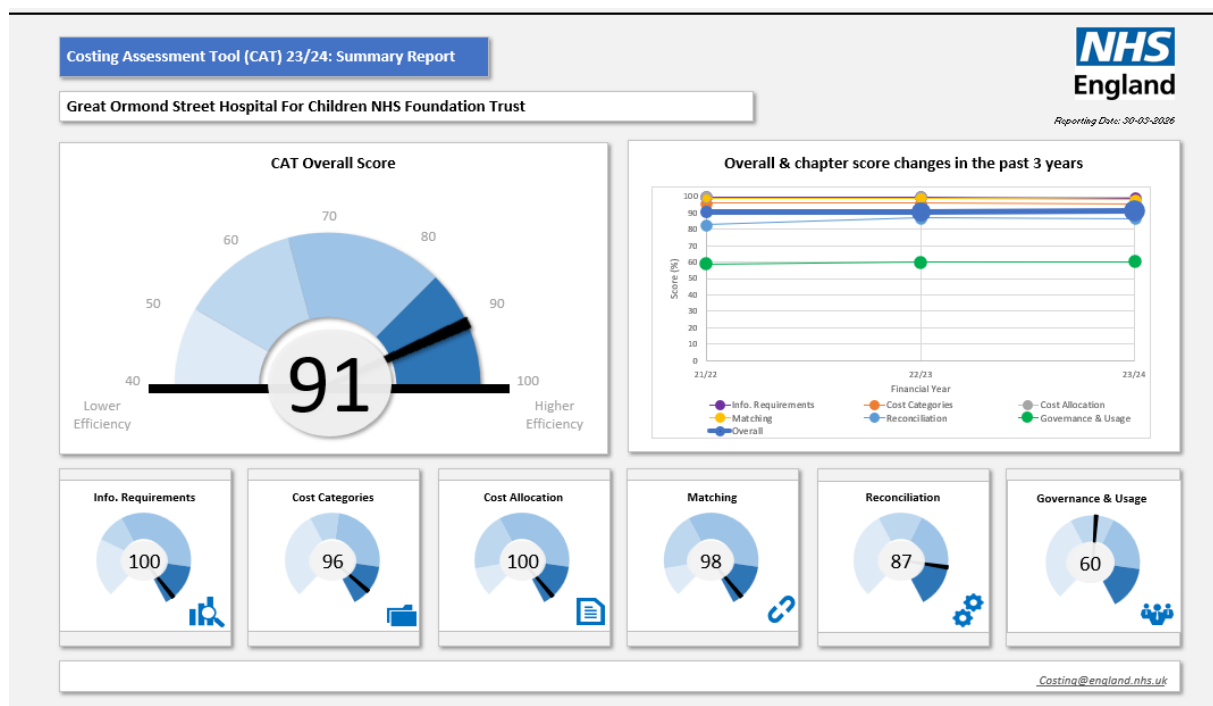
The annual cost collection where we use our business-as-usual PLICs data are basis will be prepared in line with the national guidance requirements and costing standards. The costing team continuously reviews and implements the required changes to the treatment, and apportionment of costs, ensuring ongoing compliance and changes to costing standards are made in line with approved costing guidance.

The Trust applies the NHSE costing assurance framework, which provides a structured approach to ensuring the quality, integrity and governance of costing within the NCC.

3.1 Costing Assurance Tool

As part of this framework, the Trust uses The Costing Assurance Tool (CAT) to assess the compliance with NHSE costing standards, identify areas for improvement, and support continuous development of costing processes.

The Trust achieved an overall score of 91% in 2023/24, reflecting strong compliance in Information Requirements (IR), however there are areas which the Trust achieved lower score in areas of governance, reconciliation due to the on-going engagement improvement of PLICs within the Trust and the use of data within cost allocations. These reflect known challenges associated with the use of historic allocation assumptions and the need to further strengthen data quality and engagement across the organisation.



To address this, the Trust has initiated targeted workstreams to improve the accuracy and robustness of cost allocation methodologies. Key areas of focus include:

- **Consultant job planning data** – representing a significant proportion of the workforce (c.30%), this is a critical building block for accurate patient-level costing. Work is underway with HR and Medical Workforce teams to update and improve job plan data within the PLICS model, ensuring a better understanding of how consultants deliver care to patients.
- **AHP Data** – work is underway working with therapy services to better capture therapy time and care provided to patients using existing information recorded in EPIC.
- **Ward allocation methodologies** – revisions have been made to better reflect current service delivery models and changes in ward utilisation, improving the alignment of costs to patient activity.
- **Overhead allocation methodologies** – updates to floor area data have been implemented to ensure overheads are apportioned more accurately in line with the Trust's estate and service configuration.

These enhancements have improved the accuracy and reliability of costing outputs and better reflect how services are delivered within the Trust. The costing team continues to focus on improving patient-level data and refining costing methodologies, with the aim of strengthening the accuracy, robustness, and usability of costing information across the organisation.

The CAT tool was previously completed in 2023/24 and will be refreshed for 2025/26; this will support a more comprehensive understanding of our current level of compliance with the costing standards and help identify additional areas requiring improvements. A summary of compliance areas is provided in Appendix 2; however, more detailed insights will be available once the 2025/26 CAT has been completed.

3.2 Costing Assurance Improvements

NHSE carry out formal assurance desktop exercises on all NCC 2024/25 submissions through Phase 1 and 2 processes, which provides structured review and validation of submitted costing data. The Trust's feedback from the review process on our previous year submission identified a small number of potential outliers, where the Trusts cost where above national average and with peer groups which is expected as GOSH has a complex case mix.

These areas have been noted and will be subject to further review as part of the 2025-26 submission to ensure all feedback has been reviewed and necessary adjustments made.

4. 25-26 National Cost Collection Plan and Changes

The 2025-26 submission uses Epic data to complete the return for GOSH and has been prepared in line with national costing guidance. There have been minimal essential changes introduced in 25-26 collection, which are listed below:

- Previously in NCC submission windows, there have been designated named days for Trusts to complete final submission and sign-off. However, the submission window is now open allowing Trust to make multiple submission during this period up until the final sign-off, and a submission slot must be booked in advance for the final submission and sign-off.
- Mental health provider spells

There have been changes to the data specification on the mental health data set, whereby few data items have been retired, and new fields have been included.

4.1 National Cost Collection transition to Local Cost Collection Model

NHSE is preparing to transition from NCC model to a new Local Cost Collection (LCC) model, which is expected to become mandated as the new annual national collection from 2026/27 which will be first submitted in summer 2027. The LCC is intended to better align national costing requirements with PLICs already produced locally by Trusts. This approach aims to reduce the reporting burden while improving the timeliness and usefulness of costing data to support the national analysis and local decision making.

The costing team will work with relevant teams and stakeholders to support preparation for the new LCC requirements and ensure the Trust's readiness for expected changes ahead of new collection implementation.

4.2 Costing Plan and Costing Process

This paper is presented to fulfil NHSE requirements by providing the Committee with assurance over the robustness of the costing process and to support approval of the plans for delivering the mandated costing submission for 2025/26.

The Committee is asked to review the costing plan set out below to confirm that it meets the requirements of the Approved Costing Guidance. The Committee has delegated authority from the Board to approve the Trust's costing approach.

Costing Plan

Senior review and sign-off

1. The Trust will utilise the established costing model used in previous submissions, which supports our business-as-usual PLICs reporting and has been subject to internal and external validation. In addition, routine PLICs quality reviews are undertaken to ensure the ongoing accuracy and robustness of costing outputs.
2. The system supplier will provide software updates to ensure the model remains compliant with current costing guidance, providing additional external assurance.
3. Costing methodologies and outputs are reviewed on a regular basis against national costing standards by senior finance management, including the Finance Manager (Costing), costing team, Associate Director of Finance (Financial Management) and Deputy Chief Financial Officer (Deputy CFO). The costing team also works closely with services and business units to validate outputs and ensure costing reflects how care is delivered.
4. Final review of outputs will be undertaken by the Deputy Chief Financial Officer (Deputy CFO), who will formally sign off the submission.

Quantum of cost

The NCC reconciliation will be prepared using the Trust's audited financial accounts and validated with Financial Accounts. Where material changes arise that may impact the submission, the Trust will utilise the resubmission process where appropriate.

Service activity and cost summary

The submission will include all activity and costs for 2025/26. Admitted patient care (APC) and non-APC activity will be reconciled to nationally reported datasets in line with guidance, and any variances will be clearly documented.

Costs and activity will be reviewed against the Trust's prior year submission, 2025/26 national averages, and peer organisations, including Specialist Children's Alliance Trusts, to support benchmarking and validation. Any necessary adjustments will be made with the approval of the Chief Finance Officer.

Validation of activity and costing data

Robust processes are in place to validate activity and costing data with services, including:

1. Planned meetings with clinical managers to review outputs and findings ahead of submission.
2. Regular reviews undertaken with Finance Business Partners for their respective clinical directorates.
3. Application of consistent data sources and methodologies aligned to routine PLICS outputs to ensure consistency and comparability.

Reconciliation and compliance

The Trust will undertake a comprehensive reconciliation and compliance process, including:

1. Reconciliation of key activity data to previously submitted national datasets, including SUS/HES data and contract monitoring information (SLAM).
2. Reconciliation of input costs to the Trust's audited financial accounts, with formal sign-off by the Financial Controller.
3. Completion of a full information gap analysis and costing standards gap analysis to assess compliance with Approved Costing Guidance, with any identified gaps addressed as part of the planning process.

As in previous years, the submission is expected to be substantially compliant with national standards.

Assurance process

As part of the ongoing approach to ensure the accuracy and reliability of the submission, a structured assurance process will be undertaken:

1. The data will be reviewed and validated internally by the Finance and Costing teams.
2. The submission will then be reviewed and considered for approval by the Executive Management Team.
3. During the submission window, NHS England will undertake validation checks using the Data Validation Engine (DVE), with feedback incorporated prior to final submission.

Resourcing and capability

The costing and informatics teams are adequately resourced to produce and validate the submission within the required timeline.

The Trust has an established and experienced costing function and has been producing CTP-compliant PLICs data over several years. The team continues to support wider system development through collaboration and sharing of best practice.

5. Future developments

We are planning to further develop our PLICS into a strategic tool to facilitate evidence-based conversations on improving care pathways, reducing waste, and increasing value.

NCC benchmarking and insight

The Trust is undertaking detailed analysis of National Cost Collection (NCC) outputs to strengthen its understanding of cost performance and relative position. This will support benchmarking against national averages and peer organisations, including Specialist Children's Alliance trusts, and help identify areas of variation and opportunity.

This benchmarking workstream will support identifying services where the Trust may be underfunded, as well as areas where higher costs reflect the complexity and intensity of care delivered to patients. These insights will aid and understand, where the patients we treat are often highly complex and require resource-intensive care across specialties.

It will support the organisation to provide a clearer understanding of how our cost drivers and relative efficiency aid in informing discussions on service sustainability, funding, and improvements. As well as strengthening how we use costing data to support both financial and operational decision-making across the Trust.

The Trust aims to further develop and embed the use of patient-level costing information to support more detailed clinical pathway analysis and improve understanding of how care is delivered across patient pathways.

Clinical Pathway Development using PLICS

Further development of PLICS will enable improved understanding of variation in treatment pathways, particularly for patients with complex conditions and comorbidities. By analysing patient-level costing data, the Trust will be able to identify key stages of care, understand how resources are utilised, and assess the relationship between treatment duration, clinical activity, and overall cost. There is also an opportunity to link this data with external datasets, such as Office for National Statistics (ONS) data, to provide additional insight into outcomes and population characteristics.

This enhanced pathway-level analysis will support improved understanding of cost drivers, pathway efficiency, and variation, helping to inform opportunities to optimise care models, improve patient flow, and enhance patient outcomes. The team is also exploring theatre sessional costing to provide greater insight into utilisation, productivity, and associated costs.

6. Recommendation

- Board to **note** the changes to the National cost collection process for the 2025-26 return.
- Board is asked to endorse and **approve** the following:
 - the plan (shown above) is sufficient to meet the requirements to produce the costing submission by the deadline date. Submit our first internally reviewed submission into the national portal on *10th June*.
 - senior review and sign off to ensure the return have been prepared in accordance with the Approved Costing Guidance
 - processes to validate the activity and costing data with services and
 - the information gap analysis and costing standards gap analysis have both completed and any issues addressed as part of the planning process.

Appendix 1: Examples of current application of PLICs data

Business Case, Strategic Decision Support and Specialised Services

The costing team has played a critical role in supporting strategic decision-making across the Trust and at a national level through the provision of patient-level costing and financial analysis. This has enabled services to better understand cost drivers, assess financial viability, and support evidence-based decisions on service development, investment, and sustainability.

Detailed costing analysis has supported Gastroenterology services in modelling the financial impact of service changes, including the potential transfer of activity from the Royal Free. This work enabled the development of a robust business case by providing a clear understanding of direct, variable, and overhead costs, alongside the implications for capacity and long-term sustainability.

In addition to supporting internal decision-making, the costing team has contributed to national and specialised service initiatives. This includes participation in a multi-trust NHS England exercise to provide detailed cost and activity breakdowns for ECMO services, supporting a broader understanding of the cost of care across providers. The team has also undertaken detailed analysis of high-cost therapies, such as Zolgensma, using PLICS data to assess cost-effectiveness in areas where commissioning arrangements continue to evolve.

Service	Support Provided	Outcome	Strategic Impact
Gastroenterology	Detailed breakdown of direct, variable, and overhead costs	Supported business case for additional Royal Free Hospital activity	Enabled informed service expansion decisions
ECMO	Patient-level costing analysis for Neonatal, Infant, and Paediatric ECMO services	Assessed financial sustainability and resource requirements	Supported long-term service planning

Collectively, this work demonstrates the growing role of PLICS in supporting forward-looking decision-making, moving beyond retrospective costing to actively inform service development, investment decisions, and engagement with national stakeholders. It ensures that complex and specialised services are supported by robust, transparent cost data, strengthening the Trust's ability to plan, negotiate, and deliver sustainable services.

Service Reviews - Service-Level Improvements

As part of a structured programme to improve costing data quality and engagement, the costing team has undertaken detailed "service reviews" with clinical services. These sessions have focused on validating assumptions, improving cost allocation methodologies, and strengthening alignment between costing outputs and operational reality.

Through these reviews, several service-level improvements have been delivered. In Renal Dialysis, overhead and transport allocation assumptions were reviewed and refined alongside updates to nursing activity assumptions, resulting in improved costing accuracy and a better reflection of service delivery.

In Radiology, misalignment in maintenance contract costs was identified and corrected, strengthening the relationship between costs and activity and improving the reliability of reporting. For Perinatal services, enhancements to activity capture and cost allocation methodologies have increased confidence in the accuracy of costing outputs.

Service	Issue Identified	Improvement Made	Result
Renal Dialysis	Transport and overhead allocation assumptions required review	Updated overhead allocations and nursing acuity assumptions	Improved costing accuracy
Radiology	Maintenance contract costs required alignment	Reviewed and corrected allocation of contract costs	Improved cost-to-activity alignment
Perinatal Service	Activity capture and cost allocation required refinement	Improved activity capture and cost allocation approach	Increased confidence in costing model accuracy

The service review programme has been instrumental in strengthening engagement with clinical teams and ensuring that costing outputs accurately reflect real-world service delivery. This has led to greater trust in the data and increased use of costing information in operational and financial discussions.

Contracting and Income Support

The costing team has provided analytical support to inform contract negotiations and assess the adequacy of service funding. This has strengthened the Trust's ability to engage with commissioners and advocate for appropriate reimbursement.

Support has been provided for contract negotiations across services including Child and Adolescent Mental Health Service (CAMHS) and the Newborn Screening Service (NBS) through detailed cost analysis and financial insight.

The team is currently undertaking analysis to identify underfunded services (fragile services) by assessing the gap between income and cost. This is supporting more robust, evidence-based discussions around funding adequacy, particularly for fragile and high-cost services where accurate costing is essential to ensure sustainability and appropriate reimbursement.

Overall, this work enhances the Trust's ability to engage in evidence-based contract negotiations and supports more informed discussions on financial sustainability and resource allocation.

Costing for Complex and Non-Tariff Care

The costing team has developed approaches to support the costing of services where no national tariff exists, including complex and highly specialised patient pathways. This work has enabled a clearer understanding of the true cost of care in areas where standard reimbursement mechanisms are not available.

By providing detailed costing insights, the team has supported bespoke pricing and commissioning discussions, ensuring that complex services are appropriately valued and funded. This has also improved transparency and strengthened the Trust's position in discussions with commissioners.

Training, Engagement and Accessibility

The costing team has continued to invest in training and engagement to improve understanding and use of PLICS data across the organisation. Targeted training sessions have been delivered to business partnering teams, the wider finance function, and clinical services, with a focus on improving understanding of costing methodologies and supporting the practical use of data in decision-making.

In addition, the Costing page on the Trust intranet has been enhanced to improve accessibility of information. This now includes guidance on PLICS, access to QlikView dashboards, frequently asked questions, and supporting documentation. These developments have made it easier for users to access and interpret costing information.

As a result, there has been increased awareness and use of costing data across the organisation, supporting a more data-driven approach to operational and financial decision-making.

Profitability and Financial Insight

The costing team has developed and shared PLICS-based profitability statements at service level, improving visibility of income and costs across the organisation. These outputs have been shared with Associate Directors of Operations (ADOs) to support service-level financial review and performance discussions.

This has enabled more informed conversations around service sustainability, capacity, and efficiency, while also highlighting areas where income does not align with the cost of delivery. As a result, services are better equipped to understand their financial position and identify opportunities for improvement.

Appendix 2: Costing Standards Compliance

Standards Section	Compliant	Improvements	Key risks
CP1. Ensure the correct cost quantum	Yes	PLICS is reported quarterly, with strong alignment between the costing team and finance business partners, supporting high-quality costing information.	No significant risks identified. Continued collaboration and training further strengthen alignment.
CP2. Clearly identify costs	Yes	GL is effectively mapped using a hybrid approach (Level 1 and Level 2), providing a robust and flexible cost classification framework.	No significant risks identified.
CP3. Allocate costs	Yes	Minor gaps in areas such as theatre cost components, patient-level consumables allocation, non-face-to-face activity costing, and documentation of methodologies.	Low risk – continuous improvements enhance accuracy and consistency of patient-level costing.
CP4. Match costs to activities	Yes	High matching rates across most feeds (>95%), with lower matching in medicines dispensed (74%) and supporting contacts (94%).	Minimal risk – ongoing improvements support completeness and accuracy of patient-level costing.
CP5. Reconcile costs	Partial	Strong reconciliation of costs and income (100%), with ongoing enhancements to further strengthen activity reconciliation and costing methodologies.	Low risk – continuous improvements support full reconciliation and data assurance.
CP6. Assure and use cost data (Governance & Use)	Partial	Ongoing work to position PLICS as a key tool for strategic decision-making; increasing executive engagement and use in reporting (e.g. profitability reporting to ADOs).	Low risk – continued development of governance and usage will further enhance decision-making impact.